

The logo for NgOIT features a stylized green swirl above the letter 'g'. The text 'NgOIT' is rendered in a bold, green, sans-serif font. Below this, the text '2007 National Workforce Survey' is written in a smaller, teal, sans-serif font.

**NgOIT**  
2007 National Workforce Survey

## Acknowledgements

The Platform team would like to sincerely thank:

The many individuals who took the time to complete the survey and those who encouraged their colleagues to participate

Colleagues from the Ministry of Health Mental Health Directorate for their on going support , advice and sponsorship of this project

Robyn Shearer for her long term championing of workforce issues in the Non Government sector

The HWIP team led by Rebecca Blackmore who assisted and supported this project

Our inspired graphic support

## Executive Summary

This report adds to the growing body of knowledge about non government organisations (NGOs) in New Zealand that contracted to the Crown to provide mental health and addictions services.

The numbers of people employed in the non government mental health and addictions sector is not known but the 2007 NgOIT Workforce Survey collates the results of 1833 individual respondents to create a snapshot of the industry.

Using the knowledge gained from an overview of the effectiveness of some other recent information collections the survey was shaped by the experiences of others and was then constructed to achieve high impact.

By aligning as closely as possible to the data collection model of the national Health Workforce Information Programme (HWIP) and nationally agreed job codes the survey begins to complement the work of other agencies.

The variety of occupations was extensive and demonstrating the wide range of diverse activity that is currently being undertaken by NGOs.

Women are the predominant workforce and the average age of the workforce (44.6years) which is not far from the national average age of 42.2.

The support workforce was by far the largest work group that responded to the survey. This is a critical group that usually have most contact with the people that use services and future service delivery depends on this workforce.

The highest numbers of respondents had been in their job for less than one year; however a significant group (27%) had remained in the workforce for five years or more.

The number of respondents who identified as Maori (19%) compared well with the numbers of Maori in the population (13%). Maori were well represented in all work categories; support work, management and clinical.

The survey asked respondents who were registered as Health Professionals (390) to identify their registration board. The largest group were Nurses (171) with Counsellors (74) and Social workers (52) the next largest groupings. The report suggests that there is more work to do in understanding the roles and ongoing needs of the clinical workforce that are employed within NGOs.

It was surprising to find that 77% of the respondents had undergraduate certificates or diplomas, postgraduate qualifications or degrees. This education level will need to be considered in terms of the training and development requirements that will sustain the NGO workforce.

## Summary of Recommendations

### We recommend:

1. That the mental health and addictions NGO sector be resourced to develop, analyse and report information that will support systemic strategic decision making for funders, planners and the sector. This could be achieved by either of the following options;

A lead agency with the role to interface with all the current workforce programmes to ensure there is consistency of approach to NGO workforce issues.

Or, a specific programme developed by a lead agency to undertake NGO strategic workforce planning and information analysis similar to DHBNZ's HWIP

The role of a lead agency or programme will be to drive and oversee the following 4 recommendations:

**1.1** That further analysis is undertaken that considers existing and emerging roles within support services. This may include consideration of current entry level qualifications and ongoing training and development requirements that sustains the NGO support workforce.

**1.2** That further work is undertaken to understand the roles, long-term impact and ongoing career development needs of registered health professionals who are employed in the NGO workforce.

That the upcoming Ministry of Health review of the HPCA specifically deals with the issues for Health Professionals employed in the NGO sector.

**1.3** That a standard set of NGO workforce job codes be agreed, endorsed and utilised for any future national NGO workforce information collections.

**1.4** That as future information technology solutions for NGO information collection and reporting are developed these also need to include the ability for organisations to electronically manage workforce information.

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# Background

## The Environment

### The NGO Context

In New Zealand there is no single agreed term that fully describes the diverse range of Non Government Organisations (NGOs) that are currently providing services to individuals and families whose lives are impacted by mental illness or addictions. The hundreds of trusts, associations, societies, companies, organisations and agencies all have different historical roots, purpose, legal status, culture and governance structures. They operate with various relationships to their communities of interest and with each other. The terms community, voluntary, not-for-profit, third or independent sector are often used interchangeably.

Throughout this report the generic term NGO will be used to encompass all the sector and this includes for-profit or private providers.

### Mental Health and Addictions NGOs

The last fifteen years have been dynamic and changeable times in the mental health and addictions community sector. They have been the active years of closing psychiatric hospitals throughout New Zealand; the Health system has experienced repeated systemic changes in organisation, administration, funding, purchasing, planning and governance. Community agencies have been through times of support, development and encouragement and times of abandonment; they have been seen as both problem and solution.

### Workforce Information

Ensuring there are enough of the right people with the right skills is a critical element of most of the health systems of the world. Gathering reliable information and understanding what this is telling us about the health and disability workforce that will inform future planning still remains a crucial issue and there is much to learn.

### The workforce strategy documents

of the Ministry of Health, *Tauawhitia te Wero* (2005) and *Te Awhiti* (2006) have identified NGO mental health and addiction services as important to the service system and that more workforce information is needed to plan for a future that needs to support the constantly changing demands in the delivery of health.

Understanding the health workforce is complex and over past years there have been many attempts to achieve a national overview of the health workforce. The different approaches have ranged from national, high level, generic programmes such as the Health Workforce Advisory Committee (HWAC) to sector specific, numbers approach such as Mental Health Workforce Information Project (MHWIP). Both of these examples have now ceased however there still exists a significant amount of national, regional and local agencies and initiatives undertaking disjointed activity in the area of workforce development and information collection.

District Health Boards New Zealand (DHBNZ), an organisation that facilitates and coordinates strategic activity across DHBs, has created *Future Workforce* a strategic plan for workforce development for the public health sector. This is underpinned by Health Workforce Information Programme (HWIP) as a collection framework for health workforce data. Collaboration with HWIP has been and important feature in the development of this report to ensure the collection, reporting and analysis of the workforce information was closely aligned that of the HWIP programme to allow for the possible future cross matching of information.

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### NGO Workforce Information

To date there has been little work that addresses the national workforce information collection of mental health and addictions NGOs. This means that decisions about future funding and service developments are based on government funders having to rely on their personal knowledge or anecdotal information. Without critical pieces of information such as the current gender mix, average age and qualification range to guide decision making, NGOs and government are unable to plan for the needs of the total workforce.



The NgOit 2007 Workforce Survey was undertaken in three distinct parts and each new part built on what had been learnt from the previous task. This developmental method was essential as there was no pre-existing material to inform the approach.

#### The NgOIT 2006 Workforce Project

To increase understanding about workforce issues the Ministry of Health sponsored Platform to engage with NGOs that contract with the Crown to provide mental health and addictions services. This project was in three parts and it built on the initial high level workforce information that had been undertaken by the NgOIT 2005 Landscape survey.

The report of the NgOIT 2005 Landscape Survey was published by Te Pou in 2006 and was the first of its kind - an overview of the NGO landscape from an NGO perspective. The results begin to describe who makes up the sector, what they do and confirmed that the NGOs provide an extensive range of services to a diverse group of people by working with a wide range of Government agencies. The NgOIT 2005 Landscape survey identified that in April 2006 there were 365 NGOs providing services through contractual agreements with the Crown to deliver a diverse range of activity that constitutes mental health and addiction services. These agencies are the main providers of community support and participate in a wide range of activity in mental health and addiction services. The responses indicated that Vote Health is the significant single source of funding for the sector via District Health Boards and the Ministry of Health. However it should also be noted that many other Government funding streams, particularly those of the Ministry of Social Development, contribute to sectors complex funding environment.

#### NgOIT 2007 Workforce Project

**Part One: Review of previous workforce surveys, and workforce data collection to inform the development of the NgOIT Workforce Survey (the complete findings this phase one are attached as Appendix 1)**

Eight recent mental health and addiction workforce surveys were reviewed with the purpose of learning from the experience of others and to inform the development of the 2007 NgOIT Workforce Survey.

The prime interest was the effect of the process used rather than the data that had been collected. The following collection processes and ideas gained from the review were integrated into the Workforce Survey.

- Template development that incorporated engaging questions at the start of the survey and the more mundane (i.e. demographics etc) left to the end.
- A comprehensive communication strategy with NGOs and other parties eg DHBNZ HWIP project, DHB Funding and Planning Managers, workforce site co coordinators, workforce centres and Te Pou about the reason for the workforce survey.
- Development of workforce code sets that are reflected the NGO sector and where possible utilise code sets that have already been standardised and endorsed i.e. HWIP Code Sets, Australian and NZ Standard Classification of Occupations 2005 Context etc.

- Pilot the survey template with NGOs.
- Work with a statistician to examine if the respondents from the NgOIT Survey will meet the criteria for the stratified sampling approach with the key variables.

**Part 2** Develop a workforce survey stock take tool, sampling approach and methodology. (A copy of the final survey template is attached as Appendix 2 and the complete report for rationale of the sampling mix and size is attached as Appendix 3)

Advice was sought from a statistician to find a statistically viable sampling size and mix by utilising the database that had been developed from the NgOIT 2005 Landscape Survey. The advice indicated that the Platform membership represented a sample size and mix for the survey to be statistically validated. However the survey was distributed to all contracted NGOs. As the returns were being received it became evident that the responses from the Platform membership would not achieve 100% and this would compromise the statistical validation of the survey.

This meant that another re-engagement strategy would need to be employed however in discussion with the funder it was decided to use the workforce information already collected to provide a snapshot rather than statistically valid information.

**Phase 3** Produce a final Report

# Methodology - NgOIT 2007 Workforce Survey

## Influence of the NgOIT 2005 Landscape survey

The background mapping work of the NgOit 2005 Landscape survey was vital to the NgOit 2007 Workforce Survey. It had gathered together detailed information that described many of the contracted mental health and addiction NGOs and discussed how information and outcome measures were used. Platform had developed a robust method for collecting and maintaining the data, we were confident of its reliability and used it as the base from which to expand the understanding of the of the community sector workforce.

Responses to the following questions from the NgOit 2005 Landscape survey were used to inform the areas of further enquiry.

*Question 12* What is the total number of staff employed by the organisation as at 31<sup>st</sup> October 2005?

*Question 13:* How many Worked Full Time Equivalentents does the organisation employ as at 31<sup>st</sup> of October 2005 and how many of those Worked Full Time Equivalentents are for the delivery of mental health and or addiction services?

*Question 14:* Does the organisation utilise unpaid staff?

*Question 15:* What is total number of staff that have completed The National Certificate in Mental Health?

It was clear from the responses to these questions that there was a substantial NGO workforce and they were employed in numerous small to medium sized organisations.

Total FTEs employed for mental health and or addiction services	Percent	Size of organisation	No of organisations
Less than 2	19.4%	Very small	45
More than 2, less than 5	28.5%	Small	66
More than 5, less than 10	22.4%	Medium	52
More than 10, less than 50	25%	Large	85
More than 50	4.7%	Very large	11
<b>Total organisations</b>			<b>232</b>

How the information was collected and was the method effective in achieving responses?

What processes were used for analysis and verification of accuracy and how was the information that was collected eventually used?

*What was the benefit to the NGOs of the collection?*

Essentially we were looking for what lessons could be learned from the collection process or ideas we could integrate into the planned NgOIT Workforce Survey.

The results of this review influenced the style and layout of the questions, the communication plan, and the development of workforce occupation codes. It also encouraged careful deliberation about the mode of collection.

The National Certificate in Mental Health (Mental Health Support Work) was created in 1998 as an entry level qualification for support staff working in community organisations and the Ministry of Health has historically provided training grants. Given this investment and the specific nature of the training the intention of the question was get an indication as to the number of staff with this qualification. The organisations that responded to this question (121) reported that 770 staff that held the National Certificate in Mental Health (Mental Health Support Work) were currently employed in the workforce. This was further explored in the NgOit 2007 Workforce Survey.

This qualification only relates to mental health and not to addictions or other service areas.

### Choosing a Method for collecting workforce Information

There were two significant features that determined the nature of the survey.

1. Analysis of the results of the NgOIT 2005 landscape survey identified that there was limited use of integrated client or staff management systems among the organisations that responded. This was not surprising as historically reporting has been driven by input/output service contracts using numerical measures such as number of beds used etc. However, this also meant that few agencies would be able to easily extract data electronically and most organisations have to manually access paper based staff records. The organisational diversity was evident with agencies providing services to a wide geographic area some use decentralised local offices and many operate with minimum administrative support.

It was clear that without electronic staff

management systems it would take considerable time and effort to complete the survey and this would consequently affect the take-up from NGOs.

2. Platform is an NGO industry body and as such is open to sector feedback. Anecdotally we had heard from many community agencies about what they were calling “survey overload”. It seems that they are inundated with requests to complete surveys. Many of these are from various Government agencies about a wide ranging selection of topics. There was general dissatisfaction about the way these are demanded, the amount of time they took and the lack of feedback or results.

## Direct Engagement of the Workforce

To make the collection of information effective, up to date and accurate we decided to go directly to the workforce and ask them for their help to complete the survey. This meant that each member of staff was encouraged to complete the survey either in hard copy or online.

Communication with CEOs and managers urged them to promote the workforce survey within their organisation. The collection design included an organisation code that could be used to provide aggregated data about each organisation's workforce to assist with their own workforce planning. This would enable the national results to be put alongside the organisations responses e.g. number of staff that completed the survey and how the agencies workforce is made up compared to the national picture.

## Survey Results

The following results are based on the collected data from the 1833 individuals that participated in the NgOit 2007 Workforce Survey. These respondents are representative of 210 contracted non government mental health and addiction service providers.

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# Survey Results

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## About Your Current Job

### Job Codes and Categories

Many health workforce programmes use standardised employment code sets often aligned with the Australian and New Zealand Standard Classification of Occupations 2006, District Health Boards New Zealand (HWIP) or the Health Practitioner Index (HPI). Apart from Health Professionals there are limited workforce code sets that reflect the range of staff that are employed in the NGO health and disability sector.

For the survey a standard list of 47 job codes was constructed based on sector knowledge and the activity information that had been supplied by informants to the NgOIT 2005 Landscape Survey. These were divided into the following workforce groups: support services, administration, clinical services, management and complementary/alternative medicine. Respondents were also given the option to specify their own occupation job if none of the categories best described their job.

### Health Professional Registration

Health Practitioners Competence Assurance Act 2005 introduced new process whereby health professionals are required to demonstrate competence annually and mandated registration authorities have responsibility to ensure the quality of health professionals. The impacts of these changes continue to emerge for health professionals employed in the NGO sector e.g. pay equity with those is employed in the Public sector, access to professional mentoring and workforce development.

There is very little information about the numbers and roles of clinical staff working in NGO settings however many are not employed in traditional health a professional roles. “Whilst historically the cost of professional development has been meet by the individual health professional (or at times their employer), expectation and existing, market practice falls back on employers to support health professionals to meet the requirement”. (Health Practitioners Competence Assurance Act and the Disability, Mental Health and Addictions NGO sector (November 2005).

To gather some evidence about the prevalence of health professionals working in NGOs required who are required to be registered under the HPCA respondents were asked to identify the authority they were registered with and also if registration was a requirement of their employment.

### Service Codes

From the NgOIT 2005 Landscape Survey it was evident that mental health and addictions services are not always stand alone and often delivered alongside/within other services e.g. disability support or aged care. Staff may be assigned to specific services within the agency and we were asking respondents what best described their work area from the six provided.

### About Your Education, Training & Skills Education, Training Skills

These questions were designed to overview the qualification base of the industry and identify the highest qualification completed by respondents. Specific work related qualification or training was also canvassed with particular interest about the National Support Worker Certificate (given the earlier comments P above)

### About You Ethnicity

Statistics New Zealand use a comprehensive ethnicity code set, however for the purpose of the survey only the first level of the framework was used. Respondents were also given the option to self identify.






## Total Respondents

### NgoIT 2007 WORKFORCE GROUPS

Management		Support Services			
Business Manager	15	Team Leader	111	Caregiver	49
Chief Executive Officer	31	Executive Assistant	1	Child Care Worker	7
Communication Manager	2	Office Manager	2	Community Develop Worker	18
Consumer Advisor	18	Training Research & Supervision	1	Community Support Worker	406
Corporate Services Manager	1	Health & Social Services Manager	1	Cultural Worker	16
Director	7	Quality Manager	2	Employment Worker	39
Finance Manager	15	Contracts Manager	1	Family Support Worker	34
General Manager	26	Information Consultant	2	Health Promotion Worker	28
Human Resources Manager	10	Hygiene Consultant	1	Home Aides Worker	1
IT Manager	8	Day Care Manager	1	Kaumaturua	8
Operations Manager	19	Data Analyst	1	Maintenance Staff	9
Policy & Planning Manager	8	Events/Marketing Coordinator	2	Peer Support Worker	52
Project Manager	20			Recreation Worker	13
Regional Manager	12	<b>Admin</b>		Residential Support Worker	221
Research & Develop Manager	6	Admin,clerical,secretarial etc	145	Traditional Worker	4
Service Manager	52	Reception	28	Tutor / Educator	48
Residential House Manager	1			Youth Worker	19



Support Services		Clinical Staff			
Housing Facilitator	1	Child Therapist	1	Clinical Coordinator	2
Body Therapist	1	Clinical Psychologist	3	Dual Diagnosis Clinician	1
Employment Consultant	20	Counsellor	82	Clinical Team Leader	1
Vocational Support Worker	12	Dietician	3	Midwife	1
Telephone Peer Support Worker	1	Enrolled nurse	7	Clinical Manager	1
Recovery Worker	1	General Medical Practitioner	5	Senior Counsellor	1
Community Transition Worker	2	Occupational Therapist	11	Specialist Clinician	2
Senior Support Worker	4	Registered Nurse	74	Clinical Worker	3
Music Therapist	1	Psychiatrist	2	Needs Assesor	1
Diabetes Coordinator	2	Psychologist	12		
Group Facilitator	1	Psychotherapist	6	<b>Complementary Staff</b>	
Programme Facilitator	2	Alcohol and Drug Clinician	1	Massage Therapist	5
Paths Community Worker	1	Brief Intervention Counsellor	2	Herbal Therapist	1
Brief Invention Worker	1	Social Worker	33		

	Management	377
	Admin	173
	Support Services	1022
	Clinical Staff	255
	Complementary Staff	6
<b>TOTAL RESPONDENTS</b>		<b>1833</b>

# Total respondents - at a Glance

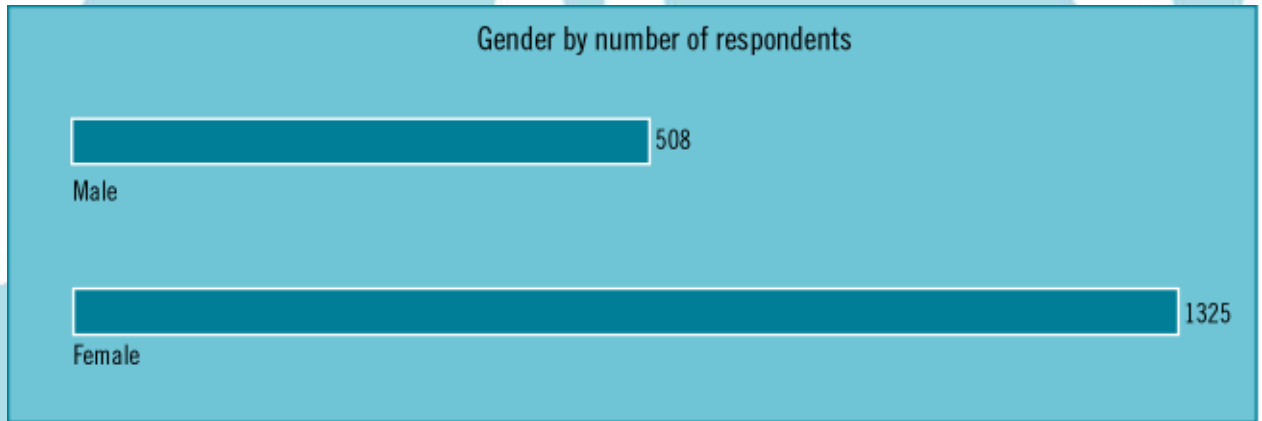
1833 respondents of the survey - the workforce at a Glance

Female 1325	Male 508	Total Respondents 1833
Employee Average Age 44.6 years (country's average – 42.2 yrs)	Ethnic Group of respondents NZ European 63% Maori 19% Pacific Peoples 5%	Average length of employment in NGOs 3.7 years
Largest workforce group Support Services 1022 or 56%	Registered Health Professionals 355	Educational Qualifications
Community Support Worker 406 Residential Support Worker 221 Peer Support Worker 52	Nurses 171 Counsellors 74 Social Workers 52	Bachelors Degree 18% Under graduate Certificate or Diploma 42%

# Survey Responses

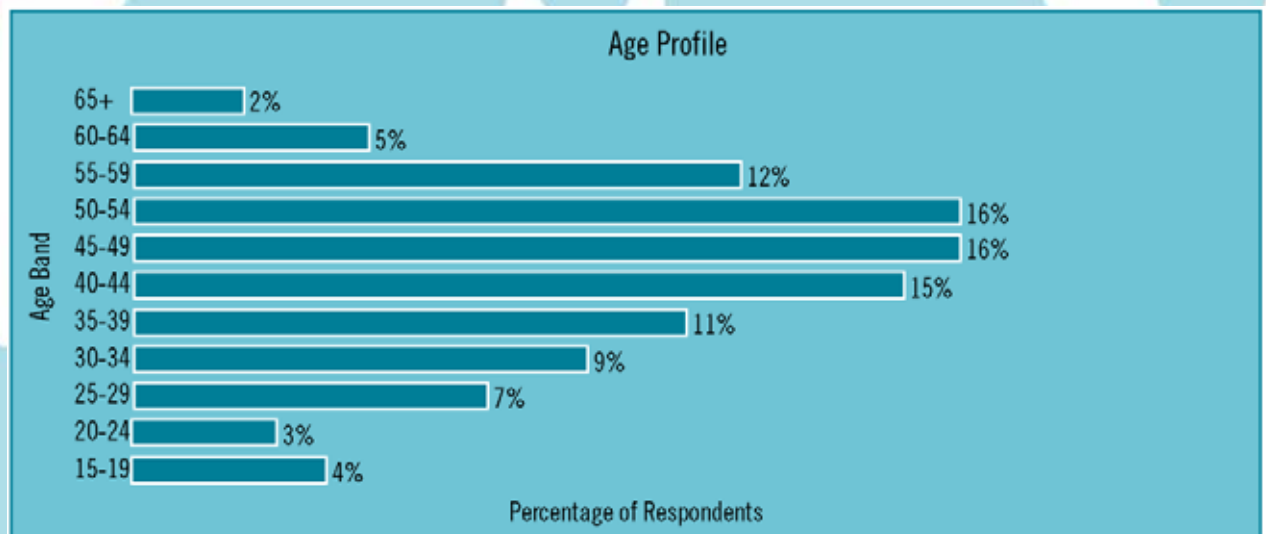
## Gender

- 72% of the 1833 respondents were female
- 28% of the 1833 respondents were male



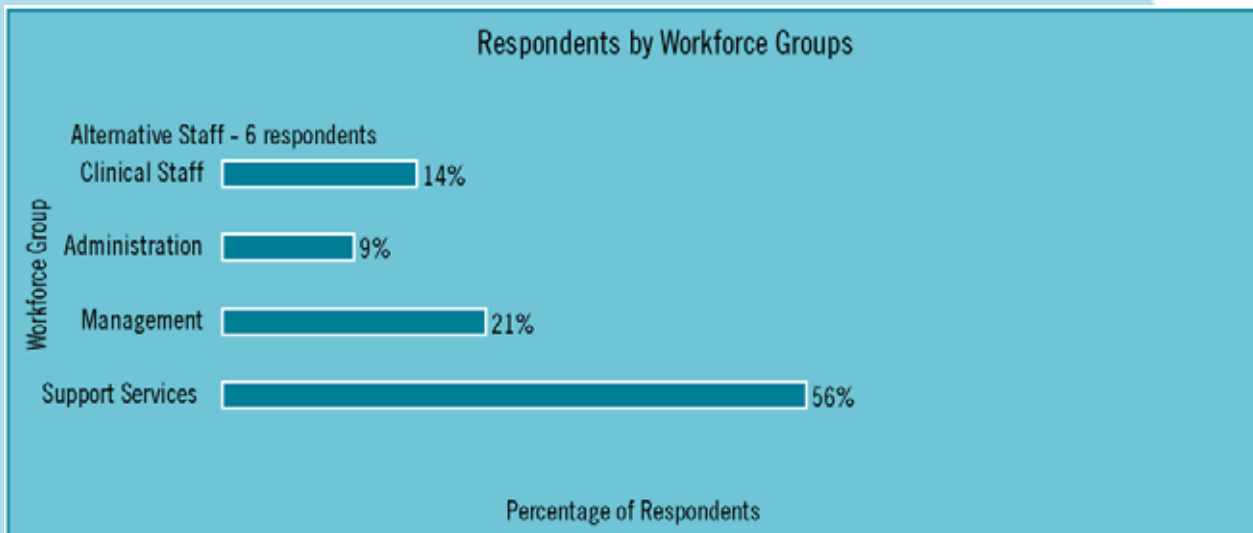
## Age

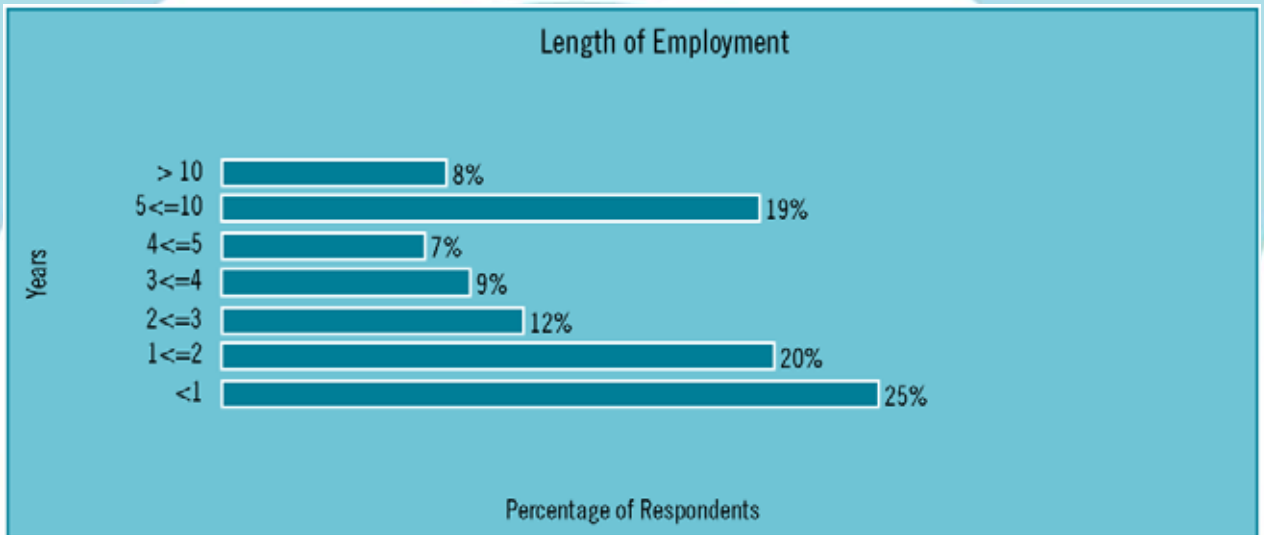
- Statistics New Zealand estimates of the working age population published in its HLFS (Households Labour force Survey) estimates the average working age population is 42.2 years old.
- DHBNZ HWIP (Health Workforce Information Programme) estimate average working age is 43.6 years.
- NgOIT Workforce Survey estimates average working age is 44.7 years. (154 respondents did not provide birth date information)



## Respondents by Workforce Group

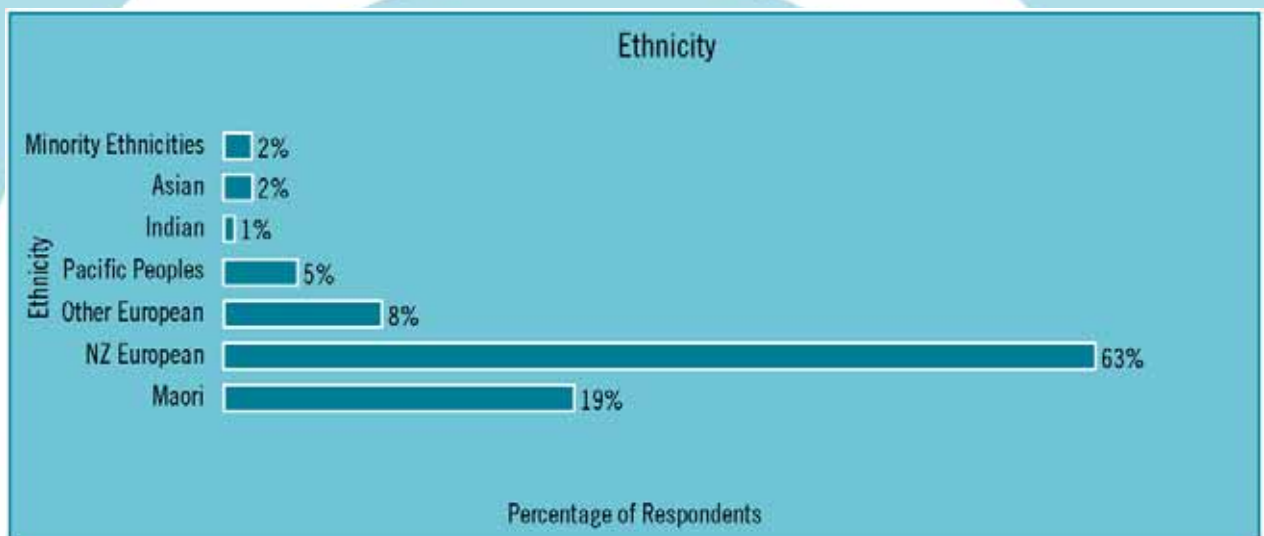
- This graph demonstrates the respondents by workforce group
- Within support services the highest response by occupation was community support worker, residential support worker and peer support worker
- Individual respondents identified a wide variety of specific tasks within the support services workforce sub set e.g. cultural worker, family support worker, health promotion worker, community development worker, diabetes coordinator, tutor/educator and youth worker
- Largest occupational response in the management set was that of Team Leader
- There was a good level of response from Administration staff
- The variety of clinical staff was surprising and included, GP, Psychiatrist, Psychologist, Psychotherapist and a Midwife
- Complimentary therapists included a massage therapist and herbal therapist





### *Estimated Length of Employment*

- The highest proportion of respondents had been in their employment for less than 12 months
- Employment stability is noted with 27% of respondents having been employed for more than five years
- DHBNZ HWIP (Health Workforce Information Programme) estimate average length of employment is 7 years.
- NgOIT Workforce Survey estimates average length of employment is 3.7years. (*19 respondents did not provide employment commencement date*)

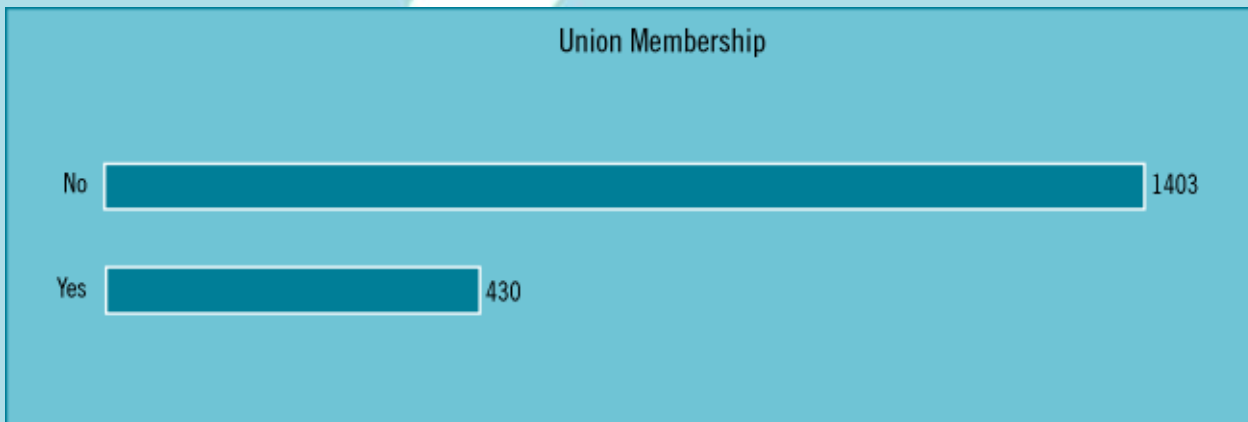


### *Ethnicity*

- 63% of respondents identified as NZ European
- New Zealand Census 2006 estimates Maori as 13.7% of the population, in the NgOIT Workforce Survey 19% of respondents identified as Maori
- New Zealand Census estimates Pacific Peoples as 6.3% of the population the NgOIT Workforce Survey identified 5% of respondents identified as Pacific Peoples

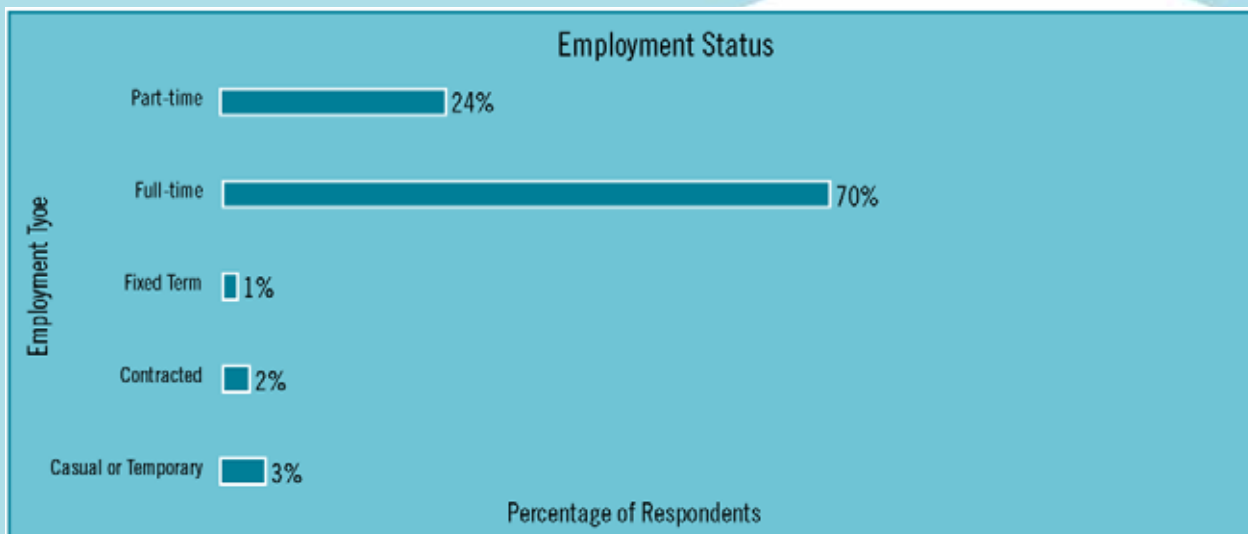
## Union Membership

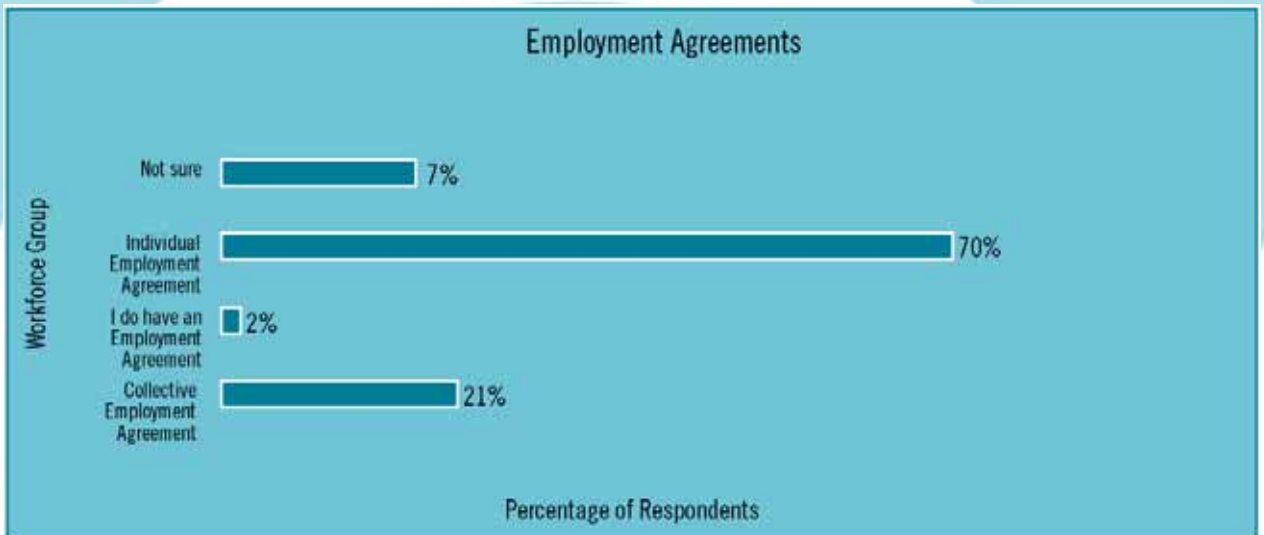
- 23% of respondents indicated union membership
- Union representation appears more significant in organisations that are larger and have been established longer



## Employment Status

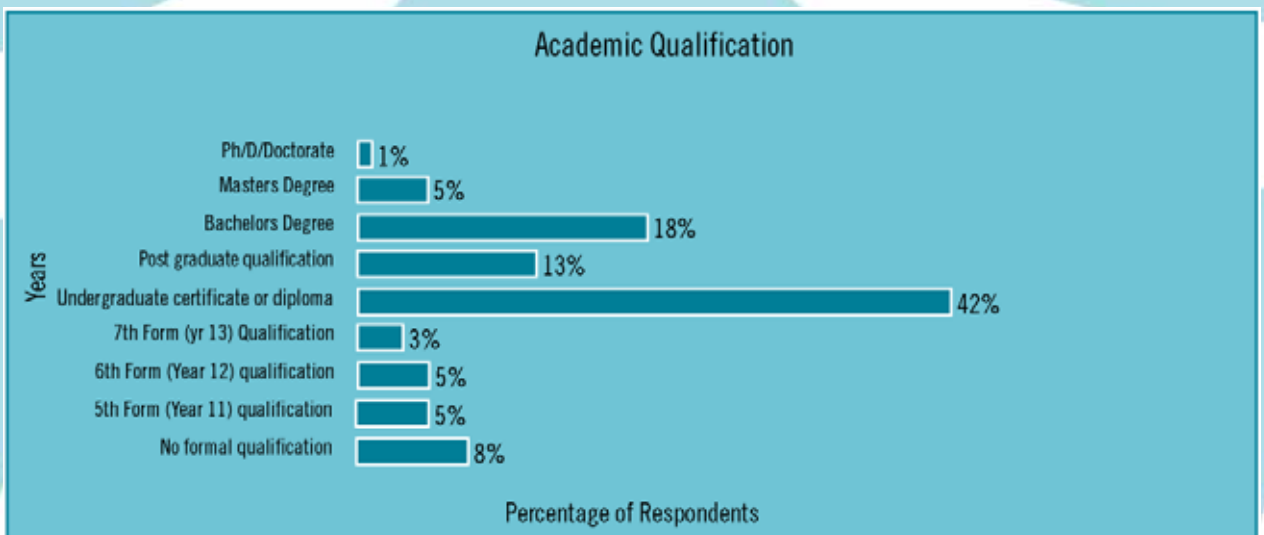
- There appears to be limited utilisation of casual, temporary or contracted staff amongst the respondents





## *Employment Agreements*

- Close to 80% of respondents were aware of the type of employment agreement they were working under

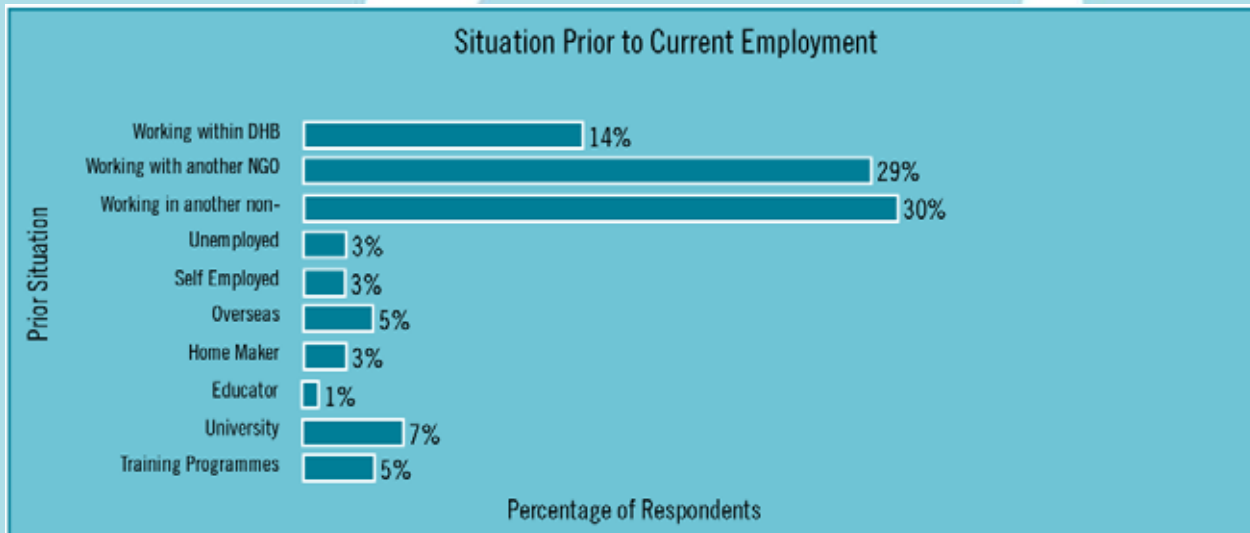


## *Highest Academic Qualifications*

- Undergraduate Certificate and/or Diploma were the highest academic qualification for 42% of respondents (includes the National Certificate in Mental Health (MHSW) L4)
- Bachelor degree 18%, Post Grad Certificate or Diploma 13%
- 8% of respondents said they had no formal qualification

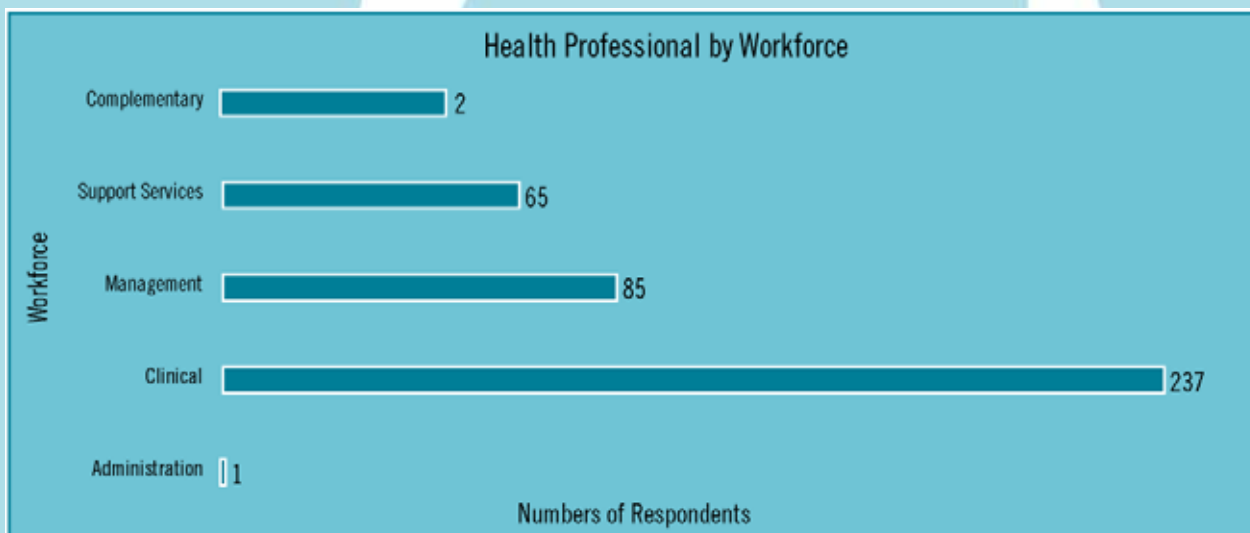
## Prior situation to current employment

- 30% of respondents entering the NGO workforce were coming from working in a non health industry
- 29% of respondents had been working with another NGO health and disability service
- 13% of respondents came from University and training programmes



## Health Professional Registration by workforce group

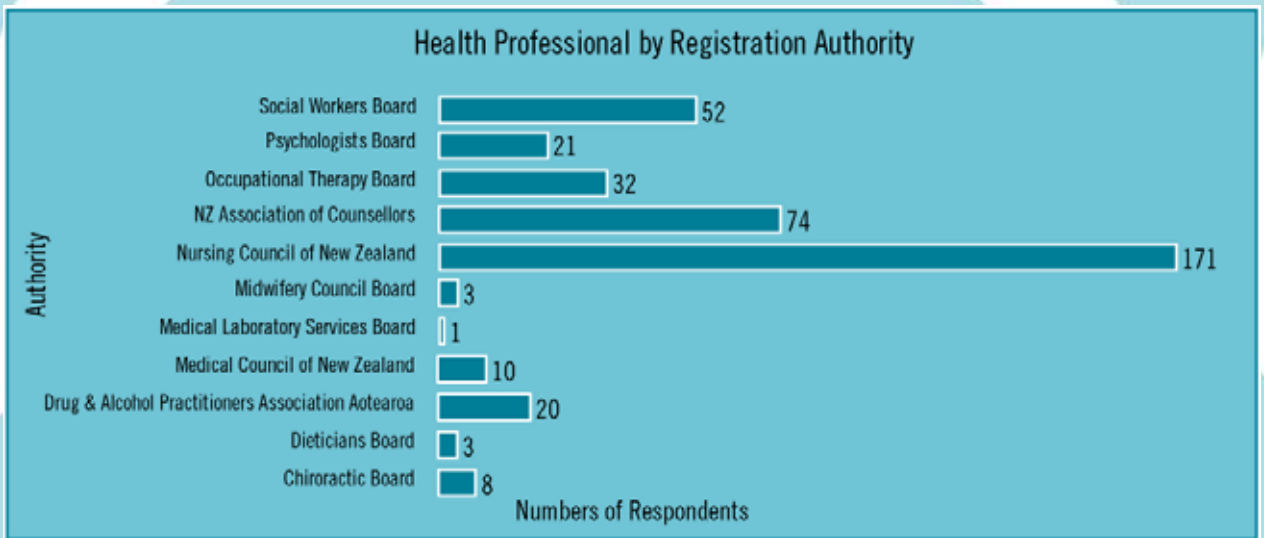
- 390 respondents hold a registration as a health professional
- 17% of respondents who had Health Professional Registration worked in support services, this may however be attributed to the organisational size and definition of occupation
- 22% of management were registered health professionals and of those one quarter were Team Leaders





## by Registration Board

- 126 were Counsellors or Social Workers
- 171 were Nurses



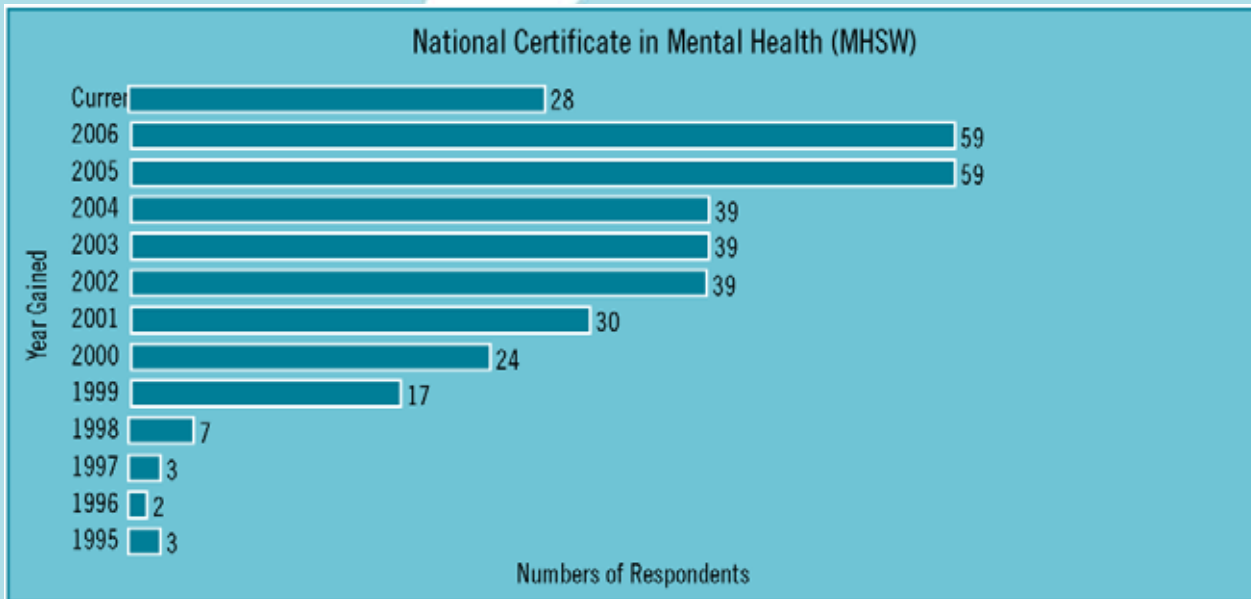
## Registration as a Condition of Employment

- 42% of respondents were required to have registration as a requirement of their employment



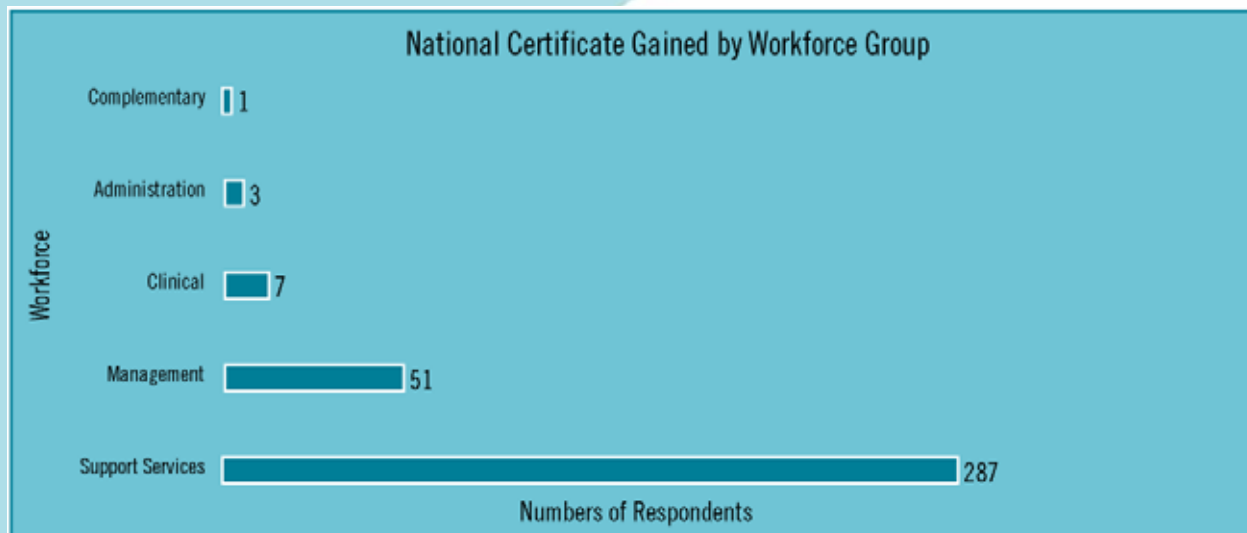
## National Certificate in mental health support work

- This graph indicates the completion dates for the 349 respondents who have completed the National Certificate in mental health (MHSW), this includes 28 who are currently studying (CS)



## National Certificate Completed - by Workforce Group

- 15% of respondents holding management positions had completed the National Certificate in Mental Health (MHSW)



# Survey Responses – Tables

## Respondents by Workforce Groups

The following set of tables show the variables of the data collected and relating that to each workforce group. This information is useful to begin to understand some of the trends that could impact on the future workforce.

## Respondents by Headcount, Gender and Workforce

Table 1.

- Turnover activity appears to be greater within support services and administration however there appears to be significant stability within management.

Workforce	Female	Male	Av Age	Av Length of Employment(Yrs)	Headcount	Proportion
Support Services	711	311	44.6	3.3	1022	0.56
Administration	155	18	42.3	2.9	173	0.09
Management	262	115	46.3	5.1	377	0.21
Clinical Staff	193	62	44.4	3.7	255	0.14
Complementary	4	2	43.1	3.7	6	0.00

Table 2.

- Compared to the New Zealand Census our survey results demonstrate that Maori are well represented across all workforce groups.

Workforce	Maori	NZ European	Other European	Pacific Peoples	Indian	Asian	Minority Ethnicities
Support Services	0.22	0.61	0.07	0.05	0.01	0.03	0.02
Administration	0.23	0.58	0.06	0.06	0.02	0.03	0.01
Management	0.17	0.67	0.09	0.04	0	0.01	0.02
Clinical Staff	0.13	0.67	0.11	0.04	0	0.02	0.04
Complementary							
<b>Total Workforce</b>	<b>0.19</b>	<b>0.63</b>	<b>0.08</b>	<b>0.05</b>	<b>0.01</b>	<b>0.02</b>	<b>0.02</b>
<b>NZ Census</b>	<b>0.13</b>	<b>0.68</b>	<b>0.06</b>	<b>0.06</b>	<b>0.02</b>	<b>0.02</b>	<b>0.03</b>

**Table 3.**

- An average of 25% of the 1883 total respondents had been employed less than one year.
- People who have been employed less than three years, 54% of respondents were in support services, Admin 63%, clinical 54% and management 35%
- People who have been employed more than five years 24% of respondents were in support services, 18% in administration, 41% in management and 25% were clinical staff.

Workforce	<1	1 <= 2	2 <= 3	3 <= 4	4 <=5	5 <=10	> 10
Support Services	0.21	0.21	0.13	0.09	0.05	0.18	0.06
Administration	0.29	0.24	0.1	0.1	0.08	0.15	0.03
Management	0.18	0.15	0.12	0.07	0.07	0.23	0.18
Clinical Staff	0.19	0.24	0.11	0.11	0.11	0.18	0.07
Complementary							
<b>Total Respondents</b>	<b>0.25</b>	<b>0.2</b>	<b>0.12</b>	<b>0.09</b>	<b>0.07</b>	<b>0.19</b>	<b>0.08</b>

**Table 4.**

- This table illustrates the highest qualification of the workforce groups and includes the average age of those respondents.
- Only 8% of total respondents had no formal qualification. This was largely represented in the areas of support services and administration.
- Secondary school education was largely reflected within the administration group.
- 79% of total respondents have a tertiary education qualification
- 77% of respondents within the support services workgroup have a tertiary qualification and of those 15% have a Bachelor's Degree

Workforce	N/F/Q	Fifth Form	Sixth Form	Seventh Form	Under Graduate	Post Graduate	Bachelors Degree	Masters	PHD
Support Services	48.3	46.7	41.3	37	46.1	44	40	42	45
% of respondents	10%	5%	5%	3%	52%	7%	15%	3%	0%
Administration	45.2	45.5	39.1	47.2	41.5	47.2	38.4	42	30
% of respondents	12%	17%	14%	6%	34%	2%	14%	1%	1%
Management	46.6	46.9	46.6	44.2	46.8	48	45	44.9	53.2
% of respondents	3%	3%	4%	1%	32%	21%	23%	11%	1%
Clinical Staff	50	66	50.1	44.9	49.5	41.8	42.3	42.1	42.7
% of respondents	0%	0%	1%	1%	28%	30%	28%	11%	1%
Complementary									
<b>Total Respondents</b>	47.7	46.6	41.9	40	46.1	44.7	41	43.4	45.7
% of respondents	8%	5%	5%	3%	42%	13%	18%	5%	1%

## Recommendations

This survey (and its predecessor the NgOIT 2005 Landscape) builds a solid base of information about non government organisations in New Zealand that are contracted by the Crown to provide mental health and addictions services. These surveys have been developed to respond to specific one-off information requests and have produced “snapshots in time”. There remains a critical need for ongoing systemic approach to information collection about the non government sector that can inform the future planning of mental health and addiction service delivery.

### We recommend:

1. That the mental health and addictions NGO sector be resourced to develop, analyse and report information that will support systemic strategic decision making for funders, planners and the sector. This could be achieved by either of the following options;

A lead agency with the role to interface with all the current workforce programmes to ensure there is consistency of approach to NGO workforce issues.

Or, a specific programme developed by a lead agency to undertake NGO strategic workforce planning and information analysis similar to DHBNZ’s HWIP

The role of a lead agency or programme will be to drive and oversee the following 4 recommendations:

The support workforce was by far the largest work group that responded to the survey, this is a critical group that usually have most contact with the people that use community services. The National Certificate in Mental Health (Mental Health Support Work) was created in 1998 as an entry level qualification for staff working in the newly developing NGO sector. This survey (whilst not a full representative of the sector) indicates that 28% within the support workforce have the certificate. There is a need for further knowledge and analysis in this area

### We recommend:

2. That further analysis is undertaken that considers existing and emerging roles within support services. This may include consideration of current entry level qualifications and ongoing training and development requirements that sustains the NGO support workforce.

The Health Practitioners Competence Assurance Act (2003) introduced the registration of Health professionals and much of the activity in this area has been targeted to the District Health Boards (where most health professionals are employed.) This survey indicates however that a growing number of health professionals employed in the NGO sector. The range of activity undertaken by health professionals in the sector, the compliance costs or comprehensive ability to meet the ongoing professional development requirements are areas that are not well understood.

**We recommend:**

3. That further work is undertaken to understand the roles, long-term impact and ongoing career development needs of registered health professionals who are employed in the NGO workforce.

That the upcoming Ministry of Health review of the HPCA specifically deals with the issues for Health Professionals employed in the NGO sector.

There are limited workforce code sets that reflect the range of staff that are employed in the NGO health and disability sector. For the survey a standard list of job codes was constructed based on sector knowledge and the activity information that had been supplied by informants to the NgOIT 2005 Landscape Survey.

**We recommend:**

4. That a standard set of NGO workforce job codes be agreed, endorsed and utilised for any future national NGO workforce information collections.

Information collection and reporting within the NGO sector can vary from organisations that have highly sophisticated IT systems to those who are solely paper based. The methodology applied to this survey was as a direct response to the limited use of computerised human resource systems within the NGO sector.

**We recommend:**

5. That as future information technology solutions for NGO information collection and reporting are developed these also need to include the ability for organisations to electronically manage workforce information.

# Appendix I

Overview of recent surveys and data collection to inform the

 **NGOIT** Workforce Programme

October 2006



## Executive Summary

Platform reviewed eight recent mental health and addiction workforce surveys in preparation for the an information collection in the form of a workforce survey/stock take of the NGO sector that will assist in the implementation of Te Kōkiri<sup>1</sup>, Tauawhitia te Wero<sup>2</sup> and Te Awhiti<sup>3</sup>. The purpose of reviewing previous workforce surveys was to learn from the experience of others and to inform the development of the NgOIT Workforce Survey.

Comparison between surveys was difficult because no standardised FTE or workforce code sets definition were used. This meant it was not possible to compare information or trends.

There has been substantial work completed over many years on agreeing job role descriptions, workforce data definitions and code sets for the DHB and regulated workforce (e.g. HISO 10006 Health Practitioner Index Code set [www.hiso.govt.nz](http://www.hiso.govt.nz) ). No such body of consistent information standards exists for NGO workforce activity or occupational groups.

The limit of organisational HR information systems made it difficult to extract workforce data.

One-off surveys are often costly and the information soon goes out of date. They tend to have a low response rate and capture a narrow perspective of the workforce.

The capability of the individuals who were designing and analysing the data was variable. It was difficult to determine the statistical validation of the survey methodology.

Most of the surveys undertaken had limited access to NGOs or pre-existing relationships with them and this limited the ability to engage or verify information.

The inadequate NGO information held by MHINC was commented on.

DHBNZ Health Workforce Information Programme Business case November 2005 states there are only two ongoing health workforce surveys operating on a regular basis: the NZ Workforce Statistics (NZHIS) Service Reporting (SSSG) neither of which address NGO (un-regulated) workforce.

Surveys on line were offered but it was evident that hard copy was the most preferred way of completing surveys. Telephone prompting and follow up increased survey response rates. Effective communication strategies were highlighted as increasing the success of returned surveys.

The use of simple technical solutions (e.g. excel wizards) assisted and simplified the collection of workforce information.

NGOs reported that they had been over surveyed however this concern was lessened when face to face contact was added.

Very few of the surveys reviewed have been published or made available to the sector that contributed to them.

<sup>1</sup> Te Kōkiri The Mental Health and Addiction Action Plan 2006-2015 Ministry of Health 2006

<sup>2</sup> Tauawhitia te Wero Embracing the Challenge National mental health and addiction workforce development plan 2006-2015 Ministry of Health 2005

<sup>3</sup> Te Awhiti National Mental Health and Addictions Workforce Development Plan for and in support of Non Government Organisations 2006-2009

There was no relationship, collaboration or even sharing lists of organisations between surveys even those funded by the same agency (e.g. Te Rau Matatini and Werry Centre)

Whilst there has been much activity in workforce information collection most of the surveys conducted in the past few years have not specifically looked at the NGO mental health/addiction workforce. In some instances the NGO mental health/addiction workforce is referred to, but there has not been a survey designed and targeted specifically for the New Zealand NGO mental health/addiction workforce.

### Recommendations for the NgOIT workforce programme

Template development needs to incorporate engaging questions at the start of the survey and leave the more mundane (i.e. demographics etc) until the end.

Implement a comprehensive communication strategy with the selected NGOs for the workforce survey including relevant stakeholders i.e. DHBNZ HWIP project, DHB

Funding and Planning Managers, workforce site co coordinators, workforce centres and Te Pou.

Develop and agree minimum workforce code sets that are reflective of the NGO sector and where possible utilise code sets that have already been standardised and endorsed i.e. HWIP Code Sets, Australian and NZ Standard Classification of Occupations 2005 Context etc.

Pilot the survey template with NGOs.

Undertake face to face interviewing to collect workforce data, it is not known if any organisations have the capacity to transmit workforce information electronically via their HR software systems.

Investigate the practicality of utilising an excel wizard application for the collection of workforce data and technical specifications required to do this.

Engage a statistician to examine if the respondents from the NgOIT Survey will meet the criteria for the stratified sampling approach with the key variables.

## Background

Ensuring there are enough of the right people with the right skills is a critical element of most of the health systems of the world. Understanding the health workforce in New Zealand has been challenging and over the past years there have been many attempts to understand how to achieve a national health workforce overview. The approach has been variable and range from national high level and generic programmes such as the Health Workforce Advisory Committee (HWAC) to sector specific numbers approach such as Mental Health Workforce Information Project (MHWIP). There has also been a wide range of local and regional variations. Collecting reliable information about the health and disability workforce that can be used to inform planning for future workforce developments still remains a crucial issue and there is much activity in this area.

To date however there has been little work that addresses the national workforce information needs of mental health and addictions non government organisations (NGOs). Recent National, Regional and local strategic plans have identified that the NGO mental health and addiction services is an important part of the service system and more workforce information is needed to plan for a future that needs to support the constantly changing demands in the delivery of health.

## Platform and the Ministry of Health

Platform and the Ministry of Health have experience of working together to improve our collective understanding of the non government mental health and addictions sector. Platform has agreed with the Ministry to undertake a project that will focus on the NGO workforce.

## Project Objectives for Phase One

- To undertake a survey/stock take and collect information and data that will assist in the implementation of Te Tahuhu, Tauawhitia te Wero – The National Mental Health & Addiction Workforce Development Plan 2006 – 2009 and Te Awhiti - The National Workforce Development Plan for the NGO Mental Health and Addiction sector
- To obtain a ‘snap shot’ of the NGO mental health and addictions workforce, (including numbers of workers) that will provide a baseline against which future workforce development may be measured
- To establish a reference group

## Review of previous documentation

The initial task was to review previous workforce surveys, work completed by workforce programmes, information collection processes and utilise this process to inform the development of the NgOIT Workforce Survey.

The following documentation was suggested:

- Mental Health Workforce Information System (MHWIS) Document (utilise agreed definitions that were developed through this project)
- Health Practitioner Index (HPI) Data Set and Code Set Health Information Standards Organisation (HISO)
- Australian and NZ Standard Classification of Occupations 2005 (utilise occupation definitions)

The following agencies were known or thought to have undertaken some workforce surveys recently and were canvassed

1. The Werry Centre
2. Te Rau Matatini
3. Mental Health Workforce Development Programme
4. DHBNZ
5. Mental Health Commission

Additionally it was known that the following agencies had also undertaken some work in this area.

6. Central TAS
7. Counties Manukau DHB
8. Nelson/Marlborough DHB

#### Note:

we have not included the work Platform has undertaken as part of the NgOIT report as this is dealt with by a separate report.

#### Purpose

The purpose of the review was to learn from what has already been done and how that might compliment the project. Our prime interest was the process that had been used rather than the data that had been collected. We were interested to know how the information was collected and was the method effective in achieving responses. What processes were used for analysis and verification of accuracy and how was the information that was collected eventually used. What was the benefit to the NGOs of the collection? Essentially we were looking for what lessons could be learned from the collection process or ideas we could integrate into the planned NgOIT Workforce Survey.

## Background to Workforce Standards

### Mental Health Workforce Information System (MHWIS)

This was an earlier project (2002) undertaken by DHBNZ in partnership with the Ministry of Health and District Health Boards to address the issues of consistency of workforce information collection. This work informed the current workforce data definitions and collection processes, it also lead the way for the utilisation of

‘wizard’ type applications. However very little of the material was available to review. The experiences from this project provided the building blocks for the 2005 Health Workforce Information Programme (HWIP) sponsored by DHBNZ.

### Health Practitioner Index (HPI)

This is a central source of core information about all health practitioners who are registered under the Health Practitioners Competency Assurance Act (2003) and provides agreed occupational data definitions.

### Australian and NZ Standard Classification of Occupations 2005

These are data code sets that describe occupational groups and information relating to workforce to ensure consistency when collecting and reporting workforce information from a variety of sources. This is critical if information is to be compared. New Zealand submits data internationally and therefore needs to work to agreed standards and definitions.

### Health Information Standards Organisation (HISO)

HISO is an organisation whose role is to engage with the health and disability sector in NZ to strategically manage the development of health information standards. In relation to workforce the HWIP programme is currently having its workforce data definition standards endorsed by HISO. This standardisation is essential to enable regional and national descriptions of the workforce.

### Summary

It is critical that any workforce data collected within the NGO sector complies with the national workforce standards set by the governing agencies.

# Review of Recent Workforce Surveys

## 1. The Werry Centre

Dept of Psychological Medicine  
Private Bag 92019  
Auckland  
www.werrycentre.org.nz

### Introduction:

The Werry Centre for Child and Adolescent Mental Health is contracted by the Ministry of Health to undertake workforce development within the child and adolescent mental health sector. It is housed within the Department of Psychological Medicine in the Faculty of Medical Sciences, University of Auckland and undertakes:

- Workforce development for the child and adolescent mental health sector
- Teaching in child and adolescent mental health
- Research in the child and adolescent mental health field

### Project

#### *Stock take of Child and Adolescent Mental Health Services in New Zealand*

The overall goal of the project was to conduct a national stock take of child and adolescent mental health services that would inform the Ministry of Health's strategic plan for child and adolescent mental health workforce development. The Mental Health Information National Collection (MHINC) was identified as the most relevant source of information for this project. NGOs that were contracted by District Health Boards to provide services to children and adolescents (0-19 yrs) were identified from Ministry of Health Price Volume Schedules and were asked to provide the following information:

#### Funding

Other Sources of Revenue  
List & Description of Service Teams and the age group for which they provide services  
Actual FTEs by Occupational group (clinical and non clinical groups)  
Actual Vacant FTEs by Occupational group  
Ethnicity (Maori, Pacific, Asian, Maori & Pacific) of staff (head count) by occupational group  
Resignations & Transfers within the service by occupational group  
Staff salaries by occupational group  
Years of child and adolescent mental health experience since qualification by occupational group  
Access criteria  
Additional feedback or comments

### Comments

80 NGO organisations were identified, 62 responded and 58 responses were analysed. Limitations to the survey included the lack of NGO data captured by MHINC. Lack of researcher time to follow up with the NGOs

## 2. Te Rau Matatini

P O Box 12175  
Palmerston North  
www.matatini.co.nz

### Introduction

Te Rau Matatini is a national Mori Mental Health development organisation funded by the Ministry of Health since 2002 to ensure that tangata whaiora have access to a well prepared and well qualified Mori Mental Health workforce. Te Rau Matatini contributes to Mori Mental Health Workforce Policy development nationally and regionally and promoting career opportunities in mental health for Mori. In the past three years, Te Rau Matatini has produced Workforce Profile II - An Extended Analysis of the Mental Health Workforce (Dec 04) and the unpublished Hapainga Manukura NGO Management & Leadership Training Survey Report (Feb 05). Both documents incorporate surveys of organisations providing mental health services to Maori.

### Project

#### *WORKFORCE PROFILE II An Extended Analysis Of The Mental Health Workforce (Dec 04)*

Conducted in 2002 this was a national survey of the Mori mental health workforce. The survey was distributed by mail to over 300 providers of mental health and addiction services throughout Aotearoa, to both DHB providers and NGO services. The survey was further available online to respondents able to access the Te Rau Matatini website during data collection.

A total of 586 respondents were generated by the survey.

Those respondents working for NGO services totalled 202 (38%), whilst 259 respondents (49%) worked for DHB provider services.

The most commonly identified role of all survey respondents was community workers (42%), with 55% (n=112) of NGO staff and 29% (n=75) of DHB provider staff identifying this as their role. Of the NGO staff, counsellors (n=18, or 9%) and other roles (n=29, or 14%) were also commonly identified.

**Hapainga Manukura NGO Management & Leadership Training Survey Report (unpublished report Feb 05)**

This report presents the findings of a Te Rau Matatini led, Maori non-government organisations (NGOs), managers and governance board members' 2004 leadership training needs survey.

103 Maori NGO providers were sent copies of the survey, 56 providers responded completing a total of 72 surveys. 45 respondents returned surveys via postal means, a follow up phone call generated a further 27 survey responses.

#### Comments:

There was a larger up take by DHBs than NGOs. A communications company was employed, this was helpful. They also used media releases, local community networks and radio stations.

Ministry of Health information was used (not MHINC) and the survey was distributed to approx. 3,000 providers. Organisations were then screened out in terms of their applicability. Telephone follow up was important and even though an on-line option of completion was given, hard copy was the most preferred.



### 3. Mental Health Workforce Development Programme (Te Pou)

Mental Health Programmes  
PO Box 108244  
Symonds Street  
Auckland  
www.tepou.org.nz

#### Introduction

The Mental Health Workforce Development Programme's goals are

- To promote a nationally coordinated approach that builds mental health workforce capacity and capability so services meet the recovery needs of adult mental health consumers.
- To inform evidence-based workforce development policy and implement workforce development initiatives.
- To provide a transparent workforce development initiative administration mechanism.
- To provide systematic evaluation of workforce initiatives to promote effectiveness, efficiency and dissemination of information

#### Project

##### *Service User / Tangata Whaiora Workforce Survey*

“By 2010 people with experience of mental illness will be a skilled, powerful, pervasive and openly identified part of the mental health workforce in New Zealand.” Service User Workforce Development Strategy Mental Health Commission (2005)”

The Service User Workforce Development Programme conducted an email survey to find out about the service user workforce; how many service users are working in the sector and what kinds of work they are doing.

The survey asks nine questions seeking basic information about the worker. This survey went out to roughly 125 people in DHBs, NGOs and other organisations. All existing consumer networks were canvassed and a hard copy of the survey only provided if requested.

#### Comments

This survey was targeting at the mental health/addiction sector, but not specifically the NGO workforce. No formal methodology was applied therefore it is difficult to determine the challenges or success of the survey process.

There was no follow up and the results are yet to be analysed.

## 4. District Health Boards New Zealand (DHBNZ)

P.O. Box 5535  
Wellington  
www.dhbnz.govt.nz

### Introduction

DHBNZ was formed by all 21 District Health Boards in December 2000 to provide a sector group through which DHBs could coordinate their activities at a national level on selected issues.

### Project:

Health Workforce Information Programme (HWIP)

DHBNZ has taken on the task of compiling information on the whole of New Zealand's health workforce. In the HWIP–Business Case, the following is stated about the programme:

- DHBNZ will provide credible workforce information, analysis and decision support outputs to meet agreed *Future Workforce*<sup>4</sup> and other agreed user requirements;
- Continuously improve existing workforce information collections improving the quality of data at source
- Fill agreed workforce information gaps
- Provide networked analytical support
- Enhance sector information and analytical capability

### Comments

The focus of HWIP to date has been on the DHB workforce and data has been collected and analysed using a number of methods that will be of interest of the roll out of the NgOIT workforce project. HWIP has not yet addressed the NGO workforce which is known as the *non regulated* workforce (i.e. occupations not regulated by the Health Practitioners Competency Assurance Act (2003)).

Discussions are in place with the Ministry of Health, Platform and DHBNZ to support DHBNZ to have an active role in the NgOIT workforce survey as there is shared interest in the outcomes.

DHBNZ has not undertaken data collection or surveys specifically of the mental health/addiction NGO sector.

<sup>6</sup> Future Workforce is a strategic plan that focuses collective priorities and actions for workforce development over the next five years.

## 5 Mental Health Commission

P O Box 12479  
Thorndon  
Wellington  
[www.mhc.govt.nz](http://www.mhc.govt.nz)

### Introduction

The Commission's specific functions are defined by the Mental Health Commission Act 1998. There are three key functions:

- monitor and report to Government on the performance of the Ministry of Health and District Health Board in the implementation of the Government's National Mental Health Strategy
- work with the sector to promote better understanding by the public of mental illness, and eliminate discrimination
- strengthen the mental health workforce.

The Commission has the flexibility to undertake whatever tasks are required to meet its responsibilities. This includes reviewing, examining and reporting back to the Minister on the status of the mental health system, the progress being made toward achieving the mental health strategy and finding out what barriers are preventing the objectives being reached.

### Project

The commission undertakes a quarterly workforce survey of DHB providers capturing the mental health workforce capacity and levels of unfilled positions across the country. This information is collected via an excel wizard which is aggregated and analysed by the Commission.

### Comment

There has been little NGO workforce activity undertaken by the mental health Commission.

The other activity the Commission has recently undertaken is a mental health NGO sustainability report which surveyed a number of NGOs.

This report has yet to be published.

## 6. Central TAS

P O Box 23075  
Wellington  
www.centraltas.co.nz

### Introduction

Central Region Technical Advisory Service (known as TAS) was established in June 2001 as a shared support agency for six District Health Boards: Capital & Coast, Hutt Valley, Wairarapa, MidCentral, Whanganui, and Hawkes Bay. TAS supports DHBs with health information, service planning, and external service audit functions.

### Project

*The Central Region Workforce Profile* was initiated to obtain an accurate picture of the whole of the health workforce in the Central Region. This included DHB, PHOs, NGOs and Disability Support Services.

CRTAS stated the following prior to carrying out the survey.

[The survey process] will include the provision of paper and web-based surveys, with follow-up by telephone and email and for some organisations there will be face-to-face contact with project workers to assist with the completion of surveys. Workforce information currently available through electronic systems will also be gathered from DHBs and some large NGOs.

Survey respondents also had the chance to win one of three prizes for filling out the survey.

### Comments

Five DHBs and 350 health and disability NGOs were identified to participate in the survey. These organisations were also responsible to distribute the individual survey to their employees resulting in more than 3000 individual employee responses.

The focus of the project was to obtain numbers and characteristics of the current Maori workforce.

The survey achieved a 100% response rate from the organisations identified and a 28% response rate from the employee survey. The main themes of the survey were; education and training, job satisfaction, working environment and other issues that included bullying, cultural awareness, mental health and GP concerns.

The project Team contacted the CEO/Managers of the organisations advising that the survey was on its way. A presentation was included in the survey packs to organisations explaining the purpose, process, results and benefits of the survey.

The survey was paper and web based with follow up via telephone and e-mail. Prizes were offered for the individual employee survey.

Not all organisations could provide a detailed breakdown of their staff as per the organisational form due to the labour intensive requirement to complete this part of the survey.

Individual surveys from the mental health and addiction NGOs achieved a 25% response rate or 208 individuals.

Respondents commented that it was beneficial having the project workers onsite when completing the survey.

The completion of the web base survey for both the organisation and individual survey rated a very low response rate, paper based or on site assistance was preferred from respondents.

The Project Team noted the importance to have an effective communication strategy in place to promote and support the survey process and collection period. It was suggested that the future workforce information collection and maintenance be electronically based into existing organisational HR systems i.e. excel wizard.

Survey was sent out as a hard copy but it was also possible to complete it on line however this was mainly completed by health professionals.

The project experienced a low response from mental health and addiction NGOs some of whom who advised they were being over surveyed.

This survey, although extensive, was for one specific region of the country. It was not specifically targeting mental health/addiction NGOs; its scope did include mental health/addiction NGOs.

## 7. Counties Manukau DHB

Private Bag 94052  
South Auckland Mail Centre  
www.cmdhb.govt.nz

### Introduction

CMDHB hold contracts with 16 NGOs delivering services locally and throughout greater Auckland. A total of 41 NGOs deliver mental health and alcohol and drug services for the people of Counties Manukau (some of which are contracted by other DHBs and/or located geographically in other DHB areas). Most types of community service delivered by NGOs include separate services specifically for Maori and for Pacific peoples.

### Project

In 2005, Counties Manukau DHB distributed the *Counties Manukau NGO & Community Workforce survey*. The audience for this survey included a wide range of services in all health areas not just mental health/addiction service.

Two separate surveys were distributed to organisations. One was specifically for individual paid staff members, asking about their work, and the other survey was to be filled out by management of the organisation asking about the organisation's workforce.

- The goal was to help the DHB plan for the needs of the district's health workforce
- The results of these surveys have yet to be compiled

### Comments

These two surveys cover a broad range of information from qualifications to language ability of the local NGO health workforce. However, the questions were not specifically targeted to mental health/addiction NGOs. The survey was conducted to build a picture of the workforce to be used to inform a larger planning document. The survey process was contracted out to an independent agency and therefore there was no existing relationship with the informants to build on or follow up with. It was a paper based survey that had a 50% response rate and we understand that the survey findings were to be analysed by the NZ Institute of Economic Research.

## 8. Nelson/Marlborough DHB

Private Bag 18  
Braemar Campus  
Waimea Road  
NELSON  
www.nmdhb.govt.nz

### Introduction

The NMDHB Strategic Plan identifies the following objectives for mental health for 2002-2012:

1. Obtain comprehensive information on the mental health of the community.
2. Support the development and implementation of community action to improve mental health.
3. Implement the national Mental Health Plan and Blueprint and the Regional Mental Health Plan to ensure access to quality services for the community.
4. Support communities to reduce the level of alcohol and other drug abuse, particularly amongst young people.

### Project

In late 2004 Nelson/Marlborough DHB conducted *informal voluntary face-to-face surveys of mental health/addiction NGOs in the district*. There were about 16 organisations surveyed. This information was compiled to be used as a snapshot of the workforce. Its main use will be as a guide for an NGO workforce development strategy for Nelson/Marlborough DHB. It used a workforce development template that requested the following information from NGOs:

- Current staffing levels, qualifications, experience and training/supervision approved
- Identification of trends
- Skills competency Gap analysis over the next five to ten years
- Core competencies for all workers
- Action Plan Strategies around Learning and Development, Recruitment and Retention, Organisational Development, Research and Evaluation

Only nine NGO's responded to the template and not all sections of the NGO template were completed.

# Appendix 3

## NgOIT Workforce Project Part Two Sampling Mix and Size

To design and undertake a further survey that will build on the existing knowledge already gathered through the 2005 Landscape Survey. This survey will collect workforce information about the staff employed by NGO mental health and addiction sector.

The plan is to survey some or all of the NGOs providing mental health and/or addiction services. Information that will be collected will be in accordance with the level of workforce inquiry stated above.

### Options

There are four options to consider for the workforce survey:

1. Re-survey all known NGOs, regardless of their responder status to the first survey.

This is likely to be more expensive than any other option, and unlikely to produce any better response than option 3 (re-surveying all the responders). Furthermore, it is likely that many of those who didn't respond to the NGOIT survey did not do so because of difficulties or costs involved in getting the information, being over surveyed and therefore they would be unlikely to respond to a second survey.

2. Re-survey a sample of all known NGOs, regardless of their responder status to the 2005 Landscape Survey.

This is likely to be more expensive than option 4 (re-survey a sample of the responders to the NGOIT survey), and unlikely to produce any better response.

3. Re-survey all responders to the NGOIT survey.

This will be more expensive than option 4 (a sample of the responders). Thus, as long as a representative sample of responders is used, option 4 is better.

4. Re-survey a sample of the responders to the NGOIT survey.

This is the best option. It will allow the relationship between staff-mix (for example, in education, length of time) and organisation characteristics (such as location, service delivery) to be explored.

There are analytic, ethical and practical issues to consider.

#### (a) Analytic issues

The sample could be strictly random, but, preferably, should be stratified random in order to ensure representative groups of NGOs across location, establishment date, service delivery and size in terms of mental health/ addiction staff numbers. But a stratified random sample has consequences for analysis – it would be more complicated, and somewhat more costly.



## (b) Ethical issues

The employee information would be provided by the NGO, rather than the individual employees, using whatever administrative system the NGO has available. Thus there *might* be some concern that personal identifying information would be provided to a third party (Platform, on behalf of the Ministry of Health) without the knowledge or approval of the employees (and it would probably be impractical to get consent from employees in the larger organisations). Inevitably, even if consent were sought, there would be some refusals to provide information, which would weaken the results. The Ministry's ethics committee could be consulted regarding this issue, if necessary. However given assurances that all information would be anonymous and confidential, and that only tabulated information would be reported, this may not, in fact, be an issue.

The organisations that belong to the Platform organisation already have a trust-relationship with Platform, so the provision of employee information to Platform should not be an ethical issue. Platform would, of course, only provide tabulated data to the Ministry of Health.

## (c) Practical issues

The large and well-established NGOs are likely to have computerised human resource management systems so that providing employee information could be relatively simple. On the other hand, many smaller and middle-sized NGOs may have paper-based systems that would require considerable effort to extract the required information to the extent that non-response might become an issue for these NGOs in view of the time and costs involved in responding.

One way to alleviate the costs is for the NGOs with paper-based administrative systems to allow a researcher from Platform to have access to the paper files and to extract the information. This would be costly but would ensure a high response rate.

As a consequence of the above issues, a survey that attempted to gain workforce information only from NGOs that are members of Platform (rather than a random sample) is a possibility, provided they are reasonably representative as far as their employee-bases are concerned.

### Comparison of the 2005 Landscape Survey of NGO respondents who do, and do not, belong to Platform as members

We do not have any personal information about the employees of the NGOs, but we do know their numbers. We also know where the NGOs are based, how old those NGOs are and the numbers of staff, total FTEs, and FTEs employed for the provision of mental health and or addiction services. These variables can be used to see if the NGOs belonging to Platform as members are in any substantial way different from those who do not.

### Establishment date

There were 232 respondents to the original NgOIT 2005 Landscape Survey. In terms of the age of the organisations, there is no statistical difference between the 62 NGOs belonging to Platform, and the remaining 170 who do not.

### Staff

In relation to the number of staff employed in the NGOs, there are considerable differences between the two groups. The Platform members who responded tend to be larger: the median number of staff in the Platform group is 15.5, but it is only 9 for the remaining responders who are not members of Platform. Clearly, the Platform group include proportionately more of the larger NGOs, where over a quarter (27.4%) have 50 or more employees overall.

### Total full time equivalents employed

The situation continues when considering staff in terms of total FTE's employed by the NGOs. The Platform members who responded tend to have more FTEs: the median number of total FTEs employed in the Platform group is 10, but it is 5.8 for the remaining responders who are not Platform members.

### Full time equivalents employed for the delivery of mental health and or addiction services.

Of greatest concern is the number of FTEs employed for the delivery of mental health and/or addiction services. As expected from the above results, the Platform members who responded have more FTEs in this area than the remaining responders who are not members of Platform. The median FTE is 7.7 for the Platform group, but it is 4 for the remaining responders who are not members of Platform.

Therefore, the available employee information from the responding NGOs shows that there is proportionately more staff among the NGOs that are members of Platform than among those who are no members off Platform. Of concern, then, is whether this statistical difference is of practical significance.

The first point to note is that there are reasonable numbers of small and medium-sized NGOs that are members of Platform.

A second point is that, NGOs employing fewer than 10 FTEs for the delivery of mental health and or addiction services, it is clear that there is no statistical difference in the distribution of FTEs between the Platform members and non Platform members. Also, NGOs that employ more than 10 FTEs for the delivery of mental health and or addiction services is higher among the respondents who are members of Platform.

### Location

Looking at the location of the NGOs we find that there are fewer Platform members based solely in the South Island (11 or 17.7%) than among the rest of the responding NGOs (69 or 40.6%), although the two largest NGOs are members of Platform and have services in both islands.

## Conclusion

There are differences between the respondents who are Platform members and the remaining NGO respondents. These differences are unlikely to be due simply to chance.

## Potential biases of using the Platform-based re-survey

First of all, we have seen that in terms of organisation size (staff FTE numbers) the responding NGOs who are members to Platform are different from the other responding NGOs who are not members. It is likely that responding NGOs who are members of Platform are different in other ways, too, by virtue of the fact that they have chosen to belong to Platform. Thus Platform respondents cannot be considered a strictly representative sample of the NGOs working in the mental health/addiction services area.

However, the responders to the original 2005 Landscape Survey were not completely evenly distributed among the DHBs. An earlier analysis of non-response showed the following:

Some of the DHBs had few NGOs. Those with fewer than 15 identified NGOs were combined for analysis of response rates by DHB. There was a significant variation in response rates. This was primarily due to the unusually high response from the Otago DHB, where 21 out of 24 NGOs responded.

Thus there is some evidence that the full group of responders is not representative of all NGOs working in the area.

The organisations who are members off Platform are currently contracted to DHBs for 70% of total budget for NGO mental health and or addiction services. This means that the information that would not be collected would possibly concern the less engaged part of the workforce – smaller organisations delivering smaller amounts of service. The question for the Ministry is how important is it to know something about the employees of these smaller organisations?

## Advantages and disadvantages of using a Platform-based re-survey

- The trust-relationship amongst the NGOs that belong to Platform should lead to a good response rate in the follow-up survey, even 100 per cent response.
- There should be no ethical issues (though the Ministry's ethics committee might not feel that the gathering of administrative data for statistical purposes constitutes an ethical problem anyway).
- A high proportion of NGOs that are members of Platform will have computerised human resource management systems which should make the gathering of the employee information relatively easy.
- The disadvantage of using only the NGOs that are members of Platform is the lack of knowledge that it will bring about the employees of some of the smaller, and possibly more isolated, NGOs.

### Advantages and disadvantages of adding a sub-sample to a Platform-based re-survey

In order to learn something more about the smaller NGOs, it would be possible to draw a second sample, in one of two ways:

1. Draw a second sample from the smaller *non-Platform members* (which would necessitate complex weighted statistics; or keeping the two samples separate which would lead to lowered, and possibly inadequate, statistical power).
2. Draw a random sample from all the smaller *NGOs* (which would leave out a few Platform-members, perhaps to the detriment of relationships (?); and which would again lead to one or other of the problems identified in (a) above).

If the Ministry of Health does require information about the employees of some of the smaller, and possibly more isolated, NGOs, then a specific, and separately-analysed sub-sample of either or both of (i) smaller and more-isolated NGOs, or (ii) non-Platform-belonging NGOs, would be the preferred option. The issues here are then threefold: probable higher costs involved in gathering information; likely poorer response rate; and lowered statistical power, as already mentioned.

Another possibility is to do a separate sub-sampling exercise of all the non-Platform NGOs, but to obtain only information that might not require searching files in the (probably smaller) 'paper-based' organisations (male/female; broad age-group; broad length of service in the organisation; number and qualifications of the supervisor(s)/team leader(s)), and as long as no ethical issues are raised. This limited information could be used to compare broad employee characteristics across the Platform and non-Platform groups, which might provide some indication about the extent of major differences between the employees of the two groups. If there are major differences, a further survey of some, or all, of this group could be considered.

### Advantages and disadvantages of using a random re-survey of the earlier responding NGOs

The main advantage would be simplicity in terms of analysis if a truly random sample was used. However, if a more sensible stratified sample is used, the analysis would become more complicated. The advantage of stratification would be to ensure representation from each sub-sample according to staff-size, and NGO location and age.

There are other disadvantages. First, the response rate may drop among the NGOs with paper-based administrative systems. Second, the overall research cost will increase substantially if a Platform researcher has to visit some NGOs to help them collect the required information.

# Conclusions

1. For simplicity, a re-survey of the Platform-belonging NGOs is the best option.
2. For practical completeness, one of two reasonable additional options could be considered:
  - 2.1. One possibility is to analyse the results of the re-survey of the NGOs who are members off Platform in terms of the size and location of the NGOs, to see how much variability in employee characteristics is observed. If there is, in fact, little variability, then a further sub-sample may not be warranted.
  - 2.2. Another possibility is to do a separate sub-sampling exercise (if ethically approved) of all the NGOs that are not members of Platform to obtain only information that might not require searching files in the (probably smaller) 'paper-based' organisations. This limited information could be used to compare broad employee characteristics across the NGOs who are members off Platform and NGOs that are not members off Platform, which might provide some indication about the extent of major differences between the employees of the two groups. If there are major differences, a further survey of some, or all, of this group could be considered.
3. For real completeness, survey the full group of NGO responders (option 3), however this would create higher costs and possibly lowered response rate.

Overall, the statistician identified that the preferred plan to undertake the workforce survey would be option 1 and if feasible combined with option 2.2 or else option 2.1.

## Workforce Survey Tool Appendix 4

198 Youth Health Centre  
Action for Mental Health Society  
Adventure Development Counselling  
Alcohol Drug Association New Zealand (ADA) Inc  
Alzheimers Canterbury  
Alzheimers Society  
Arahura Charitable Trust  
Arataki Ministries  
Aroha Ki Te Tamariki (Mirror Counselling)  
Ashburton Community Alcohol & Drug Service Inc  
Auckland Refugees As Survivors Charitable Trust  
Awhina Wahine Incorporated  
Bainbridge House Charitable Trust  
Bipolar Support Canterbury  
Blueprint Centre for Learning  
Burnley Lodge  
Care NZ Limited  
Caring for Carers Inc  
Caroline House Inc  
Case Consulting Limited (Buddies Peer Support Service)  
Central Potential Te Rito Maia  
Centre 401 Trust  
Coast Care Trust  
Comcare Charitable Trust  
Compensation Advisory Services Ltd – Lifelinks  
Consumer Operated Mental Health Service  
Corpac Trust  
Corstorphine Baptist CommunityTrust  
Dalcam Ltd St Dominics Lodge

Dayspring Trust  
Deaf Mental Health Service  
Drug and Alcohol Support Taupo Trust  
Dunedin Community Volunteer Centre Trust  
Earthlink Inc  
Eastern Bay Residential Services Ltd  
Eating Disorders Services Association  
Equip Mental Health Services  
Evolve Wellington Youth Service  
Fairleigh Lodge Limited  
Forbury House Trust  
Framework Trust  
Friends who Care Inc (Timeout Tai Whakanga)  
Gateway Housing Trust  
Golden Age Healthcare Group Limited  
Gracelands Group of Services  
GROW NZ  
Hanmer Clinic  
He Oranga Pounamu  
He Waka Tapu Limited  
Health Action Trust and Compass  
Healthcare NZ Ltd  
Hillcrest Lodge 2000 Ltd  
Hinepukohurangi Trust  
Hokianga Health Enterprise Trust  
Horizon Trust Board (Youth Programme)  
Joint Anxiety Disorders Group  
Kakapo Organic Garden Ltd & Bainfield Organic Garden Ltd  
Kapiti Crossroads Charitable Trust



Karldon Trust  
K'aute Pasifika  
Kites Trust  
Koputai Annexe Trust  
Mahia Mai A Whai Tara  
Mahitahi Trust (Te Puawai Aroha Ki Otara)  
Maketu Health & Social Services Trust  
Malologa Trust  
Mana Community Enterprises Inc  
Manaaki House (Wairoa District Society on Alcohol and Drug Misuse Inc)  
Manaaki Oranga  
Mangakino Country Lodge - Logan & Roberts Limited - Lakes  
Manna Healing Centre  
Maranga House Trust  
MASH Trust Board - Palmerston North  
Mental Health Consumer Advocacy Service  
Mental Health Consumer Union  
Mental Health Education & Resource Centre  
Mental Health Support Services Limited  
Mental Illness Survivors Team (MIST)  
Mind and Body Consultants Ltd  
Mind Matters Trust  
Mount Cargill Trust  
Murihiku Mental Health Trust  
New Progress Enterprises Charitable Trust  
Newell House Trust  
Nga Kakano Foundation  
Nga Morehu Whaiora Trust  
Ngaitai Iwi Authority  
Ngati Hine Health Trust  
Ngati Koata Trust (Te Kahui Hauora)  
Northcare Trust



Northpoint Trust  
Nova Trust Board  
Oasis Network Inc  
Odyssey House  
Odyssey House  
Otago Accommodation Trust  
Otago Mental Health Support Trust  
Otago Youth Wellness Centre  
Pacific Peoples Addiction Service  
Pacific Trust Canterbury  
PacifiCare Trust  
PACT Group  
Pathways  
Pathways to Wellbeing Inc  
Pirirakau Hauora Charitable Trust  
Platform  
Porch Limited  
Postal Natal Therapy Service Limited  
Poutiri Charitable Trust  
Pretoria Lodge  
Psychiatric Consumers Trust  
Rakeiwhenua Trust (Tuhoe Hauora Trust)  
Refugee Resettlement Support Inc  
Rubicon Youth A &D Support Services Charitable Trust  
S.C. Anti Discrimination Group  
S.F. Auckland  
S.F. Manawatu  
S.F. Marlborough  
S.F. Otago  
S.F. Pegasus Bay  
S.F. Rotorua



S.F. Southland  
S.F. Wairarapa  
S.F. Wanganui  
S.F. Wellington  
Salvation Army  
Sarona Community Trust  
Serenity Trust Home  
Sexual Abuse Survivors Trust  
Skylight Trust  
Solutions (Northland Mental Health Trust)  
Southland YMCA  
Step Ahead Trust  
Stepping Out Hauraki Incorporated  
Stepping Stone Trust  
STOP Trust  
Take 5 Te Whare Marama  
Te Ara Ki Mana Addiction Service  
Te Aratu Trust  
Te Aroha O Hinemaru Trust  
Te Awa O Te Ora Trust  
Te Awhi Whanau  
Te Hauora O Te Hiku O Te Ika Charitable Trust  
Te Hauora O Turanganui A Kiwa Limited  
Te Hauora Runanga O Wairarapa Incorporated  
Te Ika Whenua Hauora  
Te Korowai Aroha (Baptist Action)  
Te Korowai Hauora O Hauraki Incorporated  
Te Kotuku Ki Te Rangi Charitable Trust  
Te Manu Toroa Trust  
Te Ngaru O Ngati Maniapoto  
Te Paepae Arahi Trust  
Te Pou

Te Rangimarie Trust  
Te Rapuora O Te Waiharakeke Trust ( Te Rapuora Health)  
Te Rau Pani Maori Mental Health Trust  
Te Roopu Pookai Taaniwhaniwha Inc  
Te Roopu Whakapakari Ora Trust  
Te Runanga O Kirikiriroa Charitable Trust Inc  
Te Runanga O Ngai Tamawhariua  
Te Runanga o Ngati Whatua  
Te Runanga o Raukawa Incorporated  
Te Runanga o Te Whanau  
Te Runanga o Toa Rangatira Inc  
Te Taiwhenua O Heretaunga  
Te Tomika Trust  
Te Utuhina Manaakitanga Trust  
Te Whanau O Rongomaiwahine Trust  
Te Whare Atawhai Society Incorporated  
Te Whare Hauora O Ngati Porou  
Te Whare Mahana Inc  
Te Whare Puawai O Te Tangata Trust  
Te Whatuiapiti Trust Inc  
The Carroll Street Trust  
The Higher Ground Drug Rehabilitation Trust  
The Phobic Trust of NZ  
The Post Natal Psychosis Support Group  
TRANX Incorporated - Canterbury  
TRANX Services Inc Auckland  
Tuhoe Matauranga Trust (Te Kaokao o Takapau)  
Turning Point Trust  
Tuwharetoa Health Services Limited  
Vakaola



Vanessa Lowndes Centre  
Waiheke Island Supported Homes Trust  
Waihi Community Lifestyle Trust  
Waimakariri District Community Development Trust  
Waimate Care & Recreation Centre  
Wairarapa Addiction Service Inc  
Webhealth - Linkage Trust  
Wellington After-Care Association Incorporated  
Wellington Refugees as Survivors Trust  
Wellink Trust  
West Auckland Living Skills Homes Trust Board (WALSH Trust)  
West Auckland Mental Health Support Trust  
Western BOP Mental Health Trust Inc  
Whaioranga Trust  
Whaioro Trust Board  
Whakapai Hauora Charitable Trust (Best Care)  
Whanganui Community Living Trust  
Whau Valley Whaiora Support Trust  
Wise Trust  
Workwise

## Glossary



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