MORE THAN NUMBERS

Matua Raki
National Addiction Workforce Development

Te Pou
o Te Whakaaro Nui

Adult mental health and addiction consumer and peer workforce

2014 survey of Vote Health funded services

Contents

Introduction 3
Existing workforce information 3
The *2014 More than numbers* organisation workforce survey 5
Overview of the reported total adult mental health and addiction services workforce 5
What can the survey tell us about dedicated consumer and peer roles? 6
Workforce in consumer and peer roles 7
Consumer advisor workforce 8
Workforce by service types 9
Workforce by region 11
Vacancies and recruitment issues 12
Peer support workforce 13
Workforce by service types 14
Workforce by region 15
Vacancies and recruitment issues 17
Use of peer support by the general workforce 18
Comparison with earlier studies 19
Concluding comments 20
References 21

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Introduction

Rising to the Challenge: The mental health and addiction service development plan 2012-2017 (Ministry of Health, 2012) prioritises increasing the use of peer support workers in service delivery. It also promotes the role of consumer advisors in providing strategic direction and supporting the development of mental health and addiction services.

In 2014 Te Pou and Matua Raki conducted the *More than numbers* organisation workforce survey to provide information about the size and configuration of the Vote Health funded adult mental health and addiction workforce.

The information that has been collected in the survey about consumer and peer roles will support strategies and plans to increase the contribution of peer workers to mental health and addiction services.

This report describes the survey results for the consumer advisor and peer support workforce.[1] It describes the size and distribution of the workforce in these roles by provider and services delivered. It also provides information about the number of vacancies, perceived recruitment issues, and the use of peer support in service delivery.

The consumer and peer workforce draws on personal lived experience of mental health or addiction problems and recovery. They bring a strong understanding of consumer rights, mutual-aid, self-help and the recovery movement. Consumer advisors provide organisations with operational and strategic advice based upon consumer perspectives, and ensure that consumer voices influence the direction of services. Peer support workers use personal experiences from their own recovery journey to support the recovery of others, which includes helping them build resilience (Te Pou o Te Whakaaro Nui, 2014, pp. 4-5).

Existing workforce information

There is some existing workforce information for mental health and addiction service consumer advisor and peer support roles. This information is available from a University of Canterbury research paper (Scott, Doughty and Kahi, 2011) and two surveys: the 2010 *Service user workforce survey: Where are we at?* (Te Pou o Te Whakaaro Nui, 2010) and the 2011 *Addiction Services: Workforce and service demand survey 2011 report* (Matua Raki, 2011).

[1] There is another group of peer workers in mental health and addiction services who use their personal experience as family and whānau to people experiencing mental distress or addiction issues to support the family and whānau of consumers. The workforce results for those workers are described in a separate report titled *Adult mental health and addiction family and whānau roles: 2014 survey of Vote Health funded services*, which is available on the Te Pou website at www.tepou.co.nz/morethannumbers

In 2011, every district health board (DHB) in New Zealand funded mental health peer support services, many of which were offered through NGOs (Scott, Doughty and Kahi, 2011, pp. 87-88).

The 2010 *Service user workforce survey: Where are we at?* report described the results of a survey of the consumer and peer workforce. This survey was completed by 153 people in mental health or addiction consumer advisor, peer support and other service user roles. The results included that:

- around 45 per cent of consumer advisors worked in mental health services and approximately 42 per cent worked in (combined) mental health and addiction services[2]
- more than 60 per cent of peer support workers worked in mental health services and more than 25 per cent worked in combined services
- less than 5 per cent of the consumer advisor and peer support workforce worked in addiction services (Te Pou o Te Whakaaro Nui, 2010, p.19).

The 2010 survey identified the following demographic characteristics of the workforce.[3]

Table 1. Summary of demographic characteristics of surveyed consumer advisors and peer support workers

Demographic characteristics		Consumer advisors	Peer support workers
No. people surveyed	Total = 153	43 (28%)	47 (31%)
Gender	Female	79%	68%
Ethnicity*	Māori	21%	21%
	Pasifika	2%	11%
	Asian	-	5%
Age	Median age group	40 to 49 years	40 to 49 years
Employment status	Full-time (30+ hours pw)	58%	56%
	Part-time (<30 hours pw)	35%	37%
	Casual or temporary	5%	5%
	Fixed-term contract	2%	2%

Notes:
* Participants could select more than one ethnicity option. Source: Te Pou o Te Whakaaro Nui, 2010, p.14.

In addition, the 2010 service user report estimated the size of the Vote Health funded mental health consumer advisor and peer support workforce was 223 FTE positions (Te Pou o Te Whakaaro Nui, 2010, p.14).[4]

[2] The combined mental health and addiction groups are not comparable between the 2010 survey and the 2014 *More than numbers* survey. The 2010 survey used respondent self-defined information to allocate surveys to the combined service group. Surveys indicating combined services to the *More than numbers* survey were reduced to only those surveys from organisations that were funded to provide both mental health and addiction services.

[3] The 2010 survey used a different methodology to the *More than numbers* survey and may include information from people who do not work in Vote Health funded adult mental health or addiction services.

[4] This estimate was based on an assessment of funding contracts for consumer and peer support service specifications.

The 2011 Matua Raki *Addiction Services: Workforce and service demand 2011* report found the workforce in:

- consumer (leadership) roles was approximately 4 FTE positions (0.5 per cent of the surveyed workforce)
- peer support worker roles was 8 FTEs (1 per cent, Matua Raki, 2011, p. 9).

The 2014 *More than numbers* organisation workforce survey

The *More than numbers* survey profiles the size, distribution and configuration of the Vote Health funded workforce in adult mental health and addiction services.

Organisations invited to participate in the survey included the 20 DHBs and 231 non-government organisations (NGOs) contracted by DHBs or the Ministry of Health to provide adult mental health and addiction services during the year ended 30 June 2013. All 20 DHBs and 169 NGOs (73 per cent) completed the survey, giving an overall response rate of 75 per cent.[5]

The survey requested information from team leaders and managers that could be reasonably obtained, as at 1 March 2014. Respondents were asked to report their total Vote Health funded workforce for each role using a pre-set list with the option to add other roles. Most of the information provided here is based upon full-time equivalent (FTE) positions including both employed and vacant positions.

Overview of the reported total adult mental health and addiction services workforce

The total workforce reported to the survey by adult mental health and addiction services for all Vote Health funded roles was 8,929 FTE positions (employed plus vacant). Figure 1 shows that the workforce was unevenly distributed across the three main service groups, with most (79 per cent) reported by mental health services, followed by addiction services (15 per cent) and combined services (6 per cent).[6]

[5] The survey method and limitations are described in the national and regional reports at www.tepou.co.nz/morethannumbers. The survey did not collect information from services whose primary focus was Whānau Ora, primary health, youth, disability support, health promotion, policy, quality improvement, research activities and workforce development, or that did not employ any mental health or addiction staff.

[6] For this report addiction services include alcohol and other drug and problem gambling services.

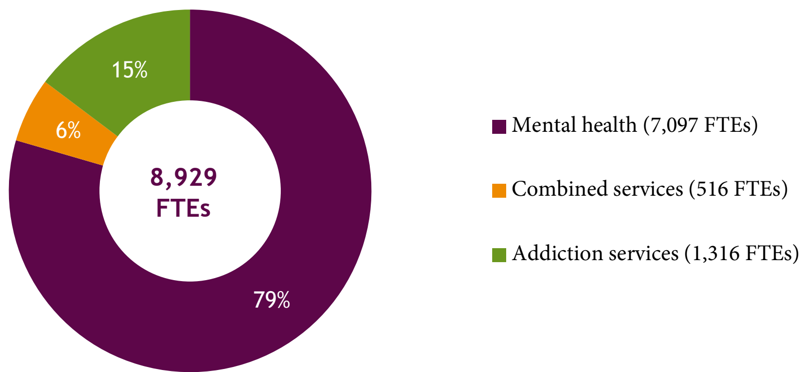

Figure 1. Proportion of the total reported workforce in each of the three service groups

In terms of the organisations reporting to the survey:

- DHBs reported a total workforce of 5,657 FTEs (63 per cent of the total workforce)
- NGOs reported 3,273 FTEs (37 per cent).

What can the survey tell us about dedicated consumer and peer roles?

The *More than numbers* survey captured information about most of the Vote Health funded dedicated consumer advisor and peer support (consumer and service user) roles in the adult mental health and addiction services' workforce. The results improve our understanding of the consumer and peer workforce in the context of services delivered and in relation to the size and composition of the total workforce surveyed.

The survey identified the following dedicated consumer and peer roles:

- consumer advisor
- peer support worker.

The survey did not capture how many people are working in adult mental health and addiction services who have had lived experience of mental health or addiction problems and recovery. In addition, the workforce in consumer and peer roles may be under-reported by the survey for the following reasons.

- Approximately one-quarter (27 per cent) of the NGOs invited to participate did not complete surveys.[7]
- The survey collected information about paid employees, whereas some peer roles in the sector are voluntary, and others are known to be funded from outside the health sector.
- Some participating DHBs and NGOs may have under- or over-reported their workforce.

Despite these limitations, it appears that under-reporting of the Vote Health funded consumer and peer workforce may be small. The consumer and peer workforce funded by 2012/13 DHB and Ministry of Health contracts totalled 221 FTE positions; a similar number to the Vote Health funded workforce identified by the *More than numbers* survey.[8] Some organisations may employ consumer and peer roles using health funding without having specific DHB or Ministry of Health contracts to do so. It is difficult to assess the incidence of this practice.

Workforce in consumer and peer roles

The Vote Health funded workforce in consumer and peer roles reported to the survey totalled 225 FTE positions (employed plus vacant).

- 61 people in consumer advisor roles, totalling 39 FTEs
- 295 people in peer support worker roles, totalling 186 FTEs.

Figure 2 shows the consumer and peer workforce as a proportion of the total mental health and addiction workforce reported to the survey.

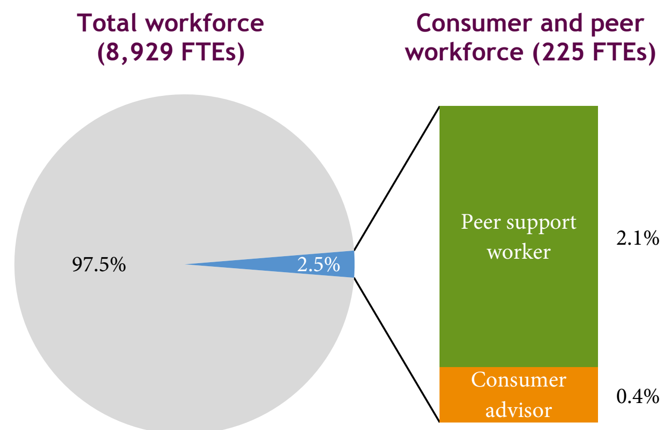

Figure 2. Peer roles as a proportion of the total surveyed workforce

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[7] The *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services* report estimates that the total NGO workforce is likely to be approximately 18 per cent greater than that reported to the survey. This report is available on the Te Pou website.

[8] This figure was calculated from funding information provided by the Ministry of Health for the year ended 30 June 2013. The method used is based upon that described by the *2010 Service user workforce survey* (Te Pou o Te Whakaaro Nui, 2010, p. 12).

The consumer and peer workforce made up a larger proportion of the NGO workforce (6 per cent) compared to the DHB workforce (less than 1 per cent). This result is mainly due to NGOs reporting a relatively large workforce in peer support roles (172 FTEs), which is consistent with the fact that NGOs hold most of the Vote Health contracts for peer support workforce.

Table 2 below shows the consumer and peer workforce reported by DHBs and NGOs. The last column shows the consumer and peer workforce as a proportion of the total workforce reported to the survey by each provider type.

Table 2. Consumer and peer workforce in DHBs and NGOs and as a proportion of the total reported workforce

Provider type	Workforce (FTEs employed plus vacant)			Proportion of the total reported workforce (%)
	Consumer advisor	Peer support worker	Total	
DHB	21.4	14.2	35.6	0.6%
NGO	17.9	171.7	189.6	5.8%
Total	**39.3**	**185.9**	**225.2**	**2.5%**

Consumer advisor workforce

The Vote Health funded workforce in consumer advisor roles totalled 39 FTE positions (employed plus vacant). This workforce represented 3 per cent of the reported workforce in the administration, management and support occupation group, and 0.2 per cent of the total workforce reported to the survey.

- 12 DHBs reported a consumer advisor workforce of 21 FTEs (55 per cent), including:
    - 28 people employed in 21 FTE positions
    - 0.4 FTEs vacant (giving a vacancy rate of 2 per cent).
- 18 NGOs reported a consumer advisor workforce of 18 FTEs (45 per cent), including:
    - 33 people employed in 18 FTE positions
    - 0.3 FTEs vacant (vacancy rate of 2 per cent).

Figure 3 shows the distribution of the workforce in consumer advisor roles across DHBs and NGOs, and across the three service groups.

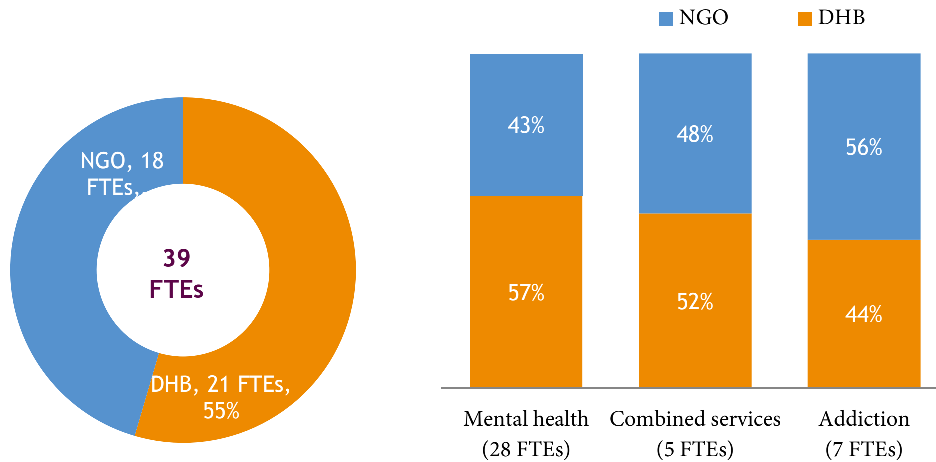

Figure 3. Distribution of consumer advisor workforce across DHBs and NGOs, and across the three service groups

The consumer advisor workforce in mental health, combined, and addiction services was fairly evenly distributed between DHBs and NGOs.

Workforce by service types

Figure 4 compares the distribution of the consumer advisor workforce across DHBs and NGOs by service types.[9] Both DHBs and NGOs reported around half their consumer advisor workforce in administration and management services (47 and 56 per cent respectively), which is consistent with the usual placement of this workforce, and one-quarter to one-third in community services (27 and 34 per cent). DHBs reported one-quarter of their workforce in inpatient and forensic services (17 and 9 per cent). In contrast, NGOs had a small proportion of their workforce in residential and other services (5 and 6 per cent). These results reflect differences in the types of services delivered by DHBs and NGOs.

[9] Survey respondents identified the predominant type of service delivered by their workforce, these services have been collated in five service types: community, inpatient, residential, forensic, administration and management, and other services.

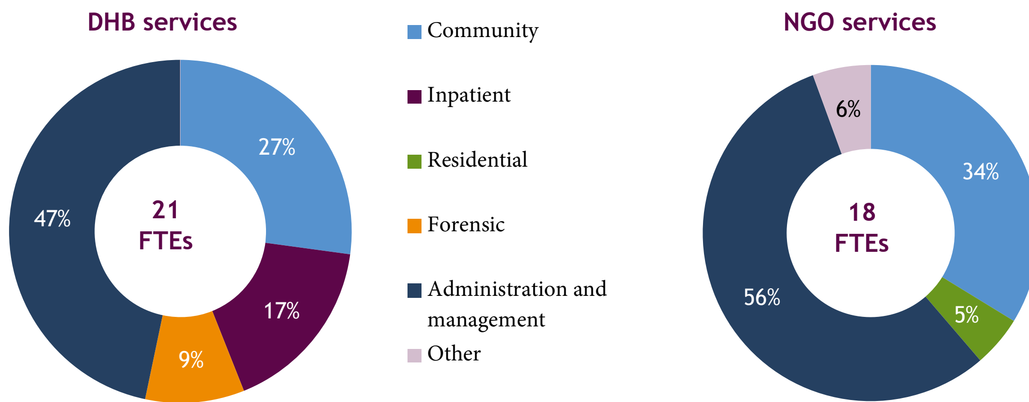

Figure 4. Distribution of the DHB and NGO consumer advisor workforce across service types

As shown earlier in Figure 3, mental health services (both DHB and NGO) reported the largest workforce in consumer advisor roles (28 FTEs). Addiction services reported 7 FTEs and combined services reported 5 FTEs.

Figure 5 shows the distribution of the consumer advisor workforce across service types within the mental health and addiction service groups. In mental health services, half of this workforce was located in administration and management services, with the remainder in community, inpatient and forensic services. In contrast, more than half this workforce in the addiction services group was located in community services with the remainder spread across residential, administration and management, and other services.

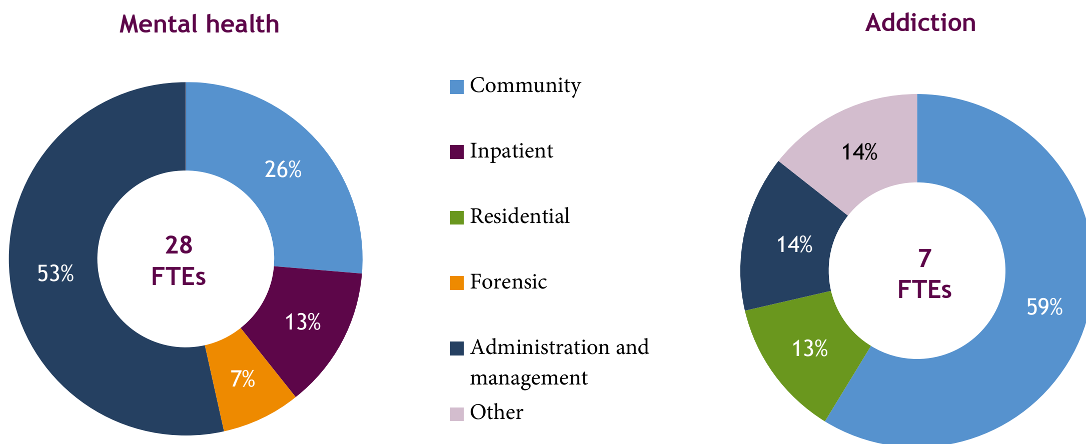

Figure 5. Proportion of the workforce providing different types of services within mental health and addiction (shared legend)

Combined mental health and addiction services reported a workforce totalling 5 FTEs. Most of this workforce was reported by administration and management services (90 per cent) with the remainder in community services (10 per cent).

Workforce by region

Figure 6 shows the workforce in consumer advisor roles was distributed unevenly across the four DHB regions.

- Northern region reported 16 FTEs employed plus vacant (42 per cent).
- Midland region reported 5 FTEs (12 per cent).
- Central region reported 9 FTEs (22 per cent).
- South Island region reported 9 FTEs (24 per cent).

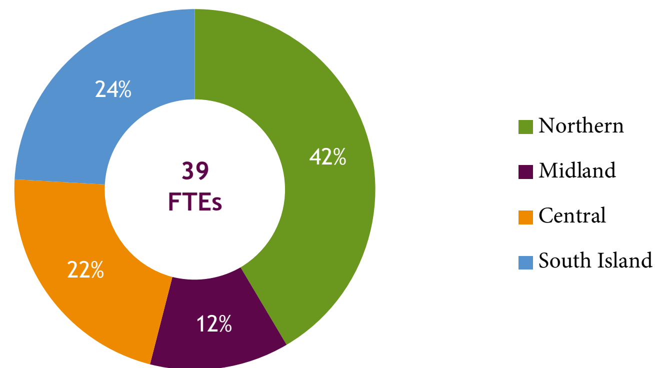

Figure 6. Distribution of the DHB and NGO consumer advisor workforce across the four DHB regions

Figure 7 uses regional information from PRIMHD and the 2013 New Zealand Population Census to compare each region's consumer advisor workforce per 1,000 consumers seen and per 100,000 adults in the region's population.

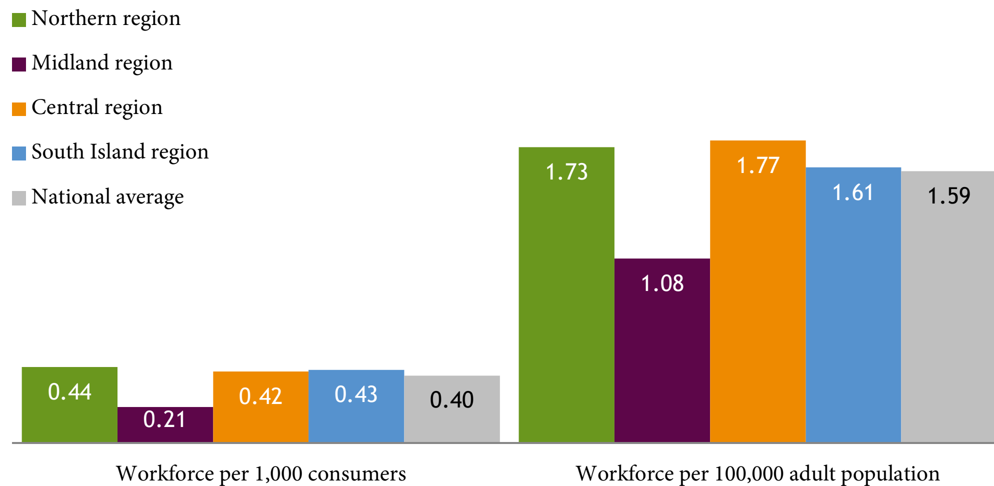

Figure 7. Workforce per 1,000 consumers seen and per 100,000 adults, by region with national average

The Northern, Central and South Island regions had fairly similar rates of workforce per consumer and per adult. These results were also similar to the national average of 0.4 FTEs per 1,000 consumers seen and 1.6 FTEs per 100,000 adults.

The Midland region's ratio of workforce to consumers seen was around half that of other regions. In part this was due to the small size of the consumer advisor workforce (5 FTEs) and was further exacerbated by the fact that service access rates were high in this region compared to the national average (3.7 per cent for adult mental health services compared to 2.9 per cent nationally, and 2 per cent for AOD services compared to 1.5 per cent nationally).

Vacancies and recruitment issues

DHBs and NGOs reported consumer advisor vacancies of less than 1 FTE position, giving a vacancy rate of 2 per cent each. This rate was lower than the average vacancy rate across the entire DHB and NGO workforce, which was 5 and 4 per cent respectively.

The survey asked respondents to identify perceptions of future recruitment issues for each of the roles they currently employed. This question was answered for consumer advisors by 16 DHB and 22 NGO respondents.[10] Figure 8 shows the proportion of these respondents who indicated potential future recruitment issues including oversupply, about right numbers, some shortage (quantified by the question as less than 20 per cent shortage), and large shortage (20 per cent or more).

[10] The structure of the survey meant that organisations provided as many responses as they needed to report their workforce by service type within DHB locality. This is why there are more respondents than organisations employing consumer advisor roles.

Three-quarters of DHB respondents thought numbers were about right for this role, and 25 per cent thought there may be a small shortage. In contrast, a small proportion of NGO respondents (5 per cent) thought there may be an oversupply for the role, 41 per cent thought the numbers were about right and another 41 per cent perceived there may be some or large shortages in the future (27 and 14 per cent respectively).

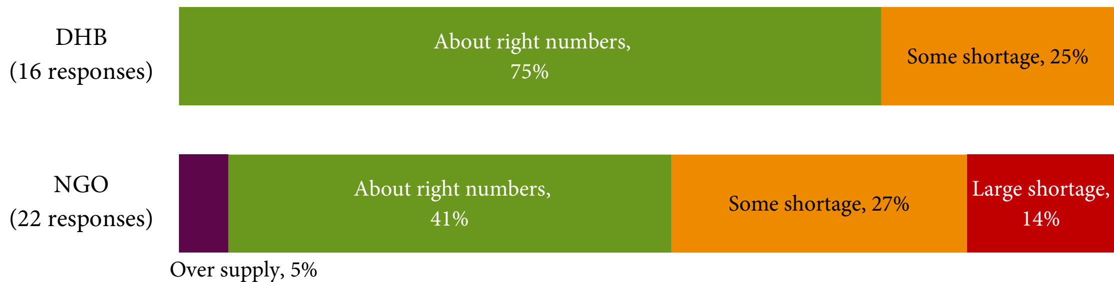

Figure 8. Proportion of respondents identifying future shortages or oversupply for the consumer advisor role

Peer support workforce

The reported Vote Health funded workforce in peer support worker roles totalled 186 FTE positions (employed and vacant). This workforce represented 7 per cent of the reported workforce in the support workers occupation group, and 2 per cent of the total workforce reported to the survey.

- 4 DHBs reported a peer support workforce totalling 14 FTEs (8 per cent), including:
  - 21 people employed in 14 FTE positions
  - no vacant FTE positions.
- 37 NGOs reported a peer support workforce totalling 172 FTEs (92 per cent), including:
  - 274 people employed in 169 FTE positions
  - 3 FTEs vacant (giving a vacancy rate of 2 per cent).

Figure 9 shows the distribution of the workforce in peer support roles (employed plus vacant) across DHBs and NGOs, and across the three service groups. NGOs reported 91 to 93 per cent of the peer support workforce in the mental health and combined services groups and all of the workforce in addiction services.

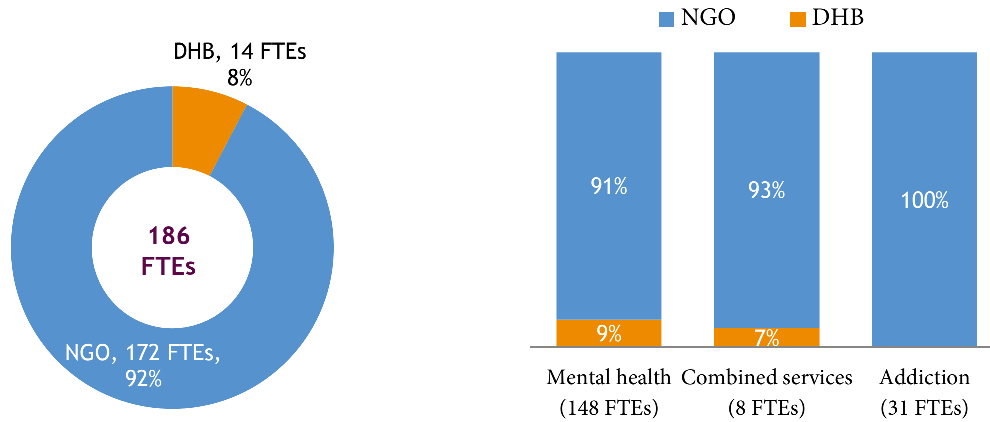

Figure 9. Distribution of peer support workforce across DHBs and NGOs, and across the three service groups

Workforce by service types

DHBs reported their entire peer support workforce was located in community services. As shown in Figure 10, the NGO peer support workforce was distributed across a variety of service types, including community, residential and other services.

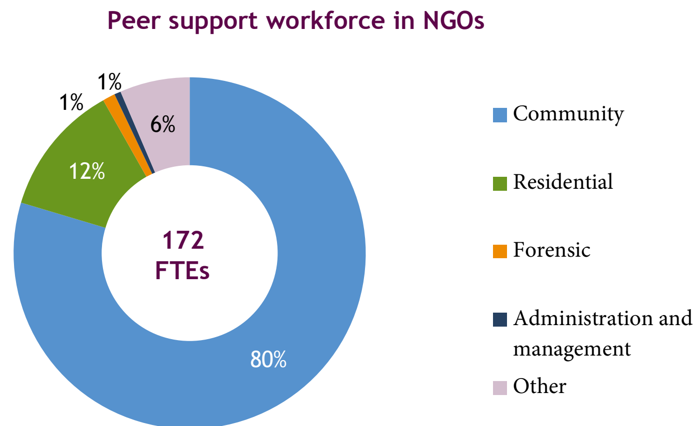

Figure 10. Distribution of the NGO peer support workforce across service types

As shown previously in Figure 9, mental health services (both DHB and NGO) reported the largest workforce in peer support worker roles (148 FTEs). Addiction services reported 31 FTEs and combined services reported 8 FTEs.

Figure 11 shows the distribution of the peer support workforce across service types within the mental health and addiction service groups. In mental health services, the peer support workforce was

distributed across community, residential, forensic and other services. In contrast, only community and residential services in the addiction group reported having a peer support workforce.

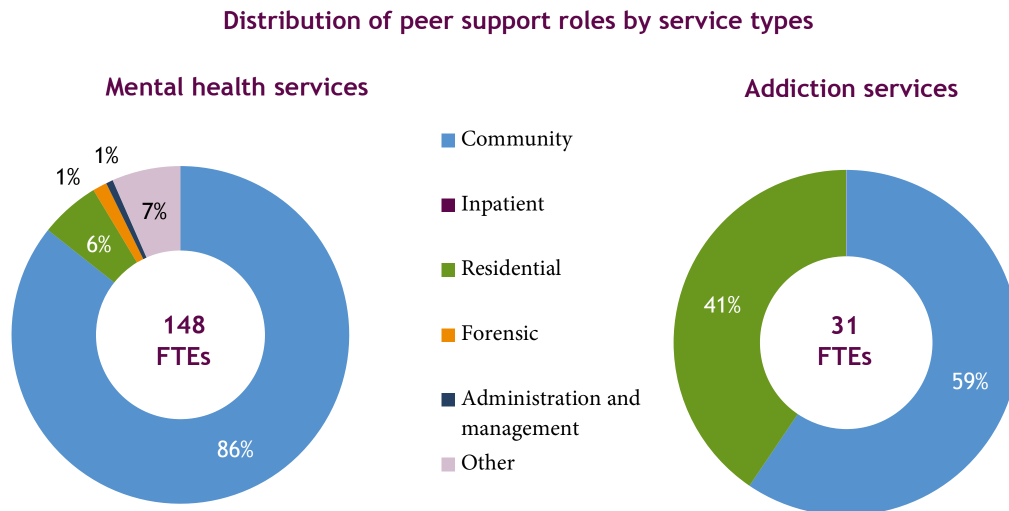

Figure 11. Proportion of the workforce providing different types of services within mental health and addiction (shared legend)

Combined services reported 82 per cent of their peer support workforce was in community services with the remaining 18 per cent in other services.

Workforce by region

The workforce in peer support worker roles was distributed unevenly across the four DHB regions, see Figure 12.

- Northern region reported 102 FTEs employed plus vacant (55 per cent).
- Midland region reported 33 FTEs (17 per cent).
- Central region reported 33 FTEs (18 per cent).
- South Island region reported 19 FTEs (10 per cent).

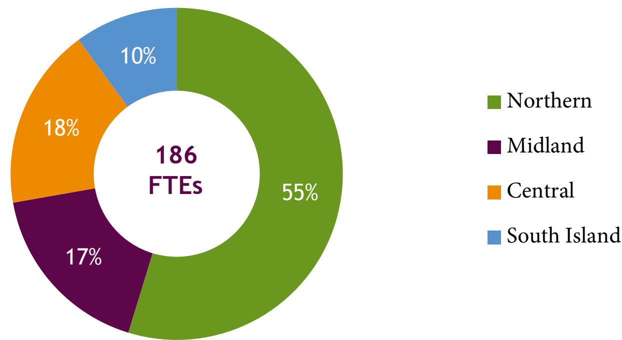

Figure 12. Distribution of the DHB and NGO peer support workforce across the four DHB regions

Figure 713 uses regional information from PRIMHD and the 2013 Census to compare the peer support workforce per 1,000 consumers seen and per 100,000 adults in the region's population. The national average was 1.9 FTE positions per 1,000 consumers seen during 2012/13 and 7.5 FTE positions per 100,000 adults in the population.

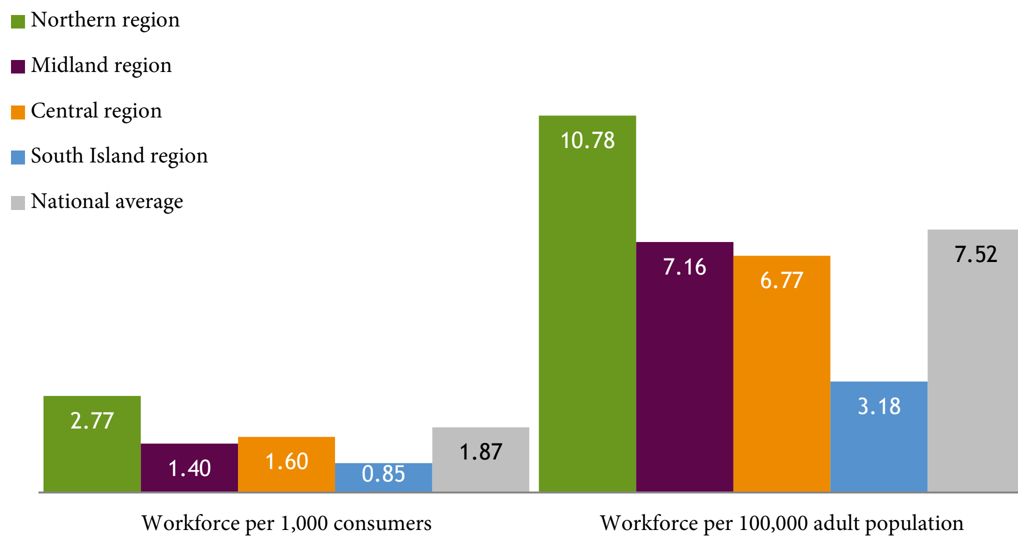

Figure 13. Workforce per 1,000 consumers seen and per 100,000 adults, by region with national average

The Northern region had the highest ratio of workforce to consumers and adult population of all the regions (2.8 FTEs per 1,000 consumers seen and 10.8 FTEs per 100,000 adults), around 45 per cent higher than the national average. The Midland and Central regions had similar ratios per 100,000 adults, although Midland had a slightly lower ratio of workforce to consumers seen than the Central region (1.4 compared to 1.6 FTEs per 1,000 consumers seen). This result reflects the higher number of

consumers seen in the Midland region compared to the Central region. The South Island region had the lowest ratio of peer support workforce to both consumers seen and population, at less than half the national average.

Vacancies and recruitment issues

DHBs reported no vacancies in peer support roles. NGOs reported 3 FTE positions vacant, giving a vacancy rate of 2 per cent. Vacancy rates of zero to 2 per cent are lower than the average rates across the entire DHB and NGO workforce, which was 5 and 4 per cent respectively.

The question about perceptions of recruitment issues was answered by 65 respondents from services employing peer support worker roles: 4 from DHBs and 61 from NGOs.[11] Figure 814 shows the proportion of these respondents who indicated potential future recruitment issues including oversupply, about right numbers, some shortage (quantified by the question as less than 20 per cent shortage), and large shortage (20 per cent or more).

One-quarter of DHB respondents thought there would be an oversupply for this role, and half thought the numbers were about right. However, the very small number of respondents indicates that these results should be used with caution.

In contrast, 11 per cent of NGO respondents thought there may be an oversupply for the role, 34 per cent thought the numbers were about right and 41 per cent perceived there may be some or large shortages in the future (28 and 13 per cent respectively).

DHB and NGO respondents' perceptions of recruitment issues

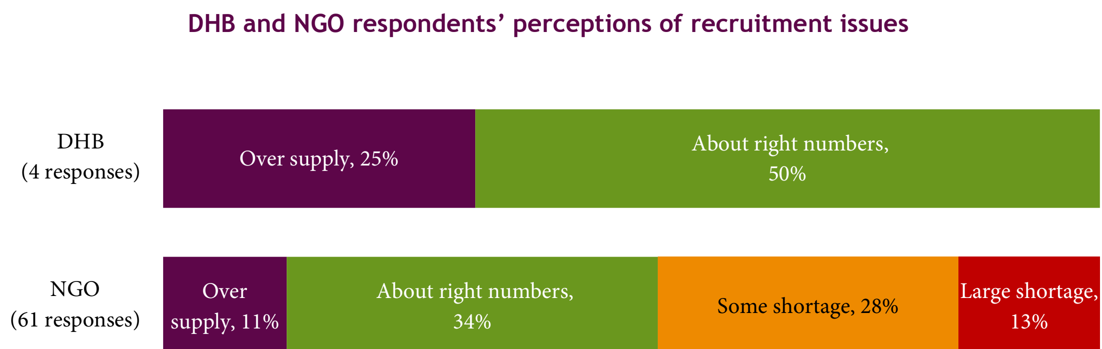

Figure 14. Proportion of respondents perceiving future recruitment issues for peer support worker roles

[11] The structure of the survey meant that organisations provided as many responses as they needed to report their workforce by service type within DHB locality. This is why there are more respondents than organisations employing consumer advisor roles.

Use of peer support by the general workforce

As mentioned in the introduction, *Rising to the Challenge* (Ministry of Health, 2012) prioritises increasing the use of peer support workers in service delivery. The *More than numbers* survey requested information from respondents about whether their workforce needed to improve knowledge and skills in particular domains, including supporting the use of peer support. The following results relate to the knowledge and skills in the general workforce and are not attributable to any particular role(s).

As shown in Figure 15, almost two-thirds (61 per cent) of DHB mental health respondents thought their workforce needed to increase knowledge and skills in supporting the use of peer support, and 88 per cent of respondents from DHB addiction services thought the same. In contrast, a smaller proportion of NGO respondents reported this need (54 and 50 per cent).[12]

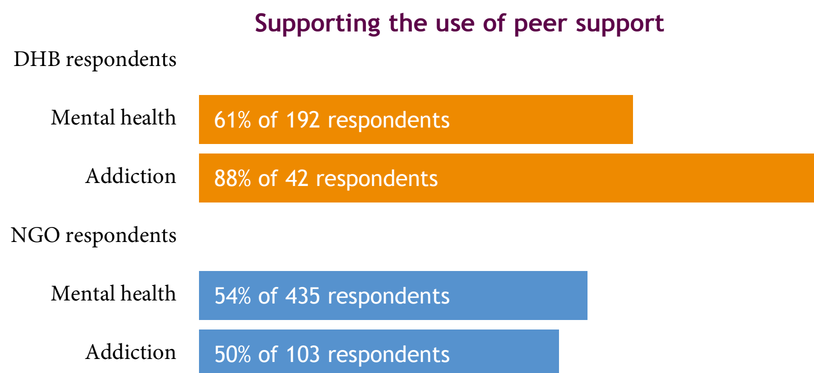

Figure 15. Proportion of DHB and NGO respondents identifying their workforce needed to increase skills in supporting the use of peer support.

Reasons for the differences in responses from DHBs and NGOs to this question are not explored by the survey. These differences could reflect that NGO respondents are more confident in their workforce's current abilities to include the peer support workforce in their practice than DHB respondents, which is consistent with the finding that most of this workforce is located in NGOs. Further exploration is required.

[12] In the analyses relating to workforce knowledge and skills, mental health services results include results for combined services.

Comparison with earlier studies

This section compares the *More than numbers* survey results for peer support roles with four recent workforce surveys.

- *2014 Stocktake of infant, child and adolescent mental health and alcohol and other drug services in New Zealand* (Werry Centre, 2015).
- 2010 *Service user workforce survey* (Te Pou o Te Whakaaro Nui, 2010).
- *Addiction Services: Workforce and service demand survey 2011 report* (Matua Raki, 2011).
- 2007 *NgOIT workforce survey* of NGO mental health and addiction services (Platform Trust, 2007).

The Werry Centre's *2014 Stocktake of infant, child and adolescent mental health and alcohol and other drug services in New Zealand* identified that a similar proportion of their workforce was in consumer advisor roles compared to the *More than numbers* survey (0.3 per cent compared to 0.4 per cent). However, the Werry Centre stocktake included peer support workers in a larger group of various roles with small workforces, so this is not available for comparison (Werry Centre, 2015, pp. 29-30).

There is some evidence to suggest there has been growth in the NGO consumer and peer workforce since 2007. For example:

- *More than numbers* found the NGO consumer and peer workforce was nearly 6 per cent of the total NGO workforce (190 FTEs) and people in these roles accounted for nearly 7 per cent of all the people reported to the survey by NGOs. In comparison, 4 per cent of the people reported to the 2007 *NgOIT workforce survey* were in consumer and peer roles (Platform Trust, 2007, p. 13).[13]
- In addiction services, *More than numbers* found 56 per cent of consumer advisor roles (4 FTEs) and all peer support roles (31 FTEs) were based in NGOs. In comparison, the Matua Raki *Addiction Services: Workforce and service demand survey 2011 report* found that NGOs reported no consumer advisor workforce, and only 36 per cent of the peer support workforce (approximately 3 FTEs, Matua Raki, 2011, p. 9).

However, the *More than numbers* survey identified a similar number of peer and consumer roles (225 FTEs) compared to the 223 FTEs estimated by the 2010 *Service user workforce survey* (Te Pou o Te Whakaaro Nui, 2010, p.14). Comparisons of the survey results suggest that the rate of growth in the consumer and peer workforce may have slowed since 2010, with the exception of roles in the addiction workforce.

Variations in the results may reflect differences in survey methodologies. *More than numbers* invited participation from all organisations with DHB or Ministry of Health contracts to deliver adult mental health or addiction services. In contrast Matua Raki used a snapshot approach focusing on selected

[13] NgOIT reported 70 people out of a total of 1,833 surveyed. However, this figure may not be representative of the total workforce and may include individuals working in services other than adult mental health and addiction.

organisations delivering addiction services (Matua Raki, 2011, p. 7). The 2010 *Service user workforce survey* and the 2007 *NgOIT workforce survey* targeted individual people working in the mental health and addiction sector, not necessarily limited to those in Vote Health funded organisations or positions.

Notwithstanding these limitations, the differences between *More than numbers* and other recent workforce surveys may indicate that the consumer and peer workforce has changed substantially in the past few years. Whilst the rate of growth may have slowed generally, the results provided here highlight growth of the NGO consumer advisor workforce and indicate the provision of peer support within addiction services has been largely transferred from DHBs into NGOs.

Concluding comments

The growth and development of the consumer and peer support workforce has been signalled as a priority for workforce development in order to increase capacity and capability across a spectrum of self-care support (Ministry of Health, 2012). The results provided here suggest the consumer and peer workforce has grown in recent years. Nonetheless, this workforce is still relatively small given that it was identified as a priority for additional workforce development in *Rising to the Challenge* (Ministry of Health, 2012). More work is needed to identify and measure the growth of the consumer and peer workforce over time, and to evaluate the contribution that these roles make, particularly to people's capacity to manage their own health and wellbeing.

Understanding the contribution this workforce makes on its own and in conjunction with the clinical workforce and the special nature of their expertise will ensure this workforce is effective, valued and sustainable.

Competencies for the mental health and addiction service user, consumer and peer workforce have been developed and are being used in services (Te Pou o Te Whakaaro Nui, 2014). There are also guides for leaders and managers of peer workers and planners and funders to better understand this workforce. In recent years, development of the consumer and peer workforce has included building the capacity of trained peer supervisors.

For the consumer and peer workforce to develop and thrive, it needs committed resourcing, leadership support and equity of opportunities. An appreciation of some of the challenges inherent in the work that peer workers do is critical to ensuring the group is valued and well supported.

While this report has focused on consumer and peer roles, it is critical that workforce and service planning considers these roles in the context of the entire workforce delivering services to tāngata whai ora and their families and whānau. Information about the Vote Health funded workforce in adult mental health and addiction services can be found in the *Adult mental health and addiction workforce: 2014 survey of Vote Health services* report (Te Pou o Te Whakaaro Nui, 2015).

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