Te Iti Me Te Rahi
EVERYONE COUNTS

Mental Health Services: Supplementary Report, 2019

TE RAU ORA
Te Iti me te Rahi: Everyone Counts

Mental Health Services: Supplementary Report, 2019


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Executive Summary

Background

This supplementary report details results from Te Iti me te Rahi: Everyone Counts, the Māori health workforce survey, focusing on service type (mental health services versus other service types). The lack of routinely produced, accurate sources of data on the Māori mental health workforce was a key motivation for this supplementary report.

The Māori mental health workforce

Estimates of the size of the mental health workforce are based on survey estimates. In 2014, the size of the adult mental health workforce was estimated to be 9,509 full time equivalent (FTE) positions, 18.7 per cent of which were filled by Māori.

Survey Methods

Participants

A total of 2,331 Māori aged 18 years and over took part in the survey. Deletion of cases with missing data resulted in a dataset including 2,056 respondent, of which 636 (30.9 per cent) were in mental health services.

Questionnaire development

The questionnaire development was undertaken through a process of co-design, led by Te Rau Matatini and supported by the National Institute of Demographic and Economic Analysis (NiDEA).

Procedure

The anonymous survey was administered by Te Rau Matatini via SurveyMonkey online survey software. Chi Square Tests were formed to assess whether or not there was an association between service type (mental health services, or other service types).

Survey Results

When compared with Māori health workers in other service types, those in mental health services were more likely to:

- be male
• work more days per week
• speak te reo Māori well or very well
• have advanced understanding of Māori health models
• have been asked about the Treaty of Waitangi in their job interview
• agree that cultural supervision is in place

Conclusion

When compared with Māori workers in other service types, those in mental health services seemed to have higher cultural competency than others, and their workplaces appeared to take more seriously the Treaty of Waitangi, and cultural supervision. However, the support from employers did not seem to extend to support to learn te reo me ōna tikanga, and to engage with marae/hapū/iwi.
1 Introduction

1.1 Background

This supplementary report details results from Te Iti me te Rahi: Everyone Counts, the Māori health workforce survey, focusing on service type (mental health services versus other service types). The survey was undertaken by Te Rau Matahi: the national centre for Māori health workforce development and excellence, who have a particular focus on Māori mental health and addiction services.

Mental health issues are a key area of health concern for Māori. Māori experience higher rates of mental illness than other ethnic groups (Reid & Reid, 2007), and have a unique mental illness profile, characterised by later presentation and higher acuity than non-Māori (Ministry of Health, 2018).

As outlined in He Korowai Oranga, The Māori Health Strategy, the Crown are obliged under the Treaty of Waitangi to achieve equitable mental health outcomes (Ministry of Health, 2016a). This requires action to address socio-economic and historical determinants of mental health, alongside improvements in mental health service delivery. The Ministry of Health (2018) has identified Māori mental health workforce development as a priority in achieving equity in mental health outcomes.

Developing the Māori mental health workforce requires a detailed understanding of the characteristics and experiences of Māori in the health workforce generally, and in mental health services in particular. The detailed analysis of survey data presented in Te Iti me te Rahi: Everyone Counts Māori health workforce survey report, 2018 provides insights into the experiences of Māori in the health workforce, which for the most part are shared between Māori in mental health services and those in other service types.

For this supplementary report, we looked at each survey item to assess whether or not it was associated with service type (i.e. whether or not the respondent worked in mental health services). In section 3, we report on the variables that were found to be associated with service type: sex, ability to speak Māori, knowledge of Māori health models, number of days worked per week, whether or not asked about the Treaty of Waitangi in job interview, whether or not cultural supervision was in place. Some implications of these findings are then briefly discussed.
2 The Māori mental health workforce

2.1 Health care and social assistance

Data from Census 2013 showed that 21,000 Māori worked in the health care and social assistance industry sector. One in ten Māori workers (10.0 per cent) were in the health care and social assistance industry sector, and the share of Māori workers in health care and social assistance had not changed between 2006 and 2013.

The proportion of workers in the health care and social assistance sector who are Māori (approximately one in seven, or 11.0 per cent) was equal to the proportion of the national workforce who are Māori (11.0 per cent). However, when this category is disaggregated into two categories—health services (hospitals and medical and other health care services) and social assistance, it is clear that Māori are over-represented in social assistance roles and under-represented in health services.

This pattern of workforce participation is mirrored in DHB workforce data, which showed that Māori were well represented in care and support roles within DHBs (representing 15.8 per cent of this occupation group) but were grossly underrepresented in senior medical officer roles (representing only 1.6 per cent of this occupation group) as well as junior medical officer roles (TAS, 2018).

2.2 Mental health services

In order to develop the Māori mental health workforce, there is a need for routinely collected, accurate data. However, no data source currently exists to meet this informational need. Census data on industry sectors does not distinguish between those in mental health services and those in other health care services. Therefore, to understand the Māori mental health workforce we currently rely on survey data.

A report on findings from the More than numbers organisation workforce survey estimated the size of the total mental health and addictions workforce in 2018 to be 10,832 full time equivalent (FTE) positions. However, the methodology used to produce this estimate precluded breakdown by ethnicity.

An earlier iteration of the survey, the More than numbers organisation workforce survey 2014 used an alternative methodology. They analysed survey responses from 189 DHB or Ministry.

1 Rounded to the nearest 100.
of Health funded adult mental health organisations. Based on the organisations’ responses, the size of the adult mental health workforce was estimated to be 9,509 full time equivalent (FTE) positions.

This methodology allowed breakdown by ethnicity. They estimated that Māori make up 18.7 per cent of the mental health workforce (12.4 per cent of the DHB mental health workforce, and 27.0 per cent of the NGO mental health workforce). This estimated proportion of Māori workers in adult mental health services is much higher than the share of Māori workers in the health workforce generally from Census 2013 data (11.0 per cent). However, as noted in the More than Numbers report, Māori are still under-represented in the clinical workforce compared with the population of mental health services consumers.
3 Te Iti me te Rahi: Everyone Counts Survey Methods

Survey Methods

For a detailed description of the survey methods, see section 3 of the original report.

Participants

Te Iti me te Rahi: Everyone Counts was open to adults aged 18 years and over who identified as Māori and worked in health. A total of 2,331 people took part in the survey. The data from respondents who skipped more than 20 per cent of questions were excluded from survey analyses, resulting in data from 2,056 respondents. Of the 2,056 Māori who participated in Te Iti me te Rahi: Everyone Counts, 636 (30.9 per cent) reported being in mental health services.

Questionnaire development

The questionnaire development was undertaken through a process of co-design, led by Te Rau Matatini and supported by the National Institute of Demographic and Economic Analysis (NIDEA). The resulting questions included a small number of questions adapted from the census and Te Kupenga wellbeing survey but predominantly featured new questions constructed specifically to meet the needs of Te Rau Matatini.

Procedure

The anonymous survey was administered by Te Rau Matatini via SurveyMonkey online survey software and was open for sixteen weeks. Participants were given the option to enter a prize draw upon completion of the survey (contact details and survey responses were collected separately). Statistical tests were performed using STATA statistical analysis software. Chi Square Tests were formed to assess whether or not there was an association between service type (mental health services, or other service types). Most variables were not associated with service type. The results indicating a significant association are presented in the following section.
4 Mental health services: Supplementary report results

4.1 Descriptive statistics

As noted in section 3 of this supplementary report, of the 2,056 respondents included in the dataset from Te tī me te Rahi: Everyone Counts survey, 636 (30.9 per cent) indicated that they worked in mental health services.

Iwi rohe affiliations

The iwi rohe to which the highest share of mental health workers affiliated in Te tī me te Rahi was Te Tairāwhiti (17.9 per cent), followed by Te Tai Tokerau/Tāmaki (16.5 per cent), Tauranga/Mātaatua (12.9 per cent), then Te Waipounamu/Wharekauri (11.9 per cent).

Figure 4.1 Iwi rohe affiliations of mental health workers (n=636)
**Highest qualification**

Respondents working in mental health services had very similar levels of highest qualification as respondents working in other health service types. For one quarter (25.2 per cent) of respondents working in mental health services, ‘undergraduate degree’ was their highest qualification. For a further two in five (39.8 per cent), a postgraduate qualification was held.

![Figure 4.2 Highest qualification (n=636)](image)

2 A Chi Square test revealed no association between highest qualification and service type.
Receipt of scholarships

Māori health workers in mental health services were not more or less likely than those in other service types to have received a Māori health scholarship or an īwi/hapū scholarship. Almost a third of mental health workers (31.0 per cent) had received a Māori health scholarship. Slightly less (28.5 per cent) had received an īwi/hapū scholarship.

Figure 4.3 Māori mental health workers’ receipt of Māori health scholarships (n=636)

Figure 4.4 Māori mental health workers’ receipt of īwi/hapū scholarships (n=636)
DHB area

For those in mental health services, the DHB within which the highest share of respondents worked was Waikato (13.2 per cent), followed by Capital and Coast (12.1 per cent), Northland (11.3 per cent), Counties (11.2 per cent), and Auckland (8.6 per cent).

Figure 4.5 Māori mental health workers’ DHB area (n=636)

Note: Multiple responses were permitted so the sum of categories exceeds 100%
Occupational role

Respondents who reported being in mental health services performed a wide range of occupational roles. One in five (20.6 per cent) mental health workers listed nurse as their role. A further one in five (19.8 per cent) listed community support worker as their role. In addition, almost one in eight (11.9 per cent) listed manager as their role. All other occupational roles listed accounted for less than 10 per cent of mental health workers.

Figure 4.6 Māori mental health workers' occupational role (n=636)

Note: Multiple responses were permitted so the sum of categories exceeds 100%
4.2 Demographic indicators

Age and sex

There was no association between age and service type (whether or not respondents worked in mental health services).

There was, however, an association between sex and service type. As identified in the Census 2013, 83.0 per cent of Māori working in health services were women. Similarly, of those who identified with a binary gender in Tī me te Rahi: Everyone Counts, 82.9 per cent were women. Sex distribution was associated with service type, however. The overrepresentation of women was less pronounced for those in mental health services (79.0 per cent women, 21.0 per cent men) than in other services (85.1 per cent women, 14.9 per cent men).

Figure 4.7 Sex by service type (n=2,048)

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3 Pearson chi2(1) = 11.7996 Pr = 0.001
4 Pearson chi2(1) = 11.7996 Pr = 0.001
4.3 Cultural competency

A survey of mental health providers found that 64 per cent of respondents identified a need for improved cultural competency within the workforce. Respondents to Te Hī me te Rahi: Everyone Counts were asked to indicate their ability to speak te reo Māori, as well as their knowledge of Māori health models.

Ability to speak Māori

An association between ability to speak Māori and service type was observed. The proportion of those who were able to speak te reo Māori well or very well was higher for Māori healthcare workers in mental health services (36.0 per cent) than for their counterparts in other service types (29.5 per cent).

Figure 4.8 Ability to speak Māori by service type (n=2,056)

Knowledge of Māori health models

An association between knowledge of Māori health models and service type was observed. The proportion of those in mental health services who had advanced knowledge of Māori mental health models (35.4 per cent) was higher than those in other service types (24.9 per cent).

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\(^5\) Pearson chi\(^2\)(4) = 13.7371  Pr = 0.008
4.4 Workplace characteristics

Number of days worked per week

An association between number of days worked per week and service type was detected. Respondents who worked in mental health services were less likely than others to work less than 5 days per week, and more likely than others to work 5 days per week. A similar share of workers were working 6 or 7 days per week across service types (mental health services and other service types).

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6 Pearson chi²(6) = 15.2189  Pr = 0.019
Figure 4.10 Number of days worked per week by service type (n=2,056)

As asked about the Treaty of Waitangi during job interview

As outlined in the New Zealand Health Strategy, Roadmap of actions 2016 (Ministry of Health, 2016b), achieving equitable health outcomes for Māori requires the health workforce to have a suitable understanding of the Treaty of Waitangi.

Survey respondents indicated whether or not they had been asked about the Treaty of Waitangi in their interview for their current position. An association between service type and whether respondents had been asked about the Treaty of Waitangi during their job interview was found. The share of respondents who had been asked about the Treaty was higher for those in mental health services (77.7 per cent) than for those in other service types (70.5 per cent).

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7 Pearson chi2(1) = 10.7506 Pr = 0.001
Figure 4.11 Asked about the Treaty of Waitangi during job interview by service type (n=1,932)

Cultural supervision

Findings from Te Ihi me te Rahi: Everyone Counts Survey Report showed that access to cultural supervision enhanced workplace satisfaction. An association between agreement that cultural supervision was in place and service type was detected.\(^8\) The share of respondents who agreed or strongly agreed that cultural supervision was in place was higher for those in mental health services (39.9 per cent) than for those in other service types (32.0 per cent).

Figure 4.12 Cultural supervision in place by service type (n=2,056)

\(^8\) Pearson chi2(4) = 15.6916 Pr = 0.003
5 Conclusion

In this supplementary report, we presented findings from the Māori health workforce survey, Te Ihi me te Rahi: Everyone Counts, conducted by Te Rau Matatini, with a specific focus on variables that were associated with service type (whether or not respondents were in mental health services).

There was no association between service type and some key variables, such as workplace satisfaction, and whether or not employers supported workers to learn te reo me ēna tikanga, or to engage marae/hapū/iwi. However, six variables were associated with service type.

The results showed that there was a higher proportion of Māori men working in mental health services, compared with the proportion of Māori men working in other health service types.

The results also showed that Māori health workers in mental health services were more likely to have proficiency in speaking te reo Māori, and knowledge of Māori health models. This result may be due to highly culturally competent Māori choosing to enter into mental health roles over other health service roles, or due to more cultural competency training being offered in professional programmes for mental health services as opposed to other service types. Alternatively, these findings may be driven by a gender effect, as Māori men reported higher levels of cultural competency than Māori women overall.

Māori health workers in mental health services were also more likely to work five (as opposed to fewer than 5) days per week when compared with Māori health workers in other service types. Mental health services are often faced with challenges recruiting staff, which may result in staff vacancies and require long hours from existing staff. However, this finding too may be driven by a gender effect, as Māori women tended to work fewer days per week than Māori men. More research is needed to ascertain whether or not it is the preference of those in mental health services to work their current number of days per week.

Those in mental health services were more likely to be asked about the Treaty of Waitangi during their job interview and were more likely to agree that cultural supervision was in place than those working in other service types. Given that cultural competency is a crucial factor in effective mental health service delivery, it may be the case that more emphasis is placed on the Treaty of Waitangi, and providing cultural supervision than is the case in
other service types. If this is the case, it begs the question why Māori in mental health services did not report more support from their employers to learn te reo me ōna tikanga, or to engage marae/hapū/iwi.

This survey report supplement was motivated by an information gap on the experiences of Māori mental health workers, necessary for building a Māori mental health workforce capable of addressing Māori health inequalities. Whether or not respondents were in mental health services was unrelated to workplace satisfaction. However, when compared with Māori workers in other service types, those in mental health services were more likely to be male and to work more days per week. Those in mental health services also seemed to have higher cultural competency than others, and their workplaces appeared to take more seriously the Treaty of Waitangi, and cultural supervision. However, the support from employers did not seem to extend to support to learn te reo me ōna tikanga, and to engage with marae/hapū/iwi.
6 References.


7 Appendices

**Data Table 1. Sex by service type frequencies.**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mental Health</th>
<th>Other Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>499</td>
<td>1,205</td>
<td>1,704</td>
</tr>
<tr>
<td>Male</td>
<td>133</td>
<td>211</td>
<td>344</td>
</tr>
<tr>
<td>Total</td>
<td>632</td>
<td>1,416</td>
<td>2,048</td>
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</table>

**Data Table 2. Ability to speak Māori by service type frequencies.**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Few words</th>
<th>Not well</th>
<th>Fairly well</th>
<th>Well</th>
<th>Very well</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>41</td>
<td>161</td>
<td>205</td>
<td>136</td>
<td>93</td>
<td>636</td>
</tr>
<tr>
<td>Other</td>
<td>109</td>
<td>399</td>
<td>493</td>
<td>284</td>
<td>135</td>
<td>1,420</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>560</td>
<td>698</td>
<td>420</td>
<td>228</td>
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</tr>
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</table>

**Data Table 3. Knowledge of Māori health models by service type frequencies.**

<table>
<thead>
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<th>Service Type</th>
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<th>Intermediate</th>
<th>Advanced</th>
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<td>19</td>
<td>81</td>
<td>311</td>
<td>225</td>
<td>636</td>
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<tr>
<td>Other</td>
<td>96</td>
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<td>687</td>
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<td>1,420</td>
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<tr>
<td>Total</td>
<td>115</td>
<td>364</td>
<td>998</td>
<td>579</td>
<td>2,056</td>
</tr>
</tbody>
</table>

**Data Table 4. Number of days worked per week by service type frequencies.**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>≤1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>8</td>
<td>9</td>
<td>43</td>
<td>71</td>
<td>468</td>
<td>12</td>
<td>25</td>
<td>636</td>
</tr>
<tr>
<td>Other</td>
<td>32</td>
<td>45</td>
<td>99</td>
<td>204</td>
<td>950</td>
<td>20</td>
<td>70</td>
<td>1,420</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
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<td>142</td>
<td>275</td>
<td>1,418</td>
<td>32</td>
<td>95</td>
<td>2,056</td>
</tr>
</tbody>
</table>

**Data Table 5. Asked about the Treaty of Waitangi in job interview or not by service type.**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>473</td>
<td>136</td>
<td>609</td>
</tr>
<tr>
<td>Other</td>
<td>933</td>
<td>390</td>
<td>1,323</td>
</tr>
<tr>
<td>Total</td>
<td>1,406</td>
<td>526</td>
<td>1,932</td>
</tr>
</tbody>
</table>

**Data Table 6. Level of agreement that cultural supervision is in place by service type.**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>75</td>
<td>133</td>
<td>174</td>
<td>147</td>
<td>107</td>
<td>636</td>
</tr>
<tr>
<td>Other</td>
<td>160</td>
<td>354</td>
<td>452</td>
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<td>170</td>
<td>1,420</td>
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<tr>
<td>Total</td>
<td>235</td>
<td>487</td>
<td>626</td>
<td>431</td>
<td>277</td>
<td>2,056</td>
</tr>
</tbody>
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