



Te Puāwaiwhero

The Second Māori Mental
Health and Addiction
National Strategic Framework
2008–2015

2008

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Te Puāwaiwhero, literally translated, means ‘the red blossom’, and is represented by the flowering pōhutukawa on the cover.

The blossom is a metaphor for a coming of age through the cycle of growth and development, including enduring environmental stresses, to ensure maturity and leadership.

This strategy provides direction and leadership to the health and disability sector by responding to Māori mental health needs and whānau ora.

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MANATŪ HAUORA

Foreword

Developments in oranga hinengaro – Māori mental health and addiction – have been at the forefront of health sector innovation and Māori development. *Te Puāwaiwhero – The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015* builds on the first framework, *Te Puāwaitanga*, launched in 2002. It provides direction to the sector as we continue to work towards achieving better outcomes for whānau and tangata whaiora living with mental illness and addiction. It is a challenge for all to take up their responsibility to improve Māori mental health outcomes.

The overall aim of this strategy is whānau ora: Māori families supported to reach their maximum health and wellbeing, and provides an overarching principle for recovery and maintaining wellness. It makes a clear statement that in 2015 the Government wants to see a system that actively supports whānau to live longer, enjoy a better quality of life without experiencing discrimination, and be well informed about mental health and wellbeing. It also aims to achieve an environment in which tangata whaiora have a choice from a range of services that are responsive to their clinical needs and that confidently address their cultural needs.

The evidence shows that unacceptable disparities continue to exist between Māori and others in terms of the prevalence, severity and burden of mental illness, and a greater lifetime risk of Māori developing a mental illness. Access to quality care to address these disparities continues to be a key priority for this Government. The strategy signals that we need to quicken the pace of development and provides a set of prioritised actions to guide the ongoing implementation of this Government's action plan for improving mental health through to 2015.

Although *Te Puāwaiwhero* provides direction, its implementation requires leadership at all levels of the sector. We would like to acknowledge the advisory group, which has been instrumental in this process, and our dedicated workforce in the Māori mental health and addiction sector. This framework is underpinned by the need to continue to grow Māori capacity to lead improvements in oranga hinengaro into the future.



Hon David Cunliffe
Minister of Health



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Associate Minister of Health

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Introduction

Background

The first Māori Mental Health National Strategic Framework, *Te Puāwaitanga*, was launched in 2002. This framework was developed within the broader government objectives for Māori mental health at the time, and set strategic objectives to assist District Health Boards (DHBs) to plan and deliver services for Māori affected by serious mental illness.

Te Puāwaitanga was developed within the context of the Mental Health Strategy, which includes *Looking Forward* (Ministry of Health 1994) and *Moving Forward* (Ministry of Health 1997), and also aligns with the key directions of the Mental Health Commission's (1998) *Blueprint for Mental Health Services in New Zealand*. There have been significant shifts in policy since the launch of the first framework.

This second Māori Mental Health National Strategic Framework (*Te Puāwaiwhero*) uses *Te Puāwaitanga* as a platform to build on the significant gains that have been achieved for oranga hinengaro (Māori mental health and wellbeing)¹. It extends the scope in line with current government directions for oranga hinengaro, and provides the sector with guidance on the inter-dependence of this approach with whānau ora.

Te Puāwaiwhero is a resource that will be used to inform those implementing the actions in *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015*. The framework has also been developed as a tool for Māori communities working with their partners in health.

The New Zealand Public Health and Disability Act 2000

The New Zealand Public Health and Disability Act 2000 requires DHBs to have a population health focus, with the overall objective of improving the health of those living in their district. Part One of the Act outlines how this legislation will be used to recognise and respect the principles of the Treaty of Waitangi with a view to improving health outcomes for Māori, and provides for mechanisms for Māori to contribute to decision-making on, and participate in, the delivery of services at all levels of the health and disability sector.

This responsibility is reinforced through key DHB accountability documents, including Crown funding agreements. DHBs have a powerful mandate to direct their resources to address Māori population health need at the local level. DHBs and the Ministry of Health negotiate on and monitor service agreements with providers in such a way as to ensure service provision achieves outcomes for tangata whaiora, whānau, iwi and the wider Māori community.

Māori mental health policy context

An overarching aim of the New Zealand health and disability sector is to improve Māori health and disability outcomes and reduce Māori health inequalities compared to other population groups. The Government is committed to addressing Māori mental health need, with the key mechanisms focused on achieving better outcomes for tangata whaiora, whānau and Māori communities. It is tackling these issues through a number of different strategies.

¹ Mental health in this document also includes addiction (see Glossary).

New Zealand Health Strategy and New Zealand Disability Strategy

The New Zealand Health Strategy and the New Zealand Disability Strategy (Minister of Health 2000, Minister for Disability Issues 2001) provide the overall direction for improving the health and wellbeing of people living in New Zealand, and for ensuring services are of the highest quality. Both strategies establish a platform for the Government's action on health by identifying priority areas, including Māori and mental health.

He Korowai Oranga

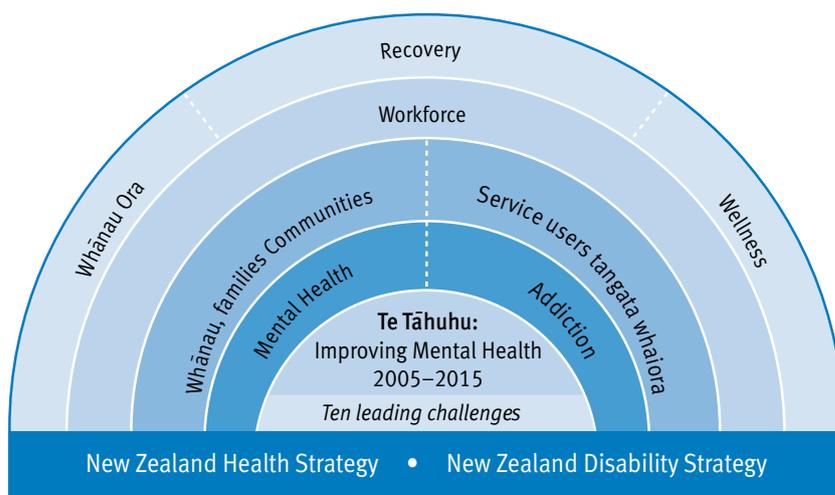
The launch of *He Korowai Oranga: Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002) set the direction for Māori health development. Along with the New Zealand Health Strategy and the New Zealand Disability Strategy, it informs other Ministry of Health strategies and planning documents. *He Korowai Oranga* places whānau at the centre of public policy and affirms Māori mental health's recognition of whānau as central to mental health, wellbeing and recovery. The overall aim of *He Korowai Oranga* is whānau ora: Māori families supported to achieve their maximum health and wellbeing.

National Mental Health Strategy

Te Tāhuhu – Improving Mental Health 2005–2015 (Minister of Health 2005) and its action plan *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health 2006) are the Government's most recent policy statements on mental health and addiction, and join *Looking Forward* (Ministry of Health 1994) and *Moving Forward* (Ministry of Health 1997) as part of the National Mental Health Strategy.

Te Tāhuhu broadens the Government's interest in mental health, expanding to cover not only people who are severely affected by mental illness but all New Zealanders, and draws together government interests in mental health and addiction (see Figure 1). The 10 leading challenges articulated in *Te Tāhuhu* provide the platform for advancing whānau ora and recovery for tangata whaiora.

Figure 1: Te Tāhuhu – Improving Mental Health



Te Kōkiri, launched in 2006, implements *Te Tāhuhu* and the 10 leading challenges:

- promotion and prevention
- building mental health services
- responsiveness
- workforce and culture for recovery
- Māori mental health
- primary health care
- addiction
- funding mechanisms for recovery
- transparency and trust
- working together.

All the 10 leading challenges of *Te Tāhuhu* have implications for Māori mental health. The most recent evidence from *Te Rau Hinengaro – The Mental Health Survey* (Oakley Browne et al 2006) affirms the Government’s commitment to *oranga hinengaro* and to addressing these challenges through to 2015.

The Mental Health Commission’s Blueprint

The Government remains committed to implementing the Mental Health Commission’s (1998) *Blueprint for Mental Health Services in New Zealand*. The Mental Health Commission recently launched a vision for the future. *Te Hononga 2015: Connecting for Greater Well-being* confirms the direction for *oranga hinengaro* and a vision of *whānau ora* (Mental Health Commission 2007).

The Evidence

Although there have been gains in Māori mental health, knowing the evidence is key to ensuring that future planning and investment into mental health promotion, prevention, primary health care and specialist services are placed in the right direction. This section starts with a demographic overview of the Māori population, then focuses on Māori mental health and addiction needs, and service utilisation.

The Māori population

Knowing Māori population demographics is an important part of determining Māori mental health need. The prevalence and pattern of common mental disorders is known to vary by ethnicity, gender, age and socioeconomic position (Oakley Browne et al 2006).

Currently more than one in seven people living in New Zealand identify as Māori. Put another way, in 2006 565,329 people living in New Zealand identified as Māori. However, the Māori population differs demographically from the general population of New Zealand in a number of ways. For one thing it is expected to grow at a faster rate: Statistics New Zealand estimates that the Māori ethnic group will increase by 28 percent by 2021, to make up 17 percent of the total population. This is in contrast to the New Zealand European population, which is projected to increase by 5 percent over the same period (Statistics New Zealand 2005b, cited by Robson and Harris 2007).

Māori as a population are also more youthful. In 2006 about half the Māori population was aged less than 25 years (Statistics New Zealand 2007c, cited by Robson and Harris 2007). The median age for Māori was 23 years in 2006, an increase from 22 years in 2001. This compares with a median age of 36 years for the total population in 2006 and reflects the youthfulness of the Māori population. Given Māori are a young population, Māori comprise a greater proportion of young people within each region.

There is much variation in terms of where Māori live by region and the proportion of each region that is Māori. Māori will have mental health needs whether living in areas of high or low Māori population density and sometimes areas with low population density have high Māori population numbers, such as Canterbury.

Socioeconomic position is a determinant of mental health and Māori are over-represented among those living in areas of highest deprivation relative to non-Māori. Māori therefore bear a disproportionate burden of risk for mental ill health due to socioeconomic disadvantage.

Key points

Youthful population

As a population Māori have a relatively young age structure, and so patterns of mental health needs differ from those of the total population and from non-Māori (which reflects an older population structure). As an example of this youthful age structure:

- one in three Māori is under 15 years old
- one in two Māori is under 23 years old.

For all people living in New Zealand, Māori make up a greater proportion of the younger age groups. Conversely, the Māori proportion decreases among older age groups. For example:

- one in five of all people under 30 years is Māori
- one in six of all people between 10 and 30 years is Māori
- one in 20 of all people 60 years and over is Māori.

The youthfulness of the Māori population has significant implications for ensuring Māori mental health need is prioritised for tamariki, rangatahi and their whānau.

Socioeconomic position

Socioeconomic position is a determinant of mental health, and Māori are disproportionately represented among low socioeconomic groups: one in every three to four people in deciles 9 and 10 Māori.² Māori therefore bear a disproportionate burden of risk for mental ill health issues due to socioeconomic risk.

Māori population need

As Table 1 shows, Māori get less health care than others for their mental health issues relative to need.

Table 1: 12-month severity and percentage of Māori and Other (non-Māori, non-Pacific) and service contact for mental health needs

Level of severity	Māori		Other		Level of disparity
	Prevalence	Access	Prevalence	Access	
Serious	9%	48%	4%	64%	Need = 5% Access = 16%
Moderate	13%	25%	9%	39%	Need = 4% Access = 14%
Mild	8%	16%	6%	19%	Need = 2% Access = 3%

Source: *Te Rau Hinengaro*

² See Glossary for definition of Area of Deprivation (decile).

The evidence shows that disparities continue to exist between Māori and others. *Te Rau Hinengaro* showed that the Māori population experiences greater prevalence, severity and burden of mental illness, and greater lifetime risk of developing a mental illness than others.³

Evidence from *Te Rau Hinengaro* provides two pictures that can assist policy developers, planners and funders to inform their decision-making. On the one hand, decision-makers can use the unadjusted figures to provide the best indication of the actual level of Māori mental health population need compared to the other population.⁴ On the other hand, the study findings were also adjusted to provide a picture of what the prevalence of mental disorders would look like if Māori and the other population group shared similar characteristics.

Te Rau Hinengaro did not look at the causes of this disparity, but it did suggest a link with demographic factors (Baxter 2008).⁵ This suggests that if all things were equal and Māori enjoyed similar levels of socioeconomic advantage to other people, and perhaps were an older population, the Māori prevalence rate of mental disorders would be reduced (Baxter 2008). However, the evidence is clear that currently Māori are a more youthful population and are more socioeconomically disadvantaged.

Of most concern are findings to suggest that young Māori today are likely to be experiencing higher rates of mental illness than earlier generations of Māori. Māori youth are particularly vulnerable, and some disorders such as alcohol and other substance-use disorders have contributed to this increase (Oakley Browne et al 2006). Because a higher proportion of Māori are in the age groups where mental disorders are likely to first occur, the impact of unmet mental health need among young Māori will have a significant impact on Māori as a population. For example, a survey of adolescents showed that Māori aged 13–17 years are 1.3 times more likely to experience depression than non-Māori.⁶

Māori have an increased risk of developing mental illness, including substance-use disorders, irrespective of where they live, whether in urban centres or rural communities. DHBs must therefore plan for Māori mental health need regardless of the Māori population density or percentage of Māori population in their region.

Along with a higher prevalence of disorders across the continuum, *Te Rau Hinengaro* identified the need for a heightened emphasis on the more common mental health issues for Māori, such as depression and anxiety disorders. This confirms the need to provide Māori-responsive care for what are emerging global mental health priorities. Many Māori also have more than one disorder, which further indicates an increased mental health need. *Te Rau Hinengaro* confirms that addressing coexisting and addiction-related needs among whānau, hapū, iwi and the wider Māori community is a priority for immediate emphasis.

Mental health problems (most commonly depression) are a significant risk factor for suicide and suicide attempts (Ministry of Health 2003). An increase in suicide rates over recent decades further reinforces concerns about Māori mental health (Oakley Browne et al 2006).

There is little information on the number of people experiencing schizophrenia in the Māori population and how this compares to non-Māori. *Te Rau Hinengaro* did not include less common disorders such as schizophrenia. However, what we do know, is that Māori rates of hospitalisation for schizophrenia are much higher than non-Māori.

3 For the purposes of this document, 'other' refers to the term used in *Te Rau Hinengaro* to describe the non-Māori, non-Pacific population.

4 For the purposes of this document, the figures presented are unadjusted.

5 Includes population age structure, education and income.

6 Youth 2000 survey.

Key points

What *Te Rau Hinengaro* showed⁷

Mental health and addiction continue to be priority health issues for Māori, not least because they have a major potential to affect future generations of Māori and their whānau, hapū, iwi and wider community. In particular:

- over half of the Māori population has experienced a mental illness some time in their life⁸
- three in five Māori will develop a mental illness at some time in their life⁹
- over a year, almost one in three Māori experienced a mental illness
- over a month, one in six Māori experienced a mental illness
- one in three of Māori will experience a substance-use disorder at some time in their life
- Māori rangatahi (youth) and pakeke (adults) commonly experience anxiety and mood disorders.

Over one year, nearly three-quarters of Māori experiencing mental illness had a serious or moderate mental disorder.¹⁰ More specifically:

- one in three had a serious disorder
- one in two had a moderate disorder
- one in four had a mild disorder
- over one in 10 Māori women and one in 18 Māori men had a serious mental disorder
- one in seven Māori in the lowest income households had serious mental disorder compared to one in 20 in the highest
- high Māori mental health need is consistent across all DHBs.

Health inequality

As a population, Māori have higher prevalence rates of mental health disorders overall than the other population (30% vs 19%) and experience greater severity, burden and impact.¹¹

If Māori were to have similar levels of socioeconomic advantage as others, the disparities in mental health would be reduced, but not eliminated.

Service utilisation

Service contact findings in *Te Rau Hinengaro* highlight significant levels of unmet need among Māori, with less than one in three Māori with a common mental health disorder having any contact with services in the past 12 months. The disparity in access to health services for Māori cannot be explained by youthfulness or socioeconomic status alone.

⁷ *Te Rau Hinengaro* was based on Māori adults aged over 16 years.

⁸ This refers to lifetime prevalence (the proportion of people known to have met criteria for a mental illness some time in their life before the interview).

⁹ This refers to projected lifetime risk.

¹⁰ *Te Rau Hinengaro* included 12-month prevalence data. This document refers to these findings as being 'over a year'.

¹¹ 12-month prevalence.

Māori with common mental health disorders (including alcohol and other drug – AOD) who do make contact with the health system use a range of services. Māori are most likely to have contact with general medical services (mainly GPs) for their mental health needs. A lower proportion have contact with mental health specialist services and other non-health care providers. With regard to general practice, the latest New Zealand Health Survey shows that Māori children and adults have a significantly higher unmet need for GP services compared to the total population (Ministry of Health 2008).

Te Rau Hinengaro found increasing health service contact with increasing severity of disorder, but this does not equate to high overall levels of need being met. Of most concern, more than half of Māori with a serious mental disorder and about three quarters of Māori with a moderate disorder also had no contact with health care providers for their mental health needs (Oakley Browne et al 2006).

Across the range of disorders, Māori with substance-use disorders are least likely to access care. Mental health data shows that Māori affected by mental illness and AOD issues continue to be over-represented in forensic mental health services.

With regard to access to specialist services, Māori adults with less common serious disorders not covered by *Te Rau Hinengaro* (such as schizophrenia), are more likely to access specialist mental health and addiction services than non-Māori.¹² However, Māori children and young people and older people access specialist mental health services less than non-Māori. Although access to specialist services has increased over the last five years, overall Māori are less likely to access health care generally at an earlier stage of their mental illness, relative to need, compared to non-Māori.

As we have seen, there is little information on the number of people experiencing schizophrenia in the Māori population and how this compares to non-Māori. What we do know is that Māori rates of hospital treatment for schizophrenia are disproportionately high, with Māori being more than three times as likely to be hospitalised than non-Māori. Māori are also twice as likely to be treated in hospital for bipolar disorder as non-Māori. The rate and pattern of hospitalisation of Māori for serious mental illness and disparities in hospitalisation rates remain very concerning.

Evidence also shows that Māori in care have different experiences of care compared to others (Tapsell 2007). This includes the administration of medications as well as treatment. For example, Māori are more likely to be secluded in inpatient services than others.

12 Ministry of Health, MHINC data. Adults in MHINC are aged 20 to 64 years.

Key points

Access

- The majority of Māori experiencing mental ill health do not receive any form of health care, and GPs are the leading point of contact for those that do.
- Over a year, half of Māori with a serious mental disorder are not receiving mental health care for their mental health needs.
- Overall, Māori experiencing alcohol and other drug issues are least likely to access care.

Health inequality

- *Te Rau Hinengaro* showed that over a year, Māori were more than twice as likely to have a serious mental disorder than others, and less likely to access care.
- Māori experiencing serious mental illness are nearly twice as likely to be hospitalised as non-Māori.
- Higher rates of Māori adults use specialist services than non-Māori.
- Māori children, young people and older people use specialist services less than non-Māori.
- Māori and non-Māori hospitalisations for deliberate self-harm are similar, but mortality rates for suicide among Māori are 1.6 times higher.
- Māori men are more than twice as likely to be hospitalised for mental disorders as non-Māori men, and rates for Māori women are 1.5 times higher.

Māori physical health status

Māori physical health status and mental health cannot be separated, and both have an impact on tangata whaiora and whānau mental health and wellbeing. It is beyond the scope of this document to cover the disparities in physical health, but it is worth pointing out that Māori as a population experience worse health, are more likely to be hospitalised, and have lower life expectancy for conditions that are amenable to prevention and treatment than non-Māori. For example:

- in 2001, non-Māori life expectancy was about eight years greater than Māori life expectancy
- Māori are nearly three times more likely to die from avoidable or amenable mortality compared with non-Māori
- Māori have higher rates of all heart disease and cancer mortality, and experience more than twice the rate of diabetes, than non-Māori.

Māori also experience high rates of risk factors that have an impact on physical health and wellbeing, such as smoking, alcohol and substance use, as well as having high rates of obesity.

Building on the Gains

Te Rau Hinengaro – The New Zealand Mental Health Survey

Launched in 2006, *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Oakley Browne et al 2006) provides the most recent information on the prevalence of common mental disorders among Māori at a population level. This differs from previous information, which focused mainly on consumers of services, and adds the population perspective for Māori.

As we have seen in the previous section, the most recent evidence in *Te Rau Hinengaro* is a key resource to assist all people working in the mental health and addiction sector to meet the requirements of the New Zealand Public Health and Disability Act 2000. Findings from this survey have been used to develop this framework and will be used to inform further policy development alongside the planning and funding of programmes and services across the continuum.

Māori participation in the health sector

Gains in Māori mental health over the last five years include an emphasis on building Māori participation across all levels – including governance, management, service delivery and workforce development.

Māori relationship boards

Over the last five years the establishment of formal health relationships between DHBs and their locally mandated iwi/hapū authorities have seen significant gains and influence on the planning and decision-making of DHBs, through increased Māori representation on DHB boards and advisory committees. The Ministry-sponsored governance skills development programme for DHB Māori relationship boards, called Te Mana Whakahiato, supports the development of these formal relationships.

Over the next five years it is envisaged that these relationships will continue to grow and strengthen at a local level. Effective and robust regional networks will ensure tangata whaiora, iwi, hapū, whānau and Māori communities participate in the planning and decision-making of DHB activities that determine the provision of local services to address Māori mental health needs.

Te Maata Whaanui

The New Zealand Public Health and Disability Act 2000 requires DHBs to include Māori in their board membership. The majority of DHBs now include Māori representation, and Te Maata Whaanui, the DHB Māori board members collective, has been established to provide a national overview and support for Māori board members. A key role of this group is to work in collaboration with mana whenua, local Māori communities and Tumu Whakarae (see below).

Tumu Whakarae

DHBs have also developed their capacity to lead Māori responsiveness at the operational level by appointing general managers of Māori health. These general managers have formed a national network called Tumu Whakarae, which collaborates and contributes to national and regional initiatives, planning and policy development.

Māori mental health regional networks

Along with Māori provider development there has been an emergence of Māori mental health regional networks across the country, providing a mechanism for support and capacity building for Māori working in the sector. Currently, regional networks represent providers working together across DHB regions by supplying co-ordinated advice from their local areas.

Māori health and disability service providers

There is evidence that Māori providers are increasing access to care for Māori and are out-performing other providers in terms of their governance, management and Māori workforce contributions (Ministry of Health 2007). The focus has shifted in recent years from increasing the number of Māori providers to building, strengthening and sustaining the quality of the services provided.

Māori mental health providers

Māori mental health providers have developed in response to diverse local communities. For example, organisations range from iwi- or hapū-based, through to urban groupings that form kaupapa-based whānau, which deliver services across the continuum of care in collaboration with mainstream service providers. Māori mental health providers have modelled ways of working to address cultural needs that can help general services to provide more responsive care to Māori. By-Māori-for-Māori services and kaupapa Māori services are pivotal to ensuring tangata whaiora and their whānau are provided with choice and, in particular, the means by which their unique needs as Māori can be addressed.

The number of Māori health providers, including Māori mental health providers, has grown significantly over the last two decades. Currently the mental health sector includes approximately 144 non-government organisations (NGO) Māori mental health providers and alcohol and other drug (AOD) services, as well as those included in the DHB provider arm. Although these services have provided greater choice for Māori, there has been only a limited increase in the range of Māori mental health services available.

Investment in Māori mental health and addiction includes the areas of:

- child and youth services
- AOD services
- forensic services
- community support services
- inpatient services
- problem gambling services.

In 1998 20 hospital and 61 NGO agencies were providing Māori mental health services (Mental Health Commission 1999). The highest proportion of funding for Māori mental health now includes community/residential services for all ages, and AOD services. There has been an overall increase in Māori mental health funding over the last six years, from \$65.8 million to \$93.1 million, which represents 9.1 percent of total mental health and addiction funding. This includes kaupapa Māori services and other providers identified as Māori. However, since 2002 Māori mental health funding has decreased (by 0.5 percent) as a proportion of the total mental health spend.

Māori participation in Primary Health Organisations

DHBs also fund Primary Health Organisations (PHOs) to provide services to meet the mental health needs of Māori in their local population. Out of the 82 PHOs in New Zealand, currently 16 are Māori-led. A total of 61 PHOs (including nine Māori-led) have received funding to develop primary mental health initiatives – 41 PHOs in 2005 and a further 20 PHOs in late 2007. The Ministry of Health now invests close to \$10 million (GST excl) annually into these sites.

The outcomes of the primary mental health initiatives are being evaluated to inform future advice to government on how these services can best respond to the needs of tangata whaiora, whānau and Māori communities. Initial indications are that the primary mental health care initiatives have contributed to providing choice for tangata whaiora, with services being delivered using a range of kaupapa Māori treatment practices. Overall, about 13 percent of all people enrolled with PHOs are Māori. As a comparison, of the service users seen across 20 of the primary health care initiatives, nearly 19 percent were Māori.

Māori providers of mental health promotion

Currently, around a third of Like Minds, Like Mine regional providers are Māori. The National Māori Caucus is a key mechanism for providing nationally co-ordinated leadership on key issues for Māori on the development and implementation of the Like Minds, Like Mine National Plan 2007–2013.

Whakaitia te Whakawhiu i te tangata – reduce your potential to discriminate.

National mental health and addiction workforce centres

The Ministry of Health funds four national mental health workforce programmes, each with a specific area of responsibility:

- Matua Raki – addiction
- The Werry Centre – child and adolescent
- Te Pou – general workforce and research development
- Te Rau Matatini – Māori.

Māori Mental Health and Addiction Workforce Development Programme

The Māori Mental Health Workforce Development Programme is designed to develop a Māori mental health workforce capable of addressing tangata whaiora requirements, both culturally and clinically. The Programme includes:

- Te Rau Matatini – a Māori development organisation focused on building workforce capacity and infrastructure, and providing sector leadership and evidence-based innovation
- Henry Rongomau Bennett Memorial – a scholarship and mentoring programme for developing leadership of Māori working in the mental health and addiction sector
- Te Rau Puawai – a programme to recruit Māori into a mental health development career pathway and prepare them for leadership in the future.

Te Puāwaiwhero

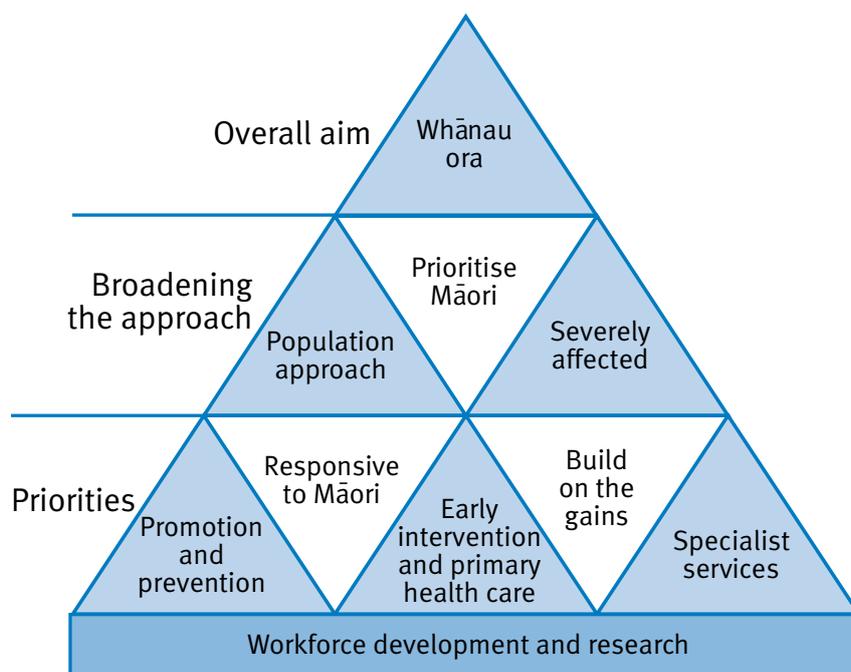
Although gains in Māori mental health have been achieved, more work needs to be done to build the momentum and act on the evidence in order to achieve whānau ora and the proposed outcomes for tangata whaiora by 2015.

Te Puāwaiwhero is a framework to guide the mental health and addiction sector towards the overall aim of whānau ora: Māori families supported to reach their maximum health and wellbeing. Not only is oranga hinengaro (Māori mental health and wellbeing) a foundation for whānau ora, but whānau ora is also a foundation for Māori mental health and wellbeing.

All 10 leading challenges of Te Tāhuhu and Te Kōkiri have implications for oranga hinengaro, and this framework draws on all 10 challenges. It provides direction for oranga hinengaro with three key principles and prioritised actions, matched with the most recent evidence to quicken the pace of development and assist decision-makers to plan well to address the mental health needs of the Māori population through to 2015.

Figure 2 shows the framework for Te Puāwaiwhero. In the rest of this section we will work through the different parts of the framework, discussing each in turn.

Figure 2: Te Puāwaiwhero: the framework





Overall aim: whānau ora

Māori families supported to achieve their maximum health and wellbeing, and provides an overarching principle for recovery and maintaining wellness.

The challenge for policy developers, planners and those delivering services to Māori is to recognise and plan for the interdependence between whānau ora and oranga hinengaro. This includes:

- an emphasis on developing whānau, hapū, iwi and Māori communities – acknowledging traditional and diverse Māori whānau realities
- seeking overall improvement in health gains for Māori and their whānau by active participation in their own wellness and recovery
- providing effective, culturally and clinically responsive health and disability services.

Tangata whaiora and recovery

Central to this framework and the overall aim of whānau ora is an understanding of the two concepts of tangata whai ora and tangata whaiora. *Tangata whai ora* refers to Māori who have experienced mental illness and are on the pathway towards wellbeing, while *tangata whaiora* are Māori who have experienced mental illness and who are managing their wellbeing. These two concepts align with the description of ‘recovery’ as both a journey and a destination (Mental Health Commission 1998). In this document we use the term ‘tangata whaiora’ to refer to both concepts.

Whānau ora outcomes

Te Puāwaiwhero confirms the outcomes sought for whānau ora, as described in He Korowai Oranga, and acknowledges that the health and wellbeing of the collective whānau will ultimately improve Māori mental health. It also recognises that improving Māori mental health and reducing inequalities cannot be achieved by health services alone. Outcomes for whānau include:

- whānau experience physical, spiritual, mental and emotional health and have control over their own destinies
- whānau members live longer and enjoy a better quality of life
- whānau members participate in te ao Māori and wider New Zealand society.

Te Tāhuhu captures outcomes for tangata whaiora and whānau wellbeing, and also seeks outcomes that contribute to the health of Māori as tangata whenua. In 2015, tangata whaiora, whānau and Māori communities can expect to:

- make informed decisions about their mental health and wellbeing
- have the same opportunities and fully participate in society and the everyday life of their whānau and communities
- experience trustworthy agencies that work across boundaries and enable tangata whaiora to support their whānau and lead their own recovery
- experience services that provide choice and are effective, efficient, timely and responsive to their needs.



Broadening the approach

This framework recognises the significant policy shift outlined in *Te Tāhuhu* by broadening the Government's interests in mental health to a wider population approach and a greater emphasis on addiction. Although it is important to embrace this population approach, the framework also recognises that it is essential to continue to place an emphasis on tangata whaiora severely affected by mental illness.

Population approach

Place tangata whaiora and whānau ora at the core of the population approach to mental health and addiction.

Te Tāhuhu and *Te Kōkiri* broadened the Government's interest in mental health, from people severely affected by mental illness to all people living in New Zealand. *Te Puāwaiwhero* confirms the shift made in *Te Tāhuhu* towards a population-based approach, drawing on all 10 leading challenges for oranga hinengaro, with a continued emphasis on tangata whaiora severely affected by mental illness and addressing Māori population need.

As the sector works to develop new initiatives and services under this wider scope, it must ensure that the needs of tangata whaiora and whānau are considered, and that developments are effective for Māori. We are now in a better position than ever before to know the needs of our populations. *Te Rau Hinengaro – The New Zealand Mental Health Survey* provides a key resource for DHBs to meet the requirements of the New Zealand Public Health and Disability Act 2000 in terms of planning and funding to address Māori mental health population need.

A population approach requires recognition of mental health across the life span and across generations. Māori are a young population, so getting things right for Māori tamariki and rangatahi is pivotal to building Māori potential for the future and reducing the impact and severity of disorders experienced by tangata whaiora and their whānau. Recent evidence (Poulton 2007) highlights the significant role that people's life experiences from their early years and environment play in determining mental health outcomes later in life.

Responding to the differences between population groups and the factors that have an impact on mental health forms part of the population approach to Māori mental health. We know that Māori mental health need is greater, but Māori are less likely to receive health care for their mental health needs than others. We are also aware that a complex interplay between cultural, psychological, social, environmental and economic factors at all levels has an impact on mental health. The evidence also suggests that Māori experience of ethnic discrimination is a major determinant of health, including mental health (Harris et al 2006). Knowing these differences is fundamental to achieving health equity.

This framework refers to the whole of the mental health and addiction continuum, encompassing the range of interventions – from prevention, to recovery and relapse prevention. All three areas of promotion and prevention, primary mental health care and specialist services should be seen as complementary – working towards addressing Māori mental health need, underpinned by workforce and research development.

As we have already stressed, whānau ora and improved outcomes for tangata whaiora will not be achieved by the mental health and addiction sector alone. The work of other sectors also affects the health and wellbeing of whānau. Improving co-ordination between health and other social agencies with a shared interest in mental health and addiction, whānau wellbeing and improved social outcomes for Māori will contribute to better mental health outcomes for Māori communities.

Tangata whaiora severely affected by mental illness

Broaden the range, quality and choice of services and supports for tangata whaiora severely affected by mental illness.

Although the population approach to mental health is a key direction, tangata whaiora continue to experience a greater prevalence, severity and burden of mental illness, a greater life-time risk of developing a mental illness, and an increased risk of being hospitalised for a mental illness than others.

Of most concern is that, relative to need, Māori as a population are less likely than others to have contact with health services for mental health reasons. Tangata whaiora experiencing serious mental illness must remain a priority, and access to effective services must be improved.



Three key principles

Te Puāwaiwhero has three key principles that can be used by policy developers, planners and funders. These principles apply across the entire framework and are firmly based on current knowledge, including the link between culture and wellbeing, the growing evidence of Māori mental health need and disparities, and learning from and building on the gains of the past.

Prioritise Māori

Act on evidence of health inequality in Māori mental health and addiction need to ensure that new and existing initiatives are responsive and effective for Māori.

Clear disparities remain between Māori and others in relation to the prevalence, severity, treatment, access and utilisation of services. Prioritising Māori in mental health is a statement that challenges decision-makers to act on the Government's directions, and on the evidence.

Prioritising Māori is critical to achieving at least equity in health for Māori. Māori must have the same opportunities to reach their potential as other population groups. Enhancing Māori potential will ultimately lead to better outcomes for all people living in New Zealand. All initiatives must be effective for Māori and address the population need in funding and planning activities across the mental health and addiction continuum.

Build on the gains

Current initiatives to improve Māori mental health and addiction are sustainable and have a development path for the future.

There has been significant development in Māori health, in particular Māori mental health. The New Zealand health and disability sector has changed dramatically during the health reforms of the last two decades. A significant feature of these changes has been the increasing participation of Māori at all levels of the health and disability sector, and Māori mental health has been at the forefront of these developments.

Māori mental health is a leader in innovation and a catalyst for new standards of responsiveness that have changed the way many health organisations deliver services. There has also been significant growth and development of a diverse range of mental health and addiction services for Māori, complemented by new initiatives in primary mental health care and a range of public health programmes.

However, the findings of *Te Rau Hinengaro* show a continuing unmet need for Māori. More work needs to be done to ensure that the gains in Māori mental health provider development are sustained, and that services and their supporting networks thrive into the future. DHBs must continue to broaden the range, quality and choice of services available and increase Māori participation – including the participation of Māori mental health providers.

Many Māori mental health providers are actively working towards whānau ora at a local level. Investing in understanding locally developed solutions will go some way towards future-proofing Māori mental health service development, building a knowledge base in relation to whānau ora, and meeting the needs of tangata whaiora. Tangata whaiora and their whānau play a pivotal role in these developments. Their active participation is vital to ongoing Māori mental health development.

The gains in Māori mental health have been supported by the development of a capable workforce and an evolving research and evaluation base. These achievements have established a solid foundation to build on.

However, the gains of the past cannot be taken for granted. As mental health and addiction decision-makers shift their thinking towards a broader approach, they must ensure that initiatives established to improve Māori mental health in the past are sustainable and part of the vision for the future.

Responsive to Māori

Build on the link between health and culture to ensure initiatives are responsive to the unique needs of Māori.

Te Puāwaiwhero acknowledges the inextricable link between health and culture. Central to this is recognition of whānau ora – building on the strengths of whānau and encouraging whānau development in the process of recovery.

Developing responsive policies, plans and services that contribute to whānau ora requires a broad knowledge and recognition of culture and the diversity of Māori. A responsive health system will address the unique needs of Māori as a population, including mechanisms for the practical application of whānau ora. Systemic responsiveness includes working in ways that address both the clinical and cultural needs of tangata whaiora and their whānau. Responding to the differences between Māori and other population groups is key to achieving at least equity in mental health for Māori by 2015.

A responsive health system also includes the development and utilisation of tools to enhance planning towards achieving the Government's objectives for improving Māori mental health and advancing whānau ora. The Ministry of Health has developed a number of tools to assist decision-makers in the health system to respond to the challenge of achieving equity in Māori health, Māori participation and advancing whānau ora, with an emphasis on the importance of all sectors working together to address the determinants of health. The tools include the Health Equity Assessment Tool (HEAT) and the whānau ora Health Impact Assessment (HIA) tool.

Improving Māori mental health is everyone's responsibility. A high proportion of Māori continue to access mainstream services, which receive the overwhelming proportion of health funding. Therefore, alongside the work with Māori mental health providers, enhancing the effectiveness and responsiveness of mainstream services to positively contribute towards improving Māori health outcomes remains a priority (Ministry of Health 2007). Responsiveness to Māori does not only apply to kaupapa Māori or Māori-specific programmes and services: the entire health system and all parts of the mental health and addiction continuum must take the lead in addressing this challenge.



Priorities: Māori responsive mental health and addiction continuum

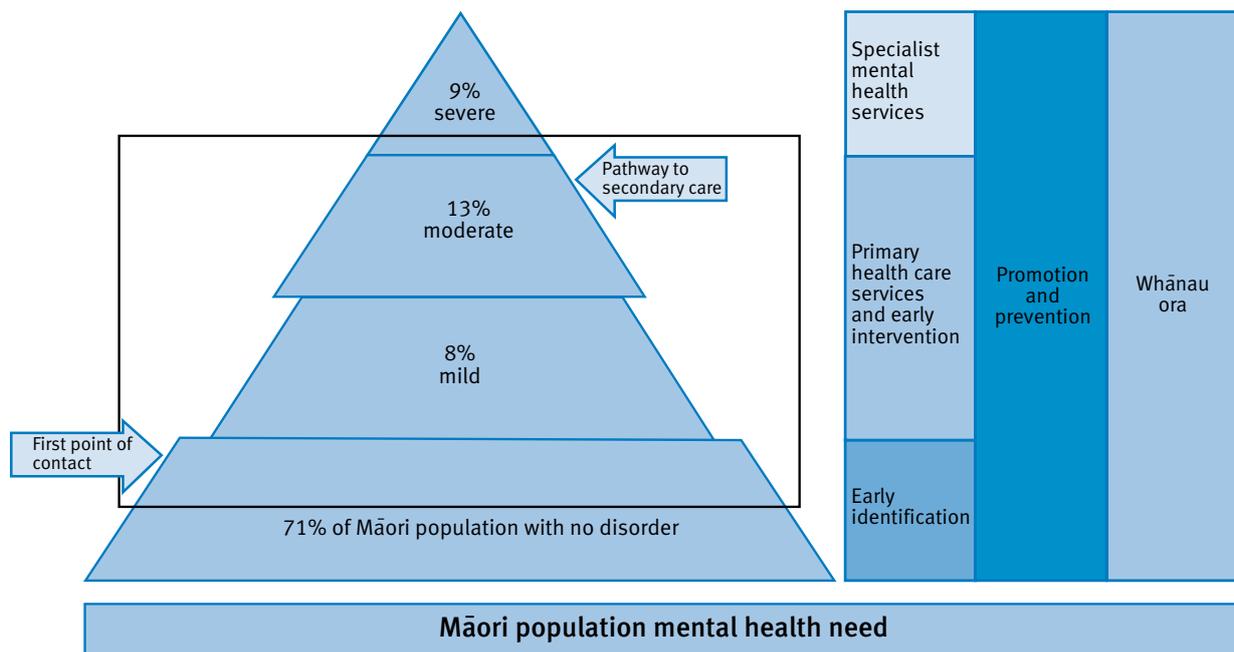
Greater emphasis on an effective and culturally relevant range of mental health and addiction policies, services and support for Māori across the continuum of care.

Te Puāwaiwhero confirms the shift towards a more responsive, integrated and seamless service provision across the mental health and addiction continuum, which includes public health programmes and primary health care. Greater emphasis on whānau ora, promoting good mental health and wellbeing, and quality and responsive primary mental health care will contribute towards reducing the severity and impact of mental illness that Māori as a population experience.

Building the capacity of the sector to address Māori mental health need by 2015 is a priority and should be reflected in the allocation of funding. Outputs related to *Te Tāhuhu* and *Te Kōkiri* are funded annually through:

- public health for prevention and promotion
- implementing the Primary Health Care Strategy, including an allocation specifically for primary mental health initiatives (currently \$10 million (GST excl))
- allocating funding for specialist mental health and addiction services, funded through the mental health ring-fence and additional Blueprint funding (currently \$1 billion).

Figure 3: Māori pathways to care across the continuum



Getting things right for Māori earlier, through responsive and effective public health and primary care services, means we can look forward to a sector that promotes greater equity and reduces the burden, impact and severity of mental illness for tangata whaiora, whānau, hapū, iwi and the wider Māori community.

Promotion and prevention

Promote Māori mental health and wellbeing and prevent mental illness and addiction through the development of programmes that are effective for diverse Māori communities.

As a population, Māori continue to experience a higher prevalence and greater severity in terms of mental illness. Emphasis must be placed on public health programmes tailored to raise awareness of mental health and substance-use issues, and of the help available. These must be delivered in a way that reaches whānau, hapū, iwi and Māori communities. The programmes need to include a heightened emphasis on disorders that affect whānau, such as depression, anxiety-related disorders AOD issues and eating disorders.

Responsive mental health promotion and mental illness prevention programmes developed in a way that promotes the culture and enhances the wellbeing of our unique Māori population are an integral part of mental health and whānau ora.

Over the last five years the Ministry of Health has invested in a number of public health programmes focused on raising awareness of mental health, encouraging people to seek help, increasing the awareness of what help is available, and reducing discrimination and the stigma associated with both mental illness and addiction. Specific initiatives include the National Depression Initiative, the Like Minds, Like Mine Campaign, the New Zealand Suicide Prevention Strategy 2006–2016 and action plan, and ongoing implementation of the National Drug Policy and Alcohol Strategy.

Agencies such as ALAC and ACC are key players in contributing towards reducing AOD-related harm. Working together in partnership with these agencies and Māori communities is pivotal to addressing the prevalence and impact of substance-use disorders disproportionately experienced by Māori. Initiatives are also under way that have an emphasis on addressing gambling-related harm experienced by Māori.

Māori-responsive public health programmes acknowledge that a ‘one size fits all’ approach is not always effective for all population groups: in future, emphasis needs to be placed on clearly identifying what works for Māori as a diverse population group.

Early intervention and primary health care

Primary mental health and addiction service models and funding arrangements are responsive to Māori mental health need and strategies.

Responsive and effective primary health care and early intervention in our health system can reduce the impact and severity of mental illness and addiction-related issues among whānau, hapū, iwi and the wider Māori community. Primary mental health care can also contribute to improving the physical health status of Māori.

Building the capacity of primary mental health care to respond to Māori population mental health need is an important part of the solution to reducing the impact of mental illness among Māori communities and is a priority for the Ministry of Health. The Primary Health Care Strategy has led to the development of 82 locally led PHOs. This has resulted in less expensive GP consultations, but cost continues to be a barrier to Māori accessing primary health care and primary mental health care. Initiatives targeting low-income Māori and their whānau are clearly an important step towards addressing this barrier and enabling Māori to access care earlier.

This framework provides direction for decision-makers to develop new initiatives in primary mental health care, including workforce development. Future initiatives will need to ensure they are responsive to Māori, effective, support innovation and build on the gains made in Māori mental health development over the last decade.

Māori led PHOs and Māori NGO providers have an important role in their future development. Over the next five years emphasis will be placed on sustainability building capability and infrastructure to deliver primary mental health care into the future.

New funding mechanisms should reflect Māori mental health population need, contribute towards achieving health equity and support whānau ora. Future service provision in primary mental health care will also place an emphasis on Māori population need by ensuring Māori tamariki, rangatahi and their whānau receive effective and quality care for their mental health needs across health, education and social service settings.

Specialist services

Tangata whaiora who require specialist services experience services that provide choice and are effective, efficient, timely and responsive to their needs.

Māori requiring specialist mental health and addiction services remain a priority, and there is an ongoing need to ensure these services are effective for tangata whaiora and their whānau. The shift to a broader population approach is not a shift away from meeting the needs of those severely affected by mental illness.

Māori as a population have more than twice the prevalence of serious mental illness compared to others. *Te Rau Hinengaro* found that over a one-year time period, over 8 percent of the Māori population experienced a serious mental disorder, compared to 4 percent of others (Oakley Browne et al 2006). This recent finding provides support for the Mental Health Commission's Blueprint suggestion that the national target for Māori accessing mental health services should be based on double the need of that for the general population (Mental Health Commission 1998).

Schizophrenia, bipolar disorders and AOD issues also continue to have a significant impact on Māori as a population.

Although access to specialist services has increased over the last five years, there remains a high level of unmet need. The current access rates for Māori children and young people to specialist services are well below target. Addressing the needs of Māori tamariki and rangatahi remains a priority for action over the next five years.

Funding and contracting must support whānau ora and address Māori population need. This framework provides direction for work on revising the National Services Framework, alongside funding mechanisms to address Māori mental health population need. More flexible funding mechanisms should also support whānau ora-based approaches, best practice, integrated service provision, seamless service delivery and developing Māori provider capacity.

The Ministry will also be undertaking work to further develop best practice guidelines for Māori mental health and addiction services. Further development of tools to support the shift towards measuring outcomes for tangata whaiora will also be of significance; for example, Hua Oranga, a measurement tool for Māori mental health outcome.



Workforce development

Build a mental health and addiction workforce, across all levels of the continuum, that responds to the cultural and clinical needs of Māori whānau.

Increased Māori participation and greater workforce capacity will enable Māori to address their own needs, and these are Government priorities for 2015. Over the last five years, the Ministry of Health has made a significant investment in building the Māori mental health and addiction workforce.

Although the workforce has grown, *Te Rau Hinengaro* shows that Māori as a population have a higher lifetime risk of developing a mental illness than others (Oakley Browne et al 2006). This evidence highlights the urgent need to continue investment in people and the systems that support them to provide quality Māori-responsive services and care across the mental health continuum.

As a growing population, if Māori continue to have a greater prevalence of disorder, emphasis must be placed on future-proofing the workforce to meet this need. Building on the significant gains made in Māori mental health workforce development remains a priority. Over the past decade the establishment of Māori-driven workforce centres such as Te Rau Matatini and programmes such as Te Rau Puawai have led to what is now a well-established hub of innovation and a solid foundation for building sector leadership into the future. This includes Māori working across all levels of the health system and across all disciplines, whose roles can ultimately have an impact on Māori mental health and wellbeing.

Te Rau Puawai, a joint venture between the Ministry of Health and Massey University, provides a scholarship and mentoring programme that has made a significant contribution to building the capability of the Māori mental health workforce, producing more than 150 graduates. Not only are these gains building the sector, but the success of these people contributes to the achievements and potential of whānau, hapū, iwi and Māori communities as a whole.

All people – including policy developers, planners, funders and those working at the ‘flax roots’ level – need to be equipped to do their part to address Māori mental health need. In particular, the evidence shows that the majority of Māori access mainstream or general services. Future investment in other national workforce centres, such as Te Pou, the Werry Centre and Matua Raki, provides significant opportunity for building sector capability towards a Māori-responsive workforce, innovation and achieving whānau ora.

In order to provide adequate access to treatment and care, it is obvious that the workforce will not only need to provide Māori-responsive care in mental health and addiction services, but cultural and clinical competencies will also be required by those working in primary health care settings and in health promotion. More work needs to be done to ensure the workforce and systems are geared towards providing seamless service delivery and integrated care.

Building sector capability to be responsive to Māori requires the ongoing development of tools and resources to assist people to benchmark, measure progress, and achieve cultural and clinical competencies in their day-to-day practice.

Research and information development

Consolidate our research and development foundation and build our knowledge base to achieve better outcomes for whānau, including tangata whaiora.

Research and development play a pivotal role in achieving outcomes for Māori, both in terms of service development and measuring progress towards outcomes for oranga hinengaro. Improving the information systems that underpin service development and support decision-making is vital for ensuring both systems and services achieve whānau ora and are capable of measuring progress towards equity and access for Māori.

What is now needed is a focus on consolidating our research and development foundation and mechanisms to build our knowledge base for the future. The Māori Mental Health Research Agenda will build on the gains made in mental health research and development and provide direction for future Ministry of Health investment in achieving whānau ora. The goal is to identify what we currently know and what the gaps in our information systems are, and to develop a robust policy base to address our research and development needs up to 2015.

Implementation of the Māori Mental Health Research Agenda will ensure that research and development activities contribute towards Māori development by building the capacity and capability of the Māori research workforce, improving service responsiveness and supporting the continued development of kaupapa Māori models of practice. The research agenda will build our knowledge base in terms of effectiveness, value for money and better outcomes for tangata whaiora, whānau, hapū, iwi and the Māori community.

Implementing *Te Puāwaiwhero*

Te Puāwaiwhero has been developed in partnership with DHBs and key people in the Māori mental health and addiction sector. Its purpose is to build on progress and innovations that have occurred in Māori mental health and addiction, but a plan is only ever as good as its implementation.

The Ministry of Health will continue to work in partnership with DHBs, other agencies, key stakeholders and the Māori community throughout the life of this plan. Achievements will be measured through formal accountability mechanisms, including:

- the district annual planning process
- progress towards achieving equity in access to services and supports for Māori in the Ministry of Health's 10 Health Targets
- targets in the mental health and addiction Healthline indicators.

Targets for indicators of DHB performance (IDPs), agreed on by the Ministry of Health and DHBs, will be reviewed annually against progress, and the key priorities and directions included in this framework.

Te Puāwaiwhero will primarily be implemented through the *Te Kōkiri* work programme. The following table provides a summary of the links between this strategic framework and actions within *Te Kōkiri*. The framework will inform the mental health sector as it responds to the 10 leading challenges from *Te Tāhuhu* and implements the actions outlined in *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015*. The three key directions of the framework underpin prioritised actions up to 2015.

The document's fold-out provides a template for those planning towards achieving the milestones of *Te Puāwaiwhero*.

All 10 leading challenges of *Te Kōkiri* have implications for oranga hinengaro. In order to quicken the pace of development, priorities have been matched with key actions from *Te Kōkiri* up to 2015. This framework will also be implemented in conjunction with He Korowai Oranga and related action plans.

Table 2: Prioritised actions, 2008–2015

Te Puāwaiwhero	The evidence	Te Kōkiri (Actions)
Overall aim: whānau ora		
<p>Māori families supported to achieve their maximum health and wellbeing and provides an overarching principle for recovery and maintaining wellness.</p>	<ul style="list-style-type: none"> • Māori are a youthful population. • The Māori population is expected to grow at a faster rate than the other population group over the next 10 years. • Māori experience a disproportionate risk for mental illness due to their socioeconomic status. 	<ul style="list-style-type: none"> • Implement initiatives that recognise and respond to families and whānau. (3.19–3.23) • Develop effective partnerships with tangata whenua. (5.12) • Plan and deliver effective, responsive, culturally relevant programmes and services across that continuum that promote whānau ora, traditional Māori treatment processes, cultural and clinical competency and whānau-inclusive practice. (5.2, 5.5) • Continue implementation of He Korowai Oranga and related action plans.
Directions: Broadening the approach		
<p>Population approach Place tangata whaiora and whānau ora at the core of the population approach to mental health and addiction.</p> <p>Severely affected by mental illness Broaden the range, quality and choice of services and supports for tangata whaiora severely affected by mental illness.</p>	<ul style="list-style-type: none"> • A higher proportion of Māori fall into the age groups in which mental disorders are likely to first occur. • Māori experience similar rates of disorders wherever they live. • Māori are more than twice as likely to experience a serious mental illness as others, and half of Māori experiencing serious mental health issues are not receiving mental health care. 	<ul style="list-style-type: none"> • Demonstrate knowledge of, plan and fund based on Māori population mental health need across the continuum. (1.1–1.4, 2.2, 2.4, 2.10, 2.11, 2.13, 3.4, 3.23, 5.1, 5.2, 9.3) • Increase access to specialist mental health and addiction services for Māori children and youth. (2.11) • Continue to broaden the range, quality and choice of mental health and addiction services for Māori. (1.2, 3.1, 10.4–10.7) • Alignment between the delivery of health services and the delivery of other government-funded social services. (7.13) • DHB have in place early intervention strategies for Māori tamariki rangatahi. (5.7)

Te Puāwaiwhero	The evidence	Te Kōkiri (Actions)	
Three key principles			
<p>Prioritise Māori Act on evidence of health inequality in Māori mental health and addiction need to ensure that new and existing initiatives are responsive and effective for Māori.</p>	<ul style="list-style-type: none"> • One in two Māori will experience mental illness some time in their life. • One in four Māori will experience a substance-use disorder. 	All actions from <i>Te Kōkiri</i> .	
<p>Build on the gains Current initiatives to improve Māori mental health and addiction are sustainable and have a development path for the future.</p>			<ul style="list-style-type: none"> • This has a major potential impact on future generations of Māori and their whānau, hapū, iwi and community.
<p>Responsive to Māori Build on the link between health and culture to ensure initiatives are responsive to the unique needs of Māori.</p>			<ul style="list-style-type: none"> • Māori physical health status has implications for mental health, and there is a relationship between the two.
Priorities: Māori-responsive mental health and addiction continuum			
<p>Greater emphasis on an effective and culturally relevant range of mental health and addiction policies, services and support for Māori across the continuum of care.</p>	<ul style="list-style-type: none"> • Mental health and addiction continue to be a significant priority health issue for Māori. 	<ul style="list-style-type: none"> • Broaden the range and choice of mental health and addiction services for Māori across the continuum of care, ensuring seamless service delivery. (5.1–5.4, 5.10– 5.12, 7.1, 7.8) 	
<p>Promotion and prevention Promote Māori mental health and wellbeing and prevent mental illness and addiction through the development of programmes that are effective for diverse Māori communities</p>	<ul style="list-style-type: none"> • Disparities in hospitalisation rates have changed little over time. • Māori continue to receive care at a later stage, and with more severe illness. 	<ul style="list-style-type: none"> • Promote mental health and wellbeing, and prevent mental illness and addiction. (1.1–1.12, 5.8) • Develop and contribute to community and intersectoral activities that promote infant and family health and wellbeing. (1.4) 	

Te Puāwaiwhero	The evidence	Te Kōkiri (Actions)
<p>Early intervention and primary health care</p> <p>Primary mental health and addiction service models and funding arrangements are responsive to Māori mental health need and strategies.</p>	<ul style="list-style-type: none"> • The majority of Māori experiencing mental health issues do not receive any form of health care. • GPs are the leading point of contact for those that do. • Māori rangatahi and pakeke experience anxiety and mood disorders. • Overall, Māori experiencing alcohol and other drug issues are least likely to access care. • Māori with moderate mental illness access less care for their mental health needs than others. • About three-quarters of Māori with a mental disorder are moderately or severely affected. 	<ul style="list-style-type: none"> • Build and strengthen the capability of the primary health care sector to promote mental health and wellbeing and to respond to the needs of people with mental illness and addiction. (2.3, 2.4, 5.7, 6.1–6.6) • Develop initiatives to strengthen primary health care and wider social services. (6.2, 7.12) • Make use of MHINC data on the source of referral towards early intervention for Māori. (5.7) • The future direction of primary mental health care will include funding models and new initiatives based on <i>Te Rau Hinengaro</i> and Māori mental health population need. (6.1) • PHOs will make mental health wellbeing and mental illness and addiction an integral part of PHO/primary health care health promotion. • Establish addiction intersectoral initiatives and frameworks for early intervention in criminal and youth justice systems. (7.14)

Te Puāwaiwhero	The evidence	Te Kōkiri (Actions)
<p>Specialist services</p> <p>Tangata whaiora who require specialist services experience services that provide choice and are effective, efficient, timely and responsive to their needs.</p>	<ul style="list-style-type: none"> • Māori experiencing serious mental illness are twice as likely to be hospitalised as others. • One in 10 Māori women have a serious mental illness. • One in 18 Māori men have a serious mental illness. 	<ul style="list-style-type: none"> • Build and broaden the range and choice of services and supports that are funded for people who are severely affected by mental illness. (2.1–2.24) • Ensure continuity of care between mental health, addiction, health and wider government social services. (2.3, 2.4, 2.6–2.9) <p>Tangata whaiora receives seamless service delivery and are supported to make informed decisions. (5.4, 5.10)</p> <ul style="list-style-type: none"> • Build responsive services for people who are severely affected by mental illness and/or addiction. (3.1–3.4) • Broaden the range of services that are funded for substance-use problems. (7.2–7.7, 7.9–7.11) • Improve access to responsive addiction services. (7.1) • Develop a coherent national approach to co-existing mental health and intellectual disability. (3.15, 3.17, 3.18) • Demonstrate an increase in Māori mental health spending. (5.3) • Develop and implement a revised National Service Framework and more flexible funding mechanisms that support whānau ora and address Māori population need. (8.1, 2.2)

Monitoring progress

Monitoring progress is vital to ensure the system is working towards achieving whānau ora and addressing Māori mental health need. The implementation of *Te Puāwaiwhero* will be monitored in a number of ways. This includes monitoring the *Te Kōkiri* work programme and wider mental health monitoring plan. Monitoring mechanisms across the health system will also gauge progress on He Korowai Oranga and related action plans .

Te Puāwaiwhero also provides direction for the development, monitoring and review of targets and other measures of performance that have relevance for oranga hinengaro, including the Ministry of Health's most recently launched 10 Health Targets.

The Mental Health Monitoring Plan includes the features summarised in Table 3.

Table 3: Monitoring progress

Monitoring level	Measure
Strategic	Health target (improved mental health services): <ul style="list-style-type: none"> • 90–100% of long-term clients have relapse prevention plans.
	Headline indicators: <ul style="list-style-type: none"> • the rate of new admissions to general acute inpatient mental health services • secondary mental health services utilisation.
	Indicators of DHB performance (IDPs): <ul style="list-style-type: none"> • improved health status of people with severe mental illness • alcohol and other drug service waiting times • results for people with enduring severe mental illness.
	Te Kōkiri implementation: <ul style="list-style-type: none"> • reports to Cabinet on <i>Te Kōkiri</i> implementation (a joint Ministry/DHB work programme) • Ministry of Health work programme (Statement of Intent) and output plan deliverables, annual business plan) • DHB work programmes and accountability arrangements (district strategic plans, Crown funding agreement, district annual plan, annual report) • formal review and evaluation of progress against <i>Te Kōkiri</i> actions and <i>Te Tāhuhu – Improving Mental Health</i>.
	He Korowai Oranga implementation Whakatātaka Tuarua implementation Administration of the New Zealand Public Health and Disability Act 2000
Operational/service delivery	<ul style="list-style-type: none"> • statutory administration of the Mental Health (CAT) Act 1992 • financial monitoring • district annual plans (DAPs) • operational policy framework (OPF) requirements • knowing the people planning (KPP) reporting • delivery of the Blueprint • intersectoral initiatives • service development, reviews and evaluations.
Contract monitoring	<ul style="list-style-type: none"> • contract management: workforce, research and development.
System-wide issues	<ul style="list-style-type: none"> • data and system development (MHINC/MH-SMART/PRIMHED) • Nationwide Services Framework and service specification review • service quality • individual DHB service profiles.

Glossary

Access	A potential service user's ability to obtain a service when they need it and within the appropriate time.
Addiction	In the context of this plan, addiction relates only to alcohol and other drug use and/or problem gambling. It refers to a maladaptive pattern of substance use, or problem gambling leading to clinically significant impairment or distress. Substance-use disorders and pathological gambling disorder are characterised by dyscontrol, tolerance, withdrawal and salience, and are considered chronic relapsing conditions.
AoD	Alcohol and other drugs.
Area of deprivation	NZDep2001 is an area-based index of socioeconomic deprivation, which ranks small areas from the least deprived (decile 1) to the most deprived (decile 10).
Assessment	A service provider's systematic and ongoing collection of information about a consumer to form an understanding of consumer needs. A clinical assessment forms the basis for developing a diagnosis and an individualised treatment and support plan with the service user, their family, whānau and significant others.
Blueprint (for Mental Health Services)	The document the Mental Health Commission developed that defines the levels of specialist mental health services, as well as the changes required to implement the Government's National Mental Health Strategy (Mental Health Commission 1998).
Capability	An individual, organisation or sector having the right skills, knowledge and attitudes to deliver high-quality and effective mental health and addiction services.
Capacity	An organisation or sector having sufficient appropriately trained staff and resources to deliver a high-quality and effective mental health and addiction service.
Children and young people	People aged 0–19 years, inclusive.
DAP	District annual plan.
Gambling harm	The Gambling Act 2003 defines harm as 'harm or distress of any kind arising from, or exacerbated by, a person's gambling, and includes personal, social, or economic harm suffered by the person; or the person's spouse/partner, family, whānau, or wider community; or in the workplace; or by society at large'.
GP	General practitioner.

Health promotion	The process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases, and is directed towards action on the determinants of health.
Hua Oranga	Māori Outcome Measurement Tool.
Integrated approach	An integrated approach addresses the continuum of need and encompasses public health approaches and intervention services.
Mental health	A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community (WHO 2001). In this plan, reference to mental health includes addiction.
Mental health promotion	The process of enabling people to increase control over, and to improve, their health. Mental health promotion is not just the responsibility of the health sector.
Mental health sector	The organisations and individuals involved in mental health to any degree and at any level.
Mental health service provider	An organisation providing as its core activity assessment, treatment or support to consumers with mental illness and/or alcohol and drug problems.
Mental illness	Any clinically significant behavioural psychological syndrome characterised by the presence of distressing symptoms or significant impairment of functioning.
Networks	For the purpose of this document, ‘networks’ refers to the broad range of existing networks that have a focus on health-related areas and mental health and addiction issues (eg, consumer networks, regional mental health networks).
NGO	Non-governmental organisation.
NSF	Nationwide Service Framework.
Outcome	A measurable change in the health of an individual, or a group of people or population, which is attributable to interventions or services.
PHO	Primary health organisation.
Prevention	Intervention that is designed to prevent mental health disorders or problems. Prevention interventions may be: <ul style="list-style-type: none"> • universal – targeted to the whole population (eg, healthy cities) • selective – targeted to individuals or groups at increased risk (eg, postnatal home visits for new mothers) • indicated – targeted to individuals with early symptoms (eg, grief therapy for individuals experiencing the loss of a close relative, partner or friend).

Primary health care	Essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to and a central function of the country’s health system, and is the first level of contact with the health system.
Problem gambling	Patterns of gambling behaviour that compromise, disrupt or damage health, personal, family or vocational pursuits. In its most extreme form it is often described as ‘pathological gambling’.
Rangatahi	The word ‘rangatahi’ literally means ‘fishing net’ and was used as a metaphor to describe young people in a famous whakatauki (proverb).
Recovery	Living well in the presence or absence of mental illness and the losses that can be associated with it. The alcohol and other drug sector have a similar yet different view of recovery – one that includes both abstinence and harm minimisation perspectives that have evolved over time, allowing consumers a choice to adopt the approach that best represents their world view. There is a long and generally held view that in the addiction field recovery involves an expectation/hope that people can and will recover from their addiction/unwellness, acceptance that recovery is a process not a state of being, and recognition that the recovery is done by the person addicted/affected, in partnership with the services (in the word’s widest sense) providing help. A challenge faced by both the mental health and addiction sectors is the ongoing development of the concept and language of recovery.
Specialist services	For the purposes of this document, ‘specialist services’ refers to all those mental health and addiction services described in the Nationwide Services Framework and funded through the mental health ring-fence. This includes NGOs and secondary mental health and addiction services.
Tamariki	Child/children.
Tangata whai ora	Māori that have experienced mental illness and are on the pathway towards wellbeing,
Tangata whaiora	Māori that have experienced mental illness who are managing their wellbeing. These two concepts align clearly with the description of ‘recovery’ as both a journey and as a destination. ¹⁴ In this document we use the term ‘tangata whaiora’ to refer to both concepts.
Te kōkiri	To action; to activate.
Te tāhuhu	The ridgepole that provides essential support.
Whānau	Kuia, koroua, pakeke, rangatahi, tamariki. The use of the term whānau in this document is not limited to traditional definitions, but recognises the wide diversity of families represented within Māori communities. It is up to each whānau and each individual to define for themselves who their whānau is.
Whānau ora	Māori families achieving their maximum health and wellbeing.

¹⁴ Mental Health Commission 1998, p1.

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Appendix 2: Ministry of Health Documents and Strategies to Consider

All of the following references can be accessed on the Ministry of Health's website: www.moh.govt.nz

Blueprint for Mental Health Services in New Zealand: How things need to be

Building on Strengths – A springboard for action: A new approach to promoting mental health in New Zealand/Aotearoa

He Korowai Oranga: Māori Health Strategy

Health of Older People Strategy

Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau

Improving Quality: A systems approach for the New Zealand health and disability sector

Looking Forward: Strategic directions for the mental health services

Matua Raki: The Addiction Treatment Sector Workforce Development Framework

Mental Health (Alcohol and other Drugs) Workforce Development Framework

Mental Health: Service use in New Zealand 2001

Moving Forward: The National Mental Health Plan for More and Better Services

National Alcohol Strategy

National Drug Policy: A national drug policy for New Zealand

National Mental Health Information Strategy 2005–2010

National Mental Health Sector Standard – He Whariki Oranga Hinengaro

National Strategic Framework for Alcohol and Drug Services

New Zealand Disability Strategy: Making a world of difference: Whakanui oranga

New Zealand Health Strategy

New Zealand Youth Suicide Prevention Strategy: In our hands: Kia Piki te Ora o te Taitamariki

Preventing and Minimising Gambling Harm Strategic Plan 2004-2010

Primary Health Care Strategy

Reducing Inequalities in Health

Services for People with Mental Illness in the Justice System: Framework for forensic mental health services

Te Puāwaitanga Māori Mental Health National Strategic Framework

Te Raukura

Te Tāhuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan

Towards a National Strategy for the Development of Research on Tobacco, Alcohol, Other Drugs and Gambling

Whakatātaka: The Māori Health Action Plan

Youth Development Strategy

Other Government strategies

Building the Future: The New Zealand Housing Strategy

New Zealand Injury Prevention Strategy

New Zealand Positive Ageing Strategy

Opportunity for All New Zealanders

Youth Offending Strategy: Preventing and reducing offending and re-offending by children and young people: Te Haonga

Other strategies

Kia Puawai Te Ararau: National Māori Mental Health Workforce Development Strategic Plan 2006–2010

Appendix 3: Te Rau Hinengaro data – inequalities in prevalence of mental health disorders, and service use across population groups

Table A1: Severity and percentage of Māori and Other (non-Māori, non-Pacific) with at least one contact with the health sector for mental health needs in the past 12 months

	Serious	Moderate	Mild	None
Māori				
Prevalence	8.7% (7.5, 10.1)*	12.6% (10.7, 14.7)	8.2% (6.8, 9.9)	70.5% (67.5, 73.3)
Mean days out of role	82.7 (65.3, 100.2)	18.2 (10.1, 26.4)	1.1 (0.3, 2.0)	
Percentage with at least one visit for mental health reasons in the health sector	47.9% (40.3, 55.7)	25.4% (19.7, 32.0)	15.7% (9.1, 25.6)	5.0% (3.7, 6.7)
Other				
Prevalence	4.1% (3.6, 4.6)	8.9% (8.1, 9.8)	6.3% (5.6, 7.0)	80.7% (79.4, 82.0)
Mean days out of role	53.8 (43.3, 64.2)	8.6 (6.5, 10.7)	1.5 (0.3, 2.6)	
Percentage with at least one visit for mental health reasons in the health sector	63.5% (57.4, 69.1)	39.2% (34.8, 43.8)	19.4% (15.6, 23.9)	5.9% (5.0, 6.9)
Total				
Prevalence	4.7% (4.2, 5.2)	9.4% (8.7, 10.2)	6.6% (6.0, 7.2)	79.3% (78.1, 80.5)
Mean days out of role	60.1 (50.9, 69.3)	10.3 (8.2, 12.4)	1.4 (0.5, 2.4)	
Percentage with at least one visit for mental health reasons in the health sector	58.0% (53.3, 62.6)	36.5% (32.9, 40.4)	18.5% (15.3, 22.3)	5.7% (5.0, 6.6)

* numbers shown in brackets are confidence intervals

