2016 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol & Other Drug Services in New Zealand

Werry Workforce
WHĀRAURAU

National Summary 2017

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2016 STOCKTAKE

OF

INFANT, CHILD AND ADOLESCENT MENTAL HEALTH AND ALCOHOL AND OTHER DRUG SERVICES IN NEW ZEALAND

NATIONAL SUMMARY

WERRY WORKFORCE- WHĀRAURAU
FOR INFANT, CHILD AND ADOLESCENT
MENTAL HEALTH
WORKFORCE DEVELOPMENT
(UPDATED AUGUST 2017)

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The Werry Workforce-Whāraurau for Infant, Child and Adolescent Mental Health Workforce Development wishes to acknowledge the valuable input from all who contributed to this project. This project was led by Julliet Bir.

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Special thanks to all staff within DHB services and NGOs who have contributed to this *Stocktake*.

FOREWORD

The latest edition of our Werry Workforce-Whāraurau *Stocktake* of the infant, child and adolescent mental health workforce and access to service comes at a time when mental health and the importance of timely access to appropriate advice and care is very topical.

This report does illustrate some positive movement in the sector and also outlines some concerns and priority areas for work.

In general, the access rates continue to grow, with target access rates for teenagers sometimes exceeded, and access rates highest overall for Māori. While the Blueprint access rates give priority to access for adolescents, the importance of intervening in the pre-school age group is increasingly being recognised. Evidence suggests that intervening in the 0-4 years age group is most cost effective and has the potential to prevent mental health problems in the long term. In this report, we identify an increase in services provided for the very young, and it is to be hoped that these services continue to develop. The economic advantage of doing this is undoubted. The encouraging response to efforts to increase access for Māori young people should be heartening and there are positive lessons to be learned as we also undertake to tackle the persistently low access rates for Pacific and Asian young people.

Unlike the improving access since 2014, we have seen too little change in funding or in the ICAMH/AOD workforce capacity. The Government has also acknowledged the importance of early intervention and we are encouraged by the Budget 2017 announcement of more funding for mental health. This is a significant step forward, so we hope a proportionate amount of this funding is channelled to infant, child and adolescent services. The report shows that children and young people continue to get a disproportionately low share of mental health funding (12% for 27% of the population). Thus, there remain persistent gaps in funding compared to *Blueprint* guidelines (Mental Health Commission, 1998) and significant disparities in comparison with the levels of funding and services available to the adult population. Many of our services indicate significant workforce stress and families are concerned about access to services and appropriate therapy for their children.

The evidence linking poverty and the risk of developing mental health issues is well established. With recent reports indicating around 150,000 New Zealand children live in significant poverty, Budget 2017 also promises progress towards lifting some families out of income and housing stress; however, the Minister of Finance admits that around 90,000 children will remain below the OECD measure. Continued efforts to address the root causes of family/whānau distress and hopelessness are required before we can expect to see sustainable improvements in child mental health or the child and youth suicide rates.

The need to focus on the workforce continues. The overall vacancy rate is higher than in 2014 (6% versus 8% now) with a 16% annual turnover rate, mainly for clinicians. Retention should be a key area of focus, as should recruitment. Further initiatives to recruit and train new graduate health professionals specifically for the infant, child and adolescent sector could be considered.

Services provided at the secondary and tertiary levels must, out of necessity, be complemented by primary level services, as they remain an essential part of the system of services needed in this country. Our persistently high youth suicide rates are a timely reminder of the need to continue to improve the availability and quality of our mental health services. We are improving, but there is still work to be done to ensure improvements continue and are sustainable.

Sue Dashfield
General Manager

EXECUTIVE SUMMARY

This is the seventh *Stocktake* of the Infant, Child and Adolescent Mental Health/Alcohol and Other Drugs (ICAMH/AOD) workforce and client access rates conducted by Werry Workforce-Whāraurau. The information collected is intended to assist the Ministry of Health (MOH), District Health Boards (DHBs), non-DHB service providers/non-government organisations (NGOs), national, regional and local planners and funders, and service leaders to assess current capacity and accurately plan for future service and workforce development.

This report provides a snapshot of activity undertaken during 2016 by DHB and non-DHB service providers. As this is the seventh such study, we can continue to identify trends and make predictions regarding capacity and demand that will help policy makers, planners, funders and services better meet the needs of their populations.

In order to effectively deliver the right service at the right time to the right people, policy makers, funders, planners and clinicians need up to date information about their workforce and who is accessing services. The information provided in this stocktake can assist services to be even more targeted in the delivery of ICAMH/AOD services and support the provision of better, sooner and more convenient services.

NATIONAL FINDINGS

INFANT, CHILD AND ADOLESCENT (0-19 YEARS) POPULATION

The population data include the 2016 infant, child and adolescent population projections (Base 2013 Census, prioritised ethnicity by DHB area) provided by Statistics NZ:

- Population projections indicated a 2% growth in the overall 0-19 year population from Census 2013 to 2016. The child and youth population will continue to grow, with a 2% growth projected for 2026.
- Infants, children and adolescents (0-19 years) make up 27% of New Zealand's total population.
    - Māori infants, children and adolescents make up 25% of New Zealand's 0-19 years population and the Māori population continues to have a young age structure, with nearly half (43%) aged between 0 and 19 years. The Māori 0-19 year population showed a projected growth of 4% from Census 2013 to 2016 and a 12% projected growth by 2026. Māori continue to experience lower socioeconomic status and have double the prevalence rates of mental health disorders compared to the general population. Therefore, Māori tamariki and rangatahi continue to be a population of high need for mental health services.
    - Pacific infants, children and adolescents make up 10% of New Zealand's 0-19 years population. The Pacific population also continue to have a young age structure with 39% of the population aged between 0 and 19 years. A 3% growth in the Pacific 0-19 year population was projected from Census 2013 to 2016, and a 9% growth is projected for 2026. Pacific peoples in New Zealand continue to experience lower socioeconomic status and experience mental health disorders at higher levels than the general population. Therefore, Pacific infants, children and adolescents continue to be a population of high need for mental health services.
    - Asian infants, children and adolescents make up 13% of New Zealand's 0-19 years population and the Asian population is now the third largest ethnic group in New Zealand. Projections continue to show large growth in the 0-19 year population with a projected growth of 19% from Census 2013 to 2016 and a 35% projected growth (the largest out of the ethnic groups) by 2026. The Asian population in New Zealand is largely an immigrant population. Consequences of the immigration process can increase the risk of developing mental health problems for the Asian population and need for mental health services.

CLIENT ACCESS TO ICAMH/AOD SERVICES

The client access to service data (number of clients seen by DHB & NGO ICAMH/AOD services) have been extracted from the *Programme for the Integration of Mental Health Data* (PRIMHD). Access data are based on the *Clients by DHB of Domicile* (residence) for the second six months of each year (July to December).

Access rates are calculated by dividing the number of clients for a six month period by their corresponding population to determine the six monthly access rates. Access rates are compared against the Mental Health Commission's (MHC) access target rates for the infant, child and adolescent population (Mental Health Commission, 1998). The *Blueprint Access Benchmark Rate* for the 0-19 year age group has been set at 3% of the population over a six month period (3% of the population should be able to access appropriate services). Due to different prevalence rates for mental illness in different age groups, the MHC has set appropriate access rates for each age group: 1% for the 0-9 year age group; 3.9% for the 10-14 year age group and 5.5% for the 15-19 year age group.

- Access to services from 2013 to 2015:
    - The majority (76%) of clients aged 0-19 years accessing ICAMH/AOD services continued to be seen by DHBs and 24% were seen by NGOs.
    - Nationally, there continues to be progress toward the benchmarked access target rates of 3% for the 0-19 year population (Mental Health Commission, 1998), from 2.64% to a national average of 2.87%.
    - Access rates by age group showed an increasing trend in all three age groups:
        - 0-9 years: from 0.81% to 0.96%; close to the 1.0% target rate.
        - 10-14 years: from 3.04% to 3.34%; also close to the 3.9% target rate.
        - 15-19 years: from 5.84% to 6.17%; exceeding access target rate of 5.5%.
    - Access rates by ethnicity also showed an increasing trend:
        - Māori clients made up 32% of clients accessing services. Access rates had improved from 3.28% to 3.66%. Māori had the highest access rate out of four ethnic groups (Māori, Pacific, Asian and Other Ethnicity), exceeding the target rate for the overall 0-19 year population of 3% but remaining below the 6% rate recommended for Māori.
        - Pacific clients made up 6% of clients accessing services. The overall access rate had improved from 1.57% to 1.82% but continued to remain below the target rate of 3%.
        - Asian clients made up 3% of clients accessing services. While the overall access rate had improved from 0.67% to 0.75%, it remains the lowest out of three ethnic groups and well below target rates.
    - Access rates by region also showed improvements in all four regions:
        - Northern: from 2.19% to 2.60%; the lowest access rate in the country and remaining below the 3.0% target rate.
        - Midland: from 2.96% to 3.18%; reporting the highest access rate and exceeding the 3.0% target rate.
        - Central: from 2.94% to 2.95%; very close to reaching the 3.0% target rate.
        - Southern: from 2.86% to 2.97%; also very close to reaching the 3.0% target rate.

CLIENT OUTCOMES

- To assess whether clients accessing mental health services experience improvements in their mental health and wellbeing, children and youth health outcomes are rated by the *HoNOSCA* (Health of the Nation Outcome Scales for Children and Adolescents) at admission and discharge from community child and adolescent mental health services. Client outcome data for the 2015/2016 period showed significant improvements in emotional related symptoms by time of discharge.

FUNDING FOR ICAMH/AOD SERVICES

Funding data for DHB and NGO services for the 2015/2016 financial year were extracted from Price Volume Schedules (PVS) supplied by the MOH.

From 2014 to 2016:

- There was an overall 7% increase in funding for ICAMH/AOD services (including Youth Primary Mental Health funding).
- Youth Forensic services showed the largest increase in funding by 79%, followed by AOD by 11%.
- There was a 6% increase in funding per head for the 0-19 year population, from $122.82 to $129.93 (excluding inpatient funding).

ICAMH/AOD WORKFORCE

The following information is derived from workforce data, comprising actual and vacant full time equivalents (FTEs) and ethnicity by occupational group, submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services and 106 NGOs, as at 30 June 2016.

Workforce changes from 2014 to 2016:

- A 1% decrease in the overall ICAMH/AOD workforce:
    - 3% increase in the DHB workforce
    - 8% decrease in the NGO workforce
    - 1% increase in the Clinical workforce
    - 10% decrease in the Non-Clinical workforce (excluding Admin/Management staff).
- A 3% increase in vacancies, with a vacancy rate of 8% overall. Vacancies were mainly in DHB services for clinical roles.
- The 16% annual staff turnover rate (DHB = 13%; NGO = 28%) was mainly for Psychologists, Mental Health Support Workers, Social Workers and Nurses. The main reasons for leaving were other job opportunities, personal/family reasons and relocating to another city/town within New Zealand.
- A 1% decrease in the overall Māori workforce was seen only in the non-clinical workforce (by 8%, excluding Admin/Management). There was a 2% increase in the clinical workforce.
- A 7% increase in the overall Pacific workforce was seen only in the clinical workforce (by 21%).
- A 36% increase in the overall Asian workforce, from 75 to 102, mainly in clinical roles.

CURRENT AND FUTURE WORKFORCE CHALLENGES

Services were asked to identify their current and future workforce challenges and gaps. All DHB provider services and 41 NGOs responded to these questions. The responses for both DHB providers and non-DHB providers were grouped under the following themes, with the lack of funding recurring across all of the themes identified.

Current Workforce Challenges/Gaps:

- Recruitment/retention of specialist staff: High turnover and shortage of specialist staff with youth mental health experience.
- Access to specialist training: Lack of specific training and lack of funding and time to access training.
- High service demand: Increasing demand for complex needs.
- Working with diverse cultures: Lack of cultural services and lack of cultural competency training.
- Lack of funding/limited resources.

Future Workforce Challenges/Gaps:

- Recruiting/retaining specialist staff: The need to attract and recruit specialist staff due to an ageing workforce.
- Meeting high service demand: The need to provide more specialist services in innovative ways to meet growing demand.
- Accessing specialist training: The need for more specialised training to cater for complex cases.
- Lack of funding/limited resources: The need to access specialist training; recruit and retain staff; and develop technology and new ways of working to meet high and complex demand.
- Working with diverse cultures: The need for services to cater for the increasing ethnic diversity in New Zealand.
- Keeping up with technology: The need to keep up with rapidly changing technology and the need to develop new ways of delivering services, e.g. e-therapies.
- Working collaboratively: The need to work across agencies.

CONCLUSION

The seven Werry Workforce stocktakes of the infant, child and adolescent mental health workforce and access to services show that there continues to be progress towards key strategic priorities of *Te Tahuhu* (Minister of Health, 2005), *Te Raukura* (Ministry of Health, 2007), *Mental Health and Addiction Action Plan* (Ministry of Health, 2010a) and *Rising to the Challenge* (Ministry of Health, 2012c).

Between 2013/2014 and 2016, there was a 2% projected growth in the 0-19 year population; a 10% increase in the total number of clients accessing ICAMH/AOD services; a 2% increase in funding to ICAMH/AOD services; and a 1% decrease in the workforce. While many gains have been made, there remain persistent gaps in funding compared to recommended Blueprint guidelines (Mental Health Commission, 1998). There are significant disparities in comparison with the levels of funding and services available to the adult population, and persistent low access rates for clients under 15 years of age, especially for Māori, Pacific and Asian infants, children and adolescents.

It is widely recognised that early intervention frequently leads to improved outcomes (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004; Ministry of Health, 2007, 2010a). These include reduced social, emotional and economic burdens on individuals, whānau and society. At times such as these, when there are significant constraints on public health funding, it is prudent to target funding to the most effective and efficient interventions. Improving access to services for children to prevent long-term negative outcomes is highly cost effective (Aos et al., 2004).

RECOMMENDATIONS:

In light of these 2016 *Stocktake* findings, and to ensure alignment with current government priorities and progress toward workforce strategic goals, the following recommendations, which span the primary to the secondary sector, are made:

- **Improving client access to services, especially for Māori, Pacific and Asian populations.**
- **Funding and planning services to meet local needs and allocating resources accordingly.**
- **Developing and providing early intervention services** such as parenting programmes, school and community based services and online e-therapy tools; and strengthening primary mental health services for early intervention and to reduce demand for specialist services.
- **Developing the workforce in specialist services:** A high turnover and an ageing workforce require continued investment in succession planning and targeted recruitment strategies for specialist roles to cater for an increase of complexity in needs and demand for services. While increasing the ICAMH/AOD workforce is a long-term solution to current workforce shortages, the retention and development of the existing ICAMH/AOD workforce is pertinent. Additionally, a quarter of all clients are accessing NGO services; therefore, addressing the workforce development needs of the NGO sector also needs to be considered. Strategies for recruiting, retaining and developing the ICAMH/AOD workforce should include:
    - ***Active recruitment and retention strategies for specialist staff.***
    - ***Training and professional development****:*
        - *Identifying key training gaps at individual and service levels and providing access and support for specialist training.*
        - *Providing career pathways for the unregulated workforce to support the specialist workforce.*
        - *Developing clinical/cultural competencies to cater for the growing ethnic diversity of clients.*
    - ***Exploring new ways of working:***
        - *Developing the Youth Consumer workforce to keep services current to client needs.*
        - *Service re-design to use limited resources more efficiently.*
        - *Working collaboratively so resources can be shared between services.*
- **Engaging in ongoing data collection** to monitor trends and to ensure that progress in services and staffing is keeping pace with client demand and moving toward improved outcomes for infants, children and adolescents and their families.

INTRODUCTION

This is the seventh *Stocktake* of the Infant, Child and Adolescent Mental Health and Alcohol and Other Drug (ICAMH/AOD) workforce and client access rates conducted by Werry Workforce-Whāraurau (formerly the Werry Centre). It provides a snapshot of activity undertaken during 2016 by District Health Board (DHB) providers and non-DHB service providers/non-government organisations (NGOs). Information collected is intended to assist the Ministry of Health, national, regional and local planners and funders, and service leaders to assess current capacity and accurately plan for future service and workforce development.

In 2004, the Werry Centre for Child and Adolescent Mental Health, Workforce Development Programme, at the request of the Ministry of Health, undertook the first national *Stocktake of Child and Adolescent Mental Health Services in New Zealand* (Ramage et al., 2005). The data indicated some progress towards the Mental Health Commission's (MHC) benchmarks, yet deficiencies in access rates and workforce numbers were evident. It was however acknowledged that the information needed to be interpreted with caution as the DHB and NGO access data may have been incomplete.

As recommended in the Werry Centre's strategic framework for the infant, child and adolescent mental health services, *Whakamārama te Huarahi* (Wille, 2006), further national *Stocktakes* were conducted in 2006, 2008, 2012 and 2014. These *Stocktakes* showed increases in funding to both DHB and NGO ICAMH/AOD services and increased focus on inter-sectoral collaborative programmes. They also highlighted ongoing deficiencies in workforce numbers and access rates against MHC's benchmarks (Mental Health Commission, 1998). The data showed that there continued to be low numbers of Māori, Pacific and Asian workers in relation to the composition of the population aged 0 to 19 years.

The Werry Workforce-Whāraurau has now completed this seventh *Stocktake*. The accumulated data provide a unique opportunity to identify trends over time in both workforce and access rates, and to consider the interactions of funding, staffing and access. While the 2004 *Stocktake* included a comprehensive report and literature summary, this report, like the 2006 to 2014 *Stocktakes*, presents data in key areas. Of particular note is the high response rate of DHB providers and NGOs returning survey data. DHB returns were 100% and NGO returns were 99%. This may well be an indication of how useful planners, funders and service leaders have found the previous stocktakes.

BACKGROUND

There are a number of strategic documents that have identified key priorities for the child and adolescent mental health/AOD sector and have informed and shaped the infant, child and adolescent mental health workforce to date:

- *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Mental Health Commission, 1998) identified workforce requirements, resource guidelines for services for children and adolescents, and benchmarks for access by children and young people to specialist mental health services.
- *Te Tahuhu—Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health, 2005) identified the mental health and wellbeing of children and youth as a key government priority.
- *Te Kokiri: The Mental Health and Addiction Plan 2006–2015* (Minister of Health, 2006) subsequently set the future direction for child and youth mental health and AOD services.
- *Te Raukura—Mental Health and Alcohol and Other Drugs: Improving Outcomes for Children and Youth* (Ministry of Health, 2007) emphasised the need to continue to build and broaden the range and choice of services and support for children severely affected by mental health issues.

While previous government priorities for the mental health and addiction sector have set the scene for service delivery, from 2008, the Government set new priorities which focused on delivering services of higher quality that provided better value for money. As of 2012, an extra $512 million has been allocated to health and an additional $174 million for mental health was planned over the next four years (Minister of Health, 2010).

The Mental Health and Addiction Action Plan (Ministry of Health, 2010a) accentuated the need for "*mental health and addiction services that help to divert children and young people away from negative pathways and increase their life chances*" (p. 3). The new priorities outlined in the action plan that pertain to infants, children, adolescents and their families include:

- Greater collaboration and new ways of delivering well connected and coordinated services involving primary care, DHBs and NGOs.
- Greater use of clinical leadership.
- Increasing the frontline workforce.
- Increasing funding for primary care and additional primary care services (early intervention, $144 million allocation), including family health centres.
- Increasing primary mental health services for mild to moderate mental health problems ($5.3 million allocation) and improving access to these services.
- Enhancing eating disorder services ($26 million allocation over four years) with funding to be invested for training and increasing the specialist workforce in this area.
- Providing additional alcohol and drug treatment programmes for young offenders.
- Implementing *Whānau Ora* which is an inter-agency, family-centred and family-driven approach to providing services for the overall wellbeing of whānau and families ($134 million has been allocated over four years for the implementation of *Whānau Ora* across New Zealand).
- Improving information about publicly funded mental health and addiction services.

FUTURE STRATEGIC DIRECTIONS FOR THE SECTOR

An increased focus on improving the wellbeing of all young people in New Zealand came as a result of information regarding high morbidity rates of young people in New Zealand relative to other developed countries. Consequently, in 2009, Prime Minister John Key requested a report on ways to improve the outcomes for young people in their transition from childhood to adulthood. The so-called "*Gluckman report*", *Improving the Transition: Reducing Social and Psychological Morbidity during Adolescence* (Office of the Prime Minister's Science Advisory Committee, 2011) was released in May 2011. This report was produced by a taskforce which included relevant academics and clinical practitioners who summarised the evidence-based information from peer-reviewed literature on ways to improve outcomes for young people in New Zealand. The essence of this report highlighted the significance of prevention and early-intervention, evidence-based strategies implemented in childhood. Furthermore, the targeting of higher risk communities was also recommended because of the likely benefits socially and economically. The report also suggested that improvements in outcomes for young people can be enhanced by collaborations between many agencies and integrated actions across ministries.

The *Youth Forensic Services Development* report (Ministry of Health, 2011) outlines the need to provide a nationally consistent service for the youth forensic population and offers guidance for DHBs on how to improve the range of services available.

Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand (Ministry of Health, 2012b) advocates for the need for DHBs, and other health planners, funders and providers of perinatal and infant mental health and AOD services, to address the mental health and AOD needs of mothers and infants.

Towards the Next Wave of Mental Health & Addiction Services and Capability: Workforce Service Review Report (Mental Health and Addiction Service Workforce Review Working Group, 2011) is a report that proposes service configurations, models of care and workforce requirements for future effective and efficient services. These proposals led to the release of *Blueprint II*: *Improving Mental Health and Wellbeing for all New Zealanders. How things need to be* (Mental Health Commission, 2012) and *Rising to the Challenge*: *The Mental Health & Addiction Service Development Plan 2012-2017* (Ministry of Health, 2012c). All of these recent documents echo the need for prevention and early intervention and are

guided by new information that "*will help the broader health and government sectors build on their current strengths to address future challenges"* within a financially constrained environment (Mental Health Commission, 2012, p. 8).

Blueprint II (Mental Health Commission, 2012) is an extension of the first Blueprint document (Mental Health Commission, 1998) and outlines five key future directions for the wider health and social service sector (p. 13):

1. Respond earlier and more effectively to mental health, addiction and behavioural issues (a life-course approach which involves intervening early and at critical life stages).
2. Improve equity of outcomes for different populations.
3. Increase access to mental health and addiction responses.
4. Increase system performance and our effective use of resources.
5. Improve partnerships across the whole of government.

Rising to the Challenge (Ministry of Health, 2012b) offers a more targeted action plan for the health sector. A life-course approach also underpins the goals outlined in the document. A key goal that directly pertains to infants, children and adolescents is "*delivering increased access for infants, children and youth while building resilience and averting future adverse outcomes"* (p.39). The document provides detailed priority actions, accountabilities and services for the next five years. The actions focus on intervening early to strengthen resilience and avert future adverse outcomes (includes infants and families/whānau with children); providing evidence-based services that are more flexible and responsive across the spectrum of service providers (DHB, NGO, primary care, maternal, child and youth health service providers); and developing greater cross-agency collaborations. The document outlines a number of priority services to be provided by DHBs (p. 45):

- Specialist mental health services for high needs families and whānau with infants (perinatal and infant mental health services for children 0-4 years)
- Programmes for children of parents with mental health and addiction issues (COPMIA).

The Children's Action Plan (New Zealand Goverment, 2012), which formed out of the *White Paper for Vulnerable Children,* recognises the need for prevention and early intervention. It outlines key actions to identify and protect the most vulnerable children that ensure they receive services that provide the protection and support they need. The key actions are:

- Ensuring services for children and families are child-centred.
- Acting early to protect children.
- Finding, assessing and connecting the most vulnerable children to services earlier and better.
- Ensuring Chief Executives of the Ministry of Social Development, Ministry of Health, Ministry of Education, Ministry of Justice, NZ Police, the Ministry of Business, Innovation, and Employment (Housing), and Te Puni Kōkiri are jointly accountable for achieving results for vulnerable children.
- Funding only those programmes and services that make a difference, based on evidence.
- Achieving better results for children in care.
- Delivering high quality care services.
- Providing a safe and competent children's workforce that takes a child-centred approach.
- Establishing mechanisms to stop abusers working with children, and provide safe care for children who have been removed from their parents.
- Encouraging individuals, corporates and other groups to step up and help vulnerable children.
- Ensuring a robust and fair Child, Youth and Family complaints system.

Prime Minister's Youth Mental Health Project (2012) provided additional and targeted initiatives that aim to provide a whole-of-government approach to improving youth mental health in New Zealand. Funding and resources are dedicated to the following initiatives for young people experiencing mild to moderate mental health issues.

- **Health sector initiatives:**
    - Making primary health care more youth friendly ($11.3 million over four years for GPs, school-based health services and Youth One Stop Shops).
    - Improving wait-times in CAMHS and follow-up primary care especially for young people with AOD concerns.
    - Reviewing referral pathways actioned by the Ministry of Social Development.
    - Reviewing alcohol and drug education programmes.
- **Family and community initiatives:**
    - Providing mental health information for parents, families and friends (NGO sector).
    - Providing a whānau ora approach to youth mental health.
    - Training for providers working with truants and disengaged young people (Ministries of Education and Social Development).
    - Ensuring young people have a say on the types of services they need (Ministry of Youth Development).
- **School-based initiatives:**
    - Encouraging nurses in decile 3 secondary schools to use the HEEADSSS (Home, Education/Employment, peer group Activities, Drugs, Sexuality, Suicide/depression, Self Image and Safety) screening tool to increase access to health services, and improve access to primary care services and referrals to mental health services.
    - Training youth workers in mental health in low decile schools to work alongside existing health workers in schools with linkages to community-based services (NGOs funded by Child, Youth and Family).
    - Trialling of the *Check and Connect* mentoring and monitoring programme for disengaged youth.
    - Making schools more responsible for student wellbeing (Education Review Office, Ministry of Education).
    - Encouraging a positive culture in secondary schools with the implementation of *Positive Behaviour School Wide* (Ministry of Education).
- **Online initiatives:**
    - Providing accessible, interactive, computer-based e-therapy for mild mental health issues that can help reduce a variety of barriers to accessing services.
    - Improving youth-friendliness of mental health resources.
    - Funding youth providers to keep their services technologically up to date via the *Social Media Innovations Funds* to enhance youth engagement.

WORKFORCE DEVELOPMENT

In order to meet the mental health/AOD needs of infants, children, adolescents and their families/whānau, effective services, delivered by a highly skilled, well supported mental health and addiction workforce, are required. However, workforce shortages in the sector are a constraint on improved service provision for infants, children, young people and their families. Therefore, increasing and improving the mental health/AOD workforce remains a key government priority.

The four mental health and addiction workforce development centres (The Werry Centre, Te Pou, Te Rau Matatini and Matua Raki) have embraced the following five strategic imperatives (Ministry of Health, 2002):

- Workforce development infrastructure
- Organisational development
- Recruitment and retention
- Training and development
- Research and evaluation.

Workforce development in the child and adolescent mental health and addiction sector was guided by the strategies outlined for the broader mental health and addiction sector, *Tauawhitia te Wero: Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006-2009* (Ministry of Health, 2005). To specifically address the needs of the infant, child and adolescent mental health and addiction sector, the Werry Centre produced *Whakamārama te Huarahi—To Light the Pathways*: *A Strategic Framework for Child and Adolescent Mental Health Workforce Development 2006-2016* (Wille, 2006). This document outlines a long-term national approach to systemic enhancements to support the capacity and capability of the infant, child and adolescent mental health and addiction workforce. Recommendations were made to support regional, inter-district and local planning processes, informed by ongoing research and evaluation, and data collection (p.7):

1. Retain and develop the existing child and adolescent mental health workforce.
2. Increase the numbers of the child and adolescent mental health workforce through training and enhanced career pathways.
3. Increase the diversity of the child and adolescent mental health workforce through the development of core competencies, new roles and new ways of working.
4. Increase Māori workforce numbers across all roles and parts of the sector.
5. Increase Pacific workforce numbers across all roles and parts of the sector.
6. Increase clinical/cultural competencies throughout the child and adolescent mental health workforce.
7. Increase capacity of related sector workforces to provide mental health screening and, where appropriate, assessment and therapeutic intervention.
8. Increase organisational capacity and sector leadership to develop and plan future workforce needs for the child and adolescent mental health sector.

Whakapakari Ake Te Tipu—Māori Child and Adolescent Mental Health and Addiction Workforce Strategy (Te Rau Matatini, 2007) also identified priorities and actions for developing the Māori child and adolescent mental health and addiction workforce. A key focus is to reduce inequalities and improve access to services for Māori and Pacific peoples.

FUTURE WORKFORCE

Blueprint II (Mental Health Commission, 2012) also addressed the future direction and development of the workforce to ensure alignment with the key priorities outlined in the document. The workforce would need to adapt and evolve to new methods of working effectively and efficiently (such as the *Stepped Care* approach, whereby the least intrusive care to meet presenting needs is used to enable people to move to a different level of care according to their changing

needs). The workforce would therefore require essential capabilities to appropriately respond to service users and their families/whānau.

The priorities outlined in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2014–2017* (Ministry of Health, 2012c) and in *The Children's Action Plan* (New Zealand Government, 2012) also have implications for the infant, child and adolescent mental health/addiction workforce. The need for greater integration between primary and specialist services would require enhancing the mental health and addiction capabilities of the primary care workforce. A continued investment in developing new roles and building the capacity of the existing workforce, in the face of shortages, is also needed.

The most recent *Mental Health and Addiction Workforce Action Plan* 2017-2021 (Ministry of Health, 2017) outlines the priority areas and actions required for workforce development for the next five years, reiterating the need to focus on early intervention. The following four priority areas for workforce development have been identified (p. viii):

1. A workforce that is focused on people and improved outcomes
2. A workforce that is integrated and connected across the continuum
3. A workforce that is competent and capable
4. A workforce that is the right size and skill mix.

THE STOCKTAKE

Effective workforce development requires accurate information concerning demand, service configuration and access to service data. Due to the comparatively small size and low profile of the sector, there was, until the last decade, very little information detailing the infant, child and adolescent mental health/addiction workforce.

To fill this gap, in 2004, the Werry Centre for Child and Adolescent Mental Health Workforce Development Programme conducted the first national *Stocktake* of the infant, child and adolescent mental health/AOD workforce at the request of the Ministry of Health (Ramage et al., 2005).

Data from the first *Stocktake* highlighted deficiencies in funding, access rates and workforce numbers compared with strategic guidelines (Mental Health Commission, 1998). It was also noted that comprehensive data collection was problematic, with incomplete returns to Mental Health Information National Collection (MHINC) and lack of data from NGOs on client access to services.

A need for centralised, regular, standardised data collection of workforce composition and access rates that is available for regional planning was identified in *Whakamārama te Huarahi* (Wille, 2006). This led to a biennial stocktake of data on the workforce and access to service. This dataset now covers the 2004 to 2016 period.

This report presents the 2016 infant, child and adolescent mental health/AOD workforce data. Like the previous reports, it aims to provide a snapshot of the workforce providing infant, child and adolescent mental health services. It also describes the population the workforce serves, the number of clients who are accessing services and how the current workforce and client numbers compare with Blueprint targets (Mental Health Commission, 1998).

While the current data reflect the strategies and actions described in *Whakamārama Te Huarahi* (Wille, 2006), *Te Raukura* (Ministry of Health, 2007) and *The Mental Health and Addiction Action Plans* (Ministry of Health, 2010a, 2017), future stocktake data (service provision and workforce) will consider current developments (*Blueprint II*, *Rising to the Challenge, the Prime Minister's Youth Health Projects and the Children's Action Plan, Mental Health and Addiction Workforce Action Plan 2017-2021*) in the mental health/addiction sector.

METHOD

The data collection for each successive *Stocktake* has been informed by brief utility surveys which follow the publication of each *Stocktake* report. While the 2004 document reported data from a national perspective, subsequent reports have included regional datasets. Based on feedback since 2004, data are now presented nationally and regionally.

The 2016 *Stocktake* includes:

- Infant, child and adolescent population data: Statistics NZ Census data (prioritised ethnicity) and projections by ethnicity and DHB.
- Infant, child and adolescent funding data from the Ministry of Health's Price Volume Schedules.
- Workforce data: Provided by 20 DHB (Inpatient & Community) Infant, Child and Adolescent Mental Health /Alcohol and Other Drug (ICAMH/AOD) Services workforce data, comprising actual and vacant full time equivalents (FTEs) and ethnicity by occupational group, and 106 non-DHB service providers, as at 30 June 2016.
- Client access to service data extracted from the Programme for the Integration of Mental Health Data (PRIMHD), which includes access to service data from the 2006 to 2015 period.
- Comparisons of access to service data against Mental Health Commission's access target rates for the infant, child and adolescent population (Mental Health Commission, 1998).

INFANT, CHILD AND ADOLESCENT POPULATION STATISTICS

Four sets of infant, child and adolescent (0-19 years) population statistics have been used in this *Stocktake*:

- The 2016, 2021 and 2026 population projections for 0-19 years (Base 2013 Census; prioritised ethnicity) used in this report were provided by Statistics NZ.
- While the 2014 population projections were available, the 2013 Census population (prioritised ethnicity) data were deemed to more accurately reflect the 2014 population aged 0 to 19 years. Therefore, the 2013 Census was used for the analysis of the 0-19 year population data and the infant, child and adolescent mental health workforce data. The 2013 Census data were provided by Statistics NZ.
- The 2008 to 2012 population projections were derived from the resident population 30 June 2006 Census (total response). The projections are based on assumptions about fertility, mortality and migration, and provide an indication of possible changes in the size of each population. These data were provided by the Ministry of Health.
- The 2006 Census (prioritised ethnicity population statistics, Māori, Pacific, Asian and Other for the 0-19 year age group) was used in the analysis of the 2006 infant, child and adolescent mental health workforce data. These data were provided by Statistics NZ. The projections were also based on prioritised ethnicity, which is defined as:

  Where a service user reports more than 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 (Statistics New Zealand, 2004a, p. 16).
- The 2005 population projections for the 0-19 year age group (based on the 2001 Census) were used to calculate the population-based access rates for the MHINC section of the 2005 data. These population data were provided by the Ministry of Health.

Prioritised ethnicity population statistics are the most frequently used by the Ministry of Health. Prioritised data are widely used in the health and disability sector for funding calculations and to monitor changes in the ethnic composition of service utilisation. The advantage of using prioritised ethnicity statistics is that they are easy to work with as each individual appears only once, hence the sum of the ethnic group populations will add up to the total New Zealand population.

2015/2016 DHB AND NGO ICAMH/AOD HEALTH FUNDING DATA

The 2016 funding data were extracted from the 2015/2016 Price Volume Schedule (PVS) supplied by the Ministry of Health. Funding information for previous *Stocktake* periods are also presented for comparison. Funding data are presented by region and DHB area.

2016 DHB & NGO ICAMH/AOD WORKFORCE DATA

The stocktake workforce surveys (see Appendix E) were sent to all DHB Chief Executive Officers (CEOs) and Mental Health Managers in early July 2016 and had a 100% response rate.

The list of DHB funded NGOs providing ICAMH/AOD services as at June 2016 was extracted from the 2015/2016 PVS supplied by the Ministry of Health. A total of 106 DHB funded, non-DHB providers (includes NGOs and Iwi Providers) were identified and surveyed by telephone in November 2016. Contracted FTE volume data from the Ministry of Health's Price Volume Schedule (PVS) were used as an estimate for the one large NGO provider in the Midland region who did not provide data.

The data gathered on the infant, child and adolescent mental health workforce have been split into two categories: "clinical" and "non-clinical".

The clinical workforce in this report includes alcohol and drug workers, counsellors, mental health nurses, occupational therapists, psychiatrists, psychotherapists, clinical or registered psychologists, and social workers.

The non-clinical workforce includes the workforce that provides direct support or care for clients and in this report includes cultural workers (kaumātua, kuia or other cultural appointments), specific liaison appointments, mental health support workers, mental health consumers, and family workers.

Although workforce data are collected and presented on the basis of the above categories, FTEs are not necessarily funded or allocated to the occupational groups. DHBs recruit staff from various disciplines based on relevant skills and competencies to fill a certain number of funded clinical FTEs. Recruitment is not necessarily conducted according to occupational groups.

PROGRAMME FOR THE INTEGRATION OF MENTAL HEALTH DATA (PRIMHD) - CLIENT ACCESS TO MENTAL HEALTH SERVICES DATA

In July 2008, the Ministry of Health conducted an integration of mental health data that incorporated both MHINC and the Mental Health Standard Measures of Assessment and Recovery (MH-SMART) to form a single national database for mental health and addiction, called PRIMHD.

The PRIMHD database contains both service activity data as well as information on outcomes at local, regional and national levels. The database also contains information on the provision of secondary mental health and alcohol and drug services purchased by the Mental Health Group (Ministry of Health). This includes secondary, inpatient, outpatient and community care provided by DHBs and NGOs. DHBs and NGOs send their previous month's mental health and addiction services data electronically, i.e. referral, activity and outcomes data, to the PRIMHD system. However, PRIMHD *does not* include data on NGO client diagnosis, classifications or legal status; nor NGO client outcome data. PRIMHD also does not include information from primary health organisations (PHOs) or general practitioners (GPs) who may be delivering mental health or addiction services.

With the implementation of PRIMHD in the NGO sector over the past few years, a significant number of NGOs are now providing client data. Therefore, NGO client data for the 2010 to 2015 period are included in this stocktake.

Access to service data for the 2004 to 2008 period was extracted from the Mental Health Information National Collection (MHINC) database. Client data from July 2008 to 2013 were extracted from PRIMHD. Client access data presented in this report are based on the *Clients by DHB of Domicile* (residence) for the second half of each year (July to December). Access rates in the Stocktake reports have been calculated by dividing users in each age band and *each six month period* by the corresponding population and will therefore differ from the Ministry of Health's one year period analyses.

The PRIMHD client access data presented in this report includes the most recent data available at the time of reporting which included data from the 2012 and 2015 periods.

LIMITATIONS

POPULATION DATA

While the use of projected population statistics tends to be less accurate than actual census data, the use of outdated projections would carry further inaccuracies especially in the Canterbury area. Furthermore, any comparisons with census data which was based on prioritised ethnicity will carry that inaccuracy.

WORKFORCE DATA

Both DHB and non-DHB provider workforce data presented in this report are subject to the quality of the data supplied by the service providers.

The 2004 to 2016 workforce data are also presented in this report and serve as a comparison. However, due to the possible inclusion of adult workforce FTEs in the NGO data, not just ICAMH workforce numbers, and the lower response rate in 2004, the 2004 data may not be directly comparable. This may largely explain some of the significant changes in the 2006 and 2008 NGO infant, child and adolescent mental health workforce. With subsequent improvements in data collection processes, the data are likely to reflect more accurately the infant, child and adolescent mental health/AOD workforce.

The workforce information is derived from workforce data (Actual & Vacant Full Time Equivalents (FTEs) & Ethnicity by Occupational Group) submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services and 105/106 NGOs as at 30 June 2016. Consistently missing data from one large NGO in the Midland region continues to impact on the accuracy of NGO workforce data. While, contracted FTE data from the MOH's Price Volume Schedule (PVS) were used to estimate this NGO's workforce, these data do not include information by ethnicity and occupational group, therefore the NGO workforce, especially for the Midland region remains underestimated.

All services that were surveyed were asked to provide the number of Māori, Pacific and Asian staff (FTE and headcount) by occupational group. Ethnicity information about staff was provided by managers and not by the individuals themselves. Additionally, FTE data by occupational group and ethnicity were also requested but were not provided in a consistent manner. Therefore, staff ethnicity data presented in this *Stocktake* should be interpreted with caution.

Although the limitations mentioned above apply to both DHB and non-DHB providers, there were a number of factors that impinged on the provision of accurate data that were specific to the NGO sector.

As identified from the first *Stocktake*, obtaining workforce data from the NGO sector via post was not a successful method; however, the majority of providers supplied data willingly when contacted by telephone. Despite an increased response rate via telephone, there are some concerns about the accuracy of some of the information about the NGO sector for the following reasons.

- Contract information from the PVS, which was used as a benchmark for this data collection, was found to be inaccurate or out of date in some instances.
- As well as Ministry of Health funding, many non-DHB providers are funded from a number of different sources (such as Ministry of Social Development, Accident Compensation Corporation, and Youth Justice). Because of their unique blending of services, it can be difficult to clearly identify which portion of funding sits with each FTE.
- A number of providers with infant, child and adolescent mental health contracts provide a seamless service spanning all ages through to adulthood. In many services, the focus may be on mental health issues within the whole family. Identifying which portion of the FTE fits within the DHB funded infant, child and adolescent contract is often difficult for providers to ascertain.

- NGO contracts may be devolved to a number of different providers. NGOs also receive a variable number of contracts over time.
- Rural and isolated areas have issues with recruiting and retaining staff who have an interest or skills in the infant, child and adolescent area. If the organisation has unfilled FTE positions, it may be required to return funds to the DHB, which can therefore lead to caution around reporting on unfilled vacancies.
- Some organisations had concerns that the *Stocktake* was a form of audit and were reluctant to participate fully.

PRIMHD ACCESS DATA

The presentation of the client access information is subject to the following limitations and therefore must be interpreted with these in mind.

- Previous MHINC and the current PRIMHD databases contain the raw data sent in by providers and are therefore subject to the variable quality of information captured by the client management systems of each DHB and NGO.
- Improvements in client access to services could be partly a result of more services over time submitting client data to PRIMHD. Alternatively, decreases seen in the number of clients could also be a result of fewer numbers of NGOs submitting to PRIMHD.
- Client access rates are calculated using the best available population data at the time of reporting. The 2006 and 2013 client access rates were calculated using census data and therefore are more accurate than the access rates (2008-2016) calculated using population projections (projected population statistics tend to be less accurate than actual census data).

USING THE STOCKTAKE

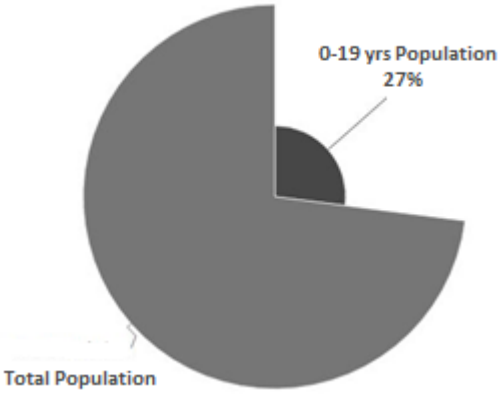
The data are made available for each DHB and NGO to assess their position. More detailed data and the previous *Stocktakes* are available on the Werry Workforce-Whāraurau website (**www.werryworkforce.org**).

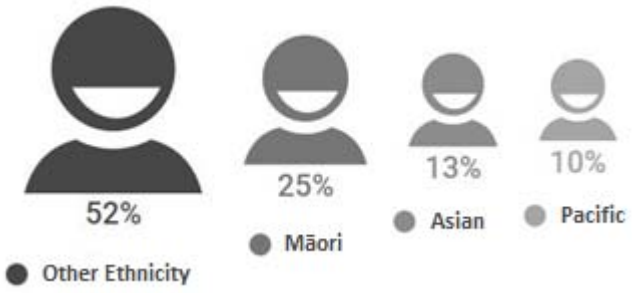
NATIONAL OVERVIEW

INFANT, CHILD AND ADOLESCENT POPULATION

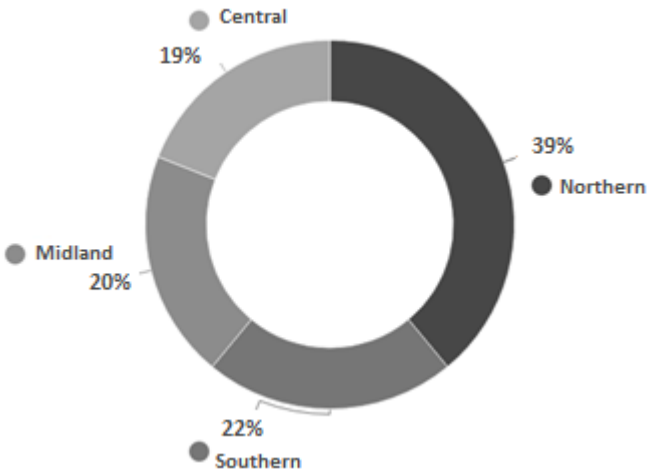
The population data include the 2016 infant, child and adolescent population projections (prioritised ethnicity, Base Census 2013) provided by Statistics NZ.

- The 2016 projections showed a 2% increase in the overall 0-19 year population since the 2013 Census (see Appendix A, Table 1).
- This increase was seen in three out of the four regions with the largest increases seen in the Northern and Southern regions by 2%. Very little change was projected for the Central region.
- In 2016, infants, children and adolescents (0-19 years) made up 27% of New Zealand's total population. Just over half (51%) of the 0-19 year population are male.
- Just over half of the 0-19 year population were in the Other Ethnicity group (52%), followed by Māori (25%), Asian (13%) and Pacific (10%).





- The majority (39%) reside in the Northern region and within this region, the largest proportions reside in the Counties Manukau (34%) and Waitemata (32%) DHB areas (see Appendix A, Table 1).
- The child and youth population will continue to grow with a 2% growth projected for 2026. This growth will be seen mainly in the Māori, Pacific and Asian populations by 12%, 9% and 35% respectively, in all four regions (see Appendix A, Table 2).

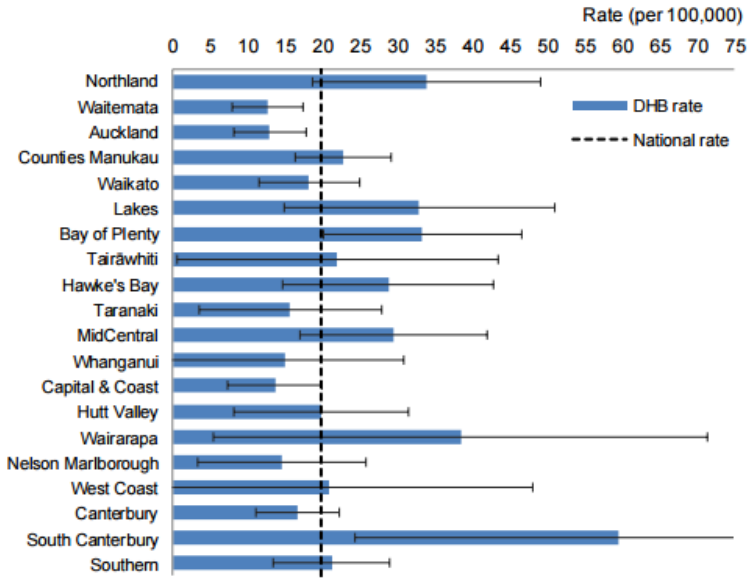


- An indicator for youth disengagement is the proportion of young people who are not in employment, education or training (NEET).
    - *The proportion of youth (aged 15-24 years) not in employment, education or training (NEET) rose 1.4 percentage points over the quarter to 12.4 per cent in March 2016, the highest rate since March 2013. This increase was due to the total number of NEET increasing by 10,000 (13.9 per cent) over the quarter, while the youth population grew by 4,000 (0.6 per cent). The increase in overall NEET rates was driven by males aged 15-19. Over both the year and quarter, this was the only group that showed a statistically significant increase in NEET rates and NEET numbers. The NEET rate for males aged 15-19 was 10.2 percent which had increased by 3.2 percentage points* (Statistics New Zealand, 2016, p. 9).
- In general, the literature highlights the following personal and social outcomes for NEETs:
    - Prolonged periods out of education and employment can lead to marginalisation and dependence, with young people failing to establish a sense of direction (Cote, 2000).
    - Unemployment can lead to poor physical and mental health outcomes. Literature notes that unemployment can result in individuals feeling lonely, powerless, anxious or depressed (Creed & Reynolds, 2001).
    - Disengagement from education and employment can lead to further exclusion and increased association with risk behaviours. Greater use of drugs, alcohol and criminal activity are often associated with unemployment (Fergusson, Horwood, & Woodward, 2001).
    - Finally, NEETs are more likely to be parents at an early age and face ongoing issues with housing and homelessness (Cusworth, et al., 2009).
- The increasing and consistently high NEET rate will continue to impact on the mental health and wellbeing of those already in high risk groups. This in turn can predict an even greater need for mental health services.
- The most recent Adolescent Health Research Group findings, via their National Youth Health School Surveys in 2012 of 8,500 secondary students aged 12-18 years old (Clark et al., 2013), found that in the previous 12 months:
    - 16% of females and 9% of males reported symptoms of depression which are likely to be clinically significant (i.e. likely to have an impact on a student's daily life) (p.22).
    - 38% of females and 23% of males reported feeling down or depressed most of the day for at least two weeks in a row during the last 12 months (p.22).
    - 29% of females and 18% of male students had deliberately harmed themselves (p.22).
    - 21% of females and 10% of male students had seriously thought about suicide.
    - 6% of females and 2% of males had made a suicide attempt.
    - Current drinkers (45%) reported a range of problems that had occurred after drinking alcohol, including unsafe sex (12%), unwanted sex (5%), or injuries (15%).
    - 13% used marijuana and 'other' drug use was uncommon. Party pills (4%) and ecstasy (3%) were the most common other drugs ever used. Most students who reported using ecstasy had used it only once. The use of other drugs, such as LSD (acid), heroin, methamphetamine ('P'), or speed, was uncommon. Less than 1% reported ever using 'P' and most of these students reported only having used it once (p.23).

- Approximately 1% reported that they were transgender (a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl e.g. Trans, Queen, Fa'afafine, Whakawāhine, Tangata ira Tane, Genderqueer, p.25). These students experienced compromised mental health and personal safety, and they described more difficulty accessing healthcare (Clark et al., 2014). Approximately 40% of transgender students had significant depressive symptoms and nearly half had self-harmed in the previous 12 months. One in five transgender students had attempted suicide in the last year. Nearly 40% of transgender students had been unable to access healthcare when they needed it.

- 2013 suicide rates were highest amongst youth (15-24 years) with a national rate of 18 suicides per 100,000 youth population compared to the national rate of 11 per 100,000 (Ministry of Health, 2016).
    - The suicide rate for 15-19 year olds was 17.6 per 100,000, accounting for 35% of all deaths; the suicide rate in this age group was higher for males (19.3 per 100,000).
    - The suicide rates by ethnicity for 15-24 year olds were as follows:
        - Māori had the highest rate of 38.4 per 100,000 (Males: 47; Females: 31.2 per 100,000).
        - Pacific: 24 per 100,000 (Males: 34.3; Females: 13.8 per 100,000).
        - Asian: 5.5 per 100,000 (Males: 7.2; Females: 3.7 per 100,000).
    - Highest suicide rates were in the highest deprivation areas (15.4 per 100,000 total population). The association between deprivation level and suicide is most apparent in the youth population (15–24 years), which were at least four times the number of suicides in deprivation quintiles 3–5 (5 represents the most deprived) compared with quintiles 1 and 2 (1 represents the least deprived).
    - By DHB area, South Canterbury, Wairarapa, Northland, Lakes, Bay of Plenty, MidCentral and Hawke's Bay had higher youth suicide rates than the national rate; however, South Canterbury and Bay of Plenty DHB areas had rates that were significantly higher than the national rate (see Figure 1).

Figure 1. Youth (15-24 years) Suicide Rates by DHB Area (2013)



Notes:

Rates are age specific and expressed per 100,000 youth population.

Error bars represent 99% confidence intervals. If a DHB region's confidence interval does not overlap the national suicide rate, the DHB rate is either statistically significantly higher or lower than the national rate.

Source: New Zealand Mortality Collection

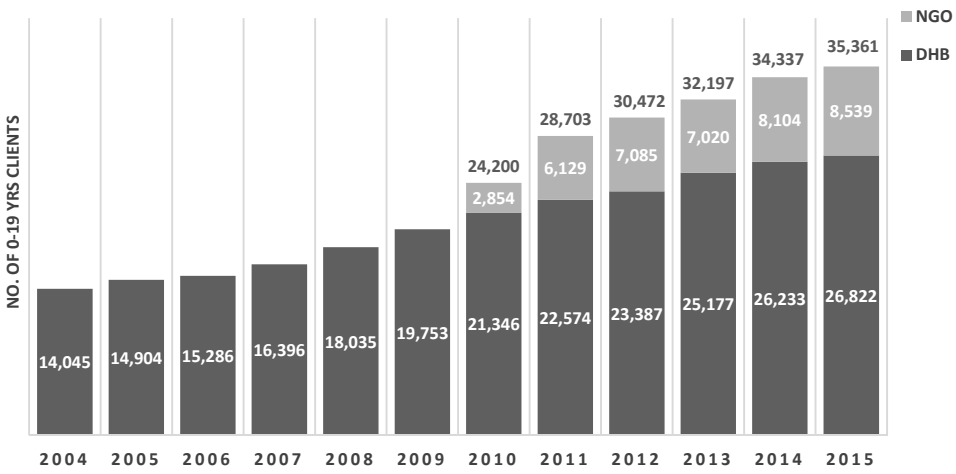
Source: Ministry of Health (2016, p. 25).

CLIENT ACCESS TO ICAMH/AOD SERVICES

The client access to service data (number of clients seen by DHB & NGO ICAMH/AOD services) have been extracted from the *Programme for the Integration of Mental Health Data* (PRIMHD). Access data are based on the *Clients by DHB of Domicile* (residence) for the second six months of each year (July to December). NGO client data have been included since 2010. Data from 142 NGOs were included in the 2014 client access information and 139 NGOs were included in the 2015 client data.

From 2013 to 2015:

- There continues to be an increasing trend in the number of clients accessing services nationally.
- There was an overall 10% increase in the total number of clients accessing ICAMH/AOD services from 2013 to 2015 (see Figure 2).
- This increase was seen in both female (by 11%) and male clients (by 9%) accessing services.
- The Northern region had the largest increase in clients (by 20%) accessing services compared to the other three regions.



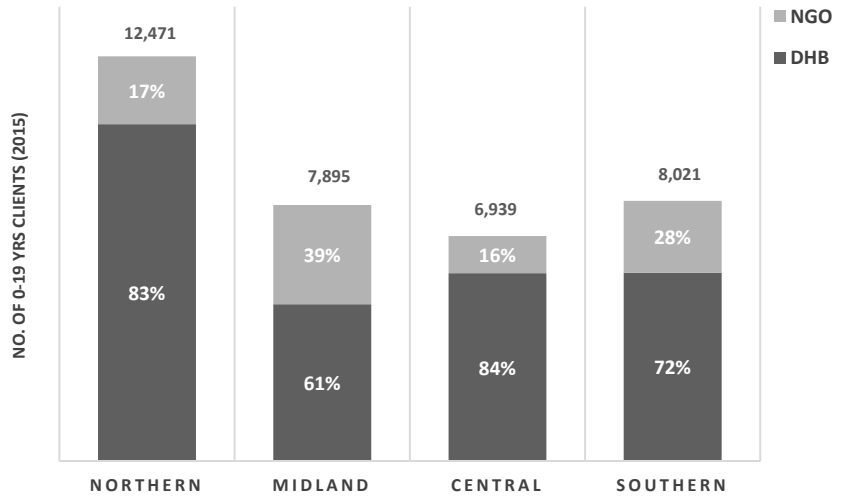
In the second half of 2015:

- Clients by age group showed that over half of all clients accessing services (55%) were in the 15-19 year age group (see Appendix B, Table 2).
- There were more male clients accessing ICAMH/AOD services (52%) than females (48%).

- Clients by ethnicity showed that the Other Ethnicity made up the majority of clients (58%), followed by Māori (32%), Pacific (6%) and Asian (3%).

- The majority of the 0-19 year clients (76%) continued to be seen by DHB provider services.
    - GP (27%), Self/Relative (12%) and Education Sector (10%) referrals were the largest referral sources for DHB provider services.
- 24% of the 0-19 year clients were seen by NGO provider services.
    - Self/Relative (21%), Education Sector (21%) and Child & Adolescent Mental Health Services (11%) referrals were the largest referral sources for the NGO sector.
- The Midland region had the largest percentage of clients accessing non-DHB provider services (39%) compared to the other three regions (see Figure 3).

Figure 3. Total 0-19 yrs Clients by Region (2015)



CLIENT ACCESS RATES

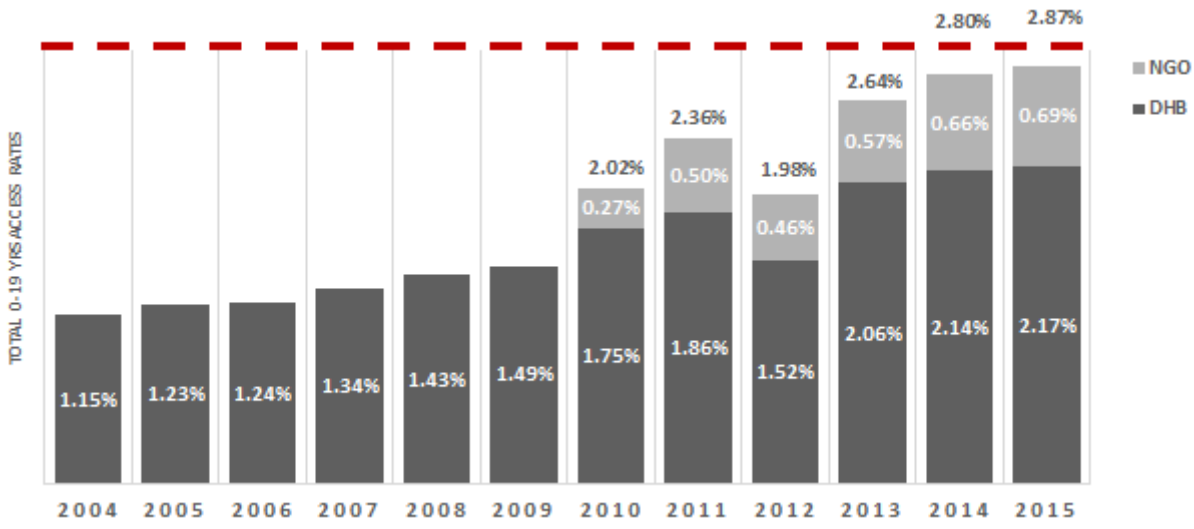
The Mental Health Commission suggested that 3% of the total infant, child and adolescent population should be able to access appropriate services according to need (which in 2015 equates to 37,008 for the 0-19 year population of 1,233,620). The *Blueprint Access Benchmark Rate* for the 0-19 year age group has been set at 3% of the population over a six month period (Mental Health Commission, 1998). Due to different prevalence rates for mental illness in different age groups, the MHC has set appropriate access rates for each age group: 1% for the 0-9 year age group; 3.9% for the 10-14 year age group and 5.5% for the 15-19 year age group.

The access rates presented in this section were calculated by dividing the clients in each age band per six month period by the corresponding population. Access rates are not affected by referral to regional services as they are based on the DHB where the client lives (DHB of Domicile). However, access rates are affected by the population data used. Client access rates are calculated using the best available population data at the time of reporting. The 2006 and 2013 client access rates were calculated using census data and are therefore more accurate than the access rates calculated using population projections (projected population statistics tend to be less accurate than actual census data).

From 2013 to 2015:

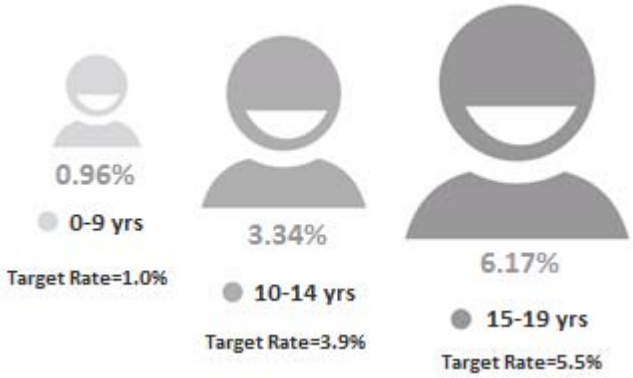
- There was an increase in access rates for the overall 0-19 year clients from 2.64% to 2.87% (see Figure 4).
- Improvements in access rates were seen in all three age groups, especially in the 10-14 and 15-19 year age groups (Appendix B, Table 8).

Figure 4. National 0-19 yrs Client Access Rates (2004-2015)



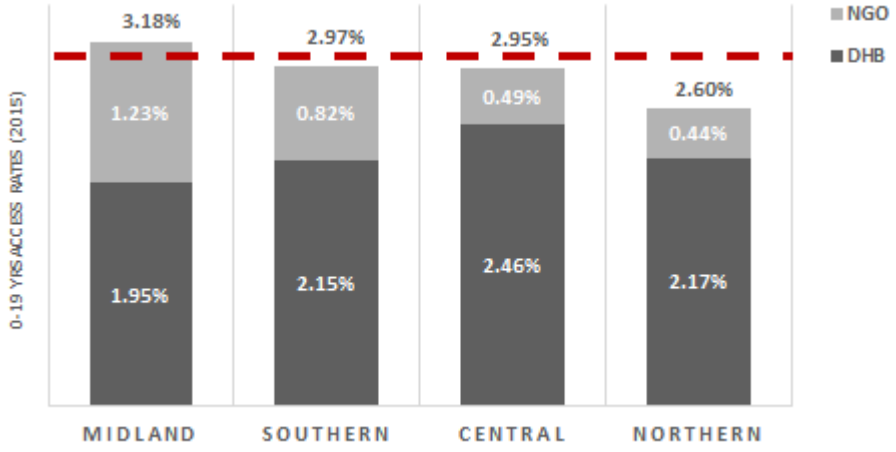
In the second six months of 2015:

- The greatest improvement was seen in the 15-19 year age group with an access rate of 6.17%, the only age to exceed the target rate of 5.5% set by the MHC for that age group (Appendix B, Table 8).
- Access rates by ethnicity showed Māori having the highest rate of 3.66% followed by Other Ethnicity (3.18%). Asian access rates continued to remain the lowest at 0.75%.



- Access rates by region showed that the Midland region was the only region in the country to exceed the target rate, while Southern and Central regions were very close (see Figure 5).
- The Northern region had the lowest access rate of 2.60%.
- While the remainder of the regions showed progress towards the target rate of 3%, access rates still need to improve for the Northern region, especially for the 10-14 year age.

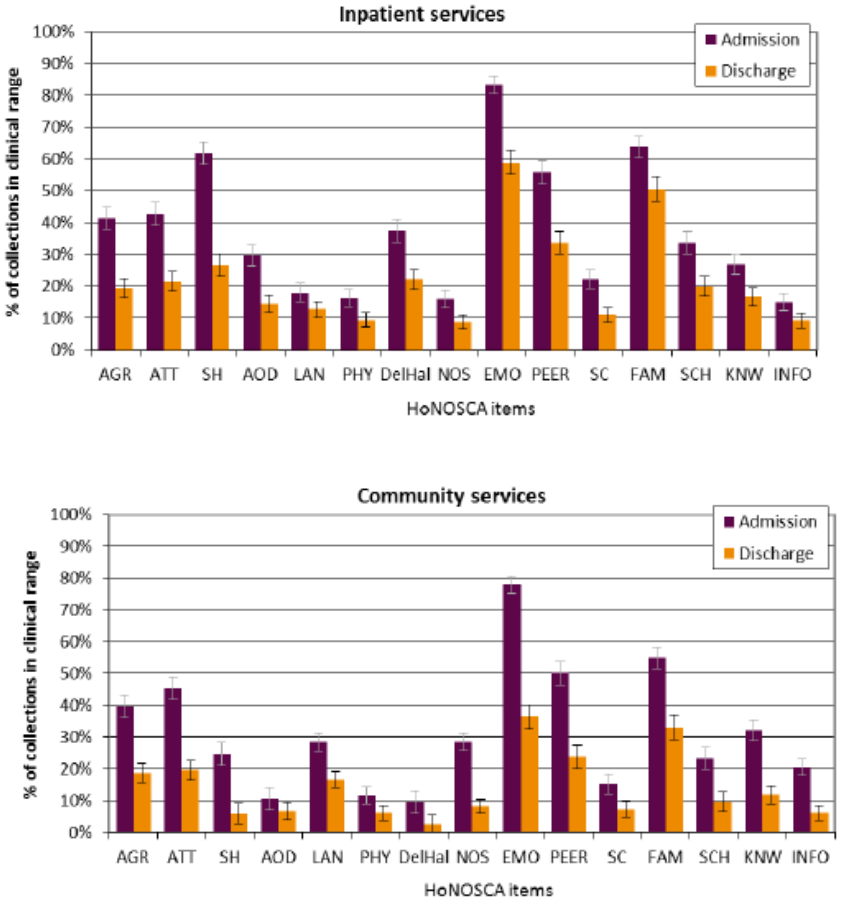
Figure 5. Total 0-19 yrs Client Access Rates by Region (2015)



CLIENT OUTCOMES

To assess whether clients accessing mental health services experience improvements in their mental health and wellbeing, children and youth health outcomes are rated by the *HoNOSCA* (Health of the Nation Outcome Scales for Children and Adolescents) for children and adolescents 4-17 years, at admission and discharge from community child and adolescent mental health services. Client outcome data for the 2015/2016 period showed significant improvements in emotional related symptoms by time of discharge from both inpatient and community mental health services (see EMO scores in Figure 6).

Figure 6. Infant, Child and Adolescent Client Outcomes by Services (2015/2016)



Note: Percentage of service users in the clinical range (2, 3 or 4) for each HoNOSCA items.
Source: Ministry of Health, PRIMHD extract, 16 January 2017, analysed and formatted by Te Pou.

Source: Ministry of Health, PRIMHD extract 16 January 2017, extracted & formatted by Te Pou.

FUNDING OF ICAMH/AOD SERVICES

Funding data for DHB and NGO services for the 2015/2016 financial year were extracted from Price Volume Schedules (PVS) supplied by the MOH.

- From 2014 to 2016:
    - There was a 7% increase in total funding for ICAMH/AOD services (including Youth Primary Mental Health funding) (see Figure 7 & Table 1).
    - Funding by provider services showed an 8% increase in DHB services and a 3% increase in NGOs (Appendix C, Table 1).
    - Funding by services showed that the largest funding increase was for Forensic services, by 79% followed by AOD services by 11% (see Table 1).

Figure 7. ICAMH/AOD Funding (2004-2016)

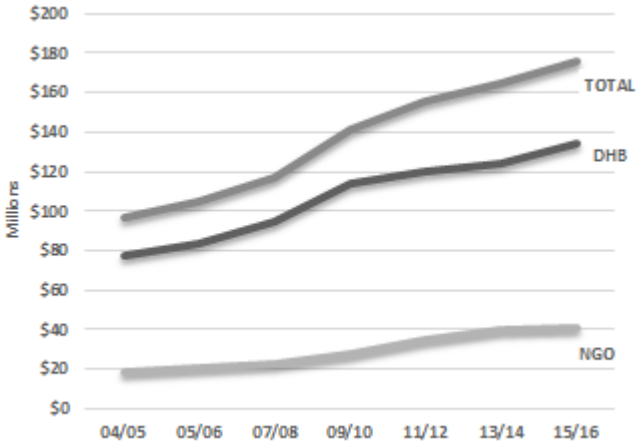


Table 1. ICAMH/AOD Funding by Services

SERVICES	ICAMH/AOD FUNDING BY SERVICES (2008-2016)					
	07/08	09/10	11/12	13/14	15/16	% Chang (2016-2014)
INPATIENT	$16,116,851	$16,233,302	$14,290,399	$14,320,606	$14,192,776	-1
ALCOHOL & OTHER DRUG	$8,688,761	$11,679,940	$18,983,015	$21,072,508	$23,386,143	11
CHILD & YOUTH MENTAL HEALTH	$91,916,224	$105,995,340	$118,895,261	$123,289,829	$126,000,120	2
FORENSIC	-	-	$1,995,477	$5,635,624	$10,066,585	79
KAUPAPA MĀORI	-	$7,683,265	$1,212,203	-	-	-
YOUTH PRIMARY MENTAL HEALTH	-	-	-	-	$1,900,000	-
TOTAL	$116,721,836	$141,591,846	$155,376,355	$164,318,566	$175,545,624	7

1. Includes Residential Services

Source: Ministry of Health Price Volume Schedule 2007-2016. *Updated July 2017.

- Youth primary mental health funding of $11.3 million has been allocated over four years from 2012/13 to 2015/16. Of this $11.3 million, $8.9 million came from within DHB baselines and a further $1.9 million was allocated across the 20 DHBs from 1 July 2015. DHBs decided on how to use the additional funding, responding to local needs and opportunities (Malatest International, 2016b, p. 7).
- DHB portfolio managers were mostly able to describe how the Ministry of Health share of the funding had been allocated but many were not able to link the redirected pharmaceutical savings to specific YPMHS activities. Redirected pharmaceutical savings may be part of the overall pool of money for mental health used for DHB services or allocated to PHO and NGO services. Where redirected savings were used to adapt or expand existing services, it may not be possible, or useful, for DHBs to report about what different funding streams have achieved in service delivery.
- The *Blueprint* recommended that infant, child and adolescent mental health services should receive 26% of the total mental health funding (Mental Health Commission, 1998, p.29). This figure was based on the estimated number of infants, children and adolescents likely to have a mental illness and require treatment; and the population of this age group.

- In 2015/2016:
    - ICAMH/AOD provider services received 13% of the overall DHB mental health funding ($1,384.8 million). While the proportion of funding appears to be below the recommended level for the infant, child and adolescent population, the relative cost of treatment for infants, children and adolescents compared to adults using current models of care remains unknown. Additionally, the cost impacts on secondary services from the increasing provision of primary mental health services (most of which have been adult-centric until recently) are also unknown. We also don't know how much service provision for 17-19 year olds is delivered by services in the adult funding stream because of ICAMHS upper age limits or other factors.
    - DHB ICAMH/AOD services received 77% of this funding while NGOs received 23% (see Appendix C, Table 1).
    - Funding by region showed that the Northern region received the largest ICAMH/AOD funding (35%) (see Table 2 & Figure 8).

- From 2014 to 2016:
    - With the inclusion of the Youth Primary Mental Health funding, funding per 0-19 years population had increased by 6%, from $122.82 to $129.93 (excluding Inpatient funding) (see Table 2).
    - Funding per 0-19 year population by region showed increases in all four regions (see Table 2).

Figure 8. ICAMH/AOD Funding by Region (2016)

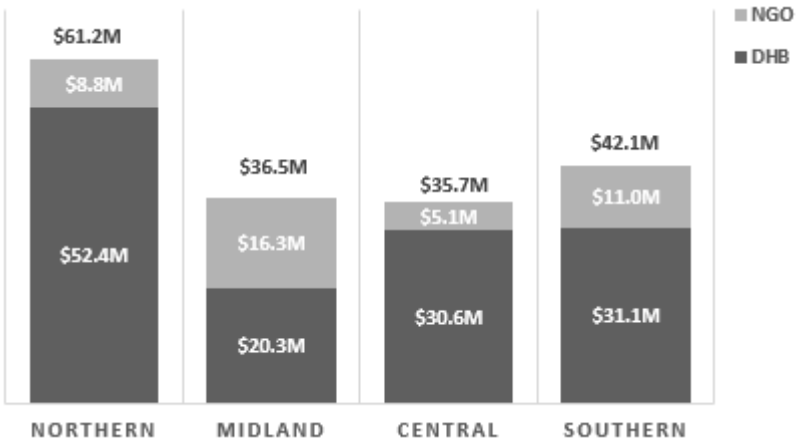


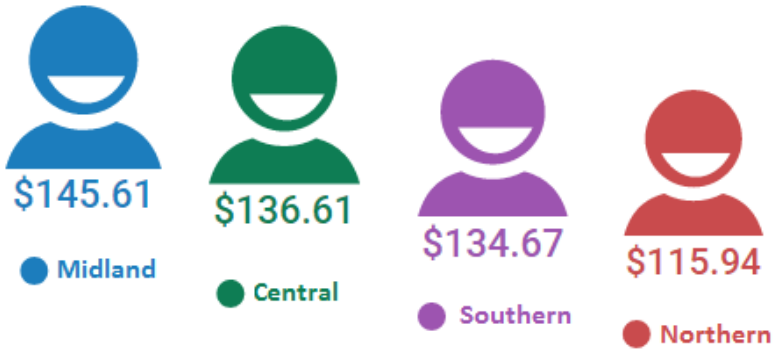
Table 2. Spend per head 0-19 years Population by Region

REGION	SPEND PER HEAD 0-19 YEARS (2004-2016)						
	04/05	05/06	07/08	09/10	11/12	13/14	15/16
NORTHERN	$50.27	$63.77	$74.47	$92.92	$103.47	$106.62	$115.94
MIDLAND	$70.91	$83.64	$77.86	$107.51	$137.94	$143.82	$145.61
CENTRAL	$76.63	$89.17	$88.75	$112.04	$125.86	$124.22	$136.61
SOUTHERN	$86.18	$87.57	$96.89	$110.75	$113.80	$130.97	$134.67
NATIONAL AVERAGE SPEND	$70.27	$78.20	$82.88	$103.57	$110.67	$122.82	$129.93

Note: Incudes DHB & MOH ICAMH/AOD & Youth Primary Mental Health Funding. Excludes Inpatient Funding. Updated July 2017.

- For the 2015/2016 financial year:
    - The Midland ($145.61) and Central ($136.61) regions had the highest spend per head of infant, child and adolescent population (see Table 2 & Figure 9).
    - The Northern region had the lowest ($115.94).

Figure 9. Spend per 0-19 year population by Region (2016)



PROVISION OF ICAMH/AOD SERVICES

- There are 20 DHBs that provide a range of specialist Inpatient and Community based Infant, Child and Adolescent (0-19 year age group) Mental Health and Alcohol and Other Drug (ICAMH/AOD) services.
- Regional child and adolescent mental health inpatient services are provided by three DHBs:
    - Auckland
    - Capital & Coast (Wellington)
    - Canterbury (Christchurch)
    - When children and youth require acute in-patient admission, they may be briefly admitted to a local paediatric or adult unit while arrangements are made for admission to one of the three regional child and youth services such as the new Youth Forensic Inpatient Unit in Kenepuru.
- ICAMH/AOD services are also provided by DHB funded non-DHB service providers which include NGOs, Iwi Services and in some cases primary health organisations (PHOs).
- For the June 2015 to July 2016 period, 106 non-DHB service providers were identified as providing DHB funded ICAMH/AOD services.
- The increases in the development and provision of services for infants, children and adolescents are aligned with the priorities of *Te Raukura* (Ministry of Health, 2007). From 2004 to 2016, increases can be seen in the number and types of services that are available for infants, children and adolescents. All services are now inclusive of infants (0-4 year age group) with either dedicated services or teams for the infant population.
- Fourteen out of the 20 DHB ICAMH services indicated that they provided care pathways for trans and gender diverse youth.
- DHBs' use of the Youth Primary Mental Health funding is based on local needs and opportunities. There are four broad service development areas, as highlighted in the recent evaluation of primary mental health services (Malatest International, 2016b, p. 7):
    - Expansion of the age range of existing primary mental health services, e.g. by increasing funding available to PHOs and other providers for packages of care and brief interventions.
    - Adapting existing primary mental health services for youth, e.g. by creating a new youth mental health co-ordinator role.
    - Expanding existing NGO or community-based initiatives, e.g. funding new roles or programmes.
    - Developing new initiatives to meet local needs, e.g. youth psychologists co-located in schools and NGO youth services, and/or funding youth specific services ranging from resilience building to treatment.

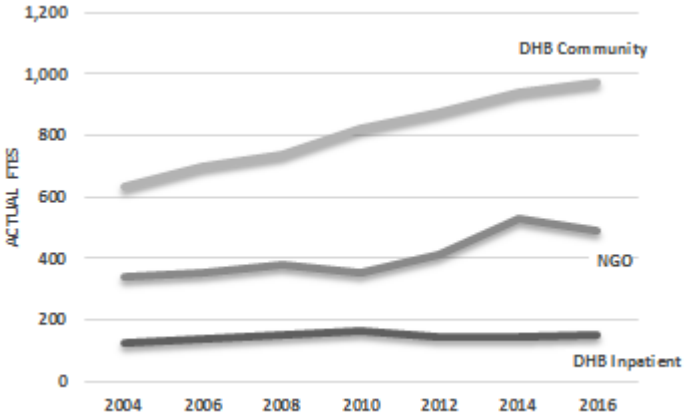
THE ICAMH/AOD WORKFORCE

The following information is derived from workforce data (Actual & Vacant Full Time Equivalents (FTEs) & Ethnicity by Occupational Group) submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services and 105/106 non-DHB service providers as at 30 June 2016. Consistently missing data from one large NGO in the Midland region continues to impact on the accuracy of NGO workforce data. While, contracted FTE data from the MOH's Price Volume Schedule (PVS) were used to estimate this NGO's workforce, these data do not include information by ethnicity and occupational group, therefore the NGO workforce, especially for the Midland region remains underestimated.

From 2014 to 2016:

- There was a 1% overall decrease in the total ICAMH/AOD workforce (DHB Inpatient & Community ICAMH/AOD & NGOs), from 1,618.7 to 1,609.9 actual FTEs (see Table 3 & Figure 10).
- This decrease in the workforce was seen in the NGO workforce by 8%, from 532.4 to 489.1 actual FTEs. This is largely due to the reduction in the number of NGOs that were funded to provide services for the 2015/2016 period (112 in 2014; 106 in 2016).

Figure 10. Total ICAMH/AOD Workforce by Provider Services (2004-2016)



- However, a 3% increase was seen in the DHB workforce (Inpatient & Community), from 1,086.34 to 1,120.9 actual FTEs, largely in clinical roles.
- There was a 3% increase in total vacancies, from 141.7 to 146.5 FTEs, with the 2016 vacancy rate at 8%. This increase in vacancies was largely seen in DHB services for Clinical roles by 10%, from 114.13 to 125.19 FTEs.

Table 3. Total ICAMH/AOD Workforce (2006-2016)

PROVIDER SERVICE	ACTUAL FTES						VACANT FTES					
	2006	2008	2010	2012	2014	2016	2006	2008	2010	2012	2014	2016
DHB INPATIENT	136.1	153.4	163.9	140.8	143.9	147.7	25.1	14.9	9.0	15.6	21.9	16.2
DHB COMMUNITY	696.2	735.5	822.9	877.5	942.4	973.61	98.6	80.5	100.5	74.3	108.2	120.0
NGO*	352.2	379.9	355.5	412.2	532.4	489.1	9.6	16.3	12.0	3.8	12.6	10.3
TOTAL	1,184.5	1,268.8	1,342.3	1,430.6	1,618.7	1,610.5	133.3	111.7	121.5	93.8	141.7	146.5

*** Missing data from one large NGO in the Midland region. Contracted FTE volume data from the MOH Price Volume Schedule (PVS) were used as an estimate.**

As at 30 June 2016:

- The Northern region had the largest ICAMH/AOD workforce (564.71 FTEs), followed by the Southern Region (398.7 FTEs) (see Figure 13).
- The majority (70%) of the ICAMH/AOD workforce was in DHB services (see Table 4).
- The ICAMH/AOD workforce was mainly NZ European (58%), followed by Māori (18%), Other Ethnicity (12%), Pacific (7%) and Asian (5%) (see Appendix D, Table 18).
- The majority of the workforce (74%) was in Clinical roles as Mental Health Nurses (16%), Social Workers (13%) and Psychologists (12%) and AOD Practitioners (8%) (see Table 4).
- The Non-Clinical workforce was mainly Mental Health Support Workers (44%), Youth Workers (27%) and in Other Non-Clinical roles (14%) (Advocacy & Peer Support roles).

Figure 11. Top 4 ICAMH/AOD Workforce by Occupational Group (2016)

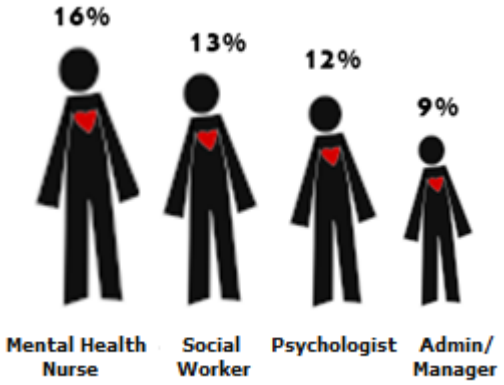
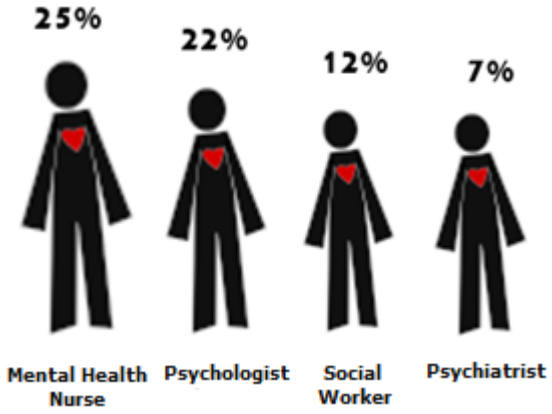


Figure 12. Top 4 ICAMH/AOD Vacancies by Occupational Group (2016)



- Vacancies were largely in DHB services for Clinical roles (Mental Health Nurses, Psychologists, Psychiatrists and Social Workers) (see Table 5 & Figure 12).
- The overall annual turnover rate for the ICAMH/AOD workforce was 16% (DHB = 13% and NGO = 28%) for Psychologists, Mental Health Support Workers, Social Workers and Nurses. The main reasons for leaving were other job opportunities, personal/family reasons and relocating to another city/town within New Zealand.

Figure 13. Total ICAMH/AOD Workforce by Region (2004-2016)

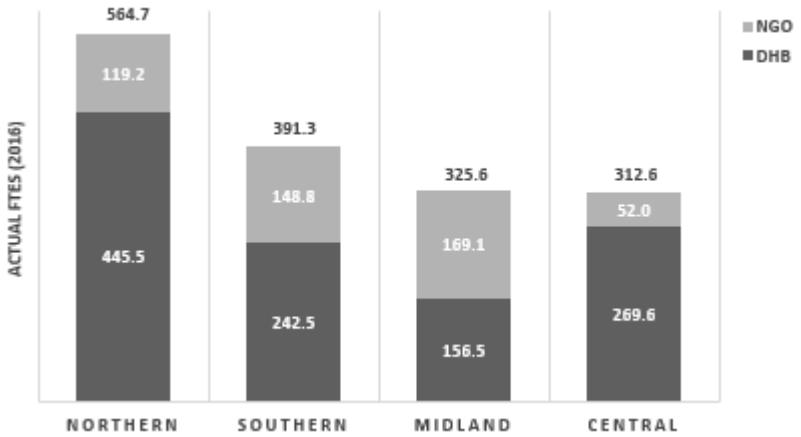


Table 4. Total ICAMH/AOD Workforce by Occupational Group (2016)

OCCUPATIONAL GROUP (ACTUAL FTES, 2016)	DHB		DHB TOTAL	NGO	TOTAL
	INPATIENT	COMMUNITY			
ALCOHOL & DRUG PRACTITIONER	-	51.0	51.0	75.05	126.05
CEP CLINICIAN	-	17.3	17.3	11.7	29.0
MENTAL HEALTH NURSE	72.24	171.25	243.49	11.6	255.09
OCCUPATIONAL THERAPIST	7.4	65.95	73.35	8.45	81.8
PSYCHIATRIST	9.12	79.05	88.17	3.4	91.57
PSYCHOTHERAPIST	1.1	25.25	26.35	2.25	28.6
PSYCHOLOGIST	11.4	168.47	179.87	6.0	185.87
SOCIAL WORKER	6.2	155.58	161.78	46.75	208.53
OTHER CLINICAL[1]	14.2	72.0	86.2	98.4	184.6
CLINICAL SUB-TOTAL	121.66	805.85	927.51	263.6	1,191.11
CULTURAL APPOINTMENT	2.2	26.9	29.10	3.90	33.0
SPECIFIC LIAISON	-	1.5	1.5	-	1.5
MENTAL HEALTH CONSUMER ADVISOR	-	4.2	4.2	1.66	5.86
MENTAL HEALTH SUPPORT WORKER	15.0	10.5	25.5	93.08	118.58
YOUTH WORKER	-	6.7	6.7	66.52	73.22
OTHER NON-CLINICAL SUPPORT FOR CLIENTS[2]	1.0	6.8	7.8	31.14	38.94
NON-CLINICAL SUPPORT FOR CLIENTS SUB-TOTAL	18.2	56.6	74.8	196.30	271.1
ADMINISTRATION/MANAGEMENT	8.0	111.16	119.16	29.15	148.31
NATIONAL TOTAL	147.86	973.61	1,121.47	489.05	1,610.52

1. **Other Clinical Occupational Group = Head Officer; C&A MOSS; Registrars; Supervisor; Counsellors. Clinical Interns (Psychology; Occupation Therapy; Social Work; Nursing); Nurses (RN; Clinical Nurse Specialist); Counsellor; Family Therapist; Clinical Coordinator; Youth Forensic; Child Therapist; Adolescent Physicians; Clinical Head; Clinical Supervisor; Dietician; Paediatrician; Eating Disorder Liaison; NESP Social Worker; Māori Mental Health Professional; Music Therapist; COPMIA; Child & Youth Liaison; Allied Health; GP Liaison; Needs Assessor; Adventure Therapist; MST Therapist.**
2. **Other Non-Clinical Support for Clients = Family/ Whānau Advisors; Community Workers; Early Childhood Teachers; Cook; Needs Assessors/Service Co-ordinators.**

Table 5. Total ICAMH/AOD Workforce Vacancies by Occupational Group (2016)

OCCUPATIONAL GROUP (VACANT FTES, 2016)	DHB		DHB TOTAL	NGO	TOTAL
	INPATIENT	COMMUNITY			
ALCOHOL & DRUG PRACTITIONER	-	3.0	3.0	0.5	3.5
CEP CLINICIAN	-	1.8	1.8	-	1.8
MENTAL HEALTH NURSE	9.4	26.82	36.22	1.0	37.22
OCCUPATIONAL THERAPIST	0.5	9.0	9.5	-	9.5
PSYCHIATRIST	2.0	8.0	10.0	-	10.0
PSYCHOTHERAPIST	-	0.75	0.75	-	0.75
PSYCHOLOGIST	1.0	31.45	32.45	-	32.45
SOCIAL WORKER	2.32	14.85	17.17	-	17.17
OTHER CLINICAL[1]	-	14.3	14.3	-	14.3
CLINICAL SUB-TOTAL	15.22	109.97	125.19	1.5	126.69
CULTURAL APPOINTMENT	-	1.95	1.95	-	1.95
MENTAL HEALTH SUPPORT WORKER	1.0	4.0	5.0	2.0	7.0
YOUTH WORKER	-	-	-	6.78	6.78
NON-CLINICAL SUPPORT FOR CLIENTS SUB-TOTAL	1.0	5.95	6.95	8.78	15.73
ADMINISTRATION/MANAGEMENT	-	4.1	4.1	-	4.1
NATIONAL TOTAL	16.22	120.02	136.24	10.28	146.52

1. **Other Clinical = Eating Disorder Liaison Clinician; Registered Nurse; Family Therapist; Registrar: Counsellor; Case Manager; Allied Health; Infant/Child Clinician**

DHB INPATIENT ICAMH WORKFORCE

From 2014 to 2016:

- A 3% increase in the Inpatient workforce from 143.9 to 147.9 FTEs (see Table 3).
- A decrease in vacancies from 21.9 to 16.2 FTEs (10% vacancy rate).

As at June 2016:

- Auckland DHB Child and Family Unit continues to report the largest Inpatient workforce (63.92 FTEs) followed by Canterbury (51.14 FTEs) and Capital & Coast (32.8 FTEs) DHBs.

Figure 14. Top 4 DHB Inpatient Workforce by Occupational Group (2016)

- The Inpatient Clinical workforce was comprised mainly of Mental Health Nurses (49%; 72.24 FTEs) (see Table 4 & Figure 14).
- The Non-Clinical Inpatient workforce (non-clinical support for clients) was comprised mainly of Mental Health Support Workers (82%; 15 FTEs).
- 94% of the vacancies were for clinical roles, mainly for Mental Health Nurses (58%; 9.4 FTEs).

DHB COMMUNITY ICAMH/AOD WORKFORCE

From 2014 to 2016:

- 3% increase in the DHB Community workforce from 942.4 to 973.6 FTEs (Table 3).
- 11% increase in vacancies from 108.2 to 120.0 vacant FTEs (11% vacancy rate).

As at June 2016:

- The Northern region reported the largest Community workforce (381.57 FTEs) followed by Central (236.81 FTEs), Southern (198.8 FTEs) and Midland (156.45 FTEs) regions.
- The Community Clinical workforce was largely comprised of Mental Health Nurses (18%), Psychologists (17%), Social Workers (16%) and Psychiatrists (8%) (see Table 4 & Figure 15).

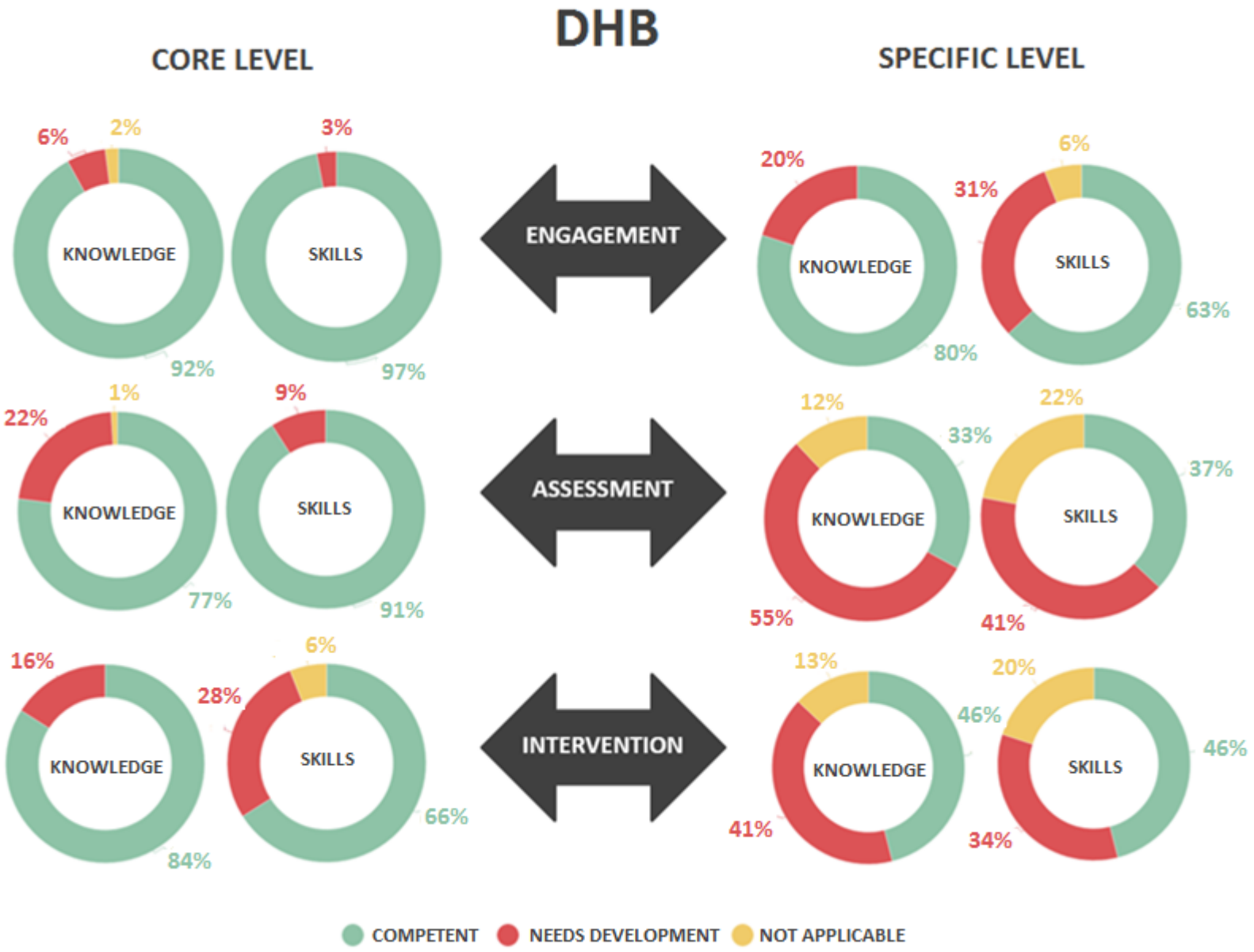
Figure 15. Top 4 DHB Community Workforce by Occupational Group (2016)

- The Non-Clinical (support for clients) workforce consisted largely of Cultural roles (3%) (see Table 4).
- 92% of the vacancies were for Clinical roles: Psychologists (26%; 31.45 FTEs), Mental Health Nurses (22%; 26.82 FTEs) and Social Workers (12%; 14.85 FTEs) (see Table 5).
- DHB services had an overall annual staff turnover rate of 13% mainly for Social Workers, Psychologists and Nurses. Reasons for leaving were job opportunities in other DHB CAMHS, relocation to another city within New Zealand and retirement.

COMPETENCY OF THE DHB WORKFORCE

- *Real Skills Plus ICAMHS* (The Werry Centre, 2009b) is a competency framework that describes the knowledge, skills and attitudes that a practitioner needs in order to work with infants, children and young people who have moderate to severe mental health and/or alcohol or other drug (AOD) difficulties. These competencies, as assessed by the *E-Skills Plus* online tool, identify areas for workforce development both for individuals and teams and can be used to plan service delivery. Individual/teams are assessed on their *Core Level Competencies,* which are basic competencies that all practitioners should possess or be working towards in ICAMH services, and *Specific Level Competencies* which are senior specialist staff skills and knowledge. Different members of the team will have different profiles of specific level competence. At a team or service level, the combination of these competencies should reflect the needs of the team or service.
- At least one individual/team from all DHB ICAMH/AOD services completed the *E-Skills Plus* tool and these data showed that the DHB ICAMH workforce met 80% of ***Core Level*** and 50% of ***Specific Level*** **(Specialist) competencies** for Engagement, Assessment and Intervention skills and knowledge across all areas (Infant, Child, Adolescent, Family and Leadership); indicating the greatest areas of development were required at the Specific (Specialist) Level (see Figure 16).

Figure 16. DHB E-Skills Plus Competencies



CULTURAL COMPETENCIES:

- Via the 2016 Stocktake Workforce Survey, services were asked to indicate the Māori and Pacific health models of practice used in service delivery. Eighteen of the 20 DHB ICAMH/AOD provider services indicated that they used Māori models and eight indicated that they used a Pacific health model of practice within their services.
- The most commonly used Māori health model was *Te Whare Tapa Wha* (Durie, 1985), followed by *Te Wheke; Mahia a Atua; Te Pounamu* and various others *(Tapu na, Pa Harakeke, Te Waka, Nga Take Pu, Te Tuariki o te ora, Te ara waiora a tane, Tuakere o te tangata, Whānau Ora; Dynamics of Whanaungatanga*). Services develop and embed these models in various ways:
    - A cultural assessment model developed by their cultural team.
    - Māori health models are embedded in all their assessment/treatment plans and form part of a service's core competencies training.
    - Services receive internal support from Māori services within their own DHBs' cultural advisors/support workers.
    - Services also receive support from a number of external Māori NGOs who provide culturally appropriate assessments, support and advice as needed.
- Pacific health models are not as widely used as Māori health models. Only eight DHBs indicated using Pacific health models in their service delivery. Where used, the most commonly used Pacific health model was the *Fonofale model* (Pulotu-Endemann, 1995). Services embed these models in various ways:
    - Pacific health models are embedded in their assessment/treatment plans and form part of a service's core competencies training.
    - Services receive internal support from Pacific teams/services and cultural advisors/support workers or have specifically appointed staff to work with Pacific clients.
    - Pacific services embed the models into their clinical and cultural assessment tools.

CURRENT AND FUTURE WORKFORCE CHALLENGES

CURRENT CHALLENGES/GAPS

As part of the 2016 workforce survey, services were also asked to identify their current and future workforce challenges and gaps. All DHB provider services responded to this question. The following themes were identified:

- Recruitment/retention of specialist staff: High turnover of staff and shortage of specialist staff with youth mental health experience.
- Access to specialist training: Lack of specific training and lack of funding and time to access training.
- Increasing service demand: Increase in complex needs.
- Working with diverse cultures: Lack of cultural services and lack of cultural competency training.
- Lack of funding/limited resources.

FUTURE CHALLENGES/GAPS

- Recruiting/retaining specialist staff: The need to attract and recruit specialist staff due to an ageing workforce.
- Meeting high service demand: The need to provide more specialist services in innovative ways to meet growing demand.
- Accessing specialist training: The need for more specialised training to cater for complex cases.
- Lack of funding/limited resources: The need to access specialist training; recruit and retain staff; and develop technology and new ways of working to meet high and complex demand.
- Working with diverse cultures: The need for services to cater for the increasing ethnic diversity in New Zealand.
- Keeping up with technology: The need to keep up with the rapidly changing technology and the need to develop new ways of delivering services, e.g. e-therapies.
- Working collaboratively: The need to work across agencies.

NGO ICAMH/AOD WORKFORCE

Consistently missing data from one large NGO in the Midland region continues to impact on the accuracy of NGO workforce data. Total contracted FTE volume data from the Ministry of Health's Price Volume Schedule (PVS) were used to estimate this NGO's workforce instead. However, these data do not include information by ethnicity and occupational group, therefore the NGO workforce, especially in the Midland region remains underestimated.

From 2014 to 2016:

- An 8% decrease in the NGO workforce from 532.4 to 489.1 actual FTEs. This could be partly due to a smaller number of NGOs that were contracted to provide ICAMH/AOD services in 2016 (112 in 2014; 106 in 2016) (see Table 3).
- This decrease was largely seen in the Non-Clinical workforce by 13% (excluding Admin/Management).
- Regionally, decreases in the NGO workforce was seen in three out of the four regions: Northern, Central and Southern, while a 4% increase was seen in the Midland region.

As at June 2016:

- The Midland region reported the largest NGO workforce (169.1 FTEs) followed by Southern (148.78 FTEs), Northern (119.22 FTEs) and Central (51.95 FTEs) regions.
- The NGO Non-Clinical (support for clients) workforce was mainly comprised of Mental Health Support Workers (47%; 93.08 FTEs), which made up 19% of the total NGO workforce, followed by Youth Workers (34%; 66.52 FTEs).
- The NGO Clinical workforce was mainly comprised of Other Clinical roles (37%; 98.4 FTEs), Alcohol and Drug Practitioners (28%; 75.05 FTEs), and Social Workers (18%; 46.75 FTEs) (see Table 4 & Figure 17).

Figure 17. Top 4 NGO Community Workforce by Occupational Group (2016)

- Vacancies were mainly for Youth Workers and Mental Health Support Workers (see Table 5).

- Annual staff turnover information was provided by 24 out of the 106 NGOs. Based on these data, the annual staff turnover rate for NGOs was at 28%, mainly for Mental Health Support Workers, AOD Practitioners and Youth Workers. The main reasons for leaving were personal reasons, other job opportunities and career development (promotions and further study).

COMPETENCY OF THE NGO WORKFORCE

- Only 5 NGOs had completed the *E-Skills Plus* tool, therefore current NGO competency information may not represent the wider NGO sector and is excluded from this report.

CULTURAL COMPETENCIES:

- The most commonly used Māori model for NGOs was *Te Whare Tapa Wha*, followed by *Whānau Ora*; *Powhiri Poutama* and *Takarangi.* Māori NGOs had largely developed their own whānau ora based health models for their services, in consultation with their clients.
- Non-Māori NGOs received support from external Māori organisations.
- The most commonly used Pacific health models were the *Fonofale Model* and Le Va's *Engaging Pasifika Model.* Other less common models included*: Sei Tapu* and *Moana Loa.* Most of the NGO services accessed cultural support from external Pacific organisations.

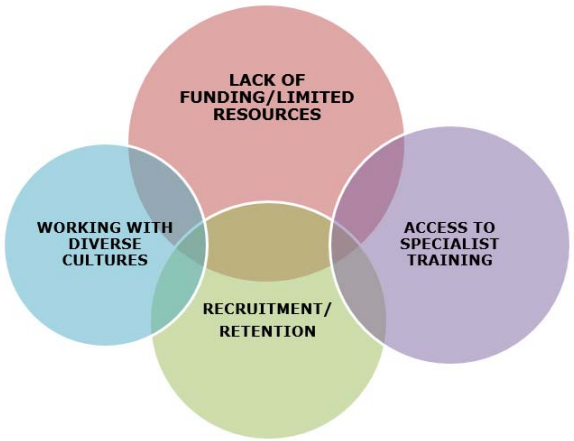
CURRENT AND FUTURE WORKFORCE CHALLENGES

Forty NGOs indicated the following workforce challenges they were currently facing and the challenges they anticipated over the next 10 years. The responses were grouped under the following themes, with the lack of funding recurring across all of the themes identified.

CURRENT CHALLENGES/GAPS

Recruitment/retention of specialist staff: Shortage of specialist staff with youth mental health experience and high turnover.

- Access to specialist training: Lack of specific training and lack of funding and time to access training.
- Working with diverse cultures: Lack of cultural services and lack of cultural competency.
- Increasing service demand: Increasing demand and complexity of needs.



FUTURE CHALLENGES/GAPS

- Recruiting/retaining specialist staff: The need to attract and recruit specialist staff due to an ageing workforce.
- Meeting high service demand: The need to provide more specialist services in innovative ways to meet growing demand.
- Accessing specialist training: The need for more specialised training to cater for complex cases.
- Lack of funding/limited resources: The need to access specialist training; recruit and retain staff; and develop technology and new ways of working to meet high and complex demand.
- Working with diverse cultures: The need for services to cater for the increasing ethnic diversity in New Zealand.

SUMMARY

New Zealand's infant, child and adolescent (0-19 years) population currently make up 27% of the total population. Population projections indicate a declining overall child and youth population; however, New Zealand's 0-19 year population is projected to become more ethnically diverse. Continued growth for Māori, Pacific and especially the Asian population are projected.

The mental health needs of children and adolescents remain high and are becoming more complex. For example, increased social acceptance of gender diversity, combined with the availability of puberty-blocking drugs, means more young people are coming out as transgender, and at an earlier age. *Youth'12* data showed that transgender youth had high rates of depression and attempted suicide and had difficulty accessing services (Clark et al., 2014).

Given the growing population and mental health needs, services should anticipate continued demand for services.

CLIENT ACCESS TO SERVICES

There continues to be an increasing trend in client access to services with the data showing a 10% increase from 2013 to 2015, largely in the female client group. The overall 2015 access rate was at 2.87% which was close to the target recommended rate of 3.0% (Mental Health Commission, 1998), with access rates in Midland (3.18%) exceeding this target rate and the Central region (2.95%) getting close to the 3% rate. Access rates by age group showed the rate for the 15-19 year age group (6.17%) had exceeded the recommended rate of 5.5%. Improvements in access rates are still required in the 0-9 year and 10-14 year age groups. Access rates also need to be improved in the Northern region as access in this region remains the lowest in the country, at 2.60%. Client outcome data have shown significant improvements for those accessing services.

The *Youth'12* survey data on high school students (Clark et al., 2013) identified several reasons for low access rates. Their data showed very little change in depressive symptoms in students from 2007 to 2012; in 2012, 16% of females and 9% of male students had clinically significant depressive symptoms. Nineteen percent of students reported that they were unable to access healthcare when needed; this was more common for females (21%) and for those from high deprivation areas (22%). Additionally, the most common barriers to access that were reported were:

- Hoping that the problems would go away or get better over time (51%)
- Didn't want to make a fuss (46%)
- Had no transport (26%).

FUNDING AND PROVISION OF SERVICES

From 2014 to 2016, there was an 8% increase in total ICAMH/AOD funding, making up 12% of the total mental health spend. There was also an increase in the types of ICAMH/AOD services that were available nationally. Twenty DHB ICAMH/AOD and 106 non-DHB service providers were funded to provide ICAMH/AOD services. DHBs continued to provide specialist mental health services. The non-DHB service sector traditionally provided support services; there has been an increase in the provision of specialist clinical services in that sector.

Despite these positive improvements, funding and service provision need to keep pace with the growing child and youth population and the growing complexity of mental health needs of infants, children and adolescents.

ICAMH/AOD WORKFORCE

The workforce data from 2014 to 2016 also showed a slight decrease in ICAMH/AOD workforce by 1%; however, DHB services reported a 3% increase, largely in the Clinical workforce. While the majority of the ICAMH/AOD workforce is in DHB services, an 8% decrease in the workforce was seen in the NGO sector, partly due to fewer services that were contracted for the 2015/2016 financial year. The overall vacancy rate was 8%, with an annual turnover rate of 16%.

Data obtained from the *E-Skills Plus* online tool indicates the capability of the ICAMH/AOD workforce. While the majority of the workforce has the required core skills for delivering services to infants, children, adolescents and their families, improvements are required at the specific (specialist) level of service delivery.

While the need for increasing the ICAMH/AOD workforce is acknowledged by services, both DHB and NGO services identified that a key challenge in increasing the workforce is that there are significant shortages in qualified clinical staff available for recruitment, and significant barriers to upskilling staff.

RECOMMENDATIONS

Between 2013 and 2015, there was a 10% increase in the total number of clients accessing ICAMH/AOD services. Between 2014 and 2016, there was a 2% increase in funding to ICAMH/AOD services and a 1% decrease in the workforce. While the relationships between funding, staffing and access are complex, it seems clear that investment in services and workforce has led to worthwhile gains. It is possible to say that while gains have been made, there are persistent gaps that still need to be addressed.

In light of these 2016 *Stocktake* findings, and to ensure alignment with current government priorities and progress toward workforce strategic goals, the following recommendations are made. Recommendations specific to Māori, Pacific and Asian service provision and workforce are outlined in the sections specific to these populations below.

IMPROVING CLIENT ACCESS TO ICAMH/AOD SERVICES

- Mental health outcome data have shown significant improvements in client emotional wellbeing as a result of accessing services. Therefore, while there have been improvements in access to services for all clients, especially Māori, continuing to build on these increased access rates remains an area of importance for the health and wellbeing of infants, children and adolescents, especially for the Pacific and Asian 0-19 years population.
- Identifying and reducing barriers to access, especially for those below 15 years of age and for Pacific and Asian clients, should continue to be a key focus.

DEVELOPMENT/PROVISION OF SERVICES

- ***Early Intervention:***
    - While Blueprint access rates give priority to access for adolescents, the importance of intervening early in the pre-school age group is increasingly being recognised. Evidence suggests that intervention in the 0-4 year age group is most cost effective (Knudsen et al., 2006), with the potential to prevent mental health problems in the longer term (Olds & Kitzman, 1993; Wouldes et al., 2011). Therefore, intervening early, developing early intervention services at primary level, and enhancing the pathways from primary to secondary services are essential.
    - Increase/enhance school-based health services in secondary schools. *Youth'12* results on health services in secondary schools showed positive associations between aspects of health services in schools and mental health outcomes of students at the same schools. There was less overall depression and suicide risk among students attending schools with any level of school health services (Denny et al., 2014); more specifically, schools with:
        - A health team on site
        - More than 2.5 hours of nursing and doctor time per week per 100 students
        - Health staff with postgraduate training
        - Routine psychosocial health screening using HEEADSSS screening.

- Given that 10% of all the 15-19 year old population are not in employment, education or training (NEET) (Statistics New Zealand, 2016), providing alternative, community-based clinics for young people who are not at school could help to alleviate some of the access issues highlighted.
- GPs continue to be the largest source of referrals to ICAMH/AOD services; therefore, continued development of primary services to deliver mental health care may help reduce the demand on ICAMH/AOD specialist services and NGOs.
- Young people in New Zealand have high rates of internet access and use (Gibson et al., 2013; Statistics New Zealand, 2004b). SPARX (Smart, Positive, Active, Realistic, X-Factor thoughts) is an evidence-based, computer-based e-therapy tool that delivers cognitive behavioural therapy (CBT) via an interactive fantasy game, designed for at-risk youth (12-19 years), for mild to moderate depression/anxiety. A recent evaluation showed overall improvements in depressive symptoms of young people who had used SPARX (Malatest International, 2016a). Therefore, developing and promoting online e-therapy tools (e.g. SPARX, Merry et al., 2012) is potentially an effective way of intervening early and increasing access to treatment.

WORKFORCE DEVELOPMENT IN SPECIALIST SERVICES

- High turnover and an ageing workforce require continued investment in succession planning and targeted recruitment strategies for specialist roles to cater for an increase of complexity in needs and demand for services. While increasing the ICAMH/AOD workforce is a long-term solution to current workforce shortages, the retention and development of the existing ICAMH/AOD workforce is pertinent. Additionally, a quarter of all clients are accessing NGO services; therefore, addressing the workforce development needs of the NGO sector also needs to be considered. Strategies for recruiting, retaining and developing the ICAMH/AOD workforce should include:
  - ***Funding and Planning:***
    - DHBs need to actively monitor local service demands and workforce development needs and ensure funding is allocated accordingly between DHB and NGOs.
    - Ensure that local schools, tertiary education providers, Youth One Stop Shops (YOSS), PHOs, NGOs and DHBs are all part of the strategic planning process.
    - Use national competency frameworks such as *Real Skills Plus* within the training sector to inform and create a 'job ready' child and adolescent mental health workforce.
  - ***Recruitment and Retention:***
    - An ageing workforce and high turnover of specialist staff require continued investment into active, targeted recruitment and retention strategies for specialist roles and to ensure these strategies are embedded in a service's strategic plans.
    - A concerted drive is required to recruit new graduates and train them to work in specialist ICAMH services in order to address this gap.
  - ***Training and Professional Development****:*
    - ***Identify Training Needs:*** Identify key training gaps at individual and service levels using the *E-Skills Plus a*ssessment tool. This tool can be used as part of individual performance appraisals, professional portfolios and obtaining guidance for ongoing study. At a service level, it can provide guidance for staff training and service development. It can also show areas to focus on when recruiting new staff.
    - ***Access to Specialist Training****:* Given the growing complexity of child and adolescent mental health needs (e.g. youth suicide; transgender youth), improvements (as assessed by the *E-Skills Plus* tool) are required in **specialist** knowledge and skill development for DHB service providers. However, accessing these specialist trainings has been identified as a key

workforce challenge for most services. Therefore, enhancing and supporting access to specialist training should be a priority.

- ***Clinical and Cultural Competency Development***: Given that the New Zealand 0-19 year population is becoming ethnically diverse and the majority of children and young people continue to access mainstream services, increasing dual clinical/cultural and cross-cultural competencies across services is needed, by implementing available competency frameworks, e.g. *Real Skills Plus CAMHS* (The Werry Centre, 2009)*; Takarangi Māori Competency Framework* (Matua Raki, 2010)*;* and *Real Skills Plus Seitapu Pacific Competency Framework* (Te Pou, 2009).
- ***Career Pathways:*** Provide career pathways to support experienced workers, especially those from the unregulated workforce, to better support the specialist workforce.

o ***Exploring New Roles and Ways of Working:***

- ***Youth Consumer Workforce:*** Currently, the youth consumer workforce makes up a very small proportion (0.3%) of the total ICAMH/AOD workforce. Building a youth consumer workforce can help services identify youth trends, keep up to date with rapidly advancing technology, identify gaps in service delivery, decrease youth continually re-entering services, improve the credibility of services and reduce barriers to access. Having youth consumer workers can also lead to increased communication with youth-driven services and projects, as addressed in the future issues identified by DHBs (The Werry Centre, 2009a).
- ***Service Re-design***: Funding constraints and limited resources were also identified as key challenges to workforce development; therefore, considering service redevelopment and design to use existing resources more efficiently is required (e.g. York & Kingsbury's 2013 *Choice and Partnership Approach*).
- ***Working Collaboratively:*** Engage in collaborative service delivery between PHOs, NGOs and DHBs. Building relationships and working in partnership with other services to overcome shortages in the workforce is occurring in some areas and could be an effective strategy in sharing limited resources, especially in providing clinical support to NGOs (particularly in rural areas). NGOs can also provide cultural support to DHBs.

DATA COLLECTION

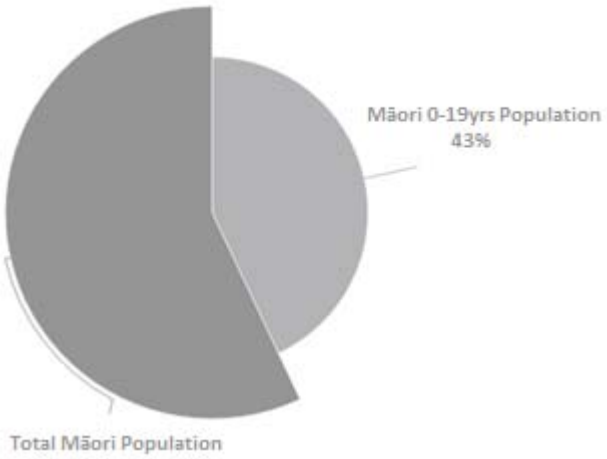
- Continue to extend data collection to include new developments in the sector (e.g. developments in early intervention and the primary mental health sector; inter-agency collaborations; innovative solutions and practice).
- Continue to monitor trends to ensure that progress in services and staffing is keeping pace with population increases and demand, and moving towards better outcomes for infants, children and adolescents and their families.

MĀORI NATIONAL OVERVIEW

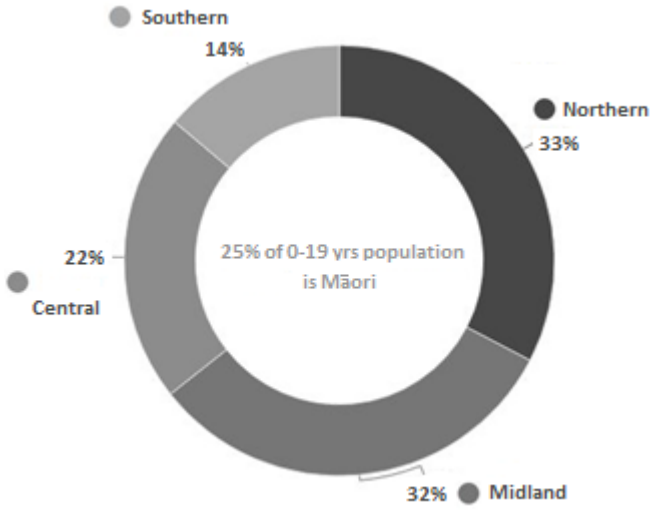
MĀORI TAMARIKI AND RANGATAHI POPULATION

The population data include the 2016 infant, child and adolescent population projections (prioritised ethnicity) provided by Statistics NZ.

- 2016 projections showed an overall increase in the Māori 0-19 year population by 4% since Census 2013 (see Appendix A, Table 1). This increase was seen in all four regions, with the largest increase in the Southern region (by 7%), followed by the Midland region (by 5%).
- Māori continue to be a youthful population. Nearly half (43%) of the Māori population in New Zealand was 0-19 years old.
- A quarter (25%) of New Zealand's 0-19 year population was Māori. About half (51%) of the Māori 0-19 year population are male.



- A third of the country's Māori infant, child and adolescent population reside in the Northern region and within the region, 37% reside in Counties Manukau, 25% in Waitemata and 25% in Northland. Auckland DHB area continues to have the lowest Māori population in the Northern region (14%) (see Appendix A, Table 1).



- An overall 12% growth is projected by 2026 across all regions, with the largest growth projected for the Southern region by 20% (see Appendix A, Table 2).

MĀORI TAMARIKI AND RANGATAHI MENTAL HEALTH NEEDS

- The Māori population in New Zealand is more likely to come from areas of greater deprivation than non-Māori (Ministry of Health, 2010b). Economic deprivation has been linked to a higher incidence of mental health problems (Fortune et al., 2010).
- Recent studies such as the *Growing Up in New Zealand* longitudinal study (Morton et al., 2014), which has followed 7,000 New Zealand children from before birth since 2009 and 2010, have shown that "*Māori & Pacific children tend to be exposed to a greater number of risk factors for vulnerability than New Zealand European or Asian children. Exposure to multiple risk factors for vulnerability at any one time point increases the likelihood that children will experience poor health outcomes during their first 1000 days of development"* (Morton et al., 2014, p. v).
- The proportion of young people who are not in employment, education or training (NEET) is used as an indicator of youth disengagement (Ministry of Business Innovation & Employment, 2016a).
- Māori have higher NEET rates than other ethnic groups. As at March 2016, there were 130,200 Māori aged 15-24 years. Of these, 27,500 people were NEET (21.1%), an increase from 25,800 a year ago. The NEET rates for both Māori females and males rose; NEET rates were 16.9% for males and 25.4% for females. The NEET rate for Māori aged 15-19 years rose from 12.5% in the March 2015 year to 14.4% in March 2016 (Ministry of Business Innovation & Employment, 2016a).
- The consistently high NEET rate will continue to impact on the mental health and wellbeing of those already in high risk groups. This in turn can predict an even greater need for mental health services.
- Higher need for mental health services for Māori children and adolescents has been documented by Fergusson, Poulton, Horwood, Milne and Swain-Campbell (2003) and reiterated by the Adolescent Health Research Group (2003), Clark et al., (2008) and Crengle et al., (2013).
- The most recent Adolescent Health Research Group findings via their National Youth Health School Surveys in 2012 (Crengle et al., 2013) of 1,701 Māori students found that:
    - Higher proportions of Māori youth lived in areas of higher deprivation compared to NZ European/Pakeha students than in 2007.
    - Access to Healthcare:
        - Māori youth accessed the following most common health services: Family Doctors (72.4%); School Health Clinics (18.6%); Hospital Emergency (17.5%); and After Hours 24hr Accident & Medical Clinics (10.5%).
        - Access to healthcare had not improved from 2007 to 2012: Māori youth were less likely to have accessed a GP in the previous 12 months than were NZ European/Pākehā students. Younger Māori (< 13 years) and those who lived in higher deprivation areas less frequently reported accessing a GP.
            - 21.9% had not been able to access healthcare when needed.
    - Emotional and Mental Health:
        - Depressive symptoms had not improved from 2007 (10.6%) to 2012 (13.9%): 13.9% reported significant depressive symptoms, with more females (18.3%) reporting symptoms than did males (8.7%). However, there were no differences in symptoms when compared to NZ European/Pākehā students.
        - Self-harm: 28.7% reported they had self-harmed in the previous 12 months, with females (36.6%) more likely than males (19.8%) to report this.

- Suicidal thoughts: 18.7% had seriously thought about killing themselves in the previous year, with suicidal thoughts more common in females (26%) than males (10.3%).
- Suicide attempts: Improvements from 2004 (11.9%) to 2007 (6.9%) and 2012 (6.5%): 6.5% had made a suicide attempt; more common in females (9.2%). Furthermore, Māori were more likely to report having made an attempt than were NZ European/Pākehā students.
- Seeking help: 22.2% had seen someone for emotional worries in the previous 12 months, with females (26.9%) seeking help more frequently than males (16.8%).
- Substance use:
    - Current smokers: 18.5%
    - Current drinkers: 56.8%; drinking increased with age
    - Current users of marijuana: 20.7%; more common in males than females. More Māori youth who lived in higher deprivation areas reported smoking marijuana weekly than did those living in medium deprivation areas.

- The latest suicide data show Māori (especially Māori youth aged 15–24 years) and those living in the most deprived areas have the highest suicide rates in the country (38.4 suicides per 100,000 youth population), compared to Pacific (24 per 100,000), European/Other (16.5 per 100,000) and Asian (5.5 per 100,000). Māori males within this age range have the highest suicide rate of 49.7 per 100,000 (Ministry of Health, 2016).
- These socioeconomic factors and mental health needs for Māori infants, children and adolescents strongly signal the need to improve mental health outcomes for Māori children and young people as a key priority.

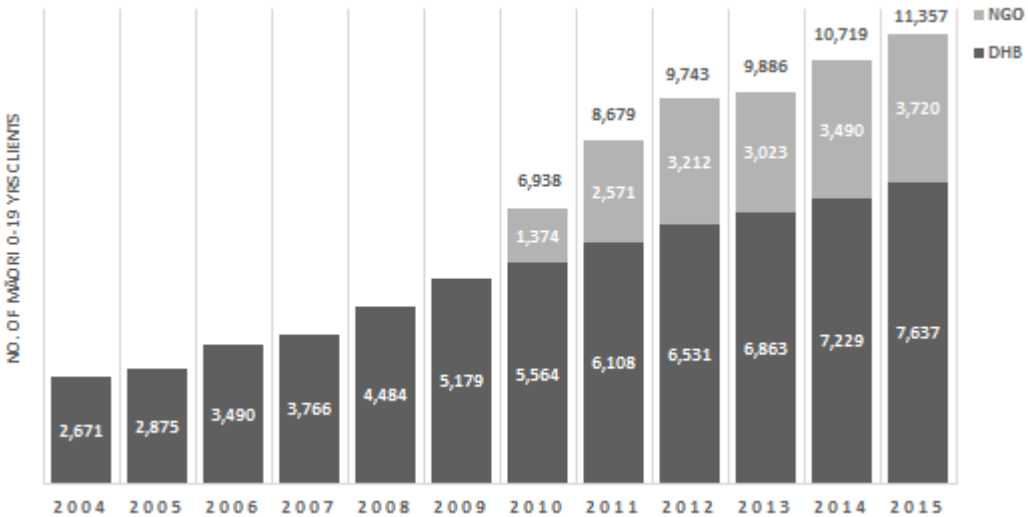
TAMARIKI AND RANGATAHI CLIENT ACCESS TO ICAMH/AOD SERVICES

The client access to service data (number of clients seen by DHB & NGO ICAMH/AOD services) have been extracted from the *Programme for the Integration of Mental Health Data* (PRIMHD). Access data are based on the *Clients by DHB of Domicile* (residence) for the second six months of each year (July to December). NGO client data have been included since 2010. Data from 142 NGOs were included in the 2014 client access information and 139 NGOs were included for the 2015 client data.

From 2013 to 2015:

- There was a 15% overall increase in the number of Māori clients accessing services nationally (see Figure 18).
- Clients by gender showed an overall increase in both Māori female and male clients (by 17% and 13% respectively).

Figure 18. Māori Tamariki & Rangatahi Clients (2004-2015)



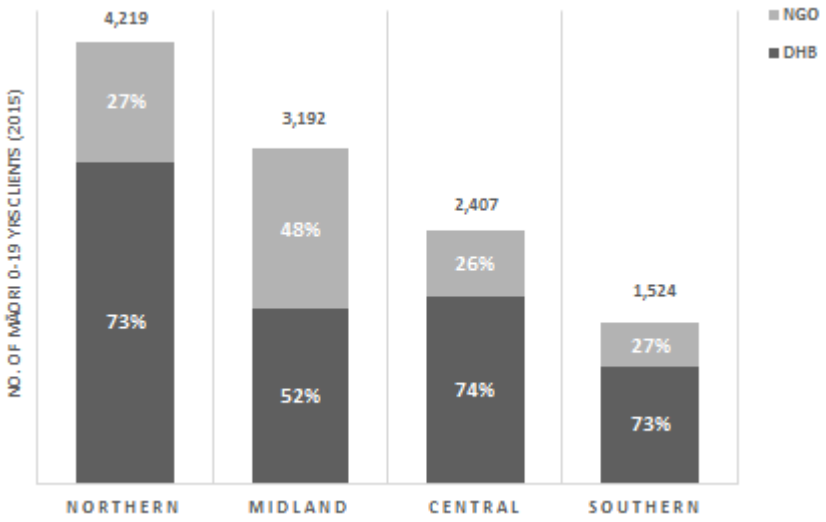
- Clients by region showed an increase in Māori clients in all four regions, with the largest increase seen in the Northern region by 29% (see Appendix B, Table 3).

In the second half of 2015:

- Māori pepe, tamariki and rangatahi made up 32% of the total clients accessing mental health/AOD services.
- There were more Māori males (56%; 6,372) accessing services than females (44%; 4,970).
- The Northern region had the largest number of Māori clients, accounting for 37% of total Māori clients (see Figure 19).

Figure 19. Māori Tamariki & Rangatahi Clients by Service Provider & Region (2015)

- Nationally, 67% of Māori clients accessed DHB services while one-third (33%) were seen by NGOs.
- While Māori clients were mainly accessing DHB services nationally, almost half (48%) of Māori clients in the Midland region were accessing NGOs.



TAMARIKI AND RANGATAHI CLIENT ACCESS RATES

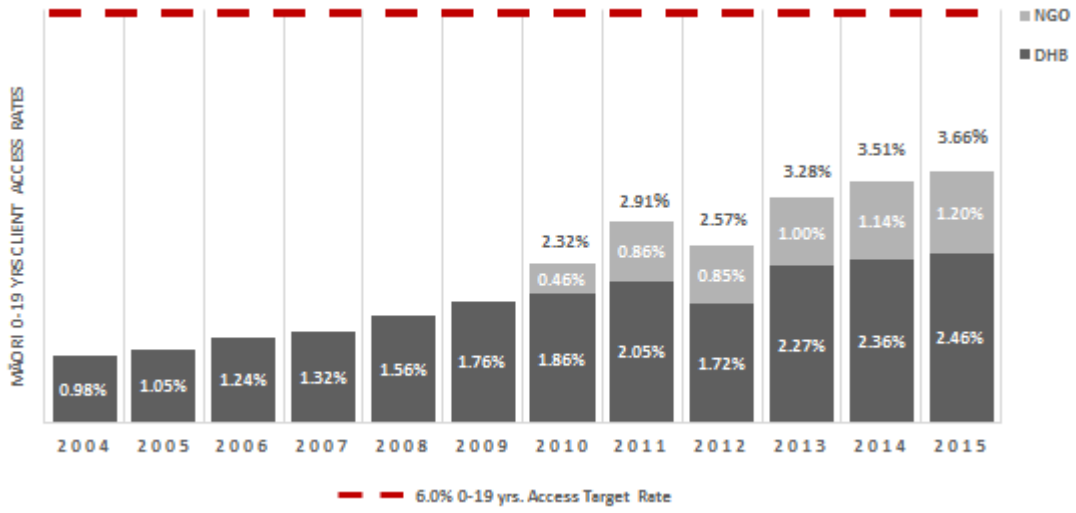
The *Blueprint Access Benchmark Rate* for the 0-19 year age group has been set at 3% of the population over a six month period (Mental Health Commission, 1998). Due to different prevalence rates for mental illness in different age groups, the MHC has set appropriate access rates for each age group: 1% for the 0-9 year age group; 3.9% for the 10-14 year age group and 5.5% for the 15-19 year age group. However, due to the lack of epidemiological data for the Māori tamariki and rangatahi population, Blueprint access benchmarks for Māori were set at 6.0% over a six month period, 3.0% higher than the general population, due to a higher need for mental health services (Mental Health Commission, 1998).

The 2004 to 2015 MHINC/PRIMHD access data were analysed by six months to determine the six monthly benchmark access rates for each region and DHB. The access rates presented in this section were calculated by dividing the clients in each age band per six month period by the corresponding population. Access rates are not affected by referral to regional services as they are based on the DHB where the client lives (DHB of Domicile). However, access rates are affected by the population data used. Client access rates are calculated using the best available population data at the time of reporting. The 2006 and 2015 client access rates were calculated using census data and are therefore more accurate than the access rates calculated using population projections (projected population statistics tend to be less accurate than actual census data).

From 2013 to 2015:

- Total Māori 0-19 years access rates increased from 3.28% to 3.66%, which was higher than the national average access rate of 2.87% but continues to remain below the recommended rate of 6.0% (see Figure 20).
- Access rates by age group showed improvements in all three 0-19 year age groups, especially in the 15-19 year age group.
- Māori access rates showed an increase in all four regions (see Appendix B, Table 10).

Figure 20. Māori Tamariki & Rangatahi Client Access Rates (2004-2015)



In the second six months of 2015:

- Nationally, Māori infants, children and adolescents had the highest access rates out of the four ethnic groups at 3.66%; with the highest access rate seen in the Northern region of 4.05% (see Figure 21).
- Despite improvements in access rates for Māori, the total Māori access rate and access rates for all three age groups have continued to remain below their respective recommended target rates, especially for the 10-14 year age group.

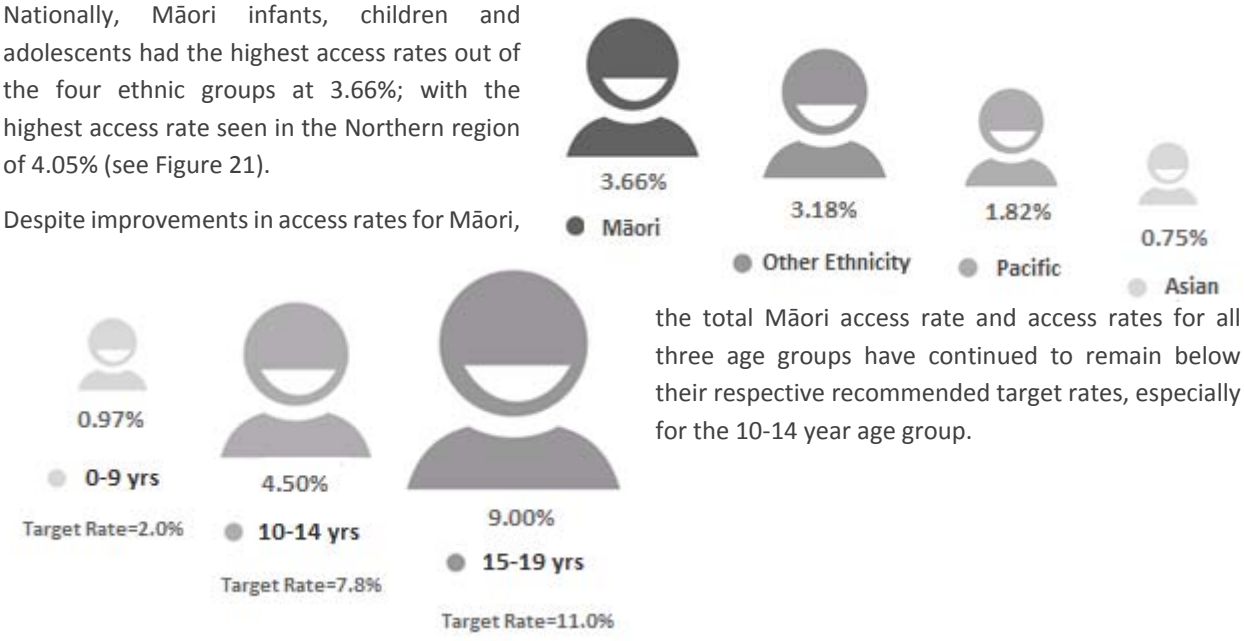
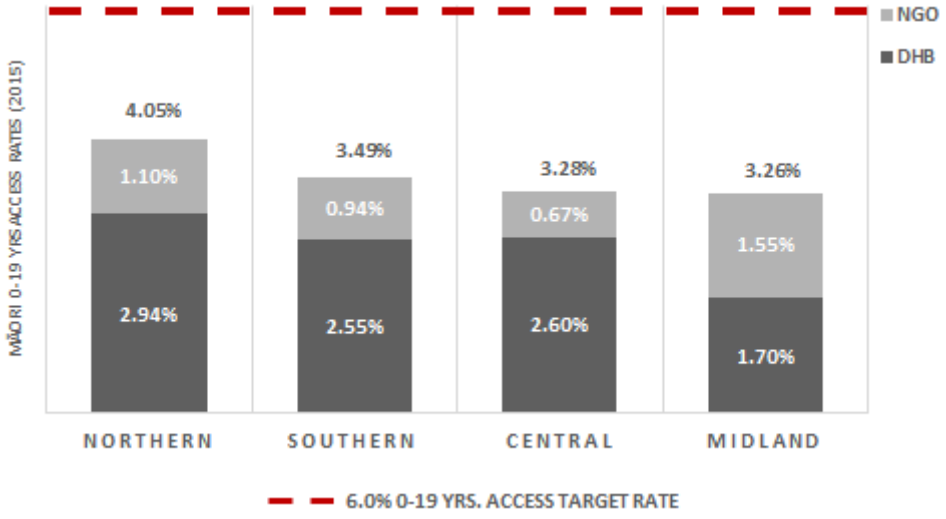


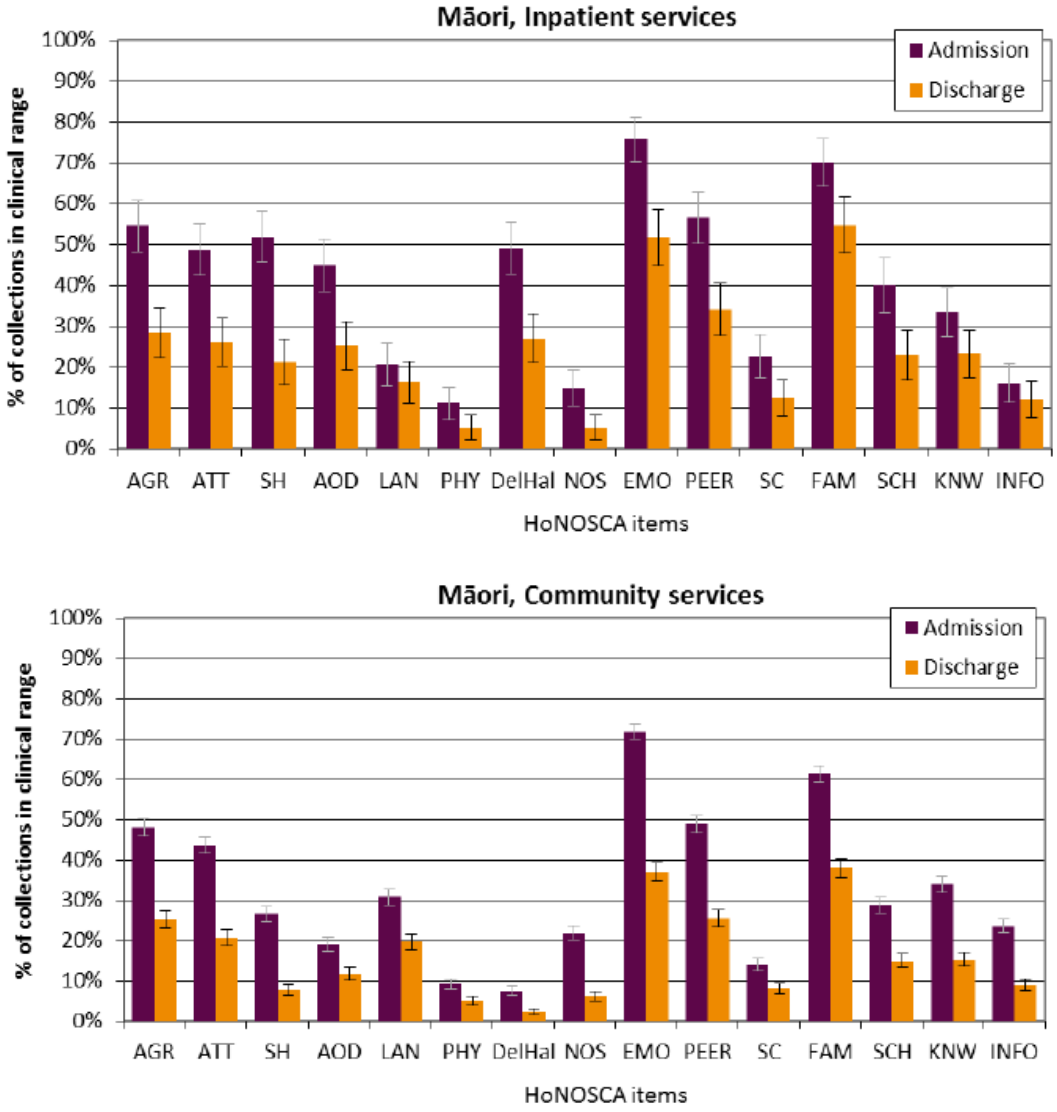
Figure 21. Māori 0-19 yrs Access Rates by Region (2015)



MĀORI CLIENT OUTCOMES

To assess whether Māori clients accessing mental health services experience improvements in their mental health and wellbeing, children and youth health outcomes are rated by the *HoNOSCA* (Health of the Nation Outcome Scales for Children and Adolescents) for children and adolescents 4-17 years at admission and discharge from inpatient and community child and adolescent mental health services. Client outcome data for the 2015/2016 period showed significant improvements in emotional related symptoms by time of discharge from both DHB inpatient and community mental health services for Māori (see EMO scores in Figure 22).

Figure 22. Māori Infant, Child and Adolescent Client Outcomes by Service (2015/2016)



Source: Ministry of Health, PRIMHD extract 16 January 2017, extracted & formatted by Te Pou.

PROVISION OF ICAMH/AOD SERVICES FOR MĀORI TAMARIKI AND RANGATAHI

- Of the 20 DHBs that provide specialist ICAMH/AOD services, only one (Wairarapa DHB) received specific Kaupapa Māori infant, child and adolescent funding (Purchase Unit Code: MHCS39). General Kaupapa Māori services/teams (i.e. not specifically child/youth focused) operate within the following DHBs: Waitemata; Counties Manukau; Capital & Coast.
- Where specific DHB Kaupapa Māori mental health/AOD services are not available, most DHBs fund local NGOs to provide these services. Of the 106 NGOs that were identified in the 2016 workforce *Stocktake*, 42 provide Kaupapa Māori infant, child and adolescent mental health/AOD services.
- Māori tamariki and rangatahi are also able to access other DHB funded mainstream child and adolescent mental health/AOD, peer-support and advocacy services.

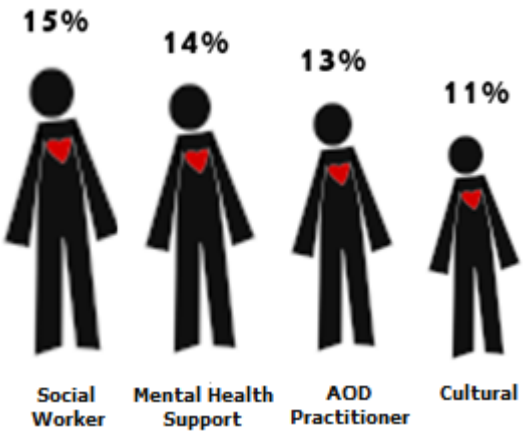
MĀORI ICAMH/AOD WORKFORCE

The following information is derived from workforce data (Actual & Vacant Full Time Equivalents (FTEs) & Ethnicity by Occupational Group) submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services and 105/106 NGOs as at 30 June 2016. Consistently missing data from one large NGO provider in the Midland region continues to impact on the accuracy of NGO workforce data. While, contracted FTE data from the MOH's Price Volume Schedule (PVS) were used to estimate this NGO's workforce, these data do not include information by ethnicity and occupational group, therefore the Māori workforce, especially for the Midland region remains underestimated.

From 2014 to 2016:

- There was a 1% decrease in the total Māori infant, child and adolescent mental health/AOD workforce, from 358 to 354 (headcount) (see Table 6).
- This decrease was seen in the Northern and Central regions only, while increases in the workforce were seen in the Midland and Southern regions by 18% and 24% respectively.
- This decrease was seen in the NGO services by 5%, from 212 to 201; while DHB services reported an increase by 5%, from 146 to 153While this decrease in the workforce was seen only in the Non-Clinical workforce by 8%, from 147 to 135, there was a 2% increase in the Māori Clinical workforce from 186 to 189.

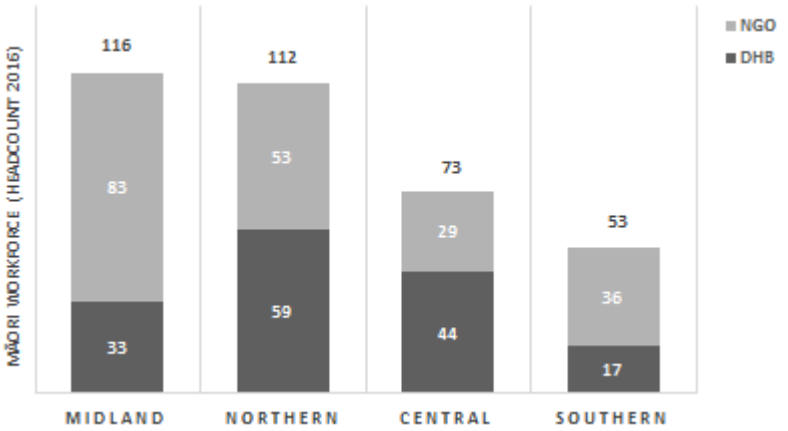
Figure 23. Top 4 Māori ICAMH/AOD Workforce by Occupational Group (2016)



As at 30 June 2016:

- The Māori workforce (354 headcount) made up 18% of the total workforce (1,952 headcount).
- The largest Māori workforces were reported in the Midland (116) and Northern (112) regions (see Figure 24).
- There were more Māori employed in NGOs (57%) than in DHB services (43%).
- Just over half (54%) of the Māori workforce was in Clinical roles as Social Workers (54), Alcohol and Drug Practitioners (45) and Mental Health Nurses (29) (see Table 7).

Figure 24. Total Māori Workforce by Region (2016)



- The remainder were in Non-Clinical roles, largely as Mental Health Support Workers (50) and Cultural (37) and Youth Workers (22) (see Table 7).

Table 6. Total Māori ICAMH/AOD Workforce (2008-2016)

REGION (HEADCOUNT)	DHB[1]					NGO					TOTAL				
	2008	2010	2012	2014	2016	2008	2010	2012	2014	2016	2008	2010	2012	2014	2016
NORTHERN	48	53	57	59	59	23	28	45	75	53	71	81	102	134	112
MIDLAND*	27	25	26	23	33	68	58	71	75	83*	95	83	97	98	116*
CENTRAL	46	37	42	49	44	39	26	41	35	29	85	63	83	84	73
SOUTHERN	12	16	16	15	17	28	22	21	27	36	40	38	37	43	53
TOTAL	133	131	141	146	153	158	134	178	212	201*	291	265	319	358	354*

1. Includes Inpatient Services
*The Māori Workforce under-estimated due to missing data from one NGO provider from the Midland region.

Table 7. Total Māori ICAMH/AOD Workforce by Occupational Group (2016)

OCCUPATIONAL GROUP (HEADCOUNT, 2016)	DHB		DHB TOTAL	NGO	TOTAL
	INPATIENT	COMMUNITY			
ALCOHOL & DRUG PRACTITIONER	-	9	9	36	45
CEP CLINICIAN	-	6	6	7	13
MENTAL HEALTH NURSE	6	18	24	5	29
OCCUPATIONAL THERAPIST	-	3	3	-	3
PSYCHIATRIST	1	5	6	-	6
PSYCHOLOGIST	-	9	9	1	10
SOCIAL WORKER	-	23	23	31	54
OTHER CLINICAL[1]	1	7	8	21	29
CLINICAL SUB-TOTAL	8	80	88	101	189
CULTURAL APPOINTMENT	4	29	33	4	37
MENTAL HEALTH CONSUMER ADVISOR	-	5	5	3	8
MENTAL HEALTH SUPPORT WORKER	3	2	5	45	50
YOUTH WORKER	-	2	2	20	22
OTHER NON-CLINICAL SUPPORT FOR CLIENTS[2]	-	1	1	17	18
NON-CLINICAL SUPPORT FOR CLIENTS SUB-TOTAL	7	39	46	89	135
ADMINISTRATION/MANAGEMENT	-	19	19	11	30
NATIONAL TOTAL 2014	15	138	153	201*	354*

1. Other Clinical = Counsellors; Early Intervention Specialists; Registered Nurses; Youth Practitioners; Community Facilitators; Family Therapists; Forensics; Child Therapists; Māori Mental Health Professional.
2. Other Non-Clinical = Advocacy/Peer Consumer/Whānau Support; Early Childhood Educators; Service Coordinators; Facilitators.
***The Māori Workforce is under-estimated due to missing data from one NGO provider from the Midland region.**

DHB INPATIENT MĀORI ICAMH WORKFORCE

From 2014 to 2016:

- There was a decrease of two Māori staff in the Inpatient workforce from 17 to 15. This decrease was only seen in non-clinical roles.
- Two out of the three Inpatient services reported a slight decrease in the Māori workforce (Auckland and Central) while Canterbury reported an increase of 1 Māori staff from 3 to 4.

As at 30 June 2016:

- The Māori Inpatient workforce was largely in Clinical roles as Mental Health Nurses (6). The remainder of the Māori workforce was in Non-Clinical roles in Cultural positions (4) and as Mental Health Support Workers (3) (see Table 7).

DHB COMMUNITY MĀORI ICAMH/AOD WORKFORCE

From 2014 to 2016:

- There was a 7% increase in the DHB Māori Community workforce, from 129 to 138 (headcount) (see Table 6).
- This increase was seen in the Non-Clinical workforce by 11% from 35 to 39 (headcount).

- The Midland, Northern and Southern regions reported increases in the Māori workforce by 10, 2 and 1 respectively, while there was a decrease in the Central region by 4.

As at 30 June 2016:

- The Northern region continues to have the largest Māori DHB Community workforce (54) followed by Central (38), Midland (33) and Southern (13) regions (see Table 6).
- The Māori workforce in the DHB Community services was mainly in Clinical roles (58%) as Social Workers (23) and Mental Health Nurses (18) (see Table 7). The Māori Non-Clinical workforce was mainly Cultural Workers (29) (see Table 7).

NGO MĀORI ICAMH/AOD WORKFORCE

Please note: The 2016 NGO Māori workforce, especially in the Midland region, remains underestimated due to consistently missing workforce data from a large NGO provider in the Midland region.

From 2014 to 2016:

- There was a 5% decrease in the NGO Māori workforce from 212 to 201 (headcount) (see Table 6).
- This decrease was seen in two out of the four regions: Northern and Central regions, with the largest decrease in the Northern region by 22, from 75 to 53 (headcount).
- However, the Southern and Midland showed increases in the workforce, the largest increase seen in the Southern region by 9.
- The decrease in the workforce was seen in Non-Clinical roles only from 103 to 89 (headcount), while the Clinical workforce had increased by 5, from 96 to 101 (headcount).

As at 30 June 2016:

- The Midland region NGOs reported the largest Māori workforce (83) followed by Northern (53), Southern (36) and Central (29) regions (see Table 6).
- Half (50%) of the NGO Māori workforce was in Clinical roles as Alcohol and Drug Practitioners (34%; 36 headcount) and Social Workers (31%; 31 headcount) and the other half were in the Non-Clinical workforce as Mental Health Support Workers (47%; 45 headcount), Youth Workers (22%; 20 headcount) and various Other Non-Clinical roles (see Table 7).

CULTURAL COMPETENCY OF THE WORKFORCE

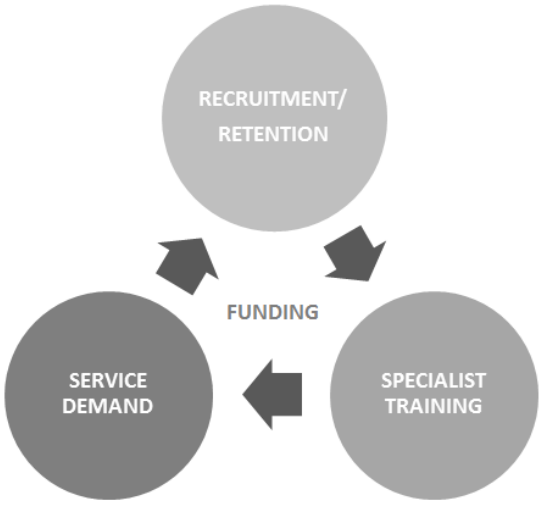
- Via the 2016 Stocktake Workforce Survey, services were asked to indicate the Māori and Pacific health models of practice used in service delivery. Eighteen of the 20 DHB ICAMH/AOD provider services indicated that they used Māori models and eight indicated that they used a Pacific health model of practice within their services.
- The most commonly used Māori health model was *Te Whare Tapa Wha* (Durie, 1985), followed by *Te Wheke; Mahia a Atua; Te Pounamu* and various others *(Tapu na, Pa Harakeke, Te Waka, Nga Take Pu, Te Tuariki o te ora, Te ara waiora a tane, Tuakere o te tangata, Whānau Ora; Dynamics of Whanaungatanga*). Services develop and embed these models in various ways:
    - A cultural assessment model developed by their cultural team.
    - Māori health models are embedded in all their assessment/treatment plans and form part of a service's core competencies training.
    - Services receive internal support from Māori services within their own DHBs from cultural advisors/support workers.

- Services also receive support from a number of external Māori NGOs who provide culturally appropriate assessments, support and advice as needed.

CURRENT AND FUTURE WORKFORCE CHALLENGES

Eighteen Māori NGOs indicated the following workforce challenges they were currently facing and the challenges they anticipated over the 10 years. The responses were grouped under the following themes, with the lack of funding recurring across all of the themes identified.

CURRENT CHALLENGES/GAPS



- **Difficulties with Recruitment/Retention:**
  - Shortage of Māori specialist staff with youth mental health experience.
  - High turnover of staff.
  - Diffculty in recruiting staff to rural, geographically isolated areas.
  - Limited number of jobs available in the NGO sector for new graduates due to limited funding.
- **Difficulties in Accessing Specialist Training:**
  - Difficulties in accessing specialist training and opportunities for professional development due to limited funding.
  - The time taken to gain specialist qualifications and the lack of specialist staff available to back-fill these positions.
- **Increasing Service Demand:**
  - Responding to the high and complex needs of clients due to lack of specialist staff and the lack of resources to cater for these needs especially in smaller rural services.

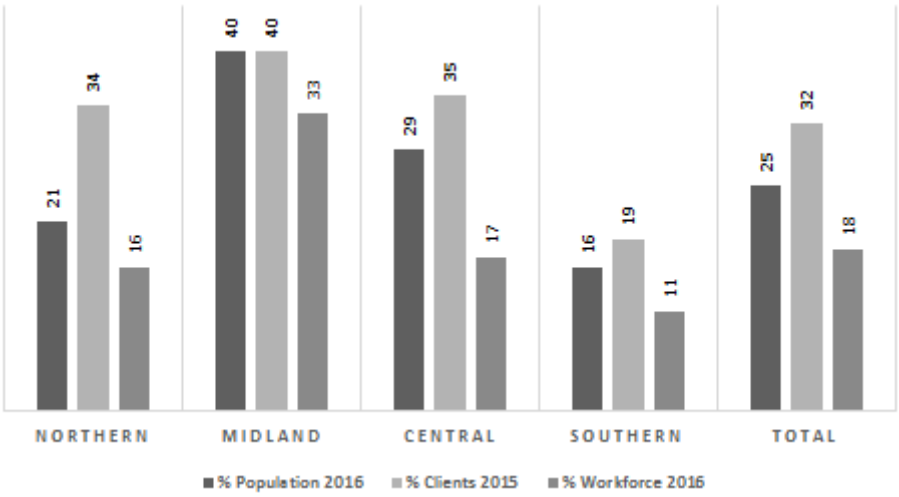
FUTURE CHALLENGES/GAPS

- **Increasing Service Demand:**
  - Meeting the needs of increasing complexity and acuity of clients.
  - Provision of specialist services in innovative ways to meet growing demand.
- **Difficulties with Recruitment/Retention:**
  - The need to attract and recruit specialist staff due to a currently ageing workforce.
- **Lack of funding/Limited resources**:
  - Funding and resources to access specialist training; recruit and retain staff; and develop technology and new ways of working to meet high and complex demand.
- **Lack of Specialist Training:**
  - The need for more specialised training to cater for complex cases.

MĀORI POPULATION, CLIENT AND WORKFORCE COMPARISONS

- Based on the 2016 population projections, Māori infants, children and adolescents made up 25% of the total 0-19 year population, 32% of all clients accessing services and the Māori workforce (324, excluding the Administration/Management workforce) made up 18% of the total workforce (1,772). However, due to the missing ethnicity data from a large NGO in the Midland region, the Māori workforce may be underestimated.
- A decrease in the total Māori workforce from 2014 to 2016 has led to greater disparities between the clients and the workforce, especially in the Northern and Central regions (see Figure 25).
- Given the increasing trend in Māori clients accessing services nationally and the decrease in the Māori workforce, there is a need to focus on increasing the Māori workforce, not only in Clinical roles but across all occupational groups, to cater for the current and future needs of the Māori infant, child and adolescent population. Enhancing cultural competency of the workforce is also a key area of development.

Figure 25. Proportion of Māori 0-19 yrs Population, Client and Workforce Comparisons by Region



SUMMARY

The Māori population is a growing and youthful population with almost half of the population between the ages of 0 and 19 years. Despite a slower growth rate relative to the Pacific and Asian populations, the Māori population will continue to have a younger age structure than the total New Zealand population due to higher birth rates.

Māori experience lower socioeconomic status and have double the prevalence rates of mental health disorders and the highest suicide rates compared to the general population. Therefore, regions with large populations of Māori pepe, tamariki and rangatahi, such as the Northern and Midland regions, and parts of the Central region (Hawke's Bay and Whanganui), should anticipate continued demand on services.

MĀORI TAMARIKI AND RANGATAHI ACCESS TO SERVICES

The majority of Māori pepe, tamariki and rangatahi continue to be seen by mainstream DHB services/teams rather than Kaupapa Māori services/teams. They are also accessing services more than any other ethnic group. However, access rates have not increased at a rate that is comparable to need. Despite significant increases in Māori tamariki and rangatahi access rates, they continue to remain below the 6% target rate recommended for Māori (Mental Health Commission, 1998), especially in the 0-9 year age group.

The *Youth'07* survey data on Māori high school students (Clark et al., 2008) identified several reasons for persistent low access rates for Māori. Their data showed that more Māori than NZ European youth reported problems with accessing healthcare and were more likely to identify barriers to accessing healthcare. These included:

- Didn't want to make a fuss
- Couldn't be bothered
- Too scared
- Worried it wouldn't be kept private
- Cost too much
- Couldn't get an appointment
- Had no transport.

Some of these barriers may contribute to access not reaching the full target.

PROVISION OF SERVICES FOR MĀORI PEPE, TAMARIKI AND RANGATAHI

From 2014 to 2016, there was very little progress in the number and types of mental health/AOD services that were available to Māori tamariki, rangatahi and their whānau nationally. There continues to be a limited number of Māori mental health/AOD services available to Māori, especially in DHB services nationally.

MĀORI ICAMH/AOD WORKFORCE

The *Stocktake* workforce data from 2014 to 2016 showed a slight decrease in the Māori workforce. This decrease was seen only in the non-clinical workforce however; there was a 2% increase in the clinical workforce. Māori in DHB services continued to be largely clinical staff, while there was a more even split between clinical and non-clinical roles in NGOs.

While the need for increasing the Māori workforce is acknowledged by services, DHB and NGO ICAMH/AOD services identified that a key challenge in increasing the Māori workforce is that recruitment of clinical roles is difficult due to lack of qualified clinical practitioners who are available, as many are largely at entry-level. These workforce capacity and capability issues are further exacerbated by the lack of funding, which is seen as a key barrier for ongoing workforce development by many services.

RECOMMENDATIONS

Given that Māori children and adolescents have high mental health needs, the current access rates indicate continued and increasing demand for services. If a declining trend in the total Māori workforce continues, this will lead to greater disparities between the clients and the workforce. Therefore, increasing the Māori workforce is a key priority, especially given the evidence that when Māori infants, children and adolescents *do* access mental health services, client outcome data show significant improvements in emotional related symptoms by time of discharge.

In light of the current *Stocktake* findings, and to ensure alignment with current government priorities (Ministry of Health, 2007; 2012b; 2016) and progress toward workforce strategic goals, the following recommendations support improvements in the mental health outcomes for all Māori pepe, tamariki and rangatahi within a whānau ora context. These recommendations have also been developed in consultation with the Werry Workforce Māori Cultural Advisors.

- **Improving Access to Services:**
    - While Māori access to services has increased, it still remains short of meeting actual need. Therefore, in consultation with tangata whaiora, effective strategies to increase Māori access rates, especially to cater for actual need, must be identified.
        - Appointing *Whānau Champions* who are respected members of the local community to facilitate and improve access to services has been used successfully in the Midland region and could be an effective strategy in other areas where access is an issue.
    - Work more collaboratively and maintain relationships between school, primary and secondary mental services to assist with referral pathways.
    - Identifying the reasons why access has improved may also assist future planning.
- **Development and Provision of Services:**
    - ***Early Intervention:***
        - Because early intervention and earlier access to services are essential for Māori (Ministry of Health, 2008b), there is ongoing need to invest in and develop early intervention strategies and services (i.e. parenting programmes and infant health/mental health services) for Māori in primary and secondary care settings.
        - School-based health services in secondary schools should be increased and enhanced with appropriately trained staff. *Youth'12* results on health services in secondary schools showed positive associations between aspects of health services in schools and mental health outcomes of students at the same schools. There was less overall depression and suicide risk among students attending schools with any level of school health services (Denny et al., 2014); more specifically, schools with:
            - A health team on site
            - More than 2.5 hours of nursing and doctor time per week per 100 students
            - Health staff with postgraduate training
            - Routine psychosocial health screening using HEEADSSS screening.
    - Given that 14% of Māori rangatahi (15-19 years) are NEET (Ministry of Business Innovation & Employment, 2013), alternative, community-based clinics for Māori young people who are not at school could help to alleviate some of the access issues highlighted.

- **Workforce Development:**
    - Due to increases in Māori need and demand for services and continued shortages in the Māori workforce, there is a continued need to increase the Māori ICAMH/AOD workforce.
    - While increasing the Māori workforce is a long-term solution to workforce shortages, there is an ongoing need to retain and develop the existing Māori ICAMH/AOD workforce.
    - Given that over half of the Māori workforce is employed in NGOs and one-third of Māori clients are seen by the NGO sector, an increased focus on addressing the workforce development needs of the NGO sector is pertinent.
    - GPs continue to be the largest source of referrals to ICAMH/AOD services, and the move to develop primary services to deliver mental health care may help reduce the demand in ICAMH/AOD specialist services and NGOs.
    - The strategies for developing the Māori workforce need to occur within workforce infrastructures and organisational levels; recruitment and retention activities; training and development; and research and evaluation that span the primary and secondary services. A multi-agency and an inter-sectoral approach is also required to progress workforce development activities. These strategies could include:
        - ***Workforce Planning****:*
            - ***Funding and Planning****:* DHBs need to actively monitor local service demands and workforce development needs such as specialist training and ensure funding takes into account a whānau ora model of service delivery.
            - ***Leadership Development:*** Developing Māori leadership within services could have a positive impact on recruitment and retention of the Māori workforce by providing organisational support and experienced role models for new staff and providing access to cultural supervision.
        - ***Recruitment and Retention:***
            - ***Recruitment/Retention Strategies:*** Ensure that active recruitment and retention and addressing Māori workforce levels is seen as a key priority and is embedded in a service's strategic plans.
            - ***Career Pathways****:*
                - Develop career pathways into the sector and ensure that local schools, tertiary education providers, PHOs, NGOs and DHBs are all part of the workforce strategic planning processes.
                - Use national competency frameworks such as *Real Skills Plus* within the training sector to inform and create a 'job ready' child and adolescent mental health workforce.
        - ***Training and Professional Development****:*
            - ***Access to Specialist Training****:* Enhance access and support for evidence-based specialist training so that the workforce has the right skills for increased and complex service demands. Considering shared training between DHB and NGOs whereby DHBs are actively looking for opportunities to include NGOs in training programmes/events could be a possible strategy where resources are limited.
            - ***Clinical/Cultural Competency Development****:* Critical workforce shortages mean Māori tamariki, rangatahi and their whānau are largely accessing mainstream services and are seen by non-Māori, therefore there continues to be a need for

increasing the dual competency of mainstream services to be clinically and culturally competent. For instance, integrate the skills and knowledge outlined in Māori competency frameworks, e.g. *Takarangi Competency Framework* (Matua Raḳi, 2010), in services nationally.

- ***Career Development****:* There is a need for specific initiatives to help transition entry-level practitioners into the clinical workforce. Therefore, training and career pathways are needed to support experienced workers, especially those from the unregulated workforce, to develop the specialist workforce and increase Māori workforce numbers across all roles and parts of the sector.

- ***Exploring New Ways of Working:***

  - ***Collaborative Service Delivery***: Engage in collaborative service delivery between PHOs, NGOs and DHBs. Building relationships and working in partnership with other services to overcome shortages in the workforce is occurring in some areas and could be an effective way to share limited resources, e.g. DHBs providing clinical support and senior clinical staff for advice/consult to NGOs; NGOs providing cultural support to DHBs.

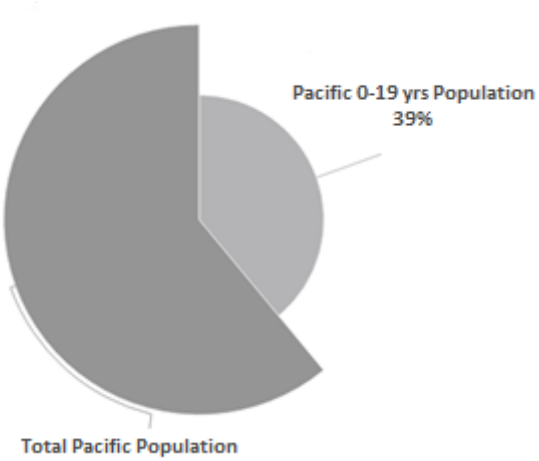
  - ***Sharing Innovative Practice***: Services could share innovative solutions/practice that are tailored to local whānau and community needs.

PACIFIC NATIONAL OVERVIEW

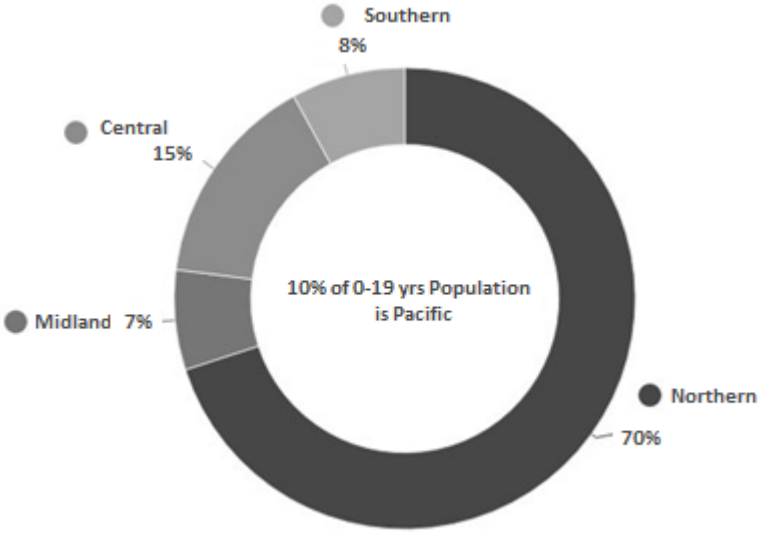
PACIFIC INFANT, CHILD AND ADOLESCENT POPULATION

The population data include the 2016 infant, child and adolescent population projections (Base Census 2013, prioritised ethnicity by DHB area) provided by Statistics NZ. Prioritised ethnicity is a method whereby a person who reports more than one ethnicity is classified into one ethnicity, i.e. Māori first, Pacific second, Asian third and Other Ethnicity fourth. While prioritised ethnicity population data are chosen for ease of use, prioritisation conceals diversity within and overlap between ethnic groups by eliminating multiple ethnicities from data (Statistics New Zealand, 2006a).

- The Pacific population in New Zealand includes a culturally diverse group made up of 22 different ethnic groups. The largest Pacific groups are Samoan, Cook Island Māori, Tongan, Niuean, Fijian and Tokelauan (Statistics New Zealand, 2002).
- The 2016 projections showed an overall increase in the Pacific 0-19 year population by 3% since the 2013 Census. While there was an increase in the population in all four regions, the largest increase was seen in the Southern region by 14% followed by the Midland region by 11% (see Appendix A, Table 1).



- The Pacific population of New Zealand is a youthful population compared to the total New Zealand population. Thirty-nine percent of the Pacific population in New Zealand were 0-19 years old.



  - Pacific infants, children and adolescents made up 10% of New Zealand's total 0-19 years population. Over half (51%) of the Pacific 0-19 year population are male.
  - The majority of New Zealand's Pacific infants, children and adolescents reside in the Northern region (70%). Over half of the Northern region's Pacific population reside in Counties Manukau (55%).
- An overall 9% growth is projected by 2026 across all regions, with the largest growth projected for the Midland (by 32%) and Southern regions (by 37%) (see Appendix A, Table 2).

PACIFIC INFANT, CHILD AND ADOLESCENT MENTAL HEALTH NEEDS

- Pacific populations in New Zealand experience higher socioeconomic deprivation than the general population (Statistics New Zealand, 2002).
- Pacific people experience mental health disorder at higher levels than the general population and NZ-born Pacific people are bearing a higher burden of mental illness. They have a 31% 12-month prevalence rate compared to 15% for Pacific migrants (Ministry of Health, 2008a).
- Psychological distress (10%) is also higher in Pacific peoples than in other ethnicities in New Zealand; with rates for Māori at 9%, Asian (7%) and European (5%) (Ministry of Health, 2012a).
- For Pacific peoples, the leading cause of mortality is injury which is largely attributable to suicide. There are also higher rates of mental health admissions for schizophrenia and schizotypal/delusional disorders (Mila-Schaaf, 2008).
- The proportion of young people who are not engaged in employment, education, or training (NEET) is used as an indicator of youth disengagement. Overall, Pacific peoples have a higher NEET rate than Europeans and Asians but lower than Māori (Ministry of Business Innovation & Employment, 2016b).
- As at March 2016, there were about 65,400 Pacific peoples aged 15-24 years. Of these, about 11,200 people were NEET (17.1%), a decrease of 600 from a year ago. The Pasifika NEET rate has been consistently higher than other ethnic groups for both males and females, except for Māori. The NEET rate decreased for males but rose for females over the year. NEET rates by gender were 13.1% for males and 21.2% for females (Ministry of Business Innovation & Employment, 2016b).
- In general, the literature highlights the following personal and social outcomes for NEETs:
    - Prolonged periods out of education and employment can lead to marginalisation and dependence, with young people failing to establish a sense of direction (Cote, 2000).
    - Unemployment can lead to poor physical and mental health outcomes. Literature notes that unemployment can result in individuals feeling lonely, powerless, anxious or depressed (Creed & Reynolds, 2001).
    - Disengagement from education and employment can lead to further exclusion and increased association with risk behaviours. Greater use of drugs, alcohol and criminal activity are often associated with unemployment (Fergusson, Horwood, & Woodward, 2001).
    - Finally, NEETs are more likely to be parents at an early age and face ongoing issues with housing and homelessness (Cusworth, et al., 2009).
- This consistently high NEET rate for Pacific youth will continue to negatively impact on the mental health and wellbeing of those already in high risk groups. This in turn is likely to lead to increased demand for mental health services.
- Recent studies such as the *Growing Up in New Zealand* longitudinal study, which has followed 7,000 New Zealand children from before birth since 2009 and 2010, have shown that "*Māori & Pacific children tend to be exposed to a greater number of risk factors for vulnerability than New Zealand European or Asian children. Exposure to multiple risk factors for vulnerability at any one time point increases the likelihood that children will experience poor health outcomes during their first 1000 days of development"* (Morton et al., 2014, p. v).
- Younger Pacific people, 16-24 years old, are more likely to experience a mental health disorder that is classified as serious compared with older Pacific people (Mila-Schaaf, Robinson, Denny, & Watson, 2008).

- The *Youth'07* study on 1,190 Pacific high school students (Helu, Robinson, Grant, Herd, & Denny, 2009) indicated that while there was no significant difference in reported depressive symptoms between Pacific (11%) and NZ European students (9%), more Pacific students than NZ European students were likely to have attempted suicide.
    - More Pacific students reported sexual abuse than did NZ European students. Reported sexual abuse was higher in female students than males with significantly more Pacific female students (25%) reporting sexual abuse compared to NZ European female students (16%).
    - Rates of smoking and using marijuana were also higher in Pacific students (12%) than amongst NZ European students (8%).
- The most recent Adolescent Health Research Group findings via their National Youth Health School Surveys in 2012 (Fa'alili-Fidow et al., 2016) of 1,445 Pacific students (12-18 years old) found that:
    - Compared to New Zealand European students, Pacific students were almost twice as likely to report being unable to access healthcare within the last 12 months.
    - Between 2001 and 2012, there was a 4% decrease in the proportion of Pacific students reporting significant depressive symptoms. The proportion of Pacific students who reported making a suicide attempt in the previous 12 months has remained stable at about 9% between 2007 and 2012.
    - Very similar proportions of Pacific and New Zealand European students reported to have experienced significant depressive symptoms. However, Pacific students were slightly more likely to report self-harm and about three times more likely to have attempted suicide within the previous 12 months than New Zealand European students.
    - Female Samoan and Tongan students were significantly more likely than their male counterparts to report having engaged in self-harm and Samoan female students reported higher rates of attempted suicide than Samoan males.
- The latest suicide data show that while Māori youth (15-24 years) have the highest suicide rates in the country, Pacific youth have the second highest (24 suicides per 100,000 youth population) ; compared to European/Other (16.5 per 100,000) and Asian (5.5 per 100,000). Pacific males within this age range have the highest suicide rate of 34.3 per 100,000, in contrast to the overall Pacific male rate of 13.3 per 100,000 (Ministry of Health, 2016).
- The socioeconomic factors and mental health needs for Pacific infants, children and adolescents strongly signal the need to improve mental health outcomes for Pacific children and young people as a key priority.

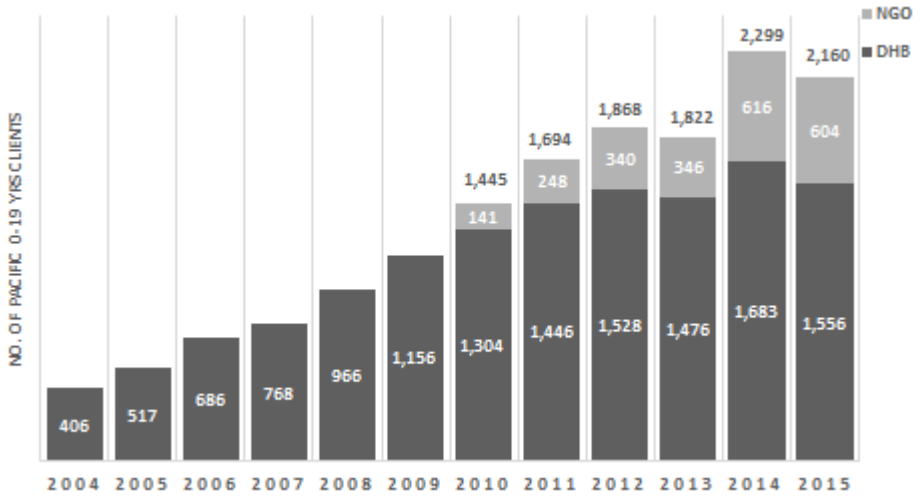
PACIFIC ACCESS TO ICAMH/AOD SERVICES

The client access to service data (number of clients seen by DHB & NGO ICAMH/AOD services) have been extracted from the *Programme for the Integration of Mental Health Data* (PRIMHD). Access data are based on the *Clients by DHB of Domicile* (residence) for the second six months of each year (July to December). NGO client data have been included since 2010. Data from 142 NGOs were included in the 2014 client access information, while 139 NGOs were included in the 2015 client data.

From 2013 to 2015:

- There was a 19% increase in the number of Pacific clients accessing services (see Figure 26).
- This increase was seen in the Pacific male client group by 17%, while there was a 20% increase in Pacific female clients accessing services nationally.
- Pacific clients by region showed increases in Pacific clients in the Midland and Southern regions only, with the largest increase in the Southern region by 31%. There was a 17% decrease in overall Pacific clients in the Central region (see Appendix B, Table 4).

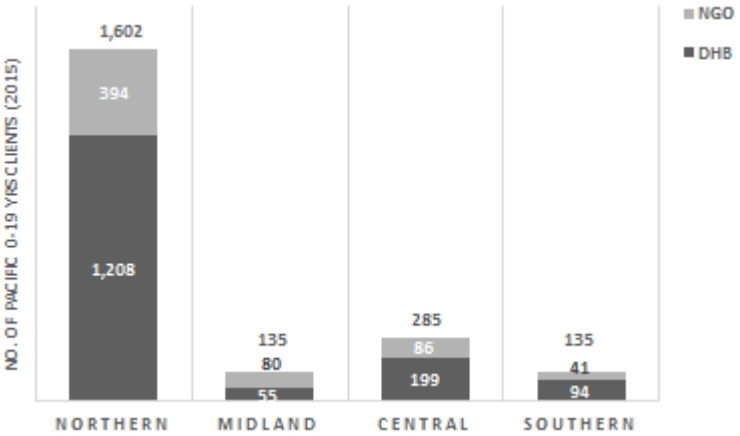
Figure 26. Pacific 0-19 yrs Clients (2004-2015)



In the second half of 2015:

- Pacific children and adolescents made up 6% of the total clients accessing mental health/AOD services.
- There were more Pacific males (57%, 1,240) accessing services than females (43%, 920).
- The Northern region had the largest number of Pacific clients, accounting for 74% of total Pacific clients (see Figure 27).
- Nationally, the majority of Pacific clients were accessing DHB services (72%) while 28% were seen by NGOs.

Figure 27. Pacific 0-19 yrs Clients by Service Provider & Region (2015)



- However, regionally, over half (59%) of the total Pacific clients in the Midland region were seen by NGOs.

PACIFIC CLIENT ACCESS RATES

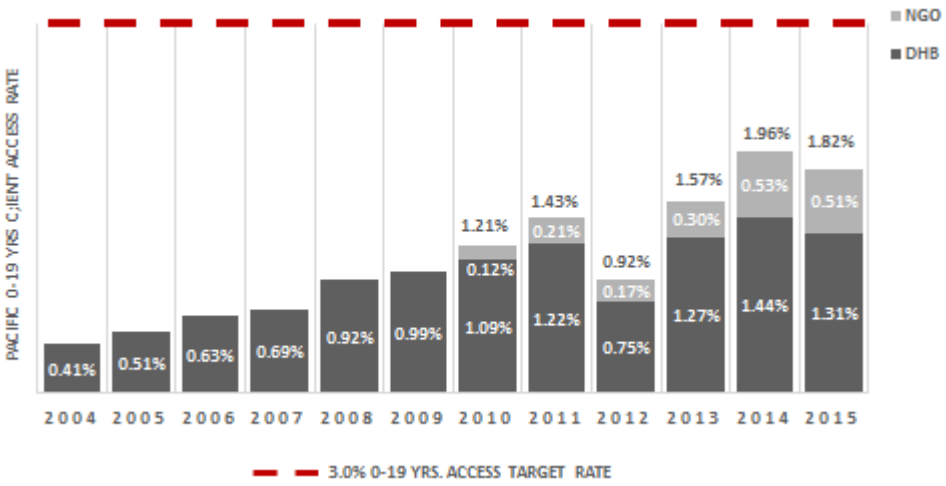
The *Blueprint Access Benchmark Rate* for the 0-19 year age group has been set at 3% of the population over a six month period (Mental Health Commission, 1998). Due to different prevalence rates for mental illness in different age groups, the MHC has set appropriate access rates for each age group: 1% for the 0-9 year age group; 3.9% for the 10-14 year age group and 5.5% for the 15-19 year age group. Due to the lack of epidemiological data for the Pacific 0-19 year population, there are no specific Blueprint access benchmarks for Pacific, therefore the Pacific access rates have been compared to the rates for the general 0-19 years population. However, the Pacific population experience higher levels of mental health disorder than the general population (Ministry of Health, 2008) and therefore the general recommended target access rates may be a conservative estimate of actual need for the Pacific population.

The 2004 to 2015 MHINC/PRIMHD access data were analysed by six months to determine the six monthly benchmark access rates for each region and DHB. The access rates presented in this section were calculated by dividing the clients in each age band per six month period by the corresponding population. Access rates are not affected by referral to regional services as they are based on the DHB where the client lives (DHB of domicile). However, access rates are affected by the population data used. Client access rates are calculated using the best available population data at the time of reporting. The 2006 and 2013 client access rates were calculated using census data and are therefore more accurate than the access rates (2007-2012) calculated using population projections (projected population statistics tend to be less accurate than actual census data).

From 2013 to 2015:

- Pacific access rates had increased from 1.57% to 1.82% (see Figure 28).
- Access rates by age group showed improvement in the 0-9 year and 15-19 year age groups only (see Appendix B, Table 11).

Figure 28. Pacific 0-19 yrs Client Access Rates (2004-2015)



In the second six months of 2015:

- Nationally, Pacific infants, children and adolescents had the third highest access rate out of the four ethnic groups at 1.82%; with the highest access rate in the Northern region (see Figure 29).
- Access rates by age group showed 15-19 year olds had the highest access rate (4.79%) followed by 0-9 year olds (0.91%).

- While there were improvements in Pacific access rates for all three age groups, the Pacific access rates remained lower than the national average access rate (2.87%) and significantly below the recommended rates set by the MHC for all three age groups.

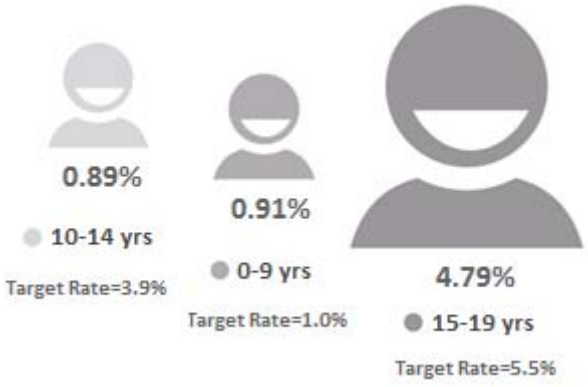
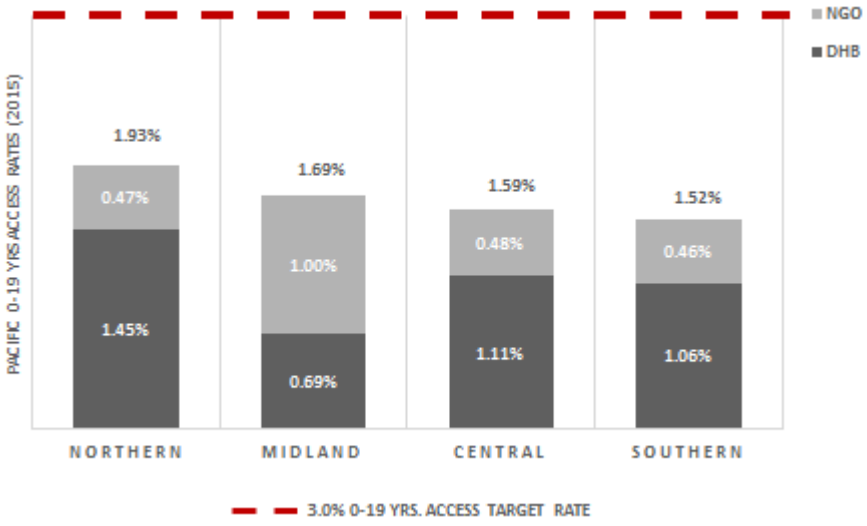


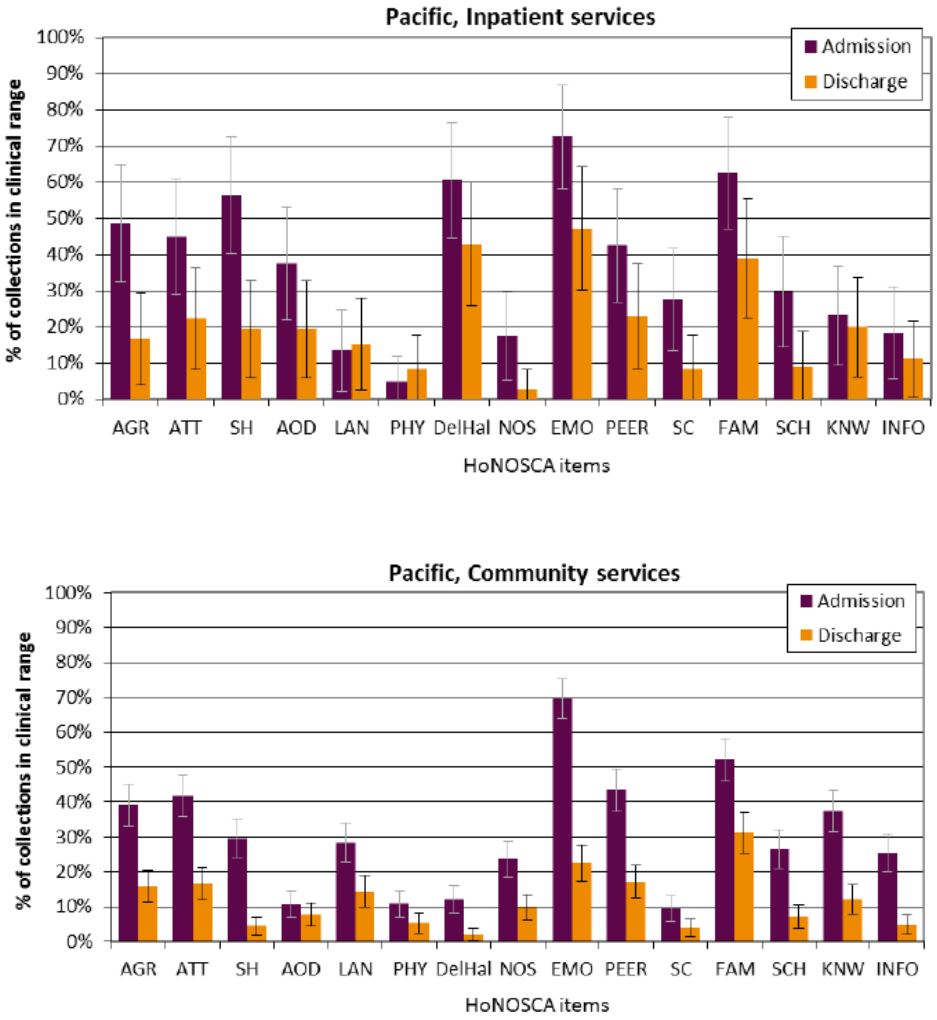
Figure 29. Pacific 0-19 yrs Client Access Rates by Region (2015)



PACIFIC CLIENT OUTCOMES

To assess whether Pacific clients accessing mental health services experience improvements in their mental health and wellbeing, children and youth health outcomes are rated by the *HoNOSCA* (Health of the Nation Outcome Scales for Children and Adolescents) for children and adolescents 4-17 years at admission and discharge from inpatient and community child and adolescent mental health services. Client outcome data for the 2015/2016 period showed significant improvements in emotional related symptoms by time of discharge from both DHB inpatient and community mental health services for Pacific (see EMO scores in Figure 30).

Figure 30. Pacific Infant, Child and Adolescent Client Outcomes by Service (2015/2016)



Source: Ministry of Health, PRIMHD extract 16 January 2017, extracted & formatted by Te Pou.

ICAMH/AOD SERVICE PROVISION FOR PACIFIC INFANTS, CHILDREN AND ADOLESCENTS

- In New Zealand, Pacific infants, children and adolescents and their families have access to both mainstream and Pacific ICAMH/AOD services. Of the 20 DHBs that currently provide specialist CAMH/AOD services, only two are providing a total of two dedicated Pacific services for the 0-19 year age group. These Pacific services/teams operate in the following regions and DHBs:
    - Northern region:
        - Counties Manukau DHB: *Vaka Toa Pacific Adolescent Team.*
    - Central region:
        - Capital & Coast DHB: *Health Pasifika Child Adolescent & Family Services.*
- In Waitemata DHB, Pacific infants, children, adolescents and their families have access to two Pacific services, *Isa Lei Pacific Mental Health Service* and *Tupu Pacific Regional Alcohol & Drug Service* which are funded under adult services.
- Where specific DHB Pacific mental health/AOD services are not available, most DHBs fund their local NGOs to provide such services.
- Of the 106 NGOs that were identified for the 2016 *Stocktake*, only four NGOs provided dedicated Pacific services in the following regions and DHB areas:
    - Northern region:
        - Counties Manukau: *Penina Trust*
    - Midland region:
        - Waikato: *K'aute Pasifika, Raukawa Charitable Trust*
    - Central region:
        - Capital & Coast: *Taeaomanino Trust*
- Pacific infants, children and adolescents are also able to access other DHB funded mainstream child and adolescent mental health/AOD, peer-support and advocacy services.
- Given that 78% of Pacific children had visited a GP in the past 12 months, as reported in the *2011/2012 New Zealand Health Survey* (Ministry of Health, 2012b), primary health care organisations have a key role in improving the mental health status of Pacific people.

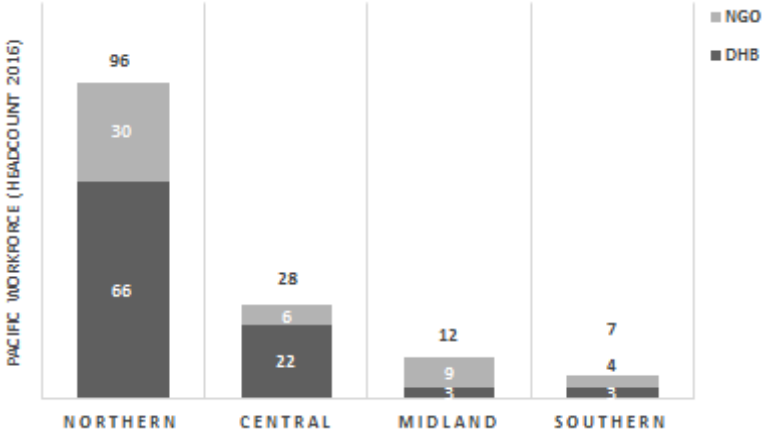
PACIFIC ICAMH/AOD WORKFORCE

The following information is derived from workforce data (Actual & Vacant Full Time Equivalents (FTEs) & Ethnicity by Occupational Group) submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services and 105/106 NGOs as at 30 June 2016. Consistently missing data from one large NGO provider in the Midland region continues to impact on the accuracy of NGO workforce data. While, the contracted FTE volume data from the Ministry of Health's Price Volume Schedule (PVS) were used to estimate this NGO's workforce, these data do not include information by ethnicity and occupational group, therefore the NGO Pacific workforce, especially in the Midland region, may remain underestimated.

From 2014 to 2016:

- There was a 7% increase in the total Pacific ICAMH/AOD workforce (DHB Inpatient & Community CAMHS and NGOs) from 134 to 143 (headcount; 123.03 actual FTEs) (see Table 8).
- Three out of the four regions showed an increase in the Pacific ICAMH/AOD workforce with the Northern and Midland regions reporting the largest increases by 5. The Southern region reported a decrease of 2, from 9 to 7 (headcount).
- The increase in the Pacific workforce was largely seen in the DHB Community services. NGOs reported a decrease in the Pacific workforce from 58 to 49.

Figure 31. Total Pacific ICAMH/AOD Workforce by Region (Headcount, 2016)

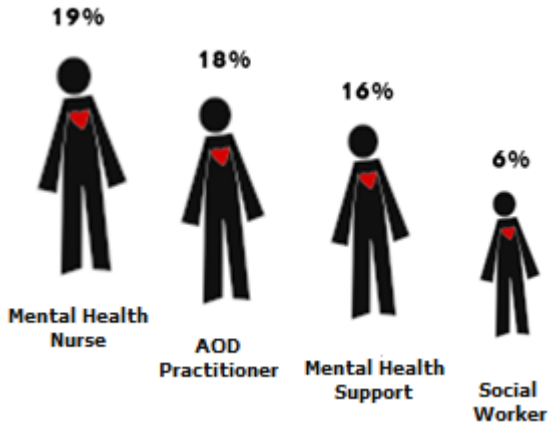


- The overall increase in the Pacific workforce was seen mainly in the Clinical workforce by 21%, from 68 to 82.

As at 30 June 2016:

- The Pacific workforce (143) made up 7% of the total ICAMH/AOD workforce (1,952, headcount).
- The Northern region had the largest Pacific workforce (96), followed by the Central region (28) (see Figure 31).

Figure 32. Top 4 Pacific ICAMH/AOD Workforce by Occupational Group (2016)



- The sub-ethnicity of the Pacific workforce consisted of Samoan (60%), Tongan (17%), Niuean (10%), Cook Island (7%), and Fijian (3%). Half of the Pacific workforce was fluent in their respective languages, while the remainder were either semi-fluent or understood some of their language.
- Just over half of the Pacific workforce (66%, 94 headcount) was employed in DHB services (see Table 9).
- The Pacific workforce was largely in Clinical roles (57%) mainly as Mental Health Nurses (27), Alcohol & Drug Practitioners (25), Social Workers (9) and Psychologists (7) (see Table 9 & Figure 32).

- The Non-Clinical Pacific workforce was mainly Mental Health Support Workers (23) and Cultural Workers (9).

Table 8. Total Pacific ICAMH/AOD Workforce (Headcount, 2006-2016)

REGION	DHB[1]					NGO					TOTAL				
	2008	2010	2012	2014	2016	2008	2010	2012	2014	2016	2008	2010	2012	2014	2016
NORTHERN	29	35	39	55	66	9	17	27	36	30	38	52	66	91	96
MIDLAND	1	2	2	1	3	7	6	4	6	9	8	8	6	7	12
CENTRAL	14	19	16	18	22	6	4	6	9	6	20	23	22	27	28
SOUTHERN	-	1	2	2	3	8	9	10	7	4	8	10	12	9	7
TOTAL	44	57	59	76	94	30	36	47	58	49	74	93	106	134	143

1. **Includes Inpatient Services**

Table 9. Total Pacific ICAMH/AOD Workforce (Headcount, 2016)

OCCUPATIONAL GROUP (HEADCOUNT, 2016)	DHB		DHB TOTAL	NGO	TOTAL
	INPATIENT	COMMUNITY			
ALCOHOL & DRUG PRACTITIONER	-	18	18	7	25
CEP CLINICIAN	-	1	1	1	2
MENTAL HEALTH NURSE	7	15	22	5	27
OCCUPATIONAL THERAPIST	-	2	2	-	2
PSYCHIATRIST	-	2	2	-	2
PSYCHOLOGIST	-	7	7	-	7
SOCIAL WORKER	-	8	8	1	9
OTHER CLINICAL[1]	-	5	5	3	8
CLINICAL SUB-TOTAL	7	58	65	17	82
CULTURAL APPOINTMENT	-	8	8	1	9
MENTAL HEALTH CONSUMER ADVISOR	-	1	1	-	1
MENTAL HEALTH SUPPORT WORKER	8	3	11	12	23
YOUTH WORKER	-	1	1	-	1
OTHER NON-CLINICAL SUPPORT FOR CLIENTS	-	-	-	7	7
NON-CLINICAL SUPPORT FOR CLIENTS SUB-TOTAL	8	13	21	31	52
ADMINISTRATION/MANAGEMENT	-	8	8	1	9
TOTAL	15	79	94	49	143

1. **Other Clinical = Counsellors.**
2. **Other Non-Clinical = Early Education; Advocacy Peer Support.**

DHB INPATIENT PACIFIC INFANT, CHILD AND ADOLESCENT MENTAL HEALTH WORKFORCE

From 2014 to 2016:

- There was a slight increase in the overall Pacific Inpatient workforce from 14 to 15 (headcount) (see Table 8).
- Auckland DHB Inpatient Services reported an increase of 3 Pacific staff, while Capital & Coast DHB Inpatient Pacific workforce reported a decrease of 2 and Canterbury Pacific Inpatient workforce has remained the same (2, headcount).

As at 30 June 2016:

- The Pacific Clinical Inpatient workforce was almost equally split between Mental Health Nurses (7, headcount) and Mental Health Support Workers (8, headcount) (see Table 9).

DHB COMMUNITY PACIFIC INFANT, CHILD AND ADOLESCENT MENTAL HEALTH/AOD WORKFORCE

From 2014 to 2016:

- There was a 27% increase in the Pacific DHB Community service workforce, from 63 to 79 (see Table 8).
- The increase in the Pacific DHB Community workforce was seen in the Clinical workforce.
- This increase was seen in all four regions.

As at 30 June 2016:

- The Northern region (58) reported the largest Pacific DHB Community workforce followed by the Central (17), Midland (3) and Southern (1) regions (see Table 8).
- The Pacific DHB Community workforce (73%) was mainly in Clinical roles as Alcohol and Drug Practitioners (18), Mental Health Nurses (15) and Social Workers (8) (see Table 9).
- The Pacific Non-Clinical workforce was mainly Cultural Workers (8, headcount).

NGO PACIFIC ICAMH/AOD WORKFORCE

Please note: The 2016 NGO Pacific workforce, especially in the Midland region, remains underestimated due to consistently missing workforce data from a large NGO provider in the Midland region.

From 2014 to 2016:

- There was a decrease in the Pacific NGO workforce, from 58 to 49 (see Table 8).
- This decrease was seen in three out of the four regions: Northern, Central and Southern, while a slight increase was seen in the Midland region, from 6 to 9.
- The decrease in the workforce was largely seen in both Clinical and Non-Clinical roles.

As at 30 June 2016:

- The Northern region (30) reported the largest NGO Pacific workforce, followed by Midland (9), Central (6) and Southern (4) regions (see Table 8).
- The Pacific NGO workforce was mainly in Non-Clinical roles as Mental Health Support Workers (11) (see Table 9).
- The Pacific Clinical workforce was mainly Alcohol and Drug Practitioners (7) and Mental Health Nurses (5).

CULTURAL COMPETENCY OF THE WORKFORCE

Via the 2016 Stocktake Workforce Survey, services were asked to indicate the Pacific health models of practice used in service delivery. Pacific health models are not as widely used as Māori health models; only eight DHBs indicated using Pacific health models in their service delivery. Where used, the most commonly used Pacific health model was the *Fonofale model* (Puloto-Endemann, 1995). Services embed these models in various ways:

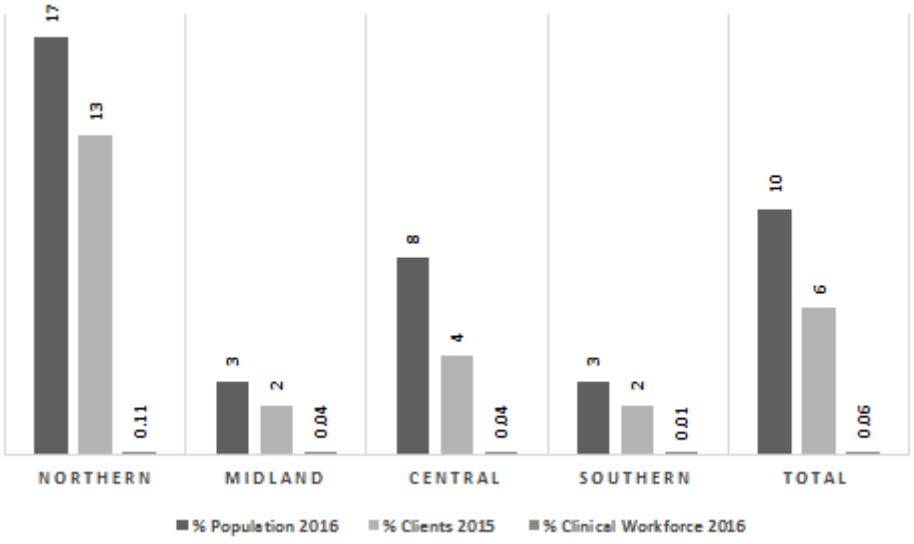
- Pacific health models are embedded in their assessment/treatment plans and form part of a service's core competencies training.
- Services receive internal support from Pacific teams/services and cultural advisors/support workers or have specifically appointed staff to work with Pacific clients.
- Pacific services embed the models into their clinical and cultural assessment tools.

PACIFIC POPULATION, CLIENT AND WORKFORCE COMPARISONS

- Based on the 2016 population projections, Pacific infants, children and adolescents made up 10% of the total 0-19 year population, 6% of all clients accessing services and the Pacific workforce (134, excluding the Administration/Management workforce) made up 8% of the total workforce (1,772).
- Due to low numbers of Pacific clients accessing services (6% in the second six months of 2015) compared to Other Ethnicity (61%) and Māori (31%), the total Pacific workforce appears to be proportional to the rates of Pacific clients at the national and regional levels (see Figure 33). However, such low access rates could indicate unmet mental health needs for the Pacific 0-19 year population. Additionally, the disparity between Pacific workforce and Pacific clients becomes evident when the Pacific *clinical* workforce is benchmarked against the actual population and clients (see Figure 34).
- Given the increasing trend in the Pacific population and clients accessing services nationally, there is a need to focus on increasing the Pacific clinical workforce across all occupational groups to cater for the current and future needs of the Pacific infant, child and adolescent population.

Figures 33. Proportion of Pacific 0-19 Population, Client and Workforce Comparisons by Region

Figure 34. Proportion of Pacific 0-19 yrs Population, Client and Clinical Workforce Comparisons by Region



SUMMARY

The Pacific population is a growing and youthful population with almost half of the population between the ages of 0 and 19 years. The Pacific population will continue to have a younger age structure than the total New Zealand population due to higher birth rates.

The Pacific population experiences greater socioeconomic deprivation, higher disengagement and greater mental health needs than the general population. Regions with large populations of Pacific infants, children and adolescents such as the Northern region (Counties Manukau, Auckland and Waitemata) and Central region (Capital & Coast and Hutt Valley) should continue to anticipate growing demand for services.

PACIFIC ACCESS TO ICAMH/AOD SERVICES

The majority of Pacific infants, children and adolescents continue to be seen by mainstream DHB services/teams. Pacific client access data from 2013 to 2015 showed a marked increase in Pacific access rates to services in all three age groups. However, Pacific access rates in the second half of 2015 continued to remain below the target access rates in all three age groups in all four regions, especially for the 10-14 year age group. While the Pacific access rates have been compared to the rates recommended by the MHC, the Pacific population experiences higher levels of mental health disorder than does the general population (Ministry of Health, 2008) and therefore the target access rates for all three age groups is a conservative estimate of actual need.

It is well noted that Pacific people are "*hard to reach New Zealanders"* (Kingi, 2008). Even if Pacific people are able to access services, they may not utilise them if these services are not responsive to their cultural norms (Kingi, 2008).

Reasons for the persistent low access rates for Pacific were identified in the *Youth'07* study on Pacific high school students (Helu et al., 2009). Their data showed that more Pacific than NZ European youth reported problems with accessing healthcare and were more likely to identify barriers to accessing healthcare. These barriers included:

- Didn't want to make a fuss
- Couldn't be bothered
- Too scared
- Worried it wouldn't be kept private
- Had no transport
- Don't know how to.

A more recent report on improving primary care delivery to Pacific peoples, *Primary Care for Pacific People: A Pacific and Health Systems Approach* (Southwick, Kenealy, & Ryan, 2012), highlighted issues that hinder Pacific access to primary care. While the participants were adult Pacific peoples, these issues may be similarly relevant in hindering Pacific families' access to secondary and ICAMH/AOD services:

- Transport problems.
- The cost of healthcare.
- A degree of frustration and disappointment at the gap between expectations and actual experience of health services.
- Difficulties in making appointments, especially with the same GP - disrupting relationship building and continuum of care.
- Lack of confidence in communicating with doctors, especially among older Pacific clients, partly due to language barriers and a lack of interpreter resources.

ICAMH/AOD PROVISION OF SERVICES FOR PACIFIC INFANTS, CHILDREN AND ADOLESCENTS

From 2014 to 2016, there was very little change in funding and in the number and types of secondary and tertiary ICAMH/AOD services that were available to Pacific infants, children and adolescents and their families. Additionally, there were fewer numbers of Pacific ICAMH/AOD NGO services available to Pacific consumers especially in areas of highest populations.

In 2016, almost three-quarters of the Pacific infant, child and adolescent population resided in the Northern region (and, of those, more than half lived in the Counties Manukau DHB area). However, there was only one DHB Pacific team at Counties Manukau DHB service and one Pacific NGO (*Penina Trust*) providing dedicated Pacific infant, child and adolescent mental health/AOD services.

Auckland DHB had the second highest Pacific infant, child and adolescent population in the region, yet was not providing any Pacific services targeting this population.

PACIFIC ICAMH/AOD WORKFORCE

From 2014 to 2016, there has been 7% growth in the Pacific workforce particularly in the clinical workforce. However, due to the increasing trends in the Pacific 0-19 year population and number of Pacific clients accessing mental health services over the same period, the clinical workforce has not kept pace with this growing demand and would therefore need to almost double in size to serve the needs of Pacific infants, children and adolescents. The largest increase in the clinical workforce is required in the Northern region.

Pacific health models are not as widely used as Māori health models; only eight DHBs indicated using Pacific health models in their service delivery.

While the need for increasing the Pacific workforce is acknowledged by services, DHBs and NGO ICAMH/AOD services identified a number of challenges that impede progress in increasing the Pacific workforce:

- Very few qualified Pacific health practitioners available for recruitment
- Loss of senior Pacific staff due to promotions into other senior positions, with few qualified staff to replace them
- Lack of dedicated funding in services for targeted recruitment initiatives
- Limited funding, especially in NGOs, which means that services are not able to recruit any more staff.

The lack of specific Pacific ICAMH/AOD services, the lack of knowledge about these services and the lack of culturally and clinically competent staff within existing services could also partly explain why Pacific infants, children and adolescents and their families are not accessing services.

RECOMMENDATIONS

Given that Pacific infants, children and adolescents have high mental health needs, the current low access rates indicate significant unmet needs for Pacific. Increasing the Pacific access rates remains a key priority, therefore, especially given the evidence that when Pacific infants, children and adolescents *do* access mental health services, client outcome data indicates significant improvements in emotional related symptoms by time of discharge.

When Pacific do access services, they are largely seen by mainstream DHB services. However, there continue to be disparities between Pacific clients and the Pacific clinical workforce, therefore the need to increase the Pacific workforce and enhance the cultural competency of the mainstream workforce is also pertinent.

In light of these 2016 *Stocktake* findings, and to ensure alignment with current government priorities (Ministry of Health, 2007; 2012; 2016) and progress toward workforce strategic goals, the following recommendations are made to improve the mental health outcomes for all Pacific infants, children and adolescents. These recommendations have also been developed in consultation with the Werry Centre Pacific Advisory Group.

- **Improving Pacific Access to Services:**
    - While Pacific access rates to services have increased, they still remain significantly short of actual need. Therefore, improving Pacific access rates should continue to be a key area of focus.
    - In consultation with Pacific service users, effective strategies to increase Pacific access rates, especially for the 10-14 year age group, to cater for actual need must be identified.
        - Engaging in mental health promotion activities and providing services in community-based settings (engaging Pacific community leaders), such as schools and churches, could help to alleviate some of the access issues highlighted for Pacific peoples.
    - A key barrier to accessing and engaging with services for some Pacific families is their difficulty in communicating in English. Having more Pacific staff in services, who are fluent in their languages, and having access to interpreters could alleviate this access issue.
- **Development and Provision of Services:**
    - ***Early Intervention**:*
        - Because early intervention and earlier access to services are essential for Pacific (Ministry of Health, 2008), there is ongoing need to develop early intervention strategies and services (i.e. parenting programmes and infant health/mental health services) for Pacific in primary and secondary care settings.
        - School-based health services in secondary schools should be increased/enhanced with appropriately trained staff. *Youth'12* results on health services in secondary schools showed positive associations between aspects of health services in schools and mental health outcomes of students at the same schools. There was less overall depression and suicide risk among students attending schools with any level of school health services (Denny et al., 2014); more specifically, schools with:
            - A health team on site
            - More than 2.5 hours of nursing and doctor time per week per 100 students
            - Health staff with postgraduate training
            - Routine psychosocial health screening using HEEADSSS screening.
        - Given that 20% of Pacific young people are NEET (Ministry of Business Innovation & Employment, 2013), alternative, community-based clinics for Pacific young people who are not at school could help to alleviate some of the access issues highlighted.

- ***Specialist Services:***
    - Due to the lack of dedicated Pacific ICAMH/AOD services, there is a need to increase the number of Pacific culturally appropriate services nationally.
    - Work more collaboratively and maintain relationships between school, primary and secondary mental services to assist with referral pathways.
    - Additionally, identifying the reasons why access has improved for Pacific may also assist future planning.

- **Workforce Development:**
    - Due to increases in Pacific access and continued critical shortages in the Pacific workforce, there is a continued need to increase the Pacific ICAMH/AOD workforce.
    - While increasing the Pacific workforce is a long-term solution to workforce shortages, there is an ongoing need to retain and develop the existing Pacific ICAMH/AOD workforce and to increase the clinical and cultural competence of the mainstream workforce to better cater for Pacific children, adolescents and their families.
    - An increasing number of Pacific clients are being seen by the NGO sector; therefore, an increased focus on addressing the workforce development needs of the NGO sector is also pertinent.
    - GPs continue to be the largest source of referrals to ICAMH/AOD services, and the move to develop primary services to deliver mental health care may help reduce the demand in ICAMH/AOD specialist services and NGOs.
    - The strategies for retaining and developing the Pacific and non-Pacific workforce that spans the primary to the secondary sectors should include:
        - ***Workforce Planning***
            - Services need to actively monitor local service demands and workforce development needs and ensure funding is allocated accordingly.
            - Continued investment in active recruitment strategies and addressing the workforce development needs of the Pacific workforce is seen as a key priority and is embedded in a service's strategic plans.
            - Ensure that local schools, tertiary education providers, PHOs and NGOs and DHBs are all part of the strategic planning process.
            - Pacific leadership development could have a positive impact on the workforce by providing experienced role models and cultural supervision to foster conditions for recruitment and retention of the Pacific workforce.
        - ***Recruitment and Retention:***
            - Due to critical shortages in the Pacific clinical workforce, there is continued need to increase the Pacific ICAMH/AOD workforce through enhanced training and career pathways into mental health/AOD.
            - Establish dedicated funding for the recruitment of Pacific staff in ICAMH/AOD services.
            - Establish dedicated Pacific intern positions in services where there are high Pacific populations.
            - Supporting the current Pacific workforce by providing support networks for those who are working in isolation in large services could improve the retention of the current Pacific workforce.

- ***Competency Development:***
    - Given the increasing access rates for Pacific who are largely accessing mainstream services, and a small number of services incorporating Pacific health models of practice into their service delivery, there continues to be a critical need for increasing the dual competency of mainstream services to be clinically and culturally competent. Therefore, a continued integration of the skills and knowledge outlined in available competency frameworks, e.g. *Real Skills Plus Seitapu Framework* (Te Pou, 2009), is required in services nationally.
    - The current workforce information indicates that only half of the existing Pacific ICAMH/AOD workforce is fluent in their respective languages. Therefore, language competency development for the current Pacific workforce and providing interpreter resources to accommodate diverse Pacific languages could be essential strategies in addressing access issues.
    - Provide cultural supervision for Pacific and mainstream staff to support service delivery to Pacific children, adolescents and their families.

- ***Training and Professional Development:***
    - Due to low numbers of Pacific clinical staff, providing career pathways for non-clinical experienced workers into the specialist workforce is required to increase the Pacific clinical workforce numbers.

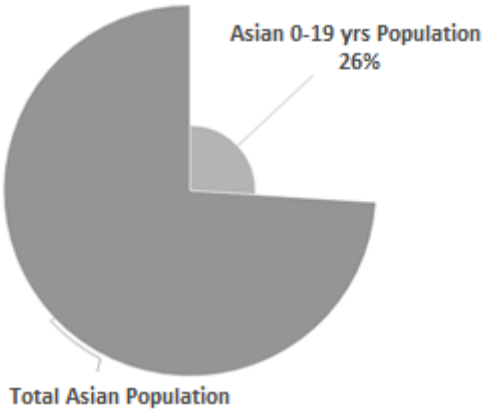
- ***New Ways of Working:***
    - Engage in collaborative service delivery between PHOs, NGOs and DHBs. Building relationships and working in partnership with other services to overcome shortages in the workforce is occurring in some areas and could be an effective way to share limited resources.

ASIAN NATIONAL OVERVIEW

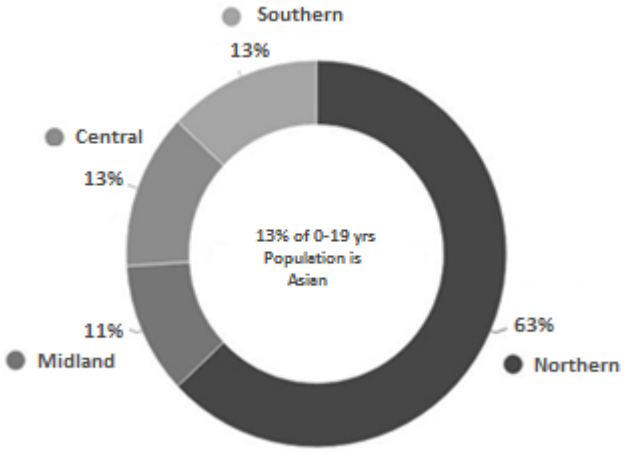
ASIAN INFANT, CHILD AND ADOLESCENT POPULATION

The population data include the 2016 infant, child and adolescent population projections (prioritised ethnicity by DHB area) provided by Statistics NZ.

- While the term "Asian" is commonly used as a single ethnic category, it actually includes a large number of ethnic groups which are very diverse in culture, language, education and migration experiences. New Zealand's "Asian" population (defined as people from East, South East and South Asia) is made up of more than 40 different ethnic groups. The three largest ethnic groups are Chinese, Indian and Filipino (Statistics New Zealand, 2013). People from the Middle East and Central Asia are excluded from this group. The latest census data (2013) has shown that among the Asian sub-groups, the number of Filipinos is on the rise in the Auckland region.



- The Asian population is the fastest growing population in New Zealand, especially in Auckland, since Census 1996 (Statistics New Zealand, 2004a).
- From 1996 to 2006, Asian population growth doubled and this growth was the largest out of the four main ethnic groups in New Zealand (European, Māori, Pacific and Asian) (Statistics New Zealand, 2006b). This increase was due largely to immigration, increase in international students and the intake of refugee populations.



- The 2016 population projections indicated that the Asian 0-19 year population continues to be the fastest growing population out of the four main ethnic groups. The Asian 0-19 year population showed a projected growth of 19% compared to the growth in the Other Ethnic group (-3%), Māori (4%) and Pacific (3%) populations for the same period, making the Asian 0-19 year population larger than the Pacific population and the third largest ethnic population in the country (see Appendix A, Table 1).
- Based on the 2016 population projections, the Asian 0-19 year population makes up 26% of the total Asian population in New Zealand.
- The Asian 0-19 year population made up 13% of New Zealand's total infant, child and adolescent population. Over half (52%) of the Asian 0-19 year population are male.
- The majority (63%) of the Asian infant, child and adolescent population resided in the Northern region with 99% of the region's population split between the Counties Manukau, Auckland and Waitemata DHB areas (see Appendix A, Table 1).
- An overall 35% growth is projected by 2026 across all regions, with the largest growth projected for the Midland (by 43%) and Southern regions (by 40%) (see Appendix A, Table 2).

- The growing numbers of Asian international students residing in New Zealand need to be considered. In 2016 (January-August), there was a total of 17,480 (10,981; 2014) international fee-paying school students (primary and secondary schools) in New Zealand, a 59% increase from 2014. Additionally, 76% (12,545/16,460) of students were from the Asian region (largely from China 37%; Japan 15%; South Korea 13% and Thailand 8%). Over half of all international students (58%) live in the greater Auckland region (Ministry of Education, 2016).
- The number of refugees arriving in New Zealand also needs to be considered. As at September 2016, 333 refugees arrived in New Zealand, 21% were from Asian countries and 40% were 17 years of age and under (The Refugee & Protection Unit, 2016).
- Additionally, as a result of the recent introduction of the Free Trade Agreement between New Zealand and China, Chinese people are allowed to work in New Zealand and some work visa holders can bring their families to New Zealand. Official figures in this area are scant.

ASIAN INFANT, CHILD AND ADOLESCENT MENTAL HEALTH NEEDS

The process of immigration can negatively affect a new immigrant's psychological wellbeing in various ways (Ho, Au, Bedford, & Cooper, 2003):

- The following groups have the highest risk of developing mental health problems:
    - Women
    - Immigrant and fee-paying students
    - Older people
    - Refugees.
- Language difficulties can prolong the process of acculturation/integration and prevent new immigrants from acquiring appropriately skilled jobs.
- Despite higher levels of tertiary qualifications, the Asian immigrant population experiences high unemployment rates which are double those of the total population. The majority earns less than $30,000 per annum (Ministry of Health, 2006). High unemployment rates have been linked to a high risk for mental health problems.
- Isolation and disruption of family and support networks impact negatively on mental health.
- For the refugee population, traumatic experiences have long-lasting consequences. This population is at higher risk for post-traumatic stress disorder, depression and psychosomatic problems. Refugee youth are a specifically vulnerable group within this high risk group.
- Migration can bring stress to family relationships and parenting practices and can exacerbate pre-existing relationship issues (Lee, 1997).
- Suicide is one of the top five causes of mortality in Asian people aged 15-74 years (Mehta, 2012).

The *Youth'07* survey (Parackal, Ameratunga, Tin Tin, Wong, & Denny, 2011), conducted with 1,310 students, aged between 13 and 17 years old, who identified with an Asian ethnic group (Chinese = 537, Indian = 365), revealed that the majority (89%) of Asian students reported being OK, very happy or satisfied with their life. However, 25% indicated having "poor" mental and emotional wellbeing, with a higher prevalence in females (31%) than males (20%):

- 13% reported depressive symptoms (12% Chinese; 12% Indian)
- 15% had suicidal thoughts (15% Chinese; 17% Indian)
- 8% had planned to kill themselves (9% Chinese; 10% Indian)
- 4% had attempted suicide (4% Chinese; 6% Indian)

- 2% reported inflicting self-harm requiring treatment (3% Chinese; 2% Indian)
- The majority of "Asian" students reported having positive family, home and school environments, and positive relationships with adults at home and school. However, Chinese and Indian students were more likely than NZ European students to experience family adversity or hardships (e.g. changing homes more often, overcrowding and unemployment among parents).

- Fee-paying Asian students may be susceptible to developing mental health problems due to their "pampered" upbringing from China's former "one-child" policy (Au & Ho, 2015; Wang & Mallinckrodt, 2006).

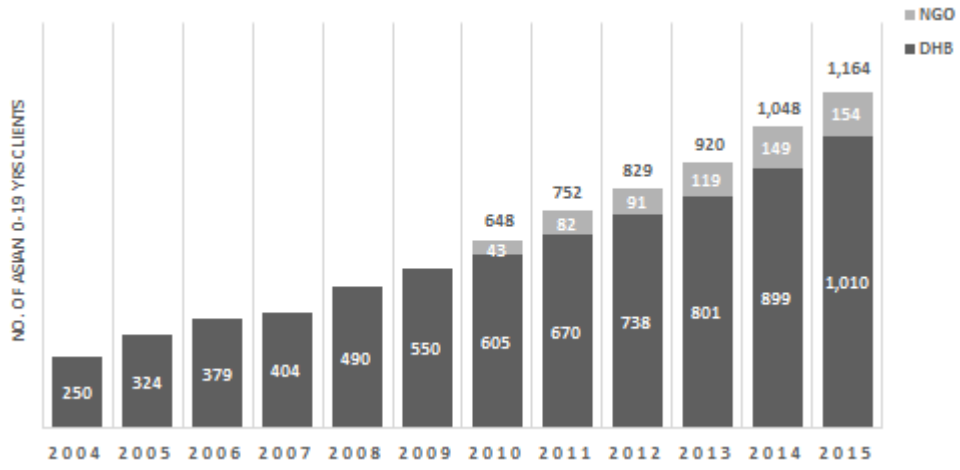
ASIAN CLIENT ACCESS TO ICAMH/AOD SERVICES

The client access to service data (number of clients seen by DHB & NGO ICAMH/AOD services) have been extracted from the *Programme for the Integration of Mental Health Data* (PRIMHD). Access data are based on the *Clients by DHB of Domicile* (residence) for the second six months of each year (July to December). NGO client data have been included since 2010. Data from 142 NGOs were included in the 2014 client access information, while 139 NGOs were included in the 2015 client data.

From 2013 to 2015:

- There continues to be an increasing trend in the number of Asian clients accessing services nationally, with a 27% overall increase in the total number of Asian clients accessing mental health/AOD services (see Figure 35).
- This increase was seen in the Asian male client group by 32%, while there was a 22% increase in Asian female clients accessing services nationally.
- Asian clients by region showed increases in Asian clients in all four regions, with the largest increase in the Southern region by 62% (from 81 to 131) (see Appendix B, Table 14).

Figure 35. Asian 0-19 yrs Clients (2004-2015)

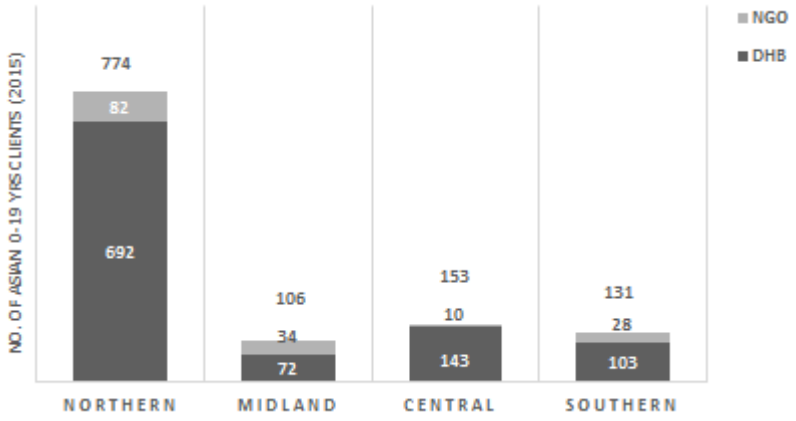


In the second six months of 2015:

- While there was an increasing trend in the number of Asian clients accessing services nationally, the overall Asian client numbers (1,164) has remained relatively low compared to Māori (11,357) and Pacific (2,160) client numbers.
- Asian children and adolescents made up 3% of the total clients accessing services (1,164/35,325).

- There were slightly more Asian males (592, 51%) accessing services than females (572, 49%).
- The Northern region had the largest number of Asian clients; representing 66% of total Asian clients (see Figure 36).
- The majority of Asian clients (87%) continue to be seen by DHB services.

Figure 36. Total Asian Clients Numbers by Region (2015)



ASIAN CLIENT ACCESS RATES

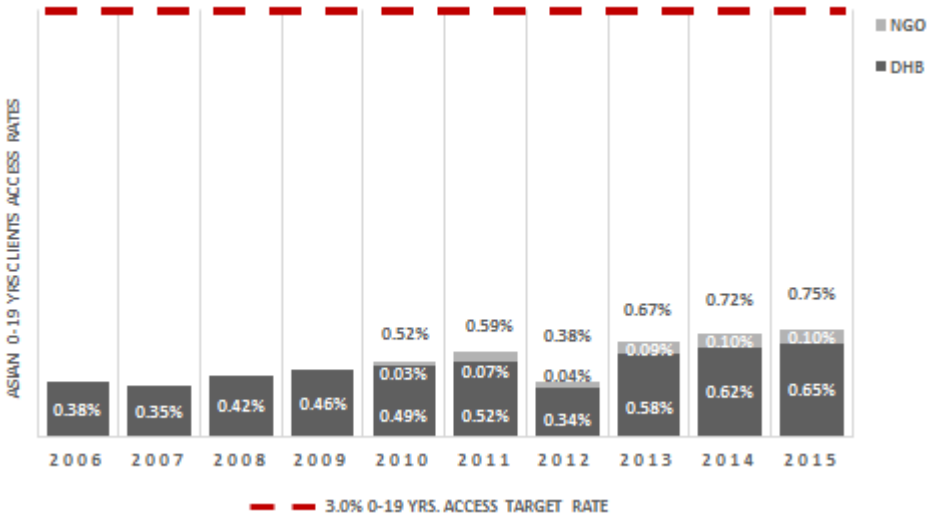
The *Blueprint Access Benchmark Rate* for the 0-19 year age group has been set at 3% of the population over a six month period (Mental Health Commission, 1998). Due to different prevalence rates for mental illness in different age groups, the MHC has set appropriate access rates for each age group: 1% for the 0-9 year age group; 3.9% for the 10-14 year age group and 5.5% for the 15-19 year age group. Due to the lack of epidemiological data for the Asian 0-19 year population, there are no specific Blueprint access benchmarks for the Asian population, therefore the Asian access rates have been compared to the rates for the general 0-19 years population.

The 2004 to 2015 MHINC/PRIMHD access data were analysed by six months to determine the six monthly benchmark access rates for each region and DHB. The access rates presented in this section were calculated by dividing the clients in each age band per six month period by the corresponding population. Access rates are not affected by referral to regional services as they are based on the DHB where the client lives (DHB of domicile). However, access rates are affected by the population data used. Client access rates are calculated using the best available population data at the time of reporting. The 2006 and 2013 client access rates were calculated using census data and are therefore more accurate than the access rates calculated using population projections (projected population statistics tend to be less accurate than actual census data).

From 2013 to 2015:

- There was an increase in the Asian 0-19 years access rate from 0.67% to 0.75% (see Figure 37).
- This increase was seen in the 10-14 year and 15-19 year age groups.
- Slight improvements in Asian client access rates were also seen in all four regions (see Appendix B, Table 14).

Figure 37. Asian 0-19 yrs Client Access Rates (2004-2015)



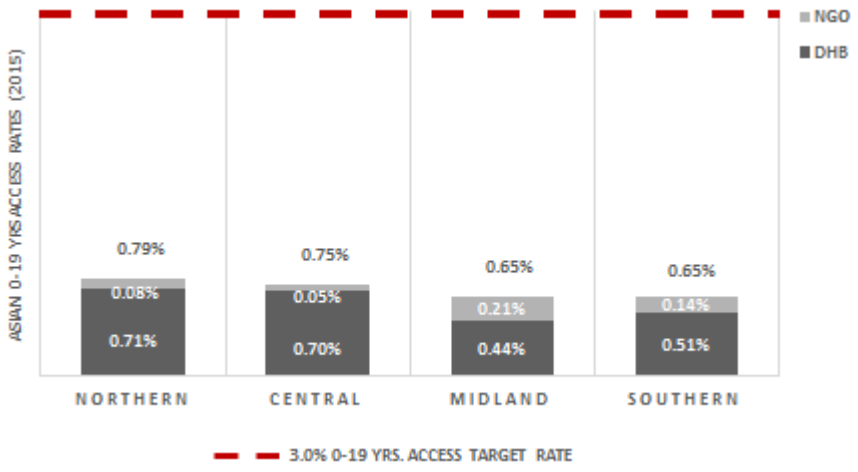
In the second six months of 2015:

- Nationally, the overall Asian access rate remains the lowest out of the four ethnic groups at 0.75%; with the highest access rate in the Northern region (see Figure 38).

- Due to the lack of epidemiological data on the mental health needs of Asian people, the Asian access rates have been compared to the MHC target rates set for the general New Zealand child and adolescent population (Mental Health Commission, 1998).

- Despite the growth of the Asian population and the inclusion of NGO client data, there continued to be very little improvement in Asian access rates for all three age groups and they remain significantly below MHC's target rates in all three age groups and across all regions.

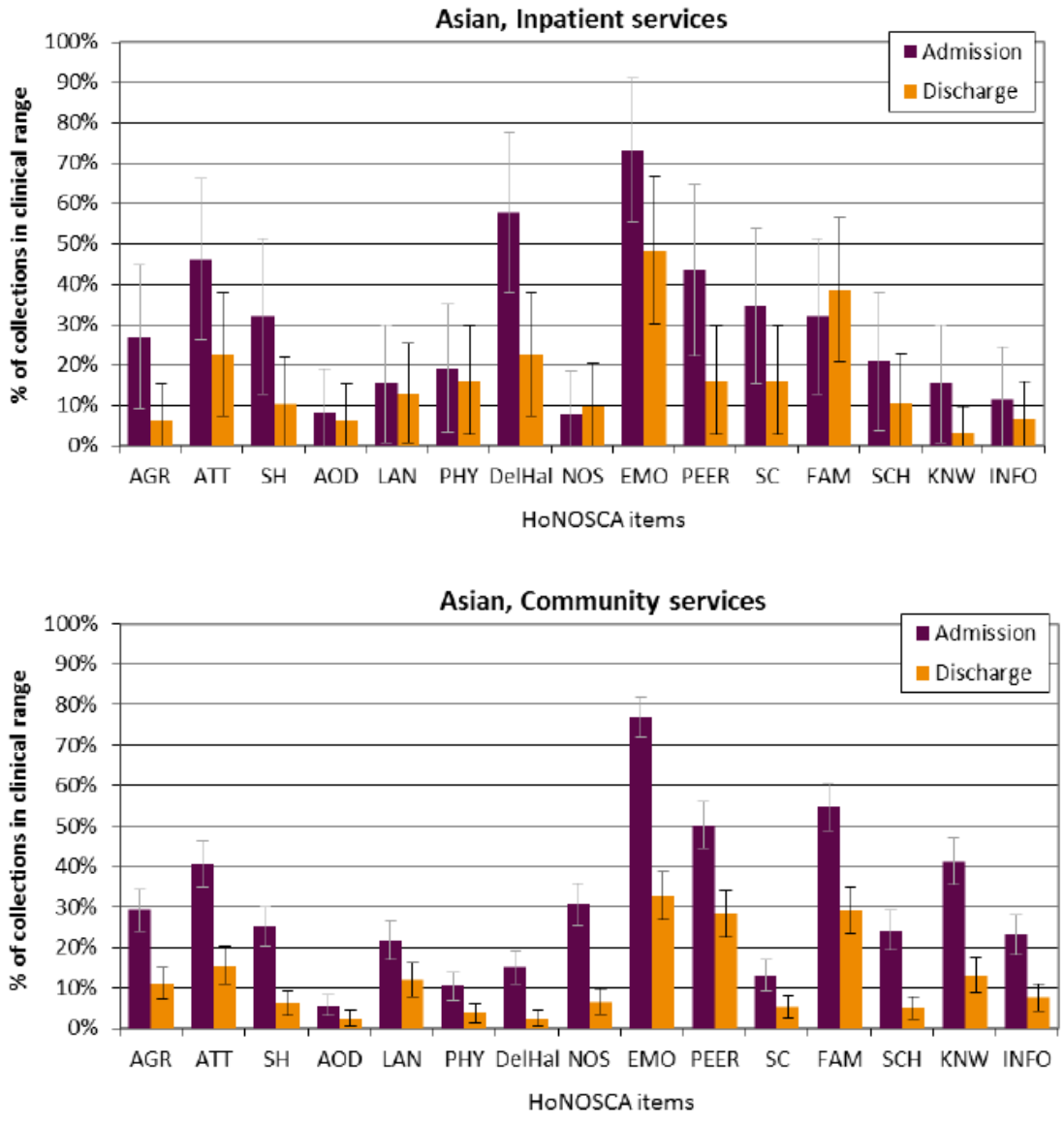
Figure 38. Asian 0-19 yrs Client Access Rate by Region (2015)



ASIAN CLIENT OUTCOMES

To assess whether Asian clients accessing mental health services experience improvements in their mental health and wellbeing, children and youth health outcomes are rated by the *HoNOSCA* (Health of the Nation Outcome Scales for Children and Adolescents) for children and adolescents 4-17 years at admission and discharge from inpatient and community child and adolescent mental health services. Client outcome data for the 2015/2016 period showed significant improvements in emotional related symptoms by time of discharge from community mental health services only for Asian clients (see EMO scores in Figure 39).

Figure 39. Asian Infant, Child and Adolescent Client Outcomes by Service (2015/2016)



Source: Ministry of Health, PRIMHD extract 16 January 2017, extracted & formatted by Te Pou.

PROVISION OF ICAMH/AOD SERVICES FOR ASIAN INFANTS, CHILDREN AND ADOLESCENTS

- Of the 20 DHBs that provide specialist ICAMH/AOD services, none are specifically funding ICAMH/AOD services for Asian infants, children and adolescents. Some DHB provider services have Asian mental health teams operating within their existing mental health services or receive specific funding for Migrant and Refugee services:
    - Canterbury DHB: *Migrant & Refugee Mental Health Services*.
- There are a number of Asian services that are available to Asian people operating within DHBs which are funded under adult services but also work alongside the ICAMH/AOD services:
    - Auckland DHB: *Asian Mental Health Team.*
    - Waitemata DHB: *Asian Health Support Services* which includes the *Asian Mental Health Client Coordination and Support Service.*
    - Counties Manukau DHB: *Asian Mental Health Service* which is mainly a coordination service providing advice on available resources, mental health services and links to support groups.
    - Where specific DHB mental health/AOD services are not available, most DHBs fund their local NGOs to provide services that can be accessed by Asian people.
    - Of the 106 NGOs that were identified for the 2014 Stocktake, none received funding to provide specific Asian ICAMH/AOD services, especially in Auckland where the majority of the Asian population reside. There are however, NGOs in Auckland which have Asian staff members available to work with Asian service users and their families.
    - In other regions, Asian children, adolescents and their families have access to the following NGO migrant and refugee services:
        - Capital & Coast DHB: *Refugee Trauma Recovery.*
        - Southern DHB: *Miramare Ltd.*
    - Asian infants, children and adolescents are able to access DHB funded, community-based mainstream ICAMH/AOD, peer-support and advocacy services.

ASIAN ICAMH/AOD WORKFORCE

The following information is derived from workforce data (Actual & Vacant Full Time Equivalents (FTEs) & Ethnicity by Occupational Group) submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services and 105/106 NGOs as at 30 June 2016. Consistently missing data from one large NGO provider in the Midland region continues to impact on the accuracy of NGO workforce data. While, the contracted FTE volume data from the Ministry of Health's Price Volume Schedule (PVS) were used to estimate this NGO's workforce, these data do not include information by ethnicity and occupational group, therefore the NGO Asian workforce, especially in the Midland region, may remain underestimated.

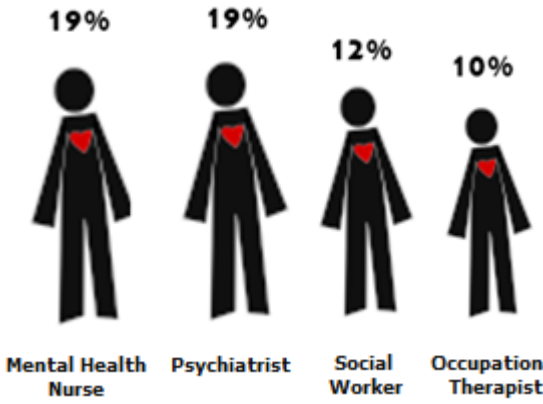
From 2014 to 2016:

- There was a 36% increase in the total Asian ICAMH/AOD workforce (DHB Inpatient & Community CAMH/AOD Services & NGOs) workforce, from 75 to 103 (72.63 actual FTEs) (see Table 10).
- Three out of the four regions showed an increase in the Asian workforce, with the Northern region reporting the largest increase from 44 to 62 while the Asian workforce in the Midland region has remained the same.
- The increase in the Asian workforce was seen in both DHB and NGO services in mainly clinical roles.

As at 30 June 2016:

- The Asian workforce (103) made up 5% of the total workforce (1,952 headcount).
- The Asian workforce was comprised of the following sub-ethnicities: Indian (47%; includes Fijian Indian & South African Indian); Chinese (16%); Sri Lankan (10%); Filipino (8%); Korean (7%); and Other Asian (13%; includes Malaysian, Japanese, Nepalese, Vietnamese and Balinese).
- The largest Asian workforce was in the Northern region (62), followed by the Midland region (16) (see Table 10 & Figure 41).
- The Asian workforce was largely employed in DHB services (71%).

Figure 40. Top 4 Asian ICAMH/AOD Workforce by Occupational Group (2016)



- They held mainly clinical roles (82%) as Psychiatrists (19), Mental Health Nurses (19) and Social Workers (12) (see Table 11 & Figure 40).
- The Asian Non-Clinical workforce was mainly Mental Health Support Workers (10).

Table 10. Total Asian ICAMH/AOD Workforce (Headcount, 2008-2016)

REGION	DHB[1]					NGO					TOTAL				
	2008	2010	2012	2014	2016	2008	2010	2012	2014	2016	2008	2010	2012	2014	2016
NORTHERN	18	33	18	32	44	3	3	7	12	18	21	36	25	44	62
MIDLAND	3	5	5	9	10	-	-	-	7	6	3	5	5	16	16
CENTRAL	5	6	9	6	10	-	-	2	3	1	5	6	11	9	11
SOUTHERN	3	1	2	6	10	2	-	1	-	4	5	1	3	6	14
TOTAL	29	45	34	53	74	5	3	10	22	29	34	48	44	75	103

1. Includes Inpatient Services

Figure 41. Total Asian Workforce by Region (Headcount, 2016)

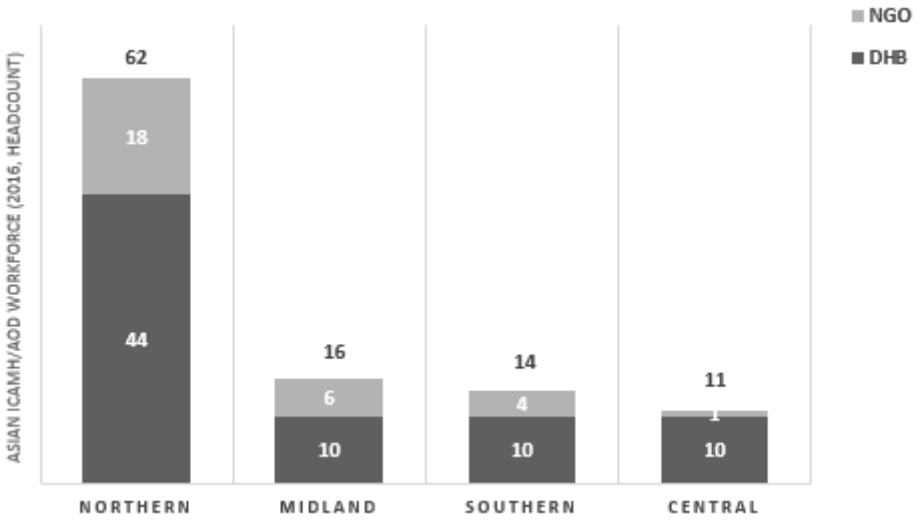


Table 11. Total Asian ICAMH/AOD Workforce by Occupation Group (2016)

OCCUPATIONAL GROUP (HEADCOUNT, 2016)	DHB		DHB TOTAL	NGO	TOTAL
	INPATIENT	COMMUNITY			
ALCOHOL & DRUG PRACTITIONER	-	-	-	7	7
CEP CLINICIAN	-	-	-	-	-
MENTAL HEALTH NURSE	8	7	15	4	19
OCCUPATIONAL THERAPIST	-	9	9	1	10
PSYCHIATRIST	2	17	19	-	19
PSYCHOTHERAPIST	-	1	1	-	1
PSYCHOLOGIST	-	8	8	1	9
SOCIAL WORKER	1	9	10	2	12
OTHER CLINICAL[1]	3	2	5	2	7
CLINICAL SUB-TOTAL	14	53	67	17	84
CULTURAL APPOINTMENT	-	-	-	-	-
SPECIFIC LIAISON	-	-	-	-	-
MENTAL HEALTH CONSUMER ADVISOR	-	1	1	-	1
MENTAL HEALTH SUPPORT WORKER	1	-	1	9	10
YOUTH WORKER	-	-	-	2	2
OTHER NON-CLINICAL[2]	-	-	-	1	1
NON-CLINICAL SUPPORT FOR CLIENTS SUB-TOTAL	1	1	2	12	14
ADMINISTRATION/MANAGEMENT	-	5	5	-	5
TOTAL	15	59	74	29	103

1. **Other Clinical = Registrars; Trainee Registrars; Interns; Counsellors.**
2. **Other Non-Clinical = Early Childhood Educators.**

DHB INPATIENT ASIAN ICAMH WORKFORCE

From 2014 to 2016:

- There was an increase in the total Asian Inpatient workforce by 7 from 8 to 15 (headcount). This increase was reported by the Auckland and Canterbury DHB Inpatient Services (see Table 10).
- The increase in the Asian Inpatient workforce was in the Clinical workforce which had doubled, from 7 to 14.

As at 30 June 2016:

- The Asian Inpatient workforce remains largely in Clinical roles as Mental Health Nurses (8), Psychiatrists (2) and in Other Clinical roles (3) (see Table 11).

DHB COMMUNITY ASIAN ICAMH/AOD WORKFORCE

From 2014 to 2016:

- There was an increase in the Asian DHB Community workforce, from 45 to 59 (headcount) (see Table 10).
- This increase was largely seen in the Northern (from 26 to 34) and Central regions (from 5 to 9).
- The increase in the Asian Community workforce was in the Clinical workforce from 45 to 53 (headcount).

As at 30 June 2016:

- The Northern region continues to have the largest Asian DHB Community workforce (34) (see Appendix D, Table 8).
- The Asian Community workforce remains largely in Clinical roles as Psychiatrists, Social Workers and Occupational Therapists (see Table 11).

NGO ASIAN ICAMH/AOD WORKFORCE

Please note: The 2016 NGO Asian workforce, especially in the Midland region, remains underestimated due to consistently missing workforce data from a large NGO provider in the Midland region

From 2014 to 2016:

- The NGO Asian workforce had increased by 7, from 22 to 29 (see Table 10).
- Two out of the four regions reported an increase in the Asian workforce (Northern and Southern regions), while slight decreases were seen in the Midland and Central regions.

As at 30 June 2016:

- The Northern region continues to have the largest Asian NGO workforce (18), followed by Midland region (6) (see Figure 40).
- The majority (59%) of the Asian NGO workforce was in Clinical roles as AOD Practitioners (7) and Mental Health Nurses (4).
- The remainder were in Non-Clinical roles as Mental Health Support Workers (9) and Youth Workers (2) (see Table 11).

ASIAN POPULATION, CLIENT AND WORKFORCE COMPARISONS

- Based on the 2016 population projections, Asian infants, children and adolescents made up 13% of the total 0-19 year population, 3% of all clients accessing services and the Asian workforce (98, excluding the Administration/Management workforce) made up 6% of the total workforce (1,772).
- Due to such low access rates for Asian clients, the current Asian workforce appears to adequately represent the proportion of Asian clients accessing services (see Figure 42). However, such low access rates for the Asian 0-19 year population could indicate unmet mental health needs.
- Given the increasing trend in the Asian population and clients accessing services nationally, there is a need to focus on increasing the Asian workforce across all occupational groups, to cater for the future needs of the rapidly growing Asian infant, child and adolescent population.

Figure 42. Proportion of Asian 0-19 yrs Population, Clients and Workforce Comparisons by Region

SUMMARY

Due to the rapid growth in the Asian infant, child and adolescent population as a result of immigration, the Asian population is now the third largest ethnic group in New Zealand. Furthermore, the Asian population will continue to grow.

Most Asian migrants are mentally healthy. However, as a consequence of the immigration process, Asian young people may have a higher risk of developing mental health problems (Ho et al., 2003). Therefore, areas with large populations of Asian infants, children and adolescents, such as the Northern (Auckland, Counties Manukau and Waitemata), Central (Capital & Coast, Hutt Valley and MidCentral) and Southern (Canterbury) regions, have a high need for culturally specific mental health services for this population.

PROVISION OF ICAMH/AOD SERVICES FOR ASIAN INFANTS, CHILDREN AND ADOLESCENTS

While some progress can be seen in the number and types of mental health services that are available to the general infant, child and adolescent population, very little progress can be seen in service provision specifically for Asian infants, children and adolescents. There are no specifically funded DHB or NGO Asian child and adolescent mental health/AOD services, although Asian infants, children, adolescents and their families have access to Asian mental health teams/services (e.g. refugee services) within existing mental health services or adult mental health services in some DHBs and NGOs.

ASIAN ACCESS TO SERVICES

While some growth was seen in Asian access rates, Asian access rates have continued to be the lowest (0.75%) out of the three ethnic groups (Māori 3.66% and Pacific 1.82% in the second six months of 2015). The overall Asian access rate of 0.75% in the second half of 2015 remained well below the target access rate of 3.0% in all regions. While the Asian access rates have been compared to the target rates recommended by the MHC, there are currently no epidemiological data to suggest that these rates represent the actual need of the Asian population.

The reasons for such low access rates are complex and may in part be attributed to the stigma associated with mental health disorders in Asian cultures. It is not uncommon that some mental health issues are interpreted in behavioural terms due to lack of understanding and cultural taboos. Grappling with an additional language; lack of awareness of existing services; lack of culturally sensitive services; lack of understanding of rights and the New Zealand health system; and cultural differences in the assessment and treatment of mental health disorders could also act as barriers to accessing mental health services for the Asian population (Ho et al., 2003).

The *Youth'07* study (Parackal et al., 2011) on "Asian" students showed that 16% of the Asian students who had needed healthcare did not access it. Reasons included:

- Did not want to make a fuss (57%)
- Cost too much (39%)
- Had no transportation to get there (25%)
- Didn't know how (24%).

The more recent *Youth'12* study reiterated these access issues to healthcare for Asian students (Ameratunga, Tin Tin, Rasanathan, Robinson, & Watson, 2008).

ASIAN ICAMH/AOD WORKFORCE

The workforce data from 2006 to 2016 showed an increasing trend in the Asian workforce. Due to this increase in the workforce, and low access rates for Asian 0-19 year clients, it appears that the current Asian workforce adequately represents the number of clients accessing services. However, such low access rates for the Asian 0-19 year population could indicate unmet mental health needs. Additionally, the increasing Asian workforce is not keeping pace with the rapid growth in the Asian 0-19 years population and significant disparities between the population and workforce have continued to exist nationally and regionally. The most significant disparity between the workforce and the population continued to be seen in the Northern region, where the largest Asian 0-19 year population resides.

While the need for increasing the Asian workforce is acknowledged by services, DHBs and NGO ICAMH/AOD services identified a number of challenges that impede progress in increasing the workforce:

- Very few Asian people are available for recruitment.
- The large variety of Asian sub-ethnicities/languages makes it difficult to match clinicians to service user.
- Increasing the Asian workforce is currently not a priority in some services, especially for NGOs where funding is limited.

Given the increasing trend in the Asian population and Asian clients accessing services nationally, there is a need to focus on increasing the Asian workforce across all occupational groups, to cater for the future needs of the rapidly growing Asian infant, child and adolescent population.

RECOMMENDATIONS

In light of these 2016 *Stocktake* findings and to ensure alignment with current government priorities (Ministry of Health, 2007; 2012) and progress toward workforce strategic goals, the following recommendations are made to improve the health outcomes for all Asian infants, children and adolescents. These recommendations have also been developed in consultation with an Asian advisor.

- **Improving Access to Services:**
    - While improvements can be seen in Asian access rates, they continue to be the lowest out of all the ethnic groups, across all three age groups, and could indicate unmet need. Therefore, improving Asian access rates should remain a key area of focus.
    - In order to address some of the barriers to access for Asian clients and their families, services should be encouraged to develop educational materials and professional interpreter services (Ho et al., 2003).
    - One of the identified barriers to accessing healthcare for Asian students was that they did not know how to access healthcare; therefore, raising awareness of available health services could improve access for Asian infants, children and young people (Ameratunga et al., 2008).
    - Engaging and working with parents who are influential in persuading the young person to use services could lead to improved access to services.
    - Working more collaboratively and maintaining relationships between schools, primary and secondary mental services could assist with referral pathways.
    - Additionally, identifying the reasons why access has improved for Asian clients may also assist future planning.

- **Development and Provision of Services:**
    - ***Early Intervention:***
        - Develop early intervention strategies and services (infant health/mental health and positive parenting programmes) for Asian people in secondary and primary care settings, which include involvement of healthcare professionals from the other health teams e.g. GP, practice nurses and Plunket nurses, working alongside maternal mental health services.
        - Increase/enhance school-based health services in secondary schools with appropriately trained staff. *Youth'12* results on health services in secondary schools showed positive associations between aspects of health services in schools and mental health outcomes of students at the same schools. There was less overall depression and suicide risk among students attending schools with any level of school health services (Denny et al., 2014); more specifically, schools with:
            - A health team on site
            - More than 2.5 hours of nursing and doctor time per week per 100 students
            - Health staff with postgraduate training
            - Routine psychosocial health screening using HEEADSSS screening.
        - Given that Asian young people have the highest access to the internet compared to other ethnicities in New Zealand (Gibson, Miller, Smith, Bell, & Crothers, 2013; Statistics New Zealand, 2004b) and higher odds of internet use including health information (Peiris-John, Ameratunga, Lee, Teevale, & Clark, 2014), the development and promotion of online e-therapies (e.g. SPARX, Merry et al., 2012) is potentially an effective way of intervening early and increasing access to treatment.
    - ***Specialist Services:***
        - Improve primary and secondary integration of services by educating GPs, especially Asian GPs, on the cultural and clinical issues relating to the mental health needs of Asian infants, children and adolescents. Primary liaison services have appeared to be effective for adult services and could also work well with ICAMH/AOD services in the early identification of mental health issues and promoting wellbeing to families via their GPs.
        - Provide interpreter services to meet language needs, at least at the assessment level.
        - In consultation with Asian community leaders and groups, develop specific, culturally appropriate DHB ICAMH/AOD and community support services for the Asian 0-19 year population. For instance, compared to adult mental health services, family support services are relatively underdeveloped in the infant, child and adolescent mental health services. Therefore, it is considered vital that Asian families are supported by culturally appropriate workers, given the lack of understanding regarding the health system and specific disorders.
- **Workforce Development in Specialist Services:**
    - A rapidly growing Asian population has potentially led to an increased need/demand for mental health services and may continue to do so. As a result, the potential demand for services means that increasing the Asian workforce to keep pace with this growing population and their needs is crucial.
    - The lack of specific Asian mental health services means that the majority of Asian clients (87%) are seen by DHB ICAMH/ADO services; therefore, a continued focus on addressing the workforce development needs of the DHB workforce to cater for a growing, culturally diverse child and adolescent population is pertinent.
    - The strategies for recruiting, retaining and developing the Asian and non-Asian workforce that spans the primary and the secondary mental health sectors should include:

- ***Workforce Planning:***
    - Ensure that active recruitment and addressing the workforce development needs of the Asian workforce is seen as a key priority and is embedded in a service's strategic plans.
    - Ensure that local schools, PHOs, NGOs and DHBs are all part of the planning process.
- ***Recruitment:***
    - There is a continued need to increase the Asian ICAMH/AOD workforce through enhanced training and career pathways into mental health/AOD.
    - Given that a high proportion of New Zealand's Asian people are employed in the health sector (Badkar & Tuya, 2010), the promotion of careers in infant, child and adolescent mental health could be a good strategy to grow the Asian workforce.
- ***Competency Development:***
    - While increasing the Asian workforce is a long-term solution to workforce shortages, there is an ongoing need to retain and develop not only the existing Asian ICAMH/AOD workforce but the non-Asian workforce as well.
    - Due to the increasing access rates for Asian clients who are largely accessing mainstream services, there continues to be a critical need for increasing the dual competency of mainstream services to be clinically and culturally competent.
    - Increasing the cultural competency of mainstream clinicians with the assistance of non-clinical staff can be an important short-term strategy (Nyar & Tse, 2006). Due to a small Asian workforce, mainstream clinicians could participate in workshops, in the form of face-to-face and online training, to ensure the provision of a culturally appropriate treatment for Asian people. For example, the *Culturally and Linguistically Diverse (CALD*) Resources website, developed and managed by Waitemata DHB Asian Health Support Services, has been widely accepted as a good starting point. Specific workshops could also be run via tertiary training institutes, community groups and in-service training.
- ***New Ways of Working:***
    - Increase the diversity of the Asian workforce in all parts of the sector through new roles and new ways of working:
        - Interpreters could train as cultural advisors, and possible co-therapists.
        - Establish a consultation team of Asian clinicians to clarify diagnosis and to ensure culturally appropriate clinical interventions for the Asian population. This team could also be available to other regions which need assistance while working with Asian clients.
    - Engage in collaborative service delivery between PHOs, NGOs and DHBs. Building relationships and working in partnership with other services to overcome shortages in the workforce is occurring in some areas and could be an effective way to share limited resources.

- **Future Research:**
    - There continues to be very little information available on the mental health issues of the Asian population in New Zealand. Kumar, Fernando and Wong (2006) have advocated for a national epidemiological study to be conducted on the Asian population in New Zealand.

> ***Results from a well-designed epidemiological study can influence mental health policy and service delivery for the third-largest ethnic group in New Zealand and may provide information that has not been available before in the history of global migration. (p. 411).***

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APPENDICES

APPENDIX A: POPULATION DATA

Table 1. Child & Adolescent (0-19 yrs) Population by Ethnicity/Region/DHB Area (2006-2016)

DHB REGION/AREA	0-19 YEAR POPULATION BY ETHNICITY (2006-2016)																			
	TOTAL				OTHER			MĀORI				PACIFIC				ASIAN				
	2006[1]	2013[2]	2016[3]	% Change (2016-2013)	2013	2016	% Change (2016-2013)	2006[1]	2013[2]	2016[3]	% Change (2016-2013)	2006[1]	2013[2]	2016[3]	% Change (2016-2013)	2006[1]	2013[2]	2016[3]	% Change (2016-2013)
NORTHERN	**436,344**	**472,780**	**484,140**	**2.4**	**201,380**	**195,720**	**-3**	**83,568**	**99,410**	**102,680**	**3.3**	**70,584**	**82,750**	**83,190**	**0.5**	**74,760**	**89,210**	**102,520**	**14.9**
Northland	45,267	47,500	47,290	-0.4	20,890	19,200	-8	19,722	24,110	25,170	4.4	822	1,220	1,370	12.3	870	1,270	1,530	20.5
Waitemata	139,758	152,230	156,560	2.8	84,780	81,670	-4	19,809	24,230	25,370	4.7	13,176	15,820	16,320	3.2	22,350	27,410	33,180	21.1
Auckland	104,139	114,410	116,700	2.0	49,870	49,950	0	11,778	14,340	14,240	-0.7	18,846	20,170	19,620	-2.7	26,840	30,020	32,890	9.6
Counties Manukau	147,180	158,640	163,590	3.1	45,880	44,900	-2	32,259	36,730	37,900	3.2	37,740	45,540	45,880	0.7	24,700	30,510	34,920	14.5
MIDLAND	**237,273**	**246,040**	**249,780**	**1.5**	**129,800**	**124,620**	**-4**	**81,954**	**95,040**	**99,330**	**4.5**	**5,733**	**7,480**	**8,330**	**11.4**	**9,180**	**13,685**	**17,470**	**27.7**
Waikato	104,574	109,510	112,040	2.3	60,100	58,120	-3	31,341	37,570	39,480	5.1	3,219	4,100	4,630	12.9	5,550	7,730	9,830	27.2
Lakes	30,990	30,510	30,230	-0.9	12,790	11,840	-7	14,190	15,320	15,770	2.9	879	970	940	-3.1	1,020	1,420	1,660	16.9
Bay of Plenty	56,700	59,490	60,670	2.0	31,600	30,420	-4	20,475	23,340	24,510	5.0	957	1,480	1,700	14.9	1,750	3,060	4,010	31.0
Tairawhiti	14,724	15,140	15,000	-0.9	4,710	4,350	-8	8,571	9,710	9,840	1.3	297	415	480	15.7	200	295	330	11.9
Taranaki	30,285	31,390	31,840	1.4	20,590	19,890	-3	7,377	9,100	9,730	6.9	381	515	580	12.6	660	1,180	1,640	39.0
CENTRAL	**234,093**	**236,110**	**235,250**	**-0.4**	**134,580**	**127,200**	**-5**	**58,299**	**65,750**	**68,290**	**3.9**	**15,633**	**17,520**	**18,095**	**3.3**	**14,150**	**18,220**	**21,675**	**19.0**
Hawke's Bay	45,327	45,440	45,150	-0.6	23,880	22,030	-8	15,024	17,600	18,490	5.1	1,764	2,380	2,610	9.7	1,090	1,570	2,020	28.7
MidCentral	46,716	46,800	46,930	0.3	27,330	25,850	-5	12,738	14,520	15,210	4.8	1,551	2,010	2,260	12.4	2,090	2,920	3,630	24.3
Whanganui	18,939	17,210	16,780	-2.5	9,410	8,630	-8	6,729	6,780	6,960	2.7	405	570	650	14.0	415	455	540	18.7
Capital & Coast	71,070	75,750	76,360	0.8	45,200	44,240	-2	11,280	13,440	13,620	1.3	7,602	7,900	7,830	-0.9	7,350	9,210	10,670	15.9
Hutt	40,785	39,760	38,940	-2.1	21,430	19,410	-9	9,810	10,220	10,690	4.6	4,017	4,290	4,350	1.4	3,030	3,820	4,500	17.8
Wairarapa	11,256	11,150	11,090	-0.5	7,350	7,040	-4	2,718	3,190	3,320	4.1	294	370	395	6.8	175	245	315	28.6
SOUTHERN	**260,010**	**266,310**	**272,630**	**2.4**	**199,930**	**196,720**	**-2**	**33,807**	**41,630**	**44,730**	**7.4**	**6,345**	**8,165**	**9,275**	**13.6**	**12,660**	**16,655**	**21,930**	**31.7**
Nelson Marlborough	34,806	35,550	35,410	-0.4	27,120	26,070	-4	5,079	6,150	6,520	6.0	576	870	1010	16.1	780	1,380	1,810	31.2
West Coast	8,151	8,250	7,980	-3.3	6,380	5,940	-7	1,356	1,520	1,590	4.6	33	125	155	24.0	90	220	290	31.8
Canterbury	125,832	129,110	134,770	4.4	95,010	94,670	0	15,420	18,960	20,540	8.3	3,918	4,710	5,310	12.7	8,750	10,430	14,250	36.6
South Canterbury	14,046	14,230	14,130	-0.7	11,500	11,040	-4	1,536	2,030	2,240	10.3	147	230	280	21.7	300	455	590	29.7
Southern	77,175	79,170	80,340	1.5	59,820	59,000	-1	10,416	12,970	13,840	6.7	1,671	2,230	2,520	13.0	2,740	4,170	4,990	19.7
TOTAL	**1,167,720**	**1,221,250**	**1,241,810**	**1.7**	**665,690**	**644,290**	**-3**	**257,628**	**301,860**	**315,040**	**4.4**	**98,295**	**115,920**	**118,890**	**2.6**	**110,750**	**137,780**	**163,590**	**18.7**

1. 2006 Census (Prioritised Ethnicity) Source Statistics NZ; Ref No: KID1617
2. 2013 Census (Prioritised Ethnicity) Source: Statistics NZ: Ref No: JOB-05958
3. 2016 Population Projections (Base 2013 Census, Prioritised Ethnicity), Ref No: JOB-07144

Table 2. Child & Adolescent (0-19 yrs) Population Projections by Ethnicity/Region/DHB Area (2013-2021)

DHB/REGION	0-19 YEAR POPULATION BY ETHNICITY (2006-2016)																			
	TOTAL				OTHER				MĀORI				PACIFIC				ASIAN			
	2013[1]	2016[2]	2021[2]	2026[2]	2013[1]	2016[2]	2021[2]	2026[2]	2013[1]	2016[2]	2021[2]	2026[2]	2013[1]	2016[2]	2021[2]	2026[2]	2013[1]	2016[2]	2021[2]	2026[2]
NORTHERN	472,780	484,140	494,840	514,150	201,380	195,720	187,340	179,420	99,410	102,680	107,140	113,680	82,750	83,190	83,350	85,750	89,210	102,520	116,980	135,280
Northland	47,500	47,290	46,820	47,090	20,890	19,200	17,180	15,390	24,110	25,170	26,160	27,670	1,220	1,370	1,620	1,880	1,270	1,530	1,850	2,160
Waitemata	152,230	156,560	162,620	171,330	84,780	81,670	77,950	75,150	24,230	25,370	27,250	29,500	15,820	16,320	17,070	18,030	27,410	33,180	40,350	48,650
Auckland	114,410	116,700	117,160	121,550	49,870	49,950	48,720	47,300	14,340	14,240	14,360	14,990	20,170	19,620	18,600	18,260	30,020	32,890	35,480	40,990
Counties Manukau	158,640	163,590	168,240	174,180	45,880	44,900	43,490	41,580	36,730	37,900	39,370	41,520	45,540	45,880	46,060	47,580	30,510	34,920	39,300	43,480
MIDLAND	246,040	249,780	248,710	250,430	129,800	124,620	113,690	104,970	95,040	99,330	103,890	109,380	7,480	8,330	9,715	11,015	13,685	17,470	21,455	25,060
Waikato	109,510	112,040	112,620	114,120	60,100	58,120	53,220	49,210	37,570	39,480	41,950	44,730	4,100	4,630	5,510	6,340	7,730	9,830	11,940	13,850
Lakes	30,510	30,230	28,870	27,980	12,790	11,840	10,280	8,960	15,320	15,770	15,760	15,890	970	940	930	900	1,420	1,660	1,920	2,220
Bay of Plenty	59,490	60,670	60,620	61,530	31,600	30,420	27,570	25,590	23,340	24,510	25,960	27,540	1,480	1,700	2,040	2,390	3,060	4,010	5,070	6,020
Tairawhiti	15,140	15,000	14,600	14,270	4,710	4,350	3,900	3,500	9,710	9,840	9,750	9,710	415	480	575	655	295	330	375	400
Taranaki	31,390	31,840	32,000	32,530	20,590	19,890	18,720	17,710	9,100	9,730	10,470	11,510	515	580	660	730	1,180	1,640	2,150	2,570
CENTRAL	236,110	235,250	230,870	229,330	134,580	127,200	114,820	104,080	65,750	68,290	71,680	76,000	17,520	18,095	18,960	19,830	18,220	21,675	25,400	29,415
Hawke's Bay	45,440	45,150	44,110	43,700	23,880	22,030	19,310	16,920	17,600	18,490	19,410	20,610	2,380	2,610	2,930	3,290	1,570	2,020	2,470	2,870
MidCentral	46,800	46,930	46,100	46,070	27,330	25,850	23,260	21,140	14,520	15,210	15,960	17,150	2,010	2,260	2,590	2,950	2,920	3,630	4,290	4,850
Whanganui	17,210	16,780	16,050	15,730	9,410	8,630	7,460	6,590	6,780	6,960	7,190	7,480	570	650	755	830	455	540	620	820
Capital & Coast	75,750	76,360	76,150	76,420	45,200	44,240	41,740	39,240	13,440	13,620	14,280	15,150	7,900	7,830	7,800	7,870	9,210	10,670	12,330	14,180
Hutt	39,760	38,940	37,620	36,790	21,430	19,410	16,530	14,240	10,220	10,690	11,330	11,820	4,290	4,350	4,460	4,450	3,820	4,500	5,320	6,270
Wairarapa	11,150	11,090	10,840	10,620	7,350	7,040	6,520	5,950	3,190	3,320	3,510	3,790	370	395	425	440	245	315	370	425
SOUTHERN	266,310	272,630	274,150	276,440	199,930	196,720	187,670	179,130	41,630	44,730	48,960	53,810	8,165	9,275	11,090	12,750	16,655	21,930	26,370	30,710
Nelson Marlborough	35,550	35,410	34,800	34,220	27,120	26,070	24,350	22,510	6,150	6,520	7,010	7,720	870	1010	1210	1360	1,380	1,810	2,190	2,610
West Coast	8,250	7,980	8,000	8,000	6,380	5,940	5,750	5,490	1,520	1,590	1,700	1,850	125	155	190	235	220	290	360	410
Canterbury	129,110	134,770	137,400	140,080	95,010	94,670	90,700	87,030	18,960	20,540	22,820	25,190	4,710	5,310	6,300	7,240	10,430	14,250	17,590	20,620
South Canterbury	14,230	14,130	13,980	14,190	11,500	11,040	10,490	10,210	2,030	2,240	2,410	2,690	230	280	360	445	455	590	710	830
Southern	79,170	80,340	79,970	79,950	59,820	59,000	56,380	53,890	12,970	13,840	15,020	16,360	2,230	2,520	3,030	3,470	4,170	4,990	5,520	6,240
TOTAL	1,221,250	1,241,810	1,248,580	1,270,360	665,690	644,290	603,490	567,660	301,860	315,040	331,720	352,910	115,920	118,890	123,140	129,310	137,780	163,590	190,220	220,480

1. Census (Prioritised Ethnicity); Source: NZ Statistics: Ref No: JOB-05958.
2. Population Projections (Base 2013 Census, Prioritised Ethnicity), Source: NZ Statistics: Ref No: JOB-07144.

APPENDIX B: PROGRAMME FOR THE INTEGRATION OF MENTAL HEALTH DATA (PRIMHD)

Table 1. Total 0-19 yrs Clients by Region & DHB Area (2012-2015)

REGION/DHB	TOTAL 0-19 YRS CLIENTS BY REGION & DHB AREA (2012-2015)											
	2012			2013			2014			2015		
	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL
NORTHERN	9,393	1,282	10,675	9,129	1,234	10,363	10,056	2,214	12,270	10,380	2,090	12,470
NORTHLAND	1,235	464	1,699	1,238	496	1,734	1,151	563	1,714	1,143	533	1,676
WAITEMATA	3,396	154	3,550	3,280	146	3,426	3,722	310	4,032	3,812	257	4,069
AUCKLAND	1,988	156	2,144	1,923	194	2,117	2,048	286	2,334	2,349	222	2,571
COUNTIES MANUKAU	2,774	508	3,282	2,688	398	3,086	3,135	1,055	4,190	3,076	1,078	4,154
MIDLAND	4,744	2,771	7,515	4,958	2,329	7,287	4,851	2,212	7,063	4,838	3,057	7,895
WAIKATO	1,310	1,558	2,868	1,406	843	2,249	1,522	854	2,376	1,688	1,656	3,344
LAKES	671	295	966	721	292	1,013	626	274	900	606	299	905
BAY OF PLENTY	1,462	728	2,190	1,493	925	2,418	1,502	778	2,280	1,460	819	2,279
TAIRAWHITI	588	99	687	593	118	711	531	123	654	460	111	571
TARANAKI	713	91	804	745	151	896	670	183	853	624	172	796
CENTRAL	4,881	1,559	6,440	5,328	1,603	6,931	5,388	1,516	6,904	5,796	1,143	6,939
HAWKE'S BAY	891	220	1,111	1,021	233	1,254	994	192	1,186	1,102	212	1,314
MIDCENTRAL	832	352	1,184	860	383	1,243	911	384	1,295	969	403	1,372
WHANGANUI	330	50	380	391	54	445	403	50	453	421	52	473
CAPITAL & COAST	1,670	465	2,135	1,804	465	2,269	1,884	443	2,327	2,060	216	2,276
HUTT VALLEY	908	376	1,284	1,000	310	1,310	983	301	1,284	1,014	115	1,129
WAIRARAPA	250	96	346	252	158	410	213	146	359	230	145	375
SOUTHERN	4,369	1,473	5,842	5,762	1,854	7,616	5,937	2,135	8,072	5,807	2,214	8,021
NELSON MARLBOROUGH	965	157	1,122	1,137	179	1,316	1,002	80	1,082	917	63	980
WEST COAST	359	73	432	329	93	422	357	89	446	291	5	296
CANTERBURY	2,126	357	2,483	2,277	598	2,875	2,486	870	3,356	2,539	935	3,474
SOUTH CANTERBURY	272	244	516	475	237	712	458	174	632	427	164	591
SOUTHERN	647	642	1,289	1,544	747	2,291	1,634	922	2,556	1,633	1,047	2,680
TOTAL	23,387	7,085	30,472	25,177	7,020	32,197	26,232	8,077	34,309	26,821	8,504	35,325

Source: PRIMHD - Data are for the second six months of each year

Table 2. Total Clients by DHB Area, Gender & Age Group (2015)

REGION/ DHB AREA	CLIENTS BY GENDER & AGE GROUP (YRS) 2015														
	MALE						FEMALE						TOTAL		TOTAL
	0-9		10-14		15-19		0-9		10-14		15-19				
	DHB	NGO	DHB	NGO	DHB	NGO	DHB	NGO	DHB	NGO	DHB	NGO	DHB	NGO	
NORTHERN	1,526	33	1,532	271	2,523	856	658	23	1,314	195	2,827	712	10,380	2,090	12,470
NORTHLAND	165	4	215	97	251	217	51	0	166	61	295	154	1,143	533	1,676
WAITEMATA	541	5	461	25	1,201	94	220	5	404	17	985	111	3,812	257	4,069
AUCKLAND	292	6	306	14	529	104	179	3	315	19	728	76	2,349	222	2,571
COUNTIES MANUKAU	528	18	550	135	542	441	208	15	429	98	819	371	3,076	1,078	4,154
MIDLAND	633	271	794	472	1,131	872	255	123	565	439	1,460	880	4,838	3,057	7,895
WAIKATO	225	192	242	252	396	452	88	81	192	212	545	467	1,688	1,656	3,344
LAKES	113	1	110	34	104	105	38	1	70	50	171	108	606	299	905
BAY OF PLENTY	169	66	237	144	372	229	82	37	182	130	418	213	1,460	819	2,279
TAIRAWHITI	89	7	91	26	96	26	27	3	55	24	102	25	460	111	571
TARANAKI	37	5	114	16	163	60	20	1	66	23	224	67	624	172	796
CENTRAL	685	34	879	239	1,278	422	388	17	713	129	1,853	302	5,796	1,143	6,939
HAWKE'S BAY	90	8	163	28	284	98	52	1	145	12	368	65	1,102	212	1,314
MIDCENTRAL	132	4	155	58	157	164	73	3	125	34	327	140	969	403	1,372
WHANGANUI	57	0	61	11	99	19	19	1	57	5	128	16	421	52	473
CAPITAL & COAST	222	14	282	77	552	46	131	6	220	42	653	31	2,060	216	2,276
HUTT VALLEY	161	4	181	35	146	41	103	1	129	8	294	26	1,014	115	1,129
WAIRARAPA	23	4	37	30	40	54	10	5	37	28	83	24	230	145	375
SOUTHERN	807	152	943	292	1,233	616	311	76	757	298	1,756	780	5,807	2,214	8,021
NELSON MARLBOROUGH	75	0	143	2	247	23	44	2	120	6	288	30	917	63	980
WEST COAST	58	1	59	1	51	1	31	0	33	1	59	1	291	5	296
CANTERBURY	367	37	427	105	522	268	131	10	348	135	744	380	2,539	935	3,474
SOUTH CANTERBURY	89	1	72	19	72	42	28	0	43	27	123	75	427	164	591
SOUTHERN	218	113	242	165	341	282	77	64	213	129	542	294	1,633	1,047	2,680
TOTAL CLIENTS	3,651	490	4,148	1,274	6,165	2,766	1,612	239	3,349	1,061	7,896	2,674	26,821	8,504	35,325

Source: MHINC/PRIMHD: second six months of 2015

Table 3. Total Māori 0-19 yrs Clients by DHB Area (2012-2015)

REGION/DHB AREA	MĀORI 0-19 YRS CLIENTS BY DHB AREA (2012-2015)											
	2012			2013			2014			2015		
	DHB	NGO	Total	DHB	NGO	Total	DHB	NGO	Total	DHB	NGO	Total
NORTHERN	2,841	697	3,538	2,698	575	3,273	2,991	1,133	4,124	3,068	1,151	4,219
NORTHLAND	605	316	921	621	320	941	568	402	970	561	410	971
WAITEMATA	907	67	974	903	44	947	976	131	1,107	1,087	143	1,230
AUCKLAND	526	62	588	438	64	502	493	97	590	576	102	678
COUNTIES MANUKAU	803	252	1,055	736	147	883	954	503	1,457	844	496	1,340
MIDLAND	1,641	1,407	3,048	1,662	1,324	2,986	1,628	1,218	2,846	1,669	1,523	3,192
WAIKATO	353	566	919	338	356	694	379	388	767	448	659	1,107
LAKES	227	182	409	248	168	416	221	118	339	238	148	386
BAY OF PLENTY	524	509	1,033	557	599	1,156	517	494	1,011	549	520	1,069
TAIRAWHITI	369	88	457	352	110	462	352	112	464	288	104	392
TARANAKI	168	62	230	167	91	258	159	106	265	146	92	238
CENTRAL	1,345	780	2,125	1,531	726	2,257	1,572	719	2,291	1,787	620	2,407
HAWKE'S BAY	344	173	517	418	164	582	396	132	528	480	157	637
MIDCENTRAL	177	128	305	223	123	346	227	156	383	263	173	436
WHANGANUI	100	30	130	124	27	151	140	25	165	141	24	165
CAPITAL & COAST	419	198	617	450	186	636	510	186	696	554	186	740
HUTT VALLEY	241	199	440	253	160	413	250	160	410	274	160	434
WAIRARAPA	64	52	116	63	66	129	49	54	103	75	79	154
SOUTHERN	704	328	1,032	972	398	1,370	1,038	420	1,458	1,113	411	1,524
NELSON MARLBOROUGH	156	63	219	196	63	259	180	13	193	181	11	192
WEST COAST	85	20	105	85	25	110	99	13	112	65	4	69
CANTERBURY	356	90	446	390	135	525	461	188	649	528	177	705
SOUTH CANTERBURY	28	16	44	57	31	88	66	29	95	70	24	94
SOUTHERN	79	139	218	244	144	388	232	177	409	269	195	464
TOTAL	6,531	3,212	9,743	6,863	3,023	9,886	7,229	3,503*	10,732*	7,637	3,720*	11,357*

Source: PRIMHD: Data are for the second six months of each year.
***2014: Includes 13 Overseas Clients; 2015: Includes 15 Overseas Clients.**

Table 4. Total Pacific Clients by DHB Area (2012-2015)

REGION/DHB AREA	PACIFIC 0-19 YRS CLIENTS BY DHB AREA (2012-2015)											
	2012			2013			2014			2015		
	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL
NORTHERN	1,260	137	1,397	1,137	114	1,251	1,343	380	1,723	1,208	394	1,602
NORTHLAND	22	3	25	27	11	38	25	4	29	22	10	32
WAITEMATA	511	9	520	451	8	459	493	28	521	404	21	425
AUCKLAND	267	21	288	216	28	244	267	61	328	256	54	310
COUNTIES MANUKAU	460	104	564	443	67	510	558	287	845	526	309	835
MIDLAND	60	49	109	60	63	123	56	40	96	55	80	135
WAIKATO	19	30	49	17	30	47	14	23	37	27	64	91
LAKES	20	9	29	11	9	20	12	6	18	6	4	10
BAY OF PLENTY	13	6	19	17	21	38	20	8	28	16	10	26
TAIRAWHITI	4	2	6	8	1	9	6	1	7	2	-	2
TARANAKI	4	2	6	7	2	9	4	2	6	4	2	6
CENTRAL	155	134	289	199	146	345	201	160	361	199	86	285
HAWKE'S BAY	20	5	25	22	8	30	28	14	42	26	11	37
MIDCENTRAL	11	4	15	19	8	27	15	8	23	16	10	26
WHANGANUI	3	1	4	6	-	6	5	-	5	6	3	9
CAPITAL & COAST	75	92	167	112	108	220	99	109	208	99	49	148
HUTT VALLEY	40	30	70	35	19	54	51	26	77	51	9	60
WAIRARAPA	6	2	8	5	3	8	3	3	6	1	4	5
SOUTHERN	53	20	73	80	23	103	83	36	119	94	41	135
NELSON MARLBOROUGH	8	1	9	10	4	14	7	-	7	12	-	12
WEST COAST	2	-	2	3	-	3	1	-	1	-	-	-
CANTERBURY	35	7	42	34	7	41	44	16	60	50	17	67
SOUTH CANTERBURY	2	3	5	8	4	12	5	2	7	2	-	2
SOUTHERN	6	9	15	25	8	33	26	18	44	30	24	54
TOTAL	1,528	340	1,868	1,476	346	1,822	1,683	616	2,299	1,556	604*	2,160*

Source: PRIMHD - Data are for the second six months of each year.
*** Includes 3 Overseas Clients**

Table 5. Total Asian Clients by DHB Area (2012-2015)

REGION/DHB AREA	ASIAN 0-19 YRS CLIENTS BY DHB AREA (2012-2015)											
	2012			2013			2014			2015		
	DHB	*NGO*	TOTAL	*DHB*	*NGO*	TOTAL	*DHB*	*NGO*	TOTAL	*DHB*	*NGO*	TOTAL
NORTHERN	**547**	**39**	**586**	**578**	**68**	**646**	**634**	**90**	**724**	**692**	**82**	**774**
NORTHLAND	7	-	**7**	14	3	**17**	**5**	**1**	**6**	**3**	-	**3**
WAITEMATA	147	5	**152**	164	8	**172**	**197**	**9**	**206**	**206**	**3**	**209**
AUCKLAND	182	16	**198**	200	14	**214**	**197**	**21**	**218**	**248**	**8**	**256**
COUNTIES MANUKAU	211	18	**229**	200	43	**243**	**235**	**59**	**294**	**235**	**71**	**306**
MIDLAND	**51**	**16**	**67**	**62**	**13**	**75**	**58**	**12**	**70**	**72**	**34**	**106**
WAIKATO	12	12	**24**	17	3	**20**	**23**	**2**	**25**	**28**	**22**	**50**
LAKES	9	1	**10**	8	1	**9**	**6**	**2**	**8**	**10**	**2**	**12**
BAY OF PLENTY	18	2	**20**	22	8	**30**	**20**	**8**	**28**	**21**	**10**	**31**
TAIRAWHITI	7	1	**8**	3	1	**4**	**4**	-	**4**	**3**	-	**3**
TARANAKI	5	-	**5**	12	-	**12**	**5**	-	**5**	**10**	-	**10**
CENTRAL	**82**	**19**	**101**	**100**	**18**	**118**	**126**	**14**	**140**	**143**	**10**	**153**
HAWKE'S BAY	8	1	**9**	6	-	**6**	**10**	-	**10**	**6**	**2**	**8**
MIDCENTRAL	9	2	**11**	11	3	**14**	**8**	**3**	**11**	**16**	**3**	**19**
WHANGANUI	4	-	**4**	-	-	**-**	**4**	**1**	**5**	**2**	-	**2**
CAPITAL & COAST	41	13	**54**	58	8	**66**	**70**	**3**	**73**	**86**	**3**	**89**
HUTT VALLEY	18	2	**20**	23	7	**30**	**33**	**6**	**39**	**32**	**2**	**34**
WAIRARAPA	2	1	**3**	2	-	**2**	**1**	**1**	**2**	**1**	-	**1**
SOUTHERN	**58**	**17**	**75**	**61**	**20**	**81**	**81**	**33**	**114**	**103**	**28**	**131**
NELSON MARLBOROUGH	6	2	**8**	10	-	**10**	**7**	**1**	**8**	**10**	**1**	**11**
WEST COAST	2	1	**3**	1	-	**1**	**4**	**1**	**5**	**2**	**0**	**2**
CANTERBURY	41	6	**47**	36	5	**41**	**40**	**18**	**58**	**57**	**13**	**70**
SOUTH CANTERBURY	3	1	**4**	4	2	**6**	**5**	**3**	**8**	**7**	**1**	**8**
SOUTHERN	6	7	**13**	10	13	**23**	**25**	**10**	**35**	**27**	**13**	**40**
TOTAL	**738**	**91**	**829**	**801**	**119**	**920**	**899**	**149**	**1,048**	**1,010**	**154**	**1,164**

Source: PRIMHD - Data are for the second six months of each year

Table 6. DHB of Domicile vs. DHB of Service (second six months 2015)

DHB WHERE CLIENTS ACCESSED SERVICES	DHB OF DOMICILE (DHB WHERE THE CLIENT LIVES)																			
	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawke's Bay	Hutt Valley	Lakes	MidCentral	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui	Total
Auckland*	2,350	35	8	22	142	7	4	7	7	5	37	-	3	4	7	56	-	295	-	1	2,990
Bay of Plenty	38	1,460	2	9	6	2	2	16	3	1	7	-	1	1	-	21	-	12	-	-	1,581
Canterbury*	9	3	2,539	26	5	8	3	1	2	16	-	16	43	1	-	6	-	2	3	1	2,684
Capital & Coast*	23	9	23	2,060	6	68	174	4	46	19	7	-	6	11	6	18	20	25	-	24	2,549
Counties Manukau	145	4	4	8	3,076	5	1	5	2	-	17	-	2	-	-	18	-	158	3	1	3,449
Hawke's Bay	6	3	7	64	6	1,102	6	5	4	1	1	-	2	-	2	10	3	5	-	1	1,228
Hutt Valley	4	2	2	182	1	7	1,014	-	11	7	2	-	1	-	-	5	3	2	-	1	1,244
Lakes	8	19	1	5	5	5	-	606	4	-	-	-	2	1	1	21	-	2	-	1	681
MidCentral	12	3	3	46	2	2	10	5	969	-	2	2	3	1	4	11	3	3	-	7	1,088
Nelson Marlborough	4	1	13	17	-	1	4	-	-	917	-	1	6	-	2	2	-	2	5	2	977
Northland	42	8	-	5	18	1	2	-	3	-	1,143	-	1	-	3	4	1	42	-	-	1,273
South Canterbury	-	-	19	-	-	-	-	-	1	1	-	427	5	-	1	-	-	-	-	-	454
Southern	2	2	41	7	4	2	1	3	2	7	1	5	1,633	-	-	5	-	4	2	-	1,721
Tairawhiti	4	1	1	11	-	-	-	1	1	-	-	-	-	460	-	2	-	1	-	-	482
Taranaki	6	-	-	5	-	1	-	1	3	1	3	1	-	-	624	5	-	4	1	1	656
Waikato	55	24	5	16	19	9	4	18	10	3	4	-	4	2	5	1,688	1	19	-	2	1,888
Wairarapa	-	-	-	18	-	3	4	-	3	-	2	-	-	-	-	2	230	-	-	1	263
Waitemata	288	12	2	24	152	6	1	2	3	3	38	-	4	1	3	15	-	3,812	1	-	4,367
West Coast	-	-	3	-	2	-	-	-	-	6	-	-	2	-	1	-	-	2	291	-	307
Whanganui	1	-	1	25	1	1	1	1	8	1	-	-	-	-	1	1	1	-	-	421	464
TOTAL	2,997	1,586	2,674	2,550	3,445	1,230	1,231	675	1,082	988	1,264	452	1,718	482	660	1,890	262	4,390	306	464	30,346

Note: Waitemata DHB: 295 Clients were referred to Auckland DHB Services; 142 Referred to Counties Manukau DHB.
Source: PRIMHD second six months of 2015

Table 7. Client Access Rates by Age Group & Region (2006-2015)

YEAR		TOTAL CLIENTS ACCESS RATES BY AGE GROUP (YRS)			
		0-9	10-14	15-19	0-19
MHC ACCESS TARGET RATES		1.00%	3.90%	5.50%	3.00%
NORTHERN	2006	0.33%	1.32%	2.27%	1.08%
	2007	0.37%	1.48%	2.50%	1.21%
	2008	0.47%	1.67%	3.02%	1.44%
	2009	0.47%	1.83%	3.68%	1.65%
	2010*	0.52%	2.03%	4.32%	1.89%
	2011*	0.58%	2.16%	4.67%	2.02%
	2012*	0.51%	2.41%	5.36%	2.00%
	2013*	0.65%	2.42%	5.01%	2.19%
	2014*	0.82%	2.80%	5.89%	2.59%
	2015*	0.92%	2.93%	5.64%	2.60%
MIDLAND	2006	0.50%	1.65%	2.37%	1.27%
	2007	0.48%	1.81%	2.51%	1.34%
	2008	0.52%	1.81%	2.70%	1.41%
	2009	0.49%	1.87%	2.89%	1.45%
	2010*	0.57%	1.99%	3.44%	1.65%
	2011*	0.62%	2.06%	3.08%	1.59%
	2012*	0.59%	3.62%	6.34%	2.24%
	2013*	0.92%	3.61%	6.60%	2.96%
	2014*	0.91%	3.43%	6.41%	2.87%
	2016*	1.01%	3.73%	7.20%	3.18%
CENTRAL	2006	0.42%	1.38%	2.30%	1.16%
	2007	0.45%	1.56%	2.64%	1.31%
	2008	0.52%	1.71%	2.85%	1.43%
	2009	0.63%	1.88%	3.10%	1.60%
	2010*	0.78%	2.22%	3.44%	1.84%
	2011*	0.79%	2.16%	3.15%	1.73%
	2012*	0.50%	3.39%	6.37%	2.04%
	2013*	0.92%	3.38%	6.41%	2.94%
	2014*	0.95%	3.36%	6.36%	2.93%
	2016*	0.95%	3.48%	6.33%	2.95%
SOUTHERN	2006	0.52%	1.91%	3.03%	1.57%
	2007	0.55%	1.91%	2.99%	1.58%
	2008	0.63%	2.02%	3.16%	1.69%
	2009	0.61%	2.12%	3.35%	1.75%
	2010*	0.73%	2.55%	4.27%	2.16%
	2011*	0.82%	2.91%	5.18%	2.52%
	2012*	0.30%	2.69%	4.64%	1.64%
	2013*	0.87%	3.26%	6.13%	2.86%
	2014*	1.10%	3.56%	6.01%	3.01%
	2016*	1.01%	3.54%	6.05%	2.97%

Source: PRIMHD - Data are for the second six months of each year. *Includes NGO Client Data.

Table 8. Total 0-19 years Client Access Rates by DHB Area (2006-2015)

REGION/DHB AREA	TOTAL 0-19 YRS ACCESS RATES BY REGION & DHB AREA									
	2006	2007	2008	2009	2010*	2011*	2012*	2013*	2014*	2015*
NORTHERN	**1.08%**	**1.21%**	**1.44%**	**1.65%**	**1.89%**	**2.02%**	**2.00%**	**2.19%**	**2.59%**	**2.60%**
NORTHLAND	1.26%	1.22%	1.37%	1.68%	2.43%	2.84%	2.78%	3.65%	**3.62%**	**3.54%**
WAITEMATA	1.18%	1.22%	1.46%	2.04%	2.29%	2.30%	2.10%	2.25%	**2.64%**	**2.63%**
AUCKLAND	0.86%	0.89%	1.25%	1.28%	1.36%	1.69%	1.72%	1.85%	**2.05%**	**2.22%**
COUNTIES MANUKAU	1.15%	1.37%	1.57%	1.52%	1.71%	1.75%	1.84%	1.95%	**2.61%**	**2.57%**
MIDLAND	**1.27%**	**1.34%**	**1.41%**	**1.45%**	**2.01%**	**2.75%**	**2.24%**	**2.96%**	**2.87%**	**3.18%**
WAIKATO	0.88%	0.83%	1.00%	1.00%	1.40%	2.43%	0.65%	2.05%	**2.16%**	**3.01%**
LAKES	1.24%	1.38%	1.20%	1.49%	2.10%	2.46%	2.08%	3.32%	**2.97%**	**2.97%**
BAY OF PLENTY	1.53%	1.70%	1.74%	1.78%	2.43%	3.29%	2.94%	4.06%	**3.83%**	**3.79%**
TAIRAWHITI	1.79%	2.14%	2.67%	2.64%	3.72%	4.23%	2.22%	4.70%	**4.33%**	**3.79%**
TARANAKI	1.91%	2.00%	1.77%	1.79%	2.40%	2.40%	1.32%	2.85%	**2.71%**	**2.52%**
CENTRAL	**1.16%**	**1.31%**	**1.43%**	**1.60%**	**2.12%**	**2.45%**	**2.04%**	**2.94%**	**2.93%**	**2.95%**
HAWKE'S BAY	0.97%	0.99%	1.35%	1.73%	2.13%	2.24%	2.42%	2.76%	**2.62%**	**2.90%**
MIDCENTRAL	1.05%	1.35%	1.52%	1.72%	2.02%	2.25%	3.56%	2.66%	**2.77%**	**2.93%**
WHANGANUI	1.81%	2.07%	2.16%	2.23%	2.48%	2.40%	0.60%	2.58%	**2.66%**	**2.78%**
CAPITAL & COAST	1.15%	1.31%	1.31%	1.52%	1.95%	2.57%	3.72%	3.00%	**3.08%**	**3.00%**
HUTT VALLEY	1.09%	1.10%	1.25%	1.17%	2.18%	2.55%	1.43%	3.29%	**3.25%**	**2.88%**
WAIRARAPA	1.72%	2.06%	1.71%	1.65%	2.87%	3.03%	1.31%	3.68%	**3.23%**	**3.38%**
SOUTHERN	**0.89%**	**1.37%**	**1.34%**	**0.83%**	**2.02%**	**2.36%**	**1.64%**	**2.86%**	**3.01%**	**2.97%**
NELSON MARLBOROUGH	2.00%	2.22%	2.67%	2.53%	2.56%	3.34%	2.20%	3.70%	**3.06%**	**2.77%**
WEST COAST	2.41%	2.82%	2.99%	3.23%	4.01%	4.25%	1.78%	5.12%	**5.51%**	**3.71%**
CANTERBURY	1.16%	1.10%	1.13%	1.30%	1.50%	1.83%	1.75%	2.23%	**2.56%**	**2.61%**
SOUTH CANTERBURY	1.28%	1.18%	1.87%	1.77%	2.18%	3.32%	1.73%	5.00%	**4.43%**	**4.15%**
SOUTHERN	1.98%	1.97%	1.97%	1.93%	2.92%	2.96%	1.18%	2.89%	**3.22%**	**3.36%**
TOTAL	**1.24%**	**1.34%**	**1.43%**	**1.49%**	**2.02%**	**2.36%**	**1.98%**	**2.64%**	**2.80%**	**2.87%**

Source: MHINC/PRIMHD - Data are for the second six months of each year. * Includes NGO Client Data.

Table 9. Māori Client Access Rates by Age Group & Region (2006-2015)

YEAR		MĀORI ACCESS RATES BY AGE GROUP & REGION			
		0-9	10-14	15-19	0-19
MHC ACCESS TARGET RATES		1.00%	3.90%	5.50%	3.00%
NORTHERN	2006	0.33%	1.80%	3.27%	1.38%
	2007	0.42%	1.79%	3.53%	1.49%
	2008	0.47%	2.21%	4.50%	1.84%
	2009	0.45%	2.64%	6.24%	2.28%
	2010*	0.58%	3.24%	7.65%	2.78%
	2011*	0.66%	3.42%	8.61%	3.06%
	2012*	0.55%	4.32%	10.23%	3.08%
	2013*	0.80%	4.05%	8.45%	3.33%
	2014*	0.91%	4.53%	10.54%	4.00%
	2015*	1.04%	4.64%	10.27%	4.05%
MIDLAND	2006	0.41%	1.30%	2.22%	1.06%
	2007	0.37%	1.51%	2.43%	1.15%
	2008	0.38%	1.59%	2.92%	1.29%
	2009	0.38%	1.72%	2.92%	1.30%
	2010*	0.47%	2.57%	4.76%	1.96%
	2011*	0.71%	4.07%	6.72%	2.88%
	2012*	0.60%	3.97%	7.24%	2.52%
	2013*	0.85%	4.09%	7.58%	3.14%
	2014*	0.84%	3.69%	7.22%	2.95%
	2015*	0.83%	4.12%	7.94%	3.26%
CENTRAL	2006	0.30%	1.41%	2.56%	1.11%
	2007	0.34%	1.34%	2.82%	1.17%
	2008	0.38%	1.58%	3.12%	1.32%
	2009	0.52%	1.84%	3.39%	1.50%
	2010*	0.60%	2.54%	5.52%	2.17%
	2011*	0.86%	3.60%	6.64%	2.81%
	2012*	0.48%	4.75%	9.89%	2.64%
	2013*	0.96%	4.09%	8.37%	3.43%
	2014*	0.90%	4.11%	8.54%	3.44%
	2015*	0.96%	4.41%	8.66%	3.57%
SOUTHERN	2006	0.45%	1.73%	3.68%	1.56%
	2007	0.55%	1.83%	3.54%	1.59%
	2008	0.67%	2.17%	4.42%	1.93%
	2009	0.62%	2.15%	4.87%	1.97%
	2010*	0.72%	2.64%	5.73%	2.30%
	2011*	0.73%	3.38%	7.22%	2.80%
	2012*	0.35%	3.35%	6.69%	1.63%
	2013*	0.89%	4.22%	7.79%	3.29%
	2014*	1.10%	4.41%	7.69%	3.43%
	2015*	1.06%	4.62%	7.89%	3.49%

Source: PRIMHD - Data are for the second six months of each year. * Includes NGO Client Data.

Table 10. Māori 0-19 years Client Access Rates by DHB Area (2006-2015)

REGION/DHB AREA	MĀORI 0-19 YRS ACCESS RATES BY REGION & DHB AREA									
	2006	2007	2008	2009	2010*	2011*	2012*	2013*	2014*	2015*
NORTHERN	**1.38%**	**1.49%**	**1.84%**	**2.28%**	**2.78%**	**3.06%**	**3.08%**	**3.33%**	**4.00%**	**4.05%**
NORTHLAND	1.19%	1.11%	1.27%	1.63%	2.39%	2.89%	3.52%	3.90%	**3.96%**	**3.91%**
WAITEMATA	1.49%	1.45%	1.91%	3.46%	4.04%	4.10%	3.48%	4.08%	**3.41%**	**4.93%**
AUCKLAND	1.37%	1.53%	2.14%	2.35%	2.56%	3.45%	3.38%	3.50%	**4.13%**	**4.76%**
COUNTIES MANUKAU	1.40%	1.72%	2.04%	1.90%	2.30%	2.37%	2.45%	2.40%	**3.66%**	**3.33%**
MIDLAND	**1.06%**	**1.15%**	**1.29%**	**1.30%**	**1.96%**	**2.88%**	**2.52%**	**3.14%**	**2.95%**	**3.26%**
WAIKATO	0.67%	0.56%	0.79%	0.74%	1.23%	2.42%	2.34%	1.85%	**2.01%**	**2.85%**
LAKES	0.89%	1.03%	1.00%	1.19%	1.86%	2.34%	2.10%	2.72%	**2.19%**	**2.46%**
BAY OF PLENTY	1.34%	1.62%	1.72%	1.78%	2.36%	**3.60%**	3.78%	4.95%	**2.18%**	**4.43%**
TAIRAWHITI	1.79%	2.04%	2.51%	2.42%	3.60%	**4.23%**	3.38%	4.76%	**4.74%**	**3.99%**
TARANAKI	1.36%	1.46%	1.29%	1.18%	2.23%	2.26%	1.07%	2.84%	**2.85%**	**2.50%**
CENTRAL	**1.11%**	**1.17%**	**1.32%**	**1.50%**	**2.17%**	**2.81%**	**2.64%**	**3.43%**	**3.44%**	**3.57%**
HAWKE'S BAY	0.98%	1.03%	1.38%	1.58%	2.16%	2.64%	4.15%	3.31%	**2.94%**	**3.49%**
MIDCENTRAL	0.93%	0.92%	1.14%	1.21%	1.67%	1.90%	2.80%	2.38%	**2.59%**	**2.90%**
WHANGANUI	1.41%	1.54%	1.63%	1.52%	1.91%	2.00%	0.71%	2.23%	**2.40%**	**2.38%**
CAPITAL & COAST	1.27%	1.25%	1.34%	1.92%	3.00%	4.47%	4.10%	4.73%	**5.32%**	**4.98%**
HUTT VALLEY	1.00%	1.16%	1.22%	1.21%	1.86%	2.74%	2.59%	4.04%	**3.84%**	**3.28%**
WAIRARAPA	1.64%	2.07%	1.46%	1.51%	2.82%	3.16%	1.69%	4.04%	**3.18%**	**4.68%**
SOUTHERN	**1.31%**	**0.99%**	**1.35%**	**2.07%**	**2.30%**	**2.80%**	**1.63%**	**3.29%**	**3.43%**	**3.49%**
NELSON MARLBOROUGH	1.79%	1.75%	2.58%	2.31%	2.65%	4.12%	2.27%	4.21%	**3.07%**	**2.99%**
WEST COAST	2.93%	3.11%	3.92%	5.13%	4.73%	5.27%	1.92%	7.24%	**7.32%**	**4.42%**
CANTERBURY	1.16%	1.22%	1.29%	1.56%	1.95%	2.15%	2.00%	2.64%	**3.34%**	**3.53%**
SOUTH CANTERBURY	1.10%	0.60%	2.01%	1.51%	2.20%	2.74%	0.76%	4.33%	**4.55%**	**4.31%**
SOUTHERN	0.62%	0.67%	0.72%	0.75%	2.36%	2.87%	1.09%	2.99%	**3.09%**	**3.44%**
TOTAL	**1.24%**	**1.32%**	**1.56%**	**1.76%**	**2.32%**	**2.91%**	**2.57%**	**3.28%**	**3.51%**	**3.66%**

Source: PRIMHD - Data are for the second six months of each year. * Includes NGO Client Data.

Table 11. Pacific Client Access Rates by Age Group & Region (2006-2015)

YEAR		PACIFIC ACCESS RATES BY AGE GROUP (YRS) & REGION			
		0-9	10-14	15-19	0-19
MHC ACCESS RATES		1.00%	3.90%	5.50%	3.00%
NORTHERN	2006	0.16%	0.68%	1.69%	0.65%
	2007	0.14%	0.82%	1.81%	0.70%
	2008	0.23%	1.05%	2.64%	1.01%
	2009	0.15%	1.12%	3.17%	1.08%
	2010*	0.18%	1.13%	4.04%	1.28%
	2011*	0.18%	1.35%	4.29%	1.41%
	2012*	0.21%	1.33%	4.92%	1.35%
	2013*	0.31%	1.30%	4.25%	1.51%
	2014*	0.45%	1.71%	5.77%	2.08%
	2015*	0.42%	1.77%	5.07%	1.93%
MIDLAND	2006	0.03%	0.73%	0.39%	0.30%
	2007	0.28%	0.67%	1.19%	0.61%
	2008	0.16%	0.84%	1.16%	0.58%
	2009	0.18%	0.79%	0.61%	0.43%
	2010*	0.35%	1.11%	2.04%	0.94%
	2011*	0.67%	1.87%	3.32%	1.60%
	2012*	0.07%	1.80%	2.78%	0.38%
	2013*	0.60%	2.09%	3.42%	1.64%
	2014*	0.44%	1.37%	2.91%	1.24%
	2015*	0.79%	2.10%	3.38%	1.69%
CENTRAL	2006	0.26%	0.67%	1.23%	0.60%
	2007	0.13%	0.84%	1.05%	0.53%
	2008	0.23%	0.71%	1.26%	0.60%
	2009	0.30%	0.82%	1.66%	0.74%
	2010*	0.40%	0.92%	2.42%	0.99%
	2011*	0.40%	2.23%	3.25%	1.52%
	2012*	0.10%	2.30%	4.47%	0.72%
	2013*	0.44%	2.40%	4.56%	1.97%
	2014*	0.52%	3.09%	4.05%	2.03%
	2015*	0.44%	2.57%	3.03%	1.59%
SOUTHERN	2006	0.12%	0.91%	1.75%	0.73%
	2007	0.42%	0.74%	2.37%	0.99%
	2008	0.36%	0.56%	2.54%	0.95%
	2009	0.35%	0.79%	2.44%	0.94%
	2010*	0.17%	0.79%	3.99%	1.19%
	2011*	0.24%	1.02%	4.03%	1.30%
	2012*	0.02%	1.07%	2.72%	0.23%
	2013*	0.35%	1.45%	3.06%	1.26%
	2014*	0.54%	1.38%	3.33%	1.39%
	2015*	0.37%	1.58%	4.21%	1.52%

Source: PRIMHD - Data are for the second six months of each year. * Includes NGO Client Data.

Table 12. Pacific 0-19 years Client Access Rates by DHB Area (2006-2015)

REGION/ DHB AREA	PACIFIC 0-19 YRS ACCESS RATES BY REGION & DHB AREA									
	2006	2007	2008	2009	2010*	2011*	2012*	2013*	2014*	2015*
NORTHERN	**0.63%**	**0.69%**	**1.01%**	**1.08%**	**1.28%**	**1.41%**	**1.35%**	**1.51%**	**2.08%**	**1.93%**
NORTHLAND	1.01%	0.61%	1.04%	0.88%	1.29%	2.45%	0.50%	3.11%	**2.27%**	**2.39%**
WAITEMATA	0.74%	0.70%	0.99%	1.96%	2.57%	2.58%	2.47%	3.00%	**3.25%**	**2.63%**
AUCKLAND	0.73%	0.70%	1.02%	0.77%	0.86%	1.13%	1.16%	1.21%	**1.64%**	**1.56%**
COUNTIES MANUKAU	0.57%	0.71%	1.00%	0.92%	1.01%	1.11%	1.07%	1.12%	**1.85%**	**1.82%**
MIDLAND	**0.30%**	**0.61%**	**0.58%**	**0.43%**	**0.94%**	**1.60%**	**0.38%**	**1.64%**	**1.24%**	**1.69%**
WAIKATO	0.20%	0.32%	0.46%	0.33%	0.93%	1.50%	0.64%	1.15%	**0.87%**	**2.05%**
LAKES	0.19%	0.48%	0.20%	0.60%	1.02%	1.58%	0.58%	2.06%	**1.89%**	**1.06%**
BAY OF PLENTY	0.75%	1.17%	1.27%	0.67%	0.91%	**2.24%**	0.36%	2.57%	**1.79%**	**1.60%**
TAIRAWHITI	0.29%	1.35%	0.51%	0.51%	1.50%	**2.05%**	0.14%	2.17%	**1.57%**	**0.43%**
TARANAKI	0.24%	1.18%	0.69%	0.23%	0.45%	0.23%	0.09%	1.75%	**1.12%**	**1.07%**
CENTRAL	**0.70%**	**0.71%**	**0.61%**	**0.32%**	**0.99%**	**1.52%**	**0.72%**	**1.97%**	**2.03%**	**1.59%**
HAWKE'S BAY	0.35%	0.34%	0.51%	0.73%	0.90%	1.04%	0.56%	1.26%	**1.70%**	**1.46%**
MIDCENTRAL	0.36%	0.48%	0.66%	0.58%	0.74%	1.05%	0.34%	1.34%	**1.10%**	**1.20%**
WHANGANUI	1.63%	0.72%	1.77%	2.89%	0.73%	1.19%	0.07%	1.05%	**0.83%**	**1.42%**
CAPITAL & COAST	0.72%	0.64%	0.58%	0.80%	1.08%	1.83%	1.92%	2.78%	**2.65%**	**1.89%**
HUTT VALLEY	0.49%	0.43%	0.52%	0.54%	0.98%	1.42%	0.58%	1.26%	**1.78%**	**1.39%**
WAIRARAPA	0.71%	0.36%	1.07%	1.32%	0.95%	1.27%	0.18%	2.16%	**1.56%**	**1.30%**
SOUTHERN	**0.71%**	**0.34%**	**0.48%**	**0.72%**	**1.19%**	**1.30%**	**0.23%**	**1.26%**	**1.39%**	**1.52%**
NELSON MARLBOROUGH	2.00%	1.60%	1.65%	1.70%	1.48%	2.95%	0.19%	1.61%	**0.76%**	**1.25%**
WEST COAST	1.00%	4.00%	1.54%	3.53%	4.44%	3.33%	0.05%	2.40%	**0.74%**	**0.00%**
CANTERBURY	0.47%	0.72%	0.57%	0.65%	0.86%	0.63%	0.47%	0.87%	**1.22%**	**1.31%**
SOUTH CANTERBURY	1.71%	1.62%	1.76%	0.53%	1.05%	3.24%	0.12%	5.22%	**2.80%**	**0.77%**
SOUTHERN	0.74%	1.30%	1.61%	1.28%	1.75%	2.05%	0.15%	1.48%	**1.89%**	**2.23%**
TOTAL	**0.63%**	**0.69%**	**0.92%**	**0.99%**	**1.21%**	**1.43%**	**0.92%**	**1.57%**	**1.96%**	**1.82%**

Source: PRIMHD - Data are for the second six months of each year. * Includes NGO Client Data.

Table 13. Asian Client Access Rates by Age Group & Region (2006-2015)

YEAR		ASIAN ACCESS RATES BY AGE GROUP (YRS) & REGION			
		0-9	10-14	15-19	0-19
MHC ACCESS RATES		1.00%	3.90%	5.50%	3.00%
NORTHERN	2006	0.10%	0.25%	0.65%	0.30%
	2007	0.12%	0.33%	0.69%	0.35%
	2008	0.18%	0.41%	0.97%	0.34%
	2009	0.16%	0.53%	1.01%	0.50%
	2010*	0.14%	0.57%	1.22%	0.55%
	2011*	0.21%	0.67%	1.17%	0.58%
	2012*	0.18%	0.69%	1.34%	0.54%
	2013*	0.28%	0.79%	1.43%	0.72%
	2014*	0.29%	0.78%	1.61%	0.78%
	2015*	0.32%	0.93%	1.52%	0.79%
MIDLAND	2006	0.16%	0.21%	0.46%	0.26%
	2007	0.11%	0.30%	0.53%	0.28%
	2008	0.11%	0.25%	0.54%	0.27%
	2009	0.08%	0.21%	0.77%	0.31%
	2010*	0.11%	0.42%	0.85%	0.39%
	2011*	0.13%	0.29%	1.59%	0.56%
	2012*	0.04%	0.48%	1.46%	0.21%
	2013*	0.17%	0.53%	1.38%	0.55%
	2014*	0.14%	0.47%	1.19%	0.47%
	2015*	0.14%	0.72%	1.74%	0.65%
CENTRAL	2006	0.13%	0.38%	0.60%	0.32%
	2007	0.17%	0.26%	0.56%	0.30%
	2008	0.11%	0.29%	0.42%	0.24%
	2009	0.17%	0.39%	0.83%	0.40%
	2010*	0.19%	0.36%	1.18%	0.49%
	2011*	0.17%	0.65%	1.41%	0.59%
	2012*	0.05%	0.81%	1.48%	0.25%
	2013*	0.31%	0.70%	1.26%	0.65%
	2014*	0.31%	0.73%	1.56%	0.73%
	2015*	0.18%	0.94%	1.76%	0.75%
SOUTHERN	2006	0.11%	0.44%	1.01%	0.53%
	2007	0.18%	0.48%	0.75%	0.47%
	2008	0.13%	0.46%	0.58%	0.38%
	2009	0.10%	0.41%	0.69%	0.39%
	2010*	0.13%	0.69%	0.80%	0.49%
	2011*	0.25%	0.67%	1.14%	0.65%
	2012*	0.03%	0.58%	0.91%	0.19%
	2013*	0.20%	0.38%	1.00%	0.49%
	2014*	0.15%	0.82%	1.23%	0.62%
	2015*	0.16%	1.15%	1.11%	0.65%

Source: PRIMHD - Data are for the second six months of each year. * Includes NGO Client Data.

Table 14. Asian 0-19 years Client Access Rates by DHB Area (2006-2015)

REGION/ DHB AREA	ASIAN 0-19 YRS ACCESS RATES BY DHB AREA									
	2006	2007	2008	2009	2010*	2011*	2012*	2013*	2014*	2015*
NORTHERN	0.30%	0.35%	0.34%	0.50%	0.55%	0.58%	0.54%	0.72%	**0.78%**	**0.79%**
NORTHLAND	0.14%	0.11%	0.33%	0.53%	0.40%	0.48%	0.14%	1.34%	**0.44%**	**0.21%**
WAITEMATA	0.30%	0.26%	0.38%	0.56%	0.56%	0.52%	0.47%	0.63%	**0.71%**	**0.67%**
AUCKLAND	0.31%	0.33%	0.52%	0.41%	0.50%	0.60%	0.57%	0.71%	**0.71%**	**0.81%**
COUNTIES MANUKAU	0.52%	0.45%	0.52%	0.52%	0.61%	0.63%	0.65%	0.80%	**0.93%**	**0.92%**
MIDLAND	**0.26%**	**0.26%**	**0.27%**	**0.31%**	**0.39%**	**0.56%**	**0.21%**	**0.55%**	**0.47%**	**0.65%**
WAIKATO	0.11%	0.15%	0.16%	0.21%	0.14%	0.46%	0.22%	0.26%	**0.30%**	**0.55%**
LAKES	0.22%	0.20%	0.37%	0.64%	0.63%	0.80%	0.19%	0.63%	**0.53%**	**0.76%**
BAY OF PLENTY	0.61%	0.50%	0.53%	0.36%	0.80%	0.67%	0.32%	0.98%	**0.84%**	**0.84%**
TAIRAWHITI	0.65%	0.00%	0.91%	0.43%	1.30%	0.83%	0.19%	1.36%	**1.27%**	**0.92%**
TARANAKI	0.48%	0.85%	0.14%	0.53%	0.74%	0.63%	0.09%	1.02%	**0.38%**	**0.68%**
CENTRAL	**0.52%**	**0.30%**	**0.21%**	**0.64%**	**0.49%**	**0.59%**	**0.25%**	**0.65%**	**0.73%**	**0.75%**
HAWKE'S BAY	0.51%	0.18%	0.35%	0.26%	0.34%	0.42%	0.18%	0.38%	**0.59%**	**0.43%**
MIDCENTRAL	0.11%	0.14%	0.05%	0.50%	0.35%	0.52%	0.25%	0.48%	**0.35%**	**0.56%**
WHANGANUI	1.26%	0.94%	0.24%	0.98%	0.99%	1.35%	0.06%	-	**1.03%**	**0.38%**
CAPITAL & COAST	0.33%	0.37%	0.26%	0.37%	0.44%	0.56%	0.71%	0.72%	**0.76%**	**0.88%**
HUTT VALLEY	0.25%	0.16%	0.25%	0.30%	0.62%	0.67%	0.16%	0.79%	**0.93%**	**0.80%**
WAIRARAPA	0.62%	1.11%	0.56%	1.62%	1.62%	0.57%	0.07%	0.82%	**0.37%**	**0.34%**
SOUTHERN	**0.53%**	**0.47%**	**0.38%**	**0.39%**	**0.49%**	**0.65%**	**0.19%**	**0.49%**	**0.62%**	**0.65%**
NELSON MARLBOROUGH	1.09%	2.07%	1.48%	0.88%	0.43%	1.21%	0.16%	0.72%	**0.52%**	**0.65%**
WEST COAST	4.44%	-	-	2.50%	1.60%	3.20%	0.07%	0.45%	**2.04%**	**0.74%**
CANTERBURY	0.26%	0.27%	0.24%	0.27%	0.36%	0.43%	0.32%	0.39%	**0.50%**	**0.54%**
SOUTH CANTERBURY	1.50%	0.63%	0.97%	1.00%	1.00%	2.03%	0.09%	1.32%	**1.58%**	**1.45%**
SOUTHERN	1.14%	0.58%	0.40%	0.43%	0.86%	0.98%	0.12%	0.55%	**0.79%**	**0.85%**
TOTAL	**0.38%**	**0.35%**	**0.42%**	**0.46%**	**0.52%**	**0.59%**	**0.38%**	**0.67%**	**0.72%**	**0.75%**

Source: PRIMHD - Data are for the second six months of each year. * Includes NGO Client Data.

APPENDIX C: FUNDING DATA

Table 1. Infant, Child & Adolescent Mental Health/AOD Funding (2008-2016)

REGION/ DHB AREA	2009/2010			2011/2012			2013/2014*			2015/2016*			
	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB		NGO	TOTAL
										C&Y MENTAL HEALTH[1]	PRIMARY MENTAL HEALTH		
NORTHERN	**$44,515,971**	**$4,793,764**	**$49,309,735**	**$46,644,982**	**$7,263,465**	**$53,908,447**	**$47,331,741**	**$8,517,755**	**$55,849,495**	**$51,730,412**	**$681,414**	**$8,789,249**	**$61,201,075**
Northland	$3,449,696	$1,278,685	**$4,728,381**	$5,691,041	$1,165,900	**$6,856,941**	$5,243,077	$1,230,893	**$6,473,970**	$6,033,576	$85,415	$1,273,595	**$7,392,586**
Waitemata	$13,611,574	$111,648	**$13,723,222**	$14,070,738	$489,492	**$14,560,230**	$14,325,541	$690,177	**$15,015,718**	$15,648,936	$213,658	$702,631	**$16,565,225**
Auckland	$17,048,568	$1,884,662	**$18,933,230**	$14,053,468	$2,756,784	**$16,810,252**	$15,154,442	$2,691,784	**$17,846,226**	$16,829,924	$176,959	$2,598,834	**$19,605,717**
Counties Manukau	$10,406,133	$1,518,769	**$11,924,902**	$12,829,734	$2,851,289	**$15,681,023**	$12,608,681	$3,904,901	**$16,513,582**	$13,217,976	$205,382	$4,214,189	**$17,637,547**
MIDLAND	**$15,494,260**	**$10,668,323**	**$26,162,583**	**$19,632,325**	**$13,341,162**	**$32,973,487**	**$19,394,360**	**$16,006,020**	**$35,400,380**	**$19,852,928**	**$398,725**	**$16,272,187**	**$36,523,840**
Waikato	$4,218,807	$6,741,419	**$10,960,226**	$6,056,183	$7,972,422	**$14,028,605**	$5,527,629	$9,770,700	**$15,298,329**	$5,626,421	$169,198	$10,239,947	**$16,035,566**
Lakes	$2,368,250	$628,470	**$2,996,720**	$2,856,181	$1,628,738	**$4,484,919**	$3,335,983	$1,859,143	**$5,195,126**	$3,228,013	$47,047	$1,545,288	**$4,820,348**
Bay of Plenty	$4,608,357	$2,624,434	**$7,232,791**	$5,807,253	$2,823,774	**$8,631,027**	$5,797,329	$3,465,570	**$9,262,899**	$6,128,769	$105,491	$3,446,180	**$9,680,440**
Tairawhiti	$1,769,619	$277,380	**$2,046,999**	$2,323,382	$457,294	**$2,780,676**	$2,063,599	$288,899	**$2,352,498**	$2,244,851	$24,011	$310,176	**$2,579,038**
Taranaki	$2,529,227	396620	**$2,925,847**	$2,589,327	$458,934	**$3,048,261**	$2,669,820	$621,708	**$3,291,528**	$2,624,874	$52,978	$730,596	**$3,408,448**
CENTRAL	**$26,325,647**	**$4,497,738**	**$30,823,385**	**$27,016,084**	**$5,877,421**	**$32,893,505**	**$27,248,993**	**$5,582,425**	**$32,831,418**	**$30,240,497**	**$373,622**	**$5,062,877**	**$35,676,996**
Hawke's Bay	$2,951,849	$1,334,099	**$4,285,948**	$3,399,861	$1,352,616	**$4,752,477**	$3,337,010	$839,700	**$4,176,710**	$3,337,010	$75,241	$410,217	**$3,822,468**
MidCentral	$4,089,315	$1,128,338	**$5,217,653**	$4,542,160	$871,601	**$5,413,761**	$4,188,141	$1,007,965	**$5,196,106**	$4,083,183	$76,915	$1,020,716	**$5,180,814**
Whanganui	$2,146,068	$109,940	**$2,256,008**	$1,918,303	$225,612	**$2,143,915**	$2,175,310	$283,612	**$2,458,922**	$2,535,041	$32,061	$224,064	**$2,791,166**
Capital & Coast	$11,954,563	$457,116	**$12,411,679**	$11,448,851	$837,708	**$12,286,559**	$12,416,440	$837,840	**$13,254,280**	$14,927,009	$109,408	$776,604	**$15,813,021**
Hutt Valley	$3,937,188	$1,304,109	**$5,241,297**	$4,487,788	$2,462,508	**$6,950,296**	$3,984,793	$2,504,312	**$6,489,105**	$3,998,954	$58,776	$2,531,352	**$6,589,082**
Wairarapa	$1,246,665	$164,136	**$1,410,801**	$1,219,121	$127,376	**$1,346,497**	$1,147,300	$108,996	**$1,256,296**	$1,359,300	$21,221	$99,924	**$1,480,445**
SOUTHERN	**$27,189,330**	**$7,970,696**	**$35,160,026**	**$26,890,659**	**$8,331,706**	**$35,222,365**	**$30,463,061**	**$9,774,212**	**$40,237,273**	**$30,674,340**	**$446,239**	**$11,023,133**	**$42,143,712**
Nelson Marlborough	$3,829,949	$619,131	**$4,449,080**	$4,014,175	$571,908	**$4,586,083**	$4,130,029	$575,674	**$4,705,703**	$3,811,412	$65,042	$919,203	**$4,795,657**
West Coast	$888,682	-	**$888,682**	$1,020,967	$24,120	**$1,045,087**	$1,048,179	$284,000	**$1,332,179**	$1,048,179	$16,890	$240,000	**$1,305,069**
Canterbury	$14,624,289	$3,474,948	**$18,099,237**	$14,403,651	$3,430,135	**$17,833,786**	$16,448,505	$3,751,388	**$20,199,893**	$16,642,285	$207,771	$4,446,390	**$21,296,446**
South Canterbury	$962,631	$569,942	**$1,532,573**	$941,869	$589,824	**$1,531,693**	$1,113,038	$725,050	**$1,838,088**	$1,061,849	$27,688	$702,204	**$1,791,741**
Southern	$6,883,778	$3,306,675	**$10,190,453**	$6,509,997	$3,715,719	**$10,225,716**	$7,723,311	$4,438,100	**$12,161,411**	$8,110,617	$128,848	$4,715,336	**$12,954,801**
MINISTRY OF HEALTH	-	$136,117	**$136,117**	-	$378,551	**$378,551**	-	-	**-**	-	-	-	**-**
TOTAL	**$113,525,208**	**$28,066,638**	**$141,591,846**	**$120,184,050**	**$35,192,305**	**$155,376,355**	**$124,438,155**	**$39,880,412**	**$164,318,566**	**$132,498,178**	**$1,900,000**	**$41,147,446**	**$175,545,624**

Source: Ministry of Health Price Volume Schedules 2009-2016. *Updated July 2017

1. Includes Inpatient

Table 2. National Funding per Head Infant, Child & Adolescent Population (2006-2016)

REGION/DHB AREA	2007/2008			2009/2010			2011/2012			2013/2014			2015/2016		
	Total DHB & NGO $	Spend/Child (Excl. Inpatient) $	Spend/Child (Incl. Inpatient) $	Total DHB & NGO $	Spend/Child (Excl. Inpatient) $	Spend/Child (Incl. Inpatient) $	Total DHB & NGO $	Spend/Child (Excl. Inpatient) $	Spend/Child (Incl. Inpatient) $	Total DHB & NGO $	Spend/Child (Excl. Inpatient) $	Spend/Child (Incl. Inpatient) $	Total DHB & NGO $	Spend/Child (Excl. Inpatient) $	Spend/Child (Incl. Inpatient) $
NORTHERN	**$41,452,834**	**$74.47**	**$89.02**	**$49,309,735**	**$92.92**	**$105.29**	**$53,908,447**	**$103.47**	**$114.42**	**$55,849,495**	**$106.62**	**$118.13**	**$61,201,075**	**$115.94**	**$126.41**
Northland	$3,783,199	$78.49	$78.49	$4,728,381	$103.76	$103.76	$6,856,941	$130.41	$152.78	$6,473,970	$109.18	$136.29	$7,392,586	$128.92	$156.32
Waitemata	$11,991,703	$79.06	$80.47	$13,723,222	$90.21	$90.95	$14,560,230	$96.00	$96.00	$15,015,718	$98.64	$98.64	$16,565,225	$105.81	$105.81
Auckland	$18,106,608	$104.29	$163.62	$18,933,230	$119.04	$170.06	$16,810,252	$113.28	$150.48	$17,846,226	$119.67	$155.98	$19,605,717	$135.67	$168.00
Counties Manukau	$7,571,325	$48.00	$48.00	$11,924,902	$74.28	$74.28	$15,681,023	$96.27	$96.27	$16,513,582	$104.09	$104.09	$17,637,547	$107.82	$107.82
MIDLAND	**$19,109,645**	**$77.86**	**$78.43**	**$26,162,583**	**$107.51**	**$108.19**	**$32,973,487**	**$137.94**	**$138.00**	**$35,400,380**	**$143.82**	**$143.88**	**$36,523,840**	**$145.61**	**$146.22**
Waikato	$7,384,161	$69.19	$69.19	$10,960,226	$102.95	$102.95	$14,028,605	$133.05	$133.05	$15,298,329	$139.70	$139.70	$16,035,566	$143.12	$143.12
Lakes	$3,481,829	$109.73	$109.73	$2,996,720	$95.83	$95.83	$4,484,919	$145.95	$145.95	$5,195,126	$170.28	$170.28	$4,820,348	$159.46	$159.46
Bay of Plenty	$4,754,377	$78.38	$80.12	$7,232,791	$119.23	$121.76	$8,631,027	$145.72	$145.72	$9,262,899	$155.71	$155.71	$9,680,440	$159.56	$159.56
Tairawhiti	$1,220,872	$77.62	$79.95	$2,046,999	$136.09	$137.01	$2,780,676	$189.01	$190.07	$2,352,498	$154.33	$155.38	$2,579,038	$161.63	$171.94
Taranaki	$2,268,405	$74.16	$74.16	$2,925,847	$98.35	$98.35	$3,048,261	$105.48	$105.48	$3,291,528	$104.86	$104.86	$3,408,448	$107.05	$107.05
CENTRAL	**$24,869,869**	**$88.75**	**$104.32**	**$30,823,385**	**$112.04**	**$130.69**	**$32,893,505**	**$125.86**	**$141.42**	**$32,831,418**	**$124.22**	**$139.05**	**$35,676,996**	**$136.61**	**$151.66**
Hawke's Bay	$4,079,353	$88.91	$88.91	$4,285,948	$94.61	$94.61	$4,752,477	$106.56	$106.56	$4,176,710	$91.92	$91.92	$3,822,468	$84.66	$84.66
MidCentral	$4,336,484	$90.63	$90.63	$5,217,653	$110.31	$110.31	$5,413,761	$116.08	$116.08	$5,196,106	$111.03	$111.03	$5,180,814	$110.39	$110.39
Whanganui	$1,940,068	$96.52	$105.90	$2,256,008	$117.23	$128.55	$2,143,915	$127.24	$127.24	$2,458,922	$142.88	$142.88	$2,791,166	$166.34	$166.34
Capital & Coast	$9,330,052	$80.35	$127.25	$12,411,679	$112.96	$168.43	$12,286,559	$119.31	$167.07	$13,254,280	$128.74	$174.97	$15,813,021	$160.72	$207.09
Hutt Valley	$4,179,428	$96.65	$99.04	$5,241,297	$123.45	$126.14	$6,950,296	$167.68	$170.31	$6,489,105	$163.21	$163.21	$6,589,082	$169.21	$169.21
Wairarapa	$1,004,483	$92.66	$92.66	$1,410,801	$134.75	$134.75	$1,346,497	$132.53	$132.53	$1,256,296	$112.67	$112.67	$1,480,445	$133.49	$133.49
SOUTHERN	**$31,275,320**	**$96.89**	**$117.53**	**$35,160,026**	**$110.75**	**$132.99**	**$35,222,365**	**$113.80**	**$134.83**	**$40,237,273**	**$130.97**	**$151.09**	**$42,143,712**	**$134.67**	**$154.58**
Nelson Marlborough	$3,958,764	$98.27	$112.46	$4,449,080	$111.53	$127.88	$4,586,083	$113.72	$134.17	$4,705,703	$123.99	$132.37	$4,795,657	$126.76	$126.76
West Coast	$869,141	$103.22	$103.22	$888,682	$108.64	$108.64	$1,045,087	$133.47	$133.47	$1,332,179	$161.48	$161.48	$1,305,069	$163.54	$202.03
Canterbury	$15,718,621	$85.78	$119.88	$18,099,237	$101.19	$137.32	$17,833,786	$103.07	$135.55	$20,199,893	$121.40	$156.45	$21,296,446	$124.03	$158.02
South Canterbury	$926,945	$65.46	$65.46	$1,532,573	$110.90	$110.90	$1,531,693	$114.82	$114.82	$1,838,088	$129.17	$129.17	$1,791,741	$126.80	$126.80
Southern	$9,801,849	$120.20	$126.95	$10,190,453	$127.23	$134.44	$10,225,716	$130.56	$137.61	$12,161,411	$146.84	$153.61	$12,954,801	$154.51	$161.25
MINISTRY OF HEALTH	$14,168	-	-	$136,117	-	-	$378,551	-	-	-	-	-	-	-	-
TOTAL	**$116,721,836**	**$82.88**	**$96.16**	**$141,591,846**	**$103.57**	**$116.98**	**$155,754,906**	**$110.67**	**$121.85**	**$164,318,566**	**$122.82**	**$134.55**	**$175,545,624**	**$129.93**	**$141.36**

Source: Ministry of Health Price Volume Schedules 2005-2016. Includes Youth Primary Mental Health Funding. Updated July 2017.

APPENDIX D: ICAMH/AOD WORKFORCE DATA

Table 1. DHB Inpatient ICAMHS Workforce (Actual FTEs, 2016)

INPATIENT WORKFORCE 30 JUNE 2016 (ACTUAL FTES)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	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
AUCKLAND[1]	-	-	24.9	3.4	5.62	1.10	8.3	1.4	8.2	**52.92**	1.0	-	-	7.0	-	**8.0**	**3.0**	**63.92**
CAPITAL & COAST	-	-	16.0	2.0	1.0	-	1.0	2.0	-	**22.0**	0.8	-	-	8.0	-	**8.8**	2.0	**32.8**
CANTERBURY[2]	-	-	31.34	2.0	2.5	-	2.1	2.8	6	**46.74**	0.4	-	-	-	1.0	**1.4**	3.0	**51.14**
TOTAL	-	-	**72.24**	**7.4**	**9.12**	**1.1**	**11.4**	**6.2**	**14.2**	**121.66**	**2.2**	-	-	**15.0**	**1.0**	**18.2**	**8.0**	**147.86**

1. Includes Consult Liaison Service
2. Includes Child Day Programme

Table 2. DHB Inpatient ICAMHS Vacant FTEs (2016)

INPATIENT VACANT FTES 30 JUNE 2016	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	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
AUCKLAND	-	-	8.4	-	-	-	1.0	0.32	-	**9.72**	-	-	-	-	-	-	-	**9.72**
CAPITAL & COAST	-	-	1.0	-	2.0	-	-	2.0	-	**5.0**	-	-	-	1.0	-	**1.0**	-	**6.0**
CANTERBURY	-	-	-	0.5	-	-	-	-	-	**0.5**	-	-	-	-	-	-	-	**0.5**
TOTAL	-	-	**9.4**	**0.5**	**2.0**	-	**1.0**	**2.32**	-	**15.22**	-	-	-	**1.0**	-	**1.0**	-	**16.22**

Table 3. DHB Inpatient Māori, Pacific & Asian ICAMH Workforce (Headcount, 2016)

INPAIENT WORKFORCE 30 JUNE 2016 (ETHNICITY, HEADCOUNT)		ALCOHOL & DRUG	CO-EXISTING PROBLEMS	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
MĀORI	AUCKLAND	-	-	1	-	1	-	-	-	1	3	1	-	-	1	-	2	-	5
	CAPITAL & COAST	-	-	2	-	-	-	-	-	-	2	2	-	-	2	-	4	-	6
	CANTERBURY	-	-	3	-	-	-	-	-	-	3	1	-	-		-	1	-	4
	TOTAL	-	-	6	-	1	-	-	-	1	8	4	-	-	3	-	7	-	15
PACIFIC	AUCKLAND	-	-	4	-	-	-	-	-	-	4	-	-	-	4	-	4	-	8
	CAPITAL & COAST	-	-	1	-	-	-	-	-	-	1	-	-	-	4	-	4	-	5
	CANTERBURY	-	-	2	-	-	-	-	-	-	2	-	-	-		-	-	-	2
	TOTAL	-	-	7	-	-	-	-	-	-	7	-	-	-	8	-	8	-	15
ASIAN	AUCKLAND	-	-	4	-	1	-	-	1	3	9	-	-	-	1	-	1	-	10
	CAPITAL & COAST	-	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1
	CANTERBURY	-	-	3	-	1	-	-	-	-	4	-	-	-	-	-	-	-	4
	TOTAL	-	-	8	-	2	-	-	1	-	14	-	-	-	1	-	1	-	15
NZ EUROPEAN	AUCKLAND	-	-	19	4	6	2	10	-	6	47	-	-	-	1	-	1	3	51
	CAPITAL & COAST	-	-	12	2	2	-	1	2	-	19	-	-	-	2	-	2	2	23
	CANTERBURY	-	-	32	3	2	-	2	4	3	46	-	-	-	-	-	-	4	50
	TOTAL	-	-	63	9	10	2	13	6	9	112	-	-	-	3	-	3	9	124
OTHER	AUCKLAND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	CAPITAL & COAST	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	CANTERBURY	-	-	1	-	-	-	1	-	1	3	-	-	-	-	1	1	-	4
	TOTAL	-	-	1	-	-	-	1	-	1	3	-	-	-	-	1	1	-	4
TOTAL		-	-	85	9	13	2	14	7	11	144	4	-	-	15	1	20	9	173

Table 4. DHB Community ICAMH/AOD Workforce (Actual FTEs, 2016)

REGION/DHB COMMUNITY WORKFORCE 30 JUNE 2016 (ACTUAL FTES)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	**32.8**	**7.8**	**57.25**	**39.05**	**28.75**	**12.75**	**62.71**	**56.23**	**31.65**	**328.99**	**11.9**	**-**	**0.4**	**-**	**2.0**	**-**	**14.9**	**37.68**	**381.57**
NORTHLAND	-	6.0	14.0	2.0	2.8	0.6	5.3	7.0	3.8	**41.5**	-	-	-	-	-	-	-	5.0	**46.5**
WAITEMATA	31.9	1.0	22.5	17.3	15.25	8.6	21.6	22.3	6.8	**147.25**	2.6	-	-	-	-	-	**2.6**	14.4	**164.25**
AUCKLAND	-	-	8.15	14.0	6.7	3.55	25.18	7.0	5.4	**69.98**	6.8	-	-	-	-	-	**6.8**	9.1	**85.88**
COUNTIES MANUKAU	0.9	0.8	12.6	5.75	4.0	-	10.63	19.93	15.65	**70.26**	2.5	-	0.4	-	2.0	-	**4.9**	9.18	**84.34**
MIDLAND	**9.6**	**3.0**	**32.4**	**4.0**	**14.5**	**1.0**	**34.3**	**27.6**	**2.35**	**128.75**	**3.6**	**--**	**1.0**	**-**	**3.7**	**2.0**	**10.30**	**17.4**	**156.45**
WAIKATO	**2.0**	**1.0**	**7.8**	**3.0**	**7.1**	**-**	**12.55**	**10.5**	**2.0**	**45.95**	**-**	**-**	**1.0**	**-**	**1.0**	**1.0**	**3.0**	**6.8**	**55.75**
LAKES	**1.0**	**-**	**5.5**	**-**	**1.2**	**-**	**5.8**	**2.3**	**0.35**	**16.15**	**1.0**	**-**	**-**	**-**	**-**	**-**	**1.0**	**3.0**	**20.15**
BAY OF PLENTY	**2.6**	**2.0**	**10.4**	**1.0**	**2.8**	**-**	**8.4**	**9.8**	**-**	**37.0**	**1.6**	**-**	**-**	**-**	**-**	**1.0**	**2.6**	**4.1**	**43.7**
TAIRAWHITI	**4.0**	**-**	**1.5**	**-**	**1.4**	**1.0**	**4.65**	**4.0**	**-**	**16.55**	**1.0**	**-**	**-**	**-**	**-**	**-**	**1.0**	**2.5**	**20.05**
TARANAKI	**-**	**-**	**7.2**	**-**	**2.0**	**-**	**2.9**	**1.0**	**-**	**13.1**	**-**	**-**	**-**	**-**	**2.70**	**-**	**2.7**	**1.0**	**16.8**
CENTRAL	**4.5**	**5.0**	**40.3**	**10.0**	**18.0**	**6.8**	**39.51**	**39.75**	**21.45**	**185.31**	**6.3**	**0.5**	**-**	**8.5**	**1.0**	**3.5**	**19.8**	**31.7**	**236.81**
HAWKE'S BAY	**1.8**	**-**	**5.0**	**0.8**	**2.0**	**-**	**2.7**	**8.8**	**4.6**	**25.7**	**1.0**	**-**	**-**	**-**	**-**	**-**	**1.0**	**4.6**	**31.3**
MIDCENTRAL	**-**	**1.0**	**6.0**	**1.0**	**2.8**	**1.0**	**6.0**	**9.9**	**1.4**	**29.1**	**1.0**	**-**	**-**	**-**	**-**	**-**	**1.0**	**5.5**	**35.6**
WHANGANUI	**1.7**	**1.0**	**4.1**	**-**	**1.2**	**-**	**1.4**	**1.6**	**0.9**	**11.9**	**-**	**0.5**	**-**	**-**	**1.0**	**-**	**1.5**	**3.6**	**17.0**
CAPITAL & COAST	**1.0**	**2.0**	**22.4**	**7.6**	**7.9**	**3.0**	**17.3**	**8.4**	**9.65**	**79.25**	**4.3**	**-**	**-**	**6.5**	**-**	**3.5**	**14.3**	**12.5**	**106.05**
HUTT VALLEY	**-**	**-**	**1.0**	**0.6**	**3.1**	**2.8**	**10.11**	**10.05**	**3.9**	**31.56**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3.6**	**35.16**
WAIRARAPA	**-**	**1.0**	**1.8**	**-**	**1.0**	**-**	**2.0**	**1.0**	**1.0**	**7.8**	**-**	**-**	**-**	**2.0**	**-**	**-**	**2.0**	**1.9**	**11.7**
SOUTHERN	**4.1**	**1.5**	**41.3**	**12.9**	**17.8**	**4.7**	**31.95**	**32.0**	**16.55**	**162.8**	**5.1**	**1.0**	**2.2**	**2.0**	**-**	**1.30**	**11.6**	**24.38**	**198.78**
NELSON MARLBOROUGH	**2.3**	**-**	**5.6**	**3.0**	**1.2**	**-**	**8.0**	**6.6**	**1.2**	**27.9**	**-**	**1.0**	**-**	**-**	**-**	**0.3**	**1.3**	**5.0**	**34.2**
WEST COAST	**-**	**1.5**	**-**	**-**	**-**	**-**	**1.3**	**0.3**	**2.25**	**5.35**	**1.0**	**-**	**-**	**-**	**-**	**-**	**1.0**	**0.5**	**6.85**
CANTERBURY	**1.0**	**-**	**19.75**	**4.2**	**10.9**	**1.0**	**14.15**	**18.7**	**5.8**	**75.5**	**3.6**	**-**	**-**	**-**	**-**	**-**	**3.6**	**12.88**	**91.98**
SOUTH CANTERBURY	**-**	**-**	**-**	**2.0**	**0.3**	**3.7**	**0.5**	**0.7**	**0.9**	**8.1**	**-**	**-**	**1.2**	**2.0**	**-**	**1.0**	**4.2**	**-**	**12.3**
SOUTHERN	**0.8**	**-**	**15.95**	**3.7**	**5.4**	**-**	**8.0**	**5.7**	**6.4**	**45.95**	**0.5**	**-**	**1.0**	**-**	**-**	**-**	**1.5**	**6.0**	**53.45**
TOTAL	**51.0**	**17.3**	**171.25**	**65.95**	**79.05**	**25.25**	**168.47**	**155.58**	**72.0**	**805.85**	**26.9**	**1.5**	**3.6**	**10.5**	**6.7**	**6.8**	**56.6**	**111.16**	**973.61**

Table 5. DHB Community ICAMH/AOD Vacancies (Vacant FTEs, 2016)

REGION/DHB COMMUNITY VACANCIES 30 JUNE 2016 (FTES)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL	STAFF TURNOVER RATE %
NORTHERN	1.0	0.8	13.02	2.0	4.6	0.5	10.2	3.35	4.7	40.17	1.0	-	-	-	-	-	1.0	1.0	42.17	8.5
NORTHLAND	-	-	-	-	-	-	1.0	-	-	1.0	-	-	-	-	-	-	-	-	1.0	12.9
WAITEMATA	1.0	0.8	6.55	-	2.6	-	1.7	1.0	3.0	16.65	-	-	-	-	-	-	-	0.5	17.15	6.1
AUCKLAND	-	-	2.47	1.0	2.0	0.5	1.6	2.35	-	9.92	-	-	-	-	-	-	-	-	9.92	9.2
COUNTIES MANUKAU	-	-	4.0	1.0	-	-	5.9	-	1.7	12.6	1.0	-	-	-	-	-	1.0	0.5	14.1	8.8
MIDLAND	2.0	1.0	2.0	2.0	-	-	5.1	-	3.8	15.9	0.4	-	-	-	-	-	0.4	-	16.3	10.5
WAIKATO	-	-	1.0	-	-	-	1.75	-	-	2.75	-	-	-	-	-	-	-	-	2.75	9.9
LAKES	1.0	1.0	-	-	-	-	-	-	2.8	4.8	-	-	-	-	-	-	-	-	4.8	4.5
BAY OF PLENTY	-	-	1.0	2.0	-	-	2.0	-	-	5.0	0.4	-	-	-	-	-	0.4	-	5.4	12.4
TAIRAWHITI	1.0	-	-	-	-	-	0.35	-	-	1.35	-	-	-	-	-	-	-	-	1.35	4.8
TARANAKI	-	-	-	-	-	-	1.0	-	1.0	2.0	-	-	-	-	-	-	-	-	2.0	21.1
CENTRAL	-	-	7.9	3.0	1.6	0.25	11.35	6.0	3.2	33.3	0.55	-	-	4.0	-	-	4.55	1.10	38.95	20.3
HAWKE'S BAY	-	-	0.8	-	0.4	-	2.0	1.0	-	4.2	-	-	-	-	-	-	-	-	4.2	18.8
MIDCENTRAL	-	-	-	2.0	-	-	4.0	1.0	1.0	8.0	0.3	-	-	-	-	-	0.3	-	8.3	41.3
WHANGANUI	-	-	-	1.0	-	-	-	-	1.0	2.0	-	-	-	-	-	-	-	-	2.0	11.1
CAPITAL & COAST	-	-	7.0	-	0.6	-	4.6	4.0	1.2	17.4	0.25	-	-	4.0	-	-	4.25	-	21.65	18.1
HUTT VALLEY	-	-	-	-	0.6	0.25	0.45	-	-	1.3	-	-	-	-	-	-	-	1.0	2.3	19.3
WAIRARAPA	-	-	0.1	-	-	-	0.3	-	-	0.4	-	-	-	-	-	-	-	0.1	0.5	7.4
SOUTHERN	-	-	3.9	2.0	1.8	-	4.8	5.5	2.6	20.6	-	-	-	-	-	-	-	2.0	22.6	18.6
NELSON MARLBOROUGH	-	-	2.4	-	0.8	-	-	-	-	3.2	-	-	-	-	-	-	-	-	3.2	11.7
WEST COAST	-	-	-	-	-	-	1.0	2.0	1.0	4.0	-	-	-	-	-	-	-	1.0	5.0	52.6
CANTERBURY	-	-	1.0	1.0	-	-	1.3	0.6	-	3.9	-	-	-	-	-	-	-	1.0	4.9	17.2
SOUTH CANTERBURY	-	-	-	-	-	-	-	-	1.0	1.0	-	-	-	-	-	-	-	-	1.0	13.3
SOUTHERN	-	-	0.5	1.0	1.0	-	2.5	2.9	0.6	8.5	-	-	-	-	-	-	-	-	8.5	20.5
TOTAL	3.0	1.8	26.82	9.0	8.0	0.75	31.45	14.85	14.3	109.97	1.95	-	-	4.0	-	-	5.95	4.1	120.02	13.3

Table 6. DHB Community Māori ICAMH/AOD Workforce (Headcount, 2016)

REGION/DHB MĀORI WORKFORCE (HEADCOUNT, 30 JUNE 2016)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	3	5	6	3	2	-	3	11	3	36	11	-	-	-	1	-	12	6	54
NORTHLAND	-	4	4	-	-	-	1	3	1	13	-	-	-	-	-	-	-	4	17
WAITEMATA	3	1	-	1	2	-	-	4	-	11	2	-	-	-	-	-	2	-	13
AUCKLAND	-	-	-	2	-	-	1	-	-	3	7	-	-	-	-	-	7	1	11
COUNTIES MANUKAU	-	-	2	-	-	-	1	4	2	9	2	-	-	-	1	-	3	1	13
MIDLAND	6	-	7	-	1	-	2	4	1	21	5	-	1	-	-	1	7	5	33
WAIKATO	-	-	2	-	-	-	-	1	1	4	-	-	1	-	-	1	2	-	6
LAKES	1	-	2	-	-	-	-	-	-	3	1	-	-	-	-	-	1	-	4
BAY OF PLENTY	-	-	1	-	-	-	1	1	-	3	2	-	-	-	-	-	2	1	6
TAIRAWHITI	5	-	1	-	1	-	-	2	-	9	2	-	-	-	-	-	2	3	14
TARANAKI	-	-	1	-	-	-	1	-	-	2	-	-	-	-	-	-	-	1	3
CENTRAL	-	1	5	-	2	-	3	7	2	20	6	-	-	4	-	1	11	7	38
HAWKE'S BAY	-	-	-	-	-	-	-	4	1	5	1	-	-	-	-	-	1	2	8
MIDCENTRAL	-	1	-	-	-	-	1	2	-	4	1	-	-	-	-	-	1	1	6
WHANGANUI	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
CAPITAL & COAST	-	-	5	-	2	-	2	-	-	9	4	-	-	2	-	1	7	3	19
HUTT VALLEY	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	-	1
WAIRARAPA	-	-	-	-	-	-	-	-	1	1	-	-	-	2	-	-	2	-	3
SOUTHERN	-	-	-	-	-	-	1	1	1	3	7	-	-	2	-	-	9	1	13
WEST COAST	-	-	-	-	-	-	-	1	1	2	1	-	-	-	-	-	1	-	3
CANTERBURY	-	-	-	-	-	-	1	-	-	1	5	-	-	-	-	-	5	1	7
SOUTH CANTERBURY	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	2	-	2
SOUTHERN	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	1	-	1
TOTAL	9	6	18	3	5	-	9	23	7	80	29	-	1	6	1	2	39	19	138

Table 7. DHB Community Pacific ICAMH/AOD Workforce (Headcount, 2016)

REGION/DHB PACIFIC WORKFORCE (HEADCOUNT, 30 JUNE 2016)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/MANAGEMENT	TOTAL
NORTHERN	17	1	9	2	2	-	5	7	3	46	6	-	-	-	1	-	7	5	58
WAITEMATA	16	-	4	1	1	-	3	1	3	29	1	-	-	-	-	-	1	3	33
AUCKLAND	-	-	1	-	-	-	-	-	-	1	4	-	-	-	-	-	4	-	5
COUNTIES MANUKAU	1	1	4	1	1	-	2	6	-	16	1	-	-	-	1	-	2	2	20
MIDLAND	1	-	1	-	-	-	1	-	-	3	-	-	-	-	-	-	-	-	3
BAY OF PLENTY	1	-	-	-	-	-	1	-	-	2	-	-	-	-	-	-	-	-	2
TAIRAWHITI	-	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
CENTRAL	-	-	5	-	-	-	1	1	2	9	2	-	-	3	-	-	5	3	17
CAPITAL & COAST	-	-	5	-	-	-	1	1	2	9	2	-	-	3	-	-	5	3	17
SOUTHERN	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-	1
SOUTHERN	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-	1
TOTAL	18	1	15	2	2	-	7	8	5	58	8	-	1	3	1	-	13	8	79

Table 8. DHB Community Asian ICAMH/AOD Workforce (Headcount, 2016)

REGION/DHB ASIAN WORKFORCE (HEADCOUNT, 30 JUNE 2016)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	-	-	5	8	7	1	5	3	2	31	-	-	1	-	-	-	1	2	34
NORTHLAND	-	-	-	-	1	-	-	-	-	1	-	-	-	-	-	-	-	-	1
WAITEMATA	-	-	2	3	5	1	2	-	-	13	-	-	1	-	-	-	1	-	14
AUCKLAND	-	-	1	3	-	-	1	-	1	6	-	-	-	-	-	-	-	-	6
COUNTIES MANUKAU	-	-	2	2	1	-	2	3	1	11	-	-	-	-	-	-	-	2	13
MIDLAND	-	-	-	-	6	-	-	4	-	10	-	-	-	-	-	-	-	-	10
WAIKATO	-	-	-	-	6	-	-	4	-	10	-	-	-	-	-	-	-	-	10
CENTRAL	-	-	1	1	3	-	1	-	-	6	-	-	-	-	-	-	-	3	9
MIDCENTRAL	-	-	1	-	-	-	1	-	-	2	-	-	-	-	-	-	-	-	2
WHANGANUI	-	-	-	-	1	-	-	-	-	1	-	-	-	-	-	-	-	-	1
CAPITAL & COAST	-	-	-	1	1	-	-	-	-	2	-	-	-	-	-	-	-	3	5
HUTT VALLEY	-	-	-	-	1	-	-	-	-	1	-	-	-	-	-	-	-	-	1
SOUTHERN	-	-	1	-	1	-	2	2	-	6	-	-	-	-	-	-	-	-	6
CANTERBURY	-	-	-	-	1	-	1	1	-	3	-	-	-	-	-	-	-	-	3
SOUTH CANTERBURY	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	-	1
SOUTHERN	-	-	1	-	-	-	1	-	-	2	-	-	-	-	-	-	-	-	2
TOTAL	-	-	7	9	17	1	8	9	2	54	-	-	1	-	-	-	1	5	59

Table 9. DHB Community NZ European ICAMH/AOD Workforce (Headcount, 2016)

REGION/DHB NZ EUROPEAN WORKFORCE (HEADCOUNT, 30 JUNE 2016)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	9	2	35	24	17	14	60	30	25	216	-	-	1	-	-	-	1	20	237
NORTHLAND	-	2	12	2	2	1	5	4	3	31	-	-	-	-	-	-	-	2	33
WAITEMATA	9	-	13	8	7	7	15	10	4	73	-	-	-	-	-	-	-	7	80
AUCKLAND	-	-	8	12	6	6	36	10	7	85	-	-	-	-	-	-	-	9	94
COUNTIES MANUKAU	-	-	2	2	2	-	4	6	11	27	-	-	1	-	-	-	1	2	30
MIDLAND	2	3	18	3	10	1	16	16	2	71	-	-	-	-	4	1	5	12	88
WAIKATO	2	1	3	3	4	-	7	4	1	25	-	-	-	-	2	-	2	7	34
LAKES	-	-	2	-	1	-	2	2	1	8	-	-	-	-	-	-	-	2	10
BAY OF PLENTY	-	2	8	-	3	-	4	7	-	24	-	-	-	-	-	1	1	3	28
TAIRAWHITI	-	-	-	-	1	1	1	2	-	5	-	-	-	-	-	-	-	-	5
TARANAKI	-	-	5	-	1	-	2	1	-	9	-	-	-	-	2	-	2	-	11
CENTRAL	3	3	30	11	20	7	44	35	24	177	-	1	-	3	1	3	8	23	208
HAWKES BAY	2	-	5	1	1	-	2	5	3	19	-	-	-	-	-	-	-	3	22
MIDCENTRAL	-	-	5	1	1	-	4	9	2	22	-	-	-	-	-	-	-	4	26
WHANGANUI	-	-	3	-	-	-	1	2	-	6	-	1	-	-	1	-	2	2	10
CAPITAL & COAST	1	2	14	8	14	3	22	8	11	83	-	-	-	2	-	3	5	6	94
HUTT VALLEY	-	-	1	1	2	4	12	10	8	38	-	-	-	-	-	-	-	5	43
WAIRARAPA	-	1	2	-	2	-	3	1	-	9	-	-	-	1	-	-	1	3	13
SOUTHERN	5	2	46	12	17	4	35	31	15	167	-	1	2	-	-	1	4	32	203
NELSON MARLBOROUGH	3	-	9	3	5	-	10	8	2	40	-	1	-	-	-	1	2	7	49
WEST COAST	-	2	-	-	-	2	-	-	2	6	-	-	-	-	-	-	-	1	7
CANTERBURY	1	-	18	5	6	1	14	17	6	68	-	-	-	-	-	-	-	16	84
SOUTH CANTERBURY	-	-	-	-	-	1	-	-	-	1	-	-	-	-	-	-	-	-	1
SOUTHERN	1	-	19	4	6	-	11	6	5	52	-	-	2	-	-	-	2	8	62
TOTAL	19	10	129	50	64	26	155	112	66	631	-	2	3	3	5	5	18	87	736

Table 10. DHB Community Other Ethnicity ICAMH/AOD Workforce (Headcount, 2016)

REGION/DHB OTHER ETHNICITY WORKFORCE (HEADCOUNT, 30 JUNE 2016)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	5	-	7	6	12	3	13	11	5	62	-	-	-	-	-	-	-	12	74
WAITEMATA	5	-	4	5	4	3	5	8	1	35	-	-	-	-	-	-	-	8	43
AUCKLAND	-	-	-	-	4	-	4	1	-	9	-	-	-	-	-	-	-	-	9
COUNTIES MANUKAU	-	-	3	1	4	-	4	2	4	18	-	-	-	-	-	-	-	4	22
MIDLAND	2	-	10	1	10	-	15	10	1	49	-	-	2	-	1	-	3	1	53
WAIKATO	-	-	3	-	4	-	7	7	-	21	-	-	2	-	-	-	2	-	23
LAKES	-	-	2	-	1	-	5	1	1	10	-	-	-	-	-	-	-	1	11
BAY OF PLENTY	2	-	3	1	4	-	3	2	-	15	-	-	-	-	-	-	-	-	15
TARANAKI	-	-	2	-	1	-	-	-	-	3	-	-	-	-	1	-	1	-	4
CENTRAL	2	1	2	-	8	-	4	1	3	21	-	-	-	-	-	-	-	1	22
HAWKES BAY	-	-	-	-	2	-	1	-	1	4	-	-	-	-	-	-	-	-	4
MIDCENTRAL	-	-	-	-	2	-	1	-	1	4	-	-	-	-	-	-	-	-	4
WHANGANUI	2	1	2	-	1	-	1	-	1	8	-	-	-	-	-	-	-	1	9
CAPITAL & COAST	-	-	-	-	2	-	-	1	-	3	-	-	-	-	-	-	-	-	3
HUTT VALLEY	-	-	-	-	1	-	1	-	-	2	-	-	-	-	-	-	-	-	2
SOUTHERN	-	-	6	3	14	3	3	6	4	39	-	-	-	-	-	-	-	-	39
WEST COAST	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CANTERBURY	-	-	6	1	11	1	2	4	2	27	-	-	-	-	-	-	-		27
SOUTH CANTERBURY	-	-	-	2	1	2	1	1	-	7	-	-	-	-	-	-	-	-	7
SOUTHERN	-	-	-	-	2	-	-	1	2	5	-	-	-	-	-	-	-	-	5
TOTAL	9	1	25	10	44	6	35	28	13	171	-	-	2	-	1	-	3	14	188

Table 11. NGO ICAMH/AOD Workforce (Actual FTEs, 2016)

NGO WORKFORCE 30 JUNE 2016 (ACTUAL FTES)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	36.1	2.0	3.0	0.5	-	-	1.6	1.3	5.4	49.9	1.5	-	0.6	28.9	26.32	2.5	59.82	9.5	119.22
NORTHLAND	8.0	2.0	1.0	-	-	-	1.0	1.0	-	13.0	-	-	-	-	3.5	-	3.5	4.5	21.0
WAITEMATA	-	-	-	-	-	-	-	-	2.0	2.0	-	-	-	-	3.0	2.5	5.5	-	7.5
AUCKLAND	18.6	-	2.0	0.5	-	-	-	-	1.0	22.1	1.5	-	-	17.9	3.0	-	22.4	3.5	48.0
COUNTIES MANUKAU	9.5	-	-	-	-	-	0.6	0.3	2.4	12.8	-	-	0.6	8.5	16.82	2.5	28.42	1.5	42.72
MIDLAND	22.8	1.5	8.5	1.0	2.7	-	1.0	30.8	52.2	120.5	2.2	-	-	16.1	6.0	19.7	44.0	1.4	165.9
WAIKATO	16.0	-	5.5	1.0	0.7	-	-	5.0	43.2	71.4	2.2	-	-	13.1	2.0	6.2	23.5	1.0	95.9
LAKES	1.0	-	2.0	-	2.0	-	-	-	7.0	12.0	-	-	-	1.0	4.0	7.0	12.0	-	24.0
BAY OF PLENTY	5.8	1.5	1.0	-	-	-	-	20.8	1.0	30.1	-	-	-	1.0	-	5.5	6.5	0.4	37.0
TAIRAWHITI	-	-	-	-	-	-	1.0	1.0	-	2.0	-	-	-	-	-	1.0	1.0	-	3.0
TARANAKI	-	-	-	-	-	-	-	4.0	1.0	5.0	-	-	-	1.0	-	-	1.0	-	6.0
CENTRAL	5.65	1.0	0.2	-	-	1.25	1.0	1.5	10.0	20.6	-	-	1.0	9.0	11.3	3.7	25.0	6.35	51.95
HAWKE'S BAY	-	-	-	-	-	-	-	0.5	-	0.5	-	-	-	3.0	-	-	3.0	0.5	4.0
MIDCENTRAL	2.5	1.0	-	-	-	-	1.0	-	-	4.5	-	-	-	1.0	9.0	1.0	11.0	1.0	16.5
WHANGANUI	1.0	-	0.2	-	-	-	-	-	-	1.2	-	-	1.0	1.0	-	-	2.0	0.2	3.4
CAPITAL & COAST	0.15	-	-	-	-	1.25	-	-	3.0	4.4	-	-	-	2.8	0.5	2.7	6.0	0.65	11.05
HUTT VALLEY	1.0	-	-	-	-	-	-	1.0	7.0	9.0	-	-	-	1.0	1.8	-	2.8	4.0	15.8
WAIRARAPA	1.0	-	-	-	-	-	-	-	-	1.0	-	-	-	0.2	-	-	0.2	-	1.2
SOUTHERN	8.9	7.2	0.9	6.95	0.6	1.0	2.4	12.15	30.8	70.9	0.2	-	0.06	38.58	21.9	5.24	65.98	11.9	148.78
NELSON MARLBOROUGH	-	-	-	0.9	-	-	-	1.0	0.6	2.5	-	-	-	2.3	6.8	-	9.1	-	11.6
WEST COAST	-	-	-	-	-	-	-	-	-		-	-	-	3.0	-	-	3.0	-	3.0
CANTERBURY	4.0	1.5	-	-	-	-	1.0	4.0	18.1	28.6	-	-	-	16.56	15.1	2.6	34.26	2.7	65.56
SOUTH CANTERBURY	-	-	0.4	3.3	-	-	-	1.7	0.9	6.3	-	-	-	2.6	-	-	2.6	0.9	9.8
SOUTHERN	4.9	5.7	0.5	2.75	0.6	1.0	1.4	5.45	11.2	33.5	0.2	-	0.06	14.12	-	2.64	17.02	8.3	58.82
TOTAL	75.1	11.7	11.6	8.5	3.4	2.3	6.0	46.8	98.4	263.6	3.9	-	1.7	93.1	66.5	31.1	196.3	29.2	489.0

Table 12. NGO ICAMH/AOD Vacant FTEs (2016)

NGO VACANT FTEs 2016	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	-	-	1.0	-	-	-	-	-	-	1.0	-	-	-	-	5.78	-	5.78	-	6.78
NORTHLAND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.9	-	0.9	-	0.9
AUCKLAND	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.0	-	1.0	-	1.0
COUNTIES MANUKAU	-	-	1.0	-	-	-	-	-	-	1.0	-	-	-	-	3.88	-	3.88	-	4.88
CENTRAL	0.5	-	-	-	-	-	-	-	-	0.5	-	-	-	-	-	-	-	-	0.5
WAIRARAPA	0.5	-	-	-	-	-	-	-	-	0.5	-	-	-	-	-	-	-	-	0.5
SOUTHERN	-	-	-	-	-	-	-	-	-	-	-	-	-	2.0	1.0	-	3.0	-	3.0
CANTERBURY	-	-	-	-	-	-	-	-	-	-	-	-	-	1.0	1.0	-	2.0	-	2.0
SOUTHERN	-	-	-	-	-	-	-	-	-	-	-	-	-	1.0	-	-	1.0	-	1.0
TOTAL	0.5	-	1.0	-	-	-	-	-	-	1.5	-	-	-	2.0	6.8	-	8.8	-	10.3

Table 13. NGO Māori ICAMH/AOD Workforce (Headcount, 2016)

NGO MĀORI WORKFORCE 30 JUNE 2016 (HEADCOUNT)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	8	1	1	-	-	-	1	2	4	17	3	-	2	14	9	4	32	4	53
NORTHLAND	2	1	-	-	-	-	-	1	-	4	-	-	-	-	2	-	2	2	8
WAITEMATA	-	-	-	-	-	-	-	-	-	-	-	-	-	-		3	3	-	3
AUCKLAND	3	-	1	-	-	-	-	-	-	4	2	-	-	5	3	-	10	1	15
COUNTIES MANUKAU	3	-	-	-	-	-	1	1	4	9	1	-	2	6	4	4	17	1	27
MIDLAND	14	2	3	-	-	-	-	24	10	53	1	-	-	15	5	9	30	-	83
WAIKATO	9	-	2	-	-	-	-	6	3	20	1	-	-	14	3	2	20	-	40
LAKES	1	-	-	-	-	-	-	-	6	7	-	-	-	-	2	1	3	-	10
BAY OF PLENTY	4	2	1	-	-	-	-	16	1	24	-	-	-	1	-	5	6	-	30
TAIRAWHITI	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	1	1	-	2
TARANAKI	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	-	1
CENTRAL	5	-	1	-	-	-	-	2	2	10	-	-	1	7	4	2	14	5	29
HAWKE'S BAY	-	-	-	-	-	-	-	1	-	1	-	-	-	2	-	-	2	1	4
MIDCENTRAL	2	-	-	-	-	-	-	-	-	2	-	-	-	-	3	-	3	-	5
WHANGANUI	1	-	1	-	-	-	-	-	-	2	-	-	-	2	-	-	2	2	6
CAPITAL & COAST	1	-	-	-	-	-	-	-	2	3	-	-	-	1	1	2	4	-	7
HUTT VALLEY	1	-	-	-	-	-	-	1	-	2	-	-	1	-	-	-	1	2	5
WAIRARAPA	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	2	-	2
SOUTHERN	9	4	-	-	-	-	-	3	5	21	-	-	-	9	2	2	13	2	36
NELSON MARLBOROUGH	-	-	-	-	-	-	-	1	1	2	-	-	-	3	1	-	4	-	6
CANTERBURY	3	1	-	-	-	-	-	2	1	7	-	-	-	6	1	2	9	-	16
SOUTHERN	6	3	-	-	-	-	-	-	3	12	-	-	-	-	-	-	-	2	14
TOTAL	36	7	5	-	-	-	1	31	21	101	4	-	3	45	20	17	89	11	201

Table 14. NGO Pacific ICAMH/AOD Workforce (Headcount, 2016)

NGO PACIFIC WORKFORCE 30 JUNE 2016 (HEADCOUNT)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKJER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	6	-	-	-	-	-	-	-	1	7	1	-	-	8	11	3	23	-	30
NORTHLAND	1	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	1	-	2
AUCKLAND	1	-	-	-	-	-	-	-	-	1	-	-	-	3	-	-	3	-	4
COUNTIES MANUKAU	4	-	-	-	-	-	-	-	1	5	1	-	-	5	10	3	19	-	24
MIDLAND	-	-	5	-	-	-	-	1	1	7	-	-	-	2	-	-	2	-	9
WAIKATO	-	-	4	-	-	-	-	-	1	5	-	-	-	2	-	-	2	-	7
BAY OF PLENTY	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	-	1
TAIRAWHITI	-	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
CENTRAL	-	-	-	-	-	-	-	-	1	1	-	-	-	2	-	3	5	-	6
HAWKE'S BAY	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	-	1
MIDCENTRAL	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	2	-	2
CAPITAL & COAST	-	-	-	-	-	-	-	-	1	1	-	-	-	1	-	1	2	-	3
SOUTHERN	1	1	-	-	-	-	-	-	-	2	-	-	-	1	-	-	1	1	4
CANTERBURY	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	-	1
SOUTHERN	1	1	-	-	-	-	-	-	-	2	-	-	-		-	-	-	1	3
TOTAL	7	1	5	-	-	-	-	1	3	17	1	-	-	13	11	6	31	1	49

Table 15. NGO Asian ICAMH/AOD Workforce (Headcount, 2016)

NGO ASIAN WORKFORCE 30 JUNE 2016 (HEADCOUNT)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	5	-	2	-	-	-	-	-	1	8	-	-	-	7	2	1	10	-	18
WAITEMATA	-	-	-	-	-	-	-	-	1	1	-	-	-		-	-	-	-	1
AUCKLAND	3	-	2	-	-	-	-	-	-	5	-	-	-	7	-	-	7	-	12
COUNTIES MANUKAU	2	-	-	-	-	-	-	-	-	2	-	-	-		2	1	3	-	5
MIDLAND	2	-	2	1	-	-	-	-	-	5	-	-	-	1	-	-	1	-	6
WAIKATO	1	-	1	1	-	-	-	-	-	3	-	-	-	1	-	-	1	-	4
LAKES	-	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
BAY OF PLENTY	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
CENTRAL	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	1
MIDCENTRAL	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	1
SOUTHERN	-	-	-	-	-	-	-	2	1	3	-	-	-	1	-	-	1	-	4
CANTERBURY	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	-	1
SOUTHERN	-	-	-	-	-	-	-	2	1	3	-	-	-	-	-	-	-	-	3
TOTAL	7	-	4	1	-	-	1	2	2	17	-	-	-	9	2	1	12	-	29

Table 16. NGO NZ European ICAMH/AOD Workforce (Headcount, 2016)

NGO NZ EUROPEAN WORKFORCE 30 JUNE 2016 (HEADCOUNT)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	19	1	1	1	-	-	1	-	2	25	-	-	-	7	6	1	14	5	44
NORTHLAND	5	1	1	-	-	-	-	-	-	7	-	-	-	-	3	-	3	3	13
WAITEMATA	-	-	-	-	-	-	-	-	1	1	-	-	-	-	3	-	3	-	4
AUCKLAND	13	-	-	1	-	-	-	-	1	15	-	-	-	7	-	-	7	2	24
COUNTIES MANUKAU	1	-	-	-	-	-	1	-	-	2	-	-	-	-	-	1	1	-	3
MIDLAND	8	-	2	1	3	-	1	9	6	30	-	-	-	10	4	9	23	2	55
WAIKATO	7	-	2	1	1	-	-	1	3	15	-	-	-	8	2	-	10	1	26
LAKES	-	-	-	-	2	-	-	1	2	5	-	-	-	1	2	6	9	-	14
BAY OF PLENTY	1	-	-	-	-	-	-	6	-	7	-	-	-	-	-	3	3	1	11
TAIRAWHITI	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	1
TARANAKI	-	-	-	-	-	-	-	1	1	2	-	-	-	1	-	-	1	-	3
CENTRAL	2	1	-	-	-	2	-	-	6	11	-	-	1	7	9	-	19	1	31
HAWKE'S BAY	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	-	1
MIDCENTRAL	1	1	-	-	-	-	-	-	-	2	-	-	-	1	9	-	10	1	13
WHANGANUI	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1	-	1
CAPITAL & COAST	-	-	-	-	-	2	-	-	-	2	-	-	-	1	-	-	1	-	3
HUTT VALLEY	-	-	-	-	-	-	-	-	6	6	-	-	-	-	-	-	2	-	8
WAIRARAPA	1	-	-	-	-	-	-	-	-	1	-	-	-	4	-	-	4	-	5
SOUTHERN	2	5	2	8	1	1	3	7	29	58	-	-	2	42	15	4	63	14	135
WEST COAST	-	-	-	-	-	-	-	-	-	-	-	-	-	3	-	-	3	-	3
NELSON MARLBOROUGH	-	-	-	1	-	-	-	-	-	1	-	-	-	1	6	-	7	-	8
CANTERBURY	2	1	-	-	-	-	1	2	15	21	-	-	-	16	9	2	27	3	51
SOUTH CANTERBURY	-	-	2	4	-	-	-	2	1	9	-	-	-	3	-	-	3	2	14
SOUTHERN	-	4	-	3	1	1	2	3	13	27	-	-	2	19	-	2	23	9	59
TOTAL	31	7	5	10	4	3	5	16	43	124	-	-	3	66	34	14	119	22	265

Table 17. NGO Other Ethnicity ICAMH/AOD Workforce (Headcount, 2016)

NGO OTHER ETHNICITY WORKFORCE 30 JUNE 2016 (HEADCOUNT)	ALCOHOL & DRUG	CO-EXISTING PROBLEMS	MENTAL HEALTH NURSE	OCCUPATIONAL THERAPIST	PSYCHIATRIST	PSYCHOTHERAPIST	PSYCHOLOGIST	SOCIAL WORKER	OTHER CLINICAL	CLINICAL SUB-TOTAL	CULTURAL	SPECIFIC LIAISON	MENTAL HEALTH CONSUMER	MENTAL HEALTH SUPPORT	YOUTH WORKER	OTHER NON-CLINICAL	NON-CLINICAL SUB-TOTAL	ADMINISTRATION/ MANAGEMENT	TOTAL
NORTHERN	-	-	-	-	-	-	1	-	-	1	-	-	-	4	-	1	5	2	8
NORTHLAND	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	1
AUCKLAND	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	2	1	3
COUNTIES MANUKAU	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	1	3	1	4
MIDLAND	2	-	-	-	1	-	1	2	-	6	-	-	-	-	1	-	1	-	7
WAIKATO	1	-	-	-	1	-	-	-	-	2	-	-	-	-	-	-	-	-	2
LAKES	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1	-	1
BAY OF PLENTY	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1
TAIRAWHITI	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	1
TARANAKI	-	-	-	-	-	-	-	2	-	2	-	-	-	-	-	-	-	-	2
CENTRAL	-	-	-	-	-	-	-	-	1	1	-	-	-	1	-	-	1	2	4
CAPITAL & COAST	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	-	1
HUTT VALLEY	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	2	3
SOUTHERN	2	1	-	-	-	1	-	-	5	9	-	-	-	8	-	-	8	-	17
CANTERBURY	1		-	-	-	-	-	-	5	6	-	-	-	7	-	-	7	-	13
SOUTHERN	1	1	-	-	-	1	-	-	-	3	-	-	-	1	-	-	1	-	4
TOTAL	4	1	-	-	1	1	2	2	6	17	-	-	-	13	1	1	15	4	36

Table 18. Total Ethnicity of the ICAMH/AOD Workforce by DHB Area (2016)

2016 TOTAL WORKFORCE ETHNICITY (HEADCOUNT)	NZ EUROPEAN			OTHER			MĀORI			PACIFIC			ASIAN			DHB	NGO	TOTAL
	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL			
NORTHERN	**288**	**44**	**332**	**74**	**8**	82	**59**	**53**	112	**66**	**30**	**96**	**44**	**18**	**62**	**531**	**153**	**684**
Northland	33	13	46	-	1	1	17	8	25	-	2	**2**	1	-	**1**	51	24	75
Waitemata	80	4	84	43	-	43	13	3	16	33	-	**33**	14	1	**15**	183	8	191
Auckland Inpatient	51	-	51	-	-	-	5	-	5	8	-	**8**	10	-	**10**	74	-	74
Auckland Community	94	24	118	9	3	12	11	15	26	5	4	**9**	6	12	**18**	125	58	183
Counties Manukau	30	3	33	22	4	26	13	27	40	20	24	**44**	13	5	**18**	98	63	161
MIDLAND	**88**	**54**	142	**53**	**7**	60	**33**	**83**	116	**3**	**9**	**12**	**10**	**6**	**16**	**187**	**159**	**346**
Waikato	34	25	**59**	23	2	25	6	40	46	-	7	**7**	10	4	**14**	73	78	151
Lakes	10	14	**24**	11	1	12	4	10	14	-	-	**-**	-	1	**1**	25	26	51
Bay of Plenty	28	11	**39**	15	1	16	6	30	36	2	1	**3**	-	1	**1**	51	44	95
Tairawhiti	5	1	**6**	-	1	1	14	2	16	1	1	**2**	-	-	**-**	20	5	25
Taranaki	11	3	**14**	4	2	6	3	1	4	-	-	**-**	-	-	**-**	18	6	24
CENTRAL	**231**	**31**	262	**22**	**4**	26	**44**	**29**	73	**22**	**6**	**28**	**10**	**1**	**11**	**329**	**71**	**400**
Hawke's Bay	22	1	23	4	-	4	8	4	12	-	1	**1**	-	-	**-**	34	6	40
MidCentral	26	13	39	4	-	4	6	5	11	-	2	**2**	2	1	**3**	38	21	59
Whanganui	10	1	11	9	-	9	1	6	7	-	-	**-**	1	-	**1**	21	7	28
Capital & Coast Inpatient	23	-	23	-	-	-	6	-	6	5	-	**5**	1	-	**1**	35	-	35
Capital & Coast Community	94	3	97	3	1	4	19	7	26	17	3	**20**	5	-	**5**	138	14	152
Hutt	43	8	51	2	3	5	1	5	6	-	-	**-**	1	-	**1**	47	16	63
Wairarapa	13	5	18				3	2	5	-	-	**-**	-	-	**-**	16	7	23
SOUTHERN	**253**	**135**	388	**43**	**17**	60	**17**	**36**	53	**3**	**4**	**7**	**10**	**4**	**14**	**326**	**196**	**522**
Nelson Marlborough	49	8	57	-	-	-	-	6	6	-	-	**-**	-	-	**-**	49	14	63
West Coast	7	3	10	-	-	-	3	-	3	-	-	**-**	-	-	**-**	10	3	13
Canterbury Inpatient	50	-	50	4	-	4	4	-	4	2	-	**2**	4	-	**4**	64	-	64
Canterbury Community	84	51	135	27	13	40	7	16	23	-	1	**1**	3	1	**4**	121	82	203
South Canterbury	1	14	15	7	-	7	2	-	2	-	-	**-**	1	-	**1**	11	14	25
Southern	62	59	121	5	4	9	1	14	15	1	3	**4**	2	3	**5**	71	83	154
TOTAL	**860**	**264**	**1,124**	**192**	**36**	**228**	**153**	**201**	**354**	**94**	**49**	**143**	**74**	**29**	**103**	**1,373**	**579**	**1,952**

APPENDIX E: DHB & NGO WORKFORCE SURVEY FORM

SECTION 1: DHB PROVIDER ARM LIST OF INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD SERVICES

In this section, we have provided a list of **DHB funded Infant, Child & Adolescent Mental Health/AoD Services** extracted from the draft 2015/2016 Price Volume Schedules provided by the Ministry of Health for your verification. Please feel free to amend or add any **other DHB funded Child & Adolescent Contracted Services** that are not included in the table below:

Table 1: DHB funded Child & Adolescent Mental Health Contracted Services as at 30th June 2016

PURCHASE UNIT CODE	PURCHASE UNIT DESCRIPTION	VOLUME	UNIT

Infant, Child & Adolescent Mental Health/AoD Services are defined by this survey as all **Mental Health/AoD 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.

SERVICE TEAMS	AGE GROUP

Does your service provide/deliver:

- **Care Pathways/Support specifically for trans* and gender diverse youth?**

☐ **YES** ☐ **NO** ☐ **DON'T KNOW**

- **Any of the following Parenting Programmes (Select as many that apply)?**

☐ **Incredible Years** ☐ **Triple P** ☐ **Parent Child Interaction Therapy (PCIT)**

☐ **Other (Please Specify below):**

Please indicate whether you use the following Cultural Health Models in your Service Delivery:

- **Māori Health Models (e.g. Te Whare Tapa Wha)** ☐ **YES** ☐ **NO** ☐ **DON'T KNOW**

If Yes, please specify:

- **Pacific Health Models (e.g. Fonofale Model)** ☐ **YES** ☐ **NO** ☐ **DON'T KNOW**

If Yes, please specify:

SECTION TWO: WORKFORCE INFORMATION:

ANNUAL STAFF TURNOVER	
No of Staff (Headcount) as at 1st July 2015:	
No of Staff (Headcount) as at 30th June 2016:	
No of Staff (Headcount) who have left during the 1 year period:	
Occupation of Staff who have left:	**Reason for Leaving**

CURRENT & FUTURE WORKFORCE
What are your service's current top 3 workforce gaps/challenges?
What do you think your workforce gaps/challenges may be in 10 years' time?

DHB: SERVICE/TEAM

Please ensure the workforce information is provided for the *DHB funded Infant, Child & Adolescent Mental Health/AoD Contract* as at 30th June, 2016 only (as outlined in Table 1).

To calculate FTEs = Number of Hours worked per week divided by 40 hours
For example: FTE calculation for 20 hours worked: 20/40 = 0.5 FTEs

TABLE 1: EMPLOYEE GROUP	ACTUAL FTES (AS AT 30TH JUNE 2016)	VACANT FTES (AS AT 30TH JUNE 2016)
Alcohol & Drug Practitioners		
Co-Existing Problems Clinicians		
Counsellors		
Mental Health Nurses/Registered Nurses		
Occupational Therapists		
Child Psychiatrists		
Adult Psychiatrists or other Senior Medical Officers		
Psychotherapists		
Registered Psychologists		
Social Workers		
Family Therapists		
Other Clinical (please state in the spaces below)		
Clinical Placements/Interns (please list below)		
Liaison/Consult Liaison Appointment		
Kaumātua, Kuia		
Advocacy/Peer Support-Consumers		
Advocacy/Peer Support-Family/Whānau		
Youth Consumer Advisors		
Family/Whanau Advisors		
Mental Health Support Workers/Kaiawhina/Kaiatawhai		
Youth Workers		
Other Non-Clinical Support (for clients) (please list in spaces below)		
Whānau Ora Practitioners		
Needs Assessors & Service Co-ordinators		
Educators		
Specific Cultural Positions not listed (please list in spaces below)		
Administration		
Management		
Other (please state in spaces below)		
TOTAL		

*Count from departure of previous employee or establishment of new position.

ETHNICITY OF THE WORKFORCE AS AT 30th JUNE 2016. Please confirm ethnicity with the individual.

TABLE 2: ETHNICITY	MĀORI		PACIFIC*		ASIAN*		NZ EUROPEAN		OTHER*		TOTAL FTES
	Actual FTEs	Head Count	Actual FTEs	Head Count	Actual FTEs	Head Count	Actual FTEs	Head Count	Actual FTEs	Head Count	FTEs in this column should equal to Table 1
Alcohol & Drug Practitioners											
CEP Clinicians											
Counsellors											
Mental Health Nurses											
Occupational Therapists											
Child/Adolescent Psychiatrists											
Adult Psychiatrists/Other SMO											
Psychotherapists											
Registered Psychologists											
Social Workers											
Family Therapists											
Other Clinical (please list below)											
Clinical Placements/Interns (please list below)											
Liaison/Consult Liaison Appointment											
Kaumātua, Kuia											
Advocacy/Peer Support-Consumers											
Advocacy/Peer Support-Family/Whānau											
Youth Consumer Advisors											
Family/Whānau Advisors											
Mental Health Support Workers/Kaiawhina/Kaiatawhai											
Youth Workers											
Other Non-Clinical Support (for clients) (please list in spaces below)											
Whānau Ora Practitioners											
Needs Assessors & Service Co-ordinators											
Educators											
Specific Cultural Positions not listed (please list in spaces below)											
Administration											
Management											
Other (please state in spaces below)											
TOTAL											

CONTACT DETAILS: NAME/PHONE/EMAIL	

Thank you

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Werry Workforce Whāraurau for Infant, Child and Adolescent Mental Health Workforce Development

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