the WERRY CENTRE for child & adolescent mental health

WORKFORCE DEVELOPMENT

Stocktake of Child and Adolescent Mental Health Services in New Zealand

OCTOBER 2005

Stocktake of Child and Adolescent Mental Health Services in New Zealand

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Foreword

This national Stocktake provides a first snapshot of who is providing and accessing government funded services for children and adolescents with mental health needs. It illustrates the current situation within the sector and serves as a baseline against which workforce and service developments can be measured.

It is intended that this report will provide service planners and funders with the kind of information they need to design services and workforce initiatives now, and in the future.

As with all snapshots, it is most accurate for the point in time that it was captured. This report can best be viewed as a foundation and template for the ongoing collection and analysis of up to date data. This data can enhance responsiveness to the needs of consumers and inform the long-term development of the sector. There is a challenge to the sector to continue to collect this data and make it available in a timely way.

Findings in this report make it clear that there are significant barriers to children, adolescents and their families accessing the mental health services they need. The child and adolescent mental health sector faces substantial challenges in recruitment and retention of skilled staff.

This Stocktake provides an excellent foundation for The Werry Centre as they develop a National Strategic Framework for Workforce Development within the child and adolescent mental health sector for the next ten years.

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The "Stocktake" has been a special challenge in that it has relied entirely on the goodwill of contributors for the information without which this document would not exist. I therefore express my gratitude to all of the contributors to this project.

By its very nature a "stocktake" is intended to give a numeric basis to activity within the sector and is therefore full of tables and unlikely to be an easy read. It is, however, my hope that this document will be used to provide a basis on which to project and plan the child and adolescent mental health workforce needed in New Zealand.

The writing of this document has been a collaborative team effort and I have deeply appreciated the dedication of the team, the support of the Werry Centre staff, the reference group and everyone else who has contributed to our understanding and knowledge.

I especially acknowledge the work of Julliet Bir who, as the only full time person on the project team, has made a significant contribution to the research processes and the writing of the report.

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I would like to thank Sally Merry and Sue Treanor whose enthusiasm and commitment to the success of the Werry Centre inspired me to take on this project.

Carol Ramage

Carol Ramage
Project Leader

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Project Team

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Carol Ramage, Team Leader, has an extensive background in health research and health management. She has over 15 years experience in hospital service management including 3 years as General Manager of Green Lane Hospital. A key area of research expertise was in statistical analysis for cardiac research and she is co-author of a number of published papers. Carol has a Bachelor of Science, majoring in applied mathematics, and a Master of Business Administration both from The University of Auckland.

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Alison Towns, contracted to undertake the literature review for the project, is self-employed as a Registered Psychologist and Director of her own company. She has twenty years of experience as a psychologist working in the mental health sector and in the family violence area. She has previously held Clinical Team Leader and Senior Clinical Psychologist roles in public mental health settings, most recently in the community child and adolescent mental health sector. She also has an extensive background in university teaching and research, and has published papers and chapters in books internationally. She gained her MSc in Psychology, First Class Honours, and her PhD in Psychology from The University of Auckland. She has been the recipient of a number of Health Research Council research grants.

Raewyn Vague MBA

Raewyn Vague was contracted to analyse the MHINC data for the project. She has an extensive background in industry as a company secretary and financial controller and has been involved in the health industry for the past 10 years. During this time she has held several positions with the Auckland District Health Board in accounting, analytical roles and health management. Since 2003, Raewyn has worked through her own company as a consulting health analyst. Raewyn has a Master of Business Administration from The University of Waikato.

Mathijs Lucassen BOccThy, PGDipHSc, NZROT, MA (Hons), Psychological Medicine

Mathijs Lucassen provided additional support with the completion of the draft report. He is a mental health occupational therapist by background and recently completed a post-graduate diploma in child and adolescent mental health (The University of Auckland).

Reference Group

The reference group provided advice on specific issues individually and as a group.

Toni Ashton	Associate Professor, Health Economics, University of Auckland
Tania Cargo	Māori Clinical Advisor, The Werry Centre for Child & Adolescent Mental Health Workforce Development
Dr Monique Niumata-Faleafa	Pacific Clinical Advisor, The Werry Centre for Child & Adolescent Mental Health Workforce Development
Justine Harris	Clinical Director, Youth Horizons Trust
Dr Sally Merry	Senior Lecturer, Department of Psychological Medicine, Faculty of Medical & Health Sciences, University of Auckland
Sue Treanor	Director, The Werry Centre for Child & Adolescent Mental Health Workforce Development
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Derek Wright	Regional Director, Northern District Support Agency
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Executive Summary

The Werry Centre for Child and Adolescent Mental Health Workforce Development, Department of Psychological Medicine, The University of Auckland, was contracted by the Ministry of Health (MOH) to undertake a Stocktake of Child and Adolescent Mental Health Services in New Zealand.

Introduction

The overall goal of the project was to conduct a national stocktake of child and adolescent mental health services that would inform the Ministry of Health's (MOH) strategic plan for child and adolescent mental health workforce development. The time frame of the project was for the period August 2004 – October 2005.

Project Objectives

The objectives of the Stocktake Project were to:

- Identify who is providing government funded services to children and adolescents with mental health needs in New Zealand by type, quantity, ethnicity and level of care in each region.
- Identify who is accessing government funded services for children and adolescents with mental health needs in New Zealand by type, quantity, age, ethnicity and level of care in each region.
- Provide an overview of the current child and adolescent mental health workforce including ethnicity data.
- From the literature and available sources, identify the barriers to children, adolescents and their families to accessing the appropriate services with attention to access for Māori, Pacific and Asian people.
- From the literature and available sources, identify the barriers to inter-agency co-ordination including the barriers between Māori and mainstream services, where appropriate.
- Develop a national resource directory of child adolescent and family mental health services with a view to developing and maintaining a web-based resource as a separate project (published separately).

The scope of the project did not include consultation with children and adolescents with mental health problems and their families.

Methodology

The term 'Child and Adolescent Mental Health Services' has been used throughout the report as a general description for child and adolescent mental health services provided to under 20 year olds.

Literature Review

In 2004, a literature review to inform the Stocktake project was conducted by Dr Alison Towns and was based on material published prior to December 2004. The brief for this review was very broad with only limited time available. The methodology therefore required expediency. Preference was given to accessible literature able to be found electronically through search engines. Searches were conducted using Medline and Google. A comprehensive range of relevant New Zealand Government Ministry websites and related links were also searched for relevant publications along with relevant international websites. Due to their specific relevance to

this review, focused searches were carried out on the New Zealand prevalence literature that has emerged from the longitudinal development studies conducted in Christchurch and Dunedin. These studies used the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) as the standard means of determining diagnosis, consistent with the recommendations in the Ministry of Health's strategic document on child and adolescent mental health services: *New Futures*. Other studies were included depending on the timeliness of their availability.

There was a notable lack of published international literature on child and adolescent mental health services, indicating the international infancy of this area of development.

Population Statistics

Population data is based on the 2001Census. The Census data and projections for subsequent years have been produced by Statistics New Zealand. Population projections initially used were from Statistics New Zealand (Ref No. CL3835RS). The MOH supplied a file: "*Ethnic Population Projections by Age and Gender and Amalgamated NZdep2001_26.xls*." to describe demographics by region and DHB.

MHINC Database

Information sources were researched for data on access to child and adolescent mental health services. The Mental Health Information National Collection (MHINC) was identified as the most relevant for this project.

At the time of the initial data request (October 2004), New Zealand Health Information Services (NZHIS) advised that the most complete and reliable MHINC data was for the 2003 calendar year. The first six months of 2004 was made available in March 2005 and was analysed for six monthly access rates.

Surveys

In order to obtain service and workforce information, surveys were conducted with organisations involved in the provision of child and adolescent mental health services.

- District Health Board (DHBs)
- DHB funded Non-Government Organisations (NGOs)
- Child, Youth and Family (CYF) Collaborative Programmes

The project focus was on secondary and tertiary services provided by DHBs. Primary services were not covered except where provided by DHB contracted NGOs.

Workforce data was collected as at March 2004 to link with data previously collected by Mental Health Commission (MHC) for the same time period.

Financial data was sought for the year 2003/2004 to link with the MHINC and workforce data. Funding data 2004/2005 was included when it became available.

Barriers to accessing child and adolescent mental health services were sought from the following referral sources:

- General Practitioners (GPs)
- Child & Adolescent Psychiatrists
- School Guidance Counsellors (SGCs)
- Social Workers in Schools

Obtaining the views of GPs was a specific requirement of the project briefing as they are the largest referrer to child and adolescent mental health services. In November 2004, TNS New Zealand (a market research company) was identified as having regular access to an existing pool of GPs, and an existing research platform, and therefore were contracted to conduct the survey of GPs.

In October 2004, a survey of child and adolescent psychiatrists initiated by the Royal Australia and New Zealand College of Psychiatrists was incorporated as one of the deliverables of the project and conducted by the project team. Data relevant to the project is presented in this report.

A subset of an independent study on School Guidance Counsellors conducted by a University of Auckland PhD candidate, Barbara Bulkeley, proved relevant to the 'barriers to access' objective and therefore is included in this report.

Social workers in schools were approached by email through the Coordinator of Social workers in Schools at CYF.

Feedback

A draft document was sent in June 2005 to 150 people for feedback. This included all DHB CEOs and Mental Health Managers; all funded NGOs; CYF; MOH; MHC; Regional Workforce Development Coordinators; Werry Centre Staff and the Project Reference Group.

There were approximately 30 detailed responses. All feedback was carefully reviewed, and where possible, within the scope and time-table of the project, incorporated. There were a number of comments suggesting more analyses and development of strategy which was not within the brief of this project. All feedback relating to workforce development strategy has been forwarded to the MOH funded *Strategic Framework Project* which is currently being undertaken by The Werry Centre.

Key Findings of the Stocktake Project

Child & Adolescent Mental Health Service Providers

- Child and adolescent mental health services are delivered by all DHBs and a number of DHB funded NGOs in diverse and complex arrangements.
- There is an increasing focus on intersectorial collaborative programmes.
- There was a 6% increase in funding (DHBs & NGOs) from 2003/2004 to 2004/2005 (Tables 23-26).
- Some DHBs were under-spent for the 2003/2004 year (Table 28). This under-spend might be related to vacancies.

Access to Child & Adolescent Mental Health Services

- The conjoint findings of the two New Zealand prevalence studies (Fergusson, 2003) showed that the prevalence of mental health problems in children and adolescents is significantly higher than the existing Blueprint targets. This finding is consistent with research conducted overseas which suggests that the rate of disorders with clinically significant impairment in functioning associated with a mental health diagnosis in children and adolescents is 15% (Waddell and Shepherd, 2002).

- In order to compare the 2003 access rates with the benchmark targets for each age group, access rates were calculated on a six monthly basis in line with the MHC resource guidelines (see Table 64). Criticism of the 2003 data led to the analysis of the first half of the 2004 dataset but showed that there was no change in access over three six monthly periods.

- When access rates were compared to the strategic benchmarks, it was clear that they were well below the benchmark in every age group. This gap is undoubtedly a ***real deficit*** in service delivery but the following may also be contributing factors:

    - Incomplete DHB returns to MHINC data (anecdotal feedback from the sector)
    - Lack of data on access via NGO (although largely not providing clinical services)
    - Lack of data on access to other government funded agencies

- The greatest shortfall of Blueprint targets against access rates was in the Northern Region.

Child & Adolescent Mental Health Workforce

- The workforce is significantly less than that required to meet the Blueprint service targets. Community Clinical FTEs across 21 DHBs and NGOs was 667 FTEs compared with the 2004 blueprint resource guideline of 1163.37 FTEs.

- DHB Psychiatrist FTEs was 58.73 compared with the World Health Organisation guideline (WHO, 2001) of 119.02 FTEs.

- Workforce vacancies were significant across all regions (Table 80).

- There were low numbers of Māori and Pacific workers in relation to the composition of the population under 20 years (Table 97 & 98).

Barriers to Accessing Child & Adolescent Mental Health Services

- Lack of knowledge of services, lack of services, and lack of specialised staff were important barriers to accessing services for clients.

- Stigma was an important barrier to accessing services for clients.

- For Māori and Pacific children, adolescents and their families, the referring professionals identified a lack of culturally appropriate services and a lack of understanding about cultural values and belief systems.

Barriers to Inter-Agency Co-ordination

- Privacy issues.

- Lack of resources (staff) resulting in a lack of available time leading to lengthy response times.

- The large number of agencies involved which make it difficult to know who to contact.

Recommendations

- Workforce numbers need to increase significantly to meet Blueprint targets.
- Workforce planning should aim to increase the specialist workforce and increase the ethnic diversity of the DHB and NGO workforce.
- Workforce data should be collected annually on a consistent basis to identify trends and to support and monitor forward planning.
- NGO data should be collected and linked to MHINC data to properly estimate the number of clients who are accessing services and progress toward the Blueprint targets.
- There is a need for nationally co-ordinated strategic workforce planning with a linkage between strategic workforce planning and strategic planning for service delivery.
- There is a need for inter-sectorial collaboration around workforce development.

Limitations

The project is limited by:

- The 73% (58/80) response rate to the workforce data survey from currently funded (2004/2005) NGOs.
- The lack of NGO data captured in MHINC.
- The difficulty of determining the number of unique clients with mental health problems when clients are seen by a number of agencies and this data is not collected centrally.
- In 2003, only 314 Asian child and adolescents accessed mental health services. Due to the small number of Asian clients, population comparisons have been limited to Māori, Pacific and Other ethnic groups.
- The quality of the workforce data provided by DHBs.
- The NGOs may receive funding from agencies other than DHBs and may use the total funding flexibly to meet their needs. Therefore the workforce data may include FTEs that are not funded by DHBs and may over-estimate the DHB funded NGO workforce.
- Ethnicity data was provided by management and not necessarily by the individual staff member.
- Ethnicity data was only requested by head count and not FTE and therefore likely to over-estimate the ethnic numbers used in population calculations and under-estimate the staffing requirements.
- The barriers to access for Asian people were not sought. They were included in the Literature Review, but not included in the survey as this was added to the project scope at a later stage.
- The project does not include an overview of primary care and therefore does not identify and quantify the private professional workforce.

Summary of the Stocktake Findings

Chapter 1: Literature Review

Government strategy in mental health has long recognised the need to address the mental health of the young in order to prevent the occurrence of mental health problems in adults. The document *New Futures* clearly details the government strategy for mental health services for those aged 0-19 years. However, no implementation plan has been developed for this strategy. *Looking Forward*, the mental health strategy, and *Moving Forward*, its implementation plan, do not provide forward planning beyond 2001 for services for young people. The Blueprint provides clear benchmarks for the development of services which the Mental Health Commission monitors. There has been considerable growth in child and adolescent services up until 2001, but growth in specialist child and adolescent mental health services appears to have stalled in recent years.

Blueprint benchmarks are to provide services to the 3 percent of young people aged 0-19 years in a six month period who have serious mental health problems. For Māori, benchmarks were set at twice this figure. Indications are that access was only available to 1.1 percent of young people in the 2002-2003 year, compared to 2% of adults. Young people under 20 years make up around 30% of the population but received only 10.5% of the overall mental health funding expenditure in the year ending June 2003.

The prevalence of mental health problems with clinical impairment among the young is substantially higher than the benchmark target. There is recognition that those in the older teenage years (15-18) are particularly vulnerable to mental health problems. Internationally, the prevalence of mental health problems with clinical impairment in children and young people has been found to be around 15%. New Zealand literature suggests that the prevalence of mental health problems among Māori is 1.5-2.0 times higher than that among non-Māori. This difference appears to be related to disadvantage.

Children and young people have particular service needs associated with their developmental age groups. The family is an important participant in the recovery of the child or young person who requires mental health care. Services may need to be structured according to the developmental age group served.

Commonly, collaboration across services such as Education, Child, Youth and Family (CYF), Health and/or Justice is needed to allow full recovery of the young person and return to their local community activities. There are key documents such as *Making Links* which are designed to assist inter-agency collaboration through the provision of an integrated service delivery. In order for collaboration across agencies to be successful, there needs to be regional co-ordination through informal networking, and formal regional partnerships which can draw on the informal networks for stakeholder information. A number of barriers to collaboration were identified.

A priority for service delivery to children and young people is to provide for those vulnerable cultural groups: Māori and Pacific people. Asian young people are a rapidly growing minority group that have limited access to services. Current indications are that for Māori, Pacific and Asian children and young people, access to services is substantially less than would be expected. Although priority has been given to the development of Kaupapa Māori services for children and young people, very few Māori children and young people had access to such services. Access for Pacific people might be enhanced by attending to the alignment of services to Pacific needs: a wellness focus, holistic perspective, outreach, recognition of traditional diagnoses etc. Access for Asian people might be enhanced by ready access to interpreters, translated information, and through the use of mature workers and flexible hours. Stigma remains an issue for Asian people.

New Futures identified twin priorities for child and adolescent mental health services: to provide specialist services to those most seriously disturbed young people and to provide consultation liaison services. The groups of young people most likely to require specialist assessment and therapy are those with serious mental health problems (e.g. psychoses), serious emotional problems (e.g. self harm), developmental problems (e.g. Attention Deficit Hyperactivity Disorder (ADHD)), and alcohol and drug dependencies. Information on access of these groups of young people to CAMHS services was not available. The Classification and Outcomes Study (CAOS) indicated that those with psychoses were most costly for inpatient services and those with self-harm behaviours and/or not attending school were most costly for community services.

There are indications of developing Early Intervention Services (EIS) for young people with serious disturbances. Such services require a recovery focus, an approach aimed at destigmatisation, outreach services, continuums of care and youth transitional programmes that assist in returning these young people back to school or into work. Consultation and liaison services are most likely to be needed for those young people who are traumatized and in the care of other agencies such as CYF, and for those young people with significant behavioural problems. For the latter, liaison may be with schools, with CYF or with the Justice system. The mental health sector is not funded to provide services to these young people unless severely traumatized or having associated mental health disorders. Some CAMHS services have developed specific consultation and liaison services for CYF, Education, general hospitals and the Justice system.

A major concern is that workforce issues are a problem not only for the mental health sector, but also for CYF. There are significant concerns about the provision of services in the Education sector to those with developmental disorders. These workforce and service provision issues can impact on the ability of other sectors to provide early intervention and prevention services to the young. For example, the Justice sector is dependent on the provision of services from CYF, Education and Health in order to intervene early with youth justice issues. Gaps in service provision therefore need to be addressed in order to provide adequately for the mental health of the young.

Chapter 2: The Provision of Child & Adolescent Mental Health Services

- All 21 DHBs provide a child and adolescent mental health service through DHB and NGO providers. DHBs provide clinical and support services while NGOs mainly provide support and ancillary services.

- Eighty NGOs in 2004/2005 provided relevant community based child and adolescent mental health services.

- The composition and nature of services varies considerably across DHB regions. NGO involvement in DHB regions also varies, for example five DHBs do not contract NGOs to provide services.

- In 2004/2005, DHBs and NGOs received total funding of $96 million (which included funding for 802 FTEs, 56,101 bed days and 29 programmes) for child and adolescent mental health services (see Tables 24, 26 & 27).

- In 2004/2005, there was a 6.8% increase over the 2003/2004 provider funding (DHBs and NGOs).

- In 2004/2005, there were 59.7 acute beds which equates to a shortfall of 21.7 beds in relation to Blueprint guideline of 81.4 beds.

- Kaupapa Māori services are purchased under a specific unit code (MHCS39) and are provided by 19 NGOs and three DHBs.

- Ten Pacific services were identified, which is of concern as Pacific mental health is a priority area for future service development (Health Funding Authority, 2000a).

- There is an increasing focus on intersectorial collaborative programmes.

- Funding per child/adolescent in New Zealand has increased considerably from $52 in 1999/2000 (Health Funding Authority, 2000a) to $81 in 2004/2005.

- Eleven of 18 DHBs were underspent on the CAMHS budget and three DHBs did not provide this information. Underspend may be an indication of unfilled FTEs.

Chapter 3: Access to Child & Adolescent Mental Health Services

- The strategic benchmarks for child and adolescent mental health services for the 0-9, 10-14, and 15-19 age groups are 1%, 3.9% and 5.5% respectively. Rates have been calculated on a six monthly basis in line with the MHC resource guidelines.

- The conjoint findings of the two New Zealand prevalence studies (Fergusson, 2003) showed that the prevalence of mental health problems is significantly higher than the existing Blueprint targets.

- In 2003, 19,307 clients (unique individuals) accessed services with a total of 184,699 attendances. Of these, more males (59%) accessed and attended services than females (41%).

- Fifty-four percent of clients attending services were 15-19 year olds with females accessing services slightly more than males in this age group only.

- The majority of 15-19 year old clients (76%) were from the 'Other' ethnic group followed by Māori (19%), Pacific (2.9%) and Asian (1.6%).

Access as a percentage of population

Analysis of access as a percentage of population showed that for the year 2003:

- There were slightly more males (1.9%) accessing services than females (1.4%).

- Access to services increased with age: 0-9 years (0.63%), 10-14 years (2.07%) and 15-19 years (3.10%).

- Although Pacific (0.56%) and Māori access rates (1.35%) were lower than the access rates for the rest of the population, access increased with age in all three ethnic groups. Māori access (3.10%) in the 15-19 year age group was close to the rest of the population (3.25%).

Access Rates compared to MHC Blueprint Benchmark Guidelines

In order to compare the 2003 access rates with the benchmark targets for each age group, access rates were calculated on a *six monthly basis* in line with the MHC resource guidelines. Criticism of the 2003 data led to the analyses of the first half of the 2004 dataset but showed that there was no change in access over the three six monthly periods.

Access Rates on a Six Monthly Basis Compared to Strategic Benchmarks for Child & Adolescent Mental Health Services

	Age (years)			
	0-9	**10-14**	**15-19**	**0-19**
Strategic Benchmark	1.0%	3.9%	5.5%	3.0%
Access Rate first 6 months 2003	0.4%	1.4%	2.0%	1.1%
Access Rate second 6 months 2003	0.5%	1.5%	2.1%	1.2%
Access Rate first 6 months 2004	0.4%	1.3%	2.1%	1.1%

When access rates were compared to the strategic benchmarks, it was clear that they were well below the benchmark in every age group. This gap is undoubtedly a ***real deficit*** in service delivery but the following may also be contributing factors:

- Incomplete DHB returns to MHINC data (anecdotal feedback from the sector)
- Lack of data on access via NGO (although largely not providing clinical services)
- Lack of data on access from other government funded agencies

Chapter 4: The Child & Adolescent Mental Health Workforce (2004)

- The DHB inpatient workforce totalled 124.7 actual FTEs with a further 27.4 FTEs that were reported vacant. The inpatient workforce was comprised mainly of Mental Health Nurses and Mental Health Support workers.

- The DHB community child and adolescent mental health workforce totalled 614.04 actual FTEs (excluding 98.77 vacant positions). The three largest occupational groups were Psychologists, Social Workers and Mental Health Nurses.

- Sixty-two 2004/2005 NGOs responded to the survey but data from 58 NGOs was analysed. Data from Kaupapa Māori services was analysed separately.

- Forty-three NGOs (excluding Kaupapa Māori services) reported a total of 301 actual FTEs with 18 FTEs that were vacant. The NGO workforce was largely comprised of Mental Health Support Workers, Social Workers and Counsellors.

- Nineteen NGO Kaupapa Māori services were surveyed and responses from 15 were analysed. These services reported a total workforce of 37 actual FTEs which was mainly comprised of Mental Health Support staff, Counsellors and Social Workers.

- The programmes coordinated by Child, Youth and Family reported a total of 34 actual FTEs with a further 12.1 FTEs that were reported vacant. The workforce was mainly comprised of Mental Health Support Workers, Mental Health Nurses and Social Workers.

- The total workforce equated to 1130 actual FTEs with a further 158 vacant FTEs.

- The total DHB and NGO community clinical FTEs were compared to the Blueprint Resource Guidelines for 2004 and a staffing increase of 74% is required (funded vacancies plus newly funded positions).

DHB & NGO Clinical Community FTEs compared to Blueprint Benchmarks (2004)

Actual DHB & NGO Community Clinical FTEs	Community Clinical FTEs as per Blueprint Benchmark for 2004	FTEs Needed	% Increase
666.82	1163.37	496.55	74

- WHO recommendations for Psychiatrists also indicated an increase of 103% based on the 2004 numbers.

- The Māori, Pacific and Asian workforce totalled 223, 64, and 23 respectively. While the Māori workforce figures appear mostly proportional to the 0-19 years Māori population, there were significant disparities between the Pacific workforce and the 0-19 years Pacific population in some regions. However, both Māori and Pacific are under represented in the clinical workforce

Chapter 5: Barriers to Accessing Child & Adolescent Mental Health Services

The barriers to accessing child and adolescent mental health services for children, adolescents and their families as identified by referring professionals (GPs, SGCs, Social Workers in Schools & Child & Adolescent Psychiatrists), were consistent with literature findings and these are summarised as follows:

- Lack of knowledge of services
- Lack of services and specialised staff
- Stigma of being referred to mental health services
- Restrictive criteria for referral/acceptance
- Lengthy delay in response to referrals
- Lengthy waiting times to get into services
- Lengthy assessment processes
- Costs to clients (private providers, GPs, transport, time off work)
- Lack of feedback/communication to referring professionals and clients

The referring professionals identified the following barriers for Māori and Pacific children, adolescents and their families:

- Lack of culturally appropriate mental health services and staff
- Lack of understanding about culture, value and belief systems

Although the barriers of access to child and adolescent mental health services has been obtained from only four professional groups, the findings were consistent with literature findings and further research of professionals is unlikely to produce any significant new information.

A significant gap in this chapter is the survey of the clients' and their families/whanau perspectives on the barriers to accessing child and adolescent mental health services. This exercise would have provided the opportunity to gain a more detailed and accurate Māori, Pacific and Asian perspective. However, the inclusion of client's perspectives was beyond the scope of this project.

Although projects have been developed by CYF and MOH (see Chapter 2.3.4) to improve access to DHB funded mental health services by CYF residents, further steps to address the barriers reported by referring professionals in this chapter should be incorporated into MOH's strategic planning.

Chapter 6: Barriers to Inter-Agency Co-ordination

Literature findings on the barriers that hinder inter-agency co-ordination were consistent with the barriers reported by GPs and Child and Adolescent Psychiatrists surveyed.

Privacy issues were seen as an important barrier by GPs while the time taken to liaise with other agencies was a significant barrier for Psychiatrists. Lack of resources (specifically the lack of experienced staff) was seen as a barrier that led to long response and waiting times and the need to protect the limited funding that the agencies received. The large number of agencies involved also meant that it was often difficult to know who to contact.

Specific funding for a dedicated staff member for inter-agency liaison was a consistent solution suggested by both professional groups.

Chapter 7: Māori, Tamariki, Rangatahi & their Whanau

Kaupapa Māori Mental Health Services

- In 2005, 17 out of 19 continue to deliver to Tamariki and Rangatahi.
- Incorporates three key aspects: tikanga Māori philosophies, holistic models of health and embraces whanaungatanga.
- Provide more services than they are funded to deliver.

Workforce

- Fifty percent of the workforce are clinical staff, 25% are non-clinical and 25% are vacancies and students in training.
- Clinical vacancies are difficult to fill, taking on average, 12 months.
- Counsellors and social workers comprise 74% of all clinical positions and have an average of 3.5 years post qualification experience.
- There were no Occupational Therapists, Psychotherapists or Psychiatrists funded under the MOH contract MHCS39.
- Non-clinical staff are seen as contributing significantly to ensuring 'dual competency' of services.

Recruitment Issues

- Lack of clinical expertise and difficulty filling clinical positions was seen by 85% of services as a key recruitment issue.
- Geographical isolation was identified by all rural services as a major barrier to recruiting staff as well as impacting on clinical services.

Retention Issues

- Services reported "*growing*" their own clinicians (12/17), upskilling through professional development (11/17) and through financial incentives (10/17) as active ways they utilised to retain staff
- The change in the Health Practitioners Competency Act (2003) has meant that some services which employ counsellors are no longer eligible for clinical positions.

Chapter 8: Pacific Children, Young People and their Families

- The numbers of young Pacific clients aged 0-19 years seen in mental health settings in New Zealand for the year 2003 was 559 (MHINC 2003). The total client population within this age group was 19,307 (MHINC 2003).

- Pacific access rates of 0.1%, 0.3%, and 0.9% (first 6 months of 2004) are by far the most significant ethnic-specific discrepancy against blueprint targets.

- *The Pacific Mental Health Services and Workforce – Moving on the Blueprint* (Mental Health Commission, 2001b) document estimates that 93 Pacific child and youth community FTEs (including both mainstream and Pacific dedicated services) are required for the year 2004 to meet *Blueprint* guidelines (p.32). Given the identified 47 (head count) in the current Pacific workforce, this would need to double to reflect the population it serves.

Chapter 1

Literature Review

1.0 Literature Review

Dr. Alison Towns

1.1 Introduction

In its recent annual report to Government (Mental Health Commission (MHC), 2004a) the Mental Health Commission lamented the lack of progress towards its goals for service provision for the mental health needs of children, young people and their families. Despite the mental health needs of this group (particularly Māori tamariki and rangatahi) being a priority area and considerable growth from the mid 1990s, little progress in the period from June 2002 to June 2003 had been made towards implementation of the recommendations made by the Mental Health Commission.

Workforce issues have consistently been identified as a constraint on progress towards service provision for children, young people and their families. A stocktake of services provided to address the mental health needs of young people is to be carried out. This stocktake is aimed at identifying the workforce needs for children and young people. The intention of this review is to provide a background to the stocktake by reviewing the mental health service needs for children, young people and their families.

In the following, I will provide the policy background to provide a context to the stocktake. I will then address the service needs for child and adolescent services by reviewing the current literature on the cultural needs of young people; by reviewing the New Zealand epidemiological literature relating to mental health disorders in the young; by identifying the special service needs of children and young people with serious mental health problems; and finally by reviewing the issues for services that provide for young people with serious mental health problems. Barriers to access and the collaboration of services will also be reviewed.

1.1.1 Methodology

The brief for this review was very broad with only limited time available. The methodology therefore required expediency. Preference was given to accessible literature able to be found electronically through search engines. Searches were conducted using Medline and Google. A comprehensive range of relevant New Zealand Government Ministry websites and related links were also searched for relevant publications. Relevant international websites were searched. Focused searches were conducted of the New Zealand prevalence literature that has emerged from the longitudinal development studies conducted in Christchurch and Dunedin, because of their specific relevance to this review. These studies used the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) as the standard means of determining diagnosis, consistent with the recommendations in the Ministry of Health's strategic document on child and adolescent mental health services: *New Futures*. Other studies were included depending on the timeliness of their availability.

There was a notable lack of published international literature on child and adolescent mental health services, indicating the international infancy of this area of development.

1.1.2 Terminology

In New Zealand, mental health services for children and adolescents are funded for those aged 0-19 years (MHC 1998). The term *children* is used by the World Health Organization (WHO) to refer to those aged 0-9 years; the term *adolescents* refers to those aged 10-19 years; and the term *youth,* refers to those aged 15-24 years (McGeorge, 1995). The WHO refers to *infants* as those aged 0-1 years. McGeorge noted that some practitioners prefer to use such terms to refer to young people's developmental stages rather than rigidly adhering to age brackets. For example, some practitioners use the term infants to refer to those aged 0-4 years; the term children to those primary school aged children, and the term adolescent may be used to refer to those secondary school aged children who are dependent or "*unemancipated*" youth, in contrast to those "*emancipated*" youth who have either left home and/or are in work.

In this chapter, unless otherwise specified, the term children is used to refer to both preschool and primary school aged children, the term young people is used to refer to those of secondary school age and up to 19 years of age. The term infant is more specifically used to refer to preschool aged children.

The term *Child and Adolescent Mental Health Services* has been adopted in New Zealand to refer to mental health services for the 0-19 age group (with the upper age range used flexibly depending on the needs of the young person) and to maintain consistency with international nomenclature.

Prior to the widespread adoption of this term, some services for this age group in New Zealand were called Child Adolescent and *Family* Mental Health Services, which more realistically captures the expected client group when working with children and young people. Furthermore, the inclusion of the term Family or Whanau in the name of the service is probably more culturally appropriate in New Zealand. However, this issue is beyond the scope of this review, and child and adolescent mental health services will be used here to maintain consistency with current nomenclature.

1.1.3 The New Zealand Context

Traditionally in New Zealand, child, adolescent and family mental health services were provided through inpatient services attached to local hospitals, through adult psychiatric hospitals and through outpatient clinics (such as the original Marinoto and Campbell Lodge in Auckland). The workforce in these services consisted of multi-disciplinary teams of psychiatrists, clinical psychologists, psychiatric nurses, social workers, occupational therapists and psychotherapists often without specialized training in child and adolescent mental health (see Werry cited in Mason et al, 1996). Children with developmental disorders such as autism were commonly institutionalized in large paediatric hospitals, where the predominant workforce consisted of paediatricians or general practitioners, nurses and nurse aids. Social workers were largely employed in the care and protection services, working with traumatized children and their families.

With the deinstitutionalisation of the psychiatric and paediatric services in the 1980s and 1990s, there was recognition that inpatient and outpatient services would not adequately address the community needs of children and young people. Similar calls for deinstitutionalisation internationally, had seen the development of community mental health centres. These centres were developed in part in recognition that the workforce would never be able to satisfy the demand for services (Korchin, 1976).

Community mental health services were expected to operate under a different philosophy from that of outpatient clinics. They were expected to offer more holistic care, to involve service users and the community in the operation and provision of services, to be in accessible family-friendly locations, to provide specialist services to those in crisis and the more seriously disturbed, to offer consultation liaison services to other service providers, and to provide early intervention and prevention programmes (Korchin, 1976). The workforce was expected to consist of professionals and non-professionals.

In the mid 1990s, recognition of the need for service development for children resulted in a substantial increase in the workforce in child and adolescent mental health services: all District Health Boards now provide child and adolescent mental health services (Chiplin pers comm.). This growth, however, has stalled in the last two years (MHC, 2004). The Mental Health Commission noted that some funding did not appear to be going to where it was intended in mental health. For example, 16.5% fewer staff were employed in Child and Youth Community Mental Health Services than were funded in the year ending June 2004 (MHC, 2004c).

1.1.4 Potential for Discrimination

The potential for discrimination against children and young people needs to be kept in mind. Young people with mental health problems suffer not only from the same associated stigma experienced by adults with mental health problems, but also from the potential for institutionalised prejudice associated with the limited resource strength of their services. They have fewer advocates, and - with easily identified stakeholders in the adult sector – mental health planners may inadvertently miss the inclusion of child mental health services when planning developments (see WHO, 2003a). Some child and young people's services have positioned themselves under paediatric

management in order to address this problem (e.g. Starship Hospital's Child and Family Unit was set up under the Paediatric services), but in doing so may have limited their access to mental health resources.

Further, being Māori (or from a minority ethnic group) means children and young people may experience difficulties accessing suitable services not experienced by their Pakeha peers. Planners may miss the inclusion of the special needs of Māori children, young people and their families, through, for example the use of ethnocentric data. Awareness of this potential "triple whammy" of discrimination relating to age, mental health, and ethnicity is important in planning any workforce development strategies (WHO, 2003a).

Relevant Government Strategy

There is recognition of the potential for discrimination at the government level. Government health strategies support child and adolescent services as a priority.

- The *Child Health Strategy* (1998a) states that "*children/tamariki should have their needs treated as paramount*"
- The report *Implementing the New Zealand Health Strategy* (2002a) noted that a cornerstone of a quality service was that it was "*equitable and accessible*" and that prejudice did not occur to access because of "*ethnicity, age, impairment or gender*"

The strategic direction for mental health has prioritised services for children and young people, and particularly Māori (see below). This endorsement is in part in recognition of the potential for the prevention of on-going mental health problems in adulthood through early intervention or prevention strategies in infancy, childhood or adolescence. It also recognises the greater mental health needs of Māori.

1.1.5 Legislative Requirements

In addition to government strategy, there are some legislative protections for children and young people in New Zealand. In addition to those protections provided under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Health and Disability Commissioner Act 1994, the Privacy Act 1993, and the New Zealand Public Health and Disability Act 2000 to all people, the following need to be considered in any service planning:

- The Mental Health Commission and the Ministry of Health have endorsed the *Treaty of Waitangi* as the founding document in any planning undertaken around mental health services. The three principles of partnership, participation and access to resources provide guidance around the provision of services to Māori (see MHC, 1998).

- The New Zealand government is a signatory to the *United Nations Convention on the Rights of the Child* (UNCRC). The implication for funding and planning of the workforce in child and adolescent mental health are made clear in the World Health Organization document *Mental Health Policy, Plans and Programmes* (WHO 2003b, p.35). In referring to the Convention the document notes:

  > *"Article A19 states that all appropriate measures to protect the child from all forms of physical and mental violence should be taken, and that a mentally or physically disabled child should enjoy a full and decent life in which participation in the community is facilitated."*

The document makes specific recommendations on the provision of mental health services for children and adolescents, and points to the obligation on signatories to involve children and young people in the planning of services to meet their needs. The New Zealand Human Rights Commission also points out the need to ensure that discrimination (direct or indirect) against children does not occur (HRC, 2004), and points to the governments obligations under the UNCRC.

- The *Children, Young Persons, and Their Families Act (1989)* states that in any matters concerning the care and protection of children and young people, or matters concerning youth justice, where there is a conflict of "*principles or interests*" the rights of the child are paramount.

These legislative requirements would suggest that priority should be given to the provision of services to children and young people, over others. Furthermore, consistent with the recovery approach advocated by the Mental Health Commission, there are clear obligations on planners of mental health services for children and young people to involve children and young people in the planning of services (HRC, 2004).

Service User Participation

Certain government documents assist with the involvement of children and young people in planning. The Ministry of Youth Development and the Ministry of Social Development has produced a literature review related to the involvement of children in planning: *Increasing the Participation of Children, Young People and Young Adults in Decision Making – A Literature Review* (Gray 2002a). Two guides were subsequently produced: *Involving Children: A Guide to Engaging Children in Decision-Making* (MSD, no date) and *The Youth Development Participation Guide* (MYD, 2003).

The Mental Health Commission has produced two recent documents in which service users describe their needs and roles in service provision: *Our Lives in 2015: A Recovery Vision* (MHC 2004b); and *Strengthening Our Foundations: Service User Roles in the Mental Health Workforce* (Hansen, no date). The Ministry of Health has recently produced *A Guide to Effective Consumer Participation in Mental Health Services* (MOH, 2005). However these documents were written from an adult perspective.

In child and adolescent mental health services, families are also service users. Some services now employ family advisors in planning and service provision roles (e.g. Kari Centre in Auckland Central. A strong service user group also participates in planning in Canterbury).

1.2 Strategic Direction

The need to address the mental health of children and young people is clearly articulated in the NZ government documents on mental health strategy. Key mental health strategy documents are:

- *Looking Forward* (with *Moving Forward* as the implementation plan)
- *New Futures*
- The *Blueprint* provides the benchmark for services

In the following, other significant documents that have informed the strategic development are also noted.

1.2.1 Looking Forward - The Mental Health Strategy

The document *Looking Forward: Strategic Directions for the Mental Health Services* (MOH, 1994) remains an important statement of the direction for mental health services to date. In this document, note was made of the lack of mental health resources available for services directed towards children and young people. Recognition was given to the need to intervene early with children and young people to prevent the development of serious mental health disorders in adults. Priorities were to develop accessible community based services particularly for Māori, young people and those who were seriously disabled by their mental health problems.

1.2.2 The McGeorge Report 1995

This report: *Child, Adolescent and Family Mental health Services* (McGeorge, 1995) set out the requirements for child and adolescent mental health services and presented a number of suggested models of care. In particular it specified the staff requirements for multi-disciplinary teams in child and adolescent mental health services and articulated a pathway for the development of services, from general to more specialised services. Recommendations were made for planning towards specialised services for the 5% of the population likely to be most affected by child and adolescent mental health problems.

1.2.3 The Mason Report

A subsequent report expressed concern that sixteen months on, child and adolescent mental health services had not progressed towards the recommended goals of the McGeorge report (Mason, Johnstone & Crowe 1996). The Mason Report: *Inquiry under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services* highlighted issues for the mental health workforce including the impact of restructuring on morale, difficulties with recruitment and retention, shortages of consultant psychiatrists and other multidisciplinary team members, resultant high case loads and related staff retention problems. It recommended the establishment of the Mental Health Commission, and that the Commission have as a priority the preparation of a strategic plan for workforce development "*and then make it work*" (p.130).

The report noted particular issues affecting mental health services for children and young people including:

- the lack of clear direction from the Ministry of Health to the funding agencies and then to the major providers;
- the "*adultocentrism of most mental health management*" and the impact on planning for children and young people;
- the staff shortages;
- lack of adequate facilities;
- issues around continuums of care between education, social welfare and health relating to the shortfall in funding to the Children and Young Persons services and to Special Education Services.

The Mason report stated that while the evidence suggested that the need for services in child and adolescent services was closer to 7% of the population, a 5% benchmark was more likely to be attainable. The authors noted that to reduce the benchmark further "*would be wrong*" "*however tempting that may be in financial terms*" (p.135).

1.2.4 Moving Forward – The Implementation Plan for Looking Forward

In 1997, the implementation plan for the mental health strategy was published. The document, *Moving Forward: The National Mental Health Plan for More and Better Services* (MOH, 1997), specified specific targets for the forthcoming three years to achieve the objectives of the strategic plan. Funding or purchasing bodies had to report on the access of children and young people to specialist mental health services and the planned increase in baseline for access to services to 2000/2001. Similarly, targets were set for Māori and for consumer participation. Targets were set for training services in all major centres in the assessment and management of mental health problems, drug and alcohol problems and for improving liaison between services. Otherwise, little mention is made in this document about specific targets for services for children, young people and their families. Rather the strategic focus for child and adolescent mental health was the focus of a document produced in 1998.

1.2.5 New Futures – The Mental Health Strategy for Children and Young People

New Futures: A Strategic Framework For Specialist Mental Health Services For Children And Young People in New Zealand (MOH, 1998b) specified the strategic direction for mental health services for children and young people. This document noted the need for more and better services for children and young people. It argued for flexibility around the upper age range depending on the developmental, social and emotional needs of the young person.

New Futures questioned the broad application of the 5% funding benchmark across all age groups, and argued that on the basis of access need, there was greater need in the older adolescent age group of 15-19 years with progressively less need in the younger age groups. In the older age group co-morbidity particularly with alcohol and drug issues increased the complexity of care. Furthermore, it argued that in each of the age groups 0-9, 10-14 and 15-19 specialist services to care for the proportion with severe mental health problems would be necessary, whereas those with less severe problems would be assisted through consultation and liaison services.

The document also noted that the 5% figure was a national figure and was not therefore representative of local need. It stated that the responsibility for assessing local or regional needs and ensuring these needs were met remained with the local funding organisations (at the time the Health Funding Agency, HFA). Service configuration to meet the needs of local community groups was also considered to be the responsibility of the funders.

The document, in page 53, noted the following twin priorities:

- *"to assess and treat those with the most severe mental health problems*
- *to ensure support and advice for other professionals involved with those with mild to moderate mental health problems"*

The main strategy was to build on existing services by:

- Expanding existing teams
- Expanding consultation liaison services
- Establishing new specialist teams as the need is identified
- Expanding specialist services for Māori
- Increasing the skills base of the workforce
- Developing respite and day services

Although targets were set for the implementation of the Mental Health strategy in *Moving Forward*, no such implementation plan with objectives or targets were set by the Ministry of Health for *New Futures*, the mental health strategy for children. Targets then, remained those set in *Moving Forward* which applied only until 2001.

1.2.6 Blueprint – Benchmarks for Mental Health Services

Following the establishment of the Mental Health Commission, benchmarks were set to achieve the new service targets in the mental health strategy documents and to address the recommendations of the Mason report. These targets were described in the *Blueprint for Mental Health Services in New Zealand: How Things Need to Be (MHC, 1998a)*. The Commission articulated the NZ Government's plan to move from the existing 0.7 per cent of population funding for children, to 3 percent of those young people aged under 20 years. Funding for adults was to move from 1.5 percent to 3 percent per total population. It is noteworthy that whereas the 3 percent funding for adults did not include funding for alcohol and drug services, the proposed 3 percent funding for children and young people did include such funding.

In an accompanying document *The Funding Needed to Implement the Blueprint for Mental Health Services in New Zealand* (MHC, 1998b) the Mental Health Commission outlined the assumptions made in revising the benchmark for children downwards from those recommended in New Futures. With the wisdom of hindsight, some of these assumptions might now be questioned in relation to mental health services for children and young people. Nevertheless, even with the revised benchmark of 3 percent, the gap in full-time equivalent staff for services for children and young people – from that funded at the time to that needed to meet the guidelines - was identified as 780.

The document stipulated the workforce requirements and other resource guidelines for services for children, and young people:

- The number of full time equivalent staff and the number of beds or "*care packages*" needed.
- Guidelines for services for young people included resource requirements for alcohol and drug services.
- The need to set aside a proportion of the resources to develop Kaupapa Māori services for Māori (at the time nearly a quarter of the 0-14 years age group and around 20 percent of the 15 to 19 years age group).
- The expectation that dedicated services be developed for Pacific Island young people to allow a choice of service.
- The need for dedicated staff to provide service co-ordination between health agencies and government and non government sectors.
- The need to address retention issues through addressing staff morale. The effect of restructuring on workforce morale was noted: "*significant growth in services indicated in this Blueprint must be achieved in ways which boost morale and increase effectiveness...*" (p.78).
- The document consistently mentioned the need for flexible interpretation of the recommendations and the desire that the guidelines not be used to stifle innovative developments.

In *Specialised Mental Health Services for Children and Youth: A Report of a Review of Recent and planned Changes*, the Mental Health Commission (1999) noted the lack of an implementation plan for *New Futures* and the lack of any co-ordinated approach to funding for child and adolescent mental health services. Determination of any improvement over the preceding years was limited by poor data information, but indications were of more services for children and young people. The report noted that:

- there were more community based child and adolescent mental health services and;
- more funding was available for further expansion in child and adolescent services;
- there was improved targeting of services towards the children and youth with moderate to severe problems

The following breakdown (Table 1) of the benchmarks for access for children and young people to services were set in this document based on the *New Futures* recommendations to provide access to specialist services and consultation and liaison services:

Table 1. Benchmarks for Access to Specialist Mental Health Services for the 0-19 yrs Population

Age Group (Yrs)	People Requiring Direct Access to Specialist Services	People Requiring Consultation/Liaison from Specialist Services
0-9	0.5%	0.5
10-14	2.2%	1.7
15-19	3.1%	2.4

Source: Specialist Mental Health Services for Children and Youth: A Report of a Review of Recent and Planned Change MHC (1999)

The greater proposed benchmark for the 15-19 year age group was in recognition that "*youth are more affected by mental illness than any other age group*" (p.20). The benchmark figures were based on the assumption of similar age and ethnic mix per 100,000 under 20 population as was present nationally. In fact, there is considerable ethnic variability across regions.

The MHC noted that the Health Funding Authority was moving towards national service specifications for children and adolescents which would help to provide consistent service delivery. However, it was sharply critical of the HFA for not including strategic documents in its planning, namely the *Blueprint*, *New Futures* and *Looking Forward*. It noted that the Northern and Midland regions were falling behind the Central and Southern regions in community service availability. Furthermore, there were significant problems in the planning and provision of services for Māori, in consultation and liaison services, in services for young people with alcohol and drug problems, and in workforce development. It noted that *"the predicted level of service availability in 2003 will fall seriously short of the MHC benchmarks"* (p.16).

He Nuka Mo Nga Taitamariki: A National Workplan for Child and Youth Mental Health Services

In the document *He Nuka Mo Nga Taitamariki: A National Workplan for Child and Youth Mental Health Services*, the HFA (2000a) addressed the concerns expressed by the Mental Health Commission review by listing its proposed services for child and adolescent mental health and its plans for workforce development. However, it noted that "*There is a substantial shortfall in funds available to bring services up to benchmark levels*" (p.1). The document did not provide specific objectives or funding targets for its proposed developments, but noted the funding required to increase services to benchmarks. There also appeared to be some confusion in this document over funding for prevention of mental health problems and over *Blueprint* funding, which is to be used to buy new and additional services for those with existing mental health problems and, in the case of children and young people, at high risk of the development of such problems.

1.2.7 Recent Concerns

Considerable growth occurred in child and adolescent mental health services from the mid 1990s. Over the past two years, however, the Mental Health Commission has recently expressed considerable concern at the lack of progress in the development of services for children and young people. In its last *Report on Progress* (MHC 2004a) it noted that for children and young people:

> *"Services are well below Blueprint guidelines and there has been little progress in recent years. For 2002/2003 the number of inpatient beds was at 60% of recommended levels, community clinical FTEs at 65% and residential and respite care packages at 35%. However, across the country 14% of funded FTEs in services for children and young people were vacant at the end of the financial year."*

1.2.8 DHB Toolkit Mental Health

Running alongside these concerns, has been the move from a centralised government controlled funding system for health, to a largely elected District Health Board system. The document *New Zealand Health Strategy DHB Toolkit Mental Health: To Improve the Mental Health Status of People with Severe Mental Illness* (MOH 2001, p. 15) outlined the Government expectations of the DHBs in relation to mental health. District Health Boards were expected to develop partnerships with other regional District Health Boards producing regional mental health networks. Through these networks the government expected the DHBs to:

- "*identify mental health needs, and funding priorities across the region*"
- "*undertake mental health service planning for the region*"
- "*facilitate joint approaches to workforce development and recruitment*"
- "*establish processes and initiatives to promote clinical leadership and accountability*"
- *"ensure processes for accountability for mental health funding and "transparency of financial management*"

Regional support agencies were set up to assist the regional networks to undertake their tasks and the national Health Funding Agency was disbanded.

Through initiatives of the CEOs and managers of the Southern mental health services, the Southern DHBs formed the South Island Regional Mental Health Network, and produced the *South Island Regional Mental Health Strategic Plan* in February 2002 designed to inform planning for the next five years. Hawke's Bay, MidCentral, Whanganui, Wairarapa, Hutt Valley and Capital & Coast DHBs formed the Central Region District Health Boards and produced the *Regional Mental Health Strategic Plan* for July 2002-June 2004. Following the 2002 period, the Northern Regional Mental Health Network, consisting of Northland, Auckland Central, Waitemata and Manukau City produced a plan for the region in February 2004 to take it through to 2005 when a full plan for the next five to ten years would be produced. Midlands, consisting some of the most impoverished areas of the country – Tairawhiti, Bay of Plenty, Lakes, Waikato and Taranaki - produced *Midland Regional Mental Health and Addiction Services Plan 2004-2005*.

The regional strategic plans allow services to access Blueprint funding through their local District Health Board. District Health Boards therefore need to be familiar with government mental health strategy and with *Blueprint* benchmarks.

Future Strategic Directions for Mental Health: Improving Mental Health

In August 2004, the Ministry of Health released its consultation strategic plan for the years 2005-2015:

- *Improving Mental Health: The Second National Mental Health and Addiction Plan 2005-2015*

It is noteworthy that among the documents mentioned in the executive summary as significant in the development of this document, neither *New Futures* nor the *The Child Health Strategy* featured. This document does, however, provide a clear statement of the objectives for mental health for children and young people and the expected targeted actions for the DHBs.

1.2.9 Workforce Strategies

There has been clear recognition by the MHC and the MOH that if the mental health strategies are to be fully implemented, there must be a corresponding development of the mental health workforce in order to meet service demand.

The National Mental Health Workforce Development Co-ordinating Committee was set up in 1998 to provide oversight of the workforce need and to provide co-ordination, recommendations and targets for workforce development. A complete and comprehensive report of the work carried out by this group is provided in *Developing the Mental Health Workforce: A Report of the National Mental Health Workforce Development Co-ordinating Committee* (NMHWDCC, 1999). The report identified the workforce need in each mental health sector including that in child and adolescent mental health.

Tuutahitia Te Wero: Meeting the Challenges: Mental Health Workforce Development Plan 2000-2005 (HFA, 2000b) set the purchasing goals to address the needs identified in the NMHWDCC report. A recent review addressed workforce constraints (Ashton 2004) but was not commissioned to address child and adolescent mental health workforce constraints.

Te Rau Matatini was established at Massey University to provide for Māori workforce development (see below). The Werry Centre for Child and Adolescent Mental Health was established at the University of Auckland in 2002 through the funding provisions of *Tuuhitia Te Wero* to address the development of the child and adolescent mental health workforce. Peters (2003, p.4) detailed the aims of The Werry Centre:

To improve the mental health of children and adolescents in New Zealand by:

- *Providing or facilitating first-class training and support to the workforce nationally*
- *Promoting research of a high quality into child and youth mental health*
- *Advocating for the mental health needs of children and adolescents*
- *Supporting the child and adolescent mental health workforce to provide high and quality care*

Relevant Documentation

Since the establishment of these centres, certain publications have been produced to inform workforce development. *Mental Health (Alcohol and Other Drugs) Workforce Development Framework* (MOH 2002b) provided a "snapshot" of the mental health workforce development initiatives and identified future directions. However, it made no reference to *New Futures* as the mental health strategy for children and adolescents. *The New Zealand Standards 2001: The National Mental Health Sector Standard – He Whariki Oranga Hinengaro* provided important expected quality standards.

Te Rau Matatini has produced certain publications relating to Māori workforce needs (see below). The Werry Centre has produced a *Needs Analysis of Current Child and Adolescent Mental Health Workforce* (Khin, 2003) which identifies the training needs of the workforce and barriers to accessing training; Peters (2003) provided a review of undergraduate training needs with recommendations to meet these needs; and Lambie and Stewart (2003) conducted a study of psychologists in the child and adolescent sector to determine the "*incentives for, and barriers to, involvement of psychologists in CAMHS*" (p.2) for child and adolescent mental health services.

Staff who are skilled in core competencies are essential for quality services in child and adolescent mental health. Several useful documents on practitioner skills requirements have been produced. The NMHWDCC produced *Competency Framework for the Mental Health Workforce* (NMHWDCC, 1999); the MHC produced *Recovery Competencies for NZ Mental Health Workers* (MHC, 2001a); Prebble (2002) produced *Competencies for the NZ Mental Health Workforce*; and Te Rau Matatini produced *Career Pathways and Core Competencies in Māori Mental Health Nursing* (TRM 2003a) and *Orientation and Preceptoring in Māori Mental Health* (TRM 2003b). Other overseas literature has followed a similar pathway e.g. *The Capable Practitioner: A Framework and List of the Practitioner Capabilities required to Implement the National Service Framework for Mental Health* (The Training & Practice Development Section of The Sainsbury Centre for Mental Health, 2001).

1.3 Special Issues for Services for Children & Young People

Children and young people present with a number of service needs not necessarily present in mainstream adult services. In the following these service needs are detailed.

1.3.1 Services that have a Developmental Perspective

Child and adolescent mental health services may need to address both child and parental/family issues. The need for a developmental perspective is imperative, widely recognized and concisely summarised in CYF (2002, p. 7):

- *Early experiences are thought to influence and shape current behaviour but not necessarily to cause them;*
- *Children of the same age may be at different stages in their development;*
- *A child has an innate capacity to adapt to his or her environment. When these environments are disordered, these adaptations may not be healthy;*
- *.. behaviour that is normal at one age can be an indicator of a mental health problem at another;*
- *the caretaking context is very important in understanding a child's mental health problems ..;*
- *normal and abnormal behaviour are often only separated by degree*
- *a child's inherited temperament influences his or her adaptational ability and style; experience modifies or amplifies this;*
- *adult behaviour is imitated by children*

The development context of the child should be understood as a dynamic interplay between the child and the parent, such that parental or family issues may affect the healthy development of the child and the child's developmental issues may affect the response of the caregiver(s) or family.

Accepting a developmental model means providing services that are established with developmental concerns as a priority for planning. For example, separate services may need to be provided for infants, for primary school age children, for dependent secondary school aged children, and for independent youth. Recognition that child development occurs within the context of the family means that service provision must involve family considerations.

1.3.2 The Need for Co-ordinated Service Delivery

Children, young people and their families who have mental health concerns often present with needs across a number of sectors including health, education, social welfare, justice, and housing. There is evidence of a link between family adversity, parental psychopathology and the development of some mental health problems in children and young people (Goodwin, Fergusson & Horwood, 2004). There are also indications that young people with mental health problems not attending school require greater input from community mental health child and adolescent services (Gaines et al, 2003). Children under the care and protection of CYF are at greater risk of suicide attempts (Brown, 2000).

Services therefore need to address the issues for children and young people using holistic models of care, and this approach is likely to require attention to appropriate caseloads. The work also requires systemic approaches which require specialised training in family work or family therapy and/or multi-systemic therapy approaches. Government strategy endorses a whole child approach (see *The Agenda for Children* and *Youth Development Strategy*).

Care and Protection

A significant number of young people who present to mental health settings have conjoint care and protection issues. For example, Goodwin, Fergusson & Horwood (2004) found that of those young people aged 16-18 years with an anxiety disorder, 19.4% had a history of inter-parental violence, 26.9% had a history of contact sexual abuse, 13.1% had a history of physical abuse and 24.8% had a history of parental criminality. The child and adolescent workforce therefore needs to be able to address issues to do with child care and protection with their Child Youth and Family colleagues.

Physical Health

Consistent with a whole child approach, the mental health of young people cannot be viewed separately from their physical health. There are three significant reasons why the physical health of the child or young person needs to be considered in mental health provision. The first is that care and protection concerns are not uncommon in the population of children and young people who attend mental health settings (see above). Indeed, some experts argue that mental health professionals working in child and adolescent settings should understand the likelihood of coexisting abuse to be the rule rather than the exception (Friedrich 2002). Two New Zealand reports highlight the importance of health professionals taking into account the young person's physical health in relation to care and protection issues. These are Judge Brown's (2000) report *Care and Protection is about Adult Behaviour*, and the *Report of the Investigations into the Deaths of Saliel Jalessa Aplin and Olympia Marisa Aplin* (Office of the Commission of Children, 2003).

Secondly, there is evidence from Australian research that adolescents with emotional and behavioural difficulties experienced more problems with their physical health, and that these problems were severe enough to require them to seek help. Of those with high levels of physical health problems, a substantial proportion (around 58%) reported not receiving help (Sawyer et al, 2000).

The third reason concerns the effect on children and young people of powerful psychotropic medications, particularly the new antipsychotic medications. For example, there are strong anecdotal reports of considerable weight gain among young people on some of the new antipsychotic medications (Bryden, Carrey & Kutcher, 2001 cited in Turner, 2002). Such weight gain has implications for the future health of the young person: for example, the potential development of diabetes. There is increasing evidence to suggest that the physical health of people with mental health problems is substantially worse than that of others (Handiside, 2004).

There is therefore a need for the involvement of other health professionals - general practitioners, dieticians, nutritionists, and/or fitness specialists - when there is a risk of weight gain or physical health problems. There is a need for routine collection of data on the physical health of young people in mental health settings.

Relevant Documentation

The Ministry of Health produced the document *Making Links: Guidelines on Service Co-ordination for Children and Young People with Severe Mental Health Problems* (MOH, 1997b). This document clearly articulates the components of good service co-ordination including the development of inter-agency protocols, processes for determining lead agencies, the roles of the various service providers, the ways to ensure culturally appropriate services, and dispute resolution processes.

1.3.3 Collaboration of Services

Recognition that young people may need care across a number of different agencies has resulted in a persistent call for collaborative care. The government has recognised the need for the collaboration of services through the development of three key documents: *Review of the Centre Integrated Service Delivery: Regional Co-ordination – Final Workstream Report*, (State Services Council (SSC), 2003), *Integrated Service Delivery and Regional Co-ordination: A Literature Review* (Gray, 2002), and *Mosaics: Whakaahua Papariki: Key Findings and Good Practice Guide for Regional Co-ordination and Integrated Service Delivery* (see MSD website). In the first document, two levels of co-ordination were identified, both of relevance to mental health: regional co-ordination, and integrated service delivery. The following key principles were considered necessary for successful collaboration at both of these levels:

- Clarity of purpose and function
- Relationships and information-sharing
- Taking account of the local context
- Appropriate mechanisms and processes
- Governance, leadership and accountability (SSC, 2003, p.5).

Regional Collaboration

Regional collaboration was described as "*multi-agency collaboration at a strategic level*" (State Services Council, 2003, p.5) through informal groups that "*focus on relationship building and information sharing*." These were called "*Networks*." "*Partnerships*" were described as more formal arrangements whose task was "*the production of strategies, systems or services.*" Under this model, the Regional Mental Health networks would therefore more correctly be called *Partnerships*, who could perhaps actively involve the informal networks that exist in mental health as *Network* stakeholders.

An excellent model of inter-agency collaboration has been provided by the work carried out on youth offending. The *Youth Offending Strategy* provided a model of collaborative leadership, strategic development and clarity around actions expected of each agency. Another well developed collaborative inter-agency approach is modelled by *Te Rito*, the family violence prevention strategy. Recovery models in mental health, however, involve the inclusion of service users (young people and their families) in the development of strategies, planning, and service development. To what extent services users were involved in the development of the *Youth Offending Strategy* or *Te Rito* is not clear.

Integrated Services

"*Integrated service delivery*" was described as "*organizations working together at an operational level*" (SSC, 2003, p.5). Models of service delivery included joint-funded services, one-stop shops, and case management approaches.

In mental health, a description of integrated service delivery is provided by the Vancouver/Richmond Health Board (V/RHB) in Canada (V/RHB, 2000, p.7). An integrated service is described as one which is:

> *"A consumer focused approach to achieving better service outcomes with children youth and their families. Service/care plans and treatment are individualized, holistic and provide continuity of care for the client. Secondarily, it is an approach to achieving certain service system objectives (e.g. elimination of duplication, identification of service gaps, development of a more comprehensive continuum of care)….Service providers must work in collaborative partnership in order to realize a comprehensive, integrated and effective continuum and system of care for the community."*

This report described the regional partnership role that related to the integration of services. There was the development of a number of cross sector provider advisory groups whose task it was to work together to determine the service needs of particular sectors and to provide assistance with the policy development, planning of services, and best practice guidelines.

Current Collaborative Approaches with Children & Young People

In New Zealand, CYF, Health, Education and Justice are involved in inter-sector collaboration through a number of funded policy initiatives including:

- *High and Complex Needs* funding for children and young people involved for at least one year with more than one agency; Research is needed to determine how accessible this funding is to those with serious mental health problems.
- *Strengthening Families* programmes (MSD, 1999; MOH, 1999; MOH, 1996) involving inter-sector co-ordination of care for children and young people;
- *Youth Offending Strategy* (MOJ, 2002) and Youth Offending Teams (YOTs);
- *Early Start* programmes such as *Family Start* (MSD, 2003a; CCFPR, 2005);
- *Te Rito*: *New Zealand Family Violence Prevention Strategy* (MSD 2002), the inter-agency collaborative strategy for the prevention of Family Violence;
- *An Interagency Strategy For Children And Young People With Severe Antisocial Behaviour* (CYF 2004) is now underdevelopment.

Indications of further collaboration of sectors within service provision are evident at the operational level. For example, in Education, of the students seen in 2001, Resource Teachers Learning and Behaviour (RTLBs) worked across sectors with 6,409 children and young people. Other sectors included not only Special Education Support teams but also counselling services (11.7% of the students with inter-sector involvement), mental health agencies (15.5%), other health agencies (16.2%), Child Youth and Family (11%), Iwi, taurahere or Māori urban authorities (3.2%), drug and alcohol agencies (1.6%), Non Government Organisations (NGOs) (3.9%) and truancy services (5.3%) (Ministry of Education, 2003).

Barriers to Collaboration

Barriers to collaboration of services were described in SSC (2003, p.13) and Gray (2002). These are summarized below as:

- The number of agencies involved
- The frequency of restructuring of government organisations and associated "*devaluing of service delivery*"
- Centralisation and associated "*variations in levels of delegation*"
- The "*diversity of regional boundaries*" in different departments

- "*Differences between agency priorities*" and national policy priorities
- Financial resources in "*small pots*"
- Core business "*outputs*" rather than of whole of government approaches
- A "*risk-averse*" public service culture that is counter to innovation and progress
- No lead agency with oversight
- Competition between agencies for resources
- Impact of the funder/provider contracting approach
- Lack of funding for co-ordination and collaboration
- Some agencies shift responsibility to others
- "*Use of the Privacy Act 1993*" to limit information sharing.

1.3.4 The Complexity of Service Delivery

Alongside the need to involve a number of agencies, presentation with more than one mental health problem has long been recognised as a feature of child and adolescent mental health work. Fergusson et al (2003) documented some of these co-morbid associations for depression, anxiety disorder, conduct disorder/antisocial personality disorder, and substance abuse in the Christchurch and Dunedin cohorts. Of the population sampled, at age 15 years about a quarter of the cohort met criteria for at least one disorder, and 6% had at least one other co-morbidity in the preceding twelve months. At 18 years, around 42-44% of both samples met criteria for one disorder and around 16-18% met criteria for two or more.

An Australian survey of mental health and well-being found that 23% of children and adolescents (aged 4-17 years) with one of the disorders surveyed (conduct disorder, attention deficit hyperactivity disorder, and depressive disorder) met criteria of a second disorder with males more likely to show co-morbidity of these disorders than females (27% and 15% respectively) (Sawyer et al, 2000).

These data point to the complexity of the work with this young age group, and associated workforce and service requirements. The workforce needs to be competent in a wide range of skills, and the complexity of the work and relative caseloads need to be considered in order that "*safe, high quality, effective services*" are maintained while services are developed (MOH, 1998b).

1.3.5 Other Relevant Documents

In addition to the documents noted above, the *Blueprint, New Futures* and the McGeorge report, a useful framework for the development of workforce services for children is provided in *Mental Health Services – Workforce Design and Development: Best Practice Guidance* (Department of Health (DH), 2003).

1.4 Prevalence of Disorders of Children & Young People

Mental health service requirements for infants, children and young people require a clear indication of the prevalence of mental health problems among the young. The following sections provide an indication of the prevalence of mental health problems in children and young people. First, population demographics are provided, and the literature on overall prevalence is then reviewed.

1.4.1 Population Demographics

Population figures for 2001 indicate that there were 1,113,027 young people aged between ages 0-19 years or around 30% of the total population (MOH, 2004b). Projected figures for 2003 indicated that there were around 1,182,300 young people aged 0-19 years in New Zealand (Statistics NZ).

1.4.2 Prevalence of Mental Health Problems in Children & Adolescents in New Zealand

Clear indications of the prevalence of mental health problems among children and young people are essential for the estimation of service planning and determination of need for access to services. Fortunately, New Zealand has strong information from its own epidemiological child development study. The Christchurch Health and Development Study (CHDS) involved a birth cohort of 1,267 children and their families studied from mid 1977, and the Dunedin cohort involved 1,037 children and their families born in 1972 and 1973. These studies have been used to calculate the level of need for the provision of mental health services for children and young people (MHC, 1998c). A report to the Ministry of Social Development, Department of Labour and Treasury (Fergusson et al. 2003) presented the conjoint findings of these two studies which were remarkably similar.

At age 11 years, prevalence of any disorder was about 18% (Fergusson, Horwood & Lynskey, 1997). At age 15 years around a quarter of the young people met criteria for one of the DSM diagnoses anxiety disorder, mood disorder, conduct disorder, or alcohol/illicit drug dependency (Fergusson & Horwood, 2001); at age 18 years around 42% meet criteria for a diagnosis of at least one of these mental health disorders in the preceding twelve months and at 21 years, around 45% met criteria for at least one mental health disorder in the preceding 12 months (Fergusson et al 2003, p.33). These findings were considered to be largely consistent with overseas research. Feehan, McGee & Williams, (1993) noted that of the Dunedin Cohort, 42% of the children with a disorder at age 11 years had a disorder at age 15 years. Nevertheless, 81% of those with a diagnosis at age 15 years had not had a previous diagnosis at age 11 years.

At ages 15 and 18 years, rates of disorders were higher among females than males largely due to greater rates of anxiety and depression. At age 18 years young men presented with higher rates of alcohol and drug abuse/dependence (Fergusson & Horwood, 2001).

Indications were of a levelling off of the rate of development of mental health problems from age 18 to 21 years with particular vulnerability between ages 15 to 18 years (Fergusson et al. 2003). Moving from school to unemployment and gaining an early parenting role placed young men at high risk of developing a disorder at age 18 years (Feehan et al, 1995).

The samples from the Christchurch and Dunedin Child Health and Development Studies are broadly representative of the South Island, differing from the North Island in under-representing Māori and Pacific Island New Zealanders. Despite this difference the authors argue that little difference is found between the samples and nationally in physical health statistics (Fergusson, et al, 2003). It is not clear if the same applies to mental health statistics. Fifteen percent of the CHDS were of Māori ethnicity and nine percent of the DMHDS compared to national Māori demographics in which Māori constituted 22% of the population of under 20 years olds in 2001 (MOH, 2004b).

Prevalence amongst Māori

Both the Christchurch and the Dunedin development studies found that Māori clients had higher prevalence rates of mental health disorders (anxiety, depression, substance use disorders, and conduct disorders) with Māori rates of disorder between 1.5-2.0 that of non-Māori (Fergusson et al, 2003). The age range 15-18 years has been found to be a high risk period for the development of depression particularly among females (Hankin, et al, 1998).

1.4.3 Prevalence of Disorders with Significant Clinical Impairment

A Canadian paper presented an overview of prevalence studies of child and adolescent mental health using as two of its criteria of inclusion that studies must be of samples of greater than 1000 and must contain a measure of disorder *and* of impairment (Waddell & Shepherd, 2002). Studies were selected from Canada, the United States, Great Britain, Australia and New Zealand, only 6 meeting the criteria. According to this review, the rate of disorders with impairment in the community for children and youth is 15%. These are figures for those young people *with clinically significant impairment* in functioning associated with a mental health diagnosis. According to

this study, prevalence of adolescent and childhood disorders was as shown in Table 2 – with adjusted figures to indicate the New Zealand numbers.

Table 2. Prevalence of Mental Health Disorders in Young People that Cause Clinically Significant Impairment

Disorder	Prevalence (%)	Approximate Numbers in NZ
Any Anxiety Disorder	6.5	76,800
Conduct Disorder	3.3	38,900
Attention Deficit Hyperactivity Disorder	3.3	39,900
Any Depressive Disorder	2.1	24,800
Substance Disorder	0.8	9,500
Pervasive Developmental Disorder	0.3	3,500
Obsessive-Compulsive Disorder	0.2	2,400
Schizophrenia	0.1	1,200
Tourette's Disorder	0.1	1,200
Any Eating Disorder	0.1	1,200
Bipolar Disorder	<0.1	<1,200
Any Disorder	**15**	**199,600**

Source: Adapted from Waddell and Shepherd (2002)

1.4.4 Persistence into Adulthood

There appears to be a persistence of childhood disorders into adulthood. Kim-Cohen et al. (2003) found that of the Dunedin birth cohort of 1,037 tested at 11, 13, 15, 18, and 21 and 26 years of age, around 74% of adult cases had a diagnosis prior to age 18 years and around 58% prior to age 15. Of those adults receiving intensive mental health services, around 78% had received a diagnosis prior to age 18 years and around 60% had received one prior to age 15 years. Self-reported disadvantage was found to be strongly related to repeat occurrences of disorders (Feehan, McGee & Williams, 1993).

These figures have significant implications for the provision of early intervention services at child and adolescent stages in order to interrupt on-going problems.

1.5 The Cultural Needs of Children & Young People with Mental Health Problems

The following will provide an indication of the various mental health needs that occur for children, young people and their families from particular cultural groups where there is recognised need because of difficulties with accessing services and/or because of prevalence: Māori, Pacific peoples and Asians. This section is intended to assist in determining current indications of workforce need through required services.

1.5.1 Māori Children & Young People

Population Demographics

In the 2001 census data, Māori children and young people under twenty made up 22% of the population of children and young people in this age group (246,009 of 1,113,027 young people) (MOH, 2004) and were projected to be 23.4% of the population in 2004 (Statistics NZ). There are considerable regional variations in the numbers of Māori young people as shown in Table 3.

Table 3. Number of Māori Children & Young People aged 0-19 Years by Age Group & Region (2004)

Age Group	Northern	Midland	Central	Southern	Total
0-9	48,790	51,970	27,980	17,620	146,360
10-14	23,090	25,690	13,420	8,630	70,830
15-19	19,570	22,170	11,690	7,950	61,380
Total	**91,450**	**99,830**	**53,090**	**34,200**	**278,570**

Source: Statistics New Zealand Projected Numbers for 2004

Prevalence

Young Māori appear to have higher prevalence rates of mental health problems, not because of their ethnicity, but because of their significant disadvantage. There are clear historical reasons for this disadvantage associated with colonisation. Māori children and young people have disproportionate mental health needs with Māori having 1.5 to 2.0 the rate of disorder of non Māori (Fergusson et al, 2003). Slightly different patterns were found between the findings of the Christchurch Health and Development study and the Dunedin Health and Development study (Fergusson et al, 2003) in the prevalence of disorders in Māori young people. Table 4 shows the results where Māori were found to have statistically significant prevalence rates compared to those of non-Māori.

Table 4. Prevalence of Statistically Significant Higher Rates of Disorders in Māori Young People (2003)

Study	Approx. Age in yrs	Disorder					
		Depression %	Anxiety %	Conduct Disorder %	Substance Abuse %	Suicide Ideation %	Any Disorder %
CHDS	15		20.2	14.1	12.1		34.3
	18	24.6		11.8	31.8		54.6
	21		22.8	9.6	36.0		57.9
DHDS	18	27.3				21.2	57.9
	21	25.4	29.6				

Source: Fergusson et al. 2003

It is important to understand that these differences cannot be explained entirely as a result of ethnicity as such. Durie (1994, 2003) noted that consideration must be given to the history of colonisation, loss of language and cultural heritage, and loss of land and economic power that Māori have experienced and the subsequent resultant social disadvantage. Fergusson (2003) noted that the Māori children in the Christchurch study were more frequently than non-Māori reared in homes with "*material disadvantage, family dysfunction and parental difficulties that were likely to contribute to future problems of adjustment*" (p.15).

Given the prevalence rates of conduct disorder and substance abuse in young Māori for the Christchurch study, it is noteworthy that Fergusson (2003, p.18) found that when these childhood factors were taken into account, "*the association between ethnicity and interpersonal violence became statistically nonsignificant..*"

Service Needs of Māori

Māori have argued for solutions that involved holistic models of health care (Durie, 1994) or attending to the framework of the Whare Tapa Wha:

- Taha wairua (spiritual wellbeing)
- Taha hinengaro (mental and emotional wellbeing)

- Taha tinana (physical wellbeing)
- Taha whanau (whanau wellbeing)

Durie argued for attention to greater social, economic and political equity for Māori, strengthening whanau (Durie, 2003) and building Māori capacity to provide a choice of mainstream or Kaupapa Māori mental health services for Māori.

These aspirations have been endorsed in the planning provisions in the *Blueprint (p.45)*.

> *"In each region a proportion of the resource guidelines should be allocated to Kaupapa Māori services, according to the proportion of Māori in the local population*."

Following Durie's recommendations, the Mental Health Commission expects that services will provide a choice for Māori between culturally supportive mainstream services and Kaupapa Māori services; that services will be relevant or culturally meaningful and able to address need; that services will be integrated with other health services and agencies; that there will be high standards of care, and that they will be cost effective (MHC, 1998a).

Service Access

Disparities exist for Māori in the availability of services. Those areas where the Māori population is highest appear to have less mental health service spend per child and young person by DHBs than those with the lowest populations of Māori (HFA, 2000a).

Despite the *Blueprint* recommendations for development of Kaupapa Māori services for tamariki and rangatahi, in 2001, only 52 clients were recorded as having been seen by Kaupapa Māori tamariki and rangatahi (child and youth) mental health services (MOH, 2004b) and not all of these clients were Māori.

Information over 12 months in 2001 indicates that 17% of clients aged 0-19 years seen in mental health settings in NZ were Māori: 3,326 of a total population of 19,561 clients seen. Table 5 provides information on the numbers of young Māori seen in mental health services by age group for 2001 (MOH 2004b), however, this data should be used with caution as data collection was being established.

Table 5. Number of Māori Clients seen in Mental Health Settings by Age Group (2001)

Gender	Age Group				
	0-4	5-9	10-14	15-19	Total
Male	69	450	730	783	2,032
Female	37	150	418	689	1,294
Total	106	600	1,148	1,472	3,326

Source: Mental Health Service use in New Zealand 2001 (MOH, 2004b)

Significant Documents Relating to Māori

There are a number of important documents which relate to issues concerning Māori and health.

The Treaty

Māori have special status in New Zealand as tangata whenua, and the New Zealand government is bound by the treaty: Tiriti O Waitangi to work in partnership with Māori iwi, hapu and whanau, to ensure that Māori have access to resources that they are entitled to, and to ensure that Māori have full opportunities and rights to participation in issues concerning Māori. The treaty is highly significant for health, and particularly for mental health, where Māori are disproportionately represented, and where access particularly to child and adolescent

services can be difficult. This significance was recognised by the government through a number of important documents related to the provision of health services for Māori.
Developments in Māori child and adolescent mental health are a *Blueprint* priority (MHC, 2004) in recognition of need and in order to give Māori a choice of services – mainstream or Kaupapa Māori. The following documents provide some guidance for the direction of these developments.

He Korowai Oranga – Māori Health Strategy

He Korowai Oranga – Māori Health Strategy (MOH, 2002c) outlined the need to work with whanau, hapu and iwi to develop healthy Māori communities. It provides the strategic direction for the development of whanau ora or healthy families and challenges the public health sector to work in good faith to provide for the needs of whanau through addressing systemic and institutionalised barriers. *Whakatataka: Māori Health Action Plan 2002-2005* (MOH, 2002d) is the action plan for *He Korowai Oranga*.

Te Puawaitanga: Māori Mental Health National Strategic Framework

Te Puawaitanga: Māori Mental Health National Strategic Framework (MOH, 2002e) provides the strategic direction for Māori Mental Health Services, with five year goals and objectives. Two gaps are evident in the goals and objectives in this document. The first is that the MHC has indicated that because of higher need amongst Māori, the target for access for Māori should be 6% of the population under twenty not 3% (MHC, 1998a, p.57). Second, there is no specific mention of goals for child and adolescent mental health, rather priority appears to be given to adult services.

The five goals focus on:

- the need to provide cultural, clinical and support services to 3% of the Māori population in most need
- the expectation of active participation in the planning and delivery of services
- the intention to develop a choice of services – mainstream or Kaupapa Māori – for 50% of adult Māori consumers/tangata whaiora
- the need to increase the Māori mental health workforce
- and the need for intersectoral and intrasectoral co-operation

Regional Documents

Whanau Oranga Hinengaro: Northern Region Māori Mental Health and Addictions Plan (NRDHBs, 2004) identified an action plan for implementing the Māori mental health strategy in the Northern region.

Workforce Policy documents - Tuutahitia Te Weo, Meeting the Challenges

Tuutahitia Te Weo, Meeting the Challenges: Mental Health Workforce Development Plan 2000-2005 (HFA, 2000b) had as its first two goals to "*strengthen and develop the Māori mental health workforce*", and to "*strengthen and develop the child/tamaiti and youth/rangatahi mental health workforce*." Te Rau Matatini of Massey University was set up to provide a centre for Māori mental health workforce development.

Māori Child, Adolescent & Whanau Workforce Development

In February 2004, *Te Rau Tipu: Māori Mental Health Child and Adolescent Workforce Conference* was held and the conference proceedings published jointly by Te Rau Matatini and The Werry Centre for Child and Adolescent Mental Health (at the University of Auckland). Another document *Māori Child, Adolescent and Whanau Workforce*

Development (Tassell & Hirini, 2004) looked specifically at the Māori child and adolescent mental health workforce needs. *Macro-analysis of the Māori Mental Health Workforce* (Ponga et al., 2004) identified the characteristics of the Māori mental health workforce and the gaps in skills base and workforce environments that require focused attention.

1.5.2 Pacific Children & Young People

Background

Pacific people are made up of a diverse group of people from various Pacific islands and this diversity is reflected in their various languages, cultures, beliefs and practices (Bathgate, Pulotu-Endemann, 1997). The Samoan ethnic group is the largest followed by the Cook Island community, Tongan, Nuiean, Fijian and Tokelauan communities.

Little has been published on Pacific mental health in New Zealand. Bathgate and Pulotu-Endemann's (1997) paper has been used to inform this document. They note that most has been written about Samoan mental health. Pacific cultures do not have words that translate easily into "*mental illness*" and mental health is considered to be inseparable from the "*overall wellbeing of the body, soul and spirit*" (p.106).

Most – but not all – disturbed behaviour is considered to be a manifestation of an external spiritual force, especially ancestral spirits who have taken possession of the person because the person or the person's family have broken a certain custom or offended the spirits in some way. In short, there is a common belief across the pacific cultures that ancestors have a constant spiritual and physical communication with living people (p.106).

Traditional treatment involves not only the individual but the whole family, with traditional healers working to restore spiritual harmony.

Bathgate and Pulotu-Endemann provided a good summary of the risk and protective factors for Pacific peoples' mental health. Indications are that strong community ties appear to be a protective factor for the mental health of young Pacific people.

Demographics of Young Pacific Peoples

In the 2001 Census data, Pacific young people aged 0-19 years made up 7.9% of the total population of young people in this age group (87,744 of 1,113,027 young people) (MOH, 2004), and were projected to be 8.5% of the population in 2004 (Statistics NZ). Table 6 provides the population statistics by region and age group.

Table 6. Number of Pacific Children & Young People aged 0-19 yrs by Age Group & Region (2004)

Age Group	Northern	Midland	Central	Southern	Total
0-9	38,575	3,635	7,780	2,820	52,810
10-14	18,885	1,875	3,830	1,555	26,145
15-19	15,765	1,610	3,490	1,475	22,340
Total	**73,225**	**7,120**	**15,100**	**5,850**	**101,295**

Source: Statistics New Zealand Projected Figures for 2004

Prevalence of Mental Health problems

Prevalence of mental health problems among Pacific children and young people was not available from the Christchurch and Dunedin child development studies due to the small numbers in the South Island population. There appears to be a dearth of good research literature on the mental health of Pacific children and young people that would allow a good indication of their service need as opposed to their service use.

There are problems with the collecting of ethnicity information which may also influence any interpretation of need, for example the collection of Mental Health Information National Collection (MHINC) data prioritises Māori ethnicity when both Māori and a Pacific ethnicity are recorded. Some young people of both Māori and Pacific ethnicity will identify more with their Pacific heritage than with their Māori and vice versa. Furthermore, ethnocentric data collection in research studies can limit a complete picture of mental health concerns for Pacific people, for example, the use of the outcome measure HONUS/HONUSCA does not fit comfortably with Pacific holistic understandings of well-being or mental health (Pulotu-Endemann, Annandale & Instone, 2004).

Services Required & Barriers to Access

Pacific people hold holistic models of health that do not readily separate mental health problems from other aspects of well-being (Pulotu-Endeman, Annandale, Instone, 2004). Pacific peoples in the Northern region have identified their priority as the development of strong Pacific primary providers (NRPMHS/ NDSA, 2003).

The Mental Health Commission *Blueprint* expects services for Pacific young people to be developed in much the same way as are Kaupapa Māori services (see p.45 of the *Blueprint*). The Mental Health Commission expects that Pacific peoples will have a choice of either Pacific services or culturally appropriate mainstream services. Attention to the cultural needs of the young person and family, attention to the culture of the clinician and clinician bias, and attention to the culture of the mental health service have been identified as important in addressing the needs of minority ethnic groups (US Dept of Health and Human Services, 2001).

Pulotu Endemann, Annandle & Instone (2004) detailed the service needs of Pacific people and the barriers to access. Table 7 is taken directly from their paper.

Mainstream mental health services require either Pacific clinical staff or strong concomitant Pacific cultural support (or both) in order to ensure sensitive practice. In addition, services need to cater for the language needs of parents and grandparents when involving families. Good interpreter services, therefore, are essential. Ideally, clinicians or cultural support staff should be from the same Pacific country as the young person and family and able to speak the language. Services need to be wary of assuming that because a staff member is a Pacific person he or she will be able to address the needs of *all* Pacific peoples who present.

Table 7. Alignment of Services that do and do not Address Pacific Peoples' Needs

Non-Alignment of Services to Pacific People	Alignment of Services to Pacific People
Services are acute and crisis focused	Services are wellness focused
Lack of appreciation of the holistic perspective	Services work with a holistic perspective
People have to come to the service	Services come to people in their communities
Consumer's families are marginalised	Consumer's families are included
Use of medical model-no scope for alternative diagnosis	Recognition of traditional diagnoses
Services not culturally friendly	Culturally friendly services
Emphasis on medication	Embrace traditional healing
People looking after mentally ill family members are not always supported	Support for people looking after mentally ill family members
Services are based around hospital/institutional delivery	Services focus on delivery in the community
Needs are determined according to diagnosis	Needs are determined according to the assistance that a consumer requires to live well with their mental illness

Source: A Pacific Perspective on the NZ Mental Health Classification and Outcomes Study (CAOS), Pulotu-Endemann, Annandale, & Instone, (2004).

Service Provision

The Mental Health Commission (2004a) noted that while funding for Pacific community alcohol and drug services increased in 2002-2003, funding for child and youth community services decreased. They noted that:

"There continues to be unmet needs for services designed for Pacific children and youth in many places. This is significant as 48% of the total New Zealand Pacific population is aged under 20 years" (p.35).

The Classification and Outcomes Study (CAOS) indicated some issues of concern for Pacific peoples. Community settings diagnosed psychotic type disorders more commonly in Pacific young people than they did in Māori, European or other (Gaines et al., 2003). Pulotu-Endemann, Annandale and Instone (2004) raised questions about the cultural sensitivity of mainstream services and the need for consideration of cultural beliefs when making diagnoses of psychosis with Pacific young people.

Service Access

Gaines et al. (2003) found that Pacific young people had the highest rate of episodes of inpatient care compared to other ethnic groups. An episode was defined as a period of contact with the service of up to 3 months. There are two ways in which this could be interpreted. It is not clear whether this higher rate is because of a greater number of young pacific people being admitted or because of a longer period of recovery for young Pacific people in inpatient care. Pacific young people with emotional problems addressed by community mental health services had higher costs in recovery (Gaines et al., 2003). Longer recovery is likely if the needs of Pacific people are not met either within the mental health setting or through difficulties with access. Interpreter services add significantly to the cost of services but little recognition has been given to this service need in funding plans.

The numbers of young Pacific clients aged 0-19 years seen in mental health settings in New Zealand over 12 months in 2001 was 467 (MOH, 2004b). The total client population within this age group was 19,561. This figure represents 2.4% of the total population under twenty years seen. Table 8 shows the numbers seen within each age group however; this data should be used with caution as data collection was being established.

Table 8. Number of Pacific Clients seen in Mental Health Settings by Gender & Age Group (2001)

Gender	Age Group				
	0-4	**5-9**	**10-14**	**15-19**	**Total**
Male	9	48	79	136	272
Female	3	16	50	95	164
Total	**12**	**64**	**129**	**262**	**467**

Source: Mental Health Service Use in New Zealand 2001 (MOH, 2004b)

Data from the MOH *Te Orau Ora: Pacific Mental Health Profile* (p.21) showed there were 743 in this age group for the 2 year period (January 2001-December 2002).

Significant Documents

There are few Ministry of Health documents that relate specifically to Pacific Island people's mental health. This is likely to be because Pacific notions of mental health do not readily separate out from holistic health perspectives. A recent MOH publication *Tupu ola Moui: The Pacific Health Chart Book 2004* provides a stocktake of the health needs of Pacific peoples and includes a comprehensive review of service utilisation, health outcomes and determinates of health (MOH, 2004c). Bathgate and Pulotu-Endemann published "*Pacific People in New Zealand*" in *Mental Health in New Zealand from a Public Health Perspective* (MOH 1997). This provides a comprehensive background to Pacific peoples' understanding of health and needs.

The strategic framework for services was outlined in *Strategic Directions for the Mental health Services for Pacific Islands People* (MOH, 1995). *The Northern Regional Pacific Mental Health and Addictions Plan (2003/2005, p.10)* provided the goals and objectives for the Northern region in relation to Pacific peoples' mental health. The goals were as follows:

- To develop Pacific primary mental health services
- To improve access for Pacific peoples to mental health services

- To develop partnerships with organisations, communities, families and service users, which will maximize opportunities for Pacific peoples involved with mental health and alcohol and other drug services
- To develop a competent and qualified Pacific mental health workforce that will meet the needs of Pacific peoples
- To ensure that information and research on Pacific mental health will inform policy planning and service development

Workforce Issues

The Mental Health Commission (2004a, p.35) noted that:

> *"There is a shortage of experienced Pacific clinicians in mental health and, given the youthful New Zealand Pacific population, demand for Pacific staff will increase."*

Developing the Pacific peoples' workforce has been a key theme of mental health strategy documents including the *Blueprint* (1998).

The Mental Health Commission (2001b) published *The Pacific Mental Health Services and Workforce – Moving on the Blueprint* detailing areas of development for Pacific mental health and workforce development. *A Pacific Perspective on Child and Adolescent Mental Health Services Workforce Development Needs: Report from the First National Fono* (Falaefa, 2004) briefly detailed the findings of this fono and highlighted the need for more time and funding to develop the needs of this sector. A priority was to invest in Pacific peoples to provide for workforce clinical and management needs.

1.5.3 Asian Children & Young People

Asian people are made up of a diverse group of people, the largest groups in New Zealand being Chinese, Indian and Korean. A recent review detailed mental health issues for Asian people in New Zealand, particularly Chinese, Indian, Korean and Cambodian and Vietnamese (Ho et al, 2003). The following summary draws substantially from this review.

Background

Stigma is a significant issue associated with mental health problems in Asian countries:

> *"Some forms of mental illness such as schizophrenia or organic brain disorder are conceived of as supernatural punishments for wrong-doings, and as such entail intense shame and stigma. Consequently many Asians are reluctant to use mental health care .."* (Ho et al. p.xi).

Young Asians are likely to be referred to mental health services by school guidance counsellors or RTLBs, or by other health services. Referral may be quite late due to the stigma associated with mental health problems.

Population Demographics

In 2001, Asian young people aged 0-19 years made up 6.9% of the total population of young people in this age group (76,881 of 1,113,027 young people) (MOH, 2004b). Most Asian young people live in the Northern region. Projected figures for 2003 were unavailable at the time of writing.

Ho et al 2003 provided a comprehensive summary of the demographics of Asian people in New Zealand. Between 1991 and 2001, the numbers of people in New Zealand who identify as Asian doubled to 240,000 or

6.4% of the population. In 2001, most of the recent immigrants (those arriving within the preceding 10 years) lived in the Auckland metropolitan region (75% of Chinese, 75% of Indians, 70% of Koreans, 69% of Vietnamese and 50% of Cambodians). Between 43 and 50 per cent of these Asian populations were less than 24 years of age in 2001. In June 2001, around 44,300 fee-paying students were from the Asian region, particularly China, Japan, South Korea, Taiwan and Thailand (Ho et al, 2003).

English language difficulties were a significant problem for one in three of the recent immigrant males from Cambodia and Vietnam, and 47% and 38% respectively of recent immigrant females. Of those from China and Korea, 22% and 28% could not speak English. Lack of English was less of a problem for Indian men and women (8% and 14% respectively) (Ho et al, 2003).

Prevalence

Ho et al (2003) noted that prevalence studies in New Zealand have been hampered by the low numbers of Asians in the population. Suggestions are of no greater prevalence of mental health disorders among Chinese than exist in the general population. Traumatic experiences prior to migration can seriously affect the mental health of Asian immigrants. Southeast Asian refugees, in particular, may be at high risk of post-traumatic stress disorder associated with prior trauma. There are also indications that depression associated with discrimination may be a problem for some groups.

The following risk factors were identified as contributing to the development of mental health problems in Asians (See Ho et al., pp 35):

- Discrimination
- No close friends
- Ethnic isolation
- Low English proficiency
- Unemployment
- Lack of university education
- Younger age range (26-35)
- Shorter residency
- Regrets about coming to New Zealand

Protective factors were:

- Family support
- Friendships
- Supportive local ethnic communities
- Receptivity of the host country

Barriers to Access

Barriers to service use were identified by Ho et al. as:

- lack of English proficiency
- lack of knowledge of services
- lack of translated information about services
- significant cultural differences in understandings of the nature of health
- inadequate translation services and interpreter services
- lack of privacy due to use of friends or family members as translators
- interruption of family hierarchical structure through the greater English proficiency of children and the use of children as translators
- stigma associated with mental health problems
- culturally inappropriate assessments

- young practitioners
- cultural conflicts in styles of communication
- negative perceptions of therapists
- inflexible appointment schedules
- available cultural match of clinicians

These barriers indicate that service needs are:

- skilled interpreters
- interpretation of document
- culturally sensitive services
- addressing issues of stigma
- use of mature and culturally sensitive clinicians
- flexible hours
- accessible services
- a workforce of diverse Asian cultures

Service Access

In 2001, 250 Asian young people aged 0-19 years were reported as being seen in mental health settings in New Zealand (MOHb, 2004). This represented 1.3% of the total number of clients aged under 20 years (19,561). Table 9 shows the distribution of young people seen within each age group.

Table 9. Number of Young Asian Clients seen in Mental Health Settings by Gender & Age Group (2004)

Gender	Age Group				
	0-4	**5-9**	**10-14**	**15-19**	**Total**
Male	2	18	34	60	114
Female	3	12	31	90	136
Total	**5**	**30**	**65**	**150**	**250**

Source: Mental Health Service use in New Zealand 2001 (MOH, 2004)

Most of these clients were seen in the Northern region, particularly in the Auckland metropolitan region.

1.6 Specialist Service Needs

Child and adolescent mental health services are expected to provide specialist services to children and young people. This section details the various groups of children that are likely to require specialist services in child and adolescent mental health centres, and their needs.

1.6.1 Children with Serious Mental Health Problems

Serious mental health problems in children and young people are those that are likely to cause significant disability and impairment in adulthood if not well managed early. The mental health problems likely to result in psychiatric hospital admissions and that may place the young person at considerable risk are those that result in psychoses – psychotic disorders and bipolar disorders in particular. Severe anxiety disorders such as obsessive compulsive disorders can also cause significant impairment, although hospitalisation is less common.

Children with serious mental health problems may be identified by health services, by secondary school services, care and protection services, or through the justice system.

Prevalence

Psychotic disorders and bipolar disorders are not common in young people. They are rare in young people under 15 years of age, most developing symptoms after age 15 years.

- **Psychosis and Bipolar Disorder**

International literature puts the prevalence of schizophrenia with impairment at 0.1% of young people, and the prevalence of bipolar at less than 0.1% (see above) (the NZ epidemiological cohorts were not big enough to allow strong conclusions to be made about such small groups). Psychotic symptoms need to persist for a period of six months for a DSM diagnosis of schizophrenia. The prevalence of psychotic episodes among young people is therefore likely to be higher than 0.1%. The development of anxiety disorders in childhood may be associated with later development of psychotic symptoms. Prior panic attacks appear to increase the odds of subsequent psychotic symptoms at age 18 and 21 years threefold (Goodwin, Fergusson & Horwood, 2003b).

In order to prevent the occurrence of prolonged psychotic symptoms, the referral to appropriate services of those young people with psychotic symptoms causing impairment in functioning is important. Beiderman et al (2004) found that 8% of 1,657 children and youth referred to a mental health service were experiencing the presence of delusions or hallucinations. These young people experienced high levels of impairment usually with associated co-morbid symptoms of disruptive behaviour, mood or anxiety disorders. For those young people with a diagnosis of bipolar disorder, the risk of suicide is high (Lewinsohn, Klein & Seeley, 1995).

Gaines et al (2003) found that young people with psychosis were the group that was most costly for inpatient services in New Zealand. Young people may require admissions to hospital if the psychosis is not identified early or if there are difficulties in maintaining the initial recovery. Admission can be traumatic for young people and good Early Intervention Services may prevent such occurrences.

- **Severe Anxiety Disorders**

Severe anxiety disorders can also be seriously disabling if not managed early and well. Obsessive compulsive disorder is one such disorder; however prevalence information is not available through the Christchurch and Dunedin study because of the small numbers. Similarly, little information is available on the prevalence of severe post-traumatic stress disorder in New Zealand children.

Key Documents

The MHC (1999) has provided guidelines for the development of Early Intervention Services. The Health Research Council has published a review of the literature on early intervention services and a stocktake of New Zealand services in its document *Evaluation of Early Intervention for Psychosis in New Zealand: What Works?* (Turner, 2002). Indications of the community cost of treating those young people with psychotic symptoms are provided in the *New Zealand Mental Health Classification and Outcomes Study: Final Report* (Gaines et al, 2003).

The *High and Complex Needs Strategy* provides a means of accessing funding for those young people with complex needs. Research needs to be conducted to determine whether this funding is being accessed by those young people with serious mental health problems.

Required Services

The MHC noted the need for both inpatient and community services for young people with serious mental health problems.

Early psychosis intervention services are now considered to be necessary in order to prevent the development of chronic and serious mental health problems in those presenting with psychotic symptoms (Turner 2002). Some of the features of Early Intervention Services are:

- a recovery focus
- an approach aimed at destigmatisation
- good continuums of care
- outreach services that provide care in the person's home
- day programmes aimed at assisting young people to transition back to peer related activities: school or vocational training, or work

EPPIC, developed in Melbourne, provides booklet resources that give guidelines for such services for adults. Young people under 20 years of age require a slightly different focus with attention to the intense family work and inter-agency involvement that is required. A multidisciplinary team and a skilled key worker approach are needed to maintain continuity of care. Auckland Central's Kari Centre Youth Early intervention Service has operated one such programme for young people in their teens (Turner, 2002). Important features that emerge following Turner's (2002) review for Early Intervention services for children and young people are detailed in Box 1.

Box 1. Service Requirements for Early Intervention Services for Children & Young People based on Turner's (2002) Report

- Consumer involvement in planning and supported recovery
- An accessible family and youth friendly community facility and service.
- An accessible keyworker or case manager with a case load that allows an intensive response to a crisis situation (during the day) – ability to provide an outreach service.
- An optimistic recovery focus and a focus on destigmatising mental health problems.
- Continuums of care with a keyworker available to work flexibly with the young person across agencies – in and out of hospital and facilitating access to- and work with other agencies.
- Access to acute inpatient care
- Access to crisis services (outside daytime hours)
- Keyworker expertise and maturity: knowledge of adolescent developmental milestones; knowledge of key therapeutic approaches including cognitive behavioural treatment for psychosis, family work, multisystemic therapy, psychoeducation, psychotropic drug effects, relapse prevention, risk assessment and alcohol and drug harm reduction approaches, assessment and management of other co-morbidities, crisis management.
- A multidisciplinary team that functions as a supportive team, with keyworker access to a variety of skills. (A back-up co-keyworker is helpful to cover keyworker leave).
- Routine involvement of the family at all stages of care.
- Culturally sensitive staff and access to cultural support and interpreters.
- Ready access to respite care, supported accommodation or foster care services, and consultation and liaison services (e.g. in schools).
- Staff knowledge of Early Intervention principles. Ongoing access to training and skills development for staff.
- Staff with knowledge of good medical practice with young people: new atypical antipsychotic medications, and low dose practice, physical health complications.
- Access to dietician and nutrition services.
- Access to a community based Youth Transitional Programme to assist with recovery through the transition of the young person back to school or into work.
- Ideally an associated after school Youth drop in centre.
- Managerial support and advocacy. Funding to support young people for as long as recovery takes. Competent clinical team leadership.

These services are best provided through community settings with back-up resources available through inpatient services; respite services and supported accommodation (see *New Futures*).

A recovery focus requires access for young people to a return to school or transition into work if their mental health problems have interfered with their usual activities. Youth Transitional Programmes have been recently reviewed by the Ministry of Social Development through its Youth Transitions Report Series 2003 (Higgins, 2003; Hill, 2003; McLaren, 2003), indicating the mental health cost to young people of long periods of inactivity. This series indicates the value to the mental health of young people of specifically designed programmes that are available to transition them into, training, work or age appropriate activities. One well developed programme, the Youth Transitional Programme, has operated from Kari Centre, Auckland District Health Board, providing individual time-limited transitional programmes to young people with serious mental health problems or serious emotional disturbances with good outcomes (Hicks, 2001).

Service Provision

The Early Intervention Service provision available within New Zealand for young people is summarised by Turner (2002). Many of the adult Early Intervention Services provide a service to young people from 17 or 18 years.

Turner's stocktake indicates that many of the services for young people surveyed did not meet the needs of young people in providing for their developmental age group: some with an age range of early teens to the thirties; others not able to provide an independent service for young people due to the rural location of the service. Young people have noted that they prefer services within their age range as they find services that they have to attend with adults scary (MOH, 2002f).

Workforce Issues

Many of the Early Intervention Services did not meet the criteria of having a multi-disciplinary team (Turner 2002). Very few had any consumer involvement in planning, and some did not have access to Māori or Pacific cultural services. The summary does not detail any Kaupapa Māori Early Intervention services or Pacific services. Some services had very little dedicated psychiatry time and some had no access to allied health professionals such as clinical psychologists, social workers or occupational therapists. The lack of these resources would seriously impact on the recovery focus of the services. There is therefore a strong need to develop the workforce and service delivery in Early Intervention services for young people.

Service Access

Specific details of access to services of this group were not available.

1.6.2 Children & Young People with Serious Emotional Problems

Children with serious emotional problems may be identified by health services, by preschool educational services or by care and protection services.

Serious emotional problems can occur in infancy, childhood or in adolescence. In infancy, such problems may show as failure to thrive, anxiety through phobias and separation anxiety, and depression evident through withdrawal may also occur. Mild occurrences may be managed through the *Early Start* or *Family Start* programmes offered in collaboration through CYF, Education and Health, but persistence and severity will require referral to paediatric services or community child and adolescent mental health services.

Children and young people with serious emotional problems may present with severe anxiety and/or depression and/or self-harm (not intended to kill) or suicide attempts. Some young people will present with eating disorders. Such problems may lead to disruption in schooling that can impact substantially on their later well-being. Gaines et al. (2003) found that those young people who were unable to attend school and/or who were self-harming were two of the high cost groups for community child and adolescent mental health services.

Prevalence

The Christchurch and Dunedin child development study provide indications for the prevalence of some of these problems.

- **Anxiety and Mood Disorders**

There were fairly similar indications of the prevalence of anxiety and mood disorders at age 15 and 18 years, although rates do not take into account clinical impairment. Fergusson, Horwood and Lynskey (1997) noted that at age 11 years, around 7.4% of young people met the criteria for an anxiety disorder and about 1.8% for mood

disorder. Fergusson and Horwood (2001) found that at 15 years, 18.8% of young females and 6.9% of young males met the criteria for an anxiety disorder; 9.2% of 15 year olds females and 3.3% of 15 year old males met the criteria for a mood disorder. At age 18 years, 22.3% of females and 11.7% of males met criteria for an anxiety disorder, and 26.4% of females and 9.7% of males met criteria for a mood disorder.

In summary, around 9.2% of 11 year olds, around 19% of 15 year olds and around 35% of 18 year olds met criteria for either an anxiety or a mood disorder. Māori may be about 1.5 times more likely to develop such disorders than Pakeha (Fergusson, Horwood and Lynskey, 1997). Females are substantially more at risk for anxiety and depression at all age levels relative to males.

- **Self Harm**

There is little New Zealand information about deliberate self harm, in young people, that is not intended to kill. Young people who self-harm and/or who have emotional symptoms have been found to require significant involvement by community mental health services in New Zealand (Gaines et al, 2003). Costs of their community care ranged from a mean of $1,403 for those with mild emotional problems to a mean of $2,983 for those with mild to severe self injury problems. Overseas research suggests that around 6-8% of young people aged around 15 years may be deliberately self-harming (De Leo & Heller, 2004; Ystgaard et al, 2003; Hawton et al, 2002), and the minority received help. Indications are that about a third of those who have experienced sexual abuse engage in acts of self-harm (Edgardh & Ormstad, 2000).

- **Suicidality**

In recent years, attention has been focused on those young people who deliberately self-harm in an attempt to kill themselves. New Zealand young people aged 15 to 24 years have been reported to be at high risk of suicide relative to other OECD countries (Pelkonen & Marthunen, 2003; MOH, 2002f). Of those in the Christchurch development study, 2% of 15 year olds reported attempting suicide and 3.6% of age 18 year olds reported a suicide attempt. Of those in the Dunedin cohort, 10.6% of those at or around 18 year reported suicide ideation (Fergusson, Poulton, Horwood, Milne, & Swain-Campbell, 2003).

In those aged under 15 years, suicide is not common. In 1999, females aged 15-19 years were at high risk of suicide (14.5 per 100,000) with young men between ages 20 to 24 having rates of 41.2 per 100,000 (MOH, 2002f). Māori young people were found to have higher rates of suicide than did non- Māori.

The New Zealand government has directed resources towards the prevention of suicides in 15-24 year olds with the Suicide Prevention Strategy: *Kia Piki Te Ora O Te Taitamariki: Strengthening Youth Wellbeing* and *In Our Hands.* A substantial suicide prevention programme operates through the Ministry of Youth Development. A comprehensive stocktake of the funded suicide prevention programmes is available on the Ministry's website.

- **Eating Disorders**

Little information was available on the prevalence of eating disorders in children and adolescents in New Zealand from the Christchurch and Dunedin studies due to the low numbers. Overseas research indicates a prevalence of 0.1% of eating disorders with clinical impairment in young people (see above).

Co-morbidity & Repeat Occurrence

Co-morbidity is common among those with severe emotional problems. Anxiety and depression are highly likely to show co-morbidity in 18 year olds (Fergusson et al., 2003). Those with anxiety disorder were between 1.3 and 3.9 times more likely to develop substance use dependencies (Goodwin, Fergusson and Horwood, 2004a), although this link was not causal. Rather, the association appeared to be related to the factors likely to bring

about the anxiety disorder – e.g. family adversity, parental psychopathology, child abuse and subsequent related substance abuse, peer affiliations and co-morbid depression.

The 13% of the Christchurch cohort that developed depression between ages 14-16 years were at increased risks of later major depression, anxiety disorder, nicotine dependence, alcohol abuse/dependence, suicide attempt, educational under-achievement, unemployment and early parenthood (Fergusson & Woodward, 2002c). Anxious/withdrawn behaviour at age 8 was found to be associated with the development of anxiety disorders and major depression at ages 16 – 21 years (Goodwin, Fergusson & Horwood, 2004).

Service Access

This group of young people are likely to be a significant number of those attending community child and adolescent mental health settings, Child Youth and Family and school guidance counsellors. Little literature was available on the access of this group to services in New Zealand.

Sawyer et al (2000, p.32) noted that of the young people that they surveyed,

> *"Seventy five per cent of those attending specialised mental health services had a very high level of [emotional and behavioural] problems, while only 41% of those who received counseling in schools had this level of problems. Approximately 60% of those attending family doctors, paediatricians and private psychologists or social workers had a very high level of problems."*

Service Need

Young people with serious emotional problems are likely to require similar services to those needed for early intervention, although with less intense involvement except during acuity. Respite care is likely to be used more than inpatient care, although inpatient care will be required periodically for those with severe eating disorders. Care and protection services and special education services may be required for a significant proportion of this group. There is a substantial literature on proven therapies for anxiety and depression, and dialectical behaviour therapy is useful for those who self-harm. The Australian and New Zealand College of Psychiatrists (RANZCP) has recently released Clinical Practice Guidelines for the treatment of Anorexia Nervosa (RANZCP, 2004).

Relevant Documents

Relevant reviews of mental health of young people in New Zealand that discuss anxiety and depression are available in *The New Zealand Youth Health Status Report* (MOH, 2002); *A Review of Evidence: In our Hands – The New Zealand Youth Suicide Prevention Strategy* (MOH, 1998); and *Mental Health in New Zealand from a Public Health Perspective* (MOH, 1997). The Ministry of Health (1999) produced *Better Times: Contributing to the Mental Health of Children and Young People*. Indications of the cost of treating those young people with emotional problems, self harm and related school attendance problems are provided in the *New Zealand Mental Health Classification and Outcomes Study: Final Report* (Gaines et al., 2003).

1.6.3 Infants, Children & Young People with Developmental Problems

Infants, children or young people with developmental problems may be identified through referrals from the health services, care and protection services, through education services or through justice services.

Developmental disorders are usually, but not always, identified during childhood. These disorders include feeding and eating disorders of infancy or childhood, difficulties with the infant-primary caregiver relationship (attachment disorders), pervasive developmental disorders such as autism and aspergers, elimination problems such as

enuresis or encopresis, problems with emotional regulation, attention deficit and early disruptive behaviour disorders.

Prevalence

Information is available on the prevalence of some of these disorders through the Christchurch and Dunedin studies.

- **Attention Deficit Hyperactivity Disorder**

This group forms a substantial number of those seen in child and adolescent mental health services. Information on the prevalence of ADHD has been collected through the Dunedin and Christchurch child development studies. The prevalence of ADHD has been found to be around 2% (Dunedin cohort) to around 5% (Christchurch cohort) in 15 year olds (Fergusson, Horwood & Lynskey, 1993). Fergusson and Horwood (2001, p. 291) noted that:

> *"…early attentional problems in the absence of early conduct problems are associated with increased risks of school failure but not with increased risks of delinquency and substance abuse."*

However children with both early attention *and* conduct problems are more likely to develop "*later delinquency, substance abuse and school failure*" (Fergusson & Horwood, 2001, p.291).

- **Pervasive Developmental Disorders**

The Christchurch and Dunedin studies were not big enough to provide firm conclusions about the prevalence of pervasive developmental disorders and other less common conditions.

- **Severe Attachment Disorders**

There was no recent literature accessed on the prevalence of attachment disorders in New Zealand.

Service Needs

Early identification of developmental disorders is important in order to pre-empt later associated problems. Identification of difficulties may occur through any of the services, but a clear diagnosis will only be possible by those trained well and with experience in child and adolescent mental health. These young people may require specialised care in Education and Health services, in addition to any care required through care and protection services. In recent years, there has been concern expressed about the available provision of funding to Health and Education services to meet the needs of those with severe ADHD and Pervasive Developmental Disorders.

Service Inter-collaboration

CYF, Health and Education have directed significant funding into *Early Start* programmes designed to address the needs of those infants to school age who are considered to be at risk. An evaluation of the *Family Start* programme is underway currently (MSD, 2003a).

An interdepartmental group, the *Autism Services Interdepartmental Working Group*, was set up to address the needs of children and young people with autistic spectrum disorders with the Ministry of Health as the lead agency.

Other agencies involved at the time were the Ministry of Education, Special Education Services, and Child Youth and Family. There was no readily available literature on the work of this group.

Service Access

Literature on access to Health, Education and CYF of this group of children and young people was not readily available and therefore has not been reviewed. It is likely that a significant group of children and young people who access CYF are at risk of attachment disorders. It is also possible that those infants accessing maternal mental health services with their mothers are at risk, and those identified by parents as "difficult" during preschool years are likely to be at risk of attachment difficulties.

Relevant Documentation

The Ministry of Education produced *An Evaluation of some Programmes for Children with Autistic Spectrum Disorder in Auckland: Opportunities, Contingencies and Illusions*. The Mental Health Commission (2000) produced *Clinical Assessment of Infants, Children and Youth with Mental Health Problems*. The Ministry of Health (2001) produced *New Zealand Guidelines for the Assessment and Treatment of Attention-Deficit/Hyperactivity Disorder*.

1.6.4 Children & Young People with Substance Abuse Problems & Other Dependencies

Young people with significant substance abuse problems may be identified through schools, CYF, through Health services or through the Justice system.

Unlike adult services, the funding for mental health services for young people includes funding for substance abuse problems. *The Blueprint* recommends that such services be part of the child and adolescent mental health services rather than situated with adult services.

Prevalence

A review of the literature, *New Zealand Youth Health Status Report* (MOH, 2002), noted that: 50% of young people who later went on to report heavy drinking had begun drinking prior to 15 years; in 2000, 14-19 year olds and females were drinking more than they were in 1995; and alcohol is a leading cause of death for youth.

Cannabis use is also common in young people with 20% of the Christchurch cohort having used cannabis prior to age 16 years (Fergusson et al., 2003). Of NZ school students aged 16 years, 50% had tried marijuana (AHRG, 2003). Arrests and convictions for cannabis use did not reduce use in young people (Fergusson, Swain-Campbell & Horwood, 2003).

A small number of NZ school students used other substances, 11.5% of males and 11.0% of females (AHRG, 2003). These other substances were ecstasy, glue, hallucinogens, narcotics, and stimulants.

Recently, the gambling acts of young people have increasingly been identified as a dependency issue of concern. The Public Health sector of the Ministry of Health has now accepted gambling as a public health issue and is involved in implementing prevention strategies.
Overall prevalence rates of substance use dependencies are provided by the Christchurch and Dunedin development studies (Fergusson et al., 2003). At age 15 years, 5.8% of the Christchurch cohort had a substance abuse or dependency problem. At age 18 years, this prevalence rate had increased to 23.7% in the Christchurch cohort. Of the Dunedin cohort, 20.8% had a substance abuse or dependency at age 18 years.

In the Christchurch cohort, at age 15 years there was no significant difference between young women and young men in the rates of substance abuse or dependency. Both the Dunedin and the Christchurch study found that at

age 18 years and 21 years, young men had significantly higher rates of substance abuse or dependency than did young women.

At all ages, Māori in the Christchurch cohort were found to have significantly higher prevalence rates of substance abuse or dependency. No such statistically significant findings occurred at ages 18 or ages 21 in the Dunedin study.

Co-morbidity

High co-morbidity was found in both the Christchurch and the Dunedin studies between substance use and conduct disorder (Fergusson et al., 2003). At age 15 years in the Christchurch study, the co-morbid association between substance abuse and conduct disorder was strong, as was the association between substance abuse or dependency and suicide attempt. At age 18 years, the Christchurch cohort and the Dunedin cohort showed strong associations between substance abuse or dependency and conduct disorder.

Those young people with anxiety disorders have been found to have a higher likelihood of an associated substance abuse disorder. Goodwin, Fergusson and Horwood (2004a) found that those young people with a diagnosis of anxiety disorder "*had odds of substance dependence that were 1.3 to 3.9 times higher*" than those young people without such a diagnosis. This association was not causal but explained by a number of intervening factors including familial and childhood factors (family adversity, parental psychiatric problems, child abuse, etc), peer relationships and comorbid depression, and prior substance use problem.

High associations have also been found between those with a psychosis and substance use disorders (Turner, 2002). In reviewing the literature, Turner noted that a "*significant minority*" of young people with a first diagnosis of psychosis had significant use of alcohol or drugs. Continued associated psychosis and drug use may reduce antipsychotic medication taking and hamper recovery.

Services Required

In 2000, the Health Funding Authority identified the following service needs for young people with alcohol or substance abuse problems:

- *Kaupapa Māori early intervention and community treatment services for tamariki and rangatahi with alcohol and drug abuse problems*
- *Early intervention and treatment services designed for and with Pacific communities*
- *Expansion of services for early intervention, consultation and liaison, specialist interventions, and dual diagnosis*
- *Designated places for opioid addicts in methadone treatment programmes*
- *Detox facilities available for youth transferring to secure service/prison*
- *Improved intersectoral responses to substance abuse (p.25)*

More recently, calls have been made to increase the skills of the mental health workforce to intervene with alcohol and drug therapies. This call has occurred because of the high level of association between substance abuse problems and other mental health problems. Recommendations are for staff to be skilled in motivational interviewing and harm reduction strategies (Turner, 2002).

Service Access

Literature on the access to services of this group of young people was not found in the literature search.

1.7 Consultation & Liaison Services

Child and adolescent mental health services are expected to provide specialist services not only to those with severe mental health disorders, but they are also expected to provide consultation and liaison to those professionals working with children with mild to moderate presentations of the disorders (MHC, 1998). This section addresses the areas of consultation and liaison.

Many of the disorders in the previous section may occur in a mild or moderate form and children and adolescents who present with these problems may be the point of liaison between other services and specialist child and adolescent mental health services. Children and young people may also present with two other problems of concern to professionals working with them: trauma, and severe behavioural problems.

In the first part of this section, information is provided on these two further problem areas that are commonly the focus of liaison with professionals in child and adolescent mental health services. The second part of the section details information about the funded child and adolescent services that are likely to be involved in liaison and consultation services, their workforce needs and strategies.

1.7.1 Traumatised Children

Traumatised children are likely to come to attention of care agencies through a number of different ways including through the family court which provides programmes for young people who have witnessed violence between their parents under the provision of the Domestic Violence Act; through CYF where young people who have been abused or neglected will be referred; through the sensitive claims unit or victim support services of Accident Compensation Corporation (ACC) for sexual abuse; through refugee services; and through schools where the response to trauma may be evident.

Mental health services are not funded to provide services to traumatised children unless they have a mental health disorder or post-traumatic stress disorder that is not resolving. Mental health services are commonly involved, however, in a consultation and liaison capacity.

Not surprisingly, many young people seen in mental health services have an accompanying background of trauma (Freidrich, 2002). A recent review of the literature indicates that it is not uncommon for professionals in mental health settings to miss the presence of abuse as a factor in the presentation of people to mental health settings (Wells, 2004). Clear policies on the identification, assessment and management of trauma in child and adolescent mental health settings are therefore important.

Prevalence

Little information is available on the prevalence of traumatised children in New Zealand as such. However, indication of the extent of the problem can be determined by attending to related statistics.

- **Children and young people who have been physically abused or neglected**

Young people under 17 years who have been physically abused or neglected may be placed under the care of CYF. Around 27,000 notifications of possible child abuse were received by this agency in the year 1999/2000; of these around 22,000 required further attention (MOH, 2001c). Eight to 10 percent of notifications received had had a previous notification within the past 12 months, and 43% had had a notification prior to the previous 12 months.

Woodward & Fergusson (2002) found that 6.2% of the Christchurch cohort reported that their mothers had regularly used physical punishment and 1.3% said they had been subject to overly frequent, harsh, or abusive treatment by their mothers during childhood. Children with behaviour problems and lower intellectual ability were at risk – conduct problems between the ages of 6-13 years being a particular risk. Other risk factors were

maternal history of strict parental discipline, maternal depression or alcohol and drug problems, early motherhood, and exposure to inter-parental violence.

- **Children and young people who witness parental violence**

Children who witness violence between their parents, particularly that initiated by the father, are more vulnerable to anxiety disorders, conduct disorders and alcohol and drug problems in their late teenage years (Fergusson & Horwood, 1998; Holden et al., 1998; Graham Bermann & Levendosky, 1998). New Zealand research indicates that around one third of men had used at least one form of physical violence against their female partners during their lifetime, and around 20% had used at least one form of physical abuse in the past year (Leibrich, Paulin & Ransom, 1995). More recent research with NZ women has confirmed the extent of the problem (Fanslow & Robinson, 2004). This research would suggest that children as witnesses of such violence in New Zealand may be common. The policy of New Zealand Police is to notify CYF when children are present at domestic violence incidents to which police are called.

- **Sexually abused children and young people**

Overseas research indicates that around a third of those young people who are sexually abused engage in self-harm (see above). Many of those young people who have been sexually abused will present to mental health services because of self-harm. Many children and young people who have been sexually abused will come to the attention of CYF through notifications if attention is drawn to the sexually abusing adult. Others may seek sexual abuse counselling services through the sensitive claims unit of ACC or through school guidance counsellors. Children exposed to more severe physical punishment are at increased risk of exposure to sexual abuse (Woodward & Fergusson, 2002). Among NZ women, 20% of those exposed to sexual abuse as a child were identified as having psychiatric disorders compared to 6.3% of those who had not been abused (Mullen et al., 1988).

- **Refugee children**

Children who settle in New Zealand as refugees will have experienced trauma and displacement. The Ministry of Education has recognised the need for services for refugee children through its publication *Interventions for Refugee Children in New Zealand Schools: Models, Methods and Best Practice*.

Services Needed

Children who have been traumatised may need services across a number of sectors including care and protection services: CYF, Health services (physical and mental), Education and Justice. Appropriate therapeutic responses require knowledge of ways of working with trauma in children. Specific programmes have been developed for child witnesses of domestic violence and traumatised children (Jaffe et al., 2000; Graham-Bermann & Edleson, 2001). A recent service at Kari Centre in Auckland provides an inter-agency centre for refugee and migrant children exposed to trauma who require collaborative care.

1.7.2 Children & Young People with Severe Behavioural Problems

Children and young people with severe behavioural problems are likely to be identified early through preschools, schools and through health services such as Plunket, general practitioners and paediatricians.

Children and young people with severe behavioural problems are likely to require significant resources particularly from Education and CYF. However, they are also at risk during adolescent years of substance

use/dependence, and of suicide attempts (Fergusson et al, 2003). Without early intervention these are the young people who may well end up in our Justice system.

Child and adolescent mental health services are not funded to provide services to those young people with behavioural disorders, but they may be expected to provide consultation and liaison services, and to be involved should serious mental health problems develop.

Prevalence

The prevalence of children with serious behaviour problems during primary school has been determined through school surveys and published in the *Church Report – The Definition, Diagnosis and Treatment of Children and Youth with Severe Behaviour Difficulties* (Church, 2003). This study of children in South Island schools found a prevalence rate of between 4.5-5.0% of all children. Around 1.5% required constant supervision.

This prevalence rate is remarkably similar to that found by Fergusson et al (2003) at ages 15 and 18 years. At around age 15 years, 5.0% of young people in the Christchurch cohort met the criteria for conduct disorder. At around 18 years, the prevalence was 4.8%. At around 18 years, 8.1% of the Dunedin cohort met the criteria for conduct disorder. At around 21 years, these rates had reduced a little to 3.8% in the Christchurch cohort and 3.2% in the Dunedin cohort. An Australian survey of 4,500 children aged 4 to 17 years found a prevalence of aggressive behaviour of 5.2% among children aged 4 to 17 years. Around 5.5% of those aged 4-12 years showed aggression problems and around 4.5% of those aged between ages 13-17 years showed problems (Sawyer et al., 2000).

There were significantly greater rates of conduct disorder among males in the Christchurch cohort with prevalences of 3.5% for females and 6.5% for males at age 15 years; 1.7% for females and 7.9% for males at age around 18 years; and 1.4% for females and 6.3% for males at age 21 years in the Christchurch cohort (Fergusson et al., 2003). Similarly in the Dunedin cohort, 3.3% of females and 12.6% of males met criteria for conduct disorder at age 18 years and 0.6% of females and 5.7% of males met criteria for antisocial personality disorder at age 21 years. Among males, chronic physical aggression during primary school years was found to be a risk factor for on-going violence and for other forms of delinquent behaviour (Broidy et al., 2003). This was not found to be the case for females.

Of the Christchurch cohort, Māori were found to have higher prevalence rates of conduct disorder/anti-social personality disorder at age 15 years (14.1% in Māori; 3.5% in non-Māori), at age 18 years (11.8% in Māori; 3.8% in non-Māori), and at age 21 years (9.6% in Māori; 3.0% in non-Māori). These differences were not found to be significant in the Dunedin cohort (Fergusson et al., 2003). It is not clear whether socio-economic status was controlled for in these data. Fergusson, Horwood & Lynskey (1997, p.140) noted that in the Christchurch cohort,

> *"…when due allowance was made for socioeconomic and related factors, the differences between Māori and non- Māori on measures of .. juvenile offending tend to be small and frequently statistically non-significant."*

Long-Term Effects

In reviewing the outcome literature, Church (2003) noted that the outcome for those young people with serious behavioural problems was not good in adulthood. The following were listed as adverse outcomes:

> *"unemployment, mental health problems and psychiatric disorders, alcoholism and other forms of substance abuse, early pregnancy and early fatherhood, drunk driving convictions and loss of licence, criminal offending, multiple arrests and imprisonment… higher rates of domestic violence, separation and divorce, higher rates of injury and hospitalization, and a shortened life expectancy."*

Of those identified at age 8-10 years as having "*conduct problems*", 40% had engaged in repeat offending or had significant problems at age 18 years. The Church report stated that about 7-9% of all boys go from being antisocial children to delinquency and adult offending.

Young people with conduct disorders were also found to have to be at greater risk of suicide attempts. For example, those in the Christchurch cohort who were identified as having conduct disorders at age 14-15 years were found to have a significantly greater risk of a suicide attempt between ages 12-15 years with an odds ratio of 9.9 (Fergusson et al., 2003). At age around 18 years, the odds ratio of a suicide attempt for the Christchurch cohort was 4.1, and of suicide ideation for the Dunedin cohort was 3.7. There was greater risk of later delinquency, substance abuse and school failure in children with early conduct *and* attention problems (Fergusson & Horwood, 2001). Those with early conduct difficulties but without associated attention problems were at risk of delinquency and substance abuse but not educational failure.

Service Needs

Health is not funded to provide therapeutic services to those children and young people with severe behaviour difficulties unless there are associated mental health problems. Children with uncomplicated conduct disorders are expected to receive services from CYF, through the Education services and through the Justice system. Resource teachers (RTLBs) provide services to such children in schools.

Recently, there has been a strong inter-agency focus on youth offending, with Health, Justice and CYF collaborating on inter-sector approaches to produce local Youth Offending Teams (YOTS). In these initiatives, youth mental health services provide assessments for mental health disorders and make recommendations for interventions.

Overseas research indicates that an aggressive population focused early intervention programme for children of early primary school age is effective in interrupting on-going severe behavioural problems (Zubrick, 2002). This programme focused on teaching parenting skills using established parenting programmes (*Triple P* Programme) with parents of children identified as having problems, with good outcomes.

The Ministry of Justice has provided a comprehensive stocktake of services in its *Youth Offending Strategy* that details a number of prevention, early intervention and therapeutic services available to address severe behavioural problems. Gaps are evident in prevention and early intervention services for school age children and for youth transitioning into work or early adulthood. An inter-agency initiative is now underway to address this gap with the development of an *Interagency Strategy for Children and Young People with Severe Antisocial Behaviour* (CYF, 2004).

1.7.3 Funded Government Services involved in Liaison & Consultation

A number of different government funded liaison services are used by children and young people with mental health problems in New Zealand. These involve Health, Education, CYF, and Justice. While child and adolescent mental health services will provide services to the children, young people and their families with moderate to severe presentation of disorders, these other sectors will provide services to those with less severe presentations. They may be critical to the identification of those who should be referred to child and adolescent mental health services for specialist care. While little published information was available on the work of these services it is important to be aware of the services offered. Some of these services are therefore briefly listed here.

Consultation Liaison Services in General Hospitals

These services consist of teams of mental health professionals who work with children young people and their families who come to the attention of health care professionals through their admission into general hospitals. These general hospital staff then refer on to the child and adolescent consultation liaison service. For example, Auckland City Hospital has a consultation liaison team consisting of child psychiatrists and child psychologists who work with this group of young people. Referrals may involve, for example, eating disorders in infants, psychosomatic disorders, and anxiety disorders.

Consultation & Liaison Services for Child Youth & Family

Some CAMHS provide dedicated teams for liaison with CYF. These services may provide assessment only services, providing psychological assessments and making recommendations for interventions to staff working for Child Youth and Family. The services are also used to provide training and liaison services to CYF. For example, Kari Centre in Auckland Central provides such a service.

Consultation & Liaison Services with the Schools

Some CAMHS provide a dedicated consultation and liaison services to schools and other primary care providers. These services may offer destigmatisation programmes to schools; dedicated consultation teams that are available on a regular basis to consult with school guidance counsellors, resource teachers, and deans over young people who are causing concern; training and education to staff about mental health problems in children and young people; and educational and information material for children, families and teachers. The Liaison Education Adolescent Programme (*LEAP*) developed at the Kari Centre is one such programme in secondary schools. This programme provides resource information for children, families and teachers on its website.

Consultation & Liaison Services for Justice

The recognition in Youth Courts of the need for the assessment of young people coming before the courts resulted in some CAMHS services forming consultation and liaison services for the Justice services. These services provide assessment and recommendations for those young people referred because they have been incarcerated and/or are causing concern, or because they are before the courts and there is a need to determine the young person's mental health status. Reports may be requested under the *Children Young Persons and their Families Act 1989*.

1.8 Funded Government Sector Services, Access Issues & Workforce Needs

Government funded services are expected to address the prevention of mental health problems in children and young people, their early intervention and late intervention. Services may be delivered across a range of sectors. In the following, the main sectors involved are detailed. Access issues relating to each of the sectors are discussed and workforce issues noted.

1.8.1 Health

Health provides funded services through mental health services for children and young people, through paediatric services, through child and adolescent liaison services in general hospitals, through public health nursing services, and through general practitioners. Most child and adolescent mental health services are provided in the community (MOH, 2004). There are three mental health inpatient services nationally for children and young people: in Auckland, Wellington and Christchurch.

Services Required

The MHC (1999, p.22) noted services in the proposed national service specifications that were considered to be needed in order to provide a range of mental health services for children, young people and their families:

- Early intervention services
- Liaison and consultation services
- Crisis intervention services
- Crisis respite services

- Carer relief
- Acute inpatient service
- Community day programme
- Intensive care service
- Child and youth primary mental health service
- Community child and youth mental health services
- Youth specialty services
- New anti-psychotic medications
- Supported accommodation ("*therapeutic foster care or residential services*")
- Kaupapa Māori services
- Alcohol and drug services

(The latter three had been omitted from the proposed HFA national service specifications)

A World Health Organization (WHO) report (WHO, 2003a) documented the priority areas for service development based on the frequency of occurrence, the degree of impairment, *"therapeutic possibilities particularly at primary care level"* and *"long-term care consequences*" (p.5). At early childhood, learning disorders and ADHD were considered to be priorities; at middle childhood, Tics (Tourette's syndrome) was a priority; and at adolescence, depression and suicidal behaviour, and psychosis were priorities. In addition, outside age group classifications, the following areas were considered to require "*treatment at higher levels of complexity*" (p.6) pervasive developmental disorder, attachment disorders, anxiety disorders, conduct disorder/anti-social personality disorders and eating disorders. Alcohol and substance abuse intervention was necessary as the latter was considered to increase and add to the complexity of these various disorders.

Continuums of Care

Health is expected to provide a service not only to those with severe to moderate mental health problems but also to those in the mild to moderate range. However, the Ministry of Health does not yet have a primary prevention strategy for mental health (Joanne Chiplin, personal communication).

Vancouver/Richmond Health Board (2000) described a model for continuums of care from prevention to early intervention, to basic mental health to structured day services, to 24 hour care; with crisis and emergency services operating across all except the prevention services.

> *"The continuum of services must be organized into a coordinated network of system of care delivered in an integrated manner. Service components of the continuum are interdependent with the effectiveness of any one component related to the availability and effectiveness of other components appropriately balanced between less and more intensive and restrictive care. Children and youth should be served within the least restrictive, most normative environment appropriate to their needs" (p.6*).

Such continuums of care would ensure smooth and coordinated access to services.

Access to Child & Adolescent Mental Health Services

While the *Blueprint* overall target is 3% of the population under 20 years, service provision and workforce capacity falls far short of this benchmark. In the 2002-2003 year period, only 1.1% of young people under 20 years of age were seen at any funded mental health services (MHC, 2004a). This compared to 2% for adults in most regions. The reported child and young people service teams have increased from 8 in 2001 to 24 in 2003 but 19,386 under 19 year olds were seen in 2003 compared to 19,561 seen in 2001 (MHINC data).

Service development for child and adolescent mental health care in NZ has fallen short of that proposed in the *Blueprint* in recent years. Young people under 20 years make up around 30% of the population but received only 10.5% of the overall mental health funding expenditure in the year ending June 2003 (Gaudin, 2004).

The Ministry of Health and the Mental Health Commission carried out a study of the District Health Boards use of mental health ring-fenced funding to determine why such little recent progress had been made in mental health service development (MOH/MHC, 2003). Of the six DHBs studied, five showed under-delivery in child and youth mental health, and four noted that of those services where under-delivery occurred, funding was diverted elsewhere (in mental health). The Mental Health Commission (2004a) noted the wide range of District Health Board disparity for this age group, with funding ranging from 41% of the *Blueprint* guidelines in Counties Manukau to 81% in Waikato District Health Board.

Access to services remains a significant problem for children and young people. A study of service use of four to17 year olds in Australia who met criteria for one of three mental health disorders (ADHD, conduct disorder, depression), showed that of those who were considered to have a significant mental health problem, and whose parents considered they needed help, only 8.7% had attended a mental health clinic, and only 17% had attended any mental health service (Sawyer et. al., 2001). Only 50% had received some sort of professional help. Among adolescent males, ADHD and oppositional defiance disorder were found to predict high service utilisation, as was substance use disorders in the parents (Cornelius et al., 2001).

Assuming a prevalence of mental health problems in children and adolescence likely to cause significant clinical impairment of 15%, current NZ service use figures for 2003 suggest that only 10% of young people who need to access a mental health service are accessing one in NZ (MHINC data). This finding is consistent with the Australian research.

Barriers to Access

Sawyer et al (2000) identified the barriers to accessing services among Australian parents and among those adolescents identified as having mental health problems. Reasons parents gave for not getting help from a professional were that they didn't know where to go for help or services were too expensive (50%); they thought they could cope alone (46%); they had tried unsuccessfully to get help or had to wait too long (slightly less than 46%); and were worried about what others would think (6%).

Of the adolescents in this study with mental health problems, barriers to access were that this group preferred to manage alone (38%); thought nothing would help (18%); did not know where to go (17%); and were worried about what others would think (14%).

Cornelius et al (2001) found that in adolescent males the main predictor of decreased use of services was the father's cannabis use. Factors that predicted unmet treatment need were the young person's conduct disorder, the mother's substance abuse disorder, greater numbers of siblings, and a parental history of anxiety disorder.

Workforce Issues

Child and adolescent mental health services have consistently been limited by shortages in the workforce. The MHC (2004a, p.32) annual report for 2002/2003 noted that:

> *"there was no growth in child and youth services. While the number of FTE positions funded continued to grow, there was a high vacancy rate across the country. Workforce development remains an issue for the sector.."*

1.8.2 Child, Youth & Family

> *"Child, Youth and Family contributes to government's broad outcomes in two sectors: the social development sector and the justice sector"* (CYFS Statement of Intent (SOI), 2005/6, p. 23).

Child, Youth and Family (CYF) have two key roles. CYF provides services to "*children who need care and protection or who offend*" and "*support and assist their families to keep their children safe.*" CYF also *"facilitate and*

collaborate in the delivery of high quality services by other service providers to children and young people who are living in circumstances where they are at risk of being in need of care and protection or committing offences" (CYFS SOI 2004/5 p8). CYF is bound by the requirements of the *Children, Young Persons and their Families Act 1989*.

"*The department delivers the following key services*" (CYFS SOI, 2004/5, p. 9):

- "*Information and education to promote public awareness and prevent child abuse and neglect, including public education programmes that relate to the safety of children and the prevention of child abuse"*
- "*Statutory care and protection and youth justice services to children, young people and their families. This includes a wide variety of activities*"
- *"The development and funding of community* services"
- *"Adoption services"*
- *"Policy advice and services to the Associate Minister for Social Development and Employment (Child Youth and Family) and other Ministers"*

CYF has an important role in the development and delivery of collaborative inter-sectorial programmes (See Chapter 1.3.3 & Chapter 2.3.4).

Workforce Issues

In 2001, the CYF workforce was described as the biggest employer of social workers in the country, with over 2000 social workers, co-ordinators and social work supervisors. This group made up 57% of the workforce with further support staff consisting of psychologists, evidential interviewers, and legal advisors (MSD, 2001).

In recent years, CYF has been under severe strain through social work staff shortages resulting in:

> *"unacceptable numbers of unallocated cases, .. social workers making decisions without adequate supervision, .. the placement of the child with its family became secondary to other statutory concerns, .. issues concerning access to therapy"* (Brown 2000, p.85).

CYF employ around 2300 staff approximately *"half of which are social workers and supervisors delivering core social work services"* (CYF SOI 2004/2005, p.8).

"The labour market supply of qualified social workers is tight, and affects most providers of care and protection and youth justice services." There are issues of both supply and capability (CYF SOI 2004/2005, pp. 26-27).

Strategies to Address Funding & Workforce Issues

Care and Protection is about Adult Behaviour: The Ministerial Review of the Department of Child, Youth and Family Services (Brown, 2000) investigated CYF responsibilities in relation to the death of a child known to the service, and identified resource difficulties and failure in government funding responsibilities. It recommended a *Blueprint* for CYF with benchmarks for services.
The strategy *New Directions* (CYF, 2001a) was designed to address the concerns identified in the Brown report in relation to CYF and the care and protection community, that is, those within and outside CYF involved in care and protection work. *Te Pounamu-Manaaki Tamariki, Manaaki Whanau* (CYF, 2001b) was the Māori strategy developed alongside *New Directions*.

Department of Child, Youth and Family Services First Principles Baseline Review (CYF, MSD & Treasury, 2003) followed an approach by CYF to government for increased funding due to the findings of the Brown report. Cabinet

requested this *Baseline Review* in order to clarify the roles, responsibilities and expected outcomes of CYF and in order to determine the baseline funding required to meet expected tasks.

The review was undertaken by the Ministry of Social Development (MSD) and CYF. It identified a service under severe strain.

> *"CYF is in a serious position now. Pressure on service delivery is high, retention of staff is difficult, and morale is variable. ..Volume pressures have increased the amount of time spent on investigation and reduced that spent on other areas of social work, such as managing children and young people who are in care. Increasingly this is likely to put client outcomes at risk."* (CYF, MSD & Treasury 2003, p.12).

The report recommended an immediate injection of funding and the development of steps to address the shortfall in funding to CYF for the 2006/2007 budget. Recommendations were made: to improve the quality of response to repeat notifications, to attend to children placed in out of home care, and to develop CYF into a "*learning organisation*" (p.12).

The Care and Protection Blueprint (CYF, 2003) was developed to improve the planning and delivery of care and protection services. Some areas of action identified were:

- To involve Māori leadership, Pacific people and young people in the planning of services and the provision of care and protection services
- To improve inter-agency co-ordination
- To address workforce issues
- To enhance good practice

Care and Protection Workforce Development: A Report from the Workforce Development Group: Action Area 8 – Care and Protection Blueprint (MSD, 2004, p.36) identified the following workforce goals for the care and protection sector based on the *Blueprint* recommendations:

- *"Developing a workforce that is responsive to the care and protection needs of Māori children and young people"*
- *"Developing a workforce that is responsive to the children and young people from Pacific and other diverse ethnic/cultural groups."*
- *"Challenging negative perceptions of care and protection work."*
- *"Developing a competent care and protection social work workforce"*

Mental Health Needs of CYF Clients

A review was carried out in 1999 to determine the number of children in CYF care with some form of mental health problems (Wells & Smith, 2000, p.21; CYF, 2002, p.13). The conclusion was that:

> *"….it is expected that over 3,100 clients of Child, Youth and Family will have a mental health problem at any one time, and that of these over 2,000 will be severe or moderate."*
>
> *".. the Department can expect that approximately one-third of youth services clients will have a moderately or severe mental health disorder."*

Young people aged between 14-20 years were mostly affected with 67.5% being male and 32.4% being female. Most were Pakeha (50%) with 37% being Māori and 5% being Pacific peoples. The main diagnoses were alcohol and drug disorders (30%); conduct disorders and oppositional defiance disorders (11% total); and attention deficit disorders (10%). Severe behavioural disorders, depression and suicidal behaviour, and post-traumatic stress disorder account for around 6-8% each. The main services provided were individual or family therapy. Full 24 hour residential care was provided for 9%; 7% receiving alcohol or drug services (Wells & Smith, 2000, p. 23; CYF, 2002, p.13).

When young people present to CYF with co-existing mental health problems, CYF will be the lead agency if the mental health problems are secondary to the care and protection, behavioural, or youth justice issues. The child and adolescent mental health sector is expected to provide for the young person's mental health needs.

Children in the care of CYF or in transition to adulthood are those vulnerable to mental health problems:

> *"It is estimated that 12% of children and young people in CYF .. will have severe mental health problems…a further 35-75% are estimated to have clinically significant emotional and behavioural problems (approximately 3000-5000). .. almost half of those who complete suicide in this age group [14-16] in the general population will have had contact with CYF*" (Brown, 2000, p.95).

In the *Ministry of Social Development: Statement of Intent 2003* (MSD, 2003) document, the Ministry noted the children and young people at risk: The substantiated abuse or neglect rate was 5.5 for every 1000 children under 17 years of age and 5% of under 17 year olds were involved in significant criminal activities (2000 figures). Furthermore, 10-17% of young people aged 15 to 19 years were not in formal education, training or work at any given time (2002 figures).

CYF Service Provision

CYF provides early intervention services to care-givers and infants under 5 years who are considered to be at risk. The Family Start programme has been undergoing evaluation and a report of the process of evaluation is available: *Family Start Process Evaluation Final Report (MOE/MOH/MSD, 2003). The MSD – Statement of Intent 2003* stated that there were 8.6 births per 1000 females aged 13-17 years in 2001. Other early intervention programmes are *He Tipu Ora*, aimed at supporting Māori mothers until the child is 5 years old, *Whanau Toko I Te Ora*, which focuses on improving outcomes for Māori through child development and strengthening cultural identity, and *Anau Ako Pasifika*, a home based early childhood and parent support programme (MSD, 2001). CYF funds a suicide prevention service – the *Towards Wellbeing National Suicide Monitoring Programme*. This programme is part of the *National Suicide Prevention Strategy*.

CYF is the key provider of services for young offenders and works with other agencies to address the needs of young people. For example, it works to provide services for young people with complex needs across agencies (*High and Complex Needs, Strengthening Families*); to provide services for young offenders across agencies (*Youth Offending Strategy*); and to address family violence issues across agencies (*Te Rito*).

Access to Services

Under the Children, Young Persons and their Families Act (1989), CYF is required to investigate reports relating to the care and protection of children and young people under 17 years of age. The Government through the Director General of CYF is required under law to ensure that there are adequate resources to carry out the provisions of the Act (Brown, 2000).

Capability issues have recently precluded the full and timely allocation of all notified cases of concern requiring investigation, although this is improving. The report *Children in New Zealand: Report on Cross-Sectoral Outcome Measures and Targets* (MOH, 2001c) details the current provision of services. There were many children returning to CYF notice through repeat notifications. There was an increased need for care and protection services: there was an increased need for out-of-family care and protection bed nights between 1999 and 2000 compared to 1997/1998 and 1998/1999. Demand for care and protection services increased at an average rate of 9.6 per cent per annum from 1996 to 2000. During the period ending 2000, CYF was unable to reach its targets to reduce child abuse notifications.
These issues have significant implications for children and young people's mental health, as the relationship between care and protection issues and poor mental health is strong (see Prevalence section).

Other Documents of Relevance

These include *Working with children and Young people with Mental Health Problems and their Families and Whanau: A Guide for Child, Youth and Family Staff* (CYF, 2002); *Te Rito – New Zealand Family Violence Prevention Strategy*; the *Youth Offending Strategy* 2002; and *High and Complex Needs Strategy*.

1.8.3 Ministry of Education

The Ministry provides early intervention support for children with moderate, high or very high needs from birth or from the time of identification, until the transition to school. Early education services may be the first place where children with developmental needs or early emotional, behavioural, or learning difficulties are identified. For this identification to occur, staff need to be trained in infant and child developmental milestones and the likely presentation of certain problems. They need to have access to liaison staff with the local child and adolescent mental health services in order to ensure that appropriate referrals occur.

Workforce

Schools provide specially trained staff to work with children with special learning and behavioural needs: speech-language therapists, special education advisers, advisers on deaf children, occupational therapists, physiotherapists, registered psychologists, kaitakawaenga, early intervention teachers, behaviour, communication and other education support workers. Group Special Education (GSE) provides specialist services to children and young people. Resource teachers (RTLBs – Resource Teachers Learning and Behaviour), school guidance counsellors and other resource workers are important referral sources to mental health clinics, often identifying children whose difficulties go beyond uncomplicated learning problems and who require further assessment through health services. Schools can buy in support programmes for children and young people with social or emotional needs if criteria for funding are reached.

School guidance counsellors are commonly employed in secondary schools, and some schools now employ other support workers such as social workers in schools (MOE, 2000). Published information on the service provision of school guidance counsellors in New Zealand, however, was not able to be found through Ministry of Education web sites. Australian research suggests that school guidance counselling is one of the services most used by children and adolescents with mental health problems (Sawyer et al., 2000). Liaison access to mental health services and CYF is therefore essential.

Access to Special Education Services

There appears to be very little literature available through the Ministry of Education websites on the access needs or use of special education services generally. Resource teachers who work with learning and behaviour difficulties (RTLBs) submit an annual report, the latest published report being in 2001 (MOE, 2003). This MOE report was used to inform this document. The report details the number of young people seen by the RTLBs and the numbers of RTLBs by region.

In 2001, RTLBs worked with 19,430 individual students. This figure excluded students that were involved in group work. A disproportionate number of boys and Māori were seen. Most RTLBs worked in primary schools (85.2%), around 40% worked in intermediate schools and around 46% worked in secondary schools – most worked with 3 or 4 schools. There were regional variations with those in the Northern region having the least involvement with secondary schools students (38% in the Northern region; 46% or more in other regions).

Workforce Issues

While the information here represents the work of RTLBs, school guidance counsellors, educational psychologists and deans are other important groups providing counselling support and assistance to students in need. Information on workforce issues was not readily available. Access to special education resources has, over the last 10 years, been the subject of considerable media comment.

1.8.4 Ministry of Justice

The youth Justice sector consists of the Ministry of Justice, the Police, CYF, and the Courts.

Certain young people come to the attention of the Justice services through criminal activities investigated by the Police. These young people may be brought before the Youth Courts where a provision may be made to determine their mental health status. Under the Children, Young Persons and their Families Act (1989) or the Criminal Justice Act (1985) legislation may be enacted in order for a psychiatric report to be provided to the court.

Some young people are incarcerated for crimes committed. These young people are held in correctional institutes such as Kingslea in Christchurch serviced by CYF. The care of these young people has usually occurred through the collaboration of CYF, Justice, and Corrections (for those over 16 years). Traditionally the Health services has not been involved in the establishment of these services, yet they may be required to provide mental health services to young people held in these services.

Overseas research suggests that incarcerated young people under 18 years have high mental health needs, one study finding nearly two thirds of males and three quarters of females meeting diagnostic criteria other than conduct disorder (Teplin et al, 2003). Around half had substance use disorders; more than 20% of females had a comorbid major depression. Indeed, co-morbidity was significant (Abram et al, 2003) with 56.5% of females and 45.9% of males having 2 or more disorders. The extent of youth offending and associated incarceration is therefore important.

The Ministry of Justice (MOJ, 2002) noted that Police apprehensions of young offenders was consistently around 21-23% of all offending, but prosecutions increased from 2,734 in 1991 to 4024 in 2000. Prosecutions were usually for property offences or violent offending. Less than 5% of young people aged under 17 years of age committed most of the youth crime, but these offenders are likely to create a significant cost to the community if their offending is not addressed (MOJ, 2002). Low risk offenders are estimated to cost $1,100 per young person, whereas 2 or 3 months custody in a CYF residence was estimated to cost $27,000 (MOJ, 2002). If the young person goes on to offend as an adult, imprisonment was estimated to cost around $50,000 per year.

Prevalence literature on conduct disorder and associated mental health problems has been reviewed above. Substance abuse has been recognised as significant for young offenders in New Zealand. A trial Youth Drug court has been an initiative driven by the Youth Court judges.

Strategic Framework

An outcome of a Ministerial taskforce established in August 2000 to address youth offending was the *Youth Offending Strategy* (MOJ 2002). This strategy sets out the goals for an inter-agency approach to youth justice including addressing leadership issues through the development of a Ministers group, the development of a senior officials group to oversee the development of local offending teams and the development of an independent advisory council. It also provides strategies to address the delivery of services in youth justice, and the development of "*new and comprehensive intensive interventions*" particularly for those young people who seriously offend. Finally it sets strategies to address the improvement of information and data collection concerning youth offending.

A comprehensive stocktake of services for children and young people is provided as an Appendix to the *Youth Offending Strategy*. This stocktake covers prevention services such as Family Start, early intervention services and later intervention services across the child and youth sector.

The *Youth Offending Strategy* provides a broad ranging approach to the prevention of crime, including clear identification of the need to provide for prevention and early intervention by addressing the well-being of infants, children and youth. This response is dependent on a strong and seamless inter-agency response. The strategy defined the following areas for action (p.19):

- *Co-ordination and leadership of the prevention and response to youth offending*
- *Develop information systems to better identify issues for young offenders and inform interventions, policy and practice*
- *Promote well-being in families in order to prevent offending*
- *Promote well-being in children and young people identified as at risk*
- *Address the Police first contact response*
- *Address the Family Group Conference response*
- *Provide an intensive response to serious young offenders*

Service Access

The *Strategy* document identified the lack of good information systems that would allow clear identification of the needs of young people, particularly of those who offend (MOJ, 2002).

The lack of resources for CYF and for mental health services for young people has been cited by the Youth Justice sector as impacting significantly on the ability of the Justice sector to intervene early with young offenders (MOJ, 2002). In particular, the sector has argued that the ability to effectively carry out family group conferences and responses to young offenders has been compromised by the need for a CYF focus on care and protection issues. The result has been neglect of the youth offending obligations of CYF. In addition, the lack of specialist mental health services for young people at risk, particularly alcohol and drug services, has seriously impacted on the youth justice sector, and compromised an early intervention response to youth offending. Comment has also been made about the inadequacy of resources for Police Youth Aid professionals who are critical to family group conferences for youth offenders (MOJ, 2002).

Information to date is that Māori are significantly over-represented in the Youth Justice system. Māori youth comprised around half of those apprehended but were up to 90% of those seen in the Youth Courts (MOJ, 2002). Māori young people have been found to be disproportionately represented in arrests and convictions for cannabis use compared to similarly using others (Fergusson, Swain-Campbell & Horwood, 2003). Concern was noted about the relationship between young Māori and the Police. Although not generally over-represented in youth justice statistics, Pacific young people were overrepresented in the violence statistics (MOJ, 2002). The Justice sector identified:

> "*..a lack of culturally-appropriate, accessible and effective services for both Māori and Pacific families and whanau experiencing multiple disadvantages, especially young parents*" (MOJ, 2002, p.27).

Being female "*is a significant protective factor*" for youth offending (MOJ, 2002, p.12), although proved female cases for violent offences had increased from 23 in 1991 to 88 in 2000.

Workforce Issues

The *Youth Offending Strategy* document identified the response to the prevention of crime as necessarily involving multiple sectors working collaboratively. The Youth Justice response is therefore significantly affected by the lack of funding of other sectors and resultant workforce issues, poor provision for liaison services, and the lack of availability of a wide range of programmes and services for children and young people (MOJ, 2002).

1.9 Concluding Comments

This review has attempted to identify the mental health service needs of children and young people. The review has described the evidence indicating the relatively high prevalence of mental health disorders with clinical impairment among young people. Internationally, a prevalence rate of 15% has been found among children and young people. Greater prevalence occurs in the teenage years and there is now strong evidence of the contribution of psychosocial factors. Māori are 1.5 to 2.0 times more likely to develop mental health problems than are non Māori. There is a trajectory of mental health problems in some young people from childhood into adulthood.

Internationally, governments have begun to recognise the need to address the mental health requirements of the young. There is now wide recognition that if children and young people are unable to access mental health services, their problems may be more complex and difficult to manage by adulthood.

Benchmarks for mental health service delivery to children and young people in New Zealand have been set at 3% of the population of 0-19 year olds over a six month period. While *New Futures* was produced to provide the strategic direction for the development of services, there has been no implementation plan developed for this strategic plan. A clear implementation plan would provide greater guidance to planners and providers of services.

Despite these benchmarks, access to services for the young remains problematic with only 1.1% of young people under 20 seen at any funded mental health service compared to 2% of adults in the year ending 2003. A growth in teams does not appear to have resulted in a growth of young people seen. Progress in the development of CAMHS appears to have stalled in the last two years.

Recognition that the workforce would never be able to fully address the mental health needs of the population was recognised in *New Futures*. The role of the mental health workforce detailed in this document was not only to provide specialist services to the seriously disturbed, but also to provide consultation and liaison services. Good models of consultation and liaison service delivery are available in some New Zealand CAMHS.

There are clear gaps in the workforce needed to provide specialised services to children and young people in all government sectors associated with child and youth care, with resultant lack of adequate care and protection services and health services for children and young people with significant mental health problems. The sectors that address youth offending have identified the high cost of adult service provision if significant behavioural problems are not addressed through early intervention or prevention services for the young through workforce shortages. Gaps in one sector were found to seriously impact on others.

Workforce issues clearly remain a concern in the mental health sector. This issue also appears to be a problem in CYF. These workforce issues impact on the delivery of prevention and early intervention services in other sectors. Further research is needed to determine the contributing factors to this ongoing problem.

Few models of service delivery for infants and children and young people were available. Internationally, mental health policy makers and planners appear to be breaking new ground in the development of services for infants, children and young people.

In New Zealand, a number of gaps in services were identified which need to be addressed if the mental health needs of young people are to be met. The literature suggests that there are issues to do with the equity of mental health service provision to young people relative to adults, to Māori and Pacific people, and to Asian people relative to others. Substantially fewer young people from each of these cultural groups were accessing services than would be expected. There are legislative obligations to address such inequities. Continuing development of the mental health workforce in these cultural groups will be essential to the healthy development of culturally appropriate services.
High costs should be expected for those with mental health problems that are not addressed through early intervention or prevention programmes. Most young adults who present to mental health problems have been found to have a history of mental health presentations prior to age 18 years. Details of the access of these seriously disturbed young people to appropriate services was not available. Better data collection will assist in determining to what extent their need is being met. Clear goals for the on-going development of Early Intervention Services may be helpful. A strategy for the primary prevention of mental health problems is needed.

While these gaps are clearly problematic, there are other initiatives which appear to provide fine models of collaborative care across sectors. Some such interventions are currently being implemented through *Early Start* programmes with at-risk infants involving CYF, Education and the Health sector. The *Youth offending Strategy* provides an excellent model of leadership and service integration and shows a level of commitment to the reduction of youth offending through the co-ordination of services and through continuums of care. This *Strategy* also showed, however, the ways in which lack of funding or quality service provision in certain sectors can impact on the outcomes for young people in other sectors. These shortfalls highlight the need for collaboration, the need for resources and the need for the development of services informed by research.

On-going evaluation of inter-agency service provision requires workforce skills in mental health and social research. The challenge is to the various government sectors to provide the leadership to address these interconnections, in order to improve the well-being for all infants, children, young people and their families.

Finally, recovery approaches in mental health require the involvement of service users: children, young people and their families, in the planning and development of services. This involvement is also expected under the United Nations Conventions on the Rights of the Child. Government documents are available to guide services in the involvement of children and young people in decision-making. Incorporating the involvement of children, young people in strategy development, in service development or planning will require a committed workforce, competent in working with young people in constructive and innovative ways.

Clearly, the mental health workforce alone will not be sufficient to address the need in child and adolescent mental health. Developing effective consultation and liaison services, and employing the experiences of service users and community support will therefore be essential.

Chapter 2

Provision of Services

2.0 Provision of Services

The objective of this Chapter is to identify to who is providing government funded services to children and adolescents with mental health needs.

2.1 Purchasing of Services

Children and adolescents require specialist mental health services which are provided in an age and developmentally appropriate manner (Mental Health Commission, 1998). These dedicated services are child and adolescent mental health services and they are provided throughout the country by both District Health Boards (DHBs) and Non-Government Organisations (NGOs) however, most NGOs mainly offer consumer and family support services. DHBs, as funders, purchase mental health services from both the DHB provider arm and NGOs. This is done by a system of national purchase units, which include various services such as: crisis, acute inpatient, community, respite and residential services. The table below lists the purchase unit codes that are used to purchase child and adolescent mental health services and their corresponding descriptions. In addition, some child and adolescent mental health services are funded and provided under adult purchase units (see Table 11). These services were not included in the DHB and NGO surveys.

Table 10. Child & Adolescent Purchase Unit Codes

Purchase Unit	Purchase Unit Description
MHCR10	Child & Youth Community Residential Care
MHCS08A	Children & Young People Community Services (Other Clinical FTEs)
MHCS08A1	Children & Young People Community Services - Needs Assessment (Other Clinical FTEs)
MHCS08B	Children & Young People Community Services (Senior Medical FTEs)
MHCS24	Child & Youth Day Services (Part of Inpatient Service)
MHCS33	Liaison with Child Youth & Family Service
MHCS38	Child & Youth Day Activities
MHCS39	Kaupapa Māori Mental Health Services - Tamariki & Rangatahi
MHCS47A	Child & Youth Intensive Clinical Support Services (Other Clinical FTEs)
MHCS47B	Child & Youth Intensive Clinical Support Services (Senior Medical)
MHCS48	Child & Youth Wrap Around Services
MHCS49	Child & Youth Acute Care Packages
MHIS07	Child & Youth Inpatient Beds
MHRE04	Child & Youth Planned Respite
MHRE05	Child & Youth Crisis Respite
MHCR19	Child & Youth Community Alcohol & Drug Residential Services
MHCS21.7	Advocacy/Peer Support/Consumers (Child)
MHCS22.7	Advocacy/Peer Support - Families/Whanau (Child & Youth)
MHCS36A	Children & Youth Alcohol & Drug Community Services (Other Clinical FTEs)
MHCS36B	Child & Youth Alcohol & Drug Community Services (Senior Medical)

Source: MOH

Table 11. Child & Adolescent Mental Health Services Purchased under Adult Codes

Contract Level DHB Name	Contract ID & Description	Purchase Unit Code	Purchase Unit Code Description	2003/04	2004/05
Capital & Coast	Kaupapa Māori Alcohol & Drug Service for Tamariki & Rangatahi	MHCS02A	Kaupapa Māori Alcohol & Drug Services (Other Clinical FTEs)	yes	yes
		MHCS02C	Kaupapa Māori Alcohol & Drug Services (Non-Clinical FTEs)	yes	yes
	Kaupapa Māori Alcohol and Drug Services - Tamariki and Rangatahi (Porirua)	MHCS02C	Kaupapa Māori Alcohol & Drug Services (Non-Clinical FTEs)	yes	yes
Counties Manukau	Child and Youth Support Packages of Care - CMDHB	MHQI01	Quality Improvements	yes	yes
Hawke's Bay	Kaupapa Māori Child & Adolescent Day Activity	MHCS19C	Kaupapa Māori Mental Health Services - Adult Community Teams (Non-Clinical FTEs)	yes	yes
MidCentral	Tamariki Ora	MHCR09.2	Other Residential Support - Community Support Work	yes	yes
		MHCS02C	Kaupapa Māori Alcohol & Drug Services (Non-Clinical FTEs)	yes	yes
		MHCS16C	Activity-Based Rehabilitation Service/Day Activity and Living Skills (Non-Clinical FTEs)	yes	yes
Northland	Child and Youth Intensive Support Pilot (One Off)	MHCR09.2	Other Residential Support - Community Support Work	no	yes
		MHQI01	Quality Improvements	no	yes
Southland	Community Child and youth mental health service	MHCR09.1	Other Residential Support - Home Based Support Services	yes	yes
		MHCR09.2	Other Residential Support - Community Support Work	yes	yes
		MHCR17	Supported Landlord Service	yes	yes
		MHRE01	Adult Planned Respite	yes	yes
Taranaki	Children & Young People Community Services	MHCS06A	Community Mental Health Service (Other Clinical FTEs)	no	yes
Waikato	Adult/Child & Youth Community Services for Primary Mental Health Integration	MHQI01	Quality Improvements	no	yes
	Child & Youth Family Services Project	MHQI01	Quality Improvements	yes	yes
	Children & Young People Community Mental Health Services	MHCS22.8	Advocacy/Peer Support - Families/Whanau (Alcohol & Drug)	yes	yes
	Community Support & Tamariki & Rangatahi Services	MHCR09.2	Other Residential Support - Community Support Work	yes	yes
	Intensive Clinical Support Wrap Around Services-Child and Youth	ADJ112	NGO - Holidays Act Adjustment	no	yes
West Coast	Child & Youth Community Support Workers- West Coast	MHCR09.2	Other Residential Support - Community Support Work	yes	yes

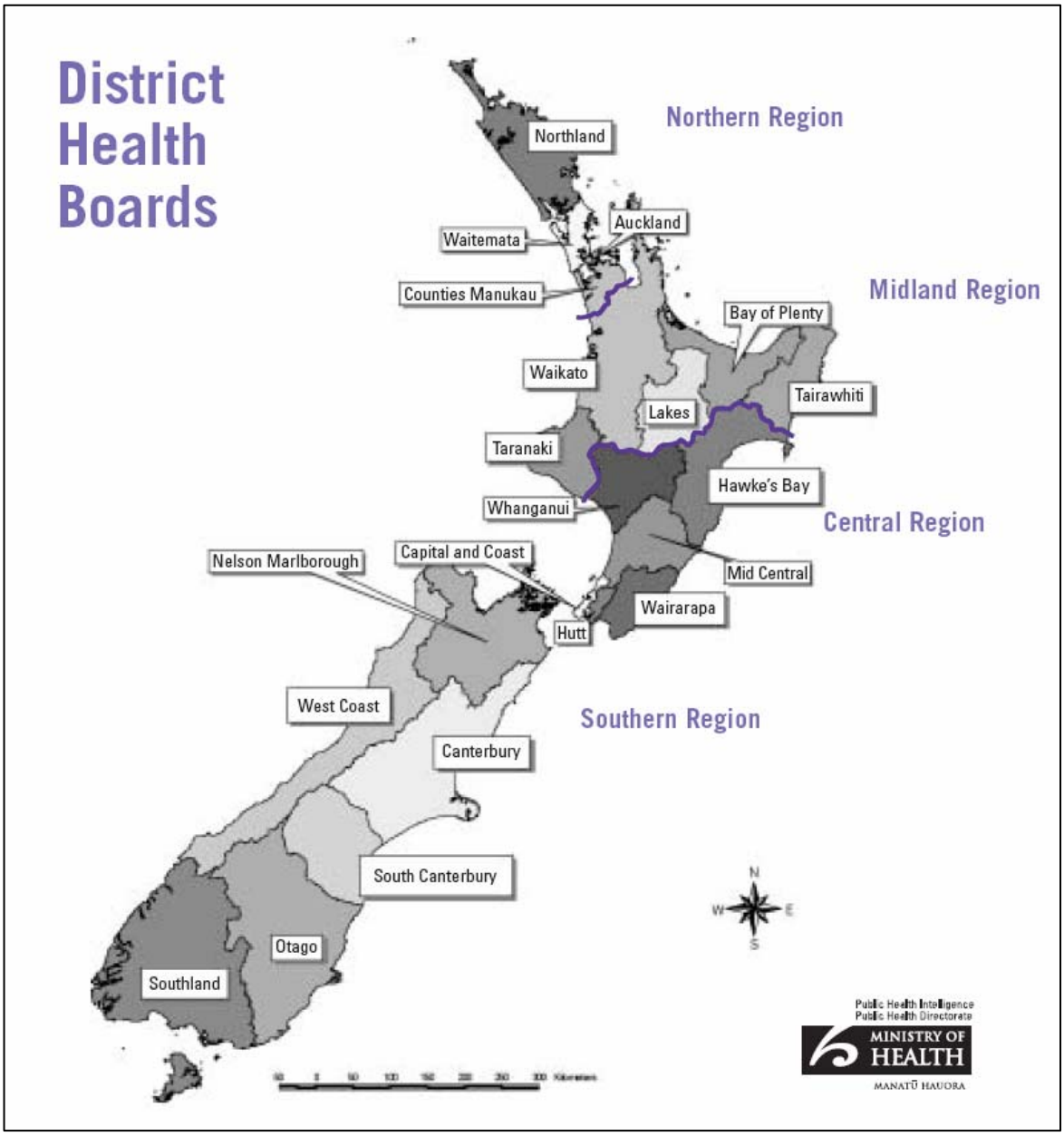
Source: MOH

2.2 Child & Adolescent Service Providers

2.2.1 DHB Child & Adolescent Mental Health Services

DHB Child and Adolescent Mental Health Services (CAMHS), provide specialist, accessible and culturally sensitive services to children, young people and their families who are experiencing significant mental health difficulties. They are free services found in all 21 DHBs throughout New Zealand (see Figure 1) for children and young people up to, and including, 19 years of age. Multidisciplinary teams are predominantly community based with inpatient units in Auckland (Child and Family Unit), Wellington (Rangatahi Unit) and Christchurch (Child and Family Inpatient Unit at the Princess Margaret Hospital, Canterbury District Health Board). Whanganui, Tairawhiti, Hutt, Nelson Marlborough, and Otago DHBs have allocated inpatient beds within local adult units. Some community services are provided on a regional basis. CAMHS are secondary mental health services, accepting referrals from other health professionals, educational and community organisations. In addition to direct clinical interventions, CAMHS also offer specialist consultation and liaison services to other agencies and maintain strong links with the communities they serve.

Figure 1. Map of District Health Boards



2.2.2 DHB Funded Non-Government Organisations

Child and adolescent services are also provided by DHB funded NGOs. These NGOs include independent community and iwi/Māori organisations. The number and functions of these NGOs varies considerably however, most offer a broad range of primary and secondary mental health services, including residential care, community support, employment, consumer and family support services.

2.2.3 Child, Youth & Family Collaborative Programmes

The provision of collaborative child and adolescent mental health services was explored across the Ministries of Health, Education, Social Development, and Justice. The only relevant contracts evident were those coordinated by Child, Youth and Family (CYF) and Youth Offending Teams (YOTs), with a new programme being piloted under the Youth Offending Strategy to provide Health and Education assessments, prior to the first Youth Justice Family Group Conference, for young people who have offended. There is also a proposal to the Ministers of Social Development and Employment, Health and Education for the development of an Inter-agency Strategy for Children and Young people with Severe Antisocial Behaviour (CYF, 2004).

CYF were asked to identify and provide data on services that might be considered as services to child and adolescent mental health clients. They identified the *High and Complex Needs Unit*, *Lower North Island Severe Conduct Disorders Programme*, *Towards Wellbeing Youth Suicide Programme* and a programme run by Youth Horizons Trust.

2.3 Child & Adolescent Mental Health Provider Survey

Providers of funded child and adolescent mental health services, which included DHB provider arm services and DHB funded NGOs, were initially identified using the 2003/2004 and 2004/2005 price-volume schedules supplied by the Ministry of Health. This was followed by a survey in October 2004 of all DHB provider arm services and DHB funded NGOs. To avoid duplication of data collection, the survey was conducted as a joint exercise with the Mental Health Commission (MHC) who regularly collects information. All 21 DHBs responded to the survey although some survey responses were incomplete.

A total of 89 NGOs were identified from the 2003/2004 (75 NGOs) and 2004/2005 (84 NGOs) MOH price-volume schedules. Two extra NGOs not in either schedules were also identified (Northland Mental Health Trust t/as Solutions and Phobic Trust of NZ). Therefore a total of 91 NGOs were identified for the survey. However only 85 NGOs were sent the stocktake survey and responses were received from 68 of the 85 (80%) NGOs surveyed. Of the 68 NGOs that responded, six (i.e. Poutiri Charitable Trust, Schizophrenia Fellowship, Ko Te Poumanawa Oranga O Te Tau Ihu O Te Waka A Maui Ltd, Ministry of Education-Group Special Education, Otago, Presbyterian Support Services, and Mt Cargill Trust) stated that their services were not directly involved in providing child and adolescent mental health services. Therefore findings from 62 of 79 relevant NGOs are documented in this Chapter (see Tables 12-15).

The surveyed DHB provider arm services and NGOs provided a summary of their services and associated age groups (refer to Tables 12 to 15 for details). Kaupapa Māori Services are also listed in a separate section of this Chapter (See Table 18).

Table 12. Child & Adolescent Mental Health Services – Northern Region (2004/2005)

District	Services Teams	Age Groups
Northland DHB	Te Roopu Kimiora – Child & Adolescent Mental Health Service	0-19
Northland NGOs Ngati Hine Health Trust Board	Kaupapa Māori Services	
Northland Mental Health Trust t/as Solutions[3]	Child & Adolescent Mental Health Services	
Rubicon Charitable Trust Board	Youth Alcohol & Drug Counselling Services	11-18
Te Hauora O Te Hiku O Te Ika[1]	Ngati Kahu Social Services: Advocacy/Peer Support	
Te Runanga O Te Rarawa Inc[1]	Child & Youth Alcohol & Drug	
Waitemata DHB	*Intensive Clinical Support Services (Waitemata, Auckland & Counties Manukau DHB)*	0-19
	Marinoto North	0-20
	Marinoto West	0-20
	Early Intervention (EPI)	16-25
	Youth Alcohol & Drug Services (Waitemata, Auckland & Counties Manukau DHB)	13-19
	Pacific Services (Isa Lei & Tupu)	
	Māori Services	
Auckland DHB	CAMHS Community Team – East	0-19
	CAMHS Community Team – West	0-19
	Youth Transitional Programme	13-19
	Youth Early Intervention Service	13-19
	Child & Adolescent Liaison Service (Waitemata & Auckland DHB)	*0-21*
	Regional Youth Forensic Service (Northland, Waitemata & Auckland DHB)	*14-16*
	On TRACC (High & Complex Needs)	0-21
	Consult Liaison Service (Starship Hospital)	
	Child & Family Unit (Inpatient Service, Starship)(Northern & Midland Region)	*0-18*
Auckland NGOs Odyssey House Trust	Child & Youth Alcohol & Drug Residential Service	13-18
	Child & Youth Alcohol & Drug Day/Evening Programme	13-18
	Behavioural School (Registered Private School)	13-22
Phobic Trust of New Zealand[2]	Mental Health Services	10-19
	Family Support Services	10-19
	24 Hour Helpline	All Ages
	Education	All Ages
	Advocacy	All Ages
Richmond Fellowship	*Regional Child & Youth Residential Service (Waitemata, Auckland & Counties Manukau DHB)*	*13-19*
	Youth Intensive Support Packages of Care	Up to 20
Counties Manukau DHB	Child & Adolescent Mental Health Services	0-19
	Kidz First Mental Health	12-19
Counties Manukau NGOs Mahitahi Trust[1]	Advocacy/Peer Support	
Raukura Hauora O Tainui Trust	Advocacy/Peer Support	
Richmond Fellowship	Child & Youth Wrap-Around Service	12-20
Waimokoia School[1]	Whanau Youth – Child & Youth	

For Tables 12-15:
Source: Survey
Services italicized are regional.
1 Nil response.
2 Additional NGOs
3 03/04 NGOs not in 04/05 Price Volume Schedule

Table 13. Child & Adolescent Mental Health Services – Midland Region (2004/2005)

District	Services Teams	Age Groups
Waikato DHB	Child & Adolescent Mental Health Services	0-19
	Whai Marama Youth Connex	0-19
Waikato NGOs CareNZ Ltd[1]	Children & Youth Alcohol & Drug Service	
Central Pacific Trust[3]	Pacific Services	
Hauora Waikato Māori Mental Health Services[1]	Kaupapa Māori Services	
Linkage Trust	Child & Young People Community Service	All Ages
Maniapoto Māori Trust Board	Kaupapa Māori Services	
Northern King Country Drug & Alcohol Counselling & Education	Child & Young People Community Drug & Alcohol & Mental Health Support Service	15 Upwards
Parentline	Community Child & Youth Mental Health Services	
People Relying on People[3]	Home-Based Family Support Services	All Ages
Raukawa Trust Board	Kaupapa Māori Services	
Richmond Fellowship	Residential Team	12-20
	Home Based Support	12-20
Rotorua Pacific Islands Development Charitable Trust[1]	Child & Young People Community Service	
Te Ahurei a Rangatahi	Child & Young People Community Service	
Te Korowai Hauora o Hauraki Inc	Kaupapa Māori Services	
Youth Horizons Trust	Intensive Clinical Intervention Service	0-18
	Respite Foster Care	0-18
Waikato Pacific Health Trust:	Kaute Pasifika-Pacific Community Services	0-19
	South Waikato Pacific Island Health Committee- Pacific Adolescent Mental Health Services	13-19
Lakes DHB	Child & Adolescent Mental Health Services (Taupo/Turangi)	0-19
	Child Mental Health Services (Rotorua)	0-14
	Youth Specialty Team (Rotorua)	15-19
Lakes NGOs Te Aratu Trust[1]	Child & Youth Day Activities	
Te Runanga O Ngati Pikiao Trust	Child & Adolescent Mental Health Services	0-19
	GP Service	All Ages
	Social Services	All Ages
Tuwharetoa Health Services Ltd	Kaupapa Māori Services	
Bay of Plenty DHB	Child & Adolescent Mental Health Services (Tauranga)	0-17
	Voyagers Child & Adolescent Mental Health Services (Whakatane)	0-17
Bay of Plenty NGOs Nga Mataapuna Oranga	Child & Young People Community Services	
Te Manu Toroa Trust[1]	Advocacy/Peer Support – Families	
	Advocacy/Peer Support	
	Child & Young People Community Service	
Te Rangimarie Trust	Mental Health Services	15-19
Te Runanga O Te Whanau Charitable Trust	Kaupapa Māori Services	
Te Tomika Trust	Child & Young People Community Service	
Tuhoe Hauora Trust	Kaupapa Māori Services	
Turning Point Trust	Child & Young People Community Service	
Tuwharetoa Ki Kawerau Hauora Trust[1]	Child & Young People Community Service	
Whakatohea Māori Trust Board[1]	Child & Young People Community Service	
	Advocacy/Peer Support – Family	
	Child & Youth Acute Care Package	
	Child & Youth Crisis Respite	
Tairawhiti DHB	Child & Adolescent Mental Health Services	0-19
Tairawhiti NGOs Te Hauora O Turanganui A Kiwa Ltd	Kaupapa Māori Services	
Taranaki DHB	Child & Adolescent Mental Health Services	0-18
Taranaki NGOs Linkage Trust	Child & Young People Community	All Ages
Tui Ora Ltd	Mahia Mai-Kaupapa Māori Services-Mental Health Assessment & Treatment Raumano- Kaupapa Māori Services-Mental Health Assessment & Treatment	

Table 14. Child & Adolescent Mental Health Services - Central Region (2004/2005)

District	Services Teams	Age Groups
Hawke's Bay DHB	Child & Adolescent Mental Health Services	0-19
Hawke's Bay NGOs Richmond Fellowship	Residential Service	12-20
	Home Based Support	12-20
Te Taiwhenua O Heretaunga[1]	Child & Youth Planned Respite	
	Children & Youth Service Delivery	
Te Whatuiapiti Trust[1]	Children & Youth Community Alcohol & Drug	
	Te Waireka Youth Residential Service	13-18
MidCentral DHB	Child, Adolescent & Family Mental Health Services (Palmerston North)	0-19
	Child, Adolescent & Family Mental Health Services (Levin)	0-19
	Alcohol & Other Drugs (AOD)	0-19
	Child, Adolescent & Family Mental Health Services (Oranga Hinengaro)	0-19
MidCentral NGO Te Runanga O Raukawa Inc[1]		
Whanganui DHB	Child, Adolescent & Family Mental Health Services	0-20
Whanganui NGOs Life to the Max Trust	Child & Youth Wrap-Around Service	9-13
Taumata Hauora Trust[1]	Nga Oranga Service	
Te Oranganui Trust Inc[1]		
Capital & Coast DHB	Child & Adolescent Mental Health Services (Wellington)	0-19
	Child & Adolescent Mental Health Services (Porirua/Kapiti)	0-19
	Child & Adolescent Mental Health Services (Youth Specialty Service)	13-19
	Early Intervention Service (Central Region)	*13-25*
	Health Pasifika (Child, Adolescent & Family Services)	0-19
	Te Whare Marie (Māori Child, Adolescent & Family Services)	0-19
	Regional Rangitahi Adolescent Inpatient Unit (Central Region)	*13-19*
Capital & Coast NGOs Taeaomanino Trust	Pacific Child & Adolescent Social and Mental Health Services	0-17
Te Runanga O Toa Rangatira	Rangitaua Mauriora Outpatient Service	
The Wellink Trust[1]	Child & Youth Crisis Respite	
Wellington Refugees as Survivors Trust	Liaison Services with Child, Youth & Family	0-19
Ministry of Health WellTrust	Drug & Alcohol Assessment, Counselling & Education Services	13-19
Hutt DHB	Child Specialty Service	0-12
	Youth Specialty Service	13-19
	Kaupapa Māori AOD Services	
	Facilitating Long Term Integrated Plans (FLIP): Case management for complex cases referred to the Regional Intensive care team.	
	Intensive Clinical Support Services (Capital & Coast, Wairarapa & Hutt DHB)	10-19
Hutt NGOs Richmond Fellowship	Te Whare Aroha-Supported Accommodation for Young People	15-19
Te Paepae Arahi Trust[1]	Kaupapa Māori Services	
VIBE (Hutt Valley Youth Health Trust)	Children & Youth Day Activities	
Wairarapa DHB	Child & Adolescent Mental Health Services	0-19
Wairarapa NGOs King Street Artworks Inc	Children & Youth Day Activities	All Ages
Wairarapa Addiction Service Inc	Alcohol & Drug Services	14 upwards

Table 15. Child & Adolescent Mental Health Services - Southern Region (2004/2005)

District	Services Teams	Age Groups
Nelson Marlborough DHB	Child & Adolescent Mental Health Services	0-18
	Adult Community Team	17-19
	Alcohol & Other Drugs (AOD)	All
	Day Hospital Programme	16-19
	24 Hr Crisis Intervention	0-19
Nelson Marlborough NGOs Care Solutions NZ Ltd	Child & Youth Planned & Crisis Respite	0-19
Gateway Housing Trust	Child & Youth Residential Care	Up to 22
Horizon Trust Board	Day Programme & Respite Service	13-19
West Coast DHB	Child & Adolescent Mental Health Service (including Youth Alcohol & Other Drugs)	0-19
Canterbury DHB	Child Specialty Services	0-8
	Youth Specialty Services	9-18
	Family Mental Health	0-65
	Intensive Case Management (West Coast DHB)	*0-18*
	Child Inpatient Unit (Southern Region) & Day Programme	0-15
	Youth Inpatient Unit (Southern Region)	*16-18*
	Youth Day Programme	13-18
	Regional Consultation Service (West Coast & South Canterbury DHB)	
Canterbury NGOs Adventure Development Ltd[1]	Child & Youth Alcohol & Drug Community Services	
Ashburton Community Alcohol & Drug Service Inc	Child & Youth Drug & Alcohol Services	0-19
Christchurch City Mission	Youth Alcohol & Drug Counselling Service	13-17
Depression Support Network	Youth Support Services	13-24
Odyssey House Trust	Youth Alcohol & Drug Day Programme	12-18
	Residential Service for Men	17 & Older
Pacific Island Evaluation Inc[1]	Children & Youth Alcohol & Drug	
Pacific Trust Canterbury[1]		
Purapura Whetu Trust	Kaupapa Māori Services	
Richmond Fellowship	Child & Youth Community Residential Care	14-19
	Child & Youth Planned Respite	14-19
	Residential Support Community Support Work	14-19
Stepping Stone Trust	Community Support Workers	14-19
	Youth Residential Service	14-19
	Youth Respite Service	14-19
	Youth High & Complex Needs	14-19
St John of God Youth & Community Services – Waipuna Trust	Young Parents Support Services	14-25
	Pacific Young Parents Support Service	14-25
	Youth Support Team	0-19
STOP Trust	Child Services	8-11
	Youth Services	12-19
STOP Trust	Kaupapa Māori Services	
Waimakariri Community Development Trust-North Canterbury Youth & Drug Service	Youth Drug & Alcohol Services	12-18
Youth Health Trust	Mental Health Services	10-25
	Peer Support Services	10-25
	Medical Services	10-25
South Canterbury DHB	Child & Adolescent Psychiatric Service	0-19
	Māori Mental Health Team	0-65
	Youth Alcohol & Other Drugs	0-19

Table 15. Cont. Child & Adolescent Mental Health Services - Southern Region (2004/2005)

District	Services Teams	Age Groups
Otago DHB	Child & Family Service	0-13
	Youth Specialty Service	14-19
Otago NGOs Adventure Development Ltd[1]	Children & Youth Alcohol & Drug Service	
Aroha Ki Te Tamariki Charitable Trust	Child & Youth Counselling Service	0-19
	Day Programme	13-17
Corstorphine Baptist Community Trust[3]	Community Support Service	10-18
Miramare Ltd	Needs Assessment and Service Co-ordination	
Otago Youth Wellness Trust	Wrap-Around Case Management	11-18
	Learning Centre	13-18
	Project K	14-16
Southland DHB	Child, Adolescent & Family Service	0-19
Southland NGOs Adventure Development[1]	Children & Youth Alcohol & Drug Service	
PACT Group	Child & Youth Crisis Respite	
	Child & Youth Community Residential	
	Children & Youth Day Activities	
	Child & Young People Community	
Te Huarahi Ki Te Oranga Pai Trust	Kaupapa Māori Services	

2.3.1 Inpatient Services

The Blueprint guidelines (MHC, 1998a) for resources recommended *two* [child and adolescent] *acute inpatient beds or 'care packages' per 100,000 of the total population* (Mental Health Commission, 1998, p. 100). In 1998, with a population of 3,777,200, this equated to 75.5 beds. In 2004, with a population of 4,067,725, this equated to 81.4 beds and in 2004/2005 there were only 59.7 acute inpatient beds. This means there is a shortfall of 21.7 beds in relation to Blueprint guidelines.

Table 16. Child & Adolescent Mental Health Inpatient Services (Purchase Code MHIS7)

Region	Service Teams	2004/05 Bed Days	2004/05 Beds	Age Groups
Northern Auckland	Child & Family Unit (Starship Hospital)	9,125	25	5 Child Beds 20 Adolescent Beds
Central Capital & Coast	Regional Rangitahi	4,745	13	
	Adolescent Inpatient Unit Youth Day Programme			6 Day Programmes (13-19 Yrs)
Southern Canterbury	Child Inpatient Beds & Day Programme	5,840	16	0-15
	Youth Inpatient Beds			16-18
	Youth Day Programme			13-18

Source: Survey

Table 17. Additional Funding for Inpatient Services (Purchase Code MHIS7)

Region	Service Teams	2004/05 Bed Days	2004/05 Beds	Age Groups
Midland Tairawhiti	Local Acute Mental Health Unit	110	0.3	Dedicated bed within adult unit
Central Hutt	Local Acute Mental Health Unit	146	0.4	Dedicated bed within adult unit
Whanganui	Local Acute Mental Health Unit	365	1	Dedicated bed within adult unit
Southern Nelson Marlborough	Local Acute Mental Health Unit	730	2	Dedicated bed within adult unit
Otago	Local Acute Mental Health Unit	730	2	Dedicated bed within adult unit

Source: Survey

2.3.2 Kaupapa Māori Services

The first priority for future service development in child and adolescent mental health is Māori tamariki, rangatahi and their whanau (Health Funding Authority, 2000). However, the future development of services for tamariki and rangatahi is highly dependent on the participation of Māori in all aspects of service delivery (Health Funding Authority, 2000). Therefore it is vital that there be Kaupapa Māori child and adolescent mental health services which cater for the needs of tamariki, rangatahi and their whanau provided by Māori workers. The following table lists all the Kaupapa Māori services by DHB and NGOs for the 2004/2005 financial year (Purchase Unit Code – MHCS39).

Table 18. DHB & NGO Providers of Kaupapa Māori Mental Health Services - Tamariki & Rangatahi (2004/2005)

Region	Area & Name
Northern	**Northland NGO**
	Ngati Hine Health Trust Board
Midland	**Waikato NGO**
	Hauora Waikato Māori Mental Health Services
	Maniapoto Māori Trust Board
	Raukawa Trust Board
	Te Korowai Hauora o Hauraki Inc
	Lakes NGO
	Te Runanga O Ngati Pikiao Trust
	Tuwharetoa Health Services Ltd
	Bay of Plenty NGO
	Nga Mataapuna Oranga
	Poutiri Charitable Trust
	Te Runanga O Te Whanau Charitable Trust
	Tuhoe Hauora Trust t/as Rakeiwhenua Trust
	Tairawhiti NGO
	Te Hauora O Turanganui A Kiwa Ltd
	Taranaki NGO
	Tui Ora Ltd-Mahia Mai -Raumano
Central	**Capital & Coast DHB—**Te Whare Marie
	Capital & Coast NGO
	Te Runanga O Toa Rangatira
	Hutt DHB
	Hutt NGO
	Te Paepae Arahi Trust
	Wairarapa DHB
Southern	**Nelson Marlborough NGO**
	Ko Te Poumanawa Oranga O Te Tau Ihu O Te Waka A Maui Ltd
	Canterbury NGO
	Purapura Whetu Trust
	STOP Trust
	Southland NGO
	Te Huarahi Ki Te Oranga Pai Trust

Source: MOH

Of note, Māori mental health workforce development is a priority area which is being addressed by Te Rau Matatini, a Māori workforce development initiative. Te Rau Matatini was established to ensure that Māori Mental Health consumers (tangata whaiora) have access to a well prepared and well qualified Māori Mental Health workforce. Te Rau Matatini works towards "*this goal by contributing to Māori Mental Health workforce policy development at a national and regional level, expanding the Māori Mental Health workforce, and promoting rewarding career opportunities in mental health for Māori*"
(Retrieved 09/05/2005,www.matatini.co.nz/aboutTRM/aboutTRM.htm).

2.3.3 Pacific Services

The second priority for future service development in child and adolescent mental health is Pacific children, youth and their extended families (Health Funding Authority, 2000). Ten Pacific services were identified from the 2003/2004 and 2004/2005 MOH schedules (see Table 19). These services were:

Table 19. DHB & NGO Providers of Pacific Services (2004/2005)

Region	Area & Name
Northern	**Waitemata DHB**
	Isa Lei
	Tupu-Alcohol & Drug Services
Midland	**Waikato NGO**
	Central Pacific Trust
	Rotorua Pacific Islands Development Charitable Trust
	Waikato Pasifika Health Trust: Contracts the following services to provide services Kaute Pasifika South Waikato Pacific Island Health Committee
Central	**Capital & Coast NGO**
	Taeamanino Trust-Child & Adolescent Social & Mental Health Services
Southern	**Canterbury NGO**
	Pacific Island Evaluation
	Pacific Trust Canterbury
	St John of God Youth & Community Services-Waipuna Trust: Pacific Parents Support Service

Source: MOH

Of note, identifying Pacific services for this project was problematic as there is no specific purchase unit code for these services. As a result Pacific services could only be identified by the name of the provider (or service), or from feedback during the Stocktake Survey. Additionally, Pacific family-based services (not identified in this project) may also include a child and adolescent mental health component to their services.

2.3.4 Child, Youth & Family Collaborative Programmes

Child, Youth & Family identified the High and Complex Needs Unit, Lower North Severe Conduct Disorders Programme, Towards Wellbeing Youth Suicide Programme and a Youth Horizons Trust Programme as services for child and adolescent mental health clients (see Table 20).

Surveys requesting data on funding, services and workforce were sent to the mentioned programmes. Information was returned from all four of the programmes and this is presented in Table 20. Data from Youth Horizons Trust has also been included in the NGO workforce data.

Table 20. The Child, Youth & Family Collaborative Programmes

Funding Agencies	Inter-Agency Programmes	Service Teams	Age Group
CYF **Ministry of Health** **Ministry of Education**	High and Complex Needs Unit (HCN)	HCN provides funding to individualised plans for children & young people where there is a high & complex unmet need that cannot be met by core services in Education, Health & CYF. Also run the pilot programme, ON TRACK. This programme is an intersectorial service provided in Auckland for children and young people with mental health and/or severe behavioural problem who come from refugee backgrounds.	0-19
CYF **Capital & Coast DHB** **Ministry of Education**	Lower North Severe Conduct Disorder	Specialist residential treatment and community programme for youth diagnosed with severe conduct disorder.	12-16 (Males)
CYF	Towards Wellbeing Youth Suicide Prevention	Monitoring of cases and provision of support to social workers who are involved in the management of young people with suicidal ideation.	12-16
CYF **Waitemata DHB**	Intensive Clinical Support Services	Intensive clinical intervention service for clients currently involved in CAMHS and CYF care. An Intensive Case Management/Wrap around Service	0-18
CYF **Hutt DHB**	Intensive Clinical Support Services	Intensive clinical intervention service for clients currently involved in CAMHS and CYF care. An Intensive in-home MST Service.	0-18
CYF **Youth Horizon Trust (Waikato DHB)**	Intensive Clinical Support Services	Intensive clinical intervention service for clients currently involved in CAMHS and CYF care. An Intensive in-home MST Service.	0-18
CYF **Canterbury DHB**	Intensive Clinical Support Services	Intensive clinical intervention service for clients currently involved in CAMHS and CYF care. An Intensive Case Management/Wrap A Around Service	0-18

Source: CYF Survey

The High and Complex Needs Unit (HCN) is funded by the Ministries of Health and Education and Child Youth and Family (CYF). A key element of the HCN's strategy is to promote "*collaboration between the sectors to improve the service for children and young people with high and complex needs*" (HCN website www.hcn.govt.nz).

Towards Wellbeing Youth Suicide Prevention Programme is contracted to Otago University, Wellington School of Medicine. The service is involved in monitoring cases and providing support for social workers who are managing young people with suicidal ideation to reduce suicide attempts and deaths. Clients are also referred to CAMHS for assessment and treatment as required.

Lower North Severe Conduct Disorder Programme (LNSCDP) has been launched by CYF for boys with severe conduct disorder in the lower North Island. The programme is run jointly by CYF, Capital & Coast DHB and the Ministry of Education. LNSCDP is a three stage specialist residential treatment and community programme. Stages 1 and 2 (residential treatment) are provided by Capital & Coast DHB and stage 3 (re-integration of the young person into their communities) was implemented in early 2005 by Youth Horizons Trust.

Youth Horizons Trust runs an intensive in-home multi-systemic therapy programme for youth who are in CAMHS and CYF care in the Waikato and Bay of Plenty regions.

CYF also employ other child and adolescent psychologists/psychotherapists in some areas in their specialist service units. Their work is mainly centred on diagnostic assessment for abuse investigations and assessment of attachment for children in care.

Colin Hamlin (MOH) provided the following information on CYF projects.

CYF is also involved in various projects that are looking into improving their client's access to mental health services. One such project is to improve access to DHB funded mental health services for CYF clients in each of the 21 DHB areas. The project has been jointly developed by CYF and the MOH and will achieve its objective by facilitating discussions and joint planning between DHB funders of mental health services, mental health service providers (including DHB contracted NGO providers) and local CYF offices to:

- Identify local services and supply issues
- Develop local action plans that will improve and increase access to mental health services for CYF clients, particularly those in residences
- Develop proposals for further policy and service development work

Some of the key issues identified between the services so far include:

- Lack of relationship between agencies at front-line staff level
- Levels of ongoing therapeutic service uptake are lower than access rates for assessment
- Lack of information about parameters on both services
- Joint casework to crisis services
- Joint casework is difficult to achieve
- Improved response too hard to engage young people required
- Substantive numbers of caregivers with adult mental health issues-more effective working with adult mental health services sought
- Lack of Alcohol & Other Drug services (AOD) across all clients types
- Information sharing between services requires clarification
- Response to Māori and Pacific Island clients requires improvement

Joint action plans have been agreed between Capital & Coast DHB and CYF for the Wellington area. Work is underway in the Auckland region (3 DHBs, 9 CYF offices and 2 residences) and the project is scheduled to be completed across the whole country by 30 June 2007.

CYF is also involved in the development of an inter-agency strategy for children and young people with severe antisocial behaviour. Responding effectively to the small proportion of children and young people who develop severe antisocial behaviours requires an intersectoral approach. It also requires a range of interventions from early intervention programmes for young children and parent/caregivers to intensive programmes for older children and young people.

In mid 2004, officials from the Ministries of Health, Education, Social Development, Justice and the Department of Child, Youth and Family Services (CYF) began work to jointly develop a strategic approach to the provision of services for children and young people with severe antisocial behaviour.

Current intervention services use differing definitions, have different outcome goals, may or may not be based on interventions that have evidence of effectiveness, are not provided to all children and young people requiring intervention, and their impact is not known. Moving to a more consistent, evidence-based, system-wide intervention approach would require significant changes to the nature, range and provision of existing services.

Work undertaken to date suggests that the priorities for the enhancement and further development of services for children and young people affected by severe antisocial behaviour should:

- Deliver preventive services, including parent training, as early as possible to population groups who experience risk factors associated with the development of antisocial behaviours
- Give particular priority to the provision of services to redress antisocial behaviours among children at an early age, preferably in early childhood through to the early school years
- Develop a continuum of service through later childhood and adolescence to limit the effects of antisocial behaviour, reflecting that while early intervention is most desirable it is not effective for all children, and that while outcomes are more limited for older age groups they are, if properly delivered, still cost-effective
- Address infrastructural issues, notably workforce capacity development and systems of quality control, that are essential to effectiveness in service provision
- Ensure that services are provided on the basis of the best available evidence of effectiveness and that evaluation and monitoring systems are in place to maintain quality and inform enhanced service development
- Respond to the over representation of Māori tamariki and rangatahi by further building on and utilising existing Māori policy frameworks such as whanau ora throughout the policy goals described above. This will also assist in the development and delivery of culturally relevant services.

The project is scheduled to develop recommendations and an implementation plan by 30 June 2006.

2.4 Funding by DHBs for the Provision of Child & Adolescent Mental Health Services

DHB and NGO providers receive DHB funding for Full Time Equivalents (FTEs), Programmes and Bed Days. Funding data for 2003/2004 and 2004/2005 was provided by the MOH.

In 2003/2004, DHBs and NGOs received a total funding of $90 million (which included funding for 799 FTEs, 49,156 bed days and 28 programmes) for child and adolescent mental health services (see Tables 21, 23 & 25).

Table 21. Contracted FTEs & Bed Days (2003/2004)

	DHB	NGO	Total
FTEs	623.42	176	**799.42**
Bed Days	16,671	32,485	**49,156**
Programmes	28.4	*	**28.4**

Source: MOH. * Programmes converted to FTEs.

In 2004/2005, DHBs and NGOs received a total funding of $96 M (which included funding for 802 FTEs, 56,101 bed days and 29 programmes) for child and adolescent mental health services (see Tables 22, 24 & 26).

Table 22. Contracted FTEs & Bed Days (2004/2005)

	DHB	NGO	Total
FTEs	627	175	**802**
Bed Days	21,426	34,675	**56,101**
Programmes	29.4	*	**29.4**

Source: MOH. * Programmes converted to FTEs

For the year 2003/2004, 82% of the total DHB provider arm funding and 73% of the total NGO funding for services was for FTEs.

In 2004/2005, there was a 6.8% increase in provider funding (DHBs 8% and NGOs 1%).

Table 23. Regional DHB Provider Funding for FTEs, Programmes, Bed Days & Attendances (2003/2004)

Regional Totals	FTE	Programmes	Bed Days	Attendances	Total
Northern	$20,663,725	$659,781	$5,266,563		$26,590,069
Midland	$9,194,446	$515,314	$55,302		$9,765,062
Central	$13,865,880	$1,591,920	$84,265		$15,542,066
Southern	$15,040,527	$307,336	$4,209,874	$362,344	$19,920,081
Total	**$58,764,578**	**$3,074,351**	**$9,616,004**	**$362,344**	**$71,817,277**

Source: MOH

Table 24. Regional DHB Provider Funding for FTEs, Programmes, Bed Days & Attendances (2004/2005)

Regional Totals	FTE	Programmes	Bed Days	Attendances	Total
Northern	$22,273,090	$677,022	$5,400,860		$28,350,973
Midland	$9,474,716	$496,519	$64,972		$10,036,207
Central	$14,131,360	$2,100,502	$2,727,061		$18,958,923
Southern	$15,372,310	$315,199	$4,317,583	$371,583	$20,376,676
Total	**$61,251,476**	**$3,589,242**	**$12,510,477**	**$371,583**	**$77,722,778**

Source: MOH

Table 25. Regional NGO Funding for FTEs, Programmes & Bed Days (2003/2004)

Regional Totals	FTE	Bed Days	Total
Northern	$1,643,799	$1,025,426	$2,669,225
Midland	$7,056,503	$25,000	$7,081,503
Central	$1,081,109	$2,729,696	$3,810,805
Southern	$3,512,506	$1,202,577	$4,715,083
Total	**$13,293,917**	**$4,982,699**	**$18,276,616**

Source: MOH

Table 26. Regional NGO Funding for FTEs, Programmes & Bed Days (2004/2005)

Regional Totals	FTE	Bed Days	Total
Northern	$2,175,301	$116,362	$2,291,663
Midland	$8,156,523	$162,380	$8,318,903
Central	$994,667	$952,384	$1,947,051
MOH-WellTrust	$222,222	$0	$222,222
Southern	$3,438,851	$2,250,376	$5,689,227
Total	**$14,765,342**	**$3,481,502**	**$18,469,066**

Source: MOH

Table 27. Ministry of Health Funding by Region (2004/2005)

Provider	DHB Funded Dollars	NGO Funded Dollars	Total
Northern	**$28,350,973**	**$2,291,663**	**$30,642,636**
Northland	$2,033,627	$770,892	$2,804,519
Waitemata	$8,407,613	$0	$8,407,613
Auckland	$12,490,617	$855,040	$13,345,657
Counties Manukau	$5,419,115	$665,732	$6,084,847
Midland	**$10,036,207**	**$8,318,903**	**$18,355,110**
Waikato	$3,051,410	$5,425,144	$8,476,554
Lakes	$1,775,504	$394,720	$2,170,224
Bay of Plenty	$2,993,392	$2,032,886	$5,026,278
Tairawhiti	$826,061	$36,079	$862,140
Taranaki	$1,389,839	$430,075	$1,819,914
Central	**$18,958,923**	**$1,947,051**	**$20,905,973**
Hawke's Bay	$2,495,263	$836,580	$3,331,843
MidCentral	$2,020,200	$82,834	$2,103,034
Whanganui	$1,575,042	$154,020	$1,729,062
Capital & Coast	$9,315,614	$293,151	$9,608,766
Hutt	$2,778,763	$453,012	$3,231,775
Wairarapa	$774,041	$127,454	$901,495
Southern	**$20,376,676**	**$5,689,227**	**$26,065,903**
Nelson Marlborough	$2,441,255	$562,546	$3,003,801
West Coast	$771,997	$0	$771,997
Canterbury	$11,109,805	$3,226,506	$14,336,312
South Canterbury	$884,255	$0	$884,255
Otago	$3,414,120	$1,225,833	$4,639,953
Southland	$1,755,244	$674,343	$2,429,586
MOH-WellTrust	**$0**	**$222,222**	**$222,222**
Total	**$77,722,778**	**$18,469,066**	**$96,191,844**

For the year 2003/2004, some DHB CAMHS reported an under-spend (see Table 28). Some DHBs did not return this data and therefore the table is incomplete. Some of the under-spend might be attributed to the vacancies in the sector.

Table 28. Child & Adolescent Mental Health Financials (2003/2004)

	Price/Volume	Price/Volume	Revenue				Expenditure		
Provider	**MOH**	**DHB**	**CTA**	**Other**	**Total Revenue**	**Personnel**	**Other**	**Total Expenditure**	**Surplus/Deficit**
Northern	**$26,590,069**	**$20,058,215**	**$114,513**	**$308,470**	**$20,481,198**	**$10,702,663**	**$6,523,159**	**$17,225,822**	**-$1,583,258**
Northland	$1,897,044	$1,897,044		$37,158	**$1,934,202**	$1,168,842	$955,469	**$2,124,311**	-$190,109
Waitemata	$7,443,575	$7,392,381			**$7,392,381**	$7,090,821	$3,768,690	**$10,859,511**	-$3,467,130
Auckland**	$11,965,078	$5,484,790	$49,513	$271,312	**$5,805,615**	$3,654,476	$1,184,158	**$4,838,634**	$966,981
Counties Manukau	$5,284,372	$5,284,000	$65,000		**$5,349,000**	$2,443,000	$1,799,000	**$4,242,000**	$1,107,000
Midland	**$9,765,062**	**$9,174,644**	**$221,500**	**$909**	**$9,397,053**	**$6,290,310**	**$2,587,241**	**$8,877,551**	**$519,502**
Waikato	$2,983,165	$2,404,644	$219,500	$909	**$2,625,053**	$2,217,310	$480,241	**$2,697,551**	-$72,498
Lakes	$1,731,307	$1,761,000			**$1,761,000**	$879,000	$533,000	**$1,412,000**	$349,000
Bay of Plenty	$2,941,764	$2,743,000	$2,000		**$2,745,000**	$1,626,000	$1,078,000	**$2,704,000**	$41,000
Tairawhiti	$719,128	$927,000			**$927,000**	$491,000	$149,000	**$640,000**	$287,000
Taranaki	$1,389,697	$1,339,000			**$1,339,000**	$1,077,000	$347,000	**$1,424,000**	-$85,000
Central	**$15,542,066**	**$9,081,675**		**$44,587**	**$9,126,262**	**$5,220,042**	**$2,372,457**	**$7,592,499**	**$1,533,763**
Hawke's Bay	$2,299,437	$2,411,000		$25,000	**$2,436,000**	$1,416,000	$870,000	**$2,286,000**	$150,000
MidCentral	$2,200,405	$1,969,000			**$1,969,000**	$1,107,000	$202,000	**$1,309,000**	$660,000
Whanganui	$1,395,061	$1,395,000		$10,000	**$1,405,000**	$480,000	$318,000	**$798,000**	$607,000
Capital & Coast*	$6,191,822								
Hutt	$2,709,667	$2,561,000		$9,587	**$2,570,587**	$1,904,560	$931,852	**$2,836,412**	-$265,825
Wairarapa	$745,675	$745,675			**$745,675**	$312,482	$50,605	**$363,087**	$382,588
Southern	**$19,920,081**	**$17,705,019**	**$171,000**	**$96,000**	**$17,972,019**	**$9,921,340**	**$5,094,291**	**$15,015,631**	**$2,090,387**
Nelson Marlborough	$2,380,551	$2,380,551			**$2,380,551**	$1,595,340.45	$558,290.60	**$2,153,631.05**	$226,918.95
West Coast*	$752,179								
Canterbury	$11,195,894	$11,378,000	$171,000	$96,000	**$11,645,000**	$7,850,000	$4,356,000	**$12,206,000**	-$561,000
South Canterbury	$869,005	$620,000			**$620,000**	$476,000	$180,000	**$656,000**	-$36,000
Otago	$3,326,468	$3,326,468			**$3,326,468**			**$866,000**	$2,460,468
Southland*	$1,395,985								
Total	**$71,817,277**	**$56,019,553**	**$507,013**	**$449,966**	**$56,976,532**	**$32,134,355**	**$16,577,148**	**$48,711,503**	**$2,560,394**

Source: DHB Survey *Nil response **DHB Price Volume excludes Inpatient Services

2.5 Current Spend per Child & Adolescent

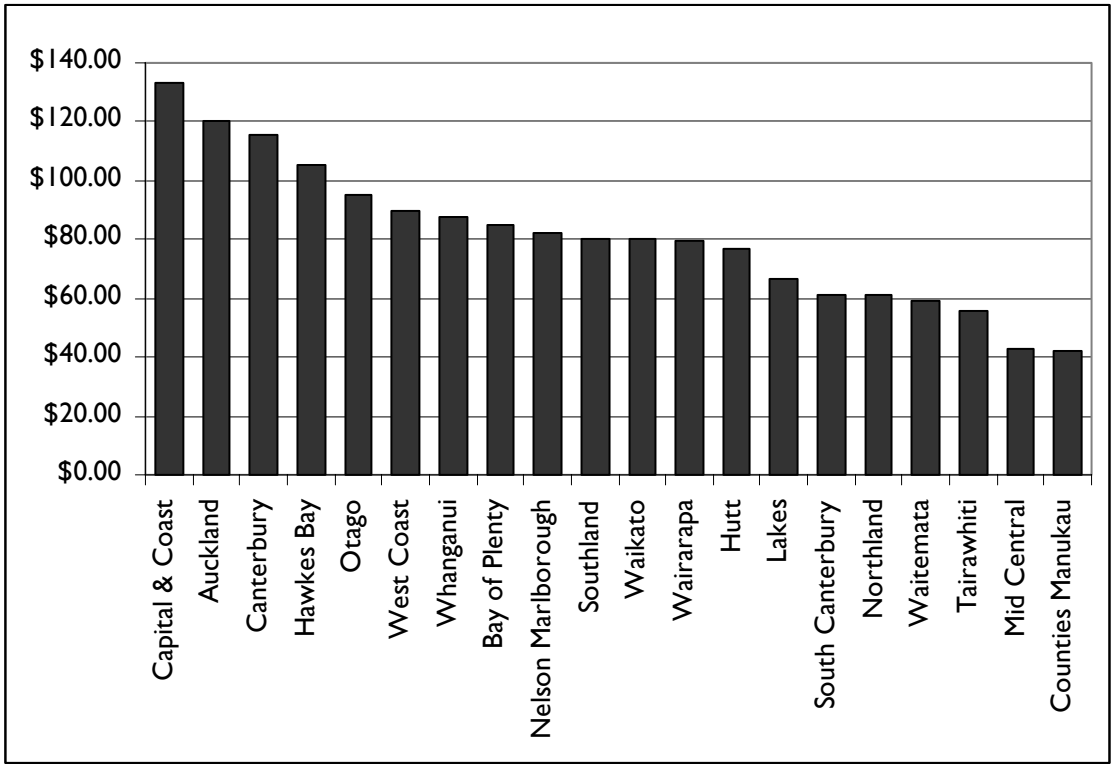
Table 29 and Figure 2 represent the 2004/2005 DHB and NGO spend on child and adolescent mental health services per head of the child/adolescent population within each region. Regional inpatient service funding has been excluded from this calculation and the funding of other regional services is assigned to the provider DHB and not allocated across other DHBs. National average spend per child/adolescent under 20 years for DHB and NGO funding increased considerably from $52 in 1999/2000 (Health Funding Authority, 2000a) to $87 (including inpatient funding) for the 2004/2005 year. Although individual DHB funding per child has been calculated (see Table 29 & Figure 2), regional services are not allocated across DHBs and therefore individual DHB funding per child should be interpreted with caution.

Table 29. Funding per Child by DHB (Excluding Inpatient Services) (2004/2005)

Provider	Total 2004/05 Dollars (DHB & NGO)	Population (0-19 Yrs) 2004 Estimates	Funding/Child	Inpatient Unit Cost (Excluded)
Northern	**$30,642,636**	**442,435**	**$69.26**	
Northland	$2,804,519	45,775	$61.27	
Waitemata	$8,407,613	141,420	$59.45	
Auckland	$13,345,657	110,860	$120.38	$5,400,860.33
Counties Manukau	$6,084,847	144,380	$42.14	
Midland	**$18,355,110**	**258,860**	**$70.91**	
Waikato	$8,476,554	105,800	$80.12	
Lakes	$2,170,224	32,430	$66.92	
Bay of Plenty	$5,026,278	59,150	$84.98	
Tairawhiti	$862,140	15,510	$55.59	
Taranaki	$1,819,914	45,970	$39.59	
Central	**$20,905,973**	**226,550**	**$92.28**	
Hawke's Bay	$3,331,843	31,690	$105.14	
MidCentral	$2,103,034	49,390	$42.58	
Whanganui	$1,729,062	19,745	$87.57	
Capital & Coast	$9,608,766	72,320	$132.86	$480,267.00
Hutt	$3,231,775	42,050	$76.86	
Wairarapa	$901,495	11,355	$79.39	
Southern	**$26,065,903**	**262,350**	**$99.36**	
Nelson Marlborough	$3,003,801	36,540	$82.21	
West Coast	$771,997	8,575	$90.03	
Canterbury	$14,336,312	123,60	$115.65	$3,456,565.07
South Canterbury	$884,255	14,385	$61.47	
Otago	$4,639,953	48,610	$95.45	
Southland	$2,429,586	30,280	$80.24	
MOH-WellTrust	**$222,222**			
Grand Total	**$96,191,844**	**1,190,195**	**$80.82**	

Note: Italicised DHBs provide Regional Services

Figure 2. Funding per Child & Adolescent (Excluding Inpatient Services) (2004/2005)



2.6 Chapter Summary

- All 21 DHBs provide child and adolescent mental health services through DHB and NGO providers. DHBs provide clinical and support services while NGOs mainly provide support and ancillary services.

- Eighty NGOs in 2004/2005 provided community-based child and adolescent mental health services.

- The composition and nature of services varies considerably across DHB regions. NGO involvement in DHB regions also varies, for example five DHBs do not contract NGOs to provide services.

- In 2004/2004, DHBs and NGOs received total funding of $96 million (which included funding for 802 FTEs, 56,101 bed days and 29 programmes) for child and adolescent mental health services

- In 2004/2005, there was a 6.8% increase over the 2003/2004 provider funding (DHBs and NGOs).

- In 2004/2005, there were 59.7 acute beds which equates to a shortfall of 21.7 beds in relation to Blueprint guideline of 81.4 beds.

- Kaupapa Māori services are purchased under a specific unit code (MHCS39) and are provided by 19 NGOs and three DHBs.

- Ten Pacific services were identified, which is of concern as Pacific mental health is a priority area for future service development (Health Funding Authority, 2000a).

- There is an increasing focus on intersectorial collaborative programmes.

- Funding per child/adolescent in New Zealand has increased considerably from $52 in 1999/2000 (Health Funding Authority, 2000a) to $87 (including inpatient funding) in 2004/2005.

- Eleven of the 18 DHBs were underspent on the CAMHS budget and three DHBs did not provide this information. Underspend may be an indication of unfilled FTEs.

Chapter 3

Access to Child & Adolescent Mental Health Services

3.0 Access to Child & Adolescent Mental Health Services

The objective of this Chapter is to identify who is accessing government funded services for children and adolescents with mental health needs by type, quantity, age, ethnicity and level of care for each region.

3.1 Literature Review & Strategic Direction

The need for more and better services was specified in the Ministry of Health report, *New Futures: A Strategic Framework for Specialist Mental Health Services for Children and Young People in New Zealand* (Ministry of Health, 1998). *The Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Mental Health Commission, 1998a) established benchmarks based on findings in *New Futures*. The benchmarks for access over a six month period for the age groups, 0-9 years, 10-14 years and 15-19 years are as follows, 1%, 3.9% and 5.5% respectively (see Tables 30 & 31).

The conjoint findings of the two New Zealand studies (Fergusson, 2003) showed that the prevalence of mental health problems is significantly higher than the existing *Blueprint* targets. This finding is consistent with research conducted overseas which suggests that the rate of disorders with clinically significant impairment in functioning associated with a mental health diagnosis in children and adolescents is 15% (Waddell & Shepherd, 2002).

Table 30. Benchmarks for Access from the New Futures Report

Age Group	People Requiring Direct Access to Specialist Services	People Requiring Consultation/ Liaison from Specialist Services
0-9 years	0.5%	0.5%
10-14 years	2.2%	1.7%
15-19 years	3.1%	2.4%

Data Source: Specialist Mental Health Services for Children and Youth: A Report of a Review of Recent and Planned Change (MHC,1999).

Table 31. Benchmarks for Access over a Six Month Period from the Blueprint

Age (yrs)	0-9	10-14	15-19
Total	1.0%	3.9%	5.5%

3.2 Access to Child & Adolescent Mental Health Services

3.2.1 Mental Health Information National Collection (MHINC)

To identify who (age 0-19 years) had accessed government funded mental health services, information available from the Ministries of Health, Education and Justice was reviewed and the Mental Health Information National Collection (MHINC) data was identified as the most relevant for this project.

MHINC is a national database of information collected by the MOH to support policy formation, monitoring, and research. The database contains information on the provision of secondary mental health and alcohol and drug services purchased by the government. This includes secondary inpatient, outpatient and community care provided by hospitals and Non-Government Organisations (NGOs).

At the time of the initial data request (October 2004), New Zealand Health Information System (NZHIS) advised that the MHINC data for the calendar year 2003 was the most complete and reliable. However, criticism of the

2003 data prompted an analysis of MHINC data for the first six months of 2004. In March 2005, the first six months of 2004 MHINC data was made available.

The analysis was modelled on the format of *Mental Health Service Use in New Zealand 2001* (Ministry of Health, 2004) although some approaches to analysis differed. The data was analysed nationally, by region and by DHB for the year 2003. The tables and graphs in this section have been prepared using data extracted by New Zealand Health Information Service (NZHIS-File No. MHC0229 (2004-0581)) from MHINC.

While there are some reservations about the completeness and accuracy of the DHB data, it is the only source of data available on a national basis. As at July 2003, most NGOs were not reporting to the MHINC. Only seven NGOs representing 117 clients are included in the 2003 MHINC database.

Population data provided by the MOH was obtained from Statistics NZ (Ref No. C13835RS). The data covers three age groups, 0-4 years, 5-14 years and 15-19 years. The census was in 2001 and all subsequent population data is projected. For the MHINC analysis, ages have been calculated at the end of the reporting period.

Ethnicity was initially split into four groups-Asian, Other, Māori and Pacific (for the MHINC definition of Ethnicity, see Appendix 2). Population data provided by the MOH did not give separate data for the Asian population and, due to the relatively small number of Asian clients (314 in 2003); Asian and Other ethnic groups were combined for population based access rates. Therefore population comparisons have been limited to Māori, Pacific and Other ethnic groups in this chapter.

The MHINC data is presented as follows:

- National access by age, gender and ethnicity 2003
- Regional access by age, gender and ethnicity 2003
- DHB access by age, gender and ethnicity 2003
- Access by Types of Service 2003
- Access by Team Types 2003
- Referrals and Referral Sources 2003
- Access Rates compared to Benchmark rates for 2003 and 2004

3.2.2 2003 National Access to Mental Health Services for Clients under 20 years

Age & Gender

In 2003, a total of 19,307 clients under 20 years of age (unique individuals) accessed mental health services. Of these, more males (59%) accessed and attended services than females (41%) (see Table 32).

There were a total of 184,699 attendances. Attendance is the number of times the mental health service has been accessed. Each attendance may be multiple bed days or multiple contacts. Attendance rates analysed by age groups revealed that the largest group of clients attending services were 15-19 year olds (54%) with females accessing services slightly more than males in this age group only (see Table 33 & Table 34).

Table 32. Clients Seen by Age Group & Gender (2003)

Clients	Age Group (yrs)			Total
	0-9	10-14	15-19	
Male	2,582	4,275	4,502	**11,359**
Female	1,056	2,192	4,697	**7,945**
Unknown	2	-	1	**3**
Total	**3,640**	**6,467**	**9,200**	**19,307**

Table 33. Attendances by Age Group & Gender (2003)

Clients	Age Group (yrs)			Total
	0-9	10-14	15-19	
Male	19,765	36,633	47,048	**103,446**
Female	7,713	20,781	52,722	**81,216**
Unknown	30	-	7	**37**
Total	**27,508**	**57,414**	**99,777**	**184,699**

Table 34. Average Attendances by Age Group & Gender (2003)

Clients	Age Group (yrs)			Total
	0-9	10-14	15-19	
Male	8	9	10	**9**
Female	7	9	11	**10**
Unknown	15	-	7	**12**
Total	**8**	**9**	**11**	**10**

Age & Ethnicity

Access rates analysed by ethnicity (for the MHINC definition of ethnicity, see Appendix 2) showed that out of the 19,307 clients that accessed mental health services, 15-19 year old clients were once again the largest age group accessing mental health services in all four ethnic groups. The majority (76%) were from the 'Other' group followed by Māori (19%), Pacific (2.9%) and Asians (1.6%) (see Table 35, 36, 37 & 38 & Figure 3).

Table 35. Clients Seen by Age Group & Ethnicity (2003)

Ethnicity of Clients	Age Group (yrs)			Total	%
	0-9	10-14	15-19		
Other	2,883	4,981	6,828	**14,692**	76.1
Māori	626	1,280	1,836	**3,742**	19.4
Pacific	87	134	338	**559**	2.9
Asian	44	72	198	**314**	1.6
Total	**3,640**	**6,467**	**9,200**	**19,307**	**100**

Table 36. Attendances by Age Group & Ethnicity (2003)

Ethnicity	Age Group			Total
Attendance	0-4	5-14	15-19	
Pacific	603	849	3,770	5,222
Asian	242	650	2,687	3,579
Māori	5,014	12,203	20,704	37,921
Other	21,649	43,712	72,616	137,977
Total	**27,508**	**57,414**	**99,777**	**184,699**

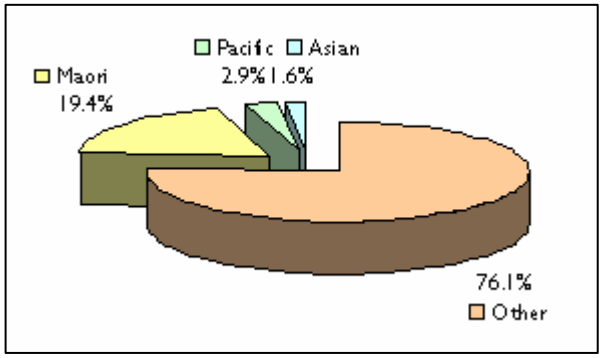
Table 37. Average Attendances by Age Group & Ethnicity (2003)

Ethnicity	Age Group			Total
Attendance	0-4	5-14	15-19	
Pacific	7	6	6	9
Asian	5	9	9	11
Māori	8	10	10	10
Other	8	9	9	9
Total	**8**	**9**	**9**	**10**

Table 38. Clients Seen by Ethnicity & Gender Under 20 yrs Population (2003)

Clients	Male		Female		Unknown		Total	
	No	%	No	%	No	%	No	%
Pacific	333	2.9	226	2.8	-	0.0	559	2.9
Asian	160	1.4	152	1.9	2	66.7	314	1.6
Māori	2,379	20.9	1,363	17.2	-	0.0	3,742	19.4
Other	8,487	74.7	6,204	78.1	1	33.3	14,692	76.1
Total	**11,359**	**100**	**7,945**	**100**	**3**	**100**	**19,307**	**100**

Figure 3. Clients Seen by Ethnicity for Population under the Age of 20 yrs for 2003



3.2.3 Population Based Access Rates by Age, Gender & Ethnicity

In order to facilitate comparisons of groups, the access rates for 2003 have been presented as a percentage of the specific populations. The percentage was calculated by dividing the number of clients by the population specific to that group. Children and adolescent population figures for 2003 are provided in Table 39 and 40.

Table 39. Population Projections (2003)

Projected NZ (under 20 years) Resident Population by Age & Gender 2003 (2001-Base)										
	Male			Female			Total			
	0-9	10-14	15-19	0-9	10-14	15-19	0-9	10-14	15-19	Total
Other	191,670	110,950	110,800	181,950	105,110	105,440	373,620	216,060	216,240	**805,920**
Māori	75,450	36,220	29,640	71,010	34,600	29,520	146,460	70,820	59,160	**276,440**
Pacific	27,060	13,290	10,840	25,860	12,540	10,400	52,920	25,830	21,240	**99,990**
Total	**294,180**	**160,460**	**151,270**	**278,820**	**152,250**	**145,360**	**573,000**	**312,710**	**296,630**	**1,182,350**

Source: Statistics New Zealand Ref No: CI 3835RS

Table 40. Projected 0-19 yrs Resident Population by Region & Age Group (2003)

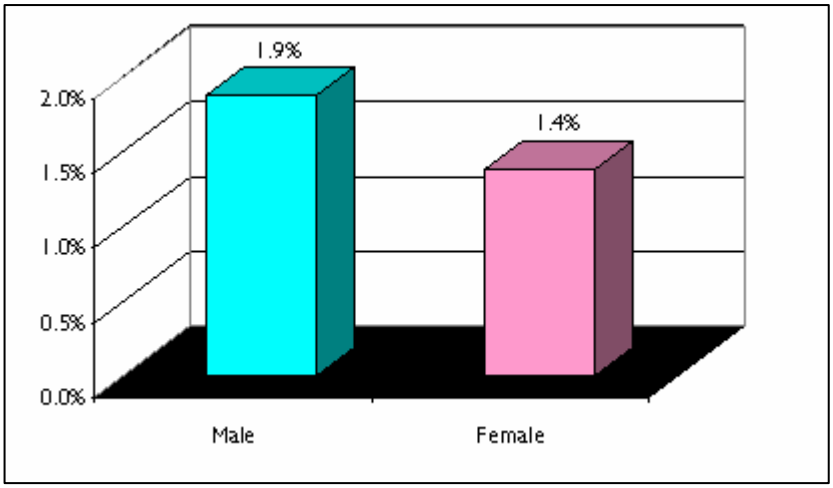
	Age Grouping			
Region	**0-9**	**10-14**	**15-19**	**Grand Total**
Northern	216,075	113,495	104,860	434,430
Midland	126,450	70,305	61,730	258,485
Central	109,365	60,150	57,320	226,835
Southern	121,135	68,735	72,680	262,550
Total	**573,025**	**312,685**	**296,590**	**1,182,300**

Source: Statistics New Zealand Ref No: C13835RS

Access by Gender

Access by gender as a percentage of population showed that in 2003, there were slightly more males (1.9%) accessing mental health services than females (1.4%) (see Figure 4).

Figure 4. Clients Seen as a Percentage of Population by Gender (2003)



Access by Age & Gender

In 2003, access by gender as a percentage of population (percentage calculated by the number of clients by population specific to that group) also showed that access to services increased with age: 0-9 years (0.63%), 10-14 years (2.07%) and 15-19 years (3.10%) (see Figures 5-7).

Figure 5. Clients Seen as a Percentage of Population by Age Group (2003)

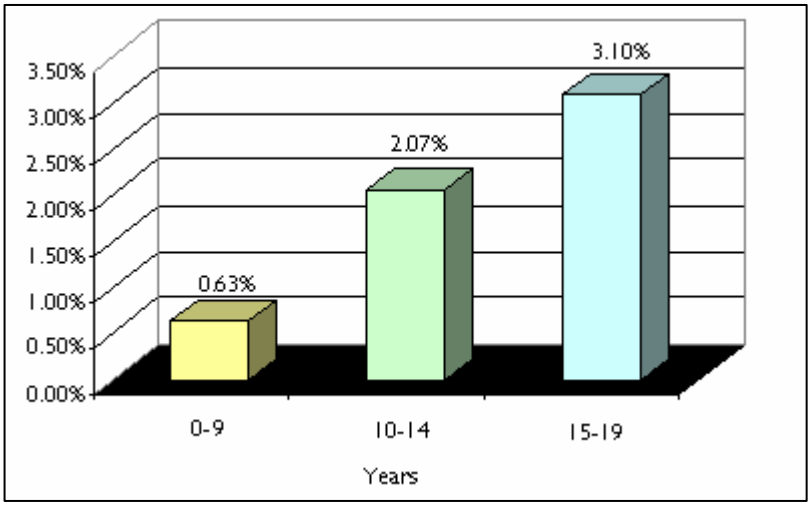


Figure 6. Male Clients as a Percentage of under 20 yrs Population by Age Group (2003)

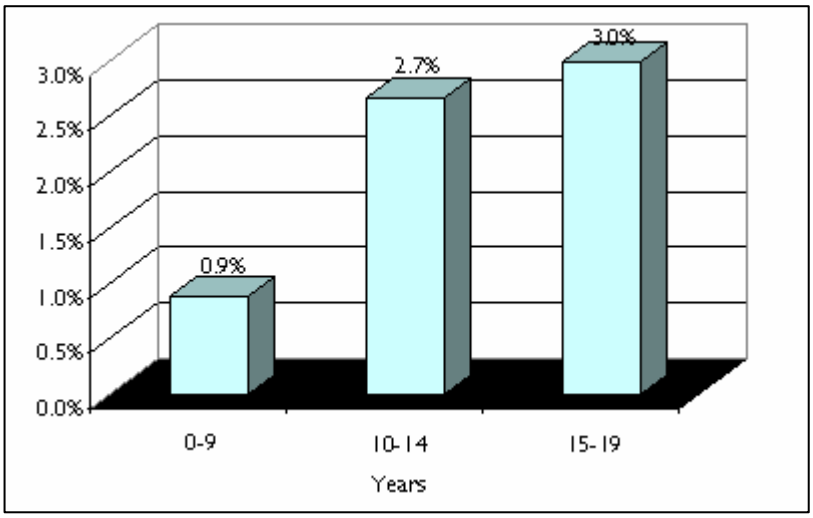
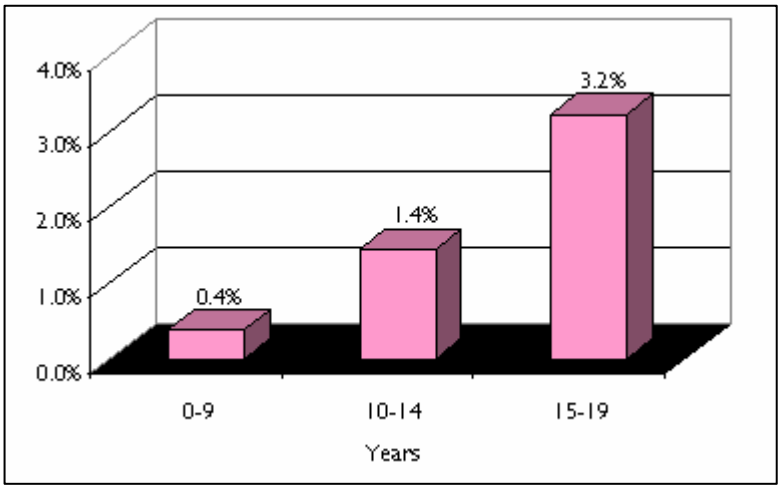


Figure 7. Female Clients as a Percentage of under 20 yrs Population by Age Group (2003)



Annual Māori & Pacific Access Rates

As a percentage of population, the Pacific (0.56%) and Māori annual access rates (1.35%) for 2003 were lower than the annual access rates for the rest of the population (Figures 8-10). Access increased with age in all three ethnic groups (Figure 9). Of note, Māori access (3.10%) in the 15-19 year age group was close to the rest of the population (3.25%).

Figure 8. Clients Seen as a Percentage of Population by Ethnicity (2003)

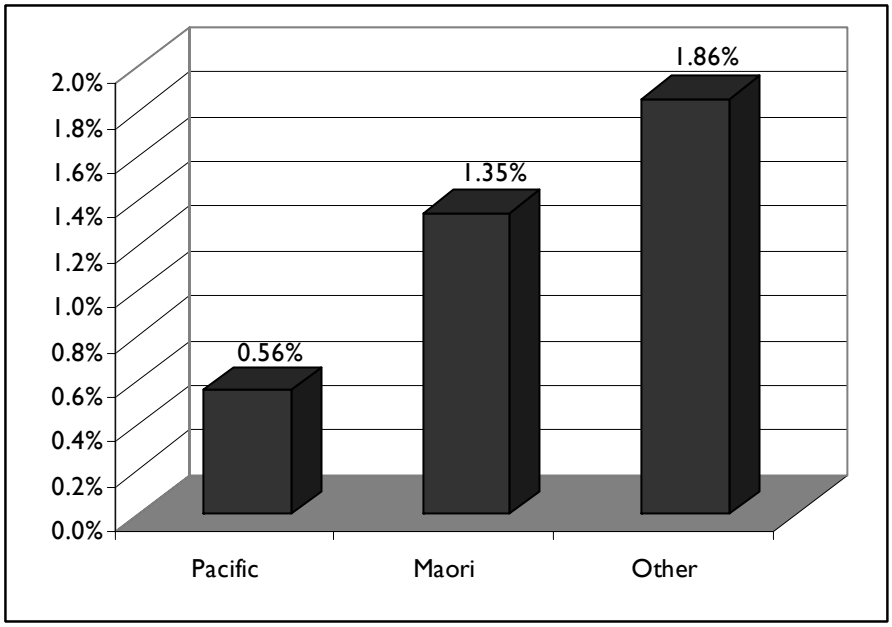


Figure 9. Clients seen as a Percentage of Population by Age Group & Ethnicity (2003)

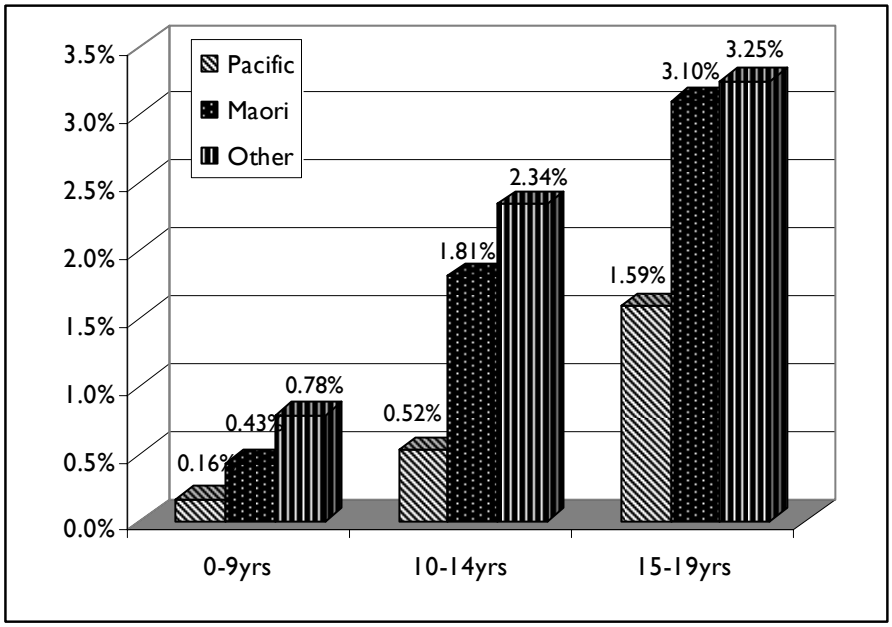
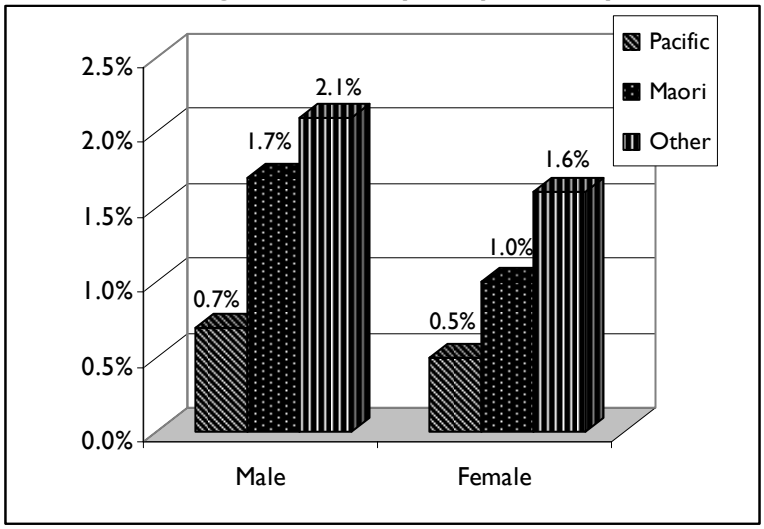


Figure 10. Clients as a Percentage of under 20 yrs Population by Gender & Ethnicity (2003)



Gender/Age/Ethnicity

Table 41. Clients under the Age of 20 yrs by Age Group, Ethnicity & Gender (2003)

2003 Calendar Year (n =19,307)									
	0-9 Years			10-14 Years			15-19 years		
Ethnicity	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown
Pacific	69	18		84	50		180	158	
Asian	33	10	1	46	26		81	116	1
Māori	460	166		860	420		1,059	777	
Other	2,020	862	1	3,285	1,696		3,182	3,646	
Total	**2,582**	**1,056**	**2**	**4,275**	**2,192**	**0**	**4,502**	**4,697**	**1**

Figure 11. Male Clients as a Percentage of under 20 yrs population by Age & Ethnicity (2003)

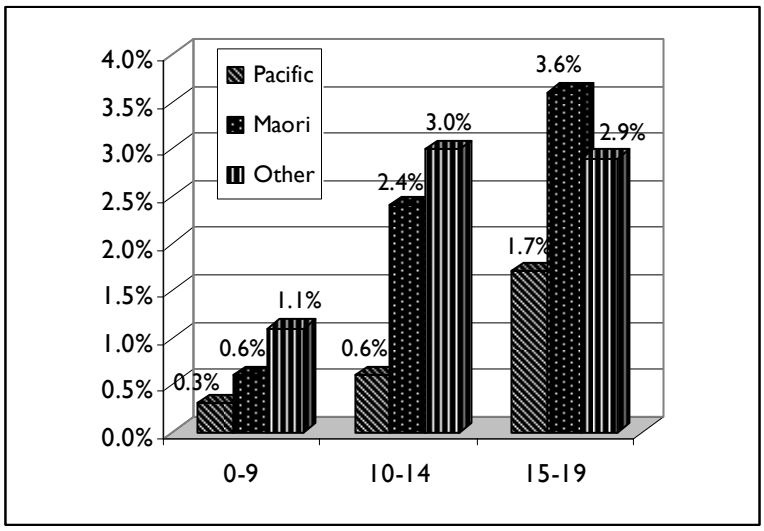
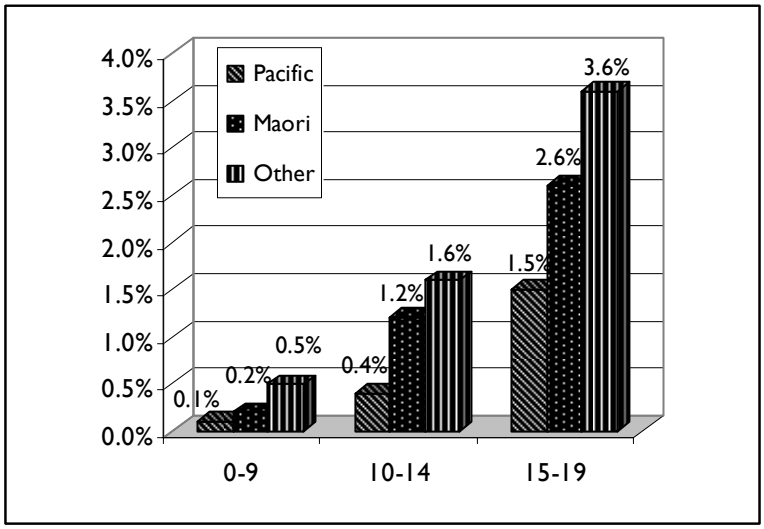


Figure 12. Female Clients as a Percentage of under 20 yrs population by Age & Ethnicity (2003)



3.2.4 Regional Access by Age, Gender & Ethnicity

All regional analysis has been conducted using the geographic codes in the access file mapped to regions. The number of unique clients aged 0-19 in New Zealand is less than the sum of clients by DHB, as clients can live in more than one DHB region in one year and maybe counted more than once.

Regional Access by Age & Gender

Regional access in 2003 analysed by gender revealed that there were more male clients in the 0-9 and 10-14 year age groups across all regions (see Table 42) while the Midland, Central and Southern had more female than male clients in the 15-19 age group.

Table 42. Clients by Region, Age Group & Gender (2003)

Region	Age Group (yrs)			Total
	0-9	10-14	15-19	
Northern	**664**	**1,428**	**2,318**	**4,410**
Female	139	448	1,126	**1,713**
Male	525	980	1,192	**2,697**
Midland	**876**	**1,506**	**2,003**	**4,385**
Female	265	498	1,036	**1,799**
Male	611	1,008	967	**2,586**
Central	**1,148**	**1,854**	**2,564**	**5,566**
Female	380	694	1,314	**2,388**
Male	768	1,160	1,250	**3,178**
Southern	**960**	**1,729**	**2,390**	**5,079**
Female	274	576	1,264	**2,114**
Male	686	1,153	1,126	**2,965**
Total	**3,648**	**6,517**	**9,275**	**19,440**
Unique Total	**3,640**	**6,467**	**9,200**	**19,307**

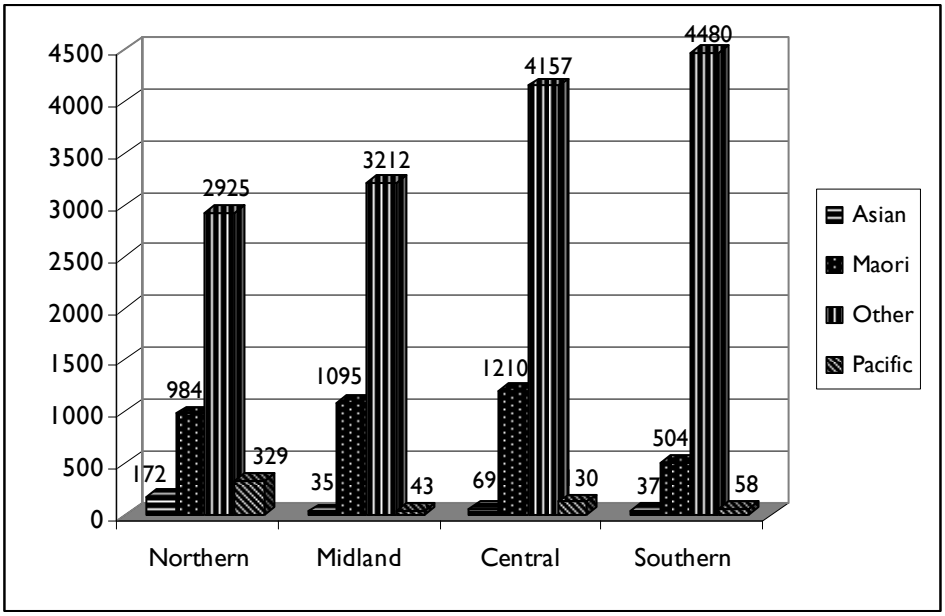
Regional Access by Age & Ethnicity

Regional access in 2003 analysed for ethnicity showed that the 'Other' group made up the bulk of the clients across all regions in all three age groups followed by Māori clients (see Table 43 and Figure 13). The largest number of Māori clients was in the Central and Midland regions in the 15-19 year age group. The Northern region had the largest numbers of Pacific and Asian clients once again in the 15-19 year age group.

Table 43. Clients by Region, Age Group & Ethnicity (2003)

Region	Ethnicity			
	Asian	Māori	Other	Pacific
Northern	**172**	**984**	**2,925**	**329**
0-9	19	152	455	38
10-14	42	335	976	75
15-19	111	497	1,494	216
Midland	**35**	**1,095**	**3,212**	**43**
0-9	5	183	674	14
10-14	9	378	1,114	5
15-19	21	534	1,424	24
Central	**69**	**1,210**	**4,157**	**130**
0-9	15	219	891	23
10-14	16	410	1,387	41
15-19	38	581	1,879	66
Southern	**37**	**504**	**4,480**	**58**
0-9	4	77	867	12
10-14	5	170	1,541	13
15-19	28	257	2,072	33
Total	**313**	**3,793**	**14,774**	**560**
Unique Total	**313**	**3,742**	**14,692**	**559**

Figure 13. Clients by Region & Ethnicity (2003)



3.2.5 Access to DHB Services by Age, Ethnicity & Gender

The analysis on the number of services accessed by clients has been conducted on the DHB of service (DHB of service is the DHB where the client received the service) rather than the DHB of domicile (DHB of domicile is the DHB area where the client lives).

"Unique Clients" is the number of distinct individuals, within certain parameters (such as by team type, by agency, by service for NZ total). If "Unique Clients" is summed across a variable (such as by team type, by agency, by service for NZ total), the total will be greater than the number of unique clients as people will be counted more than once.

In 2003, a total of 19,314 unique clients related to a total of 20,211 clients when analysed by DHB of service. Therefore all further analysis by referrals to DHBs of Service is based on the total number of clients, 20,211. Of interest is that 805 clients received services from more than one DHB (for example, 2 clients received services from 5 different DHBs) (see Table 44).

Table 44. Number of Clients to the Number of DHB Services (2003)

Number of Unique Clients	Number of DHBs of Service	DHB Clients
2	5	10
9	4	36
68	3	204
726	2	1,452
18,509	1	18,509
19,314		**20,211**

The largest number of clients was in Canterbury, Waitemata, Capital & Coast, Waikato, Otago, Bay of Plenty and Nelson & Marlborough DHBs. Additionally, the number of clients by age group and gender showed that the majority were 15-19 year old males (see Table 45).

Table 45. Clients by DHB of Service (2003)

DHB_Code & Name		Unique Clients	Bed Days	Contacts
022	Auckland	856	6,797	10,010
047	Bay of Plenty	1,313	278	13,485
121	Canterbury	2,381	4,397	18,869
091	Capital & Coast	1,543	3,976	18,926
023	Counties Manukau	970	649	7,429
061	Hawke's Bay	672	349	7,664
092	Hutt	820	124	11,775
042	Lakes	464	241	4,789
081	MidCentral	931	247	13,181
101	Nelson Marlborough	1,128	1,145	9,695
011	Northland	696	346	12,100
131	Otago	1,470	1,736	21,870
141	Southland	268	103	2,265
123	South Canterbury	788	361	6,167
051	Tairawhiti	368	121	2,670
071	Taranaki	707	444	4,705
031	Waikato	1,518	1,153	13,938
093	Wairarapa	217	119	1,901
021	Waitemata	2,257	814	26,163
111	West Coast	351	191	4,543
082	Whanganui	493	508	5,186
	Total	**20,211**	**24,099**	**217,331**
	Unique Clients	**19,314**		

Table 46. Clients by DHBs, Age Group & Gender (2003)

DHB		Male				Female				Unknown	
Code	**Name**	**0-9**	**10-14**	**15-19**	**Total**	**0-9**	**10-14**	**15-19**	**Total**		**DHB Total**
011	Northland	90	187	167	**444**	27	66	159	**252**		**696**
021	Waitemata	245	447	736	**1,428**	63	213	553	**829**		**2,257**
022	Auckland	81	153	234	**468**	20	83	285	**388**		**856**
023	Counties Manukau	119	222	234	**575**	32	113	250	**395**		**970**
031	Waikato	169	372	361	**902**	66	164	386	**616**		**1,518**
042	Lakes	78	89	93	**260**	30	46	128	**204**		**464**
047	Bay of Plenty	204	288	292	**784**	89	160	280	**529**		**1,313**
051	Tairawhiti	44	77	74	**195**	30	56	86	**172**	**1**	**368**
061	Hawke's Bay	82	132	168	**382**	29	91	170	**290**		**672**
071	Taranaki	114	170	150	**434**	51	75	147	**273**		**707**
081	MidCentral	124	207	222	**553**	60	102	216	**378**		**931**
082	Whanganui	52	107	129	**288**	28	55	122	**205**		**493**
091	Capital & Coast	216	306	370	**892**	101	165	383	**649**	**2**	**1,543**
092	Hutt	135	178	144	**457**	92	105	166	**363**		**820**
093	Wairarapa	28	33	45	**106**	14	37	60	**111**		**217**
101	Nelson Marlborough	135	222	273	**630**	62	154	282	**498**		**1,128**
111	West Coast	36	88	81	**205**	14	49	83	**146**		**351**
121	Canterbury	335	530	512	**1,377**	124	239	641	**1,004**		**2,381**
123	South Canterbury	44	65	62	**171**	7	31	59	**97**		**268**
131	Otago	194	322	328	**844**	96	173	357	**626**		**1,470**
141	Southland	89	185	203	**477**	38	90	183	**311**		**788**
	Total	**2,614**	**4,380**	**4,878**	**11,872**	**1,073**	**2,267**	**4,996**	**8,336**	**3**	**20,211**
	Unique Clients										**19,314**

Figure 14. Average Clients per Month for DHBs of Service (2003)

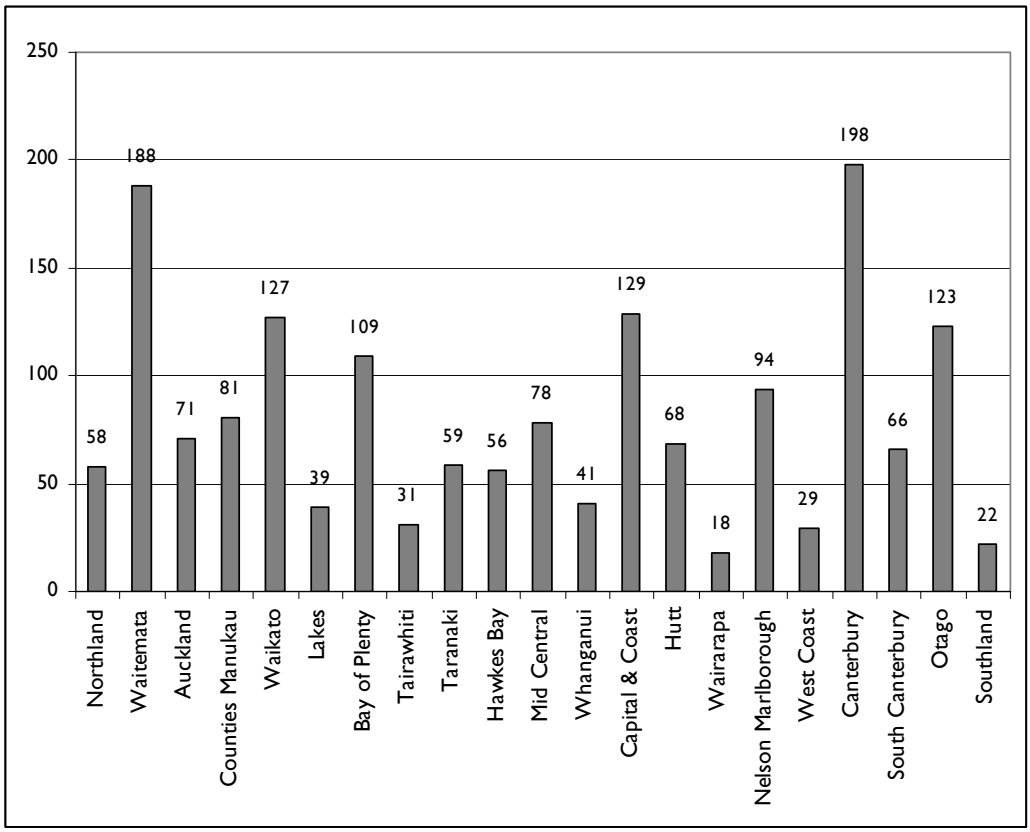


Table 47. DHB of Domicile vs. DHB of Service (2003)

	District Health Board of Service & District Health Board of Client Domicile																						
Domicile → **Service ↓**	**Auckland**	**Bay of Plenty**	**Canterbury**	**Capital & Coast**	**Counties Manukau**	**Hawke's Bay**	**Hutt**	**Lakes**	**MidCentral**	**Nelson Marlborough**	**Northland**	**Otago**	**Southland**	**South Canterbury**	**Tairawhiti**	**Taranaki**	**Unknown**	**Waikato**	**Wairarapa**	**Waitemata**	**West Coast**	**Whanganui**	**Total**
Auckland	646	5	6	3	52	1		7		1	18	2	1		2	5	1	14		132	1		**897**
Bay of Plenty	5	1385	2		3	2	1	10		3	1	2	2		1	1	8	15		3		1	**1445**
Canterbury	6	4	2198	6	12	2	3	1	1	26	2	34	10	24		5	4	8	1	9	29	3	**2388**
Capital & Coast	5	4	5	1445	4	36	94	2	42	2	3	3	1		10	6	2	8	19	5		28	**1724**
Counties Manukau	74	8	2	2	867	2	1	1	2		8				1	1	1	13		19		2	**1004**
Hawke's Bay	3	2		3	3	689	2	4	10	3	1				6		1	4		2		3	**736**
Hutt Valley	1	1	2	38		1	871	1	2	2						1			6			1	**927**
Lakes		12	2	1	1	3	1	474	1	1			1		2	1		13		1		3	**517**
MidCentral	3	6	5	34	7	13	8	4	814	4	4	4			1	4	1	10	7	9		23	**961**
Nelson Marlborough	1	1	14	4	2	1	3	1	1	1086		8	1			1	1	4	1	1	5	3	**1139**
Northland	10	5	1	16	12	2	2	3	2		670	2		1		2	1	6	1	28		3	**767**
Otago	2		11	6	2	1	3		1	4	5	1418	21	6			3	1		4	3		**1491**
South Canterbury	2	1	19	1	2	1				3		10	1	239		1	1		1	1	3		**286**
Southland	1	1	8	1		1	2		1	3	1	52	717	3				4			1	1	**797**
Tairawhiti	1	5		2	3	8	3	1	3		1		1		332	4		7		2	1	4	**378**
Taranaki		1		1	2	1	4		3							749		2		2	1	1	**767**
Waikato	6	26		1	4	2	5	24		1	5	1		2	2	7	1	1555		3		1	**1646**
Wairarapa				8	1	1	8	1	5							2	1		212	1		1	**241**
Waitemata	272	6	9	3	210	6	1	14	1	6	44	2		1	1	11	18	34		1986	1	1	**2627**
West Coast		1	1	2			1	1		1		1	1	1		1	1	1		1	343		**357**
Whanganui	1	1	2	6	2	2	4	2	11	1	1					9	1	2	1	1		465	**512**
Total	**1039**	**1475**	**2287**	**1583**	**1,189**	**775**	**1017**	**551**	**900**	**1147**	**764**	**1539**	**757**	**277**	**358**	**811**	**46**	**1701**	**249**	**2210**	**388**	**544**	**21607**

Table 48. Clients by DHBs of Domicile by Age Group & Gender (2003)

DHB Code & Name		Gender	Age Group (Yrs) 0-9	10-14	15-19	Total	DHB Total
011	Northland	Female	24	60	153	237	668
		Male	87	183	161	431	
021	Waitemata	Female	65	202	442	709	1,847
		Male	251	431	456	1,138	
022	Auckland	Female	17	81	312	410	951
		Male	77	158	306	541	
023	Counties Manukau	Female	33	113	277	423	1,090
		Male	117	229	321	667	
031	Waikato	Female	68	163	394	625	1,552
		Male	177	382	368	927	
042	Lakes	Female	31	51	130	212	483
		Male	82	98	91	271	
047	Bay of Plenty	Female	92	161	284	537	1,336
		Male	202	296	301	799	
051	Tairawhiti	Female	30	49	79	158	341
		Male	43	70	69	182	
		Unknown			1	1	
061	Hawke's Bay	Female	28	90	174	292	683
		Male	84	133	174	391	
071	Taranaki	Female	51	78	160	289	736
		Male	116	173	158	447	
081	MidCentral	Female	55	94	200	349	843
		Male	108	184	202	494	
082	Whanganui	Female	30	56	120	206	505
		Male	53	111	135	299	
091	Capital & Coast	Female	102	164	337	603	1,411
		Male	226	310	270	806	
		Unknown	2			2	
092	Hutt	Female	93	111	170	374	867
		Male	139	181	173	493	
093	Wairarapa	Female	13	36	60	109	223
		Male	29	32	53	114	
101	Nelson Marlborough	Female	64	152	279	495	1,118
		Male	135	220	268	623	
111	West Coast	Female	16	54	85	155	367
		Male	37	95	80	212	
121	Canterbury	Female	118	227	599	944	2,256
		Male	330	497	485	1,312	
123	South Canterbury	Female	7	32	54	93	256
		Male	43	65	55	163	
131	Otago	Female	101	180	365	646	1,496
		Male	195	333	322	850	
141	Southland	Female	32	86	175	293	744
		Male	86	171	194	451	
999	Unknown	Female	3	1	15	19	43
		Male	5	2	17	24	
	Total		**3,697**	**6,595**	**9,524**	**19,816**	**19,816**

Table 49. Clients by DHBs of Domicile by Ethnicity & Gender (2003)

(N = 19,816)						
			Ethnicity			
DHB Code & Name		Gender	Asian	Māori	Other	Pacific
011	Northland	Female	2	80	152	3
		Male	1	208	214	8
021	Waitemata	Female	25	110	535	39
		Male	30	175	880	53
022	Auckland	Female	30	65	278	37
		Male	37	92	344	68
023	Counties Manukau	Female	31	101	238	53
		Male	24	201	366	76
031	Waikato	Female	7	108	503	7
		Male	14	196	711	6
042	Lakes	Female	3	54	152	3
		Male	2	81	182	6
047	Bay of Plenty	Female	1	136	394	6
		Male	4	257	527	11
051	Tairawhiti	Female		73	85	
		Male		99	81	2
		Unknown	1			
061	Hawke's Bay	Female		79	209	4
		Male	3	152	231	5
071	Taranaki	Female	2	47	238	2
		Male	2	67	378	
081	MidCentral	Female		67	279	3
		Male	2	113	376	3
082	Whanganui	Female	2	46	156	2
		Male	1	86	209	3
091	Capital & Coast	Female	13	105	454	31
		Male	15	202	548	41
		Unknown	1		1	
092	Hutt	Female	13	77	264	20
		Male	16	124	340	13
093	Wairarapa	Female		26	83	
		Male		24	87	3
101	Nelson Marlborough	Female	2	50	441	2
		Male	4	76	537	6
111	West Coast	Female		27	128	
		Male		28	184	
121	Canterbury	Female	15	77	842	10
		Male	6	102	1,191	13
123	South Canterbury	Female	1	8	84	
		Male		21	139	3
131	Otago	Female	8	45	580	13
		Male	5	82	752	11
141	Southland	Female	1	46	241	5
		Male	2	75	371	3
999	Unknown	Female		3	15	1
		Male		8	14	2
	Total		**326**	**3,899**	**15,014**	**577**

Table 50. Clients by DHB of Domicile, DHB of Service & Gender (2003)

DHB Code	Name	Gender	Domicile	Service
011	Northland	Female	237	252
		Male	431	444
021	Waitemata	Female	709	829
		Male	1,138	1,428
022	Auckland	Female	410	388
		Male	541	468
023	Counties Manukau	Female	423	395
		Male	667	575
031	Waikato	Female	625	616
		Male	927	902
042	Lakes	Female	212	204
		Male	271	260
047	Bay of Plenty	Female	537	529
		Male	799	784
051	Tairawhiti	Female	158	172
		Male	182	195
		Unknown	1	1
061	Hawke's Bay	Female	292	273
		Male	391	434
071	Taranaki	Female	289	290
		Male	447	382
081	MidCentral	Female	349	378
		Male	494	553
082	Whanganui	Female	206	205
		Male	299	288
091	Capital & Coast	Female	603	649
		Male	806	892
		Unknown	2	2
092	Hutt	Female	374	363
		Male	493	457
093	Wairarapa	Female	109	111
		Male	114	106
101	Nelson Marlborough	Female	495	498
		Male	623	630
111	West Coast	Female	155	146
		Male	212	205
121	Canterbury	Female	944	1,004
		Male	1,312	1,377
123	South Canterbury	Female	93	97
		Male	163	171
131	Otago	Female	646	626
		Male	850	844
141	Southland	Female	293	311
		Male	451	477
999	Unknown	Female	19	
		Male	24	
	Total		**19,816**	**20,211**

3.2.6 Access by Types of Service

A service code describes the type of mental healthcare the healthcare user receives. A complete list of referrals to the different types of mental health service is provided in Table 52.

In 2003, a total of 19,295 unique clients receiving services related to a total of 35,409 clients. Therefore all further analysis by Service Code is based on 35,409 clients. Of interest is that 51% of the clients (9,886) received more than one type of mental health service (for example, 2 clients received 10 different types of mental health services) (see Table 51).

Table 51. Number of Unique Clients to Types of Services (2003)

Unique Clients	Number of Different Types of Mental Health Services	Clients per Service Combination
2	10	20
8	9	72
12	8	96
63	7	441
94	6	564
298	5	1,490
880	4	3,520
2,739	3	8,217
5,790	2	11,580
9,409	1	9,409
19,295		**35,409**

Clients by Service Type

In 2003, the majority of clients were for mental health individual treatment attendances (17,081) followed by mental health care co-ordination contacts (7,516), mental health contact with family/whanau (4,581) and mental health crisis attendances (2,979) (see Table 52) with slightly more male clients referred to these service types. Access to the above service types by age group showed that the bulk of the clients (17,840) were 15-19 year olds (see Table 54). Ethnic data (Table 55) showed that the majority of clients were from the "Other" ethnic group (26,343) followed by Māori (7,437), Pacific (1,021) and Asians (608).

Table 52. Clients by Service Type (2003)

Service Code	Type of Mental Health Care Service	2003 Unique Clients	Bed Days	Contacts
T01	Mental health crisis attendances	2,979	0	6,977
T02	Mental health intensive care inpatient occupied bed days	123	1,400	0
T03	Mental health acute inpatient occupied bed days	644	19,613	0
T04	Mental health sub-acute inpatient occupied bed days	16	480	0
T05	Mental health crisis respite care occupied bed days	22	132	0
T06	Mental health individual treatment attendances	17,081	0	134,325
T07	Mental health group programme attendances	904	0	4,968
T08	Mental health care co-ordination contacts	7,516	0	40,207
T09	Early psychosis intervention attendance	477	0	4,166
T10	Support needs assessment attendances	414	0	575
T12	Mental health medium secure inpatient occupied bednights	13	1,061	0
T15	Court liaison attendances	198	0	605
T16	Substance abuse detoxification occupied bed nights (medical)	7	60	0
T17	Substance abuse detoxification attendance (social)	26	0	39
T18	Methadone treatment specialist service attendances (clients of specialist services)	34	0	157
T19	Methadone treatment specialist service attendances (clients of authorized GPs)	11	0	16
T20	Substance abuse residential service occupied bed nights	5	195	0
T21	Psychiatric disability rehabilitation occupied bed nights	9	1,266	0
T22	Mental health day treatment programme attendances	132	0	3,881
T23	Mental health day activity programme attendances	34	0	272
T24	Work opportunities programme attendances	22	0	61
T26	Community mental health residential level 2 occupied bed nights	1	195	0
T27	Community mental health residential level 3 occupied bed nights	3	50	0
T28	Community mental health residential level 4 occupied bed nights	2	167	0
T30	Community mental health residential long-term occupied bed nights	4	45	0
T31	Home-based care contacts	151	0	498
T32	Mental health contact with family/whanau (new from 1 July 2002)	4,581	0	20,928
		35,409	**24,664**	**217,675**
	Unique Clients	**19,295**		

Table 53. Clients by Service Type & Gender (2003)

Service Code	Type of Mental Health Care Service	Female	Male	Unknown	Total
T01	Mental health crisis attendances	1,661	1,318		**2,979**
T02	Mental health intensive care inpatient occupied bed days	32	91		**123**
T03	Mental health acute inpatient occupied bed days	309	335		**644**
T04	Mental health sub-acute inpatient occupied bed days	7	9		**16**
T05	Mental health crisis respite care occupied bed days	16	6		**22**
T06	Mental health individual treatment attendances	7,011	10,067	3	**17,081**
T07	Mental health group programme attendances	423	481		**904**
T08	Mental health care co-ordination contacts	3,033	4,481	2	**7,516**
T09	Early psychosis intervention attendance	207	270		**477**
T10	Support needs assessment attendances	139	275		**414**
T12	Mental health medium secure inpatient occupied bednights		13		**13**
T15	Court liaison attendances	35	163		**198**
T16	Substance abuse detoxification occupied bed nights (medical)	5	2		**7**
T17	Substance abuse detoxification attendance (social)	15	11		**26**
T18	Methadone treatment specialist service attendances (clients of specialist services)	14	20		**34**
T19	Methadone treatment specialist service attendances (clients of authorized GPs)	7	4		**11**
T20	Substance abuse residential service occupied bed nights	2	3		**5**
T21	Psychiatric disability rehabilitation occupied bed nights	2	7		**9**
T22	Mental health day treatment programme attendances	79	53		**132**
T23	Mental health day activity programme attendances	13	21		**34**
T24	Work opportunities programme attendances	11	11		**22**
T26	Community mental health residential level 2 occupied bed nights		1		**1**
T27	Community mental health residential level 3 occupied bed nights	3			**3**
T28	Community mental health residential level 4 occupied bed nights	2			**2**
T30	Community mental health residential long-term occupied bed nights	3	1		**4**
T31	Home-based care contacts	63	88		**151**
T32	Mental health contact with family/whanau (new from 1 July 2002)	1,936	2,643	2	**4,581**
		15,028	**20,374**	**7**	**35,409**

Table 54. Clients by Service Type & Age Group (2003)

2003 Calendar Year (n = 35,409)				
		Age Group (Yrs)		
Service Code	Type of Mental Health Care Service	0-9	10-14	15-19
T01	Mental health crisis attendances	102	563	2314
T02	Mental health intensive care inpatient occupied bed days		2	121
T03	Mental health acute inpatient occupied bed days	25	68	551
T04	Mental health sub-acute inpatient occupied bed days		1	15
T05	Mental health crisis respite care occupied bed days	1	1	20
T06	Mental health individual treatment attendances	3,235	5,823	8,023
T07	Mental health group programme attendances	90	286	528
T08	Mental health care co-ordination contacts	1,380	2,633	3,503
T09	Early psychosis intervention attendance	56	110	311
T10	Support needs assessment attendances	75	175	164
T12	Mental health medium secure inpatient occupied bednights			13
T15	Court liaison attendances	2	24	172
T16	Substance abuse detoxification occupied bed nights (medical)			7
T17	Substance abuse detoxification attendance (social)	3	3	20
T18	Methadone treatment specialist service attendances (clients of specialist services)	4	5	25
T19	Methadone treatment specialist service attendances (clients of authorized GPs)		3	8
T20	Substance abuse residential service occupied bed nights			5
T21	Psychiatric disability rehabilitation occupied bed nights			9
T22	Mental health day treatment programme attendances		28	104
T23	Mental health day activity programme attendances		12	22
T24	Work opportunities programme attendances		3	19
T26	Community mental health residential level 2 occupied bed nights			1
T27	Community mental health residential level 3 occupied bed nights			3
T28	Community mental health residential level 4 occupied bed nights			2
T30	Community mental health residential long-term occupied bed nights			4
T31	Home-based care contacts	13	44	94
T32	Mental health contact with family/whanau (new from 1 July 2002)	1,012	1,787	1,782
	Total	**5,998**	**11,571**	**17,840**

Please note that some clients have accessed service codes that were not expected in these age-groups e.g. T18 (methadone treatment specialist service attendance) for 0-9 year olds. It is beyond the scope of this project to check the accuracy of this data back to the source.

Table 55. Clients by Service Type & Ethnicity (2003)

(n = 35,409)					
		Ethnicity			
Service Code	Type of Mental Health Care Service	Asian	Māori	Other	Pacific
T01	Mental health crisis attendances	64	647	2,163	105
T02	Mental health intensive care inpatient occupied bed days	2	49	65	7
T03	Mental health acute inpatient occupied bed days	21	179	418	26
T04	Mental health sub-acute inpatient occupied bed days		3	12	1
T05	Mental health crisis respite care occupied bed days		7	14	1
T06	Mental health individual treatment attendances	267	3,269	13,035	510
T07	Mental health group programme attendances	22	193	662	27
T08	Mental health care co-ordination contacts	113	1,794	5,409	200
T09	Early psychosis intervention attendance	9	144	306	18
T10	Support needs assessment attendances	3	58	349	4
T12	Mental health medium secure inpatient occupied bednights		8	5	
T15	Court liaison attendances	1	79	104	14
T16	Substance abuse detoxification occupied bed nights (medical)		1	6	
T17	Substance abuse detoxification attendance (social)		11	15	
T18	Methadone treatment specialist service attendances (clients of specialist services)	1	7	26	
T19	Methadone treatment specialist service attendances (clients of authorized GPs)		4	7	
T20	Substance abuse residential service occupied bed nights		1	4	
T21	Psychiatric disability rehabilitation occupied bed nights	1	4	4	
T22	Mental health day treatment programme attendances	4	18	107	3
T23	Mental health day activity programme attendances		5	27	2
T24	Work opportunities programme attendances	1	12	8	1
T26	Community mental health residential level 2 occupied bed nights			1	
T27	Community mental health residential level 3 occupied bed nights	1		2	
T28	Community mental health residential level 4 occupied bed nights		2		
T30	Community mental health residential long-term occupied bed nights			4	
T31	Home-based care contacts	1	53	93	4
T32	Mental health contact with family/whanau (new from 1 July 2002)	97	889	3,497	98
	Total	**608**	**7,437**	**26,343**	**1,021**

3.2.7 Access by Mental Health Team Types

There are 24 team types (see Appendix 1a for detailed information on team types). Twenty-one of these team types have been used in this analysis.

In 2003, a total of 19,295 unique clients that received treatment from a number of different mental health teams related to a total of 23,569 clients. Therefore all further analysis by Service Code is based on 23,569 clients. Of interest is that 3,125 clients received treatment from more than one mental health team in DHB CAMHS (for example, 1 client received treatment from 9 different mental health teams) (see Table 56).

Table 56. Number of Referrals to Team Type (2003)

Unique Clients	Number of Teams Referred	Number of Clients per Team Type
16,080	1	16,080
2,468	2	4,936
533	3	1,599
143	4	572
51	5	255
15	6	90
4	7	28
1	9	9
19,295		**23,569**

A detailed look at the number of unique clients that received treatment from the various mental health team types listed in Table 57 below showed that in 2003, the majority of clients were treated by the Child, Adolescent and Family Team (13,605) followed by Community (3,255) Youth Specialty (2,321) and Alcohol and Drug (1,574) teams (see Table 57).

Table 57. Referrals to Team Type (2003)

Team Type Code & Description		2003 Clients Seen	Bed Nights	Contacts
01	Inpatient Team	397	8,807	193
02	Community Team	3,255	36	19,824
03	Alcohol & Drug Team	1,574	232	4,986
04	Child, Adolescent & Family Team	13,605	7,754	143,178
05	Forensic Team	444	1,017	2,851
06	Kaupapa Māori Team	627	0	7,998
07	Pacific Island Team	58	0	441
08	Residential Team	18	516	31
09	Community Skills Enhancement Team	30	0	517
10	Alcohol & Drug Kaupapa Māori Team	240	0	975
11	Alcohol & Drug Dual Diagnosis Team	38	31	370
12	Intellectual Disability Dual Diagnosis Team	21	359	58
13	Psychogeriatric Team	6	0	13
14	Youth Specialty Team	2,321	5,171	31,125
15	Maternal Mental Health Team	104	577	549
16	Eating Disorder Team	98	164	1,652
17	Needs Assessment & Service Co-ordination Team	464	0	1,590
18	Specialist Psychotherapy Team	40	0	236
21	Children & Youth, Alcohol & Drug Service Team	82	0	311
22	Kaupapa Māori Tamariki & Rangatahi (Child & Youth) Mental Health Services	52	0	511
99	Other	95	0	266
		23,569	**24,664**	**217,675**
	Unique Clients	**19,295**		

Table 58. Team Type by Age Group & Gender (2003)

(n = 23569)									
		0-9 Years			10-14 Years		15-19 Years		
Team Type Code & Description		Female	Male	Unknown	Female	Male	Female	Male	Unknown
01	Inpatient Team	4	6		7	5	158	217	
02	Community Team	35	65		216	229	1,554	1,156	
03	Alcohol & Drug Team	2	4		49	107	436	976	
04	Child, Adolescent & Family Team	1,003	2,455	2	1,887	3,816	2,449	1,992	1
05	Forensic Team	1	4		7	32	67	333	
06	Kaupapa Māori Team	22	89		75	161	114	166	
07	Pacific Island Team		1		1	3	22	31	
08	Residential Team						13	5	
09	Community Skills Enhancement Team	1					9	20	
10	Alcohol & Drug Kaupapa Māori Team				12	28	72	128	
11	Alcohol & Drug Dual Diagnosis Team					1	18	19	
12	Intellectual Disability Dual Diagnosis Team	1					5	15	
13	Psychogeriatric Team	1	1			2	1	1	
14	Youth Specialty Team	6	8		191	191	1,024	901	
15	Maternal Mental Health Team	5	5		1		92	1	
16	Eating Disorder Team	3			12	1	81	1	
17	Needs Assessment & Service Co-ordination Team	20	70		56	124	91	103	
18	Specialist Psychotherapy Team	4	8		2	10	8	8	
21	Children & Youth, Alcohol & Drug Service Team				5	21	22	34	
22	Kaupapa Māori Tamariki & Rangatahi (Child & Youth) Mental Health Services		11		13	10	12	6	
99	Other				8	2	60	25	
		1,108	**2,727**	**2**	**2,542**	**4,743**	**6,308**	**6,138**	**1**

Please note that some clients have been seen by teams that were not expected in these age-groups e.g. T13 (psycho geriatric team). It is beyond the scope of this project to check the accuracy of this data back to the source but some clients are seen by adult services.

Table 59. Team Type by Ethnicity (2003)

(n=23569)					
Team Type Code & Description		**Asian**	**Māori**	**Other**	**Pacific**
01	Inpatient Team	10	133	238	16
02	Community Team	70	665	2,429	91
03	Alcohol & Drug Team	17	443	1,020	94
04	Child, Adolescent & Family Team	212	2,274	10,784	335
05	Forensic Team	6	186	233	19
06	Kaupapa Māori Team		510	108	9
07	Pacific Island Team		4	2	52
08	Residential Team	1	5	11	1
09	Community Skills Enhancement Team	2	6	22	
10	Alcohol & Drug Kaupapa Māori Team		210	25	5
11	Alcohol & Drug Dual Diagnosis Team	1	19	18	
12	Intellectual Disability Dual Diagnosis Team	1	4	15	1
13	Psychogeriatric Team		1	4	1
14	Youth Specialty Team	52	309	1,885	75
15	Maternal Mental Health Team	1	21	78	4
16	Eating Disorder Team	4	7	86	1
17	Needs Assessment & Service Co-ordination Team	4	64	392	4
18	Specialist Psychotherapy Team	2	3	32	3
21	Children & Youth, Alcohol & Drug Service Team		22	60	
22	Kaupapa Māori Tamariki & Rangatahi (Child & Youth) Mental Health Services		39	13	
99	Other	6	26	62	1
		389	**4,951**	**17,517**	**712**

3.2.8 Referrals & Referral Sources

Referrals & Referral Sources by Age & Gender

Table 60 below shows that in 2003, a total of 1,448 clients received more than one external referral to a DHB or an NGO, and 54% of these were male clients in the 15-19 year age group (see Figure 15). The majority (25%) of these referrals were from GPs (see Table 61 & Figure 16) followed by Self or Relative referrals (19%). For definitions of internal and external referrals see Appendix 1b.

Table 60. External Referrals to DHBs/NGOs (2003)

Clients	Number of Referrals	Total Referrals
1	17	17
1	15	15
1	11	11
2	10	20
6	9	54
1	8	8
5	7	35
9	6	54
21	5	105
75	4	300
216	3	648
1,110	2	2,220
8,096	1	8,096
9,544		**11,583**

Figure 15. External Referrals to DHBs/NGOs by Age Group (2003)

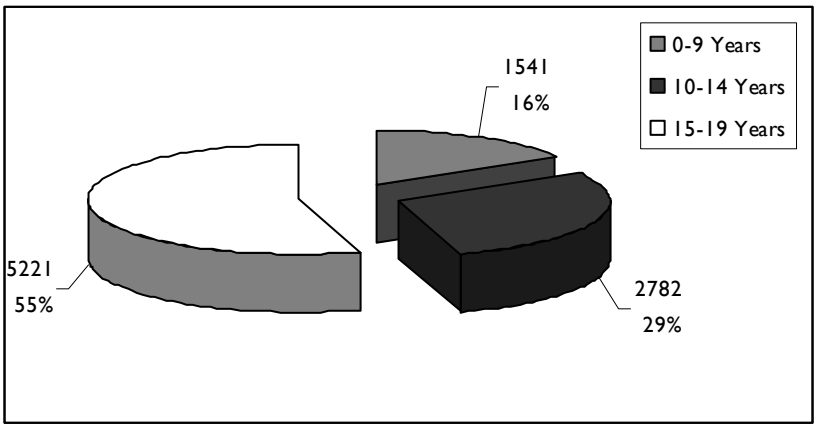
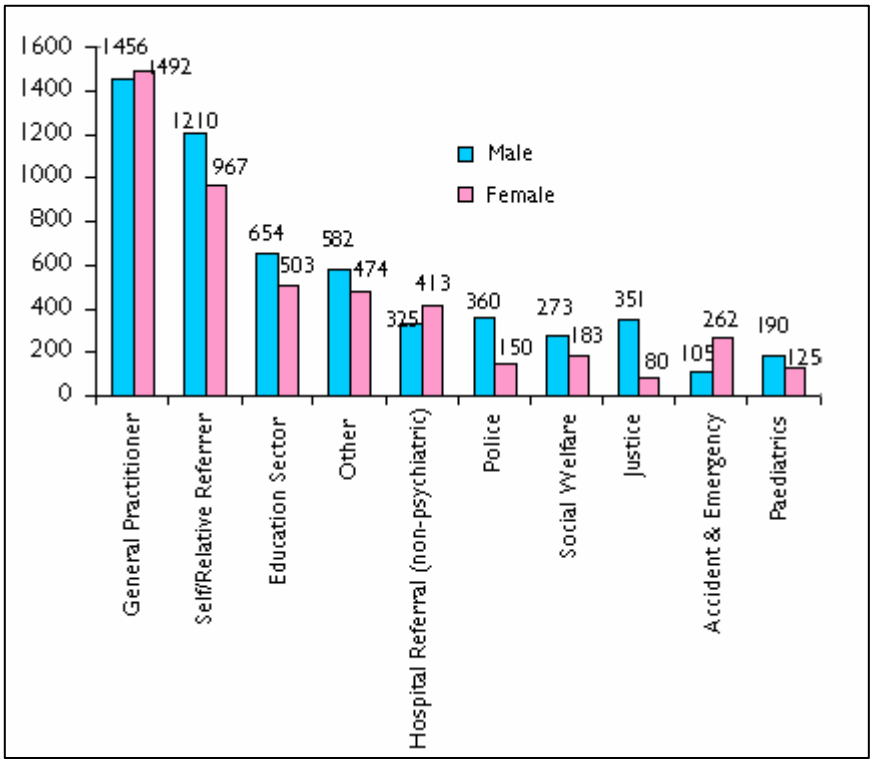


Table 61. Number of Referrals by Referral Source & Gender (2003)

Referral Source	Total		Male		Female		Unknown	
	No	%	No	%	No	%	No	%
General Practitioner	2,949	25	1,456	23	1,492	28	1	50
Self or Relative Referral	2,178	19	1,210	19	967	18	1	50
Education Sector	1,157	10	654	10	503	9	0	0
Other	1,056	9	582	9	474	9	0	0
Hospital Referral(non-psychiatric)	738	6	325	5	413	8	0	0
Police	510	4	360	6	150	3	0	0
Social Welfare	456	4	273	4	183	3	0	0
Justice	431	4	351	6	80	2	0	0
Accident & Emergency	367	3	105	2	262	5	0	0
Paediatrics	315	3	190	3	125	2	0	0
Psychiatric Inpatient	305	3	175	3	130	2	0	0
Child, Adolescent & Mental Health Services	296	3	147	2	149	3	0	0
Adult Community Mental Health Services	288	2	149	2	139	3	0	0
Public Health	159	1	90	1	69	1	0	0
Unknown	125	1	76	1	49	1	0	0
Private Practitioner	93	1	52	1	41	1	0	0
Psychiatric outpatients	58	1	30	0	28	1	0	0
Alcohol & Drug	37	0	17	0	20	0	0	0
Māori	31	0	20	0	11	0	0	0
Mental Health Residential	12	0	8	0	4	0	0	0
Needs Assessment & Co-ordination Service	11	0	5	0	6	0	0	0
Pacific Island	5	0	4	0	1	0	0	0
Day Hospital	3	0	3	0%	0	0	0	0
Mental Health Community Skills Enhancement Programme	3	0	2	0%	1	0	0	0
	11,583	**100**	**6,284**	**100**	**5,297**	**100**	**2**	**100**

Figure 16. External Referral by Gender by the Top Ten Referral Sources (2003)



External Referrals by Ethnicity

The majority (73%) of the external referrals were made up of the 'Other' ethnic group followed by Māori (22%), Pacific (3%) and Asian (2%) clients (see Figure 17).

Figure 17. External Referrals to DHBs/NGOs by Ethnicity (2003)

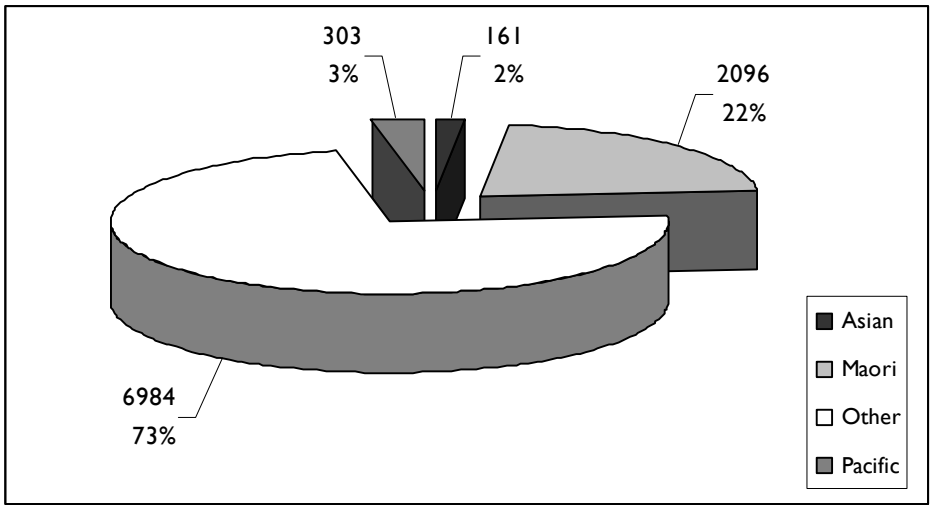


Table 62. External Referrals to DHBs/NGOs by Service & Ethnicity (2003)

(n = 11,583)				
Service Code Description	**Asian**	**Māori**	**Other**	**Pacific**
No Service Code	21	331	606	45
Mental health crisis attendances	37	366	1,169	43
Mental health intensive care inpatient occupied bed days	0	8	13	0
Mental health acute inpatient occupied bed days	12	118	276	13
Mental health sub-acute inpatient occupied bed days	0	4	3	0
Mental health crisis respite care occupied bed days	0	0	2	0
Mental health individual treatment attendances	109	1,543	4,758	234
Mental health group programme attendances	0	13	38	0
Mental health care co-ordination contacts	10	262	502	14
Early psychosis intervention attendance	2	64	118	4
Support needs assessment attendances	0	9	52	1
Mental health medium secure inpatient occupied bednights	0	5	3	0
Court liaison attendances	0	2	15	0
Substance abuse detoxification occupied bed nights (medical)	0	0	2	0
Substance abuse detoxification attendance (social)	0	1	1	0
Methadone treatment specialist service attendances (clients of specialist services)	0	1	7	0
Psychiatric disability rehabilitation occupied bed nights	0	5	1	0
Mental health day treatment programme attendances	0	1	13	0
Mental health day activity programme attendances	0	0	4	0
Community mental health residential long-term occupied bed nights	0	0	4	0
Home-based care contacts	0	9	7	0
Mental health contact with family/whanau (new from 1 July 2002)	8	99	586	9
Total	**199**	**2,841**	**8,180**	**363**

Table 63. Number of External Referrals by the Top 15 Referrers & Service Code (2003)

	Accident & Emergency	CAMHS	Adult community MH Services	Education Sector	General Practitioner	Justice	Hospital referral (non-psychiatric)	Other	Paediatrics	Public Health	Psychiatric Inpatient	Police	Self or Relative Referral	Social Welfare	Unknown
No Service Code	28	34	22	103	177	80	62	77	19	5	36	51	207	68	7
Mental health crisis attendances	227	12	25	54	263	14	181	142	10	2	39	220	397	15	9
Mental health intensive care inpatient occupied bed days	3	-	3	-	2	-	-	1	-	-	-	5	4	-	2
Mental health acute inpatient occupied bed days	28	40	81	-	8	-	65	104	-	-	11	12	45	2	11
Mental health sub-acute inpatient occupied bed days	-	-	5	-	-	-	-	-	-	-	-	-	-	-	-
Mental health crisis respite care occupied bed days	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-
Mental health individual treatment attendances	66	127	104	752	2004	276	351	549	191	127	183	180	1222	282	84
Mental health group programme attendances	-	-	1	7	23	-	1	6	-	-	-	1	7	2	1
Mental health care co-ordination contacts	9	23	24	110	166	35	49	96	24	11	22	33	110	58	3
Early psychosis intervention attendance	-	13	9	45	52	1	1	33	11	-	3		12	4	-
Support needs assessment attendances	-	31	6	2	-	1	-	2	-	-	1	1	15	-	-
Mental health medium secure inpatient occupied bednights	-	-	-	-	-	5	-	2	-	-	1	-	-	-	-
Court liaison attendances	-	-	-	-	-	16	-		-	-	-	-		1	-
Substance abuse detoxification attendance (social)	-	-	-	-	-	-	-	1	-	-	-	-	1		-
Methadone treatment specialist service attendances (clients of specialist services)	-	-	-	-	2	-	-	1	-	-	-	-	3	-	-
Psychiatric disability rehabilitation occupied bed nights	-	-	1	-	-	-	4	1	-	-	-	-		-	-
Mental health day treatment programme attendances		7	1		1	-	-	-	-	-	-	-	5	-	-
Mental health day activity programme attendances	-	-	-	-	-	-	-	-	-	-	1		3	-	-
Community mental health residential long-term occupied bed nights	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-
Home-based care contacts	-	-	-	3	-	-	-	-	-	-	2	-	6	2	-
Mental health contact with family/whanau (new from 1 July 2002)	5	9	6	80	251	3	24	41	60	14	6	7	140	22	8
Total	**367**	**296**	**288**	**1,157**	**2,949**	**431**	**738**	**1,056**	**315**	**159**	**305**	**510**	**2,178**	**456**	**125**

3.3 Access Rates for 2003 & 2004 Compared to the Mental Health Commission's Blueprint Strategic Benchmarks

Criticism of the 2003 MHINC data led to an analysis of the first six months of the 2004 year (made available from NZHIS March 2005) and showed that there was no change in access over three, six monthly periods. The first six months of 2004 cannot be doubled to compare with the full year 2003 because the analysis uses clients unique to that period and can only be compared over periods of equal length. Some clients may appear in each of the 3 periods.

3.3.1 Access Rates on a Six Monthly Basis

The strategic benchmarks for child and adolescent mental health services for the 0-9, 10-14, and 15-19 age groups are 1%, 3.9% and 5.5% respectively. In this section, rates have been calculated on a six monthly basis as the "*The Commission has developed resource guidelines for services to provide access to mental health services (including alcohol and drug services) for 3% of the [child and adolescent] population over any six month period*" (Blueprint, 1998; pg.28).

In all age groups, across all three intervals, access rates were well below access benchmark targets (See Tables 64 & 65).

Table 64. Access Rates on a Six Monthly Basis Compared to The Mental Health Commission's Strategic Benchmarks for Child & Adolescent Mental Health Services (2003/2004)

	Age (years)			
	0-9	10-14	15-19	0-19
Strategic Benchmark	1.0%	3.9%	5.5%	3.0%
Access Rate first 6 months 2003	0.4%	1.4%	2.0%	1.1%
Access Rate second 6 months 2003	0.5%	1.5%	2.1%	1.2%
Access Rate first 6 months 2004	0.4%	1.3%	2.1%	1.1%

Table 65. National Access of Unique Clients on a Six Month Comparison by Age & Gender (2003/2004)

	0-9 Years			10-14 Years			15-19 years			Total		
Clients	**1st 6 Months 2003**	**2nd 6 Months 2003**	**1st 6 Months 2004**	**1st 6 Months 2003**	**2nd 6 Months 2003**	**1st 6 Months 2004**	**1st 6 Months 2003**	**2nd 6 Months 2003**	**1st 6 Months 2004**	**1st 6 Months 2003**	**2nd 6 Months 2003**	**1st 6 Months 2004**
Male	1,643	1,921	1,609	3,003	3,095	2,805	2,987	3,016	3,009	7,633	8,032	7,423
Female	635	770	639	1,335	1,660	1,347	3,032	3,273	3,256	5,002	5,703	5,242
Unknown	2	2	1	-	-	-	1	1	-	3	3	1
Total	**2,280**	**2,693**	**2,249**	**4,338**	**4,775**	**4,152**	**6,020**	**6,290**	**6,265**	**12,638**	**13,738**	**12,666**
Population[1]	573,000	573,000	571,020	312,710	312,710	314,560	296,640	296,640	304,660	1,182,350	1,182,350	1,190,240
Access Rate %	**0.398%**	**0.470%**	**0.394%**	**1.387%**	**1.521%**	**1.320%**	**2.029%**	**2.120%**	**2.056%**	**1.069%**	**1.162%**	**1.064%**
Targeted Access Rate	**1.00%**	**1.00%**	**1.00%**	**3.90%**	**3.90%**	**3.90%**	**5.50%**	**5.50%**	**5.50%**			

Note: The number of clients has been calculated counting each "master_encrypted_hcu_id" once for each six month period. Clients therefore can be included in each period if they have accessed the Mental Health system during the period. The total number of unique clients for the total 2003 Calendar year was 19,307 while the sum of the unique clients for the two six month periods is 26,376. Therefore 7,069 clients counted in the 2nd 6 months of 2003 were already receiving treatment in the 1st 6 months i.e. new clients during the 2nd 6 months of 2003 were 6,669. The 12,666 "master_encrypted_hcu_id" count for the 1st 6 months of 2004 was compared with "master_encrypted_hcu_id" numbers in the 2nd six months of 2003. There were 6,779 matches. Therefore 5,887 unique clients in the 1st 6 months of 2004 were new clients.

[1] Population figures have been obtained using data supplied on 01.11.04 by Jessee Kokaua
Research Analyst Ministry of Health
MOH File Name: Ethnic population projections by DHB age gender and amalgamated nzdep 2001_26.xls

Table 66. Comparison of Client Access by DHB of Domicile over Three Six Month Intervals

DHB_Code & Name		1st 6 Months 2003	2nd 6 Months 2003	1st 6 Months 2004
Northern		**2,870**	**3,222**	**3,069**
11	Northland	439	496	492
21	Waitemata	1,209	1,338	1,263
22	Auckland	614	622	520
23	Counties Manukau	608	766	794
Midland		**2,788**	**3,098**	**2,873**
31	Waikato	955	1,123	1,032
42	Lakes	287	347	294
47	Bay of Plenty	893	892	830
51	Tairawhiti	199	235	225
71	Taranaki	454	501	492
Central		**2,990**	**3,262**	**2,844**
61	Hawke's Bay	386	505	451
81	MidCentral	586	612	596
82	Whanganui	317	357	278
91	Capital & Coast	978	1,007	866
92	Hutt	586	619	531
93	Wairarapa	137	162	122
Southern		**4,163**	**4,356**	**4,025**
101	Nelson Marlborough	719	733	720
111	West Coast	246	257	229
121	Canterbury	1,469	1,603	1,453
123	South Canterbury	176	171	145
131	Otago	1,028	1,089	1,036
141	Southland	525	503	442
	Unknown	**25**	**21**	16
	Total	**12,836**	**13,959**	**12,827**

Note: The number of clients has been calculated counting each "master_encrypted_hcu_id" once for each six month period. Clients therefore can be included in each period if they have accessed the Mental Health system during the period. The total number of referrals for DHBs of Service for the total 2003 Calendar year was 20,211 while the sum of the client referrals for the two six month periods is 27,256. Therefore 7,045 client referrals counted in the 2nd 6 months of 2003 were already receiving treatment in the 1st 6 months. I.e. New client referrals during the 2nd 6 months of 2003 were 6,036.

The full analysis of MHINC data 2003 and first six months of 2004 is available (not annotated) from **The Werry Centre Website: www.werrycentre.org.nz**

Regional & DHB Access Rates in 2003

The MHINC data over three six monthly periods, from January 2003 to June 2004, showed that none of the regions met the benchmarks access rates in any age group. The greatest shortfall was in the Northern region (see Figures 18, 20, 22, 24, 26, 28 & Appendix 4).

Access data by DHB showed that the West Coast DHBs met or nearly met the access benchmarks in all three periods and across all three age groups. Otago DHB met or nearly met the access benchmarks for 0-9 year olds in all three periods (see Figures 19, 21, 23, 25, 27, 29 & Appendix 4).

Figure 18. Access Rates by Region of Domicile for 0-9 yrs (1st 6 Months of 2003)

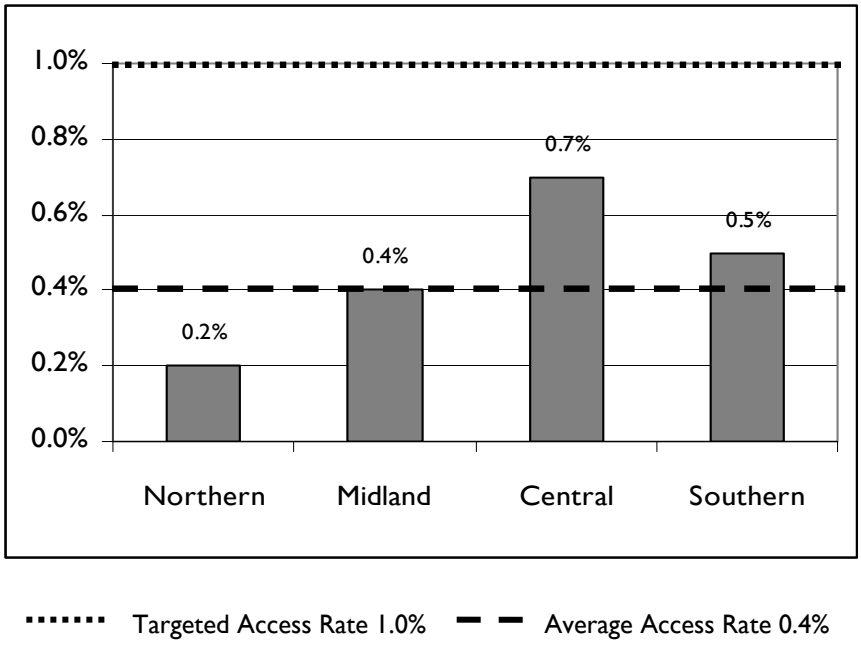


Figure 19. Access Rates by DHB of Domicile for 0-9 yrs (1st 6 Months of 2003)

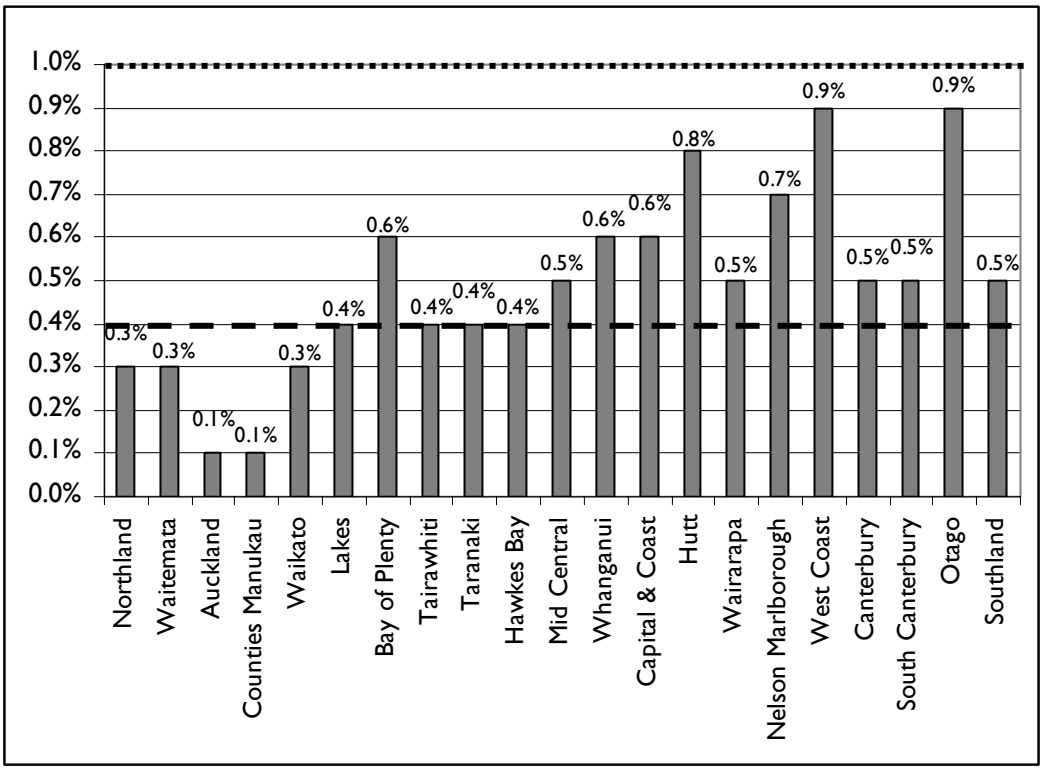


Figure 20. Access Rates by Region of Domicile for 10-14 yrs (1st 6 Months of 2003)

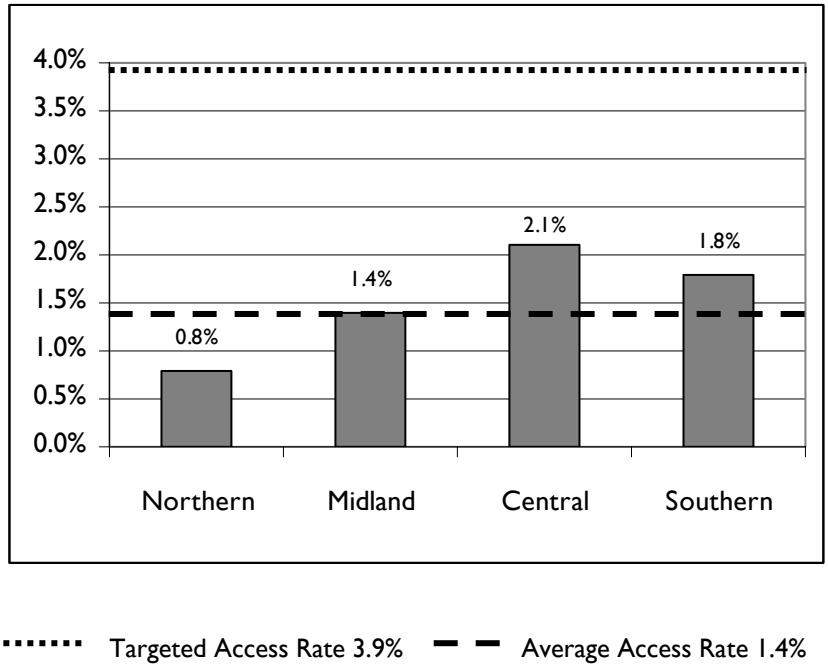


Figure 21. Access Rates by DHB of Domicile for 10-14 yrs (1st 6 Months 2003)

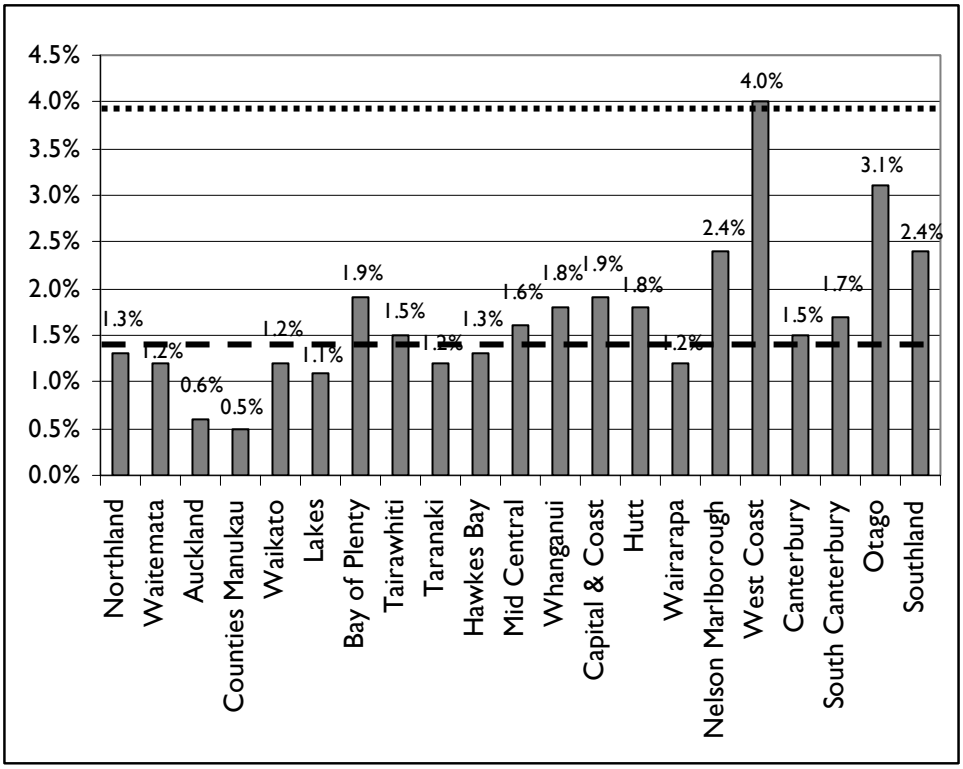


Figure 22. Access Rates by Region of Domicile for 15-19 yrs (1st 6 Months of 2003)

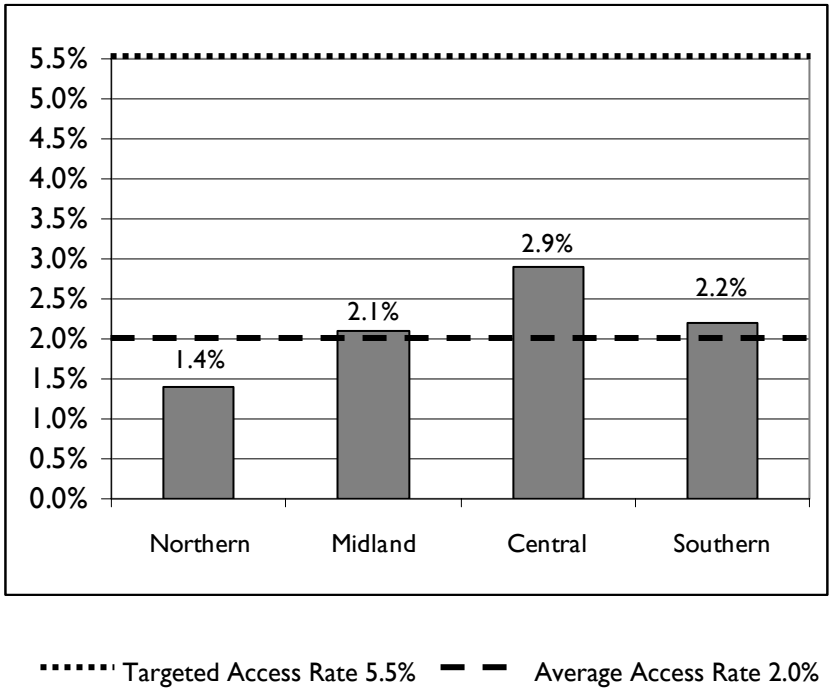
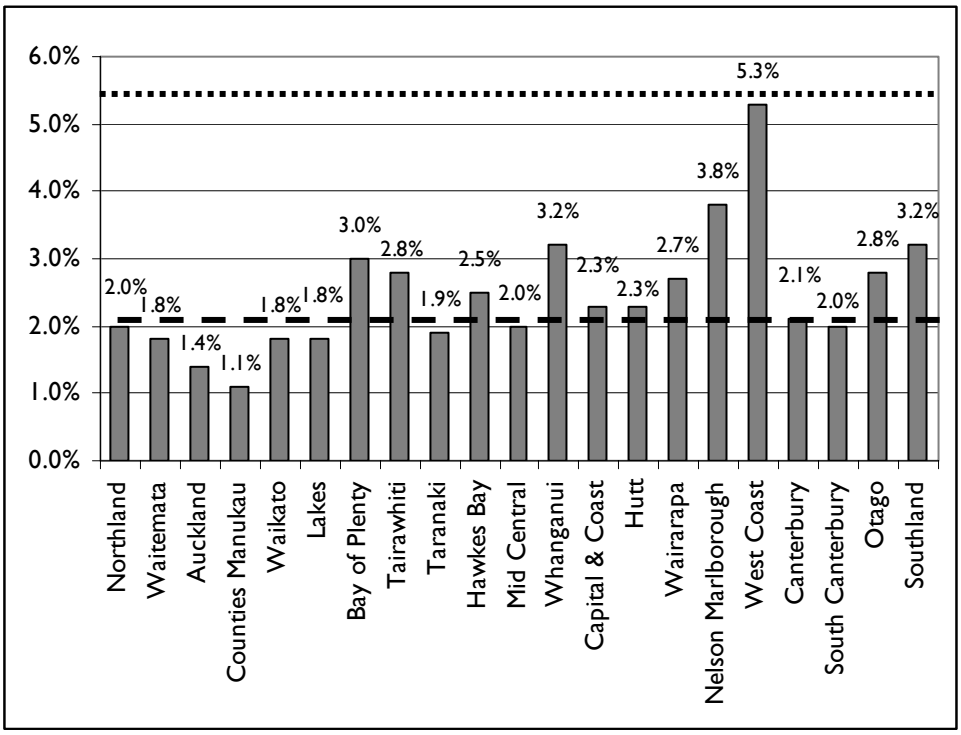


Figure 23. Access Rates by DHB of Domicile for 15-19 yrs (1st 6 Months of 2003)



Access Rates for the First 6 Months of 2004

For the first half of 2004, regionally, benchmark access rates were not met for all three age groups (see Figures 24, 26 & 28). However, analyses by DHB showed that access rates were met for the 0-9 year olds by West Coast DHB CAMHS (see Figure 25).

Figure 24. Access Rates by Region of Domicile for 0-9 yrs (1st 6 Months of 2004)

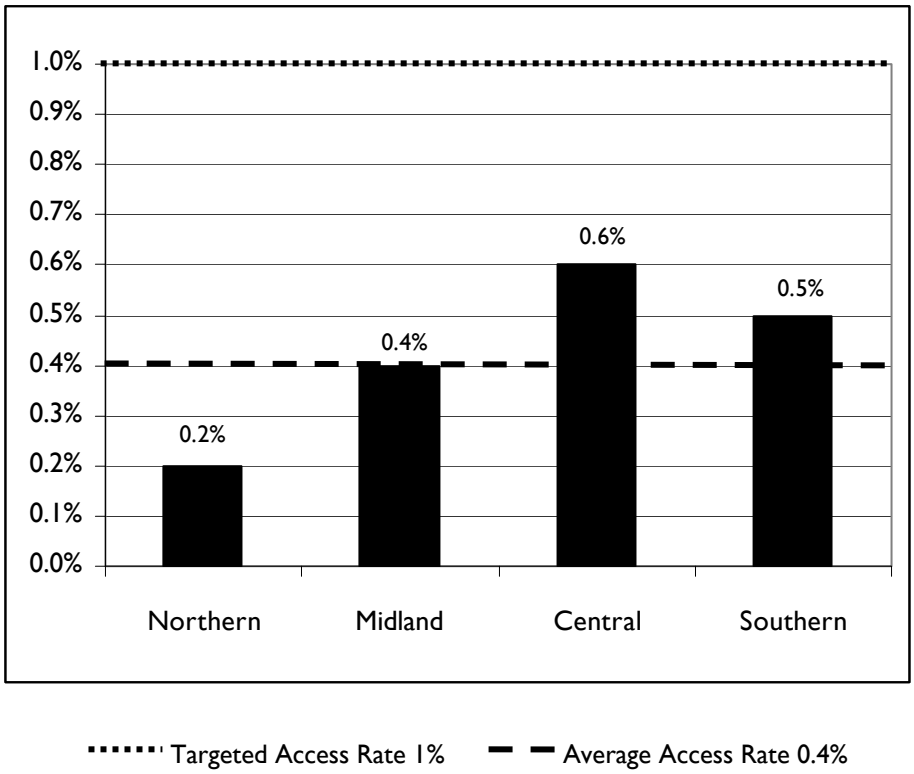


Figure 25. Access Rates by DHB of Domicile for 0-9 yrs (1st 6 Months of 2004)

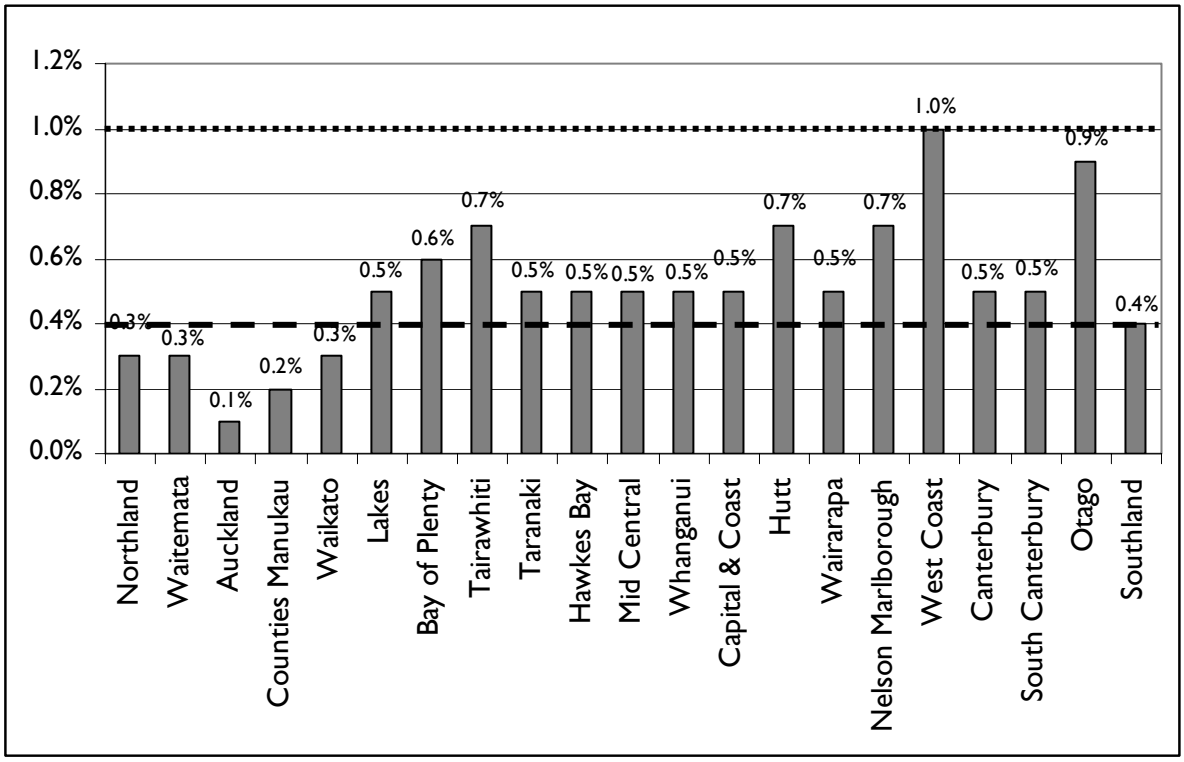


Figure 26. Access Rates by Region of Domicile for 10-14 yrs (1st 6 Months of 2004)

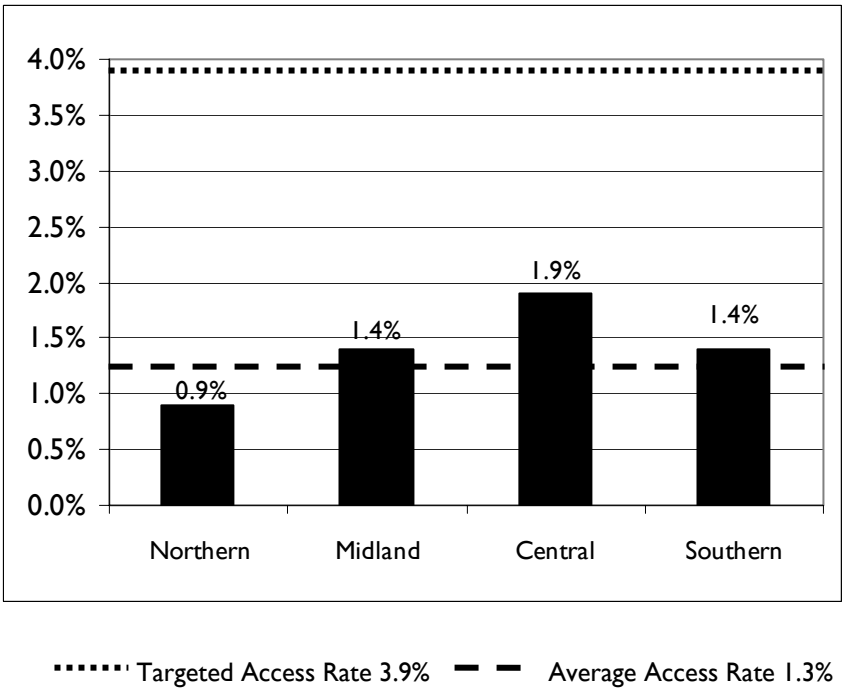


Figure 27. Access Rates by DHB of Domicile for 10-14 yrs (1st 6 Months of 2004)

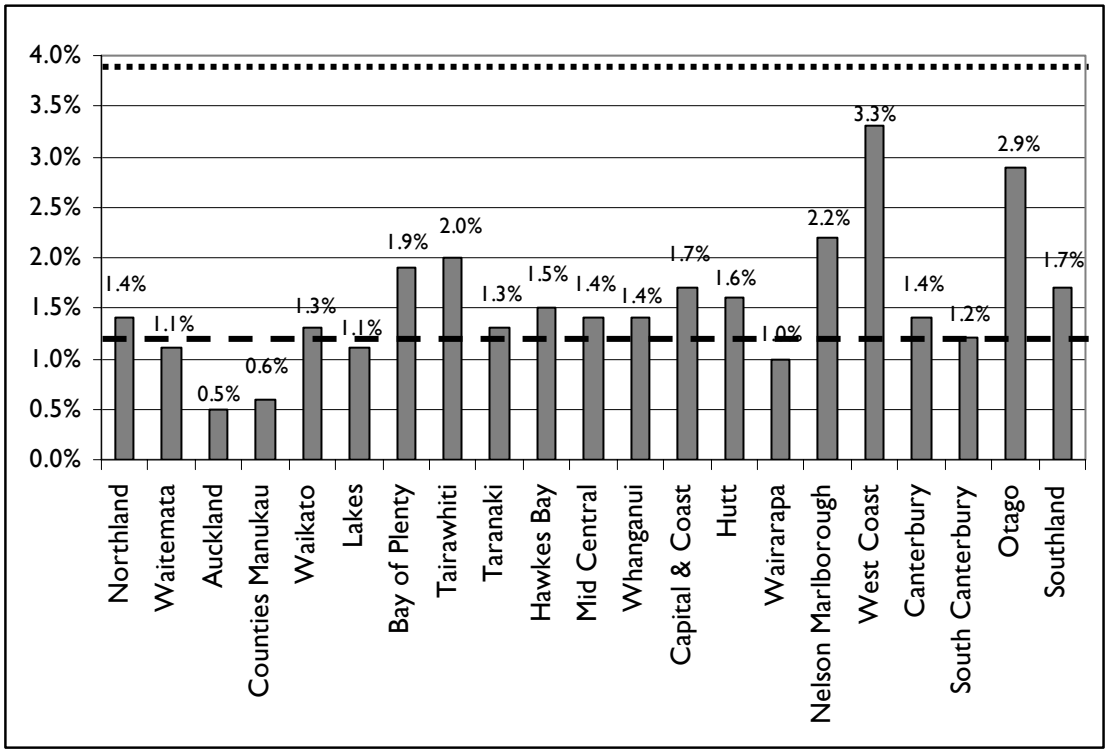


Figure 28. Access Rates by Region of Domicile for 15-19 yrs (1st 6 Months of 2004)

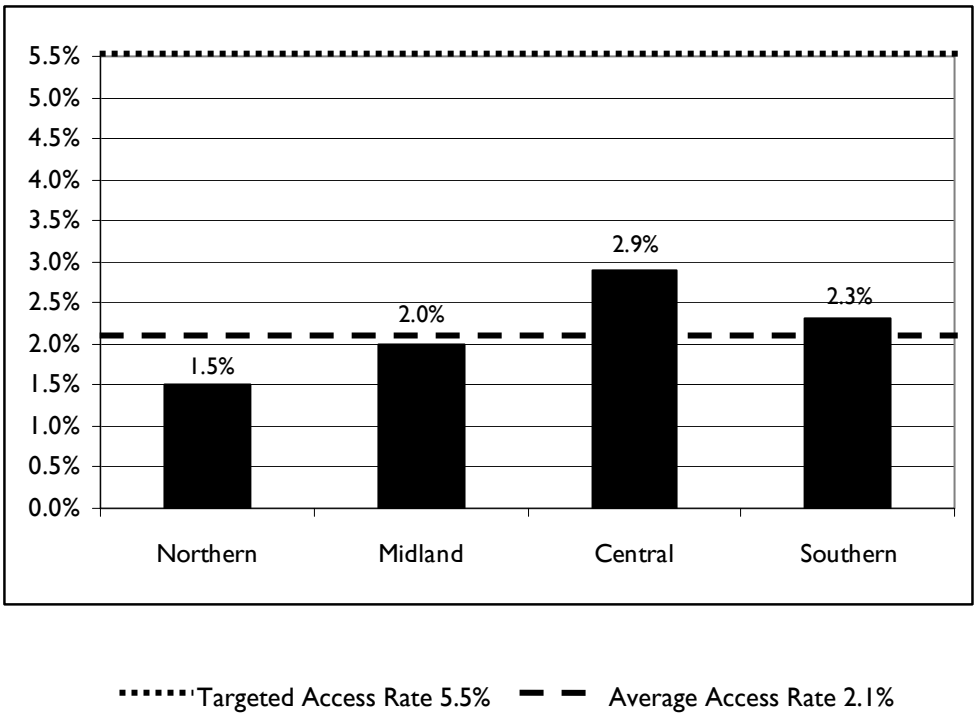
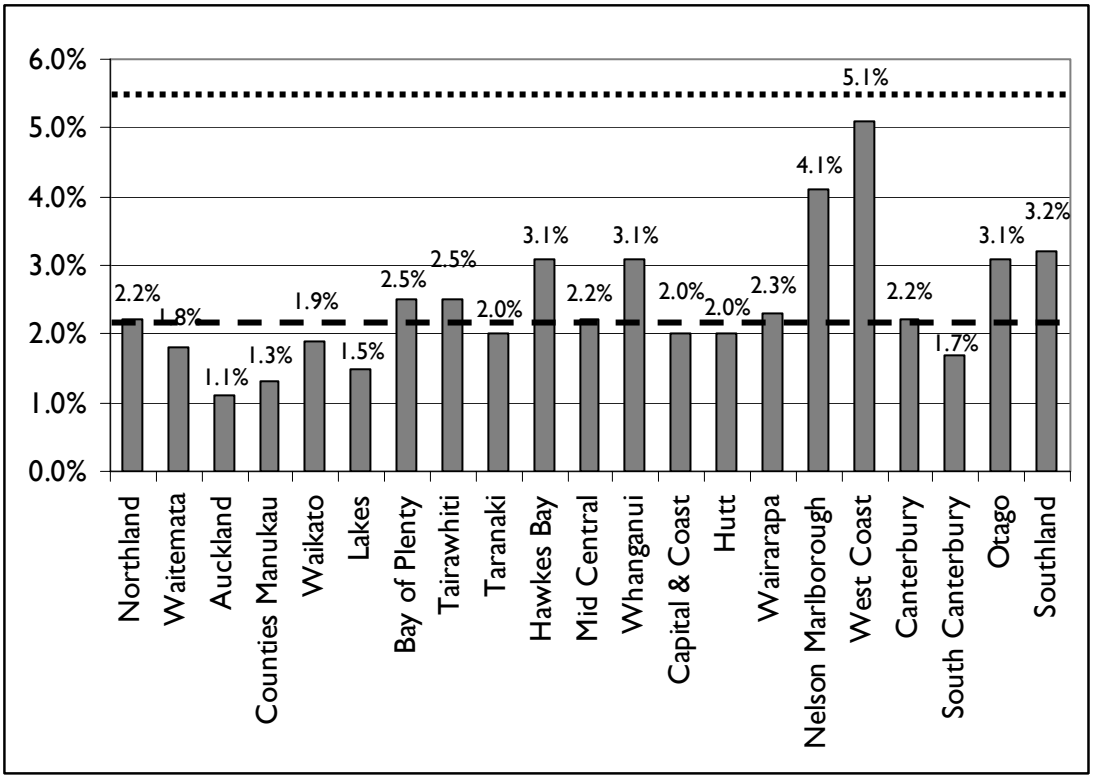


Figure 29. Access Rates by DHB of Domicile for 15-19 yrs (1st 6 Months of 2004)



3. 4 Chapter Summary

2003 Access to Child & Adolescent Mental Health Services

- The strategic benchmarks for child and adolescent mental health services for the 0-9, 10-14, and 15-19 age groups are 1.0%, 3.9% and 5.5% respectively. Rates have been calculated on a six monthly basis in line with the MHC resource guidelines.

- The conjoint findings of the two New Zealand studies (Fergusson, 2003) showed that the prevalence of mental health problems is significantly higher than the existing Blueprint targets.

- In 2003, 19,307 clients (unique individuals) accessed services with a total of 184,699 attendances. Of these, more males (59%) accessed and attended services than females (41%).

- Fifty-four percent of clients attending services were 15-19 year olds with females accessing services slightly more than males in this age group only.

- The majority of 15-19 year old clients (76%) were from the 'Other' ethnic group followed by Māori (19%), Pacific (2.9%) and Asians (1.6%).

2003 Access as a Percentage of Population

Analysis of access as a percentage of population showed that for the year 2003:

- There were slightly more males (1.9%) accessing services than females (1.4%).

- Access to services increased with age: 0-9 years (0.63%), 10-14 years (2.07%) and 15-19 years (3.10%).

- Although Pacific (0.56%) and Māori access rates (1.35%) were lower than the access rates for the rest of the population, access increased with age in all three ethnic groups. Māori access (3.10%) in the 15-19 year age group was close to the rest of the population (3.25%).

2003 Access Rates compared to Benchmark Access Rates

In order to compare the 2003 access rates with the benchmark targets for each age group, access rates were calculated on a *six monthly basis* in line with the MHC resource guidelines. Criticism of the 2003 data led to the analyses of the first half of the 2004 dataset but showed that there was no change in access over the three six monthly periods.

When regional access rates were compared to the strategic benchmarks, it was clear that they were well below the benchmark in every age group. This gap is undoubtedly a ***real deficit*** in service delivery but the following may also be contributing factors:

- Incomplete DHB returns to MHINC data (anecdotal feedback from the sector)
- Lack of data on access via NGO (although largely not providing clinical services)
- Lack of data on access from other government funded agencies

Chapter 4

The Child & Adolescent Mental Health Workforce

4.0 The Child & Adolescent Mental Health Workforce

> "*The skills, values, morale and attitudes of the mental health workforce have an enormous impact on the cost, quality and efficacy of mental health services*" (MHC, 1998a, p. 78).

The objective of this chapter is to provide an overview of the 2004 child and adolescent mental health workforce.

4.1 Resource Guidelines for the Clinical Child & Adolescent Mental Health Workforce

The *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Mental Health Commission, 1998, p.100) provided child and adolescent mental health resource guidelines by age group. For children and adolescents, the total community clinical mental health team resource guideline was 28.6 Full Time Equivalents (FTEs) per 100,000 total population (15.6 FTEs for 0-14 and 13.0 for 15-19 year age groups). In addition, 14.4 clinical FTEs and 2.6 non-clinical FTEs per 100,000 total population are included in the resource guideline for the adult services. These are for people under 20 years, mainly for the 15-19 year age group.

He Nuka no nga Taitamariki (HFA, 2000, p.38) used the same resource guidelines to plan for the growth of the clinical child and adolescent community FTES (see Table 67). They also forecast that:

> *"By the end of the 2002/03 financial year achievements towards child and youth service benchmarks will have increased at the following rates. Community FTEs increase from 540 to 734.4 (36%)."*

Table 67. Mental Health Commission's Blueprint Resource Guidelines for Child & Adolescent Mental Health Services Clinical Community FTEs

	Population Forecast	Community FTEs as per Blueprint Benchmark	Planned Resourced FTEs
99/00	3,873,500	1107.8	540.0
00/01	3,907,200	1117.4	604.8
01/02	3,936,422	1125.9	669.6
02/03	3,965,234	1134.1	734.4
03/04	4,067,725	1163.4	799.4

Developed from Blueprint Resource Guidelines

McGeorge (1995, Appendix V, p. 58) also made the following CAMHS staffing recommendations: *one community specialist mental health team per 40,000 child and adolescent population* (see Table 68 for the breakdown of the specialist team) with the assumption that these specialist teams will be adequately supported by management, administration and technological systems. For the 2003 population, this would equate to 30 teams. Nationally, there are 21 DHBs each with a child and adolescent mental health service or team. The DHBs with larger populations would have a workforce which equated to more than one team.

The McGeorge recommendations are important from a historical perspective but were written when child and adolescent services were poorly developed and McGeorge's recommendations have been superseded by the Blueprint resource guidelines.

Table 68. McGeorge's Staffing Recommendations (1995)

	FTEs
Psychiatrist	1
Psychiatric Registrar	1
Psychologist	1
Psychology Intern	1
Nurses	1-2
Psychotherapists	1-2
Social Workers	1-2
Occupational Therapists	1
Community/Cultural Workers	2-4
Clerical Assistants	2

Source: McGeorge (1995)

Recommendations on the number of psychiatrists needed have been made by The World Health Organisation (WHO, 2001). WHO recommended 10 psychiatrists per 100,000 population for the general population.

4.2 The Stocktake Findings of the Child & Adolescent Mental Health Workforce

The workforce is made up of staff in DHBs, NGOs, and a number of inter-sector services and programmes coordinated by Child, Youth and Family (CYF).

All child and adolescent mental health service providers were asked to provide workforce numbers, vacancies (reported in FTEs) and ethnicity data (head count of all Māori, Pacific and Asian staff) by Clinical and Non-Clinical occupational groups (see Section 3 and 4 of the Survey, Appendix 6) as at 31 March 2004. Due to the unavailability of data for the required period, Auckland and Waitemata DHB provided workforce data for March 2005. Capital & Coast DHB Early Intervention Service (EIS) provided data showing a total of 18.9 actual FTEs but this data was not provided by occupational groups. Data provided on the length of experience and salaries was excluded from this chapter due to incomplete information.

The workforce data in this section is presented regionally, by DHB and by clinical and non-clinical occupational groups (See Appendix 5 for definitions of occupational groups). Ethnicity of the child and adolescent mental health workforce is presented separately in this chapter.

4.2.1 The DHB CAMHS Workforce

Child and Adolescent Mental Health Services in DHBs (CAMHS) are provided by Inpatient and Community Services and make up the total DHB CAMHS workforce. Workforce data on the Inpatient and Community CAMHS workforce is presented in this section.

The DHB Inpatient Workforce

Specialist child and adolescent mental health Inpatient Services are provided by Auckland, Capital & Coast and Canterbury DHBs (see Chapter 2 for service details).

The CAMHS Inpatient Services reported a total of 124.7 actual FTEs with a further 27.4 FTEs reported vacant (see Table 69). Auckland DHB provided data for March 2005 as the data for the 2004 period was not available.

Canterbury DHB reported the largest inpatient workforce of 44.1 actual FTEs followed by Capital & Coast (41.0 actual FTEs). Due to the large number of vacancies, Auckland DHB reported the smallest Inpatient workforce of 39.6 actual FTEs (see Figure 30).

The Clinical workforce accounted for 70% (87 actual FTEs) of the total Inpatient workforce which was largely made up of Mental Health Nurses (65.8 actual FTEs). Psychiatrists (5.8 actual FTEs), Psychologists (5.1 actual FTEs), Social Workers (4.8 actual FTEs) and Occupational Therapists (4.5 actual FTEs) made up the remainder of the workforce.

The Non-Clinical Inpatient workforce accounted for 30% (37.7 actual FTEs) of the total Inpatient workforce, mainly in Mental Health Support roles (24.6 actual FTEs).

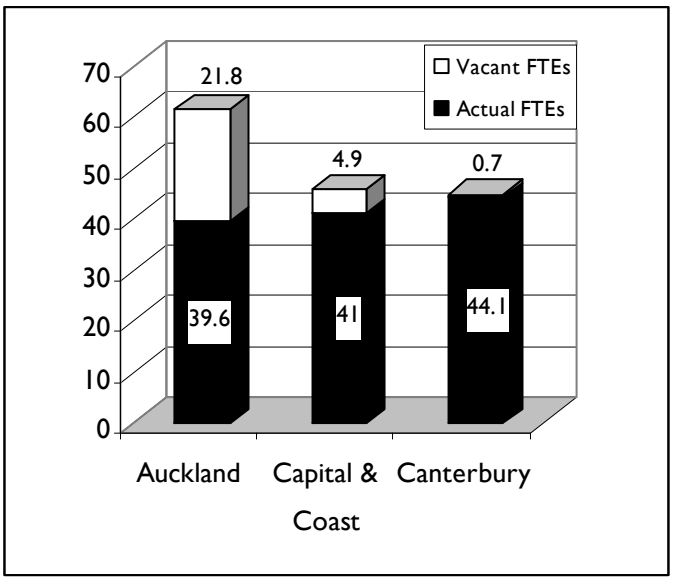
The Inpatient Services reported a total of 27.4 vacant FTEs (see Table 69), 80% (21.8 vacant FTEs) of these reported by Auckland. The majority of vacancies in Auckland were in the Clinical workforce (21.2 vacant FTEs) with the majority of vacancies (17 vacant FTEs) for Mental Health Nurses.

Table 69. DHB Actual & Vacant Inpatient FTEs (31st March 2004)

	Auckland*		Capital & Coast		Canterbury		Total	
Occupational Groups	**Actual FTEs**	**Vacant FTEs**	**Actual FTEs**	**Vacant FTEs**	**Actual FTEs**	**Vacant FTEs**	**Actual FTEs**	**Vacant FTEs**
Alcohol & Drugs Workers	-	-	-	-	-	-		
Counsellors	-	-	-	-	-	-		
Mental Health Nurses	17.0	17.0	18.0	2.0	30.8	-	65.8	19.0
Occupational Therapists	1.8	0.8	1.0	-	1.7	-	4.5	0.8
Psychiatrists	1.7	1.0	2.5	-	1.6	0.3	5.8	1.3
Psychotherapists	-	0.8	-	-	-	-		0.8
Psychologists	2.3	0.6	1.0	-	1.8	0.2	5.1	0.8
Social Workers	1.0	1.0	2.0	-	1.8	0.2	4.8	1.2
Other Clinical	-	-	-	-	1.0	-	1.0	
Clinical Sub-Total	**23.8**	**21.2**	**24.5**	**2.0**	**38.7**	**0.7**	**87.0**	**23.9**
Cultural	0.3	-	1.5	-	1.0	-	2.8	
Specific Liaison	-	-	1.0	-	-	-	1.0	
Mental Health Consumers	0.1	-	-	0.9	-	-	0.1	0.9
Mental Health Support	12.6	-	12.0	2.0	-	-	24.6	2.0
Other Non-Clinical Support	-	-	-	-	-	-	-	-
Non-Clinical Sub-Total	**13.0**	**0.0**	**14.5**	**2.9**	**1.0**	**0.0**	**28.5**	**2.9**
Administration/Management	**2.8**	**0.6**	**2.0**	**-**	**4.4**	**-**	**9.2**	**0.6**
Total	**39.6**	**21.8**	**41.0**	**4.9**	**44.1**	**0.7**	**124.7**	**27.4**

*Inpatient FTEs as at March 2005

Figure 30. DHB Total Inpatient Actual & Vacant FTEs (31st March 2004)



Note: Auckland Inpatient Actual & Vacant FTEs as at March 2005

The DHB Community Workforce

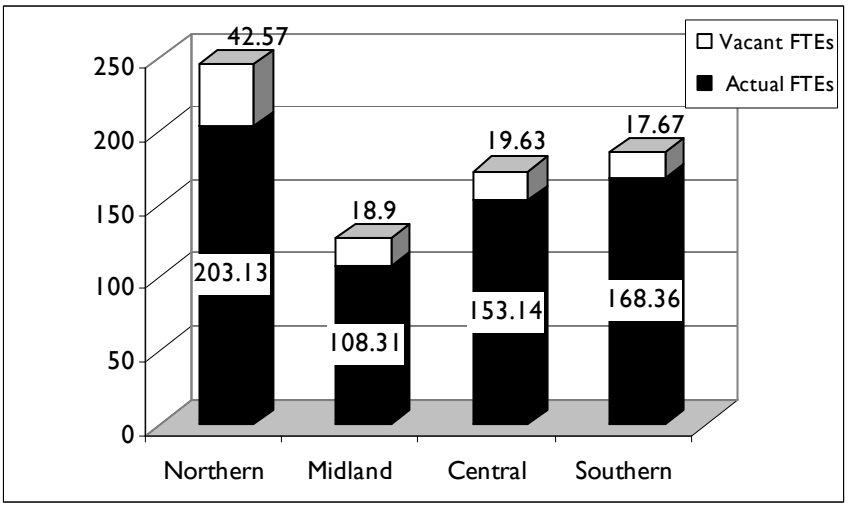
DHB CAMHS reported a total of 632.94 actual Community FTEs with a further 98.77 FTEs that were reported vacant (see Table 70 & Figure 31).

Table 70. Total Actual & Vacant FTEs (Clinical & Non-Clinical) by Region & DHB (31st March 2004)

DHB	Actual FTEs	Vacant FTEs
Northern*	203.13	42.57
Midland	108.31	18.9
Central	153.14	19.63
Southern	168.36	17.67
Total	**632.94**	**98.77**

*Auckland & Waitemata DHB FTEs as at March 2005

Figure 31. Total DHB CAMHS Community Actual & Vacant FTEs by Region (31st March 2004)



Note: Auckland & Waitemata DHB FTEs as at March 2005

Regional FTEs appear to approximately reflect the relative 0-19 population sizes except for Midland.

Actual FTE data analysed regionally showed that the largest Community CAMHS workforce (203.13 actual FTEs) was in the Northern region (see Figure 31). Waitemata DHB reported the largest community workforce of 83.86 actual FTEs followed by Auckland (56.64 actual FTEs) and Counties Manukau (42.93 actual FTEs) DHBs. The Southern region reported the second largest Community workforce of 168.36 actual FTEs, with 46% of the workforce reported by Canterbury DHB contributing a total of 77.74 actual FTEs to the regional total. The third largest Community CAMHS workforce was reported in the Central region (153.14 actual FTEs) with Capital & Coast DHB reporting the largest Community workforce (69.6 actual FTEs) in that region. Midland reported the smallest Community workforce of a 108.31 actual FTEs with the majority of the workforce in Bay of Plenty (36.1 actual FTEs) and Waikato (31.61 actual FTEs) DHBs (see Table 72).

The DHBs reported a total of 98.77 vacant Community FTEs. Regional analyses showed that the Northern region reported the highest total vacant Community FTEs (42.57 vacant FTEs) with Counties Manukau DHB contributing significantly to the regional total (19.57 vacant FTEs) followed by Auckland (13.0 vacant FTEs) and Waitemata (10.0 vacant FTEs) DHBs. Midland, Central and Southern regions reported a similar number of vacancies (18.9, 19.63 & 17.67 FTEs respectively) (see Table 73).

The DHB Community Clinical Workforce

In 2003/2004, DHBs received funding for 623.42 Community Clinical FTEs. As at 31st March 2004, DHBs reported a total of 505.1 actual Clinical FTEs and 82.6 vacant FTEs (see columns 4 & 5 of Table 71) accounting for 82% of the total CAMHS Community workforce. This data has been tabled against the data provided by the Mental Health Commission (MHC) (see columns 2 & 3 of Table 71) for relative consistency.

Regionally, the largest Clinical Community workforce was located in the Northern region reporting a total of 171.1 actual FTEs followed by the Southern (133.7 actual FTEs) and Central regions (107.6 actual FTEs) (see Figure 32). The smallest Clinical workforce was reported by Midland (92.7 actual FTEs).

Vacancy data analysed by region showed that the majority of Clinical vacancies were reported in the Northern region (33.9 vacant FTEs) with Counties Manukau DHB reporting the highest vacancies (15.1 vacant FTEs). Midland, Southern and Central regions reported a similar number of vacancies (17.7, 15.1 & 15.9 respectively).

The Community Clinical FTEs by occupational groups (see Table 72 & Figure 33), showed that the majority of the Clinical staff were Registered Psychologists (118.23 actual FTEs), Social Workers (100.58 actual FTEs) and Mental Health Nurses (99.39 actual FTEs). The majority of the Clinical vacancies were in Psychologist (17.05 vacant FTEs); Mental Health Nurses (16.1 vacant FTEs) and Psychiatrists (15.37 vacant FTEs) occupational groups.

Table 71. DHB CAMHS Community Clinical FTEs (MHC & Survey Data)

	MHC Data			Survey Data	
DHB	**Funded Community Clinical FTEs[2]**	**Actual FTEs**	**Unfilled FTEs**	**Actual FTEs**	**Vacant FTEs**
Northern	**219.0**	**182.4**	**36.5**	**171.1**	**33.9**
Northland	19.0	17.2	1.8	17.2	0.0
Waitemata[3]	75.0	70.0	5.0	71.6	9.3
Auckland[3]	69.1	58.9	10.2	48.4	9.5
Counties Manukau	55.9	36.3	19.5	33.8	15.1
Midland	**95.2**	**88.4**	**9.0**	**92.7**	**17.7**
Waikato[1]	28.6	30.8	0.0*	26.6	1.0
Lakes	14.5	9.4	5.1	12.4	11.2
Bay of Plenty	29.5	28.8	0.7	32.1	1.2
Tairawhiti	8.7	6.5	2.2	6.8	1.3
Taranaki	13.9	12.9	1.0	14.9	3.0
Central	**144.1**	**142.2**	**9.0**	**107.6**	**15.1**
Hawke's Bay	21.1	20.1	1.0	18.1	2.0
MidCentral	22.0	21.7	0.4	20.4	1.0
Whanganui	14.0	7.6	6.4	6.8	4.4
Capital & Coast	60.5	64.9	0.0*	36.6***	3.4
Hutt	19.4	22.0	0.0*	21.4	2.6
Wairarapa	7.1	5.9	1.2	4.4	1.7
Southern	**154.5**	**132.8**	**21.9**	**133.7**	**15.9**
Nelson Marlborough	22.1	19.6	2.5	17.5	4.0
West Coast	8.3	7.7	0.7	8.7	0.0
Canterbury	71.5	58.9	12.6	60.4	8.4
South Canterbury	9.7	8.7	1.1	8.8	1.0
Otago	29.3	26.3	3.0	28.2	3.0**
Southland	13.6	11.6	2.0	10.2	2.5
Total	**612.8**	**545.8**	**76.4**	**505.1**	**82.6**

* Used Zero for DHBs where Actual exceeded Funded FTEs ** Not provided used MHC Vacancy data
***Excludes 18.9 EIS FTEs as not provided by Occupational Groups 1. Waikato actual data is from vacancy templates Quarters 2 & 4 2003/04 averaged (not Q3). 2. Funded community clinical FTEs have been aligned to the Q3 DHB service level agreement (Price Volume Schedule) for each DHB, checked with the DHB. 3. Auckland & Waitemata Clinical FTEs as at March 2005 (2004 Data not available)

Figure 32. DHB CAMHS Community Clinical Workforce by Region (2004)

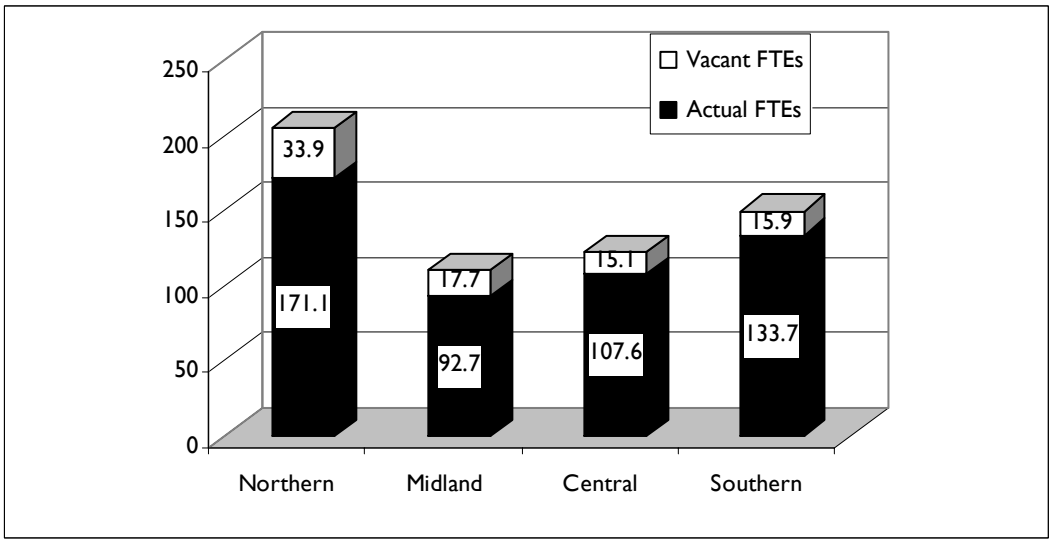


Figure 33. DHB CAMHS Community Clinical Workforce by Occupational Group (2004)

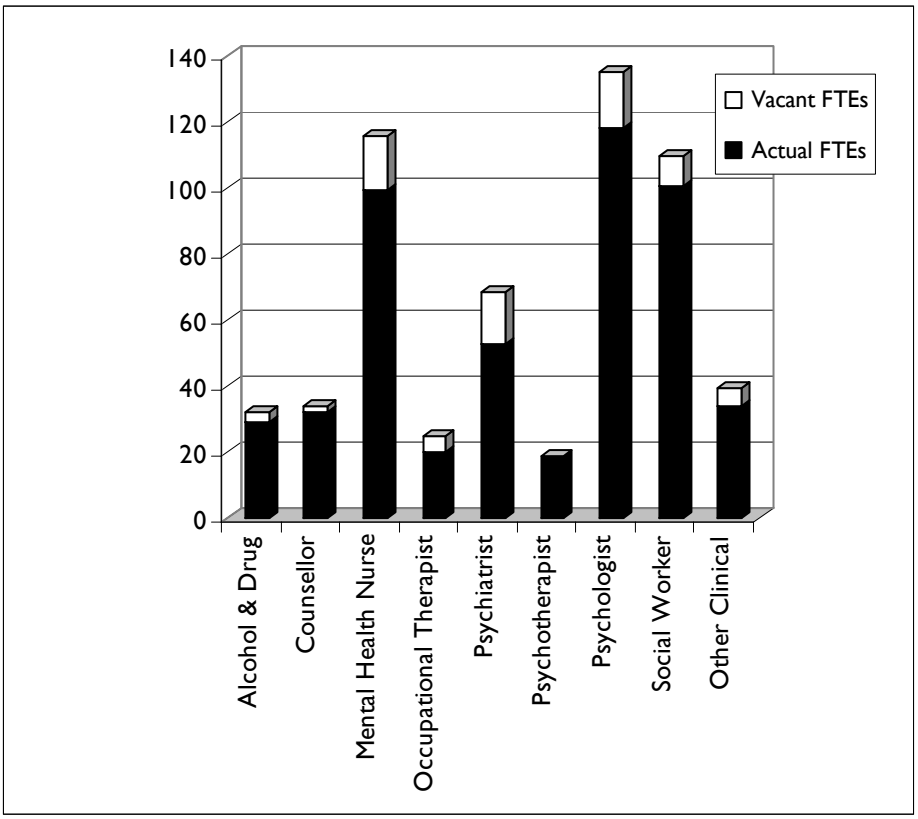


Table 72. DHB CAMHS Community Actual FTEs by Occupational Group (31st March 2004)

DHB	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**11.8**	**6.3**	**34.74**	**10.1**	**20.13**	**7.7**	**40.9**	**27.3**	**12.1**	**171.07**	**11.06**	**0**	**0.2**	**0**	**0**	**11.26**	**20.8**	**203.13**
Northland	-	1.5	8.6	-	2.6	-	1.0	1.0	2.5	**17.2**	-	-	-	-	-	**0**	2.5	**19.7**
Waitemata*	11.8	-	14.8	5.1	7.1	4.5	9.9	13.3	5.1	**71.6**	5.56	-	0.2	-	-	**5.76**	6.5	**83.86**
Auckland*	-	1.0	5.74	3.0	6.1	1.8	22.4	7.4	1.0	**48.44**	3.0	-	-	-	-	**3.0**	5.2	**56.64****
Counties Manukau	-	3.8	5.6	2.0	4.33	1.4	7.6	5.6	3.5	**33.83**	2.5	-	-	-	-	**2.5**	6.6	**42.93**
Midland	**6.0**	**13.7**	**16.5**	**0.8**	**8.72**	**1.3**	**27.87**	**14.6**	**3.21**	**92.7**	**1.0**	**0**	**0**	**0**	**0**	**1.0**	**14.61**	**108.31**
Waikato	2.0	-	5.0	-	3.62	1.3	8.77	3.0	2.86	**26.55**	-	-	-	-	-	**0**	5.06	**31.61**
Lakes	1.0	-	3.0	-	0.6	-	4.8	3.0	-	**12.4**	1.0	-	-	-	-	**1.0**	2.75	**16.15**
Bay of Plenty	-	13.7	4.5	-	2.2	-	7.8	3.9	-	**32.1**	-	-	-	-	-	**0**	4.0	**36.1**
Tairawhiti	1.0	-	1.0	-	0.3	-	1.4	2.7	0.35	**6.75**	-	-	-	-	-	**0**	1.8	**8.55**
Taranaki	2.0	-	3.0	0.8	2.0	-	5.1	2.0	-	**14.9**	-	-	-	-	-	**0**	1.0	**15.9**
Central	**5.0**	**2.0**	**13.2**	**1.88**	**12.3**	**7.6**	**24.78**	**32.38**	**8.5**	**107.64**	**7.1**	**1.0**	**0**	**1.0**	**3.0**	**12.1**	**14.5**	**153.14****
Hawke's Bay	-	-	3.4	0.88	1.7	1.4	3.5	7.18	-	**18.06**	1.1	-	-	-	-	**1.1**	-	**19.16**
MidCentral	2.0	-	1.8	-	0.8	-	6.0	9.0	0.8	**20.4**	-	-	-	-	2.4	**2.4**	-	**22.8**
Whanganui	-	-	3.0	-	0.8	1.0	-	2.0	-	**6.8**	-	-	-	-	-	**0**	3.5	**10.3**
Capital & Coast	3.0	-	4.0	1.0	5.8	2.2	11.1	9.5	-	**36.6**	6.0	1.0	-	-	0.6	**7.6**	6.5	**69.6****
Hutt	-	-	-	-	2.4	3.0	4.20	4.1	7.7	**21.38**	-	-	-	-	-	**0**	4.5	**25.88**
Wairarapa	-	2.0	1.0	-	0.8	-	-	0.6	-	**4.4**	-	-	-	1.0	-	**1.0**	-	**5.4**
Southern	**6.1**	**10.4**	**34.95**	**7.2**	**11.78**	**2.0**	**24.68**	**26.3**	**10.3**	**133.71**	**4.7**	**1.9**	**0.7**	**0**	**4.5**	**11.8**	**22.85**	**168.36**
Nelson Marlborough	-	2.0	7.6	-	1.0	-	3.95	2.2	0.7	**17.45**	-	-	-	-	1.0	**1.0**	2.22	**20.67**
West Coast	1.5	4.0	-	0.2	0.2	-	1.0	-	1.8	**8.7**	-	0.2	0.7	-	-	**0.9**	1.8	**11.4**
Canterbury	1.0	-	14.9	3.0	5.78	-	12.23	17.7	5.8	**60.41**	2.7	-	-	-	-	**2.7**	14.63	**77.74**
South Canterbury	1.6	-	2.0	1.0	0.4	1.0	1.0	0.8	1.0	**8.8**	-	-	-	-	-	**0**	-	**8.8**
Otago	1.0	3.8	8.7	2.0	4.4	-	4.5	3.8	-	**28.2**	2.0	0.2	-	-	3.5	**5.7**	2.0	**35.9**
Southland	1.0	0.6	1.75	1.0	-	1.0	2.0	1.8	1.0	**10.15**	-	1.5	-	-	-	**1.5**	2.2	**13.85**
DHB Total	**28.9**	**32.4**	**99.39**	**19.98**	**52.93**	**18.6**	**118.23**	**100.58**	**34.11**	**505.12**	**23.86**	**2.9**	**0.9**	**1.0**	**7.5**	**36.16**	**72.76**	**632.94****

*FTES as at March 2005 as 2004 data was not available

**Capital & Coast, Central & Total DHB FTEs include EIS FTE (18.9 FTEs) & Auckland DHB FTEs include Consult Liaison Services (9.1 FTEs)

Table 73. DHB CAMHS Vacant Community FTEs by Occupational Group (31st March 2004)

DHB	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**0**	**0**	**12.4**	**4.0**	**0.37**	**0.5**	**4.2**	**1.4**	**1.5**	**33.87**	**1.0**	**3.5**	**0.4**	**0**	**0**	**4.9**	**3.8**	**42.57**
Northland	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Waitemata*	-	-	6.0	1.0	0.3	0.5	1.0	-	0.5	**9.3**	-	-	0.4	-	-	**0.4**	0.3	**10.0**
Auckland*	-	-	-	-	-	-	-	-	-	**9.5**	-	-	-	-	-	**0**	3.5	**13.0**
Counties Manukau	-	-	6.4	3.0	0.07	-	3.2	1.4	1.0	**15.07**	1.0	3.5	-	-	-	**4.5**	-	**19.57**
Midland	**1.0**	**0**	**1.5**	**0**	**9.9**	**0**	**3.8**	**1.0**	**0.5**	**17.7**	**1.0**	**0**	**0**	**0**	**0**	**1.0**	**0.2**	**18.9**
Waikato	-	-	-	-	-	-	-	1.0	-	**1.0**	-	-	-	-	-	**0**	-	**1.0**
Lakes	-	-	-	-	8.0	-	3.2	-	-	**11.2**	1.0	-	-	-	-	**1.0**	-	**12.2**
Bay of Plenty	-	-	0.5	-	0.7	-	-	-	-	**1.2**	-	-	-	-	-	**0**	0.2	**1.4**
Tairawhiti	-	-	-	-	0.2	-	0.6	-	0.5	**1.3**	-	-	-	-	-	**0**	-	**1.3**
Taranaki	1.0	-	1.0	-	1.0	-	-	-	-	**3.0**	-	-	-	-	-	**0**	-	**3.0**
Central	**1.2**	**1.0**	**1.0**	**0**	**2.23**	**0**	**6.0**	**2.7**	**1.0**	**15.13**	**1.0**	**0**	**0**	**0**	**1.0**	**2.0**	**2.5**	**19.63**
Hawke's Bay	-	-	-	-	-	-	2.0	-	-	**2.0**	-	-	-	-	-	**0**	-	**2.0**
MidCentral	1.0	-	-	-	-	-	-	-	-	**1.0**	-	-	-	-	1.0	**1.0**	-	**2.0**
Whanganui	0.2	-	1.0	-	1.2	-	1.0	1.0	-	**4.4**	1.0	-	-	-	-	**1.0**	-	**5.4**
Capital & Coast	-	-	-	-	0.4	-	2.0	1.0	-	**3.4**	-	-	-	-	-	**0**	2.5	**5.9**
Hutt	-	-	-	-	0.625	-	1.0	-	1.0	**2.63**	-	-	-	-	-	**0**	-	**2.63**
Wairarapa	-	1.0	-	-	-	-	-	0.7	-	**1.7**	-	-	-	-	-	**0**	-	**1.7**
Southern	**1.0**	**0.5**	**1.2**	**1.0**	**2.87**	**0**	**3.05**	**3.8**	**2.5**	**15.92**	**0**	**0**	**0.3**	**0**	**0**	**0.3**	**1.45**	**17.67**
Nelson Marlborough	-	-	-	1.0	-	-	1.0	1.0	1.0	**4.0**	-	-	-	-	-	**0**	-	**4.0**
West Coast	-	-	-	-	-	-	-	-	-	**0**	-	-	0.3	-	-	**0.3**	-	**0.3**
Canterbury	-	-	1.2	-	1.87	-	2.05	1.8	1.5	**8.42**	-	-	-	-	-	**0**	1.45	**9.87**
South Canterbury	-	-	-	-	-	-	-	1.0	-	**1.0**	-	-	-	-	-	**0**	-	**1.0**
Otago**	-	-	-	-	-	-	-	-	-	**0.0**	-	-	-	-	-	**0**	-	**0**
Southland	1.0	0.5	-	-	1.0	-	-	-	-	**2.5**	-	-	-	-	-	**0**	-	**2.5**
Total	**3.2**	**1.5**	**16.1**	**5.0**	**15.37**	**0.5**	**17.05**	**8.9**	**5.5**	**82.62**	**3.0**	**3.5**	**0.7**	**0**	**1.0**	**8.2**	**7.95**	**98.77**

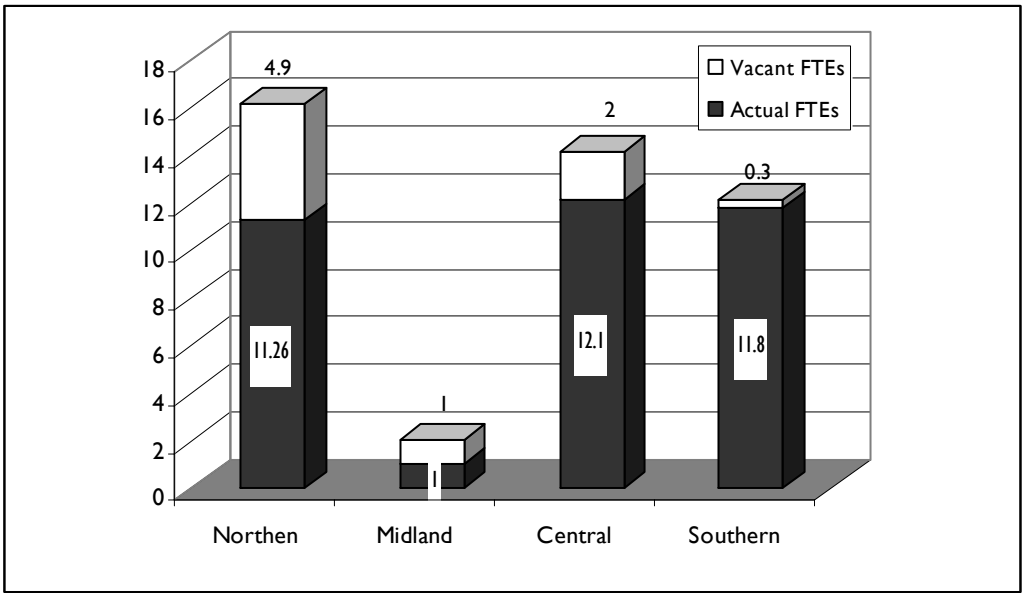
*Vacant Community FTEs as at March 2005 **Not Provided

The DHB Community Non-Clinical Workforce

The Non-Clinical Community workforce has been analysed in two groups the non-clinical professional staff who work directly with clients and the Administration/Management staff. The non-clinical professional staff accounted for 6% (36.16 actual FTEs) of the total DHB CAMHS workforce (clinical & non-clinical) (see Table 72 & Figure 34) and was mainly comprised of Cultural workers (23.86 actual FTEs). Administration/Management staff (72.76 actual FTEs) made up the remainder (12%) of the workforce.

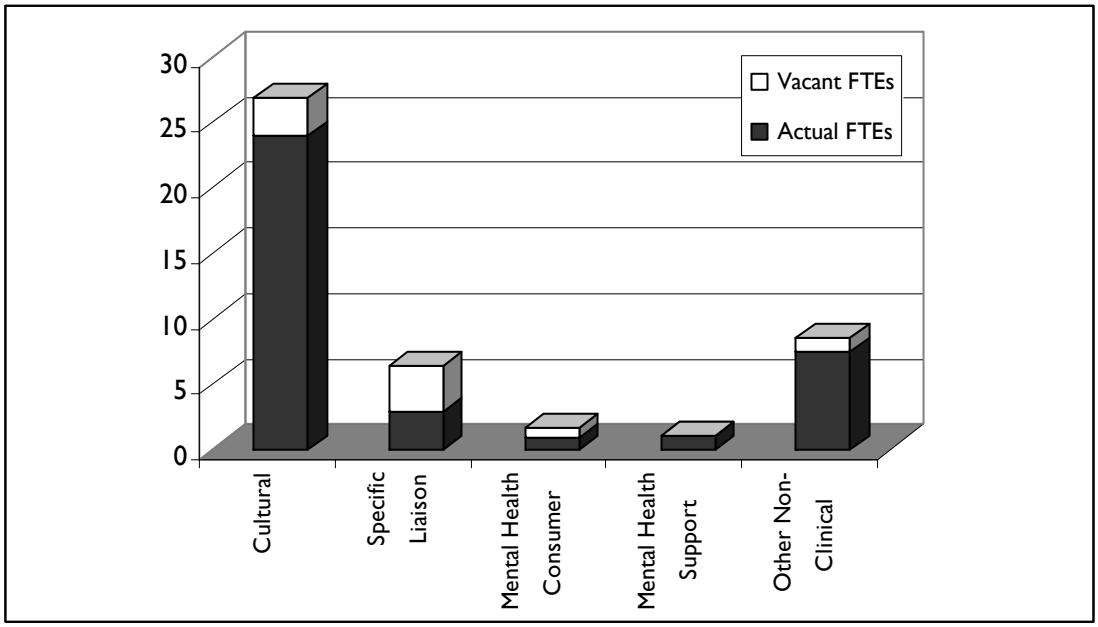
The majority of vacancies were in Specific Liaison (3.5 vacant FTEs) roles followed by Cultural appointments (3.0 vacant FTEs) (see Figure 35).

Figure 34. The DHB CAMHS Non-Clinical Actual & Vacant Community FTEs by Region (2004)



Note: Excludes Administration/Management Staff

Figure 35. The DHB CAMHS Non-Clinical Actual & Vacant Community FTEs by Occupational Groups (2004)



Note: Excludes Administration/Management Staff

4.2.2 The NGO Community Workforce

Workforce data on NGOs that are contracted to provide Kaupapa Māori Services (Purchase Unit Code MHCS39) is presented separately in this section (see Table 77 & 78).

The NGOs may receive funding from agencies other than DHBs and may use the total funding flexibly to meet their needs. Therefore the workforce data may include FTEs that are not funded by DHBs and may over-estimate the DHB funded NGO workforce.

Personal communication with many NGO services highlighted that the occupational categories provided in the Survey were more relevant for the DHB CAMHS workforce and did not appropriately capture the composition of the NGO workforce. For instance, for NGO services, the occupational categories that make up the Clinical workforce were defined somewhat differently.

Although a total of 91 NGOs were identified from the MOH 2003/2004 (72 NGOs) and 2004/2005 (84 NGOs) price-volume schedules, data from 84 NGOs from the 2004/2005 schedule will be presented in this section.

Sixty-two of the 84 NGOs responded to the survey. Four were not providing relevant services. Data from 58 of the 80 relevant NGOs is therefore reported in this section. This equates to a 73% (58/80) response rate. Fifteen of the 58 NGOs that responded were Kaupapa Māori services. Workforce data on Kaupapa Māori services is presented separately in this section. Therefore workforce data from 43 of the NGOs is presented in this section.

A total of 301.3 actual FTEs were reported by the 43 NGOs (excluding Kaupapa Māori services) that responded (see Tables 74 & 75).

The largest NGO workforce (143.2 actual FTEs) was reported in the Southern Region with Canterbury reporting the largest workforce of 71.7 actual FTES (see Table 75). Stepping Stone Trust, St John of God Youth and Community, STOP Trust and Richmond Fellowship contributed significantly to the Canterbury workforce.

Midland reported a workforce of 86.7 actual FTEs with Parentline Charitable Trust providing the bulk of the workforce (23 actual FTEs) in the Waikato district.

NGOs in the Northern region, reported a further 41.4 actual FTEs with Odyssey House Trust in Auckland contributing significantly to the Northern NGO workforce.

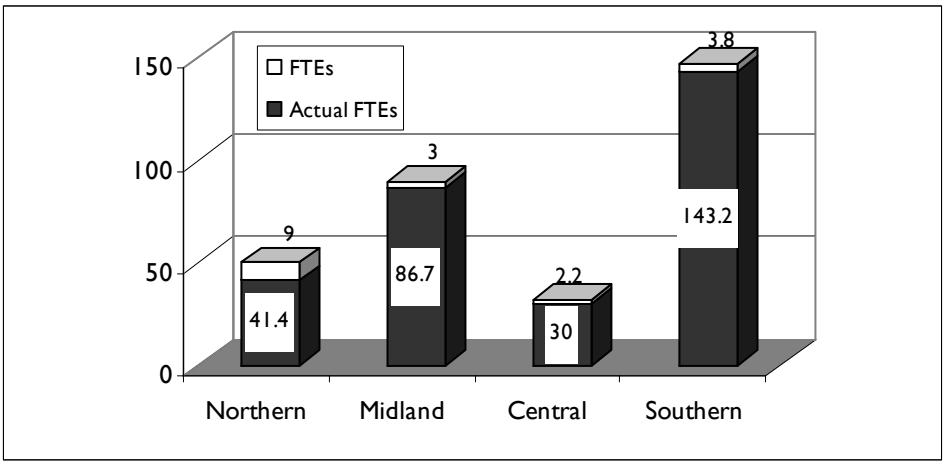
The NGOs reported a total of 18 vacant Community FTEs for the child and adolescent mental health sector (see Tables 74 & 75). Data analysed by region showed that the Northern region reported the highest vacancies (9.0 vacant FTEs) with very few vacancies reported in the other regions (see Figure 36).

Table 74. NGO Actual & Vacant Community FTEs by Region (2004)

Region	FTEs	Vacant FTEs
Northern	41.4	9.0
Midland	86.7	3.0
Central	30.0	2.2
Southern	143.2	3.8
Total	**301.3**	**18.0**

Note: Excludes Kaupapa Māori Services

Figure 36. NGO Actual & Vacant FTEs by Region (2004)



Note: Excludes Kaupapa Māori Services

The NGO workforce was largely made up of Mental Health Support Workers (68.6 actual FTEs) (see Figure 37) which clearly reflects the role of NGOs in the sector. The Clinical workforce accounted for 47% (143 actual FTEs) of the total NGO workforce and consisted mainly of Social Workers (46.9 actual FTEs), Counsellors (31.1 actual FTEs) and Alcohol & Drug Workers (23.8 actual FTEs) workers (see Table 75 & Figure 37).

Very few vacancies were reported (18 vacant FTEs) by the NGOs that responded (see Table 76). There was equal numbers of vacancies in the Clinical and Non-Clinical workforce. Social Worker positions reported the highest vacancies (3.0 vacant FTEs) in the clinical workforce, while Other Non-Clinical positions reported the highest (5.5 vacant FTEs) vacancies in the Non-Clinical workforce.

Figure 37. NGO Actual & Vacant FTEs by Occupational Group (2004)

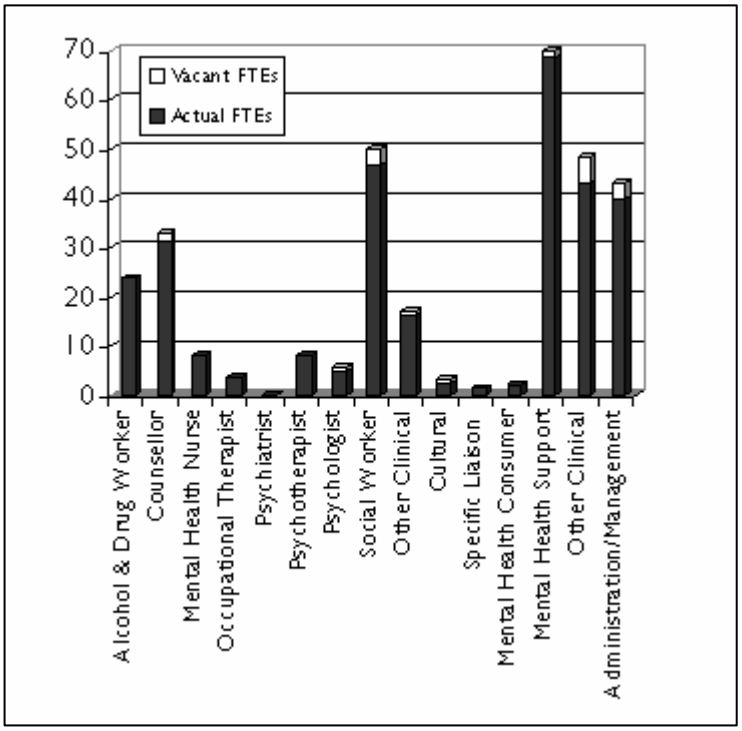


Table 75. NGO Actual Community FTEs (Excludes Kaupapa Māori Services) (31st March 2004)

NGO	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**1.0**	**8.0**	**1.0**	**0**	**0.1**	**0**	**0**	**7.5**	**6.5**	**24.1**	**0**	**0**	**1.5**	**2.0**	**11.0**	**14.5**	**2.8**	**41.4**
Northland																		
Rubicon Charitable Trust Board	-	3.0	-	-	-	-	-	-	-	**3.0**	-	-	-	-	-	**0**	-	**3.0**
Auckland																		
Odyssey House Trust	1.0	5.0	-	-	0.1	-	-	4.0	0.5	**10.6**	-	-	-	-	11.0	**11.0**	2.8	**24.4**
Richmond Fellowship	-	-	-	-		-	-	1.5	4.0	**5.5**	-	-	-	2.0	-	**2.0**	-	**7.5**
Counties Manukau																		
Raukura Hauora O Tainui Trust	-	-	1.0	-	-	-	-	1.0	1.0	**3.0**	-	-	1.5	-	-	**1.5**	-	**4.5**
Richmond Fellowship	-	-	-	-	-	-	-	1.0	1.0	**2.0**	-	-		-	-	**0**	-	**2.0**
Midland	**5.0**	**14.7**	**0**	**0**	**0**	**1.0**	**2.0**	**6.0**	**2.3**	**31.0**	**2.5**	**0.5**	**0.5**	**30.0**	**5.5**	**38.9**	**16.8**	**86.7**
Waikato																		
Linkage Trust	-	-	-	-	-	-	-	-	1.0	**1.0**	-	-	-	-	-	**0**	0.5	**1.5**
Northern King Country Drug & Alcohol Counselling & Education	2.0	-	-	-	-	-	-	-	-	**2.0**	-	-	-	1.0	-	**1.0**	-	**3.0**
Parentline Charitable Trust	-	10.0	-	-	-	1.0	1.0	5.0	1.0	**18.0**	1.0				-	**1.0**	4.0	**23.0**
Richmond Fellowship	-	-	-	-	-	-	-	-		**0**	-	-	-	9.0	-	**9.0**	1.0	**10.0**
Te Ahurei A Rangatahi	2.0	0.2	-	-	-	-	-	-		**2.2**	-	-	-	4.0	0.5	**4.5**	0.7	**7.4**
Waikato Pasifika Health Trust	-	-	-	-	-	-	-	-	0.3	**0.3**		0.5	0.45	1.5	3.0	**5.4**	6.1	**11.8**
Youth Horizons Trust	-	3.0	-	-	-		1.0	1.0		**5.0**	-	-	-	-	-	**0**	-	**5.0**
Lakes																		
Te Aratu Trust	-	-	-	-	-	-	-	-	-	**0.0**	1.5	-	-	-	1.0	**2.5**	-	**2.5**
Bay of Plenty																		
Te Rangimarie Trust	1.0	1.0	-	-	-	-	-	-	-	**2.0**	-	-	-	2.0	-	**2.0**	2.0	**6.0**
Te Tomika Trust	-	0.5	-	-	-	-	-	-	-	**0.5**	-	-	-		-	**0**	-	**0.5**
Turning Point Trust	-	-	-	-	-	-	-	-	-	**0**	-	-	-	12.5	-	**12.5**	2.5	**15.0**
Taranaki																		
Linkage Trust	-	-	-	-	-	-	-	-	-	**0**	-	-	-		1.0	**1.0**	-	**1.0**

Table 75 Continued. NGO Actual Community FTEs (Excludes Kaupapa Māori Services) (31st March 2004)

NGO	Alcohol & Drug	Counsellor	Mental Health Nurses	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Central	**4.8**	**0.5**	**1.0**	**0**	**0**	**0**	**0**	**6.0**	**2.2**	**14.4**	**0**	**0**	**0**	**13.3**	**6.7**	**13.5**	**2.1**	**30.0**
Hawke's Bay																		
Richmond Fellowship	-	-	-	-	-	-	-	-	-	**0**	-	-	-	4.0	-	**4.0**	-	**4.0**
Whanganui																		
Life to the Max Trust	-	-	-	-	-	-	-	2.0	-	**2.0**	-	-	-	-	2.0	**2.0**	0.5	**4.5**
Capital & Coast																		
Taeaomanino Trust	-	0.5	-	-	-	-	-	1.0		**1.5**	-	-	-	-	0.2	**0.2**	-	**1.7**
Wellington Refugees as Survivors Trust	-	-	-	-	-	-	-	-	1.0	**1.0**	-	-	-	-	1.0	**1.0**	-	**2.0**
Hutt																		
Richmond Fellowship	-	-	-	-	-	-	-	-	1.0	**1.0**	-	-	-	2.5	-	**2.5**	-	**3.5**
VIBE Hutt Valley Youth Health Trust	-	-	1.0	-	-	-	-	3.0		**4.0**	-	-	-	0.3	1.0	**1.3**	-	**5.3**
Wairarapa																		
King Street Artworks	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	2.5	**2.5**	0.88	**3.4**
Wairarapa Addiction Services	1.0	-	-	-	-	-	-	-	-	**1.0**	-	-	-	-	-	**0**	0.75	**1.8**
Ministry of Health																		
WellTrust	3.75	-	-	-	-	-	-	-	0.15	**3.9**	-	-	-	-	-	**0**	-	**3.9**

Table 75 Continued. NGO Actual Community FTEs (Excludes Kaupapa Māori Services) (31st March 2004)

NGO	Alcohol & Drug	Counsellor	Mental Health Nurses	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Southern	**13.0**	**7.9**	**6.1**	**4.0**	**0.1**	**7.1**	**2.9**	**27.4**	**5.0**	**73.5**	**0.3**	**1.0**	**0.5**	**23.3**	**19.9**	**51.5**	**18.2**	**143.2**
Nelson Marlborough																		
Care Solutions NZ	-	-	-	-	-	-	-	0.5	-	**0.5**	-	-	-	2.5	3.0	**5.5**	2.5	**8.5**
Gateway Housing Trust										**0**				6.5		**6.5**		**6.5**
Horizon Trust Board	1.0	-	0.2	1.0	-	-	-	-	-	**2.2**	-	1.0	-	-	-	**1.0**	1.2	**4.4**
Canterbury																		
Ashburton Community Alcohol & Drug Service	-	1.7	-	-	-	-	-	-	-	**1.7**	-	-	-	-	-	0	0.4	**2.1**
Christchurch City Mission	1.0	-	-	-	-	-	-	-	-	**1.0**	-	-	-	-	-	**0**	-	**1.0**
Depression Support Network	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	1.0	**1.0**	-	**1.0**
Odyssey House Trust	3.6	-	-	-	-	-	-	-	-	**3.6**	-	-	-	-	-	**0**	-	**3.6**
Richmond Fellowship	-	-	1.0	-	-	-	0.2	-	3.0	**4.2**	-	-	-	7.3	-	**7.3**	-	**11.5**
St John of God Youth & Community	1.0	-	-	-	-	-	0.5	8.5	-	**10.0**	-	-	-	-	1.0	**1.0**	3.5	**14.5**
Stepping Stone Trust	-	-	4.1	-	-	-	-	4.9	-	**9.0**	-	-	-	5.0	4.1	**9.1**	1.5	**19.6**
STOP Trust	-	-	-	-	-	7.1	1.2	1.0	1.0	**10.3**	0.3	-	-	-	-	**0.3**	3.4	**14.0**
Waimakariri Community Development Trust	1.4	-	-	-	-	-	-	-	-	**1.4**	-	-	-	-	-	**0**	-	**1.4**
Youth Health Trust	1.0	1.0	-	-	-	-	-	0.5	-	**2.5**	-	-	-	0.5	-	**0.5**	-	**3.0**
Otago																		
Aroha Ki Te Tamariki Trust	4.0	4.9	-	-	-	-	-	-	-	**8.9**	-	-	-	-	2.2	**2.2**	1.2	**12.3**
Miramare	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	4.5	**4.5**	-	**4.5**
Otago Youth Wellness	-	0.3	0.8	2.0	0.1	-	-	11.0	1.0	**15.2**	-	-	-	-	3.6	**3.6**	3.5	**22.3**
Southland																		
PACT Group	-	-	-	1.0	-	-	1.0	1.0	-	**3.0**	-	-	0.5	8.0	0.5	**9.0**	1.0	**13.0**
Total	**23.8**	**31.1**	**8.1**	**4.0**	**0.2**	**8.1**	**4.9**	**46.9**	**16.0**	**143.0**	**2.8**	**1.5**	**2.5**	**68.6**	**43.1**	**118.4**	**39.9**	**301.3**

Source: Stocktake Survey Data

Table 76. NGO Vacant Community FTEs by Occupational Group (Excludes Kaupapa Mãori Services) (31st March 2004)

NGO	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**0**	**2.0**	**0**	**0**	**0**	**0**	**1.0**	**3.0**	**0**	**6.0**	**0**	**0**	**0**	**1.0**	**2.0**	**3.0**	**0**	**9.0**
Auckland																		
Odyssey House Trust	-	-	-	-	-	-	-	1.0	-	**1.0**	-	-	-		2.0	**2.0**	-	**3.0**
Richmond Fellowship	-	-	-	-	-	-	-	2.0	-	**2.0**	-	-	-	1.0	-	**1.0**	-	**3.0**
Counties Manukau																		
Raukura Hauora O Tainui Trust	-	2.0	-	-	-	-	1.0	-	-	**3.0**	-	-	-		-	**0**	-	**3.0**
Midland	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1.0**	**1.0**	**0**	**0**	**0**	**0**	**1.0**	**1.0**	**1.0**	**3.0**
Waikato																		
Waikato Pasifika Health Trust	-	-	-	-	-	-	-	-	1.0	**1.0**	-	-	-	-	1.0	**1.0**	-	**2.0**
Youth Horizons Trust	-	-	-	-	-	-	-	-		**0**	-	-	-	-		**0**	1.0	**1.0**
Central	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.5**	**0.5**	**0**	**0**	**0**	**0.2**	**1.5**	**1.7**	**0**	**2.2**
Whanganui																		
Life to the Max Trust	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	1.0	**1.0**	-	**1.0**
Hutt																		
VIBE Youth Health Trust	-	-	-	-	-	-	-	-	0.5	**0.5**	-	-	-	0.2	0.5	**0.7**	-	**1.2**
Southern	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0.8**	**0**	**0**	**0**	**1.0**	**1.8**	**2.0**	**3.8**
Nelson Marlborough																		
Care Solutions NZ	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	1.0	**1.0**	2.0	**3.0**
Horizon Trust Board	-	-	-	-	-	-	-	-	-	**0**	0.8	-	-	-	-	**0.8**	-	**0.8**
Total	**0**	**2.0**	**0**	**0**	**0**	**0**	**1.0**	**3.0**	**1.5**	**7.5**	**0.8**	**0**	**0**	**1.2**	**5.5**	**7.5**	**3.0**	**18.0**

Source: Stocktake Survey Data

4.2.3 The NGO Kaupapa Māori Workforce

Nineteen NGOs that were contracted to provide Kaupapa Māori services were identified from the MOH 2004/2005 price-volume schedules (MOH purchase unit code: MHCS39). Workforce data was provided by 15 services (see Table 77 & 78).

Table 77. NGO Kaupapa Māori Services Actual & Vacant FTEs by Region (2004)

Region	FTEs	Vacant FTEs
Northern	3.0	0
Midland	23.0	2.25
Central	4.0	0
Southern	6.8	0
Total	**36.8**	**2.25**

Source: Stocktake Survey Data

An additional 36.8 actual FTEs was reported by NGOs that provide Kaupapa Māori services. The majority of the workforce (23 actual FTEs) was located in the Midland region in the Waikato district (see Table 77 & 78). Very few vacancies (2.25 FTES; 1.0 Mental Health Nurse & 1.25 Cultural) were reported by the services.

The Kaupapa Māori workforce was made up of approximately equal numbers of Clinical and Non-Clinical staff. The clinical workforce totalled 18.7 actual FTEs and staff were mainly Counsellors (9.5 actual FTEs) and Social Workers (5.5 actual FTEs) (see Figure 38). The Non-Clinical workforce totalled 18.1 actual FTEs and staff were mainly Mental Health Support Workers (9.8 actual FTEs) and Other Non-Clinical staff (4.0 actual FTEs) (see Table 78).

Figure 38. NGO Kaupapa Māori Services Actual FTEs by Occupational Group (2004)

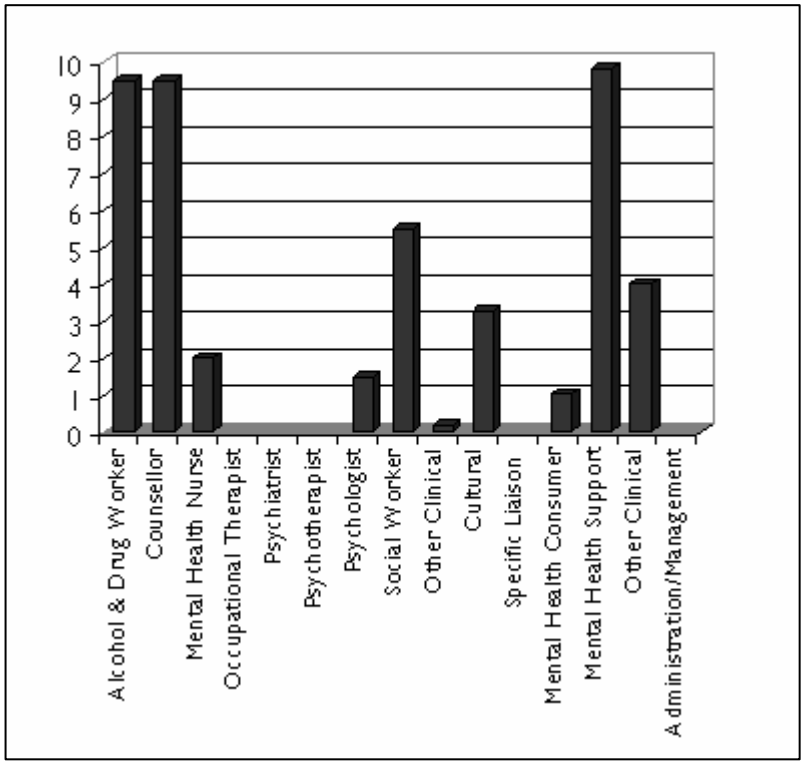


Table 78.NGO Kaupapa Māori Services Community FTEs by Occupational Group (March 2004)

Kaupapa Māori NGO Services Actual FTEs	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**1.0**	**1.0**	**0**	**0**	**1.0**	**0**	**2.0**	**0**	**3.0**
Northland																		
Ngati Hine Health Trust Board	-	-	-	-	-	-	-	1.0	-	**1.0**	1.0	-	-	1.0	-	**2.0**	-	**3.0**
Midland	**0**	**4.5**	**1.0**	**0**	**0**	**0**	**0.5**	**4.5**	**0.2**	**10.7**	**0.5**	**0**	**1.0**	**8.8**	**2.0**	**12.3**	**0**	**23.0**
Waikato																		
Maniapoto Māori Trust Board	-		-	-	-	-	-	0.5	-	**0.5**	0.5	-	-	2.0	-	**2.5**	-	**3.0**
Raukawa Trust Board	-		-	-	-	-	-		-	**0**	-	-	-	4.0	-	**4.0**	-	**4.0**
Te Korowai Hauora O Hauraki Inc	-	1.0	-	-	-	-	-		-	**1.0**	-	-	-	1.0	-	**1.0**	-	**2.0**
Lakes																		
Te Runanga Ngati Pikiao Trust	-	1.0	-	-	-	-	-	1.0	0.2	**2.2**	-	-	1.0	1.0	-	**2.0**	-	**4.2**
Tuwharetoa Health Services Ltd	-	-	-	-	-	-	-	1.0	-	**1.0**	-	-	-	-	-	**0**	-	**1.0**
Bay of Plenty																		
Nga Mataapuna Oranga	-	-	-	-	-	-	-	1.0	-	**1.0**	-	-	-	-	-	**0**	-	**1.0**
Te Runanga O Te Whanau Charitable Trust	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	2.0	**2.0**	-	**2.0**
Tuhoe Hauora Trust	-	0.5	1.0	-	-	-	0.5	-	-	**2.0**	-	-	-	0.8		**0.8**	-	**2.8**
Tairawhiti																		
Te Hauora O Turanganui A Kiwa Ltd	-	-	-	-	-	-	-	1.0	-	**1.0**	-	-	-	-	-	**0**	-	**1.0**
Taranaki																		
Tui Ora	-	2.0	-	-	-	-	-	-	-	**2.0**	-	-	-	-	-	**0**	-	**2.0**
Central	**0**	**3.0**	**0**	**0**	**0**	**0**	**1.0**	**0**	**0**	**4.0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4.0**
Capital & Coast																		
Te Runanga o Toa Rangatira Inc	-	3.0	-	-	-	-	1.0	-	-	**4.0**	-	-	-	-	-	**0**		**4.0**
Southern	**0**	**2.0**	**1.0**	**0**	**0**	**0**	**0.0**	**0**	**0**	**3.0**	**1.8**	**0**	**0**	**0**	**2.0**	**3.8**	**0**	**6.8**
Canterbury																		
Purapura Whetu	-	1.0	1.0	-	-	-	-	-	-	**2.0**	-	-	-	-	2.0	**2.0**	-	**4.0**
STOP Trust	-		-	-	-	-	-	-	-	**0**	1.8	-	-	-	-	**1.8**	-	**1.8**
Southland																		
Te Hurahi Ki Te Oranga Pai Trust	-	1.0	-	-	-	-	-	-	-	**1.0**	-	-	-	-	-	**0.0**	-	**1.0**
Total	**0**	**9.5**	**2.0**	**0**	**0**	**0**	**1.5**	**5.5**	**0.2**	**18.7**	**3.3**	**0**	**1.0**	**9.8**	**4.0**	**18.1**	**0**	**36.8**

Source: Stocktake Survey Data

4.2.4 The Child, Youth & Family Collaborative Workforce

A number of services and programmes form part of the child and adolescent mental health service collaborative workforce and these services are co-ordinated by Child, Youth and Family (CYF) Services (see Chapter 2 for details).

An additional 34 actual FTEs (12.5 Clinical and 13.1 Non-Clinical actual FTEs) were reported by Lower North Severe Conduct Disorder Programme (LNSCDP), Towards Wellbeing Youth Suicide Programme and High and Complex Needs Unit (see Table 79). Youth Horizons Trust-Waikato (YHT) is also part of this collaborative workforce. YHT FTEs (5.0) have been excluded from total FTEs reported in this section as they are already included in the NGO numbers.

The Towards Wellbeing Youth Suicide Programme and the High and Complex Needs Unit (HCN Unit) are primarily involved in providing administrative support services therefore did not report a clinical workforce. The Towards Wellbeing Youth Suicide Programme is involved in monitoring young people with suicide ideation and also provides non-clinical support to social workers who were managing these young people. Clinical assessment and treatment is provided by a DHB CAMHS.

The High and Complex Needs Unit (HCN Unit) acts as a funding agency to provide funds for services for young people with high and complex needs that cannot be met by one service alone. The unit supports the CAMHS workforce by providing administrative and non-clinical support for applications for funding and individualised plan development. The existing child and adolescent mental health service workforce (Education, Health, CYF and NGOs) is utilised according to the young person's individualised plan.

The only services involved in providing Clinical services were The Lower North Severe Conduct Disorder Programme (LNSCDP) and YHT of which the LNSCDP reported the largest Clinical workforce (12.5 actual FTEs).

Clinical services in the LNSCDP were mainly provided by a small team of Mental Health Nurses (4.0 actual FTEs), Social Workers (3.0 actual FTEs) and Occupational Therapists (2.0 actual FTEs) with support from a Psychologist (0.5 actual FTEs). The Clinical staff were also supported by a team of Non-Clinical staff members mainly in Mental Health Support roles (6.0 actual FTEs).

Youth Horizons Trust mainly specialised in providing Clinical services provided by three Counsellors, a Psychologist and a Social Worker.

A total of 11.1 vacant FTEs were also reported by the LNSCDP mainly in Mental Health Support and Other Clinical workers.

Table 79. The Child, Youth & Family Collaborative Workforce Actual & Vacant FTEs (31st March 2004)

Employee Group	Youth Horizons Trust-Waikato DHB*		Lower North Severe Conduct Disorder Programme		Towards Wellbeing Youth Suicide		High & Complex Needs Unit		Total	
	Actual FTEs	Vacant FTEs	Actual FTEs	Vacant FTEs	Actual FTEs	Vacant FTEs	Actual FTEs	Vacant FTEs	Actual FTEs	Vacant FTEs
Clinical Sub-Total	**5.0**	**0**	**12.5**	**6.3**	**0**	**0**	**0**	**0**	**17.5**	**6.3**
Alcohol & Drug Worker	-	-	-	-	-	-	-	-	**-**	**-**
Counsellor	3.0	-	-	-	-	-	-	-	**3.0**	**-**
Mental Health Nurse	-	-	4.0	-	-	-	-	-	**4.0**	**-**
Occupational Therapist	-	-	2.0	-	-	-	-	-	**2.0**	**-**
Psychiatrist	-	-	-	0.5	-	-	-	-	**-**	**0.5**
Psychotherapist	-	-	-	-	-	-	-	-	**-**	**-**
Registered Psychologist	1.0	-	0.5	1.0	-	-	-	-	**1.5**	**1.0**
Social Worker	1.0	-	3.0	1.0	-	-	-	-	**4.0**	**1.0**
Other Clinical Worker	-	-	3.0	3.8	-	-	-	-	**3.0**	**3.8**
Non-Clinical Sub-Total	**0**	**0**	**8.5**	**4.8**	**0.5**	**0**	**4.6**	**0**	**13.1**	**4.8**
Kaumatua/Kuia Cultural Appointment	-	-	1.0	-	-	-	-	-	**1.0**	**-**
Specific Liaison Appointment	-	-	-	-	-	-	-	-	**-**	**-**
Mental Health Consumer	-	-	-	-	-	-	-	-	**-**	**-**
Mental Health Support Worker	-	-	6.0	4.8	-	-	-	-	**6.0**	**4.8**
Other Non-Clinical Support	-	-	1.5	-	0.5	-	4.6	-	**6.1**	**-**
Administrative/Management	**-**	**1.0**	**1.0**	**-**	**-**	**-**	**7.4**	**-**	**8.4**	**1.0**
Total FTEs	**5.0***	**1.0***	**22.0**	**11.1**	**0.5**	**0**	**12.0**	**0**	**39.0**	**12.1**

Source: CYF Survey *Funded by Waikato DHB and included in the NGO data

4.2.5 The Total Child & Adolescent Mental Health Workforce

According to the data provided by all the child and adolescent mental health services surveyed (DHB (Inpatient & Community) NGOs and CYF), the total workforce was reported to be **1129.69 actual FTEs** (see Table 80), with a further **157.52 FTEs** that were reported vacant. Of the total workforce, 766.32 actual FTEs were Clinical (Inpatient & Community) FTEs with 94.92 Clinical actual FTEs that were reported vacant.

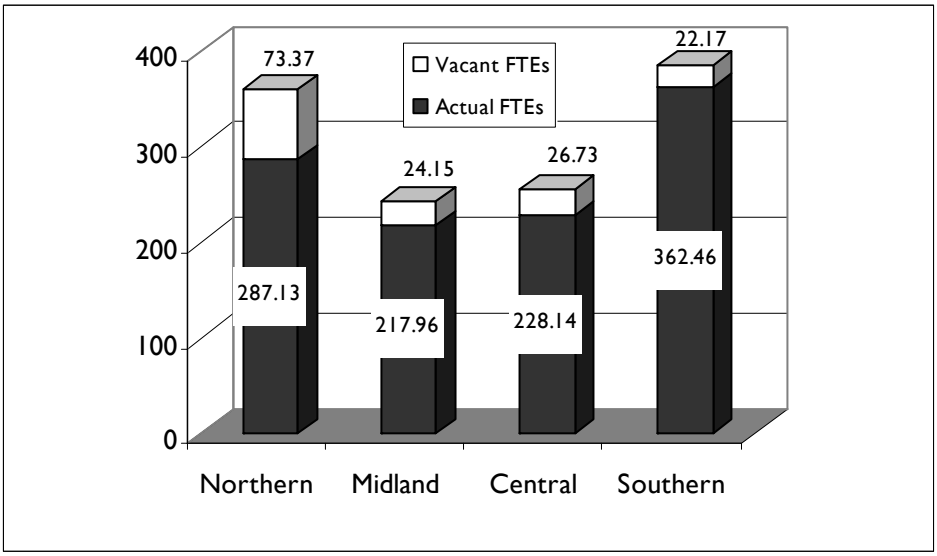
The Southern region reported the largest total workforce of 362.46 actual FTEs followed by the Northern (287.13 actual FTEs), Central (228.14 actual FTEs) and Midland (217.96 actual FTEs) regions (see Figure 39). Vacancies were prominent in the Northern region (73.37 vacant FTEs) followed by the Central region (26.73 vacant FTEs).

Table 80. Total Child & Adolescent Mental Health Workforce by Region (2004)

Region	DHB[1]		NGO[2]		CYF[3]		Total	
	Actual FTEs	Vacant FTEs	Actual FTEs	Vacant FTEs	Actual FTEs	Vacant FTEs	Actual FTEs	Vacant FTEs
Northern	242.73	64.37	44.40	9.00			287.13	73.37
Midland	108.31	18.9	109.65	5.25			217.96	24.15
Central	194.14	24.53	34.0	2.20			228.14	26.73
Southern	212.46	18.37	150.0	3.80			362.46	22.17
Total	**757.64**	**126.17**	**338.05**	**20.25**	**34**	**11.1**	**1129.69**	**157.52**

1. Includes Inpatient Data
2. Includes NGO Kaupapa Māori Services
3. Includes The Lower North Severe Conduct Disorder Programme, Towards Wellbeing Youth Suicide Prevention Programme & High & Complex Needs Unit and Excludes data from Youth Horizons Trust

Figure 39. The Total Child & Adolescent Mental Health Workforce by Region (2004)



The total child and adolescent mental health workforce in 2004 was largely made up of Mental Health Nurses (179.29 actual FTEs), Social Workers (160.78 actual FTEs), and Psychologists (130.23 actual FTEs). However, the composition of the DHB workforce differed somewhat from the NGO workforce. In DHBs, Mental Health Nurses formed the largest occupational group (165.19 actual FTEs), followed by Psychologists (123.33 actual FTEs), Social Workers (105.38 actual FTEs) and Psychiatrists (58.73 actual FTEs) and were responsible for providing 78% of the clinical services. On the other hand, Mental Health Support Workers (78.35 actual FTEs) formed the largest occupational group in NGOs followed by Social Workers (52.4 actual FTEs), Counsellors (40.6 actual FTEs) and Other Non-Clinical Support (47.07 actual FTEs) staff. The bulk of the clinical services in NGOs were provided by Social Workers (52.4 actual FTEs), and Counsellors (see Table 81).

Table 81. The Total Child & Adolescent Mental Health Workforce by Occupational Group (2004)

	DHB[1]	NGO[2]	CYF[3]	Total
Clinical Sub-Total	**592.12**	**161.70**	**12.50**	**766.32**
Alcohol & Drug Worker	28.9	23.75	0	**52.65**
Counsellor	32.4	40.6	0	**73.0**
Mental Health Nurse	165.19	10.1	4.00	**179.29**
Occupational Therapist	24.48	4.0	2.00	**30.48**
Psychiatrist	58.73	0.2	0	**58.93**
Psychotherapist	18.6	8.1	0	**26.7**
Psychologist	123.33	6.4	0.5	**130.23**
Social Worker	105.38	52.4	3.0	**160.78**
Other Clinical	35.11	16.15	3.0	**54.26**
Non-Clinical Sub-Total	**64.66**	**136.42**	**13.1**	**214.18**
Cultural	26.66	6.1	1.0	**33.76**
Specific Liaison	3.9	1.45	0	**5.35**
Mental Health Consumer	1.0	3.45	0	**4.45**
Mental Health Support	25.6	78.35	6.0	**109.95**
Other Non-Clinical	7.5	47.07	6.1	**60.67**
Administration/Management	**81.96**	**39.93**	**8.4**	**130.29**
Total	**757.64***	**338.05**	**34.0**	**1129.69**

1. Includes Total of 124.7 Inpatient FTEs (87 Clinical & 28.5 Non-Clinical FTEs & 9.2 Administration/Management). Auckland & Waitemata FTEs as at 2005
   *Total FTEs for Capital & Coast DHB includes 18.9 FTEs from EIS
2. Includes NGO Kaupapa Māori Services
3. Includes *The Lower North Severe Conduct Disorder Programme*, *Towards Wellbeing Youth Suicide Prevention Programme* & *High & Complex Needs Unit* and excludes data from *Youth Horizons Trust*.

4.3 Comparison of the Clinical Community Child & Adolescent Mental Health (DHB & NGO) Workforce to the Mental Health Commission's Resource Guidelines

Based on the total population of 2004, the MHC's Blueprint guidelines (28.6 FTEs per 100,000 total population) for Community Clinical FTEs is 1,163.37 FTEs. For the period of 2004/2005, DHB and NGO child and adolescent mental health service providers reported a total of 666.82 actual Clinical Community FTEs which is 496.55 actual FTES below the national guideline, with the largest disparity in the Northern region (see Tables 82, 84 & Figure 40). Therefore the DHB and NGO Clinical workforce would need to increase by 74% to meet the Blueprint target (see Table 83). There would need to be a 13.7% staffing increase to fill vacancies of funded FTEs. Once FTEs were filled, there would need to be an increase of 405 (53.5%) additionally funded FTEs to meet the blueprint target for 2004.

Table 82. DHB & NGO Child & Adolescent Community Clinical Workforce (2004)

	Actual	Vacant	Total Funded	Vacancy %
DHB	505	83	588	14
NGO	143	8	151	5
Kaupapa Māori	19	1	20	5
Total	**667**	**92**	**759**	**12**

Table 83. DHB & NGO Community Clinical FTEs compared to Blueprint Benchmarks (2004)

Actual Community Clinical FTEs	Community Clinical FTEs as per Blueprint Benchmark for 2004	FTE Needed	% Increase
667	1163	496	74

Table 84. DHB & NGO Community Clinical Workforce Compared to Blueprint Guidelines by Region & DHB

DHB Name	Total Population 2004	0-19 Population 2004	DHB & NGO Community Clinical FTEs	FTEs per 100,000 Population	Blueprint Guidelines
Northern	**1490150**	**442435**	**196.17**	**182.05**	**426.18**
Northland	147650	45775	21.20	46.3	42.2
Waitemata*	487660	141420	71.60	50.6	139.5
*Auckland**	427400	110860	64.54	58.2	122.2
Counties Manukau	427440	144380	38.83	26.9	122.2
Midland	**830940**	**258860**	**134.40**	**251.85**	**237.65**
Waikato	337290	105800	56.55	53.4	96.5
Lakes	102140	32430	15.60	48.1	29.2
Bay of Plenty	196810	59150	37.60	63.6	56.3
Tairawhiti	45130	15510	7.75	50.0	12.9
Taranaki	149570	45970	16.90	36.8	42.8
Central	**780320**	**226550**	**126.04**	**318.14**	**223.17**
Hawke's Bay	105645	31690	18.06	57.0	30.2
MidCentral	164660	49390	20.40	41.3	47.1
Whanganui	64875	19745	8.80	44.6	18.6
Capital & Coast	267950	72320	47.00	65.0	76.6
Hutt	137870	42050	26.38	62.7	39.4
Wairarapa	39320	11355	5.40	47.6	11.2
Southern	**966315**	**262350**	**210.21**	**457.70**	**276.37**
Nelson Marlborough	133225	36540	20.15	55.1	38.1
West Coast	30630	8575	8.70	101.5	8.8
Canterbury	460680	123960	106.11	85.6	131.8
South Canterbury	53825	14385	8.80	61.2	15.4
Otago	180220	48610	52.30	107.6	51.5
Southland	107735	30280	14.15	46.7	30.8
Total	**4067725**	**1190195**	**666.82**	**1209.75**	**1163.37**

Note: DHBs italicised provide Regional Services * Auckland & Waitemata DHB FTEs as at March 2005

Although individual DHB FTEs have also been compared to the Blueprint guidelines (see Table 84 & Figure 41), regional services are not allocated across DHBs and therefore individual DHB Blueprint guidelines should be interpreted with caution.

Figure 40. DHB & NGO Community Clinical Workforce Compared to Blueprint Guidelines for 2004 by Region

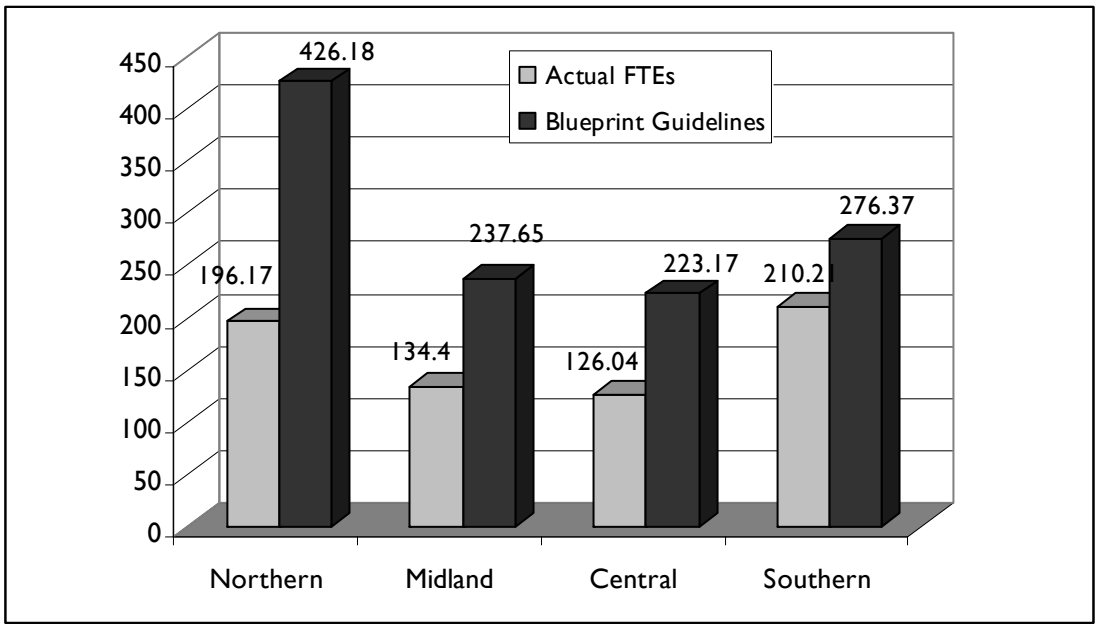
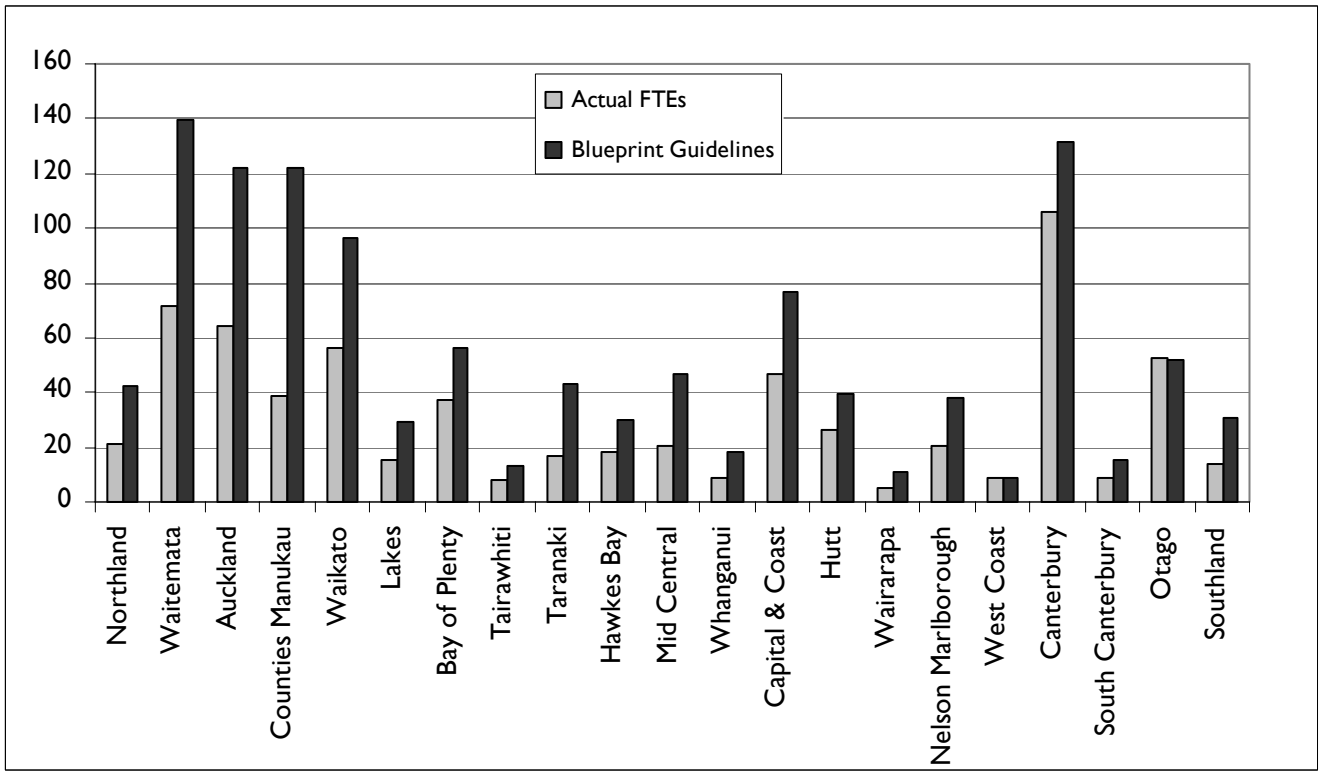


Figure 41. Community Clinical Workforce Compared to Blueprint Guidelines for 2004 by DHB



4.3.1 Recommendations for Psychiatrists

> *"There are major shortages in the child and youth mental health specialty area, especially of the highly skilled workforce, with a critical under-supply of child and adolescent psychiatrists"* (Health Workforce Advisory Committee, 2002, p.112).

The World Health Organization (2001) recommended 10 psychiatrists per 100,000 for the general population. When calculated for the 2004 child and adolescent population (0-19 years), on a population proportion basis, this equates to a total of 119.02 FTEs for all services (Inpatient & Community) (see Table 85).

DHB CAMHS reported a total of 58.73 actual FTEs (see Table 85). When compared to the WHO recommendation, nationally, there is a shortage of 60.29 FTEs. The total Psychiatry workforce would need to increase by 103% to meet the WHO recommendations. By DHB, Capital & Coast DHB CAMHS appeared to be the only CAMHS to have met the WHO recommendation (see Table 85 & Figure 43). Therefore based on the WHO recommendation, the above quote from the Health Advisory Committee that was made three years ago remains true.

Table 85. DHB Psychiatrist FTEs Compared to WHO Recommendations by Region & DHB (2004)

Region/DHB	0-19 yr population 2004	DHB Psychiatrists	Psychiatrists per 100/000 0-19 yr population	WHO Recommendation
Northern	**442,435**	**21.83**	**20.74**	**44.24**
Northland	45,775	2.6	5.68	4.58
Waitemata	141,420	7.1	5.02	14.14
Auckland	110,860	7.8	7.04	11.09
Counties Manukau	144,380	4.33	3.00	14.44
Midland	**244,580**	**8.72**	**17.24**	**24.46**
Waikato	105,800	3.62	3.42	10.58
Lakes	32,430	0.6	1.85	3.24
Bay of Plenty	59,150	2.2	3.72	5.92
Tairawhiti	15,510	0.3	1.93	1.55
Taranaki	31,690	2.0	6.31	3.17
Central	**240,830**	**14.8**	**33.60**	**24.08**
Hawke's Bay	45,970	1.7	3.70	4.60
MidCentral	49,390	0.8	1.62	4.94
Whanganui	19,745	0.8	4.05	1.97
Capital & Coast	72,320	8.3	11.48	7.23
Hutt	42,050	2.4	5.71	4.21
Wairarapa	11,355	0.8	7.05	1.14
Southern	**262,350**	**13.38**	**22.85**	**26.24**
Nelson Marlborough	36,540	1	2.74	3.65
West Coast	8,575	0.2	2.33	0.86
Canterbury	123,960	7.38	5.95	12.40
South Canterbury	14,385	0.4	2.78	1.44
Otago	48,610	4.4	9.05	4.86
Southland	30,280	0	0.00	3.03
Total	**1,190,195**	**58.73**	**94.43**	**119.02**

*Includes Inpatient Services
Note: In addition there are 0.8 NGO Psychiatry FTEs

Figure 42. DHB Psychiatrist FTEs Compared to WHO Recommendations by Region (2004)

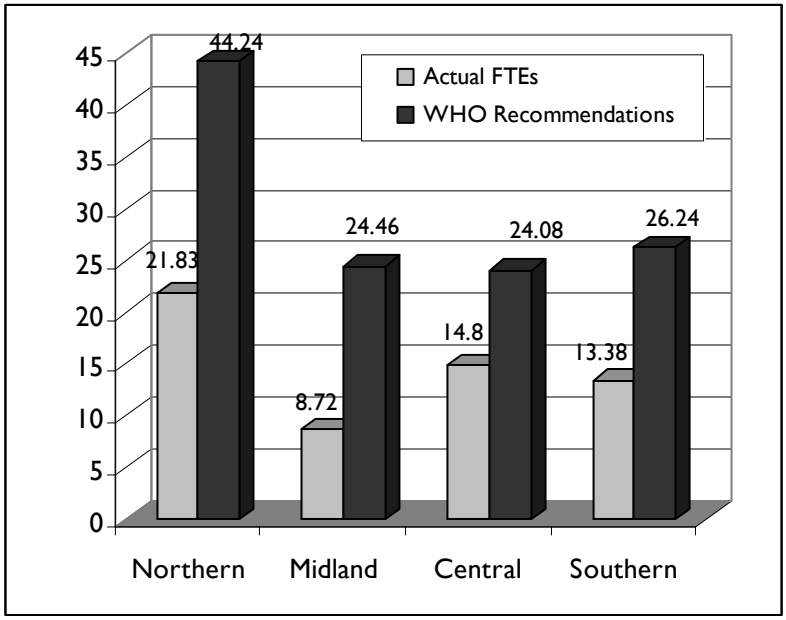
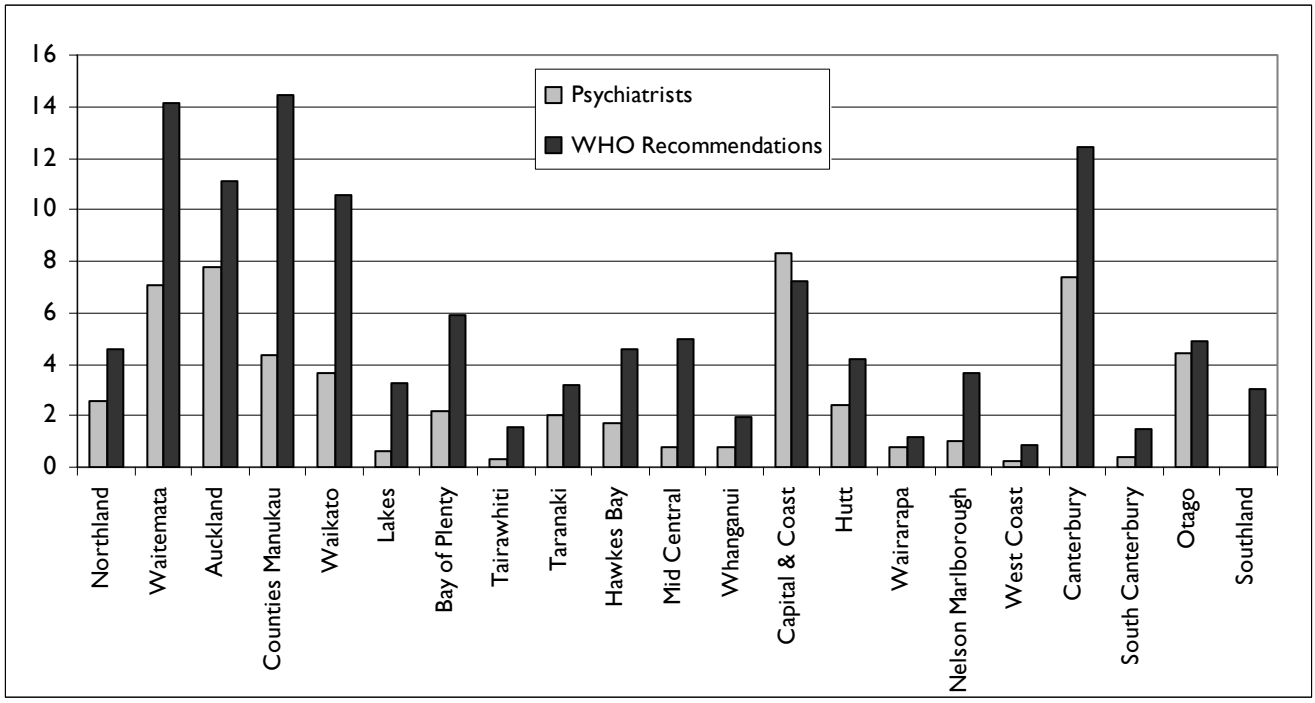


Figure 43. DHB Psychiatrist FTEs Compared to WHO Recommendations by DHB (2004)



4.4 Ethnicity of the Workforce

All child and adolescent mental health service providers surveyed were requested to provide head count data rather than actual FTE data on the Māori, Pacific and Asian workforce by occupational group. Ethnicity data was provided by the management and not necessarily by the individual staff member, therefore caution should be taken when using this data.

4.4.1 The Ethnicity of the DHB Workforce

Ethnicity of the Inpatient Workforce

Nineteen Māori, five Pacific and eight Asian staff were employed in DHB CAMHS Inpatient services (see Table 86). The majority (59%) of the Inpatient Māori, Pacific and Asian workforce were employed in Auckland DHB with no Pacific and Asian staff in the Canterbury Inpatient service team (Figure 44).

Māori staff in Inpatient services held mainly Non-Clinical (Mental Health Support Worker and Cultural) roles. Asian staff held predominately Clinical roles (Mental Health Nurses) and Pacific staff held only Non-Clinical positions as Mental Health Support Workers (see Table 86).

Figure 44. The Māori, Pacific & Asian Inpatient Workforce (Head Count 2004)

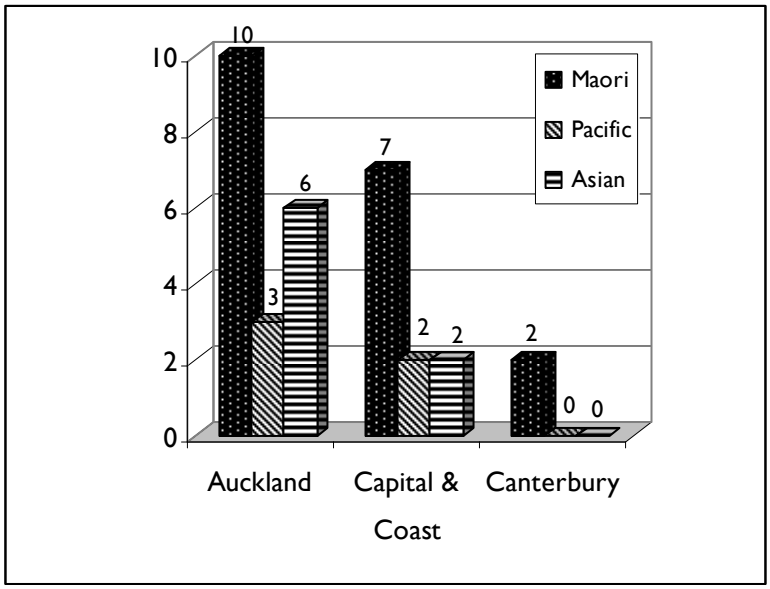


Table 86. Ethnicity of DHB CAMH Inpatient Workforce (Head Count March 2004 & March 2005)

DHB	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub -Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Māori	**-**	**-**	**4**	**-**	**-**	**-**	**-**	**1**	**-**	**5**	**5**	**-**	**-**	**9**	**-**	**14**	**-**	**19**
Auckland*	-	-	3	-	-	-	-	1	-	4	1	-	-	5	-	6	-	10
Capital & Coast	-	-	1	-	-	-	-	-	-	1	2	-	-	4	-	6	-	7
Canterbury	-	-	-	-	-	-	-	-	-	0	2	-	-		-	2	-	2
Pacific	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**1**	**-**	**4**	**-**	**5**	**-**	**5**
Auckland*	-	-	-	-	-	-	-	-	-	-	-	-	-	3	-	3	-	3
Capital & Coast	-	-	-	-	-	-	-	-	-	-	-	1	-	1	-	2	-	2
Canterbury	-	-	-	-	-	-	-	-	-	-	-	-	-		-	-	-	-
Asian	**-**	**-**	**5**	**1**	**-**	**-**	**-**	**-**	**-**	**6**	**-**	**-**	**-**	**2**	**-**	**2**	**-**	**8**
Auckland*	-	-	3	1	-	-	-	-	-	4	-	-	-	2	-	2	-	6
Capital & Coast	-	-	2	-	-	-	-	-	-	2	-	-	-		-	-	-	2
Canterbury	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**-**	**-**	**9**	**1**	**-**	**-**	**-**	**1**	**-**	**11**	**5**	**1**	**-**	**16**	**-**	**21**	**-**	**32**

*Head Count as at March 2005

The Ethnicity of the DHB Community Workforce

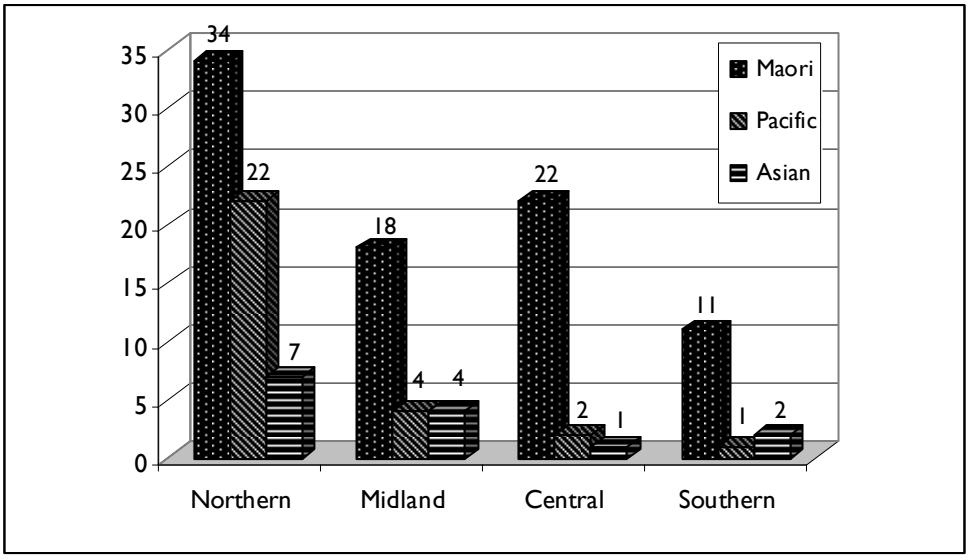
DHBs reported a total of 85 Māori, 29 Pacific and 14 Asian staff in the DHB CAMH Community services (see Tables 87, 89 & 90) with the Northern region reporting the largest Māori (34), Pacific (22) and Asian (7) workforce in the country (Figure 45).

Table 87. The Total DHB Māori Pacific & Asian Community Workforce (Head Count March 2004 & 2005)

DHB	Māori	Pacific	Asian
Northern	**34**	**22**	**7**
Northland	2	0	-
Waitemata*	16	13	2
Auckland*	6	2	4
Counties Manukau	10	7	1
Midland	**18**	**4**	**4**
Waikato	2	0	2
Lakes	3	0	2
Bay of Plenty	8	3	-
Tairawhiti	4	1	-
Taranaki	1	0	-
Central	**22**	**2**	**1**
Hawke's Bay	2	0	-
MidCentral	-	0	1
Whanganui	2	0	-
Capital & Coast	15	1	-
Hutt	1	1	-
Wairarapa	2	0	-
Southern	**11**	**1**	**2**
Nelson Marlborough	-	-	-
West Coast	1	-	-
Canterbury	5	-	1
South Canterbury	2	-	1
Otago	2	1	-
Southland	1	-	-
Total	**85**	**29**	**14**

*Head Count as at March 2005

Figure 45. The Māori Pacific & Asian CAMHS Community Workforce by Region (Head Count 2004)



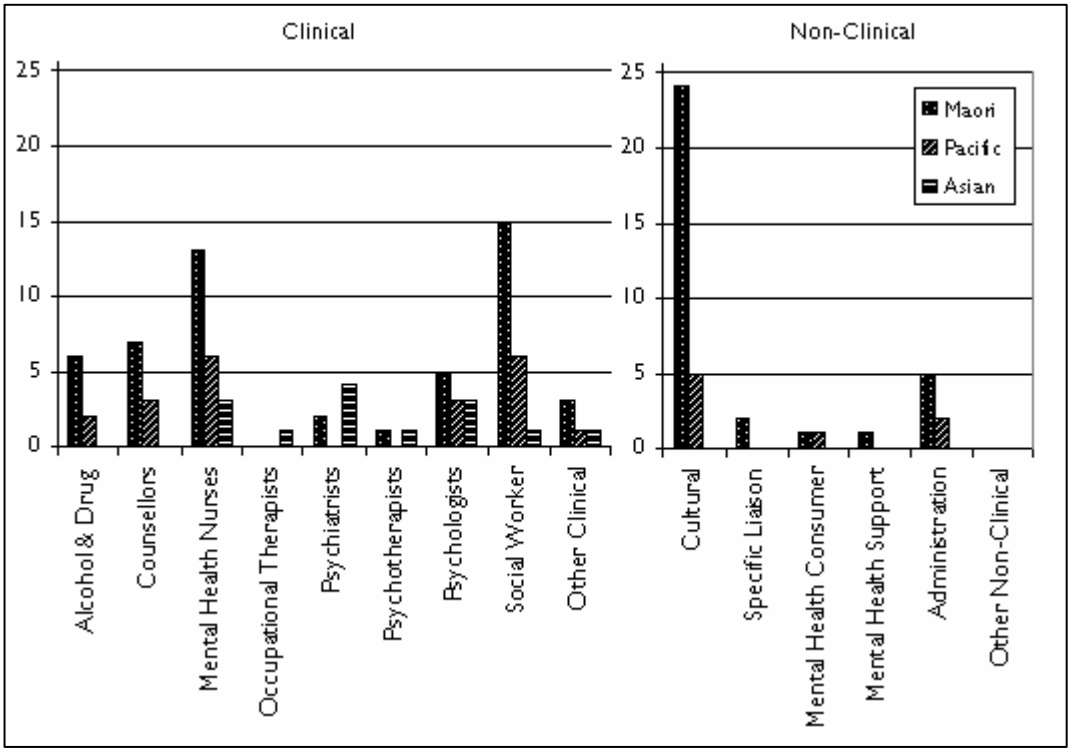
Note: Auckland & Waitemata Data as at March 2005

Māori staff numbers were consistently higher than the Pacific and Asian staff numbers across all regions with very low representation of both Pacific and Asian staff, particularly in the Central and Southern regions. Pacific staff were generally clustered in the Northern region.

Analyses by DHB showed a similar consistency of Māori staff numbers compared to the Pacific and Asian workforce across all of the DHBs. Waitemata, Capital & Coast, Counties Manukau, Bay of Plenty and Canterbury reported the highest numbers of Māori staff in their Community CAMH services. Waitemata DHB and Counties Manukau also reported higher numbers of Pacific staff while Auckland DHB reported the largest Asian workforce.

Ethnicity data by occupational group in the DHB Community CAMH services showed that Māori staff mainly held Cultural (Kaumatua/Kuia) appointments (see Figure 46). Clinically, both Māori and Pacific staff held Mental Health Nurse and Social Worker roles while Asian staff predominantly held Clinical (Psychiatrist, Mental Health Nurse and Psychologist) roles.

Figure 46. The Māori, Pacific & Asian Workforce by Occupational Group (Head Count 2004)



Note: Auckland & Waitemata DHB Data as at March 2005

Table 88. DHB Māori Community CAMHS Workforce by Occupational Group (Head Count March 2004)

DHB	Alcohol & Drug Worker	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**2**	**1**	**7**	**0**	**1**	**1**	**2**	**6**	**3**	**23**	**9**	**0**	**0**	**0**	**0**	**9**	**2**	**34**
Northland	-	-	2	-	-	-	-	-	-	**2**	-	-	-	-	-	**0**	-	**2**
Waitemata**	2	-	4	-	1	-	1	4	-	**12**	4	-	-	-	-	**4**	-	**16**
Auckland**	-	-	-	-	-	-	-	2	2	**4**	2	-	-	-	-	**2**	-	**6**
Counties Manukau	-	1	1	-	-	1	1	-	1	**5**	3	-	-	-	-	**3**	2	**10**
Midland	**2**	**5**	**2**	**0**	**0**	**0**	**1**	**4**	**0**	**14**	**1**	**0**	**0**	**0**	**0**	**1**	**3**	**18**
Waikato	1	-	-	-	-	-	1	-	-	**2**	-	-	-	-	-	**0**	-	**2**
Lakes	-	-	1	-	-	-	-	-	-	**1**	1	-	-	-	-	**1**	1	**3**
Bay of Plenty	-	5	-	-	-	-	-	2	-	**7**	-	-	-	-	-	**0**	1	**8**
Tairawhiti	1	-	1	-	-	-	-	2	-	**4**	-	-	-	-	-	**0**	-	**4**
Taranaki	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	1	**1**
Central	**1**	**1**	**4**	**0**	**1**	**0**	**1**	**5**	**0**	**13**	**6**	**1**	**1**	**1**	**0**	**9**	**0**	**22**
Hawke's Bay	-	-	1	-	-	-	-	1	-	**2**	-	-	-	-	-	**0**	-	**2**
MidCentral	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Whanganui	-	-	1	-	-	-	-	-	-	**1**	1	-	-	-	-	**1**	-	**2**
Capital & Coast	1	-	2	-	1	-	1	4	-	**9**	5	1	-	-	-	**6**	-	**15**
Hutt	-	-	-	-	-	-	-	-	-	**0**	-	-	1	-	-	**1**	-	**1**
Wairarapa	-	1	-	-	-	-	-	-	-	**1**	-	-	-	1	-	**1**	-	**2**
Southern	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**2**	**8**	**1**	**0**	**0**	**0**	**9**	**0**	**11**
Nelson Marlborough*	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
West Coast	1	-	-	-	-	-	-	-	-	**1**	-	-	-	-	-	**0**	-	**0**
Canterbury	-	-	-	-	-	-	1	-	-	**1**	4	-	-	-	-	**4**	-	**0**
South Canterbury	-	-	-	-	-	-	-	-	-	**0**	2	-	-	-	-	**2**	-	**0**
Otago	-	-	-	-	-	-	-	-	-	**0**	2	-	-	-	-	**2**	-	**0**
Southland	-	-	-	-	-	-	-	-	-	**0**	-	1	-	-	-	**1**	-	**0**
Total	**6**	**7**	**13**	**0**	**2**	**1**	**5**	**15**	**3**	**52**	**24**	**2**	**1**	**1**	**0**	**28**	**5**	**85**

*Not Provided ** As at March 2005

Table 89. DHB Pacific Community CAMHS Workforce by Occupational Group (Head Count March 2004)

DHB	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**2**	**1**	**4**	**0**	**0**	**0**	**2**	**5**	**1**	**15**	**4**	**0**	**1**	**0**	**0**	**5**	**2**	**22**
Northland	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Waitemata*	2	-	2	-	-	-	1	3	1	**9**	2	-	1	-	-	**3**	1	**13**
Auckland*	-	-	-	-	-	-	1	-	-	**1**	1	-	-	-	-	**1**	-	**2**
Counties Manukau	-	1	2	-	-	-	-	2	-	**5**	1	-	-	-	-	**1**	1	**7**
Midland	**0**	**2**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**
Waikato	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Lakes	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Bay of Plenty	-	2	1	-	-	-	-	-	-	**3**	-	-	-	-	-	**0**	-	**3**
Tairawhiti	-	-	-	-	-	-	-	1	-	**1**	-	-	-	-	-	**0**	-	**1**
Taranaki	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Central	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	**2**
Hawke's Bay	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
MidCentral	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Whanganui	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Capital & Coast	-	-	-	-	-	-	-	-	-	**0**	1	-	-	-	-	**1**	-	**1**
Hutt	-	-	1	-	-	-	-	-	-	**1**	-	-	-	-	-	**0**	-	**1**
Wairarapa	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Southern	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Nelson Marlborough**	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
West Coast	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Canterbury	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
South Canterbury	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Otago	-	-	-	-	-	-	1	-	-	**1**	-	-	-	-	-	**0**	-	**1**
Southland	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	-	**0**	-	**0**
Total	**2**	**3**	**6**	**0**	**0**	**0**	**3**	**6**	**1**	**21**	**5**	**0**	**1**	**0**	**0**	**6**	**2**	**29**

*As at March 2005 **Not Provided

Table 90. DHB Asian Community CAMHS Workforce by Occupational Group (Head Count March 2004)

DHB	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**0**	**0**	**2**	**0**	**2**	**0**	**1**	**1**	**1**	**7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7**
Northland	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Waitemata*	-	-	-	-	2	-	-	-	-	**2**	-	-	-	-	-	-	-	**2**
Auckland*	-	-	2	-	-	-	1	1		**4**	-	-	-	-	-	-	-	**4**
Counties Manukau	-	-	-	-	-	-	-	-	1	**1**	-	-	-	-	-	-	-	**1**
Midland	**0**	**0**	**0**	**0**	**2**	**1**	**1**	**0**	**0**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4**
Waikato	-	-	-	-	2	-	-	-	-	**2**	-	-	-	-	-	-	-	**2**
Lakes	-	-	-	-	-	1	1	-	-	**2**	-	-	-	-	-	-	-	**2**
Bay of Plenty	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tairawhiti	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Taranaki	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Central	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Hawke's Bay	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MidCentral	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**1**
Whanganui	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital & Coast	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hutt	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wairarapa	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Southern	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Nelson Marlborough**	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
West Coast	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Canterbury	-	-		1	-	-	-	-	-	**1**	-	-	-	-	-	-	-	**1**
South Canterbury	-	-	-	-	-	-	1	-	-	**1**	-	-	-	-	-	-	-	**1**
Otago	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Southland	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**0**	**0**	**3**	**1**	**4**	**1**	**3**	**1**	**1**	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**14**

*As at March 2005 **Not Provided

4.4.2 The Ethnicity of the NGO Workforce

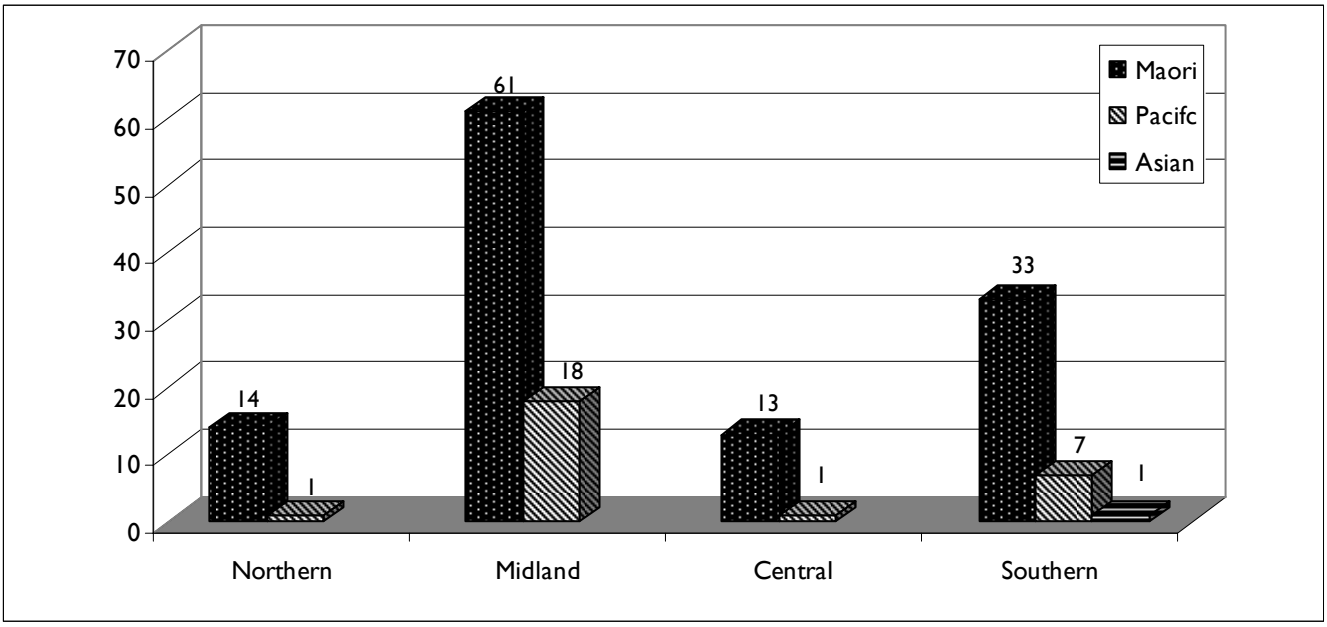
NGOs reported a total 121 Māori, 27 Pacific, and one Asian staff member (see Table 91 & Figure 47) with the Midland (61) and the Southern (33) regions reporting the largest Māori workforce. The Midland region also reported the largest Pacific (18) workforce. Only one Asian staff member was reported in the Southern region.

Table 91. Total NGO Māori, Pacific & Asian Workforce (Head Count March 2004)

DHB	Māori	Pacific	Asian
Northern	14	1	0
Midland	61	18	0
Central	13	1	0
Southern	33	7	1
Total	**121**	**27**	**1**

Note: Includes Kaupapa Māori Services

Figure 47. NGO Māori, Pacific & Asian Workforce by Region (Head Count March 2004)



NGO Māori Workforce by Occupational Group

The NGO Māori Clinical Workforce mainly consisted of Counsellor (19), Alcohol and Drug (10) and Social Worker (16) positions while the Non-Clinical workforce consisted of Mental Health Support (26) and Other Non-Clinical roles (18).

Figure 48. NGO Māori Workforce by Occupational Group (Head Count March 2004)

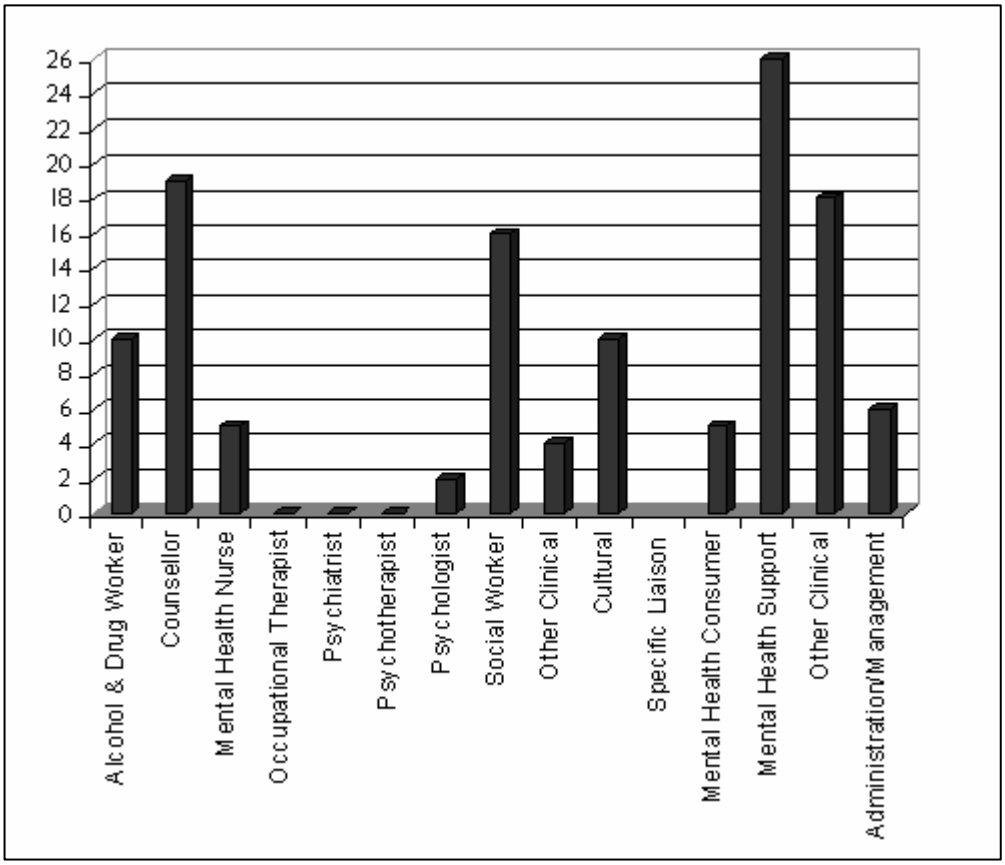


Table 92. NGO Māori Community Workforce by Occupational Group (including NGO Kaupapa Māori Services) (Head Count March 2004)

NGO	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**4**	**1**	**7**	**1**	**0**	**2**	**1**	**3**	**7**	**0**	**14**
Northland *Ngati Hine Health Trust Board*								2		**2**	1			1		**2**		**4**
Rubicon Charitable Trust Board		1								**1**						**0**		**1**
Auckland Odyssey House Trust								1		**1**					3	**3**		**4**
Counties Manukau Raukura Hauora o Tainui Trust			1					1	1	**3**			2			**2**		**5**
Midland	**5**	**10**	**2**	**0**	**0**	**0**	**1**	**5**	**2**	**25**	**4**	**0**	**3**	**19**	**5**	**31**	**5**	**61**
Waikato Linkage Trust										**0**						**0**	1	**1**
Maniapoto Māori Trust Board								1		**1**	1		2			**3**		**4**
Northern King Country Drug & Alcohol Counselling & Education Service	2									**2**				1		**1**		**3**
Raukawa Trust Board										**0**				3		**3**		**3**
Richmond Fellowship										**0**				4		**4**	1	**5**
Te Ahurei a Rangatahi	2	1								**3**				4	1	**5**	1	**9**
Te Korowai Hauora O Hauraki Inc										**0**				1		**1**		**1**
Lakes Te Aratu Trust										**0**	2					**2**		**2**
Te Runanga Ngati Pikiao Trust		1						1	2	**4**			1	1		**2**		**6**
Tuwharetoa Health Services		4						1		**5**	1				2	**3**		**8**
Bay of Plenty *Nga Mataapuna Oranga*								1		**1**						**0**		**1**
Te Rangimarie Trust	1	1								**2**				2		**2**	2	**6**
Te Runanga O Te Whanau										**0**					2	**2**		**2**
Te Tomika Trust		1								**1**						**0**		**1**
Tuhoe Hauora		1	2				1			**4**				1		**1**		**5**
Turning Point Trust										**0**				2		**2**		**2**
Tairawhiti *Te Hauora O Turanganui A Kiwa*								1		**1**						**0**		**1**
Taranaki *Tui Ora*		1								**1**						**0**		**1**

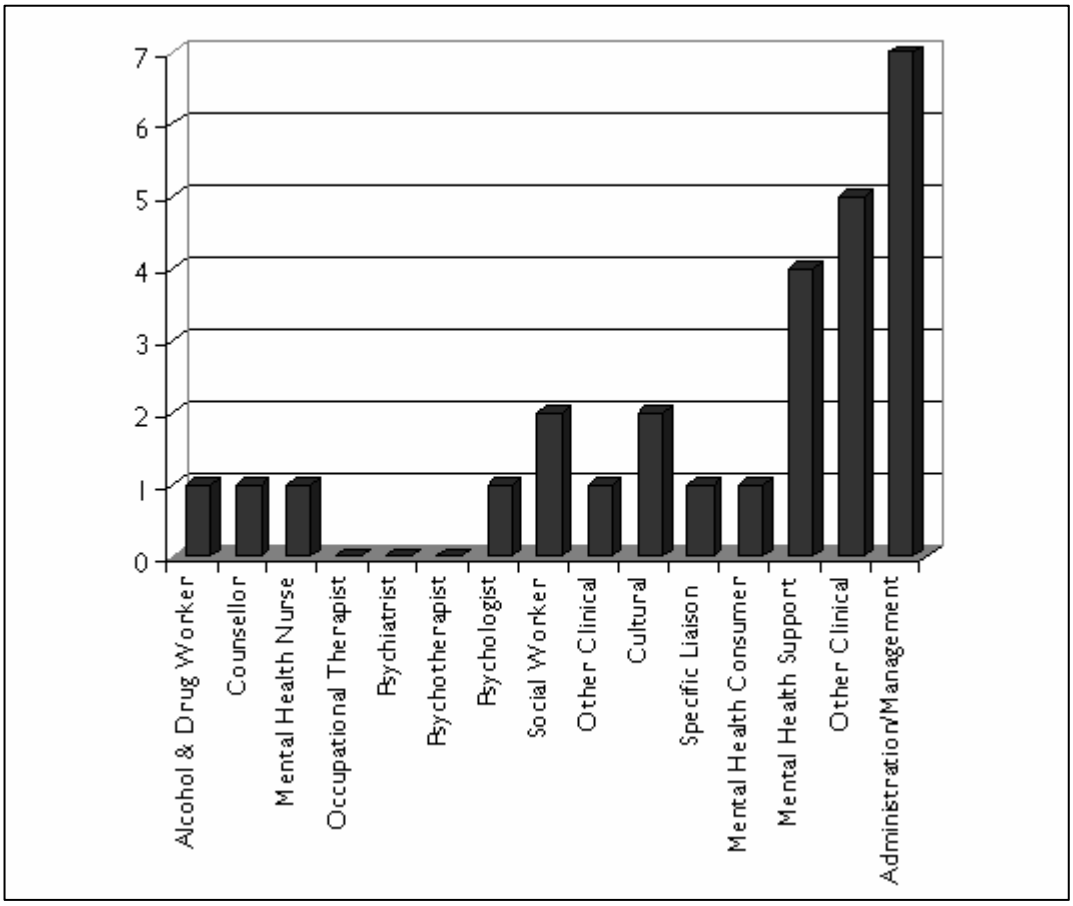
Table 92 Continued. NGO Māori Community Workforce by Occupational Group (including NGO Kaupapa Māori Services) (Head Count March 2004)

NGO	Alcohol & Drug	Counsellor	Mental Health Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Central	**0**	**3**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**5**	**0**	**0**	**0**	**1**	**6**	**7**	**1**	**13**
Whanganui																		
Life to the Max Trust								1		1						0		1
Capital & Coast																		
Gateway Housing Trust										0				1		1		1
Te Runanga O Toa Rangatira Inc		3					1			4						0		4
Hutt																		
VIBE Hutt Valley Youth Health Trust										0					2	2	1	3
Wairarapa										0						0		0
King Street Artworks										0					4	4		4
Southern	**5**	**5**	**2**	**0**	**0**	**0**	**0**	**6**	**1**	**19**	**5**	**0**	**0**	**5**	**4**	**14**	**0**	**33**
Nelson Marlborough																		
Horizon Trust Board	1									1					1	1		2
Canterbury																		
Christchurch City Mission	1									1						0		1
Odyssey House Trust	1									1						0		1
Purapura Whetu		2						1		3				1		1		4
Richmond Fellowship										0				1		1		1
Stepping Stone Trust			1					1		2					1	1		3
St John of God Youth & Community								2		2						0		2
STOP Trust										0	3					3		3
Youth Health Trust										0					2	2		2
Otago																		
Aroha ki te Tamariki Trust	2	1								3						0		3
Otago Youth Wellness		1	1					2	1	5	2					2		7
Southland																		
PACT Group										0				3		3		3
Te Huarahi Ki Te Oranga Pai Trust		1								1						0		1
Total	**10**	**19**	**5**	**0**	**0**	**0**	**2**	**16**	**4**	**56**	**10**	**0**	**5**	**26**	**18**	**59**	**6**	**121**

NGO Pacific Workforce by Occupational Group

The NGO Pacific staff predominantly held Non-Clinical positions (13) mainly in Other Non-Clinical (5) and Mental Health Support (4) roles (see Table 93 & Figure 49) while seven in total were reported to hold clinical roles.

Figure 49. NGO Pacific Workforce by Occupational Group (Head Count March 2004)



There was only one Asian staff member reported by an NGO in Canterbury who held an unspecified Clinical position.

Table 93. NGO Pacific Community Workforce by Occupational Group (Head Count March 2004)

NGO	Alcohol & Drug Worker	Counsellor	Mental Health Nurse	Occupation Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Specific Liaison	Mental Health Consumer	Mental Health Support	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
Northern Region	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Northland																		
Rubicon Charitable Trust Board	-	1	-	-	-	-	-	-	-	**1**	-	-	-	-	-	**0**	-	**1**
Midland	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**0**	**1**	**3**	**1**	**1**	**1**	**2**	**3**	**8**	**7**	**18**
Waikato																		
Richmond Fellowship	-	-	-	-	-	-	-	-	-	**0**	-	-	-	1	-	**1**	-	**1**
Waikato Pasifika Health Trust	-	-	-	-	-	-	-	-	1	**1**	1	1	1	1	3	**7**	7	**15**
Youth Horizons Trust	-	-	-	-	-	-	1	-	-	**1**	-	-	-	-	-	**0**	-	**1**
Lakes																		
Tuwharetoa Health Services Ltd	-	-	1	-	-	-	-	-	-	**1**	-	-	-	-	-	**0**	-	**1**
Central	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**1**
Whanganui																		
Life to the Max Trust	-	-	-	-	-	-	-	-	-	**0**	-	-	-	-	1	**1**	-	**1**
Southern	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**0**	**3**	**1**	**0**	**0**	**2**	**1**	**4**	**0**	**7**
Canterbury																		
Odyssey House Trust	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	0	-	1
Richmond Fellowship	-	-	-	-	-	-	-	-	-	**0**	-	-	-	2	-	**2**	-	**2**
Stepping Stone Trust	-	-	-	-	-	-	-	1	-	**1**	-	-	-	-	1	**1**	-	**2**
St John of God Youth & Community	-	-	-	-	-	-	-	1	-	**1**	-	-	-	-	-	**0**	-	**1**
STOP Trust	-	-	-	-	-	-	-	-	-	**0**	1	-	-	-	-	**1**	-	**1**
Total	**1**	**1**	**1**	**0**	**0**	**0**	**1**	**2**	**1**	**7**	**2**	**1**	**1**	**4**	**5**	**13**	**7**	**27**

4.4.3 The Ethnicity of the Child, Youth & Family Collaborative Workforce

An additional seven Māori staff were reported by the Lower North Severe Conduct Disorder (LNSCD) and Towards Wellbeing Youth Suicide Prevention Programmes (see Table 94). Māori staff in these programmes held mainly Clinical positions (Mental Health Nurses & Other Clinical Workers).

The LNSCDP reported a total of three Pacific staff. Two held Mental Health Support Worker roles and one was a Mental Health Nurse. The Pacific Psychologist reported by Youth Horizons Trust has been included in the NGO workforce section.

There were no Asian staff reported by these services and programmes.

Table 94. Māori, Pacific & Asian Workforce of Child, Youth & Family Collaborative Workforce (Head Count March 2004)

Employee Group	Ethnic Group								Total
	Māori				Pacific				
	Youth Horizons Trust	Lower North Severe Conduct Disorder	Towards Wellbeing Youth Suicide Prevention	Total	Youth Horizons Trust	Lower North Severe Conduct Disorder	Towards Wellbeing Youth Suicide Prevention	Total	
Clinical	**-**	**5**	**-**	**5**	**1**	**1**	**-**	**2**	**7**
Alcohol & Drug Worker	-	-	-	-	-	-	-	-	-
Counsellor	-	-	-	-	-	-	-	-	-
Mental Health Nurse	-	2	-	**2**	-	1	-	**1**	**3**
Occupational Therapist	-	-	-	-	-	-	-	-	-
Psychiatrist	-	-	-	-	-	-	-	-	-
Psychotherapist	-	-	-	-	-	-	-	-	-
Registered Psychologist	-	-	-	-	1	-	-	**1**	**1**
Social Worker	-	1	-	**1**	-	-	-	-	**1**
Other Clinical Worker	-	2	-	**2**	-	-	-	-	**2**
Non-Clinical	**-**	**1**	**1**	**2**	**-**	**2**	**-**	**2**	**3**
Kaumatua/Kuia Cultural Appointments	-	1	-	**1**	-	-	-	-	**1**
Specific Liaison Appointment	-	-	-	-	-	-	-	-	-
Mental Health Consumer	-	-	-	-	-	-	-	-	-
Mental Health Support Worker	-	-	-	-	-	2	-	**2**	**2**
Other Non-Clinical Support	-	-	1	**1**	-	-	-	-	**1**
Administrative/Management	**-**	**1**	**-**	**1**	**-**	**-**	**-**	**-**	**1**
Total	**-**	**7**	**1**	**8**	**1**	**3**	**-**	**4**	**12**

Source: CYF Survey

4.4.4 The Total Māori, Pacific & Asian Workforce

A total of 233 Māori, 64 Pacific and 23 Asian staff were reported by the all the services (DHBs (Inpatient & Community), NGOs and CYF) that responded (see Tables 95 & 96).

The Māori workforce is spread across the regions while Pacific and Asian staff were predominantly located in the Northern and Midland Regions (Figure 50). The largest Māori workforce (79) was reported by the NGOs (61) in the Midland region.

Table 95. The Total Māori, Pacific & Asian Workforce (Head Count March 2004)

Region	Māori	Pacific	Asian
Northern	**58**	**26**	**13**
Total DHB	44	25	13
NGO	14	1	0
Midland	**79**	**22**	**4**
Total DHB	18	4	4
NGO	61	18	0
Central	**42**	**5**	**3**
Total DHB	29	4	3
NGO	13	1	0
Southern	**46**	**8**	**3**
Total DHB	13	1	2
NGO	33	7	1
CYF	**8**	**3**	**0**
Total	**233**	**64**	**23**

Note: Auckland & Waitemata DHB Head Count as at March 2005

Figure 50. The Total Māori Pacific & Asian Workforce by Region (Head Count March 2004)

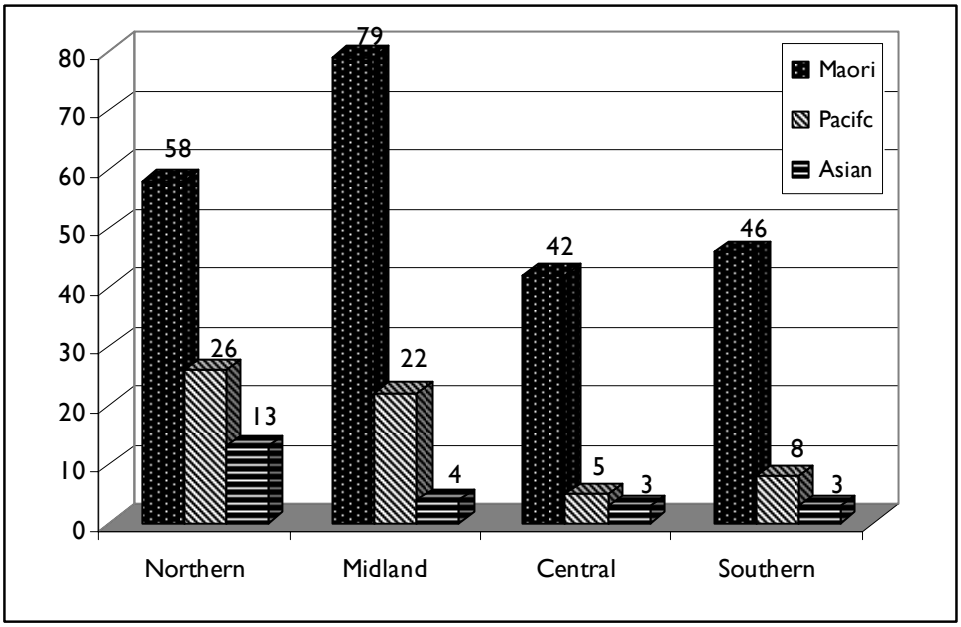


Table 96. The Total Māori Pacific & Asian Workforce by Occupational Group (Head Count March 2004)

Employee Group	Ethnic Group											
	Māori				Pacific				Asian			
	DHB[1]	NGO[2]	CYF[3]	Total	DHB	NGO	CYF	Total	DHB	NGO	CYF	Total
Clinical	**57**	**56**	**5**	**118**	**21**	**7**	**1**	**29**	**20**	**1**	**0**	**21**
Alcohol & Drug Worker	6	10	-	**16**	2	1	-	**3**	-	-	-	**-**
Counsellor	7	19	-	**26**	3	1	-	**4**	-	-	-	**-**
Mental Health Nurse	17	5	2	**24**	6	1	1	**8**	8	-	-	**8**
Occupational Therapist	-	-	-	**-**	-	-	-	**0**	2	-	-	**2**
Psychiatrist	2	-	-	**2**	-	-	-	**0**	4	-	-	**4**
Psychotherapist	1	-	-	**1**	-	-	-	**0**	1	-	-	**1**
Registered Psychologist	5	2	-	**7**	3	1	-	**4**	3	-	-	**3**
Social Worker	16	16	1	**33**	6	2	-	**8**	1	-	-	**1**
Other Clinical Worker	3	4	2	**9**	1	1	-	**2**	1	1	-	**2**
Non-Clinical	**47**	**65**	**3**	**115**	**13**	**20**	**2**	**36**	**2**	**0**	**0**	**2**
Cultural Appointments	29	10	1	**40**	5	2	-	**7**	-	-	-	**-**
Specific Liaison	2	-	-	**2**	1	1	-	**2**	-	-	-	**-**
Mental Health Consumer	1	5	-	**6**	1	1	-	**2**	-	-	-	**-**
Mental Health Support	10	26	-	**36**	4	4	2	**10**	2	-	-	**2**
Other Non-Clinical Support	-	18	1	**19**	-	5	-	**5**	-	-	-	**-**
Administrative/Management	**5**	**6**	**1**	**12**	**2**	**7**	**-**	**9**	**-**	**-**	**-**	**-**
Total	**104**	**121**	**8**	**233**	**34**	**27**	**3**	**64**	**22**	**1**	**0**	**23**

Source: Stocktake Survey Data 1. Includes Inpatient Data 2. Includes Kaupapa Māori data 3. Excludes Youth Horizons Trust
Note: Data not provided by Nelson Marlborough DHB & Auckland & Waitemata DHB data as at March 2005

4.4.5 The Māori & Pacific Workforce as a Proportion of the Specific Population

In 2004, 23% of the total 0-19 years projected population were Māori children and adolescents and the Māori workforce accounted for 20% of the total workforce (see Table 97 & Figure 51).

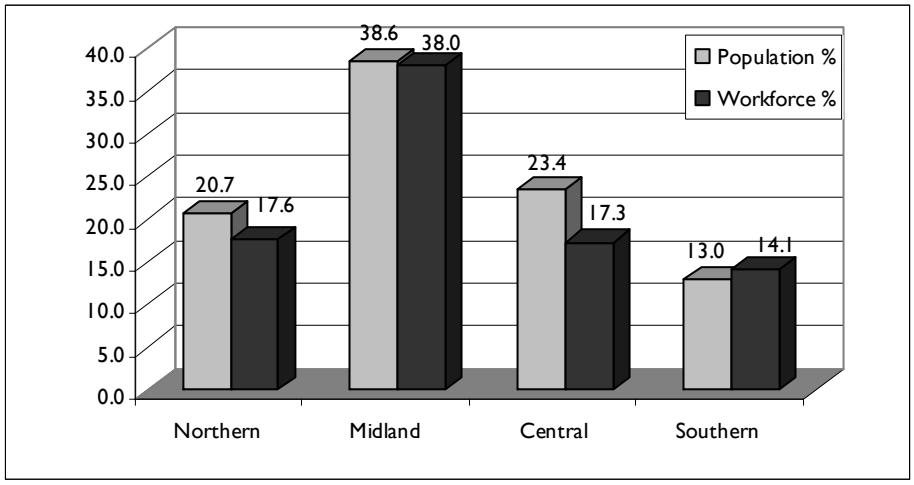
In all regions, the total Māori workforce is close to reflecting the Māori proportion of the 0-19 years population.

Table 97. The Māori Workforce as a Proportion of the Māori 0-19 yrs Population by Region (2004)

Region	2004 Total 0-19 yrs Population	2004 Māori 0-19 yrs Population	%	Total Māori Workforce	Total Workforce	%
Northern	442,435	91,450	20.7	46	261	17.6
Midland	258,860	99,830	38.6	71	187	38.0
Central	226,550	53,090	23.4	34	197	17.3
Southern	262,350	34,200	13.0	44	311	14.1
Total	**1,190,195**	**278,570**	**23.4**	**195**	**956***	**20.4**

*Estimated from FTE Data ** Excludes 34 FTEs from CYF Collaborative Programmes
Note: Excludes Administration/Management Workforce Data

Figure 51. The Māori Workforce as a Proportion of the Māori 0-19 yrs Population by Region (2004)



In 2004, 8.5% of the total 0-19 years projected population were Pacific child and adolescents while the Pacific workforce made up 4.9% of the total workforce (see Table 98).

There is a significant disparity between the Pacific workforce and the percentage of the Pacific 0-19 years population in the Northern region where most of the Pacific population resides (see Figure 52).

The Pacific workforce in the Midland and Southern regions exceeded the percentage of the Pacific child and adolescent population (see Figure 52).

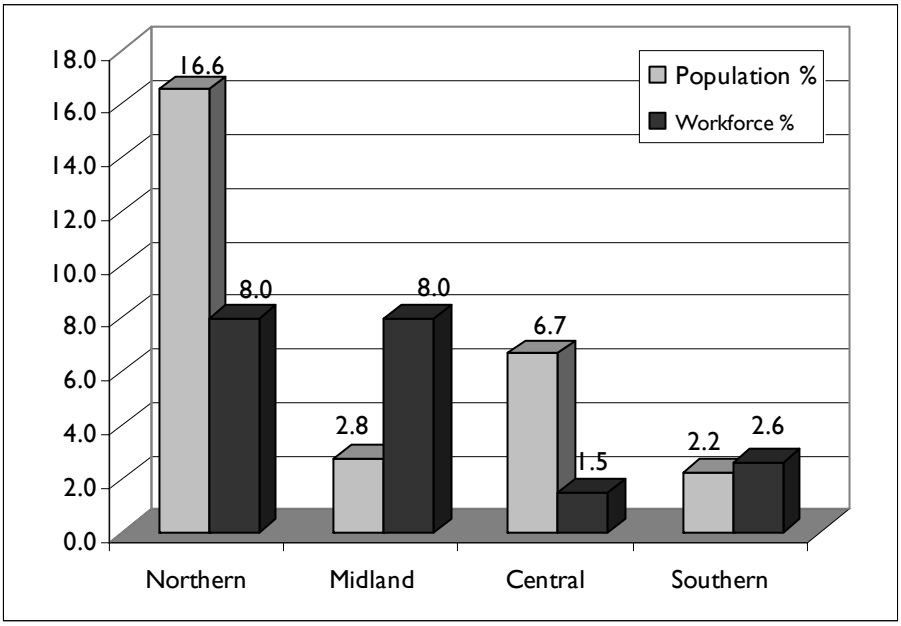
Table 98. The Pacific Workforce as a Proportion of the Pacific 0-19 yrs Population by Region (2004)

Region	2004 Total 0-19 yrs Population	2004 Pacific 0-19 yrs Population	%	Total Pacific Workforce	Total Workforce	%
Northern	442,435	73,225	16.6	21	261	8.0
Midland	258,860	7,120	2.8	15	187	8.0
Central	226,550	15,100	6.7	3	197	1.5
Southern	262,350	5,850	2.2	8	311	2.6
Total	**1,190,195**	**101,295**	**8.5**	**47**	**956***	**4.9**

*Estimated from FTE Data

Note: Excludes CYF Workforce and DHB & NGO Administration/Management Staff

Figure 52. The Pacific Workforce as a Proportion of the Pacific 0-19 yrs Population by Region (2004)



The number of Asian workers was too small to conduct a similar analysis.

4.5 Child & Adolescent Psychiatrists

The survey of Child and Adolescent Psychiatrists was initiated by The Royal Australia and New Zealand College of Psychiatry and conducted by The Werry Centre Stocktake project team and incorporated into the Stocktake report to provide a complete description of the child and adolescent mental health workforce. A detailed analysis of Psychologists in New Zealand has been conducted and published by The Werry Centre and is available on the Werry Centre website (www.werrycentre.org.nz).

The Child and Adolescent Psychiatry Workforce Survey was developed in consultation with psychiatrists, Māori and Pacific advisors and included questions on employment, practice and workload and demographics. The survey was pilot-tested prior to dissemination.

Forty-six Child and Adolescent Psychiatrists were identified from the mailing list of the Child and Adolescent Psychiatry Group and surveyed via email in October 2004. However, the Child and Adolescent Psychiatry Group List was not an exhaustive list of all psychiatrists practising in New Zealand. The Psychiatrists that were on the group list were asked to forward the survey to their colleagues, therefore it is approximated that 50 psychiatrists received the survey. Data that was specifically relevant to the objectives of the Stocktake Project is presented in this section. More detailed analyses of the information gathered from the Psychiatrists will be published separately.

The DHB survey accounted for 59 Child and Adolescent Psychiatrist FTEs (see Tables 69 & 72). From the workforce survey data, DHB Psychiatrist FTEs was 58.73 actual FTEs compared with the World Health Organisation guideline (WHO, 2001) of 119.02 FTEs.

A total of 41 Child and Adolescent Psychiatrists responded to the survey. Thirty-seven (90%) respondents were Child and Adolescent Psychiatrists, two were Medical Officer Special Scale (MOSS) in a Psychiatrist's position and two were Senior Trainees. Over half of the respondents were female (51.2%) and the majority (51%) were between the age of 40 and 49 years old. Twenty (49%) identified themselves to be New Zealanders, 10 as European, eight as 'Other' (which included NZ Asian, Indian, South African and American), two identified as Asian and one identified as Māori (see Table 99).

Table 99. Demographics of Child & Adolescent Psychiatrists (2004)

	No. Of Respondents	%
Position		
Child & Adolescent Psychiatrists	37	90
MOSS in a Psychiatrist's Position	2	5
Senior Trainees	2	5
Gender		
Female	21	51
Male	20	49
Ethnicity		
New Zealand	20	49
European	10	24
Other*	8	20
Asian	2	5
Māori	1	2

*Other includes: NZ Asian, Indian, South African and American

4.5.1 Employment

The Psychiatrists surveyed represented a total of 36.8 FTEs. Sixty-eight percent (28) of the Child and Adolescent Psychiatrists in New Zealand were employed in one organisation only while the remainder, 13, shared their clinical time with DHB, NGO, Private Practice and University appointments.

Ninety-two percent (38) were employed in a District Health Board; however only 25 worked exclusively for a DHB while 13 held DHB plus one or two appointments. Two out of the 38 Psychiatrists that were employed in a DHB worked for more than one DHB (see Table 100).

Seven Psychiatrists in total held University appointments; only two held exclusive University appointments.

Three Psychiatrists worked for Non-government funded organisations. One held an exclusive NGO appointment. Three Psychiatrists held more than 2 appointments.

Table 100. Psychiatrists' Place of Employment (Head Count 2004)

Organisation of Employment	Number	%
DHB Only	25	61
DHB + Private Practice	5	12.2
DHB + University	4	9.8
DHB+NGO	1	2.4
DHB+NGO+Private Practice	1	2.4
DHB+University+Private Practice	1	2.4
DHB+Private Practice+Other	1	2.4
University Only	2	4.9
NGO Only	1	2.4
Total	**41**	

Source: Psychiatrist's Survey

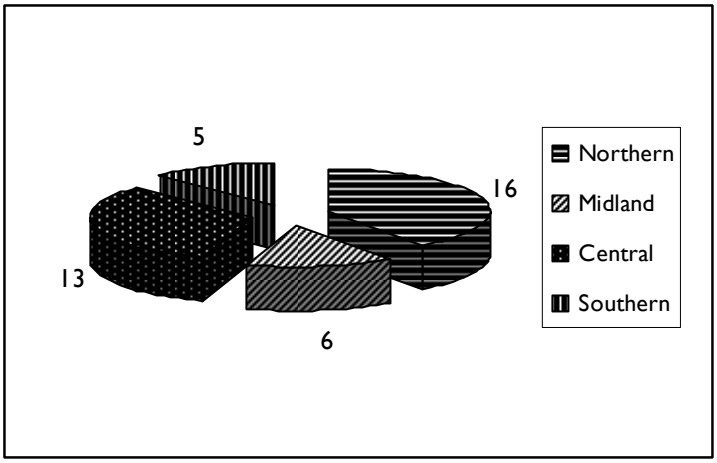
4.5.2 The Distribution of Child & Adolescent Psychiatrists by Region & DHB

Twenty-five of the 40 psychiatrists that were employed in DHBs were located in the North Island, mainly in the Northern and Central regions (see Table 101 & Figure 53) with Auckland, Capital & Coast and Waitemata DHBs having the highest numbers. Only six were located in Midland and five were located in the Southern region. The two Psychiatrists that split their time between two DHBs have also been added to the regional data in Table 101, therefore increasing the total to 40.

Table 101. Location of Child & Adolescent Psychiatrists (Head Count 2004)

Region	DHB	No. of Psychiatrists
Northern	**Total**	**16**
	Northland	1
	Waitemata	5
	Auckland	10
Midland	**Total**	**6**
	Waikato	2
	Bay of Plenty	2
	Tairawhiti	1
	Taranaki	1
Central	**Total**	**13**
	MidCentral	1
	Capital & Coast	9
	Hutt	3
Southern	**Total**	**5**
	Nelson Marlborough	1
	Canterbury	3
	South Canterbury	1
	Total	**40**

Figure 53. Regional Location of Child & Adolescent Psychiatrists (Head Count 2004)



4.5.3 The Allocation of FTEs by Role, Age Group & Clinical Settings

Although a total of 36.8 FTEs were reported by the Psychiatrists, only 38 psychiatrists provided a break-down of how their FTEs were allocated by role which accounted for a total of 34.05 FTEs. Furthermore, more Psychiatrists reported how their clinical FTEs were allocated to the different age groups and clinical settings which explains the reporting of different Clinical FTE totals in this section.

Out of the 34.05 FTEs, 26.45 FTEs were allocated to clinical work (see Figure 54) with the majority of the FTEs dedicated to adolescents (15-19 years), closely followed by children (5-14 years) who were seen mainly in Outpatient settings (see Table 102). Only 2.58 FTEs were allocated to clinical work with infants (0-4 yrs). The remainder of the FTEs (7.6 FTEs) were allocated to management, teaching, research and other roles.

Figure 54. Psychiatrists' FTE Allocation by Role (n=38) (2004)

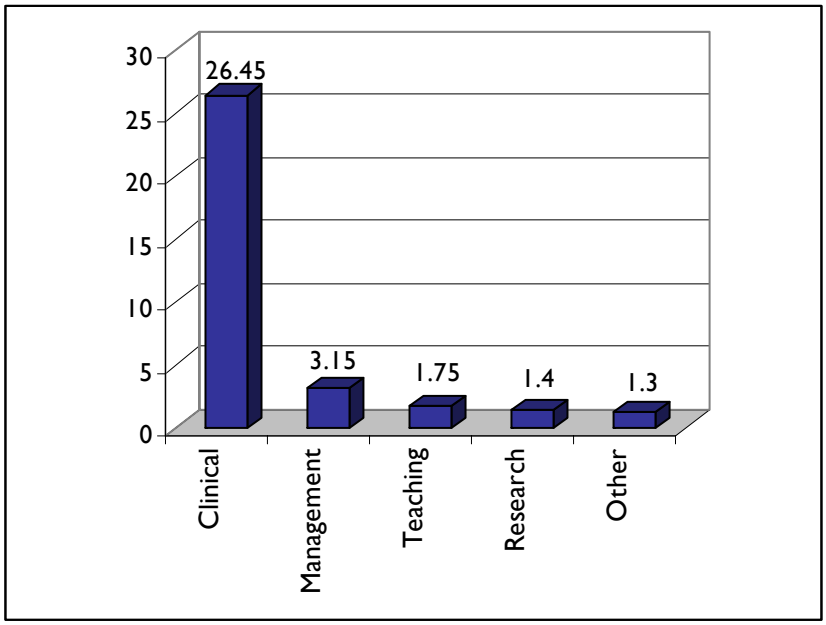


Table 102. Clinical FTEs Allocated to Age Group & Clinical Setting (2004)

	n	Sum FTEs	Mean
Age Group			
Infant (0-4yrs)	41	2.58	0.06
Child (5-14yrs)	41	14.01	0.34
Adolescent (15-19yrs)	40	17.01	0.43
Total FTEs		**33.6**	
Clinical Settings			
Inpatient	41	3.65	0.09
Outpatient	41	21.78	0.53
Rural Outreach	41	2.0	0.05
Consult/Liaison	41	3.98	0.10
Total FTEs		**31.41**	

4.5.4 Practice & Workload

Sixty-five percent (24) of the Psychiatrists had a weekly load of 10-29 clients, mainly in Outpatient settings (see Table 103). FTE allocation data revealed that the Psychiatrists spent most of their time with clients diagnosed with Depression and in Consult Liaison roles (see Table 104). The least number of FTEs was allocated to Children of Parents with Mental illness (COPMI).

Table 103. Approximate Weekly Load of Psychiatrists per Head in Various Clinical Settings (2004)

Weekly Load (Clients)	n	%
Inpatient	**35**	
None	24	68.6
1-9	6	17.1
10-29	4	11.4
30+	1	2.9
Outpatient	**37**	
None	8	21.6
1-9	4	10.8
10-19	14	37.8
20-29	10	27.0
30+	1	2.7
Rural Outreach	**35**	
None	29	82.9
1-9	1	2.9
10-19	3	8.6
Consult Liaison	**35**	
None	25	71.4
1-9	6	17.1
10-19	2	5.7
20-29	1	2.9
30+	1	2.9

Table 104. Psychiatrists' Clinical FTE Allocation by Disorder (2004)

Weekly Client Count	FTEs			Unique Clients		
	n	Sum	Mean	n	Sum	Mean
Anxiety/Depression	24	6.30	0.26	27	177	6.54
Consult Liaison	25	4.08	0.16	24	24	1.00
Pervasive Developmental Disorder	25	3.03	0.12	27	73	2.72
Attention Deficit Hyperactivity Disorder	24	2.39	0.10	27	172	6.35
First Episode Psychosis	24	2.25	0.10	26	44	1.67
Conduct Disorder	25	2.05	0.08	27	39	1.44
Youth Forensic	26	0.65	0.25	26	4	0.15
Children of Parents with Mental Illness	24	0.05	0.002	25	11	0.44

4.6 Chapter Summary

In 2004:

- The DHB inpatient workforce totalled 124.7 actual FTEs with a further 27.4 FTEs that were reported vacant. The inpatient workforce was comprised mainly of Mental Health Nurses and Mental Health Support workers.

- The DHB community child and adolescent mental health workforce totalled 614.04 actual FTEs (excluding 98.77 vacant positions). The three largest occupational groups were Psychologists, Mental Health Nurses and Social Workers.

- Sixty-two 2004/2005 NGOs responded to the survey but data from 58 NGOs was analysed. Data from NGO Kaupapa Māori services was analysed separately.

- Forty-three NGOs (excluding NGO Kaupapa Māori services) reported a total of 301 actual FTEs with a further 18 FTEs reported vacant. The NGO workforce was largely comprised of Mental Health Support Workers, Social Workers and Counsellors.

- Nineteen NGO Kaupapa Māori services were surveyed and responses from 15 were analysed. These services reported a total workforce of 37 actual FTEs which was mainly comprised of Mental Health Support staff, Counsellors and Social Workers.

- The programmes coordinated by Child, Youth and Family reported a total of 34 actual FTEs with a further 11.1 FTEs reported vacant. The workforce was mainly comprised of mental health support workers and mental health nurses and social workers.

- The total workforce equated to 1130 actual FTEs with a further 158 vacant FTEs.

- The total DHB and NGO Community Clinical FTEs were compared to the Blueprint Resource Guidelines for 2004 and a staffing increase of 74% is required (funded vacancies plus newly funded positions).

- WHO recommendations for Psychiatrists also indicated an increase of 103% based on the 2004 numbers (funded vacancies plus newly funded positions).

- The Māori, Pacific and Asian workforce totalled 223, 64, and 23 respectively. While the Māori workforce figures appear mostly proportional to the 0-19 years Māori population, there were significant disparities between the Pacific workforce and the 0-19 years Pacific population in some regions. However, both Māori and Pacific are under represented in the clinical workforce.

Chapter 5

Barriers to Accessing Child & Adolescent Mental Health Services

5.0 Barriers to Accessing Child & Adolescent Mental Health Services

The objective of this Chapter is to identify the barriers to children, adolescents and their families accessing the appropriate mental health services. The scope of the project did not include consultation with children and adolescents with mental health problems and their families. This exercise would have provided the opportunity to gain a more detailed and accurate Māori, Pacific and Asian perspective.

5.1 Literature Findings

The only reference to New Zealand client perspectives on the barriers to accessing CAMHS found in the literature was highlighted in the *He Nuka Mo Nga Taitamariki: A National Workplan for Child & Youth Mental Health Services* (HFA, 2000) report. Discussions held with young people/rangatahi in Taranaki, Christchurch and Auckland revealed that:

> *"The stigma associated with mental illness makes getting help hard. Language can be most problematic with the terms 'mental health' and 'consumer' having numerous derogatory associations. Youth/rangatahi using specialist mental health services thought that the services would be most easy to access if they were simply called child and youth health services."*
>
> *"Māori are particularly shy about getting help from specialist services. Parents will approach services if the young ones take them along and explain what is happening and why."*

The client perspective on mental illness and the services they needed is further elaborated in Appendix A (p. 43), "*Summary of Themes from Meeting with Service Users*" of the Workplan document.

A search for international data on the barriers to accessing child and adolescent mental health services for clients revealed an Australian study conducted by Sawyer (2001) with adolescents and parents of adolescents who identified as having mental health problems.

The main barriers reported by parents were:

- Didn't know where to go to get help
- Services were too expensive
- Thought they could cope alone
- Tried unsuccessfully to get help or they had to wait too long
- Worried about what others would think

The barriers reported by adolescents were:

- Thought they could manage alone
- Thought nothing could help
- Did not know where to go
- Worried about what others would think

The common barriers for both parents and adolescents were: the lack of knowledge on how to access services; the notion that they could manage the problem on their own; and the stigma of attending mental health services. An important finding was that 46% of parents and 38% of adolescents thought they could manage alone.

5.1.1 Barriers to Accessing Child & Adolescent Mental Health Services for Clients as Identified by Professional Referrers

Based on the information that General Practitioners (GPs) and the Education Sector were identified as the first and third largest referral sources from the 2003 MHINC data (the second largest source being Self/Relative referral) (see Figure 16, Chapter 3), their views on the barriers that clients encountered while accessing child and adolescent mental health services was deemed valuable and were therefore surveyed. Child and Adolescent Psychiatrists' perspectives on the barriers to access for clients were also sought.

5.2 GPs Perspectives' on Barriers to Accessing Child & Adolescent Mental Health Services for Children, Adolescents and their Families

TNS New Zealand (a market research company) was identified as having access to an existing pool of GPs, and an existing research platform, and therefore were contracted to conduct the survey of GPs.

TNS New Zealand is a global provider of market information. They analyse and interpret information collected on behalf of their clients. Their social research team provides services to the public sector, non governmental and not for profit organisations. The team has a clear understanding of governmental and policy processes and the role of research and evaluation in these processes.

5.2.1 Methodology

TNS New Zealand run a National Computer Aided Telephone Interviewing (CATI) survey of GPs 4 times a year with area quotas (primary and secondary metropolitan centres). Thus, a representative sample of the New Zealand GP population is captured. A hundred and fifty GPs are included in each wave. As several companies usually contribute questions to the survey, there is a maximum time limit of 10 minutes on the questionnaire.

Questions on the barriers to accessing child and adolescent mental health services were provided for the 4th wave of the National GP Omnibus Survey over the period of the 8th to the 26th November 2004. A full report on the questions was provided by TNS and a summary of the findings are reported below.

5.2.2 Demographics

Area quotas were used to provide a sample representative of the New Zealand GP population resulting in 45% of the GPs surveyed from Auckland, 14% from Wellington, 8% from Christchurch and the remainder from across 13 other areas (see Table 106). Seventy percent of GPs were male and 47% graduated between 1980 and 1990 (see Table 105).

Table 105. Demographics of GPs Surveyed

Gender	**150**	**%**
Male	105	70
Female	45	30
Year of Qualification		
1950-59		2
1960-69		5
1970-79		29
1980-89		47
1990 onwards		17

Table 106. Geographic Location of GPs Surveyed

City	%
Auckland	45
Wellington	14
Christchurch	8
Whangarei	1
Hamilton	5
Tauranga	1
Rotorua	4
Gisborne	1
Napier	2
Hastings	0
New Plymouth	3
Whanganui	2
Palmerston North	3
Nelson	3
Dunedin	7
Invercargill	2

5.2.3 Survey Questions

The questions asked were:

Have you worked with any children or adolescents (age up to and including 19 years) with mental health issues? If yes, what do you see are the main barriers to access to Mental Health services for children, adolescents and their families? Please list one or two important barriers.

Have you worked with any Māori children or adolescents with mental health issues? If yes, please list one or two important barriers to access for Māori children, adolescents and their whanau or families.

Have you worked with any Pacific Island children or adolescents with mental health issues? If yes, please list one or two important barriers to access for Pacific Island children, adolescents and their families.

5.2.4 Results

Seventy-four percent (111) of the GPs had worked with children and adolescents with mental health issues.

The main barriers to accessing child and adolescent mental health services reported by GPs were:

- Waiting times to get into services
- Cost to clients
- Lack of mental health professionals in services
- Lack of specialist services and the difficulty in accessing specialist services
- Stigma of mental health problems

Long waiting times and costs to clients

The long waiting lists in child and adolescent mental health services were reported by GPs as the greatest barrier to accessing mental health services for children, adolescents and their families. The alternative option for clients is to access private mental health services which for most may be too expensive. The cost of accessing public health services was also stated as a significant barrier, including transport costs for rural clients travelling to main centres.

> *"Waiting lists for the community mental care centres-they are too long for patients to wait. The cost for patients to have private consultation-it costs too much and some patients can't afford it."*

> *"It would be such things as money as if you have money you can go private and see someone straight away but if you don't then you have to wait on the waiting lists in the public systems."*

Lack of specialist staff in child and adolescent mental health services

The lack of mental health professionals, specifically psychiatrists and psychologists, in child and adolescent mental health services was also reported as a significant barrier to access for clients.

> *"The number of psychiatrists is not enough…."*

> *"There aren't many people that work in that area-lack of trained people in that area."*

> *"Lack of psychologists."*

Lack of specialist services and the difficulty in accessing specialist services in child and adolescent mental health services

GPs stated that the lack of specialist services in child and adolescent mental health services also proved to be a barrier for clients. If the services are available they were reported as being difficult to access not only for clients but for referrers as well.

> *"It would be the accessibility to mental health services-hard for people to make appointments for that kind of service."*

> *"Accessing a specialist unit. I've never been able to talk straight to a psychiatrist regarding patients."*

> *"….the availability of mental health professionals as it's hard to get into, it's hard for patients to get in to see anyone as there's often not enough staff."*

Stigma

The stigma associated with mental health issues was also thought to act as a barrier to access for clients.

> *"It would be that it's a personal thing-people don't want to know that they are affected by such an illness as mental illness. They tend to sweep it under the carpet and try to hide it. Patients need to understand that they have to come and see us so that we can help them or try and help them. The barrier is that people who need the help often tend not to seek it."*

Clients attitudes towards mental health issues also played a role. A number of GPs stated that the "culture" of adolescents has such that they did not want to seek help. Confidentiality issues were also mentioned. Adolescents were reluctant to seek help as they were concerned that their parents would find out.

> *"..they don't want the parents knowing…without the parent's consent it's hard to give help."*

Barriers to Accessing Child & Adolescent Mental Health Services for Māori Children, Adolescents & their Whanau

Sixty-four of the 111 GPs (58%) who reported working with children and adolescents with mental health issues had worked with Māori children and adolescents.

The top four barriers reported by the GPs to accessing child and adolescent mental health services for Māori clients were:

1. Cost
2. Cultural barriers
3. Family issues
4. The waiting time to get into the services

1. Cost

GPs reported cost as the major barrier to accessing services for Māori clients. Costs included financial costs (service and transport costs) and the time taken to attend services.

2. Cultural barriers

A range of cultural barriers to accessing child and adolescent mental health services for Māori clients were also reported by GPs.

One cultural barrier that GPs frequently stated was the differences in the way Māori people defined mental health problems which prevented them from seeking help.

> *"Cultural barriers like symptom interpretation, their perception is different to that of a medical advisor e.g. thinking it's a curse when it really might be depression."*

Additional cultural barriers were the lack of Māori health professionals and the lack of ethnically appropriate services available for Māori. The lack of knowledge of service availability was also an important contributing factor.

3. Family barriers

The lack of family support was also considered an important barrier to accessing services for Māori clients. GPs stated that a family's resistance to accepting the presence of a mental health problem prevented them from seeking help. This may be related to the stigma of having a mental health problem which was also reported as a major contributing factor.

4. The waiting time in child and adolescent mental health services

GPs reported that, for Māori clients, the waiting time to get into a service was also a significant barrier to accessing services.

Barriers to Accessing Child & Adolescent Mental Health Services for Pacific Children, Adolescents & their Families

Of the 111 GPs that worked with children and adolescents with mental health issues, only 38 (34%) had worked with Pacific children and/or adolescents.

The top four barriers to accessing child and adolescent mental health services for Pacific clients reported by GPs were:

1. Cultural barriers
2. Cost
3. Stigma
4. Lack of knowledge of services

1. Cultural barriers

Cultural barriers were the most frequently reported barriers to accessing services for Pacific clients. Language was considered to hinder families in accessing services. Furthermore, the lack of appropriate cultural services coupled with the inability to communicate with mental health professionals in mainstream services were considered major contributing factors.

The differences in the way Pacific families defined mental illness was also reported as a potential barrier. GPs stated that families may not identify a mental health symptom as such, may not see it as a problem or they may want to deal with the problem themselves. The availability of alternative non-professional support networks (i.e. churches) may also discourage Pacific clients from accessing services.

2. Cost

Cost of attending services was also stated as a major barrier for Pacific clients. Financial costs of attending services (i.e. transport costs) as well as time taken to attend services had an impact on attendance.

3. Stigma

Stigma of having a mental health problem in the family was also considered a barrier to accessing child and adolescent mental health services for Pacific clients. GPs stated that families often felt *"ashamed"* or were *"'shy"* to access services and *"denying and not accepting they have that illness."*

4. Lack of knowledge of services

The lack of knowledge of the types of services available was also considered a significant barrier to accessing child and adolescent mental health services for Pacific clients. They also had low expectations of what services could offer.

5.2.5 Summary

According to the GPs surveyed, waiting times and costs of accessing mental health services (both private and public services) were the major barriers to accessing child and adolescent mental health services for clients in general as well as for Māori and Pacific clients. Lack of specialist services, lack of knowledge of services and the stigma of mental health problems were recurring barriers for all. Language barriers affected access for Pacific clients and the cultural differences in the way mental health/symptoms are perceived affected access for Māori clients.

5.3 The Education Sector

The Education Sector was the third largest referral source identified from the 2003 MHINC data.

Three sub-groups working within the Education Sector were identified as referrers:

1. School Guidance Counsellors (SGCs)
2. Resource Teachers: Learning and Behaviour (RTLBs)
3. Social Workers in Schools

Information on barriers to accessing child and adolescent mental health services from this sector was not included in the project plan. However, the views of SGCs and Social Workers in Schools have been sought and are included in this section.

5.3.1 School Guidance Counsellors' Perspectives on the Barriers to Accessing DHB CAMHS

The following section on SGCs was written by Barbara Bulkeley and is based on preliminary results from the focus groups she ran in the Auckland region in 2004. This formed the first stage of the author's PhD research investigating the beliefs, knowledge and practice of SGCs in the assessment and treatment of adolescent depression.

Methodology

Using a qualitative approach, all counsellors currently employed by High Schools in the region were eligible to participate.

All High Schools and other schools with students at Year 9 or above were approached to ascertain if a School Counsellor was employed. Initial contact was made with the school Principal and if consent was given, all SGCs at that school were invited. State, integrated and private schools were included. A total of 76 schools, employing 116 SGCs, were contacted. Fifty-two principals (68.4%) returned consent forms, so the 80 SGCs in those schools were contacted. Fifty-eight of these (72.5%) agreed to participate, while 22 (27.5%) declined. Of those invited, six (7.5%) were not able to attend a group for various reasons (see Table 107).

Fifty-two SGCs attended one of nine local focus groups. Following transcription of the tapes, the portion of the data concerned with CAMHS was analysed using the QSR NVivo (1.0) program.

Table 107. Numbers of Schools Contacted (2004)

	Number
Schools Contacted	76
Principals Consent	52
SGCs Contacted	80
SGCs Consent	58
SGCs at Focus Groups	52

Focus Groups ranged in size from 3 – 11 participants. All groups were held during school hours, in a variety of settings, (church halls, schools, university and college rooms). All groups lasted between seventy-five and ninety minutes. Responses were kept confidential, and no SGC or school will be identified in any written material. The vast majority of SGCs found the opportunity to participate in a Focus Group and discuss these issues a very rewarding and enjoyable occasion.

Where more than one SGC from a school consented to participate, each was invited to a different focus group. One school with several counsellors contacted the investigator and offered to have a group there with six SGCs. After consent forms were returned, the SGCs were contacted by phone or email and invited to a local focus group. Two to three days beforehand, the SGCs were contacted by phone to confirm their attendance.

Ten semi-structured questions were asked in each group. It was the responses to the fifth question ***"How do you make decisions about referring on or co-operating with other professionals***?" which form the basis for this section. This question appeared to give an opportunity for participants to express their views about disappointments and frustrations with their local CAMHS, but also indicated their appreciation of several aspects of the work of their local CAMHS and individual staff there.

There are four DHB CAMHS in the Auckland region: Campbell Lodge (CMDHB), Kari Centre (ADHB) and Marinoto North and West (WDHB). Most SGCs engaged with one DHB CAMH service, but a number of schools had regular contact with two services, due to their location or special nature (e.g. private schools and Catholic schools). When in previous employment, many SGCs had referred to a different CAMHS.

Demographics of SGCs

Limited anonymous demographic information from SGCs was collected (see Table 108).

Table 108. Demographics of School Guidance Counsellors (2004)

Demographics	Number (n=52)
Gender	
Female	39
Male	13
Age (Yrs)	
30-39	3
40-49	16
50-59	26
60+	7
Ethnicity	
NZ European	39
Māori	1
Other European	4
East Asian	2
Others	6
Experience as SGC (Yrs)	
<2	2
2-5	9
6-10	15
11-20	26
Counselling Qualifications	
None	1
Certificate	3
Diploma	6
Bachelor	3
PG Cert/Diploma	12
Masters	27

Positive Findings

Several aspects of DHB CAMHS services were really appreciated by many SGCs.

In-school training for SGCs and other staff (e.g. on depression, anxiety, suicide) led to comments that following such visits:

> *"I've been amazed how since staff have come back and reflected how that was extremely useful."*
>
> *"Talking about mental health needs of teenagers and that always has a good follow-on effect with staff and there's often quite a few more referrals from staff."*

Consultation/Liaison was highly valued. A liaison team, which made regular visits to schools for training, was mentioned favourably by almost all SGCs in the Central area. Consultation before making a referral was much appreciated everywhere.

> *"I find being able to call the duty counsellor, and discuss it with them as well is really, really helpful, because they can often ask some quite pivotal questions that I might not have thought of."*

School visits to see certain high-needs students and families at school was greatly appreciated by SGCs.

> *"Well, the other day I had a student having a psychotic episode. Thank God they could fit him in."*
>
> *"For a while there last year I had people coming out within an hour and a half to see young people out there."*

Knowing the range of resources and services available, such as stress workshops for girls, or an Early Psychosis Intervention Team, meant SGCs were more likely to use these services.

Cultural Support provided for Māori and Pacific Island families was appreciated by SGCs region-wide.

> *"We liaised with the cultural advisor there. And I learned a lot about the importance of involving the family early on in the piece rather than dealing with things individually like we do in our Western families."*

But concerns were widespread about the need for interpreters.

> *"Mental health professionals, thank goodness they are now using an interpreter."*

Being involved in or observing assessments were a highlight for some SGCs.

> *"I'm most impressed by them. I would love to be sitting in on their sessions, and see how they work with these adolescent kids. For they do make amazing progress."*

Other Findings

The importance of relationships between SGCs & CAMHS

Personal relationships that developed over time were of great importance. SGCs reported that they were discouraged by the high turnover of CAMHS staff. There was a strong positive feeling towards those CAMHS staff who appeared to understand the experience and knowledge of the SGCs. Feeling respected and valued was critical.

"You know, I do a referral, they pick it up. Well, I suppose I've got a relationship with them and I suppose a good reputation with them, because I've done a lot with them."

"The fact is that they take you seriously."

"They've got a person you can ring up to consult with, to talk to, who knows you are not a fool."

Referrals

Reasons for referrals

Most SGCs have made referrals to their CAMHS, mainly for suicide ideation or attempts. Some have referred for serious depression, anxiety disorders including Obsessive Compulsive Disorder (OCD), psychosis and Attention Deficit Hyperactivity Disorder (ADHD).

Why refer to CAMHS?

One reason for referring depressed adolescents to CAMHS was a widely-expressed view that many GPs will start young people on anti-depressants without a thorough assessment and no follow-up counselling, and CAMHS were seen as much more reliable about assessments.

"So I refer to --- when there's complicated things and medication issues, that kind of thing."

Difficulties with referrals

A range of difficulties was reported.

"I've had very mixed responses, and initially some really terrible experiences."

"Certainly unless someone's about to kill themselves, you don't refer to --- do you?" "I sometimes referred out at the beginning. Probably for a feeling of, like they were a specialist or an expert."

When parents were not willing to give permission for a referral to CAMHS because of previous bad experiences or stigma, this created extra stress for the SGCs.

"Quite often we are left in the situation where we either have to manage that student and really communicate, engage the family."

"We couldn't get her into --- because we couldn't get her mother's signature on the paper because her mother was mentally ill."

Several SGCs talked of their ambivalence about referring to a system they do not completely trust, but is all that is available.

"OK, the system is a bit creaky, it doesn't really work, so I think probably in my practice anyway, we're constantly weighing up what will be the least harmful thing to do."

However there were widespread serious concerns expressed about the seemingly shifting criteria for admission to CAMHS. The majority of SGCs have often felt confusion as to which referrals would be accepted by CAMHS. Two main areas caused frustration, very depressed or anxious adolescents who were not suicidal, and those adolescents with sexual abuse issues and suicidality.

"One area which is always sort of a puzzle, frustration really, is where there's been past or current sexual abuse, because of the way in which --- defines working with mental health as distinct from anything that's to do with abuse and won't work with the two things combined. I don't think that's adequate, in terms of service delivery for them."

Assessments

Sometimes an assessment was carried out by CAMHS, confirming depression, and then the adolescent was "returned" to the SGC for counselling with no recommendations or advice as to how to proceed. This caused great frustration. Other SGCs mentioned the seemingly inappropriate lengthy assessment protocols.

"Well, they're very, very thorough, and that's great, you know, but it can be to the extent of a grinding painful thoroughness at times."

Understanding of CAMHS difficulties & processes

Confusion as to the role and scope of services of CAMHS

Many SGCs had been disappointed that a carefully framed referral for an adolescent was not accepted.

"I'm thinking of two examples of kids I'm working with and neither of them would fit the criteria for self harm; however it's really quite obvious that the depression is impacting on their ability, just to function in everyday life."

"And it seems that mental health intervention doesn't seem really to exist in the sense that it's kind of, it's almost as if we're policing suicidality rather than actually dealing with the problem at its root cause. "

Understanding of the pressures on CAMHS was frequently expressed.

"They've expanded their services fantastically but they're still heavily overloaded."

However there was little apparent awareness of CAMHS´ scope in servicing only the adolescents with the most severe mental health needs. It was generally felt that South Auckland had more severe cases than elsewhere and thus it was harder to access services there.

"I've got the feeling over the years that --- were dealing with a much higher, smaller group than --- in terms of what they would accept. I felt that with ---, it had to be acute suicidality."

Lengthy delays in responses to referrals often coloured SGCs views of all services offered by that CAMHS.

"But it took three weeks for this supposedly severely depressed student to actually be seen by ---."

After-hours crisis procedure and the relationship with Adult Services was not well understood:

"You ring up after hours and someone puts you on to --- and (they) put you on to the CATT team and it goes out to --- who don't have any intention of visiting them."

<u>Communication difficulties were frequent</u>

"So you can make a referral and thank you very much and you have to keep on making the overtures to find out what is going on." While it was felt that CAMHS talked of working in partnership, there were many examples of how this did not eventuate."

"I think — for all that they generally embrace the idea of working in partnership, because they have quite a team there on site, it becomes more inward in what they're doing there."

The unwillingness by CAMHS to share information caused SGCs considerable annoyance.

"They want information from us but are very reluctant to give information. And I have actually rung and asked what is the way that you're working, (with the client) so I can support it. And I've found them very reluctant to partnership with therapy."

Long-term engagement with adolescents is seen by SGCs as vital, and CAMHS were often perceived as having difficulties engaging on a long-term basis.

"I suppose I see — as limited in their ability to form a good ongoing counselling relationship that's helpful, so the counselling comes back to us."

Using different terminology and models to SGCs and use of the DSM-IV frequently caused barriers and complications.

"They're different; they're a medical model, working with those structures."

"Once you get involved in a system like —, you get captured!"

The role, training and experience of SGCs was commonly believed not to be appreciated by CAMHS.

"School counsellors can't be as well trained as people maybe in private practice, or who work for child and adolescent, family mental health service."

"I remember being tackled once by somebody at — that you know; my job is to instruct you people about depression because it's obviously not being picked up enough."

As so many SGCs are highly experienced, this type of comment coming from "new" CAMHS workers was greatly resented.

"The grass is greener on the other side!"

There was considerable discussion about services in other parts of the region, and almost all SGCs believed that other CAMHS services were superior to their own!

"Here on the —— , our mental health service is not there for us."

"Not apparently in the ——, that is quite a different story."

"They've been hugely resourced."

"You just don't even put in a referral. There's no point."

Summary

The main barriers reported by SGCs in Bulkeley's study were:

- Parent reluctance to refer
- Lack of trust of the system
- Shifting criteria for access
- Lengthy delay in responses to referral
- Lengthy time of assessment
- Return of client to SGCs without recommendations or advice
- Confusion as to role & scope of CAMHS
- Lack of service capacity
- Lack of understanding of after-hours relationship with adult services
- Communication difficulties
- Unwillingness to share information
- Lack of long term engagement with adolescents
- Different language and models of working
- Lack of understanding of the role of SGCs

The overall picture of the relationship of SGCs and CAMHS within the Auckland region has both positive and challenging elements. SGCs in all areas recognised the changes to CAMHS services over the last five or so years and appreciated those new initiatives such as the LEAP Team services offered in schools. Cultural advice was much appreciated but there was a desire for better services for non-English speaking families. The use of interpreters was increasing but was not always satisfactory. Where good relationships existed between SGCs and CAMHS workers, services offered were seen much more positively and, for example, explanations about why referrals were not accepted were better received. Communication at all stages was generally seen as problematic.

However there remain many barriers to accessing appropriate CAMHS services for adolescents. Many issues emerged which can be grouped under a lack of awareness of the philosophy and processes of CAMHS. In particular there is little understanding of how referral criteria are determined, why these may vary, and how adolescents believed by SGCs to urgently need help are low-priority to CAMHS. In view of the likelihood of increasing occasions where SGCs will be working with CAMHS it would appear greatly beneficial to both groups to have more open communication and co-operation. More understanding by SGCs of the scope, role and philosophy of CAMHS and a similar willingness for CAMHS workers to appreciate the role and experience of SGCs as well as understand their needs and concerns about access issues would be likely to help remove some of these barriers over time.

The views of the SGCs in the Auckland region appear to be increasingly positive towards CAMHS, but there is still some way to go.

5.3.2 Social Workers in Schools' Perspectives on the Barriers to Accessing Child & Adolescent Mental Health Services

Eight-five Social Workers in schools were surveyed on the barriers to accessing child and adolescent mental health services for children, adolescents and their families. The Survey was distributed by the co-ordinator of Social Workers in Schools via email in December 2004. Demographic information was not collected. Only five responses to the survey were received. The low response rate could be attributed to the time of the year (end of the school year) the survey was disseminated. Despite the low response rate, the content was deemed valuable and is included in this report.

The following themes on the barriers to access emerged from the responses that were received:

- **Long waiting times and long assessment processes**

  "Assessment process prolonged (6-8 weeks), requiring multiple visit. Barrier to families with transport difficulties, limited access to time off work."

- **Lack of consultation/communication with families**

- **Restrictive acceptance criteria in child and adolescent mental health services**

  "Acceptance criteria-assessment-excludes children who have acute care and protection issues, residential placement, custody of access issues. Excludes children/young person who have primary diagnosis of intellectual disability, Conduct Disorder, Oppositional Defiant Disorder, Sexual Abuse, Violence, Anger problems and A & D diagnosis only."

- **Lack of specialist staff in child and adolescent mental health services**

- **Cost to clients**

  "Requirement for GP to make referral-additional expense for families, some families decline service at this point."

Barriers to Accessing Child & Adolescent Mental Health Services for Māori Clients

The Social Workers were also asked to comment on the barriers to access for Māori clients. The following barriers were highlighted:

- **Lack of consultation and communication with families and lack of information provided to families by child and adolescent mental health services**

"Medical Model- professionals are the 'experts' and tell the whanau what they have to do."

"Māori families want to know what is happening to their child and why."

"Some families affronted by assumptions about ethnic identity, have been offered "Māori" services prior to initial appointment."

- **Lack of culturally appropriate specialists and lack of understanding of Māori value and belief systems**

- **Stigma of mental health problems**

- **The belief that families can manage on their own with support from their family/whanau**

Barriers to Accessing Child & Adolescent Mental Health Services for Pacific Clients

The Social Workers reported the following barriers for Pacific clients:

- **Lack of culturally appropriate resources/specialists and lack of understanding about Pacific Island culture, spirituality and family roles**

"The further south you go in the island, there are less and less Pacific Island families and support services available to them, let alone Pacific workers."

- **Lack of consultation and communication with families and lack of information provided to families by child and adolescent mental health services**

- **Lack of culturally appropriate services**

5.4 Child & Adolescent Psychiatrists' Perspectives on Barriers to Accessing Child & Adolescent Mental Health Services for Children, Adolescents & their Families

Forty-six Child and Adolescent Psychiatrists were identified from the mailing list of the child and adolescent psychiatry group and were surveyed via email.

Child and Adolescent Psychiatrists were requested to provide workforce information and were also asked their views on the barriers to accessing child and adolescent mental health services for their clients. Forty-one Psychiatrists in total responded to the survey and 34 responded to the question on barriers to access.

The most frequently reported barriers for clients as reported by Psychiatrists were:

- **Stigma**

- **Long waiting lists in services and the inability of child & adolescent mental health services to respond promptly**

  General mistrust of services by families, young people and referring agencies e.g. GPs and School Counsellors, due to poor service provision and lack of response."

  "NGOs relied on by us for less acute and less severe issues yet that have long waiting lists."

- **Lack of specialist staff including cultural staff**

  "The lack of adequate staff is the main one-there are simply not enough people to meet the demand."

- **Clients lack of knowledge of the types of mental health services that are available**

  "Community not sure on what we do and don't do."

  "Limited understanding of what child mental health services are and what they have to offer."

- **Strict acceptance criteria/strict adherence to the Blueprint 3% in child and adolescent mental health services**

  "The fact that we necessarily have such a high threshold for entry into services that we discourage people we could actually help."

  "There has also been a focus on the Blueprint 3%. This is a small proportion of the total number of children and adolescents with mental health problems."

- **Lack of mental health services**

Other less frequently reported barriers included:

- Inadequate funding
- Lack of referrals and lack of knowledge about referral processes
- Geographic location of the services

5.5 Chapter Summary

The barriers to accessing child and adolescent mental health services for children, adolescents and their families as identified by referring professionals (GPs, SGCs, Social Workers in Schools & Child & Adolescent Psychiatrists), were consistent with literature findings and these are summarised as follows:

- Lack of knowledge of services
- Lack of services and specialised staff
- Stigma of being referred to mental health services
- Restrictive criteria for referral/acceptance
- Lengthy delay in response to referrals
- Lengthy waiting times to get into services
- Lengthy assessment processes
- Costs to clients (private providers, GPs, transport, time off work)
- Lack of feedback/communication to referring professionals and clients

The referring professionals identified the following barriers for Māori and Pacific children, adolescents and their families:

- Lack of culturally appropriate mental health services and staff
- Lack of understanding about culture, value and belief systems

Although the barriers of access to child and adolescent mental health services has been obtained from only four professional groups, the findings were consistent and further research of professionals is unlikely to produce any significant new information.

A significant gap in this chapter is the survey of the clients' and their families/whanau perspectives on the barriers to accessing child and adolescent mental health services. This exercise would have provided the opportunity to gain a more detailed and accurate Māori, Pacific and Asian perspective. However, the inclusion of clients' perspectives was beyond the scope of this project.

Although projects have been developed by CYF and MOH (see Chapter 2.3.4) to improve access to DHB funded mental health services by CYF residents, further steps to address the barriers reported by referring professionals in this chapter should be incorporated into MOH's strategic planning.

Chapter 6

Barriers to Inter-Agency Co-ordination

6.0 Barriers to Inter-Agency Co-ordination

The objective of this Chapter is to identify the barriers to inter-agency co-ordination. The scope of the project did not include consultation with children and adolescents with mental health problems and their families. The survey data in this section is limited to GPs and Psychiatrists as their survey was within the scope of the project. It would have been good to seek opinion from a wide variety of health professionals and agencies but this exercise was also outside the scope of the project.

6.1 Literature Findings

The government has recognised the need for the collaboration of services given that young people may need care across a number of different agencies. As a result, CYF, Health, Education and Justice are involved in inter-sector collaboration through a number of funded policy initiatives. Despite the impetus on a collaborative approach to mental health care, The State Services Commission (SSC, 2003, p.13) and Gray (2002) highlighted the following barriers that often impede such collaborative efforts:

- The number of agencies involved
- The frequency of restructuring of government organisations and associated "*devaluing of service delivery*"
- Centralisation and associated "*variations in levels of delegation*"
- The "*diversity of regional boundaries*" in different departments
- "*Differences between agency priorities*" and national policy priorities
- Financial resources in "*small pots*"
- Core business "*outputs*" rather than of whole of government approaches
- A "*risk-averse*" public service culture that is counter to innovation and progress
- No lead agency with oversight
- Competition between agencies for resources
- Impact of the funder/provider contracting approach
- Lack of funding for co-ordination and collaboration
- Some agencies shift responsibility to others
- "*Use of the Privacy Act 1993*" to limit information sharing

The SSC Report (p.13) also identified issues and barriers to working with Māori groups and these included:

- *The need for government and other agencies to recognise diverse Māori realities rather than having a "one size fits all" approach*

- *A lack of commitment and consistency in government agencies' approaches to Māori Issues*

- *A lack of information related to the effectiveness of co-ordination and integration in terms of Māori outcomes*

6.2 Survey Findings of the Barriers to Inter-Agency Co-ordination

6.2.1 General Practitioners' Perspectives on the Barriers to Inter-Agency Co-ordination

The survey carried out by TNS New Zealand with 150 GPs included a question on barriers to inter-agency co-ordination. One hundred and eleven GPs responded to this question.

The top four barriers reported by GPs were:

1. Privacy Issues
2. Lack of knowing who to contact
3. Overworked/under-resourced organisations
4. Time taken to liaise with other agencies

1. Privacy/confidentiality issues

GPs consistently reported that privacy and confidentiality issues were the greatest barrier to inter-agency co-ordination. The rigidity of the Privacy Act makes it difficult to share client information and communicate with other agencies.

> *"It's the concerns about confidentiality and sharing this information. Previous experiences with…… they make you provide lots of information and they are not willing to share any."*

> *"The Privacy Act-just some of the services can't get enough information because of the privacy issues."*

2. Lack of knowledge on who to contact

GPs also reported that the lack of communication between agencies was also due to the lack of knowledge on who to contact.

> *"….lack of communication of the services one service doesn't know who they should be talking to from another agency. They know their own role but not anyone elses from another agency."*

3. Overworked/under-resourced organisations

GPs consistently reported that most agencies were over-worked and had neither the time nor the staff available to contact other agencies.

> *"Everyone's over-worked, they are stretched to their limits, having no co-ordinators outside the services."*

> *"The lack of resources like staff and this leads to lack of time; it's often very hard to discuss on the phone with these different services regarding patients. There's no one point of contact; it needs to be co-ordinated, a one stop mental health service."*

GPs also stated that there are often delays in response time and only the most severe cases are seen.

> *"Difficult to contact people in these areas, it's hard to get hold of them very quickly. Lack of resources adds to the whole thing."*

"The people you talk to at first who make the decision of whether your patient should be attended to urgently or not. They only get attendance if it's a life threatening situation..."

"No funding-they won't see patients unless it's urgent and it shouldn't get that far."

4. Time taken to liaise with other agencies

Although some GPs stated that time was a barrier, it appears that this is due to the lack of staff and large workloads of existing staff.

"*Time is a barrier, like the time taken to liaise ….*

"The waiting time, [for] seeking information back from the agencies concerned, sometimes it's the time delay of getting the letters back. Unsure of where the patient has to go, like what service will cover their problems."

5. Other barriers

GPs also reported that there is a general feeling of mistrust between agencies and many agencies simply do not want to collaborate.

6.2.2 Child & Adolescent Psychiatrists' Perspectives on the Barriers to Inter-Agency Co-ordination

Child and Adolescent Psychiatrists were also surveyed on their views on barriers to inter-agency co-ordination. Thirty-seven out of the 41 Psychiatrists surveyed responded to the question.

The top four responses were:

1. Lack of time (staff resource)
2. Lack of trust/patch protection/competition
3. Lack of good direction, models and interfaces
4. Calibre of agency management

1. Lack of time

The most commonly reported barrier reported by the Child and Adolescent Psychiatrists was the lack of time to liaise with other agencies, possibly driven by the lack of resources and staff.

"Lack of time to set up the structures needed to support this….lack of recognition of its importance and the time it takes."

"Levels of clinical demand are such that there is insufficient time to devote to the face to face contact that is necessary."

"How can you communicate if there are not enough people to communicate with? Many agencies are understaffed or staffed with inexperienced people."

2. Lack of trust/patch protection/competition

Lack of trust and the need to protect one's own resources due to funding limitations was also a commonly reported barrier to inter-agency co-ordination.

> *"Defensiveness based in artificial demarcations of responsibility driven by resource (funding) limitations. Agencies prioritise the protection of their budgets over service delivery or responsiveness to those in need. We are better at declining services or turfing people over to another agency when possible than working out a way for two agencies to collaborate for a better outcome. Communication can often be established, it is collaboration that is the greater challenge."*

3. Lack of good direction, models and interfaces

Child and Adolescent Psychiatrists also mentioned that there is no *"dedicated interagency policy"* and many agencies have *"different and opposing philosophies"* that seems to impede inter-agency co-ordination.

4. Calibre of agency management

Child and Adolescent Psychiatrists also stated that there is a general lack of staff at management level who are dedicated to inter-agency co-ordination.

> *"Workforce gaps-relative lack of senior, clinically adept staff to drive inter-agency co-ordination."*

5. Other barriers

The Psychiatrists also reported that the interpretation of the Privacy Act often impeded communication between agencies. The large numbers of agencies involved also meant that very little was known about the internal processes and criteria of the agencies.

6.3 Chapter Summary

Literature findings on the barriers that hinder inter-agency co-ordination were consistent with the barriers reported by GPs and Child and Adolescent Psychiatrists surveyed.

Privacy issues were seen as an important barrier by GPs while the time taken to liaise with other agencies was a significant barrier for Psychiatrists. Lack of resources (specifically the lack of experienced staff) was seen as a barrier that led to long response and waiting times and the need to protect the limited funding that the agencies received. The large number of agencies involved also meant that it was often difficult to know who to contact.

Specific funding for a dedicated staff member for inter-agency liaison was a consistent solution suggested by both professional groups.

Chapter 7

Māori Tamariki, Rangatahi & their Whanau

7.0 Māori Tamariki, Rangatahi & their Whanau

By Tania Cargo

It is important to acknowledge from the outset that Māori tamariki and rangatahi can not be viewed in isolation from their whanau. Indeed in Māori tikanga, children are viewed as an integral link between the past, present and future. *Te Komako*, the Māori training unit within the Ministry of Education stated in their manual (p.3) that children are:

> *"viewed as part of an ongoing whakapapa, their contributions simultaneously fed into the past, present and future and ensured the survival of themselves and their communities…"*
>
> *"They are the physical embodiment of tipuna, bringing together the mana, wairua, mauri, ihi, wehi, tapu of generations long-gone, and linking with generations to come, children were assured of safety and nurturing within whanau and hapu structure*."

Naturally then, any chapter that endeavours to look at the mental health needs of Māori tamariki and rangatahi, must be able to recognise that they do not sit in isolation but rather that they are surrounded and included in a vast network of whanau, hapu and iwi structures reaching back into the past and moving forward into the future.

7.1 Introduction

According to the 2001 New Zealand Census, Māori made up almost 15% of the New Zealand population (although 17% have Māori descent). Significantly, approximately one in two Māori (46.3%) were under the age of 20 and comprised almost 22% of all New Zealand young people in this age group. Population projections show that in 2021, Māori will be 27% of the 0-19 population. These figures combined with the disproportionate mental health needs of young Māori (Fergusson et al, 2003) must be at the forefront when planning for the future development of child and adolescent mental health services generally and their workforce in particular.

Additionally, Māori as the Tangata Whenua (Indigenous people) of New Zealand are in a unique position because their indigenous status is acknowledged in government legislation, i.e. the Treaty of Waitangi. The importance of the indigenous position is demonstrated through the Waitangi Tribunal which "*was established to hear the claims by Māori relating to contraventions of the Treaty of Waitangi*" (Smith 1999, pg 46). Therefore a separate chapter on Māori tamariki, rangatahi and their whanau is legitimised both on the basis of need and on indigenous status.

7.1.1 Profile of Māori Tamariki, Rangatahi & their Whanau

A general profile of the Māori population from the 2001 New Zealand Census shows that most Māori reside in the north of the North Island (60% live in Northland, Auckland, Waikato and Bay of Plenty), live in an urban environment (5 out of 6 live in urban areas), attain fewer educational qualifications and survive on median annual incomes of $14,800.

Whilst the majority of Māori tamariki and rangatahi live in two parent households, 35% of Māori children live in one parent households where the median annual income is below $15,000 (Statistics New Zealand, 2001). Māori tamariki and rangatahi predominantly live in the North (see Tables 109 & 4), make up 39% of the under 20 population in the Midland region (see Figure 55) and over 60% of all children and young people in the Te Tairawhiti area (see Figure 56). Māori are more likely than in the past to speak Te Reo with Māori tamariki and rangatahi comprising half of all identified speakers (2001Census New Zealand).

Table 109. Numbers of Māori Children & Young People aged 0-19 yrs by Region & Age Group (2003)

Age Group	Northern	Midland	Central	Southern	Total
0-9	48,640	52,170	28,060	17,660	146,530
10-14	23,020	25,690	13,520	8,550	70,780
15-19	18,780	21,470	11,200	7,700	59,150
Total	**90,440**	**99,330**	**52,780**	**33,910**	**276,460**

Source: Statistics New Zealand Projected Population for 2003

Projected Numbers of Māori Children & Young People aged 0-19 yrs by Region & Age Group (2004)

Age Group	Northern	Midland	Central	Southern	Total
0-9	48,790	51,970	27,980	17,620	146,360
10-14	23,090	25,690	13,420	8,630	70,830
15-19	19,570	22,170	11,690	7,950	61,380
Total	**91,450**	**99,830**	**53,090**	**34,200**	**278,570**

Source: Chapter 1, Table 4

Figure 55. The Māori Child & Adolescent Population (% of Total 0-19 yrs Population 2004)

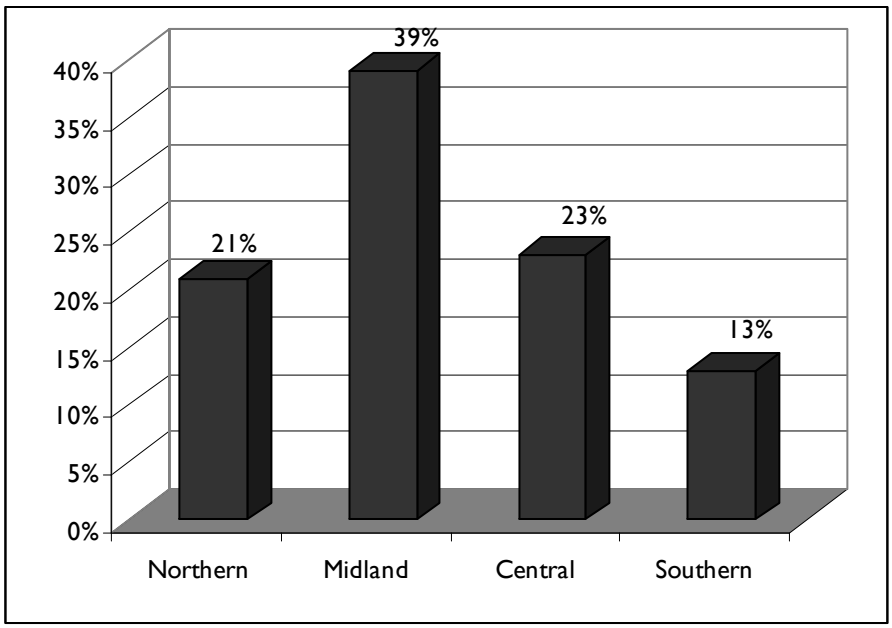
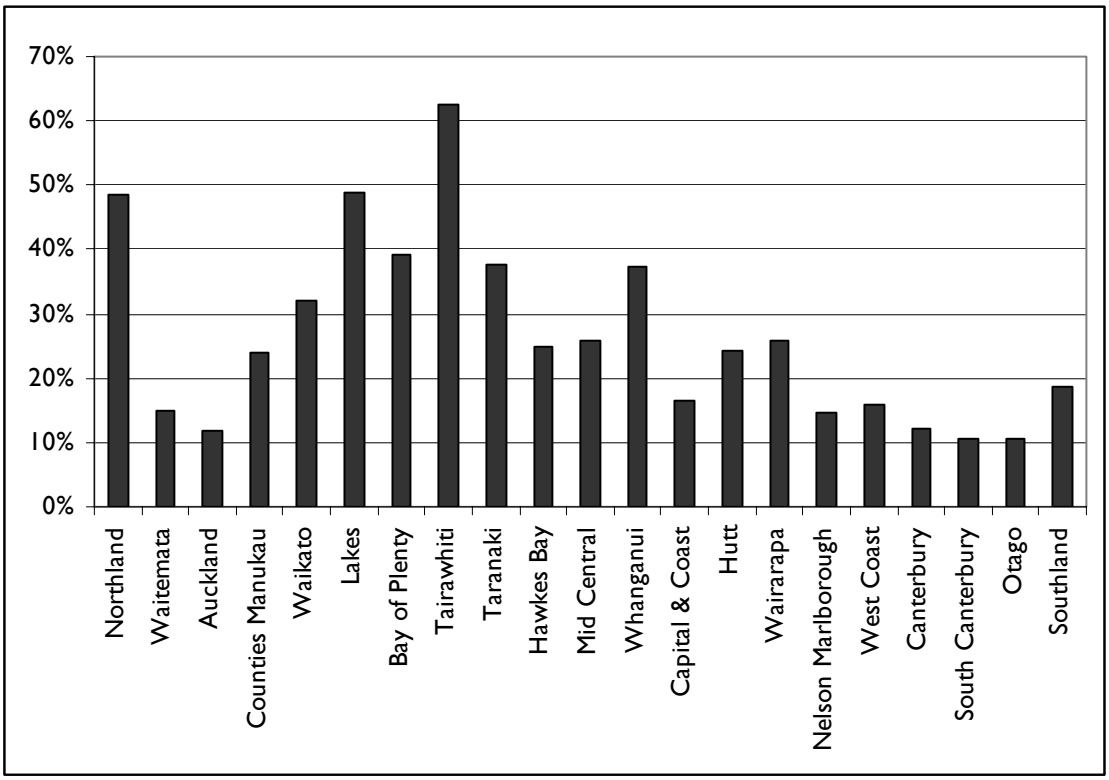


Figure 56. The Māori Child & Adolescent Population by DHB (% of Total 0-19 yrs Population 2004)



Data Source: Statistics New Zealand

7.1.2 Background

Māori Views of Mental Health

Māori, like other indigenous people, have their own models of health. In 1982, the Te Whare Tapa Wha (a four-sided house) model was discussed by Māori health leaders as a useful way of conceptualising the then contemporary Māori view of health (Durie, 2001). The model has since become a widely accepted view of Māori health, perhaps because it is relatively easy to understand, can be used with any health related issue and has been readily endorsed by Māori leaders.

According to Durie (2001, p.69):

> *"the whare tapa wha model compared health to the four walls of a house, all four being necessary to ensure strength and symmetry, though each representing a different dimension: taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side), taha whanau (family)."*

Thus Māori mental health is viewed as an interrelated phenomenon rather than an intra-personal process. Poor mental health is seen as a breakdown in harmony between the individual and their environment (Durie, 2001) and the goals for therapy focus on the integration of the individual with their environment. Such a holistic definition of mental health means that individuals cannot be viewed in isolation and that wider environmental issues are important contributors to health status.

Prevalence of Mental Health Problems

Māori rangatahi appear to have almost double the prevalence rates of serious mental health issues than non-Māori youth (see Table 4) based on two longitudinal studies conducted in Christchurch and Dunedin (Fergusson,

2003). Although there are limitations to both these studies (most importantly that in the Southern region less than 13% of all 15-19 year olds are Māori) they do provide some evidence of the disadvantages Māori rangatahi and their whanau are experiencing and the impact such disadvantage has upon mental health. Fergusson et al (2003, p.15) noted that Māori children were more likely than non-Māori to be reared in homes with:

> "*material disadvantage, family dysfunction and parental difficulties that were likely to contribute to future problems of adjustment*"

The Prevalence of the Statistically Significant Higher Rates of Disorders in Māori Young People

Study	Approx. Age in Years	Disorder					
		Depression	Anxiety	Conduct Disorder	Substance Abuse	Suicide Ideation	Any Disorder
CHDS	15		20.2%	14.1%	12.1%		34.3%
	18	24.6%		11.8%	31.8%		54.6%
	21		22.8%	9.6%	36%		57.9%
DHDS	18	27.3%				21.2%	57.6%
	21	25.4%	29.6%				

Source: Chapter 1, Table 4

Protective Factors

Like other children and youth, Māori require the same protective factors to guard against mental health problems such as:

- good problem-solving skills
- family and community social supports
- connectedness (e.g., to family, peer group, school or community)
- skills in managing conflicts and disputes

However Māori may also require additional culturally unique protective factors such as:

- Positive and secure cultural identity (Huriwai, 2002)
- Active participation and fulfilment of ones cultural roles (Durie, 2001)
- The ability to speak Te Reo Māori (Lawson Te Aho, 1998)

These factors, combined with the burden of need, support the development and maintenance of having culturally relevant services for Māori.

Māori Service Provision

Durie (2003) and Lawson (1997) have argued that Māori must not only gain social, economic and political equity with non-Māori, which will help strengthen whanau (Durie, 2003), but must also be supported to build their own capacity and Kaupapa Māori mental health services. The need for appropriate services for Māori has been acknowledged in a variety of health literature (see Chapter 1.5.1 of this document). Of interest is the fact that much of the data focuses on the Māori adult population even though one in two Māori are under the age of 20. The Ministry of Health's 2005, *Te Tahuhu* (p.13) document has targeted 3 areas for immediate emphasis:

- *Enabling Māori to present earlier to mental health and addiction services*
- *Promoting choice by supporting the implementation of Kaupapa Māori models of practice*
- *Increasing Māori participation in the planning and delivery of mental health and addiction services for Māori*

Indeed in the Blueprint (1998a, p.45), the suggestion was made that resources should be allocated according to the proportion of Māori in the local area.

> *"In each region a proportion of the resource guidelines should be allocated to Kaupapa Māori services, according to the proportion of Māori in the local population."*

In spite of this, those areas with the highest Māori population continue to have less DHB mental health service spend per child and young person (see Chapter 2, Table 29).

The Māori Tamariki, Rangatahi & Whanau Mental Health Workforce Development

Te Rau Matatini (TRM) was set up to provide a centre for Māori mental health workforce development. It now contributes significantly to Māori Mental Health workforce policy development at both national and regional levels and aims to expand the Māori Mental Health workforce and promote mental health as a rewarding career option for Māori.

In 2002, TRM conducted a survey of Māori who work in mental health, both DHBs and NGOs. From a total of 532 Māori respondents, only 78 (15%) stated they worked in a specialist mental health service for children, adolescents and whanau. The staff were predominantly female 55/78 (71%) and half were in the 30-49 year age group. This data supports the findings in this Stocktake survey which shows that there is a dearth of Māori clinicians with child and adolescent expertise.

Te Rau Matatini (Ihimaera, Maxwell-Crawford & Tassell, 2004, p.7), has emphasised the need for partnership:

> *"between health and education at all levels in order to extend the capacity and capability of those working in mental health to respond effectively to Māori mental health need."*

The Māori child and adolescent mental health workforce must not only grow to reflect true choice for Māori consumers but must also be able to provide cultural and clinical safety (Ministry of Health, 2002b) in the enhancement of whanau ora. This recognition that clinical competence cannot be separated from culture identifies a new challenge for both the education and health sectors which will be charged with the task of training and developing dually competent clinicians (Ihimaera et al., 2004).

7.2 Access to Mental Health Services by Māori Tamariki & Rangatahi

Data from the Mental Health Information National Collection (MHINC) and population data provided by the MOH (obtained from Statistics New Zealand) was utilised to inform 'Access' information.

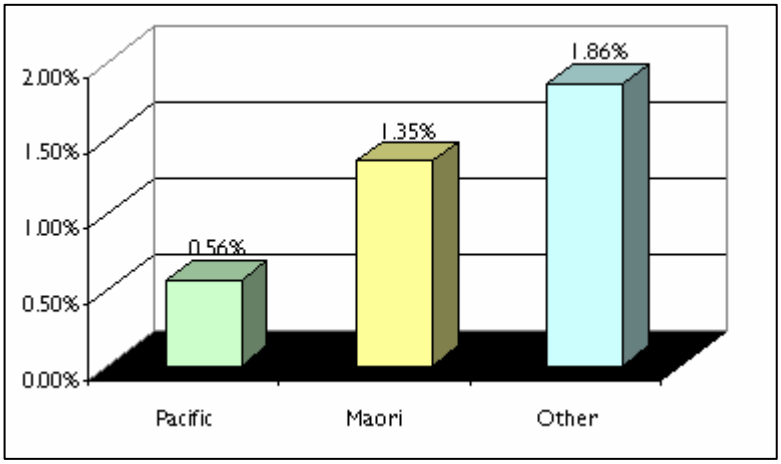
In 2003, one in five clients (3,742 of 19,307) that accessed child and adolescent mental health services were Māori with nearly twice as many males accessing services than females. The figures also showed that access increased with age for Māori so that the 15-19 year old clients were the largest group of Māori clients accessing services (see Table 110).

Table 110. Numbers of Māori Clients seen in Mental Health Settings by Age (2003)

	Age Group			
Gender	**0-9**	**10-14**	**15-19**	**Total**
Male	460	860	1,059	**2,379**
Female	166	420	777	**1,363**
Total	**626**	**1,280**	**1,836**	**3,742**

However as a percentage of the population, the Māori rate of access for 2003 was 1.35%; lower than the 1.86% of the rest of the population, but not as low as the Pacific figure of 0.56%. Information on access by types of service and team types as well as referral sources are presented in Chapter 3.

Clients Seen as a Percentage of Population by Ethnicity (2003)



Source: Chapter 3, Figure 8

The typical profile of a Māori client accessing services in New Zealand in 2003 was:

- Male (as for non-Māori)
- In the 15-19 year age group (half of all Māori clients seen)
- With a serious mental health disorder (higher prevalence rate than non-Māori)
- Attends for 10 sessions (as for non-Māori)

The *Blueprint* benchmarks for access for the child and youth population of New Zealand have not been met for any of the age groups regardless of ethnicity (see Table 111). However less than a third (0.3%) of Māori children under the age of 15 accessed child and adolescent mental health services. In the 15-19 year age group, they had similar access rates as non-Māori.

Table 111. Māori 0-19 yrs Population Access Rates (2003/2004)

	Age in years Total				Age in years Māori			
	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19
Strategic Benchmark	1%	3.9%	5.5%	3.0%	1%	3.9%	5.5%	3.0%
Access Rate first 6 months 2003	0.4%	1.4%	2.0%	1.1%	0.3%	1.1%	2.0%	0.9%
Access Rate second 6 months 2003	0.5%	1.5%	2.1%	1.2%	0.3%	1.3%	2.1%	1.0%
Access Rate first 6 months 2004	0.4%	1.3%	2.1%	1.1	0.3%	1.1%	2.0%	0.9%

7.2.1 Barriers to Access for Māori

Information on barriers to accessing child and adolescent mental health services was gathered via a survey conducted with General Practitioners (GP's) and the Education Sector throughout New Zealand. The reader should refer to Chapter 5 of this document for more detailed and contextual information.

Sixty four GP's (58%) reported that they had worked with Māori children and adolescents with mental health issues.
The three main barriers to accessing services for Māori clients were:

- cultural barriers:
    - culturally different definitions of health
    - lack of Māori health professionals
    - lack of Māori health services or knowledge about them

- family barriers:
    - culturally sanctioned or stigma associated with mental health problems

- cost of the service:
    - of transport to get to the service
    - waiting times to get into services

7.3 The Māori Tamariki & Rangatahi Mental Health Workforce

Data was collected from DHBs and DHB funded NGO providers. Data on ethnicity was based on head count rather than FTE. The ethnicity data was provided by survey respondents rather than the actual staff member and therefore, should be interpreted with caution. Detailed information is provided in Chapter 4 of this document and should be referred to for more detailed and contextual information.

There were 233 Māori staff identified through the Stocktake survey (see Table 112):

- Northern (58 workers)
- Midland (79 workers)
- Central (42 workers)
- Southern (46 workers)

The majority of the Māori child and adolescent population reside in the Midland and Northern regions (70%).

Table 112. The Māori Tamariki & Rangatahi Mental Health Workforce by Region (Head Count 2004/2005)

Workforce	Northern	Midland	Central	Southern	Total
DHB Inpatient	10	0	7	2	**19**
DHB Community	34	18	22	11	**85**
NGOs	14	61	13	33	**121**
CYF Collaborative					**8**
Total	**58**	**79**	**42**	**46**	**233**

The majority of the workforce (121) were employed by DHB funded NGOs and exactly half of the Māori staff held clinical positions. The DHB Māori clinical workforce is predominantly made up of Mental Health Nurses (17) and Social Workers (16), whilst the non-clinical roles are predominantly Cultural Workers (29) and Mental Health Support Workers (10).

NGOs reported a total of 121 Māori staff, evenly split between clinical and non-clinical staff. Counsellors (19) and Social Workers (16) were the two main clinical roles and Mental Health Support Workers (26) were the main non-clinical roles.

The Child, Youth and Family collaborative workforce (see Chapter 2) had 8 Māori staff.

The Māori Workforce as a Proportion of the Māori Population

In 2004, 23% of the total 0-19 years population were Māori children and adolescents and the Māori child and adolescent workforce only accounted for 20.4% of the total workforce (see Table 97). If the workforce is to reflect the population it serves, than the Māori workforce needs to grow by 3%.

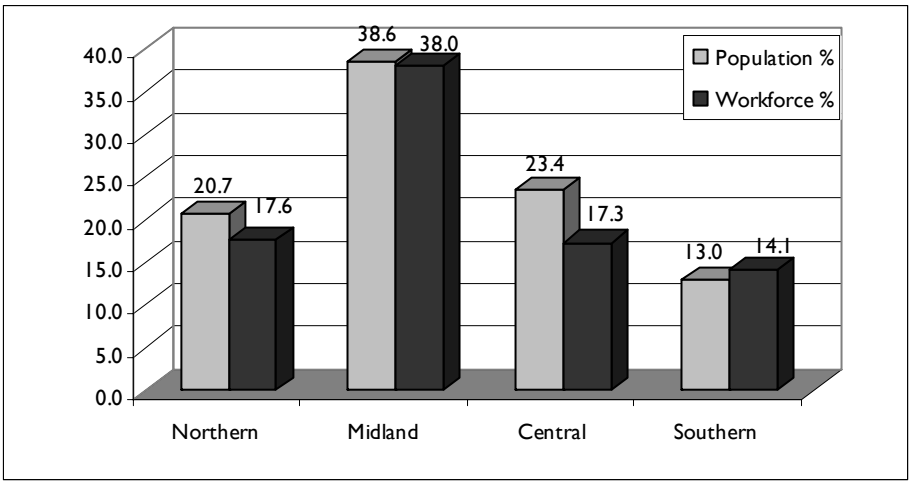
Regionally, the Māori workforce in the Southern region was close to the regional percentage of the Māori child and adolescent population. However, Māori children and adolescents who access services in the Northern regions have less opportunity to access Māori staff.

The Māori Workforce as a Proportion of the Māori 0-19 yrs Population by Region (Head Count 2004)

Region	0-19 yrs Total Population 2004	0-19 yrs Māori population 2004	%	Total Māori Workforce	Total Workforce*	%
Northern	442,434	91,450	20.7	46	261	17.6
Midland	258,860	99.830	38.6	71	187	38.0
Central	226,550	53,090	23.4	34	197	17.3
Southern	262,350	34,200	13.0	44	311	14.1
Total	**1,190,195**	**278,570**	**23.4**	**195**	**956****	**20.4**

Data Source: Chapter 4, Table 97
*Estimated from FTE Data
**Excludes Administration/Management & CYF Workforce Data
Note: Auckland & Waitemata DHBs 2005 Head Count (2004 data not available)

Māori Workforce as a Proportion of the Māori 0-19 yrs Population by Region (Head Count 2004)



Source: Chapter 4, Figure 51

7.4 Ministry of Health Funded Kaupapa Māori Child & Adolescent Mental Health Services

In 2000, the Health Funding Authority stated that the first priority for future service development in child and adolescent mental health is Māori tamariki, rangatahi and their whanau. Five years on, this statement remains pertinent with:

1. Māori tamariki and rangatahi comprising almost a quarter of all New Zealand children and young people under the age of 20.
2. Māori youth having almost double the prevalence rates of mental health problems than other New Zealand youth.
3. Māori tamariki, rangatahi and their whanau experiencing significant socio-economic disadvantage.

The Ministry of Health funded 22 agencies (19 NGOs and 3 DHBs) (purchase unit code – MHCS39) to provide Kaupapa Māori Mental Health services to tamariki and rangatahi (see Table 113). All services received a copy of the workforce survey and were followed up with an email or telephone interview. Of the 22 agencies surveyed (3 DHB and 19 NGOs). Of the 22 agencies surveyed, 20 delivered Kaupapa Māori Mental Health Services to Tamariki and Rangatahi in 2005, two agencies provided a Kaupapa Māori Mental Health service to pakeke (adults) only, one was not received in time to be included in this report and one NGO declined to participate in the survey stating the information was "commercially sensitive." This resulted data from 15/19 NGO Kaupapa Māori services being included in this section of the report.

Table 113. NGO & DHB Providers of Kaupapa Māori Mental Health Services - Tamariki & Rangatahi (2004/2005)

Region	Area & Name
Northern	**Northland NGO**
	Ngati Hine Health Trust Board Provides and early brief intervention service and education programme
Midland	**Waikato NGO**
	Hauora Waikato Māori Mental Health Services* Declined to participate
	Te Rohe Potae O Rereahu Maniapoto (Te Kuiti) Provides an early intervention service and specialist tamariki/rangatahi team
	Raukawa Trust Board Provides meaningful activities 'wellness' programme
	Te Korowai Hauora o Hauraki Inc Provides a specialist Rangatahi mental health programme
	Lakes NGO
	Te Runanga O Ngati Pikiao Trust No longer provides tamariki & rangatahi services
	Tuwharetoa Health Services Ltd Provides an A&D and mau rakau 'self esteem' programme
	Bay of Plenty NGO
	Nga Mataapuna Oranga Provides an assessment and support programme in schools
	Poutiri Charitable Trust* No longer provides tamariki & rangatahi services
	Te Runanga O Te Whanau Charitable Trust Provides a mental health programme
	Tuhoe Hauora Trust t/as Rakeiwhenua Trust Provides mental health assessments & first episode psychosis service
	Tairawhiti NGO
	Te Hauora O Turanganui A Kiwa Ltd Provides a mental health & A&D programme
	Taranaki NGO
	Tui Ora Ltd: **Mahia Mai:** Provides mental health assessments & treatment **Raumano:** Provides mental health assessments & treatment
Central	**Capital & Coast DHB**
	Te Whare Marie Provides mental health assessments & treatment
	Capital & Coast NGO
	Te Runanga O Toa Rangatira Provides A&D & addiction programmes
	Hutt DHB
	Has two Māori staff working in mainstream CAMHS
	Hutt NGO
	Te Paepae Arahi Trust*
	Wairarapa DHB
	Has one Māori staff member working in mainstream CAMHS
Southern	**Nelson Marlborough NGO**
	Ko Te Poumanawa Oranga O Te Tau Ihu O Te Waka A Maui Ltd* No longer provides tamariki & rangatahi services
	Canterbury NGO
	Purapura Whetu Trust Provides Te Pa Karakeke 'trauma treatment' programme
	STOP Trust Provides assessment & treatment for children & young people who have engaged in sexualised behaviour
	Southland NGO
	Te Huarahi Ki Te Oranga Pai Trust Provides counselling services

*Did not respond

7.4.1 Description & Philosophy of Kaupapa Māori Services

A Kaupapa Māori service was defined by all services as incorporating three key aspects:

- Operates from a Tikanga Māori philosophical base (19/19)
- Uses an holistic or Te Whare Tapa health model (19/19)
- Works using whanaungatanga (19/19)

"We provide a Kaupapa Māori service because our service is based on Māori principles of tikanga, kawa, whanaungatanga, manaakitanga and wairuatanga. As such we provide a holistic health (Tapa Wha) wraparound service." Service Manager Interview.

As well as including individual assessments and treatment, the Kaupapa Māori services also provided a variety of specialist programmes including:

- Education, prevention and early intervention programmes within schools and communities
- Alcohol, Drug and Addiction programmes
- Traditional Mirimiri, Mau Rakau and Taiaha programmes

Kaupapa Māori services also stated that at times they provide more services than they are funded for both because when working with tamariki and rangatahi you can not exclude their whanau and because the are working with children from their own communities. The following are representative of the comments reported.

"We don't exclude anyone, which is appropriate, within a tikanga whakawhanaungatanga way of working. So we do more than we are funded to. We end up providing the whanau with a total 'wrap-around' service." Service Manager Interview.

"We are only funded to do some things but we actually do a lot more because these are our kids, in our community." Manager Interview.

7.4.2 Kaupapa Māori Workforce

The 17 services had 51 FTEs available to provide the contracted services which equated to an average of 3 FTEs per service. Most services were part of larger organisations and so they were able to use resources from other parts of the agency to support any additional needs of the tamariki and rangatahi.

"We refer to other parts of the agency for things we may not have." Service Manager

Clinical staff comprised 50% of the workforce (see Figure 57) but when students and vacancies were considered this increased to 76% of the workforce. Counsellors and Social Workers made-up the majority of the clinical staff at 74% and had, an average of 3.5 years experience (see Figure 60). Mental Health Nurses comprised 20% of the workforce and had 6 years experience, whilst Psychologists made up the remaining 6% and had the most clinical experience (6.5 years).

Whilst Clinical vacancies are difficult to fill (on average being vacant for 12 or more months) there are some clinical disciplines that are absent all together (there were no Occupational Therapists, Psychotherapists or Psychiatrists funded under the MOH contract MHCS39).

Although identified as Non-Clinical positions, Kaumatua, Health educators, Mental Health Support Workers and Consumer Representatives were identified as contributing significantly to ensuring 'dual competency' of services and, as such, made up just under a quarter of the Services workforce.

Table 114. Kaupapa Māori Workforce by Occupational Group (2004)

Occupational Group	Māori Staff	Students	Actual FTEs as at July 2004	Vacant FTEs as at July 2004
Clinical Sub-Total	**25.5**	**3**	**26.5**	**5**
Alcohol & Drug Workers	-	-	-	-
Counsellors/ A&D Counsellor	9.5	1	10.5	2 (12 & 14 mths)
Mental Health Nurse	5.0	-	5	1 (8 mths)
Occupational Therapists	-	-	-	-
Psychiatrist	-	-	-	-
Psychotherapist	-	-	-	-
Registered Psychologist	1.5	1	1.5	-
Social Worker	9.5	1	9.5	2 (6 & 14 mths)
Other Clinical	-	-	-	-
Non-Clinical Sub-Total	**11.25**	**2**	**12.25**	**-**
Kaumatua/Kuia/Cultural Appointment	1.5	-	1.5	-
Specific Liaison Appointments	-	-	-	-
Mental Health Consumer & Family Worker	1.0	2	1.0	-
Mental Health Support Worker	4.75	-	5.75	-
Administrative/Management/Quality/Training	-	-	-	-
Other Non-Clinical Support	4.0	-	4.0	-
Total	**36.75**	**5**	**38.75**	**5**

Figure 57. The Composition of the Kaupapa Māori Workforce (2004)

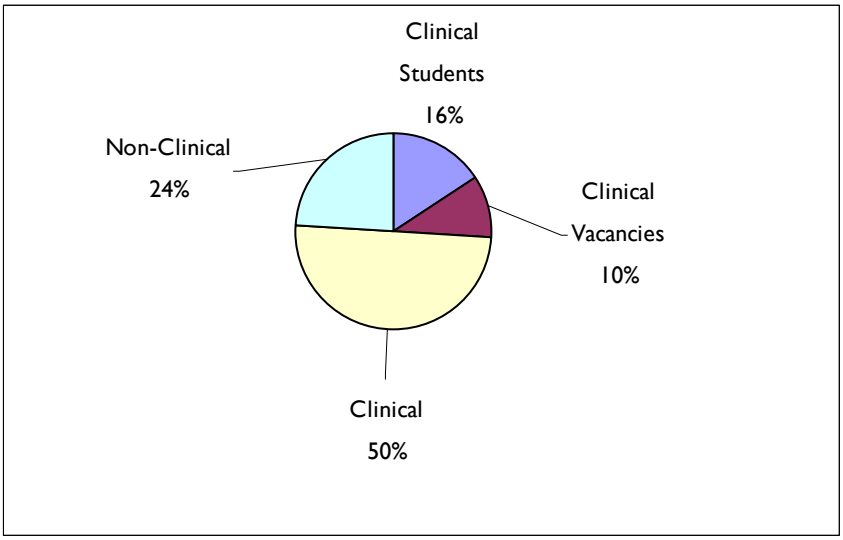
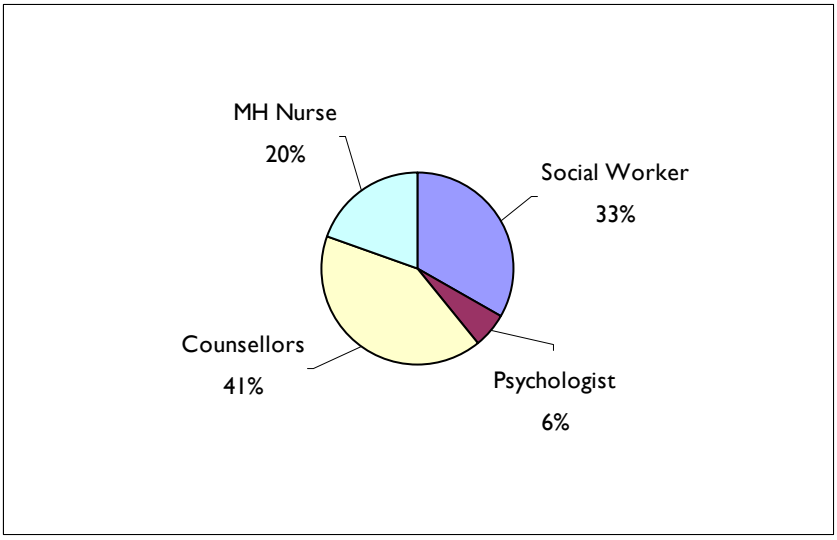


Figure 58. The Kaupapa Māori Clinical Workforce by Occupational Groups (2004)



Note: Excludes Vacancies

Figure 59. The Kaupapa Māori Non-Clinical Workforce by Occupational Groups (2004)

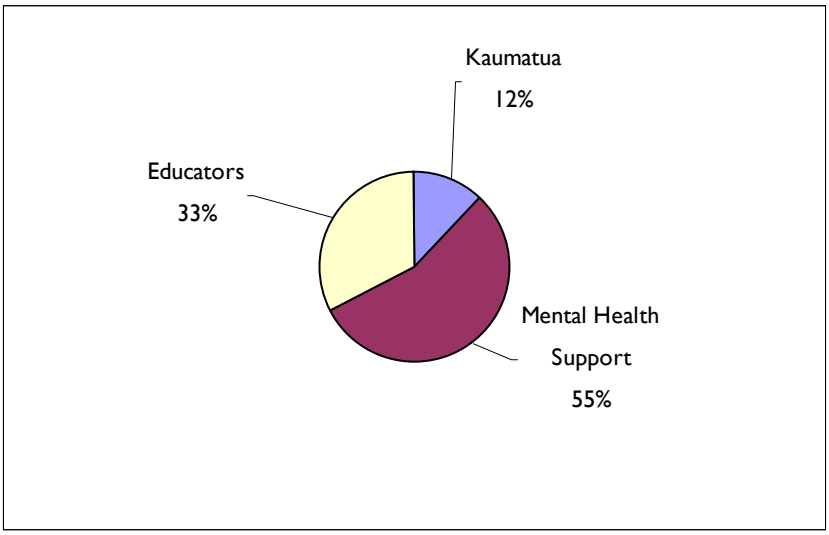
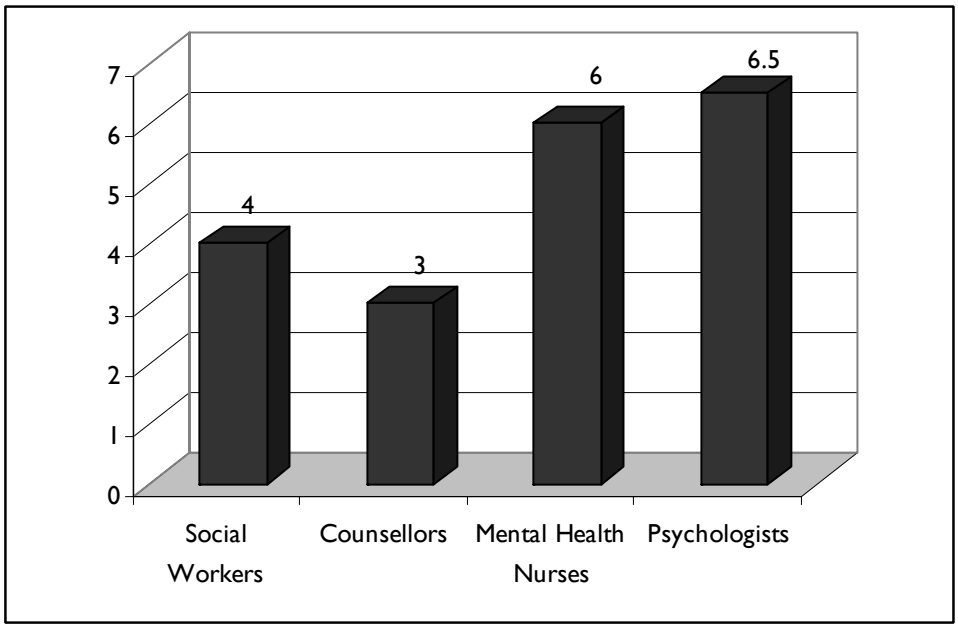


Figure 60. Years of Experience in Child & Adolescent Mental Health (2004)



7.4.3 Recruitment & Retention Issues Identified by Kaupapa Māori Services

Geographical isolation was identified by all 10 rural services as a major barrier to recruiting staff.

> *"Difficulty of attracting any skilled or professional tamariki/rangatahi staff, due to isolation,…"* Manager Interview

It was also seen as impacting on clinical issues by all 10 rural services. They noted that there was often a reluctance from mainstream services to travel to the rural areas.

> *"Isolation of … areas and reluctance of mainstream services to travel or travel alone to provide services, so these services are not provided."* Manager Interview

> *"Being rural it is difficult to get crisis team response from the main centers after 2pm."* Manager Interview

"There is a total lack of Respite and Residential programmes specific to tamariki/rangatahi generally and none for rural." Manager Interview

"Being rural shouldn't be a disadvantage for access to services." Manager Interview

Lack of clinical expertise (14/17 services) in the child and adolescent area together with difficulties in filling vacant clinical positions (15/17 services) were seen by most services as a key recruitment issue. Several services felt that financially they could not match DHB wages which was seen as a reason Māori clinical staff work in mainstream services.

"Lack of skilled community clinicians within the community arena (trained clinicians are employed by mainstream as they have the funding)." Manager Interview

Services reported creative ways of trying to retain their existing clinical staff such as "*growing*" their own clinicians (12/17 services), upskilling through professional development (11/17 services) and through financial incentives (10/17 services).

"We would like to secure a Māori Psychiatrist or Psychologist but this is really difficult to do as they get lured away. This time we have tried to 'grow our own' Psychologist by paying for their training and then bonding them to the agency. We are also aware that we have to pay higher wages for these staff as an incentive to stay here. In the order of several thousand dollars more than we might normally. But we believe this is the only way to secure such people with the clinical skills we need." Manager Interview

The growing and upskilling of the Māori workforce is a significant workforce issue. Kaupapa services are trying to do this through locally based training providers.

"We are lucky because we have (name of training provider) here and we send all our new staff on their course.." Manager Interview

The change in the Health Practitioners Competency Act has meant that some services which employ Counsellors are no longer eligible for clinical positions. Given that they make up the majority of the funded services, this is increasingly a concern for the Māori workforce.

"We have a lot of counsellors but they are not recognised as clinical staff and so we have difficulty with funding based on that. We now are encouraging them to do Masters in social work to be registered." Manager Interview.

"Our experience of having a student who came and had a degree and honours in Psychology, but who couldn't get registration because the system changed under the scopes of practice. So now she is doing a Masters in Social Work, because it would take too long the other way to become a Psychologist." Manager Interview.

The need for dual competency was noted strongly by 9/17 managers who reported that there was still a gap between clinical and cultural factors.

"Mainstream services and providers do not cope well with Māori tamariki/rangatahi, yet are funded to provide specialist services to Māori tamariki/rangatahi." Manager Interview

"We believe Māori are "at risk" from professionals who don't have the insight to see the entire Māori story." Manager Interview

Figure 61. Recruitment Issues for Kaupapa Māori Services (2004)

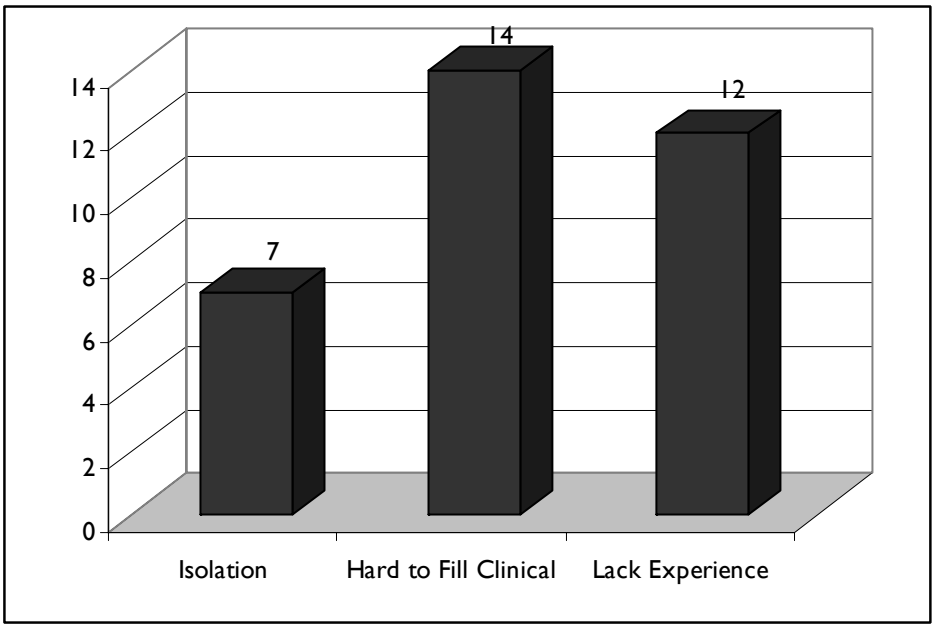
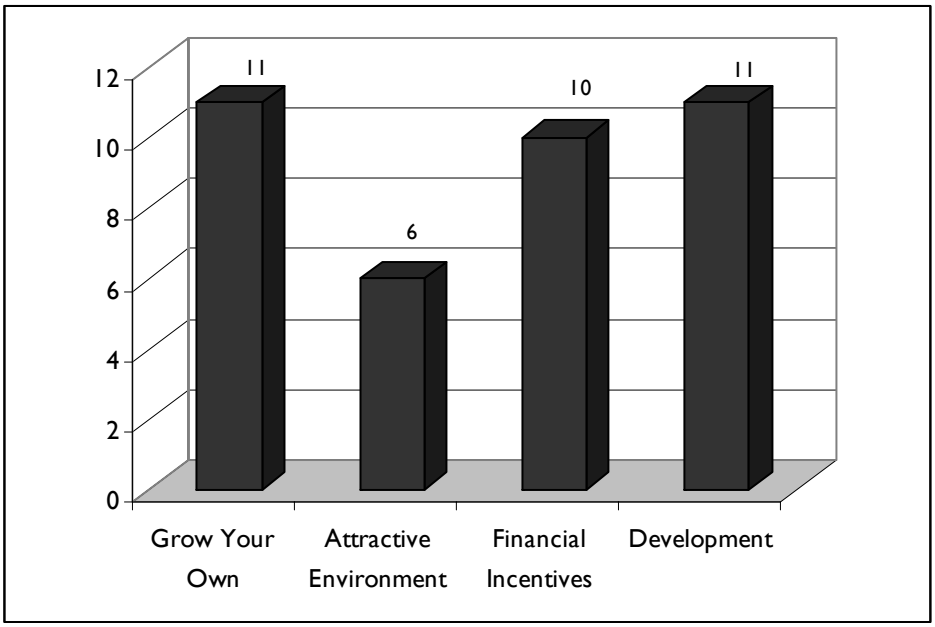


Figure 62. Retention Issues for Kaupapa Māori Services (2004)



7.5 Chapter Summary

Kaupapa Māori Mental Health Services

- In 2005, 17 out of 19 services deliver to Tamariki and Rangatahi
- Incorporates 3 key aspects: tikanga Māori philosophies, holistic models of health and embraces whanaungatanga
- Provide more services than they are funded to deliver

Workforce

- Fifty percent of the workforce are clinical staff, 25% are non-clinical and 25% are vacancies and students in training
- Clinical vacancies are difficult to fill, taking, on average 12 months
- Counsellors and social workers comprise 74% of all clinical positions and have an average of 3.5 years post qualification experience
- There were no Occupational Therapists, Psychotherapists or Psychiatrists funded under the MOH contract MHCS39
- Non-Clinical staff are seen as contributing significantly to ensuring 'dual competency' of services

Recruitment Issues

- Lack of clinical expertise and difficulty filling clinical positions was seen by 85% of services as a key recruitment issue
- Geographical isolation was identified by all rural services as a major barrier to recruiting staff as well as impacting on clinical services

Retention Issues

- Services reported "growing" their own clinicians (12/17), upskilling through professional development (11/17) and through financial incentives (10/17) as active ways they utilised to retain staff
- The change in the Health Practitioners Competency Act (2003) has meant that some services which employ counsellors are no longer eligible for clinical positions

Recommendations

The following recommendations relate to the findings in this Chapter

- Given that currently half the Māori population in New Zealand is under the age of 20 and that Māori make up almost a quarter of this age group nationally, combined with prevalence rates of mental illness of almost twice that of non-Māori, urgent resource allocation and planning needs to be used to support Māori services in the appropriate delivery of mental health services to Māori tamariki, rangatahi and their whanau.

Chapter 8

Pacific Children, Young People & their Families

8.0 Pacific Children, Young People & their Families

By Dr Monique Niumata-Faleafa

"I am not an individual,
I am an integral part of the cosmos.
I share divinity with my ancestors, the land, the seas and the skies.
I am not an individual because
I share a tofi with my family, my village, my nation.
I belong to my family and my family belongs to me.
I belong to my village and my village belongs to me.
I belong to my nation and my nation belongs to me.
This is the essence of my sense of belonging."

Tui Atua Tupua Tamasese, 1997

8.1 Introduction

Due to migration, approximately 7.0% (NZ Census 2001) of New Zealand's total population is of Pacific ethnicity and this is projected to increase to 9% by 2021. New Zealand's most recent Census reports that half of the Pacific population are Samoan (50%), followed by Cook Island Māori (23%), Tongan (18%), Niuean (9%), Fijian (3%), Tokelauan (3%) and Tuvalu (under 1%). In New Zealand, children are more ethnically diverse than adults with 18% identifying with more than one ethnic group. About two-thirds of Pacific people are located in the Auckland region. The majority of Pacific peoples (58%) are born in New Zealand and 90% of the Pacific population speak English (Statistics New Zealand, 2002 & 2003).

This chapter provides a broad overview of issues utilising a pan-Pacific approach. It is important, however, to recognise and acknowledge the cultural diversity between Pacific cultures – each Nation has its own specific set of cultural beliefs, customs, values and traditions. The status, authority, tradition, obligations and power structures are different for each group (Ministry of Pacific Island Affairs, 2001). Moreover, the diversity and distinct differences within cultures needs to be acknowledged – e.g., between "island-born" and New Zealand-born Pacific people.

This chapter incorporates information from Chapter 3 and 4 which should be referred to for more detail and contextual information.

8.1.1 Profile of Pacific Children & Young People

The Pacific population within New Zealand is relatively youthful with an increasing proportion of New Zealand's children (0-19 yrs) projected to be of Pacific ethnicity in the future (8.4% in 2001 projected to 10% in 2021). This projection is mainly due to a combination of higher fertility and the younger age structure of the population – the 2001 Census reported that Pacific peoples had a median age of 21 compared with 35 for the total population. For New Zealand-born Pacific people, the median age is 12 compared to 37 for those born overseas (Statistics New Zealand, 2003).

In 2001, a significant 37% of the entire Pacific population was under 20 years of age compared to 30% for the rest of the New Zealand population. The population projections for 2003 show there is a high number of Pacific people in the under 20 age group where Pacific children and young people make up 8.5% of New Zealand's under 20 population (Statistics New Zealand). Table 115 provides population statistics by region and age group.

The majority of this young Pacific population reside in the Northern region, making up 17% of the total under 20 Northern population (see Figure 63). Counties Manukau and Auckland DHB areas have the largest Pacific populations of this age group (Figure 64).

Table 115. Projected Numbers of Pacific Children & Young People aged 0-19 yrs by Age Group & Region (2003)

Age Group	Northern	Midland	Central	Southern	Total
0-9	38525	3670	7845	2845	52885
10-14	18555	1845	3880	1555	25835
15-19	14900	1550	3370	1420	21240
Total	**71980**	**7065**	**15095**	**5820**	**99990**

Data Source: Statistics New Zealand Projected Population for 2003

Projected Numbers of Pacific Children & Young People aged 0-19 yrs by Age Group & Region (2004)

Age Group	Northern	Midland	Central	Southern	Total
0-9	38575	3635	7780	2820	52810
10-14	18885	1875	3830	1555	26145
15-19	15765	1610	3490	1475	22340
Total	**73225**	**7120**	**15100**	**5850**	**101295**

Source: Chapter 1 Table 6

Figure 63. Pacific Child & Adolescent Population (% of Total 0-19 yrs Population 2004) by Region

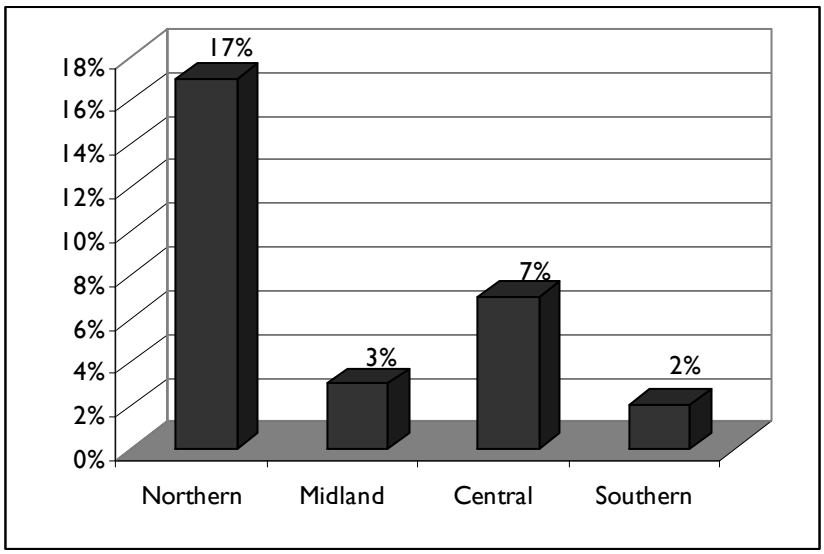
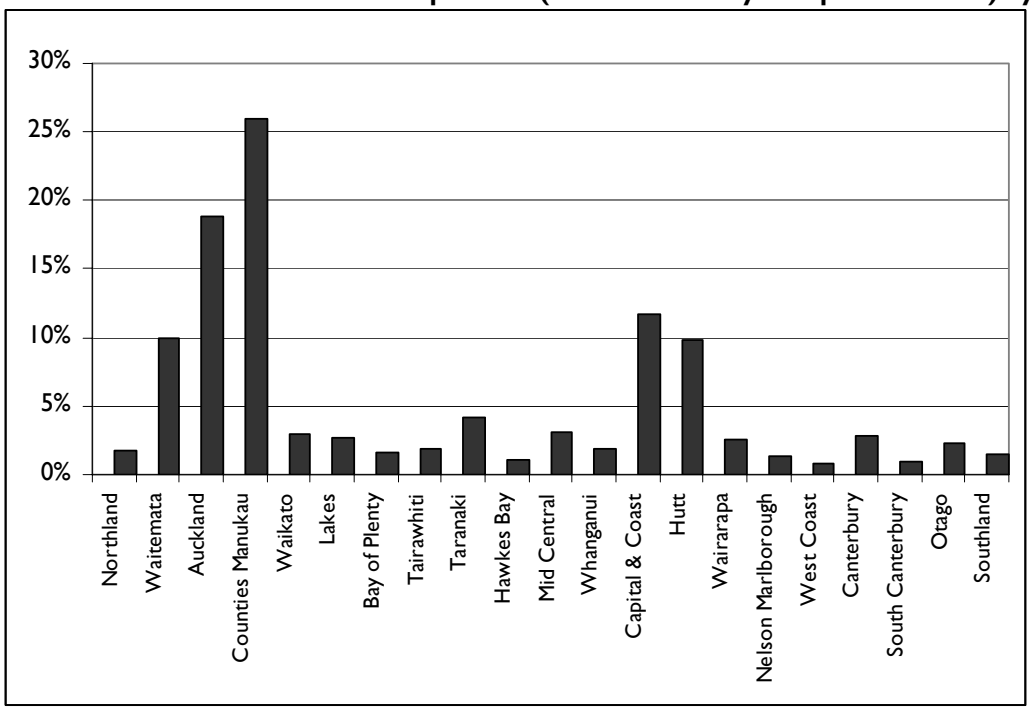


Figure 64. Pacific Child & Adolescent Population (% of Total 0-19 yrs Population 2004) by DHB



8.1.2 Background

Pacific Perspectives of Mental Health

Common values across Pacific nations are ideals such as respect, reciprocity, communalism, collective responsibility, gerontocracy, humility, love, service and spirituality (Anae, Coxon, Mara, Wendt-Samu, & Finau, 2002). Pan-Pacific concepts of family emphasise collectivity and encompass the immediate and extended family as well as the wider community - it is not uncommon for children to be raised or parented by aunties, uncles or grandparents. Traditional Pacific concepts of health are holistic, where well-being is defined by the equilibrium of mind, body, spirituality, family and environment. Pacific models of mental health include ethnic-specific frameworks such as the well-known Samoan *Fonofale (Pulotu-Endemann, 1995)* model, the Tongan *Kakala (*Helu-Thurman cited in HRC, 2004*)* model and the Cook Islands *Tivaevae* (Maua-Hodges, cited in HRC, 2004) model.

There is a paucity of published work on Pacific mental health in New Zealand. A recent Ministry of Health publication *Tupu ola Moui: The Pacific Health Chart Book 2004* provides a stocktake of the health needs of Pacific peoples and includes a comprehensive review of service utilisation, health outcomes and determinates of health (MOH, 2004c). Bathgate and Pulotu-Endemann published "*Pacific People in New Zealand*" in *Mental Health in New Zealand from a Public Health Perspective* (MOH 1997). This provides a comprehensive background to Pacific peoples' understanding of health and needs. They note that Pacific cultures do not have words that translate easily into "*mental illness*" and mental health is considered to be inseparable from the "*overall wellbeing of the body, soul and spirit*" (p.106). Most, but not all, disturbed behaviour is considered to be a manifestation of an external spiritual force, especially ancestral spirits who have taken possession of the person because the person or the person's family have broken a certain custom or offended the spirits in some way. In short, there is a common belief across the Pacific cultures that ancestors have a constant spiritual and physical communication with living people (p.106).

Given that 58% of Pacific people are New Zealand born and of these, 48% are under 20 years of age, it should be acknowledged that Pacific people, particularly youth, may experience varying levels of acculturation into the dominant western culture in New Zealand. Hence the applicability of traditional Pacific perspectives of mental heath may also vary for Pacific children and young people born in New Zealand.

Prevalence of Mental Health Problems

There appears to be a dearth of good research literature on the mental health of Pacific children and young people that would allow a good indication of their service need as opposed to their service use.

There are problems with the collecting of ethnicity information which may also influence any interpretation of need, for example the collection of MHINC data prioritises Māori ethnicity when both Māori and a Pacific ethnicity are recorded. Some young people of both Māori and Pacific ethnicity will identify more with their Pacific heritage than with their Māori and vice versa. Furthermore, ethnocentric data collection in research studies can limit a complete picture of mental health concerns for Pacific people, for example, the use of the outcome measure HoNOS/HoNOSCA does not fit comfortably with Pacific holistic understandings of wellbeing or mental health (Pulotu-Endemann, Annandale and Instone, 2004).

The Ministry of Health's Mental Health directorate recently released its first dedicated Pacific report on the mental health of New Zealand's Pacific population, *Te Orau Ora: Pacific Mental Health Profile* (2005). The report provides some preliminary information on the prevalence of Pacific mental illness based on several studies on prevalence estimates. It does not however provide estimates for the Pacific child and youth population. It estimates that over a six-month period, 23% (including alcohol and drug use disorders) of Pacific people in New Zealand could expect to experience a mental illness (based on the 2001 Pacific population) (p.20).

The MOH-funded *New Zealand Mental Health and Wellbeing Survey - Te Rau Hinengaro (MOH, MHC & HRC, 2003)* is currently being conducted and is of particular significance to Pacific communities because it will be the first time that an attempt has been made to gather epidemiological information on how Pacific people experience problems with their mental health. The survey will provide reliable prevalence information to help plan mental health and other social services.

Service Access for Pacific People

Accessing appropriate mental health services is an identified issue for Pacific people living in New Zealand. Pacific people are less likely to use mental health services than any other group in New Zealand (MOH, 2005) and Pacific youth have been reported as having a low presentation rate to mental health services (Northern Region Pacific Mental Health Addictions Plan, 2003).

Pacific people attempting to access child and adolescent mental health services are at risk of a potential "triple whammy" of discrimination relating to age, mental health, as well as ethnicity. A further contributing factor is thought to be the high degree of stigma attached to mental illness in Pacific cultures, so that the presence of mental illness or disability is shaming for the family (Huakau & Bray, 2000). This has been related to traditional spiritual explanations (e.g., as punishment from God or a curse due to a family wrong).

The numbers of young Pacific clients aged 0-19 years seen in mental health settings in New Zealand for the year 2001 was 467 (MOH, 2004b). The total client population within this age group was 19,561. This figure represents 2.4% of the total population under twenty years seen – a significant under-representation of the Pacific child and youth population. The Table below shows the numbers seen within each age group.

Numbers of Pacific Clients seen in Mental Health Settings by Age (2001)

	Age Group				
Gender	**0-4**	**5-9**	**10-14**	**15-19**	**Total**
Male	9	48	79	136	272
Female	3	16	50	95	164
Total	**12**	**64**	**129**	**262**	**467**

Source: Chapter 1, Table 8

Data from the MOH *Te Orau Ora: Pacific Mental Health Profile* (p.21) showed there were 743 in this age group for the 2 year period (Jan 2001-Dec 2002).

Service Needs

There are few Ministry of Health documents that relate specifically to Pacific People's mental health and their service needs. Within the few that do exist, there is a sense of urgency for mental health services, resources and research for the child and adolescent Pacific population to be prioritised. It appears that the implementation of these suggestions is yet to be actioned.

A strategic direction for services was outlined in *Strategic Directions for the Mental Health Services for Pacific Islands People* (MOH, 1995). *The Northern Regional Pacific Mental Health and Addictions Plan (2003/2005, p.10)* provided the goals and objectives for the Northern region in relation to Pacific peoples' mental health. The goals were as follows:

- To develop Pacific primary mental health services
- To improve access for Pacific peoples to mental health services (particularly children and young people)
- To develop partnerships with organisations, communities, families and service users, which will maximize opportunities for Pacific peoples involved with mental health and alcohol and other drug services
- To develop a competent and qualified Pacific mental health workforce that will meet the needs of Pacific peoples
- To ensure that information and research on Pacific mental health will inform policy planning and service development

The Mental Health Commission *Blueprint* (MHC 1998a, p.45) expects services for Pacific young people to be developed in much the same way as are Kaupapa Māori services. The Mental Health Commission expects that Pacific peoples will have a choice of either Pacific services or culturally appropriate mainstream services. Attention to the cultural needs of the young person and family, attention to the culture of the clinician and

clinician bias, and attention to the culture of the mental health service have been identified as important in addressing the needs of minority ethnic groups (US Dept of Health and Human Services, 2001).

Pulotu Endemann, Annandle & Instone (2004) detailed the service needs of Pacific people and the barriers to access. The Table below is taken directly from their paper. Mainstream mental health services require either Pacific clinical staff or strong concomitant Pacific cultural support (or both) in order to ensure sensitive practice. In addition, services need to cater for the language needs of parents and grandparents when involving families. Good interpreter services, therefore, are essential. Ideally, clinicians or cultural support staff should be from the same Pacific country as the young person and family and able to speak the language. Services need to be wary of assuming that because a staff member is a Pacific person he or she will be able to address the needs of *all* Pacific peoples who present.

Alignment of Services that do and do not Address Pacific Peoples Needs

Non-alignment of services to Pacific People	Alignment of services to Pacific People
Services are acute and crisis focused	Services are wellness focused
Lack of appreciation of the holistic perspective	Services work with a holistic perspective
People have to come to the service	Services come to people in their communities
Consumer's families are marginalised	Consumer's families are included
Use of medical model – no scope for alternative diagnoses	Recognition of traditional diagnoses
Services not culturally friendly	Culturally friendly services
Emphasis on medication	Embrace traditional healing
People looking after mentally ill family members are not always supported	Support for people looking after mentally ill family members
Services are based around hospital/institutional delivery	Services focus on delivery in the community
Needs are determined according to diagnosis	Needs are determined according to the assistance that a consumer requires to live well with their mental illness

Source: Chapter 1, Table 7

A recent publication by the Mental Health Research and Development Strategy, *Pacific Models of Mental Health Service Delivery in New Zealand* (Health Research Council, 2004) documented in-depth qualitative data on a snapshot of Pacific peoples perceptions of mental health services. Three points highly relevant to Pacific child and adolescent mental health were concluded in their study: Firstly, that Pacific models of care privilege the Pacific island-born adult perspective and participants argued for the need to include 'New Zealand-born' Pacific youth issues (p. ix). Secondly, that ethnic-specific group therapy approaches, often adopt an island-born-adult emphasis that can exclude New Zealand-born youth consumers, and that more inclusive approaches need to be developed (p. x). Finally, the fact that the Pacific population is so young gives rise to the question of how to incorporate Pacific youth consumer issues in Pacific matrices of care needs to be urgently addressed by the mental health sector (p. xiii).

Resource Allocation

The Mental Health Commission (2004a, p.35) noted that while funding for Pacific community alcohol and drug services increased in 2002-2003, funding for child and youth community services decreased. They noted that:

> *"There continues to be unmet needs for services designed for Pacific children and youth in many places. This is significant as 48% of the total New Zealand Pacific population is aged under 20 years."*

Te Orau Ora: Pacific Mental Health Profile (2005) highlighted that the total annual funding of mental health services specifically for Pacific people in 2001/02 was $9.8 million and a further estimated $20.7 million allocated to mainstream mental health services for Pacific peoples. Of significance was that, of the combined $30.5 million, almost 70% was allocated to adult community services and child and youth community services accounted for

only 13%. Furthermore, the document tabled that of a total of 122 full-time (worker) equivalents contracted among 21 Pacific providers, 15.4 were allocated to child and youth (see Table 116).

Table 116. Pacific Mental Health Resources by Service Category (2001/2002)

Service Category	Beds	FTE
Mainstream Mental Health Services	15	86.7
Alcohol & Other Drug	2	16.5
Child & Youth	-	15.4
Older People	-	3.3
Total	**17**	**121.9**

Source: Te Orau Ora: Pacific Mental Health Profile (2005)

Workforce Issues

Developing the Pacific peoples' workforce has been a key theme of mental health strategy documents including the *Blueprint* (MHC, 1998). In 2000, the Health Funding Authority published *Tuutahitia te Wero, Meeting the Challenges*, a mental health workforce development plan for the years 2000-2005. Child/tamaiti and youth/rangatahi mental health as well as Pacific peoples mental health and workforce development were among the top five priorities.

The Mental Health Commission (2001b) published *The Pacific Mental Health Services and Workforce – Moving on the Blueprint* reporting a significant under-representation of Pacific peoples working in the mental health sector and detailing areas of development for Pacific mental health and workforce development. The Mental Health Commission (2004a, p.35) noted that:

> *"There is a shortage of experienced Pacific clinicians in mental health and, given the youthful New Zealand Pacific population, demand for Pacific staff will increase."*

The *Blueprint* (2001b) was based on a 1999 survey which identified 175 Pacific people working in the mental health workforce – i.e. Pacific people made up 2.5% of the mental health workforce. While the document provided occupational information on the Pacific workforce, it failed to include characteristics of the Pacific child and adolescent mental health sector.

Published documents specifically aimed at workforce issues for people involved in Pacific child and adolescent mental health are sparse. Reports from two national community consultation fono by Faleafa (2004a, 2004b) on Pacific child and adolescent mental health services workforce development commented on these issues. The reports prioritised the investment in Pacific peoples to provide for the child and adolescent mental health workforce clinical and management needs. Suggested strategies also included the establishment of a national Pacific child and adolescent mental health network, building on existing skills, increased access to specialist training, and an intersectorial approach. A further report on training, recruitment and retention strategies for Pacific Psychologists highlighted the need for cultural, financial and academic support in order to attract and retain Pacific Psychologists working in child and adolescent mental health services (Faleafa, 2004c).

Initiatives aimed at developing the Pacific mental health workforce have recently been employed. The Health Research Council administers the Pacific Mental Health Workforce Awards which were established by the Ministry of Health with a vision of enhancing the Mental Health Sector by building and developing Pacific Mental Health workforce capacity. The Clinical Training Agency is also funded to administer support packages for Pacific people enrolled in Clinical Training Agency-funded mental health programmes. More recently, the Ministry of Health has funded a series of feasibility studies exploring options to increase the Pacific mental health workforce.

8.2 Pacific Access to Child & Adolescent Mental Health Services

The following information incorporates elements of Chapter 3 of this document and should be referred to for further details and contextual information. Information on the Pacific services included in this chapter is outlined in Chapter Two.

Data from the Mental Health Information National Collection (MHINC) and population data provided by the MOH (obtained from Statistics New Zealand) were utilised to inform 'Access' information.

Access rates analysed by ethnicity showed that out of the 19,307 clients that accessed services in the year 2003, 559 (2.9%) were Pacific. Access increased with age so that the 15-19 year old clients were the largest age group of Pacific clients accessing mental health services (this age group was the largest to access across the board in all four ethnic groups).

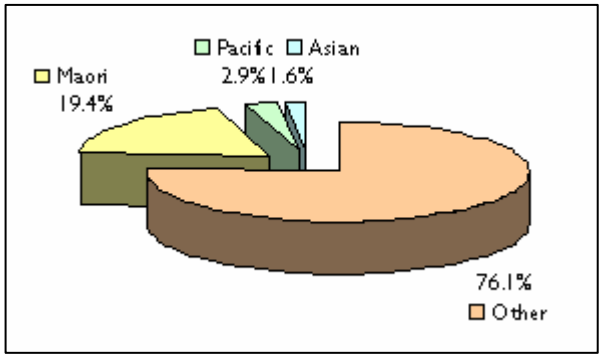
The numbers of young Pacific clients aged 0-19 years seen in mental health settings in New Zealand for the year 2003 was 559 (MHINC 2003). The total client population within this age group was 19,307 (MHINC 2003). This figure represents 2.9% of the total population under twenty years showing there has been minimal improvement in access. Table 117 shows the numbers seen within each age group.

Table 117. Numbers of Pacific Clients seen in Mental Health Settings by Age (2003)

Gender	Age Group			
	0-9	**10-14**	**15-19**	**Total**
Male	69	84	180	**333**
Female	18	50	158	**226**
Total	**87**	**134**	**338**	**559**

Data Source: MHINC 2003

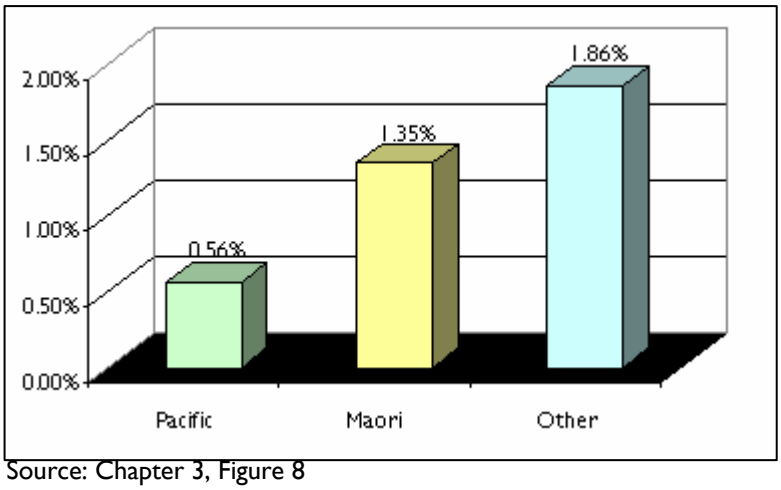
Clients Seen by Ethnic Group for Population under the Age of 20 (2003)



Source: Chapter 3, Figure 3

As a percentage of population, the Pacific access rate was 0.56% for 2003. This rate was the lowest rate by ethnicity, with the Māori rate at 1.35% and the rest of the population at 1.86%. Information on access by types of service and team types as well as referral sources are presented in Chapter Three.

Clients seen as a Percentage of Population by Ethnicity (2003)



Source: Chapter 3, Figure 8

Table 118. Pacific Access Rates (2003/2004)

	Age in years Total Population				Age (years) Pacific			
	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19
Strategic Benchmark	1.0%	3.9%	5.5%	3.0%	1.0%	3.9%	5.5%	3.0%
Access Rate first 6 months 2003	0.4%	1.4%	2.0%	1.1%	0.1%	0.3%	1.0%	0.3%
Access Rate second 6 months 2003	0.5%	1.5%	2.1%	1.2%	0.1%	0.4%	1.0%	0.4%
Access Rate first 6 months 2004	0.4%	1.3%	2.1%	1.1%	0.1%	0.3%	0.9%	0.3%

The *Blueprint* benchmarks for access for the age groups, 0-9 years, 10-14 years and 15-19 years over a six month period are as follows: 1%, 3.9% and 5.5% respectively (Mental Health Commission, 1998a). In the total population (0-19) access rates were well below benchmark targets in all age groups regardless of ethnicity (see Table 118). It is clear however that the Pacific access rate of 0.1%, 0.3%, and 0.9% (first 6 months of 2004) are by far the most significant ethnic-specific discrepancy against blueprint targets. Of further interest is that geographically, the Northern region has the largest shortfall of blueprint targets compared to other regions – where the majority of the Pacific child and youth population reside.

8.2.1 Barriers to Access for Pacific

Information on barriers to accessing child and adolescent mental health services was gathered via a survey conducted with General Practitioners and the Education Sector throughout New Zealand. The reader should refer to Chapter 5 of this document for more detailed and contextual information.

Of the 111 GPs that worked with child and adolescent mental health issues, 34% had worked with Pacific children and/or adolescents.

The main barriers for accessing child and adolescent mental health services identified by GPs and mental health workers in the education sector were: Cultural barriers/lack of culturally appropriate resources/specialists, lack of culturally appropriate services, cost, stigma, lack of knowledge of services, and lack of communication with families.

8.3 Pacific Child & Adolescent Mental Health Workforce

Data was collected from DHBs and DHB funded NGO providers. Data on ethnicity was based on head count rather than FTE (see Chapter 4 for details). The data was provided by survey respondents rather than the actual staff member therefore should be interpreted with caution.

A total of 64 Pacific staff were identified as currently working in the child and adolescent workforce as at 31 March 2004 (2005 data was provided by Auckland and Waitemata DHBs because they could not provide 2004 data). Table 119 outlines the Pacific workforce by region. Overall, the majority of the workforce lies in the Northern region, are employed by DHBs and is predominantly made up of Mental Health Support Workers, Social Workers, Mental Health Nurses, and Cultural Appointments.

Table 119. Pacific Child & Adolescent Mental Health Workforce by Region (Head Count 2004/2005)

Workforce	Northern	Midland	Central	Southern	Total
DHB Inpatient	3	-	2	-	**5**
DHB Community	22	4	2	1	**29**
NGOs	1	18	1	7	**27**
CYF Collaborative	-	-	-	-	**3**
Total	**26**	**22**	**5**	**8**	**64**

Source: Stocktake Survey Data

DHBs reported employing a total of 34 Pacific staff. Five were in Inpatient services and all of those five positions were Mental Health Nurses. The remaining 29 were working in Community services throughout the country, 22 of which were in the Northern region. The occupations of these positions were predominantly Mental Health Nurses, Social Workers and Cultural appointments.

NGOs that responded to the survey reported a total of 27 Pacific staff, 7 of which were in the Southern region. The NGO Pacific workforce mainly held Mental Health Support and Social Worker positions.

The Child, Youth and Family collaborative workforce (see Chapter Two) consisted of the High and Complex Needs Unit, Youth Horizons Trust, the Lower North Severe Conduct Disorders Programme, and Towards Wellbeing Youth Suicide Prevention Programmes. Three further Pacific staff were reported by these services.

8.3.1 The Pacific Workforce as a Proportion of the Specific Population

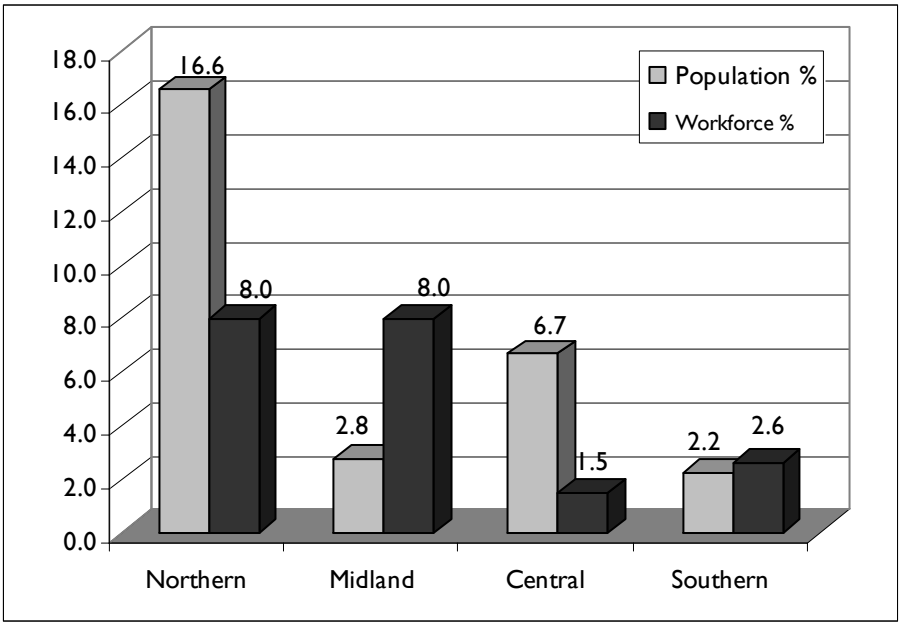
In 2004, 8.5% of the total 0-19 year population were Pacific child and adolescents while the Pacific workforce only made up 4.3% of the total child and adolescent mental health workforce (see Table 98).

Pacific Workforce as a Proportion of the Pacific 0-19 yrs Population by Region (Head Count 2004)

Region	0-19 yrs Total Population 2004	0-19 yrs Pacific Population 2004	%	Total Pacific Workforce	Total Workforce*	%
Northern	442,435	73,225	16.6	21	261	8.0
Midland	258,860	7,120	2.8	15	187	8.0
Central	226,550	15,100	6.7	3	197	1.5
Southern	262,350	5,850	2.2	8	311	2.6
Total	**1,190,195**	**101,295**	**8.5**	**47**	**956***	**4.9**

Source: Chapter 5, Table 98
*Estimated from FTE Data **Excludes Administration/Management & CYF Workforce Data
Note: Auckland Waitemata DHBs 2005 Head Count (2004 data not available)

Pacific Workforce as a Proportion to the Pacific 0-19 yrs Population by Region (Head Count 2004)



Source: Chapter 4, Figure 52

Regionally, the Pacific workforce in the Midland and the Southern regions exceeded the percentage of the Pacific child and adolescent population for the regions (see Figure 52). Of note is the significant disparity of the Pacific workforce to the percentage of the Pacific child and adolescent population in the Northern region.

As detailed in Chapter Four, an increase in DHB and NGO community clinical positions of 74% is required in order to meet benchmark figures. For Pacific, extrapolations can be made utilising *The Pacific Mental Health Services and Workforce – Moving on the Blueprint* (Mental Health Commission, 2001b) document. The document estimates that 93 Pacific child and youth community FTEs (including both mainstream and Pacific dedicated services) are required for the year 2004 to meet *Blueprint* guidelines (p.32). Given the identified 47 (head count) current Pacific workforce, this would need to double to reflect the population it serves.

8.4 Chapter Summary

- The numbers of young Pacific clients aged 0-19 years seen in mental health settings in New Zealand for the year 2003 was 559 (MHINC 2003). The total client population within this age group was 19,307 (MHINC 2003).

- Pacific access rates of 0.1%, 0.3%, and 0.9% (first 6 months of 2004) are by far the most significant ethnic-specific discrepancy against blueprint targets.

- *The Pacific Mental Health Services and Workforce – Moving on the Blueprint* (Mental Health Commission, 2001b) document estimates that 93 Pacific child and youth community FTEs (including both mainstream and Pacific dedicated services) are required for the year 2004 to meet *Blueprint* guidelines (p.32). Given the identified 47 (head count) in the current Pacific workforce, this would need to double to reflect the population it serves.

Recommendations

- Pacific workforce numbers need to increase significantly to meet Blueprint targets.
- Nationally co-ordinated strategic planning for the Pacific workforce that links workforce development and strategic planning of service delivery.
- Intersectorial linkages around Pacific workforce development.

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Appendices

Appendix 1a : MHINC Team Type Definition

Team Type Code	Team Type Description	Team Type Definition
01	Inpatient Team	Inpatient teams provide services in a medical environment such as a hospital to eligible persons who are in need of a period of close observation, intensive investigation or intervention. Note: Inpatient teams aimed at a specific client group or purpose, eg A&D, CAFS, Kaupapa Māori, should be mapped to the specific team below.
02	Community Team	Community teams provide non-residential assessment and treatment services including outpatient services. Note: Community teams aimed at a specific client group or purpose eg A&D, CAFS, Kaupapa Māori should be mapped to the specific team below.
03	Alcohol & Drug Team	Alcohol and drug teams provide assessment and treatment services to people with alcohol and other drug problems. Includes inpatient, residential or community based alcohol and drug teams. Note: Alcohol and drug Kaupapa Māori teams should be mapped to 10. Children and youth, alcohol and drug teams should be mapped to 21.
04	Child, Adolescent & Family Team	Child, adolescent and family teams provide assessment and treatment services to people aged 0-19 years inclusive. Includes inpatient, residential or community based child, adolescent and family teams. Note: Children and youth, alcohol and drug teams should be mapped to 21. Kaupapa Māori Tamariki and Rangatahi (child & youth) mental health teams should be mapped to 22.
05	Forensic Team	Forensic teams provide assessment and treatment services to alleged offenders charged with criminal offences, who have or are thought to have a psychiatric illness. Also includes individuals who are unable to be managed safely with general mental health services due to a high level of serious and persistent danger to others. Includes inpatient, residential or community based forensic teams.
06	Kaupapa Māori Team	Kaupapa Māori teams provide assessment and treatment services to people within a Māori Kaupapa. Includes inpatient, residential or Community based teams within a Māori Kaupapa (including child, adolescent and family, youth specialty and psychogeriatric services).Note: Alcohol and drug Kaupapa Māori teams should be mapped to 10. Kaupapa Māori Tamariki and Rangatahi (child & youth) mental health teams should be mapped to 22.Kaupapa Māori dual diagnosis mental health and alcohol and drug teams should be mapped to 23.
07	Pacific Island Team	Pacific Island teams provide assessment and treatment services under a Pacific model. Includes inpatient, residential or community-based teams working under a Pacific model (including alcohol & drug, child, adolescent & family, youth specialty & psychogeriatric services).
08	Residential Team	Accommodation, rehabilitation and support provided in a community residence to eligible persons with psychiatric disabilities.
09	Community Skills Enhancement Team	Community skills enhancement teams provide non-residential, activity-based services to assist people with psychiatric disabilities improve their life skills, overcome social isolation and return to optimal functioning.
10	Alcohol & Drug Kaupapa Māori Team	Alcohol and drug Kaupapa Māori teams provide assessment and treatment services within a Māori Kaupapa to people with alcohol and other drug problems. Includes inpatient, residential or community based alcohol and drug Kaupapa Māori teams. Note: Alcohol and drug Kaupapa Māori teams should be mapped to 10. Kaupapa Māori dual diagnosis mental health and alcohol and drug teams should be mapped to 23.

Appendix 1a Continued: Service Team Description

Team Type Code	Team Type Description	Team Type Definition
11	Alcohol & Drug Dual Diagnosis Team	Alcohol and drug dual diagnosis teams provide assessment and treatment services to people with coexisting problems of mental illness and alcohol and drug use. Includes inpatient, residential or community based alcohol and drug dual diagnosis teams. Note: Kaupapa Māori dual diagnosis mental health and alcohol and drug teams should be mapped to 23.
12	Intellectual Disability Dual Diagnosis Team	Intellectual disability dual diagnosis teams provide assessment and treatment services to people with coexisting problems of mental illness and intellectual disability. Includes inpatient, residential or community based intellectual disability dual diagnosis teams.
13	Psychogeriatric Team	Psychogeriatric teams provide assessment and treatment services to people aged 65 and older with some flexibility based on the nature of the presenting problems. Includes inpatient, residential or community-based psychogeriatric teams.
14	Youth Specialty Team	Youth specialty teams provide assessment and treatment services to people aged 15-19 years inclusive. Includes inpatient, residential or community-based youth specialty teams.
15	Maternal Mental Health Team	Maternal mental health teams provide assessment and treatment services to pregnant women, women in the post-partum period and their infants. Includes inpatient, residential or community-based maternal mental health teams.
16	Eating Disorder Team	Eating disorder teams provide assessment and treatment services to people with eating disorders. Includes inpatient, residential or community-based eating disorder teams
17	Needs Assessment & Service Co-ordination Team	Needs assessment and service co-ordination teams provide comprehensive assessment of needs and facilitation of ongoing provision of services and support to people with psychiatric disabilities. The assessment process meets the Standards for Needs Assessment for People with disabilities (MOH). These teams are usually community based.
18	Specialist Psychotherapy Team	Specialist psychotherapy teams provide assessment and psychotherapy treatment to people with severe psychological disorders. These teams are usually community or outpatient based.
19	Services for Profoundly Deaf Team	Services for profoundly deaf teams provide assessment, therapy and referral services for profoundly deaf people who require specialist mental health services. These teams are usually community based.
20	Refugee Team	Refugee teams provide specialist assessment, treatment and liaison services that meet the particular mental health needs of refugees. These teams are usually community based.
21	Children & Youth, Alcohol & Drug Services	Children and youth, alcohol and drug teams provide assessment and treatment services to people aged 0-19 years inclusive with alcohol and other drug problems. Includes inpatient, residential or community-based teams.
22	Kaupapa Māori Tamariki & Rangatahi (child & youth) Mental Health Services	Kaupapa Māori Tamariki and Rangatahi mental health teams provide assessment and treatment services within a Māori Kaupapa to people aged 0-19 years inclusive. Includes inpatient, residential or community-based teams.
23	Kaupapa Māori Dual Diagnosis Mental Health & Alcohol & Drug Services	Kaupapa Māori dual diagnosis mental health and alcohol and drug teams provide assessment and treatment services within a Māori Kaupapa to people with coexisting problems of mental illness and alcohol and drug use. Includes inpatient, residential or community-based teams.
99	Other	Any teams not specifically covered above.

Appendix 1b. MHINC Referral Agency Definition

Referral Agency	Referral Agency Description	Referral Agency Definition
AD	Alcohol & Drug	Alcohol and drug provider or facility
AE	Accident & Emergency	Accident and emergency department or service
CA	Child, Adolescent & Family Mental Health Services	Child, adolescent and family service
CM	Adult Community Mental Health Services	Adult community service including mobile community teams
DH	Day Hospital	Day Hospital
ED	Education Sector	Educational institution including schools, preschool, kindergarten, school guidance counsellor, special education services
GP	General Practitioner	General practitioner or medical centre, including private after-hours emergency services
JU	Justice	Justice, courts, corrections or youth justice
KM	Māori	Māori provider or facility
KP	Pacific Island	Pacific Island provider or facility
NA	Needs Assessment & Co-ordination Service	Needs assessment and co-ordination service
NP	Hospital Referral (non-psychiatric)	Hospital facility which is not psychiatric inpatient, e.g. medical ward or emergency services
NR	No further referral	
OP	Psychiatric Outpatients	Psychiatric outpatient service
OT	Other	Other service or agency not specified elsewhere
PD	Paediatrics	Paediatric setting or a paediatrician
PH	Public Health	Child or adolescent referred from or to a non-mental health community provider, e.g. public health nurse, Plunket
PI	Psychiatric Inpatient	Psychiatric inpatient service
PO	Police	Police
PP	Private Practitioner	Private practitioner, e.g. psychologist, psychiatrist, medical specialist in private practice
RE	Mental Health Residential	Mental health residential service
SE	Mental Health Community Skills Enhancement Programme	Mental health community skill enhancement programme
SR	Self or relative referral	Self, relatives, whanau, family or significant other person, or referred to relatives, whanau, family or significant other person
SW	Social Welfare	Government social welfare, e.g. CYPFA (Children, Young Persons and their Families Agency), WINZ (Work & Income New Zealand)
UN	Unknown	Not known

Appendix 1a & 1b Source: NZHIS website: http://www.nzhis.govt.nz/documentation/codetables.html

Appendix 2

Definition of Prioritised Ethnicity

"Where a service user reports one ethnicity, they are reported as Māori first, Pacific second and other ethnicity third. This means that all Māori are reported and Pacific peoples are reported if they do not also record Māori. All those who record neither Māori, Pacific nor Asian are reported as Other" (MHC, 2004a, p. 16).

Ethnic Group code	Ethnic Group code description	Priority for multiple ethnic group reporting
10	European not further defined	20
11	NZ European	21
12	Other European	19
21	NZ Māori	1
30	Pacific Island not further defined	9
31	Samoan	7
32	Cook Island Māori	6
33	Tongan	5
34	Niuean	4
35	Tokelauan	2
36	Fijian	3
37	Other Pacific Island	8
40	Asian not further defined	14
41	South East Asian	10
42	Chinese	12
43	Indian	11
44	Other Asian	13
51	Middle Eastern	17
52	Latin American / Hispanic	15
53	African	16
54	Other	18
99	Not stated	99

Source: http://www.nzhis.govt.nz/documentation/ethnicity.html

The prioritised ethnicity codes have been grouped using the following table:

Prioritised Ethnicity Code	Ethnicity code description	ethnicity grouping code	ethnicity grouping desc
30	Pacific Island not further def	1	Pacific
31	Samoan	1	Pacific
32	Cook Island Māori	1	Pacific
33	Tongan	1	Pacific
34	Niuean	1	Pacific
35	Tokelauan	1	Pacific
36	Fijian	1	Pacific
37	Other Pacific Island	1	Pacific
40	Asian not further defined	2	Asian
41	Southeast Asian	2	Asian
42	Chinese	2	Asian
43	Indian	2	Asian
44	Other Asian	2	Asian
21	Māori	3	Māori
10	European nor further defined	4	Other
11	NZ European / Pakeha	4	Other
12	Other European	4	Other
51	Middle Eastern	4	Other
52	Latin American / Hispanic	4	Other
53	African	4	Other
54	Other	4	Other
99	Not stated	4	Other

Source: http://www.nzhis.govt.nz/documentation/mhdw-dictionary/mhdw-dictionary.pdf in Appendix C

Ethnicity used in the report is the "Prioritised Ethnicity" shown on the "User table" of MH Data Warehouse. It is defined in the MH Data Warehouse data dictionary as being "The most highly prioritised ethnicity of the three ethnic groups recorded for the healthcare user, determined according to a Statistics NZ algorithm".

Note: The data dictionary also states "Prioritised ethnicity is useful for analysing overall ethnic breakdowns. However, because of the way ethnicity is weighted, care must be taken when analysing selected groups, since they may appear to be under- or over-represented."

Appendix 3

The following population tables been generated using data supplied on 01.11.04 by Jessee Kokaua, Research Analyst, Mental Health System Development, Mental Health Directorate, Ministry of Health.

MOH File Name: Ethnic population projections by DHB age gender and amalgamated nzdep 2001_26.xls. All figures are projected 2003 year.

Appendix 3a. 0-19 yrs Population by DHB

DHB	00	1-4	5-9	10-14	15-19	Grand Total
Northland	1,895	8,320	11,800	1,3215	10,545	45,775
Waitemata	6,580	26,890	34,950	37,780	35,220	141,420
Auckland	6,130	22,710	25,990	26,590	29,440	110,860
Counties Manukau	7,030	29,100	36,870	3,7650	33,730	144,380
Waikato	4,560	19,560	26,140	28,190	27,350	105,800
Lakes	1,500	6,300	8,390	8,620	7,620	32,430
Bay of Plenty	2,640	11,150	15,080	16,510	13,770	59,150
Tairawhiti	690	3,060	3,955	4,255	3,550	15,510
Hawke's Bay	1,290	5,620	7,730	8,860	8,190	31,690
Taranaki	1,960	8,560	11,650	12,770	11,030	45,970
MidCentral	2,050	8,770	11,610	12,960	14,000	49,390
Whanganui	825	3,615	4,860	5,455	4,990	19,745
Capital & Coast	3,490	14,570	17,430	18,180	18,650	72,320
Hutt	1,880	8,230	10,530	11,210	10,200	42,050
Wairarapa	470	2,065	2,845	3,215	2,760	11,355
Nelson Marlborough	1,450	6,510	8,935	10,340	9,305	36,540
West Coast	330	1,500	2,105	2,575	2,065	8,575
Canterbury	5,270	22,770	29,630	31,890	34,400	123,960
South Canterbury	560	2500	3,605	4,145	3,575	14,385
Otago	1,830	7,850	10,450	11,950	16,530	48,610
Southland	1,270	5,695	7,410	8,185	7,720	30,280
Grand Total	**53,700**	**225,345**	**291,965**	**314,545**	**304,640**	**1,190,195**

Appendix 3b

Total 0-19 yrs Population by Ethnicity, Age Groups & Gender Projected 2003 (2001 Base)

	Māori						Other						Pacific						Grand Total
Gender	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	
Female	7130	28700	35210	34580	29520	135140	16940	70610	94390	105110	105440	392490	2440	10580	12825	12545	10405	48795	576425
Male	7500	30520	37470	36200	29630	141320	17700	73950	100020	110960	110760	413390	2580	11050	13410	13290	10835	51165	605875
Grand Total	**14630**	**59220**	**72680**	**70780**	**59150**	**276460**	**34640**	**144560**	**194410**	**216070**	**216200**	**805880**	**5020**	**21630**	**26235**	**25835**	**21240**	**99960**	**1182300**

Appendix 3c

Northern Region: 0-19 yrs Population by Ethnicity, Age Groups & Gender Projected 2003 (2001 Base)

	Māori						Other						Pacific						Grand Total
DHB	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	
Northland	**1040**	**4310**	**5850**	**6070**	**4900**	**22170**	**880**	**3990**	**5940**	**6990**	**5120**	**22920**	**25**	**145**	**245**	**185**	**220**	**820**	**45910**
Female	510	2030	2890	2860	2430	10720	430	1990	2880	3410	2300	11010	10	70	120	95	105	400	22130
Male	530	2280	2960	3210	2470	11450	450	2000	3060	3580	2820	11910	15	75	125	90	115	420	23780
Waitemata	**1190**	**4650**	**5600**	**5230**	**4340**	**21010**	**4580**	**18830**	**25460**	**28280**	**26990**	**104140**	**760**	**3100**	**3570**	**3510**	**2690**	**13630**	**138780**
Female	580	2270	2730	2570	2160	10310	2240	9280	12420	13820	13110	50870	370	1510	1730	1760	1320	6690	67870
Male	610	2380	2870	2660	2180	10700	2340	9550	13040	14460	13880	53270	390	1590	1840	1750	1370	6940	70910
Auckland	**820**	**3060**	**3270**	**3160**	**2800**	**13110**	**4130**	**14540**	**16940**	**17770**	**20900**	**74280**	**1090**	**4520**	**5390**	**5340**	**4460**	**20800**	**108190**
Female	400	1440	1590	1590	1420	6440	2010	7120	8170	8610	10310	36220	530	2240	2680	2530	2200	10180	52840
Male	420	1620	1680	1570	1380	6670	2120	7420	8770	9160	10590	38060	560	2280	2710	2810	2260	10620	55350
Counties Manukau	**1990**	**7820**	**9040**	**8560**	**6740**	**34150**	**3240**	**12700**	**17680**	**18880**	**18170**	**70670**	**1830**	**8090**	**9760**	**9520**	**7530**	**36730**	**141550**
Female	970	3840	4420	4240	3380	16850	1590	6190	8520	9090	8770	34160	890	3940	4760	4620	3680	17890	68900
Male	1020	3980	4620	4320	3360	17300	1650	6510	9160	9790	9400	36510	940	4150	5000	4900	3850	18840	72650
Grand Total	**5040**	**19840**	**23760**	**23020**	**18780**	**90440**	**12830**	**50060**	**66020**	**71920**	**71180**	**272010**	**3705**	**15855**	**18965**	**18555**	**14900**	**71980**	**434430**

Appendix 3d

Midland Region: 0-19 yrs Population by Ethnicity, Age Groups & Gender Projected 2003 (2001 Base)

	Māori						Other						Pacific						
DHB	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**Grand Total**
Waikato	**1750**	**7220**	**8820**	**8630**	**7280**	**33700**	**2770**	**12010**	**16640**	**18770**	**18590**	**68780**	**130**	**600**	**840**	**840**	**730**	**3140**	**105620**
Female	850	3430	4210	4220	3720	16430	1360	5970	8020	9260	8930	33540	60	280	390	400	360	1490	51460
Male	900	3790	4610	4410	3560	17270	1410	6040	8620	9510	9660	35240	70	320	450	440	370	1650	54160
Lakes	**810**	**3300**	**4230**	**4010**	**3460**	**15810**	**690**	**2920**	**4000**	**4420**	**3810**	**15840**	**40**	**170**	**250**	**210**	**220**	**890**	**32540**
Female	390	1620	2040	1960	1690	7700	340	1430	2000	2110	1930	7810	20	90	120	110	110	450	15960
Male	420	1680	2190	2050	1770	8110	350	1490	2000	2310	1880	8030	20	80	130	100	110	440	16580
Bay of Plenty	**1130**	**4770**	**6150**	**6020**	**4790**	**22860**	**1470**	**6180**	**8670**	**9990**	**8280**	**34590**	**40**	**190**	**250**	**250**	**170**	**900**	**58350**
Female	550	2340	2940	2910	2350	11090	720	2970	4200	4880	3970	16740	20	90	130	130	70	440	28270
Male	580	2430	3210	3110	2440	11770	750	3210	4470	5110	4310	17850	20	100	120	120	100	460	30080
Tairawhiti	**470**	**2030**	**2530**	**2630**	**2100**	**9760**	**230**	**1020**	**1430**	**1650**	**1410**	**5740**	**10**	**65**	**85**	**65**	**50**	**275**	**15775**
Female	230	980	1230	1280	1080	4800	110	480	690	770	660	2710	5	30	45	30	25	135	7645
Male	240	1050	1300	1350	1020	4960	120	540	740	880	750	3030	5	35	40	35	25	140	8130
Taranaki	**870**	**3550**	**4540**	**4400**	**3840**	**17200**	**1060**	**4700**	**6820**	**7940**	**6620**	**27140**	**100**	**400**	**500**	**480**	**380**	**1860**	**46200**
Female	420	1730	2130	2210	1870	8360	520	2270	3280	3870	3170	13110	50	190	240	220	160	860	22330
Male	450	1820	2410	2190	1970	8840	540	2430	3540	4070	3450	14030	50	210	260	260	220	1000	23870
Grand Total	**5030**	**20870**	**26270**	**25690**	**21470**	**99330**	**6220**	**26830**	**37560**	**42770**	**38710**	**152090**	**320**	**1425**	**1925**	**1845**	**1550**	**7065**	**258485**

Appendix 3e

Central Region: 0-19 yrs Population by Ethnicity, Age Groups & Gender Projected 2003 (2001 Base)

	Māori						Other						Pacific						Grand Total
DHB	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	
Hawke's Bay	**380**	**1600**	**2010**	**2080**	**1800**	**7870**	**940**	**4110**	**5870**	**6820**	**6210**	**23950**	**20**	**60**	**65**	**90**	**90**	**325**	**32145**
Female	190	770	980	1000	850	3790	460	1980	2850	3330	3010	11630	10	30	35	50	40	165	15585
Male	190	830	1030	1080	950	4080	480	2130	3020	3490	3200	12320	10	30	30	40	50	160	16560
MidCentral	**640**	**2650**	**3380**	**3240**	**2760**	**12670**	**1370**	**5810**	**8040**	**9400**	**10420**	**35040**	**80**	**340**	**410**	**390**	**320**	**1540**	**49250**
Female	310	1300	1620	1640	1340	6210	670	2880	3930	4570	5160	17210	40	170	200	190	160	760	24180
Male	330	1350	1760	1600	1420	6460	700	2930	4110	4830	5260	17830	40	170	210	200	160	780	25070
Whanganui	**370**	**1520**	**1970**	**1970**	**1520**	**7350**	**470**	**2090**	**2960**	**3530**	**3290**	**12340**	**5**	**70**	**105**	**110**	**80**	**370**	**20060**
Female	180	730	970	940	760	3580	230	1020	1400	1690	1590	5930	5	35	45	60	40	185	9695
Male	190	790	1000	1030	760	3770	240	1070	1560	1840	1700	6410	0	35	60	50	40	185	10365
Capital & Coast	**680**	**2700**	**3090**	**2930**	**2470**	**11870**	**2450**	**10110**	**12120**	**12850**	**13850**	**51380**	**410**	**1820**	**2200**	**2160**	**1860**	**8450**	**71700**
Female	330	1320	1470	1440	1240	5800	1200	4950	5940	6310	7010	25410	200	910	1070	1050	930	4160	35370
Male	350	1380	1620	1490	1230	6070	1250	5160	6180	6540	6840	25970	210	910	1130	1110	930	4290	36330
Hutt	**570**	**2330**	**2640**	**2520**	**2020**	**10080**	**1170**	**5190**	**6930**	**7700**	**7020**	**28010**	**190**	**840**	**1090**	**1050**	**940**	**4110**	**42200**
Female	280	1150	1260	1230	1010	4930	570	2520	3360	3760	3290	13500	90	400	520	500	460	1970	20400
Male	290	1180	1380	1290	1010	5150	600	2670	3570	3940	3730	14510	100	440	570	550	480	2140	21800
Wairarapa	**140**	**590**	**800**	**780**	**630**	**2940**	**330**	**1450**	**2050**	**2450**	**1960**	**8240**	**10**	**60**	**70**	**80**	**80**	**300**	**11480**
Female	70	280	390	380	330	1450	160	720	1020	1260	910	4070	5	30	30	30	30	125	5645
Male	70	310	410	400	300	1490	170	730	1030	1190	1050	4170	5	30	40	50	50	175	5835
Grand Total	**2780**	**11390**	**13890**	**13520**	**11200**	**52780**	**6730**	**28760**	**37970**	**42750**	**42750**	**158960**	**715**	**3190**	**3940**	**3880**	**3370**	**15095**	**226835**

Appendix 3f

Southern Region: 0-19 yrs Population by Ethnicity, Age Groups & Gender Projected 2003 (2001 Base)

	Māori						Other						Pacific						Grand Total
DHB	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	**00**	**1-4**	**5-9**	**10-14**	**15-19**	**Total**	
Nelson Marlborough	**270**	**1130**	**1420**	**1400**	**1090**	**5310**	**1190**	**5310**	**7480**	**8710**	**7860**	**30550**	**20**	**95**	**125**	**140**	**105**	**485**	**36345**
Female	130	530	680	670	570	2580	580	2540	3590	4210	3770	14690	10	50	60	65	55	240	17510
Male	140	600	740	730	520	2730	610	2770	3890	4500	4090	15860	10	45	65	75	50	245	18835
West Coast	**60**	**270**	**360**	**400**	**290**	**1380**	**290**	**1260**	**1860**	**2140**	**1730**	**7280**	**0**	**10**	**15**	**15**	**20**	**60**	**8720**
Female	30	140	180	180	130	660	140	620	940	1040	830	3570	0	5	10	10	10	35	4265
Male	30	130	180	220	160	720	150	640	920	1100	900	3710	0	5	5	5	10	25	4455
Canterbury	**820**	**3250**	**3920**	**3690**	**3220**	**14900**	**4380**	**18830**	**24980**	**26850**	**29810**	**104850**	**170**	**710**	**880**	**940**	**840**	**3540**	**123290**
Female	400	1610	1980	1830	1640	7460	2140	9150	12240	13010	14670	51210	80	340	450	460	430	1760	60430
Male	420	1640	1940	1860	1580	7440	2240	9680	12740	13840	15140	53640	90	370	430	480	410	1780	62860
South Canterbury	**80**	**310**	**400**	**380**	**360**	**1530**	**490**	**2230**	**3240**	**3780**	**3170**	**12910**	**10**	**25**	**35**	**35**	**40**	**145**	**14585**
Female	40	160	190	180	190	760	240	1080	1550	1850	1520	6240	5	15	15	20	15	70	7070
Male	40	150	210	200	170	770	250	1150	1690	1930	1650	6670	5	10	20	15	25	75	7515
Otago	**260**	**980**	**1220**	**1260**	**1400**	**5120**	**1530**	**6760**	**9260**	**10450**	**14770**	**42770**	**60**	**230**	**260**	**300**	**270**	**1120**	**49010**
Female	130	470	620	580	700	2500	750	3260	4450	5000	7560	21020	30	110	130	150	130	550	24070
Male	130	510	600	680	700	2620	780	3500	4810	5450	7210	21750	30	120	130	150	140	570	24940
Southland	**290**	**1180**	**1440**	**1420**	**1340**	**5670**	**980**	**4520**	**6040**	**6700**	**6220**	**24460**	**20**	**90**	**90**	**125**	**145**	**470**	**30600**
Female	140	560	690	670	660	2720	480	2190	2940	3260	2970	11840	10	45	45	65	75	240	14800
Male	150	620	750	750	680	2950	500	2330	3100	3440	3250	12620	10	45	45	60	70	230	15800
Grand Total	**1780**	**7120**	**8760**	**8550**	**7700**	**33910**	**8860**	**38910**	**52860**	**58630**	**63560**	**222820**	**280**	**1160**	**1405**	**1555**	**1420**	**5820**	**262550**

	Appendix 3g: Population Projections Total 0-19 Years by DHB & Region (2001 Base)												
	DHB	**2001**	**2003**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2016**	**2021**	**2026**
011	Northland	46,090	45,910	45,385	44,965	44,500	43,920	43,330	42,570	41,865	38,985	37,480	36,695
021	Waitemata	132,870	138,780	142,860	143,940	145,100	145,810	146,480	146,750	146,500	148,560	152,470	157,360
022	Auckland	102,160	108,190	112,430	113,430	114,330	115,120	115,550	116,050	116,310	119,660	123,400	126,520
023	Counties Manukau	134,770	141,550	145,890	147,050	148,300	149,020	149,580	149,810	149,950	151,060	153,490	157,860
	Northern Region	**415,890**	**434,430**	**446,565**	**449,385**	**452,230**	**453,870**	**454,940**	**455,180**	**454,625**	**458,265**	**466,840**	**478,435**
031	Waikato	104,550	105,620	105,480	104,780	104,090	103,290	102,300	101,040	99,850	95,130	92,450	91,970
042	Lakes	32,330	32,540	32,260	32,050	31,700	31,400	31,040	30,620	30,230	28,290	27,030	26,400
047	Bay of Plenty	56,285	58,350	59,400	59,580	59,720	59,740	59,640	59,440	59,110	58,740	59,350	60,690
051	Tairawhiti	15,945	15,775	15,380	15,210	14,960	14,715	14,405	14,075	13,765	12,415	11,395	10,740
071	Taranaki	46,380	46,200	45,640	45,340	44,730	44,020	43,330	42,490	41,650	38,050	35,470	33,880
	Midland Region	**255,490**	**258,485**	**258,160**	**256,960**	**255,200**	**253,165**	**250,715**	**247,665**	**244,605**	**232,625**	**225,695**	**223,680**
061	Hawke's Bay	32,480	32,145	31,200	30,720	30,125	29,310	28,585	27,805	27,030	23,940	21,860	20,225
081	MidCentral	48,450	49,250	49,290	48,990	48,520	47,880	47,250	46,440	45,710	42,860	41,440	41,110
082	Whanganui	20,485	20,060	19,490	19,135	18,715	18,255	17,750	17,260	16,765	14,855	13,555	12,660
091	Capital & Coast	69,850	71,700	72,460	72,550	72,420	72,030	71,680	71,020	70,340	67,670	65,380	64,590
092	Hutt	42,150	42,200	42,000	41,710	41,360	40,790	40,130	39,410	38,610	35,390	32,720	31,210
093	Wairarapa	11,650	11,480	11,185	11,030	10,850	10,685	10,390	10,110	9,875	8,885	8,235	7,700
	Central Region	**225,065**	**226,835**	**225,625**	**224,135**	**221,990**	**218,950**	**215,785**	**212,045**	**208,330**	**193,600**	**183,190**	**177,495**
101	Nelson Marlborough	35,310	36,345	36,525	36,390	36,095	35,795	35,405	34,930	34,400	32,510	31,355	30,840
111	West Coast	8,805	8,720	8,425	8,245	8,035	7,855	7,670	7,430	7,165	6,050	5,510	5,180
120	Canterbury	119,840	123,290	124,040	123,710	123,110	122,380	121,600	120,350	119,110	113,980	110,250	108,890
123	South Canterbury	14,665	14,585	14,245	14,065	13,810	13,540	13,225	12,910	12,550	11,145	10,240	9,665
131	Otago	48,850	49,010	47,960	47,280	46,530	45,710	44,950	44,190	43,350	40,310	38,660	37,800
141	Southland	30,800	30,600	29,880	29,435	28,960	28,335	27,750	27,085	26,440	23,685	21,505	19,930
	Southern Region	**258,270**	**262,550**	**261,075**	**259,125**	**256,540**	**253,615**	**250,600**	**246,895**	**243,015**	**227,680**	**217,520**	**212,305**
	TOTAL	**1,154,715**	**1,182,300**	**1,191,425**	**1,189,605**	**1,185,960**	**1,179,600**	**1,172,040**	**1,161,785**	**1,150,575**	**1,112,170**	**1,093,245**	**1,091,915**

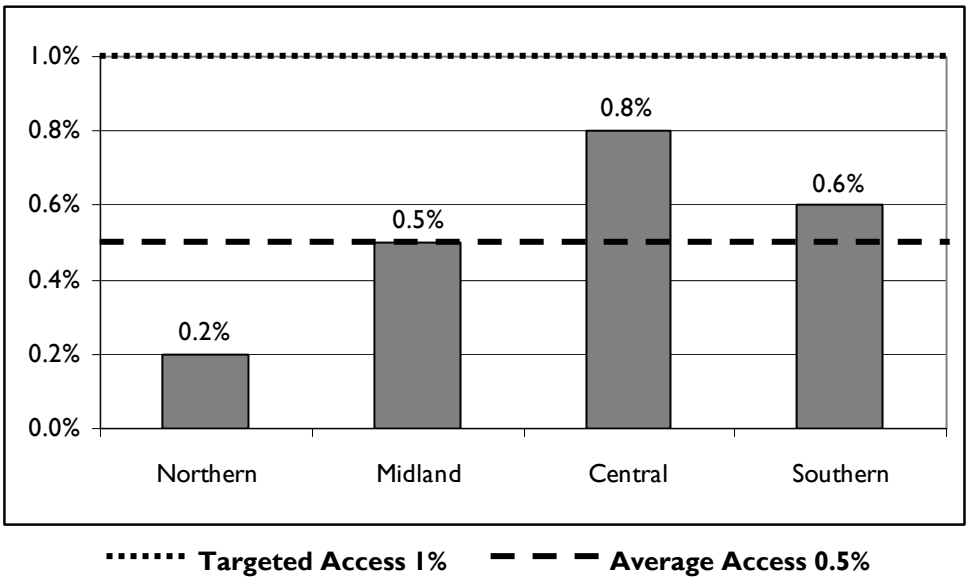
	Appendix 3h: Population Projections 0-19 Years by DHB & Region for Māori (2001 Base)												
	DHB	**2001**	**2003**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2016**	**2021**	**2026**
011	Northland	21,880	22,170	22,110	22,030	21,890	21,710	21,570	21,310	21,180	20,930	21,530	22,610
021	Waitemata	20,400	21,010	21,560	21,800	22,050	22,210	22,380	22,470	22,560	23,270	24,280	25,660
022	Auckland	12,970	13,110	13,340	13,420	13,490	13,500	13,460	13,470	13,400	13,290	13,110	12,820
023	Counties Manukau	33,010	34,150	35,190	35,700	36,120	36,420	36,670	36,870	37,030	38,250	39,960	42,090
	Northern Region	**88,260**	**90,440**	**92,200**	**92,950**	**93,550**	**93,840**	**94,080**	**94,120**	**94,170**	**95,740**	**98,880**	**103,180**
031	Waikato	33,400	33,700	34,040	34,100	34,080	34,140	34,110	33,980	33,930	34,170	34,630	35,850
042	Lakes	15,570	15,810	15,900	15,940	15,880	15,860	15,840	15,750	15,710	15,550	15,650	16,050
047	Bay of Plenty	22,080	22,860	23,310	23,550	23,710	23,800	23,870	23,940	23,990	24,550	25,660	27,400
051	Tairawhiti	9,650	9,760	9,700	9,700	9,610	9,550	9,450	9,350	9,250	8,930	8,790	8,910
071	Taranaki	16,970	17,200	17,200	17,260	17,150	17,110	17,060	17,010	16,950	16,810	17,010	17,550
	Midland Region	**97,670**	**99,330**	**100,150**	**100,550**	**100,430**	**100,460**	**100,330**	**100,030**	**99,830**	**100,010**	**101,740**	**105,760**
061	Hawke's Bay	7,780	7,870	7,810	7,800	7,760	7,670	7,600	7,480	7,450	7,370	7,480	7,760
081	MidCentral	12,520	12,670	12,790	12,810	12,810	12,820	12,810	12,750	12,710	12,740	12,960	13,590
082	Whanganui	7,310	7,350	7,360	7,330	7,270	7,260	7,160	7,120	7,020	6,820	6,730	6,790
091	Capital & Coast	11,690	11,870	12,110	12,230	12,260	12,270	12,320	12,280	12,280	12,400	12,510	12,780
092	Hutt	9,850	10,080	10,310	10,400	10,490	10,550	10,550	10,540	10,540	10,680	10,650	10,870
093	Wairarapa	2,920	2,940	2,950	2,930	2,930	2,920	2,870	2,850	2,850	2,820	2,910	3,080
	Central Region	**52,070**	**52,780**	**53,330**	**53,500**	**53,520**	**53,490**	**53,310**	**53,020**	**52,850**	**52,830**	**53,240**	**54,870**
101	Nelson Marlborough	5,190	5,310	5,390	5,430	5,460	5,490	5,500	5,510	5,490	5,540	5,690	6,010
111	West Coast	1,360	1,380	1,350	1,320	1,300	1,310	1,290	1,260	1,210	1,110	1,100	1,160
120	Canterbury	14,500	14,900	15,310	15,480	15,630	15,710	15,850	15,860	15,930	16,500	17,000	17,740
123	South Canterbury	1,500	1,530	1,530	1,520	1,500	1,490	1,500	1,490	1,490	1,490	1,510	1,570
131	Otago	5,140	5,120	5,200	5,230	5,260	5,240	5,270	5,250	5,240	5,440	5,680	5,900
141	Southland	5,610	5,670	5,650	5,590	5,570	5,540	5,520	5,540	5,510	5,580	5,710	5,910
	Southern Region	**33,300**	**33,910**	**34,430**	**34,570**	**34,720**	**34,780**	**34,930**	**34,910**	**34,870**	**35,660**	**36,690**	**38,290**
	TOTAL	**271,300**	**276,460**	**280,110**	**281,570**	**282,220**	**282,570**	**282,650**	**282,080**	**281,720**	**284,240**	**290,550**	**302,100**

Appendix 3i: Population Projections 0-19 Years by DHB & Region for Pacific (2001 Base)													
	DHB	**2001**	**2003**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2016**	**2021**	**2026**
011	Northland	850	820	775	745	710	690	690	680	675	545	470	36,695
021	Waitemata	12,820	13,630	14,470	14,920	15,290	15,610	15,880	16,120	16,290	17,610	18,950	157,360
022	Auckland	20,370	20,800	21,100	21,190	21,240	21,180	21,010	20,870	20,660	20,040	19,660	126,520
023	Counties Manukau	35,280	36,730	38,020	38,620	39,150	39,500	39,820	40,020	40,150	41,280	42,690	157,860
	Northern Region	**69,320**	**71,980**	**74,365**	**75,475**	**76,390**	**76,980**	**77,400**	**77,690**	**77,775**	**79,475**	**81,770**	**478,435**
031	Waikato	3,150	3,140	3,120	3,120	3,120	3,110	3,090	3,050	3,040	2,920	2,840	91,970
042	Lakes	940	890	860	840	810	800	790	760	750	650	570	26,400
047	Bay of Plenty	855	900	950	970	990	1,010	1,020	1,020	1,020	1,110	1,160	60,690
051	Tairawhiti	275	275	300	290	310	315	325	315	315	315	315	10,740
071	Taranaki	1,790	1,860	1,930	1,980	2,010	2,000	2,030	2,030	2,050	2,140	2,220	33,880
	Midland Region	**7,010**	**7,065**	**7,160**	**7,200**	**7,240**	**7,235**	**7,255**	**7,175**	**7,175**	**7,135**	**7,105**	**223,680**
061	Hawke's Bay	330	325	310	310	305	300	275	275	270	280	290	20,225
081	MidCentral	1,520	1,540	1,580	1,600	1,620	1,630	1,630	1,620	1,650	1,690	1,740	41,110
082	Whanganui	375	370	380	375	375	365	360	350	345	325	305	12,660
091	Capital & Coast	8,490	8,450	8,380	8,350	8,360	8,300	8,220	8,120	8,040	7,730	7,300	64,590
092	Hutt	4,090	4,110	4,130	4,150	4,170	4,170	4,170	4,160	4,150	4,120	4,090	31,210
093	Wairarapa	300	300	295	290	280	285	280	270	275	275	275	7,700
	Central Region	**15,105**	**15,095**	**15,075**	**15,075**	**15,110**	**15,050**	**14,935**	**14,795**	**14,730**	**14,420**	**14,000**	**177,495**
101	Nelson Marlborough	480	485	495	500	505	525	515	520	530	540	565	30,840
111	West Coast	65	60	65	55	45	55	50	50	45	40	40	5,180
120	Canterbury	3,470	3,540	3,620	3,610	3,640	3,670	3,670	3,690	3,690	3,780	3,960	108,890
123	South Canterbury	135	145	135	135	140	130	125	120	120	125	120	9,665
131	Otago	1,110	1,120	1,150	1,170	1,190	1,200	1,200	1,220	1,220	1,260	1,330	37,800
141	Southland	490	470	450	435	430	415	410	395	390	365	365	19,930
	Southern Region	**5,750**	**5,820**	**5,915**	**5,905**	**5,950**	**5,995**	**5,970**	**5,995**	**5,995**	**6,110**	**6,380**	**212,305**
	TOTAL	**97,185**	**99,960**	**102,515**	**103,655**	**104,690**	**105,260**	**105,560**	**105,655**	**105,675**	**107,140**	**109,255**	**1,091,915**

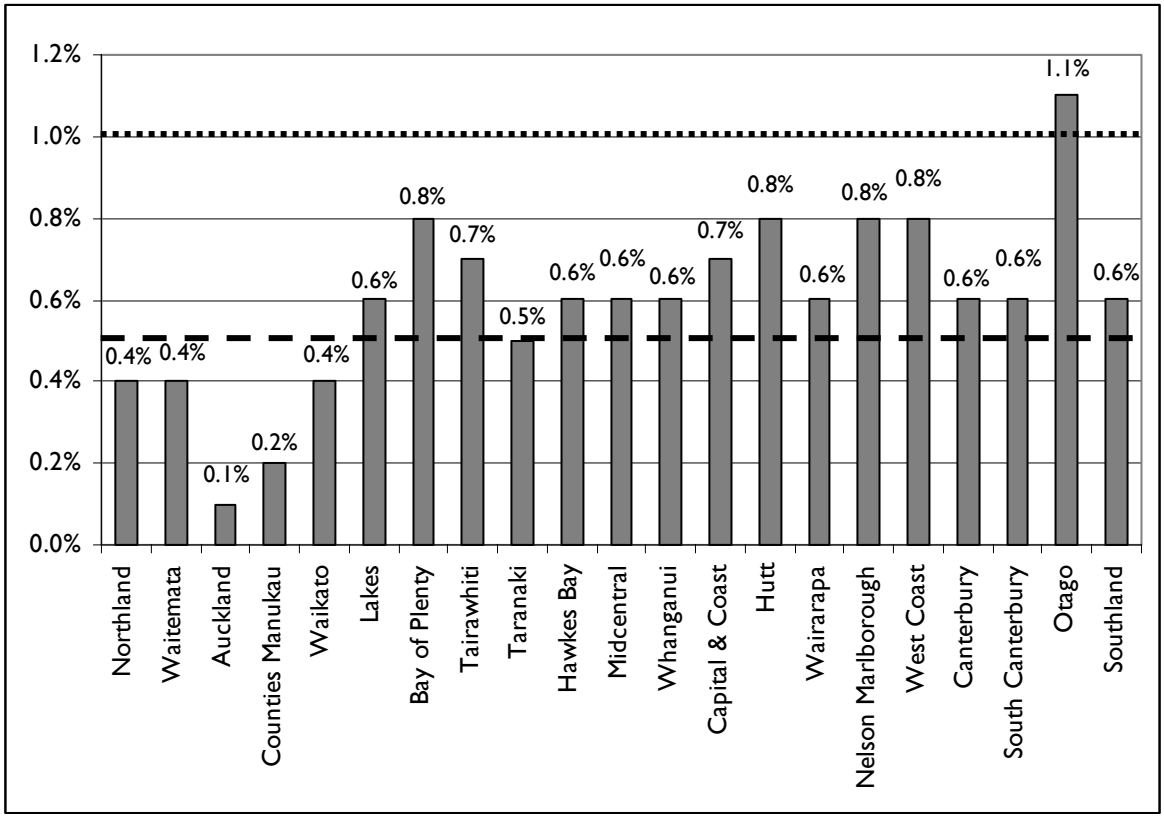
Appendix 4

Regional and DHB Access Rates in 2003 (Second Six Months)

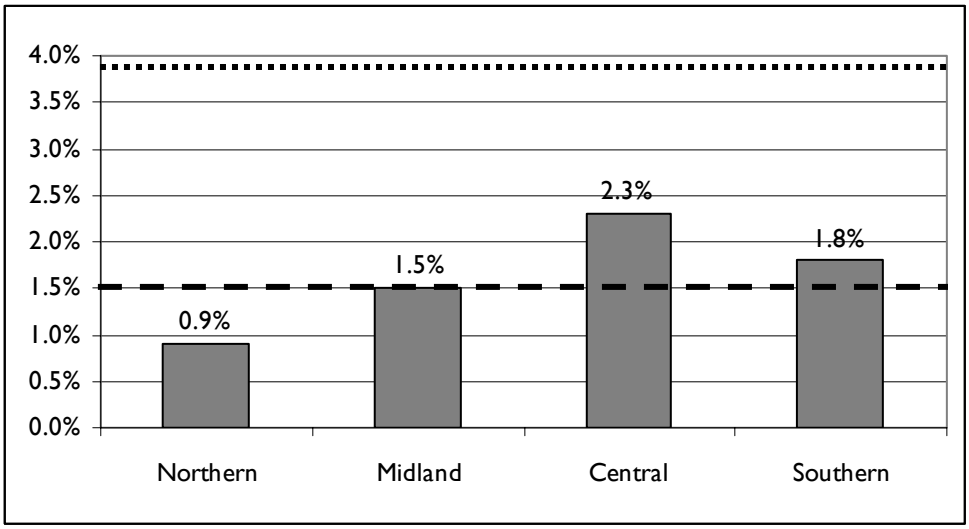
Access Rates by Region of Domicile for 0-9 yrs (2nd 6 Months of 2003)



Access Rates by DHB of Domicile for 0-9 yrs (2nd 6 Months of 2003)

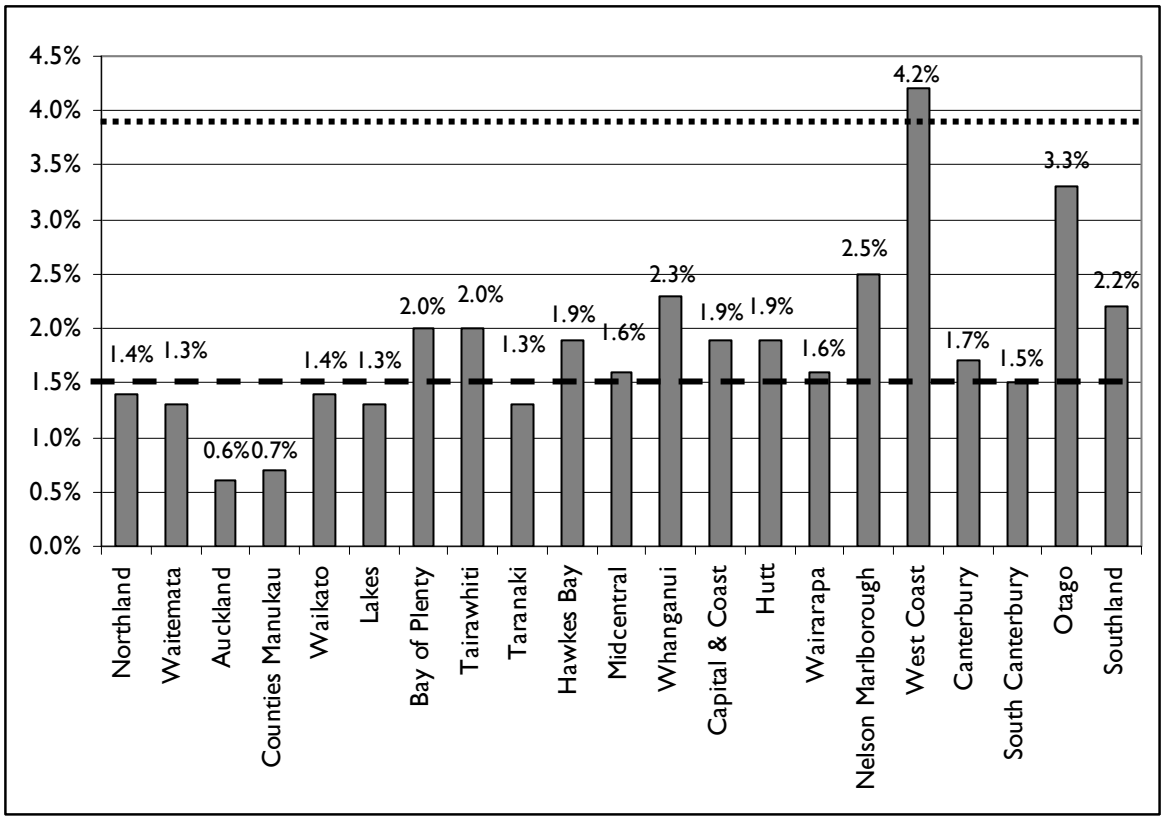


Access Rates by Region of Domicile for 10-14 yrs (2nd 6 Months of 2003)

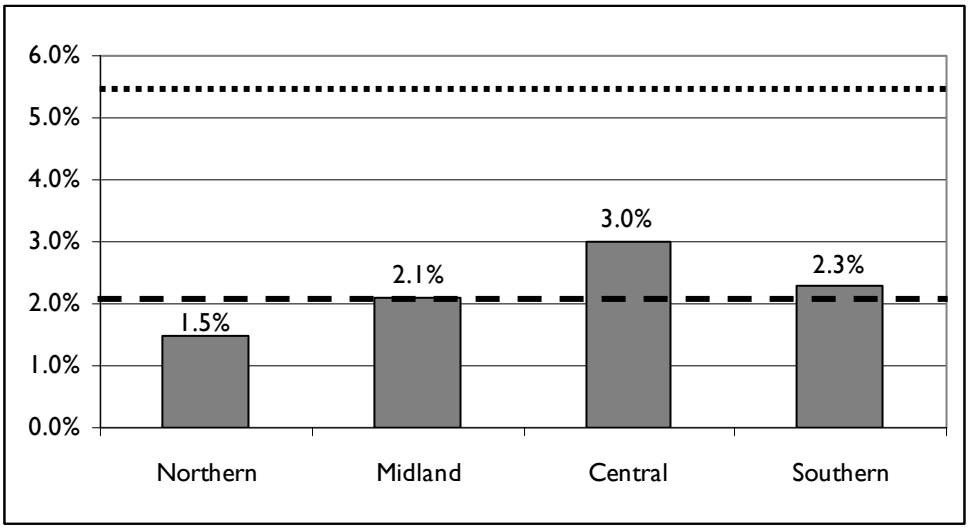


Targeted Access 3.9% — Average Access 1.5%

Access Rates by DHB of Domicile for 10-14 yrs (2nd 6 Months of 2003)

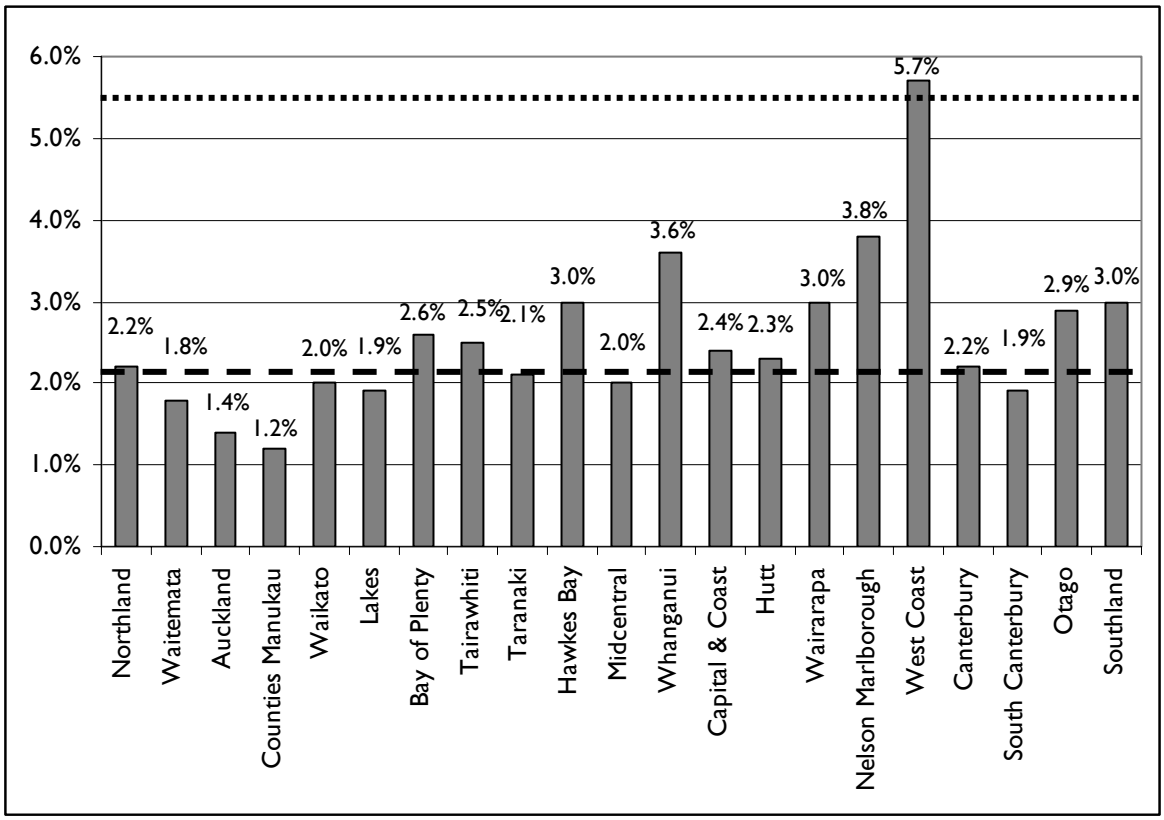


Access Rates by Region of Domicile for 15-19 yrs (2nd 6 Months of 2003)



Targeted Access 5.5% **Average Access 2.1%**

Access Rates by DHB of Domicile for 15-19 yrs (2nd 6 Months of 2003)



Appendix 5

The document, *The New Zealand Health Workforce: A Stocktake of Issues and Capacity 2001* (p. 115) produced by the Health Workforce Advisory Committee provided the following definitions for the mental health occupational groups used in the Stocktake report.

Occupational Group	Definition
Alcohol & Drug Workers	Identify, assess and plan appropriate interventions for drug and alcohol problems. They work therapeutically with individuals, groups (including family and whine), wider communities and significant networks to reduce harm associated with drug and alcohol abuse. They also assist other health and social service workers to deal effectively with those who are experiencing problems relating to alcohol and drug use. Some mental health workers and drug and alcohol workers special in 'dual diagnosis' and deliver services to people who have both a mental illness and problems with drugs or alcohol.
Counsellors	Help people deal with their feelings and responses, assist their clients to decide on actions they can take to solve problems. They may specialise in relationship counselling, grief and loss, drug addiction or family problems. Counsellors are mainly based in the private sector rather than being employed by mental health services or primary health care service organisations. However, mental health clients occasionally receive public funding via ACC or the social welfare system for counselling services. Counsellors come from a wide range of training backgrounds and they provide services mainly public sector organisations, including education, justice and health.
Clinical Psychologists	Clinical Psychologists who have undertaken training in a professional training programme have the skills to deliver the following skills: • Psychological assessment & formulation • interventions with complex problems • Psychological testing • Diagnosis of mental disorder • Training, support and supervision • Design, implementation and evaluation of evidence-based interventions • Development and evaluation of new methods and approaches • Applied research • Development of health policy At an individual and client level, clinical psychologists assess behaviour and mental health problems. They assess the current emotional and lifestyle problems of clients, their social and family histories, and examine hoe feelings, actions, beliefs and culture interact to shape the person's experience and difficulties. The interview and observe clients, including children, adults, couples, families and communities. Clinical psychologists give psychometric and neuropsychological tests to identify problems and to measure clients' skills and abilities. They develop and implement individual treatment plans or group therapy treatment plans (for some problems) to address clients' psychological difficulties.
Mental Health Consumer Workers & Family Workers	The current group mainly consists of people who were previously working in a voluntary role as service user advocates, and in some cases family advocates, or as part of a collective offering peer support options for mental health service users. There has been increasing recognition that consumer workers and better family liaison are essential in maintaining an effective service, and there is evidence that peer support activities improve the outcomes for service users. Consumer workers and a smaller number of family workers are employed in a number of different capacities within DHB and non-government mental health service providers. In many cases, consumer workers are part of the service management team and responsible for ensuring a service-user perspective is employed in service management processes.
Mental Health Support Workers	Mental health support workers are widely employed throughout the country in mainstream mental health, Kaupapa Māori, general rehabilitation. Home-based and mobile community support services. The mental health support workforce is mainly employed in the non-government support services sector. These workers provide support and deliver rehabilitation services or programmes that facilitate the recovery process for people experiencing serious mental or emotional distress. There is a growing need for this

	community-based workforce to work with people and family/whanau in their regular life activities (work, housing, learning, relationships and health).
Occupational Therapists (p. 138)	Occupational therapists may work with people to: • Assist them to learn new ways of doing things (e.g. dress or cook) • Adapt the material or equipment they use (e.g. recommend wheelchairs or provide special bath or toilet seats) • Make changes to the environment where they do their usual occupations (e.g. change layout of their home or office) • Develop new skills, abilities or interests (e.g. job-readiness programmes) • Access support available in their community Occupational therapists help to identify which activities are difficult for people, because of factors affecting: • Physical abilities (e.g. strength and co-ordination) • Mental abilities (e.g. memory or organisational skills Occupational therapists work in hospitals, private clinics, nursing homes, schools, prisons, long term care institutions, rehabilitation centres and at people's workplaces. They also work in community mental health teams, at marae and in people's homes.
Psychiatrists	Psychiatry is a branch of medicine specialising in the prevention and treatment of mental disorder, and the promotion of mental health in the community. By virtue of their specialist training, psychiatrists bring a comprehensive and integrated bio-psychosocial approach to the diagnosis, assessment, treatment and prevention of psychiatric disorder for people with emotional, behavioural and cognitive mental health problems. Psychiatrists work with clients and their families, and primary health care practitioners, to work out the best options for managing recovery and minimising distress. They prescribe and administer medication, psychotherapy and other treatment and rehabilitation programmes, and many psychiatrists have responsibilities under the Mental Health (Compulsory Assessment and Treatment) Act 1992.
Psychotherapists	Psychotherapists use particular therapeutic disciplines and attitudes of inquiry to help people in mental or emotional distress. Psychotherapy's concern in the broadest sense is assisting individuals, couples, and groups to see, think, feel or act differently. Psychotherapy is a collaborative process between the client and the psychotherapist, based on the clients' active participation. While the immediate aim of psychotherapy may be to relieve discomfort or distress, psychotherapy has the longer-range goal of changing the patterns of thinking, feeling, and acting as well as learning new, more effective and satisfying ways of living.
Social Workers (p. 85)	*Social work practice means professionally supervised interventions that are based on a systematic body of social work theory and knowledge and code of ethics which taken together provide a framework to address societal issues, social barriers, inequities and injustices faced by individuals, families/whanau, groups and communities/iwi. Such interventions may include counselling, clinical social work, casework, group work, social pedagogical work, family therapy and family/whanau work, community work, community/iwi organisation and development, social service management and administration, social and economic policy formation and political action* (Aotearoa NZ Association of Social Workers 2001) Many social workers employed in the health and disability sector (for example, mental health case management) and in private practice are clinical social workers. Clinical social work practice applies specific knowledge, theories and methods to assessment and diagnosis, treatment planning, intervention and outcome evaluation. This is done in consultation with professional colleagues, including other members of multidisciplinary teams or a GP.

SURVEY ON CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS & YOUTH SPECIALTY SERVICES)

This is a combined survey by The Werry Centre and the Mental Health Commission.

The Werry Centre has been contracted by the Ministry of Health to undertake a "Stocktake of Child and Adolescent Mental Health Services" to provide a foundation for strategic planning for child and adolescent mental health workforce development.

The Mental Health Commission project is a monitoring exercise intended to increase understanding of why child and adolescent mental health services have not developed as far as expected and to identify possible solutions. This survey is the first part of a two-part project.

There are **four sections** to this survey:

1. DHB Funder Arm
2. DHB Provider Arm
3. DHB Provider Arm Workforce Information (Inpatient)
4. DHB Provider Arm Workforce Information (Outpatient & Community)

DHBs will need to fill in the DHB Funder and the DHB Provider arm sections. Where we have been able to access information from the Ministry of Health we have included this for your verification.

We trust that you will return the survey as completely and accurately as possible as this information is important and will be used to inform the strategic direction of Child and Adolescent Mental Health Services. A further outcome of the project will be to produce a national directory of Child and Adolescent Mental Health Services.

An electronic version of this survey is available on The Werry Centre Website: www.werrycentre.org.nz. If you would prefer your individual version, please contact Julliet Bir (Contact details are provided below).

Completed surveys can be emailed, posted or faxed back to **Julliet Bir** at The Werry Centre by the:

12th of November 2004

For more information please contact:

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Section 1

Child & Adolescent Mental Health Services

Please Fill-in, Confirm or Change where necessary

DHB Funding Agreements: CAMHS/YSS

	Total Health Funding	Funding of DHB Provider Services	Funding of NGO Services	Total Actual Expenditure	Surplus (Deficit)
2002/2003					
2003/2004					

DHB Contracts 2003/04

Provider	Purchase Unit Code	Purchase Unit Description	Unit Measure	Locality	Total Dollars

NGO Contracts 2003/04

Provider	Purchase Unit Code	Purchase Unit Description	Unit Measure	Locality	Total Dollars

Any feedback Comments about the process of completing the overall questionnaire and the availability of data?

Contact Details:

Please fill in so that we can contact you to verify information as necessary.

Name	
Email Address	
Phone Number	

Section 2

(Enter Name of DHB Here) DHB Provider
Child & Adolescent Mental Health Services

Child & Adolescent Mental Health Services (CAMHS) are defined by this survey as all Mental Health Services provided specifically for ages 0-19 years. To capture how your services are structured, please list your service teams including any specialist Māori or Pasifika teams and the age group for which they provide services (e.g. CAMHS, YSS, CSS, and AOD etc.).

Service Teams	Age Group

Please ensure the workforce information is collected from all of these teams

Regional & Sub-Regional Services	DHB Areas Covered

2003/04 Child & Youth Mental Health Financials

Revenue	$$ 000
Vote Health (PV Schedule)	
Inter-District Contracts	
CTA	
Other	
Total Revenue	
Expenditure	**$$ 000**
Personnel	
Other	
Total Expenditure (Community & Inpatient)	
Surplus (Deficit) 2003/04	**$$ 000**

Other revenue 2003/04

Funding Source (Agency)	Services	Purchase Volumes	Purchase Units	Prices	Total Funding Paid to DHB $$ 000

2003/04 Child & Youth Community Mental Health Delivery to Contract

Purchase Unit Code	Description	Category	Contract Volume	Contract Prices	Contract Total Dollars	Actual FTE Volume	Actual Bed days	Actual Programme Expenditure

Trainees

CTA Funded Trainees Occupational Group	Number (2003/04)	FTE (2003/04)	Budget
Total			

Section 3 & 4

(Enter Name of DHB Here) DHB Workforce Information
Inpatient/Community Child & Adolescent Mental Health Services

2003/04 FTEs & Vacancies

CAMHS/YSS Employee Group	Actual FTEs as at 31st March 2004	Vacant FTEs as at 31st March 2004	FTES Vacant > 3 Months at 31st March 2004*	FTEs Vacant > 6 Months at 31st March 2004*
Alcohol & Drug Workers				
Counsellors				
Mental Health Nurses				
Occupational Therapists				
Psychiatrists				
Psychotherapists				
Registered Psychologists				
Social Workers				
Other Clinical				
Kaumatua, Kuia or Cultural Appointments				
Specific Liaison Appointment				
Mental Health Consumer & Family Workers				
Mental Health Support Workers				
Administrative/Management/Quality/Training				
Other Non-Clinical Support				
Total				

*** Count from departure of previous employee, or establishment of new position.**

Ethnicity of the Above Workforce

Employee Group (Total Staff Head Count)	Numbers (Total Staff Head Count)			
	Māori	Pacific	Asian	Māori & Pacific*
Alcohol & Drug Workers				
Counsellors				
Mental Health Consumer & Family Workers				
Mental Health Nurses				
Occupational Therapists				
Psychiatrists				
Psychotherapists				
Registered Psychologists				
Social Workers				
Other Clinical				
Kaumatua, Kuia or Cultural Appointments				
Specific Liaison Appointment				
Mental Health Support Workers				
Administrative/Management/Quality/Training				
Other Non Clinical Support				
Total				

***Please do not count more than once if Ethnicity is Māori and Pacific**

Resignations from & Transfers within the CAMHS Service within this DHB

CAMHS/YSS Employee Group	Resignations		Transfers	
	02/03	03/04	02/03	03/04
Alcohol & Drug Workers				
Counsellors				
Mental Health Consumer & Family Workers				
Mental Health Nurses				
Occupational Therapists				
Psychiatrists				
Psychotherapists				

Resignations from &_Transfers within the CAMHS Service_within this DHB Continued

CAMHS/YSS Employee Group	Resignations		Transfers	
	02/03	03/04	02/03	03/04
Registered Psychologists				
Social Workers				
Other Clinical				
Kaumatua, Kuia or Cultural Appointments				
Specific Liaison Appointment				
Mental Health Support Workers				
Administrative/Management/Quality/Training				
Other Non Clinical Support				
Total				

Staff Salaries

CAMHS/YSS Employee Group 2003/04 Use Base Salary	Minimum Actual Salary as at 30 June 04	Maximum Actual Salary 30 June 04	Median Actual Salary 30 June 04
Alcohol & Drug Workers			
Counsellors			
Mental Health Nurse			
Mental Health Support Workers			
Occupational Therapists			
Psychiatrists			
Psychotherapists			
Registered Psychologists			
Social Workers			

Years of Child & Adolescent Experience since Qualification

CAMHS/YSS Employee Group 2003/04	Minimum	Maximum	Median
Alcohol & Drug Workers			
Counsellors			
Mental Health Nurse			
Mental Health Support Workers			
Occupational Therapists			
Psychiatrists			
Psychotherapists			
Registered Psychologists			
Social Workers			

Do you have written access criteria for your services? (enter yes or no) If yes, please attach relevant documentation.	

Contact Details:

Please fill in so that we can contact you to verify information as necessary.

Name	
Email Address	
Phone Number	

ISBN 0-9582630-2-7

The Werry Centre for
Child and Adolescent Mental Health
www.werrycentre.org.nz

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Cover: 'Koreru's Flight'.
Artwork by Alex Ventling, 9.