

Improving Recruitment and Retention for the Pacific Mental Health Workforce

Feasibility Study

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In Association with Pava



TE POU O TE WHAKAARO NUJ

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Table of Contents

Acknowledgements	i
Table of Contents	ii
Executive Summary	1
Key Findings	1
Education/Training Supply Issues	1
Infrastructural Barriers	2
Pacific Communities Supply Issues.....	2
Recommendations.....	3
Introduction	4
Methodology	5
Background	6
Pacific Demographics	6
Pacific Mental Health Workforce.....	10
Feedback from Fono and Key Participants Interviews	14
Recruitment	14
Retention	16
Education and Preparation for Practice.....	17
Community Responsiveness	19
Pacific People’s Use of Mental Health Services	19
Summary and Conclusions	23
Recommendations	25
References	26
Appendix	29

Executive Summary

This project was undertaken to specifically review the question of the recruitment and retention of a Pacific mental health workforce and includes consideration of options that aim to:

- promote a career in the mental health sector for Pacific people;
- attract Pacific people into the mental health sector; and
- retain Pacific mental health workers within the sector.

This report is aligned with a number of other initiatives sponsored by the Mental Health Directorate of the Ministry of Health which when taken together will provide a strategic approach for the development of a Pacific mental health workforce within the New Zealand context.

Key Findings

This study has resulted in identifying three key areas that need to be taken into consideration when addressing the question of recruitment and retention of a Pacific mental health workforce.

While these three areas are limited to the specific context of a Pacific mental health workforce, it needs to be stated in the strongest possible terms that the issue of developing this workforce is not just a Pacific people's concern. Effectively addressing the question of recruitment and retention must be owned as an issue for wider mainstream agencies in collaboration with Pacific communities within the New Zealand context.

We have organised the key findings/themes into three main areas of:

- issues of supply - the educational barriers;
- infrastructural constraints/barriers to enhance recruitment and retention; and
- Pacific communities supply issues.

Education/Training Supply Issues

- One of the biggest barriers to any strategy to improve the recruitment of Pacific people into mental health is the reliance on tertiary educational institutions to increase the supply at the level of entry to practice. Apart from the Community Support Worker, no direct entry into Mental Health exists for any health profession. With the exception of one tertiary provider, the acceptance and completion rates of Pacific peoples in all tertiary providers across all health disciplines is dismal. The ability to address this issue must be owned in the first instance by the Tertiary Education Commission and the Ministry of Health. This report challenges whether it is acceptable for tertiary education providers to continue to fail to address the career aspirations of Pacific peoples within their catchment.
- In the specific instance of entry into Mental Health, the issue is more complicated than simply gaining entry into undergraduate programmes. In nursing for example, there is the added barrier that having successfully

completed a Bachelor of Nursing programme, people are also required to complete an 'Entry to Specialty Practice' (Mental Health) postgraduate certificate to gain ongoing employment in some District Health Boards' mental health services, or acceptance into new graduate programmes.

- Within health professional training programmes there is an issue of variable quality of experience that Pacific students encounter undertaking their practicums. While there are examples of best practice provided by both District Health Board (DHB) provider services and Pacific Non-Governmental Organisations (NGO), it must be frankly acknowledged that some Pacific students' experiences in mental health services act as a significant disincentive to work in this specialty service at the completion of their educational programmes. This is an issue that must be addressed at a DHB/NGO level.

Infrastructural Barriers

- One of the most frustrating aspects of growing a Pacific mental health workforce is addressing the question of how service providers can grow their capacity. Most NGOs employ FTEs to the full extent of their contracts and these do not allow flexibility beyond their contractual arrangements. Undertaking a recruitment plan to increase the Pacific workforce without addressing the issue of how these people can be employed is likely to do damage to the future development of Pacific mental health services.
- While there are examples of good management practices in some Pacific Mental Health Services, the effect of poor management of human resources has an impact of limiting recruitment and retention. Some of these issues relate to the smallness of some NGOs with their consequent inability to provide adequate mentoring and development of their staff. This is not always simply an issue of financial resources. Some of the literature on 'Magnet' organisations suggests that staff who are valued and work from a shared philosophy of care will stay in organisations despite being able to earn higher salaries elsewhere (Becker, 2005; HWAC, 2002).

Pacific Communities Supply Issues

- The current data on Pacific people's utilisation of mental health services as consumers suggests that there is a general lack of knowledge of just what the 'Mental Health Service' is/does/provides. Without a strategy specifically designed to begin addressing this issue, recruitment will largely depend on the ad hoc career aspirations of individuals. The development of a Pacific centred mental health promotion programme and education related to mental health services would have the double-edged effect of both informing Pacific communities and raising the profile of mental health services as potential employment/career possibilities.
- Unquestionably, one of the major barriers from a Pacific community perspective is the cost of tertiary education. Issues of 'cost' involve much more than just tertiary education fees, although these can be in themselves a significant disincentive. In order for Pacific people to invest in their education, they need to have confidence that they can a) successfully complete entry qualification training/education; and b) there are viable employment options at the end of that training. Strategies to effectively address this issue must go beyond the possibility of scholarship support.

Recommendations

The following recommendations are made based on the information and findings of this study.

1. That a Pacific Mental Health Centre be established to act as an independent body to facilitate, coordinate and monitor the implementation of these recommendations. This recommendation resonated strongly with the majority of the study participants.
2. That the Pacific mental health sector facilitate the development of a pedagogy of Pacific mental health.
3. That this pedagogy is used to inform a primary mental healthcare approach suitable for mental health promotion and education within Pacific communities.
4. That the pedagogy informs curriculum development for the preparation of all levels of Pacific mental health practitioners, and is used to develop 'best practice' models of care.
5. That the Tertiary Education Commission require tertiary institutions through their Charters and Profiles to actively address the health career aspirations of Pacific peoples.
6. That the Tertiary Education Commission incentivise institutions that achieve or exceed their Profile targets for Pacific achievement.
7. That the Ministry of Health, District Health Boards and Non-Government Organisations continue to work together to set challenging performance targets related to the recruitment and retention of a Pacific mental health workforce. Included in this work should be a commitment from all parties to reduce the disincentives created by contractual processes.

Introduction

This report discusses the issues that are related to current trends and identified obstacles in the recruitment and retention of a Pacific mental health workforce, with a view to developing strategies for overcoming barriers and developing an enhanced career development pathway for Pacific peoples within the mental health sector.

The report begins with a brief overview of Mental Health Service development over the past fifteen years as a way of providing contextual background. The report proceeds by describing service delivery developments specifically related to Pacific populations in New Zealand within this changing context, and identifies the workforce development issues that have arisen as a consequence. This report attempts to identify through the literature what the specific issues are related to the recruitment and retention of the Pacific Mental health workforce. This data is supplemented by input from key informers who have experience either as Pacific practitioners and/or as service providers who have practical experience of recruitment and retention issues.

On the basis of this exploration the paper articulates a number of recommendations and suggestions for the strategic development of the Pacific mental health workforce and identifies areas for further research.

Methodology

In undertaking this project we are cognisant of the fact that in recent years considerable attention has been focused on the issues of maintaining and developing a mental health workforce that has both the capacity and capability needed in order to achieve the strategic goals set out in the *Blueprint* document (Mental Health Commission, 1998). Much of this activity has been documented in a number of strategic plans, discussion documents, policies and reports and has been generated from three major sources: The Mental Health Commission (MHC), the Ministry of Health (MOH) and the Health Workforce Advisory Committee (HWAC). Hatcher, Mouly and Rasquinha et al (2005, p.7-11) provide a useful summary of this literature which we have also accessed but reviewed from a slightly different perspective in that we are interested in these documents from the point of view of how they inform the question of a Pacific mental health workforce.

As with much Pacific research, the standard literature searches of electronic databases using for example MEDLINE, PROQUEST and INNZ yielded very little and what was found was literature already familiar to us. Most sources of literature related to Pacific Health, Pacific Mental Health and Pacific Health Workforce were located in the 'Grey Literature' and was generally accessed through informal and sometimes serendipitous means drawing on our own personal knowledge and that of colleagues with knowledge and expertise in the field. As a consequence we readily acknowledge that there may be some gaps in the literature we have identified.

The literature provided one source of data for this project. A second source was the knowledge, wisdom and experience of Pacific stakeholders. For the purposes of this project these stakeholders were identified as managers of Pacific healthcare services, Pacific health professionals and staff from three Pacific mental health services. Focus group interviews were undertaken in Auckland, Wellington and Christchurch, and four one to one interviews were held with key informants to sample some of the views of stakeholders who have practical knowledge of 'what works'. They were also able to inform the question of what they saw as the barriers to increasing and enhancing this workforce.

A third source of information is the lead author's knowledge and experience in the field of health education and training particularly in relation to Nursing and the National Certificate in Mental Health (Support Workers) programmes. This experience is supplemented by my participation as a member of the review team which undertook the Review of Mental Health Services in Auckland in 2002 on behalf of the Mental Health Commission, and as a member of the Health Workforce Advisory Committee from 2000-2005. The challenges of potential bias and compromised objectivity by being both an informant and lead writer in this project are freely acknowledged. These challenges are reduced by transparent declaration and the judgement that personal experience in these areas does nevertheless contribute to the focal issues of this report.

Background

New Zealand first developed a coordinated mental health policy in 1994, with the Mental Health Strategy, *Looking Forward* (Ministry of Health, 1994). This document made Mental Health a priority for the Government and emphasised the need for more and better services for people. It also signalled the Government's commitment to developing community-based services (Ministry of Health, 2005).

In the past decade, a number of important developments have made significant changes in the way health services have been organised and impacted on the way mental health services are delivered. These changes included the establishment in the last seven years of 21 District Health Boards (DHBs), which are responsible for determining the mental health needs of their communities and the subsequent planning and delivery of appropriate services. Incorporated in these changes has been the growth of a strong consumer voice and an acknowledgement that services must be built around the needs of the people who use them (*Te Tahuhu*. Ministry of Health, 2005).

The implementation of a deinstitutionalised service provision, the increased focus on community-based care and a philosophical shift to a recovery model development has changed the capacity, capability and quality required of the mental health workforce. These relatively rapid fundamental changes to mental health service delivery have created a number of problems, but it must also be acknowledged many opportunities at the same time. Mulvale (2004), for example, argued that the implementation of rapid changes resulted in fragmentation and a lack of coordinated care between DHBs and the Non-Government Organisations (NGOs) sector. This fragmentation and lack of coordination inevitably impacts on the mental health sector's ability to recruit and retain a viable workforce.

Added to this pressure, Mulvale (2004) further argued that the funding changes first introduced by the Health Funding Agency (HFA) resulted in a rapid increase in the number of mental health service providers, increasing the recruitment and retention pressures. On the positive side, the HFA was also responsible for creating new and innovative service delivery models that resulted in the emergence of Pacific specific mental health service providers.

Pacific Demographics

Effectively addressing the issues of improved recruitment and retention of the Pacific mental health workforce needs to be understood within the context of the current labour force supply, and on the basis of projections of future changes in the labour supply market. Understanding the issues of the labour force supply, that is the pool from which one must recruit, sets some parameters around what might realistically be achieved.

There are two considerations to be kept in mind when reading these population statistics. Firstly, the numbers of people claiming affiliation with different ethnic groups totals more than the total population because within the methodology used for the Census, people can self-identify affiliation with more than one ethnicity (Statistics New Zealand, 2001). Secondly, it is a generally accepted fact that there is a significant under-enumeration of the Pacific population within the New Zealand

context, so that the demographic picture needs to be read and interpreted with some caution.

According to the 2001 census there were close to 232,000 Pacific people living in New Zealand which represented 6.7 percent of the total population (Statistics New Zealand, June 2002, p.17). The distribution pattern of this population shows that ninety-eight percent of Pacific people live in urban areas, with sixty-six percent of the total living in the Auckland area. Seventeen percent of the total Pacific population is located in the Wellington region, and the remaining seventeen percent is distributed through the rest of New Zealand with increasingly significant numbers residing in the Waikato, Hawkes Bay and Canterbury regions (Statistics New Zealand, June 2002, p.24).

Within this aggregated total of Pacific peoples, there are distinct ethnic groups, and for Pacific peoples themselves this distinction is fundamentally significant. This is an important consideration when determining recruitment strategies because it is unlikely that a “one size fits all” approach would be particularly successful.

Numbering 115,000 at the 2001 Census, the Samoan group was the largest and represents almost half of all Pacific peoples living in New Zealand. The next largest group of 52,500 people are those who self identify as Cook Island Maori. Of the other major Pacific groups 40,700 are Tongan, 20,000 Niuean, 7,000 Fijian, 6,000 Tokelauan with small numbers from other Pacific ethnic groups (Statistics New Zealand, June 2002).

For the purposes of this report, the other most significant factor apart from population size, size of ethnic groups and distribution, is the age structure of the Pacific population and the impact of this factor on future labour force supply issues.

For this section of the report we have used the National Ethnic Population Projection 2001 (base) - 2021 update published by Statistics New Zealand (<http://www2.stats.govt.nz>. Downloaded 9/05/06). Statistics New Zealand has developed a series of eleven alternative population projections to provide “... an indication of possible future changes in the size, growth rate and age-sex structure of the European, Maori, Asian and Pacific populations” covering the period from 2001 through to 2021 (ibid. p.1 of 13). From this series of projections, “...Statistics New Zealand considers that Series 6 is the most suitable for assessing future population changes” (ibid. p.2 of 13), and it is this mid-range projection that we have used in the following section.

Statistics New Zealand state that Maori, Pacific and Asian populations are making up an increasing proportion of the total population. These three populations have a more youthful age structure “... and thus a greater built-in momentum for growth than the European population” (ibid. p.4 of 13).

Between 2001 and 2021 the Pacific population is projected to grow by 29 percent, and by 2021 will number about 420,000 people compared with 260,000 in 2001. This growth will represent 9.1 percent of the total population compared with a proportion of 6.7 percent in 2001.

Table 1 reproduced from the Statistics New Zealand report provides a useful summary of the age structure of the different ethnic groups, the proportion within

each age group, and the comparison between 2001 and the projected proportions in 2021.

Table 1: Ethnic Share of New Zealand Population by Age Group 2001 and 2021

Age Group (Years)	European %	Maori %	Asian %	Pacific %
2001 (base)				
0-14	74	25	7	11
15-39	75	17	9	8
40-64	83	10	6	4
65 and over	92	4	2	2
All ages	79	15	7	7
2021				
0-14	63	28	17	17
15-39	64	20	16	11
40-64	86	17	15	9
65 and over	70	17	15	9
All ages	70	17	15	9

(Source: Statistics New Zealand, 2006, p.5.)

From this table, it is apparent that particularly in the 1-14 years and 15-39 years ages, the projection is suggesting a significant shift in the proportion of the Pacific population compared to the other populations. This is reflected in the projected relative sizes of the working age populations comparing 2001 with 2021.

The report states that “the Pacific working-age population is projected to increase from 153,000 in 2001 to 253,000 in 2021, an increase of sixty-five percent” (ibid. p.10 of 13).

In considering the question of increasing a Pacific mental health workforce, these population projections look promising in that there appears to be a growing supply of Pacific peoples entering the labour force over the next ten to fifteen years. While it may seem that projecting out to 2021 is too long a period of time, the chastening factor to consider is that the majority of Pacific people entering the labour market for the first time in 2021 are already, or soon will be, in the compulsory education system. If the potential that this new labour supply promises is to be realised and strategically targeted for the Pacific mental health workforce, considerable barriers currently existing in the compulsory education sector urgently need to be addressed.

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, 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, 2004).

In relation to this project, it is the reference to “lower levels of education” that must be of greatest concern. The ability for the health sector in general, and the mental health service in particular to attract more Pacific people, at least proportional to the size of the Pacific population, ultimately depends on how we address the education aspirations and achievement levels of Pacific peoples.

The significance of the under-achievement of Pacific students in compulsory education has been highlighted in a number of commentaries. Anae, Anderson, Benseman and Coxon (2002) state that;

“Pacific (and Maori) school-leavers clearly start their tertiary education at a distinct disadvantage in comparison to their palagi and Asian counterparts. The low level of qualifications held not only bars their entry into many programmes but also restricts the level of programme into which they can enter” (p.12).

According to Macpherson, Spoonley and Anae (2001), Pacific adults have one quarter the rate of academic qualifications as that recorded for the New Zealand population as a whole, and as noted by Pasikale, Yaw and Apa (1998) only seven percent of Pacific school leavers go into University compared to twenty-one percent of all school leavers.

The Health Workforce Advisory Committee (2002b) argued that reducing the inequalities and disparities in health for Pacific populations compared to European New Zealanders is identified in many of the Government’s health strategies as an important priority. It was the view of HWAC that the building of a Pacific health workforce required health sector changes that are actively coordinated with improvements in education, welfare, employment and other sectors. In a symposium sponsored jointly by HWAC and the Royal Society of New Zealand (2005), the education issues which acted as a barrier to the increased participation and success of Pacific (and Maori) students were canvassed and four key themes were identified to enhance success and increase their entry into health related occupations. The key themes were:

- The need to improve the responsiveness of the education system to the diversity of students in its care;
- The need to improve individual and community attitudes to science, maths and health studies by showing relevance;
- The need to improve student, parent and community knowledge about potential careers , and expectations for achieving these careers; and
- The recognition that mentoring was a vital component to achieve success (Promoting Maori and Pasifika into Health, Science and Technology Symposium. Wellington, March 2005. <http://www.hwac.govt.nz/MaoriHealthTOR.htm>).

The implications of these factors is that compulsory education provides a less than optimum launching pad for Pacific students to undertake tertiary education leading to health professional qualifications and the consequences are reflected in the numbers of Pacific peoples currently represented in the health workforce.

Pacific Mental Health Workforce

The single most significant observation to be made about the Pacific mental health workforce is that across the board, Pacific peoples are seriously underrepresented in all categories of health occupational groups (MOH, 2004), and this underrepresentation is reflected in the specialty practise area of Mental Health.

A Mental Health Commission (MHC, 2001) survey of the mental health sector found that 1999, at 2.5 percent, Pacific people are significantly under-represented in the mental health workforce compared to their representation in the population as a whole, which is currently just less than seven percent. Identified in the Central Region's Technical Advisory Services (TAS) report (2005) was the need to develop a sustainable Pacific mental health workforce that included people from all Pacific ethnic groups. The authors argued that particular efforts needed to be made to increase the percentage of Pacific mental health workers with appropriate health qualifications (TAS, 2005).

Within the health sector, the Pacific Action Plan reinforces and supports effective collaborative partnerships between the Ministry of Health and Pacific health providers, DHBs, other health organisations, Pacific families and their communities towards achieving its goals for increasing the Pacific workforce. It is important to note that in HWACs' view, every health strategy should have a Pacific focus, and that only a total sector approach will reduce health status disparities (HWAC, 2002b).

In a profile of Pacific mental health, the MOH reported that there are almost 5,500 Pacific people working in the area of health and community services, or seven percent of all Pacific people in work. Of the Pacific people who worked in these areas, five percent were specifically mental health professionals (excluding psychiatrists) (MOH, 2005).

The Ministry of Health (2005) also stated that the overall Pacific health workforce proportionately increased more between 1996 and 2001, than the total health workforce. A slightly disingenuous claim which when unpackaged provides something of a reality check. For example, in the Health and Independence Report (MOH, 2004), the statement is made that "... the percentage of Pacific peoples working in nursing and midwifery doubled from 1.4 percent in 1992 to 2.9 percent in 2003" (p.45). When looking at the workforce statistics it is useful to look at the total numbers as well as the proportions.

While in 1992 there were no psychiatrists or psychologists who identified themselves as Pacific, a small number have become qualified since then. As noted in Table 2, the Mental Health Commission Report 2001 shows Pacific health workforce having one (1) Psychiatrist and three (3) Clinical Psychologists. In 2001 to 2002, there were 149 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 drug and child and youth services (MHC, 2001).

The Mental Health Commission's document, *Pacific Island Mental Health Services and Workforce* (2001), identifies that the Pacific workforce is severely under-represented. This is attributed in part to failure of planning and support at various levels, and Pacific individuals and health professionals not perceiving mental health as an attractive career option.

The following table provides an overview of the numbers of Pacific people in different occupational groups working in Mental Health and Addiction services.

Table 2: Occupational Groups - Pacific Mental Health and Addiction Workforce

Occupation Group	Number (n=149)	Percentage of Pacific Mental Health Workforce
Community Support Workers	47	31.5
Nurses	38	25.5
Residential Caregivers	26	17.4
Social Workers	7	4.7
Managers	5	3.4
Consumer consultants	4	2.7
Administrators	4	2.0
Clinical Psychologists	3	2.0
Matua	3	2.0
Alcohol and Drug Workers	3	2.0
Psychiatric Assistants	3	2.0
Youth Workers	2	1.3
Occupational Therapists	1.3	1.3
Psychiatrists (training)	1	0.7
Counsellors	1	0.7
Total	149	100.0

(Mental Health Commission. February 2001, p.20.)

Pacific mental health professionals are in such short supply that increasing their numbers is a high priority. Pacific mental health service consumers have given a strong message that having access to a service run by a Pacific organisation and/or with Pacific staff is fundamental to their recovery. Pacific consumers can more easily identify with Pacific staff who bring Pacific cultural understandings and beliefs system to the service (Malo, 2000, p.13).

Annandale and Instone (2004) argue that all mental health services that provide services to Pacific people need their staff including support workers, to have an in-depth knowledge and understanding of cultural matters. The National Certificate of Mental Health may be an appropriate place for support workers to gather some of this information. Cultural issues identified by the Mental Health Commission (2001) include:

- Diversity within different Pacific cultures with regard to language, customs, traditions and rules of conduct;
- The central importance of language, family, religion and traditions in Pacific cultures;
- Differences between island-born and New Zealand-born Pacific people;
- The importance of involving Pacific families, communities and service users in individual and service planning as well as treatment processes; and
- Services users' rights to access traditional healing and conventional medical treatments at the same time.

The Technical Advisory Services (2005) report states that the key issues in developing a sustainable Pacific mental health workforce include the need for more Pacific people, from all Pacific ethnic groups, to be recruited at all levels and in all occupations. Particular efforts need to be made to increase the percentage of Pacific mental health workers with appropriate health qualifications and to also address issues regarding traditional healer's ability to practice in mental health and the development of valid cultural competencies (TAS, March 2005).

According to the TAS report (2005), there are few qualified Pacific psychiatrists or clinical psychologists (1 Psychiatrist and 3 Clinical Psychologists) in practice or in training. As for other professional groups, the key issues for Pacific nurses includes how to increase the numbers choosing mental health as their area of specialty practice and how to make better use of the current Pacific nursing resources. The actual number of Social Workers in the Pacific mental health workforce is currently small, and along with professions such as Occupational Therapy and Counselling have a low profile within Pacific communities. The mental health support worker initiative is relatively new in the mental health sector, but appears to be of considerable benefit to Pacific and mainstream providers (TAS, March 2005).

There appears to be difficulties in accessing education and development training, particularly for workers of small organisations/services, such as many NGO's and those outside the main centres. Numerous vacancies and problems with retention also make it more difficult to release workers to attend training (TAS, March 2005).

Annandale and Instone (2004) citing data from the New Zealand Qualifications Authority website state that the National Certificate in Mental health (Mental Health Support Work Level 4) is a first qualification for those wishing to enter mental health support work, or for those who may already be working as mental health support workers. This support work role can be undertaken by people who have been or are currently experiencing mental illness or disability. Support workers develop and implement individual lifestyle or support plans. They work in a collaborative manner alongside consumers, and sometimes with their families. It was estimated that approximately 971 people in total have graduated with the National Certificate in Mental Health. Of those 7.6% (74) have been of Pacific descent. In 2001, the total mental health workforce was estimated to number around 7,000. Pacific peoples

made up 2.5% (175) of the total and of those, 31.5% are estimated to be community support workers (MHC, 2001).

Feedback from Fono and Key Participants Interviews

As another source of information, the authors of this report undertook a series of interviews to access the experiences of people currently working in the field of Pacific mental health. The key participant interviews involved a DHB Funding Manager, Service Managers and Clinicians on a one-to one basis, and a fono involving staff working in mental health services was held in Auckland, Wellington and Christchurch. These unstructured interviews asked participants for their views on what needed to occur to enhance and develop the Pacific mental health workforce with particular attention paid to the questions of recruitment and retention. (See Appendix 1 for a list of participants.)

Recruitment

Dr Siale Foliaki from the Faleola Clinical Mental Health Service in Auckland described how this service worked proactively with the education tertiary institutions to identify Pacific students enrolled in health related professions and actively mentored and supported them through their studies.

“... we request for them to do placements with us, so that we can encourage a growing workforce.... most of my staff were once students here on placement” (Italics added).

This positive approach was also reflected in the fono with staff from this same service. They talked about the shared values and vision within the service, and held positive views about the role they had to be supportive of students when they were with them on clinical placements. They saw this as a key strategy in being able to recruit these students to the service once they had completed their initial training programmes.

In terms of future recruitment, Foliaki argued for an apprenticeship scheme for students wanting to enter the mental health workforce. He stated that:

“Part of the apprenticeship scheme would also be that they get paid so that they can still look after their families and work part-time while they are studying”.

While Foliaki’s strategy is problematic within the context of developing a professional workforce, he has nevertheless identified a key barrier for many Pacific people wanting to enter the health workforce in general and the mental health workforce in particular. Insufficient attention has been paid to the particular economic barriers faced by Pacific people entering the health workforce. Except for the Mental Health Support Worker, all other people entering the Mental Health Service must do so by first completing a professional programme of study. For example, to become a Registered Nurse working in mental health a student must first complete a three year undergraduate degree programme. For some DHBs, graduates must then complete a one year Entry to the Specialist Practice of Mental Health to formally mentor them in their first year of practice. Social Workers are currently required to complete at least a two year Diploma Programme, and to be employed in Mental Health most are required by employers to have completed a three or four year undergraduate degree. Psychiatry and Psychology can require between ten to fifteen years of study before achieving a paid position.

Very few Pacific students have the luxury of undertaking professional health studies without the necessity to supplement the families income with part-time paid employment. This is a reflection of the fact that as a whole, the Pacific population is over-represented in the low socioeconomic group compared with the total population. The number of hours students work in paid employment directly correlates to the relative ease or struggle Pacific students experience to successfully complete their professional studies. This view is supported by the National Survey of Pacific Nurses and Nursing Students undertaken by Koloto (2003). High cost of training (19%) and family, church and cultural commitments (15%) were the two most frequently cited barriers identified by the nursing student participants (Koloto, 2003, p.75-76).

A critical barrier to Pacific people entering health-related professions and successfully completing their programmes of study is the cost involved. For many, this cost is more than the direct costs of their programmes. It also involves calculating the loss of potential earnings while they are students. It cannot not be taken for granted, that the parents and families of Pacific school leavers are in a financial position to forgo the earning potential of their children while they are studying and provide them with financial support as well. In some health related occupations such as Nursing and Social Work for example, many Pacific people applying to enter programmes are “second chance” learners. For them the issue is often how to continue to support their families financially and do their studies at the same time. Most students cope by undertaking part-time employment during their studies. Unfortunately, many work too many hours to the detriment of their studies and/or their own health.

Another perspective was provided by the Team Leader of a Pacific Mental Health Service. This person stated that they had real problems recruiting good staff and had explored the option of recruiting staff from overseas.

“We went to Samoa and have recruited staff from there.”

This seems at very best a short-term solution to an immediate staffing issue.

Of more interest was the issue raised by this informant that current service contracts

“... don't pay for potentials, only actuals”.

This comment was elaborated by the view that it is:

“... difficult to encourage staff into our workplace if we don't have the funding to bring them in. This is a major barrier for us”.

The informant raises a critical systemic barrier to recruitment, and that is that current recruitment practice is a very hand to mouth affair. There seems to be no facility to build the Pacific mental health workforce pool beyond contracted FTEs. Given the current demand for Pacific health professionals across all specialty areas and disciplines, mental health services need to consider creative strategies for dealing with this issue. There seems little point in undertaking elaborate recruitment plans if there is no understanding of how and where people can ultimately be employed.

In her contribution to the debate, Margie Fepulea'i, from a health funder perspective acknowledged that there is a funder issue involved in that many of the service providers that have been established are relatively small,

"... so that when one person leaves a team of eight say, there is a disproportionate impact on those services".

This raises the issue of the difficulty of Pacific mental health services adequately dealing with the issue of ongoing staff development. With services that are so small, it is difficult to see how they can engage in continuous quality improvement and challenges the sustainability of these services at a number of levels. Again, Fepulea'i's view was that improving the recruitment and retention of a Pacific health workforce is heavily dependant on the quality and capability of managers and service providers. She makes the point that sometimes the entrepreneurial skills needed to set up services are not necessarily the same set of skills needed to manage teams of ten, twenty or fifty people. She states:

"It is an issue we have with some of our providers and that some managers are probably not supportive of their staff and apply some cultural behaviours which are not always appropriate in a management context".

There are solutions that could be adopted to address issues such as this, but they need to be undertaken at a regional level rather than at the service delivery level. For example, while each service lacks the capacity to each employ relief staff, there maybe ways to employ a shared casual or relief pool.

These considerations are worthy of further exploration, because they are ways that make the recruitment and retention of staff an attractive proposition for intending employees, and viable for small service providers. Having a stand alone Centre that could act to broker ideas such as these is what is required to move past the rhetoric and into action.

Retention

Presuming effective strategies can be developed to deal with the issues of recruitment, there remains the question of retention. An issue that is of concern across the board, but with particular consequences in the area of Pacific mental health.

Again, Foliaki provided some key messages about what might constitute best practice in terms of retaining staff. He stated that:

"staff needed to be mentored and supported in the workplace... the key I believe is the quality of the supervision, mentoring and good leadership".

His view is reflected in the comments from staff who spoke of the fact that they were encouraged with their studies and received ongoing mentoring. This helped create a positive culture within the service.

"As a team we have shared values and collective competencies which help keep us working well as a team and also keeps us communicating well. We work hard together to build staff morale. Everyones opinions are heard".

Contrast this picture with that described by Logovae's research (2002) in which she explored the experience of Pacific women working as Registered Nurses within

mainstream mental health services. Her findings suggest that because of the small numbers of Pacific nurses working in mainstream they tend to work in isolation and are unable to support each other's practice. This professional isolation, she argues, leads to job dissatisfaction. Logovae's research claims that mainstream organisations seldom acknowledge or value the particular skills and knowledge of Pacific nurses. She goes further and suggests that over time this results in the loss of competent Pacific Island mental health nurses.

The Mental Health Commission Report (2001) stated that more attention needed to be given to improving workforce morale that had been weakened by the ongoing restructuring of mental health services over the past decade. Also identified in this report was the need for greater involvement of Pacific health providers in planning, organising, and funding national workforce development strategies.

The Ministry of Health's Pacific Provider Development Fund (PPDF) (MOH, 2004) aims to strengthen Pacific provider networks and develop Pacific providers. The fund was established in 2001 and covers three specific categories for development.

- DHB initiatives.
- NGO Pacific Provider Organisation and Services Development, which has workforce development as a priority area providing funding for the providers' Pacific workforce to undertake related clinical or business training.
- The Pacific Training Scholarships Scheme, which includes the Pacific Leadership Course to develop leadership skills within Pacific services and for Pacific peoples in mainstream provider services. Within this section there are also scholarships offered by the Ministry of Health for Pacific peoples from the mental health sector to gain tertiary qualifications at the postgraduate level.

Given the perspectives shared by the participants, it might be timely to question whether the PPDF is achieving the goals for which it was originally established, and whether it is not time to demand evidence that tangible outputs are being achieved. In particular, one might question whether service providers are creating practice environments that are attractive and supportive to the Pacific mental health workforce. The establishment of a Pacific Mental Health Centre provides an opportunity to objectively develop provider organisational models that are both culturally appropriate and managerially competent and sustainable.

Education and Preparation for Practice

Key issues in developing a sustainable Pacific workforce include up-skilling workers and promoting a culture of learning (Annadale and Instone, 2004). Barriers faced by many Pacific mental health workers in gaining qualifications include course costs, a lack of supports for Pacific students, difficulties of returning to study as an adult, English as a second language and family and community obligations that hinder study (HWAC, 2002b; Koloto, 2003).

While the long-term goal for increasing the mental health workforce must involve addressing the current inadequacies of the compulsory education system, Pacific peoples and their communities cannot be expected to wait another ten to fifteen years before substantial improvements in their care occurs. Indeed, if Pacific people are to see Mental health as a viable career option, then changes must begin now. There are things that need to occur at a community level, and these will be

addressed in the next section. In this section we want to specifically address some of the strategies that could be implemented now to make the best use of the scarce resources that constitute the present Pacific mental health workforce.

We have focussed this discussion on the mental health support worker and the preparation of Pacific people for Registration as Comprehensive Nurses. We have limited our discussions to these two groups because as has been noted earlier together they represent the largest proportion of the current Pacific mental health workforce and therefore provide a resource that can be harnessed to create future developments in the shortest timeframe. This is not to argue that the Pacific Mental health workforce does not need to address increased recruitment and retention in other health-related occupations. But they are likely to require more medium- to long-term planning before any worthwhile returns can be achieved. And as was argued in the HWAC report (2002b) given the urgent need to grow the Pacific health workforce, it is necessary “to make the best use of scarce resources... [and] prioritise Pacific workforce development” (p.18).

As has been noted earlier, there does not seem to be a strong case for arguing that Pacific people are not able to be recruited into the Mental Health Support Worker role. As Redican noted in her interview, “I don’t think it is a barrier for recruiting those at the Community Support Workers level. I can find any number who seem to want to come into mental health”. Primarily because the training for this role is contiguous with people being employed at the same time as they receive their training. The barriers to increasing the number of Support Workers are more to do with the structural issue of service providers being limited to employing more FTEs by the nature of their contracts, and in some cases having difficulty in accessing appropriate training.

Recruiting more Pacific people into nursing programmes has to be addressed by challenging some of the access issues to tertiary education, particularly in the Auckland region. Without a proactive response from these institutions, it is difficult to see how the recruitment of nurses into the specialty area of mental health can be advanced. At Whitireia Community Polytechnic such a proactive response has been developed over a number of years, as can be demonstrated by the fact that the annual intake into Year 1 of the programme has almost always achieved a target of Pacific students that reflects the population in the wider community. In more recent years, the Polytechnic has begun to address the more challenging issue of successful completions of Pacific students. In 2004, the first cohort of Pacific students was enrolled into the Bachelor in Nursing (Pacific) programme. This groundbreaking curriculum has been specifically designed to address the particular learning needs of Pacific nursing students in both its’ philosophical underpinning and course content (Southwick and Scott, 2005). Not only are the students required to achieve the same learning outcomes as their colleagues enrolled in the mainstream programme, the BN (Pacific) specifically addresses the issue of preparing these students to be able to work safely and competently with their own Pacific communities. While it is early days (the first cohort completed their State Final exams in November 2006), the retention levels are very encouraging, as is the evidence of their academic achievement.

Apart from the benefits to the students themselves, this programme has also generated some positive unintended responses that if sustained will ensure that the programme will contribute considerably to increasing the numbers of Pacific registered nurses. One of these responses has been the way the programme has

galvanised support and interest from the wider Pacific communities. A second response is that the programme is providing a focal point for Pacific nurses in the region to actively engage in recruiting and supporting the Pacific students. A number of Pacific registered nurses are providing cultural and academic mentoring for the students and there is an increased awareness of supporting the students in their clinical experiences. This has been particularly evident in the Mental health services which mirrors the approach taken by Foliaki and staff at the Faleola Clinic in Auckland.

A second strategy employed at Whitireia for a number of years is the staircasing of programmes. This means those students who enrol in a Level 4 programmes, such as the Mental Health Support Workers programme for example or the Foundation Health Science programme, receive career counselling while enrolled in these programmes to ensure they understand how they can move onto higher level programmes such as Nursing or Social Work. This strategy has worked particularly well for Pacific students who may be ‘second chance’ learners.

These examples are provided to show that Pacific students can succeed in vocational education when the appropriate support is provided which includes among other things Pacific staff represented at the highest levels in this organisation. Pacific students enrolled at Whitireia know that in this institution there is an expectation that they will be successful, and that they will be supported to achieve that success.

While the possibilities being explored at Whitireia are exciting, we would be the first to acknowledge that we are only just beginning to address some of the curriculum issues of pedagogy and knowledge development. These issues are expanded further in the following section.

Community Responsiveness

The issues of pedagogy and knowledge development not surprisingly intersect with the confused levels of knowledge related to mental health services that exist within Pacific communities. In this section we begin by looking at the evidence of Pacific peoples utilisation of mental health services and how this issue relates to questions of recruitment and retention.

Pacific People’s Use of Mental Health Services

As was identified in the key themes from the HWAC symposium referred to earlier, one of the key areas participants felt needed greater attention to encourage Maori and Pacific students into health-related professions was the level of knowledge about these career options at the family and community levels.

This issue is particularly pertinent in the case of developing a recruitment strategy for a Pacific mental health workforce. The critical question is how can we attract Pacific people into the mental health workforce when the community struggles to understand what constitutes “mental health” or ‘mental illness’ in the first place. It can be argued that the low utilisation of mental health services by Pacific peoples is evidence of this lack of knowledge.

According to the Mental Health Commission (2001) there is a significant under-representation of Pacific people receiving mental health services. It is claimed this is due to several reasons including:

- A lack of appropriate services;
- The stigma associated with mental illness;
- Difficulties accessing services; and
- Late presentation leading to high committal rates and the consequent fear of being institutionalised (p.8).

The Ministry of Health's, *Te Tahuu Improving Mental Health 2005-2015 Plan (2005)*, reported that Pacific peoples generally enter mental health services at a later stage of illness and with more severe symptoms than the general population.

In the Consumers and Outcomes Study (CAOS) conducted for the Health Research Council of New Zealand (HRC), Pulotu-Endemann et al. (2004) reported that many Pacific people have a holistic view of mental health, which incorporates cultural paradigms and spiritual beliefs. They are different to mainstream conceptual models and are usually not integrated into the way mental health services are designed and delivered. As a result, many Pacific services users have had negative experiences with the New Zealand mental health system. Many Pacific people are reluctant to use mental health services until they become acutely ill and have no option but to access the services. This may be due to factors such as services not being culturally appropriate, the stigma associated with mental illness by some people or services being inaccessible or inappropriate. Pacific people like to care for their mentally ill family members in their own home but there are often inadequate support services available (Pulotu-Endemann, Annandale and Instone, 2004). These factors contribute significantly to the under-utilisation of mental health services by Pacific people (Lee, 2002).

Some Pacific mental health consumers interviewed by Malo (2000) stated that stigma and discrimination had hindered their recovery. Malo (2000) says that a lack of knowledge of mental health related issues within Pacific communities is alarming. Many family members find it difficult to understand the explanations they are given for mental illness. He argues that most Pacific mental health consumers that he spoke to had difficulty explaining their illness to their family. This, Malo says is the area that hinders recovery the most (Malo, 2002).

In a Samoan perspective of mental health and culturally appropriate services, informants thought they were discriminated against because they felt they were not taken seriously. They thought this happened because they were considered to be too poor to pay for treatment. Participants of this research project stated that an emerging strength of the mental health system was the employment of Pacific Island people as cultural advisors. The implications of having cultural advisers was viewed to be vital towards the bridging of the cultural gaps identified by the participants and evidence that there were moves towards cultural sensitivity (Tamasese et al., 1997).

Discrimination occurs within mental health services as well as in the community. Discrimination within mental health services can create a major barrier to participation. Ethnocentric practices and structure may inadvertently exclude Pacific people from using mental health services. The issue of under-utilisation by

Pacific peoples of mental health services is of considerable concern, not only for those who are currently not accessing the treatment and care their health status warrants, but also for their families and the wider Pacific communities. The disjuncture between a mental health service built on Cartesian euro-centric world views and the holistic world views of Pacific cultures is such that the average Pacific person struggles to understand the concepts of “mental health” and “mental illness”.

The authors of this report would argue that ‘discrimination’ is a consequence of the disjuncture of meaning, not a cause of the disjuncture. To focus attention on ‘discrimination’ and ‘stigma’ runs the risk of dealing with symptoms rather than addressing the underlying causes.

In relation to the focus of this report we would suggest that a central strategy for the recruitment of Pacific peoples into mental health services must begin with a strategy for building the knowledge base of the Pacific communities. Put bluntly, how can we expect to recruit people into a mental health workforce when we have not adequately established an appreciation for these services in the wider Pacific community. More needs to be done in the area of primary mental health promotion and mental health education to explicitly bridge cultural world views in order to create an environmental level of acceptance that would enable people to see a career in Mental Health as a positive and desirable option.

Education and training for mainstream providers can also help to improve services to and for Pacific consumers and their families. Mainstream mental health services have a continued duty to provide services for Pacific peoples and to continue to contribute to nurturing and growing Pacific capacity within their own workforce. At the very least, this will require them to include raising their understanding of Pacific cultures and ethnic-specific differences in relation to mental health and illness. Similarly, training is required for those working closely with mental health services. For example, the Police Service, which often deals with forensic mental health consumers, require anti-discrimination training. This includes education about mental illness, recovery, cultural beliefs and practices (Pulotu-Endemann, Annandale and Instone, 2004).

A positive example of this kind of training is that provided in the Central Region is the ‘Essentially People’ Training Programme which has been designed to implement the vision of Valuing People 2005. The Essentially People programme provides regional training to all categories of workers, from different cultural groups within the mental health sector. A working group has been established to provide advice and guidance in completing Essentially People, and consists of various stakeholders such as service users and their families, NGO’s, Maori, Pacific peoples, DHB provider arm services, mental health services, management and addiction services.

While initiatives such as these may represent a first step in increasing awareness, it does not go far enough in addressing one of the major impediments to increasing the capacity and capability of a Pacific mental health workforce.

What is clear from the previous section is that considerable work has been to demonstrate that there is a cultural difference of understanding between the body of knowledge that constitutes a western bio-psycho-social explanation of mental health and mental illness and Pacific peoples’ holistic world views.

In the preparation of a Pacific mental health practitioner, little research has occurred to begin to mediate this polarity. Pacific peoples are educated into the knowledge and arts of mental health sciences from a western perspective without, (generally), explicitly addressing mental health from a Pacific perspective. On the other hand there are some health workers, grounded in their own Pacific cultures who are skilled at understanding client's behaviours from a Pacific world view.

To date, these two world views have been presented as polar and mutually exclusive bodies of knowledge. The effect of this has been to split our Pacific mental health workforce into two. Those who are professionally educated in western knowledge's, (and criticised for being too palagi - not 'Pacific' enough), and those who have wisdom and understanding of a 'cultural' body of knowledge (often criticised for being under educated and therefore a potential risk to clients). This position is supported by Fepulea'i. She stated that:

“a tension exists between Pacific mental health workers perception of a distinction between cultural knowledge and clinical training. Some of them have told us that cultural stuff is inherent and you lose your culture if you have too much clinical”.

The consequence of this schism is to undermine the potential of this workforce. A house divided against its self will always be weak. Not only will the workforce continue to be a divided force, the Pacific communities themselves will remain confused and unconvinced that mental health services are useful and/or relevant to them as consumers or as a viable career option.

Pacific mental health requires the development of a pedagogical approach that makes explicit the competing epistemologies so that practitioners can be guided to develop their practice in a coherent and measurable way. This process would aid the articulation of 'best practice' and the associated competencies of the different levels of health workers. Two of the major causes people leaving the mental health service is role ambiguity and role conflict (Southwick, 2001; Logovae, 2002). Huse and Cummings (1985) argue that people need to be able to integrate the expectations of their work into a meaningful whole in order to perform the role effectively.

“Problems arise, however, when there is role ambiguity and the person does not clearly understand what others expect of them, or when there is role conflict and the person receives contradictory expectations and cannot satisfy the different role demands” (Huse and Cummings, 1985, p.326).

This definition of role ambiguity and role confusion would seem to describe the situation of many Pacific mental health workers who feel caught between two cultural world views with little or no support to acknowledge the particular pressures of their work experience, leaving them feeling unsafe and vulnerable, or as Logovae (2002) described, professionally isolated. We know from the interviews undertaken, that some mental health service providers are already successfully addressing these issues by providing strong mentoring and supervision along with shared philosophical values about what the service can deliver, resulting in positive recruitment and retention practises. Many of the strategies they have implemented are in keeping with the 'magnet' approach as described by HWAC (2002) as an example of good health workforce management and development.

Summary and Conclusions

In this report the authors have canvassed the major issues related to the recruitment and retention of a Pacific mental health workforce. In undertaking this work it has proven impossible to limit ourselves to a narrow view simply because the barriers for building and developing this workforce are themselves broad-ranging and deeply imbedded in systemic and institutionalised apathy.

The case for greater efforts to be made to recruit and retain a Pacific mental health workforce is premised on two main arguments.

That the current mental healthcare system does not serve Pacific consumers and their families well as indicated by the statistics that show Pacific peoples generally enter mental health services at a later stage of illness and with more severe symptoms (MOH, 2005).

And that the demographic projections that indicate the future health workforce will become increasingly reliant on Pacific (and Maori and Asian) populations. Being able to realise this potential though require changes in the current education systems (both compulsory and tertiary) and in the patterns of employment of Pacific peoples both in mainstream and Pacific specific services.

Three major barriers act to prevent the increased participation of Pacific people in the mental health sector. The first of these relates to issues at the level of Pacific communities. These barriers include:

- The apparent lack of understanding within the wider Pacific community of what benefits the mental health service provides concomitant with the failure to see mental health as a viable career option; and
- The failure to translate western concepts of mental health and illness into Pacific holistic world views and visa versa resulting in disconnected discourses both for the Pacific community and for Pacific health workers within mental health services.

The second cluster of issues relates to the educational sector and its inability to respond adequately to the educational aspirations of many Pacific peoples, creating barriers of supply. Two main areas of concern noted in the report relate to:

- The inequities that currently exist in the compulsory education system to adequately equip Pacific students to successfully access subject choices that open up career options in health-related professions; and
- The failure of the tertiary sector to adequately address the academic and career aspirations of Pacific people.

The final set of issues that creates barriers to greater recruitment and retention of a Pacific mental health workforce relate to systemic barriers and the configuration of mental health services themselves. For example:

- The systemic barriers related to the inflexibility of contracts for services that prevent appropriately trained and skilled people to be employed in Pacific mental health services when they come into the labour market; and
- The systemic service barriers that fail to promote mental health as a positive career option either in Pacific specific services or within mainstream.

From the arguments articulated in this report it ought to be obvious that there are few simple solutions or catchy “PR” promotional responses for addressing the issues of enhancing the recruitment and retention of a Pacific mental health workforce.

What will be effective is a commitment from the health and education sectors to work with Pacific communities to set a realistic goal to address actively the barriers identified in this report over the next five years.

Recommendations

The following recommendations are made based on the information and findings of this study.

1. That a Pacific Mental Health Centre be established to act as an independent body to facilitate, coordinate and monitor the implementation of these recommendations.
2. That the Pacific mental health sector facilitate the development of a pedagogy of Pacific mental health.
3. That this pedagogy is used to inform a primary mental healthcare approach suitable for mental health promotion and education within Pacific communities
4. That the pedagogy informs curriculum development for the preparation of all levels of Pacific mental health practitioners, and is used to develop 'best practice' models of care.
5. That the Tertiary Education Commission require tertiary institutions through their Charters and Profiles to actively address the health career aspirations of Pacific peoples.
6. That the Tertiary Education Commission incentivise institutions that achieve or exceed their Profile targets for Pacific achievement.
7. That the Ministry of Health, District Health Boards and Non-Government Organisations continue to work together to set challenging performance targets related to the recruitment and retention of a Pacific mental health workforce. Included in this work should be a commitment from all parties to reduce the disincentives created by contractual processes.

References

- Anae, M., Anderson, H., Benseman, J., and Coxon, E. (2002). Pacific peoples and tertiary education: Issues of participation. University of Auckland report prepared for the Ministry of Education. Wellington.
- Annandale, M., and Instone, A. (2004). *Sei Tapu. Ole Ala Ole Ola: Evaluation of the National Certificate in Mental Health Support Work*. Wellington: Mental Health Support Worker Advisory Group.
- Becker, F. (2005). *Recruitment and retention: Magnet Hospitals*. Dissertation in partial fulfilment of a Masters Degree in Nursing. Otago Polytechnic. Dunedin.
- Central Region's Technical Advisory Services (TAS). (2005). Essentially people training programme. (In draft) (2005-2009) Regional Mental Health Strategic Workforce Development Plan Discussion Document. Wellington: Central Region's Technical Advisory Services.
- Central Region's Technical Advisory Services (TAS). (2005). *Valuing People*. (2005-2009) Regional Mental Health Strategic Workforce Development Plan Discussion Draft. Wellington: Central Region's Technical Advisory Services.
- Huse, E., and Cummings, T. (1985). *Organisation and development change*. 3rd Edition. San Francisco. West Publishing Co.
- HWAC (Health Workforce Advisory Committee). (2002a). *The New Zealand Health Workforce: A stock take of issues and capacity. 2001*. Wellington: Health Workforce Advisory Committee.
- HWAC (Health Workforce Advisory Committee). (2002b). *Framing Future Directions Discussion Document*. Wellington: Health Workforce Advisory Committee.
- HWAC (Health Workforce Advisory Committee). (2005). *Promoting Maori and Pasifika into Health, Science and Technology Symposium*. Jointly sponsored by the Maori Health and Disability Sub-Committee of HWAC and the Royal Society of New Zealand. Wellington: Health Workforce Advisory Committee <http://www.hwac.govt.nz/MaoriHealthTOR.htm>.
- Instone, A. (2005). Pacific Mental Health Workforce Development Organization Feasibility Study Literature Review (In Draft). Wellington: Ministry of Health.
- Koloto, A. (2003). National survey of Pacific nurses and nursing students. Unpublished report prepared for the Ministry of Health on behalf of the Samoan Nurses Association of New Zealand. Inc.
- Lee, Evelyn, L.C.S.W., Ed.D., (Ed.). (February 2002). *Meeting the Mental Health Needs of Asian and Pacific Islander Americans*. National Technical Assistance Centre for State Mental Health Planning (NTAC). Cultural Diversities Series. University of Hawaii.
- Logovae, F. (2002). Practising at the crossroads. (Unpublished Masters Thesis). Victoria University of Wellington.

- Malo, V. (April, 2000). *Pacific People Talk About Their Experiences With Mental Illness*. Recovery Series Three. Wellington: Mental Health Commission,
- Macpherson, C., Spoonley, P., Anae, M., (2001) *Tangata o te Moana Nui: the evolving identities of Pacific Peoples in Aotearoa/New Zealand*. Palmerston North: Dunmore Press.
- Mental Health Commission. (2001). *Pacific Island Mental Health Services and Workforce. Moving on the Blueprint*. Wellington: Mental Health Commission.
- Mental Health Commission. (2003). *Annual Report*. Wellington. Mental Health Commission.
- Ministry of Health. (1994). *Looking Forward*. Wellington: Ministry of Health.
- Ministry of Health. (October 2003). *Achieving Health for All People - Whakatutuki te orange hauora mo nga Tangata katoa: A framework for public health action for the New Zealand Health Strategy*. Wellington: Ministry of Health
- Ministry of Health and Ministry of Pacific Island Affairs. (2004). *Tupu Ola Moui: Pacific Health Chart Book*. Wellington: Ministry of Health.
- Ministry of Health. (2004). *The health and independence report*. Director-General of Health's Annual Report on the State of Public Health. Wellington: Ministry of Health.
- Ministry of Health. (2005). *Te Orau Ora: Pacific Mental Health Profile*. Wellington: Ministry of Health.
- Ministry of Health. (2005). *Te Tahuu. Improving Mental Health. 2005-2015 Plan*. Wellington: Ministry of Health.
- Mulvale, G. (2004). *Health Human Resources Planning for Mental Health Services: Lessons Learned from a Review of Experiences in the U.K., Australia and New Zealand*. Ontario: Strategic Policy Unit, Mental Health and Rehabilitation Reform Branch. Ontario Ministry of Health and Long-Term Care.
- National Addiction Centre. (2005). *Matua Raki: National Addiction Treatment Sector Workforce Development Programme 2005-15*. Christchurch: National Addiction Centre.
- Pasikale, A., Yaw, W., and Apa, K. (1998). *Weaving the Way, Pacific Islands Peoples' participation in the provision of learning pathways for Pacific Islands learners*. Wellington: Education Training Support Agency.
- Puloto-Endermann, K., Annadale, M., and Instone, A. (2004). *A Pacific perspective on the New Zealand Mental Health Classification and Outcomes Study*. Auckland: Health Research Council of New Zealand.
- Southwick, S., and Scott, W. (2005). *Acknowledging the potential for hegemonic nursing as an agency for hegemonic power and learning to create the space for cultural diversity*. 31st Annual Conference of the Transcultural Nursing Society. September. New York.

- Statistics New Zealand. (2002). *Pacific Progress: A report on the economic status of Pacific Peoples in New Zealand*. Wellington: Statistics New Zealand.
- Statistics New Zealand. (2006). *National ethnic population projections 2001 (base) - 2021 update*. <http://www2.stats.govt.nz>. Wellington: Statistics New Zealand.
- Tamasese, K., Peteru, C., and Waldergrave, C. (1997). *A qualitative Investigation into Samoan Perspectives on Mental Health and Culturally Appropriate Services*. Wellington: Family Centre. Lower Hutt

Appendix

List of Participants Interviewed

Organisation	Contact
Faleola Clinical Mental Health Services	Contact: Dr Siale Foliaki Angeline Hekau
Penina Residential Care	Contact: Roine Lealaialoto
Waitemata District Health Board	Contact: Margi Fepulea'i Lincoln Papali'i
Pacificare Trust	Contact: Afa K. Manoa
Vakaola Trust	Contact: Tevita Finau
Tupu Alcohol and Drug Services	Contact: Bruce Levi
Isalei Mental Health Services	Contact: Kirk Mariner
Auckland District Health Board	Contact: Aseta Redican