Werry Workforce
WHĀRAURAU
For Infant, Child and Adolescent Mental Health

2018 Workforce Stocktake

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

ISBN 978-0-9941149-3-8

Citation:

Werry Workforce Whāraurau. (2019). ***2018 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*****. Auckland: Werry Workforce Whāraurau for Infant, Child & Adolescent Mental Health Workforce Development, The University of Auckland.**

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This workforce development initiative is funded by:
Health Workforce New Zealand, Ministry of Health, Wellington, New Zealand

This document is available on the Werry Workforce Whāraurau website:
www.werryworkforce.org

2018 STOCKTAKE

OF

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

WERRY WORKFORCE WHĀRAURAU
FOR INFANT, CHILD AND ADOLESCENT
MENTAL HEALTH
WORKFORCE DEVELOPMENT

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ACKNOWLEDGMENTS

The Werry Workforce Whāraurau team 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, NGOs and PHOs who have contributed to the 2018 *Stocktake*.

FOREWORD

Welcome to the 8th Biennial Stocktake of the ICAMH/AoD Workforce. 2019 is a seminal year for the mental health sector and we trust that this document will prove a very useful tool in the planning and decision making needed to move our sector ahead.

In our 2016 Stocktake, we noted the significant increase in the rates of young people accessing mental health services and the simultaneous plateauing of funding for ICAMH/AOD services. We noted the inequitible allocation that ICAMHS received of the total mental health funding. These themes continued and contributed to the significant concerns and stressors being conveyed by tangata whai ora, families and also by services and practitioners. Our dreadful suicide rates, including those for young people, continued to be shameful. This year we are pleased to see PHO services included in larger numbers for the first time.

In 2018, the Government Inquiry into Mental Health and Addictions held many public and private interviews with stakeholders and received more than 5,000 submissions. The public meetings heard many raw, honest and often upsetting stories from people who want care and support to be more easily accessed, be more whānau centred, and be more flexible and culturally responsive. The report heard the significant level of stress and frustration families had experienced in their attempts to get timely care and support for their loved ones in times of crisis.

In late May 2019, the Government responded to the 40 recommendations. It accepted eight recommendations as proposed, and variously agreed to another 30 (in principle or as requiring more consideration). Two were rejected: setting a suicide reduction target of 20%, and establishing a Wellbeing Commission.

The 2019 Budget announcements included very welcome and significant investment in wellbeing, especially for mental health. We look forward to supporting the very critical workforce development, and recruitment needed to achieve the goals set out in the inquiry report, *He Ara Oranga* and made possible by the new funding. We are excited for the development of new primary mental health services, increases in services for addictions and forensics, as well as firming up the specialist health services.

With all the expected development, innovation and improved access, we will maintain a strong focus on early intervention, children and young people, the generational impact of trauma and adverse childhood events (ACEs), supporting parents in their important role of growing happy and resilient young people – particularly those parents who have their own issues of mental health and addictions.

We look forward to working with you.

Sue Dashfield
Director

EXECUTIVE SUMMARY

This is the eighth *Stocktake* of the Infant, Child and Adolescent Mental Health/Alcohol and Other Drugs (ICAMH/AOD) workforce and service users 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) and Primary Health Organisations (PHOs), national, regional and local planners and funders, and service leaders across sectors to assess current capacity and accurately plan for future service and workforce development.

This report provides a snapshot of activity undertaken during 2018 by DHB and non-DHB service providers. As this is the eighth Stocktake, 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 high quality, widely available and easily accessible services for all.

FINDINGS

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

Potential current and future demand for services: Population data and projections:

- From 2016 to 2018, there was very little projected growth in the overall 0-19-year population (by 0.4%) with an overall 2% growth projected from the 2018 to 2028 period.
- Infants, children and adolescents (0-19 years) make up 26% of New Zealand's total population:
    - **Māori:** 26% of the total 0-19 years population with a young age structure and a growing population (11% growth projected by 2028).
    - **Pacific**: 10% of the total 0-19 years population, a growing population (9% growth projected by 2028) and also have a young age structure.
    - **Asian:** 14% of the total 0-19-year population, is the third largest ethnic group and a rapidly growing population (32% growth projected by 2028, the largest growth out of the four ethnic groups).
    - Māori and Pacific children and youth continue to experience lower socioeconomic status and experience mental health disorders at higher levels than the general population, and the Asian population is largely an immigrant population and the consequences of the immigration process can increase the risk of developing mental health problems indicating a continuing need for mental health services. Services would need to take these population trends and projections into consideration when planning for local service and workforce development activities according to need.

SERVICE USER ACCESS TO ICAMH/AOD SERVICES

Actual demand for services: PRIMHD service user access data:

- Access to ICAMH/AOD services from 2015 to 2017:
    - 7% increase in the overall number of 0-19 year service users accessing ICAMH services; 8% increase in DHB services; 4% increase in NGOs.
    - 76% of service users continued to be seen by DHBs; 24% were seen by NGOs.
    - Overall, the 0-19-year access rate (3.03%) exceeded the target rate of 3.0% (Mental Health Commission, 1998).

- Access rates by age group showed rates exceeding the target rates for 0-9 (1.07%) (1.0% target rate) and 15-19 (6.34%) (5.5% target rate) year age groups only, while the access rate (3.67%) remained below the target rate for the 10-14-year age group (3.9% target rate).
- Improvements in access rates were also seen for Māori, Pacific and Asian 0-19 years service users:
    - Māori service users made up 33% of all service users with an improvement in access rates from 3.66% to 3.89% from the 2015 to 2017 period. They continued to have the highest access rate out of four ethnic groups (Māori, Pacific, Asian and Other Ethnicity). While Māori access rates exceeded the overall target rates set by the MHC (3%), their current access rates fell short of the 6% rate recommended for Māori as they experience double the prevalence of mental health problems than do the general population.
    - Pacific service users made up 7% of service users with an improvement in in access rates for the same period, from 1.82% to 2.08%, but continuing to remain below the target rate of 3%.
    - Asian service users made up 4% of service users with an improvement in access rates, from 0.75% to 0.86%, but continuing to remain the lowest out of four ethnic groups and well below target rates.
- Access rates by region improved in all four regions with Midland (3.57%), Central (3.07%) and Southern (3.00%) all exceeding the 3% target rate. While an improvement was seen in the Northern region (from 2.60% to 2.75%), the access rate remained the lowest in the country and below target rates.
- Improving access to services for the 0-19 years population is pertinent as service user outcomes data (rated by the *Health of the Nation Outcome Scales for Children and Adolescents*, *HoNOSCA*, at admission and discharge from community child and adolescent mental health services) showed significant improvements in emotional related symptoms by time of discharge.

FUNDING FOR ICAMH/AOD SERVICES

Investment in the ICAMH/AOD sector for service and workforce development: Funding data for DHB and non-DHB services for the 2017/2018 financial year were extracted from Price Volume Schedules (PVS) supplied by the MOH.

From 2016 to 2018:

- 4.5% increase in funding for ICAMH/AOD services (including Youth Primary Mental Health funding).
- 0.5% increase for DHB services, 17.6% for non-DHB services.
- Largest increase: Youth Forensic Services by 39%.
- 6% increase in funding per head for the 0-19-year population, from $129.93 to $137.33 (excluding inpatient funding).

ICAMH/AOD WORKFORCE

Workforce capacity: The following information is derived from the Werry Workforce Whāraurau workforce survey, comprising actual and vacant full time equivalents (FTEs) by ethnicity and occupation, submitted by 20 DHB (Inpatient & Community) ICAMH/AOD services, including the National Youth Forensic Service, and 119 non-DHB services (108 NGOs & 11 PHOs), as at 30 June 2018.

- Workforce changes seen from 2016 to 2018:
    - 7% increase in overall ICAMH/AOD workforce
    - 1% increase in the DHB workforce
    - 21% increase in the non-DHB workforce
    - 5% increase in the clinical workforce.

- 13% increase in the non-clinical workforce (excluding Administration/Management staff).
- 15% increase in vacancies, with a vacancy rate of 9% overall. Vacancies were mainly in DHB services for clinical roles (90% of all vacancies reported).
- 20% annual staff turnover rate (DHB = 17%; non-DHB = 24%) mainly for Mental Health Support Workers, Nurses, Social Workers and Psychologists. Reasons for leaving included other job opportunities for better salaries; and relocating to another city/town within New Zealand or overseas.
- 19% increase in the overall Māori workforce, largely in the clinical workforce (by 29%)
- 18% increase in the Pacific workforce, largely in the clinical workforce (by 33%).
- 14% increase in the Asian workforce, largely in non-clinical roles.
- ***Workforce capability (knowledge and skills):*** The capability of the workforce was assessed by the *Real Skills Plus ICAMHS competency framework* (The Werry Centre, 2009b), via an online tool. This framework describes the knowledge, skills and attitudes needed to work with infants, children and young people who have mental health and/or alcohol or other drug (AOD) difficulties. *Real Skills Plus* team data from participating services in 2018 identified the following areas required for further development:
    - The DHB workforce met a number of ***Core*** level (practitioners working in specialist services focussing on mental health/AOD concerns) competencies which ranged from 65% to 96% of skills and knowledge required, and further development was indicated for the following:
        - ***Intervention Skills (27%)***
        - ***Assessment Knowledge (25%)***
        - ***Intervention Knowledge (22%).***
        - ***Skills for working with Infants (27%)***
        - ***Knowledge and Skills for Leadership roles (18%).***
    - The non-DHB workforce met a number of ***Primary*** level competencies (for people in the primary sector*)* which ranged from 64% to 96% of skills and knowledge required, and further development was indicated for the following:
        - ***Assessment Skills (31%)***
        - ***Intervention Knowledge (20%)***
        - ***Engagement Knowledge (20%).***
        - ***Knowledge and Skills for working with Young People (20%)***
- The following workforce challenges were identified by the ICAMH/AOD services via the workforce survey:
    - ***Lack of funding/limited resources***
    - ***Recruitment and retention of specialist staff***
    - ***Service demand outweighing workforce capacity***
    - ***Working collaboratively with other services/agencies.***

RECOMMENDATIONS

Based on the current findings and in alignment with the direction set by the *Mental Health and Addiction Workforce Action Plan,* 2017-2021 (Ministry of Health, 2017); *He Ara Oranga* (Government inquiry into Mental Health & Addiction, 2018), and within the context of what 1,000 young people who were surveyed by ActionStation said they would like (ActionStation, 2018), the following recommendations are made:

- **Increase and allocate appropriate levels of funding:** *Increase and ensure appropriate levels of funding are allocated for essential infrastructure, service and workforce development activities.*
- **Develop and provide early intervention programmes and services:**
    - *Develop and provide targeted early intervention programmes and parenting programmes*
    - *Provide and enhance school-based health education and services*
    - *Provide more alternative community-based services*
    - *Enhancing service user pathways from primary to secondary services via collaboration.*

- **Increase, strengthen and support primary level services and workforce through:**
    - *Targeted capacity, knowledge and skill development.*
- **Increase, strengthen and support the specialist ICAMH/AOD services and workforce through:**
    - ***Funding, planning and service re-design:*** *Use current resources more effectively and plan for future need and demand.*
    - ***Increasing workforce capacity:***
        - ***Recruitment:***
            - *Continue with targeted recruitment strategies*
            - *Expand and develop existing roles such as the peer workforce*
            - *Work collaboratively with other services to share resources.*
        - ***Retention****:*
            - *Address high vacancies and staff turnover*
            - *Look after the workforce.*
    - ***Increasing workforce capability (knowledge and skills):***
        - *Identify current knowledge and skill levels for targeted development*
        - *Identify and strengthen cultural knowledge and skills*
        - *Enable access to targeted specialist training.*
- **Continue data collection and large-scale national studies:** *To inform on-going service and workforce development based on population needs.*

INTRODUCTION

The very first national *Stocktake of Child and Adolescent Mental Health Services (*Ramage et al., 2005) at the request of the Ministry of Health, was conducted in 2004. The data indicated deficiencies in access rates and workforce numbers were evident. However, at the time it was acknowledged that the information needed to be interpreted with caution as the DHB and NGO access data may have been incomplete.

At the recommendation of the Werry Workforce Whāraurau (then known as the Werry Centre) strategic framework for the infant, child and adolescent mental health services and workforce, *Whakamārama te Huarahi* (Wille, 2006), further national *Stocktakes* were considered to add value to the existing data, so would be conducted every two years. Stocktake data to date showed increases in funding to DHB and non-DHB ICAMH/AOD services, increases in the workforce and more service users accessing these services. However, they also highlighted ongoing deficiencies in workforce numbers, especially low numbers of Māori, Pacific and Asian staff relative to service users even though service users access rates remained below the benchmarks set by the Mental Health Commission's Blueprint Guidelines (Mental Health Commission, 1998).

This is the eighth *Stocktake* of the Infant, Child and Adolescent Mental Health and Alcohol and Other Drug (ICAMH/AOD) workforce and service user access rates conducted by Werry Workforce Whāraurau (formerly the Werry Centre). The accumulated data to date provides a unique opportunity to identify trends over time in both workforce and access rates, and to consider the interactions of funding, staffing and access especially as response rates from services remain high (99% for the previous Stocktakes) and continue to improve. The 2018 response rate was at 100%, indicating high levels of engagement with services and the usefulness of this information to planners, funders and service leaders.

This report provides a snapshot of activity undertaken in 2018 by District Health Board (DHB) providers and non-DHB service providers, non-government organisations (NGOs) and primary health organisations (PHOs). 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 alignment with current government priorities.

STRATEGIC DIRECTIONS

A number of strategic documents have informed and shaped the infant, child and adolescent mental health workforce to date[1]:

- *Blueprint for Mental Health Services in New Zealand: How Things Need to Be (Mental Health Commission, 1998)*
- *Te Tahuhu—Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan (Minister of Health, 2005)*
- *Te Kokiri: The Mental Health and Addiction Plan 2006–2015 (Minister of Health, 2006)*
- *Te Raukura—Mental Health and Alcohol and Other Drugs: Improving Outcomes for Children and Youth (Ministry of Health, 2007)*
- *The Mental Health and Addiction Action Plan (Ministry of Health, 2010a)*
- *Improving the Transition: Reducing Social and Psychological Morbidity during Adolescence (Office of the Prime Minister's Science Advisory Committee, 2011)*
- *The Youth Forensic Services Development report (Ministry of Health, 2011)*
- *Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand (Ministry of Health, 2012b)*
- *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)*
- *Blueprint II (Mental Health Commission, 2012c)*

[1] **For a summary of these documents, please refer to the 2016 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand. Auckland: Werry Workforce Whāraurau for Infant, Child & Adolescent Mental Health Workforce Development, The University of Auckland.**

- *Rising to the Challenge* (Ministry of Health, 2012c)
- *The Children's Action Plan* (New Zealand Goverment, 2012)
- *Prime Minister's Youth Mental Health Project (2012).*

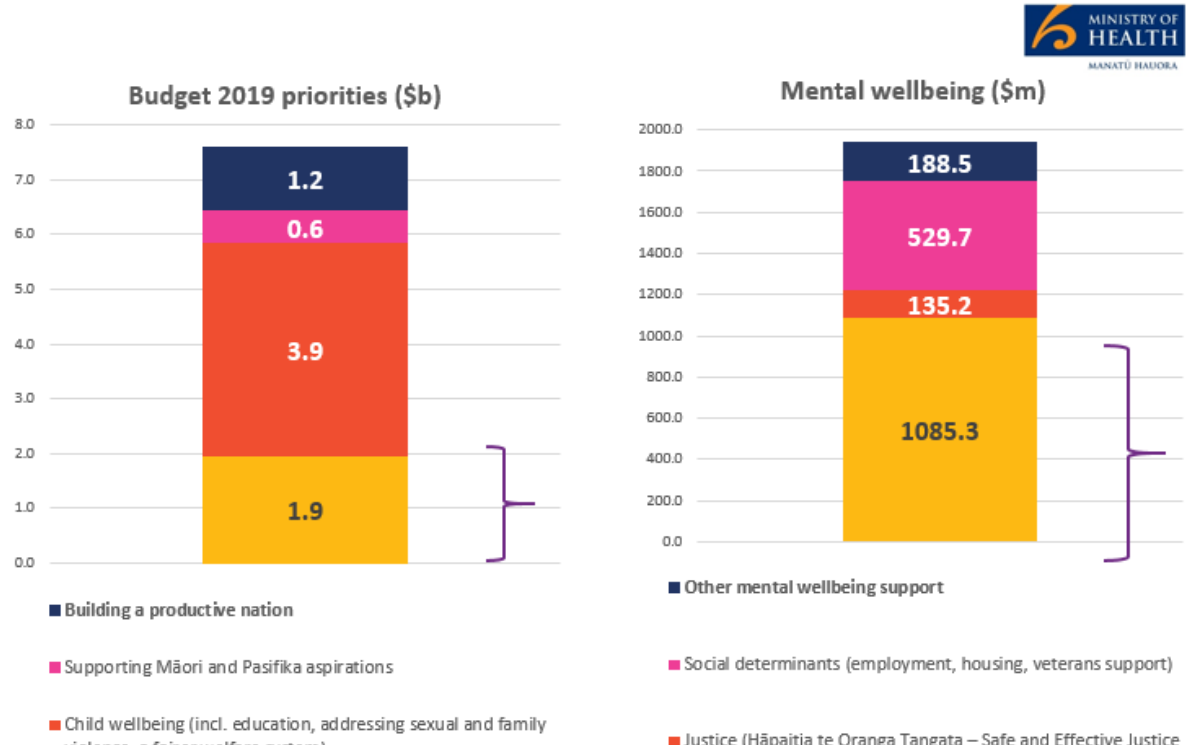
- ***He Ara Oranga*** (Government inquiry into Mental Health & Addiction, 2018) was an independent inquiry into mental health and addiction services commenced by the Government in 2018 after widespread concern about the state of mental health services in New Zealand voiced from within the mental health sector and the broader community, service users, their families and whānau, people affected by suicide, people working in health, media, Iwi and advocacy groups. Based on the extensive consultation work and information gathered, *He Ara Oranga* proposes a total of 40 recommendations for preventing and responding to mental health and addiction problems. Of this 40, seven are of relevance to children and young people:
    - ***Expand access and choice f***or those experiencing mild to moderate mental distress with a new access target of 20% (school-based mental and emotional well-being programmes, parenting programmes and perinatal support through national and community led initiatives).
    - ***Transform primary care*** to ensure people receive mental health/addiction support early and in their local communities (general practices, school-based services, and midwifery, Well Child Tamariki Ora, and NGO primary health services). Upskilling of the primary care workforce to respond appropriately to mental health and addiction challenges and increasing coordination between early childhood centres, schools and universities and other tertiary providers and child health and mental health services is required.
    - ***Strengthen the NGO sector:*** Funding insecurity, a lack of a genuine partnership with government and high compliance costs has impacted on their sustainability. A lead agency could improve the commissioning of health and social services with NGOs.
    - ***Enhance wellbeing, promotion, and prevention*** that addresses the wider social determinants that influence mental health and wellbeing would make significant inroads into improving mental health/addiction outcomes. A holistic response that includes supporting parents/caregivers with substance abuse and mental health problems, as well as embedding prevention services into the education system and workplace is required.
    - ***Place people at the centre:*** Embedding genuine co-design processes in mental health service planning by actively facilitating service user/consumer involvement, and supporting individuals and groups with the time, resources and training.
    - ***Action on drugs and alcohol*****:** A stricter regulatory approach to the sale and supply of alcohol. Investigating replacing criminal sanctions for the possession of controlled drugs for personal use with a full range of treatment and detox services which, if sufficiently resourced, could have a positive impact for young people.
    - ***Prevent suicide*****:** People who have experienced a high number of adverse childhood events (high ACE scores) are strongly correlated with an increased risk of suicidal behaviour (Smith, 2018, p. 3). Early intervention through school programmes designed to improve self-control and resilience during the transition from childhood to adulthood could also impact suicide prevention long term. Expanding the current multi-agency teams and programmes though schools, youth programmes and peer support organisations would require considered planning across government, considering the resources and training needed of the health and education workforce to support and sustain effective implementation.

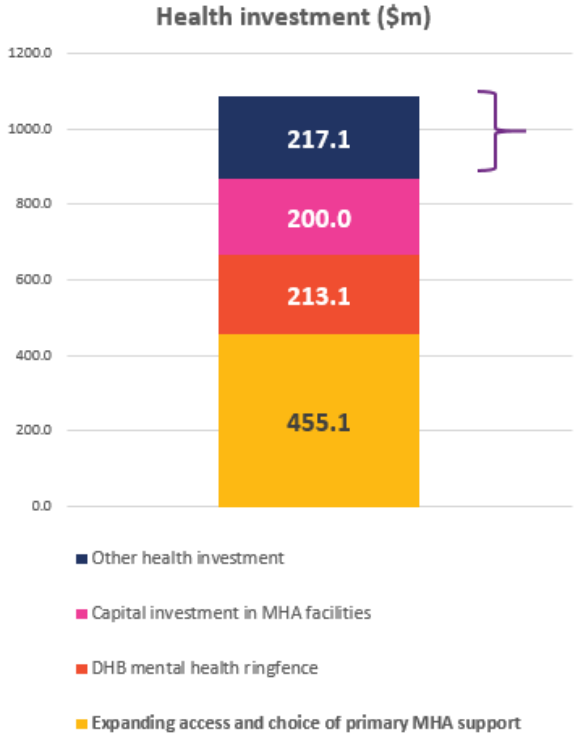
- Two of the 40 recommendations have been accepted, accepted in principle, or agreed to further consideration (Ministry of Health, 2019). The Government has rejected:
    - Directing the State Services Commission to report back with options for a locus of responsibility for social wellbeing, including, its form and location (a new social wellbeing agency, a unit within an existing agency or reconfiguring an existing agency) its functions.
    - Setting a target of 20% reduction in suicide rates by 2030, with Health Minister Dr David Clark saying, "every life matters, and one death by suicide is one death too many".

ALLOCATION OF THE BUDGET 2019:

The first step to progressing the recommendations proposed by *He Ara Oranga* (Government inquiry into Mental Health & Addiction, 2018) is the allocation of adequate of funding. Investment in mental wellbeing has been identified as a priority in the 2019 Budget and was allocated $1.9 billion over 5 years (Figure 1 shows a breakdown of allocated funding) (Ministry of Health, 2019).

Figure 1. Allocation of the Budget 2019





AOD services (specialist, primary, PPS, Te Ara Oranga)	69.0
Preventing suicide and supporting people bereaved by suicide	40.0
Forensic services (youth and adults)	34.0
School-based supports (SBHS, wellbeing resources for primary/intermediate)	21.8
Expanding telehealth and digital supports for mental wellbeing	20.8
Mental wellbeing support for parents and whānau	10.0
Improving crisis responses	8.0
Mental Health and Wellbeing Commission	8.0
Support for Christchurch	5.5

WORKFORCE DEVELOPMENT

In order to progress the strategies outlined for improving and meeting the mental health and wellbeing 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 are a constraint on improved service provision for infants, children, young people and their families. Therefore, increasing and strengthening the mental health/AOD workforce remains a key area of focus. In response to this, a number of mental health and addiction workforce development organisations (Werry Workforce Whāraurau, Te Pou o te Whakaaro Nui, Te Rau Ora, Le Va and Matua Raki) have been established that conduct work based on 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 infant, child and adolescent mental health and addiction sector had been guided by the strategies outlined for the broader mental health and addiction sector, ***Tauawhitia te Were: 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, Werry Workforce Whāraurau (then known as 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 infant, child and adolescent mental health workforce.*
2. *Increase the numbers of the infant, child and adolescent mental health workforce through training and enhanced career pathways.*
3. *Increase the diversity of the infant, child and adolescent mental health workforce through the development of core competencies, new roles and new ways of working.*
4. *Increase Māori and Pacific workforce numbers across all roles and parts of the sector.*
5. *Increase clinical/cultural competencies throughout the infant, child and adolescent mental health workforce.*
6. *Increase capacity of related sector workforces to provide mental health screening and, where appropriate, assessment and therapeutic intervention.*
7. *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 was to reduce inequalities and improve access to services for Māori and Pacific peoples.

- ***Blueprint II*** (Mental Health Commission, 2012) addressed the future direction and development of the workforce. 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), in ***The Children's Action Plan*** (New Zealand Government, 2012) and ***He Ara Oranga*** (2018) 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 ***Mental Health and Addiction Workforce Action Plan* 2017-2021** (Ministry of Health, 2017) outlines the priority areas and actions required for workforce development up to 2021, reiterating the need to focus on early intervention. The following four priority areas for workforce development have been identified (p. viii) and remain pertinent to progress the recommendations outlined in *He Ara Oranga*:

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 on the capacity and capability of the sector, service configuration and demand (access to service). Due to the comparatively small size and low profile of the sector, there was very little information detailing the infant, child and adolescent mental health/addiction workforce. To fill this gap, 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 in 2004 (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 the Mental Health Information National Collection (MHINC) and lack of data from NGOs on service user access to services. Furthermore, a need for centralised, regular, standardised data collection of workforce composition and access rates available for regional planning was identified in *Whakamārama te Huarahi* (Wille, 2006). This led to recommendations to conduct a biennial stocktake on the workforce and access to service. The dataset now covers data from 2004 to 2018.

This report presents the 2018 infant, child and adolescent population (0-19 years), mental health service user, funding, service and workforce data. It continues to provide a snapshot of the workforce providing infant, child and adolescent and youth primary mental health/AOD services; the population the workforce serves; the number of service users accessing services and how service user numbers compare with Blueprint access targets (Mental Health Commission, 1998).

METHOD

The workforce data collection for each *Stocktake* is informed by consultations with the Ministry of Health, the Werry Workforce Whāraurau team (including Youth Consumer, Māori and Pacific Advisors) and external Māori, Pacific and Asian advisory input.

The information in this report largely pertains to the World Health Organization definitions of infants and children (0-9 years) and adolescents (10-19 years). Where the term 'youth' is used, it refers to all persons between the ages of 15 and 24 and 'young people' refers to a combination of adolescents and youth (10-24 years).

The 2018 *Stocktake* includes the following data:

- **Population:** Infant, child and adolescent population (defined by persons between the ages of 0-19) by ethnicity (census and projections, prioritised ethnicity) and DHB area (2016-2028). 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 individuals appears only once, hence the sum of the ethnic group populations will add up to the total New Zealand population.
    - Limitations: Due to the unavailability of the latest census data, projections based on the 2013 Census have been used. The use of projected population statistics tends to be less accurate than actual census data.

- **Funding:** Infant, child and adolescent mental health/Alcohol and Other Drug (ICAMH/AOD) and youth primary mental health funding data extracted from the Ministry of Health's Price Volume Schedules.
    - Notes and limitations: This report only includes ICAMH services coded to child and youth purchase unit codes (including alcohol & drug and forensic), with one exception: Tui Ora Limited (Taranaki DHB) moved FTEs from MHI44C to PHOMH001 (service) in 2017/18 (child and youth services), which are included; up to $4.8m may be excluded from the report due to coding issues.
- **Workforce**: Includes workforce data from 20 DHB (Inpatient & Community) ICAMH/AOD services (including the National Youth Forensic Service), and 119 non-DHB service providers (108 NGOs and 11 PHOs) with a 100% response rate. Workforce data is collected and presented by actual and vacant full time equivalents (FTEs) and headcount by ethnicity and occupation as at 30 June 2018.
    - The Workforce Survey (Appendix E) was sent to all DHB Chief Executive Officers (CEOs) and Mental Health Managers in July 2018 and had a 100% response rate.
    - The list of non-DHB funded organisations contracted to provide ICAMH/AOD services from July 2017 to June 2018 was extracted from the 2017/2018 Price Volume Schedule. This included a total of 119 DHB funded, non-DHB providers (108 NGOs, Iwi Providers and 11 PHOs) who were surveyed by phone and email from November 2018 with a 100% response rate. This is the first time that specifically funded PHO (youth primary mental health) workforce data has been collected and presented.
    - Workforce data in the report are split into two categories: "clinical" and "non-clinical". The clinical workforce 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/care for service users and includes cultural workers (kaumātua, kuia or other cultural appointments), specific liaison appointments, mental health support workers, mental health consumers, and family workers. While workforce data are collected and reported by 'clinical' and 'non-clinical' workforce, DHBs recruit staff from various disciplines based on relevant skills and competencies required to fill a certain number of funded FTEs, therefore recruitment is not necessarily conducted according to these occupational groups.
    - **Limitations:**
        - Workforce data are subject to the quality of the data supplied by the service providers.
        - Variations in workforce data over time could be due to reporting by different staff members from the same agencies at each data collection point, therefore, as more accurate data are provided, previous data sets are updated to reflect this. Contractual changes may also account for some of the variances seen.
        - Ethnicity information is provided by managers and not by individuals themselves. The prioritisation of ethnicity when mixed ethnicity is reported may also occur at this level. Therefore, workforce ethnicity data should be interpreted with caution.
            - While these limitations apply to both DHB and non-DHB services, there are several specific factors that affect the quality of data from the non-DHB sector:
                - As well as MOH/DHB funding, many non-DHB services receive funding from different sources (i.e. Ministry of Social Development, Accident Compensation Corporation, and Youth Justice). Because of their unique blending of services, it can be difficult to identify which portion of funding sits with the specific MOH/DHB funded ICAMH/AOD contract.
                - Many non-DHB services provide a seamless service spanning all ages and 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 and is therefore, estimated.
                - Non-DHB contracts may be held by a single lead provider and contracts devolved to a number of other providers, this level of detail may not be reported, and services maybe missed and therefore not included.

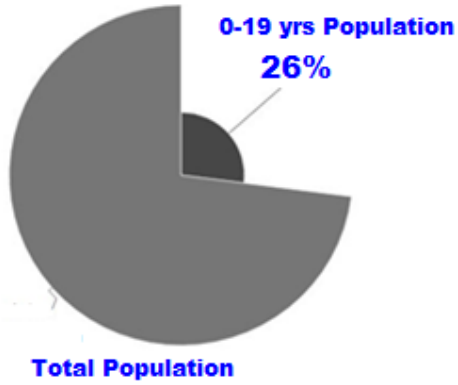
- Non-DHB services also receive a variable number of contracts over time, therefore it can be difficult to ascertain actual workforce trends for this workforce.
- Rural areas have issues with recruiting and retaining qualified staff in the ICAMH area. Therefore, unfilled FTE funding may have to be returned to the funders, which can lead to caution around reporting on unfilled vacancies.

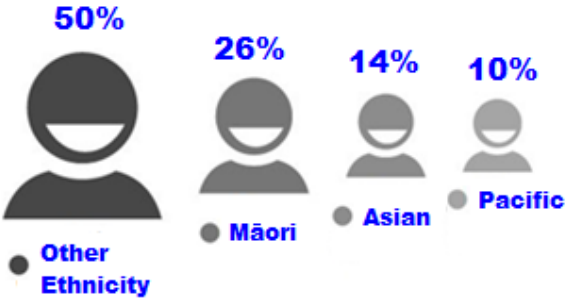
- **Service User**: Data on access to services by 0 to 19 year old service users is extracted from the Programme for the Integration of Mental Health Data (PRIMHD). The PRIMHD database contains service activity data as well as information on outcomes at local, regional and national levels. It contains information on the provision of secondary mental health and alcohol and drug services purchased by the Mental Health Group (Ministry of Health) and includes secondary, inpatient, outpatient and community care provided by DHBs and NGOs. DHBs and NGOs send their previous month's data electronically, i.e. referral, activity and outcomes data, to the PRIMHD system.
    - The service user access data reported are based on the *Service users by DHB of Domicile* (residence) for the second half of each year (July to December).
        - **Limitations:**
            - 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 service user management systems of each DHB and NGO.
            - Note: PRIMHD Service user data pertains to the most complete data available at the time of reporting (July – December 2017) and therefore, will not match the time period of the workforce data.
    - Improvements in service user access to services in this report could be partly a result of more services over time submitting data. Alternatively, decreases seen in the number of service users could also be a result of fewer numbers of NGOs contracted.
    - PRIMHD *does not* include:
        - NGO service user diagnoses, classifications or legal status; nor NGO service users outcome data.
        - Service user data from PHOs or general practitioners (GPs) contracted to deliver youth primary mental health or addiction services.
    - Service user access rates presented have been calculated by dividing all 0-19 year services users over a *six-month period* (July to December) by the corresponding population as conducted using the original MHC methodology; therefore, they may differ from the one-year period access rate calculations reported elsewhere.
        - **Limitations:**
            - Service user access rates are calculated using the best available population data at the time of reporting. Access rates calculated using census data are more accurate than those calculated using projections.

NATIONAL OVERVIEW

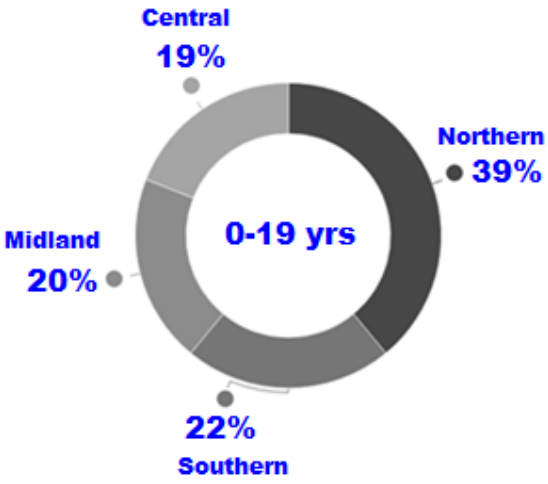
INFANT, CHILD AND ADOLESCENT (0-19 YRS) POPULATION

- 0.4% projected growth in the overall 0-19 year population since 2016 (Appendix A, Table 1).
- Growth was projected in two out of the four regions, Northern and Southern (by 0.5%) with very little change projected for the Central and Midland.
- Infants, children and adolescents make up 26% of the total population.
- Half of the 0-19 year population are in the Other Ethnicity group (50%), followed by Māori (26%), Asian (14%) and Pacific (10%).





- The majority (39%) reside in the Northern region and, within this region, the largest proportions reside in Counties Manukau (34%) and Waitemata (33%) DHB areas (Appendix A, Table 1).
- 10-year population projections (2018-2028) indicate a 2% overall growth in the 0-19 year population. Growth is mainly projected for Māori (by 11%), Pacific (by 9%) and Asian populations (by 32%) respectively, in all four regions (Appendix A, Table 2).
- These projections will assist with planning for local service and workforce development activities.



INFANT, CHILD, ADOLESCENT AND YOUTH MENTAL HEALTH NEEDS

- Strengths and Difficulties Questionnaire (SDQ) scores based on the NZ Health Survey data (2012-2016) indicated that 8% of children (3-14 years) had an overall SDQ scores indicating concern (‘*high’ or ‘concerning’* score results) (Ministry of Health, 2018). These scores can be used to predict the likelihood of social, emotional and/or behavioural problems. Concerning scores within the four aspects of development were:
    - 14*% for Peer Problems*
    - *9.7% for Emotional Symptoms*
    - *10.3% for Conduct Problems*
    - *9% for Hyperactivity*
    - *Hyperactivity and conduct problems were more prevalent in older age groups; rates of conduct and peer problems were comparable across all age groups.*
    - *Boys were more likely to experience conduct, peer and hyperactivity problems*
    - *Girls were more likely to experience emotional symptoms.*

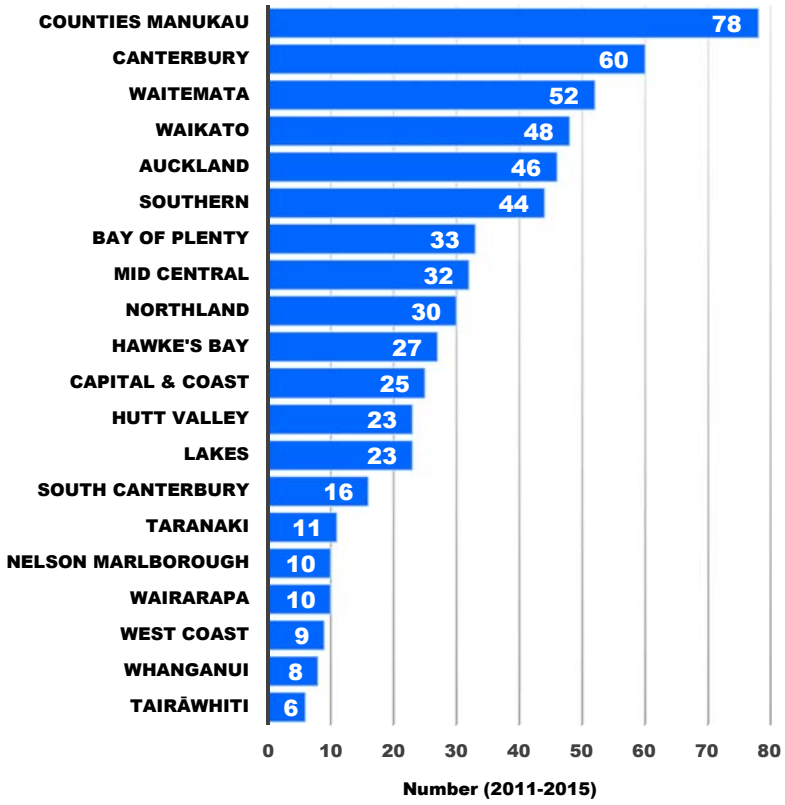
- The 2012 Adolescent Health Research Group findings, via their National Youth Health School Survey of 8,500 secondary students aged 12-18 years old (Clark et al., 2013, 99-22-25; 2014), found:
    - *16% of females and 9% of males reported symptoms of depression that were likely to be clinically significant.*
    - *38% of females and 23% of males reported feeling down or depressed most of the day for at least two weeks in a row.*
    - *29% of females and 18% of male students had deliberately harmed themselves.*
    - *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 had used only once.*
    - *Approximately 1% reported that they were transgender (defined in the study as 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). They experienced compromised mental health and personal safety. Approximately 40% of had significant depressive symptoms and nearly half had self-harmed in the previous 12 months. One in five had attempted suicide in the last year. Nearly 40% had been unable to access healthcare when needed*.

- An indicator for youth disengagement is the proportion of young people who are not in employment, education or training (NEET). The NEET rate for youth 15-24 years, as at June 2018, was 11.6%; 7.8% for 15-19 year olds; and 14.7% for 20-24 year olds. NEET rates for youth in the ‘Southern Auckland Initiative’ area was higher, at 19.2% due to higher proportions of Māori and Pacific living in this area. Pacific NEET rates were the highest at 18% for the overall 15-24 age group; 10.9% for 15-19 year olds and 25.4% for 20-24 year olds. Māori NEET rates were the second highest at 17.3% for the overall 15-24 year age group; 11.7% for 15-19 year olds and 22.5% for 20-24 year olds (Tuatagaloa & Wilson, 2018). NEET status has been shown to be associatied with a number of personal, social, health and mental health outcomes:
    - *Marginalisation and dependence, with young people failing to establish a sense of direction (Cote, 2000).*
    - *Poor physical and mental health outcomes (individuals feeling lonely, powerless, anxious or depressed (Creed & Reynolds, 2001; Henderson, et al., 2017).*
    - *Further exclusion and increased association with risk behaviours. Greater use of drugs, alcohol and criminal activity (Fergusson, Horwood, & Woodward, 2001; Henderson, et al., 2017).*
    - *More likely to be parents at an early age and face ongoing issues with housing and homelessness (Cusworth, et al., 2009).*

- The consistently high NEET rate will continue to impact on the mental health and wellbeing of those already in high risk groups, which can predict an even greater need for mental health services (Ministry of Business Innovation & Employment, 2013).
- Suicide rates in NZ remain highest amongst youth (15-24 years) at 16.9 per 100,000 and are the fifth highest amongst the OECD countries (Ministry of Health, 2018). The male suicide rate (20.3 per 100,000) was almost double that of the female rate (13.2 per 100,000). Suicide rates were the highest in the highest deprivation areas (12.6 and 15.4 per 100,000 population for quintiles 4 and 5, where 5 represents the most deprived), compared with quintile 1 (8.1 per 100,000 population, where 1 represents the least deprived).

o Youth suicide by DHB area showed Counties Manukau had the highest numbers of youth suicides over a five-year period (Figure 2).

Figure 2. Youth (15-24 years) Suicide by DHB Area (2015)



Note: Rates for the total population are five-year rates, expressed per 100,000 population and age standardised to the WHO World Standard Population. Rates are not calculated for youth. Most DHB regions had too few youth suicide deaths over the five-year period and/or a youth population that is too small to produce stable rates.

Source: New Zealand Mortality Collection published by Ministry of Health (Suicide Facts: Data tables 1996–2015, 2018).

o While population projections indicate a declining overall 0-19 year population, this population is becoming more ethnically diverse as seen in the population projections for Māori, Pacific and especially for Asians. The mental health needs of infants, children and young people continue to remain high and complex, therefore, services should anticipate continued demand for services and plan service and workforce development activities accordingly.

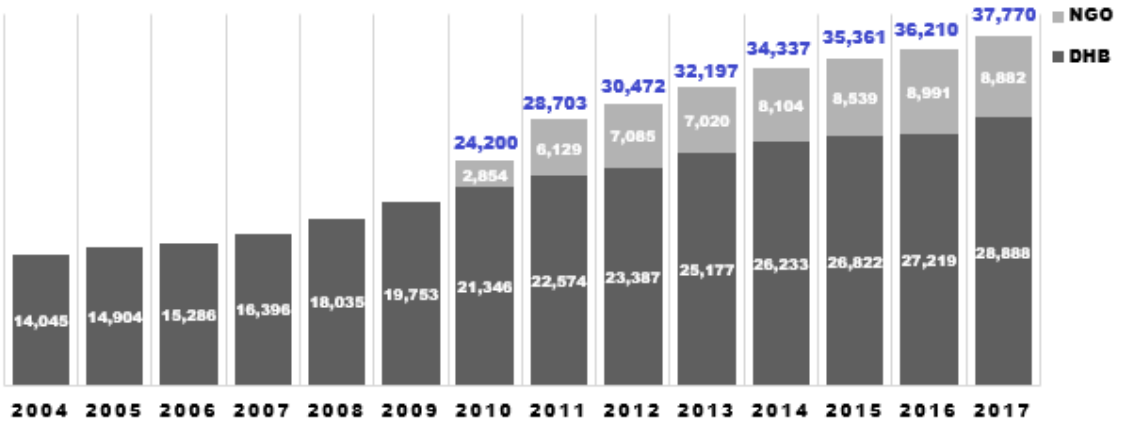
SERVICE USER ACCESS TO ICAMH/AOD SERVICES

0-19 year old service user access to mental health service are extracted from PRIMHD and includes *Service users by DHB of Domicile* (residence) for the second six months of each year (July to December). Data from 131 NGOs were included in the 2016 service user access information and 134 NGOs were included in the 2017 service user data. PHO service user data is not captured in PRIMHD; therefore all service user data pertains to DHB and NGO services only.

From 2015 to 2017:

- 7% increase in the total number of service users (both male and females) accessing services with the largest increases in the 0-9 and 10-14 age groups (Figure 3).
- 8% increase in DHB services and a 4% increase in NGOs.
- Largest increase in service users were seen in the Midland region (by 13%) followed by Northern (by 7%).

Figure 3. 0-19 yrs Service Users (2004-2017)



In the second half of 2017:

- 53% of service users were 15-19 year olds (Appendix B, Table 2). 53% were male.
- 'Other Ethnicity' made up the majority of service users (57%), followed by Māori (33%), Pacific (7%) and Asian (4%).
- 76% accessed DHB services. Largest referral sources were GP (31%), Self/Relative (11%) and Education Sector (10%).
- 24% accessed NGO services. Largest referral sources were Education Sector (23%); Self/Relative (15%), and Child & Adolescent Mental Health Services (13%).
- 35% of all service users were seen by services in the Northern region.
- While service users largely accessed DHB services, the Midland region had the largest proportion of service users accessing NGOs (40%) (Figure 4).

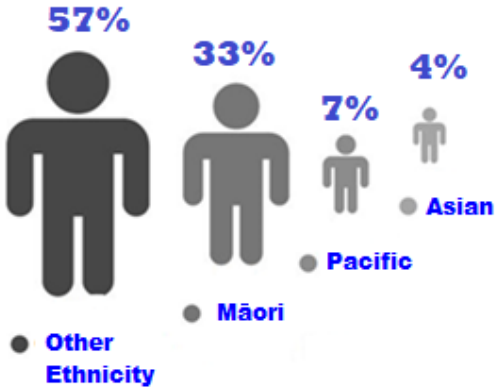
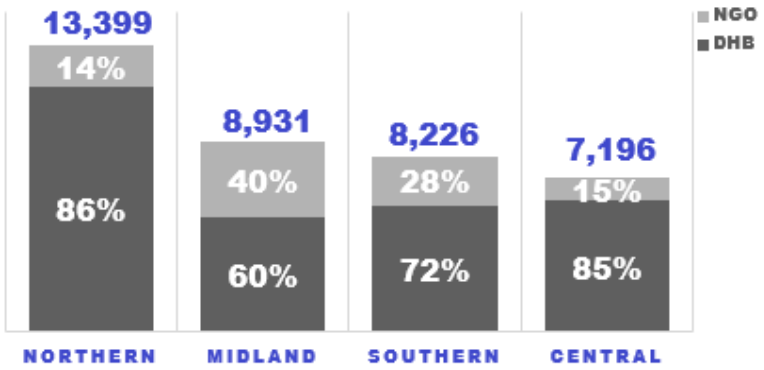


Figure 4. 0-19 yrs Service User by Region (2017)



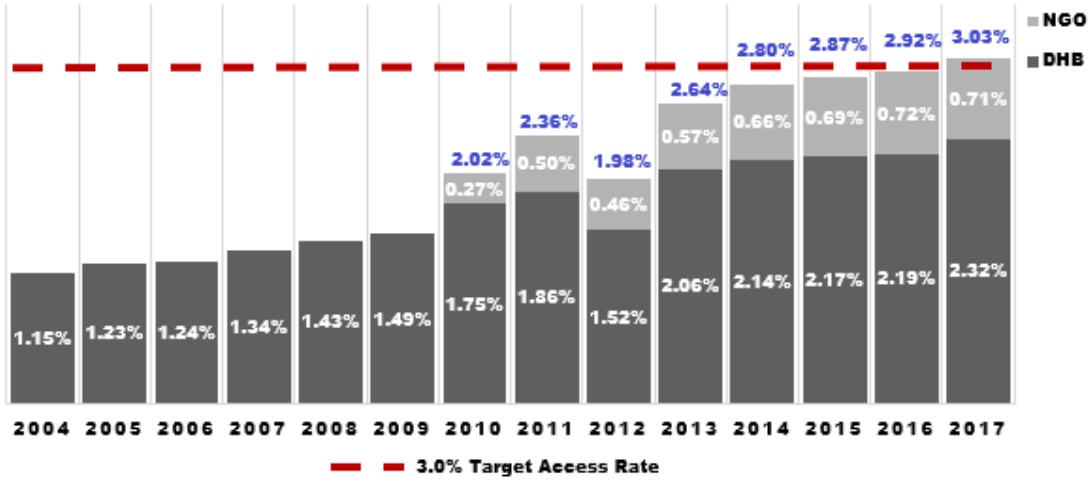
0-19 YEARS SERVICE USER ACCESS RATES

The Mental Health Commission suggested that 3% of the total infant, child and adolescent population should be able to access services (equating to 37,396 for the 2017 0-19 year population of 1,246,530), therefore, setting the access target rate for the overall 0-19 year age group at 3% over a six-month period. This overall access rate would apply up to the year 2000/2001 and move to a 5% rate by 2005. Due to different prevalence rates in mental illness in different age groups, access rates were set accordingly: 1% for 0-9 years; 3.9% for 10-14 years and 5.5% for 15-19 years (Mental Health Commission, 1998). Access rates are calculated by dividing the number of service users 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 service user lives (DHB of Domicile).

From 2015 to 2017:

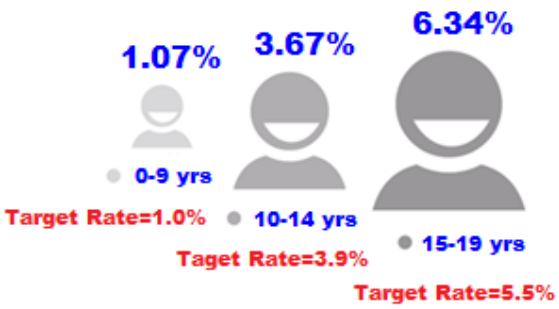
- Improvements were seen in access rates from 2.87% to 3.03%, exceeding the 3% target rate (Figure 5). Improvements were seen in all three age groups (Appendix B, Table 8).

Figure 5. 0-19 yrs Service User Access Rates (2004-2017)



Second six months of 2017:

- Access rates exceeded target rates for all three age groups.
- Māori had the highest rate of 3.89% followed by 'Other Ethnicity' (3.36%). Asian access rates continued to be the lowest at 0.86%.
- Regionally, Midland, Central and Southern exceeded the target rate. Northern remained the lowest at 2.75% and below the 3% target rate (Figure 6).



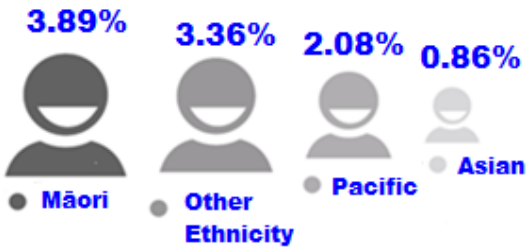
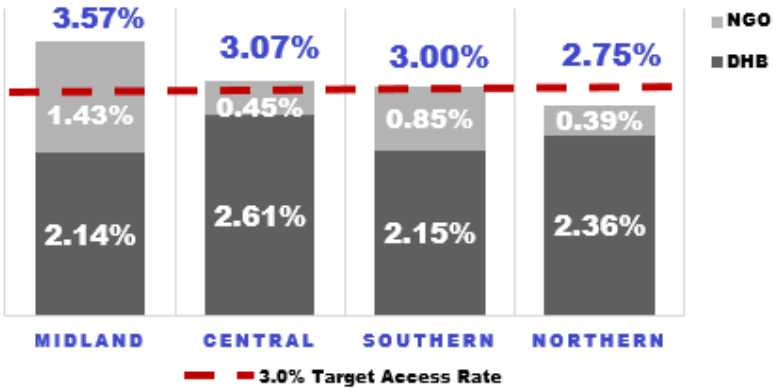


Figure 6. 0-19 yrs Access Rates by Region (2017)



SERVICE USER OUTCOMES

To assess whether children and young people accessing mental health services experience improvements in their mental health and wellbeing, health outcomes are rated by the *HoNOSCA* (Health of the Nation Outcome Scales for children and adolescent 4-17 years), at admission and discharge from infant, child and adolescent mental health services. Service user outcome data for the 2018 period showed significant improvements across all items assessed, especially in emotional related symptoms (EMO item in Figure 7) by time of discharge from both inpatient and community mental health services (Figure 7; Appendix B, Table 14 for the full list of items).

Figure 7 . Child & Youth HoNOSCA Results by Service (2018)

Note: Percentage of service users in the clinical range (2, 3 or 4) for each HoNOSCA items.
Source: Ministry of Health, PRIMHD extract, 9 April 2019, analysed and formatted by Te Pou.

FUNDING OF ICAMH/AOD SERVICES

From 2016 to 2018:

- 4.5% increase in total funding for ICAMH/AOD services (including youth primary mental health) (Figure 8 & Table 1).
- 0.5% increase in DHB services.
- 17.6% increase in non-DHB services including PHOs (Appendix C, Table 1).
- Largest funding increase was for youth forensic services by 39% (Table 1).

Figure 8. ICAMH/AOD Funding (2004-2018)

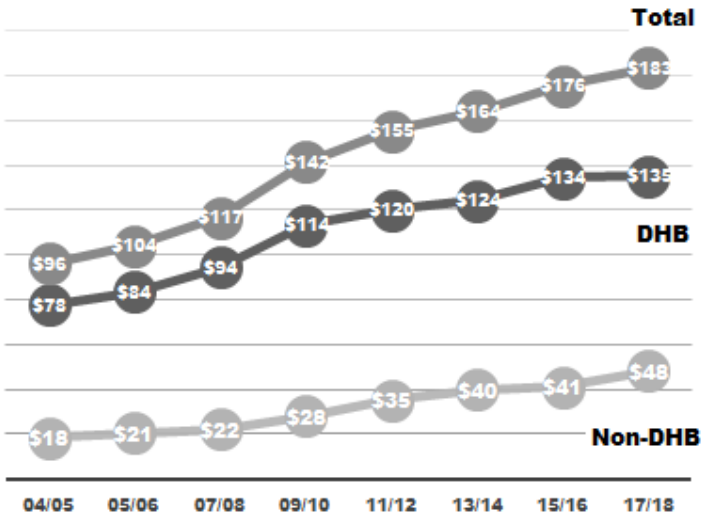


Table 1. ICAMH/AOD Funding by Service (2008-2018)

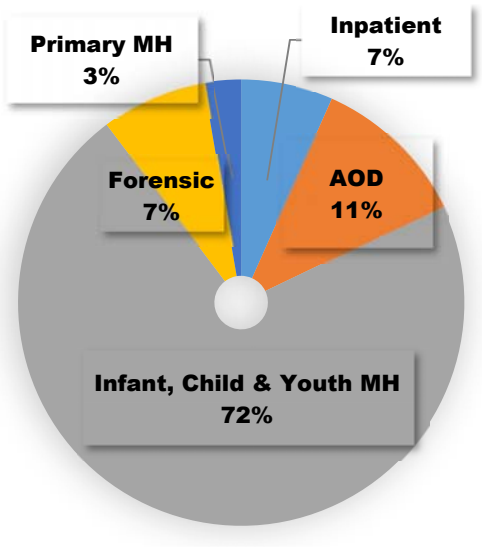
SERVICES	ICAMH/AOD FUNDING BY SERVICE (2008-2018)						
	07/08	09/10	11/12	13/14	15/16	17/18	% Change (2018-2016)
Inpatient	$16,116,851	$16,233,302	$14,290,399	$14,320,606	$14,192,776	$12,232,919	-14
AOD	$8,688,761	$11,679,940	$18,983,015	$21,072,508	$23,386,143	$20,670,687	-12
IC&Y Mental Health[1]	$91,916,224	$105,995,340	$118,895,261	$123,289,829	$126,000,120	$131,640,480	4
Youth Forensic	-	-	$1,995,477	$5,635,624	$10,066,585	$13,955,365	39
Kaupapa Māori	-	$7,683,265	$1,212,203	-	-	-	-
Youth Primary Mental Health	-	-	-	-	$1,900,000	$4,935,029*	*
TOTAL	$116,721,836	$141,591,846	$155,376,355	$164,318,566	$175,545,624	$183,434,480	4.5

1. Includes residential services Source: Ministry of Health Price Volume Schedules 2007-2018.
*Youth primary mental health funding reported for provider services for this time period only therefore %v change cannot be calculated.

For the June 2017 to July 2018 financial year:

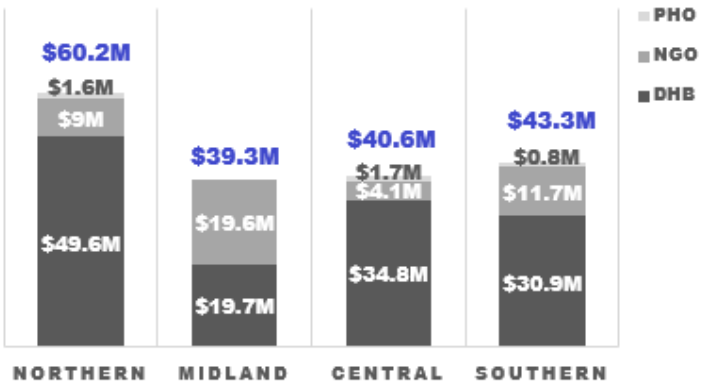
- 72% of the total funding was allocated to infant, child and adolescent mental health services, followed by AOD services (11%).
- 3% was allocated to youth primary mental health services.

- 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. Currently, 13% of the total mental health spend ($1,461.9 million) continues to be allocated to ICAMH/AOD. While this proportion appears to be below the recommended figure, the relative cost of treatment for infants, children and adolescents compared to adults using current models of care remains unknown. We also do not know how much service provision for 17-19 year olds is delivered by adult services within the adult funding stream because of ICAMHS upper age limits or other factors.



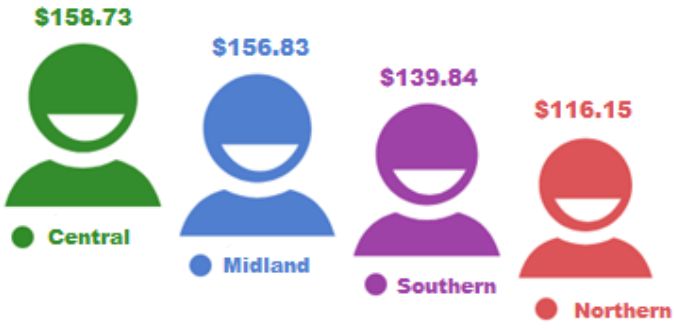
  - DHB ICAMH/AOD provider services received 74% of this funding while NGOs received 24% and PHOs received 3% (Appendix C, Table 1).
  - Northern region received the largest proportion of the ICAMH/AOD funding (33%) (Table 2 & Figure 9).

Figure 9. ICAMH/AOD Funding by Region (2018)



- From 2016 to 2018:
  - Including Youth Primary Mental Health funding, funding per 0-19 years population increased by 6%, from $129.93 to $137.33 (excluding Inpatient funding) seen in all four regions.
- For the 2017/2018 financial year:
  - Central ($158.73) and Midland ($156.83) regions had the highest spend per infant, child and adolescent population and Northern continued to have the lowest ($116.15) (Figure 10).

Figure 10. Spend per 0-19 year population by Region (2018)



PROVISION OF ICAMH/AOD SERVICES

- 20 DHBs 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. These also include regional AOD and forensics services. The upper age limit (19 years) is variable throughout the country, with each DHB determining their own service provision.
- Regional inpatient child and adolescent mental health services are provided by three DHBs: Auckland; Capital & Coast (Wellington) and Canterbury (Christchurch). In some stances, acute in-patient admissions and brief admissions are made to a local paediatric or adult units while arrangements are made for admission to the three regional inpatient child and adolescent services.
- All DHB services are now inclusive of infants (0-4 year age group) with either dedicated services or teams for the infant population. Many services are also providing care pathways for transgender and gender no-conforming youth.
- Nga Taiohi National Secure Youth Forensic Inpatient Mental Health Service, located in Kenepuru Community Hospital in Porirua, is a specialist 10-bed unit for young people aged 13 to 17 who are severely affected by mental health (or mental health & alcohol or other drug issues), who have offended or are alleged to have offended, and involved in the youth justice system.
- ICAMH/AOD services are also provided by DHB-funded non-DHB services which include NGOs, Iwi services, and primary health organisations (PHOs). For the June 2017 to July 2018 period, 119 non-DHB service providers (108 NGOs & 11 PHOs) were funded to deliver ICAMH/AOD and youth primary mental health services.
- Youth primary mental health services are largely based on local needs and opportunities and include:
    - *Enhanced school-based health services*: *GPs and Youth Nurses who deliver Year 9 HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Depression and Suicide, Sexuality, Safety) assessments and a range of health services to students in low decile secondary schools.*
    - *Packages of care and brief interventions (such as alcohol brief interventions).*
    - *Establishing Primary Mental Health Coordinator roles.*
    - *Youth psychologists in schools and NGO youth services, and/or funding youth-specific services ranging from resilience-building to treatment.*

ICAMH/AOD WORKFORCE

The following workforce information is derived from the Werry Workforce Whāraurau workforce survey and includes actual & vacant Full Time Equivalents (FTEs) by ethnicity and occupation submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services, including the National Youth Forensic service, and all 119 non-DHB service providers (108 NGOs & 11 PHOs) as at 30 June 2018.

From 2016 to 2018:

- 7% overall increase in the total workforce (DHB Inpatient & Community ICAMH/AOD & non-DHB services), from 1,585.3 to 1,698 actual FTEs. This increase reflects the inclusion of the National Youth Forensic Service and 11 PHOs contracted to deliver youth primary mental health services (Table 2).
- 21% increase in the non-DHB workforce, from 502.9 to 609.9 actual FTEs. This increase reflects the inclusion of funded PHOs delivering youth primary mental health services.
- 1% increase in the total DHB workforce (including Inpatient and the National Youth Forensic Service). 5% decrease in the DHB Community workforce, from 934.6 to 889.4 actual FTEs.
- 15% increase in reported vacant FTEs, with the 2018 vacancy rate of 9% (rates ranged from zero to 35%). Increase in vacancies was largely in DHB services for clinical roles by 20%, from 126.7 to 151.5 FTEs.

Table 2. ICAMH/AOD Workforce by Service Provider (2006-2018)

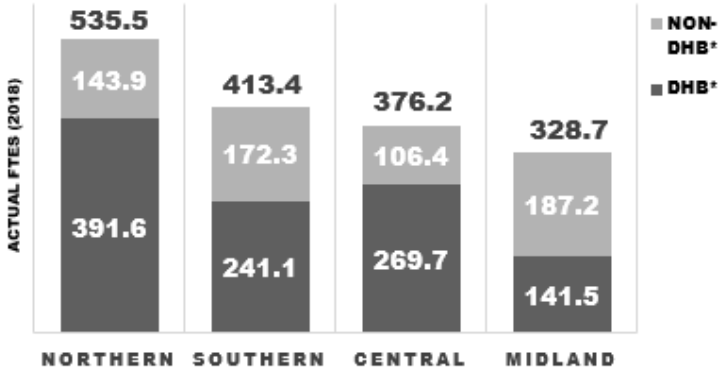
PROVIDER SERVICE	ACTUAL FTES							VACANT FTES						
	2006	2008	2010	2012	2014	2016	2018	2006	2008	2010	2012	2014	2016	2018
DHB Inpatient	136.1	153.4	163.9	140.8	144.0	147.9	154.4	25.1	14.9	9.0	15.6	21.9	16.2	17.9
DHB Community	696.2	735.5	822.9	877.5	913.9	934.6	889.4	98.6	80.5	100.5	74.3	108.2	120.0	128.6
National Youth Forensic Service	-	-	-	-	-	-	44.3	-	-	-	-	-	-	-
Non-DHB*	352.2	379.9	355.5	412.2	532.4	502.9	609.9	9.6	16.3	12.0	3.8	12.6	10.3	21.3
TOTAL	1,184.5	1,268.8	1,342.3	1,430.6	1,590.2	1,585.3	1,698	133.3	111.7	121.5	93.8	141.7	146.5	167.9

*Includes Primary Health Organisations

As at 30 June 2018:

- Northern region had the largest workforce (32%), followed by Southern (24%) (Figure 11).
- 64% of the workforce was in DHB provider services (Table 2).
- Over half of the workforce was NZ European/Pākehā (56%), followed by Māori (20%), Other Ethnicity (11%), Pacific (7%) and Asian (6%) (Appendix D, Table 18).
- 72% were in clinical roles as Nurses (20%), Social Workers (15%), Psychologists (11%) and AOD Practitioners (7%) (Table 3).
- 18% were in the non-clinical workforce (workforce providing direct support to service users), as mainly Mental Health Support Workers (9%); Youth Workers (5%), Cultural roles (9%) and Advocacy & Peer Support roles (1%).

Figure 11. ICAMH/AOD Workforce by Region (2018)



*Excludes National Youth Forensic Service

- 9% were in Administration (5%) and Management (4%) roles.
- 91% of the total vacancies were reported for clinical roles (152.9 FTEs): Nurses (29%), Psychologists (20%), Social Workers (14%), and Psychiatrists (8%) (Table 4 & Figure 13).
- The overall annual staff turnover rate was at 20% (DHB=17%; non-DHB=24%) which was higher than the 2017 national average rate of 15.6% for healthcare providers (Lawson Williams Consulting Group, 2018).
- Turnover by occupation was highest for Support Workers, Nurses, Social Workers and Psychologists. The reasons for leaving included external job opportunities for better salaries, and relocation to another city/town within New Zealand and overseas.

Figure 12. Top 4 ICAMH/AOD Workforce by Occupation (2018)

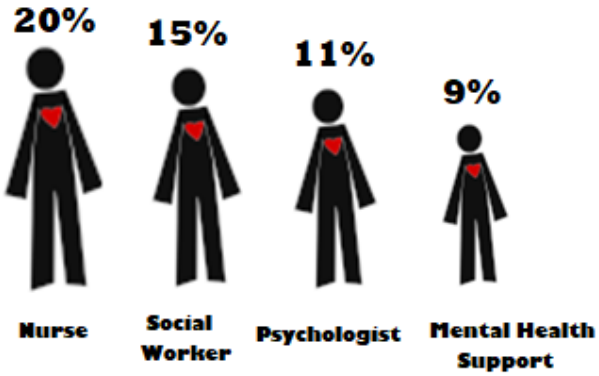
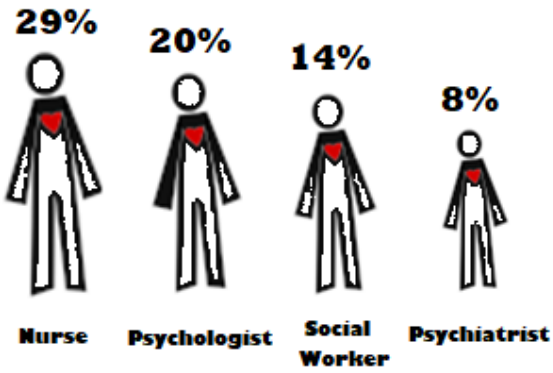


Figure 13. Top 4 ICAMH/AOD Vacancies by Occupation (2018)



DHB INPATIENT ICAMH WORKFORCE

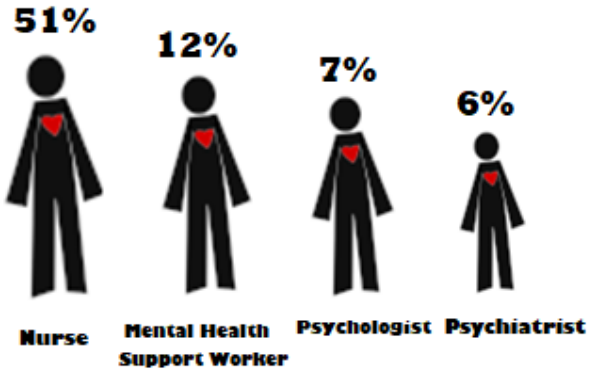
From 2016 to 2018:

- 4% overall increase in the workforce from 147.9 to 154.4 actual FTEs across all three regions (Table 3).
- 11% increase in vacant FTEs from 16.2 to 17.9 FTEs (10% vacancy rate).

As at June 2018:

- Auckland DHB Child and Family Unit continued to report the largest Inpatient workforce (64.87 FTEs, 42%) followed by Canterbury (54 FTEs, 35%) and Capital & Coast (35.5 FTEs, 23%) DHBs.
- 78% of the Inpatient workforce were in clinical roles, as Nurses (51%, incudes Mental Health Nurses; Registered Nurses and Clinical Nurse Specialists), Psychologists (7%) and Child and Adolescent Psychiatrists (6%) (Table 3 & Figure 14).

Figure 14. Top 4 DHB Inpatient Workforce by Occupation (2018)



- 14% in non-clinical roles as Mental Health Support Workers (12%) and Cultural Workers (2%).
- 9% in Administration (3%) and Management (6%) roles.
- 88% of the total vacancies were reported for clinical roles, largely for Nurses (51%).

Table 3. ICAMH/AOD Workforce by Occupation (2018)

ICAMH/AOD Workforce by Occupation (Actual FTES, 2018)	DHB			DHB Total	Non-DHB	Total
	Inpatient	Community	National Youth Forensic Service			
Alcohol & Drug Practitioner	-	36.40	1.00	37.40	88.50	125.90
Child & Adolescent Psychiatrist	9.07	58.61	1.00	68.68	5.80	74.48
Clinical Placement/Intern	-	9.30	-	9.30	4.80	14.10
Co-Existing Problems Clinician	-	13.00	-	13.00	10.10	23.10
Counsellor	0.20	6.50	-	6.70	36.66	43.36
Family Therapist	-	7.00	-	7.00	6.50	13.50
Nurse	78.70	188.15	18.40	285.25	50.10	335.35
Occupational Therapist	6.10	67.90	1.00	75.0	8.88	83.88
Psychotherapist	1.10	13.10	-	14.20	3.10	17.30
Psychologist	11.20	161.63	1.00	173.83	13.95	187.78
Registrar/Senior Medical Officer	5.50	15.30	0.20	21.00	-	21.00
Social Worker	6.60	170.78	-	177.38	71.59	248.97
Other Clinical[1]	1.30	9.00	-	10.30	29.11	39.41
Clinical Sub-Total	119.77	756.67	22.60	899.04	329.09	1,228.13
Cultural	3.10	19.65	2.70	25.45	2.50	27.95
Educator	-	-	-	-	8.20	8.20
Mental Health Consumer Advisor	-	2.00	-	2.00	3.40	5.40
Mental Health Support Worker	18.00	10.40	17.00	45.40	103.45	148.85
Peer Support/Advocacy	-	0.20	-	0.20	19.46	19.66
Services Coordinators/Needs Assessor	-	-	-	-	1.10	1.10
Whānau Ora Practitioner	-	-	-	-	7.50	7.50
Youth Worker	-	3.40	-	3.40	78.23	81.63
Other Non-Clinical[2]	-	1.70	-	1.70	8.29	9.99
Non-Clinical Sub-Total	21.10	37.35	19.70	78.15	231.13	309.28
Administration	5.00	67.10	1.00	73.10	12.95	86.05
Management	8.50	28.30	1.00	37.80	36.76	74.56
TOTAL	154.37	889.42	44.3	1,088.09	609.93	1,698.02

1. Other Clinical=House Officer; House Surgeon; GP; Referral Coordinator; Clinical Supervisor; Clinical Team Leader; Therapist; Clinical Coordinator; Kai Manaaki; Clinical Social Work Specialist; CAPA Facilitator; Speech Therapist; Clinical Interns: Psychology; Occupation Therapy; Social Work; Nursing); Nurses (RN; Clinical Nurse Specialist); MST Therapist; Triage Helpline; Medical Officer; Field Workers; Brief Intervention Clinician; Māori Physical Therapist; Adventure Therapist; Employment Specialist; Needs Assessors
2. Other Non-Clinical=Community Workers; Early Childhood Teachers; Needs Assessors/Service Co-ordinators; Specific Liaison

Table 4. ICAMH/AOD Workforce Vacancies by Occupation (2018)

ICAMH/AOD Vacancies by Occupation (Vacant FTES, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	2.00	2.00	7.60	9.60
Child & Adolescent Psychiatrist	2.28	10.94	13.22	-	13.22
Counsellor	-	-	-	0.63	0.63
Nurse	9.10	37.60	46.70	2.50	49.20
Occupational Therapist	1.00	8.70	9.70	-	9.70
Psychotherapist	-	2.30	2.30	-	2.30
Psychologist	0.40	33.43	33.83	-	33.83
Social Worker	1.00	20.20	21.20	2.00	23.20
Other Clinical[1]	2.00	8.00	10.00	0.80	10.80
Clinical Sub-Total	15.78	123.17	138.95	13.53	152.85
Cultural	1.00	2.10	3.10	-	3.10
Mental Health Consumer	-	1.40	1.40	-	1.40
Mental Health Support	-	-	-	3.25	3.25
Peer Support Worker	-	-	-	2.00	2.00
Youth Worker	-	-	-	2.14	2.14
Non-Clinical Sub-Total	1.00	3.50	4.50	7.39	11.89
Administration/Management	1.15	1.95	3.10	0.40	3.50
TOTAL	17.93	128.62	146.55	21.32	167.87

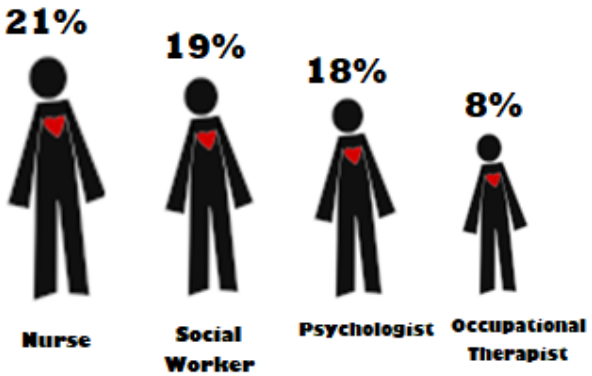
1. Other Clinical = Clinical Placement; Case Manager; Clinical Supervisor; Nursing/Allied roles not specified

DHB COMMUNITY ICAMH/AOD WORKFORCE

From 2016 to 2018:

- 5% overall decrease in the community workforce, from 934.6 to 883.1 FTEs, seen across all regions. Largest decrease was in Midland by 10% and Southern by 6%.
- 7% increase in overall vacant FTEs from 120 to 128.6 vacant FTEs (13% average vacancy rate with rates ranging from 1% to 35%). Increases in vacant FTEs were seen in the Northern and Midland regions only, with the largest increase in the Northern region by 47%.

Figure 15. Top 4 DHB Community Workforce by Occupation (2018)



As at June 2018:

- 85% of the workforce was in clinical roles as Nurses (25%), Social Workers (19%), Psychologists (18%), and Occupational Therapists (8%) (Table 3 & Figure 15).
- 4% in non-clinical roles largely in Cultural roles (2%) and Mental Health Support Workers (1%) (Table 3).
- 11% in Administration (8%) and Management (3%) roles.
- 96% of reported vacancies were for clinical roles: Nurses (29%), Psychologists (26%) and Social Workers (16%) (Table 4).

- The DHB community workforce annual turnover rate was 17%, largely for Nurses, Social Workers and Psychologists. Reasons for leaving included external job opportunities, relocation to another city within New Zealand and overseas and retirement.

COMPETENCY/CAPABILIY OF THE DHB WORKFORCE

- The capability of the workforce was assessed by the *Real Skills Plus ICAMHS competency framework* (The Werry Centre, 2009b), which describes the knowledge, skills and attitudes needed to work with infants, children and young people and whānau with a suspected or identified mental health or alcohol or other drug concern. The *Real Skills Plus online assessment tool* identifies the competencies that individual and teams meet from the framework, and highlights areas for knowledge and skill development for individuals and teams *(to access the tool and more information:* ***www.werryworkforce.org****)*.
- *Real Skills Plus* has three levels
    - **Primary Level** *for people in the primary sector that work with infants, children and young people.*
    - **Core Level** *for practitioners working in services that focus on mental health and/or AOD concerns.*
    - **Specific Level** *for senior or specialist practitioners working at an advanced level of practice.*
- *Real Skills Plus* data can be reported nationally, regionally, at service and team level and individually. The application of *Real Skills Plus* is most effective at an organisational level as it helps to develop a shared understanding of the knowledge and skills required by the whole service. It promotes the development of best practice across disciplines, creating a multi-skilled workforce at each level. *Real Skills Plus* allows targeted service development, recruitment and service delivery activities.
- The data presented in Figures 16 and 17 are a national summary of the ***Core*** level competencies met by the DHB workforce in 2018, which ranged from 65% to 96% of skills and knowledge required, and further development was indicated for the following:
    - ***Intervention Skills (27%)***
    - ***Assessment Knowledge (25%)***
    - ***Intervention Knowledge (22%).***
    - ***Skills for working with Infants (27%)***
    - ***Knowledge and Skills for Leadership roles (18%).***

Regional *Real Skills Plus* competency data vary across regions and this is included within the regional summaries.

Figure 16. DHB *Real Skills Plus* Competencies (2018)

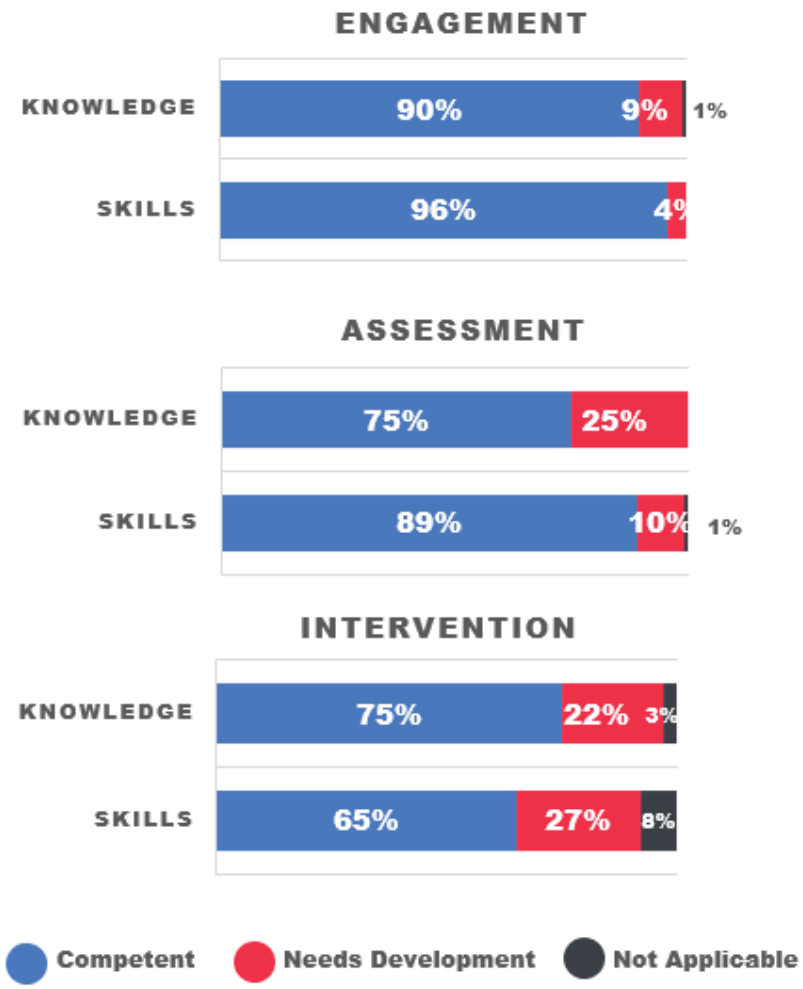
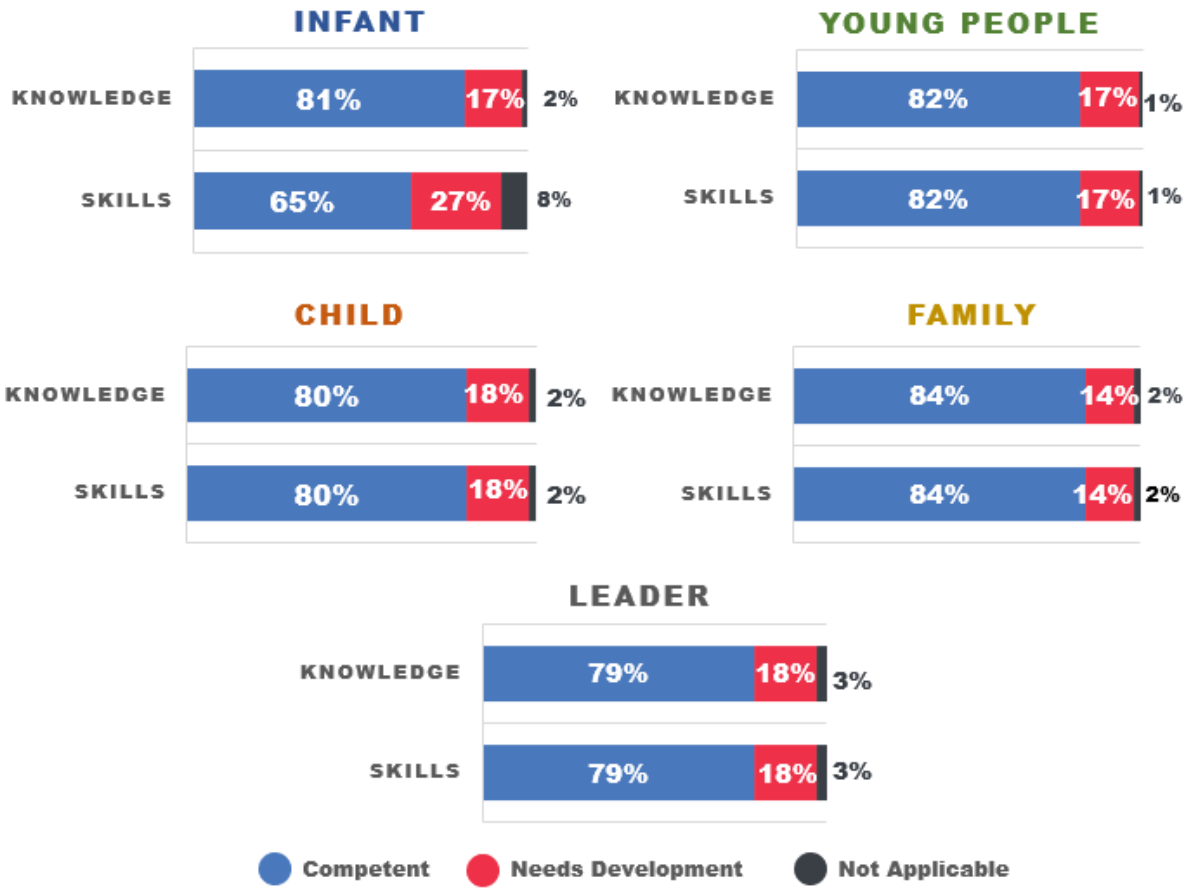


Figure 17. DHB *Real Skills Plus* Competencies by Domain (2018)



DHB WORKFORCE CHALLENGES

DHB ICAMH/AOD provider services continue to experience challenges and barriers that constrain critical service and workforce development. The following challenges were identified by all 20 DHB providers and would need to be addressed for on-going workforce development and improving future service provision:

Current/future service demands:

- *Increase in the number of service users accessing services within current workforce capacity/shortages.*
- *Increase in complexity of service user needs, whereby services are increasingly working within complex relationships between social and economic factors (i.e. break-down of families, family violence, generational AOD use, poverty and extreme behavioural problems of children and youth; youth suicide rates increased overall, social media and the impact on youth).*
- *Possible changes in the model of care, specifically the extension of service user age range to 25 years, which would mean more service users accessing ICAMHS within the current workforce capacity. This would impact on the services ability to manage further increase in service user numbers. Services would need to increase their workforce to cater for the increase in service users. Furthermore, the extension of service user age would require a workforce skilled in delivering services in a developmentally appropriate way across this age band. The extension of the service user age range would be a challenge to many services under the current workforce circumstances (limited resources and capacity available for such services/demand).*

- **Recruitment & retention:**
    - *Lack of appropriately qualified, specialist staff with child and youth mental health experience available for recruiting.*
    - *Difficulties in attracting and recruiting staff to rural areas.*
    - *Stressful work conditions leading to high turnover and persistent vacancies.*
- **Limited funding:**
    - *Limited funds available to access specialist training.*
    - *Limited funds for further service development and provision, which includes investment in developing infrastructure to support the use of advancing technology.*
- **Working collaboratively across agencies:**
    - *Difficulties in communication with other agencies due to different IT systems, which impedes crucial information sharing.*
    - *Lack of staff who are skilled in dealing with mental health issues in the primary mental health sector. Therefore, up skilling of the primary workforce is required.*

NON-DHB ICAMH/AOD WORKFORCE

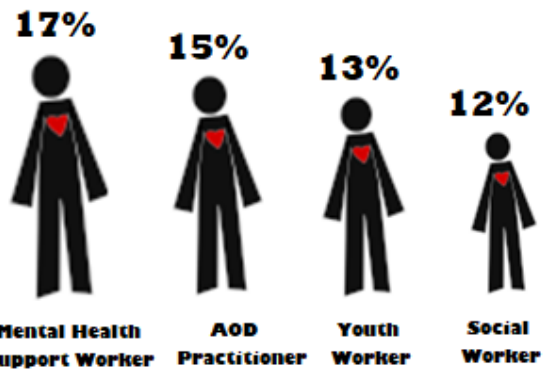
From 2016 to 2018:

- 21% increase in the non-DHB workforce from 489.1 to 609.93 actual FTEs. This increase is largely due to the inclusion of 11 PHOs contracted to provide youth primary mental health services, resulting in the expansion of the non-DHB workforce.
- Increase was seen in the clinical workforce by 20%.
- Increases in the non-DHB workforce seen in all four regions, especially in the Central region where the non-DHB provider workforce has doubled from 51.9 to 106 FTEs.

As at June 2018:

- 31% of the total non-DHB workforce are in the Midland region, followed by Southern (28%), Northern (24%) and Central (17%).
- 54% were in clinical roles, largely comprising AOD Practitioners (15%), Social Workers (12%) and Nurses (8%) (Figure 18).
- 38% in non-clinical roles mainly as Mental Health Support Workers (17%), Youth Workers (13%), and Peer Support/Advocacy roles (3%) (Table 4).
- 66% of total vacancies were reported for clinical roles largely for AOD Practitioners (36%) (Table 5).
- Non-DHB annual staff turnover rate was at 24%, for Support Workers, Youth Workers and AOD Practitioners. Main reasons for leaving included external job opportunities for better salaries and career development and change (promotions and further study).

Figure 18. Top 4 Non-DHB Workforce by Occupation (2018)



COMPETENCY/CAPABILITY OF THE NON-DHB WORKFORCE

- For the 2018 period, up to 20 non-DHB services completed the *Real Skills Plus* tool at the ***Primary*** level (skills and knowledge required for workers in the primary sector).
- The data presented in Figures 19 and 20 are a national summary (organisational level) of competencies met by the non-DHB workforce, as well as highlighting areas for further development. Regional summaries are not included as the numbers of participating services were too small to generate meaningful regional reports.
- The non-DHB workforce met a number of Primary level competencies which ranged from 64% to 96% of skills and knowledge required, and further development was indicated for the following:
    - ***Assessment Skills (31%)***
    - ***Intervention Knowledge (20%)***
    - ***Engagement Knowledge (20%).***
    - ***Knowledge and Skills for working with Young People (20%)***

Figure 19. Non-DHB *Real Skills Plus* Primary Level Competencies (2018)

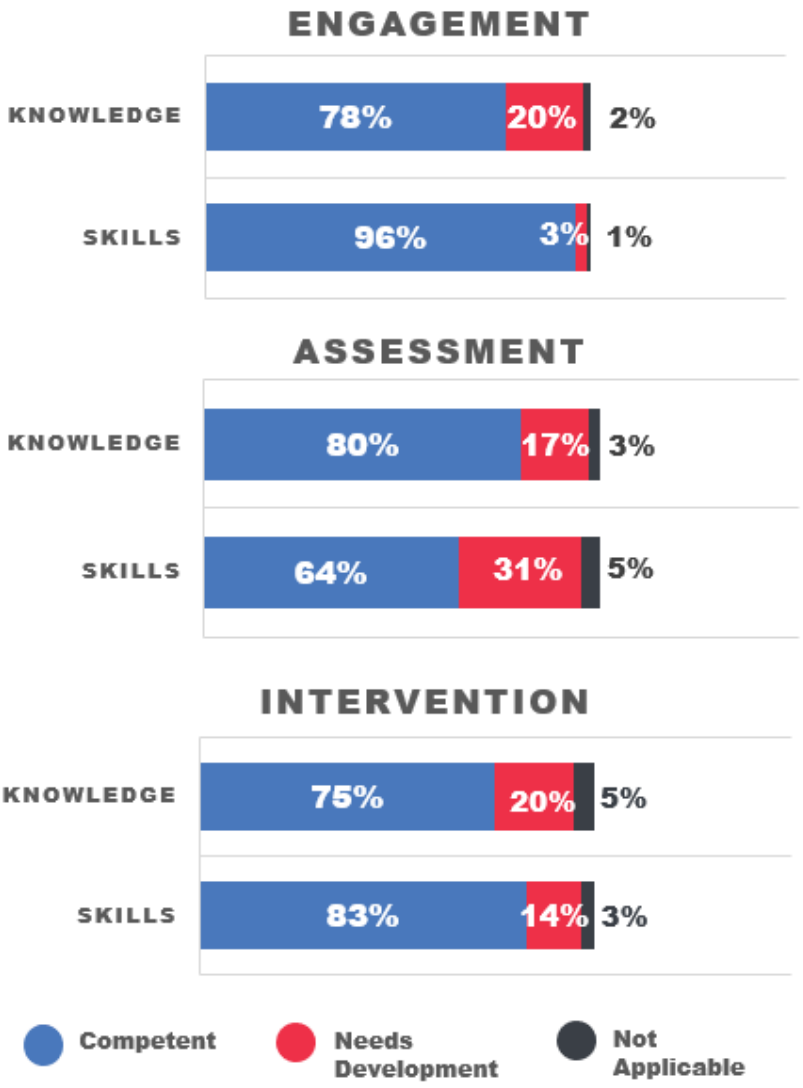
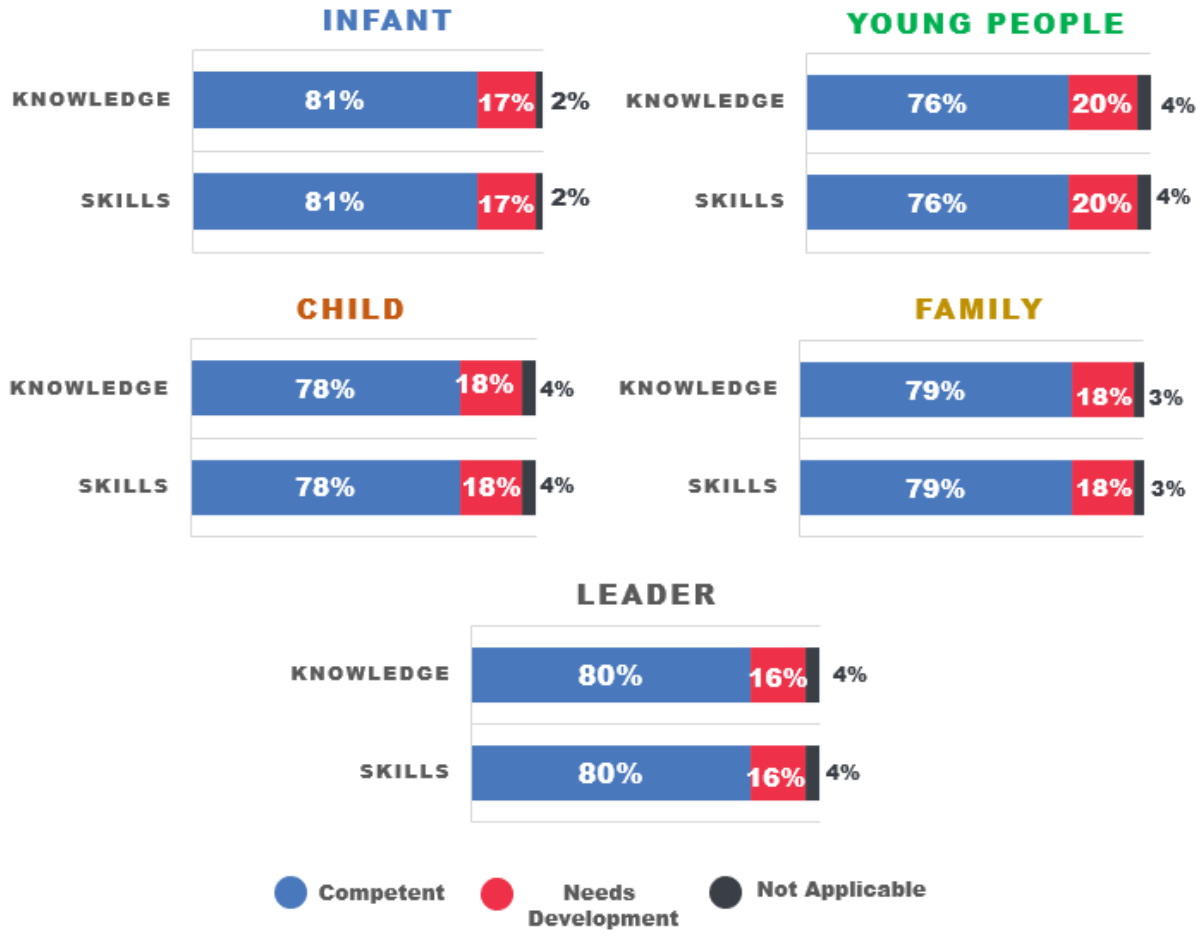


Figure 20. Non-DHB *Real Skills Plus* Primary Level Competencies by Domain (2018)



NON-DHB WORKFORCE CHALLENGES

Non-DHB services were also asked to identify their current workforce challenges and gaps. The challenges identified fell into three main themes:

- **Limited funding restricts:**
  - ***Recruitment & retention:*** *Difficulties in recruiting and retaining staff due to a lack of pay parity between non-DHB and DHB services and other organisations. Salary difference exists between different organisations for similarly qualified staff; therefore, staff are leaving to pursue better salaries in other organisations (i.e. DHBs, Oranga Tamariki).*
  - ***Service development & provision/delivery:*** *Limited funding, while inhibiting the recruitment and retention of the non-DHB workforce, has a direct flow-on effect on the service's ability to expand, develop and provide services to meet current and future service demand.*
  - ***Upskilling of existing staff:*** *Limited funding inhibits the ability of non-DHB services to invest in further professional development for their workforce.*
- **Recruitment: Recruitment issues are further exacerbated by:**
  - *Lack of specialist staff available for recruitment.*
  - *Difficulties in recruiting staff to rural areas.*
- **Service demand:**
  - *Increase in service user numbers outweighing the non-DHB workforce capacity.*
  - *Increase in complexity of cases outweighing the non-DHB workforce capabilities.*

SUMMARY

Although population projections indicate a declining overall infant, child and adolescent population, however, this population is becoming more ethnically diverse, as seen in the population projections for Māori, Pacific and especially for Asian. The mental health needs of children and young people continue to remain high and increasingly complex, therefore, services should anticipate continued intense demand for services.

The demand for services can be seen in the number of service users accessing ICAMH/AOD services. Latest PRIMHD data indicates an increasing trend with a 7% increase in the overall number of service users accessing services across the 2015 to 2017 period. These numbers equate to an overall access rate of 3.03%, for the first time nationally exceeding the former Mental Health Commission's recommended rate of 3.0% (Mental Health Commission, 1998). The access rate for 15 to 19 year olds (6.34%) has continued to exceed the corresponding target rate of 5.5%, and this is now the case for the 0-9 year olds. However, the access rate for 10-14 year olds (3.67%) remains below the corresponding target rate (3.9%), therefore improvements are required for this age group. Regionally, access rates also need to improve in the Northern region as the access rate for this region remains below the 3% target rate. Given that service user outcome data shows significant improvements for those accessing services, improving access to services for the younger age groups remains paramount. Part of improving access to services is identifying the barriers that impede access.

Funding data show a 5% increase in total ICAMH/AOD funding, but this continues to make up only 13% of the total mental health spend, half of the recommended figure of 26%. Therefore, increasing and allocating adequate funding for the provision of appropriate services and an adequate workforce to meet increasing demand are vital, especially for the growing minority ethnic populations.

A range of ICAMH/AOD services are provided by 20 DHB ICAMH/AOD services and 119 non-DHB service providers. DHB provider services continue to deliver specialist mental health services and non-DHB services, while traditionally providing support services; have been increasingly providing specialist clinical services. However, there has been very little development and provision of services specifically for Māori, Pacific and Asian populations, indicating limited choice and perhaps contributing to low access. Hence Māori, Pacific and Asian service users continue to access mainstream DHB services.

A growing demand for services as indicated by the increase in the *number* of service users, has a direct impact on the ICAMH/AOD workforce. Previous workforce data showed an increasing trend in service user numbers but a plateauing workforce, indicating a workforce that is not keeping pace with demand. The latest workforce data show a slight overall increase in ICAMH/AOD workforce (7%) largely due to the inclusion of the National Youth Forensic Service data and PHOs; however, DHB services reported very little change. Increasing vacancies and high turnover rates continue to impact on this workforce. While the need to increase the ICAMH/AOD workforce is indicated by services, they continue to face challenges due to shortages in qualified staff available for recruitment and high turnover rates. Improving the capacity of the workforce remains a critical area of focus.

Improving the capability of the workforce is just as crucial because service users are not only increasing in numbers but are also presenting to services with more complex needs. Additionally, the availability of few specific cultural services, and shortages in the respective cultural workforces, mean that Māori, Pacific and Asian service users are largely accessing mainstream services and are thereby seen by the mainstream workforce. A workforce that is adequately skilled clinically and culturally to meet this level of demand could lead to better mental health outcomes for all children, young people and their families. Current assessment of capabilities (required knowledge and skills) using the *Real Skills Plus online tool* showed that, while the majority of the workforce has the required core skills for delivering services to infants, children and adolescents, improvements are required at the ***intervention skills*** level. Current levels of cultural capability of the workforce are not consistently measured, and services have identified the gap in this area, and welcome opportunities for further development.

RECOMMENDATIONS

In light of the current findings, and in alignment with the direction set by the *Mental Health and Addiction Workforce Action Plan,* 2017-2021 (Ministry of Health, 2017); *He Ara Oranga*, and within the context of a 1,000 young people would like[2] (ActionStation, 2018), the following recommendations are made:

"More funding for mental health services."

Increase and allocate appropriate levels of funding:

- Lack of funding to support service and workforce development activities has been identified as a major barrier by all services. Allocating appropriate levels of funding is a first step in building essential infrastructure (organisational structures, technology, models of care such as trauma-informed care) to advance further service expansion and development (planning and re-design: e.g. CAPA) and to make progress on various workforce development initiatives (recruitment, retention, role development, expansion; professional development and training) is required. DHBs, in collaboration with their local key stake holders (i.e. schools, tertiary education providers, Youth One Stop Shops (YOSS), PHOs, NGOs), should engage in a strategic planning processes to identify challenges and opportunities; actively monitor local service demands; develop new models of care for their populations and enhance workforce development; and ensuring funding is allocated accordingly.

"Better mental health education to be available in schools.
Better, more accessible mental health services.
Better mental health services specific to different sexualities and gender identities."

Develop and provide early intervention programmes, services and workforce at primary level:

- While Blueprint target access rates give priority to access for adolescents, the importance of intervening early in the pre-school age group is recognised and should be prioritised. This is supported by evidence 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). Offering an early and appropriate response provides the best chance for improved life outcomes. Taking a life-course approach or providing support at particular points in a person's life can improve physical and mental health, economic wellbeing and social connectedness (Office of the Prime Minister's Science Advisory Committee, 2018; p. 15).
    - ***Provide parenting programmes:*** Evidence-based parenting programmes should be widely available such as *The Triple P – Positive Parenting Programme,* which has been shown to be one of the most effective evidence-based parenting programmes in the world for preventing and reducing children's emotional and behavioural problems. Providing evidence-based parenting programmes that work across cultures, socio-economic groups and in different kinds of family structures is critical for intervening early and improving long term outcomes for children. *Triple P Primary* also has the advantage of being suitable for delivery within services that families already engage with, such as early childhood education, social services and Well Child Tamariki Ora.
    - ***Provide and develop school-based health education and services***: Youth '12 findings on health services in secondary schools showed positive associations between aspects of health services in schools

[2] *Ara Taiohi* commissioned a report from *ActionStation* to gather the views of young people on what wellbeing looks like. This report included the perspectives of more than 1,000 young people (aged 12 to 24 years). Young people identified mental health as the biggest issue or challenge facing young people in New Zealand.

and mental health outcomes of students. 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.*

Guidelines for youth health care in secondary schools have been developed to assist planning, funding or providing primary health care services in secondary schools and can be used as a tool to continuously improve the quality of these services (Ministry of Health, 2014).

> **Mana Ake: Stronger for Tomorrow** is an example of a school-based, early intervention programme that provides support for school children aged 5-12 years across Canterbury who are experiencing on-going issues that impact on their well-being, such as anxiety, social isolation, parental separation, grief and loss, and managing emotions. This programme is also a good example of inter-agency collaboration which includes education, health, police, Oranga Tamariki and NGOs.

- ***Provide alternative community-based services:*** Developing and providing alternative community-based services *(e.g. One Stop Shops; Youth Hubs)* that are more accessible for those who are not in employment, education or training (NEET), including homeless youth, is important. Furthermore, providing more and better services specific to Māori, Pacific and Asian young people as well to young people of all sexualities, gender identities and other communities, for greater choice, is not only essential, it is also what young people want (ActionStation, 2018).

- ***Harness the power of technology:*** Young people in New Zealand have high rates of internet access and use (Gibson et al., 2013; Statistics New Zealand, 2004b). This platform provides opportunities to develop e-therapy tools to assist with easier and earlier access to treatment. An example is the NZ developed, on-line computerised cognitive behavioural therapy program, SPARX. Latest user data on the use of SPARX showed a total of 2,110 young people had registered to use SPARX for January to June period in 2019. The highest users were females (67%); by age 51% 12-14 and 28% 15-17 year olds; by ethnicity 62% NZ European, 16% Māori, 9% Asian and 5% Pacific. Largest referral source for users were their schools (39%). SPARX has been shown to be an effective resource for adolescents with depression at primary healthcare sites. The use of the program resulted in clinically significant reductions in depression, anxiety, and hopelessness and an improvement in quality of life (Merry et. al., 2012). Therefore, developing, promoting and enabling access to local and international evidence-based, or validated mental health apps, online self –help guides and e-therapy tools, and most importantly, keeping users engaged, is potentially an effective way of intervening early and increasing early access to treatment.

- ***Strengthen and support primary mental health services and workforce (capacity, knowledge and skill development):*** GPs are the largest source of referrals to ICAMH/AOD services, and nurses are a critical workforce in school-based and primary health services. Continued investment in the development and provision of primary health services, developing of new roles, and supporting and strengthening the knowledge and skill development of the respective workforces to deliver effective mental health care could alleviate the demand on ICAMH/AOD specialist services.

- ***Enhance service user pathways and collaboration between primary and specialist services***: Mental health outcome data for children and youth show significant improvements in their emotional wellbeing as a result of accessing mental health services. While there have been improvements in access to services for all service users, 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. Enhancing service user pathways to key services, especially for those below 15 years of age, should continue to be a key focus. Enabling better collaboration between primary and specialist services within an enabling infrastructure is required to advance this.

"Mental health workers should be looked after and well-trained."

Increase, strengthen and support the specialist ICAMH/AOD service and workforce:

Fund, plan and explore service re-design:

- Funding constraints and limited resources continue impede progress in service expansion and development within specialist services (DHBs and NGOs). Until more funding and resources are made available, specialist services need to consider service redevelopment and re-design strategies to use existing resources more efficiently (e.g. *Choice and Partnership Approach, CAPA,* York & Kingsbury, 2006).

Increase workforce capacity:

- ***Recruitment***: Lack of qualified staff for recruitment and a high turnover of specialist staff contribute to current workforce shortages compared to demand. A concerted drive is required to increase the capacity of the workforce (including recruitment of new graduates) to work in specialist ICAMH services. There needs to be ongoing investment into active, targeted recruitment strategies for specialist roles. Given that a quarter of all service users are accessing NGO services, increasing the NGO workforce also needs to be considered. Utilising national competency frameworks such as *Real Skills Plus* within the training sector can inform and create a "job ready" infant, child and adolescent mental health/AOD workforce. The recruitment of specialist staff can be also be enhanced by utilising *Real Skills Plus* to identify required knowledge and skills, based on local service user needs, to create a more effective infant, child and adolescent mental health workforce.

- ***Expand and develop existing roles***: Identifying fast-track solutions to address workforce shortages could include the development of existing roles**,** such as the peer workforce (which includes service user, consumer and peer workers). Currently, the peer workforce makes up a very small proportion of the total ICAMH/AOD workforce (approximately 1%). Specifically, very little progress has been seen in the development of the youth consumer workforce which continues to make up am even smaller proportion (0.3%) of the total workforce. The lack of specific funding for this role is the main reason why it remains small. There are many benefits to building a youth consumer workforce, including the assistance youth consumer workers can provide to services to identify youth trends, keep up to date with rapidly advancing technology, identify gaps in service delivery, decrease rates of 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. Opportunities exist for prioritised investment (funding) and development of this workforce. To help guide best practice in service development and quality improvement, Youth Consumer toolkits (Werry Workforce Whāraurau) and peer workforce competencies (Te Pou o Te Whakaaro Nui, 2014) have been developed for use by planners and funders, service managers, training providers and workers.

- ***Work collaboratively:*** To overcome workforce shortages, building relationships and working in partnership with other services can be an effective strategy in sharing limited resources, especially in the provision of clinical support to NGOs (particularly in rural areas). This is already occurring in some areas where NGOs provide cultural support to DHBs. However, while the need to work more collaboratively is acknowledged by services, barriers and challenges in doing so continue to exist and would need to be effectively addressed.

- ***Retain the workforce:*** Increasing the capacity of the ICAMH/AOD workforce remains a slow but important strategy in addressing current shortages. Therefore, it is vital to retain the current ICAMH/AOD workforce. High turnover and vacancies in the specialist workforce, in both DHB and non-DHB services exacerbate workforce shortages. For instance, vacancy rates in some DHB services were as high as 35%. Therefore, reasons for such high vacancy rates need to be identified and addressed. Furthermore, staff turnover is particularly high in NGO services (24%), as NGOs work within a more competitive funding environment and regularly lose staff to higher salaries offered in other services/agencies. Short term contracts, due to funding models limiting adequate funding, also hamper the recruitment and retention of NGO staff. An increase in NGO funding could allow for longer term contracts and allow pay parity for similar skilled staff, thereby aiding retention of the NGO specialist workforce

- ***Look after the workforce***: Developing workforce resilience is one of the key steps to workforce retention. Resilience protects the mental and physical health and wellbeing of staff and helps delivery of quality services. Current trends show an increasing service user demand within current workforce capacity, which can lead to stress and burnout, and this has been indicated as one of the reasons for high turnover rates in some services. A valued team, with a strong and positive set of personal relationships between team members, works more effectively by providing emotional support, informal consultation and motivation to be at work and to work effectively as a team. An example of a model of care that places an emphasis on self-care and staff wellness as an individual and organisational responsibility, is the trauma-informed care approach. An on-line training module on self-care has been developed with positive feedback from the workforce and a face-to-face workshop, based on the success of the online training, is currently under development. Furthermore, retaining senior experienced staff is also essential for providing supervision and mentoring to new or younger staff. Therefore, providing these opportunities with lower contact time or part time positions, could also aid retention of senior staff. While many services have implemented various wellbeing activities and initiatives and acknowledging the need for looking after their workforce, it should remain an essential part of a service's workforce retention strategy.

Increase workforce capability:

- ***Identify and develop knowledge and skills:*** Given the growing complexity of infant, child and adolescent mental health needs (e.g. socio-economic factors, youth suicide, and transgender youth), strengthening the current workforce with the right skills is another key area of focus. As a first step, services need to be actively engaged in identifying current competency levels and opportunities for further targeted development, using competency assessment tools such as *Real Skills Plus*. Currently, for the DHB workforce, further developments (as assessed by the *Real Skills Plus* tool) are required for *Core level Intervention* skills, *Assessment* and *Intervention* knowledge, especially for working with infants. For the non-DHB workforce, further development is required for Primary level *Assessment* skills, *Intervention* and *Engagement* knowledge, especially for working with young people. Non-DHB competency development required at the *Core* level includes *Intervention* knowledge and skills and *Assessment* knowledge for working with children. Therefore, targeted training and professional development are required in these areas.
- ***Identify and strengthen cultural knowledge and skills:*** Due to the lack of services available for Māori, Pacific and Asian service users, they are largely accessing mainstream DHB provider services and are largely seen by the "mainstream" workforce. Due to the increasing rates of all service users assessing services and expected increase in the number of Asian young people, there continues to be a critical need for increasing the dual competency of mainstream services to be both clinically and culturally competent. Due to recent events, the Ministry of Health has also prioritised support to those who are affected by the Christchurch mosque attacks. This additional support (culturally and linguistically appropriate resources, services, and interventions) requires a coordinated response from the wider health sector and will have a direct impact on the health workforce. As a result, a special emphasis has been placed on supporting workforce training in trauma-informed care. Various cultural competency frameworks, e.g. *Real Skills Plus CAMHS* (The Werry Centre, 2009)*; Takarangi Māori Competency Framework* (Matua Raki, 2010)*; Real Skills Plus Seitapu Pacific Competency Framework* (Te Pou o Te Whakaaro Nui, 2009) and C*ulturally and Linguistically Diverse (CALD*) *Resources* have been developed and are available. However, there appears to be very little consistency in the use of the available competency tools to assess levels of cultural competencies, therefore not adequately measured. Services have acknowledged and identified the gap in this area and welcome opportunities for further support and development. To rectify this, routinely utilising the available tools to identify skill gaps would provide a more efficient and targeted approach for further, ongoing cultural skill development and training.
- ***Enable access to targeted knowledge and skills training****:* Once knowledge and skill gaps have been identified, it is essential that the workforce is able to access the required evidence-based specialist and cultural training. The lack of adequate funding has been reported by the NGO sector as a key barrier to accessing

specialist training. Until more funding is allocated to NGOs, shared training between DHB and NGOs could be a possible strategy.

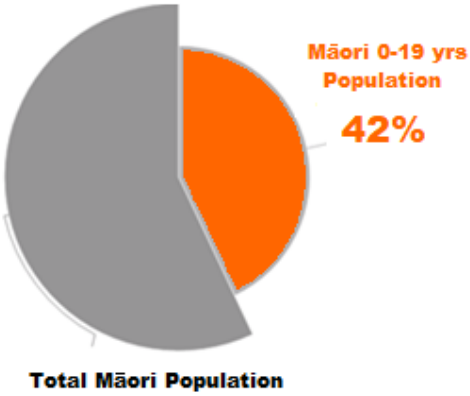
Continue data collection:

- Continue to extend data collection to explore and include new developments in the sector (e.g. developments in early intervention and the primary mental health sector; inter-agency collaborations; and innovative solutions and practice).
- Continue to invest in large scale national infant, child and youth health studies to monitor trends and to ensure that progress in service and workforce development is keeping pace with population increases, needs and demand, and therefore moving towards better health outcomes for infants, children and young people and their families.

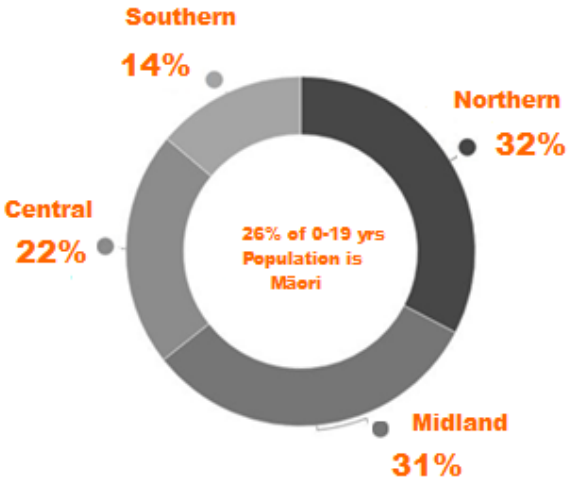
MĀORI NATIONAL OVERVIEW

MĀORI TAMARIKI AND RANGATAHI POPULATION

- 2% growth projected in the Māori 0-19 year population from 2016 to 2018 (based on Census 2013) (Appendix A, Table 1). The largest growth was projected for the Southern region (by 4%).
- Māori continue to be a youthful population with almost half (42%) of all Māori in the 0-19 age group.
- Approximately a quarter (26%) of the 0-19 year population are Māori.
- Approximately a third of the Māori 0-19 year population reside in the Northern region (32%) and within this region, 37% reside in Counties Manukau, 25% in Waitemata and 24% in Northland. Auckland DHB area continues to have the lowest Māori population in the Northern region (14%) (Appendix A, Table 1).



- 11% overall population growth projected from 2018 to 2028 across all regions, with the largest population growth projected for the Southern region by 19% (Appendix A, Table 2).
- Services would need to take these population trends and projections into consideration when planning for local service and workforce development activities.



MĀORI TAMARIKI AND RANGATAHI MENTAL HEALTH NEEDS

- The Māori population in New Zealand is more likely to come from areas of greater deprivation than are non-Māori (Ministry of Health, 2010b). Economic deprivation has been linked to a higher incidence of mental health problems (Fortune et al., 2010).
- The *Growing Up in New Zealand* longitudinal study (Morton et al., 2014), has followed 7,000 New Zealand children from before birth since 2009/2010, and has 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). Latest findings from the *Growing Up in New Zealand* study (Mind the Gap – Unequal from the Start: Addressing Inequalities Utilising Evidence from Growing Up in New Zealand, (ESRC, 2019, p.7)) showed that:

  "*Māori and Pasifika children experience the highest burden of socioeconomic disadvantage in their early years as well as an unequal burden of significant co-morbidities in terms of health and development throughout their life course. By the time they start school (at age 5 years) many are already falling behind their peers in terms of preparedness for formal education and readiness to engage in learning*."

- Strengths and Difficulties Questionnaire (SDQ) scores, based on the New Zealand Health Survey data indicated that 12% of Māori children (3-14 years) had an overall high or 'concerning' SDQ score, compared to an 8% score at that level overall (Ministry of Health, 2018). These scores can be used to predict the likelihood of social, emotional and/or behavioural problems. Concerning scores for Māori children within the four aspects of development were:
  - *18% for Peer Problems*
  - *17% for Conduct Problems*
  - *12% for Hyperactivity*
  - *11% for Emotional Symptoms*
  - *Māori children were more likely to experience peer problems, hyperactivity and had the highest rate of conduct problems compared to non-Māori children, but rates for emotional symptoms were comparable.*
- Higher need for mental health services for Māori tamariki and rangatahi has been documented in the Christchurch and Dunedin longitudinal studies (Fergusson, Poulton, Horwood, Milne & Swain-Campbell, 2003) and reiterated by the Adolescent Health Research Group (2003; Clark et al., 2008; Crengle et al., 2013). The 2012 Adolescent Health Research Group findings from 1,701 Māori students (Crengle et al., 2013) found the following emotional and mental health issues reported by Māori students:
  - ***Depressive symptoms**: No improvements from 2007 to 2012 (from 10.6% to 13.9%). More females (18.3%) reported symptoms than did males (8.7%). There were no differences when compared to NZ Europeans.*
  - ***Self-harm:** 28.7% reported they had self-harmed, with females (36.6%) more likely than males (19.8%).*
  - ***Suicidal thoughts:** 18.7% had seriously thought about killing themselves, with suicidal thoughts more common in females (26%) than males (10.3%).*
  - ***Suicide attempts** were reduced, with improvements seen from 2004 to 2012 (11.9% to 6.5%). Suicide attempts were more common in females (9.2%). Māori were more likely to report having made an attempt than were NZ Europeans.*
  - ***Seeking help**: 22.2% had seen someone for emotional worries, with females (26.9%) seeking help more frequently than males (16.8%).*
  - ***Substance use**: 18.5% were smokers: 56.8 % were drinkers: 56.8%, with drinking increasing with age. 20.7% were users of marijuana which was more common in males than females. More Māori youth living in higher deprivation areas reported smoking marijuana weekly than did those living in medium deprivation areas.*

- ***Access to healthcare:*** *No improvements in access to healthcare from 2007 to 2012. Māori young people commonly accessed Family Doctors (72.4%), School Health Clinics (18.6%), Hospital Emergency (17.5%), and After Hours 24hr Accident & Medical Clinics (10.5%), but less likely to have accessed a GP than NZ European/Pākehā students. Younger Māori (<13 years) and those who lived in higher deprivation areas less frequently accessed a GP and 21.9% had not been able to access healthcare when needed.*

- 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.***

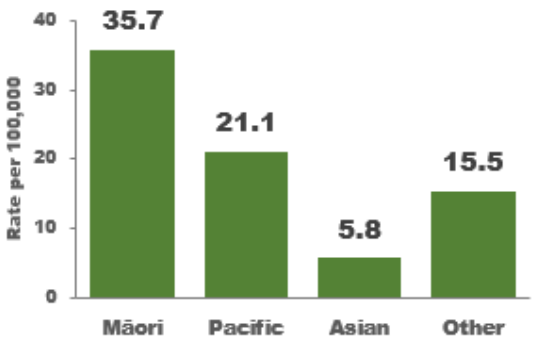
- The proportion of young people who are not in employment, education or training (NEET) is used as an indicator of youth disengagement (Ministry of Business Innovation & Employment, 2016a). The NEET rate for youth 15-24 years as at June 2018 was 11.6%; 7.8% for 15-19 year olds; and 14.7% for 20-24 year olds. NEET rates for youth in the 'Southern Auckland Initiative' were higher at 19.2% due to higher proportions of Māori and Pacific living in this area. Māori NEET rates were the second highest at 17.3% for the overall 15-24 year age group, 11.7% for 15-19 year olds and 22.5% for 20-24 year olds (Tuatagaloa & Wilson, 2018). NEET rates were 14.3% for males and 21% for females (Ministry of Business Innovation & Employment, 2018a). While Māori NEET rates have dropped from previous years, Māori continued to have higher NEET rates than other ethnic groups. NEET status has been associated with a number of personal, social, health and mental health outcomes:
    - *Marginalisation and dependence, with young people failing to establish a sense of direction (Cote, 2000).*
    - *Poor physical and mental health outcomes (individuals feeling lonely, powerless, anxious or depressed (Creed & Reynolds, 2001; Henderson, et al., 2017).*
    - *Further exclusion and increased association with risk behaviours. Greater use of drugs, alcohol and criminal activity (Fergusson, Horwood, & Woodward, 2001; Henderson, et al., 2017).*
    - *More likely to be parents at an early age and face ongoing issues with housing and homelessness (Cusworth, et al., 2009).*

- The consistently high NEET rate will continue to impact on the mental health and wellbeing of those already in high risk groups and can predict an even greater need for mental health services:

- The latest suicide data show Māori youth aged 15–24 years continue to have the highest suicide rates in the country at 35.7 suicides per 100,000 youth population compared to the national youth rate of 16.9 per 100,000 youth population. Rates for Pacific were 21.1 per 100,000 population, Other (15.5 per 100,000 population) and Asian (5.8 per 100,000 population) (Ministry of Health, 2018) (Figure 21).

- Socioeconomic inequalities and high mental health needs for Māori infants, children and young people strongly signal an urgent need for early intervention, prioritising suicide prevention, to improve the long term mental health outcomes for Māori tamariki and rangatahi.

Figure 21. Youth (15-24 years) Suicide Rates by Ethnicity



Source: New Zealand Mortality Collection, Ministry of Health (Suicide Facts: Data Tables 1996–2015, 2018).

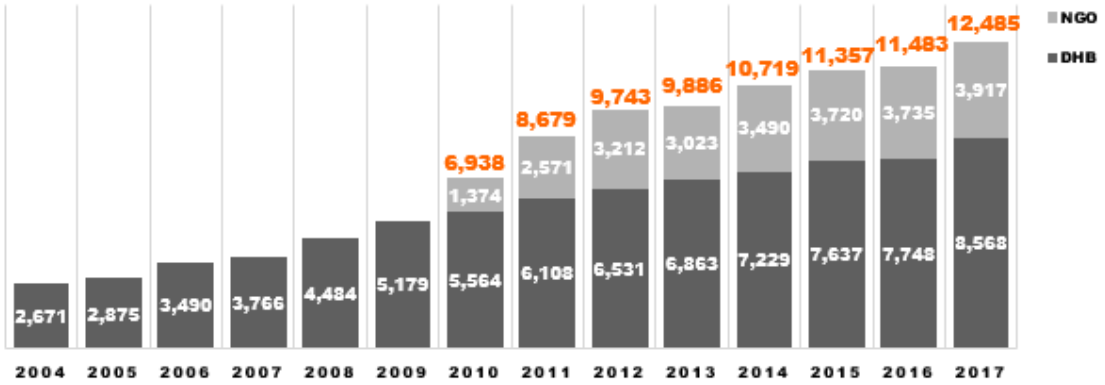
MĀORI TAMARIKI AND RANGATAHI SERVICE USER ACCESS TO ICAMH/AOD SERVICES

Māori tamariki and rangatahi (0-19 years) service user access data extracted from PRIMHD (based on the *Service users by DHB of Domicile* or residence) for the second six months of each year (July to December), provides data on the actual demand for services. Data from 131 NGOs were included in the 2016 service user access information and 134 NGOs were included in the 2017 service user data. PHO service user data is not captured in PRIMHD; therefore, all service user data pertains to DHB and NGO services only.

From 2015 to 2017:

- 9% increase in the number of Māori service users accessing services nationally, in both Māori females and males (Figure 22).
- Increase were seen in all four regions, with the largest increase in the Midland region by 18% (Appendix B, Table 3).

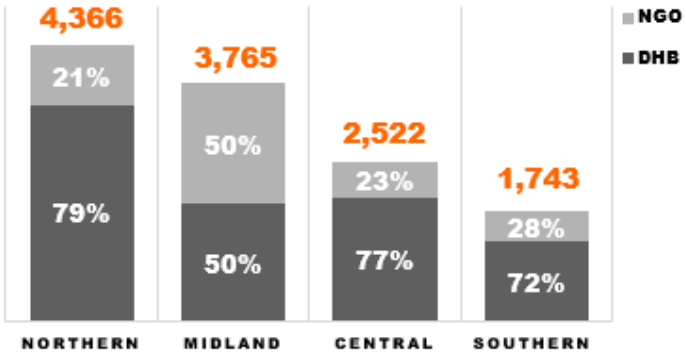
Figure 22. Māori Tamariki & Rangatahi Service User (2004-2017)



In the second half of 2017:

- 33% of all service users accessing services were Māori pepe, tamariki and rangatahi.
- 56% of Māori service users were males.
- 35% of all Māori service users in the country were seen by services in the Northern region, followed by Midland (30%) (Figure 23).
- Nationally, Māori largely accessed DHB services (68%), compared to 32% who had accessed NGOs.
- Regionally, in Midland, a larger proportion (50%) of all Māori service users accessed NGOs.

Figure 23. Māori Tamariki & Rangatahi Service User by Region (2017)



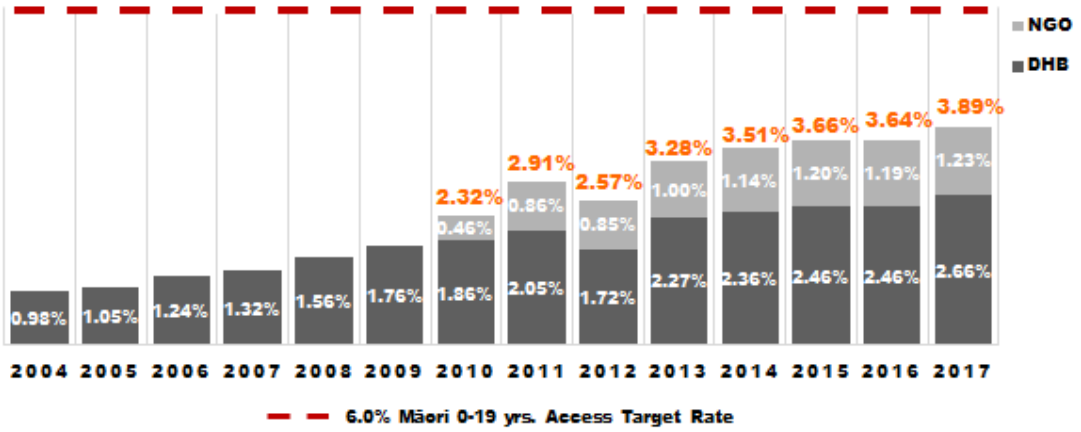
MĀORI TAMARIKI AND RANGATAHI SERVICE USER ACCESS RATES

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 the lack of epidemiological data for the Māori tamariki and rangatahi population, a 6.0% target access rate was recommended for Māori, double that of the general population, based on their higher need for mental health services (Mental Health Commission, 1998).

From 2015 to 2017:

- Improvement seen in the overall Māori access rate from 3.66% to 3.89% (Figure 24).
- Improvement was in all three 0-19 year age groups, especially in the 15-19 year age group.
- Increase was seen in all four regions (Appendix B, Table 10).

Figure 24. Māori Tamariki & Rangatahi Service User Access Rates (2004-2017)



In the second six months of 2017:

- Māori had the highest access rates out of the four ethnic groups at 3.89%; with the highest access rate for 15-19 year olds (9.15%).
- Northern region had the highest Māori access rate of 4.21% (Figure 25).
- Despite improvements, Māori access rates continued to remain below their respective recommended target rates, especially for the 10-14 year age group.

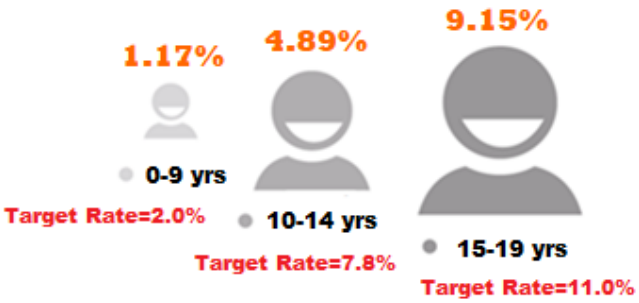
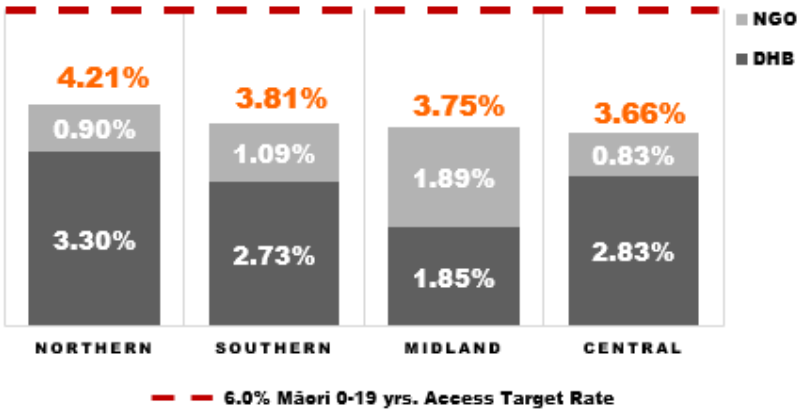


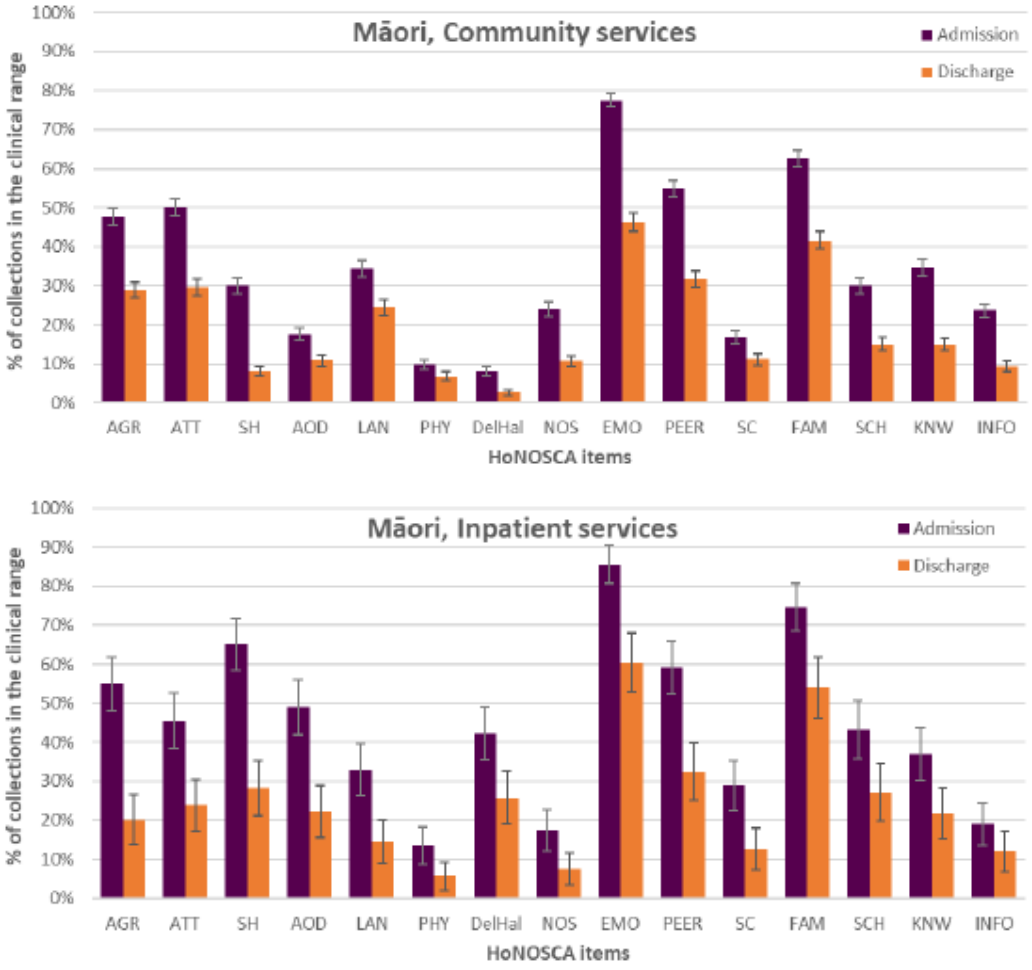
Figure 25. Māori 0-19 yrs Service User Access Rates by Region (2017)



MĀORI TAMARIKI & RANGATAHI SERVICE USER OUTCOMES

To assess whether Māori service users 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 aged 4-17 years) at admission and discharge from inpatient and community child and adolescent mental health services. Māori service user outcomes data, for the 2018 period, showed significant improvements across all items, especially for problems with *emotional or related symptoms* (EMO item) by time of discharge from community and inpatient mental health services (Figure 26).

Figure 26. Māori Chld & Youth HoNOSCA Results (2018)



Note: Percentage of service users in the clinical range (2, 3 or 4) for each HoNOSCA items.
Source: Ministry of Health, PRIMHD extract: Jan-Dec 2018, extracted 9 April 2019, analysed & 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 and Capital & Coast.
- Where specific DHB Kaupapa Māori mental health/AOD services are not available, most DHBs fund local non-DHB services to provide these services. Of the 119 non-DHB services, 38 were Kaupapa Māori infant, child and adolescent mental health/AOD services.
- Māori tamariki and rangatahi are also able to access other DHB-funded mainstream infant, child and adolescent mental health/AOD, peer-support and advocacy services.

MĀORI ICAMH/AOD WORKFORCE

The following information is derived from the Werry Workforce Whāraurau workforce survey (actual & vacant Full Time Equivalents (FTEs)) by ethnicity and occupation submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services, including the National Youth Forensic Services, and 119 DHB-funded non-DHB services (108 NGOs & 11 PHOs) as at 30 June 2018. Therefore, the changes in the workforce is the result of the inclusion of more services in this workforce Stocktake. Additionally, due to the 100% response rate from services, the data presented on the Māori ICAMHH/AOD workforce is possibly the most accurate representation to date.

From 2016 to 2018:

- 19% increase in the overall Māori infant, child and adolescent mental health/AOD workforce, from 353 to 419 (headcount) (Table 5).
- Increases were in three out of the four regions (Northern Midland & Southern), while very little change was seen in the Central region.
- 25% increase in the non-DHB workforce from 205 to 256.
- 10% increase in the DHB Māori workforce (including the National Youth Forensic Service), from 148 to 163.
- 29% increase in the Māori clinical workforce, from 186 to 240.

Table 5. Māori ICAMH/AOD Workforce by Region (2008-2018)

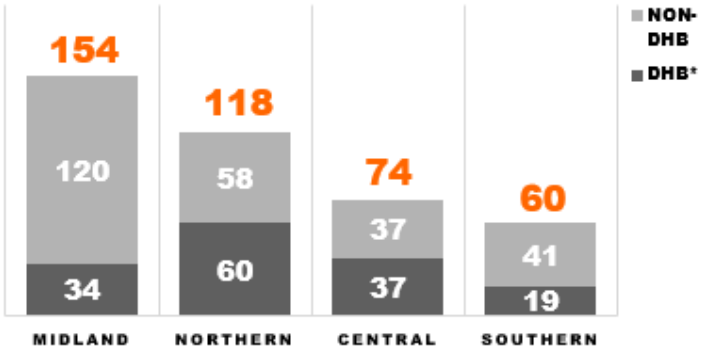
REGION (HEADCOUNT)	DHB						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NORTHERN	48	53	57	52	54	60	23	28	45	75	57	58	71	81	102	127	111	118
MIDLAND	27	25	26	23	33	34	68	58	71	75	83	120	95	83	97	98	116	154
CENTRAL	46	37	42	49	44	37	39	26	41	35	29	37	85	63	83	84	73	74
SOUTHERN	12	16	16	15	17	19	28	22	21	27	36	41	40	38	37	43	53	60
NATIONAL YOUTH FORENSIC SERVICE	-	-	-	-	-	13	-	-	-	-	-	-	-	-	-	-	-	13
TOTAL	133	131	141	139	148	163	158	134	178	212	205*	256	291	265	319	351	353	419

Note: DHB data includes Inpatient Services.
Workforce data from 2008-2018 is based on a 99% response rate from non-DHB services, therefore the Māori workforce for this period is underestimated.

As at 30 June 2018:

- The overall Māori workforce made up 20% of the total ICAMH/AOD workforce (419 out of 2,078 headcount).
- 86% of the Māori workforce was located in the North Island and within the North Island, the largest workforce was in Midland (43%), followed by Northern (33%) and Central (24%). The remainder (14%) were in the Southern region (Figure 27).
- 61% in non-DHB services and 39% in DHB services.
- 57% in the clinical workforce as Social Workers (15%), Nurses (14%), and Alcohol and Drug Practitioners (10%) (Table 6 & Figure 28).

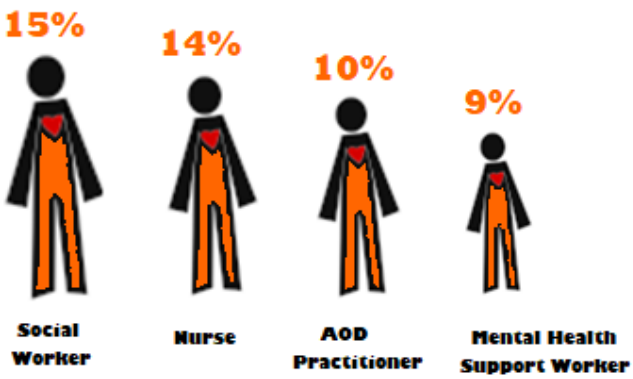
Figure 27. Māori ICAMH/AOD Workforce by Region (2018)



*Excludes National Youth Forensic Service

- 35% in the non-clinical workforce as Mental Health Support Workers (9%), Cultural (9%) and Youth Workers (8%) (Table 6).
- 7% were in Administration (4%) and Management (3%) roles.

Figure 28. Top 4 Māori ICAMH/AOD Workforce by Occupation (2018)



DHB INPATIENT MĀORI ICAMH WORKFORCE

From 2016 to 2018:

- Increase of two from 15 to 17. Increase was in non-clinical roles only.
- Increase in one out of the three Inpatient services (Auckland), no change in Capital & Coast, while Canterbury reported and a decrease of 2, from 4 to 2.

As at 30 June 2018:

- 47% (8) were in the clinical workforce as Mental Health Nurses (35%, 6).
- 53% (9) were in the non-clinical workforce as Mental Health Support Workers (29%, 5) and in Cultural roles (24%, 4) (Table 6).

DHB COMMUNITY MĀORI ICAMH/AOD WORKFORCE

From 2016 to 2018:

- No change was reported in the overall number of the Māori DHB Community workforce. However, Southern, Northern and Midland regions reported increases in the Māori workforce by 4, 2 and 1 respectively, while there was a decrease in the Central region by 7.

As at 30 June 2018:

- Northern region continued to have the largest Māori DHB Community workforce (38%) followed by Midland (26%), Central (23%) and Southern (13%) regions.
- 64% were in the clinical workforce as Social Workers (22%), Nurses (28%) and Psychologists (11%).
- 23% were in the non-clinical workforce as Cultural Workers (20%) (Table 6).
- 13% were in Administration (8%) and Management (5%) roles.

NATIONAL YOUTH FORENSIC SERVICE MĀORI WORKFORCE

As at 30 June 2018:

- The National Youth Forensic Service reported a total of 13 Māori staff largely employed as Nurses (54%), Mental Health Support Workers (31%) and Cultural Workers (15%) (Table 6).

NON-DHB ICAMH/AOD MĀORI WORKFORCE

The 2018 non-DHB Māori workforce now includes all funded NGOs and PHOs. The following workforce information is possibly the most accurate representation of the Māori ICAMH/AOD workforce to date. Due to the inclusion of additional contracted services and a 100% response rate from non-DHB services, the 2016 to 2018 data showed:

- 25% increase in the Māori non-DHB workforce, from 205 to 256 (headcount) (Table 5).
- Increases were seen in all four regions, with the largest increase in the Midland region by 37, from 83 to 120 (headcount).
- 37% increase in the clinical workforce, from 102 to 140.
- 11% increase in the non-clinical workforce, from 92 to 102.

As at 30 June 2018:

- 47% were based in the Midland region, followed by Northern (23%), Southern (16%) and Central (14%) (Table 5).
- 55% were in the clinical workforce as Alcohol and Drug Practitioners (15%), Social Workers (13%) and Nurses (9%).
- 40% were in the non-clinical workforce as Youth Workers (13%), Mental Health Support Workers (11%), Peer Support Workers (6%) and in various other non-clinical roles (Table 6).
- 5% were in Administration (2%) and Management (3%) roles.

Table 6. Māori ICAMH/AOD Workforce by Occupation (2018)

Māori ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB			DHB Total	Non-DHB	Total
	Inpatient	Community	National Youth Forensic Service			
Alcohol & Drug Practitioner	-	3	-	3	39	42
Child & Adolescent Psychiatrist	1	4	-	5	-	5
Clinical Placement/Intern	-	1	-	1	4	5
Co-Existing Problems Clinician	-	6	-	6	4	10
Counsellor	1	1	-	2	15	17
Family Therapist	-	-	-	-	3	3
Nurse	6	24	7	37	23	60
Occupational Therapist	-	1	-	1	-	1
Psychologist	-	15	-	15	7	22
Social Worker	-	29	-	29	32	61
Other Clinical[1]	-	1	-	1	13	14
Clinical Sub-Total	8	85	7	100	140	240
Cultural	4	26	2	32	4	36
Educator	-	-	-	-	3	3
Mental Health Consumer	-	1	-	1	3	4
Mental Health Support	5	2	4	11	27	38
Peer Support/Advocacy	-	-	-	-	15	15
Whānau Ora Practitioner	-	-	-	-	13	13
Youth Worker	-	1	-	1	32	33
Other Non-Clinical[2]	-	1	-	1	5	6
Non-Clinical Sub-Total	9	31	6	46	102	148
Administration	-	11	-	11	6	17
Management	-	6	-	6	8	14
Total	17	133	13	163	256	419

1. Other Clinical = Kai Manaaki; Generic Mental Health Practitioners; Therapists; Brief Intervention Clinician; Māori Physical Therapist
2. Other Non-Clinical: Caregivers; Service Coordinators

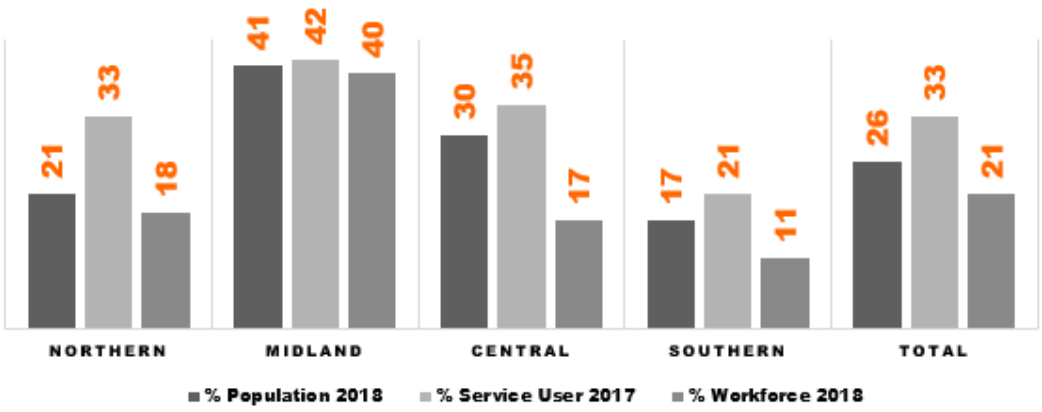
MĀORI TAMARIKI & RANGATAHI POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

The increasing trend in Māori service users accessing services indicate continued demand for services (9% increase from the 2015 & 2017 period, and a 9% average increase from 2010 to 2017). However, latest access rates for Māori remained below recommended rates for all three age groups, indicating unmet needs for the Māori infant, children and adolescent population. Given that Māori children and adolescents continue to have high mental health needs and have the highest suicide rates in the country, increasing access to services early for Māori is critical.

Due to the inclusion of all funded ICAMH/AOD service providers, the 2018 workforce data provides the most accurate representation of the Māori workforce to date. However, despite the inclusion of an additional 19% of the Māori workforce, workforce comparisons with service users continue to highlight significant disparities, especially in the Northern, Central and Southern regions (Figure 29). If the current trend seen in the Māori workforce continues, it will lead to greater disparities between the service users and the workforce. Therefore, the need to increase the Māori workforce across all occupations and strengthening and supporting the current Māori workforce with the right knowledge and skills remains a key focus.

While there has been an increase in Māori service users accessing non-DHB provider services, the majority (68%) continue to access mainstream services and are seen by the non-Māori workforce, therefore, enhancing the cultural competency of the mainstream workforce, to work effectively with Māori tamariki and rangatahi and their whānau, also remains a crucial area of development.

Figure 29. Māori 0-19 yrs Population, Service User & Workforce Comparisons



SUMMARY

The Māori population is a growing and youthful population with almost half of Māori being between the ages of 0 and 19 years. Despite a slower growth rate, relative to the Pacific and Asian populations, Māori will continue to have a younger age structure than the total New Zealand population due to the highest birth rate compared to Pacific, Asian European or Other Ethnicities (Ministry of Health, 2019). Data also show that 12% of Māori tamariki (based on SDQ scores) have a higher likelihood of developing social and behavioural problems as they have the highest rate for conduct problems compared to non-Māori children. Therefore, early intervention is critical for Māori pepe, tamariki and rangatahi.

Māori also experience lower socioeconomic status, have double the prevalence rates of mental health disorders and have the highest suicide rates in the country. Unfortunately, regions with large populations of Māori pepe, tamariki and rangatahi, such as the Northern and Midland regions, and parts of the Central region, should anticipate continued demand for services by those whānau in distress. We note that the new funding for mental health and addiction services includes targeted funding for suicide prevention and support for bereaved families. Additionally, the Ministry of Health is soon to release a new Suicide Action plan and it is hoped that this will result in a rapid change on the suicide and self-harm rates.

The majority of Māori pepe, tamariki and rangatahi continue to be seen by mainstream DHB services/teams rather than by Kaupapa Māori services/teams as there continues to be little progress in the number and types of mental health/AOD services available to Māori, especially in DHB-delivered services. Māori service users are also accessing services in higher numbers/ rates than any other ethnic group. While the number of Māori service users continues to increase, their access rates have not increased at a level that is comparable to need and continues to remain below the 6% recommended target rate (Mental Health Commission, 1998), especially in the 10-14 year age group. Improving access to services for Māori especially for under 15 year olds should remain a priority, especially when data indicate that early intervention is critical for improving long term health and mental health outcomes. Additionally, significant improvements can be seen in mental health and behavioural outcomes by time of discharge, for Māori infants, children and adolescents who *do* access specialist mental health services.

The latest workforce data includes all funded providers (100% response rate), providing the most accurate representation of the Māori workforce to date. However, despite this addition in the Māori workforce, significant disparities continue to exist between the ethnicities of service users and the workforce across all regions. Increasing the Māori workforce across all occupation groups remains a key area of focus. The need for increasing the Māori workforce is wholly acknowledged by services but challenges remain for the recruitment (lack of qualified clinical practitioners available for recruitment, with many at entry-level roles) and retention (high staff turnover) of the workforce. Building Māori workforce capacity is further hampered by the lack of funding, especially for non-DHB services. Limited funding also inhibits the ongoing capability development of their current workforce.

While there has been an increase in Māori service users accessing non-DHB services, the majority (68%) continue to access mainstream services and are seen by the non-Māori workforce. Therefore, enhancing the cultural competency of the mainstream workforce also remains a key area of development.

RECOMMENDATIONS

In light of the current data, and to ensure alignment with government priorities (Ministry of Health, 2007; 2012b; 2016) and *He Ara Oranga*, the following recommendations are made to support improvements in the mental health outcomes for all Māori pepe, tamariki and rangatahi within a whānau-centred/whānau ora context. These recommendations have been developed in consultation with the Werry Workforce Whāraurau Māori Cultural Advisors.

Increase and allocate appropriate levels of funding:

- Lack of funding to support essential service and workforce development activities has been identified as a major barrier by all services. Allocating appropriate levels of funding is a first step in building essential infrastructure (organisational structures, technology, models of care such as whānau ora, trauma-informed care) to advance further service expansion and development and progress various workforce development initiatives (recruitment, retention, role development/expansion, training) that are required. DHBs, in collaboration with their local key stake holders (i.e. schools, tertiary education providers, Youth One Stop Shops, PHOs, and NGOs), should engage in strategic planning processes to identify challenges and opportunities; actively monitor local service demands and areas of service development, including new models of care for their population, and enhance workforce development; and ensure funding is allocated accordingly.

Develop and provide early intervention programmes, services and workforce at primary level:

- **Early intervention programmes*:*** 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 and suicide prevention strategies and programmes for Māori in primary care settings.
    - ***Targeted early intervention programmes*** that target the reduction of emotional symptoms, peer problems, and especially conduct problems in Māori children (3-14 years) as identified by the Strengths and Difficulties Questionnaire (SDQ) scores from the New Zealand Health Survey data (Ministry of Health, 2018), and enhance resilience and a sense of belonging, identified to be protective factors for Māori youth, (Denny, 2016), should be developed.
    - ***Evidence-based parenting programmes*** should be widely available such as ***The Triple P – Positive Parenting Programme,*** which has been shown to be one of the most effective evidence-based parenting programmes in the world for preventing and reducing children's emotional and behavioural problems. Providing evidence-based parenting programmes that work across cultures, socio-economic groups and in different kinds of family structures is critical for intervening early and improving long term outcomes for children. *Triple P Primary* also has the advantage of being suitable for delivery within services that families already engage with such as early childhood education, social services and Well Child Tamariki Ora.
- **School-based health education and services**: School based health services 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.*

    Guidelines for youth health care in secondary schools have been developed to assist planning, funding or providing primary health care services in secondary schools and can be used as a tool to continuously improve the quality of these services (Ministry of Health, 2014).

a. ***Mana Ake: Stronger for Tomorrow*** is an example of a school-based early intervention programme that provides support for school children aged 5-12 years across Canterbury who are experiencing on-going issues that impact on their well-being such as anxiety, social isolation, parental separation, grief and loss, and managing emotions. This programme is also a good example of inter-agency collaboration which includes education, health, police, Oranga Tamariki and NGOs.

- **Provide whānau –centred/whānau ora services*:*** Provide more and better services which are whānau-centred and provide greater choice, is essential. Kaupapa Māori services commonly integrate the whānau ora approach with clinical models to offer versatility that meets the needs of whānau and community.
- **Provide alternative community-based services*:*** Provide services (e.g. *One Stop Shops; Youth Hubs)* that are more accessible for the 12% of Māori rangatahi who are not in employment, education or training (NEET), including homeless youth, as this could help to alleviate some of the access issues highlighted.
- **Harness the power of technology**: Young people in New Zealand have high rates of internet access and use (Gibson et al., 2013; Statistics New Zealand, 2004b). This platform provides opportunities to develop e-therapy tools to assist with easier and earlier access to treatment. An example is the NZ developed, on-line computerised cognitive behavioural therapy program, SPARX. Latest user data on the use of SPARX showed that from a total of 2,110 young people registered to use SPARX in 2019, 16% were Māori, the second highest registered user after NZ European (62%). The largest referral source for all users were their schools (39%). SPARX has been shown to be an effective resource for adolescents with depression at primary healthcare sites. The use of the program resulted in clinically significant reductions in depression, anxiety, and hopelessness and an improvement in quality of life (Merry et. al., 2012). Taitamariki participating in the interviews found SPARX to be helpful, the Māori designs were appropriate and useful, and the ability to customize the SPARX characters with Māori designs was beneficial and appeared to enhance cultural identity. Māori young people felt engaged which in turn, assisted with the acquisition of relaxation and cognitive restructuring skills. Using SPARX led to improved mood and increased levels of hope for the participants. In some instances, SPARX was used by wider whānau members with reported beneficial effect (Shepherd et al., 2018). Therefore, developing, promoting and enabling access to local and international evidence-based, or validated, mental health apps, online self – help guides and e-therapy tools and most importantly keeping users engaged, is potentially an effective way of intervening early and increasing early access to treatment.
- **Strengthen and support the primary mental health services and workforce (capacity, knowledge and skill development):** GPs are the largest source of referrals to ICAMH/AOD services, and nurses are a critical workforce in school-based and primary health services. Continued investment in the development and provision of primary health services, developing new roles, and supporting and strengthening the knowledge and skill development of the respective workforces to deliver early and effective mental health care and could alleviate the demand on ICAMH/AOD specialist services.
- **Improve access to services by enhancing service user pathways from primary to specialist services**: Mental health outcome data for Māori children and youth show significant improvements in their emotional wellbeing as a result of accessing specialist mental health services. While Māori access to services has increased, it still remains short of meeting actual need. In consultation with tangata whaiora, effective strategies to increase access rates must be identified. Enhancing service user pathways to key services, especially for those below 15 years of age, should be a priority. 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. Engaging in service quality improvement processes informed by whānau could also improve access. Improving access to services requires a collaborative approach between schools, primary and specialist services, within an enabling infrastructure.

Increase, strengthen and support the specialist ICAMH/AOD services and workforce:

- **Increase workforce capacity:** Due to increases in demand for services by Māori and shortages in the Māori workforce, there is a need to increase the Māori workforce (DHBs and NGOs) to adequately represent and cater for the growing number of Māori service users.
    - ***Workforce planning:*** Services need to actively monitor their local service provision (incorporating a whānau ora model of service delivery which meets the needs of whānau), potential and actual service demand within current workforce capacities and capabilities (specialist knowledge and skills required) and ensure funding is allocated accordingly. Services also need to ensure that active recruitment and retention strategies for the Māori workforce are seen as a key priority and are embedded in a service's strategic plans. Developing career pathways into the sector and ensuring that local schools, tertiary education providers, PHOs, NGOs and DHBs are all part of the workforce planning processes should also be considered. The use of national competency frameworks such as *Real Skills Plus* within the training and specialist sector can inform and create a "job ready" infant, child and adolescent mental health/AOD workforce.
    - ***Recruitment:*** Lack of qualified staff for recruitment and a high turnover of specialist staff contribute to current workforce shortages. A concerted drive is required to increase the capacity of the Māori workforce (including recruitment of new graduates, sourcing from local communities) to work in specialist ICAMH/AOD services. There needs to be ongoing investment into active, targeted recruitment strategies for specialist roles. Given that approximately a third of Māori service users are accessing non-DHB services; increasing the non-DHB workforce also needs to be considered. Specific training and career pathways to transition entry-level and experienced non-clinical workers into the clinical workforce could be a way to increase the Māori clinical workforce. Recruitment can be enhanced by utilising national competency frameworks such as *Real Skills Plus* to recruit staff with the required knowledge and skills based on local service user needs, to create a more effective workforce.
    - ***Retention:*** While increasing the capacity of the Māori workforce remains a much slower strategy in addressing current shortages, retaining the current Māori workforce should be one of the current areas of focus. High turnover of the workforce exacerbates workforce shortages. Identifying reasons for staff turnover and addressing these factors need to be considered. For instance, staff turnover is particularly high in NGO services as NGOs work within a more competitive funding environment and regularly lose staff to higher salaries offered in other services/agencies. Short term contracts, due to limited funding, also affect the recruitment and retention of NGO staff. Given that more Māori are employed in NGOs, addressing the retention of this workforce is critical. An increase in NGO funding could allow for longer term contracts and allow for pay parity for similarly skilled staff, thereby aiding retention of the NGO specialist and largely Māori workforce
        - ***Look after the workforce:*** Developing workforce resilience is one of the key steps to workforce retention. Resilience protects the mental and physical health and wellbeing of staff and helps delivery of quality services. Current trends show an increasing service user demand within current workforce capacity, which can lead to stress and burnout, and this has been indicated as one of the reasons for high turnover rates in some services. A valued team, with a strong and positive set of personal relationships between team members, works more effectively by providing emotional support, informal consultation and motivation to be at work and to work effectively as a team. An example of a model of care that places an emphasis on self-care and staff wellness as an individual and organisational responsibility, is the trauma-informed care approach. An on-line training module on self-care has been developed with positive feedback from the workforce and a face-to-face workshop, based on the success of the online training, is currently under development. Furthermore, 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. While many services have implemented various wellbeing activities and initiatives and acknowledging the need for looking after their workforce, it should be an essential part of a service's workforce retention strategy.

- ***Expand and develop existing roles:*** Identifying fast-track solutions to address workforce shortages such as the development of existing roles like the peer workforce (which includes service user, consumer and peer workers) provide good opportunities for increasing the capacity of the Māori workforce. Currently the Māori peer workforce makes up a small proportion of the overall Māori workforce (approximately 5%). Therefore, an investment in developing these roles is required. Peer workforce competencies (Te Pou o Te Whakaaro Nui, 2014) have been developed for planners and funders, service managers, training providers and workers to help guide best practice in peer workforce development in services.
- ***Explore new ways of working and work collaboratively with other services***: To overcome workforce shortages, building relationships and working in partnership with other services can be an effective strategy in sharing limited resources, especially in the provision of clinical support to NGOs (particularly in rural areas). This is already occurring in some areas where DHBs provide clinical support and senior clinical staff for advice/consultation to NGOs and NGOs provides cultural support to DHBs. However, while the need to work more collaboratively is acknowledged by services, barriers and challenges in doing so continue to exist and need to be identified and effectively addressed.

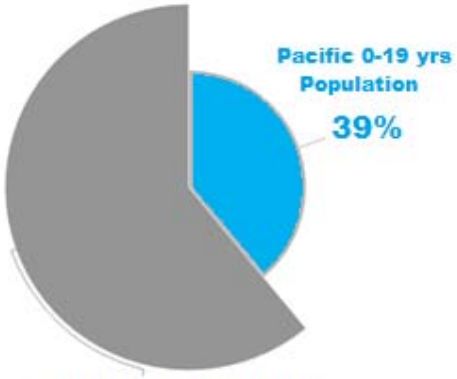
- **Increase workforce capability:** While increasing the Māori workforce is a long-term strategy to remedy current workforce shortages, there is an ongoing need to strengthen and support the existing Māori and non-Māori ICAMH/AOD workforce. Furthermore, the majority of the total Māori workforce is employed in NGO services, therefore strengthening and supporting the Māori NGO workforce is vital.

  - ***Identify and develop knowledge and skills:*** Given the growing complexity of Māori infant, child and adolescent mental health needs (e.g. socio-economic factors, youth suicide), strengthening the current Māori workforce with the right skills is another key area of focus. As a first step, services need to be actively engaged in identifying current competency levels and opportunities for further targeted development using competency assessment tools such as *Real Skills Plus*. Currently improvements (as assessed by the *Real Skills Plus* tool) are required for *Core Intervention* skills especially for infants, therefore, training and professional development in this area is required.
  - ***Identify and strengthen cultural knowledge and skills:*** Nationally, Māori service users are largely accessing mainstream DHB provider services and are largely seen by a non-Māori workforce, therefore, working within a dual clinical and cultural competency framework is essential. A continued integration of the skills and knowledge outlined in available competency frameworks, e.g. *Takarangi Māori Competency Framework* (Matua Raki, 2010) is required in services nationally. Furthermore, the capability of current Māori cultural staff to provide cultural supervision to non-Māori staff should be supported and built on, to ensure clinical and cultural safety for Māori service users and their whānau.
  - ***Enable access to targeted knowledge and skills training****:* Once knowledge and skill gaps have been identified, it is essential that the Māori and non-Māori workforce is able to access the required evidence-based specialist and cultural training. The lack of adequate funding has been reported by the NGO sector as a key barrier to accessing specialist training. Until more funding is allocated to NGOs, shared training between DHB and NGOs could be a possible strategy.

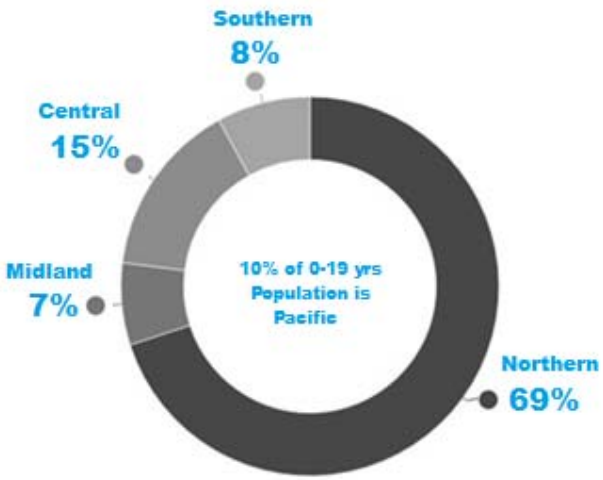
PACIFIC NATIONAL OVERVIEW

PACIFIC INFANT, CHILD AND ADOLESCENT POPULATION

- The Pacific population in New Zealand includes a culturally diverse group made up of 22 different ethnic groups. The largest Pacific groups are Samoan (49%), Cook Island Māori (21%), Tongan (20%), Niuean (8%, Fijian (5%) and Tokelauan (2%) (Statistics New Zealand, Census 2013).
- The majority of Pacific Peoples who identified with at least one Pacific ethnicity were born in New Zealand (61%). The highest proportion of New Zealand born Pacific people included Niuean (79%), Cook Island Māori (77%), Tokelauan (74%), Samoan (63%) and Tongan (60%) (Statistics New Zealand, Census 2013).
- A 2% growth in the Pacific 0-19 years population was projected from 2016 to 2018. The largest projected increase was seen in the Southern region by 8%, followed by Midland 7% (Appendix A, Table 1).



- The Pacific population is a youthful population compared to the total New Zealand population. 39% are in the 0-19 year age group.
- Pacific infants, children and adolescents currently make up 10% of the total 0-19 years population. The majority live in the Northern region (69%).
- 10-year population projections indicate a 9% growth in the Pacific population from 2018 to 2028, with the largest growth projected for the Southern (by 33%) and Midland regions (by 28%) (Appendix A, Table 2), indicating an increase in potential demand for services in these regions.
- Services would need to take these projections into consideration when planning for local service and workforce development activities.



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. 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 is also higher in Pacific peoples (10%) than in other ethnicities in New Zealand; rates for Māori are 9%, Asian 7% and European 5% (Ministry of Health, 2012a).
- 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).
- 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).

  Latest findings from the *Growing Up in New Zealand* study *(Mind the gap – unequal from the start: Addressing inequalities utilising evidence from Growing Up in New Zealand,* (Economic & Social Research Council, 2019, p.7) showed that:

  > "*Māori and Pasifika children experience the highest burden of socioeconomic disadvantage in their early years as well as an unequal burden of significant co-morbidities in terms of health and development throughout their life course. By the time they start school (at age 5 years) many are already falling behind their peers in terms of preparedness for formal education and readiness to engage in learning*."

  Lived experience of inequality and adversity during the early years has consistently shown that the detrimental effects can last long into adulthood.
- Strengths and Difficulties Questionnaire (SDQ) scores, based on the New Zealand Health Survey data indicated that 10% of Pacific children (3-14 years) had an overall high or 'concerning' SDQ score, compared to an 8% score at that level overall. These scores can be used to predict the likelihood of social, emotional and/or behavioural problems. *Concerning* scores for Pacific children within the four aspects of development were:
  - *21% for Peer Problems*
  - *12% for Emotional Symptoms*
  - *14% for Conduct Problems*
  - *7% for Hyperactivity*
  - *Pacific children were more likely to experience emotional symptoms, peer and conduct problems than were non-Pacific children, but rates for hyperactivity were lower.*
- The *Youth'07* study on 1,190 Pacific high school students (Helu, Robinson, Grant, Herd, & Denny, 2009) indicated no significant difference in reported depressive symptoms between Pacific (11%) and NZ European students (9%), but more Pacific students were likely to have attempted suicide. In addition:
  - *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 2012 Adolescent Health Research Group findings (Fa'alili-Fidow et al., 2016) on 1,445 Pacific students (12-18 years old) found that for Pacific students:
    - *Almost twice as likely to report being unable to access healthcare compared to NZ Europeans.*
    - *4% decrease in the proportion reporting significant depressive symptoms from to 2001 to 2012. However, the proportion of those who had made a suicide attempt in the previous 12 months had remained stable at about 9%.*
    - *Proportions reporting significant depressive symptoms were similar to NZ Europeans students.*
    - *Slightly more likely to report self-harm and about three times more likely to have attempted suicide. Female Samoan and Tongan students were significantly more likely than their male counterparts to have engaged in self-harm. Samoan female students reported higher rates of attempted suicide than Samoan males.*

- An indicator for youth disengagement is the proportion of young people who are not in employment, education or training (NEET). The NEET rate for youth 15-24 years as at June 2018 was at 11.6%; 7.8% for 15-19 year olds; and 14.7% for 20-24 year olds. NEET rates for youth in the Southern Auckland Initiative area were higher at 19.2% due to higher proportions of Māori and Pacific living in this area. Pacific NEET rates were the highest at 18% for the overall 15-24 age group, 10.9% for 15-19 year olds and 25.4% for the 20-24 year olds. (Tuatagaloa & Wilson, 2018). The NEET rate for both Pacific males and females 15-24 years increased over the year; 13.3% of males and 20.5% of females were NEET (Ministry of Business Innovation & Employment, 2018b). NEET status as been found to be associated with a number of personal, social, health and mental health outcomes:
    - *Marginalisation and dependence, with young people failing to establish a sense of direction (Cote, 2000).*
    - *Poor physical and mental health outcomes (individuals feeling lonely, powerless, anxious or depressed (Creed & Reynolds, 2001; Henderson, et al., 2017).*
    - *Further exclusion and increased association with risk behaviours. Greater use of drugs, alcohol and criminal activity (Fergusson, Horwood, & Woodward, 2001; Henderson, et al., 2017).*
    - *More likely to be parents at an early age and face ongoing issues with housing and homelessness (Cusworth, et al., 2009).*

- The consistently high NEET rate will continue to impact on the mental health and wellbeing of those already in high risk groups which can predict an even greater need for mental health services.

- For Pacific peoples, the leading cause of mortality is injury, largely attributable to suicide. There are also higher rates of mental health admissions for schizophrenia and schizotypal/delusional disorders (Mila-Schaaf, 2008). Latest suicide data (2015) show that while Māori young people (15-24 years) have the highest suicide rates in the country (35.7 per 100,000 population), Pacific young people have the second highest at 21.1 per 100,000 population; compared to Other Ethnicity (15.5 per 100,000 population) and Asian (5.8 per 100,000 population). Pacific males within the 15-24 age range have the highest suicide rate of 29.8 per 100,000 population, in contrast to the overall Pacific male rate of 12.6% (Ministry of Health, 2018).

- 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 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 adults, these issues may be similarly relevant in hindering Pacific families' access to essential 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 service users, partly due to language barriers and a lack of interpreter resources.*

- Socioeconomic inequalities, high mental health needs for Pacific infants, children and young people and persistent low access to services, strongly signal an urgent need for early intervention, including suicide prevention, and improving early access to services to enhance the overall long-term mental health outcomes for Pacific.

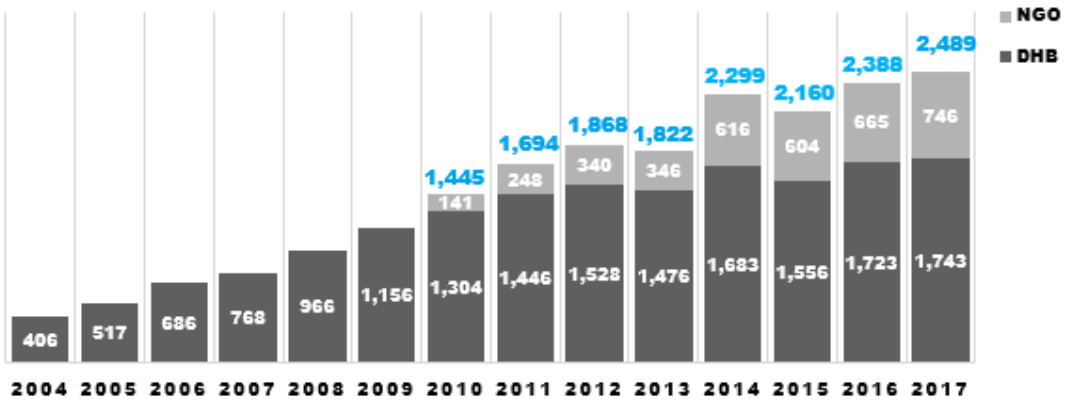
PACIFIC SERVICE USER ACCESS TO ICAMH/AOD SERVICES

Pacific service user access data extracted from PRIMHD (based on the *Service users by DHB of Domicile* or residence) for the second six months of each year (July to December) provides data on the actual demand for services. PHO service user data is not captured in PRIMHD; therefore, all service user data pertains to DHB and NGO services only.

From 2015 to 2017:

- 15% increase in the number of Pacific service users accessing services (Figure 30). Increase seen largely for females by 22%, males by 10%.
- Increases in the Northern, Midland and Central regions only, with the largest increase in Midland by 68%. A 34% decrease in Pacific service users in the Southern region (Appendix B, Table 4).

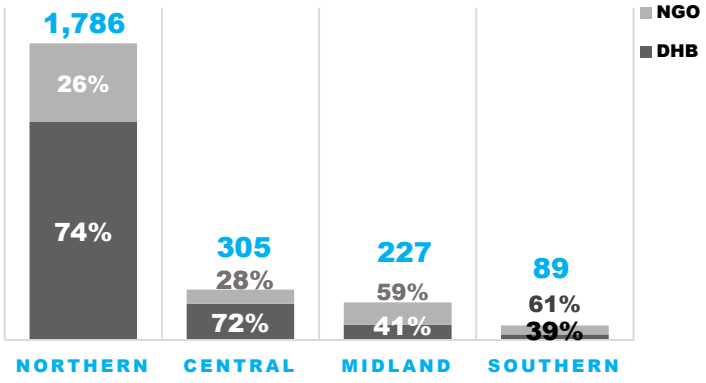
Figure 30. Pacific 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Pacific children and adolescents made up 7% of service users accessing ICAMH/AOD services.
- 55% (1,369) were Pacific males.
- Nationally, 70% accessed DHB services and 30% accessed NGOs.
- Regionally, over half of all Pacific service users in the Midland (59%) and Southern (61%) regions had accessed NGOs (Figure 31)
- 72% of all Pacific service users in the country are seen by services in the Northern region; within the Northern region, 99% in the greater Auckland area (Auckland, Waitemata & Counties Manukau) (Figure 31).

Figure 31. 0-19 yrs Pacific Service User by Region (2017)



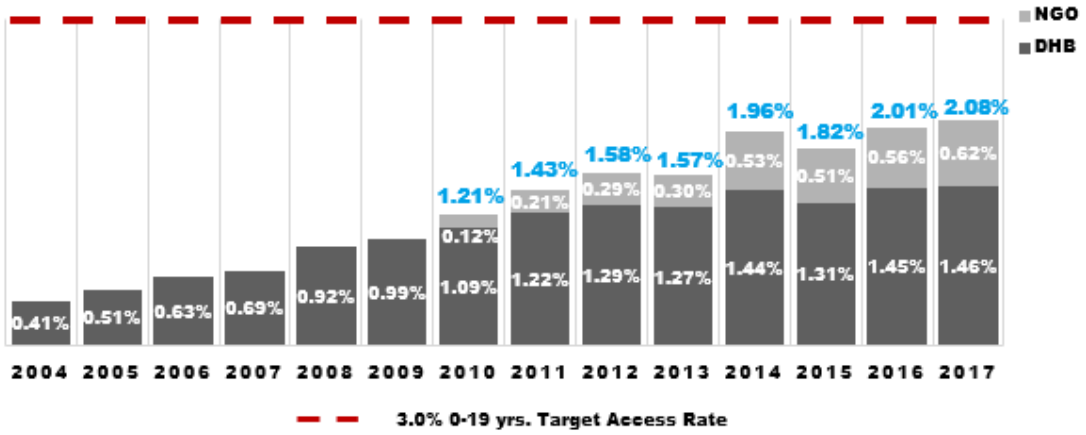
PACIFIC SERVICE USER ACCESS RATES

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 the lack of epidemiological data for the Pacific 0-19 years population, there are no specific target rates for Pacific, therefore their access rates have been compared to the rates for the general 0-19 years population. However, the Pacific population experiences higher levels of mental health disorder than the general population (Ministry of Health, 2008); therefore, the target access rates may be a conservative estimate of actual need.

From 2015 to 2017:

- Pacific access rates increased from 1.82% to 2.08% (Figure 32). Improvements were in the 0-9 year and 15-19 year age groups only (Appendix B, Table 11).

Figure 32. Pacific 0-19 yrs Service User Access Rates (2004-2017)



In the second six months of 2017:

- Pacific services users had the third highest access rate (2.08%) out of the four ethnic groups: Māori 3.89%; Other Ethnicity 3.36%; and Asian 0.86%, with the highest access rate in the Midland region (2.63%) (Figure 33).
- 15-19 year olds had the highest access rate (4.90%) followed by 10-14 year olds (2.44%).
- While improvements were seen in access rates for all three age groups, these remained lower than the national average rate of 3.03% and across all age groups and regions. Therefore, improving access rates for Pacific infants, children and adolescents, especially for the 10-14 year age group, remains a key area of focus.

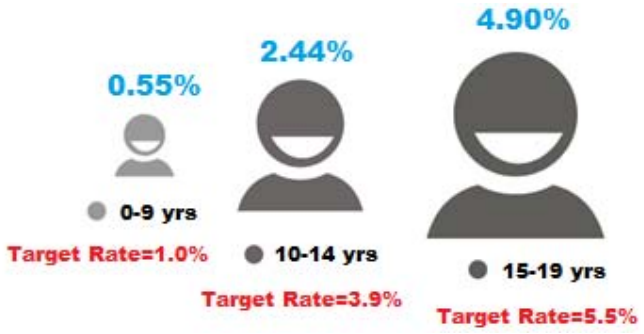
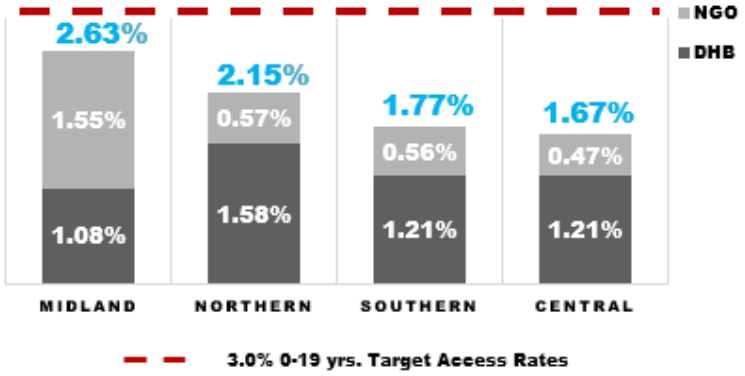


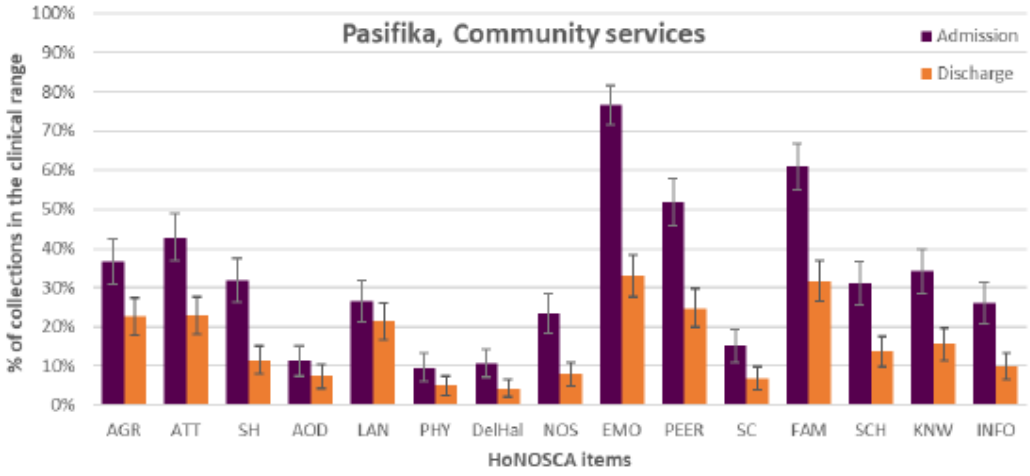
Figure 33. Pacific 0-19 yrs Service User Access Rates by Region (2017)



PACIFIC SERVICE USER OUTCOMES

To assess whether Pacific service users 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 aged 4-17 years) at admission and discharge from inpatient and community child and adolescent mental health services. Pacific service user outcome data, for the 2018 period, showed significant improvements in the majority of items assessed, especially for emotional related symptoms (EMO item), by time of discharge from DHB community mental health services (Figure 34).

Figure 34. Pacific Child & Youth HoNOSCA Results (2018)



Note: Percentage of service users in the clinical range (2, 3 or 4) for each HoNOSCA items. Numbers are too small for Pasifika Inpatient analysis. Source: Ministry of Health, PRIMHD extract: Jan-Dec 2018, extracted 9 April 2019, analysed & 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 ICAMH/AOD services, only one provides dedicated Pacific services for the 0-19 year olds:
    - Central region: Capital & Coast DHB: *Health Pasifika Child Adolescent & Family Services.*
- Where specific DHB Pacific mental health/AOD services are not available, most DHBs fund their local NGOs to provide such services.
- Of the 119 non-DHB services that were identified, only four provided dedicated Pacific services in the following regions and DHB areas:
    - Northern region: *Penina Trust (Counties Manukau)*
    - Midland region: *K'aute Pasifika, Raukawa Charitable Trust (Waikato)*
    - Central region: *Taeaomanino Trust (Capital & Coast).*
- 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, 2012a), 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 the Werry Workforce Whāraurau workforce survey (actual & vacant Full Time Equivalents (FTEs) by ethnicity & occupation) submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services, including the National Youth Forensic Service, and 119 non-DHB providers (108 NGOs & 11 PHOs) as at 30 June 2018.

From 2016 to 2018:

- The inclusion of the National Youth Forensic Service, an additional 11 PHOs and a 100% response rate from all services, has led to an 18% increase in the Pacific ICAMH/AOD workforce, from 119 to 141 (headcount) (Table 7).
- As a result of this inclusion, there was a 24% increase in the Pacific DHB workforce (from 68 to 84), mainly in the Central region.
- 33% increase in the Pacific clinical workforce, from 61 to 81.
- 6% increase in the non-clinical workforce, from 52 to 55.

Table 7. Pacific ICAMH/AOD Workforce by Region (2008-2018)

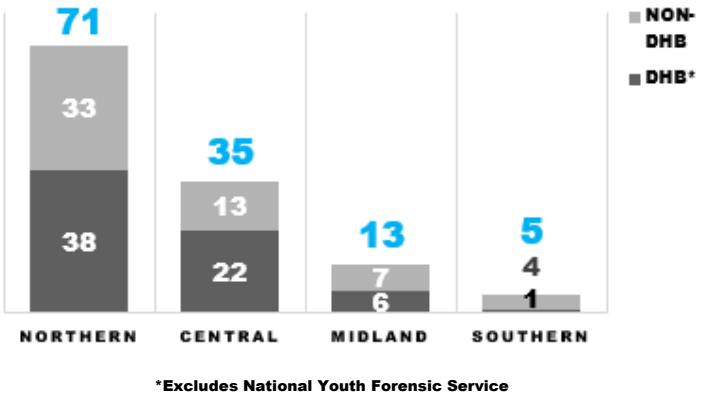
REGION	DHB[1]						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
Northern	29	35	39	35	40	38	9	17	27	36	32	33	38	52	66	71	72	71
Midland	1	2	2	1	3	6	7	6	4	6	9	7	8	8	6	7	12	13
Central	14	19	16	18	22	22	6	4	6	9	6	13	20	23	22	27	28	35
Southern	-	1	2	2	3	1	8	9	10	7	4	4	8	10	12	9	7	5
National Youth Forensic Service	-	-	-	-	-	17	-	-	-	-	-	-	-	-	-	-	-	17
TOTAL	44	57	59	56	68	84	30	36	47	58	51	57	74	93	106	114	119	141

1. Includes Inpatient and Regional Services

As at 30 June 2018:

- The Pacific workforce made up 7% of the total ICAMH/AOD workforce (141 out of 2,078 headcount).
- 96% of the total Pacific workforce was located in the North Island. Within the North Island, 52% in Northern and 38% Central (including the Pacific Youth Forensic Service workforce) (Figure 35).
- The sub-ethnicity of the Pacific workforce consisted of Samoan (60%), Tongan (10%), Tokelauan (10%), Cook Island (8%), Niuean (7%), Fijian (4%) and Tuvaluan (1%). Half of the workforce was fluent in their respective languages, while the remainder were either semi-fluent or understood some of their language.

Figure 35. Pacific ICAMH/AOD Workforce by Region (2018)



*Excludes National Youth Forensic Service

- 60% employed in DHB services (Table 7).
- 40% employed in non-DHB services.
- 57% in clinical roles as Nurses (24%), Alcohol & Drug Practitioners (11%), Social Workers (11%) and Counsellors (3%) (Table 8 & Figure 36).
- 39% in the non-clinical workforce as Mental Health Support Workers (22%), Youth Workers (7%) and Cultural Workers (4%) (Table 8).
- 4% in Admin (0.7%) and Management (3%) roles.

Figure 36. Top 4 Pacific ICAMH/AOD Workforce by Occupation (2018)

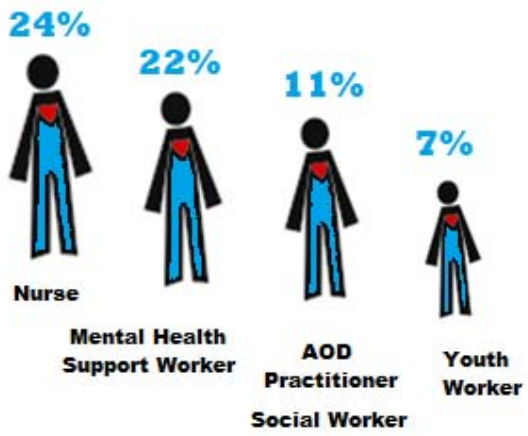


Table 8. Pacific ICAMH/AOD Workforce by Occupation (2018)

Pacific ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB			DHB Total	Non-DHB	Total
	Inpatient	Community	National Youth Forensic Service			
Alcohol & Drug Practitioner	-	3	-	3	12	15
Child & Adolescent Psychiatrist	-	3	-	3	-	3
Counsellor	-		-	-	4	4
Nurse	7	16	5	28	6	34
Occupational Therapist	-	1	-	1	-	1
Psychotherapist	-		-	-	1	1
Psychologist	-	3	-	3	-	3
Social Worker	-	12	-	12	3	15
Other Clinical[1]	-	2	-	2	3	5
Clinical Sub-Total	7	40	5	52	29	81
Caregiver	-	-	-	-	2	2
Cultural	-	5	1	6	-	6
Educator	-	-	-	-	2	2
Mental Health Consumer	-	-	-	-	1	1
Mental Health Support	9	3	11	23	8	31
Peer Support Worker	-	-	-	-	2	2
Youth Worker	-	-	-	-	10	10
Other Non-Clinical	-	-	-	-	1	1
Non-Clinical Sub-Total	9	8	12	29	26	55
Administration	-	1	-	1	-	1
Manager	-	2	-	2	2	4
Total	16	51	17	84	57	141

1. Other Clinical = Therapists; Other SMO

DHB INPATIENT PACIFIC INFANT, CHILD AND ADOLESCENT MENTAL HEALTH WORKFORCE

From 2016 to 2018:

- Very little change in the Pacific Inpatient workforce with an increase of one from 15 to 16 (headcount).
- Capital & Coast DHB Inpatient reported 3 additional Pacific staff, from 5 to 8; both Auckland & Southern DHB Inpatient Services reported a decrease of 1 Pacific staff.

As at 30 June 2018:

- The Pacific Inpatient workforce comprised Mental Health Nurses (7, headcount) and Mental Health Support Workers (9) (Table 8).

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

From 2016 to 2018:

- A decrease of two, from 53 to 51. Decrease was seen in the non-clinical workforce (Table 8).

As at 30 June 2018:

- All of the DHB Pacific community workforce was located in the North Island, 61% in the Northern, 27% in Central and 12% in Midland regions.
- 78% in clinical roles: Nurses (31%) and Social Workers (24%) (Table 8).
- 16% in the non-clinical workforce as Cultural (10%) and Mental Health Support Workers (6%).
- 6% in Administration (2%) and Management (4%) roles.

NATIONAL YOUTH FORENSIC SERVICE PACIFIC WORKFORCE

As at 30 June 2018:

- Reported 17 Pacific staff who were mainly Mental Health Support Workers (65%) and Nurses (29%).

NON-DHB PACIFIC ICAMH/AOD WORKFORCE

From 2016 to 2018:

- An increase of 6 in the non-DHB Pacific workforce, from 51 to 57 (Table 7).
- Increase seen mainly in the Central region; a slight decrease in Midland, from 9 to 7, and no change in Southern.

As at 30 June 2018:

- 93% of the non-DHB Pacific workforce was located in the North Island: 62% Northern region, 25% Central and 13% Midland. Only 7% of the Pacific non-DHB workforce was in the Southern region (Figure 35).
- 51% in clinical roles as Alcohol and Drug Practitioners (21%), Nurses (11%) and Counsellors (7%).
- 46% in non-clinical roles as Youth Workers (18%) and Mental Health Support Workers (14%) (Table 8).
- 4% in Management roles.

PACIFIC POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

- While Pacific access to services show improvements over time, it still remains low compared to target rates across all age groups, indicating unmet needs for the Pacific infant, child and youth population. Given that Pacific children and adolescents continue to have high mental health needs and have the second highest suicide rates in the country, increasing early access to services for Pacific under 15 years of age is critical.
- Due to low numbers of Pacific service users accessing services (7% of all service users), the overall Pacific workforce to service user comparison shows a representative workforce. However, some disparities between the workforce and service users can be seen in the Northern and Southern regions (Figure 37). Additionally, when Pacific service users are compared to the Pacific *clinical* workforce only, the disparity between service users and the workforce becomes even greater in the Northern region (Figure 38). Therefore, an increase in the Pacific clinical workforce is required in the Northern region.
- While the need to increase the Pacific clinical workforce remains pertinent, the majority of Pacific service users (70%) continue to access mainstream services and are seen by the non-Pacific workforce. Enhancing the cultural competency of the non-Pacific workforce, to be able to work more effectively with Pacific service users and their families, also remains a crucial area of development.

Figures 37. Pacific 0-19 Population, Service User & Workforce Comparisons

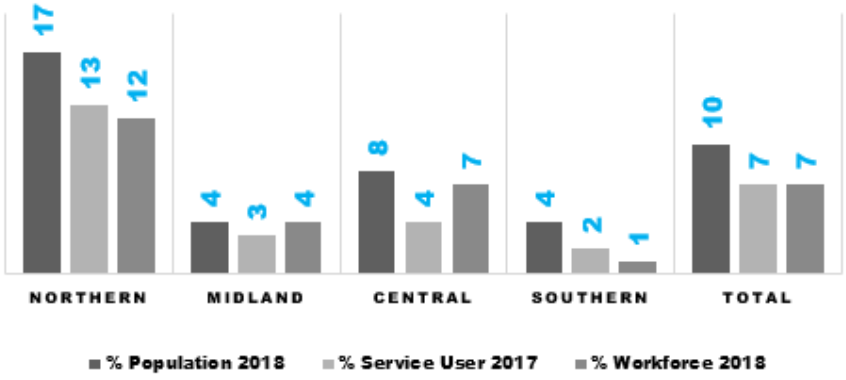
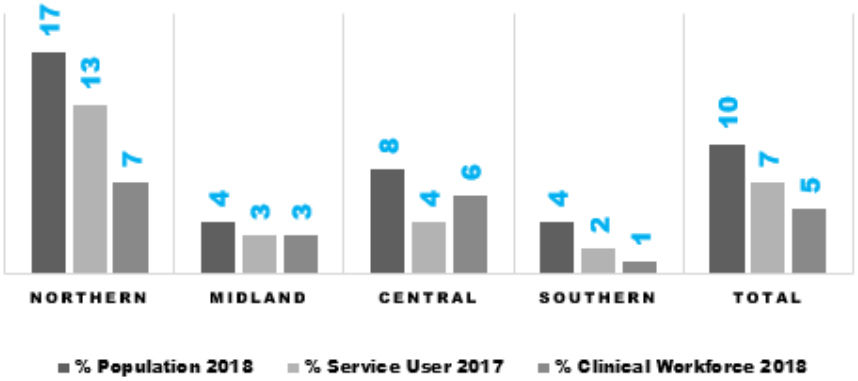


Figure 38. Pacific 0-19 yrs Population, Service User & Clinical Workforce Comparison



SUMMARY

The Pacific population is a growing and youthful population with almost half 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 the second highest birth rate (second after Māori) compared to Asian, European and Other Ethnicities (Ministry of Health, 2019). The Pacific population experiences greater socioeconomic deprivation, higher disengagement, greater mental health needs and the second highest rates of suicide (second after Māori) in the country. Data also show that 10% of Pacific children (based on their SDQ scores) have a higher likelihood of developing social, emotional and/or behavioural problems than do non-Pacific children. Therefore, early intervention is critical for the Pacific 0-19 years population.

Pacific service user access data show an increasing trend in Pacific access rates to services in all three age groups. Despite this trend, Pacific access rates for the second half of 2017 continue to remain below the target access rates in all three age groups across all four regions, especially for the 10-14 year age group. Due to the lack of specific access targets for the Pacific population, the Pacific access rates are compared to the overall child and youth rates set by the MHC. Given that Pacific infants, children and adolescents have high mental health needs, the overall target rate might be a conservative estimate of actual need for this population. Therefore, the consistently low access rates for the Pacific 0-19 year population may indicate significant unmet needs. Increasing Pacific access rates remains a key priority, especially when outcomes data indicates significant improvements in emotional related symptoms by time of discharge when Pacific infants, children and adolescents *do* access mental health services.

Regions with large populations of Pacific infants, children and adolescents (i.e. Northern and Central regions) should continue to anticipate a growing demand for services. However, there continues to be very little change in the number and types of services that are available to Pacific infants, children and adolescents, especially in the areas of highest populations and need. For instance, almost three-quarters of the Pacific infant, child and adolescent population reside in the Northern region (largely in the Counties Manukau DHB area), yet there is only one Pacific NGO (*Penina Trust*) service providing dedicated Pacific infant, child and adolescent mental health/AOD services. Auckland DHB area has the second highest Pacific infant, child and adolescent population in the region, yet are not providing any Pacific services. Significant investment in service development and provision of culturally appropriate services for Pacific in areas of high population and need is also critical.

While there has been a 18% growth in the overall Pacific workforce, this growth has not kept pace with the increasing demand for mental health services over the same period, especially in the Northern region. While the need for increasing the Pacific workforce is acknowledged by the sector, a number of factors (as identified by the services) impede such progress:

- *Very few qualified Pacific practitioners available for recruitment*
- *Lack of dedicated funding for recruitment (especially in NGOs) and for targeted recruitment initiatives*
- *Loss of senior Pacific staff to promotions into other senior positions and organisations, with few qualified staff for replacement.*

Recruitment strategies that address these factors need to be considered yet remains a long-term solution to workforce shortages.

In the interim, strengthening the current Pacific workforce and enhancing the dual competency of both the Pacific and non-Pacific workforce is essential as Pacific infants, children and adolescents and their families continue to largely access DHB and mainstream services and are seen by the non-Pacific workforce. While Pacific cultural training (competency development training such as Le Va's *Engaging Pasifika and Real Skills Plus Seitapu*) is provided in most services, and Pacific models of practice (e.g. *Fonofale Model*) are embedded within practice, very little is known about the cultural competency levels of the workforce. Pacific cultural competency development needs to continue, and assessing skills and knowledge is crucial for identifying areas of strengths and gaps and targeting further development.

The lack of specific Pacific ICAMH/AOD services, the lack of knowledge about these services and the lack of culturally and clinically competent workforce within existing services remain key issues to address.

RECOMMENDATIONS

In light of the current findings, and to ensure alignment with government priorities (Ministry of Health, 2007, 2012b; 2016) and *He Ara Oranga*, the following recommendations are made to support improvements in the mental health outcomes for all Pacific infants, children and adolescents within a family context. These recommendations have also been developed in consultation with the Werry Workforce Whāraurau Pacific Advisory Group.

Increase and allocate appropriate levels of funding:

- Lack of funding to support service and workforce development activities has been identified as a major barrier by all services. Allocating appropriate levels of funding is a first step in building essential infrastructure (organisational structures, technology, models of care such as whānau ora, trauma-informed care) to advance further service expansion and development and progress various workforce development initiatives (recruitment, retention, role development/expansion, training) that are required. DHBs, in collaboration with their local key stake holders (i.e. local schools, tertiary education providers, Youth One Stop Shops, PHOs, NGOs) should engage should engage in strategic planning processes to identify challenges and opportunities; actively monitor local service demands and areas of service development, including new models of care for their population; enhance workforce development; and ensure funding is allocated accordingly.

Develop, provide and strengthen early intervention programmes, services and workforce at primary level:

- **Develop and provide early intervention programmes and services*:*** Because early intervention and earlier access to services are essential for Pacific (Ministry of Health, 2008a), there is ongoing need to invest in and develop early intervention and suicide prevention strategies and programmes for Pacific in primary care settings.
    - ***Mental health promotion activities*** and 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.
    - ***Targeted early intervention programmes*** that target the reduction of emotional symptoms, peer problems and especially conduct problems in Pacific children (3-14 years), as identified by the Strengths and Difficulties Questionnaire (SDQ) scores from the New Zealand Health Survey data (Ministry of Health, 2018).
    - ***Evidence-based parenting programmes*** such as ***The Triple P – Positive Parenting Programme*** and ***Incredible Years*** have been shown to be effective in preventing and reducing children's emotional and behavioural problems. Providing evidence-based parenting programmes that work across cultures, socio-economic groups and in different kinds of family structures, is critical for intervening early and improving long term outcomes for children. *Triple P Primary* also has the advantage of being suitable for delivery within services that family already engage with, such as, early childhood education, social services and Well Child Tamariki Ora.
    - ***School-based health education and services****:* School-based health services 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.*

Guidelines for youth health care in schools have been developed to assist planning, funding or providing primary health care services in secondary schools and can be used as a tool to continuously improve the quality of these services (Ministry of Health, 2014).

- **Provide more and better services for Pacific*:*** Due to the lack of dedicated services for Pacific children and youth, there is a need to develop and provide more family-centred services, thereby providing greater choice. This includes alternative community-based services (e.g. *One Stop Shops; Youth Hubs)* that are more accessible for the 18% of Pacific youth who are not in employment, education or training (NEET), as this could help to alleviate some of the access issues highlighted.

- **Harness the power of technology*:*** Young people in New Zealand have high rates of internet access and use (Gibson et al., 2013; Statistics New Zealand, 2004b). This platform provides opportunities to develop e-therapy tools to assist with easier and earlier access to treatment. An example is the NZ developed, on-line computerised cognitive behavioural therapy program, SPARX. SPARX has been shown to be an effective resource for adolescents with depression at primary healthcare sites. The use of the program resulted in clinically significant reductions in depression, anxiety, and hopelessness and an improvement in quality of life (Merry et. al., 2012). The use of SPARX has also led to improvements in mood and increased levels of hope for Māori youth (Shepherd et al., 2018) and could potentially be beneficial for Pacific youth as well. Latest user data of SPARX showed that a total of 2,110 young people registered to use SPARX in 2019, with the highest registered users being NZ European (62%) and Māori (16%), however, Pacific youth only made up 5% of users. The largest referral source for all users were their schools (39%). Therefore, developing, promoting (especially in schools) and improving access to local and international evidence-based, or validated mental health apps, online self –help guides and e-therapy tools and keeping Pacific youth engaged, is potentially an effective way of intervening early and increasing early access to treatment.

- **Strengthen and support the primary mental health services and workforce (capacity, knowledge and skill development):** GPs are the largest source of referrals to ICAMH/AOD services; and Nurses are a critical workforce in the school/primary health space. Continued investment in the development and provision of primary health services, developing new roles and supporting and strengthening the knowledge and skill development of the respective workforce to deliver effective mental health care could alleviate the demand on ICAMH/AOD specialist services.

- **Improve access to services by enhancing service user pathways from primary to secondary services**: Mental health outcome data for Pacific children and youth show significant improvements in their emotional wellbeing as a result of accessing mental health services. While Pacific access to services has increased, it still remains significantly short of meeting actual need. Enhancing Pacific service user pathways to key services, especially for those below 15 years of age, should be a priority. Enhancing service user pathways to services requires a collaborative approach between schools, primary and specialist services, within an enabling infrastructure.

    - In consultation with Pacific service users, effective strategies to increase access rates must be identified. Appointing *community champions* who are respected members of the local community to facilitate and improve access to services has been used successfully in the Midland region for improving access for Māori and could also be an effective strategy for Pacific.

    - Engaging in service quality improvement processes informed by Pacific young people and families could also improve access.

    - 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.

Increase, strengthen and support the specialist ICAMH/AOD services and workforce:

- **Increase workforce capacity*:*** Due to increases in demand for services by Pacific and shortages in the Pacific clinical workforce, there is a need to increase the Pacific clinical workforce (DHBs and NGOs) to adequately represent and cater for Pacific service users.

    - ***Workforce planning****:* Services need to actively monitor their local service provision (which incorporates a whānau ora model of service delivery and meets the needs of Pacific families), potential and actual service demand within current workforce capacities and capabilities (specialist knowledge and skills required) and ensure funding is dedicated and allocated accordingly. Services also need to ensure that active recruitment and retention strategies for the Pacific workforce are seen as a key priority and are embedded in a service's strategic plans. Develop career pathways into the sector and ensure that local schools, tertiary education providers, PHOs, NGOs and DHBs are all part of the workforce planning processes. The use of national competency frameworks such as *Real Skills Plus* within the training and specialist sector can inform and create a "job-ready" infant, child and adolescent mental health workforce.

    - ***Recruitment:*** Lack of qualified staff for recruitment and a high turnover of specialist staff contribute to current workforce shortages. A concerted drive is required to increase the capacity of the Pacific workforce (including recruitment of new graduates, sourcing from local communities) to work in specialist ICAMH/AOD services. There needs to be ongoing investment into active, targeted recruitment strategies for specialist roles. Given that approximately a third of Pacific service users are accessing non-DHB services; increasing this workforce also needs to be considered. Recruitment of specialist staff can be enhanced by utilising national competency frameworks such as *Real Skills Plus* to identify staff who have the required knowledge and skills based on local service user needs. Specific training and career pathways to transition entry-level and experienced non-clinical workers into the clinical workforce could be a way to increase the Pacific clinical workforce. Establish dedicated Pacific intern positions in services where there are high Pacific populations.

    - ***Retention:*** While increasing the capacity of the Pacific workforce remains a much slower strategy in addressing current shortages, retaining the current Pacific workforce needs to be the current focus. High turnover of the specialist workforce exacerbates workforce shortages. Identifying reasons for staff turnover and addressing these factors need to be considered. For instance, staff turnover is particularly high in NGO services as NGOs work within a more competitive funding environment and regularly lose staff to higher salaries offered in other services/agencies. Short term contracts, due to limited funding, also affect the recruitment and retention of NGO staff. An increase in NGO funding could allow for longer term contracts and allow pay parity for similarly skilled staff, thereby aiding retention of the NGO specialist workforce.

        - ***Look after the workforce***: Developing workforce resilience is one of the key steps to workforce retention. Resilience protects the mental and physical health and wellbeing of staff and helps delivery of quality services. Current trends show an increasing service user demand within current workforce capacity, which can lead to stress and burnout, and this has been indicated as one of the reasons for high turnover rates in some services. A valued team, with a strong and positive set of personal relationships between team members, works more effectively by providing emotional support, informal consultation and motivation to be at work and to work effectively as a team. An example of a model of care that places an emphasis on self-care and staff wellness as an individual and organisational responsibility, is the trauma-informed care approach. An on-line training module on self-care has been developed with positive feedback from the workforce and a face-to-face workshop, based on the success of the online training, is currently under development. Furthermore, supporting the current Pacific workforce by providing support networks for those who are working in isolation in large services could improve retention. 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. While many services have implemented various wellbeing activities and initiatives, acknowledging the need for looking after their workforce, it should remain an essential part of a service's workforce retention strategy.

- ***Expand and develop existing roles:*** Identifying fast-track solutions to address workforce shortages such as the development of existing roles like the peer workforce (which includes service user, consumer and peer workers), provide good opportunities for increasing the capacity of the Pacific workforce across all roles. Currently, the Pacific peer workforce makes up a very small proportion of the Pacific workforce (approximately 2%). Therefore, an investment in developing these roles is required. Peer workforce competencies (Te Pou o Te Whakaaro Nui, 2014) have been developed for planners and funders, service managers, training providers and workers to help guide best practice in peer workforce development in services.

- ***Explore new ways of working***: To overcome workforce shortages, building relationships and working in partnership with other services can be an effective strategy in sharing limited resources, especially in the provision of clinical support to NGOs (particularly in rural areas). This is already occurring in some areas where DHBs provide clinical support and senior clinical staff for advice/consultation to NGOs and NGOs provides cultural support to DHBs. However, while the need to work more collaboratively is acknowledged by services, barriers and challenges in doing so continue to exist and need to be identified and effectively addressed.

o **Increase workforce capability*:*** While increasing the Pacific workforce is a long-term strategy to remedy current workforce shortages, there is an ongoing need to strengthen and support the existing Pacific ICAMH/AOD workforce to work more effectively with Pacific service users. Furthermore, almost half of the total Pacific workforce is employed in NGO services therefore strengthening and supporting the Pacific NGO workforce is also vital.

- ***Identify and develop knowledge and skills:*** Given the growing complexity of infant, child and youth mental health needs (e.g. socio-economic factors, youth suicide), strengthening the current Pacific workforce with the right skills is another key area of focus. As a first step, services need to be actively engaged in identifying current competency levels and opportunities for further targeted development using competency assessment tools such as *Real Skills Plus*. Currently improvements (as assessed by the *Real Skills Plus* tool) are required for *Core Intervention* skills especially for infants; therefore, training and professional development in this area is required.

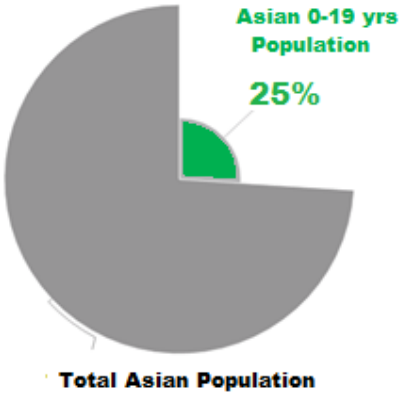
- ***Identify and strengthen cultural knowledge and skills:*** The current workforce information indicates that only half of the current Pacific ICAMH/AOD workforce is fluent in their respective languages. Therefore, language competency development for the current Pacific workforce and providing interpreter resources to accommodate diverse Pacific languages could be essential strategies in providing more effective services for service users and thereby addressing and improving access issues. 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. Furthermore, the capability of current Pacific cultural staff to provide cultural supervision to the non-Pacific workforce should be supported and built on, to ensure clinical and cultural safety for Pacific service users and their families.

- ***Enable access to targeted skills and knowledge training:*** Once knowledge and skill gaps have been identified, it is essential that the Pacific and non-Pacific workforce is able to access the required evidence-based specialist and cultural training. The lack of adequate funding has been reported by the NGO sector as a key barrier to accessing specialist training. Until more funding is allocated to NGOs, shared training between DHB and NGOs could be a possible strategy while resources are limited.

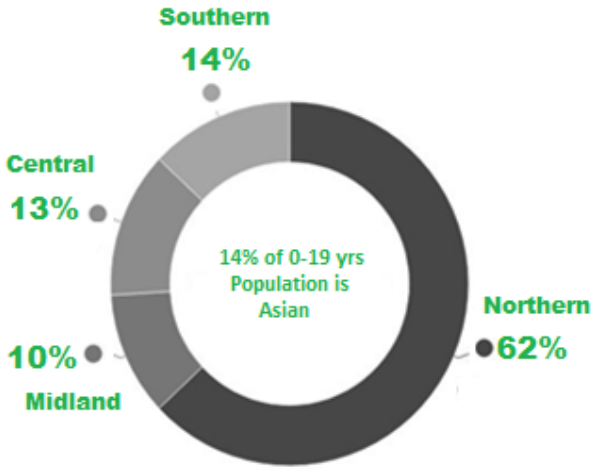
ASIAN NATIONAL OVERVIEW

ASIAN INFANT, CHILD AND ADOLESCENT POPULATION

- The term "Asian", while commonly used as a single ethnic category, actually includes a large number of ethnic groups that are very diverse in culture, language, education, resident 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.



- 2016 to 2018 population projections indicated that the Asian 0-19 year population continued to be the fastest growing population out of the four main ethnic groups. The Asian 0-19 year population showed a projected growth of 7%, 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 (Appendix A, Table 1).

- Asian 0-19 year population makes up 25% of the total Asian population and 14% of the total infant, child and youth population.

- 62% reside in the Northern region with 98% of the region's population split between the Counties Manukau, Auckland and Waitemata DHB areas (Appendix A, Table 1).

- 32% growth is projected by 2028 across all regions, with the largest growth projected for the Midland (by 56%) and Southern regions (by 34%) (Appendix A, Table 2).

- The Asian international students residing in New Zealand need to be considered. In 2017 (January-August), there was a total of 20,240 international fee-paying school students (primary and secondary schools) in New Zealand, a 5% increase from 2016 (19,200). Of these students, 80% (16,290/20,240) of students were from the Asian region (largely from China 42%, Japan 14%, South Korea 12% and Thailand 6%), and 58% continue to be based in the greater Auckland region (Ministry of Education, 2017).

- Refugees arriving in New Zealand also need to be considered. In the 2017-2018 financial year, 1,020 refugees arrived in New Zealand, 22% were from Asian countries.

- Services would need to take these projections and trends into consideration when planning for local service and workforce development activities.

ASIAN INFANT, CHILD AND YOUTH MENTAL HEALTH NEEDS

- The process of immigration could be one of the major risk factors impacting negatively on a new immigrant's psychological wellbeing (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). More recent suicide data (2018) show that 29% of all suicides in the Asian population occurred in the 10-24 year age group (Ministry of Justice, 2019).
- Strengths and Difficulties Questionnaire (SDQ) scores, based on the New Zealand Health Survey data, indicated that 5% of Asian children (3-14 years) had an overall high or 'concerning' SDQ score (Ministry of Health, 2018). These scores can be used to predict the likelihood of social, emotional and/or behavioural problems. *Concerning* scores within the four aspects of development indicated for Asian children were:
    - *13% for Peer Problems*
    - *7% for Emotional Symptoms*
    - *6% for Conduct Problems*
    - *4% for Hyperactivity*
    - *While they were less likely to experience emotional, conduct and hyperactivity problems compared to non-Asian children (overall, 8% of children with concerning scores), rates for peer problems were comparable.*
- 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 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)*
    - *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 psychosocial adjustment, academic demands and lack of support (Au & Ho, 2015; Wang & Mallinckrodt, 2006; Forbes-Mewett & Sawyer, 2016).

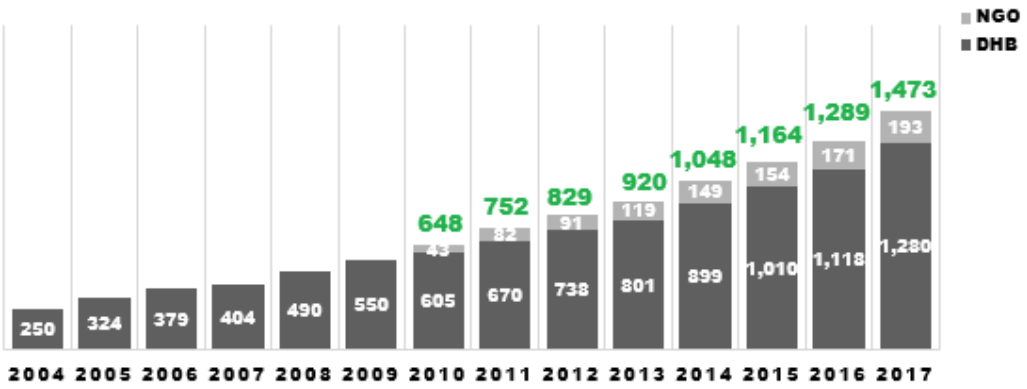
ASIAN SERVICE USER ACCESS TO ICAMH/AOD SERVICES

Asian service user access data extracted from PRIMHD (based on the *Service users by DHB of Domicile* or residence) for the second six months of each year (July to December) provides data on the actual demand for services. PHO service user data is not captured in PRIMHD, therefore, all service user data presented pertains to DHB and NGO services only.

From 2015 to 2017:

- 27% overall increase in the total number of Asian service users accessing mental health/AOD services (Figure 39).
- 35% increase in Asian female service users and 18% increase in Asian males accessing services.
- Increases in three out of the four regions; a decrease seen in the Southern region by 47% (from 131 to 70) (Appendix B, Table 14).

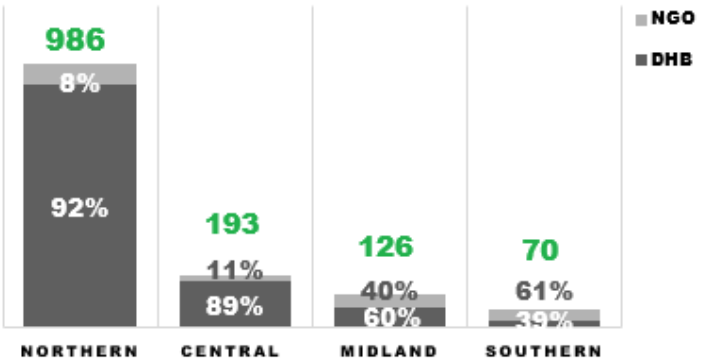
Figure 39. Asian 0-19 yrs Service User (2004-2017)



In the second six months of 2017:

- Overall Asian service user numbers (1,473) remained low, compared to Māori (12,485) and Pacific (2,489) service users; making up 4% of the total.
- 53% (774) were Asian females.
- 87% accessed DHB services.
- 13% accessed NGOs.
- 67% of all Asian service users are seen by services in the Northern region; 98% of these are seen by services in the greater Auckland area (Figure 40).

Figure 40. Asian 0-19 yrs Service User by Region (2017)



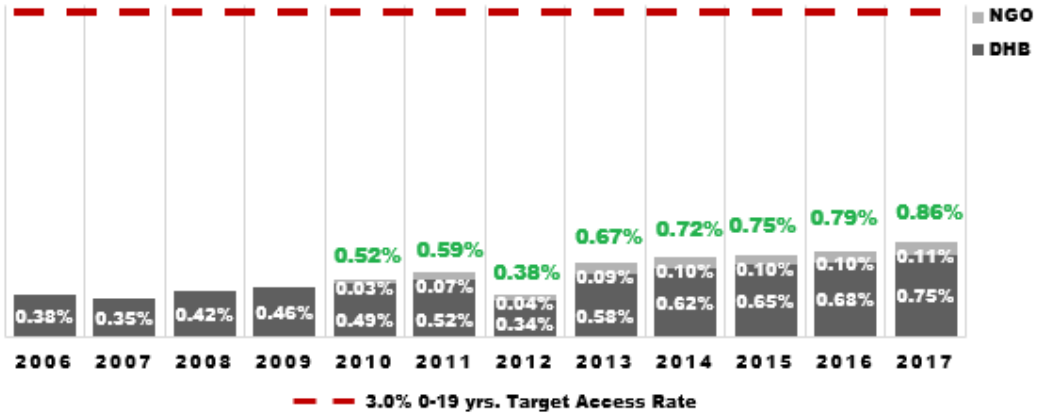
ASIAN SERVICE USER ACCESS RATES

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 the lack of epidemiological data for the Asian 0-19 year population, there are no specific target access rates for the Asian population; therefore, the Asian access rates have been compared to the rates for the general 0-19 years population.

From 2015 to 2017:

- Increase in the Asian 0-19 years access rate from 0.75% to 0.86% (Figure 41). Increase in the 10-14 year and 15-19 year age groups only.
- Slight improvements in Asian service user access rates in two out of the four regions only: Northern and Southern (Appendix B, Table 12 & 13).

Figure 41. Asian 0-19 yrs Service User Access Rates (2006-2017)



In the second six months of 2017:

- Asian access rate remained the lowest out of the four ethnic groups at 0.86%; with the highest access rate in the Northern region (0.93%) (Figure 42).
- Despite the growth in the Asian population and the inclusion of NGO service user data, there continued to be very little improvement in Asian access rates, and they remained significantly below the target rates in all three age groups and across all regions.

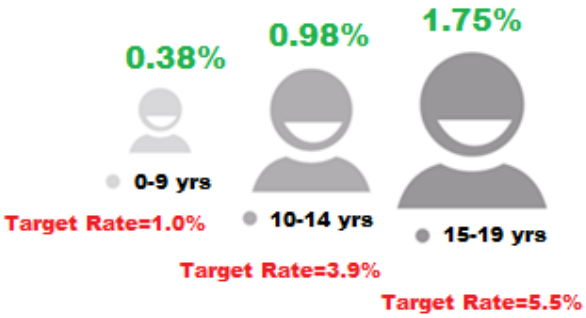
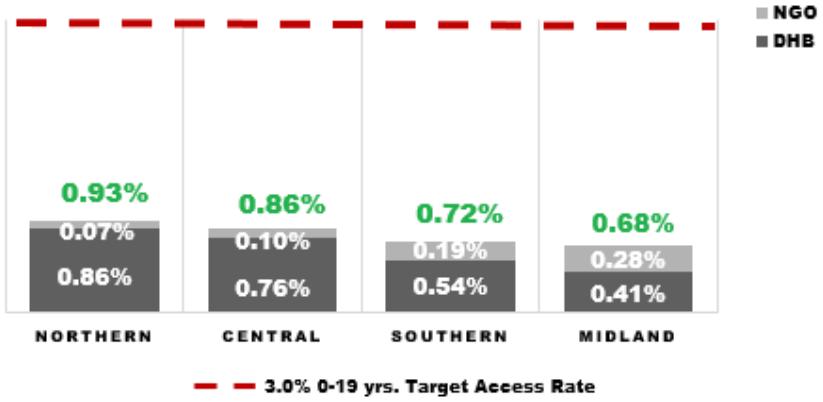


Figure 42. Asian 0-19 yrs Service User Access Rate by Region (2017)



BARRIERS TO ACCESS

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).

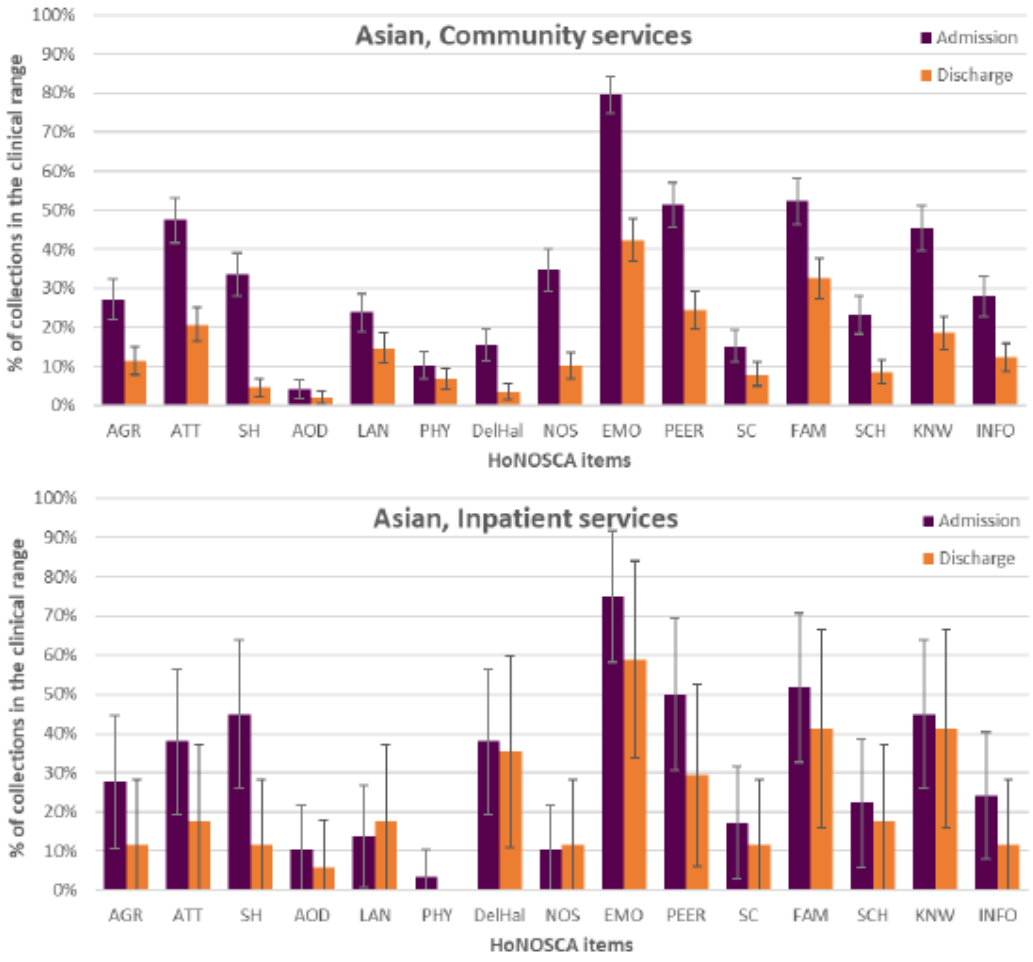
The *Youth'07* study (Parackal et al., 2011) on "Asian" students showed that 16% of the Asian students who had needed healthcare did not access it. Reasons included:

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

ASIAN SERVICE USER OUTCOMES

To assess whether Asian service users 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 aged 4-17 years) at admission and discharge from inpatient and community child and adolescent mental health services. Asian service user outcome data for the 2018 period, showed significant improvements in emotional related symptoms (EMO item) by time of discharge from community mental health services only (Figure 43).

Figure 43. Asian Child & Youth HoNOSCA Results (2018)



Note: Percentage of service users in the clinical range (2, 3 or 4) for each HoNOSCA items.
Source: Ministry of Health, PRIMHD extract: Jan-Dec 2018, extracted 9 April 2019, analysed & 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 Service Users Coordination and Support Service*.
    - Where specific DHB mental health/AOD services are not available, most DHBs fund their local non-DHB services to provide services that can be accessed by Asian people.
    - Of the 119 non-DHB services that were identified for the 2018 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, non-DHB in Auckland which have Asian staff members (who are mainly support workers) available to work with Asian service users and their families.
    - In other regions, Asian children, adolescents and their families have access to the following non-DHB migrant and refugee services:
        - *Refugee Trauma Recovery (*Capital & Coast)
        - *Miramare Ltd (*Southern DHB)
    - 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 workforce information is derived from the workforce survey (Actual & Vacant Full Time Equivalents (FTEs) & Ethnicity by Occupational Group) submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services and all 119 contracted non-DHB services (108 NGOs & 11 PHOs) as at 30 June 2018.

From 2016 to 2018:

- 14% increase in the Asian ICAMH/AOD workforce (DHB Inpatient & Community CAMH/AOD & non-DHB services (NGOs & PHOs)) workforce, from 103 to 117 (Table 9).
- Increase in three out of the four regions, with the Northern region reporting the largest increase from 62 to 70 while the Asian workforce in the Midland region had decreased from 16 to 14.
- Increase in both DHB and Non-DHB services but largely in Non-DHB services, in mainly non-clinical roles.

Table 9. Asian ICAMH/AOD Workforce by Region (2008-2018)

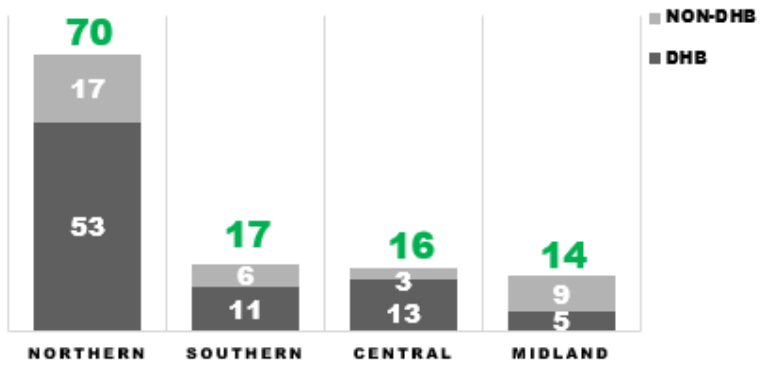
REGION (Headcount)	DHB[1]						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NORTHERN	18	33	18	32	44	53	3	3	7	12	18	17	21	36	25	44	62	70
MIDLAND	3	5	5	9	10	5	-	-	-	7	6	9	3	5	5	16	16	14
CENTRAL	5	6	9	6	10	11	-	-	2	3	1	6	5	6	11	9	11	17
SOUTHERN	3	1	2	6	10	13	2	-	1	-	4	3	5	1	3	6	14	16
TOTAL	29	45	34	53	74	82	5	3	10	22	29	35	34	48	44	75	103	117

1. Includes Inpatient Services

As at 30 June 2018:

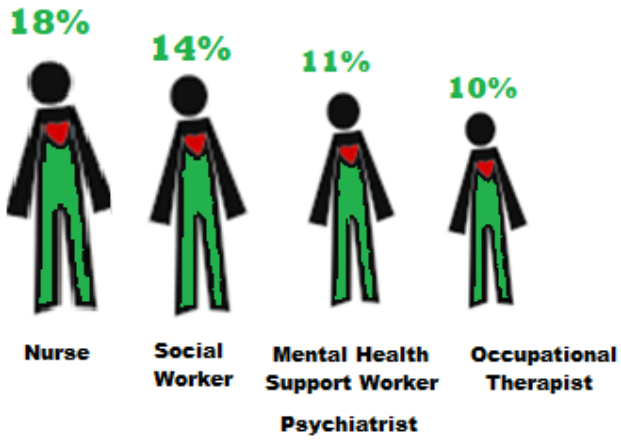
- The Asian workforce made up 6% of the total workforce (117 out of 2,078, headcount).
- They were comprised of Indian (44%; includes Fijian Indian & South African Indian); Chinese (23%); Filipino (19%); Malaysian (4%) and Other Asian (10%; Nepalese, Vietnamese; Pakistani; Sri Lankan).
- 86% of the Asian workforce was in the North Island and within the North Island, 69% were in the Northern region: 94% in greater Auckland area; 17% in Central (76% in Capital & Coast DHB area) and 14% in Midland (Waikato & Lakes DHB areas) (Figure 44).

Figure 44. Asian ICAMH/AOD Workforce by Region (2018)



- 14% were in the Southern region, mainly in services in the Canterbury DHB area (75%) (Table 9 & Figure 44).
- 70% in DHB services.
- 30% in non-DHB services.
- 77% in the clinical workforce as Nurses (18%), Social Workers (14%), Psychiatrists (11%) and Occupational Therapists (10%) and Psychologists (9%) (Table 10 & Figure 41).
- 16% in the non-clinical workforce as Mental Health Support Workers (11%).
- 7% in Administration (5%) and Management (2%) roles.

Figure 41. Top 4 Asian ICAMH/AOD Workforce by Occupation (2018)



DHB INPATIENT ASIAN ICAMH WORKFORCE

From 2016 to 2018:

- An overall increase of 3 Asian staff in the Inpatient Asian workforce, from 15 to 18 (headcount). Auckland inpatient workforce remained the same while slight increases in Capital & Coast (by 1) and Canterbury DHB Inpatient Services (by 2) (Table 9).

As at 30 June 2018:

- Almost all were in clinical roles mainly as Nurses (67%) (Table 10).

DHB COMMUNITY ASIAN ICAMH/AOD WORKFORCE

From 2016 to 2018:

- Increase by 5, from 59 to 64 (headcount) (Table 9). Increase largely in the Northern by 9 (from 34 to 43) and Southern regions by one (from 6 to 7). Increase in the Clinical workforce by three from 53 to 58 (headcount).

As at 30 June 2018:

- Northern region continued to have the largest Asian DHB Community workforce (67%) (Appendix D, Table 8).
- 91% remained largely in clinical roles as Occupational Therapists (19%), Social Workers (17%), Psychiatrists (17%), Psychologists (16%) and Nurses (13%) (Table 10).

Table 10. Asian ICAMH/AOD Workforce by Occupation (2018)

Asian ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	2	2	9	11
Child & Adolescent Psychiatrist	2	11	13	-	13
Nurse	12	8	20	1	21
Occupational Therapist	-	12	12	-	12
Psychotherapist	-	1	1	-	1
Psychologist	-	10	10	-	10
Social Worker	2	11	13	3	16
Other Clinical[1]	1	3	4	2	6
Clinical Sub-Total	17	58	75	15	90
Mental Health Support	-	-	-	13	13
Youth Worker	-	-	-	4	4
Other Non-Clinical[2]	-	-	-	2	2
Non-Clinical Sub-Total	-	-	-	19	19
Administration	-	6	6	-	6
Manager	1	-	1	1	2
Total	18	64	82	35	117

1. Other Clinical = Other SMO; Registrar; Intern
2. Other Non-Clinical = Educator; Peer Support Worker.

NON-DHB ASIAN ICAMH/AOD WORKFORCE

From 2016 to 2018:

- Increase by 6, from 29 to 35 (Table 9). Increase in two out of the four regions in (Central by 5; Midland by 3), while decreases by one in Northern and Southern regions.

As at 30 June 2018:

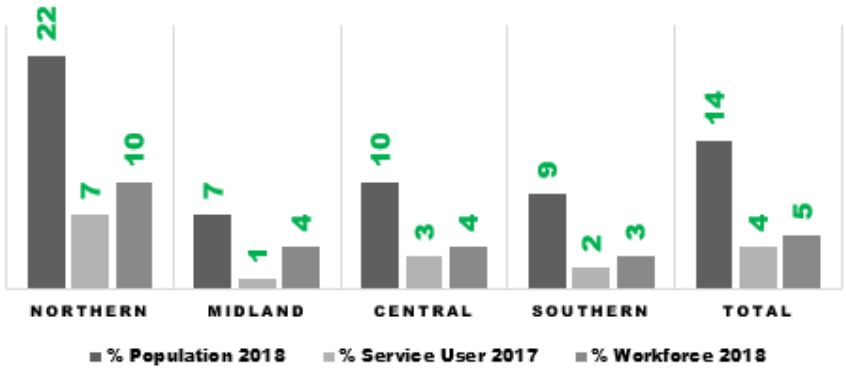
- Northern region continued to have the largest Asian non-DHB workforce (49%), followed by Midland (26%) (Figure 44).
- 54% in non-Clinical roles as Mental Health Support Workers (37%) and Youth Workers (11%) (Table 10).
- 43% in clinical roles as AOD Practitioners (26%) and Social Workers (9%)

ASIAN POPULATION, SERVICE USERS AND WORKFORCE COMPARISONS

Population projections indicate a rapidly growing Asian population (19% growth projected from the 2016 to 2018 period). The latest workforce data showed a growing Asian workforce (14% increase in the workforce for the same period). While there has been some improvement in the number of Asian service users accessing services (14% increase from 2016 to 2017 period), access rates continue to remain the lowest out of the four ethnic groups (0.86%, well below the target rate of 3.0%) (Figure 45). The *Youth 2000* study showed that 25% of Asian youth have "poor" mental and emotional wellbeing and 5% of Asian children had *concerning* SDQ scores. Therefore, low access rates to services remain a concern for the Asian 0-19 year population indicating unmet mental health needs. Improving access rates for the Asian population should be a key priority.

Furthermore, almost all of Asian service users (87%) continue to access mainstream services and are seen by the non-Asian workforce. Enhancing the cultural competency of the non-Asian workforce, to be able to work more effectively with Asian service users and their families, also remains a crucial area of development.

Figure 45. Asian 0-19 yrs Population, Service User & Workforce Comparisons



SUMMARY

Due to the rapid growth in the Asian infant, child and youth population as a result of immigration, the Asian population is now the third largest ethnic group in New Zealand. Furthermore, population projections predict that the Asian 0-19 year population will become the second largest in Auckland by 2026, therefore, the needs of the Asian population will need to be taken into consideration when planning, developing and providing infant, child and youth services spanning from primary to specialist settings.

While one may make the assumption that most Asian migrants are mentally healthy, it is described in most literature that as consequence of the immigration process, Asian young people may have a higher risk of developing mental health problems (Ho et al., 2003; Wynaden et al., 2005). Therefore, areas with large populations of immigrant 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.

While some progress can be seen in the number and types of mental health services that are available to the general infant, child and youth population, very little progress can be seen in service provision specifically for Asian infants, children and adolescents. There are no specifically funded DHB or non-DHB Asian infant, child and adolescent mental health/AOD services, although Asian infants, children and youth 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 non-DHB services.

While some growth was seen in Asian access rates, these have continued to be the lowest (0.86%) out of the three ethnic groups (Māori 3.89%; Other Ethnicity 3.36%; Pacific 2.08%; in the second six months of 2017). Therefore, Asian access rate remain well below the target access rates of 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 workforce data show an increasing trend in the Asian workforce. Due to the increase in the Asian workforce and low access rates for Asian 0-19 year service users, it appears that the current Asian workforce adequately represents the number of service users 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, 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 rapid growth and increasing trend in the Asian population and identified mental health needs, and low access rates to services, there is an urgent need to improve access to services for the Asian population. Intervening and providing services earlier would also improve outcomes for all Asian children and young people. Furthermore, given that there are no dedicated services for the 0-19 years Asian population and Asian service users are having to largely access mainstream DHB services, thereby largely seen by the “mainstream” workforce. Therefore, there needs to be a focus on developing the workforce to be more culturally competent to effectively work with Asian service users and their families.

RECOMMENDATIONS

In light of these latest findings and to ensure alignment with government priorities (Ministry of Health, 2007; 2012) and *He Ara Oranga,* the following recommendations are made to support improvements in the mental health outcomes for all Asian infants, children and adolescents within a family context. These recommendations have also been developed in consultation with an Asian advisor.

Develop and provide early intervention programmes, services and workforce at primary level:

- **Develop and provide early intervention programmes*:*** Because early intervention and earlier access to services are essential for all children and young people, there is an ongoing need to invest in and develop early intervention and suicide prevention strategies and programmes for the Asian population in primary care settings.
    - ***Targeted early intervention programmes*** are needed that target the reduction of emotional symptoms, conduct and especially peer problems in Asian children (3-14 years), as identified by the *Strengths and Difficulties Questionnaire (SDQ)* scores from the *New Zealand Health Survey* data (Ministry of Health, 2018). These could include infant health/mental health (prenatal and antenatal workshops, emotion regulation and normalising post-natal depression and childhood development disorders)
    - ***Evidence-based parenting programmes*** such as ***The Triple P – Positive Parenting Programme*** and ***Incredible Years,*** have been shown to be effective evidence-based for preventing and reducing children's emotional and behavioural problems. Providing evidence-based parenting programmes that work across cultures, socio-economic groups and in different kinds of family structures is critical for intervening early and improving long term outcomes for children. *Tripe P Primary* has an added advantage of being suitable within services that families already engage with, such as early childhood education, social services, and Well Child Tamariki Ora.
- **Expand and enhance school-based health education and services**: School-based health services 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.*

  Guidelines for youth health care in schools have been developed to assist planning, funding or providing primary health care services in secondary schools and can be used as a tool to continuously improve the quality of these services (Ministry of Health, 2014).
- **Harness the power of technology:** Access to the internet and internet use, including for seeking health information are highest among Asian young people compared to other ethnicities in New Zealand (Gibson et a., 2013; Statistics New Zealand, 2004b; Peiris-John, Ameratunga, Lee, Teevale, & Clark, 2014). This platform provides opportunities to develop e-therapy tools to assist with easier and earlier access to treatment. An example is the NZ developed, on-line computerised cognitive behavioural therapy program, SPARX. SPARX has been shown to be an effective resource for adolescents with depression at primary healthcare sites. The use of the program resulted in clinically significant reductions in depression, anxiety, and hopelessness and an improvement in quality of life (Merry et. al., 2012). Latest user data of SPARX showed that a total of 2,110 young people registered to use SPARX in 2019, with the highest registered users being NZ European (62%) and Māori (16%), however, Asian youth only made up 9% of users. The largest referral source for all users were their schools (39%). Therefore, developing, promoting (especially in schools) and improving access to local and international evidence-based, or validated

mental health apps, online self–help guides and e-therapy tools, in a variety of Asian languages, and keeping Asian young people engaged is potentially an effective way of intervening early and increasing early access to treatment.

- **Develop and provide more and better services*:*** Due to the lack of dedicated services for Asian children and youth, there is a need to develop and provide more services which provide greater choice. This includes alternative community-based and peer support services (e.g. *One Stop Shops; Youth Hubs)* that are more accessible and could help to alleviate some of the access issues highlighted.

- **Strengthen and support the primary mental health services and workforce (capacity, knowledge and skill development):** GPs are the largest source of referrals to ICAMH/AOD services, and nurses are a critical workforce in school-based and primary health services. People from Asian communities who have a mental illness tend to access health care with physical complaints (Wynaden et al., 2005). Therefore, educating GPs and other primary level workforces on the cultural issues relating to the mental health needs of Asian infants, children and adolescents is essential. Continued investment in the development and provision of primary health services, developing new roles, and supporting and strengthening the knowledge and skill development of the respective workforces to deliver effective mental health care could alleviate the demand on ICAMH/AOD specialist services.

- **Improve access to services by enhancing service user pathways from primary to secondary services**: While improvements can be seen in Asian access rates, they continue to be the lowest out of the four ethnic groups, across all three age groups, which could indicate unmet needs. Improving access to services for Asian infants, children and adolescents, therefore, remains a priority. Identifying barriers and developing strategies to address them is essential to access services earlier.

    - One of the 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). 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.

    - Coming from a collectivistic cultural background, Asian parents assume full authority to accept or decline treatment on behalf of their children. Therefore, targeting and engaging with parents who are influential in persuading their children to use services could also be an effective strategy in improving access to services.

    - Engaging in service quality improvement processes informed by Asian youth and their families could also improve access.

    - Working more collaboratively and maintaining relationships between communities, schools, and primary and specialist services could assist with enhancing referral pathways (Ho et al., 2003). Enhancing service user pathways to services requires a collaborative approach between schools, primary and specialist services, within an enabling infrastructure.

Increase, strengthen and support the specialist ICAMH/AOD services and workforce:

- **Service and workforce development planning*:*** A growing Asian population has potentially led to an increased need/demand for specialist mental health services and may continue to do so. As a result, this potential demand for services means that service planning to cater for future demand is critical. Service planning and development should include schools, PHOs, NGOs and DHBs as part of the planning process.

- **Develop and provide culturally appropriate specialist services**: In consultation and collaboration with Asian community leaders and groups, develop specific, culturally appropriate specialist services for the local Asian children, young people and their families. Family support services are relatively underdeveloped in infant, child and adolescent mental health services and could be a vital source of support for Asian families. Such services could provide culturally appropriate workers to sit alongside specialist services and promote better understanding of the health system and specific disorders. Where culturally appropriate services and workers are not available, the provision of interpreter services to meet language needs, at least at the assessment level is essential.

- **Increase workforce capacity:** Despite a rapid and large growth in the Asian population, Asian service user access to services remain very low. Due to such low access to services, the current Asian ICAMH/AOD workforce appears to adequately represent service demand from the Asian population. However, the 10-year population projection for the Asian population show continued growth in the Asian population, therefore, services need to take these projections and trends into consideration when planning for workforce development activities.
    - ***Workforce planning**:* Services need to actively monitor their local service provision (which incorporates a whānau ora model of service delivery that meets the needs of Asian families), potential and actual service demand within current workforce capacities and capabilities (specialist knowledge and skills required) and ensure funding is allocated accordingly. Services also need to ensure that active recruitment and retention strategies for the Asian workforce is embedded in a service's strategic plans. Develop career pathways into the sector and ensure that local schools, tertiary education providers, PHOs, NGOs and DHBs are all part of the workforce planning processes. The use of national competency frameworks such as *Real Skills Plus* within the training and specialist sector can inform and create a "job-ready" infant, child and adolescent mental health workforce.
    - ***Recruitment:*** Lack of qualified staff for recruitment and a high turnover of specialist staff contribute to current workforce shortages. A concerted drive is required to increase the capacity of the Asian workforce (including recruitment of new graduates, sourcing from local communities) to work in specialist ICAMH/AOD services. There needs to be ongoing investment into active, targeted recruitment strategies for specialist roles. Recruitment of specialist staff can be enhanced by utilising national competency frameworks such as *Real Skills Plus* to identify required knowledge and skills based on local service user needs. 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. Increasing the capacity of the Asian workforce could also be conducted through enhanced training and career pathways into mental health/AOD.
    - ***Retention:*** While increasing the capacity of the Asian workforce remains a much slower strategy in addressing current shortages, retaining the current Asian workforce needs to be the current focus. High turnover of the specialist workforce exacerbates workforce shortages. Identifying reasons for staff turnover and addressing these factors need to be considered. For instance, staff turnover is particularly high in NGO services as NGOs work within a more competitive funding environment and regularly lose staff to higher salaries offered in other services/agencies. Short term contracts, due to limited funding, also affects the recruitment and retention of NGO staff. An increase in NGO funding could allow for longer term contracts and allow pay parity for similarly skilled staff, thereby aiding retention of the NGO specialist workforce.
        - ***Look after the workforce**:* Developing workforce resilience is one of the key steps to workforce retention. Resilience protects the mental and physical health and wellbeing of staff and helps delivery of quality services. Current trends show an increasing service user demand within current workforce capacity, which can lead to stress and burnout, and this has been indicated as one of the reasons for high turnover rates in some services. A valued team, with a strong and positive set of personal relationships between team members, works more effectively by providing emotional support, informal consultation and motivation to be at work and to work effectively as a team. An example of a model of care that places an emphasis on self-care and staff wellness as an individual and organisational responsibility, is the trauma-informed care approach. An on-line training module on self-care has been developed with positive feedback from the workforce and a face-to-face workshop, based on the success of the online training, is currently under development. While many services have implemented various wellbeing activities and initiatives and acknowledging the need for looking after their workforce, it should remain an essential part of a service's workforce retention strategy.

- ***Expand and develop existing roles:*** Identifying fast-track solutions to address workforce shortages, such as the development of new and existing roles could be considered, such as exploring whether some interpreters could train as cultural advisors, and possible co-therapists.

- ***Explore new ways of working:*** To overcome workforce shortages, building relationships and working in partnership with other services can be an effective strategy in sharing limited resources, especially in the provision of clinical support to NGOs (particularly in rural areas). This is already occurring in some areas where DHBs provide clinical support and senior clinical staff for advice/consultation to NGOs and NGOs provides cultural support to DHBs.

o **Increase workforce capability:** While increasing the Asian workforce is a long-term strategy, there is an ongoing need to strengthen and support the existing Asian ICAMH/AOD workforce.

- ***Identify and develop knowledge and skills:*** Given the growing complexity of infant, child and adolescent mental health needs (e.g. socio-economic factors, youth suicide, and transgender youth), strengthening the current Asian and non-Asian workforces with the right skills is another key area of focus. As a first step, services need to be actively engaged in identifying current gaps in competency levels and opportunities for further targeted development using competency assessment tools such as *Real Skills Plus*. Currently, improvements (as assessed by the *Real Skills Plus* tool) are required for *Core Intervention* skills especially for infants; therefore, training and professional development in this area is required.

- ***Identify and strengthen cultural knowledge and skills:*** The lack of specific Asian mental health services means that the majority of Asian service users (87%) are seen by mainstream DHB services and the non-Asian workforce. There continues to be a critical need for increasing the dual competency of the non-Asian workforce to work effectively with the growing numbers of Asian service users and their families. Furthermore, building the capability of the current Asian workforce to provide cultural supervision and to work alongside the non-Asian workforce can be an effective strategy for working with Asian service users (Nyar & Tse, 2006). For instance, establishing a consultation team of Asian clinicians, who are available to regions, can provide assistance in clarifying diagnosis and ensuring that culturally appropriate clinical interventions are used for Asian service users.

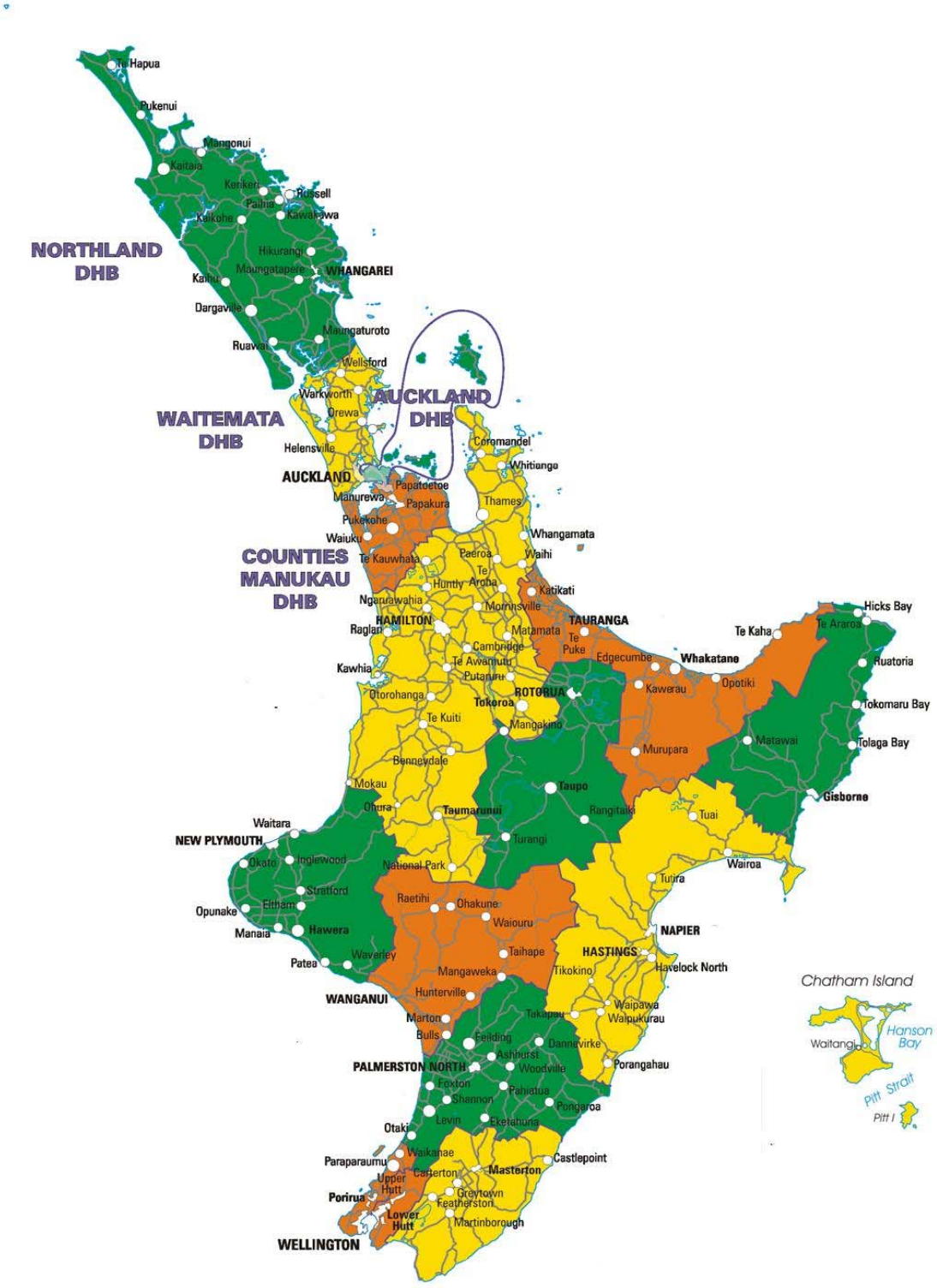
- ***Enable access to targeted knowledge and skill training****:* Once knowledge and skill gaps have been identified, it is essential that the workforce is able to access the required evidence-based specialist and cultural training. The lack of adequate funding has been reported by the NGO sector as a key barrier to accessing specialist training. Until more funding is allocated to NGOs, shared training between DHB and NGOs could be a possible strategy while resources are limited.

Future research:

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

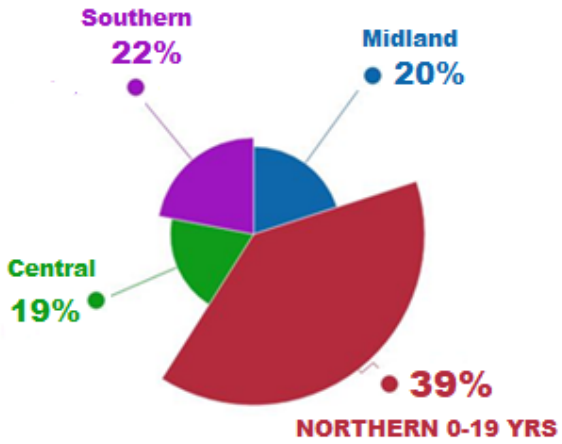
> ***"Results from a well-designed epidemiological study can influence mental health policy and service delivery for the third-largest ethnic group in New Zealand and may provide information that has not been available before in the history of global migration" (p. 411).***

NORTHERN REGION INFANT, CHILD AND ADOLESCENT MENTAL HEALTH/AOD OVERVIEW

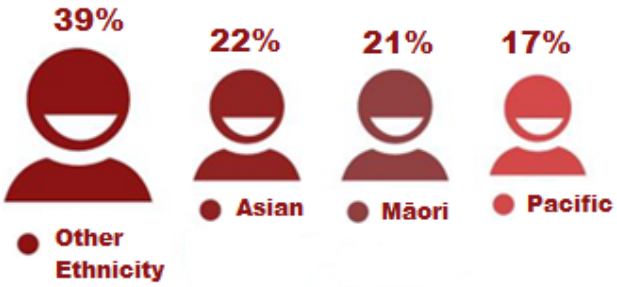


NORTHERN REGION INFANT, CHILD AND ADOLESCENT POPULATION PROFILE

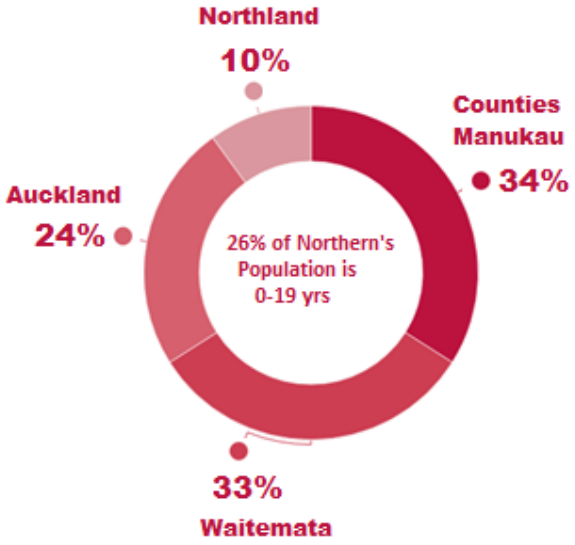
- Population projections (based on the 2013 Census) indicated a 0.6% growth in the regional 0-19 year population from 2016 to 2018 (Appendix A, Table 1).
- Projected growth was seen in two out of the four DHB areas (Waitemata and Counties Manukau), with the largest growth projected for Waitemata by 1.6%. Negative projections were indicated for Northland and Auckland DHB areas.
- Northern region continues to have New Zealand's largest 0-19 years population (39%).



- 26% of the region's total population are 0-19 year olds.



- 39% of the 0-19 year population were in the Other Ethnicity group, followed by Asian (22%), Māori (21%) and Pacific (17%).
- They resided mainly in Counties Manukau (34%) and Waitemata (33%) DHB areas.
- The 10-year regional projections (2018 to 2028) indicate an overall 6.5% projected growth in the greater Auckland area, especially in Waitemata (by 9%) and Counties Manukau (by 7%) DHB areas (Appendix A, Table 2).
- 10-year projections by ethnicity indicated the largest projected growth for Asian 0-19 year olds (by 30%), followed by Māori (by 11%) and Pacific (by 4%).



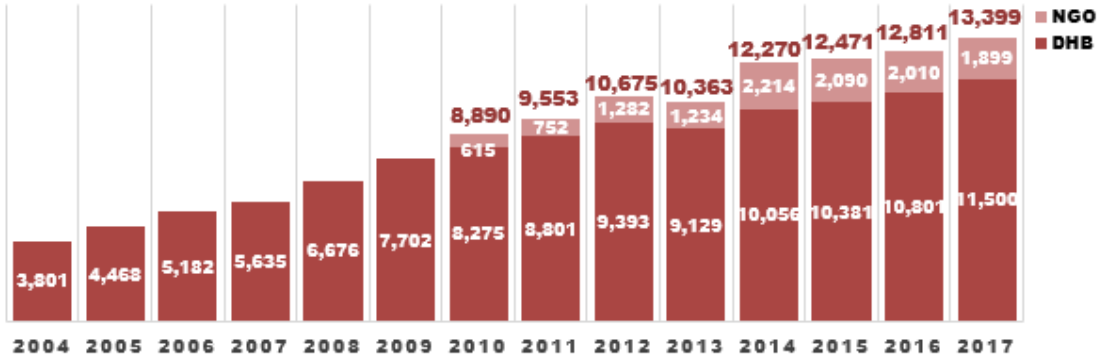
NORTHERN REGION SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December).

From 2015 to 2017:

- 7% increase in the overall number of service users accessing services in the region (Figure 1).
- Increase in both males and females, by approximately 8%.
- Largest increase in the 0-9 year age group, by 20%.
- Two out of the four DHB areas reported increases in the number of service users accessing services, largest increase was seen in Auckland by 24% followed by Waitemata by 9%. Slight decreases seen in Counties Manukau by 0.2% and Northland DHB area by 2%.

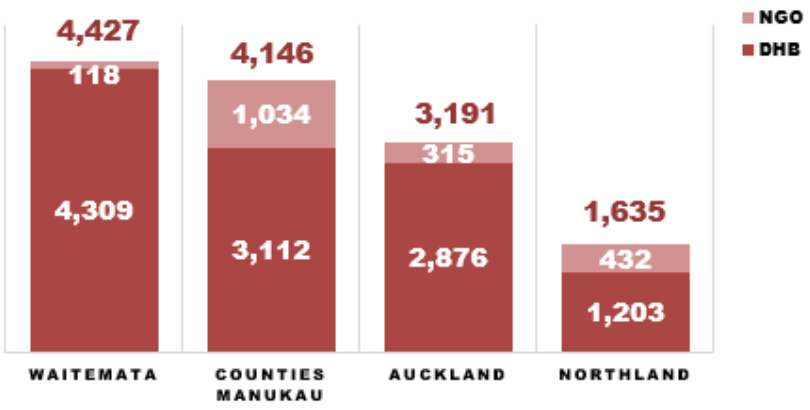
Figure 1. Northern Region Total 0-19 yrs Service User (2004-2017)



In the second six months of 2017:

- 54% of service users were male.
- 52% were 15-19 year olds.
- 86% accessed DHB services and 14% accessed NGOs (Figure 1).
- 88% of all service users in the region seen by services in the greater Auckland area, largely in Waitemata (38%), followed by Counties Manukau (35%), Auckland (27%) DHB areas (Figure 2).

Figure 2. Northern Region 0-19 yrs Service User by DHB Area (2017)



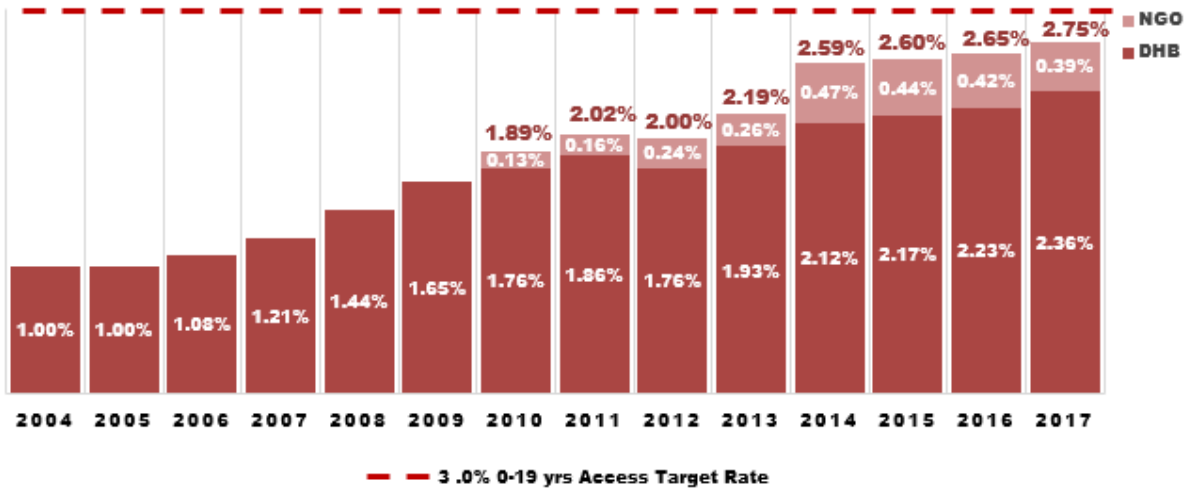
NORTHERN REGION SERVICE USER ACCESS RATES

The *Blueprint Access Benchmark Rate* for the 0-19 year age group was set at 3.0% of the population over a six-month period (Mental Health Commission, 1998). Due to different prevalence rates for mental illness in different age groups, specific access rates were set 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 rates are calculated by dividing the number of service users 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 service user lives (DHB of Domicile). However, access rates are affected by the type of population data used. Access rates that are based on census data are more accurate than those using population projections.

From 2015 to 2017:

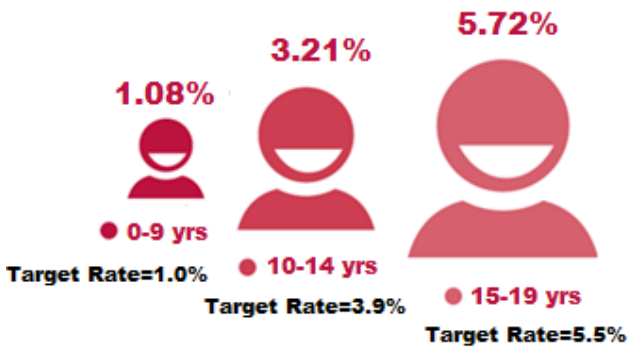
- Overall increase in the total 0-19 year access rate from 2.60% to 2.75% (Figure 3), with the largest increase in the 10-14 year age group.
- Increases in two out of the four DHB areas (Auckland and Waitemata), with the largest increase seen in Auckland, from 2.22% to 2.73% (Appendix B, Table 7).

Figure 3. Northern Region 0-19 yrs Service User Access Rates (2004-2017)

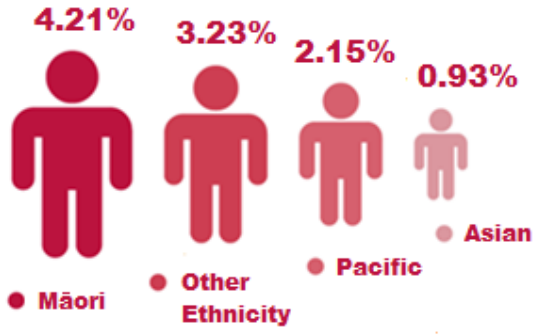


In the second six months of 2017:

- While access rates had improved for all three age groups, the only age group to exceed their target rate was the 15-19 year old age group.

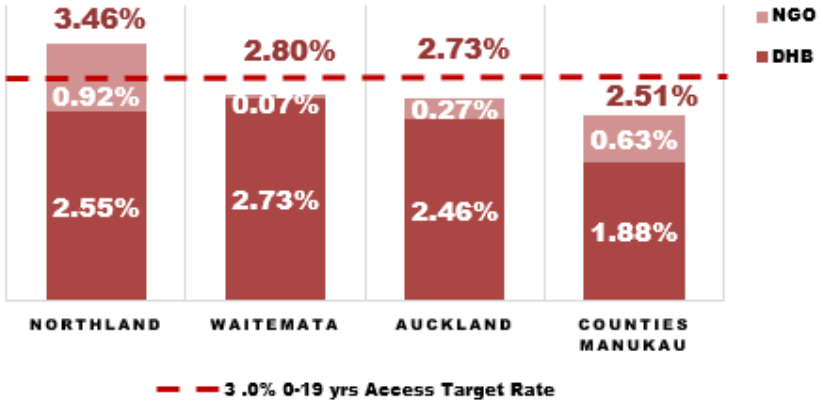


- Māori service users had the highest access rate in the region (4.21%). While exceeding the overall rate of 3.0%, this rate remained below the recommended rate for Māori (6%). Access rate for Other Ethnicity service users exceeded the target rate however; access rates for Pacific and Asian continued to remain below the target rate.



- Northland DHB area reported the highest service user access rate of 3.46%, the only area exceeding the target rate, while Counties Manukau had the lowest at 2.51% (Figure 4).
- Despite overall improvements in access rates, the regional rate remained below the national rate of 3.03%. Therefore, access rates need to improve for the region especially for Māori, Pacific and Asian service users.

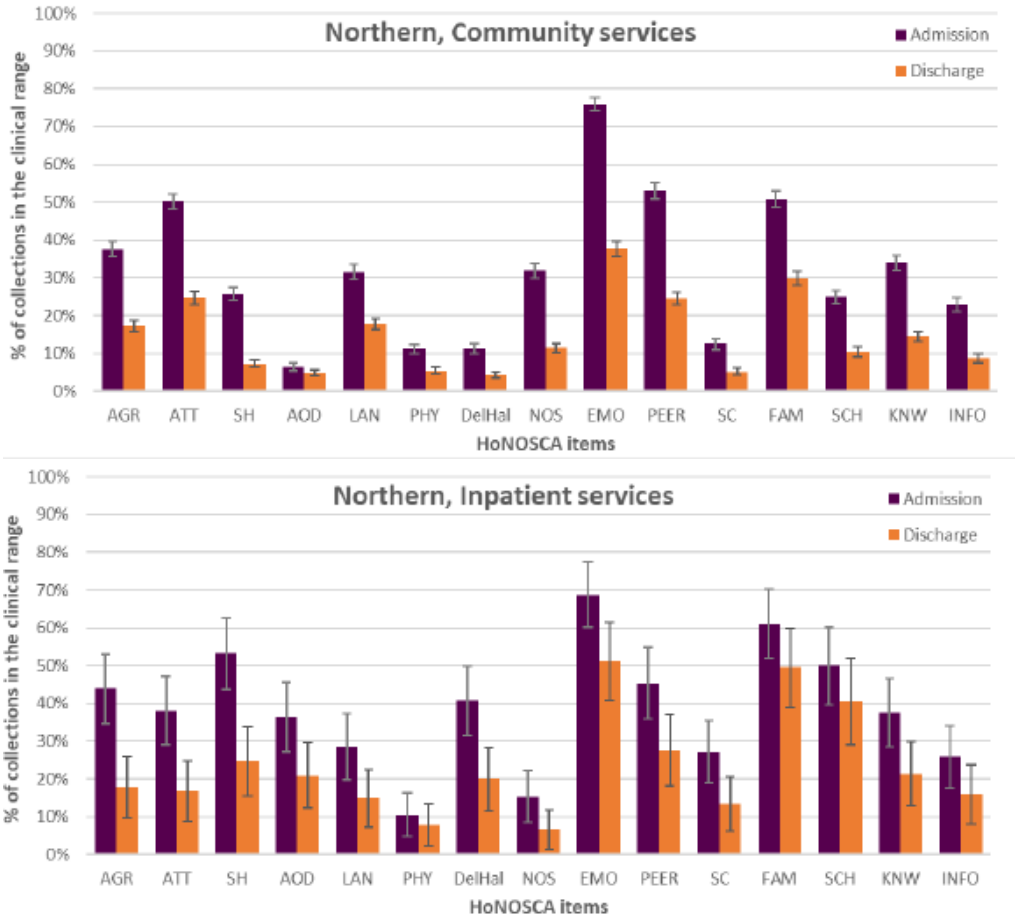
Figure 4. Northern Region 0-19 yrs Service User Access Rates by DHB Area (2017)



SERVICE USER OUTCOMES DATA

To assess whether service users 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 DHB inpatient and community child and adolescent mental health services. Service user outcome data for the 2018 period showed improvements in service user outcomes across all items by time of discharge from services (Figure 5). Improvements were statistically significant for almost all items (except for problems with alcohol, substance or solvents misuse) in community services only. While improvements were seen in all items in inpatient services, statistically significant differences were seen only in problems with disruptive, antisocial or aggressive behaviour (AGR): over-activity, attention or concentration (ATT); non-accidental self-injury (SH); and hallucinations, delusions or abnormal perceptions (DelHAL) items only (Figure 5).

Figure 5. Northern Region Child and Youth HoNOSCA Results (2018)



NORTHERN REGION FUNDING OF ICAMH/AOD SERVICES

From 2015/2016 to 2017/2018 financial year:

- 2% decrease in overall funding for ICAMH/AOD (including youth primary mental health) services (Table 1 & Figure 6).
- By provider, a 20% increase in non-DHB funding (inclusive of Primary Mental Health), while a 5% decrease in DHB funding (Appendix C, Table 1 & Figure 6).
- Decrease largely seen in Inpatient and AOD services (Table 1).
- Increase in all of the DHB areas in the region (Appendix C, Table 1).

Figure 6. Northern Region ICAMH/AOD Funding by Provider Services (2004-2018)

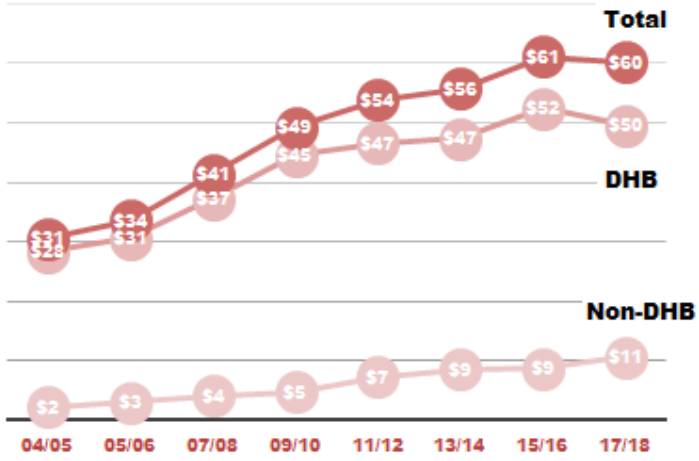


Table 1. Northern Region ICAMH/AOD Funding by Service (2008-2018)

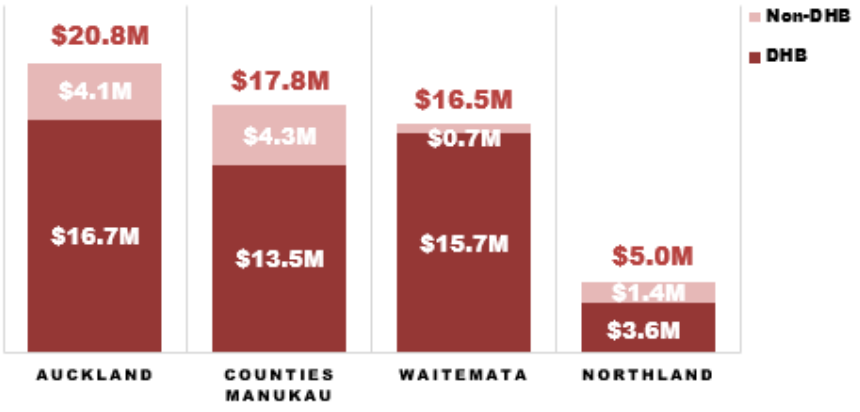
SERVICES	NORTHERN REGION FUNDING BY SERVICE (2007-2018)						
	07/08	09/10	11/12	13/14	15/16	17/18	% Change (2018-2016)
INPATIENT	$6,775,017	$5,792,472	$5,159,883	$5,442,953	$5,068,869	$3,566,645	-30
AOD	$1,800,888	$2,051,802	$3,637,894	$5,312,142	$6,028,813	$5,015,128	-17
CHILD & YOUTH MH	$32,876,930	$39,943,113	$43,605,084	$42,717,261	$45,264,766	$45,264,766	1
YOUTH FORENSIC	-	-	$1,226,286	$2,377,140	$4,157,213	$4,257,935	2
KAUPAPA MĀORI	-	$1,522,347	$279,300	-	-	-	-
YOUTH PRIMARY MH	-	-	-	-	$681,414	$1,559,848	*
TOTAL	$41,452,834	$49,309,735	$53,908,447	$55,849,495	$61,201,075	$60,159,204	-2

1. Includes Residential Services
Source: Ministry of Health Price Volume Schedule 2007-2016-Updated July 2018. *Not calculated.

For the June 2017 to July 2018 financial year:

- Northern region provider services received 33% ($60.2M) of the total funding for ICAMH/AOD services ($183. 4M) (Appendix C, Table 1).
- 76% of the regional funding was allocated to Child and Youth Mental Health Services, followed by AOD (8%) and Youth Forensics (7%).
- 3% allocated to Youth Primary Mental Health Services.

Figure 7. Northern Region ICAMH/AOD Funding by DHB Area (2018)



- Auckland DHB area had the largest proportion (35%) of funding, followed by Counties Manukau (30%) and Waitemata DHB areas (27%) (Figure 7).

FUNDING PER HEAD OF INFANT, CHILD AND ADOLESCENT POPULATION

Funding per head of population is a method by which we can look at the equity of funding across the regions and DHBs. Clearly, this is not the actual amount spent per head of the 0-19 year population, as only a small proportion of this population accesses services. When looking at individual DHBs, the calculation does not reflect inter-DHB referrals, including referrals to regional services (Appendix C, Table 2).

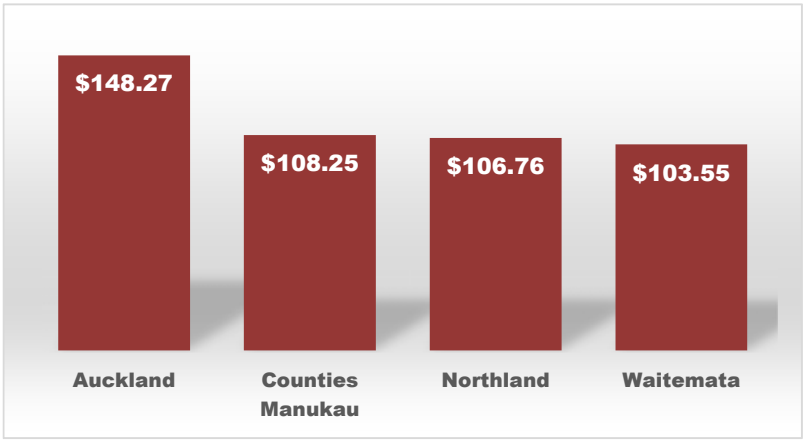
From 2016 to 2018:

- 0.2% increase in the spend per 0-19 year population (excluding Inpatient costs) by 0.2%, from $115.94 to $116.15 (Appendix C, Table 2 & Figure 8).
- Increase seen in two out of the four DHB areas with the largest increase seen in the Auckland DHB area by 9%, from $135 to $148.27 (Figure 8).

For the 2017/2018 financial year:

- Waitemata DHB area continues to have the lowest funding per 0-19 years in the region at $103.55 (Figure 8); however, a number of the DHB service users are seen in regional services provided by Auckland and Counties Manukau DHBs.

Figure 8. Northern Region spend per 0-19 yrs Population (2018)



NORTHERN REGION PROVISION OF ICAMH/AOD SERVICES

Four DHBs provide a range of specialist inpatient and community-based infant, child and adolescent mental health and alcohol and other drug (ICAMH/AOD) services in the Northern region: Northland, Waitemata, Auckland and Counties Manukau DHBs.

DHB providers also provide a number of regional services including the regional inpatient mental health service provided by Auckland DHB (*Starship Child and Family Inpatient Service*).

ICAMH/AOD and youth primary mental health services are also provided by DHB-funded non-DHB services (NGOs and PHOs). For the June 2017 to July 2018 period, 21 non-DHB services (including 2 PHOs) were identified.

All services in the Northern region by DHB area are listed in the following tables.

Table 2. Northland ICAMH/AOD Services (2017/2018)

NORTHLAND DHB
Te Roopu Kimiora: Child & Youth Mental Health & Alcohol & Other Drug Service
Early Intervention Psychosis
REGIONAL SERVICES
Youth Forensic Service
Maternal & Infant Mental Health Service

NORTHLAND DHB-FUNDED NON-DHB SERVICES
EMERGE AOTEAROA
Infant, Child, Adolescent & Youth Community Support Services
MANAIA HEALTH PHO
Youth Primary Mental Health Service
RUBICON CHARITABLE TRUST BOARD
Children & Youth Alcohol & Drug Community Services
Community Child, Adolescent & Youth Service for Co-existing Problems

Table 3. Waitemata ICAMH/AOD Services (2017/2018)

WAITEMATA DHB
Marinoto North & Rodney Child & Adolescent Mental Health Services
Marinoto West Child & Adolescent Teams
Early Psychosis Intervention
Infant Mental Health Service
Eating Disorders Liaison Service
REGIONAL SERVICES
Altered High Youth Alcohol & Drug Services (Waitemata, Auckland & Counties Manukau DHBs)
Intensive Clinical Support Services (Waitemata, Auckland & Counties Manukau DHBs)

WAITEMATA DHB-FUNDED NON-DHB SERVICES
EMERGE AOTEAROA
Infant, Child, Adolescent & Youth Crisis Respite & Day Services
HEALTHWEST
Youth Primary Mental Health Service
TE WHĀNAU O WAIPAREIRA TRUST
Kaupapa Māori Family Whānau Support Education, Information & Advocacy Service

Note: Italicised services are Kaupapa Māori services

Table 4. Auckland Infant, Child & Adolescent Mental Health Services (2017/2018)

AUCKLAND DHB
Kari Centre: Child & Adolescent Mental Health Service Community Team East
Kari Centre: Child & Adolescent Mental Health Service: Community Team West
Koanga Tupu: Infant Mental Health
Tu Tangata Tonu: Children of Parents with Mental Illness
Youth Transitional Programme
Hapai Ora: Youth Early Intervention Service
Te Kaahu (was ICSS)
Child & Adolescent Mental Health Service Intake Team
Parent Child Interaction Therapy (PCIT)
Neural Developmental Pathway
Eating Disorders Liaison
REGIONAL SERVICES
Youth Forensic Service & Child & Adolescent Liaison Service (Northland, Waitemata & Auckland DHBs)
Tupu Ora: Regional Eating Disorders Service
Child & Family Inpatient Unit (CFU) (Northern & Midland Region)
Starship Paediatric Child Consult Liaison Psychiatry

AUCKLAND DHB-FUNDED NON-DHB SERVICES
CONNECT SUPPORTING RECOVERY
Child, Adolescent & Youth & Families with a Mental Health Disorder
EMERGE AOTEAROA
Infant, Child, Adolescent & Youth Package of Care
KAHUI TU KAHA
Infant, Child, Adolescent & Youth Crisis Respite & Day Services
MAHITAHI TRUST
Community Child, Adolescent & Youth Service for Co-Existing Problems
ODYSSEY HOUSE TRUST
Child, Adolescent & Youth Community Alcohol & Drug Services with Accommodation
Children & Youth Alcohol & Drug Community Services: Amplify School Programme
PROCARE NETWORKS
Youth Primary Mental Health Service
YOUTHLINE AUCKLAND CHARITABLE TRUST
Youth Primary Mental Health Service

Table 5. Counties Manukau ICAMH/AOD Services (2017/2018)

COUNTIES MANUKAU DHB
Infant Mental Health
Whirinaki North: Punui Youth Team
Whirinaki South: Pohutukawa Youth Team
Eating Disorders Liaison Team
MĀORI SERVICES
He Kākano: Kaupapa Māori Child & Adolescent Mental Health Service (Whirinaki South)
PACIFIC SERVICES
Vaka Toa Pacific Adolescent Service (Whirinaki North)

Note: Italicised services are Kaupapa Māori services

COUNTIES MANUKAU DHB-FUNDED NON-DHB SERVICES
ANGLICAN TRUST FOR WOMEN & CHILDREN
Infant, Child, Adolescent & Youth Package of Care (Wrap Around): Mellow Parenting Groups
EMERGE AOTEAROA
Infant, Child, Adolescent & Youth Package of Care
ODYSSEY HOUSE TRUST
Child, Adolescent & Youth & Families with a Mental Health Disorder
Child, Adolescent & Youth Alcohol & Drug Community Services: Schools Programme: Stand Up & Amplify Programme
OHOMAIRANGI TRUST
Infant, Child, Adolescent & Youth Package of Care (Wrap Around): Mellow Parenting Programme
PATHWAYS HEALTH LTD
Infant, Child, Adolescent & Youth Crisis Respite
PENINA TRUST
Child & Youth Package of Care
RAUKURA HAUORA O TAINUI TRUST
Kaupapa Māori Child, Adolescent & Youth Alcohol & Drug Community Services: Te Ara Hou Alcohol & Drug Service
YOUTHLINE AUCKLAND CHARITABLE TRUST
Child, Adolescent & Youth Alcohol & Drug Community Services: Stand Up School-Based Alcohol & Drug Service

Note: Italicised services are Kaupapa Māori services

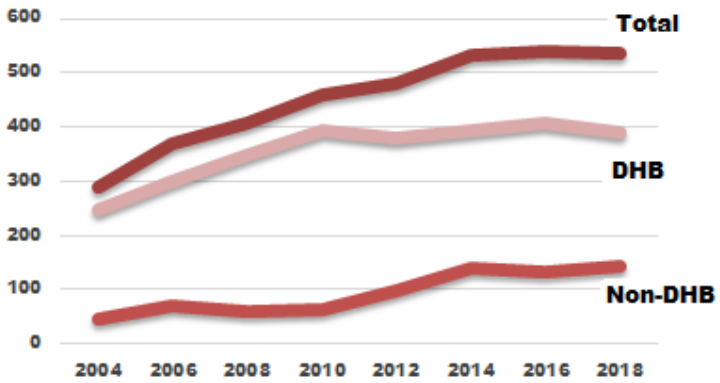
NORTHERN REGION ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity and Occupation submitted by all four DHB (Inpatient & Community) ICAMH/AOD services and all 21 contracted non-DHB services (19 NGOs & 2 PHOs) as at 30 June 2018.

From 2016 to 2018:

- 1% decrease in the total regional workforce, from 539.5 to 535.5 actual FTEs (Table 6 & Figure 9).
- 4% decrease in the DHB workforce (Inpatient & Community Services), from 406.5 to 391.6 actual FTEs.
- 8% increase in the non-DHB provider workforce largely due to the inclusion of two PHOs, from 133 to 143.9 actual FTEs.

Figure 9. Total Northern Region ICAMH/AOD Workforce (2004-2018)



- 2% increase in the clinical workforce, from 407.1 to 416 actual FTEs.
- 33% increase in the number of vacant FTEs reported, increasing the regional vacancy rate from 10% to 13% (vacancy rate ranged from 1% to 24%).

Table 6. Northern Region ICAMH/AOD Workforce (2008-2018)

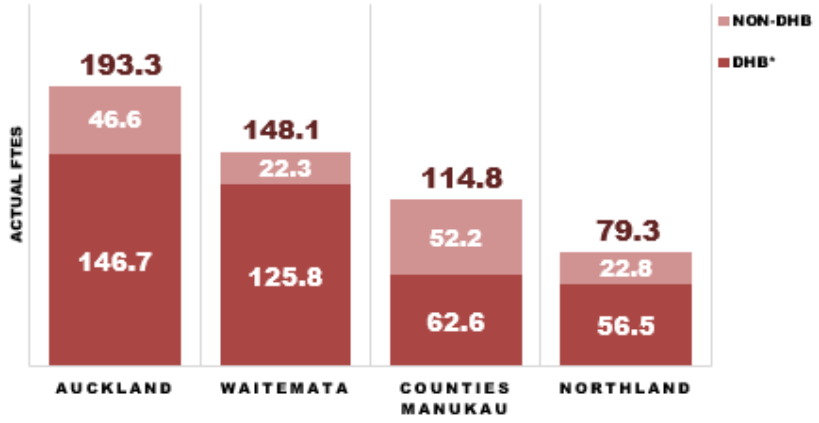
YEAR	NORTHERN REGION WORKFORCE BY SERVICE PROVIDER (2008-2018)								
	DHB[1]			NON-DHB			TOTAL		
	ACTUAL	VACANT	% VACANCY	ACTUAL	VACANT	% VACANCY	ACTUAL	VACANT	% VACANCY
2008	347.5	41.8	11	58.7	6.9	11	406.2	48.7	11
2010	392.9	52.4	12	64.9	2.0	3	457.9	54.4	11
2012	380.2	35.5	9	98.5	1.0	1	478.7	36.5	7
2014	392.2	57.9	13	138.7	6.0	4	530.9	63.9	11
2016	406.5	51.8	11	133.0	6.8	5	539.5	58.7	10
2018	391.6	61.8	14	143.9	4.3	3	535.5	78.1	13

1. Includes Inpatient and Regional Services.

As at 30 June 2018:

- 85% of the regional workforce was in services in the greater Auckland area: comprised of 42% in Auckland, 32% in Waitemata and 25% in Counties Manukau (Figure 10).
- 73% of the workforce was in DHB provider services.
- 27% was in non-DHB services.
- The workforce was largely NZ European (45%), followed by Māori (18%), Other Ethnicity (15%), Pacific (11%) and Asian (11%) (Appendix D, Table 18).
- 78% were in the clinical workforce as Nurses (18%), Social Workers (14%), Psychologists (13%) and AOD Practitioners (11%) (Table 7).

Figure 10. Northern Region ICAMH/AOD Workforce by DHB Area (2018)



*Includes Regional Services

- 15% overall were in the non-clinical workforce, largely in non-DHB services.
- 7% in Administration (3%) and Management (4%) roles.
- 94% of all vacancies were reported by DHB provider services in the clinical workforce: Nurses (41%), Psychologists (21%), Social Workers (12%) and Psychiatrists (11%) (Table 7).
- Regional annual staff turnover rate was at 14% (DHB = 9% and non-DHB = 23%) for Social Workers, Nurses and Psychologists. The main reasons for leaving included moving overseas; relocated to another city/town within NZ; took other job or opportunities external to organisation.

Figure 11. Top 4 Northern Region ICAMH/AOD Workforce (2018)

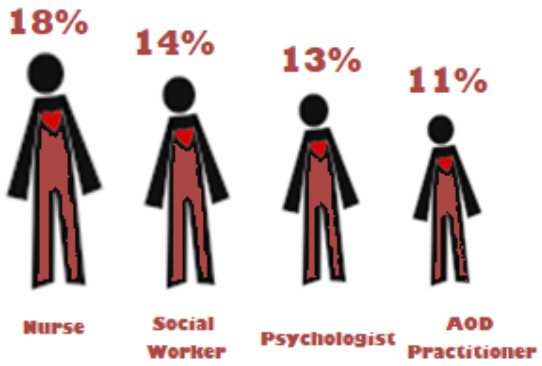


Table 7. Northern Region ICAMH/AOD Workforce by Occupation (2018)

Northern Region ICAMH/AOD Workforce by Occupation (Actual FTEs, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	18.50	18.50	40.50	59.00
Child & Adolescent Psychiatrist	5.97	22.66	28.63	0.40	29.03
Co-Existing Problems Clinician	-	8.00	8.00	2.00	10.00
Counsellor	0.20	1.90	2.10	0.80	2.90
Family Therapist	-	3.40	3.40	-	3.40
Nurse	27.10	62.35	89.45	7.80	97.25
Occupational Therapist	2.60	34.70	37.30	0.50	37.80
Other Senior Medical Officer	5.00	5.20	10.20	-	10.20
Psychotherapist	1.10	8.80	9.90	1.00	10.90
Psychologist	8.10	59.34	67.44	2.00	69.44
Social Worker	2.80	67.03	69.83	6.85	76.68
Other Clinical[1]	-	5.00	5.00	4.41	9.41
Clinical Sub-Total	52.87	296.88	349.75	66.26	416.01
Cultural	1.00	7.90	8.90	0.50	9.40
Educator	-	-	-	2.50	2.50
Mental Health Consumer	-	-	-	3.20	3.20
Mental Health Support Worker	9.00	-	9.00	27.85	36.85
Youth Worker	-	-	-	25.01	25.01
Whānau Ora Practitioner	-	-	-	2.50	2.50
Other Non-Clinical[2]	-	-	-	3.00	3.00
Non-Clinical Sub-Total	10.00	7.90	17.90	64.56	82.46
Administration	2.00	11.80	13.80	2.00	15.80
Management	-	10.10	10.10	11.00	21.10
TOTAL	64.87	326.68	391.55	143.82	535.37

1 = Interns (Psychology); GP; Referral Coordinator; Clinical Supervisor; Clinical Team Leader. 2= Needs Assessors & Service Coordinators; Programme Manager; Caregivers.

Table 8. Northern Region ICAMH/AOD Workforce Vacancies by Occupation (2018)

Northern Region ICAMH/AOD Vacancies by Occupation (Vacant FTEs, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	1.00	1.00	3.80	4.80
Child & Adolescent Psychiatrist	1.78	6.04	7.82	-	7.82
Nurse	6.60	23.30	29.90	0.50	30.40
Occupational Therapist	-	3.00	3.00	-	3.00
Psychotherapist	-	1.50	1.50	-	1.50
Psychologist	0.40	14.83	15.23	-	15.23
Social Worker	-	8.60	8.60	-	8.60
Other Clinical[1]	1.00	2.00	3.00	-	3.00
Clinical Sub-Total	9.78	60.27	70.05	4.30	74.35
Cultural	1.00	0.50	1.50	-	1.50
Non-Clinical Sub-Total	1.00	0.50	1.50	-	1.50
Administration/Management	1.15	1.05	2.20	-	2.20
TOTAL	11.93	61.82	73.75	4.30	78.05

1 = Clinical Supervisor

DHB INPATIENT ICAMH WORKFORCE

From 2016 to 2018:

- 1% increase, from 63.92 to 64.87 actual FTEs (Table 9).
- Increase in the regional vacancy rate from 13% to 16% (from 9.7 to 11.9 vacant FTEs).

As at 30 June 2018:

- 82% of the inpatient workforce in clinical roles as Nurses (42%) (Table 7).
- 15% in the non-clinical workforce as Mental Health Support Workers (14%).
- 82% of all vacancies reported for clinical roles: Nurses (55%) and Psychiatrists (15%) (Table 9).

Table 9. Northern Region DHB Inpatient ICAMH Workforce (2008-2018)

YEAR	ACTUAL FTES			VACANT FTES			% VACANCY
	CLINICAL	NON-CLINICAL	TOTAL	CLINICAL	NON-CLINICAL	TOTAL	
2008	62.05	11.2	73.3	11.0	0.3	11.3	13
2010	61.8	16.1	77.9	8.1	-	8.1	9
2012	41.6	8.90	54.5	8.9	-	8.9	14
2014	47.18	11.8	58.98	13.9	2.0	15.9	21
2016	52.92	11.0	63.92	9.7	-	9.7	13
2018	52.87	12.0	64.87	9.8	2.2	11.9	16

Note: From July 2018 number of beds had decreased as well as staffing numbers.

DHB COMMUNITY ICAMH/AOD WORKFORCE

From 2016 to 2018:

- 5% decrease in the overall DHB community workforce, from 342.57 to 326.68 actual FTEs (Table 10), decrease largely in Counties Manukau DHB by 26%.
- Increase in the workforce seen only in Northland DHB by 21%, from 46.5 to 56.48 actual FTEs.
- Regional vacancy rate increased from 11% to 16% (ranged 2% to 35%), from 42.17 to 61.82 vacant FTEs.

As at 30 June 2018:

- 91% of the workforce in clinical roles as Social Workers (23%), Nurses (21%), Psychologists (20%) and Occupational Therapists (12%) (Table 7).
- 2% in non-clinical workforce (excluding Admin/Management), all in Cultural roles.
- 97% of all vacancies reported for clinical roles: Nurses: (38%), Psychologists (24%) and Social Workers (14%) (Table 8).

Table 10. Northern Region DHB Community ICAMH/AOD Workforce by DHB Area (2008-2018)

NORTHERN REGION DHB AREA	ACTUAL FTES						VACANT FTES						VACANCY RATE (%)					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NORTHLAND	21.4	33.6	34.4	33.3	46.5	56.5	3.2	0.0	1.6	2.0	1.0	1.0	13	-	4	6	2	2
WAITEMATA	107.1	124.7	120.9	118.1	125.9	125.8	12.9	22.1	11.5	11.7	17.2	14.0	11	15	9	9	12	10
AUCKLAND	72.4	74.1	77.9	79.1	85.9	81.8	8.9	7.7	7.8	10.8	9.9	12.6	11	9	9	12	10	13
COUNTIES MANUKAU	73.4	82.6	82.8	102.8	84.3	62.6	5.5	14.5	5.8	17.4	14.1	34.2	7	15	7	14	14	35
TOTAL	274.3	315.1	315.9	333.2	342.6	326.7	30.5	44.3	26.7	41.9	42.2	61.8	10	12	8	11	11	16

DHB WORKFORCE COMPETENCIES

- The capability of the workforce was assessed by the *Real Skills Plus ICAMHS competency framework* (The Werry Centre, 2009b), which describes the knowledge, skills and attitudes needed to work with infants, children and young people and whānau with a suspected or identified mental health or alcohol or other drug concern. The *Real Skills Plus online assessment tool* identifies the competencies that individual and teams meet from the framework, and highlights areas for knowledge and skill development for individuals and teams *(to access the tool and more information:* ***www.werryworkforce.org****)*.
- *Real Skills Plus* has three levels
    - **Primary Level** *for people in the primary sector that work with infants, children and young people.*
    - **Core Level** *for practitioners working in services that focus on mental health and/or AOD concerns.*
    - **Specific Level** *for senior or specialist practitioners working at an advanced level of practice.*
- *Real Skills Plus* data can be reported at service and team level and individually. The application of *Real Skills Plus* is most effective at an organisational level as it helps to develop a shared understanding of the knowledge and skills required by the whole service. It promotes the development of best practice across disciplines, creating a multi-skilled workforce at each level. *Real Skills Plus* allows targeted service development, recruitment and service delivery activities.
- The data presented in Figures 12 and 13 are the summary of the ***Core*** level competencies met by the Northern region DHB ICAMH/AOD workforce in 2018. The workforce met a number of ***Core*** level competencies (ranging from 42% to 100% of skills and knowledge required), and further development was indicated for the following:
    - ***Assessment Knowledge (58%)***
    - ***Intervention Knowledge (50%).***
    - ***Intervention Skills (29%)***
    - ***Knowledge and Skills for Leadership roles (37%).***
    - ***Knowledge and Skills for working with Infants (29%)***

Figure 12. DHB *Real Skills Plus* Core Level Competencies (2018)

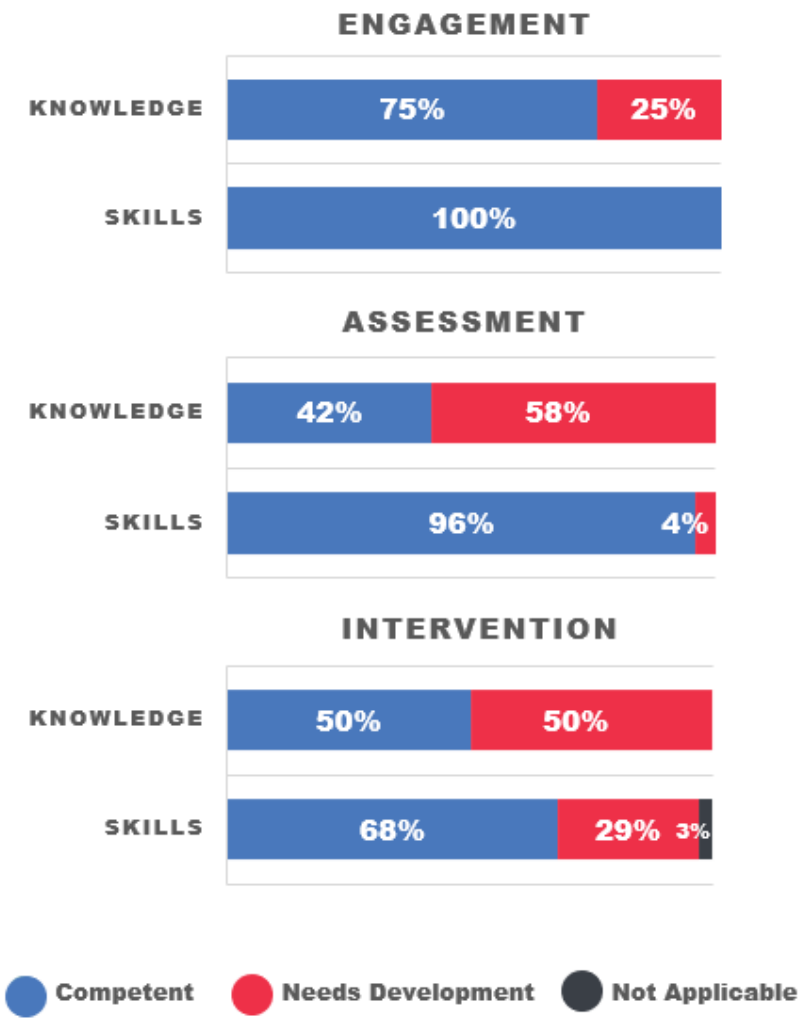
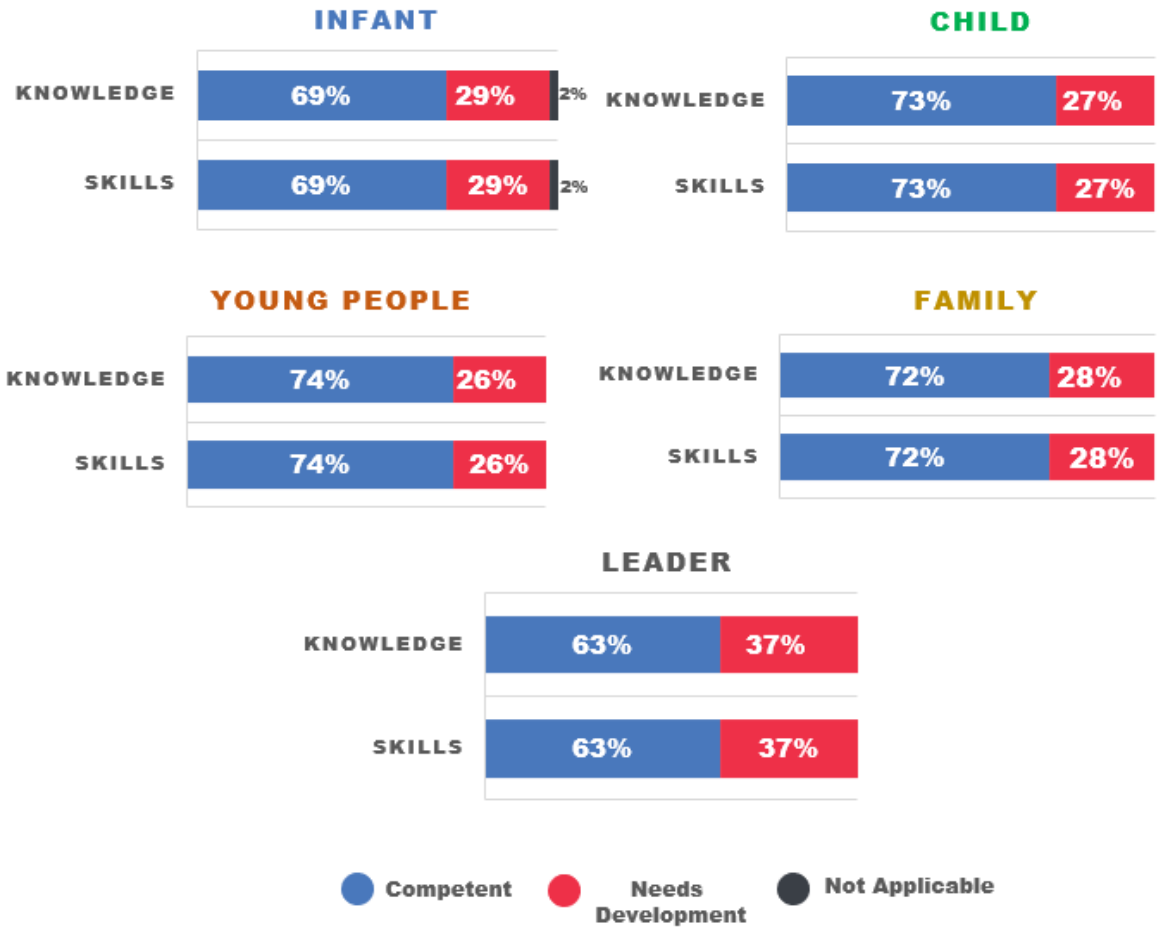


Figure 13. DHB *Real Skills Plus* Competencies by Domain (2018)



NON-DHB ICAMH/AOD WORKFORCE

From 2016 to 2018:

- 8% increase in the non-DHB workforce, from 133 to 143.9 actual FTEs (Table 11). This increase was due to the inclusion of workforce data from PHOs with contracted youth primary mental health services.
- Increase in the clinical workforce only by 11%, from 59.5 to 66.26 FTEs.
- Decrease in vacancy rate from 5% to 3%.

As at 30 June 2018:

- 21 non-DHB service providers including two PHOs were contracted to provide DHB-funded Infant, Child and Adolescent Mental Health/AOD services.
- Largest non-DHB workforce in Counties Manukau (36%) and Auckland (32%) DHB areas (Table 11).
- 46% in the clinical workforce as AOD Practitioners (28%), Nurses (5%) and Social Workers (4.7%) (Table 7).
- 45% in non-clinical workforce mainly Mental Health Support Workers (19%) and Youth Workers (17% (Table 7).
- Regional annual turnover rate 23% mainly for Mental Health Support Workers and Youth Workers. The main reasons for leaving included career development and further study, other employment opportunities (external and internal) and change in career.

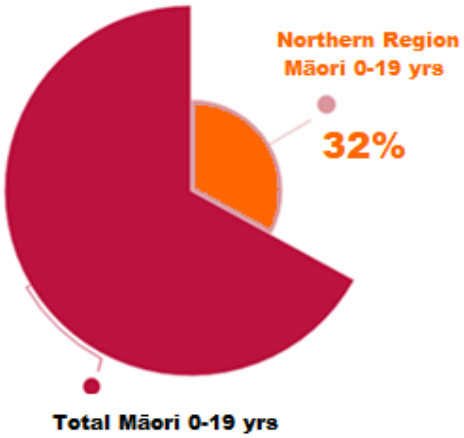
Table 11. Northern Region Non-DHB ICAMH/AOD Workforce (2008-2018)

NORTHERN REGION DHB AREA	ACTUAL FTES						VACANT FTES						VACANCY RATE (%)					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NORTHLAND	15.7	15.0	14.0	18.8	21.0	22.8	-	-	-	2.0	0.9	-	-	-	-	10	4	-
WAITEMATA	8.5	-	5.0	22.3	21.0	22.3	1.0	-	1.0	-	1.0	-	10.5	-	17	-	12	-
AUCKLAND	21.3	26.6	39.9	51.0	48.0	46.6	4.9	0.5	-	3.5	-	2.3	18.7	1.9	-	6	-	5
COUNTIES MANUKAU	13.2	23.3	39.6	46.6	42.7	52.2	1.2	1.5	-	0.5	4.9	2.0	8.3	6.1	-	1	10	4
TOTAL	58.7	64.9	98.5	138.7	133.0	143.9	7.1	2.0	1.0	6.0	6.8	4.3	10.8	2.9	1.0	4	5	3

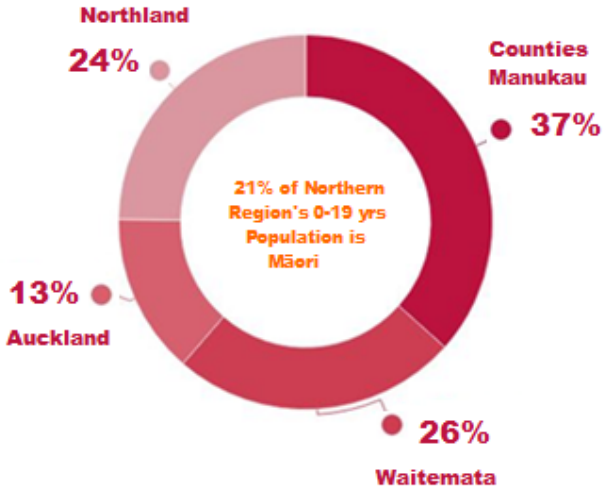
NORTHERN REGION MĀORI OVERVIEW

NORTHERN MĀORI INFANT, CHILD AND ADOLESCENT POPULATION

- Population projections from 2016 to 2018 indicated a 2% growth in the regional Māori 0-19 year population (Appendix A, Table 1).
- Projected population growth was seen in three out of the four DHB areas: Waitemata (by 3%), Northland (by 2%), and Counties Manukau (by 2%).
- Northern region continues to have one of the largest Māori infant, child and adolescent populations (a third of New Zealand's Māori infant, child and adolescent population, 32%).
- Māori infants, children and adolescents make up 21% of the region's total 0-19 years population.



- The largest Māori infant, child and adolescent population in the Northern region resides in Counties Manukau (37%), Waitemata (25%) and Northland (24%) DHB areas. However, proportionally, just over half (54%) of Northland's 0-19 population are Māori.
- 10-year projections (from 2018-2028) by ethnicity showed an 11% regional projected population growth for Māori 0-19 year olds (Appendix A, Table 2).
- 10-year projections by DHB area indicated the largest projected growth in Waitemata (by 16%), Northland (by 9%) and Counties Manukau (by 9%). A 7% growth is projected for Auckland.

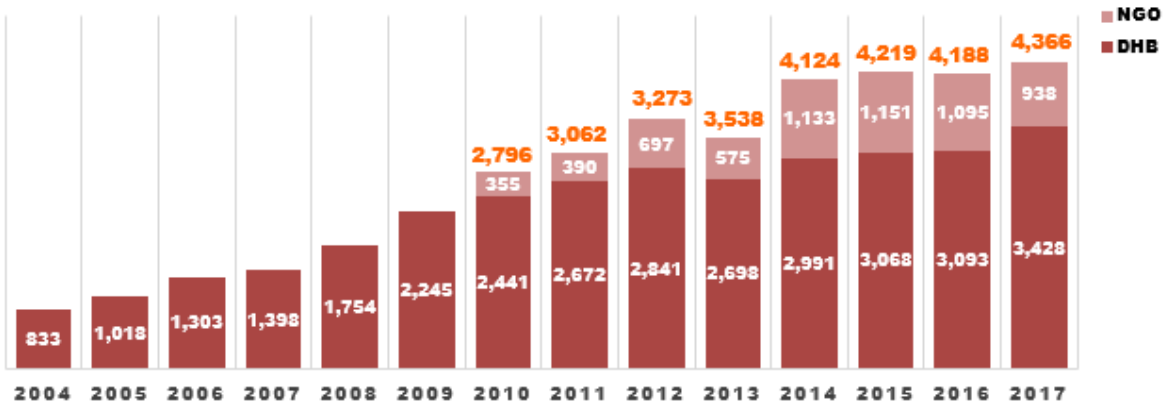


NORTHERN REGION MĀORI SERVICE USER ACCESS TO ICAMH/AOD SERVICES

From 2015 to 2017:

- 3% increase in the number of Māori service users accessing services (Figure 14). Similar increases in both Māori males and females (approx. 3%) (Appendix B, Table 1).
- Largest increase in service users in Auckland DHB area (by 26%) and Counties Manukau DHB (by 6%), with decreases in Northland (by 9%) and Waitemata (by 2%) DHB areas.

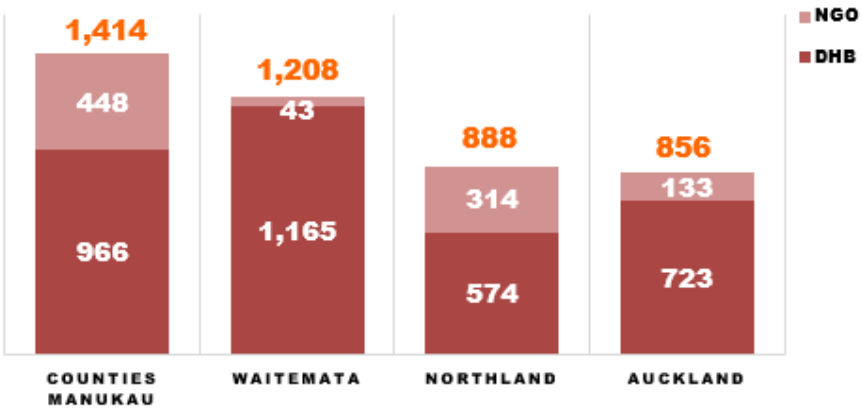
Figure 14. Northern Region Māori 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- 35% of all Māori service users accessing services in the country were in the Northern region (Appendix B, Table 9).
- 33% of total service users in the region were Māori. 58% were Māori males.
- 79% were accessing DHB services.
- 21% were accessing NGOs.
- 60% of all Māori service users in the region were seen by services in Counties Manukau (54%) and Waitemata (46%) DHB areas (Figure 15).

Figure 15. Northern Region Māori Servicce User by DHB Area (2017)



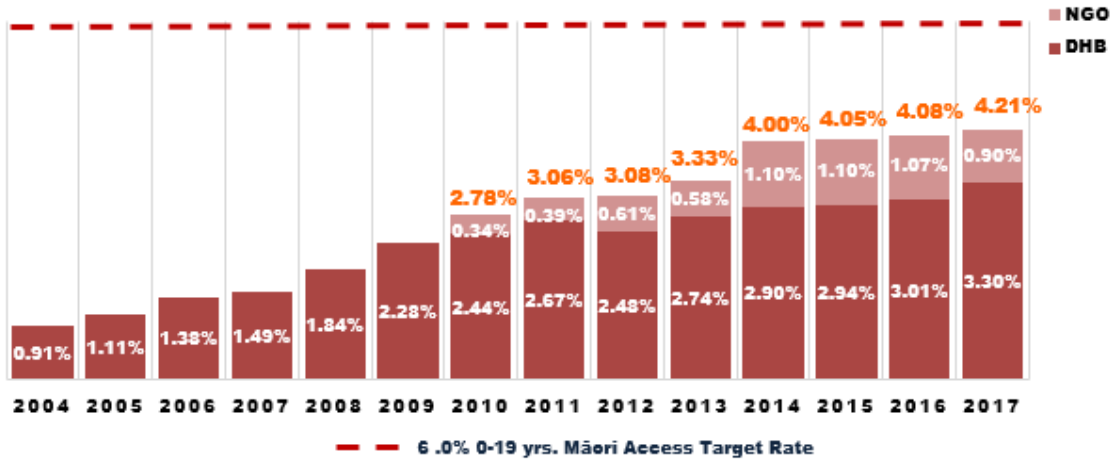
MĀORI SERVICE USER ACCESS RATES

Due to the lack of epidemiological data for Māori tamariki and rangatahi population, a 6% target access rate was recommended for Māori, double that of the general population of 3%, due to a higher need for mental health services (Mental Health Commission, 1998).

From 2015 to 2017:

- Increase in Māori access rate from 4.05% to 4.21% (Figure 16).
- Increase seen in all DHB areas.

Figure 16. Northern Region Māori 0-19 yrs Service User Access Rates (2004-2017)



In the second half of 2017:

- Māori access rate of 4.21% was higher than the overall regional access rate (including all ethnicities) of 2.75%, and the national Māori access rate of 3.89% (Appendix B, Table 9).
- While the Māori access rates were also higher than the overall rates for all three age groups, they continued to remain below recommended access target rates for Māori (6%).
- By age, Māori access rates for all three age groups remained below the recommended rates, especially for the 0-9 year age group.
- By DHB area, Auckland DHB area had the highest Māori access rate of 6.0%, reaching the recommended rate, while the remainder of the areas remained below the target rate (Figure 17).

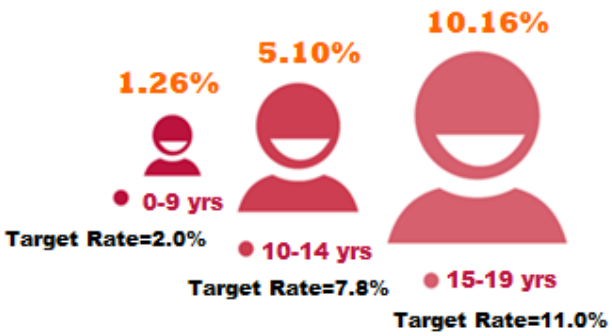
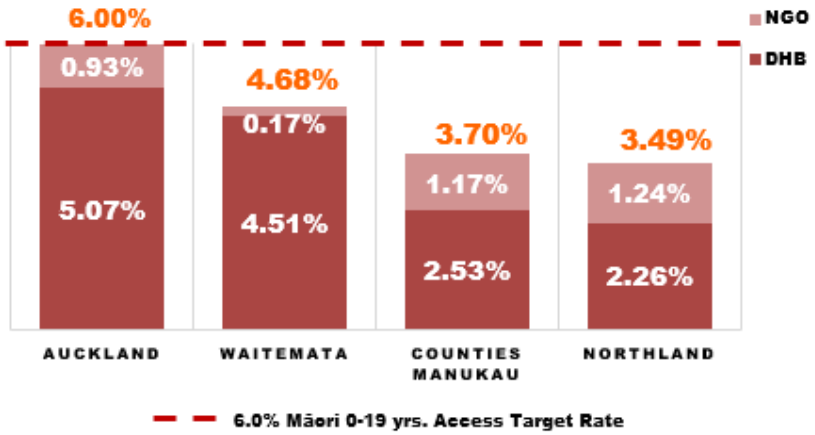


Figure 17. Northern Region Māori 0-19 yrs Service User Access Rates by DHB Area (2017)



NORTHERN REGION MĀORI ICAMH/AOD WORKFORCE

The following workforce information is derived from the workforce survey and incudes Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity and Occupation submitted by all four DHB (Inpatient & Community) ICAMH/AOD services and all 21 contracted non-DHB services (19 NGOs & 2 PHOs) as at 30 June 2018.

From 2016 to 2018:

- 6% increase in the overall Māori workforce, from 111 to 118 (Table 12).
- Increase largely in the non-DHB workforce, due to the inclusion of PHOs.
- 28% increase in the clinical workforce.

As at 30 June 2018:

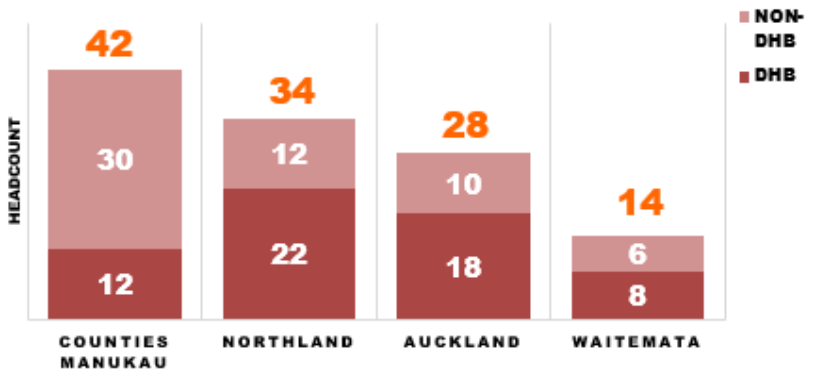
- 36% of the workforce was in services in the Counties Manukau DHB area, followed by Northland (29%), Auckland (24%) and Waitemata (12%) (Table 12 & Figure 15).
- Overall the workforce was almost equally employed in DHB and non-DHB services except in the Counties Manukau DHB area where 71% are in non-DHB services.

Table 12. Total Northern Region Māori ICAMH/AOD Workforce by DHB Area (2008-2018)

DHB AREA	NORTHERN REGION MĀORI WORKFORCE BY SERVICE PROVIDER (HEADCOUNT, 2008-2018)																	
	DHB						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NORTHLAND	5	15	12	11	17	22	13	12	8	16	8	12	18	27	20	27	25	34
WAITEMATA	12	14	14	15	13	8	-	-	-	8	7	6	12	14	14	16	15	14
AUCKLAND[1]	14	12	12	13	16	18	5	3	11	18	15	10	19	15	23	31	31	28
COUNTIES MANUKAU	17	12	19	20	13	12	5	13	26	33	27	30	22	25	45	53	40	42
TOTAL	48	53	57	59	59	60	23	28	45	75	57	58	71	81	102	127	111	118

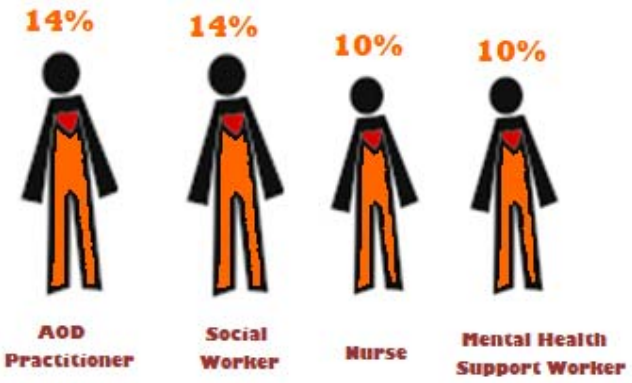
1. Includes Inpatient workforce

Figure 18. Northern Region Māori ICAMH/AOD Workforce by DHB Area (2018)



- 58% in clinical roles as AOD Practitioners (14%), Social Workers (14%) and Nurses (10%).
- 36% in non-clinical roles largely as Mental Health Support Workers (10%), Cultural (9%) and Youth Workers (9%) (Table 13).

Figure 19. Top 4 Northern Region Māori ICAMH/AOD Workforce (2018)



DHB INPATIENT MĀORI ICAMH WORKFORCE

From 2016 to 2018:

- Increase in the Māori inpatient workforce, from 5 to 9 (headcount).

As at 30 June 2018:

- 56% in clinical roles largely as Nurses (33%) (Table 13).
- 44% in the non-clinical workforce largely as Mental Health Support Workers (33%).

DHB COMMUNITY MĀORI ICAMH/AOD WORKFORCE

From 2016 to 2018:

- 4% increase from 49 to 51 (headcount) (Table 13). Increase was seen in the clinical workforce, from 32 to 37.

As at 30 June 2018:

- 67% of the regional DHB community Māori workforce was employed in Northland (43%) and Counties Manukau (24%) DHBs (Appendix D, Table 8).
- 73% in clinical roles largely as Social Workers (29%), Nurses (16%), and Co-Existing Problems Clinicians (10%) (Table 13).
- 18% in the non-clinical workforce all in Cultural roles (18%).
- 10% in Administration (4%) and Management (6%) roles.

NON-DHB MĀORI ICAMH/AOD WORKFORCE

From 2016 to 2018:

- Very little change in the Māori non-DHB workforce, from 57 to 58 (Table 12). However, there was a shift from a largely non-clinical workforce to a more even split between the clinical and non-clinical workforces.

As at 30 June 2018:

- 52% of the non-DHB Māori workforce employed in the Counties Manukau DHB area (Table 12).
- 50% in non-clinical roles, largely as Youth Workers (19%) and Mental Health Support Workers (16%) (Table 13).
- 45% in clinical roles, largely as AOD Practitioners (26%) and Therapists (14%).
- 5% in Administration (2%) and Management (3%) roles.

Table 13. Northern Region Māori ICAMH/AOD Workforce by Occupation (2018)

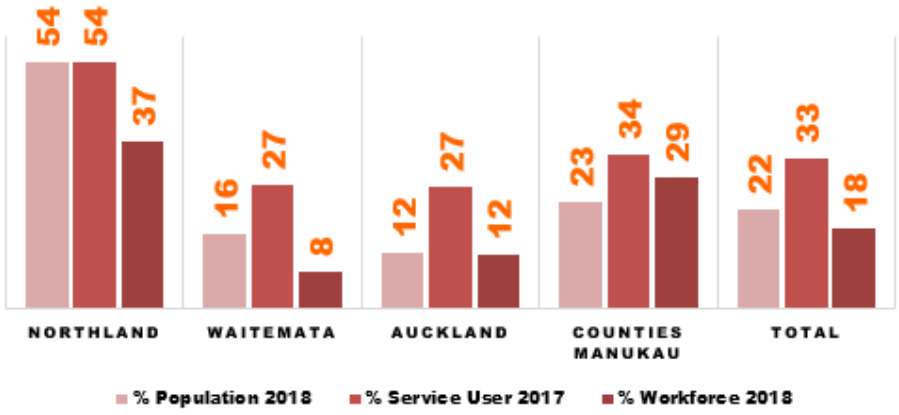
Northern Region Māori ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	1	1	15	16
Child & Adolescent Psychiatrist	1	1	2	-	2
Co-Existing Problems Clinician	-	5	5	1	6
Nurse	3	8	11	1	12
Occupational Therapist	-	1	1	-	1
Psychologist	-	5	5	-	5
Social Worker	-	15	15	1	16
Therapist	-	-	-	8	8
Other Clinical[1]	1	1	2	-	2
Clinical Sub-Total	5	37	42	26	68
Caregiver	-	-	-	3	3
Cultural	1	9	10	1	11
Mental Health Consumer	-	-	-	2	2
Mental Health Support	3	-	3	9	12
Youth Worker	-	-	-	11	11
Whānau Ora Practitioner	-	-	-	2	2
Other Non-Clinical[2]	-	-	-	1	1
Non-Clinical Sub-Total	4	9	13	29	42
Administration	-	2	2	1	3
Management	-	3	3	2	5
Total	9	51	60	58	118

1. Other Clinical = Counsellor
2. Other Non-Clinical = Educator.

NORTHERN REGION MĀORI POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

- Māori tamariki and rangatahi are accessing services more than any other ethnic group in the region, making up a one-third of all service users. The Māori workforce (18% of the total workforce) and Māori service user comparison continues to highlight significant disparities across the region, especially in Waitemata and Auckland DHB areas (Figure 20). Therefore, the need to increase the Māori workforce across all occupational groups, to cater for the growing needs of the Māori infant, child and adolescent service users remains pertinent.
- While there has been an increase in Māori service users accessing non-DHB services, the majority (59%) continue to access DHB mainstream services and are seen by the non-Māori workforce; therefore, enhancing the cultural competency of the workforce to work effectively with Māori tamariki and rangatahi service users and their whānau also remains a key area of development.

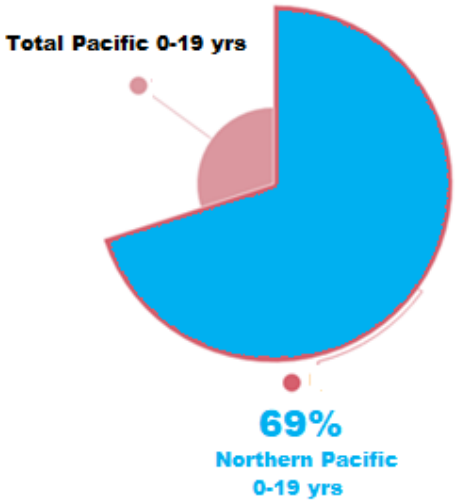
Figure 20. Northern Region Māori 0-19 yrs Population, Service User & Workforce Comparisons

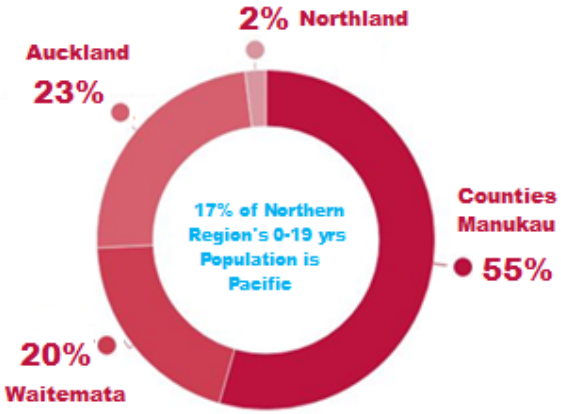


NORTHERN REGION PACIFIC OVERVIEW

NORTHERN REGION PACIFIC INFANT, CHILD AND ADOLESCENT POPULATION

- Very little change projected in the regional Pacific 0-19 year population from 2016 to 2018 (<0.1%) (Appendix A, Table 1).
- Projected growth indicated for three out of the four DHB areas, with the largest growth projected for Northland 9%, followed by Waitemata (2%). Very little change projected for Counties Manukau and a 2% decline for Auckland.
- Northern region continued to have the largest Pacific infant, child and adolescent population (69%).
- Pacific 0-19 year olds made up 17% of the region's 0-19 year population.
- Over half reside in the Counties Manukau DHB area (55%).
- 10-year projections (2018-2028) indicate a 4% regional growth in the Pacific population (Appendix A, Table 2) with the largest projected growth for Northland (by 30%), Waitemata (by 11%) and Counties Manukau (by 4%). A 5% decline is projected for Auckland.





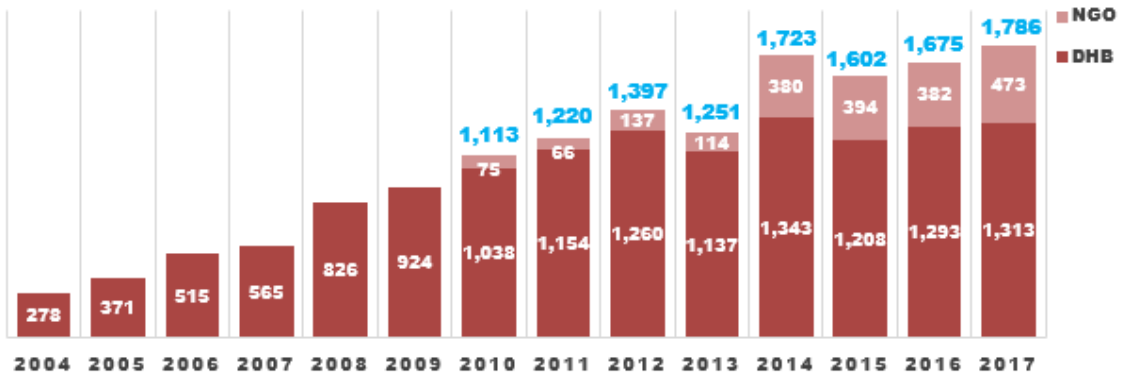
NORTHERN REGION PACIFIC SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December). PHO service user data is not captured in PRIMHD; therefore, all service user data pertains to DHB and NGO services only.

From 2015 to 2017:

- Increase in the number of Pacific service users accessing services by 11% (Figure 21), largely seen in Pacific females by 19%.
- There was an increase in service users accessing NGOs by 20%.

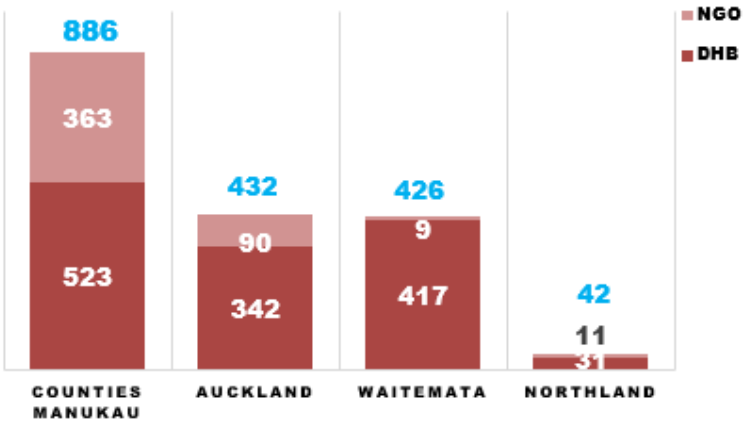
Figure 21. Northern Region Pacific 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Pacific service users made up 13% of all service users accessing services in the region. 55% were Pacific males.
- 74% accessed DHB services.
- 26% accessed NGOs.
- 98% of Pacific service users in the region were seen by services in the greater Auckland area, largely in Counties Manukau (51%), followed by Auckland (25%) and Waitemata (24%) DHB areas (Figure 22).

Figure 22. Northern Region Pacific 0-19 yrs Service User by DHB Area (2017)

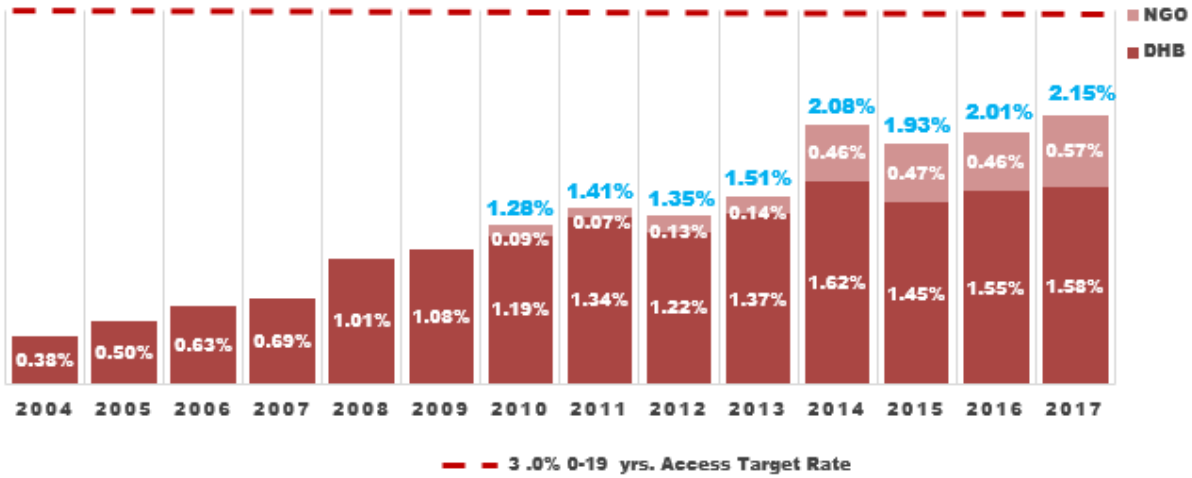


PACIFIC SERVICE USER ACCESS RATES

From 2015 to 2017:

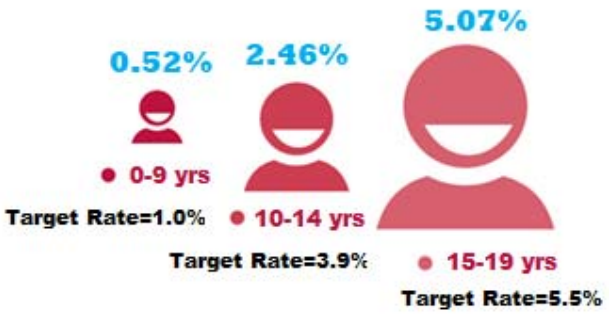
- Pacific 0-19 year access rate increased from 1.93% to 2.15% (Figure 23). Increase seen in all three age groups, especially in the 10-14 year age group.
- Increase in three of the four DHB areas (Northland, Auckland and Counties Manukau DHB areas).

Figure 23. Northern Region Pacific 0-19 yrs Service User Access Rates (2004-2017)



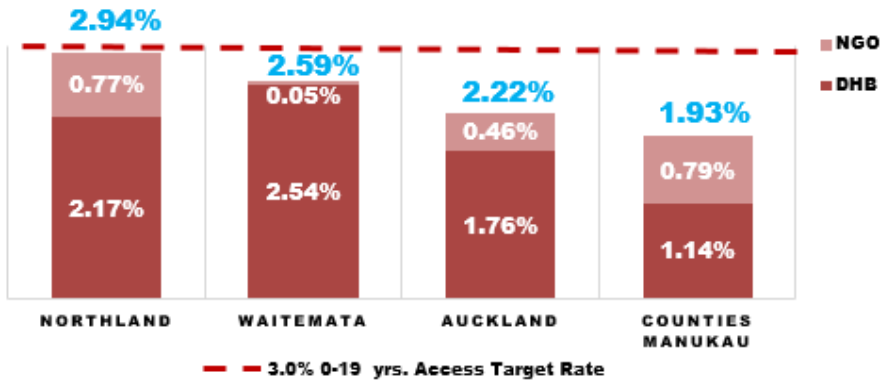
In the second half of 2017:

- Regional Pacific 0-19 year access rate of 2.15% was higher than the national Pacific access rate of 2.08%.
- By age, access rates for all three age groups remained below the recommended rates, especially for the 10-14 year age group
- By DHB area, Northland DHB area had the highest Pacific access rate (2.94%), followed by Waitemata (2.59%). Rates continued to be low Auckland (2.22%) and lowest in Counties Manukau (1.93%) DHB areas (Figure 24).



- Despite improvements in the regional Pacific service user access rates, Pacific access rates for the region continued to remain below target rates for all three age groups and four DHB areas, especially in Counties Manukau where the largest Pacific population in the region resides and the area with the greatest need for services for the Pacific population (Figure 24).

Figure 24. Northern Region Pacific 0-19 yrs Service User Access Rates by DHB Area (2017)



NORTHERN REGION PACIFIC ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity and Occupation submitted by all four DHB (Inpatient & Community) ICAMH/AOD services and all 21 contracted non-DHB services (19 NGOs & 2 PHOs) as at 30 June 2018.

From 2016 to 2018:

- A slight decrease in the regional Pacific workforce (headcount), from 72 to 71 (Table 14).

Table 14. Northern Region Pacific ICAMH/AOD Workforce by DHB Area (2008-2018)

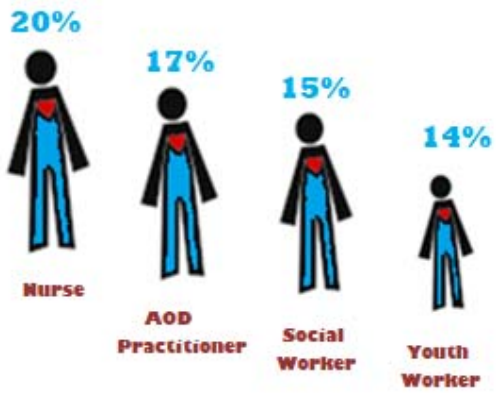
DHB AREA	NORTHERN REGION PACIFIC WORKFORCE (HEADCOUNT, 2008-2018)																	
	DHB						NON-DHB						TOTAL					
	2008	2012	2014	2014	2016	2018	2008	2012	2014	2014	2016	2018	2008	2012	2014	2014	2016	2018
NORTHLAND	-	6	1	1	-	3	2	1	1	1	2	-	2	7	2	2	2	3
WAITEMATA*	7	11	13	6	7	8	-	-	1	2	2	3	7	11	14	8	9	11
AUCKLAND[1]	12	6	11	7	13	12	4	3	9	10	4	8	16	9	20	17	17	20
COUNTIES MANUKAU	10	12	14	21	20	15	3	13	16	23	24	22	13	25	30	44	44	37
TOTAL	29	35	39	35	40	38	9	17	27	36	32	33	38	52	66	71	72	71

1. Includes Inpatient workforce. *Waitemata DHB services includes Altered High Youth AOD Regional Services

As at 30 June 2018:

- 96% of the region's Pacific workforce was in the greater Auckland area: 54% in Counties Manukau and 29% in Auckland DHB areas.
- 54% of the Pacific workforce was in DHB services (Table 15).
- 65% in clinical roles largely as Nurses (20%), Alcohol and Drug Practitioners (17%), and Social Workers (15%) (Table 15 & Figure 23).
- 34% in the non-clinical workforce largely as Youth Workers (14%) and Mental Health Support Workers (10%).

Figure 25.Top 4 Northern Region Pacific ICAMH/AOD Workforce (2018)



DHB PACIFIC ICAMH WORKFORCE

- The Pacific inpatient workforce was all Mental Health Support Workers (4) and Nurses (3) (Table 15)
- 87% of the Pacific DHB community workforce was in clinical roles largely as Mental Health Nurses (29%), Social Workers (29%) and Child and Adolescent Psychiatrists (10%) (Table 15).
- All of the Pacific non-clinical staff were in Cultural roles (10%).

NON-DHB PACIFIC ICAMH/AOD WORKFORCE

- Almost all (91%) of the regional Pacific non-DB workforce was in the Counties Manukau (73%) and Auckland (27%) DHB areas (Table 15).
- The Pacific non-DHB workforce was more equally split between clinical and non-clinical roles as Alcohol and Drug Practitioners (30%) and Youth Workers (30%) (Table 15).

Table 15. Northern Region Pacific ICAMH/AOD Workforce by Occupation (2018)

Northern Region Pacific ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	2	2	10	12
Child & Adolescent Psychiatrist	-	3	3	-	3
Nurse	3	9	12	2	14
Occupational Therapist	-	1	1	-	1
Psychologist	-	2	2	-	2
Social Worker	-	9	9	2	11
Therapist	-	-	-	2	2
Other Clinical[1]	-	1	1	-	1
Clinical Sub-Total	3	27	30	16	46
Caregivers	-	-	-	2	2
Cultural	-	3	3	-	3
Mental Health Consumer	-	-	-	1	1
Mental Health Support Worker	4	-	4	3	7
Youth Worker	-	-	-	10	10
Other Non-Clinical[2]	-	-	-	1	1
Non-Clinical Sub-Total	4	3	7	17	24
Management	-	1	1	-	1
Regional Total	7	31	38	33	71

1. Other Clinical = Other SMO
2. Other Non-Clinical = Whānau Ora Practitioner

NORTHERN REGION PACIFIC POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

- Due to low numbers of Pacific service users accessing services, the total regional Pacific workforce appears to be proportional to Pacific service user numbers (Figure 26). However, the lack of a Pacific workforce to meet the needs of the Pacific service users becomes evident when the Pacific *clinical* workforce is compared with service user numbers (Figure 27).
- Given the growth trend in the Pacific 0-19 year population and the number of Pacific service users accessing services in the Northern region, there is a need to increase the Pacific workforce, especially in clinical roles, to adequately cater for the current and future needs of the region's Pacific infant, child and adolescent service users.
- Additionally, the majority of Pacific service users (74%) continue to access DHB mainstream services and are seen by the non-Pacific workforce; therefore, enhancing the cultural competency of the workforce to work effectively with Pacific service users and their families also remains a key area of development.

Figure 26. Northern Region Pacific 0-19 yrs Population, Service User & Workforce Comparisons

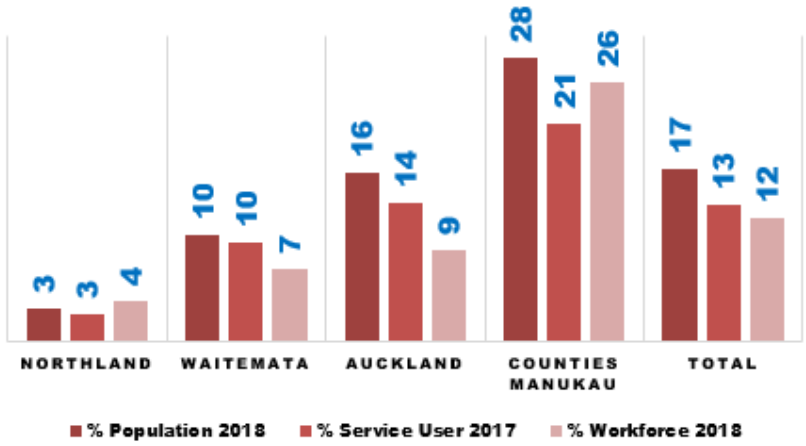
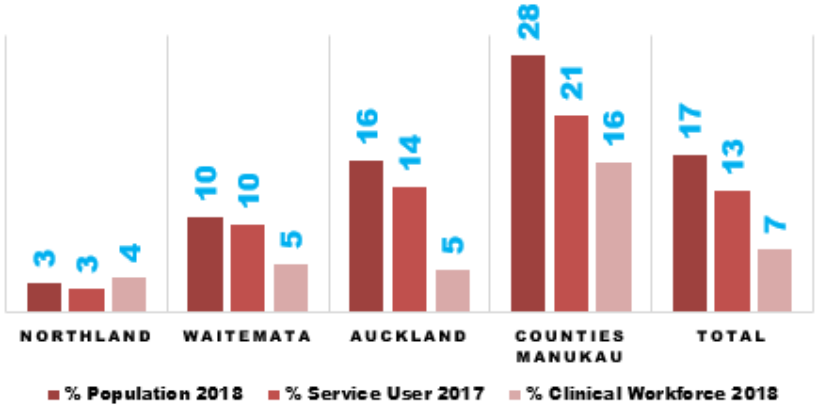


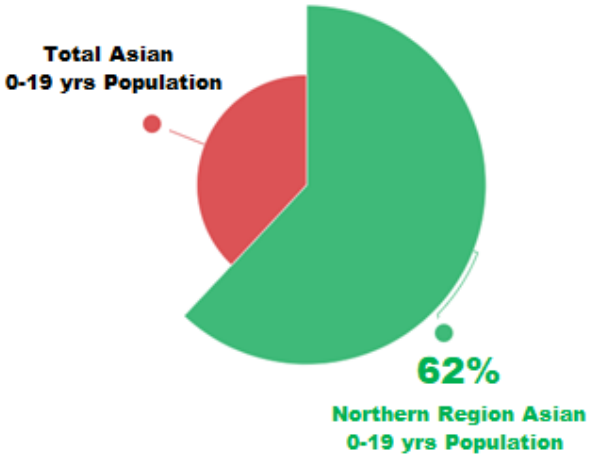
Figure 27. Northern Region Pacific 0-19 yrs Population, Service User & Clinical Workforce Comparisons



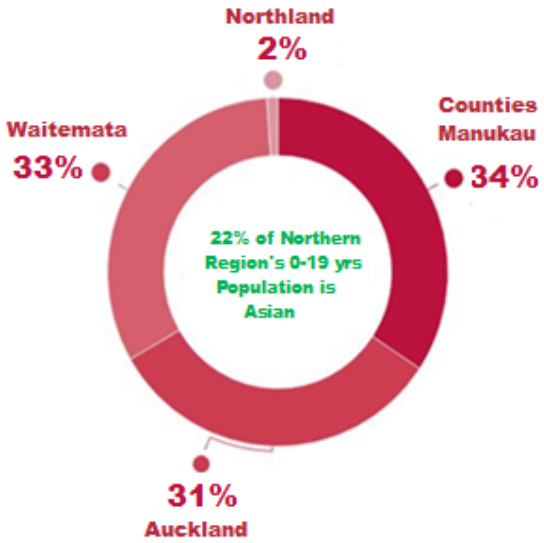
NORTHERN REGION ASIAN OVERVIEW

NORTHERN REGION ASIAN INFANT, CHILD AND ADOLESCENT POPULATION

- 2016 to 2018 population projections indicated a 6% growth in the regional Asian 0-19 year population, the largest increase out of the four main ethnic groups (Māori, Pacific, Asian and Other Ethnicity) (Appendix A, Table 1).
- This growth was seen in all four DHB areas: Northland (by 10%), Waitemata (by 9%), Counties Manukau (by 6%) and Auckland (by 3%).
- Northern region continued to have the country's largest Asian infant, child and adolescent population (62%) (Appendix A, Table 1).
- Asian infants, children and adolescents made up 22% of the region's total 0-19 year population and the majority (98%) of the region's Asian infant, child and adolescent population resided in the greater Auckland area.



- 10-year projections (2018 to 2028) indicated a 30% regional growth expected for Asian 0-19 year olds.
- Largest growth projected for Waitemata (by 43%), Northland (by 35%), Auckland (by 27%) and Counties Manukau (20%) (Appendix A, Table 2).



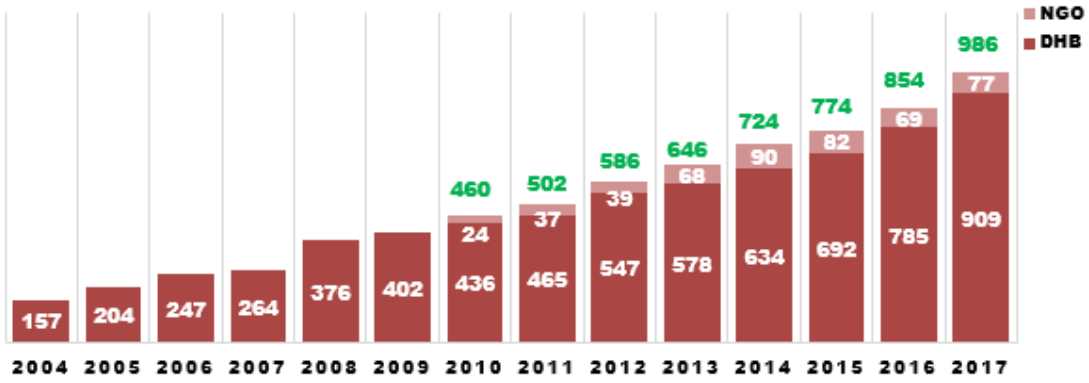
NORTHERN REGION ASIAN SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December). PHO service user data is not captured in PRIMHD; therefore, all service user data pertains to DHB and NGO services only.

From 2015 to 2017:

- 27% increase in overall numbers of Asian service users accessing services in the region (Figure 28).

Figure 28. Northern Region Asian 0-19 yrs Service User (2004-2017)

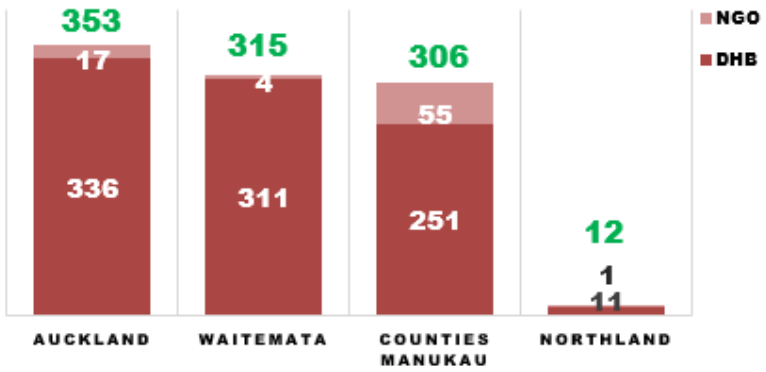


- Increase seen in both male and female service users, with the largest increase in females by 31%.
- Increases seen in two out of the three DHB areas in the greater Auckland region with no change for Counties Manukau. Asian service user numbers remained relatively low in Northland DHB due to a smaller Asian population (Appendix B, Table 5).

In the second half of 2017:

- 7% of all service users accessing services were Asian. 51% were Asian females (Appendix B, Table 5).
- 92% accessed DHB services and 8% accessed NGOs (Figure 28).
- 99% of Asian service users in the region were seen by services in the greater Auckland area: Auckland (36%), Waitemata (32%) and Counties Manukau (31%) DHB areas (Figure 29).
- Despite an overall increase, the number of Asian service users (986) has remained relatively low, compared to Māori (4,366) and Pacific (1,786) service users.

Figure 29. Northern Region Asian 0-19 yrs Service User by DHB Area (2017)

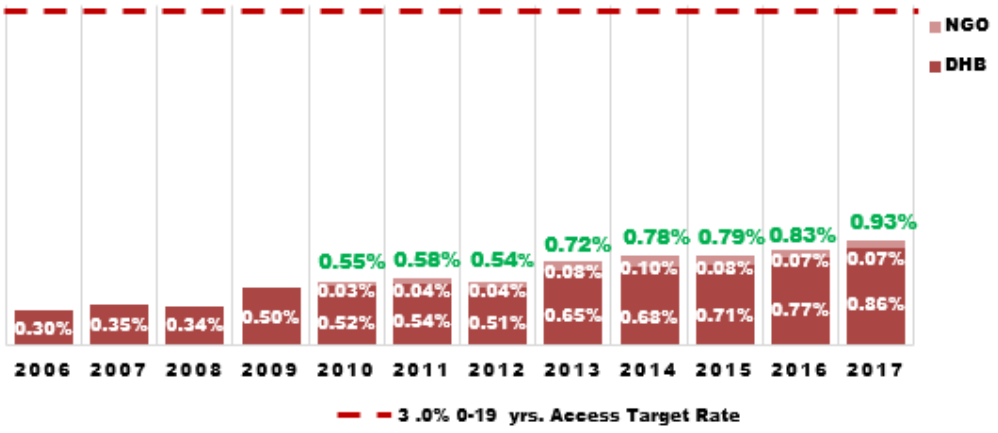


ASIAN SERVICE USER ACCESS RATES

From 2015 to 2017:

- An increase of Asian service user access rate from 0.79% to 0.93% (Figure 30), was the highest Access rate nationally (national rate = 0.86%). Increases in all three age groups, especially in the 0-9 year age group.
- Increase in access rates were in Northland, Auckland and Waitemata DHB areas, with a slight decrease in the Counties Manukau DHB area (Appendix B, Table 14).

Figure 30. Northern Region Asian 0-19 yrs Service User Access Rates (2006-2017)



In the second half of 2017:

- Despite regional improvements, Asian access rates remained the lowest of the four ethnic groups in the region (Māori 4.21%, Other Ethnicity 3.23%, Pacific 2.15%).
- Access rates remained consistently below target rates across all four DHB areas and for all three age groups, especially for 15-19 year olds (Figure 31).

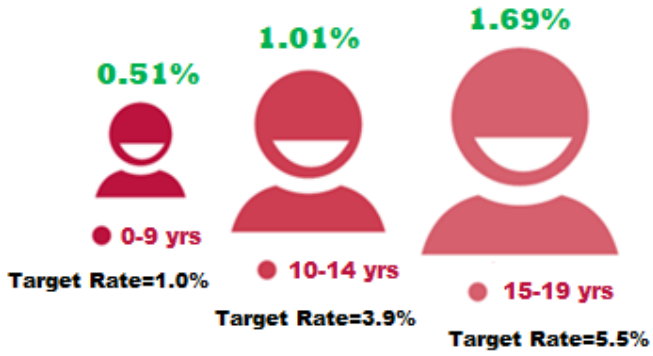
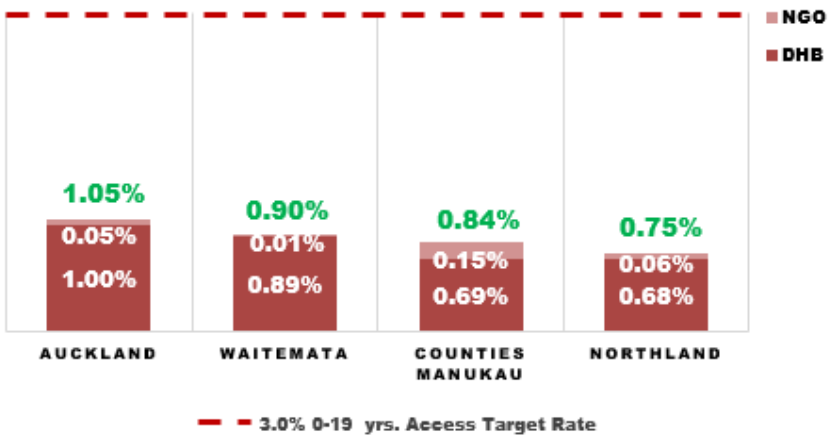


Figure 31. Northern Region Asian 0-19 yrs Service User Acces Rates by DHB Area (2017)



NORTHERN REGION ASIAN ICAMH/AOD WORKFORCE

The following information is derived from workforce data and includes Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity by Occupation submitted by all four DHB (Inpatient & Community) ICAMH/AOD services and all 21 contracted non-DHB services (19 NGOs & 2 PHOs) as at 30 June 2018.

From 2016 to 2018:

- 13% increase in the regional Asian workforce, from 62 to 70 (Table 16).
- Increase mainly seen in DHB provider services, from 44 to 53.

Table 16. Northern Region Asian ICAMH/AOD Workforce by DHB Area (2008-2018)

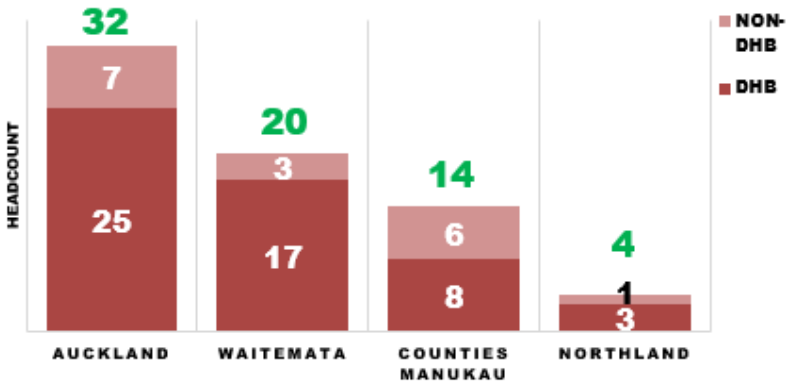
DHB AREA	NORTHERN REGION ASIAN WORKFORCE BY SERVICE PROVIDER (HEADCOUNT, 2008-2018)																	
	DHB						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NORTHLAND	-	-	-	2	1	3	-	-	-	-	-	1	-	-	-	2	1	4
WAITEMATA	7	7	5	6	14	17	3	-	-	-	1	3	10	7	5	6	15	20
AUCKLAND[1]	8	14	10	12	16	25	-	1	4	4	12	7	8	15	14	16	28	32
COUNTIES MANUKAU	3	12	3	12	13	8	-	2	3	8	5	6	3	14	6	20	18	14
TOTAL	18	33	18	32	44	53	3	3	7	12	18	17	21	36	25	44	62	70

1. Includes Inpatient workforce data

As at 30 June 2018:

- 60% of total Asian workforce in the country was in the Northern region, almost all (94%) in the greater Auckland region: 48% in Auckland and 30% in Waitemata DHB areas (Figure 32).
- 76% employed in DHB services, 24% in non-DHB services (Table 16).

Figure 32. Northern Region Asian ICAMH/AOD Workforce by DHB Area (2018)



- 81% in clinical roles as Nurses (17%), Occupational Therapists (14%), Social Workers (14%), Psychologists (11%) and AOD Practitioners (10%) (Table 17 & Figure 33).
- 13% in the non-clinical workforce as Mental Health Support Workers (7%) and Youth Workers (4%) (Table 17).
- The largest Asian sub-ethnicity groups were Indian (55%) and Chinese (27%).

Figure 33. Top 4 Northern Region Asian ICAMH/AOD Workforce (2018)

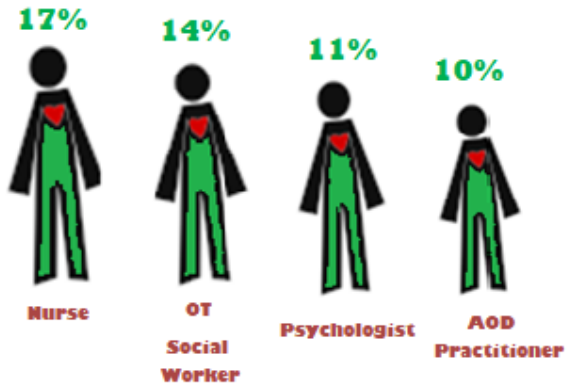


Table 17. Northern Region Asian ICAMH/AOD Workforce by Occupation (2018)

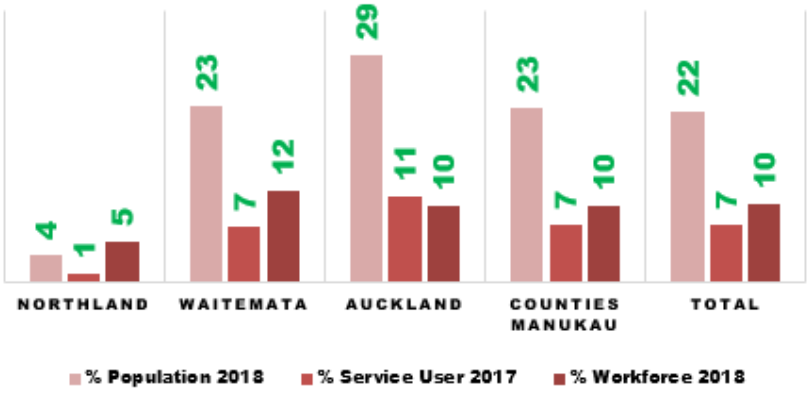
Northern Region Asian ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	2	2	5	7
Child & Adolescent Psychiatrist	1	5	6	-	6
Nurse	5	7	12	-	12
Occupational Therapist	-	10	10	-	10
Psychotherapist	-	1	1	-	1
Psychologist	-	8	8	-	8
Social Worker	2	5	7	3	10
Other Clinical[1]	1	2	3	-	3
Clinical Sub-Total	9	40	49	8	57
Mental Health Support	-	-	-	5	5
Youth Worker	-	-	-	3	3
Other Non-Clinical	-	-	-	1	1
Non-Clinical Sub-Total	-	-	-	9	9
Administration	1	3	4	-	4
Regional Total	10	43	53	17	70

1 = House Officer; Intern Psychologist; Other SMO.

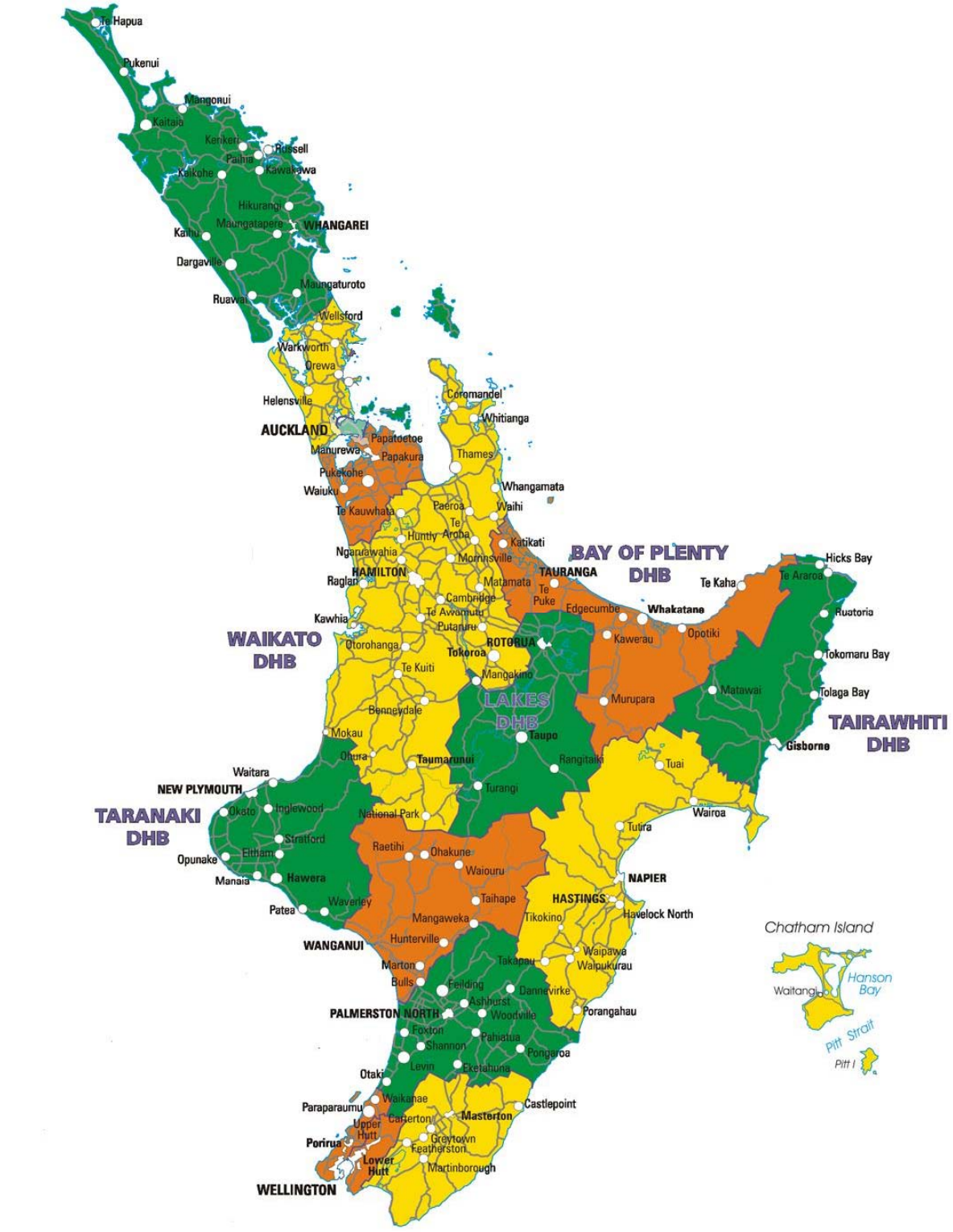
NORTHERN REGION ASIAN POPULATION, SERVICE USERS AND WORKFORCE COMPARISONS

- With such low numbers of Asian service users accessing services in the region (7%, lowest out of all ethnicities), it appears that the Asian workforce is in proportion to current service demand (Figure 34). However, such low access rates for Asian service users may indicate unmet need for services. Therefore, a focus on improving access to services for the Asian population is essential.
- A growth trend in the Asian population also indicates potential future demand for services which will need to be met by a representative workforce. Therefore, there needs to be a focus on increasing the Asian workforce, across all occupational groups, to adequately cater for the future needs of the region's growing Asian infant, child and adolescent population.
- Additionally, the majority of Asian service users (92%) continue to access DHB mainstream services and are seen by the non-Asian workforce; therefore, enhancing the cultural competency of the workforce to work effectively with Asian service users and their families also remains a key area of development.

Figure 34. Asian 0-19 yrs Population, Service User & Workforce Comparisons

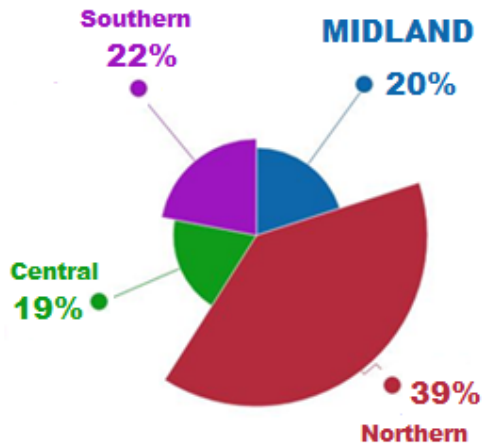


MIDLAND REGION INFANT, CHILD AND ADOLESCENT MENTAL HEALTH & AOD OVERVIEW

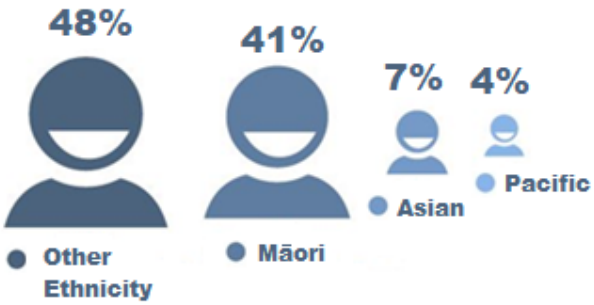


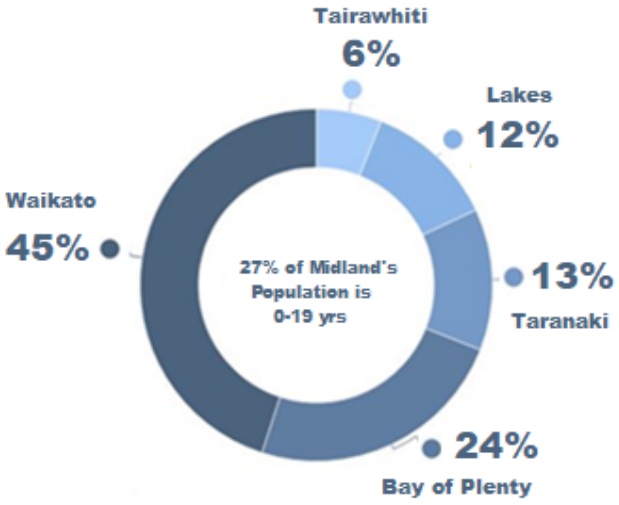
MIDLAND REGION INFANT, CHILD AND ADOLESCENT POPULATION PROFILE

- -0.1% projected decline in the overall 0-19 year population in the Midland region since 2016 (Appendix A, Table 1).
- Remains New Zealand's third largest (20%) infant, child and adolescent (0-19 years) population.
- Other Ethnicity (48%) make up the majority of the 0-19 year population, followed closely by Māori (41%), Asian (7%) and Pacific (4%).
- Majority of the population resided in Waikato (45%) and Bay of Plenty (24%) DHB areas.
- 10-year population projections indicated a declining 0-19 year population (-0.3%) by 2028.



- However, projections by ethnicity showed projected growth for Māori (by 9%), Pacific (by 28%) and the largest growth for the Asian (by 56%) (Appendix A, Table 2).





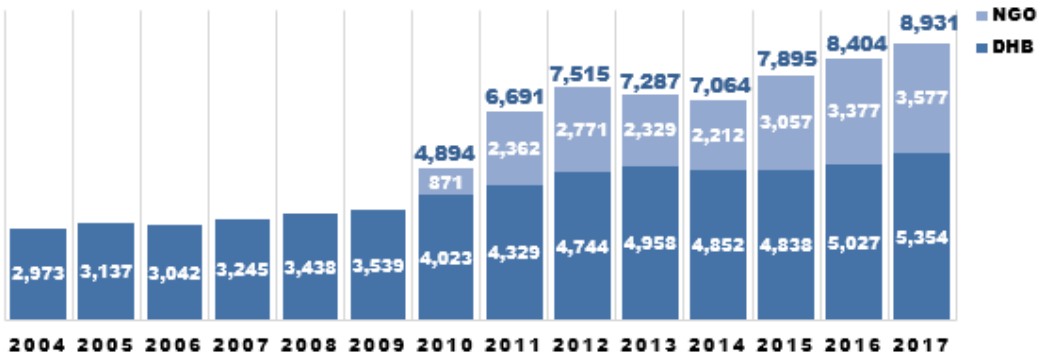
MIDLAND REGION SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December).

From 2015 to 2017:

- Increase in service users by 13% (Figure 1). Greater increase in both males (by 15%) and females (by11%).

Figure 1. Midland Region 0-19 yrs Service User (2004-2017)

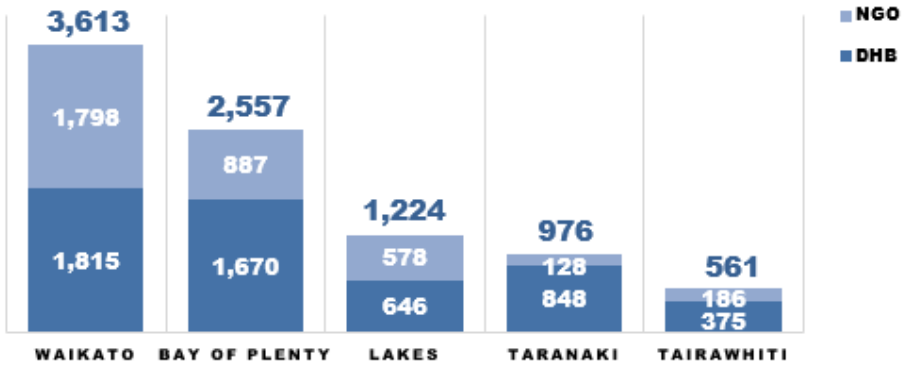


- Increases seen in all three age groups, especially younger service user: 0-9 year age group by 21% and 10-14 year age group by 26%.
- Four out of the five DHB areas showed increases in the number of service users with the largest increases seen in Lakes by 35% and Taranaki by 23%.

  In the second six months of 2017:

  - 54% of service users were males.
  - 60% of all service users accessed DHB services.
  - NGOs in Midland region proportionally saw more service users (40%) than do the NGOs in the other three regions in the country.
  - 83% of all service users in the region are seen by services in the Waikato (40%), Bay of Plenty (29%) and Lakes (14%) DHB areas (Figure 2).

Figure 2. Midland Region 0-19 yrs Service User by DHB Area (2017)



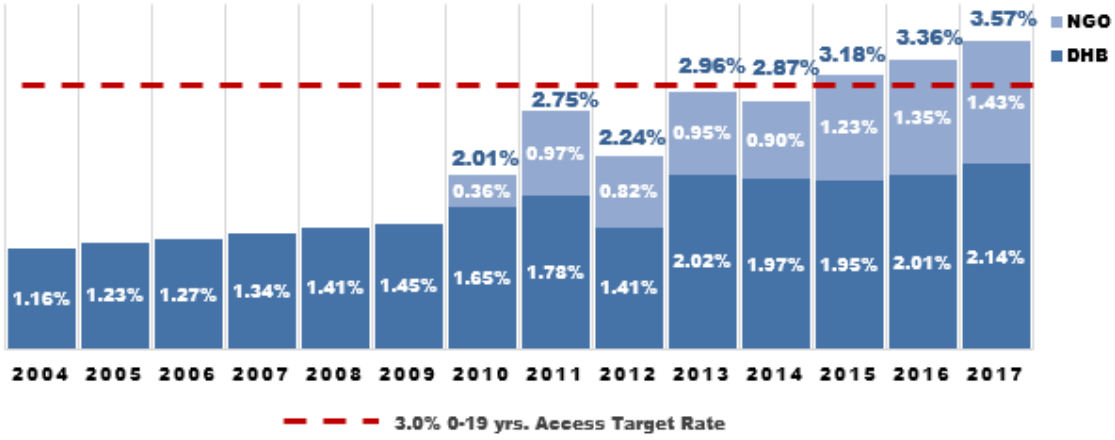
MIDLAND REGION SERVICE USER ACCESS RATES

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. Access rates are calculated by dividing the number of service users 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 service user lives (DHB of domicile). However, access rates are affected by the population data used.

From 2015 to 2017:

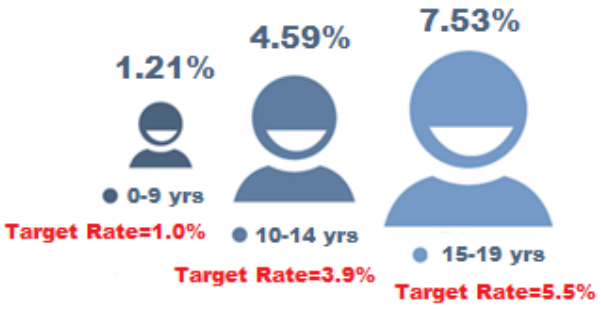
- Increase in the regional access rate from 3.18% to 3.57% (Figure 3). Increase in access rates seen in all three age groups, especially in the 10-14 year age group.
- While Lakes, Bay of Plenty, Waikato and Taranaki all showed an increase in access rates, Tairawhiti showed a decrease. This decrease was seen only in the DHB service.

Figure 3. Midland Region 0-19 yrs Service User Access Rates (2004-2017)

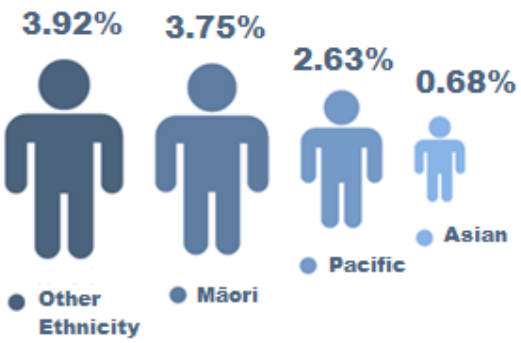


In the second half of 2017:

- Midland region had the highest service user access rate in the country at 3.57% (National rate= 3.03%).
- By age, access rates in all three age groups have exceeded the MHC's recommended rates.

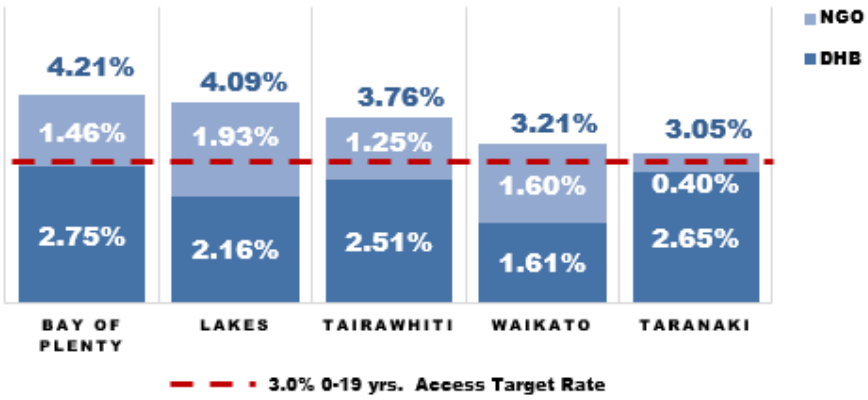


- By ethnicity, the Other Ethnicity group had the highest access rate of 3.92%, followed by Māori (3.75%). However, while the Māori rate exceeded the 3% overall rate, the recommended rate for Māori is double that of the overall rate; therefore, the Māori access rate remained significantly below the recommended rate of 6%.



- By DHB area, all five DHB areas exceeded the 3% target rate, with Bay of Plenty DHB area at the highest rate of 4.21% (Figure 4).
- However, access rates need to improve for Māori, Pacific and Asian service users across the region.

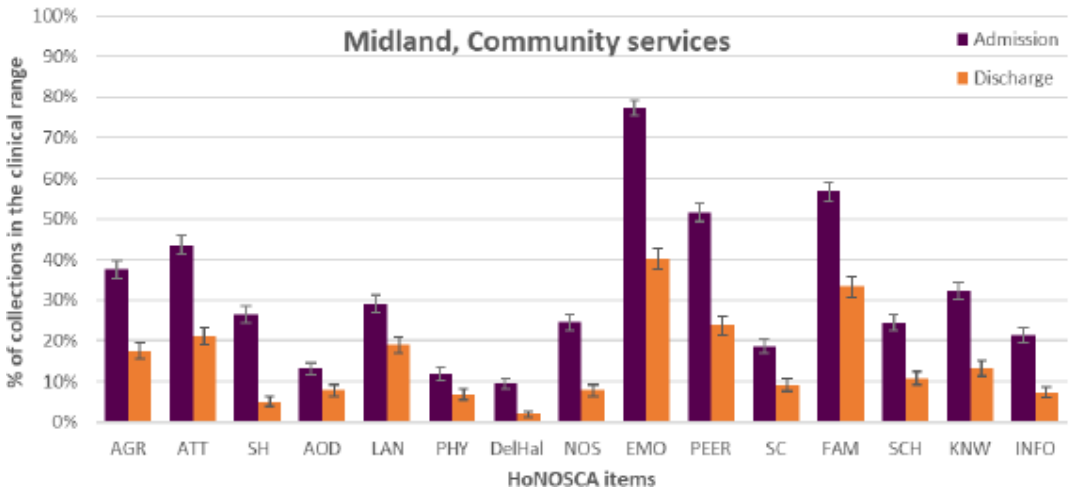
Figure 4. Midland Region 0-19 yrs Service User Access Rates by DHB Area (2017)



SERVICE USER OUTCOMES

To assess whether service users 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 aged 4-17 years at. Service user outcomes data for the 2018 period showed significant improvements across all items, especially for emotional related symptoms (EMO in Figure 5), by time of discharge from community mental health services for service users.

Figure 5. Midland Region Service User HoNOSCA Results (2018)



MIDLAND REGION FUNDING OF ICAMH/AOD SERVICES

From 2015/2016 to 2017/2018 financial year:

- 8% overall increase in regional funding for infant, child and adolescent mental health/AOD services.
- By provider, a 19% increase in non-DHB providers and 3% decrease in DHBs (Figure 6).
- By services, 10% increase in Child and Youth Mental Health Services, followed by a 9% increase for Youth Forensics and 8% for AOD services (Table 1).
- Increases in all five DHB areas, with the largest increase in Lakes non-DHB services by 89%.

Figure 6. Midland Region ICAMH/AOD Funding by Service Provider (2004-2018)

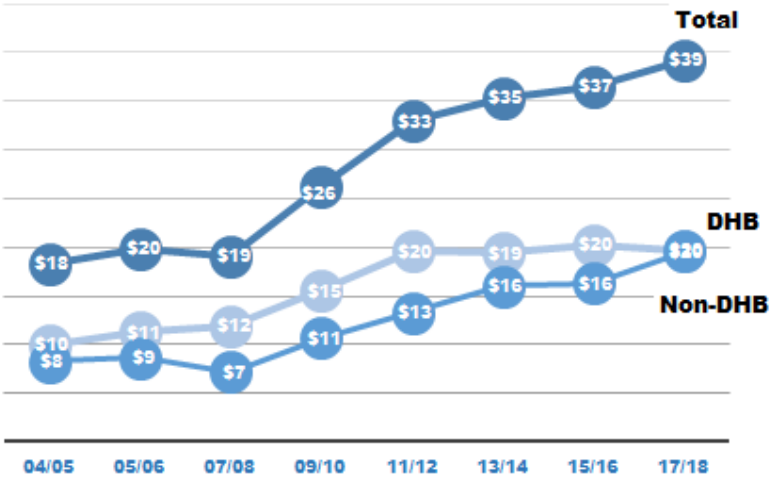


Table 1. Midland Region ICAMH/AOD Funding by Service (2008-2018)

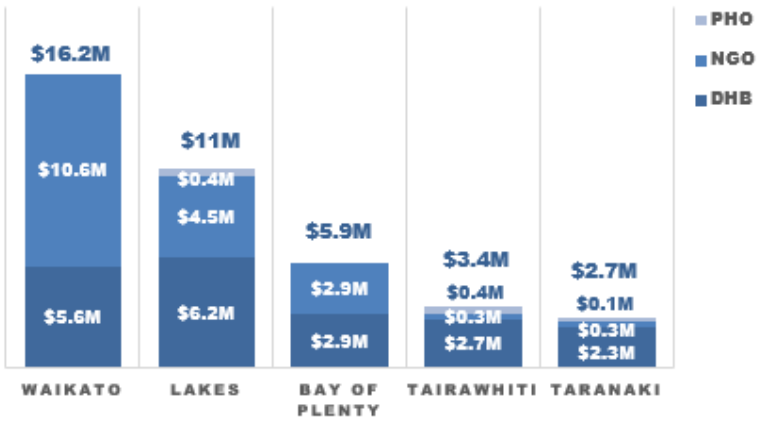
SERVICES	MIDLAND REGION FUNDING BY SERVICE (2008-2018)						
	07/08	09/10	11/12	13/14	15/16	17/18	% Chang6 (2018-2016)
Inpatient	$138,679	$164,429	$15,501	$15,872	$154,585	$163,992	6
Alcohol & Other Drugs	$1,412,810	$3,128,843	$5,988,959	$6,185,648	$7,070,687	$6,514,903	-8
Child & Youth Mental Health	$17,558,156	$19,399,770	$25,550,552	$27,232,215	$26,909,115	$29,539,683	10
Youth Forensic	-	-	$769,191	$1,966,644	$1,990,727	$2,177,556	9
Kaupapa Māori	-	$3,469,541	$649,284	-	-	-	-
Youth Primary Mental Health	-	-	-	-	$398,725	$916,464	*
TOTAL	$19,109,645	$26,162,583	$32,973,487	$35,400,380	$36,523,840	$39,312,598	8

Source: Ministry of Health Price Volume Schedule 2007-2016. *Now coded under General Mental Health. Updated July 2017. Not calculated

For the June 2017 to July 2018 financial year:

- Midland region provider services received 21% ($39.3M) of the total national funding ($183.3M) for ICAMH/AOD (Appendix C, Table 1).
- 75% of the funding was allocated to Child and Youth Mental Health Services, followed by AOD (17%) and Youth Forensics (6%).
- 2% was allocated to Youth Primary Mental Health Services.
- Midland was the only region where DHB and non-DHB provider services had almost equal proportions of the ICAMH/AOD funding. And in the Waikato DHB area, the non-DHB provider funding exceeded DHB

Figure 7. Midland Region ICAMH/AOD Funding by DHB Area (2018)



funding. Waikato non-DHB provider services had the largest proportion of the total regional funding (27%) (Figure 7).

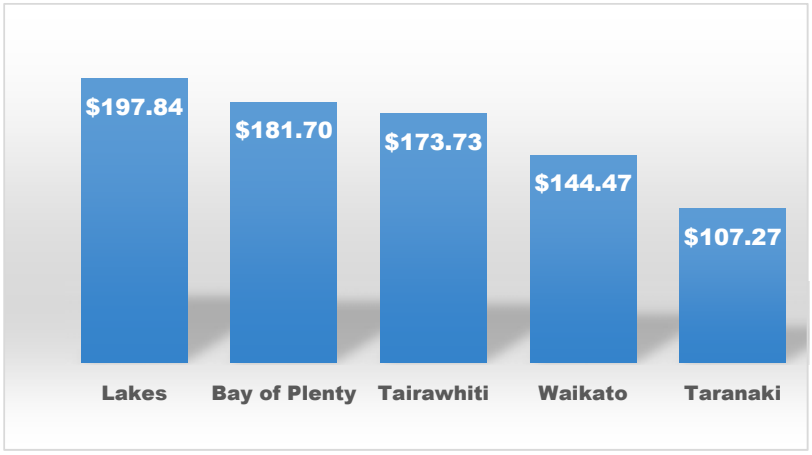
FUNDING PER HEAD OF INFANT, CHILD AND ADOLESCENT POPULATION

Funding per head of population is a method by which we can look at the equity of funding across the regions and DHBs. Clearly this is not the actual amount spent per head of population aged 0-19 years, as only a small proportion access services. The effect of inter-DHB referrals is negligible for the Midland region (see Appendix B, Table 7).

From 2016-2018:

- 8% increase in the regional spend per head of the 0-19 years population, from $145.61 to $156.83 inpatient costs excluded) (Appendix C, Table 2 & Figure 8). Increase seen in all five DHB areas.
- Lakes DHB area had the highest spend per 0-19 years population of $197.84, while the Taranaki DHB area had the lowest spend at $107.27 (Appendix C, T able 2).

Figure 8. Midland Region spend per 0-19 yrs Population (2018)



MIDLAND REGION PROVISION OF ICAMH/AOD SERVICES

Five DHBs provide a range of specialist community-based infant, child and adolescent mental health and AOD services in the Midland region: Waikato, Bay of Plenty, Lakes, Tairawhiti and Taranaki DHBs.

Regional inpatient mental health services are provided by Auckland DHB (Starship Child and Family Inpatient Service).

Infant, child and adolescent mental health/AOD (ICAMH/AOD) services are also provided by DHB-funded non-DHB services and primary health organisations (PHOs). For the June 2017 to July 2018 period, 41 non-DHB services (including 2 PHOs) were identified as providing DHB-funded infant, child and adolescent mental health/AOD and youth primary mental health services in the Midland region.

Services in each Midland region DHB area are listed in the following tables.

Table 2. Waikato ICAMH/AOD Services (2017/2018)

WAIKATO DHB
Child & Adolescent Mental Health/AOD Services (Hamilton, Hauraki & Southern Cluster)
Also provides services for: Eating Disorders, Infant Mental Health, Peer Support/Advocacy, Co-Existing Problems (CEP), COPMIA, Parenting Programmes: Parent Child Interaction Therapy (PCIT), Circle of Security

WAIKATO DHB-FUNDED NON-DHB SERVICES
CARENZ LTD
Children & Youth Alcohol & Drug Community Services
EMERGE AOTEAROA
Child, Adolescent & Youth Mental Health Community Care with Accommodation
HAUORA WAIKATO MĀORI MENTAL HEALTH SERVICES
Child, Adolescent & Youth Alcohol & Drug Community Services
Infant, Child, Adolescent & Youth Acute Package of Care
Infant, Child, Adolescent & Youth Community Mental Health Services
Community Child, Adolescent & Youth Service for Co-existing Problems
K'AUTE PASIFIKA TRUST
Infant, Child, Adolescent & Youth Community Mental Health Services
NGA RINGA AWHINA O HAUORA TRUST
Infant, Child, Adolescent & Youth Community Mental Health Services
Child & Youth Intensive Clinical Support Service
Youth Forensic Specialist Community Service
ODYSSEY HOUSE TRUST
Child, Adolescent & Youth Alcohol & Drug Community Services
RAUKAWA CHARITABLE TRUST
Family Whānau Support Education, Information & Advocacy Service
Infant, Child, Adolescent & Youth Community Mental Health Services
Child, Adolescent & Youth Alcohol & Drug Community Services

WAIKATO DHB-FUNDED NON-DHB SERVICES CONTINUED
ROSTREVOR HOUSE
Infant, Child, Adolescent & Youth Community Mental Health Services
Family Whānau Support Education, Information & Advocacy Service
TAUMARUNUI COMMUNITY KOKIRI TRUST
Family Whānau Support Education, Information & Advocacy Service
Child, Adolescent & Youth Alcohol & Drug Community Services
Infant, Child, Adolescent & Youth Community Mental Health Services
TE KOROWAI HAUORA O HAURAKI INC.
Infant, Child, Adolescent & Youth Community Mental Health Services
Family Whānau Support Education, Information & Advocacy Service
Child, Adolescent & Youth Alcohol & Drug Community Services
TE RUNANGA O KIRIKIRIROA
Child, Adolescent & Youth Community Alcohol & Drug Services with Accommodation: Rongo Atea
YOUTH HORIZONS TRUST
Child & Youth Intensive Clinical Support Service
Infant, Child & Youth Planned Respite

Note: Italicised services are Kaupapa Māori services

Table 3. Lakes ICAMH/AOD Services (2017/2018)

LAKES DHB
Child & Adolescent Mental Health Services (Taupo/Turangi)
Infant, Child & Adolescent Mental Health Services (Rotorua)
**Also receives funding/provides services for Eating Disorders & Co-Existing Problems (CEP)*

LAKES DHB-FUNDED NON-DHB SERVICES
EMERGE AOTEAROA
Child, Adolescent & Youth Mental Health Community Care with Accommodation
KPA PSYCHOLOGY
Transgender Youth - First Psychological Assessment
MANAAKI ORA TRUST: TE UTUHINA MANAAKITANGA TRUST
Children & Youth Alcohol & Drug Community Services
MENTAL HEALTH SOLUTIONS: PATHWAYS
Child, Adolescent & Youth Alcohol & Drug Community Services
STAND CHILDREN'S SERVICES: TU MAIA WHĀNAU
Infant, Child, Adolescent & Youth Community Mental Health Services

Note: Italicised services are Kaupapa Māori services

Table 4. Bay of Plenty ICAMH/AOD Services (2017/2018)

BAY OF PLENTY DHB
Maternal Infant Child & Adolescent Mental Health Service (Tauranga)
Voyagers Maternal Infant Child & Adolescent Mental Health Service (Whakatane)
Alcohol & Other Drugs Service (Whakatane & Tauranga)
Consult Liaison Service (Whakatane)
Eating Disorders Service (Whakatane &Tauranga)

BAY OF PLENTY DHB-FUNDED NON-DHB SERVICES
POU WHAKAARO: EBAT CHARITABLE TRUST
Child, Adolescent & Youth & Families with a Mental Health Disorder
EASTERN BAY PRIMARY HEALTH ALLIANCE
Youth Primary Mental Health Service
FAMILY LINK: WESTERN BAY OF PLENTY PRIMARY HEALTH ORGANISATION
Youth Primary Mental Health Service
MAKETU HEALTH & SOCIAL SERVICES
Kaupapa Māori Early Intervention & Other Drug Service Child, Adolescent & Youth
NGA KAKANO FOUNDATION
Kaupapa Māori Child, Adolescent & Youth Alcohol & Drug Community Services
NGA MATAAPUNA HAUORA: PIRIRAKAU HAUORA
Kaupapa Māori Infant, Child, Adolescent Community Mental Health Services
NGA MATAAPUNA HAUORA: TE MANU TOROA TRUST
Kaupapa Māori Infant, Child, Adolescent Community Mental Health Services
Peer Support Service for Child & Youth
NGA MATAAPUNA HAUORA: TE PUNA HAUORA KI UTA KI TAI
Kaupapa Māori Infant, Child, Adolescent Community Mental Health Services
NGA MATAAPUNA HAUORA: TE RUNANGA NGAI TAMAWHARIUA INC
Kaupapa Māori Community Child, Adolescent & Youth Service for Co-existing Problems
PATHWAYS HEALTH
Infant, Child, Adolescent & Youth Crisis Respite Service
POUTIRI CHARITABLE TRUST: TE IKA WHENUA MURAPARA
Kaupapa Māori Infant, Child, Adolescent & Youth Community Mental Health Services
Child, Adolescent & Youth Alcohol & Drug Community Services
POUTIRI CHARITABLE TRUST: TE TOI HUAREWA
Kaupapa Māori Infant, Child, Adolescent & Youth Community Mental Health Services
Child, Adolescent & Youth Alcohol & Drug Community Services
RAKEIWHENUA TRUST: TUHOE HAUORA
Child, Adolescent & Youth Alcohol & Drug Community Services
Kaupapa Māori Infant, Child, Adolescent & Youth Community Mental Health Services
TE POU ORANGA O WHAKATOHEA
Kaupapa Māori Child, Adolescent & Youth Alcohol & Drug Community Services
Infant, Child, Adolescent & Youth Community Mental Health Services
Peer Support Service for Children & Youth

BAY OF PLENTY DHB-FUNDED NON-DHB SERVICES CONTINUED
TE RUNANGA O TE WHĀNAU CHARITABLE TRUST
Kaupapa Māori Child, Adolescent & Youth Alcohol & Drug Community Services
TE TOMIKA TRUST
Kaupapa Māori Infant, Child & Adolescent & Youth Community Mental Health Services
THE SALVATION ARMY NEW ZEALAND TRUST
Child, Adolescent & Youth Alcohol & Drug Community Services
TUWHARETOA KI KAWERAU HEALTH EDUCATION & SOCIAL SERVICES
Kaupapa Māori Infant, Child & Adolescent & Youth Community Mental Health Services
Early Intervention & Other Drug Service Child, Adolescent & Youth
YOUTH HORIZONS TRUST
Child, Adolescent & Youth Intensive Clinical Support

Table 5. Tairawhiti ICAMH/AOD Services (2017/2018)

TAIRAWHITI DHB
Child & Adolescent Mental Health/ AOD Services
Also provides services for Eating Disorders, Infant Mental Health, Co-Existing Problems, Parenting Programmes: Incredible Years

TAIRAWHITI DHB-FUNDED NON-DHB SERVICES
MIDLANDS REGIONAL HEALTH NETWORK CHARITABLE TRUST
Youth Primary Mental Health Service
NGATI POROU HAUORA INC
Infant, Child, Adolescent & Youth Community Mental Health Service
TE KUPENGA NET TRUST
Peer Support Service for Children & Youth

Note: Italicised services are Kaupapa Māori services

Table 6. Taranaki ICAMH/AOD Services (2017/2018)

TARANAKI DHB
Child & Adolescent Mental Health Services

TARANAKI DHB FUNDED NON-DHB SERVICES
MENTAL HEALTH SOLUTIONS: PATHWAYS HEALTH LTD
Infant, Child, Adolescent & Youth Crisis & Planned Respite
SUPPORTING FAMILILES IN MENTAL ILLNESS
Child, Adolescents & Youth & Families with a Mental Health Disorder-COPMIA Services
TUI ORA LTD: MAHIA MAI
Child, Adolescent & Youth Alcohol & Drug Community Services
Infant, Child, Adolescent & Youth Community Mental Health Services
Primary Mental Health Service

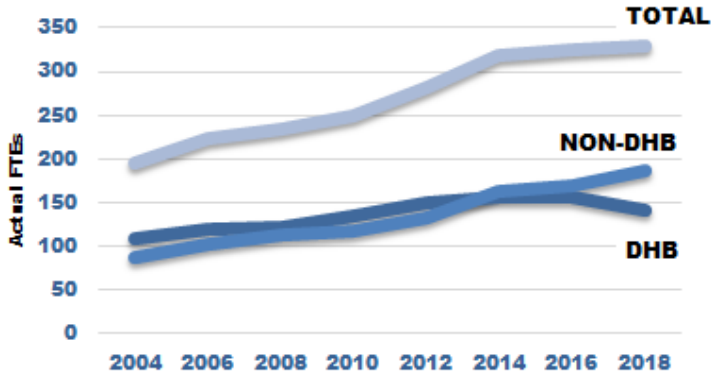
MIDLAND REGION ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by ethnicity by occupation submitted by all five DHB (Inpatient & Community) ICAMH/AOD services and all 41 contracted non-DHB services (including 2 PHOs) as at 30 June 2018.

From 2016 to 2018:

- 1% increase in the regional workforce, from 325.6 to 328.7 actual FTEs (Table 7 & Figure 9).
- 11% increase in the non-DHB workforce.
- 10% decrease in the DHB workforce.
- Increase in the non-clinical workforce by 15%.

Figure 9. Midland Region ICAMH/AOD Workforce (2004-2018)



- Regional vacancy rate increased from 5% to 8%. Vacancies largely in DHB services, with an increase in the DHB rate from 9% to 13%.

Table 7. Midland Region ICAMH/AOD Workforce (2004-2018)

YEAR	DHB			NON-DHB			TOTAL		
	ACTUAL FTES	VACANT FTES	% VACANCY	ACTUAL FTES	VACANT FTES	% VACANCY	ACTUAL FTES	VACANT FTES	% VACANCY
2004	108.3	18.9	15	86.8	5.3	6	195.1	24.2	11
2006	119.9	21.1	15	102.9	3.6	3	222.7	24.7	10
2008	120.5	21.1	15	112.9	6.9	6	233.4	27.9	11
2010	133.8	19.3	13	116.0	2.0	2	249.8	21.3	8
2012	149.4	14.5	9	132.3[1]	2.0	1	281.7	16.5	6
2014	155.2	8.8	5	163.2	3.0	2	318.4	11.8	4
2016	156.5	16.3	9	169.1	-	-	325.6	16.3	5
2018*	141.5	20.8	13	187.2*	6.6	3	328.7	27.4	8

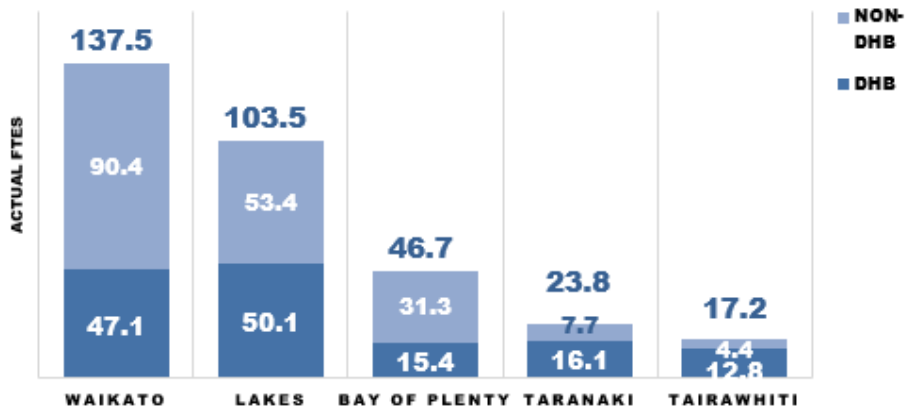
*Includes all contracted non-DHB services (100% response rate)

As at 30 June 2018:

- 57% of the region's workforce was in employed in non-DHB services. Midland region is the only region where the non-DHB workforce was larger than the DHB workforce, especially in the Waikato and Bay of Plenty DHB areas (Figure 10).
- 42% of the workforce was in services in the Waikato DHB area, 66% in non-DHB services and 34% in the DHB provider service.
- Midland workforce was made up of NZ Europeans (42%), Māori (39%), Other Ethnicity (12%), Asian (4%) and Pacific (3%).
- 74% of the workforce was in clinical roles as Social Workers and Nurses (both 19%); Psychologists (10%) and AOD Practitioners (8%) (Table 8 & Figure 11).
- 19% in the non-clinical workforce as Mental Health Support Workers (6%), Youth Workers (6%) and Peer Support Workers (3%).

- 7% in Administration (4%) and Management (3%) roles.

Figure 10. Midland Region ICAMH/AOD Wokforce by DHB Area (2018)



- 76% of vacancies were reported by DHB services.
- 86% of these vacancies were in clinical roles largely for Psychologists (27%) (Table 9).
- Regional annual staff turnover rate was 23% (DHB = 16% and non-DHB = 27%), mainly for Social Workers, Nurses, Youth Workers, Psychologists and AOD Practitioners. The main reason for leaving was for taking on external job opportunities.

Figure 11. Top 4 Midland Region Total ICAMH/AOD Workforce (2018)

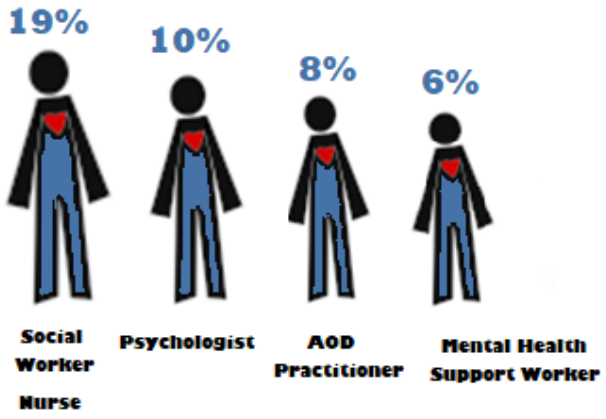


Table 8. Midland Region ICAMH/AOD Workforce by Occupation (2018)

Midland Region ICAMH/AOD Workforce by Occupation (Actual FTEs, 2018)	DHB Community	Non-DHB	Total
Alcohol & Drug Practitioner	4.00	22.80	26.80
Child & Adolescent Psychiatrist	9.60	4.60	14.20
Counsellor	-	11.50	11.50
Family Therapist	1.00	5.50	6.50
Nurse	33.20	28.80	62.00
Occupational Therapist	7.00	2.50	9.50
Psychologist	26.98	4.60	31.58
Social Worker	34.00	29.30	63.30
Other Clinical[1]	3.70	12.90	16.60
Clinical Sub-Total	119.48	122.50	241.98
Educator	-	2.00	2.00
Cultural	3.00	2.00	5.00
Mental Health Support Worker	1.00	19.50	20.50
Peer Support Worker	-	8.30	8.30
Whānau Ora Practitioner	-	5.00	5.00
Youth Worker	2.00	16.99	18.99
Other Non-Clinical[2]	-	2.60	2.60
Non-Clinical Sub-Total	6.00	56.39	62.39
Administration	13.00	1.53	14.53
Management	3.00	6.82	9.82
TOTAL	141.48	187.24	328.72

1. Other Clinical = Other SMO; Eating Disorder Liaison; Clinical Placement; Therapist; Medical Officer; Registered Health Professional; Field Workers; Brief Intervention Clinician; MH Clinician-Not Specified
2. Other Non-Clinical = Needs Assessors/Coordinators; Health & Wellbeing Programme Coordinator

Table 9. Midland Region ICAMH/AOD Workforce Vacancies by Occupation (2018)

Midland Region Vacancies by Occupation (Vacant FTEs, 2018)	DHB Community	Non-DHB	Total
Alcohol & Drug Practitioner	1.00	1.80	2.80
Child & Adolescent Psychiatrist	2.70	-	2.70
Nurse	2.00	-	2.00
Occupational Therapist	2.10	-	2.10
Psychologist	7.30	-	7.30
Social Worker	1.20	1.00	2.20
Other Clinical[1]	4.50	-	4.50
Clinical Sub-Total	20.80	2.80	23.60
Youth Worker	-	1.44	1.44
Peer Support Worker	-	2.00	2.00
Non-Clinical Sub-Total	-	3.44	3.44
Administration/Management	-	0.40	0.40
TOTAL	20.80	6.64	27.44

1. Other Clinical = Family Therapist; Mental Health Clinicians.

DHB COMMUNITY ICAMH/AOD WORKFORCE

As at 30 June 2018:

- Midland DHB community ICAMH/AOD services reported a total of 141.48 actual FTEs with 20.8 FTEs reported vacant (Table 10).
- 69% of the region's DHB community workforce was employed in Bay of Plenty (52%) and Waikato DHBs (48%).
- 84% in clinical roles largely as Social Workers (24%), Nurses (23%) and Psychologists (19%) (Table 8).
- 4% in non-clinical workforce largely in Cultural roles (2%) and Youth Workers (1%) (Table 8).
- All vacancies were in clinical roles largely for Psychologists (35%) (Table 9).
- Annual DHB staff turnover rate 16%, mainly in the clinical workforce for Social Workers and Nurses. The main reason for leaving was for other external job opportunities.

Table 10. Midland Region DHB Community ICAMH/AOD Workforce by DHB Area (2008-2018)

MIDLAND REGION DHB AREA	ACTUAL FTES						VACANT FTES						VACANCY RATE					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
WAIKATO	35.8	38.0	49.6	49.1	55.8	47.1	4.4	7.3	2.1	2.7	2.8	2.5	11	16	4	5	5	5
LAKES	18.1	21.1	21.4	22.8	20.2	15.4	6.0	3.0	4.0	2.0	4.8	6.4	25	12	17	8	19	29
BAY OF PLENTY	32.4	40.4	42.2	47.0	43.7	50.1	10.3	4.4	4.3	1.7	5.4	5.4	24	10	9	3	11	10
TAIRAWHITI	15.1	16.9	17.5	17.6	20.1	12.8	-	2.6	2.1	1.0	1.4	6.5	-	13	11	5	6	34
TARANAKI	19.2	17.4	18.8	18.7	16.8	16.1	0.4	2.0	2.0	1.4	2.0	-	2	10	10	7	11	-
TOTAL	120.5	133.8	149.4	155.2	156.5	141.5	21.1	19.3	14.5	8.8	16.3	20.8	15	13	9	5	9	13

DHB WORKFORCE COMPETENCIES

- The capability of the workforce was assessed by the *Real Skills Plus ICAMHS competency framework* (The Werry Centre, 2009b), which describes the knowledge, skills and attitudes needed to work with infants, children and young people and whānau with a suspected or identified mental health or alcohol or other drug concern. The *Real Skills Plus online assessment tool* identifies the competencies that individual and teams meet from the framework, and highlights areas for knowledge and skill development for individuals and teams *(to access the tool and more information:* ***www.werryworkforce.org****)*.
- *Real Skills Plus* has three levels:
    - **Primary Level** *for people in the primary sector that work with infants, children and young people.*
    - **Core Level** *for practitioners working in services that focus on mental health and/or AOD concerns.*
    - **Specific Level** *for senior or specialist practitioners working at an advanced level of practice.*
- Real Skills Plus data can be reported at service and team level and individually. The application of Real Skills Plus is most effective at an organisational level as it helps to develop a shared understanding of the knowledge and skills required by the whole service. It promotes the development of best practice across disciplines, creating a multi-skilled workforce at each level. Real Skills Plus allows targeted service development, recruitment and service delivery activities.
- The data presented in Figures 12 and 13 are the summary of the Core level competencies met by the Midland region DHB ICAMH/AOD workforce in 2018. The workforce met a number of Core level competencies (ranging from 42% to 100% of skills and knowledge required), and further development was indicated for the following:
    - ***Assessment Knowledge (22%)***
    - ***Intervention Knowledge (22%).***
    - ***Intervention Skills (17%)***
    - ***Knowledge and Skills for Leadership roles (17%).***
    - ***Knowledge and Skills for working with Children (14%).***

Figure 12. DHB *Real Skills Plus* Core Competencies (2018)

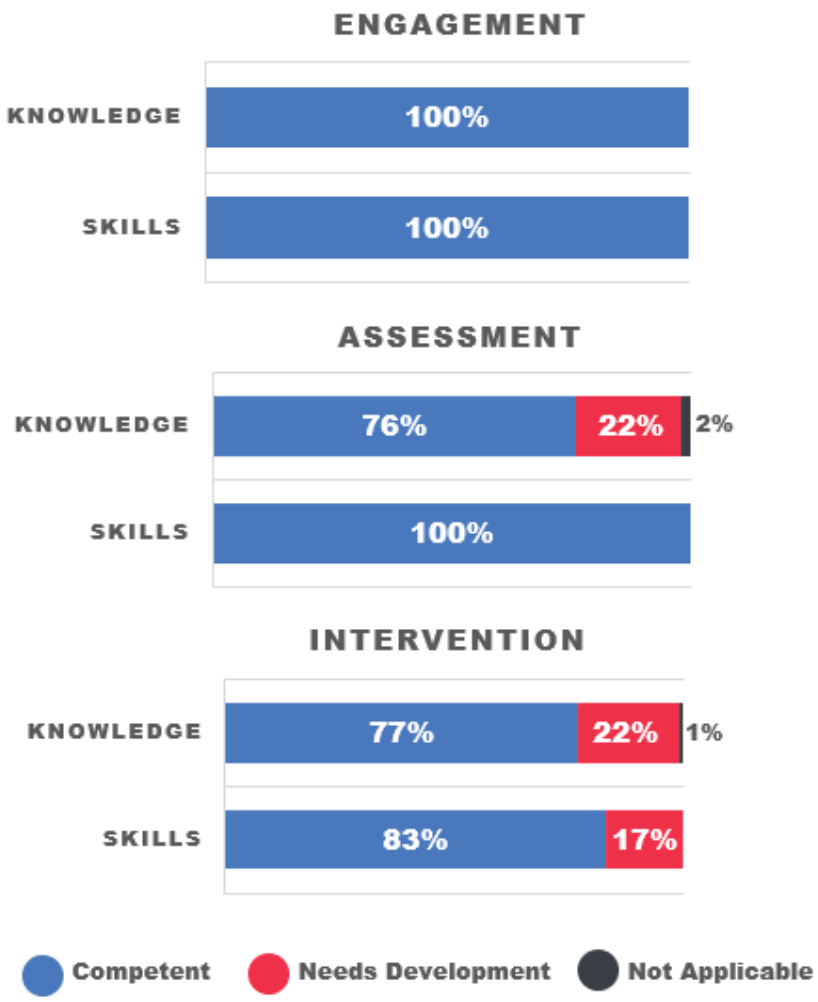
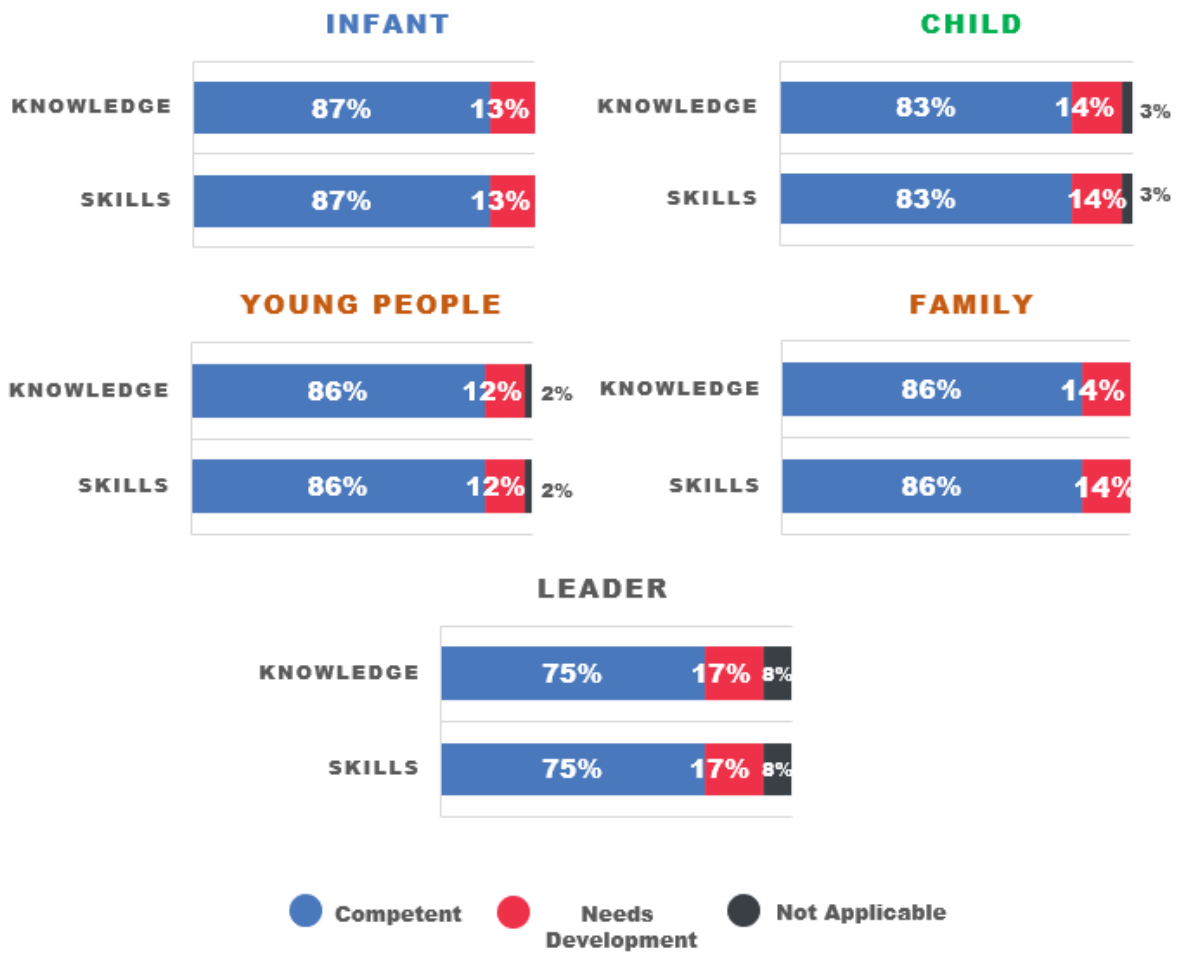


Figure 13. DHB *Real Skills Plus* Competencies by Domain (2018)



NON-DHB ICAMH/AOD WORKFORCE

- Midland region had the largest number of non-DHB services providing ICAMH/AOD services (39) and is the only region where the non-DHB workforce is larger than the DHB workforce.
- 77% of the region's workforce was in the Waikato (48%) and Bay of Plenty (29%) DHB areas (Table 11).
- 65% were in the clinical workforce as Social Workers (16%), Nurses (15%) and AOD Practitioners (12%) (Table 8).
- 30% were in non-clinical roles as Mental Health Support Workers (10%), Youth Workers (9%) and Peer Support Workers (4%) (Table 8).
- Annual non-DHB staff turnover rate 27%, mainly in the clinical workforce for Social Workers, Nurses, Psychologists and AOD Practitioners. The main reasons for leaving included taking on better paid positions in external organisations (DHB, Ministry of Education and Oranga Tamariki).

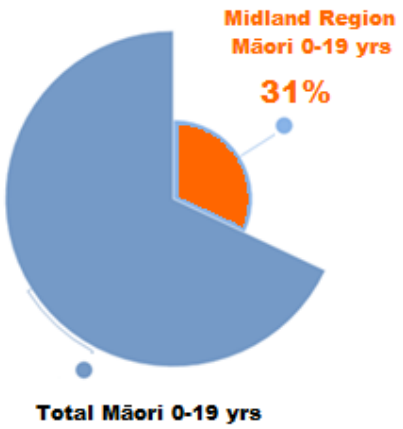
Table 11. Midland Region Non-DHB ICAMH/AOD Workforce by DHB Area (2008-2018)

MIDLAND REGION DHB AREA	ACTUAL FTES						VACANT FTES						VACANCY RATE %					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
WAIKATO	57.2	66	64.9	89.1	99.1	90.4	4.9	1.0	1.0	2.0	-	1.0	9	1	2	2	-	1
LAKES	15.5	7.0	17.8	30.1	24.0	31.3	-	-	1.0		-	-	-	-	5	-	-	-
BAY OF PLENTY	31.2	36	39.6	34.8	37.0	53.4	2.0	-	-	1.0	-	4.4	6	-	-	3	-	8
TAIRAWHITI	3.0	3.0	5.9	3.0	3.0	4.4	-	-	-		-	-	-	-	-	-	-	-
TARANAKI	6.0	4.0	4.0	6.2	6.0	7.74	-	1.0	-		-	1.2	-	20	-	-	-	13
TOTAL	112.9	116	132.3	163.2	169.1	187.2	6.9	2.0	2.0	3.0	-	6.6	6	2	1	2	-	3

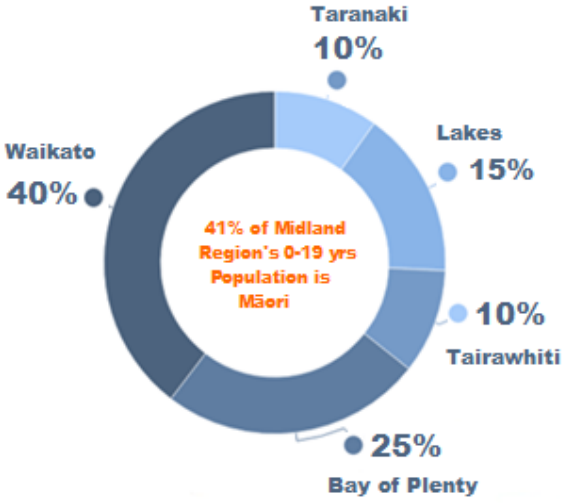
MIDLAND REGION MĀORI OVERVIEW

MIDLAND REGION MĀORI INFANT, CHILD AND ADOLESCENT POPULATION

- 2016 to 2018 population projections indicated a 2% growth in the regional Māori 0-19 year population (Appendix A, Table 1).
- Projected growth was seen in three out of the five DHB areas with a 3% projected growth for Waikato, Bay of Plenty and Taranaki.
- Midland region had the second largest Māori 0-19 year population (31%) in the country (Appendix A, Table 1).
- The region also had the largest proportion of Māori 0-19 year population in the country (41% of Midland's total 0-19 year population was Māori).
- Almost half of the region's Māori 0-19 years population resided in the Waikato DHB area but, proportionally, Tairawhiti and Lakes DHB areas had the largest proportions of Māori 0-19 year population; 66% of Tairawhiti and just over half of Lakes 0-19 year population was Māori (53%).



- 10-year projections (2018-2028) indicated a 9% regional projected population growth for Māori 0-19 year olds.
- Projections by DHB area indicated projected growth in Taranaki (by 18%), Waikato (by 12%), and Bay of Plenty (by 11%) (Appendix A, Table 2).



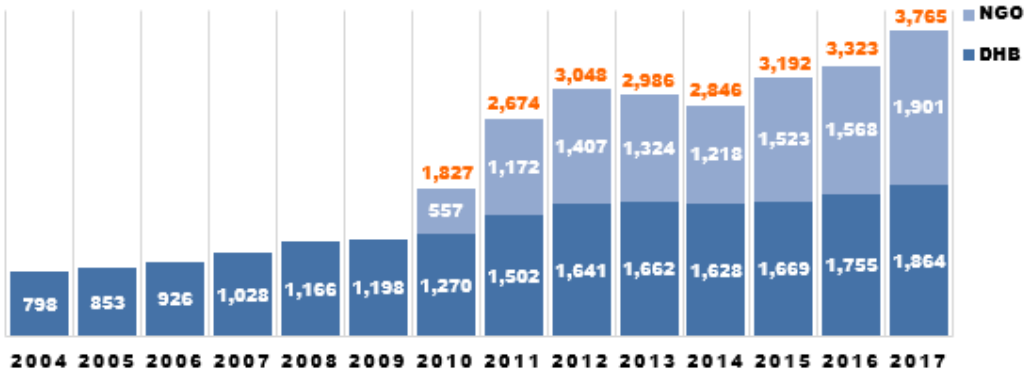
MIDLAND REGION MĀORI SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December).

From 2015 to 2017:

- 18% increase in Māori service users accessing services (Figure 14). Increase in both Māori males by 19% and females by 17%.

Figure 14. Midland Region Māori 0-19 yrs Service User (2004-2017)

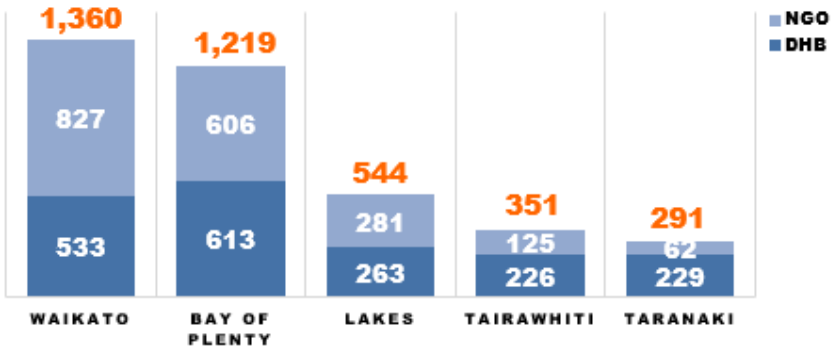


- Increase in four out of the five DHB areas with the largest increase in Lakes by 41%, while a decrease in Tairawhiti by 10%.

In the second half of 2017:

- Midland region had the second largest number of Māori service users in the country (30%) (Appendix B, Table 9).
- 42% of all service users accessing services were Māori, with Māori males making up almost two-thirds (57%) of total Māori service users.
- 68% of all Māori service users were seen by services in the Waikato (36%) and Bay of Plenty (32%) DHB areas (Figure 15).
- Overall, Māori service users equally accessed DHB and NGO services, however, 60% of Māori service users in the Waikato area were seen by NGOs.

Figure 15. Midland Region Māori 0-19 yrs Service User by DHB Area (2017)



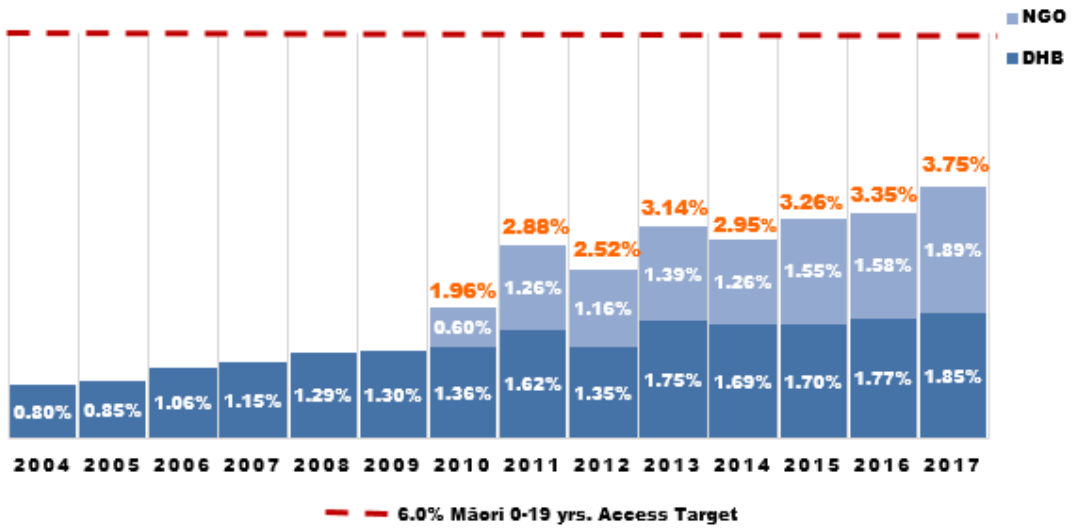
MIDLAND REGION MĀORI SERVICE USER ACCESS RATES

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). However, due to the lack of epidemiological data for the Māori tamariki and rangatahi population, the target rate 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).

From 2015 to 2017:

- Increase in the regional Māori access rate from 3.26% to 3.75%. While exceeding the overall target rate of 3%, it remains below the 6% recommended rate for Māori (Figure 16).
- Greatest improvement in access rate seen in the 0-9 year age group, while the least improvement seen in the 10-15 year age group (Appendix B, Table 9).
- Access rates improved in four of the five DHB areas, with a decrease seen in Tairawhiti (Appendix B, Table 10).

Figure 16. Midland Region Māori 0-19 yrs Service User Access Rates (2004-2017)



In the second half of 2017:

- Māori service user access rate of 3.75% was below the national average Māori access rate of 3.89% (Appendix B, Table 9).
- By age, access rates for all three age groups remained below the recommended rates, especially for the 10-14 year age group.
- Bay of Plenty (4.90%) and Tairawhiti (3.56%) DHB areas had the highest access rates, while Taranaki had the lowest (2.93%) (Figure 17).

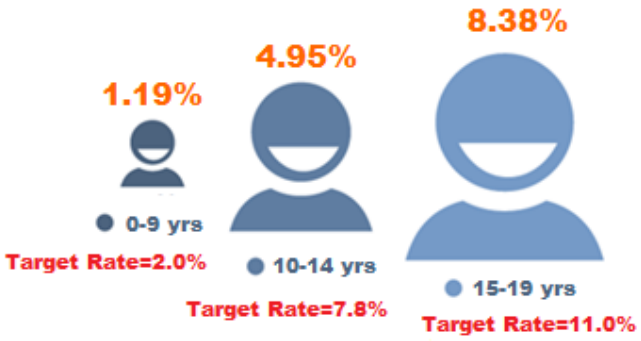
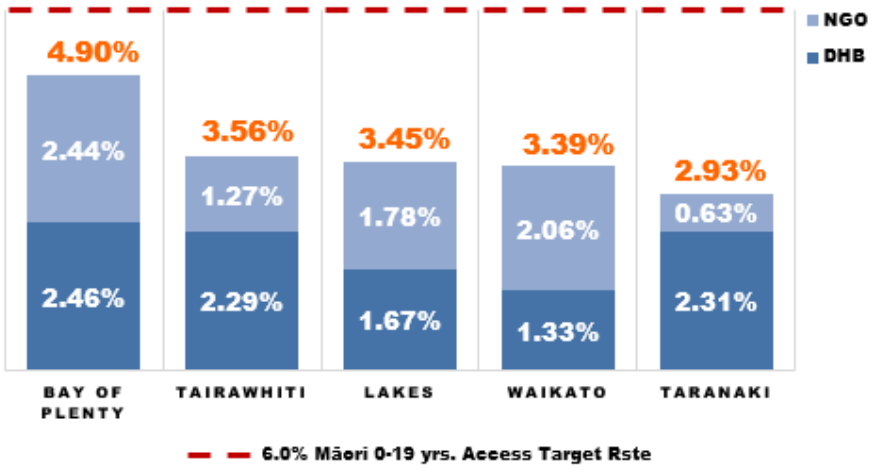


Figure 17. Midland Region Māori 0-19 yrs Service User Access Rate by DHB Area (2017)



MIDLAND REGION MĀORI ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity and Occupation) submitted by all five DHB ICAMH/AOD services and from all 41 contracted non-DHB providers (39 NGOs & 2 PHOs) as at 30 June 2018. Due to a 100% response rate from all services, the following data are a possibly a more accurate representation of the region's Māori workforce.

From 2016 to 2018:

- Due to the 100% response rate from all non-DHB providers, there was a 33% increase in the Māori workforce, from 116 to 154 (headcount) (Table 12).
- Increase in both the clinical workforce by 32% (from 74 to 98) and the non-clinical workforce by 27% (from 37 to 47).

Table 12. Midland Region Māori ICAMH/AOD Workforce by DHB Area (2008-2018)

DHB AREA	MIDLAND REGION MĀORI WORKFORCE BY DHB AREA & SERVICE PROVIDER (HEADCOUNT, 2008-2018)																	
	DHB						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
WAIKATO	4	2	6	5	6	4	21*	21*	26*	21*	40*	59	25*	23*	32*	26*	46*	63
LAKES	5	4	2	3	4	3	12	5	8	20	10	7	17	9	10	23	14	10
BAY OF PLENTY	8	7	7	6	6	13	28	26	30	29	30	47	36	33	40	35	36	60
TAIRAWHITI	9	10	9	8	14	11	2	1	4	1	2	5	11	11	13	9	16	16
TARANAKI	1	2	2	1	3	3	5	5	3	4	1	2	6	7	5	5	4	5
TOTAL	27	25	26	23	33	34	68*	58*	74*	75*	83*	120	95*	83*	100*	98*	116*	154

*Underestimate due to missing data from a NGO Provider.

As at 30 June 2018:

- 78% of the Māori workforce employed in non-DHB services and 22% in DHB services.
- 80% of the Māori workforce employed in services in the Waikato (41%) and Bay of Plenty (39%) DHB areas (Table 12 & Figure 18).
- 64% in the clinical workforce largely as Social Workers (19%), Nurses (18%) and Alcohol and Drug Practitioners (10%) (Table 13 & Figure 19).
- 31% in the non-clinical workforce largely as Whānau Ora Practitioners (7%), Youth Workers (7%) and Peer Support Workers (6%).

Figure 18. Midland Region Māori ICAMH/AOD Workforce by DHB Area (2018)

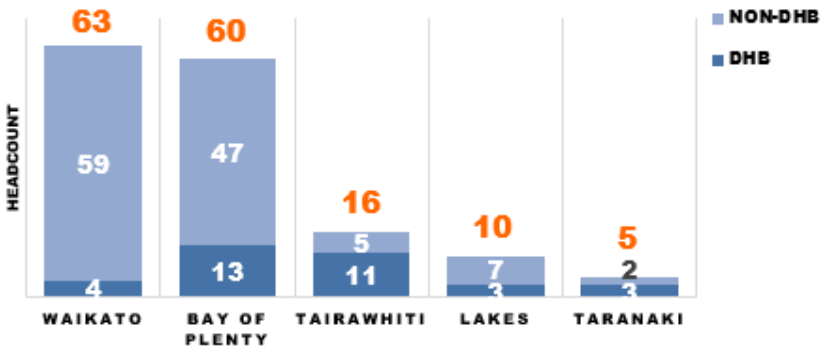


Figure 19. Top 4 Midland Region Māori ICAMH/AOD Workfore (2018)

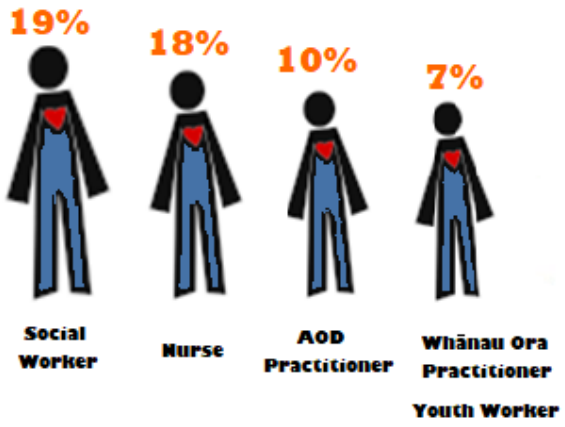


Table 13. Midland Region Māori ICAMH/AOD Workforce by Occupation (2018)

Midland Region Māori ICAMH/AOD Workforce by Occupation (Headcount, 2018)	SERVCE PROVIDER		
	DHB Community	Non-DHB	TOTAL
Alcohol & Drug Practitioner	2	14	16
Child & Adolescent Psychiatrist	1	-	1
Counsellor	-	10	10
Nurse	8	19	27
Family Therapist	-	2	2
Psychologist	4	3	7
Social Worker	6	24	30
Other Clinical[1]	1	4	5
Clinical Sub-Total	22	76	98
Cultural	4	3	7
Mental Health Support Worker	-	6	6
Peer Support Worker	-	10	10
Whānau Ora Practitioner	-	11	11
Youth Worker	1	10	11
Other Non-Clinical[2]	-	2	2
Non-Clinical Sub-Total	5	42	47
Administration	2	1	3
Management	5	1	6
TOTAL	34	120	154

1. Other Clinical = Brief Intervention Clinician; Non-Specified MH Clinicians
2. Other Non-Clinical = Needs Assessors/Service Coordinators

DHB COMMUNITY MĀORI ICAMH/AOD WORKFORCE

As at 30 June 2018:

- Very little change in the DHB Māori workforce from 2016 to 2018 (an increase of one).
- 71% of the region's DHB Māori workforce in Bay of Plenty (38%) and Tairawhiti (32%).
- 65% in the clinical workforce largely as Nurses (24%), Social Workers (18%) and Psychologists (12%) (Table 13).
- 15% in the non-clinical workforce largely as Cultural Workers (12%).
- 21% in Administration (6%) and Management (15%) roles.

NON-DHB MĀORI ICAMH/AOD WORKFORCE

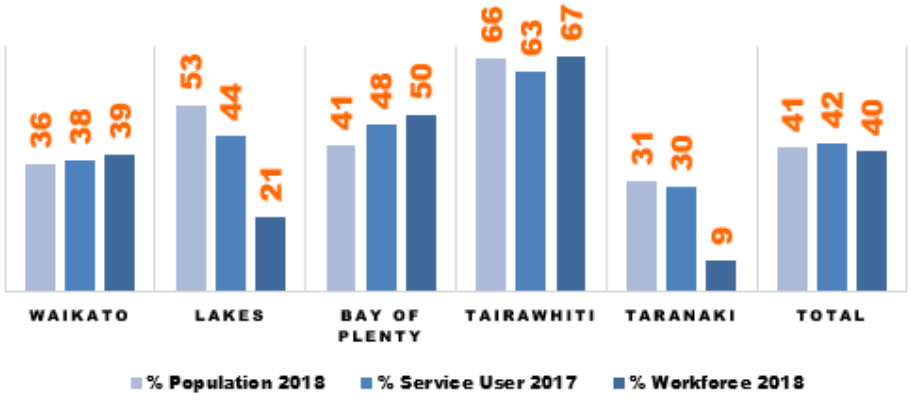
As at 30 June 2018:

- 88% of the region's non-DHB Māori workforce in Waikato (49%) and Bay of Plenty (39%) DHB areas.
- 63% in the clinical workforce largely as Social Workers (20%), Nurses (16%) and AOD Practitioners (12%) (Table 13).
- 35% in the non-clinical workforce largely as Whānau Ora Practitioners (9%), Youth Workers (8%) and Peer Support Workers (8%).

MIDLAND REGION MĀORI POPULATION, SERVICE USERS AND WORKFORCE COMPARISONS

- While the current overall Māori workforce in the Midland region appears to represent Māori service user demand for services, disparities between the workforce and service users can be seen within individual DHB areas such as Lakes and Taranaki (Figure 20).
- Increasing trends in Māori service users accessing services (18% increase from 2015 to 2017), indicate a need for increasing the Māori workforce in all services and across all occupational groups.
- Māori service user access DHB services and non-DHB equally in this region, and in some DHB areas, more Māori service users are seen by non-DHB services. Therefore, strengthening and supporting the non-DHB workforce in this region is critical.

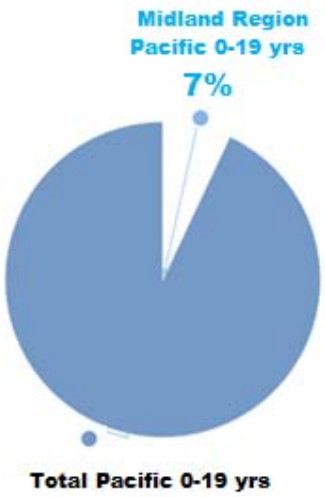
Figure 20. Māori 0-19 yrs Population, Service User & Workforce Comparisons



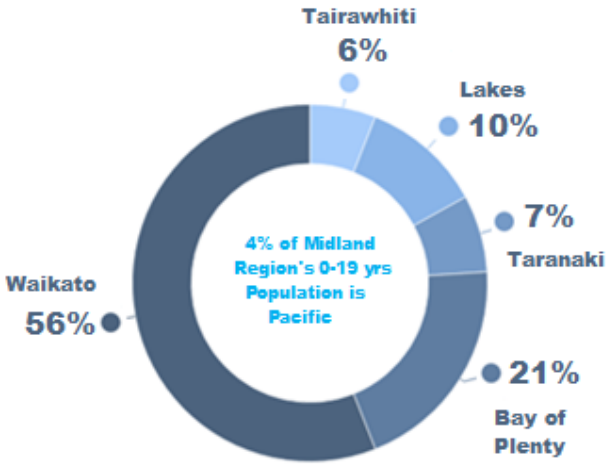
MIDLAND REGION PACIFIC OVERVIEW

MIDLAND REGION PACIFIC INFANT, CHILD AND ADOLESCENT POPULATION

- 7% growth in the regional Pacific 0-19 year population since the 2016 (Appendix A, Table 1).
- Projected growth indicated for four of the five DHB areas with the largest growth projected for the Bay of Plenty and Waikato (both by 8%) DHB areas, followed by Tairawhiti and Taranaki, both by 7%,
- The Midland region had the smallest Pacific infant, child and adolescent population (7%) in the country (Appendix A, Table 1).
- Pacific infants, children and adolescents made up 4% of the region's total 0-19 years population.
- Over half (56%) of the region's Pacific 0-19 years population resided in the Waikato DHB area.
- 10-year projections (2018-2028) indicates a 28% regional projected growth.



- Growth projected for four out of the five areas: Bay of Plenty (by 37%), Tairawhiti (by 32%), Waikato (by 31%), and Taranaki (by 23%) (Appendix A, Table 2).



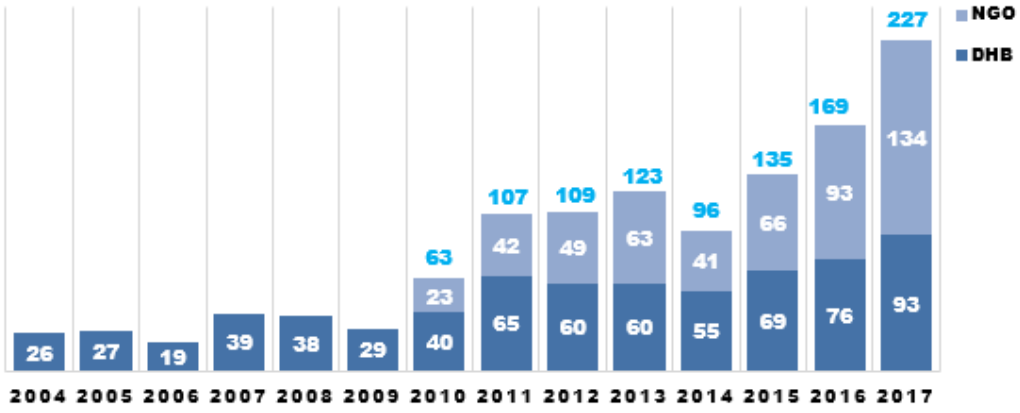
MIDLAND REGION PACIFIC SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December).

From 2015 to 2017:

- 68% increase in Pacific service users accessing services in the region (Figure 21). Increase seen in both males and females, largely for males by 113% (from 55 to 117).
- Increase seen largely in NGOs services by 103% (66 to 134).
- Increase in Pacific service users seen in all DHB areas.

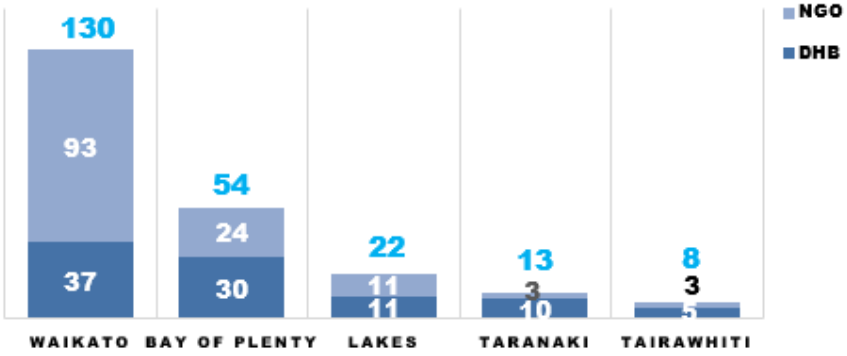
Figure 21. Midland Region Pacific 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Pacific service users made up 3% of the total number of service users accessing services in the region. 52% were Pacific males.
- 81% of all Pacific service users were seen by services in Waikato (57%) and Bay of Plenty (24%) DHB areas (Figure 22).
- 59% of Pacific service users were seen by NGOs and 41% were seen by DHB services.

Figure 22. Midland Region Pacific 0-19 yrs Service User by DHB Area (2017)

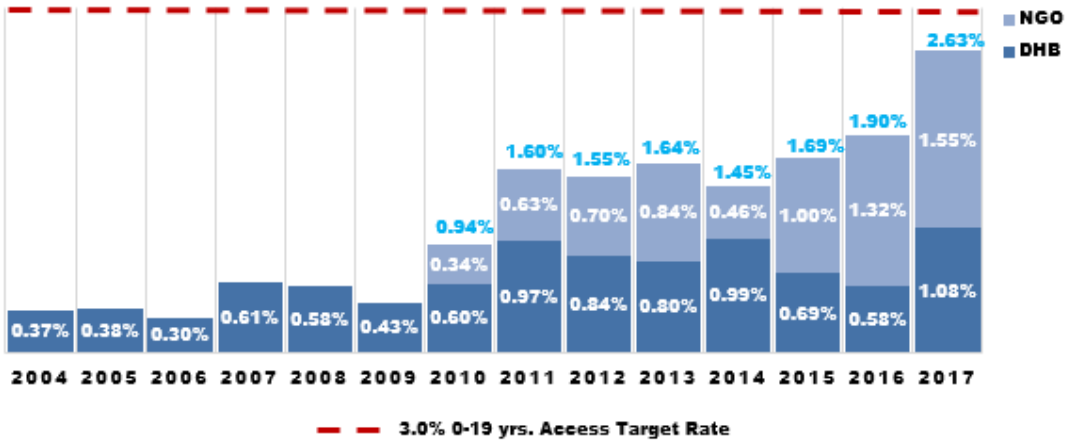


MIDLAND REGION PACIFIC SERVICE USER ACCESS RATES

From 2015 to 2017:

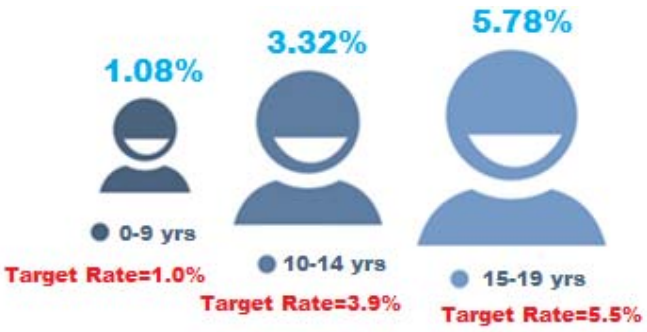
- Improvements in the overall Pacific 0-19 year access rate, from 1.69% to 2.63% (Figure 23).
- Improvement seen in all three age groups and across all DHB areas (Appendix B, Table 11).

Figure 23. Midland Region Pacific 0-19 yrs Service user Access Rates (2004-2017)



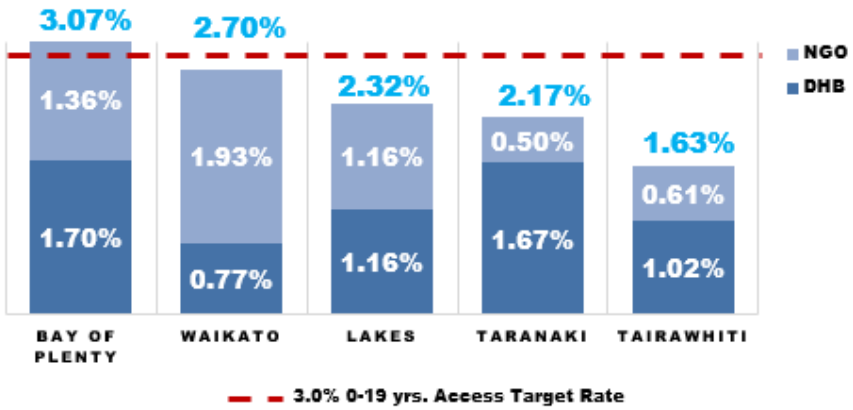
In the second half of 2017:

- Midland region 0-19 years Pacific service user access rate of 2.63% was higher than the national average Pacific access rate of 2.08%.
- By age, 0-9 and 15-19 year age groups have exceeded their respective recommended rates. However, the 10-14 year age group remained below the recommended rate. As there are no recommended rates for the Pacific population, comparisons with overall rates might be a conservative estimate of actual need for the Pacific population due to higher need for mental health services.



- By DHB area, Bay of Plenty DHB area had the highest Pacific service user access rate of 3.07%, exceeding the 3.0% target rate, while the remainder remained below the target rate (Figure 24).

Figure 24. Midland Region Pacific 0-19 yrs Service user Access Rates by DHB Area (2017)



Note: Pacific access rates by DHB area should be interpreted with caution due to very small numbers (< 20) of Pacific service users within individual DHB areas (Lakes, Taranaki and Tairawhiti). Regional access rates produce more meaningful access rates.

MIDLAND REGION PACIFIC ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes (Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity and Occupation submitted by all five DHB ICAMH/AOD services and from all 41 contracted non-DHB providers (39 NGOs & 2 PHOs) as at 30 June 2018.

From 2016 to 2018:

- Very little change in regional Pacific workforce, from 12 to 13 (Table 14).
- DHB services reported a slight increase in Pacific staff of 3, and non-DHB services reported a decrease of 2.

As at 30 June 2018:

- 77% of the region's Pacific workforce were in the Waikato and Bay of Plenty DHB areas.
- Majority of the Pacific workforce was in clinical roles (10) as Nurses (4) (Table 15).
- Pacific non-clinical workforce was all Mental Health Support Workers (3) (Table 15).

Table 14. Midland Region Pacific ICAMH/AOD Workforce by DHB Area (2008-2018)

DHB AREA	MIDLAND REGION PACIFIC WORKFORCE BY DHB AREA & PROVIDER (HEADCOUNT, 2008-2018)																	
	DHB						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2012	2016	2018
WAIKATO	-	-	-	-	-	1	5	3	2	4	7	4	5	3	2	4	7	5
LAKES	-	1	1	-	-		-	-	-	-	-	2	-	1	1	-	-	2
BAY OF PLENTY	-	-	-	-	2	4	2	2	1	1	1	1	2	2	1	1	3	5
TAIRAWHITI	1	1	1	1	1		-	1	1	1	1		1	2	2	2	2	-
TARANAKI	-	-	-	-	-	1	-	-	-	-	-		-	-	-	-	-	1
TOTAL	1	2	2	1	3	6	7	6	4	6	9	7	8	8	6	7	12	13

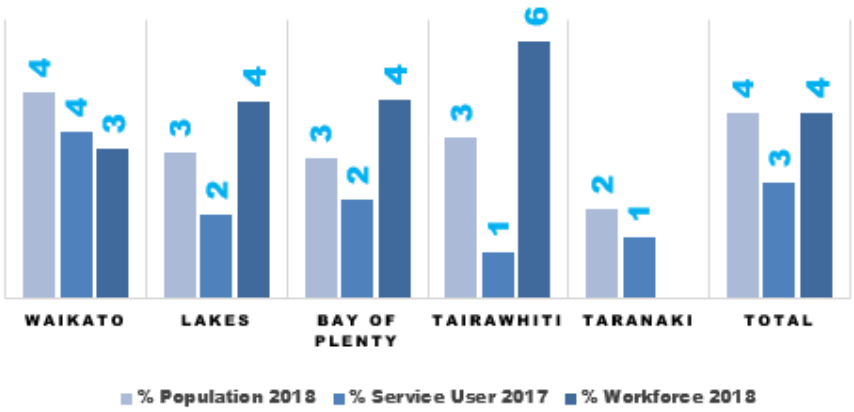
Table 15. Midland Region Pacific ICAMH/AOD Workforce by Occupation (2018)

Midland Region Pacific ICAMH/AOD Workforce by Occupation (Headcount, 2018)	SERVICE PROVIDER		
	DHB Total	NON-DHB	Total
Alcohol & Drug Practitioner	1	-	1
Nurse	3	1	4
Psychotherapist	-	1	1
Social Worker	2	-	2
Other Clinical	-	2	2
Clinical Sub-Total	6	4	10
Mental Health Support Worker	-	3	3
Non-Clinical Sub-Total	-	3	3
Regional Total	6	7	13

MIDLAND REGION PACIFIC POPULATION, SERVICE USERS AND WORKFORCE COMPARISONS

- The Midland region has a growing Pacific 0-19 year population. While Pacific service users accessing services show an increasing trend, they continue to remain below the 3% target rate. Such low numbers of Pacific service users could indicate unmet need given that the Pacific population has a higher need for mental health services. Therefore, improving access rates for Pacific in this region remains critical (Figure 25).
- Because of the low numbers of Pacific service users accessing services in the region, the regional Pacific workforce is currently proportional to service demand. However, the 10 year population projection indicates a 28% regional growth in the Pacific population and, coupled with an increasing trend in Pacific service users, development of Pacific services is key as currently there are no dedicated Pacific services available in the region. Additionally, increasing the Pacific workforce should remain an area of focus for the Midland region.
- Pacific service users are also largely seen in non-DHB services in this region; therefore, strengthening the non-DHB workforce is also critical.

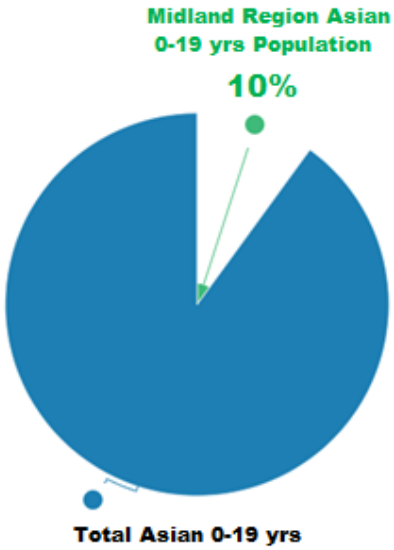
Figure 25. Proportion of Pacific 0-19 yrs Population Service User & Workforce Comparisons by DHB Area

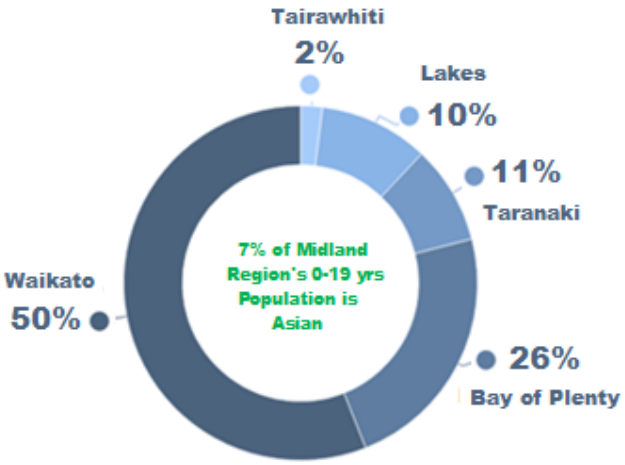


MIDLAND REGION ASIAN OVERVIEW

MIDLAND REGION ASIAN INFANT, CHILD AND ADOLESCENT POPULATION

- The 2016 to 2018 population projections indicated an overall 4% decline in the regional Asian population.
- This decline in population was for the Waikato DHB area only by 15% while growth was indicated for the remainder of the DHB areas, especially in Taranaki by 14% and Bay of Plenty by 11%.
- Midland region continued to have the smallest Asian population (10%) in the country.
- Asian infant, child and adolescent population made up 7% of the regional infant, child and adolescent population.
- Half (50%) of the region's Asian population reside in the Waikato DHB area, followed by Bay of Plenty (26%).
- 10-year population projections (2018-2028) indicated a 56% regional growth in the Asian 0-19 year population.
- Projected growth indicated for all five areas: especially in Waikato by 72%, followed by Taranaki (by 44%), Bay of Plenty (by 43%), Lakes (32%) and Tairawhiti (19%) (Appendix A, Table 2).





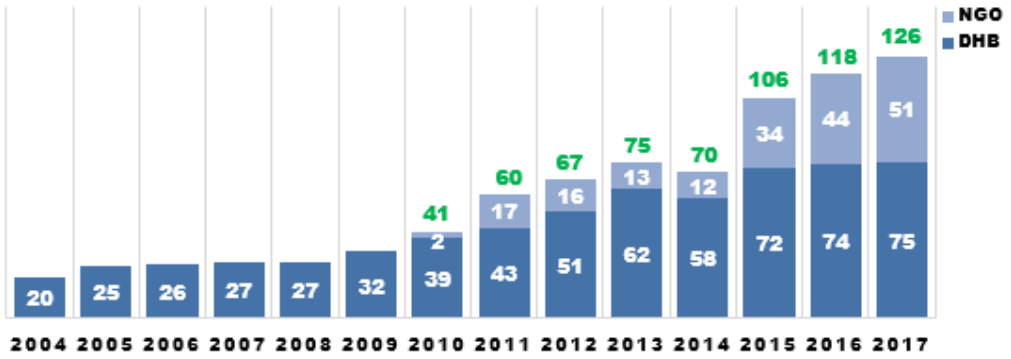
MIDLAND REGION ASIAN SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December).

From 2015 to 2017:

- A 19% overall increase in the number of Asian service users accessing services in the region (Figure 26). Increase seen largely for Asian females by 30% (from 54 to 70).
- Increase seen in four out of the five DHB areas with a slight decrease seen in Lakes.

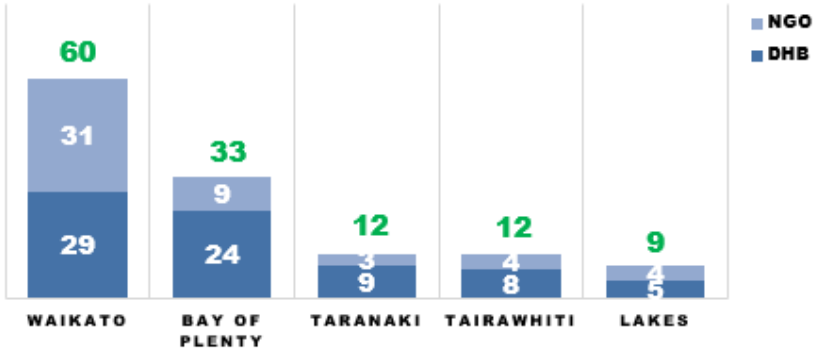
Figure 26. Midland Region Asian 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Asian service users made up 1% of the total number of service users accessing services in the region (Appendix B, Table 5).
- 56% were Asian females.
- 74% of all Asian service users in the region were seen in services in Waikato (48%) and Bay of Plenty (26%) DHB areas (Figure 27).
- While in previous years Asian service users were predominantly accessing DHB services (e.g. 83% in 2014), the number of Asian service users accessing NGOs has steadily increased, with DHBs currently representing 60% and NGOs now representing 40% of all Asian service users accessing services in the region.

Figure 27. Midland Region Asian 0-19 yrs Service User by DHB Area (2017)

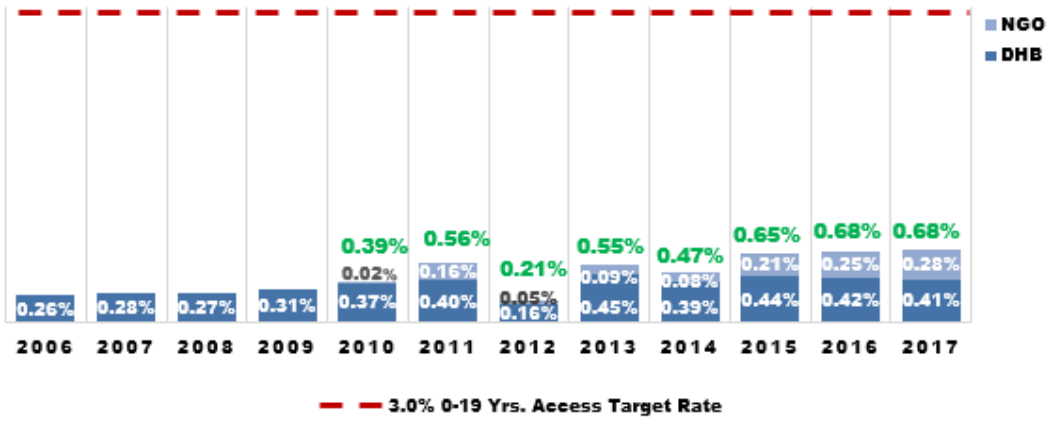


MIDLAND REGION ASIAN SERVICE USER ACCESS RATES

From 2015 to 2017:

- Slight improvement in the 0-19 year Asian access rate, from 0.65% to 0.68% (Figure 28). Improvements seen only for 0-9 and 10-14 year olds (Appendix B, Table 13).

Figure 28. Midland Region Asian 0-19 yrs. Service User Access Rates (2006-2017)



- Improvements in the Asian access rate seen in two out of the five DHB areas: Waikato and Tairawhiti (Appendix B, Table 14).

In the second half of 2017:

- The regional Asian service user access rate continued to be the lowest out of the four ethnic groups (Other Ethnicity=3.92%, Māori=3.75%, Pacific = 2.63%) and remained significantly below the target rates for all three age groups. Such low access rates could indicate unmet needs for the Asian population.

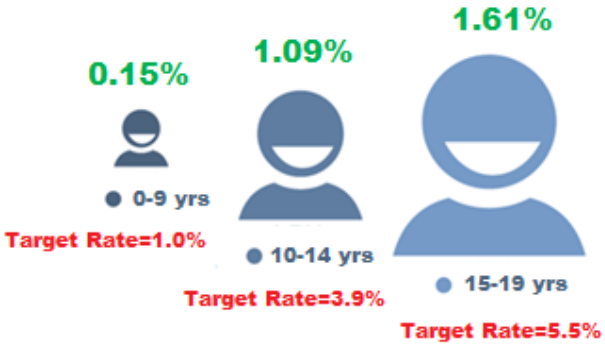
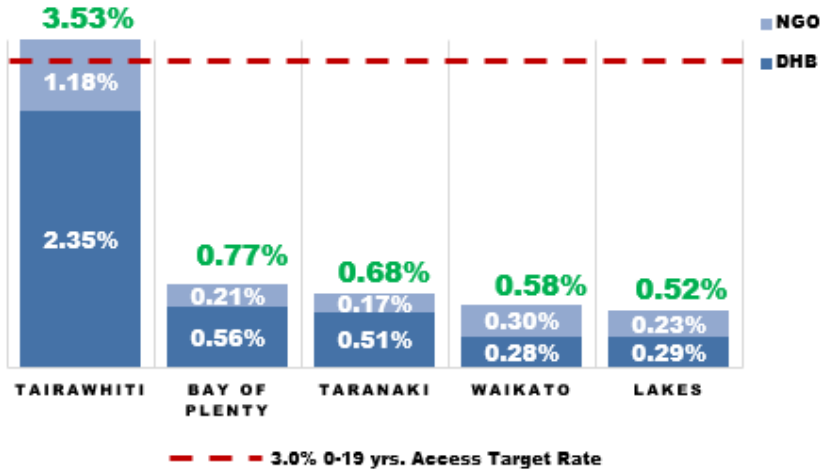


Figure 29. Midland Region Asian 0-19 yrs Service User Access Rates By DHB Area (2017)



Note: Asian access rates by DHB area should be interpreted with caution due to very small numbers (< 20) of Asian service users within individual DHB areas (Taranaki, Tairawhiti and Lakes). Regional access rates produce more meaningful access rates for the Asian population.

MIDLAND REGION ASIAN ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes (Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity & Occupation submitted by all five DHB ICAMH/AOD services and from all 41 contracted non-DHB services (including 2 PHOs) as at 30 June 2018.

From 2016 to 2018:

- Decrease of two in the overall regional Asian workforce, from 16 to 14 (Table 16). This decrease seen in DHB services by 5, from 10 to 5.
- However, a slight increase seen in the Asian non-DHB workforce by 3, from 6 to 9.

As at 30 June 2018:

- 57% of the region's Asian workforce was in services in the Waikato DHB area
- 64% of the Asian workforce was in non-DHB services.
- 71% in clinical roles as Psychiatrists (30%) and AOD Practitioners (30%) (Table 17).
- 21% in the non-clinical workforce, all Mental Health Support Workers.

Table 16. Midland Region Asian ICAMH/AOD Workforce by DHB Area (2008-2018)

DHB AREA	MIDLAND REGION ASIAN ICAMH/AOD WORKFORCE BY SERVICE PROVIDER (Headcount, 2008-2018)																	
	DHB						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
WAIKATO	2	2	2	8	10	5	-	-	-	7	4	3	2	2	2	15	14	8
LAKES	-	-	-	-	-	-	-	-	-	-	1	4	-	-	-	-	1	4
BAY OF PLENTY	1	2	2	-	-	-	-	-	-	-	1	2	1	2	2	-	1	2
TAIRAWHITI	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TARANAKI	-	1	1	1	-	-	-	-	-	-	-	-	-	1	1	1	-	-
TOTAL	3	5	5	9	10	5	-	-	-	7	6	9	3	5	5	16	16	14

Table 17. Midland Region Asian ICAMH/AOD Workforce by Occupation (2018)

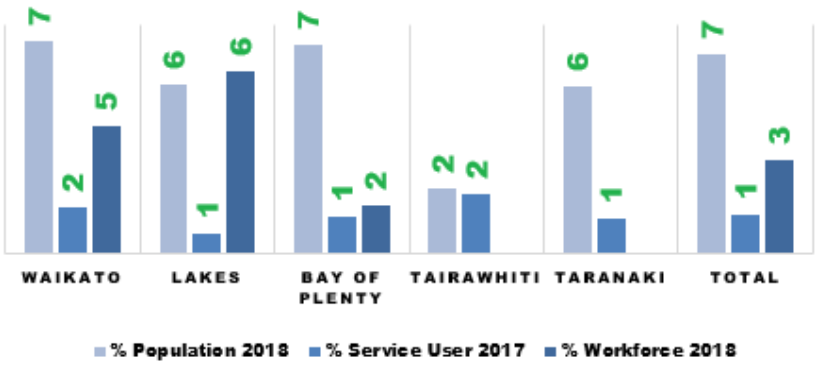
Midland Region ICAMH/AOD Asian Workforce by Occupation (Headcount, 2018)	DHB Total	Non-DHB	Total
Alcohol & Drug Practitioner	-	3	3
Child & Adolescent Psychiatrist	3	-	3
Nurse	-	1	1
Social Worker	2	-	2
Other Clinical[1]	-	1	1
Clinical Sub-Total	5	5	10
Mental Health Support Workers	-	3	3
Non-Clinical Sub-Total	-	3	3
Administration/Management	-	1	1
Regional Total	5	9	14

1. **Not identified to protect identity**

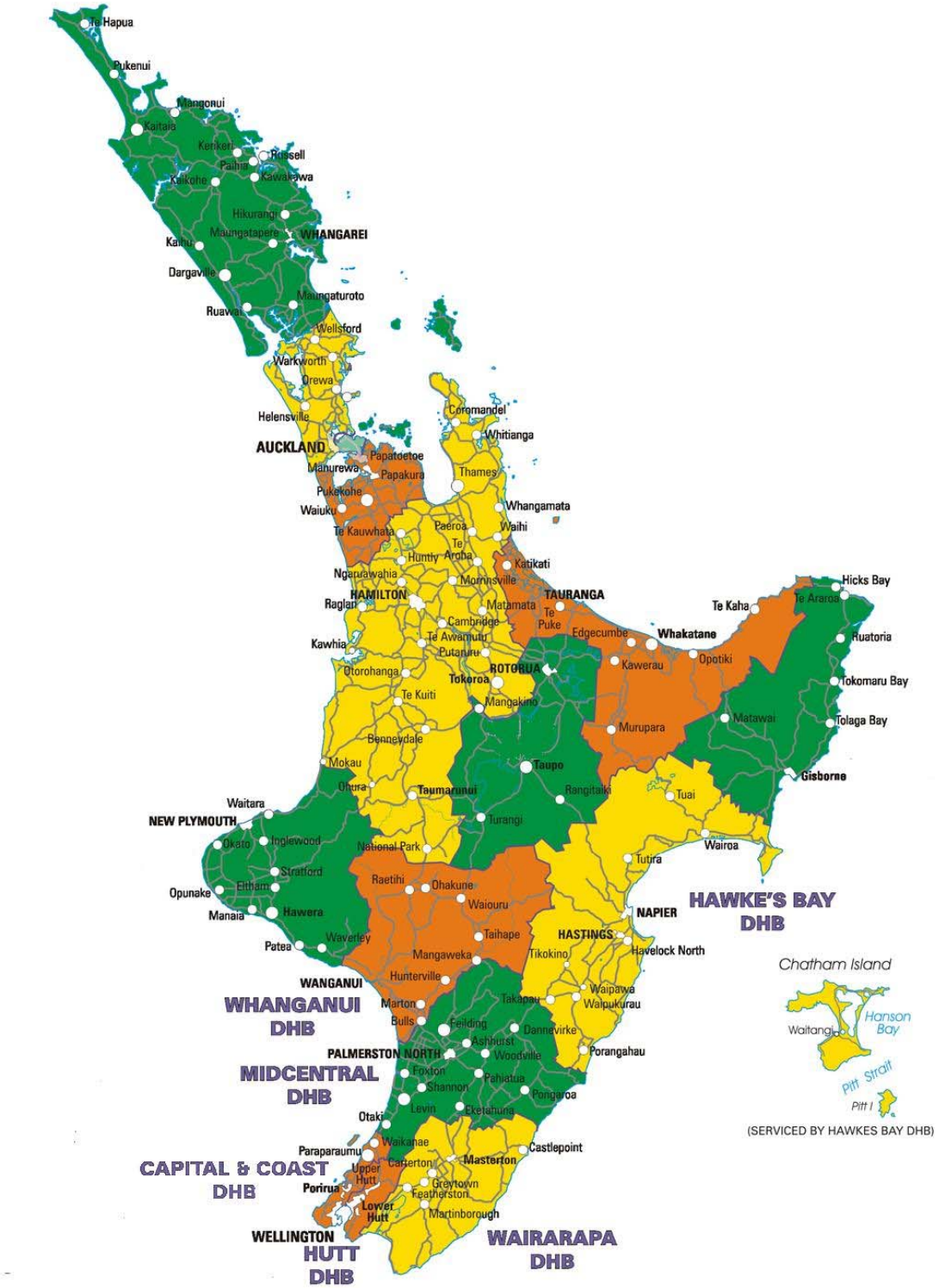
MIDLAND REGION ASIAN POPULATION, SERVICE USERS AND WORKFORCE COMPARISONS

- While Asian service users accessing services show an increasing trend, they continue to remain below the 3% target rate. Such low numbers of Asian service users could indicate unmet need for this population (Figure 30). Therefore, improving access rates for the Asian 0-19 year population in this region remains critical.
- Because of the low numbers of Asian service users accessing services in the region, the regional Asian workforce is currently proportional to service demand. However, the 10-year population projection indicates a 56% regional growth in the Asian population and, coupled with an increasing trend in Asian service users, increasing the Asian workforce and strengthening the non-DHB sector remain areas of focus for the Midland region.

Figure 30. Asian 0-19 yrs Population Service User & Workforce Comparisons by DHB Area

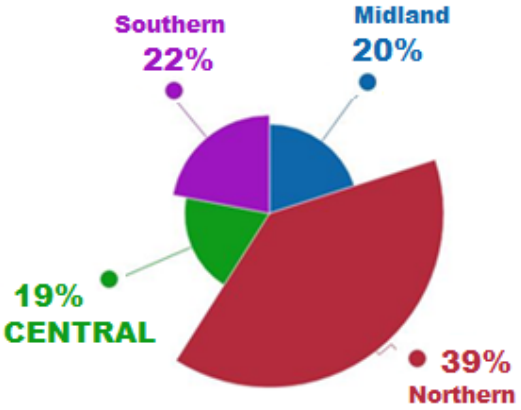


CENTRAL REGION INFANT, CHILD AND ADOLESCENT MENTAL HEALTH & AOD OVERVIEW

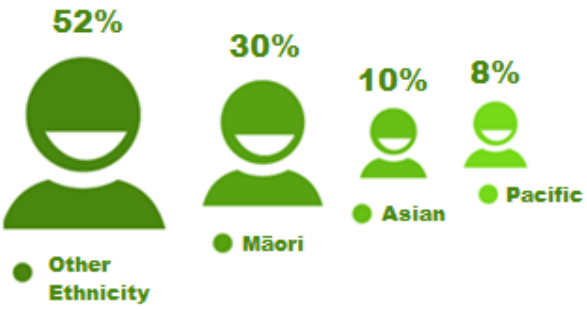


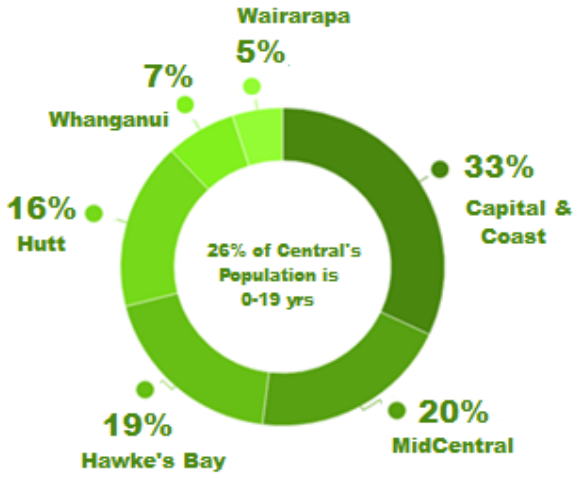
CENTRAL REGION INFANT, CHILD AND ADOLESCENT POPULATION PROFILE

- 2016-2018 population projections (based on the 2013 Census) indicated very little change (-1%) in the overall 0-19 year population. (Appendix A, Table 1).
- Central region had 19% of New Zealand's infant, child and adolescent population (0-19 years), mainly residing in Capital & Coast (33%), MidCentral (20%) and Hawke's Bay (19%) DHB areas.
- Over half (52%) of the 0-19 year population was in the Other Ethnicity group, followed by Māori (30%), Asian (10%) and Pacific (8%).
- 10-year population (2018-2028) projections indicate a declining population by 3%.



- However, projected growth indicated is for Asian by 32%, Māori by 11% and Pacific by 9% (Appendix A, Table 2).





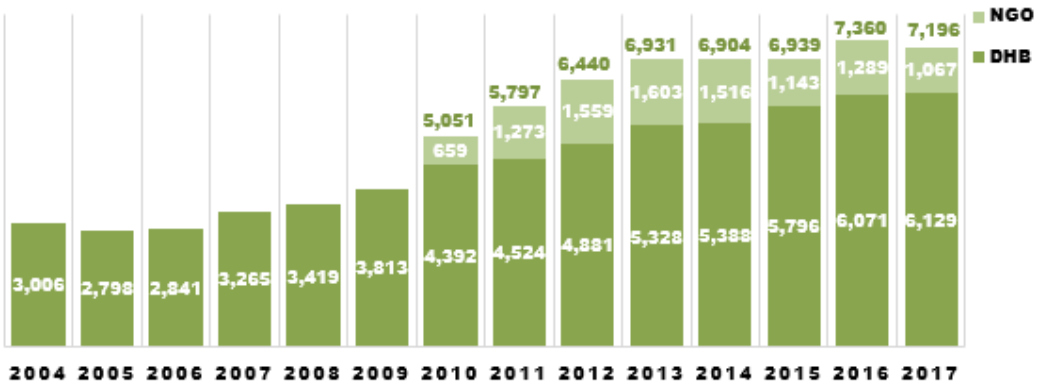
CENTRAL REGION SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December). NGO service user data has been included since 2010 and indicates a more accurate representation of service user access from this period onwards.

From 2015 to 2017:

- 4% increase in the number of service users accessing services for both males (by 5%) and females (by 2%) (Figure 1). Largest increase seen in the 10-14 year females by 16%.

Figure 1. Central Region 0-19 yrs Service User (2004-2017)

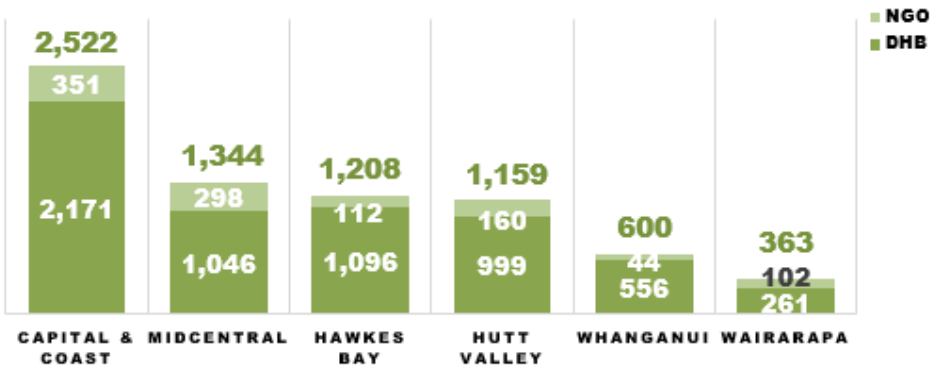


- Increase in service users in three out of the six DHB areas (Whanganui, Capital & Coast and Hutt), decreases in Hawke's Bay, MidCentral and Wairarapa. Decrease in service user numbers seen in the NGO sector by 7%, while DHB services showed a 6% increase.

In the second half of 2017:

- 54% of all service users accessing services were 15-19 year olds.
- Majority of service users were Other Ethnicity (58%) followed by Māori (35%), Pacific (4%) and Asian (3%).
- 85% accessed DHB services and 15% accessed NGOs.
- 87% of all service users in the region were seen by services in Capital & Coast (35%), MidCentral (19%); Hawke's Bay (17%) and Hutt (16%) DHB areas (Figure 2).

Figure 2. Central Region 0-19 yrs Service User by DHB Area (2017)



CENTRAL REGION SERVICE USER ACCESS RATES

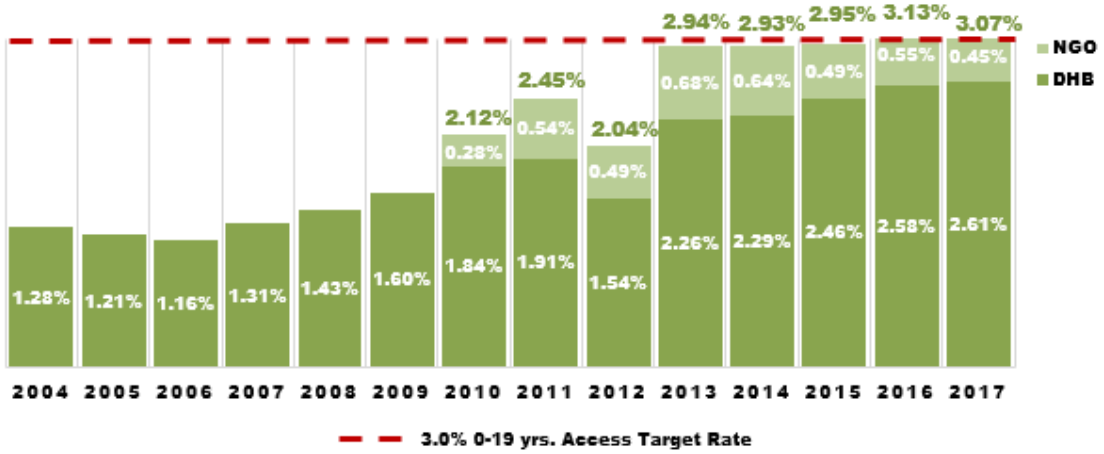
The *Blueprint Access Benchmark Rate* for the 0-19 year age group has been set at 3% of the population over a six-month period (Mental Health Commission, 1998). Due to different prevalence rates for mental illness in different age groups, the MHC has set appropriate access rates for each age group, 1% 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. Access rates are calculated by dividing service users 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 service user lives (DHB of domicile). However, access rates are affected by the population data used; access rates calculated using census data tend to be more accurate than projected data.

From 2015 to 2017:

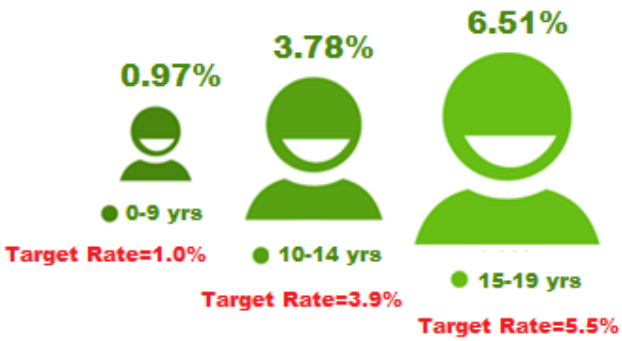
- Improvements in the region's 0-19 year service user access rate, from 2.95% to 3.07%, exceeding the 3% target rate (Figure 3). Improvement in access rates in all three age groups (Appendix B, Table 8).
- Improvements in three out of the six DHB areas only: Whanganui, Capital & Coast and Hutt Valley (see Appendix B, Table 8).

In the second half of 2017:

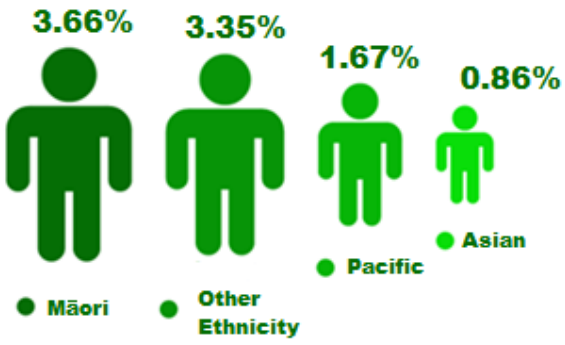
Figure 3. Central Region 0-19 yrs Service User Access Rates (2004-2017)



- Regional service user access rate of 3.07% higher than the national average access rate of 3.03%.
- By age, the 15-19 year age group access rate of 6.51% was the only age group exceeding the respective target rate of 5.5%. Access rates for 0-9 year and 10-14 year olds, while close, remained below their respective target rates.

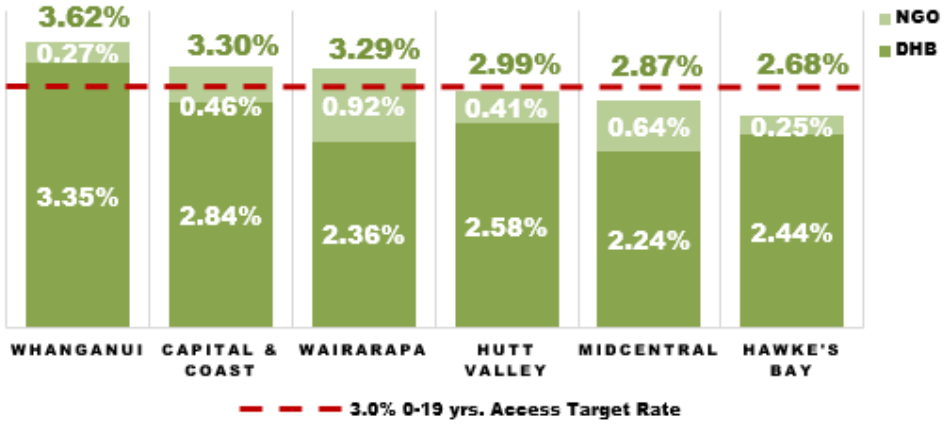


- By ethnicity, while Māori service users had the highest access rate in the region of 3.66%, it remained below the Māori recommended rate of 6%. Therefore, the overall access rate for the Other Ethnicity group of 3.35% was the only rate to exceed the 3% target rate.



- By DHB area, only three out of the six DHB areas exceeded the 3% target rate with Whanganui having the highest access rate of 3.62% followed by Capital & Coast (3.3%) and Wairarapa (3.29%). Access rates for Hawke's Bay, MidCentral and Hutt, while close, remained below the 3% target rate (Figure 4).
- Despite improvements in the regional access rate, access rates still need to improve for Māori, Pacific and Asian service users especially for 0-9 year and 10-14 year age groups.

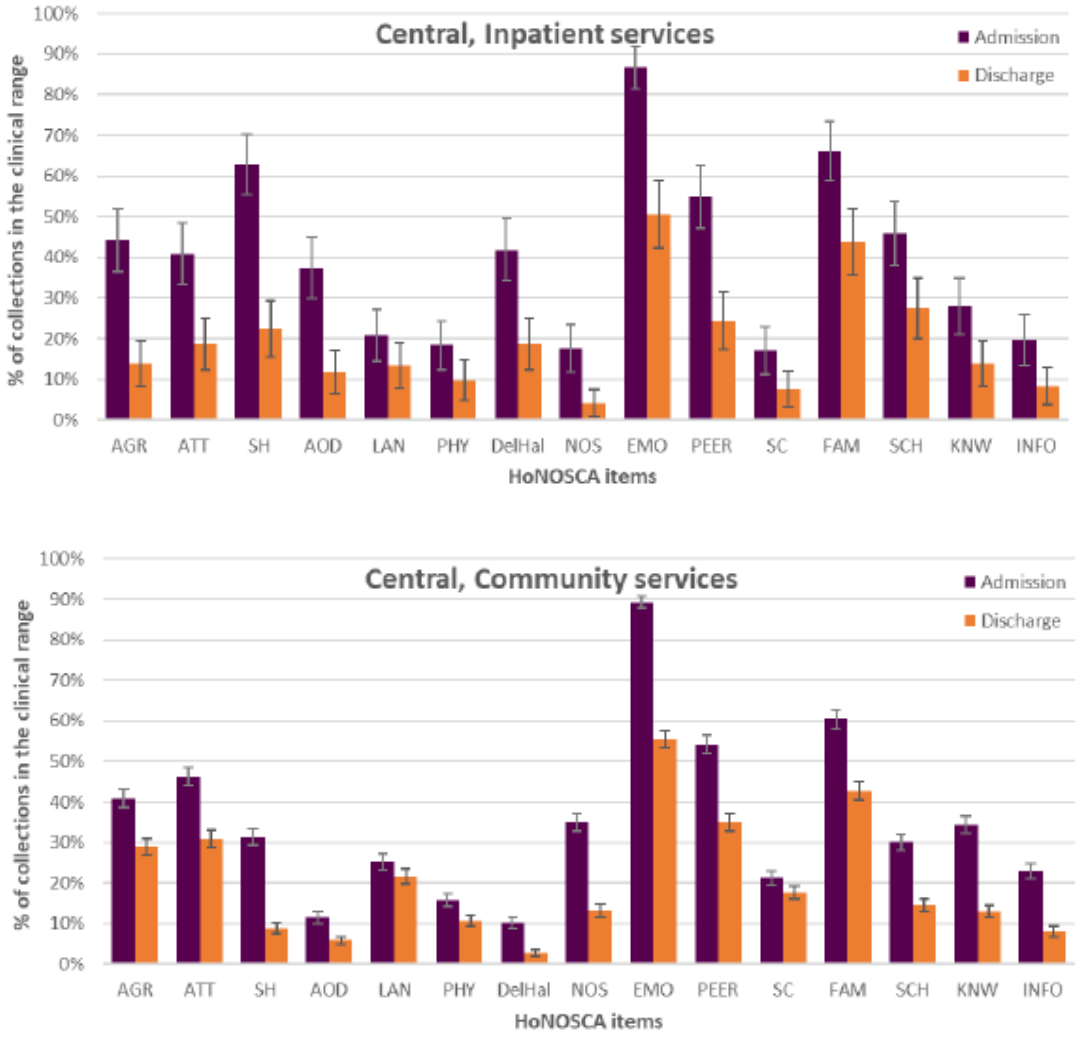
Figure 4. Central Region 0-19 yrs Service User Access Rate by DHB Area (2017)



SERVICE USER OUTCOMES

To assess whether service users 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 aged 4-17 years) at admission and discharge from community child and adolescent mental health services. Service user outcomes data for the 2018 period showed significant improvements in emotional related symptoms by time of discharge from both inpatient and community mental health services (EMO Scores in Figure 5).

Figure 5. Central Region Service User Outcomes by Service (2018)



CENTRAL REGION FUNDING OF ICAMH/AOD SERVICES

From 2015/2016 to 2017/2018 financial year:

- 14% increase in funding for infant, child and adolescent mental health/AOD services in both DHB and non-DHB provider services (Table 1 & Figure 6).
- Increases in four out of the six DHB areas. Decreases seen in Hutt Valley (by 11%) and Whanganui (by 3% (Appendix C, Table 1).

Figure 6. Central Region ICAMH/AOD Funding by Service Provider (2004-2018)

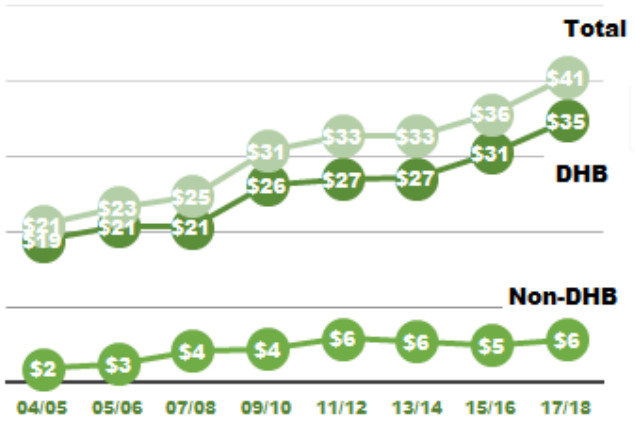


Table 1. Central Region ICAMH/AOD Funding by Service (2008-2018)

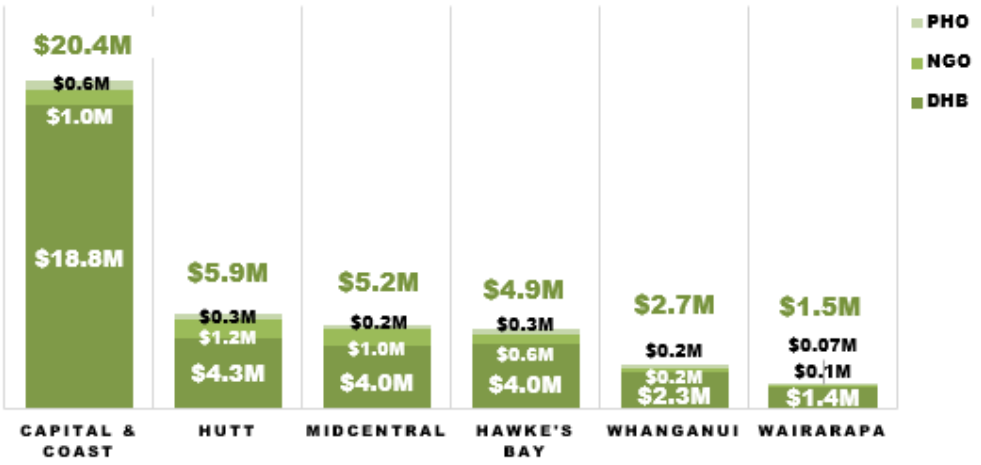
SERVICES	CENTRAL REGION ICAMH/AOD FUNDING (2008-2018)						
	07/08	09/10	11/12	13/14	15/16	17/18	% CHANGE (2018-2016)
INPATIENT	$3,711,453	$4,398,625	$3,619,480	$3,502,054	$3,540,367	$3,540,369	0.00
AOD	$1,947,178	$2,672,320	$4,986,002	$4,334,748	$4,609,915	$3,567,722	-22.6
CHILD & YOUTH MH	$19,211,238	$21,714,652	$24,083,436	$24,248,775	$23,919,827	$25,085,219	4.9
FORENSIC	-	-	-	$745,840	$3,233,266	$6,765,299	109.2
KAUPAPA MĀORI	-	$2,037,788	$204,587	-	-	-	-
YOUTH PRIMARY MH	-	-	-	-	$373,622	$1,666,959	*
TOTAL	$24,869,869	$30,823,385	$32,893,505	$32,831,418	$35,676,996	$40,625,568	14

Source: Ministry of Health Price Volume Schedule 2007-2014. *Coded under general mental health. * Not calculated.

For the June 2017 to July 2018 financial year:

- Central region provider services received 22% ($40.6M) of the total national funding ($183.4M) for infant, child and adolescent mental health/AOD services (Table 1).
- 86% of the regional funding for DHB services, 14% for non-DHB Providers
- 62% allocated to Child and Youth Mental Health Services, 17% to Youth Forensics, 9% to AOD and Inpatient. A larger proportion of the funding was allocated to Youth Primary Mental Health Services (4%).
- Services in the Capital & Coast DHB area had the largest proportion (50%) of funding in the region, followed by Hutt (18%) DHB area (Figure 7).

Figure 7. Central Region ICAMH/AOD Funding by DHB Area (2018)



FUNDING PER HEAD INFANT, CHILD AND ADOLESCENT POPULATION

Funding per head of population is a method by which we can look at the equity of funding across the regions and DHBs. Clearly, this is not the actual amount spent per head of population aged 0-19 years, as only a small proportion of this population accesses services. When looking at individual DHBs, the calculation does not reflect inter-DHB referrals, including referrals to regional services (Appendix C, Table 2).

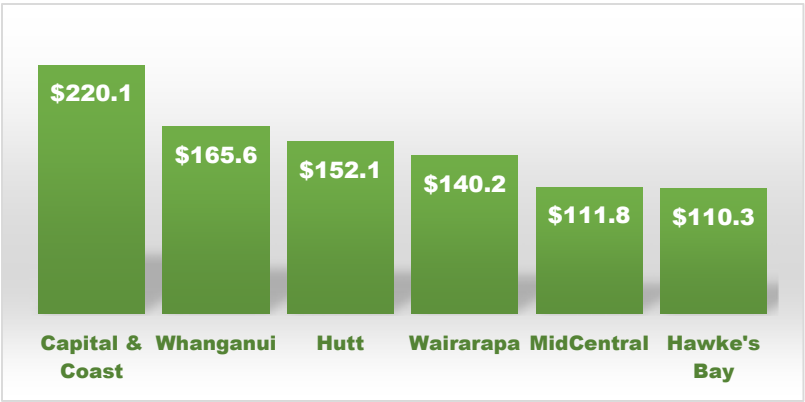
From 2016 to 2018:

- 10% increase in the regional spend per 0-19 year population (excluding Inpatient funding) from $124.22 to $136.61 (Appendix C, Table 2).
- Increases in spend per 0-19 year population in four out of the six DHB areas: Wairarapa, Whanganui, Hutt and Capital & Coast. However, Hawkes Bay and MidCentral DHB showed slight decreases, by 8% and 1% respectively.

In the 2017/2018 financial year:

- Capital & Coast DHB area had the highest spend per 0-19 year population at $220.1 and Hawke's Bay DHB had the lowest at $110.3 (Figure 8).

Figure 8. Central Region Spend per 0-19 year population (2018)



CENTRAL REGION PROVISION OF ICAMH/AOD SERVICES

Six DHBs provide a range of specialist inpatient and community-based infant, child and adolescent mental health/AOD (ICAMH/AOD) services in the Central region: Hawke's Bay, MidCentral, Whanganui, Capital & Coast, Hutt Valley and Wairarapa. Regional inpatient mental health services are provided by Capital & Coast DHB (Regional Rangatahi Inpatient Service).

Nga Taiohi National Secure Youth Forensic Inpatient Mental Health Service is a specialist 10-bed unit for young people aged 13 to 17 who are severely affected by mental health (or mental health & alcohol or other drug issues), who have offended or are alleged to have offended, and involved in the youth justice system. The unit is located at Kenepuru Community Hospital in Porirua.

ICAMH/AOD services are also provided by DHB funded non-DHB services. For the June 2017 to July 2018 period, 29 non-DHB providers (including 6 PHOs) were identified as providing DHB funded ICAMH/AOD and youth primary mental health services.

Table 2. Hawke's Bay ICAMH/AOD Services (2017/2018)

HAWKE'S BAY DHB
Child & Adolescent Mental Health/AOD Services
HAWKE'S BAY DHB FUNDED NON-DHB SERVICES
EMERGE AOTEAROA
Child, Adolescent & Youth Mental Health Community Care with Accommodation
HEALTH HAWKE'S BAY
Youth Primary Mental Health Service: Pilot School Resilience Programme
TOTARA HEALTH
Youth Primary Mental Health Service

Table 3. MidCentral ICAMH/AOD Services (2017/2018)

MIDCENTRAL DHB
Child, Adolescent & Family/ AOD (Palmerston North & Levin)
Oranga Hinengaro: Kaupapa Māori Mental Health Services (Kaumātua & Pasifika dedicated roles that can be accessed by all mental health teams)
Conduct Disorder Service

Note: Italicised services are Kaupapa Māori services

MIDCENTRAL DHB FUNDED NON-DHB SERVICES
BEST CARE (WHAKAPAI HAUORA) CHARITABLE TRUST
Community Child, Adolescent & Youth Service for Co-existing Problems
CENTRAL PRIMARY HEALTH ORGANISATION
Youth Primary Mental Health Service
MANA O TE TANGATA TRUST
Peer Support Service for Children & Youth
M.A.S.H TRUST BOARD
Infant, Child, Adolescent & Youth Crisis Respite
RAUKAWA WHĀNAU ORA.
Community Child, Adolescent & Youth Service for Co-existing Problems

MIDCENTRAL DHB FUNDED NON-DHB SERVICES CONTINUED
THE YOUTH ONE STOP SHOP
Early Intervention & Other Drug Service Child, Adolescent & Youth
Community Child, Adolescent & Youth Service for Co-existing Problems
WHAIORO TRUST BOARD
Early Intervention & Other Drug Service Child, Adolescent, Youth

Note: Italicised services are Kaupapa Māori services

Table 4. Whanganui ICAMH/AOD Services (2017/2018)

WHANGANUI DHB
Child, Adolescent & Family Mental Health Alcohol & Other Drug Service
Co-Existing Problems Service
REGIONAL SERVICES
Regional funding of Rangatahi Unit
Child & Youth Planned Respite
Child & Youth Crisis Respite
Also provides services for Eating Disorders, Infant Mental Health, COPMIA, Peer Support/Advocacy

WHANGANUI DHB FUNDED NON-DHB SERVICES
LIFE TO THE MAX TRUST
Infant, Child, Adolescent & Youth Package of Care (wrap around)
MENTAL HEALTH SOLUTIONS: PATHWAYS HEALTH LTD
Infant, Child, Adolescent & Youth Crisis & Planned Respite
MENTAL HEALTH & WELLBEING SUPPORT
Family/Whānau Support Education, Information & Advocacy Service
TE ORANGANUI TRUST
Youth Primary Mental Health Service

Table 5. Capital & Coast ICAMH/AOD Services (2017/2018)

CAPITAL & COAST DHB
Child & Adolescent Mental Health Services (Wellington)
Child & Adolescent Mental Health Services (Porirua)
Child & Adolescent Mental Health Services (Kapiti)
KAUPAPA MĀORI SERVICE
Te Whare Marie, Specialist Māori Mental Health Services
PACIFIC SERVICE
Health Pasifika Child, Adolescent & Family Services
REGIONAL SERVICES
Early Intervention Service (Central Region)
Regional Rangatahi Inpatient Unit (Central Region)
Regional Youth Forensic Service (Central Region)
Regional Secure Youth ID Services (Central Region)
Also provides services for Eating Disorders, Infant Mental Health, COPMIA, Parenting Programmes: Incredible Years, Fostering Changes

Note: Italicised services are Kaupapa Māori services

CAPITAL & COAST DHB FUNDED NON-DHB SERVICES
EMERGE AOTEAROA
Child, Adolescent & Youth alcohol & Drug Community Services
Infant, Child, Adolescent & Youth Crisis Respite
NEW ZEALAND RED CROSS
Refugee Mental Health Services: Infant, Child, Adolescent & Youth Community Mental Health Services
ORA TOA PHO
Youth Primary Mental Health Service
TAEAOMANINO TRUST
Pacific Infant, Child, Adolescent & Youth Community Mental Health Services
TE RUNANGA O TOA RANGATIRA INC
Child, Adolescent & Youth Alcohol & Drug Community Services: AOD Group Programme
TE WHANGANUI-A-TARA YOUTH DEVELOPMENT
Youth Primary Mental Health Service
TU ORA COMPASS HEALTH
Youth Primary Mental Health Service

Note: Italicised services are Kaupapa Māori services

Table 6. Hutt Valley ICAMH/AOD Services (2017/2018)

HUTT VALLEY DHB
Tautawhi: Intake, Choice & Brief Intervention
Kaiarahi: Partnership/Treatment
Youth Specialty Service
REGIONAL SERVICES
Intensive Clinical Support Services (Capital & Coast, Wairarapa & Hutt Valley DHBs)
Eating Disorders Service

HUTT VALLEY DHB FUNDED NON-DHB SERVICES
ATAREIRA
Family & Whānau Support Education, Information & Advocacy Service
EMERGE
Child, Adolescent & Youth alcohol & Drug Community Services: MST
HUTT VALLEY YOUTH HEALTH TRUST
Youth Primary Mental Health Service
Early Intervention & Other Drug Service Child, Adolescent & Youth: Alcohol Brief Intervention Youth
PACT GROUP
Child, Adolescent & Youth Alcohol & Drug Community Services
Infant, Child, Adolescent & Youth Community Support Services
TE AWAKAIRANGI HEALTH NETWORK
Youth Primary Mental Health Service

Table 7. Wairarapa ICAMH/AOD Services (2017/2018)

WAIRARAPA DHB
Child & Adolescent Mental Health Service: Te Ratonga Aranga Mokopuna Aarangi (Te Rama)
Also provides services for Eating Disorders, Infant Mental Health, Peer Support/Advocacy, Co-Existing Problems (CEP), and provides support to NGO Strengthening Families who provide the COPMIA service

WAIRARAPA DHB FUNDED NON-DHB SERVICES
KING STREET ARTWORKS INC
Child, Adolescent & Youth Community Art Based Day Activity Service
MENTAL HEALTH SOLUTIONS
Child, adolescent & youth alcohol & drug community services
TU ORA COMPASS HEALTH
Youth Primary Mental Health Service: Alcohol Brief Intervention Youth

CENTRAL REGION ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by ethnicity and occupation, submitted by all six DHB (Inpatient & Community) ICAMH/AOD services and all 29 (including 6 PHOs) contracted Non-DHB providers as at 30 June 2018.

From 2016 to 2018:

- 17% increase in the region's ICAMH/AOD workforce, from 321.6 to 376.2 FTEs (Table 8 & Figure 9).
- This increase seen in the non-DHB workforce which had doubled, from 51.9 to 106.4 FTEs due to the inclusion of data from 6 PHOs.
- Regional vacancy rate decreased from 11% to 8% (Table 8).

Figure 9. Central Region Total ICAMH/AOD Actual FTEs (2004-2018)

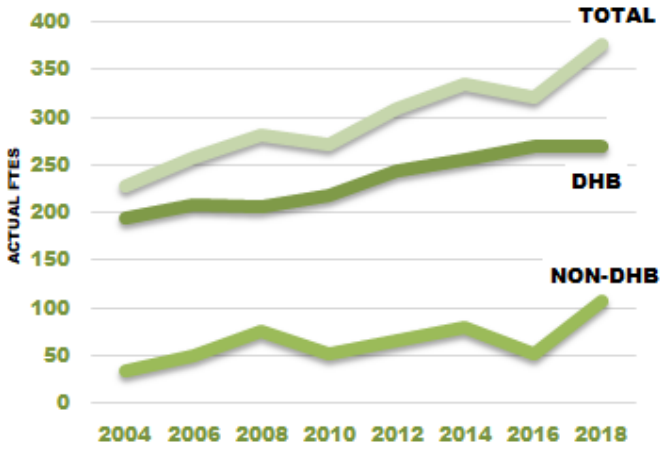


Table 8. Central Region Total ICAMH/AOD Health Workforce (2004-2018)

YEAR	DHB[1]			NON-DHB			TOTAL		
	ACTUAL FTES	VACANT FTES	% VACANCY	ACTUAL FTES	VACANT FTES	% VACANCY	ACTUAL FTES	VACANT FTES	% VACANCY
2004	194.1	24.5	11	34.1	2.2	6	228.2	26.7	10
2006	208.8	27.1	11	49.5	0.4	1	258.2	27.5	10
2008	206.5	12.8	6	75.3	-	-	281.3	12.8	4
2010	218.8	25.6	10	52.5	-	-	271.3	25.6	9
2012	243.4	18.1	7	63.4	-	-	306.8	18.1	6
2014	255.1	45.48	15	86.1	-	-	334.7	45.5	12
2016	269.6	38.9	13	51.9	0.5	1	321.6	39.5	11
2018	269.7	29.5	10	106.4	2.1	2	376.2	31.6	8

1. Includes Inpatient Workforce Data

As at 30 June 2018:

- 72% of the workforce was in DHB provider services and 28% in non-DHB provider services (Table 8).
- 47% of the region's workforce was in services in the Capital & Coast DHB area (Figure 11).
- Largely made up of NZ European (65%), followed by Māori (17%), Pacific (8%), Other Ethnicity (7%) and Asian (4%) (Appendix D, Table 18).
- 70% in the clinical workforce largely as Nurses (19%), Social Workers (15%) and Psychologists (12%) (Table 9).
- 18% in the non-clinical workforce largely as Mental Health Support Workers (8%), Youth Workers (4%) and Peer Support Workers (2%) (Figure 10).
- 12% in Administration (7%) and Management (5%) roles.

- 93% of all vacancies were reported by DHB services.
- 94% of vacancies for the clinical workforce largely for Psychologists (28%), Nurses (19%) and Social Workers (13%) (Table 10).
- Regional annual staff turnover rate 21% (DHB = 21% & non-DHB = 20%) mainly for Psychologists, Nurses, Social Workers and Mental Health Support Workers. The main reasons for leaving included taking on other external job opportunities; maternity leave; moved to another city and internal job opportunities.

Figure 10. Top 4 Central Region ICAMH/AOD Workforce (2018)

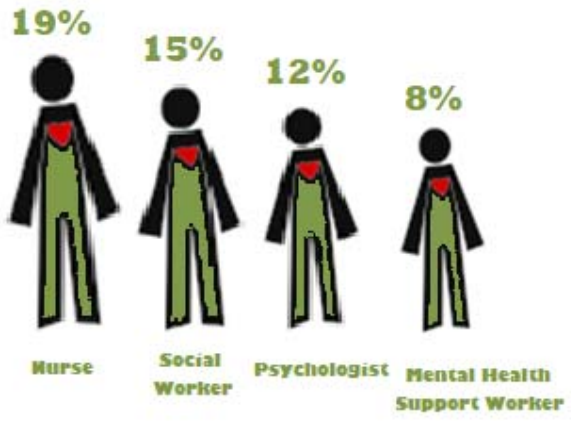


Figure 11. Central Region ICAMH/AOD Workforce by DHB Area (2018)

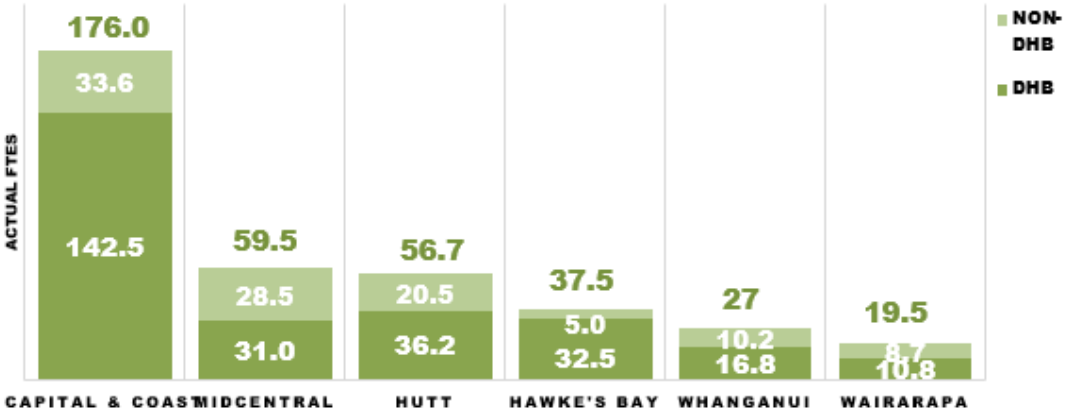


Table 9. Central Region Total ICAMH/AOD Workforce by Occupation (2018)

Central Region ICAMH/AOD Workforce by Occupation (Actual FTEs, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	3.70	3.70	8.90	12.60
Child & Adolescent Psychiatrist	1.00	14.95	15.95	0.20	16.15
Co-Existing Problems Clinician	-	4.00	4.00	1.00	5.00
Counsellor	-	3.40	3.40	11.98	15.38
Family Therapist	-	2.60	2.60	-	2.60
Intern/Clinical Placements	-	3.90	3.90	1.00	4.90
Nurse	18.60	43.70	62.30	8.60	70.90
Occupational Therapist	-	10.70	10.70	1.00	11.70
Other Senior Medical Officer/Registrar	0.90	8.40	9.30	-	9.30
Psychotherapist	-	3.80	3.80	-	3.80
Psychologist	1.00	41.26	42.26	4.20	46.46
Social Worker	1.00	44.65	45.65	9.70	55.35
Other Clinical[1]	0.30	2.30	2.60	7.30	9.90
Clinical Sub-Total	22.80	187.36	210.16	53.88	264.04
Cultural Worker	1.70	4.25	5.95	-	5.95
Educator	-	-	-	3.70	3.70
Mental Health Consumer	-	2.00	2.00	0.10	2.10
Mental Health Support Worker	9.00	9.40	18.40	13.20	31.60
Peer Support Worker	-	-	-	6.86	6.86
Youth Worker	-	1.40	1.40	14.40	15.80
Other Non-Clinical[2]	-	-	-	2.79	2.79
Non-Clinical Sub-Total	10.70	17.05	27.75	41.05	68.80
Administration	1.00	21.40	22.40	2.95	25.35
Management	1.00	8.40	9.40	8.56	17.96
Total	35.50	234.21	269.71	106.44	376.15

1=Other Clinical= House Surgeon; Dietician; Clinical Coordinator; Kai Manaaki/RHP; Doctor; Child & Youth Therapist; Māori Physical Therapist; MST Therapist
2=Other non-Clinical=Research & Training Coordinator; Service Coordinator

Table 10. Central Region ICAMH/AOD Vacancies by Occupation (2018)

Central Region ICAMH/AOD Vacant FTEs by Occupation (Vacant FTEs, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Child & Adolescent Psychiatrist	0.50	2.20	2.70	-	2.70
Nurse	1.00	5.00	6.00	-	6.00
Occupational Therapist	1.00	2.50	3.50	-	3.50
Psychotherapist	-	0.60	0.60	-	0.60
Psychologist	-	8.80	8.80	-	8.80
Social Worker	1.00	3.20	4.20	-	4.20
Other Clinical[1]	1.00	1.50	2.50	1.43	3.93
Clinical Sub-Total	4.50	23.80	28.30	1.43	29.73
Cultural Worker	-	0.30	0.30	-	0.30
Youth Worker	-	-	-	0.70	0.70
Non-Clinical Sub-Total	0.00	0.30	0.30	0.70	1.00
Management	-	0.90	0.90	-	0.90
Total	4.50	25.00	29.50	2.13	31.63

1 = Other Clinical = Case Manager; Clinical Placement; Day Programme Facilitator; Counsellor

DHB INPATIENT ICAMH WORKFORCE

From 2016 to 2018:

- 8% increase in the inpatient workforce, from 32.8 to 35.5 (Table 11).
- Decrease in the vacancy rate, from 15% to 11% (from 6 to 4.5 vacant FTEs).

As at 30 June 2018:

- 64% of the inpatient workforce in clinical roles, largely as Nurses (52%) (Table 9).
- 30% in non-clinical roles as Mental Health Support Workers (25%) and Cultural roles (5%).
- All of the vacancies were in clinical roles (Table 10).

Table 11. Central Region DHB Inpatient ICAMH Workforce (2008-2018)

YEAR	ACTUAL FTES			VACANT FTES			VACANCY RATE (%)
	CLINICAL	NON-CLINICAL	TOTAL	CLINICAL	NON-CLINICAL	TOTAL	
2008	19.4	14.5	33.9	3.6	-	3.6	10
2010	22.0	11.2	35.2	-	-	-	-
2012	22.0	11.1	35.1	2.0	2.0	4.0	10
2014	20.0	14.5	34.5	2.0	2.0	4.0	10
2016	22.0	10.8	32.8	5.0	1.0	6.0	15
2018	22.8	12.7	35.5	4.5	-	4.5	11

Note: Non-Clinical Workforce includes Administration/Management Staff

DHB COMMUNITY ICAMH/AOD WORKFORCE

From 2016 to 2018:

- 1% decrease in the DHB community workforce from 236.8 to 234.2 actual FTEs (Table 12).
- Decrease in total number of vacancies from a 14% vacancy rate to 10%.

As at 30 June 2018:

- 46% of the community workforce was in Capital & Coast DHB services.
- 80% in clinical roles, largely as Social Workers (19%), Nurses (19%), Psychologists (18%) and Psychiatrists (6%) (Table 9.
- 7% in the non-clinical workforce, largely as Mental Health Support Workers (4%) and Cultural appointments (2%).
- 13% in Administration (9%) and Management (4%) roles.
- 95% of vacancies were in clinical roles, largely for Psychologists (35%), Nurses (20%) and Social Workers (13%).
- Annual DHB staff turnover rate at 21% mainly for Psychologists, Nurses and Social Workers. The main reasons for leaving included other external job opportunities, relocating to another city within New Zealand and maternity leave.

Table 12. Central Region DHB Community ICAMH/AOD Workforce by DHB Area (2008-2018)

CENTRAL REGION DHB AREA	ACTUAL FTES						VACANT FTES						VACANCY RATE (%)					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
HAWKE'S BAY	25.4	25.1	25.8	22.4	31.3	32.5	-	3.0	1.7	11.6	4.2	2.8	-	11	4	34	12	8
MIDCENTRAL	28.9	28.5	32.11	33.9	35.6	31.0	-	6.0	2.4	4.48	8.3	6.9	-	17	7	12	19	18
WHANGANUI	16.1	17.2	16.84	16.6	17.0	16.8	3.3	-	1.0	1.0	2.0	0.5	17	-	6	6	11	3
CAPITAL & COAST	67.3	77.7	78.38	103.9	106.1	107.0	4.9	10.1	7.6	21.9	21.7	10.9	7	12	9	17	17	9
HUTT	26.2	26.6	31.2	32.3	35.2	36.2	-	3.5	1.4	2.0	2.3	2.8	-	12	4	6	6	7
WAIRARAPA	8.8	8.5	11.8	11.5	11.7	10.8	1.0	3.0	-	0.5	0.5	1.1	10	26	-	4	4	9
TOTAL	172.6	183.6	196.13	220.6	236.8	234.2	9.2	25.6	14.1	41.5	38.9	25.0	5	12	6	16	14	10

DHB WORKFORCE COMPETENCIES

- The capability of the workforce was assessed by the *Real Skills Plus ICAMHS competency framework* (The Werry Centre, 2009b), which describes the knowledge, skills and attitudes needed to work with infants, children and young people and whānau with a suspected or identified mental health or alcohol or other drug concern. The *Real Skills Plus online assessment tool* identifies the competencies that individual and teams meet from the framework, and highlights areas for knowledge and skill development for individuals and teams *(to access the tool and more information:* ***www.werryworkforce.org****)*.
- *Real Skills Plus* has three levels
    - **Primary Level** *for people in the primary sector that work with infants, children and young people.*
    - **Core Level** *for practitioners working in services that focus on mental health and/or AOD concerns.*
    - **Specific Level** *for senior or specialist practitioners working at an advanced level of practice.*
- *Real Skills Plus* data can be reported at service and team level and individually. The application of *Real Skills Plus* is most effective at an organisational level as it helps to develop a shared understanding of the knowledge and skills required by the whole service. It promotes the development of best practice across disciplines, creating a multi-skilled workforce at each level. *Real Skills Plus* allows targeted service development, recruitment and service delivery activities.
- The data presented in Figures 12 and 13 are the summary of the ***Core*** level competencies met by the Central region ICAMH/AOD DHB workforce in 2018. The DHB workforce met a number of ***Core*** level competencies (ranging from 60% to 100% of skills and knowledge required), and further development was indicated for the following:
    - ***Assessment Knowledge (29%)***
    - ***Intervention Skills (29%)***
    - ***Intervention Knowledge (22%).***
    - ***Knowledge and Skills for Leadership roles (19%).***
    - ***Knowledge and Skills for working with Children (19%).***

Figure 12. DHB *Real Skills Plus* Core Competencies (2018)

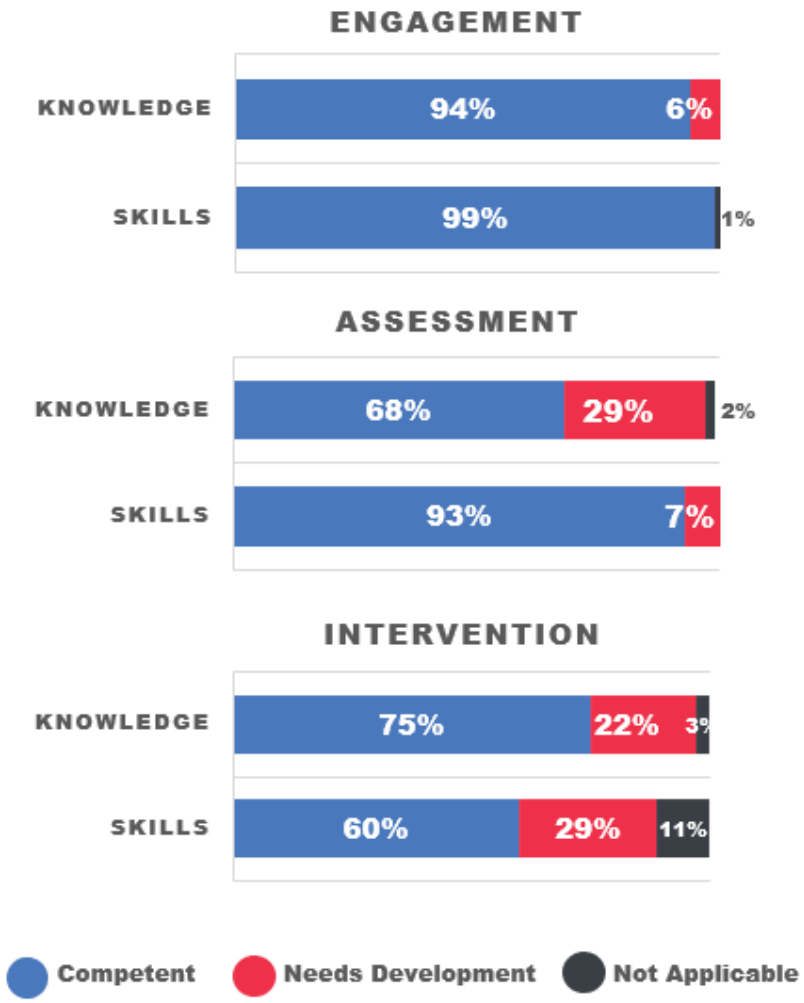
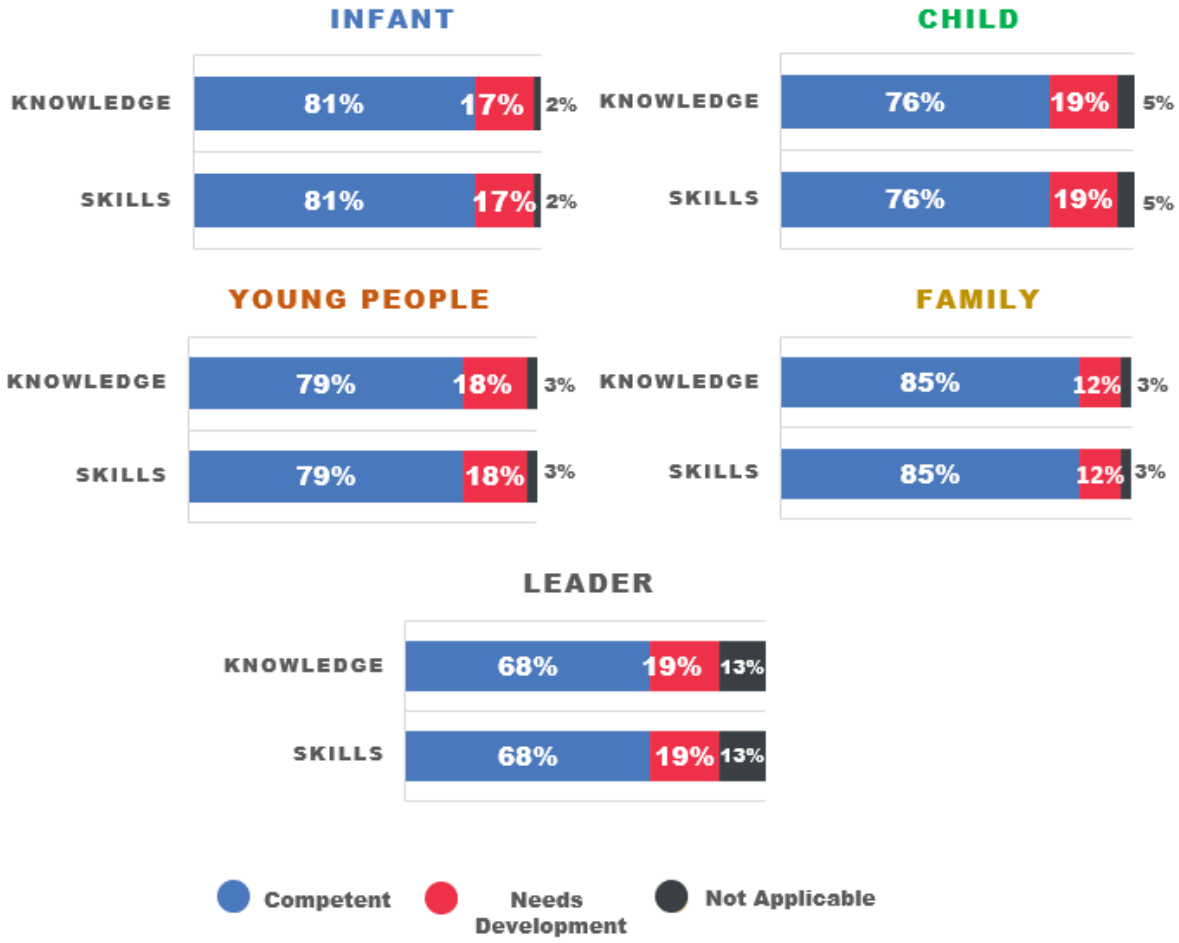


Figure 13. DHB *Real Skills Plus* Competecnies by Domain (2018)



NON-DHB ICAMH/AOD WORKFORCE

As at 30 June 2018:

- 78% of the non-DHB workforce was in the Capital & Coast (32%); MidCentral (27%) and Hutt (19%) DHB areas (Table 13).
- 51% in the clinical workforce largely as Counsellors (11%); Social Workers (9%), Alcohol & Drug Practitioners (8%) and Nurses (8%) (Table 9).
- 39% in the non-clinical workforce largely as Youth Workers (14%), Mental Health Support Workers (12%) and Peer Support Workers (6%) (Table 9).
- Annual non-DHB staff turnover rate 20% mainly for AOD Practitioners and Mental Health Support Workers. The main reasons for leaving included other external job opportunities, maternity leave and career development/further study.

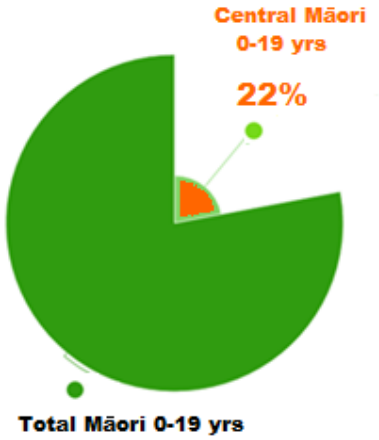
Table 13. Central Region Non-DHB ICAMH/AOD Workforce (2008-2018)

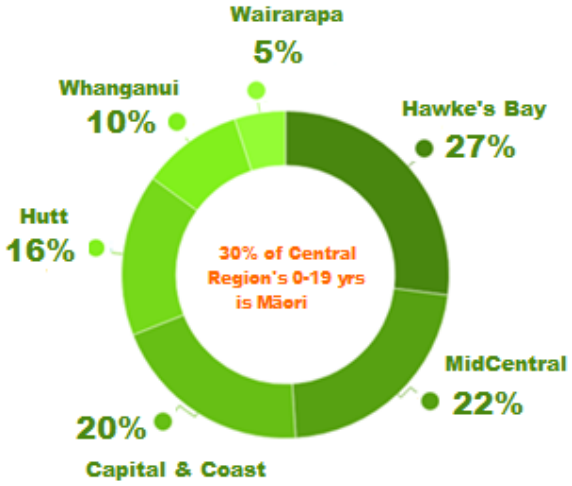
CENTRAL REGION DHB AREA	ACTUAL FTES						VACANT FTES					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
HAWKE'S BAY	23.0	11.5	10.6	14.67	4.0	5.0	-	-	-	-	-	-
MIDCENTRAL	15.2	14.6	18.7	21.5	16.5	28.5	-	-	-	-	-	-
WHANGANUI	4.1	1.0	2.95	6.25	3.4	10.2	-	-	-	-	-	6
CAPITAL & COAST	7.9	5.57	8.72	13.7	11.1	33.6	-	-	-	-	-	2
HUTT	22.5	7.8	21.0	22.3	15.8	20.5	-	-	-	--	-	-
WAIRARAPA	2.1	2.05	1.4	1.2	1.2	8.7	-	-	-	-	0.5	7
TOTAL	74.8	52.52	63.37	79.62	51.95	106.4	-	-	-	-	0.5	2

CENTRAL REGION MĀORI OVERVIEW

CENTRAL REGION MĀORI INFANT, CHILD AND ADOLESCENT POPULATION

- Population projections from 2016-2018 (based on the 2013 Census) indicated a 2% growth in the Māori 0-19 year population (Appendix A, Table 1). Increase seen across all DHB areas.
- Almost a quarter (22%) of New Zealand's Māori infant, child and adolescent population resided in the Central region (Appendix A, Table 1).
- Māori 0-19 year olds made up 30% of the region's total 0-19 years population and resided largely in Hawke's Bay and MidCentral DHB areas. Proportionally they also made up almost half of 0-19 year population in Hawke's Bay (by 42%) and Whanganui (by 43%) DHB areas.
- 10-year projections (2018-2028) indicate an 11% regional population growth across all six DHB areas: Wairarapa (by 15%), MidCentral (by 13%), Hawke's Bay (by 11%), Capital & Coast (by 10%), Hutt (by 9%) and Whanganui (by 8%) (Appendix A, Table 2).





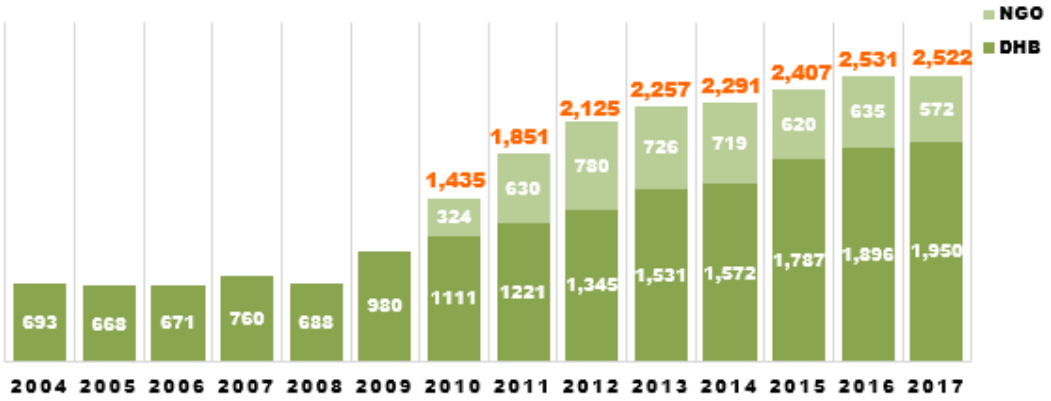
CENTRAL REGION MĀORI ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December).

From 2015 to 2017:

- 5% increase in the number of Māori service users accessing services in the region (Figure 14).
- Increase in both male and female service users by 7% and 2% respectively.
- Increase in service users in three out of the six DHB areas with the largest increase seen in Whanganui (by 42%) and Capital & Coast (by 30%) (Appendix B, Table 3). Decrease in Māori service users seen in Wairarapa (by 22%), Hawke's Bay (by 13%) and MidCentral (by 10%).

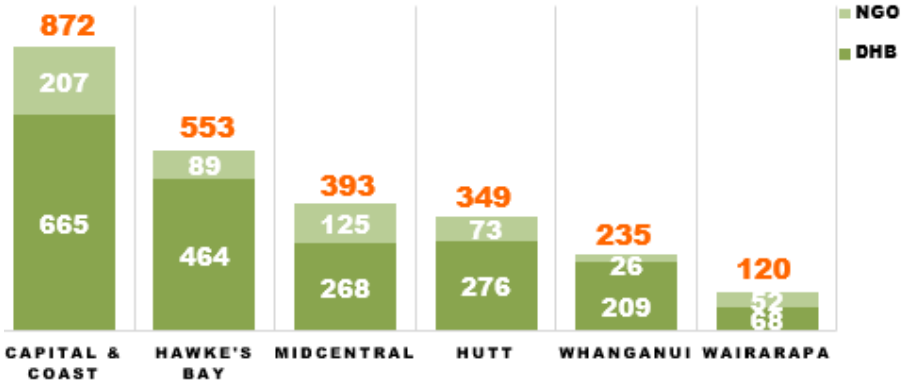
Figure 14. Central Region Māori 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Māori service users made up 35% of total service users accessing services in the region. 57% were Māori males.
- 57% of all Māori service users in the region accessed services in Capital & Coast (61%) and Hawke's Bay (39%) (Figure 15).
- 77% accessed DHB services and 23% accessed NGOs.
- Of note, 43% of Māori service users in the Wairarapa DHB area had accessed NGOs.

Figure 15. Central Region Māori 0-19 yrs Service User Access Rates (2004-2017)



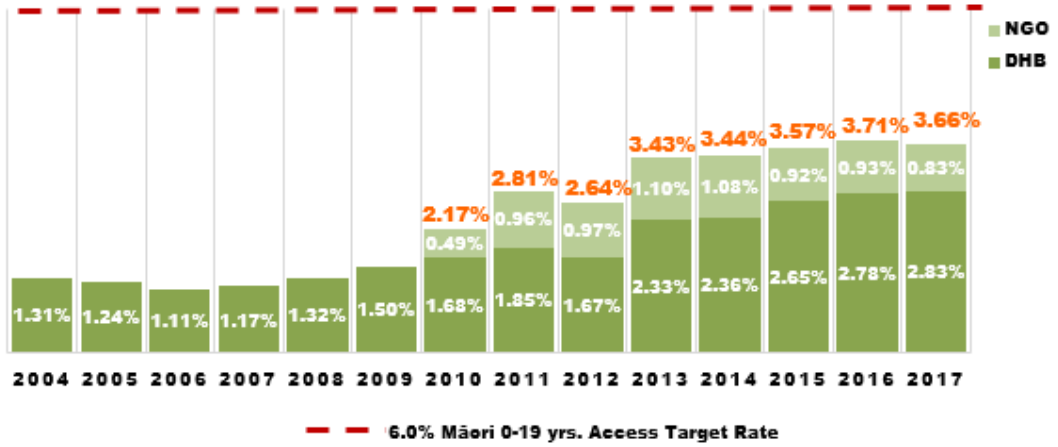
CENTRAL REGION MĀORI SERVICE USER ACCESS RATES

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, the access target rate for Māori was set at 6.0%, 3.0% higher than the general population due to a higher need for mental health services (Mental Health Commission, 1998).

From 2015 to 2017:

- Improvements in the overall regional Māori access rate from 3.57% to 3.66% (Figure 16). Improvements seen in all three age groups, especially in the 10-14 year age group (Appendix B, Table 9).
- Improvements in two out of the six DHB areas: Capital & Coast and Whanganui (Appendix B, Table 10).

Figure 16. Central Region Māori 0-19 yrs Access Rates (2004-2017)



In the second half of 2017:

- Māori service users had the highest access rate of 3.66% in the region but remained below the 6% recommended rate.
- By age, access rates for all three age groups remained below the respective recommended rates, especially for the 10-14 year age group.
- By DHB area, Capital & Coast DHB area had the highest Māori service user access rate of 6.33%, the only area exceeding the 6% recommended rate for Māori (Figure 17).
- While Māori service user access rates have improved in the region, they have not improved at a rate relative to need and therefore remain an area of focus.

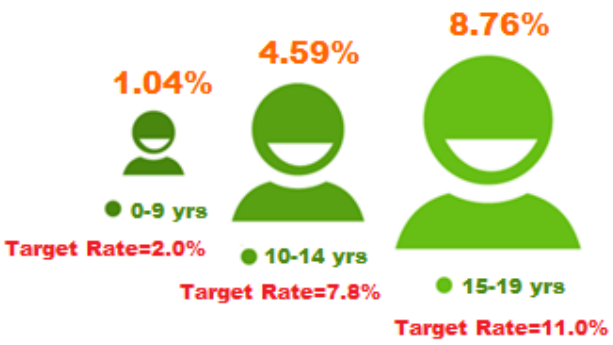
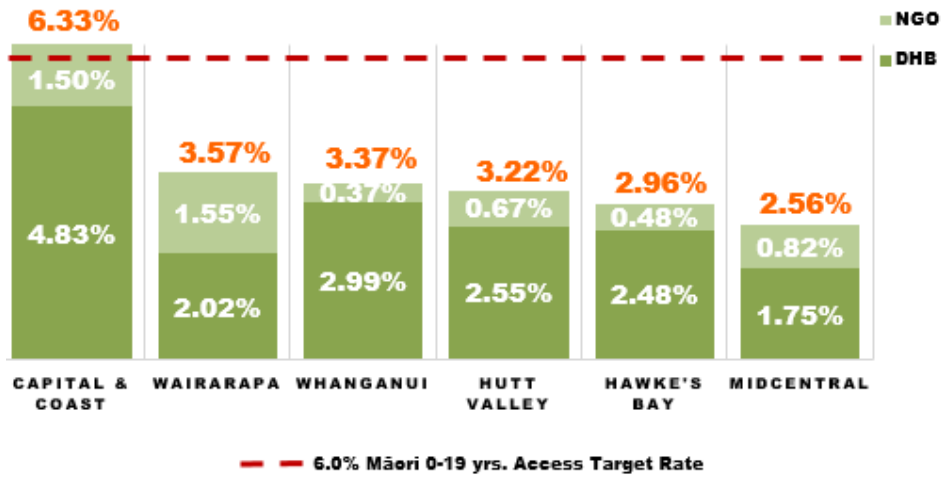


Figure 17. Central Region Māori 0-19 yrs Access Rates by DHB Area (2017)



CENTRAL REGION MĀORI ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by ethnicity & occupation submitted by all six DHB (Inpatient & Community) ICAMH/AOD services and all 29 contracted non-DHB services (Including 6 PHOs) as at 30 June 2018.

From 2016 to 2018:

- 1% overall increase in the regional Māori workforce, from 73 to 74 (Table 14).
- 28% increase in the Māori non-DHB workforce and a 16% decrease in the DHB workforce.

Table 14. Central Region Māori ICAMH/AOD Workforce by DHB Area (2008-2018)

CENTRAL REGION DHB AREA	DHB						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
HAWKE'S BAY	5	5	8	7	8	7	21	7	5	9	4	2	26	12	13	16	12	9
MIDCENTRAL	1	1	6	5	6	3	8	10	8	7	5	12	9	11	14	12	11	15
WHANGANUI	6	4	3	1	1	1	1	1	4	5	6	5	7	5	7	6	7	6
CAPITAL & COAST[1]	28	25	21	30	25	23	1	-	7	5	7	11	29	25	28	35	32	34
HUTT	3	1	1	2	1	1	7	3	15	8	5	5	10	4	16	10	6	6
WAIRARAPA	3	1	3	4	3	2	1	1	2	1	2	2	4	2	5	5	5	4
TOTAL	46	37	42	49	44	37	39	26	41	35	29	37	85	63	83	84	73	74

1. Includes Inpatient Workforce

As at 30 June 2018:

- The overall regional Māori workforce was equally split between DHB and non-DHB services. However, there were more Māori in non-DHB services within individual DHB areas such as MidCentral, Whanganui and Hutt DHB areas (Table 14).
- 66% of the Māori workforce was in the Capital & Coast (46%) and MidCentral (20%) DHB areas (Table 14 & Figure 19).
- 54% in the clinical workforce largely as Social Workers (14%), Nurses (12%) and Psychologist (11%) (Table 15 & Figure 18).

- 36% in the non-clinical workforce, largely as Youth Workers (9%), Mental Health Support Workers (9%) and Cultural Workers (9%).
- 9% in Administration (5%) and Management (4%) roles.

Figure 18. Central Region Top 4 Māori ICAMH/AOD Workforce (2018)

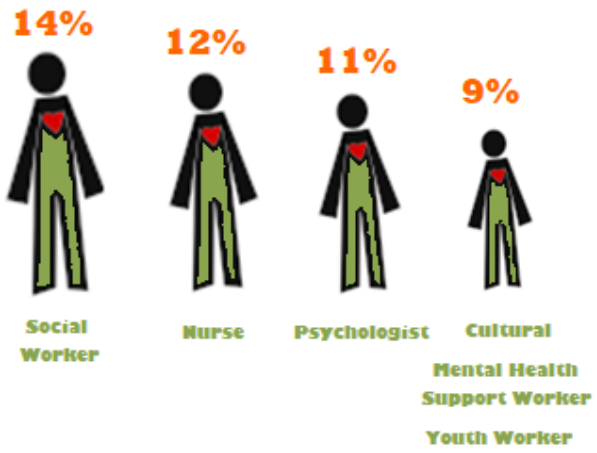
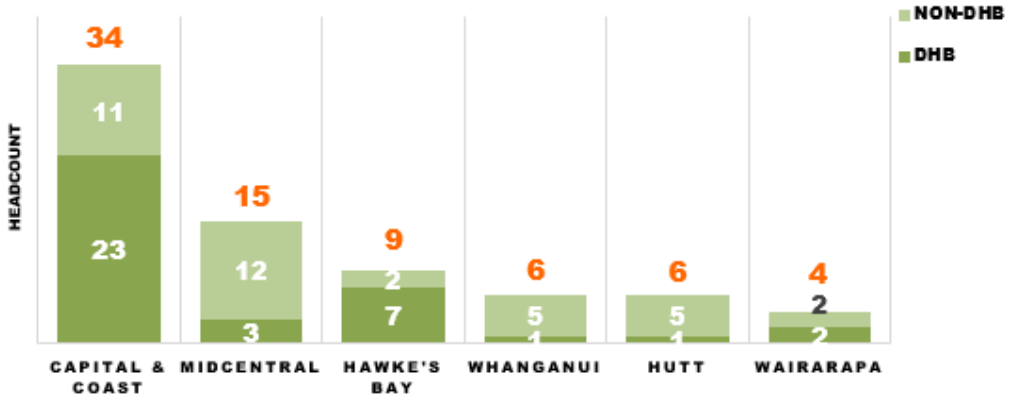


Figure 19. Central Region Māori ICAMH/AOD Workforce by DHB Area (2018)



DHB MĀORI INPATIENT ICAMH WORKFORCE

As at 30 June 2018:

- No change in the Māori inpatient workforce from 2016 to 2018.
- 67% in the non-clinical workforce as Mental Health Support Workers (2) and Cultural Workers (2).
- 33% in the clinical workforce as Nurses (2) (Table 15).

DHB MĀORI COMMUNITY ICAMH/AOD WORKFORCE

From 2016 to 2018:

- Overall decrease of 7, from 38 to 31. Decrease in the non-clinical workforce by 3, from 11 to 8.

As at 30 June 2018:

- Over half (55%) of the total Māori DHB community workforce (31) was in the Capital & Coast DHB services (17).
- 65% in the clinical workforce, largely as Social Workers (23%), Nurses (16%) and Psychologists (13%) (Table 15).
- 26% in the non-clinical workforce largely as Cultural (16%) and Mental Health Support Workers (6%).
- 10% in Administration (6%) and Management (3%) roles.

NON-DHB MĀORI ICAMH/AOD WORKFORCE

From 2016 to 2018:

- Overall increase of 8, from 29 to 37 (Table 14). Increase largely in the clinical workforce, by 8.

As at 30 June 2018:

- 62% of the Māori non-DHB workforce was in the MidCentral (32%) and Capital & Coast (30%) DHB areas.
- 49% in the clinical workforce, largely as AOD Practitioners (11%), Psychologists (11%), Counsellors (8%) and Social Workers (8%).
- 41% in the non-clinical workforce, largely as Youth Workers (19%) and Mental Health Support Workers (8%) (Table 15).

Table 15. Central Region Māori ICAMH/AOD Workforce by Occupation (2018)

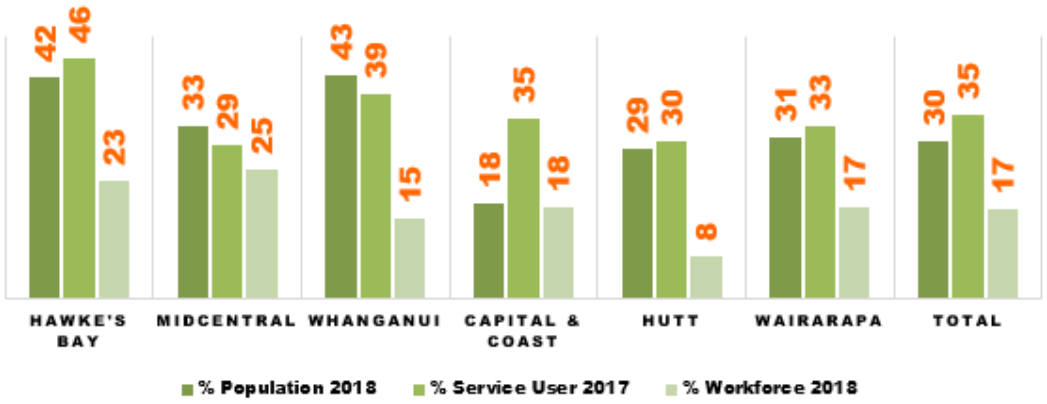
Central Region ICAMH/AOD Māori Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	-	-	4	4
Child & Adolescent Psychiatrist	-	2	2	-	2
Counsellor	-	-	-	3	3
Nurse	2	5	7	2	9
Psychologist	-	4	4	4	8
Social Worker	-	7	7	3	10
Other Clinical[1]	-	2	2	2	4
Clinical Sub-Total	2	20	22	18	40
Cultural Worker	2	5	7		7
Mental Health Consumer	-	-	-	1	1
Mental Health Support Worker	2	2	4	3	7
Peer Support Worker	-	-	-	2	2
Youth Worker	-	-	-	7	7
Other Non-Clinical[2]	-	1	1	2	3
Non-Clinical Sub-Total	4	8	12	15	27
Administration	-	2	2	2	4
Management	-	1	1	2	3
Total	6	31	37	37	74

1. Other Clinical = Clinical Placement; CEP Clinician; Kai Manaaki
2. Other Non-Clinical = Educator; Service Coordinator

CENTRAL REGION MĀORI POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

- An increasing trend can be seen in the Māori service user access to services; however, access rates remain below the target rates for all three age groups indicating unmet needs. Therefore, improving Māori access to services remains critical in the region.
- Additionally, increasing trends in Māori service users accessing services in the region (5% increase from 2015 to 2017) highlights significant disparities between service user demand and the workforce indicating a need for increasing the Māori workforce to meet current and future demand considering an 11% projected population growth by 2028 (Figure 20).
- The majority of Māori service users also continued to access DHB services and were largely seen by the non-Māori workforce. Therefore, strengthening and developing the current workforce (both Māori and non-Māori) to be clinically and culturally competent is also critical.

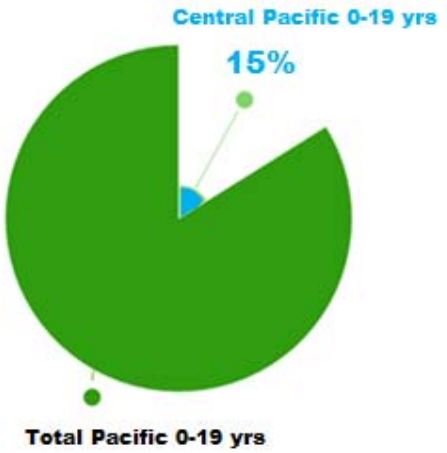
Figure 20. Māori 0-19 yrs Population, Service User & Workforce Comparisons



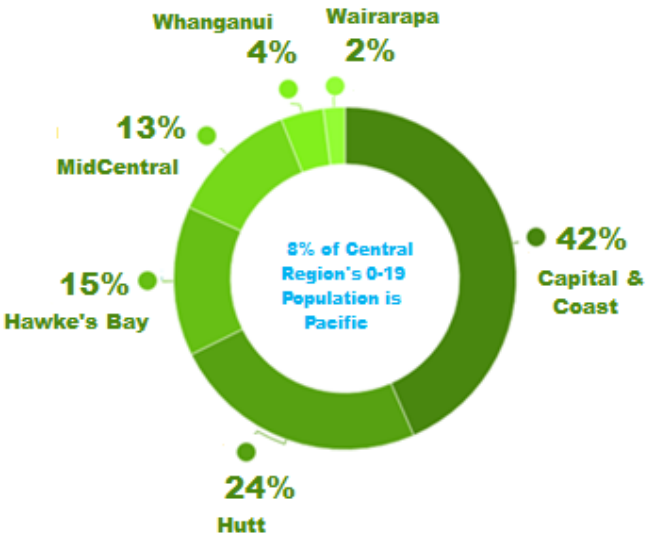
CENTRAL REGION PACIFIC OVERVIEW

CENTRAL REGION PACIFIC INFANT, CHILD AND ADOLESCENT POPULATION

- 2016 to 2018 population projections (based on Census 2013) indicated a 2% growth in the regional Pacific 0-19 year population (Appendix A, Table 1).
- Growth projected in four out of the six DHB areas, with the largest growth in MidCentral and Hawke's Bay (by 6%) and Whanganui (by 5%).
- Central region continued to have the second largest Pacific infant, child and adolescent population (15%) in the country (Appendix A, Table 1).
- Pacific infants, children and adolescents made up 8% of the region's infant, child and adolescent population.
- Almost half (42%) of the region's Pacific 0-19 year population resided in the Capital & Coast DHB area, followed by Hutt (24%).



- 10-year projections (2018-2028) indicates a 9% regional growth in Pacific 0-19 year olds.
- Projections by DHB area indicated growth in five out of the six areas: MidCentral (by 28%), Whanganui (by 25%), Hawke's Bay (by 23%), and Wairarapa (by 13%). Very little growth projected for Capital & Coast and Hutt (Appendix A, Table 2).



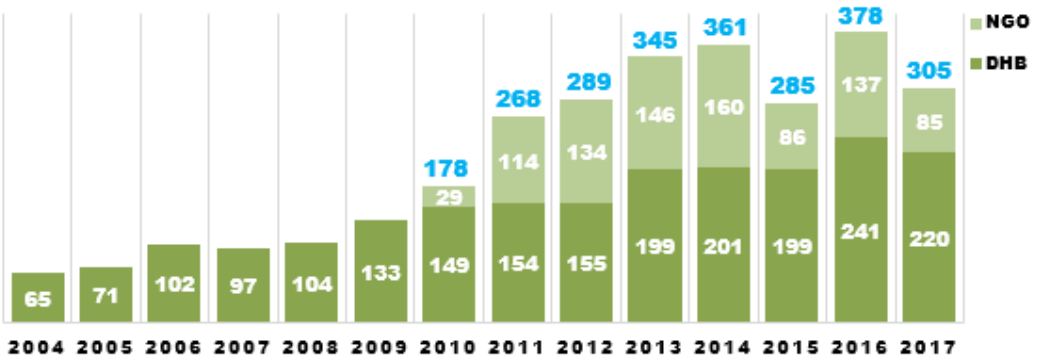
CENTRAL REGION PACIFIC SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December).

From 2015 to 2017:

- 7% increase in Pacific service users accessing services, in DHB services only (by 11%) (Figure 21). Increase in females by 18%, while males decreased by 1%.
- Increase in Pacific service users in three of the six DHB areas (Whanganui by 56%, Wairarapa by 20% and Capital & Coast by 17%), decreases in Hutt by 15% and Hawke's Bay by 5%, and no change in MidCentral.

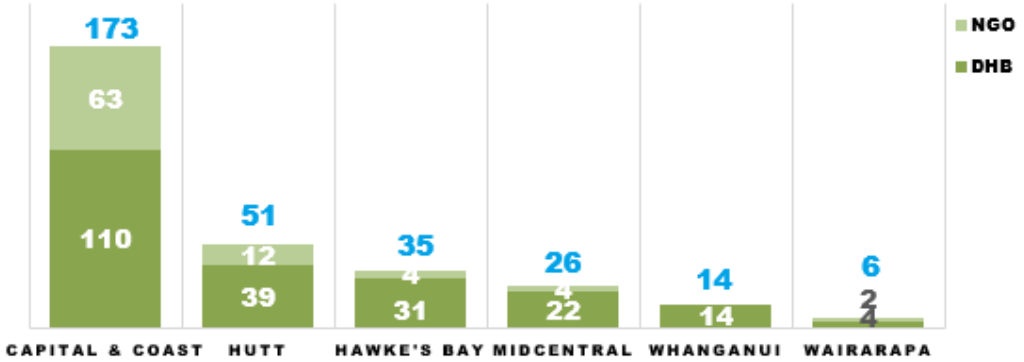
Figure 21. Central Region Pacific 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Pacific service users made up 4% of total service users accessing services. 53% were Pacific males.
- 72% accessed DHB services and 28% accessed NGOs.
- 85% of all Pacific service users in the region were seen by services in Capital & Coast (67%), Hutt (20%) and Hawke's Bay (14%) (Figure 22).

Figure 22. Central Region Pacific 0-19 yrs Service User by DHB Area (2017)



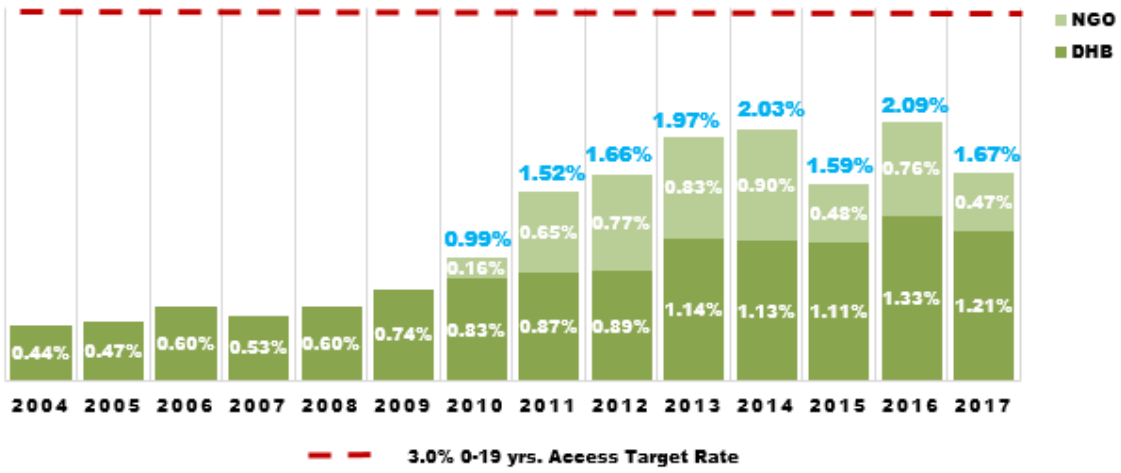
CENTRAL REGION PACIFIC SERVICE USER ACCESS RATES

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, access rates have been set 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 target rates 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, 2006) so the general recommended target access rates may be a conservative estimate of actual need.

From 2015 to 2017:

- Improvements seen in the regional Pacific service user access rate from 1.59% to 1.67% and in the 0-9 and 15-19 year age groups only. A decrease in the 10-14 year age group from 2.57% to 2.10% (Figure 23 & Appendix B, Table 11).
- Improvements in three out of the six DHB areas only: Whanganui, Capital & Coast and Wairarapa (Appendix B, Table 12).

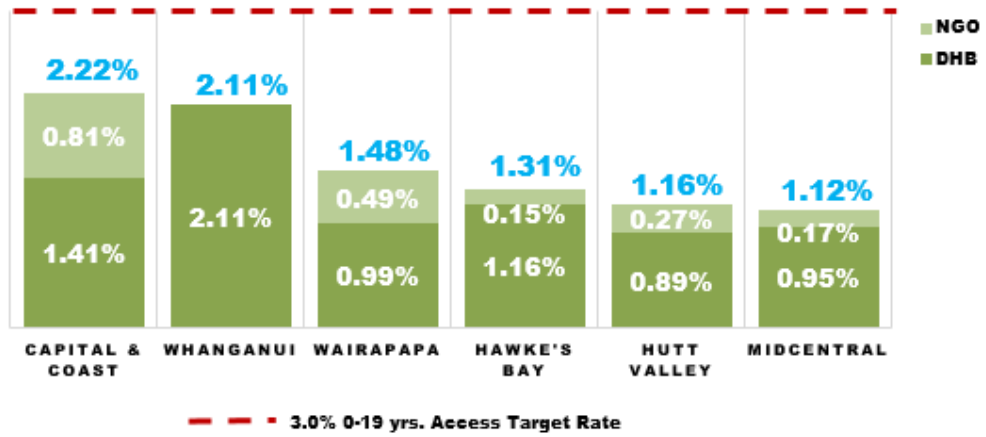
Figure 23. Central Region Pacific 0-19 yrs Service User Access Rates (2004-2017)



In the second six months of 2017:

- By age, access rates for all three age groups remained below the respective target rates, especially for the 10-14 and 15-19 year age groups.
- By DHB area, Capital & Coast had the highest Pacific service user access rate of 2.22%, followed by Whanganui (2.11%) (Figure 24).
- Despite improvements in the regional Pacific access rate, it remained below the target rates for all three age groups and across all DHB areas. Therefore, improving access to services for the Pacific population remains a key focus in this region.

Figure 24. Pacific 0-19 yrs Service User Access Rates by DHB Area (2017)



Note: While Pacific access rates by DHB area are presented, data should be interpreted with caution due to very small numbers (< 20) of Pacific service users accessing services within individual DHB areas (Whanganui & Wairarapa). Access rates based on the total number of Pacific service users in the region (i.e. regional access rates) produce more meaningful access rates.

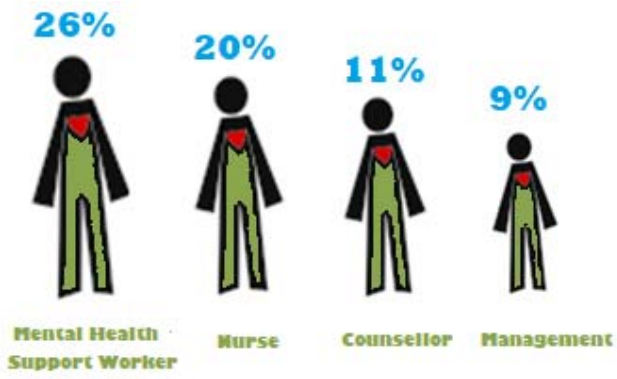
CENTRAL REGION PACIFIC ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by ethnicity and occupation, submitted by all six DHB (Inpatient & Community) ICAMH/AOD services and all 29 contracted non-DHB providers (including 6 PHOs) as at 30 June 2018.

From 2016 to 2018:

- An increase of 7 in the regional Pacific workforce from 28 to 35 (Table 16).
- Increase in the Pacific clinical workforce, from 11 to 16.

Figure 25. Central Region Top 4 Pacific ICAMH/AOD Workforce (2018)



As at 30 June 2018:

- 80% of the regional Pacific workforce was in services in the Capital & Coast DHB area (Table 16).
- 63% employed in DHB services and 37% in non-DHB services.
- 46% were in the clinical workforce largely as Nurses (20%) and Counsellors (11%) (Table 17).
- 43% were in the non-clinical workforce largely as Mental Health Support Workers (26%).
- 70% of the workforce was Samoan, followed by Cook Island, all fluent or semi-fluent in their languages.

Table 16. Central Region Pacific ICAMH/AOD Workforce by DHB Area (2008-2018)

DHB AREA	DHB[1]						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
HAWKE'S BAY	1	-	-	-	-		-	1	-	1	1		1	1	-	1	1	-
MIDCENTRAL	-	-	-	-	-		-	-	1	-	2	3	-	-	1	-	2	3
WHANGANUI	-	-	-	-	-		2	-	1	-	-	1	2	-	1	-	-	1
CAPITAL & COAST[1]	12	17	14	18	22	21	2	2	3	6	3	7	14	19	17	24	25	28
HUTT	1	2	2	-	-	1	2	1	1	2	-	2	3	3	3	2	-	3
WAIRARAPA	-	-	-	-	-		-	-	-	-	-		-	-	-	-	-	-
TOTAL	14	19	16	18	22	22	6	4	6	9	6	13	20	23	22	27	28	35

1. Includes Inpatient Services

PACIFIC DHB INPATIENT ICAMH WORKFORCE

From 2016 to 2018:

- An increase of 3, from 5 to 8 (Table 16).

As at 30 June 2018:

- The Pacific inpatient workforce was Mental Health Support Workers (63%) and Nurses (38%) (Table 17).

PACIFIC DHB COMMUNITY PACIFIC ICAMH/AOD WORKFORCE

From 2016 to 2018:

- A decrease of 3, from 17 to 14 (Table 17).

As at 30 June 2018:

- Almost all of the Pacific DHB community workforce (14) was in the Capital & Coast DHB services (14).
- 50% in the clinical workforce, largely as Nurses (29%) (Table 17).
- 36% in the non-clinical workforce, as Mental Health Support Workers (21%) and in Cultural roles (14%).

PACIFIC NON-DHB ICAMH/AOD WORKFORCE

From 2016 to 2018:

- An increase from 6 to 13, largely due to an increase in the number of services included in this stocktake (Table 17).

As at 30 June 2018:

- 1 Pacific service in the Central region, in the Capital & Coast DHB area.
- 54% of the Pacific non-DHB provider workforce was in the Capital & Coast DHB area.
- 46% in the clinical workforce, largely as Counsellors (31%).
- 38% in the non-clinical workforce, as Peer Support Workers (15%) and Educators (15%) (Table 17).

Table 17. Central Region Pacific ICAMH/AOD Workforce by Occupation (2018)

Central Region ICAMH/AOD Pacific Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Counsellor	-	-	-	4	4
Nurse	3	4	7	-	7
Psychologist	-	1	1	-	1
Social Worker	-	1	1	1	2
Other Clinical[1]	-	1	1	1	2
Clinical Sub-Total	3	7	10	6	16
Cultural	-	2	2	-	2
Educator	-	-	-	2	2
Mental Health Support Worker	5	3	8	1	9
Peer Support Worker	-	-	-	2	2
Non-Clinical Sub-Total	5	5	10	5	15
Administration	-	1	1	-	1
Management	-	1	1	2	3
Total	8	14	22	13	35

1. Other Clinical = Registrar; Family Therapist.

CENTRAL REGION PACIFIC POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

- While an increasing trend can be seen in the Pacific service users accessing services, access rate remains below the target rates for all three age groups indicating unmet needs. Therefore, improving Pacific access to services remains critical.
- With such persistently low access rates for the Pacific population, the overall regional Pacific workforce appears to be proportional to Pacific service users accessing services. However, significant disparities between service user demand and the workforce can be seen within individual DHB areas (Figures 26 & 27). An increasing trend in the Pacific population (10 year projections indicate a 9% growth by 2028) and the number of Pacific service users accessing services means that increasing the Pacific workforce to meet future demand should remain a focus.
- The majority of Pacific service users continued to access DHB services and were largely seen by the non-Pacific workforce. Therefore, strengthening and developing the current workforce to be clinically and culturally competent is also essential.

Figure 26. Pacific 0-19 yrs Population, Service User & Workforce Comparisons

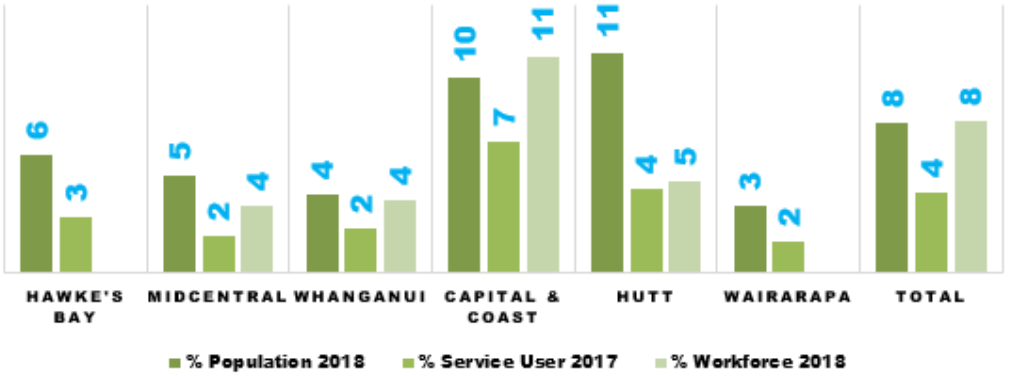
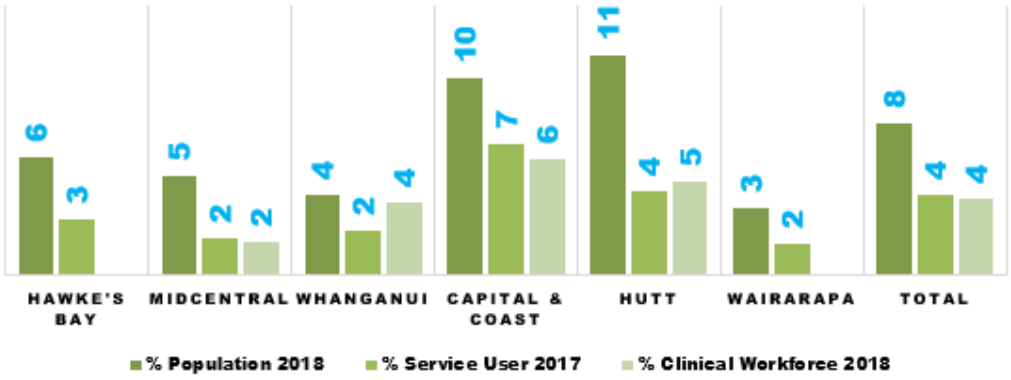


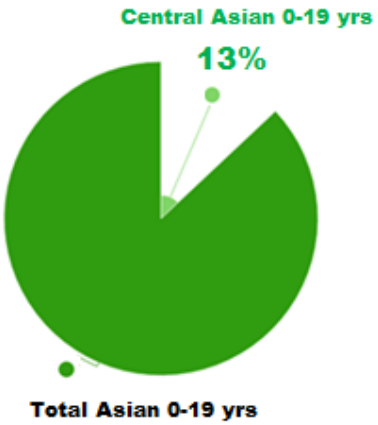
Figure 27. Pacific -19 yrs Population, Service User & Clinical Workforce Comparisons



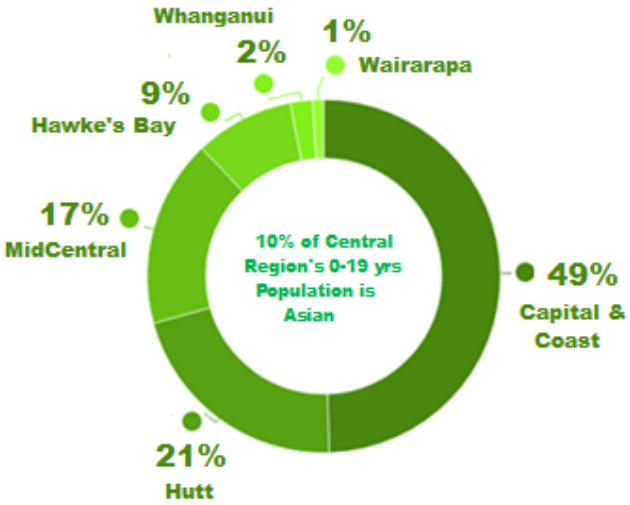
CENTRAL REGION ASIAN OVERVIEW

CENTRAL REGION ASIAN INFANT, CHILD AND ADOLESCENT POPULATION

- 2016-2018 population projections (based on Census 2013) indicated a 7% growth in the regional Asian 0-19 year population, the largest growth out of three ethnic groups (Appendix A, Table 1).
- Growth projected for all six DHB areas with the largest increase seen in Hawke's Bay and MidCentral both by 9%, followed by Wairarapa by 8%, Whanganui, Capital & Coast and Hut, all by 7%.
- Central region had the third largest Asian infant, child and adolescent population in the country (13%).
- Asian infants, children and adolescents made up 10% of the region's infant, child and adolescent population.
- Almost half (49%) of the region's Asian population resided in the Capital & Coast DHB area, followed by the Hutt (21%) and MidCentral (17%).



- 10-year projections (2018-2028) indicate a 32% regional growth in Asian 0-19 year olds, the largest population growth out of the four ethnic groups.
- Projected growth indicated in all six areas: Whanganui (by 52%), Hawke's Bay (by 37%), Hutt (by 36%), Wairarapa (by 32%), Capital & Coast (by 30%) and MidCentral (by 28%) (Appendix A, Table 2).
- Such a large projected population growth would need to be taken into consideration when planning for service and workforce development in the region.

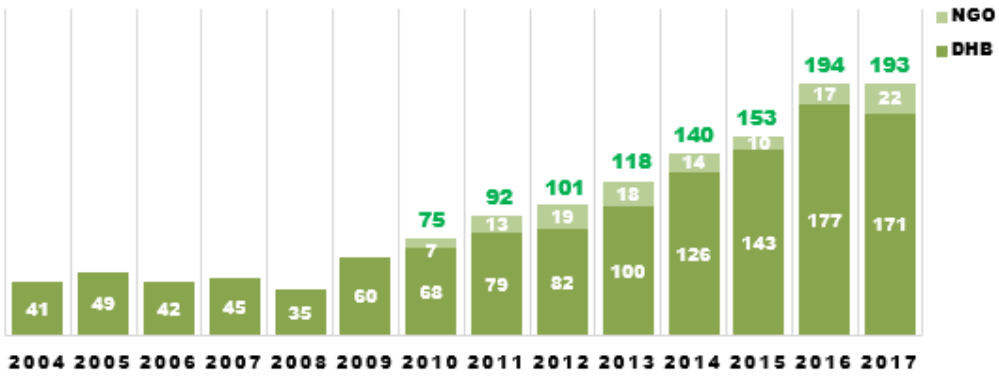


CENTRAL REGION ASIAN SERVICE USER ACCESS TO ICAMH/AOD SERVICES

From 2015 to 2017:

- 26% increase in Asian service users accessing services, especially females 47% (Figure 28).
- Increase in Asian service users in both DHB services and NGOs.

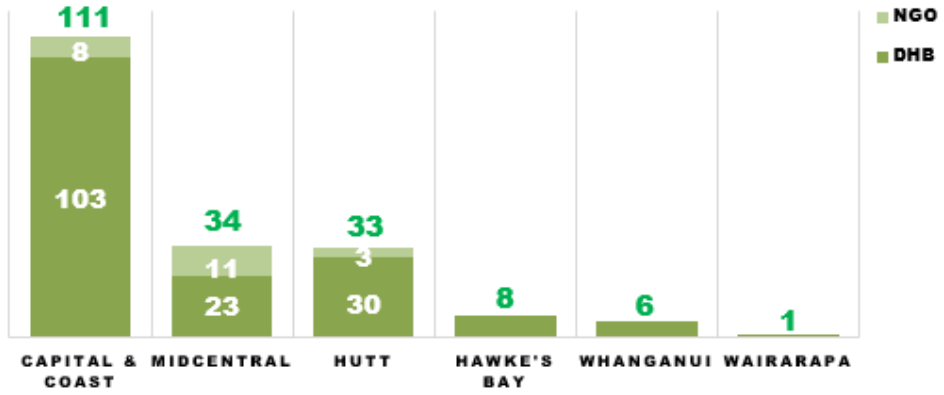
Figure 28. Central Region Asian 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Asian service users made up 3% of the all service users accessing services in the region, with Asian females making up the majority (55%) of Asian service users.
- Despite the increase, Asian service user numbers (193) have remained relatively low compared to the number of Māori (2,522) and Pacific (305) service users.
- 89% accessed DHB services and 11% accessed NGOs.
- 92% of Asian service users in the region were seen in services in the Capital & Coast (62%), MidCentral (19%) and Hutt (19%) DHB areas (Figure 29).

Figure 29. Central Region Asian 0-19 yrs Service User by DHB Area (2017)



CENTRAL REGION ASIAN SERVICE USER ACCESS RATES

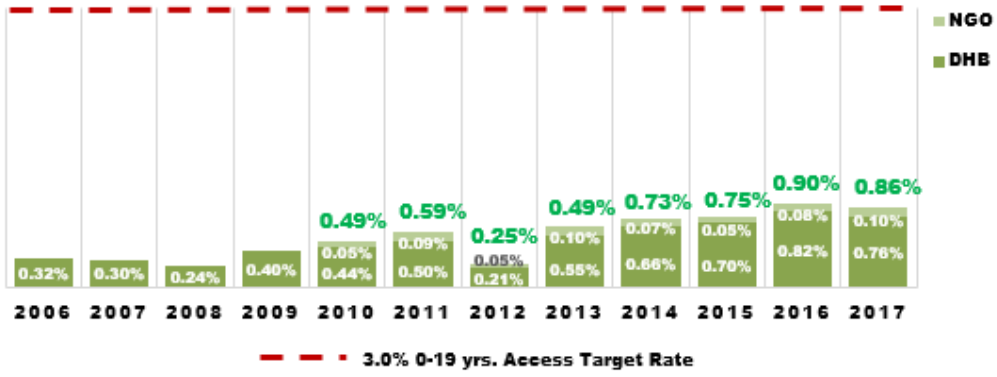
The *Blueprint Access Benchmark Rate* for the 0-19 year age group has been set at 3% of the population over a six-month period (Mental Health Commission, 1998). Due to different prevalence rates for mental illness in different age groups, the MHC has set appropriate access rates for each age group: 1% 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 access targets for Asian, therefore the Asian access rates have been compared to the 3% target rate.

From 2015 to 2017:

- Increase in Asian service users have led to an improvement in the overall Asian service user access rate, from 0.75% to 0.86% (Figure 30). Increase in access rates only for 15-19 year olds (Appendix B, Table 13).
- Improvements seen in three out of the six DHB areas: Whanganui, MidCentral and Capital & Coast (Appendix B, Table 14).

Figure 30. Central Region Asian 0-19 yrs Service User Access Rates (2004-2017)



In the second half of 2017:

- By age, access rates for all three age groups remained significantly below their respective target rates, especially for the 15-19 year age group.
- Therefore, improving access rates for the Asian population needs to be a focus in this region, especially in the Capital & Coast DHB area (Figure 31).

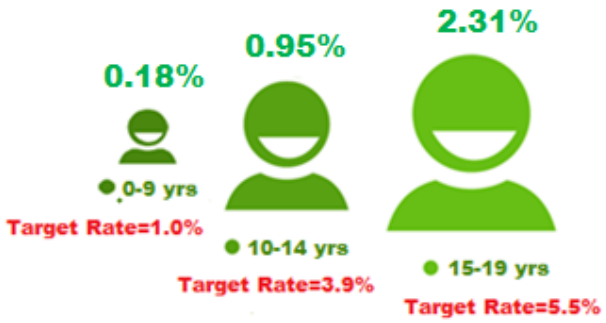
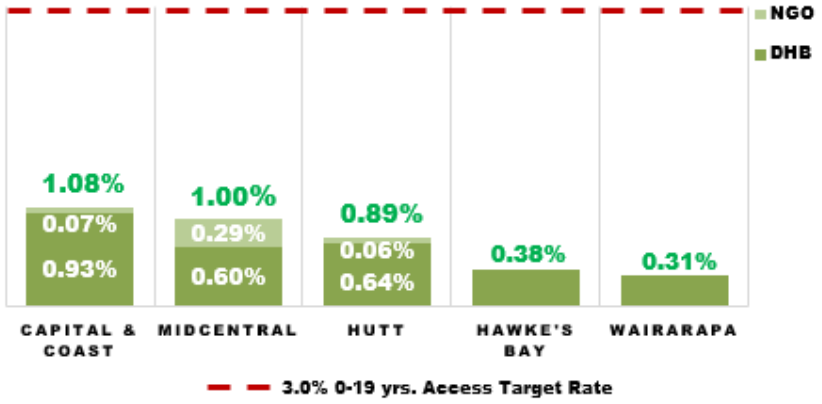


Figure 31. Central Region Asian 0-19 yrs Service User Access Rates by DHB Area (2017)



Note: Asian access rates by DHB area (Figure 27) should be interpreted with caution due to very small numbers (< 20) of Asian service users within individual DHB areas (e.g. Hawke's Bay, Whanganui & Wairarapa). Regional access rates produce more meaningful access rates for the Asian population.

CENTRAL REGION ASIAN ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by ethnicity by Occupation, submitted by all six DHB (Inpatient & Community) ICAMH/AOD services and all 29 contracted non-DHB providers (including 6 PHOs) as at 30 June 2018.

From 2016 to 2018:

- An increase of 6, from 11 to 17 (Table 18).
- Increase in the non-DHB workforce by 5, due to the inclusion of additional services.

As at 30 June 2018:

- 76% of the region's Asian workforce was in services in the Capital & Coast DHB area, largely in Capital & Coast DHB services (Table 18).
- 59% in the clinical workforce as Nurses, Occupational Therapists and Psychologists.
- The remainder were in the non-clinical workforce as Mental Health Support Workers (Table 19).

Table 18. Central Region Asian ICAMH/AOD Workforce by DHB Area (2012-2018)

DHB AREA	2012			2014			2016			2018		
	DHB	NON-DHB	TOTAL	DHB	NON-DHB	TOTAL	DHB	NON-DHB	TOTAL	DHB	NON-DHB	TOTAL
HAWKE'S BAY	1	-	1	-	-	-	-	-	-	-	-	-
MIDCENTRAL	-	2	2	1	1	2	2	1	3	2	1	3
WHANGANUI	1	-	1	1	-	1	1	-	1	-	-	-
CAPITAL & COAST[1]	6	-	6	3	1	4	6	-	6	9	4	13
HUTT	1	-	1	1	1	2	1	-	1	-	1	1
WAIRARAPA	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	9	2	11	6	3	9	10	1	11	11	6	17

1. **Includes Inpatient Workforce**

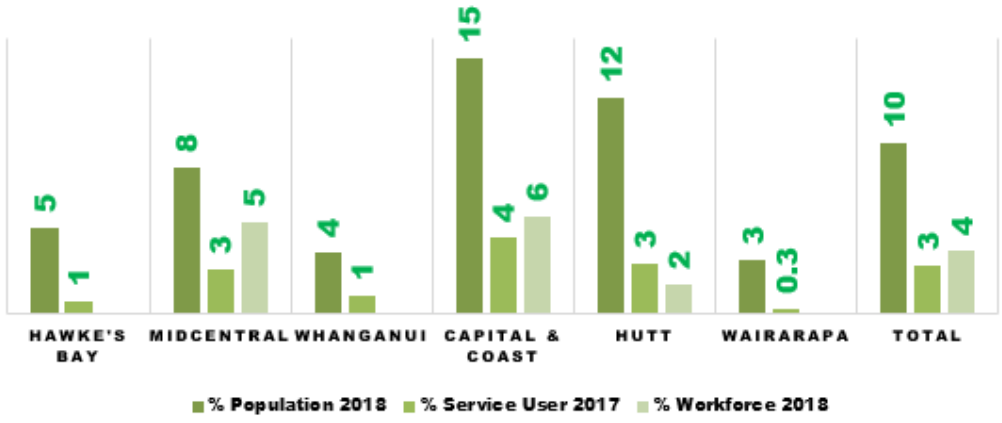
Table 19. Central Region Asian ICAMH/AOD Workforce by Occupation (2018)

Central Region ICAMH/AOD Asian Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	-	-	1	1
Child & Adolescent Psychiatrist	-	1	1	-	1
Nurse	2	-	2	-	2
Occupational Therapist	-	2	2	-	2
Psychologist	-	2	2	-	2
Other Clinical	-	1	1	1	2
Clinical Sub-Total	2	6	8	2	10
Mental Health Support Worker	-	-	-	4	4
Non-Clinical Sub-Total	-	-	-	4	4
Administration	-	3	3	-	3
Total	2	9	11	6	17

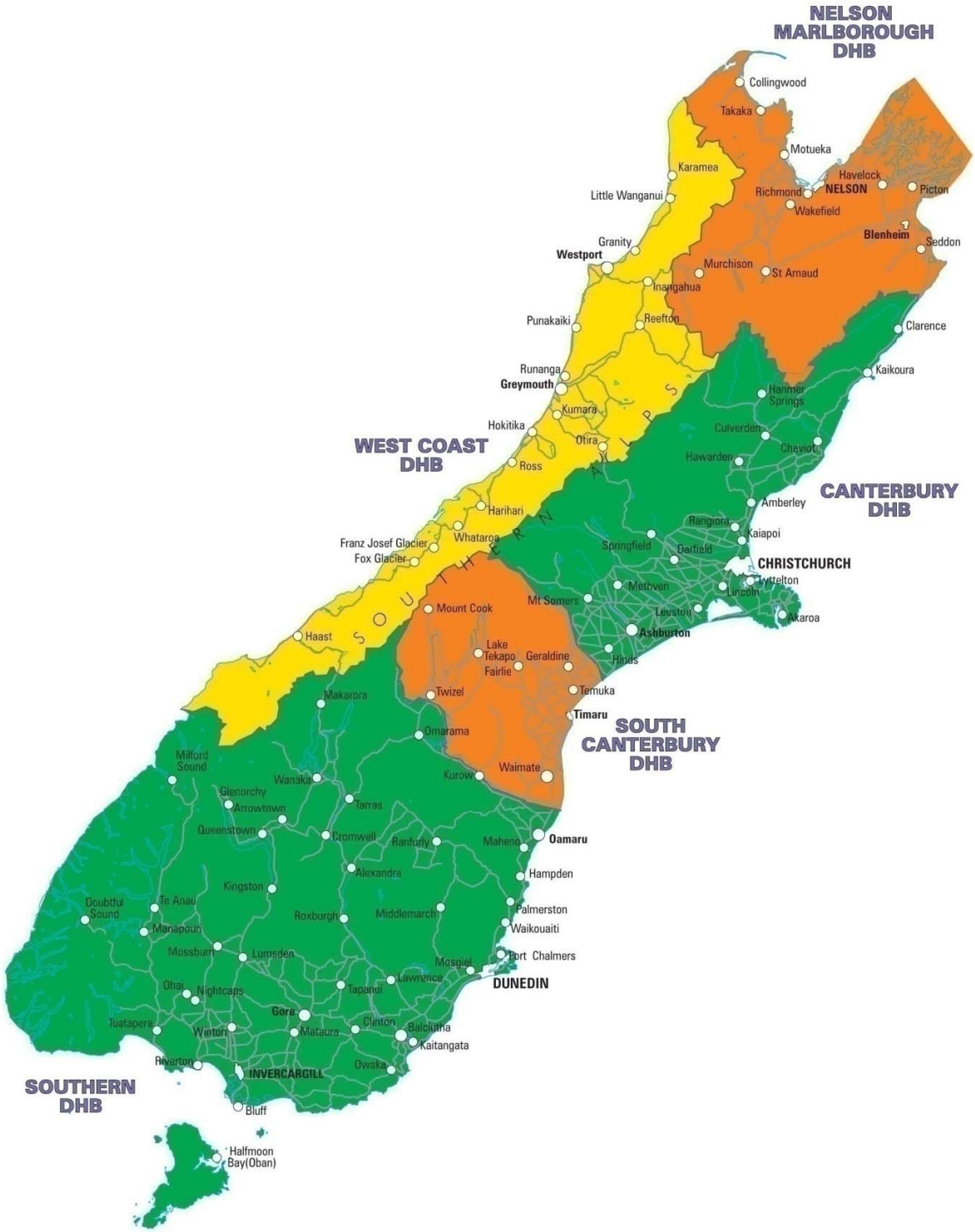
CENTRAL REGION ASIAN POPULATION, SERVICE USER & WORKFORCE COMPARISONS

- While an increasing trend can be seen in the number of Asian service users accessing services in the region, access rates remained below the target rates for all three age groups indicating unmet needs (Figure 32). Therefore, improving Asian access to services remains critical for the region.
- With such persistent low access rates for the Asian population (lowest out of the four ethnic groups), the overall regional Asian workforce appears to be representative of Asian service users accessing services. An increasing trend in the Asian population (10-year projections indicate a 32% growth by 2028, the largest projected growth out of the four ethnic groups) and the number of Asian service users accessing services means that increasing the Asian workforce to meet future demand should remain a focus.
- The majority of Asian service users continued to access DHB services and were largely seen by the non-Asian workforce. Therefore, strengthening and developing the current workforce to be clinically and culturally competent is also essential.

Figure 32. Asian 0-19 yrs Population, Service User & Workforce Comparisons

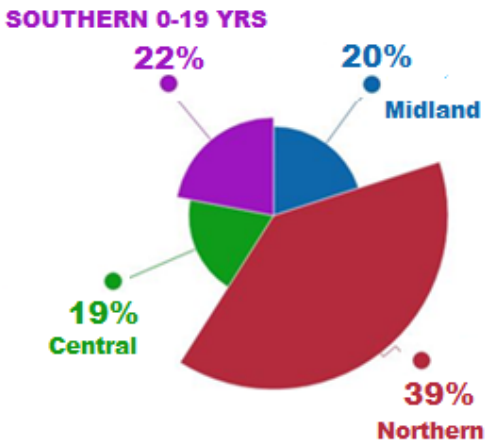


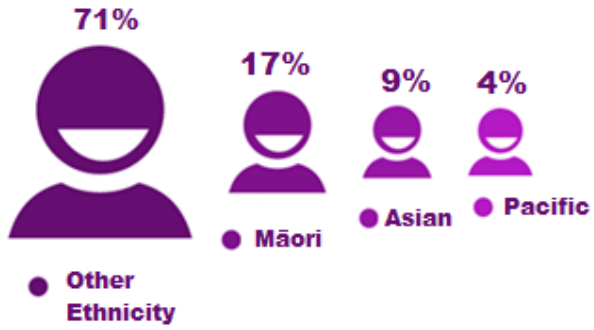
SOUTHERN REGION INFANT, CHILD AND ADOLESCENT MENTAL HEALTH & AOD OVERVIEW



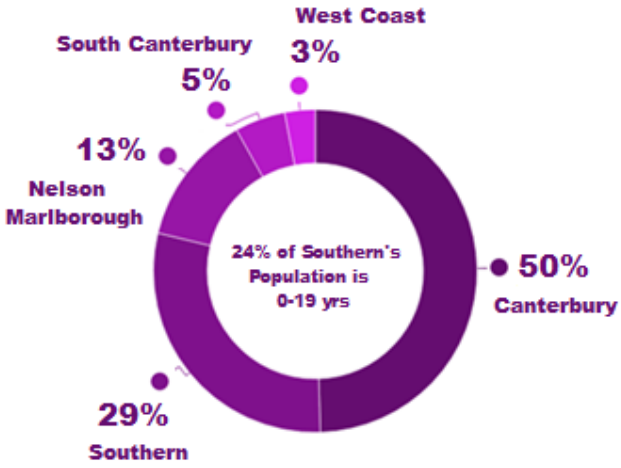
SOUTHERN REGION INFANT, CHILD AND ADOLESCENT POPULATION PROFILE

- 2016-2018 population projections (based on Census 2013) indicated an overall population growth of 1% in the regional 0-19 year population (Appendix A, Table 1).
- Growth projected for the Canterbury DHB area by 1.5% and West Coast by 1%.
- Southern region has New Zealand's second largest (22%) infant, child and adolescent (0-19 years) population.
- Majority of the regions 0-19 year population was in the Other Ethnicity group (71%), followed by Māori (17%), Asian (9%) and Pacific (4%).
- Half (50%) of the region's 0-19 year population resided in the Canterbury DHB area.





- 10-year population (2018-2028) projections indicate a somewhat static growth of only 0.2%. However, projections by ethnicity indicates population growth for Māori (by 19%), Pacific (by 33%) and the largest growth for the Asian (by 34%) 0-19 year population (Appendix A, Table 2).
- Service and workforce development planning will need to be considered in light of these population projections.



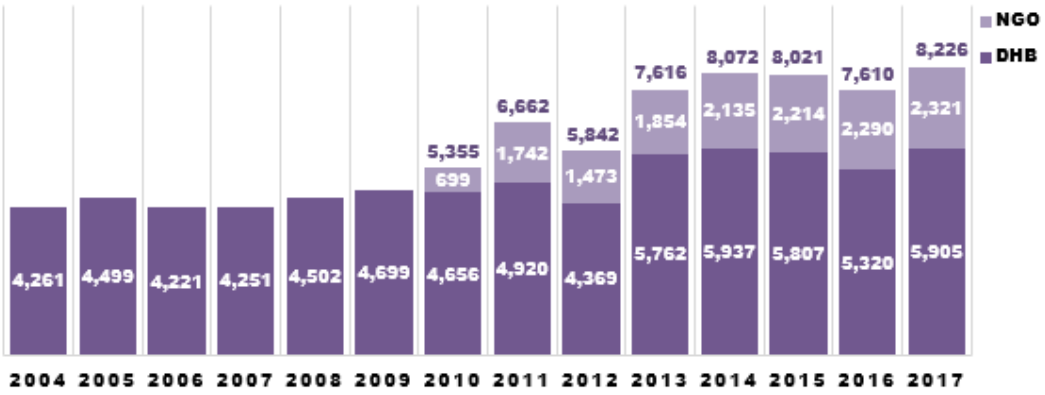
SOUTHERN REGION SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December). NGO service user data have been included since 2010.

From 2015 to 2017:

- 3% increase in the number of service users accessing services (Figure 1). Increase seen in both female and male service users, largely in the 15-19 year age group by 4% (Appendix B, Table 2).

Figure 1. Southern Region 0-19 yrs Service User (2004-2017)

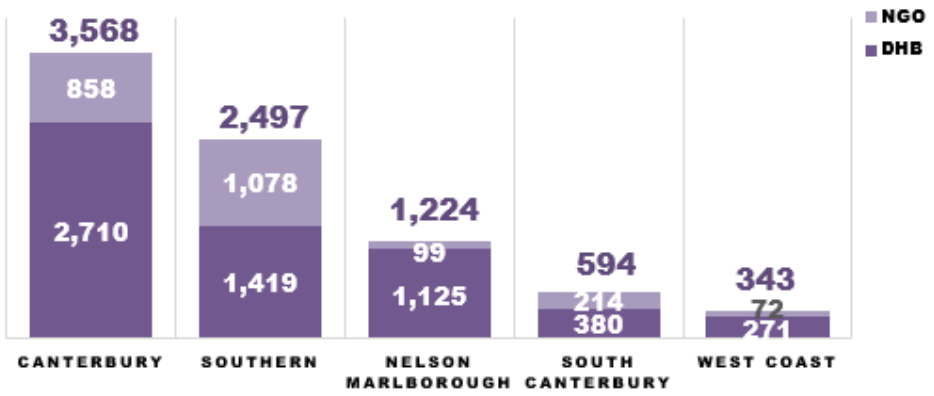


- Increase seen in four out of the five DHB areas, Nelson Marlborough (by 25%), West Coast (16%) and Canterbury (by 3%). Very little change seen in South Canterbury, and a 7% decrease in Southern.

In the second half of 2017:

- Equal proportions of male and female service users accessed services in the region (Appendix B, Table 2).
- 55% of service users were 15-19 year olds.
- 72% accessed DHB services and 28% accessed NGOs (Figure 1).
- 74% of all service users in the region were seen by services in Canterbury (59%) and Southern (41%) DHB areas (Figure 2).

Figure 2. Southern Region 0-19 yrs Service User by DHB Area (2017)



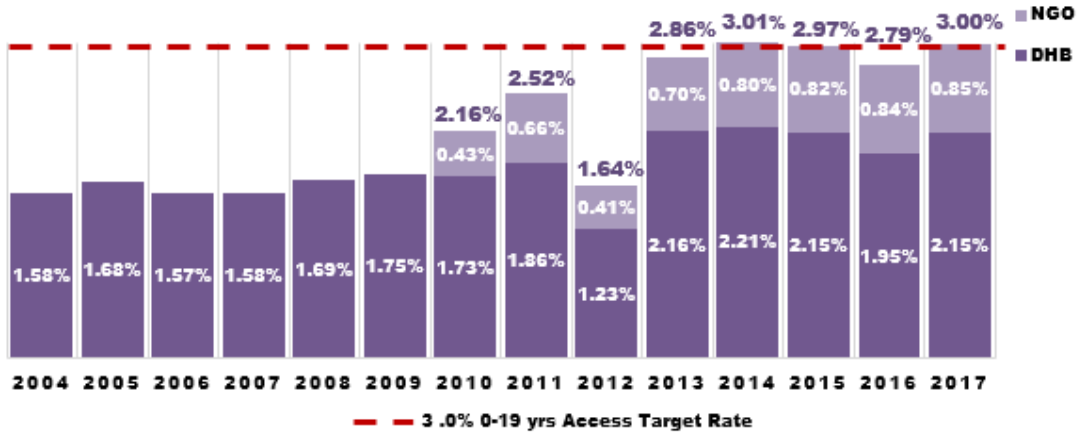
SOUTHERN REGION SERVICE USER ACCESS RATES

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.

From 2015 to 2017:

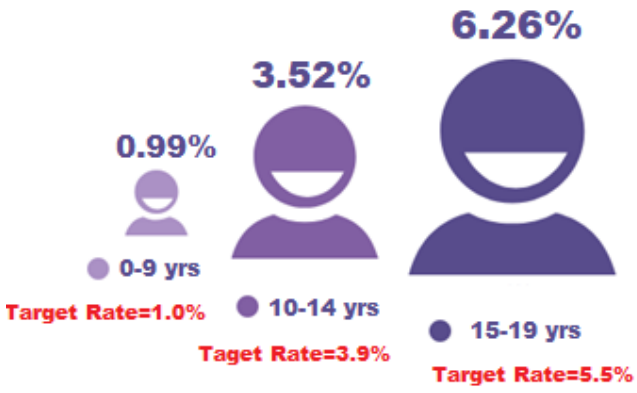
- Increase in the regional service user access rate from 2.97% to 3.0%, reaching the target rate of 3% (Figure 3). Access rate improved for 15-19 year olds year age only (Appendix B, Table 8).
- Access rates improved in four out of the five DHB areas: Nelson Marlborough, West Coast, South Canterbury and Canterbury. Decline in access rate seen for the Southern DHB area.

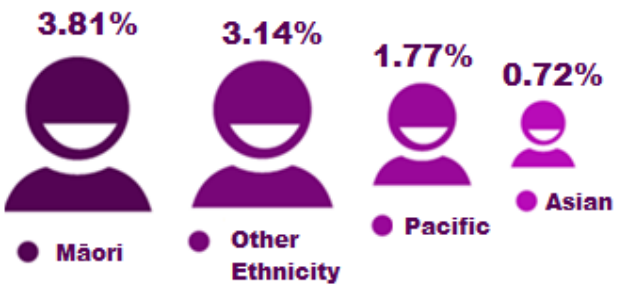
Figure 3. Southern Region 0-19 yrs Service User Access Rates (2004-2017)



In the second half of 2017:

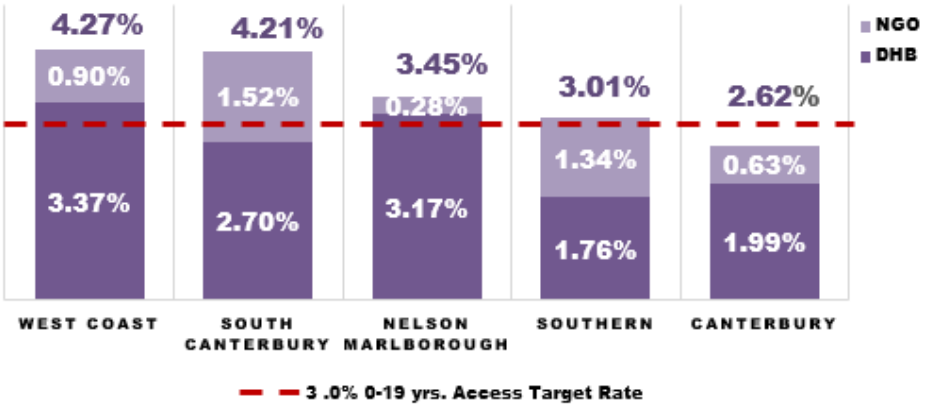
- By age, 15-19 year olds were the only age group exceeding their respective target rate, while improvements were required for 0-9 and 10-14 year olds.
- Māori had the highest access rate of 3.81% yet remained below their recommended rate of 6%. Therefore, service users from the 'Other Ethnicity' group (3.14%) were the only group with an access rate that exceeded the 3% target rate. Asian service users continued to have the lowest rate (0.72%) in the region.





- By DHB area, four out of the six DHB areas had service user access rates that exceeded the target rate of 3%, while the access rate for Canterbury (2.62%) remained below the target rate (Figure 4).
- Therefore, improving access rates for Māori, Pacific and Asian service users, especially in the Canterbury DHB area remains an area of focus.

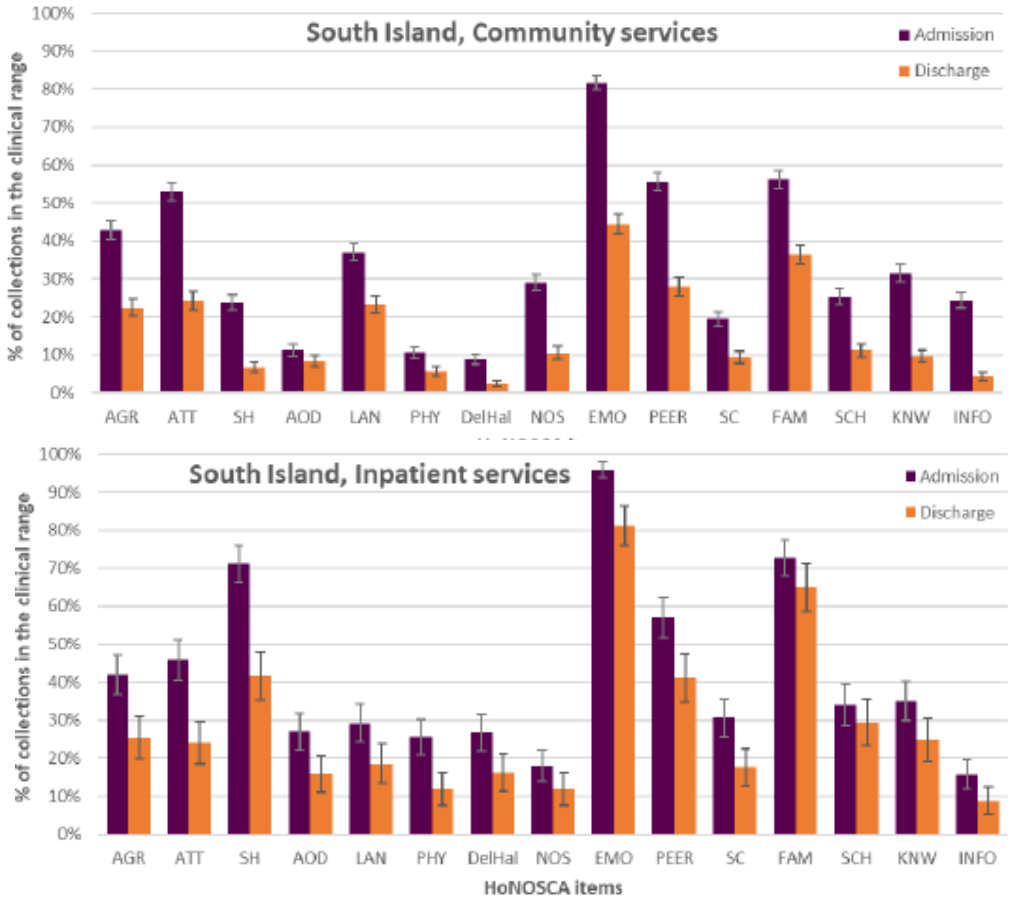
Figure 4. Southern Region 0-19 yrs Access Rates by DHB Area (2017)



SERVICE USER OUTCOMES

To assess whether service users 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 Adolescent aged 4-17 years) at admission and discharge from community child and adolescent mental health services. Service user outcome data for the 2018 period showed improvements across all items, especially emotional related symptoms, by time of discharge from both community and inpatient mental health services for service users; however, improvements were statistically significant only for community services (EMO scores in Figure 5).

Figure 5. Southern Region 0-19 yrs Service User HoNOSCA Results (2018)



SOUTHERN REGION FUNDING OF ICAMH/AOD SERVICES

From 2015/2016 to 2017/2018 financial year:

- 3% increase in total funding for ICAMH/AOD services in the Southern region (Figure 6 & Table 1).
- Increase only in non-DHB providers by 13% (Table 1 & Figure 6).
- Largest increases in funding by service in Youth Forensic by 10% (Table 1).
- Increases in three out of the five DHB areas: Southern (by 7%), Canterbury (by 5%) and Nelson Marlborough (by 2%). Slight decreases in West Coast (by 2%) and South Canterbury (by 3%).

Figure 6. Southern Region ICAMH/AOD Funding (2004-2018)

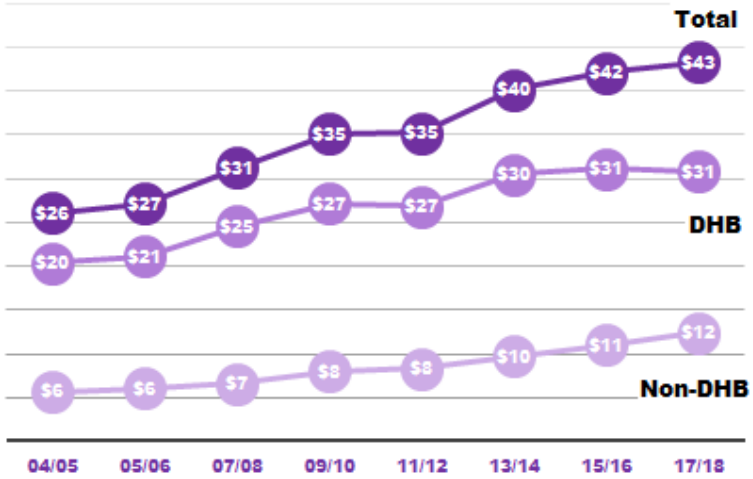


Table 1. Southern Region ICAMH/AOD Funding by Services (2008-2018)

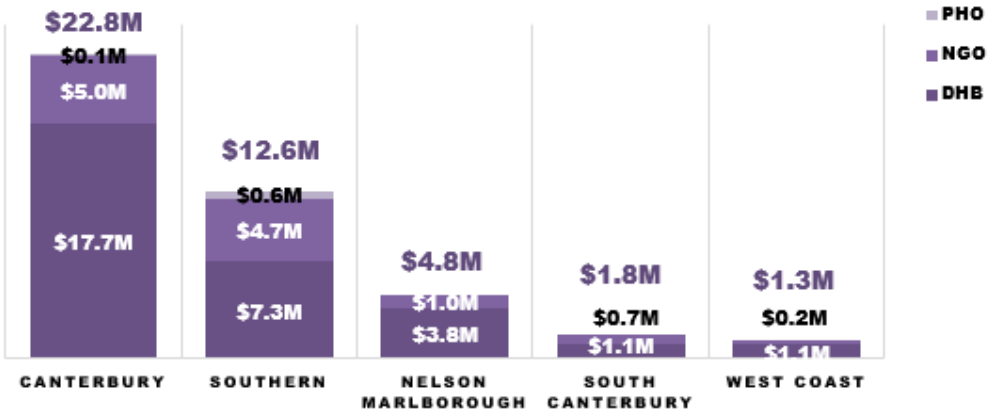
SERVICES	SOUTHERN REGION INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD FUNDING (2007-2018)						
	07/08	09/10	11/12	13/14	15/16	17/18	% CHANGE (2018-2016)
INPATIENT	$5,491,702	$5,877,775	$5,495,535	$5,359,726	$5,428,955	$4,961,913	-9
ALCHOL & OTHER DRUG	$3,513,717	$3,690,858	$4,165,985	$5,239,970	$5,676,728	$5,466,904	-4
CHILD & YOUTH MENTAL HEALTH	$22,269,900	$24,937,805	$25,481,813	$29,091,577	$29,906,412	$31,361,960	5
FORENSIC	-	-	-	$546,000	$685,379	$754,575	10
KAUPAPA MĀORI	-	$653,588	$79,032	-	-		
YOUTH PRIMARY MENTAL HEALTH	-	-	-	-	$446,239	$791,758	*
TOTAL	$31,275,320	$35,160,026	$35,222,365	$40,237,273	$42,143,712	$43,337,110	3

Source: Ministry of Health Price Volume Schedule 2007-2014. *Not calculated.

For the June 2017 to July 2018 financial year:

- Southern region provider services received 24% ($43.3 million) of the total national funding ($183.5M) for infant, child and adolescent mental health/AOD services (Table 1).
- 71% of the regional funding for DHB services; 29% for non-DHB providers.
- 72% allocated to Child and Youth Mental Health Services, 13% to AOD, 11% to Inpatient and 2% to Forensics.
- 2% of the funding was allocated to Youth Primary Mental Health Services.
- Services in the Canterbury DHB area had the largest proportion (43%) of funding in the region, followed by Southern (29%) (Figure 7).

Figure 7. Southern Region ICAMH/AOD Funding by DHB Area (2018)



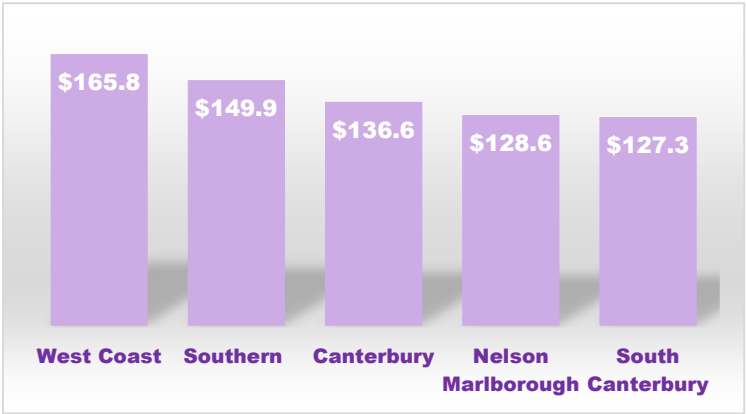
FUNDING PER HEAD INFANT, CHILD AND ADOLESCENT POPULATION

Funding per head of population is a method by which we can look at the equity of funding across the regions and DHBs. Clearly, this is not the actual amount spent per head of 0-19 years population, as only a small proportion of this population access services (Appendix B, Table 7).

From 2014 to 2016:

- 3% increase in the regional spend per 0-19 year population (excluding Inpatient funding) from $130.97 to $134.67 (Appendix C, Table 7).
- Increase in spend per 0-19 year population in four out of the five DHB areas; a decrease in South Canterbury by 2%, from $129.17 to 126.80 (Figure 8).

Figure 8. Southern Region spend per 0-19 yrs (2018)



SOUTHERN REGION PROVISION OF ICAMH/AOD SERVICES

Five DHBs provide specialist inpatient and community-based Infant, child and adolescent mental health/alcohol and other drugs (ICAMH/AOD) services: Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs. Services are now inclusive of infants with either dedicated services or teams for the infant (0-4) age group. Regional inpatient mental health services are provided by Canterbury DHB.

ICAMH/AOD services are also provided by DHB-funded NGOs and PHOs. For the June 2017 to July 2018 period, 28 non-DHB services (including 1 PHO) were identified as providing ICAMH/AOD and youth primary mental health services.

Table 2. Nelson Marlborough ICAMH/AOD Services (2017/2018)

NELSON MARLBOROUGH DHB
Child & Adolescent Mental Health Service
Alcohol & Other Drugs

NELSON MARLBOROUGH DHB-FUNDED NON-DHB SERVICES
GATEWAY HOUSING TRUST
Child, Adolescent & Youth Mental Health Community Care with Accommodation (Nelson)
Infant, Child, Adolescent & Youth Community Support Services (Nelson, Motueka, Blenheim)
TE PIKI ORANGA LTD
Kaupapa Māori Infant, Child, Adolescent & Youth Community Mental Health Services & Support Services
TE WHARE MAHANA TRUST BOARD
Infant, Child, Adolescent & Youth Community Support Services

Note: Italicised services are Kaupapa Māori services

Table 3. West Coast ICAMH/AOD Services (2017/2018)

WEST COAST DHB
Infant, Child & Adolescent Mental Health Service & Alcohol & Drug Services
Also provides services for COPMIA, Eating Disorders, Youth Forensics, Child Development Services (CDS), Parenting Programmes: Incredible Years, Parent Child Interaction Therapy (PCIT), Gateway Assessments

WEST COAST DHB-FUNDED NON-DHB SERVICES
PACT GROUP
Infant, Child, Adolescent, & Youth Community Support Services

Table 4. Canterbury ICAMH/AOD Services (2017/2018)

CANTERBURY DHB
Child, Adolescent & Family Mental Health Service: North
Child, Adolescent & Family Mental Health Service: South
Consult Liaison Service to NGOs/PHOs
Child, Adolescent & Family Rural Service
Children in Care Team
School Based Mental Health Team & Paeds Consult Liaison & Therapies
Youth Forensic Team
REGIONAL SERVICES
Child, Adolescent & Family Inpatient Unit
Child & Adolescent Day Unit
Youth Forensic Service
Also provides services for Gateway Assessments, Co-Existing Problems (CEP), Youth Forensics, Refugee, Migrant Mental Health Services, Parenting Programmes: Triple P, Circle of Security, Fostering Security

CANTERBURY DHB-FUNDED NON-DHB SERVICES
ASHBURTON COMMUNITY ALCOHOL & DRUG SERVICE INC
Children & Youth Alcohol & Drug Community Services
CHRISTCHURCH CITY MISSION
Child, Adolescent & Youth Alcohol & Drug Community Services
CHRISTCHURCH METHODIST CENTRAL MISSION
Infant, Child, Adolescent & Youth Inpatient Beds
COMMUNITY WELLBEING NORTH CANTERBURY TRUST
Children & Youth Alcohol & Drug Community Services
DEPRESSION SUPPORT NETWORK
Peer Support Service for Children & Youth
EMERGE AOTEAROA
Child, Adolescent & Youth Mental Health Community Care with Accommodation (Multi-Systemic Therapy (MST Christchurch; Supported Accommodation; Mobile Community Support)
Infant, Child, Adolescent & Youth Community Support Services
FAMILIAL TRUST
Peer Support Services: Child, Adolescents, Youth & Families with a Mental Health Disorder
HE WAKA TAPU
Child, Adolescent & Youth Alcohol & Drug Community Services
MENTAL HEALTH ADVOCACY & PEER SUPPORT TRUST
Peer Service for Children & Youth
ODYSSEY HOUSE TRUST
Child, Adolescent & Youth Community Alcohol & Drug Services with Accommodation
Alcohol & Other Drug Day Treatment Programme
Community Child, Adolescent & Youth Service for Co-existing Problems
PURAPURA WHETU TRUST
Community Child, Adolescent & Youth Service for Co-existing Problems

CANTERBURY DHB-FUNDED NON-DHB SERVICES CONTINUED
STEPPING STONE TRUST
Community Child, Adolescent & Youth Service for Co-existing Problems
Infant, Child & Youth Crisis Respite
Infant, Child, Adolescent & Youth Community Mental Health Services
Child, Adolescent & Youth Mental Health Community Care with Accommodation
ST JOHN OF GOD YOUTH & COMMUNITY SERVICES-HAUORA TRUST
Child, Adolescent & Youth Alcohol & Drug Community Services
Infant, Child, Adolescent & Youth Community Mental Health Services
Youth Primary Mental Health Service: Brief Intervention Service - Youth
STOP TRUST
Infant, Child, Adolescent & Youth Community Mental Health Services
TE TAI O MAROKURA CHARITABLE TRUST
Kaupapa Māori Child, Adolescent & Youth Alcohol & Drug Community Services

Note: Italicised services are Kaupapa Māori services

Table 5. South Canterbury ICAMH/AOD Services (2017/2018)

SOUTH CANTERBURY DHB
Child & Adolescent Psychiatric Services
Māori Mental Health Team
Youth Alcohol & Other Drug Service
Also provide services for Gateway Assessments, Peer Support/Advocacy, Youth Forensics, Family Therapy, Cognitive Behavioural Therapy (CBT) & Referrals to Peer Support Agencies

SOUTH CANTEBURY DHB-FUNDED NON-DHB SERVICES
ADVENTURE DEVELOPMENT LTD
Children & Youth Alcohol & Drug Community Services
Community Child, Adolescent & Youth Service for Co-existing Problems
Infant, Child, Adolescent & Youth Community Mental Health Services
AROWHENUA WHĀNAU SERVICES
Infant, Child, Adolescent & Youth Community Mental Health Services

Note: Italicised services are Kaupapa Māori services

Table 6. Southern ICAMH/AOD Services (2017/2018)

SOUTHERN DHB
Child, Adolescent & Family Service (Gore, Invercargill, Balclutha)
Child & Family Service (Otago, Waitaki, Wakatipu, Dunstan)
Youth Specialty Service (Otago)
Youth Forensic Service
Also provides services for: COPMIA, Eating Disorders, Co-Existing Problems (CEP) and Gateway Assessments

SOUTHERN DHB-FUNDED NON-DHB SERVICES
ADVENTURE DEVELOPMENT LTD
Child, Adolescent & Youth Alcohol & Drug Community Services
Community Child, Adolescent & Youth Service for Co-existing Problems
Youth Primary Mental Health Service
AROHA KI TAMARIKI CHARITABLE TRUST
Children & Youth Alcohol & Drug Community Services
Child & Youth Planned Respite
Community Child, Adolescent & Youth Service for Co-existing Problems
COSTORPHINE BAPTIST COMMUNITY TRUST
Child, Adolescent & Youth Mental Health Community Care with Accommodation
Infant, Child, Adolescent & Youth Community Support Services
MIRAMARE LTD
Infant, Child, Adolescent & Youth Services: Needs Assessment & Service Co-ordination
OTAGO YOUTH WELLNESS TRUST
Infant, Child, Adolescent & Youth Community Mental Health Services
PACT GROUP
Infant, Child, Adolescent & Youth Crisis Respite
Infant, Child, Adolescent & Youth Community Mental Health & Support Services
Child, Adolescent & Youth Mental Health Community Care with Accommodation
Child, Adolescent & Youth Community Based Day Activity Service
WELLSOUTH PRIMARY HEALTH NETWORK
Infant, Child, Adolescent & Youth Community Mental Health Services
Youth Primary Mental Health Service

SOUTHERN REGION ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity by Occupation submitted by all five DHB (Inpatient & Community) ICAMH/AOD services and all 28 contracted non-DHB providers (including 1 PHO) as at 30 June 2018.

From 2014 to 2016:

- 4% increase in the region's ICAMH/AOD workforce, from 398.7 to 413.4 actual FTEs (Table 7 & Figure 9).
- Increase in the non-DHB provider workforce by 16%, while a 4% decrease in the DHB workforce.
- Regional vacancy rate increased slightly to 7%, from 26.1 to 30.8 FTEs.

Figure 9. Southern Region ICAMH/AOD Workforce (2004-2018)

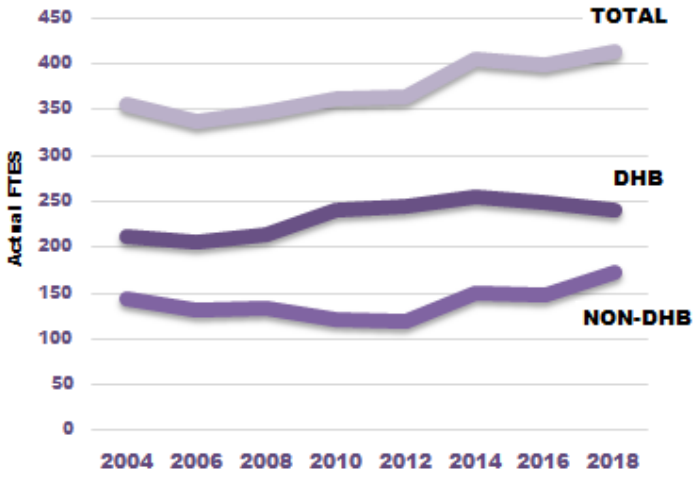


Table 7. Southern Region ICAMH/AOD Workforce (2004-2018)

YEAR	DHB[1]			NON-DHB			TOTAL		
	ACTUAL	VACANT	% VACANCY	ACTUAL	VACANT	% VACANCY	ACTUAL	VACANT	% VACANCY
2004	212.5	20.3	9	143.2	3.8	3	355.7	24.1	6
2006	204.8	21.0	9	132.6	0.5	-	337.4	21.5	6
2008	214.3	19.9	8	133.6	2.5	2	347.9	22.4	6
2010	241.1	12.2	5	122.1	8.0	6	363.1	20.2	5
2012	245.3	21.8	8	118.1	0.8	1	363.4	22.6	6
2014	258.2	17.9	7	150.9	3.6	2	406.3	21.5	5
2016	249.9	23.1	8	148.8	3.0	2	398.7	26.1	6
2018	241.1	22.5	9	172.3	8.3	5	413.4	30.8	7

1. Includes Inpatient workforce data.

As at 30 June 2018:

- 82% of the region's workforce was in services in the Canterbury (53%) and Southern (29%) DHB areas (Figure 10).
- 58% employed in DHB services and 42% in non-DHB service providers.
- Workforce largely comprised of NZ European (76%), followed by Māori (11%), Other Ethnicity (9%), Asian (3%) and Pacific (1%) (Appendix D, Table 18).
- 69% in clinical roles, largely as Nurses (21%), Social Workers (13%) and Psychologists (10%) and largely employed in DHB services (Table 9 & Figure 11).
- 18% in the non-clinical workforce largely as Mental Health Support Workers (10%) and Youth Workers (5%) (Table 8 & Figure 11). The non-clinical workforce was largely employed in the non-DHB provider services.
- 13% in Administration (7%) and Management (6%) roles.

- 81% of all vacancies in clinical roles largely reported by DHB community services for Nurses (32%) and Social Workers (27%) (Table 9).
- Regional annual staff turnover rate was at 24% (DHB = 25% and non-DHB = 23%), mainly for Nurses, Mental Health Support Workers, Social Workers and Psychologists. The main reason for leaving was to take on external job opportunities.

Figure 10. Southern Region ICAMH/AOD Workforce by DHB Area (2018)

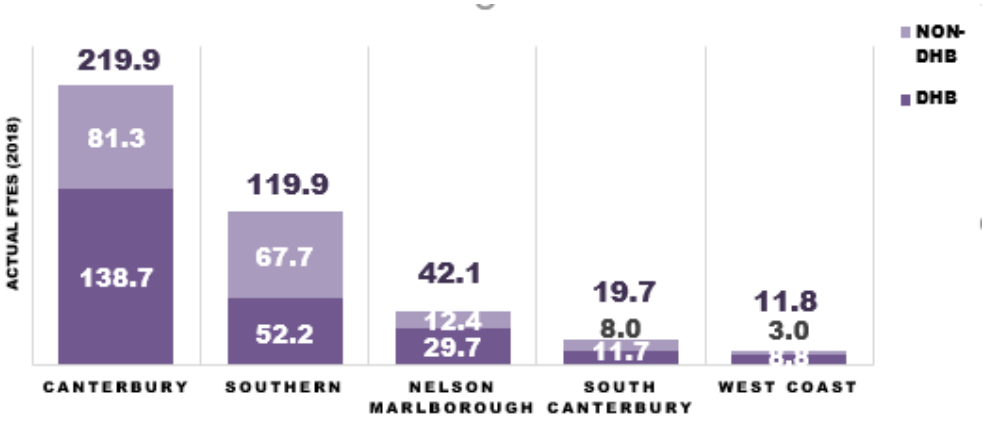


Figure 11. Southern Region Top 4 ICAMH/AOD Workforce (2018)

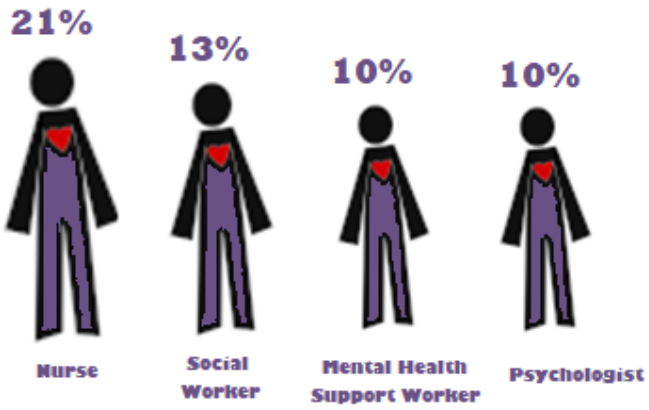


Table 8. Southern Region ICAMH/AOD Workforce by Occupation (2018)

Southern Region ICAMH/AOD Workforce by Occupation (Actual FTEs, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	10.20	10.20	16.30	26.50
Child & Adolescent Psychiatrist	2.10	11.40	13.50	0.60	14.10
Co-Existing Problems Clinician	-	-	-	7.10	7.10
Clinical Placement	-	2.00	2.00	3.80	5.80
Counsellor	-	1.20	1.20	12.38	13.58
Nurse	33.00	48.90	81.90	4.90	86.80
MST Therapist	-	-	-	3.00	3.00
Occupational Therapist	3.50	15.50	19.00	4.88	23.88
Psychotherapist	-	0.50	0.50	1.10	1.60
Psychologist	2.10	34.05	36.15	3.15	39.30
Social Worker	2.80	26.10	28.90	25.74	54.64
Other Clinical[1]	0.60	3.10	3.70	3.50	7.20
Clinical Sub-Total	44.10	152.95	197.05	86.45	283.50
Cultural	0.40	4.50	4.90	-	4.90
Mental Health Consumer	-	-	-	0.10	0.10
Mental Health Support Worker	-	-	-	42.90	42.90
Peer Support Worker	-	-	-	3.20	3.20
Specific Liaison	-	0.50	0.50	-	0.50
Youth Worker	-	-	-	21.83	21.83
Other Non-Clinical[2]	-	1.40	1.40	1.00	2.40
Non-Clinical Sub-Total	0.40	6.40	6.80	69.03	76.83
Administration	2.00	20.90	22.90	6.47	29.37
Management	7.50	6.80	14.30	10.38	24.68
TOTAL	54.00	187.05	241.05	172.33	413.38

1 = Other Clinical = Other SMO; CAPA Facilitator; Speech Therapist
2 = Other Non-Clinical = Refugee Facilitator; Researcher

Table 9. Southern Region ICAMH/AOD Vacancies by Occupation (2018)

Southern Region Vacancies by Occupation (Vacant FTEs, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	-	-	2.00	2.00
Nurse	1.50	7.30	8.80	1.00	9.80
Occupational Therapist	-	1.10	1.10	-	1.10
Psychotherapist	-	0.20	0.20	-	0.20
Psychologist	-	2.50	2.50	-	2.50
Social Worker	-	7.20	7.20	1.00	8.20
Other Clinical[1]	-	-	-	1.00	1.00
Clinical Sub-Total	1.50	18.30	19.80	5.00	24.80
Cultural	-	1.30	1.30	-	1.30
Mental Health Consumer	-	1.40	1.40	-	1.40
Mental Health Support	-	-	-	3.25	3.25
Non-Clinical Sub-Total	-	2.70	2.70	3.25	5.95
TOTAL	1.50	21.00	22.50	8.25	30.75

1. Other Clinical = Counsellor; Case Manager.

DHB INPATIENT ICAMH WORKFORCE

From 2016 to 2018:

- 3% increase in the Inpatient workforce, from 51.1 to 54 actual FTEs (Table 10).
- A slight increase in vacancies, from 0.5 FTEs to 0 1.5 FTEs, with a vacancy rate of 3%.

As at 30 June 2018:

- 82% in the clinical workforce, largely as Nurses (61%) (Table 8).
- 18% in Administration (4%) and Management roles (14%).

Table 10. Southern Region DHB Inpatient ICAMH Workforce (2008-2018)

YEAR	ACTUAL FTES			VACANT FTES			VACANCY (%)
	CLINICAL	NON-CLINICAL	TOTAL	CLINICAL	NON-CLINICAL	TOTAL	
2008	40.6	5.6	46.2	-	-	-	-
2010	45.9	4.9	50.8	0.9	-	0.9	2
2012	45.3	5.9	51.2	2.9	-	2.9	5
2014	45.6	4.9	50.5	2.0	-	2.0	4
2016	46.7	4.4	51.1	0.5	-	0.5	1
2018	44.1	9.9	54.0	1.5	-	1.5	3

Note: Non-Clinical Workforce includes Administration/Management Staff

DHB COMMUNITY ICAMH/AOD WORKFORCE

From 2016 to 2018:

- 6% decrease in the DHB community workforce, from 198.8 to 187.1 actual FTEs (Table 11). This decrease was seen in the clinical workforce.
- A slight decrease in vacancies, from 22.6 to 21 vacant FTEs, with a vacancy rate of 10%.

As at 30 June 2018:

- 73% of the workforce was in Canterbury (45%) and Southern (28%) DHB services (Table 11).
- 82% in the clinical workforce as Nurses (26%), Psychologists (18%), Social Workers (14%) and Occupational Therapists (8%) (Table 8).
- 3% in the non-clinical workforce, largely in Cultural roles (2%).
- 15% in Administration (11%) and Management (4%) roles.
- 87% of total vacancies seen in the clinical workforce for Nurses (35%) and Social Workers (34%) (Table 9).

Table 11. Southern Region DHB Community ICAMH/AOD Workforce by DHB Area (2008-2018)

DHB AREA	ACTUAL FTES						VACANT FTES						VACANCY RATE (%)					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2012	2012	2014	2016	2018
NELSON MARLBOROUGH	23.4	24.9	28.7	36.9	34.2	29.7	-	2.0	-	2.4	3.2	0.4	-	7	-	6	9	1
WEST COAST	11.5	12.4	12.8	11.0	6.9	8.8	3.8	1.2	3.2	3.2	5.0	4.0	25	9	21	23	42	31
CANTERBURY*	68.2	85.3	91.3	92.3	91.9	84.7	9.9	3.0	10.4	7.0	4.9	8.4	13	3	10	7	5	9
SOUTH CANTERBURY	10.0	10.5	9.2	9.4	12.3	11.7	-	2.7	1.2	1.4	1.0	0.4	-	20	12	13	8	3
SOUTHERN	55.0	57.4	52.2	55.4	53.5	52.2	6.2	2.4	4.1	2.0	8.5	7.8	10	4	7	3	14	13
REGIONAL TOTAL	168.1	190.5	194.1	204.9	198.8	187.1	19.9	11.3	18.9	15.9	22.6	21.0	11	6	9	7	10	10

***Includes Inpatient Services.**

DHB WORKFORCE COMPETENCIES

- The capability of the workforce was assessed by the *Real Skills Plus ICAMHS competency framework* (The Werry Centre, 2009b), which describes the knowledge, skills and attitudes needed to work with infants, children and young people and whānau with a suspected or identified mental health or alcohol or other drug concern. The *Real Skills Plus online assessment tool* identifies the competencies that individual and teams meet from the framework, and highlights areas for knowledge and skill development for individuals and teams *(to access the tool and more information:* ***www.werryworkforce.org****)*.
- *Real Skills Plus* has three levels
    - **Primary Level** *for people in the primary sector that work with infants, children and young people.*
    - **Core Level** *for practitioners working in services that focus on mental health and/or AOD concerns.*
    - **Specific Level** *for senior or specialist practitioners working at an advanced level of practice.*
- *Real Skills Plus* data can be reported at service and team level and individually. The application of *Real Skills Plus* is most effective at an organisational level as it helps to develop a shared understanding of the knowledge and skills required by the whole service. It promotes the development of best practice across disciplines, creating a multi-skilled workforce at each level. *Real Skills Plus* allows targeted service development, recruitment and service delivery activities.
- The data presented in Figures 12 and 13 are the summary of the ***Core*** level competencies met by the Southern region ICAMH/AOD DHB workforce in 2018. The DHB workforce met a number of ***Core*** level competencies (ranging from 42% to 100% of skills and knowledge required), and further development was indicated for the following:
    - ***Intervention Knowledge (25%)***
    - ***Assessment Knowledge (17%)***
    - ***Knowledge and Skills for Leadership roles (25%).***
    - ***Knowledge and Skills for working with Infants (12%)***

Figure 12. DHB *Real Skills Plus* Core Competencies (2018)

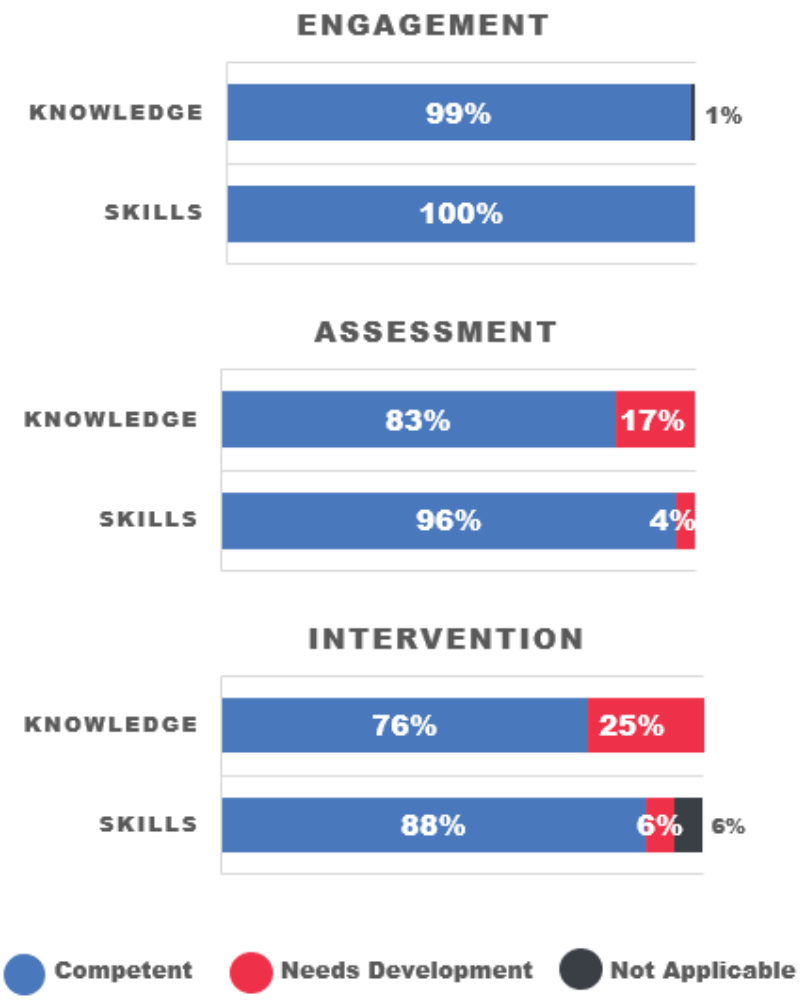
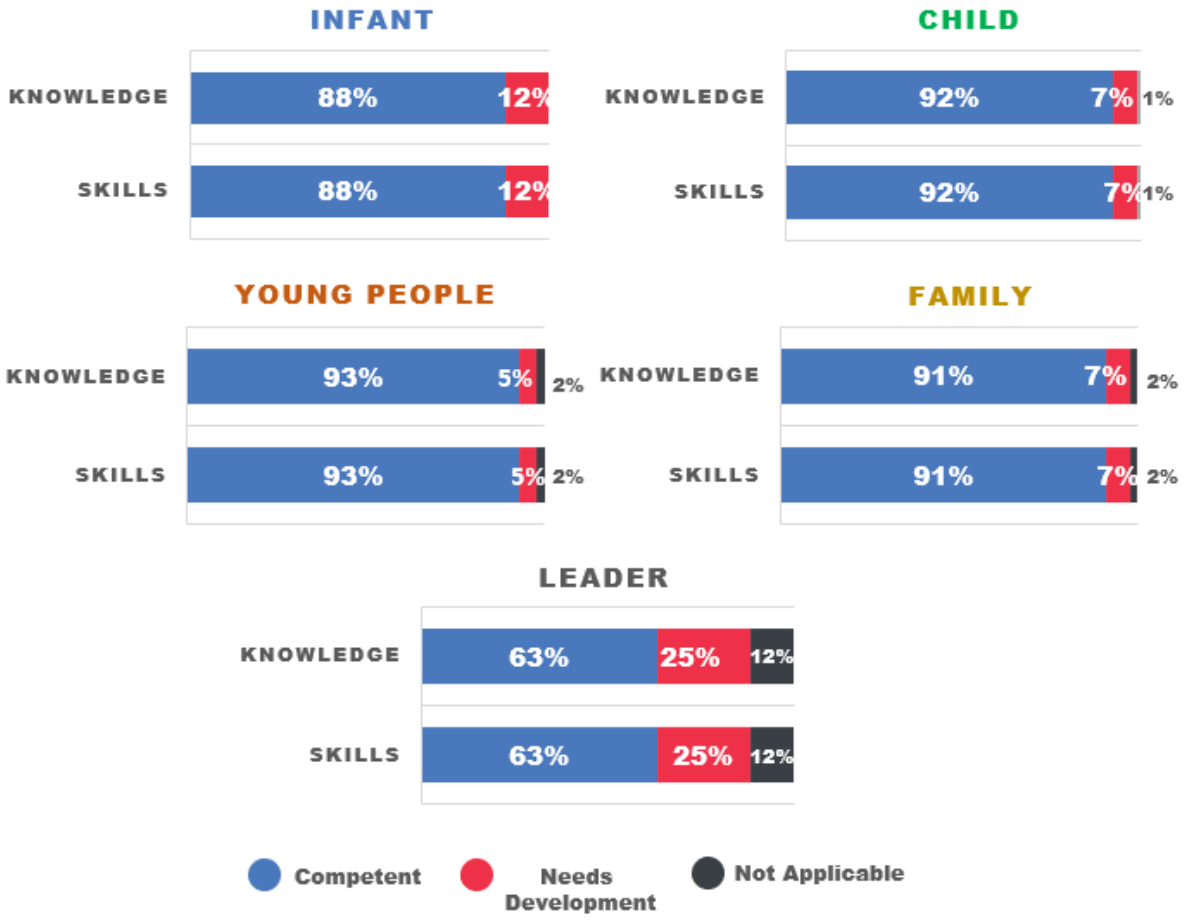


Figure 13. DHB *Real Skills Plus* Competencies by Domain (2018)



NON-DHB ICAMH/AOD WORKFORCE

From 2016 to 2018:

- 16% increase in the non-DHB provider workforce, from 148.8 to 172.3 actual FTEs (Table 12).
- Increase largely in the clinical workforce by 22%, from 70.9 to 86.5 actual FTEs.

As at 30 June 2018:

- 86% of the workforce was in services in the Canterbury (47%) and Southern (39%) DHB areas (Table 12).
- 50% in the clinical workforce, largely as Social Workers (15%), AOD Practitioners (9%) and Counsellors (7%).
- 40% in the non-clinical workforce, largely as Mental Health Support Workers (25%) and Youth Workers (13%) (8).
- 10% in Administration (4%) and Management roles (6%).

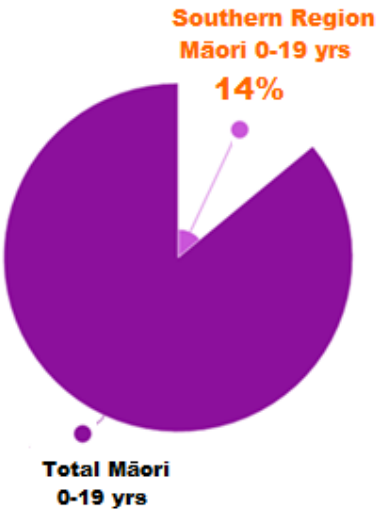
Table 12. Southern Region Non-DHB ICAMH/AOD Workforce (2008-2018)

DHB AREA	ACTUAL FTES						VACANT FTES						VACANCY RATE (%)					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
WEST COAST	-	-	-	8.0	3.0	3.0	-	-	-	-	-	-	-	-	-	-	-	19
NELSON MARLBOROUGH	15.3	11.3	6.5	12.5	11.6	12.4	-	-	-	-	-	3.0	-	-	-	-	-	6
CANTERBURY	59.4	57.2	55.3	66.3	65.6	81.3	1.5	6.6	-	2.5	2.0	5.3	2	10	-	4	3	-
SOUTH CANTERBURY	11.0	3.70	5.1	7.4	9.8	8.0	-	1.0	-	1.0	-	-	-	21	-	12	-	-
SOUTHERN	47.9	49.9	51.2	56.7	58.8	67.7	1.0	0.4	0.8	0.05	1.0	-	-	1	2	-	2	5
TOTAL	133.6	122.1	118.1	150.9	148.8	172.3	2.5	8.0	-	3.6	3.0	8.3	2	6	-	2	2	5

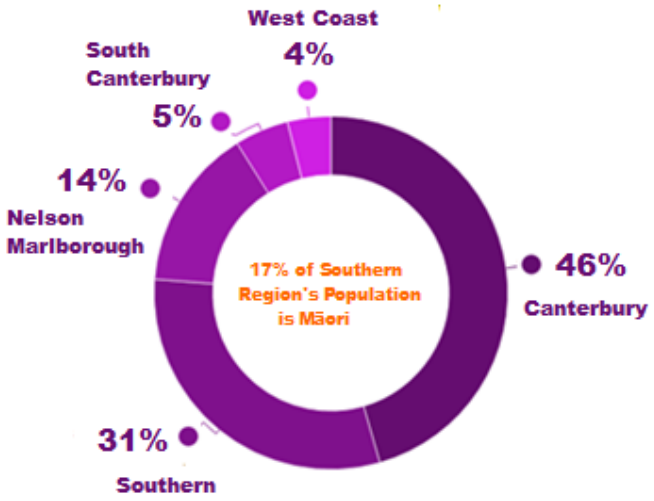
SOUTHERN REGION MĀORI OVERVIEW

SOUTHERN REGION MĀORI INFANT, CHILD AND ADOLESCENT POPULATION

- 2016 to 2018 population projections (based on Census 2013) indicated a 4% growth in the regional Māori 0-19 year population (Appendix A, Table 1).
- Projected growth seen across all DHB areas, with the largest growth in Canterbury (by 5%).
- Southern region continued to have the smallest Māori 0-19 year population (14%) in the country (Appendix A, Table 1).
- Māori 0-19 year olds made up 17% of the region's total 0-19 years population.
- Almost half (46%) of the region's Māori infant, child and adolescent population resided in the Canterbury DHB area, followed by the Southern DHB area (31%).
- 1- year projections (2018-2028) indicate a 19% population growth for the regional Māori 0-19 year population.



- Projections indicate growth in all five DHB areas: South Canterbury (by 23%), Canterbury (by 20%), Nelson Marlborough (by 18%), Southern (by 17%) and West Coast (by 16%) (Appendix A, Table 2).



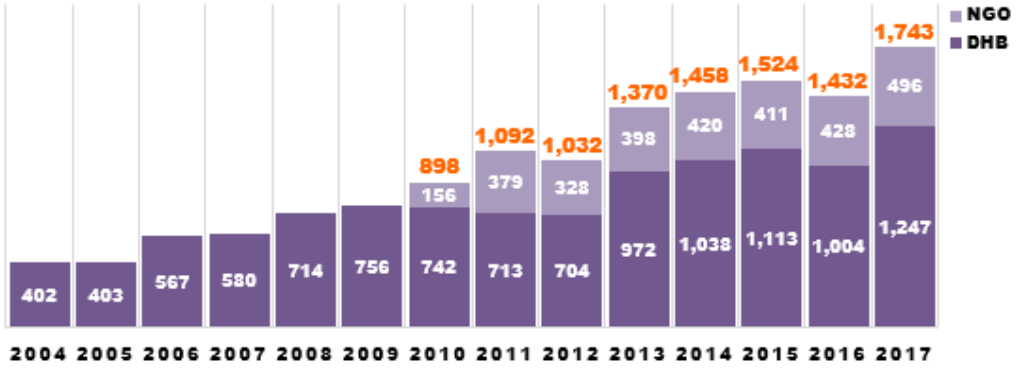
SOUTHERN REGION MĀORI SERVICE USER ACCESS TO ICAMH/AOD SERVICES

The service user access to service data (number of service users 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 *Service Users by DHB of Domicile* (residence) for the second six months of each year (July to December).

From 2015 to 2017:

- 14% increase in number of Māori service users accessing services, largely in NGOs by 21% (Figure 14). Increase in both male and female service users by 13% and 16% respectively.
- Increase in four out of the five DHB areas: South Canterbury by 31%, Nelson Marlborough by 20%, Canterbury by 18% and Southern by 8%. Decrease in Māori service users in West Coast by 12%.

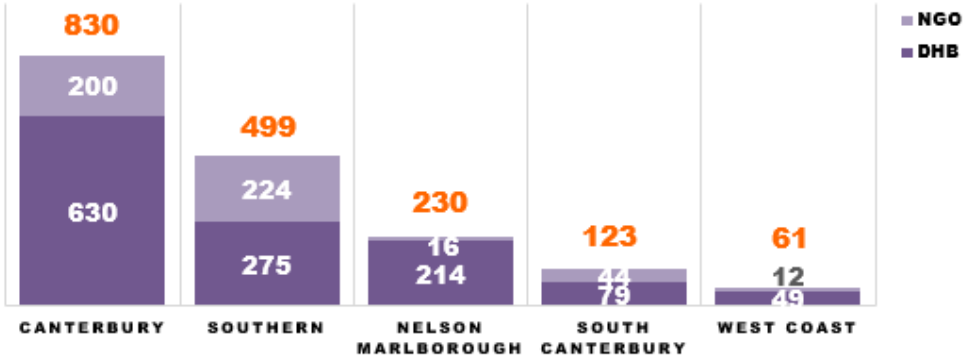
Figure 14. Southern Region Māori 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Māori service users made up 21% of total service users accessing services, with Māori males making up 53% of all Māori service users (Appendix B, Table 3).
- 72% of Māori service users accessed DHB services and 28% accessed NGOs.
- 89% of Māori service users in the region were seen by services in Canterbury (53%), Southern (32%) and Nelson Marlborough (15%) DHB areas (Figure 15).

Figure 15. Southern Māori 0-19 yrs Service User by DHB Area (2017)



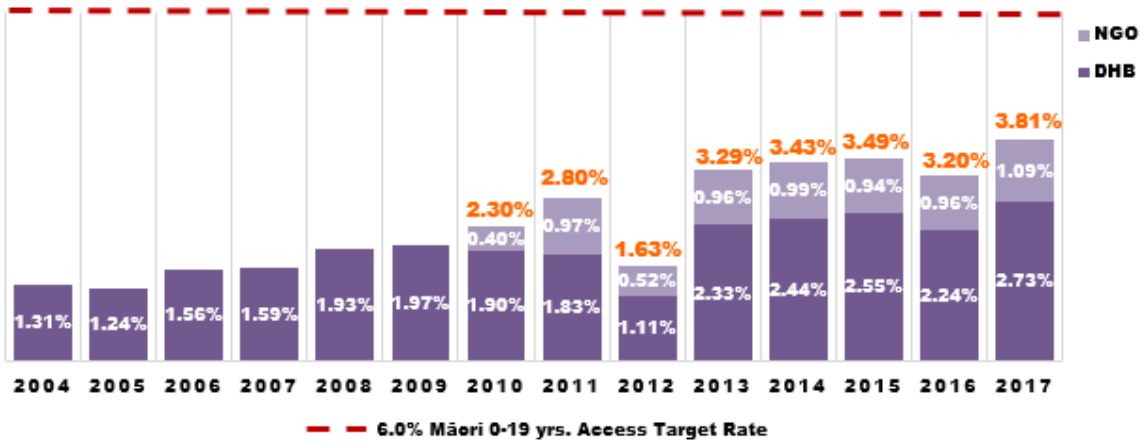
MĀORI SERVICE USER ACCESS RATES

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).

From 2015 to 2017:

- Overall regional improvement in the Māori access rate from 3.49% to 3.81%, which, while exceeding the overall target rate of 3%, remained below the recommended rate of 6% (Figure 16). Improvements in all three age groups, especially in the 15-19 year age group (Appendix B, Table 8).
- Improvements in four out of the five DHB areas: South Canterbury, Nelson Marlborough; Canterbury and Southern DHB areas (Appendix B, Table 9).

Figure 16. Southern Region Māori 0-19 yrs Service User Access Rates (2004-2017)



In the second half of 2017:

- By age, access rates for all three age groups remained below the respective recommended rates, especially for the 10-14 year age group.
- By DHB area, South Canterbury had the highest Māori access rate of 5.42%, followed by Canterbury (3.94%) (Figure 17).
- Despite improvements in the regional Māori service user access rates, they continued to remain below recommended rates for Māori in all three age groups and across all DHB areas. Therefore, improving access rates for Māori remain an area of focus for this region.

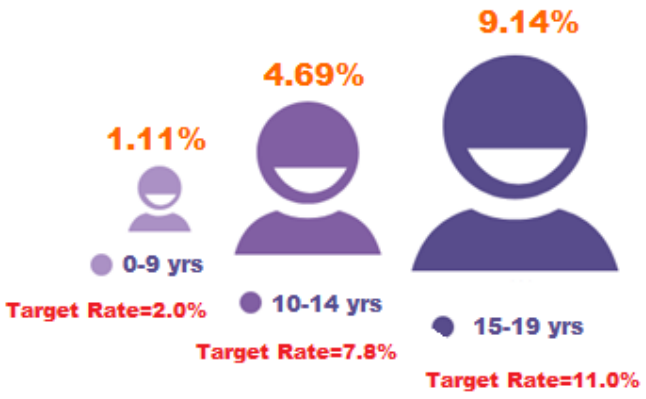
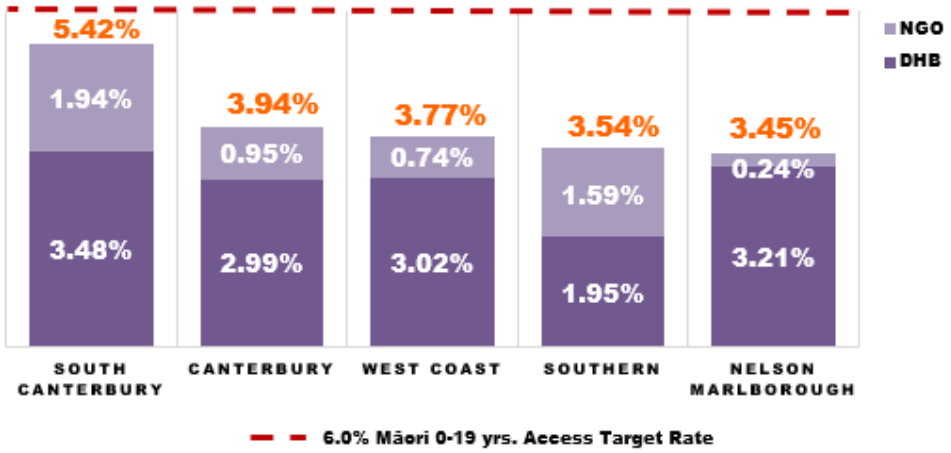


Figure 17. Southern Region Māori 0-19 yrs Access Rates by DHB Area (2017)



SOUTHERN REGION MĀORI ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by ethnicity by occupation submitted by all five DHB (Inpatient & Community) ICAMH/AOD services and all 28 contracted non-DHB providers (including 1 PHO) as at 30 June 2018.

From 2016 to 2018:

- Increase in the total Māori workforce by 7, from 53 to 60 (headcount) (Table 13).
- Increase seen in both DHB and non-DHB services.
- Increase in the non-clinical workforce by 3.

Table 13. Southern Region Māori ICAMH/AOD Workforce by DHB Area (2008-2018)

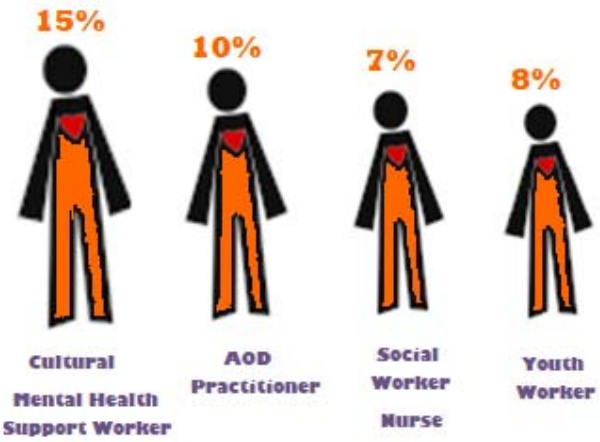
DHB AREA	DHB[1]						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NELSON MARLBOROUGH	-	-	-	1	-	1	2	3	3	6	6	6	2	3	3	7	6	7
WEST COAST	-	1	-	2	3	2	-	-	-	-	-	-	-	1	-	2	3	2
CANTERBURY	6	7	10	8	11	13	15	9	8	10	16	19	21	16	18	18	27	32
SOUTH CANTERBURY	4	4	2	2	2	2	2	-	-	1	-	1	6	4	2	3	2	3
SOUTHERN	2	4	4	2	1	1	9	10	10	10	14	15	11	14	4	12	15	16
TOTAL	12	16	16	15	17	19	28	22	21	27	36	41	40	38	37	42	53	60

1. Includes Inpatient Workforce

As at 30 June 2018:

- 68% of the regional Māori workforce was in non-DHB provider services
- 80% of the region's Māori workforce was in the Canterbury (53%) and Southern (27%) DHB areas (Table 13).
- 45% in the clinical workforce, largely as AOD Practitioners (10%), Nurses (8%) and Social Workers (8%) (Table 14 & Figure 16).
- 43% in the non-clinical workforce, largely as Cultural Workers (15%), Mental Health Support Workers (15%) and Youth Workers (7%) (Table 14 & Figure 18).

Figure 18. Southern Region Māori Top 4 ICAMH/AOD Workforce (2018)



DHB INPATIENT MĀORI ICAMH/AOD WORKFORCE

From 2016 to 2018:

- Decreased by two, from 4 to 2 (headcount) as mainly Mental Health Nurses (Table 15).

DHB COMMUNITY MĀORI ICAMH/AOD WORKFORCE

From 2016 to 2018:

- Increase by four, from 13 to 17 (Table 13).

As at 30 June 2018:

- 65% of the regional Māori DHB community workforce was in Canterbury DHB services (Appendix D, Table 6).
- 53% in the non-clinical workforce, almost all in Cultural roles (47%) (Table 15).
- 35% in the clinical workforce, largely as Nurses (18%) and Psychologists (12%) (Table 15).
- 12% in Administration roles.

NON-DHB MĀORI ICAMH/AOD WORKFORCE

From 2016 to 2018:

- Increase of 5, from 36 to 41 (Table 13).

As at 30 June 2018:

- 49% in the clinical workforce as AOD Practitioners (15%) and Social Workers (10%) (Table 14).
- 39% in the non-clinical workforce as Mental Health Support Workers (22%), Youth Workers (10%) and Peer Support Workers (7%).
- 12% in Administration (5%) and Management (7%) roles.

Table 14. Southern Region Māori ICAMH/AOD Workforce by Occupation (2018)

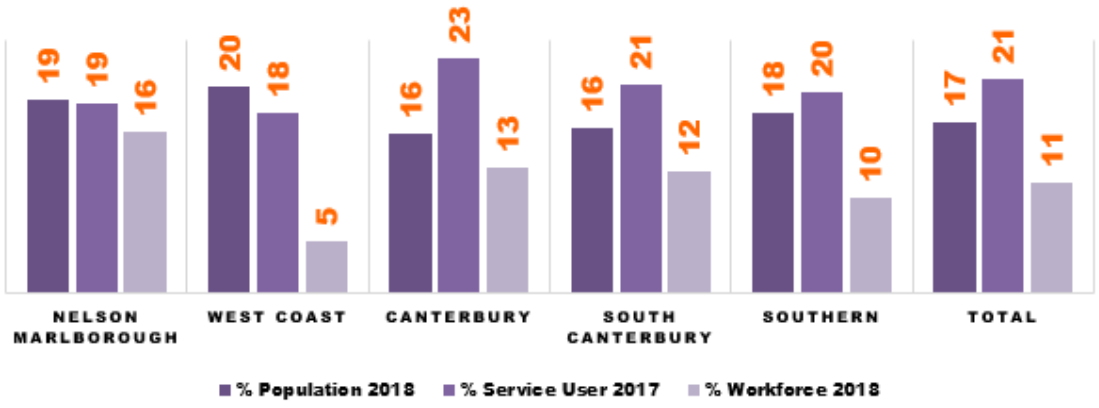
Southern Region Māori ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	-	-	6	6
Clinical Placement	-	-	-	3	3
Co-Existing Problems Clinician	-	-	-	3	3
Counsellor	-	-	-	2	2
Nurse	1	3	4	1	5
Psychologist	-	2	2	-	2
Social Worker	-	1	1	4	5
Other Clinical[1]	-	-	-	1	1
Clinical Sub-Total	1	6	7	20	27
Cultural Worker	1	8	9	-	9
Mental Health Consumer	-	1	1	-	1
Mental Health Support Worker	-	-	-	9	9
Peer Support Worker	-	-	-	3	3
Youth Worker	-	-	-	4	4
Non-Clinical Sub-Total	1	9	10	16	26
Administration	-	2	2	2	4
Management	-	-	-	3	3
TOTAL	2	17	19	41	60

1. Other Clinical = Family Therapist.

SOUTHERN REGION MĀORI POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

- While there is an increasing trend in the numbers of Māori service users accessing services, the Māori access rate remains below the recommended rates for all three age groups, indicating unmet needs. Therefore, improving Māori access to services in this region remains critical.
- Additionally, an increasing trend in Māori service users accessing services in the region (14% increase from 2015 to 2017), highlight significant disparities between service user demand and the workforce across the whole region, indicating a need for increasing the Māori workforce to meet current and future demand, considering a 19% projected population growth by 2028 (Figure 19).
- The majority of Māori service users also continued to access DHB services and were largely seen by the non-Māori workforce. Therefore, strengthening and developing the current workforce (both Māori and non-Māori) to be clinically and culturally competent is also crucial.

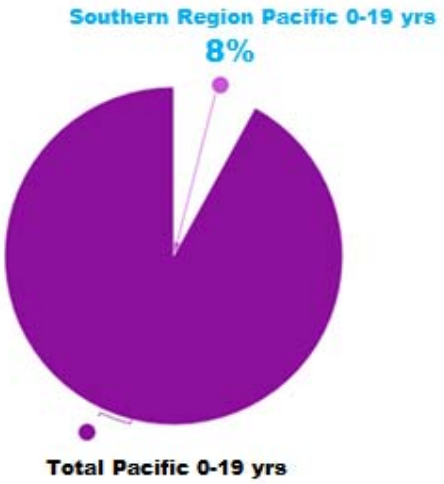
Figure 19. Māori 0-19 yrs Population, Service User & Workforce Comparisons



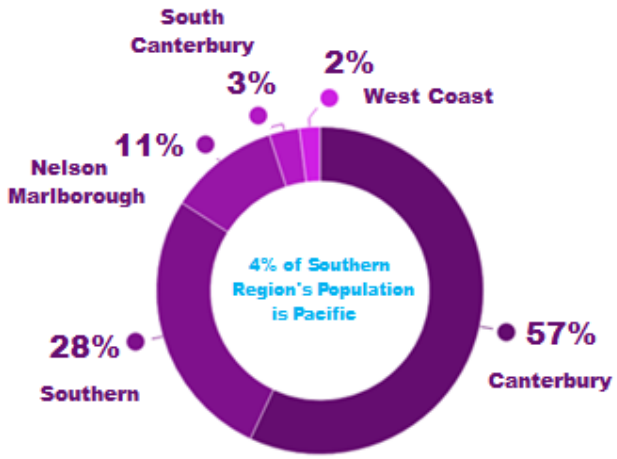
SOUTHERN REGION PACIFIC OVERVIEW

SOUTHERN REGION PACIFIC INFANT, CHILD AND ADOLESCENT POPULATION

- 2016 to 2018 population projections (based on Census 2013) indicated an 8% population growth in the regional Pacific 0-19 year population (Appendix A, Table 1).
- Population growth was projected for all five DHB areas, with the largest growth projected in the West Coast DHB area (by 13%), followed by Southern (by 9%).
- The Southern region continued to have one of the smallest Pacific infant, child and adolescent populations in New Zealand (8%) (Appendix A, Table 1).
- Pacific infants, children and adolescents made up 4% of the region's total 0-19 year population.
- Over half (57%) of the region's Pacific 0-19 year population resided in the Canterbury DHB area, followed by the Southern DHB area (28%).



- 10-year population projections (2018-2028) indicates a 33% regional growth in the Pacific 0-19 year population.
- Projected growth in all five areas: South Canterbury (by 86%), West Coast (by 34%), Canterbury (by 32%), Southern (by 31%), and Nelson Marlborough (by 30%) (Appendix A, Table 2).
- These population projections could indicate potential demand for services in the region, therefore needs to be considered for regional service and workforce planning.

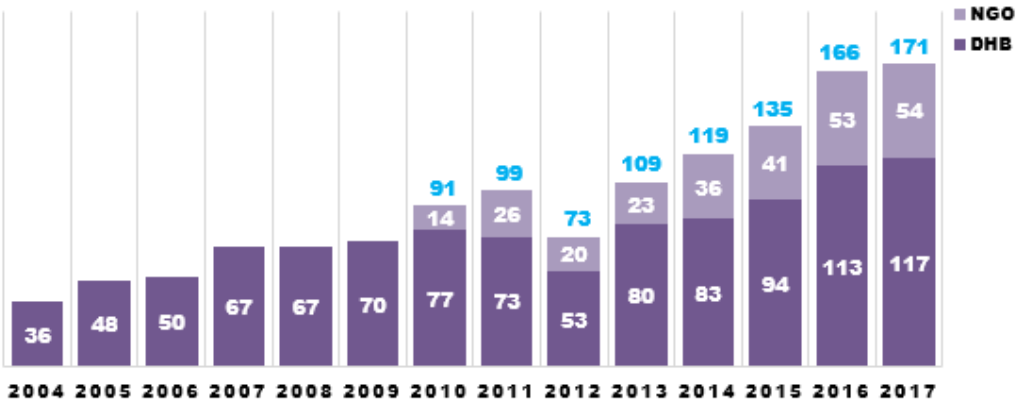


SOUTHERN REGION PACIFIC SERVICE USER ACCESS TO ICAMH/AOD SERVICES

From 2015 to 2017:

- 27% increase in the number of Pacific service users accessing services, largely in NGOs by 32% (Figure 20). Increase mainly in Pacific male service users by 44% (Appendix B, Table 4).
- Increase seen in three out of the five DHB areas, Canterbury, Southern and South Canterbury (Appendix B, Table 4).

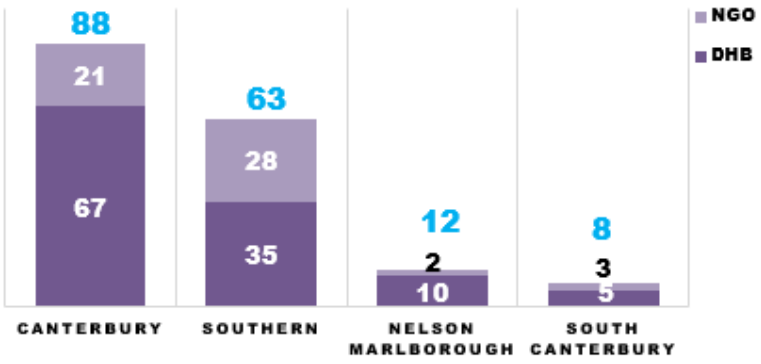
Figure 20. Southern Region Pacific 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Pacific service users made up 2% of the total service users accessing services. 59% were Pacific male service users.
- 68% accessed DHB services and 32% accessed NGOs (Figure 20).
- 88% of all Pacific service users in the region were seen by services in Canterbury (58%) and Southern DHB (42%) areas (Figure 21).

Figure 21. Southern Region Pacific 0-19 yrs Service User by DHB Area (2017)



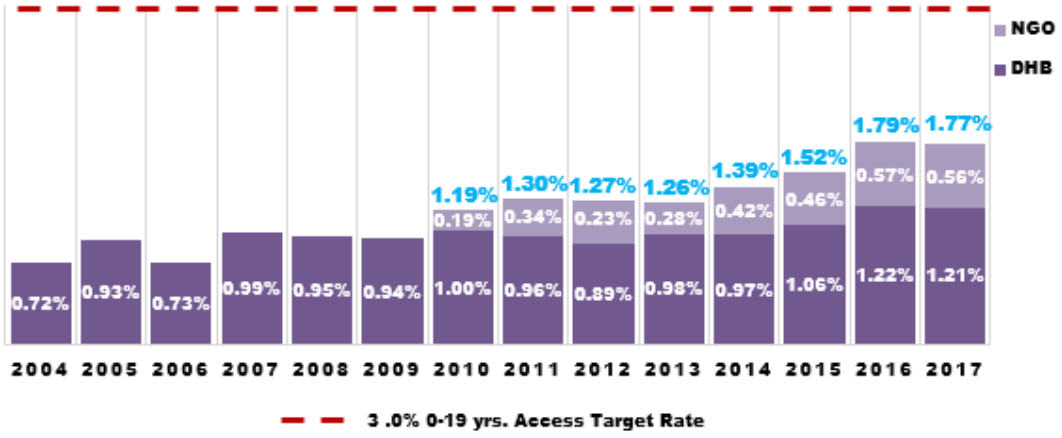
PACIFIC SERVICE USER ACCESS RATES

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 the lack of epidemiological data for the Pacific 0-19 year population, there are no specific target rates Pacific, therefore the Pacific rates have been compared to the 3% overall rate. However, the Pacific population experience higher levels of mental health disorder than the general population (Ministry of Health, 2006) and therefore, the 3% target access rate may be a conservative estimate of actual need for the Pacific population.

From 2015 to 2017:

- Overall improvement in Pacific access rate from 1.52% to 1.77% (Figure 22). Improvements in all three age groups (Appendix B, Table 12).

Figure 22. Southern Region Pacific 0-19 yrs Service User Access Rates (2004-2017)



In the second six months of 2017:

- While improvements can be seen in the regional Pacific access rate for all three age groups, they remained below the recommended rates, especially for 10-14 year olds.

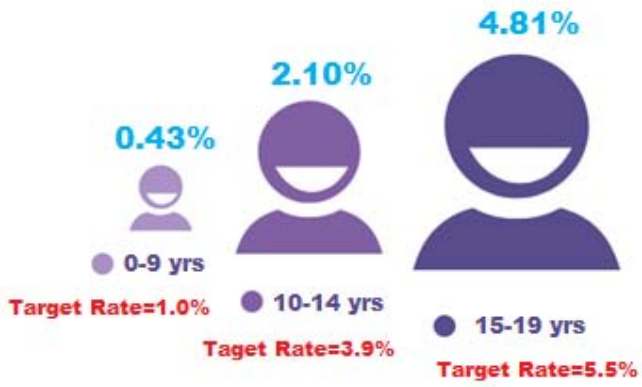
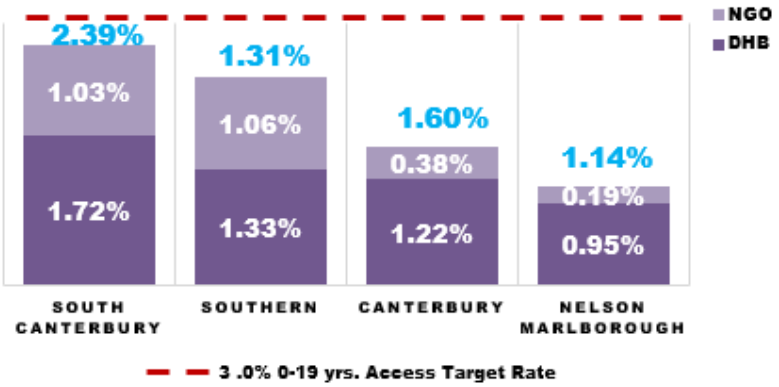


Figure 23. Southern Region Pacific 0-19 yrs Service User Access Rates by DHB Area (2017)



Note: Pacific access rates by DHB area should be interpreted with caution due to very small numbers (< 20) of Pacific service users within individual DHB areas (e.g. Nelson Marlborough, South Canterbury). Regional access rates produce more meaningful and stable access rates for the Pacific population.

SOUTHERN REGION PACIFIC ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by ethnicity by Occupation, submitted by all five DHB (Inpatient & Community) ICAMH/AOD services and all 28 contracted non-DHB service providers as at 30 June 2018.

From 2016 to 2018:

- Decrease of 2, from 7 to 5 (Table 15). Decrease in the DHB workforce from 3 to 1.

As at 30 June 2018:

- Almost all of the regional Pacific workforce was in non-DHB provider services in the Canterbury DHB area and are AOD Practitioners, Nurses and Mental Health Support Workers (Table 16).

Table 15. Southern Region Pacific ICAMH/AOD Workforce by DHB Area (2008-2018)

DHB AREA	DHB[1]						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NELSON MARLBOROUGH	-	-	-	-	-	-	1	1	-	-	-	-	1	1	-	-	-	-
WEST COAST	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CANTERBURY	-	1	1	2	2	1	4	5	9	5	-	4	4	6	10	7	2	5
SOUTH CANTERBURY	-	-	-	-	-	-	2	-	-	-	1	-	2	-	-	-	1	-
SOUTHERN	-	-	1	-	1	-	1	3	1	2	3	-	1	3	2	2	4	-
TOTAL	-	1	2	2	3	1	8	9	10	7	4	4	8	10	12	9	7	5

1. Includes Inpatient Services

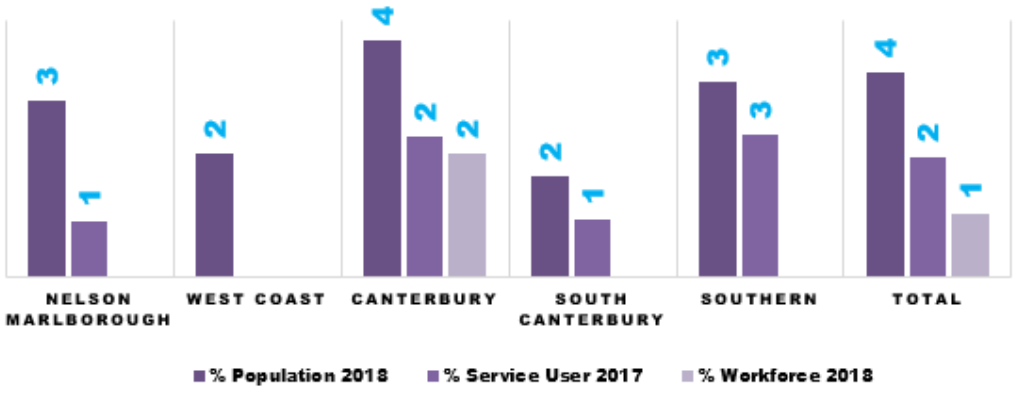
Table 16. Southern Region Pacific ICAMH/AOD Workforce by Occupation (2018)

Southern Region Pacific ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	-	-	2	2
Nurse	1	-	1	1	2
Clinical Sub-Total	1	-	1	3	4
Mental Health Support Worker	-	-		1	1
TOTAL	1	-	1	4	5

SOUTHERN REGION PACIFIC POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

- While there is an increasing trend in the number of Pacific service users accessing services, Pacific access rates remain below the target rates for all three age groups indicating unmet need (Figure 24). Therefore, improving Pacific access to services remains critical.
- Additionally, increasing trends in Pacific service users accessing services (27% increase from 2015 to 2017), coupled with a decreasing workforce, highlights significant disparities between service user demand and the workforce across the region. Such a discrepancy indicates a need for increasing the Pacific workforce to meet current and future demand given a 33% projected population growth by 2028.
- The majority of Pacific service users also continued to access DHB services and were largely seen by the non-Pacific workforce. Therefore, strengthening and developing the current workforce (both Pacific and non-Pacific) to be clinically and culturally competent is also crucial.

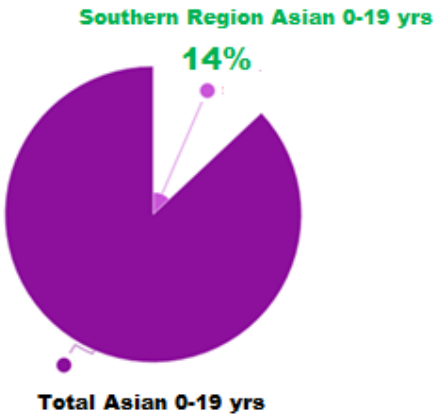
Figure 24. Pacific 0-19 yrs Population, Service User & Workforce Comparisons



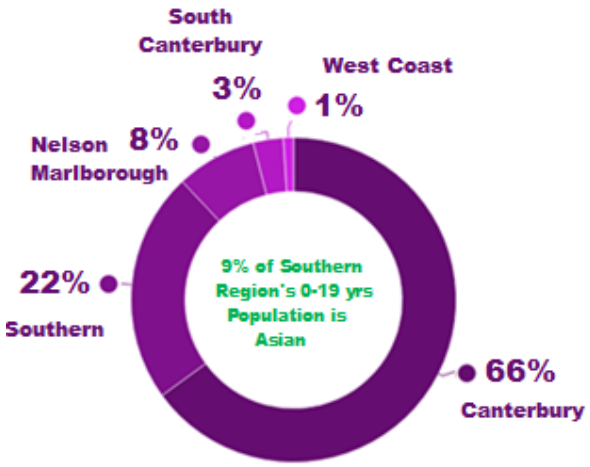
SOUTHERN REGION ASIAN OVERVIEW

SOUTHERN REGION ASIAN INFANT, CHILD AND ADOLESCENT POPULATION

- 2016-2018 population projections (based on Census 2013) indicated a 9% growth in the regional Asian 0-19 year population (Appendix A, Table 1).
- Growth projected in four out of the five DHB areas with the largest projected growth in Canterbury (by 11%) and South Canterbury by 10%.
- The Southern region had the second largest Asian population (14%) in the country (Appendix A, Table 1).
- Asian infants, children and adolescents made up 9% of the 0-19 year population, larger than the Pacific population.
- Majority (66%) reside in Canterbury DHB area, followed by Southern (22%).



- 10-year population projections (2018-2028) indicate a 34% regional growth for Asian 0-19 population by 2028.
- Projections indicate projected growth in all five areas: Canterbury (by 36%), Nelson Marlborough (by 39%), West Coast (71%), South Canterbury (by 38%) and Southern (by 24%) (Appendix A, Table 2).
- These population projections could indicate potential demand for services in the region, therefore need to be considered for service and workforce planning for the Asian population.

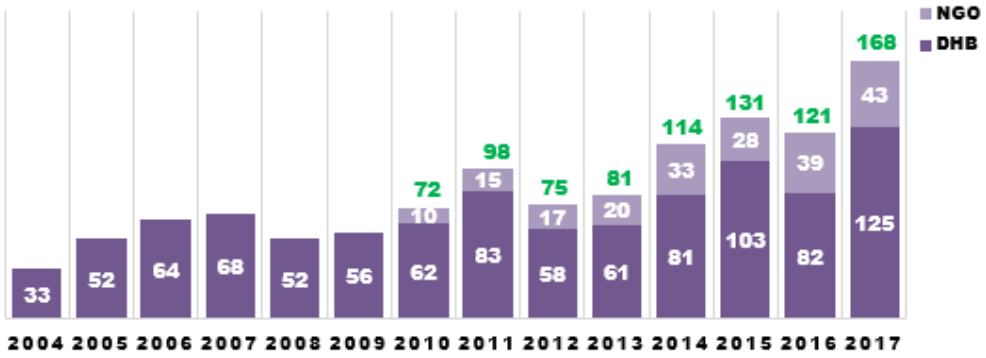


SOUTHERN REGION ASIAN SERVICE USER ACCESS TO ICAMH/AOD SERVICES

From 2015 to 2017:

- 28% increase in the number of Asian service users accessing services, largely in NGOs by 54% (Figure 25).
- Increase mainly in female service users by 51% (Appendix B, Table 5). Increases across all five DHB areas.

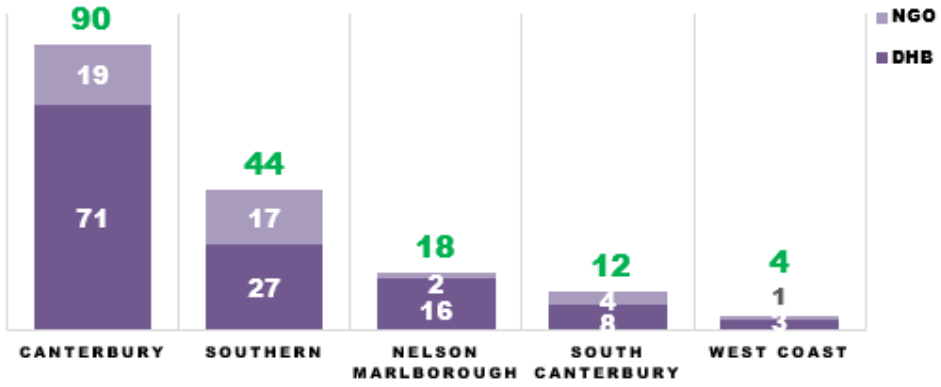
Figure 25. Southern Region Asian 0-19 yrs Service User (2004-2017)



In the second half of 2017:

- Asian service users made up 2% of the total service users. 55% of Asian service users accessing services were female.
- 74% accessed DHB services and 26% accessed NGOs (Figure 25)
- 80% of Asian service users were seen by services in the Canterbury (54%) and Southern (26%) DHB areas (Figure 26).

Figure 26. Southern Region Asian 0-19 yrs Service User by DHB Area (2017)



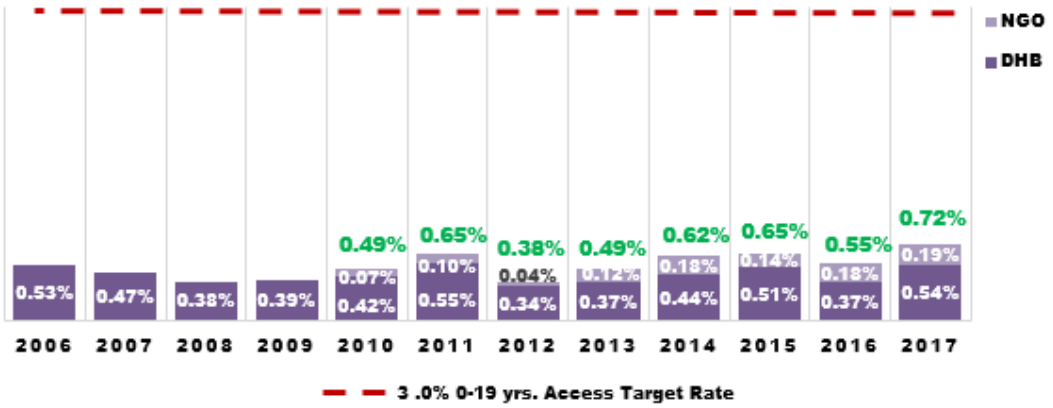
ASIAN SERVICE USER ACCESS RATES

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 the lack of epidemiological data for the Asian 0-19 year population, there are no specific Blueprint access benchmarks for Asian, therefore the Asian access rates have been compared to the rates for the general 0-19 years population.

From 2015 to 2017:

- Overall regional improvement in Asian access rate, from 0.65% to 0.72%, remaining below the 3% target rate (Figure 27). Improvements in the 15-19 year age group only (Appendix B, Table 13).

Figure 27. Southern Region Asian 0-19 yrs Service User Access Rates (2006-2017)



In the second half of 2017:

- The regional Asian service user access rate of 0.72% remained the lowest out of the four ethnic groups: Other Ethnicity (3.14%), Māori (3.81%) and Pacific (1.77%).
- By age, access rates for all three age groups remained significantly below their respective target rates, especially for the 10-14 and 15-19 year age groups.
- While overall improvements can be seen, the Asian access rates for all age groups need to improve and remain a focus for the region (Figure 28).

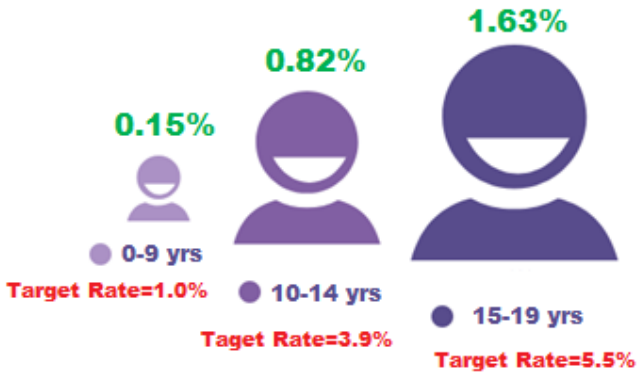
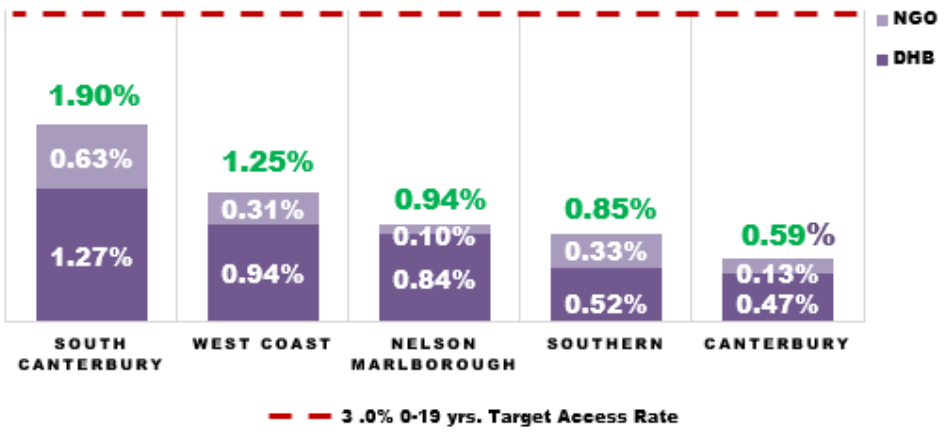


Figure 28. Southern Region Asian 0-19 yrs Service User Access Rates By DHB Area (2017)



Note: Asian access rates by DHB Area should be interpreted with caution due to very small numbers (< 20) of Asian service users within individual DHB areas (e.g. Nelson Marlborough; South Canterbury; West Coast). Regional access rates produce more meaningful and stable access rates for the Asian population.

SOUTHERN REGION ASIAN ICAMH/AOD WORKFORCE

The following information is derived from the workforce survey and includes Actual & Vacant Full Time Equivalents (FTEs) by Ethnicity & Occupation, submitted by all five DHB (Inpatient & Community) ICAMH/AOD services and all 28 contracted non-DHB service providers (including 1 PHO) as at 30 June 2018.

From 2016 to 2018:

- Increase by 2, from 14 to 16 (Table 17). Increase in DHB services only.

As at 30 June 2018:

- 75% of the region's Asian workforce was in Canterbury DHB services (10).
- 81% in the clinical workforce, as Nurses (6), Social Workers (4) and Psychiatrists (3).

Table 17. Southern Region Asian ICAMH/AOD Workforce by DHB Area (2008-2018)

DHB AREA	DHB[1]						NON-DHB						TOTAL					
	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018	2008	2010	2012	2014	2016	2018
NELSON MARLBOROUGH	1	-	-	-	-	1	-	-	-	-	-	-	1	-	-	-	-	1
WEST COAST	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CANTERBURY[1]	-	-	2	5	7	10	1	-	-	-	1	2	1	-	2	5	8	12
SOUTH CANTERBURY	-	1	-	-	1	1	1	-	-	-	-		1	1	-	-	1	1
SOUTHERN	2	-	-	1	2	1	-	-	1	-	3	1	2	-	1	1	5	2
TOTAL	3	1	2	6	10	13	2	-	1	-	4	3	5	1	3	6	14	16

1. Includes Inpatient Services

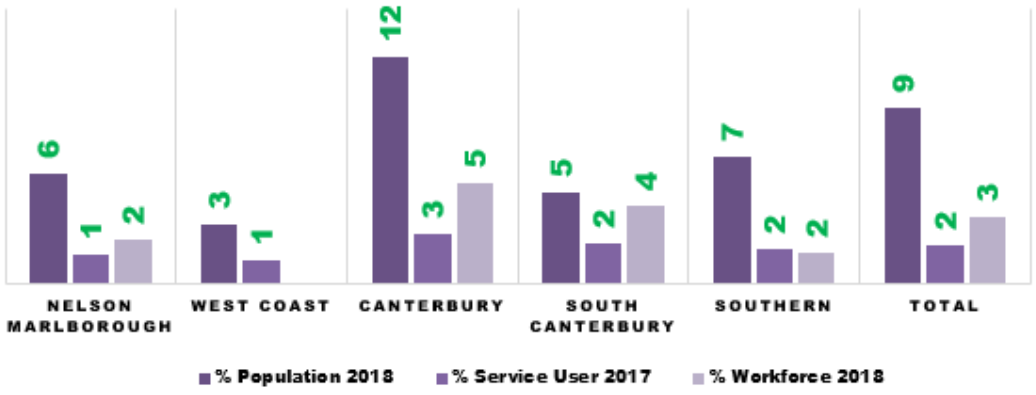
Table 18. Southern Region Asian ICAMH/AOD Workforce by Occupation (2018)

Southern Region Asian ICAMH/AOD Workforce by Occupation (Headcount, 2018)	DHB		DHB Total	Non-DHB	Total
	Inpatient	Community			
Child & Adolescent Psychiatrist	1	2	3	-	3
Nurse	5	1	6	-	6
Social Worker	-	4	4	-	4
Clinical Sub-Total	6	7	13	-	13
Mental Health Support Worker	-	-	-	1	1
Youth Worker	-	-	-	1	1
Other Non-Clinical	-	-	-	1	1
Non-Clinical Sub-Total	-	-		3	3
Total	6	7	13	3	16

SOUTHERN REGION ASIAN POPULATION, SERVICE USER AND WORKFORCE COMPARISONS

- Persistently low access rates for Asian service users accessing services means that the current Asian workforce appears to adequately represent the Asian service user demand in the region (Figure 29). However, given the increasing trend in the Asian population (a projected growth of 34% by 2028) and the number of Asian service users accessing services, there is a need to focus on increasing the Asian workforce in the region, especially in the Canterbury and Southern DHB areas.
- The majority of Asian service users also continue to access DHB services and were largely seen by the non-Asian workforce. Therefore strengthening and developing the current workforce (both Asian and non-Asian) to be clinically and culturally competent is also crucial.

Figure 29. Southern Region Asian 0-19 yrs Population, Service User & Workforce Comparisons



REFERENCES

ActionStation. (2018). *Ngā kōrero hauora o ngā taiohi. A community powered report on conversation with 1000 young people about wellbeing.* Wellington: ActionStation & Ara Taiohi.

Adolescent Health Research Group. (2003). New Zealand Youth: A profile of their health and wellbeing. Auckland: University of Auckland.

Ameratunga, S., Tin Tin, S., Rasanathan, K., Robinson, E., & Watson, P. (2008). Use of health care by young Asian New Zealanders: Findings from a national youth health survey. Journal of Paediatrics & Child Health, 44(11), 636-641.

Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci, A. (2004). Benefits and costs of prevention and early intervention programs for youth. Olympia: Washington State Institute for Public Policy.

Au, P., & Ho, E. (2015). Broken dreams? Chinese migrant families at risk: The New Zealand experience. In C. K. L. (Ed.), *Chinese migration and family at risk* (pp. 186-213). Newcastle upon Tyne, UK: Cambridge Scholars Publishing Ltd.

Badkar, J., & Tuya, C. (2010). *The Asian workforce: A critical part of New Zealand's current and future labour market*. Wellington: Department of Labour.

Clark, T. C., Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., . . . Utter, J. (2013). *Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012.* Auckland, New Zealand: The University of Auckland.

Clark, T. C., Lucassen, M. F. G., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., & Rossen, F. V. (2014). The health and well-being of transgender high school students: Results from the New Zealand Adolescent Health Survey (Youth'12). *Journal of Adolescent Health, 55*(1), 93-99.

Clark, T. C., Robinson, E., Crengle, S., Herd, R., Grant, S., & Denny, S. (2008). *Te Ara Whakapiki Taitamariki. Youth'07: The health and wellbeing survey of secondary school students in New Zealand. Results for Māori young people*. Auckland: The University of Auckland.

Crengle, S., Clark, T. C., Robinson, E., Bullen, P., Dyson, B., Denny, S., . . . The Adolescent Health Research Group. (2013). *The health and wellbeing of Māori New Zealand secondary school students in 2012. Te Ara Whakapiki Taitamariki: Youth'12.* Auckland, New Zealand: The University of Auckland.

Economic & Social Research Council. (2019). The impact of inequalities in the early years on outcomes over the life course: Using international evidence to identify creative policy solutions. Symposium:Understanding Inequalities Symposium The impact of inequalities in the early years on outcomes over the life course: Using international evidence to identify creative policy solutions March 11th 2019, Scottish Parliament.

Fa'alili-Fidow, J., Moselen, E., Denny, S., Dixon, R., Teevale, T., Ikihele, A., . . . Clark, T. C. (2016). *Youth'12 The health and wellbeing of secondary school students in New Zealand: Results for Pacific young people*. Auckland: The University of Auckland.

Fergusson, D., Poulton, R., Horwood, J., Milne, B., & Swain-Campbell, N. (2003). *Comorbidity and coincidence in the Christchurch and Dunedin Longitudinal Studies*. Wellington: Ministry of Social Development, Ministry of Education & the Treasury.

Forbes-Mewett, H., & Sawyer, A. (2016). International students and mental health. *Journal of International Students*, 6(3), 661-677.

Fortune, S., Watson, P., Robinson, E., Fleming, T., Merry, S., & Denny, S. (2010). *Youth'07: The health and wellbeing of secondary school students in New Zealand: Suicide behaviours and mental health 2001 and 2007.* Auckland: The University of Auckland.

Gibson, A., Miller, M., Smith, P., Bell, A., & Crothers, C. (2013). *The internet in New Zealand 2013*. Auckland, New Zealand: Institute of Culture, Discourse & Communication, AUT University.

Government Inquiry into Mental Health & Addiction. (2018). *He Ara Oranga. Report of the Government inquiry into mental health and addiction.* Wellington: Author.

Helu, S. L., Robinson, E., Grant, E., Herd, R., & Denny, S. (2009). *Youth'07: The health and wellbeing of secondary school students in New Zealand: Results for Pacific young people*. Auckland: University of Auckland.

Henderson, J. L., Hawke, L. D., Chaim, G., & National Youth Screening Project Network. (2017). Not in employment, education or training: Mental health, substance use,and disengagement in a multi-sectoral sample of service-seekingCanadian youth. *Children and Youth Services Review*, 75, 138-145.

Ho, E., Au, S., Bedford, C., & Cooper, J. (2003). *Mental health issues for Asians in New Zealand: A literature review*. Wellington: Mental Health Commission.

Kingi, P. (2008). Viewpoint: The cultural determinants of health. In E. Craig, S. Taufa, C. Jackson & D. Y. Han (Eds.), *The health of Pacific children and young people in New Zealand: Introduction, viewpoints and executive summary* (pp. 11-15). Auckland: Paediatric Society of New Zealand & The New Zealand Child & Youth Epidemiology Service.

Kumar, S., Tse, S., Fernando, A., & Sai Wong, S. (2006). Epidemiological studies on mental health needs of Asian population in New Zealand. *International Journal of Social Psychiatry, 52(5*), 408-412.

Lawson Williams Consulting Group. (2018). *New Zealand staff turnover survey report 2018.* Author

Lee, E. (1997). Chinese American families. In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians*. New York: Guilford Press.

Malatest International. (2016a). *Evaluation of SPARX*. Wellington: Auckland: Author.

Malatest International. (2016b). *Evaluation report: The youth primary mental health service*. Wellington: Ministry of Health.

Mehta, S. (2012). *Health needs assessment of Asian people living in the Auckland region*. Auckland: Northern DHB Support Agency.

Mental Health and Addiction Service Workforce Review Working Group. (2011). *Towards the next wave of mental health & addiction services and capability: Workforce service review report*. Wellington: Author.

Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be*. Wellington: Author.

Mental Health Commission. (2012). *Blueprint II: How things need to be*. Wellington: Author.

Merry, S. N., Stasiak, K., Shepherd, M. (2012). The effectiveness of SPARX, a computerised self help intervention for adolescents seeking help for depression: Randomised controlled non-inferiority trial. *BMJ*, 344:e2598.

Mila-Schaaf, K. (2008). Viewpoint: Pacific youth: Key messages. In E. Craig, S. Taufa, C. Jackson & D. Y. Han (Eds.), *The health of Pacific children and young people in New Zealand: Introduction, viewpoints and executive summary* (pp. 31-34). Auckland: New Zealand Paediatric Society & New Child & Youth Epidemiology Service.

Mila-Schaaf, K., Robinson, E., Denny, S., & Watson, P. (2008). *A health profile of Pacific youth: Findings of Youth2000. A national secondary school youth health survey*. Auckland: The University of Auckland.

Minister of Health. (2005). *Te Tāhuhu-Improving mental health 2005-2015: The second New Zealand mental health and addiction plan*. Wellington: Author.

Minister of Health. (2006). *Te Kokiri: The mental health and addiction plan 2006-2015*. Wellington: Ministry of Health.

Minister of Health. (2010). *Government protects health's spending power*. Retrieved 11 November, 2010, from http://www.national.org.nz/Article.aspx?articleId=32952.

Ministry of Business Innovation & Employment. (2013). Youth labour market factsheet-March 2013. Retrieved from http://www.dol.govt.nz/publications/lmr/pdfs/lmr-fs/lmr-fs-youth-mar13.pdf.

Ministry of Business Innovation & Employment. (2016a). *Māori in the Labour Market - March 2016 Year*. Wellington: Author.
Ministry of Business Innovation & Employment. (2016b). *Pacific Peoples in the Labour Market - March 2016 Year*. Wellington: Author.
Ministry of Education. (2016). Export education levy key statistics (January to August). Wellington: Author.
Ministry of Health. (2002). *Mental health (alcohol and other drugs) workforce development framework*. Wellington: Author.
Ministry of Health. (2005). *Tauawhitia te Wero: Embracing the Challenge: National mental health and addiction workforce development plan 2006-2009.* Wellington: Author.
Ministry of Health. (2006). *Asian health chart book 2006*. Wellington: Author.
Ministry of Health. (2007). *Te Raukura: Mental health and alcohol and other drugs: Improving outcomes for children and youth*. Wellington: Author.
Ministry of Health. (2008a). *Pacific Peoples and mental health: A paper for the Pacific health and disability action plan review*. Wellington: Author.
Ministry of Health. (2008b). *Te Puawaiwhero: The second Māori mental health and addiction national strategic framework 2008-2015*. Wellington: Author.
Ministry of Health. (2010a). *Mental health and addiction action plan 2010*. Wellington: Author.
Ministry of Health. (2010b). *Tatau Kahukura: Māori health chart book 2010*. Wellington: Author.
Ministry of Health. (2011). *Youth forensic services development: Guidance for the health and disability sector on the development of specialist forensic mental health, alcohol and other drug, and intellectual disability services for young people involved in New Zealand's justice system*. Wellington: Author.
Ministry of Health. (2012a). *The health of New Zealand children 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Author.
Ministry of Health. (2012b). *Healthy Beginnings: Developing perinatal and infant mental health services in New Zealand*. Wellington: Author.
Ministry of Health. (2012c). *Rising to the challenge: The mental health and addiction service development plan 2012-2017*. Wellington: Author.
Ministry of Health (2014). *Youth health care in secondary schools: A framework for continuous quality improvement.* Wellington: Author.
Ministry of Health. (2016). *Suicide facts: Deaths and intentional self-harm hospitalisations: 2013*. Wellington: Author.
Ministry of Health. (2017). *Mental health and addiction workforce action plan 2017-2021*. Wellington: Author.
Ministry of Health. (2018). *Social, Emotional and Behavioural Difficulties in New Zealand Children: Summary of findings*. Wellington: Author.
Ministry of Health. (2019a). *Report on Maternity 2017*. Wellington: Author.
Ministry of Health (2019b). *Government response to the Mental Health Inquiry.* Retieved June 2019, from https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction.
Ministry of Justice. (2019). *Asian ethnic group provision suicide data 1 July 2012 to 30 June 2017*. Coronors Office. Author: Wellington.
Morton, S. M. B., Atatoa Carr, P. E., Grant, C. C., Berry, S. D., Marks, E. J., Chen, X. M.-H., & Lee, A. C. (2014). *Growing up in New Zealand: A longitudinal study of New Zealand children and their families. Vulnerability report 1: Exploring the definition of vulnerability for children in their first 1000 days*. Auckland: Growing up in New Zealand.
New Zealand Goverment. (2012). *The Children's Action Plan. Identifying, supporting and protecting vulnerable children*. Wellington: Author.
Nyar, S., & Tse, S. (2006). Cultural competence and models in mental health: Working with Asian service users. *International Journal of Psychosocial Rehabilitation, 10*(2), 79-87.
Office of the Prime Minister's Science Advisory Committee. (2011). *Improving the transition. Reducing social and psychological morbidity during adolescence. A report from the Prime Minister's Chief Science Advisor*. Auckland: Author.
Office of the Prime Minister's Science Advisory Committee. (2018). *It's never too early, never too late: A discussion paper on preventing youth offending in New Zealand. A report from the Prime Minister's Chief Science Advisor*. Auckland: Author.
Parackal, S., Ameratunga, S., Tin Tin, S., Wong, S., & Denny, S. (2011). *Youth'07: The health and wellbeing of secondary school students in New Zealand: Results for Chinese, Indian and other Asian students*. Auckland: The University of Auckland.
Peiris-John, R., Ameratunga, S., Lee, A., Teevale, T., & Clark, T. C. (2014). *[Youth 2012] Healthcare interactions among young immigrants in New Zealand: Potential use of health information technology (Presentation).* Paper presented at the New Zealand Population Health Congress, Auckland, New Zealand.
Ramage, C., Bir, J., Towns, A., Vague, R., Cargo, T., & Nuimata-Faleafa, M. (2005). *Stocktake of child and adolescent mental health servivces in New Zealand*. Auckland: The Werry Centre for Child and Adolescent Mental Health Workforce Development.
Shepherd, M., Merry, S., Lambie, I., & Thompson, A. (2018). Indigenous adolescents' perception of an eMental health program (SPARX): Exploratory qualitative assessment. *JMIR Serious Games,* 6(3): e13. Published online 2018 Jul 5.
Smilth, M. (2018). Capability and adversity: reframing the "causes of the causes" for mental health. *Palgrave Communications, 4. DO: 10.1057/s41599-018-0066-z.*
Southwick, M., Kenealy, T., & Ryan, D. (2012). *Primary care for Pacific People: A Pacific and health systems approach. Report to the Health Research Council and the Ministry of Health*. Wellington: Ministry of Health.
Statistics New Zealand. (2002). *Census snapshot: Pacific Peoples*. Wellington: Statistics New Zealand.
Statistics New Zealand. (2004a). *Ethnic population projections: Issues and trends*. Wellington: Statistics New Zealand.
Statistics New Zealand. (2004b). *Household access to the internet*. Wellington: Author.
Statistics New Zealand. (2006a). *The impact of prioritisation on the interpretation of ethnicity data*. Wellington: Author.
Statistics New Zealand. (2006b). Projected ethnic population of New Zealand by age and sex, 2006 (base)-2026. Retrieved 12 December, 2010, from http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalEthnicPopulationProjections_HOTP2006-26/Commentary.aspx.
Statistics New Zealand. (2013). 2013 Census QuickStats about national highlights. Retrieved from http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-national-highlights/cultural-diversity.aspx.
Statistics New Zealand. (2016). Labour Market Statistics: March 2016 Quarter. Wellington: Author.
Te Pou o te Whakaaro Nui. (2014). *Competencies for the mental health and addiction service user, consumer and peer workforce*. Auckland: Author.
Te Rau Matatini. (2007). *Whakapakari Ake Te Tipu-Māori child and adolescent mental health and addiction workforce strategy*. Wellington: Author.
The Refugee & Protection Unit. (2016). *Refugee Quota Branch (RQB) Statistics*. Wellington, New Zealand: Ministry of Business, Innovation & Employment.
The Werry Centre. (2009a). *Guidelines for enabling effective youth consumer participation in CAMH and AOD services in New Zealand*. Auckland: Author.
The Werry Centre. (2009b). *Real Skills Plus CAMHS. A competency framework for the infant, child and youth mental health and alcohol and other drug workforce*. Auckland: The Werry Centre for Child and Adolescent Mental Health Workforce Development, University of Auckland.

Tuatagaloa, P. & Wilson, R. (2018). ***Youth not in employment, education or training (NEET) in Auckland. Auckland Council Technical Report, TR2018/029.***

Wang, C., & Mallinckrodt, B. (2006). Acculturation, attachment, and psychosocial adjustment of Chinese/Taiwanese international students. ***Journal of Counseling Psychology, 53(4),*** **422- 433. doi: 10.1037/0012-0167.53.4.422.**

Wille, A. (2006). ***Whakamarama te Huarahi: To light the pathways. A strategic framework for child and adolescent mental health workforce development 2006-2016.*** **Auckland: The Werry Centre for Child & Adolescent Mental Health Workforce Development.**

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that infuence Asian communities' access to mental health care. ***International Journal of Mental Health Nursing*****, 14, 88-95.**

York, A., Kingsbury, S. (2006). ***The 7 HELPFUL Habits of Effective CAMHS and The Choice and Partnership Approach*****: A workbook for CAMHS. London: CAMSH Network.**

APPENDICES

APPENDIX A: POPULATION DATA

Table 1. 0-19 yrs Population by Ethnicity & DHB Area (2013-2018)

DHB REGION/AREA	0-19 YEAR POPULATION BY ETHNICITY (2013-2018)																			
	TOTAL				OTHER				MĀORI				PACIFIC				ASIAN			
	2013[1]	2016[2]	2018[3]	% (2018-2016)	2013	2016	2018	% (2018-2016)	2013[1]	2016[2]	2018[3]	% (2018-2016)	2013[1]	2016[2]	2018[3]	% (2018-2016)	2013[1]	2016[2]	2018[3]	% (2018-2016)
NORTHERN	**472,780**	**484,140**	**487,250**	**0.6**	**201,380**	**195,720**	**192,230**	**-1.8**	**99,410**	**102,680**	**104,540**	**1.8**	**82,750**	**83,190**	**83,260**	**0.1**	**89,210**	**102,520**	**108,830**	**6.2**
Northland	47,500	47,290	47,070	-0.5	20,890	19,200	18,300	-4.7	24,110	25,170	25,590	1.7	1,220	1,370	1,500	9	1,270	1,530	1,680	10
Waitemata	152,230	156,560	159,010	1.6	84,780	81,670	80,240	-1.8	24,230	25,370	26,130	3.0	15,820	16,320	16,570	2	27,410	33,180	36,050	9
Auckland	114,410	116,700	116,540	-0.1	49,870	49,950	49,110	-1.7	14,340	14,240	14,230	-0.1	20,170	19,620	19,190	-2	30,020	32,890	34,010	3
Counties Manukau	158,640	163,590	164,630	0.6	45,880	44,900	44,580	-0.7	36,730	37,900	38,590	1.8	45,540	45,880	46,000	0.3	30,510	34,920	37,090	6
MIDLAND	**246,040**	**249,780**	**249,620**	**-0.1**	**129,800**	**124,620**	**120,180**	**-3.6**	**95,040**	**99,330**	**101,320**	**2.0**	**7,480**	**8,330**	**8,895**	**7**	**13,685**	**17,470**	**16,800**	**-4**
Waikato	109,510	112,040	112,460	0.4	60,100	58,120	56,100	-3.5	37,570	39,480	40,600	2.8	4,100	4,630	5,000	8.0	7,730	9,830	8,390	-15
Lakes	30,510	30,230	29,600	-2.1	12,790	11,840	11,190	-5.5	15,320	15,770	15,710	-0.4	970	940	930	-1	1,420	1,660	1,750	5
Bay of Plenty	59,490	60,670	60,740	0.1	31,600	30,420	29,260	-3.8	23,340	24,510	25,170	2.7	1,480	1,700	1,830	8	3,060	4,010	4,450	11
Tairawhiti	15,140	15,000	14,840	-1.1	4,710	4,350	4,160	-4.4	9,710	9,840	9,820	-0.2	415	480	515	7	295	330	340	3
Taranaki	31,390	31,840	31,980	0.4	20,590	19,890	19,470	-2.1	9,100	9,730	10,020	3.0	515	580	620	7	1,180	1,640	1,870	14
CENTRAL	**236,110**	**235,250**	**233,640**	**-0.7**	**134,580**	**127,200**	**122,410**	**-3.8**	**65,750**	**68,290**	**69,540**	**1.8**	**17,520**	**18,095**	**18,455**	**2**	**18,220**	**21,675**	**23,240**	**7**
Hawke's Bay	45,440	45,150	44,690	-1.0	23,880	22,030	20,890	-5.2	17,600	18,490	18,840	1.9	2,380	2,610	2,760	6	1,570	2,020	2,200	9
MidCentral	46,800	46,930	46,600	-0.7	27,330	25,850	24,840	-3.9	14,520	15,210	15,430	1.4	2,010	2,260	2,390	6	2,920	3,630	3,940	9
Whanganui	17,210	16,780	16,400	-2.3	9,410	8,630	8,150	-5.6	6,780	6,960	7,010	0.7	570	650	680	5	455	540	580	7
Capital & Coast	75,750	76,360	76,450	0.1	45,200	44,240	43,350	-2.0	13,440	13,620	13,910	2.1	7,900	7,830	7,830	-	9,210	10,670	11,370	7
Hutt	39,760	38,940	38,490	-1.2	21,430	19,410	18,300	-5.7	10,220	10,690	10,970	2.6	4,290	4,350	4,410	1	3,820	4,500	4,810	7
Wairarapa	11,150	11,090	11,010	-0.7	7,350	7,040	6,880	-2.3	3,190	3,320	3,380	1.8	370	395	385	-3	245	315	340	8
SOUTHERN	**266,310**	**272,630**	**274,420**	**0.7**	**199,930**	**196,720**	**193,780**	**-1.5**	**41,630**	**44,730**	**46,560**	**4.1**	**8,165**	**9,275**	**9,975**	**8**	**16,655**	**21,930**	**23,985**	**9**
Nelson Marlborough	35,550	35,410	35,280	-0.4	27,120	26,070	25,500	-2.2	6,150	6,520	6,740	3.4	870	1010	1,090	8	1,380	1,810	1,970	9
West Coast	8,250	7,980	8,040	0.8	6,380	5,940	5,900	-0.7	1,520	1,590	1,640	3.1	125	155	175	13	220	290	245	-16
Canterbury	129,110	134,770	136,700	1.4	95,010	94,670	93,530	-1.2	18,960	20,540	21,560	5.0	4,710	5,310	5,710	8	10,430	14,250	15,880	11
South Canterbury	14,230	14,130	14,050	-0.6	11,500	11,040	10,790	-2.3	2,030	2,240	2,300	2.7	230	280	250	-11	455	590	650	10
Southern	79,170	80,340	80,350	0.0	59,820	59,000	58,060	-1.6	12,970	13,840	14,320	3.5	2,230	2,520	2,750	9	4,170	4,990	5,240	5
TOTAL	**1,221,250**	**1,241,810**	**1,246,600**	**0.4**	**665,690**	**644,290**	**628,650**	**-2.4**	**301,860**	**315,040**	**321,970**	**2.2**	**115,920**	**118,890**	**120,730**	**2**	**137,780**	**163,590**	**175,260**	**7**

1. 2013 Census (Prioritised Ethnicity) Source: Statistics NZ: Ref No: JOB-05958

2. 2016 & 2018 Population Projections (Base 2013 Census, Prioritised Ethnicity), Ref No: JOB-07144

Table 2. 0-19 yrs Population Projections by Ethnicity & DHB Area (2013-2028)

DHB/REGION	0-19 YEAR POPULATION BY ETHNICITY																			
	TOTAL				OTHER				MĀORI				PACIFIC				ASIAN			
	2013[1]	2018[2]	2023[2]	2028[2]	2013[1]	2018[2]	2023[2]	2028[2]	2013[1]	2018[2]	2023[2]	2028[2]	2013[1]	2018[2]	2023[2]	2028[2]	2013[1]	2018[2]	2023[2]	2028[2]
NORTHERN	484,140	487,250	502,190	519,400	201,380	195,720	184,060	175,400	102,680	104,540	109,740	115,660	83,190	83,260	84,050	86,570	102,520	108,830	124,370	141,770
Northland	47,290	47,070	47,000	46,740	20,890	19,200	16,470	14,560	25,170	25,590	26,820	27,990	1,370	1,500	1,740	1,950	1,530	1,680	1,980	2,270
Waitemata	156,560	159,010	166,070	173,810	84,780	81,670	76,740	73,600	25,370	26,130	28,170	30,190	16,320	16,570	17,420	18,380	33,180	36,050	43,750	51,620
Auckland	116,700	116,540	118,680	123,050	49,870	49,950	48,310	46,300	14,240	14,230	14,560	15,290	19,620	19,190	18,370	18,190	32,890	34,010	37,420	43,270
Counties Manukau	163,590	164,630	170,440	175,800	45,880	44,900	42,540	40,940	37,900	38,590	40,190	42,190	45,880	46,000	46,520	48,050	34,920	37,090	41,220	44,610
MIDLAND	249,780	249,620	249,680	248,910	129,800	124,620	110,220	100,710	99,330	101,320	106,310	110,560	8,330	8,895	10,230	11,420	17,470	16,800	22,955	26,225
Waikato	112,040	112,460	113,380	113,690	60,100	58,120	51,620	47,240	39,480	40,600	43,150	45,430	4,630	5,000	5,850	6,570	9,830	8,390	12,740	14,460
Lakes	30,230	29,600	28,560	27,400	12,790	11,840	9,800	8,350	15,770	15,710	15,820	15,850	940	930	910	910	1,660	1,750	2,040	2,310
Bay of Plenty	60,670	60,740	61,010	61,470	31,600	30,420	26,700	24,760	24,510	25,170	26,680	27,870	1,700	1,830	2,180	2,500	4,010	4,450	5,460	6,350
Tairawhiti	15,000	14,840	14,500	14,050	4,710	4,350	3,750	3,320	9,840	9,820	9,760	9,620	480	515	610	680	330	340	385	405
Taranaki	31,840	31,980	32,230	32,300	20,590	19,890	18,350	17,040	9,730	10,020	10,900	11,790	580	620	680	760	1,640	1,870	2,330	2,700
CENTRAL	235,250	233,640	230,300	227,260	134,580	127,200	110,410	99,270	68,290	69,540	73,510	77,190	18,095	18,455	19,405	20,045	21,675	23,240	27,040	30,780
Hawke's Bay	45,150	44,690	43,970	43,170	23,880	22,030	18,360	15,800	18,490	18,840	19,890	20,940	2,610	2,760	3,100	3,400	2,020	2,200	2,620	3,010
MidCentral	46,930	46,600	46,120	45,730	27,330	25,850	22,390	20,150	15,210	15,430	16,460	17,470	2,260	2,390	2,760	3,050	3,630	3,940	4,510	5,060
Whanganui	16,780	16,400	15,890	15,490	9,410	8,630	7,110	6,200	6,960	7,010	7,310	7,570	650	680	790	850	540	580	700	880
Capital & Coast	76,360	76,450	76,290	76,210	45,200	44,240	40,690	38,160	13,620	13,910	14,660	15,350	7,830	7,830	7,860	7,900	10,670	11,370	13,090	14,820
Hutt	38,940	38,490	37,270	36,220	21,430	19,410	15,550	13,300	10,690	10,970	11,550	11,960	4,350	4,410	4,470	4,410	4,500	4,810	5,720	6,560
Wairarapa	11,090	11,010	10,760	10,440	7,350	7,040	6,310	5,660	3,320	3,380	3,640	3,900	395	385	425	435	315	340	400	450
SOUTHERN	272,630	274,420	275,400	275,070	199,930	196,720	184,510	174,330	44,730	46,560	50,940	55,330	9,275	9,975	11,795	13,230	21,930	23,985	28,175	32,130
Nelson Marlborough	35,410	35,280	34,700	33,710	27,120	26,070	23,760	21,610	6,520	6,740	7,300	7,950	1010	1090	1290	1420	1,810	1,970	2,360	2,730
West Coast	7,980	8,040	8,020	7,950	6,380	5,940	5,670	5,360	1,590	1,640	1,770	1,910	155	175	210	235	290	245	385	420
Canterbury	134,770	136,700	138,570	139,920	95,010	94,670	89,230	84,970	20,540	21,560	23,770	25,830	5,310	5,710	6,690	7,520	14,250	15,880	18,860	21,570
South Canterbury	14,130	14,050	14,060	14,110	11,500	11,040	10,380	9,900	2,240	2,300	2,520	2,840	280	250	395	465	590	650	770	900
Southern	80,340	80,350	80,050	79,380	59,820	59,000	55,470	52,490	13,840	14,320	15,580	16,800	2,520	2,750	3,210	3,590	4,990	5,240	5,800	6,510
TOTAL	1,241,810	1,246,600	1,257,620	1,270,660	665,690	644,290	589,150	549,770	315,040	321,970	340,460	358,760	118,890	120,730	125,460	131,250	163,590	175,260	202,510	230,880

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. 0-19 yrs Service User by Region & DHB Area (2014-2017)

REGION/DHB	TOTAL 0-19 YRS SERVICE USER BY REGION & DHB AREA (2014-2017)											
	2014			2015			2016			2017		
	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL
NORTHERN	10,056	2,214	12,270	10,380	2,090	12,470	10,801	2,010	12,811	11,500	1,899	13,399
Northland	1,151	563	1,714	1,143	533	1,676	1,152	528	1,680	1,203	432	1,635
Waitemata	3,722	310	4,032	3,812	257	4,069	3,745	225	3,970	4,309	118	4,427
Auckland	2,048	286	2,334	2,349	222	2,571	2,830	266	3,096	2,876	315	3,191
Counties Manukau	3,135	1,055	4,190	3,076	1,078	4,154	3,074	991	4,065	3,112	1,034	4,146
MIDLAND	4,851	2,212	7,063	4,838	3,057	7,895	5,027	3,377	8,404	5,354	3,577	8,931
Waikato	1,522	854	2,376	1,688	1,656	3,344	1,571	1,920	3,491	1,815	1,798	3,613
Lakes	626	274	900	606	299	905	702	469	1,171	646	578	1,224
Bay of Plenty	1,502	778	2,280	1,460	819	2,279	1,606	790	2,396	1,670	887	2,557
Tairawhiti	531	123	654	460	111	571	420	75	495	375	186	561
Taranaki	670	183	853	624	172	796	728	123	851	848	128	976
CENTRAL	5,388	1,516	6,904	5,796	1,143	6,939	6,071	1,289	7,360	6,129	1,067	7,196
Hawke's Bay	994	192	1,186	1,102	212	1,314	1,024	156	1,180	1,096	112	1,208
MidCentral	911	384	1,295	969	403	1,372	1,150	382	1,532	1,046	298	1,344
Whanganui	403	50	453	421	52	473	473	64	537	556	44	600
Capital & Coast	1,884	443	2,327	2,060	216	2,276	2,147	374	2,521	2,171	351	2,522
Hutt Valley	983	301	1,284	1,014	115	1,129	1,031	183	1,214	999	160	1,159
Wairarapa	213	146	359	230	145	375	246	130	376	261	102	363
SOUTHERN	5,937	2,135	8,072	5,807	2,214	8,021	5,320	2,290	7,610	5,905	2,321	8,226
Nelson Marlborough	1,002	80	1,082	917	63	980	996	80	1,076	1,125	99	1,224
West Coast	357	89	446	291	5	296	242	65	307	271	72	343
Canterbury	2,486	870	3,356	2,539	935	3,474	2,631	929	3,560	2,710	858	3,568
South Canterbury	458	174	632	427	164	591	349	165	514	380	214	594
Southern	1,634	922	2,556	1,633	1,047	2,680	1,102	1,051	2,153	1,419	1,078	2,497
Overseas	-	-	-	-	-	-	-	25	25	-	18	18
TOTAL	26,232	8,077	34,309	26,821	8,504	35,325	27,219	8,991	36,210	28,888	8,882	37,770

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

Table 2. Service User by DHB Area, Gender & Age Group (2017)

REGION/ DHB AREA	SERVICE USER BY GENDER & AGE GROUP (YRS) 2017														
	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	1,770	49	1,823	265	2,627	721	813	51	1,449	207	3,018	606	11,500	1,899	13,399
Northland	160	3	231	67	268	182	53	-	175	65	316	115	1,203	432	1,635
Waitemata	676	3	612	14	1,217	45	300	4	420	3	1,084	49	4,309	118	4,427
Auckland	392	16	408	28	604	119	274	16	416	31	782	105	2,876	315	3,191
Counties Manukau	542	27	572	156	538	375	186	31	438	108	836	337	3,112	1,034	4,146
MIDLAND	725	381	950	636	1,156	938	278	171	747	523	1,498	928	5,354	3,577	8,931
Waikato	245	200	311	346	387	471	88	78	250	258	534	445	1,815	1,798	3,613
Lakes	129	30	133	90	116	147	39	6	88	115	141	190	646	578	1,224
Bay of Plenty	199	121	287	161	385	220	81	70	226	115	492	200	1,670	887	2,557
Tairawhiti	68	29	72	28	70	41	26	17	53	29	86	42	375	186	561
Taranaki	84	1	147	11	198	59	44	-	130	6	245	51	848	128	976
CENTRAL	700	58	985	178	1,419	375	353	37	833	147	1,837	272	6,129	1,067	7,196
Hawke's Bay	103	1	179	5	297	65	47	-	136	5	334	36	1,096	112	1,208
MidCentral	151	4	192	43	197	131	66	1	150	30	290	89	1,046	298	1,344
Whanganui	55	-	95	7	129	15	31	1	84	3	161	18	556	44	600
Capital & Coast	235	45	300	93	595	68	115	29	271	66	654	50	2,171	351	2,522
Hutt Valley	131	4	179	17	156	59	80	2	153	22	300	56	999	160	1,159
Wairarapa	25	4	40	13	45	37	14	4	39	21	98	23	261	102	363
SOUTHERN	758	173	971	304	1,273	589	293	111	768	291	1,841	853	5,905	2,321	8,226
Nelson Marlborough	82	2	194	5	258	39	49	3	159	10	382	40	1,125	99	1,224
West Coast	66	18	49	18	55	14	18	7	32	7	51	8	271	72	343
Canterbury	405	13	450	59	564	252	141	19	368	101	782	414	2,710	858	3,568
South Canterbury	65	-	58	29	82	41	21	-	51	41	103	103	380	214	594
Southern	140	140	220	193	314	243	64	82	158	132	523	288	1,419	1,078	2,497
Overseas	-	1	-	3	-	5	-	3	-	1	-	5	-	18	18
TOTAL	3,953	662	4,729	1,386	6,475	2,628	1,737	373	3,797	1,169	8,194	2,664	28,888	8,882	37,770

Source: MHINC/PRIMHD: July-December 2017

Table 3. Māori 0-19 yrs Service User by DHB Area (2014-2017)

REGION/DHB AREA	MĀORI 0-19 YRS SERVICE USER BY DHB AREA (2012-2017)											
	2014			2015			2016			2017		
	DHB	NGO	Total	DHB	NGO	Total	DHB	NGO	Total	DHB	NGO	Total
NORTHERN	2,991	1,133	4,124	3,068	1,151	4,219	3,093	1,095	4,188	3,508	938	4,446
Northland	568	402	970	561	410	971	537	382	919	574	314	888
Waitemata	976	131	1,107	1,087	143	1,230	990	121	1,111	1,165	43	1,208
Auckland	493	97	590	576	102	678	692	125	817	723	133	856
Counties Manukau	954	503	1,457	844	496	1,340	874	467	1,341	966	448	1,414
MIDLAND	1,628	1,218	2,846	1,669	1,523	3,192	1,755	1,568	3,323	1,864	1,901	3,765
Waikato	379	388	767	448	659	1,107	425	710	1,135	533	827	1,360
Lakes	221	118	339	238	148	386	276	217	493	263	281	544
Bay of Plenty	517	494	1,011	549	520	1,069	582	510	1,092	613	606	1,219
Tairawhiti	352	112	464	288	104	392	277	70	347	226	125	351
Taranaki	159	106	265	146	92	238	195	61	256	229	62	291
CENTRAL	1,572	719	2,291	1,787	620	2,407	1,896	635	2,531	1,950	572	2,522
Hawke's Bay	396	132	528	480	157	637	420	119	539	464	89	553
MidCentral	227	156	383	263	173	436	304	149	453	268	125	393
Whanganui	140	25	165	141	24	165	170	34	204	209	26	235
Capital & Coast	510	186	696	554	186	740	634	186	820	665	207	872
Hutt Valley	250	160	410	274	160	434	293	160	453	276	73	349
Wairarapa	49	54	103	75	79	154	75	77	152	68	52	120
SOUTHERN	1,038	420	1,458	1,113	411	1,524	1,004	428	1,432	1,246	496	1,742
Nelson Marlborough	180	13	193	181	11	192	149	18	167	213	16	229
West Coast	99	13	112	65	4	69	42	7	49	49	12	61
Canterbury	461	188	649	528	177	705	566	172	738	630	200	830
South Canterbury	66	29	95	70	24	94	53	24	77	79	44	123
Southern	232	177	409	269	195	464	194	207	401	275	224	499
TOTAL	7,229	3,503*	10,732*	7,637	3,720*	11,357*	7,748	3,735*	11,483*	8,568	3,917	12,485

Source: PRIMHD: Data are for the second six months of each year.
*2014: Includes 13 Overseas Service users; 2015: Includes 15 Overseas Service users.
2016* Includes 9 Overseas Service users

Table 4. Pacific 0-19 yrs Service User by DHB Area (2014-2017)

REGION/DHB AREA	PACIFIC 0-19 YRS SERVICE USER BY DHB AREA (2014-2017)											
	2014			2015			2016			2017		
	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL	DHB	NGO	TOTAL
NORTHERN	1,343	380	1,723	1,208	394	1,602	1,293	382	1,675	1,313	473	1,786
Northland	25	4	29	22	10	32	27	12	39	31	11	42
Waitemata	493	28	521	404	21	425	400	24	424	417	9	426
Auckland	267	61	328	256	54	310	309	58	367	342	90	432
Counties Manukau	558	287	845	526	309	835	557	288	845	523	363	886
MIDLAND	56	40	96	55	80	135	76	93	169	93	134	227
Waikato	14	23	37	27	64	91	27	61	88	37	93	130
Lakes	12	6	18	6	4	10	23	13	36	11	11	22
Bay of Plenty	20	8	28	16	10	26	15	15	30	30	24	54
Tairawhiti	6	1	7	2	-	2	4	1	5	5	3	8
Taranaki	4	2	6	4	2	6	7	3	10	10	3	13
CENTRAL	201	160	361	199	86	285	241	137	378	220	85	305
Hawke's Bay	28	14	42	26	11	37	19	8	27	31	4	35
MidCentral	15	8	23	16	10	26	28	8	36	22	4	26
Whanganui	5	-	5	6	3	9	16	3	19	14	0	14
Capital & Coast	99	109	208	99	49	148	113	88	201	110	63	173
Hutt Valley	51	26	77	51	9	60	63	27	90	39	12	51
Wairarapa	3	3	6	1	4	5	2	3	5	4	2	6
SOUTHERN	83	36	119	94	41	135	113	53	166	117	54	171
Nelson Marlborough	7	-	7	12	-	12	12	2	14	10	2	12
West Coast	1	-	1	-	-	-	6	3	9	0	0	0
Canterbury	44	16	60	50	17	67	66	22	88	67	21	88
South Canterbury	5	2	7	2	-	2	6	1	7	5	3	8
Southern	26	18	44	30	24	54	23	25	48	35	28	63
TOTAL	1,683	616	2,299	1,556	604*	2,160*	1,723	665	2,388	1,743	746	2,489

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

* Includes 3 Overseas Service users

Table 5. Asian 0-19 yrs Service User by DHB Area (2014-2017)

REGION/DHB AREA	ASIAN 0-19 YRS SERVICE USER BY DHB AREA (2014-2017)											
	2014			2015			2016			2017		
	DHB	*NGO*	TOTAL	*DHB*	*NGO*	TOTAL	*DHB*	*NGO*	TOTAL	*DHB*	*NGO*	TOTAL
NORTHERN	634	90	724	692	82	774	785	69	854	909	77	986
Northland	5	1	6	3	-	3	11	-	11	11	1	12
Waitemata	197	9	206	206	3	209	219	5	224	311	4	315
Auckland	197	21	218	248	8	256	306	16	322	336	17	353
Counties Manukau	235	59	294	235	71	306	249	48	297	251	55	306
MIDLAND	58	12	70	72	34	106	74	44	118	75	51	126
Waikato	23	2	25	28	22	50	19	28	47	29	31	60
Lakes	6	2	8	10	2	12	9	6	15	5	4	9
Bay of Plenty	20	8	28	21	10	31	34	9	43	24	9	33
Tairawhiti	4	-	4	3	-	3	1	-	1	8	4	12
Taranaki	5	-	5	10	-	10	11	1	12	9	3	12
CENTRAL	126	14	140	143	10	153	177	17	194	171	22	193
Hawke's Bay	10	-	10	6	2	8	13	-	13	8	-	8
MidCentral	8	3	11	16	3	19	21	3	24	23	11	34
Whanganui	4	1	5	2	-	2	3	-	3	6	-	6
Capital & Coast	70	3	73	86	3	89	104	11	115	103	8	111
Hutt Valley	33	6	39	32	2	34	33	3	36	30	3	33
Wairarapa	1	1	2	1	-	1	3	-	3	1	-	1
SOUTHERN	81	33	114	103	28	131	82	39	121	125	43	168
Nelson Marlborough	7	1	8	10	1	11	10	-	10	16	2	18
West Coast	4	1	5	2	0	2	2	1	3	3	1	4
Canterbury	40	18	58	57	13	70	53	18	71	71	19	90
South Canterbury	5	3	8	7	1	8	2	3	5	8	4	12
Southern	25	10	35	27	13	40	15	17	32	27	17	44
TOTAL	899	149	1,048	1,010	154	1,164	1,118	171	1,289	1,280	193	1,473

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

Table 6. Service User Access Rates by Age Group & Region (2008-2017)

YEAR		SERVICE USER 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	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%
	2016*	0.97%	3.11%	5.57%	2.65%
	2017*	1.08%	3.21%	5.72%	2.75%
MIDLAND	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%
	2015*	1.01%	3.73%	7.20%	3.18%
	2016*	1.17%	4.04%	7.34%	3.36%
	2017*	1.21%	4.59%	7.53%	3.57%
CENTRAL	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%
	2015*	0.95%	3.48%	6.33%	2.95%
	2016*	1.00%	3.66%	6.79%	3.13%
	2017*	0.97%	3.78%	6.51%	3.07%
SOUTHERN	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%
	2015*	1.01%	3.54%	6.05%	2.97%
	2016*	0.97%	3.23%	5.77%	2.79%
	2017*	0.99%	3.52%	6.26%	3.00%

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

Table 7. 0-19 yrs Service User Access Rates by DHB Area (2008-2017)

REGION/DHB AREA	0-19 YRS ACCESS RATES BY REGION & DHB AREA									
	2008	2009	2010*	2011*	2012*	2013*	2014*	2015*	2016*	2017*
NORTHERN	**1.44%**	**1.65%**	**1.89%**	**2.02%**	**2.00%**	**2.19%**	**2.59%**	**2.60%**	**2.65%**	**2.75%**
Northland	1.37%	1.68%	2.43%	2.84%	2.78%	3.65%	**3.62%**	**3.54%**	3.55%	3.46%
Waitemata	1.46%	2.04%	2.29%	2.30%	2.10%	2.25%	**2.64%**	**2.63%**	2.54%	2.80%
Auckland	1.25%	1.28%	1.36%	1.69%	1.72%	1.85%	**2.05%**	**2.22%**	2.65%	2.73%
Counties Manukau	1.57%	1.52%	1.71%	1.75%	1.84%	1.95%	**2.61%**	**2.57%**	2.48%	2.51%
MIDLAND	**1.41%**	**1.45%**	**2.01%**	**2.75%**	**2.24%**	**2.96%**	**2.87%**	**3.18%**	**3.36%**	**3.57%**
Waikato	1.00%	1.00%	1.40%	2.43%	0.65%	2.05%	**2.16%**	**3.01%**	3.12%	3.21%
Lakes	1.20%	1.49%	2.10%	2.46%	2.08%	3.32%	**2.97%**	**2.97%**	3.87%	4.09%
Bay of Plenty	1.74%	1.78%	2.43%	3.29%	2.94%	4.06%	**3.83%**	**3.79%**	3.95%	4.21%
Tairawhiti	2.67%	2.64%	3.72%	4.23%	2.22%	4.70%	**4.33%**	**3.79%**	3.30%	3.76%
Taranaki	1.77%	1.79%	2.40%	2.40%	1.32%	2.85%	**2.71%**	**2.52%**	2.67%	3.05%
CENTRAL	**1.43%**	**1.60%**	**2.12%**	**2.45%**	**2.04%**	**2.94%**	**2.93%**	**2.95%**	**3.13%**	**3.07%**
Hawke's Bay	1.35%	1.73%	2.13%	2.24%	2.42%	2.76%	**2.62%**	**2.90%**	2.61%	2.68%
MidCentral	1.52%	1.72%	2.02%	2.25%	3.56%	2.66%	**2.77%**	**2.93%**	3.26%	2.87%
Whanganui	2.16%	2.23%	2.48%	2.40%	0.60%	2.58%	**2.66%**	**2.78%**	3.20%	3.62%
Capital & Coast	1.31%	1.52%	1.95%	2.57%	3.72%	3.00%	**3.08%**	**3.00%**	3.30%	3.30%
Hutt Valley	1.25%	1.17%	2.18%	2.55%	1.43%	3.29%	**3.25%**	**2.88%**	3.12%	2.99%
Wairarapa	1.71%	1.65%	2.87%	3.03%	1.31%	3.68%	**3.23%**	**3.38%**	3.39%	3.29%
SOUTHERN	**1.34%**	**0.83%**	**2.02%**	**2.36%**	**1.64%**	**2.86%**	**3.01%**	**2.97%**	**2.79%**	**3.00%**
Nelson Marlborough	2.67%	2.53%	2.56%	3.34%	2.20%	3.70%	**3.06%**	**2.77%**	3.04%	3.45%
West Coast	2.99%	3.23%	4.01%	4.25%	1.78%	5.12%	**5.51%**	**3.71%**	3.85%	4.27%
Canterbury	1.13%	1.30%	1.50%	1.83%	1.75%	2.23%	**2.56%**	**2.61%**	2.64%	2.62%
South Canterbury	1.87%	1.77%	2.18%	3.32%	1.73%	5.00%	**4.43%**	**4.15%**	3.64%	4.21%
Southern	1.97%	1.93%	2.92%	2.96%	1.18%	2.89%	**3.22%**	**3.36%**	2.68%	3.10%
TOTAL	**1.43%**	**1.49%**	**2.02%**	**2.36%**	**1.98%**	**2.64%**	**2.80%**	**2.87%**	**2.92%**	**3.03%**

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

Table 8. Māori 0-19 yrs Service User Access Rates by Age Group & Region (2008-2017)

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	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%
	2016*	1.08%	4.74%	10.39%	4.08%
	2017*	1.26%	5.10%	10.16%	4.21%
MIDLAND	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%
	2016*	0.95%	4.03%	8.17%	3.35%
	2017*	1.19%	4.95%	8.38%	3.75%
CENTRAL	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%
	2016*	1.01%	4.70%	8.88%	3.71%
	2017*	1.04%	4.59%	8.76%	3.66%
SOUTHERN	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%
	2016*	0.98%	4.06%	7.42%	3.20%
	2017*	1.11%	4.69%	9.14%	3.81%

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

Table 9. Māori 0-19 yrs Service User Access Rates by DHB Area (2008-2017)

REGION/DHB AREA	MĀORI 0-19 YRS ACCESS RATES BY REGION & DHB AREA									
	2008	2009	2010*	2011*	2012*	2013*	2014*	2015*	2016*	2017*
NORTHERN	1.84%	2.28%	2.78%	3.06%	3.08%	3.33%	4.00%	4.05%	4.08%	4.21%
Northland	1.27%	1.63%	2.39%	2.89%	3.52%	3.90%	3.96%	3.91%	3.65%	3.49%
Waitemata	1.91%	3.46%	4.04%	4.10%	3.48%	4.08%	3.41%	4.93%	4.38%	4.68%
Auckland	2.14%	2.35%	2.56%	3.45%	3.38%	3.50%	4.13%	4.76%	5.74%	6.00%
Counties Manukau	2.04%	1.90%	2.30%	2.37%	2.45%	2.40%	3.66%	3.33%	3.54%	3.70%
MIDLAND	1.29%	1.30%	1.96%	2.88%	2.52%	3.14%	2.95%	3.26%	3.35%	3.75%
Waikato	0.79%	0.74%	1.23%	2.42%	2.34%	1.85%	2.01%	2.85%	2.87%	3.39%
Lakes	1.00%	1.19%	1.86%	2.34%	2.10%	2.72%	2.19%	2.46%	3.13%	3.45%
Bay of Plenty	1.72%	1.78%	2.36%	3.60%	3.78%	4.95%	2.18%	4.43%	4.46%	4.90%
Tairawhiti	2.51%	2.42%	3.60%	4.23%	3.38%	4.76%	4.74%	3.99%	3.53%	3.56%
Taranaki	1.29%	1.18%	2.23%	2.26%	1.07%	2.84%	2.85%	2.50%	2.63%	2.93%
CENTRAL	1.32%	1.50%	2.17%	2.81%	2.64%	3.43%	3.44%	3.57%	3.71%	3.66%
Hawke's Bay	1.38%	1.58%	2.16%	2.64%	4.15%	3.31%	2.94%	3.49%	2.92%	2.96%
MidCentral	1.14%	1.21%	1.67%	1.90%	2.80%	2.38%	2.59%	2.90%	2.98%	2.56%
Whanganui	1.63%	1.52%	1.91%	2.00%	0.71%	2.23%	2.40%	2.38%	2.93%	3.37%
Capital & Coast	1.34%	1.92%	3.00%	4.47%	4.10%	4.73%	5.32%	4.98%	5.87%	6.33%
Hutt Valley	1.22%	1.21%	1.86%	2.74%	2.59%	4.04%	3.84%	3.28%	3.59%	3.22%
Wairarapa	1.46%	1.51%	2.82%	3.16%	1.69%	4.04%	3.18%	4.68%	4.58%	3.57%
SOUTHERN	1.35%	2.07%	2.30%	2.80%	1.63%	3.29%	3.43%	3.49%	3.20%	3.81%
Nelson Marlborough	2.58%	2.31%	2.65%	4.12%	2.27%	4.21%	3.07%	2.99%	2.56%	3.45%
West Coast	3.92%	5.13%	4.73%	5.27%	1.92%	7.24%	7.32%	4.42%	3.08%	3.77%
Canterbury	1.29%	1.56%	1.95%	2.15%	2.00%	2.64%	3.34%	3.53%	3.59%	3.94%
South Canterbury	2.01%	1.51%	2.20%	2.74%	0.76%	4.33%	4.55%	4.31%	3.44%	5.42%
Southern	0.72%	0.75%	2.36%	2.87%	1.09%	2.99%	3.09%	3.44%	2.90%	3.54%
TOTAL	1.56%	1.76%	2.32%	2.91%	2.57%	3.28%	3.51%	3.66%	3.64%	3.89%

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

Table 10. Pacific 0-19 yrs Service User Access Rates by Age Group & Region (2008-2017)

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	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%
	2016*	0.56%	2.22%	4.69%	2.01%
	2017*	0.52%	2.46%	5.07%	2.15%
MIDLAND	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%
	2016*	0.64%	2.18%	5.27%	2.03%
	2017*	1.08%	3.32%	5.78%	2.63%
CENTRAL	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%
	2016*	0.48%	2.62%	4.97%	2.09%
	2017*	0.52%	2.10%	3.75%	1.67%
SOUTHERN	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%
	2016*	0.39%	2.23%	4.83%	1.79%
	2017*	0.43%	2.10%	4.81%	1.77%

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

Table 11. Pacific 0-19 yrs Service User Access Rates by DHB Area (2008-2017)

REGION/ DHB AREA	PACIFIC 0-19 YRS ACCESS RATES BY REGION & DHB AREA									
	2008	2009	2010*	2011*	2012*	2013*	2014*	2015*	2016*	2017*
NORTHERN	1.01%	1.08%	1.28%	1.41%	1.35%	1.51%	2.08%	1.93%	2.01%	2.15%
Northland	1.04%	0.88%	1.29%	2.45%	0.50%	3.11%	2.27%	2.39%	2.85%	2.94%
Waitemata	0.99%	1.96%	2.57%	2.58%	2.47%	3.00%	3.25%	2.63%	2.60%	2.59%
Auckland	1.02%	0.77%	0.86%	1.13%	1.16%	1.21%	1.64%	1.56%	1.87%	2.22%
Counties Manukau	1.00%	0.92%	1.01%	1.11%	1.07%	1.12%	1.85%	1.82%	1.84%	1.93%
MIDLAND	0.58%	0.43%	0.94%	1.60%	0.38%	1.64%	1.24%	1.69%	2.03%	2.63%
Waikato	0.46%	0.33%	0.93%	1.50%	0.64%	1.15%	0.87%	2.05%	1.90%	2.70%
Lakes	0.20%	0.60%	1.02%	1.58%	0.58%	2.06%	1.89%	1.06%	3.83%	2.32%
Bay of Plenty	1.27%	0.67%	0.91%	2.24%	0.36%	2.57%	1.79%	1.60%	1.76%	3.07%
Tairawhiti	0.51%	0.51%	1.50%	2.05%	0.14%	2.17%	1.57%	0.43%	1.04%	1.63%
Taranaki	0.69%	0.23%	0.45%	0.23%	0.09%	1.75%	1.12%	1.07%	1.72%	2.17%
CENTRAL	0.61%	0.32%	0.99%	1.52%	0.72%	1.97%	2.03%	1.59%	2.09%	1.67%
Hawke's Bay	0.51%	0.73%	0.90%	1.04%	0.56%	1.26%	1.70%	1.46%	1.03%	1.31%
MidCentral	0.66%	0.58%	0.74%	1.05%	0.34%	1.34%	1.10%	1.20%	1.59%	1.12%
Whanganui	1.77%	2.89%	0.73%	1.19%	0.07%	1.05%	0.83%	1.42%	2.92%	2.11%
Capital & Coast	0.58%	0.80%	1.08%	1.83%	1.92%	2.78%	2.65%	1.89%	2.57%	2.22%
Hutt Valley	0.52%	0.54%	0.98%	1.42%	0.58%	1.26%	1.78%	1.39%	2.07%	1.16%
Wairarapa	1.07%	1.32%	0.95%	1.27%	0.18%	2.16%	1.56%	1.30%	1.27%	1.48%
SOUTHERN	0.48%	0.72%	1.19%	1.30%	0.23%	1.26%	1.39%	1.52%	1.79%	1.77%
Nelson Marlborough	1.65%	1.70%	1.48%	2.95%	0.19%	1.61%	0.76%	1.25%	1.39%	1.14%
West Coast	1.54%	3.53%	4.44%	3.33%	0.05%	2.40%	0.74%	0.00%	5.81%	0.00%
Canterbury	0.57%	0.65%	0.86%	0.63%	0.47%	0.87%	1.22%	1.31%	1.66%	1.60%
South Canterbury	1.76%	0.53%	1.05%	3.24%	0.12%	5.22%	2.80%	0.77%	2.50%	2.76%
Southern	1.61%	1.28%	1.75%	2.05%	0.15%	1.48%	1.89%	2.23%	1.90%	2.39%
TOTAL	0.92%	0.99%	1.21%	1.43%	0.92%	1.57%	1.96%	1.82%	2.01%	2.08%

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

Table 12. Asian 0-19 yrs Service User Access Rates by Age Group & Region (2008-2017)

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	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%
	2016*	0.40%	1.10%	1.44%	0.83%
	2017*	0.51%	1.01%	1.69%	0.93%
MIDLAND	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%
	2016*	0.22%	0.92%	1.53%	0.68%
	2017*	0.15%	1.09%	1.61%	0.68%
CENTRAL	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%
	2016*	0.20%	1.18%	2.16%	0.90%
	2017*	0.18%	0.95%	2.31%	0.86%
SOUTHERN	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%
	2016*	0.12%	0.68%	1.18%	0.55%
	2017*	0.15%	0.82%	1.63%	0.72%

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

Table 13. Asian 0-19 yrs Service User Access Rates by DHB Area (2008-2017)

REGION/ DHB AREA	ASIAN 0-19 YRS ACCESS RATES BY DHB AREA									
	2008	2009	2010*	2011*	2012*	2013*	2014*	2015*	2016*	2017*
NORTHERN	0.34%	0.50%	0.55%	0.58%	0.54%	0.72%	0.78%	0.79%	0.83%	0.93%
Northland	0.33%	0.53%	0.40%	0.48%	0.14%	1.34%	0.44%	0.21%	0.72%	0.75%
Waitemata	0.38%	0.56%	0.56%	0.52%	0.47%	0.63%	0.71%	0.67%	0.68%	0.90%
Auckland	0.52%	0.41%	0.50%	0.60%	0.57%	0.71%	0.71%	0.81%	0.98%	1.05%
Counties Manukau	0.52%	0.52%	0.61%	0.63%	0.65%	0.80%	0.93%	0.92%	0.85%	0.84%
MIDLAND	0.27%	0.31%	0.39%	0.56%	0.21%	0.55%	0.47%	0.65%	0.68%	0.68%
Waikato	0.16%	0.21%	0.14%	0.46%	0.22%	0.26%	0.30%	0.55%	0.48%	0.58%
Lakes	0.37%	0.64%	0.63%	0.80%	0.19%	0.63%	0.53%	0.76%	0.90%	0.52%
Bay of Plenty	0.53%	0.36%	0.80%	0.67%	0.32%	0.98%	0.84%	0.84%	1.07%	0.77%
Tairawhiti	0.91%	0.43%	1.30%	0.83%	0.19%	1.36%	1.27%	0.92%	0.30%	3.53%
Taranaki	0.14%	0.53%	0.74%	0.63%	0.09%	1.02%	0.38%	0.68%	0.30%	0.68%
CENTRAL	0.21%	0.64%	0.49%	0.59%	0.25%	0.65%	0.73%	0.75%	0.90%	0.86%
Hawke's Bay	0.35%	0.26%	0.34%	0.42%	0.18%	0.38%	0.59%	0.43%	0.64%	0.38%
MidCentral	0.05%	0.50%	0.35%	0.52%	0.25%	0.48%	0.35%	0.56%	0.66%	0.89%
Whanganui	0.24%	0.98%	0.99%	1.35%	0.06%	-	1.03%	0.38%	0.56%	1.08%
Capital & Coast	0.26%	0.37%	0.44%	0.56%	0.71%	0.72%	0.76%	0.88%	1.08%	1.00%
Hutt Valley	0.25%	0.30%	0.62%	0.67%	0.16%	0.79%	0.93%	0.80%	0.80%	0.71%
Wairarapa	0.56%	1.62%	1.62%	0.57%	0.07%	0.82%	0.37%	0.34%	0.95%	0.31%
SOUTHERN	0.38%	0.39%	0.49%	0.65%	0.19%	0.49%	0.62%	0.65%	0.55%	0.72%
Nelson Marlborough	1.48%	0.88%	0.43%	1.21%	0.16%	0.72%	0.52%	0.65%	0.55%	0.94%
West Coast	-	2.50%	1.60%	3.20%	0.07%	0.45%	2.04%	0.74%	1.03%	1.25%
Canterbury	0.24%	0.27%	0.36%	0.43%	0.32%	0.39%	0.50%	0.54%	0.50%	0.59%
South Canterbury	0.97%	1.00%	1.00%	2.03%	0.09%	1.32%	1.58%	1.45%	0.85%	1.90%
Southern	0.40%	0.43%	0.86%	0.98%	0.12%	0.55%	0.79%	0.85%	0.64%	0.85%
TOTAL	0.42%	0.46%	0.52%	0.59%	0.38%	0.67%	0.72%	0.75%	0.79%	0.86%

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

Table 14. Child & Youth HoNOSCA Items

Item 1	**AGR**	Problems with disruptive, antisocial or aggressive behaviour
Item 2	**ATT**	Problems with over activity, attention or concentration
Item 3	**SH**	Non-accidental self-injury
Item 4	**AOD**	Problem with alcohol, substance or solvent misuse
Item 5	**LAN**	Problems with scholastic or language skills
Item 6	**PHY**	Physical illness or disability problems
Item 7	**Del/HAL**	Problems associated with hallucinations, delusions or abnormal perceptions
Item 8	**NOS**	Problem with non-organic somatic symptoms
Item 9	**EMO**	Problem with emotional and related symptoms
Item 10	**PEER**	Problems with peer relationships
Item 11	**SC**	Problems with self-care and independence
Item 12	**FAM**	Problem with family life and relationships
Item 13	**SCH**	Poor school attendance
Item 14	**KNW**	Problems with knowledge or understanding about the nature of the child or adolescent's difficulties (in the previous two weeks)
Item 15	**INFO**	Problems with lack of information about services or management of the child or adolescent's difficulties.

APPENDIX C: FUNDING DATA

Table 1. Infant, Child & Adolescent Mental Health/AOD Funding (2011-2018)

REGION/	2011/2012			2013/2014			2015/2016			2017/2018		
DHB AREA	DHB*	NON-DHB	TOTAL	DHB*	NON-DHB	TOTAL	DHB*	NON-DHB	TOTAL	DHB*	NON-DHB*	TOTAL
NORTHERN	**$46,644,982**	**$7,263,465**	**$53,908,447**	**$47,331,741**	**$8,517,755**	**$55,849,495**	**$52,411,826**	**$8,789,249**	**$61,201,075**	**$49,588,907**	**$10,570,297**	**$60,159,204**
Northland	$5,691,041	$1,165,900	**$6,856,941**	$5,243,077	$1,230,893	**$6,473,970**	$6,118,991	$1,273,595	**$7,392,586**	$3,610,143	$1,415,148	**$5,025,291**
Waitemata	$14,070,738	$489,492	**$14,560,230**	$14,325,541	$690,177	**$15,015,718**	$15,862,594	$702,631	**$16,565,225**	$15,745,106	$721,096	**$16,466,202**
Auckland	$14,053,468	$2,756,784	**$16,810,252**	$15,154,442	$2,691,784	**$17,846,226**	$17,006,883	$2,598,834	**$19,605,717**	$16,742,962	$4,102,814	**$20,845,776**
Counties Manukau	$12,829,734	$2,851,289	**$15,681,023**	$12,608,681	$3,904,901	**$16,513,582**	$13,423,358	$4,214,189	**$17,637,547**	$13,490,697	$4,331,239	**$17,821,936**
MIDLAND	**$19,632,325**	**$13,341,162**	**$32,973,487**	**$19,394,360**	**$16,006,020**	**$35,400,380**	**$20,251,653**	**$16,272,187**	**$36,523,840**	**$19,736,066**	**$19,576,532**	**$39,312,598**
Waikato	$6,056,183	$7,972,422	**$14,028,605**	$5,527,629	$9,770,700	**$15,298,329**	$5,795,619	$10,239,947	**$16,035,566**	$5,649,594	$10,597,774	**$16,247,368**
Lakes	$2,856,181	$1,628,738	**$4,484,919**	$3,335,983	$1,859,143	**$5,195,126**	$3,275,060	$1,545,288	**$4,820,348**	$2,938,911	$2,917,218	**$5,856,129**
Bay of Plenty	$5,807,253	$2,823,774	**$8,631,027**	$5,797,329	$3,465,570	**$9,262,899**	$6,234,260	$3,446,180	**$9,680,440**	$6,158,124	$4,878,148	**$11,036,272**
Tairawhiti	$2,323,382	$457,294	**$2,780,676**	$2,063,599	$288,899	**$2,352,498**	$2,268,862	$310,176	**$2,579,038**	$2,303,231	$438,948	**$2,742,179**
Taranaki	$2,589,327	$458,934	**$3,048,261**	$2,669,820	$621,708	**$3,291,528**	$2,677,852	$730,596	**$3,408,448**	$2,686,207	$744,444	**$3,430,651**
CENTRAL	**$27,016,084**	**$5,877,421**	**$32,893,505**	**$27,248,993**	**$5,582,425**	**$32,831,418**	**$30,614,119**	**$5,062,877**	**$35,676,996**	**$34,840,926**	**$5,784,642**	**$40,625,568**
Hawke's Bay	$3,399,861	$1,352,616	**$4,752,477**	$3,337,010	$839,700	**$4,176,710**	$3,412,251	$410,217	**$3,822,468**	$4,016,008	$915,448	**$4,931,456**
MidCentral	$4,542,160	$871,601	**$5,413,761**	$4,188,141	$1,007,965	**$5,196,106**	$4,160,098	$1,020,716	**$5,180,814**	$3,964,581	$1,247,347	**$5,211,928**
Whanganui	1918303	225612	**$2,143,915**	2175310	283612	**$2,458,922**	2567102.285	224064	**$2,791,166**	2336177.81	380472	**2716649.81**
Capital & Coast	$11,448,851	$837,708	**$12,286,559**	$12,416,440	$837,840	**$13,254,280**	$15,036,417	$776,604	**$15,813,021**	$18,815,821	$1,552,701	**$20,368,522**
Hutt Valley	$4,487,788	$2,462,508	**$6,950,296**	$3,984,793	$2,504,312	**$6,489,105**	$4,057,730	$2,531,352	**$6,589,082**	$4,349,039	$1,504,775	**$5,853,814**
Wairarapa	$1,219,121	$127,376	**$1,346,497**	$1,147,300	$108,996	**$1,256,296**	$1,380,521	$99,924	**$1,480,445**	$1,359,300	$183,899	**$1,543,199**
SOUTHERN	**$26,890,659**	**$8,331,706**	**$35,222,365**	**$30,463,061**	**$9,774,212**	**$40,237,273**	**$31,120,579**	**$11,023,133**	**$42,143,712**	**$30,868,614**	**$12,468,496**	**$43,337,110**
Nelson Marlborough	$4,014,175	$571,908	**$4,586,083**	$4,130,029	$575,674	**$4,705,703**	$3,876,454	$919,203	**$4,795,657**	$3,813,388	$1,017,093	**$4,830,481**
West Coast	$1,020,967	24120	**$1,045,087**	$1,048,179	$284,000	**$1,332,179**	$1,065,069	$240,000	**$1,305,069**	$1,092,754	$240,000	**$1,332,754**
Canterbury	$14,403,651	$3,430,135	**$17,833,786**	$16,448,505	$3,751,388	**$20,199,893**	$16,850,056	$4,446,390	**$21,296,446**	$17,617,285	$5,175,825	**$22,793,110**
South Canterbury	$941,869	$589,824	**$1,531,693**	$1,113,038	$725,050	**$1,838,088**	$1,089,537	$702,204	**$1,791,741**	$1,067,492	$721,068	**$1,788,560**
Southern	$6,509,997	$3,715,719	**$10,225,716**	$7,723,311	$4,438,100	**$12,161,411**	$8,239,465	$4,715,336	**$12,954,801**	$7,277,694	$5,314,510	**$12,592,204**
MOH	-	$378,551	**$378,551**	-	-	-	-	-	-	-	-	-
TOTAL	**$120,184,050**	**$35,192,305**	$155,376,355	**$124,438,155**	**$39,880,412**	$164,318,566	**$134,398,178**	**$41,147,446**	$175,545,624	**$135,034,513**	**$48,399,967**	$183,434,480

Source: Ministry of Health Price Volume Schedules 2011-2018. *DHB includes Inpatient funding; Non-DHB includes NGOs & PHOs

Table 2. National Funding per Head Infant, Child & Adolescent Population (2015-2018)

REGION/DHB AREA	2015/2016			2017/2018		
	Spend/Child (Excl. Inpatient) $	Spend/Child (Incl. Inpatient) $	Total DHB & NON-DHB $	Spend/Child (Excl. Inpatient) $	Spend/Child (Incl. Inpatient) $	Total DHB & NON-DHB $
NORTHERN	$115.94	$126.41	$61,201,075	$116.15	$123.47	$60,159,204
Northland	$128.92	$156.32	$7,392,586	$106.76	$106.76	$5,025,291
Waitemata	$105.81	$105.81	$16,565,225	$103.55	$103.55	$16,466,202
Auckland	$135.67	$168.00	$19,605,717	$148.27	$178.87	$20,845,776
Counties Manukau	$107.82	$107.82	$17,637,547	$108.25	$108.25	$17,821,936
MIDLAND	$145.61	$146.22	$36,523,840	$156.83	$157.49	$39,312,598
Waikato	$143.12	$143.12	$16,035,566	$144.47	$144.47	$16,247,368
Lakes	$159.46	$159.46	$4,820,348	$197.84	$197.84	$5,856,129
Bay of Plenty	$159.56	$159.56	$9,680,440	$181.70	$181.70	$11,036,272
Tairawhiti	$161.63	$171.94	$2,579,038	$173.73	$184.78	$2,742,179
Taranaki	$107.05	$107.05	$3,408,448	$107.27	$107.27	$3,430,651
CENTRAL	$136.61	$151.66	$35,676,996	$158.73	$173.88	$40,625,568
Hawke's Bay	$84.66	$84.66	$3,822,468	$110.35	$110.35	$4,931,456
MidCentral	$110.39	$110.39	$5,180,814	$111.84	$111.84	$5,211,928
Whanganui	$166.34	$166.34	$2,791,166	$165.65	$165.65	$2,716,650
Capital & Coast	$160.72	$207.09	$15,813,021	$220.12	$266.43	$20,368,522
Hutt Valley	$169.21	$169.21	$6,589,082	$152.09	$152.09	$5,853,814
Wairarapa	$133.49	$133.49	$1,480,445	$140.16	$140.16	$1,543,199
SOUTHERN	$134.67	$154.58	$42,143,712	$139.84	$157.92	$43,337,110
Nelson Marlborough	$126.76	$135.43	$4,795,657	$128.61	$136.92	$4,830,481
West Coast	$163.54	$163.54	$1,305,069	$165.77	$165.77	$1,332,754
Canterbury	$124.03	$158.02	$21,296,446	$136.57	$166.74	$22,793,110
South Canterbury	$126.80	$126.80	$1,791,741	$127.30	$127.30	$1,788,560
Southern	$154.51	$161.25	$12,954,801	$149.93	$156.72	$12,592,204
TOTAL	$129.93	$141.36	$175,545,624	$137.33	$147.15	$183,434,480

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

APPENDIX D: ICAMH/AOD WORKFORCE DATA

Table 1. DHB Inpatient ICAMH Workforce by Occupation (2018)

Inpatient ICAMH Workforce by Occupation (Actual FTEs, 2018)	Child & Adolescent Psychiatrist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Support Worker	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
AUCKLAND[1]	5.97	27.10	2.60	1.10	8.10	2.80	5.20	52.87	1.00	9.00	10.00	2.00	64.87
CAPITAL & COAST	1.00	18.60	-	-	1.00	1.00	1.20	22.80	1.70	9.00	10.70	2.00	35.50
CANTERBURY[2]	2.10	33.00	3.50	-	2.10	2.80	0.60	44.10	0.40	-	0.40	9.50	54.00
TOTAL	9.07	78.70	6.10	1.10	11.20	6.60	7.00	119.77	3.10	18.00	21.10	13.50	154.37

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

Table 2. DHB Inpatient ICAMH Vacancies by Occupation (2018)

Inpatient ICAMH Vacancies by Occupation (Vacant FTEs, 2018)	Child & Adolescent Psychiatrist	Nurse	Occupational Therapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
AUCKLAND	1.78	6.60	-	0.40	-	1.00	9.78	1.00	1.00	1.15	11.93
CAPITAL & COAST	0.50	1.00	1.00	-	1.00	1.00	4.50	-	-	-	4.50
CANTERBURY	-	1.50	-	-	-	-	1.50	-	-	-	1.50
TOTAL	2.28	9.10	1.00	0.40	1.00	2.00	15.78	1.00	1.00	1.15	17.93

Table 3. DHB Inpatient ICAMH Workforce by Occupation & Ethnicity (2018)

Inpatient ICAMH Workforce by Occupation & Ethnicity (Headcount, 2018)		Child & Adolescent Psychiatrist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Consumer	Mental Health Support Worker	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
MĀORI	AUCKLAND	1	3	-	-	-	-	1	5	1	-	3	4	-	9
	CAPITAL & COAST	-	2	-	-	-	-	-	2	2	-	2	4	-	6
	CANTERBURY	-	1	-	-	-	-	-	1	1	-	-	1	-	2
	TOTAL	1	6	-	-	-	-	1	8	4	-	5	9	-	17
PACIFIC	AUCKLAND	-	3	-	-	-	-	-	3	-	-	4	4	-	7
	CAPITAL & COAST	-	3	-	-	-	-	-	3	-	-	5	5	-	8
	CANTERBURY	-	1	-	-	-	-	-	1	-	-	-	-	-	1
	TOTAL	-	7	-	-	-	-	-	7	-	-	9	9	-	16
ASIAN	AUCKLAND	1	5	-	-	-	2	1	9	-	-	-	-	1	10
	CAPITAL & COAST	-	2	-	-	-	-	-	2	-	-	-	-	-	2
	CANTERBURY	1	5	-	-	-	-	-	6	-	-	-	-	-	6
	TOTAL	2	12	-	-	-	2	1	17	-	-	-	-	1	18
NZ EUROPEAN	AUCKLAND	5	18	3	2	10	1	4	43	-	-	1	1	1	45
	CAPITAL & COAST	1	12	-	-	1	1	2	17	-	-	2	2	2	21
	CANTERBURY	2	31	4	-	2	4	1	44	-	-	-	-	10	54
	TOTAL	8	61	7	2	13	6	7	104	-	-	3	3	13	120
OTHER ETHNICITY	AUCKLAND	-	1	-	-	-	-	-	1	-	-	1	1	-	2
	CAPITAL & COAST	-	1	-	-	-	-	-	1	-	-	-	-	-	1
	CANTERBURY	-	-	-	-	1	-	-	1	-	-	-	-	1	2
	TOTAL	-	2	-	-	1	-	-	3	-	-	1	1	1	5
GRAND TOTAL		11	88	7	2	14	8	9	139	4	-	18	22	15	176

Table 4. DHB Community ICAMH/AOD Workforce by Occupation (2018)

DHB Community ICAMH/AOD Workforce by Occupation (Actual FTEs, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinician	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Consumer Advisor	Mental Health Support Worker	Youth Worker	Other Non-Clinical	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
NORTHERN	18.50	22.66	8.00	62.35	34.70	8.80	59.34	67.03	15.50	296.88	7.90	-	-	-	-	7.90	21.90	326.68
Northland	-	2.38	5.00	17.30	2.00	-	6.00	13.40	3.90	49.98	-	-	-	-	-	-	6.50	56.48
Waitemata*	18.50	8.45	2.00	21.10	16.10	6.30	13.00	25.80	3.80	115.05	0.10	-	-	-	-	0.10	10.60	125.75
Auckland	-	6.73	-	8.15	11.00	2.50	29.74	12.40	2.20	72.72	6.80	-	-	-	-	6.80	2.30	81.82
Counties Manukau	-	5.10	1.00	15.80	5.60	-	10.60	15.43	5.60	59.13	1.00	-	-	-	-	1.00	2.50	62.63
MIDLAND	4.00	9.60	1.00	33.20	7.00	-	26.98	34.00	3.70	119.48	3.00	-	1.00	2.00	-	6.00	16.00	141.48
Waikato	-	5.80	1.00	7.00	5.00	-	12.38	10.00	-	41.18	-	-	1.00	1.00	-	2.00	3.90	47.08
Lakes	-	1.00	-	5.00	-	-	2.60	2.60	1.20	12.40	-	-	-	-	-	-	3.00	15.40
Bay of Plenty	2.00	2.00	-	13.40	2.00	-	6.60	16.00	1.00	43.00	2.00	-	-	-	-	2.00	5.10	50.10
Tairawhiti	2.00	0.80	-	2.50	-	-	2.00	2.00	-	9.30	1.00	-	-	-	-	1.00	2.50	12.80
Taranaki	-	-	-	5.30	-	-	3.40	3.40	1.50	13.60	-	-	-	1.00	-	1.00	1.50	16.10
CENTRAL	3.70	14.95	4.00	43.70	10.70	3.80	41.26	44.65	20.60	187.36	4.25	-	2.00	9.40	1.40	17.05	29.80	234.21
Hawke's Bay	1.80	2.20	-	6.00	-	-	4.30	9.70	4.50	28.50	1.00	-	-	-	-	1.00	3.00	32.50
MidCentral	-	0.75	1.00	4.50	2.00	-	4.40	9.75	4.00	26.40	-	-	-	-	-	-	4.60	31.00
Whanganui	0.90	1.40	-	5.50	-	-	0.60	3.70	0.30	12.40	-	-	-	0.90	0.60	1.50	2.90	16.80
Capital & Coast	1.00	7.20	2.00	26.10	6.60	2.20	18.20	10.30	7.80	81.40	3.25	-	-	8.50	0.80	12.55	13.00	106.95
Hutt Valley	-	3.00	-	-	2.10	1.60	10.96	10.20	3.00	30.86	-	-	-	-	-	-	5.30	36.16
Wairarapa	-	0.40	1.00	1.60	-	-	2.80	1.00	1.00	7.80	-	-	2.00	-	-	2.00	1.00	10.80
SOUTHERN	10.20	11.40	-	48.90	15.50	0.50	34.05	25.10	7.30	152.95	4.50	0.50	-	-	1.40	6.40	27.70	187.05
Nelson Marlborough	7.00	2.00	-	4.00	2.00	-	5.50	4.50	2.20	27.20	-	-	-	-	-	-	2.50	29.70
West Coast	1.40	0.50	-	2.00	-	-	1.00	-	-	4.90	0.50	0.50	-	-	-	1.00	2.90	8.80
Canterbury	-	1.90	-	22.00	6.00	0.50	15.75	15.70	4.10	65.95	2.00	-	-	-	1.40	3.40	15.30	84.65
South Canterbury	1.00	0.40	-	2.00	2.70	-	1.60	1.00	-	8.70	2.00	-	-	-	-	2.00	1.00	11.70
Southern	0.80	6.60	-	18.90	4.80	-	10.20	3.90	1.00	46.20	-	-	-	-	-	-	6.00	52.20
DHB COMMUNITY TOTAL	36.40	58.61	13.00	188.15	67.90	13.10	161.63	170.78	47.10	756.67	19.65	0.50	3.00	11.40	2.80	37.35	95.40	889.42
National Youth Forensic Service	1.00	1.00	-	18.40	1.00	-	1.00	-	0.20	22.60	2.70	-	17.00	-	-	19.70	2.00	44.30
GRAND TOTAL	37.40	59.61	13.00	206.55	68.90	13.10	162.63	170.78	47.30	779.27	22.35	0.50	20.00	11.40	2.80	57.05	97.40	933.72

*Includes Regional AOD Service: Altered High= 27.2 Actual FTEs

Table 5. DHB Community ICAMH/AOD Vacancies by Occupation (2018)

DHB Community ICAMH/AOD Vacancies by Occupation (Vacant FTEs, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Consumer Advisor	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL	STAFF TURNOVER RATE %
NORTHERN	1.00	6.04	23.30	3.00	1.50	14.83	8.60	2.00	60.27	0.50	-	0.50	1.05	61.82	8.9
Northland	-	-	-	-	-	-	-	1.00	1.00	-	-	-	-	1.00	12.6
Waitemata*	1.00	2.60	3.00	-	1.50	4.40	-	1.00	13.50	-	-	-	0.50	14.00	-
Auckland	-	0.74	0.40	-	-	3.83	6.60	-	11.57	0.50	-	0.50	0.55	12.62	6.3
Counties Manukau	-	2.70	19.90	3.00	-	6.60	2.00	-	34.20	-	-	-	-	34.20	11.9
MIDLAND	1.00	2.70	2.00	2.10	-	7.30	1.20	4.50	20.80	-	-	-	-	20.80	16.4
Waikato	-	-	-	-	-	1.50	1.00	-	2.50	-	-	-	-	2.50	11.8
Lakes	-	0.80	2.00	-	-	3.00	0.20	0.40	6.40	-	-	-	-	6.40	-
Bay of Plenty	-	1.50	-	2.10	-	1.80	-	-	5.40	-	-	-	-	5.40	20.8
Tairawhiti	1.00	0.40	-	-	-	1.00	-	4.10	6.50	-	-	-	-	6.50	-
Taranaki	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16.7
CENTRAL	-	2.20	5.00	2.50	0.60	8.80	3.20	1.50	23.80	0.30	-	0.30	0.90	25.00	20.7
Hawke's Bay	-	-	1.80	-	-	1.00	-	-	2.80	-	-	-	-	2.80	17.1
MidCentral	-	1.00	1.00	1.00	-	2.60	-	1.00	6.60	0.30	-	0.30	-	6.90	19.4
Whanganui	-	-	-	0.50	-	-	-	-	0.50	-	-	-	-	0.50	5.0
Capital & Coast	-	0.70	2.20	1.00	-	3.30	3.20	0.50	10.90	-	-	-	-	10.90	20.8
Hutt Valley	-	0.50	-	-	0.60	1.70	-	-	2.80	-	-	-	-	2.80	27.7
Wairarapa	-	-	-	-	-	0.20	-	-	0.20	-	-	-	0.90	1.10	30.3
SOUTHERN	-	-	7.30	1.10	0.20	2.50	7.20	-	18.30	1.30	1.40	2.70	-	21.00	25.2
Nelson Marlborough	-	-	-	-	-	-	-	-	0.00	-	0.40	0.40	-	0.40	10.0
West Coast	-	-	3.00	-	-	-	1.00	-	4.00	-	-	-	-	4.00	35.3
Canterbury	-	-	1.00	1.10	0.20	2.50	2.80	-	7.60	0.80	-	0.80	-	8.40	39.5
South Canterbury	-	-	-	-	-	-	-	-	0.00	-	0.40	0.40	-	0.40	42.9
Southern	-	-	3.30	-	-	-	3.40	-	6.70	0.50	0.60	1.10	-	7.80	16.7
TOTAL	2.00	10.94	37.60	8.70	2.30	33.43	20.20	8.00	123.17	2.10	1.40	3.50	1.95	128.62	17.2

*Includes Regional AOD Service Altered High

Table 6. DHB Community Māori ICAMH/AOD Workforce by Occupation (2018)

DHB Community Māori ICAMH/AOD Workforce by Occupation & DHB Area (Headcount, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinician	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Consumer Advisor	Mental Health Support Worker	Youth Worker	Other Non-Clinical	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
NORTHERN	**1**	**1**	**5**	**8**	**1**	**-**	**5**	**15**	**1**	**37**	**9**	**-**	**-**	**-**	**-**	**9**	**5**	**51**
Northland	-	-	4	6	-	-	1	6	1	**18**	-	-	-	-	-	-	4	**22**
Waitemata	1	1	-	2	-	-	-	2	-	**6**	1	-	-	-	-	**1**	1	**8**
Auckland	-	-	-	-	1	-	1	-	-	**2**	7	-	-	-	-	**7**	-	**9**
Counties Manukau	-	-	1	-	-	-	3	7	-	**11**	1	-	-	-	-	**1**	-	**12**
MIDLAND	**2**	**1**	**-**	**8**	**-**	**-**	**4**	**6**	**1**	**22**	**4**	**-**	**-**	**1**	**-**	**5**	**7**	**34**
Waikato	-	-	-	2	-	-	-	-	-	**2**	-	-	-	1	-	**1**	1	**4**
Lakes	-	-	-	1	-	-	-	1	1	**3**	-	-	-	-	-	-	-	**3**
Bay of Plenty	-	-	-	3	-	-	3	4	-	**10**	2	-	-	-	-	**2**	1	**13**
Tairawhiti	2	1	-	2	-	-	-	1	-	**6**	2	-	-	-	-	**2**	3	**11**
Taranaki	-	-	-	-	-	-	1	-	-	**1**	-	-	-	-	-	-	2	**3**
CENTRAL	**-**	**2**	**1**	**5**	-	-	**4**	**7**	**1**	**20**	**5**	-	**2**	-	**1**	**8**	**3**	**31**
Hawke's Bay	-	-	-	2	-	-	-	4	-	**6**	1	-	-	-	-	**1**	-	**7**
MidCentral	-	-	1	-	-	-	1	1	-	**3**	-	-	-	-	-	-	-	**3**
Whanganui	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	**1**	-	**1**
Capital & Coast	-	2	-	3	-	-	3	-	1	**9**	4	-	1	-	-	**5**	3	**17**
Hutt valley	-	-	-	-	-	-	-	1	-	**1**	-	-	-	-	-	-	-	**1**
Wairarapa	-	-	-	-	-	-	-	1	-	**1**	-	-	1	-	-	**1**	-	**2**
SOUTHERN	-	-	-	**3**	-	-	**2**	**1**	-	**6**	**8**	**1**	-	-	-	**9**	**2**	**17**
Nelson Marlborough	-	-	-	1	-	-	-	-	-	**1**	-	-	-	-	-	-	-	**1**
West Coast	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	**2**	-	**2**
Canterbury	-	-	-	1	-	-	2	1	-	**4**	5	-	-	-	-	**5**	2	**11**
South Canterbury	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	**2**	-	**2**
Southern	-	-	-	1	-	-	-	-	-	**1**	-	-	-	-	-	-	-	**1**
DHB COMMUNITY TOTAL	**3**	**4**	**6**	**24**	**1**	**-**	**15**	**29**	**3**	**85**	**26**	**1**	**2**	**1**	**1**	**31**	**17**	**133**
National Youth Forensic Service	**-**	**-**	**-**	7	**-**	-	**-**	**-**	**-**	**7**	2	-	4	**-**	**-**	**6**	-	**13**
GRAND TOTAL	**3**	**4**	**6**	**31**	**1**	-	**15**	**29**	**3**	**92**	**28**	**1**	**6**	**1**	**1**	**37**	**17**	**146**

Table 7. DHB Community Pacific ICAMH/AOD Workforce by Occupation (2018)

DHB Community Pacific ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinician	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Consumer Advisor	Mental Health Support Worker	Youth Worker	Other Non-Clinical	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
NORTHERN	**2**	**3**	-	**8**	**1**	-	**2**	**9**	**2**	**27**	**3**	-	-	-	-	**3**	**1**	**31**
Northland	-	-	-	2	-	-	-	1	-	**3**	-	-	-	-	-	-	-	**3**
Waitemata*	2	1	-	1	-	-	1	3	-	**8**	-	-	-	-	-	-	-	**8**
Auckland	-	-	-	1	-	-	-	1	-	**2**	3	-	-	-	-	**3**	-	**5**
Counties Manukau	-	2	-	4	1	-	1	4	2	**14**	-	-	-	-	-	-	1	**15**
MIDLAND	**1**	-	-	**3**	-	-	-	**2**	-	**6**	-	-	-	-	-	-	-	**6**
Waikato		-	-	1	-	-	-	-	-	**1**	-	-	-	-	-	-	-	**1**
Bay of Plenty	1	-	-	1	-	-	-	2	-	**4**	-	-	-	-	-	-	-	**4**
Tairawhiti	-	-	-	1	-	-	-	-	-	**1**	-	-	-	-	-	-	-	**1**
CENTRAL	-	-	-	**4**	-	-	**1**	**1**	**1**	**7**	**2**	-	**3**	-	-	**5**	**2**	**14**
Capital & Coast	-	-	-	4	-	-	1	-	1	**6**	2	-	3	-	-	**5**	2	**13**
Hutt valley	-	-	-	-	-	-	-	1	-	**1**	-	-	-	-	-	-	-	**1**
DHB COMMUNITY TOTAL	**3**	**3**	-	**15**	**1**	-	**3**	**12**	**3**	**40**	**5**	-	**3**	-	-	**8**	**3**	**51**
National Youth Forensic Service	-	-	-	5		-	-	-	-	**5**	1	-	11	-	-	**12**	-	**17**
GRAND TOTAL	**3**	**3**	-	**20**	**1**	-	**3**	**12**	**3**	**45**	**6**	-	**14**	-	-	**20**	**3**	**68**

*Includes Regional AOD Service Altered High

Table 8. DHB Community Asian ICAMH/AOD Workforce by Occupation (2018)

DHB Community Asian ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinician	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Consumer Advisor	Mental Health Support Worker	Youth Worker	Other Non-Clinical	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
NORTHERN	**2**	**5**	**-**	**7**	**10**	**1**	**8**	**5**	**2**	**40**	**-**	**-**	**-**	**-**	**-**	**-**	**3**	**43**
Northland	-	1	-	-	-	-	1	-	1	**3**	-	-	-	-	-	-	-	**3**
Waitemata*	2	3	-	1	4	1	2	2	-	**15**	-	-	-	-	-	-	2	**17**
Auckland	-	1	-	1	4	-	5	2	1	**14**	-	-	-	-	-	-	1	**15**
Counties Manukau	-	-	-	5	2	-	-	1	-	**8**	-	-	-	-	-	-	-	**8**
MIDLAND	**-**	**3**	**-**	**-**	**-**	**-**	**-**	**2**	**-**	**5**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**5**
Waikato	-	3	-	-	-	-	-	2	-	**5**	-	-	-	-	-	-	-	**5**
CENTRAL	**-**	**1**	**-**	**-**	**2**	**-**	**2**	**-**	**1**	**6**	**-**	**-**	**-**	**-**	**-**	**-**	**3**	**9**
MidCentral	-	-	-	-	1	-	1	-	-	**2**	-	-	-	-	-	-		**2**
Capital & Coast	-	1	-	-	1	-	1	-	1	**4**	-	-	-	-	-	-	3	**7**
SOUTHERN	**-**	**2**	**-**	**1**	**-**	**-**	**-**	**4**	**-**	**7**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**7**
Nelson Marlborough	-	1	-	-	-	-	-	-	-	**1**	-	-	-	-	-	-	-	**1**
Canterbury	-	1	-	-	-	-	-	3	-	**4**	-	-	-	-	-	-	-	**4**
South Canterbury	-	-	-	-	-	-	-	1	-	**1**	-	-	-	-	-	-	-	**1**
Southern	-	-	-	1	-	-	-	-	-	**1**	-	-	-	-	-	-	-	**1**
TOTAL	**2**	**11**	**-**	**8**	**12**	**1**	**10**	**11**	**3**	**58**	**-**	**-**	**-**	**-**	**-**	**-**	**6**	**64**

***Includes Regional AOD Service Altered High**

Table 9. DHB Community NZ European ICAMH/AOD Workforce by Occupation (2018)

DHB Community NZ European ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinician	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Consumer Advisor	Mental Health Support Worker	Youth Worker	Other Non-Clinical	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
NORTHERN	5	20	-	35	29	13	44	32	12	190	-	-	-	-	-	-	12	202
Northland	-	1	-	7	2	-	2	6	2	20	-	-	-	-	-	-	2	22
Waitemata*	5	8	-	15	11	7	7	9	2	64	-	-	-	-	-	-	6	70
Auckland	-	9	-	9	16	6	32	13	1	86	-	-	-	-	-	-	2	88
Counties Manukau	-	2	-	4	-	-	3	4	7	20	-	-	-	-	-	-	2	22
MIDLAND	1	3	-	21	8	-	14	17	4	68	-	-	2	1	-	3	11	82
Waikato	-	2	-	4	5	-	7	4	-	22	-	-	2		-	2	4	28
Lakes	-	-	-	3	-	-	3	1	2	9	-	-	-	-	-	-	2	11
Bay of Plenty	1	1	-	9	3	-	2	10	1	27	-	-	-	-	-	-	5	32
Taranaki	-	-	-	5	-	-	2	2	1	10	-	-	-	1	-	1	-	11
CENTRAL	3	17	3	29	11	5	44	32	21	165	-	-	2	1	1	4	27	196
Hawkes Bay	2	3	-	4	-	-	6	7	6	28	-	-	-	-	-	-	2	30
MidCentral	-	1	-	4	1	-	4	9	3	22	-	-	-	-	-	-	5	27
Whanganui	-	-	-	5	-	-	-	1	1	7	-	-	-	1	-	1	2	10
Capital & Coast	1	8	2	14	7	2	17	6	6	63	-	-	-	-	1	1	6	70
Hutt Valley	-	4	-	-	3	3	13	9	3	35	-	-	-	-	-	-	10	45
Wairarapa	-	1	1	2	-	-	4	-	2	10	-	-	2	-	-	2	2	14
SOUTHERN	11	13	-	45	21	-	38	26	9	163	-	-	-	-	-	-	36	199
Nelson Marlborough	7	1	-	4	2	-	7	8	3	32	-	-	-	-	-	-	3	35
West Coast	2	2	-	2	-	-	-	-	-	6	-	-	-	-	-	-	4	10
Canterbury	-	3	-	19	11	-	19	13	5	70	-	-	-	-	-	-	19	89
South Canterbury	1	1	-	1	3	-	1	-	-	7	-	-	-	-	-	-	1	8
Southern	1	6	-	19	5	-	11	5	1	48	-	-	-	-	-	-	9	57
DHB COMMUNITY TOTAL	20	53	3	130	69	18	140	107	46	586	-	-	4	2	1	7	86	679
National Youth Forensic Service	1	-	-	8	1	-	1	-	1	12	-	-	-	-	-	-	2	14
GRAND TOTAL	21	53	3	138	70	18	141	107	47	598	-	-	4	2	1	7	88	693

*Includes Regional AOD Service Altered High

Table 10. DHB Community Other Ethnicity ICAMH/AOD Workforce by Occupation (2018)

DHB Community Other Ethnicity ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinician	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Consumer Advisor	Mental Health Support Worker	Youth Worker	Other Non-Clinical	NON-CLINICAL SUB-TOTAL	Administration/ Management	TOTAL
NORTHERN	5	4	3	10	6	1	14	14	10	67	-	-	-	-	-	-	5	72
Northland	-	1	1	4	-	-	2	1	-	9	-	-	-	-	-	-	1	10
Waitemata*	5	1	2	4	3	1	5	13	2	36	-	-	-	-	-	-	4	40
Auckland	-	1	-	-	-	-	2	-	1	4	-	-	-	-	-	-	-	4
Counties Manukau	-	1	-	2	3	-	5	-	7	18	-	-	-	-	-	-	-	18
MIDLAND	-	7	-	6	-	-	14	6	-	33	-	-	-	-	-	-	1	34
Waikato	-	3	-	2	-	-	8	2	-	15	-	-	-	-	-	-	-	15
Lakes	-	1	-	1	-	-	-	1	-	3	-	-	-	-	-	-	1	4
Bay of Plenty	-	2	-	2	-	-	3	-	-	7	-	-	-	-	-	-	-	7
Tairawhiti	-	1	-	-	-	-	2	1	-	4	-	-	-	-	-	-	-	4
Taranaki	-	-	-	1	-	-	1	2	-	4	-	-	-	-	-	-	-	4
CENTRAL	1	6	-	3	1	1	3	7	1	23	-	-	-	-	-	-	2	25
Hawkes Bay	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
MidCentral	-	-	-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	1
Whanganui	1	2	-	1	-	-	1	3	-	8	-	-	-	-	-	-	1	9
Capital & Coast	-	4	-	1	1	1	2	4	1	14	-	-	-	-	-	-	-	14
SOUTHERN	-	10	-	4	-	1	5	3	1	24	-	-	-	-	1	1	-	25
West Coast	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	1
Canterbury	-	7	-	3	-	1	1	3	1	16	-	-	-	-	1	1	-	17
South Canterbury	-	-	-	1	-	-	1	-	-	2	-	-	-	-	-	-	-	2
Southern	-	3	-	-	-	-	2	-	-	5	-	-	-	-	-	-	-	5
DHB COMMUNITY TOTAL	6	27	3	23	7	3	36	30	12	147	-	-	-	-	1	1	8	156
National Youth Forensic Service	-	1	-	-	-	-	-	-	-	1	-	-	2	-	-	2	-	3
GRAND TOTAL	6	28	3	23	7	3	36	30	12	148	-	-	2	-	1	3	8	159

*Includes Regional AOD Service Altered High

Table 11. Non-DHB ICAMH/AOD Workforce by Occupation (2018)

Non-DHB ICAMH/AOD Workforce by Occupation (Actual FTEs, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinician	Clinical Placement/Intern	Counsellor	Family Therapist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Consumer Advisor	Educator	Mental Health Support Worker	Peer Support Worker	Service Coordinator	Whānau Ora Practitioner	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
NORTHERN	40.5	0.4	2.0	-	0.8	-	7.8	0.5	1.0	2.0	6.9	4.4	66.3	0.5	3.2	2.5	27.9	-	0.6	2.5	25.0	2.5	64.7	13.0	143.9
Northland	8.0	-	2.0	-	-	-	1.0	-	1.0	1.0	1.0	-	14.0	-	-	-	4.0	-	-	-	1.8	-	5.8	3.0	22.8
Waitemata	0.2	0.4	-	-	-	-	5.0	-	-	1.0	4.0	-	10.6	-	0.2	-	4.0	-	-	2.5	4.0	-	10.7	1.0	22.3
Auckland	19.8	-	-	-	-	-	1.8	0.5	-	-	1.3	2.9	26.3	0.5	-	2.5	11.9	-	-	-	-	0.5	15.4	5.0	46.6
Counties Manukau	12.5	-	-	-	0.8	-	-	-	-	-	0.6	1.5	15.4	-	3.0	-	8.0	-	0.6	-	19.2	2.0	32.8	4.0	52.2
MIDLAND	22.8	4.6	-	-	11.5	5.5	28.8	2.5	1.0	4.6	29.3	11.9	122.5	2.0	-	2.0	19.5	9.4	0.5	5.0	17.0	1.0	56.4	8.4	187.2
Waikato	12.9	4.6	-	-	1.0	2.0	26.0	2.5	-	2.9	13.0	0.5	65.4	2.0	-	-	12.0	2.0	-	2.5	5.5	-	24.0	1.0	90.4
Lakes	4.0	-	-	-	-	-	1.0	-	-	1.5	3.0	2.9	12.4	-	-	-	7.0	1.0	-	-	7.9	-	15.9	3.0	31.3
Bay of Plenty	5.9	-	-	-	8.5	3.5	1.0	-	1.0	0.0	11.5	5.7	37.1	-	-	2.0	0.5	4.4	0.5	2.5	3.6	1.0	14.5	1.8	53.4
Tairawhiti	-	-	-	-	1.0	-	0.8	-	-	0.2	-	0.8	2.8	-	-	-	-	1.0	-	-	-	-	1.0	0.6	4.4
Taranaki	-	-	-	-	1.0	-	-	-	-	-	1.8	2.0	4.8	-	-	-	-	1.0	-	-	-	-	1.0	1.9	7.7
CENTRAL	8.9	0.2	1.0	1.0	12.0	-	8.6	1.0	-	4.2	9.7	7.3	53.9	-	0.1	3.7	13.2	6.9	-	-	14.4	2.8	41.1	11.5	106.4
Hawkes Bay	-	-		-	-	-	-	-	-	-	-	1.0	1.0	-	-	-	3.0		-	-	-	-	3.0	1.0	5.0
MidCentral	1.1	-	1.0	1.0	2.4	-	2.0	-	-	2.0	2.0	-	11.5	-	-	-	2.0	1.0	-	-	10.4	-	13.4	3.6	28.5
Whanganui	-	-	-	-	-	-	1.0	-	-	-	4.0	-	5.0	-	-	-	1.0	2.0	-	-	1.0	-	4.0	1.2	10.2
Capital & Coast	3.0	0.2	-	-	5.5	-	1.6	1.0	-	1.0	3.0	1.3	16.6	-	0.1	3.7	7.2	1.6	-	-	1.2	-	13.8	3.2	33.6
Hutt Valley	4.8	-	-	-	3.5	-	2.2	-	-	1.2	0.7	5.0	17.4	-	-	-	-	-	-	-	1.8	-	1.8	1.3	20.5
Wairarapa	-	-	-	-	0.6	-	1.8	-	-	-	-	-	2.4	-	0.1	-	-	2.3	-	-	-	2.8	5.1	1.2	8.7
SOUTHERN	16.3	0.6	7.1	3.8	12.4	1.0	4.9	4.9	1.1	3.2	25.7	5.5	86.5	-	0.1	-	42.9	3.2	-	-	21.8	1.0	69.0	16.9	172.3
Nelson Marlborough	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3.0	-	-	-	-	-	3.0	-	3.0
West Coast	-	-	-	-	0.8	-	-	0.8	-	-	0.8	-	2.5	-	-	-	9.4	-	-	-	0.5	-	9.9	-	12.4
Canterbury	9.5	-	1.5	1.0	4.9	-	4.0	-	0.5	1.0	13.9	5.0	41.3	-	-	-	27.9	2.5	-	-	5.0	-	35.4	4.6	81.3
South Canterbury	1.8	-	-	-	-	-	0.4	1.2	-	-	1.0	-	4.3	-	-	-	2.6		-	-	-	-	2.6	1.1	8.0
Southern	5.0	0.6	5.6	2.8	6.7	1.0	0.5	2.9	0.6	2.2	10.1	0.5	38.4	-	0.1	-	-	0.7	-	-	16.3	1.0	18.1	11.2	67.7
TOTAL	88.5	5.8	10.1	4.8	36.7	6.5	50.1	8.9	3.1	14.0	71.6	29.1	329.1	2.5	3.4	8.2	103.5	19.5	1.1	7.5	78.2	7.3	231.1	49.7	609.9

Table 12. Non-DHB ICAMH/AOD Vacant FTEs by Occupation (2018)

Non-DHB ICAMH/AOD Vacancies by Occupation (Vacant FTEs, 2018)	Alcohol & Drug Practitioner	Nurse	Social Worker	Other Clinical	Clinical Sub-Total	Mental Health Support Worker	Peer Support Worker	Youth Worker	Non-Clinical Sub-Total	Administration/ Management	Total
NORTHERN	3.8	0.5	-	-	4.3	-	-	-	-	-	4.3
Auckland	1.8	0.5	-	-	2.3	-	-	-	-	-	2.3
Counties Manukau	2.0	-	-	-	2.0	-	-	-	-	-	2.0
MIDLAND	1.8	-	1.00	-	2.8	-	2.0	1.44	3.44	0.4	6.64
Waikato	-	-	-	-	-	-	1.0		1.0		1.0
Bay of Plenty	1.8	-	1.00	-	2.8	-	1.0	0.24	1.24	0.4	4.44
Taranaki	-	-	-	-	-	-	-	1.2	1.2	-	1.20
CENTRAL	-	-	-	1.43	1.43	-	-	0.7	0.7	-	2.13
Whanganui	-	-	-	-	-	-	-	0.7	0.7	-	0.7
Capital & Coast	-	-	-	0.8	0.8	-	-	-	-	-	0.8
Wairarapa	-	-	-	0.63	0.63	-	-	-	-	-	0.63
SOUTHERN	2.0	2.0	1.0	-	5.0	3.25	-	-	3.25	-	8.25
Nelson Marlborough	-	-	-	-		3.0	-	-	3.0	-	3.0
Canterbury	2.0	2.0	1.0	-	5.0	0.25	-	-	0.25	-	5.25
TOTAL	7.6	2.5	2.0	1.4	13.5	3.3	2.0	2.1	7.4	0.4	21.3

Table 13. Non-DHB Māori ICAMH/AOD Workforce by Occupation (2018)

Non-DHB Māori ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Clinical Placement/Intern	Child & Adolescent Psychiatrist	Co-Existing Problems Clinician	Counsellor	Family Therapist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Educator	Mental Health Consumer	Mental Health Support Worker	Peer Support Worker	Youth Worker	Whānau Ora Practitioner	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
NORTHERN	15	-	-	1	-	-	1	-	-	-	1	8	26	1	1	2	9	-	11	2	3	29	3	58
Northland	3	-	-	1	-	-	1	-	-	-	-	-	5	-	-	-	3	-	2	-	-	5	2	12
Waitemata	-	-	-	-	-	-	-	-	-	-	1	-	1	-	-	-	*	-	3	2	-	5	-	6
Auckland	7	-	-	-	-	-	-	-	-	-	-	-	7	1	1	-	1	-	*	-	-	3	-	10
Counties Manukau	5	-	-	-	-	-	-	-	-	-	-	8	13	-	-	2	5	-	6	-	3	16	1	30
MIDLAND	14	-	-	-	10	2	19	-	-	3	24	4	76	3	1	-	6	10	10	11	1	42	2	120
Waikato	8	-	-	-	-	1	18	-	-	3	11	-	41	3	-	-	5	3	5	2	-	18	-	59
Lakes	2	-	-	-	-	-	-	-	-	-	-	1	3	-	-	-	-	-	4	-	-	4	-	7
Bay of Plenty	4	-	-	-	9	1		-	-	-	12	2	28	-	1	-	1	6	1	9	1	19	-	47
Tairawhiti	-	-	-	-	1	-	1	-	-	-	-	1	3	-	-	-	-	1	-	-	-	1	1	5
Taranaki	-	-	-	-	-	-		-	-	-	1	-	1	-	-	-	-	-	-	-	-	-	1	2
CENTRAL	4	1	-	-	3	-	2	-	-	4	3	1	18	-	1	1	3	2	7	-	1	15	4	37
Hawke's Bay	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	2	-	2
MidCentral	-	1	-	-	2	-	1	-	-	1	1	-	6	-	-	-	-	1	4	-	-	5	1	12
Whanganui	-	-	-	-	-	-	-	-	-	-	2	-	2	-	-	-	1	-	-	-	-	1	2	5
Capital & Coast	3	-	-	-	1	-	1	-	-	1	-	1	7	-	1	1	-	-	2	-	-	4	-	11
Hutt	1	-	-	-	-	-	-	-	-	2	-	-	3	-	-	-	-	-	1	-	-	1	1	5
Wairarapa	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	2	-	2
SOUTHERN	-	-	-	3	2	1	1	-	-	-	4	-	20	-	-	-	9	3	4	-	-	16	5	41
Nelson Marlborough	-	-	-	-	1	-	-	-	-	-	1	-	2	-	-	-	4	-	-	-	-	4	-	6
Canterbury	4	1	-	1		-	-	-	-	-	2	-	8	-	-	-	5	3	2	-	-	10	1	19
South Canterbury	-	-	-	-	-	-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1
Southern	2	2	-	2	1	1	-	-	-	-	1	-	9	-	-	-	-	-	2	-	-	2	4	15
Total	39	4	-	4	15	3	23	-	-	7	32	13	140	4	3	3	27	15	32	13	5	102	14	256

Table 14. Non-DHB Pacific ICAMH/AOD Workforce by Occupation (2018)

Non-DHB Pacific ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Co-Existing Problems Clinician	Child & Adolescent Psychiatrist	Counsellor	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Caregiver	Cultural	Educator	Mental Health Consumer Advisor	Mental Health Support Worker	Peer Support Worker	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
NORTHERN	10	-	-	-	2	-	-	-	2	2	16	2	-	-	1	3	-	10	1	17	-	33
Waitemata	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-		-	1	1	2	-	3
Auckland	3	-	-	-	2	-	-	-	1	-	6	-	-	-	-	2	-	-	-	2	-	8
Counties Manukau	7	-	-	-	-	-	-	-	-	2	9	2	-	-	1	1	-	9	-	13	-	22
MIDLAND	-	-	-	-	3	-	1	-	-	-	4	-	-	-	-	3	-	-	-	3	-	7
Waikato	-	-	-	-	3	-	-	-	-	-	3	-	-	-	-	1	-	-	-	1	-	4
Lakes	-	-	-	-	-	-	-	-	-	-		-	-	-	-	2	-	-	-	2	-	2
Bay of Plenty	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-		-	-	-	-	-	1
CENTRAL	-	-	-	4	-	-	-	-	1	1	6	-	-	2	-	1	2	-	-	5	2	13
MidCentral	-	-	-	1	-	-	-	-		-	1	-	-	-	-	-	1	-	-	1	1	3
Whanganui	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-		-	-	-	-	1
Capital & Coast	-	-	-	2	-	-	-	-	-	-	2	-	-	2	-	1	1	-	-	4	1	7
Hutt	-	-	-	1	-	-	-	-	-	1	2	-	-	-	-	-	-	-	-	-	-	2
SOUTHERN	2	-	-	-	1	-	-	-	-	-	3	-	-	-	-	1	-	-	-	1	-	4
Canterbury	2	-	-	-	1	-	-	-	-	-	3	-	-	-	-	1	-	-	-	1	-	4
Total	12	-	-	4	6	-	1	-	3	3	29	2	-	2	1	8	2	10	1	26	2	57

Table 15. Non-DHB Asian ICAMH/AOD Workforce by Occupation (2018)

Non-DHB Asian ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Co-Existing Problems Clinician	Mental Health Nurse	Occupational Therapist	Child & Adolescent Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Mental Health Consumer Advisor	Mental Health Support Worker	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
NORTHERN	5	-	-	-	-	-	-	3	-	8	-	-	5	3	1	9	-	17
Northland	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	-	1
Waitemata	-	-	-	-	-	-	-	1	-	1	-	-	2	-	-	2	-	3
Auckland	2	-	-	-	-	-	-	2	-	4	-	-	2	-	1	3	-	7
Counties Manukau	3	-	-	-	-	-	-	-	-	3	-	-	-	3	-	3	-	6
MIDLAND	3	-	1	-	-	-	-	-	1	5	-	-	3	-	-	3	1	9
Waikato	1	-	-	-	-	-	-	-	-	1	-	-	2	-	-	2		3
Lakes	1	-	1	-	-	-	-	-	-	2	-	-	1	-	-	1	1	4
Bay of Plenty	1	-	-	-	-	-	-	-	1	2	-	-	-	-	-	-	-	2
CENTRAL	1	-	-	-	-	-	-	-	1	2	-	-	4	-	-	4	-	6
MidCentral	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	1
Capital & Coast	-	-	-	-	-	-	-	-	-	-	-	-	4	-	-	4	-	4
Hutt	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	1
SOUTHERN	-	-	-	-	-	-	-	-	-	-	-	-	1	1	1	3	-	3
Canterbury	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1	2	-	2
Southern	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1	-	1
TOTAL	9	-	1	-	-	-	-	3	2	15	-	-	13	4	2	19	1	35

Table 16. Non-DHB NZ European ICAMH/AOD Workforce by Occupation (2018)

Non-DHB NZ European ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinicians	Counsellor	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Educator	Mental Health Consumer Advisor	Mental Health Support Worker	Peer Support Worker	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
NORTHERN	14	2	-	1	4	1	1	1	3	1	28	1	-	9	-	1	3	14	6	48
Northland	5	-	-	-	-	-	1	-	1	-	7	-	-	2	-	1	-	3	2	12
Waitemata	-	2	-	-	4	-	-	1	1	-	8	-	-	-	-	-	-	-	-	8
Auckland	7	-	-	-	-	1	-	-	-	-	8	1	-	5	-	-	-	6	1	15
Counties Manukau	2	-	-	1	-	-	-	-	1	1	5	-	-	2	-	-	3	5	3	13
MIDLAND	7	5	-	5	10	2	-	3	7	11	50	1	-	13	2	7	2	25	8	83
Waikato	5	5	-	2	9	2	-	1	3	1	28	-	-	8	-	2	1	11	1	40
Lakes	1	-	-	-	-	-	-	1	3	2	7	-	-	5	1	2	-	8	3	18
Bay of Plenty	1	-	-	2	1	-	-	-	1	6	11	1	-	-	-	3	1	5	3	19
Tairawhiti	-	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	1
Taranaki	-	-	-	1	-	-	-	-	-	2	3	-	-	-	1	-	-	1	1	5
CENTRAL	6	1	1	10	7	1	-	1	5	5	37	-	-	10	2	9	5	26	10	73
Hawkes Bay	-	-	-	-	-	-	-	-	-	1	1	-	-	2	-	-	-	2	-	3
MidCentral	2	-	1	-	1	-	-	1	1	-	6	-	-	2	-	7	-	9	2	17
Whanganui	-	-	-	-	1	-	-	-	1	-	2	-	-	-	-	1	2	3	1	6
Capital & Coast	-	1	-	4	1	1	-	-	3	1	11	-	-	6	-	-	1	7	3	21
Hutt Valley	4	-	-	4	3	-	-	-	-	3	14	-	-	-	-	1	-	1	1	16
Wairarapa	-	-	-	2	1	-	-	-	-	-	3	-	-	-	2	-	2	4	3	10
SOUTHERN	7	1	6	8	4	7	1	5	23	9	71	-	1	41	2	22	1	67	16	154
Nelson Marlborough	-	-	-	-	-	-	-	-	-	-	-	-	-	3	-	-	-	3	-	3
West Coast	-	-	-	-	-	1	-	-	-	-	1	-	-	12	-	1	-	13	-	14
Canterbury	4	-	1	3	2	-	1	2	13	5	31	-	-	23	1	3	-	27	3	61
South Canterbury	2	-	-	-	1	2	-	-	1	-	6	-	-	3	-	-	-	3	3	12
Southern	1	1	5	5	1	4	-	3	9	4	33	-	1	-	1	18	1	21	10	64
TOTAL	34	9	7	24	25	11	2	10	38	26	186	2	1	73	6	39	11	132	40	358

Table 17. Non-DHB Other Ethnicity ICAMH/AOD Workforce by Occupation (2018)

Non-DHB Other Ethnicity ICAMH/AOD Workforce by Occupation (Headcount, 2018)	Alcohol & Drug Practitioner	Child & Adolescent Psychiatrist	Co-Existing Problems Clinicians	Counsellor	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Mental Health Consumer Advisor	Mental Health Support Worker	Peer Support Worker	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administration/ Management	Total
NORTHERN	2	-	1	-	1	-	-	1	-	8	13	-	-	6	-	1	1	8	5	26
Northland	-	-	1	-	-	-	-	1	-	-	2	-	-	-	-	-	-	-	-	2
Waitemata	1	-	-	-	1	-	-	-	-	-	2	-	-	2	-	-	-	2	1	5
Auckland	1	-	-	-	-	-	-	-	-	8	9	-	-	4	-	-	-	4	4	17
Counties Manukau	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	2	-	2
MIDLAND	1	-	-	-	-	1	-	2	2	2	8	-	-	1	-	3	-	4	-	12
Waikato	1	-	-	-	-	1	-	-	1	1	4	-	-	1	-	-	-	1	-	5
Lakes	-	-	-	-	-	-	-	2	-	1	3	-	-	-	-	2	-	2	-	5
Bay of Plenty	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1	-	1
Taranaki	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	-	1
CENTRAL	-	-	-	1	-	-	-	-	1	-	2	-	-	-	-	-	1	1	3	6
Hawke's Bay	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
Capital & Coast	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
Hutt	-	-	-	1	-	-	-	-	1	-	2	-	-	-	-	-	1	1	1	4
SOUTHERN	3	-	-	1	-	-	1	-	2	7	14	-	-	4	1	2	-	7	1	22
Canterbury	1	-	-	1	-	-	-	-	1	3	6	-	-	4	1	-	-	5	1	12
Southern	2	-	-	-	-	-	1	-	1	4	8	-	-	-	-	2	-	2	-	10
TOTAL	6	-	1	2	1	1	1	3	5	17	37	-	-	11	1	6	2	20	9	66

Table 18. Total ICAMH/AOD Workforce by Ethnicity (2018)

TOTAL ICAMH/AOD WORKFORCE BY ETHNICITY (Headcount, 2018)	NZ EUROPEAN			OTHER			MĀORI			PACIFIC			ASIAN			TOTAL	DHB	NON-DHB	TOTAL
	DHB	NON-DHB	Total	DHB	NON-DHB	Total	DHB	NON-DHB	Total	DHB	NON-DHB	Total	DHB	NON-DHB	Total				
NORTHERN	247	48	295	74	26	100	60	58	118	38	33	71	53	17	70	654	472	182	654
Northland	22	12	34	10	2	12	22	12	34	3	-	3	3	1	4	87	60	27	87
Waitemata	70	8	78	40	5	45	8	6	14	8	3	11	17	3	20	168	143	25	168
Auckland Inpatient	45	-	45	2	-	2	9	-	9	7	-	7	10	-	10	73	73	-	73
Auckland Community	88	15	103	4	17	21	9	10	19	5	8	13	15	7	22	178	121	57	178
Counties Manukau	22	13	35	18	2	20	12	30	42	15	22	37	8	6	14	148	75	73	148
MIDLAND	82	83	165	34	12	46	34	120	154	6	7	13	5	9	14	392	161	231	392
Waikato	28	40	68	15	5	20	4	59	63	1	4	5	5	3	8	164	53	111	164
Lakes	11	18	29	4	5	9	3	7	10	-	2	2	-	4	4	54	18	36	54
Bay of Plenty	32	19	51	7	1	8	13	47	60	4	1	5	-	2	2	126	56	70	126
Tairawhiti	-	1	1	4	-	4	11	5	16	1	-	1	-	-	-	22	16	6	22
Taranaki	11	5	16	4	1	5	3	2	5	-	-	-	-	+	-	26	18	8	26
CENTRAL	217	73	290	26	6	32	37	37	74	22	13	35	11	6	17	448	313	135	448
Hawke's Bay	30	3	33	1	1	2	7	2	9	-	-	-	-	-	-	44	38	6	44
MidCentral	27	17	44	1	-	1	3	12	15	-	3	3	2	1	3	66	33	33	66
Whanganui	10	6	16	9	-	9	1	5	6	-	1	1	-	-	-	32	20	12	32
Capital & Coast Inpatient	21	-	21	1	-	1	6	-	6	8	-	8	2	-	2	38	38	-	38
Capital & Coast Community	70	21	91	14	1	15	17	11	28	13	7	20	7	4	11	165	121	44	165
Hutt	45	16	61	-	4	4	1	5	6	1	2	3	-	1	1	75	47	28	75
Wairarapa	14	10	24	-	-	-	2	2	4	-	-	-	-	-	-	28	16	12	28
SOUTHERN	253	154	407	27	22	49	19	41	60	1	4	5	13	3	16	537	313	224	537
Nelson Marlborough	35	3	38	-	-	-	1	6	7	-	-	-	1	-	1	46	37	9	46
West Coast	10	14	24	1	-	1	2	-	2	-	-	-	-	-	-	27	13	14	27
Canterbury Inpatient	54	-	54	2	-	2	2	-	2	1	-	1	6	-	6	65	65	-	65
Canterbury Community	89	61	150	17	12	29	11	19	30	-	4	4	4	2	6	219	121	98	219
South Canterbury	8	12	20	2	-	2	2	1	3	-	-	-	1	-	1	26	13	13	26
Southern	57	64	121	5	10	15	1	15	16	-	-	-	1	1	2	154	64	90	154
Youth Forensic Service	14	-	14	3	-	3	13	-	13	17	-	17	-	-	-	47	47	-	47
TOTAL	813	358	1,171	164	66	230	163	256	419	84	57	141	82	35	117	2,078	1,306	772	2,078

APPENDIX E: ICAMH/AOD WORKFORCE SURVEY FORM

SERVICE NAME

SECTION 1: DHB FUNDED 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 2017/2018 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 2018

PURCHASE UNIT CODE	PURCHASE UNIT DESCRIPTION	VOLUME	UNIT
MHI55D	Infant, child, adolescent & youth community support services - Non-clinical staff	1.0	FTE

REGIONAL & SUB-REGIONAL SERVICES	DHB AREAS COVERED

Does your service have a specific care pathway to provide/deliver care for trans* and gender diverse youth?

☐ YES ☐ NO ☐ DON'T KNOW

Does your service have someone in a Youth Advisory Role?

☐ YES ☐ NO ☐ DON'T KNOW

If answered NO, please let us know why and/or any barriers to hiring a young person in a such a role:

Does your Service provide/deliver any of the following Parenting Programmes (Select as many that Apply)?

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

☐ Other (Please Specify below):

Has your service undertaken any of the following Cultural Competency Assessments in the last 12 months (e.g. Takarangi; Sei Tapu; CALD):

- ❖ Māori ☐ YES (Specify): _____ ☐ NO ☐ DON'T KNOW
- ❖ Pacific ☐ YES (Specify): _____ ☐ NO ☐ DON'T KNOW
- ❖ Asian ☐ YES (Specify): _____ ☐ NO ☐ DON'T KNOW

If answered NO to any of the above, please let us know why below:

WORKFORCE CHALLENGES
What workforce challenges, if any, do you foresee in 5 years' time as a result of expected changes in service delivery

Is your service undertaking any wellbeing initiatives/activities for your workforce?

	YES
PLEASE SPECIFY:	
	NO
	DON'T KNOW

SECTION 2: WORKFORCE INFORMATION

TABLE 2: ANNUAL STAFF TURNOVER: 1 JULY 2017- 30 JUNE 2018	
No. of Staff (Headcount) as at 1 July 2017:	
No. of Staff (Headcount) as at 30 June 2018:	
No. of Staff (Headcount) who have left during the above 1-year period:	
Occupation of Staff who have left:	Reason for Leaving

SERVICE NAME

Please ensure the workforce information is provided for the *DHB funded Infant, Child & Adolescent Mental Health/AoD Contract* as a 30th June 2018 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

ACTUAL & VACANT FTES AS AT 30 JUNE 2018. Please provide FTEs to 1 decimal point.

TABLE 3: ACTUAL/VACANT FTES/OCCUPATION (30 JUNE 2018)	ACTUAL FTES (AS AT 30 JUNE 2018)	VACANT FTES (AS AT 30 JUNE 2018)
Alcohol & Drug Practitioners		
Co-Existing Problems Clinicians		
Child & Adolescent Psychiatrists		
Counsellors		
Family Therapists		
Mental Health Nurses		
Occupational Therapists		
Other Senior Medical Officer		
Psychotherapists		
Psychologists		
Social Workers		
Other Clinical (please list in spaces below)		
Clinical Placements/Interns (please list below)		
Advocacy/Peer Support-Consumers		
Advocacy/Peer Support-Family/Whānau		
Educators		
Family/Whānau Advisors		
Liaison/Consult Liaison Appointment		
Kaumātua/Kuia/Pacific Matua (please circle)		
Mental Health Support Workers/Kaiawhina/Kaiatawhai /Community Support Workers		
Needs Assessors & Service Coordinators		
Peer Support Workers		
Specific Cultural Positions (not listed): (please list in spaces below)		
Whānau Ora Practitioners		
Youth Consumer Advisors (i.e. staff member who provides a youth lived experience perspective)		
Youth Workers		
Other Non-Clinical Support (for clients) (please list)		
Administration		
Management		
TOTAL		

SERVICE NAME

ETHNICTY OF THE SERVICE/TEAM AS AT 30 JUNE 2018. Please confirm ethnicity with the individual.

TABLE 4: ETHNICITY/OCCUPATION 30 JUNE 2018	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 2
Alcohol & Drug Practitioners											
Co-Existing Problems Clinicians											
Child & Adolescent Psychiatrists											
Counsellors											
Family Therapists											
Mental Health Nurses											
Occupational Therapists											
Other Senior Medical Officer											
Psychotherapists											
Psychologists											
Social Workers											
Other Clinical (please list in spaces below)											
Clinical Placements/Interns (please list below)											
Advocacy/Peer Support-Consumers											
Advocacy/Peer Support-Family/Whānau											
Educators											
Family/Whānau Advisors											
Liaison/Consult Liaison Appointment											
Kaumātua/Kuia/Pacific Matua (please circle)											
Mental Health Support Workers/Kaiawhina/Kaiatawhai /Community Support Workers											
Needs Assessors & Service Coordinators											
Peer Support Workers											
Specific Cultural Positions (not listed): (please list in spaces below)											
Whānau Ora Practitioners											
Youth Consumer Advisors (i.e. staff member who provides a youth lived experience perspective)											
Youth Workers											
Other Non-Clinical Support (for clients) (please list)											
Administration											
Management											
TOTAL											

***Please Note: If applicable, sub-ethnicity information will be requested via email.**

CONTACT DETAILS: NAME/PHONE/EMAIL	

APPENDIX F: GLOSSARY OF TERMS

ACRONYM	DESCRIPTION
ACEs	Adverse Childhood Experiences
AOD	Alcohol & Other Drugs
CAPA	Choice and Partnership Approach
CBT	Cognitive Behaviour Therapy
CEP	Co-Existing Problems
COPMIA	Children of Parents with Mental Health Issues and Addictions
DHB	District Health Board
EIS	Early Intervention Service
HEEADSSS	Home, Education/Employment, Eating, Activities, Drinking & Other Drugs, Sexuality, Suicide and Depression, Safety
ICAFS	Infant Child & Adolescent Family Services
ICAMHS	Infant child & Adolescent Mental Health services
IY	Incredible Years
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex.
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Governmental Organisation
PCIT	Parent Child Interactive Therapy
PHO	Primary Health Organisation
RSP	Real Skills Plus
SACS-BI	Substance Abuse & Choices Scale – Brief Interventions
SPARX	Smart, Positive, Active, Realistic, Xfactor, Thoughts.
SPHC	Supporting Parents Healthy Children
YOSS	Youth One stop Shop Service

Werry Workforce
WHĀRAURAU
For Infant, Child and Adolescent Mental Health

2018 Workforce Stocktake

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uniservices
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THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

ISBN 978-0-9941149-3-8
www.werryworkforce.org

Cover art by Kimberley Spain