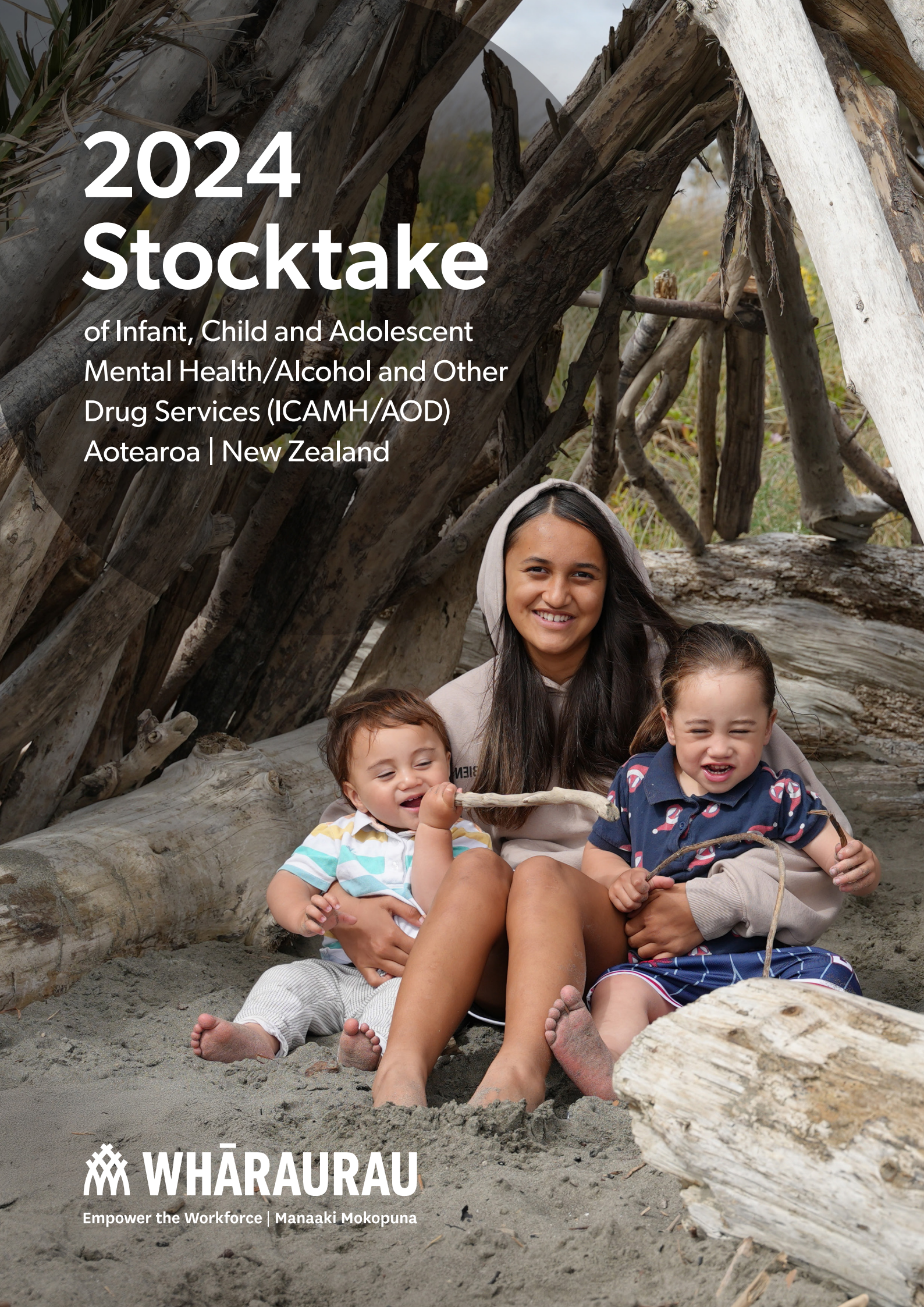
2024 Stocktake

of Infant, Child and Adolescent Mental Health/Alcohol and Other Drug Services (ICAMH/AOD) Aotearoa | New Zealand



WHĀRAURAU

Empower the Workforce | Manaaki Mokopuna

Contents

Acknowledgements

The Whāraurau team wishes to acknowledge the valuable input from all who contributed to this Stocktake report, and the Māori, Pacific and Asian Stocktake summary reports. The Stocktake project was led by Workforce Delivery Lead, Julia Kranenburg.

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A special thanks to all staff within Te Whatu Ora | Health NZ, NGO and PHO services who have contributed to the 2024 ICAMH/AOD workforce Stocktake.

Foreword

Tēnā koutou katoa

Haere mai to our 11th biennial Stocktake of the Infant, Child and Adolescent Mental Health and Alcohol and Other Drugs (ICAMH/AOD)[1] workforce.

This stocktake provides a picture of the current state of our ICAMH/AOD workforce – the breadth and number of our workers, vacancy rates and their training needs, as well the extent to which pēpi, tamariki, rangatahi and their whānau access services across community, primary and secondary settings.

The ICAMH/AOD workforce is developmental and whānau focused. Tamariki and rangatahi are seen in the context of their whānau and wider community, with ICAMH/AOD practitioners often present in spaces beyond the service setting – working with parents, families, schools, Oranga Tamariki workers and caregivers.

Our tamariki and rangatahi are resourceful and resilient when navigating the adversities and complexities of the modern world. They engage with global challenges such as climate change, poverty, and social justice, seeking solutions that can transcend local and national boundaries. Tamariki and rangatahi may also experience mental health challenges such as depression, anxiety and social isolation when navigating these issues. Factors such as negative messaging in social media, online bullying and unending online information (and misinformation), climate change and the geopolitical climate contribute to the mental health challenges experienced by our tamariki and rangatahi.

This requires a skilled and capable workforce who can keep pace with a fast-changing modern world and emerging shifts in youth culture. This workforce comprises a diverse range of people who need to work effectively with whānau including mama and pēpi in the prevention and early intervention of mental health challenges, as well as specialist interventions.

Youth lived experience roles are part of the ICAMH/AOD workforce. Whāraurau is committed to developing the youth lived experience workforce, and the clinical workforce who work alongside them, in services that are informed and supported to enable these roles to flourish. The roll out of crisis cafes and more lived experience led services has been welcomed by the sector. We hope that this will provide for more opportunity to enable the youth lived experience workforce in service provision. Whether establishing similar models alongside our Youth One Stop Shops, and Access and Choice services, or providing more varied digital and tele-support to our often more transport challenged younger whaiora.

This stocktake provides useful insight around the development and training needs of the ICAMH/AOD workforce based on a workforce survey and Real Skills Plus competency data completed over the past two years. We are excited about the first Child and Youth Mental Health and Addiction Prevalence Survey and anticipate, when available, this data will further inform workforce planning and development.

It is encouraging to see a slight decrease in vacancy rates, though workforce shortages and worker wellbeing remain key challenges. Whāraurau are finding ways to support more kaimahi online through supervision fora and communities of practice. Developing ICAMH/AOD workers across the continuum remains a priority. This means upskilling our community and primary workforces to respond to mental health challenges impacting our young people. This includes challenges increasing in prevalence and with high morbidity and mortality rates, such as eating disorders that present proportionately higher in our younger population.

The ICAMH/AOD workforce are dedicated to improving the lives of our tamariki, rangatahi and whānau and wellbeing in our communities for generations to come. We are grateful to be able to support them in this kaupapa.

Ngā mihi nui
Abigail Milnes
Director
Whāraurau

[1] Note: ICAMH/AOD refers to services supporting tamariki and rangatahi with mental health and alcohol and other drug challenges. These services also address other addictions, such as gambling and gaming.

Key findings

The 2024 Stocktake draws on workforce data and feedback from infant, child and adolescent mental health and alcohol and other drug (ICAMH/AOD) services. Additionally, it includes population data, funding information and service access activity for pēpi, tamariki and rangatahi aged 0-19, and 0-24. Te Whatu Ora | Health New Zealand (Health NZ) ICAMH/AOD services typically have an upper age limit of 19 years (Health NZ, 2024). Rangatahi over this age would likely be seen by Health NZ adult MH/AOD services. Many NGO/PHOs are funded to see pēpi, tamariki and rangatahi up until the age of 25. Hence, we present separate data for the 0-19, and 0-24 age groups in this report. The key findings are summarised below:

- **Increase in Actual FTE:** The total number of Actual Full-Time Equivalents (FTE) has risen by 19 percent since our 2022 Stocktake. Health NZ services saw a seven percent increase in Actual FTE, while NGO/PHO Actual FTE increased by 39 percent (Note: Our 2024 survey was expanded to include Access and Choice youth NGO/PHO services).
- **Decrease in vacancy rate:** The overall vacancy rate decreased from 13 percent to 11 percent since the 2022 Stocktake, although vacancy rates for psychiatrist, psychologist and occupational therapist FTE all saw an increase.
- **Growth in the lived experience and cultural workforce:** There was a 91 percent increase in the lived experience workforce (consumer advisor and peer support FTE) and a 42 percent increase in cultural roles since the 2022 Stocktake (Note: Our 2024 survey was expanded to include Access and Choice youth services).

- **Workforce challenges were identified:** Survey respondents highlighted workforce shortages, worker wellbeing and staff retention as the top three challenges facing their services.
- **Increasing ethnic diversity:** The population is projected to become more ethnically diverse. In the Northern region, Asian young people aged 0-19 and 0-24 are projected to become the largest population group, while in the Midland region, Māori aged 0-19 and 0-24 will become the largest population group (Stats NZ, 2023).
- **Need to prioritise both cultural safety and cultural competency in workforce development:** The projected growth, particularly in Māori and Asian populations, calls for responsive workforce development. This includes equipping the workforce to engage effectively with diverse populations and cultures, and ensuring that pēpi, tamariki and rangatahi and whānau experience culturally safe care and support.
- **Decline in service access:** Between 2021 and 2023, access to Health NZ and NGO ICAMH/AOD services declined overall. Among those aged 0–19, access rates fell from 4.5% to 4.2%, while for those aged 0–24, rates dropped from 5.3% to 4.7%. These trends varied across different ethnic groups and regions (Health NZ 2024, Stats NZ 2023).
- **Increase in access to Access and Choice programme:** Youth primary mental health services have seen an increase in service access over the past 2 years (Health NZ, 2024).
- **Expenditure on infant, child and youth MH/AOD:** In the 2022/23 fiscal year, Government expenditure on infant, child and youth mental health and alcohol and other drugs (MH/AOD) services accounted for 10.3 percent of the total annual expenditure on MH/AOD (Te Hiringa Mahara, 2024).

About Whāraurau

Whāraurau provide government-funded training and support to the infant, child and adolescent mental health and alcohol and other drugs (ICAMH/AOD) sector. Our work is evidence-based, and informed by national and international subject matter experts, including clinical, cultural, and youth-lived experience.

Te piko o te māhuri – tērā te tupu o te rākau.

The way in which the young sapling is nurtured (shaped), determines how the tree will grow.

About the Stocktake

This is the 11th Stocktake report for the ICAMH/AOD workforce. The Stocktake intends to support Manatū Hauora | Ministry of Health and Te Whatu Ora | Health New Zealand (Health NZ), as well as service providers and leaders, to assess current capacity and capability in the sector, and plan for workforce development. The report presents:

- Workforce data by district, role, and ethnicity.
- Training and development need as told to us by the workforce.
- Competencies and capabilities of the workforce as presented through the Real Skills Plus framework.
- Experiences of ICAMH/AOD services as told to us by rangatahi attending Whāraurau Deep and Meaningful Conversation (DMC) workshops.
- Population trends, service access activity, expenditure on mental health and alcohol and other drug (MH/AOD) services, and the impact of these factors on workforce development.

Stocktake digital dashboard

In 2025 we launched our Stocktake dashboard, which is available on the Whāraurau website. The dashboard provides a comprehensive and interactive view of ICAMH/AOD workforce data in Aotearoa. Users can compare workforce data across regions, districts, service types, roles and ethnicities.

The importance of workforce planning and development

Workforce planning and development drive initiatives, such as those which aim to expand the workforce, protect worker well-being, and foster collaboration and innovation. These efforts help to build a more resilient, adaptable, and effective mental health and alcohol and other drugs (MH/AOD) system, leading to better outcomes for our pēpi, tamariki, rangatahi and whānau.

National-level workforce planning is essential for coordinated development activities across government agencies who fund MH/AOD services. Local-level workforce planning is crucial to effectively address and adapt to demographic changes occurring within regions.

National strategies informing workforce development in the MH/AOD sector

National workforce strategies are informed by government policies, research, and efforts to improve access to MH/AOD services. Key priorities and recommendations within these strategies include:

- **Workforce expansion and development of specific disciplines**, including consumer, peer and lived experience, and in communities experiencing significant workforce shortages (Ministry of Health 2021, Health NZ, 2024). Health NZ have outlined a target to train at least 500 mental health and addiction professionals each year from 2025 onwards. Initiatives to grow the workforce also include increasing New Entry to Specialist Practice (NESP) programme capacity, increasing the number of funded psychiatry registrar and clinical psychology intern positions and training opportunities for the peer support workforce (Health NZ, 2024).
- **Expanding training and education opportunities to enhance the capacity and capability of the workforce**. The Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing report, sets out actions to promote wellbeing and increase mental wellbeing literacy for those working within the MH/AOD sector, and for professionals in other sectors including education and social services (2021).
- **Integrated and collaborative care to expand access to mental health and addiction services**. Integration and collaboration will be achieved by developing coordinated workforce development and career pathways across sectors, which will involve upskilling specific roles, including teachers, occupational therapists and social workers (Ministry of Health 2021).
- **Developing a culturally responsive workforce who have access to cultural safety and competency training**, particularly for those working with Māori, Pacific and other ethnic communities (Ministry of Health 2021). There is also a recognised need to increase the recruitment and retention of Māori and Pacific mental health and addiction professionals. This can be achieved by creating stronger pathways into management and leadership positions, ensuring Māori and Pacific perspectives on mental health are reflected in service delivery (Ministry of Health 2021, Health NZ 2024).
- **Retention and wellbeing of the workforce**, recognising that a supported, motivated and well-cared-for workforce is essential to ensuring high quality mental health and addiction services (Government Inquiry into Mental Health and Addiction, 2018). Key actions identified in Kia Manawanui Aotearoa include:
  - Supporting workforce wellbeing initiatives.
  - Maximising opportunities to accredit prior learning and support career progression.
  - Creating pathways for clinical and non-clinical workforces, including enhanced training and development opportunities to ensure people are supported to work to the top of their scope.

The Stocktake process

The 2024 Stocktake report includes:

- Workforce data for 2024, informed by consultations with Health NZ, Whāraurau (youth consumer and cultural advisors) and external Māori, Pacific, and Asian advisory. Data was collected using a workforce survey communicated via email and phone, to:
  - 20 Health NZ (inpatient and community) ICAMH/AOD services. (Note: 2022 workforce data was used for the Bay of Plenty district).
  - 121/143 (85 percent) Health NZ funded Non-Government Organisation (NGO) and Primary Health Organisation (PHO) ICAMH/AOD services. For NGOs/PHOs that did not participate in this year's survey, their previous data submission has been used as an estimate of their workforce.
- We collect workforce data as of 30 June 2024, and the data is presented by Actual and Vacant Full Time Equivalent (FTE), and headcount. We further report this data by clinical and non-clinical role type, and ethnicity.
- District level workforce data is presented in the Appendices, and is also available on the Stocktake dashboard, available on the Whāraurau website. Whāraurau can be contacted for more detailed data upon request.

Workforce data definitions and calculations	
Actual FTE	A filled permanent or fixed term FTE position (excluding casual employees). (Note: This is captured differently for PHOs where support hours are contracted out. In these cases, we have converted support hours into FTE).
Clinical	Includes alcohol and drug workers, counsellors, nurses (mental health, registered, nurse practitioners), occupational therapists, psychiatrists, psychotherapists, clinical or registered psychologists, and social workers. (Note: Health NZ and NGO/PHO services may sometimes recruit based on skills and competencies, therefore the workforce data collected may not fall strictly into the named professions described.)
Non-clinical	Includes cultural workers (kaumātua, kuia or other cultural appointments), mental health support workers, mental health consumers (family and youth consumers), peer support workers and youth workers. (Note: Health NZ and NGO/PHO services may sometimes recruit based on skills and competencies, therefore the workforce data collected may not fall strictly into the named professions described).
Full Time Equivalent (FTE)	Proportion of full-time hours worked. (Note: For some services, 40 hours worked per week is considered full-time, whereas others consider 37.5 hours full-time; both cases are treated the same i.e. FTE=1).
Headcount	Count of individuals
Vacant FTE	An unfilled permanent or fixed term FTE position (excluding casual employees) that has funding allocated and will be actively recruited in the next six months.
Vacancy rates	Calculated by dividing the vacant FTE by the sum of Actual and Vacant FTEs.
Turnover rates	Calculated by dividing the total number of staff who left between 1 July 2023 and 30 June 2024 by the average number of staff within that timeframe, multiplied by 100. These numbers do not include staff who moved teams within an organisation.

The 2024 Stocktake report includes (cont.):

- Real Skills Plus (RSP) data for 2023/24, is sourced from the Whāraurau RSP online assessment tool. RSP identifies practitioner competencies for working in the ICAMH/AOD sector, and highlights areas for development. RSP data is collected at individual, team, and service level, and is reported nationally. RSP has three levels: Primary (for workers in the primary sector), Core (practitioners focusing on mental health/AOD concerns) and Specific (senior/specialist practitioners working at advanced levels of practice). National organisational level data (July 2023 – June 2024) is used in this report to present the levels of knowledge and skills against core competencies.We summarise the findings from RSP data collected between July 2023 – June 2024 for 16 Health NZ ICAMH/AOD teams and 15 NGO providers, all who completed Core level competences.
- Population data update for 2023, is sourced from Statistics New Zealand. Census 2018 is used as the base year for projections. Prioritised ethnicity data is used to ensure each individual is counted only once; however, it is important to acknowledge that prioritised ethnicity data conceals the diversity within and the overlap between different ethnic groups by excluding multiple ethnicities from the data (Statistics New Zealand, 2006).
- Service user data for those aged 0-24 who accessed services provided or funded by Health NZ (including NGOs) is sourced from the Programme for the Integration of Mental Health Data (PRIMHD). PRIMHD contains information on service users accessing publicly funded inpatient, outpatient, and community mental health and addiction services. Data is based on service of domicile (residence) for full calendar years, and prioritised ethnicity. Service access rates are calculated by dividing the number of service users by their corresponding population. The PRIMHD data counts the number of unique service users who accessed services during the time period (calendar year). Service users may be counted twice if they accessed both Health NZ and NGO services.
- Service activity data for Access and Choice services is extracted from a Health New Zealand report called 'Expanding Access and Choice: Kaupapa Māori, Pacific and youth services - activity from November 2021'. This data has been reported to Health NZ from service providers using reporting templates. In this report, we include data for people seen (number of unique individuals seen by primary mental health and addictions services during the month).

Data quality relies on the information provided to us by service providers, Health NZ and Manatū Hauora Ministry of Health. Data will be corrected if updates are received. For a full list of the data limitations that apply to this Stocktake, please see Appendix E.

ICAMH/AOD services | Community, primary and secondary healthcare settings

The ICAMH/AOD workforce discussed in this report is funded by Health NZ, with services delivered across various settings:

- Secondary inpatient and community healthcare services delivered by 20 Health NZ districts (former DHBs).
- Community healthcare services delivered by 91 Non-Governmental Organisations (NGOs).
- Primary healthcare settings, including youth Access and Choice services ,are delivered by 15 Primary Health Organisations (PHOs), and 23 NGOs. (Note: We have not included the workforce that delivers extended GP consultations in this survey.)

This report does not include infant, child, and adolescent MH/AOD services that are funded by other government agencies, such as those funded by the Ministry of Social Development. Therefore, data for that workforce is not included in this report.

ICAMH/AOD workforce data: Actual and Vacant FTE, workforce composition, ethnicity and turnover rates

Workforce data provides valuable insight into the current capacity and makeup of the ICAMH/AOD workforce. By tracking changes over time, we can better understand how the workforce is evolving in response to Government strategies, as well as broader social and demographic shifts.

In addition to presenting 2024 workforce data, this report includes comparisons with previous workforce surveys. Our 2024 workforce survey was expanded to include the Access and Choice youth specific workforce; therefore, we advise caution when interpreting changes in NGO/PHO workforce data.

The number of Actual FTE has increased overall

There was a total of 2,098 Actual FTE in the 2024 Stocktake, which was a 19 percent increase on the 2022 figure. Health NZ services including inpatient, community and the National Youth Forensic service | Nga Taiohi), saw a seven percent increase in Actual FTE, while NGO/PHO services saw a 39 percent increase (Note: Our 2024 survey was expanded to include Access and Choice youth NGO/PHO services).

Of the total number of Actual FTE, 59 percent were employed by Health NZ, while 41 percent were employed in NGO/PHO services.

19 percent overall increase in Actual FTE
Actual FTE by service type, 2012-2024

Actual FTEs (2012 - 2024)								
ICAMH/AOD service	**12**	**14**	**16**	**18**	**20**	**22**	**24**	**% change (2022-2024)**
Health NZ inpatient	141	144	148	154	150	154	**174**	+13%
Health NZ community	878	914	935	887	960	947	**1003**	+6%
Nga Taiohi (National Youth Forensic)*	-	-	-	44	40	48	**56**	+17%
NGO/PHO	412	532	503	610	589	621	**865**	+39%†
Total	1431	1590	1586	1695	1739	1770	**2098**	+19%

Source: Whāraurau workforce survey 2012-2024
*Note: Nga Taiohi (National Youth Forensic) opened in 2016, workforce data first collected in 2018.
†Note: The 2024 workforce survey was expanded to include NGO/PHOs delivering through Access and Choice youth stream.

The vacancy rate and number of Vacant FTE decreased overall

In 2024, there was an overall vacancy rate of 11 percent, a decrease from the 2022 vacancy rate of 13 percent (see here for definition of vacancy rate).

By service type, Health NZ services (including inpatient, community and Nga Taiohi | National Youth Forensic) had the highest vacancy rate at 15 percent, with the NGO/PHO vacancy rate at 5 percent.

In actual numbers, there were 252 Vacant FTE in 2024, a five percent decrease from 2022. Health NZ inpatient and community services saw a decrease in the number of Vacant FTE, while NGO/PHOs saw an increase (Note: Our 2024 survey was expanded to include Access and Choice youth NGO/PHO services).

Vacant FTEs (2012 - 2024)
Vacant FTE by service type, 2012-2024

Vacant FTEs (2012 - 2024)								
ICAMH/AOD service	**12**	**14**	**16**	**18**	**20**	**22**	**24**	**% change (2022-2024)**
Health NZ inpatient	16	22	16	18	17	17	**15**	-6%
Health NZ community	74	108	120	129	96	214	**181**	-15%
Nga Taiohi (National Youth Forensic)*	-	-	-	0	5	2	**9**	+350%
NGO/PHO	4	13	10	21	30	33	**47**	+39%†
Total	94	143	146	168	148	265	**252**	-5%

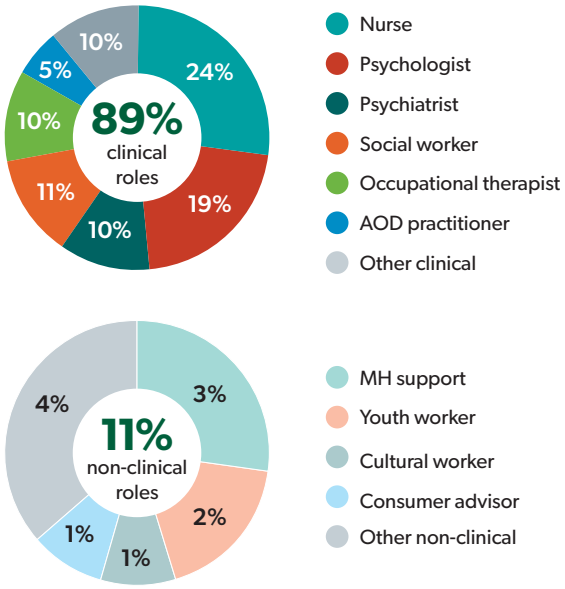
Source: Whāraurau workforce survey 2012-2024
*Note: Nga Taiohi (National Youth Forensic) opened in 2016, workforce data first collected in 2018.
†Note: The 2024 workforce survey was expanded to include NGO/PHOs delivering through Access and Choice youth stream.

Most of the Vacant FTE were clinical roles

Clinical roles represented 89 percent of total Vacant FTE. Of the Vacant FTE reported, nurses represented the highest proportion at 24 percent, followed by psychologists (19 percent), and social workers (11 percent).

Non-clinical roles accounted for 11 percent of the total Vacant FTE, with most Vacant FTEs comprising support workers, youth workers, cultural workers and consumer advisors.

89 percent of Vacant FTE were clinical roles
% proportion of total Vacant FTE, 2024



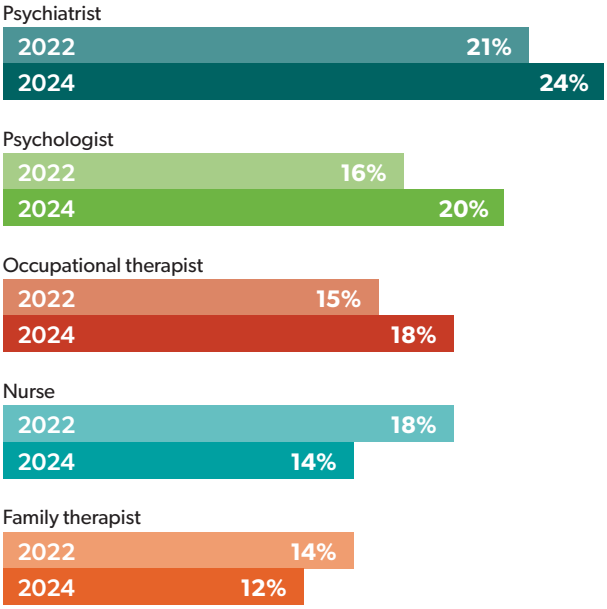
Source: Whāraurau workforce survey 2024

The psychiatrist role had the highest vacancy rate

Although the overall vacancy rate decreased from 2022, vacancy rates for psychiatrists, psychologists and occupational therapists increased between 2022 and 2024. The psychiatrist role had the highest vacancy rate (when looking at proportion of psychiatrist FTE that were vacant), with 24 percent of funded FTE remaining vacant. Conversely, nurses saw a decline of four percent in vacancy rate over this period (although in actual numbers, nurses had the highest number of vacant FTE).

Additionally, 58 percent of vacant psychiatrist FTE, 50 percent of vacant psychologist FTE, 31 percent of vacant occupational therapist FTE, and 29 percent of vacant nurse FTE, had stayed vacant for three months or longer.

Psychiatrist role had the highest vacancy rate
% top five vacancy rates by clinical role, 2022-2024



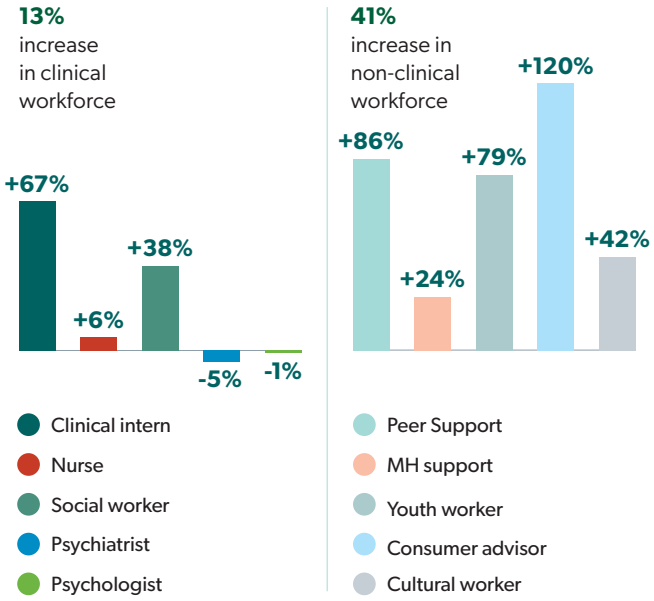
Source: Whāraurau workforce survey 2022-2024

There was an increase in clinical intern, peer support and consumer advisor FTE

The number of Actual FTE for certain clinical roles such as psychiatrists, psychologists, and AOD practitioners decreased from 2022. Meanwhile, roles like social workers, clinical interns (largely psychology interns) and nurses all saw an increase in Actual FTE.

There were also changes in the lived experience workforce with peer support and consumer advisor roles seeing a combined increase in Actual FTE, from 26.9 FTE in 2022, to 51.45 FTE in 2024. Cultural workers also saw a 42 percent increase in Actual FTE. However, caution is advised when interpreting trends over time for the non-clinical workforce due to the inclusion of the Access and Choice youth providers in the 2024 workforce survey.

There was an overall increase in Actual FTE across clinical and non-clinical roles
% change in Actual FTE 2022-2024



Source: Whāraurau workforce survey 2022-2024

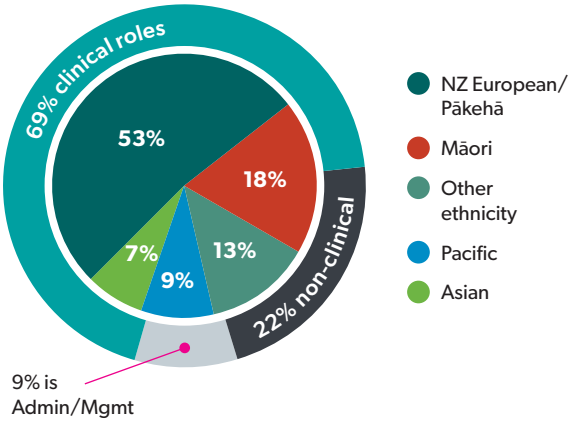
NZ European/Pākehā represented over half of the workforce

In 2024, the majority of the workforce (Actual FTE) was of New Zealand European | Pākehā ethnicity, followed by Māori, Other, Pacific, and Asian ethnicities.

Māori were more likely to be employed in NGO/PHO services, while NZ European/Pākehā, Pacific, Asian and Other were predominantly employed in Health NZ services (Appendix B).

For more detailed information on ethnicity and the ICAMH/AOD workforce, please refer to our Māori, Pacific, and Asian summary reports, available on the Whāraurau website.

Workforce by ethnicity
% headcount by ethnicity, 2024



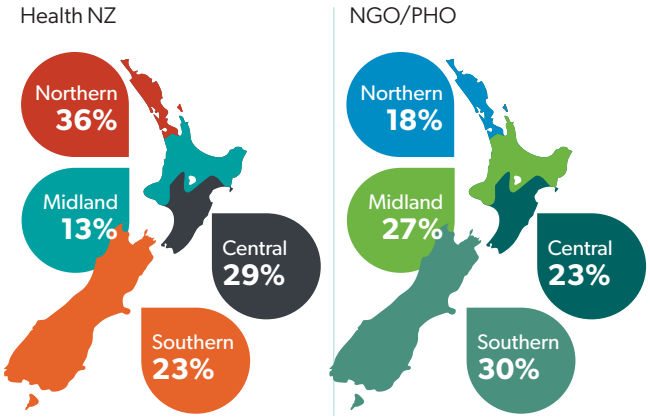
The Northern region had the highest share of the workforce

In 2024, the Northern region accounted for the largest share of the national workforce, representing 29 percent of total Actual FTE. This was largely due to its higher concentration of Health NZ workforce, the highest among all regions.However, the Northern region had the lowest share of the NGO/PHO workforce.

The Midland region had the smallest share of Health NZ workforce at 13 percent but held the second highest share of NGO/PHO workforce. The Southern region had the highest NGO/PHO workforce share with 30 percent. The Central region contributed 29 percent of the Health NZ workforce and 23 percent of the NGO/PHO workforce, making up 27 percent of the total national workforce. Appendix B presents further district level workforce data.

Regional share of total workforce

% Actual FTE by region, 2024



Source: Whāraurau workforce survey 2024

There was an overall turnover rate of 17 percent

Turnover information tells us how many individuals left their roles between July 2023 and June 2024, along with their reason for leaving. These numbers do not include staff who moved teams within their organisation.

The combined turnover rate for the Health NZ and NGO workforce was 17 percent. Health NZ services experienced a turnover rate of 13 percent, while NGO/PHO services had a turnover rate of 22 percent.

Health NZ workforce

Between July 2023 and June 2024, 172 individuals left their roles within Health NZ services. The majority of those who left were nurses, followed by psychologists, social workers, occupational therapists and psychiatrists.

The most common reasons for leaving included:

- Moving from the area (23 percent)
- Family reasons/personal (14 percent)
- Moving overseas (12 percent)
- Private sector (12 percent)
- Left ICAMHs (7 percent)
- Retirement (7 percent)

NGO/PHO workforce

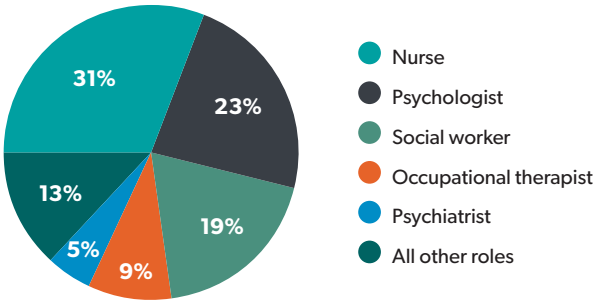
Between July 2023 and June 2024, 205 individuals left their roles within NGO/PHO services. The majority of those who left were mental health support workers, followed by youth workers, social workers, AOD practitioners and counsellors.

The most common reasons for leaving included:

- Left organisation for another role in the sector (26 percent)
- Family reasons/personal (17 percent)
- Career development (8 percent)
- Moving overseas (7 percent)

Nurses made up the largest proportion of those who left their role

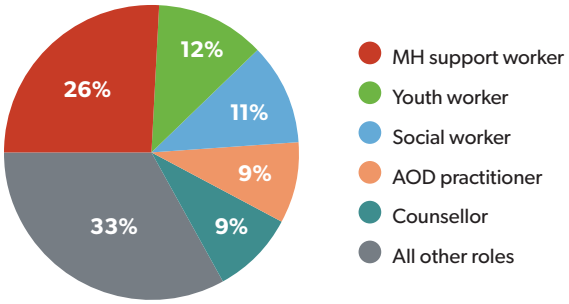
% share of those who left by role, headcount, Health NZ services, 2024



Source: Whāraurau workforce survey 2024

MH support workers made up the largest proportion of those who left their role

% share of those who left by role, headcount, NGO/PHO services, 2024



Source: Whāraurau workforce survey 2024

What is the workforce telling us?

As part of our workforce survey, a qualitative survey was completed by 84 team leaders and service managers from ICAMH/AOD services within Health NZ and NGO/PHO settings. Below, we summarise the key messages from their feedback.

The workforce is facing challenges

Respondents to our survey let us know the top three workforce challenges they were facing. Below are the most frequently recorded responses:

- Staff shortages and recruitment were the most pressing concerns impacting the sector. While workforce data indicates that vacancy rates are decreasing, we heard of difficulties recruiting specific roles, such as psychiatrists, nurses, occupational therapists and psychologists, as well as a broader lack of practitioners with experience in the ICAMH/AOD sector. Respondents also spoke about workforce shortages within rural areas. Additionally, challenges in workforce planning were reported, caused by a reduction in budgets and the inability to backfill vacant positions.
- Worker wellbeing was the second most common concern, frequently mentioned in relation to stress, fatigue, vicarious trauma, and the negative effects of high-pressure work environments on staff. We heard how pressures brought about by the increasing complexity and severity of caseloads, alongside a lack of resources, is creating unsustainable pressure on teams.
- Closely related to worker wellbeing, staff retention emerged as the third most significant issue, exacerbated by concerns around worker wellbeing and high-pressured working environments.The NGO workforce also highlighted difficulties in recruiting and retaining staff due to higher salaries offered within Health NZ services.

"Lots of time is spent getting inexperienced new staff capable, this impacts on waitlist management, with experienced staff spending additional time mentoring new staff"

Workforce retention initiatives are making a difference

Despite these challenges, services told us about the retention and early career supports that are available to support and retain staff. These initiatives included:

- Professional development and training.
- Supervision and mentoring.
- Comprehensive support for students and new graduates.
- Opportunities for career advancement through secondment opportunities, as well as support with further study and post-graduate qualifications.
- Workforce wellbeing initiatives such as whitiwhiti kōrero, a platform for practitioners to share concerns and offer mutual support.
- Implementation of specific models and programmes, such as the Choice and Partnership Approach (CAPA) model which includes ideas around looking after staff, and professional development (York & Kingsbury, 2006).

Cultural training was identified as a need

Feedback around training and development needs highlighted a strong demand for cultural training, especially when working with Pacific and Asian pēpi, tamariki, rangatahi and whānau. Respondents highlighted a gap in available training, alongside increasing referrals from these population groups.

On a positive note, there were frequent mentions of available training that focused on engaging with whānau Māori, incorporating Māori models of practice and addressing racism and unintentional bias, both within Health NZ and NGO/PHO services.

Specific workforce development needs were identified

Respondents highlighted several key areas for workforce development, with the most frequently cited being:

Training and support for staff who are new to the ICAMH/AOD sector.

Capacity to support increased acuity and complexity, including navigating systems to address social needs.

Family engagement and therapy including working confidently with families, family therapy, and collaborative note writing.

Core skills training in Dialectical Behaviour Therapy (DBT), Cognitive Behavioural Therapy (CBT), distress tolerance, and sensory modulation.

Working with neurodiverse rangatahi and their whānau.

Higher-level training in infant mental health, play therapy and specific trainings related to children.

Trauma-informed care and trauma training.

Working with rangatahi presenting with eating disorders/ disordered eating.

Barriers to accessing training were identified

We heard about the following barriers that prevented access to workforce training and development opportunities:

- **Affordability:** References were made to the high cost of trainings and the lack of allocated professional development funds; an issue particularly highlighted by NGOs.
- **Accessibility:** The difficulty of accessing training in rural areas, particularly with travel restrictions in place within Health NZ.
- **Time constraints:** Time pressures and workload capacity limiting the ability to attend trainings and professional development opportunities.

Capability of the ICAMH/AOD workforce

Real Skills Plus (RSP) is a competency framework that describes the knowledge and skills necessary to work with pēpi, tamariki, rangatahi and whānau. The framework identifies areas of strengths and opportunities for further development. The online assessment tool, available on the Whāraurau website, enables individuals to complete a self-assessment of their level of knowledge and skills against a range of competencies that sit within the engagement, assessment and intervention domains. These three domains reflect the processes that pēpi, tamariki, rangatahi and whānau encounter during their contact with services:

- Engagement involves forming supportive and therapeutic relationships with pēpi, tamariki, rangatahi and whānau, that are strengths focused, culturally affirming and informed by whānau experiences and perspectives.
- Assessment looks at knowledge and skills around developmental milestones, trauma-informed approaches and common MH/AOD concerns, and the skills to utilise screening tools and develop plans for ongoing treatment and support.
- Intervention focuses on the knowledge and skills to utilise specific interventions such as parenting programmes, distress tolerance skills, trauma-informed approaches and cultural frameworks.

Here we summarise the findings from RSP data collected between July 2023 – June 2024 for 16 Health NZ and 15 NGO ICAMH/AOD teams, all who completed Core level competences.

The workforce has high levels of competency in the engagement domain

Both the Health NZ and NGO/PHO workforce demonstrated similar trends across the three domains, with both workforces showing higher levels of competency against the engagement domain. Within the engagement domain, both workforces also showed higher competency in their knowledge of engagement processes, as compared to their skills in applying this in practice.

The data for both Health NZ and NGO/PHO workforce's signals that there are opportunities for workforce development initiatives aimed at enhancing knowledge and skill competencies within the assessment and intervention domains. Below we provide more detail on the strengths identified, as well as the opportunities for development within each domain.

Engagement

There were high levels of competency in working with young people and whānau to form positive therapeutic and trusting relationships, and the ability to work in a person-centred, strengths-based and culturally responsive way.

While there was a higher level of competency in understanding the impact of stigma and discrimination, individuals identified a need for further development in how to address the impact of stigma and discrimination with tamariki, rangatahi and their whānau to enhance engagement.

Assessment

The data showed higher levels of competency in understanding the importance of trauma and colonisation on young people and whānau, and the potential impact of parents' mental health difficulties on young people.

The majority identified needing development in the understanding of indigenous and cultural frameworks and treatments, and how to incorporate these in the assessment process.

Intervention

Most individuals identified themselves as competent in delivering interventions using a whānau-focused approach, and able to coordinate the necessary meetings to ensure young people and whānau receive coordinated care in a timely manner.

Over half of individuals within the Health NZ and NGO workforce reported needing development in skills for specific interventions such as Dialectical Behaviour Therapy (DBT), dynamic psychotherapy, Eye Movement Desensitisation (EMDR), family therapy, infant therapies, interpersonal therapy, Acceptance and Commitment Therapy (ACT), mana enhancing and mana protecting practice and solution-focused therapy.

What are rangatahi telling us about their experience of services?

In 2024, the Youth Advisory team at Whārauraau held seven Deep and Meaningful Conversation (DMC) workshops across the country, with rangatahi aged 16-25 invited to participate. These workshops are designed to amplify the voices of rangatahi in decision-making spaces, with a specific focus on the ICAMH/AOD sector. The workshops were planned in partnership with organisations such as Rainbow Youth, Neurodiversity in Education Coalition, New Zealand National Refugee Youth Council (NZNRYC), and Mind and Body.

Below we provide an overview of participants' experiences with accessing services, and the key attributes that they value in the ICAMH/AOD workforce. The full DMC report is available on the Whārauraau website.

Most participants expressed hesitation in accessing services

Those who were aware of available services often reported hesitation in seeking support, feeling they were not "bad enough" to access help or fearing they might take the place of someone in greater need. This hesitation was compounded by awareness of long wait times, and by negative personal or peer experiences with service access.

Long waitlists and entry criteria were seen as a barrier to accessing services

The experience of waiting for support was described as mentally draining. Some participants shared experiences of being denied access to services because they were not considered at high enough risk. Some were told they could not be referred to a service because they "weren't in crisis," while others spoke about gaining access to support after reaching a "disaster point." These experiences highlighted concerns that the support system sometimes fails to meet the needs of rangatahi, unless they have reached a crisis stage.

Participants spoke of a lack of adequate and available care for those with multiple concerns or diagnoses

This was particularly true for neurodiverse rangatahi, who often felt services weren't equipped to meet their comprehensive needs. A concern for many participants, particularly those who are transgender, takatāpui, or non-binary, was the inconsistent access to gender-affirming care. Participants pointed to under-resourcing and the need for more inclusive healthcare approaches that prioritise autonomy and inclusion.

Participants let us know the key attributes of effective and inclusive support

Participants expressed a strong desire for practitioners who understand their unique socio-cultural backgrounds and lived experiences. They reported frustration when clinicians did not respect their pronouns, mispronounced their names, or lacked knowledge of Te Ao Māori. Some felt more comfortable working with clinicians from the same cultural or ethnic background, while others noted they could work with practitioners from different backgrounds if they showed respect and understanding for diverse identities. Additionally, participants highlighted that practitioners should not assume that a shared demographic identity automatically makes that person the right fit.

Lived experience was valued by participants

Participants said they felt understood and connected when support was provided by those with lived experience, as it created a more empathetic and relatable environment. There was appreciation for practitioners who are willing to listen and learn from lived experiences.

Overview: population, service access and funding

While workforce data allows us to understand the current capacity, composition and capability of the workforce; population and service activity data can contribute to a base understanding of current and future demand for services. This information is important to inform workforce development activities and to ensure the workforce has the adequate numbers to respond to the needs of pēpi, tamariki, rangatahi and whānau, both now and in the future.

In this section, we present data on population, service access activity, and funding expenditure, while recognising that many other measures and indicators are also important for a comprehensive view of current and future service demand.

Population data for 0-19- and 0-24-year-olds: Regional variations, ethnic diversity, and changes over time

National population and projection data gives us valuable insights into the current and future size and composition of Aotearoa's population. Below we present population data for 2023, and population projections for the year 2033 (Stats NZ, 2023).

Health NZ ICAMH/AOD services typically have an upper age limit of 19 years (Health NZ, 2024). Rangatahi over this age would likely be seen by Health NZ adult MH/AOD services. Many NGO/PHOs are funded to see pēpi, tamariki and rangatahi up until the age of 25. Hence, we present separate data for the 0-19, and 0-24 age groups in this report. (Note: Other Ethnicity group in this section includes NZ European/Pākehā.)

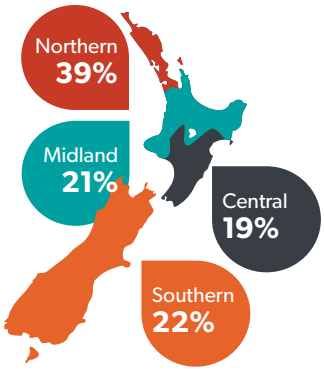
The Northern region had the largest population share of those aged 0-19 and 0-24

In 2023, the population aged 0-19 and 0-24 made up 26 percent and 33 percent of the national population, respectively. The Northern region had the largest proportion of pēpi, tamariki and rangatahi aged 0-19 and 0-24 years old, at nearly double that of the Midland, Central and Southern regions.

Over the next decade, the Northern region is projected to see a one percent increase in the population aged 0-19, and a five percent increase in those aged 0-24. The Midland region is expected to see a three percent increase in those aged 0-24, while the Southern region anticipates a one percent increase in the same age range. The Central region is expected to see a decline across both age groups (Appendix C, Table 1 & 2).

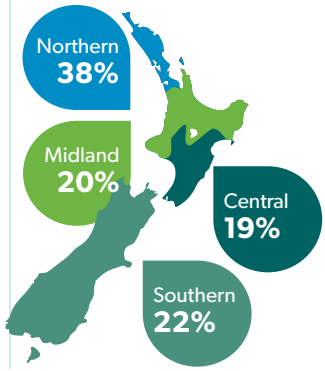
26 percent of Aotearoa's population is 0-19 years

% regional share of 0-19 yr. population, 2023



33 percent of Aotearoa's population is 0-24 years

% regional share of 0-24 yr. population, 2023



Source (both): Stats NZ Population Projections, 2023 update, base Census 2018.

Ethnic diversity in the population is projected to increase

In 2023, Other Ethnicity (which includes NZ European/Pākehā) accounted for the largest population share for both age groups, followed by Māori, Asian and Pacific (Appendix C, Table 1 & 2).

National population projections indicate that over the next decade, the ethnic diversity of pēpi, tamariki and rangatahi aged 0-19 and 0-24 years will increase, with growth projected in Māori and Asian populations. The Pacific population is anticipated to see only a small rise among those aged 0-24, while the Other Ethnicity population is projected to experience a decline across both age groups.

In the Northern region, the Asian population aged 0-19, and 0-24 is projected to surpass the Other Ethnicity group by 2033, while in the Midland region, the Māori population is anticipated to overtake Other Ethnicity population to become the largest population group (Appendix C, Table 1 & 2).

What does this mean for our workforce?

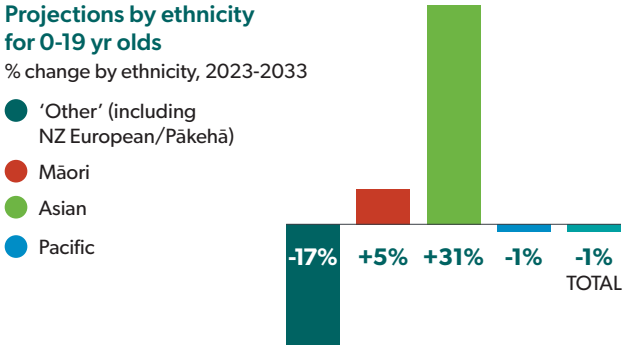
The projected growth in Māori, Asian, and Pacific populations, highlights the importance of regionally tailored workforce planning, particularly in areas that are projected to undergo significant demographic shifts. As Aotearoa's population becomes increasingly diverse, it is essential to equip the workforce with the skills to engage effectively across cultures and

populations. Key strategy documents and action plans highlight the importance of investment into cultural competency training to ensure services are responsive to pēpi, tamariki and rangatahi in Aotearoa (Ministry of Health 2021, Health NZ 2024).

Equally important is the embedding of cultural safety initiatives to address persistent inequities in MH/AOD care, and ensure pēpi, tamariki, rangatahi, and their whānau receive care that is respectful, inclusive, and responsive to their cultural identities.

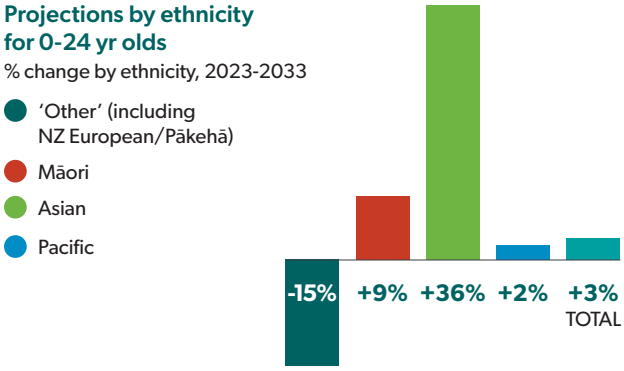
Projections by ethnicity for 0-19 yr olds

% change by ethnicity, 2023-2033



Projections by ethnicity for 0-24 yr olds

% change by ethnicity, 2023-2033



Source (both): Stats NZ Population Projections, 2023 update, base Census 2018.

Service activity | Health NZ, NGO and Access and Choice services

Service access rate data for pēpi, tamariki and rangatahi can help to identify inequities in service access, particularly when comparing rates across different ethnicities and regional areas. However, a full understanding of access to services and the reasons behind variations in access rates would require examining a wide range of interconnected measures, such as referral sources, service type, wait times and number, type and length of care episodes.

In this report we present data on just one of these measures - service access rate data for Health NZ provided services (including forensic, inpatient and community services) and Health NZ funded NGOs. Access rates are calculated by dividing the number of pēpi, tamariki and rangatahi who accessed services within each ethnicity group by their corresponding population.

Health NZ ICAMH/AOD services typically have an upper age limit of 19 years (Health NZ, 2024). Rangatahi over this age would likely be seen by Health NZ adult MH/AOD services. Many NGO/PHOs are funded to see pēpi, tamariki and rangatahi up until the age of 25. Hence, we present separate data for the 0-19, and 0-24 age groups in this report.

There has been an overall decline in access to Health NZ and NGO ICAMH/AOD services

In 2023, 4.2 percent of those aged 0-19 years, and 4.7 percent aged 0-24 years accessed services, with the majority in each age group accessing Health NZ services. This represented a decline in access rates compared to 2021.

Service access rates declined

Access rates to ICAMH/AOD services by service type, 2021-2023

Service access rates (2021-2023)			
Year	Service type	0-19	0-24
2021	Health NZ	3.20%	3.60%
	NGO	1.30%	1.60%
	Total	4.50%	5.30%
2023	Health NZ	3.0%	3.30%
	NGO	1.20%	1.40%
	Total	4.20%	4.70%

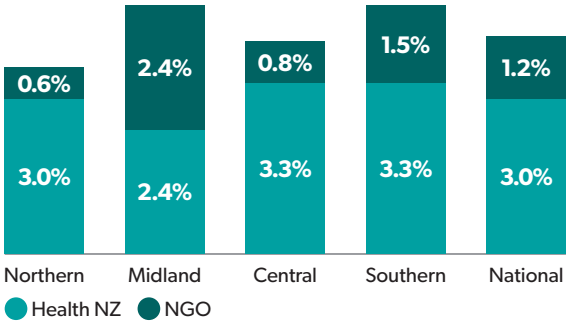
Source: Stats NZ Population Projections 2023 update, base Census 201, and 2021- 2023 PRIMHD.

In 2023, the Midland and Southern regions reported the highest rates of access to services for the 0-19 age group. The Midland region had the highest rate of access to services for the 0-24 age group and additionally had the highest rate of access to NGO services compared with other regions.

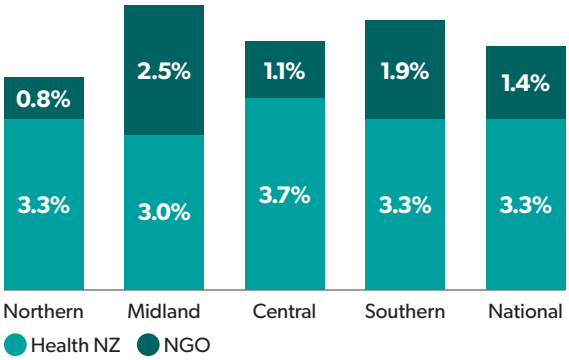
Notably, those aged 0-19 in the Midland region accessed NGO services at the same rate as Health NZ services, the only region to display this trend.

The Northern region showed the lowest rates of access across both age groups, and the lowest rate of access to NGO services.

4.2 percent of 0-19 yr olds accessed services
Access rates by service type and region, 2023



4.7 percent of 0-24 yr olds accessed services
Access rates by service type and region, 2023



Source: Stats NZ Population Projections 2023 update, base Census 201, and 2021- 2023 PRIMHD.

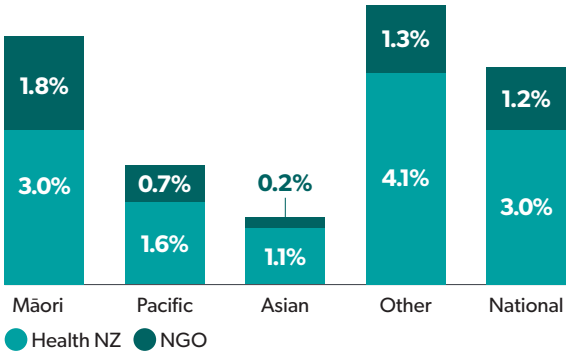
There are variations in service access rates for different ethnic groups

In 2023, access rates to services for those aged 0-19 were highest for Other Ethnicity group (which includes NZ European Pākehā), followed by Māori, Pacific and Asian. A similar trend was evident in the 0-24 age group, though Māori had slightly higher access rates than the Other Ethnicity group.

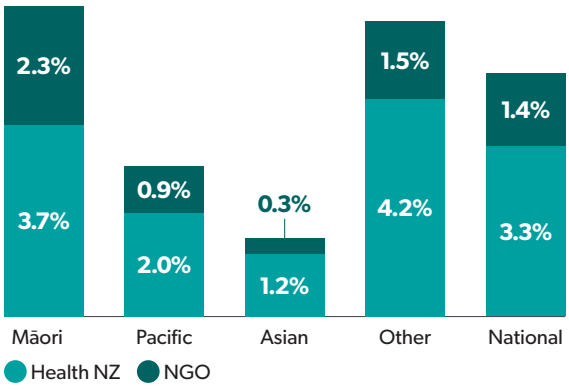
Across both age groups, a higher proportion of Māori accessed NGO services, while Other Ethnicity was most likely to access Health NZ services. Asian pēpi, tamariki and rangatahi had the lowest rates of access to both NGO and Health NZ services across both age groups.

Between 2021 and 2023, access rates declined for all ethnic groups (Appendix D, table 8).

Service access rates for 0-19 yr olds differed across ethnicity groups
Service access rates by ethnicity, 2023



Service access rates for 0-24 yr olds differed across ethnicity groups
Service access rates by ethnicity, 2023



Source: Stats NZ Population Projections 2023 update, base Census 201, and 2023 PRIMHD.

Access and Choice service activity is growing

The Access and Choice programme was developed in response to 'He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction' and was launched at the start of 2020. The programme was established to provide better access to services, aiming to support those with mild to moderate MH/AOD needs who were presenting in primary health settings. A summary of service activity for the youth stream (0-25 years) shows:

- The programme delivered 53,735 sessions in 2023, seeing an average of 2,504 youth each month.
- Those reported as Other Ethnicity represented the highest proportion of new people seen throughout most months in 2023, followed by Māori, Pacific and Asian youth.
- Services most commonly saw tamariki and rangatahi aged 12 to 17 years.
- The uptake of youth services under the programme has increased, with 33,688 sessions delivered in 2022, compared to 33,774 sessions delivered in the first seven months of 2024.

What does this mean for our workforce?

Service activity data highlights an overall decline in service access rates to Health NZ and NGO services, with notable regional and ethnic variations. Data also shows a growing uptake of youth primary mental health services through the Access and Choice programme.

While national population data shows an increasingly ethnically diverse population, access rates for Pacific and particularly Asian tamariki and rangatahi are significantly below those for Other Ethnicities. This warrants further investigation to determine how workforce development activities can ensure services are accessible and equipped to respond to the needs of these groups.

Māori aged 0-24 years accessed NGO services at a higher rate than other population groups. This underlines the importance of the continued expansion of Kaupapa Māori services and investment into the Kaupapa Māori workforce, who are well-placed in the community to support the needs of Māori.

Regional differences in access rates can pinpoint areas where workforce development initiatives are most necessary. Effective workforce planning will ensure that professionals with the appropriate capabilities and skills are available to meet service demands in each region, ensuring these services are provided where they are most needed.

Funding for ICAMH/AOD services, Access and Choice and workforce development

Te Hiringa Mahara released the '2024 Kua Timata Te Haerenga | The Journey Has Begun' monitoring report, detailing Health NZ and Te Aka Whai Ora expenditure on the MH/AOD sector in 2022/23.

Below we provide a summary of this information and further highlight a range of youth-focused initiatives that were funded through the 2019 and 2022 Budgets.

Total expenditure on specialist mental health and addiction services has increased, however varies across service types

- Total expenditure on mental health and addiction services in 2022/23 was about $2.28 billion (this includes expenditure on adult MH/AOD services). This was a 17 percent increase on the 2021/22 expenditure of $1.95 billion. The rise was largely due to an increase in expenditure on services delivered through Health NZ and an increase in delivery in the Access and Choice programme.
- NGO services delivering mental health and addiction services (excluding primary and COVID-19 response services) saw a three percent increase in expenditure from 2021/22, Access and Choice delivery saw a 64 percent increase, and Health NZ hospital and specialist services saw a 20 percent increase.
- Expenditure on Māori teams or services across Health NZ and NGO specialist services was $235.4 million, which represented 10.3 percent of otal expenditure in MH/AOD services in 2021/22. Of this expenditure, 86.3 percent was for services that NGOs deliver (including Kaupapa Māori organisations).

Expenditure on infant, child and youth services represented 10.3 percent of the total annual expenditure on MH/AOD

In 2022/23 expenditure on infant, child and youth services was $233.8 million, a 2.5 percent increase from 2021/22. This growth is lower than the overall 17 percent increase in total MH/AOD expenditure during the same time-period.

Expenditure for specialist Pacific and maternal mental health services decreased

Expenditure between 2021/22 and 2022/23 decreased by 9.9 percent for Pacific services, and 3.7 percent for maternal mental health services.

Funding has been allocated for a range of initiatives to increase access to services

Below, we provide details of several initiatives designed to enhance access to MH/AOD services, with a focus on pēpi, tamariki, rangatahi, and whānau. This information was sourced from the '2024 Te Hiringa Mahara | New Zealand Mental Health and Wellbeing Commission, Budget 2019 to Budget 2022 investment in mental health and addiction report'.

Expanding access and choice of primary mental health and addiction support, including funding for:

- Youth specific primary health services support those aged 12-25 with mild to moderate mental health and addiction needs presenting in primary health settings. This initiative also includes funding for a national Youthline help line.
- Kaupapa Māori, and Pacific community-based services which are available for all ages, providing support that is grounded in cultural values, beliefs, languages and models of care. As of June 2023, there were 32 Kaupapa Māori services and nine Pacific services across the country.
- Workforce development to grow and upskill existing workforces and develop new workforces. This investment funded initiatives including psychology internships, New Entry to Specialist Practice (NESP) nursing places, an eating disorders advisory group, a perinatal mental health workforce development programme, and peer support FTE in specialist services. From the 2022 Budget, $1 million was allocated for workforce development to provide skills and knowledge growth and early career retention in speciality areas, including:
  - Maternal mental health workforce development support.
  - National advanced training framework and support for eating disorder services.
  - Parent–child interaction therapy (PCIT) training in the infant, child, and youth sector.
  - Creation of a workforce development plan for ICAMHs kamahi working with Oranga Tamariki rangatahi and tamariki.
  - Increasing Mātauranga Māori knowledge for eating disorder practitioners working with Māori.

Expansion of specialist youth services for regions in need, including funding for:

- The expansion of specialist ICAMH services in Counties Manukau, Waitematā and Tairāwhiti, through an annual $3.5 million funding boost. Data shows these three regions historically have received lower levels of investment compared to other regions (Beehive, March 2025). Each region has a plan for the additional funding:
    - Counties Manukau plan to establish a dedicated clinical team for children up to intermediate age who have moderate to severe mental health needs.
    - Waitematā plan to fund specialist clinical roles to meet the needs of children with neurodevelopmental issues.
    - Tairāwhiti expects to expand hospital and specialist services to support the mental health needs of rangatahi.
- Increasing capacity in specialist ICAMH/AOD services in collaboration with Oranga Tamariki. The funding is allocated to ICAMH/AOD services with historically lower levels of investment per capita, which include Midcentral, Northland and Hawke's Bay. Funding will go towards Oranga Tamariki social workers in inpatient units, and additional specialist mental health and addiction support in Oranga Tamariki care and protection services.

Enhancing and expanding schools-based services, including funding for:

- The expansion of School Based Health Services (SBHS) for decile five schools (decile one to five schools are funded) with a particular focus on services for populations who are not well serviced by mainstream services, including Māori, Pacific, rainbow, care-experienced, and disabled pēpi, tamariki and rangatahi.
- The expansion of Mana Ake mental wellbeing support for primary and intermediate schools in Canterbury and Kaikōura, and the rollout of the programme in schools across Northland, Counties Manukau, Lakes, Bay of Plenty and the West Coast.

Preventing suicide and supporting people bereaved by suicide:

- Funding has been allocated to expand suicide prevention efforts and responses, including the establishment of a national wellbeing and resiliency service for Asian communities, and two rainbow wellbeing and resiliency services.

Enhancing forensic services for young people:

- Funding has been allocated for additional community-based FTE to support the five regional youth forensic services. A small portion of this funding will go to clinical workers to complete postgraduate studies.

Expenditure on MH/AOD services for pēpi, tamariki and rangatahi as compared to population size

In the 2022/23 fiscal year, 10.3 percent of total MH/AOD expenditure went to ICAMH/AOD services. This appears disproportionate when considering that in 2023, those aged 0-19 and 0-24 represented 26 percent and 33 percent of the population, respectively. However, drawing conclusions from funding versus population size is complex, due to the intricate service provisions and funding arrangements that exist.

In a positive step, the Government has committed funding for a child and youth mental health and addiction prevalence survey to measure the range, proportion, and distribution of mental health conditions among tamariki and rangatahi. (Ministry of Health, 2024). The results of this survey will provide essential information on the type of services and support required to meet the needs of tamariki, rangatahi and whānau, and will be crucial in guiding investment decisions.

Summary and key messages

Our workforce has grown

The 2024 workforce survey showed a 19 percent increase in the total number of Actual FTE positions compared to 2022. Health NZ services saw a seven percent increase in Actual FTE, while NGO/PHO Actual FTE increased by 39 percent (Note: Our 2024 survey was expanded to include Access and Choice youth NGO/PHO services).

Pressures remain because of workforce shortages

Despite the overall increase in Actual FTE, the number of psychologist and psychiatrist FTE decreased. This aligns with workforce feedback which highlighted significant shortages in these disciplines, particularly in rural areas. Difficulty recruiting to these positions was also reflected in the workforce data, with 58 percent of vacant psychiatrist FTE and 50 percent of vacant psychologist FTE remaining vacant for three months or more.

Shortages in these clinical roles have been seen nationwide, with the number of psychiatrists employed by Health NZ falling from 518 to 497 during the two years prior to September 2024 (O'Neill, 2025). Psychiatrists who left their roles within the public mental health system spoke of unsustainable workloads, burnout, workforce shortages and insufficient pay.

Similarly, a 2021 survey on psychologists' experiences of burnout in Aotearoa also pointed to overwork, high caseloads, waitlists, and poor workplace experiences as factors impacting wellbeing, leading many to consider leaving their positions (Blayney & Kercher, 2021).

Expansion of the workforce needs to be sustainable

Health NZ's workforce strategy aims to expand the psychiatry and psychology workforces, and sustainable growth is essential to ensure these workforces are adequately resourced and supported to meet the needs of our pēpi, tamariki, rangatahi and whānau. A reliance on overseas-trained practitioners, as can be seen in the psychiatry discipline, raises considerations about cultural competence and higher turnover rates, as compared to practitioners trained in Aotearoa (Auditor General, 2024; NZ Herald, 2023).

Another important consideration for workforce planning is the aging profile of certain professions. According to the Medical Council of New Zealand's 2024 Workforce Survey Report, the average age of psychiatrists is 55 years, making psychiatry one of the oldest medical specialties in Aotearoa. This trend underscores the need for proactive strategies to ensure workforce sustainability, including succession planning, targeted recruitment, and support for early-career professionals entering the field.

Health NZ acknowledges the urgent need to promote and strengthen pathways into relevant education and training in Aotearoa, focusing on growing domestic training capacity and ensuring there are clear and sustainable career pathways into the ICAMH/AOD sector. There are indications that their planned efforts are progressing with workforce data showing an increase in intern psychology positions. In 2026, the sector is expected to see the establishment of the assistant psychologist training programme which aims to support psychology graduates to advance their careers in mental health, through experience working within ICAMH/AOD services. Health NZ has stated that these roles will receive supervision by registered psychologists, and frameworks to support the establishment of this new role will be developed (Health NZ, 2025).

There was growth in the lived experience workforce

The 2024 workforce data showed an increase in the lived experience workforce (consumer advisors and peer support FTE). This workforce has an important role within the ICAMH/AOD sector, providing valuable support to our pēpi, tamariki, rangatahi and whānau. Participants in the 2024 DMC workshops told us they felt understood and connected when support was provided by those with lived experience (Whāraurau, 2024). Alongside the beneficial support for pēpi, tamariki, rangatahi and whānau, these workforces can be quickly employed in the areas most needed without extensive training pipelines (Auditor General, 2024: Te Hiringa Mahara, 2024). Although no formal registrations or qualifications are required for lived experience roles, it is crucial for this workforce to be supported with training and development opportunities (Te Hiringa Mahara, 2023). Whāraurau has developed resources to support the youth lived experience workforce, including the KaRangaTahi youth lived experience training and supervision tool kit, available on the Whāraurau website.

Wellbeing initiatives are crucial for workforce retention

Staff retention was identified as a significant challenge for the workforce, and teams across the country have responded by implementing various staff retention and wellbeing measures. Such measures include secondment and career development opportunities, further study, mentoring for new staff, and initiatives for wellbeing.

Studies have reported that initiatives to embed wellbeing practices and provide development opportunities at an organisational level can act as protective factors against burnout (Blayney & Kercher, 2021). The World Health Organisation, in its 2025 publication of quality standards for child and youth mental health services, recognised the importance of staff being supported to develop strong therapeutic relationships with young people and whānau. Measures to achieve this included access to professional development, training and supportive supervision, with examples such as peer-group supervision and team away days seen as crucial to maintaining supportive working environments.

Many specialist services across Aotearoa have implemented the Choice and Partnership Approach (CAPA), a clinical service framework that focuses on collaborative care with tamariki, rangatahi and whānau, with a key focus on team relationships (York, A., & Kingsbury, S., 2006). CAPA was acknowledged in our workforce survey as a framework that supports staff wellbeing, through measures that foster collaboration and supportive team environments, with team away days, and peer group supervision seen as key components of the framework.

Comprehensive training and peer networks are essential for practitioners new to ICAMH/AOD

Ensuring that new practitioners entering the ICAMH/AOD workforce receive robust supervision, and foundational training, is essential for safe and effective practice. However, survey respondents highlighted the additional strain this can place on existing teams, who need to balance mentoring responsibilities with their own clinical caseloads.

It is important to provide structured forums where new practitioners, and those looking to upskill, can learn, problem-solve, and build confidence through shared experiences. Initiatives such as peer group supervision and Communities of Practice (CoPs) offer valuable opportunities for cross-disciplinary collaboration, skill development, and ongoing professional support. Te Pou have developed a guide to establishing a CoP for the lived experience workforce, available on their website. Whāraurau facilitates a range of CoPs and hosts practitioner support forums for the ICAMH/AOD workforce.

There is a need to prioritise both cultural competency and cultural safety in workforce development

The need for cultural competency has been consistently highlighted in our Stocktake reports. While population projection data shows an increasingly diverse population, options for Māori, Pacific and Asian pēpi, tamariki, rangatahi and whānau to access culturally specific specialist services are limited (Auditor General, 2024). Survey responses from the Health NZ workforce strongly emphasised the need for cultural training, with gaps particularly highlighted in engaging and working with Asian and Pacific tamariki, rangatahi and whānau.

Cultural safety is also fundamental to addressing inequities in MH/AOD care. A 2024 report from the Youth2000 survey series highlights that Māori, Pacific and ethnic minority youth experience greater mental health inequities compared to NZ European/Pākehā. These disparities have deepened over the past two decades, with increasing experiences of racism and unequal access to healthcare reported. Alongside this, Real Skills Plus data indicates that many in the workforce are reporting a need for development in understanding how to address stigma, and incorporating indigenous and cultural frameworks into assessment practices.

To respond meaningfully to these inequities, organisations must commit to embedding culturally safe practices throughout their operations. Curtis et al. (2019) emphasise that cultural safety involves a critical self-reflection by organisations and practitioners on how their own cultural backgrounds, biases, privilege, and power dynamics influence clinical interactions. Embedding cultural safety means integrating it into every layer of the organisation—including policies, workplace culture, staff relationships, training programs, and infrastructure (Curtis et al. 2025). To ensure these efforts are effective and are focused on achieving health equity, their impact on health outcomes and the broader working environment should be regularly assessed and monitored (Curtis et al, 2019). By acknowledging and addressing these factors, organisations will be able to hold themselves accountable for providing care and support that is equitable and experienced as culturally safe by those receiving it.

Decreased access rates to ICAMH/AOD services amid increasing need requires investigation

Decreases in access to services are concerning given research that points to rising MH/AOD issues in Aotearoa. The 2024 NZ Health Survey reported that those aged 15-24 continue to experience increasing levels of psychological distress and have the highest incidence and prevalence of mental illness compared to other age groups (Ministry of Health, 2024). In 2025, UNICEF reported that the suicide rate for youth in Aotearoa was almost three times higher than the international average for high-income counties (UNICEF Aotearoa, 2025).

It is important to consider how the increased accessibility of new primary MH/AOD services through the Access and Choice programme may be alleviating some pressure on specialist services by providing youth community services without the need for referrals. Despite this, in 2023/24, those aged 0-18 experienced the longest waits for Health NZ specialist mental health services (Te Hiringa Mahara, 2024).

It is vital to deepen our understanding of the factors contributing to wait times for ICAMH/AOD specialist services against a backdrop of decreasing access rates. Rangatahi who took part in the 2024 DMC events shared that long wait times for services can make them hesitate to seek support (Whāraurau, 2024). We heard how workforce shortages are resulting in increased caseloads for clinicians and putting pressure on wait times. We also heard about the rising acuity and complexity of cases, with some respondents highlighting a shortage of skills and knowledge to address the needs of pēpi, tamariki, rangatahi and whānau.

Further investigation is needed into how increasing acuity and complexity of needs, alongside persistent workforce shortages, are impacting the capacity of MH/AOD to respond to pēpi, tamariki, rangatahi and whānau. To ensure the workforce is equipped to respond effectively, a range of targeted measures will need to be put in place to respond. Many of these have been outlined throughout this summary and include:

- Access to peer group supervision, practitioner support networks, and Communities of Practice, which offer structured opportunities for shared learning, problem-solving, and professional development.
- Supervision training for senior practitioners to strengthen leadership and support within clinical teams.
- Foundational MH/AOD training for practitioners, that is responsive to emerging trends and the needs of pēpi, tamariki, rangatahi and whānau.
- Implementation of the CAPA framework. CAPA has a focus on capacity and demand planning, alongside a focus on skill development within teams. Services who have implemented CAPA and maintain fidelity to the key components are able to demonstrate their demand, how they are placed in terms of capacity to respond, and the skill mix that exists within their team.This type of information is valuable from a service and system workforce planning perspective, as it can highlight where pressures might lie.

Glossary of terms

Acronym	Description
AOD	Alcohol & other drugs
CAPA	Choice and Partnership Approach
CBT	Cognitive Behaviour Therapy
CEP	Co-Existing Problems
CoP	Communities of Practice
DHB	District Health Board (former organisations responsible for healthcare within specific geographical areas)
DBT	Dialectical Behaviour Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
FTE	Full Time Equivalent
ICAMH/AOD	Infant, child and adolescent mental health and alcohol and other drug
MH/AOD	Mental health and alcohol and other drug
NESP	New Entry to Specialist Practice
NGO	Non-Governmental Organisation
Pēpi	Infant(s)
PHO	Primary Health Organisation
PCIT	Parent–Child Interaction Therapy
Rangatahi	Youth/young people
RSP	Real Skills Plus
SBHS	School Based Health Services
Tamariki	Child/children
Whānau	Extended family or family group. Can also encompass a broader sense of community and kinship

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