SERVICE USER WORKFORCE SURVEY:
WHERE ARE WE AT?

Te Pou o Te Whakaaro Nui
The NATIONAL CENTRE *of* MENTAL HEALTH RESEARCH, INFORMATION *and* WORKFORCE DEVELOPMENT
www.tepou.co.nz

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Published in October 2010 by Te Pou o Te Whakaaro Nui
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ISBN 978-1-877537-65-3

ACKNOWLEDGEMENTS

A number of organisations have provided advice and input for this project. Thank you to the Mental Health Commission, Matua Raki, Werry Centre, and District Health Boards New Zealand's (DHBNZ's) Health Workforce Information Programme for your contribution. Special thanks to Rhonda Robertson, Shona Clarke, Fiona Howard and Kelly Ware.

The assistance of the Ministry of Health, Northern District Health Board Support Agency (NDSA) and district health board planners and funders in providing information for this survey is appreciated. In particular, Ros Coulter, Glenda Schnell and Toni Gutschlag for your insight and advice.

This project would not have been possible without the participation of people in the service user workforce. Te Pou would like to sincerely thank all who took the time to complete the survey and for the rich information you willingly supplied. Your participation has enabled a greater understanding of your workforce development and training needs.

Carolyn Swanson
Service user workforce development manager

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Researcher

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BACKGROUND

Service user workforce development is a priority in national mental health and addiction policies and plans. People with experience of mental illness, distress and/or addiction can make a unique and valuable contribution towards enhancing service effectiveness and responsiveness. The development of a strong and skilled service user mental health and addiction workforce is a pragmatic, useful and valuable direction towards better and improved services in New Zealand (NZ). The development of the service user workforce is a key approach to building the mental health and addiction workforce outlined in *Te Tāhuhu - Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health, 2005) and *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015* (Minister of Health, 2006).

There are a number of service user designated roles in the mental health and addiction sector. Health and Disability Sector Standards specify the involvement and participation of consumers in the planning, implementation and evaluation at all levels of services to ensure services are planned, coordinated and appropriate to consumer needs (Standards New Zealand, 2008). Service user designated roles include, but are not limited to, consumer advisors, auditors, trainers, advocates and peer support workers. Consumer advisors for example provide and facilitate service user input into the planning, development and monitoring of services. Peer support workers share a common experience of mental illness/distress and/or addiction with the people they work with and provide purposeful support towards well-being.

The number of people working in designated service user roles is currently estimated to be less than one per cent of the district health board (DHB) and at least four per cent of the non-government organisation (NGO) mental health and addiction workforce. Information describing service user workforce roles and activities, as well as training and professional development needs has not previously been collected. Improved information would better inform future workforce planning and development, and contribute to building more responsive mental health and addiction services. A survey of the service user workforce was therefore undertaken to examine service user roles, associated tasks and activities, as well as professional development and training needs. In total, 153 people took part in the workforce survey, reflecting an estimated response rate of at least 56 per cent of the service user workforce.

KEY FINDINGS

WORKFORCE CHARACTERISTICS

- More than half (52 per cent) of respondents reported working in a mental health service, over one-third (38 per cent) in a mental health and addiction service, and three per cent an addiction service.
- The total contracted full time equivalents (FTEs) nationally for the service user workforce was 223.
- About one-quarter of the service user workforce surveyed were Māori (22 per cent; 84 per cent European/Other; less than one per cent Pacific or Asian).
- Thirty seven per cent of respondents were aged 50 years and over.
- The level of education of the service user workforce is higher than the general population and comparable to the NGO mental health and addiction workforce. Nearly half (46 per cent) had obtained a tertiary qualification and more than one-third (37 per cent) were currently undertaking relevant education or training.
- Half were earning at least $40,000 per year, in line with the median income for NZ wage and salary earners.

- The stability of the service user workforce is similar to the NGO workforce. The average length of time in current and any service user role is estimated to be 3.5 and 5.5 years respectively.

SERVICE USER WORKFORCE ROLES

- Overall, nearly 60 per cent were very satisfied with their current role and 30 per cent intended working in the mental health and/or addiction sector for at least another 10 years.
- Key service user workforce roles included peer support workers (31 per cent) and consumer advisors (28 per cent). Administration/management (13 per cent) was the next largest service user workforce group.
- Key peer support role tasks and activities included support, recovery coaching, encouragement and empowerment.
- Consumer advisor key tasks and activities included providing advice, research/evaluation, training, service development, quality improvement, and obtaining feedback from service users.
- The roles of consumer advisors in DHB inpatient and community settings were similar.

SUPERVISION & TRAINING

- Four in five people (82 per cent) received mentoring or professional supervision.
- The main reasons for not receiving supervision were a lack of organisational funding and no appropriate supervisor being available.
- More than 85 per cent of participants indicated learning and training opportunities were very important. Training and workforce development that would benefit future service user roles included peer support and supervision/professional development.
- Training needs differed for peer support workers and consumer advisors.

CONCLUSION

The survey has addressed current knowledge gaps about the characteristics of the service user workforce, service user roles, associated tasks and activities, as well as professional development and training needs. The survey findings indicate there is a high level of satisfaction amongst the existing service user workforce. In addition, most respondents received mentoring or supervision, and training over the last two years.

The survey findings can contribute to developing the future capacity and capability of the service user workforce. Several key areas were identified. There is a need to clearly specify and map career pathways and competencies for the mental health and addiction service user workforce. This could be based on the *Let's get real* framework of the essential skills, values and attitudes required for the mental health and addiction workforce. The clear description and specification of service user workforce roles will also provide greater national consistency. Regular service user workforce surveys will help monitor progress in building the capacity and capability of the service user workforce. Planned recruitment strategies targeting specific age and ethnic service user groups at national, regional and local levels will help ensure that the future service user workforce is representative of service users. Increased provision of mentoring or supervision will also enhance service user workforce capability.

Further development of the service user workforce requires sector wide leadership and commitment. It requires a multi-agency approach that builds on existing workforce development strategies. The report provides the mental health sector with useful information that describes the current status of the mental health service user workforce in 2010. It provides detailed information about their roles and experience of training and supervision. This part of the mental health workforce has experienced significant growth over the last few years. The survey results provide a baseline from which to evaluate the impact of future service user workforce recruitment and retention initiatives.

INTRODUCTION

Service user mental health and addiction workforce development has been identified as a priority in national mental health and addiction policies and plans. Service user involvement at all levels of service delivery is specified in Health and Disability Sector Standards to ensure services are planned, coordinated and appropriate to consumer needs (Standards New Zealand, 2008). There are a number of service user only designated roles in the mental health and addiction sector, such as consumer advisors, auditors, advocates, trainers and peer support workers. Information describing service user roles, their associated tasks and activities, professional development and training needs is however limited. This section describes the background and development of service user roles, what is currently known about the service user workforce, and knowledge gaps. To address information gaps a survey of the service user workforce was carried out. The methodology used in this survey is described in the following section. Workforce survey results are then presented followed by a discussion and conclusions for progressing service user workforce development.

BACKGROUND

POLICY

Service user workers with experience of mental illness, distress and/or addiction, and their journeys of recovery and building resilience, are important to improving and developing responsive and effective mental health and addiction services in New Zealand (NZ). The development of a service user workforce is a priority in a number of NZ policies. The *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Mental Health Commission, 1998) outlined changes required by mental health services to attain national mental health and addiction strategy objectives. As well as incorporating a focus on recovery and supporting resilience, the *Blueprint* recommended the expansion of the service user workforce to develop better and improved mental health and addiction services.

More recent national mental health and addiction policies continue to emphasise the importance of the service user workforce and a culture of resilience and recovery. *Te Tāhuhu - Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health, 2005) has identified building a mental health and addiction workforce as a leading challenge for the sector. In order to achieve this outcome, a key approach described in *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015* (Minister of Health, 2006) includes supporting service users to become a valued part of the mental health and addiction workforce. Future visions of the mental health sector outlined in *Te Hononga 2015: Connecting for Greater Well-being* (Mental Health Commission, 2007) reiterate the need for a strong contribution of the service user workforce to the sector.

> Our workforce – including service users and tangata whaiora – is vital in providing leadership and improving mental health and addiction in New Zealand over the next 10 years… [The workforce] will play a pivotal role in developing services and leading changes towards a culture of recovery. (Minister of Health, 2006, p. 36)

SERVICE USER WORKFORCE DEVELOPMENT

People with experience of mental illness, distress and/or addiction can make a unique and valuable contribution to services. Service users can provide expertise and advice from a different perspective. They are well positioned to role model recovery, provide empathetic support to people, and contribute to building workplace cultures respectful of service users (Mental Health Commission, 2005). A *Service User Workforce Development Strategy for the Mental Health Sector 2005-2010* (Mental Health Commission, 2005) has been developed. The strategy not only sees the building of a service user workforce as pragmatic and expected by policy, but also ethical.

The *Service User Workforce Development Strategy* suggests:

- the philosophy of recovery should be led by service users
- workforce development should enable service user participation and leadership
- the interests of consumers are paramount to the people and systems that provide them with goods and services.

Achieving better outcomes for people with experience of mental illness, distress and/or addiction requires a workforce that can address population needs. As highlighted in *Tauawhitia te Wero – Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006-2009* (Ministry of Health, 2005), a systematic approach is required to align the workforce with population need. This approach must be supported by a well-developed service user workforce. The health system currently faces challenges in developing a skilled and diverse workforce able to address population demand (Ministerial Review Group, 2009). Service users remain an underutilised resource which could be strengthened to address current workforce shortages and contribute to building a more effective mental health and addiction workforce (Mental Health Commission, 2005; Ministry of Health, 2005).

SERVICE USER WORKFORCE PROFILE

In developing a service user workforce, consideration should be given to the diversity among people in the population and service users. *Te Rau Hinengaro: the New Zealand Mental Health Survey* (Oakley Browne, Wells, & Scott, 2006) examined the prevalence of mental illness and/or addiction among adults in the general population. The survey found over a 12-month period that one in four adults had experienced any mental illness and/or addiction, and 4.7 per cent a serious disorder.[*] Rates of mental illness, distress and addiction are higher for some population groups. Māori and Pacific peoples have a higher risk and are more likely to experience mental health problems (Oakley Browne et al., 2006). Development of the service user workforce needs to reflect this population diversity. Table 1 summarises a vision by service users for a diverse mental health and addiction workforce.

Table 1. *Service Users' Mental Health and Addiction Workforce Vision*

DIVERSE POSITIVE WORKFORCE
• The mental health sector is an exciting and ground-breaking place to work and has a workforce that is stable, competent and available. • All mental health workers develop trusting partnerships with service users. • Experience of mental illness is a valued attribute for working in the mental health sector; we are a major part of the workforce in all roles and in all services. • The composition and skills of the mental health workforce reflects the new philosophy and broader range of services as well as the diversity, age range and cultural mix of service users. • Leadership is shared among the different occupational groups. • Māori and Pacific peoples are an integral and valued part of the workforce.
Source: Mental Health Commission. (2004). *Our Lives in 2014. A recovery vision from people with experience of mental illness for the second mental health plan and the development of the health and social sectors.* Wellington: Mental Health Commission.

[*] The 12-month prevalence of any disorder was 29.5 per cent Māori, 24.2 per cent Pacific, and 19.3 per cent other in Te Rau Hinengaro. The prevalence of serious disorders was 8.7 per cent for Māori, 6.0 per cent Pacific and 4.1 per cent other. The prevalence of any and serious disorders can partly be explained by age, sex, education and household income (Oakley Brown et al., 2006).

The identified service user workforce is currently estimated to make up about one to four per cent of the total mental health and addiction workforce. This estimate is based on earlier workforce surveys, including child and adolescent, non-government organisation (NGO), alcohol and other drug (AOD) treatment services (Matua Raki, 2009; Platform, 2007; Werry Centre, 2007, 2009). Findings from these surveys are summarised in Table 2. The NGO workforce survey also found nearly eight per cent of services were led by service users or were peer support organisations. These workforce surveys provide some information about the service user workforce. There is however limited research capturing the number of Māori, Pacific or Asian peoples employed in these roles. Improved data about the size of this workforce and career pathways is required to better inform service user workforce development (Mental Health Commission, 2005).

Table 2. *Service User Workforce Estimates*

SURVEY	SERVICE USER WORKFORCE ROLE	DHB %	NGO %
2008 stocktake of CAMH services in NZ	Mental health consumer	0.47 *	0.28 †
2006 stocktake of CAMH services in NZ	Mental health consumer	0.40 ‡	0.56 ≠
2008 stocktake of AOD treatment services in NZ	Consumer advisor	1.17 ±	
2008 stocktake of AOD treatment services in NZ	Peer support worker	0.15 ±	2.56 +
2008 stocktake of AOD treatment services in NZ	Consumer		0.77 +
2007 NgOIT workforce survey	Consumer advisor		0.98 #
2007 NgOIT workforce survey	Peer support worker		2.89 #

Note. CAMH = child and adolescent mental health. DHB = district health board. NGO = non-government organisation. NZ = New Zealand.

* Total DHB CAMH/alcohol and drug (AOD) mental health consumer FTEs = 4.2, Total DHB CAMH = 888.88.
† Total NGO child and adolescent (C&A)/AOD mental health consumer FTEs = 1.00, total NGO CAMH/AOD FTEs = 360.25.
± Total DHB AOD headcount = 681, including 8 consumer advisors and 1 peer support/advocacy worker.
\+ Total NGO AOD headcount = 780, including 6 consumers and 20 peer support workers
‡ Total DHB CAMH/AOD mental health consumer FTEs = 3.3, total DHB CAMH FTEs = 832.3.
≠ Total NGO C&A/AOD mental health consumer FTEs = 2.1, total NGO CAMH/AOD FTEs = 374.99
\# The number of NGO workforce respondents was 1833, and included 53 peer support workers and 18 consumer advisors.

Source: (Matua Raki, 2009; Platform, 2007; Werry Centre, 2007, 2009).

SERVICE USER WORKFORCE ROLES

There are a range of service user workforce roles. Some people with experience of mental illness and addiction may be employed in *any* mental health or addiction role, such as nurses or occupational therapists, without being identified as service users. A national survey of the addiction treatment workforce, for example, found one-third were in recovery from a substance use problem (Adamson, Deering, Schroder, Townshend, & Ditchburn, 2009). Personal histories of substance use problems are common in the addiction sector and reflect career pathways and the historical development of addiction services.[*]

There are relatively new service user designated roles. Health and Disability Service Standards specify the involvement of consumers in the planning, implementation and evaluation at all levels of services to ensure services are planned, coordinated and appropriate to consumer needs (Standards New Zealand, 2008). Consumer advisors and advocates were amongst the earliest paid service user positions. Consumer advisor roles emerged following the *Blueprint* and subsequent allocation of funding by district health boards (DHBs) for consumer participation in service delivery. Consumer advisors provide and facilitate service user input into the planning, development and monitoring of services.

[*] Robertson, R, personal communication.

Other designated service user roles include, but are not limited to, peer support workers, service user auditors, trainers and governance board members.[*] Peer support workers for example have a common experience of mental illness, distress and/or addiction with service users and provide purposeful support towards wellbeing (Te Pou, 2009b).[†] Peer support work is underpinned by recovery and strength-based philosophies and driven by mutuality, empathy, empowerment, hope and choice (Te Pou, 2009b). There is however limited information detailing the number of people employed in designated service user roles for the sector. Information defining and describing specific service user workforce roles is required to advance service user workforce development (Mental Health Commission, 2005).

SUPERVISION & TRAINING

Improved training and professional development of the existing service user workforce will help build a sustainable and responsive workforce. Achieving sustainable workforce growth also requires aligning professional development and training needs with population demand for services (Future Workforce Group, 2009).

> Training and development includes all aspects of education and training focused on developing the knowledge, skills and attitudes of people to work in mental health and addiction services, as well as ongoing training and development once people are working in the sector. (Ministry of Health, 2005)

Training is necessary to ensure service users have the skills and knowledge they need. An understanding of the professional development and training needs of the service user workforce is essential to developing more responsive and effective mental health and addiction services.

> Providing better mental health outcomes is dependent on recruiting and retaining suitably trained, qualified and supervised people. (Mental Health Workforce Development Programme, 2006, p. 41)

KNOWLEDGE GAPS

Improved information about the service user mental health and addiction workforce would better inform future workforce development and planning. Currently, there are gaps in our knowledge about the number of people employed in designated service user roles, associated activities and tasks, as well as professional development and training needs. This information will contribute to building and supporting the development of a skilled and capable service user workforce.

[*] The *NgOIT Workforce Survey* (Platform, 2007) suggests key workforce groups include peer support workers and consumer advisors.
[†] Rather than informal support we get from our friends and family.

METHOD

SAMPLE

The target population for this workforce survey included people:

- with experience of mental illness, distress and/or addiction, *and*
- working in an identified service user role, such as a consumer advisor, auditor, peer support worker, or any other service user role.

People with experience of mental illness and/or addiction working in services *not* in an identified service user role were excluded. The target population also excluded family members of people with experience of mental illness and/or addiction.

A list of 209 service users/consumer/peer support workers and service user leaders was compiled from those known to Te Pou. Service user leaders were also asked to distribute information about the survey to their networks.

PROCEDURE

CONTRACTED FTES

Contracted full time equivalents (FTEs) were obtained from the Ministry of Health to gain a conservative estimate of the service user workforce size. Purchase unit (PU) codes included MHCS21, MHCS21.1, MHCS21.2, MHCS21.7, MHCS21.8 and MHCS25. DHB planners and funders were contacted to verify FTE data for the service user workforce. FTEs were adjusted following feedback.

SURVEY QUESTIONNAIRE

A survey questionnaire was developed based on a range of items used in previous studies and workforce surveys, such as the *NgOIT 2007 Workforce Survey* (Platform, 2007) and *2008 Stocktake of Child & Adolescent Mental Health Services in New Zealand* (Werry Centre, 2009). The survey questionnaire was piloted with a small convenience sample and externally reviewed by service user leaders before the main survey was undertaken.

A print and online version of the survey questionnaire was developed and is attached in Appendix A. The web version was developed using Surveymonkey.[*] The questionnaire was expected to take 5-10 minutes to complete. Respondents were advised all questions were optional, information provided would be kept confidential, and consent to take part in the survey was implied by completing the survey questionnaire.

DATA COLLECTION

Data was collected in April 2010. Potential participants were contacted by e-mail and invited to take part in the survey. Information about the survey was provided along with survey access through the Te Pou website. Two follow-up reminder/thank you e-mails were sent to all potential participants.

Participants could distribute information about the survey to others working in service user roles. An invitation to take part in the survey was also included in the NGO health and Te Pou electronic newsletters, and posted on the BINZ e-group discussion forum. NGO services were also informed of the survey.

[*] www.surveymonkey.com

During the period of data collection, information about the survey was available on the Te Pou website, by telephone or e-mail.

SURVEY ITEMS

SERVICE USER ROLE

Participants were asked about their current and previous service user roles. Survey items included current role (e.g., consumer advisor, peer support worker, administration/management, governance/board member), key role activities, length of time in role, and overall role satisfaction. For example, "describe the main activities involved in your current role" and "overall how satisfied are you in your current role?". Experience working in any service user role (paid or unpaid) and prior employment was also examined.

Information about services (e.g., mental health and/or addiction), service setting (e.g., service user led organisation, DHB inpatient, DHB community, NGO), and area worked within the organisation (e.g., service delivery, development or administration) was collected.

Participants were asked to indicate how long they intended to work in the mental health and addiction field in the future.

TRAINING & SUPERVISION

The survey included questions about training and supervision. Participants were asked whether they had received mentoring or professional supervision and who provided this (e.g., internally or externally). Those not receiving mentoring or supervision were asked about the reasons for not receiving this (e.g., funding, supervisor availability, interest).

Respondents were asked to rate how important it was to learn and train in their job and whether workplaces assisted their training. Training received over the last two years, and training that would help the service user workforce become more effective in their role and assist their professional development was also examined. For example, "list any specific training that would help you be more effective in your role and assist your professional development and indicate if this training is currently available".

SERVICE USER WORKFORCE CHARACTERISTICS

Characteristics of the service user workforce were examined, including highest academic qualification, age, ethnicity (e.g., NZ European, Māori, Pacific peoples, Asian and other), gender, employment status (e.g., full-time, part-time), income and location (e.g., city/region).

ANALYSES

The data was screened prior to analysis. Analyses were performed on responses provided to each survey item as there was only a small amount of missing data. Descriptive statistics were used to summarise results. Separate analyses were conducted for consumer advisors and peer support workers – the two largest service user workforce groups. Responses to open-ended questions were categorised based on themes emerging from participant responses. In analyses of role activities and tasks, responses of less than 10 per cent were not reported in order to identify key tasks. Data analysis was carried out using SPSS version 17 and Excel.

RESULTS

CHARACTERISTICS

In total, 153 people took part in the survey. Participant characteristics are summarised in Table 3, along with specific characteristics of peer support workers and consumer advisors. Based on adjusted Ministry of Health data, the total number of contracted FTEs for the service user workforce was 222.6.

Table 3. *Service User Workforce Characteristics, N = 153*

		TOTAL†		PEER SUPPORT WORKERS		CONSUMER ADVISORS	
DETAILS		NUMBER	%	NUMBER	%	NUMBER	%
Total		153		47		43	
Gender	Male	44	(29.7)	14	(31.8)	9	(20.9)
	Female	104	(70.3)	30	(68.2)	34	(79.1)
Ethnicity*	NZ European/other	124	(83.8)	34	(77.3)	38	(88.4)
	Māori	33	(22.3)	9	(20.5)	9	(20.9)
	Pacific peoples	6	(0.4)	5	(11.4)	1	(2.3)
	Asian	5	(0.3)	2	(4.5)	-	
Highest academic qualification	No school qualification	8	(5.4)	3	(6.8)	4	(9.3)
	Secondary school qualification	23	(15.6)	13	(29.5)	2	(4.7)
	Certificate or diploma	48	(32.7)	17	(38.6)	16	(37.2)
	Bachelor's degree	36	(24.5)	9	(20.5)	11	(25.6)
	Post-graduate qualification	32	(21.8)	2	(4.6)	9	(20.9)
Age group	Under 29 years	14	(9.5)	3	(6.8)	5	(11.6)
	30 to 39 years	28	(18.9)	10	(22.7)	7	(16.3)
	40 to 49 years	51	(34.5)	17	(38.6)	14	(32.6)
	50 to 59 years	36	(24.3)	7	(15.9)	13	(30.2)
	60+ years	19	(12.9)	7	(15.9)	4	(9.3)
Employment status	Full-time (30 hours+)	94	(64.8)	23	(56.1)	25	(58.1)
	Part-time (< 30 hours)	39	(26.9)	15	(36.6)	15	(34.9)
	Casual or temporary	8	(5.5)	2	(4.9)	2	(4.7)
	Fixed-term contract	4	(2.8)	1	(2.4)	1	(2.3)
Income	Less than $25,000	21	(14.6)	9	(20.5)	6	(15.0)
	$25,001 to $30,000	10	(6.9)	5	(11.4)	3	(7.5)
	$30,001 to $40,000	41	(28.5)	23	(52.3)	7	(17.5)
	$40,001 to $50,000	28	(19.4)	5	(11.4)	12	(30.0)
	$50,001 to $70,000	34	(23.6)	1	(2.3)	10	(25.0)
	$70,000 or more	10	(7.0)	1	(2.3)	2	(5.0)
Region	Northern	64	(43.8)	25	(58.1)	16	(38.1)
	Midland	21	(14.4)	4	(9.3)	4	(9.5)
	Central	25	(17.1)	2	(4.7)	9	(21.4)
	Southern	36	(24.7)	12	(27.9)	13	(31.0)

Note. † Total includes peer support workers, consumer advisors and other service user roles. *Participants could select more than one

CURRENT TRAINING OR EDUCATION

Current training is summarised in Table 4. Over one-third (37 per cent) of respondents were currently completing training or qualifications related to their role.

Table 4. *Current Training or Education, N = 153*

	Total		Peer support workers		Consumer advisors	
TYPE	NUMBER	%	NUMBER	%	NUMBER	%
None	96	(62.7)	25	(53.2)	30	(69.8)
National mental health certificate	19	(12.4)	13	(27.7)	3	(7.0)
Other certificate or diploma	11	(7.2)	2	(4.3)	2	(4.7)
Bachelor's degree	9	(5.9)	2	(4.3)	2	(4.7)
Post-graduate qualification	6	(4.0)	-	-	4	(9.3)
Other	12	(7.9)	5	(10.7)	2	(4.6)
Any current training	57	(37.3)	22	(46.8)	13	(30.2)

CURRENT & PREVIOUS ROLES

ANY SERVICE USER ROLE

More than one in three people (37 per cent) had worked in any service user role between three and five years, as illustrated in Figure 1. Twenty per cent of participants had been employed in any service user role for 10 years or more.

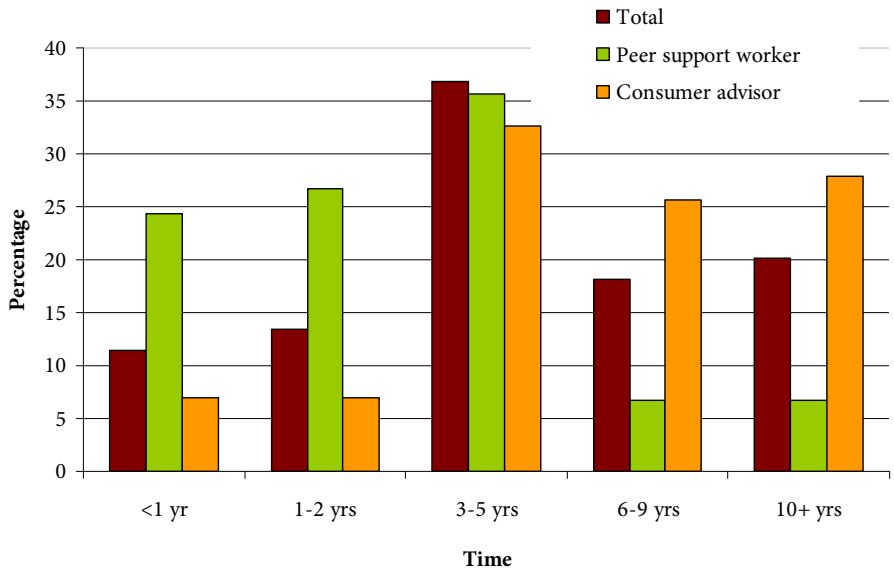
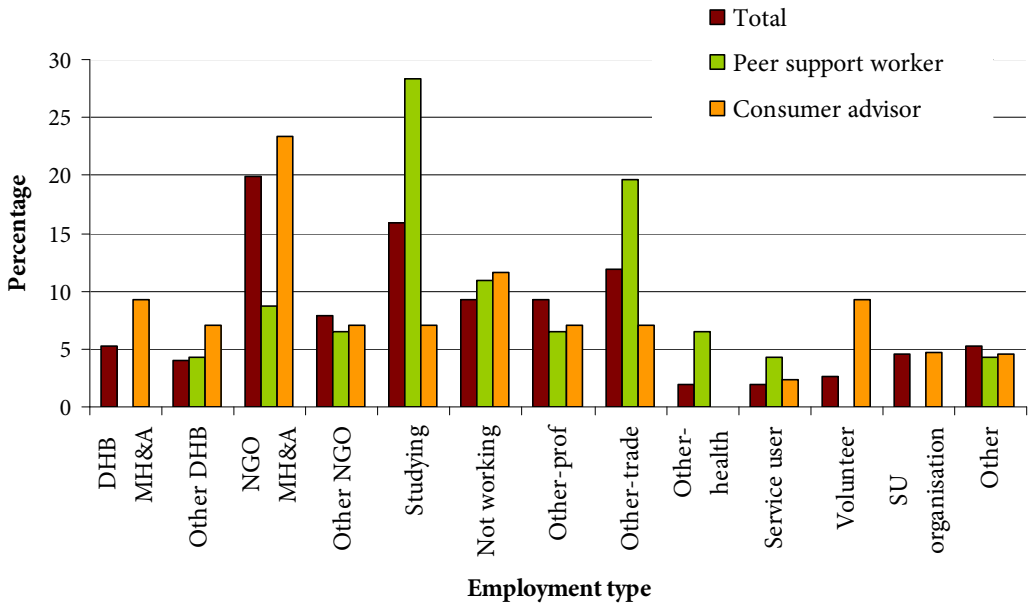


Figure 1. Time worked in any service user role, *N* = 149.

PRIOR EMPLOYMENT

Prior to current role, 20 per cent of respondents were working in a NGO mental health and/or addiction service, 16 per cent were studying, and 12 per cent were employed in a non-health trade industry, as illustrated in Figure 2.



Note. MH&A = Mental health and addiction, DHB = District health board, NGO = non-government organisation, prof = professional, SU = service user.

Figure 2. Situation prior to current role, *N* = 151.

CURRENT ROLE

Nearly one-third (31 per cent) of the service user workforce surveyed were employed as peer support workers, 28 per cent as consumer advisors, and 13 per cent in management or administration positions (see Figure 3).

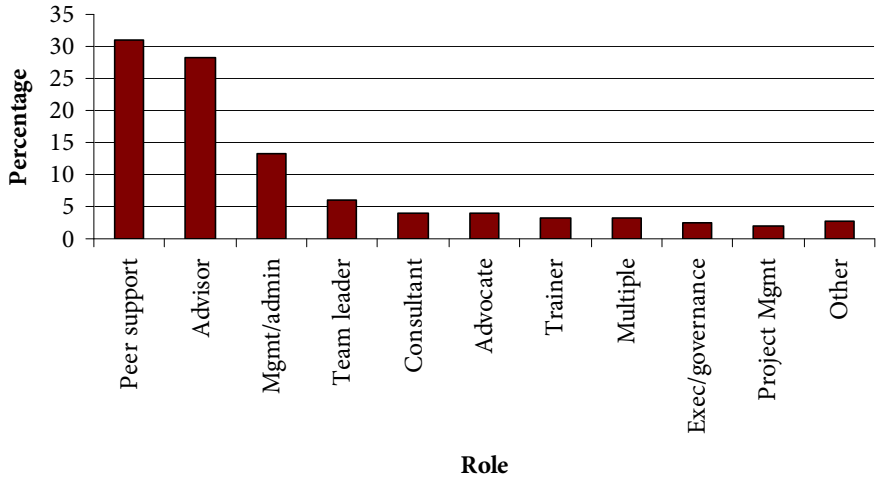


Figure 3. Current role, *N* = 152.

Illustrated in Figure 4 are the main roles and activities associated with consumer advisor roles.[*] The tasks reported most frequently by consumer advisors included providing advice, research/evaluation, training, service development, obtaining feedback and quality improvement.

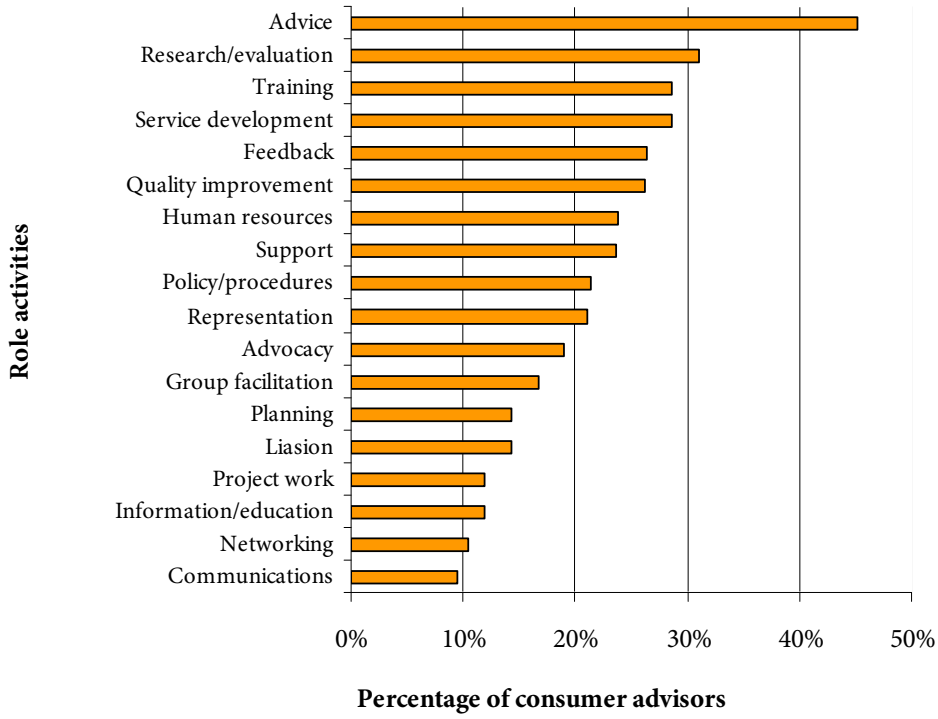


Figure 4. Consumer advisor roles and activities, $N = 42$.

The key tasks and activities for peer support workers are highlighted in Figure 5. Tasks reported most frequently by peer support workers included providing support, recovery coaching, encouragement and empowerment for service users.

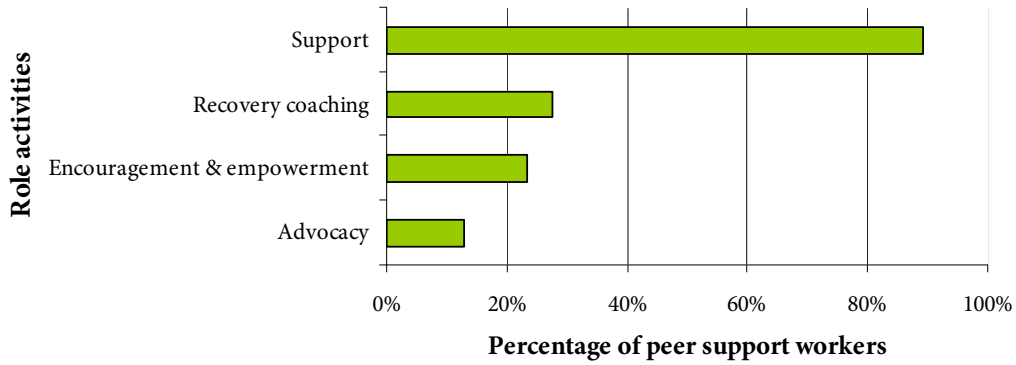


Figure 5. Peer support worker roles and activities, $N = 47$.

[*] Activities noted by less than 10 per cent of respondents in each role are not reported to identify key role tasks and activities for consumer advisor, peer support worker and administration/management roles.

Summarised in Figure 6 are the key tasks and activities for the service user workforce employed in administration or management roles.

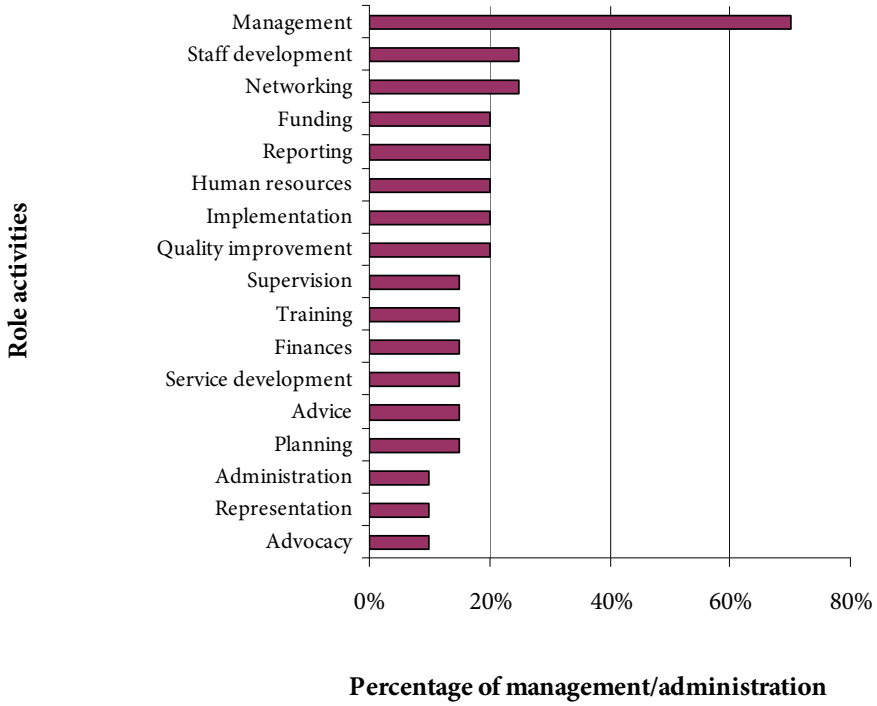


Figure 6. Management/administration roles and activities, *N* = 21.

Figure 7 shows the time employed in current roles for the total service user workforce, as well as peer support workers and consumer advisors. More than one-third (35 per cent) of respondents had been employed in their current role between three and five years, and 29 per cent between one and two years.

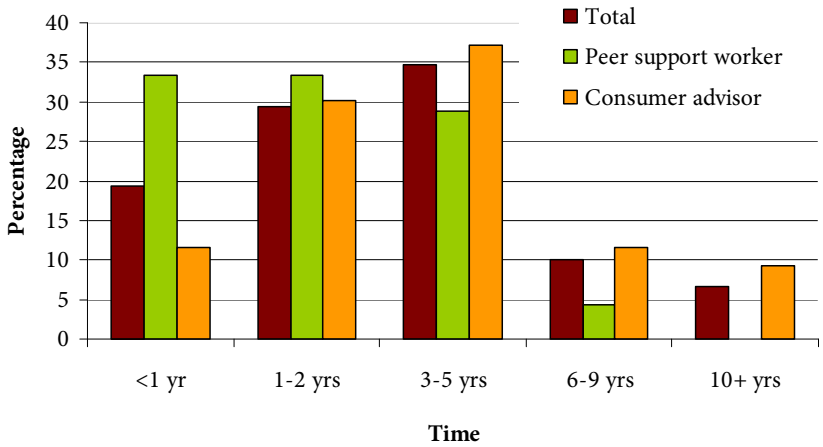


Figure 7. Time in current role, *N* = 150.

SERVICE & SETTING

Over half of survey respondents (52 per cent) worked in a mental health service, and more than one-third (38 per cent) in a mental health and addiction service (see Figure 8).

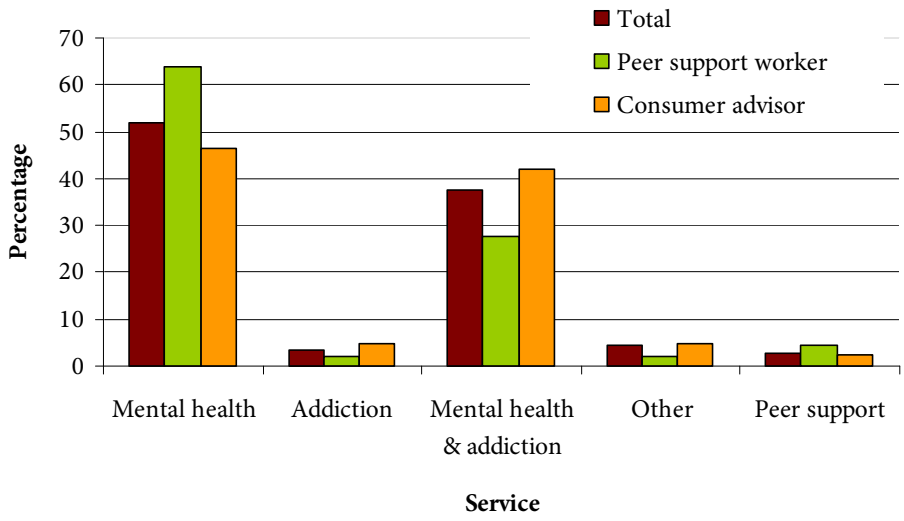


Figure 8. Mental health and/or addiction service, *N* = 152.

The type of service worked in is summarised in Table 5. Overall, participants were most likely to work in a service user led or peer support organisation, followed by a NGO. This was true for peer support workers. Consumer advisors were more likely to work in DHB settings.

Table 5. *Service Type, N = 149*

	TOTAL	
SERVICE TYPE	NUMBER	%
Service user led/peer support organisation	46	(31.0)
DHB inpatient and community	21	(14.1)
DHB inpatient only	3	(2.0)
DHB community only	16	(10.7)
NGO	44	(29.5)
PHO	3	(2.0)
Kaupapa Māori or Pacific service	11	(7.4)
Other	5	(3.3)

Service delivery (45 per cent) and development (36 per cent) were the main areas within an organisation in which respondents were employed (see Figure 9). Less than five per cent of participants were employed in the areas of governance, administration, project management, multiple or other areas.

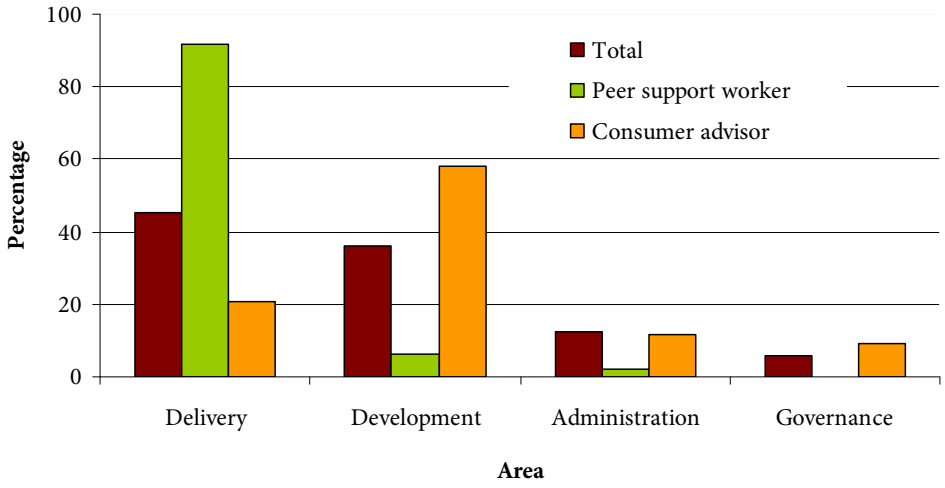


Figure 9. Area within organisation, *N* = 152.

SATISFACTION & INTENTIONS

Nearly 60 per cent of respondents were either highly or extremely satisfied with their current role, as illustrated in Figure 10.

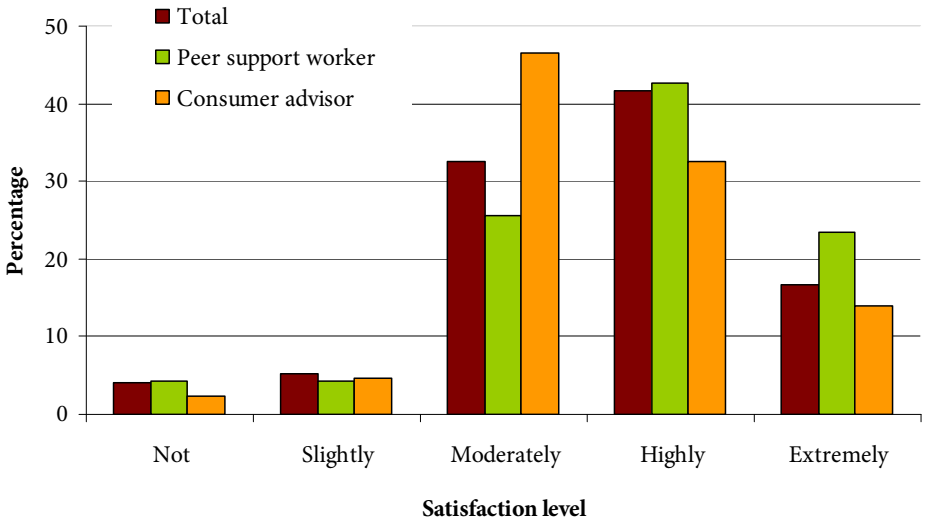


Figure 10. Role satisfaction, *N* = 151.

Only a small percentage of participants intended to work in mental health and addiction for less than one year. Nearly one-third (30 per cent) intended to work in mental health and addiction for 10 years or more (see Figure 11).

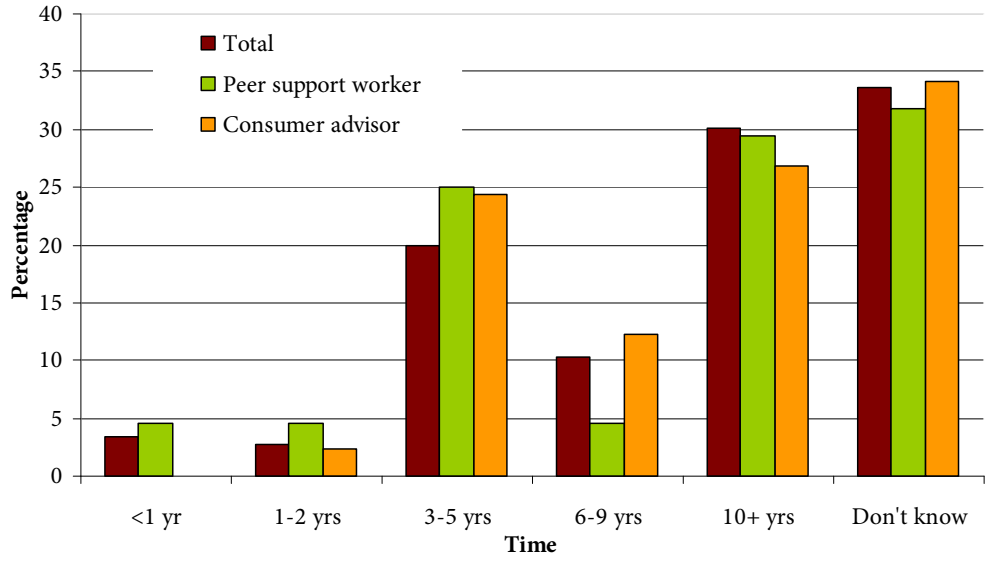


Figure 11. Future intentions of working in mental health and/or addiction, $N = 146$.

MENTORING OR SUPERVISION

Whether mentoring or supervision had been received by the service user workforce was examined. Professional supervision has been defined as enabling workers to develop their knowledge and competence, be responsible for their own practice, and promote service users' health outcomes and safety (Ministry of Health, 2006). In total, 122 participants (82 per cent) received mentoring or supervision in their role, as summarised in Table 6. Most mentoring or supervision was provided one to one (93 per cent) and at least one-third received group supervision. Overall, a similar number of participants received mentoring or supervision internally and externally.

In total, 23 respondents did not receive mentoring or supervision. The main reasons were a lack of organisational funding (n = 11) and no appropriate supervisor being available (n = 14). Mentoring or supervision was perceived as not required or important by four individuals and/or their organisations. Three people indicated mentoring or supervision was going to be organised or had at least been suggested.

Table 6. *Mentoring or Supervision, N = 148*

	Total		Peer support workers		Consumer advisors	
Service type	number	%	number	%	number	%
Received mentoring or supervision						
Yes	122	(82.4)	40	(90.9)	31	(72.1)
No	26	(17.6)	4	(8.5)	12	(27.9)
Total	148	(100.0)	47	(100.0)	43	(100.0)
Type of mentoring or supervision*						
One to one supervision	113	(92.6)	36	(90.0)	30	(96.8)
Group supervision	42	(34.4)	21	(52.5)	6	(19.4)
Any supervision	122	(100.0)	40	(100.0)	31	(100.0)
Provision of mentoring or supervision*						
Internal	74	(60.6)	33	(82.5)	20	(64.5)
External	77	(63.1)	25	(62.5)	14	(45.2)
Any supervision	122	(100.0)	40	(100.0)	31	(100.0)

Note. Participants could select more than one option. Percentages are calculated as a proportion of those receiving supervision.

TRAINING

In total, 85 per cent of participants had received training during the last two years. About 70 per cent of training was provided internally and the same amount externally. The type of training received and future training that would help the workforce be more effective and assist their professional development is summarised in Tables 7-9.

Table 7. *Training Received and Beneficial to Role and Professional Development, N = 148*

	Training received		Future training	
Training type	number	%	number	%
Any training	126	(85.1)	104	(70.3)
Peer support	31	(20.9)	13	(8.8)
Supervision/professional development	20	(13.5)	12	(8.1)
Cultural training	16	(10.8)	4	(2.7)
Leadership	16	(10.8)	6	(4.1)
Interviewing and interpersonal skills	16	(10.8)	6	(4.1)
Tertiary training/mental health certificate	15	(10.1)	9	(6.1)
First aid health and safety	14	(9.5)		
Recovery and advocacy	13	(8.8)	7	(4.7)
Non-violent crisis intervention	12	(8.1)	3	(2.0)
Mental health and/or addiction	10	(6.8)	7	(4.7)
Assessment and outcomes	9	(6.1)	1	(0.7)
Management/governance	9	(6.1)	10	(6.8)
Consumer advisor	8	(5.4)	8	(5.4)
Research and evaluation	8	(5.4)	8	(5.4)
Suicide prevention	7	(4.7)		
Human resources	6	(4.1)	1	(0.7)
Law, policy & practice	6	(4.1)	1	(0.7)
Computer skills	6	(4.1)	3	(2.0)
Facilitation of groups and meetings	5	(3.4)	5	(3.4)
Training and education	5	(3.4)	6	(4.1)
Presentation and/or writing skills	2	(1.4)	8	(5.4)
Other	54†	(36.5)	24	(16.2)
None			6	(4.1)
Unsure			7	(4.7)

Note. Percentages have been calculated as a proportion of all 148 participants. *Participants could select more than one option. †Includes unspecified training and conference attendance. Responses of less than three per cent have been included as other.

Table 8. *Training Received and Beneficial to Role and Professional Development, Peer Support Workers, N = 44*

	Training received		Future training	
Training type	number	%	number	%
Any training	39	(88.6)	33	(75.0)
Peer support	17	(38.6)	7	(15.9)
Supervision/professional development	8	(18.2)		
Cultural training	3	(6.8)	1	(2.3)
Leadership	5	(11.4)		
Interviewing and interpersonal skills	4	(9.1)	3	(6.8)
Tertiary training/mental health certificate	6	(13.6)	6	(13.6)
First aid	7	(15.9)		
Recovery and advocacy	6	(13.6)	4	(9.1)
Non-violent crisis intervention	2	(4.5)		
Mental health and/or addiction	4	(9.1)	3	(6.8)
Assessment and outcomes	2	(4.5)		
Consumer advisor			2	(4.5)
Research and evaluation	1	(2.3)		
Suicide prevention	4	(9.1)		
Human resources	2	(4.5)	1	(2.3)
Facilitation of groups and meetings	1	(2.3)	3	(6.8)
Training and education	1	(2.3)	2	(4.5)
Clinical practice	1	(2.3)	2	(4.5)
Lifestyle behaviours	2	(4.5)		
Team building work			2	(4.5)
Other	15	(34.1)	4	(9.1)
None			3	(6.8)
Unsure			2	(4.5)

Note. Participants could select more than one option. †Includes unspecified training and conference attendance. Responses of less than three per cent were included in other.

Table 9. *Training Received and Beneficial to Role and Professional Development, Consumer Advisors, N = 43*

	Training received		Future training	
Training type	number	%	number	%
Any training	36	(83.7)	30	(69.8)
Peer support	6	(14.0)	2	(4.7)
Supervision/professional development	4	(9.3)	6	(14.0)
Cultural training	3	(7.0)	3	(7.0)
Leadership	2	(4.7)	1	(2.3)
Interviewing and interpersonal skills	7	(16.3)	2	(4.7)
Tertiary training/mental health certificate	2	(4.7)	2	(4.7)
First aid	3	(7.0)		
Recovery and advocacy	2	(4.7)	1	(2.3)
Non-violent crisis intervention	4	(9.3)	1	(2.3)
Mental health and/or addiction	2	(4.7)		
Assessment and outcomes	4	(9.3)		
Management/governance	2	(4.7)	4	(9.3)
Consumer advisor	6	(14.0)	3	(7.0)
Research and evaluation	6	(14.0)	4	(12.9)
Law, policy & practice	2	(4.7)	1	(2.3)
Computer skills	3	(7.0)	3	(7.0)
Facilitation of groups and meetings	4	(9.3)	2	(4.7)
Training and education	2	(4.7)		
Project management			3	(7.0)
Mental health promotion	2	(4.7)		
Presentation and/or writing skills			4	(9.3)
Other†	18	(41.9)	4	(9.3)
None			1	(2.3)
Unsure			1	(2.3)

Note. Participants could select more than one option. †Includes unspecified training and conference attendance. Responses of less than three per cent have been included in other.

More than 85 per cent of participants indicated learning and training opportunities were highly or extremely important (see Figure 12).

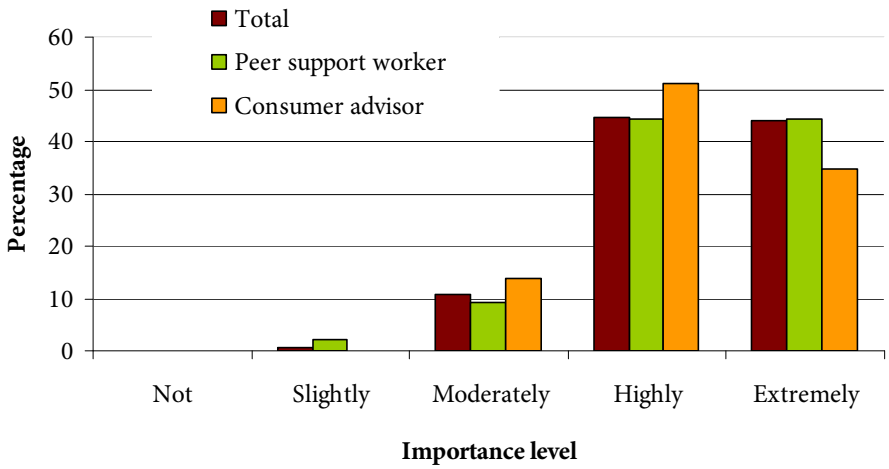


Figure 12. Importance of learning and training opportunities, *N* = 148.

In total, 84 per cent had received some organisational assistance with training as summarised in Table 10.

Table 10. *Organisational Training Assistance, N = 140*

	Total		Peer support workers		Consumer advisors	
Support type	number	%	number	%	number	%
No assistance	22	(15.7)	6	(15.0)	7	(17.5)
Funding	52	(37.1)	15	(37.5)	13	(32.5)
Time off work	60	(42.9)	16	(40.0)	17	(42.5)
Travel costs	16	(11.4)	3	(7.5)	4	(10.0)
Unspecified assistance	29	(20.7)	7	(17.5)	9	(22.5)
Other	15	(10.7)	5	(12.5)	4	(10.0)
Any workplace assistance*	118	(84.3)	34	(85.0)	33	(82.5)

Note. Participants were asked to describe how their workplaces supported their training and could indicate more than option.

DISCUSSION

A service user mental health and addiction workforce survey was undertaken to develop a better understanding of workforce characteristics, roles and activities, professional development and training needs. Information collected is intended to support future service user workforce development. Robust information is required on the characteristics of the health workforce and how they change over time to successfully address future workforce priorities and actions (Future Workforce Group, 2008).

CHARACTERISTICS

Several approaches were taken to assess the size of the service user workforce. The contracted service user workforce is conservatively estimated to be just over 220 FTEs. Based on earlier workforce surveys (Matua Raki, 2009; Platform, 2007; Werry Centre, 2009) it is anticipated the actual number of people working in service user roles is about 270.[*] Therefore, at least 56 per cent of the service user workforce likely participated in this survey.

The characteristics of survey respondents were similar to other health and mental health workforces in NZ. Responses from each region were representative of the general health workforce and population, as summarised in Table 11.

Table 11. *Survey Respondents by Region*

REGION	SERVICE USER WORKFORCE	HEALTH WORKFORCE†	GENERAL POPULATION*
Northern	44%	49%	37%
Midland	14%	15%	19%
Central	17%	16%	20%
Southern	25%	20%	24%

Note. † Future Workforce Group (2008). *Statistics NZ (2007).

Similar to the DHB health workforce[†] (Future Workforce Group, 2008), the vast majority of survey participants were female (70 per cent). In line with NGO mental health and addiction services (Platform, 2007), overall one-quarter were employed part-time. Part-time employment was more common among consumer advisors. The age profile of participants did not differ from the overall health or mental health and addiction workforces (Future Workforce Group, 2008; Ministry of Health, 2008b), with the majority aged between 40 and 59 (60 per cent).[‡] A large proportion of the current service user workforce will retire in the next 5-15 years.

The level of education was higher among respondents than the general population (Statistics NZ, 2007b) and comparable to the NGO mental health and addiction workforce (Platform, 2007).[§] Peer support workers tended to have a lower level of education than consumer advisors but were more likely to be currently undertaking some form of training or education. Half of the service user workforce surveyed were earning at least $40,000 per year, in line with the median income for NZ salary and wage earners (Statistics NZ, 2009).[**] Peer support workers however tended to earn less, with more than half earning between $30,001 and $40,000 per year.

[*] The Ministry of Health (2008) indicated there were between 12136 and 12432 people working in the mental health and addiction sector in 2008, of which about 60 per cent worked in DHBs. Estimates of the service user workforce are included in child and adolescent, addiction and NGO workforce surveys.
[†] 80% of the DHB workforce was female.
[‡] On average, the DHB health workforce is 44.2 years.
[§] About one-third had achieved a certificate or diploma qualification and half a university degree or higher qualification.
[**] The median income for wage and salary earners was $760 per week in the June 2009 quarter – $630 females and $866 males.

The service user workforce is largely comprised of people identifying as NZ European/other. This result is representative of the NZ population (Statistics NZ, 2007a). More than 20 per cent of respondents were Māori, which is slightly higher than the 15 per cent identifying as Māori in the 2006 Census. This finding is consistent with the 2005 Matua Raki survey which found Māori make up one-fifth of alcohol and drug workers (Ministry of Health, 2008b). Nevertheless, more than one-quarter of adults with the most serious mental health problems are Māori (Oakley Browne et al., 2006; Statistics New Zealand, 2007). Similarly, the Pacific service user workforce was underrepresented[*] given Pacific peoples reflect an estimated eight to nine per cent of adults with the most serious disorders (Oakley Browne et al., 2006; Statistics New Zealand, 2007). Compared with general population size, the Asian service user workforce was also lower than expected.

> There is a concern in areas where there are high Māori, Pacific and Asian populations, because international and New Zealand evidence indicates that services delivered by providers and workers from the relevant communities are likely to be more effective than services delivered by members of other communities (Ministry of Health, 2002c). (Ministry of Health, 2005, p. 7)

SERVICE USER ROLES

The survey findings identified that entry into the service user workforce involved a number of pathways. Prior to their current role, respondents were mainly working in NGO mental health and addiction services, non-health related industries[†] or studying. These key sectors were also identified in the *NgOIT Workforce Survey* (Platform, 2007) and should be targeted in service user workforce recruitment strategies.

One indicator of workforce stability is length of service (Future Workforce Group, 2008). The average length of time in current and any service user role is estimated to be 3.5 and 5.5 years respectively. The stability of the service user workforce is similar to the NGO mental health and addiction workforce (Platform, 2007) but lower than DHB services (Future Workforce Group, 2008).[‡] [§] It is possible people move from working in NGOs to DHBs. This was not examined however in the survey. The service user workforce was nevertheless committed to the sector with about one in three intending to work in mental health and addiction for at least another 10 years.

Key service user workforce roles included peer support workers and consumer advisors. Collectively, more than 60 per cent of respondents were employed in these roles. The *NgOIT Workforce Survey* (Platform, 2007) also found these to be key service user roles.[**] The next largest service user workforce group identified was management/administration.[††]

The background of peer support workers and consumer advisors differed. Peer support workers were more likely to be new to the mental health and addiction sector. Most peer support workers had previously been studying, and more than one-quarter had been working in a non-health related industry.[‡‡] Consumer advisors, on the other hand, were more experienced and likely to have been working in a NGO or DHB setting. The career pathways and experience of peer support workers and consumer advisors therefore differs and likely impacts on training needs.

Most peer support workers were employed by a NGO, service user led or peer support organisation in the area of service delivery. In line with this, key aspects of the peer support role included offering support to

[*] Pacific peoples reflected less than one per cent of service user workforce respondents.
[†] In total, 21 per cent were previously working in non-health related industries (nine per cent in professional and 12 per cent in trade roles).
[‡] The estimated average length of employment in NGO mental health and addiction services is 3.7 years (Platform, 2007).
[§] The average length of service for the DHB health workforce is estimated to be seven years (Future Workforce Group, 2008).
[**] Three per cent of the NGO mental health and addiction workforce identified themselves as peer support workers. In addition, one per cent were consumer advisors in the *NgOIT Workforce Survey* (Platform, 2007), despite results from this survey suggesting consumer advisors are most likely to be working in DHB settings.
[††] Thirteen per cent of respondents were employed in management/administration.
[‡‡] Seven per cent professional and 20 per cent trade role.

service users, recovery coaching, empowerment and encouragement. Overall, peer support workers were most satisfied in their current role and were more likely to be employed in the Northern and Southern DHB regions.[*]

Consumer advisors tended to work in DHB settings across both inpatient and community settings.[†] There was a high degree of similarity in the roles and tasks performed by consumer advisors in these settings.[‡] Consumer advisors primarily provided advice and training. Tasks also included receiving and obtaining feedback, undertaking evaluations and audits, and contributing to service development and quality improvements. The involvement of consumers in the planning, implementation and evaluation of mental health and addiction services is specified in the Health and Disability Sector Standards (Standards New Zealand, 2008).

Although nearly half of consumer advisors were very satisfied with their role, they tended to be slightly less satisfied overall. This may reflect a wider range of challenging tasks and responsibilities entailed in consumer advisor positions and the location of their roles primarily within service development.[§]

Despite key workforce groups being identified, the service user workforce is diverse. The range of other service user roles included consumer auditors or evaluators, consultants, trainers or facilitators, team leaders, advocates, project managers, and executive managers or governance board members. The range of service user roles suggests the workforce development and training needs associated with different roles will vary.

PROFESSIONAL SUPERVISION

Professional supervision enables workers to develop their knowledge and competence, be responsible for their own work practice, and promote service users' health outcomes and safety (Ministry of Health, 2006).[**] Most participants received mentoring or supervision at a level comparable to other professions such as nursing (McKenna, Thom, Howard, & Williams, 2008).[††] The rate was slightly lower however among consumer advisors. One to one supervision was most common and to a lesser extent, group supervision, especially among peer support workers. Other aspects of supervision such as the quality, frequency and impact were not assessed in this survey. Whether supervision or mentoring was being provided by a person with experience of mental illness and/or addiction or if this was important was also not examined. These areas should be considered in future workforce surveys.

While the extent of mentoring and supervision is positive and encouraging, gaps exist. One of the seven Real Skills included in the *Let's get real* framework of the essential knowledge, skills and attitudes required for people working in mental health and addiction services is professional and personal development. That is, "every person working in a mental health and addiction treatment service actively reflects on their work and practice and works in ways that enhance the team to support the recovery of service users" (Ministry of Health, 2008a, p19). More than one in six workers were not currently receiving mentoring or supervision. The most common reasons for not receiving mentoring or supervision included a lack of organisation funding and an appropriate supervisor being unavailable.

[*] Northern DHB region = Northland, Waitemata, Auckland and Counties Manukau DHBs and Southern DHB region = all South Island DHBs
[†] 58 per cent inpatient and 63 per cent community. More than 40 per cent of consumer advisors worked in both DHB inpatient and community settings.
[‡] There was some degree of variability in responses for consumer advisors in different DHB regions. However the sample sizes were only small and likely to be less reliable.
[§] 21 per cent are also located in administration/management.
[**] Professional supervision uses critical reflection to identify professional issues that can be addressed to improve practice.
[††] It is estimated 75 per cent of nurses currently receive professional supervision (McKenna et al., 2008).
http://www.tepou.co.nz/file/Professional-Supervision-for-Mental-Health-and-Addiction-Nurses.pdf

> Although some organisations may view professional supervision as expensive, White and Winstanley (2006) found that the cost of one-to-one professional supervision represented about 1% of annual salary. (McKenna et al., 2008, p. 17)

To support a nationally consistent approach to supervision, professional supervision guidelines have recently been developed for mental health and addiction nurses (Te Pou, 2009a). These may also have broader applicability to the service user workforce. Gaps in the provision of professional supervision or mentoring should therefore be addressed for the service user workforce.

TRAINING

For the vast majority of respondents, learning and training opportunities were considered very important. This is consistent with a survey of disability support workers (Ministry of Health & University of Auckland, 2004).

There was a high level of support by organisations for training, which is in line with Māori mental health and addiction treatment workforce surveys (Tassell, 2004).[*] However, the Māori mental health workforce survey found organisational support for training did not necessarily translate into a training/professional development plan being put in place.[†] In the current survey, organisational support for training was most likely to consist of providing time off work and funding. This type of support helps address some of the key barriers to training summarised in Table 12.

Table 12. *Workforce Training Barriers*

TRAINING BARRIERS	
• Cost • Admission requirements • Knowledge of training opportunities	• Literacy skills • Time available to study • Employment limitations
Source: (Ashton, King, & McRae, 2004; Suaali-Sauni et al., 2007)	

The most common types of training received were peer support and supervision/professional development. While the quality, relevance and use of training in practice were not assessed, overall peer support and supervision/professional development were considered most beneficial to future role and professional development.

Table 13. *Future Training Beneficial to Role Development, Peer Support & Consumer Advisors*

TRAINING TYPE*	PEER SUPPORT	CONSUMER ADVISOR
Peer support	■	
Tertiary training/mental health certificate	■	
Recovery and advocacy	■	
Supervision/professional development		■
Management/governance		■
Research and evaluation		■
Presentation and writing skills		■
*Reported by at least 10 per cent of survey item respondents.		

[*] 92 per cent of the addiction treatment workforce were at least moderately supported to undertake as much training as needed (Tassell, 2004).
[†] Just over half of Māori mental health workers had a training/professional development plan.

Future training needs specific to peer support workers and consumer advisors were identified (see Table 13). Peer support workers indicated peer support training, relevant mental health and addiction tertiary training, and recovery and advocacy training would be useful for their future role development. Future training beneficial to consumer advisors included supervision/professional development, management/ governance, research and evaluation, presentation and business writing skills. Different types of training are therefore indicated for people working in different service user roles.

LIMITATIONS

Several limitations need to be taken into account when interpreting survey results. Contracted FTEs for service user roles were obtained from the Ministry of Health and verified by DHBs. Contracted FTEs will however underestimate the total service user workforce. This underestimation is due in part to the purchase unit (PU) code assigned to a contract (for example, PU codes being assigned to consumer led services based on the programme or service model rather than specific workforce), contracts that do not include specific FTEs (for example, a contract based on a fixed financial amount), organisations employing service users despite not having been specifically contracted to do so (for example, funded through organisational overheads), and some service user positions being voluntary or unpaid.[*] Contracted FTEs therefore underestimate the actual service user workforce. In addition, people with experience of mental illness, distress and/or addiction who do not work in an identified service user role will not be captured by contracted service user FTEs.

Only a small number of people working in addiction services took part in this survey. There are however few dedicated AOD consumer and/or peer support funded roles and dedicated consumer-led organisations (Matua Raki, 2009). This largely reflects a limited focus on developing service user roles within the AOD sector over the past decade.[†] This is due in part to the recognised number of addiction workers with personal journeys of recovery from substance use problems. The characteristics, career pathways, professional development and training needs for the addiction sector may therefore differ from mental health. Further analysis of the addiction workforce specifically was prohibited by the small sample size. While there are similarities between mental health and addiction, the differences were not captured by this survey. Qualitative research will enable greater in-depth understandings.

Key tasks and activities for peer support, consumer advisors and administration/management roles were identified in response to an open-ended question "describe the main activities in your current role". This relied on participants recalling their main tasks. No standardised response options or definitions were provided. Individual interpretations of similar roles and activities may have differed.[‡] In addition, similar responses were grouped together during data analysis. Consequently, there may be greater variability in tasks among those employed in the same role. The tasks associated with service user roles may also vary in different service settings, regions or locations. The small sample size however limited analysis of these factors.

The number of service users employed in governance roles was low. The governing bodies of mental health and addiction services need to ensure services are "planned, coordinated, and appropriate to the needs of consumers" and that "consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals" (Standards NZ, 2008, p36). While this finding indicates a need for more service users to be included on governance boards, the method of survey distribution may have resulted in low uptake from governance board members. Therefore the number of governance board members is likely to be underestimated along with those working in unpaid or voluntary positions.[§]

[*] Gutschlag, T., Coulter, R., Robertson, R., & Schnell, G, personal communication.
[†] Robertson, R, personal communication.
[‡] Robertson, R, personal communication.
[§] This might be particularly relevant for governance/board members and others who have less frequent contact with services and the service user workforce. When examining pay rates an inclusion of an unpaid voluntary position option should also be included.

Those who took part in the survey may not represent the overall service user workforce. A snow-ball sampling method was used to invite survey participation. This practical method was chosen, given the absence of a suitable sampling frame. That is, no database or list of people working in identified service user roles or key organisations was available for survey distribution. Participants were therefore not randomly sampled and results may not be generalisable to those who did not participate.

The characteristics and workforce needs of survey participants may differ from non-respondents. Participants may have been more educated and interested in training and workforce development than non-participants. In addition, the total ethnic diversity of the actual service user workforce may not be fully reflected, especially for those whom English is a second language. Although the characteristics of participants were in line with expectations, findings may differ for those who did not take part.

Mental health and/or addiction services for specific population age groups (such as child, youth and older adult) were not examined. Therefore, information is not available for those working in child and adolescent, general adult, or older adult services. The Werry Centre stocktakes of the child and adolescent mental health and addiction workforce and a current survey by Te Pou examining the older adult workforce will provide some information about services for these population groups. These services should however be included in future workforce surveys.

CONCLUSION

Despite limitations, this survey provides quality and up-to-date information about the service user mental health and addiction workforce at this time. The survey has addressed current knowledge gaps about the characteristics of the service user workforce, service user roles, tasks and activities, as well as professional development and training needs. The survey findings can aid future development of this workforce. Development of the service user mental health and addiction workforce has been identified as a priority in national policies and plans. The service user workforce can be better utilised to develop a sustainable and responsive mental health and addiction workforce. Based on survey findings a number of conclusions have been made.

Career pathways and competencies for the mental health and addiction service user workforce would be beneficial to develop using the *Let's get real* framework of the essential skills, values and attitudes required for the mental health and addiction workforce as a starting point. Te Pou is planning to develop a discussion document on how to bridge and make *Let's get real* relevant to the service user workforce, in particular peer support workers. This discussion document will incorporate the philosophies of recovery and the unique areas of effectiveness and expertise from having a lived experience of mental illness, distress and/or addiction.

Māori, Pacific and Asian peoples were underrepresented in the survey compared to population need. Among adults with serious mental illness and/or addiction more than one-quarter are estimated to be Māori and nine per cent Pacific peoples (Oakley Browne et al., 2006; Statistics New Zealand, 2007). While the prevalence of mental illness or addiction among Asian peoples was not examined in *Te Rau Hinengaro,* the proportion of service users identifying as Asian in this survey was below expectations in relation to population size. The Māori, Pacific and Asian service user workforce therefore needs to be increased by at least 30 per cent to reflect population need for services. This would require national, regional and local level commitment.

Nearly two-thirds of survey participants were either consumer advisors or peer support workers. There is no consistent or widely agreed definition for the consumer advisor role. The scope, key tasks, activities, and expectations associated with consumer advisor and peer support worker roles are varied in practice and this will likely increase in future. New service user roles are also emerging including service user evaluators, auditors and researchers. These roles also need to be clearly articulated and defined by key stakeholders including service user leaders and people in these roles. It would be useful to specify the

breadth of responsibilities and tasks involved in these roles, in order to inform planning for future workforce needs. A description of these roles and their tasks should be informed by survey findings and people working in these roles. Some work has been undertaken by the Werry Centre in developing guidelines for youth consumer advisors and services.[*] It is timely for the consumer advisor resource kit available on the Te Pou website[†] to be updated in order to provide some national consistency for these roles.

Training offered to peer support workers and consumer advisors needs to be relevant to their role and tasks. Survey findings could also be used to inform national, regional and local workforce development and relevant tertiary education programmes to better meet the needs of the service user workforce. For example, tailoring of content and delivery of training to meet the needs of the addiction service user workforce could be considered.[‡].

Services need to address gaps in the number of people in the service user workforce receiving supervision. About 20 per cent of the service user workforce surveyed did not receive supervision. Services need to ensure suitable supervision is provided and sufficiently budgeted for. Evidence suggests the budget required for professional supervision is about one per cent of annual salary (White & Winstanley, 2006; cited in McKenna et al., 2008). This will help ensure the service user workforce is supported to develop their knowledge, skills and confidence. Work is also being carried out by Te Pou to expand the mental health and addiction professional supervision guidelines for nurses for the regulated and non-regulated workforce. These guidelines will help support service user workforce supervision.

Recruitment strategies for the mental health and addiction workforce need to support growth of the service user workforce. The development of the service user workforce is a priority in national mental health and addiction policies. Nearly 40 per cent of the current service user workforce is aged 50 years and over and will be retiring in the next 5-15 years. Recruitment strategies should be included in national, regional and local workforce development plans.[§] Key areas which could be targeted in recruitment strategies include the current NGO service user workforce and people working in non-health related industries.

Information about the service user workforce should continue to be collected to monitor progress in developing the capacity and capability of this workforce. Based on workforce group size, information about consumer advisors and peer support workers should be specifically gathered in ongoing routine health workforce data collections by Health Workforce New Zealand and other national workforce surveys. There also needs to be greater consistency in the methodology used in future national workforce surveys to enhance the comparability of survey findings.

Communication and dissemination of information to the service user workforce is challenging, given only two of the four regional networks now remain in the Midland and Northern regions. There is an absence of a central database, national network or organisation to reach this workforce. Currently, the BINZ email discussion group and the Te Pou e-bulletin newsletter may be useful in accessing some, but not all, of the service user workforce.[**] There are also challenges in developing and maintaining comprehensive contact lists, including employment changes and capturing unpaid/voluntary positions. The development of a database or annual registration of the service user workforce would aid better communication and information distribution. For the peer support workforce, this may be addressed by the current development of a National Peer Support e-network by Balance NZ.

All indications are that the service user workforce is vibrant, skilled, committed and eager to be the best and most effective they can be. It is hoped this report will help mental health planners and funders,

[*] http://www.werrycentre.org.nz/385/Youth_Consumer_Participation
[†] http://www.tepou.co.nz/page/151-service-user-workforce-development+consumer-advisor-resource-kit
[‡] For example, scenarios that reflect the addiction paradigm (Robertson, R, personal communication).
[§] Some factors which may improve recruitment and retention include (a) flexible rosters, hours of work, (b) child care availability, (c) feeling valued, (d) good organisational structure, (e) adequate staffing and resources, (f) access to training opportunities, (g) supportive environment, (g) team approach to supporting people, and (h) safe practice within area of expertise (Ashton et al., 2004; Kumar, Robinson, & Lau, 2004).
[**] Acceptance criteria may also limit membership.

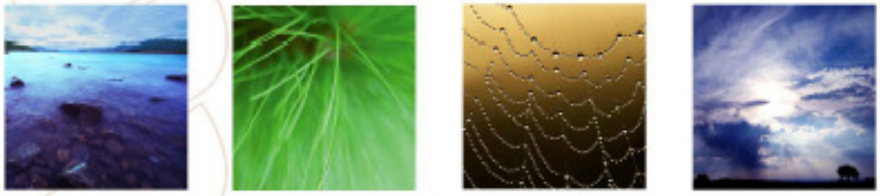
general and service managers to recognise the quality and value of this workforce and how to support their future growth. Development of the service user workforce needs to be incorporated into workforce planning at all levels. Survey findings help identify where investment might be best targeted to support, grow and empower this rich but as yet underutilised resource.

Te Pou's work programme addresses some of key areas identified above. Further development of the service user workforce requires sector wide leadership and commitment. It requires a multi-agency approach that builds on existing workforce development strategies. The report provides the mental health sector with useful information that describes the current status of the mental health service user workforce in 2010. It provides detailed information about their roles and experience of training and supervision. This part of the mental health workforce has experienced significant growth over the last few years. The survey results provide a baseline from which to evaluate the impact of future service user workforce recruitment and retention initiatives.

APPENDIX: SURVEY QUESTIONNAIRE

WHERE ARE WE AT?

SERVICE USER/CONSUMER/PEER SUPPORT SURVEY



Te Pou o Te Whakaaro Nui

The NATIONAL CENTRE of MENTAL HEALTH RESEARCH, INFORMATION and WORKFORCE DEVELOPMENT

www.tepou.co.nz

Where are we at?

This survey aims to capture a true picture as possible of the service user workforce at this time. This information is not currently available and would be very useful for future workforce development planning.

This information will be used to:

- Find out who is doing what and where
- Identify what training is currently happening and what is missing
- Get good information about mentoring and supervision and its availability
- Provide current information about the service user mental health and addiction workforce
- Develop a better understanding of the contribution this workforce makes to the sector

This survey is being conducted by Te Pou on behalf of the Ministry of Health. Survey participation involves completing this brief questionnaire. All questions are optional but the more information you provide the clearer the picture will be.

All information will be treated as confidential. At the end of the survey you can choose to receive a summary of survey findings. Your contact details will be separated from survey responses to preserve your anonymity.

You can choose to complete this survey:

- by completing this questionnaire
- by calling (09) 373 2125 or emailing info@tepou.co.nz to arrange a suitable time
- online at www.surveymonkey.com/s/workforce-development-1

Thank you for contributing to this important mental health and addiction workforce project.

If you have any questions or would like additional information about this survey please contact Monica Palmer by telephone (09) 373 2125 or email info@tepou.co.nz.

How to complete this survey

Please complete this survey:

- if you are a person with experience of mental illness or mental distress, and
- you work in an identified service user/consumer/peer support role, such as a consumer advisor, consumer auditor, peer support worker, or any other service user role.

Please read carefully

- There are no right or wrong answers; choose the response that is best for you.
- All information you give to us is confidential and will only be used for the purposes of this survey.
- Completion of the questionnaire implies consent to take part in this survey.

About your role

We would like to ask you some questions about your current and previous roles. Please tick the relevant box or write details in the space provided.

1. How long have you worked in your current role?

☐ Less than one year
☐ 1 to 2 years
☐ 3 to 5 years
☐ 6 to 9 years
☐ 10 years or more

2. How long have you worked (paid or unpaid) in <u>any</u> service user role? (include time worked in a service user role for other mental health organisations, networks or services)

☐ Less than one year
☐ 1 to 2 years
☐ 3 to 5 years
☐ 6 to 9 years
☐ 10 years or more

3. What were you doing prior to your current role? (select <u>one</u> option)
An NGO is a non-government organisation and DHB refers to district health board.

☐ Working in a NGO mental health and/or addiction service
☐ Working in a DHB mental health and/or addiction service
☐ Studying
☐ Other NGO service
☐ Other DHB service

Other (please specify)

……

4. What type of health service do you currently work for? (select <u>one</u> option)

☐ Mental health only
☐ Addiction only
☐ Mental health and addiction

Other (please specify)

……

5. What type of service setting do you currently work in? (tick all that apply)

☐ Service user led organisation
☐ Primary health organisation
☐ DHB inpatient
☐ Kaupapa Māori health service
☐ DHB community
☐ Pacific health service
☐ NGO
☐ Asian, refugee or migrant service

Other (please specify)

……

6. What is your current role? (select <u>one</u> option)

☐ Consumer advisor
☐ Māori consumer advisor
☐ Peer support worker
☐ Consumer facilitator/trainer
☐ Telephone peer support worker
☐ Team leader
☐ Consumer auditor and/or evaluator
☐ Administration/management
☐ Consumer consultant
☐ Governance/board member

Other (please specify)

……

7. Where does your role primarily sit within the service you work in? (select <u>one</u> option)

☐ Service delivery
☐ Administration
☐ Service development/management
☐ Governance

Other (please specify)

……

8. Describe the main activities involved in your current role.

……..

……

9. Overall how satisfied are you in your current role?

☐ Not satisfied
☐ Slightly satisfied
☐ Moderately satisfied
☐ Highly satisfied
☐ Extremely satisfied

About your training

We would like to ask you for some information about your training and supervision. Please tick the relevant box or write details in the space provided.

10. Do you receive mentoring or professional supervision in your role? (tick all that apply)

☐ Yes, one to one supervision

☐ Yes, group supervision

☐ No (go to question 12)

☐ Don't know (go to question 13)

11. If yes, who provides your mentoring or supervision?

☐ Internal (provided by someone working in your organisation)

☐ External (provided by someone outside your organisation)

☐ Both (you have access to both types of supervision)

12. If no, please indicate the reason for not receiving mentoring or supervision (tick all that apply)

☐ My organisation does not fund this

☐ No appropriate supervisor is available

☐ I'm not interested

☐ N/A

Other (please specify)

……

13. Have you received training relevant to your role in the last two years? (include internal and external training)

☐ No

☐ Yes, internal training

☐ Yes, external training

If yes, please specify what training you have received

……

……

14. List any specific training that would help you be more effective in your role and assist your professional development and indicate if this training is currently available.

……

……

15. How important is it to you to learn and train within your job?

☐ Not important

☐ Slightly important

☐ Moderately important

☐ Highly important

☐ Extremely important

16. List any specific training and/or qualifications you are currently working towards related to your job.

……

……

……

17. Does your workplace support you in your training in any way? (for example, course fee assistance, paid time off work to attend).

☐ No

☐ Yes

If yes, please describe how

……

18. What is your highest academic qualification? (select <u>one</u> option)

☐ No formal qualification

☐ Secondary school qualification

☐ Undergraduate certificate or diploma

☐ Bachelors Degree

☐ Post-graduate qualification

☐ Masters Degree

☐ PhD/Doctorate

Other (please specify)

……

About you

Lastly, we would like to ask for some information about you. Please tick the appropriate box or write details in the space provided. All questions are optional but your answers will give us important information and will be kept confidential.

19. How long do you intend to work in the mental health and addiction field in the future?

☐ Less than one year
☐ 1 to 2 years
☐ 3 to 5 years
☐ 6 to 9 years
☐ 10 years or more
☐ Don't know

20. What is your age group?

☐ Under 20
☐ 20 to 29
☐ 30 to 39
☐ 40 to 49
☐ 50 to 59
☐ 60 to 64
☐ 65+

21. Which ethnic group(s) do you identify most closely with? (tick all that apply)

☐ Asian
☐ Māori
☐ New Zealand European
☐ Pacific peoples

Other (please specify)

……

22. Gender

☐ Male
☐ Female

23. What is your current employment status? (select <u>one</u> option)

☐ Full-time (30-40 hours a week)
☐ Part-time
☐ Casual or temporary
☐ Fixed term contract

24. How much do you earn each year in your job (before tax)? (If you work part-time please state how much you would earn in a year if you were full-time).

☐ Less than $25,000
☐ $25,001 to $30,000
☐ $30,001 to $40,000
☐ $40,001 to $50,000
☐ $50,001 to $70,000
☐ $70,001 to $100,000
☐ $100,001 or more

25. What region or city do you work in?

……

26. Any other comments or feedback you have about this survey

……

……

……

……

……

……

Thank you for taking the time to complete this survey

If you would like to receive our e-bulletin newsletter or a summary of the survey results once they have been completed, please include your contact details below.

Please note, your name and address will be detached from the questionnaire once it has been returned to ensure your responses are kept completely confidential.

Name .....

Address .....

.....

Email address .....

Send me ☐ e-bulletin ☐ summary of results

RETURN ADDRESS FOR QUESTIONNAIRE

Service user/consumer/peer support workforce survey
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GLOSSARY OF TERMS

AOD	Alcohol and other drugs
Admin	Administration
CAMH	Child and adolescent mental health
Central DHB region	Whanganui, MidCentral, Hawke's Bay, Capital and Coast, Hutt Valley and Wairarapa DHBs
DHB	District health board
Exec	Executive
FTE	Full-time equivalent
Governance/ board members	People who have responsibility for the overall direction of the organisation, including the development of policy, which determines the goals and purpose of the service*
HWIP	Health Workforce Information Programme
Let's get real	*A* framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services (see http://www.moh.govt.nz/moh.nsf/indexmh/letsgetreal)
Mgmt	Management
MH&A	Mental health and addiction
Midland DHB region	Taranaki, Waikato, Lakes, Bay of Plenty and Tairawhiti DHBs
NGO	Non-government organisation
Northern DHB region	Northland, Auckland, Waitemata and Counties Manukau DHBs
N	Total number
n	The total number in a sub-group
NZ	New Zealand
Peer support	Peer support work in mental health and/or addiction workforce is provided in a purposeful contextual framework. Peer support workers have their own experiences and are trained to support people currently experiencing mental illness/distress and/or addiction issues towards wellbeing (see http://www.tepou.co.nz/page/697-service-user-workforce-development+peer-support+what-is-peer-support)‡
Prof	Professional
Recovery	Recovery is defined as the ability to live well in the presence or absence of one's mental illness (or whatever people choose to name their experience)**

Service delivery	The act of service provision by the organisation or service provider to the consumer*
Service user	Someone who has experienced mental illness/distress and/or addiction and who has used mental health and/or addiction services
Consumer	Someone with experience of mental illness/distress and/or addiction.
Tangata Whaiora	Māori term for people seeking wellness
Southern DHB region	South Island DHBs (Nelson/Marlborough, West Coast, Canterbury, South Canterbury and Southern)
Stigma	Sign of social unacceptability. In this instance, negative thoughts or feelings towards others based on their diagnosis of a mental illness* †
SU	Service user

Note. *Standards NZ (2008). ** Mental Health Commission (1998). ‡ (Te Pou, 2009b). † Encarta U.K.

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