MORE THAN NUMBERS

NGO adult mental health and addiction workforce

2014 survey of Vote Health funded services

Te Pou
o Te Whakaaro Nui

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National Addiction Workforce Development

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Introduction

Current government policy encourages services to address complex social problems at a community level across a number of sectors, including health (Platform Trust and Te Pou o Te Whakaaro Nui, 2015, p. 15). For mental health and addiction services these changes are described in *Rising to the Challenge* (Ministry of Health, 2012). They include refocusing services towards helping people address currently unmet needs earlier in their life-course using less intense interventions and promoting self-care via integrated community and primary care services.

These changes position non-government organisations (NGOs) as an important point of entry into the health system, working collaboratively across sectors and primary and secondary care to reduce the long-term impact of the social determinants of health (Platform Trust and Te Pou o Te Whakaaro Nui, 2015, pp. 7-9).

Workforce planning approaches are needed to support transformational changes to the way NGOs work. In this respect, access to high quality, regularly updated workforce information is incredibly important.

Alongside Platform Trust, Te Pou is developing reports and resources to support organisations, networks and regional and national bodies to plan and develop the current and future mental health and addiction sector workforce (see for example Platform Trust and Te Pou o Te Whakaaro Nui, 2015; Te Pou o Te Whakaaro Nui, 2014).

This report summarises the NGO workforce results from the 2014 *More than numbers* organisation workforce survey of adult mental health and addiction services. To provide a context for these results we also present Vote Health funding information and comparisons with DHB provider arm results and the 2005 *NgOIT Landscape survey.*

About the survey

The *More than numbers* organisation workforce survey aimed to describe the size, distribution and configuration of the Vote Health funded workforce delivering adult mental health and addiction services, as at 1 March 2014. It also aimed to understand current and future workforce challenges, knowledge and skill needs, and the strength of relationships with other services and sectors.[1]

The survey sample included 231 NGOs with Ministry of Health or district health board (DHB) contracts to deliver adult mental health and addiction services during the year ended 30 June 2013. The response rate was 73 per cent, with 169 organisations completing and returning surveys.

Survey results are summarised in three service groups: mental health (125 NGOs), addiction (48 NGOs) and combined mental health and addiction (16 NGOs) (see Figure 1).[2] Sixteen of these organisations offered services in more than one service group (nine per cent).

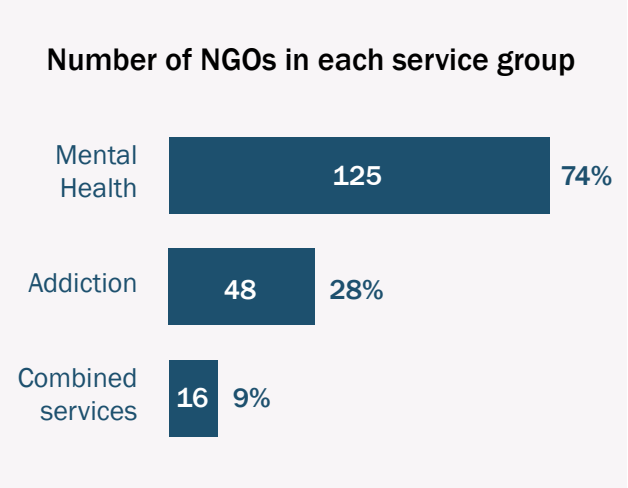

Figure 1. Number of NGOs in each service group (n=169 NGOs)

1 The survey did not collect information from services whose primary focus was Whānau Ora, primary health, youth, disability support, health promotion, policy, quality improvement, research activities, workforce development or which did not employ any mental health or addiction staff. The information collected related only to paid employees and contractors.

2 Surveys were allocated to one of the three service groups based on the main service that respondents stated their workforce provided. More details are available from the *More than numbers* national and regional reports available from the Te Pou website: www.tepou.co.nz/morethannumbers

The total mental health and addiction workforce reported by the responding 169 NGOs comprised:

- 4,524 people working in 3,673 FTE positions, including 125 vacant FTE positions.
  - Of these, the Vote Health funded workforce totalled 3,273 FTE positions.
  - The workforce funded from other sources totalled 400 FTE positions.[3]
- The average mental health and addiction workforce size reported by NGOs was 22 FTE positions and the median size was 9 FTE positions.
  - The largest organisation reported its total workforce was 371 FTE positions.
  - The smallest organisation reported its total workforce was half an FTE position.

Figure 2 shows the total workforce reported by NGOs, grouped by organisation size.[4]

Large and very large NGOs (those with a total workforce of 10 FTE positions or more) reported 89 per cent of the total NGO workforce (1,169 FTE positions and 2,087 FTE positions respectively, see Figure 2).

In contrast very small, small and medium NGOs (more than 50 per cent of all organisations surveyed) reported 11 per cent of the workforce (Figure 2).

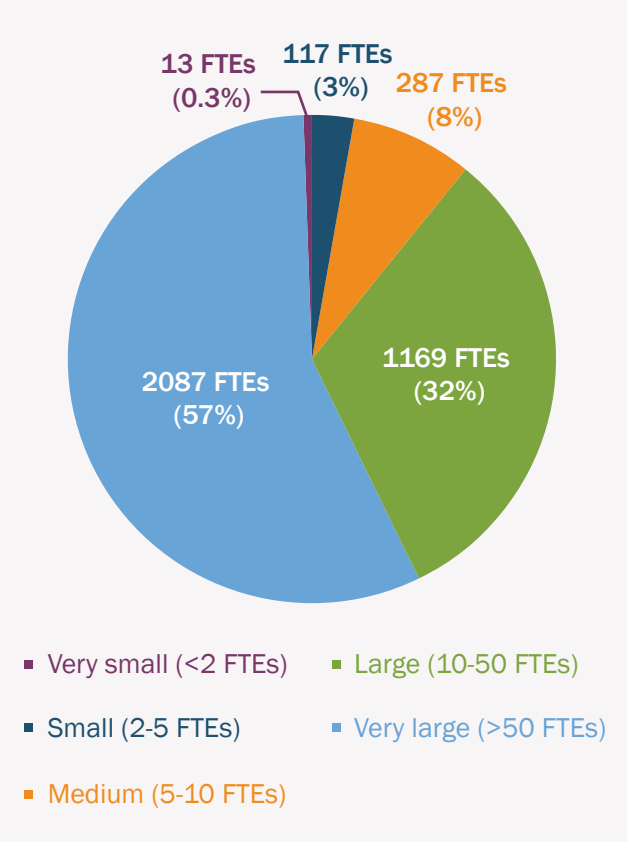

Figure 2. Total workforce reported by NGOs by organisation size (n=3,673 FTE positions)

Table 1 shows the number of NGOs in each service group by total workforce size using the same scale as the *NgOIT Landscape survey* (Platform Trust, 2005). More than half of the NGOs in the addiction services group (56 per cent) had a total workforce of 10 FTE positions or more. For those organisations in the mental health services group, 46 per cent had a total workforce of 10 FTEs or more.

3 The results in this section describe all the workforce reported to the survey including that funded by Vote Health and from other sources. The subsequent section describes the Vote Health funded workforce only.

4 The size groups are based upon the organisation size groups used in the *NgOIT Landscape survey* (Platform Trust, 2005, p.7).

Table 1. Number of NGOs surveyed in each service group by total reported workforce size

Service groups	Very small	Small	Medium	Large	Very large	Unspecified	Total
Organisation size^	(<2 FTEs)	(2-5 FTEs)	(5-10 FTEs)	(10-50 FTEs)	(>50 FTEs)		
Mental health	11	25	31	43	14	1	125
Combined services		1	2	10	3	-	16
Addiction	1	10	10	20	7		48
Total number of organisations	**12**	**36**	**41***	**61***	**18***	**1**	**169**
Proportion of total organisations	7.1%	21.3%	24.3%	36.1%	10.7%	0.6%	100.0%
Average workforce size (FTE positions)	**1.1**	**3.3**	**7.0**	**19.2**	**116.0**	**-**	**21.7**

Notes:
The 'unspecified' column relates to one NGO that did not complete the survey for FTE positions employed and vacant.
^ Organisation size ranges are the same as those used to analyse the *NgOIT 2005 Landscape survey* (Platform, 2005, p.10).
* Indicates that some organisations of this size are reported in more than one service group.

Vote Health funding and workforce

The survey sample was limited to organisations that received Vote Health funding during the 2012/13 year (231 NGOs). NGOs completing the survey reported that Vote Health contributed between 2 per cent to 100 per cent of their total income to provide adult mental health and addiction services (average 83 per cent).

In total, 2012/13 Vote Health contracts, totalling $356 million in funding, were held by 391 NGOs. This included $61 million for 160 NGOs whose contracts were limited to activities outside the survey scope and thus were not included in the survey sample.[5] 231 NGOs with contracts valued at $295 million were invited to participate in the survey. Figure 3 describes the total 2012/13 Vote Health funding for all NGOs invited to participate in the survey and those completing the survey. Response rates are presented in two ways.

- By NGOs: the number of organisations completing the survey as a proportion of those invited to participate.
- By funding: the total funding received by organisations completing the survey as a proportion of the funding received by those invited to participate.

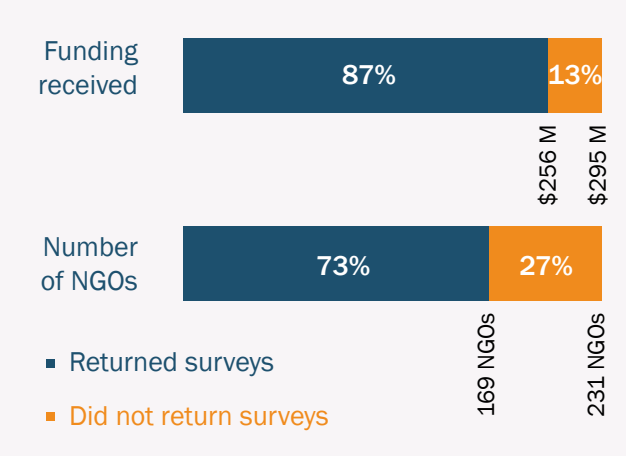

Figure 3. Responses to the survey as a proportion of the number of NGOs invited to participate and the total funding received.

Source: Ministry of Health Price Volume Schedule 2012/13.

Figure 4 shows the number of NGOs in each region who were invited to participate in the survey and those that completed the survey with relevant Vote Health funding totals for each group. As previously stated, response rates are presented as a percentage of the total of all eligible NGOs and as a percentage of total funding of those NGOs.

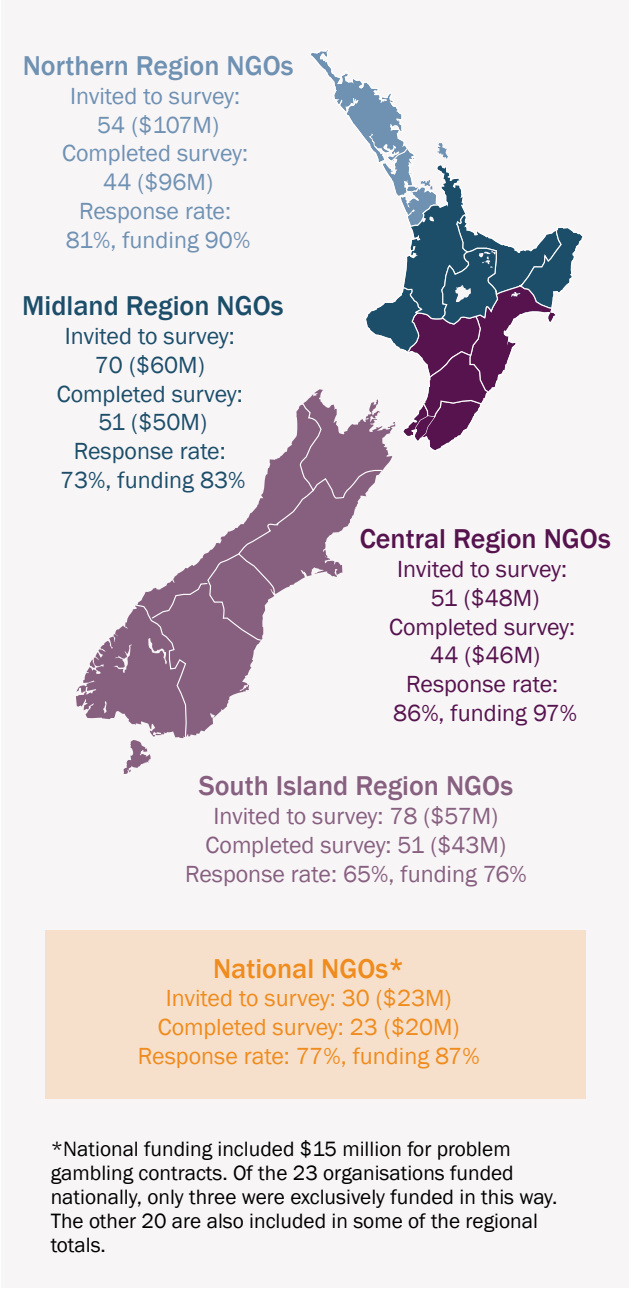

Figure 4. Distribution of funding for NGOs by region and by survey outcome with response rates

5 Activities outside the survey scope included primary care, aged care, workforce development, research, and quality and audit activities.

Respondents were asked to report the workforce funded by Vote Health separately from the workforce funded by other sources of income. They identified the number of people employed, and FTE positions employed and vacant for each role. Most (92 per cent) of the reported NGO workforce was Vote Health funded (3,273 FTE positions).

Table 2 shows the number of NGOs reporting to the survey and the Vote Health funded workforce for each of the four health regions, within the three service groups. Survey results cannot be matched directly with funding information due to differences in data collection.

Table 2. Number of organisations that completed the survey by region with the total workforce reported in each of the three service groups

Region	No. NGOs completing the survey^	Vote Health funded workforce reported# (FTE positions employed plus vacant)			
		Mental health	Combined services	Addiction	Total
Northern	46	937.6	63.8	207.7	1,209.1
Midland	51	525.1	83.1	162.8	770.9
Central	45	495.5	19.0	115.7	630.3
South Island	52	458.3	6.9	197.0	662.3
Total organisations	**169**	**2,416.5**	**172.8**	**683.3**	**3,272.6**

Notes:
^The number of NGOs is a count of unique organisations reporting workforce in each region. Individual organisations may be counted in more than one region. The total organisations row displays the number of unique organisations surveyed rather than the sum of those reporting in each region. #Workforce information is allocated to a region based upon the reported DHB area where services are mainly delivered, as described in the completed survey. All organisations that were funded nationally identified a DHB area or region of service provision in the completed survey, so the workforce is included in the relevant region(s) workforce totals.

Figure 5 compares the NGO workforce (FTE positions employed plus vacant) with the DHB workforce reported to the survey, showing the proportion of the workforce reported in each service group.

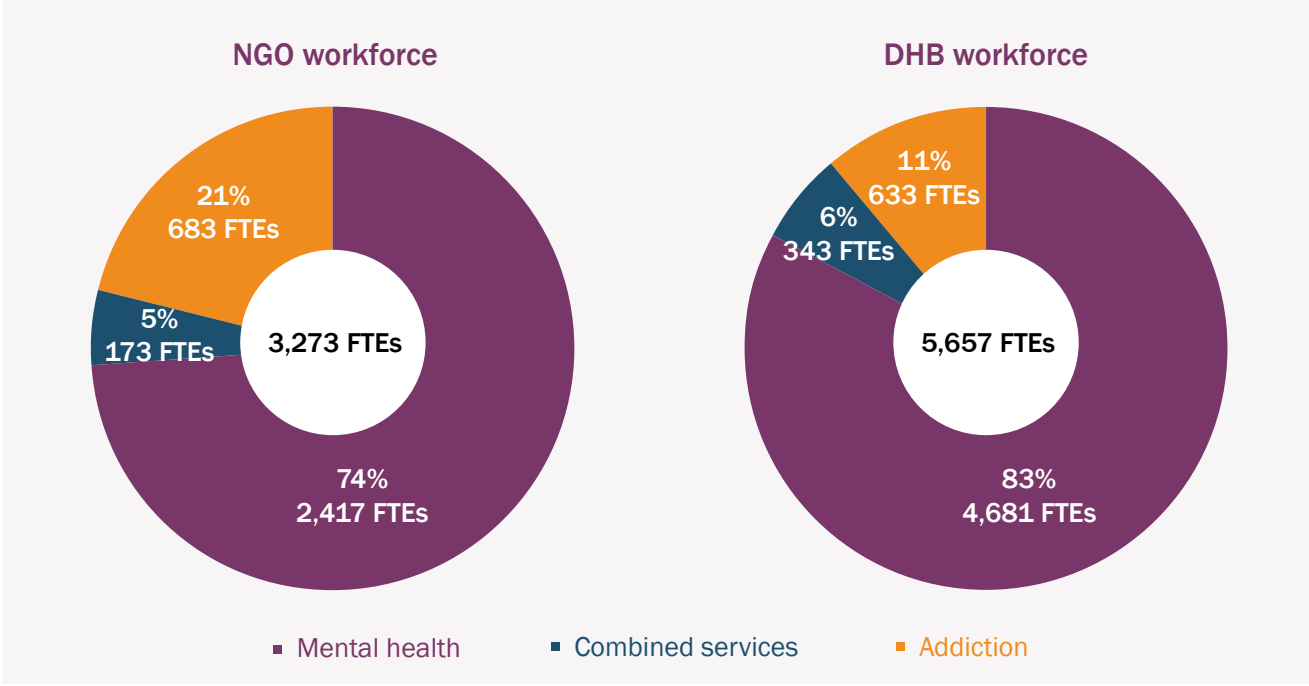

Figure 5. Vote Health funded workforce reported to the survey by NGOs and DHBs within sector groups

NGO and DHB addiction services had similar sized workforces (683 FTE positions compared to 633 FTE positions respectively). However, addiction services were a much larger proportion of the total NGO workforce (21 per cent compared to 11 per cent reported by DHBs). NGOs reported a smaller proportion of the workforce in mental health services than DHBs (74 per cent compared to 83 per cent).

Other income and workforce

In Section A of the survey, NGOs were asked if their mental health and addiction services were funded from other sources in addition to Vote Health. They were asked to identify the sources of other funding from a pre-set list.

Respondents from 86 NGOs selected one or more other sources. The most commonly identified sources of other income were philanthropic (charity) followed by fundraising and contracts with the Ministry of Social Development (Figure 6).[6]

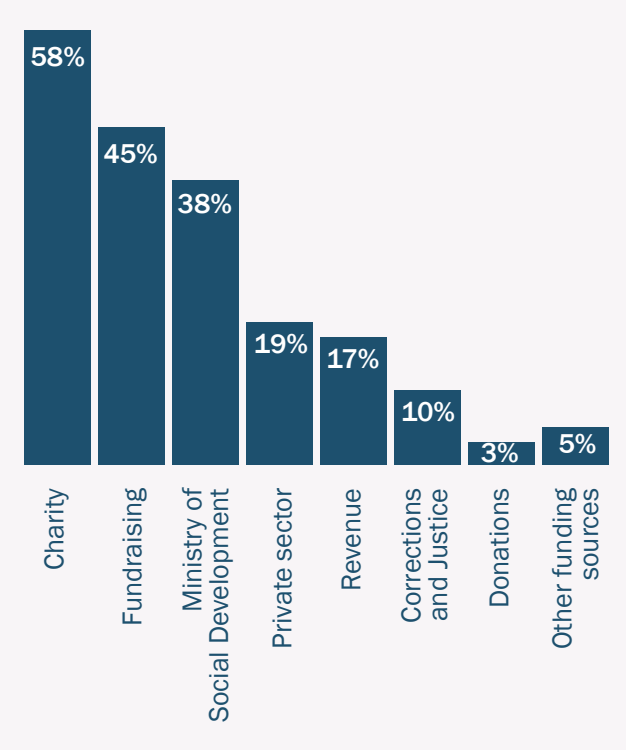

Figure 6. Proportion of NGOs reporting other sources of income (n=86 NGOs)

In Section B of the survey, 59 NGOs reported a workforce funded from other sources of income; totalling 400 FTE positions (11 per cent of the total NGO workforce reported to the survey), compared to 8 FTE positions reported by DHBs.[7] Figure 7 shows the number of organisations surveyed, grouped by the proportion of the total reported workforce that was funded from other sources of income, including those organisations that did not report any workforce in this category.[8]

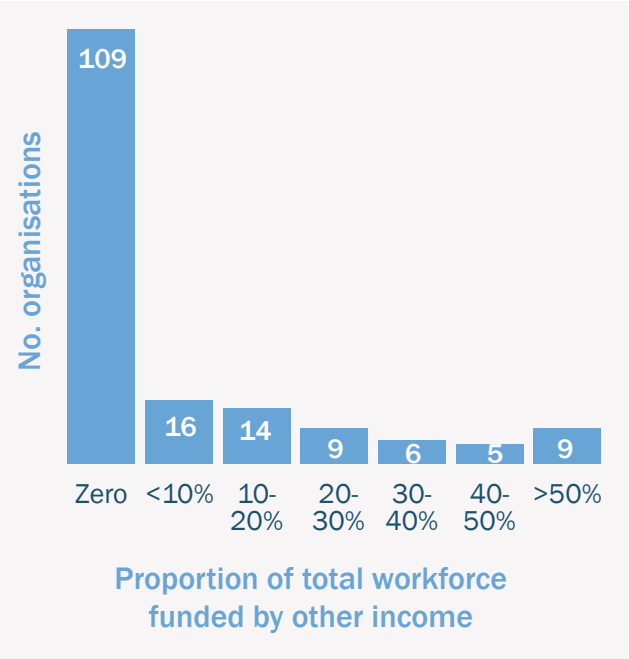

Figure 7. Number of NGOs reporting workforce funded by other income sources by workforce size (n=168 NGOs)

Thirty of the 59 NGOs (51 per cent) had less than 20 per cent of their reported workforce funded by other income sources. Only nine NGOs (15 per cent) reported that other income sources funded more than 50 per cent of their total workforce.

The roles most commonly reported as funded by other sources of income were employment workers (12 per cent of the workforce funded by other sources of income), residential support workers (9 per cent), administrative and technical support (13 per cent) and senior managers (9 per cent).

These results are specific to organisations that receive some Vote Health funding, because the survey sample was to these services. For these services, the proportion of the workforce reported to be funded by other sources was seven per cent for mental health, 20 per cent for combined mental health and addiction services and 22 per cent for addiction services. The results do not necessarily reflect funding arrangements for all organisations delivering mental health and addiction services.

6 In Figure 6 charity includes funding received from philanthropic organisations, community trusts and other contestable funding of a non-specific nature, eg lottery grants.

7 Anecdotal evidence and sector intelligence suggest that the non-health funded workforce was likely to be under-reported by organisations participating in the survey, particularly for addiction services.

8 One NGO reported the number of people employed without corresponding FTE positions so is excluded from Figure 7.

Comparison to *NgOIT 2005*

The *NgOIT Landscape survey* (Platform, 2005) collected information from 232 out of 361 organisations (64 per cent) identified from websites and NGO networks as well as DHB and Ministry of Health contracts.

These NGOs delivered a range of services including child and youth, and older adults' mental health and addiction, as well as services to other sectors such as disability. It is unclear from the *NgOIT* results how many of the responding organisations did not receive any Vote Health funding (Platform, 2005, p.16).[9] Consequently, our ability to compare the *More than numbers* survey results with *NgOIT* is limited. This section presents an overview of the differences between the sizes of the organisations reporting to the two surveys. The results presented from *More than numbers* in this section include all workforce reported to the survey including that which was funded from other sources of income.

Figure 8 compares the number of responding organisations in each workforce size group for *NgOIT* and the *More than numbers* surveys.

NgOIT received responses from 45 to 66 NGOs in each size apart from very large organisations, of which *NgOIT* surveyed 11 NGOs.

In contrast *More than numbers* received surveys from fewer small to medium organisations (14 to 41 NGOs) and slightly more large and very large organisations (61 and 18 NGOs respectively).

These differences may reflect a number of factors including the different scopes of the two surveys; with *More than numbers* having a much narrower scope to its survey sample than *NgOIT*. In addition, government funding priorities have changed in recent years reflecting an intention to work with fewer and larger organisations. Sector intelligence suggests NGOs have responded to this imperative in a variety of ways, including shifts in service focus and organisation growth, mergers and closures. The higher number of large NGOs reported in *More than numbers* is likely to at least partially reflect real changes in the average size of NGOs.

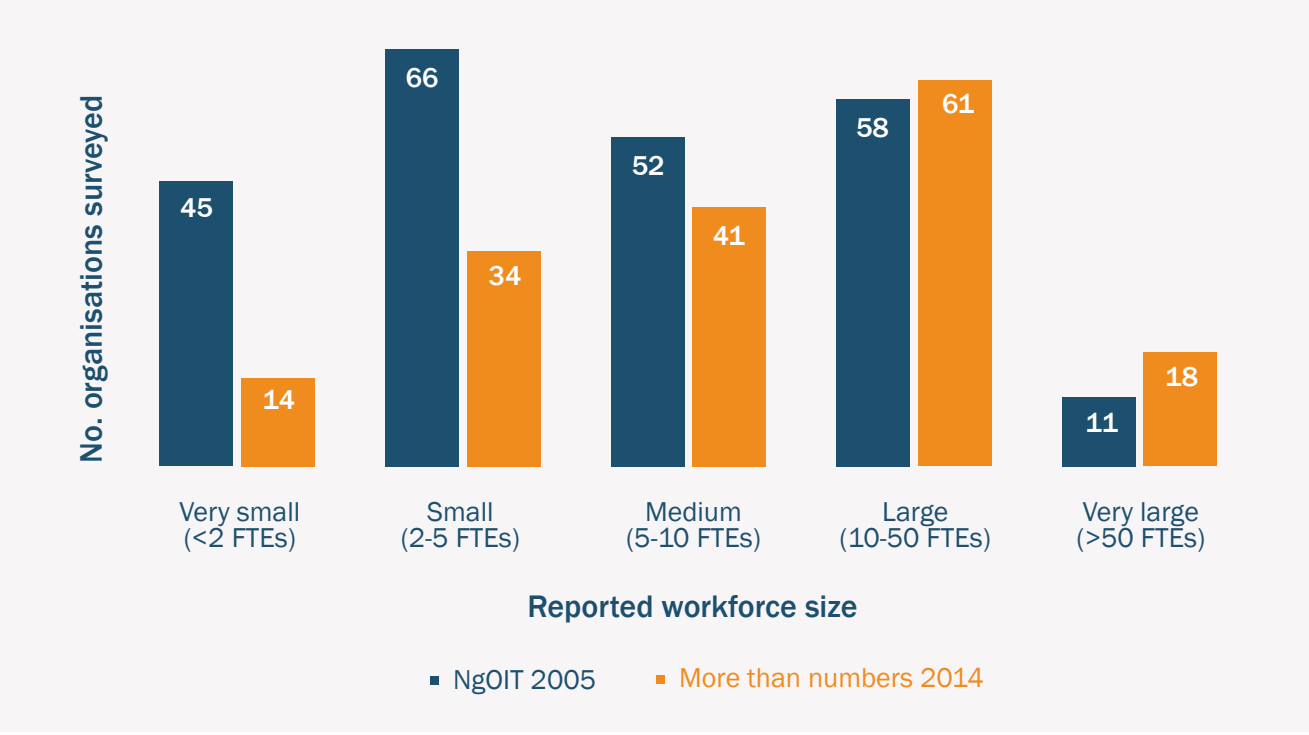

Figure 8. Number of organisations reporting to the More than numbers and NgOIT surveys, by organisation size

9 The total workforce delivering mental health and addiction services reported to *NgOIT* was 3,723 FTE positions.

Vote Health funded NGO workforce

This section describes the Vote Health funded workforce reported to the *More than numbers* survey, comparing NGOs and DHBs.

Overview

NGOs reported a Vote Health funded workforce totalling 3,273 FTE positions (employed plus vacant), which was 37 per cent of the total Vote Health funded mental health and addiction services workforce nationally (8,929 FTE positions).

Figure 9 shows the proportion of the total workforce reported by NGOs and DHBs in each of the three service groups.

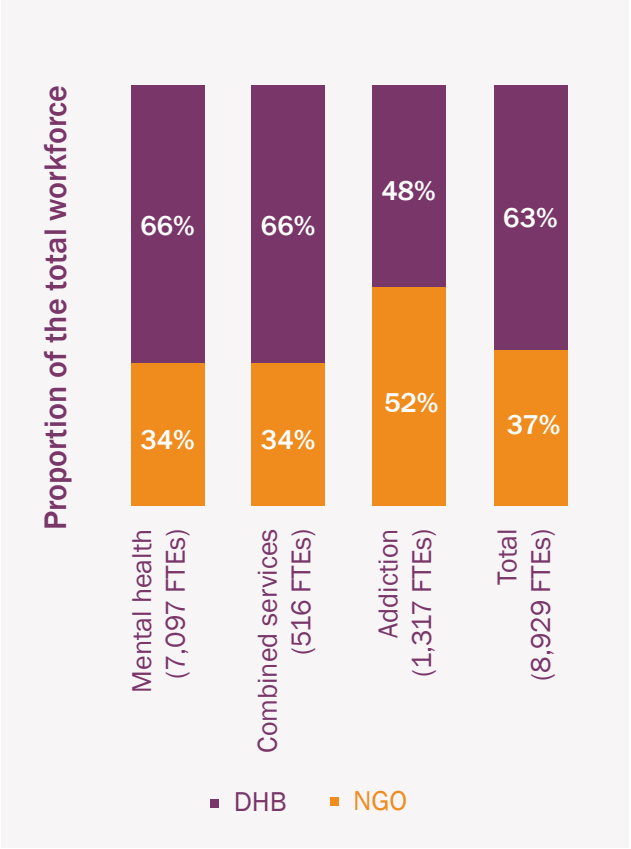

Figure 9. Workforce reported by NGOs and DHBs by service provided (n=8,929 FTE positions)

Respondents were asked to identify the predominant service type provided by their workforce using a list of pre-set options. Table 3 summarises the total reported workforce across the three service groups, within six service types (community, residential, inpatient, forensic, administration and management, and other services).[10]

Table 3. NGO workforce by service types

Service type	Workforce (FTE positions employed plus vacant)				Proportion of the NGO workforce (%)
	Mental health	Combined services	Addiction	Total	
Community	1,132.3	102.8	413.8	1,648.9	50.4
Residential	906.6	11.0	257.5	1,175.1	35.9
Forensic	43.1	-	-	43.1	1.3
Administration and management^	129.3	49.9	8.4	187.5	5.7
Other	205.2	9.2	3.6	218.0	6.7
Total	**2,416.5**	**172.8**	**683.3**	**3,272.6**	**100.0**

Note:
^ The administration and management service type includes the workforce providing management, oversight and technical or clinical support working across multiple services within an organisation.

10 The allocation of survey responses to each of these service types is described in the regional reports on the Te Pou website: www.tepou.co.nz/morethannumbers.

Some service types were more common in NGOs than DHBs and vice versa (see Figure 10). Both DHBs and NGOs reporting to the survey had half of their workforce in community services and similar proportions of the workforce in administration and management services. However, NGOs had a much larger proportion of the workforce delivering residential and other service types compared to DHBs.[11] DHBs had a greater investment in the workforce providing forensic and inpatient service. When comparing the workforce across service types it is important to acknowledge that DHB services are supported by a corporate structure outside adult mental health and addiction services, and this workforce will not have been captured by this survey.

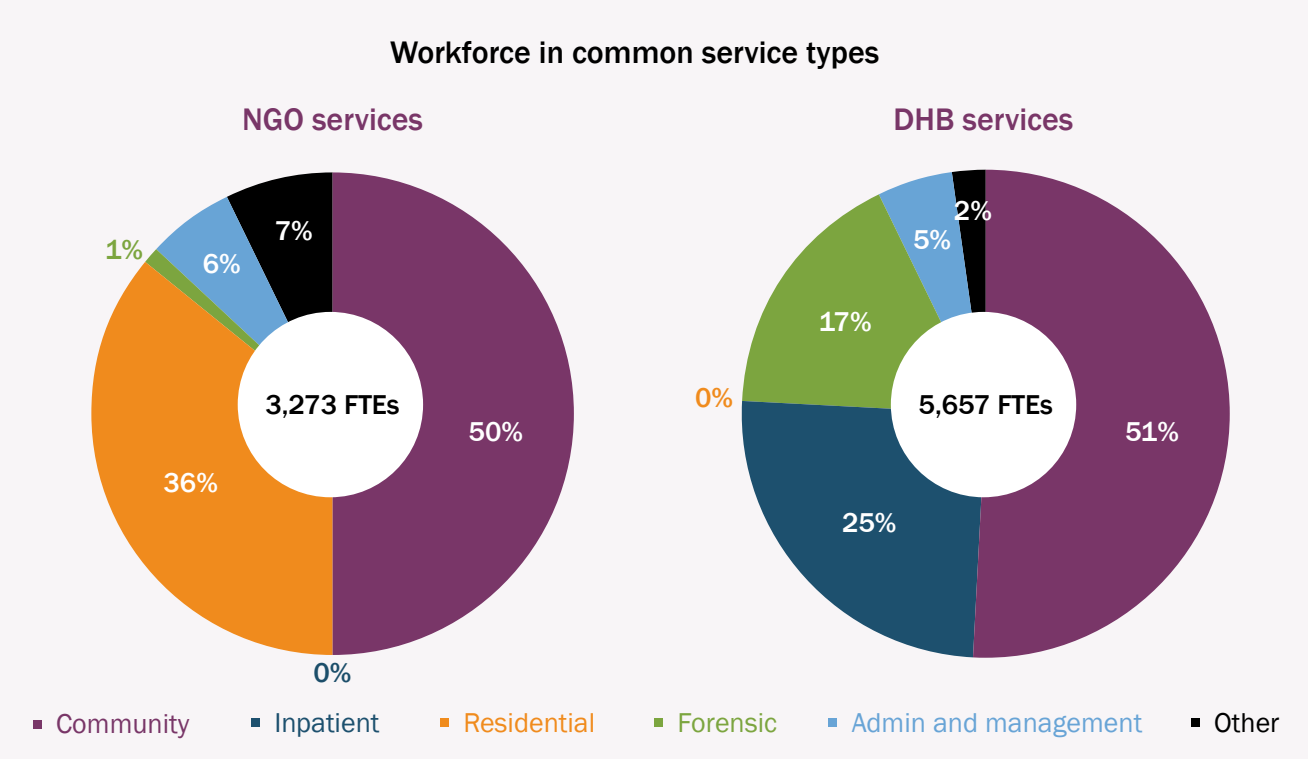

Figure 10. Proportion of the NGO and DHB workforce in the main service types reported to the survey

Distribution of the NGO workforce

Regional NGO and DHB workforce surveys provided information about the adult mental health and addiction sector workforce by DHB locality. This section describes the distribution of the NGO workforce by health region and compares each region's NGO workforce with the DHB workforce and the adult population. Whereas the rest of this report describes the survey results as reported, this section uses estimates of the NGO workforce. The NGO workforce reported to the survey was under-represented because 27 per cent of NGOs invited to participate in the survey did not respond. In addition some NGOs that participated may have under-reported the workforce.

Using information about the Vote Health funding received by NGOs in 2012/13, the average funding per FTE position reported to the survey was used to estimate the total workforce in organisations that did not respond to the survey.

This analysis indicates an under-reporting of the NGO workforce by approximately 580 FTE positions.[12] These estimates are used in this section to describe the total NGO workforce by region.

NGOs were estimated to have 41 per cent of the national adult mental health and addiction services' workforce and DHBs had 59 per cent. The proportion of the workforce in NGOs and DHBs varied across the regions. Figure 11 summarises the distribution between NGOs and DHBs at regional level, using the total estimated workforce for NGOs.

11 Other included a wide range of service types, for example advocacy and driving programmes.

12 Calculations are described in *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services* on the Te Pou website. These calculations can be generalised to only the mental health and addiction services groups in DHB areas and are not able to be used to estimate the workforce in particular roles.

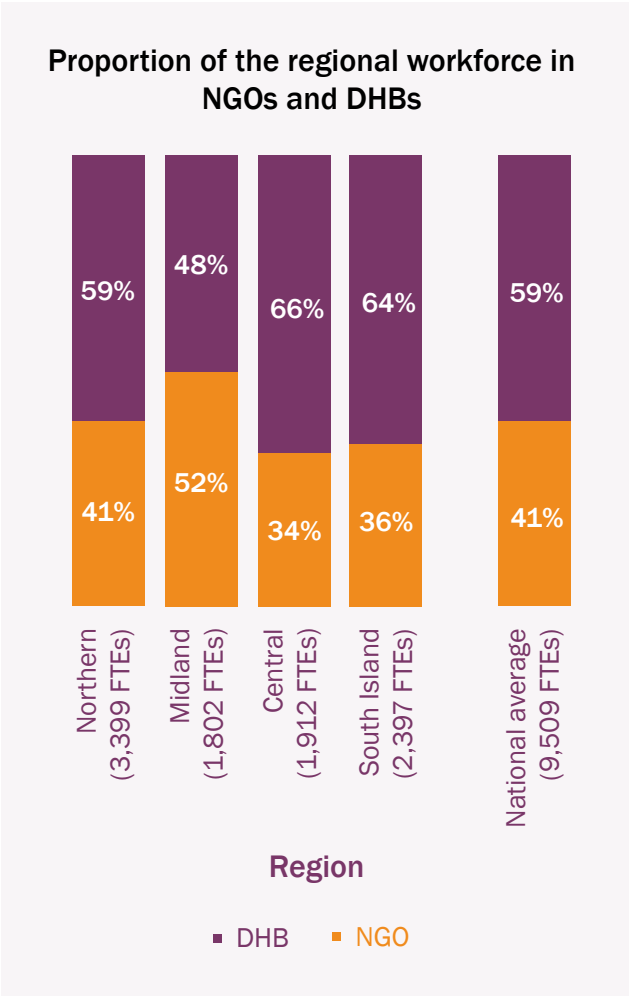

Figure 11. Proportion of the workforce in DHBs and NGOs by region (using estimated total workforce for NGOs)

Figure 12 shows the ratio of estimated FTE positions to population in each of the four regions and nationally for NGOs and DHBs. The national average for NGOs was 1.6 FTE positions per 1,000 adults compared to DHBs which had 2.3 FTE positions per 1,000 adults. The Midland region had the highest ratio of NGO workforce to population, and was the only region where the NGO ratio exceeded the DHBs' ratio. The Central and South Island regions had the largest gap between NGO and DHB ratios (1.17 and 1.18 FTE positions per 1,000 adults respectively).

As the goals described in *Rising to the Challenge* are realised, we might see these ratios change, both in terms of the number of FTE positions per 1,000 adults and the distribution of the workforce between NGOs and DHBs.

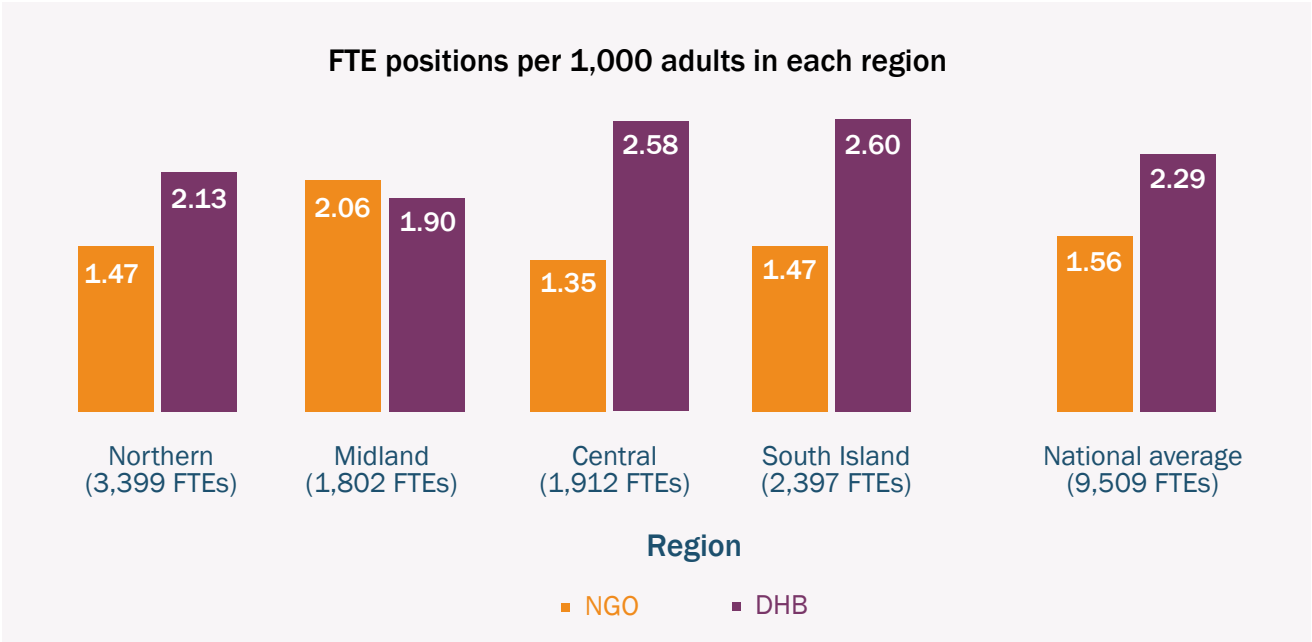

Figure 12. DHB and NGO workforce per 1,000 adults by region with national average (using estimated total workforce for NGOs)

Workforce composition

Respondents were asked to identify the number of people and FTE positions (employed and vacant) in the workforce by role. This section describes the reported workforce (not the estimated workforce) summarising results into occupational groups, and describing the roles that make up the largest groups, have the most vacancies, and those most commonly identified as having recruitment and retention issues. Information about all roles reported to the survey is included in Table 7 and Table 8 in the Appendix.

Workforce in role groups

This section describes the survey results grouped by clinical roles, non-clinical roles, and administration, management and support roles.[13] Information about the workforce by roles, within the three service groups, is contained in the Appendix. Table 7 is about the reported total workforce (FTE positions employed plus vacant) and Table 8 is about vacancies (FTE positions vacant).

Figure 13 summarises the proportion of the workforce in clinical, non-clinical and administration and management roles for DHB and NGO adult mental health and addiction services.

In mental health services NGOs differed sharply from DHBs; 75 per cent of the NGO workforce was in non-clinical roles (1,811 FTE positions) compared to just 14 per cent of the DHB mental health services workforce (663 FTE positions in non-clinical roles).

In addiction services, there was less of a distinction between the workforce composition of NGOs and DHBs; 58 per cent of the NGO workforce was in clinical roles (399 FTE positions) compared to 79 per cent (503 FTE positions) within DHBs.

In combined mental health and addiction services both DHBs and NGOs had around one-third of the workforce in administration, management and support roles. This result shows that a large proportion of this group is comprised of roles that support and manage both mental health and addiction service delivery within their organisation.

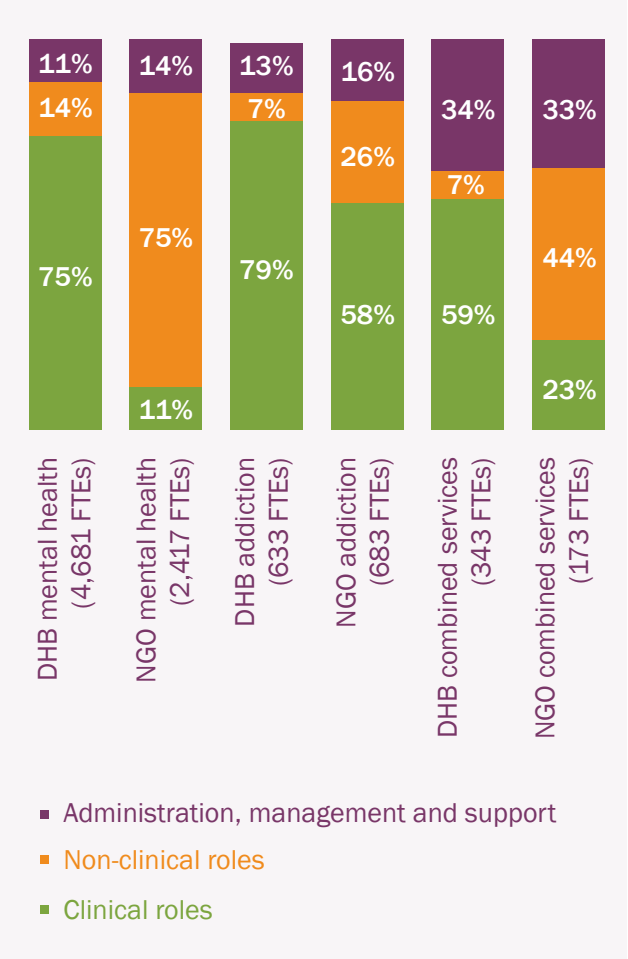

Figure 13. Proportion of the workforce reported by NGOs and DHBs by service groups and role types

Figure 14 shows the six roles that make up the largest workforce groups in NGO service delivery.[14] The number at the centre of each column is the total FTE positions (employed plus vacant) for that role. Its proportion of the relevant group's total NGO workforce is shown as a percentage at the end of each column. Although the three service groups have very different workforce sizes and compositions, community and residential support worker, peer support – consumer and service user, and registered nurses were among the largest roles for all three groups.

13 The survey defined clinical staff as professionals who are qualified and competent to provide intervention and/or treatment independently, albeit while part of a team. They will typically be registered under the *HPCA Act 2003, Social Workers Registration Act 2003*, or *dapaanz* practitioner registration.

14 Management, administration and groups of roles under the catchall 'other' have been excluded from this analysis. A table showing the NGO workforce FTE positions employed and vacant by roles and relative to the total workforce is contained in the appendix.

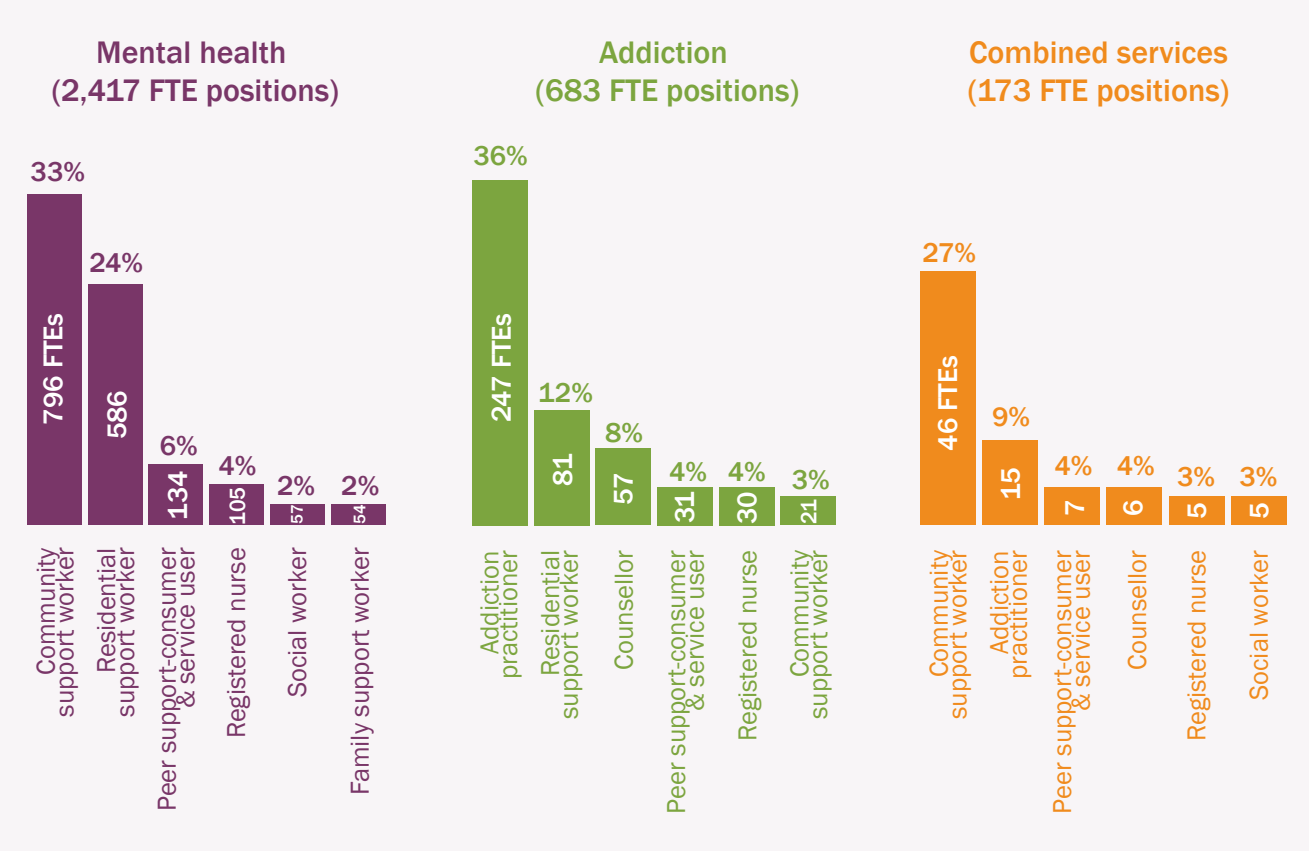

Figure 14. The top six service delivery roles by workforce number in each service group including the proportion of the group's total NGO workforce

Vacancies

Three per cent of the total FTE positions in the NGO workforce were reported vacant on 1 March 2014. In contrast, DHB services reported 5 per cent of FTE positions as vacant. NGO vacancy rates were similar for mental health (3.5 per cent) and addiction services (3.2 per cent).

Table 4 shows the four roles with the largest number of vacant FTE positions for NGOs and DHBs. A full list of vacancies in NGOs for each service group is in the appendix to this report.

Table 4. Roles with the largest number of FTEs vacant in the NGO and DHB workforce

NGO common vacant roles	DHB common vacant roles
Community support worker	Registered nurse
Residential support worker	Healthcare assistant
Registered nurse	Clinical psychologist
Addiction practitioner	Occupational therapist

Recruitment and retention issues

In addition to identifying roles in the workforce, respondents were asked if they thought there would be any shortages of staff to fill those roles during the next two years. The most prevalent roles in the NGO workforce were also identified as being subject to recruitment issues. Table 5 shows the five roles most often identified by NGO respondents as having future workforce shortages, alongside those most often identified by DHB respondents.

Table 5. Top five roles perceived to have future workforce shortages by NGO and DHB respondents

NGO	DHB
Addiction practitioner	Registered nurse
Registered nurse	Consultant psychiatrist
Community support worker	Clinical psychologist
Residential support worker	Occupational therapist
Peer support – consumer and service user	Dual diagnosis and co-existing problems clinician

In contrast to DHBs, NGOs expressed concerns about three non-clinical roles, reflecting the fact that NGOs had a larger proportion of non-clinical roles in the workforce than DHBs (26 per cent compared to 75 per cent, see Figure 13).

Perceived shortages of staff for particular roles may indicate other issues beyond a shortage of qualified applicants, including barriers in career pathways, unpopularity of the sector with new graduates, or difficulties accessing the required postgraduate education and experience.

Cultural competence and ethnic representation in the NGO workforce

A representative and culturally competent workforce is required to support the goal of improving outcomes for Māori, and for people in Pasifika and Asian ethnic groups. This is particularly important for NGOs because PRIMHD[15] shows a greater proportion of NGO service consumers are Māori, compared to those seen by DHBs. In 2013, 30 per cent of all adult mental health service consumers seen by NGOs were Māori compared to 22 per cent of those seen by DHBs.[16] For NGO AOD services, 40 per cent of consumers were Māori compared to 29 per cent of those seen by DHB AOD services. This section describes the survey results relating to the cultural knowledge and skills needed by the workforce, and describes the ethnicity of the workforce by region comparing the survey results to the available information about population and service use.

Cultural competence

A large proportion of survey respondents indicated the workforce needed to increase cultural competence for working with Māori, Pasifika and Asian ethnic groups. In particular, around three-quarters of NGO respondents[17] reported that their workforce needed to increase skills in cultural competence for working with Māori and Pasifika, understanding Māori models of health and Pasifika family structures and values. Figure 15 shows the four cultural competency-related knowledge and skill areas that respondents most commonly identified as skills that their workforce needed to increase.

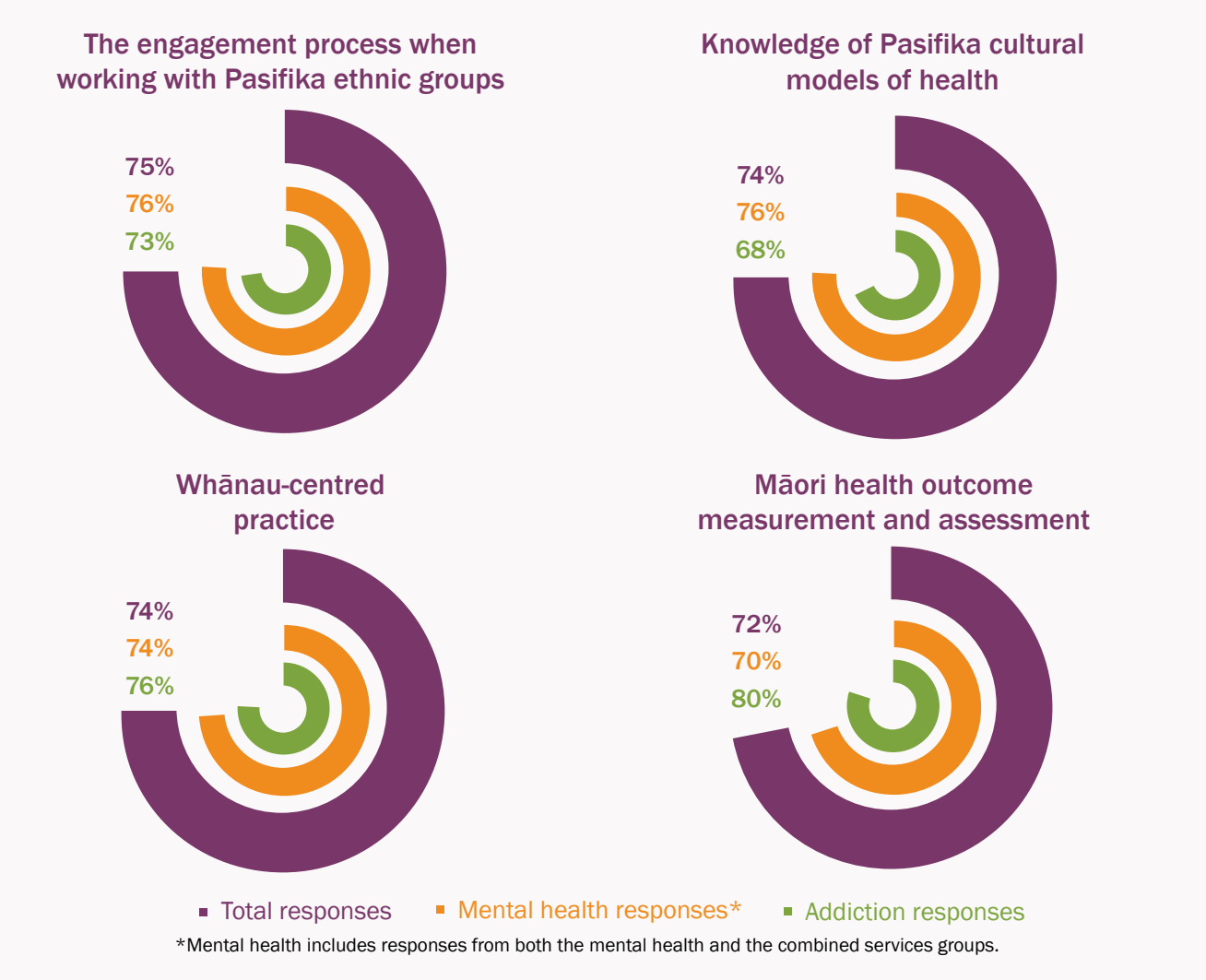

Figure 15. Cultural competence areas most often identified by NGO respondents from the mental health and addiction service groups

In contrast, a larger proportion of DHB respondents indicated their workforce needed to increase cultural competence for working with Māori (78 per cent of respondents), Pasifika (88 per cent) and Asian ethnic groups (86 per cent).

15 Ministry of Health Programme for the Integration of Mental Health Data.

16 Including those consumers seen by both DHBs and NGOs.

17 These results were collected from service and team managers; this means that more than one survey response could be received from each NGO.

Māori representation in the workforce

Increasing Māori contribution to the development and delivery of NGO services is needed to ensure ongoing momentum towards improving Māori health outcomes. Current population projections based on the 2013 New Zealand Population Census indicate that 16 out of the 20 DHB areas around the country can expect the Māori population to increase by more than 10 per cent by 2026, adding another 95,000 people to the Māori population. In the South Island region and the Taranaki and Waitematā DHB areas the Māori population is projected to increase by nearly 20 per cent or more.[18]

The survey focused on one aspect of representation: workforce ethnicity. Respondents were asked to record how many staff members were Māori and the number of FTE positions employed.[19] NGOs completing this question generally reported a higher representation of Māori in the workforce compared to DHBs.

Nationally, Māori representation in the reported NGO workforce was high compared to the proportion of Māori adults in the population, but it was lower than the proportion of Māori as consumers of NGO services, particularly for AOD services.

Figure 16 shows the national results for the NGO mental health and AOD services workforce compared to the consumer ethnicity information from PRIMHD and the New Zealand population census. Results for problem gambling services are supplied here.[20]

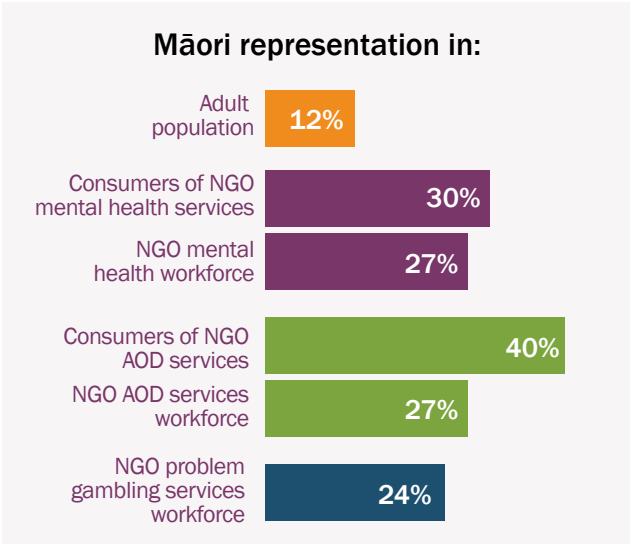

Figure 16. Proportion of Māori in the adult population, as service consumers, and in the NGO mental health, AOD and problem gambling services' workforce

18 Statistics New Zealand (2014). Note that these projections were produced by Statistics New Zealand according to assumptions specified by the Ministry of Health.

19 Respondents were asked to provide employee self-identified information.

20 For the method underpinning calculation of these proportions see the regional reports.

Rates of Māori representation in the NGO workforce varied across the regions. Figure 17 shows the results for NGO mental health and AOD services for each region.

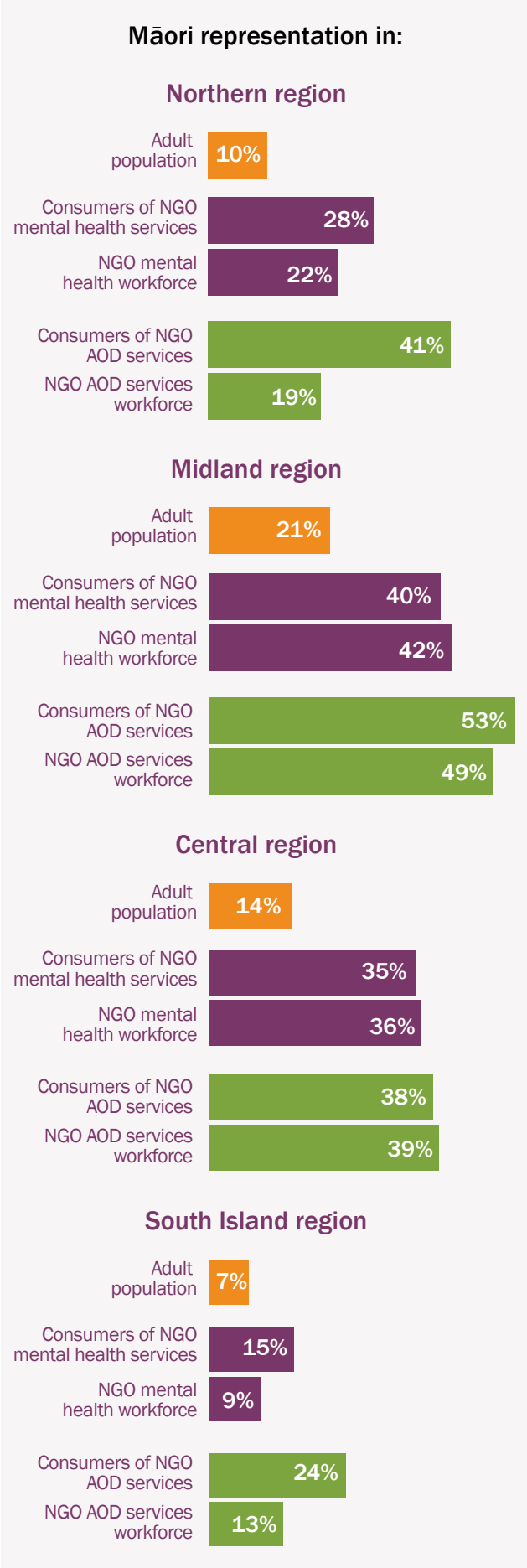

Figure 17. Representation of Māori in the regional adult population, as consumers of services and in the NGO workforce

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In Northern region AOD services, Māori were substantially under-represented compared to consumers. This result may be impacted by a low response rate from Māori organisations in the region. In the Midland region, the workforce for both mental health and AOD services only slightly under-represented the Māori workforce compared to consumers. NGOs in the Central region had similar proportions of Māori working in services to consumers. The South Island region had very low Māori representation in its workforce compared to service consumers for mental health and AOD services, as well as the lowest population representation of all the regions.

More than two-thirds of the 58 NGO respondents who answered the recruitment and retention question about Māori staff thought that in the next two years there would be shortages of Māori staff members to fill clinical roles, and 43 per cent of 165 NGO respondents thought there would be shortages of Māori staff members to fill non-clinical roles (see Figure 18).

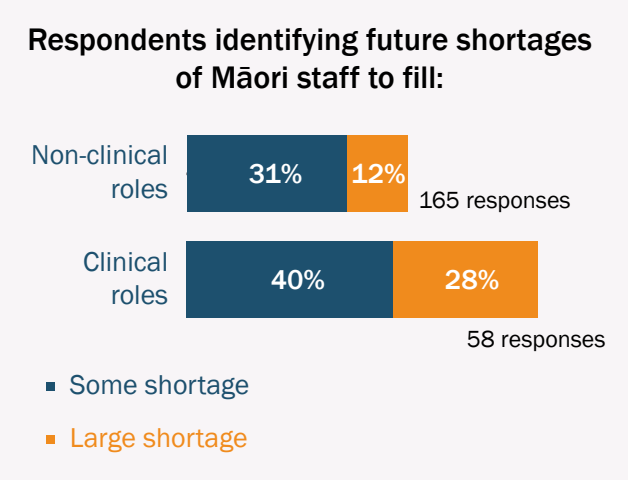

Figure 18. Proportion of NGO respondents indicating potential future shortages of Māori staff to fill clinical and non-clinical roles

These results suggest that coordinated strategies are needed to improve Māori uptake of careers in mental health and AOD services in the Northern and South Island regions in particular. Ongoing work will also be needed to ensure Māori participation in the design, development and management of future services.

Representation of Pasifika ethnic groups in the workforce

Nationally, Pasifika representation in the NGO workforce was higher than or consistent with Pasifika representation as consumers of services (see Figure 19).

Figure 19. Proportion of Pasifika in the adult population, as service consumers, and in the NGO mental health, AOD and problem gambling workforce

The Northern region had the largest representation of Pasifika people in the adult population (11 per cent). In addition, the Northern region mental health services workforce had slightly lower Pasifika representation than mental health service consumers (11 per cent compared to 13 per cent of consumers). The Central region had the next largest proportion of Pasifika adults in its population (5 per cent) and also had lower Pasifika representation in its workforce compared to consumers of AOD services (1 per cent of the workforce compared to 4 per cent of consumers).

More than half of the 21 NGO respondents who answered the recruitment and retention question about Pasifika staff thought that over the next two years there would be shortages of Pasifika staff members to fill clinical roles, and 36 per cent of 74 NGO respondents thought there would be shortages of Pasifika staff members to fill non-clinical roles (see Figure 20).

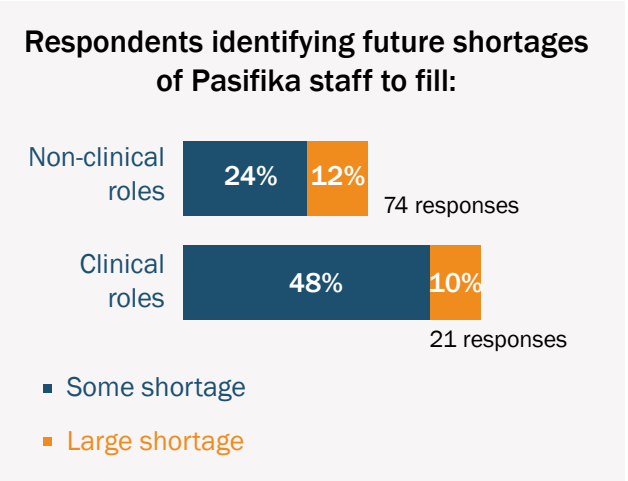

Figure 20. Proportion of NGO respondents indicating potential future shortages of Pasifika staff to fill clinical and non-clinical roles

Although the Pasifika adult population in New Zealand is relatively small, population projections to 2026 indicate that most DHB areas will see an increase in the Pasifika population of somewhere between 20 and 70 per cent - around 57,000 people with nearly two-thirds living in the Northern region.[21] While most regions currently report a balance between the representation of Pasifika consumers and workforce, the survey results suggest that ongoing strategies to encourage mental health and addiction careers among Pasifika people will help prevent an imbalance occurring in the future.

Representation of Asian ethnic groups in the workforce

The representation of Asian people within the NGO workforce was higher than within consumers of mental health and AOD services, but lower than the total adult Asian ethnic population (13 per cent, see Figure 21). Of note, nationally, 24 per cent of problem gambling services' workforce were identified as Asian.[22]

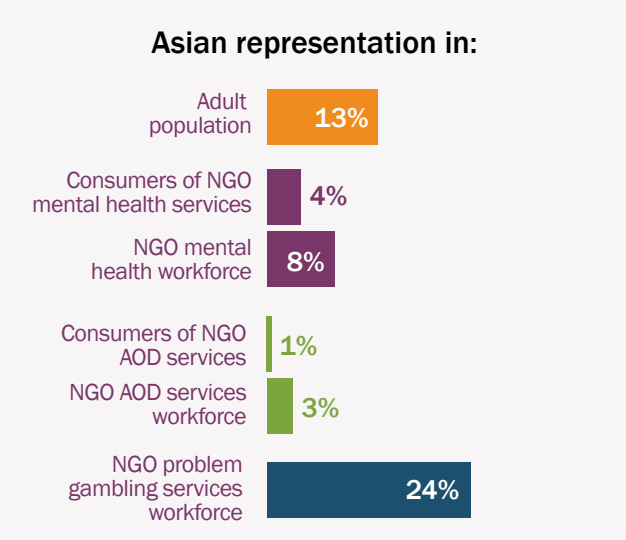

Figure 21. Proportion of Asian ethnic groups in the adult population, as service consumers, and in the NGO mental health, AOD and problem gambling workforce

Adults in the Asian ethnic group make up 22 per cent of the Northern region's total adult population, 9 per cent of service consumers, and 14 per cent of the NGO workforce in both mental health and addiction services. In the other regions Asian representation in the adult population was small, (6 to 8 per cent) with representation in the workforce ranging from 3 to 4 per cent, slightly higher than the proportion of consumers who identified in the Asian ethnic group.

Some respondents indicated concerns about recruitment difficulties for Asian staff. Nearly one-third (30 per cent) of the 64 NGO respondents who answered this recruitment and retention question thought that over the next two years there would be shortages of Asian staff members to fill non-clinical roles, and 33 per cent of 18 NGO respondents thought there would be shortages of Asian staff members to fill clinical roles (see Figure 22). A few respondents thought there would be an oversupply of Asian staff members for these roles (8 per cent and 11 per cent respectively).

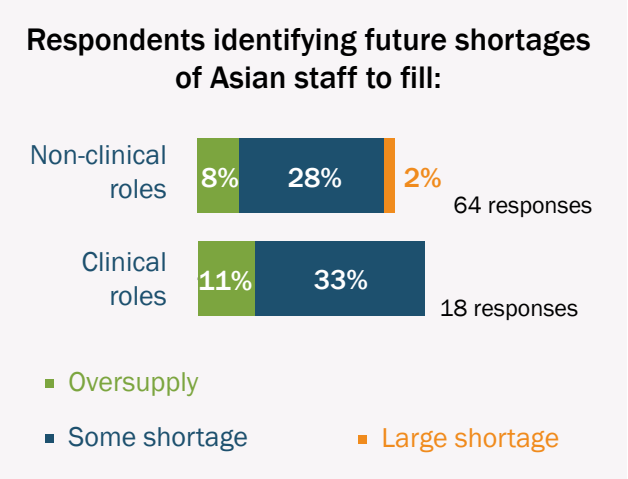

Figure 22. Proportion of NGO respondents indicating potential future shortages of Asian staff to fill clinical and non-clinical roles

The Asian population in New Zealand is one of the fastest growing populations through both natural increase and immigration. Population projections suggest that by 2026 the Asian population in all DHB areas will have increased by between 30 and 75 per cent, adding another 276,000 people to New Zealand's Asian population.[23] Workforce planning will need to ensure Asian representation in the workforce and general cultural competence levels increase as the Asian population grows.

21 See footnote 18.

22 Because of the very small workforce in problem gambling services and the low response rate to this question we are unable to calculate Asian representation in this workforce.

23 See footnote 18.

Challenges faced by NGOs

An adaptive and flexible workforce within a well-developed NGO sector is critical to delivering the transformational changes to mental health and addiction services promoted by *Rising to the Challenge*. However, NGOs face a number of challenges to achieving these goals in a fiscally constrained environment (Platform Trust and Te Pou o Te Whakaaro Nui, 2015, p. 45). This section summarises the survey results for NGOs responding to questions about workforce challenges, knowledge and skill needs, and cross-sector relationships.

Workforce challenges

Respondents were asked to identify their top four workforce challenges from a list of seven pre-set options, and rank these challenges from 1 to 4, with 1 being the biggest challenge. Table 6 shows the proportion of NGO respondents including these seven challenges in their top four, in order from most to least commonly selected. The corresponding results from DHB respondents are also provided for comparison.

NGO respondents commonly ranked static or reduced funds, following by managing pressure on staff due to increased complexity and increased demand for services among their top challenges. While it appears DHB respondents are not as concerned about financial pressures as NGOs, it may be that these respondents experience funding constraints as increased demand.

The overall NGO results predominantly reflect the views of the NGO mental health services group. Respondents from NGO addiction services were more likely to rank the cost of training and other professional development in their top four challenges, and were less likely to include managing pressure due to changing service delivery models.

Knowledge and skills

In addition to cultural competence skills already described in a previous section, respondents were asked to indicate whether their workforce needed to increase knowledge and skills against a list of key service and policy areas.

Figure 23 shows the top four policy and service areas identified by NGO respondents. Three-quarters of respondents reported their workforce needed to increase knowledge and skills in working with new technologies and IT. Nearly as many indicated the need to increase skills in co-existing problems capability, psychological interventions and risk assessment, and the knowledge and use of legislation.

Table 6. Proportion of NGO and DHB respondents ranking their top four workforce challenges

Workforce challenges	NGO responses (%)	DHB responses (%)
Static or reduced funds*	65	30
Managing pressure on staff due to increased complexity	61	70
Managing pressure on staff due to increased demand for service**	58	77
Recruiting qualified and experienced staff	51	59
Cost of training and other professional development	51	31
Retaining qualified and experienced staff	49	46
Managing pressure on staff due to changing service delivery models	37	57

Note:
* Static or reduced funds was the challenge most often ranked first by NGO respondents (33 per cent of respondents).
** Managing pressure on staff due to increased demand for service was most often ranked first by DHB respondents (36 per cent).

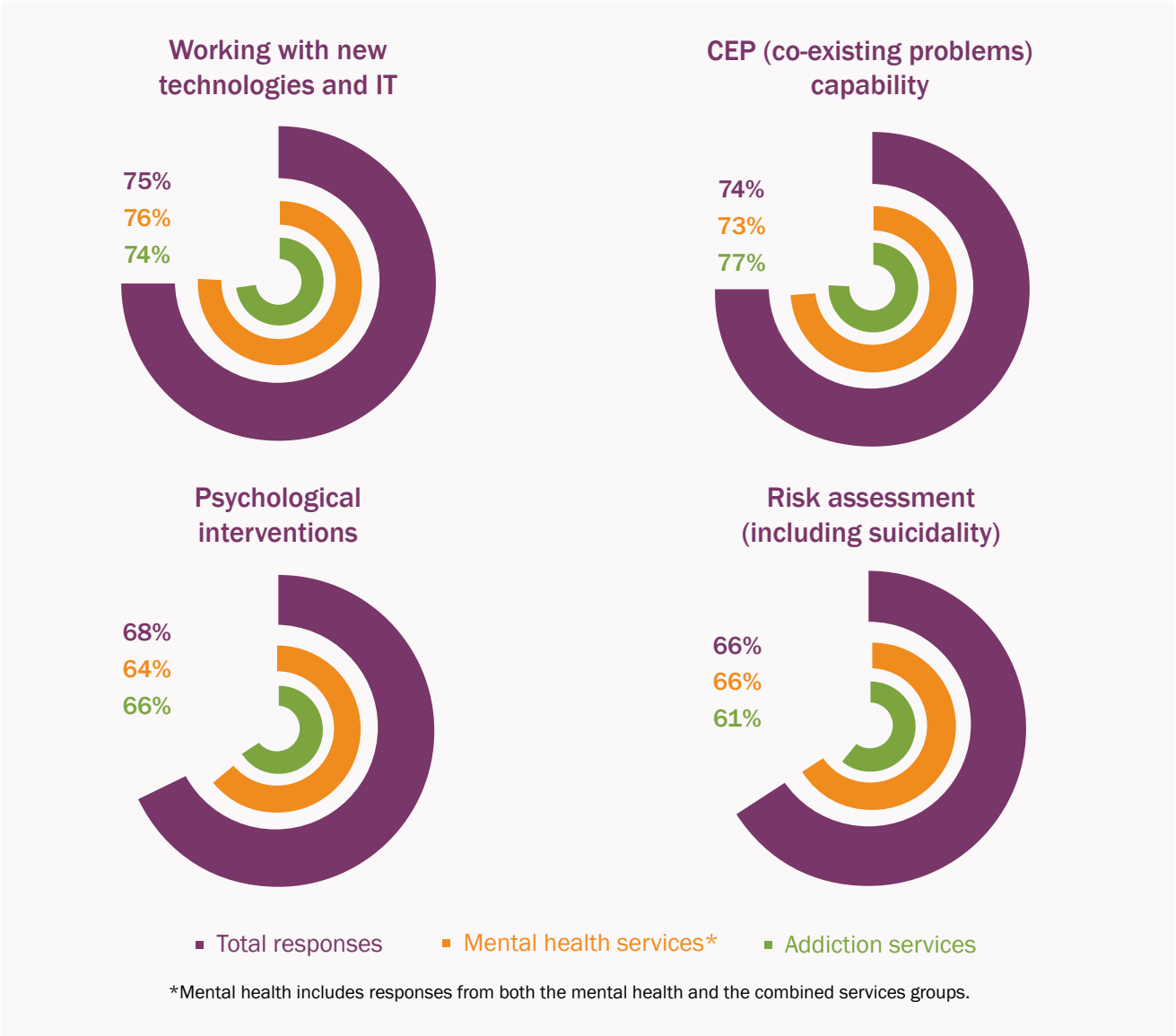

Figure 23. Service and policy areas needing some or large increases in workforce skills and knowledge as identified by NGO respondents

NGO results were similar to the top four from DHB respondents, who also identified the need to increase skills in working with new technologies and IT (90 per cent of respondents), co-existing problems capability (85 per cent), psychological interventions (80 per cent), and supporting self-managed care and risk assessment (70 per cent each).

Cross-sector relationships

The survey asked respondents to identify the strength of their relationships with a number of other sectors and services, choosing from a pre-set list. Overall, NGO respondents thought that more relationships were working adequately or well than needing improvement.

See Figure 24 for the top three relationships reported as working well.

Relationships most often identified as needing improvement by mental health services were with Work and Income and primary health practices. Respondents from addiction services most commonly identified needing to improve relationships with mental health services for older people, and Housing New Zealand Corporation and accommodation providers (see Figure 25).

In contrast, DHB respondents indicated the need to improve relationships with Housing New Zealand Corporation and accommodation providers (39 per cent), the disability sector (35 per cent), primary health practices (33 per cent) and general hospitals and emergency departments (31 per cent).

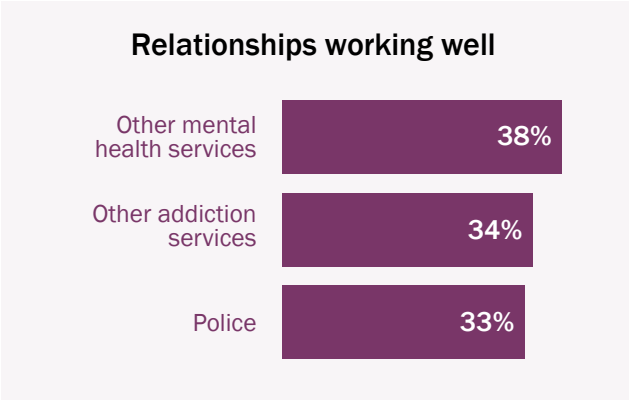

Figure 24. Cross-sector relationships most commonly identified by NGOs as working well

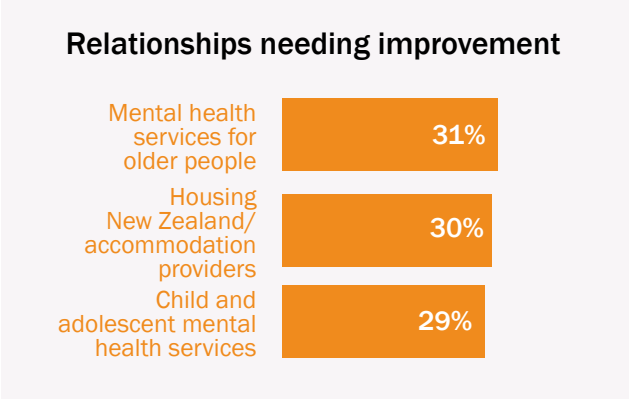

Figure 25. Cross-sector relationships most commonly identified by NGOs as needing improvement

Concluding comments

This report describes the size, distribution and configuration of the Vote Health funded NGO workforce delivering adult mental health and addiction services, as at 1 March 2014. It also outlines perceived current and future workforce challenges, knowledge and skill needs, and the strength of relationships with other services and sectors. In doing so it highlights workforce development challenges common across NGO services that would benefit from coordinated workforce development strategies. In addition, some results highlight that there needs to be further exploration of the factors underpinning these responses locally, regionally and nationally; for example understanding why some roles are challenging to recruit for and why certain cross-sector relationships are perceived to need improvement.

Future directions signalled for mental health and addiction services offer NGOs a wealth of development opportunities as well as challenges. NGO services are community-led; it is likely the development of this sector and its workforce will proceed in a number of different ways across the country. These developments may shift and blur traditional boundaries between roles, organisations, and sectors in an effort to meet the needs of the communities they serve (Platform Trust and Te Pou o Te Whakaaro Nui, 2015).

The *More than numbers* survey results reported here will support workforce planning for future NGO services by providing a starting point for analysing changes to the NGO sector over time. A more complete picture of the mental health and addiction sector workforce can be gained by combining the results presented here with those from the Werry Centre's 2014 stocktake of child and adolescent services (The Werry Centre, 2015). This information can help facilitate conversations about what "good" workforce composition might look like, and help to identify areas where development is needed. Workforce planning should be undertaken using a systematic, forward-thinking approach. *Getting it right* (Te Pou o Te Whakaaro Nui, 2014) describes a process for using workforce information to inform workforce development actions that align with decisions about service delivery models.

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Appendix

Table 7. The NGO mental health and addiction workforce by service groups

Roles	NGO workforce (FTE positions)				Proportion of NGO workforce (%)	Proportion of total workforce (%)
	Mental health services	Combined services	Addiction services	Total		
Allied health						
Addiction practitioner/clinician	10.6	15.3	246.7	272.7	8.3	3.1
Dual diagnosis practitioner/CEP clinician	1.5	3.0	16.7	21.2	0.6	0.2
Counsellor	7.9	6.3	56.5	70.7	2.2	0.8
Educator/trainer	12.5	3.5	-	16.0	0.5	0.2
Occupational therapist	20.3	-	1.0	21.3	0.6	0.2
Clinical psychologist	11.1	-	2.1	13.2	0.4	0.1
Other psychologist	7.0	-	0.5	7.5	0.2	0.1
Social worker	57.5	4.5	14.5	76.5	2.3	0.9
Other allied health	6.4	-	-	6.4	0.2	0.1
Total (allied health)	**134.7**	**32.6**	**338.1**	**505.4**	**15.4**	**5.7**
Medical and other professionals						
General practitioner	0.7	-	0.9	1.6	0.05	0.02
House surgeon	1.0	-	-	1.0	0.03	0.01
Consultant psychiatrist	0.4	0.2	-	0.6	0.02	0.01
Medical officer special scale	1.0	-	0.4	1.4	0.04	0.02
Psychiatric registrar	1.7	-	-	1.7	0.05	0.02
Liaison/consult liaison	1.0	-	-	1.0	0.03	0.01
Other medical professionals	-	-	-	-	-	-
Total (medical and other professionals)	**5.9**	**0.2**	**1.3**	**7.3**	**0.2**	**0.1**
Nursing						
Registered nurse	105.4	5.3	29.6	140.3	4.3	1.6
Enrolled nurse	3.9	-	2.0	5.9	0.2	0.1
Nurse practitioner/nurse specialist/ nurse educator	3.0	-	1.0	4.0	0.1	0.04
Other nursing professionals	-	-	-	-	-	-
Total (nursing)	**112.3**	**5.3**	**32.6**	**150.2**	**4.6**	**1.7**
Other clinical roles	**15.3**	**2.0**	**26.5**	**43.8**	**1.3**	**0.5**
Total (clinical roles)	**268.2**	**40.1**	**398.5**	**706.7**	**21.6**	**7.9**
Support workers						
Community development worker	45.0	-	-	45.0	1.4	0.5
Employment worker	42.0	1.9	-	43.9	1.3	0.5
Community support worker	796.2	46.1	20.7	863.0	26.4	9.7
Te whānau tautoko/family support worker	54.3	3.0	13.5	70.8	2.2	0.8

Roles	NGO workforce (FTE positions)				Proportion of NGO workforce (%)	Proportion of total workforce (%)
	Mental health services	Combined services	Addiction services	Total		
Healthcare assistant	9.0	-	-	9.0	0.3	0.1
Peer support - consumer and service user	133.9	7.1	30.7	171.7	5.2	1.9
Peer support - family and whānau	10.6	1.2	3.5	15.3	0.5	0.2
Psychiatric assistant	-	-	-	-	-	-
Residential support worker	586.1	-	81.3	667.4	20.4	7.5
Other support workers	86.2	9.0	16.2	111.3	3.4	1.2
Total (support workers)	**1,763.3**	**68.3**	**165.8**	**1,997.4**	**61.0**	**22.4**
Cultural advice and support						
Cultural supervisor	5.1	3.0	2.6	10.7	0.3	0.1
Kaumātua	13.6	2.7	1.9	18.2	0.6	0.2
Taua/kuia	5.7	-	1.0	6.7	0.2	0.1
Pukenga atawhai/kaiāwhina	1.0	0.1	0.5	1.6	0.05	0.02
Traditional Māori health practitioner	16.0	1.0	2.5	19.5	0.6	0.2
Matua	0.2	-	0.3	0.5	0.02	0.01
Pasifika cultural advisor	1.2	-	1.1	2.3	0.1	0.03
Other cultural advisor	3.8	0.2	1.2	5.2	0.2	0.1
Total (cultural advice and support)	**46.6**	**7.0**	**11.0**	**64.6**	**2.0**	**0.7**
Other non-clinical roles	**1.5**	**-**	**0.8**	**2.3**	**0.1**	**0.03**
Total (non-clinical roles)	**1,811.4**	**75.2**	**177.6**	**2,064.2**	**63.1**	**23.1**
Administration, management and support						
Administrative and/or technical support	72.3	16.5	42.8	131.7	4.0	1.5
Senior manager	57.3	12.6	18.7	88.6	2.7	1.0
Clinical director	5.1	-	2.0	7.1	0.2	0.1
Professional leader	7.9	2.0	10.0	19.9	0.6	0.2
Service manager/team leader	163.8	24.1	27.1	215.0	6.6	2.4
Consumer advisor/consumer leader	11.8	2.2	3.9	17.9	0.5	0.2
Family/whānau advisor	4.3	0.2	-	4.5	0.1	0.1
Other administration and management	14.4	-	2.7	17.1	0.5	0.2
Total (administration, management and support)	**336.9**	**57.6**	**107.2**	**501.7**	**15.3**	**5.6**
Total (All roles)	**2,416.5**	**172.8**	**683.3**	**3,272.6**	**100.0**	**36.7**

Table 8. Roles and relevant FTE positions vacant for each of the three service groups with vacancy rates for each role

Roles	NGO vacancies (FTE positions)				Vacancy rate (%)
	Mental health services	Combined services	Addiction services	Total	
Allied health					
Addiction practitioner and clinician			10.6	10.6	3.9
Counsellor			5.5	5.5	7.8
Occupational therapist	1.0			1.0	4.7
Clinical psychologist	3.0		0.6	3.6	27.3
Social Worker	2.0			2.0	2.6
Other allied health	1.2			1.2	18.8
Total (allied health)	**7.2**		**16.7**	**23.9**	**4.7**
Nursing					
Registered nurse	16.0		1.0	17.0	12.1
Enrolled nurse	0.5			0.5	8.5
Nurse practitioner/specialist/educator			0.5	0.5	12.5
Total (nursing)	**16.5**		**1.5**	**18.0**	**12.0**
Other clinical	**3.0**		**2.4**	**5.4**	**12.3**
Total (clinical roles)	**26.7**		**20.6**	**47.3**	**6.7**
Support workers					
Community development worker	0.5			0.5	1.1
Employment worker	0.5			0.5	1.1
Community support worker	27.4	1.5		28.9	3.3
Family support worker			1.2	1.2	1.7
Peer support-consumer and service user	3.2			3.2	1.9
Residential support worker	17.3			17.3	2.6
Other support workers	7.2			7.2	6.5
Total (support workers)	**56.1**	**1.5**	**1.2**	**58.8**	**2.9**
Cultural advice and support					
Cultural supervisor	1.0			1.0	9.4
Kaumātua	1.0	0.2		1.2	6.6
Kuia	1.0			1.0	14.9
Total (cultural advice and support)	**3.0**	**0.2**		**3.2**	**5.0**
Total (non-clinical roles)	**59.1**	**1.7**	**1.2**	**62.0**	**3.0**
Administration, management and support					
Administration or technical support	1.0	0.4		1.4	1.1
Senior manager	1.0			1.0	1.1
Service manager/team leader	1.0			1.0	0.5
Consumer advisor/consumer leader		0.3		0.3	1.7
Family/whānau advisor	0.5			0.5	11.1
Total (administration, management and support)	**3.5**	**0.7**		**4.2**	**0.8**
Total (positions vacant)	**89.3**	**2.4**	**21.8**	**113.4**	**3.5**