



2010 Stocktake

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



MIDLAND REGION
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INTRODUCTION

BACKGROUND

There are a number of recent strategic developments that identify key priorities for the child and adolescent mental health/AoD sector.

Te Tahuu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan (Minister of Health, 2005) identified the mental health and wellbeing of children and youth as a key government priority.

Te Kokiri: The Mental Health and Addiction Plan 2006–2015 (Minister of Health, 2006) subsequently set the future direction for child and youth mental health and Alcohol and Other Drugs (AoD) services.

Te Raukura – Mental Health and Alcohol and Other Drugs: Improving Outcomes for Children and Youth (Ministry of Health, 2007) emphasised the need to continue to build and broaden the range and choice of services and support for children severely affected by mental health issues.

The Mental Health and Addictions Action Plan (Ministry of Health, 2010) accentuated the need for “mental health and addictions services that help to divert children and young people away from the negative pathways and increase their life chances.”

While previous government priorities for the mental health and addictions sector still inform service delivery, a change of government in 2008 has led to new priorities that aim to deliver services of higher quality and better value for money. As of 2010, an extra \$512 million has been allocated to health and an additional \$174 million for mental health is planned over the next four years (Minister of Health, 2010).

The new priorities outlined in *Mental Health and Addiction Action Plan, 2010* (Ministry of Health, 2010) pertain to infants, children, adolescents and their families and include:

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

Workforce Development

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

The four mental health and addictions workforce development centres have embraced the following five strategic imperatives (Ministry of Health, 2002):

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

Effective workforce development requires accurate information (research & evaluation) concerning demand, service configuration and access data. Due to the comparatively small size and low profile of the sector there has been very little information detailing the infant, child and adolescent mental health/addictions workforce.

To fill this gap, in 2004, the Werry Centre for Child and Adolescent Mental Health, Workforce Development Programme conducted the first *National Stocktake* of the infant, child and adolescent mental health/AoD workforce at the request of the Ministry of Health.

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

To progress workforce development in this sector, the Werry Centre produced *Whakamārama te Huarahi – To Light the Pathways: A Strategic Framework for Child and Adolescent Mental Health Workforce Development 2006-2016* (Wille, 2006). This document outlines a long term national approach to systemic enhancements to support the capacity and capability of the workforce. Recommendations were made to support regional, inter-district and local planning processes informed by ongoing research and evaluation (data collection).

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

As recommended in *Whakamārama te Huarahi* (Wille, 2006), the Werry Centre has undertaken biennial workforce and access to service data collection. This dataset covers the 2004 to 2010 period.

This current report presents the 2010 *Stocktake* of the infant, child and adolescent mental health/AoD workforce. Like the previous reports, it aims to provide a snapshot of the infant, child and adolescent mental health service environment. It describes the population the workforce serves, the number of clients who are accessing services and how the current workforce compares to government Blueprint targets. It also provides a comparison in terms of government priorities, the MHC's resource guidelines for the workforce and access to service target rates for New Zealand's infant, child and adolescent population.

METHOD

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

The 2010 *Stocktake* includes:

- Infant, child and adolescent population data: Statistics NZ Census data and projections by ethnicity and DHB
- DHB service workforce data: DHB (Inpatient & Community) Infant, Child and Adolescent Mental Health (CAMHS)/Alcohol and Other Drug (AoD) Services workforce data (actual & vacant Full Time Equivalents (FTEs) & ethnicity by occupational group) as at 30th June 2010
- NGO workforce data: DHB funded Non-Government Organisations (NGOs) workforce data (actual & vacant FTEs by occupational group & ethnicity) as at 30th June 2010
- Access to service data extracted from the Programme for the Integration of Mental Health Data (PRIMHD) which includes access to service data from the 2006 to 2009 period
- Comparisons of workforce data against the Mental Health Commission's strategic benchmarks set in the *Blueprint for Mental Health Services in New Zealand (MHC,1998)*
- Comparisons of access to service data against MHC's access target rates for the child and adolescent population.

The workforce data collection occurred in two phases.

Phase one began in August 2010 and included the survey of all DHB (Inpatient & Community) CAMH/AoD services (see Appendix E).

Phase Two included a survey of DHB funded NGOs and began in October 2010 and ended in December 2010.

The 2010 National workforce dataset is reported by region. The 2010 aggregated workforce data is included in the Appendices (for a more detailed description of workforce data, please refer to the *Stocktake* reports available on the Werry Centre website (www.werrycentre.org.nz)).

2010 DHB ICAMH/AOD Workforce Survey

The workforce surveys were sent to all DHB Chief Executive Officers (CEOs) and Mental Health Managers in early August 2010 and had a 100% response rate.

2010 DHB Funded ICAMH/AOD Non-Government Organisation Workforce Survey

The list of DHB funded NGOs providing infant, child and adolescent mental health and AoD services as at June 2010 was extracted from the 2009/2010 Price Volume Schedules (PVS) supplied by the Ministry of Health.

A total of 83 DHB funded NGO providers were identified for this *Stocktake*. These services were surveyed by post in October 2010. A telephone survey follow-up from October to December 2010 was also conducted. Of the 83 NGOs, 82 provided data for this *Stocktake* resulting in a 99% response rate.

Workforce Categories

The data gathered on the infant, child and adolescent mental health workforce has been split into two categories: Clinical and Non-Clinical.

The Clinical workforce in this report includes Alcohol and Drug Workers, Counsellors, Mental Health Nurses, Occupational Therapists, Psychiatrists, Psychotherapists, Clinical or Registered Psychologists, and Social Workers.

The Non-Clinical Workforce includes the workforce that provides direct support or care for clients and in this report includes Cultural workers (Kaumātua, Kuia or other cultural appointments), Specific Liaison Appointments, Mental Health Support Workers and Mental Health Consumers and Family Workers.

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

2009/2010 DHB & NGO Infant, Child & Adolescent Mental Health/AOD Health Funding Data

The 2009/2010 funding data was extracted from the 2009/2010 Price Volume Schedule supplied by the Ministry of Health. Funding information for previous *Stocktake* periods are also presented for comparison. Funding data is presented by Region and DHB.

Mental Health Information National Collection/Programme for the Integration of Mental Health Data (PRIMHD)-Client Access to Mental Health Services Data

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

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

While all 20 DHBs are now reporting to PRIMHD, of the approximately 375 NGOs that are providing mental health and addictions services, only 83 NGOs are reporting to PRIMHD. It is expected that the implementation of PRIMHD for the remainder of the NGO sector will be over the next three years.

Due to the incomplete data from the NGO sector, all *Stocktake* reports thus far include only DHB client data.

Access to service data for the 2004 to 2008 period was extracted from the Mental Health Information National Collection (MHINC) database. The July to December 2008 to 2009 period was extracted from PRIMHD. Client access data is based on the second half of each year. The comparisons/findings described in this report are from the 2007 (the last data point reported in the previous *Stocktake*) to 2009 period. The complete analysis of the 2004 to 2009 data can be downloaded separately from the Werry Centre website (www.werrycentre.org.nz).

Infant, Child & Adolescent Population Statistics

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

- The 2008 and 2010 population projections are derived from the resident population 30 June 2006 Census (total response). The projections are based on assumptions about fertility, mortality, and migration and provide an indication of possible changes in the size of each population. This data was provided by the Ministry of Health.
- The 2006 Census (prioritised ethnicity population statistics, Māori, Pacific, Asian and Other for the 0-19 year age group) was used in the analysis of the 2006 infant, child and adolescent mental health workforce data. This data was provided by Statistics NZ. The projections were also based on prioritised ethnicity which is defined as;

“Where a service user reports more than one ethnicity, they are reported as Māori first, Pacific second and other ethnicity third. This means that all Māori are reported and Pacific Peoples are reported if they do not also record Māori. All those who record neither Māori, Pacific, nor Asian are reported as Other” (Ministry of Health, 2004a, p.16).

- The 2005 population projections for the 0-19 year age group (based on the 2001 Census) were used to calculate the population based access rates for the MHINC section of the 2005 data. This population data was provided by the Ministry of Health.

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

LIMITATIONS

Workforce Data

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

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

Missing data from one large NGO in the Midland region also impacts on the accuracy of this *Stocktake*. Total FTE volume data from the Ministry of Health’s PVS was used to estimate this NGO’s workforce instead. However, this data does not include FTE information by ethnicity and occupational group and therefore limits the analysis of the Midland region workforce.

All services that were surveyed were asked to provide the number of Māori, Pacific and Asian staff (FTE & Head Count) by Occupational Group. Ethnicity information of staff was provided by managers and not by the individuals themselves. Additionally, FTE data by occupational group and ethnicity was also requested but this

was not provided in a consistent manner. Therefore, ethnicity data presented in this *Stocktake* should be interpreted with caution.

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

As identified from the first *Stocktake*, obtaining workforce data from the NGO sector via post was not a successful method; however the majority of providers supplied data willingly when contacted by telephone. Despite an increased response rate via telephone, there continues to be difficulties in obtaining completely accurate information about the NGO sector for the following reasons:

- Contract information from the PVS which was used as a benchmark for this data collection was found to be inaccurate or out of date in some instances
- There is no central agency that holds information on all mental health contracts currently being delivered
- A number of infant, child and adolescent contracts are initiated locally and are funded through regional or local funding surpluses. Information around these contracts is not held centrally. Although information around some of these contracts became available during the *Stocktake*, all data may not have been fully captured
- As well as Ministry of Health funding, many NGO's are funded from a number of different sources (such as Ministry of Social Development (MSD), Accident Compensation Corporation (ACC), and Youth Justice). Because of their unique blending of services, it is difficult to clearly identify which portion of funding sits with each FTE
- A number of NGO's with infant, child and adolescent mental health contracts provide a seamless service spanning ages through to adulthood. In many services, the focus may be on mental health issues within the whole family. Identifying which portion of the FTE fits within the DHB funded infant, child and adolescent contract is often difficult for providers to ascertain
- NGO contracts may be devolved to a number of different providers. NGOs also receive a variable number of contracts over time
- Rural and isolated areas have issues with recruiting and retaining staff who have an interest or skills in the infant, child and adolescent area. If the organisation has unfilled FTE positions, they may be required to return funds to the DHB. This can lead to caution around reporting on unfilled vacancies
- Some organisations had a concern that the *Stocktake* was a form of audit and were reluctant to participate fully

MHINC/PRIMHD Access Data

Previous MHINC and the current PRIMHD database contains the raw data sent in by providers and is therefore subject to the quality of information captured by the client management system of each DHB and NGO.

Of the 83 NGOs that currently report to PRIMHD, only 21 that were surveyed for this *Stocktake* were included in the dataset. Due to the lack of data from 75% of the NGOs that were identified for this *Stocktake*, the NGO access to service data is excluded for the analysis. As a result, access data presented in this report is limited to DHB clients. This has a negative impact on access rates against the MHC's strategic access benchmarks.

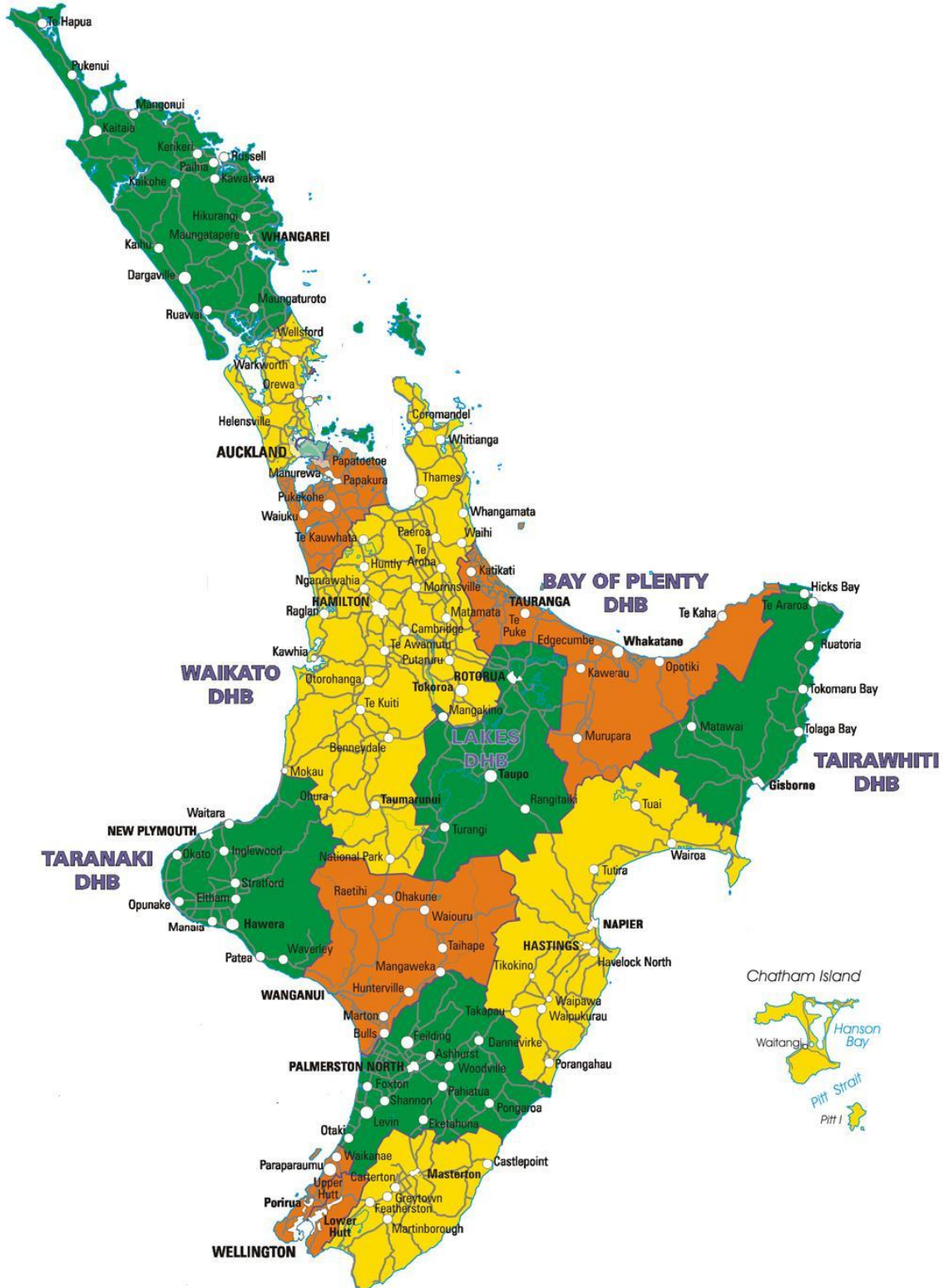
Population Data

The 2010 population statistics used in this report are based on medium projections (2006 base, total response) and the use of projected population statistics tends to be less accurate. Any comparisons with Census data which was based on prioritised ethnicity will carry that inaccuracy.

USING THE *STOCKTAKE*

The data is made available for each DHB to assess their position. More detailed data and the previous *Stocktakes* are available on the Werry Centre website (www.werrycentre.org.nz).

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

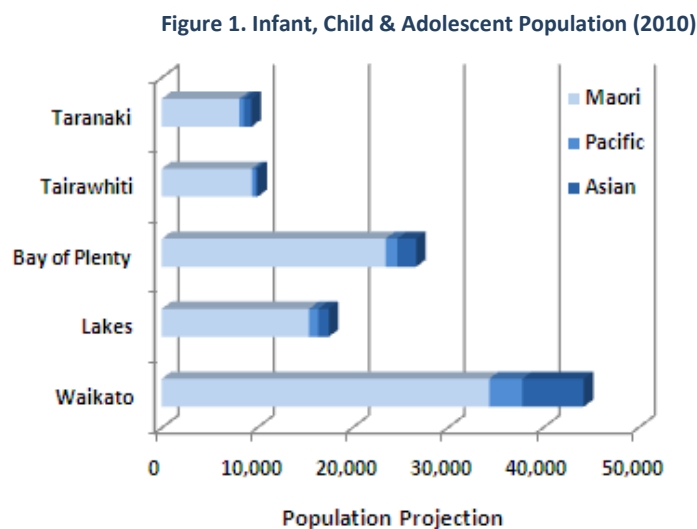


INFANT, CHILD & ADOLESCENT POPULATION PROFILE

Based on the 2010 population projections, the Midland region had New Zealand's third largest (20%) infant, child and adolescent (0-19 yrs) population (see Appendix A, Table 1 & Figure 1).

The 2008 to 2010 population projections indicated a slight decrease (1%) in the regional 0-19 years population (see Appendix A, Table 1).

The majority of the population resided in Waikato (44%) and Bay of Plenty (25%) DHB areas (see Appendix A, Table 1).



Māori Infant, Child & Adolescent Population

In 2010, the Midland region had the second largest Māori 0-19 year population (31%) in the country.

The 2008 to 2010 population projections indicated a 1% increase in the regional Māori population. Projections by DHB show that Bay of Plenty had the largest increase by 2% (see Appendix A, Table 1).

The Māori infants, children and adolescents made up 38% of the region's total 0-19 years population with large proportions of Māori infants, children and adolescents residing in Tairāwhiti (63%) and Lakes (49%) (see Appendix A, Table 1).

Pacific Infant, Child & Adolescent Population

In 2010, the Midland region had the smallest Pacific infant, child and adolescent population (6%) in the country.

The 2008 to 2010 population projections indicated a slight increase in the region's Pacific infant, child and adolescent population by 0.3% (see Appendix A, Table 1).

The Pacific infants, children and adolescents make up 3% of the region's total 0-19 years population.

Over half (53%) of the region's Pacific infants, children and adolescents resided in the Waikato DHB area (see Appendix A, Table 1).

Asian Infant, Child & Adolescent Population

In 2010, the Midland region continued to have the smallest Asian population (8%) in the country.

The 2008 to 2010 population projection indicated a 6% increase in the regional Asian population; the largest growth out of the three three main ethnic groups (see Appendix A, Table 1).

The Asian infant, child and adolescent population made up 4% of the regional infant, child and adolescent population.

The majority of the Asian population (61%) resided in the Waikato DHB area.

PROVISION OF INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD SERVICES

Five DHBs provide a range of specialist Community based infant, child and adolescent mental health and AoD services in the Midland region: Waikato, Bay of Plenty, Lakes, Tairāwhiti and Taranaki DHBs.

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

Infant, child and adolescent mental health/AoD services are also provided by DHB funded NGOs and in some cases, Primary Health Organisations.

In 2006, Waikato DHB conducted a review and appraisal of the infant, child and adolescent mental health and addictions services which highlighted that despite the increased number of NGOs delivering services to infants, children and adolescents in the region, there remains low access to services, inadequacies in service integration, gaps and duplications and a lack of trust and credibility in the services (Waikato DHB, 06-07). As a result of these findings, the Waikato DHB area has undergone considerable changes in the NGO sector.

As a result of the review, for the June 2009 to July 2010 period, 30 NGOs were identified as providing DHB funded infant, child and adolescent mental health and AoD services in the Midland region. Of the 30 NGOs, 7 were contracted AoD providers.

From 2008 to 2010, progress can be seen in funding and in the number and types of services available for infants, children and adolescents in the region. Some services are now more inclusive of infants with either dedicated services or teams for the infant (0-4 age group) population.

The progress in the development and provision of services for infants, children and adolescents has been in line with the priorities outlined in *Te Raukura* (Ministry of Health, 2007):

- *Youth Forensic Services*: Waikato DHB.
- *Child and Adolescent AoD Services/Funding*:
 - All five DHBs.
 - Seven NGOs.
- *Eating Disorder Funding*: Bay of Plenty and Tairāwhiti DHBs.
- *Services for Māori*: Kaupapa Māori services:
 - Bay of Plenty DHB.
 - Fourteen Kaupapa Māori NGOs
- *Services for Pacific*: No dedicated Pacific DHB or NGO services, however Pacific infants, children and adolescents have access to Māori or mainstream DHB and NGO mental health/AoD services in the region.

Table 1. Waikato Infant, Child & Adolescent Mental Health/AoD Services (2009/2010)

WAIKATO DHB
Child & Adolescent Mental Health/AoD Services
REGIONAL SERVICES
Youth Forensic Service
WAIKATO NGOS
CARENZ LTD
Children & Youth Alcohol & Drug Community Services
HAUORA WAIKATO MĀORI MENTAL HEALTH SERVICES
Kaupapa Māori Mental Health Services-Tamariki & Rangatahi
Children & Young People Community Services
Children & Youth Alcohol & Drug Community Services
Child & Youth Acute Care Packages
NGA RINGA AWHINA O HAUORA TRUST
Children & Youth Alcohol & Drug Community Services
Child & Youth Intensive Clinical Support Service
Children & Young People Community Services
Kaupapa Māori Mental Health Services - Tamariki & Rangatahi
Advocacy/Peer Support - Families/Whānau
RAUKAWA TRUST BOARD
Kaupapa Māori Mental Health Services-Tamariki & Rangatahi
Advocacy/Peer Support - Families/Whānau
RICHMOND FELLOWSHIP
Child & Youth Community Residential Care
ROSTREVOR HOUSE
Children & Young People Community Services
Advocacy/Peer Support - Families/Whānau
TAUMARUNUI COMMUNITY KOKIRI TRUST
ICAY community mental health services Kaupapa Māori
Kaupapa Māori Mental Health Services - Tamariki & Rangatahi
Advocacy/Peer Support - Families/Whānau
TE KOROWAI HAUORA O HAURAKI INC.
Kaupapa Māori Mental Health Services-Tamariki & Rangatahi
Children & Young People Community Services
Advocacy/Peer Support - Families/Whānau

WAIKATO NGOs Continued**TE RUNANGA O KIRIKIROA**

Whai Marama Youth Connex

Children & Young People Community Services

Advocacy/Peer Support - Families/Whānau

Child, Adolescent & Youth Community - Accommodation

Rongo Atea: Youth Community Alcohol & Drug Services -Accommodation

Children & Youth Alcohol & Drug Community Services

THE YOUTH HORIZONS TRUST

Child & Youth Intensive Clinical Support Service

Child & Youth Wrap Around Services

Child & Youth Planned Respite

Note: Italicised Services are Kaupapa Māori Services (PU Code MHCS39)**Table 2. Lakes Infant, Child & Adolescent Mental Health/AoD Services (2009/2010)****LAKES DHB**

Child & Adolescent Mental Health Services (Taupo/Turangi)

Child Mental Health Services (Rotorua)

Youth Specialty Team (Rotorua)

LAKES NGOs**Te Utuhina Manaakitanga Trust**

Children & Youth Alcohol & Drug Community Services

Note: Italicised Services are Kaupapa Māori Services (PU Code MHCS39)**Table 3. Bay of Plenty Infant, Child & Adolescent Mental Health/AoD Services (2009/2010)****BAY OF PLENTY DHB**

Child & Adolescent Mental Health Services (Tauranga)

Voyagers Child & Adolescent Mental Health Services (Whakatane)

Early Intervention 1st Time Psychosis: Delivered through the Intensive Case Management roles (Tauranga & Whakatane)**Also receives funding for Eating Disorders***BAY OF PLENTY NGOs****HEALTHCARE OF NEW ZEALAND LTD**

Child & Youth Wrap Around Services

MAKETU HEALTH & SOCIAL SERVICES

Kaupapa Māori Mental Health Services-Tamariki & Rangatahi

Children & Youth Alcohol & Drug Community Services

BAY OF PLENTY NGOs Continued
<i>POUTIRI CHARITABLE TRUST: TE IKA WHENUA HAUORA INC</i>
Kaupapa Māori Mental Health Services-Tamariki & Rangatahi
Advocacy/Peer Support-Families/Whānau
<i>POUTIRI CHARITABLE TRUST: NGA KAKANO FOUNDATION</i>
Kaupapa Māori Mental Health Services-Tamariki & Rangatahi
Advocacy/Peer Support-Families/Whānau
<i>TE MANU TOROA TRUST</i>
Children & Young People Community Services
Advocacy/Peer Support/Consumers/Families/Whānau
Peer Support Service - Kaupapa Māori - Children Adolescents and Youth
<i>TE PUNA HAUORA MAORI SERVICES</i>
Kaupapa Māori Mental Health Services-Tamariki & Rangatahi
<i>TE RUNANGA NGAI TAMAWHARIUA INC</i>
Children & Young People Community Services
Advocacy/Peer Support/Consumers
Peer Support Service - Kaupapa Māori - Children Adolescents & Youth
<i>NGA MATAPUNA ORANGA PHO: TE RUNANGA NGATI PIKIAO TRUST</i>
Kaupapa Māori Mental Health Services - Tamariki & Rangatahi
<i>TE TOMIKA TRUST</i>
Children & Young People Community Services
<i>THE YOUTH HORIZONS TRUST</i>
Child & Youth Planned Respite
Child & Youth Crisis Respite
Child & Youth Intensive Clinical Support Service
Child & Youth Wrap Around Services
<i>TOUGHLOVE TAURANGA/COASTAL BOP INC</i>
Advocacy /Peer Support-Families/Whānau
<i>TUHOE MATAURANGA TRUST</i>
Whānau Ora Contract: Eke Panuku Programme (Mental Health Programme for Youth at Risk)
<i>TUHOE HAUORA TRUST RAKEIWHENUA TRUST</i>
Kaupapa Māori Mental Health Services-Tamariki & Rangatahi
<i>TUWHARETOA KI KAWERAU HEALTH EDUCATION & SOCIAL SERVICES</i>
Children & Young People Community Services
ICAY Community Mental Health Services Kaupapa Māori
<i>WESTERN BAY OF PLENTY PRIMARY HEALTH ORGANISATION LTD</i>
NeedAssessment & Service Co-ordination

BAY OF PLENTY NGOs Continued**WHAKATOHEA MĀORI TRUST BOARD**

Children & Young People Community Services

Advocacy/Peer Support/Consumers/Families/Whānau

ICAY community mental health services Kaupapa Māori

Peer Support Service - Kaupapa Māori - Children Adolescents & Youth

Table 4. Tairāwhiti Infant, Child & Adolescent Mental Health/AoD Services (2009/2010)**TAIRAWHITI DHB**

Child & Adolescent Mental Health Services

Also receives funding for Eating Disorders & AoD*TAIRAWHITI NGOs****NGATI POROU HAUORA INC**

Children & Young People Community Services

TE KUPENGA NET TRUST

Advocacy/Peer Support/Consumers

Table 5. Taranaki Infant, Child & Adolescent Mental Health/AoD Services (2009/2010)**TARANAKI DHB**

Child & Adolescent Mental Health Services

TARANAKI NGOs***TUI ORA LTD.: MAHIA MAI***

Kaupapa Māori Mental Health Services-Tamariki & Rangatahi

Children & Young People Community Services

TUI ORA LTD.: RAUMANO

Kaupapa Māori Services-Mental Health Assessment & Treatment

Children & Young People Community Services

Note: Italicised Services are Kaupapa Māori Services (PU Code MHCS39)

FUNDING FOR INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD SERVICES

For the June 2009 to July 2010 financial year, the Midland region provider services received \$26,060,397 for infant, child and adolescent mental health/AoD services (see Appendix B, Table 1).

From 2007 to 2010, there was a 14% increase in total funding for infant, child and adolescent mental health/AoD services (see Appendix B, Table 1).

This increase was seen in DHB funding only (29%) while there was a 5% decrease in NGO funding (see Figures 2 & 3).

Figure 2. Infant, Child & Adolescent Mental Health/AOD Funding (2004-2010)

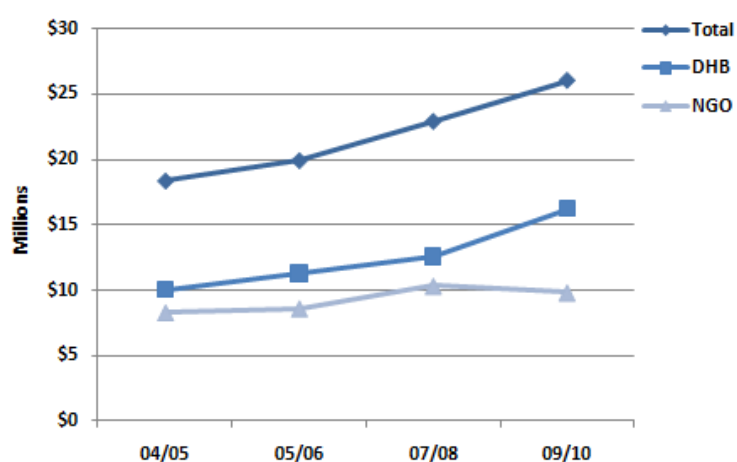
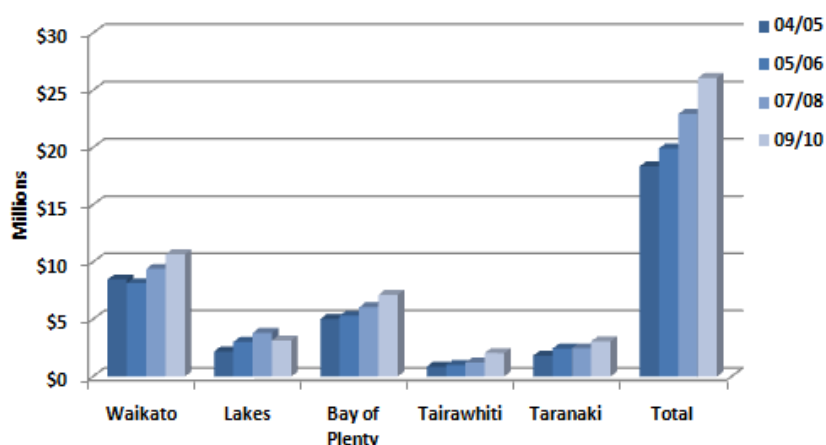


Figure 3. Infant, Child & Adolescent Mental Health/AOD Funding by DHB (2004-2010)



From 2007 to 2010, the largest increase in funding was in Alcohol and Other Drugs services, while Kaupapa Māori funding had decreased by 20% (see Table 6).

Table 6. Funding by Services (2007-2010)

Services	Year		
	2007/2008	2009/2010	% Change
Inpatient	\$138,679	\$164,429	19
Alcohol & Other Drugs	\$1,412,810	\$2,510,423	78
Kaupapa Māori	\$3,812,197	\$3,053,355	-20
All Other Services	\$17,558,156	\$20,332,190	16
Total	\$22,921,842	\$26,060,397	14

Source: Ministry of Health Price Volume Schedule 2007/2008 & 2009/2010

Funding per Head of Infant, Child & Adolescent Population

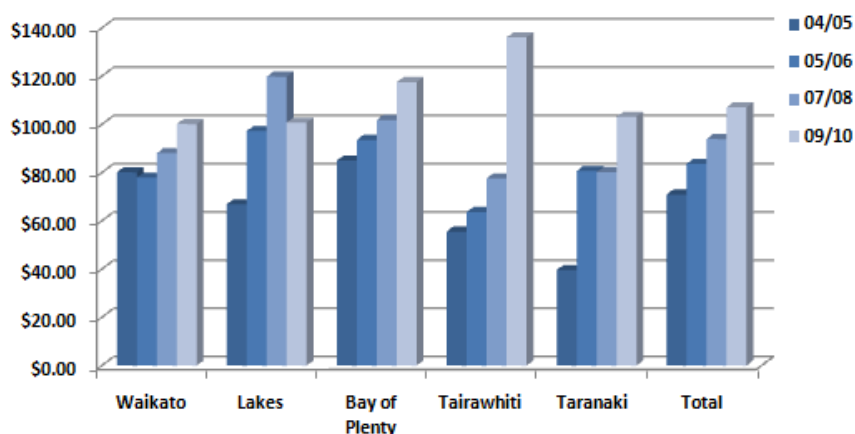
Funding per head of population is a method by which we can look at the equity of funding across the regions and DHBs. Clearly this is not the actual amount spent per 0-19 years as only a small proportion of this population access services. The effect of inter DHB referrals is negligible for the Midland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

From 2007 to 2010, there was a 15% increase in the regional spend per head of the 0-19 population (Inpatient costs included) (see Appendix B, Table 2 & Figure 4).

For the 2009/2010 financial year, the Midland region spend per head of the 0-19 year population was \$107.77 (see Appendix B, Table 2).

The largest increase in spending per 0-19 years was seen in the Tairāwhiti DHB area. However, spend per 0-19 years had decreased in the Lakes DHB area (see Figure 4).

Figure 4. Funding per Head of Infant, Child & Adolescent Population (2004-2010)



INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD WORKFORCE

Please note that due to missing data from one NGO provider in the Waikato area, the workforce data presented for this region may not reflect the actual Midland region workforce for 2010. Where possible, the total FTE volume figure extracted from the Price Volume Schedule has been used to estimate this NGOs workforce. However, this FTE figure is not broken down by occupational group and ethnicity therefore limits the presentation of the Midland region workforce.

In 2010, the Midland region DHB CAMH/AoD services and NGOs reported a total of 249.82 actual FTEs with a further 21.3 FTEs reported vacant. The majority of vacancies were reported by DHB services.

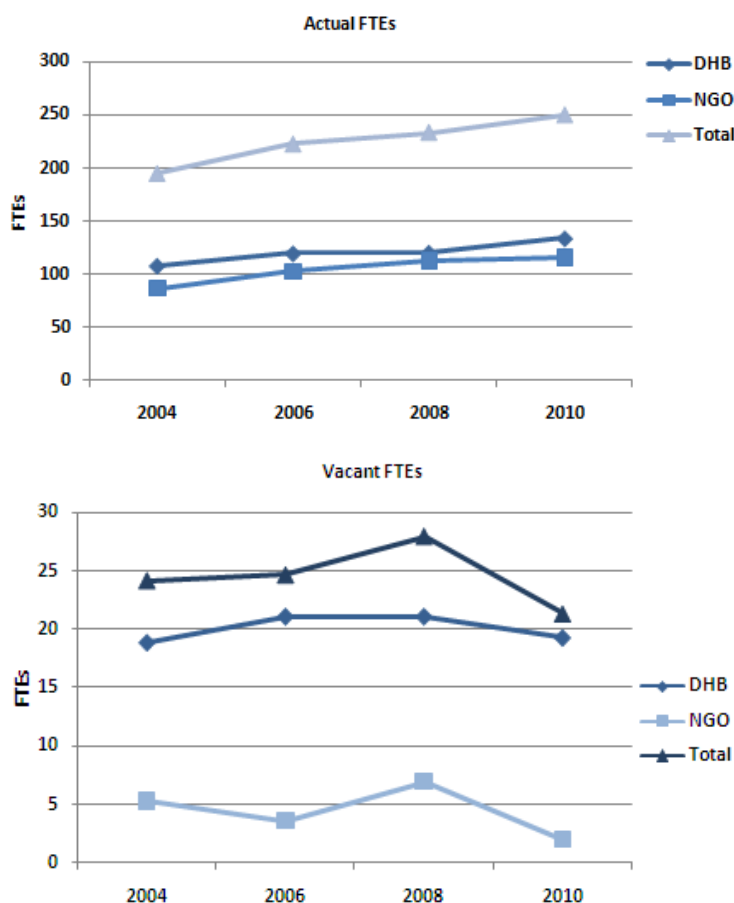
From 2008 to 2010, total workforce had increased by 7% and vacancies had decreased by 24% with a vacancy rate of 8% reported in 2010 (see Table 7 & Figure 5).

Table 7. Total Infant, Child & Adolescent Mental Health/AoD Workforce (2004-2010)

Year	DHB			NGOs			Total		
	Actual FTEs	Vacant FTEs	% Vacancy	Actual FTEs	Vacant FTEs	% Vacancy	Actual FTEs	Vacant FTEs	% Vacancy
2004	108.31	18.90	15	86.80	5.25	6	195.11	24.15	11
2006	119.85	21.05	15	102.86	3.6	3	222.71	24.65	10
2008	120.50	21.05	15	112.93	6.9	6	233.43	27.95	11
2010	133.80	19.30	13	116.04 ¹	2.0	2	249.82	21.30	8

1. Includes 29.24 Contracted FTEs for Hauora Waikato for the 2009/2010 period

Figure 5. Total Infant, Child & Adolescent Mental Health/AOD Workforce Actual & Vacant FTEs (2004-2010)



The increase in the total workforce was seen in the Clinical workforce in both DHB services and NGOs (from 158.88 to 170.03 FTEs).

The majority of the Midland region workforce (68%) were in Clinical roles and mainly (64%) employed in DHB CAMH/AoD services (see Table 8 & Figure 6).

The remainder of the workforce (20%) were in Non-Clinical roles largely as Administrators and Managers and Mental Health Support Workers (see Table 8 & Figure 6).

Figure 6. Infant, Child & Adolescent Mental Health/AOD Workforce by Occupational Group (2010)

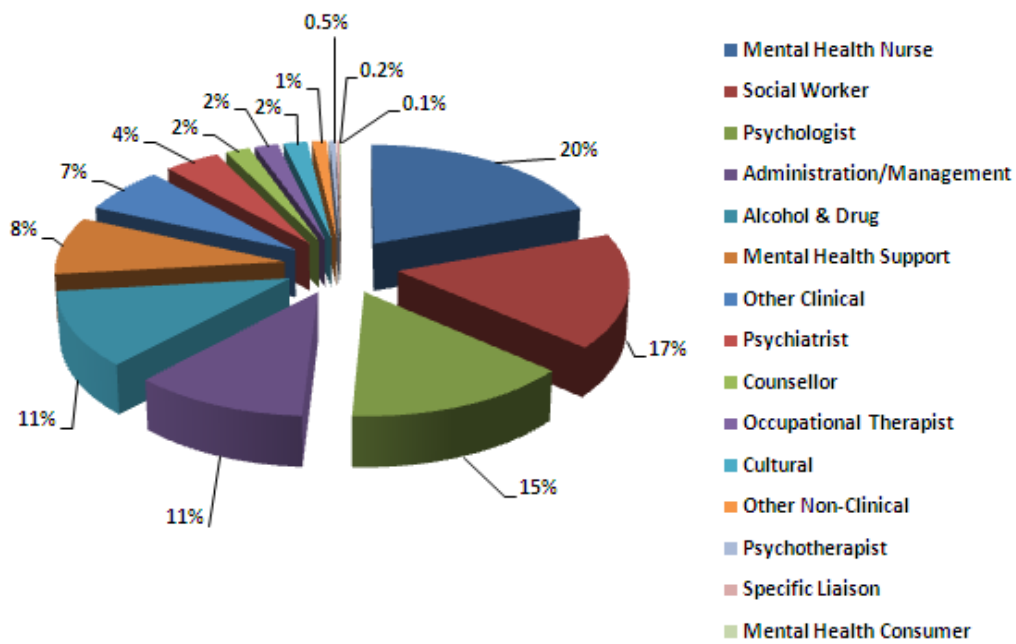


Table 8. Infant, Child & Adolescent Mental Health/AoD Workforce by Occupational Group (2010)

Occupational Group	DHB	NGOs	Total
Alcohol & Drug Worker	7.0	17.0	24.5
Counsellor	1.6	2.5	4.1
Mental Health Nurse	31.8	11.3	43.1
Occupational Therapist	4.0	-	4.0
Psychiatrist	9.2	0.3	9.5
Psychotherapist	1.0	-	1.0
Psychologist	32.03	-	32.03
Social Worker	18.3	18.8	37.1
Other Clinical Appointment ²	3.7	11.0	14.7
Clinical Sub-Total	109.13	60.9	170.03
Cultural Appointment	4.0	-	4.0
Specific Liaison	0.5	-	0.5
Mental Health Consumer	0.2	-	0.2
Mental Health Support Worker	1.0	17.6	18.6
Other Non-Clinical Support for Clients ³	-	2.5	2.5
Non-Clinical Support for Clients Sub-Total	5.7	20.1	25.8
Administration/Management	18.95	5.8	24.75
Regional Total	133.8	116.04¹	249.82¹

1. Total FTE includes 25.7 FTEs for Hauora Waikato

2. Other Clinical Group includes = Family Therapists; Clinical ICAY Assessor; Educational Psychologists; Clinical Supervisor; CAFS Support Workers; Interns: Counselling, Social Work.

3. Other Non-Clinical = Advocacy Peer Support Family/Whānau/Consumer Roles; Educators Primary Liaison Role

Table 9. Infant, Child & Adolescent Mental Health/AOD Workforce Vacancies by Occupational Group (2010)

Occupational Group	DHB	NGOs	Total
Alcohol & Drug Worker	5.0	-	5.0
Counsellor	-	-	-
Mental Health Nurse	2.0	2.0	4.0
Occupational Therapist	-	-	-
Psychiatrist	2.6	-	2.6
Psychotherapist	1.0	-	1.0
Psychologist	4.3	-	4.3
Social Worker	2.0	-	2.0
Other Clinical Appointment ¹	1.0	-	1.0
Clinical Sub-Total	17.9	2.0	19.9
Cultural Appointment	-	-	-
Specific Liaison	-	-	-
Mental Health Consumer Advisor	0.4	-	0.4
Mental Health Support Worker	1.0	-	1.0
Non-Clinical Support for Clients Sub-Total	1.4	-	1.4
Administration/Management	-	-	-
Regional Total	19.3	2.0	21.3

1. Other Clinical Group = Registrar

DHB Community Infant, Child & Adolescent Mental Health/AoD Workforce

In 2010, the Midland region DHB Community CAMH/AoD services reported a total of **133.8** actual FTEs with a further **19.3** FTEs reported vacant.

Bay of Plenty and Waikato DHBs reported the largest workforce in the region (see Table 10).

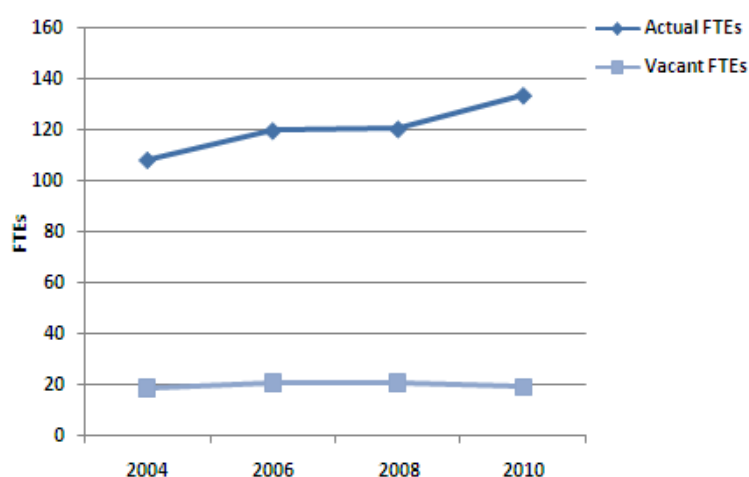
From 2008 to 2010, there was an 11% increase in the total Community workforce. Bay of Plenty DHB reported the largest increase from 32.35 to 40.4 FTEs (25% increase).

From 2008 to 2010, the vacancy rate had decreased slightly to 13% (see Table 10).

Table 10. DHB Community Infant, Child & Adolescent Mental Health/AOD Workforce (2004-2010)

DHB	Actual FTEs				Vacant FTEs				Vacancy Rate %			
	2004	2006	2008	2010	2004	2006	2008	2010	2004	2006	2008	2010
Waikato	31.61	40.9	35.8	38.0	1.0	8.0	4.4	7.3	3	16	11	16
Lakes	16.15	19.4	18.1	21.1	12.2	7.2	6.0	3.0	43	27	25	12
Bay of Plenty	36.1	32.35	32.35	40.4	1.4	5.2	10.25	4.4	4	14	24	10
Tairāwhiti	8.55	10.7	15.05	16.9	1.3	0.65	-	2.6	13	6	-	13
Taranaki	15.9	16.5	19.2	17.4	3.0	-	0.4	2.0	16	-	2	10
Total	108.31	119.85	120.5	133.8	18.9	21.05	21.05	19.3	15	15	15	13

Figure 7. DHB Community Infant, Child & Adolescent Mental Health/AOD Actual & Vacant FTEs (2004-2010)



The increase in the DHB Community workforce was largely seen in the Clinical workforce by 6% (from 103 to 109.13 FTEs).

Bay of Plenty DHB Community CAMHS reported the largest increase in the Clinical workforce (from 28.35 to 34.23 FTEs).

In 2010, 82% of the DHB Community Clinical CAMH/AoD staff were in Clinical roles.

From 2008 to 2010, the largest growth in the Clinical workforce occurred in the following roles:

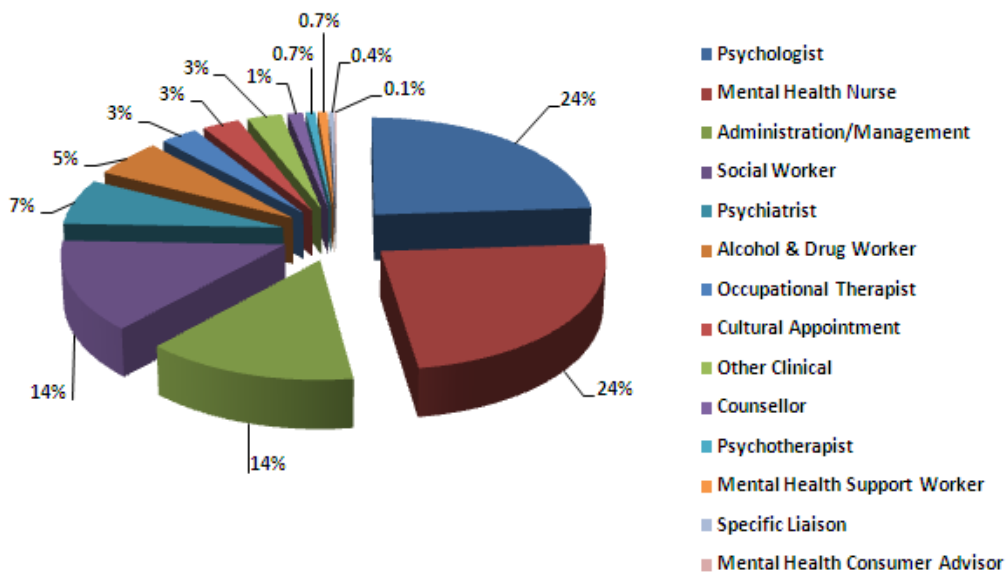
- Occupational Therapists (from 2.5 to 4.0 FTEs)

- Alcohol and Drug Workers (from 5.0 to 7.5 FTEs)
- Mental Health Nurses (from 25.5 to 31.8 FTEs)

In 2010, Clinical vacancies were largely for Alcohol and Drug Workers and Psychologists (see Table 9).

The DHB Non-Clinical Community CAMH/AoD workforce (24.65 actual FTEs including Administration/Management) made up the remainder of the Midland region community workforce mainly in Administration/Management and Cultural roles (see Table 8).

Figure 8. DHB Community Infant, Child & Adolescent Mental Health/AOD Workforce (2010)



NGO Infant, Child & Adolescent Mental Health/AoD Workforce

Please note that although every attempt is made to ensure data accuracy, the quality of data is dependent on the source. Variations in data over time could also be due to the reporting of data by different staff members from the same agencies at each data collection point and contractual changes may also account for some of the variances seen.

As at 30th June 2010, a total of 30 NGOs were identified as providing infant, child and adolescent mental health and AoD services in the Midland region. Due to missing data from a large provider in the Waikato area, the data provided in this section may not be an accurate representation of the NGO sector in the Midland region and therefore should be interpreted with caution.

Furthermore in 2006/2007, Waikato DHB conducted a review and appraisal of the infant, child and adolescent mental health and addictions services which highlighted that despite the increased number of NGOs delivering services to infants, children and adolescents in the region, there remains low access to services, inadequacies in service integration, gaps and duplications and a lack of trust and credibility in the services (Waikato DHB, 06-07). As a result of these findings, the Waikato DHB area has undergone considerable changes in the NGO sector which is reflected in the data presented.

In 2010, the NGOs in the Midland region reported a total of 116.04 actual FTEs and a further 2.0 vacant FTEs.

From 2008 to 2010, there was a 3% increase in the NGO workforce (see Table 11).

Regional vacancies had decreased to a vacancy rate of 2% for the same period.

In 2010, NGOs in the Waikato and the Bay of Plenty areas reported the largest NGO workforce in the region (see Table 11).

Table 11. NGO Infant, Child & Adolescent Mental Health/AOD Workforce (2004-2010)

NGOs	Actual FTEs				Vacant FTEs				Vacancy Rate (%)			
	2004	2006	2008	2010	2004	2006	2008	2010	2004	2006	2008	2010
Waikato ¹	70.7	70.83	57.23	66.34 ¹	3.0	3.6	4.9	1.0	4	5	9	2
Lakes	7.7	16.7	15.5	7.0	1.0	-	-	-	13	-	-	-
Bay of Plenty	27.3	28.15	31.2	35.7	1.25	-	2.0	-	5	-	6	-
Tairāwhiti	1.0	3.0	3.0	3.0	-	-	-	-	-	-	-	-
Taranaki	3.0	5.0	6.0	4.0	-	-	-	1.0	-	-	-	20
Total	109.7	123.68	112.93	116.04¹	5.25	3.6	6.9	2.0	5	3	6	2

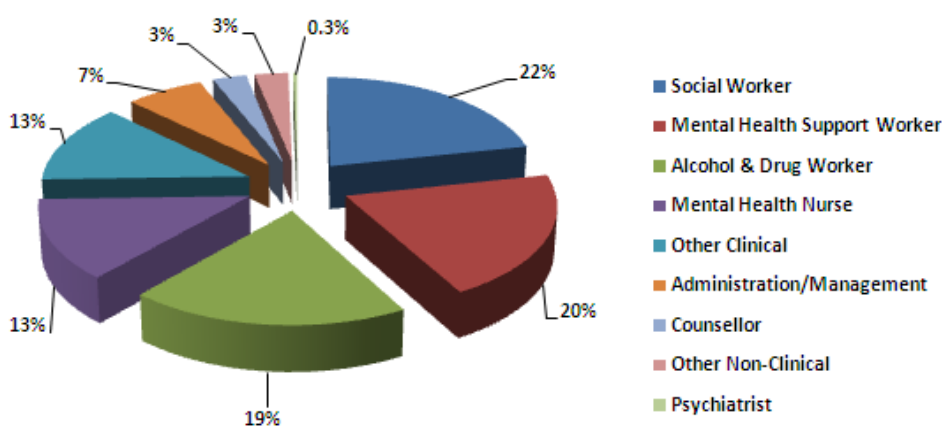
1. Includes Contracted (29.24 FTEs) not Actual FTE Volumes for Hauora Waikato

The increase in the NGO workforce from 2008 to 2010 was seen in the Clinical workforce.

In 2010, the Clinical workforce made up 52% of the total NGO workforce. The NGO Clinical workforce was mainly Social Workers, Alcohol and Drug Counsellors and Mental Health Nurses (see Table 8 & Figure 8).

The remainder of the workforce (22%) were in Non-Clinical roles as Mental Health Support Workers (see Table 8 & Figure 8).

Figure 9. NGO Infant, Child & Adolescent Mental Health/AOD Workforce (2010)



Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to the MHC’s Resource Guidelines

From 2004 to 2010, there was an increasing trend in the region’s Community Clinical workforce (see Table 12).

Due to the 7% growth in the Community Clinical workforce from 2008 to 2010, the regional Clinical workforce had made some progress towards the 2010 recommended Resource Guideline for the region (see Table 12).

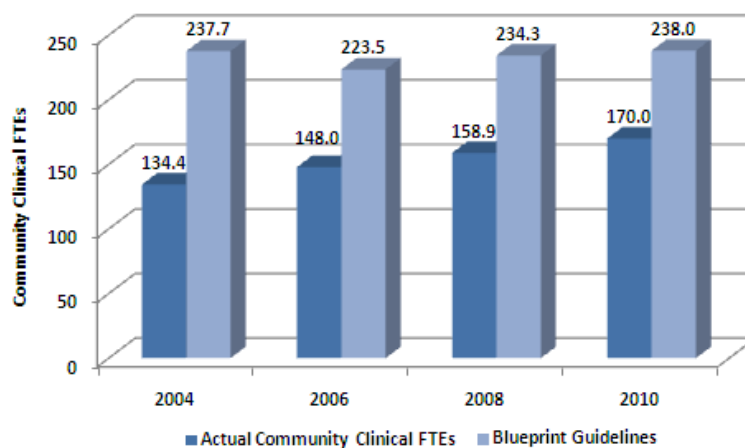
However, the Community Clinical workforce would still need to increase by 40% to meet MHC’s recommended resource guideline of 238.04 FTEs for the region’s infant, child and adolescent population (see Table 12 & Figure 10).

Table 12. Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to MHC’s Blueprint Guidelines (2004-2010)

Year	Actual Community Clinical FTEs ³	Blueprint Guidelines ⁴	FTEs Needed	% Increase
2004	134.4	237.65	103.25	77
2006 ¹	147.96	223.52	75.6	51
2008 ²	158.9	234.32	75.4	47
2010 ²	170.03	238.04	68.0	40

1. 2006 Census (Prioritised Ethnicity)
2. 2008/2010 Population Projections (Base 2006, Total Response, Medium Projections)
3. Includes DHB Community & NGO CAMH/AoD Services
4. Mental Health Commission Blueprint Resource Guidelines for Community Clinical: 28.6/100,000 Total Population (MHC, 1998).

Figure 10. Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to MHC’s Blueprint Guidelines (2004-2010)



CLIENT ACCESS TO CHILD & ADOLESCENT MENTAL HEALTH/AOD SERVICES

The 2004 to 2009 Client access data has been extracted from the MHINC/PRIMHD. Due to incomplete data from the NGO sector, NGO client data has been excluded. Therefore this section only contains MHINC/PRIMHD DHB client data that is relevant to each region and could account for the low access rates reported in this section. The complete MHINC/PRIMHD National DHB client data is available on the Werry Centre Website (www.werrycentre.org.nz).

In the second half of 2009, the Midland region had the third largest number of clients accessing mental health/AoD services in the country (see Appendix D, Table 1). Male clients made up the majority of clients accessing services in the region (60%).

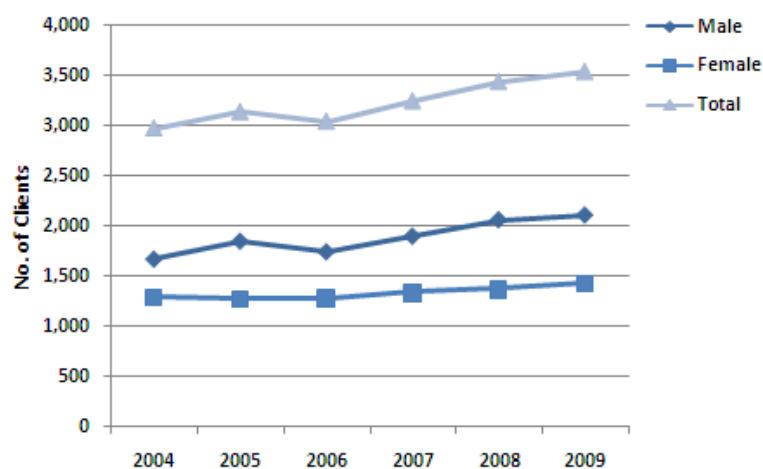
From 2007 to 2009, there was a 9% increase in the total number of clients accessing services in the Midland region (see Table 13 & Figure 11).

Table 13. Clients by Gender & Age Group (2004-2009)

Year	Gender								DHB Total
	Male				Female				
	0-9	10-14	15-19	Total	0-9	10-14	15-19	Total	
2004	395	672	611	1,678	176	421	698	1,295	2,973
2005	437	748	668	1,853	144	366	774	1,284	3,137
2006	411	675	664	1,750	161	365	766	1,292	3,042
2007	412	737	754	1,903	147	396	799	1,342	3,245
2008	459	732	873	2,064	152	401	821	1,374	3,438
2009	440	751	919	2,110	152	410	867	1,429	3,539

Note: Data is for the 2nd 6 months of each year

Figure 11. 0-19 yrs Clients by Gender (2004-2009)



In the second half of 2009, Waikato DHB reported the highest number of clients (30%) in the region followed by Bay of Plenty DHB (29.8%) (see Table 14 & Figure 12).

From 2007 to 2009, most DHBs reported an increase in client numbers. Waikato DHB reported the largest increase of 20% followed by Tairawhiti DHB (see Table 14).

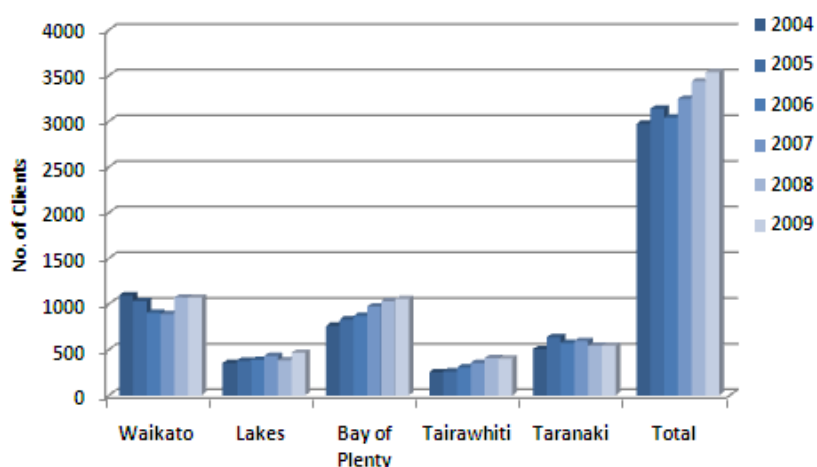
Taranaki DHB reported a decrease by 9% for the same period (see Table 14).

Table 14. 0-19 yrs Clients by DHB (2004-2009)

DHB	Year					
	2004	2005	2006	2007	2008	2009
Waikato	1,096	1,030	905	890	1,072	1,071
Lakes	354	377	386	430	382	468
Bay of Plenty	763	832	872	974	1,032	1,056
Tairawhiti	254	260	305	356	409	401
Taranaki	506	638	574	595	543	543
Total	2,973	3,137	3,042	3,245	3,438	3,539

Note: Data is for the 2nd 6 months of each year

Figure 12. 0-19 yrs Clients by DHB (2004-2009)



0-19 yrs Client Access Rates Compared to MHC's Access Benchmarks

The 2004 to 2008 MHINC/PRIMHD access data was analysed by six months to determine the six monthly benchmark access rates for each Region and DHB. The access rates presented in this section were calculated by dividing the clients in each age band per six month period by the corresponding population. Access rates are not affected by referral to regional services as they are based on the DHB where the client lives (DHB of Domicile).

In the second six months of 2009, the Midland region access rate was the lowest in the country (see Appendix D, Table 9).

However, client access rates from 2004 to 2009 had improved from 1.16% to 1.45%. Access rates by age showed improvements in the 10-14 and 15-19 year age groups only (see Table 15).

Table 15. Client Access Rates by Age Group (2004-2009)

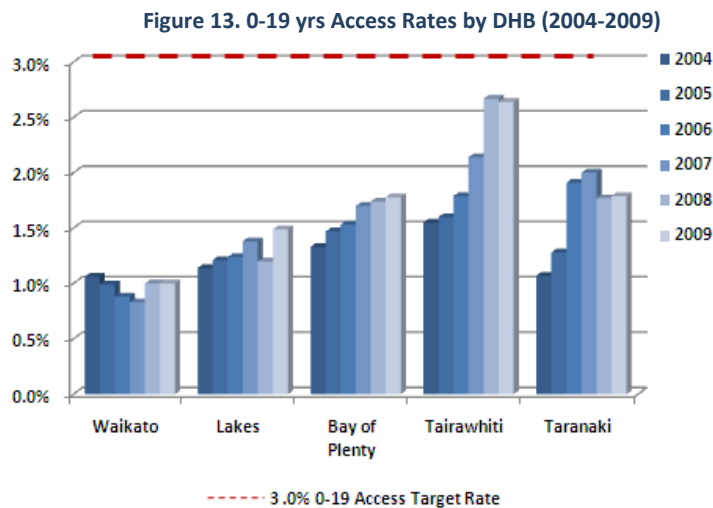
Year	Age Group (yrs)				National Access Rate 0-19
	0-9	10-14	15-19	0-19	
MHC Access Benchmarks	1.0%	3.9%	5.5%	3.0%	3.0%
2004	0.46%	1.58%	2.06%	1.16%	1.15%
2005	0.48%	1.61%	2.26%	1.23%	1.23%
2006	0.50%	1.65%	2.37%	1.27%	1.24%
2007	0.48%	1.81%	2.51%	1.34%	1.34%
2008	0.52%	1.81%	2.70%	1.41%	1.43%
2009	0.49%	1.87%	2.89%	1.45%	1.49%

Note: Data is for the 2nd 6 months of each year

From 2007 to 2009, most of the DHBs, except for Taranaki DHB, reported an increase in access rates.

In the second half of 2009, Tairawhiti DHB reported an access rate of 2.64% which was close to the target rate of 3% (see Appendix D, Table 9, Table 15 & Figure 13). Waikato reported the lowest access rates (1.0%) in the region.

Despite the increase, access rates in all DHBs have remained significantly below target rates for all three age groups, with the largest disparity in the 15-19 year age group (see Table 15).



MĀORI INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD WORKFORCE

Due to non-response of a major provider in the Waikato DHB area, the Māori workforce numbers reported for this region are likely to be underestimated and should be interpreted with caution.

In 2010, the Midland region DHB and NGO CAMH/AoD services reported a total of 83 Māori staff (71.7 actual FTEs).

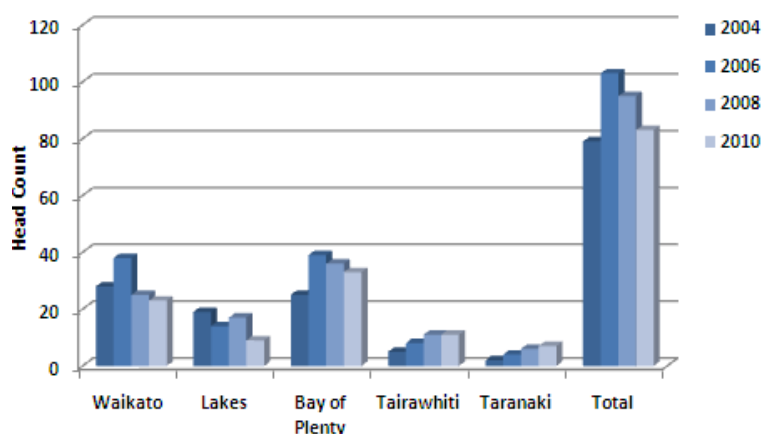
The majority of the Māori workforce (70%) were employed in NGOs in the Bay of Plenty and Waikato DHB areas (see Table 16 & Figure 14).

From 2008 to 2010, there was a 13% decrease in the Māori workforce (see Table 16). This decrease was largely seen in the NGOs in Waikato due to the restructure of NGOs in that area.

Table 16. Māori Infant, Child & Adolescent Mental Health/AOD Workforce (Headcount, 2004-2010)

DHB	DHB				NGO				Total			
	2004	2006	2008	2010	2004	2006	2008	2010	2004	2006	2008	2010
Waikato	2	12	4	2	26	26	21	21	28	38	25	23
Lakes	3	3	5	4	16	11	12	5	19	14	17	9
Bay of Plenty	8	13	8	7	17	26	28	26	25	39	36	33
Tairāwhiti	4	5	9	10	1	3	2	1	5	8	11	11
Taranaki	1	1	1	2	1	3	5	5	2	4	6	7
Total	18	34	27	25	61	69	68	58	79	103	95	83

Figure 14. Māori Infant, Child & Adolescent Mental Health/AOD Workforce by DHB (Headcount, 2004-2010)



The decrease in the regional Māori workforce was seen in the NGO Non-Clinical workforce (see Table 17).

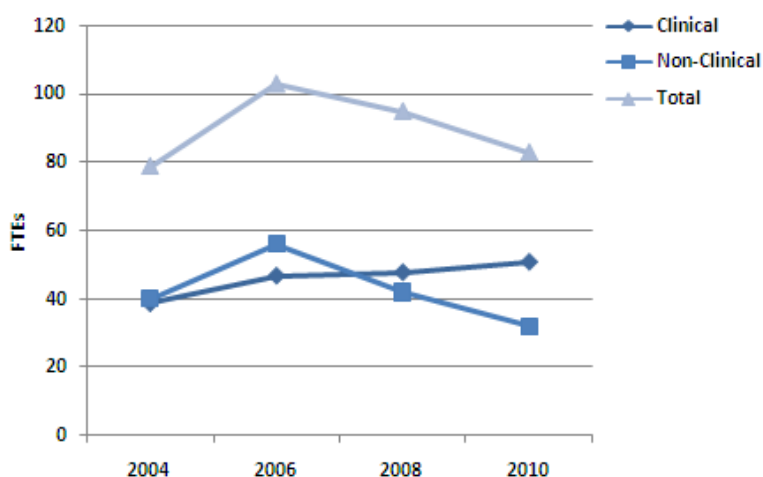
From 2008 to 2010, the Clinical Māori workforce had increased and therefore the majority of the Māori workforce in 2010 was in Clinical roles (61%) (see Table 17 & 18 and Figures 14 & 15).

Table 17. Māori Clinical & Non-Clinical Infant, Child & Adolescent Mental Health/AOD Workforce (Headcount, 2004-2010)

Year	DHB Community			NGOs			Total		Total
	Clinical	Non-Clinical	Total	Clinical	Non-Clinical	Total	Clinical	Non-Clinical	
2004	14	4	18	25	36	61	39	40	79
2006	22	12	34	25	44	69	47	56	103
2008	14	8	27	34	34	68	48	42	95
2010	11	14	25	40	17	58	51	32	83

Note: Non-Clinical Workforce includes Administration/Management Staff

Figure 15. Māori Clinical & Non-Clinical Infant, Child & Adolescent Mental Health/AOD Workforce (Headcount, 2004-2010)



DHB Community Māori Infant, Child & Adolescent Mental Health/AoD Workforce

In 2010, the Midland region DHB Community services reported a total of 25 Māori staff. Tairāwhiti DHB CAMHS reported the largest Māori workforce in the region (10) (see Table 16).

Māori staff in DHB Community services were mainly in Clinical roles (see Table 18).

From 2008 to 2010, the DHB Community services reported a decrease of two Māori staff.

NGO Māori Infant, Child & Adolescent Mental Health/AoD Workforce

In 2010, NGOs reported a total of 58 Māori Staff (51.5 FTEs). Please note, due to the non-response of a major Kaupapa Māori service provider in the region, the total number of Māori staff is likely to be under estimated (see Table 16).

The majority of the Māori workforce were in Clinical roles as Alcohol and Drug Workers and Social Workers (see Table 18). The remainder of the workforce were Mental Health Support Workers.

From 2008 to 2010, there was a 17% decrease in the NGO Māori workforce. This decrease was seen in the Non-Clinical workforce (see Table 17).

Fourteen NGOs were contracted to provide Kaupapa Māori services (Purchase Unit Code: MHCS39), received approximately 26% (\$2,519,749) of the total regional NGO funding (\$9,826,867) and reported almost half (47%, 27/58) of the Māori NGO staff in the region.

Out of the 27 Māori staff reported by the Kaupapa Māori services, the majority were in Clinical roles as Social Workers (8) and Alcohol and Drug Workers (4) while the remainder were Mental Health Support Workers (6).

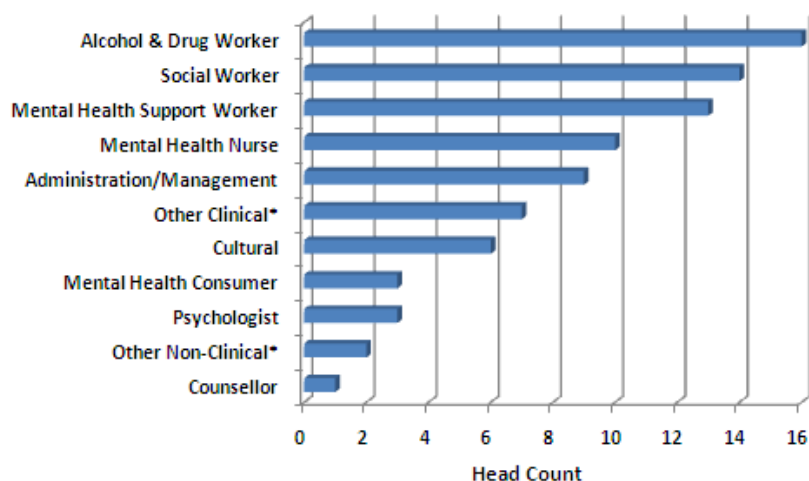
Table 18. Māori Infant, Child & Adolescent Mental Health/AOD Workforce by Occupational Group (Headcount, 2010)

Occupational Group	DHB	NGO	Total
Alcohol & Drug Worker	3	13	16
Counsellor	-	1	1
Mental Health Nurse	3	7	10
Occupational Therapist	-	-	-
Psychiatrist	-	-	-
Psychotherapist	-	-	-
Psychologist	3	-	3
Social Worker	2	12	14
Other Clinical Appointment ¹	-	7	7
Clinical Sub-Total	11	40	51
Cultural Appointment	5	1	6
Specific Liaison	-	-	-
Mental Health Consumer Advisor	1	1	2
Mental Health Support Worker	-	13	13
Other Non-Clinical Support for Clients ²	-	2	2
Non-Clinical Support for Clients Sub-Total	6	17	23
Administration/Management	8	1	9
Regional Total	25	58	83

1. Other Clinical Group=Family Therapists

2. Other Non-Clinical Group= Educators Primary Liaison Role; Youth Worker

Figure 16. Māori Infant, Child & Adolescent Mental Health/AOD Workforce by Occupational Group (Headcount 2010)



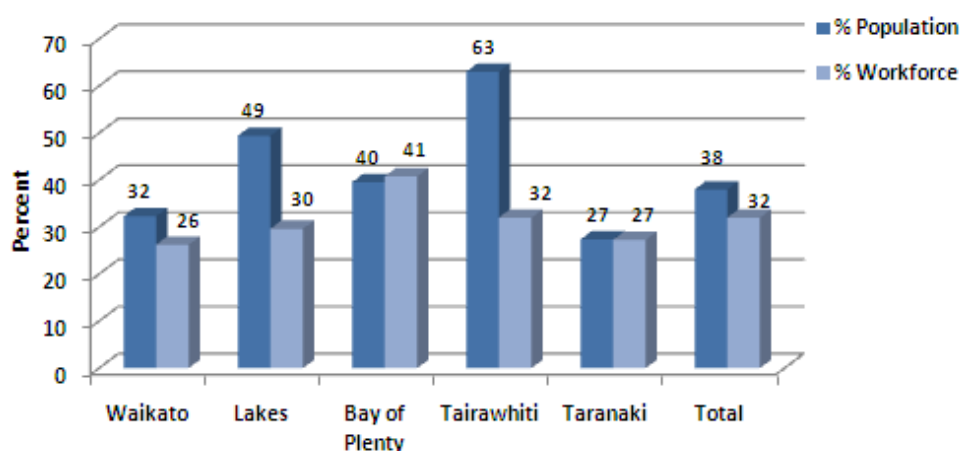
Workforce & Population Comparisons

Based on the 2010 population projections, the regional Māori infant, child and adolescent population made up 38% of the population and the Māori workforce (excluding Administration/Management) made up 32% of the total regional workforce (74/230).

The disparity between the workforce and the population is difficult to ascertain due to the missing data from a large Kaupapa Māori NGO provider in Waikato.

While the regional disparity between the workforce and the population cannot be accurately measured, workforce and population comparisons conducted at an individual DHB level (excluding Waikato) showed significant disparities in the Tairāwhiti and Lakes DHB area (see Figure 17).

Figure 17. Proportion of Māori Workforce compared to Proportion Māori 0-19 yrs Population (2010)



Māori Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to MHC's Resource Guidelines

Since there are no specific Blueprint Resource Guidelines for the Māori Community Clinical workforce, the recommended Māori Clinical Resource Guideline was estimated from the Blueprint Resource Guideline for the general 0-19 year population.

When the guidelines were calculated for the regional Māori 0-19 years proportion of the population, the recommended Māori Resource Guideline for the Northern region Community Clinical workforce was estimated at 89.4 FTEs (see Table 19).

From 2008 to 2010, there was an increase of only 2.4 FTEs in the total Māori Clinical workforce from 43.6 to 46.0 FTEs (see Table 19).

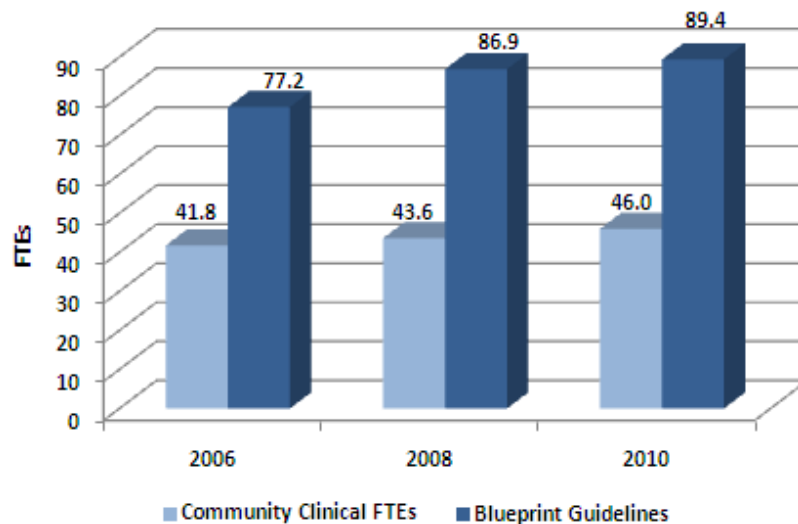
Due to a small increase in the Māori Clinical Community workforce in the region, a significant increase in the workforce is still required by 43.4 FTEs to meet the needs of the regional Māori infant, child and adolescent population (see Table 19).

Table 19. Māori Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to MHC's Blueprint Guidelines (2006-2010)

Year	Māori Community Clinical FTEs ³	Blueprint Guidelines ⁴	FTEs Needed
2006 ¹	41.8	77.2	31.9
2008 ²	43.6	86.9	43.3
2010 ²	46.0	89.4	43.4

1. 2006 Census (Prioritised Ethnicity)
2. 2008/2010 Population Projections (Base 2006, Total Response, Medium Projections)
3. Includes DHB Community CAMH/AoD Services & NGOs
4. Using the MHC's Blueprint Resource Guidelines for Community Clinical: 28.6/100,000 Total Population & proportioning according to the regional 0-19 Māori population (MHC, 1998).

Figure 18. Māori Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to MHC's Blueprint Resource Guidelines (2006-2010)



MĀORI CLIENT ACCESS TO INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD SERVICES

Due to incomplete data from the NGO sector, NGO client data has been excluded. Therefore this section only contains MHINC/PRIMHD DHB client data that is relevant to each region, which could account for the low access rates reported in this section.

In the second half of 2009, Māori clients made up 34% of the total number of clients in the Midland region. Māori males made up the majority (64%) of the Māori Clients accessing services in the region (see Table 20 & Figure 19).

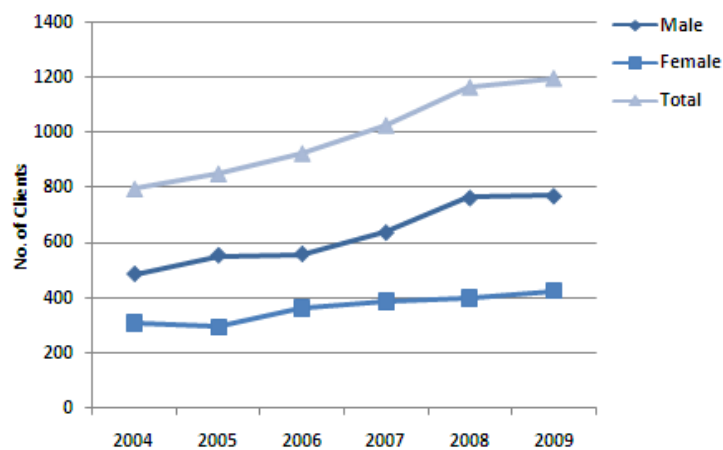
From 2007 to 2009, there was a 17% increase in the total number of Māori clients accessing services. This increase was largely seen in the Māori male client group by 21% (see Figure 19).

Table 20. Māori 0-19 yrs Clients by Gender (2004-2009)

Year	Māori 0-19 yrs Clients by Gender			Total Clients
	Male	Female	Total	
2004	487	311	798	3,027
2005	555	298	853	3,217
2006	560	366	926	3,093
2007	638	390	1,028	3,273
2008	764	402	1,166	3,438
2009	771	427	1,198	3,539

Note: Data is for the 2nd 6 months of each year

Figure 19. Māori 0-19 yrs Clients by Gender (2004-2009)



In the second half of 2009, Bay of Plenty DHB reported the largest number of Māori clients (35%) and Tairāwhiti DHB reported the largest proportion of Māori clients (58% of total clients, 401) accessing services in the region (see Table 21 & Figure 20).

From 2004 to 2009, most of the DHBs, except for Taranaki, reported a steady increase in Māori clients.

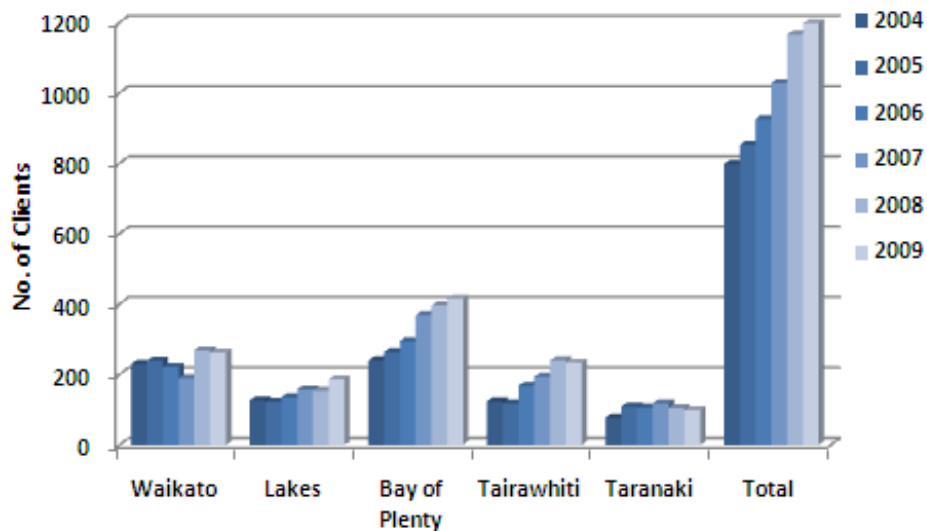
From 2007 to 2009, Taranaki DHB reported a 16% decrease in Māori clients (Table 21 & Figure 20).

Table 21. Māori 0-19 yrs Clients by DHB (2004-2009)

Year	DHB					
	Waikato	Lakes	Bay of Plenty	Tairāwhiti	Taranaki	Total
2004	230	127	240	124	77	798
2005	239	123	264	118	109	853
2006	221	136	295	168	106	926
2007	189	158	369	194	118	1,028
2008	269	155	397	240	105	1,166
2009	262	187	416	234	99	1,198

Note: Data is for the 2nd 6 months of each year

Figure 20. Māori 0-19 yrs Clients by DHB (2004-2009)



Māori 0-19 yrs Client Access Rates

From 2004 to 2009, there was a steady increase in Māori access rates in the Midland region from 0.8% to 1.3% (see Table 22). However, in the second half of 2009, Māori access rates to services in the Midland region remained below the regional average rates in all three age groups (see Table 22).

Due to a higher need for mental health services, the MHC (1998) has recommended that the Blueprint access benchmarks for Māori be set at 6% over a 6 month period. While access rates have increased from 2004 to 2009, they have not increased at a rate that is relative to need and have yet to reach either 3% (recommended for the general 0-19 year population) or the 6% target rate recommended for Māori.

Table 22. Māori Client Access Rates by Age Group (2004-2009)

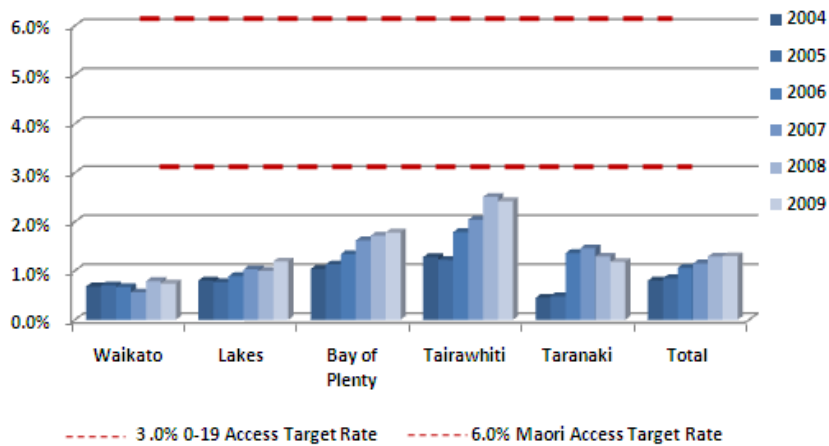
Year	Age Group (yrs)			
	0-9	10-14	15-19	0-19
MHC Strategic Access Benchmarks	1.0%	3.9%	5.5%	3.0%/6.0%
2004	0.26%	1.23%	1.57%	0.80%
2005	0.30%	1.19%	1.72%	0.85%
2006	0.41%	1.30%	2.22%	1.06%
2007	0.37%	1.51%	2.43%	1.15%
2008	0.38%	1.59%	2.92%	1.29%
2009	0.38%	1.72%	2.92%	1.30%
Regional Rate 2009	0.49%	1.87%	2.89%	1.45%

Note: Data is for the 2nd 6 months of each year

From 2004 to 2009, Lakes and Bay of Plenty DHBs were the only two DHB services in the region that reported an increase in Māori access rates.

Despite a decreasing trend seen in the Māori access rate in Tairāwhiti DHB, this DHB reported the highest access rate of 2.42% in the second half of 2009 which was close to the target rate of 3% set for the general 0-19 population. However for Māori, this rate remained significantly short of the 6% recommended rate (see Figure 21).

Figure 21. Māori 0-19 yrs Client Access Rate by DHB (2004-2009)



PACIFIC INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD WORKFORCE

In 2010, DHB CAMH/AoD services and NGOs reported a total of 8 Pacific staff (6.5 actual FTEs).

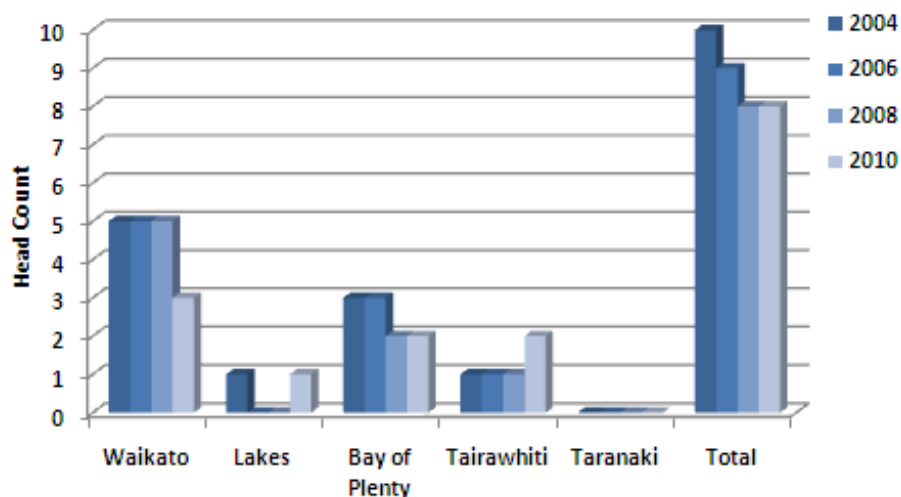
From 2008 to 2010, there was no change in the regional Pacific infant, child and adolescent mental health workforce. However, slight changes in the workforce were seen in individual DHB areas (see Table 23 & Figure 22).

From 2008 to 2010, DHB services reported an increase of one Pacific staff while NGOs reported a decrease of one (see Table 23).

Table 23. Pacific Infant, Child & Adolescent Mental Health/AOD Workforce (Headcount, 2004-2010)

DHB	DHB				NGO				Total			
	2004	2006	2008	2010	2004	2006	2008	2010	2004	2006	2008	2010
Waikato	-	-	-	-	5	5	5	3	5	5	5	3
Lakes	-	-	-	1	1	-	-	-	1	-	-	1
Bay of Plenty	3	3	-	-	-	-	2	2	3	3	2	2
Tairāwhiti	1	1	1	1	-	-	-	1	1	1	1	2
Taranaki	-	-	-	-	-	-	-	-	-	-	-	-
Total	4	4	1	2	6	5	7	6	10	9	8	8

Figure 22. Pacific Infant, Child & Adolescent Mental Health/AOD Workforce by DHB (Headcount, 2004-2010)



In 2010, the regional Pacific workforce was evenly split between Clinical and Non-Clinical roles.

From 2008 to 2010, there was no change in the Pacific Clinical workforce (see Table 24).

Pacific staff in Clinical roles were Mental Health Nurses and Social Workers (see Table 25).

Pacific in Non-Clinical roles were Mental Health Support Workers (see Table 25).

Table 24. Pacific Infant, Child & Adolescent Mental Health/AOD Clinical & Non-Clinical Workforce (Headcount, 2004-2010)

DHB	DHB			NGOs			Total		Total
	Clinical	Non-Clinical	Total	Clinical	Non-Clinical	Total	Clinical	Non-Clinical	
2004	4	-	4	3	3	6	7	3	10
2006	3	1	4	2	3	5	5	4	9
2008	1	-	1	3	4	7	4	4	8
2010	1	1	2	3	3	6	4	4	8

Note: Non-Clinical Workforce includes Administration/Management Staff

Table 25. Pacific Infant, Child & Adolescent Mental Health/AOD Workforce by Occupational Group (Headcount, 2010)

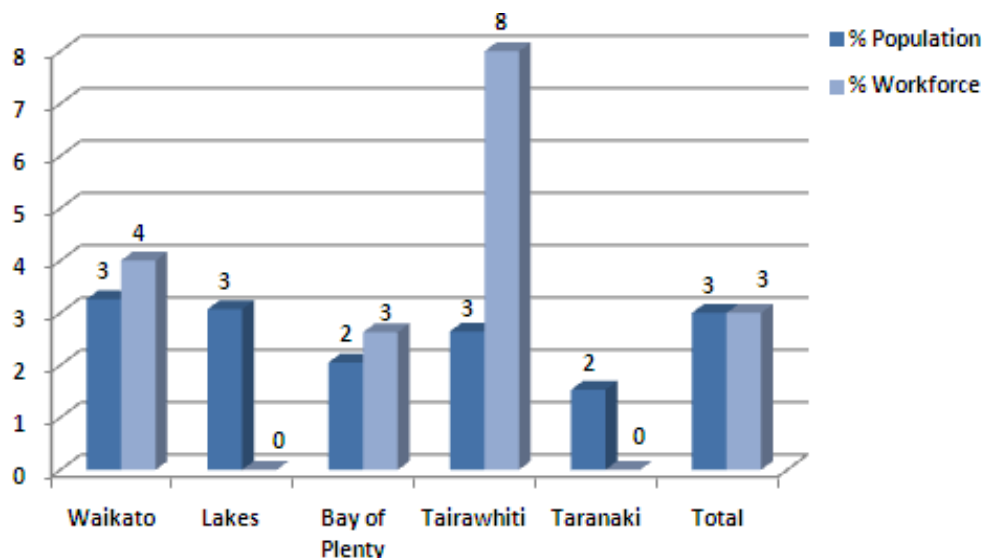
Occupational Group	DHBs	NGOs	Total
Alcohol & Drug Worker	-	-	-
Counsellor	-	-	-
Mental Health Nurse	-	2	2
Occupational Therapist	-	-	-
Psychiatrist	-	-	-
Psychotherapist	-	-	-
Psychologist	-	-	-
Social Worker	1	1	2
Clinical Sub-Total	1	3	4
Cultural Appointment	-	-	-
Specific Liaison	-	-	-
Mental Health Consumer Advisor	-	-	-
Mental Health Support Worker	-	2	2
Non-Clinical Support for Clients Sub-Total	1	2	3
Administration/Management	1	-	1
Regional Total	2	5	7

Workforce & Population Comparisons

Based on the 2010 population projections, the Pacific infant, child and adolescent population made up 3% of the total regional population and the Pacific workforce (excluding Administration/Management staff) made up 3% of the total workforce (7/230).

While regionally there appears to be no disparity between the Pacific workforce and the Pacific population, disparities can be seen in individual DHB areas, such as in Lakes and Taranaki (see Figure 23).

Figure 23. Proportion of Pacific Workforce compared to Proportion of Pacific 0-19 yrs Population (2010)



Pacific Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to MHC's Blueprint Guidelines

Since there are no specific MHC Blueprint Resource Guideline for the Pacific Community Clinical workforce, the recommended Pacific Clinical Resource Guideline was estimated from the MHC's Blueprint Resource Guideline for the general 0-19 year population.

When the guidelines were calculated for the regional Pacific 0-19 years proportion of the population, the recommended Pacific Resource Guideline for the Midland region Community Clinical workforce was estimated at 6.4 FTEs (see Table 26).

From 2008 to 2010, there was no change in the Pacific Clinical workforce.

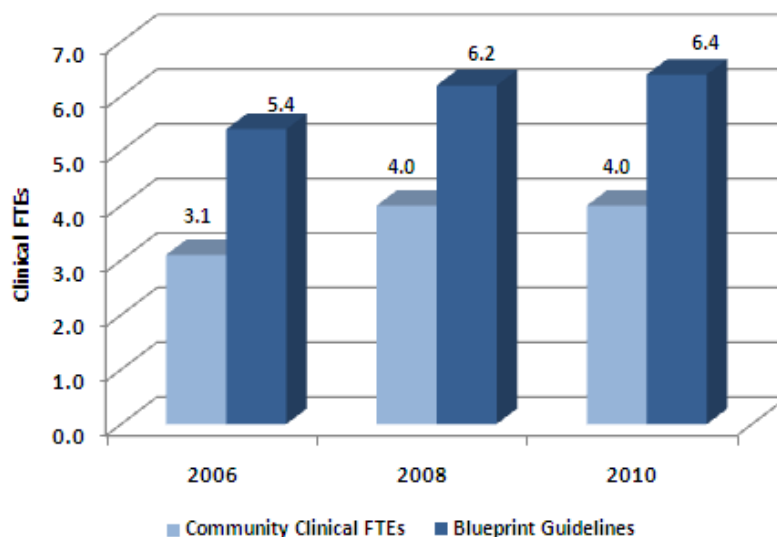
The Pacific workforce in the Midland region was very close to the Blueprint Guideline and would only need an additional 2.4 FTEs to meet the needs of the regional Pacific infant, child and adolescent population (see Table 26).

Table 26. Pacific Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to MHC's Blueprint Guidelines (2006-2010)

Year	Pacific Community Clinical FTEs ³	Blueprint Guidelines ⁴	FTEs Needed
2006 ¹	3.1	5.4	2.3
2008 ²	4.0	6.2	2.2
2010 ²	4.0	6.4	2.4

1. 2006 Census (Prioritised Ethnicity)
2. 2008/2010 Population Projections (Base 2006, Total Response, Medium Projections)
3. Includes DHB Community CAMH/AoD Services & NGOs
4. Using MHC's Blueprint Resource Guidelines for Community Clinical: 28.6/100,000 Total Population & proportioning according to the regional Pacific 0-19 years population (MHC, 1998).

Figure 24. Pacific Community Clinical Infant, Child & Adolescent Mental Health/AOD Workforce compared to MHC's Blueprint Guidelines (2006-2010)



PACIFIC CLIENT ACCESS TO INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD SERVICES

Due to incomplete data from the NGO sector, NGO client data was excluded. Therefore this section only contains MHINC/PRIMHD DHB client data and could account for the low access rates that are presented.

In the second half of 2009, the Midland region had the lowest number of Pacific clients in the country (see Appendix D, Table 4).

In the second half of 2009, Pacific infant, children and adolescents made up 1% of the total number of clients in the region. Pacific Male clients made up the majority (62%) of the clients accessing services in the region (see Table 27 & Figure 25).

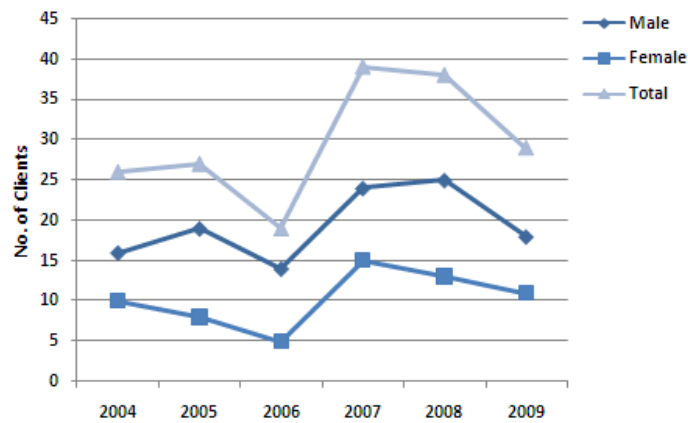
While Pacific client numbers showed a variable trend from 2004 to 2006, there was a decreasing trend seen in Pacific client numbers accessing services in the region from 2007 to 2009 (see Table 27).

Table 27. Pacific 0-19 yrs Clients by Gender (2004-2009)

Year	Pacific Clients by Gender			Total Clients
	Male	Female	Total	
2004	16	10	26	3,027
2005	19	8	27	3,217
2006	14	5	19	3,093
2007	23	14	37	3,273
2008	25	13	38	3,438
2009	18	11	29	3,539

Note: Data is for the 2nd 6 months of each year

Figure 25. Pacific 0-19 yrs Clients by Gender (2004-2009)



In the second half of 2009, Waikato DHB reported the largest number of Pacific clients in the region (41%).

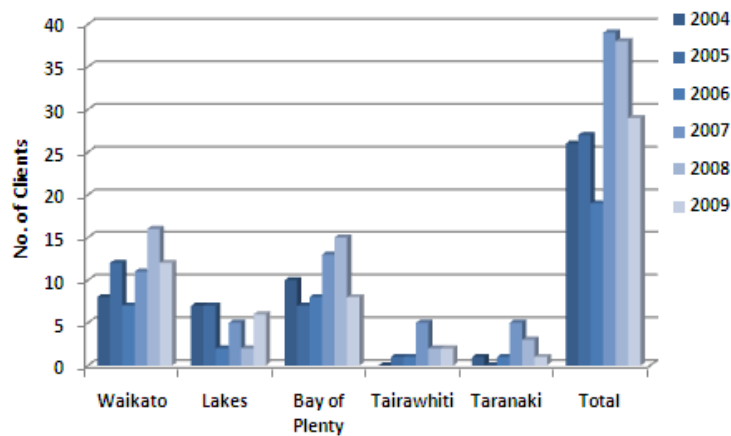
Waikato and Lakes DHBs were also the only services that reported an increase in Pacific clients from 2007 to 2009 (see Table 28 & Figure 26).

Table 28. Pacific 0-19 yrs Clients by DHB (2004-2009)

Year	DHB					Total
	Waikato	Lakes	Bay of Plenty	Tairāwhiti	Taranaki	
2004	8	7	10	0	1	26
2005	12	7	7	1	0	27
2006	7	2	8	1	1	19
2007	11	5	13	5	5	39
2008	16	2	15	2	3	38
2009	12	6	8	2	1	29

Note: Data is for the 2nd 6 months of each year

Figure 26. Pacific 0-19 yrs Clients by DHB (2004-2009)



Pacific 0-19 yrs Client Access Rates

From 2004 to 2009, Pacific access rates in the Midland region showed a variable trend. However, there was a general improvement in the Pacific access rate from 0.37% to 0.43% for the same period (see Table 29). Improvements in Pacific access rates were only seen in the 10-14 and 15-19 year age groups.

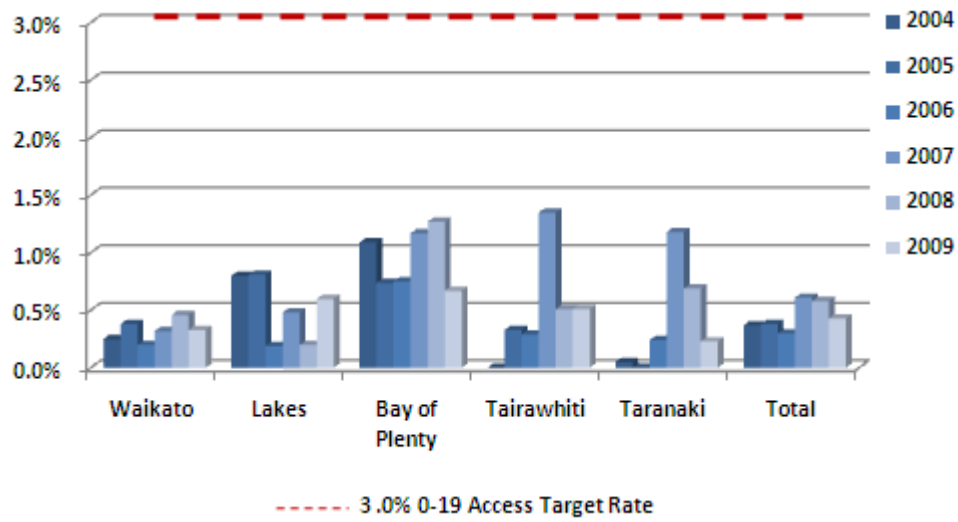
Despite these regional improvements, Pacific client access rates have remained low. They were lower than the average regional rate and therefore significantly lower than the target access rate for all three age groups (see Table 29 & Figure 27).

Table 29. Pacific 0-19 yrs Client Access Rates (2004-2009)

Year	Age Group (yrs)			
	0-9	10-14	15-19	0-19
MHC Strategic Access Benchmarks	1.0%	3.9%	5.5%	3.0%
2004	0.19%	0.32%	0.81%	0.37%
2005	0.22%	0.38%	0.71%	0.38%
2006	0.03%	0.73%	0.39%	0.30%
2007	0.28%	0.67%	1.19%	0.61%
2008	0.16%	0.84%	1.16%	0.58%
2009	0.18%	0.79%	0.61%	0.43%
Regional Rate 2009	0.49%	1.87%	2.89%	1.45%

Note: Data is for the 2nd 6 months of each year

Figure 27. Pacific 0-19 yrs Access Rates by DHB (2004-2009)



ASIAN INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD WORKFORCE

In 2010, the Midland region DHB CAMH/AoD services reported a total of five Asian staff (4.8 Actual FTEs).

From 2008 to 2010, there was an increase of two Asian staff in the region (see Table 30). This increase was reported by DHB services only.

All of the Asian staff held Clinical positions as Psychiatrists (2), Social Workers (2) and a Mental Health Nurse.

Table 30. Asian Infant, Child & Adolescent Mental Health/AOD Workforce (Headcount, 2004-2010)

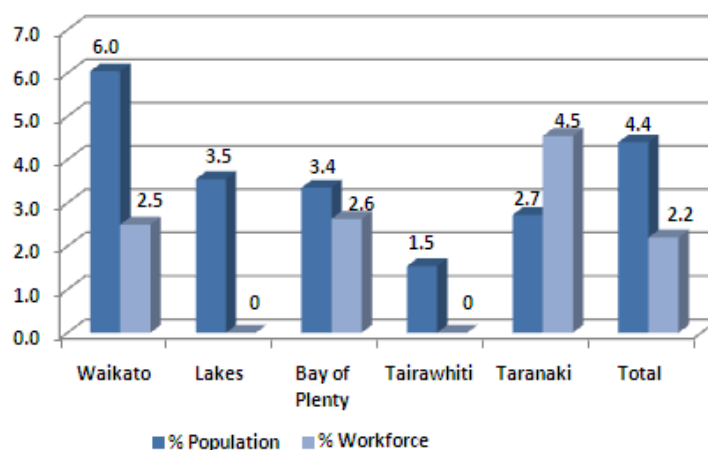
DHB	DHB				NGO				Total			
	2004	2006	2008	2010	2004	2006	2008	2010	2004	2006	2008	2010
Waikato	2	-	2	2	-	-	-	-	2	-	2	2
Lakes	2	-	-	-	-	-	-	-	2	-	-	-
Bay of Plenty	-	-	1	2	-	-	-	-	-	-	1	2
Tairāwhiti	-	-	-	-	-	-	-	-	-	-	-	-
Taranaki	-	-	-	1	-	1	-	-	-	1	-	1
Total	4	-	3	5	-	1	-	-	4	1	3	5

Workforce & Population Comparisons

Based on the 2010 population projections, the Asian infant, child and adolescent population made up 4% of the region's population, and the Asian workforce (excluding Administration/Management) made up 2% of the total Midland region workforce (5/230).

The very small growth in the regional Asian workforce, from 2008 to 2010, was not large enough to reduce the regional disparities that exist between the population and the workforce (see Figure 28). Therefore, significant disparities between the Asian population and the Asian workforce have continued to exist in the Waikato, Lakes DHB areas.

Figure 28. Asian Proportion of Workforce compared to Asian 0-19 yrs proportion of Population (2010)



ASIAN CLIENT ACCESS TO INFANT, CHILD & ADOLESCENT MENTAL HEALTH/AOD SERVICES

Due to incomplete data from the NGO sector, NGO client data was excluded from the analysis. Therefore this section only contains MHINC/PRIMHD DHB client data and could account for the low access rates that are presented.

In the second half of 2009, the Midland region had the lowest number of Asian clients in the country (see Appendix D, Table 5).

Asian clients in the Midland region made up 1% of the total clients in the region.

There were slightly more Asian females accessing services than males (see Table 31).

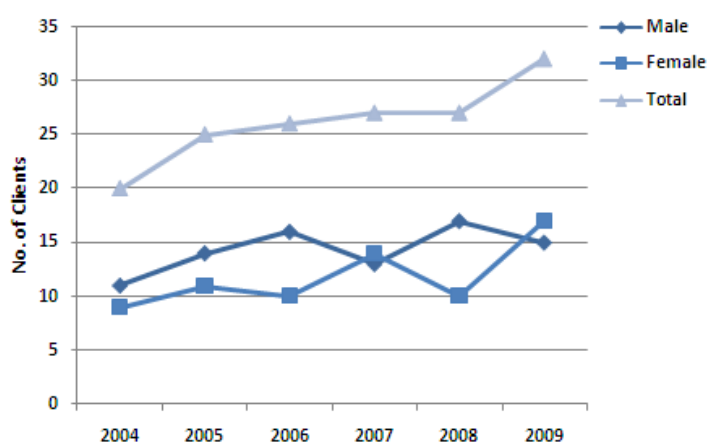
From 2007 to 2009, there was very little change seen in Asian client numbers accessing services in the region (see Table 31).

Table 31. Asian 0-19 yrs Clients by Gender (2004-2009)

Year	Asian 0-19 yrs Clients by Gender			Total Clients
	Male	Female	Total	
2004	11	9	20	3,027
2005	14	11	25	3,217
2006	16	10	26	3,093
2007	13	14	27	3,273
2008	17	10	27	3,438
2009	15	17	32	3,539

Note: Data is for the 2nd 6 months of each year

Figure 29. Asian 0-19 yrs Clients by Gender (2004-2009)



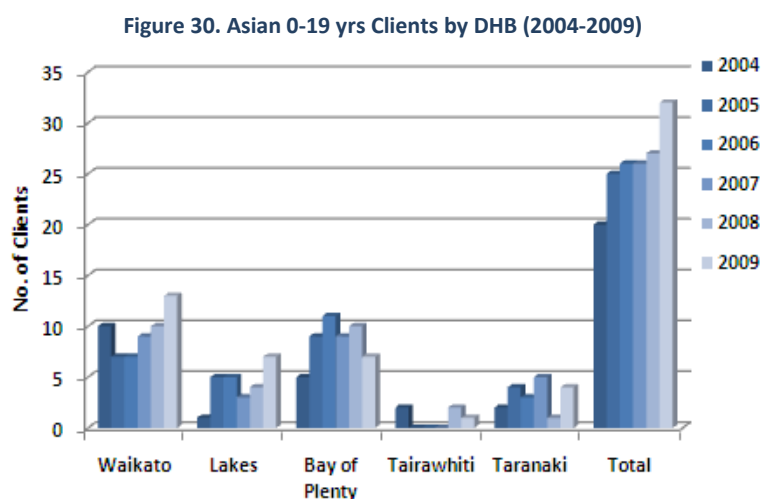
In the second half of 2009, Waikato DHB reported the largest number of Asian clients in the region (see Table 32 & Figure 30).

From 2008 to 2010, most of the DHBs, except for Bay of Plenty DHB, reported an increase in Asian clients.

Table 32. Asian 0-19 yrs Clients by DHB (2004-2009)

Year	DHB					
	Waikato	Lakes	Bay of Plenty	Tairawhiti	Taranaki	Total
2004	10	1	5	2	2	20
2005	7	5	9	0	4	25
2006	7	5	11	0	3	26
2007	9	3	9	0	5	26
2008	10	4	10	2	1	27
2009	13	7	7	1	4	32

Note: Data is for the 2nd 6 months of each year



Asian 0-19 yrs Client Access Rates

While there was a slight improvement in the regional Asian access rate from 2006 to 2009, Asian access rates by age group showed improvements in the 10-14 and 15-19 year age groups only.

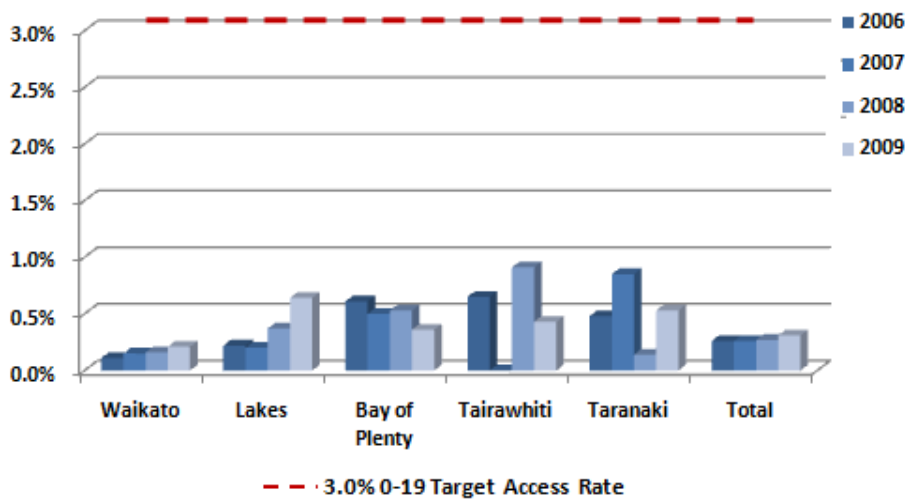
In the second half of 2009, Asian access rates had continued to be the lowest out of the three ethnic groups (Māori 1.30%, Pacific 0.43% & Asian 0.31%) and therefore continued to remain significantly below the access target rate of 3% (see Table 33 & Figure 31).

Table 33. Asian 0-19 yrs Client Access Rates (2006-2009)

Year	Age Group (yrs)			
	0-9	10-14	15-19	0-19
MHC Strategic Access Benchmarks	1.0%	3.9%	5.5%	3.0%
2006	0.16%	0.21%	0.46%	0.26%
2007	0.11%	0.30%	0.53%	0.28%
2008	0.11%	0.25%	0.54%	0.27%
2009	0.08%	0.21%	0.77%	0.31%
Regional Rate 2009	0.59%	1.87%	2.89%	1.45%

Note: Data is for the 2nd 6 months of each year

Figure 31. Asian 0-19 yrs Access Rates by DHB (2006-2009)



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