MORE THAN NUMBERS

Overview of the adult mental health and addiction workforce

2014 survey of Vote Health funded services

Te Pou
o Te Whakaaro Nui

Matua Raki
National Addiction Workforce Development

Preface

The health sector, including mental health and addiction services, is increasingly being asked to develop ways to deliver more effective services with the same or less money. Understanding how the mental health and addiction workforce is currently configured will assist the sector to adapt to predicted changes in models of service delivery and demand.

This overview report presents a brief snapshot of the results of the 2014 Te Pou o Te Whakaaro Nui and Matua Raḵi *More than numbers* organisation workforce survey. The survey aimed to describe the size, distribution and configuration of the adult mental health and addiction services' workforce as at 1 March 2014.

It provides important baseline information about the workforce in both district health board (DHB) provider arm and non-government organisation (NGO) services. The intention is that this information will be used to inform future-focused service and workforce development activities.

High response rates are often difficult to achieve in this type of survey. However, a good level of participation was received with more than 75 per cent of the invited organisations completing the survey (all DHBs and 73 per cent of NGOs), representing more than 90 per cent of all full-time equivalent positions (FTEs). As a consequence, the reader can have a reasonable level of confidence that the findings accurately reflect the composition and complexity of the workforce operating in the adult mental health and addiction sector.

In the interests of making the survey results as accessible as possible, to as many people as possible, this overview report presents the key points from the main report along with a brief accompanying narrative, some tables, graphs, and recommendations.

Much has been omitted from the main report for the purpose of creating this overview. Readers are encouraged to refer to the main report for more comprehensive and important supplementary information about the actual survey, the methods used and the complete set of findings.

The survey results have also been summarised in a number of brief spotlight reports that present the findings by workforce groups and geographic regions, including four regional reports, 20 DHB locality reports and a number of

brief profiles of various workforce groups. These spotlight reports can be downloaded from Te Pou's website.

It is also worth noting that this overview report and the main report include an estimate of the sector's total number of FTE positions. This includes reported FTEs and an estimate of missing FTEs based on the funding allocated to organisations who did not participate. However, the other reports related to the survey focus only on those FTEs that organisations actually reported to the survey.

For easy reference, Figure 1 below provides an overview of the estimated Vote Health funded FTEs in the occupation groups for each major service type (DHB addiction, NGO addiction, DHB mental health and NGO mental health). Additional information about each occupation group can be found in section 4 of this overview report and in Chapter 5 of the main report.
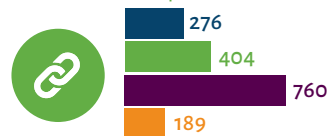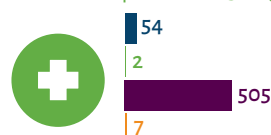
Support workers^ FTE positions = 2,988 (31%)

- 41
- 211
- 593
- 2,142
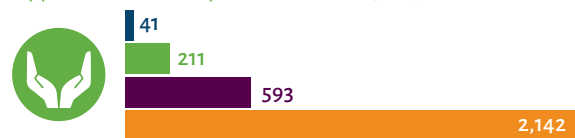
Nurses FTE positions = 2,704 (28%)

- 188
- 39
- 2,338
- 137

Allied health FTE positions = 1,629 (17%)

- 276
- 404
- 760
- 189

Medical FTE positions = 568 (6%)

- 54
- 2
- 505
- 7

Other FTE positions* = 1,622 (17%)

- 104
- 187
- 797
- 534
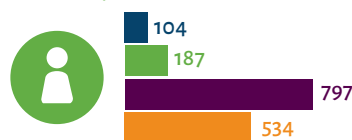
Legend:
- ■ DHB addiction
- ■ NGO addiction
- ■ DHB mental health
- ■ NGO mental health

Figure 1: Estimated FTE positions for the key occupational groups by service type

^ The support workers group includes the peer and family support roles (321 FTEs).
* The other roles group includes administration and management roles (1,301 FTEs), other roles (149 FTEs) and cultural advice and support (172 FTEs).

Contents

1.0 Introduction

As highlighted in *Rising to the challenge* (Ministry of Health, 2012), mental health and addiction services have experienced two decades of compelling growth and change. This has included a significant increase in investment in mental health and addiction services, "from $270 million per year in 1993/94 to $1.2 billion per year in 2010/11 when mental health and addiction services accounted for 9.5 per cent of the total Vote Health budget" (2012, p.2). Alongside increased investment, there has been major growth (51 per cent) in access to secondary mental health and addiction services, from 87,724 people in 2002/03 to 132,682 in 2010/11 (2012, p.2).[1]

Rising to the challenge (Ministry of Health, 2012), *Blueprint II* (Mental Health Commission, 2012) and *Towards the next wave of mental health and addiction services capability* (Mental Health and Addiction Service Workforce Review Working Group, 2011) all foreshadow a change in the way mental health and addiction services will be delivered in the future. Understanding how the workforce is currently configured will enable the sector to adapt to the predicted changes. The intention is that the workforce information collected through this survey will be used to inform future-focused service and workforce development activities.

1.1 Method

Scope

The scope of the *More than numbers* organisation workforce survey included all organisations contracted by the Ministry of Health or DHBs to deliver adult mental health and addiction services during 2012/13. The final survey sample included 20 DHBs and 231 NGOs identified in the Ministry of Health's Price Volume Schedule for 2012/13.

Survey design

The survey aimed to collect information consistent with that collected by the Werry Centre in its workforce stocktake of infant, child and adolescent services. This was done to ensure information from both surveys could be combined to give an overview of the child, youth and adult mental health and addiction workforce.

Additional questions focused on recruitment and retention issues, major workforce challenges, the knowledge and skills needs of the workforce and the organisation's views on the effectiveness of cross-sector and agency collaborative relationships.

Distribution and collection

Survey packs were delivered by post to participating organisations during March and April 2014. The collection period ran from 1 April to 30 June. Completed surveys were returned to Te Pou, checked and collated. A data entry company entered the returned surveys twice to reduce the risk of data entry errors. The dataset was then provided to Te Pou for analysis.

Response rate

One hundred and eighty-nine (189) organisations returned completed surveys, including all 20 DHBs and 169 NGOs (73 per cent). Overall, the response rate was 75 per cent, representing 96 per cent of Vote Health funding for adult mental health and addiction services. Those NGOs that did not complete the survey received 13 per cent of Vote Health funding for adult NGO mental health and addiction services.

Analyses

Analyses contained in this report utilised the survey results as well as data from the following five additional information sources.

- Population information from the 2013 New Zealand Population Census.
- Vote Health funding information for adult mental health, alcohol and other drug (AOD), and problem gambling services (sourced from the Ministry of Health Price Volume Schedule 2012/13).
- Information about adult mental health and AOD 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's Client Information Collection (CLIC) database.
- Information from *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Oakley Browne, Wells & Scott, 2006).

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1 – The number of consumers seen by DHBs and NGOs is provided via PRIMHD data and includes access to child, youth, adult and older adult mental health and addiction services. NGO reporting to PRIMHD became mandatory in 2008 thereby increasing the number of eligible organisations reporting to PRIMHD. Whilst service user access rates have appeared to increase over time, it is difficult to make accurate comparisons pre and post 2008.

Adjustments for non-reported FTE positions

The survey results in this overview report have been adjusted to include the estimated workforce of the organisations that met the criteria for inclusion in the survey, but did not participate. The reader is referred to the assumptions and the subsequent calculations for these estimates in Appendix C in the main report.

Limitations

As with any survey, there were several limitations, such as the reliance on the accuracy of reports provided by participants. The reader is referred to Appendix B in the main report for details.

2.0 Workforce size and distribution

This section provides an estimate of the total Vote Health funded workforce in adult mental health and addiction services (including estimated FTE positions). These estimates are then used to describe the distribution of the workforce across DHB and NGO mental health and addiction services by service type.

It is important to recognise that estimates for the non-reported workforce assume the funding per workforce ratio was consistent in both organisations that completed the survey and those that did not. It also assumes that organisations that participated in the survey reported their workforce data accurately.

2.1 Results

2.1.1 Vote Health funded adult workforce

- The total Vote Health funded adult mental health and addiction workforce is estimated to be 9,509 FTE positions (a reported total of 8,929 FTE positions plus an additional estimated 580 FTE positions in the NGOs that did not participate in the survey).
- The survey results included more than 90 per cent of the estimated Vote Health funded workforce across adult mental health and addiction services.

2.1.2 Distribution of the workforce between adult mental health and adult addiction services

- Adult mental health services have 8,003 FTE positions (84 per cent).
- Adult addiction services have 1,506 FTE positions (16 per cent).
- A small proportion (5.8 per cent) of the workforce work in organisations that were funded to deliver both specialist mental health and addiction services.[2]

2.1.3 Distribution of the workforce across DHB and NGO services

- Around half (52 per cent) of the workforce were based in DHB mental health services.
- Around one-third (32 per cent) of the workforce were based in NGO mental health services.
- DHB addiction services had seven per cent of the workforce and NGO addiction services had nine per cent.

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2 – These teams have been distributed between the adult mental health workforce and the addiction workforce using the average ratio of mental health to addiction funding assigned to combined mental health and addiction services.
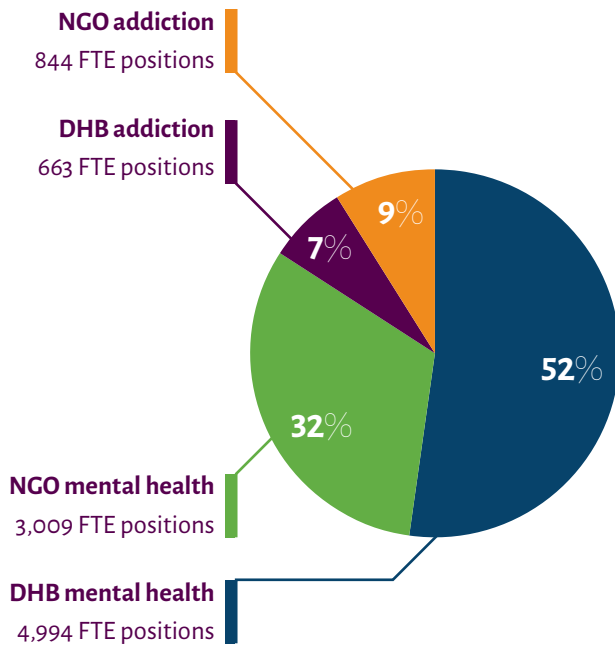
NGO addiction
844 FTE positions

DHB addiction
663 FTE positions

9%

7%

52%

32%

NGO mental health
3,009 FTE positions

DHB mental health
4,994 FTE positions

Figure 2. Distribution of DHB and NGO FTEs across the adult mental health and addiction sector (9,509 reported plus estimated missing FTEs)

2.1.4 Distribution of the workforce by service types

- More than 55 per cent of the workforce provide community-based services, while 35 per cent of the workforce is based in inpatient or residential services.

- Within mental health services, 24 per cent of the workforce is in inpatient services including acute and forensic services. Another 13 per cent is in NGO residential services.

- Within addiction services, 24 per cent of the workforce is in residential or inpatient services.

2.1.5 Total mental health and addiction workforce

Combining the estimated total adult mental health and addiction services' workforce (adjusting for non-reporting organisations) with surveys of older persons and child and youth services, the total Vote Health workforce across all secondary mental health and addiction services is estimated to be around 12,000 FTE positions. This includes:

- 9,509 total FTE positions in adult mental health and addiction services, of which:
  - 8,003 FTE positions in adult mental health services (84 per cent)
  - 1,506 FTE positions in addiction services (16 per cent)

- 1,761 total FTE positions in child and youth mental health and addiction services (Werry Centre, 2015)
- 403 employed FTE positions in 9 of 11 DHB mental health services for older people (MHSOP) services across New Zealand (Te Pou o Te Whakaaro Nui, 2011).[3]

It is important to note that the MHSOP number is likely to be underestimated, therefore the total number of secondary mental health and addiction workforce positions working across both adult and older person services is approximately 12,000 FTEs.

2.1.6 Percentage of the total health workforce

- The adult mental health and addiction services' workforce is estimated to make up approximately seven per cent of the total health workforce (DHB and NGO) described in the 2014 report on the health workforce in New Zealand.[4]

2.2 Comment

Since the 1970s, the major shift of care for mental health and addiction services has been from large psychiatric hospitals to a wide range of community-based services, including residential support services. This shift is evident in the high proportion of the workforce that is based in community settings (55 per cent). This pattern is common across DHB and NGO adult mental health and addiction services. However, at the same time, there is still a reasonably large part of the workforce that is still based in inpatient and residential settings (35 per cent).

International evidence indicates that a combination of a strong primary care sector working closely with a well-developed NGO sector and a wide range of social, housing, education and justice agencies will be critical to the development of a contemporary alternative to the current mental health and addiction system.[5]

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3 – The MHSOP results do not include the workforce in services where mental health and general health are integrated. The estimated 403 FTEs only include those people working in 9 of the 11 DHBs with specialist mental health services for older people.

4 – Ministry of Health. (2014). *Health of the Health Workforce 2013 to 2014: A report by Health Workforce New Zealand.* Wellington: Ministry of Health.

5 – World Health Organisation, & Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health.* Geneva: World Health Organisation.

3.0 Workforce in relation to population, funding and service demand

The delivery of effective and efficient mental health and addiction services is influenced by the level of resourcing its workforce receives in relation to the population it serves and the need for services. This section examines relationships between the estimated workforce, population served, Vote Health funding and the number of consumers seen by adult mental health and addiction services.

3.1 Results

3.1.1 Regional workforce in relation to population, consumers seen and funding

Workforce distribution across the four health regions (Northern, Midland, Central and South Island) closely aligns with regional distribution of the adult population, funding for adult mental health and addiction services and the proportion of consumers seen by services (PRIMHD numbers) in each region (see Figure 3).

More detail is provided in the four regional reports which can be found on Te Pou's website. The results suggest that, at a regional level, the population-based funding formulae (PBFF) is working to distribute resources across New Zealand in relation to the population.

3.1.2 Distribution of the workforce across the four regions

Figure 4 highlights the distribution of the adult mental health and addiction workforce across the four health regions. It shows the South Island and Central regions have the highest proportion of DHB FTE positions in adult mental health and addiction services and Midland has 52 per cent of the FTE positions situated in NGO services.
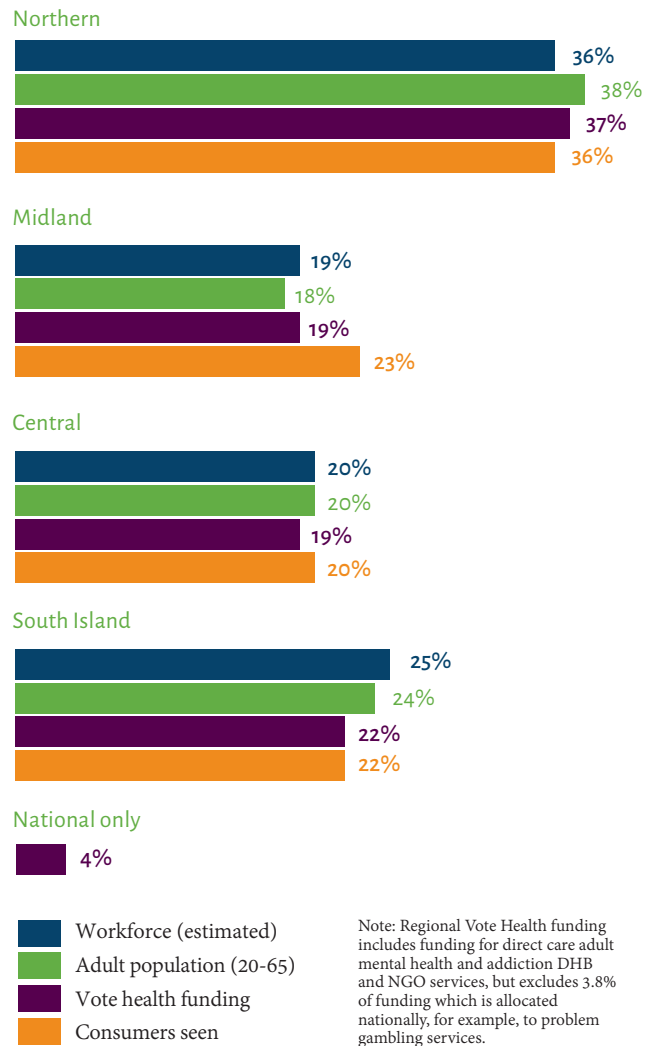

Northern
- Workforce (estimated): 36%
- Adult population (20-65): 38%
- Vote health funding: 37%
- Consumers seen: 36%

Midland
- Workforce (estimated): 19%
- Adult population (20-65): 18%
- Vote health funding: 19%
- Consumers seen: 23%

Central
- Workforce (estimated): 20%
- Adult population (20-65): 20%
- Vote health funding: 19%
- Consumers seen: 20%

South Island
- Workforce (estimated): 25%
- Adult population (20-65): 24%
- Vote health funding: 22%
- Consumers seen: 22%

National only
- Vote health funding: 4%

Legend:
- Workforce (estimated)
- Adult population (20-65)
- Vote health funding
- Consumers seen

Note: Regional Vote Health funding includes funding for direct care adult mental health and addiction DHB and NGO services, but excludes 3.8% of funding which is allocated nationally, for example, to problem gambling services.

Figure 3. Adult mental health and addiction workforce in relation to population, funding and consumers seen by region

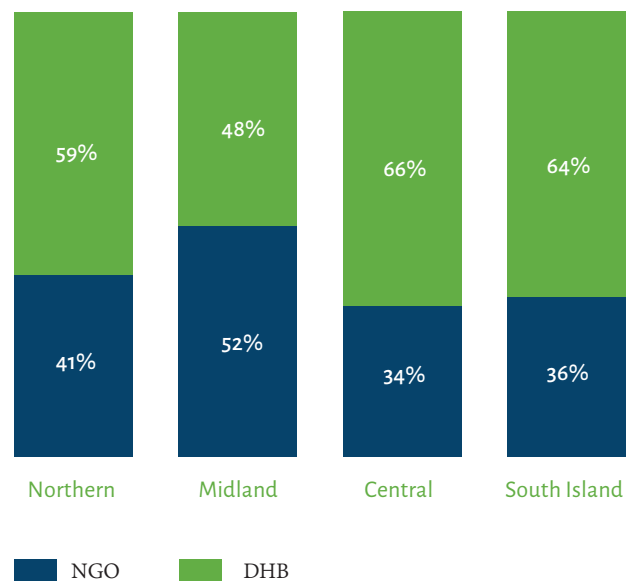|	Northern	Midland	Central	South Island
DHB	59%	48%	66%	64%
NGO	41%	52%	34%	36%

Legend: NGO, DHB

Figure 4. Distribution of workforce (reported plus estimated FTE positions) across the four health regions

3.1.3 Consumers seen by local DHB district

Overall, the numbers of consumers seen in DHB districts are similar to the distribution of each DHB district's workforce, funding and population. However, there is some variation in the alignment of workforce, funding and population at the local level. Some of the discrepancies between workforce numbers, population and funding may reflect under or over reporting of the workforce in survey responses.

3.1.4 Distribution of mental health and addiction FTE positions by DHB district

The following two graphs profile the distribution of the adult mental health and addiction workforce in DHB services (see Figure 5) and NGO services (see Figure 6) across DHB districts.
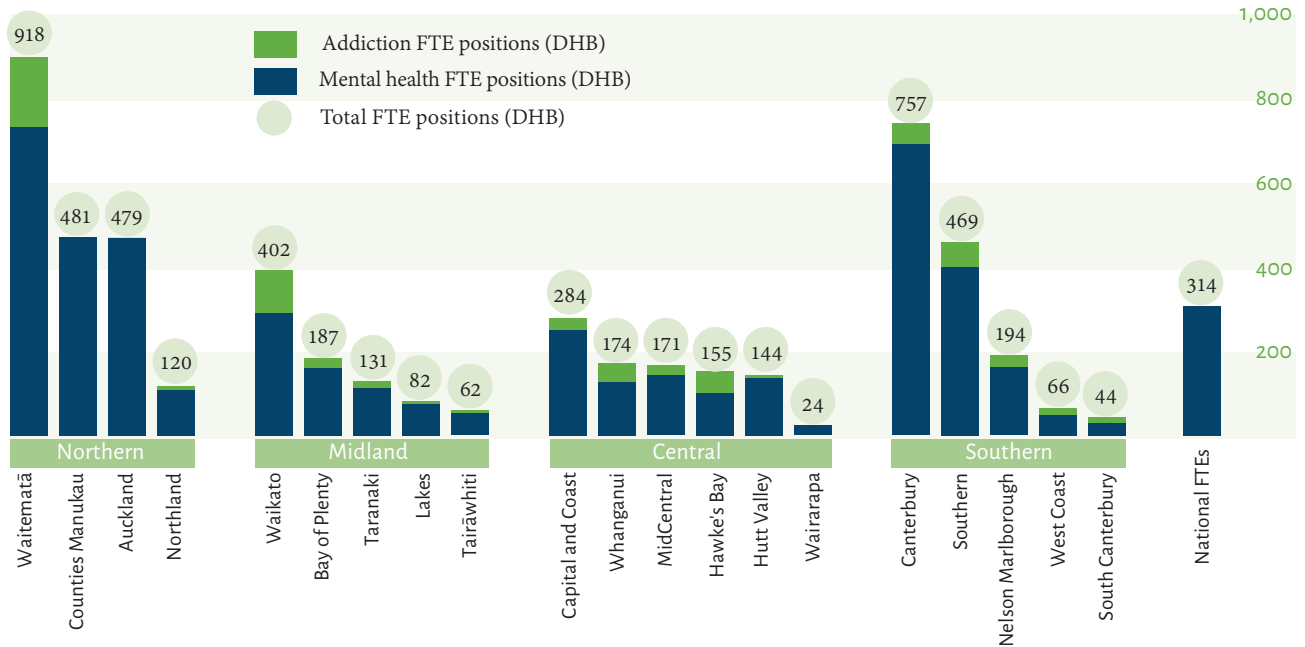

Figure 5. Total (reported plus estimated) DHB FTE positions across mental health and addiction services by local DHB district

Overall the highest number of FTE positions was reported by Waitematā DHB. However, this reflects the fact it is the largest DHB and includes the Northern region AOD workforce in its total FTE positions. For this reason, Auckland and Counties Manukau DHB services did not report any addiction FTE positions.
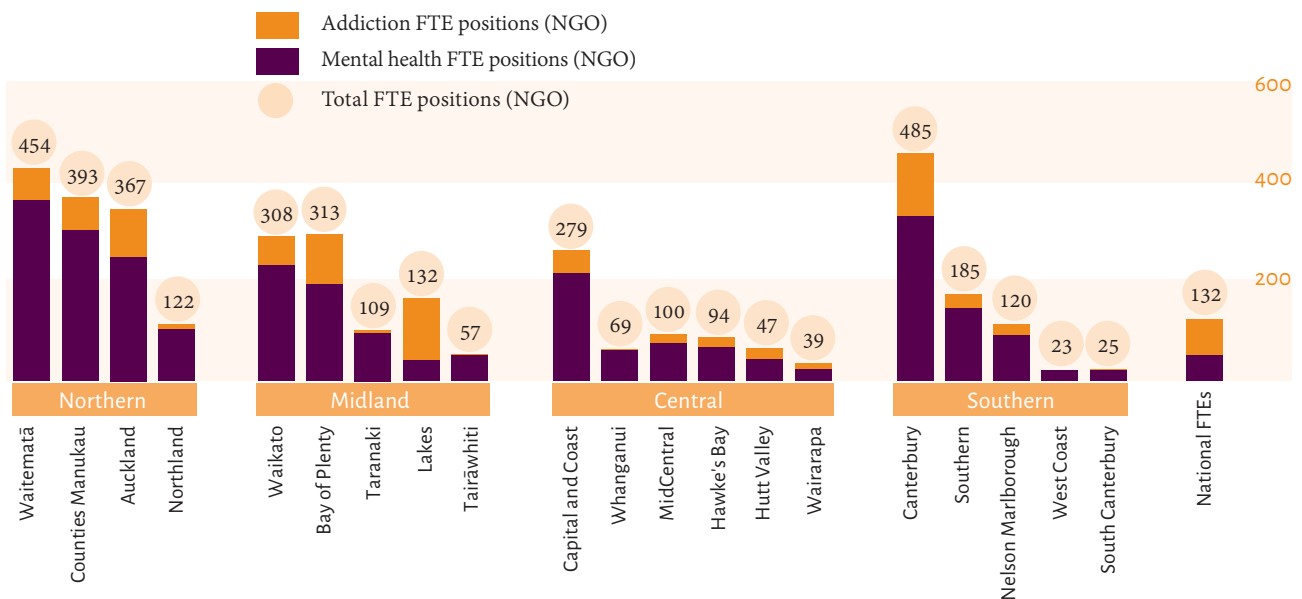
Figure 6. Total (reported plus estimated) NGO FTE positions across mental health and addiction services by local DHB district

It is clear from Figure 6 that the total number of NGO FTE positions varies considerably between local DHB districts. Some of the variations will be from differences in population size and the application of the population-based funding formulae. However, this does not explain all the variations between DHB districts. For example, Bay of Plenty DHB district (adult population of 111,339) reported more NGO FTE positions than Capital & Coast DHB district (adult population of 176,019) (Statistics New Zealand, 2014). Canterbury, Lakes and Bay of Plenty DHB districts all reported higher proportions of addiction NGO FTE positions relative to other similarly-sized DHBs.

3.2 Comment

While there is close alignment of workforce, funding and population, it is important to acknowledge there are significant differences in the proportion of the total workforce across DHB and NGO adult mental health and addiction services.

Some of the variations will be driven by differences in service models, which may be subject to a review process in response to the shift towards more community-based service provision. In addition, some DHB districts have a greater need for funding as a result of rapid changes in population and/or significant adverse events. For example, the Canterbury earthquake caused a decrease in its population, but an increase in the need for mental health and addiction services among those that remain. Other DHB districts, such as Auckland metro DHBs, have experienced a significant increase in population because of migration, which present unique challenges in terms of providing consumers with access to culturally appropriate services.

4.0 Composition of the workforce

This section examines the composition of the workforce by occupational groups and roles (such as support workers, nurses, allied health, medical and cultural support) across DHB and NGO services.

4.1 Results

4.1.1 Composition of the adult mental health and addiction workforce

As seen in Figure 7, there is a predominantly clinical (regulated) mental health workforce in the DHB provider arm, in contrast to the NGO mental health workforce which is comprised of mainly non-clinical roles (the non-regulated workforce).

The composition of the NGO workforce is different in each part of the sector, with 56 per cent of the workforce in NGO addiction services in clinical roles and 27 per cent in non-clinical roles compared to 12 per cent of the workforce in NGO mental health services in clinical roles and 73 per cent in non-clinical roles.
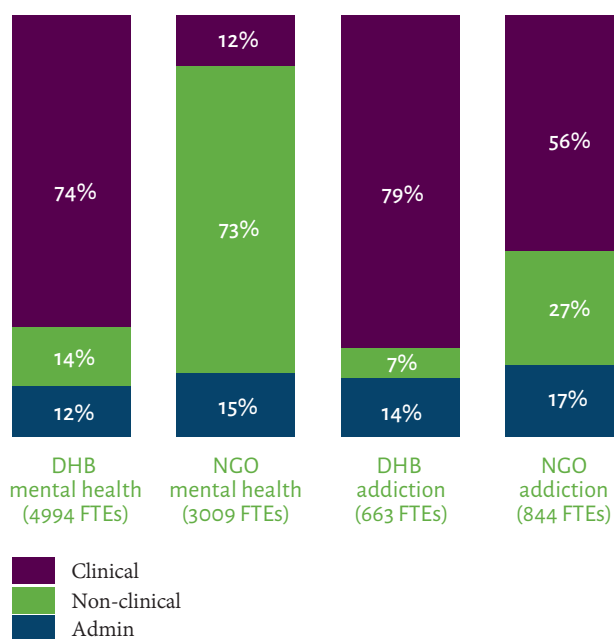

Figure 7. Distribution of clinical, non-clinical and other roles across DHB and NGO mental health and addiction services

4.1.2 Support workers

As seen in Figure 8, the largest workforce is support workers (31 per cent) with 2,988 estimated FTE positions. Most of the support workforce is based within adult mental health NGO services (72 per cent; 2,142 of 2,987 support worker FTE positions). Twenty per cent of the support workforce is within DHB mental health services, seven per cent is in NGO addiction services and only one per cent is in DHB addiction services.
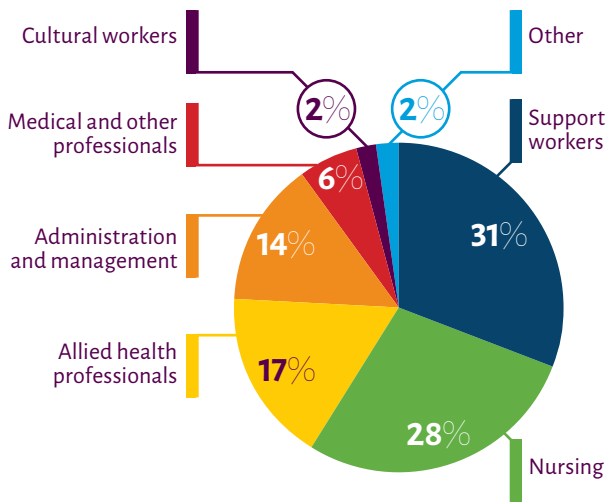

Figure 8. Adult mental health and addiction services workforce (percentage of reported plus estimated missing FTEs)

4.1.3 Peer support workers

Peer support roles are provided by 216 FTEs, making up two per cent of the total estimated workforce. These roles are predominantly located in mental health NGO services. An additional 42 consumer advisor FTEs are located in mental health and addiction services.

4.1.4 Nursing

Nurses make up the second largest occupation group (28 per cent) with 2,704 FTE positions, of which 86 per cent are based in adult mental health DHB services and a further seven per cent in addiction DHB services. Only seven per cent of nursing staff work in NGO services, with five per cent working in adult mental health NGOs. Nursing also has the highest number of vacancies (180 FTEs, 7 per cent vacancy rate).[6]

4.1.5 Allied health

A number of professions are included in the allied health occupation group, many of whom are registered under the Health Practitioners Competence Assurance (HPCA) Act or the Social Workers Registration Act 2003. Allied health professionals identified in the survey included social workers (416 FTEs), addiction practitioners (405 FTEs), clinical psychologists (260 FTEs) and occupational therapists (224

FTEs). Within addiction services, 60 per cent of the allied health group is in NGOs whereas within mental health services only 20 per cent of the allied health group roles are in NGOs.

The addiction services workforce has a different occupational composition relative to the total adult mental health and addiction workforce. For example, allied health professionals comprise 42 per cent of DHB addiction services and 48 per cent of NGO addiction services. Many staff identify as addiction practitioners, occupational therapists and social workers. This may reflect contrasting historical sector developments and differences in role descriptions within the sector. Addiction service respondents predicted future shortages in dual diagnosis clinician and addiction practitioner roles.

4.1.6 Medical workforce

Doctors and psychiatrists make up a small proportion of the total workforce, including 293 FTE positions for consultant psychiatrist roles, 125 FTE positions for psychiatric registrars and 120 FTE positions for additional medical professional roles. The majority (89 per cent) work in adult mental health DHB services. Only 10 per cent of medical staff work within DHB addiction services and just one per cent work within NGO mental health or addiction services.

4.1.7 Cultural workforce

The survey identified 172 cultural worker FTE positions (two per cent). Fifty two per cent of the cultural workforce is employed within DHB mental health services, and the role with the largest workforce was cultural advisors.

4.1.8 Vacancies

Of the 9,509 FTEs comprising the adult mental health and addiction workforce, there were 5 per cent estimated vacancies (438 FTEs). Most of the vacancies were in DHB mental health services (66 per cent of all vacancies), with the nursing occupation group reporting the most vacancies (41 per cent of all vacancies).

4.2 Comment

Survey results indicate that the addiction workforce looks very different from the mental health workforce in terms of both the major occupation groups and its distribution across DHB and NGO services. Important differences include the greater proportion of clinical roles, especially nurses and medical staff, in the DHB mental health workforce along with a higher proportion of addiction practitioners and counsellors within the addiction workforce, particularly in NGOs. These differences reflect the contrasting historical sector developments and differences in role descriptions, particularly within the addiction sector.

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6 – There may be small discrepancies between FTE position totals due to the impact of rounding.

The workforce composition described in this section has evolved over time to support current models of care in mental health and addiction services. *Towards the next wave* (Mental Health and Addiction Service Workforce Review Working Group 2011, p. 55) signalled the need to develop new models of care that reflect an emphasis on community and primary care settings with support from a core team of specialist mental health and addiction professionals. This will mean the current workforce composition will need to be reviewed and consideration given to developing different roles and/or a different configuration of existing roles to meet the estimated increase in demand for services. Examples of emerging roles that have been identified include peer support workers and employment consultants (Ministry of Health, 2012). Analysis presented in Section 8.3 of the *Adult mental health and addiction* (Te Pou o Te Whakaaro Nui, 2015) report provide an example of how potential changes in role composition arising from changes in model of care would impact on future workforce needs.

5.0 Ethnic makeup and cultural competence

5.1 Ethnic-specific services

Overall, kaupapa Māori, Pasifika and Asian services together make up 12 per cent of the reported mental health and addiction services workforce (see Figure 9).

Ethnic-specific services have 11 per cent (844 FTEs) of the reported mental health services' FTE positions and 17 per cent (235 FTEs) of the reported addiction services' FTE positions.

Most of the workforce in ethnic-specific services are located in kaupapa Māori services. Kaupapa Māori services reported around 10 per cent of the mental health sector workforce, and 13 per cent of addiction sector workforce.
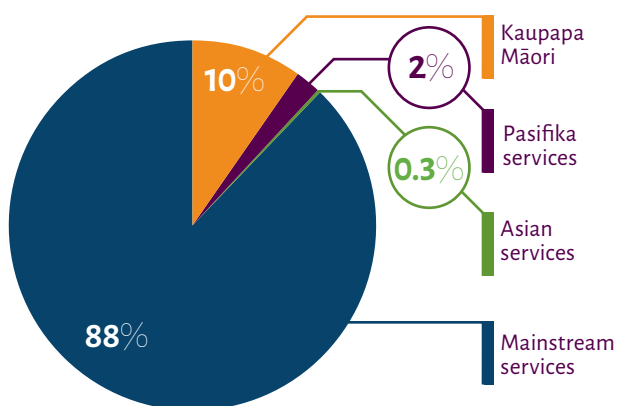
DHB mental health ethnic-specific services have a larger workforce (515 FTE positions employed plus vacant) relative to NGO mental health ethnic-specific services (329 FTE positions). However it is the opposite in addiction services; 39 FTE positions in DHB services compared to 196 FTE positions in NGO ethnic-specific addiction services.

5.2 Ethnic make-up of the workforce

While ethnicity information collected in the survey is unlikely to be an exact representation of the workforce, it does provide some indications about where population and workforce composition do not align. The reported Māori and Pasifika workforce under-represents the proportion of consumers who identify with these groups, particularly in clinical roles. For example, 26 per cent of consumers identify as Māori but only 15 per cent of the clinical occupation group was reported as Māori. Twenty four per cent of the non-clinical occupation group were Māori.

Likewise, Pasifika staff were employed in seven per cent of non-clinical roles, but only three per cent of clinical roles. Asian staff were employed in six per cent of non-clinical roles but only four per cent of clinical roles.

The proportion of staff who were identified as Māori, Pasifika or Asian was usually much higher in NGO services relative to DHB services (see Table 1). The ethnic differences between NGO and DHB services likely reflects the ethnic difference between non-clinical and clinical roles.

Addiction services reported a higher proportion of Māori and Pasifika staff than mental health services, particularly in

Figure 9. Proportion of the total reported mental health and addiction workforce in ethnic-specific services (n = 8929 reported FTEs)

- 10% Kaupapa Māori
- 2% Pasifika services
- 0.3% Asian services
- 88% Mainstream services

Table 1. Proportion of staff identified as belonging to each ethnic group by service type

	Mental health			Addiction		
	Proportion Māori (%)	Proportion Pasifika (%)	Proportion Asian (%)	Proportion Māori (%)	Proportion Pasifika (%)	Proportion Asian (%)
DHB	12.4	2.8	3.7	15.9	6.4	2.3
NGO	27.0	7.6	8.0	27.5	5.9	5.0
Total %	18.7	4.9	5.6	22.6	6.1	3.9

Note. These percentages are based on respondents' report of the ethnic identification of their staff. Some services did not report on ethnic identification. The above percentages are based on responses from services who did report ethnic identification (6,329 FTEs).

DHB services, whereas the proportion of staff identifying as Asian was higher in mental health services. There was also some regional variations in the ethnic composition of staff, with higher ethnic composition among those regions with a high ethnic composition in their population.

5.3 Areas for cultural competency improvement

5.3.1 Cultural competency requirements by health region

Respondents were also asked to report their perception of the need for their workforce to improve skills and knowledge in a number of areas of cultural competency. At least 64 per cent of respondents in each region reported that the workforce needed to improve cultural competency for working with Māori, Pasifika and Asian consumers. Nonetheless there was some regional variation in the specific proportion of people reporting skill and knowledge needs for each ethnic group. In particular, the South Island region more commonly reported skill and knowledge needs for working with Pasifika and Asian groups compared to the national results. Northern region respondents less commonly reported needs for building skills and knowledge relevant for working with Māori and Asian groups relative to the national results. Regional differences in cultural competency development needs may reflect the ethnic composition of the workforce and existing investment in cultural competency training. Specific percentages of respondents reporting a need in each area are provided in the regional reports which can be found on the Te Pou website.

5.3.2 Cultural competency requirements by service type

The proportion of respondents reporting a need to improve cultural competency was similar between addiction and mental health services. DHB services were slightly more likely to report needs for increased cultural competency for each ethnic group than NGO services. Perhaps surprisingly, a similar proportion of respondents from ethnic-specific services reported the need to improve cultural competency with the ethnic-group they serve, relative to mainstream services. The similarity may be the result of ethnic-specific services seeing consumers with higher cultural needs and greater expectations about what counts as cultural competence within an ethnic-specific service. It may also reflect the complexities of achieving cultural competency given that each ethnic group reflects a range of languages, values and customs.

5.4 Comment

Cultural responsiveness and cultural competency are particularly important given that Māori and Pasifika are disproportionately affected by mental health and addiction concerns (Oakley Browne, Wells & Scott, 2006) In addition, mainstream ways of working do not necessarily reflect the beliefs, values, language and interpersonal relationship structures valued by ethnic populations. Improving cultural responsiveness and perceived cultural responsiveness may help increase services' abilities to meet the needs of Māori, Pasifika and Asian communities.

Survey results suggest that cultural competence continues to be a major priority for workforce development in both mental health and addiction services. Increasing skills in cultural knowledge and models of health when working with Māori, Pasifika and Asian ethnic groups were rated as high priorities by most respondents. There are a number of existing strategies for improving workforce cultural competence that could be extended.

6.0 Workforce and service challenges

In addition to providing information about their workforce, services provided feedback on potential priorities for building knowledge and skills and improving relationships with other sectors. Services also reported a number of workforce-related challenges to service provision (such as recruitment needs, static or reduced funds and managing pressure on staff due to increased complexity), all of which reflect the emphasis on providing better services with fewer resources. This situation is not unique to New Zealand and reflects trends in many other health care systems throughout the world.

6.1 Results

Workforce development challenges for leaders and managers

- Managing pressure on staff due to increased demand for complexity (64 per cent of respondents) and increased demand for services (64 per cent) were most commonly reported as major challenges for workforce development.
- Static or reduced funds was also a significant challenge for 65 per cent of NGO service respondents.

Knowledge and skills identified for development

- Between 50 and 62 per cent of respondents indicated a need to improve skills for working with children, youth, other agencies, older people and families.
- Working with new technologies and IT was identified as needing some or a large increase in skills by 80 per cent of respondents.
- Co-existing problems (CEP) capability was identified as needing some or a large increase in skills by 77 per cent of respondents.
- At least 60 per cent of respondents reported staff needing some or a large increase in a range of therapeutic skills including psychological interventions, supported self-management, risk assessment and the use of strengths-based approaches.
- About 55 per cent of respondents reported the need for either some or a large increase in skills for collaborating with different sectors or agencies, with a third identifying a need for better relationships with Housing New Zealand Corporation and accommodation providers.

6.2 Comment

The areas identified as needing knowledge and skill development will be useful for planning and prioritising future workforce development activities. A number of these already reflect priority areas for future service delivery (such as CEP capability and supporting self-managed care) as well as core aspects of service provision (such as risk assessment and psychological interventions). The fact many services identified these areas highlights the importance of a continued focus on these core topics in training, supervision and other activities that support skill development and knowledge building.

Building effective working relationships across professional and organisational boundaries, as well as across sectors, requires a workforce that is skilled in collaboration and partnership. These skills do not necessarily form part of the current educational curriculum and, for that reason, this area of workforce development is worthy of further consideration.

7.0 Future workforce needs

One of the primary reasons for surveying the health workforce is to identify and assess any gaps that may exist between the current workforce and what is going to be required of the future workforce. Assessing future needs is a complex task but one that is important for prioritising workforce development actions. This section provides the results of two forecasting models that were used to examine the future needs of the adult mental health and addiction workforce. The first approach utilised a simple population projection model and the second approach considers the impact of changes in service access on future workforce needs, drawing on the work that was undertaken in *Towards the next wave of mental health and addiction services capability* (Mental Health and Addiction Service Workforce Review Working Group, 2011). It is important to note that these forecasts are estimates only and based on a number of assumptions.

7.1 Results

7.1.1 Predicted need based on a population projection model

Using population projections and the 2014 ratio of workforce to adult population it is possible to model the number of FTEs needed to meet population growth. This model is based on projected population increases only and assumes the current model of care will be unchanged in the future.

Using this model, the adult mental health and addiction workforce would need to increase by nine per cent (estimated 856 FTE positions) by 2030 to meet the nine per cent increase in population predicted by Statistics New Zealand as part of its median growth estimates.[7]

7.1.2 Predicted need based on changes in consumer access and models of care

Rising to the challenge (Ministry of Health, 2012b) and *Towards the next wave* (Mental Health and Addiction Service Workforce Review Working Group, 2011) signal a need to support more consumers than the three per cent of people experiencing severe mental health and addiction issues benchmarked in the 1998 *Blueprint for mental health services in New Zealand* (Mental Health Commission, 1998).

To increase service access further will require a greater growth in workforce than the population projection model. For example, drawing on modeling outlined in *Towards the next wave of mental health and addiction services capability* (Mental Health and Addiction Service Workforce Review

Working Group, 2011), the workforce would need to grow by 1,424 FTEs to increase service access from the estimated 3.9 per cent in 2014 to 4.1 per cent by 2030. To increase service access to 4.4 per cent it would need to grow by 2,034 FTEs.

7.1.3 Population projections by occupation group

To meet population growth and maintain the current workforce composition, it is estimated that the size of the nursing workforce would need to grow by 243 FTEs, medical roles would need to grow by 49 FTEs, allied health would need to grow by 147 FTEs, support workers would need to grow by 269 FTEs and other roles would need to grow by 148 FTEs. However future changes to models of service delivery will generate the need for different levels of growth in each occupation groups. Chapter 8 of the main report provides an example of growth needs under one example of an alternative workforce composition.

The numbers outlined in this section underestimate how many people will need to be trained or recruited as many of the current workforce will retire or leave the workforce for other reasons by 2030. These numbers are also estimates only and rely on a number of assumptions. Please refer to Section 8.3 of the main report for more detail about these models.

7.2 Comment

Current policy directions signal a need to change how and where services are delivered and by whom. More work is required to identify the impact of increased consumer demand for services and the impact of trends that are likely to influence the configuration and mix of the mental health and addiction services' workforce for child and youth, adult and older adult services.

In addition, there needs to be some investigation into workforce demographics and turnover rates in different occupation groups. This information is required to understand the implications of the projected increase in demand for services on the number of additional staff who will need to be trained and/or recruited into the workforce.

The outcome of these investigations will influence decisions about the best way to develop a workforce that can successfully meet a projected increase in consumer demand based on a very different model of care. The *Getting it right* workforce planning approach (Te Pou o Te Whakaaro Nui, 2014) provides a framework for incorporating service delivery models and workforce data into the prioritisation of important workforce development activities.

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7 – This is based on median projected population growth for the population aged 18 to 65 years. A range from 513 to 1216 FTE positions has been estimated based on low (5th percentile) to high (95th percentile) projected population increases (Statistics New Zealand).

8.0 Conclusion and recommendations

New Zealand's health services are confronted by a mismatch of service demand, supply and affordability. This climate is forcing stakeholders to consider new and innovative ways of funding and delivering health services so that more people can be seen closer to home, at a low cost and with good outcomes (Platform Trust & Te Pou, 2015).

The many change pressures that will influence the composition of New Zealand's future mental health and addiction workforce include an increase in the needs of a diverse and ageing population, trends in service development, best practice requirements, improved technology, increased use of the peer support workforce, integrated clinical pathways and an emphasis on integrated primary care and community-based service delivery (Platform Trust & Te Pou, 2015). These factors make it imperative that more attention is placed on the strategic development of the mental health and addiction workforce now so that it is better equipped to deliver effective mental health and addiction services in future.

It is acknowledged that it is possible to achieve a level of productivity gains through workforce innovations and reforms such as changes to models of care, adjustments to skill mix, staff working to their full or expanded scope of practice and the introduction of technological innovations such as eHealth and telehealth. These changes, together with national policies, health promotion and illness prevention measures, as well as the changing expectations of consumers, will see an ongoing reduction in the demand for certain services, such as residential beds, and an increase in the demand for others, such as peer support services and employment coaches. The extent of these changes also raises questions about the capacity and competencies of the generalist and specialist mental health and addiction workforce that will be required to meet new service directions.

Smart workforce planning and clear strategies will be important to maintain and improve the quality of service provision, improve the health and equity of the population and continue to deliver value for money. These three linked goals are commonly referred to as the 'Triple Aim' (Berwick, Nolan, & Whittington, 2008), and currently inform national policy development and service planning activity in New Zealand.

The *More than numbers* survey identified a number of areas where the current mental health and addiction workforce is not yet fully aligned with the policy direction outlined in *Rising to the challenge* (Ministry of Health, 2012). In addition, respondents' perspectives on future workforce needs also provide a number of priorities for future workforce development activity and investment.

The following text summarises the key conclusions and recommendations from the *Adult mental health and addiction workforce* (Te Pou o Te Whakaaro Nui, forthcoming) report. The full text of these recommendations are contained in the main report.

Future workforce demand

Forecasting projections suggest that total workforce numbers will need to grow by 856 FTEs by 2030 to meet current workforce to population ratios. *Towards the next wave* (Mental Health and Addiction Service Workforce Review Working Group, 2011) promotes early intervention and integrated cross-sector responses in order to increase access and reduce demand however the secondary mental health and addiction workforce would also need to grow to meet and future increases in access targets if the current model of service delivery is maintained. To increase service access from the estimated 3.9 per cent in 2014 to 4.1 per cent by 2030 the workforce would need to grow by 1,424 FTEs or to increase service access to 4.4 per cent it would need to grow by 2,034 FTEs.

- These projections, while somewhat rudimentary, indicate the need for substantial investment in recruitment, training and strategies to retain existing members of the workforce.
- Meeting future need with current ways of working will require substantial additional workforce and funding. Thus it will also be important to think about different ways of working and new models of care to enable the workforce to respond to predicted increases in need due to population growth and changing expectations for service delivery.

Workforce composition

Support workers currently make up around one third of the mental health workforce.

- Investment in support roles will be important to facilitate workforce substitution, increased integration of clinical and non-clinical services and shifts towards greater emphasis on primary care and community-based service delivery signalled in *Rising to the challenge* (Ministry of Health, 2012).
- Peer support workforce numbers appear to be low given this group was identified as a priority for additional workforce development in *Rising to the challenge* (Ministry of Health, 2012). For this occupation group to develop and thrive, committed resourcing, leadership support and equity of opportunities will be important.

Role vacancies, recruitment and retention

Respondents predicted future shortages in a number of roles. In mental health services shortages were commonly reported for registered nurses, psychiatrists, psychologists and community support workers. In addiction services shortages were commonly reported for addiction practitioners and dual diagnosis clinicians.

- These findings suggest the need to consider a number of strategies to meet the projected increase in demand for these roles. This could include strengthening recruitment and retention strategies, developing an investment plan that considers the full workforce and testing options for workforce substitution.
- In light of ongoing shortages in the clinical workforce and predicted increases in demand for services, it may be useful to strengthen early intervention to limit need for secondary services. It may also be useful to extend the skills and competencies of the non-clinical workforce to perform activities that do not require a clinical qualification but are currently being performed by clinicians.

Ethnic makeup and cultural competence

Māori and Pasifika were consistently under-represented in the clinical workforce relative to the consumer population.

- Cultural competency for working with Māori, Pasifika and Asian communities was commonly identified as needing improvement, suggesting ongoing investment in cultural competency training or other innovative solutions to building cultural competency is required. To support the cultural responsiveness of services to these communities it will be important to continue to invest in strategies which support recruitment and retention of Māori and Pasifika.

Relative workforce size between children and youth, adult and older adult services

While not included in this summary, the main report identifies large differences in the size of the adult, older adult and child and youth mental health and addiction workforce relative to each population group.

- It is important to investigate whether the relative size of each workforce in relation to the population it serves is adequate.

Knowledge and skill development

A number of skill and knowledge areas were identified as needing improvement by the majority of respondents.

- Respondents' feedback suggests the need to increase the knowledge and skills of staff so they are comfortable working with people who have co-existing problems, new technologies and IT systems and in a range of skill and knowledge areas discussed in Chapter seven. For addiction services, common knowledge and skill needs included co-existing problems capacity, supporting the use of peer support, psychological interventions and supporting self-managed care.
- Many of the knowledge and skill areas (for example working with new technologies and IT systems and co-existing problems), were not specific to a region or service type, therefore regional and national strategies to develop these skillsets would be worthwhile.

Service planning and collaboration

- Respondents' feedback suggests the need to increase access to knowledge, tools and frameworks that build effective cross-sector collaborative relationships in ways that enhance consumer access to community resources and support.
- The provision of tools, resources and training that enable leaders and managers of teams to enhance their skills in addressing the increased demand for services with limited increases in funding.

Ongoing mental health and addiction workforce planning

The survey provides the first comprehensive picture of the Vote Health funded mental health and addiction workforce. To support robust workforce planning activities, a considered, longer-term approach to collecting mental health and addiction workforce data needs to be implemented. The approach will need to:

- gather information about demographics, retention and registration, in addition to monitoring the size and the composition of the workforce
- be guided by relevant strategic policy initiatives, service development and client outcome priorities
- consider how demographic (i.e. aging), technological and environmental changes will impact on how, and where work, is conducted
- be based on a more explicit understanding of the drivers of healthcare demand and workforce supply, and the determinants of health care utilisation

- include a clear methodological approach to workforce forecasting
- be strongly linked to existing health workforce planning and systems
- be linked to educational planning and workforce supply
- enhance and supports local provider workforce planning and development
- be underpinned by systems of collection and management that enable reliable and robust workforce data.

Given the Government's current focus on responding to the rapidly changing landscape of healthcare, the release of this report is timely. The findings offer stakeholders an invaluable benchmark to inform workforce policy development and planning activity. This is urgently needed to ensure New Zealand builds the right workforce to deliver mental health and addiction services in the most effective way in the future.

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Acknowledgments

Te Pou

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