Building workforce capacity and capability to implement mental health promotion: a family and sexual violence example

Janet L Fanslow, PhD, MNZM
Associate Professor, School of Population Health – Mental Health Promotion
Co-Director, New Zealand Family Violence Clearinghouse
Overview

• Why focus on violence as a key feature of mental health promotion?

• Who are the violence (prevention and response) workforces?

• What capacities and capabilities do we need to build?

• What workforce development strategies have other specialist workforces tried?
Mental Health Promotion Framework 2005 – 2007

Key Social & Economic Determinants of Mental Health & Themes for Action

Social inclusion
- Supportive relationships
- Involvement in community & group activities
- Civic engagement

Freedom from discrimination & violence
- Valuing of diversity
- Physical security
- Self determination & control of one's life

Access to economic resources
- Work
- Education
- Housing
- Money
In Aotearoa New Zealand:
1 in 4 girls experience child sexual abuse before the age of 15 years.
In Aotearoa New Zealand: 1 in 3 women have experienced physical and/or sexual intimate partner violence in their lifetime.

Mental Health
- Emotional distress
- Suicidal thoughts
- Suicide attempts

Reproductive health
- Miscarriage
- Stillbirth
- Abortion
- Violence in pregnancy

Physical Health
- Injury
- Chronic pain
- Increased hospitalisation
- Self-rated poor health
- Etc.
In Victoria, Australia:
Intimate Partner Violence is the biggest risk factor contributing to
disease burden (women, 15-44 yrs)

Health outcomes contributing to disease burden of IPV in Victorian women
Health Consequences of Intimate Partner Violence

**Physical.** Abdominal/thoracic injuries, Bruises and welts, **Chronic pain syndromes,** **Chronic disease,** Disability, Fibromyalgia, Fractures, Gastrointestinal disorders, Irritable bowel syndrome, Lacerations and abrasions, Ocular damage, Reduced physical functioning

**Sexual and Reproductive.** Gynaecological disorders, Infertility, Pelvic inflammatory disease, **Pregnancy complications/miscarriage,** Sexual dysfunction, Sexually transmitted diseases, including HIV/AIDS, Unsafe abortion, **Unwanted pregnancy**

**Psychological and Behavioural,** Alcohol and drug abuse, Depression and anxiety, Eating and sleep disorders, Feelings of shame and guilt, Phobias and panic disorder, Physical inactivity, Poor self-esteem, Post-traumatic stress disorder, Psychosomatic disorders, Smoking, Suicidal behaviour and self-harm

Changing the story requires that we have workforce(s) to do the job

**Capacity**
whether we have the people needed and whether we have enough to deliver services.

**Capability**
whether the workforce has the right knowledge and skills and can apply these to achieve desired outcomes or whether these need to be developed or new people hired.

Who are ‘the workforce?’

• Individuals
  • Regulated professional workforce (e.g., doctors, teachers, social workers)
  • Unregulated workforce: registration or accreditation not a legal requirement, including volunteer workforce

• Organisations
  • Government, crown entities
  • Non-government organisations, or self-employed
    • Including private, charitable, not-for-profit

• Wider system
  • Referring workforce (with responsibility to recognise and refer)
  • Responding workforce (victims, perpetrators, and family and whanau, across the lifespan)

• Prevention workforce
  • May have more of a community focus, social norm change, etc.

What do we want the workforce to do?
Strategies for promoting well-being & quality of life

Strategies for promoting well-being & quality of life


Building Healthy Relationships, Violence Prevention, Violence Response
Family Violence
Sexual Violence
Violence within W

WORKFORCE CAPABILITY FRAMEWORK

Family Violence Risk Assessment and Management Framework

A COMMON APPROACH TO SCREENING, ASSESSING AND MANAGING RISK
What has worked well for others?: Ingredients for success in building the Alcohol and other Drug (AOD) workforces

• Focus on specialised learning overlaying generic undergraduate professional training
• Core commitment to practice-orienting teaching
• Investment in training by government bodies
• Parallel emergence of
  • professional bodies,
  • registration systems, and
  • collaborative relationships across agencies

What we need: Investment in coordinating and training bodies

Mental Health and Addictions Workforces

Family and sexual violence
Next Steps:
Practical strategies that would move us forward

Stocktake
  To assess existing courses and training opportunities

Engage key players and providers
  service providers
  education providers
  Government and Policy makers

Build training delivery mechanisms
  Online
  Blended
  Face to face

Incorporate core knowledge into undergraduate programmes
Opportunities

• Find and capitalize on local pockets of excellence & experience

• Foster allies in related disciplines, e.g.,
  • Health promotion
  • Specialist treatment providers

• In partnership with tangata whenua, build approaches for Aotearoa New Zealand

• Draw on international best practice where appropriate

Challenges

• Need for succession planning
  • High rates of burnout and stress related illness
  • Aging workforce

• “Poaching” of limited workforce across settings and sectors
  • Linked with recognition, remuneration, and job stability

• Kaupapa Māori organisations and practitioners need equitable resourcing and support

• ‘Mainstream’ workforces need increased capability to work effectively with Māori

• Specialist and ‘mainstream’ organisations increased need capability to work effectively with marginalised communities

The Big One

Violence prevention and response need to be seen as real, tangible, worthwhile, and possible.
• Thank you.
References


