Targeted Recruitment Strategies

For the Child and Adolescent Mental Health and Addictions Workforce, with a Māori and Pacific Focus

Werry Centre

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Executive Summary

Background

Māori and Pacific people in New Zealand have youthful populations that experience high levels of mental illness but have low access to treatment. There is a failure of current mental health delivery systems to adequately provide responsive and accessible services to these fast-growing population groups. There are low numbers of Kaupapa Māori and Pacific services serving children and adolescents with mental health and addiction issues. The significantly low number of Māori and Pacific clinicians working in child and adolescent mental health is also a major contributing factor (Bir et al., 2007; Ramage et al., 2005).

There is high and increasing demand for a culturally and clinically competent child and adolescent mental health and addictions workforce. However, the current supply to meet this demand is limited and there is urgent need to develop and strengthen workforces.

Identifying appropriate recruitment strategies for Māori and Pacific people is a step in the direction towards increasing the capacity and capability of the Māori and Pacific child and adolescent mental health and addictions sector.

It is hoped that medium to long term strategies will develop a critical mass of Māori and Pacific workers employed in child and adolescent mental health services, over the next 2-5 years. Such strategies should emphasise the necessity of collaborative relationships between mental health services and mental health workforce suppliers i.e. training institutions.

Māori

The international indigenous recruitment literature provides a variety of themes which are relevant to the Māori workforce in child and adolescent mental health. The need to reclaim our unique indigeneity, developing “by and for us” solutions as well as ensuring that we engage our future workforce recruits early in their educational journey are clear themes consistently repeated in the literature.

The New Zealand literature has a growing body of Māori writings, which showcase organisations that are innovative in how they have increased their own Māori workforce numbers (Te Rau Matatini, 2007b). Naturally then, it makes sense to take the learnings from innovations and best practice, the literature, and working models, and align them to specialist Māori child and adolescent mental health and addictions workforce recruitment initiatives.

Some examples of effective Māori recruitment strategies are:

- Target Māori students and their whānau early in the secondary school process (Nikora, Rua, Duirs, Thompson, & Amuketi, 2004; Ratima et al., 2007; Te Rau Matatini, 2006) (Rangatahi Programme, 2007).
- Utilise existing promotional youth careers material e.g. *Whaia Te Ara Mou* (Te Rau Matatini, 2007a) (He Waka Oranga, 2006, Rangatahi Programme, University of Auckland's Vision 20:20 programme).
- Provide financial assistance alongside a culturally safe and affirming learning environment (Nikora et al., 2004; Ratima et al., 2007).
- Provide a culturally responsive wraparound and indigenous mentoring programme including part-time work in the sector (Nikora et al., 2004; Ratima et al., 2007). (Rangatahi Programme, 2007).
- Recruit Māori mentors to act as recruitment brokers (Rangatahi Programme, 2007).
- Encourage better relationships between tertiary education and child and adolescent mental health services (Ihimaera, Maxwell-Crawford, & Tassell, 2004).
- Look towards developing new roles and extending the training of professions with related skills e.g. teachers as a potential new group to recruit into mental health.

Pacific

Due to the lack of systematic evidence-based research and little international literature on diversity or minority recruitment strategies, it is difficult to determine what is 'best-practice' in terms of recruiting minority groups. New Zealand literature has highlighted major barriers in recruiting Pacific people into mental health. Stigma attached to mental health issues, education levels, low socio-economic status, and a lack of knowledge by Pacific communities of the range of health careers and opportunities are all contributing factors.

Pacific targeted recruitment strategies in the New Zealand mental health sector identified in the fieldwork are:

- Pacific mental health scholarship schemes
- Work placement programmes including apprenticeships
- Pacific sector leadership

- Pacific led recruitment campaigns and drives

Pacific recruitment strategies in other sectors of merit have been:

Pacific recruitment brokers and support in the Education sector and for the New Zealand Police, Pacific specific education qualifications (e.g. Bachelor of Pacific nursing), affirmative action programmes for Pacific students in medicine, nursing, pharmacy and health sciences, "bridging" programmes, Pacific career expo's, family-friendly workplace approaches, and an innovative strategy utilising an electronic social networking service.

A Way Forward: Pipeline Approach

The proposed framework for medium to long-term workforce strategies is based on a "pipeline" approach where workforce development is perceived as a pathway. This approach allows a whole-of-system approach, promotes intersectoral collaboration, and presents a range of recruitment intervention points for the target populations (see Figure 1).

"Entry Level" targeted points of intervention are:

1) Secondary schools with high Māori and Pacific populations:

Student workplace exposure with ongoing learning and experience follow up; promotion of science and health study and careers, identification and targeted promotion of pathways into child and adolescent mental health careers.

2) Career Changers in Social Work and Nursing:

Introduction of a Māori and/or Pacific Mental Health Recruitment Broker at regional level; Apprenticeship-style recruitment (with the "earn as you learn" approach); and the support and promotion of cohort-style child and adolescent mental health training during employment.

3) Non-practising general Pacific nurses:

Design and implementation of a specialist Pacific child and adolescent mental health and addictions return-to-nursing programme; the Māori/Pacific Recruitment Broker and Apprenticeship-style recruitment; and the cohort-style CAMH training (as above).

"Tertiary Education" targeted points of intervention are the "Harakeke Model" (Figure 2):

1) Māori and Pacific "recent and near graduates" in Social Work and Nursing.

The major recruitment strategy here is the implementation of the Harakeke model adapted for Child and Adolescent Mental Health Workforce Development (see Figure 2). This model of scholarship and support can also be applied to tertiary students, "Career Changers", Pacific

“return to career nurses”, as well as secondary school leavers. It also complements the Apprenticeship-style strategy as well as the cohort-style training strategy.

“Service Level” targeted points of intervention are:

Enhanced cultural responsiveness and cultural competency within organisations. Strategies include conducting an organisational cultural competency assessment, developing an organisational cultural competency plan, promotion of dual clinical and cultural competency frameworks such as ‘*Lets Get Real*’ (Ministry of Health, 2007d) and *‘Real Skills Plus’* (The Werry Centre for Child and Adolescent Mental Health Workforce Development, 2008b) and promotion of career pathways and leadership.

Figure 1. Pipeline Approach for Māori & Pacific CAMH & Addictions Recruitment

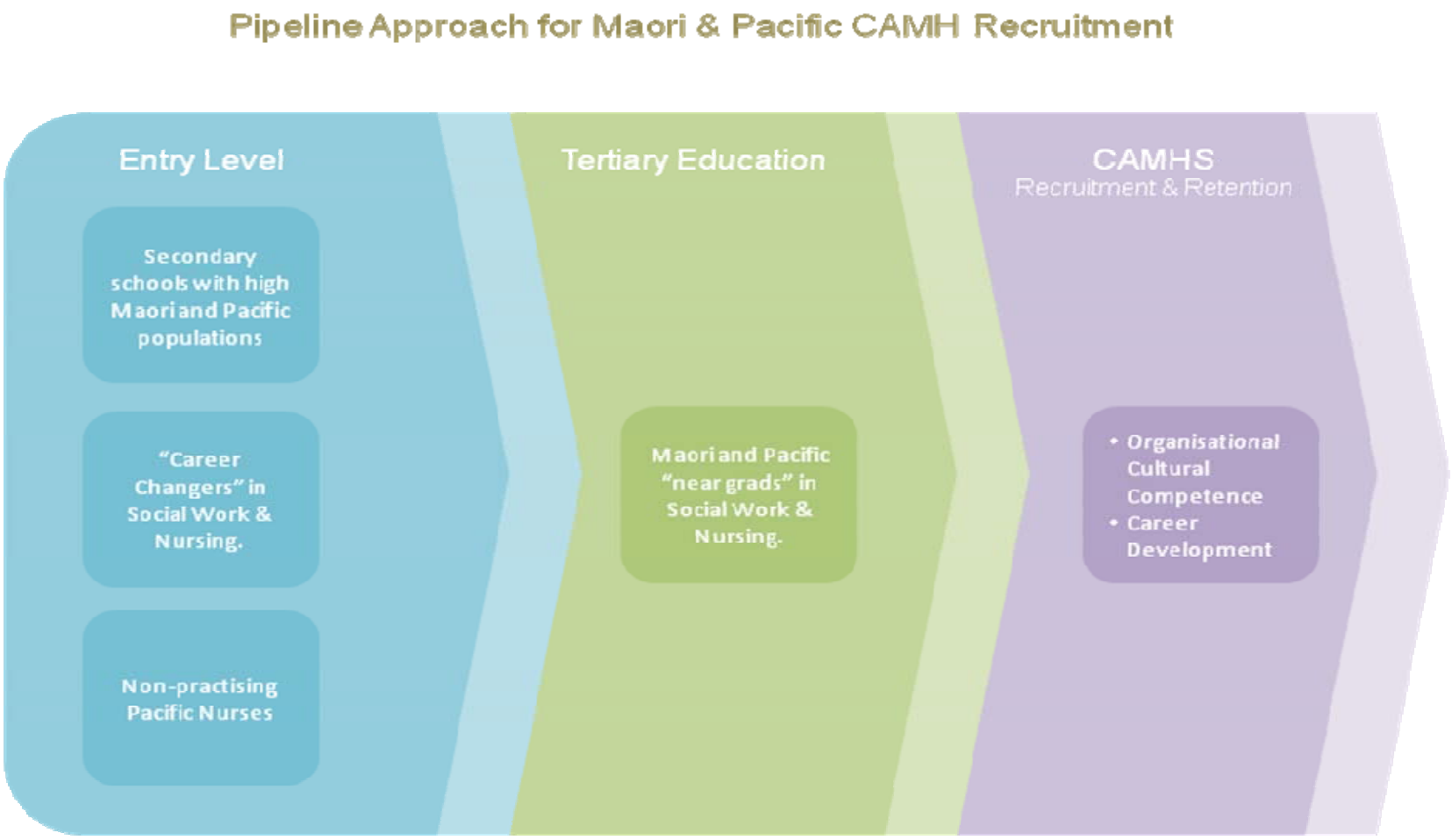
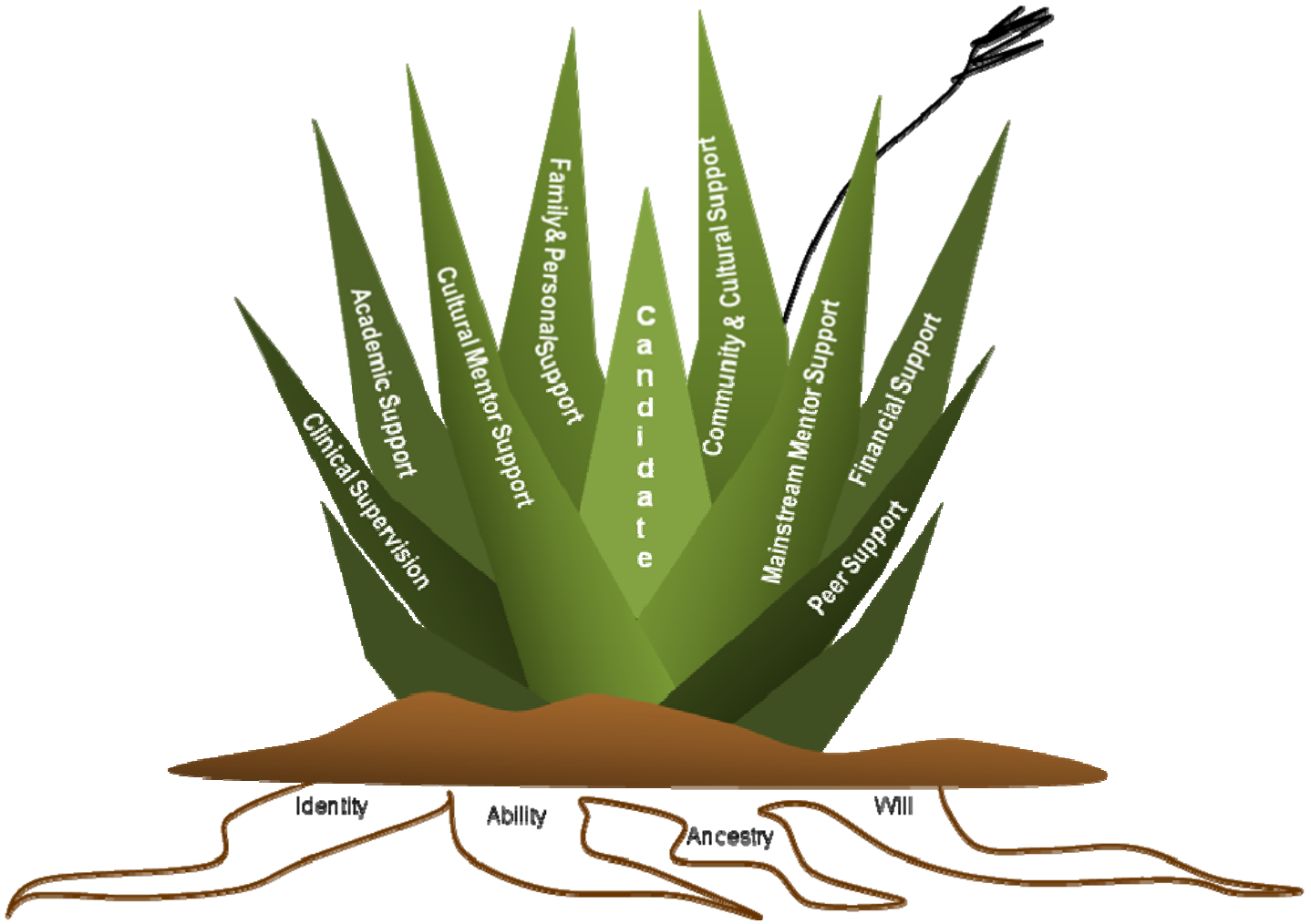


Figure 2. Harekeke Model

Child and Adolescent Mental Health Workforce Development



“Health care systems and structural processes of care are shaped by the leadership that designs them and the workforce that carries them out. From this organisational standpoint, one factor that impinges on both the availability and acceptability of health care for members of minority racial/ethnic groups is the degree to which the nation’s health care leadership and workforce reflect the racial/ethnic composition of the general population”

(Betancourt, Green, Carrillo, & et al., 2003)