Scope it right

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

Introduction

Scope it right is a workforce development resource to support organisations, services and practitioners in mental health and addiction (MH&A) to work at the top of scope of practice. *Scope it right* reviews the international literature to identify key features of top of scope and provides information to support workforce planning and development, service (re)design, recruitment and retention processes and enhanced practice. The emphasis is on creating the right practice environments to support individual employees to work to their potential, foster an environment of best practice, and enhance the effectiveness of service delivery, with the service user and their family and whānau at the centre of all MH&A practice.

This document:

- summarises the key findings from the *Scope it right* literature review
- describes some of the barriers to working to top of scope
- provides best practice case studies
- includes reflective questions for services to consider.

Defining top of scope

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 a 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.

Scope it right is relevant to all MH&A workforce groups

Scope it right is relevant to all MH&A workforce groups under the following regulatory frameworks:

- The Health Practitioners Competence Assurance (HPCA) Act 2003
- The Social Workers Registration Act 2003

- The dapaanz framework for addiction practitioners
- Voluntary registration of some workforce groups and practice outside of formal regulation

MH&A workforce groups have different professional philosophies and different ways of thinking about the determinants of health and wellbeing. *Scope it right* is relevant regardless of where a workforce group sits along the social–medical continuum of practice, and applies across the range of professional and specialised frameworks of practice.

Areas of top of scope

The *Scope it right* literature review focused on the following areas of top of scope:

- Regulation – important for clarity around accountability and enhanced safety.
- Innovation – apparent in evolving practice roles, reconfigured services and new models of care.
- Adaptive practice – critical in the context of changing health care roles, task shifting, and enhanced breadth (generalist) and depth (specialist) of practice.
- Workforce capability – central to cultural responsiveness, inter-professional behaviour and relationships, and effectiveness in multidisciplinary practice, supervision, and leadership.
- Professional identity – complex in the context of expanding specialist and generalist practice and collaborative work environments.
- Education and training – crucial for workforce fitness for purpose, particularly the development of inter-professional skills.

Exclusions

In order to keep the size of the review manageable, the following areas of literature were excluded: predictors of job satisfaction or burnout, the effects of workload and increased acuity, competency frameworks, and skill enhancement.

Case studies

There are numerous examples of innovative practice in New Zealand, however the case studies profiled in this document showcase top of scope and effective practice in international contexts. In particular, the case studies focus on applied models of care and care pathways, integration across the primary/secondary continuum, innovation in roles and services, improved efficiency in practice, enhanced breadth and depth of practice and shifts in professional identity.

New models of care

The literature review highlights that models of care are a crucial starting point for workforce development and innovation in healthcare provision. Models of care provide greater clarity for workforce in terms of their roles, the care process, inter-professional relationships, and responsibility for outcomes. Most of the case studies identified in the review are based on one of the following World Health Organization (2014) models:

1 Integrated care pathways – supported by multidisciplinary teams and based around the service user's journey.

2 Organisation level integration focusing on service user led goal setting, care planning, and self-management support, and based around the use of multidisciplinary teams, new roles, and continuity of care.

3 Integration between primary and secondary care including training and support for primary health workers and integrated management of co-morbidities.

4 Collaborative care in primary care settings often via case management and holistic care plans.

5 Stepped care based around low-intensity, low-cost interventions, moving to higher intensity treatment if and when necessary.

How does your service's model of care assist roles to work to top of scope?

Features of top of scope

Role clarity

Role clarity is defined as "certainty about duties, authority, allocation of time, and relationships with others" and is one of the most important features of working to top of scope (Davis, 2011, p. 78). Lack of role clarity is a significant barrier to working to top of scope and leads to:

- inconsistent practice
- inefficiency and underutilisation of skills
- task creep and role overload
- conflict between workers
- employee frustration and reduced job satisfaction
- poor workforce retention.

Role clarity is particularly important in acute settings with busy work schedules and constant change. It is also important when work roles are changing, for example, enhanced specialist practice, or when generalist practitioners are working at the edge of their scope of practice.

Are employees clear about:

- ***roles***
- ***tasks***
- ***responsibilities?***

Are they clear about their own role relative to others?

Task shifting

Healthcare roles are changing significantly as MH&A services evolve to better meet the needs of service users and as tasks shift between workforce groups. Task shifting is defined as "the rational redistribution of tasks among health workforce teams" where often specific tasks move from more qualified workers to those with fewer qualifications and less training (World Health Organization, 2008, p. 2). Task shifting occurs in response to challenges around workforce supply, changes to traditional professional spheres of practice, and better matching of workforce expertise with service user need. Task shifting often occurs in rural, isolated, or hard to staff locations.

Task shifting also occurs through the development of innovative care plans with new roles, redistributed tasks and functions, and a broader, more effective workforce. Common examples of task shifting include: consumer and family delivery of services, the development of expanded nurse practitioner roles, allied support roles, mental health support workers, nurse anaesthetists and anaesthetic technicians, and expanded prescribing roles by nurses, psychologists and ambulance officers. Task shifting can result in disruption to professional identity and existing hierarchies of practice.

Role changes

There is extensive and wide-ranging literature on health workforce role changes, this is particularly evident in the literature on the extension of nursing practice and the development of nurse practitioners.

There are four main ways healthcare roles are changing: role enhancement, role enlargement, role substitution, and role delegation (Dubois & Singh, 2009).

Role enhancement includes development of:

- a broader skill set and range of responsibilities
- non-traditional roles and skills outside of routine practice e.g. dual cultural and clinical skills.

Role enhancement does not involve undertaking tasks or functions from other professional groups (Dubois & Singh, 2009).

Case study role enhancement: Integrated addiction/parenting service

An integrated adult addiction programme in Sydney, Australia combines parenting support (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 (KYH)). The integrated programme focuses on each mother holistically but identifies a wide range of needs.

The programme also looks at the learning needs of two different groups of health professionals: clinical psychologists and drug and alcohol workers at KYH and allied health professionals and family health nurses at Tresillian. Each professional group retains their professional roles but an integrated, collaborative work programme and an inter-professional team approach allows for enhanced scope of practice and the development of greater expertise.

Feedback from mothers and staff members on the programme is very positive. Mothers appreciate being able to separate out their AOD issues from their role as a parent. Opportunities for good parenting are enhanced, supporting greater motivation for change, and allowing mothers to more effectively deal with their addiction issues (Rossiter, Fowler, Dunston, Sherwood, & Day, 2013).

Role enlargement involves:

- new skills at the same or lower levels to develop broader, more integrated roles
- better management of population groups, often with chronic conditions
- skills including case or programme management, development of care plans, and improved communication with a wide range of parties (Dubois & Singh, 2009).

Case study role enlargement: Home care services

A nurse led home care service in the Netherlands sees nurses taking on tasks most often devolved to home help and personal care services, as well as existing community nursing functions. 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 twelve nurses; they have responsibility for a defined population and 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, they are more productive and achieve improved outcomes (KPMG International, 2012).

Role substitution involves:

- extending practice outside professional scopes of practice into the domain of other professions
- support for hard to staff areas, for example, rural services, or to cover workforce shortages
- mixed efficacy, depending on context, for example, substitution of nurses for physicians, particularly in primary care, results in good outcomes and in some instances in greater service user satisfaction. In contrast, substituting highly qualified nurses with less qualified workers is less efficacious in terms of patient outcomes (Dubois & Singh, 2009).

Case study role substitution: Advanced mental health nursing practice

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 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 is supported through "critical companion mentorship systems" and competency frameworks. 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 more holistic skill set. Skill enhancement includes use of a capability framework to promote a rights-based, recovery-focused practice.

Ongoing support and supervision 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. The enhanced competency framework for the mental health advanced nursing practice role includes competencies around addictions and physical illness (Gilfedder, Barron, & Docherty, 2009).

Role delegation involves:

- breaking down existing job demarcations
- handing over responsibility for some tasks to less qualified and lower paid workers (typically in assistant roles)
- freeing up existing higher-qualified workers to utilise their specialised skills (Dubois & Singh, 2009).

Case study role delegation: Development of social work assistant role

Queensland Health implemented a model of care to encourage "full or advanced scope of professional social work practice alongside assistant staff". The 2009 project aimed to address inpatient acute setting pressure on social workers to manage high volume urgent referrals that resulted in less time on more meaningful interventions. Other issues included inconsistency in task execution, inconsistent processes within and between teams, and staff perception that they were not working to full scope of practice.

Queensland Health piloted a new social work assistant role based on 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 allows for better articulation of social worker role and purpose, a better understanding of the scope of practice for social workers, and the relative complexity of social work tasks and practice. The pilot has been so successful that the model has been rolled out in other Queensland Health social work departments (O'Malia, Hills, & Wagner, 2013).

Enhanced capability

Capability is defined as reflective, adaptive, ethical, effective, evidence-based practice based on ongoing implementation of new knowledge (Sainsbury Centre for Mental Health, 2001). Capability is necessary for the provision of holistic, recovery-oriented, collaborative services, with the service user at the centre. Capability is distinct from competency. Capability emphasises the 'how' of working while competency is the 'what' of working.

Barriers to the development of capability include:

- task-focused practice
- mono-disciplinary practice
- static, non-adaptive practice
- separation of ethical and clinical decision-making
- inadequate access to workforce support such as supervision and professional development.

Capability and working in teams

The literature review describes a shift from MH&A workforce defined by professional differences to multidisciplinary teams defined by skills, competencies, and capability. Multidisciplinary practice is based on complementary competencies, sophisticated communication, open and respectful behaviour, accountability for behaviour and outcomes, and collaborative interdependence (Chan, Lam, & Lam, 2013).

What are the features of multidisciplinary practice in your service?

What changes need to occur to enhance multidisciplinary practice?

Multidisciplinary practice incorporates:

- transparency of team composition, skill mix, and role clarity
- empowerment of individuals around professional practice and adaptive decision-making
- clearly defined goals
- an explicit model of care or care pathway.

Barriers to multidisciplinary practice include:

- lack of role clarity
- professions guarding their scope of practice
- resistance to change
- poor change management.

Case study: Integrated model of care for mental health

Development of an integrated model of care for mental health consumers by Intermountain Healthcare across two states in the US places mental health services at the heart of primary healthcare. Mental health integration clinics cater for both physical and mental health needs. Care and support is 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 talk therapy and the National Alliance on Mental Illness (NAMI) organisation providing information and education, and access to mentors. Training for 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).

Capability and leadership

Multidisciplinary practice requires capacity for and clarity around leadership, and expanded opportunities for leadership. Good leadership is collaborative, inclusive and open, and supports individual processes around expanding and extending scopes of practice, including opportunities for specialisation. Good leadership is critical for sustained system change, innovation and implementation of models of care. Service users need to know who is leading or coordinating care.

Barriers to effective leadership include:

- lack of role clarity
- confusion around types of leadership
- hierarchical, historic leadership structure
- lack of professional development for leaders
- poor institutional support for change and innovation.

Types of leadership in health care settings

1. ***Management*** – transactional and operational, links performance with objectives.
2. ***Leadership*** – responsible for transformational change in complex systems through the engagement of partners.
3. ***Clinical leadership*** – responds to strategic vision and leads improvements in services, team function, and service user care.
4. ***Professional leadership*** – leads professional identity and standards in the context of organisational goals.
5. ***Team leaders*** – responsible for team process, conflicts, relationships with other teams, team collectiveness around organisational goals and change processes (Department of Health, 2007).

Are leadership responsibilities clearly understood and acted on?

Capability and supervision

The World Health Organization (2006, p. xxii) 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.

Supervision supports reflective practice and has a protective role against employee burnout, emotional exhaustion and employee turnover. Supervision supports staff working with challenging behaviours and has benefits around the development of clinical knowledge and competence. Supervision supports workforce groups that sit outside formal training and regulation frameworks. Supervision needs to be educational, consistent and responsive to specific problems.

Barriers to effective supervision include:

- confusion around supervision versus management
- failure to build supervision into everyday practice
- failure to consider supervision within a broader context of good human resource practice and retention strategies.

Cultural responsiveness

System wide cultural responsiveness has two main components:

1. Cultural competency across the broader workforce.
2. Specialised, culturally competent, indigenous or culturally specific workforce (Baker & Levy, 2013).

The features of a culturally responsive organisation include:

- system-wide commitment to culturally responsive practice
- participation and partnership at all levels of the organisation
- action plans to develop and measure cultural competency
- development and retention of a diverse and culturally competent workforce
- systems to manage grievances (Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013).

What features of cultural responsiveness are apparent in your workplace?

What are your next steps around developing more culturally responsive practice?

Cultural competency is defined as the capacity 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. (Tiatia, 2008).

Case study: Whānau ora framework

The whānau ora framework developed by Te Rau Matatini (2014) in New Zealand addresses multiple features of cultural responsiveness. The framework 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.

Barriers to the implementation of cultural responsiveness include:

- deficit thinking
- piecemeal approaches
- lack of organisational commitment
- inadequate frameworks and support for cultural competency.

Case study: Expanded Aboriginal primary care service

The high burden of mental illness and addiction for aboriginal people in the Northern Territory, Australia has lead 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 health care service provider.

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

1 - Tiatia, J. (2008). *Pacific Cultural Competencies: A literature review.* Wellington: Ministry of Health.

Professional boundaries and profession-less roles

Professional boundaries and poor relationships between professional groups are significant barriers to working to top of scope. This happens particularly where there are:

- role overlaps between professional groups
- lack of role clarity
- difference in management approaches between professions
- conflict around role changes and task shifting
- lack of valuing or appreciation of professional groups.

How much do relationships between professional groups enhance or limit effectiveness in your service?

There is an emphasis in the literature review on breaking down professional barriers and moving towards thinking "in terms of competence, not profession" and sharing of "knowledge, skills and competencies across professional and practitioner boundaries" (Department of Health, 2007, p. 11). Professional background should not determine the shape and nature of care provided or the way that services are configured. The literature review considers a model of care or care pathway populated by the right mix of workforce skills and capability.

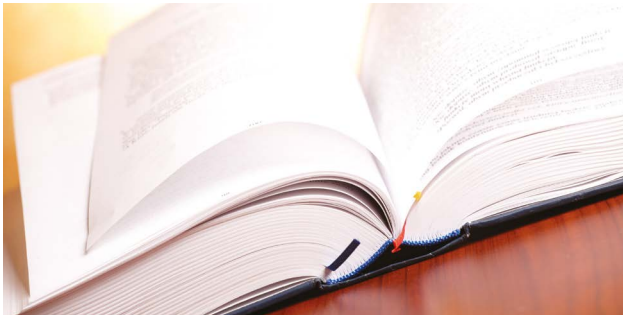
In some contexts, this shift in emphasis has resulted in the development of a generic mental health worker based on new roles, new training and new professional identities. These roles have been introduced in the UK to mixed success. Barriers to their successful implementation have included lack of role clarity, competition with existing professional groups over delivery of specific programmes, hierarchical teams, and insufficient role support (Brown, Simons, & Zeeman, 2008).

Case Study: Integrated model of care - dual diagnosis

Jigsaw is an Australian dual diagnosis service for young people aged 15-25 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 and 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. Jigsaw clinicians have access to psychiatric and other mental health support. Staff are provided with ongoing opportunities for study and professional development. The overall focus is on integrated treatment. The model results in better use of time and resources and improved outcomes for the young people in the service (Australian Healthcare Associates, 2011).

Education and training



Challenges around inter-professional behaviour and mono-disciplinary practice are addressed through inter-professional education where "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 no page number). Inter-professional education:

- prepares students for collaborative teamwork
- optimises employee skills
- allows for shared case management
- results in better health and wellbeing outcomes.

Case study: Inter-professional education – nursing and social work

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

The research highlights the value of inter-professional education for:

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

The authors emphasise the importance of continual 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).

Making a difference locally

This *Scope it right* resource supports services to think about the features of top of scope that make a difference in a local context. The reflective questions and the case studies encourage consideration of enhanced practice, innovation in service design, and opportunities for effective practice through implementation of a model of care or care pathway.

Given the effect of inter-professional relationships on working to top of scope, what are the critical aspects of:

- ***professional ideology and identity***
- ***professional skills and capability***

In particular, *Scope it right* encourages discussion about:

Models of care

- What would a model of care or care pathway look like in a service and how would that change roles and responsibilities?
- How do services better integrate across the primary/secondary continuum?

Roles

- Are roles, tasks and responsibilities clear?
- Are particular tasks the best use of a person's skill set?
- What changes to roles and functions would improve service user experience?
- How is generalist or specialist practice best supported?

Capability

- How do individuals and teams practice collaboratively?
- Are different types of leadership clear and explicit?
- Is leadership supporting working to top of scope?
- How could cultural responsiveness be developed?
- Is supervision being used to support effective practice?

Professional boundaries

- What is the nature of professional identity?
- How do professional boundaries impact on day-to-day practice?
- Does education support employees to be fit for purpose?

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