



Scope it right

Working to top of
scope literature review
Mental health and
addiction workforce



LeVa



Contents

 Executive summary.....	3	<i>Case study: advanced mental health nursing practice in Kilmarnock, Scotland.....</i>	19
Introduction and context	3	<i>Case study: development of social work a ssistant role in Queensland, Australia</i>	20
Defining working to top of scope	3	<i>Case study: youth early psychosis service model in Victoria, Australia</i>	23
Key findings.....	3		
Value of literature review and next steps	4		
Recommendations	4		
 Introduction.....	5	4 - Enhanced capability	24
Context.....	5	<i>Case study: integrated model of care for mental health in Utah and Idaho, USA</i>	26
Areas of focus in this literature review	6	5 - Cultural responsiveness	28
<i>Effectiveness</i>	6	<i>Case study: Te Rau Matatini Māori workforce development in New Zealand</i>	30
<i>Definition.....</i>	6	<i>Case study: Pasifikology psychology group in New Zealand.....</i>	30
<i>Case studies.....</i>	6	<i>Case study: development of expanded Aboriginal primary care service in Northern Territory, Australia</i>	31
<i>Exclusions from the literature review.....</i>	6		
Outline of literature review	7	6 - Professional boundaries and profession-less roles.....	32
<i>Structure of literature review</i>	7	<i>Case study: weight management programme for adult service users in the UK.....</i>	33
		<i>Case study: integrated model of care - dual diagnosis in Victoria, Australia</i>	34
 Methodology	8	7 - Education and training	35
 What is top of scope?.....	8	<i>Case study: inter-professional education - nursing and social work in Hong Kong.....</i>	37
Context.....	8	 Discussion	37
Professional regulation and definition of scope of practice	9	Models of care.....	37
<i>Health Practitioners Competence Assurance Act 2003</i>	9	Role clarity	38
<i>Professional scopes of practice.....</i>	9	Expanded practice.....	38
<i>Regulation and scopes of practice</i>	10	Professional identity.....	39
		Capability	40
New models of care	11	Culturally responsive practice.....	40
<i>Case study: Torbay Care Trust in Torbay, England</i>	12	Leadership	41
<i>Case study: psychiatric outpatient departments in Germany</i>	12		
 Features of top of scope.....	13	 Conclusion.....	41
1 - Role clarity	13	Recommendations	42
2 - Task shifting	15		
3 - Role changes	17	 References	43
<i>Case study: integrated addiction and parenting service in Sydney, Australia</i>	18		
<i>Case study: home care service in Buurtzorg, the Netherlands</i>	18		

Executive summary

Introduction and context

Scope it right - working to top of scope explores the meaning and application of working to top of scope of practice in mental health and addiction (MH&A) services. It also responds to broader policy requirements to more effectively use current MH&A resources, including the workforce.

This document reviews the literature on working to top of scope, so that any subsequent workforce design is grounded in evidence-based practice. The review is aspirational and focuses on the future shape and nature of MH&A service delivery and workforce development.

The outcome of the review has been the identification of a set of features that are essential to:

- support individual employees to work to their potential
- foster an environment of best practice
- enhance the effectiveness of service delivery.

The review identifies barriers to working to top of scope, and contains a number of case studies as contextual examples of the features of working to top of scope.

Defining working to top of scope

The challenge has been to define what working to top of scope means across the broad MH&A workforce,¹ particularly given the varying approaches to regulation, differing degrees of specialisation of practice, and differing emphases on the role of ethics and contextualised decision-making in professional practice, across a multitude of settings.

Working to top of scope is defined as follows:

At a systems-level, working to top of scope means optimising workforce capacity and effectiveness through:

- validating and maintaining current best practice
- developing new roles and new ways of practising
- ensuring that policy, provider, and service environments support these new roles and practices to succeed.

At an individual and practice level, working to top of scope means enhanced opportunities and capacity to utilise specialised knowledge and expertise in a way that is efficient, adaptive, collaborative, holistic and ethical, and fundamentally supports the service user and their wider family and whānau.

Defining working to top of scope in this way acknowledges the necessity of using the existing MH&A workforce better, as well as the importance of developing a more capable workforce. The definition also directs the review towards a system approach: thinking about scope of practice at the level of the model of care, the provider, the service, the team, always with the service user at the centre. The focus on changing roles takes account of specialist and generalist practice, changes in workforce supply, and the evolving nature of MH&A services.

Key findings

This literature review highlights that developing and using models of care are central to enhancing the effectiveness of services and workforce. Models of care provide a framework within which to resolve a range of other issues that are barriers to working to top of scope, such as lack of role clarity, inter-professional disputes, hierarchical practice and unclear practice. Effective and innovative models of care demonstrate a number of key features of working to top of scope including: integration; holistic approaches to the service use pathway; positive and productive inter-professional and inter-agency relationships; shifts in traditional roles and responsibilities; and clear scopes of practice and opportunities for broader (generalist) or deeper (specialist) scopes of practice.

The literature identifies that role clarity is a significant feature of working to top of scope; that roles, tasks and responsibilities need to be clear and explicit at individual, team and professional levels. The changing nature of health practice has led to tasks shifting between roles, with enhanced, enlarged, substituted and delegated roles. Within these changing roles, organisations need to be more specific about what employees are intended to do and why, and more purposeful about using individual expertise effectively and efficiently.

Changing healthcare roles highlight opportunities for working to top of scope, including more responsive practice, more technically specialised practice, innovation, increased collaboration and improved job satisfaction. Expanded practice can also be the cause of job dissatisfaction, where workers lose the opportunity to deliver basic care and support, where there is poor institutional support for expanded practice, and where expanded practice is a means for increased efficiency at the expense of quality of practice.

Inter-professional conflict is commonly cited in the literature as cause for reduced effectiveness and is a significant barrier to working to top of scope. More specifically, professional siloed behaviour, inter-professional disputes and variations

¹ - Includes occupational therapy, nursing, psychology, psychiatry, psychotherapy, social work, addiction practitioners, counsellors, mental health support workers and the peer support workforce.

in practice, professional ownership of practice, and poor knowledge about what others can do, are commonly identified barriers. Much of the literature is clear that professional background should not determine the shape and nature of the care provided. Instead, the emphasis should be on a model of care that is populated by the right mix of workforce skills and capability, including, at an organisational and individual level, the right values and attitudes. There is also emphasis in the literature on inter-professional education and the development of profession-less roles to overcome inter-professional barriers. Critical conversations should be encouraged about the nature of professional identity in the context of changing roles and the development of profession-less roles.

The discussion around capability in the literature highlights features such as multidisciplinary practice, support for reflective and ethical practice through supervision and mentoring, and the development of effectiveness through clear, determined, and consistent leadership. Cultural responsiveness is also considered, in terms of organisational readiness and support for cultural capability across mainstream services, as well as the lack of system-wide commitment to developing a culturally specific or indigenous workforce, which could specialise in bridging the gap between western and indigenous practices.

Value of literature review and next steps

The literature review identifies key features of working to top of scope that support employees to work to their potential, foster an environment of best practice and enhance service effectiveness.

These key features provide useful points of focus for services to use when assessing whether they are providing an environment that supports working to top of scope. The review also provides guidance for workforce development initiatives and organisations around MH&A workforce redesign.

The review will help to inform national, regional and local workforce development planning and initiatives. The review

will also add value to wider sector projects around productivity, education and training of the MH&A workforce, health sector cultural responsiveness, and the development of models of care.

Recommendations

- 1 MH&A services take account of the features of top of scope that support the workforce planning approach described in *Getting it right – workforce planning guide* (Te Pou o Te Whakaaro Nui, 2014b).
- 2 MH&A services consider:
 - how the use of a model of care will enhance workforce effectiveness through assisting roles to work to top of scope
 - how improving role clarity and role changes will lead to improvements in service delivery and service user experience
 - how to incorporate key aspects of enhanced capability (multidisciplinary practice, leadership and supervision) in service development and effective practice
 - how professional identity and professional relationships enhance or limit effective practice.
- 3 The development of mainstream cultural responsiveness and the development of a culturally competent indigenous workforce is a priority for MH&A services and workforce development initiatives.
- 4 Opportunities for innovation in educating and training the MH&A workforce are explored, particularly around enhanced multidisciplinary practice and inter professional education.
- 5 The national MH&A workforce development centres use the results of the literature review to inform and support existing workforce development and training programmes.
- 6 Professional associations consider building capability into scopes of practice.

Introduction

This document reviews the literature on working to top of scope across the range of mental health and addiction (MH&A) services and professions in order to provide an evidence-base for future-focused workforce design. The outcome of the review is the identification of a set of features that support individual employees to work to their potential, foster an environment of best practice and enhance the effectiveness of service delivery. The review identifies barriers to working to top of scope and contains a number of case studies as contextual examples of the features of working to top of scope.

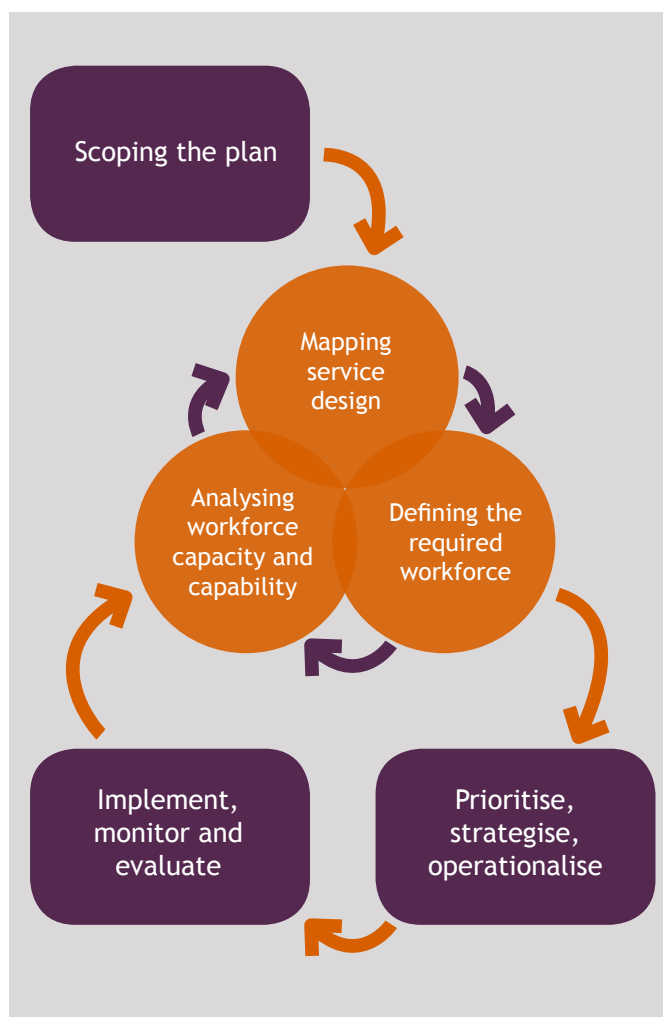
Context

The wider context for this review is the New Zealand government's emphasis on more effective use of current resources in MH&A environments. The Ministry of Health's *Rising to the Challenge* (2012) MH&A policy statement highlights opportunities for improved provider performance, and more efficient and effective service delivery. *Rising to the Challenge* emphasises collaborative work practices, information sharing about innovation and effective practice, improved and demonstrated cultural competence, development of whānau ora initiatives, development of a more explicit model of care in primary care settings, and support for and strengthening of the existing MH&A workforce. In particular, *Rising to the Challenge* states that "greater coordination and integration are required through a shared systems response" (Ministry of Health, 2012, p. 18). Particular types of integration identified in the policy include more seamless and effective services across the primary–specialist continuum, improved consistency of services, and more consistent workforce capability.

This literature review responds to these policy objectives, in particular, the focus on improved effectiveness, integration, collaboration, cultural competence and workforce capability, and considers the shape and nature of future MH&A service delivery and workforce. The emphasis is on workforce planning, in terms of ensuring the right people, skills, place, time, attitude, work, cost and outputs, with the service user at the heart of the process (World Health Organization, 2010b).

The literature review is guided by Te Pou's workforce planning approach, which outlines a systematic step-based structure to workforce planning (Te Pou o Te Whakaaro Nui, 2014a). This literature review provides information for services, in line with steps 2 to 5 of Te Pou's approach, namely:

- **step 2:** mapping service design – this review provides guidance around models of care, future workforce roles and changes to existing roles
- **step 3:** defining the required workforce – this review provides information on some key features to consider when looking at future workforce roles
- **step 4:** analysing workforce capacity and capability – this review supports a gap analysis process that considers the current workforce, and the evidence or otherwise of the key features of working to top of scope, as well as next steps for ensuring top of scope features are built into future workforce roles
- **step 5:** prioritise, strategise, operationalise – this review supports services to prioritise what features of top of scope should be included in a workforce plan.



Areas of focus in this literature review

Effectiveness

This literature review outlines the New Zealand regulatory system that defines scope of practice, including the legal parameters of scope of practice for each professional group working in MH&A services. Beyond these technical issues, the review draws on the literature to identify features of the healthcare system that support individual employees to work to their potential and foster an environment of best practice. The intent of the project is to be able to pinpoint which aspects of the healthcare system have the most impact, in terms of supporting healthcare workers and services to be more effective.

Effectiveness in this context does not specifically mean efficiency (which has a focus on minimising wastage), although more effective practice will often be more efficient. The emphasis on effectiveness focuses instead on the capacity of the system to meet both organisational and individual employee goals and objectives, where those objectives might be, for example, better use of a skill set, or reduced task overlap between employees, or a shift in attitude, or a refocusing of priorities.

Definition

There is not a strong body of literature on top of scope, so the definition of working to top of scope developed is based on a general consensus gleaned from a range of literature. The definition developed is as follows.

At a systems-level, working to top of scope means optimising workforce capacity and effectiveness through:

- *validating and maintaining current best practice*
- *developing new roles and new ways of practising*
- *ensuring that policy, provider, and service environments support these new roles and practices to succeed.*

At an individual and practice level, working to top of scope means enhanced opportunities and capacity to utilise specialised knowledge and expertise in a way that is efficient, adaptive, collaborative, holistic and ethical, and fundamentally supports the service user and their wider family and whānau.

Considering top of scope in this broader way directs the review towards a system approach: thinking about scope of practice at the level of the model of care, the provider, the service, the team, with the service user at the centre. The focus on changing roles takes account of opportunities for enhanced specialist and generalist practice, changes in workforce supply, and the evolving nature of MH&A services. At an individual level, the definition focuses on the workforce being able to use their

skills in the best possible way, both in terms of time spent (what people do) and capability (how they do it).

Case studies

This review provides case studies as contextual, best practice examples of working to top of scope, to add comparative value and utility to the MH&A sector in New Zealand. The case studies selected are all developed-world examples, but otherwise have been selected to represent a range of workforce groups, across the breadth of MH&A services, and primary and secondary settings.

Exclusions from the literature review

The project's scope required that any analysis of working to top of scope should identify the capacity to add value and utility to the MH&A sector. However, the review's analysis is limited to those factors that impact on scope of practice. The review does not directly address health sector productivity, nor does it review the literature on efficiency. There is also a considerable volume of literature on predictors of job satisfaction, and the effects of workload and changes to patient acuity; these aspects are also outside the scope of this review. This review also does not consider the literature on individual skill enhancement, skill mix, or competency.

It is worth noting that the New Zealand Mental Health Commissioner has commissioned a concurrent and separate literature review on health sector productivity. The Mental Health Commission review sits alongside this top of scope review, but takes a more high-level approach. It addresses systemic and organisational responses to health-sector productivity, with workforce being one component of the broader analysis.

A cautionary approach is taken with the international literature, much of which is reactive in terms of pressures around fiscal restraint in healthcare and problems of workforce supply. For example, some of the literature (Elsom, Happell, & Manias, 2009) deals generally with the challenges faced by professional groups in the face of the expansion of nursing practice. There is no doubt that the nursing profession is in a significant state of change and there are numerous consequences for the nature of health services provided, the scopes of practice of other professional groups, and for the practice of nursing itself. However, the filter applied in this literature review is to remain relatively apolitical about the nature of change in the broader health sector, and concentrate instead on examples of enhanced scope of practice, demonstrated benefits in terms of improved provision of care and support, and evidence of improved effectiveness.

Outline of literature review

This literature review has two distinct parts. The first is the development of a definition of working to top of scope that is applicable across MH&A services in New Zealand. This involved a review of legal scopes of practice across the following professional groups: psychiatry, psychology, social work, nursing, occupational therapy and the registered addiction workforce in New Zealand. Some consideration was also given to counsellors, support workers and the peer workforce as significant workforce groups within MH&A services. It also involved a more superficial review of the literature to establish a definition of working to top of scope.

The second phase of the literature review involved a substantial review of the literature to:

- validate the definition
- identify barriers that prevent practitioners practising at the top of their scope, as well as strategies used to overcome barriers
- identify best practice or specific initiatives that are addressing top of scope issues.

Structure of literature review

This introduction is followed by an outline of the review methodology. The next section (What is top of scope?) provides some context for the review, and includes a review of the New Zealand regulatory framework and the scopes of practice for relevant professions where they exist.

The review then shifts into an international context looking at the literature around defining models of care and how healthcare roles are evolving under a model of care approach. The review considers the importance of role clarity and task shifting, and clarifies what is meant by the terms role enhancement, role enlargement, role substitution and role delegation. The expansion of nursing practice is looked at in more detail, because of the significant changes the profession is undergoing and the weight of evidence in the literature around working to top of scope in nursing.

The review then shifts focus onto what the literature says about capability, in particular, capability in the context of ethical and reflective practice, multidisciplinary practice, supervision and leadership. The review also considers cultural responsiveness in terms of the features of top of scope. This is followed by consideration of the impact of professional boundaries, the shift towards profession-less roles, and how the education and training sectors are responding to challenges around professional training.

Barriers to working to top of scope are considered throughout the review, and case studies are used to illustrate points made. The discussion considers the key themes in the literature, and frames those themes in terms of the system-level changes that need to occur to better support the health workforce to work at top of scope.

The conclusion contains recommendations on how the results of this literature review should be considered in the context of broader MH&A workforce planning and development projects.

I Methodology

The literature search was undertaken with the assistance of the reference librarian at the Ministry of Health and focused on scope of practice in health and MH&A sectors. The search was undertaken in May 2014 and looked at grey literature and peer-reviewed studies. Date limits were not applied, however, most of the peer-reviewed results dated from 2005 onwards, with the remainder dated from 1997 onwards.

The primary databases used for peer-reviewed studies were Medline, Psycinfo, Scopus and Google Scholar, and the search strategy focused specifically on MH&A. Most of the grey literature was sourced through a citation-search approach (Booth, 2008). Additional peer-reviewed articles and reports were found using a snowball approach (Greenhalgh & Peacock, 2005). Te Pou provided some reports on workforce development in New Zealand, while additional web-based New Zealand resources were also found using a snowball approach. Limiters were used to limit access to English language articles. The initial search results were dominated by peer-reviewed literature and much of this concerned the expansion of specialist nursing practice. Additional, more specific searches were undertaken to locate literature on cultural capability, non-nursing workforces and inter-professional education. Subsequent searches used the DeepDyve search tool.

Key words used for the initial search included: top of scope, scope of practice, professional role, nurse* role, physician* role, job description, mental disorders, mental health, addiction*, psychiatric department, hospital or emergency services or nursing, social work, productiv*, clinical practice, best practice, clinical competence, specialisation, enrichment, enlargement, expansion, redesign, role clarity, role clarif*, speciality framework, competenc* framework, capability framework.

It's important to note, in the context of the nursing literature, the use of terminology around extended nursing practice. This review does not differentiate between the types of specialised nursing roles, due to differences in terminology throughout the international literature. This review uses the terms expanded nursing practice or specialisation of nursing practice to encompass the terms used in the literature, including: clinical nurse specialist, nurse specialist, advanced nurse practitioner, advanced nursing practice, nurse prescriber, advanced practice nurse and consultant nurse.

I What is top of scope?

Context

The international context for healthcare provision, and workforce supply and demand, is important in terms of framing the discussion around working to top of scope. Much of the literature (Australian Health Workforce Advisory Committee, 2005; Duckett & Breadon, 2014; World Health Organization, 2008) describes the impact of fiscal constraint on health services, as well as the considerable challenges around supplying a workforce to respond more effectively to need. Research by KPMG (KPMG International, 2012a, p. 7) shows that OECD countries face a workforce shortfall of between 22 and 29 per cent by 2022. This shortfall is caused by increased demand driven by medical technology and increased prosperity, and an aging population that both fuels demand and reduces workforce supply, along with increased numbers of the workforce being in part-time work and working fewer hours (KPMG International, 2012a, p. 8).

Santos and Amaral (2011, p. 330) describe a new “era of accountability” in healthcare, and the international research is replete with analyses of enhanced workforce productivity, skill mix and cost-effectiveness that focus on increasing efficiency within an expanding appetite for health intervention and a diminishing workforce. However, the broader debate also focuses on best practice, more effective responses to need, determination of desired outcomes, improved service quality and new models of care, as well as enhanced and enlarged workforce roles (Australian Health Workforce Advisory Committee, 2005; Dubois & Singh, 2009; Kislov, Nelson, de Normanville, Kelly, & Payne, 2012; Sainsbury Centre for Mental Health, 2001; Santos & Amaral, 2011).

The nature of MH&A practice has altered considerably as services have shifted away from institutional settings. The Sainsbury Centre for Mental Health² (2001, p. 4) describes the gravitation of MH&A provision towards “integrated community-based services” and a “changing terrain of service provision [that] is now more varied, complex and dispersed than ever before”. The shift of MH&A services from institutional to community settings has brought about significant changes to traditional ways of working within these services. There is much more emphasis in the literature (Australian Health Workforce Advisory Committee, 2005; Miller, Siggins, Ferguson, & Fowler, 2011) on community-based care and self-directed care, integrated models of care and multidisciplinary practice, and the development of a non-professional workforce alongside the development of a more specialist MH&A workforce.

2 - The Sainsbury Centre for Mental Health is now known as the Centre for Mental Health. The former title is used throughout this review, as this was the organisation's name when it developed its Capable Practitioner Framework (Sainsbury Centre for Mental Health, 2001).

The evolution of MH&A services away from an institutionalised medical approach to mental illness, to a community-based, recovery approach to mental health, highlights tensions between the “psychological-humanistic versus biomedical-physiological conflict” (Holmes, 2006, p. 408). The challenge for top of scope in this context is to move away from a hierarchy of clinical practice to an understanding of the importance of the range of roles and professions in MH&A services.

Professional regulation and definition of scope of practice

MH&A services encompass a disparate range of professional groups: from MH&A-specific professions, such as psychiatry, or the newly evolved and unregulated MH&A support worker workforce; to professions like nursing that work across health with branches of specialisation in MH&A; to professional groups like social workers or occupational therapists that work across a range of health and social services. These professional groups all have a varied genesis, and fundamentally different epistemological approaches to professional knowledge and practice, with differing degrees of specialisation and differing ethical emphases.

Health Practitioners Competence Assurance Act 2003

In part, the variation between professional healthcare groups in New Zealand has been mediated by the introduction of the Health Practitioners Competence Assurance Act 2003, which dictates the responsibilities of professional authorities in terms of overseeing health practitioner competency. Authorities are required to manage registration, including through granting annual practising certificates, and to determining competence and fitness to practise. Authorities manage complaints and discipline, and are responsible for quality assurance and competency programmes.

The Health Practitioners Competence Assurance Act 2003 applies to a range of professional groups. In the context of MH&A services these groups include psychiatry, nursing, psychology, psychotherapy and occupational therapy. Section 11 of the act requires the relevant authorities to define scopes of practice for each profession. The act also introduces systems to limit practice outside of scope and restricts activities to particular professions. Authorities have a reasonable degree of latitude around defining scopes of practice, but generally this includes prescribing the qualifications required to practise within each scope, and naming the practice by reference to:

- an area of science or learning
- common tasks
- illnesses or conditions to be diagnosed, treated or managed.

Professional scopes of practice

The scopes of practice that apply to MH&A professions under the Health Practitioners Competence Assurance Act 2003, and the authorities that set them, are as follows.

Occupational Therapy Board of New Zealand (2014)

- Has one scope of practice that states what occupational therapists are and what they do.
- The scope also outlines minimum qualifications and defines evidence-based practice in the context of occupational therapy.

New Zealand Psychologists Board (2012)

- Has tiered scopes of practice based on qualifications for each category.
- The generic scopes of practice apply to psychologists, intern psychologists and trainee psychologists.
- The vocational scopes of practice apply to clinical, counselling and educational psychologists.

The Psychotherapists Board of Aotearoa New Zealand (2014)

- Has differentiated scopes of practice for psychotherapists, psychotherapists with child and adolescent specialism, and interim psychotherapists.

Medical Council of New Zealand (2014)

- The scopes of practice for medical doctors are categorised around general and provisional, vocational and special purpose scopes of practice.
- Scopes of practice are based on specialty areas, qualifications and management of registration.
- The scope of practice for psychiatry is a description of psychiatric diagnosis and treatment interventions, and contains a more detailed description of the qualifications necessary to work as a psychiatrist.

Nursing Council of New Zealand (2014)

- Has a tiered regime of scopes of practice for enrolled nurses, registered nurses and nurse practitioners.
- Also defines particular areas of nursing based on qualifications, professional development and experience.
- An individual nurse’s practising certificate outlines the area of nursing they are qualified to work in and any conditions attached to that, for example, “registered nurse; may only practice in mental health nursing” (Nursing Council of New Zealand, 2014, p. no page number).

Social work

Social workers are covered by the Social Workers Registration Act 2003. Under that act, the Social Work Registration Board is responsible for registration, practising certificates, competence, a code of conduct, standards around social work education and training, and other matters (Ministry of Justice, 2014). Social workers have their own professional body: the Aotearoa NZ Association of Social Workers. In addition, the Tangata Whenua Social Workers Association represents Māori social workers in New Zealand. Registration as a social worker is voluntary and the title of social worker is not linked to particular qualifications, experience or competency, or to particular obligations around supervision or professional development. The Social Work Registration Board has recommended mandatory social work registration and limits on who is able to practise as a social worker (Social Workers Registration Board, 2012). The board acknowledges challenges around defining the scope of social work practice, because of the range of tasks and settings and areas of specialty that social workers work in.

dapaanz (The Addiction Practitioners' Association, Aotearoa–New Zealand)

The dapaanz network of addiction practitioners represents a variety of professions working in addiction services. Membership of dapaanz is voluntary. The association provides resources to support registered practitioner competency, deals with complaints and resolves grievances. Dapaanz does not define a scope of practice for addiction practitioners, however, members may have a scope of practice determined for them through other professional bodies. For example, a psychologist working in addiction services may register with dapaanz only, but would still have a scope of practice through their professional authority. Dapaanz has its own code of ethics, developed in 2005 (dapaanz, 2005). In 2011, it developed an *Addiction Intervention Competency Framework* (dapaanz, 2011).

Other professions and other unregulated workforce groups

A number of professions that work in the MH&A field are not included under the auspices of the Health Practitioners Competence Assurance Act 2003 and are therefore not required to have a defined scope practice. Counsellors, for example, are not included under the act – their professional association has applied to be included, but that application is on hold pending a review of the legislation (P. Marshall, personal communication, 2 April, 2014). Counsellors have their own professional association, a detailed code of ethics and professional standards. However, registration is not mandatory and there is no defined scope of practice.

Support workers are an unregulated workforce. They don't have a defined scope of practice and are not included under any regulatory body, apart from generic responsibilities under the Health and Disability Commissioner Act 1994.

Regulation and scopes of practice

Clearly there is a range of approaches to regulating workforces and defining scopes of practice across the professions working in MH&A services. There are different emphases on the need for, and nature of regulation of, professional practice, variation in defining scope of practice, different frameworks around supporting specialisation of practice, variance in the role of ethics in underpinning professional practice, and different degrees of clarity around the margins of professional practice.

As a generalisation, the more medically clinical a profession is, the more highly regulated it is, the more structured and hierarchical the qualification framework, and the greater the opportunities and framework for specialisation are. In this way, psychiatry is the antithesis of social work and, in terms of defining working to top of scope, there is some tension between such a highly regulated clinical profession and a less regulated, but highly ethically based, profession like social work. In addition, the more clinical professions (nursing and psychiatry in particular) start their training with a generalist base, and develop specialist knowledge and skills that are supported by their relative regulatory frameworks. This also happens to a limited extent in psychology and the therapies.

Regulating the workforce through professional registration is a key aspect of working to top of scope, because of flow-on accountability through competency and quality assurance frameworks, determination of fitness for role, complaints and disputes mechanisms, and clarity around qualifications. Regulation generally separates the registration process from the disciplinary process. It allows for and supports the development of workforce competency to effectively implement high-quality interventions, and has an overall focus on improved public health and safety.

In the New Zealand context, the lack of regulation of the mental health support worker workforce, and the mixed regulation of the social work workforce, are issues that need further discussion and resolution. The unregulated workforces are particularly vulnerable, because they lack scopes of practice and frameworks for safety and accountability and often have limited access to supervision.

New models of care

The definition of working to top of scope developed emphasises effectiveness through best practice, new roles and ways of practising, as well as organisational and institutional accountability for improved effectiveness. This approach is supported in the literature, particularly in the research around the use of models of care as the starting point for workforce development and innovation in healthcare provision.

The literature describes a shift away from management of workforce supply and cost issues through skill mix, to management through the development of innovative models of care that improve existing workforce retention and utilisation, and enhance quality of care (Davidson, Halcomb, Hickman, Phillips, & Graham, 2006; Dubois & Singh, 2009; World Health Organization, 2014). Models of care are also used to respond more effectively to the challenges posed by the increasing burden of chronic disease (World Health Organization, 2014).

A model of care is defined as:

An overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence based practice and defined standards. It consists of defined core elements and principles and has a framework that provides the structure for the implementation and subsequent evaluation of care. (Davidson et al., 2006, p. 49).

Models of care is a term that is used liberally and often without specificity, but various models of care have been established internationally and exist as benchmarks for expanding the approach. The WHO Chronic Care Model, for example, was developed in 2002 and has had a significant effect on health systems' responsiveness to chronic disease management, in particular through its emphasis on integration, shared care and person-centred practice (World Health Organization, 2014). The 2014 World Health Organization report on integrated care for mental disorders and other chronic diseases describes a number of models of care or ways of thinking about models of care.

- 1 Patient level integration via integrated care pathways that focus on the service user's overall journey supported by multidisciplinary teams.
- 2 Organisation level integration that focuses on: use of multidisciplinary teams; task shifting, continuity of care; monitoring and follow-up; service user-led goal setting and care planning; service user self-management support; and links to social / community care.

- 3 Integration with primary care via training and support for primary health workers, links to secondary services and integrated management of co-morbidities.
- 4 Collaborative care as an evidence based approach to management in primary care settings often via a case management approach and the development of holistic care plans.
- 5 Stepped care – similar to collaborative care is typically found in primary care settings introducing low-intensity, low cost interventions, moving to higher intensity treatment if and when necessary (World Health Organization, 2014, pp. 24-27).

The UK Department of Health's New Ways of Working mental health framework (2007) is based around a distributed responsibility model of care, and is characterised by team-based capable practitioners occupying new roles, and matching clinical skills and expertise against service-user need. In Australia, the Victorian mental health workforce strategy (Department of Health, 2009) outlines a vision that includes well-articulated and diverse career pathways, new service delivery models and innovative use of the existing workforce. The Australian Health Workforce's models of care report (Australian Health Workforce Advisory Committee, 2005) identifies common features of models of care, including: the provision of high-quality care; multidisciplinary practice utilising a full range of caregivers, and based around a particular population and the staff mix required to deliver services; analysis of present and future service delivery targets and needs assessments; sustainable workforce planning that is linked in with the provision of education and training.

The KPMG (2012a) review of healthcare best practice supports the development of models of care. The review identifies key components of innovative healthcare practice as:

- inspirational and determined sponsorship from leaders
- support for staff to "critically re-examine care processes and simplify service user flows"
- consideration of the care process from the service users' point of view (KPMG International, 2012a, p. 4).

Other characteristics identified in the KPMG review include capacity for partnership, between individuals, teams and organisations; holistic assessment of individual needs; single organisation or team responsibility for the entire value chain; use of high-quality information to support decisions; capacity for open-mindedness; and clarity around clinical objectives linked to accountability frameworks (KPMG International, 2012a, pp. 4-5).

Models of care are often applied at a smaller scale, and this is particularly apparent in the literature around the development of advanced nursing practice (Feistritzter & Jones, 2014; Harris & McGillis Hall, 2012; Sayers & DiGiacomo, 2010). The following two cases studies are examples of smaller-scale models of care used in local health and social care contexts.

Case study: Torbay Care Trust in Torbay, England

The Torbay Care Trust was established in 2005 to provide community health services in Torbay and Southern Devon in England. The trust has implemented an integrated model of care that combines health and social care staff, and primary and secondary care. The trust is divided into five zones, and a team of health and support professionals (district nurse, social worker, physiotherapist, occupational therapist, care support worker) and a manager are responsible for each zone. Each team has its own budget and can commission whatever care and support is needed to meet individual service user needs. Emphasis within team practice is on holistic care, and on working in partnership with the service user, within the team and with other agencies (Torbay and Southern Devon Health and Care NHS Trust, 2014).

Evidence of success of the model is in improvements in service user and staff satisfaction, and improvements in service productivity. The trust was awarded the UK Health Service Journal national award for managing long-term care, and received commendation for improving service user access and mental health innovation (KPMG International, 2012a).

Case study: psychiatric outpatient departments in Germany

A recent development in Germany has seen an expansion of a psychiatric outpatient services to provide more comprehensive support for mental illness. The psychiatric outpatient department model of care includes a team of specialists – psychiatrists, psychologists, mental health nurses, social workers and therapists – who meet with a service user before and after their inpatient episode to provide support and offer long-term group therapy. Service users do not have to wait to get an appointment, and emergency care and support is available day and night. Evidence of the success of the model is through more successful service user support in the community, reduced inpatient admissions, reduced lengths of stays and cost savings for hospitals (Bratan, Engelhard, & Ruiz, 2013).

| Features of top of scope



1 - Role clarity

The focus when thinking about models of care is very much at a macro level, but implementation of models of care needs to be underpinned by detailed understanding of service user pathways, care processes, and communication and team processes, as well as much more explicit clarity around roles and responsibilities. There is a significant volume of literature on role clarity, particularly in the context of workforce supply challenges and role changes, and this relates directly to identifying key features of top of scope.

Working to top of scope requires clear roles and identified tasks and responsibilities within those roles. Role clarity is defined as, “certainty about duties, authority, allocation of time, and relationships with others” (Davis, 2011, p. 78). There are two key aspects to this definition: the first concerns clarity about individual roles, the second is clarity around the roles of others, and the boundaries between the two. Lack of role clarity leads to inconsistent practice, conflict between workers, task creep and role overload, while poor role definition is linked with employee frustration, reduced job satisfaction and poor workforce retention (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004; Davis, 2011; Miller et al., 2011; Tulin & Kutanis, 2009).

Pace’s (2009) research into mental health support workers in New Zealand describes unclear boundaries between professional and para-professional staff resulting in support workers commonly operating outside of their job description. Pace’s (2009) results are replicated in a Canadian study (Berta, Laporte, Deber, Baumann, & Gamble, 2013) on healthcare aides. Berta et al.’s research found a lack of clarity around the role boundaries for healthcare aides, particularly around delegated tasks, “extra-role behaviours” such as emotional support, and the performance of tasks outside their expected scope of practice (2013, p. no page number).

Davis’ (2011) research into job satisfaction among MH&A peer providers showed that role clarity was the strongest predictor of job satisfaction. Indicators of role clarity included:

- explicitness around the amount of authority held by peer providers
- position goals and objectives
- understanding of what others expected of them
- role specificity that supported independent function within the role (p. 78).

Acker (2004, cited in Davis, 2011, p. 32) looked at the effect of role ambiguity, role conflict, case load, service type and opportunities for professional development, alongside demographic variables, to measure which variable or combinations of variables had the most effect on job satisfaction and intention to leave amongst social workers in community mental health services in New York state. Acker found that, of the workplace variables, role ambiguity had the most effect on intention to leave, and that this effect was significantly more than the effect of demographic variables.

Bresner and Doran's (2005) Canadian research on nurse perceptions of working to top of scope identified significant role confusion both within nursing and between nurses and other professional groups. The authors interviewed 167 nurses, and 53 allied support staff and other team members across a number of inpatient units within two Canadian provinces. Their research identified significant task overlap, with little evidence that decisions about staff mix were taking account of similarities and differences in the professional knowledge base. Study participants reported under-utilisation of their nursing abilities, based on incomplete knowledge by others about nurse capabilities. These factors resulted in inefficiency and role confusion, and a mismatch between "the complementary roles of health professionals" and the model of service delivery (Bresner & Doran, 2005, pp. 2-3).

A 2008 Royal Australian and New Zealand College of Psychiatrists project to develop multidisciplinary education and provide training and information around collaboration for mental health professionals identified insufficient role delineation (especially between mental health nurses, social workers and occupational therapists) as a significant barrier to collaboration. In addition, the project identified "perceptions of irrelevance" of social work and occupational therapy by other professional groups, and poor understanding by services users of the role of social work and occupational therapy in mental health (Royal Australian and New Zealand College of Psychiatrists, 2008 cited in Miller et al., 2011, p. 51).

Chan, Lam and Lam's (2013) review of social work roles and inter-professional relationships found that role clarity between professional groups was particularly important in acute hospital settings, where workers are subject to busy work schedules, "systems of distributed expertise" and constant change, and have fewer opportunities for interaction (p. 5).

Expansion of nursing roles into advanced nursing practice necessitates role clarity, particularly where there is an extension of existing scopes of practice, task shifting and migration into the scopes of practice of other professional groups (Bryant-Lukosius et al., 2004).

Lloyd Jones' (2005) meta-analysis of research on the barriers to implementation of new nursing roles identified that role clarity or ambiguity and inter-professional relationships are the most important factors influencing the successful implementation of innovative specialist nursing roles. Lloyd Jones' analysis also showed that role clarity and inter-professional relationships are interlinked, and that the introduction of new specialist nursing roles and the subsequent effectiveness of those roles is highly dependent upon explicit role definitions and objectives that are clearly communicated to relevant staff groups (Lloyd Jones, 2005).

The New Ways of Working framework (Department of Health, 2007) in mental health in the UK highlights issues for social workers about social work identity, particularly for social workers working in hospital settings. Feedback from social workers described professional isolation within mental health teams, a feeling of not being valued, a lack of effective supervision and significant work pressure. In response, the New Ways of Working for social workers programme has developed a statement articulating "the role and values of a social worker and the unique contribution social workers can make to the delivery of mental health services" (Department of Health, 2007, p. 113).



2 - Task shifting

2 - Task shifting

The international response to workforce shortages has in part been through task shifting, which has been defined as “the rational redistribution of tasks among health workforce teams” with specific tasks moving from highly qualified workers to those with fewer qualifications and less training (World Health Organization, 2008, p. 2). Task shifting is often a necessary response for services in isolated or rural locations (Miller et al., 2011). There are numerous examples of task shifting, including expanded nurse practitioner roles, consumer and family delivery of services, development of allied professional support roles, nurse anaesthetists, renal dialysis technicians, anaesthetic technicians, mental health support workers, radiography assistants, therapeutic radiographers, enrolled and assistant nurses, and expanded prescribing roles by nurses, psychologists and ambulance officers (Australian Health Workforce Advisory Committee, 2005; Duckett & Breadon, 2014; Eddy, 2010; Fellows, Lyscom, Burge, & Edwards, 2014; World Health Organization, 2008).

Not all of these examples of task shifting are driven by workforce shortages and fiscal constraint, and the literature contains numerous examples of the implementation of innovative care plans containing new roles, redistributed tasks and functions, and a broader, more effective workforce, to generate better outcomes for both service users and workers (Duckett, 2005; Duckett & Breadon, 2014; Wand & Fisher, 2006).

Development of a social work assistant role in Queensland, Australia³ (O’Malia, Hills, & Wagner, 2013) involved redistribution of tasks undertaken by social workers in hospital settings. The rationale for the change included frustrations for social workers at the professional constraint resulting from managing high-volume, urgent referrals; and the amount of time spent on low-level, often administrative tasks that prevented social workers from working to the full scope of their practice. Differentiation of social work assistant and social work roles in the Queensland study was based on a clear process of:

- developing a role description
- process-mapping the care journey
- identifying each task across the care pathway and across caseloads, and determining whether the task required the skills of a social worker
- ranking tasks in terms of their risk and complexity
- identifying the skills, competencies and training needed to do each duty
- delegating tasks to form the basis of a social work assistant role (O’Malia et al., 2013, pp. 3-4).

Questions were raised within the Queensland study about whether the social work assistant tasks were impacting on the professional identity of social workers. Were those tasks

3 - See the case study in the section on role delegation on page 21.

integral to the social work role? Would task shifting increase role fragmentation and impact on continuity of care? In practice, social workers retained the right to withhold any referral to the social work assistant if they deemed it necessary. Assessment of the initial trial showed that the introduction of the assistant role did not undermine social work outcomes. In fact, the project allowed more effective articulation of the scope and complexity of social work practice and allowed social workers more time to provide more meaningful interventions (O'Malia et al., 2013).

In other contexts, task shifting has a very political component. This manifests most around the interface between medical practitioners and nursing, as nurse practitioners expand their practice to include prescribing, ordering diagnostic tests, making specialist referrals and other tasks that were previously the domain of medical staff (Elsom, Happell, & Manias, 2008). As traditional professional spheres of practice and hierarchies are modified, there can be considerable disruption in professional identity. The Mental Health: New ways of working for everyone framework (Department of Health, 2007, p. 14) in the UK frames this reorganisation of roles as a “cultural shift”; and an opportunity to match workers with the most experience and expertise with service users who have the most complex needs and for less experienced and skilled staff to extend their own practice at other levels of service delivery.

Successful implementation of task shifting, includes good change management processes, consideration of organisational influences, whole-system commitment to change, opportunities for flexibility and innovation, comprehensive and specific education, training and supervision, and maintenance of professional credibility and identity (Ball & Cox, 2004; Dubois & Singh, 2009; Duckett, 2005; Duckett & Breadon, 2014; Eddy, 2010; Gilfedder, Barron, & Docherty, 2009).



3 - Role changes

3 - Role changes

There is extensive and wide-ranging literature on health workforce role changes, and none more so than with regard to the extension of nursing practice and the development of nurse practitioners. In this literature review, the majority of peer-reviewed articles on specialisation or role change were concerned with the nursing profession, followed by social work, with relatively few articles on other professions. The grey literature is more comprehensive in terms of the coverage across a range of health professions. However, the nursing literature is extensive and contains key messages about working to top of scope and is reviewed below in some detail. But care must be taken when generalising from nursing-related research and also in terms of the applicability of research findings from different settings.

Dubois and Singh's (2009) influential review of the range of methods used to optimise the health workforce distinguishes between role enhancement, role enlargement, role substitution and role delegation. Their review of the broader literature on role changes is commonly cited and provides a comprehensive assessment across a range of health professions. All of the methods they describe link to ways of working to top of scope.

Role enhancement

According to Dubois and Singh (2009, p. 5), role enhancement involves broadening the skill set of workers so they can take on a "wider and higher range of responsibilities through innovative and non-traditional roles". It does not involve undertaking tasks or functions from other professional groups, but is instead focused on development of skills outside of routine practice. Role enhancement generally results from continued professional growth and development, and is more commonly seen in primary and preventive care. Role enhancement can include the specialisation of dual cultural and clinical skills utilised by indigenous health workers (M. Baker & Levy, 2013).

Case study: integrated addiction and parenting service in Sydney, Australia

An integrated adult addiction programme in Sydney combined parenting support (through Tresillian Family Care Centres child and family health services) and an existing small alcohol and other drug (AOD) rehabilitation service for women (Kathleen York House). The Kathleen York House Integrated Programme was developed in 2008 to address the needs of mothers with AOD dependence who had young children to provide early intervention to break the “intergenerational cycle of dysfunctional parenting” in some AOD-dependent families (Rossiter, Fowler, Dunston, Sherwood, & Day, 2013, p. 10). The programme focused on each mother holistically, but identified a wide range of needs. It also considered their role as parents or as part of a wider community, and focused on the needs of their children.

The programme also looked at the learning needs of two different groups of health professionals – clinical psychologists and drug and alcohol workers – at Kathleen York House, and allied health professionals and family health nurses at Tresillian. Each professional group retained their professional role, but an integrated, collaborative work programme, and an “inter-professional team-based approach” allowed for enhanced scope of practice and the development of greater expertise (Rossiter et al., 2013, p. 6).

Feedback from mothers and staff members on the programme was very positive. In particular, mothers appreciated being able to separate out their AOD issues from their role as a parent, and other features of their lives. Opportunities for good parenting were enhanced, supporting greater motivation for change and allowing mothers to more effectively deal with their addiction issues. The Tresillian nurses extended their understanding of AOD issues and the links with parenting. The Kathleen York House staff improved their understanding of “the parent/child relationships and parenting” and the links with AOD issues (p. 36).

Role enlargement

Role enlargement involves development of new skills at the same or lower levels. In healthcare contexts it is often a response to increasing specialisation or a desire to shift from a siloed, task-oriented approach to broader, more integrated management of a population group, often with long-term conditions. Skill acquisition can involve case management, programme management, systems design, improved communication with other health and social care services, development of care plans, and team behaviour (Dubois & Singh, 2009, pp. 7-8).

Case study: home care service in Buurtzorg, the Netherlands

A nurse-led home care service in the Netherlands involved nurses taking on tasks most often devolved to home help and personal care services, as well as existing community nursing functions. In this example of reverse task shifting, nurses organise their own work and deliver all the care that service users need, with a goal to empower service users to be more self-sufficient.

The nurses operate in small teams of up to 12 nurses and have responsibility for a defined population. The nurses in the teams work together, to ensure continuity of care. They develop long-term, lasting relationships with service users and aim to develop local solutions to enhance outcomes. The teams are supported by a centralised service organisation.

The success of the programme is measured in the reduced hours of support needed by service users. The nurses have a higher per hour cost, but are needed for less time and achieve significantly higher productivity and improved outcomes (KPMG International, 2012b).

Role substitution

Role substitution involves extending practice across and outside of professional scopes of practice into the domain of other professions. It often occurs where there are workforce shortages or a need for cost management. It results in blurred boundaries between professions and may create confusion for service users (Dubois & Singh, 2009). It is a common strategy used for expanding service coverage in under-served areas, for example, in rural or remote communities (Miller et al., 2011). The evidence for improvements in outcomes for role substitution is mixed and the effect depends upon the context. For example, substitution of nurses for physicians, particularly in primary care, results in good health outcomes and in some instances results in greater service user satisfaction – particularly around the relative strength of nurse interpersonal skills and nurses’ tendency to have longer consultation times (Dubois & Singh, 2009, p. 8 citing a range of literature; Laurant et al., 2005). In contrast, there is some evidence that substituting highly qualified nurses with less qualified workers is much less efficacious in terms of patient outcomes (Dubois & Singh, 2009).

Case study: advanced mental health nursing practice in Kilmarnock, Scotland

Challenges in Scotland around the availability of psychiatric support (both specialists and junior psychiatric doctors), and the broader shift in the UK towards expanded, specialised nursing roles has led to the development of an innovative advanced nursing practice service.

The Hospital At Night service was introduced in 2006 as a general overnight advanced nursing practice service, with a reduced number of specialty doctors, and advanced nursing practitioners who are responsible for triage, initial assessment, diagnosis, and treatment of acutely unwell adults within specific guidelines. The Hospital At Night service has expanded to include mental health, with extra training provided to mental health advanced nursing practitioners to enable them to work across the entire hospital, including the emergency department. Expansion of skills has been supported through “critical companion mentorship systems” and competency frameworks that include methods around proficiency progress (Gilfedder et al., 2009, p. 37).

Benefits include the transfer of knowledge and learning across all services, with mental health advanced nursing practitioners having advanced physical skills and general advanced nursing practitioners having a wider skill set based around holistic care. Skill enhancement includes use of a capability framework to promote a rights-based, recovery-focused practice.

Ongoing support and supervision for mental health advanced nursing practitioners is through clinical input from the consultant psychiatrist and prescribing support from a designated medical practitioner. The development of the new service has had significant buy in and support from existing medical colleagues. Clinical supervision is kept separate from line management supervision. The enhanced competency framework for the mental health advanced nursing practitioners role includes competencies around addictions and physical illness.

Role delegation

Role delegation involves breaking down existing job demarcations and handing over responsibility for some tasks to less qualified and lower paid workers. Role delegation typically involves the development of assistant roles, for example, assistant nurses, allied health support staff, radiography assistants and mental health support workers. The emphasis is on freeing up existing higher-qualified workers to utilise their specialised skills (Dubois & Singh, 2009).

Case study: development of social work assistant role in Queensland, Australia

A 2009 Queensland Health Models of Care project was based around an objective to implement models of care that encourage “full or advanced scope of professional practice alongside assistant staff” (O’Malia et al., 2013, p. 2). The project’s aim was to address issues concerned with the pressure on social workers in inpatient acute settings to manage high-volume urgent referrals, resulting in less time spent on more meaningful interventions. Other issues included inconsistency in task execution, inconsistent processes within and between teams, and staff perceptions that they were not working to their full scope of practice.

Queensland Health piloted a new social work assistant role, based on the identified tasks, skills, competencies and qualifications needed for safe and effective practice of both the social work assistant, and the existing social work function. Post-implementation surveys of staff showed very strong support for the social work assistant role (88 per cent) and improvements in productivity and efficiency (100 per cent).

The implementation of the social work assistant role allowed for better articulation of the social workers’ role and purpose, and a better understanding of the scope of practice for social workers and the relative complexity of social work tasks and practice. The pilot was so successful that the model has been rolled out in other Queensland Health social work departments.

Specialist and generalist roles

Questions about the benefits of role substitution and role delegation include discussion around the relative benefits of a more specialised versus more generalised workforce. Thistlethwaite (2011) argues the health workplace is increasingly complex due to the proliferation of specialised roles and that a better approach might be to extend the scope of practice of the existing workforce instead of creating new roles.

An example of this can be found in the Occupational Therapy Board of New Zealand’s expanded scope of practice for occupational therapists. Occupational therapists are supported to provide services at the outer reach of their scope, so they can be more responsive around continuity of care and collaboration with service users and other workplace colleagues. The occupational therapy board has developed a set of reflective questions, underpinned by the relevant regulatory and ethical frameworks, competency and other contextual factors, including the availability of support and supervision, to allow occupational therapists to navigate the often ambiguous boundaries of their scope of practice (Occupational Therapy Board of New Zealand, 2011a, 2011b).

The application of specialist and generalist roles depends on context. Rural, remote, and under-resourced services are more likely to have expanded generalist roles, with service provision being more dependent on fewer individuals who are able to perform a wider range of tasks (Miller et al., 2011; Thistlethwaite, 2011). Some authors (McAllister et al., 2014, p. 37 citing Brunero et al. (2009) and Sharrock and Happell (2006)) argue, however, that generalists are insufficiently prepared and lacking in the clinical confidence and knowledge needed to work with service users with complex mental health needs.

The other aspect of increasing specialisation is the potential load it places on individual practitioners. Garfinkel, Bagby, Schuller, Dickens, and Schulte (2005) looked at predictors of job satisfaction in Canadian psychiatrists. The authors hypothesised that tasks that gave variety to clinical practice, such as collaborative interaction and administrative tasks, also provided “respite from demanding patients ... [to reduce] ... the overall emotional burden of the job” (p. 339).

The specialist vs generalist debate also gets picked up in the discussion below around the extension of nursing practice, particularly as nurses report concerns about specialisation impacting on their capacity to maintain broad nursing practice.

Expansion of nursing practice

Much of the literature on expanded nursing practice takes a positive view of the opportunities available through expanded roles, and the research around specialist nursing practice outlines key ideas around working to top of scope. For example, the Australian College of Mental Health Nurses (2013, pp. 5-6) developed a scope of practice for mental health nurses to “permit the expansion and extension of practice” in order to be more responsive to the reality of MH&A work environments: variety of context, diversity of population, and flexible and adaptive work practice. Advanced practice roles were seen as a natural conclusion of the nature of mental health nursing, and allowed enhanced opportunities for individual nurses to “develop expanded and extended roles in the community and primary health contexts” (Australian College of Mental Health Nurses, 2013, pp. 5-6).

Likewise, Te Ao Maramatanga: New Zealand College of Mental Health Nurses (2012) had developed a guide to advanced practice for New Zealand mental health nurses. This guide was removed from publication at the time of the third revision of the practice standards in 2012. However, practice standard three continues to include a statement that mental health nurses are required to demonstrate an understanding of their scope of practice in order to work within the Aotearoa New Zealand context (Te Ao Maramatanga: New Zealand College of Mental Health Nurses Inc., 2012).

Advantages of expanded nursing practice identified in the literature include: the capacity to engage in more technical aspects of clinical practice (Pearcey, 2007); greater emphasis on therapeutic approaches (N. Baker, 2010); opportunities for shared leadership between physicians and nurses (Holm & Severinsson, 2010); opportunities for more innovative practice (Gilfedder et al., 2009); opportunities for collaborative working (Currie & Crouch, 2008); better management of long-term conditions and provision of long-term aged care (Holloway, 2011); and improved job satisfaction and retention of nurses (Duckett, 2005).

However, nurses report concern about expansion of nursing practice, due to: reduced opportunities for delivering basic care (Currie & Crouch, 2008; North & Hughes, 2012; Pearcey, 2007); task overload (Currie & Crouch, 2008); lack of institutional support for extended roles including poor supervision (Currie & Crouch, 2008); erosion of the role of generalist nurses (Smoyak, 2008); and exacerbation of existing nursing shortages (North & Hughes, 2012).

The literature reveals a disjoint between the potential of

advanced nursing practice and nurses’ everyday reality. Nurses interviewed in Bresner and Doran’s (2005) research into nursing scope of practice, generally conceptualised fullness of scope as a series of tasks undertaken in a practical, day-to-day manner, rather than what Bresner and Doran described as “differences in depth or breadth of knowledge” that evolve out of education, knowledge, experience, and ongoing professional development (p. 8). Nurses that worked in more technical or specialised contexts, for example, intensive care units, were more likely to consider fullness of scope as involving a big picture approach to patient care, including holistic assessment, liaison with families, advocacy, collaborative management, care coordination and other tasks that employ a full range of skills (pp. 11-12). Interestingly also, registered psychiatric nurses in Bresner and Doran’s study were more likely to report working to full scope, particularly where they worked as part of an “extended treatment team, were able to provide holistic care, patient and family education, counselling, psychotherapy and engage in goal setting with patients” (p. 12)

In another Canadian study (Oelke et al., 2008) looking at nurse perceptions of working to top of scope, researchers reported that barriers to top of scope included high workload and patient acuity, insufficient time to complete work, and poor communication and teamwork. Nurses in the study identified the factors that support working to top of scope, including teamwork, management and leadership support, and opportunities for professional development and education.

Canadian research (Bryant-Lukosius et al., 2004, p. 524) into advanced nursing identified that development of advanced nursing practice roles often over-emphasised the issue of physician-replacement instead of focusing on the development of “practice characterised by coordinated, integrated, holistic and patient-centred care designed to maximise health, quality of life and functional capability”.

Wand and Fisher (2006) reviewed the expansion of mental health nurse practitioner roles in emergency departments in New South Wales in Australia. The authors argued that the development of nurse practitioner roles was not about “substituting nurses for doctors but about nurses being recognised as specialist practitioners in their own right”, with the emphasis being on collaborative practice and a focus on taking a positive attitude to change and generating the best outcomes for service users (p. 206).

The Victorian mental health workforce strategy (Department of Health, 2009) clearly lays out the capacity for expanded specialist mental health roles, including nurse practitioners, to

increase the capacity of the mental health workforce. Expansion of practice is based on acquisition of further skills through professional development, improved career structures and expanded scopes of practice. This approach is mirrored in the Australian *National Mental Health Workforce Strategy*, which calls for increasing the scope of practice and development of mental health nurse practitioners to support their career progression and job satisfaction. The strategy outlines the potential for expanded roles to manage chronic disease, conduct physical health screenings, implement smoking cessation and drug and alcohol interventions, and initiate health promotion and healthy lifestyle management (Mental Health Workforce Advisory Committee, 2011).

Elsom and colleagues' (2008) study of rural and urban community mental health nurses in Australia focused on nurses' attitudes to expanded nursing practice. Nurses reported high levels of confidence in their ability to prescribe, order diagnostic tests, refer to specialists, authorise involuntary detention and issue absence from work certificates (p. 776). Nurses reported being aware of the boundaries of their scope of practice and felt confident about managing work at the extent of their scope. Elsom and colleagues argue that expansion of mental health nursing practice "creates the conditions for a radical reshaping of health care as it is currently known" (p. 778).

Wand and Fisher (2006), however, report relatively low numbers of nurse practitioners in New South Wales: in 2006 there were 60 in total, with only eight in mental health. In New Zealand, there are seven nurse practitioners employed in MH&A services, five in community mental health services, one in an inpatient mental health service, and one in addiction services (The Nursing Council of New Zealand, 2014).

These low numbers are backed up by Miller and colleagues' (2011) review of mental health workforce issues in Australia. They describe varying reasons for the low numbers of mental health nurse practitioners and why mental health nurses are prevented from working to full scope of practice. These reasons include professional siloed behaviour that prevents collaboration, ownership of different types of therapy by particular members or disciplines within multidisciplinary teams, and failure to build on the common skills of both nurses and social workers (Miller et al., 2011, p. 50). Other authors point to the failure to differentiate effectively between generalist and specialist mental health nurses, and lack of a clearly articulated framework for nurse specialisation and expanded practice (Holloway, 2012; Santos & Amaral, 2011).

UK research (Bradshaw & Pedley, 2012; Howard & Gamble, 2011) into role extension of mental health nurses considers opportunities for advanced mental health nursing practice to better respond to the poor health statistics for people with serious mental illness. Bradshaw and Pedley (2012) report evidence of a significant gap in medical intervention for people with serious mental illness, with mental health nurses lacking confidence and training in managing physical illness, and nurses in primary health lacking the skills to be able to respond adequately to service users with mental illness. The authors argue mental health nurses must expand their practice and "adopt a more balanced approach to their role by placing equal importance on meeting the physical, as well as the mental health care needs of their patients" (Bradshaw & Pedley, 2012, p. 268).

In the New Zealand context, Matua Rāki's Addiction Speciality Nursing Competency Framework (2012) describes the clinical pathway for nurse specialisation in addiction services in New Zealand. The framework describes levels of practice, clarifies what specialist-level nursing practice looks like for external stakeholders, and provides guidance about education and training for specialist nursing practice.

Case study: youth early psychosis service model in Victoria, Australia

The youth early psychosis service is based around providing support for youth first presenting to mental health services, in an environment where youth and their families struggle to access services and where services face issues of compliance. The role of the mental health nurse practitioner has been developed to engage youth when they first present, by developing an ongoing therapeutic relationship in order to keep youth in treatment and reduce occurrence of their mental illness (Baker, 2010).

The youth early psychosis service mental health nurse practitioner role is an expanded one and is clearly defined to include the following responsibilities:

- leadership around access and entry to the programme – assessment, early intervention, health promotion and education
- clinical expertise, case management of complex cases, applied extended practice, including prescribing, ordering diagnostic tests and formulating acute care planning
- broad consultation, eg to hospital emergency departments
- education for community support and treatment agencies
- autonomous, collaborative, multidisciplinary practice (Baker, 2010).

Issues for psychiatry

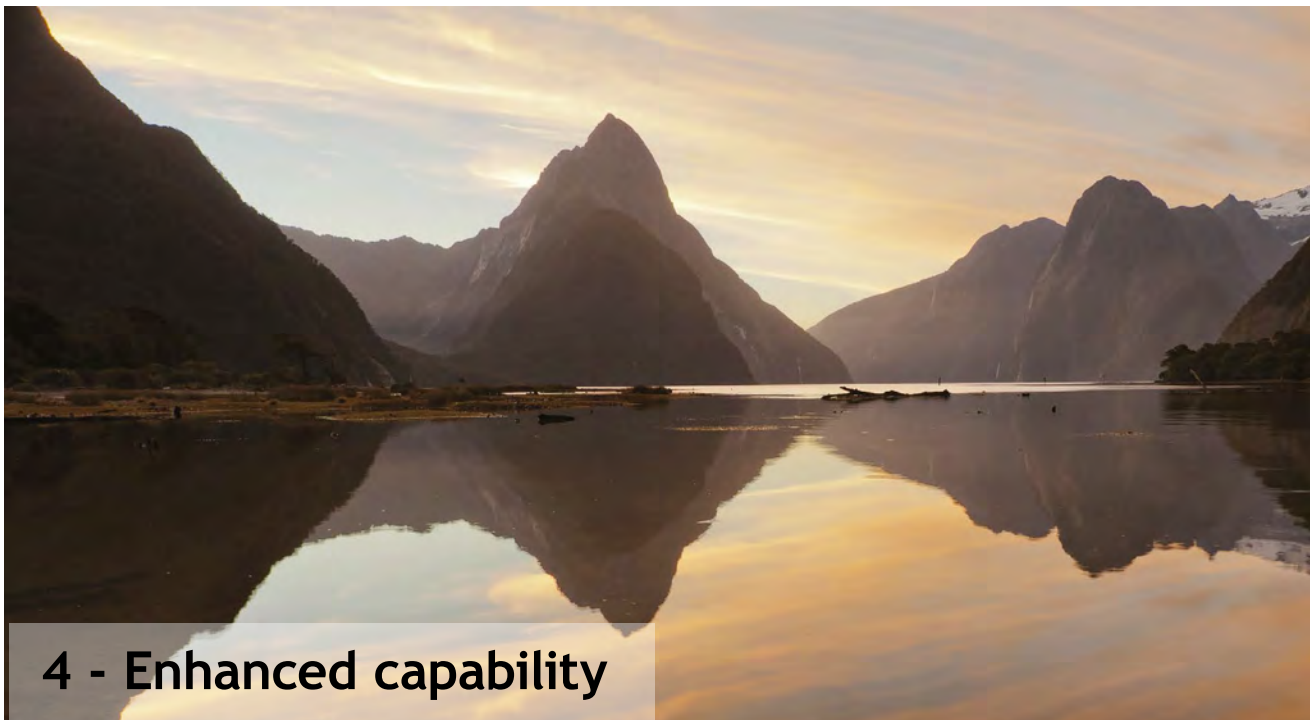
Concomitant role changes for psychiatry have been proposed in the face of reduced workforce numbers, and the expanding specialisation of other professions. *The New Ways of Working for Psychiatrists* review in the UK (cited in Miller et al., 2011) proposed that the most effective use of psychiatry was to:

- focus on people with the most complex needs
- act as consultant to multidisciplinary teams
- “promote distributed responsibility for culture change”
- “work flexibly to achieve a motivated workforce able to offer high quality service” (Miller et al., 2011, p. 21).

The previously discussed case study on advanced nursing practice in Scotland (Gilfedder et al., 2009) demonstrated a number of these features. The Hospital At Night nurse practitioners received ongoing clinical input from the consultant psychiatrist and prescribing support from a designated medical practitioner. Part of the success of the programme was due to significant support from medical colleagues who bought into the need for distributed clinical expertise and flexible work practice.

The continued shortage of the specialist mental health workforce (predominantly psychiatrists) is an identified problem in New Zealand. Health Workforce New Zealand (2011) have noted the importance of increasing the supply of psychiatrists, making better use of the existing psychiatry workforce, and continuing to diversify the broader MH&A workforce.

The Royal Australian and New Zealand College of Psychiatrists has responded to this challenge. In particular, it has enhanced the training regime for psychiatry with a new competency-based fellowship programme launched over 2012/13 and an expanded specialist-training programme. The college notes the success of the changes, with enrolments for the 2014 fellowship scheme at the highest level ever (The Royal Australian and New Zealand College of Psychiatrists, 2013, p. 13).



4 - Enhanced capability

4 - Enhanced capability

Working to top of scope necessarily includes a focus on how work is done, as well as what work is done. Enhanced capability is a critical component of the ‘how’ aspect, and includes the development of values and attitudes and effective approaches for the delivery of MH&A services. The Sainsbury Centre for Mental Health’s capability framework is a cornerstone of the development of capability within MH&A practice internationally (Sainsbury Centre for Mental Health, 2001). The Sainsbury framework lists five dimensions of capability that are required across the range of professional groups operating within adult mental health services. The five dimensions are:

- 1 performance – skills and achievements in the workplace
- 2 ethics – integrated knowledge of culture, values and social awareness
- 3 reflection – reflective practice in action
- 4 effectiveness – implementation of evidence-based interventions
- 5 learning – ongoing implementation of new knowledge and practice (Sainsbury Centre for Mental Health, 2001, p. 2).

The Sainsbury framework reflects the changes in mental health practice such as new service configurations, emphasis on effectiveness, co-ordination and communication within teams, and between teams and other health practitioners and agencies, and the complexity of community-based service provision.

The Australian College of Mental Health Nurses’ scope of practice (2013) is capability-based. It applies to all practising mental health nurses and is holistic, person-centred, focused on provision of evidence-based, recovery-oriented services, committed to collaboration and partnership with all stakeholders, and underpinned by reflective practice and ethicality in practice and decision-making. The scope covers a wide range of roles and needs including physical illness, is focused on prevention, treatment and support, and is dynamic and adaptive in its coverage.

The *Let’s get real* framework (Ministry of Health, 2008, p. 2) in New Zealand is a capability framework for developing “the essential knowledge, skills and attitudes” needed to effectively deliver MH&A services. The framework cuts across roles and professions to develop and strengthen shared understandings and values, affirm best practice, and enhance effective workforce development across the sphere of MH&A services.

All the MH&A professional groups in New Zealand have established codes of ethics, although there is a substantial difference between professions around the relevance of these codes in assessing competency and fitness for work. This is arguably the strength of the social work profession, due to the substantive nature of the social work code of ethics and the embedded nature of ethics in social work education, implementation of practice standards and the management of

competency. The challenge around working to top of scope is ensuring that ethical capacity is built into everyday behaviour and decision-making. This can be supported by access to comprehensive effective supervision, effective and collaborative team environments, ethical leadership, and communication of ethical expectations (World Health Organization, 2006b).

Lester and Chapman (2008) describe features of capability in individual practitioners.⁴ Their research looked at assessing capability in practice based on interviews with people who were considered more than competent; who were capable. The authors defined capability as “the ability to go beyond what would normally be considered competent into excellence, creativity or wisdom” (p. 2). Capable people are considered to have a “personal ‘envelope’ of abilities”, and are “ecologic”, that is they are personally adaptive to the environment within which they operate and at the same time, adapt the environment in order to be effective and fulfil personal potential (pp. 6-7).

Edmonstone (2011) describes capability as the capacity to continually improve, to reflect and generate new understanding, to be both reactive and proactive. In addition, Edmonstone argues that capability is not something that can be taught, but is developed through experience and the necessity of adapting to new circumstances.

Capability and working in teams

Multidisciplinary practice is a cornerstone of mental health practice capability and working to top of scope, and is discussed extensively in the literature. The New Ways of Working framework in the UK (Department of Health, 2007) prescribes a shift from a mental health workforce defined by professional differences to a multidisciplinary team defined by skills, competencies and capability. Barriers to this change identified in the framework include lack of role clarity, professions guarding their scope of practice, resistance to change and inadequate management of change (Department of Health, 2007; Miller et al., 2011).

Chan, Lam and Lam (2013, p. 3) describe a high-functioning multidisciplinary environment as being underpinned by complementary competencies, sophisticated communication, openness and respect, and “collaborative interdependence”. Feistritzer and Jones’s (2014) review of the redesign of the advanced nursing practice role in a surgical inpatient unit similarly outlines the components required for successful team development: cohesiveness, communication, role clarity, clearly defined goals and an understanding of how to achieve those goals. They add that team effectiveness is based on clarity about team composition and roles, including leadership within

the team, empowerment of individuals around professional practice and adaptive decision-making, and accountability for behaviour and outcomes. Miller and colleagues (2011) state that the transition to multidisciplinary teams has to be based on good governance, support for change at an organisational level including appropriate resourcing, and support and attitudinal shift from service managers and programme leaders.

Bresner and Doran’s (2005, p. 12) research into nurse perceptions of what working to top of scope looks like, revealed that mental health nurses were most likely to report working to full scope when providing holistic care, service user and family education, and service user goal setting, as part of an “extended treatment team”.

A position paper on teamwork and psychiatric services developed by the Royal Australian and New Zealand College of Psychiatrists states that the barriers to effective team work include lack of role clarity, including around leadership roles and responsibilities, variable understanding of the difference between responsibility and accountability, and what it describes as “inter-professional misconceptions” (The Royal Australian and New Zealand College of Psychiatrists, 2002, p. 2). The position paper clarifies that effective teamwork should be based on:

- agreed goals
- an agreed approach – particularly around philosophy of care and collaborative style
- effective communication
- established ground rules
- clear team rules
- competent leadership (p. 2).

4 - The study did not focus on health practitioners, but looked at a range of professions.

Case study: integrated model of care for mental health in Utah and Idaho, USA

Development of an integrated model of care for mental health consumers by Intermountain Healthcare places mental health services at the heart of primary healthcare. Mental health integration clinics cater for both physical and mental health needs, with care and support led by family doctors who work within a broader team of mental health professionals to provide support to families.

The mental health integration team includes the service user and their family, their doctor, a care manager or health advocate, a psychiatrist or psychiatric advanced practice registered nurse, a psychologist or social worker to provide counselling and talking therapies, and the National Alliance on Mental Illness organisation, which provides information, education and access to mentors (KPMG International, 2012a).

Training for MH integration team members includes a focus on team practice, using standardised clinical tools, and is based around clearly defined and complementary team roles (Intermountain Healthcare, 2014; KPMG International, 2012a).

Capability and leadership

Thistlethwaite (2011) explains leadership is a fundamental component of good team practice; and argues that teamwork skills include capacity for leadership and clarity around leadership, and that service users need to know who is leading or coordinating their care. Holm and Severinsson (2010) reviewed literature around leadership in mental health nursing, and identified the following factors as critical to the development of mental health nurse leadership roles:

- role responsibility, particularly in terms of expectations of colleagues, emphasis on teamwork, and maintaining focus on service user outcomes
- use of evidence-based practice – in terms of service user outcome and organisational change
- responsibility for effective communication within and between teams, and for empowering and nurturing team members (Holm & Severinsson, 2010, pp. 467-468).

There is considerable emphasis in the literature about the importance of leadership in providing direction for system change, innovation and implementation of new models of care. KPMG analysis of leadership in healthcare shows “inspirational” and “determined” leadership is universal across all best practice case studies reviewed in their study (KPMG International, 2012a, p. 4). Implementation of new healthcare roles or models of care depends on strong leadership in order to have lasting effect (Duckett & Breadon, 2014).

The Mental Health: New ways of working for everyone framework (Department of Health, 2007, p. 29) in the UK defines a range of types of leadership in healthcare settings. The framework differentiates between leadership and management, with the former described as involved with making transformational change in complex systems through engagement of partners, and the latter as more transactional and operational, linking performance with objectives. The framework also differentiates between clinical and professional leadership. Clinical leadership responds to strategic vision and leads improvements in services, team function and service user care. Professional leadership is about leading professional identity and standards in the context of organisational goals. The authors also clarify that a team leader is responsible for team process, conflicts, relationships with other teams, team coherence around organisational goals and change processes.

The Australian College of Mental Health Nurses (2013, p. 6) describes an additional type of leadership. It argues that in the context of an evolving mental health service and practice framework, mental health nurses are “taking the lead” in defining their own scope of practice, with greater opportunities for individual mental health nurses to “develop expanded and extended roles in the community and primary health contexts”.

Capability and supervision

The World Health Report 2006 (World Health Organization, 2006a) on international health workforce development considers factors that enhance the performance of health workers. The report describes supervision as “one of the most effective instruments available to improve the competence of individual health workers”, especially when it sits alongside clear job descriptions and is supported by constructive performance feedback (p. xxii). The report explains that supervision reliably improves performance, but it needs to be supportive, educational, consistent and responsive to specific problems. Supervision should be available to supervisors, lay healthcare providers and private providers (World Health Organization, 2006a).

Supervision is a key component of the capacity to practise reflectively and reflective practice is a critical dimension of capability (Edmonstone, 2011; Sainsbury Centre for Mental Health, 2001; Walsh, Gordon, Marshall, Wilson, & Hunt, 2005). Supervision is strongly linked to a protection against employee burnout, emotional exhaustion and employee turnover (Edwards et al., 2005; Knudsen, Ducharme, & Roman, 2008). Supervision also supports staff working with challenging behaviours, and has benefits around developing clinical knowledge and competence, including cultural competence (Cookson, Sloan, Dafters, & Jahoda, 2014; Miller et al., 2011).

Much of the literature positions supervision within a broader context of good human resource practice and retention strategies (Department of Health, 2009; KPMG International, 2012a, 2012b; Mental Health Workforce Advisory Committee, 2011; Miller et al., 2011). KPMG's assessment of the features of multidimensional productivity in healthcare includes active management of staff performance including an overall emphasis on employee wellbeing, support for staff in the face of change, systems for high-quality feedback and appraisal, support for and training in leadership and working in teams, and ongoing coaching and mentoring (KPMG International, 2012b).

The Victorian mental health workforce strategy (Department of Health, 2009) similarly positions supervision within a broader approach to attract, motivate and retain mental health staff. The key elements of this approach include effective "leadership and management practice, work safety and wellbeing, organisational climate, professional and personal support, manageable workloads, and adequate remuneration and work-life balance" (p. 45). Miller (2011) describes strategies identified in the literature for improving job satisfaction and workforce retention. These include increased provision of clinical supervision, clear role definition, opportunities for advancement, and protected training and professional development time.



5 - Cultural responsiveness

5 - Cultural responsiveness

As noted in the introduction, the wider policy context for this review includes a government emphasis on improved and demonstrated cultural competence and development of whānau ora initiatives (Ministry of Health, 2012). A fundamental consideration in any review of working to top of scope is the extent and nature of embedded cultural responsiveness. The World Health Organization (2001) frames cultural responsiveness in terms of human rights, and the vulnerability around the health and wellbeing of particular groups, including indigenous populations, ethnic minorities and refugees; however, this approach positions cultural responsiveness within more of a deficit model.

An American review (Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013) of international literature on multicultural competence in healthcare identified seven essential strategies for cultural responsiveness.

- 1 Executive leadership and promotion of multicultural organisational development as an integral part of service delivery and system organisation, including dissemination of cultural competence standards and accountability measures.
- 2 Participation and partnership at all levels of the organisation.
- 3 Measurement of cultural competency through assessment of service user satisfaction and outcome data.

- 4 Development of realistic cultural competence action plans.
- 5 Development of organisational linguistic competence.
- 6 Development and retention of a diverse and culturally competent workforce across the organisation.
- 7 Development of systems to manage grievance processes for employees and service users (Delphin-Rittmon et al., 2013).

A 2008 study into Pacific cultural competence (Tiatia, 2008) identified that cultural competency is having the capacity (skills, experience, understanding) to bring into play the values and customs of other cultural groups, to work with people from other cultures, and to shape and target service delivery to better meet service users' social and cultural needs.

A New Zealand review (Moko Business Associates, 2003) of competencies and career pathways in Māori mental health nursing identified a lack of identified core competencies for nurses to develop practices in specialities such as Māori mental health. Criticisms of existing competencies included that cultural competencies were either too focused on tasks, or were too broad, lacking specific measures of knowledge, skills and values. The authors argued that competencies should be applicable across a range of settings and specific to particular settings.

The *Let's get real* (Ministry of Health, 2008) framework in New Zealand addresses cultural responsiveness directly, with one of the seven Real Skills being “Working with Māori” and including an objective that “every person working in mental health and addiction treatment service contributes to whānau ora for Māori” (p. 4). The framework outlines specific performance indicators across a continuum of skill levels: essential, practitioner and leader.

Many of the competency frameworks that apply to MH&A professions also address the issue of cultural responsiveness. For example, the Takarangi Competency Framework (Matua Raki, 2010, p. 2) is a voluntary competency framework for use by the addiction workforce and other mental health workers to measure “professional capacity, capability and personal competency to work with Māori”. The framework integrates clinical and cultural knowledge and practice into competencies that are focused on positive outcomes, and represent a standard of excellence for the workforce to aspire to.

New Zealand healthcare researchers, Baker and Levy (2013, p. 473), argue the basis of provision of appropriate care for Māori and whānau is a clinically and culturally “capable and competent Māori health workforce” and that the development of this workforce needs to happen within the broader context of Māori development. The authors argue for the development of indigenous health practitioners who are capable of bridging the “interface between indigenous and western knowledge bases”, but state that this needs to occur alongside the development of indigenous health leadership and training programmes that support the specialisation of indigenous health practice (p. 474). Baker and Levy identify barriers to working to top of scope in the context of cultural capability, including the technical and task-focused emphasis of competency frameworks that focus on individual employees rather than system-wide cultural competency. The authors also emphasise a generalised lack of distinction between culturally capable non-Māori health workers and a specialised indigenous Māori workforce.

A 2012 review (Midland District Health Board, 2012) of the New Zealand addiction sector identified gaps in workforce development for the Māori addiction workforce and limited cultural responsiveness to tāngata whai ora. The authors recommended better alignment with specific cultural competency frameworks and workforce development tools for working with tāngata whai ora.

The *Rising to the Challenge: Mental health and addiction service development plan 2012–2017* (Ministry of Health, 2012) emphasised greater alignment between MH&A services

and whānau ora providers. In the context of health and social services, whānau ora focuses on self-management, healthy lifestyles, social participation and participation in te ao Māori, economic security, and cohesive, resilient, nurturing communities (Te Rau Matatini, 2014 citing Taskforce on Whānau-centred initiatives, 2009). A whānau ora workforce provides “culturally appropriate whānau-centred best practice services to whānau”, building on a foundation of Māori culture, including understanding whānau as a collective, emphasising “intergenerational dynamics” and group self-determination, and supporting positive roles for whānau (Te Rau Matatini, 2014, p. 5, citing Durie, 2013). Whānau-centred best practice is an approach that applies to all professional groups across a range of health and social services.

Case study: Te Rau Matatini Māori workforce development in New Zealand

Te Rau Matatini is a New Zealand government-funded organisation committed to building a strong Māori workforce across the New Zealand health and disability sectors. Te Rau Matatini has undertaken four key pieces of work to support the development of the Māori MH&A workforce.

- *Kia Puāwai Te Ararau: National Māori mental health workforce development strategic plan 2006–2010* (Te Rau Matatini, 2006), which includes expanding the capacity of the Māori health workforce through:
 - » recruitment and retention
 - » strengthened clinical and cultural expertise
 - » more coordinated workforce development.
- Huarahi Whakatū – a professional development framework for Māori registered nurses (Te Rau Matatini, no date), based on dual clinical and cultural competencies, and providing a pathway for Māori nursing professional growth and development. It supports the development of an indigenous health workforce.
- *Whiria te Oranga: Kaumātua workforce strategy for mental health and addiction services* (Te Rau Matatini, 2008), which focuses on developing kaumātua as community leaders and to provide support for the MH&A workforce in service delivery and planning in the context of whānau ora and recovery approaches.
- *A Mental Health and Addiction Workforce Framework: A whānau ora approach* (Te Rau Matatini, 2014) provides direction to MH&A services to support the delivery of whānau-centred best practice. The framework focuses on developing cultural knowledge bases, developing systemic change to support more integrated practice, improving communication and collaboration, and incorporating whānau-centred best practice across a range of organisations and programmes.

Pacific practice

Le Va is a New Zealand-based Pacific organisation and hub for MH&A workforce development and disability support service coordination. Le Va has developed the Engaging Pasifika cultural training programme (Le Va, 2014a), designed to enable non-Pacific health and disability workers to improve their workforce skills and understanding of Pacific values and identity, and to respond more effectively to the needs of Pacific service users and their families. The Engaging Pasifika programme uses online resources, live training workshops, and post-training forums to support the development of cultural competency. The programme focuses on themes around family, language and tapu to develop reflective understanding in practitioners and more successful engagement with Pacific families.

The Engaging Pasifika programme builds on the Seitapu framework (Le Va, 2007) of Pacific cultural and clinical competencies. The Seitapu framework blends cultural and clinical theory and practice, which are considered around themes of families, language, tapu and organisation, and underpinned by ethical paradigms and support from health sector organisations.

Le Va has also developed the *Talking Therapies for Pasifika Peoples* guide (Le Va, 2010 no page number) to support therapists to “build rapport and maintain engagement” with Pasifika individuals and their families. The Le Tautua emerging leaders programme (Le Va, 2014b) supports emerging Pacific leaders to develop their leadership knowledge and skills to become more effective Pacific leaders and managers.

Case study: Pasifikology psychology group in New Zealand

Pasifikology is a collective of Pacific psychologists whose objective is ensuring that psychology practice is more relevant for Pacific people in New Zealand. The group’s focus is on growing the Pacific psychologist workforce via an assisted pathway based on support and mentoring. The group shares knowledge and information, networking opportunities and support. The Pasifikology fono is open to Pasifika psychologists, as well as graduates and students of psychology. The group combines western perspectives of psychology with cultural knowledge and skills, and promotes the development of more culturally responsive psychology practice (Pasifikology, 2014).

International examples

In the international context, the New Ways of Working framework (Department of Health, 2007, p. 31) in the UK outlines the development of a number of new roles in mental health, including community development workers for black and minority communities who “act at a strategic level as change agents, service developers, capacity builders and access facilitators for the whole of the [black and minority ethnic] community”.

In Australia, specific training programmes for Aboriginal mental health workers are producing clinically and culturally skilled local mental health workers. Graduate numbers are low, however, and graduates are often recruited by other sectors (Miller et al., 2011). Miller highlights challenges and barriers around training indigenous Australian health workers in mainstream mental health services. Problems include lack of “organisational readiness” in terms of attitudes and capacity for support from existing staff, unclear role definition, and inadequate mentoring and supervision (p. 11). The Aboriginal Medical Services Alliance case study below is an example of an expanding culturally specific, effective, autonomous and local indigenous service initiative. This example highlights best practice around culturally responsive, appropriate and effective services for indigenous people, including community control, integration with existing practice, cultural “locatedness”, local autonomy and evidence-based in terms of what works for particular population groups (Aboriginal Medical Services Alliance Northern Territory, 2008).

Case study: development of expanded Aboriginal primary care service in Northern Territory, Australia

The high burden of mental illness and addiction for aboriginal people in the Northern Territory has led to the development of a revised model of care within existing Aboriginal community-controlled health services.

Access to mental health and AOD services by Aboriginal people in remote areas has traditionally been poor. Building on established and effective primary care infrastructure, the new service includes integrated treatment and rehabilitation for both physical and MH&A issues within a single comprehensive primary healthcare service provider.

The proposal involves expansion of the existing scope of practice for Aboriginal family support workers to include preventative and health promotion approaches to MH&A, in conjunction with other practitioners, based on clinical pathways and referral protocols that are matched to local needs. Training for family support workers is central to the initiative to enable them to provide brief interventions and refer clients onto other team members for more comprehensive assessment and treatment (Aboriginal Medical Services Alliance Northern Territory, 2008).



6 - Professional boundaries and profession-less roles

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There is considerable evidence in the literature that professional boundaries and poor relationships between professional groups are significant barriers to working to top of scope (Antunes & Moreira, 2013; Bresner & Doran, 2005; Chan et al., 2013; Duckett, 2005; Elsom et al., 2008; Holmes, 2006; Kislov et al., 2012; Miller et al., 2011; Sayers & DiGiacomo, 2010).

Bresner and Doran's (2005) Canadian research on nurse perceptions of the extent to which they were able to work to full scope linked role clarification with issues around inter-professional relationships. Mental health nurses in that study reported barriers to working at top of scope where there was role overlap with other health professions, as well as where there were differences in service user management approaches between professions, particularly between physicians and mental health nurses. On the other hand, all of the nurses in the study identified that working to top of scope was enhanced by the quality of inter-professional relationships including valuing each other's knowledge and skills, being listened to, and being supported to work to the full extent of their capability, for example by having input into care plans.

Professional boundary issues are also apparent around the interface between physical and mental health, with uncertainty amongst mental health nurses about their role in relation to physical health needs. Researchers (Bradshaw & Pedley, 2012; Howard & Gamble, 2011) describe significant ambiguity and

uncoordinated care around this interface, with inconsistency around which branch of nursing is responsible for physical health in people with serious mental illness and between nursing and medical staff.

A recent New Zealand review (Te Pou o Te Whakaaro Nui, 2014c, p. 10) of the international literature around serious mental illness and poor physical health outcomes confirmed the impact of reduced access to healthcare for people with serious mental illness, as well as issues around poorer quality of healthcare due to "financial barriers, stigma and discrimination" and lack of clarity around roles and responsibilities. Interventions identified in this review include co-locating primary care professionals in mental health services, routine screening, assessments and monitoring within mental health services, and training for mental health workers to better respond to physical health needs.

Case study: weight management programme for adult service users in the UK

This mental health-specific weight management programme supports adult mental health service users to manage weight gain caused by a range of factors, including medication side-effects. The programme is led by a senior physiotherapist and exercise specialist, with input from other allied health professionals, pharmacists, mental health professionals and gym staff. The programme is based on the application of improved exercise and eating habits to support weight loss, healthier lifestyle and improved self-esteem (Department of Health, 2007, p. 68)

Duckett's (2005) health workforce review highlighted significant differences between professions around professional education, professional practice, and professional ideology and identity. Duckett argues for greater realignment of responsibilities between the professions and a reform of the "monodisciplinarity" of health professionals (p. 205). Kislov (2012) describes the established nature of professional jurisdictions and the resistance to change and inter-professional conflict that arises out of role change and task shifting. McAllister et al (2014, p. 36) argue that graduates from disciplines commonly found in mental health services "are likely to be well versed in their own discipline views, but may lack the insights, experiences, and vocabulary needed to understand and question tacit assumptions operating within and across different health disciplines". Chan et al (2013) call for an "unlearning" of traditional ways of relating and interacting that are based around differences in professional identities and result in "conflicts caused by organizational structure, hierarchy and unequal power" (p. 5). They argue that inter-professional competence should be based around "openness and respect", equality, ethical safety in the workplace, and the development of common values and goals. The UK New Ways of Working framework (Department of Health, 2007, p. 11) emphasises thinking "in terms of competence, not profession" and sharing "knowledge, skills and competences across professional and practitioner boundaries".

The development of a generic healthcare worker and cross-disciplinary professional is a recurrent theme in the literature,

although not surprisingly this support tends not to come from within the profession-specific literature. Holmes (2006) argues that existing professional boundaries and hierarchies are established around the biomedical model and prevent holistic, multidisciplinary care and support. Holmes calls for the development of a generic mental health worker who provides "a service which focuses on a specific constellation of problems or needs, and the required services, without identifying themselves as belonging to a particular discipline" (p. 408). Holmes also argues that the Sainsbury Centre's "capable practitioner" (Sainsbury Centre for Mental Health, 2001) is an example of a generic mental health worker and that the new workforce needs be made up of new roles, based on new training and new professional identities. The Australian Health Workforce Advisory Committee (2005, p. 16) report into models of care highlights the need to move away from profession and occupation-based approaches to health workforce planning, focusing instead on "competencies, skill mix and whole of workforce planning approaches", within which a multi-health professional role is a key response to workforce supply pressures.

The Mental Health Practitioner programme (J. Brown, Simons, & Zeeman, 2008) in the UK has seen the development of a new trans-disciplinary role in mental health that bridges psychology, nursing and occupational therapy, and works alongside mental health nurses in acute inpatient units. Most mental health practitioners are psychology graduates and the aim of the new role is, in part, to improve inpatient access to psychological therapies. The success of the programme has been mixed, often because of issues around professional boundaries and role clarity. In a review of the new roles in practice, mental health practitioners reported difficulty distinguishing themselves from mental health nurses, and a lack of understanding of their role by other colleagues. Not all mental health practitioners had opportunities to undertake therapeutic or psychological activities with service users, with barriers including insufficient staff capacity, lack of role clarity compared to nurses, or competing with occupational therapists and clinical psychologists to deliver this activity. In some instances, mental health practitioners reported that other staff did not view therapeutic activities positively or that clinical psychologists were unwilling to work with them, or that the multidisciplinary team was very hierarchical. Many mental health practitioners had a much more positive experience through being accepted into the team and supported through their transition onto the ward and into their role (Brown, 2003).

Case study: integrated model of care - dual diagnosis in Victoria, Australia

Jigsaw is a dual diagnosis service for young people aged 15 to 25 years. The service was developed to better respond to the high prevalence of substance use in youth with mental health disorders. The service brings together clinical mental health and AOD practitioners based around two hubs in regional Victoria. All clinicians have a generic job description and are expected to have both mental health and AOD knowledge. Where there are gaps in knowledge, specific training is provided.

Service users are screened over the phone with some coming in for full psychosocial assessment. Case managers are allocated based on expertise and service user need and Jigsaw clinicians have access to psychiatric and other mental health support. Staff members are provided with ongoing opportunities for study and professional development. The overall focus is on integrated treatment, and the model results in better use of time and resources and improved outcomes for the young people in the service (Australian Healthcare Associates, 2011, pp. 40-41).



7 - Education and training

7 - Education and training

A common theme in the literature is the disjoint between professionally-based education and the collaborative and community nature of MH&A service provision. This is reflected in the previous section on professional boundaries and profession-less roles. The Centre for Workforce Intelligence (Fellows et al., 2014) in the UK reviewed big picture challenges for the future workforce to provide context for future models of care. In the context of “health and social care system and design” the authors identified “better integration between health, social care and support organisations” (p. 4). The authors emphasised the problematic separation of professions throughout their education until they are trained, at which point they are required to work in integrated teams and may fail due to “attitudinal biases, lack of understanding of others’ professional roles and expertise, and an absence of the competencies needed for effective teamwork and collaborative practice” (Fellows et al., 2014, p. 8 quoting Thibault, 2013).

The response to this challenge has been increasing calls for inter-professional education and training (Cox & Naylor, 2013; Garling, 2008; Sayers & DiGiacomo, 2010; World Health Organization, 2010a). Inter-professional education is defined as: “when two or more professions learn with, from, and about each other to improve collaboration and the quality of care” (Centre for the Advancement of Interprofessional Education, 2014). The World Health Organization (2010a) undertook a major review of inter-professional education and collaborative

practice in 2010. The report explained that inter-professional education is a fundamental component of the transition of health systems from “fragmentation to a position of strength” (p. 10). It found that inter-professional education prepares students to enter the health workplace ready to work as part of a collaborative team, better optimises employee skills, allows for shared case management, and results in better health and wellbeing outcomes .

In a substantive review of the literature around inter-professional education, Thistlethwaite (2011) argues there is a lack of long-term evaluation of inter-professional education and that meta-analyses show mixed results, but overall, there is evidence that inter-professional education “encourages inter-professional collaboration and that it improves client care” (Thistlethwaite, 2011).

There are relatively few studies looking at inter-professional education in mental health-specific contexts (Priest et al., 2011). McAllister et al (2014, p. 36) state that most Australian MH&A service delivery is multidisciplinary, but that inter-professional training is either completely absent or at best ad hoc, and that current clinical training “reinforces individual professional boundaries ... and maintains perceptions of differential power and status”. McAllister and colleagues’ research aimed to expand the evidence base for inter-professional education research that was specific to MH&A contexts and professions.

Their research assessed the benefits of inter-professional education for final year undergraduate students from health promotion, nursing, paramedic science, psychology, social work and occupational therapy, as well as graduate students from psychology. The study had a relatively small sample size and no control group, and the authors noted the difficulty of generalising beyond the sample group. However, the research did show that inter-professional education in this context built connections between disciplines and promoted “more seamless care for clients and consumers” (p. 42).

Other aspects of the education debate focus on training for purpose within professional groups. Bresner and Doran’s (2005) research on the features of working to top of scope in nursing highlights the disjoint between what nurses are educated to do versus what they do in practice. Bresner and Doran (p. 3) describe this as an opportunity to “improve nurses’ ability to optimize their skills and knowledge”, and give an example of a mental health nurse in the study explaining that their nursing training included group therapy and wanting to implement this approach in practice, but their day-to-day work reality prevented this from happening. Other nurses in the study explained that the busyness and task focus of everyday practice prevented nurses from advancing their practice into areas they were educated for (pp. 19-20).

Changes to training and education programmes internationally include the development of and training for new roles (Brown et al., 2008), changes to curriculum (Department of Health, 2007; Miller et al., 2011), and blended learning programmes (Eddy, 2010; Garling, 2008). *Mental Health: New ways of working for everyone* (Department of Health, 2007, p. 78) in the UK outlines a review of the training models for applied psychologists⁵, which was carried out to facilitate the unification of the branches of applied psychology and to support the development of “new and flexible roles”. Training for psychiatrists in the UK has also been reviewed, based on significant change in the role of consultant psychiatrists. Training for psychiatrists in the UK includes a broad range of skills and experience to competently deal with the most complex cases and to supervise other colleagues in multidisciplinary settings (Department of Health, 2007).

Some authors (Brunero, Yun-Hee, & Foster, 2012) have questioned the educational preparation of generalist health practitioners for work in mental health. Brunero et al. (2012) reviewed literature on mental health education programmes for generalist health practitioners and showed the positive effects of these programmes on practitioners’ knowledge,

skill and attitudes. The review also showed that “supervised clinical experience, role play and case scenarios” were more effective methods of learning (p. 428).

The Australian Association of Social Workers (Miller et al., 2011) introduced core curriculum mental health content for all undergraduate social workers from 2010. This means that all Australian-trained graduate social workers will have core mental health competencies, with the benefit of what Miller and colleagues describe as increased mental health literacy in other work settings. This practice is not reflected in the New Zealand social work training context. The Australian Association of Social Workers has also developed practice standards for accreditation as a mental health social worker (Miller et al., 2011, p. 7).

Miller et al. (2011, p. 41) describe the broader scope of MH&A practice and capabilities that need to be reflected in undergraduate education including: home and community-based services, new values, skills and attitudes, multidisciplinary practice environments, partnerships with a range of stakeholders, cultural competence, individualised care, and skills such as facilitation, negotiation and consensus building.

Working to top of scope in increasingly complex work environments requires system characteristics that support holistic contextual practice and the capacity to process and reflect on multiple sources of information (Fraser & Greenhalgh, 2001). Fraser and Greenhalgh argue that educating employees to be capable practitioners should be based on education and training that goes beyond content-based curricula, to curricula that is process-focused with supported opportunities for informal and unplanned learning, self-directed learning and non-linear learning (Fraser & Greenhalgh, 2001, no page reference).

5 - Including clinical, counselling, educational and child, forensic, health, occupational, sport and exercise psychology, and neuropsychology.

Case study: inter-professional education - nursing and social work in Hong Kong

Nursing students and social work students received combined training in two community settings (a school and a retirement village) to explore opportunities to develop multidisciplinary work practices. The opportunities for reflective feedback throughout the research highlighted a lack of understanding about the roles, values and scopes of practice of each profession by the other group.

The intent of the research was to highlight the value of inter-professional education in terms of:

- clarifying roles
- learning about own strengths and weaknesses
- developing enhanced communication practice
- understanding teamwork and multidisciplinary practice
- breaking down stereotypes.

The authors emphasised the importance of continued reflective learning in a practice environment where there is often “fragmented collaboration” between nursing and social work, as well as the importance of constructing a shared identify and purpose beyond professional boundaries (Chan et al., 2013, p. 5).

| Discussion

There is no doubt that the international healthcare sector is under significant pressure as a result of workforce supply issues and increased demand for healthcare. The health sector is also in a significant state of change due to increased emphasis on accountability and productivity, and shifting terrain around the location of and outcomes sought from health services, with numerous opportunities for services and practice to focus on increased effectiveness. Within MH&A services, practice is more dispersed throughout community settings and there are many examples in the literature of innovative practices that are revisiting traditional ways of providing services.

The New Zealand policy context emphasises increased effectiveness through innovation, collaboration, cultural competence, use of models of care, and strengthening the existing workforce. The focus is on a more seamless experience for service users, and better alignment between services around consistency of practice and workforce capability.

The definition of working to top of scope identified at the outset of this review incorporates ideas about system features that support workforce effectiveness, as well as an emphasis on the importance of adaptive roles and practice in a rapidly changing healthcare environment. Within the broader policy context, and using the definition as a guide, this literature review identifies the key features of working to top of scope across a disparate range of professional groups, with different ways of practising, across a multitude of MH&A settings.

Models of care

The emphasis on models of care is central to this discussion, because models of care provide a framework within which to resolve a range of other issues that present barriers to working to top of scope. The emphasis in the literature (Davidson et al., 2006; Dubois & Singh, 2009; World Health Organization, 2014) on models of care shifts the focus away from supply, cost and skill-mix issues, to service innovation, improved quality of care and a focus on improved utilisation of the existing workforce.

Most the case studies in this review are based on realised models of care, where the model of care is used as the framework for innovative role change or service development. The case studies outlined are important, because they translate the discussion about models of care as systems, into real-life examples of services that improve the everyday experience of service users. The case studies share a number of features that are central to

this discussion around working to top of scope. These common features include:

- integration – between health and social services, or across the primary–secondary healthcare continuum
- holistic approaches to the service user pathway, with an emphasis on social and personal wellbeing
- positive and productive inter-professional and inter-agency relationships
- shifts in traditional roles and responsibilities
- clearer scopes of practice and opportunities for broader (generalist) or deeper (specialist) scopes of practice.

Whatever the model of care looks like, it should support the development of a care pathway that allows for a seamless experience for service users, their families and whānau, with workforce shape, function, roles and tasks mapped along that pathway. Models of care can be very local, and should allow services to articulate what the pathway looks like in their service, and to specify what workforce resources are needed to give effect to that pathway. In this way, the emphasis moves away from professional background being the determinant of the shape and nature of care provided, to a pathway populated by the right mix of workforce skills and capability.

This top of scope work supports services to identify common barriers to implementation of a seamless care pathway, such as lack of role clarity, inter-professional disputes, hierarchical practice and unclear scopes of practice. It also supports services by identifying critical components when resourcing a pathway, including: the development of explicit and purposeful roles, tasks and responsibilities; opportunities for innovative specialist and generalist roles; clarity around professional identity, skills and knowledge within a multidisciplinary environment; enhanced support for capable practice; better matching between education, training and practice; and clarity around leadership responsibility and function.

Role clarity

Role clarity has a huge impact on working to top of scope. Roles, tasks and responsibilities need to be clearly identified at an individual health worker level, within and between teams, within and between professional groups, and along the care pathway. The shifting nature of health practice, especially in an environment of task shifting, role enhancement, role enlargement, role substitution and delegation, puts the onus on organisations to be specific and explicit about what employees are intended to do and why. Role changes need to

be positioned within a broader, system-wide conceptualisation of change, including clarity about models of care, backed up by good change management processes, comprehensive and specific education and training, supervision, and support for professional credibility and expertise. The example of the Queensland Health (O'Malia et al., 2013) development of social work assistants is a good example of change positioned within a model of care framework, and is an example of a proactive response to a problem to allow for much more effective and articulate use of the social work skill set.

Expanded practice

Examples in the literature review (Department of Health, 2007; Dubois & Singh, 2009; Thistlethwaite, 2011; Wand & Fisher, 2006; World Health Organization, 2008) highlight issues around both specialisation and generalisation of practice. There is a place for both, but again the existence of either should be positioned within a clear model of care, and underpinned by explicit expectations about what staff are expected to do, and are capable of doing. The Occupational Therapy Board of New Zealand's (2011a) consideration of broad occupational therapy practice is a good example of how to support generalists at the margin of their scope. The success of this model is in the encouragement of reflective decision-making, underpinned by regulatory, ethical and competency frameworks, as well as the provision of high-quality support and supervision.

The literature (N. Baker, 2010; Currie & Crouch, 2008; Gilfedder et al., 2009; Holloway, 2011; O'Malia et al., 2013; Pearcey, 2007; The Australian College of Mental Health Nurses, 2013) identifies that proliferation of specialised and expanded practice, particularly in nursing, provides many opportunities for working to top of scope, including opportunities for more responsive practice, more technically specialised practice, opportunities for innovation, increased collaboration and improved job satisfaction. Challenges around expanded practice occur where workers lose the opportunity for provision of basic care, where there is poor institutional support for expanded practice, and where expanded practice is used solely as a mechanism to wring more efficiency out of the system.

Barriers to expanded practice are clearly identified in the literature (Bradshaw & Pedley, 2012; Bresner & Doran, 2005; Miller et al., 2011; Oelke et al., 2008) as professional siloed behaviour, inter-professional disputes and variation in practice, ownership of particular interventions by professions, minimal differentiation between specialists and generalists, and incomplete knowledge about what others in the team

can do, and what they do in practice. Bresner and Doran's (2005) research into nursing scope of practice highlighted the consistent underestimation of ability, and the effect this had on nurses' job satisfaction and capacity to work to top of scope. Barriers to expanded nursing practice also include a poorly articulated framework for specialisation and it is fair to say this lack of framework probably applies across many other professional groups.

Professional identity

The initial scope of the review was limited to psychiatry, nursing, occupational therapy, psychology and social work. The parameters of the review were later broadened to include counsellors, support workers, the peer workforce and the emerging kāumatua workforce. It is acknowledged that the support workforce and the kāumatua workforce are not being regulated. In terms of future workforce development in New Zealand, *Rising to the Challenge* (Ministry of Health, 2012) clearly signals the strengthening of community-based services, including an enhanced support workforce, and the development of a whānau ora workforce. Discussions are underway nationally on the registration of the support worker workforce, and this may include the development of a competency framework or practice standards.

The reality is that the features of top of scope apply, no matter what workforce group is being considered. For example, Pace (2009) describes unclear boundaries between generic mental health support workers and professional staff resulting in support workers commonly operating outside of their job description.

Professional boundaries and relationships are a key influence in working to top of scope. The literature demonstrates that when professional relationships work well, scope of practice is enhanced (Bresner & Doran, 2005; J. Brown et al., 2008). Poor professional boundaries are regularly identified in the literature as the most significant barrier to working to top of scope and this issue has significant overlap with the need for role clarity (Antunes & Moreira, 2013; Chan et al., 2013; Duckett, 2005; Elsom et al., 2008; Holmes, 2006; Kislov et al., 2012; Miller et al., 2011; Sayers & DiGiacomo, 2010). Many commentators (Australian Health Workforce Advisory Committee, 2005; Brown et al., 2008; Department of Health, 2007; Duckett, 2005; Fellows et al., 2014; Kislov et al., 2012; McAllister et al., 2014) call for a reform of the mono-disciplinary nature of health practice, particularly in the context of MH&A services, arguing that workforce should be considered in terms of multidisciplinary competence and capability. In addition, these authors argue professional background should not be

the determinant of the shape and nature of the care provided, instead the emphasis should be on a model of care populated by the right mix of workforce skills and capability.

A number of international authors (Brown et al., 2008; Department of Health, 2007; Holmes, 2006; Miller et al., 2011) are signalling the development of new profession-less roles within MH&A services to bypass professional boundary issues and barriers to top of scope. These roles are being developed to mixed success and, in part, the effectiveness of profession-less roles seems dependent on high-level organisational support and sponsorship. Consideration of these roles in the New Zealand context should be part of a separate review. The literature (Brunero et al., 2012; Miller et al., 2011) also highlights the need for improved training for generalist practitioners.

The implementation of the mental health practitioner model in the UK (Brown et al., 2008) highlights challenges around role clarity and purpose, and difficulties in integrating the mental health practitioner workforce into existing professionally-based workforce environments. In the New Zealand context, since the implementation of the Health Practitioners Competence Assurance Act 2003, the development of a MH&A key worker or case manager role has posed similar challenges around the scope of the generic role versus the scope of the professional role, the ability to maintain the professional identity of the employee, and the competency requirements of their professional affiliation (H. P. Hamer, personal communication, 1 September, 2014). The generic versus specialist multidisciplinary approach in MH&A settings poses a continuing challenge for professionals to demonstrate the competencies within their professionally determined scope of practice.

The dapaanz framework (dapaanz, 2011) negotiates this dilemma more effectively. Many New Zealand drug and alcohol workers are trained and registered as nurses, social workers or psychologists, yet their primary professional identity is as a drug and alcohol worker and their professional behaviour is regulated through their voluntary membership of dapaanz. The *Let's get real* framework (Ministry of Health, 2008) takes a similar approach, cutting across roles and professions to determine more explicitly what it means to be a capable MH&A worker in New Zealand.

Duckett (2005) differentiated between professional education, professional practice, and professional ideology and identity, and argued that narrow concepts of professional identity are significant barriers to effectiveness. His work raises the question of how to make a distinction between what it means to be a professional in the context of MH&A with a particular

set of skills and capabilities, and a professional limited by the bounds of professional training and professional ideology.

There needs to be further discussion in the New Zealand context around the nature of professional identity, professional scope and professional practice, particularly when thinking about the evidence of barriers to effectiveness that are based around professional boundaries and hierarchies.

The Australian College of Mental Health Nurses' scope of practice (The Australian College of Mental Health Nurses, 2013) takes a different approach to the issue of professional identity, through the implementation of a capability-based scope of practice that responds to the changing expectations around provision of MH&A services. The Royal Australian and New Zealand College of Psychiatrists has changed the training for its fellowship scheme to a competency-based framework to ensure training is relevant to contemporary psychiatry and to increase the number of people attracted to that speciality area.

There is also a significant push in the literature around inter-professional education and there is solid evidence for its efficacy in resolving barriers to top of scope (Cox & Naylor, 2013; Garling, 2008; Sayers & DiGiacomo, 2010; World Health Organization, 2010a). However, a number of authors (McAllister et al., 2014; Thistlethwaite, 2011) are clear that the 'how' and 'what' of inter-professional education is important and needs further research particularly in the context of MH&A services. This warrants separate consideration and further review in the New Zealand context. The literature (Bresner & Doran, 2005) also points to a disjoint between training for purpose, and limited opportunities to exercise that purpose in the work context due to workload pressure and the task-focused nature of everyday practice. Enhanced top of scope at an individual level is fundamentally about doing what you are trained to do, as effectively as possible, without that function being undermined by other tasks or responsibilities. The development of the social work assistant role in Queensland is a good example of task delegation, where the social work capacity for effectiveness was enhanced by clarity around and separation of roles (O'Malia et al., 2013).

Capability

The discussion around capability in the literature (Ministry of Health, 2008; Sainsbury Centre for Mental Health, 2001; The Australian College of Mental Health Nurses, 2013) looks at top of scope in terms of both the individual and the system. There are several aspects of capability that are explored further in this review that are fundamental to working to top of scope.

Multidisciplinary practice involves a shift away from defining care and support in terms of professional differences, to team practice defined by skills, competencies and capability; what Chan et al. (2013) describe as "complementary competencies". Multidisciplinary practice allows for empowerment of professional skills and practice, but can be undermined by lack of organisational support, poor change management processes, lack of role clarity and resistance to change in practice.

The links in the literature (Department of Health, 2007; KPMG International, 2012b) between multidisciplinary practice and leadership are crucially based around the attitudinal changes required to move away from professionally-defined relationships and hierarchies. Good leadership is required to initiate change and support innovation, as well as for supporting consistent good-quality practice.

The World Health Report 2006 (2006b, p. xxii) describes supervision as "one of the most effective instruments available to improve the competence of individual health workers", but clarifies that the quality and type of supervision is important. Supervision needs to be supportive, educational, consistent and responsive to specific problems. Professional and clinical supervision should be distinct from line management. The literature also shows that supervision is strongly linked to reflective practice and has a key role in the development of capable practice (Edmonstone, 2011; Sainsbury Centre for Mental Health, 2001; Walsh et al., 2005); and is protective against staff burnout and is particularly important in the context of MH&A services (Cookson et al., 2014; Edwards et al., 2005; Knudsen et al., 2008). A number of authors (Department of Health, 2009; KPMG International, 2012a; Mental Health Workforce Advisory Committee, 2011) position supervision and mentoring in a broader context of good human resource management.

Multidisciplinary practice and support for individual competence through supervision should be evident in all New Zealand MH&A services. As features of top of scope, they support individual practitioners to more effectively navigate ambiguities around scope of practice and professional interface issues, particularly in a context of changing roles and changing service environments.

Culturally responsive practice

New Zealand is relatively advanced in its consideration of culturally capable practice and there is evidence of a number of innovative programmes (Le Va, 2007, 2010, 2014a, 2014b; Te Rau Matatini, 2006, 2008, no date) to support the effectiveness of Māori and Pasifika practitioners, and the development of

culturally specific programmes, as well as the development of cultural competency across wider health services (Le Va, 2014a; Matua Raki, 2010; Ministry of Health, 2008). However, the literature (M. Baker & Levy, 2013; Delphin-Rittmon et al., 2013; Midland District Health Board, 2012; Moko Business Associates, 2003) is clear that barriers can include a lack of organisational readiness and support for developing cultural responsiveness and cultural competency. The issue for provider networks is the attitudinal shifts required for the development and integration of both an indigenous and culturally specific workforce, and culturally competent practice across mainstream services.

Leadership

Finally, the literature (Department of Health, 2007; Duckett & Breadon, 2014; KPMG International, 2012b; Thistlethwaite, 2011) is unequivocal about the importance of reform driven by clear, determined and consistent leadership. Enhanced effectiveness through working to top of scope can be achieved through concrete approaches to role clarity and role changes, multidisciplinary practice, cultural responsiveness, changes to professional relationships and altered education paradigms, but the fundamental push for these changes has to come from system-wide commitment to change, and comprehensive and sustained leadership.

Overall, the literature reviewed and the case studies included in this report, emphasise that improved effectiveness of individual, team, service or organisational practice is dependent upon change at a system level. Working to top of scope requires a focus on clarity of purpose, the outcomes sought, and the future shape and nature of services and roles to support the MH&A workforce to be effective. The literature shows that focussing less on productivity and efficiency, and more on organisational responses, will result in getting the best out of a highly professional and skilled workforce.

Conclusion

This literature review brings together a number of disparate features identified in the health workforce literature under the umbrella of working to top of scope. The review builds a picture around these key features, in order to support individual employees to work to their potential, to foster an environment of best practice, and enhance the effectiveness of service delivery. The emphasis on effectiveness focuses the analysis on the capacity of the system to meet organisational and individual employee goals and objectives. The review is future-focused and identifies ways of optimising the MH&A workforce through the development of new roles and new ways of practice, and ensuring that policy, provider and service environments support these new roles and practices to succeed.

The features identified in the review provide useful points of focus for services to use when assessing whether they provide an environment that supports working to top of scope. This review includes a summary document, which aims to encourage services to talk about top of scope. The expectation is that the summary document will encourage discussion about:

- whether roles, tasks and responsibilities are clear
- whether particular tasks are the best use of a person's skill set
- how innovative roles might improve service user experience
- the nature of professional identity
- better ways of supporting generalist or specialist work practice
- the role of supervision in supporting effectiveness
- how leadership considers the features of top of scope in workforce planning
- how professional boundaries impact on day-to-day practice
- what a model of care or seamless care pathway should look like, and how that might change work practice.

The review also provides guidance for workforce development initiatives and organisations around MH&A workforce redesign. It identifies some of the fundamentals that organisations must consider when reconfiguring a service environment to meet broader policy objectives.

Recommendations

- 1 MH&A services take account of the features of top of scope that support the workforce planning approach described in *Getting it right – workforce planning guide* (Te Pou o Te Whakaaro Nui, 2014b).
- 2 MH&A services consider:
 - how the use of a model of care will enhance workforce effectiveness through assisting roles to work to top of scope
 - how improving role clarity and role changes will lead to improvements in service delivery and service user experience
 - how to incorporate key aspects of enhanced capability (multidisciplinary practice, leadership and supervision) in service development and effective practice
 - how professional identity and professional relationships enhance or limit effective practice.
- 3 The development of mainstream cultural responsiveness and the development of a culturally competent indigenous workforce is a priority for MH&A services and workforce development initiatives.
- 4 Opportunities for innovation in educating and training the MH&A workforce are explored, particularly around enhanced multidisciplinary practice and inter professional education.
- 5 The national MH&A workforce development centres use the results of the literature review to inform and support existing workforce development and training programmes.
- 6 Professional associations consider building capability into scopes of practice.

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