

Adult addiction workforce

MORE THAN
NUMBERS

Adult addiction workforce

2014 survey of Vote Health funded services



Te Pou
o Te Whakaaro Nui

Matua Raki
National Addiction Workforce Development

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Addiction services' workforce summary

Addiction services are provided by district health board organisations (DHBs) and non-government organisations (NGOs), and across the domains of the Corrections Department, Whānau Ora and primary care. These services are funded by a range of government sectors including the Ministry of Health, Corrections Department, Ministry of Social Development, and by philanthropic and private sources.

Within the health sector, changes to the future direction and delivery of addiction services were signalled in *Rising to the Challenge: The mental health and addiction service development plan 2012–2017* (Ministry of Health, 2012b). These changes include refocusing services towards addressing currently unmet needs across the life-span, and promoting self-care, resilience and recovery through well integrated community and primary care services.

Meeting these goals will require changes to service delivery models, the size and composition of the workforce, and to the way services interact with each other and consumers. Implementing such wide-ranging changes across services will require a workforce planning approach that uses quality workforce information in a systematic way. Such approaches should predict future service delivery patterns and needs, and identify the resources needed to meet those future demands (Te Pou o Te Whakaaro Nui, 2014b).

To support workforce planning and development, in 2014 Te Pou and Matua Raki undertook the *More than numbers* organisation workforce survey of adult addiction and mental health services.¹ The survey aimed to describe the size, distribution and configuration of the Vote Health funded adult mental health and addiction services' workforce as at 1 March 2014, and to understand current and future workforce challenges, knowledge and skill needs, the strength of relationships within and across sectors, and wait list management.

Overview of the workforce

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).

- Alcohol and other drug (AOD) and problem gambling services employed 1,771 people in 1,504 FTE positions (employed plus vacant).
- Combined mental health and addiction (MH&A) services employed 614 people in 559 FTE positions.²
- Mental health services employed 8,460 people in 7,274 FTE positions.
- The majority of these positions were funded by Vote Health (96 per cent).

¹ This survey is phase one of the *More than numbers* workforce stocktake of adult addiction and mental health services. More information about the project can be found on the Te Pou website at www.tepou.co.nz/morethannumbers.

² 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).

This report focuses on the survey results for the Vote Health funded workforce in adult addiction services,³ including:

- AOD services (1,215 FTE positions)
- problem gambling services (101 FTEs)
- combined mental health and addiction (MH&A) services (516 FTEs).

Of the organisations invited to participate in the survey, 17 DHBs and 77 NGOs had Vote Health contracts to deliver AOD or problem gambling services. Surveys identifying addiction services were completed by:

- all 17 DHBs
- 57 out of 77 NGOs (74 per cent).

The following sections summarise the size, composition and distribution of the adult addiction services' workforce reported to the survey.

Workforce size and services delivered

This section summarises the overall results for the Vote Health funded workforce in adult addiction services by size and services delivered.

DHBs reported 53 per cent of the workforce (976 FTE positions) and NGOs reported 47 per cent (755 FTE positions). NGOs reported the entire problem gambling services workforce.

The workforce in addiction services was distributed across a number of different types of services. They are reported here in five main service types.

- Community services reported 67 per cent of the adult addiction services workforce.
- Residential and inpatient services reported 18 per cent.
- Problem gambling services reported 5 per cent.
- Administration and management services reported 9 per cent.
- Other services reported 1 per cent.

Of the ethnic-specific services reported to the survey:

- kaupapa Māori services reported a workforce of 266 FTE positions (employed plus vacant)
- Pasifika services reported 44 FTE positions
- Asian specific services reported 13 FTE positions.

Occupational groups and roles

Clinical roles made up 63 per cent of the total FTE positions across addiction services. The most common clinical roles in this workforce were:

³ Reports for the national mental health workforce, the national mental health and addiction workforce, and regional and DHB locality reports are available from www.tepou.co.nz/morethannumbers.

- addiction practitioners (30 per cent of the clinical role workforce)
- registered nurses (28 per cent)
- dual diagnosis practitioners (10 per cent).

Non-clinical roles made up 17 per cent of the total workforce across addiction services. The most common non-clinical roles in this workforce were:

- community support workers (25 per cent of the workforce in non-clinical roles)
- residential support workers (25 per cent)
- peer support – consumer and service users (12 per cent).

Management and administration roles comprised 20 per cent of the adult addiction workforce.

Of the total adult addiction workforce (1,832 FTE positions):

- 1,766 FTE positions were currently employed on 1 March 2014
- 66 FTE positions were vacant (4 per cent of the workforce).

Of those vacant positions:

- 63 per cent were reported by DHB provider arm services
- 37 per cent were reported by NGO services, including all problem gambling vacancies which comprised 9 per cent of problem gambling services workforce.

DHB adult addiction services' workforce

DHB services reported 53 per cent of this workforce (976 FTE positions employed plus vacant).

- Employed roles comprised 934 FTE positions.
- Vacant roles comprised 42 FTE positions.

The reported DHB adult addiction workforce was comprised of:

- 72 per cent in clinical roles, including;
 - registered nurse roles (37 per cent of the DHB clinical workforce)
 - dual diagnosis practitioners and co-existing problems clinicians (13 per cent)
 - addiction practitioner or clinicians (12 per cent)
- 7 per cent in non-clinical roles, including:
 - psychiatric assistants (37 per cent of the non-clinical workforce)
 - community support workers (22 per cent)
 - healthcare assistants (15 per cent)
- administration and management roles (21 per cent of the DHB workforce).

NGO adult addiction services' workforce

NGO services reported 47 per cent of the workforce (755 FTE positions employed plus vacant).

- Employed roles comprised 731 FTE positions.
- Vacant roles comprised 24 FTE positions.

The reported NGO adult addiction workforce was comprised of:

- 47 per cent in clinical roles, including:
 - addiction practitioners and clinicians (71 per cent of the NGO clinical workforce)
 - registered nurse roles (10 per cent)
 - counsellor roles (7 per cent)
- 33 per cent in non-clinical roles, including:
 - residential support workers (33 per cent of NGO non-clinical positions)
 - community support workers (26 per cent)
- administration and management roles (20 per cent of the 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.

Māori representation in the addiction workforce (23 per cent) was high compared to the adult Māori population (12 per cent). However, Māori representation as consumers of AOD services was higher than representation in the AOD workforce overall (33 per cent compared to 22 per cent overall). NGO AOD services reported twice the rate of Māori representation in their clinical workforce compared to DHBs (32 per cent compared to 15 per cent). Problem gambling services reported that 24 per cent of the workforce was Māori compared to 31 per cent of consumers.

Pasifika representation in the addiction workforce overall (6 per cent) was similar to the Pasifika adult population (6 per cent), AOD consumers and AOD workforce (both 6 per cent). Results for problem gambling services differed, with 11 per cent of the workforce identified as Pasifika compared to 20 per cent of consumers. DHB AOD services reported slightly higher representation of Pasifika in their workforce than NGO AOD services (7 per cent and 6 per cent respectively).

Asian representation in the addiction workforce overall (4 per cent) was lower than in the adult population (13 per cent). Asian representation in the AOD workforce was 4 per cent, and was 2 per cent of consumers. Results for problem gambling services differed, with 24 per cent of the workforce identified as Asian compared to 7 per cent of consumers.

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 three-quarters of respondents from addiction services identified the need to increase workforce cultural competence across most areas relating to working with Māori, Pasifika and Asian ethnic groups. AOD and MH&A services commonly identified the need to increase skills in whānau-centred practice. Problem gambling services most commonly identified the need to increase skills in Māori health outcome measurement.

Workforce and service challenges

The following sections summarise results for questions related to workforce planning and development needs and issues.

Recruitment and retention issues

Overall, addiction services most commonly expected recruitment and retention issues in the next two years for addiction practitioner (80 per cent of respondents), dual diagnosis practitioner (70 per cent), registered nurse (67 per cent), clinical psychologist (65 per cent), and community support worker (52 per cent) roles. All three sector groups reported concerns about finding Māori staff to fill clinical roles, and NGO MH&A services were also concerned about finding Māori staff to fill non-clinical roles.

Workforce development and service challenges

The most commonly identified top four workforce planning and development challenges included managing pressure on staff due to increased demand for service (67 per cent of respondents) and increased complexity (60 per cent), alongside static or reducing funds (54 per cent) and recruiting qualified and experienced staff (51 per cent).

Knowledge and skill levels

Respondents working across adult addiction services reported that in the next two years increases were needed in a number of areas in the policy- and practice-related knowledge and skills of their workforce. For example, more than three-quarters of respondents identified the need to increase workforce knowledge and skills relating to working with new technologies and IT (79 per cent of respondents) and co-existing problems capability (77 per cent).

Cross-sector relationships

Generally, more respondents indicated that relationships with other agencies and sectors needed to improve than thought these were working well. Relationships that were most likely to be identified as working well included those with other addiction services (56 per cent of respondents), the Corrections Department (49 per cent) and other mental health services (33 per cent).

Respondents were most likely to report the need to improve relationships with Housing New Zealand Corporation and other accommodation providers (46 per cent of respondents), mental health services for older people (40 per cent) and general hospitals and emergency departments (30 per cent).

Wait list management

AOD and problem gambling services were asked about wait list prevention and management. Nearly half of respondents reported managing a wait list. Key actions taken to prevent, reduce or manage a wait list (by both those with wait lists and the 52 per cent without wait lists) included internal triage (56 per cent of respondents), referral to self-help groups or the peer support workforce (56 per cent), providing pamphlets and information (54 per cent) and prioritisation in multi-disciplinary team meetings (50 per cent).

Conclusion

This report presents the results for the Vote Health funded workforce reported by 17 DHBs and 57 NGOs delivering adult AOD services, problem gambling services and MH&A services.⁴

It provides a snapshot of the addiction services' workforce within the health sector; by services provided, occupational groups and roles. The *More than numbers* organisation workforce survey builds on the valuable picture of the AOD and wider addiction services' workforce gained through previous workforce stocktakes and

⁴ 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.

surveys including the 1998 and 2004 national telephone sampling surveys (Adamson, Deering, Schroder, Townshend, & Ditchburn, 2009), and the 2010 and 2011 workforce surveys conducted by Matua Raki.

The *More than numbers* survey results reported here will support workforce planning for the future of adult addiction services by providing a starting point for analysing changes over time. The workforce information that has been collected through this survey is intended to be used to inform future-focused service development and workforce development activities undertaken by a number of different stakeholders.

This report describes the workforce reported to the survey by addiction services. Some 26 percent of the NGOs with addiction contracts 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 addiction services is under-reported by approximately 15 per cent.

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 addiction and mental health 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.

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1.0 Introduction

1.1 Addiction service context

Addiction treatment services work to reduce the burden caused by alcohol and drug use, and by problem gambling. Currently, alcohol and other drug abuse is the sixth highest contributor to the burden of disease in New Zealand (National Committee for Addiction Treatment, 2011, p. 2). Likewise, in New Zealand problem gambling is an issue that causes substantial problems for those who gamble and their families, whānau, employers and wider communities (Ministry of Health, 2012c, p. 1). As the health needs of New Zealanders change, challenges are created for the delivery of health services, including the way that addiction treatment is delivered and by whom.

In the past 40 years, the addiction sector's services and workforce have undergone significant changes. Early workers were often volunteers practicing on the basis of their own life experiences. From the 1970s multiple small, semi-professional non-government organisations (NGOs) supported consumers, usually with a local, abstinence-based focus. Services were invariably under-resourced, and operated in relative isolation from the health, welfare and justice sectors. Today, these services are provided by district health boards (DHBs) and non-government organisations (NGOs), and within the domains of the Corrections Department, Whānau Ora and primary care. Services are now funded by a range of government sectors including the Ministry of Health, Corrections Department, Ministry of Social Development, and by philanthropic and private sources.

Rising to the Challenge: The mental health and addiction service development plan 2012–2017 (Ministry of Health, 2012b) signals changes to the future direction and delivery of addiction services within the health sector. These changes include refocusing services towards addressing currently unmet needs across the life-span, and promoting self-care, resilience and recovery through well integrated community and primary care services. Meeting these goals will require changes to service delivery models, the size and composition of the workforce, and to the way that services interact with each other and consumers. Implementing such wide-ranging changes will require a workforce planning approach that uses quality workforce information in a systematic way to predict future service delivery patterns and needs, and identify the resources needed to meet those future demands (Te Pou o Te Whakaaro Nui, 2014b).

To support workforce planning and development, this report presents results for adult addiction services from the 2014 *More than numbers* organisation workforce survey of adult addiction and mental health services.⁵ The survey has the following aims.

1. To understand the workforce delivering services in:
 - a. the DHB provider arm
 - b. NGOs contracted by the Ministry of Health and DHBs.
2. To describe, in relation to services offered by DHB region and locality, the workforce size and composition in terms of roles and ethnicity.

⁵ This survey is phase one of the More than numbers workforce stocktake of adult addiction and mental health services. More information about the project can be found on the Te Pou website at www.tepou.co.nz/morethannumbers.

3. To understand current and future workforce challenges, knowledge and skill needs, and cross-sector relationships.

The survey results will assist the Ministry of Health, Health Workforce New Zealand and others to assess current workforce capacity, and are intended to support workforce planning and development at local, regional and national levels. The World Health Organization describes the goal of health workforce planning as having “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).

Workforce planning occurs in the context of changing consumer demographics, changing models of care, increased technological input and emphasis on evidence-based practice. Good workforce planning requires a whole of systems approach, focusing on the changes needed for individuals, organisations and environments to effectively deliver planned new models of care within and across organisations, sectors and regions.

Te Pou has developed a systematic approach to workforce planning, *Getting it Right – Workforce planning guide* (Te Pou o Te Whakaaro Nui, 2014a), that comprises six steps. Each step provides the information and structure that is essential for moving to the next step effectively, see Figure 1.⁶

The *More than numbers* survey results discussed in this report profile the current workforce, providing essential information for steps three and four of this workforce planning approach. Understanding the size, distribution and composition of the existing workforce, and its current challenges, will support plans for moving beyond reproducing the status quo to identifying pathways populated by the right mix of skills and capability to meet the aims described in *Rising to the Challenge*.

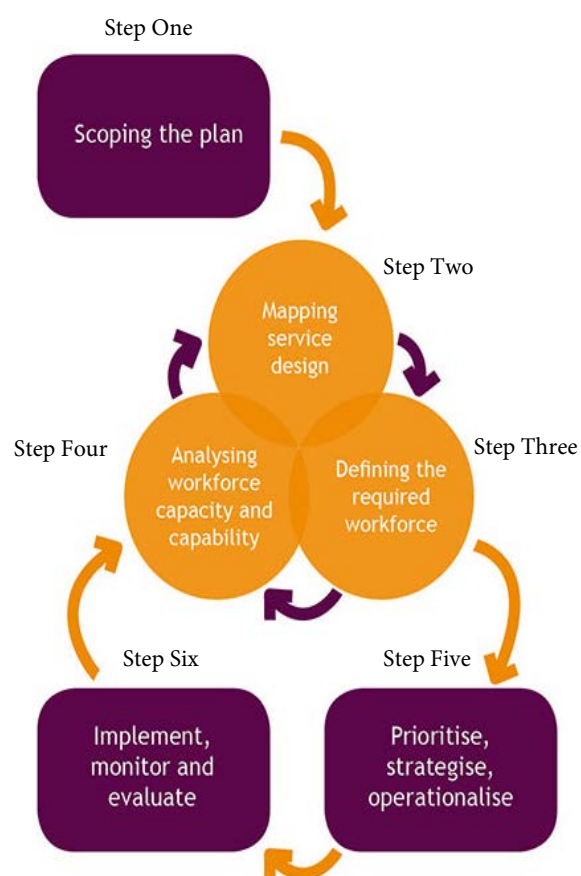


Figure 1. A six-step workforce planning approach (Te Pou o Te Whakaaro Nui, 2014a).

⁶ The six steps have been adapted from the *Six Steps Methodology to Integrated Workforce Planning* (Cannon, Catherwood, Sandilands, & Wylie, n.d.) and draws significantly on the work of the National Health Service Scotland (Skills for Health – Workforce Projects Team, 2008).

1.2 Reports in this series

This report presents the *More than numbers* organisation workforce survey results for the national addiction services' Vote Health funded workforce. For the purposes of this report, 'addiction services' include the following services delivered by DHBs and NGOs with health contracts.⁷

- Alcohol and other drug (AOD) services.
- Problem gambling 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 entire workforce reported to the survey, and estimates the total workforce size and distribution with analyses against population, funding, service demand and projected future demand. In addition, this report gives an overview of previous surveys of the addiction workforce in the past decade.⁹
- *Adult mental health workforce: 2014 survey of Vote Health funded services* presents the results for the national adult mental health services' Vote Health funded workforce.¹⁰

There are also four reports presenting survey results for mental health and addiction services in each DHB region, and 20 reports presenting results for each DHB locality.¹¹ Summary reports related to particular sections of the workforce have also been developed.¹²

A visual summary of the national survey results for the AOD and problem gambling workforce is available. There is also a visual summary of the national mental health and addiction workforce and four regional mental health and addiction workforce summaries.

1.3 Summary of survey responses

All DHBs (20) 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.¹³ Of these organisations, 17 DHBs and 77 NGOs had contracts to deliver AOD or problem gambling services.¹⁴ Surveys identifying addiction services were completed by:

⁷ Other reports in this series may report addiction services as including only AOD and problem gambling services, see Section 1.2.

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

⁹ Workforce information 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 (see Appendix D: About population, funding and service provision for adult mental health and addiction services).

¹⁰ The results for MH&A services are also included in this report.

¹¹ These reports describe addiction services including AOD and problem gambling services only. The MH&A services' results are integrated with mental health services. Reports are available from the Te Pou website www.tepou.co.nz/morethannumbers.

¹² Reports are available from the Te Pou o Te Whakaaro Nui Ltd website www.tepou.co.nz/morethannumbers.

¹³ 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.

¹⁴ The funding information received from the Ministry of Health did not specify any contracts for MH&A services, however a number of organisations reported to the survey that their workforce delivered MH&A services.

- all 17 DHBs
- 57 NGOs (74 per cent).

The DHBs and NGOs that completed surveys for addiction services received 95 per cent of the 2012/13 Vote Health funding for AOD and problem gambling services. The 57 NGOs that completed the survey received 89 per cent of the NGO funding for Vote Health addiction service contracts.

Organisations were asked to provide survey returns for each team or service in a local DHB area to enable workforce data to be presented at the local and regional level. The results reported here are based on 192 survey responses.¹⁵

- 133 from AOD services.
- 18 from problem gambling services.
- 41 from MH&A 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.¹⁶

There were a number of challenges to identifying addiction services' results from a survey of adult addiction and mental health services. 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 addiction roles. To minimise the likelihood that the addiction workforce might be unnecessarily inflated with mental health roles, this group of surveys was reduced to those services whose organisations were contracted to deliver AOD or problem gambling services and mental health services,¹⁷ and is reported here as combined mental health and addiction (MH&A) services.

Of the NGOs with addiction contracts that were invited to participate in the survey, 26 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 addiction services' workforce is approximately 18 per cent greater than that reported to the survey.

While all DHBs with addiction contracts responded to the survey, there may be some over- or under-reporting of workforce positions and under-reporting of the range of addiction services delivered.

¹⁵ The 189 organisations returning surveys provided 808 responses in total, of these 616 responses related to mental health services.

¹⁶ The limitations to this survey are fully described in Appendix B.

¹⁷ The method for allocating services to the MH&A group is fully described in the limitations to this report, in Appendix B. It should be noted that the survey did not identify integrated addiction and mental health services.

The addiction sector is funded from a variety of sources. While survey respondents were asked to identify their non-Vote Health funded workforce, the results suggest this has not been fully captured. This report is therefore focused on reporting results for the Vote Health funded workforce.

More information about the survey methodology and limitations is provided in Appendix B.

1.5 Categories used for reporting

This report presents survey results for addiction services in total and, where appropriate, itemises results for each of the component service groups (AOD, problem gambling and MH&A). At the end of each chapter is a summary in which the significant similarities and differences between these groups are highlighted.

The following chapters report the survey results in the following three categories, which are explained in more detail below.

1. Provider and sector groups.
2. Service type groups.
3. Occupational groups.

Provider and sector groups

In this report we describe the workforce findings in terms of provider types, being DHBs and NGOs, and within three sector groups.

- AOD services, including dual diagnosis and co-existing problems services.
- Problem gambling services.
- MH&A services.

Analyses have been conducted in the following combinations.

- DHB provider arm AOD services (DHB AOD).
- DHB provider arm combined addiction and mental health services (DHB MH&A).
- NGO AOD services (NGO AOD).
- NGO combined addiction and mental health services (NGO MH&A).
- Problem gambling services (NGO PG).

Service type groups

Results are also reported in service type groups, based upon the predominant type of service provided by the workforce. These service types are summarised into the following groups (the glossary to this report shows the services allocated to each group).

- Community.
- Residential and inpatient.
- Management, administration and support.¹⁸
- Other.

Occupation groups

The report also summarises the workforce by roles within three occupation groups.

- Clinical.
- Non-clinical.
- Administration and management.

1.6 Chapter outline

This report presents results from the 2014 *More than numbers* organisation workforce survey of adult addiction services. The chapters present the following information and analysis in relation to the survey results.

Chapter 1 introduces the report, summarises the survey method and limitations, and describes the reporting method and chapter outline. It finishes with an overview of the survey results for the total adult addiction and mental health workforce, including both the Vote Health funded and non-health funded workforce.

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

Chapter 3 focuses on the results for Vote Health funded workforce ethnicity and cultural competence. Section 3.1 profiles the ethnicity of the workforce, describing Māori, Pasifika and Asian representation across different provider and sector groups, and services provided. Section 3.2 presents the results for the 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

¹⁸ The management, administration and support category is described in Chapter 3.

- knowledge and skill development needs in key policy and practice areas
- cross-sector relationships
- wait list management (AOD and problem gambling services only).

Chapters 2 to 4 present results for the Vote Health funded workforce in addiction services. Where appropriate, these chapters first summarise the results for all addiction services (providing total results for AOD, problem gambling and MH&A services). The subsequent sections summarise separately the results for AOD, problem gambling and MH&A services.

The concluding Chapter 6 summarises the highlights and significant survey results for the addiction workforce.

1.7 Overview of adult addiction and mental health services' workforce

To provide context to the results for addiction services, this section describes the overall *More than numbers* survey results for adult addiction and mental health services. These results include the Vote Health funded workforce and the workforce reported as funded from other sources of income (non-health funded workforce).¹⁹

The survey collected information from:

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

The main survey findings for the total addiction and mental health workforce are summarised below.

- A total of 10,845 people were employed across all services. Of this group:
 - 1,771 people were employed in AOD and problem gambling services
 - 614 were employed in MH&A services
 - 8,460 people were employed in mental health services.
- The total workforce reported to the survey was 9,337 FTE positions (employed plus vacant) including:
 - 8,929 FTE positions funded by Vote Health
 - 408 FTE positions funded from other sources of income.²⁰
- The AOD and problem gambling workforce totalled 1,504 FTE positions. This workforce was comprised of:
 - 1,317 FTE positions funded through Vote Health
 - 188 FTE positions funded through other sources of income.

¹⁹ 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.

²⁰ Sector intelligence suggests that the non-health funded workforce has been generally under-reported to the survey, particularly for addiction services.

- The MH&A workforce totalled 559 FTE positions. This workforce was comprised of:
 - 516 FTE positions funded through Vote Health
 - 43 FTE positions funded through other sources.
- The mental health workforce totalled 7,274 FTE positions. This workforce was comprised of:
 - 7,097 FTE positions funded through Vote Health
 - 177 FTE positions funded through other sources.

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 sector group.²¹

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

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

The Vote Health funded workforce reported to the survey totalled 8,929 FTE positions. The addiction workforce reported here comprised 21 per cent of this workforce (1,832 FTE positions employed plus vacant).

- Adult AOD and problem gambling services comprised 15 per cent (1,317 FTE positions employed plus vacant) of the total workforce reported to the survey.
- Adult MH&A services comprised 6 per cent (516 FTE positions).
- Adult mental health services comprised 79 per cent (7,097 FTE positions).

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 AOD services and mental health 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 AOD and problem gambling services, MH&A services, and mental health services with their relative proportion of the reported workforce for each region.

²¹ 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.

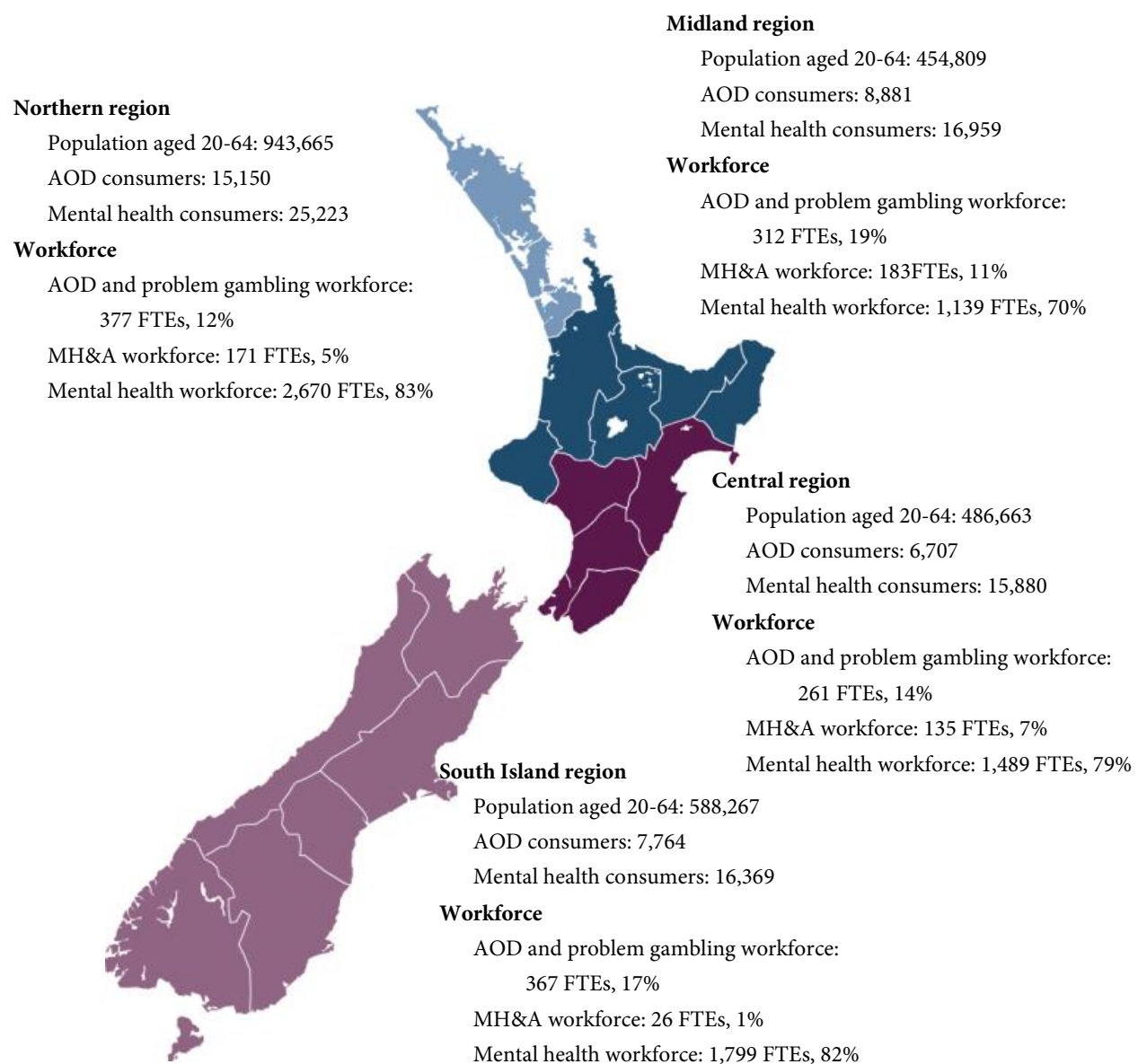


Figure 2. Distribution of the Vote Health funded workforce for adult addiction and mental health services by the four DHB regions

2.0 Adult addiction services' workforce

This chapter provides information about the Vote Health funded adult addiction services' workforce. The information provided here describes survey results received from:

- AOD services (including dual diagnosis and co-existing problems services)
- problem gambling services
- MH&A services.²²

DHBs and NGOs completing the survey identified a workforce of 1,832 FTE positions (employed plus vacant), including:

- 1,215 FTE positions in AOD services (67 per cent)
- 101 FTEs in problem gambling services (5 per cent)
- 516 FTEs in MH&A services (29 per cent).

This chapter summarises the characteristics of this workforce by provider and sector, occupational groups and workforce roles. The first section describes the number of organisations reporting addiction services. The second section describes the workforce by provider types and service sector groups. The third section describes the occupational groups and roles in the workforce and the last section outlines the roles and FTE positions vacant.

2.1 Workforce reported by DHBs and NGOs

The addiction workforce as at 1 March 2014 was 1,832 FTE positions (employed plus vacant), of which 66 FTEs were vacant (4 per cent).

- DHB provider arm services reported 53 per cent of the workforce (976 FTEs employed plus vacant).
- NGO services reported 47 per cent of the workforce (856 FTEs), including the entire workforce for problem gambling services (101 FTEs).

Figure 3 shows the distribution of the workforce between DHBs and NGOs.

²² This and subsequent chapters use groups and categories that are outlined in the reporting categories section of the Introduction.

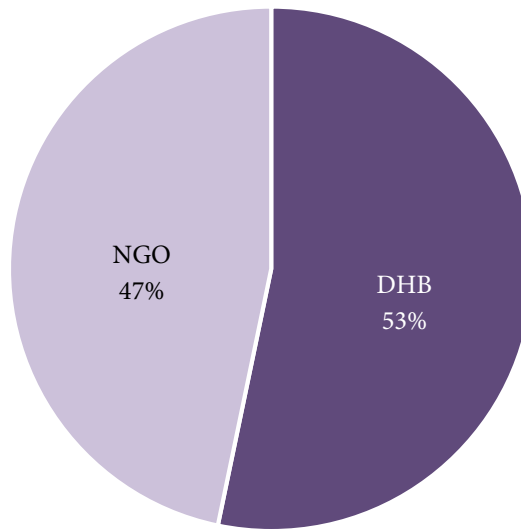


Figure 3. Distribution of adult addiction services' workforce across DHBs and NGOs (n=1,832 FTE positions)

All 17 DHBs funded to deliver addiction services responded to the survey (100 per cent).

- 14 DHBs reported a workforce in AOD services, at least two of these (Capital and Coast and Waitematā) provided services regionally.
- 10 DHBs reported a workforce in MH&A services, three of these only provided MH&A services.
- Seven DHBs reported providing both AOD and MH&A services.

Nearly three-quarters (57 or 74 per cent) of the 77 NGOs invited to participate in the survey reported a workforce delivering addiction services.

- 10 of the 57 reported providing more than one type of service.
- 44 reported a workforce delivering AOD services.
- 7 reported a workforce delivering problem gambling services.
- 16 reported a workforce delivering MH&A services.

2.2 Workforce reported in provider and sector groups

The following analyses presents results by provider and sector groups to highlight differences in the workforce between these groups.²³

As shown in Figure 4, AOD services reported 67 per cent of the addiction workforce.

- DHB AOD services reported 35 per cent of the addiction workforce.
- NGO AOD services reported 32 per cent.

Problem gambling services comprised 5 per cent of the addiction workforce, all of which were reported by NGOs.

²³ These categories are described in the Introduction.

MH&A services reported 28 per cent of the addiction workforce.

- DHB MH&A services reporting 19 per cent of the addiction workforce.
- NGOs MH&A services reporting 9 per cent.

Figure 4 shows the proportion of the addiction workforce reported by services in each of the provider and sector groups.

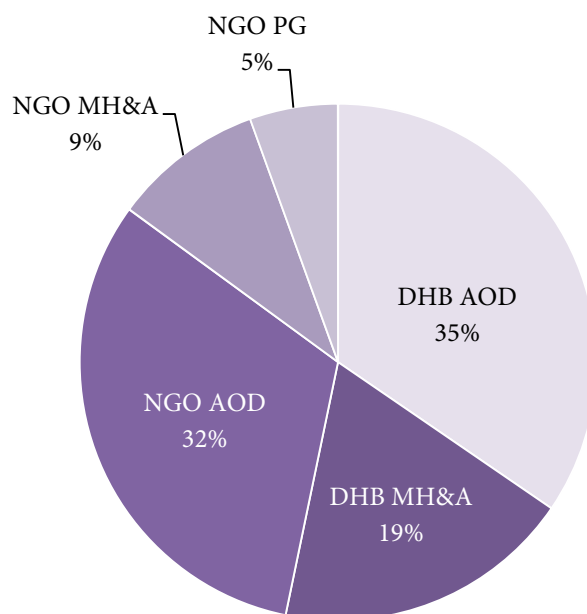


Figure 4. Proportion of the adult addiction services' workforce in each provider and sector group (n=1,832 FTE positions)

Table 2 summarises the addiction workforce in each of the provider and sector group categories.

Table 2. Adult addiction services' workforce by provider and sector groups

Provider and sector group	Workforce reported to the survey (FTE positions employed plus vacant)		
	Employed	Vacant	Total
DHB AOD	607.7	25.5	633.2
DHB MH&A	326.3	16.3	342.6
NGO AOD	569.3	12.9	582.2
NGO MH&A	170.5	2.4	172.8
NGO PG	92.2	8.9	101.1
Total	1,766.0	66.0	1,832.0

When describing their service, respondents were asked to identify whether the service provided was a kaupapa Māori, Pasifika or Asian service, with all other services reported as general or mainstream. The workforce in kaupapa Māori services totalled 266 FTE positions (15 per cent of the addiction workforce). Just under half of those positions were located in NGO AOD services. The workforce in Pasifika services totalled 44 FTEs (2 per cent of the adult addiction workforce).

Table 3 summarises the total workforce reported by the different kinds of services (mainstream, kaupapa Māori, Pasifika and Asian) for each of the provider and sector group categories.

Table 3. *Adult addiction services' workforce reported by provider and sector groups, by services provided*

Provider and sector group	Workforce in services (FTE positions employed plus vacant)				Total workforce
	Mainstream	Kaupapa Māori	Pasifika	Asian	
DHB AOD	595.9	20.3	17.0	-	633.2
DHB MH&A	324.0	18.6		-	342.6
NGO AOD	438.6	131.6	12.0	-	582.2
NGO MH&A	82.9	79.9	10.0	-	172.8
NGO PG	67.8	15.2	5.1	12.9	101.1
Total	1,509.3	265.6	44.1	12.9	1,832.0

2.3 Workforce by service types

This section describes the workforce reported in four main service types - community, residential and inpatient, administration and management,²⁴ and other. Analyses have been based on the predominant service delivered by the workforce as reported to the survey by AOD and MH&A respondents.²⁵ Problem gambling service results are reported in their own category.

The first sub-section summarises results for all addiction services (providing total results for AOD, problem gambling and MH&A services). To ensure the characteristics of each of these three groups remain visible the following sub-sections separately summarise results for AOD, problem gambling and MH&A services.

Addiction services

Figure 5 shows the proportion of the workforce in each of the four service types (for AOD and MH&A services) and problem gambling services.

- Community services reported 67 per cent of the addiction workforce (1,235 FTE positions).
- Residential and inpatient services reported 18 per cent (325 FTEs).
- Administration and management services reported 9 per cent (158 FTEs).
- Problem gambling services reported 5 per cent (101 FTEs).
- Other services reported 1 per cent (13 FTEs).

²⁴ The management, administration and support category is described in Chapter 3.

²⁵ Respondents identified the predominant service their workforce provided, chosen from a pre-set list of options. Allocation of service types described in the survey to one of the four service type groups is described in the glossary.

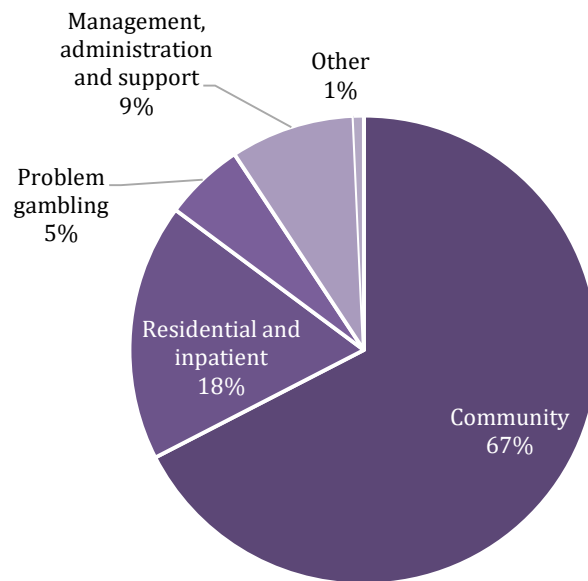


Figure 5. Proportion of the adult addiction services' workforce by types of service provided (n=1,832 FTE positions)

Table 4 shows how the size of the workforce in DHBs and NGOs varied across the different types of services investigated.

Table 4. *Adult addiction services' workforce reported by DHBs and NGOs, by service types*

Service types	Workforce (FTE positions employed plus vacant) in:			Proportion of addiction services' workforce (%)
	DHB services	NGO services	Total	
AOD services				
Community	577.8	312.7	890.6	48.6
Residential and inpatient	47.4	257.5	304.9	16.6
Management, administration and support	8.0	8.4	16.4	0.9
Other		3.6	3.6	0.2
Total AOD services	633.2	582.2	1,215.4	66.3
Problem gambling	-	101.1	101.1	5.5
MH&A services				
Community	241.8	102.8	344.6	18.8
Residential and inpatient	9.4	11.0	20.4	1.1
Management, administration and support	91.4	49.9	141.3	7.7
Other	-	9.2	9.2	0.5
Total MH&A services	342.6	172.8	515.5	28.1
Total	975.8	856.1	1,832.0	100.0

Note:

* The management, administration and support service type refers to those senior management, administration and support staff who have an oversight role or provide support for multiple service delivery units in an organisation. Within DHB provider arm services, the management services reported here are likely to provide support to child and adolescent mental health services, and adult mental health and addiction services, as well as to mental health services for older adults. The total workforce in management services reported here is lower than the total workforce for administration and management roles reported elsewhere. The difference is because administration and management roles are not limited to the management service type, for example team leader roles may be reported within community or residential and inpatient services.

AOD services

In AOD services specifically, the workforce comprised 1,215 FTE positions.

- Community services reported 73 per cent of the AOD workforce (891 FTEs).
- Residential and inpatient services reported 25 per cent (305 FTEs).

Figure 6 summarises the workforce reported by AOD services within the four main types of service (community, residential and inpatient, administration and management, and other).

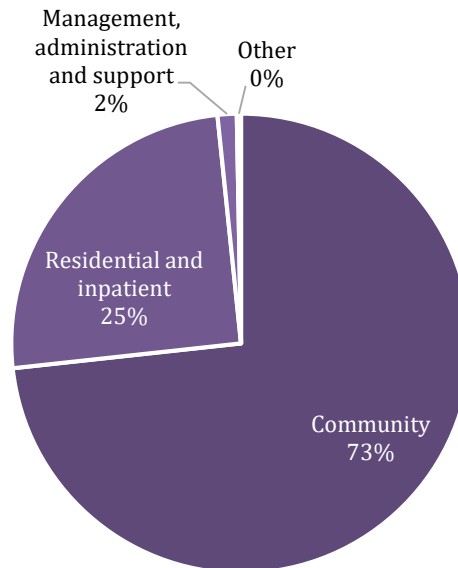


Figure 6. Proportion of adult AOD services' workforce by service type (n=1,215 FTE positions)

Problem gambling services

Problem gambling services were all delivered in the community. This workforce comprised 5 per cent of the total adult addiction services' workforce and was entirely reported by NGOs.

MH&A services

MH&A services, as distinct from the AOD or problem gambling services described previously, had 67 per cent of the workforce in community services (345 FTE positions) and 27 per cent in management, administration and support services (141 FTEs).

More than one-quarter (27 per cent) of the workforce in the MH&A group was reported in administration and management services. This result is characteristic of this group's composition in that it includes a large proportion of senior management teams overseeing services in organisations that provided either separate services for addiction and mental health, or integrated services.

Figure 7 summarises the workforce reported by MH&A services into the same service type categories as Figure 6.

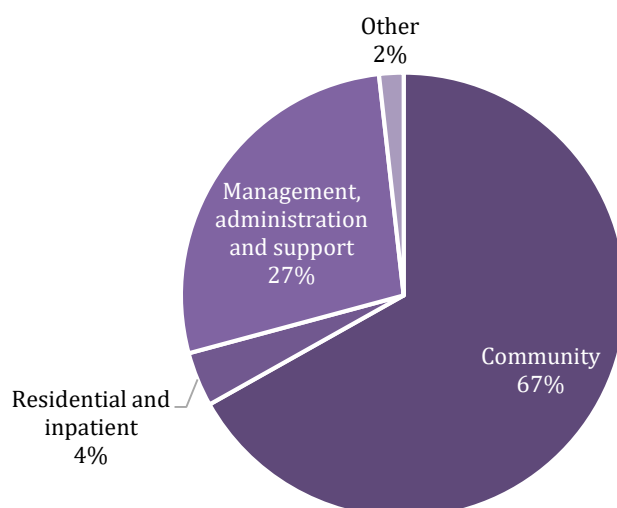


Figure 7. Proportion of the MH&A services' workforce by service type (n=516 FTE positions)

2.4 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 FTE positions employed and vacant using a list of roles common to adult addiction services.²⁶

Respondents were asked to allocate staff members to roles according to the activities performed, not the employee's qualifications or professional body affiliations. For example, a qualified social worker employed to perform the role of an addiction practitioner would be recorded as the latter. Therefore, the analysis here is relevant only to roles, and is not intended to reflect workforce qualifications, skills or competencies.²⁷

For the purposes of the survey and this report, roles are categorised according to whether they are clinical or non-clinical, and each role has been allocated to an occupation group. Occupation groups for clinical roles include allied health, nursing, and medical and other professionals. There are two occupation groups for non-clinical roles; support workers and cultural advice and support. The administration and management occupation group is reported separately. This group incorporates some clinical and non-clinical roles, for example team and senior management roles may have both clinical and management responsibilities, as in the case of a charge nurse manager.

²⁶ These roles were sourced from earlier Matua Raki surveys, the Werry Centre stocktake of child and youth services, and the Australian and New Zealand Standard Classification of Occupations (Pink & Bascand, 2009).

²⁷ 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.

Addiction services

The adult addiction services' workforce was comprised of 1,832 FTE positions.

- DHB provider arm services reported 53 per cent of the workforce (976 FTE positions).
- NGO services reported 47 per cent of the workforce (856 FTE positions).

Nearly two-thirds (62 percent) of the addiction workforce was made up of clinical roles (1,145 FTE positions).

Clinical roles were primarily:

- addiction practitioners or clinicians (19 per cent of the addiction workforce)
- registered nurses (16 per cent)
- dual diagnosis practitioners and co-existing problems clinicians (6 per cent).

Nearly one-fifth (18 per cent) of the addiction workforce was made up of non-clinical roles (221 FTE positions).

- Most non-clinical roles were support workers, including:
 - community support worker (4 per cent of the addiction workforce)
 - residential support worker (4 per cent)
 - peer support worker (2 per cent).
- Cultural workers comprised less than 2 per cent of the addiction workforce.

One-fifth (20 per cent) of the addiction workforce was made up of administration and management roles.

- Administration and technical support roles were 9 per cent of the addiction workforce
- Service managers and team leaders were 6 per cent.

Figure 8 shows the workforce (including FTE positions employed plus vacant) reported by each of the provider and sector groups summarised into occupation groups.²⁸ It highlights that allied health roles made up most of the addiction workforce, followed by administration and management roles, then nursing roles.

²⁸ The roles in each of the occupation groups are summarised in Appendix C.3: Data dictionary on occupation groups and roles.

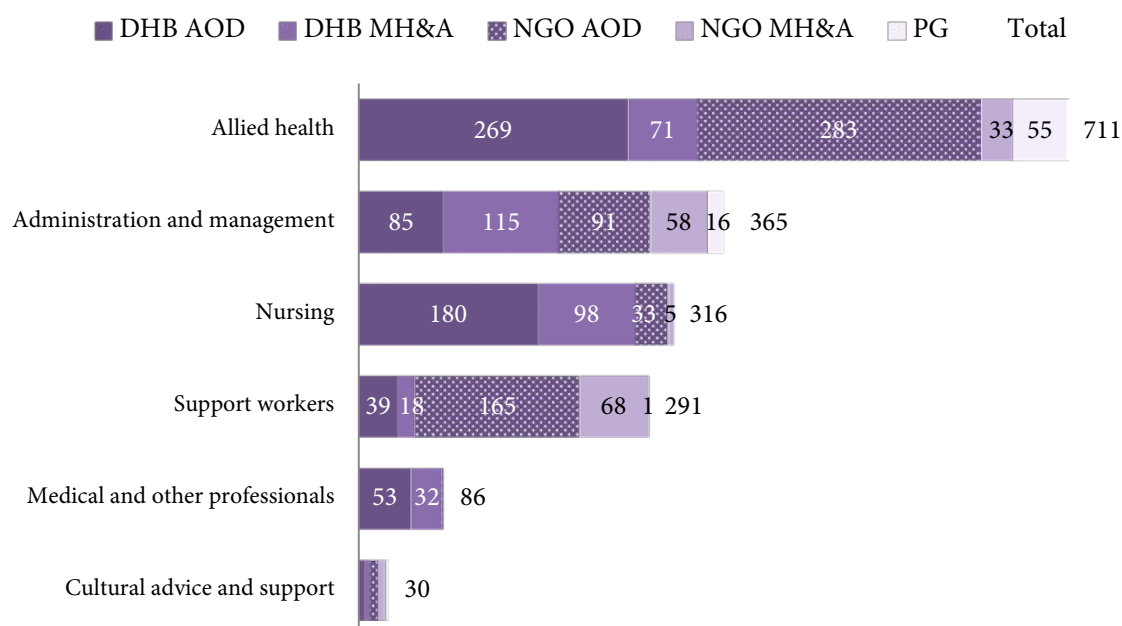


Figure 8. Total workforce (FTE positions employed plus vacant) reported for each of the occupation groups in addiction services

Table 5 shows the total addiction workforce (FTE positions employed plus vacant) for each role in each of the provider and sector groups, with totals for DHB and NGO AOD and MH&A services.²⁹

Table 5. Workforce (FTE positions employed plus vacant) by roles and provider and sector groups

Role	DHB workforce (FTE positions)			NGO workforce (FTE positions)				Total
	AOD	MH&A	Total	AOD	MH&A	Total	Problem gambling	
Clinical roles								
Addiction practitioner/clinician	70.6	10.7	81.3	238.0	15.3	253.3	8.8	343.4
Dual diagnosis practitioner/co-existing problems clinician	90.3	3.0	93.3	11.7	3.0	14.7	5.0	113.0
Counsellor	11.7	11.1	22.8	17.7	6.3	24.0	38.9	85.6
Educator/trainer	1.0	2.0	3.0	-	3.5	3.5	-	6.5
Occupational therapist	13.6	9.5	23.1	1.0	-	1.0	-	24.1
Clinical psychologist	22.1	18.1	40.2	2.1	-	2.1	-	42.3
Other psychologist	1.8	0.8	2.6	0.5	-	0.5	-	3.1
Social worker	56.2	14.0	70.2	12.0	4.5	16.5	2.5	89.2
Other allied health professionals	2.3	1.5	3.8	-	-	-	-	3.8
General practitioner	2.4	0.2	2.6	0.9	-	0.9	-	3.5
House surgeon	2.0	2.0	4.0	-	-	-	-	4.0
Consultant psychiatrist	30.0	19.8	49.8	-	0.2	0.2	-	50.1

²⁹ The workforce for each role reported by the different types of services (eg inpatient, community), for both DHBs and NGOs is provided in tables in Appendix E: Additional tables.

Role	DHB workforce (FTE positions)			NGO workforce (FTE positions)				Total
	AOD	MH&A	Total	AOD	MH&A	Total	Problem gambling	
Medical officer special scale	5.3	5.0	10.3	0.4	-	0.4	-	10.7
Psychiatric registrar	10.6	3.6	14.2	-	-	-	-	14.2
Liaison/consult liaison	1.2	1.0	2.2	-	-	-	-	2.2
Other medical professionals	-	-	-	-	-	-	-	-
Registered nurse	175.5	87.5	263.0	29.6	5.3	34.8	-	297.8
Enrolled nurse	-	-	-	2.0	-	2.0	-	2.0
Nurse practitioner/nurse specialist/nurse educator	4.2	10.6	14.8	1.0	-	1.0	-	15.8
Other nursing professionals	0.2	-	0.2	-	-	-	-	0.2
Other clinical roles	2.0	3.0	5.0	-	2.0	2.0	26.5	33.5
Sub-total clinical roles	502.9	203.3	706.2	316.8	40.1	356.9	81.7	1,144.8
Support workers								
Community development worker	-	-	-	-	-	-	-	-
Employment worker	-	-	-	-	1.9	1.9	-	1.9
Community support worker	8.1	6.8	14.9	19.7	46.1	65.8	1.0	81.7
Family support worker	-	2.0	2.0	13.5	3.0	16.5	-	18.5
Healthcare assistant	5.8	4.4	10.2	-	-	-	-	10.2
Peer support – consumer and service user	-	0.5	0.5	30.7	7.1	37.8	-	38.3
Peer support – family and whānau	-	-	-	3.5	1.2	4.7	-	4.7
Psychiatric assistant	25.4	-	25.4	-	-	-	-	25.4
Residential support worker	-	-	-	81.3	-	81.3	-	81.3
Other support workers	-	4.0	4.0	16.2	9.0	25.2	-	29.2
Sub-total support workers	39.2	17.7	56.9	164.8	68.3	233.1	1.0	291.0
Cultural advice and support								
Cultural supervisor	-	-	-	1.1	3.0	4.1	1.5	5.6
Kaumātua	2.0	1.6	3.6	0.7	2.7	3.4	1.2	8.2
Kuia	-	0.5	0.5	1.0	-	1.0	-	1.5
Kaiāwhina	3.1	1.0	4.1	0.5	0.1	0.6	-	4.7
Traditional Māori health practitioner	-	-	-	2.5	1.0	3.5	-	3.5
Matua	-	-	-	0.3	-	0.3	-	0.3
Pasifika cultural advisor	-	-	-	1.1	-	1.1	-	1.1
Other cultural advisor	0.8	3.0	3.8	1.2	0.2	1.4	-	5.2
Sub-total cultural advice and support	5.9	6.1	12.0	8.3	7.0	15.3	2.7	30.0

Role	DHB workforce (FTE positions)			NGO workforce (FTE positions)				Total
	AOD	MH&A	Total	AOD	MH&A	Total	Problem gambling	
Administration and management								
Administrative/technical support	44.8	53.3	98.1	38.8	16.5	55.4	4.0	157.5
Senior manager	4.7	8.6	13.3	16.5	12.6	29.1	2.2	44.5
Clinical director	0.7	5.8	6.5	2.0	-	2.0	-	8.5
Professional leader	0.6	4.3	4.9	4.0	2.0	6.0	6.0	16.9
Service manager/team leader	28.9	23.5	52.4	25.6	24.1	49.7	1.5	103.6
Consumer advisor/consumer leader	3.1	2.4	5.5	1.9	2.2	4.1	2.0	11.6
Family/whānau advisor	2.5	9.9	12.4	-	0.2	0.2	-	12.5
Other administration and management	-	7.7	7.7	2.7	-	2.7	-	10.4
Sub-total administration and management	85.2	115.5	200.7	91.5	57.6	149.0	15.7	365.4
Other non-clinical roles	-	-	-	0.8	-	0.8	-	0.8
Total (all roles)	633.2	342.6	975.8	582.2	172.8	755.0	101.1	1,832.0

AOD services

The AOD services' workforce comprised 1,215 FTE positions, 66 per cent of the total addiction workforce.

- DHB services reported 52 per cent of the AOD workforce (633 FTEs)
- NGO services reported 48 per cent of the AOD workforce (582 FTEs).

DHB AOD services reported a higher proportion of their workforce in clinical roles than the other provider and sector groups.

- Clinical roles were predominant (79 per cent of the DHB AOD workforce). These roles included:
 - registered nurses (28 per cent of the DHB AOD workforce)
 - dual diagnosis practitioners and clinicians (14 per cent)
 - addiction practitioners and clinicians (11 per cent)
 - consultant psychiatrists (5 per cent).
- Non-clinical roles accounted for 7 per cent of the DHB AOD workforce. No peer support worker roles were reported. The non-clinical roles included:
 - psychiatric assistants (4 per cent of the DHB AOD workforce)
 - cultural workers (less than 1 per cent).
- Administration and management roles were 13 per cent of the DHB AOD services workforce, including 6 FTE positions for consumer advisor and family advisor roles.

NGO AOD services reported that slightly more than half their workforce was in clinical roles (54 per cent of the NGO AOD workforce).

- Addiction practitioners or clinicians were the primary clinical role in NGO services (41 per cent of the NGO AOD workforce).
- Non-clinical roles made up 30 per cent of the NGO AOD workforce, including:
 - residential support workers (14 per cent of the NGO AOD workforce)
 - peer support – consumer and service user roles (5 per cent)
 - cultural workers (1 per cent).
- Administration and management roles made up 16 per cent of this workforce.

Problem gambling services

Problem gambling services reported 5 per cent of the adult addiction workforce; all problem gambling services were reported by NGOs.

The problem gambling workforce was predominantly comprised of clinical roles (81 per cent) and administration and management roles.

- The most common clinical roles were:
 - counsellors (38 per cent of the problem gambling workforce)
 - addiction practitioners or clinicians (9 per cent)
 - dual diagnosis practitioners and co-existing problems clinicians (5 per cent)
 - other clinical roles (26 per cent).
- Non-clinical roles were 4 per cent of the workforce, and comprised mainly cultural advice and support roles.
- The main administration and management roles reported were:
 - professional leader (6 per cent of the problem gambling workforce)
 - administration and technical support (4 per cent)
 - consumer advisor or leader (2 per cent).

MH&A services

In MH&A services, as distinct from the AOD or problem gambling services described previously, the workforce comprised 516 FTE positions, 28 per cent of the adult addiction workforce.

- DHB services reported 66 per cent of the MH&A workforce (343 FTEs).
- NGO services reported 34 per cent of the MH&A workforce (173 FTEs).

DHB MH&A services reported similar proportions of their workforce in nursing and psychiatry roles to that of the DHB AOD workforce.

- Clinical roles made up 59 per cent of the DHB MH&A workforce, including:
 - registered nurses (26 per cent of the DHB MH&A workforce)

- clinical psychologists (5 per cent)
- consultant psychiatrists (6 per cent)
- other practitioner roles including addiction practitioners, dual diagnosis practitioners, occupational therapists and social workers (2 to 4 per cent).
- Administration and management FTE position numbers were relatively higher (34 per cent) compared to the other sector groups. Administration and management roles included:
 - 16 per cent for administrative and technical support
 - 7 per cent for service managers and team leaders.

NGO MH&A services reported a relatively large proportion of their workforce in non-clinical roles (44 per cent) and administration and management roles (33 per cent), with just 23 per cent in clinical roles. Key results for the workforce in NGO MH&A services follow.

- Community support workers were the largest single role (27 per cent of the total NGO MH&A workforce).
- Addiction practitioner and clinician was the largest clinical role (9 per cent).
- Of all the provider groups, this one had the largest proportion of cultural workers (4 per cent).
- The two main administration and management roles were service manager and team leader (14 per cent) and senior manager (7 per cent).

2.5 Vacancies

The survey found there were 66 vacant FTE positions, accounting for 4 per cent of the addiction services' workforce. NGO AOD services and MH&A services reported vacancy rates of 2 and 1 per cent respectively. This was lower than their equivalents in DHB AOD and MH&A services (4 and 5 per cent respectively, see Table 6). Problem gambling services had the highest vacancy rate (9 per cent). This likely reflects the proportionately small size of this workforce compared to the other provider and sector categories.

For each provider and sector group, Table 6 shows the total number of FTE positions vacant and the vacancy rate. The vacancy rate is the number of FTEs vacant as a proportion of the total FTE positions employed plus vacant for each row.

Table 6. Number of FTE positions vacant by provider and sector groups, with vacancy rates

Provider and sector group	Total FTE positions vacant	Vacancy rate (%)
DHB AOD	25.5	4.0
DHB MH&A	16.3	4.8
NGO AOD	12.9	2.2
NGO MH&A	2.4	1.4
Problem gambling	8.9	8.8
Total	66.0	3.6

As shown in Figure 9, 39 per cent of the vacant FTE positions were in DHB AOD services and one-quarter were in DHB MH&A services.³⁰

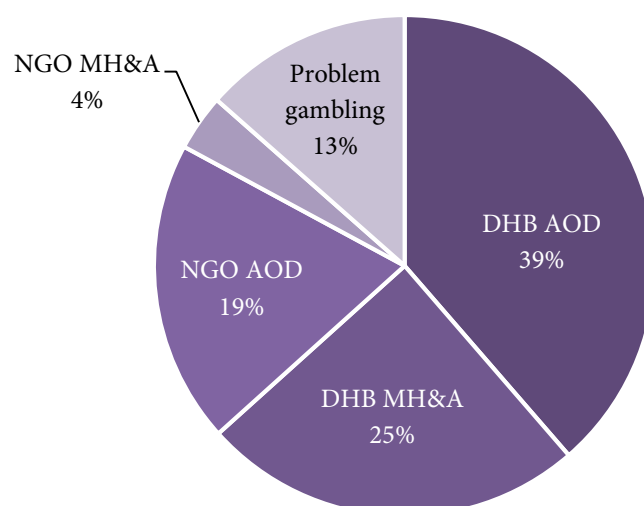


Figure 9. Proportion of vacancies across the adult addiction services' workforce by provider and sector groups

2.6 Chapter summary

This chapter has summarised the size and composition of the adult addiction services' workforce reported to the survey by 17 DHBs and 57 NGOs. The workforce totalled 1,832 FTE positions (employed and vacant), and was evenly split between DHB provider arm (53 per cent) and NGO (47 per cent) services.

The workforce was distributed across AOD (67 per cent), MH&A (28 per cent) and problem gambling (5 per cent) services.

The entire problem gambling workforce delivered community services, compared to AOD and MH&A services, which had three-quarters to two-thirds of their workforce in community services, respectively.

³⁰ Tables showing vacancies for each role and as a percentage of the total workforce are included in Appendix E: Additional tables.

Compared to MH&A and problem gambling services, AOD services had a large proportion of the workforce in residential and inpatient services. MH&A services reported more than one-quarter of their workforce was in management, administration and support services. This result reflects the unique composition of this group, which has captured some of the workforce providing oversight and support within organisations that deliver both addiction and mental health services.

Overall, addiction services had a high proportion of their workforce in clinical roles, relative to mental health services (Te Pou, 2015). With the exception of NGO problem gambling services, NGOs tended to have a lower proportion of their workforce in clinical roles than DHBs. Across the three sector groups, the roles with the largest workforce differed; addiction and dual diagnosis practitioners were prevalent in AOD services, and DHB AOD services had a large number of registered nurses. Counsellor roles made up the largest workforce in problem gambling services.

The composition of the MH&A workforce was influenced by this group's provision of mental health services in addition to addiction services. In DHB MH&A services, registered nurses were prevalent. However, in contrast to AOD services, addiction and dual diagnosis practitioners were less prevalent in both the DHB and NGO workforce. In NGO MH&A services, a larger proportion of the workforce was in community support worker roles than in other services.

Survey results for questions about workforce ethnicity and cultural competence development needs are summarised in the next chapter.

3.0 Ethnic makeup and cultural competence

The priority actions in *Rising to the Challenge* (Ministry of Health, 2012b) include improving service responsiveness to Māori, Pasifika, Asian and refugee populations. An ethnically diverse workforce that reflects the population served is one aspect of supporting culturally responsive services for people using addiction services.

This chapter summarises the survey findings in relation to the Māori, Pasifika and Asian workforce in adult addiction services.³¹ It describes the areas of cultural competence that respondents identified as needing improvement in their overall workforce.

Cultural responsiveness is particularly important given certain ethnic groups are disproportionately affected by mental health and addiction concerns. *Te Rau Hinengaro* (Oakley Browne, Wells & Scott, 2006) showed the prevalence of any substance use disorder was twice as high among Māori compared to the general population (8.6 per cent compared to 3.5 per cent). Pasifika people also have higher prevalence rates for any substance use disorder than the general population (5.3 per cent compared to 3.5 per cent).³² *Te Rau Hinengaro* (Oakley Browne et al., 2006) did not collect data about the prevalence of substance use disorders in Asian ethnic groups.

When it comes to problem gambling, Māori have the same prevalence rates as the general population (3.1 per cent), and Pasifika and Asian people have lower rates. However, compared to other ethnic groups, Māori and Pasifika people are more likely to be affected by the gambling problems of others (Ministry of Health, 2012c, p. 9). *The health of New Zealand adults 2011/2012: Key findings of the New Zealand Health Survey* (Ministry of Health, 2012a, p. 16) reported that Asian people were similar to the total sample for 'having any risk of gambling problems' (3.3 per cent compared to 3.1 per cent).

It is important to recognise that Māori service consumers and the workforce comprise of diverse groups, as are consumers identified in Pasifika and Asian ethnic groups.³³ The survey and its associated reports use aggregated population groups to describe the ethnicity of the workforce. However, aggregating different populations into groups risks homogenising their differences. For the purposes of workforce development and planning, it is essential to consider the cultural diversity that is inherent within these groups.

The first section in this chapter describes the survey results for workforce ethnicity focusing on the representation of Māori, Pasifika and Asian people in the workforce. This is followed by results for questions about the cultural competence development needs for the entire workforce.

³¹ 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 workforce ethnicity.

³² For prevalence rates see Appendix D: About population, funding and service provision for adult mental health and addiction services.

3.1 Ethnicity of the workforce

Respondents were asked to indicate, as at 1 March 2014, how many staff members in their workforce were Māori, Pasifika or Asian.³⁴ They were asked to complete this question by totalling the number of people employed and the number of FTE positions for clinical staff, using the definitions provided in the survey,³⁵ and for staff considered non-clinical.³⁶

Of the 181 completed surveys received from addiction services, 146 (81 per cent) indicated staff ethnicity. By provider, 39 DHB services and 107 NGOs responded to this question. By sector group, the responses received were as follows.

- 97 from AOD services.
- 13 from problem gambling services.
- 36 from MH&A services.

Of the 146 respondents:

- 23 per cent had no staff members of the specified ethnicities (34 responses)
- 77 per cent completed the question for Māori, Pasifika and Asian staff members in clinical and non-clinical roles (112 responses).

The following analyses are based only on those surveys providing ethnicity data, including those indicating they had no staff in the specified groups. The total workforce reported by these respondents was 1,367 FTE positions, which is 75 per cent of the surveyed addiction services' workforce. The workforce in services giving non-responses or indicating the information was not available has been excluded from the analysis. Because of the response size, all results are presented in percentage form.

The information provided in this chapter should be used with caution for two reasons. Firstly, an ethnically-representative workforce does not necessarily imply cultural competence in service delivery. Secondly, there was potential for subjective, rather than informed, responses to this question. Respondents were advised that if they did not have an accurate record of employee ethnicity they should indicate that the information was not available, rather than guess employee ethnicity; however, it is not possible to ascertain the extent to which this has occurred.

Māori population, service use and workforce

As shown in Figure 10, in 2013 Māori adults made up 12 per cent of the total New Zealand adult population (aged 20 to 64 years). This age group accounted for 51 per cent of the total Māori population living in New

³⁴ Respondents were asked to use employee self-identified information to answer this question. Respondents who were unable to access this information were advised to indicate that the information was not available.

³⁵ Clinical staff were defined by the survey as people who are qualified and competent to provide intervention and/or treatment independently, albeit while part of a team. They will typically be registered under the *HPCA Act 2003*, *Social Workers Registration Act 2003* or have *dapaanz* practitioner registration.

³⁶ For the purposes of this report, results for non-clinical staff include those in administration and management.

Zealand. PRIMHD (Programme for the integration of mental health data) recorded that 33 per cent of AOD service consumers identified as Māori.³⁷ A higher proportion of consumers using NGO services were Māori (40 per cent), compared with those using DHB services (29 per cent).³⁸ NGOs also reported more than twice the proportion of Māori in the clinical workforce than DHBs, which may reflect the results of targeted strategies over recent years to increase the number of Māori clinicians in NGO services.

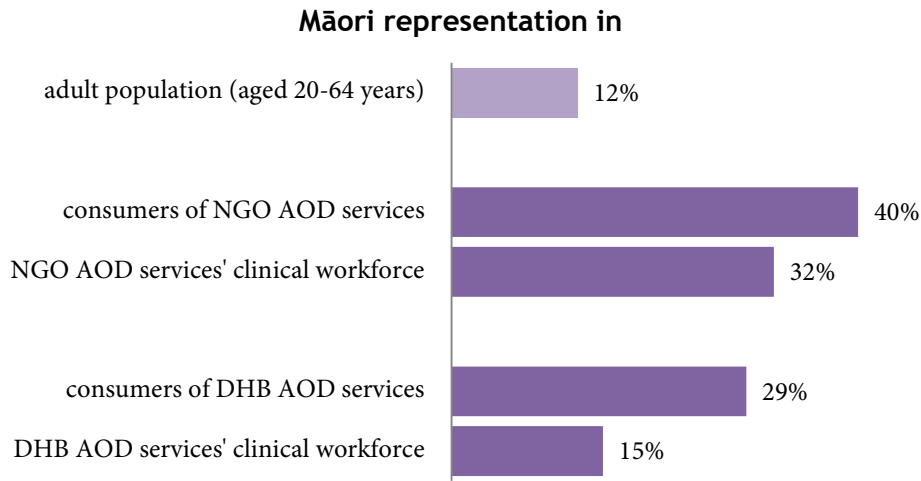


Figure 10. Māori as a proportion of the adult population, AOD service consumers and AOD workforce in DHBs and NGOs

The Problem Gambling Client Information Collection (CLIC) database recorded that 31 per cent of problem gambling service consumers were Māori.

Figure 11 summarises the preceding points relative to the problem gambling workforce.

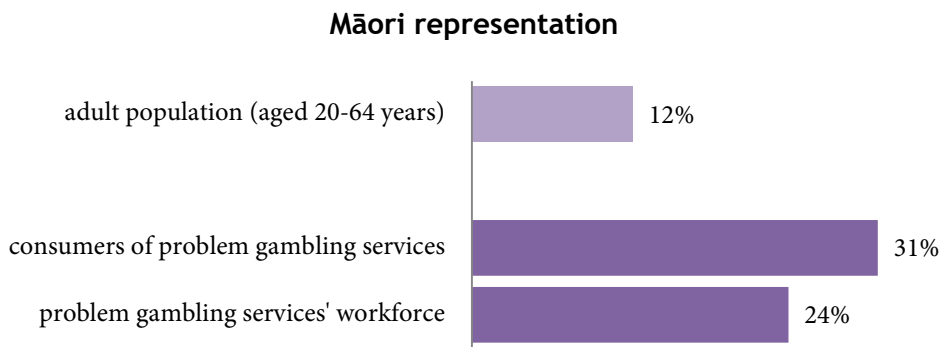


Figure 11. Māori as a proportion of the adult population, problem gambling service consumers and problem gambling workforce

Māori staff members filled 309 FTE positions in the addiction workforce (23 per cent of 1,367 FTE positions). Overall, the Māori workforce made up 22 per cent of the reported workforce in clinical roles and 24 per cent of

³⁷ PRIMHD reports Māori using prioritised ethnicity data. Under prioritised ethnicity, clients 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. The 37,520 unique consumers included those seen by both AOD and mental health services, but excluded those only seen by mental health services only.

³⁸ For more information about the ethnicity of consumers of adult AOD services, see Appendix E: Additional tables.

the workforce in non-clinical, administration and management roles. Respondents from kaupapa Māori services reported that more than two-thirds (69 per cent) of their workforce identified as Māori.

NGO respondents reported a workforce with a higher proportion of Māori than DHBs. As shown in Table 7 below, Māori representation in clinical roles in NGO MH&A services was particularly high (53 per cent). There was also a high proportion of Māori staff in the problem gambling workforce (24 per cent), particularly in non-clinical, administration and management roles (47 per cent).

Table 7 shows the proportion of the workforce filled by Māori staff in clinical and non-clinical, administration and management roles, and in the total workforce for each of the provider and sector categories. The last column shows the total overall proportion of Māori in the workforce for each row.

Table 7. *Māori representation in the workforce, by provider and sector groups*

Māori staff members in:	DHB AOD (%)	DHB MH&A (%)	NGO AOD (%)	NGO MH&A (%)	Problem gambling (%)	Total (%)
Clinical roles	14.9	13.9	31.7	52.8	17.9	21.9
Non-clinical, administration and management roles	18.5	24.0	21.5	28.2	46.5	23.8
Total representation (%)	15.7	17.7	27.4	33.9	24.4	22.6

Table 8 shows the proportion of Māori staff in the workforce within different service types and sector groups, reporting DHB services separately from NGO services. Of the service types, DHB MH&A residential and inpatient services and NGO MH&A residential and inpatient services reported the highest representation of Māori in the workforce (64 and 82 per cent respectively), however these proportions are each based on a total workforce of less than 10 FTE positions and should be interpreted with caution.

Table 8. *Māori representation in the workforce, by provider and sector groups, and service type*

Service type	Māori representation in:		
	DHB workforce (%)	NGO workforce (%)	Total workforce (%)
AOD services			
Community	14.0	33.5	22.3
Residential and inpatient	36.9	20.7	22.7
Management, administration and support	-	7.2*	7.2*
Other	-	-	-
Total	15.7	27.4	22.2
Problem gambling	-	24.4	24.4
MH&A services			
Community	15.6	39.6	23.2
Residential and inpatient	63.8*	81.8*	73.5
Management, administration and support	18.2	9.3	15.1
Other	-	-	-
Total	17.7	33.9	23.3
Total representation (%)	16.6	28.6	22.6

Note:

An * denotes percentage based on a workforce totalling less than 10 FTE positions and ** less than 5 FTE positions. A missing value denotes that no people were identified as employed in that service type.

Pasifika population, service use and workforce

As shown in Figure 12, in 2013 Pasifika adults made up 6 per cent of the total New Zealand adult population (aged 20 to 64 years). This age group accounted for 49 per cent of the total Pasifika population living in New Zealand. PRIMHD recorded that 6 per cent of AOD service consumers identified as Pasifika. Similar proportions of Pasifika consumers were seen by NGO services (5 per cent) and DHB services (6 per cent).³⁹

³⁹ For more information about the ethnicity of consumers of adult AOD services see Appendix E: Additional tables. PRIMHD reports Pasifika 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 people, and then other.

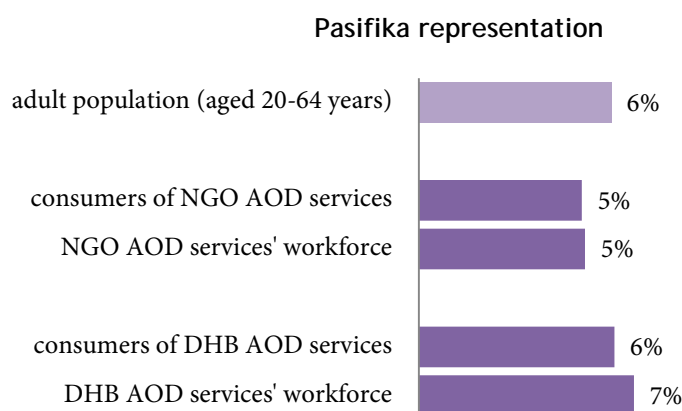


Figure 12. Pasifika as a proportion of the adult population, AOD service consumers and AOD workforce in DHBs and NGOs

In problem gambling services, the CLIC database recorded that 20 per cent of consumers were Pasifika. Figure 13 summarises the preceding points relative to the problem gambling workforce.

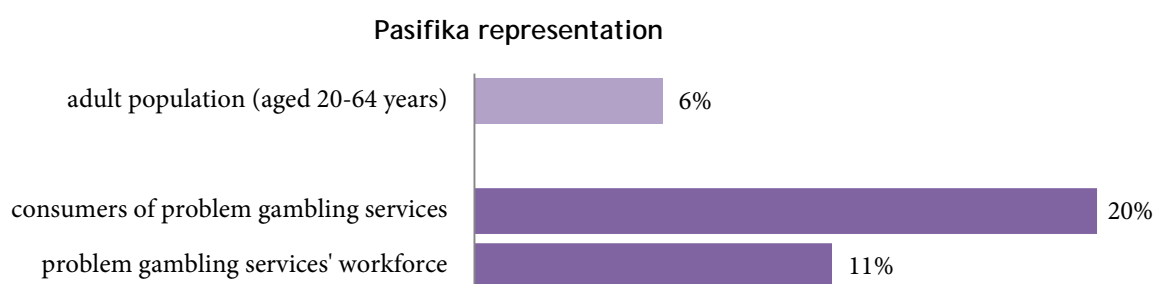


Figure 13. Pasifika as a proportion of the adult population, problem gambling service consumers and problem gambling workforce

Pasifika staff members filled 79 FTE positions (6 per cent) in the adult addiction workforce. Pasifika FTE positions were represented at similar rates in clinical roles and non-clinical, administration and management roles (both at 6 per cent). Almost all people employed in Pasifika addiction services were of Pasifika ethnicity (93 per cent).

Of all the provider and sector categories, problem gambling services had the highest proportion of Pasifika staff in their workforce (11 per cent), particularly those in non-clinical, administration and management roles (22 per cent). DHB MH&A services had a low proportion of Pasifika staff (3 per cent).

Table 9 shows the proportion of Pasifika staff in clinical and non-clinical, administration and management roles, and in each of the provider and sector categories. The last row and column show the total overall proportion of Pasifika staff in the workforce by clinical and non-clinical roles and sector groups.

Table 9. *Pasifika representation in the workforce, by provider and sector groups*

Pasifika staff members in:	DHB AOD %	DHB MH&A %	NGO AOD %	NGO MH&A %	Problem gambling %	Total %
Clinical roles	8.0	2.8	4.0	5.7	8.0	5.5
Non-clinical, administration and management roles	2.2	2.8	6.3	11.0	21.9	6.3
Total representation (%)	6.6	2.8	5.1	9.8	11.2	5.8

Compared to the adult population, Pasifika representation in NGO MH&A community services (15 per cent) was relatively high. Pasifika representation in management, administration and support roles was low.

Table 10. *Pasifika representation in the workforce, by provider and sector groups, and service type*

Service types	Pasifika representation in:		
	DHB workforce (%)	NGO workforce (%)	Total workforce (%)
AOD services			
Community	7.2	4.7	6.2
Residential and inpatient	-	5.7	5.0
Management, administration and support	-	-	-
Other	-	-	-
Total	6.6	5.1	5.8
Problem gambling	-	11.2	11.2
MH&A services			
Community	3.2	14.9	6.9
Residential and inpatient	-	-	-
Management, administration and support	1.6	-	1.1
Other	-	-	-
Total	2.8	9.8	5.2
Total representation (%)	5.0	6.6	5.8

Note:

An * denotes a percentage based on less than 10 FTE positions in the addiction workforce and ** less than 5 FTE positions. A dash (-) denotes that no Pasifika staff were employed, and a missing value denotes that no people were identified as employed in that service type.

Asian population, service use and workforce

As shown in Figure 14, in 2013 Asian peoples made up 13 per cent of the total New Zealand adult population (aged 20 to 64 years). This age group accounted for 66 per cent of the total Asian population living in New

Zealand. PRIMHD recorded that 2 per cent of people using AOD services were identified as Asian. A higher proportion of Asian consumers were seen by DHB services (2 per cent) than NGO services (1 per cent).⁴⁰

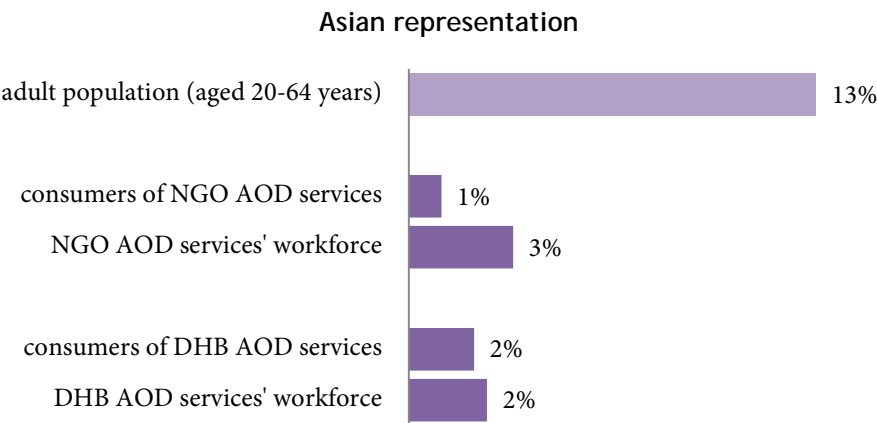


Figure 14. Asian ethnic groups as a proportion of the adult population, AOD service consumers and AOD workforce

The CLIC database recorded that 7 per cent of problem gambling consumers identified as Asian.

Figure 15 summarises the preceding points relative to the AOD and problem gambling workforces.

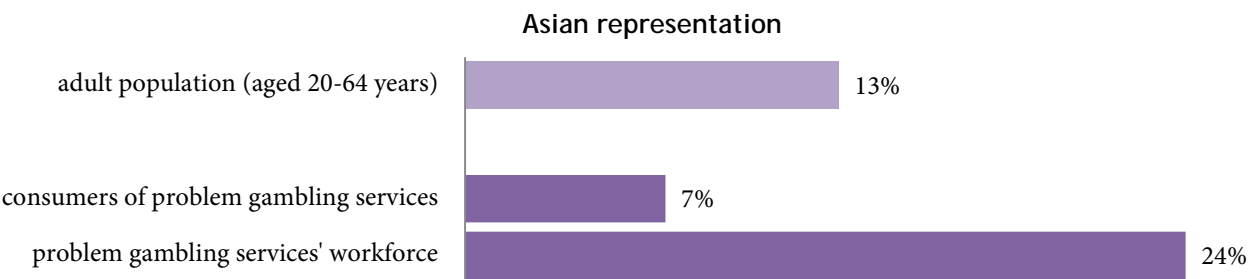


Figure 15. Asian ethnic groups as a proportion of the adult population, problem gambling consumers and problem gambling workforce

Asian staff filled 45 FTE positions (3 per cent) in the adult addiction workforce.⁴¹ There were similar proportions of Asian staff in clinical roles (3 per cent) compared to non-clinical, administration and management roles (4 per cent). There was one Asian-specific problem gambling service reported in the survey, which employed 11 FTE positions. All staff working in this service were identified as Asian.

⁴⁰ For more information about the ethnicity of consumers of adult AOD services see Appendix E: Additional tables. The 37,520 unique consumers included those seen by both AOD and mental health services, but excluded those seen by mental health services only. PRIMHD reports Asian ethnicity using a prioritised system. 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 people, and then other.

⁴¹ Asian ethnic groups encompass a very broad range of identities. The definition used for the organisation workforce survey is contained in the data dictionary. For an ethnicity definition table see Appendix C. For the purposes of the survey, respondents were asked to include Fijian Indian ethnicity as Asian, not indigenous Pasifika.

Problem gambling services reported the highest representation of Asian staff across all addiction services (24 per cent) and in non-clinical, administration and management roles (51 per cent). However, it must be noted that the total workforce for problem gambling services is very small compared to other services.

Table 11 shows the proportion of Asian staff in the workforce by clinical and non-clinical, administration and management roles, and by provider and sector groups. The last column shows the total overall proportion of Asian staff members in the workforce for each row.

Table 11. *Asian representation in the workforce, by provider and sector groups*

Asian staff members in:	DHB AOD %	DHB MH&A %	NGO AOD %	NGO MH&A %	Problem gambling %	Total %
Clinical role workforce	3.1	3.0	1.1	2.9	16.0	3.0
Non-clinical, administration and management role workforce	-	-	5.7	1.7	51.2	3.7
Total representation (%)	2.4	1.9	3.2	2.0	24.1	3.3

Table 12 shows the representation of Asian staff in different service types.

Table 12. *Asian representation in the workforce, by provider and sector group, and service type*

Service types	Representation of Asian ethnic groups in:		
	DHB workforce (%)	NGO workforce (%)	Total workforce (%)
AOD services			
Community	2.5	2.9	2.7
Residential and inpatient	0.0	3.3*	2.9*
Management, administration and support	-	12.0*	12.0*
Other	-	-	-
Total	2.4	3.2	2.8
Problem gambling		24.1	24.1
MH&A services			
Community	1.6	3.0	2.0
Residential and inpatient	21.3**	-	9.8**
Management, administration and support	-	-	-
Other	-	-	-
Total	1.9	2.0	1.9
Total representation (%)	2.1	4.5	3.3

Note:

An * denotes a percentage based on less than 10 FTE positions in the addiction workforce and ** less than 5 FTE positions. A dash (-) denotes that no Asian staff were employed and a missing value denotes that no people were identified as employed in that service type.

3.2 Cultural competence

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 this question, plus 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 findings for the knowledge and skill areas are based on a total of 182 responses to this question (95 per cent). In regards to providers, 56 responses were received from DHB services and 126 responses from NGOs. By sector group, responses were as follows.

- 127 from AOD services.
- 18 from problem gambling services.
- 37 from MH&A services.

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.

Addiction services

Respondents indicated that some or large increases in cultural competence were needed in the next two years. More than 75 per cent of respondents felt skills needed to increase in the areas of working with Māori, and for working with Pasifika and Asian ethnic groups.

Particularly knowledge and skills in:

- whānau-centred practice (75 per cent of respondents)
- cultural competence for working with Māori (76 per cent)
- te reo Māori me ona tikanga (Māori language and custom) (75 per cent)

- Māori health outcomes measurement (79 per cent)
- cultural competence for working with Pasifika ethnic groups (79 per cent)
- Pasifika cultural models of health (77 per cent)
- Pasifika family values, structure and concepts (80 per cent)
- basic concepts of tapu across Pasifika cultures (78 per cent)
- cultural competence for working with Asian ethnic groups (78 per cent).

AOD services

Respondents from AOD services specifically identified a number of areas in which their workforce needed to increase cultural competence. These are shown in the following two graphs for DHBs and NGOs respectively.⁴² The graphs illustrate the proportion of respondents indicating there was a need for some increase or large increase in their workforce knowledge and skills for working with Māori, Pasifika and Asian ethnic groups.

- The first part of the bar presents the proportion of respondents who identified the need for some increase in knowledge and skills.
- The second part of the bar reports 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 AOD respondents who indicated a need for any increase in knowledge and skills.

⁴² The full set of responses, including for the MH&A and problem gambling groups can be found in Appendix E: Additional tables.

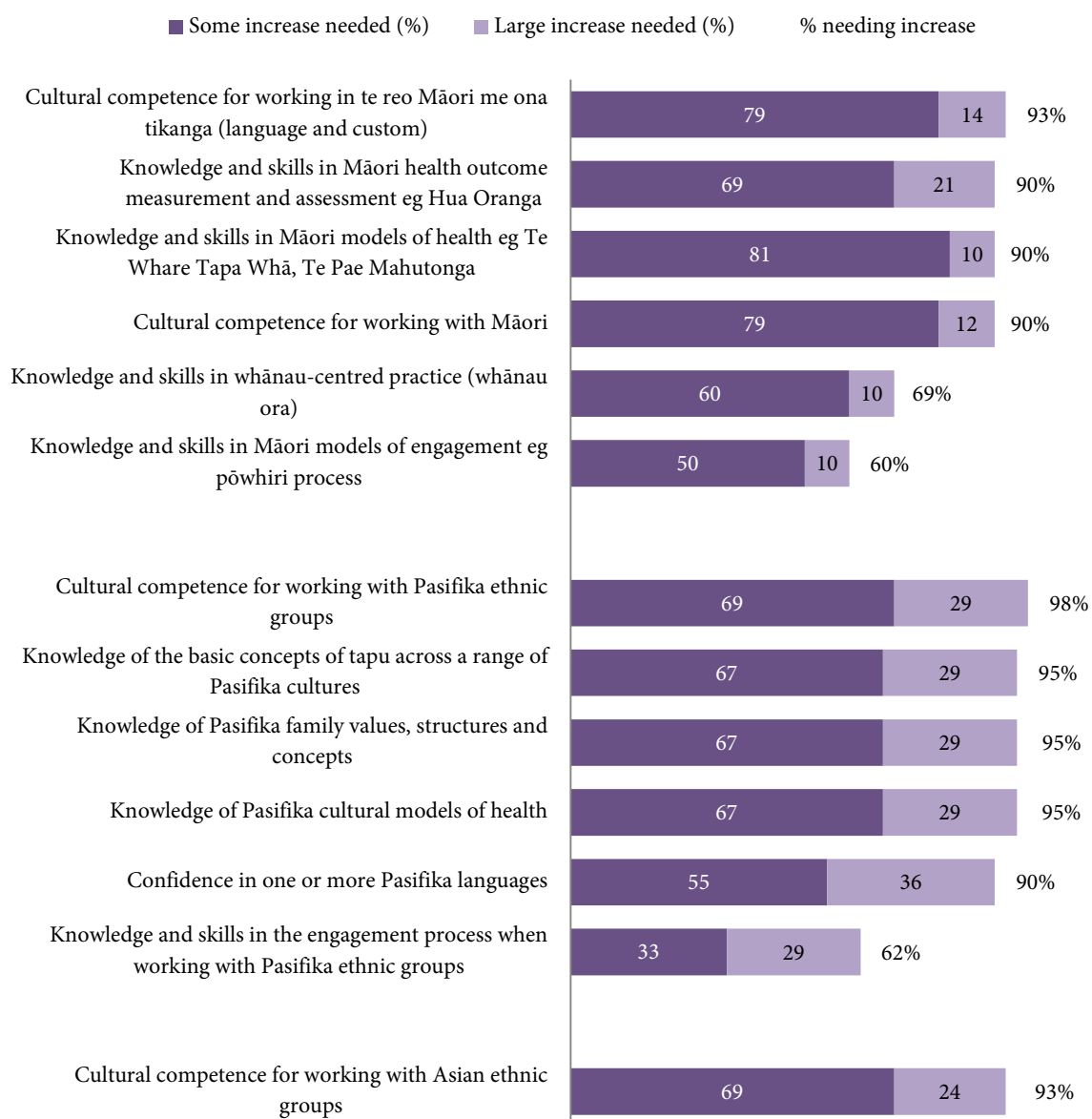


Figure 16. Proportion of DHB AOD service respondents indicating the need to improve workforce knowledge and skills in cultural competence (n= 42 responses)

DHB AOD services highlighted a need to increase workforce knowledge and skills in most areas relating to working with Māori, Pasifika and other ethnic groups.

- More than 90 per cent of these respondents felt that staff skills needed to improve in working with Māori, Pasifika and Asian ethnic groups. In particular:
 - cultural competence for working with Pasifika ethnic groups (98 per cent of respondents)
 - knowledge of Pasifika cultural models of health (95 per cent)
 - cultural competence for working in te reo Māori me ona tikanga (language and customs) (93 per cent).
- Fewer responses were received for:
 - whānau-centred practice (69 per cent of respondents)
 - Māori models of engagement (60 per cent)
 - the engagement process when working with Pasifika ethnic groups (62 per cent).

Figure 17 shows responses received from NGO AOD services.

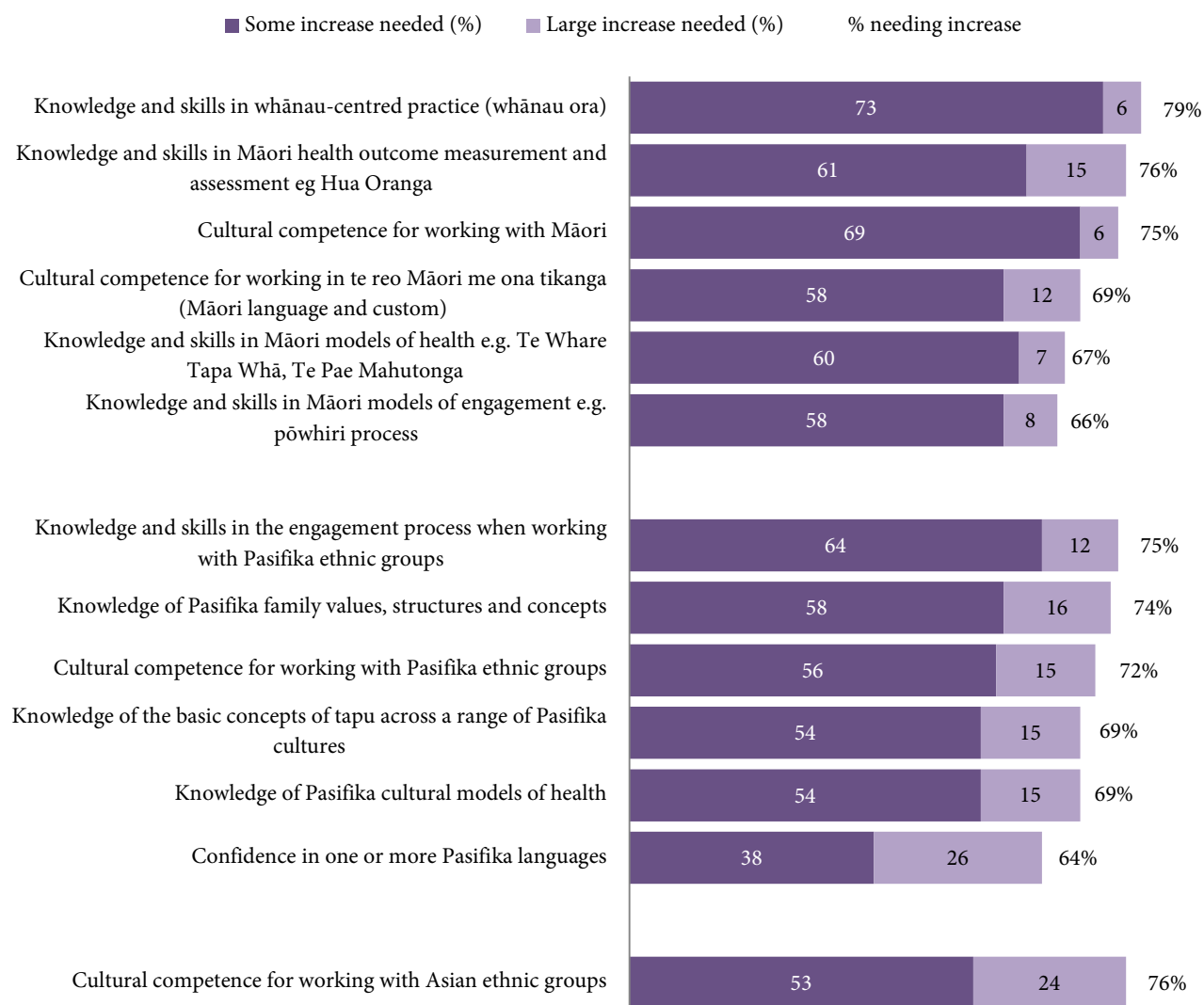


Figure 17. Proportion of NGO AOD service respondents indicating the need to improve workforce knowledge and skills in cultural competence (n= 85 responses)

In contrast to their DHB counterparts, NGO AOD service respondents identified the need to increase knowledge and skills in other areas.

- At least 75 per cent of these respondents identified the need for some or large increases in knowledge and skills in:
 - whānau-centred practice (79 per cent of respondents)
 - Māori health outcomes measurement and assessment, eg Hua Oranga (76 per cent)
 - cultural competence for working with Asian ethnic groups (76 per cent)
 - cultural competence for working with Māori (75 per cent)
 - the engagement process when working with Pasifika ethnic groups (75 per cent).
- Fewer responses were received for:
 - Māori models of engagement (66 per cent of respondents)

- confidence in one or more Pasifika languages (64 per cent, although 26 per cent thought their workforce needed a large increase in this area).

Problem gambling services

Problem gambling respondents reported a need for knowledge and skills in nearly all domains relating to working with Māori, Pasifika and Asian ethnic groups.

In particular, knowledge and skills in:

- Māori health outcomes measurement and assessment (94 per cent of respondents)
- Māori models of health (72 per cent)
- all but one competency in relation to working with Pasifika (61 per cent each, the exception is shown in the following list)
- cultural competence for working with Asian ethnic groups (61 per cent).

Fewer responses were received for:

- confidence in one or more Pasifika languages (28 per cent of respondents)
- cultural competence for working with Māori (44 per cent).

MH&A services

Most DHB MH&A service respondents identified their workforce need to increase knowledge and skills in:

- whānau-centred practice (86 per cent of respondents)
- cultural competence for working with Pasifika ethnic groups (93 per cent)
- Pasifika models of health (86 per cent).

Fewer responses were received for:

- confidence in one or more Pasifika languages (57 per cent)
- Māori health outcomes measurement (64 per cent).

Most NGO MH&A service respondents identified their workforce needed to increase knowledge and skills in:

- Pasifika cultural models of health (78 per cent)
- cultural competence for working with Māori (78 per cent)
- knowledge of Pasifika family values, structures and concepts (78 per cent).

Fewer responses were received for:

- Māori models of engagement (57 per cent)
- Māori health outcome measurement (61 per cent).

3.3 Chapter summary

This chapter has summarised survey results for questions about workforce ethnicity in relation to Māori, Pasifika and Asian ethnic groups, and cultural competence development needs.

Māori representation in the addiction workforce was high compared to the Māori adult population but lower than Māori representation as consumers of services. Pasifika representation in the workforce was similar to that of Pasifika AOD service consumers, although lower than Pasifika problem gambling consumers. Asian representation in the addiction workforce was generally low, with the exception of problem gambling services. It was also substantially higher than Asian representation as consumers of services across both AOD and problem gambling services.

Compared to DHBs, NGOs reported employing substantially higher proportions of Māori in their workforce, with the exception of kaupapa Māori services. Pasifika representation in DHB AOD services was slightly higher than in NGO AOD services.

In terms of the overall workforce, more than three-quarters of respondents from addiction services identified the need to increase workforce cultural competence across most areas relating to working with Māori, and Pasifika and Asian ethnic groups; AOD and MH&A services commonly identified whānau-centred practice, while problem gambling services most commonly identified Māori health outcomes measurement.

Chapter 4 presents the results for questions about workforce and service challenges, including recruitment and retention issues, workforce planning and development challenges, knowledge and skill needs in relation to key policy and practice areas, cross-sector relationships and wait list management.

4.0 Workforce and service challenges

This chapter describes workforce and service challenges based on 192 responses received from the 17 DHBs and 57 NGOs that completed the survey. In most cases, results reflect the opinions of service team leaders and managers as the main respondents to the survey, including any input they sought from others.⁴³

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 placed against one of six options.

Large shortage (20 per cent plus)	Some shortage	About right	Oversupply	Not likely to be employing	Don't know
--------------------------------------	---------------	-------------	------------	----------------------------	------------

A total of 180 responses to this question were received (94 per cent response rate), including 56 from DHB services and 124 from NGOs. By sector group, the responses were as follows.

- 129 from AOD services
- 13 from problem gambling services
- 38 from MH&A services.

This section contains analyses relevant to the Vote Health funded roles reported as either filled or vacant. The analysis is based on responses offering detail about large or small shortages, the right number or an oversupply of staff for these roles.⁴⁴ As respondents were only answering the question for existing roles in their workforce, the number of responses for each role varies. The full set of responses for AOD, problem gambling and MH&A services can be found in Appendix E: Additional tables.

Addiction services

The roles addiction service respondents suggested may have recruitment issues were:

- addiction practitioners (80 per cent of 69 respondents suggested some or large shortages)
- dual diagnosis practitioners (70 per cent of 23 respondents)
- registered nurses (67 per cent of 48 respondents)
- clinical psychologists (65 per cent of 20 respondents)
- community support workers (52 per cent of 25 respondents)
- administrative and technical support roles (38 per cent of 60 respondents).

⁴³ 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 have been used as a template for the specified survey responses.

⁴⁴ Responses ticked for against the 'not likely to be employing' or 'don't know' options, were excluded from the analyses.

AOD services

The graphs below present results for DHB and NGO AOD provider and sector categories, including only those roles that respondents had filled or were vacant at the time, and for which 10 or more valid survey responses were received.

Figure 18 shows responses from DHB AOD services. The dark purple part of the bar shows the proportion of responses indicating some shortage for the role, the lighter purple part shows the proportion of responses indicating a large shortage. The numbers on each section of the bar are the proportion (as percentages) of contributing respondents and the number at the far right is the total number of responses received for each role.

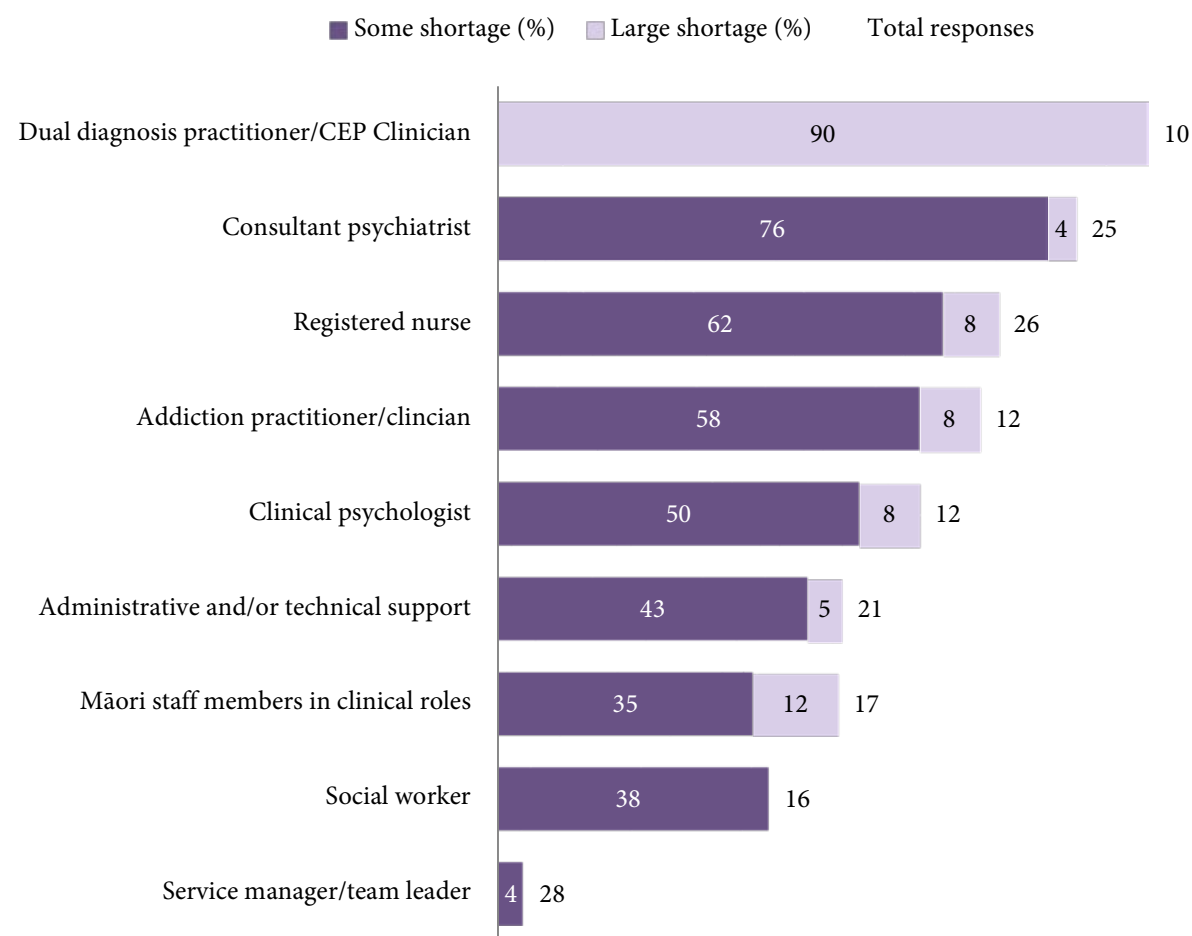


Figure 18. Proportion of DHB AOD service respondents perceiving future oversupply or shortage by roles (n=42 responses)

DHB AOD services were mainly concerned about some shortages rather than large shortages, and identified these across most roles in their workforce. The exception was for dual diagnosis practitioners or co-existing problems clinicians, where the majority respondents employing these roles expected a large shortage (90 per cent of 10 respondents).

Overall, the roles most commonly highlighted were:

- consultant psychiatrist roles (80 per cent of respondents expected at least some shortage)
- registered nurses (70 per cent of respondents expected at least some shortage).

Very few DHB services expected shortages for service managers and team leaders (one out of 28 responses). None of the roles receiving more than 10 responses were identified as having a potential oversupply in the next two years.

Figure 19 shows results for NGO AOD services in the same format as Figure 18.

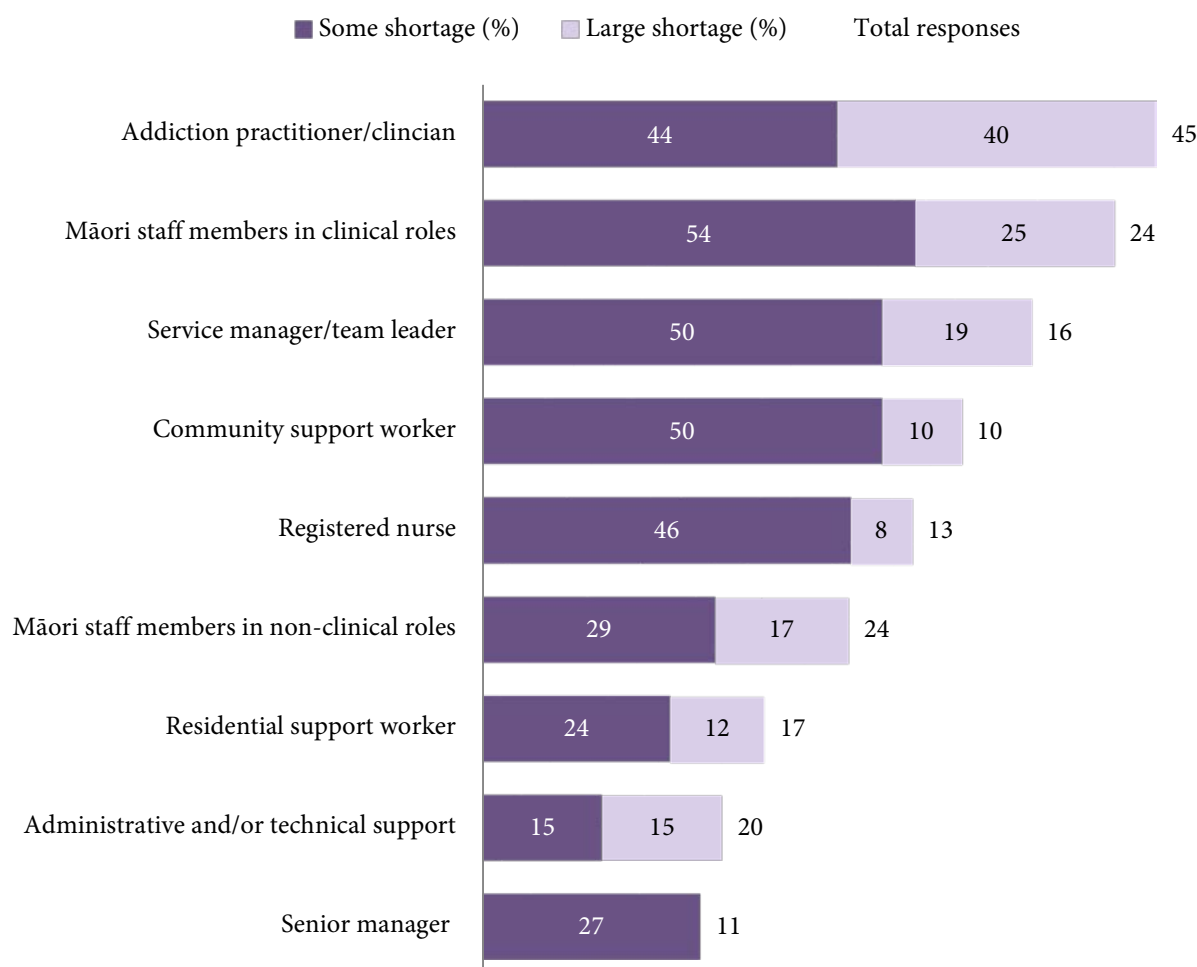


Figure 19. Proportion of NGO AOD service respondents perceiving future oversupply or shortage by roles (n=87 responses)

NGO AOD services reported concerns about staff shortages for the following roles.

- Addiction practitioners or clinicians; 84 per cent of 45 respondents expected shortages with half of those expecting large shortages.
- Māori staff members to fill clinical roles; 79 per cent of 24 respondents, with 25 per cent of respondents expecting large shortages.
- More than half of the respondents identified future shortages for:
 - service manager and team leader roles (69 per cent of 16 respondents)
 - community support worker roles (60 per cent of 10 respondents)

- registered nurses (54 per cent of 13 respondents).

None of the respondents suggested there might be an oversupply for any of the roles identified by the survey.

Problem gambling services

There were 13 responses to this question from problem gambling services. The roles most commonly identified as having potential future shortages included counsellors and dual diagnosis and co-existing problems clinicians. Problem gambling respondents were also concerned about shortages of Māori staff to fill clinical roles.

MH&A services

There were 38 responses to this question from MH&A services. The roles most commonly identified by DHB MH&A services as having potential future shortages included:

- consultant psychiatrist
- clinical psychologist
- administrative and technical support roles.

The roles most commonly identified by NGO MH&A services as having potential future shortages included:

- addiction practitioner roles
- community support worker
- Māori staff members for non-clinical roles.

4.2 Workforce planning and development challenges

Respondents identified the top four challenges for 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 issues they are facing within their current contexts.

There were a total of 144 responses to this question (75 per cent response rate) including 49 from DHB services and 95 from NGOs. By sector group, the responses were as follows.

- 97 from AOD services
- 17 from problem gambling services
- 30 from MH&A services.

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

The ranking of the challenges across different addiction categories varied by respondent. This is perhaps a reflection of the differing complexities of consumer presentation and organisational contexts within the sector.

Addiction services

The following list includes the seven challenges that were reported and the proportion of survey respondents that ranked the challenge in their top four,

- Managing pressure on staff due to increased demand for service (67 per cent of responses).
- Managing pressure on staff due to increased complexity (60 per cent).
- Static or reduced funds (54 per cent).
- Recruiting qualified and experienced staff (51 per cent).
- Retaining qualified and experienced staff (49 per cent).
- The cost of training and other professional development (45 per cent).
- Managing pressure on staff due to changing service delivery models (42 per cent).

The two challenges respondents most commonly ranked as their biggest challenge were:

- static or reduced funds (24 per cent of 144 respondents)
- recruiting qualified and experienced staff (24 per cent).

AOD services

The following two graphs present results for DHB and NGO AOD services.

Figure 20 shows the proportion of DHB AOD service respondents and the ranking of 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 the top four. Figure 21 provides results for NGO AOD services.⁴⁶

⁴⁶ For more information about all of the addiction categories, as well as the main DHB and NGO service types, see Appendix E: Additional tables.

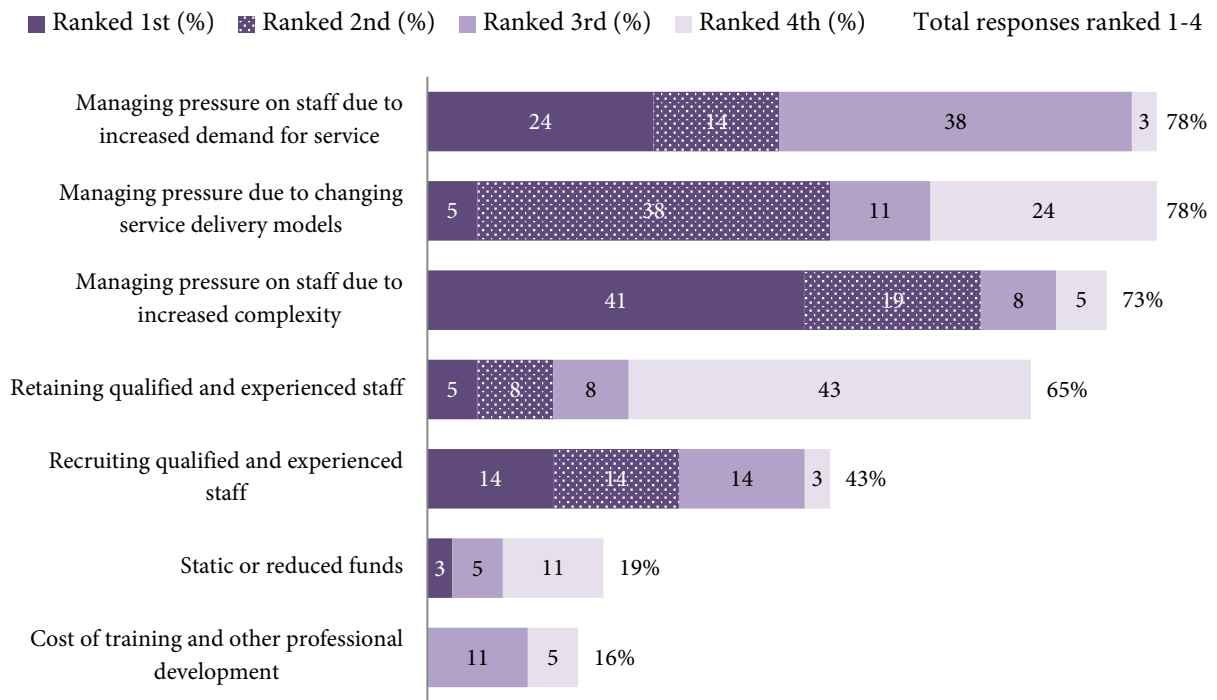


Figure 20. DHB AOD top workforce challenges (n=37 responses)

Respondents from DHB AOD services provided different responses to this question compared to the results for all addiction services. These differences included:

- managing pressure due to changing service delivery models; 78 per cent of respondents, compared to 42 per cent of all addiction service respondents
- managing pressure on staff due to increased complexity; 73 per cent, compared to 60 per cent of all addiction service respondents (respondents most commonly identified this challenge as their top challenge)
- retaining qualified and experienced staff; 65 per cent, compared to 51 per cent of all addiction service respondents.

The challenges least commonly selected by DHB AOD respondents included:

- the cost of training and other professional development (16 per cent, compared to 45 per cent of all addiction service respondents)
- static or reduced funds (19 per cent, compared to 54 per cent of all addiction service respondents).

Figure 21 shows the proportion of NGO AOD service respondents and the ranking of 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 the top four.

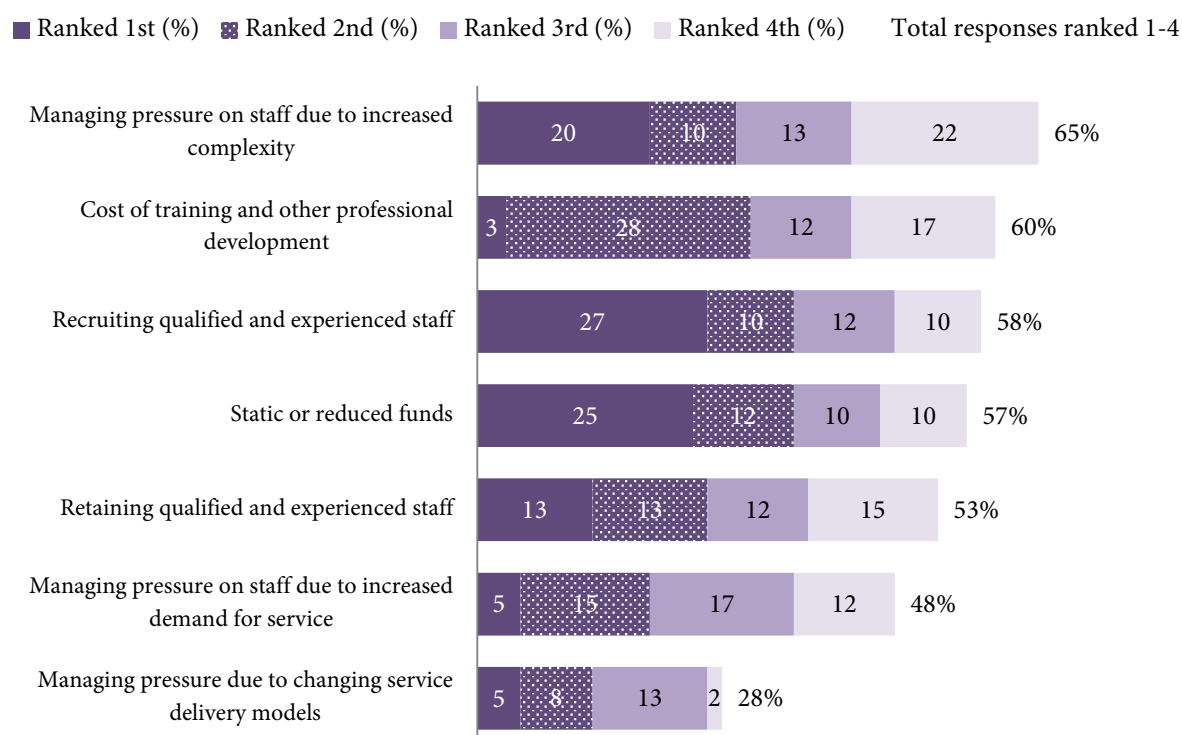


Figure 21. NGO AOD top workforce challenges (n=60 responses)

NGO AOD services most commonly identified managing pressure on staff due to increased demand for service as their top challenge. Compared to all addiction respondents, NGO AOD respondents provided different responses for:

- managing pressure on staff due to increased complexity (65 per cent of responses, compared to 60 per cent)
- the cost of training and other professional development (60 per cent, compared to 45 per cent for all addiction services)
- recruiting qualified and experienced staff (58 per cent, compared to 51 per cent for all addiction services).

Problem gambling services

Results for the 17 problem gambling service respondents compared to results for addiction services as a whole are described below.

- All problem gambling respondents identified static or reduced funds in their top four challenges (100 per cent, compared with 54 per cent for all addiction services).
- More than three-quarters ranked managing pressure on staff due to increased demand for service in the top four (77 per cent, compared with 67 per cent all addiction services).
- None of these respondents identified managing pressure due to changing service delivery models (compared with 42 per cent for all addiction services).

- Fewer problem gambling services selected retaining qualified and experienced staff (25 per cent, compared with 49 per cent for total addiction responses).

MH&A services

The differences between DHB MH&A and addiction services are highlighted below.

- The challenge most often ranked in the top four by DHB MH&A services was managing pressure on staff due to increased demand for service (83 per cent, compared to 67 per cent for all addiction services).
- The next most commonly ranked challenge was static or reduced funds (67 per cent, compared to 54 per cent for all addiction services).
- Only a few of these respondents ranked retaining qualified and experienced staff in the top four challenges (25 per cent, compared to 49 per cent for all addiction services).

There were some differences that stood out in the challenges identified by NGO MH&A services, compared with those for all addiction services.

- The challenges most often ranked in the top four by these respondents were:
 - managing pressure on staff due to increased demand for service (89 per cent, compared with 67 per cent for all addiction services)
 - static or reduced funds (67 per cent, compared with 54 per cent for all addiction services).
- Fewer respondents in this group ranked:
 - retaining qualified and experienced staff (39 per cent, compared with 49 per cent for all addiction services)
 - managing pressure on staff due to increased complexity (44 per cent, compared with 60 per cent for all addiction services).

4.3 Knowledge and skill levels

This section describes results for the question about workforce knowledge and skills relating to policy and current practice areas. The results for areas relating to cultural competence are described in section 4.2.

Respondents were asked to indicate whether or not their workforce needed to increase knowledge and skill levels in specific domains in the next two years, 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 this question, plus any input they sought from others. Answers were provided 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 182 responses were received for this question (95 per cent), including 56 from DHB services and 126 from NGOs. By sector group, responses were as follows.

- 127 from AOD services.
- 18 from problem gambling services.
- 37 from MH&A services.

Care should be taken when interpreting the information provided here. Areas less frequently identified as needing an increase in workforce skills cannot be interpreted as an indication of high levels of workforce competence. The results may reflect other factors, such as 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 this knowledge and these skills.

Addiction services

Most respondents indicated that some or large increases in staff knowledge and skills were needed in the next two years in a number of areas.

- A large proportion of respondents identified needing to increase skills for:
 - working with new technologies and IT (79 per cent of respondents)
 - co-existing problems capability (77 per cent)
 - working with older people (71 per cent)
 - psychological interventions (69 per cent)
 - working with families (68 per cent).
- Knowledge of community resources was the only area identified by less than half of the respondents (44 per cent).

AOD services

Knowledge and skills results for DHB and NGO AOD services are presented in the following series of graphs (Figure 22 and Figure 23), with one for DHB services and another for NGO services.⁴⁷ The graphs illustrate the proportion of respondents indicating there was either some or a large increase needed in workforce knowledge and skills.

- The first part of the bar presents 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.

⁴⁷ For the full set of responses, including for MH&A and problem gambling groups, see Appendix E: Additional tables.

- The percentage shown to the right of the bars is the proportion of respondents who indicated a need for any increase in knowledge and skills.

Figure 22 shows results for DHB AOD services in current policy and practice areas.

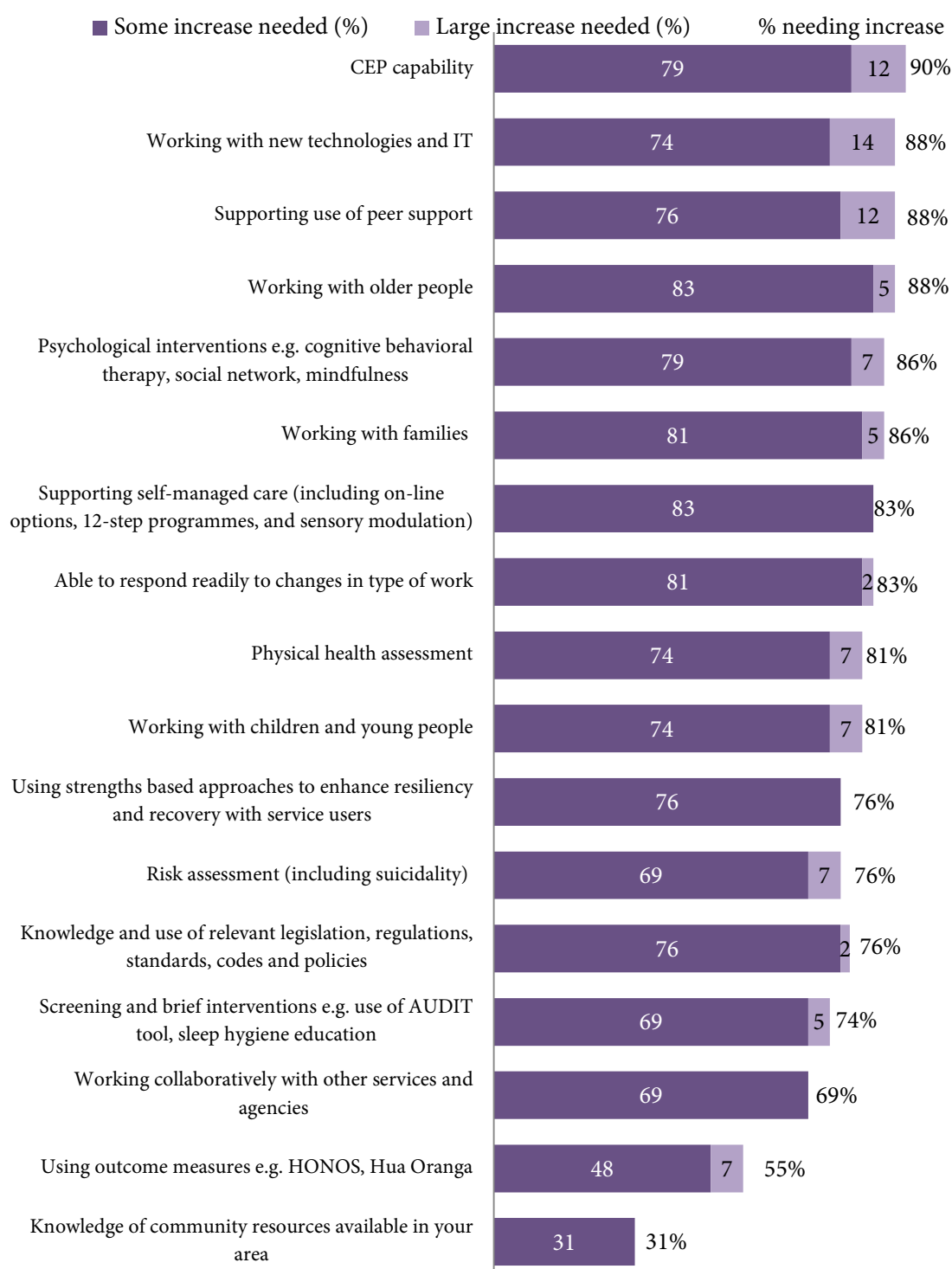


Figure 22. Proportion of DHB AOD services' respondents indicating the need to increase workforce knowledge and skill levels: current policy areas (n=42 responses)

DHB AOD respondents indicated the need for some or large increases in workforce knowledge and skills in the following areas.

- Co-existing problems capability (91 per cent of respondents).
- Working with new technologies and IT (88 per cent).
- Supporting use of peer support (88 per cent).
- Working with older people (88 per cent).
- Working with families (86 per cent).
- Psychological interventions (86 per cent).

Fewer respondents reported a need to increase knowledge and skills in:

- knowledge of community resources (31 per cent of respondents)
- using outcomes measures (55 per cent).

In general, DHB AOD respondents reported that their workforce needed to increase knowledge and skills more frequently than those from other addiction categories (eg MH&A or problem gambling). The notable exceptions were:

- knowledge of community resources available in their area (31 per cent of DHB AOD service responses, compared to 44 per cent for all addiction services)
- knowledge and skills in the engagement process when working with Pasifika ethnic groups (62 per cent, compared to 71 per cent for all addiction services).

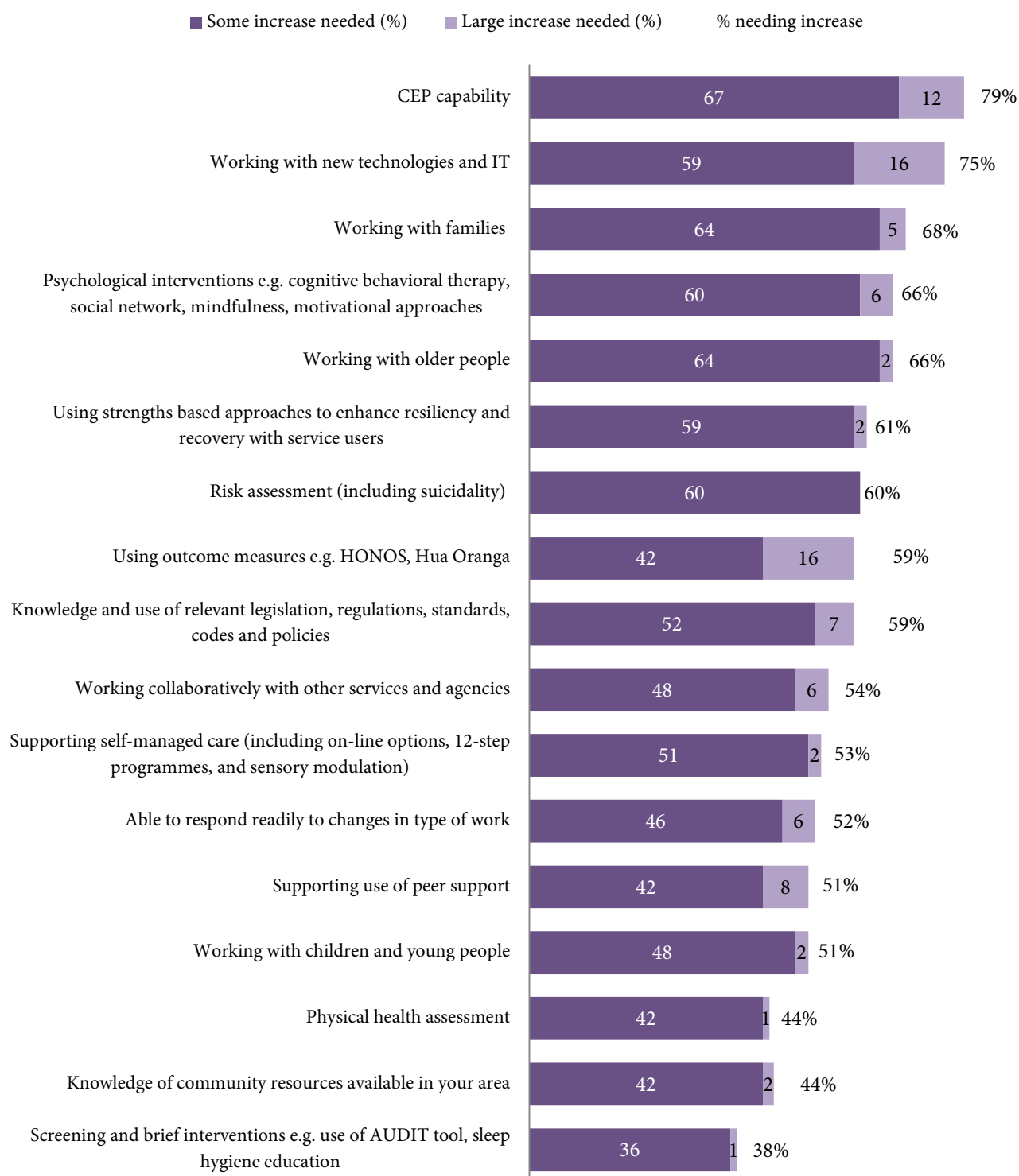


Figure 23. Proportion of NGO AOD respondents indicating the need to increase workforce knowledge and skill levels: current policy areas (n=85 responses)

In contrast to their DHB counterparts, NGO AOD respondents identified that their workforce needed to increase knowledge and skills in other areas.

- At least 75 per cent of these respondents identified the need for some or large increases in knowledge and skills for:
 - co-existing problems capability (79 per cent)

- working with new technologies and IT (75 per cent).
- Respondents were less likely to identify need in:
 - screening and brief interventions, eg use of AUDIT tool, sleep hygiene education (38 per cent)
 - physical health assessment (44 per cent of respondents)
 - knowledge of community resources available in your area (44 per cent).

Problem gambling services

Problem gambling respondents identified that their workforce needed to increase knowledge and skills in most areas, particularly:

- use of relevant legislation, regulations, standards, codes and policies (89 per cent)
- working with older people (67 per cent)
- working with new technologies and IT (67 per cent).

Fewer responses were received for:

- working collaboratively with other services and agencies (33 per cent)
- knowledge of community resources available in your area (50 per cent).

MH&A services

DHB MH&A respondents most commonly reported the need for increased knowledge and skills in relation to:

- working with new technologies and IT (93 per cent of respondents)
- co-existing problems capability (71 per cent).

Fewer responses were received for:

- using outcomes measures (29 per cent)
- risk assessment (including suicidality) (36 per cent).

NGO MH&A respondents identified a need to increase knowledge and skills in:

- risk assessment (83 per cent)
- working with new technologies and IT (74 per cent).

Fewer responses were received for:

- screening and brief interventions (44 per cent)
- working with children and young people (48 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 186 responses were received for this question (97 per cent), including 56 responses from DHB services and 130 from NGOs. By sector group, the responses were as follows.

- 131 from AOD services
- 18 from problem gambling services
- 37 from MH&A services.

The following analysis excludes non-responses and those indicating that a relationship with the sector is 'not applicable'. Results are reported for those who thought their relationships were working well and those who thought they needed to improve.⁴⁸ Additional tables showing the results for MH&A and problem gambling services are located in Appendix E: Additional tables.

Addiction services

For most of the sector relationships presented in the survey, a smaller proportion of addiction service respondents reported that their relationships were working well compared to those who thought they needed improving.

Between one-third and a half of these respondents identified their relationships were working well with:

- other addiction services (56 per cent of respondents)
- Corrections Department (49 per cent)
- other mental health services (33 per cent)
- primary health practices (32 per cent).

Respondents were most likely to report needing to improve relationships with:

- Housing New Zealand Corporation and other accommodation providers (46 per cent, compared to 13 per cent who said the relationship was working well)
- mental health services for older people (40 per cent; 16 per cent said it was working well)
- general hospitals and emergency departments (30 per cent; 23 per cent said it was working well)
- education (29 per cent; 22 per cent said it was working well)
- primary health practices (28 per cent; 32 per cent said it was working well).

⁴⁸ Responses that selected a given sector more than once have also been excluded.

AOD services

Figure 24 and Figure 25 show DHB and NGO AOD service results respectively. To the left of the zero axis, the bar shows the proportion of respondents (in percentages) needing to improve relationships with this sector, service or organisation. On the right hand side of the axis, the first part of the bar shows the proportion of respondents who thought the relationship was working adequately and the second part is the proportion for which relationships were working well. The total number of responses received (excluding those who did not select an option or selected not applicable) is presented at the right hand end of the bar.

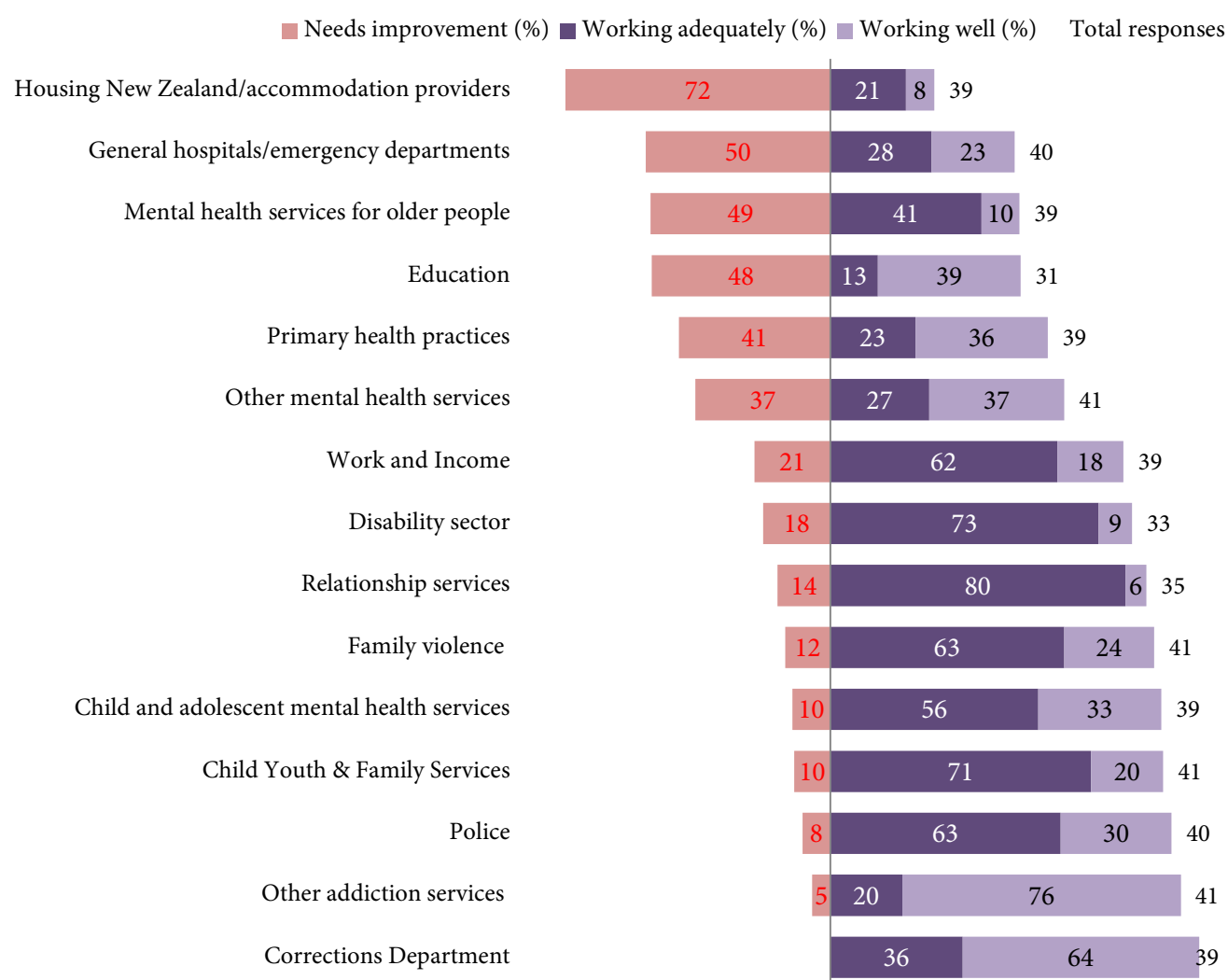


Figure 24. Proportion of respondents from DHB AOD services indicating the strength of cross-sector relationships (n=42 responses)

DHB AOD respondents thought relationships were working well with:

- other addiction services (76 per cent of respondents)
- Corrections Department (64 per cent)

- the education sector (39 per cent)
- other mental health services (37 per cent)
- primary health practices (36 per cent).

These respondents reported that relationships needed to improve with:

- Housing New Zealand Corporation and other accommodation providers (72 per cent of respondents)
- general hospitals and emergency departments (50 per cent)
- mental health services for older people (49 per cent)
- the education sector (48 per cent)
- primary health practices (41 per cent).

Figure 25 shows the results for NGO AOD services.

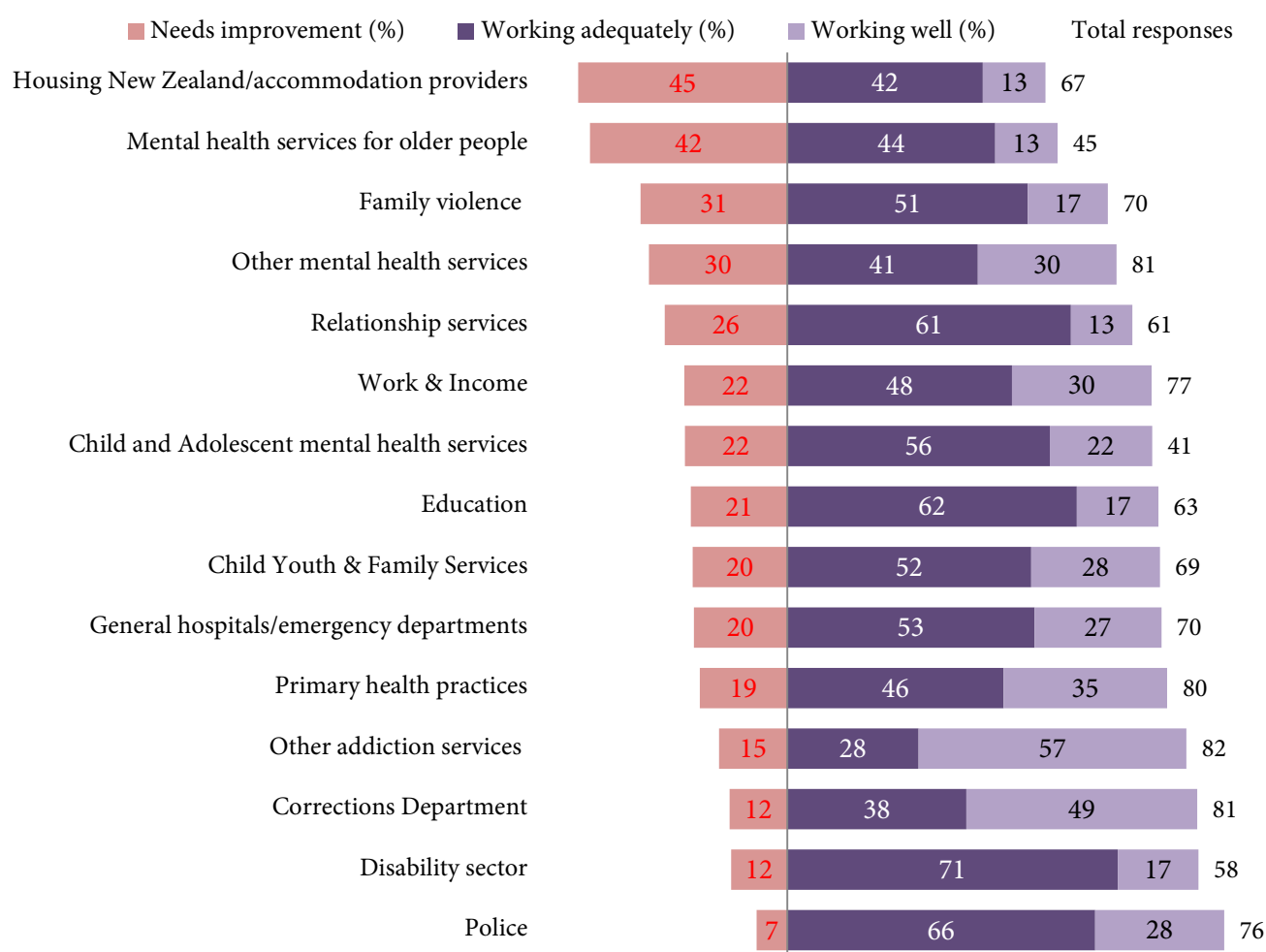


Figure 25. Proportion of respondents from NGO AOD services indicating the strength of cross-sector relationships (n=89 responses)

NGO AOD respondents reported their relationships were working well with:

- other addiction services (57 per cent of respondents)

- Corrections Department (49 per cent)
- primary health practices (35 per cent)
- Work and Income (30 per cent)
- other mental health services (30 per cent).

These respondents reported relationships needed to improve with:

- Housing New Zealand Corporation and other accommodation providers (45 per cent of respondents)
- mental health services for older people (42 per cent)
- family violence sector (31 per cent)
- other mental health services (30 per cent)
- relationship services (26 per cent).

Problem gambling services

Problem gambling respondents reported that relationships were working well with:

- Corrections Department (56 per cent of 18 respondents)
- other addiction services (53 per cent of 17 respondents)
- relationship services (50 per cent of 18 respondents)
- the family violence sector (50 per of 18 respondents cent)
- Work and Income (50 per cent of 18 respondents).

These respondents thought relationships needed to improve with:

- mental health services for older people (54 per cent of 18 respondents)
- the disability sector (54 per cent of 13 respondents)
- Child, Youth and Family (54 per cent of 13 respondents)
- general hospitals and emergency departments (47 per cent of 15 respondents)
- Police (35 per cent of 17 respondents)
- Corrections Department (33 per cent of 18 respondents).

MH&A services

MH&A respondents thought relationships were working well with:

- Police (34 per cent of 32 respondents)
- other mental health services (29 per cent of 34 respondents)
- other addiction services (29 per cent of 34 respondents)
- Work and Income (27 per cent of 33 respondents)
- mental health services for older people (27 per cent of 26 respondents).

These respondents thought relationships needed to improve with:

- the disability sector (42 per cent of 26 respondents)

- Child, Youth and Family Services (42 per cent of 26 respondents)
- Housing New Zealand Corporation and other accommodation providers (30 per cent of 33 respondents)
- the education sector (26 per cent of 27 respondents)
- primary health practices (20 per cent of 30 respondents).

4.5 Wait list management

A priority area for the wider health sector, and particularly the addiction and mental health sectors, is timely access to services. For many service providers managing wait lists is a key aspect of their duty of care. The previous Matua Raki *Addiction services: Workforce and service demand survey 2011 report* indicated there was a general increase in pressure on services, including in relation to client volumes and contractual demands (Matua Raki, 2011, p. 21). Information about wait list management is not currently or consistently captured elsewhere. Participants were asked:

1. whether they managed a wait list, and
2. what actions were taken to prevent, manage and/or reduce their wait list.

This question was asked only of addiction services. The following section describes responses received only from AOD and problem gambling services, and excludes responses from MH&A services.

AOD and problem gambling services

This question received 149 responses from AOD and problem gambling services (99 per cent response rate). Of these:

- 52 per cent did not manage a wait list
- 44 per cent did manage a wait list
- 3 per cent were unsure.

Choosing from a pre-set list of options, more than three-quarters (77 per cent) of the 149 respondents indicated taking actions to prevent, manage or reduce wait lists. Responses included a high proportion who reported not managing a wait list (52 per cent), potentially indicating that these actions prevented the need to have a wait list.

The actions reported to prevent, manage or reduce a wait list included:

- providing internal triage by the service (56 per cent of responses)
- referring to self-help groups (54 per cent)
- providing information (54 per cent)
- prioritising in a multi-disciplinary team (50 per cent).

Results differed across provider and sector categories. Table 32 shows results for DHB and NGO AOD services and problem gambling services. The last column shows the result for all responses from AOD and problem gambling services to the survey.

Table 13. *Actions to manage adult AOD and problem gambling services' wait lists*

Actions take to manage/reduce wait lists	DHB AOD (%)	NGO AOD (%)	Problem gambling (%)	Total (%)
n=	41	90	18	149
Prioritise in multi-disciplinary team meeting	75.6	44.4	22.2	50.3
Internal triage by service for appropriate treatment pathway	78.0	46.7	50.0	55.7
Referral to self-help groups or peer support workforce	65.9	50.0	44.4	53.7
Provide pamphlets and information	73.2	45.6	50.0	53.7
Referral to helpline (Alcohol Drug or Problem Gambling Helpline/Lifeline/Youthline)	63.4	41.1	38.9	47.0
Monitored and supported by other mental health and addiction services	70.7	30.0	44.4	43.0
Single point entry process/service coordination	65.9	31.1	5.6	37.6
Refer to pre-entry to service group	41.5	24.4	0.0	26.2
Interim opioid substitution prescribing	14.6	1.1	0.0	4.7
Choice and Partnership Approach (CAPA)	9.8	5.6	0.0	6.0
No action - have a wait list	0.0	2.2	0.0	1.3
No actions - don't have a wait list	7.3	24.4	38.9	21.5
No actions - don't know	0.0	1.1	0.0	0.7

AOD services

Most (93 per cent) DHB AOD service respondents reported taking actions to prevent, manage or reduce wait lists. Four actions were recorded by more than 70 per cent of these respondents (see Table 32).

- Provide internal triage (78 per cent of responses).
- Prioritise in a multi-disciplinary team (76 per cent).
- Provide information (73 per cent).
- Access support by another agency (71 per cent).

Selecting options from a pre-set list, just under three-quarters (72 per cent) of the NGO AOD respondents indicated taking actions to prevent, manage or reduce their wait lists. The most commonly identified responses included:

- making referrals to self-help or peer support (50 per cent)
- provided internal triage (47 per cent)
- prioritising in a multi-disciplinary team meeting (44 per cent).

Nearly one-quarter (24 per cent) stated they did not have a wait list and were taking no actions.

Problem gambling services

More than half (60 per cent) of the respondents from problem gambling services reported taking actions to prevent, manage or reduce waiting lists. The main actions identified included:

- providing information (50 per cent)
- providing internal triage (50 per cent)
- monitoring and support by other services (44 per cent)
- referring to self-help groups (44 per cent).

4.6 Chapter summary

This chapter presented survey results for workforce and service challenges facing adult addiction services.

Overall, addiction services most commonly expected recruitment and retention issues in the next two years for addiction practitioner, dual diagnosis practitioner, registered nurse, clinical psychologist, and community support worker roles.

Variations in the staffing concerns of the different provider and sector groups reflected their different workforce compositions. DHB AOD services highlighted concerns about staffing dual diagnosis practitioner, registered nurse and consultant psychiatrist roles. In contrast, NGO AOD services identified addiction practitioner and community support worker roles. Problem gambling services were concerned about staffing counsellor and dual diagnosis practitioner roles. DHB MH&A services highlighted consultant psychiatrist and clinical psychologist roles, whereas NGO MH&A services identified addiction practitioner roles. All three sector groups reported concerns about finding Māori staff to fill clinical roles.

The most commonly identified top four workforce planning and development challenges for addiction services included managing pressure on staff due to increased demand for service, and increased complexity, alongside static or reducing funds, and recruiting qualified and experienced staff (the last two were ranked as the top challenge by nearly one-quarter of all respondents).

In their top four challenges DHB AOD services commonly identified managing pressure on staff due to increased demand for service, and increased complexity, as well as retaining qualified and experienced staff. NGO AOD services also identified increased complexity in their top four challenges alongside the cost of training and development, and recruiting qualified and experienced staff. All problem gambling respondents ranked static or reduced funds in their top four challenges. Both DHB and NGO MH&A services identified increased demand for service, and static or reduced funds.

Around three-quarters of all addiction service respondents identified the need to increase workforce knowledge and skills relating to working with new technologies and IT, co-existing problems capability (these were

commonly identified by respondents across all the different groups analysed), working with older people and psychological interventions. In addition, DHB AOD services also indicated the need to increase knowledge around the use of peer support. Problem gambling respondents identified the need to increase understanding of relevant legislation and skills for working with older people, as well as working with new technologies. NGO MH&A services identified the need to improve workforce skills in risk assessment.

Generally, addiction services were less likely to identify that cross-sector relationships were working well than needed improving. Relationships most commonly identified as working well included those with other addiction services and the Corrections Department. Relationships most commonly identified as needing improvement were with Housing New Zealand Corporation and accommodation providers, mental health services for older people, and general hospital and emergency departments. In addition to these relationships, NGO AOD services identified their relationships with the family violence sector needed to improve. Problem gambling services and MH&A services also needed to improve relationships with the disability sector and Child, Youth and Family Services.

Nearly half of all AOD and problem gambling service respondents reported managing a wait list. Actions taken to prevent, reduce or manage a wait list (both by those with wait lists and 52 per cent of those without wait lists) included internal triage, referral to self-help groups, provision of information and prioritising in a multi-disciplinary team meeting. Problem gambling services also used monitoring and support by other agencies.

Chapter 5 provides a short conclusion to this report highlighting the main points.

5.0 Conclusion

This report presents results for the Vote Health funded workforce reported by 17 DHBs and 57 NGOs delivering adult AOD, problem gambling and MH&A services.⁴⁹ It provides a snapshot of the workforce providing addiction services within the health sector as reported by 17 DHBs and 57 NGOs.

The *More than numbers* organisation workforce survey builds on the valuable picture of the AOD and wider addiction services' workforce gained through previous workforce stocktakes and surveys including the 1998 and 2004 national telephone sampling surveys (Adamson, Deering, Schroder, Townshend, & Ditchburn, 2009), and the 2010 and 2011 workforce surveys conducted by Matua Raki 2011.

Overall, the report highlighted the following characteristics of this workforce.

- Adult addiction services reported a total of 1,832 FTE positions (employed and vacant).
 - AOD services reported 1,215 FTE positions.
 - Problem gambling services reported 101 FTE positions.
 - MH&A services reported 516 FTE positions.
- DHBs reported 53 per cent of the workforce and NGOs reported 47 per cent.
- 66 FTE positions were reported vacant (4 per cent), of which 63 per cent were DHB roles.
- Vacancy rates for adult addiction services were:
 - 4 per cent of the DHB workforce
 - 2 per cent of the NGO AOD and MH&A workforce
 - 9 per cent of the problem gambling workforce
- The adult addiction workforce was comprised of:
 - clinical roles (62 per cent)
 - non-clinical roles (18 per cent)
 - administration and management roles (20 per cent).
- Clinical roles with the largest workforce were:
 - addiction practitioners (19 per cent of the addiction workforce)
 - registered nurses (16 per cent)
 - dual diagnosis practitioners and co-existing problems clinicians (6 per cent).
- Non-clinical roles with the largest workforce were:
 - community support worker (4 per cent of the addiction workforce)
 - residential support workers (4 per cent)
 - peer support workers (2 per cent).
- Shortages were expected in the next two years for the following roles: addiction practitioners (80 per cent of 69 respondents), dual diagnosis practitioners (70 per cent of 23 respondents), registered nurses (67 per cent of 48 respondents), clinical psychologists (65 per cent of 20 respondents) and community support workers (52 per cent of 25 respondents).

⁴⁹ The *More than numbers* organisation workforce survey collected workforce information from 189 organisations with contracts to deliver adult mental health and addiction services during 2012/13 (a response rate of 75 per cent). Surveys were completed by all 20 DHBs and 73 per cent of the 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.

- Māori representation in the addiction workforce was 23 per cent, compared to 33 per cent of AOD service consumers and 24 per cent of problem gambling service consumers.
- Pasifika representation in the addiction workforce was 6 per cent, compared to 6 per cent of AOD service consumers and 20 per cent of problem gambling service consumers.
- Asian representation in the addiction workforce was 3 per cent, compared to 2 per cent of AOD service consumers and 7 per cent of problem gambling service consumers.
- The cultural workforce comprised 1.6 per cent of the reported adult addiction workforce (30 FTE positions).
- There were also 266 FTEs in kaupapa Māori services, 44 in Pasifika services and 13 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 need for increased workforce knowledge and skills.
- A number of cross-sector relationships were reported to be working well. However, respondents notably reported they needed to improve relationships with sectors such as Housing New Zealand Corporation and other accommodation providers, mental health services for older people, general hospitals and emergency departments.
- While not all AOD and problem gambling services had wait lists at the time of the survey, the majority of services reported taking actions to prevent, manage or reduce wait lists (77 per cent).

The *More than numbers* survey results reported here will support workforce planning for future adult addiction services by providing a starting point or benchmark for analysing changes over time. The workforce information that has been collected through this survey is intended to be used to inform future-focused service development and workforce development activities undertaken by a number of different stakeholders.

Workforce information can be used to support workforce planning, which 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.

Recommendations for workforce development across the addiction and mental health sectors are outlined in the full report *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services* (Te Pou o Te Whakaaro Nui, 2015).

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Appendices

Appendix A: Glossary of terms

A.1 Key terms

Addiction services:

For this report, addiction services includes alcohol and other drug (AOD) services, problem gambling services, and combined mental health and addiction (MH&A) 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 regions include the following DHB localities.

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:

These 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 DHB contracts.

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:

People who completed and returned valid organisation workforce survey sections on behalf of their organisation. The survey was expected to be completed by managers and team leaders within organisations.

Team and service types used by PRIMHD:

See Appendix E.

Vote Health funding:

Funding associated with the Ministry of Health or DHB contracts for adult mental health and addiction service delivery. 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:

Respondents self-reported the predominant service provided by their workforce choosing from a pre-set list of options. Survey responses have been consolidated into service type groups as described below.

Group name	Services included	
	Mental health	Addiction
Residential and inpatient	Residential Inpatient	Residential addiction treatment Withdrawal management (inpatient)
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)
Forensic	Forensic – inpatient Forensic – community	
Administration, management and support	Administration, management and support	Administration, management and support
Other	Employment Advocacy	Housing/supportive landlord Driving programmes Consumer advisor services

A.3 List of acronyms

CLIC: Ministry of Health Client Information Collection database

DHB: District Health Board

FTE: Full time equivalent

HWNZ: Health Workforce New Zealand

MH&A: Mental health and addiction

PRIMHD Programme for the integration of mental health data

NGO: Non-governmental organisation

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 organisation workforce survey asked about the:

- number of people employed
- full-time equivalent (FTE) positions employed and vacant by role (to two decimal places). The roles included all the major professional groups, support workers, cultural advice and support, administration and management roles. 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.
- FTE positions 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, and peer support
- the DHB locality where the service is delivered. Respondents had the option of identifying a number of DHB localities, as well as specifying the area they predominantly provided services in.

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.

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.

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 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. Some 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 how to complete 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 locality and type of service(s) delivered. Respondents were asked to fill in one Section B for the main DHB locality 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
- Vote 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 locality or region.⁵⁰ 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) 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 (MH&A) services.⁵¹ Table B. 3 shows the national distribution of survey returns.

⁵⁰ This strategy enabled workforce information to be presented at the region or by DHB locality.

⁵¹ These figures represent the distribution of responses to the survey and may not accurately reflect the distribution of services in the community.

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

The analyses presented in this report and 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, 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.

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

A key aim 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 (MH&A services). Responses in the last group covered a wide range from those offering integrated 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 MH&A service were reduced to those received 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 addiction and mental health services will be under-reported. In practice, many services are working with or supporting people who have both addiction and mental health issues, albeit using 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 locality. 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 locality. 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 FTE positions 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,⁵² 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.

94 ⁵² 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.

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.

Appendix C: Survey data dictionaries

C.1 Data dictionary on ethnicity and ethnic 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	<i>Tokelauan</i> New Georgian/ New Irelander 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
Asian	Burmese Cambodian Filipino Indonesian/ Javanese Kampuchean/ Khmer Lao/Laotian Malay/Malayan South East Asian Sundanese/ Sumatran Thai/Tai/Siamese Vietnamese	Chinese Hong Kong Chinese Kampuchean Chinese Malaysian Chinese Singaporean Chinese Taiwanese Chinese Vietnamese Chinese	Anglo Indian Bengali Fijian Indian Gujarati Indian Punjabi Sikh Tamil Afghani Bangladesh Eurasiani	Japanese Korean Nepalese Other Asian Pakistani Sinhalese Tibetan Sri Lankan Tamil

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 document 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 (CEP)	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.	
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

Service type	Services provided	Corresponding PRIMHD teams
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.	
Peer support	Peer support teams can be located within NGOs, DHBs 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 stay.	

Service type	Services provided	Corresponding PRIMHD teams
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	These 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.	
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 occupational groups and roles

The following table presents descriptions of roles and occupational 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		
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 other 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
Liaison/consult liaison	Examples include mental health and eating disorders liaison, Police, court liaison.	Werry Centre
Nursing		
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
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 hapori.	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
Clinical director	n/a	Werry Centre 134212

Role name	Description	Included on other surveys and occupation classification codes
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 5 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	Proportion 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.

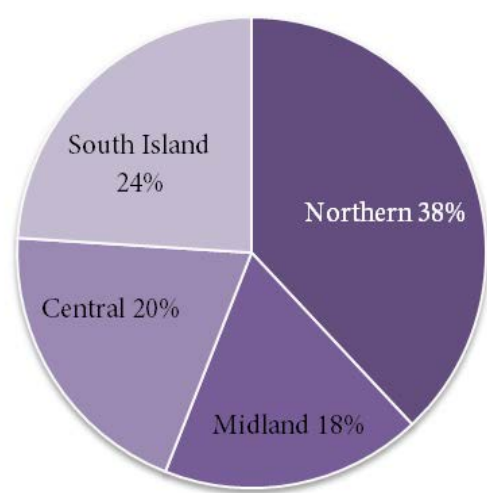


Figure D. 1 Proportion of New Zealand adult population (aged 20–64 years) by region

Population table

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

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
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

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
Southern															
Nelson	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
Marlborough															
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 substance use disorders

Te Rau Hinengaro: The New Zealand mental health survey (Oakley Browne et al., 2006) identified the prevalence rate for any substance use disorder was 3.5 per cent of the adult population.⁵³ However, the prevalence rates for Māori and Pasifika adults are higher at 8.6 per cent and 5.3 per cent respectively.⁵⁴ Table D.3 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, 2012a) 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).

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 (%)
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).

Prevalence of mental health disorders

Te Rau Hinengaro (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

⁵³ Including 2.6 per cent for alcohol abuse and 1.2 per cent for drug abuse.

⁵⁴ 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).

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).

Te Rau Hinengaro did not identify the prevalence of psychotic disorders in New Zealand. There is a paucity of information about their prevalence. The 2006/07 New Zealand health survey identified that 0.3 per cent of New Zealand adults meet a diagnosis of schizophrenia (Ministry of Health, 2008a, p. 24).

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 funding for mental health, AOD and problem gambling contracts 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.⁵⁵ 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.⁵⁶

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

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

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

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.

⁵⁵ \$1.082B excludes funding of \$ 3,368,613 specified as not mental health funding in the Price Volume Schedule.

⁵⁶ Funding information received from the Ministry of Health was categorised as for mental health, AOD or problem gambling services. However, it should be noted that in this report the addiction workforce includes combined MH&A services, which have no specific funding category. The extent to which organisations are contracted to deliver joint or integrated services is not able to be assessed from funding information.

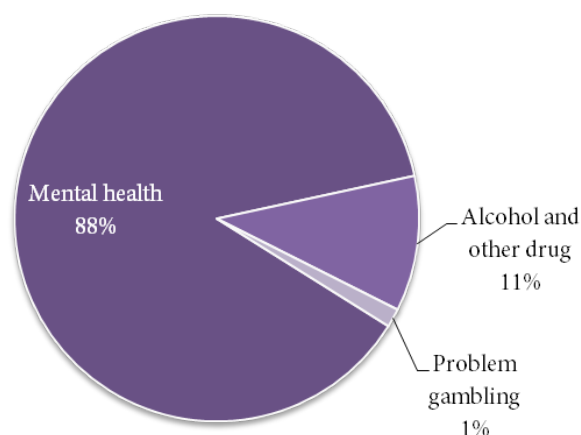


Figure D. 2. Proportion of Vote Health funding allocated to mental health, AOD and problem gambling contracts for the year ended 30 June 2013

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.⁵⁷ 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 funding that is not allocated regionally; this figure includes \$16 million allocated to problem gambling funding.

Table D. 5. 2012/13 Vote Health spend on adult addiction and mental health services per head of population by region

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

Note: *Total average spend includes funding for services that did not provide direct care and national funding for services, including problem gambling services, 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).

⁵⁷ This includes only a small proportion of the problem gambling funding, which is mostly distributed nationally rather than to local DHBs or regions.

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 organisations surveyed, by survey outcome and contracted service*

Survey outcome	Contracted service			Total health funds
	Mental health	AOD	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

Note. Funding displayed in this table is restricted to services that were within the survey scope.

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.

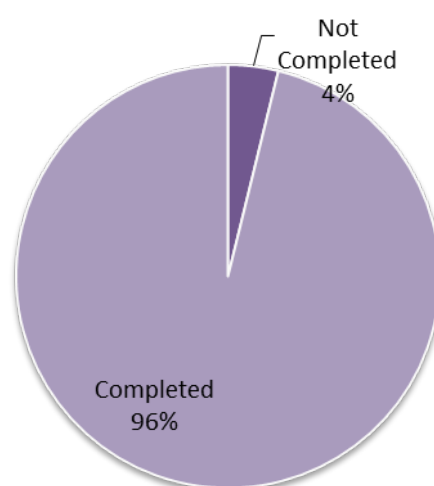


Figure D. 3. Proportion of Vote Health funding received by organisations surveyed, by survey outcome

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 DHB locality, organised by regions. This includes all funded services, not just those invited to participate in the survey.

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

DHB region and locality	Contracted 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

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 locality*

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

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

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.⁵⁸ 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.⁵⁹ The majority of organisations identified charity, fundraising and the Ministry of Social Development as key sources of income.

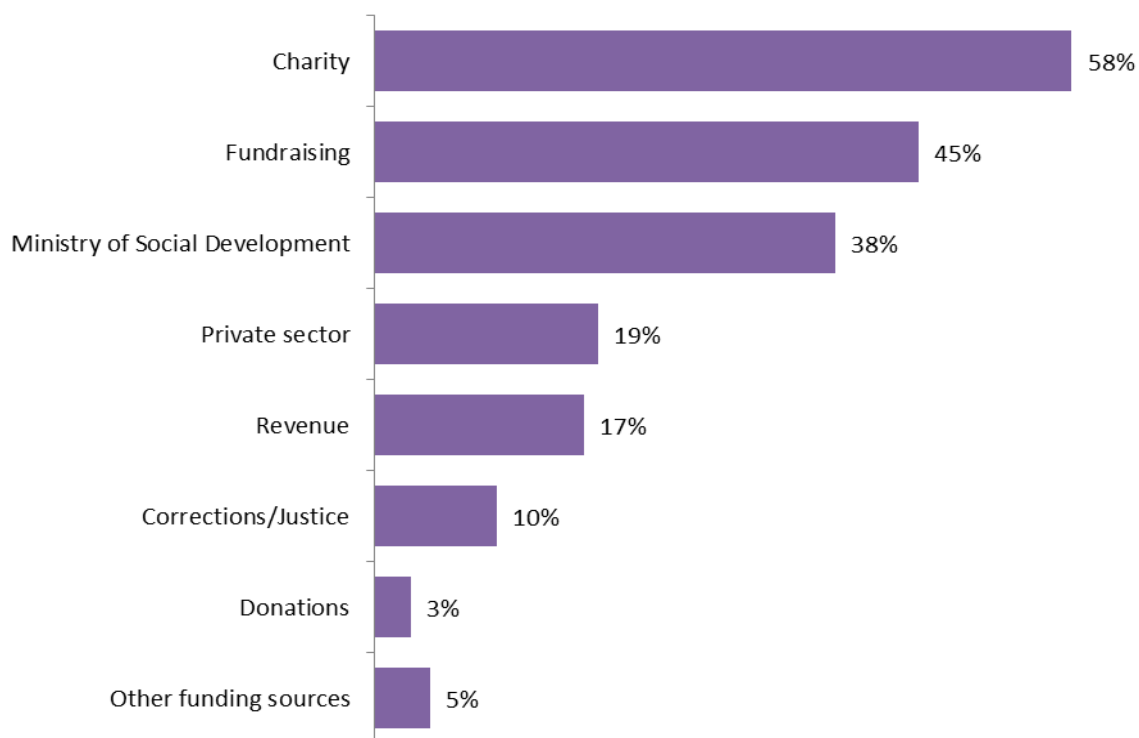


Figure D. 4. Sources of funding other than Vote Health received by NGOs (n=86)

⁵⁸ This question was based on the Matua Raki *Addiction Services: Workforce and service demand survey 2011 report* (2011).

⁵⁹ The percentages do not relate to the amount of funding received.

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.⁶⁰

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 AOD services

Table D. 9 summarises by region the number of adult consumers of AOD services 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 contained in these figures.

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. 9. *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.

⁶⁰ 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.

Table D.10 and Table D.11 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.10, the majority of consumers were seen by AOD community teams. A very small number were seen by co-existing problems, inpatient and residential teams.

Table D. 10. *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	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.

Table D.11 shows that community teams saw most consumers seen by NGOs. A much smaller proportion was seen by the NGO co-existing problems services (Table D. 11).

Table D. 11. *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 problems (community)	414	-	7,660	5,669
Co-existing problems (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.10 and Table D.11 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.12 and Table D.13 below.⁶¹

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. 12. *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 locality. 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. 13. *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.

Adult mental health services

Table D. 14 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.

⁶¹ The CLIC data relies on self-report by services, but there are checks on the quality of the data submitted.

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. 14. *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.

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

Table D. 15. *DHB 2012/13 service activity for adult mental health service consumers (aged 18–64) by PRIMHD team type*⁶²

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 and 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. 16 shows that NGO mental health service consumers were mostly seen by community teams. NGOs provided extensive residential accommodation to consumers.

Table D. 16. *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 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.

The 18 and 19 year olds reported in Table D.15 and Table D. 16 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

⁶² The team type categories used in this analysis predate the July 2014 HISO changes to team type codes.

period.⁶³ It is likely that most of people in this age group continue to be seen by child and adolescent services, including early intervention in psychosis services with child and adolescent mental health services.

Consumer and service use by DHB locality

Table D. 17. *Total adult (20–64 years) DHB and NGO consumers of AOD services by region and DHB locality*

Region and DHB	Adult AOD 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.

⁶³ These people represent unique consumers.

Table D. 18. Total adult (20 to 64 years) DHB and NGO mental health service consumers by region and DHB locality

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.

Appendix E: Additional tables

E.1 Chapter three additional tables

Table E. 1. *Workforce in roles as a proportion of the total addiction services workforce, by provider and sector groups*

Role	DHB AOD (%)	DHB MH&A (%)	NGO AOD (%)	NGO MH&A (%)	Problem gambling (%)	Total (%)
n=	633.2 FTEs	342.6 FTEs	582.2 FTEs	172.8 FTEs	101.1 FTEs	1832.0 FTEs
Clinical roles						
Addiction practitioner/clinician	11.1	3.1	40.9	8.9	8.7	18.7
Dual diagnosis practitioner/co-existing problems clinician	14.3	0.9	2.0	1.7	4.9	6.2
Counsellor	1.8	3.2	3.0	3.6	38.4	4.7
Educator/trainer	0.2	0.6	-	2.0	-	0.4
Occupational therapist	2.1	2.8	0.2	-	-	1.3
Clinical psychologist	3.5	5.3	0.4	-	-	2.3
Other psychologist	0.3	0.2	0.1	-	-	0.2
Social worker	8.9	4.1	2.1	2.6	2.5	4.9
Other allied health professionals	0.4	0.4	-	-	-	0.2
General practitioner	0.4	0.1	0.1	-	-	0.2
House surgeon	0.3	0.6	-	-	-	0.2
Consultant psychiatrist	4.7	5.8	-	0.1	-	2.7
Medical officer special scale (MOSS)	0.8	1.5	0.1	-	-	0.6
Psychiatric registrar	1.7	1.1	-	-	-	0.8
Liaison/consult liaison	0.2	0.3	-	-	-	0.1
Other medical professionals	0.2	-	-	-	-	0.1
Registered nurse	27.7	25.5	5.1	3.1	0.0	16.3
Enrolled nurse	0.0	0.0	0.3	0.0	0.0	0.1
Nurse practitioner/nurse specialist/nurse educator	0.7	3.1	0.2	0.0	0.0	0.9
Other clinical roles	0.2	0.9	-	1.2	26.3	1.8
Total (clinical roles)	79.4	59.4	54.4	23.2	80.8	62.5
Non-clinical roles						
Employment worker	-	-	-	1.1	-	0.1
Community support worker	1.3	2.0	3.4	26.7	1.0	4.5
Family support worker	-	0.6	2.3	1.7	-	1.0
Healthcare assistant	0.9	1.3	-	-	-	0.6
Peer support – consumer and service user	-	0.1	5.3	4.1	-	2.1
Peer support – family and whānau	-	-	0.6	0.7	-	0.3
Psychiatric assistant	4.0	-	-	-	-	1.4
Residential support worker	-	-	14.0	-	-	4.4
Other support workers	-	1.2	2.8	5.2	-	1.6
Cultural supervisor	-	-	0.2	1.7	1.5	0.3

Role	DHB AOD (%)	DHB MH&A (%)	NGO AOD (%)	NGO MH&A (%)	Problem gambling (%)	Total (%)
n=	633.2 FTEs	342.6 FTEs	582.2 FTEs	172.8 FTEs	101.1 FTEs	1832.0 FTEs
Kaumātua	0.3	0.5	0.1	1.6	1.2	0.4
Kuia	-	0.1	0.2	-	-	0.1
Kaiāwhina	0.5	0.3	0.1	0.1	-	0.3
Traditional Māori health practitioner	-	-	0.4	0.6	-	0.2
Matua	-	-	0.1	-	-	-
Pasifika cultural advisor	-	-	0.2	-	-	0.1
Other cultural advisor	0.1	0.9	0.2	0.1	-	0.3
Other non-clinical roles	-	-	0.1	-	-	-
Total (non-clinical roles)	7.1	6.9	29.9	43.5	3.7	17.6
Administration and management						
Administrative/technical support	7.1	15.5	6.7	9.6	4.0	8.6
Senior manager	0.7	2.5	2.8	7.3	2.2	2.4
Clinical director	0.1	1.7	0.3	-	-	0.5
Professional leader	0.1	1.3	0.7	1.2	5.9	0.9
Service manager/team leader	4.6	6.9	4.4	13.9	1.5	5.7
Consumer advisor/consumer leader	0.5	0.7	0.3	1.3	2.0	0.6
Family/whānau advisor	0.4	2.9	-	0.1	-	0.7
Other administration/management/support	-	2.2	0.5	-	-	0.6
Total (administration and management)	13.5	33.7	15.7	33.3	15.5	19.9
Total (all roles)	100.0	100.0	100.0	100.0	100.0	100.0

Tables E.2 and E.3 show the workforce in each of the service type groups for DHBs and NGOs.

Table E. 2. Total DHB workforce (FTE positions employed plus vacant) in each role by service type

Roles	DHB AOD services (FTE positions)			DHB MH&A services (FTE positions)			Total
	Community	Residential and inpatient	Admin & management	Community	Residential and inpatient	Admin & management	
Clinical roles							
Addiction practitioner/clinician	70.6	-	-	10.7	-	-	81.3
Dual diagnosis practitioner/CEP clinician	90.3	-	-	3.0	-	-	93.3
Counsellor	9.6	2.1	-	11.1	-	-	22.8
Educator/ trainer	1.0	-	-	-	-	2.0	3.0
Occupational therapist	13.1	0.5	-	9.5	-	-	23.1
Clinical psychologist	22.1	-	-	18.1	-	-	40.2
Other psychologist	1.8	-	-	0.8	-	-	2.6
Social worker	55.2	1.0	-	14.0	-	-	70.2
Other allied health professionals	1.0	1.3	-	-	1.0	0.5	3.8
General practitioner	2.1	0.3	-	0.2	-	-	2.6
House surgeon	2.0	-	-	1.0	1.0	-	4.0
Consultant psychiatrist	27.3	1.7	1.0	18.8	1.0	-	49.8
Medical officer special scale	5.3	-	-	5.0	-	-	10.3
Psychiatric registrar	10.6	-	-	3.6	-	-	14.2
Liaison/consult liaison	1.2	-	-	1.0	-	-	2.2
Other medical professionals	-	-	-	-	-	-	-
Registered nurse	147.5	28.0	-	87.5	-	-	263.0
Enrolled nurse	-	-	-	-	-	-	-
Nurse practitioner	4.2	-	-	4.0	-	6.6	14.8
Other nursing professionals	0.2	-	-	-	-	-	0.2
Other clinical roles	2.0	-	-	2.0	-	1.0	5.0
Total (clinical roles)	467.0	34.9	1.0	190.2	3.0	10.1	706.2
Non-clinical roles							
Support workers							
Community development worker	-	-	-	-	-	-	-
Employment worker	-	-	-	-	-	-	-
Community support worker	4.9	3.2	-	6.8	-	-	14.9
Family support worker	-	-	-	2.0	-	-	2.0
Healthcare assistant	0.8	5.0	-	-	4.4	-	10.2
Peer support - consumer and service user	-	-	-	0.5	-	-	0.5
Peer support - family and whānau	-	-	-	-	-	-	-

Roles	DHB AOD services (FTE positions)			DHB MH&A services (FTE positions)			Total
	Community	Residential and inpatient	Admin & management	Community	Residential and inpatient	Admin & management	
Psychiatric assistant	25.4	-	-	-	-	-	25.4
Residential support worker	-	-	-	-	-	-	-
Other support workers	-	-	-	-	-	4.0	4.0
Total (support workers)	31.0	8.2	-	9.3	4.4	4.0	56.9
Cultural advice and support							
Cultural supervisor	-	-	-	-	-	-	-
Kaumātua	2.0	-	-	1.1	-	0.5	3.6
Kuia	-	-	-	-	-	0.5	0.5
Kaiāwhina	2.9	0.2	-	1.0	-	-	4.1
Traditional Māori health practitioner	-	-	-	-	-	-	-
Matua	-	-	-	-	-	-	-
Pasifika cultural advisor	-	-	-	-	-	-	-
Other cultural advisor	0.8	-	-	3.0	-	-	3.8
Total (cultural advice and support)	5.7	0.2	-	5.1	-	1.0	12.0
Other non-clinical roles	-	-	-	-	-	-	-
Total (non-clinical roles)	36.7	8.4	-	14.4	4.4	5.0	68.9
Administration and management							
Administrative and/or technical support	42.4	0.4	2.0	22.7	-	30.6	98.1
Senior manager	3.4	1.3	-	0.6	1.0	7.0	13.3
Clinical director	0.2	0.5	-	-	-	5.8	6.5
Professional leader	-	-	0.6	0.9	-	3.4	4.9
Service manager/team leader	24.5	2.0	2.4	12.0	1.0	10.5	52.4
Consumer advisor/consumer leader	2.1	-	1.0	-	-	2.4	5.5
Family/whānau advisor	1.5	-	1.0	1.0	-	8.9	12.4
Other administration and management	-	-	-	-	-	7.7	7.7
Total (administration and management)	74.1	4.1	7.0	37.2	2.0	76.3	200.7
Total (all roles)	577.8	47.4	8.0	241.8	9.4	91.4	975.8

Table E. 3. *Total NGO workforce by roles and service types*

Roles	NGO AOD services (FTE positions)			NGO MH&A services (FTE positions)				Problem gambling services	Total
	Community	Residential and inpatient	Admin & management	Community	Residential and inpatient	Admin & management	Other		
Clinical roles									
Addiction practitioner/clinician	150.7	86.3	-	12.5	1.0	1.8	-	8.8	262.1
Dual diagnosis practitioner/CEP clinician	8.7	3.0	-	1.0	-	2.0	-	5.0	19.7
Counsellor	11.5	6.2	-	6.3	-	-	-	38.9	62.8
Educator/ trainer	-	-	-	3.5	-	-	-	-	3.5
Occupational therapist	0.5	0.5	-	-	-	-	-	-	1.0
Clinical psychologist	1.6	0.5	-	-	-	-	-	-	2.1
Other psychologist	0.5	-	-	-	-	-	-	-	0.5
Social worker	6.0	6.0	-	4.5	-	-	-	2.5	19.0
Other allied health professionals	-	-	-	-	-	-	-	-	-
General practitioner	0.2	0.7	-	-	-	-	-	-	0.9
House surgeon	-	-	-	-	-	-	-	-	-
Consultant psychiatrist	-	0.0	-	0.2	-	-	-	-	0.2
Medical officer special scale	0.4	-	-	-	-	-	-	-	0.4
Psychiatric registrar	-	-	-	-	-	-	-	-	-
Liaison/consult liaison	-	-	-	-	-	-	-	-	-
Other medical professionals	-	-	-	-	-	-	-	-	-
Registered nurse	18.2	11.4	-	4.0	-	1.3	-	-	34.8
Enrolled nurse	-	2.0	-	-	-	-	-	-	2.0
Nurse practitioner	-	1.0	-	-	-	-	-	-	1.0
Other nursing professionals	-	-	-	-	-	-	-	-	-
Other clinical roles	-	-	-	2.0	-	-	-	26.5	28.5
Total (clinical roles)	198.2	117.6	-	34.0	1.0	5.1	-	81.7	438.5
Non-clinical roles									
Support workers									
Community development worker	-	-	-	-	-	-	-	-	-
Employment worker	-	-	-	1.0	-	-	0.9	-	1.9
Community support worker	17.6	2.1	-	31.9	9.0	-	5.2	1.0	66.8
Family support worker	11.0	2.5	-	3.0	-	-	-	-	16.5
Healthcare assistant	-	-	-	-	-	-	-	-	-
Peer support - consumer and service user	18.2	12.4	-	5.8	-	-	1.4	-	37.8
Peer support - family and whānau	3.5	-	-	1.2	-	-	-	-	4.7

Roles	NGO AOD services (FTE positions)			NGO MH&A services (FTE positions)				Problem gambling services	Total
	Community	Residential and inpatient	Admin & management	Community	Residential and inpatient	Admin & management	Other		
Psychiatric assistant	-	-	-	-	-	-	-	-	-
Residential support worker	7.7	72.0	-	-	-	-	-	-	81.3
Other support workers	12.4	3.8	-	9.0	-	-	-	-	25.2
Total (support workers)	70.5	92.8	-	51.8	9.0	-	7.4	1.0	234.1
Cultural advice and support									
Cultural supervisor	1.1	0.0	-	0.6	-	2.4	-	1.5	5.6
Kaumātua	0.5	0.2	-	0.3	-	2.4	-	1.2	4.6
Kuia	1.0	-	-	-	-	-	-	-	1.0
Kaiāwhina	-	0.5	-	0.1	-	-	-	-	0.6
Traditional Māori health practitioner	2.0	0.5	-	1.0	-	-	-	-	3.5
Matua	-	0.3	-	-	-	-	-	-	0.3
Pasifika cultural advisor	1.1	-	-	-	-	-	-	-	1.1
Other cultural advisor	0.7	0.5	-	0.2	-	-	-	-	1.4
Total (cultural advice and support)	6.3	2.0	-	2.2	-	4.8	-	2.7	18.0
Other non-clinical roles	0.8	-	-	-	-	-	-	-	0.8
Total (non-clinical roles)	77.6	94.8	-	54.0	9.0	4.8	7.4	3.7	252.8
Administration and management									
Administrative and/or technical support	19.0	16.3	3.6	4.2	-	11.6	0.8	4.0	59.4
Senior manager	5.5	8.0	3.0	1.0	-	10.6	1.0	2.2	31.3
Clinical director	1.0	-	1.0	-	-	-	-	-	2.0
Professional leader	1.0	3.0	-	-	-	2.0	-	6.0	12.0
Service manager/team leader	10.5	14.2	0.8	9.0	1.0	14.1	-	1.5	51.2
Consumer advisor/consumer leader	-	0.9	-	0.5	-	1.8	-	2.0	6.1
Family/whānau advisor	-	-	-	0.2	-	-	-	-	0.2
Other administration and management	-	2.7	-	-	-	-	-	-	2.7
Total (administration and management)	37.0	45.1	8.4	14.8	1.0	40.0	1.8	15.7	164.7
Total (all roles)	312.7	257.5	8.4	102.8	11.0	49.9	9.2	101.1	856.1

Table E. 4. *FTE positions vacant by role and by provider and sector groups*

Role	FTE positions vacant					
	DHB AOD	DHB MH&A	NGO AOD	NGO MH&A	Problem gambling	Total
Clinical roles						
Allied health						
Addiction practitioner/clinician	5.0	-	9.6	-	1.0	15.6
Dual diagnosis practitioner/co-existing problems clinician	4.0	-	-	-	-	4.0
Counsellor	0.3	-	-	-	5.5	5.8
Educator/trainer	-	-	-	-	-	-
Occupational therapist	2.1	2.0	-	-	-	4.1
Clinical psychologist	1.7	2.4	0.6	-	-	4.7
Other psychologist	-	-	-	-	-	-
Social worker	1.4	-	-	-	-	1.4
Other allied health professionals	-	-	-	-	-	-
Total (allied health)	14.5	4.4	10.2	-	6.5	35.6
Medical and other professionals						
General practitioner	-	-	-	-	-	-
House surgeon	-	-	-	-	-	-
Consultant psychiatrist	0.1	-	-	-	-	0.1
Medical officer special scale (MOSS)	-	-	-	-	-	-
Psychiatric registrar	0.5	-	-	-	-	0.5
Liaison/consult liaison	-	-	-	-	-	-
Other medical professionals	-	-	-	-	-	-
Total (medical and other professionals)	0.6	-	-	-	-	0.6
Nursing	9.4	3.4	1.5	-	-	14.3
Other clinical roles	-	-	-	-	2.4	2.4
Total (clinical roles)	24.5	7.8	11.7	-	8.9	52.9
Non-clinical roles						
Support workers						
Community development worker	-	-	-	-	-	-
Employment worker	-	-	-	-	-	-
Community support worker	-	-	-	1.5	-	1.5
Family support worker	-	-	1.2	-	-	1.2
Healthcare assistant	-	-	-	-	-	-
Peer support – consumer and service user	-	-	-	-	-	-
Peer support – family and whānau	-	-	-	-	-	-
Psychiatric assistant	-	-	-	-	-	-
Residential support worker	-	-	-	-	-	-
Other support workers	-	1.0	-	-	-	1.0

Role	FTE positions vacant					
	DHB AOD	DHB MH&A	NGO AOD	NGO MH&A	Problem gambling	Total
Total (support workers)	-	1.0	1.2	1.5	-	3.7
Cultural advice and support						
Cultural supervisor	-	-	-	-	-	-
Kaumātua	-	-	-	0.2	-	0.2
Kuia	-	-	-	-	-	-
Kaiāwhina	-	-	-	-	-	-
Traditional Māori health practitioner	-	-	-	-	-	-
Matua	-	-	-	-	-	-
Pasifika cultural advisor	-	-	-	-	-	-
Other cultural advisor	-	-	-	-	-	-
Total (cultural advice and support)	-	-	-	0.2	-	0.2
Other non-clinical roles	-	-	-	-	-	-
Total (non-clinical roles)	-	1.0	1.2	1.7	-	3.9
Administration and management						
Administrative/technical support	1.0	-	-	0.4	-	1.4
Senior manager	-	1.0	-	-	-	1.0
Clinical director	-	1.0	-	-	-	1.0
Professional leader	-	0.4	-	-	-	0.4
Service manager/team leader	-	1.0	-	-	-	1.0
Consumer advisor/consumer leader	-	-	-	0.3	-	0.3
Family/whānau advisor	-	4.1	-	-	-	4.1
Other administration/management/support	-	-	-	-	-	-
Total (administration and management)	1.0	7.5	-	0.7	-	9.2
Total (all roles)	25.5	16.3	12.9	2.4	8.9	66.0

Table E. 5. Vacancy rates for roles (FTE positions vacant as a proportion of the total FTE positions (employed plus vacant) for each role) by provider and sector groups

Role	Vacancy rate (%)					
	DHB AOD	DHB MH&A	NGO AOD	NGO MH&A	Problem gambling	Total
Clinical roles						
Allied health						
Addiction practitioner/clinician	7.1	-	4.0	-	11.4	4.5
Dual diagnosis practitioner/co-existing problems clinician	4.4	-	-	-	-	3.5
Counsellor	2.6	-	-	-	14.2	6.8
Educator/trainer	-	-	-	-	-	-
Occupational therapist	15.4	21.1	-	-	-	17.0
Clinical psychologist	7.7	13.3	28.6	-	-	11.1
Other psychologist	-	-	-	-	-	-
Social worker	2.5	-	-	-	-	1.6
Other allied health professionals	-	-	-	-	-	-
Allied health vacancy rate	5.4	6.2	3.6	-	25.6	5.0
Medical and other professionals						
General practitioner	-	-	-	-	-	-
House surgeon	-	-	-	-	-	-
Consultant psychiatrist	0.3	-	-	-	-	0.2
Medical officer special scale (MOSS)	-	-	-	-	-	-
Psychiatric registrar	4.7	-	-	-	-	3.5
Liaison/consult liaison	-	-	-	-	-	-
Other medical professionals	-	-	-	-	-	-
Medical and other professionals vacancy rate	1.1	-	-	-	-	0.7
Nursing	5.2	3.5	4.6	-	-	4.5
Other clinical roles	-	-	-	-	9.0	7.4
Clinical roles vacancy rate	4.9	3.8	3.7	-	10.9	4.6
Non-clinical roles						
Support workers						
Community development worker	-	-	-	-	-	-
Employment worker	-	-	-	-	-	-
Community support worker	-	-	-	3.3	-	1.8
Family support worker	-	-	8.9	-	-	6.5
Healthcare assistant	-	-	-	-	-	-
Peer support – consumer and service user	-	-	-	-	-	-
Peer support – family and whānau	-	-	-	-	-	-
Psychiatric assistant	-	-	-	-	-	-
Residential support worker	-	-	-	-	-	-

Role	Vacancy rate (%)					
	DHB AOD	DHB MH&A	NGO AOD	NGO MH&A	Problem gambling	Total
Other support workers	-	25.0	-	-	-	3.4
Support worker vacancy rate	-	5.6	0.7	2.2	-	1.3
Cultural advice and support						
Cultural supervisor	-	-	-	-	-	-
Kaumātua	-	-	-	7.4	-	2.4
Kuia	-	-	-	-	-	-
Kaiāwhina	-	-	-	-	-	-
Traditional Māori health practitioner	-	-	-	-	-	-
Matua	-	-	-	-	-	-
Pasifika cultural advisor	-	-	-	-	-	-
Other cultural advisor	-	-	-	-	-	-
Cultural advice and support worker vacancy rate	-	-	-	2.9	-	0.7
Other non-clinical roles	-	-	-	-	-	-
Non-clinical roles vacancy rate	-	4.2	0.7	2.3	-	1.2
Administration and management						
Administrative/technical support	2.2	-	-	2.4	-	0.9
Senior manager	-	11.6	-	-	-	2.2
Clinical director	-	17.2	-	-	-	11.8
Professional leader	-	9.3	-	-	-	2.4
Service manager/team leader	-	4.3	-	-	-	1.0
Consumer advisor/consumer leader	-	-	-	13.6	-	2.6
Family/whānau advisor	-	41.4	-	-	-	32.7
Other administration and management	-	-	-	-	-	-
Administration and management vacancy rate	1.2	6.5	-	1.2	-	2.5
Vacancy rate for all roles	4.0	4.8	2.2	1.4	8.8	3.6

NGO non-health funded workforce

Respondents were asked to differentiate staff by health and non-health funding. For addiction services, a total of 230 non-health funded FTE positions were reported in the survey. Most non-health funded positions were located in NGOs.

Table E. 6 shows the number of non-health funded FTE positions reported by NGOs (only one DHB non-health funded FTE position was reported and this was a community support worker). The number of FTE positions filled and vacant for each addiction category are also reported here.

Table E. 6. *NGO non-health funded workforce (FTE positions employed and vacant) by workforce roles*

Role	NGO non-health funded FTE positions		
	Employed	Vacancies	Total
Clinical roles			
Addiction practitioner/clinician	32.1	1.0	33.1
Dual diagnosis practitioner/co-existing problems clinician	13.0	-	13.0
Counsellor	2.0	-	2.0
Educator/trainer	1.0	-	1.0
Occupational therapist	0.8	-	0.8
Other psychologist	2.0	-	2.0
Social worker	14.0	-	14.0
General practitioner	0.3	-	0.3
Consultant psychiatrist	3.6	-	3.6
Registered nurse	22.7	3.3	26.1
Total (clinical roles)	91.5	4.3	95.9
Non-clinical roles			
Support workers			
Employment worker	2.6	-	2.6
Community support worker	4.4	-	4.4
Family support worker	4.0	-	4.0
Peer support – consumer and service user	0.1	-	0.1
Psychiatric assistant	3.3	-	3.3
Residential support worker	34.1	-	34.1
Other support workers	16.0	-	16.0
Total (support workers)	64.5	-	64.5
Cultural workers			
Cultural advisor	0.1	-	0.1
Kaumātua	1.7	-	1.7
Kuia	0.4	-	0.4
Matua	1.0	-	1.0
Other cultural advisor	2.0	-	2.0
Total (cultural workers)	5.3	-	5.3
Total (non-clinical roles)	69.7	-	134.1

Role	NGO non-health funded FTE positions		
	Employed	Vacancies	Total
Administration and management			
Administrative/technical support	28.7	-	28.7
Senior manager	17.7	-	17.7
Clinical director	3.0	-	3.0
Professional leader	3.0	-	3.0
Service manager/team leader	8.5	-	8.5
Family/whānau advisor	3.0	-	3.0
Other administration and management	0.4	-	0.4
Total (administration and management)	64.3	-	64.3
Total (all roles)	225.6	4.3	229.9

Table E. 7. *Non-health funded total workforce (FTE positions employed plus vacant) by provider and sector groups*

Roles	Workforce (FTE positions employed plus vacant)			
	NGO AOD	NGO MH&A	Problem gambling	Total
Clinical roles				
Addiction practitioner/clinician	33.1	-	-	33.1
Dual diagnosis practitioner/co-existing problems clinician	13.0	-	-	13.0
Counsellor	-	-	2.0	2.0
Educator/trainer	1.0	-	-	1.0
Occupational therapist	0.8	-	-	0.8
Other psychologist	2.0	-	-	2.0
Social worker	-	14.0	-	14.0
General practitioner	0.3	-	-	0.3
Consultant psychiatrist	3.6	-	-	3.6
Nursing	25.1	1.0	-	26.1
Total (clinical roles)	78.9	15.0	2.0	95.9
Non-clinical roles				
Support workers				
Community development worker	-	-	-	-
Employment worker	1.4	1.2	-	2.6
Community support worker	0.4	4.0	-	4.4
Family support worker	4.0	-	-	4.0
Peer support – consumer and service user	0.1	-	-	0.1
Peer support – family and whānau	-	-	-	-
Psychiatric assistant	3.3	-	-	3.3
Residential support worker	34.1	-	-	34.1
Other support workers	15.0	1.0	-	16.0

Roles	Workforce (FTE positions employed plus vacant)			
	NGO AOD	NGO MH&A	Problem gambling	Total
Total (support workers)	58.3	6.2	-	64.5
Cultural workers				
Cultural supervisor	-	0.1	-	0.1
Kaumātua	1.5	0.2	-	1.7
Kuia	0.2	0.2	-	0.4
Matua	-	1.0	-	1.0
Other cultural advisor	-	1.0	1.0	2.0
Total (cultural workers)	1.8	2.5	1.0	5.3
Other non-clinical roles	-	-	-	-
Total (non-clinical roles)	60.1	8.7	1.0	69.8
Administration/management support				
Administrative/ technical support	14.3	14.4	-	28.7
Senior manager	13.5	4.2	-	17.7
Clinical director	3.0	-	-	3.0
Professional leader	3.0	-	-	3.0
Service manager/team leader	7.5	1.0	-	8.5
Family/whānau advisor	3.0	-	-	3.0
Other administration/management/support	0.4	-	-	0.4
Total (administration/management/support)	44.7	19.6	-	64.3
Total (all roles)	183.6	43.3	3.0	229.9

Table E. 8. *Non-health funded FTE positions vacant by provider and sector groups*

Role	FTE positions vacant			
	NGO AOD	NGO MH&A	Problem gambling	Total
Addiction practitioner/clinician	1.0	-	-	1.0
Nursing	3.3	-	-	3.3
Total	4.3	-	-	4.3

E.2 Chapter four additional tables

Table E. 9. *Ethnicity of AOD service consumers, aged 20–64 years old (%) (PRIMHD)*

Ethnicity or ethnic group	Consumers seen by			Total
	DHBs only	NGOs only	DHBs and NGOs	
Māori	27.3%	44.1%	35.0%	33.4%
Pasifika	6.1%	5.1%	4.5%	5.5%
Asian	2.9%	1.1%	1.4%	2.1%

Table E. 10. *Ethnicity of AOD service consumers, aged 20–64 years old (count) (PRIMHD)*

Ethnicity or ethnic group	Consumers seen by			Total
	DHBs only	NGOs only	DHBs and NGOs	
Māori	5,458	4,404	2,654	12,516
Pasifika	1,212	511	340	2,063
Asian	573	107	104	784
Total unique consumers seen	19,959	9,986	7,575	37,520

E.3 Chapter five additional tables

Recruitment and retention issues

Table E. 11 presents results for the recruitment and retention question for DHB and NGO AOD services only. Table E. 12 presents results for DHB and NGO MH&A and problem gambling services alongside the total results for all addiction services (including AOD services).

Note. The total responses columns present the total number of responses received about perceived recruitment and retention issues for each role; it is not the number of respondents reporting perceived shortages for the role. Because many roles received less than 10 responses overall, the results presented here should be interpreted with appropriate caution.

Table E. 11. *Proportion of AOD service respondents who perceived some or large shortages for roles they employ.*

Roles	DHB respondents		NGO respondents	
	Perceiving some or large shortage (%)	Total responses	Perceiving some or large shortage (%)	Total responses
Clinical roles				
Allied health				
Addiction practitioner/clinician	66.7	12	84.4	45
Dual diagnosis practitioner/co-existing problems clinician	90.0	10	42.9	7
Counsellor	20.0	5	25.0	8
Educator/trainer	-	1	-	0
Occupational therapist	25.0	8	33.3	3
Clinical psychologist	58.3	12	66.7	3
Other psychologist	50.0	2	100.0	1
Social worker	37.5	16	22.2	9
General practitioner	40.0	5	100.0	2
House surgeon	-	1	-	0
Consultant psychiatrist	80.0	25	100.0	1
Medical officer special scale	62.5	8	-	0
Psychiatric registrar	25.0	8	-	0
Liaison/consult liaison	100.0	1	-	0
Registered nurse	69.2	26	53.8	13
Enrolled nurse	-	0	50.0	2
Nurse practitioner/nurse specialist/nurse educator	-	4	50.0	2
Staff by ethnicity				
Māori staff for clinical roles	47.1	17	79.2	24

Roles	DHB respondents		NGO respondents	
	Perceiving some or large shortage (%)	Total responses	Perceiving some or large shortage (%)	Total responses
Pasifika staff for clinical roles	25.0	4	83.3	6
Asian staff for clinical roles	25.0	4	50.0	4
Non-clinical roles				
Support workers				
Community development worker	-	0	-	0
Employment worker	-	0	-	0
Community support worker	20.0	5	60.0	10
Family support worker	-	0	50.0	2
Healthcare assistant	-	1	-	0
Peer support – consumer and service user	-	0	37.5	8
Peer support – family and whānau	-	0	100.0	2
Psychiatric assistant	-	2	-	0
Residential support worker	-	0	35.3	17
Cultural workers				
Cultural supervisor	-	0	-	0
Kaumātua	20.0	5	60.0	10
Kuia	-	0	50.0	2
Kaiāwhina	-	1	-	0
Traditional Māori health practitioner	-	0	37.5	8
Matua	-	0	100.0	2
Pasifika cultural advisor	-	2	-	0
Other cultural advisor	-	0	35.3	17
Administration and management				
Administrative/technical support	47.6	21	30.0	20
Senior manager	-	5	27.3	11
Clinical director	-	1	100.0	1
Professional leader	-	1	100.0	1
Service manager/team leader	3.6	28	68.8	16
Consumer advisor/consumer leader	25.0	4	25.0	4
Family/whānau advisor	-	3	-	0
Staff by ethnicity				
Māori staff for non-clinical roles	25.0	4	45.8	24
Pasifika staff for non-clinical roles	-	1	62.5	8
Asian staff for non-clinical roles	-	0	42.9	7

Table E. 12 presents results for DHB and NGO MH&A and problem gambling services alongside the total results for all addiction services (including AOD services).

Table E. 12. *Roles suggested to be at risk of shortage by DHB and NGO MH&A services and problem gambling services*

Roles	DHB MH&A		NGO MH&A		Problem gambling		Total addiction*	
	Perceiving some or large shortage (%)	Total responses	Perceiving some or large shortage (%)	Total responses	Perceiving some or large shortage (%)	Total responses	Perceiving some or large shortage (%)	Total responses
Clinical roles								
Addiction practitioner/clinician	33.3	3	100.0	7	50.0	2	79.7	69
Dual diagnosis practitioner/co-existing problems clinician	50.0	2	50.0	2	100.0	2	69.6	23
Counsellor	-	2	50.0	2	50.0	8	32.0	25
Educator/trainer	50.0	2	-	1	-	0	25.0	4
Occupational therapist	40.0	5	-	0	-	0	31.3	16
Clinical psychologist	80.0	5	-	0	-	0	65.0	20
Other psychologist	-	1	-	0	-	0	50.0	4
Social worker	20.0	5	100.0	2	50.0	2	35.3	34
General practitioner	-	1	-	0	-	0	50.0	8
House surgeon	-	0	-	0	-	0	0.0	1
Consultant psychiatrist	100.0	5	-	0	-	0	83.9	31
Medical officer special scale	33.3	3	-	0	-	0	54.5	11
Psychiatric registrar	100.0	3	-	0	-	0	45.5	11
Liaison/consult liaison	-	1	-	0	-	0	50.0	2
Registered nurse	66.7	6	100.0	3	-	0	66.7	48
Enrolled nurse	-	0	-	0	-	0	50.0	2
Nurse practitioner/nurse specialist/nurse educator	33.3	6	-	0	-	0	25.0	12
Staff by ethnicity								
Māori staff for clinical roles	50.0	4	80.0	5	66.7	3	66.0	53
Pasifika staff for clinical roles	100.0	2	100.0	1	-	1	64.3	14
Asian staff for clinical roles	-	1	-	0	-	1	30.0	10
Non-clinical roles								
Support workers								
Community development worker	-	0	-	0	-	0	-	0
Employment worker	-	0	50.0	2	-	0	50.0	2
Community support worker	-	2	85.7	7	-	1	52.0	25
Family support worker	-	0	50.0	2	-	0	50.0	4
Healthcare assistant	-	0	-	0	-	0	-	1
Peer support – consumer and service user	-	1	-	6	-	0	20.0	15

Roles	DHB MH&A		NGO MH&A		Problem gambling		Total addiction*	
	Perceiving some or large shortage (%)	Total responses	Perceiving some or large shortage (%)	Total responses	Perceiving some or large shortage (%)	Total responses	Perceiving some or large shortage (%)	Total responses
Peer support – family and whānau	-	0	-	1	-	0	66.7	3
Psychiatric assistant	-	0	-	0	-	0	-	2
Residential support worker	-	0	-	0	-	0	35.3	17

Cultural advice and support								
Cultural supervisor	-	0	-	4	100.0	1	37.5	8
Kaumātua	66.7	3	25.0	4	100.0	1	42.9	14
Kuia	100.0	1	-	0	-	0	50.0	2
Kaiāwhina	-	1	-	1	-	0	12.5	8
Traditional Māori health practitioner	-	0	-	1	-	0	33.3	3
Matua	-	0	-	0	-	0	100.0	1
Pasifika cultural advisor	-	0	-	0	-	0	-	2
Other cultural advisor	-	0	-	1	-	0	20.0	5

Administration and management								
Administrative/technical support	36.4	11	50.0	6	-	2	38.3	60
Senior manager	-	5	-	3	-	0	12.5	24
Clinical director	-	6	-	0	-	0	12.5	8
Professional leader	-	3	-	1	-	0	16.7	6
Service manager/team leader	28.6	7	44.4	9	-	2	29.0	62
Consumer advisor/consumer leader	66.7	3	50.0	4	50.0	2	41.2	17
Family/whānau advisor	50.0	6	100.0	1	-	0	40.0	10

Staff by ethnicity								
Māori staff for non-clinical roles	50.0	6	62.5	8	-	2	45.5	44
Pasifika staff for non-clinical roles	50.0	2	-	2	-	0	46.2	13
Asian staff for non-clinical roles	-	0	-	1	-	0	37.5	8

Note:

* Total addiction services includes responses from AOD services, problem gambling services and MH&A services.

Knowledge and skill development needs

Table E. 13. *Proportion of respondents indicating need for improvement in workforce knowledge and skills, by provider and sector groups*

Knowledge and skills	DHB AOD (%)	DHB MH&A (%)	NGO AOD (%)	NGO MH&A (%)	Problem gambling (%)	Total (%)
n=	42	14	85	23	18	182
Working with Māori						
Knowledge and skills in whānau-centred practice (whānau ora)	69.0	85.7	78.8	73.9	61.1	74.7
Cultural competence for working with Māori	90.5	78.6	75.3	78.3	44.4	76.4
Cultural competence for working in te reo Māori me ona tikanga (language and custom)	92.9	71.4	69.4	73.9	61.1	74.7
Knowledge and skills in Māori models of engagement, eg pōwhiri process	59.5	78.6	65.9	56.5	61.1	63.7
Knowledge and skills in Māori models of health, eg Te Whare Tapa Whā, Te Pae Mahutonga	90.5	71.4	67.1	65.2	72.2	73.1
Knowledge and skills in Māori health outcomes measurement and assessment, eg Hua Oranga	90.5	64.3	76.5	60.9	94.4	78.6
Working with Pasifika						
Cultural competence for working with Pasifika ethnic groups	97.6	92.9	71.8	78.3	61.1	79.1
Knowledge of Pasifika cultural models of health	95.2	85.7	69.4	78.3	61.1	76.9
Confidence in one or more Pasifika languages	90.5	57.1	63.5	56.5	27.8	64.8
Knowledge and skills in the engagement process when working with Pasifika ethnic groups	61.9	78.6	75.3	73.9	61.1	70.9
Knowledge of Pasifika family values, structures and concepts	95.2	92.9	74.1	78.3	61.1	79.7
Knowledge of the basic concepts of tapu across a range of Pasifika cultures	95.2	92.9	69.4	78.3	61.1	77.5
Working with other groups						
Cultural competence for working with Asian ethnic groups	92.9	78.6	76.5	69.6	61.1	78.0
Working with children and young people	81.0	57.1	50.6	47.8	50.0	57.7
Working with older people	88.1	57.1	65.9	69.6	66.7	70.9
Working with families	85.7	50.0	68.2	56.5	55.6	68.1
Working collaboratively with other services and agencies	69.0	50.0	54.1	69.6	33.3	57.1
Other policy and practice areas						
Able to respond readily to changes in type of work	83.3	64.3	51.8	65.2	50.0	61.5
Supporting use of peer support	88.1	35.7	50.6	60.9	50.0	59.3
Knowledge and use of relevant legislation, regulations, standards, codes and policies	76.2	35.7	58.8	65.2	88.9	64.8
Working with new technologies and IT	88.1	92.9	75.3	73.9	66.7	78.6
Knowledge of community resources available in your area	31.0	35.7	43.5	69.6	50.0	44.0
Risk assessment (including suicidality)	76.2	35.7	60.0	82.6	66.7	65.4

Knowledge and skills	DHB AOD (%)	DHB MH&A (%)	NGO AOD (%)	NGO MH&A (%)	Problem gambling (%)	Total (%)
n=	42	14	85	23	18	182
Physical health assessment	81.0	42.9	43.5	47.8	66.7	54.9
Screening and brief interventions, eg use of AUDIT tool, sleep hygiene education	73.8	42.9	37.6	43.5	55.6	48.9
Psychological interventions, eg cognitive behavioural therapy, social network, mindfulness, motivational approaches	85.7	57.1	65.9	60.9	66.7	69.2
Supporting self-managed care (including online options, 12-step programmes, and sensory modulation)	83.3	57.1	52.9	69.6	66.7	63.7
Co-existing problems capability	90.5	71.4	78.8	56.5	66.7	76.9
Using strengths-based approaches to enhance resiliency and recovery with consumers	76.2	42.9	61.2	73.9	55.6	64.3
Using outcomes measures, eg HoNOS, Hua Oranga	54.8	28.6	58.8	52.2	66.7	55.5

Table E.14 presents the proportion of respondents from DHBs and NGOs who indicated their workforce needed to increase knowledge and skills, showing results by service type where 10 or more responses were received. Service types with fewer than 10 responses have been consolidated into the ‘all other services’ columns for DHBs and NGOs.

Table E. 14. *Proportion of DHB and NGO respondents indicating need for improvement in workforce knowledge and skills, by services delivered*

Knowledge and skills	DHB Community (%)	DHB all other services (%)	NGO Community (%)	NGO Residential (%)	NGO all other services (%)
n=	38	4	51	24	10
Working with Māori					
Knowledge and skills in whānau-centred practice (whānau ora)	71.1	50.0	76.5	87.5	70.0
Cultural competence for working with Māori	89.5	100.0	70.6	79.2	90.0
Cultural competence for working in te reo Māori me ona tikanga (language and custom)	92.1	100.0	58.8	87.5	80.0
Knowledge and skills in Māori models of engagement, eg pōwhiri process	60.5	50.0	54.9	83.3	80.0
Knowledge and skills in Māori models of health, eg Te Whare Tapa Whā, Te Pae Mahutonga	89.5	100.0	58.8	83.3	70.0
Knowledge and skills in Māori health outcomes measurement and assessment, eg Hua Oranga	89.5	100.0	74.5	83.3	70.0
Working with Pasifika					
Cultural competence for working with Pasifika ethnic groups	97.4	100.0	70.6	75.0	70.0

Knowledge and skills	DHB Community (%)	DHB all other services (%)	NGO Community (%)	NGO Residential (%)	NGO all other services (%)
n=	38	4	51	24	10
Knowledge of Pasifika cultural models of health	94.7	100.0	64.7	83.3	60.0
Confidence in one or more Pasifika languages	89.5	100.0	58.8	79.2	50.0
Knowledge and skills in the engagement process when working with Pasifika ethnic groups	63.2	50.0	74.5	87.5	50.0
Knowledge of Pasifika family values, structures and concepts	94.7	100.0	72.5	83.3	60.0
Knowledge of the basic concepts of tapu across a range of Pasifika cultures	94.7	100.0	64.7	83.3	60.0
Working with other groups					
Cultural competence for working with Asian ethnic groups	92.1	100.0	76.5	83.3	60.0
Working with children and young people	78.9	100.0	51.0	50.0	50.0
Working with older people	86.8	100.0	68.6	58.3	70.0
Working with families	84.2	100.0	66.7	79.2	50.0
Working collaboratively with other services and agencies	68.4	75.0	49.0	62.5	60.0
Other policy and practice areas					
Able to respond readily to changes in type of work	81.6	100.0	49.0	54.2	60.0
Supporting use of peer support	86.8	100.0	47.1	54.2	60.0
Knowledge and use of relevant legislation, regulations, standards, codes and policies	76.3	75.0	54.9	66.7	60.0
Working with new technologies and IT	89.5	75.0	66.7	87.5	90.0
Knowledge of community resources available in your area	34.2	0.0	37.3	50.0	60.0
Risk assessment (including suicidality)	76.3	75.0	68.6	54.2	30.0
Physical health assessment	78.9	100.0	49.0	41.7	20.0
Screening and brief interventions, eg use of AUDIT tool, sleep hygiene education	73.7	75.0	35.3	41.7	40.0
Psychological interventions, eg cognitive behavioural therapy, social network, mindfulness, motivational approaches	86.8	75.0	68.6	75.0	30.0
Supporting self-managed care (including online options, 12-step programmes, and sensory modulation)	84.2	75.0	51.0	66.7	30.0
Co-existing problems capability	89.5	100.0	80.4	87.5	50.0
Using strengths-based approaches to enhance resiliency and recovery with consumers	76.3	75.0	66.7	58.3	40.0
Using outcome measures, eg HoNOS, Hua Oranga	55.3	50.0	60.8	62.5	40.0
Promotion of restraint and seclusion reduction initiatives	26.3	0.0	29.4	12.5	10.0

Workforce planning and development challenges

Table E. 15. *Proportion of DHB and NGO respondents reporting items in their top four challenges, by provider and sector groups*

Challenges	DHB AOD (%)	DHB MH&A (%)	NGO AOD (%)	NGO MH&A (%)	Problem gambling (%)	Total (%)
n=	37	12	60	18	17	144
Cost of training and other professional development	16.2	41.7	60.0	50.0	52.9	45.1
Retaining qualified and experienced staff	64.9	25.0	53.3	38.9	29.4	49.3
Static or reduced funds	18.9	66.7	56.7	66.7	100.0	54.2
Recruiting qualified and experienced staff	43.2	50.0	58.3	50.0	47.1	51.4
Managing pressure on staff due to increased demand for service	78.4	83.3	48.3	88.9	76.5	67.4
Managing pressure due to changing service delivery models	78.4	50.0	28.3	44.4	0.0	41.7
Managing pressure on staff due to increased complexity	73.0	41.7	65.0	44.4	47.1	60.4

Table E. 16 and E.17 summarise responses from DHB and NGO respondents respectively, by service types that received greater than 10 responses. The results for those service types that received fewer than 10 responses are summarised in the ‘all other services’ columns.

Table E. 16. *The proportion of DHB respondents reporting challenges in their top four, by service types*

Challenges	AOD Community (%)	All other AOD services (%)	All other MH&A services (%)	Total (%)
n=	33	4	12	49
Cost of training and other professional development	18.2	0.0	41.7	22.4
Retaining qualified and experienced staff	60.6	100.0	25.0	55.1
Static or reduced funds	18.2	25.0	66.7	30.6
Recruiting qualified and experienced staff	45.5	25.0	50.0	44.9
Managing pressure on staff due to increased demand for service	78.8	75.0	83.3	79.6
Managing pressure due to changing service delivery models	75.8	100.0	50.0	71.4
Managing pressure on staff due to increased complexity	72.7	75.0	41.7	65.3

Table E. 17. *The proportion of NGO respondents reporting challenges in their top four, by service types*

Challenges	AOD community (%)	AOD residential (%)	All other AOD services (%)	MH&A community (%)	All other MH&A services (%)	Problem gambling (%)	Total (%)
n=	37	14	9	13	5	17	95
Cost of training and other professional development	64.9	50.0	55.6	46.2	60.0	52.9	56.8
Retaining qualified and experienced staff	51.4	64.3	44.4	38.5	40.0	29.4	46.3
Static or reduced funds	54.1	64.3	55.6	61.5	80.0	100.0	66.3
Recruiting qualified and experienced staff	56.8	71.4	44.4	53.8	40.0	47.1	54.7
Managing pressure on staff due to increased demand for service	51.4	35.7	55.6	84.6	100.0	76.5	61.1
Managing pressure due to changing service delivery models	29.7	28.6	22.2	46.2	40.0	0.0	26.3
Managing pressure on staff due to increased complexity	62.2	71.4	66.7	46.2	40.0	47.1	57.9

Cross-sector relationships

Table E. 18. *Proportion of respondents identifying relationship working well for DHB and NGO MH&A and problem gambling services, with total results for all addiction services (including AOD services)*

Cross-sector relationships	DHB MH&A		NGO MH&A		Problem gambling		Total addiction services*	
	n=	%	n=	%	n=	%	n=	%
Child and adolescent mental health services	4	28.6	3	25.0	3	60.0	32	28.8
Child, Youth and Family Services	1	8.3	3	21.4	4	30.8	35	23.5
Corrections	2	16.7	6	30.0	10	55.6	83	48.8
Disability sector	1	7.7	3	23.1	3	23.1	20	15.4
Education	1	9.1	3	18.8	2	14.3	29	21.5
Family violence	0	-	4	28.6	9	50.0	35	22.6
General hospitals/emergency departments	5	35.7	2	12.5	0	-	35	22.6
Housing New Zealand Corporation/accommodation providers	1	8.3	3	14.3	4	28.6	20	13.1
Mental health services for older people	6	50.0	1	7.1	3	23.1	20	16.3
Police	5	38.5	6	31.6	5	29.4	49	29.7
Primary health practices	3	21.4	5	31.3	4	22.2	54	32.3
Relationship services	0	-	1	10.0	9	50.0	20	14.9
Work and Income	4	36.4	5	22.7	9	50.0	48	28.7
Other mental health services	5	38.5	5	23.8	8	44.4	57	32.8
Other addiction services	5	38.5	5	23.8	9	52.9	97	55.7

Notes:

n= denotes the total number of respondents giving a valid answer for the relevant sector or agency and includes all responses, not only those reporting that the relationship was working well.

* Total addiction services includes responses from AOD services, problem gambling services and MH&A services.

Table E. 19. *Proportion of respondents identifying relationship needs improvement for DHB and NGO MH&A and problem gambling services, with total results for all addiction services (including AOD services)*

Cross-sector relationships	DHB MH&A		NGO MH&A		Problem gambling		Total addiction services*	
	n=	%	n=	%	n=	%	n=	%
Child and adolescent mental health services	3	21.4	6	50.0	2	40.0	24	21.6
Child, Youth and Family Services	5	41.7	6	42.9	7	53.8	36	24.2
Corrections	3	25.0	2	10.0	6	33.3	21	12.4
Disability sector	6	46.2	5	38.5	7	53.8	31	23.8
Education	4	36.4	3	18.8	4	28.6	39	28.9
Family violence	2	16.7	2	14.3	3	16.7	34	21.9
General hospitals/emergency departments	2	14.3	4	25.0	7	46.7	47	30.3
Housing New Zealand Corporation/accommodation providers	4	33.3	6	28.6	3	21.4	71	46.4
Mental health services for older people	2	16.7	2	14.3	7	53.8	49	39.8
Police	2	15.4	0	-	6	35.3	16	9.7
Primary health practices	5	35.7	1	6.3	9	50.0	46	27.5
Relationship services	2	20.0	3	30.0	1	5.6	27	20.1
Work and Income	1	9.1	5	22.7	1	5.6	32	19.2
Other mental health services	0	-	0	-	1	5.6	40	23.0
Other addiction services	3	23.1	2	9.5	1	5.9	20	11.5

Notes:

n= denotes the total number of respondents giving a valid answer for the relevant sector or agency and includes all responses, not only those reporting that improvement was needed.

* Total addiction services includes responses from AOD services, problem gambling services and MH&A services.



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