2020 STOCKTAKE

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

WHĀRAURAU
Empower the Workforce | Manaaki Mokopuna

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Content

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Foreword

Tēnā koutou katoa

Welcome to the ninth biennial *Stocktake of the Infant, Child, and Youth Mental Health Workforce*. Here we provide data from 2017 to 2020/21 on the access rates of our young people to mental health services and the various roles of those who work hard to support them. While there continue to be significant challenges in meeting the mental health needs of our children and youth, it is important to acknowledge the dedication of this workforce to our young people and whānau experiencing mental distress. We recognise and appreciate their efforts to improve the wellbeing of our communities and the future adults of Aotearoa.

Both here and across the globe, 2020 has been a big year. The impact of COVID-19 has increased experiences of mental distress of our children and youth. In Aotearoa, mental health workers have noticed increased experiences of anxiety and depression associated with lockdown and returning to school. This is consistent with international findings.

The impact of COVID-19 on the livelihoods of whānau (and flow-on effects on mental health) have added to the existing mental health needs of children and youth and the demand on existing services. This highlights the need for us to expand our understanding of what we consider a mental health service and a mental health worker, not only to provide more support to more young people and whānau but also to provide greater access and choice for our population.

The Government's *Access and Choice* programme is providing promising results with the roll-out of integrated primary mental health and addiction services, the initial establishment of more youth-focused services and more partnerships with kaupapa Māori and Pacific services. With the Mental Health and Wellbeing Commission's recent review calling for greater prioritisation of services for Māori, Pacific and youth, we are hopeful for positive shifts in future *Stocktake* data.

In 2020, the *Youth19* survey was also released. It showed that while many students are happy or satisfied with their lives and have good wellbeing, a large number also reported high levels of distress. The *Youth19* survey also found persistent and growing mental health inequity between Māori, other ethnic groups and gender diverse young people and that socioeconomic deprivation is an important factor. Symptoms of depression and rates of suicide attempts were found to be generally higher among those living in lower income communities.

These findings demonstrate how crucial cross-sector collaboration will be to support the delivery of mental health and wellbeing community supports and make a difference for young people and their whānau.

At the time of writing, *Kia Manawanui Aotearoa – The long-term pathway to mental wellbeing* recognises the need to broaden our understanding of who we think makes up the mental health and addiction workforce. It also recognises the need to grow and support our existing workforce with new skills and competencies to help transform how mental health and wellbeing support is accessed.

These plans for change are encouraging and signal the potential for real improvements in the mental health and wellbeing outcomes for more children and young people in Aotearoa.

We look forward to getting on and joining you in this mahi.

Ngā mihi nui

Abigail Milnes
Acting Director
Whāraurau

Executive Summary

The 2020/21 Stocktake of the Infant, Child and Adolescent Mental Health/Alcohol and Other Drugs (ICAMH/AOD) Workforce, and service users' access data, provide a snapshot of current and potential future demand for services via population data, actual demand for services (via service user data), investment in service provision (via funding data), and the capacity and capabilities of the workforce (via the workforce survey data and *Real Skills Plus ICAMH/AOD*).

Infant, Child, and Adolescent (0-19 years) Population (2020-2030): Population data and projections indicate current and potential future demand for services:

- 26% of Aotearoa's 2020 population was 0-19 years old: 48% were Other Ethnicity (includes NZ European/Pākehā) group, 26% were Māori, 16% Asian, 10% Pacific.
- 10-year population projections indicate +0.2% growth for the overall 0-19 years population from 2020 to 2030; however, projections indicate a trend towards a growing ethnically diverse population: +26% for the Asian population (the largest projected growth), +8% growth for Māori tamariki and rangatahi, and +6% for Pacific.

Service user access to ICAMH/AOD services: Service user data, extracted from the Programme for the Integration of Mental Health Data (PRIMHD), indicate actual demand for services and the rates at which service users are accessing services relative to need.

From 2017-2019:

- +4% increase seen in the number of 0–19-year-olds accessing services. **+7%** increase in female service users and a -1% decrease in male service users.
- +6% increase in access to NGOs; +3% increase to DHB services.
- Improvement seen in overall access rate to services from 4.4% to 4.5%; however, this remains below the target rate of 5% set by the Mental Health Commission (MHC) for the overall 0–19 years age group (Mental Health Commission, 1998).
- Improvement in access rates seen for Māori, Asian and Other Ethnicity service users, but not for Pacific.
- Improvement in access rates seen in three out of the four regions: Midland, Central, and Southern, but not for Northern.

2019:

- 76% of all service users had accessed DHB services; 24% had accessed NGOs.
- 56% of all service users were in the "Other Ethnicity" ethnic group (includes NZ European); followed by 33% Māori, 6% Pacific and 5% Asian.
- Māori continue to have the highest access rate of 5.72% out of the four ethnic groups (5.15% Other Ethnicity, 2.87% Pacific, 1.35% Asian). Although this exceeds the overall 0–19 years rate of 5%, target rates for Māori are set at double the overall rate (10%) due to higher prevalence of mental health disorders. Therefore, current access rates indicate significant unmet mental health needs. Pacific and Asian service user access rates continue to remain below the 5% target rate.

ICAMH/AOD funding: Funding data for ICAMH/AOD services indicate the level of investment in the ICAMH/AOD sector for service provision and workforce development activities:

2018-2020:

- +16% increase in funding for ICAMH/AOD services.
- +22% increase for non-DHB services; +13% increase for DHB services.

- +14% increase in funding per head for the 0-19 years population, from $147 to $167 (including inpatient and youth primary mental health funding).

ICAMH/AOD workforce: ICAMH/AOD workforce data indicate the capacity and capabilities of the ICAMH/AOD workforce relative to service demand. Workforce information is based on data provided by 20 DHB-funded DHB (Inpatient, Community and Forensics) services and 103/122 non-DHB (112 NGOs & 10 PHOs) services. The 2018 non-DHB workforce data were used for those services who were not able to participate. Due to delays caused by COVID-19 lockdowns in 2020, workforce data include data from June 2020 to August 2021.

2018 to 2020/21:

- +2% increase in the overall ICAMH/AOD workforce.
- +6% increase in the DHB workforce; -4% decrease in non-DHB.
- +4% increase in the clinical workforce; -3% decrease in the non-clinical workforce.
- +1% increase in the Māori workforce; +4% increase in the Pacific workforce; -3% decrease in the Asian workforce.
- -12% decrease in reported vacancies, largely in the DHB community workforce by -26%.

2020/21:

- 66% employed in DHB services, 34% in non-DHB services.
- 51% NZ European/Pākehā, 20% Māori, 16% Other Ethnicity, 7% Pacific and 5% Asian.
- 73% in clinical roles and 17% in non-clinical (excluding Administration and Management).
- 8% vacancy rate (vacancies ranged from 0% to 32%). Vacancies largely for clinical roles.
- 19% overall turnover rate (28% in non-DHBs; 14% in DHBs) for Support Workers, Nurses, Social Workers and Psychologists. Turnover reasons included external job opportunities for better salaries, relocation to another city/town, internal job opportunities and pursuing further education/career development opportunities.

The *Real Skills Plus ICAMH/AOD online* tool assesses competency levels (capability) of the workforce, which includes knowledge and skills needed to work with ICAMH/AOD populations. Data showed development was needed in:

- *Knowledge and Skills: Assessment and Intervention.*
- *Knowledge and Skills by area: Cultural and Leadership skills.*

Workforce development needs: Both DHB and non-DHB services identified the following needs:

- *Recruitment of staff with ICAMH training and experience.*
- *Training in therapeutic interventions.*

Recommendations:

- Engage in prevention and mental health promotion activities to inform, educate, and improve mental health literacy and reduce stigma to improve access to services.
- Invest in and provide early intervention programmes and services in schools and the community, including evidence-based digital intervention and resources.
- Increase and allocate appropriate levels of funding for enabling essential infrastructure, service, and workforce development activities.
- Expand and strengthen primary mental health services and workforce to alleviate demand for specialist mental health services.
- Continue to develop new and better youth-informed services, especially for Māori, Pacific, and Asian young people.
- Collaborate with other services and agencies for holistic service provision.
- Increase, strengthen and support the specialist ICAMH/AOD services and workforce through:
  - *Funding, planning, and re-designing service delivery and engaging in essential workforce development activities.*
  - *Increasing capacity via effective and targeted recruitment and retention strategies.*
  - *Increasing capability by identifying current knowledge and skill levels for targeted development and enabling access to these training and development opportunities.*

Introduction

Str*ategic Directions*

Several strategic documents have informed and shaped the ICAMH/AOD workforce to date[1]:

- *Blueprint for Mental Health Services in New Zealand: How Things Need to Be (Mental Health Commission, 1998)*
- *Te Tāhuhu—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, 2012)*
- *Rising to the Challenge (Ministry of Health, 2012c)*
- *The Children's Action Plan (New Zealand Government, 2012)*
- *Prime Minister's Youth Mental Health Project (2012)*
- *He Ara Oranga (Government Inquiry into Mental Health and Addiction, 2018)*
- *Child and Youth Wellbeing Strategy (Department of the Prime Minister and Cabinet, 2019)*

The *Child and Youth Wellbeing Strategy* (Department of the Prime Minister and Cabinet, 2019) is a key document outlining the strategy for working with children and young people to ensure their involvement and empowerment in decision making. The following initiatives were highlighted to improve the mental wellbeing and reduce suicide among children and young people:

- *Improved access and choice of primary mental health and addiction support*, including a focus on kaupapa Māori and youth-friendly services that are accessible, culturally appropriate and build on the strengths of young people and their supports to increase capacity and resilience.
- *Review of the Well Child Tamariki Ora programme* which ensures child wellbeing by providing health and development checks to all children from birth to five years.
- *Expansion and enhancement of school-based health services*, including using electronic assessments, to enable more targeted responses and follow-up support.
- *Improved support for parent*s with mental health and addiction needs.
- *Developing resources* to enhance the resilience and mental wellbeing of primary and intermediate school-aged children.

Every Life Matters – He Tapu te Oranga o ia tangata (Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand) is another key document aimed at improving the wellbeing of children and young people. The premise of this work aspires toward a future where there is no suicide in Aotearoa. Emphasis is placed on building a strong system through leadership, using evidence to make a difference, developing the workforce, and evaluation and monitoring. Young people, males and users of mental health and addiction services are identified as priority groups, making each of the action areas relevant to child and adolescent services. There are actions that distinctly focus on children and young people within the areas of promotion, prevention and postvention:

- *Promotion - Promoting wellbeing* through the provision of increased wellbeing and support for children and young people in places of learning and through transitions between life stages. This includes a focus on creating culturally responsive resources that support inclusive education, enhancing and expanding school-based health services and

[1] For a summary of these documents, please refer to the *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.

establishing a resource to support high school students to transition into further study or work. It involves working closely with Māori, DHBs and NGOs to develop plans and initiatives that facilitate wellbeing.

- *Prevention – Responding to distress* by working with people with lived experience to develop a programme of activities for young people experiencing suicidal distress within their learning environment. This also includes providing best-practice guidelines to schools, developing referral pathways between school-based health services and other community mental health services, and ensuring young people in care have access to interventions and support.
- *Postvention – Supporting individuals, whānau and families, and communities after a suicide* through developing culturally safe resources to guide best postvention practices in schools and places of learning, and through actively working with schools to ensure traumatic incident teams maintain positive learning environments following a traumatic event. This work with schools is supplemented by the resources and initiatives that support entire communities through postvention.

Allocation of the Budget

The first step to progressing the recommendations proposed by recent strategy documents is the allocation of adequate funding for essential service and workforce development. Investment in mental wellbeing was identified as a priority in the 2019 Budget and was allocated $1.9 billion over 5 years.

The 2020 Budget allocation for Health ($5.6 billion operating total and $755 million total capital) included:

- $980M DHBs - Additional Support: Funding to maintain DHB services, such as hospital care, mental health support, primary health care and support. It will enable DHBs to continue providing health services for NZ's growing and changing population, in the face of price and wage inflation.
- $750M DHBs - Capital Investment: Funding for priority capital projects within the health sector for the delivery of safe and appropriate healthcare by providing facilities, infrastructure, and technology to appropriately meet current and future demand.

Future Directions and Focus

The COVID-19 pandemic has had devastating effects on the already vulnerable on a global scale, but a second cohort of newly at-risk people—as a result of the economic downturn and expected ongoing rise in unemployment—is anticipated. Further outbreaks and/or rapid cycling up and down between COVID-19 protection levels can be expected to compound these challenges and increase psychological distress (Poulton et al., 2020). All future work will need to take on the added responsibility of addressing and tackling the strain on people's health and wellbeing, particularly for children and young people. *Koi Tū: The Centre for Informed Futures* advocates for a need to move to a more community-based model of mental-health service delivery, beginning with the integration of support services into general practice and the development of other community settings, all within the health and disability sector reforms which started from March 2021. Primary and community care in the future system will be reorganised to serve communities through locality networks focused on population health needs, and hospital and specialist services will be planned and managed by Health NZ. The *NZ Health Plan* will serve as a foundation of the new system and a key enabler of the intended outcomes of the reform. It will be jointly developed by Health NZ and the Māori Health Authority with input from other key agencies, with an interim plan developed by 2022.

Workforce Development

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 Wero: Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006-2009* (Ministry of Health, 2005). To specifically address the needs of the infant, child and adolescent mental health and addiction sector, 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). While this document outlined a national approach to systemic enhancements to support the capacity and capability of the ICAMH/AOD workforce up to 2016, the recommendations made to support regional, inter-district and local planning processes, informed by ongoing research and evaluation and data collection (p. 7), continue to apply:

- *Retain and develop the existing ICAMH workforce.*
- *Increase the numbers of the ICAMH workforce through training and enhanced career pathways.*
- *Increase the diversity of the ICAMH workforce through the development of core competencies, new roles, and new ways of working.*
- *Increase Māori and Pacific workforce numbers across all roles and parts of the sector.*
- *Increase clinical/cultural competencies throughout the ICAMH workforce.*
- *Increase capacity of related sector workforces to provide mental health screening and, where appropriate, assessment and therapeutic intervention.*
- *Increase organisational capacity and sector leadership to develop and plan for future workforce needs in the ICAMH sector.*

Whakapakari Ake Te Tipu—Māori Child and Adolescent Mental Health and Addiction Workforce Strategy (Te Rau Matatini, 2007) prioritised 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 of workforce development where it would need to adapt and evolve to new methods of working effectively and efficiently, requiring essential capabilities to appropriately respond to service users and their families/whānau.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2014–2017 (Ministry of Health, 2012c), *The Children's Action Plan* (New Zealand Government, 2012) and *He Ara Oranga* (2018) proposed a need for greater integration between primary and specialist services. This requires enhancing the mental health and addiction capabilities of the primary care workforce.

The *Mental Health and Addiction Workforce Action Plan* 2017-2021 (Ministry of Health, 2017) reiterates the need to focus on early intervention. Four areas for workforce development were identified (p. viii) and remain pertinent to current workforce development priorities, envisaging:

> A workforce that is:
>
> 1. *Focused on people and improved outcomes.*
> 2. *Integrated and connected across the continuum.*
> 3. *Competent and capable.*
> 4. *The right size and skill mix.*

To progress the strategies 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. Therefore, increasing the ICAMH/AOD workforce continues to remain a key area of focus. A continued investment in developing new roles, in the face of shortages, is also needed.

The Stocktake

Effective workforce development requires accurate information on the capacity and capability of the sector and service configuration relative to demand. Due to the comparatively small size and low profile of the sector, very little information detailing the infant, child and adolescent mental health/addiction workforce was known. 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). Furthermore, a need for centralised, regular (to be conducted every two years), standardised data collection of workforce composition and service user access rates for regional planning was identified in *Whakamārama te Huarahi* (Wille, 2006). The accumulated data to date provides a unique opportunity to identify trends over time in both workforce and demand for services, and to consider the interactions of funding, staffing and access.

Method

The ninth *Stocktake* of the ICAMH/AOD workforce commenced in November 2020. This *Stocktake* was conducted during a period of significant disruptions caused by the COVID-19 pandemic. At the time of data collection, many services reported a significant increase in workload and service user waitlists and were unable to participate due to the need to prioritise their core activities.

The 2020 *Stocktake* report includes the following data:

- Population: 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 2016-2030 infant, child, and adolescent population (0-19 years) by ethnicity and DHB area is based on census and projections (prioritised ethnicity). Prioritised ethnicity data are widely used in the health and disability sector as they are easy to work with, as each individual appears only once, hence the sum of the ethnic group populations will not add up to the total NZ population (Statistics New Zealand, 2006). Population data used in the report are projections based on the 2013 Census due to the unavailability of the projections based on the 2018 census data. The use of projected population statistics, while easier to use, tend to be less accurate.
- Funding: Infant, child and adolescent mental health/Alcohol and Other Drug (ICAMH/AOD) and youth primary mental health funding data were extracted from the Ministry of Health's Price Volume Schedules (PVS). This report only includes ICAMH services coded to child and youth purchase unit codes (including alcohol & drug and forensic); therefore, services that are not coded accordingly but may provide ICAMH services may not be captured.
- Workforce: Workforce data collection for each *Stocktake* is informed by consultations with the Ministry of Health, the Whāraurau team (including Youth Consumer, Māori, and Pacific Advisors) and external Māori, Pacific, and Asian advisory input.

    1. Workforce information is based on DHB (Inpatient & Community) ICAMH/AOD services (including the National Youth Forensic Service), and DHB-funded, non-DHB service providers (NGOs and PHOs). Workforce data are collected and presented by actual and vacant full-time equivalents (FTEs) and headcount by ethnicity and occupation from 30 June 2020 to June 2021. Workforce data were provided by all 20 DHBs.
    2. The list of non-DHB funded organisations contracted to provide ICAMH/AOD services from July 2019 to June 2020 was extracted from the 2019/2020 Price Volume Schedule. A total of 122 DHB-funded, non-DHB providers (112 NGOs, Iwi Providers and 10 PHOs) were surveyed by phone and email from December 2020. There were 103/122 that provided data. The 2018 workforce data were used as an estimate of the 2020 workforce for the remainder of the services who were too busy and unable to participate.
    3. Workforce data are reported by "clinical" and "non-clinical" categories:
        - *Clinical includes alcohol and drug workers, counsellors, mental health nurses, occupational therapists, psychiatrists, psychotherapists, clinical or registered psychologists, and social workers.*
        - *Non-clinical 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, peer support workers and youth workers.*
        - It is noted that while workforce data are collected and reported by these two categories, 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 categories.

        Limitations:

        - Workforce data are subject to the quality of the information supplied by service providers. Variations over time could be due to the reporting of data by different staff members from the same agencies. As more accurate data are provided, analyses 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, ethnicity data should be interpreted with caution.
- While the above 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:
  - Non-DHB services receive funding from different sources (e.g., Ministry of Social Development, Accident Compensation Corporation, 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 often 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 in the PVS, and therefore services may be missed.
  - Non-DHB services also receive a variable number of contracts, therefore it can be difficult to ascertain actual workforce trends over time.
  - Rural areas have issues with recruiting and retaining qualified staff. Unfilled FTE funding may have to be returned to the funders, which means reporting on unfilled vacancies should be viewed cautiously.

- Service User Data: Service user data are extracted from the Programme for the Integration of Mental Health Data (PRIMHD), which contains information on the provision of secondary mental health and AOD 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. PRIMHD *does not* include NGO service user diagnoses, classifications, or legal status, nor NGO service user's outcome data; PHOs or general practitioners (GPs) contracted to deliver youth primary mental health or addiction services are also not included.

  Limitations:

  - PRIMHD databases contain raw data sent in by providers and are therefore subject to the variable quality of information captured by the service user management systems.
  - Data reported are based on the *Service users by DHB of Domicile* (residence) for the full calendar year. Data pertain to the most complete information available at the time of reporting and may not match the time period when the workforce data were reported.
  - Improvements in service user access to services could be partly due to more services over time submitting data. Alternatively, decreases seen in the number of service users could also be due to fewer numbers of NGOs contracted.
  - Service user access rates are calculated by dividing the number of 0–19-year service users, per year, by the corresponding population. The access rates presented in this report are based on population projections and are less accurate than the rates calculated using census data.

The information collected and presented in this report 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 service and workforce development, in alignment with government priorities. Regional data are available upon request.

National Overview

Infant, Child, Adolescent and Youth Mental Health Needs

- The current data on the health and wellbeing of the population aged 0–19 years can be used to anticipate need and provide opportunities for prevention and early intervention activities, including appropriate service and workforce development, thereby reducing long-term, adverse outcomes, especially for the vulnerable 0–19-year population.
- The Strengths and Difficulties Questionnaire (SDQ) scores can be used to predict the likelihood of social, emotional and/or behavioural problems in children and adolescents. The 2012-2016 NZ Health Survey data indicated that 8% of children (3-14 years) had overall SDQ scores indicating concern ("high" or "concerning" score results) (Ministry of Health, 2018). 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 latest NZ Health Survey results (MOH, 2020) reported the following prevalence of diagnoses for 2- to 14-year-olds (diagnosed):
    - *6% emotional and/or behavioural problems*
    - *3.9% anxiety disorder*
    - *2.4% attention-deficit hyperactivity disorder (ADHD)*
    - *2.2% autism spectrum disorder (includes Aspergers)*
    - *0.8% depression*.
- For 0- to 14-year-olds: 74.5% visited a GP in the past 12 months and 20.1% had experienced one or more types of unmet needs for primary health care (NZ Health Survey, MOH, 2020):
    - *17.7% were unable to get an appointment at usual medical centre within 24 hrs*
    - *2.4% lack of childcare*
    - *1.6% cost*
    - *1.6% lack of transport.*
- The latest Youth19 data report (Fleming et al., 2020) provides more recent information on the health and wellbeing of secondary students aged 12-18 years from 2012 to 2019. Data showed:
    - *Increase in the proportion of young people with depression symptoms, from 13% to 23%. They were high for those at low decile schools and living in high deprivation neighbourhoods (i.e., lower income communities). More females (29%) reported significant depression symptoms than did males (17%).*
    - *Increase in suicide attempts, particularly among males; 6% had attempted suicide in the past 12 months. This was also high for students at low decile schools (13%) compared to those at medium decile (6%) and high decile (3%) schools. Living in high deprivation neighbourhoods was also associated with higher rates of attempting suicide (11% compared to 6% in medium and 3% in low deprivation areas).*
    - *Almost one-fifth (19%) had difficulties getting help for feeling bad or having a hard time; this was slightly more common for those aged 15 and older. More females (24%) than males (14%) reported such difficulties.*
- Youth NEET (not in employment, education, or training) rates provide an indicator of youth disengagement and are 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, with 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 et al., 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 June 2020 youth (15-24 years) NEET rate was 12.5%; higher for females (13.8%) than males (11.3%). Regionally, youth NEET rates were highest in the Gisborne/Hawke's Bay area (15.2%), followed by Taranaki (13.6%), Manawatu/Whanganui (13.4%) and Northland (13.2%) (MBIE, 2020a). If high NEET rates persist or get worse, it 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.

- New Zealand ranked 35th out of 41 EU and OECD countries in child wellbeing outcomes and the 15- to 19-year age group has the second highest youth suicide rate in the developed world (14.9 deaths per 100,000, more than double the average of 6.5 deaths per 100,000 population), as reported in the latest *UNICEF Innocenti Report Card* (2020). UNICEF recommends decisive action be taken to reduce income inequality and poverty and ensure that all children have access to the resources they need, including rapidly addressing the serious gaps in mental health services for children and adolescents.

- In Aotearoa, suicide is the second leading cause of death for those aged 15 to 24 years; although a rare occurrence, it remains a serious issue. The youth (15-19 years) suicide rate of 18.7 per 100,000, continues to be higher than the general population rate of 13.01 per 100,000 population. Furthermore, youth suicide is a significant issue for males, with a rate of 22.4 per 100,000 population, which is significantly higher than that of females (15 per 100,000 population). The Ministry of Health recognises the need to urgently address this issue and has released a Suicide Action plan, *Every Life Matters* (MOH, 2019c). With the establishment of the Suicide Prevention office, as part of the action plan in reducing suicide in Aotearoa, the action plan, guided by research, includes leadership development, delivery of education programmes, provision of essential support services and the development of a capable workforce. It is hoped that this will result in a rapid change in suicide and self-harm rates.

- The COVID-19 lockdowns in 2020, based on survey results from more than 1400 children and young people aged 8 to 18 years, has had both positive and negatives outcomes for children (Children's Commissioner, 2020). Positive outcomes included strengthened family relationships and more control over their time, including more time to explore interests. On the other hand, 23% reported life was worse than their life before lockdown. Negative outcomes included missing friends, tough family dynamics and mental health challenges (boredom, lack of motivation, anxiety and depression). While these results provide some understanding of children and young people's experience during lockdowns, there was an over-representation of young people from high decile schools; therefore, these results may not reflect the experiences of those who are already living in difficult situations and facing existing inequities.

- Depression and anxiety appear to be consistent outcomes during and after lockdowns. Te Hiringa Hauora/Health Promotion Agency commissioned an online survey on people's experiences of the COVID-19 Level 4 lockdown (April 2020) and post-lockdown (June 2020). Data from over 1000 people showed experiences of depression and anxiety were common for young people, both during and post-lockdown (Nicholson & Flett, 2020). Almost 60% of young people had some experience of depression or anxiety post-lockdown (57%), with 10% being severe.

- Experiences of depression and anxiety were twice as common for people without enough money to meet their everyday needs than for those with enough money (Nicholson & Flett, 2020). There were 14% who reported not having enough money, this was higher for Pacific (22%). Post-lockdown, 10% reported loss of their main source of income; again, this was higher for Pacific and Asian people than for NZ Europeans. Almost three in 10 people reported a reduction in income; this was higher for Asian people than NZ Europeans. The economic stressors caused by COVID-19 are likely to be long-term and have an impact on the mental health needs of families and their children.

- COVID-19 will not only have a devastating effect on the already vulnerable, but a second cohort of newly at-risk people is anticipated, as a result of the economic downturn and expected ongoing rise in income inequality. Further outbreaks and/or rapid cycling up and down security levels can be expected to compound these challenges and increase psychological distress. School leavers especially are going to need support dealing with (un)employment challenges. Children who are not showing signs of distress now may instead be "incubating" poor mental wellbeing, only to have it spill over in later years via stress sensitisation processes (Poulton et al., 2020).

- Globally, movement restrictions, loss of income, isolation, overcrowding and high levels of stress and anxiety are increasing the likelihood that children experience and observe physical, psychological, and sexual abuse at home – particularly those children already living in violent or dysfunctional family situations (WHO, 2020). The reported rise in family harm during lockdowns, and the impact of this, particularly on children, cannot be ignored. Research from the University of Otago found that 9% of adult New Zealanders (18 years and older) had directly experienced some form of family harm during the 2020 lockdown, including sexual assault, physical assault, or harassment and threatening behaviour (Every-Palmer et al., 2020). These rates are between three and four times higher than the levels reported the year before, in the NZ Crime and Victims Survey 2018/9 (Ministry of Justice, 2018).

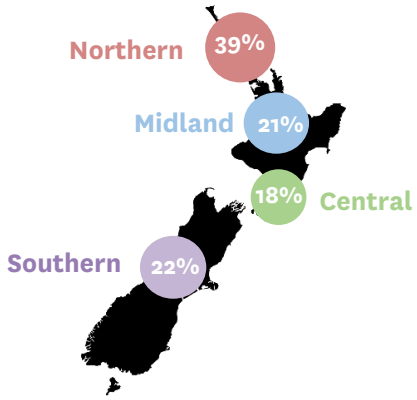
- The growing socioeconomic inequalities, existing high mental health needs, persistent low access to services for Pacific and Asian populations, with the additional impact of COVID-19, are likely to be extensive and enduring, with the mental health needs of infants, children and young people remaining high and even more complex. These factors strongly signal an urgent need for early intervention and prioritising suicide prevention to improve long-term mental health outcomes for all infants, children, and young people. Additionally, services should anticipate continued demand, and plan service and workforce development accordingly.

Infant, Child, and Adolescent (0-19 yrs.) Population (2020-2030)

Population trends can be used to gauge potential demand for services and to plan local services and workforce development activities.

The 2020 population and 10-year projections show:

- 26% of the population were 0-19 years old and are ethnically diverse: 48% Other Ethnicity, 26% Māori, 16% Asian, 10% Pacific.
- 10-year population projections (2020-2030; 2013 Census, Statistics NZ) show very little change in the overall 0–19-year population of +0.2%; however, it is projected to grow more ethnically diverse: +26% Asian, +8% Māori, +6% Pacific, -13% Other Ethnicity (Appendix A, Table 1).



Service User Access to ICAMH/AOD Services (0–19 Years)

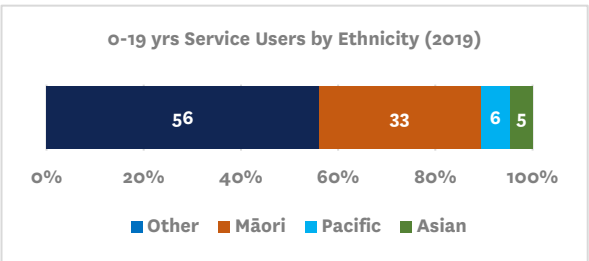
Service user data show the actual demand for services. The 0–19-year-old service user access to mental health services are extracted from PRIMHD and include *Service users by DHB of Domicile* (residence) for the full calendar year. Data from 125 NGOs were included in the 2017 service user access information and 120 NGOs were included in the 2019 service user data. PHO service user data are not captured in PRIMHD. Detailed service user data for the 2017 and 2019 period are presented in Appendix A, Tables 1-8.

2017 to 2019:

- **+4%** overall increase in the number of service users, largely for those aged 10–14 years by +8%.
- **+7%** increase in female service users largely aged 10–14 years by +14%.
- -1% decrease in male service users largely aged 0–9 years by -6%.
- +6% increase in access to NGOs, +3% increase in access to DHBs.
- Largest increase in the Southern region by +10%, followed by Midland (+7%), no change in Central, and a decrease in Northern by -0.3%.

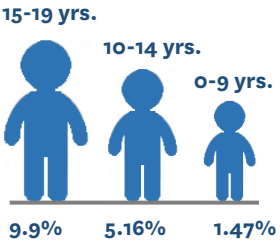
2019:

- 51% male, 49% female.
- 54% of service users were aged 15–19 years.
- 56% identified as Other Ethnicity, 33% Māori, 6% Pacific, 5% Asian.

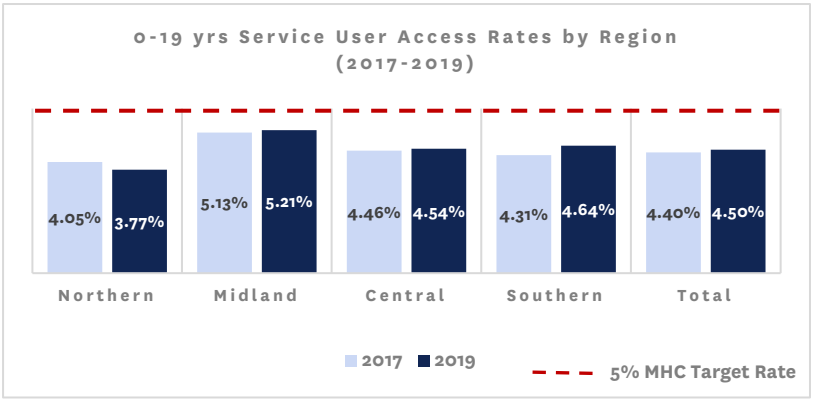


- 76% accessed DHB services[2]: Largest referral sources 33% GP, 11% Self/Relative, 9% Education Sector.
- 24% accessed NGOs: Largest referral sources 20% Education Sector, 18% GP, 14% Self/Relative, 12% CAMHS.

0-19 yrs. Service User Access Rates by Age Group (2019)



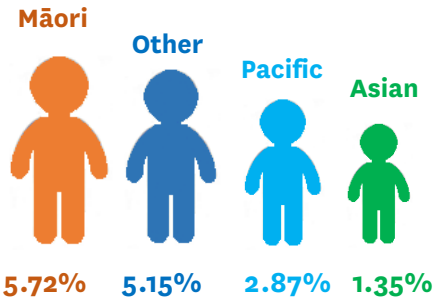
Service user access rates are benchmarked against the Mental Health Commission (MHC) target rates (MHC, 1998) to highlight progress and identify areas for improvement. The MHC target rate was that 3% of those aged 0–19 years should be able to access services. This rate was set for the 1998 to 2001 period and would move to a 5% rate by 2005. Different access rates to reflect different prevalence rates in mental illness for different age groups were also set: 1% for 0-9 years, 3.9% for 10-14 years and 5.5% for 15–19 years. Target rates by age group beyond 2005 are not available. Therefore, access rates by age group are only reported without benchmarking against target rates.



2017-2019:

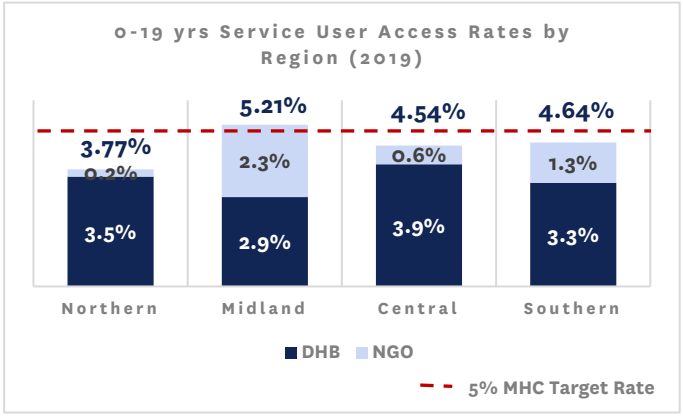
- Improvements in access rate were seen in the overall rate from 4.4% to 4.5%, but remain below the 5% target rate.
- Improvements were seen only in the 10–14-year age group (from 5.13% to 5.15%) and 15-19 years (from 9.49% to 9.90%). There was a decrease in the 0-9 year age group from 1.51% to 1.47%.
- Improvements were seen in three out of the four regions: Midland, Southern and Central. A decrease was seen in Northern.

Service User Access Rates by Ethnicity (2019)



2019:

- Māori had the highest access rate of 5.72% out of the four ethnic groups; with 5.15% Other Ethnicity, 2.87% Pacific and Asian had the lowest, 1.35%.
- Midland had the highest access rate, 5.21%, exceeding the 5% target rate; Northern had the lowest at 3.77%.



[2] Service users mostly access DHB services in most regions, except in Midland where they access both DHB (55%) and NGO (45%) services almost equally.

Complexity of Service User Needs

Via the Whāraurau workforce survey, services reported an increase in the complexity of service user needs and are working with complex relationships between social and economic factors:

- complex family dynamics
- anxiety and mood disorders
- AOD/substance use
- poverty, homelessness
- increasing suicide ideation and attempts, and self-harm
- trauma, historical and intergenerational
- co-morbidities, and multiple diagnoses
- eating disorders
- developmental disorders.

Service user needs reported by services in the Whāraurau workforce survey, 2020

Funding of ICAMH/AOD Services

2018 to 2020:

- +16% increase in total funding of ICAMH/AOD services compared to a 5% increase for the 2018-2020 period.
- +22% increase in funding for non-DHB services, +13% increase for DHB services (Appendix C, Table 1).
- Largest increase for Youth Forensic services by +40%, followed by +21% AOD Services.

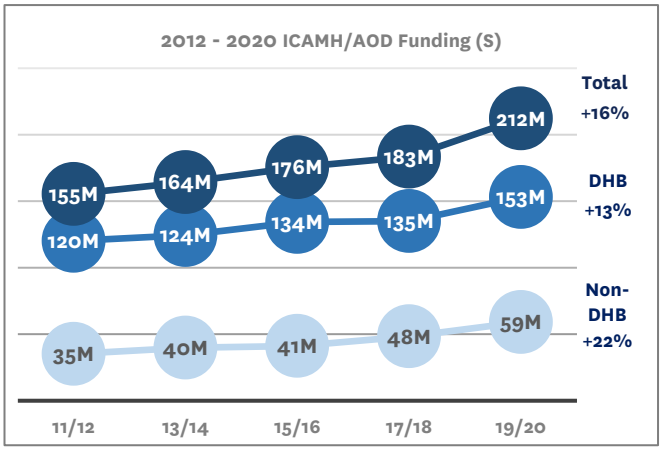


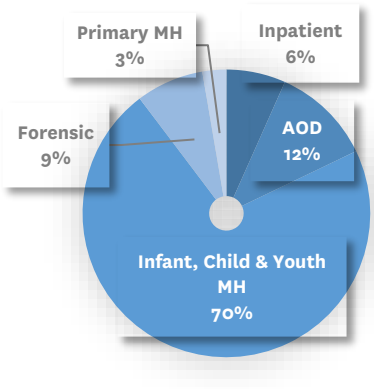
Table 1. ICAMH/AOD Funding by Service (2015/16–2019/20)

SERVICES	ICAMH/AOD FUNDING BY SERVICE (2015/2016-2019/2020)			
	15/16	17/18	19/20	% Change (18-20)
Inpatient	$14,192,776	$12,232,919	$13,559,509	+11
AOD	$23,386,143	$20,670,687	$25,023,668	+21
IC&Y Mental Health[1]	$126,000,120	$131,640,480	$148,759,025	+13
Youth Forensic	$10,066,585	$13,955,365	$19,474,664	+40
Youth Primary Mental Health	$1,900,000	$4,935,029	$5,458,979	+11
Total	$175,545,624	$183,434,480	$212,275,844	+16

1. Includes residential services.
2. Source: DHB Price Volume Schedules (PVS) 2019/20, CMS & CCPS (as at 20/10/20).

June 2019 to July 2020:

- 13% of total MH funding ($1,693.8M) allocated to ICAMH/AOD services, compared to 26% *Blueprint* recommendation (Mental Health Commission, 1998, p. 29) which was estimated based on the number of infants, children and adolescents likely to have a mental illness and require treatment.[3]
- 72% of the funding allocated to DHB provider services, 28% to non-DHB (including PHOs) provider services (Appendix C, Table 1).

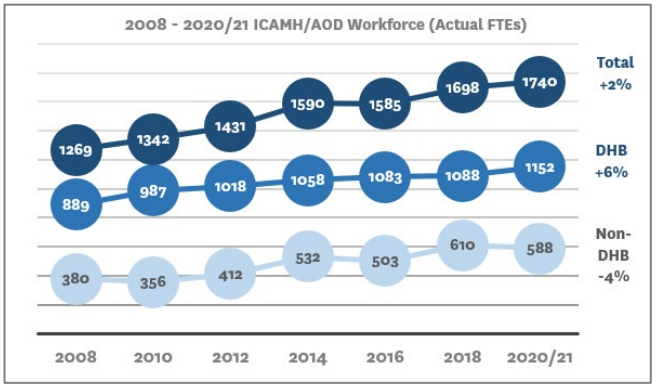


- Funding per 0-19 years

population from 2018 to 2020 increased by +14%, from $147 to $167 (including inpatient funding). Increase was seen in all four regions; however, Northern remains the lowest (Appendix C, Table 2).

[3] The relative cost of treatment for infants, children and adolescents compared to adults using current models of care and 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) remains unknown.

Infant, Child and Adolescent Mental Health/Alcohol and Other Drugs Workforce



Workforce information presented in this section includes actual and 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 103/122 non-DHB service providers (112 NGOs & 10 PHOs) from June 2018-2020 and to August 2021. The 2018 non-DHB workforce data that were consistent with the 2020 contractual information were used to estimate the workforce for those services who were not able to participate. Due to delays caused by COVID-19 lockdowns in 2020, workforce data from June 2020 to August 2021 are included. See detailed DHB and non-DHB workforce data in Appendix D, Tables 1-19.

2018 to 2020/2021:

- +2% overall increase in the ICAMH/AOD workforce (Table 2).
- +6% increase in the DHB workforce (Community, Inpatient, National Youth Forensic Service).
- -4% decrease in the non-DHB workforce.
- +4 increase in the clinical workforce, and a -3% decrease in the non-clinical workforce.
- -12% overall decrease in reported vacant FTEs, largely in DHB Community services by -26%.
- -1% percentage point decrease in the overall annual turnover rate (from 20% to 19%).

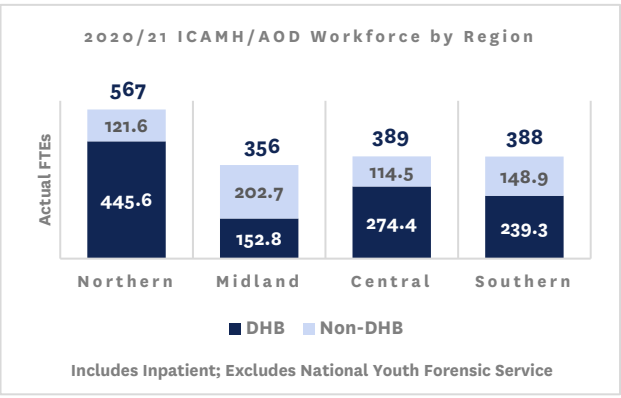
Table 2. ICAMH/AOD Workforce by Service Provider (2008-2020/21)

Provider Service	Actual FTEs							Vacant FTEs						
	08	10	12	14	16	18	20/21	08	10	12	14	16	18	20/21
DHB Inpatient	153.4	163.9	140.8	144	147.9	154.4	149.6	14.9	9	15.6	21.9	16.2	17.9	17.2
DHB Community	735.5	822.9	877.5	913.9	934.6	889.4	962.5	80.5	100.5	74.3	108.2	120	128.6	96.1
National Youth Forensic Service	-	-	-	-	-	44.3	40.1	-	-	-	-	-	-	5.0
Non-DHB*	379.9	355.5	412.2	532.4	502.9	609.9	587.7	16.3	12	3.8	12.6	10.3	21.3	29.6
Total	1,269	1,342	1,431	1,590	1,585	1,698	1,740	111.7	121.5	93.8	141.7	146.5	167.9	147.9

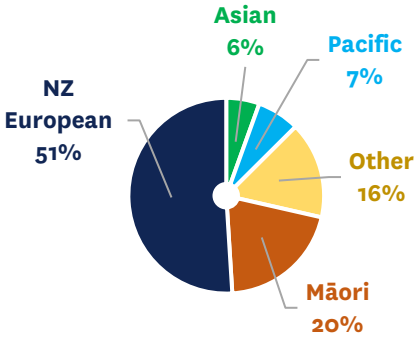
*Includes Primary Health Organisations

2020/21:

- 66% of the workforce were employed in DHB services, 34% in non-DHB services nationally. A similar distribution of the workforce was seen in three out of the four regions; however, the Midland region had more than half (57%) of the workforce employed in non-DHB services.
- 33% of the workforce were based in the Northern region, followed by 23% in both Central and Southern regions and the smallest group in Midland (21%).

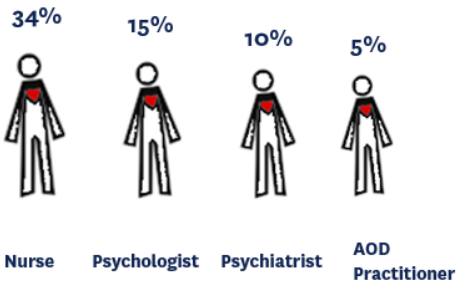


- 51% were NZ European/Pākehā, 20% Māori, 16% Other Ethnicity, 7% Pacific and 6% Asian.
- 73% in clinical roles, largely 21% Nurses, 14% Social Workers, 11% Psychologists, 7% AOD Practitioners, 6% Occupational Therapists (Table 3).
- 17% in non-clinical roles, largely 9% Mental Health Support Workers, 4% Youth Workers, 1% Cultural Roles, 1% Peer Support (Table 3).
- 5% in Administration and 4% in Management roles (Table 3).
- 8% overall vacancy rate (rates ranged from 0% to 32%).
- 85% vacancies were for clinical roles, largely 34% Nurses, 15% Psychologists, 10% Psychiatrists, 5% AOD Practitioners, and 4% Social Workers (Table 4).
- 19% overall turnover rate (higher than the Q4 2019 national average rate of 10.7% for healthcare; MBIE, 2020a, Quarterly Labour Market Report, p. 10); 28% turnover rate in non-DHB services, 14% in DHBs.
- Turnover by occupation was largely for 19% Mental Health Support Workers, 17% Nurses, 14% Social Workers, and 13% Psychologists. Reasons for leaving included external job opportunities due to better salaries, relocation to another city/town, internal job opportunities within the same organisation and pursuing further education/career development opportunities.



Total ICAMH/AOD: Top 4 Occupations (2020/21)

Total ICAMH/AOD: Top 4 Vacancies (2020/21)



DHB ICAMH/AOD Workforce

Twenty DHBs provide a range of specialist inpatient and community based ICAMH/AOD services. The upper age limit (19 years) is variable throughout the country, with each DHB determining their own service provision criteria. Services also include regional AOD, eating disorders, and forensic services.

DHB Inpatient

Regional inpatient child and adolescent mental health services are provided by three DHBs: Auckland, Capital & Coast (Wellington) and Canterbury (Christchurch). In some areas, acute inpatient admissions and brief admissions are made to local paediatric or adult units while arrangements are made for admission to the three regional inpatient child and adolescent facilities.

2018 to 2020/21:

- -3% decrease in the inpatient workforce (Table 2).
- -4% decrease in reported vacant FTEs.

2020/21:

- 87% of the inpatient workforce were in clinical roles, largely 49% Nurses (includes Mental Health Nurses, Registered Nurses & Clinical Nurse Specialists), 10% Psychologists, and 6% Psychiatrists (Table 3).
- 8% in non-clinical roles (excluding admin and management), largely 7% Mental Health Support Workers and 1% Cultural Workers (Table 3).
- 10% vacancy rate for inpatient services. Most vacancies were for clinical roles (78%): 62% for Nurses, 12% Psychiatrists and 5% Psychologists (Table 4).
- Vacancies in the non-clinical inpatient workforce were largely 10% Cultural and 6% Mental Health Support roles (Table 4).
- 9% turnover rate. Largely for clinical roles: 53% Nurses, 13% Social Workers, 13% Mental Health Assistants. Reasons for leaving included: Not happy in the role, internal job opportunities (another team/service in same organisation), moved to another city/town, retired, external job opportunities.

National Secure Youth Forensic Service

The Nga Taiohi National Secure Youth Forensic Inpatient Mental Health Service, located in Kenepuru Community Hospital (Porirua) provides specialist inpatient services for young people aged 13 to 17 who are severely affected by mental health and/or AOD issues, who have offended or are alleged to have offended, and are involved in the youth justice system.

2018 to 2020:

- -10% decrease in the national inpatient youth forensic workforce (Table 2).

2020:

- 42% in clinical roles, largely 35% Nurses (includes Mental Health Nurses, Registered Nurses & Clinical Nurse Specialists), 2% Psychologists, Psychiatrists and Occupational Therapists (Table 3).
- 47% in non-clinical roles (excluding admin and management), largely 40% Mental Health Support Workers and 7% Cultural Workers (Table 3).
- 11% vacancy rate: 60% vacancies in clinical roles, largely 20% Nurses, AOD Practitioners and Psychologists; 40% non-clinical vacancies all for Cultural workers (Table 4).

DHB Community

2018 to 2020/21:

- +8% increase in the total community workforce (Table 2).
- -26% decrease in reported vacant FTEs.

2020/21:

- 84% in clinical roles largely 23% Nurses, 18% Social Workers, 16% Psychologists, 9% Occupational Therapists, and 7% Psychiatrists (Table 3).
- 5% in non-clinical roles (excluding admin and management) largely 2% in Cultural roles, and 1% Mental Health Support Workers (Table 3).
- 9% vacancy rate: 93% of vacancies were for clinical roles, largely 38% Nurses, 21% Psychologists, and 13% Psychiatrists (Table 4).

- 15% turnover rate: Largely 29% Nurses, 25% Psychologists and 18% Social Workers. Reasons for leaving included: External job opportunities, relocation to another city, internal job opportunities within same organisation.

Table 3. ICAMH/AOD Workforce by Occupation (2020/21)

ICAMH/AOD Workforce by Occupation (Actual FTES, 2020/21)	DHB			DHB Total	Non-DHB[3]	Total
	Inpatient	Community	National Youth Forensic Service			
Alcohol & Drug Practitioner	-	29.0	-	29.0	90.2	119.2
Child & Adolescent Psychiatrist	9.08	67.7	1.0	77.78	5.6	83.38
Clinical Placement/Intern	-	17.6	-	17.6	1.30	18.9
Co-Existing Problems Clinician	-	7.0	-	7.0	7.0	14.0
Counsellor	-	7.0	-	7.0	30.05	37.05
Family Therapist	-	2.3	-	2.3	5.5	7.8
Nurse	73.18	217.41	14.0	304.59	52.28	356.87
Occupational Therapist	6.2	82.4	1.0	89.6	13.08	102.68
Psychotherapist	1.6	9.8	-	11.4	2.3	13.7
Psychologist	15.1	154.7	1.0	170.8	18.4	189.2
Registrar/Senior Medical Officer	6.35	21.37	-	27.72	0.5	28.22
Social Worker	7.2	177.76	-	184.96	57.74	242.7
Other Clinical[1]	11.25	16.73	-	27.98	36.43	64.41
Clinical Sub-Total	129.96	810.77	17.0	957.73	320.37	1,278.1
Cultural	1.6	16.65	2.75	21.0	3.51	24.51
Mental Health Consumer Advisor	-	1.6	-	1.60	2.1	3.7
Mental Health Support Worker	10.0	14.0	16.0	40.0	114.61	154.61
Peer Support	-	2.35	-	2.35	13.4	15.75
Whānau ora Practitioner	-	-	-	-	5.0	5.0
Youth Worker	-	4.9	-	4.90	59.7	64.6
Other Non-Clinical[2]	-	5.3	-	5.30	27.58	32.88
Non-Clinical Sub-Total	11.6	44.8	18.75	75.15	225.90	301.05
Administrator	5.0	64.93	1.0	70.93	11.78	82.71
Manager	3.0	42.0	3.3	48.0	29.66	77.96
TOTAL	149.56	962.50	40.05	1,152.11	587.71	1,739.82

1. Other Clinical = Clinical Team Coordinator; MOSS; Referral Coordinator; Paediatrician; Clinical Supervisor; Eating Disorder Liaison; Clinical Team Leader; Health Care Assistants; Clinical Pacific Consultant; Clinical Case Manager; Māori Clinical Worker; Generic ICAMH Practitioners; Educator; Withdrawal Management Practitioner; Clinical Community Workers; Needs Assessors & Service Coordinators.
2. Other Non-Clinical = Researcher; Educator; Needs Assessor; Case Manager; Programme Facilitator.
3. Includes PHOs.

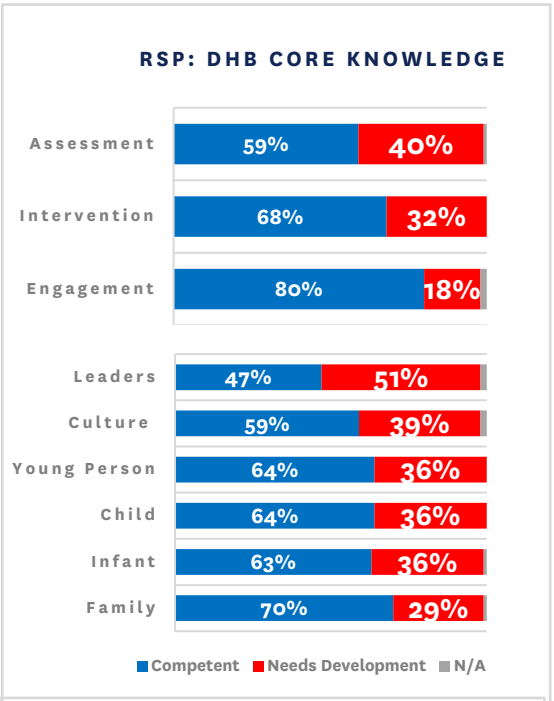
Table 4. ICAMH/AOD Workforce Vacancies by Occupation (2020/21)

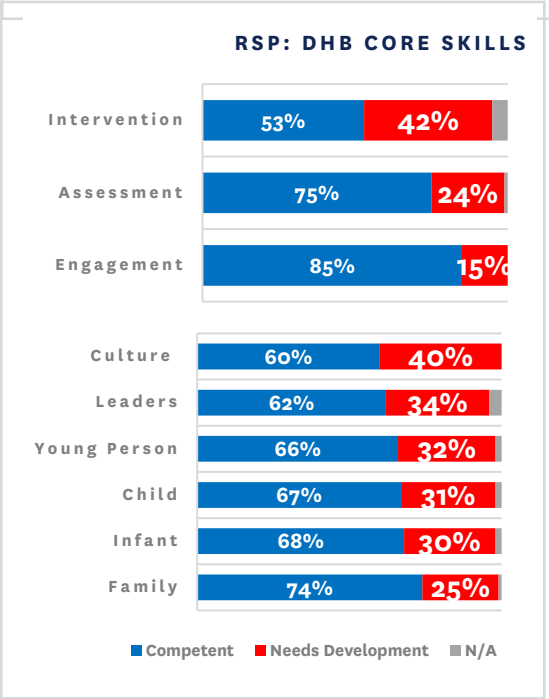
ICAMH/AOD Vacancies by Occupation (Vacant FTES, 2020/21)	DHB			DHB Total	Non-DHB[2]	Total
	Inpatient	Community	National Youth Forensic Service			
Alcohol & Drug Practitioner	-	3.0	1.0	4.0	4.0	8.0
Child & Adolescent Psychiatrist	-	2.0	-	2.0	-	2.0
Clinical Intern/Placement	2.0	12.6	-	14.6	-	14.6
Co-Existing Problems Clinician	-	0.8	-	0.8	-	0.8
Counsellor	-	-	-	-	1.0	1.0
Family Therapist	-	1.8	-	1.8	-	1.8
Nurse	10.62	36.8	1.0	48.42	1.4	49.82
Occupational Therapist	-	4.05	-	4.05	-	4.05
Psychotherapist	-	0.2	-	0.2	-	0.2
Psychologist	0.8	20.45	1.0	22.25	0.6	22.85
Registrar/Senior Medical Officer	-	2.4	-	2.4	-	2.4
Social Worker	-	4.4	-	4.4	2.0	6.4
Other Clinical[1]	-	1.2	-	1.2	10.87	12.07
Clinical Sub-Total	13.42	89.7	3.0	106.12	19.87	125.99
Cultural	1.8	1.33	2.0	5.13	1.40	6.53
Mental Health Consumer	-	-	-	-	0.1	0.1
Mental Health Support	1.0	-	-	1.0	5.0	6.0
Peer Support Worker	-	1.35	-	1.35	0.2	1.55
Youth Worker	-	-	-	-	1.0	1.0
Other Non-Clinical	-	1.0	-	1.0	-	1.0
Non-Clinical Sub-Total	2.8	3.68	2.0	8.48	7.7	16.18
Administrator	-	1.3	-	1.3		1.3
Manager	1.0	1.4	-	2.4	2.0	4.4
TOTAL	17.22	96.08	5.0	118.3	29.57	147.87

1. Other Clinical = Mātanga Whai Ora; Mental Health Clinicians.
2. Includes PHOs.

Capability of the DHB ICAMH/AOD Workforce

Workforce capability is assessed using the *Real Skills Plus ICAMH/AOD competency framework,* developed by The Werry Centre in 2009 (The Werry Centre, 2009b), and recently revised in 2019. It describes the knowledge, skills and attitudes needed to work with infants, children, young people and whānau with a suspected or identified mental health/AOD concern. The *Real Skills Plus ICAMH/AOD online assessment tool* (available on the Whāraurau website) has been designed to identify practitioner competencies against those outlined in the framework, and to highlight areas for development. Data from *Real Skills Plus* (RSP) can be reported at individual, team, service, and organisational levels, nationally and regionally. The organisational level data are most effective as they help to develop a shared understanding of the knowledge and skills required by the whole service. RSP promotes the development of best practice across disciplines, with an aim to create a multi-skilled workforce at each level, and allows for targeted service development, recruitment, and service delivery activities.





- *Real Skills Plus* has three levels:
  - Primary Level*: For practitioners in primary sector who work with infants, children, and young people.*
  - Core Level*: For practitioners 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.*
- For the 2020 period, 18/20 DHBs (56 individual teams) completed the RSP assessment tool for core level competencies. National organisational summary data showed the DHB competency levels ranged from 53% to 85% in the knowledge and skills required, and further development was indicated for the following areas:
  - *Knowledge: Assessment (40%)* and *Intervention (32%) knowledge* were assessed as *needing development. Specific knowledge development* was required for *Leadership (51%)* and *Cultural (39%) knowledge.*
  - *Skills:* Core skills in *Intervention (42%)* and *Assessment (24%) needed development. Specific skill development* was required for *Cultural (39%)* and *Leadership (34%) skills.*

DHB ICAMH/AOD Workforce Development Needs

DHB ICAMH/AOD provider services continue to experience challenges and barriers that constrain critical service and workforce development. Services identified the following workforce development needs:

- Recruitment of staff with ICAMH training and experience.

"CAMHS RECRUITMENT: WE HAVE A JUNIOR WORKFORCE WHO HAVE MINIMAL CAMHS BACKGROUND, INABILITY TO RELEASE STAFF FOR LONGER PERIODS OF TRAINING (DUE TO WORKFORCE SHORTAGES). RELIANT ON OVERSEAS SMOS AND NURSING STAFF (WHICH TAKE TIME TO ARRIVE)." *(Workforce survey DHB participant)*

- Training in therapeutic interventions (specifically, Family Based Therapy for Eating Disorders, Family Therapy, Acceptance & Commitment Therapy, Dialectical Behaviour Therapy, Cognitive Behaviour Therapy).

"WE EMPLOYEE CLINICIANS WITHOUT EXPERIENCE WORKING WITH YOUNG PEOPLE. EVEN IF THEY HAVE SIGNIFICANT EXPERIENCE WITH ADULT MH AND ADDICTIONS, THEY STRUGGLE TO ADJUST IN THIS FIELD AS MUCH MORE THERAPUTIC WORK IS REQUIRED AS OPPOSED TO WORKING WITH THE CHRONIC ADULT CLIENT (THERAPEUTIC SKILLS LIKE FBT, CBT, DBT)." *(Workforce survey DHB participant)*

Workforce development needs reported by services in the Whāraurau workforce survey, 2020

Non-DHB ICAMH/AOD Workforce

ICAMH/AOD services are also provided by DHB-funded, non-DHB services which include NGOs, iwi services, and primary health organisations (PHOs). The provision of youth primary mental health services are largely based on local needs and opportunities and include enhanced school-based health services; GPs and Youth Nurses delivering 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); establishment of 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.

For the June 2019 to July 2020 period, 122 non-DHB service providers (112 NGOs & 10 PHOs) were funded to deliver ICAMH/AOD and youth primary mental health services. Workforce data were provided by 103 out of 122 services, and the 2018 data were used to estimate the workforce of the remainder of services who could not participate. Therefore, the non-DHB workforce data may not be representative of the current workforce and must be interpreted with caution.

2018 to 2020/21:

- -4% decrease in the non-DHB workforce (Table 2).
- Decrease in both clinical (-3%) and non-clinical (-2%) workforces.

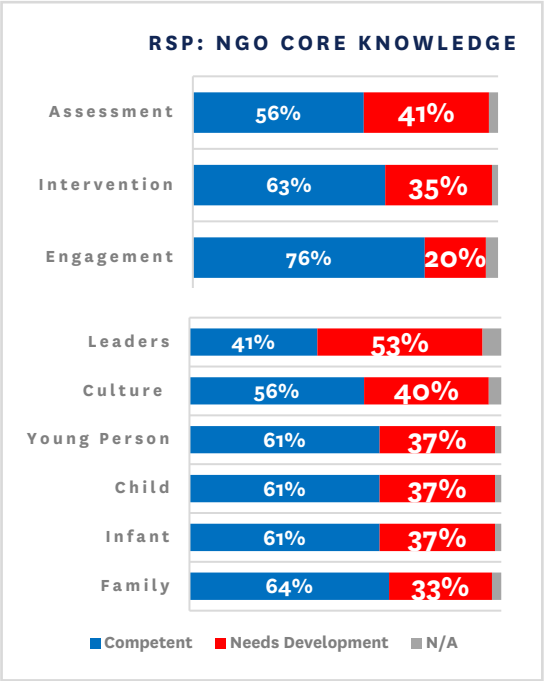
2020/21:

- Largest non-DHB workforce located in the Midland region (34%), followed by 25% Southern, 21% Northern and smallest in 19% Central (Table 2).
- 55% in clinical roles: Largely 15% AOD Practitioners, 10% Social Workers, 9% Nurses, and 5% Counsellors (Table 3).
- 38% in non-clinical roles (excluding admin and management), largely 20% Mental Health Support Workers, 10% Youth Workers, and 2% Peer Support (Table 3).
- 5% vacancy rate: 67% vacancies in clinical roles, largely 14% AOD Practitioners, 7% Social Workers, and 5% Nurses (Table 4).
- 26% vacancies for non-clinical roles, largely 17% Mental Health Support and 5% Cultural workers (Table 4).
- 28% turnover rate largely for 37% Mental Health Support Workers, 10% AOD Practitioners, 9% Social Workers. Reasons for leaving included external job opportunities for better salaries, pursuing further education and career development opportunities and relocated to another city/town.

Capability of the non-DHB ICAMH/AOD Workforce

For the 2020 period, 29 non-DHB services completed the *Real Skills Plus ICAMH/AOD* online tool. National organisational summary data showed the non-DHB competency levels ranged from 50% to 81% of skills and knowledge required, and further development was indicated for the following areas:

- *Knowledge:* Development needed for *Assessment (41%)* and *Intervention (35%) knowledge. Specific knowledge development* was required for *Leadership (53%)* and *Cultural (40%) knowledge.*
- *Skills:* Core skills development was needed for *Intervention (41%)* and *Assessment (28%) skills. Specific skill development* required for *Cultural (39%), Leadership (38%) skills* and for both *child* and *young person (34%).*



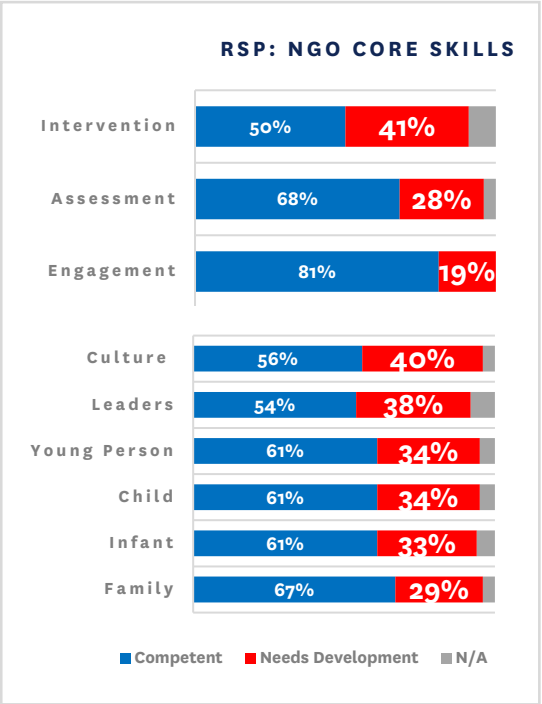
Non-DHB Workforce Development Needs

Non-DHB services identified similar workforce development needs to the DHB workforce, but reported a greater need for training, specifically for training in therapeutic and interventions (specifically for self-harm and suicidal ideation, AOD, complex needs, cultural/bicultural).

"WE ARE SEEING THE AGE RANGE WE WORK WITH TRENDING DOWN. WE NEED TO UPSKILL WORKING WTH 6-12 AGE RANGE. RISK PLANNING. MOTIVATIONAL INTERVIEWING. NEURODIVERSITY. TRAUMA INFORMED. MODELS LIKE CIRCLE OF SECURITY, FAMILY &/OR PARTNER VIOLENCE." *(Workforce survey non-DHB participant)*

Non-DHB services also identified difficulties in recruitment and retention of qualified staff.

"WE ARE STRUGGLING TO ATTRACT EXPERIENCED STAFF. WE HAVE THREE VACANCIES CURRENTLY AND NO SUITABLE APPLICANTS. FIVE EXPERIENCED STAFF HAVE LEFT SINCE OCTOBER CITING HUGE WAITLISTS AS A CONTRIBUTING FACTOR. INEQUALITIES IN FUNDING HAVE LED TO MANY STAFF MOVING TO DHB WORK, ORANGA TAMARKI OR ACC FUNDED. NGO ARE POOR COUSINS." *(Workforce survey non-DHB participant)*



Summary

Overall population projections indicate a declining infant, child and adolescent population; however, it is a population that is becoming more ethnically diverse, as indicated by projections for Māori, Pacific and especially for the Asian population. The impact of COVID-19 on economic factors and mental health adds to the already existing mental health needs of children and young people in Aotearoa. The needs will continue to remain high and increasingly complex, and services should anticipate continued intense demand for services.

Increasing demand for services can be seen in the 4% increase in the number of service users from the 2017 to 2019 period, with a noticeable increase in the numbers of female service users by 7%. Demand has not only grown in number, but in complexity. The impact of COVID-19 on service demand is currently unknown due to the unavailability of the data at the time of reporting. Services have anecdotally indicated that they are experiencing a surge in service user numbers with increasing waitlists as a consequence of COVID-19 lockdowns. Additionally, at a youth *Deep and Meaningful Conversation (DMC)* event (Whāraurau, 2021), young people reported that lockdowns have meant that they have had fewer opportunities for in-person, face-to-face therapy sessions, which they stated were part of the genuine connection that they needed for effective service provision. The overall 2019 access rate was at 4.5%, which remains below MHC's recommended rate of 5% (Mental Health Commission, 1998). Regionally, the Northern region has NZ's largest and most ethnically diverse population yet continues to have the lowest access rates in the country; therefore, it remains a critical region of focus for improving access to services.

With an increased government investment into mental health, funding data showed a 16% increase in the total ICAMH/AOD funding from the 2018 to 2020 period. While this is the largest increase in funding seen since the commencement of the *Stocktake*, it continues to make up only 13% of the total mental health spend, half of the MHC recommendation of 26%. Inadequate funding allocation to child and youth mental health may explain the little progress seen in the development and provision of services for Māori, Pacific and Asian populations, indicating limited choice and perhaps contributing to low access numbers, especially for Pacific and Asian service users. The resulting lack of choice could also explain why Māori, Pacific and Asian service users continue to largely access mainstream DHB services.

Increased allocation of the budget for mental health could allow a rapid response in the provision of much needed mental health services. As part of the *Child and Youth Wellbeing* programme of action, more mental health and addiction services were to be available to over 60,000 young New Zealanders across four regions: Rotorua and Taupō, Wairarapa, South Canterbury, Dunedin, and Southland, from October 2020. This is the start of a $16 million programme that will fund more services to be available in more areas across NZ and will be delivered in youth-friendly locations, including sports clubs, community events and schools. It is hoped that such an investment into the provision of mental health services for youth will lead to more equitable access to services.

Furthermore, $28 million has been invested in an in-school mental health and wellbeing programme, *Mana Ake,* or *Stronger for Tomorrow*. It is an early intervention programme aimed at addressing mild to moderate mental health needs and having had success in Canterbury for children affected by the earthquakes, it will be expanded and rolled out to the West Coast, Bay of Plenty, Rotorua, Taupō, South Auckland and Northland. It is heartening to see such investment in funding and provision of more mental health services for children and young people. We hope to see its full impact on improving access to services and outcomes in years to come.

A growing demand for services (in number and complexity) requires a workforce that is not only the right size but also capable of handling such demand. The latest workforce data show a 2% increase in the size of the ICAMH/AOD workforce compared to a 4% increase in service user numbers pre-COVID-19. While services reported a decrease in vacant FTEs, vital clinical positions (Psychiatrists, Psychologists, Nurses) have remained difficult to fill, with positions remaining vacant for more than 3 months. Turnover rates have remained similar to the 2018 rates for the same clinical roles. Difficulties in recruiting qualified staff and retaining the existing workforce remain persistent workforce challenges. These figures indicate a workforce that is not keeping up with "normal/usual" demand and the disparity between demand and capacity is anticipated to increase due to the psychological, social, economic and community impacts of COVID-19 on children and young people in the foreseeable future.

The increasing complexity of service user needs (co-morbidities/multiple diagnoses exacerbated by socioeconomic factors such as housing and poverty affected by COVID-19) requires a workforce that not only has the right knowledge and skills but that is also connected to the right services (such as Kāinga Ora, education, health, police, Oranga Tamariki, PHOs)—

and working effectively with them—for a collaborative and holistic approach to meeting service user 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 therefore seen by the mainstream workforce. Current assessment of competencies (from the *Real Skills Plus ICAMH/AOD online tool)* showed that, while the workforce has the adequate levels of the core skills required, further development is needed in overall assessment and intervention knowledge and skills, and specific cultural and leadership competencies. Therefore, investing (resources and training) in the development of a workforce that is adequately skilled clinically and culturally will lead to better mental health outcomes for all children, young people, and their families.

Recommendations

The following recommendations are based on current findings and advocate a youth-informed framework to guide service delivery, service, and workforce development activities. *Youth-Informed Transformation* (Werry Workforce Whāraurau, 2019) shares the aspirations of young people with lived experience of mental health and addiction challenges that were expressed in the *Deep and Meaningful Conversations*: *Lived experience workshops designed by youth, for youth*. Participants advocated for holistic approaches to care that incorporate whānau, nature, identity, giving back and a focus on wairua. The *Youth-Informed Transformation* also proposes a model of service delivery, titled "*Ecosystems of Care"*, that advocates for cross-service collaboration that ensures young people receive the care that is right for them, regardless of the service they initially access. Finally, it provides guidance on how to create "safe spaces" for young people, with suggestions on everything from décor to recruitment. Services genuinely need to be accountable to the population they serve and have a robust feedback mechanism that includes young people and their whānau in their governance structures.

Continue to monitor and allocate appropriate levels of funding

- Lack of funding to support service and workforce development has been consistently identified as a major barrier by all services in previous reports. Recent budget allocations have seen a much-needed boost in funding for mental health services. The need to continue to prioritise and allocate appropriate levels of funding is an important first step in building essential infrastructure (organisational structures, technology, models of care) to advance further service expansion and development (planning and re-design, better and more stable contracting arrangements for smaller organisations) and to make progress on various workforce development initiatives (recruitment, retention, role development and expansion; professional development supervision and training). DHBs, in collaboration with their local key stakeholders (i.e., service users, schools, tertiary education providers, Youth One Stop Shops, PHOs, NGOs), should engage in strategic planning to identify challenges and opportunities; actively monitor potential and local service demands; develop new models of care for their populations; and increase their efforts on workforce development activities.

Enable collaboration

- The increasing complexity of service user needs (co-morbidities/multiple diagnoses exacerbated by socioeconomic factors such as housing and poverty affected by COVID-19) requires a workforce that is connected and working effectively with the right services (such as Kāinga Ora, education, health, police, Oranga Tamariki, PHOs) for a collaborative and holistic approach to meeting service user needs. However, while the need to work more collaboratively is accepted by services, barriers and challenges in doing so continue to impede collaboration and need to be identified and addressed.

Develop and provide early intervention programmes, services, and workforce

- *Blueprint* target access rates give priority to access for adolescents. However, although service users aged 0 to 4 years currently make up a very small proportion (2%) of the total 0-19 years population accessing services, the importance of intervening early in this age group is recognised and should be prioritised. Evidence shows 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 (Lambie, 2018, p. 15).

- *Provide parenting programmes:* Evidence-based parenting programmes should be widely available such as *Incredible Years* and *Triple P – Positive Parenting Programme* (now also available to parents online). Both have been shown to be effective, evidence-based parenting programmes for preventing and reducing children's emotional and behavioural problems, including for Māori and non-Māori. *Triple P Primary Care* 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. Providing evidence-based parenting programmes that work across cultures, socioeconomic groups and in different kinds of family structures is critical for intervening early and improving long-term outcomes for children.

- *Provide and develop school-based health education and services:* School settings provide an opportunity to reach many young people, especially those who are at risk of experiencing poor outcomes. School-based mental health promotion and education, as well as cultural training, could be an important part of the curriculum for youth. Through such programmes, we may be able to reconnect young people with their whakapapa and develop a more universal cultural competency among the next generation. This will be immensely helpful for young people to be able to draw on their own and different cultural views on mental health/wellbeing. Schools can play a crucial role in supporting young people and their wellbeing and enabling interventions targeted at an earlier stage. Youth12 findings on health services in secondary schools showed positive associations between aspects of health services in schools 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). There is also mounting evidence on the effectiveness of delivering both universal and targeted school-based learning and mental health interventions that improve outcomes for the short and long term (Clarke et al., 2021). Guidelines for youth healthcare in secondary schools have been developed to assist planning, funding, or providing primary health services in secondary schools; these can be used as a tool to continuously improve the quality of these services (Ministry of Health, 2014). Schools are also going to be important for identifying early intervention opportunities as part of the COVID-19 recovery response. Not only should they be able to recognise early signs of mental distress, but staff would also need to facilitate their students' prompt access to support (Poulton et al., 2020).

- *Continue to 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 essential to improving health and mental health equity. Furthermore, providing more services, of high quality, that are specific to Māori, Pacific, and Asian young people, as well to young people of all sexualities, gender identities and other communities, is not only essential for greater choice, but also what young people want (ActionStation, 2018).

- *Use of digital tools and resources:* Young people in Aotearoa have high rates of internet access and use (Gibson et al., 2013; Statistics New Zealand, 2004b) and now perhaps more so due to the COVID-19 lockdowns (although a persistent "digital divide" has also become more apparent amongst high-deprivation communities (Gurney et al., 2021; Ioane et al., 2021a; Litchfield et al., 2021). The reliance on and use of technology has been fast-tracked during the pandemic, with the development of many everyday activities onto web-based applications. This provides an opportunity for the development of local and international evidence-based, validated mental health apps, online self-help guides and e-therapy tools. While there are concerns and negative links between the use of smartphones, social media, and youth mental health (Abi-Jaoude et al., 2020), a balanced approach needs to be taken. There are many positive aspects of the use of online platforms providing important benefits such as

EXAMPLE:

SPARX is a NZ-developed, online computerised cognitive behavioural therapy program that has been shown to be an effective resource for adolescents with depression at primary healthcare sites, showing clinically significant reductions in depression, anxiety, and hopelessness and an improvement in quality of life (Merry et al., 2012). Studies have also shown effectiveness and acceptability in culturally diverse adolescents excluded from mainstream education (Fleming et al., 2012). A revised version of SPARX, SPARX-R has since been developed for universal use such as in healthcare classes in schools (Fleming et al., 2019).

easier and earlier access to social support, information, and therapy that young people may have difficulties accessing in real life. COVID-19 lockdowns have forced the digital transformation of the mental health sector, at pace. Services have reported greater use of virtual appointments, telephone and text messages and use of social media to maintain contact and service provision, as a matter of necessity, but may continue to build on "virtual" contact for those who prefer this method of service delivery.

- *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 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 specialist ICAMH/AOD 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 attending mental health services. Therefore, enhancing service user pathways to key services, especially for those under 15 years of age, should continue to be a key focus. Furthermore, enabling better collaboration between primary and specialist services, through more effective infrastructure, is also required to progress this.

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

Fund, plan and explore service re-design:

- Funding constraints and limited resources continue to impede progress in service expansion and development within services (DHBs and NGOs). Until more funding and resources are made available, services need to consider service redevelopment and re-design strategies to use existing resources more efficiently (e.g., *Choice and Partnership Approach*, 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 relative to demand. A concerted drive is required to increase the capacity of the workforce (including recruitment of new graduates) to work in specialist ICAMH/AOD 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 is also required. Utilising national competency frameworks such as *Real Skills Plus ICAMH/AOD* 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 also be enhanced by utilising *Real Skills Plus ICAMH/AOD* 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:* A fast-track solution to addressing workforce shortages could include the development of existing roles, such as the peer workforce (which includes service user, consumer, and peer workers). There are many benefits to building a youth consumer workforce, including the assistance they can provide in identifying youth trends, keeping up to date with rapidly advancing technology, identifying gaps in service delivery, decreasing rates of youth continually re-entering services, improving the credibility of services, and reducing barriers to access. Having youth consumer workers can also lead to increased communication with youth-driven services and projects. Currently, the peer workforce makes up a very small proportion of the total ICAMH/AOD workforce (approximately 1%) and very little progress has been seen in the

One of the themes from the latest Deep and Meaningful Conversation (DMC) event was to increase the number of clinical psychologists, which meant increasing the number of people admitted into the programme. Part of the admissions process that youth wanted to see change was a higher priority of admissions to Māori, Pacific, and Rainbow people. Additionally, the admissions process should prioritise applicants who demonstrate higher emotional intelligence AND lived experience, rather than basing admission on grades (Whāraurau, 2021)

development of the youth consumer workforce, which continues to make up an even smaller proportion (0.1%). The lack of specific funding for this role is the main reason why it remains underdeveloped. Therefore, prioritised funding and further development of this workforce should remain an important area of focus. To help guide best practice in youth consumer service development and quality improvement, youth consumer toolkits (Werry Workforce Whāraurau, 2009a) 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.

- *Share resources:* Building relationships and working in partnership with other services by sharing limited resources can be an effective strategy in addressing interim workforce shortages. For instance, providing clinical support to NGOs who are struggling to recruit qualified clinicians is useful, particularly in rural areas where recruitment is even more difficult. This is already occurring in some areas where NGOs provide cultural and, in some cases, clinical support to DHBs (and vice versa).

- *Retain the workforce*: Increasing the capacity of the ICAMH/AOD workforce remains a slow strategy in addressing current shortages. Therefore, it is vital to retain the current workforce. High turnover and vacancies in the specialist workforce, in both DHB and non-DHB services, continue to exacerbate workforce shortages. For instance, vacancy rates in some DHB services were as high as 32%. Therefore, reasons for high vacancy rates and staff turnover need to be identified and addressed. Staff turnover is particularly high in NGO services (28% compared to 24% in 2018), 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 current funding models limiting adequate funding, also hamper the recruitment and retention of NGO staff. A review of the current funding models, in partnership with the non-DHB sector, needs to occur. An increase in funding to this sector can also allow for longer term employment contracts and providing pay parity with similarly skilled staff, which may aid the retention of the NGO specialist workforce. Additionally, retaining senior, experienced staff is also essential for providing supervision and mentoring to new or younger staff. Providing these opportunities with lower contact time, or part-time positions, could also aid retention of senior staff.

- *Look after the workforce:* Developing workforce resilience is one of the key steps to workforce retention as resilience protects the mental and physical health and wellbeing of the workforce. 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. The trauma-informed care approach is an example of a model of care that emphasises self-care and staff wellness, as both an individual and organisational responsibility. Online training modules and face-to-face workshops on self-care have been developed and are widely available. Furthermore, while many services have implemented various wellbeing activities and initiatives, and acknowledge the need for looking after their workforce, it should remain an essential part of a service's workforce retention strategy. "Virtual" teams having to practise in a COVID-19 environment make this even more difficult, but there are guidelines on remote working and maintaining connections, until more in-person teamwork is possible.

Increase workforce capability:

- *Identify and develop knowledge and skills:* Given the growing complexity of service user needs, 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 and reviewing current competency levels and enabling opportunities for targeted development, using competency assessment tools such as the *Real Skills Plus ICAMH/AOD* online tool. Currently, RSP data shows further developments in knowledge and skills on assessment and intervention are required.

- *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 therefore seen by the "mainstream" workforce. Due to the increasing rates of all service users assessing services, and expected growth in the proportions of Māori, Pacific and Asian young people in the population, there continues to be a critical need for increasing the dual competency of mainstream services to be both clinically and culturally competent. Various cultural competency frameworks are available, e.g., *Real Skills Plus ICAMH//AOD* (The Werry Centre, 2009a); *Takarangi Māori Competency Framework* (Matua Raki, 2010); *Real Skills Plus Seitapu Pasifika Competency Framework*

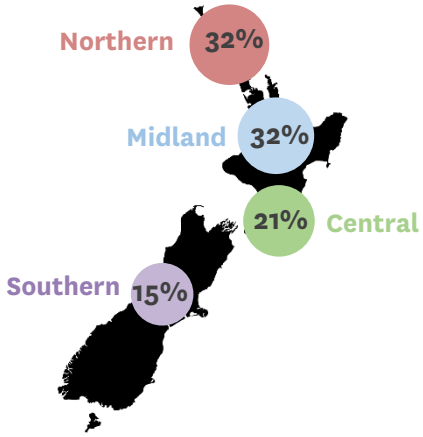
(Te Pou o Te Whakaaro Nui, 2009) and resources for culturally and linguistically diverse (CALD) populations. These resources are available to guide and enable cultural competency development within services. However, there appears to be very little consistency in the use of the available tools to assess current levels of cultural competence, therefore competency is not adequately measured and known. 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. Services who have assessed their competencies using the RSP tool have identified further developments are required in cultural knowledge and skills. Access to experienced cultural practitioners for cultural guidance and supervision should also be an integral part of a service's capability to provide a culturally capable service.

- *Provide and enable access to targeted training and development:* Services report that, due to current staff shortages, they are unable to release staff for required and necessary training and upskilling. Until recruitment and retention issues are addressed, shared training between DHB and NGOs and the development and provision of more online or e-based training could provide opportunities for further development until adequate resources and workforce capacity have been built up.

Māori National Overview

Māori Tamariki and Rangatahi Population

- 41% of Aotearoa NZ's total Māori population are 0-19 years old (a youthful population).
- They make up 26% of the total NZ population of those aged 0 to 19 years.
- +8% growth is projected from 2020 to 2030 across all regions, with the largest growth projected for the Southern region by +14% (Appendix A, Table 1).



Māori Tamariki and Rangatahi Mental Health Needs

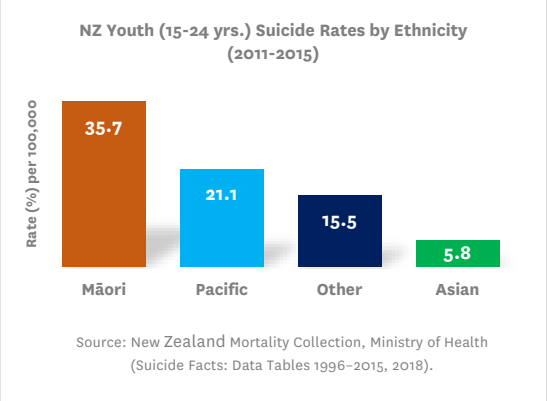
- The Māori population is more likely to come from areas of greater deprivation than are non-Māori (Ministry of Health, 2010b). Economic deprivation has been linked to a higher incidence of mental health problems (Fortune et al., 2010).
- The *Growing Up in New Zealand* longitudinal study (Morton et al., 2014) has followed 7000 NZ children from before birth since 2009/2010, and has shown that, "*Māori & Pasifika 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, as cited in the international *Understanding Inequalities* project (ESRC, 2019), reiterated the inequalities faced by Māori children in their early years.

> "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." (ESRC, 2019, p. 7)

- The Strengths and Difficulties Questionnaire (SDQ) scores, based on the New Zealand Health Survey data, indicated that 12% of Māori children (aged 3 to 14 years) had an overall "high" or "concerning" SDQ score, compared to an 8% score at that level overall (Ministry of Health, 2020). 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 et al., 2003) and reiterated by the Adolescent Health Research Group (2003; Clark et al., 2008; Crengle et al., 2013).
- The more recent Youth19 Research Group findings (Fleming et al., 2020) reported concerning trends in emotional and mental health issues for Māori students from 2012 to 2019:
    - *A drop in rates of good wellbeing (measured by the WHO-5 wellbeing index) from 75% to 67%. Māori females (39%) reported worse mental and emotional wellbeing than did Māori males (19%).*
    - *A rise in rates of significant depressive symptoms, from 14% to 28%.*
    - *A rise in the proportion who had attempted suicide in the past 12 months, from 6% to 13%.*

- *Higher socioeconomic deprivation was associated with a higher prevalence of depressive symptoms (30% of Māori who live in high deprivation areas, compared to 23% in low deprivation areas); higher proportion who had attempted suicide in the past 12 months (13% in high compared to 7% in low deprivation areas).*
- *An increasing equity gap between Māori and Pākehā/other European. Māori had a higher proportion with significant depressive symptoms (28%) compared to Pākehā/other European (20%), and a higher proportion who have attempted suicide in the past 12 months (13%) compared to Pākehā/other European (3%).*
- *There were 27% unable to access healthcare when needed or wanted in the previous year, compared to their Pākehā/other European peers (17%).*

- An indicator for youth disengagement is the proportion of young people who are not in employment, education, or training (NEET). NEET status has 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 et al., 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).*
- Māori 15-24 years olds had the second highest NEET rate of 17.8% as at June 2020, an increase of 1.4% from June 2019. NEET rate was highest for females (19%), compared to 16.6% for males (MBIE, 2020b). The NEET rate for Māori aged 15-19 years had also increased to 13.4%, up 0.7% from 2019 to June 2020. The consistently high NEET rate will continue to impact on the mental health and wellbeing of those already in high-risk groups, especially females, meaning a greater need for mental health services.
- Suicide continues to remain a significant issue for Māori, especially for Māori youth. Suicide rates for Māori youth aged 15–24 years were the highest 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 in 2018 (Ministry of Health, 2018). Latest Māori youth suicide rates were not available at the time of reporting. Provisional suicide statistics published by the Chief Coroner for the 2019/2020 period reported an overall Māori (all ages) suicide rate of 20.24 per 100,000 population, highest out of the four ethnicities reported (European/Other = 12.08, Asian = 7.91, Pacific = 7.07) (Coronial Services of New Zealand, 2020). The provisional number of deaths by suicide reported for 10-14 and 15-19 age groups accounted for 15% (23/157) of all Māori suicide deaths. Over half (56%) of suicide deaths within this age group were reported for females.



- The COVID-19 lockdowns in 2020, based on survey results from more than 1400 children and young people aged 8 to 18 years, has had both positive and negatives outcomes for children (Children's Commissioner, 2020). Positive outcomes included strengthened family relationships and more control over their time, including more time to explore interests. On the other hand, 23% reported life was worse than their life before lockdown. Negative outcomes included missing friends, tough family dynamics and mental health challenges (boredom, lack of motivation, anxiety, and depression). While these results provide some understanding of children and young people's experience during lockdowns, there was an over-representation of young people from high decile schools; therefore, these results may not reflect the experiences of those who are already living in difficult situations and facing existing inequities.
- Depression and anxiety appear to be consistent outcomes during and after lockdowns. Te Hiringa Hauora/Health Promotion Agency commissioned an online survey on people's experiences of the COVID-19 Level 4 lockdown (April 2020) and post-lockdown (June 2020). Data from over 1000 people showed experiences of depression and anxiety were common for young people, both during and post-lockdown (Nicholson & Flett, 2020). Almost 60% of young people had some experience of depression or anxiety post-lockdown (57%), with 10% being severe. The impacts of COVID-19 on youth mental wellbeing are likely to be extensive and enduring.

- The economic stressors caused by COVID-19 are likely to be long-term and its impact on the mental health of families and their children cannot be ignored. Experiences of depression and anxiety were twice as common for people without enough money to meet their everyday needs than for those with enough money (Nicholson & Flett, 2020). There were 14% who reported not having enough money and, at post-lockdown, 10% reported loss of their main source of income.
- Globally, movement restrictions, loss of income, isolation, overcrowding and high levels of stress and anxiety are increasing the likelihood that children experience and observe physical, psychological, and sexual abuse at home – particularly those children already living in violent or dysfunctional family situations (WHO, 2020). The reported rise in family harm during lockdowns, and the impact of this, particularly on children, cannot be ignored. Research from the University of Otago found that 9% of adult New Zealanders (18 years and older) had directly experienced some form of family harm during the 2020 lockdown, including sexual assault, physical assault, or harassment and threatening behaviour (Every-Palmer et al., 2020). These rates are between three and four times higher than the levels reported the year before, in the NZ Crime and Victims Survey 2018/9 (Ministry of Justice, 2018).
- Increasing socioeconomic inequalities, existing high mental health concerns, and the additional impact of COVID-19 are likely to be extensive and enduring with mental health needs of Māori pēpē, tamariki and rangatahi remaining high and even more complex. These factors strongly signal an urgent need for early intervention, prioritising suicide prevention in order to improve the long-term mental health outcomes for Māori pēpē, tamariki and rangatahi. Additionally, services should anticipate continued demand for services and plan services and workforce development activities accordingly.

Māori Tamariki and Rangatahi Service User Access to ICAMH/AOD Services

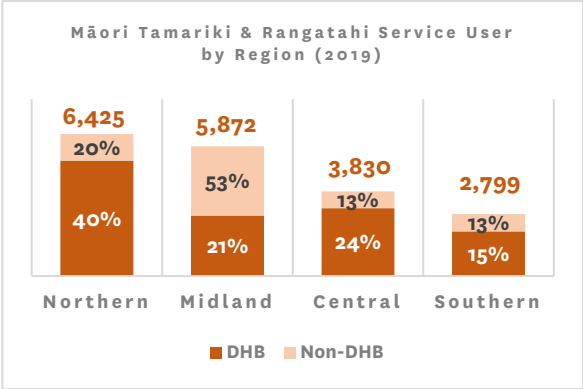
Māori tamariki and rangatahi (0-19 years) service user access data extracted from PRIMHD, based on the *Service users by DHB of Domicile* (residence), provides data on the actual demand for services. Data from 120 NGOs were included in the 2019 service user data. PHO service user data is not captured in PRIMHD (Detailed service user data for the 2017 and 2019 periods are presented in Appendix B, Tables 1-8.).

2017 to 2019:

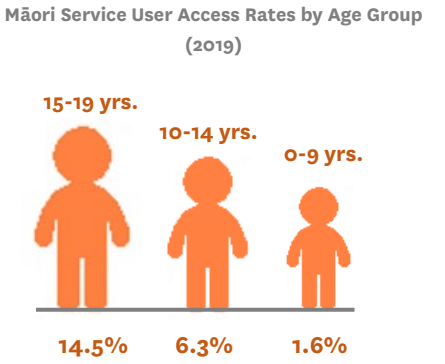
- +6% overall increase in the number of Māori service users: +12 increase in female service users; +1% increase in males.
- Increase in service users in both NGOs (by +8%) and DHB services (by +5%).
- Increase seen in all four regions, largest in the Southern region (+13%), smallest in the Northern (0.03%) (Appendix B, Table 3).

2019:

- Māori made up the largest proportion of all service users: 33%.
- 54% were male, 46% female.
- 15% were 0-9 years old, 29% were 10-14 and 56% were 15–19 years old.
- 69% accessed DHB services, 31% accessed NGOs nationally; however, Māori were largely seen by NGOs in the Midland region.

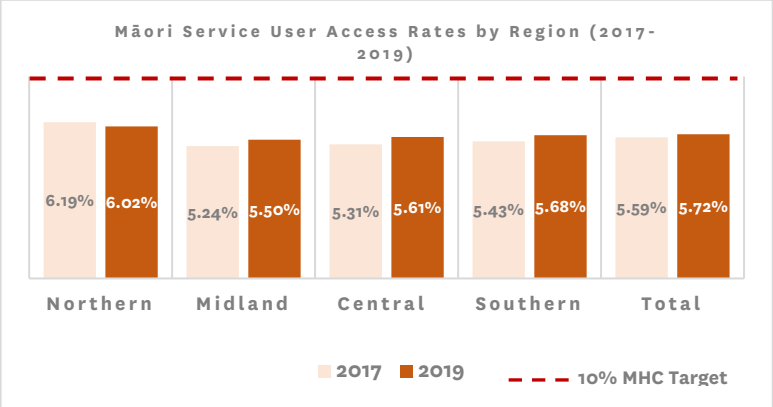


The Mental Health Commission suggested that 3% of the total infant, child and adolescent population should be able to access services, therefore setting the access target rate for the overall 0–19-year age group at 3% over a six-month period, up to the year 2000/2001, moving to a 5% rate by 2005. Due to the lack of epidemiological data at the time 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 for the same initial period (Mental Health Commission, 1998). Current Māori access rates are benchmarked against a 10% *Blueprint* access target rate (double the 5% target set for the overall 0–19-year population) to highlight progress and indicate areas requiring improvement. Target rates by age group beyond 2005 are not available. Therefore, access rates by age group are not benchmarked against targets.



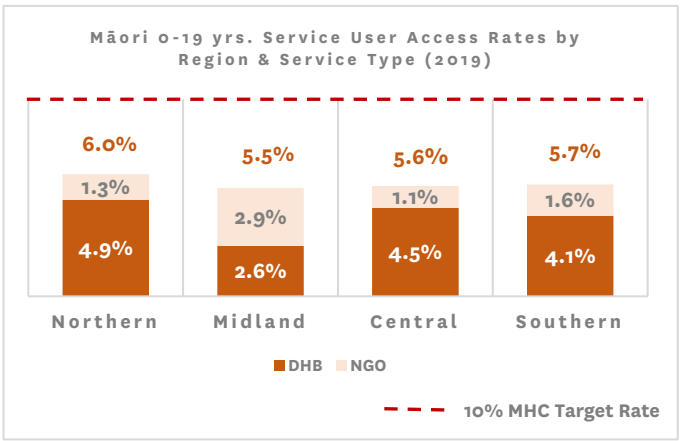
2017 to 2019:

- Improvements were seen in the overall access rate for Māori from 5.6% to 5.7%, with Māori continuing to have the highest rate out of the four ethnic groups, yet this remains below the target rate of 10%.
- Improvements were seen in the 0–9-year age group (from 1.59% to 1.63%) and the 15–19-year age group (13.75% to 14.48%), but not for those aged 10–14 (from 6.66% to 6.35%) (Appendix B, Table 2d).
- Improvements were seen in three out of the four regions—Midland, Central and Southern—but not in Northern.



2019:

- Māori access rates remained the highest for age 15–19 at 14.5%, and lowest for age 0–9 at 1.6%.
- Access rates for Māori were highest in the Northern region at 6.0%, and lowest in Midland at 5.5%, and remained below the 10% target rate.



Māori ICAMH/AOD Workforce

The following information is based on the Whāraurau workforce survey and reports actual and vacant full-time equivalents (FTEs) by ethnicity and occupation, submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services, including the National Secure Youth Forensic Service, and 103/122 DHB-funded non-DHB services (112 NGOs and 10 PHOs) for the 2020/21 period. Due to a lower participation rate of non-DHB services, the 2018 workforce data have been used to estimate the Māori workforce for services that were unable to participate; therefore, the Māori workforce information should be interpreted with caution. Detailed ICAMH/AOD workforce data are presented in Appendix D, Tables 1-19.

2018 to 2020/21:

- +1% increase in the total Māori workforce. Increases seen in two out of the four regions (Northern, Central), no change in the Southern region, and a -4% decrease in the Midland region (Table 2.1).
- By service provider, +13% increase seen in DHB services, -6% decrease in the non-DHB services (Table 2.1).
- +5% increase in the Māori clinical workforce (Table 2.1).

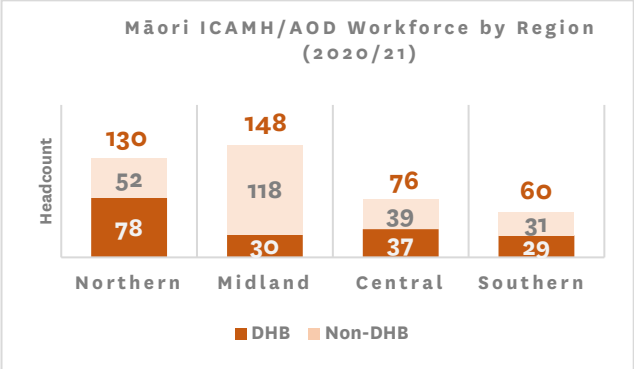
Table 2.1. Māori ICAMH/AOD Workforce by Region (2010-2020/21)

Māori (Headcount, 2020/21)	DHB						Non-DHB						Total					
	10	12	14	16	18	20	10	12	14	16	18	20	10	12	14	16	18	20
Northern	53	57	52	54	60	78	28	45	75	57	58	52	81	102	127	111	118	130
Midland	25	26	23	33	34	30	58	71	75	83	120	118	83	97	98	116	154	148
Central	37	42	49	44	37	37	26	41	35	29	37	39	63	83	84	73	74	76
Southern	16	16	15	17	19	29	22	21	27	36	41	31	38	37	43	53	60	60
National Youth Forensic	-	-	-	-	13	10	-	-	-	-	-	-	-	-	-	-	13	10
Total	131	141	139	148	163	184	134	178	212	205	256	240	265	319	351	353	419	424

Note: DHB data includes Inpatient Services.
Workforce data: 2010-2016 based on a 99% response rate from non-DHB services, 2018 data based on a 100% response rate and 2020 is based on 84%, with 2018 data used to estimate the remainder of the 2020 workforce.

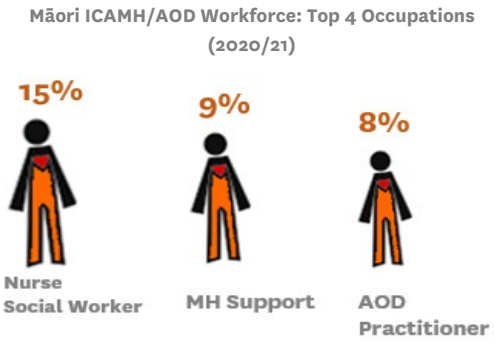
2020/21:

- Māori made up 20% of the total ICAMH/AOD workforce.
- 86% were based in the North Island (including the Youth Forensic Service workforce), largely in the Midland region (Table 2.1).
- Nationally, more Māori were employed in non-DHB services 57%. However, regionally, more Māori were employed in non-DHB services in the Midland (80%) and Southern and Central regions (52% and 51% respectively) regions (Table 2.1).



Excludes National Youth Forensic Service

- **59%** of the Māori workforce were in clinical roles, largely **15%** Social Workers, **15%** Nurses, **8%** Alcohol and Drug Practitioners, and **6%** Psychologists (Table 2.2).
- **33%** in non-clinical roles (excluding admin and management), largely **9%** Mental Health Support Workers, **7%** in Cultural roles, and **4%** Youth Workers (Table 2.2).
- **5%** in Management, **3%** in Administration (Table 2.2).



DHB Māori Workforce

Inpatient:

2018 to 2020/21:

- No change in the overall number of Māori staff in inpatient services (Table 2.1). However, an increase was seen in the number of Māori reported in clinical roles and a decrease reported in non-clinical roles.

2020/21:

- 76% of the Māori inpatient workforce were in clinical roles, largely 47% Nurses, 12% Mental Health Assistants, 6% Psychologists and 6% Psychiatrists (Table 2.2).
- 24% in non-clinical roles (excluding admin and management), largely 18% Mental Health Support Workers and 6% in Cultural roles (Table 2.2).

Community:

2018 to 2021:

- +18% increase in overall number of the Māori DHB Community workforce. Regionally, increases were seen in Northern, Central and Southern regions, with a decrease in the Midland region (Table 2.1).

2020/21:

- The largest Māori community workforce is in the Northern region, 41%, followed by 19% Central, 18% Midland, and the smallest in Southern, 16% (Table 2.2).
- 67% are in clinical roles, largely 21% Social Workers, 17% Nurses and 11% Psychologists (Table 2.2).
- 22% in non-clinical roles (excluding admin and management), largely 13% in Cultural roles, 3% Mental Health Support Workers and Youth Workers (Table 2.2).

Table 2.2. Māori ICAMH/AOD Workforce by Occupation (2020/21)

Māori ICAMH/AOD Workforce by Occupation (Headcount, 2020/21)	DHB			DHB Total	Non-DHB[3]	Total
	Inpatient	Community	National Youth Forensic Service			
Alcohol & Drug (AOD) Practitioner	-	1	-	1	34	35
Child & Adolescent Psychiatrist	1	2	-	3	-	3
Clinical Placement/Intern	-	6	-	6	1	7
Co-Existing Problems Clinician	-	3	-	3	3	6
Counsellor	-	2	-	2	9	11
Family Therapist	-	-	-	-	3	3
Nurse	8	27	5	40	25	65
Occupational Therapist	-	8	-	8	2	10
Psychologist	1	17	-	18	7	25
Psychotherapist	-	1	-	1	-	1
Registrar/SMO	-	1	-	1	-	1
Social Worker	-	33	-	33	30	63
Other Clinical[1]	3	4	-	7	15	22
Clinical Sub-Total	13	105	5	123	129	252
Cultural	1	21	2	24	5	29
Mental Health Consumer	-	1	-	-	2	3
Mental Health Support	3	5	2	10	29	39
Peer Support	-	2	-	2	13	15
Whānau Ora Practitioner	-	-	-	-	7	7
Youth Worker	-	4	-	4	15	19
Other Non-Clinical[2]	-	1	-	1	25	26
Non-Clinical Sub-Total	4	34	4	42	96	138
Administration	-	8	-	9	5	13
Management	-	10	1	11	10	21
Total	17	157	10	185	240	424

1. Other Clinical = House Surgeon; Mental Health Care Assistant; Māori Clinical Worker.
2. Other Non-Clinical: Needs Assessor.
3. Includes PHOs.

National Secure Youth Forensic Service:

2018-2020/21:

A slight decrease of 3 Māori staff members was reported, from 13 to 10 (Table 2.1).

2020/21:

- Half were in clinical roles as Nurses (50%) (Table 2.2).
- 40% were in non-clinical roles (excluding admin and management), largely 20% Mental Health Support Workers and 20% Cultural Workers (Table 2.2).

Non-DHB Māori ICAMH/AOD Workforce

There were 103 out of 122 non-DHB providers that submitted data for the 2020/21 period. The 2018 workforce data were used to estimate the workforce of the remainder of the services that did not submit data. Therefore, the information presented may not be an accurate representation of the current workforce and should be interpreted with caution.

2018 to 2020:

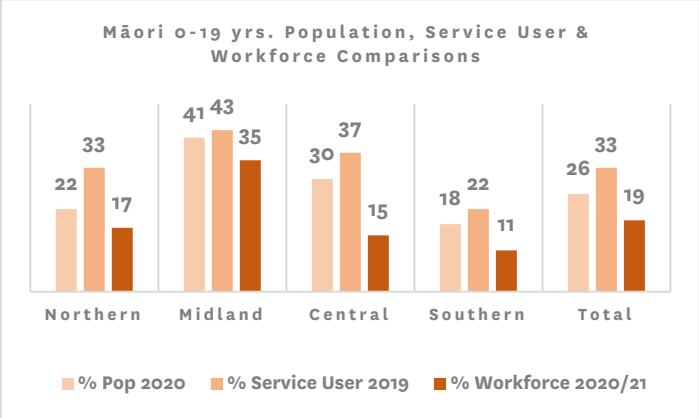
- -6% in the non-DHB Māori workforce. Decreases in Northern, Midland and Southern regions. An increase of +4% in Central (Table 2.1).

2020/21:

- The largest non-DHB workforce is in the Midland region 49%, followed by Northern 22%, Central 16%, and Southern 13% (Table 2.1).
- **54%** were in clinical roles, largely 14% AOD Practitioners, 13% Social Workers, 10% Nurses, 6% in generic child and youth mental health clinician roles, and 4% Counsellors (Table 2.2).
- 40% in non-clinical roles (excluding admin and management), largely 12% Mental Health Support Workers, 6% Youth Workers, 5% Peer Support Workers, 3% Whānau Ora Practitioners and 2% Cultural roles (Table 2.2).

Māori Tamariki and Rangatahi Service User & Workforce Comparisons

Māori tamariki and rangatahi service user and workforce comparisons continue to highlight significant disparities between demand for services and workforce capacity, especially in the Northern, Central and Southern regions. If the current trends continue, it will lead to even greater disparities between service demand and workforce capacity to handle demand. Therefore, the need to increase, retain, strengthen, and support the Māori workforce across all occupations remains a priority. Furthermore, enhancing the cultural competency of the non-Māori workforce, to work more effectively with Māori service users and their whānau, also remains a crucial area of development, given that a large proportion of Māori service users (69%) continue to access mainstream services and are largely seen by the non-Māori workforce.



Note. Excludes Admin/Management Workforce

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 NZ population due to the highest birth rate compared to Pacific, Asian, European or Other Ethnicities (Ministry of Health, 2019a). 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 of conduct problems compared to non-Māori children. Therefore, early intervention is critical for Māori pēpē, 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 pēpē, 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. Whānau-centred approaches to suicide prevention activities, supports and services designed, delivered, and evaluated by Māori are integral to reducing the Māori suicide rate. The Ministry of Health has released a new Suicide Action plan, *Every Life Matters* (MOH, 2019c), and it is hoped that this will result in a rapid change in suicide and self-harm rates.

The majority of Māori pēpē, tamariki and rangatahi continue to be seen by mainstream DHB services/teams (69%) 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.

Service user and workforce comparisons indicate significant disparities between Māori service users and the workforce across all regions. Data showed a 6% overall increase in Māori service users compared to a 1% increase in the Māori workforce, indicating a workforce that is not keeping up with demand. Therefore, there continues to be a need to increase the Māori workforce across all occupation groups. This 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 the current workforce.

While there has been an increase in Māori service users accessing non-DHB services, a large proportion continue to access mainstream services and are largely seen by the non-Māori workforce. Therefore, enhancing the Māori cultural competency of the mainstream workforce continues to remain a key focus of workforce development.

Recommendations

Based on the findings, the following recommendations are made to support improvements in the mental health outcomes for all Māori pēpi, tamariki and rangatahi within a whānau-centred/whānau ora context. These recommendations have been developed in consultation with the Whāraurau Māori Cultural Advisors.

A whānau-centred approach is integral for building and supporting the wellbeing of Māori whānau, hapū and iwi. Whānau can mean immediate family or much wider family. As well as whakapapa whānau, there are also kaupapa whānau: people joined together for a common purpose with a sense of group unity. It is grounded in Māori models of wellbeing, including *Te Whare Tapa Whā* and *Te Wheke*, and sits behind the Whānau Ora Outcomes Framework (Te Puni Kokiri, 2016). A whānau-centred approach is one way that organisations and those responsible for the wellbeing of children, particularly Māori children can progress the framework. It can be applied to policy, service design and delivery settings and is characterised by:

- placing whānau at the centre, with an emphasis on the collective, as well as the individual
- acknowledging whānau values, aspirations, needs and strengths at the core
- applying holistic wellbeing approaches that include cultural and spiritual influences, grounded in te ao Māori and kaupapa Māori in such a way that restores and strengthens whānau

- focusing on measuring effectiveness based on outcomes - sometimes over generations
- enabling whānau to determine their own future
- being strengths based
- promoting cultural concepts while acknowledging whānau diversity
- enhancing collaboration and integration across government.

The Whānau Ora Review: Tipu matoro ki te ao: Final report to the Minister for Whānau Ora (Te Puni Kōkiri, 2018) identified that a whānau-centred approach can result in positive change for whānau and can create the conditions for that change to be sustainable. The report contained recommendations to extend the reach of Whānau Ora, which Te Puni Kōkiri is leading. In extending the Whānau Ora approach, opportunities may arise for more effective ways to deliver services to children and young people in the context of their whānau. Taking advantage of these opportunities is part of the next steps for the Strategy.

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. Therefore, 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 to progress various workforce development initiatives (recruitment, retention, role development/expansion, training) that are required. DHBs, in collaboration with their local key stakeholders (i.e., service users, 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; enhance workforce development; and ensure funding is allocated accordingly.

Develop 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* should be developed that target the reduction of emotional symptoms, peer problems, and especially conduct problems in Māori children (3-14 years, as identified by the SDQ scores from the NZ Health Survey; Ministry of Health, 2018), and enhance resilience and a sense of belonging, identified to be protective factors for Māori youth, (Denny, 2016).
    - *Evidence-based parenting programmes* should be widely available such as *Incredible Years* and *Triple P – Positive Parenting Programme,* which has been shown to be effective for preventing and reducing children's emotional and behavioural problems. *Triple P Primary Care* 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. *Incredible Years* has been shown to be effective with parents of various ethnic backgrounds including Māori families (Fergusson et al., 2009; Sturrock & Gray, 2013; Sturrock et al., 2014). Providing evidence-based parenting programmes that work across cultures, socioeconomic groups and in different kinds of family structures is critical for intervening early and improving long-term outcomes for children.
- School-based health education and services: School settings provide an opportunity to reach a large number of young people, especially those who are at risk of experiencing poor outcomes. School-based mental health promotion and education, as well as cultural training, could be an important part of the curriculum for youth. By doing so, we may be able to reconnect young people with their whakapapa and develop a more universal cultural competency among the next generation. This will be immensely helpful for young people to be able to draw on their own and different cultural views on mental health/wellbeing. Schools can play a crucial role in supporting young people and their wellbeing and enabling interventions targeted at an earlier stage. Youth12 findings on health services in secondary schools showed positive associations between aspects of health services in schools 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 (Clark et al., 2013). There is also mounting evidence on the effectiveness of delivering

both universal and targeted school-based learning and mental health interventions that improve outcomes for the short and long term (Clarke et al., 2021). Guidelines for youth healthcare in secondary schools have been developed to assist planning, funding, or providing primary health services in secondary schools and can be used as a tool to continuously improve the quality of these services (Ministry of Health, 2014). Also, as part of the COVID-19 recovery response, schools are going to be important for identifying early intervention opportunities. Not only should they be able to recognise early signs of mental distress, but staff would also need to facilitate their students' prompt access to support (Poulton et al., 2020).

- Provide whānau-centred/whānau ora services*:* Providing more whānau-centred services, of higher quality, is essential to provide greater choice. 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.
- Digital tools and resources: Young people in NZ Aotearoa have high rates of internet access and use (Gibson et al., 2013; Statistics New Zealand, 2004b) (although a persistent "digital divide" has also become more apparent amongst high-deprivation communities (Gurney et al., 2021; Ioane et al., 2021a; Litchfield et al., 2021). This platform provides opportunities to develop e-therapy tools to assist with easier and earlier access to treatment. While there are concerns and negative links between the use of smartphones, social media, and youth mental health (Abi-Jaoude et al., 2020), a balanced approach needs to be considered. There are many positive aspects of the use of online platforms providing important benefits such as easier and earlier access to social support, information, and therapy that young people may have difficulties accessing in real life. 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, at least as a means of keeping young service users engaged, is potentially an effective way of intervening early and increasing early access to in-person 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

EXAMPLES:

Manaaki Ora App: A self-help app to support individuals and whānau to know what to do if they're concerned about someone's mental or emotional wellbeing, developed by Te Rau Ora and The Centre for Māori Suicide Prevention. The application is available through the App store and Google Play.

SPARX is a NZ online, computerised cognitive behavioural therapy program. User data of 2,110 young people, registered to use SPARX in 2019, showed 16% were Māori, the second highest user group after NZ European (62%). Schools were the largest referral source (39%). SPARX is an effective resource for adolescents with depression at primary healthcare sites, resulting in clinically significant reductions in depression, anxiety, and hopelessness and an improvement in quality of life (Merry et al., 2012). Taitamariki interviewed found it to be helpful, the Māori designs appropriate and useful, and the ability to customise the characters with Māori designs was beneficial and appeared to enhance cultural identity. They felt engaged, assisting with the acquisition of relaxation and cognitive restructuring skills, and using SPARX led to improved mood and increased levels of hope. In some instances, it was used by wider whānau members with beneficial effects (Shepherd et al., 2018). Studies have also shown effectiveness and acceptability in culturally diverse adolescents excluded from mainstream education (Fleming et al., 2012). A revised version of SPARX, SPARX-R has been developed for universal use such as in healthcare classes in schools (Fleming et al., 2019).

development of the respective workforces to deliver early and 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 specialist services: While Māori access to services has increased, it 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 under 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 iwi, schools, primary and specialist services, within an enabling infrastructure.

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

- Māori leadership: Identifying and appointing experienced Māori leaders within services should be an integral part of informing and guiding all aspects of service delivery and workforce development activities. 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 and mentorship for new staff and providing access to cultural supervision.
- 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 capacity (DHBs and NGOs) to adequately represent and cater for the growing demand for services by Māori.
    - *Workforce planning:* Services need to actively monitor their local service provision (incorporating a whānau ora model) against 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 occur. The use of national competency frameworks such as *Real Skills Plus ICAMH/AOD* within the training and specialist sector can inform and create a "job-ready" infant, child and adolescent mental health/AOD workforce, which can help to address the challenges, reported by services, of recruiting practitioners with the essential competencies required.
    - *Recruitment:* Lack of qualified staff for recruitment and a high turnover of 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 all 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 ICAMH/AOD* to recruit staff with the required knowledge and skills based on local service user needs. Establishing dedicated Māori intern positions in services and retaining them where there are high Māori populations could also be an effective strategy to increase the capacity of the workforce.
    - *Retention:* While increasing the capacity of the Māori workforce remains a much slower strategy to address current shortages, retaining the current Māori workforce should be one of the immediate areas of focus. High turnover of the workforce exacerbates workforce shortages. Reasons for staff turnover need to be identified and addressed. Reasons for staff turnover were not collected by ethnicity, therefore reasons for turnover for Māori staff specifically are unknown. However, overall turnover information shows turnover remains particularly high in NGO services. Given that more Māori are employed in NGOs, addressing the retention of the NGO workforce is critical. Reasons for such high turnover included the limited and competitive funding environments, whereby NGO services can only offer short-term contracts, as their funding is often for a short-term service which may not be renewed. As a result, they lose their staff to better salaries and more stable work conditions offered in other services. An increase in NGO funding could allow for longer term contracts and allow pay parity for similarly skilled staff, thereby aiding retention of the Māori NGO specialist workforce.
        - *Mentoring, Supervision and Peer Support:* Supporting the current Māori workforce by providing access to Māori mentors for supervision and support networks, especially for those who are working in isolation in large services, could improve retention.
    - *Look after the workforce:* Developing workforce resilience can also aid in workforce retention. Resilience protects the mental and physical health and wellbeing of staff and helps delivery of quality 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. Current trends show an increasing service user demand within current workforce capacity, which could

potentially increase due to the consequences of COVID-19, and lead to increased stress and burnout. Stress and burnout have been associated with high turnover rates. The trauma-informed care approach is an example of a model of care that emphasises self-care and staff wellness, as both an individual and organisational responsibility. Online training modules and a face-to-face workshop on self-care (which has received positive feedback from the workforce) have been developed and are widely available. The COVID-19 pandemic has highlighted and increased the need to look after staff wellbeing. Services have implemented flexible work conditions and regular wellbeing checks and activities over the past year, and this will need to be remain prioritised alongside responding to ever-increasing service demand.

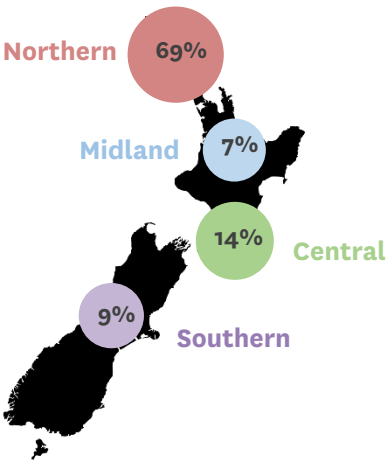
- *Expand and develop existing roles:* Identifying fast-track solutions to address workforce shortages, such as the development of existing roles like the peer workforce (which includes service user, consumer, and peer workers), provide good opportunities for increasing the capacity of the Māori workforce. 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 to 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 shortages, there is an ongoing need to strengthen and support the existing Māori workforce. As the majority of the total Māori workforce is employed in NGO services, strengthening the Māori NGO workforce is also vital.
  - *Identify and develop knowledge and skills:* Given the growing complexity of Māori infant, child, and adolescent mental health needs (e.g., socioeconomic 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 targeting development based on gaps using competency assessment tools such as *Real Skills Plus ICAMH/AOD*. Currently, there are no data on the RSP competency levels of the Māori workforce, but overall data (all ethnicities) show further developments are needed in both knowledge and skills in assessment and intervention, and in leadership and cultural aspects. Training and professional development would therefore need to be targeted to these areas.
  - *Identify and strengthen Māori cultural knowledge and skills:* Identifying further Māori competencies of the current Māori workforce using appropriate competency tools e.g., *Takarangi Māori Competency Framework* (Matua Raki, 2010) to work effectively with Māori whānau is also required. Even within the current Māori workforce, Māori staff may require different levels of cultural competency development. Investing in the capability/competency development of the Māori workforce can enable Māori staff to provide cultural supervision to the non-Māori workforce, to ensure clinical and cultural safety for all Māori service users and their families until the Māori workforce capacity can be built up.
  - *Enable access to targeted knowledge and skills training:* Once knowledge and skill gaps have been identified, it is essential that the 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. Furthermore, staff shortages hinder access to training as staff cannot be released for training. Until recruitment and retention issues are addressed, shared training between DHB and NGOs and the development and provision of more online, e-based training could provide opportunities for further development, until adequate resources and workforce capacity are available.

Pacific National Overview

Pacific Infant, Child, and Adolescent Population

NZ's Pacific population is a culturally diverse group and is made up of many different ethnic groups. The largest are 43% Samoan, 19% Cook Island Māori, 19% Tongan, 7% Niue, 5% Fijian and 2% Tokelauan (Census 2018, Statistics NZ).



- 66% were NZ born (Census 2018).
- 37% were 0-19 years old; a youthful population, making up 10% of the 0–19year population.
- 69% resided in the Northern region.
- +6% population growth is projected from 2020 to 2030. Largest growth is expected in Midland and Southern (+23% in both regions) (Appendix A, Table 1).
- Services would need to take these population trends into consideration when planning for local service and workforce development activities.

Pacific Infant, Child, and Adolescent Mental Health Needs

- Pacific populations in NZ experience higher socioeconomic deprivation than the general population (Statistics New Zealand, 2002).
- 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).
- 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).
- *Growing Up in New Zealand* has followed 7000 NZ children from before birth since 2009 and 2010 and has shown that:

  > *Māori & Pasifika 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 *Growing Up in New Zealand* (Economic & Social Research Council, 2019) reiterated that lived experience of inequality and adversity during the early years consistently show that the detrimental effect can last long into adulthood.

- Strengths and Difficulties Questionnaire (SDQ) scores, based on the NZ Health Survey data, indicated that 10% of Pacific children (3-14 years) had an overall "high" or "concerning" SDQ score, compared to an 8% overall score. 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.*
- 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 et al., 2008).

- An indicator for youth disengagement is the proportion of young people who are not in employment, education, or training (NEET). Pacific 15-24 years olds had the highest NEET rate of 18.4% as at June 2020, an increase from June 2019. NEET rate was highest for Pacific females (21.3%) compared to 15.2% for males (MBIE, 2020c). NEET status has 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 et al., 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, especially females, which can predict a greater need for mental health services.
- For Pacific peoples, the leading cause of mortality is injury, largely attributable to suicide. Suicide data (2015) show Pacific young people have the second highest suicide rate, at 21.1 per 100,000 population, and are highest within the 15–24-year age group, at 29.8 per 100,000 population, compared to the overall Pacific male rate of 12.6% (Ministry of Health, 2018).
- The recent Youth19 research group findings (Fleming et al., 2020) on Pacific students (12-18 years old) found that between 2012 and 2019:
    - *There was an increase in significant depressive symptoms from 14% to 25% and an increase in the proportion who had attempted suicide in the past 12 months from 7% to 12%.*
    - *Rates of significant depressive symptoms were especially high among females (33%) compared to males (15%) and amongst those in high deprivation areas (25%) compared to those in low deprivation areas (15%).*
    - *A greater proportion reported attempting suicide in the past 12 months (12%) than did their Pākehā/other European peers (3%); this was also higher for those in high deprivation areas (14%) compared to low deprivation areas (2%).*
- It is well noted that Pacific people are "*hard to reach New Zealanders"* (Kingi, 2008) because of the non-Pacific approach of mainstream services. Even if Pacific people are able to access services, they may not engage if these services are not responsive to their cultural norms (Kingi, 2008). Reasons for the persistent low access rates to mental health treatment for Pacific were identified in the *Youth07* study on Pacific high school students (Helu et al., 2009):
    - *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 Pasifika People: A Pasifika and Health Systems Approach* (Southwick et al., 2012), highlighted issues that hinder Pacific access to primary care. While the participants were adults, these issues may also hinder Pacific families' access to essential health 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 Pasifika service users, partly due to language barriers and a lack of interpreter resources.*
- The COVID-19 lockdowns in 2020, based on survey results from more than 1400 children and young people aged 8 to 18 years, has had both positive and negatives outcomes for children (Children's Commissioner, 2020). Positive outcomes included strengthened family relationships and more control over their time, including more time to explore interests. On the other hand, 23% reported life was worse than their life before lockdown. Negative outcomes included

missing friends, tough family dynamics and mental health challenges (boredom, lack of motivation, anxiety and depression). While these results provide some understanding of children and young people's experience during lockdowns, there was an over-representation of young people from high decile schools; therefore, these results may not reflect the experiences of those who are already living in difficult situations and facing existing inequities.

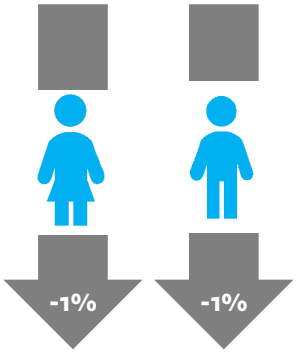
- Depression and anxiety appear to be consistent outcomes during and after lockdowns. Te Hiringa Hauora/Health Promotion Agency commissioned an online survey on people's experiences of the COVID-19 Level 4 lockdown (April 2020) and post-lockdown (June 2020). Data from over 1000 people showed experiences of depression and anxiety were common for young people, both during and post-lockdown (Nicholson & Flett, 2020). Almost 60% of young people had some experience of depression or anxiety post-lockdown (57%), with 10% being severe. The impacts of COVID-19 on youth mental wellbeing are likely to be extensive and enduring.
- The economic stressors caused by COVID-19 are likely to be long-term and its impact on mental health of families and their children cannot be ignored. Experiences of depression and anxiety were twice as common for people without enough money to meet their everyday needs compared to those with enough money (Nicholson & Flett, 2020). There were 14% overall who reported not having enough money; this was higher for Pacific (22%). Post-lockdown, 10% reported loss of their main source of income; again, this was higher for Pacific than for NZ Europeans. News reports have indicated that students have taken jobs during lockdown to support families struggling with the financial impact of COVID-19 with fears that they may not return to complete their high school education.
- Globally, movement restrictions, loss of income, isolation, overcrowding and high levels of stress and anxiety are increasing the likelihood that children experience and observe physical, psychological, and sexual abuse at home – particularly those children already living in violent or dysfunctional family situations (WHO, 2020). The reported rise in family harm during lockdowns, and the impact of this, particularly on children, cannot be ignored. Research from the University of Otago found that 9% of adult New Zealanders (18 years and older) had directly experienced some form of family harm during the 2020 lockdown, including sexual assault, physical assault, or harassment and threatening behaviour (Every-Palmer et al., 2020). These rates are between three and four times higher than the levels reported the year before, in the NZ Crime and Victims Survey 2018/9 (Ministry of Justice, 2018).
- The growing socioeconomic inequalities, existing high mental health needs, persistent low access to services, with the additional impact of COVID-19 are likely to be extensive and enduring, with the mental health needs of Pacific children and young people remaining high and even more complex. These factors strongly signal an urgent need for early intervention, prioritising suicide prevention in order to improve the long-term mental health outcomes for Pacific children and young people. Additionally, services should anticipate continued demand for services and plan services and workforce development activities accordingly.

Pacific Service User Access to ICAMH/AOD Services

Pacific service user access data extracted from PRIMHD is based on the *Service users by DHB of Domicile* (residence) data for a full calendar year of 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. Detailed service user data for the 2017 and 2019 period is presented in Appendix B, Tables 1-8.

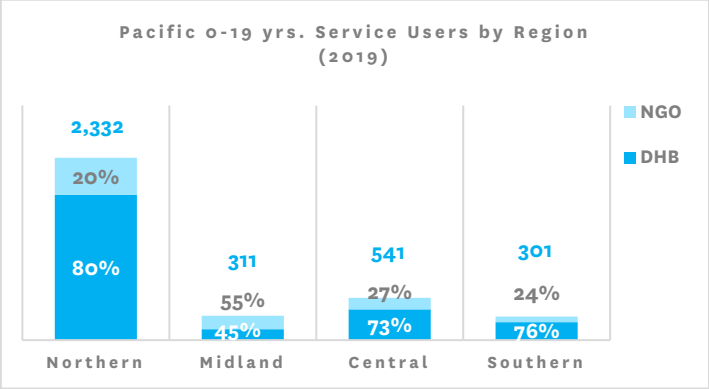
2017 to 2019:

- -1% overall decrease in Pacific service users, for both female and male service users.
- +2% increase in DHB services and a -9% decrease in NGOs.
- An -8% decrease in service users in the Northern region. However, increase in service users seen in Midland, Central and Southern regions, with the largest increase in Southern by +28%.

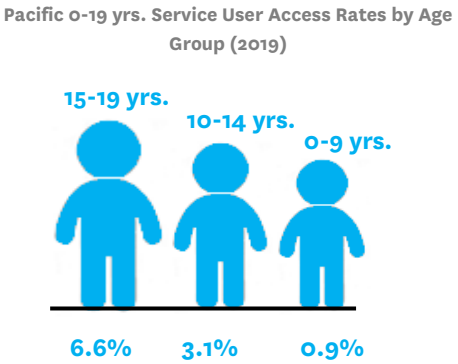


2019:

- Pacific made up 6% of total service users, 53% were male.
- 16% were 0-9 years old, 28% were 10-14, and 57% were aged 15–19 years.
- 75% accessed DHB services; 25% accessed NGOs.
- Northern region had the largest number of Pacific service users in the country (67%), 98% in the greater Auckland area (Auckland, Waitemata & Counties Manukau).

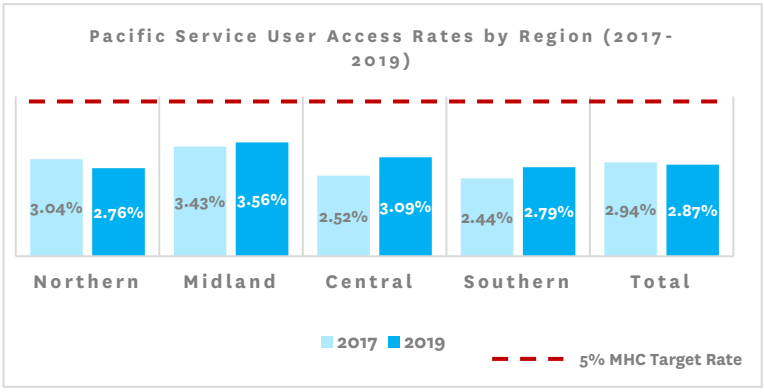


The *Blueprint* access benchmark rate for those aged 0–19 years has been set at 5% of the population (Mental Health Commission, 1998). Due to the lack of epidemiological data for the Pacific 0-19 years population, there are no target rates set for Pacific; therefore, access rates are compared to the overall 5% rate. The Pacific population experiences higher levels of mental health disorder than the general population (Ministry of Health, 2008); therefore, the target rates may be a conservative estimate of actual need. Target rates by age group beyond 2005 are not available. Therefore, access rates by age group are not benchmarked against target rates.



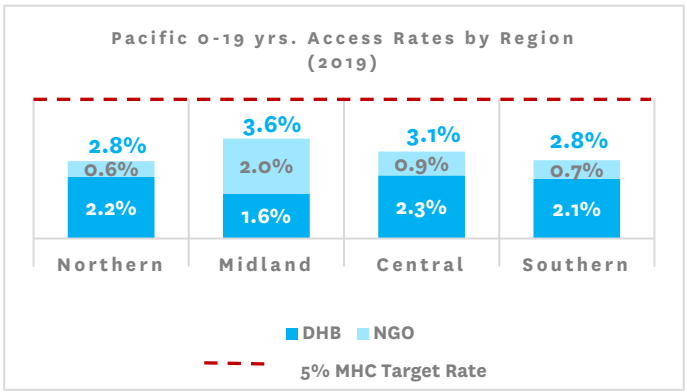
2017 to 2019:

- Decrease in the overall Pacific access rate from 2.94% to 2.87% due to the decrease seen in the Northern region. However, an improvement in access rate seen in the 0–9 years age group (from 0.81% to 0.89%) only. Decreases in those aged 10-14 (3.15% to 3.09%) and 15-19 (7.14% to 6.59%).
- Improvements seen in three out of the four regions: Midland, Central, and Southern; a decrease in Northern.



2019:

- Pacific had the third highest access rate out of the four ethnic groups but remain below the 5% target rate, indicating unmet needs.
- Those aged 15–19 years had the highest access rate at 6.6%, followed by those aged 10–14 at 3.1%. The lowest rates were for the 0-9 years age group at 0.9%.
- Pacific access rates were highest in the Midland region (3.56%) and lowest in the Northern (2.76%).
- Improving access rates for Pacific infants, children, and adolescents, especially for the 0–14-year age group, needs to remain a key area of focus.



Pacific ICAMH/AOD Workforce

The following information is based on the Whāraurau workforce survey and reports headcount by ethnicity and occupation submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services, including the National Secure Youth Forensic Service, and 103/122 DHB-funded non-DHB services (112 NGOs and 10 PHOs) for the 2020/21 period. Due to a lower participation rate of some non-DHB services, the 2018 workforce data has been used to estimate the Pacific workforce for those services; therefore, the Pacific workforce information should be interpreted with caution. Detailed ICAMH/AOD workforce data are presented in Appendix D, Tables 1-19.

2018 to 2020/21:

- +4% increase in the overall Pacific workforce, including +5% increase in the DHB workforce and a +2% increase in the non-DHB workforce (Table 3.1).
- Regionally, increases in the Pacific workforce were seen in the Northern region by +14%. In the Southern region, the workforce had more than doubled, from a headcount of 5 to 11 (Table 3.1).
- +9 increase seen in the clinical workforce, and -4% decrease seen in the non-clinical workforce.

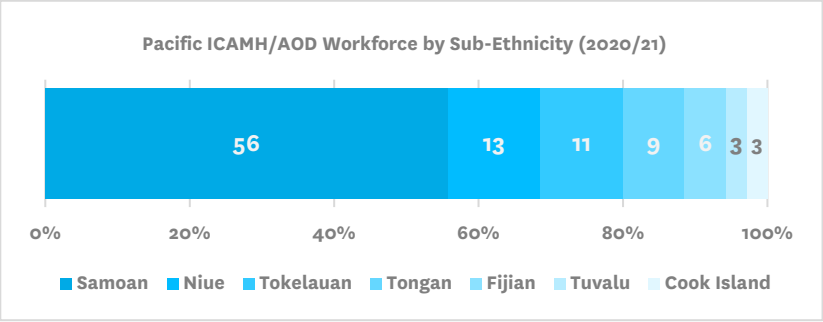
Table 3.1. Pacific ICAMH/AOD Workforce by Region (2010-2020/21)

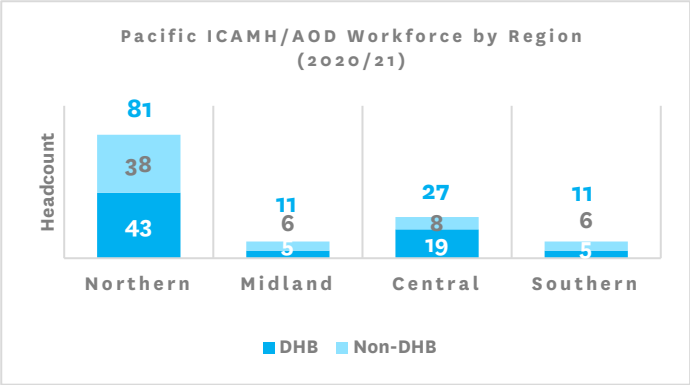
Region (Headcount)	DHB[1]						Non-DHB[2]						Total					
	10	12	14	16	18	20	10	12	14	16	18	20	10	12	14	16	18	20
Northern	35	39	35	40	38	43	17	27	36	32	33	38	52	66	71	72	71	81
Midland	2	2	1	3	6	5	6	4	6	9	7	6	8	6	7	12	13	11
Central	19	16	18	22	22	19	4	6	9	6	13	8	23	22	27	28	35	27
Southern	1	2	2	3	1	5	9	10	7	4	4	6	10	12	9	7	5	11
National Youth Forensic	-	-	-	-	17	16	-	-	-	-	-	-	-	-	-	-	17	16
TOTAL	57	59	56	68	84	88	36	47	58	51	57	58	93	106	114	119	141	146

1. Includes Inpatient & Regional Services.
2. Includes NGOs and PHOs.

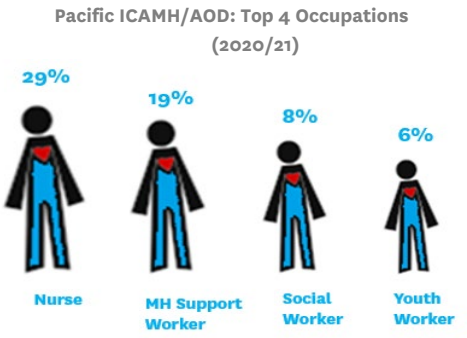
2020/21:

- 7% of the ICAMH/AOD workforce were Pacific.
- 56% were Samoan, 13% Niue, 11% Tokelauan, 9% Tongan, 6% Fijian, 3% Tuvaluan and 3% Cook Island. Approximately 57% of those who provided data were fluent in their respective languages, 35% were semi-fluent and the remainder 8% did not speak or understand their respective languages.





*Excludes National Youth Forensic Service



- 92% were employed in services in the North Island: 55% in the Northern region and 29% Central (including the Pacific Youth Forensic Service workforce) (Table 3.1).
- 60% were employed in DHB services; 40% in non-DHB services (Table 3.1).
- 60% were in clinical roles, largely 29% Nurses, 8% Social Workers, 5% Alcohol & Drug Practitioners, 3% Counsellors and Mental Health Assistants (Table 3.2).
- 36% were in non-clinical roles (excluding admin and management), largely 19% Mental Health Support Workers, 6% Youth Workers, and 4% in Cultural roles (Table 3.2).

DHB Pacific ICAMH/AOD Workforce

Pacific infants, children and adolescents and their families have access to both mainstream and Pacific ICAMH/AOD services. Of the 20 DHBs ICAMH/AOD services, only one provides a dedicated Pacific service for those aged 0–19 years, namely *Health Pasifika Child Adolescent & Family Services* at Capital & Coast DHB.

DHB Inpatient

2018 to 2020/21:

- An increase by +2, from 16 to 18 (headcount), including +3 in Auckland, -2 in Capital & Coast DHB; +1 in Southern DHB Inpatient Services (Table 3.1).

2020/21:

- 72% were in clinical roles, including 50% Mental Health Nurses and 22% Mental Health Assistants (Table 3.2).
- 28% were in non-clinical roles (excluding admin and management), including 22% Mental Health Support Workers and 6% in Cultural roles (Table 3.2).

DHB Community

2018 to 2020:

- +6% increase in the Pacific workforce (Table 3.1).

2020:

- 96% were based in the North Island: 61% in the Northern region, 24% in Central, 9% in Midland. The remaining 6% were based in the South Island (Table 3.1).

- 81% were in clinical roles, largely 50% Nurses, 13% Social Workers (Table 3.2).
- 13% were in non-clinical roles (excluding admin and management), including 7% Mental Health Support Workers and 6% in Cultural roles (Table 3.2).

National Youth Forensic Service

2018-2020:

- A decrease of one from the clinical workforce (Nurse), headcount 17 to 16 (Table 3.1).

2020:

- 75% were in non-clinical roles (excluding admin and management), largely 69% Mental Health Support Workers and Cultural roles 6% (Table 3.2). The remainder were in clinical roles as Nurses, 25% (Table 3.2).

Non-DHB Pacific ICAMH/AOD Workforce

Of the 122 non-DHB services funded, only four provide dedicated Pacific services to the 0–19-year age group. *Penina Trust* (Counties Manukau), *K'aute Pasifika* and *Raukawa Charitable Trust* (Waikato), and *Taeaomanino Trust* (Capital & Coast). There were 103/122 non-DHB providers that submitted data for the 2020/21 period. The 2018 workforce data were used to estimate the workforce of the remainder of the services who did not submit data. Therefore, the information presented may not be an accurate representation of the current workforce and should be interpreted with caution.

From 2018 to 2020/21:

- An increase of one in the non-DHB Pacific workforce, from 57 to 58. Slight increases seen in the Northern and Southern regions only.

2020/21:

- 90% were based in the North Island: 66% in the Northern region, 14% in Central and 10% in Midland. There were 10% in the Southern region (Table 3.1).
- 47% were in clinical roles, largely 12% Alcohol and Drug Practitioners, 7% Social Workers, 5% Counsellors, 3% Nurses and 3% were Clinical Interns/Placement students (Table 3.2).
- 50% were in non-clinical roles (excluding admin and management), largely 16% Youth Workers, 16% Mental Health Support Workers, 7% Peer Support Workers, 7% Educators and 2% Cultural workers (Table 3.2).

Table 3.2. Pacific ICAMH/AOD Workforce by Occupation (2020/21)

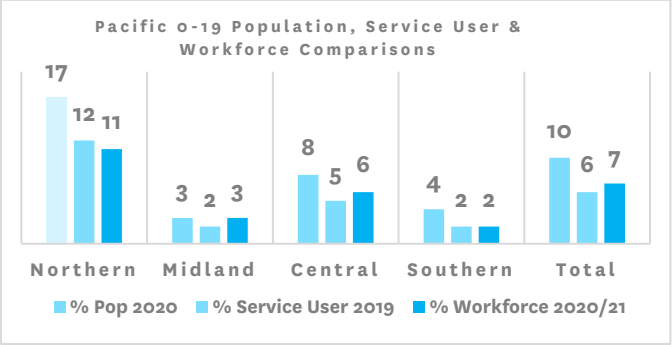
Pacific ICAMH/AOD Workforce by Occupation (Headcount, 2020/21)	DHB			DHB Total	Non-DHB[3]	Total
	Inpatient	Community	National Youth Forensic Service			
Alcohol & Drug Practitioner	-	-	-	-	7	7
Child & Adolescent Psychiatrist	-	2	-	2	-	2
Clinical Placement/Intern	-	1	-	1	2	3
Co-Existing Problems Clinician	-	-	-	-	1	1
Counsellor	-	1	-	1	3	4
Mental Health Assistants	4	-	-	4	-	4
Nurse	9	27	4	40	2	42
Occupational Therapist	-	3	-	3	-	3
Psychologist	-	-	-	-	1	1
Psychotherapist	-	1	-	1	1	2
Social Worker	-	7	-	7	4	11
Other Clinical[1]	-	2	-	2	6	8
Clinical Sub-Total	13	44	4	61	27	88
Cultural	1	3	1	5	1	6
Educator	-	-	-	-	4	4
Mental Health Consumer	-	-	-	-	1	1
Mental Health Support	4	4	11	19	9	28
Peer Support Worker	-	-	-	-	4	4
Whānau ora Practitioner	-	-	-	-	1	1
Youth Worker	-	-	-	-	9	9
Non-Clinical Sub-Total	5	7	12	24	29	53
Administration	-	2	-	2	-	2
Manager	-	1	-	1	2	3
Total	18	54	16	88	58	146

1. Other Clinical = Clinical Team Leader; Pacific Clinical Consultant; Mātanga Whai Ora; GP; Helpline Triage.
2. Includes PHOs.

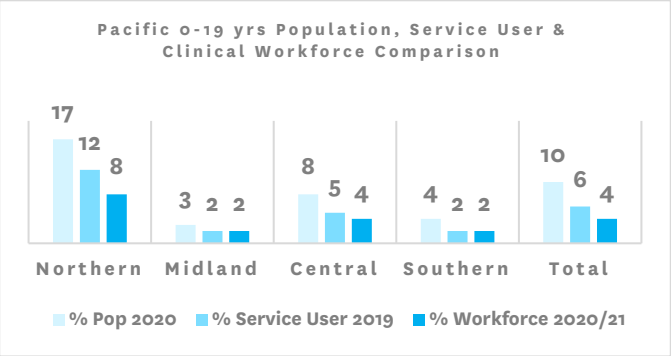
Pacific Population Service User & Workforce Comparisons

Due to low numbers of Pacific service users accessing services (6% 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 region where the majority of Pacific population reside. When Pacific service users are compared to the Pacific *clinical* workforce, the disparity between service demand and the workforce capacity becomes more apparent and even greater in the Northern region. Therefore, the need to improve access to services for the Pacific population and increase retain, strengthen, and support the Pacific workforce across all occupations should remain a key focus.

Furthermore, given that the majority of Pacific service users (75%) are continuing to access mainstream services and are therefore seen by the non-Pacific workforce, enhancing the cultural competency of the non-Pacific workforce, to work more effectively with Pacific service users and their families, also remains a crucial area of development.



*Excludes Admin/Management Workforce



Summary

The Pacific population is a growing and youthful population with almost half between the ages of 0 and 19 years. They continue to have a younger age structure than the total NZ population due to the second highest birth rate (second after Māori), compared to Asian, European and Other Ethnicities (Ministry of Health, 2019). They also experience greater socioeconomic deprivation, higher disengagement, greater mental health needs and the second highest rates of suicide (after Māori). 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, reducing socioeconomic inequities and intervening early are critical for improving long-term outcomes for the Pacific population.

Pacific service user access data show a decreasing trend in access to services, therefore remaining below the recommended MHC target rates. Given that Pacific infants, children, and adolescents have high mental health needs, the consistently low and declining access rates indicate significant unmet needs, especially for those aged 10–14 years. Increasing Pacific access rates to services for those who need them must be prioritised.

Low access to services could be partly due to the lack of Pacific services available, especially in the areas of highest populations and need (Northern and Central regions). 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 service (*Penina Trust*) 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 the DHB is 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. Recent budget allocation has seen more funding allocated to mental health in general, including $1.5M allocated to develop and grow the primary mental health and addiction services for Pacific peoples in Auckland, Hamilton, and Canterbury. This is a 5-year programme to develop existing services for rapid expansion, as well establishing new services. This includes a new mental health service in West Auckland and expansion of services for *K'Aute Pasifika* in Hamilton, which provides services for children and young people (NZ Government, 2020).

The growth in the Pacific workforce remains slow (by 4% since 2018) due to very few qualified Pacific practitioners being available for recruitment, lack of dedicated funding for targeted recruitment initiatives (especially in non-DHB services)

and loss of senior Pacific staff to promotions and jobs in other organisations. Growing a qualified Pacific workforce requires a long-term approach, therefore, the interim focus should be on retaining, supporting, and strengthening the current Pacific workforce. Additionally, because very few Pacific services are currently available for Pacific families, they are either not accessing services at all or accessing mainstream services (DHBs) and are thereby largely seen by the non-Pacific workforce. Pacific models of practice (e.g., *Fonofale Model*) are well known to services and embedded in some of them, and Pacific competency training (e.g., Le Va's *Engaging Pasifika a*nd *Real Skills Plus Seitapu*) is available to all services. Yet very little is known about the Pacific cultural competency levels of the workforce. Therefore, another critical area of workforce development focus is enhancing the dual competency of both the Pacific and non-Pacific workforce, which includes assessing required skills and knowledge and identifying areas of strengths and gaps, to be able to target development.

Recommendations

Based on the current data, 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 Whāraurau Pacific Advisors and Advisory Group.

Allocate appropriate levels of funding:

Allocating appropriate levels of funding for Pacific, especially for children and young people, 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. In collaboration with their local key stakeholders (i.e., service users, community leaders, schools, tertiary education providers, Youth One Stop Shops, PHOs, and NGOs), services 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 the workforce accordingly. A whānau-centred approach should also be integral to Pacific service development and delivery.

EXAMPLES:

1. Mana Pasifika: To support those in the Pacific community experiencing mental distress, Te Hiringa Hauora, in collaboration with Mapu Maia, Vaka Tautua, the Mental Health Foundation and Pacific health leaders Phil Siataga, Stephanie Erick, and Tui Tararo, launched *Mana Pasifika,* a campaign to encourage and destigmatise help-seeking for depression and anxiety in Pacific communities. This strengths-based and story-driven approach is by Pacific, for Pacific and with Pacific (Nicolson & Flett, 2020).
2. Le Va: www.mentalwealth.nz: A mental health literacy programme for youth.

Mental health promotion to increase mental health literacy and reduce stigma:

Data show that the need for mental health services remains high for Pacific children and youth, and may increase, yet access to services remains low, highlighting significant and ongoing unmet mental health needs. Low mental health literacy and stigma add to a number of barriers for such access to services for Pacific. Therefore, more mental health promotion, resources and activities that are ethnic and language-specific for Pacific families and youth are needed in community-based settings, such as schools and churches, as well as online, to improve attitudes and knowledge about mental health, reduce stigma, and provide information on how to access services early when needed. These resources need to be developed in collaboration with—and supported and promoted by—Pacific community leaders to help alleviate some of the access issues highlighted for Pacific infants, children, adolescents, and their families.

Early intervention programmes, services, and workforce:

Early intervention and earlier access to services are essential for Pacific (Ministry of Health, 2008a); therefore, greater investment in developing prevention, early intervention resources and services for Pacific needs to occur. While funding has been allocated to enhancing existing Pacific services and developing new services across the country, only one existing service in Hamilton, that caters for the mental health needs of children and youth, has been identified for further expansion. Population data indicate that the largest Pacific 0–19-year population live in the Counties Manukau and Waitemata DHB areas and very little information about the types of Pacific services planned in these areas of greatest need is available. Therefore, development of more services for Pacific infants, children, and adolescents needs to urgently occur in these areas using a variety of delivery methods.

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 scores from the NZ Health Survey data (Ministry of Health, 2018) would also be highly beneficial. Evidence-based parenting programmes (such as *Triple P – Positive Parenting Programme* and *Incredible Years*) have been shown to be effective in preventing and reducing children's emotional and behavioural problems. *Triple P Primary Care* 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. Incredible Years has been shown to be effective with parents of various ethnic backgrounds including Māori families (Fergusson et al., 2009; Sturrock & Gray, 2013; Sturrock et al., 2014). However, no research has yet been conducted on examining the effectiveness among Pacific families. Qualitatively, a small number of Pacific families did indicate that *Incredible Years Parent* principles and concepts were universal and relevant culturally to them, particularly the emphasis on relationships, but further adaptations were needed to enhance understanding of concepts, and resources developed/translated for their specific languages (Maiava, 2014). The programme would need to be delivered by Pacific as this would enhance engagement, acceptability, and accessibility. Further support for the workforce in delivering an acceptable and sustainable programme also needs to occur. Therefore, funding, enhancing, and delivering such evidence-based parenting programmes, that work across cultures, socioeconomic groups and in different kinds of family structures, is critical for intervening early and improving long-term outcomes for Pacific children.

- *Use of digital tools and resources.* Young people in NZ Aotearoa have high rates of internet access and use (Gibson et al., 2013; Statistics New Zealand, 2004b) (although a persistent "digital divide" has also become more apparent amongst high-deprivation communities (Gurney et al., 2021; Ioane et al., 2021a; Litchfield et al., 2021). This platform provides opportunities to develop e-therapy tools to assist with easier and earlier access to treatment. While there are concerns and negative links between the use of smartphones, social media, and youth mental health (Abi-Jaoude et al., 2020), including for Pacific people (Ioane et al., 2021b), a balanced approach needs

EXAMPLES:

SPARX, a computerised, interactive fantasy game based on cognitive behavioural training has been shown to be beneficial and resulted in reductions in depression, anxiety, and hopelessness and an improvement in quality of life (Merry et al., 2012). It has also led to improvements in mood and increased levels of hope for Māori youth (Shepherd et al., 2018) and could be beneficial for Pacific as well. Studies have also shown effectiveness and acceptability in culturally diverse adolescents excluded from mainstream education (Fleming et al., 2012). A revised version of SPARX, SPARX-R has since been developed for universal use such as in healthcare classes in schools (Fleming et al., 2019).

Le Va has developed the following resources with and for Pacific youth - to help them and their families to improve their mental health and nurture the Va (relational space) between each other. These resources have been developed within a Pacific people's wellbeing framework which includes Pacific values such as love and service, maintaining their spiritual and physical wellbeing and having the ability to positively contribute to and maintain the Va:

- **www.auntydee.nz:**
  A problem-solving tool to support finding the best solutions.
- **www.atumai.nz:**
  A national violence prevention programme for Pacific youth.
- **www.catchyourself.nz:**
  Supporting communities to have respectful relationships in times of distress.

to be considered. There are many positive aspects of the use of online platforms providing important benefits such as easier and earlier access to social support, information, and therapy that young people may have difficulties accessing in real life. Therefore, reaching and keeping Pacific youth and families engaged in web-based resources is potentially an effective way of promoting and enhancing mental health literacy, intervening early, and allowing early access to in-person treatment.

- *School-based health education and services:* School settings provide an opportunity to reach a large number of young people, especially those who are at risk of experiencing poor outcomes. School-based mental health promotion and education, as well as cultural training, could be an important part of the curriculum for youth. By doing so, we may be able to reconnect young people with their Pacific roots and develop a more universal cultural competency among the next generation. This will be immensely helpful for young people to be able to draw on their own and different cultural views on mental health/wellbeing. Schools can also play a crucial role enabling interventions targeted at an earlier stage. Youth12 findings on health services in secondary schools showed positive associations between aspects of health services in schools 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). There is also mounting evidence on the effectives of delivering both universal and targeted school-based learning and mental health interventions that improve outcomes for the short and long term (Clarke et al., 2021). Guidelines for youth healthcare in secondary schools have been developed to assist planning, funding, or providing primary health services in secondary schools and can be used as a tool to continuously improve the quality of these services (Ministry of Health, 2014). Also, as part of the COVID-19 recovery response, schools are going to be important for identifying early intervention opportunities. Not only should they be able to recognise early signs of mental distress, but staff would also need to facilitate their students' prompt access to support (Poulton et al., 2020).
- 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-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 effective mental health care could alleviate the demand on ICAMH/AOD specialist services. *Core Elements of Pasifika primary mental health and addiction service provision* (Faleafa, 2020) provides six core elements in developing and providing primary mental health services that improve health equity and wellbeing of Pacific early and for the long-term. While these recommendations were aimed at primary mental health and addictions services, they should be applied to the spectrum of services that already exist for Pacific and guide the development of new services. Services should be:
    - Pacific-led and work towards reducing barriers to access, such as cost, transport, language, stigma, confidentiality, mental health literacy, cultural competency, and cultural safety. Service delivery that is uniquely Pacific should include *cultural assessments, holistic models of care, an inviting atmosphere using Pacific motifs and hospitality practices, use of Pacific languages and recognition of co-existing spiritualities.*
    - Family-centred: Services should meet the needs of Pacific young people within the context of their families and take into account young people who identify with multiple ethnicities, how intergenerational communication can be more effective, and ensure that youth-centred Pacific worldviews are included at all levels of service design and delivery.
    - Holistic: Services should equally address physical and mental health concerns, promoting a deeper understanding of problems in a wider context.
    - Clinically and culturally integrated: Pacific mental health and addiction workers should have the ability to converge two worldviews in their practice to ensure cultural values are respected and clinical services are culturally safe.
    - Community-based: Primary mental health and addiction services may be the first point of contact for many Pacific people, so appropriate settings and a welcoming environment are critical for effective engagement. Churches remain an important part of life for Pacific communities and act like villages for family life and support systems. Services in community-based locations can also reduce stigma, thereby enhancing access to services. Other popular locations for social support that can enhance connectedness include community centres, non-government organisations, sports clubs, youth-health hubs, and marae.

- Connected: Given Pacific people's co-morbidities with physical health and mental wellbeing are further exacerbated by socioeconomic factors, services should be integrated and connected with other related and existing services (such as local health, social and community services, NGOs, general practice, churches, youth hubs, cultural supports, rainbow services, disability services and secondary or specialist mental health and addiction services), with systems in place that enable better connection. This also includes working across sectors, which include education, employment, and housing.

Improve access to services by enhancing service user pathways from primary to secondary services:

Pacific access to services continues to remain significantly short of meeting actual need. Enhancing Pacific service user pathways to key services, especially for those under 15 years of age, should remain 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 workforce:

- Increase workforce capacity*:* Pacific service access and workforce comparisons indicate an ongoing trend in the discrepancies between service users and the clinical workforce. Therefore, the recommendation to build the capacity of the Pacific workforce (both in DHB and NGO services) remains relevant and critical. 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 also need to occur.
    - *Workforce planning:* Services need to actively monitor their local service demand and provision 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. The use of national competency frameworks such as *Real Skills Plus ICAMH/AOD* 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, clinical roles. Given that approximately a third of Pacific service users are accessing non-DHB services, increasing the expertise of this workforce also needs to be considered. Recruitment of specialist staff can be enhanced by utilising national competency frameworks such as *Real Skills Plus ICAMH/AOD* 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. Establishing dedicated Pacific intern positions in services where there are high Pacific populations could also be an effective strategy to increase the capacity of the workforce.

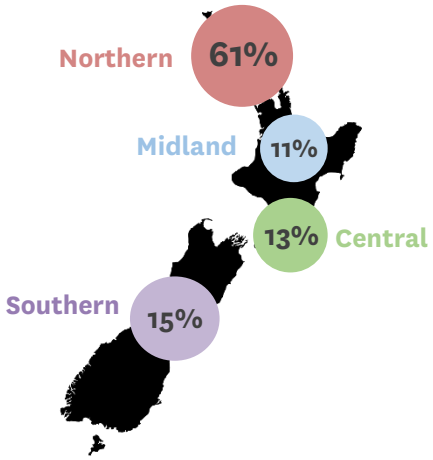
- *Retention:* While increasing the capacity of the Pacific workforce remains a slow strategy in addressing shortages, retaining the current Pacific workforce needs to be the immediate focus. Continuing high turnover of the specialist workforce indicates retention issues that need to be addressed. Reasons for staff turnover were not collected by ethnicity; therefore, reasons for turnover for Pacific staff are unknown. However, overall turnover information shows turnover remains particularly high in NGO services. Reasons for such high turnover included the limited and competitive funding environments, whereby NGO services can only offer short-term contracts, as their funding is often for a short-term service which may not be renewed. As a result, they lose their staff to better salaries and more stable work conditions offered in other services. 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, including Pacific.
    - *Mentoring, Supervision and Peer Support:* Supporting the current Pacific workforce by providing access to Pacific mentors for supervision and support networks, especially for those who are working in isolation in large services, could improve retention. Therefore, focusing on 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.
- *Look after the workforce*: Developing workforce resilience can also aid in workforce retention. Resilience protects the mental and physical health and wellbeing of staff and helps delivery of quality 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. Current trends show an increasing service user demand within current workforce capacity, which could potentially increase due to the consequences of COVID-19, and lead to increased stress and burnout. Stress and burnout have been associated with high turnover rates. The trauma-informed care approach is an example of a model of care that emphasises self-care and staff wellness, as both an individual and organisational responsibility. Online training modules and a face-to-face workshop on self-care (which has received positive feedback from the workforce) have been developed and are widely available. The COVID-19 pandemic has highlighted and increased the need to look after staff wellbeing. Services have implemented flexible work conditions and regular wellbeing checks and activities over the past year, and this will need to be remain prioritised alongside responding to ever-increasing service demand.
- *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 overall 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 provide cultural support to DHBs. However, while the need to work more collaboratively is acknowledged by services, barriers and challenges to doing so continue to exist and need to be identified and effectively addressed.

- Increase workforce capability: Given the growing complexity of infant, child, and youth mental health needs presenting at services, strengthening the current Pacific workforce with the right knowledge and skills is another important area of focus. There is an ongoing need to ensure that the current Pacific workforce is equipped to effectively work both clinically and culturally. Almost half of the Pacific workforce is employed in NGO services; therefore, strengthening and supporting the Pacific NGO workforce is also vital.

- *Identify and develop knowledge and skills:* As a first step, services need to be actively engaged in identifying current competency levels and targeting development based on gaps using competency assessment tools such as *Real Skills Plus ICAMH/AOD*. Currently, there are no data on the RSP competency levels of the Pacific workforce, but overall data (all ethnicities) show further developments are needed in both knowledge and skills in assessment and intervention, and in leadership and cultural aspects. Training and professional development would therefore need to be targeted to these areas.
- *Identifying and strengthening Pacific cultural knowledge and skills:* Information collected via the 2020 *Stocktake* workforce survey indicated that only half of the current Pacific workforce is fluent in their respective languages. Therefore, targeting language competency development for those who need it (and providing interpreter services and ethnic and language specific resources in the interim) could be an effective strategy in providing better services for Pacific children and families. Identifying further Pacific competencies of the current Pacific workforce using appropriate competency tools, e.g., *Real Skills Plus Seitapu Framework* (Te Pou, 2009), to work effectively with Pacific families is required. Even within the current Pacific workforce, Pacific staff will require different levels of cultural competency development; for instance, NZ-born Pacific staff will have different competency levels and areas of development compared to Island-born Pacific staff. Investing in the capability/competency development of the Pacific workforce can enable Pacific staff to provide cultural supervision to the non-Pacific workforce, to ensure clinical and cultural safety for Pacific service users and their families until Pacific workforce capacity can be built up.
- *Enable access to targeted skills and knowledge training:* Once knowledge and skill gaps have been identified, the workforce needs to be able to access the required specialist and cultural training. The lack of funding has been reported by the NGO sector as a key barrier to accessing specialist training and development. Furthermore, staff shortages hinder access to training, as staff cannot be released for training. Until more funding is allocated to NGOs, and recruitment and retention issues are addressed, shared training between DHB and NGOs and the development and provision of more online, e-based training could provide opportunities for further development, until adequate resources and workforce capacity are available.

Asian National Overview

Asian Infant, Child, and Adolescent Population



- "Asian" ethnicity includes a large number of ethnic groups, diverse in culture, language, education, resident, and migration experiences. NZ's "Asian" population (people from East, Southeast & South Asia) is made up of more than 40 different groups[4]. The three largest in NZ total 707,598 and comprise 33% Chinese (231,916), 31% Indian (221,916), 11% Filipino (72,612) (Census 2018, Statistics NZ).
- 77% of the total NZ Asian population were overseas-born; 23% were NZ-born (Census 2018).
- 25% of all Asians in NZ were 0-19 years old, making up 16% of the 0–19-year population.
- 61% resided in the Northern region: 98% split between the Counties Manukau, Auckland and Waitemata DHB areas (Appendix A, Table 1).
- International fee-paying students, who are largely from Asian regions, are usually an addition to NZ's Asian population. There was a +6% increase in the number of international fee-paying students (primary and secondary school age) from 2018 to 2019 (n = 22,895), largely from Asian regions (82%, headcount 18,755, made up of 21% from Japan, 16% China, 10% India, 8% South Korea, and 5% Thailand) (Ministry of Education, 2019), and largely residing in the Auckland region (69%). However, these student numbers from 2020 will be significantly affected by COVID-19 pandemic border closures.
- 797 refugees arrived in NZ in 2020, 31% (251) were from Asian countries. Of those from Asian countries, 82% (207) were from Myanmar, 13% (33) from Pakistan and 4% (11) from Sri Lanka (Parliamentary Service, 2021).
- There is +26% growth expected for the Asian population in the 10-year projections (2020-2030), meaning it continues to be the fastest growing population. Largest growth is projected in the Midland region by +33%, followed by +32% Southern, +29% Central and +22% Northern (Appendix A, Table 1).

Asian Infant, Child, and Youth Mental Health Needs

- The process of immigration can negatively impact on an immigrant's psychological wellbeing (Ho et al., 2003; 2015). Women, fee-paying students, older people, and refugees have the highest risk of developing mental health problems. Factors that can impact on mental health and wellbeing include:
    - Language difficulties, which can increase the risk of developing mental health problems and can also prolong the process of acculturation/integration, including preventing new immigrants from acquiring appropriately skilled jobs.
    - High unemployment rates: Despite higher levels of tertiary qualifications, the Asian population experiences higher unemployment rates (5.2%) than the total population (3.7%) (Statistics NZ, 2020) and are over-represented in occupational groups that are lower paid (Public Service Commission, 2020).

[4] People from the Middle East and Central Asia are excluded.

- Isolation and disruption of family and support networks.
- 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, including both NZ born and international students (Ministry of Justice, 2019). Academic pressures, unrealistic parental expectations, parent-child conflicts and possible identity and sexuality crises were noted as risk factors for Asian youth, with international students being a high-risk group (Ho et al., 2015).
- The Strengths and Difficulties Questionnaire (SDQ) scores, based on the NZ Health Survey data, indicated that 5% of Asian children (3-14 years) had an overall "high" or "concerning" SDQ score (Ministry of Health, 2018). SDQ scores can 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. They were less likely to experience emotional, conduct and hyperactivity problems compared to non-Asian children (overall, 8% of children with concerning scores), but rates for peer problems were comparable.
- The latest Youth19 survey (Peiris-John et al., 2021), conducted with 7,311 students aged between 13 and 17 years, included 26% who identified with an Asian ethnic group (East Asian and South Asian). Data revealed that for the 1272 East Asian students (largely Chinese, Filipino, Korean, Japanese):
  - 49% were NZ born.
  - 21% lived in high-deprivation areas.
  - 29% had experienced depressive symptoms, higher than their European peers (23%). The prevalence was significantly higher in females (33%) than in males (22%).
  - 23% had self-harmed in the previous 12 months; again, self-harm was significantly higher in females (28%) than in males (15%).
  - 23% had seriously thought about attempting suicide, 16% had made a plan, and 5% had attempted. More females had thought about suicide (27% compared to 19% of males), planned it (18% compared to 13% of males) and attempted suicide than had males.
  - 21% reported that they were unable to access healthcare when needed, compared to 18% of their European peers. Most common reasons were:
    - *Hoping problem would go away by itself (35%)*
    - *Didn't want to make a fuss (30%)*
    - *Was too scared (15%)*
    - *Didn't know how (14%)*
    - *Was too embarrassed (14%)*
    - *Couldn't get appointment (13%).*

- Youth19 results for Southeast Asian students (n = 604, largely Indian, Sri Lankan, Pakistani, Afghani, Bangladeshi) showed:
  - 56% were NZ born.
  - 32% lived in high-deprivation areas.
  - 24% had experienced depressive symptoms, higher than their European peers (23%). The prevalence was significantly higher in females (35%) than in males (11%).
  - 21% had self-harmed in the previous 12 months; again, self-harm was significantly higher in females (27%) than in males (15%).

- 18% had seriously thought about attempting suicide, 11% had made a plan, 6% had attempted. More females had thought (26% compared to 10% of males), planned (16% compared to 6% of males) and attempted (9% compared to 2% of males) than males.
- 18% were unable to access healthcare when needed. Most common reasons were:
    - *Hoping problem would go away by itself (30%)*
    - *Didn't want to make a fuss (24%)*
    - *Couldn't get appointment (15%)*
    - *Was too embarrassed (11%)*
    - *Was too scared (10%).*

- The reasons for low access rates for the Asian population 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. Other aspects that could act as barriers to accessing mental health services for the Asian population include 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 (Ho et al., 2003).

- 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; Forbes-Mewett & Sawyer, 2016; Wang & Mallinckrodt, 2006).

- The COVID-19 lockdowns in 2020, based on survey results from more than 1,400 children and young people aged 8 to 18 years, has had both positive and negatives outcomes for children in general (Children's Commissioner, 2020). Positive outcomes included strengthened family relationships and more control over their time, including more time to explore interests. On the other hand, 23% reported life was worse than their life before lockdown. Negative outcomes included missing friends, tough family dynamics and mental health challenges (boredom, lack of motivation, anxiety, and depression). While these results provide some understanding of children and young people's experience during lockdowns, there was an over-representation of young people from high decile schools; therefore, these results may not reflect the experiences of those who are already living in difficult situations and facing existing inequities.

- Depression and anxiety appear to be consistent outcomes during and after lockdowns. Te Hiringa Hauora/Health Promotion Agency commissioned an online survey on people's experiences of the COVID-19 Level 4 lockdown (April 2020) and post-lockdown (June 2020). Data from over 1000 people showed experiences of depression and anxiety were common for young people, both during and post-lockdown (Nicholson & Flett, 2020). Almost 60% of young people had some experience of depression or anxiety post-lockdown (57%), with 10% being severe. The impacts of COVID-19 on youth mental wellbeing are likely to be extensive and enduring.

- The economic stressors caused by COVID-19 are likely to be long-term and its impact on mental health of families and their children cannot be ignored. Experiences of depression and anxiety were twice as common for people without enough money to meet their everyday needs than for those with enough money (Nicholson & Flett, 2020). There were 14% overall who reported not having enough money and, post-lockdown, 10% reported loss of their main source of income; this was higher for Asian people than for NZ Europeans. Almost three in 10 people reported reduction in income, with figures higher for Asian than for NZ Europeans.

- Globally, movement restrictions, loss of income, isolation, overcrowding and high levels of stress and anxiety are increasing the likelihood that children experience and observe physical, psychological, and sexual abuse at home – particularly those children already living in violent or dysfunctional family situations (WHO, 2020). The reported rise in family harm during lockdowns, and the impact of this, particularly on children, cannot be ignored. Research from the University of Otago found that 9% of adult New Zealanders (18 years and older) had directly experienced some form of family harm during the 2020 lockdown, including sexual assault, physical assault, or harassment and threatening behaviour (Every-Palmer et al., 2020). These rates are between three and four times higher than the levels reported the year before, in the NZ Crime and Victims Survey 2018/9 (Ministry of Justice, 2018).

- The growing socioeconomic inequalities, persistent low access to services, with the additional impact of COVID-19 are likely to be extensive and enduring, with the mental health needs of Asian children and young people remaining high and even more complex. These factors strongly signal an urgent need for early intervention, prioritising suicide prevention in order to improve the long-term mental health outcomes for Asian children and young people. Additionally, services should anticipate continued demand for services and plan services and workforce development activities accordingly.

Asian Service User Access to ICAMH/AOD Services

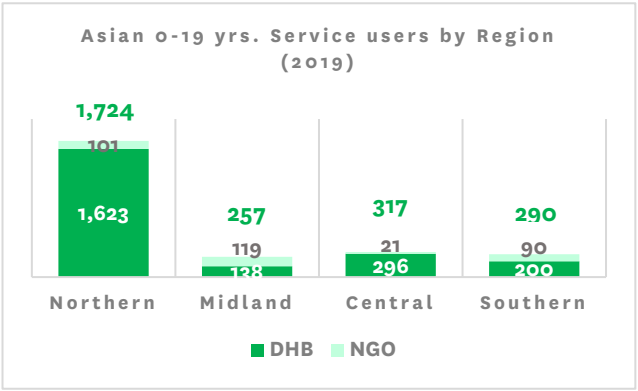
Asian service user access data extracted from PRIMHD, based on the *Service users by DHB of Domicile* (residence) for the full calendar year, provides data on the actual demand for services. PHO service user data are not captured in PRIMHD; therefore, all service user data presented pertains to DHB and NGO services only. Detailed service user data for the 2017 and 2019 period are presented in Appendix B, Tables 1-8.

2017 to 2019:

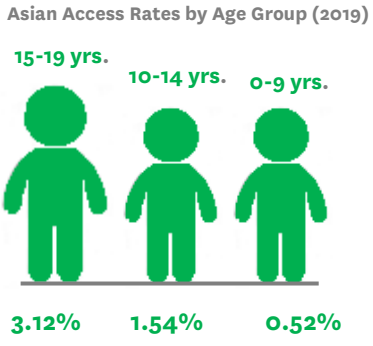
- +19% overall increase in Asian service users: +21% increase in females, +16% increase in males.
- Increase seen in both DHB services (+19%) and NGOs (+16%).
- Increase seen in all four regions, with the largest increase in the Midland region by +35% (Appendix B, Table 14).

2019:

- Asians made up 5% of all service users.
- More Asian females (53%) accessed services than did males (47%).
- 21% were 0-9 years old, 26% were 10-14, 53% were aged 15–19 years.
- 87% accessed DHB services; 13% NGOs.
- 67% accessed services in the Northern region: 99% in the greater Auckland area.



The *Blueprint* access benchmark rate for the 0–19 years age group has been set at 5% of the population from 2005 (Mental Health Commission, 1998). Due to the lack of epidemiological data for the Asian 0–19 years population, there are no specific target access rates set for the Asian population. Therefore, Asian access rates have been compared to the rates for the overall 0-19 years population. Target rates by age group beyond 2005 are not available. Hence, access rates by age group are not benchmarked against target rates.

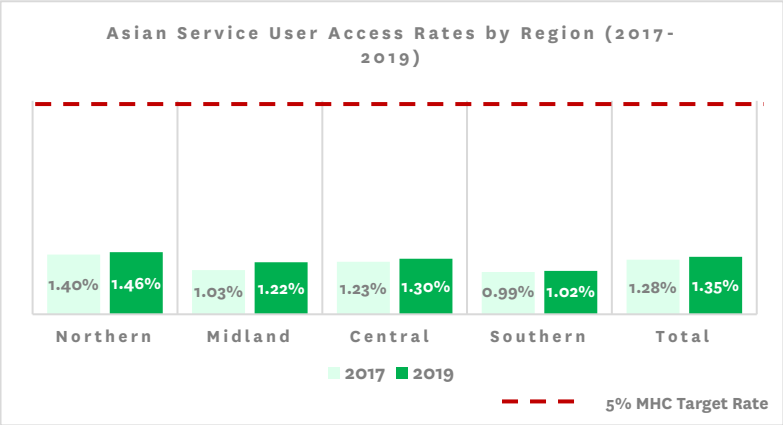


2017 to 2019:

- Improvements were seen in the overall Asian access rate from 1.28% to 1.35%.
- Improvements were seen in the 10–14-year age group (from 1.46% to 1.54%) and 15-19 years (2.59% to 3.12%) only. There was a decrease in the 0-9 year age group (from 0.56% to 0.52%).
- Improvements in access rates were seen in all four regions.

2019:

- Asian service users had the lowest access rate (1.35%) out of the four ethnic groups (Māori 5.72%, Pacific 2.87%, Other Ethnicity 5.15%).
- Northern region continued to have the highest Asian access rate at 1.46%, and Southern the lowest at 1.02%.
- Despite the growth in the Asian population, there continues to be very little improvement in access rates, and they remained significantly below the target rate across all regions.



Asian ICAMH/AOD Workforce

The following information is based on the Whāraurau workforce survey and reports headcount by ethnicity and occupation submitted by all 20 DHB (Inpatient & Community) ICAMH/AOD services, including the National Secure Youth Forensic Service, and 103/122 DHB-funded non-DHB services (112 NGOs and 10 PHOs) for the 2020/21 period. Due to a lower participation rate of non-DHB services, the 2018 workforce data have been used to estimate the Asian workforce for services who were unable to participate; therefore, the Asian workforce information should be interpreted with caution. Detailed ICAMH/AOD workforce data are presented in Appendix D, Tables 1-19.

2018 to 2020/21:

- -3% decrease in the Asian workforce, from 117 to 114 (Table 4.1). Decrease seen in both DHB (-1%) and non-DHB services (-6%) (Table 4.1).
- Increases in two out of the four regions: Midland (+2 practitioners) and Central (+4 practitioners). Decreases in Northern (-4 practitioners) and Southern (-5 practitioners) (Table 4.1).

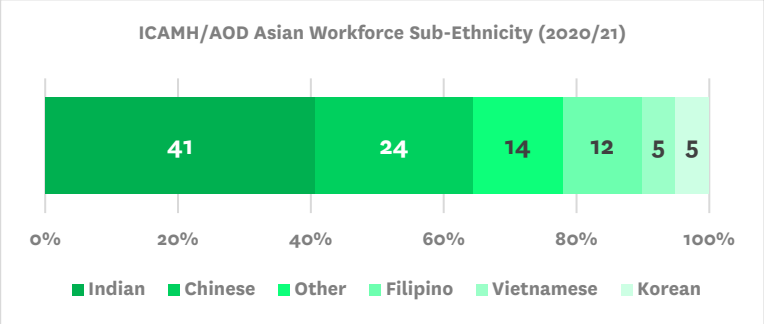
Table 4.1. Asian ICAMH/AOD Workforce by Region (2010-2020/21)

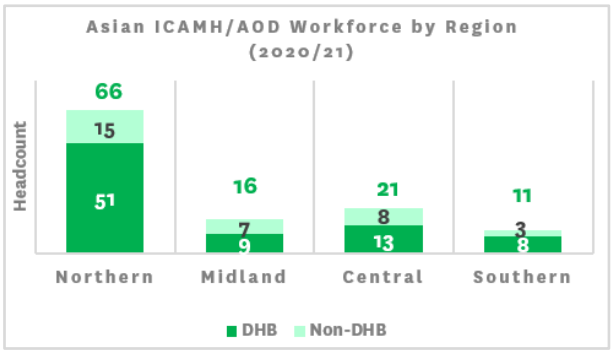
Region (Headcount)	DHB[1]						NON-DHB						TOTAL					
	10	12	14	16	18	20	10	12	14	16	18	20	10	12	14	16	18	20
Northern	33	18	32	44	53	51	3	7	12	18	17	15	36	25	44	62	70	66
Midland	5	5	9	10	5	9	-	-	7	6	9	7	5	5	16	16	14	16
Central	6	9	6	10	11	13	-	2	3	1	6	8	6	11	9	11	17	22
Southern	1	2	6	10	13	8	-	1	-	4	3	3	1	3	6	14	16	11
Total	45	34	53	74	82	81	3	10	22	29	35	33	48	44	75	103	117	114

1. Includes Inpatient Services.

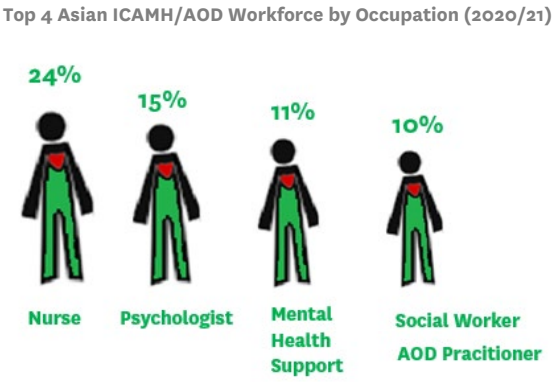
2020/21:

- Asians made up 6% of the total ICAMH/AOD workforce.
- The largest Asian sub-ethnic group were Indian (41%) (includes Fijian Indian & South African Indian), followed by 24% Chinese, 12% Filipino, 5% Vietnamese, 5% Korean, and the remaining 14% were Pakistani, Sri Lankan, Thai, Malaysian, and Japanese.





- 90% of the Asian workforce were based in the North Island: 58% in the Northern region, 18% in Central, 14% in Midland, and 10% in the Southern region (Table 4.1).
- 71% were employed in DHB services, 29% in non-DHB services (Table 4.1).
- 82% were in clinical roles, largely 24% Nurses, 15% Psychologists, 10% Social Workers and 10% AOD Practitioners (Table 4.2).
- 14% in non-clinical roles (excluding admin and management roles), largely 11% Mental Health Support Workers (Table 4.2).



DHB Workforce

Of the 20 DHBs that provide specialist ICAMH/AOD services, none has specifically funded ICAMH/AOD services for Asian infants, children, and adolescents. 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.*
- Asian infants, children and adolescents are also able to access DHB-funded, community-based mainstream ICAMH/AOD, peer-support and advocacy, refugee, and migrant services.

DHB Inpatient:

2018 to 2020/21:

- There was an increase of one in the Asian Inpatient workforce (from 17 to 18) (Table 4.1).

2020:

- All were in clinical roles largely 78% Nurses, 11% Psychologists, 6% Psychiatrists, and 6% Social Workers (Table 4.2).

DHB Community:

From 2018 to 2020/21:

- -2% decrease in the Asian workforce, from 64 to 63 (headcount) (Table 4.1).

2020/21:

- 63% of the community Asian workforce were based in the Northern region, followed by 14% in Midland, 13% in Central and 10% in Southern (Table 4.1).
- 92% were in clinical roles largely 24% Psychologists, 19% Nurses, 14% Occupational Therapists, 13% Social Workers, 8% Psychiatrists (Table 4.2).
- 3% were in non-clinical roles (excluding admin and management) in Cultural and Consumer Advisor roles (Table 4.2).

Non-DHB Workforce:

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 122 non-DHB services that were identified for the 2020 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 services in Auckland which have Asian staff members available to work with Asian service users and their families such as the *Asian Family Services*. In other regions, Asian children, adolescents, and their families have access to non-DHB migrant and refugee services such as the *Red Cross Refugee Trauma Recovery (Capital & Coast).*

From 2018 to 2020/21:

- A decrease of two seen, from 35 to 33 (headcount) (Table 4.1).

2020/21:

- 52% in clinical roles made up of 30% AOD Practitioners, 6% Social Workers, 3% Nurses and 3% Counsellors (Table 4.2).
- 42% were in non-clinical roles (excluding admin and management roles): 36% Mental Health Support Workers, 3% Youth Workers and 3% Peer Support Workers (Table 4.2).
- 45% were based in the Northern region, followed by 24% in Central, 21% in Midland and 9% in Southern (Table 4.2).

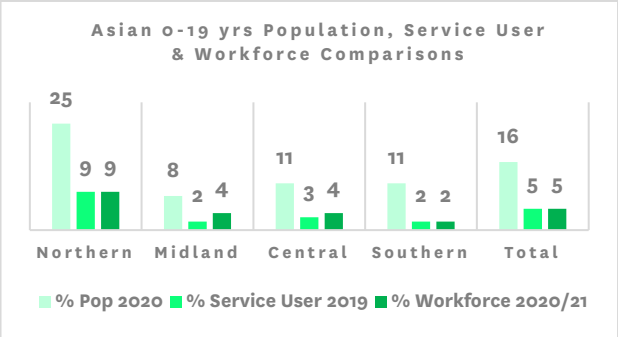
Table 4.1. Asian ICAMH/AOD Workforce by Occupation (2020/21)

Asian ICAMH/AOD Workforce by Occupation (Headcount, 2020/21)	DHB		DHB Total	Non-DHB[3]	Total
	Inpatient	Community			
Alcohol & Drug Practitioner	-	1	1	10	11
Child & Adolescent Psychiatrist	1	5	6	-	6
Clinical Placement/Intern	-	2	2	-	2
Nurse	14	12	26	1	27
Occupational Therapist	-	9	9	-	9
Psychologist	2	15	17	-	17
Registrar/SMO	-	3	3	-	3
Social Worker	1	8	9	2	11
Other Clinical[1]	-	3	3	4	7
Clinical Sub-Total	**18**	**58**	**76**	**17**	**93**
Cultural	-	1	1	-	1
Mental Health Consumer	-	1	1	-	1
Mental Health Support	-	-	-	12	12
Peer Support	-	-	-	1	1
Youth Worker	-	-	-	1	1
Non-Clinical Sub-Total	**-**	**2**	**2**	**14**	**16**
Administration	-	3	3	-	3
Manager	-	-	-	2	2
Total	**18**	**63**	**81**	**33**	**114**

1. Other Clinical = Counsellor; Psychotherapist; Paediatrician; Clinical Team Coordinator; Educator.
2. Includes PHOs.

Asian Population, Service Users and Workforce Comparisons

Due to low numbers of Asian service users accessing services (5% of all service users), the current Asian workforce appears to be representative of service demand. However, 10-year projections indicate a 26% population growth in the Asian population and *Youth19* data indicates growing mental health concerns. This could potentially lead to an increase in demand for services and would therefore need to be factored into future service and workforce development activities. The need to increase, retain, strengthen, and support the Asian workforce across all occupations remains a key focus.



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

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 NZ (Census 2018). Because of this increase, one would anticipate an increase in demand for and utilisation of mental health services. 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.

A large proportion of the Asian population are overseas born. While one may assume that most Asian migrants are mentally healthy, the consequences of the immigration process may lead to a higher risk of developing mental health problems (Ho et al., 2003; Wynaden et al., 2005). The latest Youth19 survey has also indicated concerning mental health needs (depressive symptoms, suicidal ideation, and attempts) for both East and South Asians, significantly for females. Therefore, areas with large populations of Asian infants, children, and adolescents, such as the Northern region (Auckland, Counties Manukau and Waitemata DHBS), Central (Capital & Coast, Hutt Valley and MidCentral) and Southern (Canterbury), may have a high need for culturally specific mental health services. Intervening and providing services earlier would also improve outcomes for all Asian children and young people.

While some improvements can be seen in access to services for the 0–19-year Asian population, access has continued to be the lowest (1.35% access rate) out of the four ethnic groups (Māori 5.72%; Other Ethnicity 5.15%; Pacific 2.87%) and therefore continues to remain well below the target access rate (5%), indicating unmet mental health needs. Therefore, low access rates to services remains a concern for the Asian 0–19-year population. Given the rapid growth and increasing trend in the Asian population and identified mental health needs, there is an urgent need to improve equitable access to services for the Asian population. Reducing stigma of mental health needs for the Asian population and reducing barriers to accessing services, as identified in the Youth19 report, need to be actioned.

Low access rates to services could also be partly due to the lack of culturally appropriate services available for the Asian population, especially in the areas of highest populations and need (Northern and Central regions). For instance, almost two-thirds of the Asian infant, child and adolescent population reside in the Northern region (largely in the greater Auckland area), yet there are no services providing dedicated Asian infant, child and adolescent mental health/AOD services. Therefore, significant investment in service development and provision of culturally appropriate services for the Asian 0–19-year population in areas of high population and need is also required.

The growth in the Asian workforce remains slow and latest workforce data showed a -3% decrease since 2018. This lag in growth could be due to the lack of Asian practitioners available for recruitment, demand for practitioners from international organisations offering better renumeration, and the large variety of Asian sub-ethnicities/languages which makes it difficult to match clinicians to service user. In addition, increasing the Asian workforce is not often a priority for services, especially for NGOs, as funding is limited.

Growing a qualified and diverse Asian workforce is a long and slow process and requires a long-term approach, therefore, the interim focus should be on retaining, supporting, and strengthening the current Asian workforce. Furthermore, because there are no culturally appropriate services currently available for Asian infants, children, and their families, they are either not accessing services at all or accessing mainstream services (DHBs), thereby are largely seen by the non-Asian workforce. RSP data have shown that services have identified the need for further development in cultural knowledge and skills. While culturally and linguistically diverse (CALD) resources may be well known and available to services, very little is specifically known about the Asian cultural competency levels of the workforce. Therefore, another critical area of workforce development focus for both the Asian and non-Asian workforces includes identifying and assessing the required clinical and cultural skills and knowledge gaps for targeted development.

Recommendations

Based on the latest data and consultation with our Asian advisor, the following recommendations are made to support improvements in the mental health outcomes for all Asian infants, children, adolescents, and their families, beginning with formalising and embedding the need to improve Asian health and mental health wellbeing into government policy and strategy.

Engage in m**ental health promotion to increase mental health literacy and reduce stigma**:

- Data show the need for mental health services remains high, and may increase, for Asian children and youth, yet access to services remains low, highlighting significant and ongoing unmet mental health needs. Low mental health literacy and stigma make up a number of barriers for such access to services. Therefore, more mental health promotion, resources and activities that are ethnic and language-specific for Asian families and youth are needed in community-based settings such as schools, as well as online, to improve attitudes and knowledge about mental health, reduce stigma, and provide information on how to access services early when needed. These resources need to be developed in collaboration with Asian youth and community leaders, and supported and promoted by them, to help alleviate some of the access to service issues highlighted for Asian infants, children, adolescents, and their families.

Develop and provide early intervention programmes, services, and workforce:

- 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.
    - *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 SDQ scores from the New Zealand Health Survey data (Ministry of Health, 2020). These could include infant health/mental health (prenatal and antenatal workshops, emotion regulation and normalising postnatal depression and childhood development disorders).
    - *Evidence-based parenting programmes*, such as *Triple P – Positive Parenting Programme* and *Incredible Years*, have been shown to be effective, evidence-based programmes for preventing and reducing children's emotional and behavioural problems. *Triple P Primary Care* 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. Providing evidence-based parenting programmes that work across cultures, socioeconomic groups and in different kinds of family structures is critical for intervening early and improving long-term outcomes for children.

- Develop digital tools and resources: Access to the internet and internet use, including for seeking health information, are highest among Asian young people compared to other ethnicities in NZ (Gibson et al., 2013; Statistics NZ, 2004b; Peiris-John et al., 2014). The COVID-19 pandemic has fast-tracked the development of many everyday activities to web-based applications and therefore provides a greater opportunity for the development of local and international evidence-based, validated mental health apps, online self-help guides and e-therapy tools. While there are concerns and negative links between the use of smartphones, social media, and youth mental health (Abi-Jaoude et al., 2020; Gurney et al., 2021; Ioane et al., 2021a), a balanced approach needs to be taken. There are many positive aspects of the use of online platforms providing important benefits such as easier and earlier access to social support, information, and therapy that young people may have difficulties accessing in real life. Development and promotion (especially in schools) of such tools and resources, in a variety of Asian languages, and keeping Asian young people engaged is an effective way of intervening early and increasing early access to in-person treatment. COVID-19 lockdowns have forced and sped up the digital transformation of the mental health sector. Services have reported greater use of virtual appointments, telephone and text messages and use of social media to maintain contact and service provision, as a matter of necessity, but may continue to build on "virtual" contact for those who prefer this method of service delivery.

  EXAMPLE:

  SPARX is a NZ-developed, online computerised cognitive behavioural therapy program which has been shown to be an effective resource for adolescents with depression at primary healthcare sites, resulting in clinically significant reductions in depression, anxiety and hopelessness and an improvement in quality of life (Merry et al., 2012). Studies have also shown effectiveness and acceptability in culturally diverse adolescents excluded from mainstream education (Fleming et al., 2012). A revised version of SPARX, SPARX-R has since been developed for universal use such as in healthcare classes in schools (Fleming et al., 2019).

- Expand and enhance school-based health education and services: School settings provide an opportunity to reach a large number of young people, especially those who are at risk of experiencing poor mental health outcomes. School-based mental health promotion and education as well as cultural training could be an important part of the curriculum for youth. By doing so, we may be able to reconnect young people with their cultural roots and whakapapa and develop a more universal cultural competency among the next generation. This will be immensely helpful for young people to be able to draw on their own and different cultural views on mental health/well-being. Schools can also play a crucial role in enabling interventions targeted at an earlier stage. Youth12 findings on health services in secondary schools showed positive associations between aspects of health services in schools 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 (Clark et al., 2013). There is also mounting evidence on the effectiveness of delivering both universal and targeted school-based learning and mental health interventions that improve outcomes for the short and long term (Clarke et al., 2021). Guidelines for youth healthcare in secondary schools have been developed to assist planning, funding, or providing primary health services in secondary schools and can be used as a tool to continuously improve the quality of these services (Ministry of Health, 2014). And as part of the COVID-19 recovery response, schools are going to be important for identifying early intervention opportunities. Not only should they be able to recognise early signs of mental distress, but staff would also need to facilitate their students' prompt access to support (Poulton et al., 2020).
- 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 healthcare with physical complaints (Wynaden et al., 2005). Recruiting an Asian primary mental health workforce (such as Health Improvement Practitioners) that matches the diversity of the Asian population is important. Additionally, educating and developing the cultural competencies of GPs and other primary level workforces on the cultural issues relating to the mental health needs of Asian infants, children and adolescents is essential. There needs to be continued investment in the development and provision of primary health services, development of new roles, and supporting and strengthening the knowledge and skill development of the respective workforces for early detection and intervention and thereby potentially preventing the need for specialist mental health services. This also could alleviate the high demand on 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 care 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 collectivist cultural backgrounds, many 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 and increasing mental health concerns, as indicated by the latest Youth19 survey, has potentially led to an increased need/demand for specialist mental health services and may continue. 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 service users, 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: The 10-year population projections for the Asian population show continued growth; 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 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 ICAMH/AOD* 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 ICAMH/AOD* 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 immediate focus. High turnover of the specialist workforce continues to exacerbate workforce shortages. Identifying reasons and addressing these factors need to be conducted. 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. Online training modules and a face-to-face workshop on self-care (which has received positive feedback from the workforce) have been developed and are widely available. The COVID-19 pandemic has highlighted and increased the need to look after staff wellbeing. Services have implemented flexible work conditions and regular wellbeing checks and activities over the past year, and this will need to be remain prioritised alongside responding to ever-increasing service demand.
- *Expand and develop existing roles:* Development of new and existing roles could be a fast-track solution to address shortages, such as exploring whether interpreters could train as cultural advisors, and possible co-therapists.
- *Explore new ways of working:* 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 provide cultural support to DHBs. For instance, establishing a consultation team of Asian clinicians, who are available to regions, can also aid in clarifying diagnosis and ensuring that culturally appropriate clinical interventions are used for Asian service users.

- Increase workforce capability: Given the growing complexity of infant, child, and adolescent mental health needs (e.g., complex interactions between socioeconomic and psychosocial factors), strengthening the current Asian workforce with the right knowledge and skills is another key area of focus. There is an ongoing need to strengthen and support the existing Asian and non-Asian ICAMH/AOD workforce to work more effectively— culturally and clinically— with Asian service users and their families.

- *Identify and develop knowledge and skills of the Asian workforce:* As a first step, services need to be actively engaged in identifying current competency levels and targeting development based on gaps using competency assessment tools such as *Real Skills Plus ICAMH/AOD*. Currently there are no data on the RSP competency levels of the Asian workforce, but overall data (all ethnicities) show further developments are needed for both knowledge and skills on assessment and intervention (especially therapeutic interventions) and on leadership and cultural aspects. Therefore, training and professional development would need to be targeted to these areas.
- *Identify and strengthen cultural knowledge and skills of the Asian workforce:* Identifying the levels of cultural competencies of the current Asian workforce using appropriate competency development tools (e.g., CALD) to work effectively with Asian children, young people and families is also required. Even within the current Asian workforce, staff will require different levels of competency development; for instance, NZ-born Asian staff will have different competency levels and areas of development compared to overseas-born Asian staff. Providing and having access to ongoing cultural supervision from an ethnically diverse group of experienced Asian practitioners should also be considered to provide additional support to both the Asian and non-Asian workforces. Investing in the capability/competency development of the Asian workforce can also enable qualified Asian staff to provide cultural supervision to the non-Asian workforce, to ensure clinical and cultural safety for Asian service users and their families, until a representative Asian workforce is built up.
- *Enable access to targeted knowledge and skills training:* Once knowledge and skill gaps have been identified, the workforce needs to be 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 and development. Furthermore, staff shortages hinder access to training as staff cannot be released for training. Until more funding is allocated to NGOs, and recruitment and retention issues are addressed, shared training between DHB and NGOs and the development and provision of more online, e-based training could provide opportunities for further development, until adequate resources and workforce capacity are available.

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Appendices

Appendix A: Population Data

Table 1. 0-19 yrs. Population by Ethnicity & DHB Area (2018-2030)

0-19 yrs. Population by Ethnicity & DHB Area (2018, 2020, 2030)	Total				Māori				Pacific				Asian				Other Ethnicity			
	2018	2020	2030	% Change (20-30)	2018	2020	2030	% Change (20-30)	2018	2020	2030	% Change (30-20)	2018	2020	2030	% Change (20-30)	2018	2020	2030	% Change (20-30)
Northern	487,250	491,740	503,930	2.5	104,540	107,390	112,200	4.5	83,260	84,200	85,260	1.3	108,830	122,470	149,720	22.3	192,230	177,680	156,750	-11.8
Northland	47,070	50,920	50,950	0.1	25,590	27,690	29,760	7.5	1,500	1,440	1,760	22.2	1,680	1,970	2,880	46.2	18,300	19,820	16,550	-16.5
Waitemata	159,010	161,240	172,260	6.8	26,130	26,120	28,430	8.8	16,570	16,600	17,880	7.7	36,050	42,600	55,460	30.2	80,240	75,920	70,490	-7.2
Auckland	116,540	109,320	107,620	-1.6	14,230	13,640	12,790	-6.2	19,190	18,120	16,810	-7.2	34,010	34,640	40,710	17.5	49,110	42,920	37,310	-13.1
Counties Manukau	164,630	170,260	173,100	1.7	38,590	39,940	41,220	3.2	46,000	48,040	48,810	1.6	37,090	43,260	50,670	17.1	44,580	39,020	32,400	-17.0
Midland	249,620	265,655	264,680	-0.4	101,320	108,120	115,700	7.0	8,895	8,820	10,890	23.5	16,800	22,295	29,590	32.7	120,180	126,420	108,500	-14.2
Waikato	112,460	118,740	120,450	1.4	40,600	43,350	47,820	10.3	5,000	4,950	6,170	24.6	8,390	12,960	16,780	29.5	56,100	57,480	49,680	-13.6
Lakes	29,600	32,070	30,420	-5.1	15,710	17,060	17,370	1.8	930	1,020	1,060	3.9	1,750	2,290	3,110	35.8	11,190	11,700	8,880	-24.1
Bay of Plenty	60,740	66,655	67,210	0.8	25,170	26,960	29,710	10.2	1,830	1,745	2,390	37.0	4,450	4,920	6,790	38.0	29,260	33,030	28,320	-14.3
Tairawhiti	14,840	14,945	14,140	-5.4	9,820	10,020	9,390	-6.3	515	430	480	11.6	340	305	360	18.0	4,160	4,190	3,910	-6.7
Taranaki	31,980	33,245	32,460	-2.4	10,020	10,730	11,410	6.3	620	675	790	17.0	1,870	1,820	2,550	40.1	19,470	20,020	17,710	-11.5
Central	233,640	230,995	222,360	-3.7	69,540	68,980	74,960	8.7	18,455	17,645	19,410	10.0	23,240	25,310	32,630	28.9	122,410	119,060	95,360	-19.9
Hawke's Bay	44,690	47,240	45,200	-4.3	18,840	19,940	21,660	8.6	2,760	2,700	3,400	25.9	2,200	2,470	3,690	49.4	20,890	22,130	16,450	-25.7
MidCentral	16,400	17,825	16,990	-4.7	7,010	7,500	7,890	5.2	680	795	910	14.5	580	760	1,260	65.8	8,150	8,770	6,930	-21.0
Whanganui	46,600	48,410	47,220	-2.5	15,430	16,370	18,090	10.5	2,390	2,360	2,860	21.2	3,940	4,060	5,040	24.1	24,840	25,620	21,230	-17.1
Capital & Coast	38,490	40,450	38,690	-4.4	10,970	11,110	12,110	9.0	4,410	4,150	4,280	3.1	4,810	5,830	7,150	22.6	18,300	19,360	15,150	-21.7
Hutt	76,450	77,070	74,260	-3.6	13,910	14,060	15,210	8.2	7,830	7,640	7,960	4.2	11,370	12,190	15,490	27.1	43,350	43,180	35,600	-17.6
Wairarapa	11,010	11,800	11,325	-4.0	3,380	3,730	4,250	13.9	385	405	435	7.4	340	485	640	32.0	6,880	7,180	6,000	-16.4
Southern	274,420	281,140	280,590	-0.2	46,560	50,270	57,380	14.1	9,975	11,095	13,670	23.2	23,985	30,245	39,860	31.8	193,780	189,530	169,680	-10.5
Nelson Marlborough	35,280	36,330	34,490	-5.1	6,740	7,280	8,420	15.7	1,090	1,140	1,300	14.0	1,970	2,420	3,460	43.0	25,500	25,490	21,310	-16.4
West Coast	8,040	7,340	6,740	-8.2	1,640	1,550	1,630	5.2	175	135	150	11.1	245	275	340	23.6	5,900	5,380	4,620	-14.1
Canterbury	136,700	140,000	144,250	3.0	21,560	23,390	27,490	17.5	5,710	6,400	7,860	22.8	15,880	19,860	26,230	32.1	93,530	90,350	82,670	-8.5
South Canterbury	14,050	14,170	14,220	0.4	2,300	2,530	2,980	17.8	250	390	510	30.8	650	940	1,350	43.6	10,790	10,310	9,380	-9.0
Southern	80,350	83,300	80,890	-2.9	14,320	15,520	16,860	8.6	2,750	3,030	3,850	27.1	5,240	6,750	8,480	25.6	58,060	58,000	51,700	-10.9
TOTAL	1,246,600	1,269,530	1,271,560	0.2	321,970	334,760	360,240	7.6	120,730	121,760	129,230	6.1	175,260	200,320	251,800	25.7	628,650	612,690	530,290	-13.4

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. Northern Region 0-19 yrs. Service User by DHB Area & Ethnicity (2017 & 2019)

Service Users by Ethnicity & Gender (2017)							Service Users by Ethnicity & Gender (2019)						% Change				
DHB of Domicile	Gender	Ethnicity				Total	Ethnicity				Total		Ethnicity				Total
		Asian	Māori	Other	Pacific		Asian	Māori	Other	Pacific			Asian	Māori	Other	Pacific	
Northland	Female	10	539	440	35	1,024	13	542	417	32	1,004		30	1	-5	-9	-2
	Male	7	762	559	26	1,354	7	699	493	25	1,224		-	-8	-12	-4	-10
	Total	17	1,301	999	61	2,378	20	1,241	910	57	2,228		18	-5	-9	-7	-6
Waitemata	Female	218	665	1,685	205	2,773	264	704	1,691	196	2,855		21	6	0.4	-4	3
	Male	234	1,104	1,973	386	3,697	219	980	1,861	369	3,429		-6	-11	-6	-4	-7
	Unknown	-	-	-	-	-	-	4	-	-	4		-	-	-	-	-
	Total	452	1,769	3,658	591	6,470	483	1,688	3,552	565	6,288		7	-5	-3	-4	-3
Auckland	Female	289	577	1,291	318	2,475	366	639	1,334	273	2,612		27	11	3	-14	6
	Male	262	733	1,127	322	2,444	271	811	1,177	341	2,600		3	11	4	6	6
	Unknown	-	-	-	-	-	-	-	1	-	1		-	-	-	-	-
	Total	551	1,310	2,418	640	4,919	637	1,450	2,512	614	5,213		16	11	4	-4	6
Counties Manukau	Female	244	941	1,061	606	2,852	286	984	1,013	532	2,815		17	5	-5	-12	-1
	Male	221	1,102	1,177	630	3,130	298	1,060	1,216	563	3,137		35	-4	3	-11	0.2
	Unknown	-	-	-	-	-	-	2	3	1	6		-	-	-	-	-
	Total	465	2,043	2,238	1,236	5,982	584	2,046	2,232	1,096	5,958		26	0.1	-0.3	-11	-0.4
Regional Total		1,485	6,423	9,313	2,528	19,749	1,724	6,425	9,206	2,332	19,687		16	-	-1	-8	-0.3
National Total		2,184	17,860	31,329	3,519	54,892	2,590	18,935	31,912	3,486	56,923		19	6	2	-1	4

Note: Unknown refers to gender not stated or inadequately described.

Table 2. Midland Region 0-19 yrs. Service User by DHB Area & Ethnicity (2017 & 2019)

Service Users by Ethnicity & Gender (2017)							Service Users by Ethnicity & Gender (2019)						% Change				
DHB of Domicile	Gender	Ethnicity				Total	Ethnicity				Total		Ethnicity				Total
		Asian	Māori	Other	Pacific		Asian	Māori	Other	Pacific			Asian	Māori	Other	Pacific	
Waikato	Female	60	778	1,572	76	2,486	90	1,106	1,871	83	3,150		50	42	19	9	27
	Male	35	1,165	1,658	85	2,943	75	1,357	1,841	107	3,380		114	16	11	26	15
	Unknown	-	-	-	-	-	-	-	1	-	1		-	-	-	-	-
	Total	95	1,943	3,230	161	5,429	165	2,463	3,713	190	6,531		74	27	15	18	20
Lakes	Female	12	349	430	15	806	17	381	493	16	907		42	9	15	7	13
	Male	4	415	486	19	924	10	415	423	13	861		150	-	-13	-32	-7
	Unknown	-	-	-	-	-	-	2	-	-	2		-	-	-	-	-
	Total	16	764	916	34	1,730	27	798	916	29	1,770		69	4	-	-15	2
Bay of Plenty	Female	22	765	883	41	1,711	27	748	832	28	1,635		23	-2	-6	-32	-4
	Male	33	970	930	34	1,967	19	909	885	29	1,842		-42	-6	-5	-15	-6
	Unknown	-	-	-	-	-	-	-	1	-	1		-	-	-	-	-
	Total	55	1,735	1,813	75	3,678	46	1,657	1,718	57	3,478		-16	-4	-5	-24	-5
Tairawhiti	Female	7	184	93	6	290	2	301	122	13	438		-71	64	31	117	51
	Male	1	224	121	3	349	6	329	168	4	507		500	47	39	33	45
	Total	8	408	214	9	639	8	630	290	17	945		-	54	36	89	48
Taranaki	Female	8	189	447	9	653	8	159	341	3	511		-	-16	-24	-67	-22
	Male	9	229	452	8	698	3	165	336	15	519		-67	-28	-26	88	-26
	Total	17	418	899	17	1,351	11	324	677	18	1,030		-35	-22	-25	6	-24
	Regional Total	191	5,268	7,072	296	12,827	257	5,872	7,314	311	13,754		35	11	3	5	7
	National Total	2,184	17,860	31,329	3,519	54,892	2,590	18,935	31,912	3,486	56,923		19	6	2	-1	4

Note: Unknown refers to gender not stated or inadequately described.

Table 3. Central Region 0-19 yrs. Service User by DHB Area & Ethnicity (2017 & 2019)

Service Users by Ethnicity & Gender (2017)							Service Users by Ethnicity & Gender (2019)					% Change				
DHB of Domicile	Gender	Ethnicity				Total	Ethnicity				Total	Ethnicity				Total
		Asian	Māori	Other	Pacific		Asian	Māori	Other	Pacific		Asian	Māori	Other	Pacific	
Hawke's Bay	Female	7	356	459	19	841	4	377	426	26	833	-43	6	-7	37	-1
	Male	8	425	433	29	895	3	362	358	27	750	-63	-15	-17	-7	-16
	Unknown	-	-	-	-	-	-	-	2	-	2	-	-	-	-	-
	Total	15	781	892	48	1,736	7	739	786	53	1,585	-53	-5	-12	10	-9
Midcentral	Female	20	260	654	23	957	16	288	531	32	867	-20	11	-19	39	-9
	Male	24	343	681	27	1,075	21	308	539	28	896	-13	-10	-21	4	-17
	Total	44	603	1,335	50	2,032	37	596	1,070	60	1,763	-16	-1	-20	20	-13
Whanganui	Female	5	175	252	14	446	4	206	264	10	484	-20	18	5	-29	9
	Male	3	164	247	5	419	6	199	256	7	468	100	21	4	40	12
	Unknown	-	-	1	-	1	-	-	1	-	1	-	-	-	-	-
	Total	8	339	500	19	866	10	405	521	17	953	25	19	4	-11	10
Capital & Coast	Female	75	484	989	116	1,664	99	596	1,144	165	2,004	32	23	16	42	20
	Male	74	769	954	140	1,937	99	824	1,141	155	2,219	34	7	20	11	15
	Unknown	-	-	-	-	-	-	2	2	-	4	-	-	-	-	-
	Total	149	1,253	1,943	256	3,601	198	1,422	2,287	320	4,227	33	13	18	25	17
Hutt Valley	Female	37	243	561	46	887	33	240	489	52	814	-11	-1	-13	13	-8
	Male	22	260	526	34	842	28	253	332	28	641	27	-3	-37	-18	-24
	Unknown	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-
	Total	59	503	1,087	80	1,729	61	494	821	80	1,456	3	-2	-24	-	-16
Wairarapa	Female	2	94	176	7	279	3	103	161	9	276	50	10	-9	29	-1
	Male	1	92	139	-	232	1	71	141	2	215	-	-23	1	-	-7
	Total	3	186	315	7	511	4	174	302	11	491	33	-6	-4	57	-4
	Regional Total	278	3,665	6,072	460	10,475	317	3,830	5,787	541	10,475	14	5	-5	18	0
	National Total	2,184	17,860	31,329	3,519	54,892	2,590	18,935	31,912	3,486	56,923	19	6	2	-1	4

Note: Unknown refers to gender not stated or inadequately described.

Table 4. Southern Region 0-19 yrs. Service User by DHB Area & Ethnicity (2017 & 2019)

Service Users by Ethnicity & Gender (2017)							Service Users by Ethnicity & Gender (2019)						% Change					
DHB of Domicile	Gender	Ethnicity				Total	Ethnicity				Total		Ethnicity				Total	
		Asian	Māori	Other	Pacific		Asian	Māori	Other	Pacific			Asian	Māori	Other	Pacific		
Nelson Marlborough	Female	10	165	697	7	879	18	132	624	11	785		80	-20	-10	57	-11	
	Male	15	175	634	10	834	12	141	557	11	721		-20	-19	-12	10	-14	
	Unknown	-	1	-	-	1	-	-	2	-	2		-	-	-	-	100	
	Total	25	341	1,331	17	1,714	30	273	1,183	22	1,508		20	-20	-11	29	-12	
West Coast	Female	1	35	136	-	172	1	39	129	2	171		0	11	-5	-	-1	
	Male	4	51	231	-	286	2	50	184	5	241		-50	-2	-20	-	-16	
	Total	5	86	367	-	458	3	89	313	7	412		-40	3	-15	-	-10	
Canterbury	Female	76	582	1,934	63	2,655	81	678	2,163	78	3,000		7	16	12	24	13	
	Male	53	608	1,821	61	2,543	80	733	1,915	67	2,795		51	21	5	10	10	
	Total	129	1,190	3,755	124	5,198	161	1,411	4,078	145	5,795		25	19	9	17	11	
South Canterbury	Female	7	99	373	3	482	4	84	366	7	461		-43	-15	-2	133	-4	
	Male	9	80	343	7	439	2	88	344	9	443		-78	10	0.3	29	1	
	Total	16	179	716	10	921	6	172	710	16	904		-63	-4	-1	60	-2	
Southern	Female	28	304	1,392	31	1,755	42	431	1,823	55	2,351		50	42	31	77	34	
	Male	27	383	1,298	53	1,761	48	421	1,493	56	2,018		78	10	15	6	15	
	Unknown	-	-	-	-	-	-	2	3	-	5		-	-	-	-	-	
	Total	55	687	2,690	84	3,516	90	854	3,319	111	4,374		64	24	23	32	24	
	Regional Total	230	2,483	8,859	235	11,807	290	2,799	9,603	301	12,993		26	13	8	28	10	
Overseas	Female	-	11	7	-	18	-	4	1	1	6		-	-64	-86	-	-67	
	Male	-	10	6	-	16	2	5	1	-	8		-	-50	-83	-	-50	
	Total	-	21	13	-	34	2	9	2	1	14		-	-57	-85	-	-59	
	National Total	2,184	17,860	31,329	3,519	54,892	2,590	18,935	31,912	3,486	56,923		19	6	2	-1	4	

Note: Unknown refers to gender not stated or inadequately described.

Table 5. Northern Region 0-19 yrs. Service User Access Rates by DHB Area, Ethnicity & Age Group (yrs.) (2017 & 2019)

2017 & 2019 Service User Access Rates by Region, DHB, Service, Ethnicity & Age Groups (yrs)																				
Region/DHB Area: Northern Region	Year	Service Type	Māori				Pacific				Asian				Other Ethnicity				Total			
			0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19
Northland	2017	DHB	0.88%	4.38%	7.21%	3.15%	0.39%	5.00%	7.58%	3.15%	0.0%	0.91%	3.06%	0.87%	1.60%	5.22%	9.66%	4.4%	1.1%	4.67%	8.04%	3.57%
		NGO	0.01%	2.16%	6.35%	1.96%	0.0%	1.47%	3.33%	1.12%	0.0%	0.3%	0.56%	0.19%	0.02%	0.74%	3.27%	0.94%	0.02%	1.47%	4.85%	1.47%
		TOTAL	0.89%	6.53%	13.56%	5.12%	0.39%	6.47%	10.91%	4.27%	0.00%	1.21%	3.61%	1.06%	1.62%	5.96%	12.93%	5.34%	1.12%	6.14%	12.89%	5.04%
	2019	DHB	0.80%	3.64%	7.31%	2.92%	0.91%	3.06%	8.85%	2.95%	0.28%	0.95%	2.78%	0.91%	0.92%	4.42%	8.43%	3.63%	0.83%	3.85%	7.67%	3.12%
		NGO	0.02%	1.83%	5.35%	1.62%	0.0%	1.39%	4.23%	1.15%	0.0%	0.0%	0.83%	0.16%	0.01%	0.85%	3.03%	0.94%	0.02%	1.37%	4.19%	1.29%
		Total	0.82%	5.47%	12.66%	4.54%	0.91%	4.44%	13.08%	4.1%	0.28%	0.95%	3.61%	1.07%	0.93%	5.27%	11.46%	4.57%	0.84%	5.22%	11.87%	4.41%
Waitemata	2017	DHB	2.06%	6.22%	17.41%	6.5%	0.90%	2.61%	9.73%	3.52%	0.70%	1.31%	2.56%	1.28%	2.28%	4.39%	8.30%	4.4%	1.72%	3.93%	8.54%	3.97%
		NGO	0.01%	0.22%	1.28%	0.35%	0.0%	0.05%	0.27%	0.08%	0.0%	0.0%	0.06%	0.01%	0.02%	0.04%	0.36%	0.12%	0.01%	0.06%	0.42%	0.13%
		Total	2.07%	6.44%	18.69%	6.85%	0.9%	2.66%	10.0%	3.60%	0.70%	1.31%	2.62%	1.30%	2.30%	4.43%	8.66%	4.52%	1.73%	3.99%	8.96%	4.09%
	2017	DHB	1.92%	5.68%	16.43%	6.09%	1.04%	2.47%	8.68%	3.34%	0.47%	1.26%	3.10%	1.18%	2.03%	4.69%	8.76%	4.5%	1.47%	3.84%	8.67%	3.79%
		NGO	0.04%	0.16%	1.71%	0.44%	0.01%	0.0%	0.26%	0.07%	0.0%	0.0%	0.02%	0.01%	0.02%	0.03%	0.36%	0.11%	0.02%	0.04%	0.48%	0.13%
		Total	1.96%	5.84%	18.13%	6.54%	1.05%	2.47%	8.95%	3.41%	0.47%	1.26%	3.12%	1.19%	2.05%	4.72%	9.12%	4.61%	1.48%	3.88%	9.14%	3.93%
Auckland	2017	DHB	2.89%	8.72%	17.58%	7.9%	1.10%	3.35%	5.02%	2.71%	1.03%	1.90%	2.22%	1.57%	2.43%	5.12%	8.89%	4.67%	1.88%	4.47%	6.98%	3.85%
		NGO	0.31%	1.31%	3.25%	1.28%	0.06%	0.35%	1.70%	0.58%	0.01%	0.09%	0.12%	0.06%	0.06%	0.1%	0.67%	0.22%	0.08%	0.28%	0.95%	0.36%
		Total	3.20%	10.03%	20.83%	9.18%	1.17%	3.70%	6.72%	3.29%	1.05%	1.99%	2.35%	1.64%	2.49%	5.22%	9.56%	4.89%	1.96%	4.75%	7.93%	4.21%
	2019	DHB	3.32%	8.48%	22.41%	9.47%	1.41%	3.21%	5.29%	2.92%	0.95%	1.95%	3.32%	1.81%	2.69%	5.94%	9.78%	5.56%	1.98%	4.70%	8.49%	4.44%
		NGO	0.36%	0.83%	2.85%	1.11%	0.05%	0.44%	1.08%	0.42%	0.02%	0.07%	0.1%	0.05%	0.06%	0.14%	0.5%	0.2%	0.08%	0.26%	0.74%	0.31%
		Total	3.68%	9.31%	25.26%	10.58%	1.46%	3.66%	6.37%	3.34%	0.96%	2.01%	3.41%	1.86%	2.75%	6.08%	10.28%	5.77%	2.06%	4.96%	9.23%	4.75%
Counties Manukau	2017	DHB	1.61%	4.96%	7.26%	3.69%	0.64%	2.13%	3.56%	1.73%	0.49%	1.23%	2.01%	1.02%	2.05%	5.32%	8.07%	4.39%	1.20%	3.56%	5.24%	2.75%
		NGO	0.07%	1.71%	5.37%	1.66%	0.04%	0.91%	2.88%	0.96%	0.11%	0.19%	0.65%	0.26%	0.22%	0.54%	1.41%	0.59%	0.11%	0.84%	2.52%	0.87%
		Total	1.68%	6.67%	12.63%	5.35%	0.68%	3.04%	6.45%	2.69%	0.59%	1.42%	2.66%	1.28%	2.27%	5.86%	9.48%	4.99%	1.31%	4.4%	7.76%	3.62%
	2019	DHB	1.94%	4.41%	8.01%	3.9%	0.68%	1.87%	2.79%	1.51%	0.60%	1.60%	2.34%	1.21%	3.07%	6.01%	7.81%	5.13%	1.48%	3.45%	5.13%	2.85%
		NGO	0.12%	1.12%	4.06%	1.24%	0.04%	0.56%	2.42%	0.76%	0.07%	0.26%	0.41%	0.19%	0.20%	0.34%	1.13%	0.49%	0.10%	0.57%	1.98%	0.67%
		Total	2.07%	5.53%	12.07%	5.14%	0.72%	2.43%	5.21%	2.27%	0.66%	1.86%	2.75%	1.40%	3.26%	6.35%	8.94%	5.62%	1.58%	4.02%	7.1%	3.52%
Regional Total	2017	DHB	1.72%	5.60%	11.31%	4.84%	0.79%	2.56%	5.18%	2.34%	0.71%	1.45%	2.27%	1.28%	2.20%	4.87%	8.51%	4.47%	1.52%	4.00%	7.01%	3.49%
		NGO	0.07%	1.41%	4.28%	1.35%	0.04%	0.62%	2.09%	0.70%	0.04%	0.1%	0.27%	0.12%	0.08%	0.25%	0.92%	0.33%	0.06%	0.53%	1.63%	0.57%
		Total	1.79%	7.01%	15.59%	6.19%	0.83%	3.18%	7.27%	3.04%	0.75%	1.55%	2.54%	1.40%	2.28%	5.12%	9.43%	4.8%	1.58%	4.53%	8.64%	4.05%
	2019	DHB	1.81%	5.04%	11.98%	4.9%	0.91%	2.3%	4.59%	2.20%	0.64%	1.57%	2.91%	1.37%	2.28%	5.26%	8.78%	4.8%	1.51%	3.90%	7.33%	3.54%
		NGO	0.11%	1.04%	3.63%	1.13%	0.03%	0.44%	1.71%	0.56%	0.03%	0.11%	0.19%	0.09%	0.06%	0.22%	0.83%	0.31%	0.03%	0.2%	0.67%	0.23%
		Total	1.91%	6.08%	15.6%	6.02%	0.94%	2.74%	6.3%	2.76%	0.67%	1.68%	3.1%	1.46%	2.35%	5.48%	9.61%	5.11%	1.55%	4.09%	8.0%	3.77%

*Calculated using 2017 & 2019 Population Projections (Base 2013 Census, prioritised ethnicity) & full year Service User data from PRIMHD.

Table 6. Midland Region 0-19 yrs. Service User Access Rates by DHB Area, Ethnicity & Age Group (yrs.) (2017 & 2019)

2017 & 2019 Service User Access Rates by Region, DHB, Service, Ethnicity & Age Groups (yrs)																						
Region/DHB Area: Midland Region	Year	Service Type	Māori				Pacific				Asian				Other Ethnicity				Total			
			0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19
Waikato	2017	DHB	0.52%	2.24%	4.86%	1.91%	0.33%	1.0%	2.62%	0.98%	0.09%	0.29%	1.21%	0.4%	1.16%	3.46%	5.65%	2.94%	0.77%	2.7%	4.89%	2.26%
		NGO	0.67%	3.92%	7.24%	2.93%	1.64%	2.73%	3.88%	2.37%	0.15%	0.59%	1.33%	0.52%	1.13%	3.36%	4.84%	2.69%	0.88%	3.32%	5.28%	2.56%
		Total	1.19%	6.16%	12.10%	4.84%	1.97%	3.73%	6.5%	3.34%	0.24%	0.88%	2.54%	0.92%	2.29%	6.82%	10.50%	5.64%	1.66%	6.02%	10.17%	4.82%
	2019	DHB	0.72%	2.29%	6.08%	2.32%	0.44%	1.46%	3.73%	1.45%	0.12%	0.70%	2.01%	0.63%	1.27%	3.86%	6.87%	3.39%	0.9%	2.9%	6.05%	2.63%
		NGO	1.14%	4.39%	7.7%	3.44%	1.49%	3.33%	3.82%	2.49%	0.23%	0.91%	1.89%	0.72%	1.54%	4.06%	4.75%	3.03%	1.24%	3.86%	5.47%	2.92%
		Total	1.87%	6.69%	13.78%	5.76%	1.93%	4.8%	7.55%	3.94%	0.35%	1.61%	3.89%	1.35%	2.81%	7.91%	11.62%	6.42%	2.13%	6.75%	11.52%	5.55%
Lakes	2017	DHB	0.93%	3.15%	5.01%	2.44%	0.61%	2.73%	4.58%	2.11%	0.0%	1.05%	1.36%	0.58%	2.29%	5.87%	7.62%	4.5%	1.37%	4.17%	5.74%	3.12%
		NGO	0.32%	3.31%	6.03%	2.4%	0.2%	2.27%	3.33%	1.47%	0.0%	0.26%	1.14%	0.35%	0.48%	4.16%	9.08%	3.46%	0.35%	3.48%	6.77%	2.66%
		Total	1.25%	6.46%	11.05%	4.85%	0.82%	5.00%	7.92%	3.58%	0.0%	1.32%	2.50%	0.93%	2.76%	10.03%	16.70%	7.96%	1.73%	7.65%	12.51%	5.78%
	2019	DHB	0.69%	1.99%	5.53%	2.09%	0.19%	2.50%	2.8%	1.39%	0.0%	0.0%	2.56%	0.46%	1.52%	5.39%	8.87%	4.36%	0.92%	3.16%	6.63%	2.8%
		NGO	0.01%	3.23%	8.11%	2.63%	0.0%	1.25%	4.8%	1.49%	0.0%	1.20%	2.82%	0.79%	0.0%	4.33%	8.87%	3.34%	0.01%	3.47%	8.02%	2.73%
		Total	0.70%	5.22%	13.64%	4.72%	0.19%	3.75%	7.60%	2.87%	0.00%	1.20%	5.38%	1.25%	1.52%	9.72%	17.74%	7.7%	0.92%	6.63%	14.65%	5.53%
Bay of Plenty	2017	DHB	1.23%	3.99%	8.53%	3.55%	0.21%	3.17%	6.58%	2.27%	0.29%	1.51%	2.16%	0.98%	1.63%	5.57%	10.23%	4.84%	1.31%	4.64%	8.93%	3.97%
		NGO	1.32%	4.3%	7.39%	3.42%	0.31%	2.2%	6.05%	1.99%	0.13%	0.65%	0.41%	0.3%	0.35%	1.41%	2.72%	1.23%	0.74%	2.54%	4.46%	2.08%
		Total	2.55%	8.30%	15.92%	6.98%	0.52%	5.37%	12.63%	4.26%	0.42%	2.15%	2.58%	1.29%	1.98%	6.98%	12.95%	6.07%	2.05%	7.17%	13.39%	6.05%
	2019	DHB	1.17%	3.62%	8.26%	3.36%	0.72%	2.13%	4.47%	1.87%	0.19%	0.85%	2.33%	0.77%	1.12%	4.74%	9.51%	4.07%	1.06%	3.97%	8.46%	3.49%
		NGO	0.8%	3.69%	6.82%	2.88%	0.21%	1.49%	3.68%	1.26%	0.16%	0.0%	0.67%	0.22%	0.24%	1.34%	2.67%	1.11%	0.46%	2.19%	4.19%	1.76%
		Total	1.96%	7.31%	15.09%	6.24%	0.93%	3.62%	8.16%	3.13%	0.35%	0.85%	3.0%	0.99%	1.37%	6.08%	12.18%	5.18%	1.52%	6.16%	12.65%	5.25%
Tairawhiti	2017	DHB	1.81%	4.49%	6.87%	3.66%	0.0%	3.08%	5.0%	1.84%	0.0%	4.29%	9.09%	2.35%	2.26%	5.73%	10.45%	4.99%	1.83%	4.83%	7.79%	3.95%
		NGO	0.1%	0.32%	1.48%	0.48%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.22%	0.05%	0.07%	0.20%	1.07%	0.33%
		Total	1.91%	4.82%	8.35%	4.14%	0.0%	3.08%	5.00%	1.84%	0.0%	4.29%	9.09%	2.35%	2.26%	5.73%	10.67%	5.04%	1.89%	5.04%	8.87%	4.28%
	2019	DHB	1.05%	2.68%	4.95%	2.32%	0.0%	2.11%	5.56%	1.71%	0.61%	1.43%	5.0%	1.69%	2.09%	4.52%	4.00%	3.2%	1.29%	3.13%	4.65%	2.54%
		NGO	1.51%	4.71%	9.05%	3.97%	0.44%	2.11%	7.78%	2.44%	0.0%	2.86%	1.67%	1.02%	2.14%	4.33%	5.65%	3.62%	1.62%	4.51%	7.74%	3.77%
		Total	2.56%	7.39%	14.0%	6.29%	0.44%	4.21%	13.33%	4.15%	0.61%	4.29%	6.67%	2.71%	4.22%	8.85%	9.65%	6.82%	2.90%	7.64%	12.38%	6.31%
Taranaki	2017	DHB	0.73%	4.55%	8.18%	3.31%	0.33%	2.50%	6.67%	2.33%	0.18%	1.47%	1.76%	0.73%	1.23%	4.78%	9.72%	4.13%	0.99%	4.52%	8.83%	3.65%
		NGO	0.00%	0.56%	3.42%	0.91%	0.0%	0.0%	2.22%	0.5%	0.0%	0.0%	1.18%	0.23%	0.02%	0.16%	1.62%	0.43%	0.01%	0.27%	2.16%	0.57%
		Total	0.73%	5.11%	11.6%	4.21%	0.33%	2.5%	8.89%	2.83%	0.18%	1.47%	2.94%	0.96%	1.25%	4.94%	11.34%	4.56%	1.00%	4.79%	10.99%	4.22%
	2019	DHB	0.27%	2.68%	7.75%	2.5%	0.63%	0.56%	6.29%	2.09%	0.09%	0.0%	3.00%	0.57%	0.69%	3.16%	8.39%	3.12%	0.52%	2.82%	7.92%	2.77%
		NGO	0.04%	0.21%	2.3%	0.56%	0.0%	0.0%	2.29%	0.6%	0.0%	0.0%	0.33%	0.06%	0.01%	0.07%	0.98%	0.25%	0.02%	0.11%	1.39%	0.34%
		Total	0.31%	2.89%	10.05%	3.06%	0.63%	0.56%	8.57%	2.69%	0.09%	0.0%	3.33%	0.63%	0.7%	3.23%	9.37%	3.37%	0.53%	2.93%	9.31%	3.11%
Regional Total	2017	DHB	0.9%	3.28%	6.3%	2.71%	0.32%	1.88%	4.08%	1.51%	0.13%	0.85%	1.59%	0.62%	1.43%	4.52%	7.68%	3.81%	1.06%	3.73%	6.61%	3.06%
		NGO	0.66%	3.23%	6.13%	2.53%	1.02%	2.18%	3.93%	1.93%	0.12%	0.51%	1.07%	0.42%	0.65%	2.32%	4.07%	1.95%	0.62%	2.56%	4.64%	2.07%
		Total	1.56%	6.51%	12.43%	5.24%	1.34%	4.06%	8.01%	3.43%	0.25%	1.36%	2.66%	1.03%	2.08%	6.85%	11.75%	5.77%	1.69%	6.29%	11.25%	5.13%
	2019	DHB	0.81%	2.65%	6.59%	2.56%	0.46%	1.67%	4.06%	1.59%	0.12%	0.63%	2.25%	0.65%	1.19%	4.14%	7.83%	3.61%	0.91%	3.21%	6.85%	2.88%
		NGO	0.8%	3.63%	7.15%	2.94%	0.88%	2.39%	3.96%	1.97%	0.17%	0.69%	1.59%	0.56%	0.83%	2.73%	4.1%	2.14%	0.76%	2.94%	5.1%	2.33%
		Total	1.62%	6.28%	13.74%	5.50%	1.35%	4.06%	8.02%	3.56%	0.29%	1.31%	3.84%	1.22%	2.01%	6.87%	11.93%	5.75%	1.67%	6.14%	11.95%	5.21%

Table 7. Central Region 0-19 yrs. Service User Access Rates by DHB Area, Ethnicity & Age Group (yrs.) (2017 & 2019)

Region/DHB Area: Central Region	Year	Service Type	Māori				Pacific				Asian				Other Ethnicity				Total			
			0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19
Hawke's Bay	2017	DHB	0.9%	4.51%	8.67%	3.53%	0.35%	2.03%	2.9%	1.34%	0.0%	0.89%	2.39%	0.71%	1.10%	4.08%	9.42%	3.96%	0.91%	4.0%	8.43%	3.47%
		NGO	0.02%	0.2%	2.60%	0.65%	0.0%	0.0%	1.94%	0.45%	0.0%	0.0%	0.0%	0.0%	0.0%	0.07%	0.7%	0.19%	0.01%	0.12%	1.5%	0.39%
		Total	0.92%	4.72%	11.26%	4.18%	0.35%	2.03%	4.84%	1.79%	0.00%	0.89%	2.39%	0.71%	1.10%	4.15%	10.11%	4.15%	0.92%	4.12%	9.93%	3.86%
	2019	DHB	0.66%	3.86%	9.16%	3.31%	0.78%	1.75%	4.1%	1.77%	0.08%	0.16%	1.11%	0.3%	0.90%	3.44%	7.98%	3.37%	0.74%	3.37%	7.93%	3.11%
		NGO	0.0%	0.17%	1.82%	0.43%	0.0%	0.0%	0.98%	0.23%	0.0%	0.0%	0.0%	0.0%	0.0%	0.10%	0.37%	0.12%	0.0%	0.12%	0.94%	0.25%
		Total	0.66%	4.03%	10.98%	3.75%	0.78%	1.75%	5.08%	2.0%	0.08%	0.16%	1.11%	0.30%	0.90%	3.54%	8.35%	3.49%	0.74%	3.49%	8.87%	3.36%
MidCentral	2017	DHB	1.08%	3.72%	5.55%	2.76%	0.79%	1.35%	4.53%	1.77%	0.20%	0.86%	1.75%	0.79%	1.96%	5.26%	7.08%	4.23%	1.44%	4.30%	6.03%	3.34%
		NGO	0.06%	1.09%	3.72%	1.17%	0.08%	0.19%	1.32%	0.39%	0.05%	0.29%	0.96%	0.37%	0.05%	0.95%	2.81%	1.05%	0.06%	0.92%	2.84%	1.0%
		Total	1.14%	4.80%	9.26%	3.93%	0.87%	1.54%	5.85%	2.16%	0.25%	1.14%	2.72%	1.15%	2.02%	6.21%	9.89%	5.28%	1.49%	5.22%	8.87%	4.35%
	2019	DHB	0.84%	3.82%	5.29%	2.61%	0.42%	0.83%	4.62%	1.47%	0.19%	1.06%	1.67%	0.74%	1.31%	4.73%	6.20%	3.53%	1.0%	3.98%	5.51%	2.9%
		NGO	0.1%	1.04%	3.43%	1.08%	0.0%	0.5%	4.42%	1.13%	0.0%	0.35%	0.52%	0.21%	0.03%	0.52%	1.62%	0.59%	0.05%	0.69%	2.19%	0.75%
		Total	0.93%	4.86%	8.72%	3.69%	0.42%	1.33%	9.04%	2.60%	0.19%	1.41%	2.19%	0.95%	1.34%	5.25%	7.82%	4.12%	1.05%	4.67%	7.70%	3.65%
Whanganui	2017	DHB	0.85%	6.04%	10.58%	4.26%	0.26%	2.0%	10.77%	2.71%	0.34%	0.95%	3.75%	1.44%	1.81%	6.37%	12.27%	5.51%	1.27%	5.93%	11.19%	4.73%
		NGO	0.03%	0.83%	1.75%	0.60%	0.0%	0.0%	0.77%	0.15%	0.0%	0.0%	0.0%	0.00%	0.0%	0.37%	1.48%	0.45%	0.01%	0.54%	1.5%	0.49%
		Total	0.88%	6.86%	12.34%	4.86%	0.26%	2.00%	11.54%	2.86%	0.34%	0.95%	3.75%	1.44%	1.81%	6.74%	13.74%	5.97%	1.29%	6.46%	12.69%	5.22%
	2019	DHB	0.97%	6.33%	12.03%	4.72%	0.25%	1.54%	6.06%	1.83%	0.51%	1.88%	2.78%	1.37%	2.01%	6.31%	11.41%	5.53%	1.41%	5.97%	11.05%	4.86%
		NGO	0.0%	0.77%	2.41%	0.71%	0.0%	0.0%	1.82%	0.39%	0.0%	0.0%	0.0%	0.00%	0.0%	0.46%	1.00%	0.37%	0.0%	0.55%	1.53%	0.5%
		Total	0.97%	7.09%	14.43%	5.44%	0.25%	1.54%	7.88%	2.22%	0.51%	1.88%	2.78%	1.37%	2.01%	6.76%	12.41%	5.9%	1.41%	6.52%	12.58%	5.36%
Capital & Coast	2017	DHB	1.61%	6.40%	20.22%	7.02%	0.45%	1.68%	6.22%	2.17%	0.29%	1.46%	3.28%	1.24%	1.64%	4.46%	7.72%	4.15%	1.28%	4.16%	8.9%	4.04%
		NGO	0.86%	4.24%	2.66%	2.08%	0.37%	2.70%	1.14%	1.12%	0.02%	0.18%	0.26%	0.11%	0.01%	0.42%	0.57%	0.28%	0.22%	1.33%	0.9%	0.66%
		Total	2.47%	10.64%	22.88%	9.09%	0.82%	4.38%	7.36%	3.28%	0.30%	1.64%	3.55%	1.34%	1.65%	4.88%	8.29%	4.43%	1.50%	5.49%	9.80%	4.71%
	2019	DHB	2.53%	8.75%	20.5%	8.50%	0.7%	3.56%	6.65%	2.98%	0.57%	2.21%	3.52%	1.63%	2.04%	6.46%	8.03%	5.03%	1.74%	6.01%	9.28%	4.94%
		NGO	0.16%	3.68%	2.48%	1.64%	0.0%	3.25%	1.45%	1.2%	0.02%	0.04%	0.15%	0.05%	0.02%	0.19%	0.48%	0.2%	0.04%	1.14%	0.84%	0.54%
		Total	2.69%	12.43%	22.98%	10.14%	0.7%	6.80%	8.10%	4.19%	0.58%	2.25%	3.66%	1.68%	2.05%	6.65%	8.51%	5.23%	1.78%	7.15%	10.11%	5.48%
Hutt	2017	DHB	1.71%	4.64%	7.09%	3.63%	0.59%	1.35%	2.64%	1.28%	0.56%	1.21%	2.55%	1.13%	2.16%	6.84%	9.18%	5.14%	1.64%	5.01%	7.17%	3.8%
		NGO	0.0%	1.15%	3.28%	1.02%	0.0%	0.27%	1.98%	0.55%	0.0%	0.11%	0.47%	0.13%	0.12%	0.58%	1.61%	0.62%	0.06%	0.65%	1.96%	0.66%
		Total	1.71%	5.79%	10.37%	4.64%	0.59%	1.62%	4.62%	1.83%	0.56%	1.32%	3.02%	1.26%	2.27%	7.41%	10.80%	5.76%	1.69%	5.67%	9.12%	4.46%
	2019	DHB	0.9%	3.36%	7.57%	3.06%	0.25%	1.81%	3.54%	1.46%	0.3%	0.74%	3.13%	0.96%	0.99%	4.23%	8.22%	3.67%	0.79%	3.29%	7.00%	2.9%
		NGO	0.12%	2.04%	3.78%	1.45%	0.05%	0.34%	1.56%	0.49%	0.0%	0.17%	0.45%	0.12%	0.04%	0.49%	1.31%	0.48%	0.06%	0.86%	1.88%	0.69%
		Total	1.03%	5.39%	11.35%	4.51%	0.3%	2.16%	5.1%	1.94%	0.3%	0.91%	3.57%	1.09%	1.04%	4.72%	9.53%	4.15%	0.85%	4.15%	8.88%	3.6%
Wairarapa	2017	DHB	0.80%	4.46%	6.96%	3.15%	0.0%	0.95%	3.00%	0.99%	0.0%	2.86%	1.43%	0.92%	1.22%	4.36%	7.76%	3.62%	1.01%	4.22%	7.16%	3.30%
		NGO	0.29%	3.01%	6.33%	2.38%	0.0%	1.90%	1.00%	0.74%	0.0%	0.0%	0.0%	0.0%	0.23%	0.85%	2.36%	0.91%	0.23%	1.49%	3.45%	1.32%
		Total	1.09%	7.47%	13.29%	5.54%	0.0%	2.86%	4.0%	1.73%	0.0%	2.86%	1.43%	0.92%	1.46%	5.21%	10.12%	4.53%	1.24%	5.71%	10.61%	4.62%
	2019	DHB	0.85%	2.77%	9.11%	3.14%	0.0%	4.44%	5.71%	2.53%	0.0%	0.91%	3.33%	0.89%	0.74%	3.81%	8.17%	3.38%	0.72%	3.40%	8.19%	3.18%
		NGO	0.16%	1.49%	5.06%	1.57%	0.0%	1.11%	0.0%	0.25%	0.0%	0.0%	0.0%	0.0%	0.26%	0.57%	2.23%	0.82%	0.21%	0.86%	2.89%	1.01%
		Total	1.01%	4.26%	14.18%	4.72%	0.0%	5.56%	5.71%	2.78%	0.00%	0.91%	3.33%	0.89%	1.00%	4.38%	10.40%	4.19%	0.92%	4.25%	11.08%	4.18%
Regional Total	2017	DHB	1.2%	4.89%	10.11%	4.12%	0.49%	1.6%	4.74%	1.78%	0.3%	1.27%	2.74%	1.09%	1.68%	5.03%	8.33%	4.35%	1.29%	4.43%	8.02%	3.77%
		NGO	0.21%	1.56%	3.08%	1.19%	0.17%	1.28%	1.46%	0.75%	0.02%	0.16%	0.42%	0.14%	0.05%	0.51%	1.34%	0.52%	0.10%	0.85%	1.72%	0.70%
		Total	1.41%	6.45%	13.18%	5.31%	0.66%	2.88%	6.20%	2.52%	0.32%	1.42%	3.16%	1.23%	1.72%	5.54%	9.68%	4.86%	1.39%	5.27%	9.74%	4.46%
	2019	DHB	1.19%	5.2%	11.28%	4.49%	0.55%	2.5%	5.45%	2.25%	0.4%	1.5%	2.94%	1.22%	1.52%	5.37%	8.31%	4.41%	1.21%	4.74%	8.38%	3.94%
		NGO	0.08%	1.54%	2.99%	1.11%	0.01%	1.57%	1.79%	0.85%	0.01%	0.11%	0.26%	0.09%	0.04%	0.35%	0.98%	0.38%	0.05%	0.78%	1.49%	0.6%
		Total	1.27%	6.73%	14.27%	5.61%	0.56%	4.07%	7.24%	3.09%	0.40%	1.61%	3.20%	1.30%	1.56%	5.72%	9.29%	4.79%	1.26%	5.51%	9.87%	4.54%

Table 8. Southern Region & National 0-19 yrs Service User Access Rates by DHB Area, Ethnicity & Age Group (yrs) (2017 & 2019)

Region/DHB Area: Southern Region	Year	Service Type	Māori				Pacific				Asian				Other Ethnicity				Total			
			0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19	0-9	10-14	15-19	0-19
Nelson Marlborough	2017	DHB	1.07%	5.89%	11.69%	4.67%	0.17%	1.92%	4.29%	1.43%	0.19%	1.14%	3.54%	1.2%	1.13%	5.41%	11.18%	4.74%	1.03%	5.24%	10.67%	4.45%
		NGO	0.03%	0.38%	1.49%	0.45%	0.0%	0.0%	0.95%	0.19%	0.0%	0.0%	0.42%	0.1%	0.04%	0.15%	1.39%	0.4%	0.03%	0.18%	1.34%	0.39%
		Total	1.1%	6.27%	13.18%	5.12%	0.17%	1.92%	5.24%	1.62%	0.19%	1.14%	3.96%	1.31%	1.17%	5.56%	12.57%	5.14%	1.07%	5.42%	12.01%	4.83%
	2019	DHB	0.80%	4.34%	9.47%	3.55%	0.36%	3.03%	3.64%	1.8%	0.16%	1.40%	3.33%	1.14%	0.98%	4.63%	9.46%	4.18%	0.86%	4.34%	8.98%	3.79%
		NGO	0.0%	0.16%	1.07%	0.27%	0.0%	0.0%	0.91%	0.18%	0.0%	0.0%	0.83%	0.18%	0.05%	0.26%	1.21%	0.41%	0.03%	0.22%	1.16%	0.36%
		Total	0.8%	4.5%	10.53%	3.82%	0.36%	3.03%	4.55%	1.98%	0.16%	1.40%	4.17%	1.32%	1.03%	4.89%	10.67%	4.58%	0.90%	4.56%	10.14%	4.15%
West Coast	2017	DHB	2.27%	3.89%	10.26%	4.51%	0.0%	0.0%	0.0%	0.0%	0.54%	1.54%	2.86%	1.25%	3.0%	6.18%	9.20%	5.12%	2.67%	5.51%	9.07%	4.74%
		NGO	0.34%	0.83%	1.84%	0.80%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.43%	0.31%	0.69%	1.58%	1.36%	1.06%	0.58%	1.36%	1.45%	0.96%
		Total	2.61%	4.72%	12.11%	5.31%	0.0%	0.0%	0.0%	0.0%	0.54%	1.54%	4.29%	1.56%	3.69%	7.76%	10.56%	6.18%	3.25%	6.87%	10.52%	5.7%
	2019	DHB	1.69%	5.53%	11.76%	4.84%	4.29%	10.0%	3.33%	5.38%	0.69%	1.43%	0.0%	0.75%	2.27%	4.60%	9.13%	4.51%	2.12%	4.75%	9.29%	4.46%
		NGO	0.6%	1.05%	1.47%	0.90%	0.0%	0.0%	0.0%	0.0%	0.0%	1.43%	0.0%	0.38%	0.78%	1.47%	1.89%	1.23%	0.7%	1.36%	1.72%	1.11%
		Total	2.29%	6.58%	13.24%	5.74%	4.29%	10.00%	3.33%	5.38%	0.69%	2.86%	0.00%	1.13%	3.05%	6.07%	11.02%	5.73%	2.81%	6.11%	11.01%	5.56%
Canterbury	2017	DHB	1.29%	5.58%	10.35%	4.34%	0.36%	1.92%	4.75%	1.69%	0.15%	0.85%	1.45%	0.65%	1.27%	3.74%	5.42%	3.02%	1.10%	3.70%	5.58%	2.91%
		NGO	0.11%	1.07%	4.41%	1.31%	0.0%	0.16%	2.38%	0.56%	0.01%	0.11%	0.6%	0.2%	0.06%	0.62%	2.85%	0.96%	0.06%	0.63%	2.77%	0.91%
		Total	1.40%	6.65%	14.76%	5.65%	0.36%	2.08%	7.13%	2.25%	0.16%	0.96%	2.06%	0.85%	1.33%	4.36%	8.27%	3.98%	1.16%	4.32%	8.35%	3.82%
	2019	DHB	1.48%	5.7%	11.05%	4.71%	0.49%	2.55%	4.44%	1.88%	0.14%	0.81%	1.67%	0.64%	1.30%	4.22%	6.54%	3.49%	1.12%	3.98%	6.54%	3.24%
		NGO	0.1%	1.07%	5.06%	1.47%	0.03%	0.68%	1.19%	0.45%	0.0%	0.17%	0.82%	0.22%	0.02%	0.78%	2.81%	0.98%	0.03%	0.75%	2.84%	0.94%
		Total	1.58%	6.77%	16.10%	6.18%	0.52%	3.23%	5.63%	2.33%	0.14%	0.97%	2.49%	0.86%	1.32%	5.00%	9.35%	4.48%	1.15%	4.73%	9.37%	4.17%
South Canterbury	2017	DHB	2.1%	5.37%	11.11%	5.02%	1.62%	1.82%	4.0%	2.07%	0.29%	1.54%	5.63%	1.9%	2.11%	4.5%	7.99%	4.17%	2.01%	4.48%	8.31%	4.16%
		NGO	0.0%	2.22%	9.81%	2.86%	0.0%	3.64%	4.0%	1.38%	0.0%	0.77%	1.88%	0.63%	0.02%	2.7%	6.87%	2.39%	0.01%	2.56%	7.06%	2.37%
		Total	2.10%	7.59%	20.93%	7.89%	1.62%	5.45%	8.0%	3.45%	0.29%	2.31%	7.50%	2.54%	2.13%	7.20%	14.85%	6.56%	2.02%	7.04%	15.36%	6.53%
	2019	DHB	1.61%	5.91%	10.0%	4.7%	1.86%	2.11%	8.57%	3.16%	0.22%	0.0%	1.58%	0.46%	1.59%	5.57%	10.0%	4.67%	1.51%	5.22%	9.49%	4.38%
		NGO	0.0%	2.42%	7.02%	2.27%	0.0%	0.0%	5.71%	1.05%	0.0%	0.45%	0.53%	0.23%	0.0%	2.3%	6.41%	2.15%	0.00%	2.16%	6.16%	2.03%
		Total	1.61%	8.33%	17.02%	6.96%	1.86%	2.11%	14.29%	4.21%	0.22%	0.45%	2.11%	0.69%	1.59%	7.87%	16.41%	6.83%	1.51%	7.38%	15.65%	6.40%
Southern	2017	DHB	0.88%	3.88%	6.54%	2.95%	0.49%	3.05%	4.75%	2.05%	0.04%	1.15%	1.31%	0.72%	0.87%	3.05%	5.92%	2.86%	0.81%	3.11%	5.57%	2.71%
		NGO	0.69%	2.64%	3.90%	1.92%	0.35%	1.02%	3.11%	1.14%	0.13%	0.38%	0.58%	0.35%	0.63%	2.13%	3.16%	1.73%	0.6%	2.11%	3.04%	1.65%
		Total	1.57%	6.52%	10.44%	4.88%	0.83%	4.07%	7.87%	3.18%	0.17%	1.54%	1.89%	1.07%	1.50%	5.18%	9.08%	4.59%	1.41%	5.22%	8.61%	4.37%
	2019	DHB	1.07%	4.08%	6.65%	3.24%	0.53%	2.97%	6.2%	2.5%	0.1%	0.59%	1.8%	0.76%	1.02%	4.06%	6.08%	3.26%	0.94%	3.80%	5.80%	3.04%
		NGO	0.64%	2.75%	5.26%	2.34%	0.33%	1.22%	3.24%	1.25%	0.17%	0.74%	1.23%	0.64%	0.57%	2.76%	5.04%	2.43%	0.55%	2.57%	4.68%	2.23%
		Total	1.70%	6.83%	11.91%	5.58%	0.86%	4.19%	9.44%	3.75%	0.27%	1.32%	3.03%	1.4%	1.59%	6.82%	11.12%	5.69%	1.49%	6.37%	10.48%	5.27%
Regional Total	2017	DHB	1.21%	5.03%	9.36%	4.0%	0.41%	2.19%	4.62%	1.74%	0.14%	0.97%	1.66%	0.75%	1.24%	3.9%	6.49%	3.33%	1.10%	3.84%	6.38%	3.17%
		NGO	0.28%	1.5%	4.01%	1.43%	0.09%	0.46%	2.45%	0.7%	0.03%	0.17%	0.62%	0.24%	0.24%	1.13%	2.94%	1.20%	0.23%	1.11%	2.86%	1.14%
		Total	1.49%	6.53%	13.37%	5.43%	0.51%	2.64%	7.08%	2.44%	0.18%	1.14%	2.28%	0.99%	1.48%	5.04%	9.43%	4.53%	1.33%	4.95%	9.24%	4.31%
	2019	DHB	1.27%	5.0%	9.33%	4.09%	0.59%	2.78%	5.00%	2.13%	0.14%	0.79%	1.81%	0.7%	1.22%	4.32%	6.99%	3.61%	1.08%	4.06%	6.79%	3.34%
		NGO	0.26%	1.53%	4.59%	1.59%	0.11%	0.71%	1.89%	0.66%	0.03%	0.30%	0.93%	0.32%	0.21%	1.39%	3.48%	1.42%	0.20%	1.29%	3.36%	1.30%
		Total	1.53%	6.52%	13.92%	5.68%	0.69%	3.49%	6.89%	2.79%	0.17%	1.09%	2.74%	1.02%	1.43%	5.71%	10.47%	5.03%	1.28%	5.35%	10.14%	4.64%
National	2017	DHB	1.28%	4.62%	9.19%	3.89%	0.68%	2.33%	5.0%	2.14%	0.51%	1.30%	2.17%	1.11%	1.66%	4.54%	7.67%	3.97%	1.29%	3.99%	6.98%	3.38%
		NGO	0.31%	2.04%	4.56%	1.70%	0.14%	0.82%	2.14%	0.8%	0.04%	0.16%	0.42%	0.17%	0.23%	0.97%	2.24%	0.95%	0.22%	1.13%	2.51%	1.02%
		Total	1.59%	6.66%	13.75%	5.59%	0.81%	3.15%	7.14%	2.94%	0.56%	1.46%	2.59%	1.28%	1.89%	5.51%	9.91%	4.91%	1.51%	5.13%	9.49%	4.4%
	2019	DHB	1.28%	4.29%	9.72%	3.94%	0.79%	2.33%	4.71%	2.15%	0.48%	1.34%	2.67%	1.17%	1.58%	4.76%	7.94%	4.11%	1.24%	3.94%	7.31%	3.43%
		NGO	0.35%	2.06%	4.76%	1.78%	0.1%	0.76%	1.88%	0.71%	0.04%	0.2%	0.45%	0.17%	0.27%	1.13%	2.32%	1.04%	0.24%	1.22%	2.59%	1.07%
		Total	1.63%	6.35%	14.48%	5.72%	0.89%	3.09%	6.59%	2.87%	0.52%	1.54%	3.12%	1.35%	1.84%	5.89%	10.25%	5.15%	1.47%	5.15%	9.9%	4.5%

Appendix C: Funding Data

Table 1. Infant, Child & Adolescent Mental Health/AOD Funding (2013/2017-2017/2020)

Region/ DHB Area	2013/2014			2015/2016			2017/2018			2019/2020		
	DHB*	NON-DHB	TOTAL	DHB*	NON-DHB	TOTAL	DHB*	NON-DHB	TOTAL	DHB*	NON-DHB*	TOTAL
Northern	$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	$54,518,610	$12,111,675	$66,630,285
Northland	$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	$4,508,839	$1,815,372	$6,324,211
Waitemata	$14,325,541	$690,177	$15,015,718	$15,862,594	$702,631	$16,565,225	$15,745,106	$721,096	$16,466,202	$16,476,534	$832,473	$17,309,007
Auckland	$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	$18,792,042	$4,636,373	$23,428,415
Counties Manukau	$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	$14,741,195	$4,827,457	$19,568,652
Midland	$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	$21,370,475	$25,226,032	$46,596,507
Waikato	$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	$6,521,744	$15,095,321	$21,617,065
Lakes	$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	$2,799,010	$3,358,540	$6,157,550
Bay of Plenty	$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	$6,860,902	$5,513,430	$12,374,332
Tairawhiti	$2,063,599	$288,899	$2,352,498	$2,268,862	$310,176	$2,579,038	$2,303,231	$438,948	$2,742,179	$2,396,281	$468,444	$2,864,725
Taranaki	$2,669,820	$621,708	$3,291,528	$2,677,852	$730,596	$3,408,448	$2,686,207	$744,444	$3,430,651	$2,792,538	$790,297	$3,582,835
Central	$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	$36,826,043	$7,787,916	$44,613,959
Hawke's Bay	$3,337,010	$839,700	$4,176,710	$3,412,251	$410,217	$3,822,468	$4,016,008	$915,448	$4,931,456	$4,016,008	$1,520,874	$5,536,882
MidCentral	$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	$3,964,576	$1,526,173	$5,490,749
Whanganui	2175310	283612	$2,458,922	2567102.285	224064	$2,791,166	2336177.81	380472	2716649.81	2191738.4	404796	$2,596,534
Capital & Coast	$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	$20,403,667	$2,356,929	$22,760,596
Hutt Valley	$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	$4,835,837	$1,772,037	$6,607,874
Wairarapa	$1,147,300	$108,996	$1,256,296	$1,380,521	$99,924	$1,480,445	$1,359,300	$183,899	$1,543,199	$1,414,216	$207,107	$1,621,323
Southern	$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	$40,441,147	$13,993,947	$54,435,094
Nelson Marlborough	$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	$3,954,983	$831,523	$4,786,506
West Coast	$1,048,179	$284,000	$1,332,179	$1,065,069	$240,000	$1,305,069	$1,092,754	$240,000	$1,332,754	$1,141,029	$281,652	$1,422,681
Canterbury	$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	$26,549,862	$6,454,848	$33,004,710
South Canterbury	$1,113,038	$725,050	$1,838,088	$1,089,537	$702,204	$1,791,741	$1,067,492	$721,068	$1,788,560	$1,128,056	$750,204	$1,878,260
Southern	$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	$7,667,218	$5,675,720	$13,342,938
Total	**$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	$153,156,274	$59,119,570	$212,275,844

Source: Ministry of Health Price Volume Schedules 2013-2020. *DHB includes Inpatient funding; non-DHB includes NGOs & PHOs.

Table 2. National Funding per Head Infant, Child & Adolescent Population (2017/2018-2019/2020)

Region/DHB Area	2017/2018			2019/2020		
	Spend/Child (Excl. Inpatient) $	Spend/Child (Incl. Inpatient) $	Total DHB & NON-DHB $	Spend/Child (Incl. Inpatient) $	Spend/Child (Excl. Inpatient) $	Total DHB & NON-DHB $
Northern	$116.15	$123.47	$60,159,204	$135.50	$127.88	$66,630,285
Northland	$106.76	$106.76	$5,025,291	$124.20	$124.20	$6,324,211
Waitemata	$103.55	$103.55	$16,466,202	$107.35	$107.35	$17,309,007
Auckland	$148.27	$178.87	$20,845,776	$214.31	$180.04	$23,428,415
Counties Manukau	$108.25	$108.25	$17,821,936	$114.93	$114.93	$19,568,652
Midland	$156.83	$157.49	$39,312,598	$175.40	$174.76	$46,596,507
Waikato	$144.47	$144.47	$16,247,368	$182.05	$182.05	$21,617,065
Lakes	$197.84	$197.84	$5,856,129	$192.00	$192.00	$6,157,550
Bay of Plenty	$181.70	$181.70	$11,036,272	$185.65	$185.65	$12,374,332
Tairawhiti	$173.73	$184.78	$2,742,179	$191.68	$180.27	$2,864,725
Taranaki	$107.27	$107.27	$3,430,651	$107.77	$107.77	$3,582,835
Central	$158.73	$173.88	$40,625,568	$193.14	$176.28	$44,613,959
Hawke's Bay	$110.35	$110.35	$4,931,456	$117.21	$117.21	$5,536,882
MidCentral	$111.84	$111.84	$5,211,928	$308.04	$308.04	$5,490,749
Whanganui	$165.65	$165.65	$2,716,650	$53.64	$53.64	$2,596,534
Capital & Coast	$220.12	$266.43	$20,368,522	$562.68	$466.42	$22,760,596
Hutt Valley	$152.09	$152.09	$5,853,814	$85.74	$85.74	$6,607,874
Wairarapa	$140.16	$140.16	$1,543,199	$137.40	$137.40	$1,621,323
Southern	$139.84	$157.92	$43,337,110	$193.62	$173.18	$54,435,094
Nelson Marlborough	$128.61	$136.92	$4,830,481	$131.75	$123.48	$4,786,506
West Coast	$165.77	$165.77	$1,332,754	$193.83	$193.83	$1,422,681
Canterbury	$136.57	$166.74	$22,793,110	$235.75	$200.88	$33,004,710
South Canterbury	$127.30	$127.30	$1,788,560	$132.55	$132.55	$1,878,260
Southern	$149.93	$156.72	$12,592,204	$160.18	$153.39	$13,342,938
Total	$137.33	$147.15	$183,434,480	$167.21	$156.53	$212,275,844

Source: Ministry of Health Price Volume Schedules 2017/2018, 2018/2020. Includes Youth Primary Mental Health Funding.

Appendix D: ICAMH/AOD Workforce Data

Table 1. DHB Inpatient ICAMH Workforce by Occupation (2020/21)

Inpatient ICAMH Workforce by Occupation (Actual FTEs, 2020/21)	Child & Adolescent Psychiatrist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Registrar/Senior Medical Officer	Social Worker	Other Clinical	CLINICAL SUB-TOTAL	Cultural	Mental Health Support Worker	NON-CLINICAL SUB-TOTAL	Administrator	Manager	Total
Auckland[1]	7.18	26.0	1.6	1.6	11.8	4.75	3.4	10.25	66.58	-	1.00	1.0	2.00	2.0	71.58
Capital & Coast	0.3	12.0	2.0	-	1.0	1.0	2.0	1.0	19.3	1.0	9.0	10.0	1.0	-	30.3
Canterbury[2]	1.6	35.18	2.6	-	2.3	0.6	1.8	-	44.08	0.6	-	0.6	2.0	1.0	47.68
Total	9.08	73.18	6.2	1.6	15.1	6.35	7.2	11.25	129.96	1.6	10.0	11.6	5.0	3.0	149.6

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

Table 2. DHB Inpatient ICAMH Vacancies by Occupation (2020/21)

Inpatient ICAMH Vacancies by Occupation (Vacant FTEs, 2020/21)	Child & Adolescent Psychiatrist	Nurse	Psychologist	CLINICAL SUB-TOTAL	Cultural	Mental Health Support	NON-CLINICAL SUB-TOTAL	Manager	Total
Auckland	1.0	0.8	-	1.8	-	-	-	-	1.8
Capital & Coast	1.0	5.0	-	6.0	0.8	1.0	1.8	-	7.8
Canterbury	-	4.82	0.8	5.62	1.0	-	1.0	1.0	7.62
Total	2.0	10.62	0.8	13.42	1.8	1.0	2.8	1.0	17.22

Table 3. DHB Inpatient ICAMH Workforce by Occupation & Ethnicity (2020/21)

Inpatient ICAMH Workforce by Occupation & Ethnicity (Headcount, 2020/21)		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	Administrator	Manager	Total
MĀORI	Auckland	1	4	-	-	1	-	2	8	-	-	1	1	-	-	9
	Capital & Coast	-	2	-	-	-	-	1	3	-	2	-	2	-	-	5
	Canterbury	-	2	-	-	-	-	-	2	1	-	-	1	-	-	3
	Total	1	8	-	-	1	-	3	13	1	2	1	4	-	-	17
PACIFIC	Auckland	-	6	-	-	-	-	4	10	-	-	-	-	-	-	10
	Capital & Coast	-	1	-	-	-	-	-	1	1	-	4	5	-	-	6
	Canterbury	-	2	-	-	-	-	-	2	-	-	-	-	-	-	2
	Total	-	9	-	-	-	-	4	13	1	-	4	5	-	-	18
ASIAN	Auckland	1	7	-	-	2	1	-	11	-	-	-	-	-	-	11
	Capital & Coast	-	5	-	-	-	-	-	5	-	-	-	-	-	-	5
	Canterbury	-	2	-	-	-	-	-	2	-	-	-	-	-	-	2
	Total	1	14	-	-	2	1	-	18	-	-	-	-	-	-	18
NZ EUROPEAN	Auckland	3	1	-	1	4	-	2	11	-	-	-	-	-	-	11
	Capital & Coast	-	4	-	-	-	1	1	6	-	-	3	3	1	-	10
	Canterbury	3	34	3	-	2	3	1	46	-	-	-	-	2	-	48
	Total	6	61	3	1	6	4	4	63	-	-	3	3	3	-	69
OTHER ETHNICITY	Auckland	5	12	2	1	8	3	7	39	-	-	-	-	2	2	43
	Capital & Coast	1		2	-	1	1	-	5	-	-	-	-	-	-	5
	Canterbury	-	4	-	-	1	-	-	5	-	-	-	-	1	-	6
	Total	6	16	4	1	10	4	7	49	-	-	-	-	3	-	54
GRAND TOTAL		14	86	7	2	19	9	18	156	2	2	8	12	6	2	176

Table 4. DHB Community ICAMH/AOD Workforce by Occupation (2020/21)

DHB Community FTEs by Occupation (2020/21)	Alcohol & Other Drugs Practitioner	Co-Existing Problems Clinician	Clinical Intern	Counsellor	Family Therapist	Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Registrar/ Senior Medical Officer	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Mental Health Consumer Advisor	Mental Health Support	Peer Support	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Manager	Total
Northern	19.2	2.0	8.1	3.0	0.6	84.05	37.25	19.8	7.2	55.4	10.37	68.73	9.4	325.1	7.3	1.0	3.0	0.4	4.0	0.5	16.2	18.4	14.3	374.0
Northland	2.0	2.0	1.0	1.0	-	19.8	3.0	5.3	-	3.6	1.8	12.0	-	51.5	-	-	-	0.4	4.0	-	4.4	2.6	3.0	61.5
Waitemata*	17.0	-	2.0	-	0.6	19.9	19.6	5.8	4.9	14.2		27.8	5.4	117.2	-	-	-	-	-	-	-	7.0	3.9	128.1
Auckland	0.2	-	3.1	-	-	11.25	4.65	2.0	2.3	20.9	2.47	14.13	-	61.0	7.3	-	3.0	-	-	-	10.3	8.3	5.4	85.0
Counties Manukau	-	-	2.0	2.0	-	33.1	10.0	6.7	-	16.7	6.1	14.8	4.0	95.4		1.0	-	-	-	0.5	1.5	0.5	2.0	99.4
Midland	1.0	1.0	0.8	2.0	-	32.4	9.2	12.6	1.0	27.95	3.0	34.9	3.9	129.75	1.5	-	-	1.65	-	2.8	5.95	10.0	6.3	152.8
Waikato	1.0	-	-	-	-	7.8	5.6	5.0	-	10.7	1.6	9.5	-	41.25	-	-	-	1.65	-	-	1.65	3.8	2.3	49.0
Lakes	-	-	0.8	-	-	5.6	1.0	2.0	-	2.9		3.0	0.2	15.5	-	-	-	-	-	-		2.0	1.0	18.5
Bay of Plenty	-	-	-	2.0	-	13.3	2.6	2.0	-	7.8	1.3	11.7	1.8	42.5	0.5	-	-	-	-	2.8	3.3	2.0	3.0	50.8
Tairawhiti	-	-	-	-	-	1.0	-	0.6	-	2.6	0.1	5.0	-	9.3	1.0	-	-	-	-	-	1.0	2.0	-	12.3
Taranaki	-	1.0	-	-	-	4.7	-	3.0	1.0	3.9		5.7	1.9	21.2	-	-	-	-	-	-		1.0	-	22.2
Central	3.6	4.0	4.7	1.0	1.7	53.96	15.15	14.6	1.6	43.3	7.7	45.83	2.93	200.07	2.25	-	9.0	-	0.9	1.6	13.75	17.9	12.4	244.12
Hawke's Bay	1.8	-	-	-	1.3	5.4	1.0	3.0	-	4.2	-	7.0	-	23.7	1.0	-	1.0	-	-	-	2.0	3.0	2.0	30.7
MidCentral	-	1.0	1.0	-	-	8.	4.0	1.5	-	7.6	-	10.5	0.2	33.8	-	-	-	-	-	-		3.3	1.0	38.1
Whanganui	1.8	-	-	-	-	7.06	-	1.4	-	-	-	5.7	-	15.96	-	-	-	-	0.9	0.8	1.70	1.9	1.4	20.96
Capital & Coast	-	2.0	1.3	-	0.4	30.6	8.25	6.0	0.8	19.9	4.5	11.43	2.73	87.91	1.25	-	7.0	-	-	0.8	9.05	8.5	5.0	110.46
Hutt	-	-	2.0	-	-		1.90	2.7	0.8	10.2	1.8	11.2	-	30.6	-	-	-	-	-	-		-	2.0	32.6
Wairarapa	-	1.0	0.4	1.0	-	2.9	-		-	1.4	1.4	-	-	8.1	-	-	1.0	-	-	-	1.0	1.2	1.0	11.3
Southern	5.2	-	4.0	1.0	-	47.0	20.8	20.7	-	28.05	0.3	28.3	0.5	155.85	5.6	0.6	2.0	0.3	-	0.4	8.9	17.83	9.0	191.58
Nelson Marlborough	3.0	-	1.0	1.0	-	9.2	2.0	5.3	-	-	-	5.6	-	27.1	-	-	1.0	-	-	-	1.0	-	-	28.1
West Coast	1.4	-	-	-	-	0.5	1.0	0.4	-	1.0	-	-	-	4.3	-	-	-	-	-	-		-	1.0	5.3
Canterbury	-	-	1.0	-	-	20.6	5.9	9.3	-	15.45	0.3	17.8	-	70.35	4.6	-	-	-	-	0.4	5.0	13.3	6.0	94.65
South Canterbury	-	-	-	-	-	1.8	2.9	0.4	-	0.5	-	1.5	-	7.1	-	-	-	0.3	-	-	0.3	-	-	7.4
Southern	0.8		2.0			14.9	9.0	5.3		11.1		3.4	0.5	47.0	1.0	0.6	1.0				2.6	4.53	2.0	56.13
Total	29.0	7.0	17.6	7.0	2.3	217.41	82.4	67.7	9.8	154.7	21.37	177.76	16.73	810.77	16.65	1.6	14.0	2.35	4.9	5.3	44.8	64.93	42.0	962.5

*Includes Regional AOD Service Altered High.

Table 5. DHB Community ICAMH/AOD Vacancies by Occupation (2020/21)

DHB Community Vacant FTEs by Occupation (2020/21)	Alcohol & Other Drug Practitioner	Co-Existing Problems Clinician	Clinical Intern	Family Therapist	Psychiatrist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Registrar/Senior Medical Officer	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Mental Health Consumer	Mental Health Support	Peer Support	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Manager	Total
Northern	2.0	-	-	-	7.5	17.8	1.4	-	10.9	2.4	-	1.0	43.0	-	-	-	1.0	-	1.0	2.0	0.4	0.4	45.8
Northland	-	-	-	-	2.9	-	-	-		-	-	-	2.9	-	-	-	-	-	-	-	-	-	2.9
Waitemata*	2.0	-	-	-	3.6	5.5	-	-	3.1	-	-	-	14.2	-	-	-	-	-	-	-	-	-	14.2
Auckland	-	-	-	-	0.8	2.0	-	-	3.6	2.4	-	-	8.8	-	-	-	-	-	-	-	0.4	0.4	9.6
Counties Manukau	-	-	-	-	0.2	10.3	1.4	-	4.2	-	-	1.0	17.1	-	-	-	1.0	-	1.0	2.0	-	-	19.1
Midland	-	-	-	-	0.6	3.6	-	-	3.35	-	-	-	7.55	1.0	-	-	0.35	-	-	1.35	-	1.0	9.9
Waikato	-	-	-	-	-	1.6	-	-	0.35	-	-	-	1.95	1.0	-	-	0.35	-	-	1.35	-	-	3.3
Lakes	-	-	-	-	-	1.0	-	-	1.6	-	-	-	2.6	-	-	-	-	-	-	-	-	-	2.6
Tairawhiti	-	-	-	-	0.6	1.0	-	-	1.4	-	-	-	3.0	-	-	-	-	-	-	-	-	1.0	4.0
Central	1.0	2.0	0.8	1.8	2.5	9.4	1.75	0.2	5.2	-	3.4	0.2	28.25	0.33	-	-	-	-	-	0.33	0.9	-	29.48
Hawke's Bay	1.0	-	0.8	1.8	-	1.0	-	-	0.8	-	2.0	-	7.4	-	-	-	-	-	-	-	-	-	7.4
MidCentral	-	1.0	-	-	1.0	1.0	-	-	1.0	-	1.0	-	5.0	-	-	-	-	-	-	-	0.4	-	5.4
Capital & Coast	-	1.0	-	-	0.7	7.4	1.15	0.2	2.5	-	0.4	-	13.35	0.33	-	-	-	-	-	0.33	0.5	-	14.18
Hutt	-	-	-	-	0.8		0.6	-	0.9	-	-	0.2	2.5	-	-	-	-	-	-	-	-	-	2.5
Southern	-	-	-	-	2.0	6.0	0.9	-	1.0	-	1.0	-	10.9	-	-	-	-	-	-	-	-	-	10.9
Nelson Marlborough	-	-	-	-	1.0	-	-	-	-	-	-	-	1.0	-	-	-	-	-	-	-	-	-	1.0
West Coast	-	-	-	-	-	1.5	-	-	1.0	-	-	-	2.5	-	-	-	-	-	-	-	-	-	2.5
Canterbury	-	-	-	-	-	3.5	0.9	-	-	-	1.0	-	5.4	-	-	-	-	-	-	-	-	-	5.4
Southern	-	-	-	-	1.0	1.0	-	-	-	-	-	-	2.0	-	-	-	-	-	-	-	-	-	2.0
Total	3.0	2.0	0.8	1.8	12.6	36.8	4.05	0.2	20.45	2.4	4.4	1.2	89.7	1.33	-	-	1.35	-	1.0	3.68	1.3	1.4	96.08

*Includes Regional AOD Service Altered High.

Table 6. DHB Community ICAMH/AOD Vacancies > 3 months by Occupation (2020/21)

DHB Community Vacant FTEs > 3mo by Occupation (2020/21)	Alcohol & Drug Practitioner	Psychiatrist	Nurse	Occupational Therapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Administrator	Manager	Total
Northern	2.0	7.3	2.0	-	1.0	-	3.4	15.7	0.4	0.4	16.5
Northland	-	2.9	-	-	-	-	-	2.9	-	-	2.9
Waitemata*	2.0	3.6	-	-	-	-	1.0	6.6	-	-	6.6
Auckland	-	0.8	1.0	-	-	-	2.4	4.2	0.4	0.4	5.0
Counties Manukau	-	-	1.0	-	1.0	-	-	2.0	-	-	2.0
Midland	-	0.6	1.0	-	3.0	-	-	4.6	-	1.0	5.6
Lakes	-	-	1.0	-	1.6	-	-	2.6	-	-	2.6
Tairawhiti	-	0.6	-	-	1.4	-	-	2.0	-	1.0	3.0
Central	1.0	1.8	-	-	2.6	2.7	2.6	10.7	-	-	10.7
Hawke's Bay	1.0	-	-	-	0.8	2.0	2.6	6.4	-	-	6.4
MidCentral	-	1.0	-	-	1.0	-	-	2.0	-	-	2.0
Capital & Coast	-	-	-	-	0.8	0.7	-	1.5	-	-	1.5
Hutt	-	0.8	-	-	-	-	-	0.8	-	-	0.8
Southern	-	1.0	2.7	1.1	1.0	-	0.2	6.0	-	-	6.0
West Coast	-	-	1.5	-	1.0	-	-	2.5	-	-	2.5
Canterbury	-	-	1.2	1.1	-	-	0.2	2.5	-	-	2.5
Southern	-	1.0	-	-	-	-	-	1.0	-	-	1.0
Total	3.0	10.7	5.7	1.1	7.6	2.7	6.2	37.0	0.4	1.4	38.8

*Includes Regional AOD Service Altered High.

Table 7. DHB Community Māori ICAMH/AOD Workforce by Occupation (2020/21)

DHB Community Māori Workforce by Occupation (Head Count 2020/21)	Alcohol & Other Drug Practitioner	Psychiatrist	Clinical Placement	Co-Existing Problems Clinician	Counsellor	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Registrar/Senior Medical Officer	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Mental Health Consumer	Mental Health Support	Peer Support	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Manager	Total
Northern	1	1	5	1	2	12	6	-	5	1	15	-	49	6	-	2	1	4	-	13	1	6	69
Northland	1	-	1	1	1	8	-	-	3	-	8	-	23	-	-	-	1	4	-	5	1	4	33
Waitemata*	-	1	1	-	-	2	2	-	-	-	1	-	7	-	-	-	-	-	-	-	-	-	7
Auckland	-	-	2	-	-	1	2	-	-	-	2	-	7	6	-	2	-	-	-	8	-	1	16
Counties Manukau	-	-	1	-	1	1	2	-	2	1	4	-	12	-	-	-	-	-	-	-	-	1	13
Midland	-	-	1	-	-	3	1	1	6	-	8	3	23	3	-	-	1	-	-	4	2	1	30
Waikato	-	-	-	-	-	1	-	-	-	-	1	-	2	-	-	-	1	-	-	1	-	1	4
Lakes	-	-	1	-	-	2	1	-	1	-	1	-	6	-	-	-	-	-	-	-	-	-	6
Bay of Plenty	-	-	-	-	-	-	-	-	3	-	3	3	9	1	-	-	-	-	-	1	-	-	10
Tairawhiti	-	-	-	-	-	-	-	-	1	-	3	-	4	2	-	-	-	-	-	2	1	-	7
Taranaki	-	-	-	-	-	-	-	1	1	-	-	-	2	-	-	-	-	-	-	-	1	-	3
Central	-	-	-	2	-	7	-	-	4	-	9	-	22	4	-	2	-	-	1	7	1	2	32
Hawke's Bay	-	-	-	-	-	2	-	-	-	-	3	-	5	1	-	-	-	-	-	1	-	1	7
MidCentral	-	-	-	1	-	1	-	-	1	-	3	-	6	-	-	-	-	-	-	-	-	-	6
Whanganui	-	-	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	1	1	-	-	2
Capital & Coast	-	-	-	1	-	4	-	-	3	-	1	-	9	3	-	2	-	-	-	5	1	1	16
Hutt	-	-	-	-	-		-	-	-	-	1	-	1	-	-	-	-	-	-	-	-	-	1
Southern	-	1	-	-	-	5	1	-	2	-	1	1	11	8	1	1	-	-	-	10	4	1	26
Nelson Marlborough	-	1	-	-	-	2	-	-	-	-	-	-	3	-	-	-	-	-		-	-	-	3
West Coast	-	-	-	-	-	1	-	-	-	-	-	-	1	-	-	-	-	-		-	-	-	1
Canterbury	-	-	-	-	-	1	-	-	2	-	1	-	4	6	-	-	-	-		6	3	-	13
Southern	-	-	-	-	-	1	1	-	-	-	-	1	3	2	1	1	-	-		4	1	1	9
Total	1	2	6	3	2	27	8	1	17	1	33	4	105	21	1	5	2	4	1	34	8	10	157

*Includes Regional AOD Service Altered High.

Table 8. DHB Community Pacific ICAMH/AOD Workforce by Occupation (2020/21)

DHB Community Pacific Workforce by Occupation (Headcount 2020/21)	Clinical Placement	Counsellor	Psychiatrist	Nurse	Occupational Therapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Mental Health Support	Non-Clinical Sub-Total	Administrator	Manager	Total
Northern	1	-	-	15	3	1	6	1	27	3	1	4	1	1	33
Northland	-	-	-	1	-	-	-	-	1	-	-	-	-	-	1
Waitemata*	-	-	-	1	-	1	3	-	5	-	-	-	1	-	6
Auckland	-	-	-	3	-	-	2	-	5	3	1	4	-	-	9
Counties Manukau	1	-	-	10	3	-	1	1	16	-	-	-	-	1	17
Midland	-	1	-	3	-	-	1	-	5	-	-	-	-	-	5
Waikato	-	-	-	1	-	-	-	-	1	-	-	-	-	-	1
Bay of Plenty	-	1	-	1	-	-	1	-	3	-	-	-	-	-	3
Tairawhiti	-	-	-	1	-	-	-	-	1	-	-	-	-	-	1
Central	-	-	-	8	-	-	-	1	9	-	3	3	1	-	13
Capital & Coast	-	-	-	8	-	-	-	1	9	-	3	3	1	-	13
Southern	-	-	2	1	-	-	-	-	3	-	-	-	-	-	3
Canterbury	-	-	2	1	-	-	-	-	3	-	-	-	-	-	3
Total	1	1	2	27	3	1	7	2	44	3	4	7	2	1	54

*Includes Regional AOD Service Altered High.

Table 9. DHB Community Asian ICAMH/AOD Workforce by Occupation (2020/21)

DHB Community Asian Workforce by Occupation (Headcount 2020/21)	Alcohol & Other Drug Practitioner	Clinical Intern	Psychiatrist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Registrar/Senior Medical Officer	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Mental Health Consumer	Non-Clinical Sub-Total	Administrator	Total
Northern	1	-	2	8	5	1	12	2	3	2	36	-	1	1	3	40
Northland	-	-	-	1	-	-	-	-	-	-	1	-	-	-	-	1
Waitemata*	1	-	1	1	3	-	5	-	1	-	12	-	-	-	2	14
Auckland	-	-	-	-	1	1	2	1	-	-	5	-	-	-	1	6
Counties Manukau	-	-	1	6	1	-	5	1	2	2	18	-	1	1	-	19
Midland	-	-	2	1	2	-	1	1	2	-	9	-	-	-	-	9
Waikato	-	-	2	1	2	-	1	1	2	-	9	-	-	-	-	9
Central	-	1	1	3	2	-	1	-	-	-	8	-	-	-	-	8
MidCentral	-	-	-	3	1	-	-	-	-	-	4	-	-	-	-	4
Capital & Coast	-	-	1	-	1	-	1	-	-	-	3	-	-	-	-	3
Hutt	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	1
Southern	-	1	-	-	-	-	1	-	3	-	5	1	-	1	-	6
Nelson Marlborough	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	1
Canterbury	-	-	-	-	-	-	1	-	2	-	3	1	-	1	-	4
South Canterbury	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-	1
Total	1	2	5	12	9	1	15	3	8	2	58	1	1	2	3	63

*Includes Regional AOD Service Altered High.

Table 10. DHB Community NZ European ICAMH/AOD Workforce by Occupation (2020/21)

DHB Community NZ European Workforce by Occupation (Headcount, 2020/21)	Alcohol & Other Drugs Practitioner	CEP Clinician	Clinical Intern	Counsellor	Family Therapist	Psychiatrist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Registrar/Senior Medical Officer	Social Worker	Other Clinical	Clinical Sub-Total	Mental Health Consumer	Mental Health Support	Peer Support	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Manager	Total
Northern	12	-	3	-	1	10	45	29	8	42	8	32	5	196	-	-	1	-	1	2	14	8	220
Northland	1	-	-	-	-	2	7	3	-	-	1	4	-	18	-	-	1	-	-	1	2	-	21
Waitemata	10	-	1	-	1	4	16	18	5	10	-	12	5	82	-	-	-	-	-	-	4	5	91
Auckland	1	-	2	-	-	-	9	3	3	23	2	11	-	55	-	-	-	-	-	-	8	3	66
Counties Manukau	-	-	-	-	-	4	13	5	-	9	5	5	-	41	-	-	-	-	1	1	-	-	42
Midland	-	2	2	1	-	2	23	6	-	13	1	19	2	71	-	-	1	-	4	5	7	2	85
Waikato	-	1	-	-	-	1	5	3	-	7	-	4	-	21	-	-	1	-	-	1	4	-	26
Lakes	-	-	-	-	-	-	3	-	-	1	-	1	1	6	-	-	-	-	-	-	1	1	8
Bay of Plenty	-	-	-	1	-	-	10	3	-	1	-	6	-	21	-	-	-	-	3	3	1	1	26
Tairawhiti	-	-	-	-	-	1	-	-	-	1	1	2	-	5	-	-	-	-	-	-	1	-	6
Taranaki	-	1	2	-	-	-	5	-	-	3	-	6	1	18	-	-	-	-	1	1	-	-	19
Central	2	2	3	1	3	15	26	13	2	42	5	35	3	152	-	4	-	1	1	6	13	6	177
Hawke's Bay	2	-	-	-	2	3	3	1	-	4	-	4	-	19	-	1	-	-	-	1	4	-	24
MidCentral	-	-	-	-	-	1	4	3	-	7	-	8	1	24	-	-	-	-	-	-	4	1	29
Whanganui	-	-	-	-	-	-	7	-	-	-	-	1	-	8	-	-	-	1	1	2	1	2	13
Capital & Coast	-	1	1	-	1	6	11	7	1	17	3	12	2	62	-	2	-	-	-	2	3	1	68
Hutt	-	-	1	-	-	4	-	2	1	12	2	10	-	32	-	-	-	-	-	-	-	1	33
Wairarapa	-	1	1	1	-	1	1	-	-	2	-		-	7	-	1	-	-	-	1	1	1	10
Southern	6	-	4	-	-	16	44	28	-	35	1	28	1	163	1	-	1	-	-	2	20	10	195
Nelson Marlborough	3	-	1	-	-	-	8	2	-	5	-	6	-	25	-	-	-	-	-	-	-	-	25
West Coast	2	-	-	-	-	-	-	1	-	-	-	-	-	3	-	-	-	-	-	-	-	1	4
Canterbury	-	-	1	-	-	8	20	12	-	18	1	18	1	79	-	-	-	-	-	-	16	7	102
South Canterbury	-	-	-	-	-	1	2	3	-	1	-	1	-	8	-	-	1	-	-	1	-	-	9
Southern	1	-	2	-	-	7	14	10	-	11	-	3	-	48	1	-	-	-	-	1	4	2	55
Total	20	4	12	2	4	43	138	76	10	132	15	114	11	582	1	4	3	1	6	15	54	26	677

*Includes Regional AOD Service Altered High.

Table 11. DHB Community Other Ethnicity ICAMH/AOD Workforce by Occupation (2020/21)

DHB Community Other Ethnicity Workforce by Occupation (Headcount 2020/21)	Alcohol & Other Drugs Practitioner	Co-Existing Problems Clinician	Psychiatrist	Nurse	Occupational Therapist	Psychotherapist	Psychologist	Registrar/Senior Medical Officer	Social Worker	Other Clinical	Clinical Sub-Total	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Manager	Total
Northern	6	1	8	10	2	1	17	4	18	3	70	-	-	3	2	75
Northland	-	1	2	4	-	-	1	1	-	-	9	-	-	-	-	9
Waitemata	6	-	1	2	1	1	2	-	13	2	28	-	-	2	-	30
Auckland	-	-	2	1	1	-	10	1	2	-	17	-	-	1	2	20
Counties Manukau	-	-	3	3	-	-	4	2	3	1	16	-	-	-	-	16
Midland	-	-	9	8	1	-	16	2	8	1	45	-	-	2	4	51
Waikato	-	-	2	1	1	-	6	-	3	1	14	-	-	-	2	16
Lakes	-	-	2	1	-	-	1	-	1	-	5	-	-	1	-	6
Bay of Plenty	-	-	2	6	-	-	7	2	4	-	21	-	-	1	2	24
Tairawhiti	-	-	-	-	-	-	1	-	-	-	1	-	-	-	-	1
Taranaki	-	-	3	-	-	-	1	-	-	-	4	-	-	-	-	4
Central	2	-	9	10	3	-	6	4	6	2	42	1	1	8	6	57
Hawke's Bay	-	-	1	1	-	-	2	-	-	-	4	-	-	-	1	5
MidCentral	-	-	1	-	-	-	-	-	-	1	2	-	-	-	-	2
Whanganui	2	-	2	1	-	-	-	-	4	-	9	-	-	1	-	10
Capital & Coast	-	-	4	6	3	-	4	4	1	1	23	1	1	5	4	33
Hutt	-	-	-	-	-	-	-	-	1	-	1	-	-	-	1	2
Wairarapa	-	-	1	2	-	-	-	-	-	-	3	-	-	2	-	5
Southern	-	-	10	8	-	1	6	-	3	1	29	-	-	-	-	29
West Coast	-	-	1	-	-	-	1	-	-	-	2	-	-	-	-	2
Canterbury	-	-	6	6	-	1	2	-	2	1	18	-	-	-	-	18
Southern	-	-	3	2	-	-	3	-	1	-	9	-	-	-	-	9
Total	8	1	36	36	6	2	45	10	35	7	186	1	1	13	12	212

*Includes Regional AOD Service Altered High.

Table 12. Non-DHB ICAMH/AOD Workforce by Occupation (2020/21)

Non-DHB Workforce by Occupation (Actual FTEs, 2020/21)	Alcohol & Other Drugs Practitioner	Co-Existing Problems Clinician	Clinical Intern	Counsellor	Family Therapist	Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Registrar/Senior Medical Officer	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Consumer Advisors	Mental Health Support	Peer Support	Whānau Ora Practitioner	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Management	Total
Northern	29.9	-	-	-	-	7.1	1.5	0.4	0.8	4.53	-	8.7	4.23	57.15	-	1.2	29.4	1.0	2.5	16.8	5.8	56.7	2.0	5.7	121.55
Northland	8.0	-	-	-	-	-	-	-	-	-	-		1.0	9.0	-	-	4.0	-	-	1.8	-	5.8	-	-	14.8
Waitemata	0.2	-	-	-	-	5.0	1.0	0.4	-	1.0	-	4.0		11.6	-	0.2	4.6	-	2.5	4.0	-	11.3	-	-	22.9
Auckland	10.2	-	-	-	-	2.1	0.5	-	-	1.33	-		2.73	16.85	-	-	11.6	-	-	-	1.0	12.6	-	2.9	32.35
Counties Manukau	11.5	-	-	-	-	-	-	-	0.8	2.2	-	4.7	0.5	19.70	-	1.0	9.2	1.0	-	11.0	4.8	27.0	2.0	2.8	51.5
Midland	29.9	1.0	1.0	6.6	5.5	37.6	3.5	4.6	-	2.9	0.5	24.5	13.7	131.3	2.0	0.5	24.8	7.3	2.5	20.9	4.5	62.5	1.6	7.33	202.73
Waikato	16.4	-	1.0	-	2.0	26.0	2.5	4.6	-	2.9	0.5	13.0		68.9	2.0	-	11.8	1.0	-	7.0	2.5	24.3	1.0	3.0	97.2
Lakes	4.0	-	-	-	-	9.4	-	-	-	-	-	2.0		15.4	-	-	7.0	1.0	-	6.2	-	14.2	0.6	1.93	32.13
Bay of Plenty	9.5	1.0	-	3.80	3.5	1.2	1.0	-	-	-	-	6.5	12.7	39.2	-	0.5	5.0	4.3	2.5	6.6	1.0	19.9	-	1.4	60.5
Tairawhiti	-	-	-	1.80	-	-	-	-	-	-	-			1.8	-	-	-	1.0	-	-	-	1.0	-	-	2.8
Taranaki	-	-	-	1.0	-	1.0	-	-	-	-	-	3.0	1.0	6.0	-	-	1.0	-	-	1.1	1.0	3.1	-	1.0	10.1
Central	15.4	-	0.3	10.68	-	5.68	0.95	-	-	5.58	-	9.36	8.5	56.44	0.51	-	20.4	1.0	-	10.0	15.28	47.19	2.48	8.38	114.49
Hawke's Bay	-	-	-	3.0	-	0.1	-	-	-	-	-	1.2	1.0	5.3	-	-	3.3	-	-	-	-	3.3	-	1.0	9.6
MidCentral	3.9	-	-	0.2	-	-	-	-	-	1.8	-	1.0	7.5	14.4	-	-	8.0	1.0	-	-	11.0	20.0	-	-	34.4
Whanganui	-	-	-	0.08	-	1.0	-	-	-	-	-	1.26		2.34	-	-	0.7	-	-	1.2	-	1.9	0.28	-	4.52
Capital & Coast	9.7	-	-	4.7	-	1.95	0.95	-	-	3.15	-	3.35		23.8	-	-	4.6	-	-	2.0	3.15	9.75	2.0	5.0	40.55
Hutt	1.8	-	0.3	2.7	-	1.3	-	-	-	0.3	-	1.9		8.3	-	-	3.8	-	-	5.8	-	9.6	-	1.8	19.7
Wairarapa	-	-	-	-	-	1.33	-	-	-	0.33	-	0.65		2.3	0.51	-	-	-	-	1.0	1.13	2.64	0.2	0.58	5.72
Southern	15.0	6.0	-	12.77	-	1.9	7.13	0.6	1.5	5.4	-	15.18	10.0	75.48	1.0	0.4	40.01	4.1	-	12.0	2.0	59.51	5.7	8.25	148.94
West Coast	-	-	-	-	-	-	-	-	-	-	-			-	-	-	-	-	-	3.0	-	3.0	-	-	3.0
Nelson Marlborough	-	-	-	0.83	-	-	0.83	-	-	-	-	0.83		2.49	-	-	6.21	-	-	0.5	-	6.71	-	-	9.2
Canterbury	11.0	-	1.0	5.5	-	1.0	-	-	0.5	2.0	-	6.3	9.0	36.3	-	-	19.65	3.0	-	1.5	-	24.65	0.7	2.0	63.65
South Canterbury	-	-	1.0	0.74	-	0.4	1.0	-	-	0.8	-	1.6		5.54	0.1	-	2.4	-	-	-	-	2.5	0.5	0.5	9.04
Southern	4.0	6.0	1.6	5.7	1.0	0.5	5.3	0.6	1.0	2.6	-	6.45	1.0	35.75	0.9	0.4	11.75	0.6	-	7.0	2.0	22.65	4.5	5.75	68.65
Total	90.2	7.0	1.3	30.05	5.5	52.28	13.08	5.6	2.3	18.4	0.5	57.74	36.43	320.37	3.51	2.1	114.61	13.4	5.0	59.7	27.58	225.9	11.78	29.66	587.71

Table 13. Non-DHB ICAMH/AOD Vacant FTEs by Occupation (2020)

Non-DHB Vacant FTEs by Occupation (2020/21)	Alcohol & Other Drugs Practitioner	Counsellor	Nurse	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Consumer Advisors	Mental Health Support	Peer Support	Youth Worker	Non-Clinical Sub-Total	Management	Total
Northern	3.0	-	-	0.6	-	4.0	7.6	-	-	3.0	-	-	3.0	1.0	11.6
Northland	2.0	-	-	-	-	4.0	6.0	-	-	-	-	-	-	-	6.0
Auckland	-	-	-	0.6	-	-	0.6	-	-	3.0	-	-	3.0	-	3.6
Counties Manukau	1.0	-	-	-	-	-	1.0	-	-	-	-	-	-	1.0	2.0
Midland	1.0	-	1.4	-	2.0	2.0	6.4	1.0	-	1.0	-	1.0	3.0	-	9.4
Waikato	1.0	-	-	-	1.0	-	2.0	1.0	-	-	-	1.0	2.0	-	4.0
Lakes	-	-	0.4	-	1.0	-	1.4	-	-	-	-	-	-	-	1.4
Bay of Plenty	-	-	-	-	-	1.0	1.0	-	-	1.0	-	-	1.0	-	2.0
Tairawhiti	-	-	1.0	-	-	-	1.0	-	-	-	-	-	-	-	1.0
Taranaki	-	-	-	-	-	1.0	1.0	-	-	-	-	-	-	-	1.0
Central	-	-	-	-	-	3.3	3.3	-	-	-	-	-	-	-	3.3
MidCentral	-	-	-	-	-	3.3	3.3	-	-	-	-	-	-	-	3.3
Southern	-	1.0	-	-	-	1.57	2.57	0.4	0.1	1.0	0.2	-	1.7	1.0	5.27
Canterbury	-	-	-	-	-	-	-	0.4	0.1	1.0	0.2	-	1.7	-	1.7
Southern	-	1.0	-	-	-	1.57	2.57	-	-	-	-	-	-	1.0	3.57
Total	4.0	1.0	1.4	0.6	2.0	10.87	19.87	1.40	0.1	5.0	0.2	1.0	7.7	2.0	29.57

Note: Includes PHOs.

Table 14. Non-DHB Māori ICAMH/AOD Workforce by Occupation (2020/21)

Non-DHB Māori Workforce by Occupation (Headcount, 2020/21)	Alcohol & Other Drugs Practitioner	Co-Existing Problems Clinicians	Clinical Placement	Counsellor	Family Therapist	Nurse	Occupational Therapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Consumer Advisors	Mental Health Support	Peer Support	Whānau Ora Practitioner	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Management	Total
Northern	11	-	-	-	-	1	-	1	4	1	18	-	1	7	-	2	6	12	28	3	3	52
Northland	4	-	-	-	-	-	-	-	-	1	5	-	-	1	-	-	2	-	3	-	-	8
Waitemata	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-	2	3	-	5	-	-	6
Auckland	2	-	-	-	-	1	-	-	-	-	3	-	-	2	-	-	-	-	2	-	-	5
Counties Manukau	5	-	-	-	-	-	-	1	3	-	9	-	1	4	-	-	1	12	18	3	3	33
Midland	18	1	-	6	2	20	1	3	22	12	85	2	-	10	7	5	7	1	32	-	1	118
Waikato	12	-	-	-	1	20	-	3	14	-	50	2	-	7	1	2	3	-	15	-	-	65
Lakes	2	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-	1	-	1	-	-	3
Bay of Plenty	4	1	-	5	1	-	1	-	6	12	30	-	-	2	5	3	3	1	14	-	-	44
Tairawhiti	-	-	-	1	-	-	-	-	-	-	1	-	-	-	1	-	-	-	1	-	-	2
Taranaki	-	-	-	-	-	-	-	-	2	-	2	-	-	1	-	-	-	-	1	-	1	4
Central	3	-	-	1	-	3	-	1	2	2	12	1	-	7	2	-	1	12	23	1	3	39
Hawke's Bay	-	-	-	1	-	2	-	-	2	-	5	-	-	4	-	-	-	-	4	-	-	9
MidCentral	3	-	-	-	-	-	-	-	-	2	5	-	-	3	2	-	-	11	16	-	-	21
Whanganui	-	-	-	-	-	1	-	-	-	-	1	-	-	-	-	-	-	-	-	1	1	3
Capital & Coast	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	1
Hutt	-	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	2	3
Wairarapa	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1	-	2	-	-	2
Southern	2	2	1	2	1	1	1	1	3	-	14	2	1	5	4	-	1	-	13	1	3	31
Nelson Marlborough	-	-	-	1	-	-	-	-	1	-	2	-	-	-	3	-	-	-	3	-	-	5
Canterbury	-	-	-	1	-	-	-	-	-	-	1	-	-	3	1	-	1	-	5	-	-	6
South Canterbury	-	-	-	-	-	1	-	-	-	-	1	1	-	1	-	-	-	-	2	-	-	3
Southern	2	2	1	-	1	-	1	1	2	-	10	1	1	1	-	-	-	-	3	1	3	17
Total	34	3	1	9	3	25	2	6	31	15	129	5	2	29	13	7	15	25	96	5	10	240

Note: Includes PHOs.

Table 15. Non-DHB Pacific ICAMH/AOD Workforce by Occupation (2020/21)

Non-DHB Pacific Workforce by Occupation (Headcount, 2020/21)	Alcohol & Other Drugs Practitioner	Co-Existing Problems Clinician	Clinical Placement	Counsellor	Nurse	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Cultural	Consumer Advisor	Educator	Mental Health Support	Peer Support	Whānau Ora Practitioner	Youth Worker	Non-Clinical Sub-Total	Manager	Total
Northern	6	-	-	-	1	-	1	4	4	16	-	1	3	4	4	1	7	20	2	38
Waitemata	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	1	1	2	-	3
Auckland	3	-	-	-	1	-	1	-	4	9	-	-	1	2	-	-	-	3	1	13
Counties Manukau	3	-	-	-	-	-	-	3	-	6	-	1	2	2	4	-	6	15	1	22
Midland	-	-	-	-	1	1	-	-	-	2	-	-	-	3	-	-	1	4	-	6
Waikato	-	-	-	-	1	-	-	-	-	1	-	-	-	2	-	-	-	2	-	3
Lakes	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	2	-	2
Bay of Plenty	-	-	-	-	-	1	-	-	-	1	-	-	-	-	-	-	-	-	-	1
Central	-	-	1	3	-	-	-	-	2	6	-	-	1	1	-	-	-	2	-	8
MidCentral	-	-	-	-	-	-	-	-	2	2	-	-	-	-	-	-	-	-	-	2
Capital & Coast	-	-	-	2	-	-	-	-	-	2	-	-	1	-	-	-	-	1	-	3
Hutt	-	-	1	1	-	-	-	-	-	2	-	-	-	1	-	-	-	1	-	3
Southern	1	1	1	-	-	-	-	-	-	3	1	-	-	1	-	-	1	3	-	6
Canterbury	1	-	-	-	-	-	-	-	-	1	-	-	-	1	-	-	1	2	-	3
Southern	-	1	1	-	-	-	-	-	-	2	1	-	-	-	-	-	-	1	-	3
Total	7	1	2	3	2	1	1	4	6	27	1	1	4	9	4	1	9	29	2	58

Note: Includes PHOs.

Table 16. Non-DHB Asian ICAMH/AOD Workforce by Occupation (2020/21)

Non-DHB Asian Workforce by Occupation (Headcount, 2020/21)	Alcohol & Other Drugs Practitioner	Nurse	Counsellor	Social Worker	Other Clinical	Clinical Sub-Total	Mental Health Support	Peer Support	Youth Worker	Non-Clinical Sub-Total	Manager	Total
Northern	4	-	-	1	2	7	7	-	1	8	-	15
Waitemata	-	-	-	1	-	1	2	-	-	2	-	3
Auckland	1	-	-	-	-	1	4	-	-	4	-	5
Counties Manukau	3	-	-	-	2	5	1	-	1	2	-	7
Midland	3	1	-	-	-	4	2	-	-	2	1	7
Waikato	1	-	-	-	-	1	-	-	-	-	-	1
Lakes	1	1	-	-	-	2	2	-	-	2	1	5
Bay of Plenty	1	-	-	-	-	1	-	-	-	-	-	1
Central	3	-	-	1	-	4	3	-	-	3	1	8
Capital & Coast	3	-	-	-	-	3	2	-	-	2	-	5
Hutt	-	-	-	1	-	1	1	-	-	1	1	3
Southern	-	-	-	-	1	2	-	1	-	1	-	3
Canterbury	-	-	-	-	1	1	-	1	-	1	-	2
Southern	-	-	1	-	-	1	-	-	-	-	-	1
Total	10	1	1	2	3	17	12	1	1	14	2	33

Note: Includes PHOs.

Table 17. Non-DHB NZ European ICAMH/AOD Workforce by Occupation (2020/21)

Non-DHB NZ European Workforce by Occupation (Headcount, 2020/21)	Alcohol & Other Drugs Practitioner	Co-Existing Problems Clinicians	Counsellor	Nurse	Occupational Therapist	Psychiatrist	Psychotherapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Consumer Advisors	Mental Health Support	Peer Support	Whānau Ora Practitioner	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Management	Total
Northern	8	-	-	-	6	2	1	5	1	14	37	-	11	-	-	1	-	12	-	4	53
Northland	2	-	-	-	-	-	-	-	-	-	2	-	2	-	-	-	-	2	-	-	4
Waitemata	-	-	-	-	5	2	-	1	1	-	9	-	4	-	-	-	-	4	-	-	13
Auckland	5	-	-	-	1	-	-	2	-	10	18	-	2	-	-	-	-	2	-	3	23
Counties Manukau	1	-	-	-	-	-	1	2	-	4	8	-	3	-	-	1	-	4	-	1	13
Midland	14	-	3	18	2	5	1	1	5	6	55	-	15	1	1	4	3	24	-	4	83
Waikato	11	-	-	8	2	5	1	1	1	-	29	-	7	-	1	-	-	8	-	1	38
Lakes	1	-	-	8	-	-	-	-	2	-	11	-	5	1	-	-	-	6	-	2	19
Bay of Plenty	2	-	1	1	-	-	-	-	1	6	11	-	3	-	-	2	2	7	-	1	19
Tairawhiti	-	-	1	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	1
Taranaki	-	-	1	1	-	-	-	-	1	-	3	-	-	-	-	2	1	3	-	-	6
Central	6	-	5	12	-	-	-	3	7	5	38	-	13	-	-	3	5	21	1	2	62
Hawke's Bay	-	-	1	9	-	-	-	-	2	1	13	-	1	-	-	-	-	1	-	-	14
MidCentral	2	-	1	-	-	-	-	2	1	4	10	-	7	-	-	-	-	7	-	-	17
Whanganui	-	-	-	-	-	-	-	-	2	-	2	-	1	-	-	2	-	3	1	-	6
Capital & Coast	3	-	1	-	-	-	-	1	-	-	5	-	2	-	-	-	5	7	-	1	13
Hutt	1	-	2	3	-	-	-	-	2	-	8	-	2	-	-	-	-	2	-	1	11
Wairarapa	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1	-	-	1
Southern	9	5	11	2	7	2	1	2	11	12	62	2	21	3	-	2	-	28	6	8	104
Nelson Marlborough	-	-	-	-	1	-	-	-	-	-	1	-	-	-	-	1	-	1	-	-	2
Canterbury	7	-	4	-	-	-	-	-	4	6	21	-	10	2	-	1	-	13	-	1	35
South Canterbury	-	-	1	1	1	-	-	1	2	1	7	-	2	-	-	-	-	2	1	1	11
Southern	2	5	6	1	5	2	1	1	5	5	33	2	9	1	-	-	-	12	5	6	56
Total	37	5	19	32	15	9	3	11	24	37	192	2	60	4	1	10	8	85	7	18	302

Note: Includes PHOs.

Table 18. Non-DHB Other Ethnicity ICAMH/AOD Workforce by Occupation (2020/21)

Non-DHB Other Ethnicity Workforce by Occupation Group (Headcount, 2020/21)	Alcohol & Other Drugs Practitioner	Counsellor	Nurse	Occupational Therapist	Psychologist	Social Worker	Other Clinical	Clinical Sub-Total	Mental Health Support	Youth Worker	Other Non-Clinical	Non-Clinical Sub-Total	Administrator	Management	Total
Northern	1	-	1	-	-	-	7	9	5	3	-	8	-	1	18
Northland	-	-	-	-	-	-	-	-	1	-	-	1	-	-	1
Waitemata	1	-	1	-	-	-	-	2	-	-	-	-	-	-	2
Auckland	-	-	-	-	-	-	7	7	2	-	-	2	-	1	10
Counties Manukau	-	-	-	-	-	-	-	-	2	3	-	5	-	-	5
Midland	3	-	2	1	-	-	-	6	1	5	-	6	1	-	13
Waikato	2	-	-	1	-	-	-	3	1	-	-	1	-	-	4
Lakes	-	-	2	-	-	-	-	2	-	2	-	2	1	-	5
Bay of Plenty	1	-	-	-	-	-	-	1	-	3	-	3	-	-	4
Central	2	1	4	-	1	-	-	8	2	-	2	4	2	7	21
Hawke's Bay	-	1	3	-	-	-	-	4	1	-	-	1	-	1	6
MidCentral	-	-	-	-	1	-	-	1	-	-	-	-	-	-	1
Capital & Coast	-	-	-	-	-	-	-	-	-	-	-	-	1	3	4
Hutt	2	-	-	-	-	-	-	2	1	-	-	1	-	2	5
Wairarapa	-	-	1	-	-	-	-	1	-	-	2	2	1	1	5
Southern	1	2	-	-	-	1	-	4	5	-	-	5	-	-	9
Canterbury	1	1	-	-	-	1	-	3	4	-	-	4	-	-	7
Southern	-	1	-	-	-	-	-	1	1	-	-	1	-	-	2
Total	7	3	7	1	1	1	7	27	13	8	2	23	3	8	61

Note: Includes PHOs.

Table 19. Total ICAMH/AOD Workforce by Service Type, Ethnicity & Region (2020/21)

Total ICAMH/AOD Workforce by Ethnicity (2020/21)	Māori			Pacific			Asian			NZ European			Other Ethnicity			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	78	52	130	43	38	81	51	15	66	231	53	284	118	18	136	521	176	697
Midland	30	118	148	5	6	11	9	7	16	85	83	168	51	13	64	180	227	407
Central	37	39	76	19	8	27	13	8	21	187	62	249	62	21	83	318	138	456
Southern	29	31	60	5	6	11	8	3	11	243	104	347	35	9	44	320	153	473
National Youth Forensic	10	-	10	16	-	16	-	-	-	10	-	10	5	-	5	41	-	41
Total	184	240	424	88	58	146	81	33	114	756	302	1,058	271	61	332	1380	693	2,074

*Includes Inpatient Workforce. ** Non-DHB includes NGOs & PHOs.

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

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