Primary Health Organisations
Service development toolkit for mental health services in primary health care
Foreword

Approximately 20 percent of the general population experiences a mental disorder at any time, but only one person in three receives appropriate treatment.

The establishment of Primary Health Organisations (PHOs) provides an opportunity for health providers to ensure mental health services are an integral part of primary health services. PHOs can develop services that address the mental health needs of their enrolled populations who present with mild to moderately severe mental health problems or disorders, as well as form strong relationships with existing mental health services for more effective care for people with moderate to severe disorders.

The Primary Health Organisations: Service development toolkit for mental health services in primary health care has been developed for PHO managers to assist them in building PHOs’ capacity and capability to respond to the mental health needs that can be managed effectively in primary care. This resource sets out how a PHO may begin to develop a plan of action for addressing the mental health issues of its enrolled population.

It is recognised that PHOs are at various stages of development, all PHOs are configured differently, and there is no ‘one size fits all’ plan or solution.

This document pulls together the evidence and outlines useful links with specialist mental health and other community and health services.

This document does not provide treatment or clinical guideline for clinicians. However, it does present useful information about possible service models and references to assist clinicians and PHO managers.

Counties Manukau District Health Board developed this toolkit by undertaking an extensive consultation process and literature review, while working closely with a range of key stakeholders. Editing and publishing have been the responsibility of the Ministry of Health.

The Ministry recognises that this toolkit is a ‘first edition’ and there is a need to update and expand it in the future. There is a focus on the development of PHO services for adults with mental health problems, but an acknowledgement that the needs of children and young people with mental health problems are important but not covered. PHOs are expected to identify and manage mild to moderate mental health problems in children and young people, but more work is required for national guidance for these critical populations.

An initiatives and innovations funding package for PHOs is to be released with this resource document through an RFP process. This is part of a package of PHO funding programmes and will assist PHOs in consolidating and developing existing mental health initiatives, and developing, piloting and evaluating new initiatives.

The Ministry is considering recommendations from Counties Manukau District Health Board about a mechanism for the continued development of the toolkit and developing a
network of key stakeholders, but it is acknowledged that there needs to be a process for discussion and sharing between PHOs in the development of this challenging area.

I would like to thank Counties Manukau District Health Board, the Primary Mental Health Steering Group and Working Group, and the many contributors to this document during the national consultation, hui and fono. Their valuable knowledge will ensure mental health services provided by PHOs meet the needs of primary health consumers and make a positive and meaningful difference to their lives.

Karen O Poutasi (Dr)
Director-General of Health
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1 Introduction

Primary Health Organisations (PHOs) are accountable for achieving improved health outcomes for their enrolled population.

Each PHO is required to develop an annual business plan that is agreed with its respective District Health Board (DHB). As mental health care is a core component of primary health care, PHOs need to develop a mental health plan as part of their overall business plan. PHOs must decide what they need to do and how they need do it in order to improve the mental health outcomes for their specific population.

PHOs are key providers of mental health services

Primary health care practitioners provide a wide range of mental health services (including services relating to alcohol and other drugs, and gambling) to a large number of people. It is well established that in any one year around 20 percent of the community will have a mental health problem. Not all these people will seek help; nor do they probably need to. However, in the event that they do seek help, most people will seek help from a primary health care practitioner, because mental health and physical health are inextricably linked.

Unlike specialist mental health services, neither the role nor the source of funding is explicit for mental health care provision in primary health care. However, in the current environment, the expectations of PHOs are more explicit.

To meet this challenge, PHOs need to:

- know their enrolled populations’ needs
- understand the way in which mental health services are delivered by providers and understand the links with other service providers
- assess the fit of their current services with the needs of their enrolled population and their practitioners
- identify opportunities for aligning current services to be more effective in achieving improved mental health
- decide what additional services will be necessary for an even greater improvement in mental health outcomes in the long term.

Developing and implementing a mental health plan that covers these issues will assist PHOs to deliver on their accountability to their enrolled population.
Ideas for action

Different PHOs are at different stages of development in their approach to mental health care.

- Some PHOs are only just developing mental health services for their enrolled populations. This document provides those PHOs with ideas for planning a comprehensive mental health service in primary health care.
- While PHOs are new entities, many have practitioners who have been providing mental health care for many years. Some have existing programmes and/or relationships with other mental health and social services that are effective and successful. For those PHOs, this document should provide a basis for identifying further opportunities for service delivery.

A mental health plan that best meets community needs

The aim of this toolkit is to encourage PHOs and their practitioners to develop a mental health plan that will build on their existing strengths, in order to develop better and more effective mental health services in primary care. The intent is to stimulate further action so PHOs give mental health care the highest possible priority.

PHOs should develop mental health plans that meet the specific needs of their enrolled populations by:

- ensuring access for people who have mental health care needs – especially Māori, Pacific peoples and people from lower socioeconomic groups
- improving the quality of the mental health care provided by their practitioners
- engaging with other organisations to promote mental wellness, prevent mental illness, and co-ordinate care.

This plan should build on the current strengths and activities of the PHO and other health care practitioners. It should also outline a clear vision of the most complete service necessary for its enrolled population, rather than being based on the money available now or in the short term. Implementation will be expected to occur over several years.

A PHO’s mental health plan needs to describe:

- the need within the PHO’s enrolled population
- its long-term strategic vision for offering mental health services, including substance abuse services, to its enrolled population
- its specific actions for the coming year
- its methods for measuring its performance in relation to its strategic vision.
One of the outcomes of the mental health plan may be to introduce a new programme. It is important that PHOs recognise the interrelated nature of services. Thus a new programme should not be considered without consideration of the effects in other areas, such as workforce development, and links with other providers of mental health services, including non-government organisations (NGOs).

**Why develop a toolkit?**

As well as PHOs being accountable for delivering improved health outcomes for their enrolled population, there is a growing community demand for primary mental health services. The following trends and factors illustrate the need to improve the way primary mental health care is provided.

- The increased understanding that physical and mental health are intrinsically linked, so a holistic approach to health care is required. This has been recognised internationally, nationally and locally.
- The recognition of the high mental health service needs of those with the poorest health outcomes (namely Māori, Pacific peoples, people in rural communities and people from lower socioeconomic groups) and a commitment to improving these outcomes.
- The acknowledgement that mental health care is effectively delivered at the primary level, but it has not been sufficiently resourced.
- Evidence that early intervention and effective treatment by primary health care providers may prevent or delay the onset of more severe problems and achieve good outcomes.
- An increasing prevalence of some mental health disorders such as depression.

Importantly, the physical health status of people with mental health problems (especially people who have especially high mental health care needs) is significantly lower and poorer than the rest of the population. This means establishing effective links between primary and secondary providers could also lead to improved physical health outcomes for those people.

This toolkit was developed to assist PHOs in developing their mental health services by:

- summarising current thinking about the provision of primary health care services
- stimulating discussion about how these primary health care services might best be provided given each PHO’s circumstances
- providing a worksheet to help PHOs draw up a mental health plan.

The toolkit is based on extensive literature reviews (see the further information section at the end of most chapters and the complete list of references at the end of the document), discussions with skilled providers and consultation with key stakeholders, including meetings specifically targeted at Māori, Pacific peoples and NGOs. (See Appendix 1 for more information about the process used to develop this toolkit.)
Structure of this document

As the provision of mental health services in primary health care must be considered in the context of national policy, this toolkit:

- overviews the prevalence of mental health disorders in New Zealand
- discusses the barriers to access and the provision of services
- outlines options for promoting wellness and preventing mental illness
- provides implementation options from both service and provider levels
- describes the links between specialist and primary providers.

Each chapter provides links to the available evidence and includes local feedback and interpretation. Examples are included to illustrate each chapter, but they should not be regarded as definitive models, guidelines or practices.

Prompts and further information are included at the end of most chapters to stimulate discussion and to help PHOs develop their own mental health plan. All prompts are listed in the worksheet for PHOs to use when developing their mental health plan (see chapter 12).

This toolkit does not replicate previous policy documents in the primary, mental health or public health arenas. Also, it does not set out to describe clinical best practice guidelines for common mental health problems, but to act as a catalyst for the development of mental health care services.

Further information

2  Context

Mental health is more than the mere absence of mental illness. It is about a person’s psychological, social and behavioural functioning within their world and their sense of ease with this. It encompasses a person’s feelings, coping strategies and satisfaction with the various aspects of their life, and the extent to which their spiritual and cultural needs are met. Improving a person’s mental health depends on the provision of appropriate health services as well as the broader social, economic and cultural environments.

The national policy context within which PHOs provide mental health care is described by a range of documents, including:

- the New Zealand Health Strategy (see Minister of Health 2000)
- the New Zealand Disability Strategy (see Minister for Disability Issues 2001)
- the Primary Health Care Strategy (see Minister of Health 2001)
- the National Mental Health Strategy embodied in Looking Forward (Ministry of Health 1994), Moving Forward (Ministry of Health 1997) and Blueprint for Mental Health Services in New Zealand (Mental Health Commission 1998)
- Building on Strengths: A Guide for Action (Ministry of Health 2001)

An overview of some of these strategies is in Appendix 2. However, it is well worth reading these strategies in more detail before formulating a mental health care plan.
Further information


3 Population Focus

As PHOs evolve, they are gathering a considerable amount of data about their enrolled populations including age, ethnicity, gender, deprivation and primary health care use. One of the challenges is to use this data in conjunction with other available information to build a comprehensive picture of the mental health needs (as part of a greater picture of need) within their enrolled populations.

Information necessary to understand the extent of mental health service needs includes:

- prevalence rates of common mental health disorders
- broader determinants of health and degree of deprivation within the PHO’s enrolled population, such as adequacy of housing, employment rates, educational attainment levels and socioeconomic status
- known indicators within their enrolled population that increase the risk of a person’s developing a mental health problem, for example, levels of violence, abuse and self-harm
- misuse of alcohol and other drugs; and problem gambling
- barriers to access that prevent or limit individuals and their families accessing care.

Additional information about the prevalence rates of common mental health disorders is in chapter 6.
4 Health Perspectives and Considerations among High Need Groups

It is important to understand how groups with high health service needs perceive health and wellbeing, as this will support more effective and appropriate workforce development as well as service planning, development and delivery.

To provide services that are responsive to groups with high health service needs, consider the following points.

- **Holistic perspectives of health**: Services that fragment the dimensions of life – physical, spiritual and mental wellbeing – do not allow for the importance of maintaining a balance in these dimensions for many populations.

- **Relationships with family/whānau and spiritual icons**: The state of family/whānau and other important relationships (for example, with God or other spiritual deities or spiritual traditions) often have a strong influence on people and are important indicators of mental health and wellbeing.

  A responsive provider will create an environment that recognises and builds on these key relationships and supports users’ ability to stay in touch with important cultural support systems. While strong family/whānau connections can encourage recovery, care needs to be taken to recognise that sometimes families and family/whānau relationships may be part of the problem and may hinder or interfere with recovery.

- **Deprivation**: The correlation between low incomes and unemployment, and mental illness is widely known and researched. Understanding the socioeconomic condition of an individual and how it limits their ability to live a fulfilling life with family/whānau and friends is another important indicator of mental health and wellbeing.

For all high need groups, PHOs need to ensure the development and implementation of their mental health plans:

- enable early identification and subsequent intervention for mental health problems and access to specialist mental health services – this would mean services are accessed at a less acute level

- improve the first contact outcomes for users through the development of holistic tools, better community provider connections and effective follow-up

- provide service delivery approaches that reflect the nature and needs of their populations

- reduce the need for people to access mental health services through the justice system.

It is important to understand how Māori, Pacific peoples, migrants, refugees and people who live in rural communities perceive health and wellbeing. This will support more effective and appropriate service planning, development and delivery. It will also help providers align treatment and service delivery options with informed decision-making.
It is also important to recognise that providing services that are responsive to Māori and Pacific peoples will require:

- effective Māori and Pacific representation on governance bodies
- Māori and Pacific workforces.

**Importance of building relationships**

Many practitioners already engage and support participation from service users and their families/whānau in care plans and approaches to managing mental illness at home and/or in the community. Building relationships is a key component of delivering primary mental health services to the Māori, Pacific and other high needs communities. We recommend further reading below for those PHOs looking to develop services for these groups.

**Māori health**

To deliver effective, efficient and appropriate services to Māori there are some key points or which PHOs should be aware when deciding how best to provide those services.

- The Māori population is diverse (Pomare et al 1995).
- The Māori population is young. Of those in the 1996 Census who identified as Māori 23.6 percent were aged 0–14 and 19.7 percent were aged 15–17 (*Mental Health in Primary Health Care Interim Report*, Publication series TRM/03/05, Te Rau Matatini Māori Mental Health Workforce Development).
- A delay in early intervention, assessment and treatment and associated trauma are risk factors for poor treatment outcomes.
- Māori enter secondary and tertiary services at a more severe stage in their illness, so early intervention at the primary health care stage would vastly improve this trend.
- Public health priority areas have a direct relationship to services provided by PHOs:
  - reducing tobacco consumption
  - reducing Māori suicide rates
  - addressing physical activity and nutrition issues and reducing obesity
  - improving immunisation rates
  - reducing interpersonal violence.
- Active Māori participation in the design, development and delivery of services can improve assessment, treatment and follow-up.
- Māori models of health acknowledge all dimensions of the person, family and community, so represent an important element that needs to be included in the design and delivery of services (for example, Whare Tapa Wha and Whānau Ora) (Minister of Health and Associate Minister of Health 2002).
- Māori wellness is inextricably related to social, economic, historical, cultural and spiritual factors.
The outcomes that PHOs should be looking to promote through the development of this resource are:

- earlier access by Māori to mental health services, so Māori access services at a less acute level
- a reduction in the access of Māori to mental health services through justice and welfare agencies
- improved first contact outcomes for Māori through the development and/or incorporation of holistic assessment tools, better Māori community provider connections and effective follow-up
- service delivery processes that reflect the nature and needs of the population.

**Elements of a kaupapa Māori service**

It is generally accepted that culture and health are closely linked. Therefore, it is important that health providers are aware of that link and understand how they might provide a service that acknowledges that relationship and aligns with improved outcomes. This may require the application of ‘cultural inputs’ (Durie et al 1995):

- whānau participation
- use of Māori language
- Māori leisure pursuits
- a Māori workforce.

**Framework for considering high quality health care for Māori**

Professor Mason Durie suggests, on the basis of the New Zealand experience, that it is possible to construct a 12-point framework within which quality care for Māori can be assessed (Durie 2003b).

**Twelve-point framework**

The 12-point framework within which quality care for Māori can be assessed has (Durie 2003b):

- Three goals:
  - equitable access
  - human dignity – related to the process of care
  - best outcomes.
- Three principles:
  - indigeneity
  - clinical expertise
  - cultural competence.
• Three pathways:
  – Māori-centred
  – Māori added pathways
  – collaborative pathways.

• Three performance indicators
  – legislative and policy framework
  – workforce capacity
  – indicators and measures.

(For further information, see Appendix 3.)

**Pacific health perspective**

Most Pacific peoples have a holistic view of their health and wellbeing, which means all the important dimensions of their life – physical, spiritual and mental wellbeing – must be in balance. Furthermore, the health of the significant relationships in their lives (for example, with family/whānau, God or other spiritual deities) is fundamental to their health and the way in which they manage their lives. What is happening in these relationships may be regarded as a reason for ill health. For example, disease and illness may be interpreted as being related to a breach in a family relationship.

In broad terms, this means many Pacific peoples:

• are likely to try to manage mental illness within their families without intervention or seeking help early, because there is a reluctance to involve outsiders in what may be seen as a family issue

• may be distrustful of service providers who are not known and do not have an ongoing relationship with the family; many Pacific families are protective and wary of any outsiders providing care to their loved ones.

As a consequence many Pacific peoples are:

• unlikely to access early intervention services and/or support, and more commonly present to primary mental health care services acutely or when conditions have deteriorated

• less likely to access services if the first (or any) episode of contact has not been effective from their perspective, they do not trust the skills of a service provider or they do not form a positive relationship with a service provider

• less likely than other members of the community to know what support services are available outside their church and family environment.
Fuimaono Karl Pulotu-Endemann, in Appendix 4, Effective primary mental health for Pacific peoples, provides a more complete account of:

- the Pacific health perspective
- key issues in relation to meeting their mental health needs
- relevant policies and research
- implications for PHOs.

### Migrants and refugees

On arrival in New Zealand, many refugees experience significant ongoing psychological and cultural adjustment difficulties.

Tremendous grief and loss can accompany resettlement. Losses include the loss of family and friends, culture, country, material goods, physical health, mental health and socioeconomic status. Refugee grief is often complex, unresolved and fuelled by survivor guilt and the retraumatisation of the resettlement process.

This tends to be exacerbated as family and community are often unavailable to provide the support that would normally assist with coping, and mourning rituals for those killed or lost are rarely given the necessary time due to war and flight. Depression, anxiety, psychosis, psychosomatic presentations and relationship/attachment changes frequently occur after settlement (Ministry of Health 2001).

PHOs need to be aware of these factors if they have enrolled migrant communities.

### Rural communities

Providing primary mental health care in rural areas may offer particular difficulties because of the remote location of many members of the enrolled population and distance from other health care providers and services. PHOs will need to identify and develop links with other providers, not only within local communities but in distant cities to ensure effective service delivery.

Specific areas to consider include:

- developing and maintaining a rural workforce skilled in mental health service provision
- improving access to support and advice for practitioners from distant providers
- improving access to specialist mental health services
- using innovative delivery models such as telepsychiatry clinics
- using mobile outreach services.
Physical health needs of service users

People who have long-term needs for mental health services and support often have poor physical health compared with the general population.

An Australian study of 240,000 people over 20 years who had contact with mental health services compared their mortality and hospital admissions with the general population. This report concluded:

- people with enduring mental illness had poor global health outcomes and early mortality from both under-diagnosed and under-treated physical illnesses
- behavioural factors, particularly smoking, alcohol and other drug use, lack of exercise and poor nutrition, were important contributors to their increased mortality
- their physical health also suffered because of side-effects and complications associated with medications prescribed for their mental health.

It is now generally recognised that:

- mental health operates as an independent risk factor for the development of physical disease
- there is a higher incidence of mental health disorders in people with chronic physical health problems
- there is a higher rate of physical health problems in people with mental health disorders.

Therefore, it is essential that there is greater collaboration between primary health care practitioners and specialist services, so the physical health outcomes of all mental health service users are improved.

Further information


5 Who Provides Primary Mental Health Services?

To understand its role in the provision of mental health care, a PHO should consider:
• how other individuals and organisations are involved
• how this influences the way in which a PHO provides its services
• what opportunities exist, or need to be developed, to maximise the health gains for the PHO’s enrolled population.

Where several PHOs provide services to a single community, there will also be opportunities for partnership.

Those involved with the provision of primary mental health services include groups within the community, such as family and community agencies, and primary health care practitioners. These are outlined below.

Community resources

Individuals have a variety of resources available to them within their community. These include:
• family/whānau
• friends
• churches
• community agencies such as school guidance counsellors, community counselling services, social services and community support agencies
• workplaces
• marae services
• sports and recreation clubs.

These are often the first resources where possible mental health problems are identified or where people turn to for help in resolving mental health issues. However, for some people, this support will not be sufficient and they will need to access more intensive services of a primary health care practitioner.

Community development models of health provision

The international drive to adopt community development models of health provision originated with the Ottawa Charter 1986. This stated, as its central tenet, that individuals must be empowered to take responsibility for their own wellbeing. It identified that the prerequisites and prospects for health could not be ensured by the health sector alone.
The power and potential of a community-based model of service development is that it taps into a wealth of talent, expertise and altruism that mainstream methods of service delivery have traditionally under-used. Stronger, community-owned primary health service provision leads to better use of hospital and specialist mental health services, thanks to greater individual and family/whānau awareness of these services.

**Primary health care practitioners**

Primary health care practitioners include a wide range of health professionals including GPs, primary health care nurses, community health workers, pharmacists, and community counselling and psychological services.

The role of primary health care practitioners in the provision of mental health services is to ensure that individuals return to their full level of functioning by identifying and subsequently managing the mental health issue. Not all primary health care practitioners will be able to deliver all the necessary components of this service. This means that a PHO needs to consider:

- the current capacity and capability of its practitioners
- what relationships currently exist and what need to be developed between its primary health care practitioners and other primary providers.

Primary health care practitioners delivering GP services to Māori populations often provide a variety of additional services including budgeting, social services, education and income support services. These services may be delivered in a range of settings; for example, traditional healthcare clinics, marae and community venues. These realities need to be considered when determining the most appropriate method of service delivery.

**Specialist mental health and addiction service providers**

This toolkit concentrates on the provision of mental health services in primary health care. As the majority of people who access these services will not require referral to specialist mental health services, we have not included a detailed discussion of these. However, we have included a consideration of the close working relationship that is necessary between primary health care and specialist mental health services in chapter 10, ‘Interface between primary health care and specialist mental health services’.

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**Further information**

6 Prevalence of Mental Health Problems in New Zealand

Prevalence in the community

The major, community-based survey of the prevalence of mental health problems in New Zealand was undertaken in Christchurch in 1986 and published three years later (Oakley-Brown et al 1990). The results from this survey are broadly comparable with other countries that have done similar studies.

From this survey, we can conclude that about a third of all New Zealanders will have experienced a diagnosable mental disorder at some stage in their lifetime. The most commonly encountered mental health problems are alcohol abuse/dependency, depression and anxiety disorders. These have lifetime prevalence rates of 19 percent, 13 percent and 31 percent respectively. Women have higher rates of depression and anxiety disorders and lower rates of alcohol abuse/dependency than men.

Table 1: Rates of common disorders in the community

<table>
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<th>Problem</th>
<th>Six-month prevalence</th>
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<td>Depression</td>
<td>The six-month prevalence for males is about 6% and females 12%.</td>
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<tr>
<td>Alcohol</td>
<td>One in six adults do not drink within safe limits.</td>
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<td></td>
<td>Six-month prevalence of abuse/dependency of 14% for men and 4% for women.</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Six-month prevalence of around 5% for men and 12% for women.</td>
</tr>
<tr>
<td>Dementia</td>
<td>There is an 8% prevalence rate of dementia for all people over the age of 65.</td>
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<td>This rate increases from 4% in the 69–74 year age to 40% in the 90+ age bracket.</td>
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When a disorder is diagnosed, there is a strong chance (50 percent) that an individual will be diagnosed with more than one mental health problem.

Problem gambling

The 1999 National Problem Gambling Prevalence Survey estimated that there were about 36,800 adults in New Zealand with gambling problems of varying severity (Abbott and Volberg 2000). This estimate of about 1.3 percent of the adult population having a gambling problem is considered conservative. Since the survey there has been an increase in gambling opportunities that may well affect prevalence rates. The survey reported high rates of problems for Māori respondents and a lesser but similar trend was found for Pacific peoples. A survey of young Asians found that 12 percent rated themselves as having a moderate to serious gambling problem.
Prevalence in specific ethnic groups

There is no accurate data on the rate of mental health problems within specific ethnic groups. However, a nationwide community prevalence study is currently being carried out and will augment knowledge in this area.

Prevalence in young people and adolescents

Many mental health disorders first manifest themselves during adolescence. The Youth 2000 survey was a profile of the health and wellbeing of nearly 10,000 New Zealand secondary school students chosen at random from throughout the country. This survey contains several findings that are relevant to primary mental health care.

- **Suicidal thoughts** are common – 34 percent of 15-year-old females and 20 percent of males reported thoughts about killing themselves in the past 12 months.
- **Suicide attempts** in the past 12 months were reported by 14 percent of 15-year-old females and 6 percent of males.
- **Anxiety symptoms** (suggestive of a problem) were present in 5.4 percent of males and 4.2 percent of females, with **severe behavioural problems** in 4.2 percent of males and 2.9 percent of females.
- More than a third of all students reported an episode of **binge drinking** within the last four weeks.
- About 50 percent of male and 40 percent of female students reported being hit or **physically harmed** in the last 12 months.
- An experience of **unwanted sexual behaviour** from another person was reported by 11 percent of males and 22 percent of female students.
- **Bullying** was common, with 9 percent of male and 5 percent of female students being bullied at least once a week.

Prevalence and utilisation in primary health care

The World Health Organization recently conducted a study in 14 countries and concluded that, across this sample, around one in four people who visited a GP had a mental health problem reaching the ICD-10 criteria. A further 9 percent had what was termed a ‘sub-threshold’ disorder.

In New Zealand, the MaGPIe study of attendees at primary health care practices concluded that about a third of all people who consulted a GP in the previous 12 months had a diagnosable mental health problem (MaGPIe Research Group 2003). Of these:

- 13 percent had an anxiety disorder
- 7 percent had a depressive disorder
- 3 percent a substance use disorder.

In about half these patients, the disorder was current within the past month. The GPs themselves estimated that about half of their patients had experienced psychological
problems, and that the mental health problems were moderate to severe in about 10 percent of those.

Although a body of prior research has suggested that GPs ‘miss’ half the psychological problems present in their patients, the MaGPIe study found that, in New Zealand, this was only a problem among patients who had little recent contact with their GP.

**Interventions to improve patient outcomes**

These results suggest that interventions to improve patient outcomes by addressing GP recognition of mental disorder may be more effective if they:

- foster continuity of care
- focus on the disorders most likely to be missed
- take high levels of co-morbidity of common mental disorders into account
- encourage patient disclosure of psychological issues
- target new or infrequent attendees (MaGPIe Research Group (in press)).

Although 20–25 percent of the general population will experience a mental disorder at any point in time, only one in three of those with a disorder will get any treatment. What is more, only one in four of those treated will reach specialist mental health services, while the rest will be treated by the primary health care team (Hornblow et al 1990).

**Providing effective treatment**

There are concerns that, if a problem is identified at the primary health care level, the most effective treatment is only being provided to a small number of people. A cross-sectional survey in the US found that less than 15 percent of people with a diagnosable mental disorder were receiving care that could be considered consistent with evidence-based treatment. Even for those with the most severe and impairing mental illness, only 25 percent received guideline-concordant treatment. Racial minorities and the poor were particularly at risk for not receiving evidence-based care.

Although the rates of primary health care utilisation vary. For example, 80 percent of people who have an anxiety or depressive disorder consult their primary health care practitioner. However, the rate is lower for those with alcohol-related disorders. Mental health issues are frequently not the focus of the consultation, because of barriers to disclosure (Wells et al 1994).

**Predictors of future mental health issues**

Violence and abuse rates are high in our society. They are not limited to one gender, religious, cultural or income group – and they are associated with poor mental health.

A summary of the available research indicates that childhood sexual abuse and being the victim of violence increases the risk of later mental illness and mental health problems. Early unstable and unsatisfactory childhood and adolescent family life experiences also predict poorer mental health later in life.
The impact of mental illness on individuals and their community is large, with increased:
- direct medical costs via increased utilisation of health services
- indirect costs through absenteeism and loss of productivity
- personal cost in terms of distress and suffering.

Prompts
- Given the demographic mix of your enrolled population, what is the incidence of the differing mental health issues likely to be?
- What are the particular high-risk groups within your PHO’s enrolled population?
- Are there specific disorders that will have a greater incidence due to the nature of your enrolled population?

Further information


MaGPIe Research Group. Psychological medicine research: the MaGPIe study: the mental health and general practice investigation. Wellington School of Medicine and Health Sciences. URL: http://www.wmneds.ac.nz/academic/psych/research/magpie.html


7 Barriers to Access

There are many reasons why mental health care is not accessed. We have considered the barriers to access from the perspectives of the individual, community, provider and PHO, but this list is not exclusive.

Individual

An individual may not access mental health care because they:

- do not recognise their mental health care need, especially in combination with physical conditions
- do not know where to go for help
- have time and financial constraints, especially people in high needs groups
- have had negative experiences when they sought help previously and/or the help was not useful
- may be confused about the development of a mental health problem versus a culturally appropriate diagnosis (for example, Mate Māori)
- may not see their mental health needs as a priority compared with other issues (for example, providing for their family/whānau or ensuring their children and partner receive services)
- feel they should be able to manage on their own
- feel embarrassed or ashamed.

Community

Barriers in the community that discourage people from accessing mental health care, include:

- the stigma associated with mental illness that leads to discrimination against people with experience of mental illness
- a lack of community recognition
- a lack of confidentiality in the community setting leading to the person’s fear
- a lack of clarity about the level and quality of services provided by community service organisations.


**Provider**

Barriers in service providers that discourage people from accessing mental health care, include:

- stigma expressed through staff prejudices and stereotypes about people with experience of mental illness
- inadequate provider behaviour that deters a person from presenting an emotional issue
- a lack of recognition of a mental health service need that may coexist with other conditions
- a lack of cultural knowledge and accessibility such as language, for example, staff may misread cultural behaviours as rude, disrespectful or signs of illness
- not knowing what to do when a person’s mental health service need is identified
- the provision of ineffective interventions
- the provision of only a limited range of interventions (for example, access to psychological therapists but not traditional healers)
- inadequate resources to assist people for whom English is a second language
- a lack of knowledge or experience in dealing with mental health issues
- the marginalisation of mental health services when they exist as part of a larger range of services
- being in a location that is difficult to reach, for example not close to bus stops, trains or parking.

**PHO**

Barriers in PHOs that discourage people from accessing mental health care, include:

- services not being delivered where the community or sections of a community can access them easily
- low priority being given to mental health services at strategic and business planning stages
- an insufficiently skilled workforce that does not have ongoing training and professional development
- inadequate mental health services as a result of a misunderstanding about the range of services that should be provided by a PHO.
Prompts

- What are the most relevant barriers to the provision of mental health services in your PHO?
- What barriers do Māori, Pacific peoples and people from lower socioeconomic groups face?
- How could these barriers be overcome?
8 Promotion and Prevention

Promotion and prevention of mental health issues can help break existing cycles that lead to poor mental wellbeing and mental illness. In particular, promotion and prevention can:

- raise family, whānau and community awareness and acceptance of mental health issues
- increase the mental wellbeing of the whole community
- assist in the early detection and treatment of mental health problems
- reduce the prevalence of mental health issues in enrolled populations
- assist in the recovery of individuals who have experienced a mental health problem.

While primary health care practitioners have not focused explicitly on promotion and prevention, PHOs are expected to be active participants in this area. To do this, PHOs will need to develop closer relationships and partnerships with existing agencies that currently deliver mental health promotion and prevention, including those that target specific groups within the community such as secondary school students.

Mental health promotion

Promotion of mental health issues aims to:

- improve the mental wellbeing and health of the whole community
- encourage people, their families and communities to take more control over their own health
- change some of the known factors that determine mental health wellbeing, such as reducing stigmatisation.

Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice and personal dignity.

To date, programmes have focused on:

- increasing opportunities for participation in social networks and structures, as well as enhancing learning and educational opportunities
- reducing poverty and promoting environments that reduce inequity
- reducing the number of people who are socially disadvantaged, socially isolated and suffering discrimination
- decreasing the trauma of being a victim of violence and all forms of abuse.
Prevention

Prevention of mental health problems is about reducing the incidence and prevalence of mental health illness or problems.

Traditionally, prevention has been divided into three types of intervention (although this classification is not universally agreed upon).

- **Primary prevention** seeks to decrease new occurrences of a specific problems (ie, reduce the incidence).

- **Secondary prevention** is about intervening early in the course of a person’s illness and managing with the person and their family/whānau the optimal intervention to allow the quickest return to full health. It is about reducing the prevalence in the community.

- **Tertiary prevention** is about reducing relapses of established illness and minimising the disability associated with that illness.

Examples of mental health promotion and prevention programmes

1. ‘Like minds, like mine’ is an ongoing New Zealand public health project which aims to reduce the stigma of mental illness and the discrimination that people with experience of mental illness face in the community. The project comprises two main components: a national public relations and media campaign, and a comprehensive range of community-based services. External evaluations of the project have been commissioned and the findings are positive. Go to [www.likeminds.govt.nz](http://www.likeminds.govt.nz) for information and resources on the project.

2. Webhealth has been specifically developed to provide access for people to connect with Health and Social Services. This web-based approach builds on the strengths of people and families to determine their support needs. More information is available at [www.webhealth.co.nz](http://www.webhealth.co.nz).

3. Gatehouse Project is an Australian-based programme that aims to make changes in the social and learning environments of schools as well as to promote change at the individual level. Rigorous evaluation has demonstrated substantial reduction in morbidity associated with the use of tobacco, alcohol and illicit drugs by young people. More information is available at [http://www.rch.org.au/gatehouseproject/](http://www.rch.org.au/gatehouseproject/).

Prompts

- What role does your PHO have in mental health promotion?
- How might a PHO engage more effectively with Māori, Pacific, migrant Asian and lower socioeconomic groups in order to undertake mental health promotion?
- How does your business plan reflect this role?
- How do you deliver on these mental health promotion goals?
- What partnerships does your PHO have with organisations that offer or undertake mental health promotion?
• What role does your PHO have in preventing mental illness?
• What information does your PHO have regarding NGOs and other agencies leading prevention and community development programmes?
• What capabilities will the PHO require in order to fulfil the role decided upon?
• What are the culturally specific needs that should be addressed in prevention programmes?
• How should you develop your relationship with secondary providers to meet the needs of your population for secondary and tertiary prevention?

Further information
Webhealth: www.webhealth.co.nz
9 Screening to Identify ‘At Risk’ Individuals

Primary health care services play a key role in screening, including mental health screening.

Screening aims to reduce the risk of disease/condition or its complications through early detection and treatment but it is not a guarantee of prevention, diagnosis or cure (National Health Committee 2003). Screening is basically an exercise in risk reduction and is most often used to select those people who are at higher risk of developing a disease or condition and to offer them an intervention aimed at either the prevention of serious outcomes of the existing condition or the prevention of the development of the condition.

Screening is often taken to mean a single test, however screening actually consists of a number of steps – from the identification of the population at risk, to the invitation of those individuals, to the diagnosis of disease or condition or its precursor in certain individuals, to the treatment of those individuals, to the monitoring and evaluation. This process is often referred to as the ‘screening pathway’. Screening for mental health problems needs to be viewed in the context of this pathway.

The purpose of screening for mental health conditions is to detect and recognise mental health problems and improve outcomes more generally. Screenings aims to identify individuals who are more likely to have a mental health problem or problems. Screening does not replace clinical assessment.

Screening occurs in two ways – through screening programmes and opportunistically. Screening programmes are population health programmes and they are planned, funded and monitored from a population health perspective. Opportunistic screening occurs in the absence of formal co-ordination, monitoring and evaluation, usually where a person presents to the health system for another reason. Opportunistic screening occurs in New Zealand for a range of conditions and risk factors. Screening for mental health problems is an example of opportunistic screening.

Don’t think we need to distinguish between universal and targeted screening necessarily.

Screening has become a widespread health care activity. There is a commonly held belief that ‘early diagnosis’ of disease is beneficial and therefore screening will invariably be effective. However, a number of factors need to be considered before screening is implemented, for example:

- is there evidence of effectiveness?
- is there a suitable test and treatment?
- are there adequate assessment and treatment services available and accessible?
- does the possible benefits of screening outweigh the possible harms?
- has there been some consideration of social, ethical and cost-benefit issues?
Screening to identify new cases of mental health problems may increase numbers of individuals with that condition and therefore it would be essential to ensure that appropriate assessment and treatment services are in place prior to commencing any screening. Practitioners who screened for a high prevalence problem such as depression sometimes found that the primary health care capacity to manage the subsequent additional workload was limited. The required frequency for screening for most common psychological problems is uncertain. The management of people with known mental health problems should take priority over screening to identify new cases of mental health problems.

The MaGPIe data concluded that about a third of all people who consulted a GP in the previous 12 months had a diagnosable mental health problem (MaGPIe Research Group 2003). Therefore, one suggestion of people to screen for mental health problems is new and infrequent primary health care attendees.

Other possibilities for screening include:

- all new mothers in the post partum period at the time of their baby’s immunisations (for post partum depression)
- all people enrolled in chronic care management programmes for depression
- those people with a previously recorded diagnosis of depression or alcohol abuse when they routinely present to their primary health care practitioner.

**Choosing a screening tool**

When deciding which screening tool to use, a PHO may wish to consider:

- the identified needs of the enrolled population
- the resources available, for example assessment and treatment services
- the effectiveness of a screening
- how the PHO will manage screening (along the whole screening pathway).
Examples of screening tools

1. **AUDIT – Alcohol Use Disorders Identification Test**: This is a tool designed to identify early, risky and problematic use of alcohol with the aim of reducing subsequent morbidity, mental health risks and social costs. It can be administered by a range of trained practitioners and its use needs to be combined with brief intervention. Training is available through the TADS (Tobacco, Alcohol and Drug) Training programme undertaken by the Goodfellow Unit, Auckland University (World Health Organization Collaborative Report 2002).

2. **The MIST (Multi-item Screening Tool) Lifestyle questionnaire**: This tool has been developed by Auckland University for use in primary health care to screen for lifestyle and mental health risk factors. It aims to identify a range of early, harmful behaviours and the interactive impact of these on mental health. A brief, opportunistic intervention needs to be provided to any person identified as having an emerging harmful behaviour.

3. **Arroll et al 2003**: The approach described outlines a screening process for depression that requires the health practitioner to ask two questions verbally. The questions were brief and showed reasonable validity, in that they detected most cases of depression.

4. A comprehensive review of *case-finding instruments* (ie, screening tools) for depression in primary health care is available at http://www.ahrq.gov/clinic/uspsfix.htm

5. Pignone et al 2002 summarised the evidence for screening for depression in adults. They conclude that screening can improve the outcome when combined with system changes to help ensure adequate treatment and follow-up. (See section 13.)

Prompts

- What screening could be used to meet the needs of your enrolled population?
- How will you take cultural considerations into account?
- What are the provider constraints on implementing the proposed screening programme?
- What are the organisational constraints when implementing screening?
- What will happen to people identified by the screening process?

Further information


10  Assessment and Management in Primary Health Care

Introduction
Improving mental health outcomes in primary health care will require a number of different responses from a PHO and its practitioners. Changes will need to occur on multiple levels, as single changes such as implementing a screening programme or provider education are unlikely to lead to improved outcomes.

A PHO will need to make sure its practitioners understand their roles so that the question ‘Who does what to whom and when?’ is answered clearly. The answer will depend on:
- the skill and interests of the practitioners within the primary health care team
- the resources available
- the characteristics of the mental health issue identified.

Over the last 10 years, research within primary health care has been undertaken to determine what needs to happen to improve the mental health outcomes for people. The literature would suggest that the following are key components to achieving improved outcomes:
- comprehensive assessment
- personal health care management
- organisational change
- improving linkages with other agencies.

Each of these components is discussed further in the following sections.

Comprehensive assessment
Primary health care practitioners currently demonstrate a wide range of skills, expertise and experience in the assessment and management of mental health issues. When a person presents with a mental health problem (or has been identified by the practitioner as having such a problem), a comprehensive assessment that covers physical, psychological, social, cultural and spiritual issues must be undertaken.

Building a therapeutic alliance is critical. An established relationship between the person and his or her practitioner increases the likelihood of a strong therapeutic alliance, making good outcomes more likely.

A PHO needs to ensure that there is an adequate standard of skill within its providers if high quality services are to be delivered.
The skill of practitioners within a PHO and ensuring sufficient time is available are critical to the delivery of high quality services. Where the skill base is inadequate and effective comprehensive assessments cannot be undertaken, the PHO needs to consider workforce development and/or recruiting additional personnel into the existing team (see ‘Organisational changes’ below).

**Prompts**
- Does your PHO know about the workforce capability of your providers?
- How will your PHO use this information?
- Do your practitioners have adequate time and resources available to undertake what is required?
- If not, what are the possible solutions?

**Personal health care management**

For most people with mental health problems that are being treated within the primary health care setting, the standard concept of follow-up by the practitioner may be sufficient. However, for those who have more acute or complex issues, a case management approach will be needed. This is a similar management practice to that used by primary health care practitioners in chronic care management and by specialist mental health services.

Irrespective of the management approach adopted, there must be the ability to provide differing levels of intensity to ensure that the approach best meets the needs of the person and their family/whānau. PHOs also need to identify therapeutic options that will support individuals and families.

**Key points for case management**

Whatever management is necessary, there are some key points to consider.
- **Self-help**: the person needs to be an active participant in their management.
- The development of a **clear management plan** formed in conjunction with the person and their whānau. This plan should identify individuals and the agencies involved in their management as well as a process for reviewing progress.
- Knowledge and availability of **evidence-based practice treatments**.
- **Flexible intensity of follow-up**: more rigorous when a problem is acute and less when things are more settled.
- **Monitoring** of progress and a person’s response to treatment, as well as any apparent barriers to progress and ways to overcome these (this may include an early team review if necessary).
• **A variety of follow-up methods** to best fit with the lifestyle of the person. For example, follow-up could include telephone consultation, email interactions and text messaging.

• **Advocating** on behalf of the person and their family/whānau. This may be done within the practice team, but could also utilise community agencies.

• Ensuring that those **individuals and agencies involved** in the management are the right ones. For instance, there is no reason why other professional skills that currently exist in the primary health care sector could not be utilised (eg, pharmacists for medication education, monitoring compliance and active reviewing of side-effects, and traditional healers and church elders).

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**Examples of personal health care management approaches**

1. Gilbody et al 2003 reviewed educational and organisational interventions to improve the **management of depression in primary care**. Strategies that improved patient outcome were generally complex interventions that incorporated clinician education, an enhanced role for primary health care nursing (nurse care management) and a better degree of liaison between primary health care and specialist mental health services.

2. Hunkeler et al 2000 showed that a programme of **practice nurse phone calls** improved clinical outcomes in primary health care patients treated with antidepressants. Patient satisfaction ratings were high and the authors commented that the programme fitted well into busy primary health care settings.

3. Watkins et al 2003 reviewed the use of the chronic care model to improve **treatment of alcohol use disorders** in primary health care settings. The paper explains the benefits a chronic care model developed from the delivery of physical health care might have for the management of alcohol use disorders, given their often chronic nature.

4. Unutzer et al 2002 found that by adopting a **collaborative care management approach** for those suffering depression in later life, outcomes were significantly better than for usual care. A depression care manager (usually a specially trained nurse) was assigned to provide education and support to patients, to track symptoms and side effects associated with changes in antidepressant treatment and to provide counselling.

5. The **New Zealand Guidelines Group** has developed clinical guidelines for a variety of mental health issues in primary care. These can be accessed on the website: [http://www.nzgg.org.nz](http://www.nzgg.org.nz).

6. The **Rochester Health Commission’s Guidelines 2002** for the Identification and Treatment of Major Depression in Primary Care in Adults provides a comprehensive and up-to-date series of diagnostic and treatment algorithms: [www.rhealth.org/guidelines/depression](http://www.rhealth.org/guidelines/depression).

7. The **MacArthur Initiative on Depression and Primary Care at Dartmouth and Duke** have excellent checklists and clinical memory aids in both the assessment and management of patients, along with copies of patient handouts and references to other patient information websites.
Prompts

• How does the care provided within individual practices currently match this active follow-up approach?
• How will the PHO allow providers to use evidence-based treatment options with its enrolled population?
• How will the different management needs of Māori and Pacific peoples be addressed?

Organisational changes

There are a number of ways in which organisations are able to change in order to build capability. These are:

1. **additional new workforce**: adding a new skill or competency to the primary health care team (e.g., psychologist, community mental health nurse and nurse practitioners, counsellor, community support worker)

2. **workforce development**: strengthening the existing primary health care team with additional training, and supporting the development of a well-functioning, multi-disciplinary team within that existing team

3. **structural changes** that reinforce and facilitate the roles of the many participants.

Additional new workforce

Enhancing the mental health care provided to people who do not require specialist services may mean that additional workforce resources are required. It is our view, supported by existing literature, that these additional skills should be located within the existing practitioner structures rather than in standalone primary mental health services.

This means that PHOs need to identify those additional skills that are required and then look within the community at where they might be available. For example, a PHO may require cognitive behavioural therapy capability or closer liaison with social agencies. The literature provided several examples where professional groups have been used to supplement the existing workforce.

To establish the additional workforce requirements, a PHO needs to consider:

• the identified needs of the population
• the plan it has to address the needs of its population
• the skills currently within the individual practice teams
• evidence about what is effective
• the availability of the skills that are required in the community
• the capacity of the current providers.
Prompts

- How much do you know about your workforce capability?
- How does this competency base enable appropriate assessment of Māori, Pacific and Asian people and people from different cultures?
- What are the skills required to deliver on the mental health action plan?
- Are these skills available within existing providers? If not where and how are you going to obtain these skills?

Workforce development

In general terms, workforce development is about ensuring that the health practitioners of a PHO have the right skill mix. The skill mix needs to be reinforced through the PHO’s quality framework and to contribute directly to the achievement of the health goals for the PHO. Workforce development cannot be restricted to the distribution of documentation, but must be action-based and leveraged off other activity occurring within the PHO or wider health sector.

Workforce development can occur internally (within a specific practice), across a number of practices or teams, or through external agencies. PHOs should provide the leadership in:

- establishing a recognition of the need for workforce development
- ensuring the link with the quality framework
- facilitating the provision of the training, either internally, through partnerships or from external providers.

Some of the skills that will be required will be generic, while others will be more specific (such as cognitive behavioural therapy).

Examples addressing organisational change

1. **Wells et al 2000** evaluated two models of improved depression care. One model focused on improved quality of drug treatment (training of clinical staff, screening for depression, practice nurse-led patient education and active follow-up). The other model concentrated on improving access to and quality of cognitive behavioural therapy (screening for depression, identification/training of psychologists to provide cognitive behavioural therapy and free access to therapy). Compared to usual care, both interventions led to significant improvement in outcomes.

2. **Procare linkages programme** in Auckland provides clinical psychologist skills to its primary health care practitioners for short evidence-based interventions at no cost to the patient. Evaluation has shown clear benefits to the patient and is well supported by practitioners.

3. **Bower’s 2001 review** ‘On-site mental health workers in primary care: Effects on professional practice’ as part of the 2001 Cochrane review found no evidence to support the concept of replacing existing primary health care providers of mental health services with on-site mental health workers.
4. A review of the national and international literature of secondary school-based services (Mathias 2002) showed that greatly improved access to primary mental health care and enhanced utilisation of mental health services resulted from providing these services.

5. Trailblazers is a primary and secondary training programme that was developed in England. It involves a multi-disciplinary approach by modelling good practice at local levels of care. More information is available on the website www.nimhe.org.uk.

6. The National Institute for Clinical Excellence is a branch of the National Health Service. Its aim is to provide guidance to the community, patients and health professionals on current ‘best practice’. Under the clinical guidelines section there are excellent and comprehensive guidelines for the management of a range of mental health problems. These include depression, schizophrenia and anxiety disorders. They have the advantage of covering management from both primary and secondary perspectives and are extensively referenced. The website is www.nice.org.uk.

7. Innovate is a website at www.innovate.org.uk, which lists new developments in primary health care delivery both clinically and at an organisational level. It lists a number of primary health care mental health innovations and provides a description of the programme and any evaluation as well as contact details.

8. Linkages is a Waikato-based partnership between an NGO (Pathways), primary health care provider (Pinnacle) and the Waikato DHB. It aims to help people access information and services that best meet their health and social service needs. The Linkages programme provides individual assistance either by self/family referral or by a health practitioner. For more information, go to www.webhealth.co.nz/links/linkage.

Prompts
When developing an educational programme, you may wish to consider the following points.

- Building relationships with experienced educators including cultural competency professionals, mental health practitioners and consumers who can provide additional expertise to a programme.

- The current range of help that is available to practitioners, and whether or not practitioners know this.

- What training your practitioners consider that they need, given their own views of their strengths and weaknesses.

- Establishing clinical leaders that will provide leadership in the development of core primary mental health competencies.

- The development of learning objectives that are clear, cover all knowledge, skill and attitudinal requirements, and that state what the provider can do at the end of the session.

- How to relate learning to real clinical practice. This means that training needs to be interactive, for example by using videotaping, role-playing.
• Evaluation of the training (ie, what has been learnt – skills, knowledge and attitudinal change).
• What other changes are necessary to reinforce any gains from the education programme, for example any organisational change.
• What ongoing training will be provided so that the training outcomes are reinforced.
• Introducing scholarships to encourage practitioners to undertake training, for example Māori and Pacific mental health scholarships.

**Structural changes**

The structure of the PHO can reinforce its leadership position. This section looks at:

- **governance structure**
- management of knowledge through the use of **information systems**
- **site location**.

**Governance**

Planning for improvement in mental health outcomes needs to be reflected in the annual business planning processes. This means that, within the annual business plan, new services may be identified. It also means that practitioners will need to look at what they currently do, to see if any improvements can be realised within current budgets.

PHO staff should consider how they provide advice to the board and any committees, and whether or not this is adequate. For instance, should a mental health group, including consumers, be established? This approach has been adopted in some places by the establishment of a mental health overview group.

**Information systems**

Primary Health Organisations should not only consider how they store information, but also how data from a variety of sources may be retrieved and then amalgamated with PHO or practice-held information so that:

- they can develop a greater understanding of the needs of their enrolled population by assessing indicators such as utilisation, clinical indicators, ethnicity data and disease coding
- there is support of follow-up elements
- outcomes are monitored
- the option of case management/disease registers is provided for
- monitoring for continual quality improvement is undertaken.

**Site location**

There are many options for where a service might be delivered. Where a service is located is a tangible way in which a primary health practitioner can demonstrate responsiveness to the needs of the enrolled population. Current examples include:
• marae-based primary health care services
• secondary school-based health centres
• youth-specific ‘one stop shop’ services.

The key is that the service is provided in a setting that provides greatly increased access for those populations that have difficulty in accessing traditional primary health care. This is critical, as the evidence suggests that access to a regular primary health care provider leads to improvements in health status, regardless of income.

Prompts

• How would you know the degree of organisational change required in your PHO?
• What is your current workforce capacity to deliver improved primary mental health services?
• What is the capability of your workforce to deliver on your PHO’s primary mental health action plan?
• How would you know that the workforce development that has been undertaken has led to improved health outcomes?
• Has the barrier of the location of primary health services been addressed for your enrolled population?

Improving links with other agencies

The integration and co-ordination of service across the spectrum of providers is vital, as the total benefit of the service provided is greater than that of its component parts.

A PHO needs to consider:
• how they link with community services, including NGOs
• how the primary service interfaces with specialist mental health services
• how they link with local health promotion programmes/organisations.

Note: Chapter 5 discusses the range of other organisations that are involved in the provision of primary mental health services.

Links with community services

Throughout this document, we have stressed that improving mental health outcomes needs an holistic perspective. This means looking at people’s housing, employment, social network, family/whānau and spiritual wellbeing. Addressing many of these areas is beyond the scope of the primary health care practitioner. However, if they are not addressed, the actions of the primary health care practitioner are less likely to lead to good outcomes.

Facilitating a co-ordinated approach involving other services will be easier to achieve where a pre-existing relationship between the various provider services exists. A
number of NGOs recognises the value of close links and many already link with primary health care practitioners. Therefore a PHO needs to consider how to build on those existing relationships.

However, in some cases, the relationship between primary health care providers and the NGO sector is not developed sufficiently well. Primary health care and NGO providers need to work together more closely to enhance service outcomes, learning from each other’s experience and skills and developing links at both managerial and clinical levels.

From a community perspective, a number of community-based services are already operating. These include self-help groups, private counsellors, church groups and other health agencies. A PHO should develop, or have access to, a list of support agencies that can assist their practitioners.

Examples of linkages with other agencies

1. **Canterbury Plunket postnatal adjustment programme** is a NGO-led programme providing health promotion, support, and group and individual therapy to women and their families with problems during the postnatal period. The programme, which has been operating for three years, has developed close links with primary health care. It takes referrals from Plunket nurses and primary health care practitioners and liaises closely with specialist mental health services.

2. [www.spinz.org.nz](http://www.spinz.org.nz) is a New Zealand NGO whose main purpose is to provide quality information on youth suicide that supports effective intervention and prevention activities across the country. It provides a list of relevant publications, information and links to other sites and organisations with similar goals.

3. **Family Start** is a targeted home-based support programme for families with a newborn baby whose difficult circumstances put them at risk of poor health, education and social outcomes for their children. The Family Start programme provides high intensity and long duration input to the most at-risk families. Participation in Family Start is voluntary. The referral window is six months prior to birth to six months post-birth. [http://www.strengtheningfamilies.govt.nz/familystartabout.htm](http://www.strengtheningfamilies.govt.nz/familystartabout.htm).

4. **Strengthening Families** is a programme where personnel from health, education, welfare, justice, housing and employment sectors work together to support improved service co-ordination for children and young people. Generally the process aims to achieve:
   - better outcomes for children by helping families meet their care, control and support responsibilities
   - improvements in families’ abilities to resolve difficulties and problems, and maximise the outcomes and opportunities for their children
   - clearer definitions and better collaboration between the health, education and welfare sectors locally and nationally
   - better use of existing resources.

5. **Youth Justice Health Assessments** is an initiative that is part of the Government’s *Youth Offending Strategy* and is a joint initiative between the Ministry of Health, the Ministry of Education and Child, Youth and Family. It provides for a comprehensive health and/or education assessment for some high-risk children and young people prior to their Youth Justice Family Group Conference (FGC). This assessment aims to assist the FGC decision-making process.

**Interface between primary health care and specialist mental health services**

Achieving stronger links will require primary and specialist providers to focus on their shared goal of meeting the mental health needs of the population and assuring a life worth living for people with mental health problems and their families.

The specialist mental health service uses the recovery principle. This means ‘living well in the presence or absence of mental illness’ (Mental Health Commission).

There are several factors that determine the extent to which a person lives well.

- Inclusion of people with mental illness in society and the role communities take to assist recovery.
- The range of treatments and supports that are holistic and meet the needs of the user, including psychological, spiritual, and social approaches. These services may be instead of, or in addition to, a more biological approach.
- Equality, rights and respect, including the leadership of service users in decisions that affect them.
- Enabling users to take an active role in their own recovery by using their own resourcefulness.

A seamless relationship between primary and specialist mental health and addiction services is fundamental if we are to effectively meet the mental health needs. The importance of this was consistently emphasised during consultation with primary health care providers and the community.

**Levels of input**

From the perspective of primary health care providers, there need to be three levels of input:

1. advice about what to do for non-referred people
2. one-off assessments by specialist mental health clinicians, with advice about ongoing management in primary health care
3. assessment and ongoing care within specialist services that have frequent communication with the primary health care team.

In turn, specialist mental health providers need:

- good information in referrals from primary health care
• primary health care providers who are knowledgeable about mental health
• referral to secondary care of people whose mental health needs cannot be met more appropriately elsewhere.

**Developing strong relationships**

Building collegial relationships will enable these requirements to be met. There are many issues to consider.

• Areas of concern from both sectors, raising awareness about the work that each does, and starting the process of relationship development. The engagement could be at both managerial and practitioner levels.

• Development of tools for communication and methods to improve this. For example, referral and discharge processes, using IT to facilitate this with electronic referrals and discharges.

• Protocol development with delineation of responsibilities, for example protocols related to urgent referrals.

• Development of formal shared care agreement arrangements.

Once a strong relationship is established a joint plan can be developed that addresses issues such as:

• improving communication in both directions
• rapid access to telephone advice
• providing advice to specialist mental health providers about primary care
• one point of entry and criteria for access to specialist services
• discharge planning that involves the primary health care team for complex problems.

**Shared care**

At times, primary and specialist mental health services will share in the management of patients or service users. Shared care is a demonstration of an effective working relationship between primary and specialist mental health services and shared care models have been developed in the last 20 years throughout the world.

A comprehensive evaluation of mental health/primary health care shared services in New Zealand was published in 2003. The review found that there was limited knowledge about the effectiveness of shared care programmes in improving health outcomes. However, the review did report that all programmes that had undertaken any form of evaluation had reported positively on the benefits of their programmes. While there is no agreed definition of what constitutes shared care, there are three basic models.

• **Consultation liaison**: this is where a consultant psychiatric professional works alongside the primary health care team. This is common in the UK, with psychiatric nurses most likely to be the professional that links to the primary health care provider. The focus tends to be on mental health problems in the general practice population rather than on those people with an ongoing mental illness.
• **Shifted outpatient:** here, the psychiatric professional team runs specialist clinics within practices. The aim is to improve accessibility and acceptability to people. In general, this seems successful in terms of delivering increased outpatient services.

• **Formal shared care arrangement:** responsibility for the mental health care is shared between different providers including housing, primary health care, NGOs and specialist mental health services.
Examples of service linkages

1. **The WIPA primary health care and specialist mental health liaison programme** aims to ensure that clinical care for people with severe mental health needs is arranged so that the patient receives the treatment in the right place, at the right time, from the right practitioner with the right skills and with the right support systems in place. This programme has addressed the barriers to mental health consumers accessing primary health care through an effective transfer process including new roles and capitation funding. It ensured that consumers were involved in every step of developing the programme and has maximised the consumer’s choice as the capitation follows them. The programme delivered training to all practice staff and was positively evaluated by consumers.

2. **The Newtown Union Health Centre** provides a primary health care health service to people on low incomes. The primary mental health programme is delivered by the GP and a primary mental health nurse based at the centre. Consultations are provided at no charge and each fortnight a consultant-liaison service is provided by a psychiatrist.

3. **Wanganui Regional PHO** uses a community mental health nurse with a large primary health care practice. They work part time and provide a range of services, including a link between primary and specialist mental health services. They provide additional skills aiding primary health care management and follow up discharged patients by the community mental health team. While it has not been evaluated, all participants are very supportive.

Prompts
- Building relationships takes time. How will this be undertaken and how will those relationships be shared across the PHO?
- Who will be responsible for ensuring that these working relationships are maintained?
- Where links with other agencies and specialist mental health services are working well, how might these be built upon?
- Have you identified all of the organisations that can refer to, or provide services within, your PHO?
- Do you have working agreements with these organisations?
- How can you strengthen these relationships?
- What processes do you have within your planning to involve people who have used mental health services?
Further information


Atun, RA. 2004. *What are the Advantages and Disadvantages of Restructuring a Health Care System To Be More Focused on Primary Care Services?* World Health Organization.


Gatehouse Project. URL: http://www.rch.org.au/gatehouseproject/.


MacArthur Initiative on Depression and Primary Care. 2003. Depression Management Tool Kit.


Trailblazer programme. URL: www.nimehe.org.uk.


11 Developing a Primary Mental Health Plan for Your PHO

Each PHO is required to develop an annual business plan that is agreed with its respective DHB. Within the context of this business plan and the higher-level strategic plan, PHOs will have a number of targeted strategies: the mental health plan is one of these.

As a PHO, your mental health plan needs to describe:

- the need within your enrolled population
- the long-term strategic vision of how you will offer mental health and substance abuse services to your enrolled population
- specific actions for the coming year
- methods for measuring performance in relation to your strategic vision.

We have included prompts throughout this document to encourage discussion about such issues as workforce capability and the needs of the enrolled population, as well as provide some options for action. In particular, we hope that these prompts will encourage you to consider your current actions and plans from the perspective of the user.

The worksheet in chapter 12 summarises these prompts to help with formulating a mental health plan.

We anticipate that the primary outcome of this process will be a plan that sets out those primary mental health services that a PHO will provide to its enrolled population – both in the short and long term. Some initiatives will be able to be undertaken within current resources, others will require the reallocation of existing resources and some services will require additional resources.

Prompts

- Who will you consult with in the development of your mental health action plan?
- How will you keep the plan ‘alive’ to ensure that services are developed and improved over time?
- How will you incorporate evaluation and develop continuous quality improvement to measure the effectiveness of your service delivery?
Further information


12 Worksheet

Prevalence of mental health problems in your enrolled population

- Given the demographic mix of your enrolled population, what is the prevalence of the differing mental disorders likely to be?
- What are the particular high-risk groups within your PHO's enrolled population?
- Are there specific disorders that will have a greater prevalence due to the nature of your enrolled population?

Barriers to access

- What are the most relevant barriers to the provision of mental health services in your PHO?
- What barriers do Māori, Pacific and lower socioeconomic groups face?
- How could some of these barriers be overcome?

Promotion and prevention

- What role does your PHO have in mental health promotion?
- How might a PHO engage more effectively with Māori, Pacific, migrant Asian and lower socioeconomic groups in order to undertake mental health promotion?
- How does your business plan reflect this role?
- How do you deliver on these mental health promotion goals?
- What partnerships does your PHO have with organisations that offer or undertake mental health promotion?
- What role does your PHO have in preventing mental illness?
- What information does your PHO have regarding NGOs and other agencies leading prevention and community development programmes?
- What capabilities will the PHO require in order to fulfil the role decided upon?
- What are the culturally specific needs that should be addressed in prevention programmes?
- How should you develop your relationship with secondary providers to meet the needs of your population for secondary and tertiary prevention?

Screening to identify people at a higher risk of mental health problems

- What screening will be used to meet the needs of your enrolled population?
- How will you take cultural considerations into account?
• What are the provider constraints on implementing the proposed screening programme?
• What are the organisational constraints when implementing screening?
• What will happen to people identified by the screening process?

Assessment and management in primary health care

Comprehensive assessment
• Does your PHO know about the workforce capability of your providers?
• How will your PHO use this information?
• Do your practitioners have adequate time and resources available to undertake what is required?
• If not, what are the possible solutions?

Personal health care management
• How does the care provided within individual practices currently match this active follow-up approach?
• How will the PHO allow providers to use evidence-based treatment options with its enrolled population?
• How will the different management needs of Māori and Pacific peoples be addressed?

Organisational changes
• How much do you know about your workforce capability?
• How does this competency base enable appropriate assessment of Māori, Pacific and Asian people and people from different cultures?
• What are the skills required to deliver on the mental health action plan?
• Are these skills available within existing providers? If not where and how are you going to obtain these skills?

Workforce development
When developing an educational programme, you may consider several points.
• Building relationships with experienced educators including cultural competency professionals, mental health practitioners and consumers who can provide additional expertise to a programme.
• The current range of help that is available to practitioners, and whether or not practitioners know this.
• What training your practitioners consider that they need, given their own views of their strengths and weaknesses?
• Establishing clinical leaders that will provide leadership in the development of core primary mental health competencies.

• The development of learning objectives that are clear, cover all knowledge, skill and attitudinal requirements, and that state what the provider can do at the end of the session.

• How to relate learning to real clinical practice. This means that training needs to be interactive, for example by using videotaping, role-playing.

• Evaluation of the training – ie, what has been learnt – skills, knowledge and attitudinal change.

• What other changes are necessary to reinforce any gains from the education programme, for example any organisational change?

• What ongoing training will be provided so that the training outcomes are reinforced?

• Introducing scholarships to encourage practitioners to undertake training, for example Māori and Pacific mental health scholarships.

**Structural changes**

• How would you know the degree of organisational change required in your PHO?

• What is your current workforce capacity to deliver improved primary mental health services?

• What is the capability of your workforce to deliver on your PHO’s primary mental health action plan?

• How would you know that the workforce development that has been undertaken has led to improved health outcomes?

• Has the barrier of the location of primary health services been addressed for your enrolled population?

**Improving links with other agencies**

• Building relationships takes time. How will this be undertaken and how will those relationships be shared across the PHO?

• Who will be responsible for ensuring that these working relationships are maintained?

• Where links with other agencies and specialist mental health services are working well, how might these be built upon?

• Have you identified all of the organisations that can refer to, or provide services within, your PHO?

• Do you have working agreements with these organisations?

• How can you strengthen these relationships?

• What processes do you have within your planning to involve people who have used mental health services?
Developing your primary mental health plan

- Who will you consult with in the development of your mental health action plan?
- How will you keep the plan ‘alive’ to ensure that services are developed and improved over time?
- How will you incorporate evaluation and develop continuous quality improvement to measure the effectiveness of your service delivery?
13 Definitions

Primary health care

Primary health care is ‘first-contact, continuous, comprehensive and co-ordinated care provided to populations undifferentiated by gender, disease or organ system’ and is ‘essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods’.

It is also community-based and comprises a range of services from health promotion and screening through to diagnosis and treatment of medical conditions, provided by a range of community based health practitioners and support workers.

Primary mental health care is that component of primary health care that addresses a person’s and their family/whānau’s psychological distress and illness.

Mental health promotion

This can be defined as the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice and personal dignity.

Non-government organisations (NGOs)

NGOs provide a broad range of services and programmes in the community that contribute to the holistic nature of mental wellbeing. These services include employment, peer support, recreation, education, family/whānau support, accommodation and housing. NGOs are involved in community resources such as those providing mental health promotion and working in the area of prevention. They provide services in the primary health care setting as a person’s first contact and they also provide services for those needing specialist mental health care and support.
Appendix 1: Process Used to Develop this Document

The Ministry of Health contracted Counties Manukau District Health Board (CMDHB) to develop this toolkit. However, it needs to be a living document if it is to remain relevant and provide a robust and current framework for the provision of primary mental health care.

Project structure

CMDHB co-sponsors
- Bernard Te Paa, CMDHB – General Manager Māori Health
- Dr Allan Moffitt, CMDHB – Clinical Advisor Primary Care

Project team
- Dr John Cosgriff – GP Liaison Adult Mental Health Services
- Fran Silvestri – Project Manager

Steering group
- Bernard Te Paa – General Manager Māori Health CMDHB
- Dr Allan Moffitt – Clinical Advisor Primary Care CMDHB
- Elizabeth Powell – Senior Advisor, Primary Health Team Ministry of Health
- Karen Coutts – Senior Analyst Mental Health Directorate Ministry of Health
- Margie Fepulea’i – General Manager Pacific Health CMDHB
- Dr Sue Hallwright – Manager Mental Health Development CMDHB
- Helen Hamer – Senior Lecturer University of Auckland/Nurse Consultant ADHB
- Kristan Johnston – Mental Health Directorate Ministry of Health
- Robyn Priest – Project Co-ordinator HealthCare Aotearoa
- Dr Helen Rodenburg – General Practitioner Wellington

Working party
- Dr Margaret Aimer – Clinical Director Mental Health Services CMDHB
- Dr Lynette Ashby – General Practitioner Pukenaho
- Associate Professor John Bushnell – Wellington School of Medicine
- Barbara Docherty – National Project Director TADS University of Auckland
- Dr William Ferguson – General Practitioner Kumeu
- Allan Greenslade – Chief Executive Officer HealthWest
- Donny Rangiaho – General Manager Mahitahi
- Manu Sione – General Manager Pacific Trust Canterbury
- Suzy Stevens – Partnership Works
- Eru Thompson – Manawhenua
- Sauaina Vaoita Turituri – Service Manager Lotofale, Pacific Mental Health Service ADHB
- Dr Joe Williams – General Practitioner Auckland
- Te Puea Winiata – Mental Health Directorate Ministry of Health
The purpose of the working party and steering groups were:

**Steering group**  
To provide oversight for the project and ensure target dates were met.

**Working party**  
To provide detailed suggestions on the accuracy, completeness and relevance of the content as well as on the structure and appropriateness of the toolkit.

The preparation of this toolkit involved:

- a literature review
- discussions with skilled providers on ‘what they faced’ as well as the release of an initial high level document to determine ‘what was required’
- preparation of the draft toolkit
- consultation on the draft including meetings specifically targeted at Māori, Pacific peoples and NGOs.

**Literature review**

Two complementary searches were undertaken.

- The Goodfellow Unit of the University of Auckland was contracted to undertake a literature review. Standard medical databases were used to locate literature since 1997 relating to certain criteria, and this resulted in a report delivered to CMDHB on 30 September 2003.

- A CMDHB literature search was also carried out, involving the use of CMDHB networks within New Zealand and overseas. In addition, stakeholders were asked to provide operational documents and toolkits on all aspects of mental health services delivered in primary health care settings.

The main themes emerging from the literature review are described in the body of this toolkit.

From these literature reviews, it is clear that the provision of primary mental health care services is an area of current research interest. This means that developments in this area in relation to what we do and how we do it are likely to be rapid.

Therefore, a process will have to be considered and adopted that the way in which we provide mental health services remains current.

**Consultation**

A consultation process was designed to ensure that the views of key stakeholders on the reality of primary mental health care provision were captured and used to develop our thinking on this issue. There were three key phases in the consultation process.
Phase 1

A. **Initial consultation** based around a high-level conceptual document. This was used to stimulate thinking and to encourage responses from stakeholders. It included meetings with:
   - regional mental health and addiction networks
   - Mental Health Advocacy Coalition (MHAC)
   - PHOs in Counties Manukau DHB
   - written submissions from individuals and groups.

At the same time, the Ministry of Health and Health Care Aotearoa convened a number of face-to-face meetings with community providers about their issues and concerns around mental health services in primary health care.

Phase 2

A. Using the information from the first phase, a **draft document** was prepared and released on 9 December 2003 for comment. A number of approaches were used to ensure that a broad spectrum of comments were received.

B. Stakeholder consultation meetings were held in Auckland, Wellington and Christchurch to review the draft toolkit.

C. An opportunity to respond electronically was provided by posting the toolkit on the Ministry of Health website and also by encouraging relevant associations to either post the toolkit on their own website or to provide a link to the Ministry of Health site.

D. The draft toolkit was sent to those on the project’s email distribution list.

E. Hui and fono were held for Māori and Pacific stakeholders in Auckland, Wellington and Christchurch.

F. Submissions were accepted until 20 January 2004.

Phase 3

A. **The toolkit was finalised**, using the advice received from the submission process.
Appendix 2: Strategic Policies and Documents

In this appendix, we summarise strategies relevant to the provision of primary mental health services in a New Zealand context.

New Zealand Health Strategy

The New Zealand Health Strategy identifies priority areas for health and aims to ensure that health services are directed at those areas where greatest benefit will be realised. Specifically, the strategy aims to ensure accessible and appropriate services for Māori and Pacific peoples and those from lower socioeconomic groups. This includes improving the health status of people with severe mental illness.

The strategy has a number of principles, with the central one being the special relationship between Māori and the Crown under the Treaty of Waitangi.

New Zealand Disability Strategy

The strategy is about disabled people having full and rich lives with:

- a sense of inclusion
- full participation in society
- full opportunity in their lives.

He Korowai Oranga – Māori Health Strategy

The overall aim of He Korowai Oranga is whānau ora: supporting Māori families to achieve their maximum health and wellbeing. Whānau is recognised as the foundation of Māori society. It is the source of strength, support, security and identity and plays a central role in Māori wellbeing, both individually and collectively. Whānau recognises the wide diversity of families represented in Māori communities.

He Korowai Oranga challenges the health and disability sector to recognise:

- the interdependency of people
- that health and wellbeing are influenced and affected by the ‘collective’ as well as by the individual
- the importance of working with people in a social context, not just by addressing their physical symptoms.

The strategy affirms the Māori models that are holistic in nature and address wellness, as well as improving Māori outcomes. An holistic approach to mental health care provision by PHOs is complementary to this strategy.
Pacific Health and Disability Action Plan

The Pacific Health and Disability Action Plan envisions healthy people achieving their full potential throughout their lives. It outlines four key principles, which are that:

- dignity and the sacredness of life are integral to the delivery of health and disability services
- active participation of Pacific peoples in all levels of health and disability services is encouraged and supported
- successful Pacific services recognise the integral roles of Pacific leadership and Pacific communities
- Pacific peoples are entitled to excellent health and disability services that are co-ordinated, culturally competent and clinically sound.

Primary Health Care Strategy

A number of other strategies have been developed from the over-arching documents mentioned above. One of these is the Primary Health Care Strategy 2001. Primary health care is defined as essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods that are:

- universally accessible to peoples in their communities
- inclusive of community participation
- integral to, and a central function of, New Zealand’s health system
- the first level of contact with our health system.

The vision for the document when it was released was that there would be an evolutionary process over the ensuing 5–10 years, in which:

- people would be part of local primary health care services that improved their health, kept them well, were easy to access and co-ordinated their ongoing care
- primary health care services would focus on better health for a population, and would work actively to reduce health inequalities between different groups.

The directions for achieving this vision are to:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people’s health
- co-ordinate care across service areas
- develop the primary health care workforce
- continuously improve quality using good information.
Appraisal for partnership, participation and protection

In order to recognise and respect the principles of the Treaty of Waitangi and with a view to improving health outcomes for Māori, the New Zealand Public Health and Disability Act 2000, Part 3, provides mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

The principles of partnership, participation and protection underpin this relationship.

- **Partnership**: working together with iwi, hapū and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

- **Participation**: involving Māori at all levels in decision-making, planning,
  development and delivery of health and disability services.

- **Protection**: working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.
Appendix 3: Māori Health Perspective

Māori view of health

Traditionally, Māori have taken a holistic approach to health. These elements have been expounded in the Whare Tapa Wha concept, which describes four dimensions of health as contributing to health and wellbeing:

- te taha tinana (physical aspects)
- te taha hinengaro (mental and emotional aspects)
- te taha wairua (spiritual aspects)
- te taha whänau (family and community aspects).

Te whare tapawha expresses the Māori world view in an action-oriented manner and is seen as one of a number of Māori models of working. This is indicative of the need for health professionals to have a range of skills and models with which to work with patients effectively.

Māori health experts also see health as the result of a complex set of relationships that include social, economic, political, cultural, historical and spiritual factors. Mental health is inextricably linked to those other factors or aspects, so that interventions, particularly in the primary health care setting, must reflect that.

The whänau (kuia, koroua, pakeke and tamariki) is identified as the foundation of Māori society. Whänau is a principle source of strength, support, security and identity, and plays a central role in the wellbeing of Māori individually and collectively.

A healthy family realises its potential to participate in and contribute positively to Te Ao Māori (the Māori world) and to wider New Zealand society. For whänau, this means that they are able to actively participate in developing services for Māori and work with providers to improve the services they access, both mainstream and Māori-specific.

It is essential that health professionals in PHOs understand the paradigm of wellbeing held by Māori, and that there are Māori models of practice and approaches to address illness and maintain wellness for whänau living in the community. These models begin with general models, as identified with Te Whare Tapa Wha, and develop into community-specific approaches to implementation.

It must be emphasised that Te Whare Tapa Wha is just one of several models that could be used by health providers, so that the challenge is to develop a range of appropriate health interventions. PHOs will need to develop appropriate resources as well as establish key relationships with Māori providers in the NGO sector and Māori mental health services in the DHBs (Coghlan et al 2001).

Effective services to Māori are services where whänau:

- experience physical, spiritual, mental and emotional health and have control over their own destinies
- live longer and enjoy a better quality of life
have whānau members who are able to participate in Te Ao Māori and wider New Zealand society

have the confidence to access services closest to them.

The benefits to PHOs of having a greater understanding of Māori health perspectives are:

- supporting evidenced-based funding and planning processes which contribute to improved service effectiveness and clinical safety
- ensuring that the information base utilised by planners reflect the needs of Māori
- that whānau are encouraged to participate more fully in the provision of health care services
- providing services that promote informed decision-making processes, thereby supporting Māori aspirations for the achievement of whānau ora (Minister of Health and Associate Minister of Health 2002).

**Service provision to Māori whānau**

Māori providers operate from a series of holistic service delivery models based on Tikanga (Māori protocols and practices). The models are implicit and explicit, and are unique to Māori service delivery and effectiveness. These models place whānau at the centre of all processes and incorporate other components such as whakapapa (genealogy), te reo (language) and kaumatua (elder) guidance to ensure wellness and whānau empowerment.

Māori whānau experience diverse realities (eg, rural and urban, economic hardship, etc). Current generations can be influenced by contemporary ideals that impact on traditional Māori tikanga and perspectives, such as the wellbeing of individuals. However, the concept of whānau ora is maintained as the prevailing view. Essential to whānau ora is recognition of the roles of individuals within a whānau environment and its universal applicability. Taken in the context of primary health care provision, whānau ora is the basis of early or minimal interventions that support an environment for empowerment and wellness.

**Desired outcomes for PHOs and primary health care practitioners**

This toolkit has been developed to assist PHOs in providing services that:

- are seen to encompass diverse cultural needs (for example, take into consideration all dimensions of Māori models of wellness)
- seek to identify the opportunities for services to work better with Māori whānau
- assist Māori in the management of mental health issues in the whānau environment, and to refer appropriately when needed
- ensure effective co-ordination and continuity of service provision
ensure all providers have an understanding of Māori mental health issues and an identified model of intervention
ensure that Māori access mental health services when they need to
give Māori the confidence to establish long-term relationships with their chosen health provider.

The outcomes we are looking to promote through the development of this toolkit are:
- early access by Māori of mental health services – this would mean Māori are accessing services at a less acute level
- a reduction in the historical access of Māori to mental health services through the justice system
- an improvement in first contact outcomes for Māori through the development of holistic assessment tools, better community provider connections and effective follow-up
- the development of service delivery processes that reflect the nature and needs of the population.

Critical success factors

In identifying the critical success factors for implementation of this toolkit, it is important to note the service implementation mechanism that is the key to delivery of services to Māori. Whānaungatanga (familyness), whakapapa (genealogy), tikanga (protocols) and te reo (language) are the key components to ensure success with Māori consumers and their whānau. This means that the services focus on developing robust, effective and appropriate relationships with not only the consumer but also the whānau in mind. These can be defined further by the adoption of the following key deliverables:
- Māori participation at all levels
- active partnership in service delivery
- protection and improvement of Māori health status.

The table below highlights suggested recovery aids and barriers for Māori from the Mental Health Commission Māori Recovery Stories report. Their application is equally useful for PHOs to consider in understanding the appropriate options for intervention and/or support for Māori with mental illness.

PHOs may wish to incorporate and/or discuss how these approaches may be integrated into service delivery models where Māori service utilisation is predictable.

<table>
<thead>
<tr>
<th>Recovery aids and barriers for Māori</th>
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<table>
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<th>Recovery aids</th>
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<td>Being treated with dignity and respect</td>
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<td>Family understanding of mental illness and support</td>
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</table>
• Involvement of service users and families in design and delivery of individual care planning and treatment
• 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
• Kaupapa Māori services
• Expert Māori staff
• Right medication and treatments
• Working in the mental health sector (eg, 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 whānau of mental health issues
• Discrimination
• Exclusion by whānau, hapū and iwi
• Lack of self-help information, especially in the 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 Māori people
• Side-effects of medication and/or electro-convulsive therapy
• Cultural inequality and misunderstanding in services
• Authoritarian services that reinforce dependence rather than independence

While PHOs will be able to provide the majority of services at a primary health care level, it is important to note that there are a range of Māori mental health services in the community. These providers, which are sometimes referred to as Kaupapa Māori services, have developed their models of care/service packages to complement the needs of the communities that they serve. Māori providers have a wide range of settings in which to deliver services (such as from the marae to kohanga reo or in the home).

The relationships that Kaupapa Māori services have with mental health providers varies. However, there continues to be a necessity for Māori providers and PHOs to form relationships to deliver complimentary models of service.

A Kaupapa Māori service provider would have as its core elements:
• whānaungatanga
• whakapapa
• cultural assessment
- empowerment and tangata whaiora and their whānau
- te reo Māori
- tikanga
- kaumatua capacity
- access to traditional healing
- access to mainstream health services
- quality performance measures relevant to Māori
- Āta Whakaaro Māori.

All these elements, together with sound management systems and practices, are essential if a service is to be considered a kaupapa Māori service and effective to achieve whānau ora.
Appendix 4: Effective Primary Mental Health for Pacific Peoples

By Fuimaono Karl Pulotu-Endemann.

Introduction

This appendix aims to:

- identify the key issues in relation to meeting the mental health needs of Pacific populations in a primary care setting
- point PHOs and primary health care practitioners to important documents and developments that have guided the development of Pacific primary health care and Pacific mental health
- identify the key learnings in mental health service development that may be useful for PHOs in developing their organisations to be more responsive to the needs of their enrolled Pacific populations.

This appendix represents a guide for PHOs on understanding the mental health needs of Pacific populations and ideas for how barriers to accessing care in a primary health care setting can be reduced and/or addressed. It summarises the key themes from a number of documents that may provide a useful point of reference for PHOs who want to be responsive to Pacific peoples’ mental health and wellbeing, including:


There is a dearth of information on the prevalence of mental illness among Pacific peoples. The main document identifies research projects that will soon be able to give some indication of prevalence of mental illness among ethnic specific populations.
Pacific perspectives on mental health and wellbeing

Central to the effectiveness of PHOs in addressing the mental health needs of Pacific peoples is the need for them to fully understand Pacific perspectives on health.

The overarching critical success factor is that PHOs recognise that the mental health of Pacific peoples is intrinsically bound to the holistic view of health. The Fonofale model encapsulates this belief by using the framework of a Samoan fale (house) to encapsulate the key elements of Pacific mental health and wellbeing (excerpt from Moving on the Blueprint).

- **Roof**: The roof represents cultural values and beliefs that are the shelter for life. These can include beliefs in traditional methods of healing as well as in Western methods. Culture is dynamic and therefore constantly evolving and adapting. In New Zealand, culture includes the culture of New Zealand-reared Pacific peoples as well as those Pacific peoples 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 practise 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.

- **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.

- **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 wellbeing that 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 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 peoples 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 peoples.
- **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 are politics and socioeconomics.

Since the emergence of the Fonofale model, other approaches based on traditional Pacific perspectives have emerged that are specific to each ethnic group. These frameworks offer a useful approach to identifying the issues that may be leading and/or contributing to general physical as well as mental unwellness. They also supplement and/or complement generic assessment tools and options for intervention to restore the balance in a Pacific person’s life.

In most situations, the key elements that are most helpful to a Pacific person’s mental wellbeing are often their faith, family and personal strengths. These can also be sources of problems and can contribute to poor mental health. For example, some families may stigmatise mental health because of a lack of understanding of services available or because services themselves may be difficult to access.

**Pacific peoples’ beliefs about the cause of mental illness**

The various Pacific cultures do not have a specific word in their language that translates easily for mental illness. This may be because ‘mental’ wellbeing is not separate from the overall wellbeing of the body.

Ma’ia’i 1994, Crawley et al 1995 and Peteru et al 1997 have emphasised the importance of culture in the understanding of Pacific peoples’ views of health. The culture-bound views and practices of Pacific peoples concerning mental illness are very different from those of Western psychiatric diagnosis.

Traditionally, Pacific peoples do not consider mental illness to result from a condition originating within, and totally confined to, a person exhibiting certain types of disturbed behaviour. Rather, it is considered a manifestation of an external spiritual force, especially of ancestral spirits who have taken possession of the person because the person or the person’s family has broken a certain custom or offended the spirits in some way.
The analysis of the Like Minds, Like Mine campaign in 2001 found that Pacific elders strongly supported this view. Middle-aged Pacific peoples, though supportive of this view, also recognised environment and stress as major factors. Younger Pacific peoples agreed that possession as well as stress could lead to being mentally ill and added other factors such as alcohol, drugs, and physical causes such as brain injury.

However, notwithstanding the traditional belief and spiritual curative practices across the Pacific cultures, there are considerable differences in terminology used for the behavioural disturbances.

Samoans use the terms such as Ma’i Samoa or Samoan sickness, and there a number of culture-bound syndromes that come to the fore when there is a breach of ‘tapu’ (things forbidden to the ordinary) or ‘sa’ (things that are sacred).

- **Ma’i Aitu** (spirit possession) manifested by bad temper, impulsive behaviour, use of foul language or out of character behaviour.
- **Ma’i Fasia**: geographical areas in Samoa are under the custody of a fasia or spirit guardian. If a person visiting such an area does something untoward such as laughing or wearing certain colours, that person can be stricken with hallucinations.
- **Ma’i Valea**: emotional sickness considered to be caused by contact with some object that belonged to a deceased person.

According to well-known Auckland Tongan doctor, Dr Leopino Foliaki, the Tongan term ‘fakasesele’ refers to a person who is said to be totally out of reality and doing ‘all sorts of absolutely wonderful things’, ‘angaangaua’ (two characters) to someone who is displaying two personalities; and ‘te’ia’ to a victim who is hit suddenly and falls under the control of a dead person.

Many Tongan people traditionally believed that all illnesses from a migraine through to severe depression resulted from an action that affected the ancestral spirit (Ministry of Health 1993).

**Diversity within Pacific populations**

Pacific peoples in New Zealand come from very separate and diverse groups. There are also a growing number of Pacific peoples born in New Zealand who are influenced by contemporary ideas that change their view of traditional cultural values and perspectives. However, their holistic beliefs of wellbeing prevail.

Therefore, greater acknowledgement of and respect for the cultural and intergenerational diversity that exists amongst Pacific peoples is 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 world view on mental health.
A thorough health needs analysis of Pacific populations enrolled in a PHO will identify:

- socioeconomic deprivation
- ethnic-specific information (Level 2 of Ethnicity Coding, NZ Statistics)
- diagnosis codes and utilisation analysis (eg, repeat attenders with a mix of complex conditions)
- provider knowledge of the family context (eg, single parent, mix of New Zealand and Pacific born peoples within a household) and/or their community (eg, church attendance and activities).

**Factors critical to Pacific health and wellbeing**

Pacific peoples 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 following discussion highlights factors that are critical to addressing the mental health needs of Pacific peoples.

**Families (excerpt from Mental Health Commission 2001)**

The family is a key component of Pacific cultures and plays an important role in Pacific peoples’ lives. However, to Pacific peoples, the family can either hold the key to recovery or be a great hindrance to recovery. Therefore, it is essential that appropriately skilled and trained Pacific health professionals are engaged to work with families to:

- establish and build working relationships with Pacific families
- identify any barriers or concerns from the family
- assist in formulating solutions to any problems or issues identified.

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 an 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.’
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 accessing mental health 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, education for non-English speaking Pacific peoples will have to be one of the priorities. This does not mean that making available interpreters and/or translated material will suffice. It means that primary mental health workers (who are also language speakers) must be trained and available to families for discussion and information-sharing to ensure full understanding for the patient and their families. This happens through constant dialogue and relationship building.

Bathgate and Pulotu-Endemann 1997 identified the following risk and protective factors for mental health.

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support networks and cultural expression</strong></td>
<td><strong>Weakened support networks and cultural expression</strong></td>
</tr>
<tr>
<td>Family support</td>
<td>Lack of family support</td>
</tr>
<tr>
<td>Community (culture bound support)</td>
<td>Lack of community support</td>
</tr>
<tr>
<td>Awareness and esteem of own culture</td>
<td>Lack of awareness and esteem</td>
</tr>
<tr>
<td>Involvement in activities of own culture</td>
<td>Lack of involvement in own culture</td>
</tr>
<tr>
<td>Self-esteem and lack of discrimination</td>
<td>Lack of self-esteem and presence of discrimination</td>
</tr>
<tr>
<td>Exercise of authority, leadership</td>
<td>Lack of strong leadership or recognition of authority</td>
</tr>
<tr>
<td>Parenting – two parents and extended family life</td>
<td>Parenting – solo and/or no extended family support</td>
</tr>
<tr>
<td>Parenting supportive and confident of transition to or balance of Western and traditional perspectives</td>
<td>Parenting is not supportive or confident about negotiating Western and traditional perspectives and expectations</td>
</tr>
<tr>
<td>Safe and secure environment</td>
<td>Insecure – violence in the home (physical, verbal)</td>
</tr>
<tr>
<td>Successful adaptation and co-existence between Western and traditional culture, mores and behaviours</td>
<td>Confusion about acceptable and appropriate cultural mores and behaviours. Discomfort with bicultural environment.</td>
</tr>
<tr>
<td><strong>Economic security</strong></td>
<td><strong>Economic insecurity</strong></td>
</tr>
<tr>
<td>Adequate housing</td>
<td>Overcrowding, poor quality housing</td>
</tr>
<tr>
<td>Satisfactory employment</td>
<td>Unemployment or lack of satisfactory job</td>
</tr>
<tr>
<td>Adequate income to support family and meet church and social obligations</td>
<td>Inadequate income to support family and meet church and social obligations</td>
</tr>
<tr>
<td><strong>Absence of substance use</strong></td>
<td><strong>Presence of substance abuse</strong></td>
</tr>
<tr>
<td>Nil or minimal use of alcohol</td>
<td>Excessive use of alcohol</td>
</tr>
<tr>
<td>Avoidance of illicit drugs</td>
<td>Use of illicit drugs</td>
</tr>
</tbody>
</table>

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70 Primary Health Organisations:
Service development toolkit for mental health services in primary health care
Traditional beliefs

Another issue is that the family's understanding of mental illness may be different from the medical view. The family perspective may be based on traditional beliefs and values, which can be very different from those of the clinician and health professional. This may result in the two parties talking past each other, making it difficult to build relationships, and is one barrier to access.

What does this mean for PHOs?

Primary Health Organisations need to be aware of their enrolled Pacific population and their ethnic constituents, and to develop a relationship with the key Pacific groups and leaders.

Building a relationship with Pacific consumers and their families is an important factor for effectiveness for primary health care practitioners. Many already engage and support participation from Pacific consumers and their families in care plans and approaches to managing mental illness at home and/or in the community. Factors for effectiveness include encouraging and supporting families to be involved in the care and recovery of their loved ones where appropriate.

Factors for effectiveness also include supporting community efforts to promote healthy living, especially the promotion of protective factors and lessening of risk factor activities.

Reducing the stigma of mental health

Stigma and discrimination play a role in hindering recovery. Pacific service users find that they not only experience stigma within their communities, but are also confronted with lack of understanding within mental/primary health services.

Sometimes this is expressed through staff prejudice and stereotypes, where Pacific peoples 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.

What does this mean for PHOs?

Primary Health Organisations have an important opportunity to reduce stigma and encourage access to primary mental health services by working with their local communities, consumers and their families to reduce the stigmatisation of mental illness and support recovery. Primary Health Organisations can do this by building stronger relationships with their local Pacific communities through:
- participation in management/governance structures and processes
- ensuring that their delivery models and/or processes (e.g., assessment, options for intervention) reflect a cultural assessment and a strong family-centred approach where appropriate
- participation in workshops focusing on the experiences of Pacific consumers and their families.

**Poor access to mainstream mental health and primary health care services**

Many services can be difficult for Pacific peoples to access for a number of reasons, including:

- cost of services
- difficulties with transport, particularly for low income populations
- language – complex situations and/or issues may be difficult to discuss if English is a second language for a patient
- needs may not be met by one provider or health professional
- lack of knowledge of where mental health services are situated
- lack of established pathways for people to access mental health services from a PHO or GP
- stigma associated with mental illness
- mental health services are not culturally sensitive to the needs of Pacific peoples.

There is the suggestion that there is less stigma associated with obtaining your mental health care from a primary health care practitioner than having to access a specialist mental health service.

The solution may be to establish good links/pathways between PHOs and specialist mental health services to improve access, including holding mental health clinics in primary health settings. However, as a consequence of the various barriers to access, Pacific peoples are less likely to use community/primary health care services for their mental health needs. They may either present late for mental health services and, by that point, may be in acute or crisis situations. Alternatively, they may be presenting for various other physiological conditions (e.g., chronic illness and disease) but their mental health condition is unidentified.

**What does this mean for PHOs?**

Pacific mental health workers in Auckland have found that the majority of people with mental health issues are currently being seen by a GP. Many of these people are reluctant to seek specialist help for a variety of reasons including stigma. 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). Families can also understand mental illness better when they can communicate in their own language with the service and be comfortable in a supportive cultural environment.

The Pacific mental and primary health sectors comprise a wide range of providers and services that specialise in working with Pacific peoples. PHOs may wish to formalise and build a relationship with existing Pacific providers who have a critical mass of Pacific health professional expertise to support the delivery of primary health care to Pacific consumers.

In particular, PHOs situated in the seven Pacific-designate DHBs can use community support workers appropriate to the ethnic breakdown of their population to liaise between their own services, secondary or specialist mental health services and inter-agencies such as WINZ, Housing New Zealand and CYFS.

**Community development approaches**

The international drive for adoption of community development models of health provision originated with the Ottawa Charter (1986). The Charter’s central tenet was 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 peoples 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 by the Pacific communities themselves.

Current developments by the Mental Health Directorate and the Mental Health Commission (December 2003 meetings) have concentrated on models of service delivery that focus on the client and family/ethnic community/pan-Pacific community development and building workforce services and service delivery models around that. This is also complementary to the focus of this project.

**What does this mean for PHOs?**

Many PHOs already practise community development through concrete and effective community participation in setting priorities, making decisions, planning strategies and implementing them to achieve better health outcomes.

However, according to the feedback from the consultation fono, there needs to be some education programme by the PHO or DHB for the Pacific community on what a PHO actually is, how it can help them and what their involvement should be. There were different levels of understanding of the role of a PHO in the community generally, as well as different levels of understanding and participation within each ethnic group.
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 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 over-arching organisations with a representative mandate to carry out several tasks.

- Include Pacific service users in their Pacific communities and in wider society.
- Integrate mental health services into pre-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, community and cultural workers practising alongside to advise clinicians on culturally safe practice.
- Recruit and support Pacific peoples into the mental health workforce, using their extensive community networks in the short term and taking a more proactive role in the medium to 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.
- Ensure mental health services are more understanding of traditional perspectives, allow for alternative ways of treating Pacific consumers and relinquish some of the power that rests with medical practitioners.

The power and potential of a community-based model of health service development is that it taps into the wealth of talent, expertise and altruism that conventional mainstream methods of service delivery have under-utilised. Stronger, community-owned Pacific 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.

Many PHOs have already incorporated community representation at governance and other management levels of their organisations. Where there are significant proportions of Pacific populations enrolled, PHOs may consider strengthening Pacific community representation within their organisations.
Summary of significant issues for Pacific peoples

In summary, there are many significant issues that Pacific peoples face in relation to mental health.

- 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. Patients presenting more acutely is also leading to higher costs per episode (CAOS study report confirms this).
- A lack of services specifically designed to meet the needs of Pacific peoples, whose language and cultural beliefs can make successful engagement difficult. This is especially evident in the area of child, youth and family, alcohol and drug services.
- 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 their local Pacific populations and how they will consult with Pacific providers, service users and communities.
- High readmission rates.
- Lack of knowledge of where mental health services are situated.
- Lack of established pathways for people to access mental health services from a PHO or GP.
- Stigma associated with mental illness as defined under the medical model.
- Mental health services not culturally sensitive to the needs of Pacific peoples.
- The sustaining and promotion of pan-Pacific and ethnic-specific PHOs such as TaPasefika and Langimalie PHOs as well as generic PHOs catering for Pacific populations to be successful.

While many of these challenges are being addressed through the current PHO structures, a greater commitment to addressing these would make an enormous positive difference to the recovery of Pacific peoples with mental illness.
The table below highlights suggested recovery aids and barriers for Pacific peoples from the Mental Health Commission Pacific Recovery Stories report. Their application is equally useful for PHOs to consider in understanding the appropriate options for intervention and/or support for Pacific peoples with mental illness. PHOs may wish to incorporate and/or discuss how these approaches may become part of their normal service delivery where access by Pacific peoples is anticipated.

<table>
<thead>
<tr>
<th>Recovery aids and barriers for Pacific peoples</th>
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<tbody>
<tr>
<td>(This information has been taken from Malo (2000).)</td>
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<tr>
<td><strong>Recovery aids</strong></td>
</tr>
<tr>
<td>• Being treated with dignity and respect</td>
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<tr>
<td>• Family understanding of mental illness and support</td>
</tr>
<tr>
<td>• Involvement of service users and families in design and delivery of individual care planning and treatment</td>
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<tr>
<td>• Faith and spirituality</td>
</tr>
<tr>
<td>• Personal strength to overcome adversity of mental health experience</td>
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<tr>
<td>• Effective strategies for overcoming cultural and communication (language) barriers</td>
</tr>
<tr>
<td>• Community-oriented services</td>
</tr>
<tr>
<td>• Supportive staff who put great effort into, and care about, what they do</td>
</tr>
<tr>
<td>• Pacific peoples services and staff</td>
</tr>
<tr>
<td>• Right medication and treatments</td>
</tr>
<tr>
<td>• Working in the mental health sector (eg, as a consumer advisor, advocate, interpreter, mental health worker)</td>
</tr>
<tr>
<td><strong>Recovery barriers</strong></td>
</tr>
<tr>
<td>• Lack of understanding by communities and families</td>
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<tr>
<td>• Cultural stigma of having mental illness</td>
</tr>
<tr>
<td>• Lack of knowledge within Pacific communities of mental health issues</td>
</tr>
<tr>
<td>• Discrimination</td>
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<tr>
<td>• Exclusion by the church</td>
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<tr>
<td>• Lack of self-help information especially in early stages of illness</td>
</tr>
<tr>
<td>• Coercive staff practices and breaches of human rights</td>
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<tr>
<td>• Lack of staff understanding of cultural differences</td>
</tr>
<tr>
<td>• Ineffective and uninspiring rehabilitation services</td>
</tr>
<tr>
<td>• Lack of care and support from staff</td>
</tr>
<tr>
<td>• Staff prejudice and stereotyping of Pacific peoples</td>
</tr>
<tr>
<td>• Lack of access to needed staff in mainstream or Pacific services</td>
</tr>
<tr>
<td>• Side-effects of medication and/or electro-convulsive therapy</td>
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<tr>
<td>• Cultural inequality and misunderstanding in services</td>
</tr>
<tr>
<td>• Authoritarian services that reinforce dependence rather than independence</td>
</tr>
</tbody>
</table>
What does this mean for PHOs?
Non-Pacific PHO staff may wish to participate in Pacific cultural safety workshops in order to understand the cultural values and beliefs of their enrolled Pacific populations better. These workshops could include awareness of Pacific cultural-bound views on health and mental health, as well as recovery competencies for Pacific peoples (Mental Health Commission).

Organisation development
Many Pacific providers have developed 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 and may have a range of different relationships with other existing PHOs.

A service that considers itself responsive to Pacific peoples may have the following key elements:
- service delivery that is culturally appropriate for Pacific peoples (e.g., language, ethnic-specific contacts)
- services provided for Pacific users, but so that non-Pacific peoples may access the service
- a philosophy based on Pacific values and beliefs
- a basis on Pacific models of health or on models of health that encompass Pacific beliefs and values
- involvement of Pacific peoples in the governance and management of the service
- Pacific peoples as a significant number of the staff and health professionals.

If one or more of these key factors are absent, then a service cannot be considered a Pacific-responsive service.

What does this mean for PHOs?
Although there is no single Pacific approach to mental health issues, it is expected that Pacific primary mental health services would embrace common principles that are inclusive of the diverse taonga of Pacific peoples. Suggested principles include:
- commitment to, and use of, the Fonofale and/or other proven Pacific models that emphasise an holistic approach to mental health service delivery and that include mental, spiritual, emotional and family wellbeing
- the acknowledgement, support and accommodation of cultural differences, both within Pacific ethnic groups and communities and between Pacific peoples and others
- taking into account the diverse needs, experiences and circumstances of Island-born and New Zealand-born Pacific peoples
- supporting pan-Pacific as well as ethnic-specific groups to develop their own models of care, specific services and workforce to meet the needs of their own people
• valuing and protecting Pacific knowledge, including traditional knowledge, with appropriate controls over access to, and use of, such knowledge
• ensuring that values of interdependence, collectivity, alofa, faaaloalo (respect), anticipation and collaboration are fundamental to the service.
References

Note: References have also been listed at the end of the chapters in which they are first mentioned. However, many of them are relevant to more than just one section and should be considered in a wider context.


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