PACIFIC MENTAL HEALTH SERVICES AND WORKFORCE

Moving on the *Blueprint*

Mental Health COMMISSION

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Foreword

Talofa lava; Kia orana; Malo e lelei; Fakalofa lahi atu; Taloha ni;
Ni sa bula vinaka; Kia ora; Greetings

This paper presents the culmination of work originated by Dr Siale Foliaki with the assistance of the Mental Health Commission's Pacific People's Advisory Committee (1997-2001) to raise awareness and understanding about key Pacific mental health service and workforce capacity building issues. It emphasises the importance of acknowledging the cultural and intergenerational values and diversity that exists amongst Pacific people. It proposes that Pacific perspectives on health must be fully understood if the needs of Pacific people are to be better met by mental health services in New Zealand. The Pacific view on mental health is intrinsically bound to the holistic view of health. It is therefore important that future planning of Pacific mental health services and other health services are fully informed of this world-view in their service planning for Pacific peoples.

This can best be done by working at all levels in partnership with Pacific peoples and by all agencies making sure they have good processes in place to incorporate a Pacific point of view. This is an essential response required of all District Health Boards.

This paper builds on the Pacific sections of the Commission's 1998 *Blueprint for Mental Health Services in New Zealand*, which is now Government mental health policy. The *Blueprint* describes the resources and service-user centred approach to service delivery that the sector needs to fully implement the National Mental Health Strategy; section 7 is dedicated to Pacific services.

The purpose of this paper is to inform the Ministry of Health's future policy, District Health Boards' funding decisions and all providers who work with Pacific peoples, to assist them to develop effective ways of addressing those issues. It is very encouraging to see a growing number of Pacific mental health service providers working to meet the mental health needs of Pacific peoples, especially in the NGO sector. It is particularly important that all District Health Boards are responsive to the needs of Pacific service users, and their families and communities, not just in areas of high Pacific population, but wherever there are Pacific people who need to access culturally-relevant mental health services.

This paper is intended as a key resource for the mental health sector, but others with an interest in Pacific mental health, such as non-health policy analysts, public health and educator workers and community groups, may also find this paper useful.

The Mental Health Commission welcomes comments and further discussion on the paper.

Dr Barbara Disley	Bob Henare	Mary O'Hagan
Chair	Commissioner	Commissioner

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Executive Summary

This discussion paper highlights key issues for Pacific mental health services and workforce development. Pacific people living in New Zealand comprise approximately 6 percent of the New Zealand population, which will double to 12 percent by 2051. Socio-economic trends, together with the demographic characteristics of the Pacific population suggest particular mental health needs of Pacific people will need to be addressed.

The Mental Health Commission has developed this discussion document as part of its work to ensure implementation of the National Mental Health Strategy. Overall, this report highlights the need for a long-term, planned approach to the provision of Pacific mental health services and workforce development. The right services need to be planned for Pacific peoples in the right amounts, in the right places, and performed by the right people at the right times.

Pacific perspectives on mental health

Central to more effectively meeting the mental health needs of Pacific people is to fully understand Pacific perspectives on health. The mental health of Pacific people is intrinsically bound to the holistic view of health captured by the Fonofale model that incorporates beliefs and values relating to family, culture and spirituality.

Basic to a Pacific community development model for mental health are Pacific services. There is no simple definition of a Pacific mental health service, but there are some key factors to be considered in determining whether a service can be called a Pacific service. These include the key elements of Pacific involvement in governance and management of the service, Pacific staff and health professionals, a service based on Pacific models of health and Pacific beliefs and values, and a focus on providing for Pacific people in culturally appropriate ways.

The provision of mental health services for Pacific people

In the 2000/01 funding period, $9.51 million was directed to Pacific mental health services.[1] This does not include mainstream services used by Pacific peoples. The $9.51 million funds approximately 112 FTEs and 17 residential beds around the country. There are several major Pacific non-government organisations offering a variety of services in Auckland, Wellington and Canterbury regions. In addition, a number of Pacific mental health services are located within DHBs. The 2000/01 expenditure on specifically Pacific mental health services was distributed among 20 providers, including six DHBs.

This discussion paper identifies a range of key problems in the provision of mental health services for Pacific people including:

- stigma and discrimination against those with mental illness is a serious problem in the mental health system, in Pacific communities and in the wider society
- Pacific-focused services are viable in areas where the Pacific population is highly concentrated, and mainstream services everywhere need to be responsive and flexible for their Pacific communities
- there are issues concerning the quality and sustainability of Pacific services, including provider infrastructure and management, the skills of the workforce and service standards
- a lack of appropriate services of Pacific people is particularly evident in the area of child, youth and family

[1] Figures supplied by Ministry of Health.

- greater application of holistic models for Pacific mental health is required, including establishing and maintaining links between mental health, primary health and social services
- DHBs need to understand, and be responsive to the needs of Pacific communities with regard to mental health service planning, funding and delivery
- there is a significant dearth of timely, accurate and rigorous data and research about the mental health status of Pacific people. Information on the Pacific mental health workforce must also be routinely collected.

The Pacific mental health workforce

A survey of the mental health sector, commissioned by the Mental Health Commission in 1999,[2] provided an estimate of the number of Pacific workers in the mental health workforce. A total of 175 Pacific staff from various ethnic groups and working in a range of occupations in the mental health workforce were surveyed, and results were obtained from 167 respondents. The survey indicates that, at 2.5 percent of the mental health workforce, Pacific people are significantly under-represented in the mental health workforce compared to their representation in the population as a whole.

Key issues in developing a sustainable Pacific mental health workforce are:

- more Pacific people need to be recruited into the mental health workforce, at all levels and in all occupations
- Pacific mental health professionals are in such short supply that increasing their numbers is a high priority
- retention of the workforce is a critical issue
- significant effort is needed to increase the percentage of Pacific mental health workers with appropriate health qualifications
- there is a pressing need to upskill the current Pacific mental health workforce so that they are culturally as well as clinically competent
- people from all Pacific ethnic groups need to be recruited into the mental health workforce
- a variety of issues regarding traditional healers need addressing.

With regard to specific occupational groups:

- there are very few Pacific psychiatrists and Pacific clinical psychologists in practice or in training
- key issues for Pacific nurses include how to increase the numbers choosing mental health nursing (especially attracting male nurses), and how to make better use of current Pacific nursing staff in the sector
- the social work profession attracts a considerable number of Pacific people, however, the actual number of social workers in the Pacific mental health workforce is still small
- occupational therapy and counselling have a low profile among Pacific people
- the mental health support worker initiative is relatively new in the mental health sector, but appears to be of considerable benefit to Pacific service users and mainstream providers
- Pacific consumer advisors have an important role in ensuring that mental health services are culturally relevant and beneficial to Pacific peoples

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[2] See Section 5 for a discussion of the Pacific workforce survey.

- the role of matua must be recognised as an integral part of mental health services for Pacific people
- successful progress towards increasing the number and skills of Pacific managers is essential for Pacific provider development and growing sector capacity.

Estimates of resources needed

Section 7 provides estimates of the mental health services resource needs of the Pacific population, including the resources required to provide dedicated Pacific secondary mental health services that are consistent with the Mental Health Commission *Blueprint for Mental Health Services in New Zealand: How things need to be* (Blueprint) resource guidelines. The analysis takes population data and the *Blueprint* resource guidelines as the basis of determining a fair allocation of resources for Pacific people in New Zealand across both mainstream and dedicated Pacific mental health services. Overall, the analysis suggests that 291 inpatient and community beds and 383 community FTEs are required for the Pacific population. Of those, around 101 inpatient and community beds and 152 community FTEs could be expected to be delivered through to dedicated Pacific services.

Recommendations

The paper makes recommendations for further work to be done in the following areas:

- Pacific mental health service framework development
- Pacific provider development
- Pacific workforce development
- increasing cultural responsiveness of mainstream services to Pacific peoples
- promoting and implementing anti-discrimination work among Pacific peoples
- partnerships with Pacific service users
- information and research needs in relation to Pacific mental health.

1 Introduction

The purpose of this discussion paper is to:

- highlight key issues for Pacific mental health services and workforce development
- explore Pacific perspectives and models of mental health service provision
- estimate the resources required for the provision of mental health services for Pacific people, and
- recommend further work for developing effective and responsive Pacific mental health services, delivered by both Pacific and mainstream services.

The Mental Health Commission has developed this discussion paper as part of its work to ensure implementation of the National Mental Health Strategy. This paper is informed by a number of key reports outlined in Appendix 1. In particular, it draws on the Mental Health Commission's *Blueprint for Mental Health Services in New Zealand* (Blueprint).

Overall, this report highlights the need for a long-term, planned approach to the provision of Pacific mental health services. Government has recognised the complexities involved in protecting the mental health of Pacific people and meeting the needs of Pacific individuals and their families using mental health services. The significant deficiencies in mental health services for Pacific people have been well documented, with considerable work on identifying issues, setting goals and making recommendations for the comprehensive provision of Pacific mental health services. Yet there has been little movement in providing appropriate and effective services for Pacific people *(Ministry of Health 1998: 48)*. Analysis of current policy settings suggests that there is a weak strategic focus on Pacific mental health. A stronger and more sustained focus is needed to ensure that health agencies respond more effectively to the mental health needs of Pacific communities.

The Mental Health Commission considers that there is a pressing need for capacity building in the Pacific mental health sector to ensure that District Health Boards (DHBs) and Pacific providers are able to address the mental health needs and priorities of Pacific peoples. It is particularly important that DHBs in areas of high Pacific population increase their capacity to respond effectively. It is equally important that Pacific people living outside of those areas also receive the most appropriate and effective services.

The Mental Health Commission expects that this report will assist the Ministry of Health and DHBs in understanding firstly, the issues involved in Pacific mental health services and workforce development, and secondly, to develop effective ways of addressing those issues.

The report is structured as follows. Section 2 provides a contextual overview by setting out the socio-economic characteristics of Pacific peoples in New Zealand and the relevant health policies and structures in the context of Government's priorities to improve socio-economic outcomes for Pacific peoples. Section 3 presents Pacific perspectives on mental health, including the concept of recovery from a Pacific perspective and a Pacific community development model for mental health.

Services for Pacific people with mental illness need to recognise and use both the recovery approach and Pacific community-based approaches to mental health service delivery, such as the Fonofale model. The next four sections address Pacific service and workforce needs:

- section 4 describes the current range of mental health services available for Pacific people, and identifies key issues and gaps in services
- section 5 reports on a survey of the Pacific mental health workforce undertaken in 1999 for the Mental Health Commission
- section 6 identifies key issues for Pacific workforce development

- section 7 provides estimates of the resources needed for the provision of mental health services for Pacific people.

Finally, section 8 makes recommendations for developing effective and responsive Pacific mental health services.

2 Contextual Overview

The Pacific population

Pacific people[3] living in New Zealand comprise just over 200,000, approximately 6 percent of the New Zealand population. The Pacific population is characterised by high fertility and a high population growth rate that has the momentum for further growth in the 21st century. Projections estimate that the Pacific population will double from 6 percent of the population in 1996 to 12 percent by 2051 (*Cook et al 1999)*. The Pacific population has distinctive characteristics, being generally a more youthful and more urban-based population than other New Zealanders. According to the 1996 Census *(Statistics New Zealand 1998a)*, key features of the Pacific population are:

- the Pacific population is ethnically diverse. It is predominately made up of four island groups, namely Samoan (50 percent), Cook Island (23 percent), Tongan (16 percent) and Niuean (9 percent)
- the majority (58 percent) of Pacific people were born in New Zealand. However, those born overseas tend to be older, with a median age of 35.6 years, whereas New Zealand-born have a median age of just over 11 years
- the overseas-born Pacific population is well settled in New Zealand, with 61 percent having lived in the country for 10 years or more
- only 4.6 percent of the Pacific population were 60 years and older in 1996, compared to 15.4 percent for the total New Zealand population. Thirty-nine percent of the Pacific population were under 15 years, compared to 23 percent for the total population. In 1996 the median age of the Pacific population was 20.4 years, compared to 33 years for the total population
- change in Pacific families show a significant trend away from marriage, as well as marriage at older ages. In 1996 sole parent families made up almost one in three families in which there was at least one member of Pacific ethnicity. Just over one third of Pacific people lived in extended families in 1996
- more than 80 percent of Pacific people live in urban areas of 30,000 and over. The majority of Pacific people (65 percent) live in the Auckland Regional Council area, with large concentrations in south and central Auckland. Only the Tokelauan group is more likely to live outside of Auckland, with 53 percent in the greater Wellington urban area
- there is diversity in language knowledge and use. Eighty-nine percent of the Pacific population in New Zealand speak English. The most common Pacific language is Samoan, spoken by 35 percent of Pacific people. The next most common language spoken is Tongan. Those two Pacific communities have the largest proportions of people who do not speak English. Ability to converse in two languages is relatively high among Pacific people, with 48 percent reporting this in 1996. Those born overseas are at least twice as likely as New Zealand-born to speak their Island language.

Social and economic status

There are clear gaps in the health, educational, employment, income and housing status of Pacific peoples compared to other New Zealanders. Many commentators do not expect those

[3] 'Pacific people' describes the wide variety of people living in New Zealand who have migrated from the Pacific Islands or who identify with the Pacific Islands because of ancestry or heritage. The term encompasses a range of ethnic, national, language and cultural groupings *(Ministry of Pacific Island Affairs 1999)*.

gaps to close quickly *(Ministry of Pacific Island Affairs 1999: 11)*. According to the Ministry of Pacific Island Affairs:

- Pacific people's unemployment rate is consistently higher than that of the total population
- the median income of Pacific people is the lowest median income of all ethnic groups. However, the New Zealand-born Pacific population has a higher median income than Pacific people born overseas.

In addition:

- Pacific adults are less likely to have a degree or vocational tertiary qualification, and Pacific school leavers are less likely to go directly on to tertiary education than the rest of the population *(Ministry of Education 1999)*
- Pacific households are over-exposed to household overcrowding. They experience the highest overcrowding rates of all groups *(Statistics New Zealand 1998b)*
- Pacific households are less likely to own a car or to have a telephone than other households *(Ministry of Pacific Island Affairs 1999: 11)*.

Socio-economic impacts on Pacific peoples' mental health

Many overseas studies that have investigated rates of psychiatric illness in immigrant populations show that understanding the mental health of immigrant populations is a complex matter. Migrants face particular mental health issues associated with adjustment, a potentially weakened cultural base and economic difficulties. Migrant communities that fail by the second generation to make progress up the economic ladder will be at risk of major increases in rates of mental illness, particularly as their own culture comes increasingly under siege in their new country. Improved social and economic conditions will be important for the maintenance of Pacific cultures and therefore of Pacific people's mental health.

Socio-economic trends, together with the demographic characteristics of the Pacific population suggest there are a number of significant risk factors influencing Pacific mental health. Experts on Pacific mental health consider that Pacific people may be the biggest at risk group in this country in coming years (*Ministry of Health 1997a:25*). This is because of:

- the relatively youthful age structure of the Pacific population at risk of developing serious mental illnesses
- increasing numbers of New Zealand-born Pacific people growing up in single parent households with the accompanying dislocation from extended family networks and resulting in increasing cultural and community fragmentation
- the weakened position of the church in New Zealand's Pacific cultures
- rising unemployment, low income, and poor housing, with a second generation of New Zealand-born Pacific people likely to grow up in relative poverty, and
- rising alcohol and drug problems especially among Pacific youth.

As a socially disadvantaged group, Pacific peoples are likely to be more vulnerable to mental stressors and some disorders. Pacific peoples experience high levels of discrimination and inequity. It has been recognised that strategies are needed that remove discrimination and promote true equity and self-determination opportunities for Pacific peoples across all levels of social institution – political, social, educational, religious, cultural and family *(Ministry of Health 1997c: 469)*. The right services need to be planned for Pacific peoples in the right amounts, in the right places, and performed by the right people at the right times.

However, there are limitations in data collected on Pacific mental health. Currently, much of the key evidence about Pacific people's mental health is drawn from institutional statistics, primarily admissions to psychiatric facilities. The sparse data available on Pacific mental health status

suggests that there is a low incidence of many conditions of mental illness among Pacific people *(Health Funding Authority 1999)*. Pacific people appear to have low first admission rates to psychiatric hospitals, public hospital psychiatric units and institutions licensed under the Alcohol and Drug Addiction Act *(Public Health Commission 1995)*. Pacific youth suicide also appears to be low, although health workers in Pacific communities regard suicide and self-harm attempts among young Pacific people as under-recorded, and a serious mental health issue.

Published statistics do not adequately represent the levels of stress and trauma faced by Pacific people. There is dissonance between the available data on the mental health status of the Pacific population, and the experience of Pacific advisory groups and those working with Pacific communities, in that Pacific people are increasingly at risk of mental illness.

> *While the incidence of mental illness is low, migration, social disorganisation, unemployment and urbanisation have been found to be closely linked with increasing incidence of mental illness. These adverse circumstances are usual for many Pacific families living in New Zealand and it is only a matter of time before serious mental illness incidence will exceed event rates reported for other New Zealanders ... Responses from health agencies to the health problems of Pacific people in New Zealand have been predictable and ineffective ... It is clear that conventional thinking is inadequate and Pacific communities need innovative solutions together with greater participation. (Tukuitonga, 1997: 5).*

The Treaty of Waitangi

The Treaty of Waitangi is acknowledged in all aspects of health service provision. The Pacific peoples of New Zealand acknowledge and respect the Treaty of Waitangi as a covenant between the tangata whenua of Aotearoa and the government representatives of all other settlers of this land. Special recognition is also given to the whanaungatanga relationship that exists between the tangata whenua and peoples of the Pacific. Our shared ancestry is a uniting force in our collective aspirations for our peoples.

The policy context

In acknowledgement of these critical demographic, social and economic features of the Pacific population in New Zealand, one of the Government's priorities is to improve social and economic outcomes for Pacific peoples.

Improvements in Pacific health are expected to come about through two key mechanisms:

- improving responsiveness and accountability of public sector agencies to Pacific health needs and priorities, and
- building the capacity of Pacific peoples, through provider, workforce and professional development, to deliver health and disability services and to develop their own solutions to health issues.

The Ministry of Pacific Island Affairs, the Ministry of Health, District Health Boards and the Mental Health Commission all have key roles in improving Pacific mental health. Their roles and responsibilities are outlined below.

Ministry of Pacific Island Affairs: Pacific capacity building

The *Pacific Vision Strategic Pacific Directions* (1999) document released by the Ministry of Pacific Island Affairs has a key vision to improve health outcomes for Pacific peoples in New Zealand. Its focus is on building the capacity of Pacific peoples. To implement that strategy, the Ministry of Pacific Island Affairs has developed eight Programmes of Action on behalf of Pacific communities

in eight regions.[4] The Programmes of Action reflect what the communities have identified as their priorities in health, housing, education, employment, economic development and social services, and the specific actions deemed necessary to address these priorities.

Ministry of Health: improving Pacific health

The Ministry of Health is required through the Crown Funding Agreement to develop and implement plans to improve Pacific health. Specific outputs include developing Pacific providers, and improving Pacific provider effectiveness in delivering health and disability services. The Ministry of Health has established a Pacific Health Branch to focus on Pacific health issues, and also a Pacific Reference Group to support the Ministry's accountability for improving Pacific health.

The health strategies and implementation plans released by the Ministry of Health that impact on Pacific peoples are:

- the *New Zealand Health Strategy* (2000) is the key framework within which the health sector will develop. The Strategy has a priority objective to reduce health inequalities for Pacific peoples. Improving service delivery for Pacific peoples is a short to medium priority
- the *New Zealand Disability Strategy* (2001) seeks to promote a fully inclusive society where disabled people are valued and can fully participate in community life. Objective 12 requires actions for promoting participation of disabled Pacific peoples
- the *Primary Health Care Strategy* (2001) provides an overall framework for District Health Boards for the organisation and delivery of primary health care. Pacific peoples face considerable barriers in accessing primary services, including cost and cultural barriers.

Mental Health Commission: implementing the *Blueprint*

The Mental Health Commission gives high priority to improving Pacific mental health. The implementation of the Mental Health Commission's *Blueprint* framework for mental health service development is a requirement under the Crown Funding Agreement. The focus of the *Blueprint* is on a recovery approach to service delivery.

The *Blueprint*'s message on Pacific mental health services is that it supports services using an holistic approach to Pacific mental health and increasing ownership and provision of services for Pacific people as the best means of achieving improvements in the quality of life for Pacific consumers. However, the Mental Health Commission also recognises that provision of separate services is not feasible in all areas, and that there must be good provision for Pacific people in mainstream mental health services.

The Mental Health Commission currently has a Pacific person on its advisory committee and the Service User Reference group, has access to strategic advice from an eight member Pacific Reference Group, and runs a Pacific mental health work programme. Special focus has been given to promoting the Pacific user perspective in recovery from mental illness including funding Samoan and Tongan translations of the Pacific recovery booklet *(Malo 2000)*. Recovery competencies have been developed for mental health workers that require demonstrated knowledge of Pacific cultures *(Mental Health Commission 2001)*. In addition, the Commission has produced a checklist to assist mental health services to ensure that their services are assisting Pacific people's recovery *(Mental Health Commission 2000a)*.

District Health Boards: funding the provision of Pacific services

Twenty-one District Health Boards (DHBs) have been established with the enactment of the New Zealand Public Health and Disability Act 2000 to replace the funding and planning functions of the

[4] The eight regional Pacific communities were: North Shore, Auckland Central, Waitakere City, Manukau City, Hamilton, Hutt Valley, Porirua and Christchurch.

former Health Funding Authority. DHBs are responsible for deciding on the mix, level and quality of health and disability services to be provided for the populations, including Pacific peoples that they serve, according to government-set parameters. On July 1 2001, the responsibility for funding services in mental health, personal health and Maori health was transferred from the Ministry of Health to DHBs by Order in Council. Further service agreements will be devolved to DHBs in October 2001.

DHBs are required to assess local Pacific population needs and priorities, consult local Pacific communities, and plan, fund and support further development of Pacific providers and organisations. Active participation of Pacific peoples at all levels of the health and disability sector, especially in health decision-making, is a critical success factor in obtaining positive health outcomes for Pacific peoples. DHBs can be expected to develop a long-term commitment to working with Pacific constituents. Seven DHBs with significant Pacific populations in their regions[5] should have an especial Pacific focus and ensure input into DHB health planning from Pacific providers, communities and users.

[5] Waitemata, Auckland, South Auckland (Counties-Manukau DHB), Waikato, Hutt Valley (Hutt DHB), Wellington (Capital and Coast DHB), and Canterbury.

3 Pacific Perspectives on Mental Health

Pacific people in New Zealand come from very separate and diverse groups. There is also a growing number of Pacific people born in New Zealand who are influenced by contemporary ideas that change their view of traditional cultural values and perspectives. Greater acknowledgement and respect for the cultural and intergenerational diversity that exists amongst Pacific people is therefore essential. It is difficult to always capture this diversity and the differing perspectives and systems of social organisation of different Pacific groups and generations. However there are sufficient shared characteristics that allow identification and discussion of a "Pacific worldview" on mental health.

Pacific perspectives on health must be fully understood if the needs of Pacific people are to be better met by mental health services in New Zealand. The mental health of Pacific people is intrinsically bound to the holistic view of health captured by the Fonofale model.

The Fonofale model of health

The Fonofale model was created by Fuimaono Karl Pulotu-Endemann as a Pacific Island model of health for the use in the New Zealand context. The Fonofale model is named after Fuimaono Karl's maternal grandmother Fonofale Talauega Pulotu Onofia Tivoli.

A description of the Fonofale model first appeared in the Ministry of Health report, *Strategic Directions for Mental Health Services for Pacific Island People (1995).* However, the Fonofale model's development dated back to 1984 when Fuimaono Karl was teaching nursing and health studies at Manawatu Polytechnic. The model had undergone many changes prior to 1995.

The Fonofale model incorporates the values and beliefs that many Samoans, Cook Islanders, Tongans, Niueans, Tokelauans and Fijians had told Fuimaono Karl during workshops relating to HIV/AIDS, sexuality and mental health in the early 1970s to 1995. In particular, these groups all stated that the most important things for them included family, culture and spirituality. The concept of the Samoan fale or house was a way to incorporate and depict a Pacific way of what was important to the cultural groups as well as what the author considered to be important components of Pacific people's health. The Fonofale model incorporates the metaphor of a house, with a roof and foundations.

The roof

The roof represents cultural values and beliefs that is the shelter for life. These can include beliefs in traditional methods of healing as well as western methods. Culture is dynamic and therefore constantly evolving and adapting. In New Zealand, culture includes the culture of New Zealand-reared Pacific people as well as those Pacific people born and reared in their Island homes. In some Pacific families, the culture of that particular family comprises a traditional Pacific Island cultural orientation where its members live and practice the particular Pacific Island cultural identity of that group. Some families may lean towards a Palagi orientation where those particular family members practise the Palagi values and beliefs. Other families may live their lives in a continuum that stretches from a traditional orientation to an adapted Palagi cultural orientation.

The foundation

The foundation of the Fonofale represents the family, which is the foundation for all Pacific Island cultures. The family can be a nuclear family as well as an extended family and forms the fundamental basis of Pacific Island social organisation.

The pou

Between the roof and the foundation are the four pou or posts. These pou not only connect the culture and the family but are also continuous and interactive with each other. The pou are:

> *Spiritual – this dimension relates to the sense of well-being which stems from a belief system that includes either Christianity or traditional spirituality relating to nature, language, beliefs and history, or a combination of both.*
>
> *Physical – this dimension relates to biological or physical wellbeing. It is the relationship of the body, which comprises anatomy and physiology as well as physical or organic substances such as food, water, air, and medications that can either have positive or negative impacts on the physical wellbeing.*
>
> *Mental – this dimension relates to the health of the mind, which involves thinking and emotion as well as behaviours expressed.*
>
> *Other – this dimension relates to various variables that can directly or indirectly affect health such as, but not limited to, gender, sexual orientation, age, social class, employment and educational status.*

The Fale is encapsulated in a cocoon that contains dimensions that have direct or indirect influence on one another. These are:

> *Environment – this dimension addresses the relationships and uniqueness of Pacific people to their physical environment. The environment may be a rural or an urban setting.*
>
> *Time – this dimension relates to the actual or specific time in history that impacts on Pacific people.*
>
> *Context – this dimension relates to the where/how/what and the meaning it has for that particular person or people. The context can be in relation to Pacific Island-reared people or New Zealand-reared people. Other contexts include politics and socio-economics.*

The concept of recovery from a Pacific perspective

Recovery happens when an individual can live well in the presence or absence of his or her mental illness. It is different for everyone. Pacific people believe that mental health is dependent on all aspects of a person's life being in harmony: spiritual, physical, emotional and family. This holistic approach to mental health is inherent in the different belief systems and life quality needs of Pacific peoples.

The family is a key component of Pacific cultures and plays an important role in Pacific people's lives. The support of one's family and community are perhaps the areas most critical for an individual's recovery *(Malo 2000: 28)*. As Malo *(2000: 16-17)* comments:

> *With the important role of the extended family in the lives of Pacific Islanders, cousins often become their friends, the elders become their leaders, and the extended family as a whole, becomes the community. Pacific Island cultures are different from almost every other culture in New Zealand because the extended family plays such as important role in their lives. This is why families can have such a large impact on recovery.*
>
> *Even Pacific Island mental health service providers create a family unit within the service, where consumers are able to stay in touch with themselves, and seek out their cultural heritage. If the true family environment is lacking at home, Pacific Island services provide a family environment, under a strong Polynesian influence.*

To Pacific peoples, the family can either hold the key to recovery, or be a great hindrance to recovery. An aspect causing particular distress for many Pacific service users is the difficulties their families face in understanding mental illness in general, as well as the specifics of the individual's illness. The role of mental health services in educating families about mental health and assisting them is crucial to the individual's recovery. Information about mental health issues in Pacific languages is severely lacking in New Zealand. Many Pacific families and communities have to learn about mental health issues from what information they can gather as they see a family or community member through services. This severely disadvantages Pacific peoples because most of the information is in English, a language that some find difficult to speak, let alone read. If any steps towards recovery for Pacific peoples are to be made in mental health services, education for non-English speaking Pacific peoples will have to be one of the priorities.

Pacific mental health service users 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. Importantly, Pacific consumers can more easily identify with Pacific staff who bring Pacific cultural understandings and belief systems to the service *(Malo 2000: 13)*. It also helps families to better understand mental illness when they can communicate in their own language with the service, and be comfortable in a supportive cultural environment.

Stigma and discrimination play a role in hindering recovery. Pacific service users find they not only experience stigma within their communities, but are also confronted with lack of understanding within mental health services. Sometimes this is expressed through staff prejudice and stereotypes, where Pacific people are assumed to be violent, or certain behaviour is misconstrued as rude or disrespectful *(Malo 2000: 21)*. Some staff misread normal cultural behaviour as signs of illness. In other instances, inappropriate counselling models based on European cultural values and practices are delivered to Pacific clients.

In summary, significant issues that Pacific people face in relation to mental health include:

- a high degree of stigma associated with experiencing mental illness in both Pacific and other communities
- poor access to mainstream mental health services
- late presentation leading to high rates of committal under the Mental Health (Compulsory Treatment and Assessment) Act and incarceration within the forensic mental health services
- a lack of services specifically designed to meet the needs of Pacific people whose language and cultural beliefs make successful engagement difficult. This is especially evident in the area of child, youth and family
- a lack of a sufficiently large and appropriately skilled Pacific mental health workforce
- the lack of an acknowledged, credible model for addressing the challenges facing Pacific communities in relation to their mental health
- the absence of Pacific representation at a national level. Currently the mental health sector does not have any Pacific individual or organisation with lead responsibility for addressing Pacific mental health issues
- lack of clarity around how DHBs will develop capability in assessing the needs of local Pacific population, and consult with Pacific providers, service users and communities.

Addressing these challenges would make an enormous positive difference to the recovery of Pacific people with mental illness. It is clear however that conventional approaches and thinking have been inadequate in addressing Pacific mental health issues. There is a need for a strong community-based approach to Pacific mental health service development.

Table 3.1: Recovery aids and barriers for Pacific people[6]

Recovery aids
• Being treated with dignity and respect • Family understanding of mental illness and support • Involvement of service users and families in design and delivery of individual care planning and treatment • Faith and spirituality • Personal strength to overcome adversity of mental health experience • Effective strategies for overcoming cultural and communication (language) barriers • Community-oriented services • Supportive staff who put great effort into, and care about what they do • Pacific peoples services and staff • Right medication and treatments • Working in the mental health sector e.g. as a consumer advisor, advocate, interpreter, mental health worker
Recovery barriers
• Lack of understanding by communities and families • Cultural stigma of having mental illness • Lack of knowledge within Pacific communities of mental health issues • Discrimination • Exclusion by the church • Lack of self-help information especially in early stages of illness • Coercive staff practices and breaches of human rights • Lack of staff understanding of cultural differences • Ineffective and uninspiring rehabilitation services • Lack of care and support from staff • Staff prejudice and stereotyping of Pacific people • Lack of access to needed staff in mainstream or Pacific services • Side-effects of medication and/or electro-convulsive therapy • Cultural inequality and misunderstanding in services • Authoritarian services that reinforce dependence rather than independence

A Pacific community development model for mental health

The international drive for adoption of community development models of health provision originated with the Ottawa Charter (1986), which had as its central tenet that individual citizens and their communities must be empowered to take responsibility for their own wellbeing.

The Charter identified that the prerequisites and prospects for health cannot be ensured by the health sector alone. Consequently, improvement of the overall mental health status of Pacific people demands co-ordinated action by all concerned: by government; by the health sector and other social and economic sectors; by non-government and voluntary organisations; by local authorities; by industry; by media and finally the Pacific communities themselves.

Community development works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better mental health. At the heart of this process is the empowerment of Pacific communities through increasing their ownership and control of their own endeavours and destinies. If Pacific

[6] From Malo (2000).

communities are not sufficiently organised to take on these greater responsibilities then government has an obligation to assist them to do so.

A community development model of mental health service provision would mean support for Pacific communities to form overarching organisations with a representative mandate to:

- include Pacific service users in their Pacific communities, and into wider society
- integrate mental health services into already existing Pacific health providers in their communities. Services appropriate for integration would include clinical services, community support services, accommodation services, rehabilitation services and mental health promotion services. This type of integration would be consistent with the holistic view of the Fonofale Model
- develop and promote Pacific frameworks for mental health service provision that include cultural practices such as having matua practising alongside clinicians
- recruit and support Pacific people into the mental health workforce using their extensive community networks in the short term and taking a more proactive role in the medium and long term towards vocational capacity building
- reduce discrimination by making more effective and efficient use of existing social structures
- take greater responsibility for individuals and families within their communities that are known to have mental health related problems
- allow for a closer relationship between modern and traditional healing practices and a more accepting attitude within Pacific communities for alternative practices.

The power and potential of a community-based model of mental health service development is that it taps into the wealth of talent, expertise and altruism that conventional mainstream methods of service delivery leave under-used. Stronger community-owned Pacific mental health service provision would also lead to better use of hospital based and specialist mental health services due to greater individual and family awareness of services that effective community involvement would generate.

The definition of a Pacific service

Basic to a Pacific community development model for mental health is Pacific services. There is no simple definition of a Pacific mental health service. The concept of a 'Pacific' service is a generic one, yet it must be recognised that Pacific peoples are diverse in their culture, language and background.

Currently Pacific providers are developing their own models of Pacific health service delivery (including mental health services) according to local needs and priorities. Pacific services may operate in a range of settings. They may be delivered in Pacific non-government organisations (NGOs) or be delivered by Pacific teams in hospital settings.

In Pacific NGOs and the DHBs, there are some key factors to be considered in determining whether a service can be called a Pacific service. A Pacific service is a service that is run "by Pacific people for Pacific people". The service must have these key elements:

- service delivery is culturally appropriate for Pacific people
- the services provided are for Pacific users, but non-Pacific people may access the service
- the philosophy of the service is based on Pacific values and beliefs
- the service is based on Pacific models of health or models of health that encompass Pacific beliefs and values
- Pacific people are involved in the governance and management of the service
- Pacific people provide a significant number of the staff and health professionals.

If one or more of these key factors is absent then a service cannot be considered a Pacific service.

Although there is no single Pacific approach to mental health issues, it is expected that Pacific mental health services would embrace common principles that are inclusive of the diverse taonga of Pacific people. Suggested principles include:

- commitment to and use of the Fonofale model that emphasises an holistic approach to mental health service delivery that includes mental, spiritual, emotional and family wellbeing
- cultural differences, both within Pacific ethnic groups and communities, and between Pacific peoples and others, must be acknowledged, supported and accommodated
- the diverse needs, experiences and circumstances of Island-born and New Zealand-born Pacific people must be taken into account
- Pacific knowledge, including traditional knowledge, must be valued and protected, with appropriate controls over access to and use of such knowledge
- values of interdependence, collectivity, alofa, anticipation and collaboration must be fundamental to the service.

4 Mental Health Services for Pacific People

This section identifies the range of current mental health services for Pacific people. Some are located in mainstream mental health services, while others have been developed by Pacific organisations. Then the main issues in the provision of mental health services for Pacific people are discussed.

Current mental health services for Pacific people

Table 4.1 is for stand-alone or specific services for Pacific peoples. It does not include expenditure in mainstream services.

Table 4.1: Pacific mental health services expenditure for 2000/01[7]

Service category	Pacific mental health expenditure $
Community mental health teams	4,123,848
Community residential	546,643
Home-based support services	1,731,014
Consumer advisory service	178,212
Family advisory and family-run initiatives	58,024
Alcohol and drug community assessment and treatment	982,432
Alcohol and drug residential services	45,424
Children and young people community services	1,492,897
Community services for older people	340,977
Quality improvements	15,000
Total	9,514,470

Infobox 1 (below) shows the range of Pacific mental health services that are developing in centres with a large population of Pacific peoples. While not a definitive list, it demonstrates that there are several major Pacific non-government organisations offering a variety of services in Auckland, Wellington and Canterbury regions including mental health services, drug and alcohol services, primary health care services, community support and residential services, rehabilitation services, clinical advisory services and child health services. In addition, a number of Pacific mental health services are located within DHBs. These typically provide a range of community support work and clinical services. Other DHB services include older persons, and drug and alcohol services with Pacific cultural components.

Infobox 1: Mental health services for Pacific people[8]

Service type[(1)]	DHB services[(2)]	NGO services[(3)]	DHB district[(4)]

[7] Provided by the Ministry of Health.

[8] Provider information from Ministry of Health.

Service type[1]	DHB services[2]	NGO services[3]	DHB district[4]
Adult mental health service	Isalei Pacific Mental Health Services	West Auckland Pacific Island Fono	Waitemata*
	Lotofale Pacific Islands Mental Health Services	N/a	Auckland*
		Richmond Fellowship Inc – Malologa Trust and Cook Islands Services	Auckland*
		Spectrum Care Trust	Auckland*
	Faleola Mental Health Services	Pacificare Trust	Counties-Manukau*
	Community service for Pacific peoples	N/a	Hawkes Bay
	Pacific community support service	N/a	Hutt*
	Health Pasifika Mental Health Service	Pacific Community Health Inc	Capital Coast*
	N/a	Pathways Trust	Capital Coast*
	N/a	Pacific Canterbury Trust	Canterbury*
Drug and alcohol service	N/a	Pacific Islands Drug and Alcohol Service	Auckland
	N/a	Na'a'o Felelenite Alcohol Rehab Support Club	Waikato*
	N/a	Tanumafili Trust Social Service	Hutt*
	N/a	Taeomoana Pacific Islands and Alcohol & Drug Service	Hutt*
	N/a	Pacific Island Evaluation Inc	Canterbury*
Forensic psychiatry service	N/a	N/a	N/a
Child and adolescent service	Community Child Adolescent and Family Service	N/a	Auckland*
	N/a	Central Pacific Trust	Waikato*
	N/a	Pacific Island Evaluation Inc	Canterbury*
	N/a	Pacific Trust Canterbury	Canterbury*
Older persons service	Community mental health services for older persons	N/a	Northland
	Community mental health services for older persons	N/a	Auckland*
	Community mental health services for older persons	N/a	Waitemata*
Other services	N/a	Pacificare Trust – consumer advisor	Counties-Manakau*
	N/a	Penina Pacific Ltd – family support	Counties-Manakau*
	N/a	Pacific Island Evaluation Inc – quality improvement	Canterbury*
	N/a	Pacific Canterbury Trust – consumer advisor	Canterbury*

Notes
(1) Main service types as classified by Ministry of Health mental health purchase framework.
(2) Designated Pacific services located within mainstream DHB mental health services.
(3) Non-government organisations with Pacific mental health service capacity.
(4) Asterisk (*) denotes districts in which services are designated by the Ministry of Health as one of seven Pacific-relevant DHB districts with high Pacific population.

Issues in the provision of Pacific mental health services

The development of services specifically for Pacific people is a positive first step in the delivery of more and better mental health services to Pacific people as required by the Government's Mental Health Strategy. But these services can by no means meet current diverse Pacific mental health

needs, nor are they likely to match the potential range and growth of future demand. More services are needed.

A number of significant issues affecting both Pacific and mainstream mental health services need to be resolved before further progress can be made on developing services that are responsive to Pacific needs. Key issues in the provision of mental health services for Pacific people include:

- the type, level and location of services required
- cultural responsiveness of mainstream services
- quality and sustainability of Pacific services
- services provided by traditional healers
- links between services
- information and research services
- effective partnerships between service providers and Pacific service users.

The type, level and location of services

There are a variety of issues to consider in relation to the configuration of services for Pacific people. The youthfulness of the Pacific population, and different needs of overseas-born and New Zealand-born, are two particularly important factors that need to be taken into account. Identification and analysis of services needed should include:

- the types of services required, e.g. for different age groups and for different types of illness
- the level of services required, e.g. for acute illness, ongoing high-level support needs, respite, early intervention, community services and health promotion
- how and to what extent, services can be provided to Pacific people living in areas outside of the high-density Pacific populations.

Cultural responsiveness of mainstream services

Mainstream capacity to meet the mental health needs of Pacific people must be improved. Some Pacific people are not accessing mental health services, in part because those services are not acceptable to Pacific people.

Pacific-focused services are only likely to be viable in areas where the Pacific population is highly concentrated. The *Blueprint* suggests that only the largest population centres can sustain specialised clinical services, such as those provided in psychiatric intensive care inpatient hospital settings, detoxification units and forensic services. It is unlikely to be feasible for all such services to be run on an ethnic specific basis.

Mainstream services everywhere need to be responsive and flexible for their Pacific communities. Specialised services must understand how to provide culturally acceptable methods of treatment to a Pacific individual, and consider providing these services in Pacific cultural or family settings.

Despite the requirement for all providers to meet *The National Mental Health Standards (Ministry of Health 1997d)*, some mainstream mental health services fall well short of providing culturally appropriate and sensitive care to Pacific people. A particular gap is in the lack of training available for non-Pacific staff to improve their responsiveness to Pacific service users.

All agencies that provide mental health services to Pacific peoples need knowledge and understanding about:

- 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 peoples

- the importance of involving Pacific communities, families and service users in both individual and service planning and treatment processes
- the need to treat Pacific peoples with compassion, respect and equality
- services users' right to access traditional healing and conventional medical treatments at the same time
- barriers, such as lack of transport or information, that make it difficult for some Pacific service users to access the care they need
- discrimination that Pacific people can experience as Pacific people and as people with mental illness *(Mental Health Commission 2001)*.

Quality and sustainability of Pacific services

It is important to increase the number of quality Pacific mental health service providers so that Pacific people have a choice in using mental health services and feel more comfortable and safe in doing so.

Pacific providers report problems with a shortage of skilled staff, not being able to meet demands due to limited funding arrangements, staff burnout due to many competing demands, and serious incidents occurring which can be partly attributed to factors outside of the control of small Pacific providers. Among Pacific providers there is a commitment to delivering a quality service. However, more time, support and effort is required to establish a nationwide network of Pacific mental health service providers of the highest quality.

Anecdotal evidence illustrates the difficulties many would-be and new Pacific mental health providers have in attracting funding. Although Pacific communities may have the skills and the knowledge to deliver the necessary services, significant limiting factors include the management, accounting, contracting, organisational and financial aspects of mental health service delivery. Unless new Pacific organisations can demonstrate strong governance, management and accountability processes, it is difficult for funders to contract with them.

The development of effective organisational and service practices that underpin all aspects of Pacific service user care requires:

- strong vision and leadership
- effective service management to ensure safe services are provided
- clear lines of reporting and accountability
- efficient financial management
- an organisational culture of training, research and development
- effective recruitment and retention of staff to ensure excellence in practice
- support for innovation
- alignment of individuals' training and performance to agreed core work practice competencies.
- strong partnerships with service users at every level of the service.

The mental health sector needs to ensure that Pacific mental health service providers are sustainable. There must be mechanisms for Pacific providers to develop and maintain their infrastructure, to acquire appropriate clinical and managerial training, and to access appropriate advice and external expertise where required.

Services provided by traditional healers

Although it is not known exactly how many Pacific people choose to access traditional healers for their mental health needs, there are indications that a large percentage of Pacific people use traditional healers. The Pacific community is sending clear signals to mainstream services that

they would like to have a meaningful choice between different types and combinations of mental health services that can be provided by Pacific providers, mainstream health services and traditional healers.

The revised *National Mental Health Sector Standards* (April 2001) require that services provide for the use of culturally acceptable treatment options. Standard 2: Pacific people states:

> *2.3 The mental health service delivers and facilitates culturally safe services for Pacific people. With the informed consent of the person receiving the service, these services will include culturally accepted treated options, which are inclusive of the person's family. This includes and is not limited to:*
>
> - *cultural assessment*
> - *cultural therapies/counselling treatments*
> - *cultural audit*.

In addition, Standard 3: Cultural safety states:

> *3.4 The mental health service delivers and facilitates treatment and support in a manner that is sensitive to the cultural and social beliefs, values, practices of the person receiving the treatment.*

Mainstream mental health services need to recognise the significant role of traditional healers in Pacific communities. There are examples of successful partnerships between Pacific mental health services and a Pacific traditional healer:

- Pacificare (NGO) has a traditional healer employed on contractual basis to provide services to service users within Pacificare that request it.
- Lotofale Pacific Nations Mental Health Services (Auckland DHB) facilitate Community Support Workers to assist Pacific service users to access traditional healers.
- Faleola Services (Counties-Manakau DHB) and Isalei Pacific Mental Health services (Waitemata DHB) support and monitor Pacific service users who wish to access traditional healers.

The implication of the use of traditional healers and the relationship of traditional healing to the mainstream mental health sector has yet to be addressed. A number of issues will need to be resolved before mainstream mental health services and traditional healers can effectively work together.

Links between services

Links that promote the appropriate mental health services for Pacific people must be established between Pacific and mainstream services, and also between mental health and other services. This will require:

- support and collaboration between Pacific mental health providers, especially in Auckland where there are several. Sharing information and joint education sessions would strengthen all the services and result in better care of Pacific service users and their families. There should also be a commitment by the established Pacific mental health providers to support any new Pacific mental health services as they enter the sector
- integration of the various aspects of care for the mental health consumer must be achieved so that maximum health gains can be made. In the Pacific context this means clinical and community support services as well as Pacific primary care providers working closely together. This type of integrated care would be advanced by:
  - regular liaison between services with shared supervision
  - negotiating and documenting transparent shared care arrangements, e.g. memorandums of understanding
  - sharing common forms of in-service and other training.

  - provide mentoring at both an individual and organisational level

- consideration of linkages and co-ordination of mental health recovery services with other services such as social support services, employment, training and housing
- consideration of how links can be effectively developed and maintained with traditional healers
- acknowledgement that Pacific people may not be accessing the mental health services they need, and that they are more likely to interact with other services than mental health services. An essential part of linking mental health services to Pacific people includes building, improving and maintaining links with mainstream GPs, church-based and other community services, schools, and government departments, in particular Child Youth and Family, Department of Work and Income, and justice sector agencies.

A way of creating links and facilitating integration between different services and groups is through liaison staff. Liaison may be one function of a position, or a specific position may be created. The liaison role can act as link between mainstream and Pacific mental health services, and also between Pacific health and social services and secondary mental health services.

Partnerships with Pacific service users

The *Blueprint* states that "mental health services [should] involve service users as equals in all decisions made within the services that affect users' lives". Furthermore, service users "as individuals [should] take part in their assessments and in decisions about their treatment and support. As a collective, they [should] be involved in the planning and evaluation of services at all levels. People with experience of mental illness, with the right aptitude and skills, should be encouraged to seek employment in mental health services" *(Mental Health Commission 1998: 17)*.

There is a growing number of new Pacific mental health services as well as an increase in Pacific peoples working within mainstream mental health. Whether a service is mainstream or a specialist Pacific provider, partnership with Pacific service users must be reflected in processes for active involvement of Pacific service users in decisions about the mental health system and services that affect their lives.

Partnerships are therefore needed that ensure:

- recognition of the diversity of Pacific cultures and perspectives on health, especially the central importance and influence of faith, family and culture in the lives of Pacific peoples
- involvement of Pacific service users in a culturally appropriate manner and non-discriminatory way
- real opportunities for Pacific service users to influence decision-making
- market rates for remuneration for Pacific service user participation in services
- provision of resources, knowledge, information and supports required (e.g. Pacific interpreters, advocates) to facilitate effective partnership with Pacific service users.

Discrimination is a major barrier to Pacific service users participating fully in services. Pacific peoples face double discrimination because of being service users and also because of their ethnicity or cultural identity. It is important, therefore, that staff at all levels of the service provider, from senior management to those delivering services directly to Pacific service users understand barriers to effective Pacific service user participation, and have a commitment to eliminating these within services.

Partnerships with Pacific providers

Some Pacific people are concerned that the visibility of Pacific peoples will be lost in the transition to DHBs. Pacific network structures and processes will be needed to ensure Pacific interests are

adequately represented at DHB level, and create governance and advisory opportunities in regional planning, especially in Pacific-relevant DHBs. It must be recognised that Pacific providers lack capacity to form Pacific "regional networks". DHB support will therefore be needed to enable Pacific regional network planning and development work. Pacific "regional networks" may work more effectively as a collective entity in areas of high population. There are already examples of DHBs co-operating in the development of such networks. The three DHBs in the Auckland region combining to form an Auckland Pacific network, Hutt Valley and Capital and Coast DHBs combining together in the Wellington region, and Canterbury forming a collective of the South Island DHBs.

There is scope for a national Pacific organisation to be set up along the lines of the Maori Development Organisation. A "Pacific Development Organisation" could therefore be formed as a collective legal entity that provided member organisations with a broad range of governance, management, brokerage, and advocacy functions. Further discussion is needed on how DHBs and Pacific communities can best work together at national and regional level. Advice from Pacific managers in Pacific mental health services is therefore needed on how mental health providers, both mainstream and specialist Pacific, can inform regional and national networks.

Information and research services

Comprehensive and reliable information and research are essential inputs to Pacific mental health service design and delivery, effective service evaluation, and culturally appropriate assessment. A fundamental problem in addressing the mental health needs of the Pacific population is the lack of data and research about the mental health status of Pacific peoples. Existing data is sparse and often out of date. There are also questions about the accuracy of ethnic definitions of people within the mental health system. In some areas there is no data. For example, no statistics are collected on Pacific people receiving community care.

Existing data suggest that Pacific people are under-represented in psychiatric and other mental health services in New Zealand. However, it may also indicate the current limitations in data collection and quality, and an unknown level of unmet need for mental health services among the Pacific population. A population survey is required to tell us more accurately and comprehensively about the nature and extent of mental illness among the Pacific population. The New Zealand Mental Health Epidemiology Survey is expected to provide information on Pacific mental health prevalence and service use in 2003.

The collection of mental health information should be improved following the implementation of the Mental Health Information Project run by the Ministry of Health. Local initiatives like the Patient Information Management System in South Auckland have a number of features that will greatly enhance collection of important mental health data for all users of mental health services.

Pacific mental health service providers will also need to develop information collection and reporting systems in order to effectively meet the needs of Pacific consumers. Involvement in research and service evaluation enables Pacific service providers to develop partnerships with mainstream researchers that result in transfer of research skills and better analysis and critique of research involving Pacific people.

The considerable information and research needs of the Pacific mental health sector are currently hampered by a huge lack of qualified Pacific researchers and a corresponding absence of Pacific research leadership. The Pacific community relies on the dominant research community to undertake research into the Pacific community. There is ample evidence of insensitive research practices, and at times dubious research conclusions. There is a perception in the Pacific community that a lot is taken by researchers and little is given back in return.

5 The Pacific Mental Health Workforce: The Current Situation

This section is based on a survey of the mental health sector commissioned by the Mental Health Commission in 1999. It provides an estimate of the number of Pacific workers in the mental health workforce, and gives some information on their characteristics. A total of 175 Pacific staff from various ethnic groups and working in a range of occupations were surveyed. Results presented below are based on the 167 respondents who returned useable surveys.

This is the first attempt to record up to date workforce information about Pacific people working in the sector. Because of gaps in the quantitative workforce information available, this sector scan was the only means of getting reasonably accurate data and of providing a benchmark for future work.

Twenty-three Hospital Health Services and over 300 non-government organisations were contacted to gather information on Pacific workers. Key staff, such as general or service managers, or team leaders were sent a letter explaining the purpose of the survey and a questionnaire, and asked to forward these to all Pacific staff for completion.[9]

Number of Pacific people in the mental health workforce

The survey provides an estimate of 175 Pacific people in the mental health workforce. This indicates that Pacific people are significantly under-represented in the mental health workforce. Pacific peoples currently make up around 6 percent of New Zealand's population, and are the fastest growing population group. Yet, in a mental health workforce of around 7000, Pacific workers make up only 2.5 percent of that workforce.[10] Detailed estimates of Pacific workforce requirements are presented in Section 7.

Ethnicity

Samoans make up the largest group of Pacific mental health workers. The ethnic composition of the Pacific mental health workforce is generally consistent with their distribution in the total Pacific population (see Table 5.1). The exception is the Cook Island Maori workforce, which is somewhat less than their percentage of the total Pacific population.

Table 5.1: Ethnicity of Pacific mental health workers

Ethnicity	Number	Percent	Percent of Pacific population (1996 Census)
Samoan	75	44.9	50
Cook Island Maori	27	16.2	23
Tongan	23	13.8	16
Niuean	20	12.0	9
Tokelauan	7	4.2	2
Fijian	3	1.8	4

[9] See Appendix 2 for further details of the methodology.

[10] The Mental Health Commission estimate of the mental health workforce in 2000 is 7000.

Other (includes mixed)	12	7.2	–
Total	167	100.0	104*

* Adds to more than 100 percent because people reporting multiple ethnic groups may be included in more than one Pacific ethnic group.

Occupational distribution

Table 5.2 presents the occupations of the respondents. Eighteen respondents did not record their current occupation. The largest occupational groups of those who responded are community support workers (31.5 percent) and psychiatric nurses (25.5 percent). There is a serious lack of Pacific psychiatrists.

Table 5.2: Pacific mental health occupational groups

Occupational group	Number (n=149)*	Percent
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	2.7
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	2	1.3
Psychiatrists (training)	1	0.7
Counsellors	1	0.7
Total	149	100.0

* 18 non-respondents.

Age

Table 5.3 presents the age of respondents. Seventy-four respondents did not record their age. Over half the Pacific workforce are between the ages of 25 and 38 years. The majority of workers are in the 25–52 age range.

Table 5.3: Age of Pacific mental health workers

Age group	Number (n=93)*	Percent
18-24 years	6	6.5
25-31 years	28	30.1

32-38 years	20	21.5
39-45 years	16	17.2
46-52 years	17	18.3
53 years or more	6	6.5
Total	93	100.0

* 74 non-respondents.

Length of service in current organisation

Table 5.4 presents the length of service of respondents. Twelve respondents did not record their length of service. Almost two-thirds of the Pacific mental health workforce have been in their current position for three years or less.

Table 5.4: Length of service for Pacific mental health workers

Years	Number (n=155)*	Percent
Under 1 year	15	9.7
1 to 3 years	83	53.5
4 to 6 years	23	14.8
7 to 9 years	10	6.5
10 to 12 years	7	4.5
Over 12 years	17	11.0
Total	155	100.0

* 12 non-respondents.

Qualifications

Table 5.5 presents the qualifications of respondents. Sixty-nine respondents did not record their qualifications. Just over half the survey participants have a certificate, diploma or degree qualification in a health area. Although no participants said that they had no formal qualifications, anecdotal evidence indicates that a high number of the Pacific workforce do not have formal qualifications. It is likely that a majority of those who did not respond to the question have no formal qualifications.

Table 5.5: Qualifications of the Pacific mental health workforce

Qualifications	Number (n=98)*	Percent
Diploma/degree in health	66	67.3
NZQA Certificate (health qualification)	23	23.5
Currently undertaking diploma/degree in health	7	7.1
Qualification (not in health)	2	2.0

Total	98	100.0

* 69 non-respondents.

Regional distribution

Auckland has the greatest number of Pacific mental health workers. Over two-thirds of survey participants work in the greater Auckland area. One-fifth work in the greater Wellington area. There are a few Pacific workers spread over a range of other areas including Northland, Waikato, Palmerston North, Christchurch, Otago and Southland. Numbers ranged from two to eight in those areas.

The distribution of the Pacific mental health workforce is similar to that of the Pacific population, with the majority of the population residing in the Auckland Regional Council area.

Concluding comments

Although a 'snapshot in time', this survey provides important baseline information on the Pacific mental health workforce that will contribute to future workforce and service policy, planning and development. Main points arising from the survey are:

- more Pacific people need to be recruited into the mental health workforce, at all levels and in all occupations
- retention of the workforce is a critical issue. Most workers have been in their current position for less than three years. However, most workers are in the 25 to 38 age groups. If they can be kept in the mental health workforce then an experienced mental health workforce will be available to the sector in 10 years
- significant effort is needed to increase the percentage of Pacific mental health workers with mental health qualifications and competency in working with Pacific service users
- more Cook Island Maori people may need to be attracted into working in the mental health sector, as they have the lowest representation of all Pacific ethnic groups, in relation to their proportion in the total Pacific population.

Accurate data on the state of the Pacific mental workforce needs to be collected regularly so that the state of the workforce and sustainability of service development can be monitored. This is particularly important as more funding and effort is put into increasing the size and quality of the Pacific workforce over the next five years.

6 Issues for Pacific Mental Health Workforce Development

Section 5 indicated the current configuration of the Pacific mental health workforce. That baseline survey and other investigation show a serious lack of Pacific people across all mental health occupations, and a lack of certain skills and qualifications. Pacific mental health professionals are in such short supply that increasing their numbers is high priority. A concerted effort must be made by professional leadership, management and policy makers in the mental health sector to develop a sustainable Pacific workforce.

This section focuses first on the main issues for Pacific mental health workforce development, and then considers specific occupations that are required. Key issues in developing a sustainable Pacific mental health workforce are:

- staff recruitment
- staff retention
- upskilling workers, and
- promoting a culture of learning.

Recruitment

The Pacific mental health workforce is severely under-represented in the sector. There are various reasons for this. In part, the under-representation of Pacific mental health workers in mental health can be attributed to a failure in planning and support at various levels. Furthermore, Pacific health professionals have not seen mental health as an attractive area in which to work. Providers' employment policies must ensure that Pacific people with skills in languages, cultures, and customs are recruited.

Two new programmes, introduced by the Auckland School of Medicine's Department of Maori and Pacific Studies as part of Vision 20/20, will greatly assist in recruitment of Pacific people into mental health professions. The programmes are designed to increase the number of Pacific students gaining entry into medical school and the health related sciences. The Wellesley Programme and the Certificate in Health Science take students who have performed well in their bursary year but not sufficiently well to gain entry into medical school. These students are able to take the one-year certificate course in health science and are given extra support and tuition. At the completion of the certificate they can apply to medical school. If their grades are not sufficient to gain entry to medical school they are actively encouraged to take up health-related courses such as nursing, clinical psychology, and physiotherapy. These programmes have proved effective in increasing the numbers of Pacific students gaining entry into medical studies, with the long-term effect being a greater pool from which to recruit future psychiatrists.

Retention

Job satisfaction is recognised as an important component in retaining staff and thus increasing the size of the workforce. Several reports emphasise that job satisfaction in mental health service organisations is low. This contributes to staff reluctance to keep working in such organisations.

Pacific mental health workers often feel isolated and unsupported, and the highly technical aspects of the job can be very intimidating. It is not always evident that their background and skills are valued, and at times this has resulted in the loss of competent Pacific mental health workers from the mental health sector. The Pacific mental health worker is a scarce commodity and for this reason must be highly valued by the organisation.

Factors that may contribute to, and improve the retention of Pacific mental health workers include competitive remuneration, supportive mentoring, emphasis on the importance of cultural aspects of care, and creation of stand-alone Pacific services.

Staff retention may also be improved by involving staff in service development and planning. Many Pacific mental health staff feel isolated from service planning and confused about how the current health system works. When staff are involved in service planning, they contribute to its improvement and help ensure that the system reflects consumer needs.

Upskilling workers

There is a clear need for greater investment in upskilling and education of the Pacific mental health workforce. The percentage of Pacific mental health workers with no mental health qualification is too high. Ideally, all Pacific mental health workers should have as a minimum qualification the National Certificate in Mental Health (Mental Health Support Work).

Many Pacific mental health workers face barriers to gaining qualifications that are experienced by other Pacific people, such as course costs, a lack of supports for Pacific students, difficulties of returning to study as an adult, having English as a second language, and family and community obligations that hinder study. Pacific mental health workers need to be given the necessary support when undertaking training.

The majority of Pacific providers and professionals view positively the requirement of core competencies for all members of the mental health workforce. There is strong support for the use of specified competencies as a focus for education and training programmes and for performance appraisals for staff. However, there is also a view that the Pacific mental health workforce has not been operating within the framework of professional competency and standards already available *(National Mental Health Workforce Development Co-ordinating Committee 1999)*. Clear inclusion of competencies and standards in training, work practices and performance agreements would integrate the Pacific workforce more effectively with current competency requirements. In addition, competencies need to include those specific to the Pacific mental health worker.

More discussion is taking place between various educational institutions and mental health service providers and workers. However, greater effort is needed to achieve active collaboration between mental health education providers, Pacific providers, mainstream providers and communities in order to ensure that Pacific people have equal access to training.

Agencies involved in workforce development need to draw on Pacific people with expertise in mental heath and workforce development, and with strong community links, to develop a strategic overview and guidance on education and training for the Pacific mental health sector.

Promoting a culture of learning

One of the best means of Pacific mental health organisations supporting their staff and improving their delivery of effective services is to ensure a culture of learning exists. Mainstream mental health services employing Pacific staff should also ensure that they are encouraged to access training and development.

There needs to be a continuing programme of upskilling Pacific staff to meet consumer needs, as well as training new staff. There should be demonstrable career pathways agreed to by the service and the individual. these should be documented in the individual's performance plan.

Basic to the culture of learning is the provision of workplace practice as an integral part of education and training *(National Mental Health Workforce Development Co-ordinating Committee 1999)*. Access to workplace practice requires the co-operation and resource support of mental health service providers.

Exposure to ongoing cultural training is as important as clinical training, as the knowledge required to work successfully with Pacific families cannot be guaranteed by ethnicity alone. Ongoing cultural training needs to be a part of the core ethos of any organisation that serves Pacific people. Furthermore, trainee mental health workers need to be placed with existing Pacific mental health providers or Pacific teams wherever possible.

Mainstream mental health services must also develop an appropriate learning climate where non-Pacific staff working with Pacific mental health service users are trained in delivering culturally appropriate services.

Occupations required

The current lack of Pacific people across all occupations in the mental health sector indicates that no one occupation can be focused on for workforce development, to the exclusion of others. Table 6.1 shows that workforce planning and development needs to occur across a broad range of occupations. The following discussion outlines the main occupations where more Pacific workers are required, the key issues for each occupation, and some ways in which recruitment and retention may be addressed.

Table 6.1: Occupational issues

Occupation	Comment
Clinical psychologists	• Very few Pacific clinical psychologists are currently in practice or training. • Recruitment strategies are needed.
Consumer advisors	• Consumer advisors are particularly needed in the DHBs in areas of high Pacific population. • Very few consumer advisors are from Pacific communities.
Counsellors	• Very few Pacific counsellors are currently in practice or training. • Recruitment strategies are needed.
Independent service user advocates	• A key role for ensuring promotion of rights and inclusion of people whose equal participation is threatened by others. • Training and recruitment strategies are needed.
Interpreters	• A key role for ensuring smooth entry of Pacific service users and their families into the mental health system. Interpreters and cultural advocates may need to be involved in cultural assessment to ensure communications are effective and assist the interpretation and understanding of the service user's diagnosis, recommended treatment and particular cultural requirements for recovery. • Pacific interpreters need to be accredited, and have an understanding of mental health concepts and processes.
Managers	• Increasing the number and skills of managers is essential for Pacific provider development.
Matua	• A key role that is fundamental to the Pacific community development model. • Matua role needs to be recognised by mental health services for Pacific people, and funded.

Mental health support workers	• A new initiative that has helped improve service delivery. • Numbers need to be increased. • A relevant qualification is available – this will need to be extended to increase skills.
Occupation therapists	• Very few Pacific occupational therapists are currently in practice or training. • Recruitment strategies are needed.
Psychiatrists	• Very few Pacific psychiatrists are currently in practice or training. • Numerous obstacles in recruitment and training need to be addressed.
Registered nurses	• Numbers need to be increased. • Better use of current Pacific nursing staff in the sector is required. • More Pacific nurses are gaining higher qualifications.
Service auditors	• This is an emerging occupation.
Social workers	• Pacific social workers tend to go into mental health, but numbers are still small. • A focus on post-graduate training is needed.

Clinical psychologists

There are very few Pacific clinical psychologists currently working in the sector and in training. It appears that the major problem in recruiting Pacific people into the field is the lack of awareness in the Pacific community of what a clinical psychologist actually does. It is not a profession that has the same profile as social work, nursing or medicine. With the major drive initiated by the Auckland School of Medicine to increase the number of Pacific medical students, it is expected that there will be a flow-on to clinical psychology and other health-related professions.

A concerted recruitment drive for clinical psychology and other low profile occupations in mental health could prove very successful. It would assist this process greatly if the Pacific clinical psychologists in the sector were actively involved in a recruitment process.

Consumer advisors

Pacific consumer advisors have an important role in ensuring that mental health services are culturally relevant and beneficial to Pacific peoples, and meet quality expectations as required by *The National Mental Health Standards* 2 (Pacific peoples) and 9 (Consumers). The Mental Health Strategy requires all contracted providers to demonstrate involvement of and participation of consumers in mental health services (Ministry of Health 1997b, Target 3.2.2). Involvement of Pacific consumer advisors is of particular relevance to the seven DHB providers located in areas of high Pacific population.[11]

Government agencies have recognised that employment opportunities for consumers to play an active role in mental health are important in aiding consumer recovery *(Health Funding Authority 2000; Malo 2000: 14)*. However, the mental health sector has not yet addressed the workforce development needs of consumers *(Mental Health Commission 1999a: 15)*. In 1999, the Mental Health Commission estimated that 13 of 22 HHS mental health services employed consumers to provide a consumer perspective in planning, delivery and monitoring of services. None were identified as having a specific role in Pacific mental health service delivery *(Mental Health Commission 2000b:54-55)*. The Pacific mental health workforce survey reported in section 5 identified only four Pacific consumer consultants.

[11] The seven DHBs are Waitemata, Auckland Healthcare, South Auckland, Waikato, Capital Coast Health, Hutt Valley and Canterbury.

Counsellors

The avenue of entry into training and the rewards of this occupation are not well known to the Pacific community. Yet culturally appropriate marriage and relationship counselling, grief, anger, sexual abuse and self-identity counselling for Pacific people is in great demand. In addition, there is much exciting work to do in integrating current accepted theories of European cultural and clinical-based counselling practices with Pacific approaches to counselling.

As with the other low profile occupations, an appropriately targeted advertising and recruitment campaign is needed to lift Pacific communities' awareness of counselling.

Independent service user advocates

Independent advocates work outside mental health services as part of an independent service user network. They can help to bridge cultural barriers between Pacific service users and mental health services that hinder full Pacific user inclusion and participation. Pacific advocate roles need to be developed within mental health services, especially in the seven DHBs that service localities with high Pacific population.

Interpreters

Interpreters (and cultural advocates) may need to be involved in cultural assessment to ensure communications are effective and assist the interpretation and understanding of the service user's diagnosis, recommended treatment and particular cultural requirements for recovery.

Pacific interpreters need to be accredited, and have an understanding of mental health concepts and processes.

Managers

Successful progress towards increasing the number and skills of Pacific managers is essential for Pacific provider development and growing sector capacity. Sustainability of Pacific mental health services depends on these services being led by competent and well-trained managers. Currently there are very few Pacific managers, and the mental health sector competes with other sectors that are often able to offer higher paying jobs to Pacific managers.

Matua

Pacific mental health providers are strongly of the view that the role of matua must be recognised as an integral part of mental health services for Pacific people. Having matua who provide a strong cultural basis for the service in many areas such as consumer and family support, advisory, staff training, planning and delivery is fundamental to the Pacific community development model. It is essential that funding for matua is included in service budgets.

Mental health support workers

The mental health support worker initiative is relatively new in the mental health sector. Pacific people who have entered support work are mature, with a range of life experiences, strong community links and extensive knowledge of cultural matters. All are bilingual, and some are multilingual. A balance of men and women has been achieved.

Almost all the Pacific people training in the Mental Health Support Work programmes work for mainstream mental health service providers. Mainstream providers have found that having access to Pacific mental health support workers has greatly improved the delivery of services. Anecdotal evidence reveals high levels of Pacific consumer satisfaction and mental health gains as a direct result of access to Pacific support workers. They have been of considerable benefit to

Pacific service users and have assisted mainstream providers to better understand the needs of those users.

Increasing the number of mental health support workers is an effective way of making a considerable difference in the short term, as with relatively short training times the support workers are soon actively participating in the mental health sector and doing valuable work.

The National Certificate in Mental Health (Mental Health Support Work) was established in 1998 to provide a relevant qualification for the largely unqualified workforce of support workers. In future years, there will be a need to add to this generic qualification, to enable support workers to develop further skills in areas such as child and youth work *(Health Funding Authority 2000: 22)*.

Occupational therapists

Occupational therapy has a low profile among Pacific people, a major reason for the lack of Pacific people choosing this career option. In the last five years very few Pacific people graduated from the Auckland Institute of Technology Occupational Therapy course and figures from Otago are not available. Despite the low numbers currently undertaking training, mental health appears to be a preferred career option for occupational therapists.

Occupational therapy offers opportunities for creative people, and could be promoted as an appealing and worthwhile career choice in Pacific communities. A high profile advertising and recruitment campaign is needed to lift Pacific communities' awareness of occupational therapy.

Psychiatrists

There are very few Pacific psychiatrists in practice or in training. Numerous obstacles impact on the recruitment and training of Pacific psychiatrists, including:

- a very small pool of Pacific medical undergraduates
- the prospect of specialising in psychiatry can be daunting
- very high academic entry criteria
- psychiatry is seen as a low status medical specialty in comparison with some other specialties
- there is a stigma attached to working in the mental health sector
- lengthy post-graduate training programmes
- a difficult examination process with a low pass rate across all candidates
- lack of support and mentors to assist candidates.

Increasing the number of Pacific doctors choosing psychiatry could be helped by mentoring programmes, support networks, mental health careers days in schools, conference funding, undergraduate placement with Pacific mental health providers and summer studentships.

Registered nurses

Key issues include how to:

- increase the numbers choosing mental health nursing (especially attracting male nurses)
- better use current Pacific nursing staff in the sector.

The overall number of Pacific nurses in training has steadily increased, although more could go into mental health. There appears to have been a fall off in Pacific male nurses entering the mental health field. However, there is increasing support among hospital and health service

providers for Pacific nursing staff to gain degree qualifications and the post graduate certificate in advanced nursing (mental health).

The majority of Pacific mental health nurses are in mainstream organisations where their special cultural expertise is not being formally acknowledged. To meet *National Mental Health Sector Standards* (2001) all mental health providers will be expected to make better use of their Pacific staff.

A number of commentators have identified the need for good mentoring in order to attract Pacific nurses into careers in mental health. This can be achieved by placement with credible Pacific mental health providers who have experienced Pacific mental health nurses and selecting Pacific nurses in mainstream organisations to mentor students. The development of effective mentoring processes requires close collaboration between the education and mental health sectors.

Other ways to increase the numbers of Pacific nurses choosing mental health include more effective marketing of mental health as a career, career days in schools, scholarships, conference funding for undergraduates, and foundation programmes to enable Pacific nurses who want a career change to gain entry to the mental health sector.

Service auditors

The proposed Health and Disability Services (Safety) Bill replaces licensing of hospitals and rest homes and registration of residential care with a new certification process. Designated auditors will be required to audit health services, including any kind of hospital, residential or rest home care to certify both current and new providers. A key challenge for the new audit regime is to ensure that provider audits are carried out with due cultural sensitivity and understanding. To be culturally sensitive, audit teams need to use auditors with mental health service user experience and understanding of mental health services. For audits of Pacific services, it will be imperative to have auditors who understand not only Pacific culture, but also the characteristics and attributes and needs of Pacific service users, services and staff.

Social workers

The social work profession attracts a considerable number of Pacific people. A large percentage of undergraduate social work students at Manukau Institute of Technology in South Auckland and Whitireia in Porirua are Pacific people.

Anecdotal evidence suggests that the mental health field is a preferred career option for Pacific social workers, in contrast to Pacific doctors and nurses, who appear to be less attracted to mental health services. However, the actual number of social workers in the Pacific mental health workforce is still small.

A focus on post-graduate training for Pacific social workers, particularly in priority areas for Pacific people such child and youth mental health, and alcohol and drug rehabilitation would benefit the Pacific community. Their effectiveness in the mental health sector would also be increased through the establishment of a Pacific mental health social work network that could be involved in recruitment and post-graduate training.

7 Estimates of the Resources Needed for Provision of Mental Health Services for Pacific People

This section attempts to quantify the mental health service resource needs of the Pacific population to be delivered across both mainstream and dedicated Pacific mental health services. The analysis takes population data and the *Blueprint* resource guidelines as the basis of determining a fair allocation of resources for Pacific people in New Zealand. Overall, the analysis suggests that 291 inpatient and community beds and 383 community FTEs are required for the Pacific population. Of those, around 101 inpatient and community beds and 152 community FTEs could be expected to be delivered through to dedicated Pacific services.

Four ideas need to be kept in mind in following through the calculations and drawing conclusions.

1 This work does not assume any particular model of service delivery, apart from that which underpins the *Blueprint* guidelines. Therefore, it should be considered to be a starting point only. A different model of service delivery might emphasise different aspects of services, and this could affect the optimal resource levels or the distribution of resources within a geographic area.

2 The *Blueprint* resource guidelines are estimates of the number of staff or beds required to provide secondary mental health services for a population of 100,000 people, that is services to meet the needs of the 3 percent of people with serious mental illness in any six-month period. The guidelines do not include primary mental health services that can be provided by general practitioners and other primary health care providers for the 17 percent of the population with mild and moderate mental health problems.

3 The guidelines were developed for the purpose of planning services for large populations, particularly for the whole of New Zealand. Therefore they need to be used with caution in planning for the regions. They are indicative only for other smaller populations.

4 The calculations in this section assume a fully-funded mental health sector. However, it will take some years and significantly increased funding before the mental health services in New Zealand are fully resourced to the level indicated by the *Blueprint*. The conclusions reached regarding Pacific service levels are intended to be useful for planning for the future. Some of the recommended resources will not be available at this time.

The share of resources for Pacific people is likely to continue to be divided between mainstream services and some separate Pacific services. Some staff may work in both. Separate Pacific services could be provided by both DHBs and NGOs. The *Blueprint* states:

> *Pacific people need access to both the full range of mainstream services (which should acknowledge and affirm Pacific cultures) and, where viable given local population needs and numbers, separate Pacific people's services. In areas with larger Pacific people populations, priority should be given to the development and funding of mental health services for Pacific people (Mental Health Commission 1998:52).*

In all parts of the country, regardless of whether or not dedicated Pacific services are provided in a region, it is reasonable to expect that all mainstream services employ Pacific staff in proportion to the population of Pacific people in the region.

Pacific population predictions

For planning purposes, it is important to base estimates of service levels on future population predictions. This allows for population growth and changes in age structure and population

distribution while services develop. The analysis in this section uses population predictions for 2004, based upon the 1996 Census.

Table 7.1 shows:

- the predicted 2004 Pacific population, by age group, of each of the four regions of New Zealand served by the former Regional Health Authorities[12]
- the total Pacific population in each region
- the Pacific population of each region as a percentage of the total New Zealand population, and the bottom row shows
- the proportion of the Pacific population in each age group.

Table 7.1: Predicted Pacific population 2004

Region	Pacific population 2004 under 20 years	Pacific population 2004 20–64 years	Pacific population 2004 65 years and over	Total Pacific population 2004	Pacific population as a proportion of the New Zealand population
Northern	70,910	83,850	5,960	160,700	4.1%
Midland	5,505	7,400	590	13,580	0.3%
Central	16,335	22,170	1,565	40,030	1.0%
Southern	5,885	7,920	455	14,220	0.4%
Total[13]	98,640	121,320	8,640	228,600	5.8%
Proportion of Pacific population	43%	53%	4%	100%	

Age distribution

Approximately 98,640 or 43 percent of the total Pacific population is predicted to be under 20 years of age in 2004. This can be compared with 29 percent of the total New Zealand population. It means that particular attention will need to be directed towards services for children and young people.

On the other hand, only 4 percent are predicted to be 65 years or older, compared with 12 percent of all New Zealanders.

Total resources for Pacific people

Table 7.2 shows the resources that would need to be available to Pacific people to meet *Blueprint* guidelines.[14] These include resources for both mainstream and dedicated services. Note that the full-time equivalent (FTE) figures represent staff providing services to people in the community, and are additional to staff numbers in inpatient and residential services.

Tables 7.2 and 7.3 include community liaison staff. These staff are not part of the *Blueprint* model. They have been included in the analysis for discussion, as a possible way of facilitating

[12] The Northern region includes Northland and Auckland; Midland region includes the Waikato, Bay of Plenty, Lakes, Tairawhiti and Taranaki; Wellington region includes Wanganui, Hawkes Bay, Wairarapa and Wellington; the Southern region covers all of the South Island.

[13] Parts do not necessarily add up to the total because of rounding errors, but this does not affect the conclusions reached.

[14] Guidelines in the *Blueprint* have been added together as necessary to simplify the table, but all have been included.

integration between Pacific health and social services, and secondary mental health services. The number of liaison staff and the nature of their work would need to be locally determined according to the configuration of Pacific services, the Pacific population, social and geographic factors, and workforce availability.

In addition, staff of Pacific services may need to act in a liaison role to assist mainstream providers to ensure that services provided are culturally appropriate for Pacific service users. No additional resource has been allowed for this function.

Table 7.2: Estimated national mental health service requirements for Pacific people

Resource categories	*Blueprint* guideline per 100,000 population (without age adjustment)	Total resources required for the Pacific population 2004 (228,600) in accordance with *Blueprint* guidelines (adjusted for the Pacific age structure)
Inpatient beds and day places	49[15]	98
Community residential beds	78	166
Drug and alcohol inpatient and community beds	13	27
Total inpatient and community residential beds (all age groups combined)	**140**	**291**
Adult community non-clinical support FTEs	42	88
Adult community drug and alcohol FTEs	20	41
All other *Blueprint* adult and older people community clinical FTEs	78	142
Child and youth community clinical FTEs	29	93
Community liaison FTEs	(19)[16]	19
Total community FTEs	**188**	**383**

Dedicated Pacific services

The following discussion focuses on the estimated resources that would be required to provide separate, dedicated Pacific secondary[17] mental health services, consistent with *Blueprint* resource guidelines.

An assumption of the analysis, is that in general, people need mental health services provided close to where they live. Another assumption is that there need to be sufficient people in an area to form a "critical mass" that will allow for the provision of services that are both clinically and financially viable. These ideas are important when thinking about where to establish dedicated Pacific services.

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15 As well as general adult inpatient beds, this includes beds and day places for children and young people, older persons, forensic services and other specialty services.

16 There is no *Blueprint* guideline for this. The figure has been calculated on the basis of 1:100 Pacific mental health service users in Midland and Southern regions where few dedicated Pacific services are proposed; 1:200 in Auckland and Central regions where there should be dedicated Pacific services.

17 In Waikato and Canterbury, the Pacific population is sufficient that it may be feasible and desirable to provide dedicated *primary* mental health services, but this analysis is about secondary services for people with serious mental illness.

Decisions about what is the critical mass depend on both the service type and the resource guideline. For instance, an adult acute inpatient service (resource guideline 15 beds per 100,000 total population) requires quite different considerations than a community mental health clinical team (resource guideline 42 FTEs per 100,000 total population). An area with 100,000 Pacific people could reasonably have five Pacific community teams of eight staff, each team serving 20,000 people, but it could probably have only one viable inpatient service.

Based on 1996 Census data, by 2004 70 percent of New Zealand's Pacific population will be in the Northern region, and in particular, 69 percent (that is, 158,300 people) will be in the area covered by three adjacent DHBs, Waitemata, Auckland and Counties Manukau. This means that by 2004 there will be approximately 4,750 Pacific people in these three DHB areas, who are in the 3 percent target group for access to secondary mental health services over any six-month period.

By 2004, 18 percent of the Pacific population will live in the Central region. In particular, the area covered by the adjacent Capital and Coast and Hutt Valley DHBs is predicted to have 14 percent of the Pacific population (31,000 people). There will be approximately 930 in the 3 percent target group in these two DHBs.

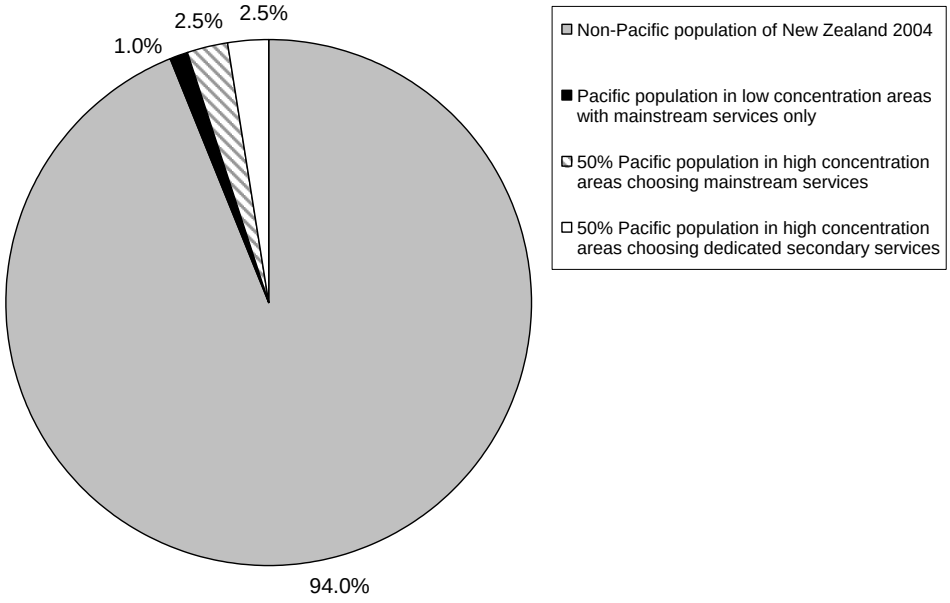
Assuming half of Pacific people would choose to use separate Pacific services if available, then the three Auckland DHBs would have a target population for separate services of nearly 2400, and the Wellington/Hutt area approximately 465 in any six-month period. These numbers are sufficient to establish some viable separate services for Pacific people.

No other adjacent DHB areas will have more than 10,000 Pacific people. That is, no other area is likely to have more than 300 Pacific people altogether needing specialist mental health services in any six-month period. Therefore, separate, dedicated mental health services are unlikely to be viable in these areas. A possible exception is in Canterbury, where the Pacific population may warrant a community residential service.

The diagram below adds clarity to these ideas. It shows:

- the 1 percent of the New Zealand population that is made up of Pacific people in low concentration areas, and
- the 5 percent of the New Zealand population that is made up of Pacific people in the high concentration regions of the Waitemata, Auckland, South Auckland, Capital and Coast and Hutt DHBs. The 5 percent is further divided into 2.5 percent who might use dedicated Pacific secondary mental health services, and 2.5 percent who might not.

Figure 1: Estimating the target population for secondary mental health services for Pacific people



Assumptions made in estimating dedicated Pacific services

To develop estimates of service levels needed by the Pacific population, the analysis assumes:

- the *Blueprint* estimate of 3 percent six-month prevalence of serious mental illness is appropriate for Pacific people (as for the population as a whole)
- the *Blueprint* service model and resource guidelines for the New Zealand population are appropriate for Pacific people
- the 2004 Pacific population structure is as predicted by Statistics NZ
- the "regions" are the four Regional Health Authority regions
- 50 percent of the Pacific population might choose to use a dedicated Pacific service in their area, if available.

Regarding the issue of viability, four assumptions have been made on the basis of estimated cost, clinical risk and staffing requirements:

- 10 beds are sufficient for a viable mixed acute and sub-acute inpatient unit, requiring a minimum Pacific adult population of 74,000[18] in the catchment area
- five beds are sufficient for a viable mixed-level community residential service, requiring a minimum Pacific adult population of 14,000 in the catchment area
- six FTEs are sufficient for a viable community clinical team, requiring a minimum Pacific adult population of 24,000 in the catchment area
- 10 FTEs are sufficient for a viable community non-clinical support team, requiring a minimum Pacific adult population of 48,000 in the catchment area.

[18] 10 (beds per viable unit) divided by 27 (*Blueprint* acute, medium term and extended care beds/100,000 people) multiplied by 100,000 (people) divided by 50% (people choosing dedicated services) = approximately 74,000 people per viable unit dedicated for Pacific users.

Further discussion is needed regarding the assumptions about demand, and regarding service viability. Also, no distinction has been made between communities with different Pacific origins. It is assumed that dedicated Pacific services would provide for all Pacific groups.

The data analysis for the whole of the New Zealand Pacific population is shown in Appendix 3, by four groups: general adult, drug and alcohol, child and youth, and older people's services. Appendix 3 lists just the universally provided service categories, ones for which dedicated services are most likely to be feasible (but not forensic and other specialty service areas).

The suggested allocation of dedicated Pacific services has been determined by comparing the assumed viable service levels with the service requirements of the populations in each region.

For example, the estimate of adult inpatient beds for half the Pacific mental health population is:

- Northern region 20
- Midland region 2
- Central region 5
- Southern region 2.

Only the Northern region needs more than the viable level of 10 beds, and therefore, according to this methodology, this is the only region that could justify a dedicated Pacific inpatient service. Table 7.3 shows just the 20 beds for the Northern region in the second row of the third column.

Table 7.3 summarises the results found when this approach is applied to all services.

Table 7.3: Estimated national requirements for dedicated Pacific mental health services

Resource categories	Total resources required for the Pacific population 2004 in accordance with *Blueprint* guidelines[19] (column 3 from Table 7.2)	Suggested allocation of dedicated Pacific services 2004 (for calculations, see Table A3 Appendix 3)
Inpatient beds and day places	98	20
Community residential beds	166	71
Drug and alcohol inpatient and community beds	27	10
Total inpatient and community residential beds (all age groups combined)	**291**	**101**
Adult community non-clinical support FTEs	88	31
Adult community drug and alcohol FTEs	41	15
All other *Blueprint* adult and older people community clinical FTEs	142	46
Child and youth community clinical FTEs	93	41
Community liaison FTEs (see footnote 16)	19	19
Total community FTEs	**383**	**152**

Regionally, the estimates for dedicated services would be allocated as set out in Table 7.4. Table 7.4 indicates no dedicated secondary services for the Midland and Southern regions, apart from liaison FTEs and a residential service in the South Island.

[19] FTE estimates have been adjusted for the Pacific population age structure.

Table 7.4: Estimated regional requirements for dedicated Pacific mental health services

Resource categories	Northern Region (2004 Pacific population 160,700)	Midland Region (2004 Pacific population 13,580)	Central Region (2004 Pacific population 40,030)	Southern Region (2004 Pacific population 14,220)	Total (Column 3 from Table 7.3)
Inpatient beds	20	–	–	–	20
Community residential beds	53	–	13	5 (Canterbury DHB)	71
Drug and alcohol inpatient and community beds	10	–	–	–	10
Total adult inpatient and community residential beds					101
Adult community non-clinical support FTEs	31	–	–	–	31
Adult community drug and alcohol FTEs	15	–	–	–	15
All other *Blueprint* adult and older people community clinical FTEs	37	–	9	–	46
Child and youth community clinical FTEs	33	–	8	–	41
Community liaison FTEs (see footnote 16)	12	2	3	2 (primarily Canterbury DHB)	19
Total community FTEs					152

8 Conclusions

The following areas are critical for service delivery to Pacific People with mental health service needs:

- 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
- information and research needs.

A Pacific mental health service framework development

There is a lack of strategic planning for Pacific mental health. While key documents such as *Strategic Directions for Mental Health Services for Pacific Islands People*, and the *Blueprint for Mental Health Services in New Zealand*, identified significant issues and put forward various recommendations, a comprehensive framework and plan for Pacific mental health services and workforce still needs to be developed.

This discussion paper provides a basis for development of such a framework and plan. In particular section 7 provides estimates of the mental health services resource needs of the Pacific population, including the resources required to provide dedicated Pacific secondary mental health services that are consistent with *Blueprint* resource guidelines.

Pacific provider development

The capacity of Pacific providers requires urgent attention. There are issues concerning provider infrastructure and management, the skills of the workforce and service standards. Maori health providers, the HFA and now the Ministry of Health have been working together on provider development through Maori Development Organisations (MDOs). This model may be usefully considered by Pacific mental health organisations, particularly in the Auckland area.

Pacific workforce development, including Pacific service users

The under-representation of Pacific people across all occupations in the mental health sector needs to be addressed urgently. There is also a pressing need to upskill the current Pacific mental health workforce so that they are both culturally and clinically competent. There is strong support among Pacific providers for the use of specified competencies as a focus for education and training programmes and for performance appraisals for staff.

There is a particular need for more Pacific mental health support workers, and for them to be supported in achieving as a minimum qualification the National Certificate in Mental Health (Mental Health Support Work).

A variety of issues regarding traditional healers need addressing. These include: the nature and extent of use of traditional healers, registration, accreditation, professionalisation, quality, ethics and safety. There is a particular need to conduct research about use of traditional healers,

including levels and type of use, reasons for use, and impacts of traditional treatment on conventional medical treatments.

Pacific services users also need opportunities and support to develop workforce roles in mental health services.

Increasing cultural responsiveness of mainstream services

Mainstream capacity to meet the mental health needs of Pacific people must be improved. Pacific focused services are only likely to be viable in areas where the Pacific population is highly concentrated, and mainstream services everywhere need to be responsive and flexible for their Pacific communities. Greater application of holistic models for Pacific mental health is required, including establishing and maintaining links between mental health, primary health and social services.

Mental health services also play an important role in involving families in the individual's recovery and helping families gain a better understanding of mental health issues, including the medical and technical aspects of mental illness and recovery.

It is imperative that the new DHBs understand, and are responsive to the needs of Pacific communities with regard to mental health service planning, funding and delivery. This will require diverse responses and effective consultation processes. There is also a significant need to develop Pacific leadership across the mental health sector.

Promoting and implementing anti-discrimination work

Work on eliminating stigma and discrimination affecting Pacific people with mental illness must recognise and deal with the diverse and compounding aspects of discrimination they encounter. In the mental health system, Pacific communities and wider society, stigma and discrimination against those with mental illness is a serious problem. The provision of culturally inappropriate services can result in barriers to accessing mental health services and impede recovery. Pacific people may also be exposed to discrimination more generally in accessing housing, employment or other services. This in itself may pose risks to mental health and recovery.

Partnerships with Pacific service users

There are a growing number of new Pacific mental health services as well as an increase in Pacific peoples working within mainstream mental health. Whether a service is mainstream or a specialist Pacific provider, partnership with Pacific service users must be reflected in processes for active involvement of Pacific service users in decisions about the mental health system and services that affect their lives.

Discrimination is a major barrier to Pacific service users participating fully in services. Pacific peoples face double discrimination because of being service users and also because of their ethnicity or cultural identity. It is important, therefore, that staff at all levels of the service provider, from senior management to those delivering services directly to Pacific service users understand barriers to effective Pacific service user participation, and have a commitment to eliminating these within services.

Information and research needs

An up to date and comprehensive knowledge base is essential for policy development and service planning. There is a significant dearth of timely, accurate and rigorous data and research

about the mental health status of Pacific people. Information on the Pacific mental health workforce must also be routinely collected. The Pacific mental health workforce survey discussed in section 5 provides an important baseline.

The current policy of the Health Research Council of New Zealand (HRC) identifies Pacific mental health research as a priority. However, little is known about the nature and extent of research already undertaken on Pacific mental health by tertiary education institutions, and by private researchers. There is also an urgent need to increase the pool of Pacific mental health researchers.

9 Recommendations

It is recommended that:

1 **The Ministry of Health** develop a strategic framework to support Pacific mental health service and workforce development at national, regional and local levels by June 2002.

2 **The Ministry of Health and the Mental Health Commission**, by 2002, investigate the desirability and feasibility of establishing a Pacific provider development organisation that would:

- conduct needs analyses of Pacific mental health service needs
- undertake service contracts with funders, and sub-contract provision with member service providers
- provide support and advice for Pacific provider development
- undertake an advocacy function with Government and its agencies on behalf of Pacific providers
- develop strategic plans for capacity building and service provision with Pacific development organisation geographic areas
- monitor contract compliance of all member service providers.

3 **The Ministry of Health, DHBs, and Pacific providers** develop innovative ways to upskill the Pacific mental health workforce including:

- using recruitment and information processes specifically targeted to Pacific communities
- mentoring for Pacific workers in mental health
- provision of ongoing training in both cultural and clinical skills
- involving a group of Pacific leaders to advise on Pacific workforce development.

4 **The Ministry of Health and Pacific providers** establish a comprehensive, relevant and achievable set of cultural competency standards to provide a clear statement of desired performance for the mental health workforce delivering services to Pacific people.

5 **DHBs and service providers, in areas with significant Pacific populations**, support the development of Pacific service users as employees, and the involvement of Pacific consumer advisers in mental health services by developing Pacific service users in mental health workforce roles (e.g. advisors, representatives, advocates, mental health workers with detailed understanding of mental health concepts and processes).

6 **DHBs and other services** develop partnerships with Pacific service users that:

- recognise the diversity of Pacific cultures and perspectives on health, especially the central importance and influence of faith, family and culture in the lives of Pacific peoples
- involve Pacific service users in a culturally appropriate manner and non-discriminatory way
- ensure Pacific service users influence decision-making at all levels of the service
- provide market rates for remuneration for Pacific service user participation in services

- provide resources, knowledge, information and supports required (e.g. Pacific interpreters, advocates etc.) to facilitate effective partnership with Pacific service users.

7 **DHBs** establish partnership mechanisms with their Pacific communities that address Pacific needs concerning service planning, funding and delivery, and workforce development.

8 **DHBs** ensure that their mental health services support and actively assist Pacific people to:

- access the mental health services most appropriate and useful for them
- deal with discrimination against Pacific people with mental illness
- use other services required for recovery, including social services, employment services, training services and housing services.

9 **DHBs** undertake regular monitoring and evaluation of mental health services delivered to Pacific people by:

- establishing and maintaining appropriate monitoring systems and databases that collect comprehensive and accurate information on Pacific mental health service users
- collecting information on the Pacific mental health workforce.

10 **The Ministry of Health** strengthen the effectiveness of its monitoring and evaluation framework in contributing to improved mental health outcomes for Pacific people by:

- encouraging DHB and other mental health service providers to collect and maintain Pacific ethnicity data that meets quality criteria
- ensuring that DHBs collect the range and quality of information required to deliver appropriate services for Pacific people

11 **The Ministry of Health** commissions research that accurately and comprehensively identifies the nature and extent of mental illness among the Pacific population.

12 **The agencies with responsibility for public good health research funding and purchase**:

- undertake a stocktake of Pacific mental health research activity and capacity by December 2001, as a first step to addressing gaps in research and setting strategic directions
- in consultation with Pacific research leaders produce a Pacific mental health research strategy that includes developing the capacity of Pacific mental health researchers, by June 2002.

Glossary

Alofa	Affection; love (Samoan)
District Health Board	Means the District Health Board established under s32 of New Zealand Public Health and Disability Act 2000. DHBs were established to assume many of the planning and funding functions previously carried out by the HFA, and to perform the services formerly carried out by HHSs.
Fonofale	The traditional Samoan meeting house.
FTE	Full-time equivalent.
Hospital and Health Services (HHSs)	A term to describe former Crown-owned entities that provided health and disability support services. HHSs were disestablished on enactment of the New Zealand Public Health and Disability Act 2000.
Matua	Parent (Samoan). This term has also evolved in the health sector to describe a Pacific person, usually an elder, whose credibility in Pacific communities is due to their work for Pacific people, who is held in high regard by the people the person services, and who has expert knowledge in cultural belief and protocols that has been accepted and supported from the people the person serves.
National Mental Health Standards	Standards developed by the Ministry of Health for use by mental health service providers to improve quality of services and ensure consistency for people who need to use them. The standards were revised by Standards New Zealand in 2001.
National Mental Health Strategy	An overall strategy for mental health covering Government's goals, principles, and objectives for mental health services. It is encapsulated by two key documents: Looking Forward: Strategic Directions for Mental Health Services published in June 1994; and Blueprint for Mental Health Services in New Zealand published in November 1998.
Pacific people	Describes the wide variety of people living in New Zealand who have migrated from the Pacific Islands or who identify with the Pacific Islands because of ancestry or heritage. The term encompasses a range of ethnic, national, language and cultural groupings.
Palagi	European, white man; European ways (Samoan). Short for *papalagi*, but first vowel often omitted in colloquial usage.
Recovery	Living well in the presence or absence of mental illness.
Service user	A person who experiences or has experienced mental illness, and who uses or has used mental health services. Other terms frequently used are consumer, survivor, patient, resident, and client.
Tangata whenua	People of the land or region; hosts; the indigenous people of New Zealand/Aotearoa (Maori).
Taonga	Treasures; special possessions (New Zealand Maori).
Whanaungatanga	Family relationships; family cohesion (New Zealand Maori).

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Appendix 1: Key Documents Concerning Pacific Mental Health

The following documents are presented in chronological order.

Strategic directions for mental health services for Pacific Islands people (1995)

Published by the Ministry of Health after extensive Pacific consultation, the document put forward numerous recommendations for services including:

- a national advisory council for Pacific Islands Mental Health. This advisory council was never established, although there is now a Pacific reference group to the Pacific Chief Advisor to the Minister of Health. There is also the Pacific Peoples Advisory Committee to the Mental Health Commission
- a cultural advocacy service for Pacific consumers of mental health services. Cultural advocacy services have been established widely to make mainstream services more responsive to the delivery of more culturally appropriate and safe services. However, cultural advocacy cannot substitute for ensuring that there are more Pacific mental health professionals
- early intervention services in relation to deliberate self-harm and youth suicide. Effective services for Pacific people requires Pacific staffed and driven services working under accepted models of care unique to and compatible with Pacific values and methods of working
- funding and training for Pacific families to enable them to care for relatives with mental and other disabilities at home. Pacific families still care for the majority of Pacific people with high on-going support needs. This area has not received adequate attention and continues to be problematic
- identification of areas where Pacific providers could develop Pacific services, e.g. the child and youth, and forensic areas. Training to develop the Pacific mental health professional workforce in needed areas is also required
- cultural safety education at service and community levels. The Health Funding Authority had funded Pacific cultural safety workshops, especially in Auckland since 1998. There is a growing need for Pacific educators designing and running these workshops to consult more widely as the number of mental health practitioners increases. This will ensure the material being presented in these workshops is consistent with increasing knowledge amongst mental health practitioners from the various Pacific ethnic groups. There is a growing number of Pacific psychologists, social workers, registered nurses and researchers in the sector.

Towards better mental health services (1996)

The report of the National Working Party on Mental Health Workforce Development provides a comprehensive analysis of the issues confronting the mental health sector, specifically in relation to workforce development. It identified strategies to move the mental health workforce in the directions required for meeting changing service delivery patterns.

Making a Pacific difference: strategic initiatives for the health of Pacific people (1997)

Based on consultation with Pacific people and Pacific health workers, this document sets out the first national strategy for a range of health services and other resources to improve, promote and protect the health of Pacific people.

Moving forward: the national mental health plan for more and better services (1997)

National Objective 3.8: To improve the responsiveness of mental health services to Pacific people states that, "The development of the Pacific mental health workforce is an important prerequisite for the further development of Pacific people's services, as well as more responsive mainstream services" *(Ministry of Health 1997b: 41)*.

The blueprint for mental health services in New Zealand (1998)

This is the Mental Health Commission's description of the mental health service developments required for implementation of the Government's National Mental Health Strategy. The *Blueprint* gives special consideration to the mental health service needs for Pacific people. It supports increasing ownership and provision of services for Pacific people as the best means of achieving improvements in the quality of life for Pacific consumers of mental health services.

In the *Blueprint* the Pacific Peoples Advisory Committee of the Mental Health Commission recommended a range of Pacific-focused additional services for areas with significant numbers of Pacific people *(Mental Health Commission 1998: 71)*. Such services are likely to become increasingly important in Porirua and parts of Auckland where half of all children and youth are Pacific people, and in the Wellington region and South Waikato, where one quarter of all children and youth are Pacific people. Needed services include:

- support and education for recovery services
- residential services for those with higher support needs
- child and youth assessment, treatment, inpatient and community residential services, including 'at risk' youth residential services
- alcohol and drug residential treatment services (including 'dual diagnosis services), supported living services, and community residential services
- Pacific community support workers and support for Pacific people consumer services
- support for traditional health services offering alternative treatment options.

The *Blueprint* states that the following measures are needed to progress Pacific workforce development *(Mental Health Commission 1998: 69)*.

- The mental health sector must make a genuine commitment to training Pacific people with experience of mental illness for meaningful jobs in the sector.
- Training of Pacific Mental Health Support Workers must be given priority.
- There must be collaboration between mental health education providers and Pacific providers and communities. Pacific people need equitable access to undertake training.
- Positive affirmation and funding is required to attract Pacific undergraduates in the health sciences to choose a career in mental health. Increasing the understanding and knowledge of Pacific cultures must be facilitated by continuing education and training, and the employment of more Pacific people in mental health services.

- The mental health sector needs to provide management training for Pacific people to take on management roles in mainstream services and Pacific services.
- There needs to be consistency and quality in the material that is being taught across programmes and throughout all education providers in the sector. This will require active collaboration between mental health education providers and Pacific providers. A Pacific body should have responsibility and ownership of this.
- There needs to be acceptance and funding for creditable traditional healers.

Developing the mental health workforce (1999)

The report of the National Mental Health Workforce Development Co-ordinating Committee emphasises that the most critical priority in Pacific workforce development is to develop an appropriately skilled workforce. The report recommended several strategies including: recruitment initiatives, increasing the numbers of Pacific mental health researchers, managers of Pacific mental health services and Pacific mental health support workers, making available clinical placements for Pacific students, attention to remuneration, and establishing a network of Pacific mental health workers.

Tuutahitia te wero: meeting the challenges (2000)

This document sets out a seven point strategy, with indicative funding, to achieve a strong Pacific people's mental health workforce *(Health Funding Authority 2000: 17)*.

- Support training initiatives to further develop Pacific peoples service delivery models.
- Establish a programme analogous to Te Rua Puawai for Maori workers, to support undergraduate and graduate education for Pacific people who plan to work in mental health.
- Fund preceptorships for new Pacific peoples mental health staff in HHSs and NGOs (registered health professionals).
- Fund access and support packages for all Pacific people enrolled in Clinical Training Agency (CTA)-funded mental health programmes.
- Prioritise staff of Pacific mental health services, and Pacific peoples staff in all services to enrol in any new generic training opportunities.
- Review and revise all CTA training specifications to enhance their relevance to working with Pacific people.
- Encourage new entrants to the Pacific mental health workforce through positive profiling of the sector in Pacific communities.

Appendix 2: Survey of the Pacific Workforce in the Mental Health Sector

Twenty-three Hospital Health Services (HHSs) and over 300 non-government organisations (NGOs) were contacted to gather information on Pacific workers. Contact details for each of the HHSs and NGOs were established by information from the Mental Health Commission, Internet, Mental Health Foundation, and through personal networks. To ensure that data received was current, additional information was gathered from individual HHSs, including names and details for all NGOs within each region.

The larger HHSs such as those in Auckland, Wellington and Christchurch, were sent a letter and questionnaire to the team leader of each individual mental health and alcohol and drug team/service. The team leader was responsible for co-ordinating staff to complete the questionnaire and return it in a self-addressed pre-paid envelope.

The smaller HHSs were contacted by phone and key personnel in each were identified, such as general or service managers. A letter and questionnaire were then sent to those people, who co-ordinated the return of the questionnaires. Each provider was asked to send a return, regardless of whether they employed any staff of Pacific ethnicity to ensure that all services had returned the information. All returns were recorded as received, and checked off against the contact record.

Once individual staff had been identified, and the initial questionnaire form returned, a second letter was sent to the individual worker to complete any details, and to provide their consent to be identified within a directory.

Appendix 3: Estimates of Resources required for Pacific Mental Health Services

Table A3 shows the analysis for four groups of guidelines: general adult, drug and alcohol services, child and youth, and older people's services. Each row represents a category or kind of service that is available throughout the country; highly specialised services such as forensic services and separate mother-and-baby services have been excluded.

It might be possible to support dedicated Pacific services in some regions, as shown by the highlighted cells in the table, assuming that:

- 50 percent of the Pacific population might choose to use a dedicated Pacific service in their area, if available
- 10 beds is sufficient for a viable inpatient unit
- five beds is sufficient for a viable mixed-level community residential service
- six FTEs is sufficient for a viable community clinical team
- 10 FTEs is sufficient for a viable community non-clinical support team
- two or more liaison staff could be employed effectively.

Table A3: Analysis for four groups of guidelines

Column 1 Service category	Column 2 Purchase unit	Column 3 *Blueprint* guideline[20] per 100,000 population	Column 4 Age-adjusted guideline per 100,000	Column 5 Guideline per Pacific population New Zealand 2004[21]	Column 6 Estimated Pacific resources at 50% of total guideline	Column 7 Assumed viable resource levels for dedicated Pacific services	The four columns below, show how the resources in column 6 would be divided between the four regions on the basis of the distribution of the Pacific population			
							Auckland 70% of Pacific population	Midland 6%	Wellington 18%	Southern 6%
Adult inpatient	Bed	27	47	56	28	10	20	2	5	2
Adult community residential	Bed	72	123	150	75	5	53	4	13	5
Adult community clinical	FTE	51	87	106	53	6	37	3	9	3
Adult non-clinical support	FTE	42	72	88	44	10	31	3	8	3
Drug and alcohol (D&A) inpatient and community	Beds	13	22	27	14	10	10	1	2	1
D&A community	FTEs	20	34	41	21	6	15	1	4	1
Child and youth community clinical	FTE	29	94	93	47	6	33	3	8	3
Older people beds/day care	Bed/care package	8	68	6	3	10	2	0	1	0
Older people community clinical	FTE	9	73	6	3	6	2	0	1	0
Liaison FTEs					19	2	12	2	3	2

Note that white cells indicate service categories and regions where dedicated services could be provided.

[20] Figures have been rounded to the nearest whole number.

[21] These figures have been adjusted for the lower proportion of adults, and particularly people 65 years and over, compared with the New Zealand population as a whole.