

A review of work-force development literature for the Māori addiction treatment field in Aotearoa/New Zealand

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Abstract

Māori, like Indigenous Australians and other indigenous people world-wide, are simultaneously over-represented among those presenting with addiction-related problems and under-represented within various health professions. Providing the opportunity for individuals and whanau (family/extended family) to work with ethnically matched health workers is likely to increase service accessibility and to improve treatment outcomes. In New Zealand, a number of initiatives have been instigated to increase the capacity of the Māori health work-force and reduce related barriers to treatment. This article provides an analysis of relevant literature and policy documents, and identifies five strategic imperatives currently informing work-force development in the Māori alcohol and other drug (AOD) and gambling treatment sector. [Robertson PJ, Haitana TN, Pitama SG, Huriwai TT. A review of work-force development literature for the Māori addiction treatment field in Aotearoa/New Zealand. *Drug Alcohol Rev* 2006;25:233–239]

Key words: alcohol, indigenous, Māori, other drug, work-force development.

Introduction

Among the health strategy and policy documents produced in New Zealand and Australia over the last decade, there is an increasing body of work focusing on the issues of Māori and Aboriginal mental health and addiction. This has been part of the response to research which has identified continued health and social disparities for indigenous peoples worldwide [1–9]. Problematic use of a range of substances and addiction, including gambling, has been clearly implicated in the maintenance of such disparities [10–18].

Like other indigenous peoples, Māori are over-represented in most health client populations including mental health and alcohol and drug, but under-represented in health professions [1,19–22]. Strategies to enhance the indigenous health work-force have, however, tended to be fairly general to date, offering little specific guidance for development [20,23]. Similarly, although consideration of the needs of indigenous peoples within the ‘mainstream’ [6,18,24] has highlighted a requirement for increased competence of non-indigenous clinicians, details of how this might

be achieved have also been limited. The latter area should not, however, be conflated with indigenous work-force development, given different needs and expectations.

Limitations are also apparent in the general literature on the alcohol and other drugs (AOD) work-force, which has begun only relatively recently to have its specific needs considered separately within the broader context of mental health [25–26]. Such limitations in indigenous and general AOD literature notwithstanding, a recent report on the Māori mental health work-force has provided a useful summary of issues pertinent to indigenous AOD work-force development [20]. Key areas addressed in this report included: recruitment and retention, training, research and evaluation and infrastructure development.

Approach

The current review was undertaken as part of the literature review for the New Zealand National Addiction Work-force Strategic Plan [25]. The primary

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aim was to ensure that the needs and aspirations of Māori would be accounted for within this plan, which provides part of the foundation for a national addiction treatment work-force development programme Matua Raki. Literature was identified primarily by keyword searches within a range of electronic databases, websites and web-based search engines. Searches were limited to literature published in English between 1990 and 2005. All indigenous addiction and mental health work-force development-related publications were included, along with key literature on 'mainstream' work-force development. While the primary focus of the review was on Māori, consideration was also given to Australian and, to a lesser extent, other indigenous developments.

The following databases and web-based search engines were used to identify a range of both academic and grey literature: MEDLINE; PsychINFO; Web of Knowledge; Science Direct; Proquest Medical Databases; Google. The following keyword search terms were used: Work-force Development; Work-force AND Indigenous OR Māori OR Aboriginal OR First Nations; Work-force Development AND Health OR Policy OR Addiction OR Alcohol OR Drugs; Māori AND Alcohol OR Drugs. Further searches were carried out through the references of key publications in order to locate additional relevant literature.

Key findings

The review revealed five key areas related to Māori and other indigenous work-force development. These were elucidated most clearly in Te Rau Matatini's [National Māori Mental Health Work-force Development Programme] (TRM) *Macro-analysis of the Māori mental health work-force* [20], and provide the primary focus of discussion in this section.

Increasing capacity: recruitment and retention

Increasing the number and capacity of indigenous workers, along with retention of those currently employed in the sector, has been identified as vital for ensuring indigenous clients' access to effective and appropriate treatment [19,20,22–24,26–30]. Forecasted work-force requirements estimated the need to increase the number of Māori workers by 24–93%, depending on specific roles [24–28]. A similar need, although no specific figures were provided, was also identified in the Australian context [22,30].

While all literature reviewed advocated the need to recruit and retain indigenous staff, for the most part only general suggestions were provided for how this might be achieved. Only TRM's document [20] outlined more detailed strategies. Although focused on Māori mental health work-force development, the

issues addressed below are clearly relevant to the indigenous addiction treatment sector.

- *Education in secondary/tertiary sector.* TRM noted that although more Māori are engaging in higher education, they continue to leave school early and complete less advanced tertiary qualifications than non-Māori. Identifying career pathways for young Māori through introductory level health courses was recommended as part of addressing recruitment issues. Better remuneration was also cited as critical to attracting and retaining individuals in the sector.
- *Supportive working environments* were noted as being vital. It was suggested that the mental health field must establish a reputation for providing positive working environments for Māori, including support for ongoing relevant training and normalisation of Māori frameworks, practices, and values.
- *Gender imbalance* was identified as problematic due to the Māori mental health work-force being comprised largely of women, while a majority of service users are men. TRM's report recommended a specific focus on attracting more men into the sector.
- *Population growth and ageing* was also identified as providing a challenge for the Māori mental health work-force. It was also noted, however, that demographic trends could increase the pool of potential workers.

While the *macro-analysis* [20] identified important issues in terms of operationalising Māori work-force development policies, not all suggestions were as salient for the AOD treatment sector. Some recent studies indicate, for example, that Māori men make up just over half of the work-force (52%) in the Māori AOD treatment field [31–35]. Additionally, while gender congruency may contribute to treatment success, other worker characteristics may also have an influence [15,32,36]. It also appears that although female clients tend to have a preference for gender congruency this is less marked for males who make up the majority of the AOD clientele [15,32,33]. Thus, a number of aspects of the AOD work-force suggest that gender-specific recruitment may not be a high priority at this point.

Improving remuneration and developing clear career pathways is clearly important to recruitment and retention, although the potential impact of fiscal constraints within the health sector on this must be acknowledged. Additionally, the fact that Māori are more likely to be employed in lower-paid support roles rather than as 'professionals' needs to be accounted for [33,34,36]. Thus, it is critical to address both the low

pay of support workers and increase the number of Māori with ‘professional’ qualifications. This would improve overall pay parity in the work-force as well as contributing to pressure to increase the cultural responsiveness of specific ‘professions’.

Proposals to develop strategies for recruitment of school leavers and younger Māori as a means of addressing staffing issues clearly have merit. This should not, however, be the only recruitment option, as a sole focus on youth ignores possibilities for encouraging more mature individuals with relevant experience and skills to work in the sector. This is especially pertinent in the AOD treatment field, particularly for Māori and Indigenous Australians, as entering the work-force from one’s own recovery has been a common pathway [30,35,37]. This group is likely to have specific needs in terms of recruitment and training, not necessarily accounted for within more generic approaches to work-force development.

Increasing capability: training and development

Training and development has been promoted routinely within the work-force development literature, characteristically in close alignment with recruitment and retention strategies [5,19,20,22,23,25–28,30,38]. Generally, the AOD work-force has been identified as containing a substantial minority of workers with limited formal qualification [28,30,34]. Given the significant number of Māori and Indigenous Australians included in this group in their respective countries, it is important to ensure that training processes and materials are compatible with indigenous experiences and practices. It is also important to recognise that those defined as ‘under trained’ are likely to have a range of relevant experience and skills [30].

The need to support the training of both new entrants and existing workers has been recognised within proposals for increased training scholarships and other financial supports [27,28,39]. This has been promoted across all areas, including the health ‘professions’, management and research, as well as cultural and community development [23,28,29].

Te Rau Matatini’s *macro analysis* [20] identified the following as important in indigenous focused training and development;

- *dual cultural/clinical competency* across all ‘professions’ was highlighted as a key area for development;
- clearly identifying and addressing specific *barriers to education and training*;
- *technological advancement and support* was identified as critical for developing innovative workers and services; and

- *supportive working environments* were identified as essential to facilitating training and ongoing professional development.

Increasing the skill base of Māori staff in relation to cultural and clinical areas of competence has been proposed as an essential element of development [19,20,23,31]. While building so-called ‘dual cultural and clinical’ competencies is crucial, the integrative development of these elements is not a simple task. Some work has been undertaken in this area; however, this is still in the early stages and further conceptual development is needed [17,30,36,40–42]. Work in *kaupapa Māori* research is pertinent here in terms of its identification of the ontological and epistemological challenges involved in such integration, which precludes mere parallel application of cultural and clinical elements [43] [*Kaupapa Māori* refers to services or research founded on Māori beliefs, values and practices, and governed/controlled by Māori organisations/groups]. Thus, while integration of these elements is crucial to indigenous work-force development, there is a need to develop a more sophisticated conceptualisation of the relationship between them, particularly in the context of clinical practice.

It is also important to consider the overlap between clinical/cultural competence and organisational development. While it is desirable for individual workers to possess a high level of competence across a range of areas, it may be more feasible to adopt a team approach which allows individuals to draw on the complementary expertise of colleagues and members of the community [20]. This may involve non-indigenous workers; however, it is critical that indigenous workers and communities maintain control over development and implementation strategies. Failure to locate real power with indigenous peoples is likely to contribute to continued marginalisation of their needs and aspirations.

Training non-indigenous clinicians to work more effectively with indigenous peoples is crucial to developing more responsive services, given that a large number of indigenous clients access non-indigenous clinicians for a range of reasons, including the limited number of trained indigenous workers [22,30,36,41]. While not within the scope of the current review, it needs to be noted that the development of such training can be easily ignored if the onus for cultural responsiveness is placed solely on indigenous peoples.

Providing supportive working environments: organisational/service development

Individually focused developments are likely to have limited impact in the absence of changes at an organisational level. In terms of recommendations in

this area, the literature has tended to fall into two broad categories: general service development and more individually focused ‘best practice’ [20,22,44].

In terms of broader development, Te Rau Matatini’s [20] recommendations mirrored their focus in other areas on enhancement and maintenance of ‘dual’ cultural and clinical competence. They noted, however, that failure to develop a comprehensive structure for this to occur within could lead to a significant extra load on Māori staff. Additionally, ongoing monitoring and evaluation of trends in service use, as well as the characteristics of clients, were cited as important to the development of infrastructure and training.

A smaller subset of the literature in the area of organisational/service development described elements of ‘best practice’ [22,23,26,41,44]. Some guidelines focused primarily on ‘cultural’ elements [23,26], while others also included discussion of Euro-western ‘clinical’ facets of practice [41,44]. In the New Zealand context, much of the focus has been on developing clinical treatment, while Australian literature has included consideration of broader interventions, including those related to supply [22].

In terms of ‘cultural’ elements, use of Māori language and processes, along with inclusion of *kaumatua* (elders) and *tohunga* (traditional healers), were identified as being integral to work-force development, potentially mirroring the Australian promotion of Indigenous ‘perspectives’ [17,19,22,45]. Additionally, *whanau* (family/extended family) and community involvement have been identified routinely as integral to the development of indigenous services in the context of work-force development [22,44,46]. Most work in this area in New Zealand has noted the need for services to account for the diversity of experience and expectation of Māori in contemporary society [45–47].

While guidelines such as those discussed above have been aimed commonly at the development of *kaupapa Māori* services, the requirement for so called ‘mainstream’ organisations to respond effectively to the needs of Māori has also been highlighted [23,29,44]. This theme has been evident in much of the general work-force development literature in New Zealand [19,20,26,31,38,44], frequently being linked to nationally applicable principles of the Treaty of Waitangi [48].

Evidence-based practice: research and evaluation

As noted above, there is limited published material about indigenous work-force development initiatives or even what constitutes effective treatment for indigenous peoples [20,28,30]. There is a dearth of information about the level, nature and impact of training being taken up by indigenous workers [20,30] although this situation is improving in the New Zealand context, with recent surveys of the Māori AOD treatment and mental

health work-force [17,33,34]. With regard to treatment, there is some broadly focused evidence related to the desirability of incorporating culturally congruent content and processes; however, more developed information is sparse [36,39,41,45,46].

Such limitations are exacerbated by the paucity of information on indigenous individuals accessing services due to inadequate collection and interpretation of ethnicity data in this area [20,23,28,29,49]. This has contributed to difficulties in assessing the impact of indigenous initiatives as well as the monitoring and refining of services [23,29]. Accurate collection of ethnicity data is therefore integral to work-force development, as it provides the basis for accurate evaluation, planning and resource allocation.

Bringing it all together: work-force development infrastructure

Differences in focus notwithstanding, in both New Zealand and Australia the need for national indigenous work-force infrastructure development has been recognised [22,28,30,31]. In New Zealand Te Rau Matatini (TRM), a Māori-run and -governed work-force development programme, has been charged with managing initiatives to ‘strengthen and develop the Māori mental health work-force’ [28, p. 15]. More recently the National Addiction Centre (NAC) has been given the responsibility for developing the national addiction work-force development plan and programme—Matua Raki [25]. NAC is engaging with TRM and other Māori stakeholders to ensure alignment of strategies for Māori with more broadly focused developments.

Specific activities being undertaken by NAC to ensure responsiveness to Māori in the strategic plan include the current literature review and, in partnership with the Māori/Indigenous Health Institute (MIHI), carrying out a telephone survey of Māori AOD workers [34]. Documentation of the history of the Māori addictions treatment work-force is also being undertaken. Additionally, NAC/MIHI will be working with Te Rau Matatini and other Māori stakeholders to develop integrated training based on specific Māori addiction practitioner competencies, which are currently being developed.

Implications and conclusions

There is an urgent need for a coherent approach to indigenous work-force development to enable increased access to indigenous workers and/or services. A number of relevant policy and planning documents have been developed, but have tended to only provide broad principles and little specific guidance for operationalisation. Additionally, it is apparent that initiatives, to a greater or lesser extent, continue to be

contained within dominant culture paradigms and institutions with only limited autonomy and/or control being afforded to indigenous peoples. To be effective strategies, policy and practices must move beyond indigenous 'perspectives' and 'input' to ownership and control.

A comprehensive strategy for development also needs to move beyond individualised training and recruitment issues to ensure that broader organisational, institutional and societal elements are accounted for. Such an approach needs to be implemented within the key areas apparent in the literature: (1) recruitment of new workers and retention of those currently employed; (2) indigenous specific training and development; (3) organisational development; (4) research and evaluation; and (5) development of regional and national infrastructure through which strategies can be implemented, monitored and managed. It is apparent, however, that there is still considerable work to be undertaken in New Zealand, Australia and beyond to develop and implement comprehensive indigenous addiction work-force development strategies.

A key area of need apparent in the literature is developing training and contexts which enable indigenous workers to operate within the parameters of clinically sound, culturally responsive best practice. Constitution of a truly integrated cultural/clinical approach to treatment within work-force development initiatives remains a key challenge. This is integral to both increasing indigenous work-force capacity and improving the skills of non-indigenous clinicians.

Research and evaluation also remains an important area for development. The availability of some relevant mental health literature notwithstanding, a key barrier to Māori and other indigenous addiction work-force development strategies has been the dearth of detailed information. An emergent literature in the indigenous AOD treatment field is helping to ameliorate this situation to some extent. This provides a filter for the more general and non-indigenous literature, which has contributed to the basis for developments to date. Such a filter is important, given that there are unique elements in the indigenous addiction treatment field that need to be considered.

Most Australian and other international literature identified the same core elements as that emanating from New Zealand; however, it tended not to account for broader issues, such as service and infrastructure development to the same degree. The New Zealand literature characteristically provided more fully explicated frameworks, strategies and principles on which to base autonomous indigenous development. There was also a strong focus on developing Māori-specific training and treatments founded on Māori values, practices and experiences, rather than the injection of indigenous elements into 'mainstream' interventions.

Thus, while some work from overseas mirrored aspects of New Zealand developments, its contribution to the further consolidation of a Māori addiction treatment work-force was limited.

One critical area of contrast was indigenous control, as indicated by the degree to which recommendations for development were located within dominant culture institutions and paradigms. While Māori are arguably advantaged in this area, compared to other indigenous peoples, there is still considerable work to be done. It is also noted that gains made are not necessarily irreversible and remain subject to fluctuations in the socio-political climate [50–53].

In summary, indigenous addiction treatment work-force development is best conceptualised within a broad framework. This needs to consider not only workers, clients and their whanau/communities, but also service and broader infrastructure, not to mention the socio-historic context within which treatment is delivered. The development of effective integrated indigenous services, as well as skilled individuals, needs to remain a primary focus, however. In this context, developing and supporting autonomous indigenous leadership must be a priority, within both the addiction sector and the broader community. The challenge is to continue to build a sound base for meeting the unique needs of indigenous addiction treatment work-forces and the people they serve. Such development will not only enhance addictions treatment, but also the mental and general health arenas, as well as the broader community.

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