Feasibility Study into the Establishment of a Pacific Mental Health Workforce Development Organisation

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In Association with Pava
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Talofa lava, Kia orana, Malo e lelei, Fakaalofa lahi atu, Taloha ni, Ni sa bula vinaka, Fakatalofa atu

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<td>ALAC</td>
<td>Alcohol Advisory Council</td>
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<tr>
<td>Alofa</td>
<td>Love and compassion (Samoan)</td>
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<tr>
<td>CAOS</td>
<td>New Zealand Mental Health Classification and Outcomes Study, conducted by the Health Research Council of New Zealand</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive of the Organisation</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CHFA</td>
<td>Central Health Funding Authority</td>
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<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>DHC</td>
<td>District Health Committee</td>
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<tr>
<td>FTE</td>
<td>Full-Time Equivalent</td>
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<tr>
<td>hauora.com</td>
<td>Common name and website name of the National Maori Health Workforce Development Organisation.</td>
</tr>
<tr>
<td>HFA</td>
<td>Health Funding Authority</td>
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<tr>
<td>HRC</td>
<td>Health Research Council of New Zealand</td>
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<td>HWAC</td>
<td>Health Workforce Advisory Committee</td>
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<td>MHWDP</td>
<td>Mental Health Workforce Development Programme</td>
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<tr>
<td>MHWDC</td>
<td>Mental Health Workforce Development Committee</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NAAPIMHA</td>
<td>National Asian American and Pacific Islander Mental Health Association</td>
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<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
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<tr>
<td>NAC</td>
<td>National Addiction Centre</td>
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<tr>
<td>NHS</td>
<td>National Health Service (Britain)</td>
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<td>NIMHE</td>
<td>National Institute of Mental Health in England</td>
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<td>NMHWDO</td>
<td>National Mental Workers Development Organisation</td>
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<tr>
<td>NZDHB</td>
<td>New Zealand District Health Board</td>
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<tr>
<td>NZHTA</td>
<td>New Zealand Health Technology Association</td>
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<tr>
<td>Palagi</td>
<td>Samoan for a non-Pacific person.</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>WAT</td>
<td>Workforce Action Team - a British NHS committee</td>
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Executive Summary

Objective

To provide an analysis for the options available for the establishment of a Pacific Mental Health Workforce Development Organisation (PMHWDO) providing a description of the options, how they would work, be evaluated and linked to the community it serves.

Background

The purpose of this literature review was to discuss the feasibility of establishing a PMHWD Organisation. This comes at a time when mental health service delivery is moving from institutional care to community-based care. As a result of this movement, the mental health workforce is lacking in the required capacity to meet demands. There are insufficient Pacific mental health workers in all professions and increasing their numbers is a stated high priority. Further to this mental health planning is fragmented due to the involvement of many disparate organisations. For example, Te Orau Ora (Ministry of Health, 2005) reiterates the need to increase the Pacific mental health workforce which was first highlighted in Moving Forward: The National Mental Health Plan for More and Better services (Ministry of Health, 1997) and again in Pacific Health Services and Workforce: Moving on the Blueprint (Mental Health Commission, 2001). That report also emphasised the need to up-skill the current Pacific workforce.

In 2004, 8.5% of the total 0-19 year population were Pacific child and adolescents while the Pacific workforce only made up 4.3% of the total child and adolescent mental health workforce. A total of 61 Pacific staff were identified as currently working in the child and adolescent workforce as at 31 March 2004. The stock take undertaken by the Werry Centre notes that the majority of the workforce lies in the Northern region, are employed by DHB’s and is predominantly made up of mental health support workers, social workers, mental health nurses, and cultural appointments (Werry Centre, 2005).

While there is a clear need for a PMHWD Organisation that can focus on building the capacity and capability of the Pacific mental health workforce, care must be taken to ensure that it does not merely add to the list of organisations currently involved in mental health workforce planning. To this end, our report is one of a suite of projects commissioned by the Ministry of Health and the Health Research Council of New Zealand to investigate Pacific mental health. Readers are strongly encouraged to examine the other project reports to gain a complete picture. The other projects include: a feasibility study of recruitment and retention for Pacific People; Pacific Community Mental Health Worker Training and Development Needs Analysis; Pacific Mental Health Infrastructure and Organisational Development; Cultural and Clinical Standards; and Mental Health Workforce Development Training.

Literature Review

An international literature review was undertaken to provide a wider context for discussing the feasibility of establishing a PMHWD Organisation in New Zealand.
The aim was to include key sources such as documents on ethnic workforce organisations, Pacific workforce development and Pacific workforce capability. While there was a wealth of literature about general mental health workforce development, there was a lack of quality material on Pacific or other indigenous mental health workforce development issues.

A systematic method of literature searching, selection and appraisal was employed in the preparation of this report.

The feasibility study consisted of a review of the New Zealand and international literature on Pacific mental health service delivery, to assess the evidence base for service delivery, interviews with key informants and a document analysis of New Zealand health workforce reports.

**Key Informant Interviews**

Interviews with key informants were conducted in order to assess the perceived need for a PMHWDO, identify the priority issues that could be addressed by a PMHWDO, and the contextual issues and resource capacity in New Zealand that may influence the effectiveness of a PMHWDO.

Key informants were included the following:

- Key Pacific leaders in Mental Health and wider general health sector;
- Pacific consumers;
- A wider interest group expert Mental Health professionals;
- Key mental health organisations;
- Ministry of Health mental health directorate staff; and
- Existing stakeholders within the four MHWD organisations.
Key Results, Conclusions and Recommendations

The literature review and key informants identified the following characteristics of an effective PMHWDO. The main dominating theme from the key informants was that they expressed strong support for the establishment of a PMHWDO.

The report addressed the following critical themes:

- The vision, mission, objectives and key functions of the PMHWDO Organisation.
- The key informants stated that the PMHWDO needed to be lead by a visionary Pacific leader.

Another common theme that should be captured by the PMHWDO’s vision statement is accountability. This was stated by a number of respondents in terms of governance accountability, financial accountability and community accountability.

One recurring theme from the key informant interviews was that the PMHWDO needed effective governance structures. One of the key issues here is that of governance referring to accountability of the PMHWDO Board/Trustees to the Mission of the PMHWDO it governs.

Effective governance of PMHWDO requires an effective Mission statement. The Mission statement has the effect of ‘gluing’ the PMHWDO together, working towards a common and well understood goal.

Strategic objectives for the PMHWDO that provide organisational focus should include:

1. Empower Pacific consumers and families as caregivers and educators.
2. Actively recruit and retain a qualified Pacific mental health workforce in adequate numbers. Annual recruitment targets should be established and adequately funded.
3. Use effective training strategies.
4. Develop Pacific mental health managers and leaders for all segments of the workforce through engagement in appropriate Pacific health leadership training programmes.
5. Ensure that Pacific mental health workforce education, development, and oversight processes (certification, accreditation) have relevance to current mental health practice.
6. Secure sustainable core funding that is adequate to maintain a highly qualified Pacific mental health workforce that creates incentives for personal and professional excellence and provides for infrastructure development.

The PMHWD Organisation could perform the following broad functions:

- Pacific mental health research;
- mental health workforce training;
- education, which will centre on a best practice approach to providing education; and
- dissemination of the PMHWDO’s work programme.
The critical success factors that will support the successful establishment and ongoing effectiveness of the PMHWD Organisation

A success factor identified by hauora.com as being critical for its own success is staying passionate about developing the Maori mental health workforce, being adaptable and being responsive to external environmental factors. A number of other critical success factors were briefly highlighted for consideration.

The proposed governance, management and staffing/organisational structure of the PMHWD Organisation, including specifying full-time equivalents, at each stage of development of the PMHWD Organisation

While there are a number of legal entity options for the PMHWD Organisation there are also a number of options for the establishment of the PMHWD Organisation. The options that key informants suggested were:

1. Umbrella model - for example, umbrella with Te Rau Matatini or umbrella with University or Polytechnic or other organisation;
2. Buddy model - for example, buddy with Te Rau Matatini;
3. Tender model - tender for PMHWD Organisation in the market place; and
4. Integrated model - add PMHWD Organisation EFTS into existing MHWD organisation/structures such as Te Rau Matatini or MHWDP or other existing MHWD organisations.

Assuming that a stand alone, umbrella or buddy model is adopted for the PMHWD Organisation, an indicative configuration of core funded staffing arrangements was provided for illustrative purposes only.

The key characteristics, skills, competencies and abilities of the personnel recommended for key positions in the PMHWD Organisation

For illustrative purposes a list of key characteristics, skills, abilities and competencies of personnel was provided as a starting point for discussion.

The establishment funding required to set up, and ongoing funding required to support, the functions of the PMHWD Organisation

An indicative list of the main cost centres for the establishment and ongoing running of the PMHWD Organisation includes:

- Staffing costs;
- Professional costs;
- Operational costs; and
- Infrastructure/overhead costs.

This list is indicative and provides a starting point for discussion. Further details are provided in the body of the report.
The phases and timeframe for establishing and maintaining the PMHWD Organisation, including transitions and growth stages

The key phases for establishing and maintaining the PMHWD Organisation include:

- Constitution/rules;
- Working Group and Board;
- Organisation structure;
- Strategic and business plans; and
- Promotion of the organisation.

Timeframes and milestones are presented in the body of the report.

The suggested programme of work over the establishment and then the first two years of operation of the PMHWD Organisation, including audiences, strategies, key milestones, responsibilities (who does what) and performance indicators.

Indicative lists of suggested work programme activities, milestones and performance indicators are provided in the body of the report. For example, indicative organisational performance indicators include:

- Management indicators;
- Service provision indicators;
- Quality indicators; and
- Accountability indicators.

The networks and linkages within and external to the mental health sector and Pacific communities, required to be developed by the PMHWD Organisation to support its effective operation.

The report provides an indicative list of networks and linkages within and external to the mental health sector and Pacific communities, required to be developed by the PMHWD Organisation to support its effective operation.

Conclusions

The role of a PMHWD Organisation should be acknowledged by the mental health and addiction community as the expert on Pacific mental health workforce issues. This would provide a focal point for the workforce and others who have an interest in the development of the Pacific mental health workforce. While it is most likely that funding for such an organisation would come from the Ministry of Health, it would be helpful if the organisation was independent in its operation. This would enable it to focus on workforce issues without political interference.

It is suggested that a working group of appropriately qualified people be appointed by the funder to get the organisation underway. The task of this committee will be to assist with planning the new organisation and to undertake project management and administrative functions to assist the Board. The Board will also be appointed by the funders. Its purpose will be to determine the purpose and mission of the organisation and to establish the organisation and put governance structures in
place. Once the working group has completed its tasks, it will dissolve and the Board will continue with its governance role.

It is clearly agreed by all interviewed that the need for a PMHWD Organisation would enhance the education, training, and workforce development needs to address Pacific mental heath issues.

Recommendations

From the literature review

1. Working Group

A small working group of appropriately qualified people should be set up to assist the Board of the PMHWD Organisation by undertaking project management and administration. This group should disband, once their work has been accomplished.

2. Board of Governors

A governance board of appropriately qualified people should be appointed. Their task would be to govern the organisation and approve the structure, functions and constitution/rules of the organisation, including recommendations for ongoing funding. The Board will initially be supported by the working group. Once its work has been completed, the Board will be supported by management and staff.

3. Funding

The new Pacific mental health workforce development organisation will need a source of secure funding in order to set up and become established. The Ministry of Health currently funds four existing mental health workforce development programmes - Werry Centre, Te Rau Matatini, the Mental Health Workforce Development Programme and Matua Raki. It is recommended that the Ministry of Health fund the establishment and development stages of the new organisation. The Board can then recommend the best way to secure ongoing funding in order to achieve the mission that they have developed for the organisation.

4. Organisation Functions

The success of a PMHWD Organisation will be dependent on the service that it provides for meeting Pacific mental health and addiction workforce needs. It is recommended that a needs assessment of the workforce be undertaken to establish what those needs might be. To assist with meeting the Pacific mental health workforce needs and to assist with developing the workforce, it is recommended that the new PMHWD Organisation include:

- championing the Pacific mental health and addiction workforce;
- coordinating Pacific mental health and addiction workforce planning;
- developing core service provision competencies for community-based mental health and addiction providers;
- developing employment standards for recruitment, selection and performance management of the Pacific mental health and addiction workforce;
• ensuring that there are sufficient managers available who are competent to work in mental health and addiction;
• liaising and collaborating with other organisations involved with mental health and addiction workforce development; and
• undertaking activities that assist with the achievement of Government’s aims for Pacific mental health and addiction.

5. Timeframes and Milestones

It is estimated that a PMHWD Organisation will take about eight months from the appointment of the working group to establish and become operational. It is recommended that the timeframes and milestones indicated in Table 9 of this literature review be adopted. This provides for:

• establishing the organisation - 8 months until all staff have been hired;
• employing the CEO and other staff - 8 months after commencement;
• transition from development to full operation - 12 months after commencement; and
• growth - ongoing.

From the key informant interviews and document analysis

1. This feasibility study recommends that the establishment of PMHWD Organisation has significant potential to build the Pacific mental health workforce and recommends that it is a necessary development to be progressed.
2. It is important that this organisation is funded adequately to establish an accountable, robust and transparent PMHWDO.
3. The community of Pacific stakeholders needs to be continually consulted during the process of establishment.
4. While initial primary focus is on mental health workforce development, it should be remembered that mental health intrudes into other areas of health including disability and public health.
5. The PMHWDO should be underpinned by Pacific values and principles that promote professional and quality management processes.
6. The research identified gaps in the child and adolescent workforce mental health and a key objective of the PMHWD Organisation should be to build the Pacific CAMHS workforce. This may include possible training at the secondary school level around mental illness and the career pathways possible for those wanting to work in this area.
7. The organisation should be staffed by a “best person for the job” fit. The abilities and skill mix of the PMHWD Organisation should be underpinned by a philosophy of a by Pacific for Pacific approach.
8. The PMHWD Organisation has responsibility to ensure that it reflects a pan-Pacific approach to its internal development and workforce programmes. Managing risks include ensuring that ethnic politics do not monopolise programme development and dilute the workforce programme objectives.
Managing the Pacific community expectations is essential where Pacific peoples have significant critical mass. The Pacific community is divergent and stakeholder groups might place undue expectation on the PMHWD Organisation and pressures to be unrealistic to perceived needs to be included in everything Pacific Island and or mental health would lead dilution.

9. The PMHWD Organisation can play a key role in developing future leaders. It was raised during interviews that present leadership has often emerged without the guidance or support to grow. A leadership development role would address this gap.

10. The PMHWD Organisation is to coordinate, facilitate, design and deliver training opportunities for mainstream organisations working with Pacific service users to better understand Pacific peoples' needs and be able to deliver culturally appropriate services that produce positive Mental Health outcomes.

11. The PMHWD Organisation location should be given due consideration taking into account the:
   - accessibility to the programmes for Pacific peoples; and
   - strategic alliances to MHWD O
   - rganisations, and the benefits of stakeholder credibility if the options of umbrella or buddy model are progressed.

12. The PMHWD Organisation should establish key linkages with Industry Training Organisations (ITOs) particularly as there is a focus on workplace assessment at entry level.

13. The PMHWD Organisation should undertake and coordinate research which prioritises the importance of family-based interventions which are aligned with the Te Tahuhu direction report.

14. Critical to the success of the PMHWD Organisation is ensuring that the financial accountabilities of the organisation and the governance role are managed by quality processes which involve evaluation and quality and financial audits of performance.

15. The models presented carry risks and advantages however, a stand alone organisation would carry the most risk. Nor would the tendering as this gives opportunity for what essentially could be a stand alone operation to exist. It is therefore recommended that, one of the two options should be considered.

16. The PMHWD Organisation would also have a key objective to develop leadership, through training, supportive environments and assistance with the New Zealand-born/Island-born role in leadership development.

17. The PMHWD Organisation key objective is to provide leading strategic direction to the workforce in the development of Pacific mental health workers through workforce development planning aligned with sector developments by establishing secondary school, tertiary and postgraduate and a range of workforce development programmes to cater for entry and advance qualifications.

18. The PMHWD Organisation should be responsive to Maori mental health workforce development and needs to identify clearly the learning needs of the PMHWD Organisation and establish action plans which integrate the cultural training required to be a genuinely culturally aware organisation.
19. A PMHWD Organisation programme should be aligned with the Maori workforce development organisation, Te Rau Matatini which has already established credibility in the wider mental health sector with special focus on the development of dual competency.

20. Future recommendation of potential strategic development after establishment phases includes possibilities of links to the Pacific mental health community support work programmes either existing, or assisting in the establishment of CSW training scheme.
Section 1: Literature Review

Scope of the Literature Review

The literature review was undertaken using national and international literature, to inform the feasibility of establishing a Pacific mental health workforce development organisation. Options for establishing and maintaining such an organisation are reviewed and known critical success factors and implementation programmes are discussed. An international literature review was undertaken to provide a wider context for discussing the feasibility of establishing a PMHWD Organisation in New Zealand.

The aim was to include key sources such as documents on ethnic workforce organisations, Pacific workforce development and Pacific workforce capability. While there was a wealth of literature about general mental health workforce development, there was a lack of quality material on Pacific or other indigenous mental health workforce issues.

The reviewers identified five recommendations for forming and running a PMHWD Organisation.

Method

The review uses published literature to conduct a critical appraisal of the identified articles. Literature was sourced from published articles, books and electronic literature using computer searches. Most of the available New Zealand material has been published by Government ministries, agencies and Government funded organisations. An international literature search was undertaken by NZHTA. The search included literature published in English from 1995 to 2005. It proved difficult to locate quality literature on Pacific and other indigenous mental health workforce issues.

Two separate searches of bibliographic resources were undertaken\(^1\). The first was on the establishment and functioning of mental health workforce organisations in general. The second was on Pacific or other indigenous mental health workforce organisations. Sources searched include:

- Bibliographic databases,
  - Embase
  - Current Contents
  - Cochrane Central Register of Controlled Trials
  - Index New Zealand
  - Medline
  - Cinahl
  - Science/Social Science Citation Index
  - Psychinfo

\(^1\) Further details of the literature searches are provided in Appendix 1.
Section 1: Literature Review

- Te Puna - New Zealand Bibliographic Database;
- University library catalogues,
  - Auckland University of Technology
  - Massey University
  - University of Otago
  - Victoria University
  - Lincoln University
  - University of Auckland
  - University of Canterbury
  - Waikato University; and
- Other sources,
  - Published articles
  - Internet Website searches
  - Published books.

Background

New Zealand is currently in the midst of a major reform of mental health and addiction service delivery. The reform is derived from the transferral of care from institutions to community-based care. The focus on community-based care has changed the capacity, capability and quality required of the mental health and addiction workforce. This in turn has changed the requirements for training and recruitment of the workforce. Similar reforms have been occurring in the U.K. and Australia (Mulvale, December 2004). These are also mentioned in this review. The following literature review discusses the feasibility of establishing a PMHWD Organisation and gives guidance as to how that might be achieved.

Pacific Demographics

Pacific people have been migrating to New Zealand since the War II. There was a large migration in the 1960s and 1970s. By 2001 there were close to 232,000 Pacific people living in New Zealand. Pacific peoples make up 6.5% of the total population (Statistics New Zealand, June 2002, p.17). These people represent more than 20 different ethnic communities, each having their own culture, language, history of settlement in New Zealand and health status (Ministry of Health and Pacific Island Affairs, September 2004). The Pacific population in New Zealand is young with 58% having been born here. As part of establishing themselves in a new country, Pacific peoples have had to adapt to a “new social and economic environment” (Statistics New Zealand, June 2002, p.17).

Numbering 115,000 people at the 2001 Census, the Samoan ethnic group was the largest, making up almost half of the Pacific population. This was followed by Cook Islands people with over 52,500, then Tongan (40,700), Niuean (20,000), Fijian (7,000) and Tokelauan (6,000), with small numbers from other Pacific ethnic groups (Statistics New Zealand, June 2002).
Ninety-eight percent of Pacific people live in urban areas, with 66% living in the Auckland area (Statistics New Zealand, June 2002, p.24). There are also Pacific people living in Wellington, Christchurch, Dunedin and Waikato (Annandale and Instone, 2004). According to Statistics New Zealand (2002) 78% of Tongans and Niueans live in Auckland, 53% of Tokelauans live in Wellington and 24% of Tokelauans live in Auckland. While Fijians are more likely than other Pacific ethnic groups to live in rural areas (5.5%), Cook Islands people and Tokelauans are more likely than others to live in secondary urban areas (6%+) (Statistics New Zealand, June 2002, p.24). There are also smaller Pacific communities in Hawkes Bay, Waikato and Southland (Mental Health Commission, June 2003).

Statistics New Zealand cited in National Addiction Centre (June 2005) change forecasts for Pacific population indicate that by 2021, the median age of the Pacific population will have increased by two and a half years. They also predict that the Pacific population will make up a higher proportion of the overall population than it does now and will have a growth rate of 58%.

Previously existing economic disparities, particularly for younger New Zealand-born Pacific people have improved since the 1960s and 1970s. However, Pacific people are still over-represented among the unemployed, lower-skilled workers and low income earners (Statistics New Zealand, June 2002). Their health status is poorer than the rest of the population due to increased exposure to low incomes, unemployment, poor housing and lower levels of education (Ministry of Health and Ministry of Pacific Island Affairs, September 2004).

**Pacific Health**

The consumers mentioned in this literature review represent the 3% of mental health consumers who have serious mental illness and are treated in the mental health sector. The 17% of mental health consumers who have mild to moderate mental illness are usually cared for by general practitioners and primary health providers (Mental Health Commission, September 2001).

Most adults, regardless of ethnicity, rate their general and mental health as being between good and excellent. This includes Pacific peoples, whose health status is poorer than other ethnic groups in New Zealand (Ministry of Health, 2003). Low income and the resulting poverty contribute to poor health through nutrient deficiencies, which can also contribute to obesity and other health problems (Ryan, June 2005). Other Pacific health statistics include:

- the life expectancy of Pacific males is reducing while it is increasing for males in the rest of the population;
- the Pacific infant mortality rate is 40% higher than the New Zealand average;
- Pacific children and infants are more likely to be hospitalised for asthma and lower respiratory tract infection than the national average;
- Pacific children have twice the meningococcal disease rate and up to five times the rheumatic fever rate of the New Zealand average; and
- The Pacific mortality rate for cardiovascular disease is higher than for the total population (Ministry of Health. The Health of Pacific Peoples, April 2005).
In the New Zealand Health Survey, one twelfth of Pacific adults reported that they had seen a Pacific health provider during the last year (Ministry of Health, 2003). However, Pacific people are less likely than others to see a doctor, even when they think there is a need to do so (Ministry of Health, The Health of Pacific Peoples, April 2005).

Pulotu-Endemann et al. (2004) reported that more Pacific males than females (60%) were included in the mental health statistics of the New Zealand Mental Health Classification and Outcomes Study (CAOS). They also reported that Pacific males who are mental health consumers, are more likely than Pacific female mental health consumers to live in areas of high social deprivation. Both were highly represented in the 8th and 10th decile of deprivation, where 10 is the highest level of deprivation (Pulotu-Endemann et al. 2004). This is significant given that social deprivation has been found to impact detrimentally on health.

In the Mental Health Classification and Outcomes Study conducted for the Health Research Council of New Zealand (HRC), the highest proportion of mental health consumers was in the 20 to 29 age group. This was followed by the 30 to 39 age group. In contrast to this, the highest proportion of Pacific female mental health consumers was in the 55 to 59 age group (Pulotu-Endemann et al. 2004).

Other facts about Pacific peoples from the CAOS Study include:

- they are more likely to receive direct community care than inpatient care, but their rate of inpatient care is higher than that of the rest of the population;
- children and youth had the highest incidence of inpatient care of any group;
- children and youth had the highest incidence of assessment only, meaning they were assessed, but not admitted for treatment;
- people over the age of 59, do not feature in the mental health statistics; and
- mental health consumers are more likely than others to be involuntary consumers with major problems (cited in Pulotu-Endemann et al. 2004).

The Classification and Outcomes Study did not include the cause of illness, so according to (Pulotu-Endemann et al. 2004) it is possible that dual diagnoses, including drug and alcohol related conditions could also be present. Sixty-six percent of Pacific adult episodes compared to thirty-nine percent of European episodes were diagnosed as schizophrenia, paranoia or acute psychotic disorders. For Pacific children and youth “other” episodes were most common for community episodes followed by stress and adjustment disorders. For inpatient episodes in Pacific children and youth, schizophrenia, paranoia and acute psychotic disorders were most common. It should be noted that the conditions of consumers included in the Classification and Outcomes Study were acute (Pulotu-Endemann, et al. 2004).

**Pacific Mental Health Services in New Zealand**

New Zealand has 21 District Health Board (DHB) health providers and 350 Non-Government Organisation (NGO) community health providers. NGO providers use one third of the total health expenditure on mental health and addiction services. They also represent one of the largest NGO mental health sectors in the developed world, according to the Ministry of Health (2004) quoted in Mulvale, (December 2004).
The Mental Health Commission (June 2003) reported that there were 20 providers of Pacific targeted mental health services in New Zealand, whose services were mostly provided in the community. This included fourteen NGO and six DHB providers that practiced in areas where Pacific populations number over 4,000. These areas include Waitemata, Auckland, South Auckland, Waikato, Wellington, Hutt Valley, Canterbury, Northland and Hawke’s Bay.

Pacific mental health services have been set up for varying reasons. One community service that provides support in clients’ homes as well as day activities was set up in 1996 in response to a needs assessment project undertaken in Porirua in 1994. The purpose of a drug and alcohol service in the Central Health Funding Authority (CHFA) district was to “improve health, prevent harm and reduce health risks in a culturally appropriate environment” (Pacific Peoples’ Advisory Committee of the Mental Health Commission, 1998, p.19).

**Areas of Need**

The Mental Health Commission (June 2003) in its 2002 annual report observed that there was an unmet need in many places for mental health services for Pacific children and youth. This was said to be significant as nearly half (48%) of the Pacific population is less than 20 years old. The Ministry of Health (April 2005) later supported this observation by saying that in the future, the 10 to 30 year age group is likely to have the greatest need for mental health services, as they are the age group in which mental illness is most likely to occur for the first time. Further, the fast rate of increase in this age group will impact on service provision in the near future. According to Gough (2004, cited in Mulvale, December 2004) there are insufficient existing community mental health services and they are greatly under-resourced.

**Service Use**

The Ministry of Health (April 2005) indicated that mental health services were used by Pacific ethnic groups at the rates shown in Table 1. The figures indicate the percentage of each ethnic group that used mental health services.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Usage</th>
<th>Ethnicity</th>
<th>Usage</th>
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<tbody>
<tr>
<td>Samoan</td>
<td>43%</td>
<td>Cook Islander</td>
<td>20%</td>
</tr>
<tr>
<td>Tongan</td>
<td>11%</td>
<td>Fijian</td>
<td>7%</td>
</tr>
<tr>
<td>Other Pacific</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
</tbody>
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The figures shown in Table 1 are: low for Tongans at 11% as they make up 15% of the Pacific population; high for Fijians at 7% as they make up 3% of the Pacific population; and also high for others at 18% as they make up 13% of the Pacific population (Ministry of Health, April 2005).

In the past, Pacific people have had no choice but to use mainstream mental health services. According to Annandale and Instone, (2004, p.14), “the first Pacific services were attached to the District Health Committees” and helped to improve access for Pacific people. They were most likely to be located in hospitals, but were
staffed by Community Support Workers rather than the doctors and nurses, who staffed mainstream services (Annandale, and Instone, 2004).

However, the under-utilisation of one Pacific mental health clinic was thought to be due to its location within a hospital (Annandale and Instone, 2004). The Pacific Peoples’ Advisory Committee of the Mental Health Commission (1998) confirmed that some Pacific people feel uncomfortable in a hospital setting. However, Pacific mental health services that use a holistic approach that acknowledges Pacific belief systems have met the expectation of some consumers (Annandale and Instone, 2004).

**Pacific Perceptions of Mental Health**

Many Pacific peoples’ view of health is holistic. The cause of mental health conditions is viewed by some as spiritual or inherited (Ministry of Health, April 2005). Lee (2002) states that in many Pacific cultures there is no translation for mental illness. Psychological and emotional difficulties are considered to be part of biological, cognitive and spiritual functions.

Some Pacific people find it difficult to identify with the Western idea that there is a biological cause for mental illness or that it is caused by a chemical imbalance. Behaviours that are seen by Westerners to be unusual or extreme are sometimes more easily accepted by Pacific people (Ministry of Health, April 2005). Lee (2002) observes that as Pacific people in America become acculturated to the American culture, their view of mental health becomes more ‘westernised’. Lui (2003) agrees with this by suggesting that some Samoans do not understand traditional perspectives on mental illness either because they have grown up with Western influence or they have been acculturated into believing that a Western paradigm is better. The impact of acculturation on mental health remedies and services is likely to become more relevant as the proportion of New Zealand-born Pacific people increases.

**Traditional Healing and Care**

Pacific people often seek treatment for mental health conditions from traditional or spiritual healers (Ministry of Health, April 2005). Pacific mental health and addiction consumers have indicated that they would like to use traditional healers alongside mainstream mental health services, according to the Mental Health Workforce Development Co-ordinating Committee (July 1999). Lui (2003) states that the traditional practice of Samoan healing is based on the premise that healers provide services out of love (alofa) for people and the desire to help them. The healing skill is a gift that is passed from the donor to the receiver. The new healer can then perform the same healing that the donor performed. The treatment given by the healer (love and care) usually consists of gentle talking and massage. The people seeking treatment show their alofa by offering gifts such as food, fine mats or money in return for the service (Lui, 2003).

The traditional Samoan way is for families to care for those who have mental health issues. The person being cared for takes part in everyday activities and the entire village may be involved with his/her care. Lui (2003) also maintains that some families try to continue this practice in New Zealand, but find it difficult due to the different environment and relationships that exist in New Zealand.
Families and Mental Health

In many Pacific cultures, family is an important and integral part of mental health consumers’ everyday lives. It is necessary for family to be included in the recovery of Pacific mental health consumers (Annandale and Instone, 2004). However, Annandale and Instone (2004) suggest that mainstream mental health services are not designed for the inclusion of consumer families in recovery programmes. They say that although some consumers may not want family involved in their recovery, for many it is vital.

Families need to be educated about the mental illness of their family member so they can assist with recovery (Annandale and Instone, 2004). They also say that mental health services can play a pivotal role in assisting families to understand mental illness. This helps consumers with their recovery process.

In reference to providing for the health needs of Pacific Island Americans, Lee (February 2002) said that it is important that cultural and social links are provided between service providers and consumers’ families. This says Lee, will integrate mainstream and Pacific approaches by empowering families and using their strengths. As a result, families and communities become actively involved in consumers’ recovery processes. The National Addiction Centre (June 2005) says that families of mental health consumers spend the most time with consumers and support consumers’ recovery. Practitioners, they say, only spend a limited time with consumers and so can only provide limited support.

Challenges for the Pacific Mental Health Workforce

Mulvale (December 2004) claims that workforce challenges such as lack of coordination of care result from a rapid increase in the number of mental health service providers. Providers have been subject to tighter auditing and monitoring, but have not had any funding increases to help with compliance and data collection costs. Mulvale says it is difficult for NGOs to absorb compliance costs because they do not offer a full range of services like DHBs do.

According to the Mental Health Commission (June 2003) there is a shortage of experienced Pacific mental health clinicians and the demand for them is likely to increase as the now young Pacific population ages. 1996 statistics show that over half of Pacific health workers (579) were nurses and of these, only 33 were mental health nurses. This indicates an increase of 27 mental health nurses since 1992 (Ministry of Health, April 2005). Social workers or case workers represented more than one quarter (666 people) of the Pacific health workforce in 2001.

The Ministry of Health (April 2005) stated that the overall Pacific health workforce increased more between 1996 and 2001, than the total health workforce. While in 1992 there were no Pacific psychiatrists or psychologists, a small number have become qualified since then. In 2001 to 2002, there were 121.9 full-time equivalent Pacific mental health workers. The majority, 86.7% worked in mainstream mental health services. The rest were evenly distributed between alcohol and other drug and child and youth services. Just 3.3% worked with older people. However, this may be a reflection of the relatively low numbers of Pacific people in the older age group, assuming that Pacific health workers prefer to work with Pacific people.
Mental Health Networks and Workforce Organisation Programmes

Networks

There are four regional mental health networks in New Zealand. The regional networks are:

- **Southern Regional Mental Health Network** - incorporating the six South Island DHBs as follows,
  - Canterbury
  - Nelson-Marlborough
  - Otago
  - South Canterbury
  - Southland
  - West Coast;

- **Central Regional Mental Health and Addictions Network** - incorporating the following DHBs,
  - Capital and Coast
  - Hawkes Bay
  - Hutt Valley
  - MidCentral
  - Wairarapa
  - Whanganui;

- **Midland Regional Mental Health Network** - incorporating the following DHBs,
  - Bay of Plenty
  - Lakes
  - Tairawhiti
  - Taranaki
  - Waikato; and

- **Network North Coalition** - incorporating the following DHBs
  - Auckland
  - Counties Manukau
  - Northland
  - Waitemata (Goodhead and Cumming, March 2005).

The original purpose of the networks was to assist regional planning and to act as a vehicle for developing the mental health sector. Although not workforce organisations as such, they influence service delivery and hence workforce issues. The role of the networks is to provide funding and planning for services that DHBs can not provide. The membership of the networks is comprised of the DHBs in the geographical area covered by the network as shown above. The networks focus on the tasks that are common to all of the DHBs and can be enhanced by a regional
focus. The success of the networks has been varied, but it is considered that more time is needed for the full benefits to become apparent (Goodhead and Cumming, March 2005).

In New Zealand, there are four Government funded mental health workforce development programmes. One of these, Te Rau Matatini is an ethnic specific programme, for Maori. The other three focus on a particular area of mental health. These programmes are the Mental Workforce Development Programme, the National Addiction Centre’s Matua Raki programme and the Werry Centre. There is also a Maori health workforce development organisation called the National Maori Health Workforce Development Organisation or hauora.com (the name that is used in day-to-day communication). hauora.com is supported by Maori health professionals and its focus includes Maori mental health workforce issues. Its website hauora.com is used to communicate with stakeholders (hauora.com).

**Mental Health Workforce Development Programme (MHWDP)**

The Mental Health Workforce Development Programme (MHWDP) is a partnership between the District Health Committee, which is comprised of DHB CEOs and the Ministry of Health. It is administered by the Health Research Council of New Zealand and was launched in Wellington in May 2003 (Mental Health Workforce Development Programme, 2005). Its purpose is to address workforce issues including:

- increasing staff numbers to meet demand;
- ensuring that the workforce includes appropriate skill mixes;
- sufficient effective training for working in a different delivery environment; and
- adequate services that are delivered in an appropriate way to children and youth, Maori and Pacific people (MHWDP Programme, November, 2005).

The goals of the MHWDP Programme are to:

1. implement workforce development initiatives and inform evidence-based workforce development initiatives;
2. provide a transparent workforce development administration mechanism;
3. systematically evaluate workforce initiatives in order to ensure that the initiatives are effective and efficient; and
4. promote a nationally coordinated approach that will increase mental health workforce capacity and capability. Mental health services will then be able to meet adult mental health consumers’ needs (Mental Health Workforce Development Programme, November 2005).

The MHWDP manages 25 projects that are directed by the Ministry of Health. The projects encompass the following areas:

- organisational development;
- recruitment and retention;
- training and development; and
- research and evaluation.

As well as managing projects and publishing project reports, MHWDP undertakes the following:
• publishes a fortnightly newsletter;
• manages a website;
• provides an online project management and contract reporting system; and
• maintains relationships with stakeholders (Mental Health Workforce Development Programme, 2005).

National Addiction Centre – Matua Raki

In 1996, the National Addiction Centre was set up by the Alcohol Advisory Council of New Zealand (ALAC) as an alcohol and drug treatment resource (Adamson, 2004). Currently funded by the Ministry of Health, it is based in Christchurch with satellites in Wellington and Hamilton (Hatcher, February 2005). Its Addiction Treatment Sector Workforce Development Programme, ‘Matua Raki’ is comprised of a ten year strategic plan for developing the addiction treatment sector workforce (Adamson, August 2005). The aim of Matua Raki is to provide the addiction treatment workforce with the following resources:
• encouragement;
• resources and rewards for excellence in addiction treatment;
• training;
• support the New Zealand School of Addiction;
• consult on the strategic plan; and
• build research and evaluation capacity in the area of addictions (Mental Health Directorate, 2005).

The addictions sector is being consulted as part of this project via a reference group and other key people (Adamson, August 2005).

Other activities of the National Addiction Centre include conducting research, providing training programmes and consultation and liaison. Its overarching goal is to improve the care and treatment of people with alcohol and drug-related problems (Adamson, 2004).

Werry Centre

The purpose of the Werry Centre is to improve New Zealand children’s and adolescents’ mental health (Faleafa, January 2004). Part of the University of Auckland’s faculty of medical sciences, it undertakes workforce development in the area of child and adolescent mental health, under contract to the Ministry of Health. As well as workforce development, the Werry Centre provides teaching, training and research services. It is contracted to progress organisational development, recruitment and retention, and workforce development infrastructure within the child and adolescent mental health sector (The Werry Centre, 2004).

The Werry Centre aims to develop a network of Pacific mental health workers who work with children and adolescents. They are also working to establish the needs of the child and adolescent mental health workforce (Faleafa, January 2004).
**Te Rau Matatini**

Funded by the Ministry of Health, Te Rau Matatini was established in 2002 to give Maori mental health consumers access to qualified Maori mental health workers and mental health professionals (Te Rau Matatini, 2002). It was initially located at Massey University in Palmerston North, but has since become an independent charitable trust that is contracted to the Ministry of Health (Hatcher et al. February 2005). Te Rau Matatini’s aim is to increase career opportunities for the Maori mental health workforce. It is also concerned with staff retention issues and the quality of the Maori mental health workforce (Te Rau Matatini, 2002). Health and workforce issues are addressed by undertaking projects, providing resources such as videos, publications and other information as well as education and training (Te Rau Matatini, 2002).

**hauora.com**

hauora.com is a Maori health organisation whose mission is to build an effective and united Maori-led health workforce (Hatcher, February 2005). It is a national initiative that came about in response to the need for Maori health professionals, managers and workers to be active in their own development. hauora.com is supported by Maori professional health associations (hauora.com, August 2005).

**U.S. Workforce Organisations**

The following four American organisations are samples of U.S.A.-based organisations that are targeted at specific groups. Although not set up as workforce organisations per se, they have a strong workforce and/or social service component in the work that they do.

The Asian American Federation of New York supports thirty-five member community service organisations. It is a non-profit leadership organisation that works to improve the quality of life for Asian Americans in the New York metropolitan area. One of its programmes provides culturally appropriate mental health services to two ethnic groups that have reportedly not been serviced well in the past. Increasing the number of professionals who are qualified to work with the targeted communities is an integral part of the programme (Carrasco and Weiss, 2005).

The Asian American Psychological Association was set up in December 1972 by psychologists and mental health professionals. The purpose was to ensure that American mental health professionals had appropriate training and education and that mental health issues were discussed and addressed where appropriate. The work of the Association was to include collaboration and networking with peers. The Association advances Asian American Psychology and advocates on behalf of Asian Americans. It is reported to be a leader of the ‘multicultural psychology movement’ (Carrasco and Weiss, 2005, p.33).

The Association of Asian Pacific Community Health Organisations is a national association that was formed in 1987. It represents community health organisations that are dedicated to improving the health and access to health services for Asian Americans, Hawaiians and Pacific people in the United States. It runs training conferences for health professionals and provides assistance for establishing and maintaining Asian and Pacific community health centres (Carrasco and Weiss 2005).
The National Asian American and Pacific Islander Mental Health Association (NAAPIMHA) came into being following recommendations from a mental health summit held in Washington D.C. in July 1999. A major focus for NAAPIMHA is workforce development, based on five advocacy areas, which each build on the success of the others. These advocacy areas are:

1. enhancing the collection of appropriate and accurate data;
2. identifying current service and best practice models;
3. increasing capacity building including the provision of technical assistance and training for professional and para-professional service providers;
4. conducting research and evaluation; and
5. working to engage consumers and families (Carrasco and Weiss, 2005, p.38).

Some other organisations are dedicated to a single health profession such as psychiatry. This includes organisations such as the Indo-American Psychiatric Association (Carrasco and Weiss, 2005, p.37). See Table 2 for a summary of health workforce organisation activities.

Mental Health Sector Challenges

The Minister of Health (June 2005) identified ten leading challenges for the whole mental health sector over the next ten years. These challenges may have to be redefined as they are met and as new challenges arise. The challenges are a mixture of high level and operational level action priorities put together in response to a complex mental health sector. The challenges, which are discussed in more detail later in this document, follow. They are targeted primarily at mental health consumers whose condition is severe. The challenges are to:

- promote mental health and wellbeing and prevent mental illness and addiction from occurring. This includes addressing discrimination, increasing awareness about how to maintain good mental health and wellbeing and improving peoples’ understanding of addictive behaviours and the importance of early intervention in preventing and limiting harm;
- increase the funded services available for children and young people and for older people and broaden the range of funded services for adults;
- improve the responsiveness of mental health services for Pacific people immediately;
- build the mental health workforce so that it has a recovery-focused culture and is committed to delivering high quality services;
- continue to improve the quality and choice of services available to Maori;
- enable the primary healthcare sector to promote mental health and wellbeing and respond to the needs of mental health consumers;
- improve addiction services by making them more readily available, more accessible and of a high standard. Strengthen the alignment between mental health services and addiction services;
- ensure that funding mechanisms for mental health will support recovery, enable collaboration and advance best practice;
• create an open environment with readily available information and results-focused service delivery. This should strengthen the public’s trust in the mental health sector; and

• encourage DHBs to collaborate and work together regionally and nationally. This should ensure optimal use of resources, minimise clinical risk and maximise workforce capabilities. Health service providers and other government-funded social services need to become aligned.

Table 2: Health Workforce Organisation Activities

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MHWDP</td>
<td>2003</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>Werry Centre</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
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<td>2002</td>
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<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hauora.com</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian American Federation of New York</td>
<td>1972</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assn of Asian Pacific Community Mental Health Organisations</td>
<td>1987</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Asian American &amp; Pacific Islander Mental Health Assn</td>
<td>1999</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 summarises the activities of health workforce organisations. It gives an indication of the known activities undertaken by the listed workforce organisations and is not an exhaustive list. It shows that the most common activity is workforce development, followed equally by research and evaluation and training programmes.

Delivering mental health services to Pacific communities is currently more difficult and expensive than delivering mental health services to the general population according to the Ministry of Health (April 2005). The Ministry says that this is due to poor regional planning, coordination and collaboration. It is the transient and mobile
nature of the Pacific population that make effective service coordination difficult to achieve. In the future, says the Ministry, there is likely to be a growth of ethnic-specific mental health services to deal with this. Some of these services may operate as part of general health services. Goodhead and Cumming (March 2005) suggest that there is a need for mental health to be integrated with primary care, as mental health consumers are often involved with multiple health services at the same time.

Goodhead and Cumming (March 2005) in their report on regional approaches to mental health, said that informants identified poor communication within the sector as an issue that needed to be addressed. In particular, poor communication was identified as one of the barriers to building closer relationships between DHB and NGO providers. This, say Good and Cumming has resulted in NGOs not being utilised as well as they could be. Further, lack of communication has led to misunderstanding between DHBs and NGO providers, resulting in unequal pricing distributions and accountability processes. It was also claimed that mental health is separated from other parts of the health sector.

In addition to communication concerns, informants raised issues to do with mental health workforce capacity and capability. This included insufficient staff with the appropriate skills, inadequate upskilling, poor staff retention rates and difficulty recruiting good managers. Informants claimed that advocacy and clinical leadership are currently ineffective. Some informants were unclear about lines of accountability saying that they were unsure whether the NGO mental health sector is accountable to the Ministry of Health, or the DHBs (Goodhead and Cumming, March 2005).

**Government Outcomes for Pacific Mental Health**

*‘The Government expects State agencies to demonstrate that mental health services are trustworthy, accountable and produce results’*  
(Minister of Health, June 2005, p.4).

Services for all people with severe mental conditions should be of high quality and focused on wellness and recovery. Delivered in an unrestricted environment using proven delivery methods, services should be based on the understanding that biological as well as psychological, social, cultural and spiritual factors are involved in mental health (Minister of Health, June 2005). The Ministry of Health (April 2005) on an earlier occasion said that it is ‘imperative’ that practices encompassing Pacific holistic views of health are incorporated into mainstream service provision.

**Pacific Mental Health Workforce**

The Health Funding Authority (HFA) (September 2000, p.1) specifies that there are deficiencies in mental health human resources in the following areas:

- workforce development coordination;
- the numbers of workers with the required skills;
- workforce attitudes and values;
- training to deal with a changed delivery environment; and
- recruitment and retention.
The Ministry of Health notes that there is a high growth of Pacific adolescents and young people of working age. This is the age group that has the highest risk of developing mental illness. Therefore, a higher number of Pacific people are likely to develop mental illness. However, the rapid growth in this age group also means that within 20 years, there will be potentially more Pacific people available to be mental health workers (Ministry of Health, April 2005).

The Health Workforce Advisory Committee\(^2\) (October 2002) identified the current failure of the education system to meet the needs of Pacific people as being a major contributing factor to the shortage of Pacific people in the health workforce, and by implication the mental health and addiction workforce. The Committee suggests that this is exacerbated by many schools not providing adequate career guidance to Pacific students. Further, it claims that many Pacific students find it difficult to complete medical training due to heavy family and cultural responsibilities.

Other features that impact on the health workforce have been identified as a lack of pathways into the workforce and a lack of organisational support. In 2002, The Health Workforce Advisory Committee (HWAC) claimed that it can be difficult for Pacific health practitioners who were trained overseas, to meet the New Zealand criteria for registration. It was suggested that Pacific people do not have easy access to funding that would enable mid-career shifts. Further, the remuneration for Pacific health workers often does not reflect the value of their cultural competence (Health Workforce Advisory Committee, October 2002).

**Strategies for Increasing and Improving the Pacific Mental Health Workforce**

The Mental Health and Workforce Development Co-ordinating Committee\(^3\) (July 1999) identified strategies that are important for improving the number and skills of the Pacific mental health workforce. These included:

- recruiting Pacific people into mental health professional training programmes;
- promoting appropriate staff retention policies;
- increasing the number of mental health support workers;
- establishing a coalition of Pacific workers; and
- establishing a mental health forum for Pacific people.

A general observation by the Committee was that there are many organisations with an interest in workforce development, but they are fragmented and lack clarity about roles and responsibilities. The Health Funding Authority (HFA)\(^4\) (September 2000) stated that there were insufficient Pacific registered health professionals working in mental health. Statistics on the Pacific mental health workforce were

\(^2\) HWAC provides strategic advice on the health and disability workforce to the Minister of Health.

\(^3\) The Mental Health Workforce Development Co-ordinating Committee is a committee of the Mental Health Workforce Development Programme. The Programme’s purpose is to ensure a nationally coordinated approach to workforce development in the mental Health sector. The programme is a partnership between the DHB CEO’s and the Ministry of Health (Hatcher et al. February 2005).

\(^4\) The HFA was the part of the Ministry of Health that allocates resources to gain the best health and independence for New Zealanders (HFA Strategic Business Plan: For the Period 1/7/99 to 30/6/00: Wellington: HFA, Retrieved from [www.moh.govt.nz/moh.nsf/](http://www.moh.govt.nz/moh.nsf/)).
published by the Mental Health Commission in *Moving on the Blueprint* in September 2001. They are reproduced in the *The Size of the Pacific Mental Health Workforce* section of this report.

To address the lack of comprehensive up-to-date Pacific mental health workforce information, a mental health workforce database was set up. Funded by the Mental Health Commission, its purpose is to address workforce deficiencies by enabling planning and the consequent targeted funding to be put in place (Mental Health Workforce Development Co-ordinating Committee, July 1999).

The revised *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, November 1998) describes the developments required for mental health services so that the Government can implement its mental health strategy. This includes innovative mental health and addiction service delivery that will meet the needs of the 3% of people who have severe forms of mental illness. The Revised *Blueprint* focuses on the recovery approach, which empowers mental health consumers to participate fully in society. It supports an increase of Pacific owned services for Pacific people as the best way of improving life for Pacific mental health consumers (Mental Health Commission, November 1998).

In *Pacific Mental Health Services and Workforce, Moving on the Blueprint* (Mental Health Commission, 2001), which followed on from the *Revised Blueprint*, it was suggested that Pacific mental health and addiction workers are under-represented in the sector. This they said was due to a lack of planning and support as well as mental health not being perceived as an attractive area in which to work. If the numbers of Pacific mental health workers are to be increased, support services such as adequate training must be provided. In addition, in order to retain skilled people Pacific mental health workers feel valued. This according to the Mental Health Commission (September 2001) requires pay scales to be competitive. In addition, effective mentoring programmes must be provided and cultural aspects of care must be acknowledged and supported. Mental health service providers must have enabling employment policies in place.

Upskilling the Pacific mental health and addiction workforce will also help to address the shortages in all mental health occupations. A culture of learning in mental health services with easy access to training and development will help Pacific staff to improve their skills (Mental Health Commission, September 2001).

It was also suggested by the Mental Health Commission (September 2001) that the creation of mental health and addiction services targeted at Pacific people, would assist in the improvement of Pacific mental health and addiction worker retention. It added that Pacific mental health and addiction staff should be involved with planning services to help ensure that services meet consumer needs. Community liaison staff could facilitate the integration ‘between Pacific health and social services and secondary mental health services’ (Mental Health Commission, September 2001, p.32). Pacific services could assist mainstream services to provide culturally appropriate services for Pacific people.

The Mental Health Commission (September, 2001) made the following general assumptions about the provision of services to Pacific people:

- mental health services need to be located close to where people live;
- it is likely that 50% of the Pacific population will choose to use Pacific dedicated services; and
before a mental health service is set up in an area, it must be established that there are sufficient potential service users to ensure that the service will be financially and clinically viable.

The Mental Health Commission (September 2001, p.37) concluded that the critical areas for Pacific mental health service delivery are:

- the development of a Pacific mental health service framework;
- Pacific provider development;
- Pacific workforce development, including Pacific service users;
- increasing cultural responsiveness of mainstream services;
- promoting and implementing anti-discrimination work;
- partnerships with Pacific service users; and
- information and research needs.

**Children and Young People’s Mental Health**

Gaps in the services available for children and young people with severe mental health and addiction issues identified by the Health Funding Authority (July 2000) included:

- insufficient forensic services;
- a lack of respite and community-based intensive recovery programmes;
- inadequate drug and alcohol services;
- poor access to services for youth with complex needs; and
- poor access for those living in rural areas.

The Authority also stated that a higher percentage of Pacific children and young people than others appear in the justice system for serious offences that involve alcohol and drug dependence and abuse.

**Ministry of Health Strategy**

The purpose of the health strategy (Ministry of Health, October 2003) was to provide a three to five year public health action framework. Its three public health goals were to:

- guide the Ministry and District Health Committees in planning and funding health services;
- guide public health providers; and
- provide an action framework for organisations that influence public health.

It was once thought that Auckland is the only region in New Zealand large enough to sustain Pacific run mental health services. The possibility of developing Pacific mental health services in other areas where there is a substantial Pacific population has now been accepted by Government agencies according to the Ministry of Health (April 2005).
According to Mulvale (2004) New Zealand has moved towards meeting its goals in the reform of mental health generally. Mulvale suggests that the biggest success has come from introducing new categories of workers, such as mental health support workers and improving the competence of the existing workforce. However, says Mulvale, there are still resource shortages and providers are not well distributed.

Barriers to workforce planning have included the lack of quality data and the scarcity of resources and expertise within mental health agencies. Mulvale (2004) says that if a competency framework is developed to address competency issues, it must go beyond the functions that need to be carried out to include the skills, knowledge and attitudes that are required to support mental health and addiction care in the community. It must also provide an insight into the complex environment within which mental health services are developed.

Table 3 summarises the desired outcomes for Pacific mental health and addiction that have been signalled by Government and are included in this literature review.

**Pacific Mental Health Workforce Development Organisation**

Annandale and Instone (2004) suggest that rapidly growing Pacific populations together with inequalities in health status between Pacific people and European New Zealanders is driving the demand for more Pacific directed health services. According to Annandale and Instone, these services must be accessible to Pacific people, be of high quality and delivered in a culturally competent manner. They say that in order for this to happen in the mental health and addiction sector, more Pacific people need to be recruited in all occupations and at different levels and existing workers need to be upskilled. The Ministry of Health (November 2004) states that although there is a lack of comprehensive data on the Pacific health workforce, it is widely acknowledged that there are insufficient qualified Pacific health and disability workers to meet the needs of Pacific communities.

The Pacific Health and Disability Workforce Development Plan (Ministry of Health, November 2004) includes service provider development as well as workforce development in its priority areas. Service provider development includes increasing the capacity and capability of Pacific providers together with sharing resources between Pacific and mainstream service providers. Betancourt et al. (2003) cited in Ministry of Health (November 2004) puts forward a case for developing a Pacific health workforce. They claim that systems and processes are shaped by the leaders who design structural processes and healthcare systems, together with the workforce that carries them out. Further, they claim that health leaders and the health workforce must reflect the ethnic composition of the general population in order for healthcare to be available to minority ethnic groups.

Mental health and addiction sector development could be achieved by way of a Pacific mental health workforce development organisation with a leadership role in the development of the Pacific mental health workforce and Pacific mental health service providers. As an advisor, distributor of information, collector of statistics, researcher and assessor of Pacific mental health consumer needs, this organisation’s role could be vital in ensuring that Pacific communities have access to quality, culturally appropriate mental health services.

**Table 3: Government’s Desired Outcomes for Pacific Mental Health**
**Mental Health Service Providers**

- Recruitment and retention policies.
- Increased services for Pacific people.
- Enabling employment policies.

**Mental Health Service Delivery**

- High Quality delivery.
- Holistic views of mental Health are embraced i.e. biological, psychological, cultural, and spiritual.
- Forensic services are provided for children and young people.
- More respite and community-based intensive recovery programmes are provided.
- Recovery focused.
- Culturally responsive - including mainstream services.
- Adapt to cope with the demands of increased numbers of younger people with mental illness.

**Mental Health Workforce**

- Career guidance.
- Workforce development.
- Effective staff monitoring programmes.
- A coalition of Pacific workers.
- Career pathways.
- Competitive pay scales.
- Capacity building including upskilling.

**Mental Health and Addiction Sector**

- Establish a Pacific mental health forum.
- Provider development occurs.
- Develop a Pacific mental health service framework.
- Promote and implement anti-discrimination policies.

This table shows Government’s desired outcomes for mental health as identified in the ‘ Desired Government Outcomes’ section of this document. The four sections include identified outcomes for service providers, service delivery, the workforce, and the mental health and addiction sector in general.

**Desirable Characteristics of a Pacific Mental Health Workforce**

**Context**

The Ministry of Health’s vision is for a mental health and addiction workforce that is responsive to the needs of mental health and addiction consumers and contributes to the recovery journey of service users. Workforce development should be owned and driven by DHBs and non-government organisations with the focus on developing the mental health workforce to achieve successful implementation of the Blueprint for Mental Health Services in New Zealand, a Mental Health Commission initiative (1998). In developing the mental health workforce, recruitment and retention issues need to be addressed as they are of concern for the entire mental health and alcohol and drug sector according to the Health Funding Authority (September 2000).
The Health Funding Authority (September 2000) cited a study undertaken in 1998, which found that only 40% of workers in the mental health sector had qualifications. The Authority suggested that with long lead-in times to train and upskill staff, new service models that may be developed, are likely to have a strong home care component.

The National Institute of Mental Health in England (NIMHE) et al. (August 2004) informed by a study undertaken by an external working group, maintain that to be effective, a modern mental health workforce must have strong support. The type of support required is indicated in Table 4. It includes the size and skill mix of the workforce, training for managers and working conditions for mental health and addiction service providers.

Table 4: Mental Health and Addiction Workforce Support Requirements

<table>
<thead>
<tr>
<th>Mental Health Workforce</th>
<th>Mental Health Managers</th>
<th>Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Size and skill mix is adequate to meet service user needs.</td>
<td>• Protected time is available for clinical managers to carry out their non-clinical responsibilities</td>
<td>• Service users have a choice of easily accessible advocacy services.</td>
</tr>
<tr>
<td>• The workforce is an acknowledged part of a network</td>
<td>• All managers receive advanced management and leadership training.</td>
<td>• Services are well led and managed.</td>
</tr>
<tr>
<td>• Skills are supported/required by mental health services.</td>
<td></td>
<td>• Service design and practice is values and evidence-based.</td>
</tr>
<tr>
<td>• Employees are trained to do the jobs they are employed and asked to do.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Continuing professional development is available to all staff. Dedicated time and the required resources are available to enable professional development to be undertaken.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Regular appraisals are undertaken.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mentoring and supervision are readily available for those who want it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Qualified and properly informed legal advice about mental health consumer consent and information sharing is accessible for staff.</td>
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<td></td>
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</table>

Table 4 is adapted from information in NIMHE et al. (August 2004, p.31). It includes the size and skill mix of the workforce, training for managers and working conditions for mental health and addiction service providers.
In the Pacific mental health sector there is the increasing need for managers with sound business and planning skills to manage and maintain sustainable Pacific mental health and addiction services. Competent well-trained managers can reassure funders that applications are of high quality and that the applicants have adequate operational and procedural systems in place (Mental Health Workforce, July 1999).

**Size of the Pacific Mental Health Workforce**

The Mental Health Commission (February 2001, p.20) surveyed the Pacific mental health workforce to establish how many people were working in each occupational group. Eighteen people did not respond to the survey. As a result of the survey a table was published, which showed the distribution of occupational groups. That table has been reproduced in this document as Table 5. It shows that close to one third of Pacific mental health workers were community support workers. Nurses had the next highest representation at nearly one quarter of the workforce. Residential caregivers represented 17.4% of the workforce and other occupations had minimal representation. At the time the table was published, there was only one Pacific psychiatrist and one Pacific counsellor. Anecdotal evidence suggests that a few more Pacific people have completed training in these occupations since then. However, these numbers are still very small.

Other tables published by the Mental Health Commission (February 2001) indicated that the highest percentage (30%) of Pacific mental health workers were in the twenty-five to thirty-one age group, and that over 50% of Pacific mental health workers stay with the same employer for only one to three years. It should be noted that these statistics are now four years old, and in workforce occupations and numbers may have changed since then.

According to the Ministry of Health (April 2005) the need to increase the Pacific mental health and addiction workforce was first mentioned in *Moving Forward* (Ministry of Health, 1997) and restated in *Moving on the Blueprint* (Mental Health Commission, 2002). There is an expectation that Pacific people will be employed in proportion to their representation within any given region whether mental health services are dedicated to Pacific people or not (Mental Health Commission, September 2001). However, this may not be realistically achievable in rural areas where Pacific populations have low representation.

The Mental Health Commission (September 2001) cited a survey undertaken in 1999, which indicated that 2.5% of the mental health workforce were Pacific. This compares to Pacific people comprising 6% of the total New Zealand population. At that time, there was a shortage of Pacific mental health and addiction workers in all occupations and at all levels. These occupations range from clinical psychologists to managers to mental health support workers, as listed in Table 5. Increasing the Pacific mental health and addiction workforce and workforce retention had priority (Mental Health Commission, September 2001). They are still priority areas.
Table 5: Occupational Groups - Pacific Mental Health and Addiction Workforce

<table>
<thead>
<tr>
<th>Occupational Group</th>
<th>Number (n=149)</th>
<th>Percent of Pacific Mental Health Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Support Workers</td>
<td>47</td>
<td>31.5</td>
</tr>
<tr>
<td>Nurses</td>
<td>38</td>
<td>25.5</td>
</tr>
<tr>
<td>Residential caregivers</td>
<td>26</td>
<td>17.4</td>
</tr>
<tr>
<td>Social workers</td>
<td>7</td>
<td>4.7</td>
</tr>
<tr>
<td>Managers</td>
<td>5</td>
<td>3.4</td>
</tr>
<tr>
<td>Consumer consultants</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Administrators</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Clinical psychologists</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Matua</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Alcohol and drug workers</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Psychiatric assistants</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Youth workers</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Psychiatrists (training)</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Counsellors</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>149</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

This table is a reproduction of the table published by the Mental Health Commission (February 2001, p.20). It shows that nearly one third of the Pacific mental health and addiction workforce were community support workers, followed by nurses who make up one quarter of the workforce. The next highest representation was residential caregivers. Other occupations had minimal representation.

**Future Pacific Mental Health and Addiction Requirements**

In 2001, the Pacific mental health and addiction resource requirement estimate for the future indicated that 291 inpatient and community beds plus 383 community full-time equivalents (FTEs) would be required by the Pacific population. It was expected that approximately 152 FTEs would be required from services dedicated to Pacific people (Mental Health Commission, September 2001).

The National Mental Health Workforce Development Co-ordinating Committee (July 1999) suggested that it would take too long to train doctors and nurses to increase
the workforce immediately. Therefore, they said, focusing on training mental health support workers would be a good interim solution as they can train while working and the time required for training them is less than the time required to train doctors and nurses.

**Workforce Skill Level**

The Ministry of Health (2005) as mentioned previously requires mental health and addiction service delivery to be of a high standard. Practices must encompass holistic views of mental health. To achieve quality service delivery, training is needed to ensure that services are delivered in a culturally appropriate way. Annandale and Instone (2004) say that the disparities in Pacific peoples’ health are partly due to a lack of cultural sensitivity in assessment and treatment and this discourages people from seeking help early. Training more Pacific people in mental health and addiction and including cultural competence training would go some way to making mental health consumers feel more comfortable about seeking treatment.

All mental health and addiction workers, whatever their occupations, must be trained to deliver what they are employed to deliver (NIMHE et al. August 2004). They must also have the knowledge and attitudes required of competent mental health workers (Mulvale, 2004). A well trained, skilled and culturally competent workforce that follows best practice guidelines is required to ensure that the development and planning of mental health services for Pacific people is of a high standard (Ministry of Health, September, 2002). According to Annandale and Instone (2004) the current Pacific mental health workforce needs to be upskilled. They say that all mental health workers should have the National Certificate in Mental Health Support Work as minimum qualification. As well as being upskilled, the Pacific mental health workforce must be supported and sustainable (Mental Health Workforce, July 1999).

**Scope of the Pacific Mental Health and Addiction Workforce**

The Minister of Health (Jun, 2005) wants mental health services to be broadened to include a wider offering of services and support systems for people with severe mental health conditions. This, the Minister says would involve increasing the availability of funded services for children and young people and elderly and broadening the type of mental health services and supports for adults. In addition to developing new services, existing services need to be further developed to meet the needs of Pacific people, according to the Minister.

**Capacity Building**

In the future, primary healthcare will play a greater role in providing mental health services in the community. Successful delivery of these services will require the skills of a wide range of health professionals according to Annandale and Instone (2004). The mental health workforce needs to be ‘knowledgeable, skilled, competent, recovery-focused’ and culturally capable of meeting ‘the needs of diverse ethnic communities’ (Minister of Health, June 2005, p.12). It must deliver the appropriate mix of services to meet demand. The increasing numbers of Pacific and Maori young people together with the increase in the Asian population may require the development of new skills and new areas of specialised knowledge, to ensure that mental health consumers’ needs are met. Workforce development must
continue with appropriately skilled people being encouraged to take up governance and leadership roles. This will support the mental health and addiction workers who work directly with consumers according to the Minister of Health (June 2005).

HWAC (October 2002, p.80) identified the following four key areas for developing Pacific health workforce capacity:

- clinical and non-clinical expertise in social work, health promotion, community support work and so forth;
- business and management competence so that service providers are able to operate effectively in complex funding environments;
- expertise in planning, funding and policy development to inform decision-making; and
- health research competence to ensure the effectiveness Pacific health interventions (Health Workforce Advisory Committee, October 2002, p.80).

The capacity of the Maori mental health and addiction workforce, and presumably the Pacific mental health and addiction workforce, can be extended by strengthening the expertise of workers in fields that are related to mental health. This says Ihimaera et al. (December 2004) enables relevant and comprehensive services to be made available to consumers and their families.

**Cultural Competence**

An area of concern for participants in a workforce survey, undertaken by Te Rau Matatini was that more training is needed in the areas of Maori culture, Maori language and ways of incorporating traditional ways into mental health practice. There was a lesser demand for training in cultural assessment and more traditional forms of Maori healing (Hirini and Durie, April 2003). As there are some commonalities in cultural practices and similarities in interpretation with Maori, it may be assumed that Pacific mental health workers have similar areas of need.

In a later study, there was a request for models of care to be developed that are culturally relevant as well as being appropriate to particular services (Holdaway, October 2003). Being culturally and clinically competent was considered to be extremely important by 54% of participants in a study on Maori child, adolescent and whanau workforce development (Tassell and Hirini, July 2004). The Mental Health Commission (2001) quoted in Annandale and Instone (2004) stated that the Pacific mental health workforce also needed urgent upskilling in the areas of cultural and clinical competence. The Health Workforce Advisory Committee (August 2003) suggested that increasing the capacity of the Pacific health workforce would require ethnic-specific approaches to be used.

**Child and Youth Mental Health and Addiction Workforce**

Support systems that could be implemented to enhance the child and youth mental health and addiction workforce development include:

- strong national leadership;
- readily available training and development opportunities;
• an adequate supply of experienced Pacific clinicians and other Pacific health workers; and

• a coordinated overseas recruitment programme (Health Funding Authority, July 2000).

According to the Health Funding Authority, freeing key service personnel from their role of supervising students and teaching/upskilling the workforce would make more skilled people available to provide services to clients. Education guidance services would need to be available at secondary schools and at tertiary education level to promote careers in mental health. Providers would also need to educate potential mental health workers about their career options (Health Funding Authority, July 2000).

**Other Workforce Development Initiatives**

HWAC suggested that sharing resources between mainstream and Pacific health providers would help to develop the capability and capacity of the Pacific health workforce. They also said that organisational tools that address discrimination of individuals and institutions need to be developed (The Health Workforce Advisory Committee, August 2003). Hansen (unpublished) maintained that in addition to addressing discrimination, work environments should be modified, where applicable, to accommodate employees with disabilities, including those with mental illness. Hansen also said that qualified employees with disabilities must have the same employment rights and privileges as those with no disability. Hansen suggested that ways in which workplaces can be modified to accommodate those with a disability include:

• restructuring jobs so that marginal functions are passed on to others;
• part-time working hours;
• qualified assistance with reading, interpreting and writing where required; and
• adapting equipment and work areas to meet the needs of workers with disabilities (Hansen, unpublished).

**Workforce Planning**

Piazza et al. (December 2003) claimed that a fragmented approach to mental health workforce planning in Australia, contributed to the ineffective implementation of national mental health policy. They added that the composition and distribution of the Australian mental health workforce prevents it from being responsive to population needs.

The Sainsbury Centre for Mental Health (SCMH, 2000; SCMH, 2003) in Britain cited in Piazza et al. (December 2003) advocates for a coordinated mental health workforce planning process that includes multiple agencies. It contends that there are three key elements involved in increasing the supply of mental health and presumably also addiction workers, in this case nurses. The first is to employ policies that attract people to mental health careers and are conducive to retaining them once they have joined up. The second is to lead and inspire, and the third is to provide supportive and sustainable working environments. In the United Kingdom, establishing recruitment targets appears to have gone some way to increasing the numbers of mental health nurses (Piazza et al. December 2003).
Contacting providers rather than mental health professionals, when assessing local area needs, may result in more effective mental health workforce planning and avoid fragmentation. Once needs have been identified, the education sector could assist with training a workforce that has the skills required to meet local area needs (Piazza Rickwood and Morrison, December 2003).

In order to achieve good workforce planning, according to the (U.K.) Department of Health (March 2003), attention must be paid to obtaining robust workforce data on the numbers of staff, their occupations, skill mix and needs. There must also be local strategies for Government and NGO providers, effective links between service planning and service delivery, and enthusiasm for working across disciplines and professions. To minimise risks, good workforce planning should include:

- strong partnerships and collaboration between organisations;
- information systems that are able to produce the required data in the required format; and
- strong leadership and commitment to make the plan work.

The Department of Health (March 2003) adds that the roles and responsibilities of the stakeholder organisations must be clear.

The National Addiction Centre (June 2005) suggests that a comprehensive workforce development plan needs to include provision for training, ongoing education and career development. Together with workload management, risk management and operational decision making, this will help to address the health system's needs.

**Recruitment and Retention**

Piazza et al. (December 2003) say that the skill level and mix of the mental health workforce must be based on client need, so it follows that mental health workforce recruitment planning must have regard for the whole mental health and addiction workforce. This requires prioritisation and coordination at national and local levels to ensure that some communities are not disadvantaged due to their location. Team work models need to include complementary and supportive roles in each mental health discipline. Piazza et al. suggest that difficulties with retaining mental health nurses, particularly in Australia are partly due to ‘burnout’ and the main reason for ‘burnout’ is lack of resources.

Providing a workplace that is supportive of family responsibilities and work that is satisfying, interesting, allows people to work independently and has good interpersonal relationships will go a long way to assisting with staff recruitment and retention. All staff want to be able to develop their skills and abilities and to feel that the work they are doing is valued say Piazza et al. (December 2003).

Service and Workforce Planning, Victorian Government Department of Human Services (2005) suggest that staff retention rates can be improved by providing:

- adequate induction programmes for new workers;
- peer support and mentoring to assist staff with dealing with the stresses involved with mental health work;
- professional development opportunities to improve skills and knowledge and improved customer service; and
• flexible and safe working conditions that include flexible working hours, interesting work and involvement in decision-making.

Participants at a Pacific Child and Adolescent Workforce fono agreed that recruitment and retention of Pacific mental health workers in mainstream services would increase the workforce and provide the best way to service children, young people and their families. They thought it important to start by upskilling existing staff to fill higher level positions and then to increase workforce numbers. This, they said, would also encourage staff retention. They also suggest that remuneration levels need to be raised to encourage clinicians with cultural competencies to remain in the mental health sector in New Zealand (Faleafa, January 2004).

**Career Pathways**

Career pathways are defined by Grant Wood (http://www.aea10.K12.ia.us/stw/pathways/index.html-ssi) and quoted in Hansen (unpublished, p.20) as ‘clusters of occupations/careers that are grouped because of shared skills and aptitudes.’ Hansen adds that ‘all pathways include a variety of occupations that require different levels of education and training’. Those who select a career pathway gain an area of focus, flexibility and purpose.

The Department of Health (December 2004) says that career progression is also important for workforce retention. They say that an important part of career progression and workforce retention is upskilling the workforce. However, they warn that there also needs to be a clear career pathway for all professions within the health workforce for those who wish to take advantage of it. Each workforce group should be able to see where they fit within the pathway and how they can progress to where they want to go.

HWAC has indicated that there should be an increase in the number of Pacific people employed by DHBs. This, they say could be achieved by developing career pathways, involving Pacific communities in strategic planning for Pacific workforce development, and educating Pacific people about available health career options (Health Workforce Advisory Committee, August 2003).

**Ideal Objectives and Functions for a Mental Health Workforce Organisation**

The MHWDP describes mental health workforce development as including any initiative that influences entry to or exit from the sector (Mental Health Workforce Development Programme, 2005). As previously highlighted, there are four Government-funded mental health workforce organisations in New Zealand. Each focuses on different aspects of mental health. These organisations are:

• **MHWDP** - mental health workforce development using a coordinated approach;
• **Te Rau Matatini** - Maori mental health;
• **Werry Centre** - child and adolescent mental health; and
• **Matua Raki (part of NAC)** - alcohol and addiction.

In addition to the organisations mentioned above, hauora.com is an NGO Maori health workforce development organisation.
Organisation Structure

The four mental health workforce organisations and the Maori health workforce organisation all have different organisation structures, which are explained below.

**Mental Health Workforce Development Programme**

Funded by the Ministry of Health, the MHWDP is a partnership between the Mental Health Directorate of the Ministry of Health and the Health Research Council of New Zealand. The Secretariat is located at the Health Research Council of New Zealand in Auckland. Its purpose is to add value to workforce development that is undertaken by DHBs, NGOs and mental health and addiction service users. It was planned to promote the national coordination of workforce development (Read, May 2003).

**Te Rau Matatini**

Funded by the Ministry of Health, Te Rau Matatini was originally located at Massey University in Palmerston North, its host institution. It maintained a close relationship with the university, while also retaining independence from it. The relationship was set out in a Memorandum of Understanding and a Service Agreement (Maxwell-Crawford, Hirini and Durie, April 2003). Te Rau Matatini is now located away from Massey University in the city of Palmerston North.

**Werry Centre**

The Werry Centre for Child and Adolescent Mental Health has a three year contract to supply workforce development services to the Ministry of Health. It is hosted by the Department of Psychological Medicine at the University of Auckland (Workforce Development, July 2005).

**National Addition Centre – Matua Raki**

The National Addiction Centre, of which Matua Raki is part, is located in the Department of Psychological Medicine at Christchurch School of Medicine and Health Sciences. Set up as an alcohol and drug treatment resource, its overarching goal is to improve the care and treatment of people with alcohol and drug-related problems (Adamson May 2004). It also has satellite centres in Wellington and Hamilton (Hatcher, February 2005).

**hauora.com**

hauora.com provides workforce development services via the Internet. It is supported by Maori professional medical associations such as Te Ohu Rata O Aotearoa (Maori Doctors’ Association), National Council of Maori Nurses, Nga Maia Maori Midwives Collective and Miria te Hinengara - a collective of Maori mental health providers, consumers and workers (hauora.com).

**Governance Structure**

The role of trustees and non-profit organisation committee members is to provide oversight of the organisation rather than to manage it. Their responsibilities include...
determining compensation for the CEO and management team, approving strategies and the annual budget, ensuring that the organisation complies with the law and ensuring that the organisation operates ethically (Brountas, 2004). The governance structures of the workforce organisations mentioned above can be found in Table 6.

**Mental Health Workforce Development Programme**

Governance of the Mental Health Workforce Development Programme is undertaken by a steering committee of seven and a development committee of five. Committee membership comes from District Health Committees, Non-Government Organisations, consumer families, Maori, Pacific people, clinicians and the Mental Health Commission (Mental Health Workforce Development Programme).

**Te Rau Matatini**

Te Rau Matatini has a governing committee made up of sixteen members, who are representative of the Maori mental health sector (Te Rau Matatini, 2005). Members of the committee are chosen for their experience, knowledge and networks within Maori mental health. Their functions are those of a normal committee including accountability and guiding staff on Te Rau Matatini’s main work, which is the development of projects (Maxwell-Crawford, Hirini and Durie, April 2003).

**Werry Centre**

The Werry Centre is governed by a Workforce Development Advisory Committee that consists of representatives from the child and youth mental health sector, the general mental health sector, the NZDHB, Te Rau Matatini, adolescent consumers, Maori, the urban sector and the NGO sector (Workforce Development, July 2005).

**hauora.com**

hauora.com’s governance team consists of five appointed Trustees. They are chosen for their expertise in Maori health, social services, policy development, governance or management (hauora.com).

**Management Structures**

The four Government workforce organisations and hauora.com, all have different management structures. However, they all have managers and support staff. The organisations that have a service delivery function include clinical and/or medical staff. The size of the organisation appears to determine the staff numbers. The management structures of the workforce organisations mentioned above can be found in Table 7.
Table 6: Governance of Mental Health Workforce Organisations

<table>
<thead>
<tr>
<th>Governance</th>
<th>MHWDP</th>
<th>Te Rau Matatini</th>
<th>Werry Centre</th>
<th>hauora.com</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance</strong></td>
<td>• Steering Committee (7 members)</td>
<td>• Governing Committee (16 people)</td>
<td>• Workforce Development Advisory Committee</td>
<td>• Trustees (5 people)</td>
</tr>
<tr>
<td></td>
<td>• Development Committee (5 people)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Committee/Board</td>
<td>• Mental Health Commission</td>
<td>• People with experience, knowledge</td>
<td>Experts in:</td>
<td></td>
</tr>
<tr>
<td>Membership</td>
<td></td>
<td>and Maori mental health networks</td>
<td>• Maori health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• District Health Committees</td>
<td></td>
<td>• social services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• NGOs</td>
<td></td>
<td>• policy development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Consumer families</td>
<td></td>
<td>• governance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Maori</td>
<td></td>
<td>• management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pacific peoples</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Clinicians</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Table 6 shows the different governance structures for four mental health workforce organisations. Of note is that the Maori workforce development organisations’ criterion for governance team membership is expertise in different aspects of mental health, whereas the other organisations’ criterion is stakeholder representation.

**Workforce Organisation Objectives**

**Te Rau Matatini**

Te Rau Matatini was established in December 2001 to strengthen the Maori mental health workforce. It does this by;

- contributing to regional and national Maori mental health and addiction workforce policy;
- contributing to the expansion of the Maori mental health and addiction workforce;
- promoting career opportunities; and
- contributing to excellent Maori mental health workforce clinical and cultural practice (Maxwell-Crawford, Hirini and Durie, April 2003).
<table>
<thead>
<tr>
<th>Organisations</th>
<th>Director</th>
<th>Kaumatua</th>
<th>Managers</th>
<th>Academic/Clinical/medical Staff</th>
<th>Support Staff</th>
<th>Advisors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Workforce Development Programme</td>
<td>Manager</td>
<td></td>
<td>• Programme</td>
<td></td>
<td>• Analyst</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Project (part-time)</td>
<td></td>
<td>• Administrators (1 + part-time)</td>
<td></td>
</tr>
<tr>
<td>Te Rau Matatini</td>
<td>1/2 time</td>
<td></td>
<td>• Senior Programme</td>
<td></td>
<td>• Executive Assistant</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Programme</td>
<td></td>
<td>• Specialist Trainer</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Clinical Coordinator</td>
<td></td>
<td>• Communications and Research Assistant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Project Coordinator</td>
<td></td>
<td>• IT Specialist</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>• PHC Project Coordinator</td>
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<td></td>
<td></td>
<td></td>
<td>• IT and Administration Coordinator</td>
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<td></td>
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<td></td>
<td>• Research Coordinator</td>
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<td></td>
<td></td>
<td></td>
<td>• Kaituruki Tikanga (Cultural Facilitator)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Accounts and Communications Coordinator</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The Werry Centre</td>
<td>1</td>
<td>1</td>
<td>• Manager</td>
<td>• PA to the Director</td>
<td></td>
<td>Maori Clinical Advisor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Programme Manager</td>
<td>• Project Support/Administrator</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Project Leaders x 3</td>
<td>• Senior Advisor</td>
<td></td>
<td>Pacific Clinical Advisor</td>
</tr>
<tr>
<td>Organisations</td>
<td>Director</td>
<td>Kaumatua</td>
<td>Managers</td>
<td>Academic/Clinical/medical Staff</td>
<td>Support Staff</td>
<td>Advisors</td>
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</tr>
<tr>
<td>National Addictions Centre - including Matua Raki</td>
<td></td>
<td></td>
<td></td>
<td>• Psychiatrists x 3</td>
<td>• Assistant Research Fellows x 2</td>
<td>• Nursing Advisor</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Clinical Psychologists x 2</td>
<td>• Northern Clinical Placement Coordinator x 2</td>
<td>• Youth Consumer Advisor</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Registered Psychologist</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Nurses x 2</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Maori Health Workforce Development Organisation (hauora.com)</td>
<td>General Manager</td>
<td></td>
<td></td>
<td>• Clinical Training</td>
<td>• Research Fellows x 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Business</td>
<td>• Assistant Research Fellows x 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Regional Network Coordinators x 5</td>
<td>• Maori Assistant Research Fellow</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Support Coordinator</td>
<td>• Secretarial Support Staff x 3</td>
<td></td>
</tr>
</tbody>
</table>

The information in this table came from Workforce Development (July 2005); Adamson (May 2004); hauora.com; Te Rau Matatini (2005), Read (May 2003).
**Werry Centre**

The Werry Centre, named after Professor John Werry who established it, was launched on 14 March 2003. It undertakes workforce development in the area of child and adolescent mental health and carries out work in the areas of:

- research and evaluation;
- training and development;
- organisational development;
- recruitment and retention; and
- workforce development infrastructure.

These activities help to progress the 2000-2005 Mental Health Workforce Development Plan (Workforce Development, July 2005). The Werry Centre is currently involved in five projects ranging from a stocktake of child and adolescent mental health services to parent management training.

**Matua Raki**

As well as placing emphasis on proven effectiveness, the National Addictions Centre aims to contribute to a clinical culture in treatment units that is responsive to treatment development and research development. Its mission is Matua Raki or passion, commitment and excellence. Matua Raki is also the name of its workforce development programme (Adamson, August 2005).

Matua Raki’s ten year vision is for an addiction treatment workforce that is passionate and committed and has a sound infrastructure. This, they say will enable the provision of excellent service to consumers and their families and assist with reducing addiction-related harm and improving health and wellbeing (Matua Raki, June 2005). Matua Raki’s key objectives are based on the Ministry of Health’s five strategic workforce development directives. These are:

- infrastructure development;
- organisational development;
- recruitment and retention;
- training and development; and
- research and evaluation (Adamson, August 2005).

**Mental Health Workforce Development Programme**

The MHWDP was launched in 2003 as a joint initiative between the Mental Health Directorate of the Ministry of Health and the Health Research Council of New Zealand. The programme manages 25 projects in the areas of organisational development, recruitment and retention, training and development and research and evaluation. The overall aim of the programme is to provide a sustained systemic response to regional mental health workforce development needs (Mental Health Workforce Development Programme). In doing this it provides coordinated approaches for workforce initiatives in the areas of:

- recruitment and retention;
• organisational development;
• training and development;
• research and evaluation; and
• infrastructure development (Read, May 2003).

*Hauora.com*

The mission of hauora.com is to develop an effective and unified Maori-led health workforce.

**Workforce Development Organisation Functions**

The workforce development planning principles stated in the National Mental Health Workforce Development Plan 2006–2009 suggest that workforce development must:

• be centred on service users needs;
• respond to Maori, Pacific peoples, Asian peoples and other diverse workforce and service users;
• be driven by leaders;
• place reliance on collaboration and networking;
• fit within the wider systemic context of health and disability workforce development, including primary care; and
• be delivered to DHBs and NGO mental health services by way of national workforce development centres (Mental Health Directorate, 2005).

*Matua Raki*

Matua Raki is based on the Ministry of Health’s five strategic directives for workforce development as mentioned previously. Its foundation principle is that a tangata whaiora/client-oriented service must be supported by workforce development (Adamson, August 2005).

The National Addiction Centre (2005) says that in developing Matua Raki the addictions sector was consulted widely. The organisations consulted gave an indication of the type of organisations that a PMHWD Organisation would need to consult and network with in order to be effective. Organisations consulted by the National Addiction Centre in setting up Matua Raki included:

• Te Rau Matatini, the Maori mental health workforce development programme mentioned previously;
• the Mental Health and Addiction Workforce Development Programme;
• the National committee for Addiction Treatment;
• Aotearoa New Zealand Alcohol and Drug National Consumer Network;
• the National Pacific Treatment Committee;
• District Health Committees;
• key alcohol and drug treatment services;
• key problem gambling intervention services;
• umbrella NGOs nationally; and
• other workforce development organisations and training providers such as universities, polytechnics and the National Treatment Training Providers’ Network, The Mental Health Commission (National Addiction Centre, June 2005, p.5).

Read (May 2003) maintains that the then proposed MHWDP was potentially an effective system for improving the mental health workforce. The stated advantages of having an organisation such as MHWDP included the provision of:
• adequate resources;
• infrastructure to manage the resource;
• assessment and evaluation systems for the projects to ensure that funding decisions were based on evidence;
• upholding the Blueprint by way of active service user participation; and
• recognition of the importance of the Treaty of Waitangi to mental health workforce development.

Read (May 2003) suggested that the outcomes of investing in workforce development are likely to be:
• consistent organisational development;
• effective and efficient workforce development projects;
• consistent training programmes and standards; and
• a national computer database that allows mental health workforce development information sharing.

Mulvale (2004) suggests that mental health workforce planning in New Zealand must be flexible so that it can respond to the needs of a constantly changing environment. This requires mental health workforce organisations to be flexible in their approach, so they can adapt services and research efforts to reflect changes in the environment. In addition, says Mulvale tighter standards are needed for community-based health providers and this can be achieved by developing core competencies. Mulvale (2004, p.14) further suggests that the core competencies should include:
• adoption of practices and disciplines to meet current and future service needs;
• benchmarks for new workers;
• guidelines for educators and trainers; and
• employment standards for recruitment, selection and performance management.

The development of these competencies could include mapping mental health service delivery functions. This would enable the required skill mix and competencies of the mental health workforce to be mapped. For example, the competence of community support workers could be increased by way of requiring the National Certificate in Mental Health Support Work to be the mental health and addiction sector minimum qualification for mental health and addiction workers (Mulvale, 2004, p.14).

A PMHWD Organisation could undertake the following:
• champion the Pacific mental health and addiction workforce sector;
• coordinate Pacific mental health and addiction workforce planning;
• develop Pacific mental health workforce competencies; and
• help to coordinate educators and funders to provide the training required to achieve the required competencies.

This would go some way to meeting the needs that Mulvale suggests are currently unmet.

**Critical Success Factors of a Pacific Mental Health Workforce Organisation**

Key informants of a recent study into regional approaches to mental health identified the main issues for the health sector to be:

• poor connections;
• lack of coordination;
• uneven distribution of skills; and
• poor measurement, accountability and processes (Goodhead and Cumming, March 2005).

A success factor identified by hauora.com as being critical for its own success is staying passionate about developing the Maori mental health workforce, being adaptable and being responsive to external environmental factors. hauora.com has success measurements built into its stated ‘Critical Success Factors’. The interest areas covered by the success measurements include:

• students, health professionals, funders and other organisations;
• trustees, staff and taumata;
• service delivery and brokerage;
• finance; and
• the capacity to integrate health and workforce development activities in order to build a Maori workforce capable of meeting the future demands that may be placed on it (hauora.com).

Other critical success factors might include providing useful services to the Pacific mental health community, leading sector discussions on current issues and staying in touch with providers, workers and consumers.

**Leadership and Management**

An effective leader influences a group toward the achievement of goals. S/he communicates the goals and vision of the organisation to others and motivates them to assist in achieving the goals. An effective leader is the soul of the organisation. As a leader, the chief executive of the organisation (CEO) must be able to cope with change and establish the organisation’s direction, while ensuring that the work of the organisation is carried out (Robbins et al. 1994). It is important for an organisation such as a PMHWD Organisation to have a CEO who displays the traits mentioned above.
Managers bring about order and consistency by engaging in planning, designing structures and monitoring results against plans (Robbins et al. 1994). The National Addiction Centre (June 2005) states that competent managers are necessary to achieve an effective addiction treatment workforce. They also say that it is vital for managers and clinical leaders to work collaboratively. This, they say, requires the provision of mutual support and respect when striving to meet agreed objectives.

Infrastructure

Research on workforce development in Wales has indicated the infrastructure support needed by staff employed by mental health services includes:

- high quality management and leadership;
- service delivery that is underpinned by opportunities for audit and research;
- provision of the right initial and ongoing training to obtain good service delivery;
- appropriate and adequate levels of clerical and administrative support; and
- a pleasant physical working environment of adequate size and with pleasant décor. Employees have unrestricted access to the equipment they need to carry out their job effectively. This includes items such as telephones and computers, which are housed in a suitable environment (National Institute of Mental Health in England et al. August 2004).

Read (2003) states that sound infrastructure is the key to workforce development. He suggests that training and development is crucial for increasing the skill set of the workforce. It can assist workers to adapt to changes in the philosophy and setting of mental healthcare. This includes the relatively new demand for workers who are competent in applying recovery principles. Read suggests that areas where training would be of benefit include:

- working in multi-disciplinary teams; and
- specialist skills such as community management of mental unwellness in children.

Business Practices

hauora.com (p.11) uses a ‘nine point management framework’ for good management practice. The nine points include leadership, relationships, staff development, strategic planning, monitoring and evaluation, and Tikanga Maori. Robbins et al. (1994) adds that employees should be directly responsible to one person only so that the work that is required of them is clear. When managers and employees are given authority to do something, they should also have the responsibility for ensuring that the task is carried out in the way it should be, and delivered on time.

Robbins et al. (1994) say that an organisation must be able to monitor customer needs and respond to them. They suggest that dividing the organisation into departments can assist with monitoring customer needs. They add that in a PMHWD Organisation this might entail having a department or person responsible for each of the following:

- training and development programmes;
- information dissemination;
- collection of data concerning the Pacific mental health workforce;
• website development;
• Pacific mental health workforce development including recruitment and retention;
• infrastructure development;
• provider organisation development; and
• research and evaluation.

Models of Service Delivery

The Workforce Action Team (WAT) (NHS Executive, August 2001) in its report on workforce development stated that one of the aims of the workforce development programme is to ensure that the mental health and addiction workforce has the skills required to deliver high quality mental health and addiction care. Underpinning this is the need to know how many people are in the workforce and what their occupations are. Successful methods for recruitment and retention need to be identified together with the skills, competencies and training required to meet consumer needs. They say it is also important, to identify the ideal skill mix for the workforce.

WAT (NHS Executive, August 2001) further identified key areas of focus. These areas were chosen because WAT was able to have influence on the issues. The areas included:

• improve workforce recruitment and retention levels. This involves raising the profile of mental health and addiction careers and making information about them easy to access; developing a learning organisation culture; providing a family-friendly working environment and ensuring that there is equality for all people in all parts of the workforce;

• put minimum occupational standards in place. These standards would identify the functions that are required for service delivery and good service delivery practice. They would also include standards on recruitment, career planning and appraisal and provide a platform for developing national qualifications in areas where they do not currently exist;

• determine the knowledge and skills required to deliver each standard;

• ensure that the workforce has the right mix of skills;

• including non-professionally affiliated people as well as professionally affiliated people in the workforce;

• address primary mental healthcare workforce issues. In New Zealand mental health strategy focuses only on the 3% of mental health consumers whose condition is acute (Mental Health Commission, November 1998). For workforce development purposes it may be prudent to extend coverage to all mental health workers, including those working in primary care as this is often the first point of contact for mental health consumers;

• liaison and consultation with professional and regulatory bodies around issues to do with qualifications and continuing professional development; and

• take steps to address the stigma that is attached to working in the area of mental health.
Hope (August 2004) identifies ten essential shared capabilities for mental health practice. Some of these have been adapted below to suit a PMHWD Organisation.

- **Work in partnership** with stakeholders including funders, mental health service providers, DHBs, consumer representatives and so forth.
- **Respect and value diversity** including age, race, culture, disability, gender, spirituality and sexuality.
- **Operate ethically** by recognising the rights and aspirations of employees, mental health consumers and their families. Take cognizance of legal requirements, local codes of practice and contractual obligations.
- **Challenge inequality** by addressing the causes and consequences of stigma, discrimination and professional inequality in the Pacific mental health workforce.
- **Promote recovery** to mental health service providers. Mental health consumers and more likely to have better quality of life when their lifestyle is incorporated into their recovery programme.
- **Identify employees’ strengths and weaknesses** so that they can be employed in areas where they can give the most value and can work on improving their skills and knowledge to enhance their career pathway.
- **Achievable and meaningful goals** should be negotiated with all mental health workers including workforce organisation employees. A timeframe for achieving each goal is needed and outcomes and achievements should be evaluated regularly.
- **Service quality** - the services provided should be based on the needs of the Pacific mental health workforce.
- **Personal development and learning** provides the Pacific mental health workforce as well as the workforce development organisation employees with the opportunity to keep up-to-date with current practice and develop professionally.

### Services Provided by Health Workforce Organisations

Table 8 shows the activities undertaken by a sample of workforce development organisations. Three of these organisations, hauora.com, Te Rau Matatini and the American NAAPIMHA are targeted at a particular ethnic group or groups. While the activities indicated are not exhaustive of the activities undertaken by the organisations mentioned, there are three areas of activity that are common to and seem fundamental to the operation of the majority of the organisations mentioned. These are research and evaluation, providing training programmes or teaching and, operating a website. It would appear that research and evaluation informs training and that the websites are the main method of communication with diverse audiences that are spread over wide geographical areas.

### Cultural Approaches

NAAPIMHA advocates that cultural competency should be reflected at all levels of an organisation (Carrasco and Weiss, 2005). The U.S. Department of Health and Human Sciences (2001) claims that the main premise behind cultural competency in relation to mental health service delivery is that after the cultures of consumers have been recognised, skills, knowledge and policies are developed to enable effective treatments to be delivered. The delivery of culturally appropriate services is
assumed to encourage ethnic minorities to seek treatment and to improve outcomes, once treatment has begun. Cultural competence, which is more than a sum of its parts, is an approach that enables the delivery of mental health services to meet the diverse needs of all mental health consumers (U.S. Department of Health and Human Sciences, 2001). The U.S. Department of Health and Human Sciences (2001) also observed that most cultural competence models make the effectiveness of treatment the responsibility of the system, not the people seeking treatment.

Research

It is well known that there has been limited research undertaken on the mental health of Pacific peoples. The Health Funding Authority (August 1999) claimed that there was an absence of data on the mental health status of New Zealanders. Since then the New Zealand Mental Health Classification and Outcomes Study (CAOS) has been completed. However, this study only included people whose illness was acute. In addition, the sample size for Pacific people was small compared to the total treated population (Pulotu-Endemann, Annandale and Instone, February 2004). As observed by Mental Health Funding Authority (August 1999) regarding mental health research in New Zealand, the CAOS study was focused on the prevalence of pathology. The Authority went on to say that good health is more than an absence of illness and that measurements of good health should be added to measurements for morbidity.

Workforce Research and Evaluation

The Mental Health Workforce Development Co-ordinating Committee (July 1999) identified that Pacific research is needed to be undertaken by Pacific people. The Committee said that Pacific research was often being undertaken by mainstream researchers who sometimes used an inappropriate cultural framework to reach research conclusions. There has also been a perception in Pacific communities that researchers, who have mostly been palagi, take a lot from Pacific people and give very little in return. In highlighting the need for well-trained Pacific researchers in the area of mental health the Mental Health Workforce Co-ordinating Committee suggested that a major obstacle to recruiting suitable Pacific researchers was the cost of training. The Ministry of Health (April 2005) drew attention to awards and scholarships such as such as the Pacific Mental Health Workforce Awards that were set up to encourage more Pacific people into the Pacific Mental Health Workforce. However, as awards and scholarships can not assist everyone with training, steps need to be taken to address the issue.

In the area of research and development, hauora.com undertakes to do research in Maori health workforce development and other related fields. They proposed to increase knowledge of the following:

- the profile of the Maori health workforce;
- the training needs of the Maori health workforce;
- cultural and clinical best practice; and
- Maori workforce recruitment, retention, planning and education.

hauora.com will work with research institutes on initiatives that advance Maori workforce aspirations.
Agnew et al. (September 2004) say that because the time and resources required to conduct rigorous culturally sensitive research with Pacific people are often grossly underestimated, good research methods, consultation and feedback processes should be developed at the beginning of any research undertaking. This issue needs to be addressed so that future Pacific research projects can be designed realistically.

Workforce

Te Rau Matatini (2005) requires its staff to be skilled. They must be excellent at solving problems, able to set their own targets and priorities, able to work in a team environment effectively and have strong oral and written skills. Te Rau Matatini prefers staff to be competent in Te Reo Maori and able to apply Tikanga. hauora.com also claims to employ and develop skilled and committed staff. It says that its work environment is stimulating and discrimination free. Most personnel have iwi affiliations (hauora.com).

The positions filled in New Zealand health workforce organisations can be found in Table 8. All personnel appear to be suitably qualified and experienced for the position they hold.

Discussion

The ideal staff skill mix for a mental health workforce development organisation depends on the focus that the organisation takes. However, all staff should be competent at what they do, and sympathetic to the cause. There must be advisers on issues such as the role of culture and the level of involvement that consumers should have, if any, in such an organisation.

Workers employed in the organisation should be competent in the required skills, which may vary between different organisations. While Te Rau Matatini prefers fluency in Te Reo Maori, for a Pacific workforce organisation, fluency in any Pacific language might be a preferred skill. However, it might not be possible to get proportional representation of every Pacific ethnicity among the workforce and still get the required skill level of staff.

Continuous Improvement

Undertaking an evaluation of a project, or an organisation's services can inform continuous improvement. The evaluation will give an indication of how well the organisation is performing, and what its clients or audience think of the service. Client satisfaction surveys are one way of assessing performance another is outcome assessment. This measures how the effort put into an activity has influenced the outcome of the activity. To be successful, this assessment requires outcomes to be measured before the activity begins and again after the activity has been completed. This is so that the degree of change, if any, as a result of the activity can be measured (Carrasco and Weiss, 2005).

hauora.com uses the continuous improvement cycle to drive quality performance. They strive for excellence by using a systems approach to management in nine management categories. These categories range from Tikanga Maori to monitoring and evaluation. They also employ a monitoring system in key activity areas to measure performance outcomes.
Table 8: Mental Health Workforce Organisations’ Activities

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<tbody>
<tr>
<td>Capacity Building</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Career and Scholarship Information</td>
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<tr>
<td>Data Collection</td>
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<td></td>
<td>✓</td>
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<tr>
<td>Developing Workforce Leadership</td>
<td>✓</td>
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<tr>
<td>Development Activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>Include Consumers and Families</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Increasing Education Opportunities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td></td>
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<tr>
<td>Liaison and Consultation</td>
<td></td>
<td></td>
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<td>✓</td>
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<tr>
<td>Mentoring</td>
<td></td>
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<td>✓</td>
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<tr>
<td>Networking - Sector</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>Networking - Workforce Support</td>
<td></td>
<td></td>
<td></td>
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<td>✓</td>
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<tr>
<td>Newsletter</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Organisational Development</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Piloted Mental Health Worker Induction Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
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<tr>
<td>Recruitment and Retention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Research and Evaluation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Table 8 shows that research and evaluation, providing training programmes or teaching and operating a website appear to be fundamental to most of the above organisations.

**Establishing Sector and Pacific Community Links and Networks**

**Collaboration**

Pacific participants at a national summit on health and disability workforce issues held in March 2003 stressed that there is a need for collaboration between Pacific leaders in the health and disability sector, the Pacific community and the Ministries of Health and Education. This collaboration, they said, would be necessary to enable development of the Pacific health workforce (Health Workforce Advisory Committee, August 2003).

The Ministry of Health (September 2002) comments that the mental health workforce development system is made up of many different organisations with different roles and contributions to make. These different organisations will need to collaborate with each other in order to achieve good workforce outcomes. An example is given of the medical schools having to collaborate with the DHBs regarding psychologists training.

hauora.com in its strategy states the need to form and expand relationships with the health, education and social service sectors in order to assist with Maori workforce development (National Maori Health Workforce Development Organisation). NIMHTE et al.'s (August 2004) suggestions for effective collaboration include the following:

- having clear agreement between agencies and between departments within agencies as well as team members, about who does what;
- forming long-term relationships;
- training together; and
- learning from success.

**Meeting Pacific Mental Health and Addiction Workforce Needs**

**Workforce Development and Capacity Building**

At a Pacific fono on workforce development, the capability and capacity of the Pacific mental health workforce was an issue of great concern. Participants
indicated that it is important for Pacific mental health models and the workforce to be able to address holistic Pacific needs. Workforce problems and challenges to workforce development were seen as the greatest barriers to providing mental health services for Pacific people. It was suggested that cultural training should be provided for mainstream professionals as well as Pacific workers and professionals (Ministry of Health, May 2005).

Workforce Training

In order to improve and develop the Pacific mental health workforce, training must be available in areas where there is a skills shortage or where skills need updating. Trainers who provide training for the workforce would be able to provide some of the internal training requirements. Following is a discussion of the types of training that a Pacific workforce development organisation might provide.

At a child and adolescent mental health services national fono, participants identified that Pacific peoples’ wisdom, particularly cultural knowledge and experience should be acknowledged. They also strongly suggested that training should be balanced in its clinical and cultural content, so that cultural competency can be practised when working with Pacific clients. Pacific training, they said needs to have strong guidance and adequate financial support (Faleafa, January 2004).

Ihimaera et al. (December 2004) suggest that the Maori mental health workforce will not be able to meet the demands for modern mental healthcare without adequate training. They add that as well as tertiary education programmes, other programmes that cater for the wider sectoral workforce are needed. They claim that clinical and cultural competence cannot be separated; therefore the mental health workforce needs competence in both areas. Durie (2001) cited in Ihimaera et al. (December 2004) says that being certain of one’s identity is essential for good mental health. To achieve this, one must have access to culture and be able to express it. It is claimed that when the culture of workers and health consumers is matched, clinical outcomes improve. The workforce must be aware of this and must be provided with the opportunity to develop these skills and apply them.

Ihimaera et al. (December 2004) also say that providing training programmes that are relevant to Maori, is important but the curriculum, supervision, practice guidelines and service performance indicators must meet the expectations of Maori health needs and world views. They go on to say that in order to equip people for the workforce, education must be aligned with the needs of the workforce. As mentioned earlier, the alignment of education with the needs of Pacific peoples has been discussed.

Tse et al. (May 2005) say that mental health workers working with Asian people suffering from mental illness, must be appropriately trained and educated to provide effective service. They go on to suggest possible indicators that cultural competence has been achieved. These include:

- knowledge of the cultural makeup of New Zealand;
- understanding that European-derived cultures are dominant;
- being aware of one’s own limitations regarding culture; and
- being aware of the diversity within Asian/different ethnic cultures and so on.
Hansen (unpublished) in discussion about service user run organisations, suggests that many of the growing number of service user run organisations have contracted out their administrative services and mentoring. Hansen says that if there is no clear communication process between the service organisation and the administrative service, problems can result. To avoid such difficulties, training for both service and administration organisation staff would be useful in the following areas (Hansen, unpublished, p.20):

- establishing a working inter-organisational relationship;
- policy writing and analysis;
- business, strategic and annual plans;
- budgeting/accounting/bookkeeping;
- filing contractual reports;
- record-keeping;
- writing job descriptions;
- employment processes; and
- understanding governance, management and their specific accountabilities.

A Pacific Mental Health Workforce Development Organisation

Organisational Development Phases

The following organisational development phases have been suggested on the basis that the type of organisation recommended in this literature review will be established. If this is not the case, adjustments may need to be made to this plan. It is also assumed that sufficient funding will be available to establish such an organisation. Suggestions are based on information contained in this literature review and the writer’s knowledge of organisational infrastructure and development.

Constitution/Rules

The constitution/rules and the ways in which Board members are to be appointed will have to be developed. It will have to be decided whether Board members sit for a fixed term and then retire or, whether they stay on the committee until they wish to retire. The method of appointing and replacing Board members will also need to be decided together with the Board structure.

Working Group and Board

A working group will need to be set up to get the organisation underway. The purpose of this group is to assist with planning the new organisation (Carrasco and Weiss, 2005). They will undertake project management and administration functions to assist the Board. The group should be relatively small in order that it can work efficiently and effectively. The skill base for this team should reflect the skills and knowledge needed to perform the required tasks.

The Board should be appointed within two months of the working group having been established. It should include at least one person who is an expert or specialist in setting up organisations and has sound business acumen. Board members should be
representative of the Pacific mental health and addiction workforce community (Carrasco and Weiss, 2005). To complement the existing mental health organisations it may be useful to have the following capabilities represented on the Board:

- senior health research experience;
- financial literacy;
- knowledge of education and training;
- in depth knowledge of the health sector;
- knowledge of government infrastructure and processes; and
- a consumer representative to present the consumer perspective and provide the opportunity to develop consumer capability.

As anecdotal evidence suggests that Pacific organisations have faced challenges with governance issues, it would be prudent for Board members to have advanced skills. Board members may or may not be Pacific and do not necessarily have to be business experts, but do need to be competent to engage in the establishment and governance of such an organisation.

Organisation structure

The governing board will report to the funder(s). The board members must have a comprehensive understanding of the mental health and addiction workforce and infrastructure (Carrasco and Weiss, 2005). All Board members must be competent to govern and there must be at least one person who is competent to act in a treasury role and can oversee the accounts, set budgets and monitor spending against budget.

The management team will report to the Board through the CEO. The organisation does not need to be large as work can be subcontracted out if necessary. Consideration might be given to setting up a committee/advisory group who are representative of or are familiar with key stakeholder needs. It is important that relationships are maintained with other stakeholders including the workforce development organisations so that work is carried out collaboratively and to avoid work being repeated. This will foster the efficient use of resources across the different workforce organisations and increase the effectiveness of a Pacific organisation.

Strategic and Business Plans

The Board will first have to define the vision and mission of the new organisation, the potential goals and objectives for the organisation will need to be set (Carrasco and Weiss, 2005). This should be supported by determining what activities the organisation is going to carry out and the resources it will require. A strategic plan will need to be developed in consultation with stakeholders (Department of Health, March 2003). The Board may also wish to undertake a needs assessment to determine the needs of the Pacific mental health workforce to inform the strategic plan (Carrasco and Weiss, 2005). This will also help to determine whether the Government’s objectives and the needs of the Pacific mental health workforce are aligned.

As part of the strategic planning process, a business plan will need to be prepared. It will need to include a budget for the first year of operation and a projected budget.
for the second year of operation. These budgets may be modified to a small degree by the CEO when appointed as he/she establishes the best way for the organisation to operate to achieve its mission.

**Promotion of the Organisation**

The new organisation will need to be promoted to stakeholders, including the Pacific community. A communications plan will need to be developed to assist with this. The plan should include a message theme and items such as press releases, methods of communicating messages to the mental health workforce and other stakeholders, newspaper articles and advertisements (Carrasco and Weiss, 2005).

**Desired Skills and Characteristics of Key Personnel**

It is important to have the right skill mix in any workforce or organisation. A PMHWD Organisation has the added requirement of setting an example for other Pacific mental health organisations to follow. A PMHWD Organisation must have strong leadership and quality management capability. It must also provide opportunities for staff to upskill. This could take the form of internal and/or external training. A budget could also be set aside for capacity building, so that Pacific people are brought into the organisation to broaden their skill base or to learn new skills.

**Job Descriptions**

Board portfolio responsibilities will have to be created prior to appointment. When the strategic direction has been set job descriptions will need to be created for the CEO, Chief Financial Officer (CFO), managers and staff. The CEO will appoint the managers and staff in tandem with the completion of business planning.

**Transition**

It is suggested that the working group dissolve, when it has completed its work. The Board will then decide how it is going to operate and what the management reporting requirements will be. It will also need to review the business plan and budgets. Networks, coalitions and alliances will need to be formed with other workforce development organisations, mental health professional groups, service providers and so forth. Developing relationships with organisations that already meet some of the mental health and addiction workforce needs will provide access to members of the mental health workforce and lead to opportunities for addressing the support needs of the Pacific mental health workforce. This may occur by way of collaboration on projects, joint funding opportunities, or joint research opportunities (Carrasco and Weiss, 2005). The CEO will need to play a major role in developing relationships with sector leaders and other key stakeholders.

**Organisation maintenance**

Evaluations and reviews of the success of an organisation need to be carried out regularly. These could include workforce and stakeholder satisfaction surveys and/or outcome assessments that measure any changes in the Pacific mental health workforce that might have been initiated by the organisation’s activities. As well as external evaluations, internal evaluation should be carried out to assess the
effectiveness of staff. These could take the form of annual appraisals according to Carrasco and Weiss (2005).

**Growth - the first two years**

The purpose of a strategic plan is to set the directions of an organisation. Effective business planning will assist with improving organisational and business processes in a systematic way in order to achieve the organisation’s desired outcomes. The strategic plan, in particular, will help to:

- develop vision driven leadership;
- enhance team dynamics;
- improve efficiency, reduce costs;
- improve customer satisfaction; and
- map critical success factors.

The strategic plan can include the following factors that will help the organisation to be successful:

- the organisation’s vision and mission;
- the organisation’s strategy and how it is to be achieved;
- an alignment of employees and strategies;
- the desired skill mix of employees;
- how to develop individuals to be leaders;
- processes that are aligned to a client’s, in this case the Pacific mental health workforce, needs;
- sector trends; and
- critical success factors for the organisation (Wilds, 2005).

In the first year of operation, the organisation will be establishing the services it will be providing based on the strategic and business plans. This will include setting up robust administrative and accounting system. By the end of the first year if should have established all of the functions that were set out in the strategic and business plans. In the second year of operation the organisation will be continuously improving by consulting the Pacific mental health workforce and providing services that meet its needs.

**Milestones and Timeframes**

Table 9 indicates the suggested milestones and timeframes for the establishment, transition and growth of a new PMHWD Organisation. As it is not known, when such an organisation is likely to be set up, the timeframes are indicative of the time that is likely to be required to achieve each milestone from the commencement date.
Funding for a Pacific Mental Health Workforce Development Organisation

Establishment Funding

The four mental health workforce development organisations as mentioned earlier in this literature review are Government funded. One of these, Te Rau Matatini was initially funding by the Ministry of Health as part of the Mental Health Workforce Development Plan to strengthen the Maori mental health workforce (Maxwell-Crawford, Hirini and Durie, April 2003).

Another organisation, the Werry Centre for Child and Adolescent Mental Health is funded to supply a child and adolescent mental health workforce development programme. Its current funding ends in June 2007 (Workforce Development, July 2005). The National Addiction Centre was initially set up by ALAC, who wanted a clinically focused national centre. It is now funded by the Ministry of Health. The funding for hauora.com appears to come from professional health organisations.

The Ministry of Health would need to fund the establishment of a PMHWD Organisation. There are currently no other organisations that have the means, or the appropriate skill-set to establish such an organisation.

Development Funding

The Board would be in the best position to determine how the organisation should be funded for the first two years of operation. When developed, the strategic and business plans will indicate the required level of funding. This will be determined by the activities to be undertaken by the new organisation, and level of staffing required to run the organisation effectively.

Ongoing Funding

It is likely that the initiative will be mostly Government funded like the other mental health workforce development organisations. However, additional funds could be earned through:

- providing research services;
- charging for resources such as promotional material or library services; and
- a membership fee for providers, individuals and professional mental health organisations if it is decided that the organisation should be member driven. If a membership fee were to be charged, the mental health workforce organisation would need to be clear about what was being provided in return for the fee.

The benefits derived from the work of the organisation are likely to be beneficial to everyone in the Pacific mental health and addiction workforce.
### Table 9: Timeframes and milestones

<table>
<thead>
<tr>
<th>Phase</th>
<th>Milestones</th>
<th>Completion</th>
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<tbody>
<tr>
<td>Establishment</td>
<td>- MOH funds and sets up an establishment team of appropriately qualified people to undertake project management and administration to assist the Board with establishing the organisation.</td>
<td>Commencement.</td>
</tr>
<tr>
<td>Establishment</td>
<td>- MOH funds and appoints the Board of governors, which includes stakeholder representatives.</td>
<td>Commencement.</td>
</tr>
<tr>
<td>Establishment</td>
<td>- The Board develops its constitution/rules.</td>
<td>3 months.</td>
</tr>
<tr>
<td>Establishment</td>
<td>- The Board determines the mission and vision of the workforce organisation.</td>
<td>3 months.</td>
</tr>
<tr>
<td>Establishment</td>
<td>- The Board determines the structure of the new organisation and how it should be funded long-term.</td>
<td>4 months.</td>
</tr>
<tr>
<td>Establishment</td>
<td>- The Board determines the needs of the Pacific mental health workforce.</td>
<td>3 months.</td>
</tr>
<tr>
<td>Establishment</td>
<td>- Strategic plan is developed.</td>
<td>4 months.</td>
</tr>
<tr>
<td>Establishment</td>
<td>- Job descriptions are prepared for the CEO and CFO of the new organisation.</td>
<td>5 months.</td>
</tr>
<tr>
<td>Establishment</td>
<td>- The business plan is prepared including budgets for the first and second years of operation.</td>
<td>12 months.</td>
</tr>
<tr>
<td>Personnel</td>
<td>- The CEO and CFO are appointed. The CEO reports to the Board.</td>
<td>9-12 months.</td>
</tr>
<tr>
<td>Personnel</td>
<td>- CEO appoints managers and other staff.</td>
<td>12 months.</td>
</tr>
<tr>
<td>Personnel</td>
<td>- Board subcommittees are appointed if required.</td>
<td>As needed.</td>
</tr>
<tr>
<td>Transition</td>
<td>- The Establishment Team is disbanded.</td>
<td>When work is completed.</td>
</tr>
<tr>
<td>Transition</td>
<td>- CEO reviews the business plan and budgets.</td>
<td>7 months.</td>
</tr>
<tr>
<td>Transition</td>
<td>- Relationships are formed with professional mental health groups, service providers and so forth.</td>
<td>Ongoing from commencement.</td>
</tr>
<tr>
<td>Transition</td>
<td>- The organisation is promoted to stakeholders. Message themes and methods of communication delivery are established.</td>
<td>Ongoing. Starts with appointment of Board. A major promotion is completed by the end of year 1.</td>
</tr>
<tr>
<td>Growth</td>
<td>- The organisation carries out all of the functions in the strategic and business plan.</td>
<td>End of first year.</td>
</tr>
<tr>
<td>Growth</td>
<td>- The organisation continuously improves by providing services that meet Pacific mental health workforce needs.</td>
<td>Ongoing.</td>
</tr>
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</table>
Conclusions

The purpose of this literature review was to discuss the feasibility of establishing a PMHWD Organisation. This comes at a time when mental health service delivery is moving from institutional care to community-based care. As a result of this movement, the mental health workforce is lacking in the required capacity to meet demands. There are insufficient Pacific mental health workers in all professions and increasing their numbers is a high priority. Further to this mental health planning is fragmented due to the involvement of many disparate organisations. While there is a clear need for a PMHWD Organisation that can focus on building the capacity and capability of the Pacific mental health workforce, care must be taken to ensure that it does not merely add to the list of organisations currently involved in mental health workforce planning.

The role of a PMHWD Organisation should be acknowledged by the mental health and addiction community as the expert on Pacific mental health workforce issues. This would provide a focal point for the workforce and others who have an interest in the development of the Pacific mental health workforce. While it is most likely that funding for such an organisation would come from the Ministry of Health, it would be helpful if the organisation was independent in its operation. This would enable it to focus on workforce issues without political interference.

Suggestions have been made in this paper as to how the organisation could be set up and run for the first two years. The critical success factors include:

- strong leadership;
- a clear mission and vision;
- quality management capability;
- appropriately qualified staff employed at all levels; and
- advocating for and being responsive to the needs of the organisation’s mental health workforce clients.

It is suggested that a working group of appropriately qualified people be appointed by the funder to get the organisation underway. The task of this committee will be to assist with planning the new organisation and to undertake project management and administrative functions to assist the Board. The Board will also be appointed by the funders. Its role will be to determine the purpose and mission of the organisation and to establish the organisation and put governance structures in place. Once the working group has completed its tasks, it will dissolve and the Board will continue with its governance role.

Recommendations for the establishment of a new PMHWD Organisation are contained in the next section of this review.

Recommendations

1. Working Group

A small working group of appropriately qualified people should be set up to assist the Board of the PMHWD Organisation by undertaking project management and administration. This group should disband, once their work has been accomplished.
2. Board of Governors

A governance board of appropriately qualified people should be appointed. Their task would be to govern the organisation and approve the structure, functions and constitution/rules of the organisation, including recommendations for ongoing funding. The Board will initially be supported by the working group. Once its work has been completed, the Board will be supported by management and staff.

3. Funding

The new Pacific mental health workforce development organisation will need a source of secure funding in order to set up and become established. The Ministry of Health currently funds four existing mental health workforce development programmes - the Werry Centre, Te Rau Matatini, the Mental Health Workforce Development Programme and Matua Raki. It is recommended that the Ministry of Health fund the establishment and development stages of the new organisation. The Board can then recommend the best way to secure ongoing funding in order to achieve the mission that they have developed for the organisation.

4. Organisation Functions

The success of a PMHWD Organisation will be dependent on the service that it provides for meeting Pacific mental health and addiction workforce needs. It is recommended that a needs assessment of the workforce be undertaken to establish what those needs might be. To assist with meeting the Pacific mental health workforce needs and to assist with developing the workforce, it is recommended that the new PMHWD Organisation include:

- championing the Pacific mental health and addiction workforce;
- coordinating Pacific mental health and addiction workforce planning;
- developing core service provision competencies for community-based mental health and addiction providers;
- developing employment standards for recruitment, selection and performance management of the Pacific mental health and addiction workforce;
- ensuring that there are sufficient managers available who are competent to work in mental health and addiction;
- liaising and collaborating with other organisations involved with mental health and addiction workforce development; and
- undertaking activities that assist with the achievement of Government’s aims for Pacific mental health and addiction.

5. Timeframes and Milestones

It is estimated that a PMHWD Organisation will take about eight months from the appointment of the working group to establish and become operational. It is recommended that the timeframes and milestones indicated in Table 9 of this literature review be adopted. This provides for:

- establishing the organisation - 8 months until all staff have been hired;
- employing the CEO and other staff - 8 months after commencement;
• transition from development to full operation - 12 months after commencement; and
• growth - ongoing.
Section 2: Key Informant Interviews and Document Analysis

Introduction

Te Orau Ora: Pacific Mental Health Profile

Te Orau Ora (Ministry of Health, 2005) reiterates the need to increase the Pacific mental health workforce which was first highlighted in Moving Forward: The National Mental Health Plan for More and Better services (Ministry of Health, 1997) and again in Pacific Health Services and Workforce: Moving on the Blueprint (Mental Health Commission, 2001). That report also emphasised the need to up-skill the current Pacific workforce.

Table 10 below shows the number of people working in public or psychiatric hospitals and community residential homes, by occupation and ethnic group between the years 1996-2001. Of the Pacific people who worked in this area, five percent were specifically mental health professionals (excluding psychiatrists).

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Pacific Workforce</th>
<th>Non-Pacific Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellor</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Mental Health nurse</td>
<td>33</td>
<td>42</td>
</tr>
<tr>
<td>Psychologist</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Mental Health</td>
<td>45</td>
<td>63</td>
</tr>
<tr>
<td>Professionals</td>
<td>Nurses</td>
<td>579</td>
</tr>
<tr>
<td></td>
<td>Physicians</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Social/case worker</td>
<td>174</td>
</tr>
<tr>
<td></td>
<td>Therapists</td>
<td>6</td>
</tr>
<tr>
<td>Total all operations</td>
<td>918</td>
<td>1155</td>
</tr>
</tbody>
</table>


* Percentages in brackets refer to total mental health professionals’, for example; in 2001 there were 42 Pacific mental health nurses. This represented four percent of the total
Pacific mental health workforce and 67 percent of all Pacific Mental Health Professionals, therefore, in the percent (%) column this is shown as ‘4 (67)’.

Table 11 below provides information on selected mental health and addiction occupational group workforce numbers, 2004.

### Table 11: Selected mental health and addiction occupational group workforce numbers, 2004

<table>
<thead>
<tr>
<th>Occupational group</th>
<th>Total Number</th>
<th>Maori</th>
<th>Pacific</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction practitioners</td>
<td>950</td>
<td>22%</td>
<td>4%</td>
<td>Matua Raki 2005&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Nurses (active registered)</td>
<td>3052</td>
<td>13.2%</td>
<td>2.7%</td>
<td>New Zealand Health Information Service Workforce statistics, 2004</td>
</tr>
<tr>
<td>Support workers</td>
<td>1423</td>
<td>33.0%</td>
<td>8.2%</td>
<td>New Zealand Qualifications Authority&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Psychiatrists and other medical practitioners working in mental health and addiction services</td>
<td>528</td>
<td>3.0%</td>
<td>0.4%</td>
<td>Medical Council of New Zealand and Workforce Survey, 2003&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Psychologists</td>
<td>1404</td>
<td>4.3%</td>
<td>0.2%</td>
<td>New Zealand Health Information Service Workforce statistics, 2004&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Social workers</td>
<td>311</td>
<td>-</td>
<td>-</td>
<td>Hatcher et al. 2005</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7668</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> There are approximately 850 alcohol and drug workers and 100 problem gambler practitioners.

<sup>b</sup> This is the number of graduates of the National Certificate in Mental Health Support Work. Note not all Mental Health support workers have completed the National Certificate, and not everyone who has completed the Certificate is working in mental health.

<sup>c</sup> Includes Specialists (288), medical officers special scale (65), registrars (166) and other (5). Although the survey recorded no Pacific doctors working in psychiatry, this table includes two Pacific practitioners because there is at least one psychiatrist and one doctor training in psychiatry who would identify as Pacific.

<sup>d</sup> Of current surveyed registered psychologists (907), a total of 788 work in the field of clinical psychology, rehabilitation, psychotherapy and counselling. The ethnicity percentages are from those surveyed psychologists.


### Child and Adolescent Mental Health (CAMHS)

Child and Adolescent Mental Health Services are provided in the main by mainstream Specialist Mental Health Service providers. Lacussen and Merry (2005) commented that historically CAMHS has been under-resourced. The Werry Centre has published a recent stocktake of the CAMHS workforce nationally. Table 12 below identifies the
Pacific workforce in this area by region. The southern region has a total of 8 Pacific Workers.

Table 12: Pacific Child and Adolescent Mental Health Workforce by Region (Head Count 2004-2005)

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Northern</th>
<th>Midland</th>
<th>Central</th>
<th>Southern</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB Inpatient</td>
<td>3</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>DHB Community</td>
<td>22</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>NGOs</td>
<td>1</td>
<td>18</td>
<td>1</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>CYF Collaborative</td>
<td>-</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>22</td>
<td>5</td>
<td>8</td>
<td>61</td>
</tr>
</tbody>
</table>

In 2004, 8.5% of the total 0-19 year population were Pacific child and adolescents while the Pacific workforce only made up 4.3% of the total child and adolescent mental health workforce. A total of 61 Pacific staff were identified as currently working in the child and adolescent workforce as at 31 March 2004. The stock-take notes that the majority of the workforce lies in the Northern region, are employed by DHB’s and is predominantly made up of mental health support workers, social workers, mental health nurses, and cultural appointments (Werry Centre, 2005).

The Blueprint benchmarks for access for the age groups, 0-9 years, 10-14 years and 15-19 years over a six month period are as follows; 1%, 3.9% and 5.5% respectively. Access rates are far below benchmark targets across all ethnicities. Northern region show the greatest shortfall. The Pacific access rate of 0.1%, 3% and 0.9% (first six months of 2004) are the most significant ethnic-specific discrepancy against Blueprint targets (Werry Centre, 2005).

Seven of the Southern Pacific workers in the child and adolescent field are in NGO services and one employed in a DHB community service. Pacific Trust Canterbury employs one FTE alcohol and other addictions youth worker. Otago Pacific Health Trust has expressed the need to provide Pacific Mental Health Support Worker Services in Otago.

Methodology

Consultations with key informants – interviews and focus group discussions

The focus group discussion is a qualitative research technique used to obtain data about feelings, opinions, perceptions, beliefs and behaviours of a small group of participants, representative of the population of interest, about a given experience, service or other phenomenon. It enables the researcher to gain a broad understanding of why participants think and act the way they do. Focus group discussions are particularly useful where rather little is known about the subject under investigation.

Subject recruitment is tailored to the research aims. Selection criteria generally specify the demographic characteristics of the target population. Group members may share a particular health problem (e.g., mental health condition) or use the

Section 2: Key Informant Interviews and Document Analysis 66
same health services (e.g., mental health) or represent an interest group (e.g., consumers). Purposive sampling is used most frequently for selecting focus group participants.

Development of the focus group discussion guide requires careful consideration. As in questionnaire design, each item in the discussion guide should have a specific purpose related to the objectives of the research study. The discussion guide is a detailed protocol of sequenced open-ended questions and probes which allows the facilitator to keep the session on track. As well as using the discussion guide, the facilitator follows the leads presented by participants and allows them to talk freely and spontaneously in their own vocabulary.

Focus groups allow the researcher to get more detailed information than is possible from other research methods because the facilitator asks open-ended in-depth questions and can deviate from the discussion guide to follow up points that arise in discussion between multiple participants who can stimulate one another's thoughts on the topic under discussion. A far larger number of ideas, issues, topics and solutions to a problem can be generated through group discussion than through individual conversations. In a focus group discussion, the facilitator gets the participants to interact with each other by commenting on each others' experiences and by exchanging anecdotes that reveals additional information. It is this ‘open-ended group interaction’ or ‘group dynamic’ effect that distinguishes focus group discussions from the more traditional style of one-to-one, face-to-face interviewing approaches. The focus group approach is particularly useful for exploring participant’s knowledge and experiences of the subject under investigation and understanding what people think, how they think and why they think that way.

The focus group discussion is usually tape recorded and transcribed. These records are the raw data used for analysis, along with the facilitator’s field notes about context, highlights and insights. These data are used to generate a list of key ideas, words, phrases, and verbatim quotes that capture the participant’s sentiments. The participant’s ideas are then clustered into various categories that form the themes of the discussion. The focus group themes provide the major headings for the written report of focus group discussions.

Focus groups also have the advantages that they do not discriminate against people who cannot read or write and they encourage participation in a group discussion setting from people who may otherwise be reluctant to be interviewed on their own.

Focus group discussions are an appropriate research method for examining the attitudes and experiences of representatives from a target population, and how knowledge and ideas are developed, constructed and expressed in a given cultural context. Kitzinger (1995) concluded:

Thus while surveys repeatedly identify gaps between health knowledge and health behaviour, only qualitative methods, such as focus groups, can actually fill these gaps and explain why these occur (Kitzinger, (1995). British Medical Journal, 311, 299-302).

Key informant interviews and focus group discussions were undertaken by the research team. Interview schedules use both closed and open-ended questions and allow for individual variations and exploration of information and ideas.

Three types of qualitative interviewing may be used:
• informal, conversational interviews;
• semi-structured interviews; and
• standardised open-ended interviews.

Participants

The research participants included the following staff:
• Ministry of Health nominated senior officials from the Mental Health Directorate;
• the four existing mental health workforce development organisations;
• Mental Health Commission;
• Ministry of Pacific Island Affairs;
• Pacific (staff) priority District Health Boards i.e. Counties Manukau, Auckland, Waitemata, Waikato, Hutt Valley, Capital and Coast, Canterbury and Lakes;
• Pacific Health Professional Organisations including the Pacific Medical Association and the Samoan Nurses Association;
• Health Research Council of New Zealand;
• Mental Health Support Workers Advisory Group;
• Community Support Services Industry Training Organisation;
• National Workforce Development organisations;
• National Addictions Centre;
• Werry Centre;
• Mental health consumer Pacific Non-government organisations;
• Clinical Training Agency;
• Director of Health Sciences - University of Canterbury;
• School of Health and Community at UNITEC;
• Blueprint Centre of Learning;
• Matua Raki;
• Clinical Research and Resource Centre, Waitemata District Health Board;
• ALAC (Alcohol Advisory Council of New Zealand);
• Odyssey House (Christchurch);
• Former ALAC Pacific Manager; and
• Mental Health Foundation.

A total of forty-four structured interviews were conducted with key informants from a range of backgrounds including:
• Pacific Health;
• Multicultural Health;
• Population Health;
• Mental Health Promotion and Alcohol; and
• Drug Addiction Services.

A focus group with nine Pacific mental health consumers was also conducted. It was organised by the Canterbury Pacific Trust Consumer Advisory Group.

Data from the interviews, written responses and focus group were transcribed and analysed to identify main issues and themes arising from responses to the questions.

Analytical Framework and Feasibility Report

Qualitative data was collected from documentary records, focus groups and interviews. In brief, data was analysed to identify themes that emerge from the raw data.

Interviews were transcribed and notes taken from untaped interviews (that is, when participants do not wish to be taped) were entered into an individual Microsoft Word file relating to each participant or group of participants.

Data analysis involved interrogation of qualitative data to allow identification of key themes emerging for each of the issues listed in the research scope of this proposal. Themes were compared across all respondents and significant themes identified and considered in relation to the research scope. Data was interrogated to identify indicators of the service deliverables listed in the service schedule of the RFP for this research.

Cultural Integration

Pacific peoples usually respond well to processes that are delivered in a culturally appropriate manner. We applied culturally appropriate approaches as the need arose when undertaking the feasibility study. This involved using Pacific team members who understand Pacific values and belief systems. Some of the common ethical practice that underpins our approach included cultural safety, respect for others and the importance of reciprocity.

Our ethical approach is in line with the emerging research guidelines by Pacific peoples for researchers intending working with Pacific peoples. These include the Pacific research guidelines produced by the Health Research Council of New Zealand and the Ministry of Education.

Document Review

An organisational document review has also been undertaken to identify the key resources that address the issues detailed in the background section of this report, such as the key success factors for establishing organisations and or programmes of work such as the PMHWD Organisation. The relevant documentation was available from:

• the four mental health workforce development organisations; and
• Ministry of Health, Pacific priority DHBs, Pacific Health Professional Organisations and other key Pacific community organisations and individuals.

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Results

Key informant interview and focus group responses

The respondents had various backgrounds, expertise, experiences and perspectives and naturally highlighted their own concerns and interests. The result is that, whilst common themes emerged, there were also diverse responses and varying priorities identified.

The literature review together with the interviews with key informants identified a number of factors that underpinned the feasibility of establishing a PMHWD Organisation. Those factors derived from the key informant interviews and document analysis is presented in this section of the report. The findings from the literature review are presented in Section A of the report.

Do you think a Workforce Development Organisation (like Te Rau Matatini, National Addiction Centre or the Werry Centre) will work for Pacific?

The overwhelming and universal response by key informants to this question was yes. No-one indicated this was not a good idea. Some of their responses are presented below:

“Go for it but make sure the right skill mix (management and business Skills) are recruited.”

“Yes, Absolutely.”

“Oh absolutely, definitely and you can see that from the stats from the number of admissions of the Pacific people into acute units sections. I think it needs to be a workforce organisation and it needs to be carefully thought of what the strategy of that organisation is and who or the people you have in those roles that run that organisation and that you’ve got the right people right from the start....”

“Yes it will be good for Pacific....”

Yes. In a context that is very conscious of that sort of a broader workforce development system and structures that are already in place, and because a lot of those as you already know how to deliver, there’s a whole range of training available and that probably a great majority of which is mainstream but parts of that will contain Pacific elements and Pacific components, so the first thing I am thinking about is “What is the current workforce development programme? What is the current Mental Health A and D workforce development system?” and within that what is already happening to this Pacific and if I was someone that was going to be involved with something, you would want to have a really good understanding about that, beyond that, it seems to me that there are very clear indicators about the need for paying specific attention to Pacific workforce development, i.e. the sort of basic stuff, the growing Pacific population in New Zealand....”

“Yes, I think it would, one thing to be aware of is work in collaboration with other centres (TRM, Werry etc).”
“There is need for Pacific to have a voice. In our work it is easy to lose the passion for Pacific development simply because of the demands of our own work. That doesn’t absolve us of our own responsibilities to be more proactive in response to Pacific needs but it does represent a reality we face.”

Will it benefit/improve the Pacific workforce?

Again, many key informants believed the development of a PMHWD Organisation would benefit and improve the Pacific workforce. Some of their comments included:

“I believe it will. It can help to consolidate and coordinate training for Pacific. Improve quality and provide credible qualifications.”

“1) Funding, workforce training, education, vocational training
2) Ability to plan ahead - not just the bitsy way training is done at the moment
3) Provide a vision and ability not just to provide mental health training but in future as a general training centre focal point for all health
4) Consistency and quality
5) More control, planning in Pacific hands - long-term planning (at moment it’s to bitsy - little bit here, scholarship here, other training happening there
6) Using workforce money innovatively - “if we going down the same old line like producing doctors and nurses, there will be no Pacific Island Mental Health Services”, if we produce the same old we get the same old, CSW for example has done a lot for Pacific because it focused on what Pacific needs and its not reductionist and illness focused.”

“Organises training and development, maintain quality or training, get experts to do the training. Far greater impetus in developing Pacific workforce.”

“Benefits are we can up skill our people to meet the New Zealand criteria.”

“Provide coordination role for workforce issues and help to drive things for Pacific. Sector is fragmented and such an organisation can assist in ensuring there is a vision, clear objectives and goals. It can ensure that the needs are identified and proper solutions and strategies are implemented to fill the need.”

“By having your own - you can focus on recruitment of Pacific. Focus on Pacific for Pacific
Small group of mental health leaders - organisation can develop more capacities for leaders etc.
Consult with Pacific communities.
Promote Pacific models - Fonofale, alternatives to current treatment, can benefit Non-Pacific people as well.”

“It will benefit Pacific by providing more focus on Pacific issues.”

“Help to coordinate and bring together Pacific providers.”
In summary, the key points include:

- It will add value to Pacific workforce development and may provide value for the other workforce development programmes as a kind of authority for other groups to refer to;
- It needs a clear focus and vision. Whatever else happens this is essential for its development to ensure that it does not wonder off. Clear deliverables and high level management;
- Key performance indicators need to be specific and written into the service provision contracts - without ambiguity; and
- Its location is important. An organisation for Pacific would be well placed where decision makers are - such as Wellington. Alternatively, most Pacific people are in Auckland and hence it makes sense to locate it in Auckland.

A Pacific Mental Health Workforce Development Organisation or a Pacific Health Workforce Development Organisation

One issue to consider is whether the focus of the proposed organisation should be narrow on mental health or broad across the health spectrum. Whatever focus a Pacific workforce organisation takes; it will need to integrate itself into the current organisational structures and issues facing workforce development in New Zealand. Recently, a structural view of workforce issues was provided by Marrilyn Rimmer, DHBNZ, at a NGO forum in Wellington (2005). This is presented in Figure 1 below.

**Figure 1: Structural view of workforce issues in New Zealand**

Source: Rimmer, M. Presentation to NGO forum (2005).
The 2004/2005 DHB workforce action plan detailed future services having the following characteristics:

- New models of care;
- Consumer centred;
- Primary health/community-based;
- Wellness and prevention approaches;
- Integrated services across continuum;
- Hospitals as high intensity environments; and
- New technologies.

This configuration of services has workforce implications such as:

- Team work/interdisciplinary;
- Numbers and skill mix;
- Specialist vs. generalist skills;
- Expanded roles;
- Consumer participation;
- Innovation; and
- Intersectoral.

Added to the above the 04/05 workforce action plan the “Future Workforce” Project being undertaken on behalf of DHBs detailed eight priority areas as follows:

- **Priority I:** Fostering supportive environments and positive cultures;
- **Priority II:** Enhancing people strategies;
- **Priority III:** Education and Training;
- **Priority IV:** Models of Care;
- **Priority V:** Primary health workforce;
- **Priority VI:** Maori health workforce;
- **Priority VII:** Pacific health workforce; and

Further details regarding these priority areas are presented in Appendix 2. A future PHWDO will need to be able to feed into these priority areas for health workforce development, especially Priority VII - Pacific Health Workforce.

A number of key informants discussed the issue of whether the organisation should focus primarily on mental health or be broader and focus on health generally. There were advantages and disadvantages for each option.
Pacific Mental Health Workforce Development Organisation

A number of advantages and disadvantages were suggested and these are listed below:

- **Advantages**
  - A PMHWDO will advance Pacific Leadership in the sector through
    (i) leadership development of staff
    (ii) providing focus on strategic research objectives for the sector that enhance mental health service users (consumers) and their families mental health and wellbeing
    (iii) provision of expert advice to the sector
    (iv) supporting the upskilling of Pacific peoples through research and career development planning initiatives
    (v) strategic collaborations with other mental health workforce development organisations and programmes
    (vi) provision of training initiatives
  - It will provide a focused perspective that is governed by Pacific values and principles aligned to the sector
  - Enhance Pacific consultation and community input through building on established Pacific linkages and relationships in the sector
  - Provide a workforce development for mental health that otherwise might be lost if incorporated into a Pacific health workforce development organisation.

- **Disadvantages**
  - There is a need to build up Pacific health workforce capacity and capability across the entire health spectrum rather than putting resources into Pacific mental health
  - By focusing on mental health this could be perceived as compartmentalising health whereas Pacific has a holistic view of health.

While this is seen as an important issue for Pacific to address, informants stated mental health was a useful starting point which would allow the organisation, as it grew, to have a holistic approach. For example:

“...one of the major concerns that came through was why don’t we leave it to mental health? And could it be extended to Pacific Island health. I am, professionally, I’m actually quite sympathetic with the idea....and quite clearly we’re saying as Pacific Island people we see health in a holistic way... If you think that you see this as holistic then it does make sense that eventually it will have to be rather than compartmentalise it to mental health etc. then it will come up as a one stop shop scenario that we’ve been talking about...Unfortunately the way the funding and the policy study it’s still in mental health, public health and things.”

“But the risk I guess, while there’s a general kind of thinking out there that we need to go more holistic and broader. But starting it with mental health, because of that focus, mental health is really, when you compared to general
health, is really ahead of its time, and it’s mobilised and despite our differences in opinion we always seem to be ahead of the pack as far as getting things done. Especially getting new ideas through and moving with it. So maybe that’s a good beginning”.

The Vision, Mission, Objectives and Key Functions of the PMHWDO Organisation

PMHWDO Vision Statement

While the key informants did not espouse a clear Vision statement for the PMHWDO per se they did indicate a number of components that could form the basis of a Vision statement for the PMHWDO. It was mentioned that the PMHWDO needed to be led by a visionary Pacific leader. There was widespread belief in this. But before the PMHWDO Governance Board/Trustees select the leader/director/CEO they have to have a clear idea of what the position entails. Board directors/Trustees therefore must have a detailed understanding of what the director/leader/CEO will do. The director/leader/CEO will be directly responsible to the Board/Trustees for carrying out the PMHWDO’s policies. They will be responsible for the PMHWDO’s day-to-day operations and for carrying out its strategic objectives. Without a clear vision of what the Board/Trustees wants the PMHWDO to do and to become, it cannot determine the kind of director/leader/CEO it needs. A simple, clearly articulated strategic vision for the PMHWDO will dictate the type of personality and background needed for the position.

Hence the development of a strategic vision statement needs to be one of the first key tasks to be undertaken by the PMHWDO Board/Trustees before a director can be appointed.

Another common theme that should be captured by the PMHWDO’s vision statement is accountability. This was stated by a number of respondents in terms of governance accountability, financial accountability and community accountability.

The vision statement developed by the PMHWDO Board/Trustees should be realistic and credible, easily understood, appropriate, ambitious, and responsive to a changing health environment. The vision statement should focus the PMHWDO’s resources and serve as a guide to action. It should be consistent with the PMHWDO’s values. In short, the PMHWDO’s vision statement should challenge and inspire the PMHWDO to achieve its mission.

By way of comparison for the PMHWDO to consider, Te Rau Matatini in its 2004-2005 Draft Business Plan provided the following statement for its Vision:

VISION STATEMENT
“Te Rau Matatini will strengthen the Maori mental health workforce to lead New Zealand’s mental health sector through utilisation of dual clinical and cultural expertise to deliver services that support best health outcomes for whanau.” (Te Rau Matatini, 2004).

Te Rau Matatini expanded its Vision statement in its 2005-2006 Business Plan as follows:

VISION STATEMENT
Mā te whakapakari i te hunga hāpai, e piki ai te hauora hinengaro o te whanau
To strengthen the Maori workforce to maximise mental health gains for whanau.

Te Rau Matatini will strengthen the Maori mental health workforce to achieve the above vision and in doing so lead mental health service-responsiveness through:

- the utilisation of dual clinical and cultural expertise to deliver services that support best health outcomes for whanau;
- increased mental health early recognition and intervention by strengthening the wider health and social service sectors’ knowledge of and responsiveness to mild-moderate mental health need in the community; and
- the advanced development of mental health best practice founded on the highest clinical standards underpinned by indigenous values and healing modalities. (Te Rau Matatini, 2005).

Te Rau Matatini stated the Vision for Maori Mental Health Workforce Development as follows:

“Over the next ten years there will be a significant increase in the number of Maori working at all levels of mental health services. The Maori mental health workforce, located in both dedicated mental health services, and wider health and social support services, will be internationally recognised for their cultural and clinical expertise leading to best health outcomes for Maori.” (Te Rau Matatini, 2005a).

The National Addiction Centre’s (NAC’s) Vision Statement on their website (http://www.addiction.org.nz/) is as follows:

“A university-based National Centre dedicated to developing and promoting effective interventions for people with alcohol, drug and addiction related problems in Aotearoa New Zealand.”

Underpinning NAC’s Vision is a set of core values:

“Guiding all the activities of the NAC are three core values:

1. The NAC is committed to working in accord with the letter and spirit of the Treaty of Waitangi as the founding document of modern New Zealand society.
2. The NAC is focused on the people in Aotearoa New Zealand who have alcohol, drug and addiction-related problems, and their families/whanau.
3. The NAC is dedicated to assembling scientific evidence as the basis for improving treatment for people with these problems.” (http://www.addiction.org.nz/).

Matua Raki: National Addiction Treatment Sector Workforce Development Programme (NATSWDP) Plan for 2005-2015 stated the Vision for Matua Raki as follows:

“In 10 years’ time, a passionate and committed addiction treatment workforce with a sound infrastructure will provide excellent service to tangata whaiora/clients and their whanau/families to reduce addiction-related harm and improve their health and wellbeing.”. Source:
The Ministry of Health’s report: *Tauawhitia te Wero - Embracing the Challenge: National mental health and addiction workforce development plan 2006-2009* provided a Vision for the sector as follows:

“He roopu kaimahi whanui tonu mo te hauora hinengaro, hei tautoko, hei tauawhi i nga momo tu ahuatanga o nga tangata e whai ana te oranga mo ratou, me o ratou whanau tuturu, whanau whanui hoki; tu rangatira to ratou tu i runga ano i te huarahi o te oranga nui. Koia nei te moemoea o te kaupapa, Tauawhitia te Wero.

The vision of Tauawhitia te Wero is a diverse mental health and addiction workforce:

• responsive to the needs of service users, their families/whanau and significant others; and

• confident in their positive and unique contribution to the journey of recovery.

This vision for the mental health and addiction workforce relates specifically to the Government’s policy to address the needs of the 3 percent of the population who are most severely affected by mental illness.” (Ministry of Health, 2005).

The above quote mentions the estimated prevalence of adult New Zealanders who have severe mental health disorders, namely three percent. This target population was identified by adapting international studies and, in particular, the work by Gavin Andrews in South Wales referred to as the Tolkien report (Andrews, 2001). In addition to this work, the Christchurch-based epidemiological study of mental illness reported 20 percent of New Zealand’s adult population have a diagnosable mental illness (including alcohol and drug disorders) at any one time (Oakley-Browne et al. 1989). This information is illustrated in Figure 2 below.

**Figure 2: Estimated prevalence of mental health problems amongst adult New Zealanders**

![Figure 2: Estimated prevalence of mental health problems amongst adult New Zealanders](image)

The development of the PMHWDO Vision statement should take into consideration, but not necessarily be limited to, the Vision statements espoused for the mental health sector by the Ministry of Health and other MHWD organisations.

**PMHWDO Mission Statement**

One recurring theme from the key informant interviews was that the PMHWDO needed effective governance structures. One of the key issues here is that of governance referring to accountability of the PMHWDO Board/Trustees to the Mission of the PMHWDO it governs.

Effective governance of PMHWDO requires an effective Mission statement. The Mission statement has the effect of ‘gluing’ the PMHWDO together, working towards a common and well understood goal. So what then is an effective Mission Statement? Peter Drucker stated it as follows:

“The mission focuses the organisation on action. It defines the specific strategies needed to attain the crucial goals. It creates a disciplined organisation. It alone can prevent the most common degenerative disease of organisations . . . splintering their always limited resources.” (Peter Drucker, “What Business Can Learn From Non-Profits”. Harvard Business Review, July-August 1989).

The PMHWDO’s Mission Statement should identify its purpose and philosophy. In doing so, one needs to consider the PMHW Organisational arrangements and the philosophical perspectives underpinning them. One such organisational model is that developed for Maori (Knox, et al. 2002) as presented Figure 3.

While this model is useful it is not ideal for Pacific. Maori policies and their understanding are more aligned with Pacific values, compared to mainstream thinking. As the model is based on Maori culture and Maori values and they are the most closest to Pacific culture and values. However, while there are similarities between Maori and Pacific but there are also differences. Differences in protocols and in processes and that would be a challenge to negotiate. Another model to consider is a Pacific-focused model developed by Phil Siataga - A Multi-Disciplinary Cultural Responsivity Model: The MALAGA Model, Siataga (2004). This is illustrated in Figure 4. The Malaga Model is presented in detail below not because it is seen as a “preferred” approach but rather because it has laced documentation in the literature whereas the other Pacific models of care mentioned below have received attention in the literature and hence are not described in detail in this report.

Special thanks to Fuimaono Karl Pulotu-Endemann and Vito Malo for the appropriate naming and consideration of the Malaga Model. Note: Community Social Workers and Community Support Workers are suggested in this model as essentially providing the same services although it is acknowledged that there are ‘operational/managerial’ and professional development considerations which may factor in how the terms are applied.
Figure 3: Maori Organisational Arrangements

<table>
<thead>
<tr>
<th>MAORI TRADITIONAL INSTITUTIONS</th>
<th>SERVICE DELIVERY ORGANISATIONS</th>
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<tbody>
<tr>
<td>HAPU</td>
<td>OWNERS</td>
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<tr>
<td>PURPOSE</td>
<td>PURPOSE</td>
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<tr>
<td>Sustain</td>
<td>Profit</td>
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<tr>
<td>Promote wellbeing</td>
<td>Survival</td>
</tr>
<tr>
<td>Identity membership</td>
<td>self Interest</td>
</tr>
<tr>
<td>Develop Social Cohesion</td>
<td>Expansion/Growth</td>
</tr>
<tr>
<td>Unbounded</td>
<td>Bounded - by laws or rules</td>
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Unbounded Plans Resources People Bounded - by laws or rules

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<tr>
<th>TASKS</th>
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<tr>
<td>Rituals</td>
<td>Production</td>
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<td>Spiritual Guidance</td>
<td>Delivery</td>
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<tr>
<td>Dispute Resolution</td>
<td>Accounting</td>
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<td>Facilitation</td>
<td>Management</td>
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<tr>
<td>Accountability</td>
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<th>MEMBERSHIP</th>
<th>SHAREHOLDERS</th>
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<tr>
<td>Responsible To Who?</td>
<td>Horizons encompass more than 1 generation</td>
</tr>
<tr>
<td>Horizons are usually limited to less than 1 generation</td>
<td></td>
</tr>
</tbody>
</table>

Source: Knox, C., 2002, Te Nahu, L, Whakapūmau Te Mauri, A Capacity Building Programme, Te Wānanga o Raukawa.®
The MALAGA model presented by Siataga (2004) has been developed as part of his research to conceptualise a cohesive, integrated and multi-disciplinary approach. It validates both existing and developing knowledge’s within four critical dimensions:

1. Clinical;
2. Managerial;

Malaga is a Samoan word meaning ‘journey’.
3. Pacific Provider; and
4. Models of Care and Cultural Competency.

Each of these overlapping spheres has its own historical development. Each has an important part to play within its own sphere of influence with respect to Pacific consumer treatment/service delivery and recovery competencies but cannot achieve cultural responsivity in any one sphere alone. Communication links the four spheres with this commonality of purpose. This model therefore avoids becoming a polarizing debate about biomedical versus cultural world views while seeking to identify what is of value from each for the wellbeing of the people served. It further highlights the Pacific service user (consumer) and their family at the centre of the model for service delivery, highlighting the ‘natural’ supports as well as the need to consider familial dynamics in treatment and recovery.

The macro-context includes demographic, social, economic and political trends impacting policy development and vice versa. These influence resource allocation, research development and training, clinical and managerial leadership and ultimately service delivery. At the centre is the consumer for whom services are developed. In my opinion Pacific peoples and mental health professionals need to approach recovery fundamentally from a Partnership perspective. Inter-dependence is the principle upon which this is based which upholds the dignity of individuals both receiving and providing services while at the same time recognising that ‘recovery’ involves a group of people with the right mix of skills and experience working well together. A partnership perspective is balanced and provides a philosophical orientation which is responsive to Pacific peoples.

A multi-disciplinary approach within the context of integrated care models inclusive of Pacific communities, families and Pacific providers is vital to improving the quality of care of Pacific peoples across a range of mental health services. There is some way to go before this is established. However, there are significant developments which can progress this if new knowledge(s) and dialogue is nurtured across clinical, therapeutic, cultural and managerial dimensions through appropriate training. The PMHWDO will have a key role to play in this regard.

Pacific Models of Mental Health Service Delivery in New Zealand (“PMMHSD”) Project (Ministry of Health, 2004), identified a number of models mentioned by the participants in this study. The executive summary listed the models as follows:

“There were eight different models of care raised by participants: the ‘wellness model’; the ‘illness model’; the ‘Fonofale model’; the ‘Te Vaka model’; the ‘Faafaelu model’; the ‘Strands or Pandanus Mat Model’; the ‘Strengths-based model’; and the ‘Traditional Healing model’. Participants raised these models in passing. Apart from the traditional healing model, the other models cited are more health belief type models rather than service delivery models. They inform service delivery but are not in themselves models of service delivery.” (Ministry of Health, 2004).

The report also detailed from the results what is unique about Pacific models of care. It stated in part:

“To talk about ‘what is uniquely’ Pacific about Pacific approaches is inevitably to highlight the philosophical value system adopted by these approaches. This value system is inherent or embodied in many of the different techniques
adopted by Pacific service providers interviewed in this study. These techniques include the ‘roundabout’ rapport building approach, understandings of spirituality, the cultural value of group therapy, and the use of Pacific language and hospitality practices. These uniquely Pacific aspects were seen to be more implicit than explicit. Moreover, participants noted that part of what made a Pacific service uniquely Pacific was for them the presence of Pacific motifs, ornaments and/or decorations within service buildings.” (Ministry of Health, 2004).

A draft PMHWDO Mission Statement for consideration and consultation is provided below:

“To ensure development of a Pacific mental health workforce that is sufficient in size and skill base to meet the needs of Pacific peoples and others with mental illnesses and addictions by providing training, education, research and care that is culturally competent, safe, person and family centred, effective, efficient, equitable and timely.” The “six aims” of care are adapted from the Institute of Medicine’s Crossing the Quality Chasm: A New Health System for the 21st Century (2001).

Again by way of comparison, Te Rau Matatini’s Mission statement provided in their 2002 Business Plan is presented below.

MISSION STATEMENT – Te Rau Whakahirahira ki Mua

The above whakatauki underpins the direction and development of Te Rau Matatini. It refers to many strands being brought together in cohesion to strengthen, enhance, equip and progress forward.

The aim of Te Rau Matatini is to strengthen the Maori mental health workforce by:

• Contributing to Maori mental health workforce policy at a national and regional level;
• Contributing to a Maori mental health workforce that subscribes to excellence in cultural, clinical and management practices;
• Expanding and extending the Maori mental health workforce; and
• Promoting rewarding career opportunities in mental health for Maori.

In meeting these aims Te Rau Matatini will work to contribute to the following four areas within Maori mental health workforce development: workforce expansion; workforce extension; workforce excellence; and workforce navigation. Te Rau Matatini (2002).

Te Rau Matatini in its 2004-2005 Draft Business Plan provided the following statement for its Mission:

MISSION STATEMENT

Te Rau Matatini will strive to achieve the vision through:

• Workforce Expansion;
• Workforce Extension;
• Workforce Excellence; and
• Workforce Navigation.
Strategic objectives of the PMHWD Organisation

Strategic objectives for PMHWDO include:

1. **Empower Pacific consumers and families** as caregivers and educators. That is, Pacific mental health consumers and their family members are actively engaged as teachers of the Pacific mental health workforce.

2. **Actively recruit and retain** a qualified Pacific mental health workforce in adequate numbers. Annual recruitment targets should be established and adequately funded.

3. **Use effective training** strategies. That is, teaching and training should be:
   - professional and cultural competency-based
   - engage the Pacific mental health workforce in a process of *life-long learning*
   - practice guidelines that are culturally appropriate are used as teaching tools
   - teaching methods are problem- and evidence-based.

4. **Develop Pacific mental health managers and leaders** for all segments of the workforce through engagement in appropriate Pacific health leadership training programmes.

5. Ensure that Pacific mental health workforce education, development, and oversight processes (certification, accreditation) have *relevance to current mental health practice*. That is:
   - adopt a best practice approach in education and training should be adopted
   - curricula should be routinely updated to address Pacific values, knowledge and skills that are essential for culturally appropriate best practice in the mental health sector
   - professional development should encourage reflective thought in students of the competing service delivery models, and the professional, economic, social and cultural factors that shape the delivery of mental health services in New Zealand.

6. **Secure sustainable core funding** that is adequate to maintain a highly qualified Pacific mental health workforce that creates incentives for personal and professional excellence and provides for infrastructure development.

These strategic objectives of the PMHWDO will need to be aligned to the organisation’s mission statement as well as national policy documents on mental health workforce development in New Zealand. They are presented as an indicative list to provide a starting point for discussion.

Draft functions of the PMHWD Organisation

The PMHWD Organisation could perform the following broad functions:

- Pacific mental health research;
- mental health workforce training;
- education, which will centre on a best practice approach to providing education that includes,
  - methods of teaching which is evidence-, competency- and culturally-based
− students are taught the process of life-long learning that involves critical reflection on the scientific, professional, economic, social and cultural factors shaping mental healthcare service delivery in New Zealand and internationally

− curricula should be routinely updated to address culture values, knowledge and skills that are essential to the delivery of mental health services in New Zealand

− skill development should focus on cultural, clinical, management and administrative competencies and capabilities to deliver effective mental health services in New Zealand

− teachers, trainers and supervisors should be experienced in providing mental health services in the New Zealand context; and

• dissemination of the PMHWDO’s work programme.

To provide a high quality service that meets the needs of purchasers, PMHWD Organisation staff will require the requisite skills and experience to perform the above broad functions of the PMHWD Organisation. To this end, the PMHWD Organisation will need to be supported by an administrative infrastructure to be sustainable.

The functions of the PMHWDO will need to be aligned to the organisation’s mission statement as well as national policy documents on mental health workforce development in New Zealand. Again, the functions mentioned above are presented as an indicative list to provide a starting point for discussion.

The critical success factors that will support the successful establishment and ongoing effectiveness of the PMHWD Organisation

Factors critical to success

The following factors are considered critical to the success of the PMHWD Organisation.

Intellectual integrity, independence and credibility

Having the PMHWD Organisation as an autonomous unit independent of the purchasers is important to its credibility, especially with provider organisations and individual healthcare practitioners.

Credibility is both scientific and political. For scientific credibility, recognised expertise and rigorous standards of methodology are essential. For political credibility, the PMHWD Organisation governance body must be independent from the Ministry of Health and not chosen on the basis of their organisational affiliation.

If the PMHWDO was an autonomous unit based at a University or Polytechnic this would enable staff to have access to a broad range of clinical, technical and librarian expertise.

Community credibility amongst the Pacific Providers networks is built on establishing quality relationships. Communication is achieved through ensuring Pacific provider
networks are informed of the PMHWDO vision and objectives through a variety of communication channels involving appropriate levels of consultation.

_relevant to the mental health sector_

The purpose of the PMHWD Organisation will be to facilitate the development of better Pacific mental health sector workforce policy, purchaser and provider decisions by providing timely research-based information on which purchaser and policy decision-makers can rely. The PMHWD Organisation will be responsive to purchasers’ priorities and will anticipate future needs and develop capabilities to meet them.

The overall purpose and direction will be secured by the PMHWD Organisation identifying priority topics and negotiating directly, through their representative, with the Ministry of Health. These priorities, or mechanisms for determining them, will be incorporated into the annual business plan. This process will produce a programme that is planned, relevant, organised and is practically focused on the mental health needs of the New Zealand population in general and the New Zealand Pacific population in particular.

_proactive_

Dissemination of Pacific mental health information is seen as a key function of the PMHWD Organisation. The PMHWD Organisation will disseminate information on Pacific mental health in a targeted way to relevant health professionals and consumers of healthcare.

Dissemination of information will include both active and passive processes. Active dissemination includes:

- the preparation of a quality bulletin of information relating to the PMHWD Organisation, covering such topics as, what’s new in the PMHWD Organisation for information on Pacific and international developments in mental health policy, education, training, workforce development and service delivery;
- an annual catalogue of services and products detailing the aims and objectives of the PMHWD Organisation and the services offered;
- a list of recent publications by the PMHWD Organisation staff will be produced and disseminated; and
- PMHWD Organisation staff will also make contributions to various publications and relevant conferences.

Passive dissemination includes:

- providing access to PMHWD Organisation’s databases through a website home page;
- E-mail discussion list to provide an exchange of information and ideas with those individuals interested in Pacific mental health issues; and
- online discussion forum providing another mechanism for dissemination and exchange of information with the mental health sector.
Responsive, accountable and valuing people

The management of the PMHWD Organisation will be structured, through the development of an annual business plan to reflect the necessary responsibility to incorporate technical changes and information as the organisation grows through an establishment phase into an operational phase.

PMHWD Organisation staff will monitor new developments in the mental health environment through their local, national and international collaborative networks.

The PMHWD Organisation will be very much a client (people) focused learning organisation. Its philosophy is to best meet the needs of clients by providing services that are timely, of high quality and within budget. As a learning organisation it will value client feedback.

Pacific mental health experience and track record

The PMHWD Organisation staff will need to have a track record of successfully undertaking training, education, workforce development activities, as well as dissemination activities of high quality.

Size and critical mass of expertise

This PMHWD Organisation will need to bring together a team of highly qualified and experience staff that is large enough to be able to undertake the work required as outlined in its annual business plans. The PMHWD Organisation’s size should enable increased flexibility for their working patterns.

PMHWD Organisation staff skill mix

As discussed above, size and collaborative networking should be embedded within a multi-disciplinary skill mix necessary to be able to deal with all aspects of the PMHWD Organisation’s work programme. The key skills required will cover the following areas:

- Management and governance expertise;
- Specialist mental health research skills, especially with Pacific populations;
- Statistical, economic and other quantitative analytical skills;
- Presentation, evaluation, communication and community consultation skills;
- Database management and quality assurance systems;
- Maintenance of computer software and hardware systems;
- Financial planning and control;
- Marketing and development;
- Publication and dissemination of information;
- Training and education of the mental health workforce; and
- Administration.
PMHWD Organisation Staff Factors

- PMHWD Organisation should have high calibre staff who are results orientated while maintaining a high level of ethical and cultural sensitivity.
- PMHWD Organisation should be a stimulating and challenging work environment that incorporates respect, understanding and support between team members.
- PMHWD Organisation staff will generate high quality education and training programmes and mental health research information by ensuring that the activities are carried to the highest scientific standards.
- PMHWD Organisation will deliver a work programme to mental healthcare professionals, policy makers and purchasers in a way that will influence their behaviour.
- PMHWD Organisation governance, management and staff will have credibility with mental health professionals, policy makers, purchasers and academics.
- PMHWD Organisation will need to develop and implement an information technology structure that provides reliable and easy access to the information housed by the PMHWD Organisation.
- PMHWD Organisation will need to develop systems to monitor and evaluate performance, and to identify information needs and target groups.

Mental health client orientation

We understand the pressures that the health policy decision-making process generates and the need to collaborate closely and flexibly with Ministry of Health staff and other stakeholders and to produce work to agreed deadlines. The PMHWD Organisation should be a client-focused organisation and strive to meet all their client’s needs.

Health networks

The PMHWD Organisation will establish extensive links within the health sector and networks of mental health clinicians, nurses and workers to advise on the key issues impacting on mental health workforce development with particular emphasis on the needs of Pacific. Pacific mental health needs will be identified by the communities of interest and partnerships between Indigenous and Pacific mental health workers, communities, and non-Indigenous mental health worker will be developed.

Mental health workforce training capacity

- Interim step - first phase develop training needs analysis of the MHS.
- It will need to consider needs in relation to youth workforce, as well as adult training needs.
• Training will be a key deliverable of the PMHWD Organisation. The PMHWD Organisation staff will have conducted training/teaching courses and will develop new courses committed to the continued professional development of the mental health workforce.

• The PMHWD Organisation will pay a key role in the ongoing development of the Cultural Competency dialogue in the Mental Health sector.

Project management skills

The PMHWD Organisation will establish processes and structures for the management of projects. Such projects will have explicit timelines and quality assurance steps built in. The PMHWD Organisation track record should demonstrate that they will deliver to high quality and on time.

Quality assurance programmes

The PMHWD Organisation operation will take place within a multi-disciplinary team environment led by the Director implementing the work programme with formal quality assurance steps built in at each stage. The process will be continually reviewed and updated in the light of advances in training and research developments and best practice.

Total Quality Management practices

The PMHWD Organisation staff will be committed to continuous self and critical reflection to improve their working practices and will establish formal processes for this. For example, after the completion of a research deliverable or training module, the entire staff team should get together for a debriefing meeting to reflect on how the process had gone and how it could be more efficient in the future, and are there any lessons for best practice in the future.

Performance Appraisal systems will be developed for all staff.

The quality and nature of working relationships can be assessed through management processes such as 360 degree interviewing and Motivational Interviewing if applicable. The organisation would benefit in formally planning this process from the outset. Exit interviews with staff should also be factored into the recruitment and induction phase ensuring that as staff develop and/or move on important experiential feedback is anticipated for the PMHWD Organisation.

The PMHWD Organisation should therefore recognise and ensure that it learns from experience and implements innovative strategies to improve their efficiency and quality. The PMHWD Organisation will support continued professional development training of its entire staff at every grade by attendance at relevant educational and training workshops and conferences nationally and internationally.

The structure of the PMHWD Organisation should incorporate the following guiding principles:

• aligns functions to achieve maximum efficiency and effectiveness;
• provides for flexibility;
• is robust and allows for growth;
• ensures that there are clear accountabilities;
• ensures that staff are very clear about their roles and functions; and
• ensures that services meet the needs of clients.

The PMHWD Organisation within a TQM framework will implement workplace policies pertinent to health promoting behaviours that include:

• employee assistance programme;
• ethical behaviour policy and procedures;
• equal employment opportunities policy;
• accident reporting and rehabilitation policy;
• good employer policy;
• smoke free policy; and
• health and safety policy.

Business focus

• The PMHWD Organisation will need to maintain a clear focus on its business objectives, roles and deliverables and thus on developing a competitive edge.
• The PMHWD Organisation will be client focused and is service driven.
• The PMHWD Organisation will provide services to meet client needs that are timely, quality assured and cost effective within budget with a reputation for excellence.
• The PMHWD Organisation will be business orientated with clear lines of accountability and responsibility.

Security and data protection procedures

The PMHWD Organisation will need to implement measures to preserve system integrity, data availability and information privacy. Emphasis will be placed on the security of information. The PMHWD Organisation will need to implement the following security measures:

• control access to the PMHWD Organisation functions, files and databases;
• control access to the PMHWD Organisation work environment by appropriate security measures;
• transaction logs and audit trails will be maintained for all activities;
• archiving - off-line data storage will be actioned; and
• Virus protection, spy ware software protection procedures will be actioned.
The proposed governance, management and staffing/organisational structure of the PMHWD Organisation, including specifying full-time equivalents, at each stage of development of the PMHWD Organisation

*The legal entity of the PMHWD Organisation - options*

A number of alternative legal structures are possible for consideration. Options and advantages and disadvantages of each option are presented below.

*Charitable Trust*

A charitable trust is a legal entity created in law by a trust deed. The charitable trust is governed by the trustees appointed in the trust deed. The powers of the trustees are contained in the trust deed and trust law.

Advantages include:
- It sets out clearly the intentions of those forming the trust;
- Trustees have the powers to carry out the activities of the trust; and
- Trustees generally have limited liability to the extent of the trust assets except for fraud.

Disadvantages include:
- Trustees must adhere to the terms of the trust deed and this might restrict the activities of the trust's operations;
- The terms of the trust deed can be difficult to change; and
- Any borrowing of money will require guarantees of support.

*Company*

A company is a separate legal entity. A company must have a minimum of two shareholders. The shareholders appoint directors who are responsible for the day-to-day management of the company.

Advantages include:
- As a separate legal entity it can contract in its own name;
- Managed by the elected directors who must act in the best interests of the company; and
- Change of shareholding is simple.

Disadvantages include:
- More expensive to administer than some other ownership structures;
- Must be incorporated and this may involve specialised tailoring of company rules;
- Any borrowing of money requires guarantees of support; and
- There are accounting, secretarial, filing fees and audit compliance costs.
**Incorporated society**

An incorporated society is a body of not less than 15 persons associated for common interest but not for pecuniary gain. It is governed and operated by the rules of the society which are drafted in accordance with the Incorporated Societies Act. The Society can contract in its own right. Officers of the society are elected in terms of the rules of the society and are responsible for compliance with the society’s rules.

Advantages include:

- Incorporated for the purpose of common interest and cannot be for the pecuniary gain of members;
- Members are not generally liable for the obligations of the society; and
- It can be managed by the elected officers of the society, like directors of a company.

Disadvantages include:

- Incorporation costs which will normally involve tailoring of society rules to meet specific objectives; and
- Any borrowing of money will require guarantees of support.

**Joint venture**

A joint venture is an agreement between two or more parties to jointly participate in some activity. There is no specific law governing the operation of a joint venture. A joint venture is generally governed by an agreement executed by the joint venture parties.

Advantages include:

- A joint venture can be extremely flexible and informal; and
- Do not have formal statutory requirements to keep records or hold formal meetings or elect officers.

Disadvantages include:

- There is no specific law governing the operation of a joint venture and therefore it can become difficult if “things go wrong”; and
- It necessitates a specific legal agreement in order to formalise matters.

Te Rau Matatini’s 2002 Business Plan noted the legal entity as a Charitable Trust. The Business Plan stated the broader aims of the Trust are to contribute to:

(i) the development and promotion of Maori health in Aotearoa New Zealand;
(ii) the development and promotion of Maori mental health in Aotearoa New Zealand; and
(iii) the development and promotion of a Maori mental health workforce within Aotearoa New Zealand.

Te Rau Matatini was established with close a working relationship with Massey University and this was formalised through a Memorandum of Understanding between the two parties. In addition to the MoU, a service agreement was entered into by
the parties establishing the operational and financial arrangements between them. This was diagrammatically represented as follows:

![Diagram showing the relationships between Ministry of Health, Te Rau Matatini, Massey University, and other parties.]


**Establishment models for the PMHWD Organisation**

While there are a number of legal entity options for the PMHWD Organisation there are also a number of options for the establishment of the PMHWD Organisation. The options that key informants suggested are detailed below.

1. **Umbrella model - for example, umbrella with Te Rau Matatini or umbrella with University or Polytechnic or other organisation**

   Advantages include:
   - infrastructure support systems of “umbrella” organisation already up and running and available to the PMHWD Organisation such as financial management systems, HR policies, library resources, etc;
   - linkages and access to “umbrella” organisation’s staff that have similar professional interests to that of the PMHWD Organisation;
   - the above may result in cost savings to the PMHWD Organisation, especially during the establishment phase of operation;
   - a university or polytechnic “umbrella” organisation would provide an educational and training environment for the PMHWD Organisation; and
   - would provide integrity for the PMHWD Organisation especially during the establishment phase of operation. It gives a profile for the new organisation.

   An “umbrella” organisation in the NGO sector would provide key established linkages with stakeholder organisations and assist with credibility building in the sector.

   Consumers felt that a polytechnic would be good because Pacific people are more hands on and they see polytechnic being a more practical sort of learning style. That is, a bit of theory and some practical hands-on experience.
Disadvantages include:

- costs associated with “umbrella” organisation, such as infrastructure/overhead would be passed onto the PMHWD Organisation;
- may be difficult to create separate identity or “brand” yourself in the community from “umbrella” organisation, that is, could be swamped by the “umbrella” organisation “brand”;
- could be philosophical differences between “umbrella” organisation and the PMHWD Organisation in terms of strategic direction;
- while during the establishment phase the “umbrella” organisation gives you the credibility to get on with developing the PMHWD Organisation, later on it gives you layers and layers of bureaucracy to work your way through, and this can slow down the innovation; and
- doing things for Pacific there’s a one size doesn’t fit all. So this implies that we need to do some things that are innovative. They might be slightly different or in some times vastly different from the way things are. And that might be harder than when you don’t have the full autonomy to actually do that.

2. **Buddy model – for example, buddy with Te Rau Matatini**

Advantages include:

- same as for “umbrella” organisation model above;
- Te Rau Matatini also has mental health focus and similar vision, mission, objectives and functions to the PMHWD Organisation, similar philosophical perspectives. Their policies and their understanding would be more aligned with Pacific values, the values they’ve put into their policy development. It’s already there and that’s what holds them apart from any other organisation because it’s based on Maori culture and Maori values and that’s the closest to Pacific; and
- could develop a Memorandum of Understanding between “buddy” organisation and the PMHWD Organisation. By MoU arrangement is meant a “hosting you while you grow” situation. That is, the PMHWD Organisation is very clear on what they want from the hosting organisation, and the “buddy” organisation is very clear what they want from the PMHWD Organisation. This could be seen as a temporary arrangement during the establishment phase of operation before other options are explored and implemented.

Disadvantages include:

- maybe difficult to create separate identity or “brand” yourself in the community from “buddy” organisation, that is, could be swamped by the “buddy” organisation “brand”;  
- developing a MoU arrangement will take time to negotiate an acceptable outcome to both parties;
- there are similarities between Maori and Pacific but there are also differences. Differences in protocols and in processes and that would be a challenge to negotiate. When you buddy up with somebody you can have a kind of senior - junior relationship so that is going to be a challenge as well; and
- a new “Pacific” presence might dilute the Maori workforce development focus and create unproductive tensions.
3. **Tender model - tender for PMHWD Organisation in the market place**

A tendering model would seek market response to a request for tender (RFT) or request for proposal (RFP) communicated to the health sector by a single funding body (or multiple funding bodies) to invite responses to establish and maintain the PMHWDO.

Advantages include:

- go to the market and seek tenders to respond to a RFP process. You would establish an advisory group to set the agenda for putting together an RFP as a contestable tender process and then the preferred applicant would be asked to set up and establish the PMHWD Organisation;
- tender process can be single vs. multiple stage, that is, can ask for Expression of Interest (EoI) and then select from EoIs those applicants to submit a full proposal;
- tender process can be open or restricted;
- may provide some innovative and value for money options; and
- tender scored against prestated criteria in advertisement or tender document.

Disadvantages include:

- transactional costs associated with the RFP process;
- may be difficult to get the “right mix” in a single or multiple applications and hence may then need to implement another procurement process; and
- if the tender criteria was based solely on value for money you might get different organisations tendering not necessarily because they want to improve the Pacific mental health workforce, but because of the financial opportunity available.

5. **Integrated model - add PMHWD Organisation EFTS into existing MHWD organisation/structures such as Te Rau Matatini or MHWDP or other existing MHWD organisations**

Advantages include:

- add a Pacific mental health capability to existing mental health workforce development organisations, a team within a team approach; and
- build on existing mental health workforce development organisations, that is, shared administration and infrastructure costs hence a cost-effective approach.

Disadvantages include:

- dilution of Pacific mental health workforce development activities and expertise across existing mental health workforce development organisations, that is not able to establish a critical mass of Pacific mental health workforce development expertise in one location;
- potential for Pacific mental health issues to be secondary to other activities of the existing mental health workforce development organisations;
- difficult to establish a “Pacific” identity and brand in existing mental health workforce development organisations;
• could be perceived as tokenistic and difficult to implement PMHWD Organisation Vision, Mission, objectives across multiple organisations each with limited Pacific capacity/EFTs;
• it maybe difficult to get community buy-in;
• innovation maybe difficult to achieve or stifled; and
• with this distributed staffing model across existing MHWD organisations its not clear where the strategic direction for the Pacific mental health workforce development staff would come from.

**Preferential Option**

An autonomous PMHWDO in a start up phase would face onerous difficulties on cost effectiveness and establishing key linkages which an “umbrella” or “buddy” model could ameliorate through already established infrastructure, through already established credibility and relationships in the sector. The tendering model presents risk given the need for a consortium of interest groups to establish high trust working relationships across potential conflicting organisational and individual stakeholder interests and could take a long to establish creating credibility problems in the Pacific mental health sector and also wider mental health sector. It could also potentially create an autonomous organisation with the disadvantages mentioned.

Cultural sensitivities in working with Maori organisations are not “givens” and assumptions about working across cultures which do not explicitly factor in the need to develop the Pacific and Maori organisation cross-cultural competencies from an operational perspective could create unproductive cultural barriers diluting both organisations respective key objectives. This would be particularly difficult for a new PMHWD Organisation to manage in start up phase and have medium- and long-term repercussions for the development of Pacific mental health and Maori mental health. A buddy approach or umbrella approach would require very clear and explicit detail on how to address these areas of cross-cultural learning for both organisations.

Either a buddy or umbrella approach appears to present the best options for a establishing a PMHWD Organisation as the benefits of working with an established mental health workforce development infrastructure and key stakeholder relationships is critical to:

(i) building the credibility of the organisation in the sector; and
(ii) adding value to the systems development in order to allow the PMHWD Organisation to focus on ‘other’ important aspects of development.

With careful planning and clear objectives outlined, anticipating risks as well as identifying added value potential in joint projects, the PMHWD Organisation and buddy or umbrella group would be well placed to enhance each others core objectives.

While there are benefits to working under a University in terms of educational expertise but the financial costs (or contributions for this expertise) would need to be worked through to the satisfaction of all parties concerned.

A PMHWD Organisation ‘does not have to recreate the wheel’ and the success of Te Rau Matatini establishment with its linkage to Massey University provides some
practical learning lessons and operational practicalities for reflection and development.

**Organisational structure**

**Governance of PMWDO**

A number of options are available to discharge the governance functions of a PMHWDO. One option is to establish a Board of Directors.

The Te Rau Matatini’s 2002 Business Plan stated their Board structure as follows:

**Te Rau Matatini Board**

Te Rau Matatini is an independent Trust governed by a Board of a minimum of 10 and maximum of 20 members. The current 16 members have been purposefully selected for their experience, knowledge and networks within Maori mental health and therefore are largely representative of the Maori mental health sector. The functions and procedures of the Board are outlined below and a list of members, as at August 2002, is included in Appendix 4 [of the Business Plan].

**Main Functions:**

- to ensure that the policies adopted by Te Rau Matatini are consistent with the overall aim of enhancing the Maori mental health workforce;
- to promote the kaupapa of Te Rau Matatini within the health sector and especially within the Maori mental health sector;
- to ensure that Te Rau Matatini is properly accountable;
- to facilitate interaction between Te Rau Matatini and key stakeholders;
- to enter into a contractual agreement with the Ministry of Health for the purposes of promoting Maori mental health workforce development;
- to reach agreement with Massey University for services related to meeting the goals of Te Rau Matatini;
- to approve contractual agreements between Te Rau Matatini and other agencies;
- to approve performance monitoring reports from Te Rau Matatini to the Ministry of Health;
- to appoint Te Rau Matatini representatives to other Boards and key stakeholder organisations;
- to arrange for Board participation in projects undertaken by Te Rau Matatini as required by the Board; and
- to investigate the establishment of a Maori mental health electoral college for the purpose of ensuring fair representation of the sector.

**Board Procedures**

- The Te Rau Matatini Chair and Deputy Chair have been elected by the Board.
- The Chair of Te Rau Matatini is Hayden Wano.
- The Deputy Chair of Te Rau Matatini is Materoa Mar.
The Director will ensure that the Board is adequately resourced to undertake its functions.

It is expected that the Board will meet up to three times a year.

Implementation Team
The implementation team consists of:

- Director (Mason Durie);
- Programme Manager (Kirsty Maxwell-Crawford);
- Clinical Coordinator (Paul Hirini); and
- Administrator (Toni Waetford).

The team are employed as Massey University staff, seconded to Te Rau Matatini. A brief description of their roles is included in Appendix 5 [of the Business Plan].”


**Governance Board of the PMHWD Organisation**

Governance is defined by Shortnell and Kaluzny (1993) as follows:

“Governance is the function which holds management and the organisation accountable for its actions, and helps provide management with overall strategic direction in guiding agency activities.”

In order for Board members to effectively fill their role of governance they should be familiar with PMHWD Organisation’s policies, plans and priorities.

The terms of reference for the Board are the formal documentation of the purpose, role and scope of the Board. The terms of reference provide the framework for the operation of the Board. It assists the chairperson and members to quickly and accurately comprehend their roles and responsibilities. The terms of reference should be considered a “living document” which can be altered and amended as tasks change, and certainly to reflect the outcome of any review of Board activities and functions.

Below is an indicative list of potential roles and responsibilities for the PMHWD Organisation’s Board.

**Requirements for Board Membership**

Board members should demonstrate a commitment to work for the greater good of the PMHWD Organisation and its clients.

Ideally Board members will bring knowledge, expertise and influence in one or more areas of board responsibility: policy development, financial and organisational management and personnel practices, in one or more areas of PMHWD Organisation’s programmes and services or in advocacy relevant to the PMHWD Organisation. Board members may also represent particular interests (e.g. Ministry of Health, Pacific mental health).
Role of the Board

Policy

The PMHWDO Board will be responsible for establishing and ensuring achievement of PMHWD Organisation’s Mission and Objectives through effective policy development management. It will:

- develop and monitor policy guidelines for the PMHWD Organisation; and
- review and approve the business plan.

Programmes and Services

The PMHWDO Board will be responsible for monitoring PMHWD Organisation’s various programmes and services. It will:

- approve annual programme plans, reports and budgets;
- monitor the outputs against programmed intentions; and
- advise on new services and programmes.

Personnel

The PMHWDO Board will be responsible for ensuring the development and implementation of appropriate personnel policies. It will:

- advise on prospective Board members and developing and reviewing appraisal mechanisms for the Board itself and its members;
- participate in the selection and appointment of a PMHWD Organisation Director; and
- monitor the performance of the PMHWD Organisation Director.

Financial and Organisational Development

The PMHWDO Board will be responsible for the establishment and maintenance of sound financial and organisational practices and policies. It will:

- review financial policies and identify areas for financial planning or development; and
- approve the annual budget and monitor expenditure and revenue on a regular basis.

Advocacy

- The PMHWDO Board will assist the PMHWD Organisation to enhance its public identity through appropriate advocacy.

Evaluation

The Board will undertake a review of its activities and goals on an annual basis. Such a review will encompass the PMHWD Organisation’s achievements and the achievements of the Board during the preceding year.
An annual planning and goal setting meeting will be scheduled or incorporated into a regular board meeting.

**Appointment and term of office**

Board members will be recruited on a ‘mixed appointments’ basis, that is, as nominees of an organisation (Ministry of Health, host institution, Maori, Pacific, community) or as having specialist skills (mental health practitioner).

Board members will be recruited in a planned systematic way which recognises the need for a balanced skill-mix, perspectives and personal contributions.

Board members will serve a three-year period in office. If a Board member resigns the organisation nominating that Board Member will nominate a replacement.

Board members are selected as follows:
- Ministry of Health nominee;
- Maori nominee;
- Pacific nominee;
- Community nominee;
- Pacific mental health consumer;
- Mental Health practitioner nominee
- Director - PMHWD Organisation - ex officio; and
- Other nominees as required.

The Board is to select its Chairperson and deputy-Chairperson at the first meeting of the Board. The Chairperson will have a term of three years.

**Time commitment**

The Board will meet at least four times a year, one of which will comprise the annual review and planning meeting.

**Reporting requirements**

The distribution of the Board minutes will be the major formal mechanism for reporting. The Board will also approve an annual business plan. The annual business plan would provide a mechanism for summarising the Board’s and the PMHWD Organisation’s activities and for raising any outstanding issues.

**PMHWD Organisation Executive Management Committee**

An Executive Management Committee will have management responsibility for the PMHWD Organisation, which could be a sub-committee of the Governance Board. The Executive Management Committee will comprise the PMHWD Organisation’s Director, and 2-3 Governance Board nominees.
The Executive Management Committee will need to meet initially monthly during the establishment phase of the PMHWD Organisation and then bi-monthly. There will need to be regular weekly PMHWD Organisation staff meetings to discuss topical issues and to provide formal feedback to and from the Executive Management Committee meetings through the PMHWD Organisation’s Director.

PMHWD Organisation’s staffing structure

In order to help the PMHWD Organisation develop and attain high standards of professional excellence and have credibility with mental health professional organisations, purchasing bodies, government agencies, academic institutions and the general public, a range of well respected and experienced individuals will be invited to advise or act as collaborators to the PMHWD Organisation. Some of these individuals will be members of the PMHWD Organisation’s Governance Board and Executive Management Committee.

Assuming that a stand alone, umbrella or buddy model is adopted for the PMHWD Organisation then the following configuration of core funded staffing arrangements is presented as a possible option.

Skill mix and experience of staff members

The proposed core staffing structure for the PMHWD Organisation is presented below.

<table>
<thead>
<tr>
<th></th>
<th>FTE (%)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>50</td>
<td>70</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Programme Manager</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Clinical Co-coordinator/Trainer</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Pacific Mental Health Researcher</td>
<td>50</td>
<td>70</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

The above staffing arrangements follow the Te Rau Matatini operational model with the addition of a Pacific Mental Health Researcher. The Te Rau Matatini job descriptions for Director, Programme Manager, Clinical Coordinator and Administrator (the implementation team) and other staff are presented in Appendix 3.

These arrangements should be regarded as indicative to provide a starting point for discussion.

The key characteristics, skills, competencies and abilities of the personnel recommended for key positions in the PMHWD Organisation

PMHWD Organisation Director

The director will have responsibility for managing the PMHWD Organisation and providing visionary, cultural, clinical, educational, managerial and academic leadership. The Director will administer the PMHWD Organisation and be responsible for the maintenance of high academic standards of excellence. The overall accountability of the Director is:
To assist in the development of a Pacific mental health workforce that is sufficient in size and skill base to meet the needs of Pacific, Māori and mainstream individuals with mental illnesses and abuse use disorders by providing training, education, research and clinical care that is culturally appropriate and safe, person and family centred, effective, efficient, equitable and timely.

This accountability will be achieved by:

- negotiating the PMHWD Organisation work programme requirements with the purchasers of the PMHWD Organisation and other stakeholders;
- exercise strategic thinking and organise his/her workload according to and in order to meet priorities, targets and deadlines;
- developing an annual business plan;
- communicating the outputs of the PMHWD Organisation to the purchasers, DHBs, the wider mental health sector, the Pacific community and the public;
- ensuring that staff and other resources are available and used efficiently and effectively to achieve outputs;
- maintaining a quality assurance and evaluation programme of the activities undertaken by the PMHWD Organisation;
- maintaining effective collaborative partnerships with other local and international MHWD organisations, Government mental health agencies, DHBs, NGOs and academic institutions;
- fulfilling the requirements and obligations under the Treaty of Waitangi and promoting equal employment opportunities;
- having knowledge of the role and contribution of training, education, workforce development, research, and planning to health policy-making and purchaser decisions;
- providing high quality computer systems maintenance and development of the IT infrastructure of the PMHWD Organisation; and
- maintaining the security and integrity of information held by the PMHWD Organisation.

**Pacific Mental Health Researcher**

The Pacific mental health researcher will be responsible for the development of PMHWD Organisation research programme, in collaboration and consultation with colleagues and other stakeholders. The overall accountability of the researcher is:

*The provision of high quality and culturally appropriate research and professional advice on evidence-based mental health workforce information obtained and disseminated by the PMHWD Organisation.*

This accountability is achieved by:

- developing and implementing culturally appropriate and relevant research protocols for collecting and assessing Pacific mental health workforce information;
• supporting and supervising experts commissioned to conduct research on behalf of the PMHWD Organisation;
• maintaining a strong business and client focus in the negotiation, management and delivery of outputs;
• producing training materials on cultural appropriate Pacific mental health research methods and the use of the Internet; and
• engaging in methodological work on the conduct of Pacific mental health research.

Pacific Clinical Coordinator

The role of the Clinical Coordinator will have responsibility for coordinating the training programmes associated with the PMHWD Organisation.

This role is achieved by:
• managing projects where a significant training component is required;
• liaising with mental health training agencies in order to establish opportunities for the PMHWD Organisation;
• assisting training agencies in the development of programmes that will meet the aims of the PMHWD Organisation;
• contributing to the development of educational resources that will be useful for Pacific mental health workforce development
• ensuring that training programmes endorsed by the PMHWD Organisation are of the highest standards;
• consulting and maintaining links with other mental health workforce development programmes;
• networking with the Pacific mental health sector in order to ascertain training needs and opportunities for enhanced service delivery;
• providing leadership in the integration of clinical and (Pacific) cultural practices; and
• undertaking research aimed at strengthening the Pacific mental health workforce.

Secretary/Clerical Support - Administrator

The administrator will be responsible for undertaking PMHWD Organisation administrator support activities. The overall accountability of the administrator is:

The provision of a support role to PMHWD Organisation staff and Governance Board and Executive Management Committee established by the PMHWD Organisation.

This accountability is achieved by:
• Personal Assistance to Director;
• Word Processing;
• Database Management;
Financial Records and Purchasing;
• Human Resources;
• Health and Safety;
• Reception;
• Building Maintenance and Security; and
• Other Administrative Tasks.

The establishment funding required to set up the PMHWD Organisation

Below is an indicative list of the main cost centres for the PMHWD Organisation.

1. **Staffing costs**

   • Staffing resources include academic staff computing support, administrative support and technical support. Staff remuneration and development costs.
   • Provision for promotion, sick or maternity leave, visiting academics, consultancy fees and casual assistance.

2. **Professional costs**

   • Establishment costs - appointments, Board and Executive committee, Board and Executive Committee meetings, legal fees and accountant costs.

3. **Operational costs**

   Direct costs such as:
   • building costs, refurbishment costs, and office equipment and consumables costs;
   • Administration;
   • training programmes;
   • workplace participation;
   • working parties; and
   • travel costs.

4. **Infrastructure/overhead costs**

   • Costs normally covered by overheads associated with the contract for services.

Again taking Te Rau Matatini as a model for the establishment of the PMHWD Organisation and having a six month establishment phase and adjusting the Te Rau Matatini first six month budget by an annual average 3% inflation from 2002-2005 provides an establishment budget for the PMHWD Organisation of $470,400. See Table 13 below for details.
Table 13: PMHWD Organisation indicative establishment phase budget

<table>
<thead>
<tr>
<th>Cost centre</th>
<th>Amount ($) [GST exclusive]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel costs</td>
<td>92,354.00</td>
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<tr>
<td>Professional costs</td>
<td>34,720.00</td>
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<tr>
<td>Contracted services</td>
<td>33,600.00</td>
</tr>
<tr>
<td>Operational costs</td>
<td>236,936.00</td>
</tr>
<tr>
<td>Overhead/infrastructure costs</td>
<td>72,800.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>470,400.00</strong></td>
</tr>
</tbody>
</table>

This budget is indicative only to provide a starting point for discussion.

The ongoing funding required to support the functions of the PMHWD Organisation

Below is an indicative list of the main cost centres for the PMHWD Organisation.

1. **Staffing costs**

- Staffing resources include academic staff computing support administrative support and technical support. Staff remuneration and development costs.
- Provision for promotion, sick or maternity leave, visiting academics, consultancy fees and casual assistance.

2. **Operational costs**

Direct costs such as:

- Costs associated with managing the project (e.g. expenses for the Governance Board and Executive Management Committee meetings);
- Administration;
- training programmes;
- workplace participation;
- working parties; and
- travel costs.

3. **Infrastructure/overhead costs**

- Infrastructure costs include building costs, refurbishment costs, and office equipment and consumables costs.
- Costs normally covered by overheads associated with the contract for services.

Again taking Te Rau Matatini as a model for the ongoing operation of the PMHWD Organisation and providing cost estimates for the first year of the operational phase [following the establishment phase] and adjusting the Te Rau Matatini’s operational
budget by an annual average 3% inflation from 2002-2005 provides a first year of operation budget for the PMHWD Organisation of $817,600. See Table 14 below for details.

Table 14: PMHWD Organisation first year of operation budget

<table>
<thead>
<tr>
<th>Cost centre</th>
<th>Amount ($) [GST exclusive]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel costs</td>
<td>238,560.00</td>
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<tr>
<td>Professional costs</td>
<td>159,040.00</td>
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<tr>
<td>Operational costs</td>
<td>232,960.00</td>
</tr>
<tr>
<td>Overhead/infrastructure costs</td>
<td>187,040</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>817,600.00</strong></td>
</tr>
</tbody>
</table>

This budget is indicative only to provide a starting point for discussion.

The suggested programme of work over the establishment and then the first two years of operation of the PMHWD Organisation, including audiences, strategies, key milestones, responsibilities (who does what) and performance indicators

Implementation Schedule - establishment phase

The immediate focus will be the establishment of the Governance Board, the Executive Committee, the appointment of PMHWD Organisation staff and the purchase of computer and office equipment.

Year 1 of the PMHWD Organisation work programme will focus on:

- the establishment of PMHWD Organisation’s processes and structures;
- the design and development of a database of Pacific scholarships and development of scholarship programme;
- the establishment of a database of Pacific mental health research, training and educational opportunities;
- An investigation of external dissemination requirements including a study of Pacific mental health workforce development needs which would be undertaken with our collaborative MHWDO partners;
- Establishment of working links with other centres including MHWDOs, Government health agencies, DHBs, NGOs, private sector providers, and university institutions;
- Initial identification of priority areas for education, training, research and consultation;
- Completion of prioritisation and consultation exercises;
- Development, piloting and implementation of an information dissemination strategy, and promotion and marketing plan;
- Development and implementation of an enquiry service for Pacific mental health workforce development issues; and
- Development of the PMHWD Organisation’s website.
Year 1 - operational phase

Some indicative areas of work for year one includes:

- undertaking and completing training, education and research activities;
- continued development and maintenance of PMHWD Organisation’s databases;
- further development of an information dissemination and promotion and marketing strategy;
- continued identification of teaching, research and training priorities;
- further round of consultation; and
- continued maintenance of the PMHWD Organisation’s website.

Year 2 – operational phase

Some indicative areas of work for year two includes:

- undertaking and completing the PMHWD Organisation’s work programme;
- continued maintenance of the information technology systems;
- enhancements and refinements to the PMHWD Organisation’s information dissemination and marketing strategy;
- continued identification of work programme priorities;
- continued provision of training workshops and seminars; and
- external evaluation of the performance of the PMHWD Organisation.

Milestones - Year 1

An indicative list of the major milestones for the operation of PMHWD Organisation is presented below:

- appoint PMHWD Organisation Board, Executive Committee, PMHWD Organisation Director and staff;
- undertake initial consultation with national and international stakeholders;
- identify review priorities for PMHWD Organisation;
- development of PMHWD Organisation internal processes and structures;
- development of Information Technology infrastructure;
- undertake first round of consultation;
- pilot dissemination strategy;
- development and refinement of dissemination strategy;
- outputs from first round of consultation;
- PMHWD Organisation databases operational;
- enquiry and current awareness services are operational;
- PMHWD Organisation marketing and information disseminated;
- piloting of educational and training initiatives; and
- development of PMHWDO website.
Evaluation and Review of the PMHWD Organisation

An essential element in the management and development of the PMHWD Organisation will be the monitoring and evaluation processes. Evaluation will focus on both the process of providing the clearing house and critical appraisal service and its results and outputs.

The incorporation of evaluation/review processes into the operation of the PMHWD Organisation is important for both decision-making and accountability purposes. In order for the PMHWD Organisation to obtain a measure of its effectiveness, evaluation and review processes will be developed and implemented.

The use of these processes will enable focus to be maintained towards maximum achievement of the Service’s aims.

The evaluation/review will focus on the outputs and outcomes from the delivery and management of the PMHWD Organisation. Measures will include the use of specific performance indicators applied to the professional activities undertaken by the PMHWD Organisation and the overall management of the PMHWD Organisation. Key questions include:

- Is the PMHWD Organisation reaching the target population?
- Is the PMHWD Organisation meeting the information needs of the target population?
- Is the PMHWD Organisation being implemented as specified by the business plan?
- Is the PMHWD Organisation effective?
- What is the cost of the PMHWD Organisation relative to its effectiveness?

The evaluation and review process will focus on the outputs and outcomes from the delivery and management of the service. Measures will include the use of specific performance indicators applied to the professional activities undertaken by the PMHWD Organisation and the overall management of the PMHWD Organisation.

Development of a promotion and marketing Plan

One of the initial tasks of the PMHWD Organisation staff will be the development of a promotion and marketing plan. One of the components of such a plan will be the development and distribution of a promotion brochure that details, among other things:

- aims of the PMHWD Organisation;
- activities of the PMHWD Organisation, for example, details about proposed marketing brochures, reports or information bulletins and the databases assembled by the PMHWD Organisation;
- collaborative training, education, research and information dissemination activities with other MHWD organisations;
- documentation of potential future directions for the PMHWD Organisation; and
- information on how to access PMHWD Organisation’s information and staff.
Organisational and staff development plan

The objective of the development plan will be to expand the operation of the PMHWD Organisation as determined by demand for its services. As demand increases this will permit expansion to reach a critical mass of research, training and support staff.

Key Performance indicators

Key Performance Indicators will include:
- Management indicators – Governance Board and Executive Management Committee;
- Service provision indicators;
- Quality indicators; and
- Accountability indicators.

Key Performance Indicators in Year 1 of the PMHWD Organisation will include the formulation of:
- an overall PMHWD Organisation development plan;
- an annual business plan;
- a promotion and marketing plan;
- a Strategic Plan; and
- a Communication Plan.

Governance Board Performance Indicators

An indicative list of Board Key Performance Indicators is provided below:
- develop terms of reference for the PMHWD Organisation Board;
- establish and implement PMHWD Organisation’s structure (management and personnel);
- recruit PMHWD Organisation staff;
- secure PMHWD Organisation accommodation;
- approve a PMHWD Organisation’s strategic development plan;
- approve a PMHWD Organisation’s annual business plan;
- undertake an annual planning and goal setting meeting; and
- undertake annual reviews of its activities. Reviews encompass assessment of PMHWD Organisation’s achievements during the previous year and result in a report being presented to the Ministry of Health.

Executive Management Committee Key Performance Indicators

Executive Management Committee key Performance Indicators include:
- develop terms of reference for the Executive Management Committee;
- develop and implement project and financial planning processes;
• implement work breakdown and work plans;
• oversee programme reports and project communications; and
• be responsible for quality assurance matters.

**Service provision Key Performance Indicators**

Service provision Key Performance Indicators include the following:

- The establishment of an information bank;
- The establishment of training and education programmes;
- develop PMHWD Organisation service provision protocols;
- develop and maintain in-house computer-based databases to monitor/evaluate PMHWD Organisation activities. For example, information would be collected on the following indicators,
  - number of requests for information
  - number of individuals/groups provided with advice
  - number of individuals in training programmes
  - number of individuals in scholarship programmes
  - number of communications undertaken
  - number of requests for information
  - number of individuals/groups provided with advice
  - proportion of requests for assistance outstanding at any one time;
- develop and maintain an electronic network of information, the web home page, the electronic mailing list;
- develop and maintain professional liaison with other MHWD organisations, government departments, universities, other mental health organisations (NGOs), professional organisations, mental healthcare purchasers, mental healthcare providers, etc;
- conduct training and educational programmes for constituency groups/individuals; and
- develop a computer database directory of names/addresses of people interested in Pacific mental health education, training, purchasing, policy development and implementation and research.

**Quality Key Performance Indicators**

Quality Key Performance Indicators include:

- the formulation of key performance indicators, which are then applied; and
- the development of training programmes for staff of the PMHWD Organisation.

Quality of the services provided by the PMHWD Organisation will be measured and facilitated by:

- development and maintenance of internal and external peer review mechanisms;
• development and maintenance of constituency group satisfaction measures and mechanisms of implementation; and
• PMHWD Organisation staff professional development opportunities identified through participation in a performance management/appraisal/development assessment process.

Accountability Key performance Indicators

High standards of accountability will be expected from all personnel involved with the PMHWD Organisation and these indicators will be built into organisational processes, practices and procedures.

The networks and linkages within and external to the mental health sector and Pacific communities, required to be developed by the PMHWD Organisation to support its effective operation

The following is an indicative list of networks and linkages within and external to the mental health sector and Pacific communities, required to be developed by the PMHWD Organisation to support its effective operation.

Key Stakeholders

Ministry of Health
Mental Health Commission
ALAC
Health Workforce Advisory Committee
Pacific Providers Nationally
Pacific regional networks of providers such as Moana Pasifika in Auckland
South Island Pacific umbrella Group
Workforce Development Programmes
Te Rau Matatini: Maori MHWDO
Werry Centre
Matua Raki: National Addictions Centre
District Health Boards
Clinical Training Agency
Universities and Polytechnics.

Summary, Conclusions and Recommendations

Summary

The main dominating theme from the key informants was they expressed strong support for the establishment of a PMHWDO.
PMHWDO Vision

While the key informants did not espouse a clear Vision statement for the PMHWDO *per se* they did indicate a number of components that could form the basis of a Vision statement for the PMHWDO. One of them was that the PMHWDO needed to be lead by a visionary Pacific leader.

The development of a strategic vision statement needs to be one of the first key tasks to be undertaken by the PMHWDO Board/Trustees before a Director can be appointed.

Another common theme that should be captured by the PMHWDO’s vision statement is accountability. This was stated by a number of respondents in terms of governance accountability, financial accountability and community accountability.

The vision statement developed by the PMHWDO Board/Trustees should be realistic and credible, easily understood, appropriate, ambitious and responsive to a changing health environment. The vision statement should focus the PMHWDO’s resources and serve as a guide to action. It should be consistent with the PMHWDO’s values. In short, the PMHWDO’s vision statement should challenge and inspire the PMHWDO to achieve its mission.

PMHWDO Mission

One recurring theme from the key informant interviews was that the PMHWDO needed effective governance structures. One of the key issues here is that of governance referring to accountability of the PMHWDO Board/Trustees to the Mission of the PMHWDO it governs.

Effective governance of PMHWDO requires an effective Mission statement. The Mission statement has the effect of ‘gluing’ the PMHWDO together, working towards a common and well understood goal.

The PMHWDO’s Mission Statement should identify its purpose and philosophy. In doing so, one needs to consider the PMHWD Organisational arrangements and the philosophical perspectives underpinning them. Possible organisational models to consider include Maori organisational arrangements and a Multi-Disciplinary Cultural Responsivity Model (The MALAGA Model). Also, models of care to consider include: the ‘wellness model’; the ‘illness model’; the ‘Fonofale model’; the ‘Te Vaka model’; the ‘Faafaletui model’; the ‘Strands or Pandanus Mat Model’; the ‘Strengths-based model’; and the ‘Traditional Healing model’.

A draft PMHWDO Mission Statement for consideration and consultation is provided below:

*To ensure development of a Pacific mental health workforce that is sufficient in size and skill base to meet the needs of Pacific peoples and others with mental illnesses and addictions by providing training, education, research and care that is culturally competent, safe, person and family centred, effective, efficient, equitable and timely.*
**PMHWDO Objectives**

Strategic objectives for PMHWDO include:

1. *Empower Pacific consumers and families* as caregivers and educators;
2. Actively *recruit and retain* a qualified Pacific mental health workforce in adequate numbers. Annual recruitment targets should be established and adequately funded;
3. Use *effective training* strategies;
4. *Develop Pacific mental health managers and leaders* for all segments of the workforce through engagement in appropriate Pacific health leadership training programmes;
5. Ensure that Pacific mental health workforce education, development, and oversight processes (certification, accreditation) have relevance to *current mental health practice*; and
6. Secure *sustainable core funding* that is adequate to maintain a highly qualified Pacific mental health workforce that creates incentives for personal and professional excellence and provides for infrastructure development.

**PMHWDO functions**

The workforce development planning principles stated in the National Mental Health Workforce Development Plan 2006–2009 suggest that workforce development must:

- be centred on service users needs;
- respond to Maori, Pacific peoples, Asian peoples and other diverse workforce and service users;
- be driven by leaders;
- place reliance on collaboration and networking;
- fit within the wider systemic context of health and disability workforce development, including primary care; and
- be delivered to DHBs and NGO mental health services by way of national workforce development centres (Ministry of Health, Mental Health Directorate, 2005).

A PMHWD Organisation could undertake the following:

- champion the Pacific mental health and addiction workforce sector;
- coordinate Pacific mental health and addiction workforce planning;
- develop Pacific mental health workforce competencies; and
- help to coordinate educators and funders to provide the training required to achieve the required competencies.

The PMHWD Organisation could perform the following broad functions:

- Pacific mental health research;
- mental health workforce training;
• education, which will centre on a best practice approach to providing education that includes:
  – methods of teaching which is evidence-, competency- and culturally-based
  – students are taught the process of life-long learning that involves critical reflection on the scientific, professional, economic, social and cultural factors shaping mental healthcare service delivery in New Zealand and internationally
  – curricula should be routinely updated to address culture values, knowledge and skills that are essential to the delivery of mental health services in New Zealand
  – skill development should focus on cultural, clinical, management and administrative competencies and capabilities to deliver effective mental health services in New Zealand
  – teachers, trainers and supervisors should be experienced in providing mental health services in the New Zealand context; and
• dissemination of the PMHWDO’s work programme.

The critical success factors that will support the successful establishment and ongoing effectiveness of the PMHWD Organisation might include:
• providing useful services to the Pacific mental health community;
• leading sector discussions on current issues;
• staying in touch with providers, workers and consumers;
• intellectual integrity, independence and credibility;
• relevant to the mental health sector;
• responsive, accountable and valuing people;
• proactive;
• Pacific mental health experience and track record;
• size and critical mass of expertise;
• PMHWD Organisation staff skill mix and staff factors;
• mental health client orientation;
• health networks;
• Mental health workforce training capacity;
• Project management skills;
• Quality assurance programmes;
• Total Quality Management practices;
• Business focus; and
• Security and data protection procedures.
The proposed governance, management and staffing/organisational structure of the PMHWD Organisation, including specifying full-time equivalents, at each stage of development of the PMHWD Organisation

A number of alternative legal structures are possible for consideration. Options include:

- Charitable Trust;
- Company;
- Incorporated society; and
- Joint venture.

The four Government workforce organisations and hauora.com, all have different management structures. However, they all have managers and support staff. The organisations that have a service delivery function include clinical and/or medical staff. The size of the organisation appears to determine the staff numbers.

While there are a number of legal entity options for the PMHWD Organisation there are also a number of options for the establishment of the PMHWD Organisation. The options that key informants suggested are detailed below.

1. Umbrella model - for example, umbrella with Te Rau Matatini or umbrella with a University or Polytechnic or other organisation.
2. Buddy model - for example, buddy with Te Rau Matatini.
3. Tender model - tender for PMHWD Organisation in the market place.
4. Integrated model - add PMHWD Organisation EFTS into existing MHWD organisation/structures such as Te Rau Matatini or MHWDP or other existing MHWD organisations.

Either a buddy or umbrella approach appears to present the best options for establishing a PMHWD Organisation as the benefits of working with an established MHW development infrastructure and key stakeholder relationships is critical to:

(i) building the credibility of the organisation in the sector; and
(ii) adding value to the systems development in order to allow the PMHWD Organisation to focus on ‘other’ important aspects of development.

With careful planning and clear objectives outlined, anticipating risks as well as identifying added value potential in joint-projects, the PMHWD Organisation and buddy or umbrella group would be well placed to enhance each others core objectives.

**Governance of PMHWDO**

A number of options are available to discharge the governance functions of a PMHWDO. One option is to establish a Board of Directors.
In order for Board members to effectively fill their governance role they should be familiar with PMHWD Organisation’s policies, plans and priorities. An indicative list of potential roles and responsibilities for the PMHWD Organisation’s Board includes:

- **Policy** - the Board will be responsible for establishing and ensuring achievement of PMHWD Organisation’s Mission and Objectives through effective policy development management.
- **Programmes and services** - the Board will be responsible for monitoring PMHWD Organisation’s various programmes and services.
- **Personnel** - The PMHWDO Board will be responsible for ensuring the development and implementation of appropriate personnel policies.
- **Financial and Organisational Development** - The PMHWDO Board will be responsible for the establishment and maintenance of sound financial and organisational practices and policies.
- **Advocacy** - The PMHWDO Board will assist the PMHWD Organisation to enhance its public identity through appropriate advocacy.

It is a key priority to establish the PMHWDO Board as soon as practical.

**PMHWD Organisation Executive Management Committee**

An Executive Management Committee will have management responsibility for the PMHWD Organisation, which could be a sub-committee of the Governance Board. The Executive Management Committee will comprise the PMHWD Organisation’s Director, and 2-3 Governance Board nominees.

**PMHWDO’s staffing structure**

Assuming that a stand alone, umbrella or buddy model is adopted for the PMHWD Organisation then the following configuration of core funded staffing arrangements is likely to be implemented.

The proposed core staffing structure for the PMHWD Organisation is presented below.

<table>
<thead>
<tr>
<th>Role</th>
<th>FTE (%)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director</td>
<td>50</td>
<td>70</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Programme Manager</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Clinical Co-coordinator/Trainer</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Pacific Mental Health Researcher</td>
<td>50</td>
<td>70</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

The above staffing arrangements follow the Te Rau Matatini operational model with the addition of a Pacific Mental Health Researcher.
The key characteristics, skills, competencies and abilities of the personnel recommended for key positions in the PMHWD Organisation

The following key positions are listed as follows:

- **PMHWD Director** - will have responsibility for managing the PMHWD Organisation and providing visionary, cultural, clinical, educational, managerial and academic leadership;
- **Pacific Mental health Researcher** - will be responsible for the development of PMHWD Organisation research programme, in collaboration and consultation with colleagues and other stakeholders;
- **Pacific Clinical Coordinator** - will have responsibility for coordinating the training programmes associated with the PMHWD Organisation; and
- **Secretary/clerical support - administrator** - will be responsible for undertaking PMHWD Organisation administrator support activities.

The establishment funding required to set up the PMHWD Organisation

An indicative list of the main cost centres for the establishment of the PMHWD Organisation includes:

- staffing costs;
- professional costs;
- operational costs; and
- infrastructure/overhead costs.

PMHWD Organisation indicative establishment phase budget is estimated at $470,400 (GST exclusive) as detailed below.

<table>
<thead>
<tr>
<th>Cost centre</th>
<th>Amount ($) [GST exclusive]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel costs</td>
<td>92,354.00</td>
</tr>
<tr>
<td>Professional costs</td>
<td>34,720.00</td>
</tr>
<tr>
<td>Contracted services</td>
<td>33,600.00</td>
</tr>
<tr>
<td>Operational costs</td>
<td>236,936.00</td>
</tr>
<tr>
<td>Overhead/infrastructure costs</td>
<td>72,800.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>470,400.00</strong></td>
</tr>
</tbody>
</table>

The ongoing funding required to support the functions of the PMHWD Organisation

An indicative list of the main cost centres for the ongoing running of the PMHWD Organisation includes:

- Staffing costs;
- Operational costs;
- Infrastructure/overhead costs.
PMHWD Organisation first year operational (ongoing) budget is estimated to be $817,600 (GST exclusive) as detailed below.

<table>
<thead>
<tr>
<th>Cost centre</th>
<th>Amount ($) [GST exclusive]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel costs</td>
<td>238,560.00</td>
</tr>
<tr>
<td>Professional costs</td>
<td>159,040.00</td>
</tr>
<tr>
<td>Operational costs</td>
<td>232,960.00</td>
</tr>
<tr>
<td>Overhead/infrastructure costs</td>
<td>187,040</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>817,600.00</strong></td>
</tr>
</tbody>
</table>

The suggested programme of work over the establishment and then the first two years of operation of the PMHWD Organisation, including audiences, strategies, key milestones, responsibilities (who does what) and performance indicators

The immediate focus will be the establishment of the Governance Board, the Executive Committee, the appointment of PMHWD Organisation staff and the purchase of computer and office equipment.

Year 1 of the PMHWD Organisation work programme will focus on:

- the establishment of PMHWD Organisation’s processes and structures;
- the design and development of a database of Pacific scholarships and development of scholarship programme;
- the establishment of a database of Pacific mental health research, training and educational opportunities;
- an investigation of external dissemination requirements including a study of Pacific mental health workforce development needs which would be undertaken with our collaborative MHWDO partners;
- establishment of working links with other centres including MHWDOs, Government health agencies, DHBs, NGOs, private sector providers and university institutions;
- initial identification of priority areas for education, training, research and consultation;
- completion of prioritisation and consultation exercises;
- development, piloting and implementation of an information dissemination strategy and promotion and marketing plan;
- development and implementation of an enquiry service for Pacific mental health workforce development issues; and
- development of the PMHWD Organisation’s website.
Year 1 - operational phase

Some indicative areas of work for year one includes:

- undertaking and completing training, education and research activities;
- continued development and maintenance of PMHWD Organisation’s databases;
- further development of an information dissemination and promotion and marketing strategy;
- continued identification of teaching, research and training priorities;
- further round of consultation; and
- continued maintenance of the PMHWD Organisation’s website.

Year 2 - operational phase

Some indicative areas of work for year two includes:

- undertaking and completing the PMHWD Organisation’s work programme;
- continued maintenance of the information technology systems;
- enhancements and refinements to the PMHWD Organisation’s information dissemination and marketing strategy;
- continued identification of work programme priorities;
- continued provision of training workshops and seminars; and
- external evaluation of the performance of the PMHWD Organisation.

Milestones - Year 1

An indicative list of the major milestones for the operation of PMHWD Organisation is presented below:

- appoint PMHWD Organisation Board, Executive Committee, PMHWD Organisation Director and staff;
- undertake initial consultation with national and international stakeholders;
- identify review priorities for PMHWD Organisation;
- development of PMHWD Organisation internal processes and structures;
- development of Information Technology infrastructure;
- undertake first round of consultation;
- pilot dissemination strategy;
- development and refinement of dissemination strategy;
- outputs from first round of consultation;
- PMHWD Organisation databases operational;
- enquiry and current awareness services are operational;
- PMHWD Organisation marketing and information disseminated;
- piloting of educational and training initiatives; and
- development of PMHWDO website.
Other milestones include:

- evaluation and review of the PMHWD Organisation;
- development of a promotion and marketing plan; and
- organisational and staff development plan.

Associated with these milestones are organisational performance indicators that include:

- management indicators - Governance Board and Executive Management Committee;
- service provision indicators;
- quality indicators; and
- accountability indicators.

The networks and linkages within and external to the mental health sector and Pacific communities, required to be developed by the PMHWD Organisation to support its effective operation

The following is an indicative list of networks and linkages within and external to the mental health sector and Pacific communities, required to be developed by the PMHWD Organisation to support its effective operation.

Key Stakeholders

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- Workforce Development Programmes
- Te Rau Matatini: Maori MHWDO
- Werry Centre
- Matua Raki: National Addictions Centre
- District Health Boards
- Clinical Training Agency
- Universities and Polytechnics

Conclusions

The purpose of the key informant and document analysis component of this project was to present the feasibility of establishing a PMHWD Organisation.
It was clearly agreed by all interviewed that a PMHWD Organisation would enhance the education, training and workforce development needs required to address Pacific mental health issues.

The role of a PMHWD Organisation should be acknowledged by the mental health sector as the expert on Pacific mental health workforce issues. This would provide a focal point for the workforce and others who have an interest in the development of the Pacific mental health workforce. The PMHWD Organisation should align itself, and work closely with, the other established mental health workforce organisations.

Suggestions have been made in this report as to how the organisation could be set up and run for the first two years and these were summarised above.

Recommendations from the key informant interviews and document analysis for the establishment of a new PMHWD Organisation are presented in the next section of the report.

Recommendations

The following recommendations are from the key informant interviews and document analysis:

1. This feasibility study recommends that the establishment of PMHWD Organisation has significant potential to build the Pacific mental health workforce and recommends that it is a necessary development to be progressed.

2. It is important that this organisation is funded adequately to establish an accountable, robust and transparent PMHWDO.

3. The community of Pacific stakeholders needs to be continually consulted during the process of establishment.

4. While initial primary focus is on Mental Health workforce development it should be remembered that mental health intrudes into other areas of health including disability and public health.

5. The PMHWDO should be underpinned by Pacific values and principles that promote professional and quality management processes.

6. The research identified gaps in the child and adolescent workforce mental health and a key objective of the PMHWD Organisation should be to build the Pacific CAMHS workforce. This may include possible training at the secondary school level around mental illness and the career pathways possible for those wanting to work in this area.

7. The organisation should be staffed by a “best person for the job” fit. The abilities and skill mix of the PMHWD Organisation should be underpinned by a philosophy of a by Pacific for Pacific approach.

8. The PMHWD Organisation has responsibility to ensure that it reflects a pan-Pacific approach to its internal development and workforce programmes. Managing risks include ensuring that ethnic politics do not monopolise programme development and dilute the workforce programme objectives. Managing the Pacific community expectations is essential where Pacific peoples have significant critical mass. The Pacific community is divergent and stakeholder groups might place undue expectation on the PMHWD Organisation.
and pressures to be unrealistic to perceived needs to be included in everything Pacific Island and or mental health would lead dilution.

9. The PMHWD Organisation can play a key role in developing future leaders. It was raised during interviews that present leadership has often emerged without the guidance or support to grow. A leadership development role would address this gap.

10. The PMHWD Organisation is to coordinate, facilitate, design and deliver training opportunities for mainstream organisations working with Pacific service users to better understand Pacific peoples needs and be able to deliver culturally appropriate services that produce positive mental heath outcomes.

11. The PMHWD Organisation location should be given due consideration taking into account the:
   − accessibility to the programmes for Pacific peoples; and
   − strategic alliances to MHWD organisations, and the benefits of stakeholder credibility if the options of umbrella or buddy model are progressed.

12. The PMHWD Organisation should establish key linkages with Industry Training Organisations (ITOs) particularly as there is a focus on workplace assessment at entry level.

13. The PMHWD Organisation should undertake and coordinate research which prioritises the importance of family-based interventions which are aligned with the Te Tahuhu direction report.

14. Critical to the success of the PMHWD Organisation is ensuring that the financial accountabilities of the organisation and the governance role are managed by quality processes which involve evaluation and quality and financial audits of performance.

15. The models presented carry risks and advantages however, a stand alone organisation would carry the most risk. Nor would the tendering as this gives opportunity for what essentially could be a stand alone operation to exist. It is therefore recommended that, one of the two options should be considered

16. The PMHWD Organisation would also have a key objective to develop leadership, through training, supportive environments and assistance with the New Zealand-born/Island-born role in leadership development.

17. The PMHWD Organisation key objective is to provide leading strategic direction to the workforce in the development of Pacific mental health workers through workforce development planning aligned with sector developments by establishing secondary school, tertiary and postgraduate and a range of workforce development programmes to cater for entry and advance qualifications.

18. The PMHWD Organisation should be responsive to Maori mental health workforce development and needs to identify clearly the learning needs of the PMHWD Organisation, and establish action plans which integrate the cultural training required to be a genuinely culturally aware organisation.

19. A PMHWD programme should be aligned with the Maori workforce development organisation Te Rau Matatini which has already established credibility in the wider mental health sector with special focus on the development of dual competency.
20. Future recommendation of potential strategic development after establishment phases includes possibilities of links to the Pacific mental health community support work programmes either existing, or assisting in the establishment of CSW training scheme.
References


References


Ramage, Carol, Bir, Juliet; Towns, Alison; Vague, Raewyn; Cargo, Tania; Nuimata-Faleafa, Monique; (2005). Stocktake of Child and Mental Health Adolescent Health Services in New Zealand. The Werry Centre for Child and Adolescent Mental Health. Auckland: University of Auckland.


Appendix 1: Literature Search Strategies

Comments on the literature searches

Two separate searches of the bibliographic resources were performed by Susan Bidwell, Information Specialist, New Zealand Health Technology Assessment (NZHTA) Research Unit, Christchurch School of Medicine and Health Sciences, (http://nzhta.chmeds.ac.nz). Search A was on the establishment and functioning of mental health workforce organisations in general and search B on Pacific or other indigenous mental health workforce organisations.

Search A - there was a reasonable amount of literature on the mental health workforce. The main challenge with this part of the search was to distinguish between workforce and broader issues of mental health service provision. While obviously related, in that the type of mental health service provided influences workforce demands, attempts were made to exclude service delivery where possible. References to general articles on workforce training were included where they came up but there was no search for general training articles specifically as this literature is extensive and could easily have dominated the results to the exclusion of organisational aspects.

Search B - Pacific mental health workforce literature. The literature on the Pacific mental health workforce can only be described as meagre. Apart from the few full text documents from New Zealand sources most of the literature includes only passing mention of workforce issues, often as part of a broader topic. The search also covered the mental health workforce of other indigenous communities but was not much more successful.

The search of electronic resources was as wide ranging as possible. However, it is likely that other documents such as in-house reports or unpublished research may be in existence. If these have not been declared to the New Zealand national record, formally published, or published on a website they would not have been located in this type of search. To obtain a fully comprehensive overview of work done on the Pacific mental health workforce it would be necessary to go beyond electronic resources by contacting key authors and researchers both in New Zealand and elsewhere. This is outside the scope and time frame of an Information Package as requested.

Sources Searched

Bibliographic Databases

- Medline
- Embase
- Cinahl
- Current Contents
- Science/Social Science Citation Index
- Cochrane Central Register of Controlled Trials
- Psychinfo
- Index New Zealand
- Te Puna - New Zealand Bibliographic Database
University Library Datalogues

Auckland University of Technology http://aut.lconz.ac.nz
Lincoln University http://www.lincoln.ac.nz/libr
Massey University http://kea.massey.ac.nz/search
University of Auckland http://www.library.auckland.ac.nz
University of Otago http://www.library.otago.ac.nz
University of Canterbury http://www.library.canterbury.ac.nz
Victoria University http://www.vuw.ac.nz/library
Waikato University http://www.waikato.ac.nz/library

Other Sources

Mental Health Commission http://www.mhc.govt.nz
Werry Centre for Child & Adolescent Mental Health, University of Auckland http://werrycentre.org.nz
New Zealand Ministry of Health Pacific Health Branch http://www.moh.govt.nz
Ministry of Pacific Island Affairs http://www.minpac.govt.nz
Health Canada http://www.hc-sc.gc.ca
index_e.html
Counties Manukau District Health Board http://www.cmdhb.org.nz/Counties
Capital and Coast District Health Board http://www.ccdhb.org.nz
Auckland Regional Public Health Service http://www.arphs.govt.nz
University of Auckland Division of Maori and Pacific Health
Hawaii State Department of Health http://www.hawaii.gov/health/mental-health
US Substance Abuse and Mental Health Services Administration http://www.samhsa.gov
Australian Department of Health and Ageing http://www.health.gov.au
Department of Human Services, Victoria http://www.dhs.vic.gov.au
NSW Health http://www.health.nsw.gov.au
Aboriginal and Torres Strait Islander Commission http://www.atsic.gov.au
Queensland Health http://www.health.qld.gov.au
South Australia Department of Health http://www.health.sa.gov.au
US Indian Health Service http://www.his.gov
Pacific Mental Health Workforce Development Organisation - Feasibility Study 97
Search Strategies

Search A: General Mental Health workforce

1. mental health workforce.mp. (11)
2. *mental health services/ma (347)
3. 1 or 2 (352)
4. limit 3 to english (313)
5. from 4 keep (selected references) (63)
6. exp *mental health services/ma (648)
7. psychiatric nursing/ma (232)
8. psychology, clinical/ma (52)
9. social work, psychiatric/ma (47)
10. psychiatry/ma (592)
11. or/6-10 (1447)
12. 11 not 3 (1099)
13. og.fs. (222842)
14. td.fs. (154883)
15. organisational policy/ (8232)
16. delivery of healthcare/og (6447)
17. professional practice/ (11016)
18. professional competence/ (10971)
19. or/13-18 (378695)
20. 12 and 19 (296)
21. limit 20 to english (257)
22. from 21 keep (selected references) (45)
23. health planning/ (17874)
24. 12 and 23 (21)
25. from 24 keep 2,4-6 (4)
26. 5 or 22 or 25 (109)

Embase

1. mental health workforce.tw. (7)
2. mental health service/ (8776)
3. Staff Training/ (3788)
4. 2 and 3 (165)
5. *mental health service/ (3669)
6. (workforce or manpower).tw. (3097)
7. 5 and 6 (23)
8. 3 and 5 (77)
9. 4 or 7 or 8 (188)

Cinahl

1. (mental health and workforce).mp. (120)

Psychinfo

1. mental health workforce.tw. (31)
2. exp mental health services/ (18310)
3. exp *mental health personnel/ (18946)
4. mental health personnel supply/ (127)
5. 2 and (3 or 4) (1040)
6. limit 5 to yr=1980-2005 (975)
7. models/ (37953)
8. 6 and 7 (22)
9. 1 or 8 (53)
10. from 9 keep (selected references)(19)
11. from 1 keep (selected references) (16)
12. 10 or 11 (22)

Current Contents
1. TI=Mental Health
2. TI= Workforce OR workforce OR worker OR manpower
3. #1 AND #2

Search B: Pacific and/or indigenous mental health workforce

Medline
1. pacific.mp. (8506)
2. mental health.mp. (53540)
3. (workforce or workforce or personnel).mp. (161767)
4. 1 and 2 and 3 (7)
5. exp Pacific Islands/ (28331)
6. 2 and 3 and 5 (50)
7. (indigenous or first nations or inuit).mp. (8598)
8. 2 and 3 and 7 (19)
9. health manpower/ or ma.fs. (47655)
10. (1 or 5) and 9 (543)
11. exp health Personnel/ (242116)
12. (mental or psychiatric).mp. (291215)
13. 7 and 2 and (9 or 11) (36)
14. 10 and 12 (22)
15. (1 or 5 or 7) and (9 or 11) (2660)
16. 12 and 15 (147)
17. 4 or 6 or 8 or 13 or 14 or 16 (183)
18. exp Mental Disorders/ (566953)
19. (1 or 5 or 7) and 18 and (9 or 11) (82)
20. 17 or 19 (212)
21. oceanic ancestry group/ (3656)
22. 21 and (18 or 12) and (3 or 9 or 11) (25)
23. 20 or 22 (224)
24. from 23 keep (selected references)
25. health services, indigenous/ma (60)
26. 25 not 23 (54)
27. from 26 keep (selected references)
28. 24 or 27 (62)

Embase
1. pacific.mp. (4873)
2. (indigenous or first nations or inuit).mp. (5363)
3. exp Pacific Islands/ (5290)
4. exp Native Americans/ (0)
5. or/1-4 (14554)
6. mental health.mp. (37798)
7. (mental or psychiatric).tw. (104360)
8. exp Mental Disorders/ (442740)
9. exp *Mental Health Services/ (3669)
10. or/6-9 (479463)
11. exp Health Personnel/ (157510)
12. (workforce or workforce or personnel).mp. (47144)
13. exp Health Manpower/ (824)
14. ma.fs. (0)
15. or/11-14 (172006)
16. 5 and 10 and 15 (70)
17. from 16 keep(selected references)
18. aborigine/ or american indian/ or pacific islander/ (3434)
19. 10 and 15 and 18 (39)
20. 19 not 16 (26)
21. from 20 keep 4-5,7,12,18,22 (6)
22. 17 or 21 (18)
23. find similar to The indigenous mental health worker (16)
24. from 23 keep 12 (1)
25. 5 and (workforce or workforce or manpower).mp. (52)
26. 25 not (16 or 19) (47)
27. from 26 keep (selected references)
28. 22 or 24 or 27 (29)

Cinahl

1. pacific.mp. (820)
2. (indigenous or first nations or inuit).mp. (1132)
3. exp Pacific Islands/ (5739)
4. exp Native Americans/ (2153)
5. or/1-4 (9225)
6. mental health.mp. (21271)
7. (mental or psychiatric).tw. (32180)
8. exp Mental Disorders/ (73410)
9. exp *Mental Health Services/ (9268)
10. or/6-9 (97579)
11. exp Health Personnel/ (127174)
12. (workforce or workforce or personnel).mp. (47513)
13. exp Health Manpower/ (128095)
14. ma.fs. (3578)
15. or/11-14 (155504)
16. 5 and 10 and 15 (110)
17. Health Services, Indigenous/ma [Manpower] (3)
18. 16 or 17 (113)
19. from 18 keep 4-5,16 (3)
20. from 18 keep (selected references)(14)
21. 19 or 20 (17)
22. 5 and (workforce or workforce or manpower).mp. (129)
23. 22 not 18 (117)
24. from 23 keep (selected references)(8)
25. 21 or 24 (25)
Appendix 1: Literature Search Strategies

**Psychinfo**

a. pacific.mp. (1219)
b. exp pacific islanders/ or indigenous populations/ or hawaii natives/ (637)
c. 1 or 2 (1768)
d. (workforce or workforce).mp. (2411)
e. exp health personnel/ (49593)
f. manpower.mp. (651)
g. worker$.mp. (32214)
h. or/4-7 (80601)
i. exp mental disorders/ (242273)
j. exp mental health services/ (18310)
k. (mental or psychiatric).tw. (209301)
l. or/9-11 (381076)
m. 3 and 8 and 12 (30)
n. 3 and 8 (121)
o. from 14 keep (selected references)

**Cross database search (Medline, Embase, Psychinfo, Cinahl combined)**

- pacific$.mp. (16733)
- (workforce or workforce or health worker$).mp. (23418)
- and 2 (116)
- remove duplicates from 3 (87)
- from 5 keep (selected references)

**Current Contents, Science/Social Science Citation Index**

a. Pacific OR indigenous OR first nations OR inuit
b. Native american OR american indian OR samoan OR tongan OR fijian OR hawaiian OR Hawaiian
c. #1 OR #2
d. workforce OR workforce OR manpower OR health worker
e. #3 AND #4

**Other sources of information**

All other sources were searched using combinations of the words in the strategies above adapted for the individual resource and the level of complexity supported.

- **Priority I: Fostering supportive environments and positive cultures**

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote appropriate shared clinical, management and cultural leadership models.</td>
</tr>
<tr>
<td>Share across DHBs best practice tools that foster supportive environments and positive cultures.</td>
</tr>
<tr>
<td>Support new graduates in their transition into clinical practice.</td>
</tr>
<tr>
<td>Establish mentor training and related sector-wide networks for both clinicians and management.</td>
</tr>
<tr>
<td>Ensure HR have capacity and capability to help foster a supportive environment.</td>
</tr>
</tbody>
</table>

- **Priority II: Enhancing people strategies**

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create an affirmative action programme that attracts and retains older people in the health and disability workforce.</td>
</tr>
<tr>
<td>Establish alternative career pathways/opportunities across all health and disability professions, both vertical and lateral.</td>
</tr>
<tr>
<td>Workforce Strategy Groups: ER strategies and negotiations are informed by the sector’s workforce context, direction and required outcomes.</td>
</tr>
<tr>
<td>Implement policies and programmes that enable work/life balance.</td>
</tr>
<tr>
<td>Integrate organisational values into everyday activities such as:</td>
</tr>
<tr>
<td>- competencies descriptions</td>
</tr>
<tr>
<td>- corporate processes such as recruitment.</td>
</tr>
<tr>
<td>Resource workforce planning across sector including DHBs and NGOs:</td>
</tr>
<tr>
<td>- DHB workforce toolkit/HWIS/Workforce modelling.</td>
</tr>
</tbody>
</table>

- **Priority III: Education and Training**

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create a relationship with the education sector to enable formal engagement on workforce supply issues - access, numbers, workforce categories, mix and competencies.</td>
</tr>
<tr>
<td>Agree health sector requirements: Facilitate a round table discussion with education, health sector, professional organisations etc to redesign health education in New Zealand.</td>
</tr>
<tr>
<td>Develop a brand that increases the attractiveness of health sector careers.</td>
</tr>
<tr>
<td>Establish national e-learning systems (including hardware and electronic competency support) for individual and group learning to cover.</td>
</tr>
<tr>
<td>DHBs agree that competencies (such as IV certificate, epidural certificate etc) become portable across DHBs and between disciplines.</td>
</tr>
</tbody>
</table>
• **Priority IV: Models of Care**

<table>
<thead>
<tr>
<th>Incentivise innovative models of care that support job redesign, team building and shared competencies development within the HPCA framework.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify and actively progress the removal of barriers to health practitioners fully exercising their scopes of practice e.g. regulation and contracts.</td>
</tr>
<tr>
<td>Support new models of care by developing flexible models of employment/contracting health practitioners.</td>
</tr>
<tr>
<td>Fund initiatives to encourage the introduction of new models of team working which are health outcome focused.</td>
</tr>
<tr>
<td>Strengthen and value the role of the generalist in the sector by:</td>
</tr>
<tr>
<td>- describing generic competencies</td>
</tr>
<tr>
<td>- ensuring the right mix of generalists and specialists are deployed</td>
</tr>
<tr>
<td>- use integrated team approaches to patient care such as generalist led teams</td>
</tr>
<tr>
<td>- expand flexibility by using opportunities available under the HPCA Act.</td>
</tr>
</tbody>
</table>

• **Priority V: Primary health workforce**

<table>
<thead>
<tr>
<th>Develop primary health models that explicitly recognise the range of competencies and skills that provide for the diverse needs of the population i.e. doctors, nurses, allied health professionals, NGOs, non-regulated workers and volunteers etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop teams in the primary sector that are integrated with the secondary sector through, for example: joint appointments; case management models etc.</td>
</tr>
<tr>
<td>Align funding mechanisms to enable coherent workforce development that reflects service direction.</td>
</tr>
<tr>
<td>Develop tools that support the workforce to provide integrated services and a team-based approach e.g.: integrated information systems across the continuum of care; single client record; and nationally consistent decision support tools.</td>
</tr>
</tbody>
</table>

• **Priority VI: Maori health workforce**

<table>
<thead>
<tr>
<th>Resource workforce planning and workforce information including ethnic specific data.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage with TEC to increase successful Maori participation in health and disability education and training, including developing kaupapa Maori programmes.</td>
</tr>
<tr>
<td>DHBs engage with school sector locally to improve Maori participation in health and disability education and training.</td>
</tr>
<tr>
<td>Ensure access of Maori and non-Maori clinicians and staff to Maori health/Haurora Maori competency development and training opportunities.</td>
</tr>
<tr>
<td>Invest and develop Maori workforce capacity (numbers, professionals, non-professionals) and infrastructure (training opportunities, standards).</td>
</tr>
</tbody>
</table>
- **Priority VII: Pacific health workforce**

<table>
<thead>
<tr>
<th>Create organisational environments that recognise and support the ethnically and culturally diverse health and disability workforce.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognise community health workers’ skills and prior learning to reduce barriers to entering other parts of the health and disability sector.</td>
</tr>
<tr>
<td>Create/enhance Pacific roles in the health and disability sector, including:</td>
</tr>
<tr>
<td>- promoting the health and disability sector as a career option</td>
</tr>
<tr>
<td>- creating career pathways for Pacific health and disability workforce.</td>
</tr>
<tr>
<td>Create incentives for the education sector to ensure a greater proportion of Pacific students complete their courses.</td>
</tr>
<tr>
<td>Develop and support access to leadership and professional development programmes for Pacific health professionals within their local communities and across all sectors.</td>
</tr>
</tbody>
</table>

- **Priority VIII: Non-regulated and voluntary health and disability workforce**

<table>
<thead>
<tr>
<th>Understand and define this workforce. As appropriate use available research to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- match skills to service delivery requirements</td>
</tr>
<tr>
<td>- develop flexible contracts and work environments</td>
</tr>
<tr>
<td>- understand the role of the volunteer sector.</td>
</tr>
<tr>
<td>Identify an appropriate education framework (NZQA) for paid carers that meet the needs of both carers and provider.</td>
</tr>
</tbody>
</table>

Appendix 3 - Te Rau Matatini Role Description 2002-2005

Establishment phase - Implementation Team [2002 Business Plan]

Director

Role:

• The Director will provide overall guidance for Te Rau Matatini.

Main Functions:

• to develop working relationships with key stakeholders including Maori mental health services, Ministry of Health, District Health Boards, Tertiary Education Commission, Mental Health Commission, professional bodies and mental health training programmes
• in association with the Chairman of the Board, to represent Te Rau Matatini in discussions and negotiations
• to develop a strategy for Maori mental health workforce development
• to ensure that the Board is sufficiently informed to be able to make sound decisions
• to develop an infrastructure that will enable Te Rau Matatini to meet its contractual obligations
• to supervise staff employed in Te Rau Matatini, and in specific projects
• to communicate the aims and goals of Te Rau Matatini to wider audiences
• to engage with the wider health sector on issues of workforce development
• to provide advice to the Ministry of Health on issues relating to the Maori mental health workforce
• to guarantee that all advice and recommendations from Te Rau Matatini is based on sound evidence, quality research and the principles of best practice
• to demonstrate leadership in the Maori mental health sector
Programme Manager

Role:

- The Programme Manager will have administrative and managerial responsibility for Te Rau Matatini.

Main Functions:

- to ensure that all projects outlined in the service Description are
  - well designed
  - completed on time
  - within budget
- to manage specific projects identified by the Director
- as required by the Director to provide reports for the Board, the Ministry of Health, other bodies
- to develop a business plan for Te Rau Matatini
- to institute systems of management and administration that will enable Te Rau Matatini to operate in an efficient and effective manner
- to develop an infrastructure that will enable Te Rau Matatini to meet its contractual obligations
- to establish close links with the Maori mental health networks
- to contribute to leadership in Maori health workforce development
- to establish a database relevant to Maori mental health workforce development
- to undertake research aimed at strengthening the Maori health workforce
Clinical Coordinator

Role:

- The Clinical Coordinator will have responsibility for coordinating the training programmes associated with Te Rau Matatini.

Main Functions:

- manage projects where a significant training component is required
- liaise with mental health training agencies in order to establish opportunities for Te Rau Matatini
- assist training agencies in the development of programmes that will meet the aims of Te Rau Matatini
- contribute to the development of educational resources that will be useful for Maori mental health workforce development
- ensure that training programmes endorsed by Te Rau Matatini are of the highest standards
- consult and maintain links with other mental health workforce development programmes
- network with the Maori mental health sector in order to ascertain training needs and opportunities for enhanced service delivery
- provide leadership in the integration of clinical and (Maori) cultural practices
- undertake research aimed at strengthening the Maori mental health workforce
Administrator

The responsibilities of the Administrator role include the development and maintenance of the administration and communication systems of the Te Rau Matatini Programme.

The main functions of the position are:

- to ensure effective and efficient office operations
- to maintain Te Rau Matatini database
- to maintain the Te Rau Matatini website
- to arrange travel and accommodation for Te Rau Matatini staff, visitors and Board members
- to liaise with Government agencies, Maori health services, professional bodies, communities and iwi to progress Te Rau Matatini business
- to answer and respond to public queries through the 0800 Matatini number
- to assist in the preparation of Te Rau Matatini presentations and publicity material
- to assist in the preparation of Board papers
- to record the minutes of Te Rau Matatini Board meetings
Te Rau Matatini Implementation Team [2003 Business Plan]

**Director**

The role of the Director is to provide overall guidance for Te Rau Matatini. The main functions are:

- to develop working relationships with key stakeholders including Maori mental health services, Ministry of Health, District Health Boards, Tertiary Education Commission, Mental Health Commission, professional bodies, and mental health training programmes
- in association with the Chairman of the Board, to represent Te Rau Matatini in discussions and negotiations
- to develop a strategy for Maori mental health workforce development
- to ensure the Board is sufficiently informed to be able to make sound decisions
- to develop an infrastructure that will enable Te Rau Matatini to meet its contractual obligations
- to supervise staff employed in Te Rau Matatini, and in specific projects
- to communicate the aims and goals of Te Rau Matatini to wider audiences
- to engage with the wider health sector on issues of workforce development
- to provide advice to the Ministry of Health on issues relating to the Maori mental health workforce
- to guarantee all advice and recommendations from Te Rau Matatini are based on sound evidence, quality research, and the principles of best practice
- to demonstrate leadership in the Maori mental health sector
Programme Manager

The Programme Manager has administrative and managerial responsibility for Te Rau Matatini. The main key functions of the role include:

- to manage specific projects identified by the Director
- as required by the Director, to provide reports for the Board, the Ministry of Health, other bodies
- to develop a business plan for Te Rau Matatini
- to institute systems of management and administration that will enable Te Rau Matatini to operate in an efficient and effective manner
- to develop an infrastructure that will enable Te Rau Matatini to meet its contractual obligations
- to establish close links with the Maori mental health networks
- to contribute to leadership in Maori health workforce development
- to establish a database relevant to Maori mental health workforce development
- to undertake research aimed at strengthening the Maori health workforce

Clinical Coordinator

The role of the Clinical Coordinator is to coordinate the training programmes associated with Te Rau Matatini, and the main functions include:

- to manage projects where a significant training component is required
- to liaise with mental health training agencies in order to establish opportunities for Te Rau Matatini
- to assist training agencies in the development of programmes that will meet the aims of Te Rau Matatini
- to contribute to the development of educational resources that will be useful for Maori mental health workforce development
- to ensure training programmes endorsed by Te Rau Matatini are of the highest standards
- to consult and maintain links with other mental health workforce development programmes
- to network with the Maori mental health sector in order to ascertain training needs and opportunities for enhanced service delivery
- to provide leadership in the integration of clinical and (Maori) cultural practices
- to undertake research aimed at strengthening the Maori mental health workforce.

IT and Administration Coordinator

The responsibilities of the IT and Administration Coordinator role include the development and maintenance of the administration, communication and information technology (IT) systems of the Te Rau Matatini Programme. The main functions of the position are:
• to ensure effective and efficient office operations
• to produce monthly expenditure reports
• to maintain Te Rau Matatini databases
• to establish and maintain Te Rau Matatini internal-library
• to maintain and extend Te Rau Matatini website
• to remain informed on e-learning and e-communication developments and scope future possibilities for Te Rau Matatini
• to arrange travel and accommodation for Te Rau Matatini staff, visitors and Board members
• to liaise with Government agencies, Maori health services, professional bodies, communities and iwi to progress Te Rau Matatini business
• to answer and respond to public queries through the 0800 Matatini number
• to help prepare Te Rau Matatini presentations and publicity material
• to design and collate Te Rau Matatini newsletters
• to assist in the preparation of Board papers
• to record the minutes of Te Rau Matatini Board and team meetings.
Te Rau Matatini Implementation Team (2004-2005)

Te Rau Matatini implementation team from draft business plan 2004-2005 illustrating expanding workforce and roles

**Project Manager - Transition**

The Programme Manager has administrative and managerial responsibility for Te Rau Matatini. The main key functions of the role include:

- to assist with the transition of Te Rau Matatini
- to act as a resource to Te Rau Matatini projects to ensure consistency across projects
- to report on Te Rau Matatini as required by the Ministry of Health
- to develop a Business Plan
- to maintain oversight of the programme budget
- to develop Te Rau Matatini’s infrastructure and systems to contribute to the ongoing efficient running of Te Rau Matatini, and
- to maintain close contact with the Board, the Ministry of Health, and key stakeholders.

**Group Manager (Workforce Training and Development)**

The role of the Group Manager (Workforce Training and Development) is to oversee and facilitate the implementation of training-focussed Te Rau Matatini projects and the Maori Child and Adolescent Te Rau Tipu project. The main key functions of the role include:

- to lead Te Rau Whakaemi (Maori Mental Health Services Training)
- to develop the strategic direction of Te Rau Matatini training projects
- to support the training Project Leaders by acting as a resource to, and overseeing the progress of, five training-focussed Te Rau Matatini projects
- to support the Project Leader by acting as a resource to, and overseeing the progress of, the Te Rau Tipu project
- to provide mentoring and regular support to Te Rau Matatini staff as appropriate
- to supervise staff employed to progress the training, child and adolescent focussed projects
- to ensure that all outputs and recommendations from the training, child and adolescent focussed projects are based on sound evidence, quality research, and the principles of best practice
- to contribute to the development of policies, strategic planning and significant external factors that will be useful for Maori mental health. workforce development

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Specialist Mental Health Hutt DHB, Generic Mental Health Hutt DHB, Tangata Whaiora Training Pilot, NGO Managers/Trustees Training Pilot, and Te Rau Whakawhānui.
• to progress Maori child, adolescent and whanau workforce development through Te Rau Tipu Phase II
• to undertake research aimed at strengthening the Maori health workforce, and
• to support other Te Rau Matatini projects within own area of expertise.

**Group Manager (Workforce Systems)**

The role of the Group Manager (Workforce Systems) is to oversee and facilitate the implementation of workforce development systems-focused Te Rau Matatini projects and lead Te Rau Ararau Phase II. The main key functions of the role include:

• to lead Te Rau Ararau (Maori Mental Health Career Pathways)
• to develop the strategic direction of Te Rau Matatini workforce systems projects
• to support the training Project Leaders by acting as a resource to, and overseeing the progress of, workforce systems-focused Te Rau Matatini projects
• to provide mentoring and regular support to Te Rau Matatini staff as appropriate
• to ensure that all outputs and recommendations from the workforce systems projects are based on sound evidence, quality research, and the principles of best practice
• to contribute to the development of policies, strategic planning and significant external factors that will be useful for Maori mental health workforce development
• to undertake research aimed at strengthening the Maori health workforce, and
• to support other Te Rau Matatini projects within own area of expertise.

**Kaituruki Tikanga (Cultural Facilitator)**

The role of the Kaituruki Tikanga (Cultural Facilitator) is to assist in the overall tikanga Maori leadership and development of Te Rau Matatini by contributing to team project work and hui, supporting training developments and advising on relationships with whanau, hapu and iwi and the wider Maori community. The main key functions of the role include:

• to build relationship development with Maori stakeholders is facilitated according to the appropriate Tikanga and Kawa of the rohe
• to support cultural components of all Te Rau Matatini programmes are appropriate and are inclusive of whanau, hapu and iwi values and participation
• to support staff cultural training and cultural supervision plans and processes are appropriate and include the aims and aspirations of all staff
• to provide active and focussed participation in the training activities of Te Rau Matatini
• to provide ongoing constructive cultural advice to the development of policies, strategic planning and significant external factors that will be useful for Maori mental health workforce development.

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8 Specialist Mental Health Hutt DHB, Generic Mental Health Hutt DHB, Tangata Whaiora Training Pilot, NGO Managers/Trustees Training Pilot, and Te Rau Whakawhānui.
**Kaiako Motuhake Specialist Trainer**

The role of the Specialist Trainer is to assist in the overall development of Te Rau Matatini Training programmes by contributing to project work, supporting and facilitating the development and implementation of training project initiatives. The main key functions of the role include:

- to manage the implementation of Te Rau Matatini training programmes/projects as agreed to with the Group Manager: Wk Training and Development
- to contribute to the development of policies, strategic planning and significant external factors that will be useful for Maori mental health workforce training development
- to contribute to the development of educational resources that will be useful for Maori mental health workforce training development
- to develop and design training Te Rau Matatini training packages
- to provide mentoring, coaching and regular support and feedback to training team(s) as appropriate
- to facilitate ongoing training and development to support mentoring and coaching opportunities.

**IT and Project Coordinator**

The role of the IT and Project Coordinator is to assist in the overall development of Te Rau Matatini by maintaining and extending Te Rau Matatini’s IT infrastructure and e-workforce development activities as well as Maori child, adolescent and whanau workforce development focussed Project work.

The main key functions of the role include:

- maintain website of Te Rau Matatini as Project Leader of Te Rau Tukutuku
- develop the e-workforce development extensions to the website
- initiate improvements to the website in-line with national standards
- remain up to date with national and international e-learning and e-workforce development progressions
- progress and support the IT needs of other Te Rau Matatini projects (e.g. Te Rau Arataki)
- progress Maori child, adolescent and whanau workforce development as Project Leader of Te Rau Tipu Phase II
- undertake research aimed at strengthening the Maori health workforce.

**Project Analyst**

The role of the Policy Analyst is to develop resources and workforce development systems, contributing to workforce systems and career promotion-related activities that will lead to the enhancement of the Maori mental health workforce.
The main key functions of the role include:

- to manage Te Rau Arataki phase II and Te Rau Piataata phase III (as Project Leader)
- to undertake research aimed at strengthening the Maori mental health workforce
- to contribute to the development of policies, strategic planning and significant external factors that will be useful for Maori mental health workforce development
- to contribute to the development of Maori mental health workforce resources that will be useful for Maori mental health workforce development, and
- to contribute to the project activities of Te Rau Matatini.

**Research Assistant**

The role of the Research Officer is to work as part of the Workforce Systems team across a number of Te Rau Matatini projects to undertake and support research-related components of the projects, largely contributing to the establishment and evaluation stages.

The main key functions of the role include:

- Undertake research aimed at strengthening the Maori mental health workforce
- Support the sound establishment and evaluation of relevant Te Rau Matatini Workforce Systems projects.

**Senior Administrator**

The role of the Senior Administrator is to lead and manage administration systems, and be able to identify and implement practices to maximise the efficiency and effectiveness of administration and computer support.

The main key functions of the role include:

1. Lead and manage administration systems
   - Implement and review policies and practices to ensure effective and efficient office operations
   - Maintain and extend the Te Rau Matatini library database
   - Manage correspondence and appointments for the management team
   - Prepare Board reports and correspondence
   - Minute meetings of the management team and Board
   - Format reports, presentations, publicity and other materials
   - Correspond and type various forms and reports etc

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9 Based on sound research practices and in a way which reflects best practice standards when researching with Maori (in accordance with Tuhiiwai-Smith, 1998 and Walsh-Tapiata, 1997)
10 Primarily act as a resource to Whakamaru Phase II, undertake a literature review for Te Rau Ararau Phase II, drafting of the Training Nexus Report
11 Participating in the evaluation of Te Rau Arataki
− Design databases for electronic filing and data storage
− Data entry
− Proof reading of Te Rau Matatini documents
− Maintain Health and Safety practices (including fire safety and first aid)
− Maintain Te Rau Matatini asset register
− Assistance with Te Rau Matatini budgets
− Other duties required by the management team

2. Provide computer support across the Te Rau Matatini Programme
− Identify computer training needs of staff, design and facilitate computer workshops to increase the computer capability of the Te Rau Matatini team
− Execute regular computer back-ups
− Assist staff with the preparation of presentations, reports etc
− Provide one to one staff computer support.

Project Officer Transition

The role of the Project Officer Transition is to primarily support the Project Manager - Transition in the development of internal Te Rau Matatini policies and procedures. A higher tertiary qualification in a relevant subject is required, together with proven experience in organisational policy development, and project coordination.

The main key functions of the role include:
• Contribute to the development of internal organisational policies
• Coordinate Te Rau Matatini reference group meetings
• Provide project coordination support.

To be appointed, Project Administrator

The role of the Project Administrator is to assist in the overall development of Te Rau Matatini by maintaining and extending the administration systems, providing reception duties and supporting the public relations activities of the Te Rau Matatini Programme.

The main key functions of the role include:
• Maintain the administration systems of Te Rau Matatini
• Ensure effective and efficient project administration operations
• Receive, sort and distribute Te Rau Matatini mail
• Maintain an effective filing system of Project documents
• Maintain Te Rau Matatini databases
• Arrange travel and accommodation for Te Rau Matatini staff and visitors
• Schedule appointments for Te Rau Matatini project staff
• Order stationary and office equipment
• Answer, follow-up and respond to incoming calls on the 0800 number
• Produce quarterly Te Rau Matatini newsletter
• Prepare Te Rau Matatini project presentations
• Assist with reference group preparations and administration needs.