

MORE THAN
NUMBERS



Adult mental health workforce

2014 survey of Vote Health funded services

Adult mental health workforce



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o Te Whakaaro Nui

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National Addiction Workforce Development

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Mental health services' workforce summary

The efficient and effective use of the health workforce is a priority focus for both leaders and managers of health services. The World Health Organization describes the health workforce as the “most costly [and] indispensable” resource in the health system (World Health Organization, 2010, p. 1). Health workforce planning aims to ensure the sector has the right number of people, with the right skills, at the right time, to support people using services.

This report presents the results of the 2014 *More than Numbers* organisation workforce survey led by Te Pou and Matua Raki. It describes the workforce delivering adult mental health services across the district health board (DHB) provider arm and the non-government organisation (NGO) sector.¹ In doing so it provides important baseline information on the workforce, particularly as organisations address challenges posed by increased demand for mental health services in a fiscally constrained environment (Mental Health and Addiction Service Workforce Review Working Group, 2011).

The organisation workforce survey² had the following aims.

1. Understand the workforce delivering adult mental health and addiction services in:
 - a. the DHB provider arm
 - b. NGOs receiving Ministry of Health funding.
2. Describe, in relation to services offered, the region and DHB district, and the workforce composition in terms of roles and ethnicity.
3. Understand current and future workforce challenges, knowledge and skill needs, and cross-sector relationship needs.

This report is a supplementary document to the *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services* report which provides results for both the mental health and addiction workforce and links the results to information about funding, service delivery and predicted increases in demand for services.

¹ Another national report describes the workforce delivering adult addiction services.

² See Appendix B: Organisation workforce survey method for an outline of the survey methodology and limitations.

Overview of all survey results

The total mental health and addiction workforce reported by all 20 DHBs and 169 out of 231 NGOs surveyed included 10,845 people employed in 9,337 full-time equivalent (FTE) positions (employed plus vacant).

- Mental health services employed 8,460 people in 7,274 FTE positions.
- Combined mental health and addiction (MH&A) services employed 614 people in 559 FTE positions.³
- Alcohol and other drug (AOD) and problem gambling services employed 1,771 people in 1,504 FTE positions (employed plus vacant).
- The majority of these positions were funded by Vote Health (96 per cent).

Vote Health funded adult mental health workforce

This report focuses on the survey results for the Vote Health funded workforce in adult mental health services⁴ that totalled 7,613 FTEs, including workforce reported by:

- mental health services (7,097 FTEs, 93 per cent of the adult mental health workforce)
- MH&A services (516 FTEs, 7 per cent).

The following sections summarise the size, composition and distribution of the Vote Health funded mental health workforce reported to the survey.

Size and services delivered

Figure A shows that 66 per cent of the workforce was in the DHB provider arm (5,023 FTEs), and 34 per cent in NGOs (2,589 FTEs).

Vacancy rates in DHBs and NGOs reporting the survey were calculated as:

- 6 per cent of the DHB workforce
- 4 per cent of the NGO workforce.

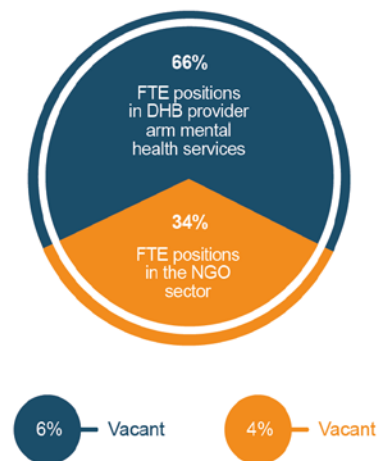


Figure A. Proportion of the Adult mental health services workforce (FTEs employed plus vacant) in DHB and NGO services for each sector including vacancy rates

³ This group self-identified as providing both addiction and mental health services and belonged to organisations that were funding to provide both services. This process is reported in the limitations to this report (Section 1.4).

⁴ Reports for the national adult addiction workforce, the national adult mental health and addiction workforce, and regional and DHB locality reports are available from www.tepou.co.nz/morethannumbers.

The workforce in addiction services was distributed across a number of different types of services, including:

- community services reported 36 per cent of the mental health workforce (employed plus vacant).
- inpatient services reported 18 per cent of the workforce
- residential services reported 12 per cent of the workforce.

Of the ethnic-specific services reported to the survey:

- Kaupapa Māori services reported a workforce of 744 FTEs (employed plus vacant), 10 per cent of the mental health workforce reported in the survey.
- Pasifika services reported 109 FTEs (1.4 per cent).

Occupation groups and roles

The workforce reported to the survey was made up of:

- clinical roles (52 per cent of the total FTE positions)
- non-clinical roles (34 per cent)
- administration, management and support roles (13 per cent).

Figure B shows the distribution of the DHB and NGO workforce across clinical, non-clinical and administration, management and support roles.

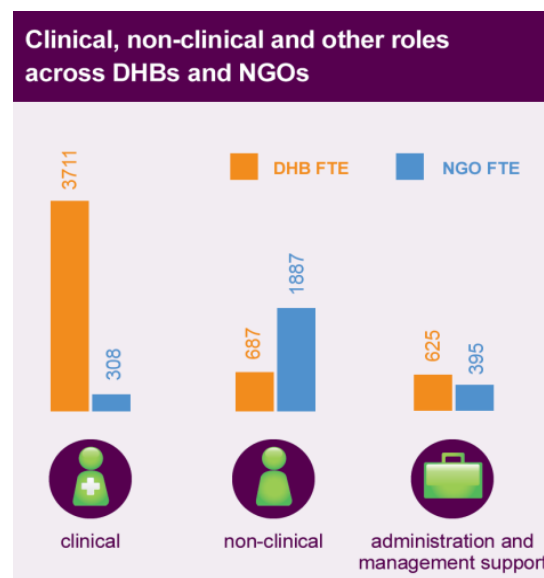


Figure B. Total Adult mental health services workforce (FTEs employed plus vacant) by role type and provider

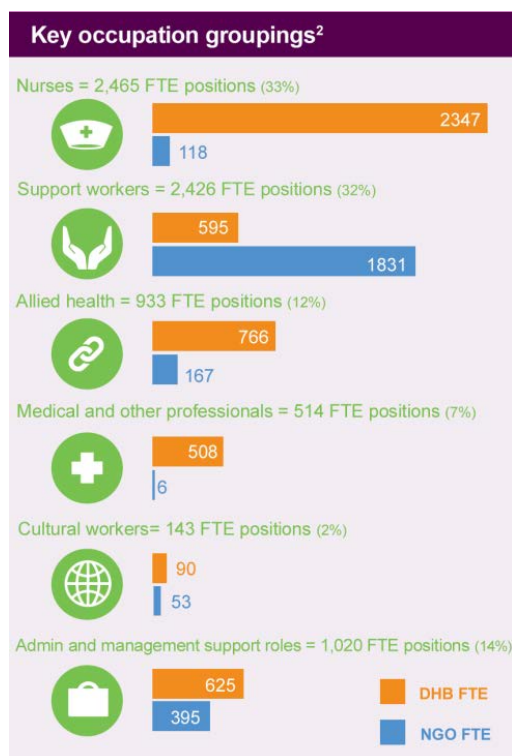


Figure C. Workforce for adult mental health services by main occupational groups

Figure C shows the total workforce reported to the survey by occupation groups.

- The largest occupation group was nursing (33 per cent of the mental health workforce)
- The next largest group was support workers (32 per cent)
- allied health (12 per cent)
- medical and other professionals had 13 per cent

Vacancies

Of the 7,613 FTEs reported by adult mental health services:

- 7,243 FTEs were currently employed
- 370 FTEs were vacant (5 per cent of the workforce)
- Of the vacant FTEs, 75 per cent were in DHBs and 25 per cent in NGOs.

DHB Adult mental health services workforce

DHB services reported a total of 5,023 FTEs (4,745 employed and 278 reported as vacant).

The DHB workforce was comprised of mostly clinical roles (74 per cent):

- nursing roles accounted for 63 per cent of the DHB workforce in clinical roles
- allied health professionals were 21 per cent
- social workers were 7 per cent
- consultant psychiatrists 7 per cent
- clinical psychologists 6 per cent.

The DHB workforce in non-clinical roles included:

- healthcare assistants (39 per cent of the DHB workforce in non-clinical roles)
- psychiatric assistants (24 per cent)
- community support workers (15 per cent)
- peer support workers reported by DHBs totalled 14 FTEs.

DHBs reported that administration and management roles accounted for 12 per cent of the workforce.

The majority of vacancies in DHBs were in clinical roles (77 per cent, 215 of 278 FTE positions). Nurses comprised the largest group of DHB clinical role vacancies (67 per cent, 144 of 215 FTE positions).

NGO Adult mental health services workforce

NGO services reported a total of 2,589 FTEs (2,498 employed and 92 reported as vacant).

The majority of the NGO workforce was made up of non-clinical roles (73 per cent).

- Support workers were nearly the entire non-clinical workforce (97 per cent), including:
 - community support workers (45 per cent of the non-clinical workforce)
 - residential support workers (31 per cent)
 - consumer peer support workers (7 per cent).

NGOs reported a clinical role workforce of 308 FTEs (12 per cent of the total NGO workforce), including:

- nursing roles (38 per cent)
- social workers (20 per cent).

Administration and management roles accounted for 15 per cent the total NGO workforce.

Ethnic makeup and cultural competence

This section describes results for ethnic representation within the workforce. These results are compared with information about population and service use. The results for questions about the cultural competency needs of the workforce are also provided here.

Ethnicity of the workforce

Analyses in this section are based only on the results provided by respondents who indicated staff ethnicity (Māori, Pasifika or Asian) including those who stated there were no staff members in the specified ethnic groups.

Representation of Māori in the adult mental health services workforce

Māori adults make up 12 per cent of New Zealand's adult population. In mental health services, nearly one quarter (23 per cent) of consumers are Māori. The Māori workforce reported in the survey made up 19 per cent of the adult mental health services workforce, including 13 per cent in clinical roles and 24 per cent in non-clinical, administration and management roles.

Representation of Pasifika in the adult mental health services workforce

Pasifika adults make up six per cent of New Zealand's adult population. They also represent six per cent of all mental health service consumers. The Pasifika workforce reported in the survey comprised five per cent of the adult mental health services workforce, including three per cent in clinical roles and seven per cent in non-clinical, administration and management roles.

Representation of Asian peoples the adult mental health services workforce

Asian adults make up 13 per cent of New Zealand's adult population. In mental health services, they represent five per cent of all consumers. The Asian peoples workforce reported in the survey comprised six per cent of the adult mental health services workforce, including five per cent in clinical roles and six per cent in non-clinical, administration and management roles.

Cultural competence

This section describes the survey results about workforce knowledge and skills that relate to cultural competence for working with Māori, Pasifika and Asian ethnic groups.

In terms of the overall workforce, more than two-thirds to four-fifths of respondents from mental health services identified the need to increase workforce cultural competence across most areas relating to working with Māori, Pasifika and Asian ethnic groups (see Figure D). DHBs were more likely to identify a need for increased knowledge and skills in a range of areas, but especially in working with Māori, Pasifika and Asian peoples.

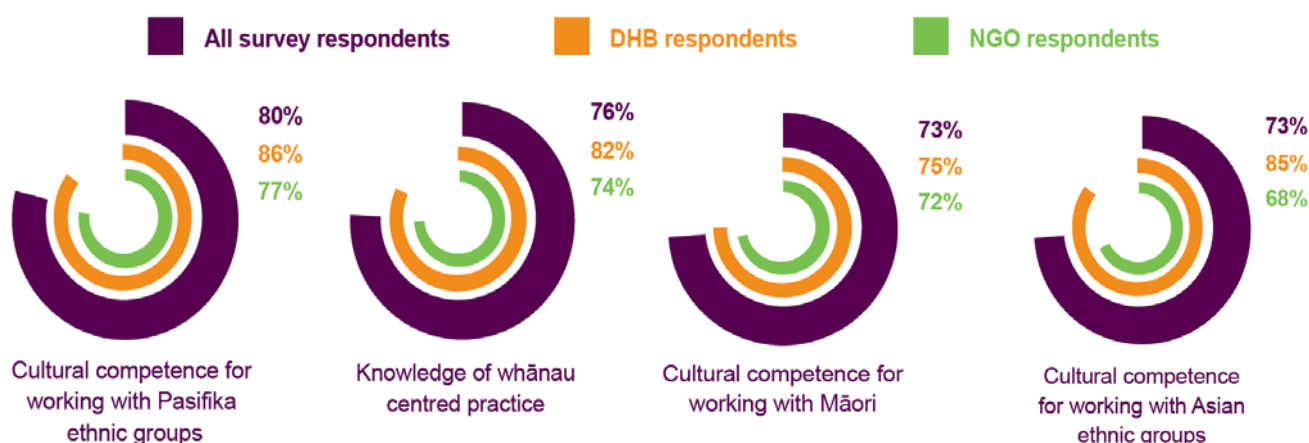


Figure D. Cultural competency areas identified as needing improvement in workforce knowledge and skills by provider

Workforce planning and development challenges

The following sections summarise the responses of 657 leaders and managers who completed questions relating to workforce planning and development needs and issues for their teams.

Roles at risk of shortage

A number of roles were identified by survey respondents as likely to be at risk of future shortage.⁵ These roles included nurses, consultant psychiatrists, clinical psychologists, occupational therapists, community support workers and residential support workers (see Figure E). There is a need to consider training, recruitment and retention strategies for these roles, along with implementing new roles or different models of care that place less emphasis on these roles.



Figure E. Top three roles at risk of shortage as ranked by all respondents (proportion of respondents shown as percentage)

⁵ Key findings are only reported for those roles with 10 or more responses.

Workforce development and service challenges

Survey respondents most frequently reported managing pressure on staff due to increased demand for service and increased complexity in the top four workforce development challenges (selected from a pre-identified list of seven items, see Figure F).

DHB respondents were more likely than NGO respondents to report managing pressure on staff due to increased demand for service in their top four challenges.

NGO respondents were more likely than DHB respondents to report static or reduced funds in their top four challenges.

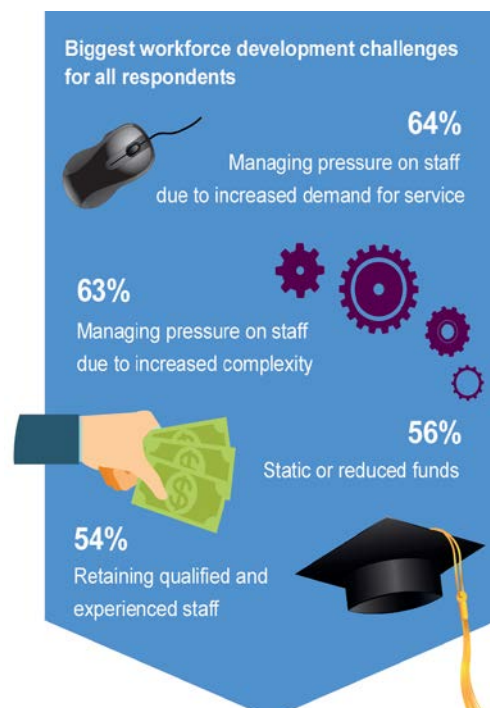


Figure F. Top four challenges ranked by all respondents who currently employed those roles

Knowledge and skill levels

Respondents reported that workforce knowledge and skills needed to increase across a range of policy and practice areas, including:

- working with new technologies and IT (80 per cent)
- co-existing problems capability (76 per cent, see Figure G).

Increased skills in working with new technologies and IT was indicated by 91 per cent of DHB respondents compared to 76 per cent of those from NGOs. Increased skills in co-existing problems capability was indicated by 84 per cent of DHBs compared to 73 per cent of NGOs.

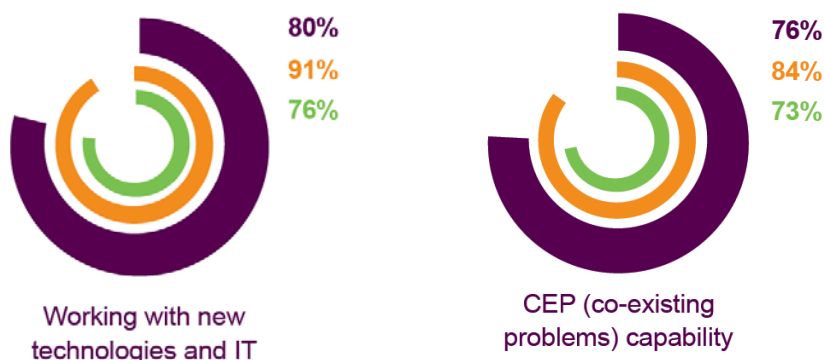


Figure G. Areas identified as needing improvement in workforce knowledge and skills by provider

Cross-sector relationships

The proportion of respondents who thought relationships with other sectors were working “adequately” or “well” outweighed the proportion who thought they needed improving (see Figure H).

Respondents most commonly reported relationships were “adequate” or “working well” with:

- other mental health services (88 per cent)
- police (87 per cent)
- child and adolescent mental health services (81 per cent)
- relationship services (80 per cent).

Respondents were most likely to report the need to improve relationships with:

- Housing New Zealand Corporation and other accommodation providers
- the disability sector
- education sector
- mental health services for older people.

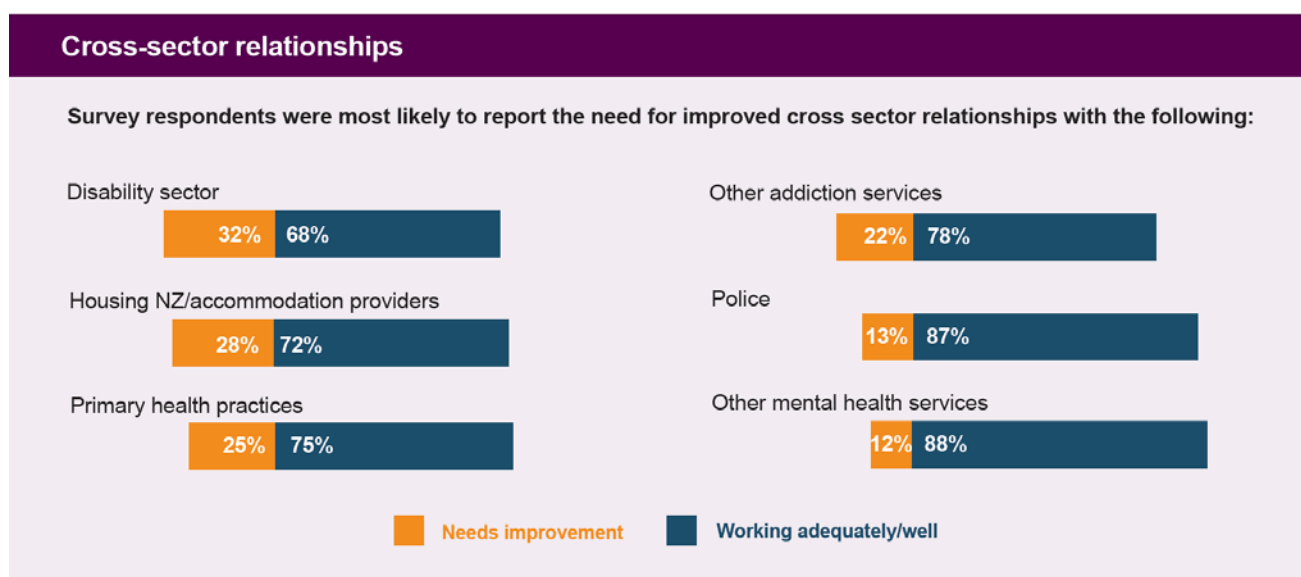


Figure H. *Proportion of respondents identifying strength of relationships*

DHB respondents reported that relationships needed to improve with:

- the disability sector (38 per cent)
- primary health practices (31 per cent)
- Housing New Zealand Corporation and other accommodation providers (31 per cent).

NGO respondents reported that relationships needed to improve with:

- child and adolescent mental health services (30 per cent)

- the disability sector (29 per cent)
- the education sector (29 per cent).

Conclusion

Rising to the Challenge (Ministry of Health, 2012), *Blueprint II* (Mental Health Commission, 2012) and *Towards the Next Wave* (Mental Health and Addiction Service Workforce Review Working Group, 2011) all foreshadow a change in the way that mental health and addiction services will be delivered in the future. Understanding how the workforce is currently configured is important for service planning and workforce development to enable the sector to adapt to these challenges.

This report presents results for the Vote Health funded workforce reported by 20 DHBs and 137 NGOs delivering adult mental health or MH&A services.⁶ It summarises the adult mental health workforce by occupation groups and roles, and services provided. The report highlights some areas that will need attention from national, regional and local mental health leaders, managers, planners and funders, and policy makers. The *Adult mental health and addiction workforce* report provides a set of recommendations arising from the survey.

This report describes the workforce reported to the survey by mental health services. Some 27 percent of the NGOs invited to participate in the survey did not respond. This means the NGO workforce is likely to be under-reported. The full report *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services* (Te Pou o Te Whakaaro Nui, 2015) uses funding information to estimate that the NGO workforce in mental health services is likely to be approximately 18 per cent greater than the workforce size reported to the survey.

As outlined in the full report *Adult mental health and addiction workforce* (Te Pou o Te Whakaaro Nui, 2015), workforce information can be used alongside recommendations for workforce development across the mental health and addiction sector. Such workforce planning should be undertaken using a systematic, forward-thinking approach. *Getting it right* (Te Pou o Te Whakaaro Nui, 2014) describes a process for using workforce information to inform workforce development actions that align with decisions about service delivery models.

⁶ The *More than numbers* organisation workforce survey collected workforce information from 189 organisations with contracts to deliver adult addiction and mental health services during 2012/13; a response rate of 75 per cent). Surveys were completed by all 20 of the DHBs and 73 per cent of invited NGOs (169 out of 231 organisations). Organisations that completed the survey received 96 per cent of the 2012/13 Vote Health funding for adult addiction and mental health services.

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1.0 Introduction

At a time of considerable fiscal restraint for many nations, the efficient and effective use of the health workforce to best meet the needs of people accessing mental health and addiction services is a priority focus for policy makers and leaders and managers. In New Zealand this is particularly relevant in the context of changing demographics and models of care, and the increased emphasis on technological input and evidence-based planning. The World Health Organization describes the health workforce as the “most costly [and] indispensable” resource in the health system (World Health Organization, 2010, p. 1). The goal of health workforce planning, as described by the World Health Organization, is to have:

- “the right number of people
- with the right skills
- in the right place
- at the right time
- with the right attitude
- doing the right work
- at the right cost
- with the right work output” (World Health Organization, 2010, p. 1).

A ‘whole of systems’ approach focusing on individual, organisational and environmental changes is needed to effectively deliver planned new models of care within and across organisations, sectors and regions. The *Getting it Right – Workforce planning guide* (Te Pou o Te Whakaaro Nui, 2014a) sets out six steps for undertaking workforce planning. The information in this report contributes to step four: analysing workforce capacity and capability.

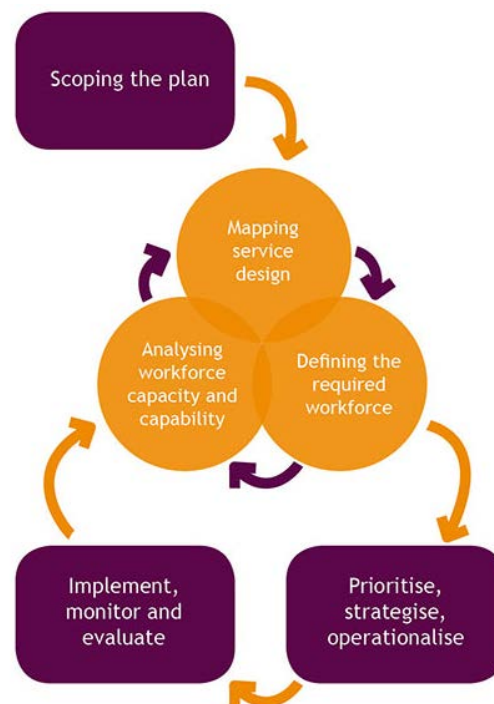


Figure 1. A six-step workforce planning approach (Te Pou o Te Whakaaro Nui, 2014a).

This report presents the results of the 2014 *More than Numbers* organisation workforce survey of the workforce delivering adult mental health services across the district health board (DHB) provider arm and the non-government organisation (NGO) sector.⁷ It provides important baseline information on the workforce delivering adult mental health services, particularly as organisations address the challenges posed by increased demand for these services in a fiscally constrained environment (Mental Health and Addiction Service Workforce Review Working Group, 2011).

⁷ Another national report describes the workforce delivering adult addiction services.

1.1 Survey aims

The survey had the following aims.

1. To understand the workforce delivering adult mental health and addiction services in:
 - a. the DHB provider arm
 - b. NGOs receiving Ministry of Health funding.
2. To describe, in relation to services offered, the region and DHB district, and the workforce composition in terms of roles and ethnicity.
3. To understand current and future workforce challenges, knowledge and skill needs, and inter-sectoral relationships.

Information arising from the *More than Numbers* survey will contribute to analysing the capacity and capability of the New Zealand mental health and addiction workforce. The information presented can assist the Ministry of Health, Health Workforce New Zealand and others to assess current capacity, while supporting workforce planning at a national level to meet future service and workforce development needs. The results provide leaders and managers of services and regions, planners and funders, policy makers and clinicians with information about their workforce and the people accessing services. The results are intended to enhance workforce planning and development at a local, regional and national level.

1.2 Reports in this series

This report presents the *More than Numbers* organisation workforce survey results for the adult mental health services' Vote Health funded workforce. The results reported include those for:

- mental health services
- combined mental health and addiction (MH&A) services.⁸

There are two other national reports in this series.

- *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services* presents the survey results from both addiction and mental health services. It presents estimates of the total workforce size and distribution with analyses in regards to population, funding, service demand and predicted future demand, and includes recommendations. In addition, it provides an overview of previous surveys of the mental health and addiction services' workforce from the past decade.⁹
- *Adult addiction workforce: 2014 survey of Vote Health funded services* presents the results for the adult addiction services' Vote Health funded workforce. This report includes survey results from:
 - Alcohol and other drug (AOD) services
 - problem gambling services
 - MH&A services.

⁸ This group is described in the limitations to this report in Section 1.4.

⁹ Workforce data has greater utility when presented in the context of population and funding information. Joint appendices for the three national reports contain additional information about population, funding and service use.

- There is a visual summary of the national mental health and addiction workforce national survey results, and a visual summary of the AOD and problem gambling workforce.

There are also four reports presenting the survey results for mental health and addiction services in each DHB region and a visual summary for each region, and 20 reports present the results for DHB localities. The reports aim to better support service and workforce planning at regional and local DHB district. Summary reports related to particular sections of the workforce have also been developed.¹⁰

Important gaps to note in this series of reports include the workforce supporting older adults with mental health and addiction issues (Te Pou o Te Whakaaro Nui, 2011), and the workforce in primary care. In addition, in 2014 the Werry Centre undertook its sixth stocktake of the workforce delivering secondary child and youth mental health and addiction services. A more complete picture of the mental health and addiction sector workforce can be gained by combining the results presented here with those from the Werry Centre's 2014 stocktake of child and adolescent services (The Werry Centre, 2015).

1.3 Summary of the survey responses

All 20 DHBs and 231 NGOs with 2012/13 Ministry of Health or DHB contracts for the delivery of adult addiction and mental health services were invited to participate in the survey.¹¹ Of these organisations, all 20 DHBs and 169 NGOs returned surveys. This represents an overall response rate of 75 per cent.

This report presents the results for the Vote Health funded adult mental health workforce reported by 20 DHBs and 137 NGOs delivering mental health and MH&A services.¹² These organisations received 96 per cent of the 2012/13 Vote Health funding for mental health services. The 137 NGOs that completed the survey received 86 per cent of the Vote Health funding for NGO mental health contracts.

Organisations were asked to provide survey returns for each team or service in a local DHB district or region to enable workforce data to be presented at DHB district both of these levels. The results reported here are based on 657 responses:

- 616 responses received from mental health services
- 41 responses from MH&A services.

¹⁰ Reports are available from the Te Pou o Te Whakaaro Nui Ltd website www.tepou.co.nz/morethannumbers.

¹¹ A total of 251 organisations met the criteria for inclusion in the survey. Of this group 189 organisations returned completed surveys: all 20 DHBs and 169 out of 231 NGOs (73 per cent), the organisation response rate was 75 per cent overall.

¹² These organisations included 125 NGOs delivering mental health services and 16 NGOs delivering MH&A services, with four of these NGOs delivering both types of services.

1.4 Limitations

While the majority of Vote Health funded organisations have been captured by this survey, a number of key limitations should be noted. These are outlined below.¹³

Identifying the workforce as delivering mental health or addiction services proved challenging. With the Ministry of Health increasingly encouraging service integration, a number of respondents identified their workforce as providing both addiction and mental health services. However, it was not always evident that this workforce included specific mental health or addiction roles. Because of disparities in size between the mental health and addiction workforce, this group of surveys was reduced to those services whose organisations were contracted to deliver mental health services and AOD or problem gambling services,¹⁴ and is reported here as MH&A services. It should be noted, however, this group does not accurately reflect the extent of service integration in the sector.

Of the 231 NGOs invited to participate in the survey, 27 per cent did not respond. This means the NGO workforce is likely to be under-reported. The full report *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services* (Te Pou o Te Whakaaro Nui, 2015) uses funding information to estimate that the NGO mental health services' workforce is likely to be approximately 18 per cent greater than the workforce size reported to the survey.

Information about staff ethnicity was not provided by some services, and while people were asked to check rather than guess ethnicity we cannot verify that this was done.

While respondents were asked to report their workforce funded from non-Vote Health sources of income, they were not obliged to do so and the survey sample was limited to services funded through Vote Health. Therefore, only a subsection of the non-Vote Health funded workforce in mental health services was captured in the survey results.

More information about the survey methodology and limitations is provided in Appendix B: Organisation workforce survey method.

1.5 Chapter outline

This report presents results from the 2014 *More than numbers* organisation workforce survey of adult mental health services. An outline of each chapter and the information and analysis presented in relation to the survey results follows.

¹³ The limitations to this survey are fully described in Appendix B: Organisation workforce survey method.

¹⁴ The method for allocating services to the MH&A group is fully described in the limitations to this report, in Appendix B: Organisation workforce survey method. It should be noted that the survey did not identify integrated addiction and mental health services.

Chapter 2 describes the size, configuration and distribution of the adult mental health services' Vote Health funded workforce across provider and sector groups, by services provided, by occupation groups and roles, and by roles vacant.

Chapter 3 focuses on the results for Vote Health funded workforce ethnicity and cultural competence. The first three sections profile workforce ethnicity, describing Māori, Pasifika and Asian representation across different provider and sector groups, and services provided. The fourth section presents the results for cultural competence-related knowledge and skill development needs of the workforce.

Chapter 4 summarises the results for questions relating to workforce planning and development challenges, including:

- recruitment and retention issues
- workforce planning challenges
- knowledge and skill development needs in key policy and practice areas
- cross-sector relationships.

Chapter 5 concludes the report, and summarises the key results for mental health services.

The remaining section of this chapter summarises the overall results from the survey, with results for addiction services in context with results received from mental health services, including the Vote Health funded and non-health funded workforce totals.

1.6 Overview of the adult mental health and addiction services' workforce

To provide context to the results for mental health services, this section describes the overall *More than numbers* survey results for adult mental health, and AOD and problem gambling (addiction) services. These results include the Vote Health funded workforce and the workforce reported as funded from other sources of income (non-health funded workforce).¹⁵ The remaining chapters of the report focus specifically on the Vote Health funded workforce in mental health and MH&A services.

The survey collected information from:

- mental health services
- MH&A services
- AOD services
- problem gambling services.

¹⁵ Respondents provided information about their workforce in columns separating the workforce in Vote Health funded roles from those roles funded by other sources of income (the non-health funded workforce). This information included numbers of employees and FTE positions employed and vacant as at 1 March 2014.

Survey findings for the total mental health and addiction workforce are summarised below.

- A total of 10,845 people were employed across all services. Of this group:
 - 8,460 people were employed in mental health services
 - 614 were employed in mental health and addiction (MH&A) services
 - 1,771 people were employed in alcohol and other drugs (AOD) and problem gambling services.
- The total workforce reported to the survey was 9,337 FTEs including:
 - 8,929 FTEs funded by Vote Health
 - 408 FTEs funded from other sources of income.¹⁶
- The mental health services' workforce totalled 7,274 FTEs. This workforce included:
 - 7,097 FTE Vote Health-funded positions
 - 177 FTEs funded through other sources.
- The MH&A services' workforce totalled 559 FTEs. This workforce included:
 - 516 FTE Vote Health-funded positions
 - 43 FTEs funded through other sources.
- The AOD and problem gambling services' workforce totalled 1,504 FTEs. This workforce included:
 - 1,316 FTEs funded through Vote Health
 - 188 FTEs funded through other sources of income.

To be included in the combined mental health and addiction group, the organisation needed to have a contract with the Ministry of Health or DHB for the delivery of both mental health and AOD or problem gambling services. This strategy limited this group to services provided by organisations contracted to employ both addiction and mental health staff.

¹⁶ Sector intelligence suggests that the non-health funded workforce has been generally under-reported to the survey, particularly for addiction services.

Table 1 summarises the Vote Health funded and non-health funded workforce (FTE positions employed and vacant) and shows the total number of people employed within each group.¹⁷

Table 1. *Total FTE positions employed and vacant by sector and funding source (n=9,337 FTEs)*

Group	Vote Health FTE positions		Non-health FTEs		Total		
	Employed	Vacant	Employed	Vacant	People employed	FTEs employed	FTEs vacant
Mental health	6,745.9	351.4	169.3	7.5	8,460	6,915.2	358.8
MH&A	496.8	18.7	43.3	-	614	540.1	18.7
AOD and problem gambling	1,269.2	47.3	183.3	4.3	1,771	1,452.5	51.6
Totals	8,511.9	417.3	395.9	11.8	10,845	8,907.7	429.1

The Vote Health funded workforce (DHB and NGO) reported to the survey totalled 8,929 FTEs.

- Adult mental health services reported 7,097 FTEs (employed plus vacant).
- and the combined adult mental health and addiction services workforce totalled 516 FTEs
- AOD and problem gambling services' reported 1,317 FTEs (employed plus vacant).

Figure 2 shows the following demographic information and Vote Health funded workforce distribution across the four regions.

- The size of the adult population (sourced from the 2013 New Zealand Population Census).
- The number of unique consumers seen by mental health services and AOD services (sourced from PRIMHD).
- The funding per head of adult population (calculated from the Ministry of Health Price Volume Schedule 2012/13 and 2013 Census information).
- The total Vote Health funded workforce reported by DHBs and NGOs with their relative proportion of the reported workforce for each region.

The next three chapters will focus on the adult mental health services survey results only. The results for addiction providers who participated in the survey are presented in a companion report: *Adult addiction workforce: 2014 survey of Vote Health funded services*.

¹⁷ Total people employed needs to be treated with caution. Some people may be counted more than once, for example those working across multiple teams within an organisation and those employed by more than one organisation. For this reason, reporting in the following chapter is based upon FTE positions rather than people employed.

Northern region

Population aged 20-64: 943,665
Mental health consumers: 25,223
AOD consumers: 15,150
Funding average per person: \$428
DHB workforce: 2,009 FTEs, 62%
NGO workforce: 1,209 FTEs, 38%
Vacancies: 137 FTEs, 4.3%

Midland region

Population aged 20-64: 454,809
Mental health consumers: 16,959
AOD consumers: 8,881
Funding average per person: \$439
DHB workforce: 863 FTEs, 53%
NGO workforce: 771 FTEs, 47%
Vacancies: 80 FTEs, 4.9%

Central region

Population aged 20-64: 486,663
Mental health consumers: 15,880
AOD consumers: 6,707
Funding average per person: \$413
DHB workforce: 1,255 FTEs, 67%
NGO workforce: 630 FTEs, 33%
Vacancies: 111 FTEs, 5.9%

South Island region

Population aged 20-64: 588,267
Mental health consumers: 16,369
AOD consumers: 7,764
Funding average per person: \$402
DHB workforce: 1,530 FTEs, 70%
NGO workforce: 662 FTEs, 30%
Vacancies: 90 FTEs, 4.1%

Figure 2. Distribution of the Vote Health funded workforce for adult mental health and addiction services by the four DHB regions¹⁸

¹⁸ All DHBs invited to participate in the survey did so. NGO participation varied across the regions. Central had the highest participation rate with 86 per cent of invited NGOs returning a completed survey. Northern was next with 78 per cent returned, then Midland with 68 per cent of NGOs participating. The South Island response rate was the lowest with 62 per cent of the invited NGOs participating in the survey.

2.0 Adult mental health services workforce

This chapter describes the Vote Health funded workforce working in adult mental health services, including mental health and MH&A services.¹⁹ This chapter outlines information on full-time equivalent positions (FTEs) and vacancies for services and roles.

The Vote Health funded mental health services workforce reported to the survey totalled 7,613 FTEs (employed plus vacant).

- Mental health services reported a total of 7,097 FTEs
- MH&A services reported 516 FTEs.

2.1 Adult mental health services workforce by service types

Background on the survey method

Survey respondents were asked to identify the predominant service provided by their workforce from a pre-set list of options.²⁰ In this process respondents also identified whether the service provided was a specific cultural service (kaupapa Māori, Pasifika or Asian) or mainstream (that is not specifically targeted to one of those three groups).

A number of respondents identified their workforce provided multiple types of services (eg peer support, early intervention, maternal mental health). Where this was the case preference was given to the predominant setting of the services selected, for example if most or all of the selected services were delivered in the community, surveys were allocated to the community service type.

In addition, although the survey invitation requested respondents complete one survey form for each individual team or service within a DHB locality, some respondents returned a single form for more than one service of the same type. As a result, the number of responses received is not equivalent to the specific number of services or teams in the sector.

Workforce by service types

The following tables and graphs show a detailed breakdown of the total workforce (FTEs employed plus vacant) across the various service types reported to the survey.

¹⁹ More information about non-health-funded FTEs can be found Appendix D: About population, funding and service provision for adult mental health and addiction services.

²⁰ The full service list and definitions are described in Appendix C: Survey data dictionaries. This list was compiled from both PRIMHD team types, prior surveys and sector intelligence. Grouping of these different services into service types is described in the glossary to this report.

Table 2 summarises the workforce in the mental health service types by general, kaupapa Māori, Pasifika and Asian services.

- Kaupapa Māori services reported 10 per cent of the total mental health workforce (744 FTEs)
- Pasifika services reported 1.4 per cent (109 FTEs)
- Asian services reported 0.2 per cent (13 FTEs)
- All other services (mainstream) reported 89 per cent (6,747 FTEs).

The total workforce reported by service types included:

- community services reported one-third of the total mental health workforce (2,775 FTEs)
- inpatient services reported 18 per cent (1,390 FTEs)
- forensic services reported 13 per cent (985 FTEs)
- residential services reported 12 per cent (935 FTEs)
- there was a small workforce reported by specialist community services, such as early intervention and maternal mental health services.

Table 2. *Adult mental health services workforce (FTEs employed plus vacant) by mainstream and ethnic-based services (n=657 responses)*

Service type	Workforce (FTEs employed plus vacant)				Total
	Mainstream	Kaupapa Māori	Pasifika	Asian	
Community	2,357.1	320.1	85.1	13.1	2,775.3
Inpatient	1,385.6	4.0	-	-	1,389.6
Forensic – inpatient and community	685.8	290.1	9.0	-	984.9
Residential	843.5	84.5	6.8	-	934.8
Specialist community	540.8	19.6	-	-	560.4
Administration and management*	427.3	16.4	4.1	-	447.7
Peer support – consumer	136.6	4.0	2.0	-	142.6
Employment	77.6	3.0	-	-	80.6
Eating disorders	57.9	-	-	-	57.9
Family/whānau	49.0	-	2.0	-	51.0
Intellectual disability/Dual Diagnosis	37.5	-	-	-	37.5
Other	148.8	1.8	-	-	150.6
Total	6,747.2	743.5	108.9	13.1	7,612.7

Note: * Administration and management service type refer to services that provide support for direct service delivery teams in an organisation. These are often separate from the direct care services. Within DHB provider arm services, these services are likely to provide support to child and adolescent mental health services, adult mental health and addiction services as well as mental health services for older adults. The total workforce reported for administration and management services reported here is lower than the total workforce in administration and management roles reported in Tables 16 and 17. Total administration and management roles reported there include 1,020 FTEs. The difference is due to the identification of administration and management support based within all direct care services, not just the separate administration and management services.

As described above, most respondents identified the predominant service that their workforce provided from the list supplied on the survey. Some chose to self-define as 'other'. The most common 'other mental health' service types included housing or supportive landlord, and eating disorders. Others included advocacy, art therapy, refugee services, suicide prevention, needs assessment and coordination, referral or triage, dialectical behaviour therapy, physical activity service, consumer network, regional personality disorder service, programme delivery, women's wellness, intellectual disability and mental health dual diagnosis, and research.

DHBs reported the largest proportion of the mental health workforce (66 per cent) and NGOs reported 34 per cent. Table 3 summarises the workforce in DHBs and NGOs, grouped into six service types.²¹

Table 3. *Adult mental health services workforce by DHB and NGO (n=657 responses)*

Service type	Workforce (FTEs employed plus vacant)		
	DHB	NGO	Total
Community	2,298.8	1,235.1	3,533.9
Inpatient	1,406.8	-	1,406.8
Residential	-	917.6	917.6
Forensic – inpatient and community	941.8	43.1	984.9
Administration and management*	268.5	179.2	447.8
Other	107.4	214.4	321.9
Total	5,023.3	2,589.4	7,612.7

Note: * Administration and management services refer to those senior management or administration services that provide support for direct service delivery teams in an organisation.

The following pie charts show the proportion of the workforce reported by DHBs and NGOs respectively, within each of the six service types used in Table 3. DHBs reported nearly half of their workforce in community services (46 per cent), with 28 per cent of the DHB workforce in inpatient services and the remainder in forensic services (19 per cent), administration and management (5 per cent) and other services (2 per cent).

²¹ The allocation of services to these groups is described in the glossary to this report.

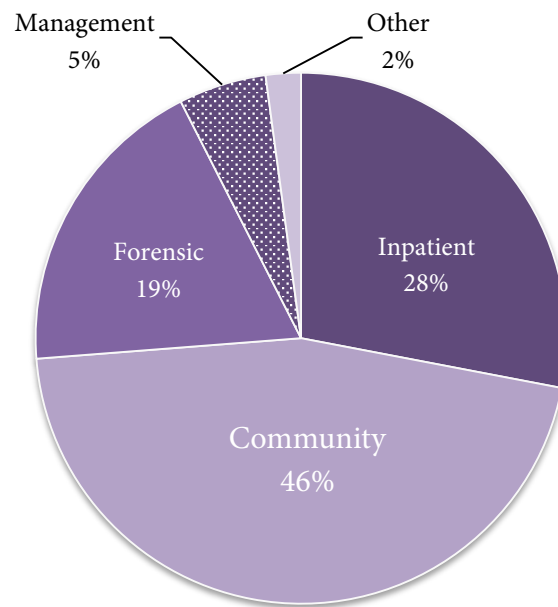


Figure 3. Proportion of DHB workforce by types of mental health services

In contrast, NGOs reported a slightly larger proportion of their workforce in community services (48 per cent) and more in residential services (35 per cent), management and administration services (7 per cent) and other services (8 per cent). There was a very small workforce in NGO forensic services (2 per cent of the total NGO workforce).

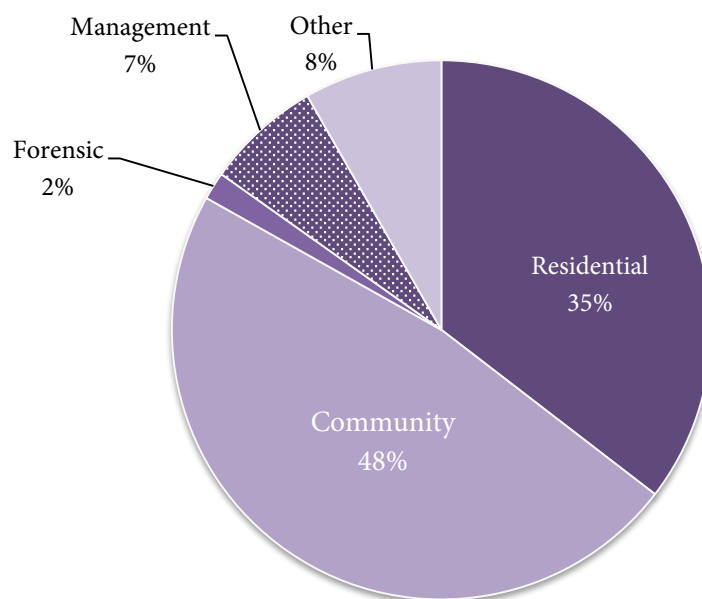


Figure 4. Proportion of NGO workforce by types of mental health services

2.2 Occupation groups and roles in the workforce

This section summarises the survey findings specific to workforce roles. Respondents were asked to identify staff numbers and FTEs employed and vacant for a list of roles common to adult mental health and addiction services. They were asked to allocate staff according to the role performed, not the incumbent's qualifications or professional body affiliations. For example, a qualified social worker employed to perform the role of community support worker would be recorded as the latter. Therefore, the analysis here is relevant only to roles and does not necessarily reflect employees' qualifications, skills or competencies.²²

For the purposes of the survey and this report, roles are divided according to whether they are clinical or non-clinical. Each role is allocated to an occupation group of similar roles (allied health, medical and other professionals, nursing, support workers, cultural advice and support, administration and management). These groups have been based on those used by Australian and New Zealand Standard Classification of Occupations (ANZSCO) (eg allied health, nursing) or for roles with similar functions (eg support workers, administration and management).²³

The clinical occupation groups include nursing, allied health, medical and other professionals. Non-clinical occupation groups include support workers, and cultural advice and support. The administration and management occupation group stands apart; incorporating some clinical and some non-clinical roles. For example, team and senior management roles may have both clinical and management responsibilities as in the case of the charge nurse manager.

Figure 5 shows the distribution of major occupation groupings for DHBs and NGOs. The numbers on the bar graph indicate the total FTEs (employed plus vacant) by DHB and NGO. DHBs employ the largest clinical workforce; they make up 74 per cent of the DHB workforce. NGOs employ mostly non-clinical roles; 73 per cent of their workforce.

Key points in relation to the total clinical workforce roles (employed and vacant) reported in the survey across adult mental health services.

- Clinical roles make up 53 per cent of the total workforce across the mental health sector.
 - Nursing roles were 61 per cent of the clinical role workforce (not including nurse managers who are included in management and administration roles)
 - 23 per cent were in allied health, of these social workers, psychologists and occupational therapist were the most common allied health roles
 - 13 per cent were medical and other professionals, consultant psychiatrists were the most common role among medical professionals.

²² In some cases, particularly for clinical roles, there may be minimum qualification requirements to use specific role titles, eg in the case of registered nurses and clinical psychologists. The data dictionary outlined a general description for each role and showed how these have been used in other workforce surveys and data sets. See Appendix C: Survey data dictionaries.

²³ See Appendix C: Survey data dictionaries for an outline of roles and their definitions. A data dictionary was available to survey respondents. It outlined a general description for each role and showed how these have been used in other workforce surveys and data sets, including the Australian and New Zealand Standard Classification of Occupations codes..

Key points in relation to the non-clinical workforce reported in the survey.

- Support workers comprised 32 per cent of the total FTEs across the mental health sector. Among support workers:
 - 39 per cent of the support workforce were in community support worker roles
 - 24 per cent were in residential support worker roles
- cultural workers form 1.9 per cent of the total workforce. It is likely that this figure under-represents this workforce as it does exclude unpaid workers. Information about unpaid workers and volunteers was not collected in the survey.

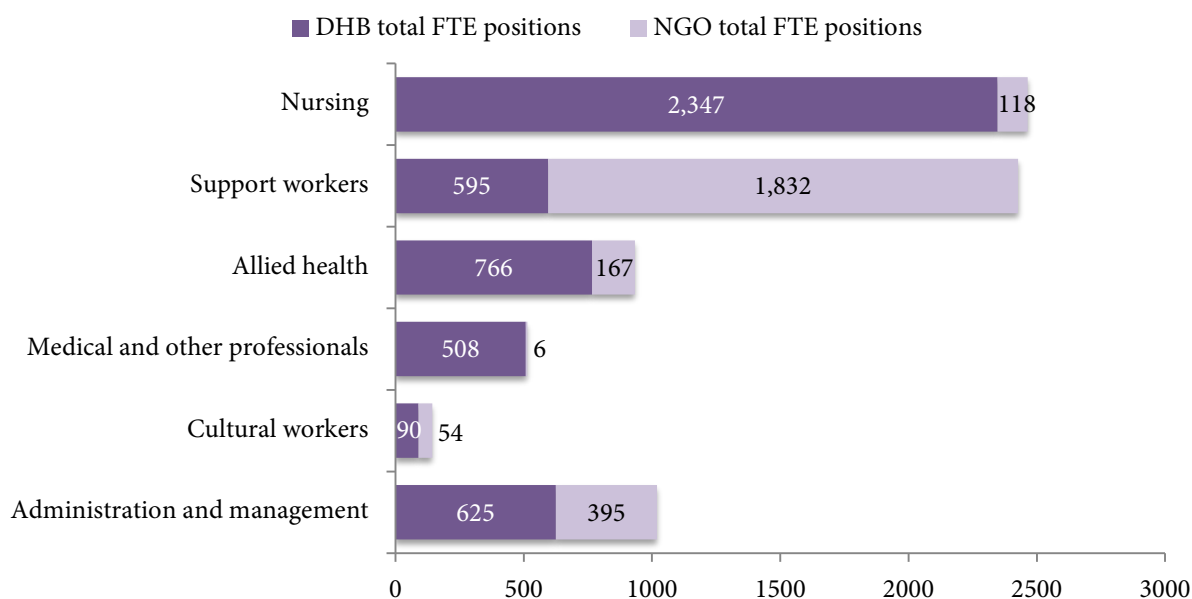


Figure 5. DHB and NGO total workforce by occupation groups

Table 4 shows the FTEs (employed plus vacant) in the DHBs and NGOs for each role. The final column shows the workforce reported for each role as a proportion of the total mental health workforce reported in the survey.²⁴

DHB mental health services reported a total workforce of 5,023 FTEs (employed plus vacant). The DHB workforce comprised of mostly clinical roles (74 per cent).

- Allied health professionals were 21 per cent of the DHB clinical role workforce, within this group:
 - occupational therapist roles were 24 per cent
 - clinical psychologist roles, 29 per cent
 - social worker roles, 35 per cent.
- Nursing roles were 63 per cent of the DHB clinical role workforce.

²⁴ However, sub-totals for each group of roles, eg allied health professionals, represents the total proportion for that group of roles across the whole mental health workforce reported in the survey.

- Psychiatrists, house surgeons, medical officers (special scale) and registrars comprised 13 per cent of the DHB clinical role workforce, and the rest of the medical professionals were a mix of other medical roles.

The DHB workforce in non-clinical roles was dominated by healthcare assistants (39 per cent), psychiatric assistants (24 per cent) and community support workers (15 per cent).

Administration and management roles accounted for 12 per cent of the total workforce reported by DHBs.

NGO mental health services reported a total workforce of 2,589 FTEs (employed plus vacant).

- The NGO workforce comprised of mostly non-clinical roles (73 per cent).
 - Support workers were the largest occupation group (97 per cent of the NGO non-clinical role workforce).
- NGOs reported their clinical role workforce was 308 FTEs (12 per cent of the total NGO workforce).
 - Nursing roles were the majority of the NGO clinical workforce (38 per cent).
 - Social worker roles were 20 per cent.
- Administration and management roles accounted for 15 per cent of the total NGO workforce.

Table 4. *Adult mental health services workforce by roles (FTEs employed plus vacant)*

Roles	DHB	NGO	Total	Proportion of total FTEs (employed plus vacant)
Clinical roles				
Allied health				
Addiction practitioner/clinician	15.2	25.9	41.1	0.5%
Dual diagnosis practitioner/co-existing problems clinician	8.5	4.5	13	0.2%
Counsellor	23.1	14.1	37.3	0.5%
Educator/ trainer	5.4	16	21.3	0.3%
Occupational therapist	184.8	20.3	205.1	2.7%
Clinical psychologist	222.1	11.1	233.3	3.1%
Other psychologist	11.2	7	18.2	0.2%
Social worker	269.5	62	331.4	4.4%
Other allied health professionals	26.2	6.4	32.6	0.4%
Sub-total (Allied health)	766.1	167.3	933.4	12.3%
Medical and other professionals				
General practitioner	4.8	0.7	5.6	0.1%
House surgeon	51	1	52	0.7%
Consultant psychiatrist	261.7	0.6	262.3	3.4%
Medical officer special scale	50.1	1	51.1	0.7%

Roles	DHB	NGO	Total	Proportion of total FTEs (employed plus vacant)
Psychiatric registrar	112.4	1.7	114.1	1.5%
Liaison/consult liaison	27.3	1	28.3	0.4%
Other medical professionals	0.6	-	0.6	0.0%
Sub-total (Medical and other professionals)	507.9	6.1	513.9	6.8%
Nursing				
Registered nurse	2,146.50	110.7	2,257.20	29.7%
Enrolled nurse	66.4	3.9	70.3	0.9%
Nurse practitioner	90.5	3	93.5	1.2%
Other nursing professionals	43.5	-	43.5	0.6%
Sub-total (Nursing)	2,346.90	117.6	2,464.50	32.4%
Other clinical roles	90.4	17.3	107.7	1.4%
Total (Clinical roles)	3,711.20	308.2	4,019.40	52.8%
Non-clinical roles				
Support workers				
Community development worker	-	45	45	0.6%
Employment worker	-	43.9	43.9	0.6%
Community support worker	106.2	842.3	948.6	12.5%
Family support worker	3.5	57.3	60.8	0.8%
Healthcare assistant	264.5	9	273.5	3.6%
Peer support - consumer and service user	14.2	141	155.2	2.0%
Peer support - family and whānau	-	11.8	11.8	0.2%
Psychiatric assistant	165.4	-	165.4	2.2%
Residential support worker	-	586.1	586.1	7.7%
Other support workers	41.1	95.2	136.2	1.8%
Sub-total (Support workers)	594.9	1,831.50	2,426.40	31.9%
Cultural workers				
Cultural advisor	5.6	8.1	13.7	0.2%
Kaumātua	12.6	16.3	28.9	0.4%
Kuia	5.3	5.7	11	0.1%
Kaiāwhina	26.7	1.1	27.8	0.4%
Traditional Māori health practitioner	1	17	18	0.2%
Matua	1.5	0.2	1.7	0.0%
Pasifika cultural advisor	1	1.2	2.2	0.0%
Other cultural advisor	36.3	4	40.3	0.5%
Sub-total (Cultural workers)	90	53.6	143.6	1.9%

Roles	DHB	NGO	Total	Proportion of total FTEs (employed plus vacant)
Other non-clinical roles	2	1.5	3.5	0.0%
Total (Non-clinical roles)	686.9	1,886.60	2,573.50	33.8%
Administration and management				
Administrative and/or technical support	330.3	88.9	419.2	5.5%
Senior manager	47.3	69.9	117.2	1.5%
Clinical director	20.8	5.1	25.9	0.3%
Professional leader	17.7	9.9	27.6	0.4%
Service manager/team leader	156.8	187.9	344.7	4.5%
Consumer advisor/consumer leader	18.3	14	32.3	0.4%
Family/whānau advisor	18.5	4.5	23	0.3%
Other admin/management/support	15.4	14.4	29.8	0.4%
Sub-total (Administration and management)	625.2	394.5	1,019.80	13.4%
Grand Total (all roles)	5,023.30	2,589.40	7,612.70	100.0%

2.3 Vacancies

The following table presents total vacancies by roles for DHBs and NGOs. The last column calculates the vacancy rate²⁵ for each role and the sub-total rows present the vacancies and vacancy rates for each occupation group.

The greatest number of vacancies were among nurses, with DHBs reporting 144 FTEs vacant and NGOs reporting 17 FTEs vacant. The roles with the highest vacancy rates included family advisors (24 per cent), kaumātua (11 per cent) and kuia (18 per cent) as well as psychiatric registrars (9 per cent). However, it is important to recognise the small size of the total workforce in these roles means that one or two vacancies create very high vacancy rates.

²⁵ This is done by dividing the total vacancies for each row by the total workforce for that role (FTEs employed plus vacant).

Table 5. *Adult mental health service workforce vacancies by roles (total FTEs vacant) with vacancy rates by role*

Roles	DHB	NGO	Total vacant FTEs	Vacancy rate
Clinical roles				
Allied health				
Occupational therapist	14.8	1.0	15.8	7.7%
Clinical psychologist	17.6	3.0	20.6	8.8%
Other psychologist	1.3	-	1.3	7.1%
Social worker	11.1	2.0	13.1	4.0%
Addiction practitioner/clinician	1.0	-	1.0	2.4%
Dual diagnosis practitioner/co-existing problems clinician	1.1	-	1.1	8.5%
Counsellor	-	-	-	-
Educator/trainer	-	-	-	-
Other allied health professionals	-	1.2	1.2	3.7%
Sub-total (allied health)	46.9	7.2	54.1	5.8%
Medical and other professionals				
General practitioner	0.2	-	0.2	3.6%
House surgeon	1.0	-	1.0	1.9%
Consultant psychiatrist	6.7	-	6.7	2.6%
Medical officer special scale	2.3	-	2.3	4.5%
Psychiatric registrar	10.0	-	10.0	8.8%
Liaison/consult liaison	1.0	-	1.0	3.5%
Other medical professionals	-	-	-	-
Sub-total (medical and other professionals)	21.2	-	21.2	4.1%
Nursing				
Registered nurse	135.8	16.0	151.8	6.7%
Enrolled nurse	3.9	0.5	4.4	6.3%
Nurse practitioner/nurse specialist/nurse educator	3.2	-	3.2	3.4%
Other nurses	1.5	-	1.5	3.4
Sub-total (nursing)	144.4	16.5	160.9	6.5%
Other clinical roles	2.5	3.0	5.5	5.1%
Total (clinical roles)	215.0	26.7	241.7	6.0%
Non-clinical roles				
Support workers				
Community development worker	-	0.5	0.5	1.1%
Employment worker	-	0.5	0.5	1.1%
Community support worker	6.0	28.9	34.9	3.7%
Family support worker	-	-	-	-
Healthcare assistant	21.3	-	21.3	7.8%

Roles	DHB	NGO	Total vacant FTEs	Vacancy rate
Peer support – consumer	-	3.2	3.2	2.1%
Peer support – family and whānau	-	-	-	-
Psychiatric assistant	3.5	-	3.5	2.1%
Residential support worker	-	17.3	17.3	3.0%
Other support workers	3.0	7.2	10.2	7.5%
Sub-total (support workers)	33.8	57.5	91.3	3.8%
Cultural workers				
Cultural supervisor	-	1.0	1.0	7.3%
Kaumātua	1.9	1.2	3.1	10.7%
Kuia	1.0	1.0	2.0	18.1%
Kaiāwhina	-	-	-	-
Traditional Māori health practitioner	-	-	-	-
Matua	-	-	-	-
Pasifika cultural advisor	-	-	-	-
Other cultural advisor	2.7	-	2.7	6.7%
Sub-total (cultural workers)	5.6	3.2	8.8	6.1%
Other non-clinical roles	1.0	-	1.0	28.6%
Total (non-clinical roles)	40.4	60.7	101.1	3.9%
Administration and management				
Administrative/technical support	2.8	1.4	4.2	1.0%
Senior manager	4.5	1.0	5.5	4.7%
Clinical director	1.0	-	1.0	3.9%
Professional leader	0.4	-	0.4	1.4%
Service manager/team leader	8.1	1.0	9.1	2.6%
Consumer advisor/consumer leader	0.4	0.3	0.7	2.2%
Family/whānau advisor	4.9	0.5	5.4	23.5%
Other administration and management	1.0	-	1.0	3.4%
Total (administration and management)	23.1	4.2	27.3	2.7%
Grand total (all roles)	278.4	91.6	370.1	4.9%

3.0 Ethnic makeup and cultural competence

Rising to the Challenge's (Ministry of Health, 2012) priority actions include improving service responsiveness for Māori and Pasifika populations. An ethnically diverse workforce that reflects the population served is one strategy for supporting culturally responsive services for people using mental health services. Cultural competency among the overall workforce is also important. This chapter summarises the survey findings in relation to the Māori, Pasifika and Asian workforce and results relating to areas of workforce cultural competence needing improvement in adult mental health services.²⁶

Cultural responsiveness is particularly important given certain ethnic groups are disproportionately affected by mental health and addiction concerns. Prevalence rates for mental disorders among the population reported in the *Te Rau Hinengaro* survey indicate high rates of mental disorder for Māori and Pasifika people, more so than any other ethnic group. The results suggested that for mental health disorder in the past 12 months, the prevalence was 29.5 per cent for Māori, 24.4 per cent for Pasifika and 19.3 per cent for all others (Oakley Browne, Wells, & Scott, 2006, p. 173). This highlighted that Māori and Pasifika experience a greater burden as a result of mental health issues.

At the same time, the results reported in *Te Rau Hinengaro* showed Pasifika, and Maori were less likely to access services in relation to mental health concerns. In the past 12 months the following proportion of people in each ethnic group with a mental health disorder made a mental health visit:

- 25 per cent of Pasifika people
- 33 per cent of Māori
- 41 per cent of others (Oakley Browne, Wells & Scott, 2006, p. xxi).²⁷

It is important to recognise that Māori consumers and workforce comprise of diverse groups. This is also the situation with Pasifika and Asian groups. In this report, it has been necessary to report ethnicity using aggregated population groups. However, aggregating population group risks homogenising diverse populations. Workforce planning and development needs to consider the diversity of cultures and practices.

3.1 Workforce ethnicity

The organisation workforce survey asked respondents to indicate how many Māori, Pasifika or Asian people were employed in clinical and non-clinical roles, and the total FTEs employed. Respondents were asked to include all employees within all the specified groups for both head counts and FTEs, meaning that some people's information may be included more than once if they belong to multiple ethnic groups.

²⁶ Only these three groups were included in the survey, as it relied on managers and team leaders identifying workforce ethnicity. An individual census would be required to gain a more in-depth understanding of the ethnicity of the workforce.

²⁷ The results from *Te Rau Hinengaro* are not directly comparable with the PRIMHD information about mental health activities and consumers. Visits reported in *Te Rau Hinengaro* include all health visits related to a mental health issue which will include a wider range of providers. In comparison, PRIMHD reports on activities and consumers related to specialist mental health and addiction services.

Of the 657 mental health respondents, 580 respondents indicated staff ethnicity in relation to Vote Health funded workforce (88 per cent of respondents, 71 per cent of the total adult mental health FTEs identified). Of the respondents:

- one-quarter (146) had no staff members of the specified ethnicities
- three-quarters (434) completed the questions for Māori, Pasifika and Asian staff members in clinical and non-clinical roles
- DHBs contributed 164 responses
- NGOs contributed 416 responses.

The following analyses are based on only those surveys providing ethnicity data, including those indicating that they had no staff of the specified ethnicities. The total workforce reported by this group was 5,404 FTEs employed. Non-responses and those indicating the information was not available have been excluded.

The information provided in this chapter should be used with caution for three reasons. First, workforce ethnicity or representativeness does not necessarily imply cultural competence in service delivery. Second, survey respondents were advised to only provide self-identified ethnicity information for their workforce and to indicate if this information was not available, rather than guess employee ethnicity; however, it is not possible to ascertain the extent to which this has occurred. Third, a number of respondents did not report the ethnicity of their staff members, therefore the total workforce counts will under-report the number of people of each ethnic group working in the sector.

Māori population, service use and workforce

In 2013, adult Māori made up 12 per cent of the total New Zealand adult population (aged 20 to 64 years). This age group was 51 per cent of the total Māori population living in New Zealand (Statistics New Zealand, 2013).²⁸ PRIMHD recorded that 23 per cent of the consumers seen by adult mental health services were Māori.²⁹

Figure 6 shows the proportion of Māori in the adult population, as consumers of mental health services,³⁰ and in the mental health workforce. There was a slightly smaller proportion of Māori in the total workforce than as consumers of services (19 per cent compared to 23 per cent). However, there was a wide disparity between the proportion of the clinical workforce identified as Māori (13 per cent) compared to the workforce in non-clinical, administration and management roles (24 per cent).

²⁸ See summary tables in Appendix D: About population, funding and service provision for adult mental health and addiction services²⁹ PRIMHD reports Māori using prioritised ethnicity data. Under prioritised ethnicity, consumers who report belonging to more than one ethnic group are reported according to a priority list, with the order of priority being given first to Māori, then Pasifika and Asian peoples, and then other.

²⁹ PRIMHD reports Māori using prioritised ethnicity data. Under prioritised ethnicity, consumers who report belonging to more than one ethnic group are reported according to a priority list, with the order of priority being given first to Māori, then Pasifika and Asian peoples, and then other.

³⁰ The group of mental health consumers identified in PRIMHD include those seen only by mental health services, and those who were seen by both mental health and AOD services. Consumers seen only by AOD services are not included.

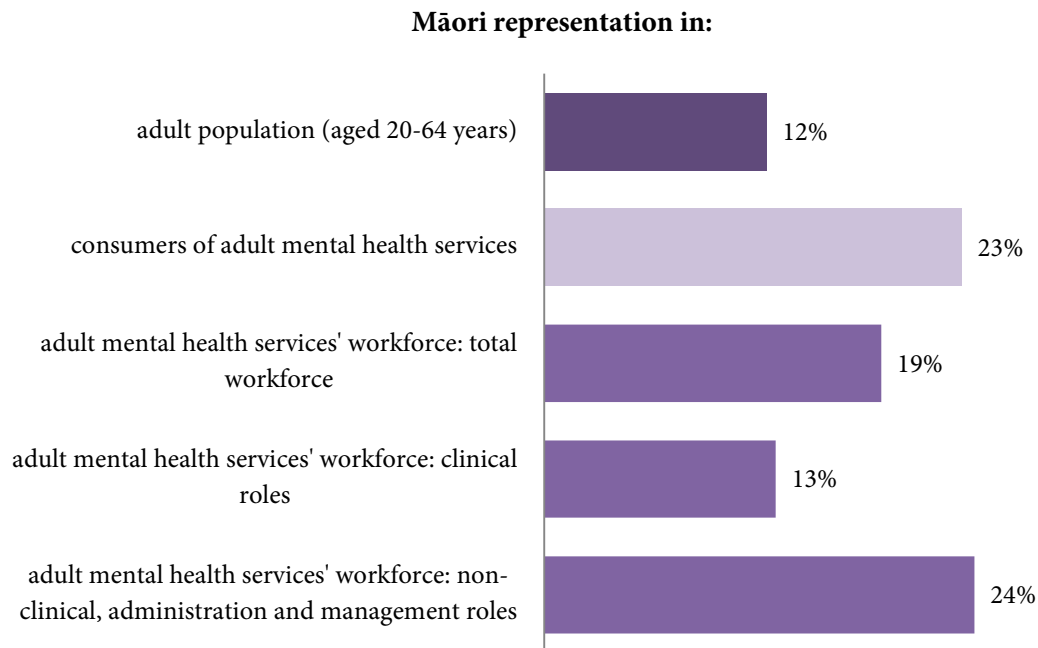


Figure 6. Māori as a proportion of the adult population, consumers and workforce in adult mental health services

Māori staff members filled 1,017 FTE positions in the mental health workforce (19 per cent of 5,404 FTEs employed). NGO respondents reported a higher proportion of Māori in their workforce than DHBs. Māori were 27 per cent of the NGO workforce and 13 per cent of the DHB workforce FTEs. Compared to DHBs, NGOs had a higher proportion of Māori workforce for both clinical roles (2.5 times greater) and non-clinical roles (1.6 times greater).

Table 6 summarises by DHB and NGO, the proportion of the workforce filled by Māori staff in clinical, non-clinical, administration and management roles, and in the total workforce employed.³¹

³¹ This analysis is based only on the surveys received with completed staff ethnicity questions. It excluded those stating that the information was not available or unknown.

Table 6. *Māori representation in DHB and NGO adult mental health services*

Māori staff members in:	Proportion of the workforce (%)			Total workforce (FTEs employed)	
	DHB	NGO	DHB & NGO	Māori workforce	Total FTEs*
Clinical roles	11.1	28.1	12.9	327.2	2,532.3
Non-clinical, administration and management	16.4	26.9	24.0	689.4	2,872.0
Kaupapa Māori service workforce**	82.1	74.1	76.4	282.7	369.9
Total adult mental health workforce	12.5	27.0	18.8	1,016.6	5,404.3

Note:

* The total workforce used for this analysis is less than the total workforce reported in Chapter 2. This is because only those surveys reporting staff ethnicity information were included in the analysis. This gives a much lower overall total FTEs than reported elsewhere in the report.

** The workforce in kaupapa Māori services has also been included in the calculations for clinical roles and non-clinical, administration and management roles.

The lower proportion of Māori workforce in the DHBs may be explained by the DHBs having a large proportion of their workforce in clinical roles. Respondents to the survey noted recruitment and retention issues for Māori clinical roles, with 34 per cent of employers perceiving some shortage of Māori staff for clinical roles and 22 per cent perceiving large shortages. In contrast 29 per cent of respondents perceived shortages of Māori staff for non-clinical roles and 10 per cent perceived a large shortage.³²

Table 7 shows the proportion of the workforce identified as Māori for different service types, such as inpatient, residential or community services. The results show that residential and community NGO staff were more likely to be Māori, compared to staff in DHB and other types of services.

Table 7. *Māori representation in the workforce by service types*

Service types	Māori representation in:			Total workforce (FTEs employed)	
	DHB workforce (%)	NGO workforce (%)	DHB & NGO workforce (%)	Māori workforce	Total FTEs
Inpatient	14.6	-	14.6	119.8	821.8
Residential	16.1	27.5	27.3	236.1	864.3
Community	12.8	30.0	20.3	517.9	2,554.0
Forensic –inpatient and community	9.6	7.5	9.4	54.8	580.5
Management	10.3	14.8	12.4	38.4	308.2
Other	8.3	21.7	18.0	49.6	275.7
Total	12.5	27.0	18.8	1,016.6	5,404.3

³² Chapter 6 describes the survey results for the question on roles at risk of shortage.

Table 8 shows the proportion of FTEs filled by Māori staff of all positions employed within kaupapa Māori services identified in the survey. Seventy-six per cent of the workforce in kaupapa Māori services were identified as Māori. A total of 283 FTEs out of 370 FTEs in kaupapa Māori services were filled by Māori staff. Most Māori staff employed in kaupapa Māori services were employed in community services (73 per cent).

Table 8. *Māori representation in DHB and NGO kaupapa Māori services*

Service type	Māori representation in kaupapa Māori services:			Total workforce (FTEs employed)	
	DHB workforce (%)	NGO workforce (%)	DHB & NGO workforce (%)	Māori workforce	Total FTEs
Inpatient – forensic	100.0	-	100.0	4.0	4.0
Residential	-	82.3	82.3	67.9	82.5
Community	81.4	68.2	73.3	195.4	266.6
Management	-	96.7	96.7	11.6	12.0
Other	-	79.2	79.2	3.8	4.8
Total	82.1	74.1	76.4	282.7	369.9

Pasifika population, service use and workforce

In 2013, adult Pasifika comprised 6 per cent of the total New Zealand adult population (aged 20 to 64 years) and 49 per cent of the total Pasifika population living in New Zealand.³³ Pasifika encompasses a very broad range of ethnic identities.³⁴

Six per cent of those people using adult mental health services were identified as Pasifika in PRIMHD (a total of 4,304 consumers).³⁵ Figure 10 shows the proportion of Pasifika in the adult population, as consumers of mental health services,³⁶ and in the mental health workforce.

There was a slightly smaller proportion of Pasifika in the total workforce than as consumers of services (5 per cent compared to 6 per cent). However, Pasifika representation in the clinical workforce (3 per cent) was less than half that of the non-clinical, administration and management workforce (7 per cent).

³³ See summary population tables in Appendix D.1 Adult New Zealand population.

³⁴ See Appendix C: Survey data dictionaries for an ethnicity definition table. For the purposes of the survey, respondents were asked to include Fijian Indian ethnicity as Asian, not indigenous Pasifika.

³⁵ See summary PRIMHD tables in Appendix D: About population, funding and service provision for adult mental health and addiction services.

³⁶ The group of mental health consumers identified in PRIMHD include those seen only by mental health services, and those who were seen by both mental health and AOD services. Consumers seen only by AOD services are not included.

Pasifika representation in:



Figure 7. Pasifika as a proportion of the adult population, consumers and workforce in adult mental health services

Table 9 summarises Pasifika representation in the total workforce for DHB and NGO respondents that completed the ethnicity questions, including those with no Pasifika employees and excluding those that stated the information was not available.

NGOs reported slightly higher representation of Pasifika in their workforce than Pasifika consumers of mental health services. NGO respondents also reported Pasifika representation in the workforce was more than twice that of DHBs (8 per cent compared to 3 per cent).

Table 9. *Pasifika representation in DHB and NGO adult mental health services*

Pasifika staff members in:	Proportion of the workforce (%)			Total workforce (FTEs employed)	
	DHB	NGO	DHB & NGO	Pasifika workforce	Total FTEs*
Clinical roles	2.3	6.3	2.7	69.4	2,532.3
Non-clinical, administration and management roles	4.0	7.9	6.8	195.5	2,872.0
Adult Pasifika service workforce**	68.5	83.0	78.3	58.6	74.9*
Total adult mental health workforce	2.8	7.7	4.9	264.9	5,404.3

Note:

* The total workforce used for this analysis is less than the total workforce reported in Chapter 2. This is because only those surveys reporting staff ethnicity information were included in the analysis. This gives a much lower overall total workforce than reported elsewhere in the report.

** The workforce in adult Pasifika services has also been included in the calculations for clinical roles and non-clinical, administration and management roles.

As was suggested for Māori, the lower rates of Pasifika workforce for DHBs may be related to shortages of Pasifika clinical staff. Chapter 5 describes how 50 per cent of respondents perceived some shortage of Pasifika staff for clinical roles, and another 6 per cent perceive large shortages. For non-clinical roles, fewer respondents thought there would be some shortage (22 per cent) and 9 per cent, a large shortage.

The table below summarises Pasifika representation in the workforce across different types of services. Forensic services reported a high proportion of Pasifika staff. The table highlights the uneven distribution of Pasifika staff across the various service types.

Table 10. *Percentage of employed positions in different service types filled by Pasifika*

Service type	Pasifika representation in:			Total workforce (FTEs employed)	
	DHB workforce (%)	NGO workforce (%)	DHB & NGO workforce (%)	Pasifika workforce	Total FTEs*
Inpatient	3.5	-	3.5	29.0	821.8
Residential	-	8.7	8.6	74.4	864.3
Community	2.9	7.1	4.7	120.6	2,554.0
Forensic: inpatient and community	2.4	31.9	4.4	25.8	580.5
Management	0.6	2.3	1.4	4.4	308.2
Other	-	5.3	3.8	10.6	275.7
Total	2.8	7.7	4.9	264.9	5,404.3

Note:

* The total workforce used for this analysis is less than the total workforce reported in Chapter 2. This is because only those surveys reporting staff ethnicity information were included in the analysis. This gives a much lower overall total FTEs than reported elsewhere in the report.

Pasifika services employed a total of the 75 FTEs. Of this workforce:

- Pasifika staff filled 59 FTEs (78 per cent) overall.
- Pasifika community services employed most of the workforce (54 FTEs, 72 per cent of the total Pasifika services workforce)
 - 80 per cent of the Pasifika community services workforce were identified as Pasifika.

Asian population, service use and workforce

In 2013, the adult Asian population was 13 per cent of the total New Zealand adult population (aged 20 to 64 years) and 66 per cent of the total Asian population living in New Zealand.³⁷ Asian ethnic groups encompass a

³⁷ See summary population tables in Appendix D.1 Adult New Zealand population.

very broad range of ethnic identities.³⁸ Thus the following results do not reflect the representation of all Asian ethnic groups in the workforce.

PRIMHD recorded 4.5 per cent of mental health consumers were Asian, a total of 3,252 consumers.³⁹

Figure 8 shows the proportion of Asian people in the New Zealand adult population, as consumers of adult mental health services, and in the mental health workforce. The proportion of consumers who are Asian is much lower than the proportion of the New Zealand population who identify as Asian (5 per cent compared to 13 per cent). Asian representation in the workforce is similar to mental health consumers (5 to 6 per cent compared to 5 per cent).⁴⁰

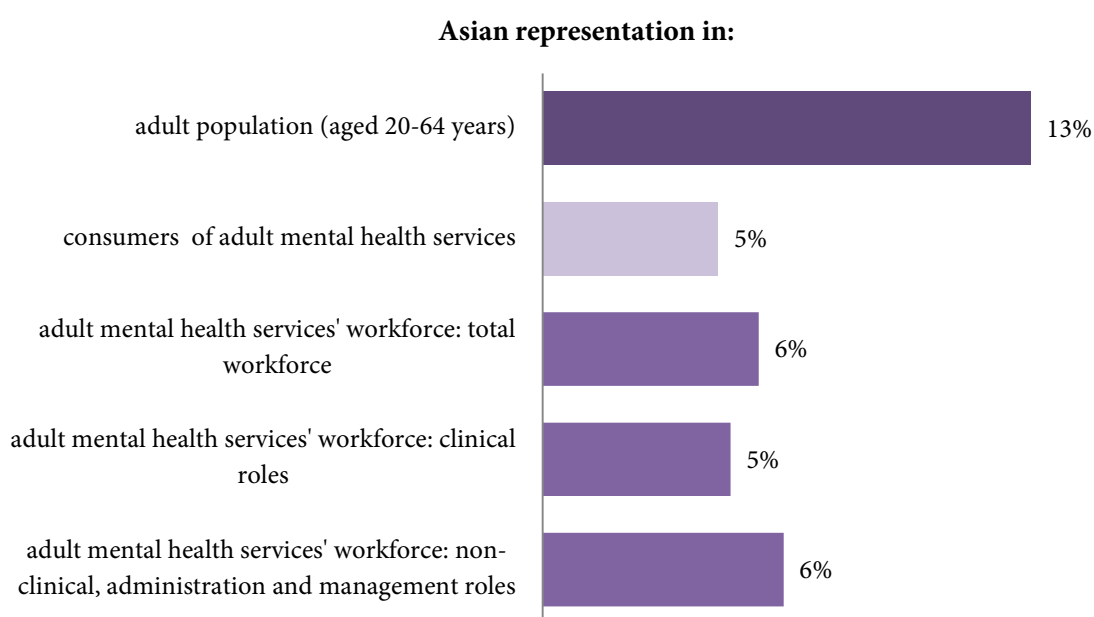


Figure 8. Asian people as a proportion of the adult population, consumers and workforce in adult mental health services

Asian staff members filled 299 FTE positions in the mental health workforce (per cent of 5,404 FTEs employed). NGOs had a higher proportion of Asian workforce than DHBs (more than double the rate), with their Asian workforce on a par with the proportion of consumers who were Asian. DHBs specified lower proportions of Asian workforce than NGOs for both clinical and non-clinical, administration and management roles.

³⁸ The definition used for ethnicity in the organisation workforce survey is outlined in Appendix C.1 Data dictionary on ethnic-based groups. For the purposes of the survey, respondents were instructed to categorise Fijian Indian ethnicity as Asian, not indigenous Pasifika.

³⁹ See summary PRIMHD tables in Appendix D.3 Service use and activity.

⁴⁰ It is difficult to assess if the proportion of Asian consumers accessing adult mental health services matches need for services as there is no information on the prevalence of mental disorders for this population in New Zealand.

Table 11 summarises by DHB and NGO, the proportion of the workforce filled by Asian staff in clinical, non-clinical, administration and management roles, and in the total workforce employed.⁴¹

Table 11. *Asian representation in DHB and NGO adult mental health services*

Asian staff members in:	Proportion of the workforce (%)			Total workforce (FTEs employed)	
	DHB	NGO	DHB & NGO	Asian workforce	Total FTEs*
Clinical roles	4.3	9.0	4.8	121.9	2,532.3
Non-clinical, administration and management	1.9	7.8	6.2	177.4	2,872.0
Asian services workforce	**	**	**	**	**
Total adult mental health workforce	3.7	7.9	5.5	299.3	5,404.3

Note:

* The total workforce used for this analysis is less than the total workforce reported in Chapter 2. This is because only those surveys reporting staff ethnicity information were included in the analysis. This gives a much lower overall total FTEs than reported elsewhere in the report.

** The numbers were too small to report here due to missing information about total FTEs.

Fewer respondents to the survey thought that there would be a shortage of Asian staff to fill clinical roles compared to responses for Māori and Pasifika staff. Chapter 5 shows that 5 per cent of respondents thought there would be an oversupply of Asian staff for clinical roles, while 27 per cent noted some shortage and 7 per cent noted a large shortage. Respondents perceived that non-clinical roles would be less affected by shortages, with 8 per cent thinking there would be an oversupply, 23 per cent perceiving some shortage and only 2 per cent perceiving a large shortage.

⁴¹ This analysis is based only on the surveys received with completed staff ethnicity questions. It excluded those stating that the information was not available or unknown.

Table 12 shows the proportion of the workforce identified as Asian for different service types, such as inpatient, residential or community. The results show that a Asian staff were more likely to be employed by NGOs (62 per cent of the Asian workforce). Most (69 per cent) of the Asian workforce were employed in community services.

Table 12. *Asian representation in the DHB and NGO workforce by service types*

Service types	Asian representation in:			Total workforce (FTEs employed)	
	DHB workforce (%)	NGO workforce (%)	DHB & NGO workforce (%)	Asian workforce	Total FTEs
Inpatient	6.8	-	6.8	55.7	821.8
Residential	-	10.3	10.2	88.0	864.2
Community	2.7	7.8	4.9	125.4	2,554.0
Forensic –inpatient and community	2.4	10.0	2.9	17.1	580.5
Management	**	**	**	**	308.2
Other	**	**	**	**	275.6
Total	3.7	7.9	5.5	299.3	5,404.3

Note: ** The numbers were under 10 FTEs and are too small to report here.

3.2 Cultural competency

This section describes the survey results about workforce knowledge and skills relating to cultural competence when working with Māori, Pasifika and Asian ethnic groups. The results for knowledge and skills relating to key policy and current practice areas are described in Section 5.3.

Respondents were asked if their workforce needed to increase cultural competence for working with Māori, Pasifika and Asian ethnic groups, in order to meet the policy and service priorities identified in *Rising to the Challenge* (Ministry of Health, 2012b).

The following analysis is based on the views of those who answered, plus any input they sought from others. In response to each question, respondents were asked to indicate the required level of need for an increase in cultural competence, from the following options.

Large increase needed	Some increase needed	No increase needed	Not applicable	Don't know
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The following findings are based on a total of 627 responses to this question; a response rate of 95 per cent. DHBs provided 192 responses and NGOs provided 435 responses.

The results reflect a perceived need for increased cultural competence in most areas. However, care should be taken when interpreting the information provided here. Areas that are less frequently identified cannot be read

as an indication of high levels of workforce competence. Such results may reflect other factors, including a lack of demand for the particular skill outside of specialised services, such as in Pasifika languages. These results may also reflect a view that the workforce includes knowledgeable and skilled staff who can support others in these areas, rather than an expectation that all staff must have this knowledge and these skills.

The following three graphs show the percentage of respondents indicating the need to increase workforce knowledge and skills in the following areas:

- working with Māori
- working with Pasifika ethnic groups
- Asian ethnic groups.

The graphs present the following information:

- the percentage of respondents indicating that they perceive a need for some increase in knowledge and skills is presented on the first part of the bar to the right of the zero axis
- the second part represents the percentage of respondents who thought there needed to be a large increase
- the overall percentage of respondents indicating a need for increased knowledge and skills is shown at the end of each bar.

Figure 9 shows the percentage of respondents indicating a need to increase knowledge and skills for working with Māori. More than half of the respondents thought there was a need for some increased skills around all of these competencies (52 per cent to 64 per cent), with 12 to 21 per cent indicating there needed to be a large increase. Knowledge and skills in Māori health outcome measurement and assessment was the category most in need of a large increase (21 per cent) and knowledge and skills in whānau-centred practice was the category most in need of some increase (64 per cent).

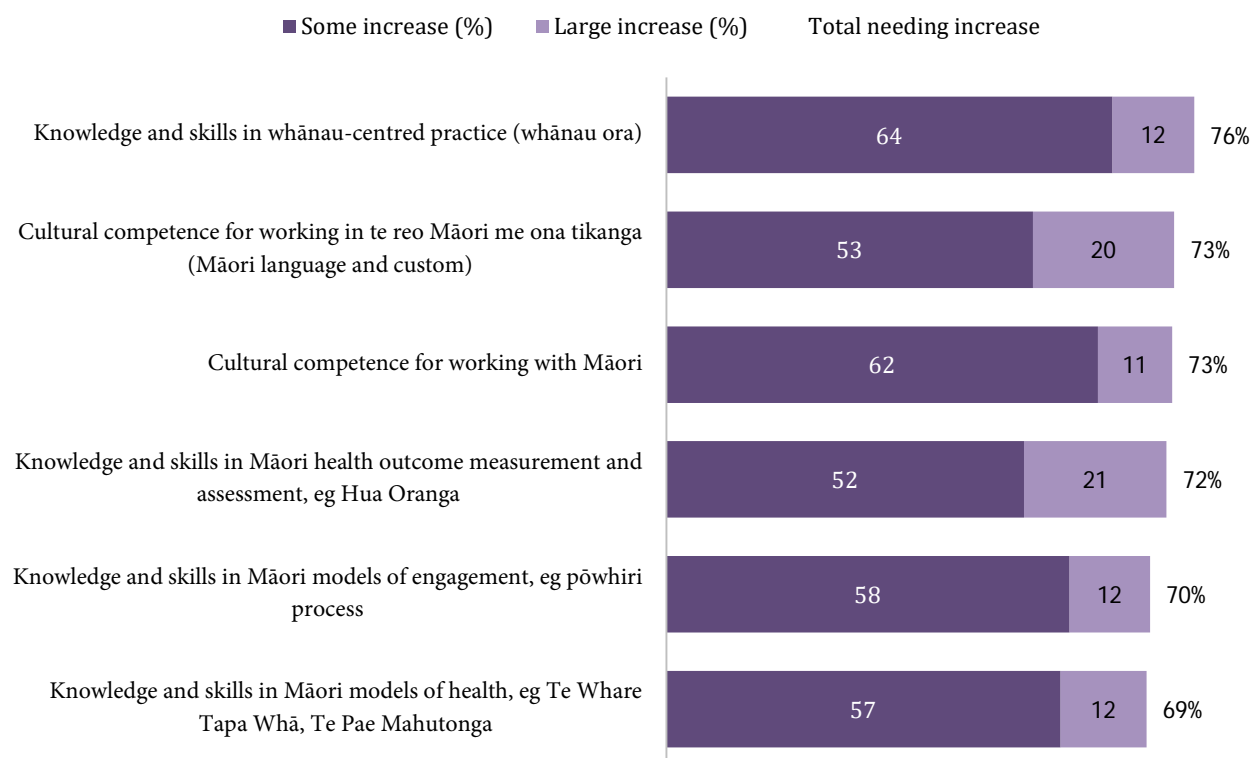


Figure 9. Proportion of respondents indicating need for increased workforce knowledge and skills for working with Māori (n= 627 responses)

A greater proportion of respondents indicated a need for improvement in competencies for working with Pasifika. Between 64 per cent and 80 per cent of respondents indicated a need for some or large improvement. More than half (59 per cent) of respondents thought their workforce needed some improvement in their knowledge of Pasifika family values, structures and concepts. The category that most respondents thought needed large improvement was confidence in one or more Pasifika languages (30 per cent).

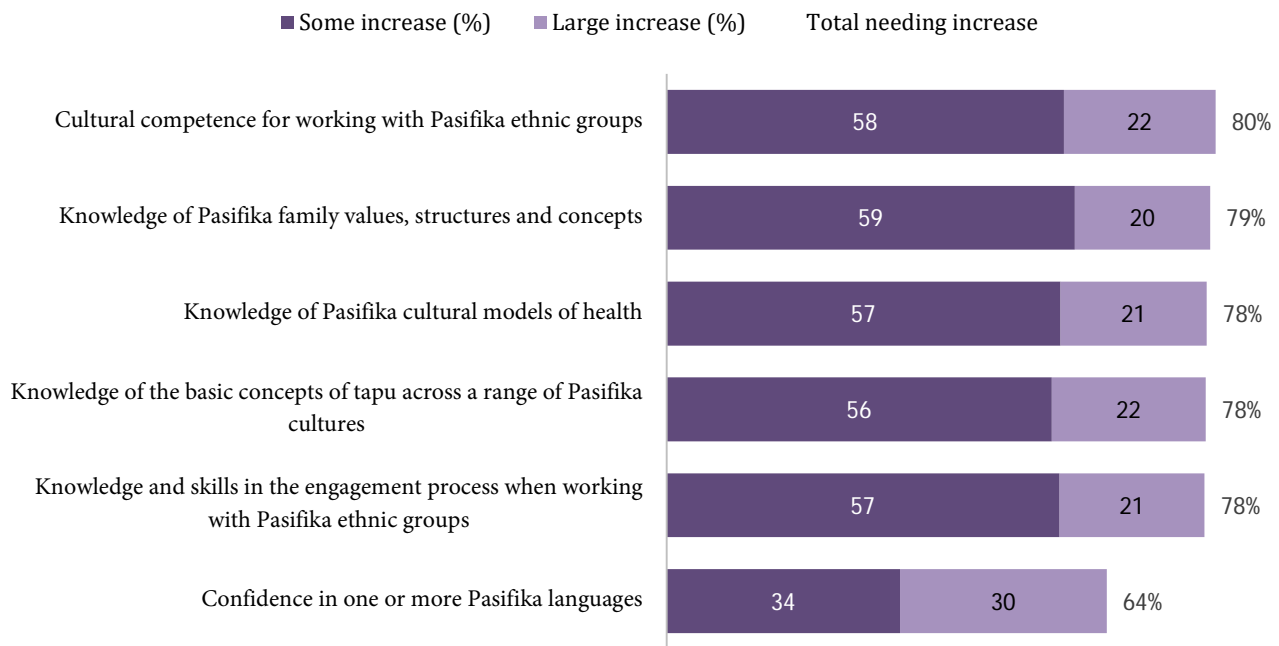


Figure 10. Proportion of respondents indicating need for increased knowledge and skills for working with Pasifika (n=627 responses)

Cultural competence for working with Asian ethnic groups was also perceived to be in need of improvement by a large proportion of respondents (73 per cent, see Figure 11).

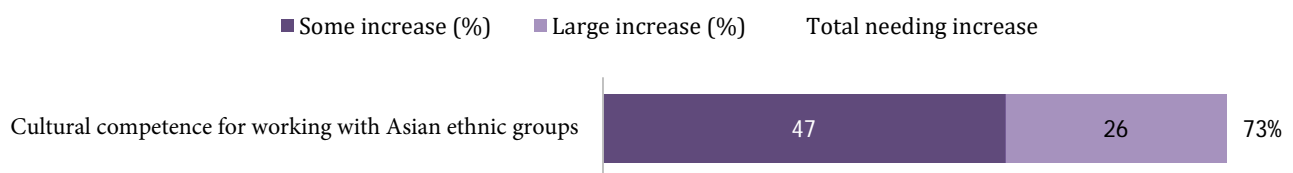


Figure 11. Proportion of respondents indicating need for increased knowledge and skills for working with Asian ethnic groups (n=627 responses)

Respondents from DHBs and NGOs varied in the proportion that suggested their workforce needed to increase knowledge and skills in many areas. A higher proportion of DHB respondents identified needing to increase workforce knowledge and skills in most areas of cultural competence compared to NGOs, including:

- working with Pasifika ethnic groups (86 per cent for DHBs compared to 77 per cent for NGO responses)
- the engagement process when working with Pasifika ethnic groups (83 per cent for DHBs compared to 76 per cent for NGO responses)
- whānau-centred practice (82 per cent for DHBs compared to 74 per cent for NGO responses)

- Māori health outcome measurement and assessment, eg Hua Oranga (77 per cent for DHBs compared to 70 per cent for NGO responses)
- cultural competence for working with Asian ethnic groups (85 per cent for DHBs compared to 68 per cent for NGO responses).

4.0 Workforce and service challenges

This chapter describes responses to survey questions about workforce and service challenges facing adult mental health services. The responses reflect the opinions of respondents, in most cases team leaders and managers, including any input they sought from others.⁴²

4.1 Recruitment and retention issues

For each role employed and looking two years ahead, each respondent was asked to indicate whether they thought there would be any shortages or oversupply of staff. They were also invited to consider any likely changes to service scope or capacity. Answers were ticked against one of six options.

large shortage (20% plus)	some shortage	about right	oversupply	not likely to be employing	don't know
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This section contains analyses relevant to Vote Health funded roles that respondents currently employ or that have vacancies. As respondents were only answering the question for roles they currently employ the number of responses for each role varies.

The percentage of respondents indicating they perceive a potential oversupply is shown to the left of the zero axis. On the right-hand side of the zero axis, the first part of the bar is the percentage of respondents who thought there would be some shortage. The second part represents the percentage of respondents who thought there would be a large shortage. The response rate for each role is shown on the far right of each bar.

The following two graphs show the distribution of responses to this question for each role currently employed or vacant. The first graph is for clinical roles and the second graph for non-clinical, administration and management roles.⁴³ A large proportion of respondents (40 per cent to 80 per cent) perceived some or large shortages for a number of clinical roles, including addiction practitioner, dual diagnosis practitioner, occupational therapist, psychiatrist, psychologist and registered nurse.

⁴² Some respondents indicated that although they had completed the questions on only one Section B form, the answers were applicable across some or all other forms submitted by their organisation. In these cases, the answers supplied as a template for the specified surveys have been used.

⁴³ See Appendix E for further tables on the workforce and service challenges that describe the survey results by DHB and NGO.

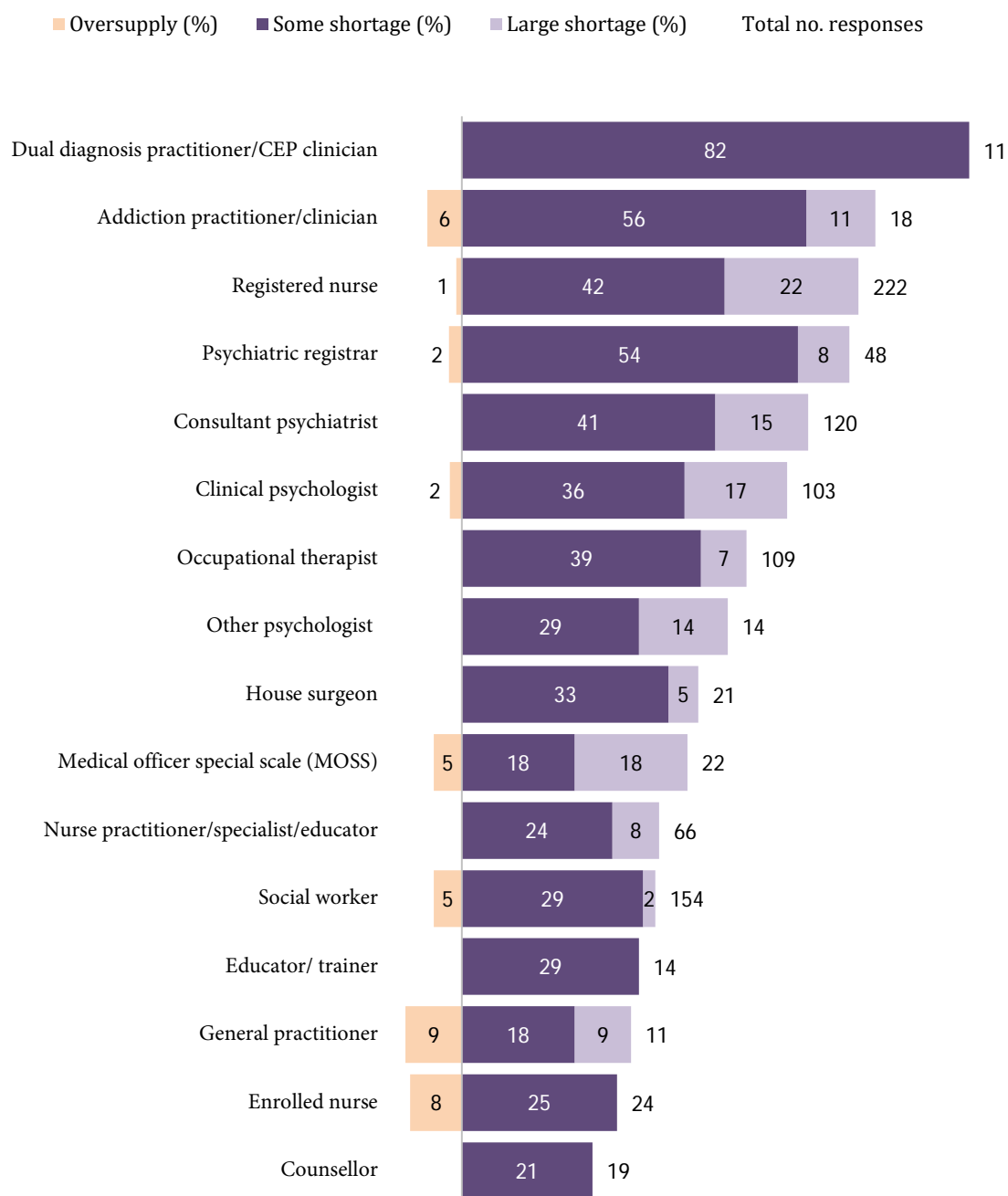


Figure 12. Percentage of respondents perceiving future oversupply or shortage for adult mental health workforce clinical roles

A smaller proportion of respondents perceived future shortages of staff for non-clinical roles, with the exception of employment, community, residential, family and peer support workers. Some cultural roles were also perceived to have shortages, particularly kuia and traditional Māori health practitioners.

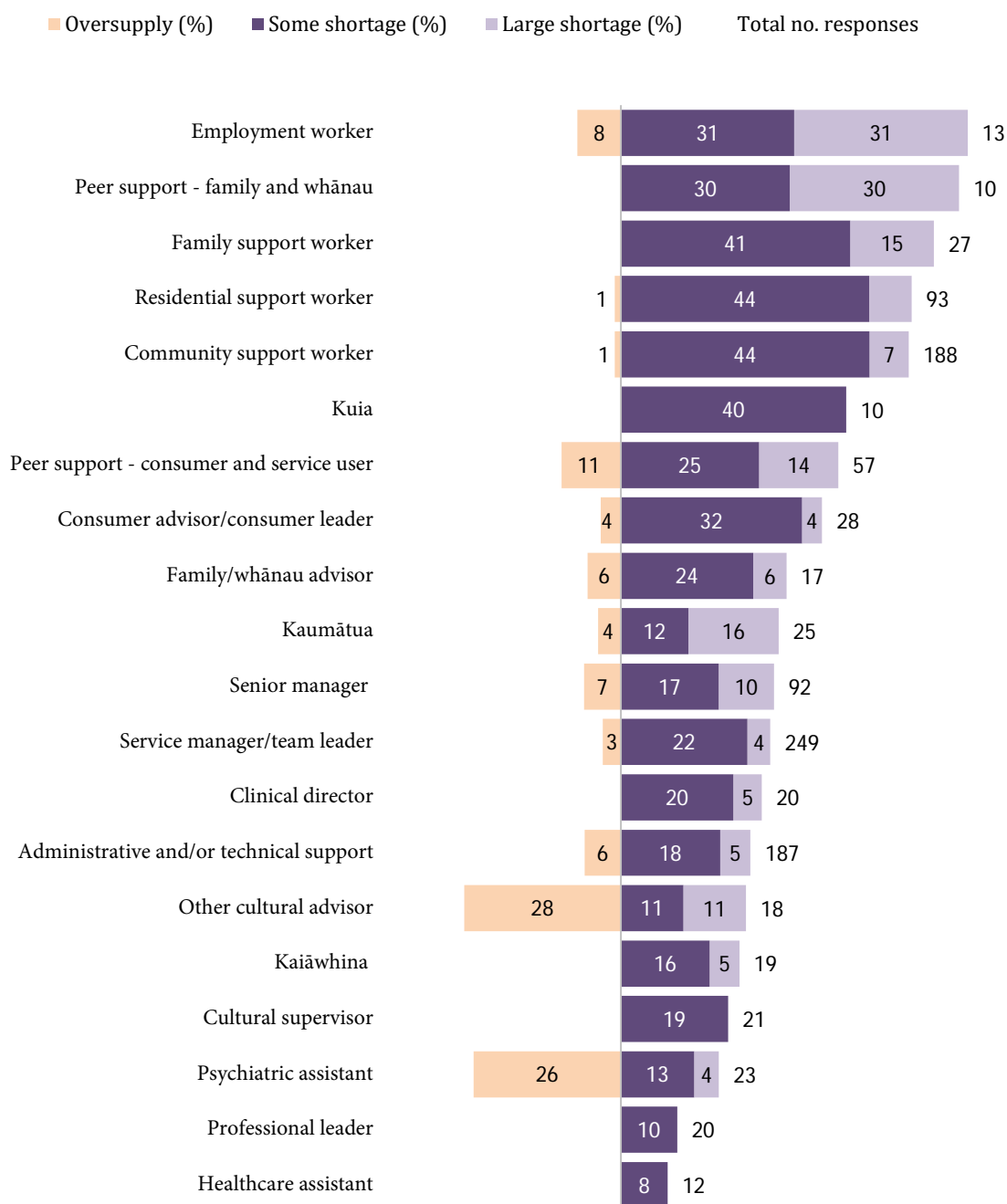


Figure 13. Proportion of respondents perceiving future oversupply or shortage for adult mental health workforce non-clinical, administration and management roles

Some roles, particularly those with small numbers of responses, had fairly large perceived oversupply and shortages, for example enrolled nurses and psychiatric assistants. These apparently contradictory results may be an artefact of small numbers of responses.

Respondents were also asked to identify perceived shortages for Māori, Pasifika and Asian staff to fill clinical and non-clinical roles. The following graph shows the survey results, with respondents perceiving some or large shortages for all categories. Nearly 60 per cent of respondents perceived a shortage for Māori (56 per cent) and Pasifika (56 per cent) staff in clinical roles. Some respondents indicated a potential oversupply of Pasifika and Asian staff for non-clinical roles, and Asian staff for clinical roles.

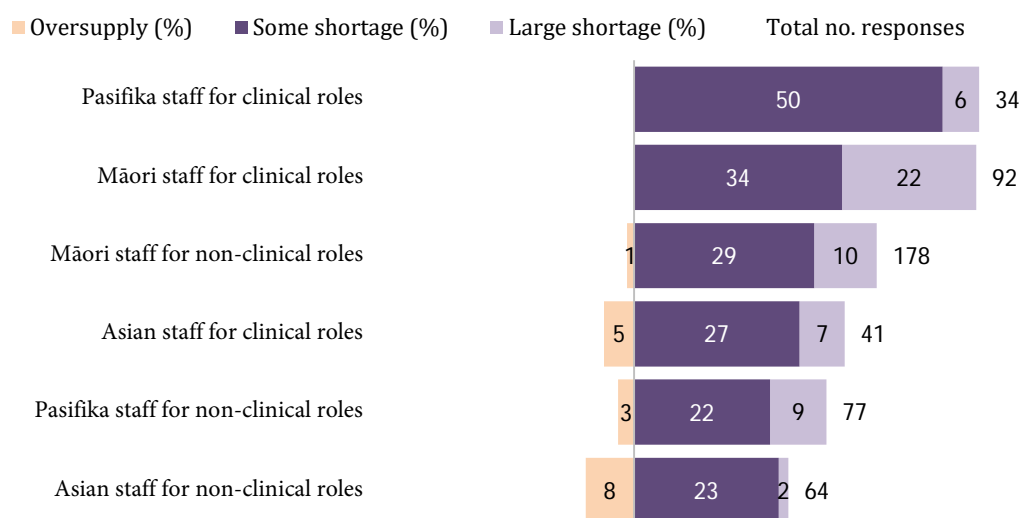


Figure 14. Proportion of respondents perceiving future oversupply or shortage of Māori, Pasifika and Asian staff for clinical and non-clinical roles in adult mental health services

There were similarities and differences between respondents from DHBs and NGOs for some roles. Both NGO and DHB respondents noted concerns about shortages for occupational therapists, clinical psychologists and nurses. NGOs were more likely to perceive future shortages for community and residential support workers. DHBs were more likely to perceive future shortages for consultant psychiatrists.⁴⁴

4.2 Workforce planning and development challenges

Respondents identified the top four challenges to their service's workforce planning and development. They were asked to rank the challenges from 1 to 4 (with 1 being the most challenging) from a pre-set list of seven challenges, with the option of adding others.⁴⁵ The results presented here highlight respondents' views of the key issues they are facing within their current contexts.

A total of 533 responses were received for this question (81 per cent response rate); including 159 responses from DHBs and 374 responses from NGOs. There were a high number of missing responses.

⁴⁴ See Appendix E for the table outlining DHB and NGO results.

⁴⁵ Responses giving the same number for more than one option were removed from the data set.

Figure 15 shows the proportion of respondents ranking each challenge from 1 (highest) to 4. The percentage at the end of the bar represents the proportion of respondents who selected this challenge as one of their four biggest.

As can be seen in the graph below, the challenges most commonly selected in the top four were:

- managing pressure on staff due to increased demand for service (64 per cent of respondents)
- managing pressure on staff due to increased complexity (63 per cent).

Static or reduced funds was the challenge most commonly selected as number 1 (26 per cent).

The following challenges received the fewest responses:

- cost of training and other professional development (45 per cent)
- managing pressure due to changing service delivery models (44 per cent).

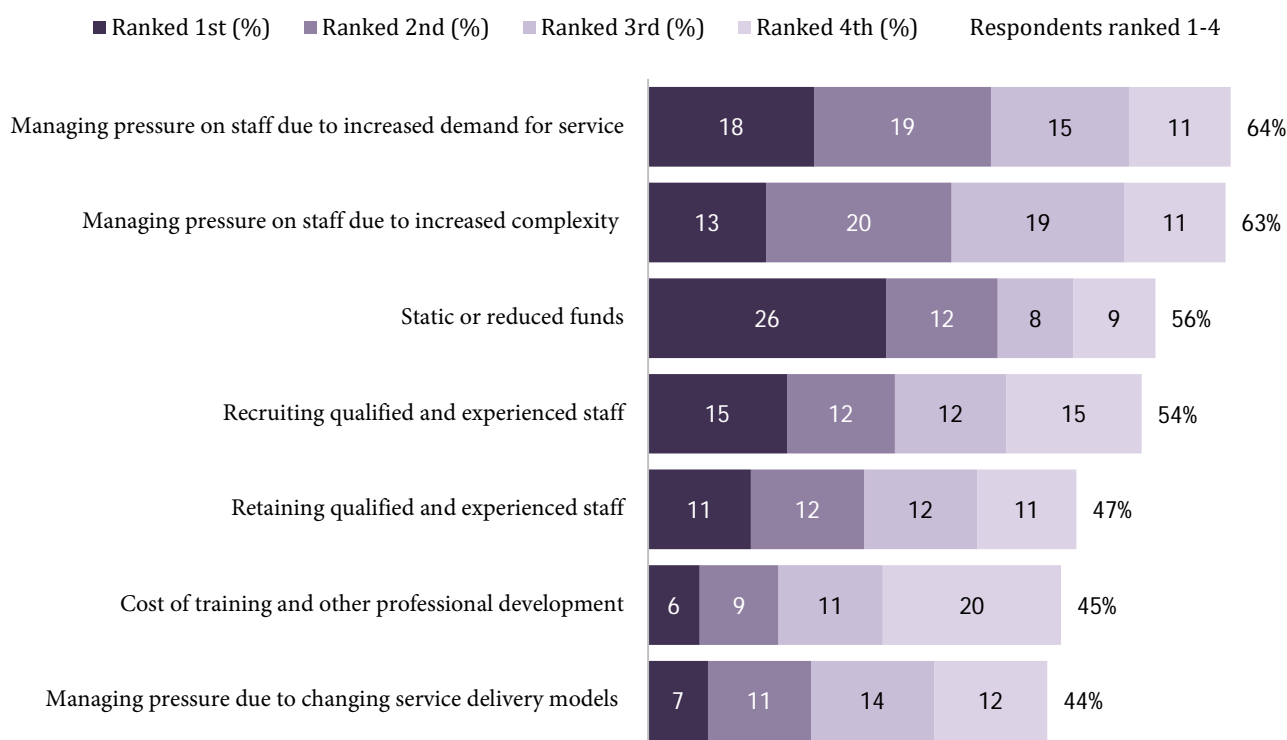


Figure 15. Percentage of respondents ranking workforce challenges as among their top four (n= 533 responses)

Results for DHBs and NGOs are summarised separately by the different service types in Appendix E: Additional tables.

DHB respondents working in mental health services were more likely than others to report the following as their three biggest challenges:

- managing pressure on staff due to increased demand for service (77 per cent)
- managing pressure on staff due to increased complexity (69 per cent)

- recruiting qualified and experienced staff (62 per cent).

Fewer DHB respondents reported the following in their top four challenges:

- cost of training and other professional development (35 per cent)
- static or reduced funds (33 per cent).

NGO respondents most commonly identified the following in their top four challenges:

- static or reduced funds (65 per cent)
- managing pressure on staff due to increased complexity (61 per cent)
- managing pressure on staff due to increased demand for services (58 per cent).

Table 13 uses mean scores to represent the respondents' rankings of each challenge. Each response was allocated a score, based on the ranking given, according to the following scale:

Ranked first = 4	Ranked second = 3	Ranked third = 2	Ranked fourth = 1
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The higher the score, the more challenging the issues are for respondents. This table shows how the pressures experienced by the DHBs and NGOs may differ. However, differences in the operating context for both providers should be considered when interpreting these results. NGOs describe being challenged most by static or reducing funds (mean score = 2.1), whereas DHBs are challenged most by the pressures of demand for service (mean score = 2.4). This example may reflect different experiences of the same challenge; an environment of fiscal restraint coupled with increased service demand.

Table 13. Mean score for DHBs and NGOs workforce challenges (n= 533 responses)

Rating of challenges	DHB n=159	NGO n=374	Total mean score
Static or reduced funds	0.8	2.1	1.7
Managing pressure on staff due to increased demand for service	2.4	1.4	1.7
Managing pressure on staff due to increased complexity	1.8	1.5	1.6
Recruiting qualified and experienced staff	1.5	1.3	1.4
Retaining qualified and experienced staff	1.0	1.3	1.2
Managing pressure due to changing service delivery models	1.3	0.9	1.0
Cost of training and other professional development	0.7	1.0	0.9

4.3 Knowledge and skill levels

Respondents were asked to indicate whether their workforce needed to increase knowledge and skills in specific domains over the next 2 years, in order to meet the policy and service priorities identified in *Rising to the Challenge* (Ministry of Health, 2012b).

The following is based on the views of those who answered for their workforce, plus any input they sought from others. Answers were ticked against one of five options.

Large increase needed	Some increase needed	No increase needed	Not applicable	Don't know
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The findings are based on the responses of those who answered this question. A total of 627 responses were received for this question (95 per cent), including 192 from DHB services and 435 from NGOs.

Care should be taken when interpreting the information provided here. Areas less frequently identified as needing an increase in workforce skills cannot be read as an indication of high levels of workforce competence. The results may reflect other factors, such as a lack of demand for the particular skill outside of specialised services. These results may also reflect a view that the workforce includes knowledgeable and skilled staff who can support others in these areas, rather than an expectation that all staff must have all of this knowledge and these skills.

The following four graphs show the proportion of respondents indicating a need for their workforce to increase knowledge and skills in the following areas:

- related to policy and service initiatives
- working with families and other groups.

The graphs present the following information:

- the first part of the bar shows the proportion of respondents who identified the need for some increase in knowledge and skills
- the second part of the bar presents the proportion of respondents who indicated the need for a large increase in knowledge and skills
- the percentage shown to the right of the bars is the proportion of respondents who indicated a need for any increase in workforce knowledge and skills.

Working with new technologies (80 per cent) and co-existing problems capability (76 per cent) had the largest proportion of responses indicating a need for improvement. These two competencies were also subject to the highest proportion of responses indicating a need for a large increase in knowledge and skills (20 per cent and 22 per cent respectively). At least two thirds of respondents reported that supporting self-managed care, psychological interventions, and risk assessment needed at least some or a large increase.

Promotion of restraint and seclusion reduction initiatives was the area least commonly identified as needing an increase in knowledge and skills (37 per cent), with a higher proportion of DHB respondents (57 per cent) identifying need in this area compared to NGO respondents (28 per cent).⁴⁶ These results likely reflect the fact that this practice occurs mainly in mental health inpatient services.

⁴⁶ Results for DHBs and NGOs are reported in Appendix E: Additional tables.

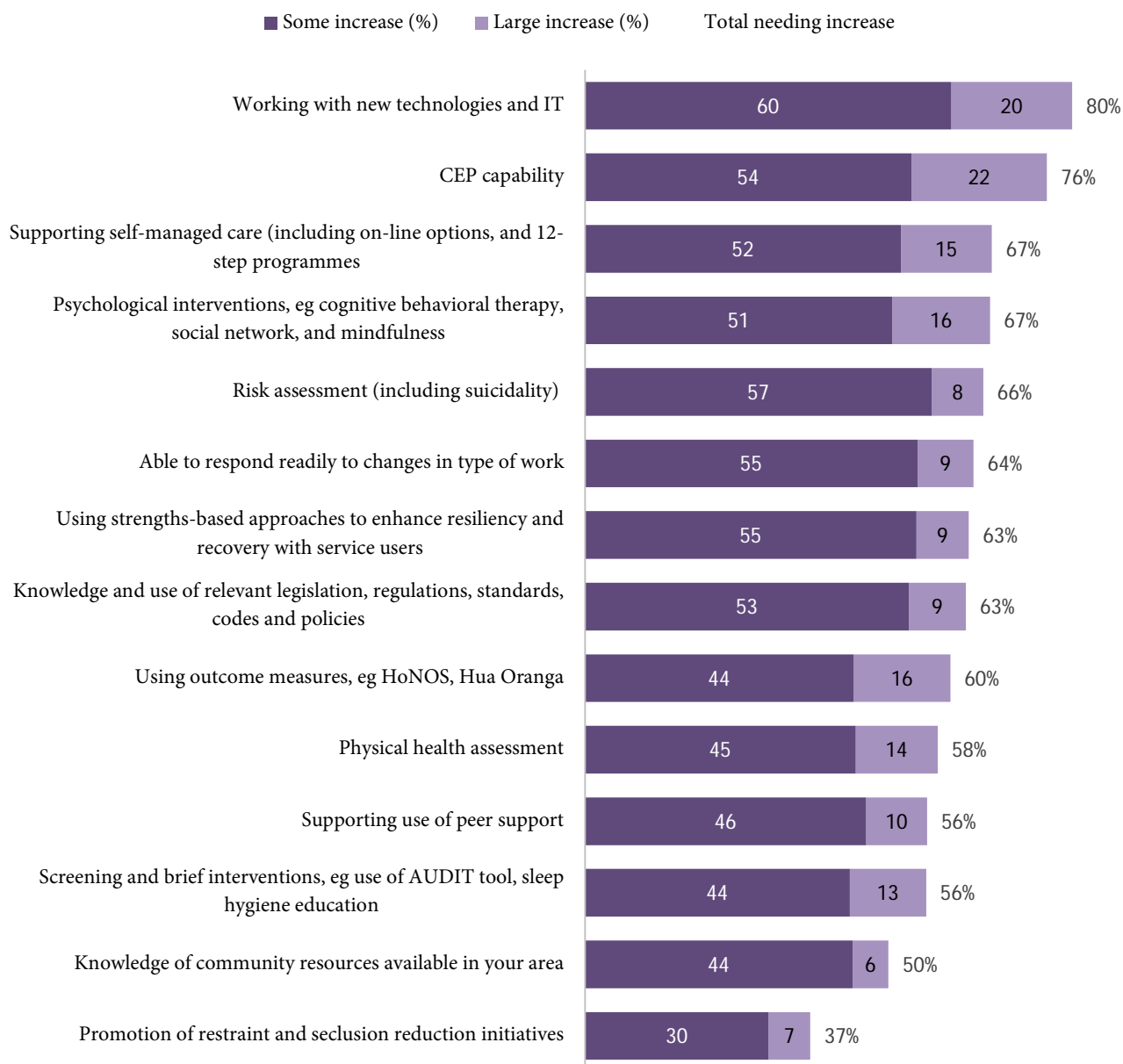


Figure 16. Percentage of respondents indicating need for increased knowledge and skills for key areas (n= 627 responses)

Responses for some competencies differed between DHBs and NGOs, in particular:

- working with new technologies and IT (91 per cent of DHB respondents compared to 76 per cent of NGO respondents)
- co-existing problems capability (84 per cent for DHBs compared to 73 per cent for NGOs).

One-third to half of respondents felt there was some need for improvement in knowledge and skills for working with families, older people, children and young people (see Figure 17). Overall the proportion of respondents identifying the need to increase workforce skills in these areas tended to be lower than for more specific skills, including cultural competency skills (see Figure 9, Figure 10 and Figure 11).

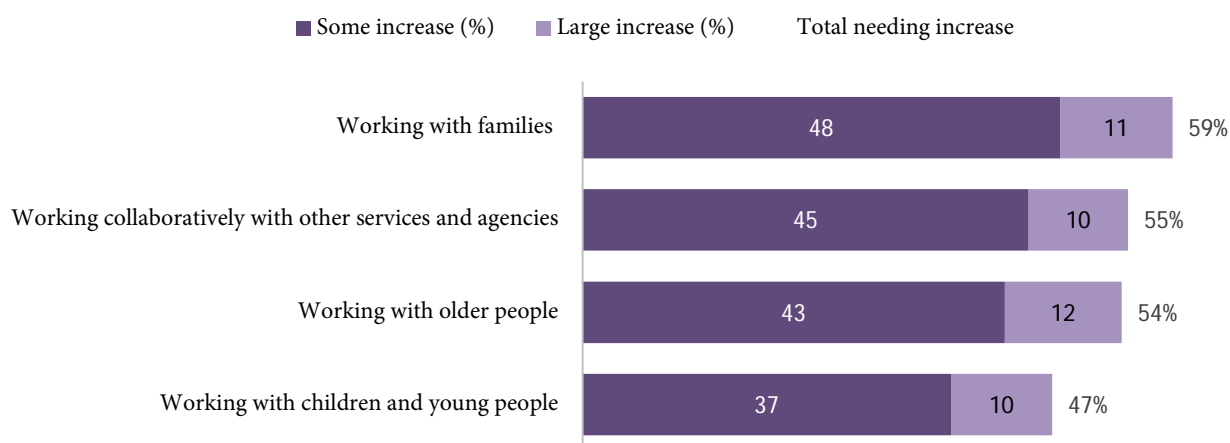


Figure 17. Percentage of respondents indicating need for increased knowledge and skills for working with families and other groups (n= 627 responses)

Relatively few respondents thought the competencies detailed in the preceeding two figures were not applicable to their workforce. The exceptions were the promotion of restraint and seclusion reduction initiatives (39 per cent of respondents thought this area was not applicable to their workforce), working with children and youth (22 per cent), physical health assessment (16 per cent), screening and brief interventions (16 per cent) and supporting self-managed care (15 per cent).

4.4 Cross-sector relationships

Current policy initiatives encourage the development of cross-sector relationships. Respondents were asked to describe the strength of their relationships with a range of other sectors. They were asked to provide their answer using the supplied options.

Working well	Working adequately	Needs improvement	Not applicable
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A total of 602 responses were received for this question (92 per cent), including 185 responses from DHBs and 417 responses from NGOs. However, not all respondents provided answers for every sector given on the survey list. The following analysis excludes non-responses and those indicating that a relationship with the sector is 'not applicable'.⁴⁷ Additional tables showing responses specific to DHBs and NGOs are located in Appendix E: Additional tables.

Figure 18 shows the distribution of responses to this question for each sector. The percentage of respondents indicating they perceived the relationship needs improving is shown on the left of the zero axis. On the right-hand side, the first part of the bar is the percentage of respondents who thought the relationship was working

⁴⁷ Responses with more than one tick against a given sector have also been excluded.

adequately. The second part is the percentage of respondents for whom relationships were working well. The total responses received for each sector (excluding those who did not select an option or selected not applicable) is printed to the right of the bar.

Results showed considerable variation, with all sectors having respondents in each category. Most respondents (47 per cent to 64 per cent) indicated relationships with all sectors were working adequately.

Respondents most commonly indicated that relationships were working well with:

- other mental health services (38 per cent of respondents)
- the police (36 per cent)
- child and adolescent mental health services (29 per cent)
- other addiction services (28 per cent)
- primary care (25 per cent).

Respondents reported relationships needed improvement with:

- the disability sector (32 per cent of respondents)
- Housing New Zealand and accommodation providers (28 per cent),
- Child Youth and Family Services (27 per cent)
- the education sector (27 per cent).

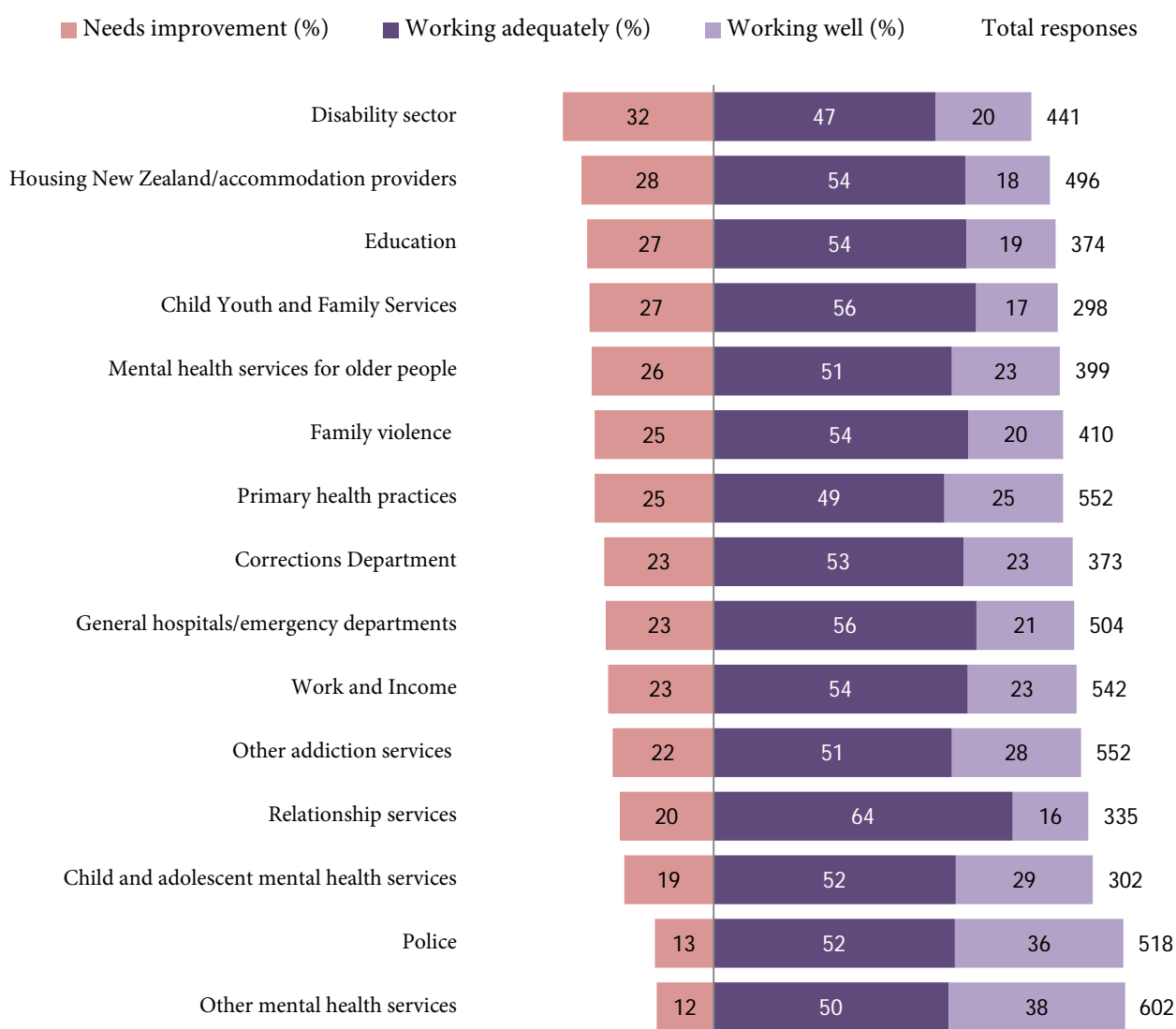


Figure 18. Percentage of respondents indicating strength of cross-sector relationships (n= 602 responses)

There were some differences between DHB and NGO survey respondents' ratings of cross-sector relationships. The tables summarising this information on the percentage of survey respondents reporting a need for improvement by DHBs and NGOs is in Appendix E: Additional tables.⁴⁸

NGO survey respondents highlighted the following sectors and providers that needed improvement:

- child and adolescent mental health services (30 per cent)
- disability sector (29 per cent)
- education (29 per cent)
- mental health services for older people (28 per cent)
- Child Youth and Family (28 per cent).

DHB survey respondents highlighted the following sectors and providers that needed improvement:

- disability sector (38 per cent)

⁴⁸ The tables in Appendix E on cross-sector relationships also highlight differences by types of team.

- primary health practices (31 per cent)
- Housing New Zealand and other accommodation providers (31 per cent)
- family violence (27 per cent)
- general hospitals (27 per cent).

The next table uses average scores (means) to summarise the strength of the relationships that DHB and NGO respondents had with other sectors. To calculate the mean relationship rating score, each response was allocated a score according to the following scale.

Working well = 2	Working adequately = 1	Needs improvement = -1	Not applicable = 0
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The scores for each sector were first aggregated, then the average calculated to give the mean relationship rating score. The lower the score (i.e. the closer the score is to 0, or if it is in negative numbers) the higher the need for improvement.

The table below highlights that DHB respondents suggested the relationship with the disability sector was in need of improvement (0.3). While NGOs indicated a need for improved relationships with mental health services for older people and the education sector (0.6 for both).

Table 14. *Cross-sector relationships for DHBs and NGOs (mean relationship rating scores)*

Rating of cross-sector relationships	DHB		NGO	
	Mean score	Total responses	Mean score	Total responses
Child and adolescent mental health services	0.9	147	0.7	155
Child Youth and Family	0.6	123	0.7	175
Corrections	0.8	129	0.8	244
Disability sector	0.3	151	0.7	290
Education	0.7	120	0.6	254
Family violence	0.6	162	0.7	248
General hospitals/emergency departments	0.7	177	0.8	327
Housing New Zealand/accommodation providers	0.5	161	0.7	335
Mental health services for older people	0.8	139	0.6	260
Police	1.2	166	1.1	352
Primary health practices	0.6	172	0.8	380
Relationship services	0.8	116	0.8	219
Work and Income	0.7	156	0.8	386
Other mental health services	1.1	185	1.2	417
Other addiction services	0.8	176	0.8	376

5.0 Conclusion

The *More than numbers* organisation workforce survey collected workforce information from 189 organisations with Vote Health contracts to deliver adult mental health and addiction services during 2012/13. Surveys were completed by all DHB provider arm mental health and addiction services and 73 per cent of the invited NGOs (169 out of 231 organisations); the overall survey response rate was 75 per cent. Organisations that completed the survey received 96 per cent of the 2012/13 Vote Health funding for adult mental health and addiction services.

This report presents the results for the Vote Health funded workforce reported by 20 DHBs and 137 NGOs delivering mental health and/or MH&A services. The report provides a snapshot of this workforce by services provided, occupation groups and roles.

This report has highlighted the following characteristics of the adult mental health services workforce, as reported in the survey.

- The workforce totalled 7,613 FTE positions (employed and vacant):
 - mental health services reported 7,097 FTEs
 - combined mental health and addictions services reported 516 FTEs.
- Vacancies totalled 370 FTEs, giving a vacancy rate of 5 per cent. More than half (58 per cent) were for clinical roles (6.0 per cent vacancy rate).
- Sixty six per cent of the workforce were based in the DHB provider arm, and 34 per cent in NGOs.
- The two largest occupation groups in adult mental health services were support workers (32 per cent) and nurses (32 per cent).
- Consumer and peer support workforce roles comprise 3 per cent of the total workforce including:
 - 155 FTE consumer peer support workers
 - 32 FTE consumer advisor positions.
- Most of the workforce was based in community services (46 per cent) and inpatient and residential services (31 per cent). This distribution was similar across both NGOs and DHBs.
- Shortages were expected in the next two years for the following roles:
 - registered nurse (64 per cent of 222 respondents)
 - consultant psychiatrist (56 per cent of 120 respondents)
 - clinical psychologist (53 per cent of 103 respondents)
 - dual diagnosis practitioner/clinician (82 per cent of 11 respondents)
 - addiction practitioner/clinician (67 per cent of 18 respondents).
- Māori made up 27 per cent of the reported NGO workforce and 13 per cent of the DHB provider arm workforce, while 12 per cent of the adult New Zealand population and 23 per cent of consumers identified as Māori.
- Pasifika peoples made up eight per cent of the NGO workforce and three per cent of the DHB provider arm workforce, while six per cent of the adult New Zealand population and six per cent of consumers identified as Pasifika.

- Asian peoples made up eight per cent of the NGO workforce and four per cent of the DHB provider arm workforce, while 13 per cent of the adult New Zealand population and five per cent of mental health consumers identified as Asian.
- The cultural workforce comprised 1.9 per cent of the reported adult mental health services workforce (144 FTEs).
- There were also 744 FTEs in kaupapa Māori services, 109 FTEs in Pasifika services and 13 FTEs in Asian-specific services.
- Improving co-existing problems capability in the workforce (alongside skills for working with new technologies and IT), was the most commonly identified area of skill development need.
- At least a quarter of respondents identified the need to improve relationships with sectors and organisations such as the disability sector, Housing New Zealand Corporation and other accommodation providers, education, Child, Youth and Family Services, and mental health services for older people.

Recommendations for workforce development across the mental health and addiction sector have been made based on the overall survey results. These are outlined in the *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services* (Te Pou o Te Whakaaro Nui, 2015) report.

References

- Cannon, J., Catherwood, J., Sandilands, K., & Wylie, J. (n.d.). *Taking the six steps: Maximising the potentials of the AHP workforce in Scotland*. Retrieved from <http://www.workforceplanning.scot.nhs.uk/media/14907/nhss%20six%20steps%20final.pdf>
- Mental Health and Addiction Service Workforce Review Working Group. (2011). *Towards the next wave of mental health and addiction services and capability: Workforce service review report*. Wellington: Ministry of Health.
- Mental Health Commission. (2012). *Blueprint II: Improving mental health and wellbeing for all New Zealanders: How things need to be*. Wellington: Mental Health Commission.
- Ministry of Health. (2012a). *Rising to the challenge: The mental health and addiction service development plan 2012–2017*. Wellington: Ministry of Health.
- Ministry of Health. (2012b). *The health of New Zealand adults 2011/2012: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health
- Ministry of Health. (2013). *Mental health and addiction: Service use 2009/10*. Wellington: Ministry of Health.
- Oakley Browne, M. A., Wells, J. E., & Scott, K. M., (eds). (2006). *Te rau hinengaro: The New Zealand mental health survey*. Wellington: Ministry of Health.
- Skills for Health – Workforce Projects Team. (2008). *Six steps methodology to integrated workforce planning*. Retrieved from <http://www.clph.net/writedir/5ec5Six%20Steps%20Refresh.pdf>
- Statistics New Zealand. (2013). 2013 Census QuickStats about Māori. Retrieved from <http://www.stats.govt.nz/~media/Statistics/Census/2013%20Census/profile-and-summary-reports/quickstats-about-maori/qs-maori-tables.xls>. Date accessed: 19 May 2015.
- Statistics New Zealand. (2014). *2013 Census district health board tables*, Obtained from <http://www.stats.govt.nz/Census/2013-census/data-tables/dhb-tables.aspx> Date accessed: 1 May 2014.
- Te Pou o Te Whakaaro Nui. (2011). *Mental health and addiction services for older people: Workforce survey*. Retrieved from: <http://www.tepou.co.nz/resources/mental-health-and-addiction-services-for-older-people-workforce-survey/89>
- Te Pou o Te Whakaaro Nui. (2014a). *Getting it right – workforce planning guide*. Retrieved from: <http://www.tepou.co.nz/library/tepou/mental-health-and-addiction-workforce-planning-guide>
- Te Pou o Te Whakaaro Nui. (2015). *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services*. Auckland: Te Pou o Te Whakaaro Nui.
- The Werry Centre. (2015). *2014 Stocktake of infant, child and adolescent mental health and alcohol and other drug services in New Zealand*. Auckland: The Werry Centre for Child & Adolescent Mental Health Workforce Development, University of Auckland.
- World Health Organization. (2010). *Workload indicators of staffing need: Users manual*. Geneva: World Health Organization.

Appendices

Appendix A: Glossary of terms

A.1 Key terms

Addiction services:

Includes alcohol and other drug (AOD) and problem gambling services.

Consumer:

A person who accesses mental health and addiction services (i.e. a “consumer” of services). The use of the term in this report is equivalent to the term “service user”.

Health regions:

There are four health regions in New Zealand: Northern, Midland, Central and South Island. The following DHBs come within each.

Region	DHB districts
Northern	Northland
	Waitematā
	Auckland
	Counties Manukau
Midland	Waikato
	Bay of Plenty
	Lakes
	Tairāwhiti
	Taranaki
Central	Hawke’s Bay
	Whanganui
	MidCentral
	Hutt Valley
	Wairarapa
	Capital & Coast
South Island	Nelson Marlborough
	West Coast
	Canterbury
	South Canterbury
	Southern

FTE position:

A full time equivalent (FTE) position is a unit of measurement of the hours spent in work as a ratio of the total possible hours in a typical role (i.e. 40 hours). An FTE of 1.0 equates to full time employment.

Kaupapa Māori services:

They have been specifically developed, and are delivered by, providers who identify as Māori. Providers and teams are expected to use a Māori framework and models of care that encompass a holistic approach to health and are cognisant of the health and wellbeing aspirations of Māori.

Non-health funding:

Funding received from sources other than the Ministry of Health or DHBs.

Pasifika services or teams:

Provide a holistic approach that recognises Pasifika frameworks as necessary to increase the service access rates of Pasifika people and engage them within a service for the duration of treatment. Services and teams recognise the significance of the family for wellbeing. Key values for Pasifika people are acknowledged in the delivery of services: love, respect, humility, caring, reciprocity, spirit quality, humour, unity and belief in the importance of family.

Provider type:

The type of provider may be non-government organisation (NGO) or district health board (DHB).

Respondents:

Managers, team leaders and staff working at organisations invited to complete the survey, who completed and returned valid organisation workforce survey sections.

Team and service types used by PRIMHD:

See Appendix D: About population, funding and service provision for adult mental health and addiction services.

Vote Health funding:

Funding associated with the Ministry of Health or DHB mental health and addiction service delivery contracts. This definition of health funding does not include Ministry of Health whānau ora or primary care funding.

A.2 Service type groups used to present survey results:

Group name	Services included	
	Mental health	Addiction
Community	Community Crisis assessment and emergency treatment Early intervention Home-based treatment Maternal mental health Psychiatric liaison Peer support Family and whānau support	Problem gambling interventions Dual diagnosis and co-existing problems services Community-based services (home, community) Opioid treatment services Peer support Withdrawal management (home, community)
Inpatient	Inpatient	
Residential	Residential	
Residential and inpatient		Residential addiction treatment Withdrawal management (inpatient)
Forensic	Forensic – inpatient Forensic – community	
Management	Management administration and support	
Other	Employment Advocacy	Housing/supportive landlord Driving programmes Consumer advisor services

A.3 List of acronyms

AOD	Alcohol and other drug
AUDIT	Alcohol Use Disorders Identification Test
CEP	Co-existing problems
CLIC	Ministry of Health Client Information Collection database
DHB	District health board
FTE	Full-time equivalent
IT	Information technologies
HoNOS	Health of Nation Outcome Scale
HWNZ	Health Workforce New Zealand
MH&A	Mental health and addiction
NGO	Non-government organisation
PRIMHD	Ministry of Health's Programme for the Integration of Mental Health Data

Appendix B: Organisation workforce survey method

The organisation workforce survey and associated documents are available online at:

<http://www.tepou.co.nz/supporting-workforce/workforce-planning/more-than-numbers>

B.1 Survey aims

The organisation workforce survey aimed to collect information consistent with that which the Werry Centre collects through its workforce stocktake of child and youth services. This was done in order to ensure the information from both surveys could be combined to give an overview of the child, youth and adult mental health and addiction workforce. The survey asked about the following aspects of the workforce.

- Number of people employed.
- Full-time equivalent (FTE) positions employed and vacant by role (to two decimal places). For roles, all the major professional groups, support workers, cultural advice and support, administration and management roles were included. As no one previous survey or classification system included all the roles identified in adult mental health and addiction services, the list of roles was drawn from the Werry Centre survey, the NgOIT survey, the Matua Raki surveys and the Australian and New Zealand Standard Classification of Occupations codes.
- FTEs filled by Māori, Pasifika and Asian staff in clinical and non-clinical roles.
- Type of mental health or addiction service delivered. Respondents could select from a range of common service choices including community, inpatient, residential, early intervention, peer support and so on
- DHB districts where the service is delivered. Respondents had the option of identifying a number of DHB districts, as well as specifying the DHB district they predominantly provided services in.

A number of additional questions were included in the survey in relation to:

- recruitment and retention issues for their workforce
- the biggest workforce challenges they experienced in their services
- the knowledge and skills needs of their workforce
- their views on the effectiveness of cross-sector and agency collaborative relationships.

In addition, we asked organisations to provide information about the workforce (employed and vacant) that was not health funded, and about sources of additional funding.

B.2 The research process

The planning of workforce information collection, including this survey, aims to ensure the information collected is as reliable and robust as possible within the constraints of funding and time. The survey process was supported by the national workforce centres, including Le Va, Te Rau Matatini and the Werry Centre. The

centres worked closely to ensure that the Werry Centre and the Te Pou organisation workforce surveys were similar, to allow for joint reporting about the workforce across adult and child and youth. Le Va and Te Rau Matatini helped develop the list of organisation roles and the skill and knowledge needs questions. Achieving high quality information involves some key strategies and these are presented below.

Pilot survey testing

The survey was piloted with 12 services: two DHBs and 10 NGOs. Each pilot site was asked to fill the survey out and then provide feedback on the process in terms of ease of obtaining the information requested, along with an assessment of clarity and perceived usefulness of the questions asked. Minor changes were made to the survey as a result of the pilot. A further review of the survey instructions and structure resulted in further changes to improve clarity and ease of completion. The latter review did not result in substantive changes to the survey questions.

The survey package

Each organisation received a survey pack that included a letter to the service manager with information about how to distribute the survey. Each survey pack included blank surveys with instructions and information about the survey. The pack included one copy of the Section A, and a number of copies of Section B.

Distribution and collection

The survey packs were posted out by a distribution company during the week of 1 April 2014 and were in the field initially for an eight-week period. The collection period was then extended for another five weeks to enable more organisations to participate in the survey. Key support people were engaged with each organisation depending on its location, size and service provided. Regional workforce planning leads liaised with DHBs and provided support to most mental health NGOs. Matua Raki engaged with most alcohol and other drug (AOD) and problem gambling services, and Te Pou supported some of the national mental health organisations. All organisations were given the option of either filling in a hard copy survey or an electronic version.

Senior managers completed one Section A for the entire organisation. The organisation filled out as many Section B surveys as they felt were needed, dependent on region, DHB district and type of service(s) delivered. Respondents were asked to fill in one Section B for the main DHB district served. Section B was commonly filled out by a team leader or service manager.

Completed surveys were returned to Te Pou, checked and collated. A data entry company entered the returned surveys twice in order to reduce the risk of data entry errors. The dataset was then provided to Te Pou to undertake analysis.

B.3 Survey sample and responses

The survey scope included all organisations contracted by the Ministry of Health or DHBs to deliver adult mental health and addiction services during 2012/13. The organisations were identified from the Ministry of Health's Price Volume Schedule.

Organisations were excluded if their total contracts were limited to the following:

- Ministry of Health Te Kete Hauora and Te Ao Auahatanga contracts (Whānau Ora)
- mental health services for older people and aged care services
- primary health services
- youth services
- disability support services
- non-health-funded employment services
- non-health-funded day activity services
- health promotion activities
- private health services
- health-funded policy and workforce development, telephone helplines, parenting programmes, quality and audit activities.

Exclusions were identified through the purchase unit codes and descriptors, which outlined the service that was being contracted for by the Ministry of Health or DHB.

Twenty district health boards (DHBs) and 261 non-government organisations (NGOs) were invited to complete the survey. Following distribution, 30 NGOs were withdrawn from the sample for the following reasons.

- Twenty-two did not employ mental health or addiction treatment staff, 20 of these organisations were rest homes receiving funding for bed nights only. One organisation used volunteers to deliver its services and another organisation subcontracted out all its adult mental health services.
- Six organisations were no longer funded to provide adult mental health and addiction service contracts and did not provide a service in 2014.
- One organisation had merged with another surveyed organisation and the information was combined into the one survey.
- One organisation was unable to be contacted.

Responses

The final survey sample included 20 DHBs and 231 NGOs. In total, 189 organisations returned completed surveys; all 20 DHBs and 169 NGOs (73 per cent): the response rate was 75 per cent overall.

Table B. 1 shows the numbers of organisations invited to participate in the survey for each region (based upon postal address) and the number of surveys that were returned (for NGOs only, all DHBs returned surveys). The second to last column shows the response rate for NGO services and the last column gives the overall response rate for DHB and NGO services in each region.

Table B. 1. Survey return rates for each region by DHB and NGO

Region	DHBs returning surveys	NGO services invited to participate				Overall response rate (%)
		Survey returned	Survey not returned	Total	NGO response rate (%)	
Northern	4	35	10	45	78	80
Midland	5	40	19	59	68	70
Central	6	37	6	43	86	88
South Island	5	44	27	71	62	64
Sub-total region	20	156	62	218	72	74
National/sub-national organisations*	-	13	-	13	-	-
Total	20	169	62	231	73	75

*The national and sub-national organisations provided survey returns for multiple regions.

Organisations completing the survey received 96 per cent of the Vote Health funding for all organisations invited to participate. Table B. 2 shows the regional response rates by funding, which are calculated using the total funding received by organisations completing the survey as a proportion of the funding received by all those invited to participate. Note that the allocation of funding to regions is based upon the location of the contracting DHB provider arm, not the NGO's postal address as was the case in the previous table.

Table B. 2 Survey response rates for each region based on funding.

Region	DHB response rate (%)	NGOs invited to participate				Overall response rate (%)
		Survey returned (\$)	Survey not returned (\$)	Total (\$)	NGO response rate (%)	
Northern	100.0	96,102,510	10,938,046	107,040,556	89.8	97.2
Midland	100.0	49,545,828	10,253,685	59,799,513	82.9	94.4
Central	100.0	46,399,188	1,382,963	47,782,151	97.1	99.3
Southern	100.0	43,592,140	13,542,809	57,134,949	76.3	94.0
National/sub-national	100.0	20,303,356	3,162,736	23,466,092	86.5	87.9
Total	100.0	255,943,022	39,280,240	295,223,262	86.7	96.2

Organisations were asked to provide survey returns for each team or service in a DHB district or region.⁴⁹ The 189 organisations completing the survey provided 808 responses across the four health service regions; 258 (32 per cent) were completed by DHBs and 550 (68 per cent) by NGOs. Of these responses, 616 (76 per cent)

⁴⁹ This strategy enabled workforce data to be presented at the region or DHB district level.

provided services in the mental health sector group, 151 (19 per cent) provided services in the addiction sector group and 41 (five per cent) identified as combined mental health and addiction services.⁵⁰ Table B. 3 shows the national distribution of survey returns.

Table B. 3. *Survey returns by DHB and NGO services*

Provider type	Met criteria for inclusion		Surveys completed		Response rate (%)
	No. of organisations	Proportion of total (%)	Section A	Section B	
DHB	20	32	20	258	100
NGO	231	68	169	550	73
Total	251	100	189	808	75

B.4 Additional data sources

This report and/ or its appendices include information from five other sources.

- Population information from the 2013 New Zealand Population Census for adults aged 20 to 64 years.
- Vote Health funding information for adult mental health, alcohol and other drug (AOD), and problem gambling services (sourced from the Ministry of Health Price Volume Schedule 2012/13).
- Information about adult mental health and addiction consumers and service activity from the Ministry of Health's Programme for the Integration of Mental Health Data (PRIMHD).
- Information about problem gambling consumers from the Ministry of Health Client Information Collection (CLIC) database.
- Information from *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Oakley Browne et al., 2006).

B.5 Limitations

There were several limitations to the organisation workforce survey.

The survey was limited to reporting on health-funded organisations delivering mental health and addiction services. Participating organisations were asked to provide information about roles in their workforce funded by other sources of income (eg from the Department of Corrections or Ministry of Social Development). However, they were not obliged to do so. Therefore, the survey provides a partial view of the breadth of mental health and addiction services being delivered in New Zealand and funded through other sources than the Vote Health budget.

⁵⁰ These figures represent the distribution of responses to the survey and may not accurately reflect the distribution of services in the community.

There are likely to be gaps in the survey results in relation to the following mental health and addiction services:

- independent practitioners, unless also employed by a participating organisation
- employment substance-testing services
- services funded solely by primary care or the Department of Corrections.

The same survey structure, service and role options were used for both DHB services and NGO services. Some of the detail about core differences between these two workforces may be lost as a result. This is particularly so in management roles, which may be clinical roles within DHB services and non-clinical in NGOs.

One of the aims of the workforce survey was to describe the workforce in terms of ethnicity. Respondents were asked to utilise employee self-identified ethnicity information only. As surveys were completed by employers, managers or team leaders this information may not have been available so it is likely that under-reporting of staff ethnicity has occurred. However, it is also possible that the information provided was determined by respondents instead.

The survey asked people to identify the service their workforce provided from lists categorised into sector groups including mental health, addiction, and combined mental health and addiction (combined services). Responses in the last group covered a wide range from those offering combined mental health and addiction treatment services to those providing mental health services to consumers with mental health and addiction service needs or to their family and whānau. For reporting purposes survey responses indicating a combined service were reduced to those from organisations with Ministry of Health or DHB provider arm contracts to provide both mental health and AOD or problem gambling services. This strategy limited this group to services provided by organisations contracted to employ both addiction and mental health staff. However, it also means the integration of mental health and addiction services will be under-reported. In practice, many services are working with people with mental health and addiction issues and supporting them, albeit with different skill sets.

The survey consisted of two sections: A and B. Each organisation invited to participate in the survey was asked to complete one Section A form for the entire organisation. Section B was requested at team or service level; respondents were invited to complete as many of these forms as they felt were needed to reflect their workforce and services provided by DHB district. This meant multiple responses could be returned from one organisation. Some large organisations chose to complete one form for all services of the same type working in the same DHB district. Consequently the findings drawn from these responses may not fully represent the diverse views held within larger organisations.

To identify services provided and workforce roles the survey used lists of pre-defined categories and set response options. These lists were drawn from funding categories (Ministry of Health contract purchase code descriptions) existing data sets (eg PRIMHD team types) or other surveys (eg NgOIT and the Werry Centre stocktake of child and youth mental health and addiction services). While such an approach allows for comparison across different surveys, it assumes similar role and service structures exist across all service providers. It is likely the results do not fully identify variations that exist across the sector and may obscure differences in roles or services.

Questions about total staff numbers or FTEs requested information about paid employees. Volunteers were not included in the scope of the survey. This exclusion may mean cultural roles are under-reported in the survey results. A number of services indicated they use unpaid kaumātua and kuia. One organisation was excluded from the sample because its service delivery was entirely provided by volunteers.

PRIMHD is updated by DHBs and NGOs to record mental health and AOD service consumer contact information, demographics and outcomes. During the year ended 30 June 2013, all 20 DHBs and 233 NGOs (88 per cent of all NGOs delivering services) achieved PRIMHD compliance. However, following the merger of Otago and Southland DHBs there are known gaps in the data for Southern DHB.

Adult mental health and addiction services are funded for people aged from 18 to 64 years, although in practice adult services may see older or younger people and child and youth services may see people up to the age of 24 years. However, the population and some service use and activity information provided in this report uses the age range from 20 to 64 years,⁵¹ because of the way that this information is recorded. The analyses present in this report specifies if it includes the 20-64 year age group or the 18-64 year age group.

PRIMHD records the ethnicity of consumers using a prioritised scale set by the Ministry of Health. If a consumer indicates multiple ethnic backgrounds only one ethnicity is recorded; the one with the highest priority on the scale. The scale begins with Māori, followed by Pasifika ethnic groups, then Asian ethnic groups, then others. This means that PRIMHD statistics are likely to slightly under-represent Pasifika, Asian and other non-Māori ethnic groups (Ministry of Health, 2013, p. 7).

In addition, PRIMHD consumer ethnicity information has other limitations. These limitations include under-reporting of consumer ethnicity and that ethnicity may be determined by others rather than self-identified. The PRIMHD information collection system has improved the collection and recording of ethnicity by consumers and staff. However, it is difficult to determine the extent to which staff members may guess a consumer ethnicity.

⁵¹ The PRIMHD consumer information uses the age range from 20 to 64 years to identify access rates by population, with this being consistent with the New Zealand Population Census groups.

Appendix C: Survey data dictionaries

C.1 Data dictionary on ethnic-based groups

For this survey, ethnicity was defined according to the ethnicity data protocols for the health and disability sector. These are available at: www.health.govt.nz/publications/ethnicity-data-protocols-health-and-disability-sector. The text below displays how ethnicity is grouped under these protocols.

Ethnicity	Includes			
Māori	Māori			
Pasifika	<i>Samoan</i> <i>Fijian</i> <u>Except</u> Fijian Indian Indo-Fijian	<i>Tongan</i> <i>Cook Islands:</i> Aitutaki Islander Atiu Islander Cook Island Māori Mangaia Islander Manihiki Islander Mauke Islander Mitiaro Islander Palmerston Islander Penrhyn Islander Pukapuka Islander Rakahanga Islander Rarotongan	<i>Niuean</i> <i>Others including:</i> Admiralty Islander Austral Islander Australian Aboriginal Belau/Palau Islander Bismark Archipelagoan Bougainvillean Caroline Islander Easter Islander Gambier Islander Guadalcanalian Guam Islander/ Chamorro Hawaiian I-Kiribati/ Gilbertese Kanaka/Kanak Malaitian Manus Islander Marianas Islander Marquesas Islander Marshall Islander Nauru Islander New Britain Islander New Georgian/ New Irelander	<i>Tokelauan</i> Ocean Islander Banaban Papuan New Guinean Phoenix Islander Pitcairn Islander Rotuman Islander Santa Cruz Islander Society Islander (incl. Tahitian) Solomon Islander Thursday Islander Torres Strait Islander Tuamotu Islander Tuvalu Islander Ellice Islander Vanuatu Islander New Hebridean Wake Islander Wallis Islander Yap Islander

Ethnicity	Includes			
Asian	Burmese	Chinese	Anglo Indian	Japanese
	Cambodian	Hong Kong Chinese	Bengali	Korean
	Filipino	Kampuchean	Fijian Indian	Nepalese
	Indonesian/	Chinese	Gujarati	Other Asian
	Javanese	Malaysian Chinese	Indian	Pakistani
	Kampuchean/	Singaporean Chinese	Punjabi	Sinhalese
	Khmer	Taiwanese Chinese	Sikh	Tibetan
	Lao/Laotian	Vietnamese Chinese	Tamil	Sri Lankan
	Malay/Malayan		Afghani	Tamil
	South East Asian		Bangladesh	
	Sundanese/		Eurasiani	
	Sumatran			
	Thai/Tai/Siamese			
	Vietnamese			

C.2 Data dictionary for service and team types

The following table presents descriptions of service types described in the survey. This table was developed based on PRIMHD team types, services described in previous surveys, and a review of prior documents and sector intelligence. It was made available online during data collection to support consistent categorisation of services on the survey returns.

Service type	Services provided	Corresponding PRIMHD teams
Mental health and addiction		
Dual diagnosis/co-existing problems	Services focused on the interaction of substance use and mental health problems. Also known as dual diagnosis, co-occurring substance use and mental health disorders, co-existing disorders and comorbidity. 'Co-existing' implies more interaction than 'co-occurring' or 'dual'.	Co-existing problems team Kaupapa Māori dual diagnosis alcohol and other drug (AOD) services (until 17/2014)
Management, administration and support	Senior managers, administration, service and other support staff including technical support.	n/a
Addiction		
Community-based services (home, community)	Services based within the community that may be delivered in the community or in hospital outpatient settings.	Community team
Opioid treatment services	Treatment services for consumers /tāngata whai ora addicted to opioids including the use of methadone, buprenorphine, or naltrexone. Services may include medically supervised withdrawal and/or maintenance treatment, psychosocial and other types of supportive care. May also be referred to as methadone maintenance or opioid substitution treatment.	Alcohol and [other] drug team
Peer support	Peer support teams can be located within NGOs, DHBs and/or organisations that are consumer owned, developed and operated. There are many styles of peer support services including community support, phone support, peer run 24-hour respite and alternatives to acute inpatient stays.	Alcohol and [other] drug team

Service type	Services provided	Corresponding PRIMHD teams
Problem gambling interventions	Services that may include a spectrum of interventions such as a helpline and information services, assessment, brief intervention, full intervention and follow-up.	n/a
Residential treatment	Services providing 24-hour-a-day intensive/structured treatment, typically based in non-hospital settings integrating a range of treatment modalities including modified 12-step approaches. This treatment is distinct from other supportive forms of residential housing.	Residential/accommodation team
Withdrawal management (home, community)	Medical and/or social support for consumers/tāngata whai ora. These services ensure the safety and alleviation of symptoms of withdrawal from a substance. Provided through home visits or in community settings.	Alcohol and [other]drug team
Withdrawal management (inpatient)	Medical and/or social support for consumers/tāngata whai ora dependent on particular substances. These services ensure the safety and alleviation of symptoms of withdrawal from a substance. Provided in a hospital or residential setting.	Alcohol and [other] drug team
Management, administration and support	Senior managers, administration, service and other support staff including technical support.	n/a
Mental health		
Community (including but not limited to community knowledge/skills enhancement and recovery)	Services based within the community that may be delivered in the community or in hospital outpatient settings.	Community team
Crisis assessment/emergency treatment	Services providing emergency psychiatric care for consumers/tāngata whai ora experiencing a mental health crisis.	

Service type	Services provided	Corresponding PRIMHD teams
Early intervention (in psychosis/related mood disorders)	Services for consumers/tāngata whai ora with first presentation of psychosis or related mood disorders.	Early intervention team
Employment	Supporting education and employment for consumers/tāngata whai ora.	Employment/supported teams
Forensic – community	Community-based forensic teams providing assessment and treatment services to alleged offenders charged with criminal offences, who have or are thought to have an illness. Includes individuals who are unable to be managed safely with general mental health services due to a high level of serious and persistent danger to others.	Forensic team
Forensic – inpatient	Forensic teams in residential or inpatient settings providing assessment and treatment services to alleged offenders charged with criminal offences, who have or are thought to have an illness. Includes individuals who are unable to be managed safely with general mental health services due to a high level of serious and persistent danger to others.	Forensic team
Home-based treatment	Intensive home based treatment and support for people who would otherwise be admitted to a mental health inpatient unit.	
Inpatient	Services in a medical environment such as a hospital for eligible people who are in need of a period of close observation, intensive investigation or intervention.	Inpatient team
Maternal mental health	Assessment and treatment services for pregnant women, women in the post-partum period and their infants. Includes inpatient, residential or community-based maternal mental health teams.	Maternal mental health team
Psychiatric liaison	Services provide support to consumers/tāngata whai ora in general hospital settings who may have mental health problems that can cause complications for their physical healthcare.	

Service type	Services provided	Corresponding PRIMHD teams
Peer support	<p>Peer support teams can be located within NGOs, DHBs or organisations that are consumer owned, developed and operated.</p> <p>There are many styles of peer support services, including community support, phone support, peer run 24-hour respite and alternatives to acute inpatient stay.</p>	
Residential, eg supported accommodation, respite	Accommodation, rehabilitation and support provided in a community residence to eligible consumers/tāngata whai ora with mental health issues.	Residential team
Management, administration and support	Senior managers, administration, service and other support staff including technical support.	
Other		<ul style="list-style-type: none"> • Kaupapa Māori team (until 1/7/2014) • Intellectual disability dual diagnosis team • Eating disorder team • Needs assessment and service coordination team • Specialist psychotherapy team • Services for profoundly deaf team • Refugee team • Speciality team
Kaupapa Māori services or teams	<p>These have been specifically developed and are delivered by providers who identify as Māori.</p> <p>Providers and teams are expected to use a Māori framework and models of care that encompass a holistic approach to health, and are cognisant of the health and wellbeing aspirations of Māori.</p>	

Service type	Services provided	Corresponding PRIMHD teams
Pasifika services or teams	These teams provide a holistic approach that recognises Pasifika frameworks as necessary to increase the service access rates of Pasifika people and engage them within a service for the duration of treatment. Services and teams recognise the significance of the family for wellbeing. Key values for Pasifika people are acknowledged in the delivery of services: love, respect, humility, caring, reciprocity, spirit quality, humour, unity and belief in the importance of family.	

C.3 Data dictionary on occupation groups and roles

The following table presents descriptions of roles and occupation groups described in the survey. This table was developed based on roles in the Australian and New Zealand Standard Classification of Occupation (ANZSCO) tables, roles described in previous surveys and identified in a review of prior documents, and sector intelligence. It was made available online during data collection to support consistent categorisation of roles on the survey returns. Note: In the third column, the six-digit numerical codes are the ANZSCO codes.

Role name	Description	Included on other surveys and occupation classification codes
Support workers		
Community development worker	Work with individuals, families and communities to empower them to improve quality of life.	NgOIT
Employment worker	Support consumers/tāngata whai ora to improve employment opportunities.	NgOIT
Community support worker	Support consumers/tāngata whai ora and families and whānau in their regular daily activities, build relationships with people and support them to manage their health and wellbeing. They may also assist people in attending appointments and activities.	411711
Family support worker	Work with families and whānau to reduce the impact of mental illness, offering support and advocacy and holding a holistic view of families and whānau. Many have social work or support worker qualifications.	411713
Healthcare assistant	A support worker in a clinical area who works under the supervision of a registered practitioner who is accountable for the support worker's standards and activities.	
Peer support - consumer and service user	Social and emotional support mutually offered or provided by people with a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change.	Matua Raki, Werry Centre, NgOIT
Peer support - family and whānau	Services provided for families and whānau who have a loved one experiencing a mental health condition.	Matua Raki, Werry Centre, NgOIT

Role name	Description	Included on other surveys and occupation classification codes
Psychiatric assistant	Support consumers/tāngata whai ora with mental or emotional conditions or disabilities, following the instructions of physicians or other health practitioners.	
Residential support worker	Support consumers/tāngata whai ora in their regular daily activities, build relationships with people and support them to manage their health and wellbeing. They may also assist people in attending appointments and activities. Includes addiction residential night supervisor.	NgOIT 411715
Allied health professionals		
Addiction practitioner	Clinicians working with AOD and problem gambling. May include social workers, occupational therapists, counsellors and nurses.	Matua Raki, Werry Centre 272112
Dual diagnosis practitioner/co-existing problems clinician	Clinicians providing clinical case work, support and consultancy to consumers/tāngata whai ora with co-existing mental health and addiction-related problems.	
Counsellor	Professionally-registered counsellors, therapists and psychotherapists.	Werry Centre, NgOIT 272199 272314
Educator/trainer	Educators and tutors not including nurse educators (see nurses group).	Werry Centre, NgOIT
Occupational therapist	Registered health professionals who enable occupation to optimise human activity and participation in all life domains across the lifespan, and thus promote the health and wellbeing of individuals, groups and communities.	Matua Raki, Werry Centre, NgOIT 252411

Role name	Description	Included on other surveys and occupation classification codes
Clinical psychologist	Psychologists investigate, assess and provide treatment and counselling for behavioural and mental health issues. Registered with the NZ Psychologists Board.	Matua Raki, Werry Centre, NgOIT 272311
Other psychologist	Registered psychologists, educational and organisational psychologists not including clinical psychologists.	Matua Raki, NgOIT 272312 272313 272313
Social worker	Provide advice, advocacy and support to individuals and families and whānau with personal and social problems, including emotional and mental health concerns. They also help with community and social issues.	Matua Raki, Werry Centre 272511
Medical and nursing professionals		
General practitioner	Registered medical professional who covers a variety of medical problems in patients of all ages, usually working in primary care.	253111
House surgeon	New Zealand registered medical professionals employed by a district health board as an intern or house officer/surgeon, typically for a period of two years, supporting the functions of the consultant/surgeon.	253112 253999
Consultant psychiatrist	Medical professionals registered as Fellows of the Royal Australian and New Zealand College of Psychiatrists providing assessment, diagnosis and treatment of people with psychological, emotional, or cognitive problems resulting from psychiatric disorders, physical disorders or any other cause.	Werry Centre, NgOIT 253411
Medical officer special scale	Qualified medical professionals who work in a specialist role, eg opioid treatment service. This role is a non-training position for a doctor who has not yet specialised or gained a post-graduate qualification, or an international medical graduate who is not eligible for a consultant role.	Matua Raki

Role name	Description	Included on other surveys and occupation classification codes
Psychiatric registrar	Registered medical professionals working towards becoming specialist psychiatrists, who support the functions of their consultant psychiatrist.	Werry Centre, NgOIT 253411
Registered nurse	Registered nurses who use nursing knowledge and complex nursing judgement to assess health needs and provide care, advice and support for people to manage their health.	Matua Raki, Werry Centre, NgOIT 254422 254414 254499 254416 254412 254417 254413
Enrolled nurse	Enrolled nurses practise under the direction of a registered nurse or midwife to implement nursing care for people who have stable and predictable health outcomes in situations that do not call for complex nursing judgement.	NgOIT 411411
Nurse practitioner/nurse specialist/nurse educator/nurse researcher	Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills.	254211 254212 254411
Liaison/consult liaison	Examples include mental health and eating disorders liaison, Police, court liaison.	Werry Centre
Cultural advice and support		
Cultural supervisor	Facilitates a process that explores and reconciles clinical and cultural issues. Provide appropriate management strategies, and develops skills and confidence for supervisees working across cultures, and/or wishing to retain their cultural identity and integrity. Cultural supervision may take place on a one-to-one basis or as part of a group.	
Kaumātua and kuia	Elders or knowledgeable Māori who offer cultural support to the workforce and/or consult and liaison role with whānau, hapū, iwi and/or hāpori.	Werry Centre, NgOIT

Role name	Description	Included on other surveys and occupation classification codes
Kaiāwhina	Includes a number of roles including community health workers, support workers, addiction practitioners and counsellors. Responsible for delivering services that will assist consumers and family and whānau to improve access to services, exercise better self-management of their health and wellbeing, and/or improve relationships and networks in the community and with other services.	Werry Centre, NgOIT 411512
Traditional Māori health practitioner	Rongoā Māori is the traditional healing system of Māori, incorporating the use of plant-based remedies, physical therapies and spiritual healing. Tohunga are the practitioners of Rongoā Māori.	252215
Matua	Elders or knowledgeable Pasifika who offer cultural support to the workforce and/or consult and liaise with Pasifika consumers/tāngata whai ora and families and whānau.	
Pasifika cultural advisor	Elders or knowledgeable Pasifika who offer cultural support to the workforce and/or consult and liaise with Pasifika consumers/tāngata whai ora and families and whānau.	
Other cultural advisor		Matua Raki, Werry Centre
Administration and management		
Administrative and/or technical support	Administration roles supporting direct service provision.	Matua Raki, Werry Centre, NgOIT
Senior manager	CEOs, general managers and other management.	Werry Centre, NgOIT 132111 132511 132211 111211 132311 111111 132411 134212

Role name	Description	Included on other surveys and occupation classification codes
Clinical director	n/a	Werry Centre 134212
Professional leader	n/a	
Service manager/team leader	Managers and team leaders managing service delivery teams.	Werry Centre NgOIT 134299 134111 134214 254311
Family/whānau advisor	Promote the family/whānau voice, enabling families and whānau of consumers/tāngata whai ora to have a positive and beneficial experience when attending a service with their family member.	Werry Centre, NgOIT
Consumer advisor/consumer lead	Provide a bridge between consumers and service providers. Advisors combine personal experience with professional skills and expertise.	
Other		
Other allied health professionals	Needs assessors and coordinators, dieticians and other social professionals.	Matua Raki, Werry Centre, NgOIT 251111 272499
Other support worker	Include nursing support worker, personal care assistant, caregivers, aged care and domestic duties aide.	411716 421111 272612 272613 411311 411412 411712 423111 423311 423312 423313 423314 423411 423412 423413

Appendix D: About population, funding and service provision for adult mental health and addiction services

This appendix describes the context in which organisations participating in the organisation workforce survey deliver services. The information presented here is drawn from the New Zealand Population Census 2013, Vote Health funding information from the Ministry of Health Price Volume Schedule for the year ended 30 June 2013, and the Ministry of Health Programme for the Integration of Mental Health Data (PRIMHD) for the year ended 30 June 2013.

D.1 Adult New Zealand population

Table D. 1 uses the New Zealand Population Census 2013 to describe the New Zealand adult population by regional groups, and shows each region's proportion of the total adult population. For the purposes of this report, the adult population is defined as people aged 20 to 64 years. The adult population was nearly 2.5 million people, an increase of five per cent since the 2006 census. The Northern region experienced the largest growth in adult population between 2006 and 2013 (8 per cent).

Table D. 1. *New Zealand adult (20–64 years) population by region*

Region	NZ adult population (aged 20–64 years)		
	NZ Census 2013	Percentage adult population	% increase from 2006 census
Northern	943,665	38.2	7.5
Midland	454,809	18.4	3.8
Central	486,663	19.7	2.5
South Island	588,267	23.8	2.6
Total	2,473,404	100.0	4.6

Source: (Statistics New Zealand, 2014)

Figure D. 1 highlights the proportion of the adult population aged 20-64 across the four regions.

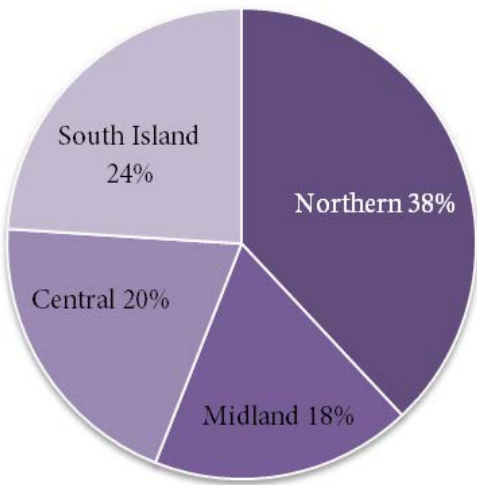


Figure D. 1. Percentage of New Zealand adult population (aged 20–64 years) by region

Population table

Table D. 2. Adult New Zealand population aged 20–64 years by ethnicity, region and DHB district

DHB district and region	Total people			Māori			Pasifika			Asian			All other		
	2006 Census	2013 Census	% change	2006	2013	% change	2006	2013	% change	2006	2013	% change	2006	2013	% change
Northern															
Northland	81,642	81,546	-0.1	20,949	22,314	6.5	1,407	1,755	24.7	1,524	2,472	62.2	57,771	55,008	-4.8
Waitematā	288,024	312,123	8.4	21,720	23,805	9.6	17,280	19,647	13.7	43,794	59,274	35.3	205,233	209,406	2.0
Auckland	261,378	281,043	7.5	17,028	18,123	6.4	25,401	26,898	5.9	63,774	79,533	24.7	155,178	156,483	0.8
Counties Manukau	246,906	268,953	8.9	32,961	33,687	2.2	43,902	50,772	15.6	44,910	64,839	44.4	125,133	119,649	-4.4
Midland															
Waikato	193,050	202,947	5.1	33,498	37,542	12.1	4,650	6,150	32.3	10,986	16,098	46.5	143,922	143,160	-0.5
Lakes	55,638	54,867	-1.4	15,771	16,083	2.0	1,566	1,692	8.0	2,049	3,243	58.3	36,246	33,846	-6.6
Bay of Plenty	107,010	111,339	4.0	22,581	23,706	5.0	1,572	2,067	31.5	3,090	5,853	89.4	79,773	79,722	-0.1
Tairāwhiti	24,021	23,742	-1.2	9,879	10,056	1.8	555	663	19.5	402	591	47.0	13,179	12,438	-5.6
Taranaki	58,506	61,914	5.8	7,704	9,018	17.1	573	735	28.3	1,365	2,337	71.2	48,867	49,830	2.0
Central															
Hawke's Bay	82,875	83,049	0.2	16,836	17,409	3.4	2,367	2,877	21.5	2,106	3,114	47.9	61,569	59,649	-3.1
Whanganui	33,954	32,781	-3.5	7,062	7,239	2.5	573	801	39.8	702	918	30.8	25,614	23,820	-7.0
MidCentral	89,778	90,882	1.2	12,945	14,019	8.3	2,049	2,604	27.1	4,491	5,970	32.9	70,290	68,289	-2.8

DHB district and region	Total people			Māori			Pasifika			Asian			All other		
	2006 Census	2013 Census	% change	2006	2013	% change	2006	2013	% change	2006	2013	% change	2006	2013	% change
Hutt Valley	79,449	81,432	2.5	10,980	11,253	2.5	5,850	6,054	3.5	6,072	8,280	36.4	56,550	55,851	-1.2
Capital and Coast	167,193	176,019	5.3	14,334	15,633	9.1	11,199	11,700	4.5	17,073	21,624	26.7	124,587	127,068	2.0
Wairarapa	21,525	22,500	4.5	2,589	3,099	19.7	369	471	27.6	333	549	64.9	18,228	18,378	0.8
South Island															
Nelson Marlborough	76,479	77,631	1.5	5,499	6,219	13.1	789	1,074	36.1	1,446	2,613	80.7	68,736	67,722	-1.5
West Coast	18,627	18,993	2.0	1,398	1,644	17.6	135	162	20.0	213	474	122.5	16,878	16,710	-1.0
Canterbury	278,109	287,199	3.3	16,944	19,758	16.6	5,124	6,225	21.5	18,822	23,034	22.4	237,225	238,179	0.4
South Canterbury	30,084	30,774	2.3	1,497	1,848	23.4	225	261	16.0	456	879	92.8	27,909	27,777	-0.5
Southern	169,968	173,670	2.2	11,538	13,017	12.8	2,274	2,898	27.4	5,820	8,481	45.7	150,339	149,274	-0.7
Total nationwide	2,364,216	2,473,404	4.6	283,713	305,472	7.7	127,860	145,506	13.8	229,428	310,176	35.2	1,723,227	1,712,259	-0.6

Prevalence of mental health disorders

Te Rau Hinengaro: The New Zealand mental health survey (Oakley Browne et al., 2006) presents the results from a New Zealand community prevalence study for major mental disorders among those aged 16 and over. The survey examined four groups of mental disorders. These included anxiety, mood, substance use and eating disorders. The survey highlighted that mental disorders in these groups are common in New Zealand with 46.6 per cent of the population predicted to meet the criteria for a disorder some time in their lives, and 21 per cent of the population having had an experience of mental disorder in the previous 12 months (Oakley Browne et al., 2006, p. xix).

Prevalence of substance use disorders

Te Rau Hinengaro identified the prevalence rate for any substance use disorder was 3.5 per cent of the adult population, (Oakley Browne et al., 2006).⁵² However, the prevalence rates for Māori and Pasifika adults are higher at 8.6 per cent and 5.3 per cent respectively.⁵³ *Te Rau Hinengaro* shows the prevalence rates for Māori and Pasifika against the national averages, indicating that Māori and Pasifika are affected by alcohol dependence at three times the rate of the general population.

No prevalence data for substance use disorders was published for the New Zealand Asian population as part of *Te Rau Hinengaro* (Oakley Browne et al., 2006 *The health of New Zealand adults 2011/2012: Key findings of the New Zealand Health Survey* (Ministry of Health, 2012b) reported that Asian people were similar to the total sample for 'having any risk of gambling problems'. The rate described for Asian ethnic groups was 3.3 per cent (2.0 to 5.7 per cent), compared with the total sample rate of 3.1 per cent (2.7 to 3.5 per cent).

⁵² Including 2.6 per cent for alcohol abuse and 1.2 per cent for drug abuse.

⁵³ No prevalence data for substance use disorders was published for the New Zealand Asian population as part of *Te Rau Hinengaro* (Oakley Browne et al., 2006).

Table D. 3. *Prevalence of substance use disorders for people aged 16 years and over: total sample, Māori and Pasifika*

Substance use disorders	12-month prevalence total sample (%)	12-month prevalence Māori (%)	2 month prevalence Pasifika (%)
Māori			
Alcohol abuse	2.6 (2.3-3.0)	6.7 (5.5-8.1)	3.7 (2.8-5.0)
Alcohol dependence	1.3 (1.1-1.5)	3.9 (3.0-5.0)	3.4 (2.4-4.7)
Drug abuse	1.2 (0.9-1.4)	3.7 (2.8-4.8)	1.1 (0.7-1.8)
Drug dependence	0.7 (0.5-0.9)	1.9 (1.3-2.8)	0.7 (0.4-1.3)
Any substance use disorder	3.5 (3.1-4.0)	8.6 (7.1-10.4)	5.3 (4.1-6.8)

Source: Oakley Browne et al., 2006.

Problem gambling

The health of New Zealand adults 2011/2012: Key findings of the New Zealand Health Survey (Ministry of Health, 2012a) reported that the population rate for having any risk of gambling problems was 3.1 per cent (2.7 to 3.5 per cent). The rate for Māori was 7.0 per cent (5.6 to 8.7 per cent) and for Pasifika was 7.8 per cent (5.4 to 11.1 per cent).

D.2 Funding of adult mental health and addiction services

Vote Health funding for adult mental health and addiction services

The Ministry of Health's Price Volume Schedule documents Vote Health funding for mental health and addiction services. The following two tables summarise the total mental health and addiction funding for the year ended 30 June 2013.

Total Vote Health funding for adult mental health and addiction services during 2012/13 was \$1.082 billion.⁵⁴ Mental health services received 88 per cent of Ministry of Health funding; AOD services received 10.5 per cent; problem gambling services 1.5 per cent.⁵⁵

Table D. 4 describes the total Vote Health funding received by DHB and NGO providers for adult mental health, AOD and problem gambling services.

⁵⁴ \$1.082B excludes funding of \$ 3,368,613 specified as not mental health funding in the Price Volume Schedule.

⁵⁵ In this report, the term 'addiction service' is used to describe the combined alcohol and other drug (AOD) and problem gambling services.

Table D. 4. *Vote Health funding for adult mental health and addiction services by provider type for 2012/13*

Provider type	Sector			Total health funding
	Mental health	AOD	Problem gambling	
DHB	\$663,308,216	\$62,393,122	\$ 352,928	\$726,054,266
NGO	\$287,569,376	\$53,362,169	\$15,482,314	\$356,413,859
Total	\$950,877,592	\$115,755,291	\$15,835,242	\$1,082,468,125

Note: Funding identified as 'not mental health' was excluded from this table.

Source: Ministry of Health's Price Volume Schedule 2012/13. Data extracted 28 April 2014.

Figure D. 2 shows the proportion of total Vote Health funding allocated to mental health, AOD and problem gambling contracts.

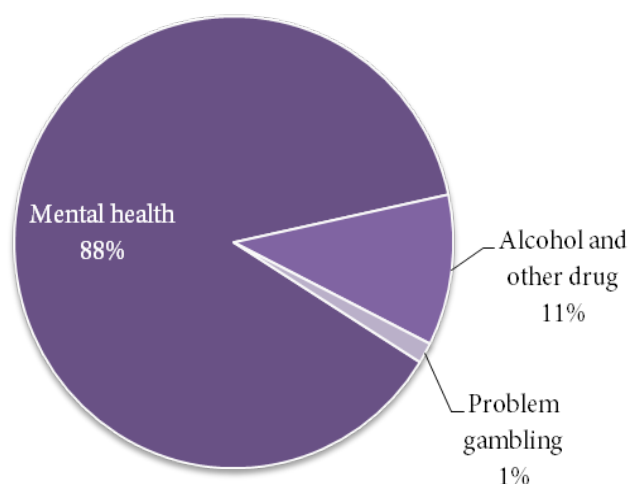


Figure D. 2. Proportion of Vote Health funding allocated to mental health, AOD and problem gambling contracts for the year ended 30 June 2013

Just over two-thirds (67 per cent) of total Vote Health funding for mental health and addiction services went to DHBs, although there was a marked difference in the DHB share across services. DHBs received 74 per cent of mental health funding, 54 per cent of AOD funding and 3 per cent of problem gambling funding (as reported in the Price Volume Schedule 2012/13).

Table D. 5 uses the Ministry of Health Price Volume Schedule 2012/13 and NZ Census 2013 data to calculate the health spend per head of adult population on adult mental health and addiction services in each of the four regions.⁵⁶ The Central and South Island regions have the lowest spend per adult, followed by the Northern region. Midland has the highest spend. The total average spend includes \$41 million in national

⁵⁶ This includes only a small proportion of the problem gambling funding, which is mostly distributed nationally rather than to local DHBs or regions.

funding that is not allocated regionally; this figure includes \$16 million allocated to problem gambling funding.

Table D. 5. *Adult mental health and addiction service spend per head of population for 2012/13 by region*

Region	\$ spend per adult
Northern	\$ 428
Midland	\$ 439
Central	\$ 413
South Island	\$ 402
Total average spend including problem gambling	\$ 437*

Note: *Total average spend includes national funding for problem gambling, which is not included in funding allocated to a region.

Source: Ministry of Health's Price Volume Schedule 2012/13 and NZ Census 2013 data (Statistics New Zealand, 2014).

The total Vote Health funding of \$1.082 billion included a range of contracts unrelated to direct care services and therefore outside of the scope of the organisations included in the survey (\$62 million) for example contracts related to research, and infrastructure or workforce development.

The organisations invited to participate in the survey had adult mental health and addiction contracts totalling \$1.021 billion. These organisations included all 20 DHBs, which received \$726 million (71 per cent) and 231 NGOs, which received just under \$295 million of funding (29 per cent). The survey was completed by 75 per cent of invited organisations: all the DHBs and 73 per cent of NGOs. Together these organisations received 96 per cent of the survey sample's total funding. NGOs completing the survey received 87 per cent of the funding for NGOs.

Table D. 6 shows the distribution of Vote Health funding among organisations that completed the survey and those that did not.

Table D. 6. *Vote Health funding for mental health and addiction surveyed organisations by survey outcome and contracted service*

Survey outcome	Service provided			Total health funds
	Mental health	Alcohol and other drug	Problem gambling	
Not completed	\$32,423,263	\$5,135,129	\$1,721,848	\$39,280,240
Completed	\$861,975,911	\$110,346,562	\$9,674,816	\$981,997,288
Total surveyed	\$894,399,173	\$115,481,691	\$11,396,664	\$1,021,277,528

Figure D. 3 shows the proportion of survey sample's Vote Health funding received by organisations that completed the survey and those that did not.

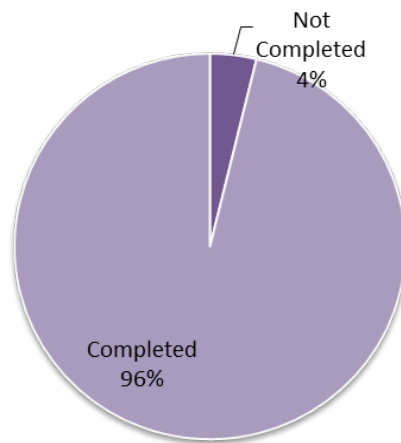


Figure D. 3. Proportion of Vote Health funding for mental health and addiction services received by survey outcome

Vote Health funding tables

Table D. 7 and Table D.8 show the total Vote Health funding for adult mental health, AOD and problem gambling contracts for DHBs and NGOs in each of the DHB districts, organised by regions. This includes all funded services, not just those who participated in the survey.

Table D. 7. *Vote Health funding for adult mental health and addiction services by region and DHB district*

DHB region and locality	Contract service (\$)			Total health funding (\$)
	Mental health	AOD	Problem gambling	
Northern region total	363,242,664	40,697,631		403,940,295
Auckland	96,616,149	7,766,616		104,382,765
Counties Manukau	94,460,166	3,805,632		98,265,798
Northland	36,139,196	6,214,180		42,353,375
Waitematā	136,027,153	22,911,203		158,938,356
Midland region total	175,984,909	23,859,910		199,844,819
Bay of Plenty	35,927,567	6,218,138		42,145,705
Lakes	19,730,194	3,715,393		23,445,587
Tairāwhiti	10,224,294	1,416,106		11,640,399
Taranaki	21,105,137	3,086,307		24,191,444
Waikato	88,997,717	9,423,966		98,421,683
Central region total	183,200,395	18,039,334		201,239,729
Capital & Coast	78,930,526	4,814,397		83,744,923
Hawke's Bay	26,705,603	3,778,064		30,483,667
Hutt Valley	24,964,974	3,301,178		28,266,152
MidCentral	26,715,698	3,368,441		30,084,139
Wairarapa	6,310,467	941,004		7,251,471
Whanganui	19,573,126	1,836,251		21,409,377
South Island region total	211,825,855	24,784,801		236,610,655
Canterbury	101,778,663	13,757,300		115,535,963
Nelson Marlborough	26,295,872	3,863,922		30,159,794
South Canterbury	7,728,537	925,238		8,653,775
Southern	64,853,090	5,466,357		70,319,447
West Coast	11,169,693	771,984		11,941,677
Other national total	16,623,770	8,373,615	15,835,242	40,832,627
Total	950,877,592	115,755,291	15,835,242	1,082,468,125

Note: Funding identified as 'not mental health' was excluded from this table.

Source: Ministry of Health's Price Volume Schedule 2012/13. Data extracted 28 April 2014.

Table D. 8. *Vote Health funding for adult mental health and addiction services by provider type, and by region and local DHB district*

DHB region and locality	Mental health services (\$)		AOD services (\$)		Problem gambling (\$)		Total (\$)	
	DHB	NGO	DHB	NGO	DHB	NGO	DHB	NGO
Northern region total	266,000,942	97,241,721	24,606,628	16,091,003			290,607,570	113,332,724
Auckland	71,091,115	25,525,034		7,766,616			71,091,115	33,291,650
Counties Manukau	59,544,046	34,916,120		3,805,632			59,544,046	38,721,752
Northland	26,109,337	10,029,859	4,359,160	1,855,020			30,468,496	11,884,879
Waitematā	109,256,444	26,770,708	20,247,468	2,663,735			129,503,913	29,434,443
Midland region total	111,310,409	64,674,500	11,880,233	11,979,677			123,190,643	76,654,177
Bay of Plenty	22,591,345	13,336,222	2,856,476	3,361,662			25,447,821	16,697,884
Lakes	10,861,518	8,868,676	1,031,964	2,683,429			11,893,483	11,552,105
Tairāwhiti	5,979,718	4,244,576	989,482	426,624			6,969,199	4,671,200
Taranaki	14,218,110	6,887,027	2,116,527	969,780			16,334,637	7,856,807
Waikato	57,659,718	31,337,998	4,885,784	4,538,182			62,545,503	35,876,181
Central region total	129,666,630	53,533,765	10,565,884	7,473,450			140,232,514	61,007,215
Capital & Coast	56,108,802	22,821,724	3,513,812	1,300,585			59,622,614	24,122,309
Hawke's Bay	18,169,157	8,536,446	2,104,385	1,673,679			20,273,542	10,210,125
Hutt Valley	18,640,943	6,324,031	1,120,095	2,181,083			19,761,038	8,505,114
MidCentral	20,246,544	6,469,153	2,332,325	1,036,116			22,578,869	7,505,269
Wairarapa	3,739,600	2,570,867		941,004			3,739,600	3,511,871
Whanganui	12,761,583	6,811,543	1,495,268	340,983			14,256,851	7,152,526

DHB region and locality	Mental health services (\$)		AOD services (\$)		Problem gambling (\$)		Total (\$)	
	DHB	NGO	DHB	NGO	DHB	NGO	DHB	NGO
South Island region total	154,755,913	57,069,942	14,567,177	10,217,624			169,323,090	67,287,565
Canterbury	70,515,309	31,263,354	5,949,485	7,807,816			76,464,794	39,071,170
Nelson Marlborough	19,236,891	7,058,981	2,666,406	1,197,516			21,903,297	8,256,497
South Canterbury	5,340,171	2,388,366	768,590	156,648			6,108,761	2,545,014
Southern	51,225,993	13,627,097	4,410,713	1,055,644			55,636,707	14,682,741
West Coast	8,437,549	2,732,144	771,984				9,209,533	2,732,144
Other national	1,574,322	15,049,448	773,199	7,600,416	352,928	15,482,314	2,700,449	38,132,178
Total	663,308,216	287,569,376	62,393,122	53,362,169	352,928	15,482,314	726,054,266	356,413,859

Note: Funding identified as 'not mental health' was excluded from this table.

Source: Ministry of Health's Price Volume Schedule 2012/13. Data extracted 28 April 20

Other sources of funding for the NGO workforce

This section presents findings from the organisation workforce survey in relation to non-Vote Health or other sources of funding reported by NGOs. The results combine information reported by both mental health and addiction services.

NGOs fund their services from a variety of sources to meet demand. The survey asked respondents to identify the proportion of their organisation's total income for adult mental health and addiction services received from health contracts.⁵⁷ One-hundred and fifty-six NGOs answered this question (response rate 92 per cent). Sixty-four NGOs (41 per cent) stated that they received all funding through Vote Health and 92 NGOs (59 per cent) reported they did not receive all funding through Vote Health.

For the 156 responding organisations, health funding averaged 83 per cent of their organisation's income, ranging from two per cent to 100 per cent. For the 92 NGOs indicating they received funding from both Vote Health and other sources, the average health funding was 72 per cent, with a minimum of 2 per cent and a maximum of 99 per cent. Of those 92 organisations, 86 selected the source of that income by choosing from a list provided on the survey with the option to add others (a response of 87 per cent to this question).

Figure D.4 shows the proportion of these 86 NGOs who selected each of the specified other sources of income.⁵⁸ The majority of organisations identified charity, fundraising and the Ministry of Social Development as key sources of income.

⁵⁷ This question was based on the Matua Raki *Addiction Services: Workforce and service demand survey 2011 report* (2011).

⁵⁸ The percentages do not relate to the amount of funding received.

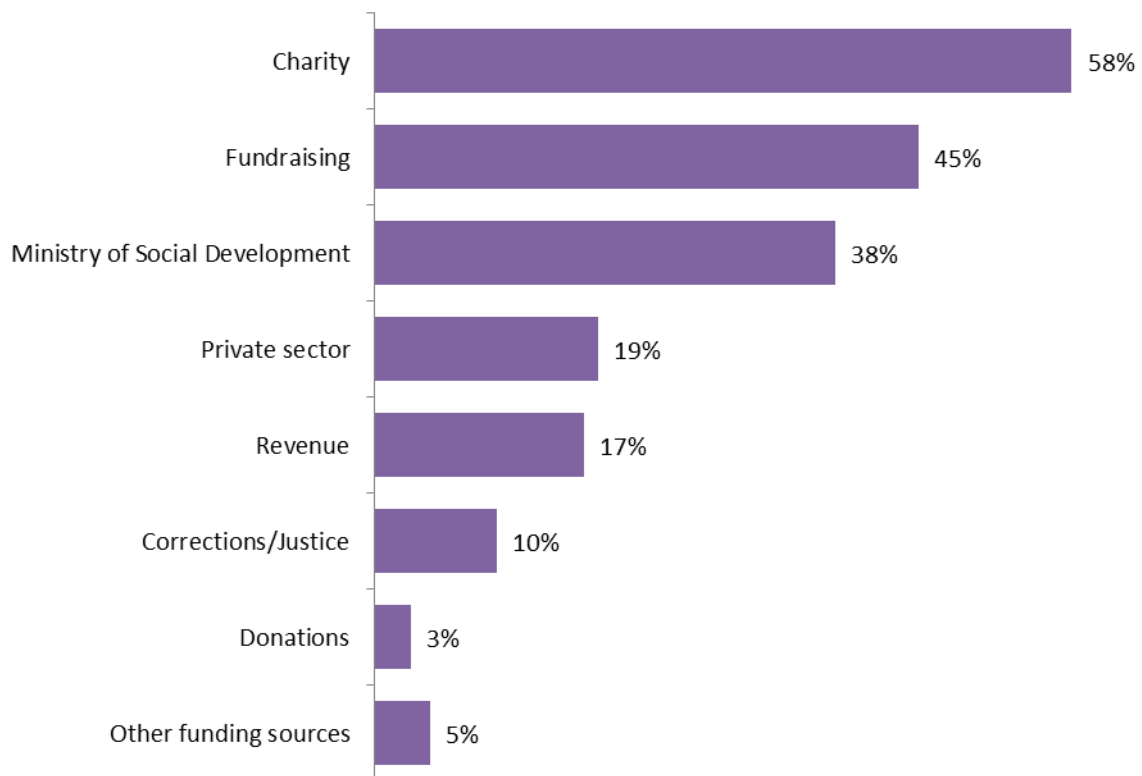


Figure D. 4. Sources of funding other than Vote Health received by NGOs (n=86)

D.3 Service use and activity

PRIMHD collects information about access to mental health and addiction services and related service activity. This section provides information available for the period from 1 July 2012 to 30 June 2013. The information consists of national and regional totals for all adult services reporting to PRIMHD.⁵⁹

PRIMHD is updated by DHBs and NGOs to record mental health and AOD service consumer contact information, demographics and outcomes. It is important to note that not all NGOs are reporting to PRIMHD.

Adult mental health services

Table D. 9 summarises by region the number of mental health service consumers seen by DHBs only, NGOs only, and those seen by both provider types. Because the same consumers may be included in more than one region, the bottom row records the total number of unique consumers seen by mental health services.

Sixty-two per cent of consumers were seen only by DHBs, and nine per cent only by NGOs. However, 28 per cent of consumers were seen by both DHB and NGO mental health services.

Table D. 9. *Total adult (20–64 years) mental health service consumers for 2012/13 by DHB and NGO for each region*

Region [#]	Adult mental health service consumers aged 20-64* seen by				Access rate
	DHBs	NGOs	DHBs and NGOs	Total	
Northern	16,306	1,522	7,395	25,223	2.7
Midland	9,240	2,155	5,564	16,959	3.7
Central	9,687	1,846	4,347	15,880	3.3
South Island	11,530	1,463	3,376	16,369	2.8
Total unique consumers seen	44,922	6,806	20,270	71,998	2.9

Notes: [#]Consumer allocation to regions is based on where the person reported they lived. The location of the service provider may differ. Consumers are counted only once in a region, but may be included in more than one region if they have moved during the year.

This table includes consumers seen by both mental health and AOD services, but not those seen only by AOD services.

The final row represents the unique adult mental health service consumers seen in New Zealand. As a result, the sum of consumers seen by the regions is higher than the total unique consumers seen nationally.

* The 20-64 year age group has been included in this table to enable a population access rate to be determined using the available census information which is provided in age bands of 5 years, eg 20-24.

Source: PRIMHD 2012/13 data extract obtained 30 January 2014.

⁵⁹ PRIMHD access data counts some individual consumers more than once, for example if consumers move from one DHB district to another (access data is based upon consumer domicile, not location of service provider). In the following tables, presentation of unique consumer data is signalled in the row and column descriptors and the table notes.

The following two tables summarise the number of consumers seen (aged 18-64 years), the number of contacts and bed nights reported to PRIMHD by DHBs and NGOs respectively. Twenty-eight per cent of consumers seen by DHBs were also seen by NGOs.

Table D. 10 describes service activity for DHBs, most DHB mental health service consumers were seen in the community.

Table D. 10. *DHB 2012/13 service activity for adult mental health service consumers (aged 18–64) by PRIMHD team type*⁶⁰

DHB team types	Consumers seen	Bed nights	Contacts	Face-to-face activities [#]
Community [^]	66,968	3,363	1,517,984	892,964
Inpatient	7,799	231,075	847	8,973
Other MH service teams	6,103	10,907	77,753	45,103
Forensic	5,029	79,648	51,225	30,442
Residential/Accommodation	467	4,041	9,230	8,123
Total (by all team types)	69,556*	329,034	1,657,039	985,605

Notes: Some consumers are seen by more than one service type therefore the total unique consumers does not equal the sum of consumers seen by each service type.

[#]Face-to-face activities are when a consumer is physically present. Care and liaison coordination activities, contact with family and whānau-written correspondence, telephone calls and text messages are excluded from this count.

[^]Community teams includes community skills enhancement teams.

Source: PRIMHD 2012/13 data extract obtained 9 July 2014.

Table D 11 shows that NGO mental health service consumers were mostly seen by community teams. NGOs provided extensive residential accommodation to consumers.

Table D. 11. *NGO 2012/13 service activity for adult mental health service consumers (aged 18–64) by PRIMHD team type*

NGO team types	Consumers seen	Bed nights	Contacts	Face-to-face activities [#]
Community	24,734	16,480	991,829	764,878
Forensic	35	7,322	722	629
Residential accommodation	5,475	512,088	92,755	83,130
Other MH service teams	1,736	2,584	17,705	9,537
Total (by all team types)	26,280*	538,474	1,103,011	858,174

Notes: * Some consumers are seen by more than one team type therefore the total unique consumers does not equal the sum of consumers seen by each service type.

[#]Face-to-face activities are when a consumer is physically present. Care and liaison coordination activities, contact with family and whānau-written correspondence, telephone calls and text messages are excluded from this count.

[^]Community teams includes community skills enhancement teams.

Source: PRIMHD 2012/13 data extract obtained 9 July 2014.

⁶⁰ The team type categories used in this analysis predate the July 2014 HISO changes to team type codes.

The 18 and 19 year olds reported in Table D. 10 and Table D. 11 represent a small proportion of the total consumers seen by adult mental health services. DHB services saw 4,753 people aged 18 and 19 years during the period from 1 July 2012 to 30 June 2013, while NGO services saw 1,385 people of the same age during the same period.⁶¹ It is likely that some of these people in this age group are seen by or continue to be seen by child and adolescent services.

Adult AOD services

Table D. 12 summarises by region the number of adult consumers of AOD services seen by DHBs only, NGOs only and those seen by both provider types reported in PRIMHD. Because the same consumers may be included in more than one region, the bottom row records the total number of unique consumers.

A total of 37,520 consumers were seen by adult AOD services for the year end 30 June 2013. Of this group, 53 per cent were seen by DHBs only, 27 per cent by NGOs only and 20 per cent were seen by both DHBs and NGOs.

Table D. 12. *Total adult (20–64 years) consumers of AOD services for 2012/13 by DHB and NGO for each region*

Region [#]	Adult consumers of AOD services aged 20-64* seen by				Access rates
	DHBs	NGOs	DHBs and NGOs	Total	
Northern	10,426	1,990	2,734	15,150	1.6
Midland	3,389	3,532	1,960	8,881	2.0
Central	2,926	2,423	1,358	6,707	1.4
South Island	3,885	2,255	1,624	7,764	1.3
Total unique consumers seen	19,959	9,986	7,575	37,520	1.5

Notes: [#]Consumer allocation to regions is based on where the person reported they lived. The location of the service provider may differ. Consumers are counted only once in a region, but may be included in more than one region if they have moved during the year. This table includes consumers seen by both AOD and mental health, but not those seen only by mental health services. The final row represents the unique adult consumers of AOD services seen in New Zealand. As a result, the sum of consumers seen by the regions is higher than the total unique consumers seen nationally.

* The 20–64 year age group has been included in this table to enable a population access rate to be determined using the available census information which is provided in age bands of 5 years, eg 20–24.

Source: PRIMHD 2012/13 data extract, data extract obtained 30 January 2014.

As already outlined above, PRIMHD collates activity information for specified team types. The following tables summarise service activity for DHBs and NGOs respectively, by PRIMHD team types. Consumers seen by both DHBs and NGOs are included in the tables set out below.

Table D. 13 and Table D. 14 summarise consumers seen (aged 18 to 64 years), contacts and bed nights for DHBs and NGOs respectively, reported to PRIMHD for adult AOD services. As shown in Table D. 11, the majority of consumers were seen by general adult AOD teams. A very small number were seen by co-existing problems teams.

⁶¹ These people represent unique consumers.

Table D. 13. *DHB 2012/13 service activity for adult consumers of AOD services (aged 18–64) by PRIMHD team type*

DHB team types	Consumers seen	Bed nights	Contacts	Face-to-face activities [#]
AOD community	26,180	637	365,633	203,632
Co-existing problem community	1,034	.	12,701	6,818
AOD inpatient	775	6,185	.	149
AOD residential co-existing problems	88	.	538	510
Total (all team types)	26,690*	6,822	378,872	211,109

Notes: * Some consumers are seen by more than one service type therefore the total unique consumers does not equal the sum of consumers seen by each service type.

[#]Face-to-face activities are when a consumer is physically present. Care and liaison coordination activities, contact with family and whānau-written correspondence, telephone calls and text messages are excluded from this count.

Source: PRIMHD 2012/13 data extract obtained 9 July 2014.

Like the DHB adult AOD services, most consumers were seen by general NGO community services. A much smaller proportion was seen by the NGO co-existing problems services (Table D. 14).

Table D. 14. *NGO 2012/13 service activity for adult consumers of AOD services (aged 18–64) by PRIMHD team type*

NGO team types	Consumers seen	Bed nights	Contacts	Face-to-face activities [#]
AOD community	15,823	4,052	184,083	133,200
AOD residential	2,095	113,558	7,197	6,626
Co-existing problem community	414	-	7,660	5,669
Co-existing problem residential	166	16,811	21	18
AOD inpatient	23	92	.	.
Total (all team types)	16,468*	134,513	198,961	145,513

Notes: * Some consumers are seen by more than one service type therefore the total unique consumers does not equal the sum of consumers seen by each service type.

[#]Face-to-face activities are when a consumer is physically present. Care and liaison coordination activities, contact with family and whānau-written correspondence, telephone calls and text messages are excluded from this count.

Source: PRIMHD 2012/13 data extract obtained 9 July 2014.

The 18 and 19 year olds reported in Table D. 11 and Table D. 12 represent a small proportion of the total consumers seen by adult AOD services. DHB services saw 1,451 people aged 18 and 19 years during the period from 1 July 2012 to 30 June 2013, while NGO services saw 1,096 people of the same age during the same period. These are unique consumers seen by services.

Adult problem gambling services

Organisations providing problem gambling services funded by the Ministry of Health are required to supply monthly data to the Ministry of Health on service use by consumers, and their families or others who are affected by the behaviour of problem gamblers. Data from this problem gambling national database, known as CLIC, is shown in Table D. 15 and Table D. 16 below.⁶²

In the 12 months up to 30 June 2013, 4,471 problem gamblers aged 20 to 64 years received treatment. Services were also provided to 1,603 family members and others in the same age range. These figures exclude those receiving brief interventions alone. When all age groups were considered, 4,882 problem gamblers and 2,049 family members and affected others were identified.

Table D. 15. *Problem gambling services consumers and their family/affected others aged 20–64 years*

Consumer type	July 2012 to June 2013	
	Consumers (count)	Consumers (%)
Family/affected other	1,603	26
Gambler	4,471	74
Total	6,074	100

Source: Problem Gambling Client Information Collection (CLIC) database 2012/13 data extract February 2014.

CLIC data is not collected by DHB districts. Regional analysis can be provided for the North Island and South Island only. The South Island region had 1,168 consumers, which was 19 per cent of the total (those using services as problem gamblers and as family/affected others are combined).

Table D. 16. *Adult (20–64 years) problem gambling consumers and family/affected other by region*

Region	July 2012 to June 2013	
	Consumers (count)	Consumers (%)
North Island	4,906	81
South Island	1,168	19
Total	6,074	100

Source: Problem Gambling Client Information Collection (CLIC) database 2012/13: data extract February 2014.

⁶² The CLIC data relies on self-report by services, but there are checks on the quality of the data submitted.

Consumer and service use tables from PRIMHD

Table D. 17. *Total adult (20 to 64 years) DHB and NGO mental health service consumers by region and DHB district*

Region and DHB	Adult mental health service consumers seen by				Access rate (%)
	DHBs only	NGOs only	DHBs and NGOs	Total	
Northern region	16,306	1,522	7,395	25,223	2.7
Northland	1,671	154	1,060	2,885	3.5
Auckland	5,911	303	2,140	8,354	3.0
Waitematā	5,395	492	1,970	7,857	2.5
Counties Manukau	4,747	650	2,616	8,013	3.0
Midland region	9,240	2,155	5,564	16,959	3.7
Waikato	3,365	1,204	2,882	7,451	3.7
Lakes	1,975	162	704	2,841	5.2
Bay of Plenty	2,301	612	1,199	4,112	3.7
Tairāwhiti	841	71	189	1,101	4.6
Taranaki	1,049	144	664	1,857	3.0
Central region	9,687	1,846	4,347	15,880	3.3
Hawke's Bay	2,226	624	621	3,471	4.2
MidCentral	1,300	415	944	2,659	2.9
Whanganui	526	171	373	1,070	3.3
Capital and Coast	3,648	253	1,410	5,311	3.0
Hutt Valley	2,155	239	846	3,240	4.0
Wairarapa	279	204	258	741	3.3
Southern region	11,530	1,463	3,376	16,369	2.8
Nelson Marlborough	1,689	94	611	2,394	3.1
West Coast	598	23	103	724	3.8
Canterbury	4,785	828	1,475	7,088	2.5
South Canterbury	722	90	126	938	3.0
Southern	4,098	445	1,093	5,636	3.2
Total unique consumers seen	44,922	6,806	20,270	71,998	2.9

Notes: Information is based on consumer domicile. The location of the service provider may differ.

This table includes consumers seen by both mental health and AOD services, but not those only seen by AOD services.

Consumers are counted only once in a DHB row, but may be included in more than one DHB row.

Region totals represent unique consumers for that region. Consumers may be included in more than one region.

The final row represents the unique adult mental health service consumers seen in New Zealand.

Source: PRIMHD 2012/13 data extract 9 July 2014.

Table D. 18. Total adult (20–64 years) DHB and NGO consumers of AOD services by region and DHB district

Region and DHB	Adult alcohol and other drug consumers seen by				Access rate (%)
	DHBs only	NGOs only	DHBs and NGOs	Total	
Northern	10,426	1,990	2,734	15,150	1.6
Northland	1,405	519	423	2,347	2.9
Auckland	3,267	505	816	4,588	1.6
Waitematā	3,936	410	818	5,164	1.7
Counties Manukau	2,737	702	804	4,243	1.6
Midland	3,389	3,532	1,960	8,881	2.0
Waikato	959	1,641	880	3,480	1.7
Lakes	160	893	271	1,324	2.4
Bay of Plenty	1,222	822	525	2,569	2.3
Tairāwhiti	263	92	38	393	1.7
Taranaki	852	136	266	1,254	2.0
Central	2,926	2,423	1,358	6,707	1.4
Hawke's Bay	1,083	70	195	1,348	1.6
MidCentral	705	612	328	1,645	1.8
Whanganui	508	128	140	776	2.4
Capital and Coast	501	818	406	1,725	1.0
Hutt Valley	211	423	243	877	1.1
Wairarapa	4	444	87	535	2.4
Southern	3,885	2,255	1,624	7,764	1.3
Nelson Marlborough	1,404	156	218	1,778	2.3
West Coast	327	20	38	385	2.0
Canterbury	753	1,431	801	2,985	1.0
South Canterbury	324	39	79	442	1.4
Southern	1,227	658	519	2,404	1.4
Total unique consumers seen	19,959	9,986	7,575	37,520	1.5

Notes: Consumer allocation to regions is based on where the consumer reported they lived. The location of the service provider may differ.

Consumers are counted only once in a region, but may be included in more than one region if they have moved during the year.

Consumers are counted only once in a DHB, but may appear in more than one DHB.

This table includes consumers seen by both mental health and AOD services, but not those seen only by mental health services.

Regional totals represent the unique consumers seen for that region.

The final row represents the unique adult consumers of AOD services seen in New Zealand. As a result, the sum of consumers seen by the regions is higher than the total unique consumers seen nationally.

Source: PRIMHD 2012/13 data extract 9 July 2014.

Appendix E: Additional tables

E.1 Chapter three additional tables

Table E.1 shows DHB and NGO FTE positions filled by staff as at 1 March 2014, by role. The final column shows the total FTE positions employed for each role as a proportion of the total mental health workforce employed.⁶³

Table E. 1. *Adult mental health services workforce employed (FTE positions employed) by roles*

Roles	Workforce (FTE positions employed)			Proportion of employed workforce
	DHB	NGO	Total	
Clinical roles				
Allied health				
Occupational therapist	170.0	19.3	189.3	2.6%
Clinical psychologist	204.6	8.1	212.7	2.9%
Other psychologist	9.9	7.0	16.9	0.2%
Social worker	258.4	60.0	318.3	4.4%
Addiction practitioner/clinician	14.2	25.9	40.1	0.6%
Dual diagnosis practitioner/co-existing problems clinician	7.4	4.5	11.9	0.2%
Counsellor	23.1	14.1	37.3	0.5%
Educator/trainer	5.4	16.0	21.3	0.3%
Other allied health professionals	26.2	5.2	31.4	0.4%
Sub-total (allied health)	719.2	160.1	879.3	12.1%
Medical and other professionals				
General practitioner	4.6	0.7	5.4	0.1%
House surgeon	50.0	1.0	51.0	0.7%
Consultant psychiatrist	255.0	0.6	255.6	3.5%
Medical officer special scale	47.8	1.0	48.8	0.7%
Psychiatric registrar	102.4	1.7	104.1	1.4%
Liaison/consult liaison	26.3	1.0	27.3	0.4%
Other medical professionals	0.6	-	0.6	0.0%
Sub-total (medical and other professionals)	486.7	6.1	492.7	6.8%
Nursing				
Registered nurse	2,010.7	94.7	2,105.4	29.1%
Enrolled nurse	62.5	3.4	65.9	0.9%
Nurse practitioner/nurse specialist/nurse educator	87.3	3.0	90.3	1.2%

⁶³ However, sub-totals for each group of roles, eg allied health professionals, represents the total proportion for that group of roles across the whole mental health workforce reported in the survey.

Roles	Workforce (FTE positions employed)			Proportion of employed workforce
	DHB	NGO	Total	
Other nursing	42.0	-	42.0	0.6%
Sub-total (nursing)	2,202.5	101.1	2,303.6	31.8%
Other clinical roles	87.9	14.3	102.2	1.4%
Total (clinical roles)	3,496.2	281.5	3,777.7	52.2%
Non-clinical roles				
Support workers				
Community development worker	-	44.5	44.5	0.6%
Employment worker	-	43.4	43.4	0.6%
Community support worker	100.3	813.5	913.7	12.6%
Family support worker	3.5	57.3	60.8	0.8%
Healthcare assistant	243.2	9.0	252.2	3.5%
Peer support – consumer	14.2	137.8	152.0	2.1%
Peer support – family and whānau	-	11.8	11.8	0.2%
Psychiatric assistant	161.9	-	161.9	2.2%
Residential support worker	-	568.8	568.8	7.9%
Other support workers	38.1	88.0	126.0	1.7%
Sub-total (support workers)	561.1	1,774.0	2,335.1	32.2%
Cultural workers				
Cultural supervisor	5.6	7.1	12.7	0.2%
Kaumātua	10.7	15.1	25.8	0.4%
Kuia	4.3	4.7	9.0	0.1%
Kaiāwhina	26.7	1.1	27.8	0.4%
Traditional Māori health practitioner	1.0	17.0	18.0	0.2%
Matua	1.5	0.2	1.7	0.0%
Pasifika cultural advisor	1.0	1.2	2.2	0.0%
Other cultural advisor	33.6	4.0	37.6	0.5%
Sub-total (cultural workers)	84.4	50.4	134.8	1.9%
Other non-clinical roles	1.0	1.5	2.5	0.03%
Total (non-clinical roles)	646.5	1,825.9	2,472.4	34.1%
Administration and management				
Administrative/technical support	327.5	87.5	415.0	5.7%
Senior manager	42.8	68.9	111.7	1.5%
Clinical director	19.8	5.1	24.9	0.3%
Professional leader	17.3	9.9	27.3	0.4%
Service manager/team leader	148.8	186.9	335.6	4.6%
Consumer advisor/consumer leader	17.9	13.7	31.6	0.4%

Roles	Workforce (FTE positions employed)			Proportion of employed workforce
	DHB	NGO	Total	
Family/whānau advisor	13.6	4.0	17.6	0.2%
Other administration and management	14.4	14.4	28.8	0.4%
Total (administration and management)	602.2	390.3	992.5	13.7%
Grand total (all roles)	4,744.9	2,497.7	7,242.6	100.0%

Workforce vacancies

The following table describes the vacancy rates for DHB and NGO adult mental health services within the different service types. Vacancy rates are calculated from the FTE positions vacant as a proportion of the total workforce (FTEs employed plus vacant).

Table E. 2. *Vacancy rates for DHB, NGO and total adult mental health workforce, by service type*

Service type	Vacancy rate (%)		
	DHB	NGO	Total
Inpatient	5.2	-	5.2
Residential	-	4.0	4.1
Community	4.7	3.4	4.2
Forensic	6.0	7.0	6.0
Management	12.6	0.8	7.9
Other	6.2	4.1	4.8
Total vacancies/FTEs (employed plus vacant)	5.5	3.5	4.9

Workforce by regions

The following table describes the total workforce (FTEs employed and vacant) for each role by region for DHBs and NGOs.

Table E. 3. *Adult mental health workforce roles employed and vacant by region and provider type*

Roles	DHB workforce (FTEs employed plus vacant)				NGO workforce (FTEs employed plus vacant)			
	Northern	Midland	Central	South Island	Northern	Midland	Central	South Island
Clinical roles								
Allied health								
Occupational therapist	89.1	25.0	33.9	36.9	14.7	1.0	3.0	1.6
Clinical psychologist	91.2	35.0	43.3	52.6	4.1	1.8	5.2	-
Other psychologist	2.60	1.5	2.6	4.5	5.2	-	1.8	-
Social worker	119.3	40.0	53.5	56.7	32.1	10.9	5.6	13.3
Addiction practitioner	1.6	3.5	6.1	4.0	2.5	16.6	5.8	1.0
Dual diagnosis practitioner/co-existing problems clinician	3.0	4.0	1.0	0.5	1.5	1.0	2.0	-
Counsellor	13.1	4.2	1.3	4.5	1.1	10.3	0.9	1.9
Educator/trainer	0.9	-	1.5	3.0	7.7	5.5	1.5	1.3
Other allied health	10.4	3.4	4.0	8.4	2.9	1.5	-	2.0
Sub-total (allied health)	331.2	116.6	147.2	171.1	71.8	48.6	25.8	21.1
Medical and other professionals								
General practitioner	2.4	-	2.0	0.4	-	-	0.5	0.3
House surgeon	16.0	6.0	15.0	14.0	1.0	-	-	-
Consultant psychiatrist	97.7	44.7	56.2	63.1	-	0.2	0.4	-
Medical officer special scale	35.0	2.0	10.6	2.5	1.0	-	-	-
Psychiatric registrar	42.1	13.5	22.5	34.3	1.6	-	0.1	-
Liaison/consult liaison	2.3	1.0	21.0	3.0	1.0	-	-	-
Other medical professionals	-	-	-	0.6	-	-	-	-
Sub-total (medical and other professionals)	195.4	67.2	127.3	117.9	4.6	0.2	1.0	0.3
Nursing								
Registered nurse	775.1	308.3	465.0	598.1	27.1	39.4	26.9	17.3
Enrolled nurse	11.3	3.7	6.9	44.5	1.9	1.0	1.0	-
Nurse practitioner/nurse specialist/nurse educator	25.6	15.6	27.5	21.8	3.0	-	-	-
Other nursing roles	14.0	2.8	-	26.7	-	-	-	-
Sub-total (nursing)	826.0	330.4	499.3	691.1	32.0	40.4	27.9	17.3

Roles	DHB workforce (FTEs employed plus vacant)				NGO workforce (FTEs employed plus vacant)			
	Northern	Midland	Central	South Island	Northern	Midland	Central	South Island
Other clinical roles	5.0	2.0	2.0	81.4	9.0	6.0	1.3	1.0
Total (clinical roles)	1,357.6	516.2	775.9	1,061.5	117.4	95.2	56.0	39.7

Non-clinical roles								
Support workers								
Community development worker	-	-	-	-	9.0	12.0	21.5	2.5
Employment worker	-	-	-	-	10.1	28.1	1.3	4.5
Community support worker	59.8	2.4	16.8	27.3	354.6	163.6	170.4	153.7
Family support worker	2.0	-	-	1.5	15.0	19.5	10.5	12.4
Health care assistant	116.4	17.4	123.5	7.2	-	1.0	8.0	-
Peer support – consumer	13.2	0.5	0.5	-	59.9	32.1	32.0	17.1
Peer support – family	-	-	-	-	1.5	7.4	1.5	1.3
Psychiatric assistant	46.0	69.7	18.9	30.8	-	-	-	-
Residential support worker	-	-	-	-	236.5	126.3	90.0	133.3
Other support worker	24.3	6.5	3.0	7.3	28.0	6.1	30.6	30.5
Sub-total (support workers)	261.6	96.5	162.7	74.1	714.5	396.1	365.8	355.1

Cultural workers								
Cultural supervisor	-	2.0	3.2	0.4	3.7	2.0	2.4	-
Kaumātua	7.6	1.0	2.5	1.5	3.5	10.6	2.2	-
Kuia	4.0	0.5	-	0.8	4.7	1.0	-	-
Kaiawhina	4.0	3.0	1.3	18.4	-	1.1	-	-
Traditional Māori health practitioner	-	1.0	-	-	-	17.0	-	-
Matua	1.0	-	0.5	-	0.2	-	-	-
Pasifika cultural advisor	-	-	1.0	-	1.2	-	-	-
Other cultural advisor	17.0	3.0	11.5	4.8	2.5	0.2	0.3	1.0
Sub-total (cultural workers)	33.6	10.5	20.0	25.9	15.8	31.9	4.9	1.0
Other non-clinical roles	2.0	-	-	-	-	1.5	-	-
Total (non-clinical role)	297.2	107.0	182.7	100.0	730.3	429.5	370.7	356.1

Administration and management								
Administration/technical support	113.1	45.0	74.5	97.7	29.4	21.3	18.7	19.5
Senior manager	9.6	8.0	11.8	18.0	28.0	11.4	16.0	14.5
Clinical director	3.6	2.5	6.0	8.7	2.0	1.8	1.3	-
Professional leader	7.2	2.3	5.7	2.5	4.0	2.0	2.3	1.7
Service manager/team leader	46.1	20.0	37.8	53.0	78.8	43.8	39.7	25.6
Consumer advisor/leader	3.9	2.0	5.4	7.0	9.1	1.9	2.7	0.3

Roles	DHB workforce (FTEs employed plus vacant)				NGO workforce (FTEs employed plus vacant)			
	Northern	Midland	Central	South Island	Northern	Midland	Central	South Island
Family/whānau advisor	1.8	3.2	8.0	5.5	2.0	1.3	1.2	-
Other administration and management	-	7.1	1.9	6.4	0.4	-	6.0	8.0
Sub-total (administration and management)	185.3	90.1	151.0	198.8	153.7	83.4	87.9	69.5
Total	1,840.1	713.4	1,109.6	1,360.3	1,001.4	608.1	514.6	465.3

NGO non-health-funded workforce for adult mental health services

This section presents findings from the organisation workforce survey in relation to the NGO non-health-funded workforce. The section shows the results for non-health-funded FTEs in the adult mental health workforce only.

Survey respondents were asked to differentiate their staff by those funded through Vote Health and those funded through other sources of funding. Mental health service respondents identified a total of 220 FTE (employed plus vacant) positions funded through other sources than Vote Health funding, representing 3 per cent of the total mental health workforce. Most of the positions funded through other sources were located in NGOs (97 per cent).

Only a minority of clinical positions were funded through other sources of funding, representing just 14 per cent of the total non-health-funded FTE (employed plus vacant) positions. The most common clinical positions were for allied health professionals (14 per cent of total FTEs). Non-clinical roles were mainly support worker roles, which were 47 per cent of total FTEs, and administration and management roles (37 per cent).

The following table shows the number of FTEs (employed plus vacant) funded through sources other than Vote Health funding that were identified by DHBs and NGOs by role. The DHB column shows only employed FTEs, as there were no vacancies identified by DHB respondents for positions funded through other sources of funding.

Table E. 4. Number of FTEs (employed and vacant) funded through other sources of funding than Vote Health by DHB and NGO for each role

Roles	DHB	NGO		
	FTEs employed	FTEs employed	FTEs vacant	Total workforce
Clinical roles				
Allied health				
Counsellor	-	4.4	-	4.4
Educator/trainer	-	5.1	2.0	7.1
Occupational therapist	-	1.0	-	1.0
Clinical psychologist	-	0.3	-	0.3
Other psychologist	-	2.5	-	2.5
Social worker	-	14.0	-	14
Sub-total (allied health)	-	27.3	2.0	29.3
Medical and other professionals				
Consultant psychiatrist	1.2	-	-	-
Medical officer special scale	-	0.1	-	0.1
Psychiatric registrar	0.5	-	-	-
Other medical professionals	-	-	-	-
Sub-total (medical and other professionals)	1.7	0.1	-	0.1
Nursing				
Registered nurse	-	1.0	-	1.0
Nurse practitioner/specialist/educator	1.2	-	-	-
Sub-total (nursing)	1.2	1.0	-	1.0
Other clinical roles		0.4		0.4
Total (clinical roles)	2.9	28.8	2.0	30.8
Non-clinical roles				
Support workers				
Community development worker	-	4.8	-	4.8
Employment worker	-	44.1	2.0	46.1
Community support worker	0.6	28.4	0.3	28.7
Family support worker	-	1.2	-	1.2
Peer support – consumer	2.0	2.5	-	2.5
Peer support – family and whānau	1.0	0.1	-	0.1
Residential support worker	-	1.0	-	1.0
Other support workers	-	15.9	-	15.9
Sub-total (support workers)	3.6	98.0	2.3	100.3
Cultural workers				
Cultural supervisor	-	0.1	-	0.1
Kaumātua	-	0.2	-	0.2
Kuia	-	0.2	-	0.2
Kaiāwhina	-	0.6	-	0.6

Roles	DHB	NGO		
	FTEs employed	FTEs employed	FTEs vacant	Total workforce
Matua	-	2.0	-	2.0
Other cultural advisor	-	1.4	-	1.4
Sub-total (cultural workers)	-	4.5	-	4.5
Total (non-clinical roles)	3.6	102.5	2.25	104.8
Administration and management				
Administrative/technical support	-	34.9	3.2	38.1
Senior manager	-	20.4	-	20.4
Professional leader	-	0.9	-	0.9
Service manager/team leader	-	18.7	-	18.7
Consumer advisor/consumer leader	0.1	0.1	-	0.1
Total (administration and management)	0.1	75	3.2	78.2
Grand total (all roles)	6.6	206.3	7.5	213.8

E.2 Chapter four additional tables

Table E. 5. *Proportion of the workforce identified as Māori, Pasifika or Asian in clinical and non-clinical roles by DHB and NGO*

Workforce	DHB n=164 responses		NGO n=416 responses		DHB and NGO n=580 responses	
	People (%)	Workforce (%)	People (%)	Workforce (%)	People (%)	Workforce (%)
Māori clinical workforce	10.7	11.1	20.5	28.1	12.0	12.9
Māori non-clinical workforce	16.3	16.4	22.8	26.9	21.2	24.0
Pasifika clinical workforce	2.1	2.3	4.4	6.3	2.4	2.7
Pasifika non-clinical workforce	3.5	4.0	6.6	7.9	5.8	6.8
Asian clinical workforce	4.1	4.3	7.7	9.0	4.5	4.8
Asian non-clinical workforce	1.8	1.9	6.7	7.8	5.5	6.2

E.3 Chapter five additional tables

Workforce shortages over the next two years

Table E. 6 shows the proportion of respondents (with DHBs reported separately from NGOs) who thought there would be a shortage for particular roles that they currently employ, and the total number of responses received DHBs and NGOs. The table highlights the similarities and differences between DHBs and NGOs around perceptions of future shortages for some roles. Both NGO and DHB respondents noted concerns about shortages for occupational therapists, clinical psychologists and nurses. NGOs were more likely to perceive shortages for community and residential support workers. DHBs were more likely to perceive shortages for consultant psychiatrists

Table E. 6. *Workforce roles perceived as having future shortage in the DHB and NGO adult mental health services (n=625 responses)*

Roles	DHB		NGO	
	Percentage expecting some or large shortage	Total responses	Percentage expecting some or large shortage	Total responses
Allied health professionals				
Occupational therapist	46.7	92	41.2	17
Clinical psychologist	50.5	93	70.0	10
Other psychologist	30.0	10	75.0**	4
Social worker	31.5	111	30.2	43
Addiction practitioner/clinician	50.0*	6	75.0	12
Dual diagnosis practitioner/co-existing problems clinician	83.3*	6	80.0**	5
Counsellor	10.0	10	33.3*	9
Educator/trainer	25.0	4	30.0	10
Medical and other professionals				
General practitioner	33.3*	9	-	2
House surgeon	40.0	20	-	1
Consultant psychiatrist	55.8	120	-	
Medical officer special scale	30.0	20	100.0**	2
Psychiatric registrar	63.0	46	50.0**	2
Liaison/consult liaison	-	7	-	1
Nursing professionals				
Registered nurse	65.4	156	60.6	66
Enrolled nurse	19.0	21	66.7**	3
Nurse practitioner/specialist/educator	32.8	61	20.0*	5
Workforce by ethnicity				

Roles	DHB		NGO	
	Percentage expecting some or large shortage	Total responses	Percentage expecting some or large shortage	Total responses
Māori staff for clinical roles	54.1	61	58.1	31
Pasifika staff for clinical roles	60.0	20	50.0	14
Asian staff for clinical roles	35.7	28	30.8	13
Support workers				
Community development worker	-	0	16.7*	6
Employment worker	-	0	61.5	13
Community support worker	15.2	33	58.7	155
Family support worker	-	2	60.0	25
Healthcare assistant	-	10	50.0**	2
Peer support – consumer	-	4	41.5	53
Peer support – family and whānau	-	0	60.0	10
Psychiatric assistant	17.4	23	-	0
Residential support worker	-	0	51.6	93
Cultural advice and support				
Cultural supervisor	20.0	10	18.2	11
Kaumātua	33.3	12	23.1	13
Kuia	25.0**	4	50.0*	6
Kaiāwhina	23.5	17	-	2
Traditional Māori health practitioner	100.0**	1	60.0*	5
Matua	50.0**	2	-	1
Pasifika cultural advisor	-	1	-	2
Other cultural advisor	15.4	13	40.0**	5
Administration and management				
Administrative/technical support	23.1	104	22.9	83
Senior manager	17.2	29	31.7	63
Clinical director	20.0	15	40.0*	5
Professional leader	-	11	22.2*	9
Service manager/team leader	18.4	87	30.9	162
Consumer advisor/consumer leader	25.0	12	43.8	16
Family/whānau advisor	30.8	13	25.0**	4
Workforce by ethnicity				
Māori staff for non-clinical roles	28.2	39	42.4	139
Pasifika staff for non-clinical roles	18.2	11	33.3	66
Asian staff for non-clinical roles	-	7	28.1	57

Note: * The numbers were between 5 and 10 FTEs . The percentage results need to be treated with caution.

** The numbers were under 5 FTEs. The percentages need to be treated with caution.

Workforce challenges

Table E. 7 uses mean scores to show DHB responses regarding workforce challenges by service types, showing the main service delivery service types (inpatient and residential, and community) separate from other service types which includes administration and management (but excludes forensic services which are allocated between inpatient and residential or community). This table indicates the variability of challenges experienced by the different service types. For example, increased complexity affects inpatient, residential and community service delivery types (1.9-2.1 mean ranking) far more than the other service types which are mainly management and administration services (1.1).

Table E. 7. *The biggest workforce challenges for DHB services (mean scores, n= 533 responses)*

Rating of challenges	DHB service type			
	Inpatient/ residential	Community	Other	Total
Managing pressure on staff due to increased demand for service	2.1	2.4	2.6	2.4
Managing pressure on staff due to increased complexity	2.1	1.9	1.1	1.8
Recruiting qualified and experienced staff	1.6	1.4	1.6	1.5
Managing pressure due to changing service delivery models	1.5	1.1	1.5	1.3
Retaining qualified and experienced staff	1.1	1.0	0.8	1.0
Static or reduced funds	0.5	0.7	1.2	0.8
Cost of training and other professional development	0.5	0.8	0.5	0.7

Table E. 8 uses mean scores to show NGO responses regarding workforce challenges by service types. This table indicates a small range of variability of challenges experienced across the different types of teams and services. For example, managing pressure on staff due to increased complexity affects inpatient, residential and community (1.5 to 1.8 mean ranking) far more than it affects those teams included under other (1.2). The other category includes management and administration teams.

Table E. 8. *The biggest workforce challenges for NGO services (mean scores, n= 533 responses)*

Rating of challenges	NGO types of team			
	Inpatient/ residential	Community	Other	Total
Static or reduced funds	2.0	2.0	2.2	2.0
Managing pressure on staff due to increased complexity	1.8	1.5	1.2	1.5
Managing pressure on staff due to increased demand for service	1.1	1.6	1.5	1.4
Recruiting qualified and experienced staff	1.6	1.3	1.0	1.3
Retaining qualified and experienced staff	1.3	1.3	1.2	1.3
Cost of training and other professional development	1.0	1.0	1.1	1.0
Managing pressure due to changing service delivery models	1.0	0.7	1.0	0.9

The following two tables show the percentage of DHB and NGO respondents that ranked the challenges in the top four by different service types .

Table E. 9. *Proportion of DHB respondents by service type identifying these in their top four workforce challenges (n=159 responses)*

Workforce challenges	Percentage DHB respondents ranking from 1-4					
	Inpatient (n=24)	Community (n=93)	Forensic (n=12)	Management (n=21)	Other (n=9)*	Total (n=159)
Cost of training and other professional development	33.3	37.6	33.3	23.8	33.3	34.6
Retaining qualified and experienced staff	54.2	40.9	41.7	28.6	44.4	41.5
Static or reduced funds	20.8	33.3	33.3	47.6	22.2	32.7
Recruiting qualified and experienced staff	70.8	59.1	66.7	66.7	55.6	62.3
Managing pressure on staff due to increased demand for service	75.0	76.3	58.3	85.7	88.9	76.7
Managing pressure due to changing service delivery models	66.7	48.4	41.7	61.9	44.4	52.2
Managing pressure on staff due to increased complexity	75.0	75.3	50.0	47.6	66.7	69.2

Note: *The total contributing responses is less than 10 for this service type . The percentages need to be treated with caution.

Table E. 10. *Proportion of NGO respondents by service type identifying these in their top four workforce challenges (n=374 responses)*

Workforce challenges	Percentage NGO respondents ranking from 1-4					
	Residential (n=101)	Community (n=176)	Forensic (n=6)*	Management (n=34)	Other (n=57)	Total (n=374)
Cost of training and other professional development	43.6	48.9	16.7	58.8	61.4	49.7
Retaining qualified and experienced staff	50.5	48.9	100.0	47.1	43.9	49.2
Static or reduced funds	63.4	63.6	50.0	76.5	68.4	65.2
Recruiting qualified and experienced staff	59.4	51.7	83.3	26.5	42.1	50.5
Managing pressure on staff due to increased demand for service	43.6	66.5	50.0	55.9	61.4	58.3
Managing pressure due to changing service delivery models	48.5	35.2	16.7	38.2	43.9	40.1
Managing pressure on staff due to increased complexity	71.3	59.7	83.3	50.0	49.1	60.7

Note: *The total contributing responses is less than 10 for this service type . The percentages need to be treated with caution.

Knowledge and skill needs

Table E. 11 shows number of respondents indicating some or large need for increase in knowledge and skills for each area and their relative proportion of the total responses received, differentiating DHB responses from NGO responses.

Table E. 11. *Percentage of responses for improvement in knowledge and skills by provider type (n= 627 responses)*

Knowledge and skills for mental health workforce	DHB n=192			NGO n=435		
	% increase needed			% increase needed		
	Some	Large	n	Some	Large	n
Working with Māori						
Knowledge and skills in whānau-centred practice (whānau ora)	73.4	8.9	158	60.5	13.1	320
Cultural competence for working with Māori	67.2	7.8	144	60.2	12.0	314
Cultural competence for working in te reo Māori me ōna tikanga (Māori language and custom)	57.8	19.3	148	50.8	20.9	312
Knowledge and skills in Māori models of engagement, eg pōwhiri process	67.7	7.3	144	54.0	13.6	294
Knowledge and skills in Māori models of health, eg Te Whare Tapa Whā, Te Pae Mahutonga, Te Wheke	59.4	13.0	139	55.9	12.2	296

Knowledge and skills for mental health workforce	DHB n=192			NGO n=435		
	% increase needed			% increase needed		
	Some	Large	n	Some	Large	n
Knowledge and skills in Māori health outcome measurement and assessment, eg Hua Oranga	58.9	18.2	148	48.5	21.6	305
Working with Pasifika						
Cultural competence for working with Pasifika ethnic groups	67.7	18.2	165	53.1	23.7	334
Knowledge of Pasifika cultural models of health	66.1	18.2	162	53.1	22.5	329
Confidence in one or more Pasifika languages	38.5	29.7	131	31.7	30.1	269
Knowledge and skills in the engagement process when working with Pasifika ethnic groups	65.1	17.7	159	53.3	22.5	330
Knowledge of Pasifika family values, structures, concepts	67.2	17.7	163	55.6	20.5	331
Knowledge of the basic concepts of tapu across a range of Pasifika cultures	65.6	19.8	164	51.5	23.4	326
Working with other groups						
Cultural competence for working with Asian ethnic groups	63.5	21.4	163	39.8	27.8	294
Working with children and young people	50.5	3.6	104	31.3	13.1	193
Working with older people	45.3	5.2	97	41.4	14.7	244
Working with families	57.3	4.7	119	44.1	14.3	254
Working collaboratively with other services and agencies	55.7	5.2	117	40.2	14.3	228
Other						
Able to respond readily to changes in type of work	69.8	7.3	148	48.3	10.1	254
Supporting use of peer support	53.6	7.3	117	43.2	11.3	237
Knowledge and use of relevant legislation, regulations, standards, codes and policies	52.6	4.7	110	53.8	11.5	284
Working with new technologies and IT	68.8	21.9	174	56.8	19.1	330
Knowledge of community resources available in your area	47.9	3.6	99	42.5	6.9	215
Risk assessment (including suicidality)	57.8	6.3	123	57.0	9.4	289
Physical health assessment	54.7	15.1	134	40.2	12.9	231
Screening and brief interventions, eg use of AUDIT tool, sleep hygiene education	53.1	11.5	124	39.5	13.1	229
Psychological interventions, eg cognitive behavioural therapy, social network, mindfulness, motivational approaches	56.8	16.7	141	48.0	15.9	278

Knowledge and skills for mental health workforce	DHB n=192			NGO n=435		
	% increase needed			% increase needed		
	Some	Large	n	Some	Large	n
Supporting self-managed care (including online options, 12-step programmes and sensory modulation)	55.7	16.7	139	50.6	14.3	282
Co-existing problems capability	59.9	24.0	161	51.3	21.6	317
Using strengths-based approaches to enhance resiliency and recovery with consumers	60.9	5.7	128	52.0	9.9	269
Using outcome measures, eg HONOS, Hua Oranga	51.0	12.5	122	41.4	17.5	256
Promotion of restraint and seclusion reduction initiatives	50.0	7.3	110	21.6	6.7	123

The following two tables provide a break-down of the responses across the different options of some, large, non-applicable and unknown for the DHB and NGO survey responses.

Table E. 12. *Knowledge and skill needs responses by DHB survey respondents (%) (n=192 responses)*

Knowledge and skills	No increase/ don't know (%)	Some increase needed (%)	Large increase needed (%)	Not applicable (%)	Total (%)
Working with Māori					
Knowledge and skills in whānau-centred practice (whānau ora)	16.7	73.4	8.9	1.0	100
Cultural competence for working with Māori	24.0	67.2	7.8	1.0	100
Cultural competence for working in te reo Māori me ōna tikanga (Māori language and custom)	18.8	57.8	19.3	4.2	100
Knowledge and skills in Māori models of engagement, eg pōwhiri process	22.4	67.7	7.3	2.6	100
Knowledge and skills in Māori models of health, eg Te Whare Tapa Whā, Te Pae Mahutonga, Te Wheke	25.0	59.4	13.0	2.6	100
Knowledge and skills in Māori health outcome measurement and assessment, eg Hua Oranga	14.1	58.9	18.2	8.9	100
Working with Pasifika					
Cultural competence for working with Pasifika ethnic groups	10.9	67.7	18.2	3.1	100
Knowledge of Pasifika cultural models of health	12.0	66.1	18.2	3.6	100
Confidence in one or more Pasifika languages	17.7	38.5	29.7	14.1	100
Knowledge and skills in the engagement process when working with Pasifika ethnic groups	12.5	65.1	17.7	4.7	100
Knowledge of Pasifika family values, structures, concepts	12.0	67.2	17.7	3.1	100

Knowledge and skills	No increase/ don't know (%)	Some increase needed (%)	Large increase needed (%)	Not applicable (%)	Total (%)
Knowledge of the basic concepts of tapu across a range of Pasifika cultures	10.9	65.6	19.8	3.6	100
Working with other groups					
Cultural competence for working with Asian ethnic groups	11.5	63.5	21.4	3.6	100
Working with children and young people	31.3	50.5	3.6	14.6	100
Working with older people	37.0	45.3	5.2	12.5	100
Working with families	35.9	57.3	4.7	2.1	100
Other					
Working collaboratively with other services and agencies	37.5	55.7	5.2	1.6	100
Able to respond readily to changes in type of work	22.9	69.8	7.3	0.0	100
Supporting use of peer support	36.5	53.6	7.3	2.6	100
Knowledge and use of relevant legislation, regulations, standards, codes and policies	42.7	52.6	4.7	0.0	100
Working with new technologies and IT	9.4	68.8	21.9	0.0	100
Knowledge of community resources available in your area	47.4	47.9	3.6	1.0	100
Risk assessment (including suicidality)	33.3	57.8	6.3	2.6	100
Physical health assessment	26.0	54.7	15.1	4.2	100
Screening and brief interventions, eg use of AUDIT tool, sleep hygiene education	31.3	53.1	11.5	4.2	100
Psychological interventions, eg cognitive behavioural therapy, social network, mindfulness	24.5	56.8	16.7	2.1	100
Supporting self-managed care (including online options, 12-step programmes and sensory modulation)	23.4	55.7	16.7	4.2	100
Co-existing problems capability	14.1	59.9	24.0	2.1	100
Using strengths-based approaches to enhance resiliency and recovery with consumers	31.8	60.9	5.7	1.6	100
Using outcome measures, eg HoNOS, Hua Oranga	33.9	51.0	12.5	2.6	100
Promotion of restraint and seclusion reduction initiatives	24.0	50.0	7.3	18.8	100

Table E. 13. *Knowledge and skill needs responses by NGO survey respondents (%) (n=435 responses)*

Knowledge and skills	No increase/don't know (%)	Some increase needed (%)	Large increase needed (%)	Not applicable (%)	Total (%)
Working with Māori					
Knowledge and skills in whānau-centred practice (whānau ora)	21.8	60.5	13.1	4.6	100
Cultural competence for working with Māori	25.7	60.2	12.0	2.1	100
Cultural competence for working in te reo Māori me ōna tikanga (Māori language and custom)	22.1	50.8	20.9	6.2	100
Knowledge and skills in Māori models of engagement, eg pōwhiri process	29.4	54.0	13.6	3.0	100
Knowledge and skills in Māori models of health, eg Te Whare Tapa Whā, Te Pae Mahutonga, Te Wheke	29.0	55.9	12.2	3.0	100
Knowledge and skills in Māori health outcome measurement and assessment, eg Hua Oranga	21.6	48.5	21.6	8.3	100
Working with Pasifika					
Cultural competence for working with Pasifika ethnic groups	18.4	53.1	23.7	4.8	100
Knowledge of Pasifika cultural models of health	19.1	53.1	22.5	5.3	100
Confidence in one or more Pasifika languages	26.7	31.7	30.1	11.5	100
Knowledge and skills in the engagement process when working with Pasifika ethnic groups	18.2	53.3	22.5	6.0	100
Knowledge of Pasifika family values, structures, concepts	18.4	55.6	20.5	5.5	100
Knowledge of the basic concepts of tapu across a range of Pasifika cultures	19.1	51.5	23.4	6.0	100
Working with other groups					
Cultural competence for working with Asian ethnic groups	27.1	39.8	27.8	5.3	100
Working with children and young people	30.3	31.3	13.1	25.3	100
Working with older people	34.5	41.4	14.7	9.4	100
Working with families	35.9	44.1	14.3	5.7	100
Other					
Working collaboratively with other services and agencies	44.4	40.2	12.2	3.2	100
Able to respond readily to changes in type of work	38.9	48.3	10.1	2.8	100
Supporting use of peer support	40.0	43.2	11.3	5.5	100
Knowledge and use of relevant legislation, regulations, standards, codes and policies	33.8	53.8	11.5	0.9	100
Working with new technologies and IT	22.8	56.8	19.1	1.4	100

Knowledge and skills	No increase/don't know (%)	Some increase needed (%)	Large increase needed (%)	Not applicable (%)	Total (%)
Knowledge of community resources available in your area	48.5	42.5	6.9	2.1	100
Risk assessment (including suicidality)	25.1	57.0	9.4	8.5	100
Physical health assessment	25.1	40.2	12.9	21.8	100
Screening and brief interventions, eg use of AUDIT tool, sleep hygiene education	26.0	39.5	13.1	21.4	100
Psychological interventions, eg cognitive behavioural therapy, social network, mindfulness	16.3	48.0	15.9	19.8	100
Supporting self-managed care (including online options, 12-step programmes and sensory modulation)	15.2	50.6	14.3	20.0	100
Co-existing problems capability	16.3	51.3	21.6	10.8	100
Using strengths-based approaches to enhance resiliency and recovery with consumers	32.2	52.0	9.9	6.0	100
Using outcome measures, eg HoNOS, Hua Oranga	21.6	41.4	17.5	19.5	100
Promotion of restraint and seclusion reduction initiatives	24.1	21.6	6.7	47.6	100

Cross-sector relationships

The following tables describe the proportion of DHB and NGO respondents indicating a need to improve relationships with other services and sectors for each of the different service types included in the survey.

Table E. 14. *Proportion of DHB respondents indicating a need to improve relationships with other sectors*

Cross-sector relationships	Percentage DHB respondents indicating a need for improvement by type of team						No of. responses
	Inpatient	Community	Forensic	Management	Other	Total	
Child and adolescent mental health services	2.0	12.9	1.4	2.0	0.7	19.0	147
Child Youth & Family	3.3	18.7	-	2.4	-	24.4	123
Corrections	4.7	14.0	-	1.6	0.8	20.9	129
Disability sector	8.6	23.2	0.7	3.3	2.6	38.4	151
Education	2.5	14.2	0.8	3.3	2.5	23.3	120
Family violence	4.9	16.7	1.9	0.6	2.5	26.5	162
General hospitals/emergency departments	5.6	15.3	4.5	0.6	0.6	26.6	177
Housing New Zealand/accommodation providers	9.3	15.5	2.5	3.1	0.6	31.1	161
Mental health service for older people	5.8	13.7	-	0.7	2.2	22.3	139
Police	2.4	7.2	0.6	0.6	0.6	11.4	166
Primary health practices	4.7	22.7	-	2.3	1.7	31.4	172
Relationship services	2.6	12.9	-	0.9	-	16.4	116
Work & Income	3.2	14.1	0.6	0.6	1.3	19.9	156
Other mental health services	1.1	8.6	1.1	1.1	0.5	12.4	185
Other addiction services	2.3	15.3	0.6	1.7	0.6	20.5	176

Table E. 15. *Proportion of NGO respondents indicating a need to improve relationships with other sectors*

Cross-sector relationships	Percentage NGO respondents indicating a need for improvement by type of team						No of responses
	Inpatient	Community	Forensic	Management	Other	Total	
Child and adolescent mental health services	2.6	20.0	-	1.9	5.8	30.3	155
Child Youth & Family	3.4	17.7	-	2.3	4.6	28.0	175
Corrections	4.1	11.9	0.8	1.2	6.6	24.6	244
Disability sector	7.9	14.1	0.7	2.4	3.8	29.0	290
Education	5.9	12.6	0.8	3.5	5.9	28.7	254
Family violence	6.0	13.3	0.8	2.0	2.4	24.6	248
General hospitals/Emergency departments	5.5	10.1	0.9	1.5	3.1	21.1	327
Housing New Zealand/accommodation providers	7.8	13.4	1.2	0.6	3.9	26.9	335
Mental health service for older people	8.5	13.5	0.8	1.5	3.8	28.1	260
Police	3.7	4.5	0.9	1.1	2.8	13.1	352
Primary health practices	6.1	9.7	0.5	1.8	4.5	22.6	380
Relationship services	4.1	14.2	0.9	0.9	1.8	21.9	219
Work & Income	7.8	10.9	0.5	1.0	3.4	23.6	386
Other mental health services	3.1	5.0	0.5	0.5	2.9	12.0	417
Other addiction services	6.6	8.2	0.5	1.9	4.8	22.1	376

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