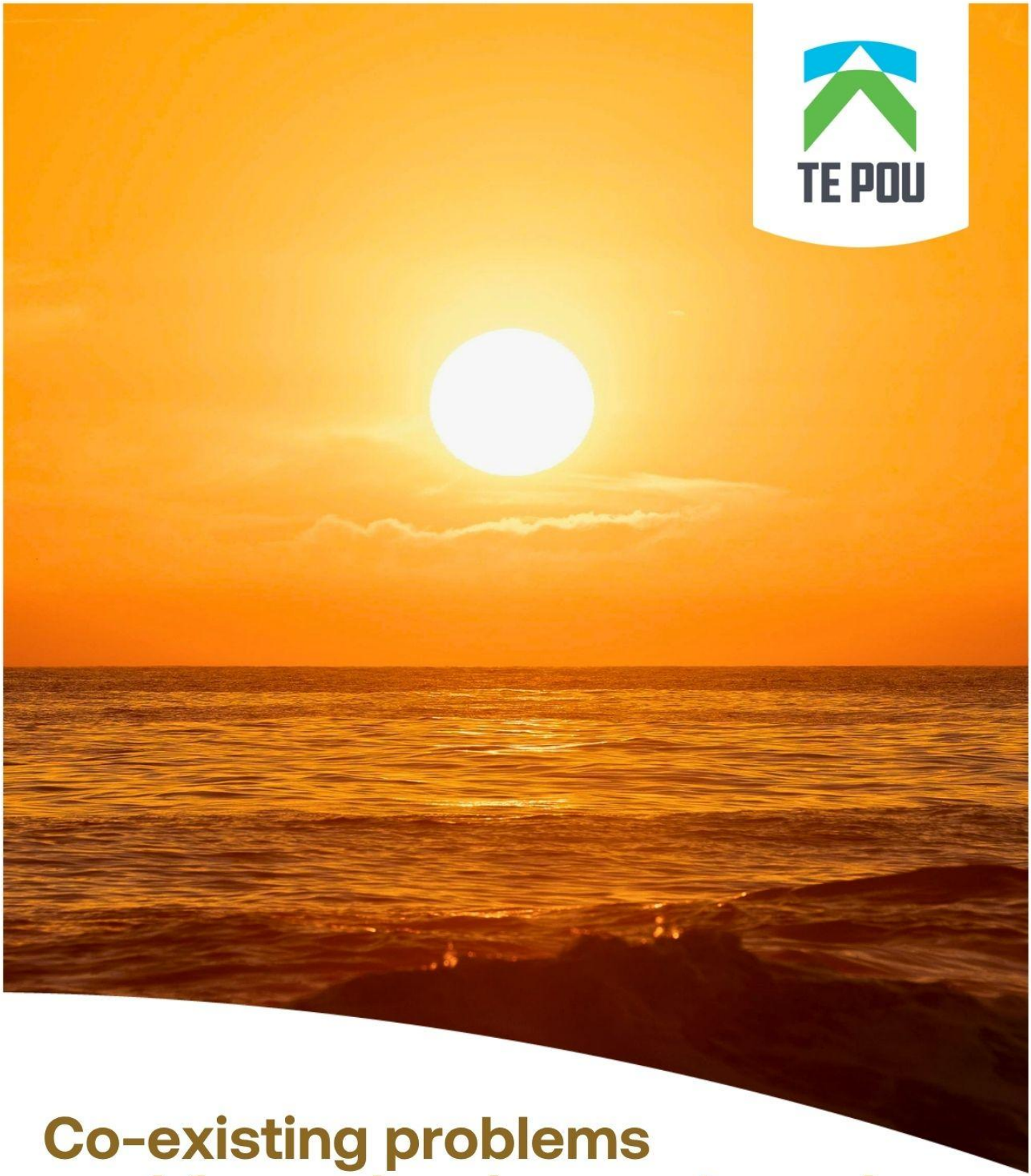

TE POU

Co-existing problems workforce development needs

A survey of the addiction and mental health workforce

June 2026

tepou.co.nz

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This report was written by Te Pou. It presents findings from a survey of the mental health and addiction sector. Te Pou warmly acknowledges and appreciates the contribution of all those who completed the survey.

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Contents

List of figures

List of tables

Executive summary

The term ‘co-existing problems’ (also known as ‘CEP’) is used to refer to when people experience more than one addiction or mental health challenge at the same time (Todd, 2010). In April and May 2026, Te Pou surveyed addiction and mental health workers (kaimahi). The survey aimed to understand kaimahi confidence for working alongside tāngata whai ora who have co-existing problems, use of frameworks like *Te Ariari o te Oranga* (Te Ariari; Todd, 2010) and The Werry Centre’s (2013) *Co-existing Problems (CEP) and Youth*, prior training, and areas for future workforce and organisational development.

Survey findings

The survey was completed by 152 kaimahi, of whom 99 reported on their ethnic and employment profile. Thirty-five percent identify as Māori and 9 percent in Pasifika or Asian ethnic groups. Three-fifths are grouped as clinicians and one-quarter as support workers. The rest are managers or team leaders with a few in other roles like advisors and educators. Half of the kaimahi work in mental health services, one-quarter in alcohol and drug services, and one-quarter in other services like primary healthcare and social services. Two-fifths work for NGOs and similar for Health New Zealand | Te Whatu Ora. More kaimahi work in the Central | Te Ikaroa and South Island | Te Waipounamu regions than Northern.

Most kaimahi responding to the survey often work alongside tāngata whai ora with co-existing problems relating to mental health or substance use. Half or more also sometimes or often work alongside tāngata whai ora with various other challenges, like gambling harm and concerning behaviours, physical health problems, disabilities, and poverty. In their practice, kaimahi say they use a mix of Māori models of health, co-existing problems frameworks, whānau ora and collaborative or integrated approaches, and other tools and resources. One-quarter use the *Te Ariari* framework and 20 percent use The Werry Centre’s (2013) *Co-existing Problems (CEP) and Youth* framework. About half of kaimahi report not using any co-existing problems frameworks in their mahi. Many kaimahi say they are confident in their knowledge and skills across different areas of co-existing problems practice, like engaging with whānau, upholding Te Tiriti o Waitangi (Te Tiriti) principles and equity, and doing comprehensive assessments. However, 1 in 5 are not confident in using screening or assessment tools or maintaining their own learning.

Kaimahi surveyed describe various prior training on co-existing problems via tertiary education and workplace-based or workforce centre training. Some rely on their own experience. One in 5 say they have had no training. Kaimahi want more training to develop skills for working with tāngata whai ora from other cultures and with whānau, using co-existing problems models and tools, and improving their community knowledge and connections. They prefer learning in-person or online, such as wānanga or e-learning modules. Many kaimahi describe barriers to effective practice across various areas, including a lack of resources, siloed and restrictive services and systems, difficulties

achieving collaboration, limited knowledge and skills, and bias and discrimination. Kaimahi say helpful organisational changes would include more professional and service development, additional or specialist staffing, improved collaboration, organisational culture and process development, and access to more co-existing problems models, tools, and resources.

Discussion

The survey findings are consistent with the national and international literature on workforce and service responses to tāngata whai ora with co-existing problems (Fonseca et al., 2026; Harris et al., 2023; Searby et al., 2025; Te Pou, 2022). There are various opportunities for future workforce development across three levels of the health system: workforce, organisations, and systems.

The following are opportunities for future workforce development identified by kaimahi responding to the survey.

- Applying Māori models of health and cultural safety in practice and working collaboratively with kaupapa Māori and other providers and services.
- Using co-existing problems frameworks, screening and assessment tools, and access to other professional development like reflective practice.
- Learning and development specific to different types of roles, like working collaboratively with other kaimahi and services, and building positive attitudes towards tāngata whai ora with co-existing problems.
- Improving kaimahi ability to deliver various cultural, integrated, collaborative, and collective approaches in their practice.

Kaimahi surveyed identified the following organisational development opportunities that would support continuous and ongoing improvement in responses to tāngata whai ora with co-existing problems.

- Growing Te Tiriti-based relationships and partnerships with other providers and strengthening referral pathways for tāngata whai ora with co-existing problems.
- Leadership and organisational culture development that supports ongoing improvement in co-existing problems service design, policies, procedures, and practices.
- Resource development to ensure kaimahi have the resources they need in their mahi, such as access to models and tools, and supports like reflective practices.

System development is crucial to provide the right environment that supports organisation responsiveness and enable kaimahi to grow in their practice. There are opportunities at this level to update co-existing problems frameworks and guidance, improve the coordination, integration, and alignment of services, and distribute resources more equitably across the sector.

Conclusion

Overall, the survey provides valuable insights for future co-existing problems workforce development across different levels of the health system. Kaimahi surveyed describe being flexible, skilled, and creative in responding to tāngata whai ora with co-existing problems. They want more workforce development opportunities to continue to improve their knowledge and skills, and organisational and systems development that will support them to grow in their practice. Next steps include bringing people with lived experience (personal and whānau), hapori Māori, and other communities' perspectives together to inform future workforce development decision-making and design.

Background

In the addiction and mental health sector, co-existing problems generally refers to people's experience of more than one such challenge at the same time. It is estimated at least 70 percent of tāngata whai ora accessing alcohol and drug services will have co-existing problems with mental health (Todd, 2010). Many tāngata whai ora will likely also experience other wellbeing challenges with their physical health, or from gambling and other behaviours and the social determinants of health (Lockett et al., 2018; A. McLachlan, 2008; A. D. McLachlan, 2017; Searby et al., 2025; Te Pou, 2023b).

People experiencing health inequities and social disadvantage are more likely than others to have co-existing problems, including Māori and Pasifika peoples, disabled people, Rainbow communities, children and older people, and those in low socio-economic circumstances (Te Pou, 2023; Todd, 2010). Co-existing problems can complicate the hauora journey for tāngata whai ora and whānau, adding to the inequities they experience in access to and choice of addiction and mental health services, and impacting their safety and outcomes (Government Inquiry into Mental Health and Addiction, 2018; Kapeli et al., 2020; Roy et al., 2023; Te Pou o te Whakaaro Nui, 2019; Waitangi Tribunal, 2023).

The addiction and mental health workforce is highly skilled and experienced, overall (Te Pou, 2024). Kaimahi working alongside tāngata whai ora and whānau can use various knowledge and skills, models, tools, and resources to respond to co-existing problems in ways that uphold people's mana and support achieving their health and wellbeing aspirations (Government Inquiry into Mental Health and Addiction, 2018; Potaka-Osborne, 2022; Todd, 2010). This occurs in a service delivery context that often delivers services separately by different providers working in isolation (Todd, 2010). This situation is not unique to Aotearoa New Zealand, as similar situations exist in other countries (Bratt, 2025; Fonseca et al., 2026; Harris et al., 2023; Searby et al., 2025).

Kaimahi can use various approaches to respond to tāngata whai ora with co-existing problems. In Aotearoa New Zealand, Māori models of health are widely used. These are holistic and encompass all dimensions of health (eg tinana, wairua, hinengaro, and whānau) supported by cultural values, practices, and relationships across communities, whenua, and te taiao, past, present, and future (Wilson et al., 2021). In te ao Māori, all challenges are considered interrelated and are responded to together within whānau ora and other collective cultural approaches (Huriwai et al., 2022; McLachlan, 2017; Te Rau Matatini, 2014). Kaimahi may also use co-existing problems frameworks like *Te Ariari* (which is currently being updated), *Te Whare o Tiki* (Matua Raki & Te Pou o te Whakaaro Nui, 2013), and The Werry Centre's (2013) *Co-existing problems (CEP) and Youth* framework, and various integrated approaches (Te Pou, 2022). These frameworks and approaches aim to align and coordinate services to better respond to tāngata whai ora with co-existing problems.

Kaimahi working alongside tāngata whai ora with co-existing problems may be supported in various ways by their organisations. Approaches vary widely depending on the workforce, service, organisation, and available resources and relationships (Harris et al., 2023). Organisations may have policies and protocols in place to respond to tāngata whai ora with co-existing problems, they may directly employ kaimahi with specialist co-existing problems knowledge within their service delivery teams, have specific co-existing problems services, or have agreed interagency referral pathways, and kaimahi from different organisations may deliver their services at the same time with various levels of collaboration and coordination, for example working in interdisciplinary teams (Fonseca et al., 2026; Harris et al., 2023; Searby et al., 2025; Todd, 2010).

Workforce development across all levels of the health system helps to ensure that systems, organisations, and kaimahi can continuously improve the supports available to tāngata whai ora with co-existing problems, and their whānau. This helps to build general and specialist knowledge and skills in the workforce, and use of co-existing problems models, tools, and other resources.

Aims and objectives

This project aims to gather information to support future workforce development for kaimahi working alongside tāngata whai ora with co-existing problems. The objectives were to better understand kaimahi:

- engagement with and confidence working alongside tāngata whai ora who have co-existing problems and use of co-existing problems frameworks
- learning and development, including prior training received, desired development, and learning methods
- access to organisational supports, barriers, and supportive changes needed.

Method

A survey was distributed between 29 April and 15 May 2026 to addiction and mental health kaimahi via the Te Pou monthly e-bulletin newsletter and by social media. Recipients were invited to forward the survey link to others, and the link was also distributed by other workforce centres and sector networks. Two reminder emails were sent out in the weeks following its release. Because of this method, we cannot identify exactly how many kaimahi received the survey and so cannot calculate a response rate.

Questionnaire design

The questionnaire was designed by Te Pou and peer reviewed by Whāraurau. Its content is based on *Te Ariari* principles, *Te Whare o Tiki* (Matua Raḵi & Te Pou o te Whakaaro Nui, 2013) capabilities, recent literature on co-existing problems organisational supports (Koning et al., 2017), and competencies for integration (Te Pou, 2022). It was also informed by good practices in workforce development and implementation (Te Pou, 2025a, 2025b). All

questions were optional and respondents could complete their own answers to questions if they did not want to choose from the list of options we provided. The survey was administered using Survey Monkey.

Screening and analysis

All completed surveys were screened before analysis. A small number were updated to include answers to 'other' questions in relevant specified options. For example, recoding 'AOD with…' to alcohol and drug service.

Analyses were conducted in Microsoft Excel and MAXQDA using all available data from completed questions. Analyses for each question present the total number of survey responses. Surveys that answered "Not applicable to my role" were excluded from the analysis of questions about kaimahi confidence and organisational support. All other information from surveys was included in analyses. No artificial intelligence assistance was used in designing the survey or its analysis and reporting.

Analysis of kaimahi ethnicity is based on the Ministry of Health | Manatū Hauora Ethnicity Data Protocols, to promote equity for priority groups; see Health Information Standards Organisation (2017). This method only counts kaimahi in one ethnic group. All kaimahi who identify as Māori are categorised as Māori; those who identify in one or more Pasifika ethnic groups and who are not Māori are categorised as Pasifika, and those who identify in one or more Asian ethnic groups and who are neither Māori nor Pasifika are categorised as Asian. Others are remaining kaimahi who identify with various other ethnic groups that are not Māori, nor Pasifika, nor Asian. Most people in the other groups identify as New Zealanders or others of British or European descent.

Table 1 summarises how survey responses were grouped for analysis and reporting.

Table 1. Ethnicity, role, and service groupings used to analyse surveys

Groups for analysis	Description
Ethnicity	**Māori**, everyone whose ethnic identity included Aotearoa New Zealand Māori. **Non-Māori**, everyone who do not identify as Māori and who identify with other ethnic group(s), including people who identified as Pasifika or Asian, or in other groups.
Role	**Clinicians**, are addiction practitioners registered with *dapaanz* and kaimahi whose practice requires registration under the 2003 HPCA Act, like nurses and occupational therapists. **Support workers**, are unregulated service delivery roles such as peer support workers, cultural support workers, and other support workers. **Managers or team leaders**, everyone who identified in a manager or team leader role, including chief executives. **Other roles**, roles not included in any of the above groups like advisors and educators.

Groups for analysis	Description
Service	**Addiction**, kaimahi who work in an alcohol and drug or gambling harm service. **Mental health**, kaimahi who work in a mental health service. **Other services**, kaimahi who specified a service not included in the addiction or mental health groups, such as primary healthcare.

Survey responses are analysed across three categories to show differences between kaimahi groups.

1. Overall responses from everyone who answered questions.
2. Responses from kaimahi Māori separate from non-Māori kaimahi.
3. Responses from support workers separate from clinicians and managers or team leaders.

Quotes provided in the report specify the contributor's mental health and addiction role and service to inform interpretation.

Limitations

The survey findings reflect the views of kaimahi who responded to the survey. These may not be representative of the overall addiction and mental health workforce, which numbers over 16,000 full-time equivalent positions. Further exploration of the views of managers and leaders, and people with lived experience, hapori Māori, and other communities will help to inform future workforce development activities.

Findings may not fairly reflect the views of people who work in the Northern region compared to Central | Te Ikaroa and South Island | Te Waipounamu regions, as the latter two regions contributed most responses.

Around 1 in every 3 people who started the survey did not complete the organisation support and personal profile questions. So, analyses for these questions are based on a smaller group than earlier questions and this may affect the reliability of these findings relative to others.

Findings

The survey explored addiction and mental health kaimahi confidence, prior training, and their workforce development and organisational support needs to enhance knowledge and skills for working alongside tāngata whai ora with co-existing problems. One hundred and fifty-two addiction and mental health kaimahi answered questions on co-existing problems. Findings are described in the following sections.

- Kaimahi profile, including ethnicity, role, service, workplace, and location.
- Engaging tāngata whai ora with co-existing problems, frameworks used, and kaimahi confidence in their knowledge and skills.
- Kaimahi development needs, including prior and desired training and development and preferred learning methods.
- Organisational development, including organisational responsiveness to tāngata whai ora with co-existing problems, barriers to practice, and supportive changes.

Kaimahi profile

Of the 152 survey responses from kaimahi, 99 completed questions about their ethnicity and employment, including role, service, workplace, and location. Table 2 shows the distribution of kaimahi in reporting groups, in total and the relative shares who identify as Māori or non-Māori.[1]

Overall, one-third identified as Māori, a small share identified in Pasifika or Asian ethnic groups (5 and 4 percent respectively). The remainder were mostly New Zealanders or others of British or European descent. Three-fifths worked as clinicians and one quarter as support workers including peer, cultural, and other types of support workers. The rest were managers or team leaders and a few in other roles such as advisors and educators.

Half of reporting kaimahi worked in mental health services and one-quarter in alcohol and drug services. No one said they worked in Preventing and Minimising Gambling Harm services. About one-quarter of kaimahi worked elsewhere including in private practice, primary healthcare, social services, education, and sexual and family violence services. Two-fifths worked in NGOs, with about one-third of these kaimahi working in kaupapa Māori NGOs. Another two-fifths worked in Health New Zealand | Te Whatu Ora, and the rest in other workplaces including self-employment and general practice clinics. Most kaimahi worked in either the Central | Te Ikaroa or South Island | Te Waipounamu regions (32 and 35 percent respectively).

Support workers, kaimahi from addiction services, those working in an NGO, and those from the Northern region were more likely than others to identify as Māori.

[1] More information about the allocation of kaimahi to reporting groups is available in the Methods section (Table 1).

Table 2. Summary of 99 kaimahi reporting any profile information to the survey in total and for Māori and other ethnic groups

Reporting groups	No. reporting kaimahi	Reporting kaimahi share (%)	Kaimahi Māori share (%)	Non-Māori kaimahi share (%)
All reporting kaimahi	**99**		**34.7**	**65.3**
Role groups				
Clinicians	59	59.6	29.3	70.7
Support workers	24	24.2	50.0	50.0
Manager or team leader	11	11.1	36.4	63.6
Other	5	5.1	20.0	80.0
Service				
Addiction	24	24.7	41.7	58.3
Mental health	50	51.6	32.0	68.0
Other	23	23.7	31.8	68.2
Workplace				
NGO	40	40.8	37.5	62.5
Health New Zealand	42	42.9	33.3	66.7
Other	16	16.3	33.3	66.7
Location				
Northern	18	18.4	44.4	55.6
Midland | Te Manawa Taki	19	19.4	36.8	63.2
Central | Te Ikaroa	30	31.6	26.7	29.7
South Island | Te Waipounamu	34	34.7	32.4	33.6

Notes. Fifty-three to 55 kaimahi did not complete some or all profile information and therefore are excluded from analyses in the table. Four kaimahi reported working in more than one region.

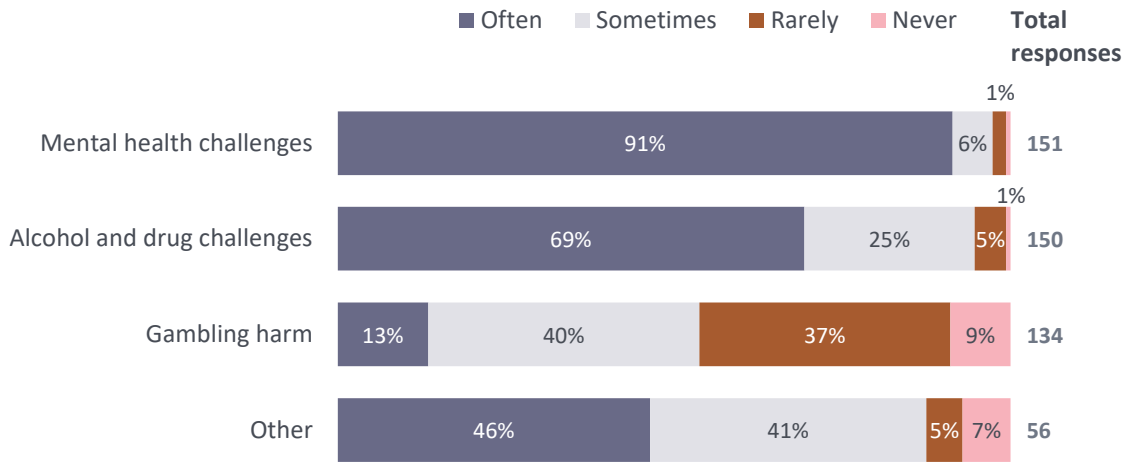
Engaging tāngata whai ora with co-existing problems

Up to 151 kaimahi described how often they work alongside tāngata whai ora with co-existing problems, the frameworks they use in their mahi, and their confidence working alongside tāngata whai ora and whānau.

Tāngata whai ora with co-existing problems

Figure 1 shows that nearly all kaimahi said they often work alongside tāngata whai ora with co-existing problems relating to mental health challenges and two-thirds say the same for alcohol and drug challenges.

Figure 1. Share of 151 kaimahi reporting how often they work alongside tāngata whai ora with co-existing problems



Some results differed for some groups of kaimahi. Kaimahi Māori were more likely than non-Māori to say they often work alongside tāngata whai ora with co-existing problems relating to substance use. Support workers were slightly more likely than clinicians to say they often work alongside tāngata whai ora with coexisting problems relating to mental health, substance use, and gambling harm.

Forty-four kaimahi identified other types of challenges impacting tāngata whai ora they work alongside, including:

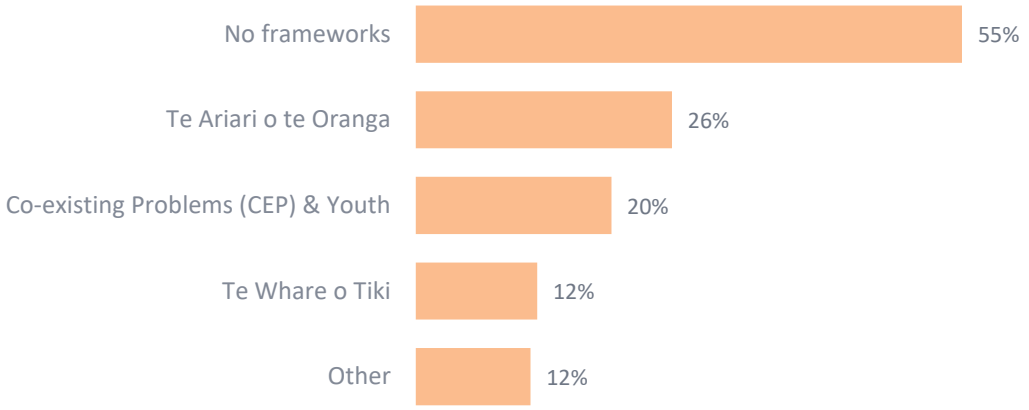
- behaviours relating to sex, pornography, gaming, hoarding, and food (16 kaimahi)
- trauma and past and present experience of violence, including whānau violence (14 kaimahi)
- poverty including housing challenges and homelessness, food insecurity, and work, educational, or income difficulties (10 kaimahi)
- challenges in their relationships and whānau (six kaimahi)
- disabilities including foetal alcohol spectrum disorder, cognitive impairment, neurodiversity, and intellectual disabilities (five kaimahi)
- various other challenges relating to physical health, identity, and engagement with authorities (each aspect was reported by three kaimahi).

For these other challenges, kaimahi Māori were more likely to describe issues relating to poverty than non-Māori. Non-Māori kaimahi were more likely than Māori to describe concerning behaviours and disabilities. Support workers were more likely than clinicians to describe challenges relating to disabilities. Clinicians were more likely than support workers to describe concerning behaviours, violence and trauma.

Use of frameworks

Figure 2 shows one-fifth to one-quarter of kaimahi surveyed use *Te Ariari* or The Werry Centre's (2013) *Co-existing Problems (CEP) and Youth* frameworks. Just over half of kaimahi say their practice is not informed by any co-existing problems framework.

Figure 2. Share of 149 kaimahi reporting their practice is informed by co-existing problems frameworks



Note. Results add up to more than 100 percent because kaimahi could select more than one framework.

A similar share of kaimahi Māori and non-Māori used *Te Ariari*, *Te Whare o Tiki*, or *Co-existing problems (CEP) and Youth*. Support workers were more likely than clinicians to say they used no clinical frameworks, which is consistent with support worker role expectations.

Seventeen kaimahi identified other models and approaches they use in their mahi, including:

- various Māori models of health, practices, and tools like Te Whare Tapa Whā, Whānau Ora, Hua Oranga, Principles of Āta, and Mahi a Atua (eight kaimahi)
- other approaches and models like early psychosis intervention, therapeutic communities, recovery health model, State Spinal Cord Injury Service model, and motivational interviewing (seven kaimahi)
- Pasifika health models like Fonofale and the Matalafi Matrix (two kaimahi).

Kaimahi Māori and support workers were more than twice as likely to report using Māori models, practices, and tools than non-Māori kaimahi and clinicians, who were more likely to report using other approaches.

Comments

Forty-eight kaimahi surveyed commented on their use of co-existing problems frameworks. Comments show these kaimahi are exercising their agency by using and adapting various Māori and other models, integrated approaches, practices, and tools and resources to meet the needs of their communities.

Ten kaimahi described their use of Māori models of health and approaches aligned with te ao Māori, describing these in terms of holistic and responsive practice centred on Māori values and practices.

> "Utilising ngā taonga tuku iho me ngā Atua Pūrākau to reconnect whānau to Ko Wai Au and expose whānau to the healing energies within Te Ao Māori" (Manager or team leader).

> "My teams use these frameworks alongside other Māori screening and engagement frameworks, retrieving those from their kete that meet the need of our whaiora within the competency level of the kaimahi" (Manager or team leader).

> "[Te Whare Tapa Whā] prepares me to understand how different areas of someone's life can impact their mental health and recovery" (Support worker in a mental health service).

> "Past: Understanding and dealing with past traumas; reconnecting to tūpuna knowledge. Present: Making physical, mental and spiritual changes. Future: Using the learned from the past and present to map out a new future."

Seventeen kaimahi commented on integration approaches, including cultural connection, other theoretical models, and self-reflection.

> "Our programs supporting whaiora focuses on spending time in the land (nature/rivers), strengthening whānau ties (kai/noho marae), engaging with stories of people, connection to other organisation for further supports" (Clinician in an addiction service).

> "Fonofale used as a baseline, matalafi used in reoccurring difficulties with focus on a specific domain. While the popao used in transitioning to primary care from secondary services. Applied Pacific models in context of continuum of care and use with a view of *Te Ariari* o te Oranga principles being applied in practice" (Clinician in a mental health service).

> "We use a [Home Education Activities/Alcohol Diet/Drugs Self-esteem/Sexuality Safety/Suicide] Assessment model by going through different aspects of the [young

person's] life and very helpful in identifying the issue [they are] facing" (Clinician in a mental health service).

Fifteen kaimahi specifically mentioned using *Te Ariari* and other frameworks, either directly in support or for reference in their mahi.

> "*Te Ariari o te Oranga* provides a solid foundation for developing a treatment plan when working with service users. As a suitable tool for group facilitation, I find it has limitations with application process" (Manager or team leader in a mental health service).

> "In the screening, assessment, understanding and formulation of presenting and enduring problems and how best to support tāngata whai ora and care teams working alongside tāngata whai ora and other professionals in the [multidisciplinary] team" (Clinician in a mental health service).

> "[*Te Ariari*] It's the [co-existing problems] bible, looking forward to the refresh, hint, hint, let's get it published!!" (Clinician)

Ten kaimahi discussed other aspects of integration approaches that influence their practice.

> "[We have a] specific [co-existing problems] intake pathway option" (Clinician in a mental health service).

> "Assessment, safe intervention, Whakaoho Oranga, Whānau and individual healing" (Other role in a mental health service).

> "As one example we use the latest research on particular co-morbidity issues which do not always use 'Frameworks'" (Clinician in an addiction service).

> "Applying knowledge gained through years of work in mental health field. Awareness of cultural needs and barriers to accessing support."

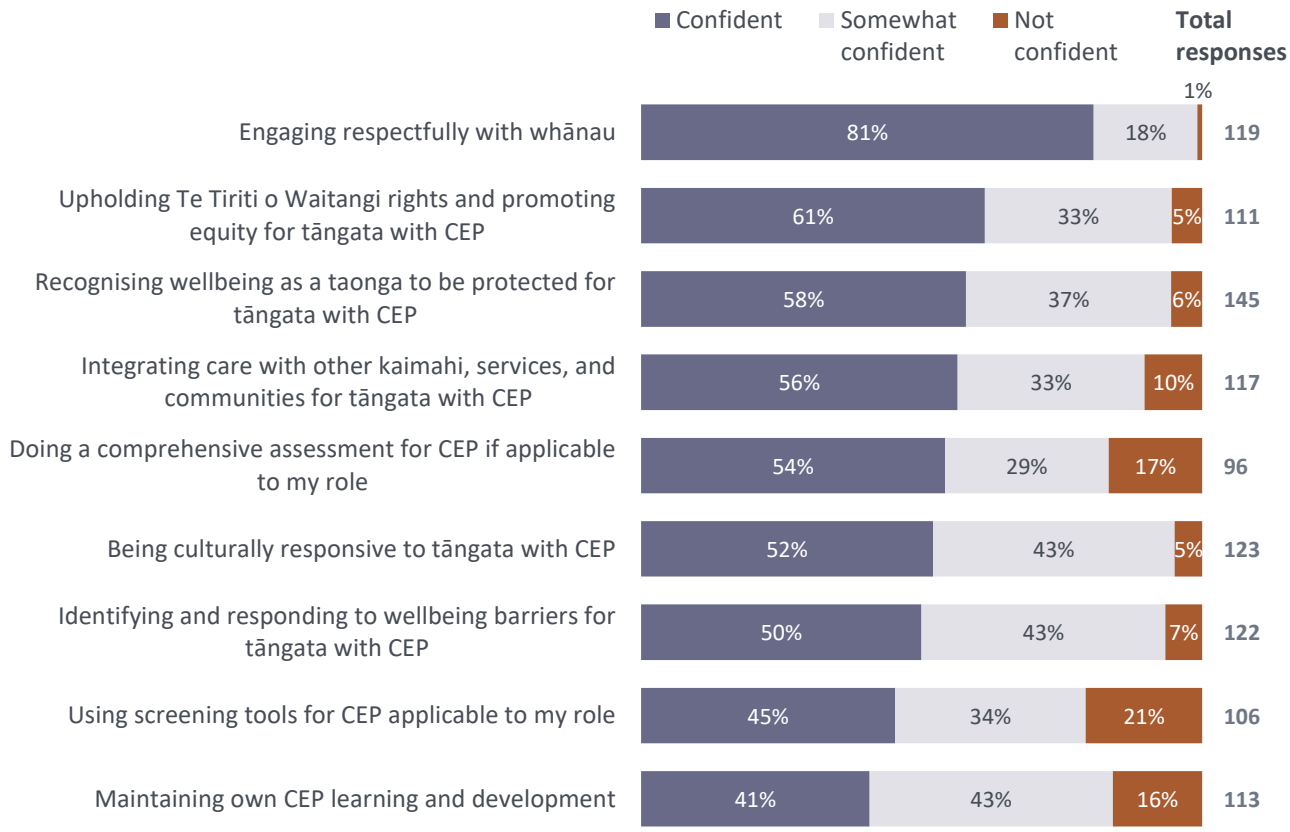
Kaimahi Māori were substantially more likely than non-Māori to discuss Māori models. Support workers were more likely than clinicians to discuss Māori models and integration approaches. Clinicians were more likely to discuss *Te Ariari* or *Te Whare o Tiki*.

Confidence in knowledge and skills

Figure 3 shows that most kaimahi felt confident engaging respectfully with whānau, and half or more were confident upholding Te Tiriti rights and promoting equity, recognising wellbeing as a taonga, integrating care, doing a comprehensive assessment, being culturally responsive, and responding to wellbeing barriers. Fewer than half felt confident using screening tools and maintaining their own learning around co-existing problems. Around 1 in

5 kaimahi said they were not confident with screening, comprehensive assessment, and maintaining their learning.

Figure 3. Share of 145 kaimahi rating their confidence for working alongside tāngata whai ora with co-existing problems



Confidence varied between different groups for some areas of co-existing problems practice. Kaimahi Māori were more likely than non-Māori to say they felt confident being culturally responsive to tāngata whai ora and doing comprehensive assessments. Non-Māori kaimahi were more likely to say they felt confident engaging respectfully with whānau, as well as maintaining their own learning than kaimahi Māori.

Support workers and managers surveyed were more likely than clinicians to say they felt confident recognising wellbeing as a taonga and upholding Te Tiriti rights and promoting equity.

Comments

Thirty-four kaimahi commented further on their confidence working alongside tāngata whai ora with co-existing problems. Themes raised include formal and informal professional development, the impact of resourcing, integration and collaboration challenges, practical aspects relating to their mahi, and cultural challenges.

Thirteen kaimahi identified formal and informal professional development activities they have had or would like to have.

> “Having recently completed a post-graduate qualification in applied [mental health and addiction] counselling, I now have the capacity to deliver a clinical based process for service users. This has definitely given [me] more confidence to apply a practice framework that is also informed” (Manager or team leader in a mental health service).

> “My confidence comes from being able to build safe relationships, work at the pace of the person, and recognise the wider context influencing their wellbeing. At the same time, I stay aware that co-existing problems can be complex, and I am always learning” (Support worker).

> “Difficulty to confidently integrate care with colleagues and teams due to lack of organisational training of these international pathways and processes to work with wider community.”

> “I'd love the chance to upskill and learn techniques or gain a qualification whilst working for my organisation” (Support worker).

Eleven kaimahi described the influence of resourcing on their confidence to respond to co-existing problems in their mahi.

> “[The] service is really under pressure. We need resource” (Clinician in a mental health service).

> “No, my confidence is only undermined by the resources available to me including appropriate space to have conversations” (Clinician in a mental health service).

> “I only want to say [co-existing problems] lost its prominence some years ago. Any new practice focus needs to be on workplans and agendas for at least 15 years.”

> “While [co-existing problems] is not a direct focus of my work, it is threaded throughout. Criteria for our service looks at vulnerabilities like mental [and] physical health, family violence, addiction and statutory involvement” (Clinician).

Nine described the status of integration and collaboration in their mahi, negatively and positively.

> “Limited support services for [Te Whatu Ora] outside mental health and addiction” (Support worker in a mental health service).

> “There is a lack of integrated cooperation between [alcohol and drug] and [mental health] services – it would be good to be able to work together” (Clinician in a mental health service).

> “I think integrated care can sometimes be complicated based on what is available but also with [co-existing problems] many services only tend to one element and not the others so sometimes getting the right wrap around care can be really difficult” (Clinician in a mental health service).

> “Importance of team approach involving [general practitioner or nurse practitioner] and other services as required referring when required.”

Eight described the practical aspects of their co-existing problems mahi.

> “[I] have basic knowledge of Stages of Change model but lack confidence in how to respond to each of those stages” (Manager or team leader in a mental health service).

> “… I don't have clinical [co-existing problems] knowledge, however my lived experience knowledge and skills straddle multiple life experiences, and I am fluent in meeting almost all of the tāngata I walk alongside where they are, wherever they are. Once or twice over almost 3 years in my role I have identified that I am not the right person to deal with a particular person based on the limits of my own lived experience” (Support worker in an addiction service).

> “[Co-existing problems] has drifted off the focus in [alcohol and drug] treatment sector and in learning opportunities” (Clinician in an addiction service).

> “[The Matilda Centre in Sydney] is where I go for the very best information which is not about ‘frameworks' but about the real research and training around comorbidity. Fantastic resources by experts in their field” (Clinician in an addiction service).

Six described cultural challenges or benefits.

> “Blending comprehensive assessments (Fraser Todd) and [co-existing problems] screening tools alongside ngā taonga tuku iho and [mental health and addiction services] specific tools, alongside dedicated practitioners, enables whānau choice, different perspectives and hope” (Manager or team leader).

> “My focus is on mana-enhancing practice, cultural safety, and supporting tāngata whai ora and whānau to lead their own pathways” (Support worker).

> “Since some areas in the life of [tāngata whai ora is] sensitive to discuss, I find it a bit challenging to go through those in detail, and not really confident to go through those due to cultural barriers surrounding those topics” (Clinician in a mental health service).

Comments varied for different groups. Kaimahi Māori and support workers were more likely than non-Māori and clinicians to comment about formal and informal professional development and less likely to comment on resources. Support workers were also more likely than clinicians to comment on integration and collaboration challenges.

Kaimahi development needs

Up to 102 kaimahi described their previous training and development, and desired future development, along with the learning methods they thought would be useful.

Previous training and development

Eighty-nine kaimahi described their previous co-existing problems training and development. Of these, 16 (18 percent) said they had received no training or development. The remainder described a wide range of experiences across the following areas.

- Tertiary education ranging from the Level 4 Certificate in Health and Wellbeing to postgraduate qualifications (28 kaimahi).
- Other unspecified learning and development, like attending webinars, workshops, and conferences (20 kaimahi).
- Lived and/or workplace experience (17 kaimahi).
- Programmes run by the workforce centres like Whāraurau and Te Pou (12 kaimahi).
- In-work trainings (12 kaimahi).
- Supervision and reflective practice supports (three kaimahi).

Kaimahi Māori were twice as likely as non-Māori kaimahi to say they had received training through the workforce centres and were much less likely to say they had received no training. Support workers were nearly twice as likely as clinicians to say they had had no training or training through the workforce centres, in the workplace, or via their own experience. In contrast, clinicians were more likely to describe tertiary education and access to supervision.

Some relevant comments are below.

> “Years ago, nothing recently” (Clinician).

> “I have done the level 4 Health and Wellbeing Certificate and Intentional Peer Support training. I've also had trauma informed training and [Borderline Personality Disorder] 101 training. I've not had much training in [co-existing problems] but have

had lots of workplace experience with it" (Support worker in a mental health service).

"Limited training but worked in the community NGO for addictions and [mental health] for a while and learnt most of my [co-existing problems] knowledge from front line experience and one training through Whāraurau" (Clinician in a mental health service).

"Post grad studies in mental health nursing over 10 years ago. More recently motivational interviewing with pūrākau through Whāraurau" (Clinician).

Desired training and development

Eighty-one kaimahi described the training and development activities they thought would enhance their co-existing problems knowledge and skills. These covered various areas, including a desire for more in-depth training, understanding different populations and types of co-existing problems, using co-existing problems tools and models, working with different cultures and whānau, and making community connections. Seven kaimahi said they were unsure about their answer and another seven said they felt they were ongoing in their skills development.

Twenty-two kaimahi said they would like more in-depth training options, including postgraduate training and education targeted to specific roles.

"Specific [co-existing problems] training" (Clinician in an addiction service).

"Master's in addictions post [graduate] in health psychology as addiction field widens to include all addictions outside of [alcohol and drugs] that result in enduring lifestyle diseases, like diabetes, heart disease and alike" (Clinician in a mental health service).

"Education targeted specifically at [mental health] clinicians that might be working with those with [substance use] issues, i.e. not education targeted at those who are already specialist [alcohol and drug] clinicians" (Clinician in a mental health service).

Nineteen kaimahi wanted training that would improve their ability to work alongside different population groups and types of co-existing problems.

"Cultural issues. Finding answers to why people from different cultures have significantly different [alcohol and drug] problems" (Clinician in a mental health service).

> “More understanding on substance use for [mental health] staff to walk alongside their tāngata whai ora with [co-existing problems] as we are always having to advocate due to negative attitudes towards people who use substances” (Clinician in an addiction service).

> “How [co-existing problems] relates to Mental Health in the perinatal period and post-partum” (Clinician in a mental health service).

> “Understanding of [co-existing problems] issues in over 65 aged population” (Clinician in a mental health service).

Fourteen kaimahi wanted training on using co-existing problems tools, models, and approaches.

> “Postgrad diploma in [Cognitive Behavioural Therapy] and Cognitive Analytic Therapy, both of which integrate [co-existing problems] within the frameworks” (Clinician in a mental health service).

> “Learning more about the [co-existing problems] models and assessments.”

Ten kaimahi wanted more cultural and whānau-focused training.

> “Kaupapa Māori short noho wānanga” (Support worker in a mental health service).

> “More Māori and Pasifika specific training in addiction and [co-existing problems]” (Clinician in a mental health service).

> “More opportunities to learn from Māori clinicians, kaimahi, and kaupapa Māori services.”

> “Cultural clinical facilitators or cultural facilitation of discussions in a Pacific 5CS model approach” (Clinician in a mental health service).

Twelve kaimahi described types of learning opportunities they would like to receive including conferences, online learning, workshops, and in-person training.

> “Continued [one-to-one] clinical supervision, further studies” (Support worker in an addiction service).

> “It would be so helpful to have more in-person or online opportunities from my teams to refresh/remind and upskill here in [our city]” (Manager or team leader).

> “More hands on less electronic” (Clinician in a mental health service).

> “In person or online training for relevant recent skills and assessment” (Clinician).

> “Case-based learning that shows how to apply [co-existing problems] frameworks in real scenarios These would help me deepen my confidence and refine my practice when supporting tāngata whai ora with multiple, interacting needs” (Support worker).

Eight kaimahi said they would like to make more community connections to support their mahi and four said they wanted more support or lived experience training.

> “Also, continuing to broaden my knowledge and networks with services and resources within my community that focus in on specific [mental health] issues – connecting people with what they need is often as important in my role as providing it directly” (Support worker in an addiction service).

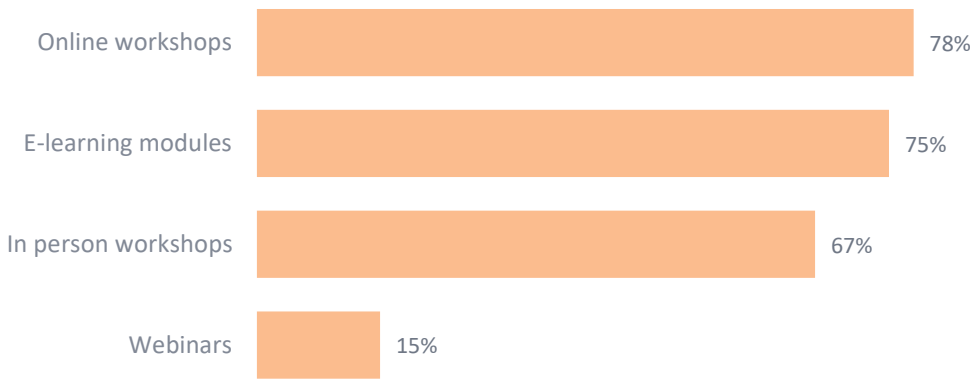
> “Training on how to manage co-existing conditions from a lived experience perspective” (Clinician in a mental health service).

Some training needs differed by group. Kaimahi Māori were more likely than non-Māori to say they wanted more training focused on culture and working with whānau and using co-existing problems tools and models. Support workers were more likely than clinicians to say they wanted in-depth training, tools and models training, or were unsure about what they wanted. In contrast, clinicians were more likely to want training on different populations and types of co-existing problems and to specify the types of learning opportunities they would like.

Learning methods

Figure 4 shows that the most popular options for kaimahi learning are in-person and online workshops and e-learning modules. In contrast, very few (15 percent) said webinars would be useful.

Figure 4. share of 102 kaimahi reporting the learning methods or approaches useful for improving their co-existing problems capabilities



Fifteen people specified other options. Kaimahi Māori preferred Māori methods like wānanga, whereas non-Māori offered up a range of options, including guidelines, conferences, blended learning, and tertiary education. Clinicians also described a similar range of options, and support workers were more focused on accessible options and content applicable to their roles.

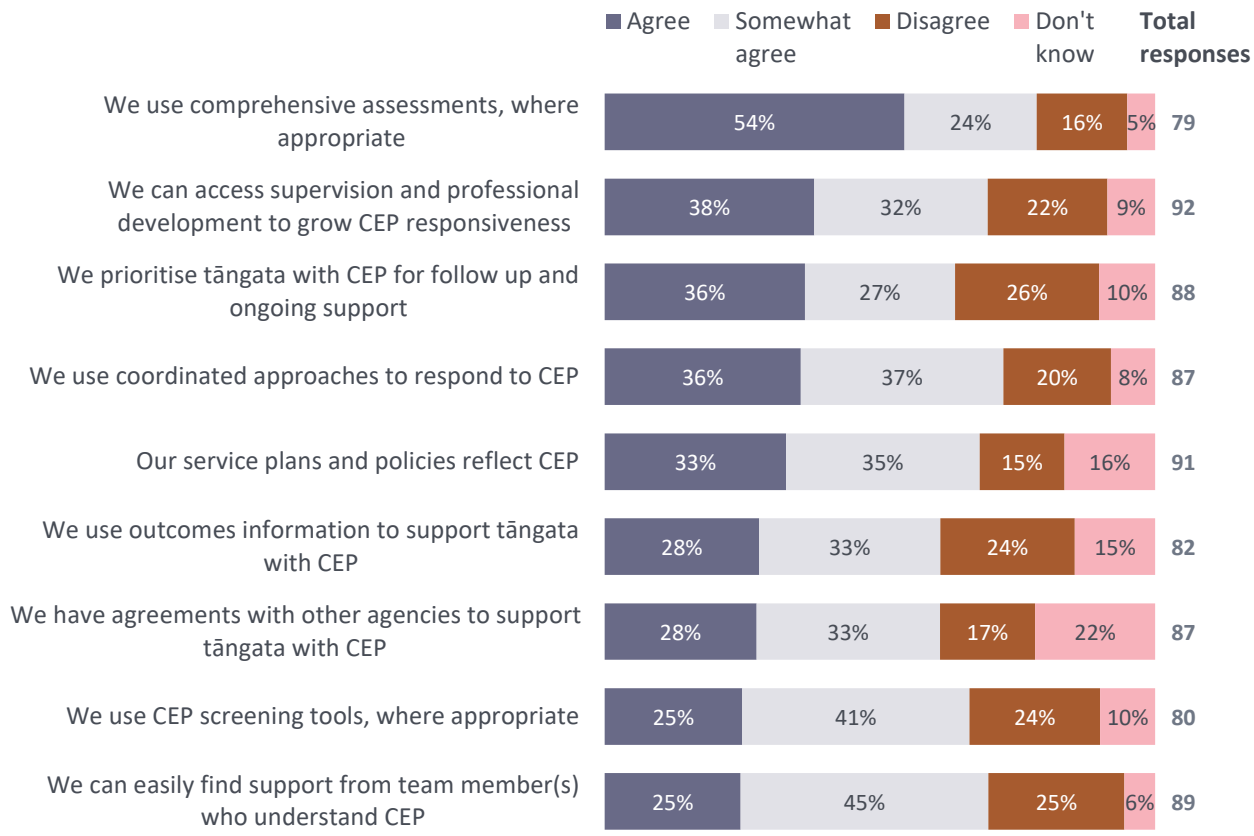
Organisational development

All kaimahi (regardless of their role) were invited to provide feedback about their organisation's support for working alongside tāngata whai ora with co-existing problems and whānau, the barriers they experience, and organisational changes that would support their practice. Up to 92 kaimahi responded.

Organisation responsiveness

Figure 5 shows that half of kaimahi agreed that their organisation uses comprehensive assessments where appropriate, and another quarter somewhat agreed. Fewer than 40 percent agreed they can access professional development, prioritise tāngata whai ora for follow up, use coordinated approaches, and have service plans that reflect co-existing problems. Up to one-quarter disagreed with these statements, and between 5 and 22 percent said they did not know the answer.

Figure 5. Share of 92 kaimahi reporting on organisational supports for co-existing problems



Kaimahi Māori were more likely than non-Māori to agree their organisation uses comprehensive assessments and coordinated approaches. For most other organisational supports, both groups were similar. Support workers and managers were twice as likely as clinicians to agree their organisation prioritises tāngata whai ora with co-existing problems for follow up and ongoing support, have agreements with other agencies, can access supervision, and use coordinated approaches than clinicians. Clinicians were more likely than support workers to agree they use comprehensive assessments.

Barriers to co-existing problems responsiveness

Seventy-five kaimahi described barriers to their organisation responding effectively to tāngata whai ora with co-existing problems. Themes that emerged included a lack of resources, restrictive systems, siloes and a lack of collaboration, kaimahi knowledge and skills, discrimination and biased attitudes towards tāngata whai ora with co-existing problems, and cultural and language barriers.

Twenty-eight kaimahi said the lack of resources was a barrier to their organisation responding effectively to tāngata whai ora with co-existing problems. Various themes identified include funding, time, capacity, insufficient kaimahi numbers or roles, and access to supervision.

> “Individuals limitations over organisational failures. However increased resources for would in my opinion benefit practitioners” (Support worker in an addiction service).

> “I don't believe that addictions practitioners are able to address both addiction and mental health issues in an addiction setting. Despite both being prevalent in the tāngata whai ora we work with, there is not enough support to fully address both issues effectively” (Other role in an addiction service).

> “We don't have a specific [alcohol and drug] clinician” (Clinician in a mental health service).

> “Key barriers include limited time, high caseloads, and the complexity of [co-existing problems] presentations, which often require more intensive support than our service can consistently provide” (Support worker).

Twenty-three kaimahi say restricted systems are a barrier. Themes include lack of beds and accommodation, service centred processes, and risk aversion.

> “Having effective access and responses from Te Whatu Ora clinical services” (Support worker in a mental health service).

> “Over 50% of clients are declined as either being too risky or their [mental health] is not stable enough. The process of accessing residential [alcohol and drug] services [takes] far too long” (Clinician in a mental health service).

> “Wait times. Access to appropriate after care and supportive environments to assist in reintegration and sustaining gains made” (Clinician in a mental health service).

Twenty kaimahi said service and organisational siloes and a lack of collaboration were barriers. Many described the lack of cohesion across different services, challenges with different entry processes and priorities, and lengthy wait times.

> “Silos and access patch holding remain barriers between mental health and [alcohol and drug] services. Secondary services within these silos still don’t always know how to share views and share plans” (Support worker).

> “A siloed and separate [alcohol and drug] service that are not responsive in an unplanned intervention context.” (Clinician in a mental health service).

> “… Some tāngata are unable to access non-addictions [mental health] treatment due to addiction issues and unable to access addiction treatment due to other [mental health] issues. (Support worker in an addiction service).

> “Access to specialist [alcohol and drug] or mental health services can be slow, and long waitlists make it difficult to respond early” (Support worker).

Eighteen kaimahi described their own and others' knowledge and skills around co-existing problems as barriers. Themes included the lack of specifically trained kaimahi for working alongside tāngata whai ora with co-existing problems and a general lack of understanding about co-existing problems and how to respond effectively.

> “I currently work in a Medical clinic – and I don't believe the nurses or some of the doctors understand these things very well I believe [they] need more training in this area” (Clinician).

> “[They] believe their service scope is too small to include [co-existing problems] into practice [that is] we are only in for such a short amount of time we don’t have funding to provide this extra time or we don’t have the skill set or scope to hold this type of practice” (Clinician in a mental health service).

> “… a general low level of knowledge or understanding regarding harm reduction, spirit of motivational interviewing” (Clinician in an addiction service).

Ten kaimahi raised discrimination and biased attitudes towards tāngata whai ora with co-existing problems within the workforce as barriers. Themes included personal and institutional biases against tāngata whai ora with co-existing problems.

> “Negative attitudes towards people who use substances” (Clinician in an addiction service).

> “Over the years I have seen clinicians’ individual bias including not being that interested in [co-existing problems] being a barrier” (Manager or team leader).

> “Service- and bureaucracy- centred treatment instead of person-centred. Even the concept of [co-existing problems] is in my opinion not truly person-centred – we are not our diagnoses, and we cannot be carved up into separate diagnoses” (Support worker in an addiction service).

Four kaimahi described specific cultural and language barriers including attitudes to whānau, cultural barriers, and lack of effective cultural supervision.

> “The organisations policies indicate a response but language and practice differ in respect to applied knowledge present in each team” (Clinician in a mental health service).

Kaimahi Māori were more likely than non-Māori to discuss barriers relating to resourcing, kaimahi knowledge and skills, and restrictive systems. Non-Māori kaimahi were more likely

to discuss siloes and discrimination as barriers. Clinicians were more likely than support workers to discuss barriers like lack of resources and kaimahi knowledge and skills. Support workers were more likely to discuss siloes and lack of collaboration as barriers.

Organisational supports or changes

Sixty-six kaimahi identified organisational supports or changes that would help them to be more responsive to tāngata whai ora with co-existing problems. Themes include more professional development, service development, staffing changes, growing collaborative capacity, changing organisational culture and processes, and adding tools and models.

Twenty-one kaimahi said more professional development would support them. Themes included mandatory or compulsory training, more internal learning opportunities like cultural supervision and reflective practice, and formal education options.

> “More online training as very hard to get approval for in person workshops especially when held away from home” (Clinician in an addiction).
>
> “More [co-existing problems] -specific training, regular case-based learning, and access to specialist consultation would strengthen our responsiveness” (Support worker).
>
> “Mandatory training and champions within the service” (Clinician in a mental health service).
>
> “Cultural peer supervision” (Clinician in a mental health service).

Sixteen kaimahi said service development would support them. Themes included better communication between organisations, more capacity and resources within services, shared priorities and plans across services.

> “Robust referral systems to other more appropriate agencies when required. Better collaboration with [mental health] services” (Manager or team leader in an addiction service).
>
> “A complete re-think of the whole sector from a truly whai ora [and] whanau centred perspective, designed by lived experience visionaries with input from clinicians where needed, flexible and responsive to client needs, and adequately funded” (Support worker in an addiction service).
>
> “More coordinated priority to this group of people from within health [and] mental health services to reduce stigma, discrimination, and easy for other services to decline support due to perceived complexities” (Manager or team leader).

> “Providing counselling transport options (bus card/ taxi chit) [alcohol and drug] programs in rural areas [and] towns” (Clinician in an addiction service).

Fifteen kaimahi said changes to staffing would support them. Themes included more staff generally, more specialist trained and dedicated roles, and more connections across kaimahi.

> “Better staffing increased education” (Clinician in a mental health service).

> “Increased knowledge [and] networking” (Clinician in a mental health service).

> “A clinical lead dedicated to [co-existing substance use] issues. We have one for mental health (which is used as a catch all), but they are not [co-existing problems or alcohol and drug] experienced at all” (Clinician in a mental health service).

> “More staff” (Clinician in a mental health service).

Fourteen kaimahi said growing collaborative capacity in their organisation would support their mahi. Themes included improving communication across organisations, reducing risk aversion and biases in policies and practices, and making partnering and referral agreements to better integrate services.

> “Strengthening partnerships with kaupapa Māori services would further enhance cultural safety and outcomes for tāngata whai ora” (Support worker).

> “I do believe there needs to be more open communication across all mental health and addiction services” (Other role in an addiction service).

> “Closer connections to other NGOs and specialist services – confidence in their standards and patient-centric treatment” (Manager or team leader in a mental health service).

> “Clearer pathways for referral, faster access to [alcohol and drug] and mental health services, and more integrated care planning would also help” (Support worker).

Ten kaimahi said that changes to organisational culture and processes would support their mahi. Themes included developing systems and processes for working with other agencies, internal support for learning and development, and prioritising tāngata whai ora with co-existing problems for support.

> “Robust referral systems to other more appropriate agencies when required” (Manager or team leader in an addiction service).

> “Additional time for engagement, supervision, and whānau-centred practice would support safer and more effective responses” (Support worker).

> "…a support mechanism to ensure that learnings become embedded in practice but also in the team culture for a sustainable response" (Clinician in a mental health service).

Five kaimahi said tools and models would support their mahi. These included family and whānau approaches, recording and improving outcomes like key performance indicators, initial assessment tools, and flexible tools that enable positive responses to tāngata whai ora with co-existing problems.

> "Being able to flex more from the standard … consult, for more patient-centred approach where acuity and complexity is high" (Clinician).

Kaimahi Māori were more likely than non-Māori to say that professional development and more staff would support their mahi. Non-Māori kaimahi were more likely to say that service development, and changes to organisational collaborative capacity, culture, and processes would support their mahi.

Support workers were more likely than clinicians to say that professional development and increasing organisations' collaborative capacity would support their mahi. Clinicians were more likely than support workers to discuss service development, staffing changes, and improving tools and models.

Discussion

The survey identified kaimahi experience of working with tāngata whai ora who have co-existing problems, their use of co-existing problems frameworks and confidence in their knowledge and skills; prior and desired future training and development; and organisational supports. The following discusses key findings in relation to the national and international literature and implications for future workforce development projects.

Key findings

The findings show that kaimahi surveyed want training and development for supporting tāngata whai ora with co-existing problems. They often work alongside tāngata whai ora with co-existing problems related to substance use and mental health, and gambling harm and various other health and disability, behavioural, and social challenges. In their practice, kaimahi used Māori models of health, *Te Ariari* and *Co-existing Problems (CEP) and Youth* frameworks alongside whānau ora and other cultural and collaborative approaches, various tools and resources, referral pathways, and relationships with other providers. It is noted in earlier quotes that two kaimahi thought that the addiction and mental health sector had lost sight of its earlier focus on tāngata whai ora with co-existing problems.

Kaimahi surveyed identified many barriers to supporting tāngata whai ora with co-existing problems. These are summarised across the different levels of the health system below and are consistent with the national and international literature (Bratt, 2025; Fonseca et al., 2026; Searby et al., 2025; Te Pou, 2022; Todd, 2010).

- **Workforce** challenges, including inconsistent knowledge about co-existing problems and skills for working alongside tāngata whai ora, understanding of and ability to work collaboratively with other kaimahi and services, and ability to use screening and assessment tools and access to other resources like reflective practice.
- **Organisational** challenges relating to relationships between providers, different eligibility criteria and wait times, service-centred rather than people-centred approaches, and differing expectations for factors like risk and abstinence.
- **Systems** challenges relating to separate service delivery pathways, structural barriers to coordinated and integrated services, and resourcing inequities for tāngata whai ora with co-existing problems.

Workforce development opportunities

The survey findings support the understanding that training and other forms of workforce development are crucial enablers of co-existing problems responsiveness. Kaimahi identify many opportunities for future workforce development that are summarised below across the three health system levels.

These opportunities should be considered alongside robust engagement with people who have lived experience (personal and whānau) and hapori Māori and other communities (Ministry of Health, 2023). Some relate to strengthening health sector responsiveness to Māori and upholding Te Tiriti principles for tino rangatiratanga, equity, access, and choice of options. These activities would need to be led by Māori with the right authority and knowledge (Kukutai et al., 2023).

Workforce development

Most kaimahi we surveyed had views on the type and nature of workforce development that would improve their confidence and responsiveness to tāngata whai ora with co-existing problems, including the following.

- Developing Māori and other cultural knowledge and skills, so kaimahi of all backgrounds can appropriately apply cultural models and Te Tiriti principles in their mahi and work in partnership with kaimahi Māori and kaupapa Māori services.
- Growing kaimahi access to and use of relevant co-existing problems frameworks, screening and assessment tools and resources, skills for delivering person- and whānau-centred services, and access to other development like reflective practice (or supervision).
- Building kaimahi co-existing problems knowledge and confidence relevant to roles, training to build a compassionate workforce, and growing kaimahi abilities to practice cultural safety in their mahi.
- Other cultural development opportunities, like use of other cultural models, delivering whānau ora and other collective and integrated approaches, and collaborating with other cultural groups and services.
- Growing the number and type of kaimahi in services who can work with tāngata whai ora with co-existing problems and their whānau. Building workforce capabilities across multiple types of co-existing problems and levels of severity to help minimise the number of barriers tāngata whai ora face accessing support.

Organisational development

Organisations provide crucial support for kaimahi to successfully embed and enact their learning and development into practice and enhance their knowledge and skills for working alongside tāngata whai ora with co-existing problems (Bratt, 2025; Fonseca et al., 2026; Searby et al., 2025). The survey findings suggest there are organisational development opportunities, including the following.

- Strengthening organisations' Te Tiriti-based relationships and partnerships with kaupapa Māori and other services and developing relationships and pathways to improve equity, access, and choice for tāngata whai ora with co-existing problems.
- Developing organisation leaders' co-existing problems knowledge, confidence, and compassion to support future organisational culture and kaimahi development.

- Co-designing with people who have lived experience specific co-existing problems services, policies, and procedures to better support kaimahi in their practice, particularly around follow up and coordinated service delivery.
- Resourcing kaimahi with access to relevant models, tools, and other development opportunities like training and reflective practice (supervision).

Systems development

Developing the health system infrastructure provides the right environment for organisations, services, and kaimahi to work effectively alongside tāngata whai ora with co-existing problems. The survey identified opportunities to improve service coordination, integration, and alignment. Similar opportunities are noted overseas (Bratt, 2025; Fonseca et al., 2026).

Kaimahi surveyed identified various system level enablers that can inform infrastructure development through health entities and the workforce centres. These include updating cultural and co-existing problems resources and other integration-related models and tools, building cultures of collaboration and inter-agency cooperation into health system structures, and ensuring adequate resourcing for co-existing problems.

Flexible approaches

Kaimahi surveyed report diverse ways they deliver services to tāngata whai ora with co-existing problems. These responses differed for clinicians and support workers, reflecting the different expectations of their roles. This is consistent with the national and international evidence that there is no one ‘best’ way to deliver such services and these are often comprised of a mix of different approaches depending on settings and roles (Harris et al., 2023; Searby et al., 2025; Substance Abuse and Mental Health Services Administration, 2020; Te Pou, 2022; Todd, 2010).

It is important that future workforce development honours and upholds this kaimahi commitment to delivering services in ways that best fit their communities (Ministry of Health, 2020b, 2020a, 2023). Learning and development activities should be sufficiently flexible so that kaimahi can continue to shape and adapt the tools and resources available to them. Organisations and the health system and its entities like Health New Zealand | Te Whatu Ora are crucial enablers of effective practice and can foster the right environment for kaimahi to grow in their practice and promote positive and equitable outcomes for tāngata whai ora and whānau.

Conclusion

The survey provides valuable insights into addiction and mental health kaimahi experience of supporting tāngata whai ora with co-existing problems in their mahi, their confidence and responsiveness, and workforce and organisation development needs. It shows that kaimahi are flexible, creative, and skilled in using the available knowledge, skills, models and tools, while also wanting more development to continue growing their ability to best support tāngata whai ora with co-existing problems.

The survey provides substantial information to inform future workforce development, tailored to specific groups and levels of the health system. Next steps can include bringing people with lived experience, hapori Māori, and other communities' perspectives into decision-making processes to support the design of workforce development activities.

Appendix: Co-existing problems knowledge and skills survey

Kia ora koutou

You are invited to complete this survey about your knowledge and skills, development needs, and organisational support for working alongside tāngata whai ora and whānau who have co-existing problems (also known as CEP). The term 'co-existing problems' is used to describe when tāngata whai ora have more than one addiction and/or mental health challenge at the same time.

The survey can be completed by anyone working in addiction or mental health services, including support workers, addiction practitioners, team leaders, and people in other roles. Responses will be used to inform future workforce development activities to build support for tāngata whai ora with co-existing problems.

The survey should take about 10 to 15 minutes to complete. You can answer as many or few questions as you like. Your response will be anonymous. Te Pou will aggregate survey responses and you will be able to access the published summary on the website. Results will be used to inform the project's next steps.

The survey will close on **15 May 2026**. You can forward its link to others to complete, if you wish. If you have any questions or want to know more about the project, contact Lissa.Carlino@tepou.co.nz

Co-existing problems knowledge and skills

Q1. How often do you work alongside tāngata whai ora with the following co-existing problems in your addiction and/or mental health mahi?

	Never	Rarely	Sometimes	Often	Not applicable
Mental health challenges	O	O	O	O	O
Alcohol and drug challenges	O	O	O	O	O
Gambling harm	O	O	O	O	O
Other (please specify)	O	O	O	O	O

Q2. Is your practice informed by any of the following co-existing problems frameworks? Select as many as apply.

- ☐ Te Ariari o te Oranga
- ☐ Te Whare o Tiki
- ☐ Co-existing Problems (CEP) & Youth
- ☐ Other (please specify)
- ☐ None of the above

Q3. Tell us how you use these frameworks in your mahi [skip if Q2 = none of the above]

Q4. How do you rate your confidence for working alongside tāngata whai ora and whānau with co-existing problems in the following knowledge and skills areas?

	Confident	Somewhat confident	Not confident	Not applicable to my work
Upholding Te Tiriti o Waitangi rights and promoting equity for tāngata with CEP	O	O	O	O
Recognising wellbeing as a taonga to be protected for tāngata with CEP	O	O	O	O
Being culturally responsive to tāngata with CEP	O	O	O	O
Identifying and responding to wellbeing barriers for tāngata with CEP	O	O	O	O
Engaging respectfully with whānau	O	O	O	O
Using screening tools for CEP applicable to my role	O	O	O	O
Doing a comprehensive assessment for CEP if applicable to my role	O	O	O	O
Integrating care with other kaimahi, services, and communities for tāngata with CEP	O	O	O	O
Maintaining own CEP learning and development	O	O	O	O

Q5. Is there anything else you want to say about your confidence working alongside tāngata whai ora and whānau who have co-existing problems?

Development needs

Q6. What training or other development have you received on understanding co-existing problems?

Q7. What training or other development activities would enhance your co-existing problems knowledge and skills?

Q8. What learning methods or approaches would be useful for improving your co-existing problems capabilities? Select as many as apply.

- ☐ E-learning modules
- ☐ Online workshops
- ☐ In-person workshops
- ☐ Webinars
- ☐ Other (please specify)

Organisational supports

Q9. Next we are interested in your organisation or service's responsiveness to tāngata whai ora with co-existing problems. Please rate your level of agreement with each of the following statements.

	Agree	Somewhat agree	Disagree	Not applicable to my role	Don't know
Our service plans and policies reflect CEP	O	O	O	O	O
We have agreements with other agencies to support tāngata with CEP	O	O	O	O	O
We use CEP screening tools, where appropriate	O	O	O	O	O
We use comprehensive assessments, where appropriate	O	O	O	O	O
We use outcomes information to support tāngata with CEP	O	O	O	O	O
We use coordinated approaches to respond to CEP	O	O	O	O	O
We prioritise tāngata with CEP for follow up and ongoing support	O	O	O	O	O
We can easily find support from team member(s) who understand CEP	O	O	O	O	O
We can access supervision and professional development to grow CEP responsiveness	O	O	O	O	O

Q10. What are the barriers to effectively responding to tāngata whai ora who have co-existing problems in your organisation or service?

Q11. What other organisational or service changes would support you to better respond to tāngata whai ora with co-existing problems?

Please tell us about yourself

This will help us understand the diversity of people who responded to this survey.

Roles

Q 12. Which of the following best reflects your main workforce role? Select the one that most applies.

- ☐ AOD CEP practitioner
- ☐ AOD or gambling practitioner
- ☐ Addiction nurse
- ☐ Other clinical role (eg social worker, psychiatrist, psychologist, occupational therapist, mental health nurse,
- ☐ psychotherapist)
- ☐ Support worker
- ☐ Cultural support worker
- ☐ Peer support worker
- ☐ Whānau worker
- ☐ Manager or team leader
- ☐ Other role (please specify

Area of work

Q13. What type of service do you work in? Select the one that most applies.

- ☐ Alcohol and drug service
- ☐ Preventing and minimising gambling harm service
- ☐ Mental health service
- ☐ Social or other health service
- ☐ Other (please specify)

Workplace

Q 14. Which option best describes where you work? Select the one that most applies.

- ☐ Kaupapa Māori NGO
- ☐ Pasifika NGO
- ☐ Asian NGO
- ☐ Other type of NGO
- ☐ Health New Zealand | Te Whatu Ora mental health and addiction services
- ☐ Ara Poutama Aotearoa | Corrections
- ☐ Primary Healthcare Organisation or other primary healthcare provider
- ☐ Other (please specify)

Ethnic group(s)

Q15. Which ethnic group(s) do you identify with? Select all that apply.

- ☐ Aotearoa New Zealand Māori
- ☐ Pasifika ethnic group(s) eg Samoan, Tongan, Indigenous Fijian
- ☐ Asian ethnic group(s) eg Chinese, Indonesian, Fijian Indian
- ☐ New Zealander or other person of British or European descent eg English, Irish, Scottish, Spanish, German
- ☐ Other ethnic groups (please specify)

Region

16. In which region(s) do you currently work?

- ☐ Northern (Te Tai Tokerau, Waitematā, Auckland, Counties Manukau districts)
- ☐ Midland | Te Manawa Taki (Waikato, Lakes, Bay of Plenty, Tairāwhiti, Taranaki districts)
- ☐ Central | Te Ikaroa (Whanganui, Hawke's Bay, MidCentral, Wairarapa, Hutt Valley, Capital and Coast districts)
- ☐ South Island | Te Waipounamu (Nelson Marlborough, Canterbury, West Coast, South Canterbury, Southern districts)

Thank you

Thank you for your time in sharing your feedback. A summary will be published on the Te Pou website once available.

If you have any questions about this survey, please email Lissa.Carlino@tepou.co.nz

To keep up to date about this project, you can sign up to receive the Te Pou e-bulletin: https://www.tepou.co.nz/newsletter-subscription

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