

# **The Northern Regional Pacific Mental Health and Addictions Plan**

**2003/05**





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Developed in consultation with the  
Northern Regional Pacific Mental Health Sector.

A copy of this document can be obtained from  
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# The Northern Regional Pacific Mental Health and Addictions Plan

2003/05







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## **Foreword**

**Malo e lelei, Kia Orana, Talofa lava, Fakaalofa lahi atu, Taloha ni, Ni sa bula vinaka, Kia Ora and Greetings.**

This plan is an acknowledgment of the commitment to delivering improved Mental Health services to Pacific communities. It builds on the previous work undertaken by the Mental Health Commission, in particular the Mental health committee, Ministry of Health, District Health Boards and Non Governmental Sector in particular Pacific Mental health providers regarding the Mental health of Pacific peoples in New Zealand.

Pacific Mental Health services are still in development and we acknowledge the commitment and hard work of those long serving advocates for the development of Pacific mental health services.

New strategies and additional funding have been directed towards mental health services, however we are aware Pacific peoples continue to experience difficulties in access, treatment and follow-up.

The four northern district health boards have sponsored the development of this plan which has been developed collaborately with the Pacific Mental Health sector.

This plan provides the opportunity to identify the way forward. It will be a guide for the future development of Pacific Mental health services in the Greater Auckland and Northland regions, for planners, funders, providers, communities and consumers.

The key to its success will be the ability for us to work together to make the “plan” a reality and to ensure better outcomes for all the Pacific peoples of these regions.



## Acknowledgments

Special thanks to the people who enabled this project to be accomplished, for the constant support, direction, knowledge and vision:

### The Reference Group:

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### The Sponsors:

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We would also like to acknowledge and thank the Pacific communities and service users for their support and input, the Auckland Regional Networks, Pacific Sector reference group, providers and the many people who gave up their time to provide assistance. Special thanks to Lita Foliaki, Karl Pulotu-Endermann and David Lui for comments on drafts and providing assistance. Many thanks to the project manager, Tevita L Hingano, for his dedication and efforts in coordinating this project.





## Executive Summary

This Plan is the result of a project sponsored by the Mental Health funders for the Northern region. It identifies the key directions and focus areas for Pacific mental health developments in the Northern region for the next 3-5 years.

It builds on the work undertaken over the past 10 years by both Pacific and mainstream mental health providers.

## Future Visions

**“Healthy Pacific people achieving their full potential throughout their lives<sup>1</sup>.”**

Our long term vision for Pacific Mental Health is of well informed Pacific communities, able to protect and preserve the mental health of their residents, able to recognise when help is needed and where to go for that help, and able to support people with serious mental health problems to achieve recovery. Our vision is of a time when there are no longer health disparities for Pacific people and when people can live well in the presence or absence of his or her mental illness.

## Values

**Compassion, Courage, Total commitment, Generosity, Humility, Empathy and Service<sup>2</sup>**

## Principles

<b>Dignity</b>	Dignity and the sacredness of life are integral in the delivery of health and disability services
<b>Participation</b>	Active participation of Pacific peoples in all levels of health and disability services is encouraged and supported
<b>Pacific Leadership</b>	Successful Pacific services recognise the integral role of Pacific leadership and Pacific communities
<b>Excellence</b>	Pacific peoples are entitled to excellent health and disability services that are coordinated, culturally competent and clinically sound <sup>4</sup> .
<b>Partnership</b>	Mental health services must work in partnership with Pacific families as an integral catalyst to the recovery of individuals with mental illness.

<sup>1</sup>Pacific Health and Disability Action Plan 2002)

<sup>2</sup>Pacific Mental Health Cultural Competency Waitemata District Health Board 2002)





## **Proposed Pacific Mental Health Model**

The proposed future mental health system sees the Primary Care Team as the primary point of contact. Pacific Specialist Mental Health and Addictions Services (including youth services and Family Services) would provide back-up advice to the Primary Care Team. When this advice is insufficient, Pacific Mental Health and Addictions Services would become directly involved in delivering care, always with a view to Primary Care resuming primary responsibility for ongoing problems as soon as appropriate. The Pacific Mental Health and Addictions Services work closely with the Primary Care Team and are preferably co-located with that team.

When a person has very high treatment needs, other secondary/tertiary mental health services (e.g. inpatient care, out of hours crisis services, dual disability team, etc.) could be accessed through the Pacific Mental Health and Addictions Services. During use of these services the Pacific Mental Health and Addictions Services would remain actively involved with the person and the secondary/tertiary service in planning care.

When a person has very high support needs in order to recover a life in the community, recovery services could be accessed through the Pacific Mental Health and Addictions Services. There would be specific Pacific Recovery Services as well as mainstream services. These services would take responsibility for linking in with appropriate community supports and working with the service user and their family to help establish a full life in the community. Clinical treatment for this group of people would continue to be offered by the Pacific Mental Health and Addictions Services and/or Primary Care Team, who would be very responsive to the Recovery Services and service users involved with them.

Recovery services would work to strengthen supports for service users in the community and to assist service users to access the full range of community resources, including those supplied by other Government agencies and those provided by mental health support/rehabilitation services.



## Key Directions

- Pacific Primary Mental Health
- Improved access to mental health services
- Partnerships
- Workforce
- Information and Research
- Quality

## Objectives 2003-2005

The table that follows details three-year objectives that relate to each of the above priority areas.

Goals	Objectives
To develop Pacific primary Mental health services	<ul style="list-style-type: none"> <li>▶ To develop a model for Pacific primary mental health services</li> <li>▶ Implement a pilot for Pacific primary mental health services</li> <li>▶ To develop mental health expertise for Pacific Primary care staf</li> </ul>
To improve access for Pacific peoples to Mental Health services	<ul style="list-style-type: none"> <li>▶ To expand and develop ‘by Pacific for Pacific’ Mental health services with a particular focus on:               <ul style="list-style-type: none"> <li>• Pacific primary mental health care</li> <li>• Pacific youth services</li> <li>• Pacific family support services</li> <li>• Pacific ‘recovery’ service</li> <li>• Regional Alcohol And Other Drugs Services</li> <li>• Pacific Clinical Team</li> </ul> </li> <li>▶ To support the growth and development of Pacific Mental health services with an emphasis on:               <ul style="list-style-type: none"> <li>• information systems</li> <li>• business processes</li> </ul> </li> <li>▶ To ensure that mainstream mental health services who provide services to significant Pacific populations are more responsive and culturally competent, including awareness of family structure and dynamics. Priority areas for focus are:               <ul style="list-style-type: none"> <li>• Crisis and early intervention teams</li> </ul> </li> </ul>



Goals	Objectives
	<ul style="list-style-type: none"> <li>• Child and youth services</li> <li>• Intensive clinical treatment teams</li> </ul> <p>▶ To ensure equitable access for Pacific peoples to specialist mental health services across the region</p>
<p>To develop partnerships with organisations, communities, families and service users, which will maximise opportunities for Pacific peoples involved with Mental Health and Alcohol and other Drug services.</p>	<ul style="list-style-type: none"> <li>▶ Work with Pacific communities to reduce stigma and provide support and the promotion of healthy lifestyles</li> <li>▶ Work with employers, housing providers and local communities to enhance opportunities for Pacific peoples</li> <li>▶ Develop partnerships with agencies and organisations to develop opportunities and improve outcomes with a focus on Education, Housing and Social Service providers</li> <li>▶ Develop close working relationship between the Alcohol and other Drug and mental health services.</li> </ul>
<p>To develop a competent and qualified Pacific Mental health workforce that will meet the needs of Pacific peoples</p>	<ul style="list-style-type: none"> <li>▶ Introduce recruitment and retention strategies to increase the range and number of Pacific Mental health workers both clinical and support staff in the following areas:               <ul style="list-style-type: none"> <li>• Psychiatrists</li> <li>• Nurses</li> <li>• Recovery staff</li> <li>• Child and youth workers</li> <li>• Primary mental health workers</li> <li>• Alcohol and other drug service workers</li> <li>• Managers</li> </ul> </li> <li>▶ To ensure all mental health services providing service to Pacific peoples develop skills and understanding of Pacific primary care, dual diagnosis in relation to Pacific service users and Pacific health issues</li> <li>▶ To establish a Pacific Mental health workforce plan including database</li> </ul>
<p>To ensure that information and research on Pacific Mental health will inform policy planning and service development</p>	<ul style="list-style-type: none"> <li>▶ To collect, collate and analyse ethnic specific information for policy and service development</li> <li>▶ To develop a Pacific mental health research capacity which will focus on the effectiveness of Pacific and mainstream mental health models</li> <li>▶ To disseminate information to Pacific communities, service users and families on Pacific Mental health issues</li> </ul>



Goals	Objectives
<p>To improve the Quality of Mental Health services</p>	<ul style="list-style-type: none"> <li>▶ To ensure Pacific providers reflect 'best practice' and have systems in place to ensure Quality.</li> <li>▶ To develop cultural competency standards and training programs for Pacific and mainstream services with an emphasis on service provision and workforce</li> <li>▶ To develop information for service users, families and communities on what to do when you are unwell, how to stay well, what services are available</li> <li>▶ To develop Pacific service user and Pacific family networks which will provide input into service monitoring, evaluation and planning</li> <li>▶ To implement monitoring and evaluation systems for all Pacific Mental health providers</li> <li>▶ To ensure Pacific representation and input into regional and local stakeholder networks.</li> <li>▶ To collate all existing groups and organisations of Pacific providers with a mental health and/or alcohol and other drugs focus in a single data base</li> </ul>

It is anticipated that these objectives will inform regional and local DHB planning for Pacific mental over the coming three years. Achieving these objectives would result in substantial movement toward our vision of a time when there are no longer mental health disparities for Pacific people.

## Future Work

This report describes the broad key directions and objectives for the development of pacific mental health and addiction services over the next three to five years. In order to ensure that these developments are achieved, the following additional work will be needed:

- ▶ Formation of a formal Pacific Regional Network to consult on the implementation of this plan
- ▶ Estimation of Resources/ Funding needed for Pacific mental health in the region for closing the gap against the Blueprint benchmark over the next 10 years
- ▶ Annual Planning with stakeholders on Pacific Mental Health and Addiction Service developments that are aligned with the objectives detailed in this document
- ▶ Ongoing Pacific representation in all formal planning and funding structures.
- ▶ Development of a regional approach to planning, configuring and delivering Pacific mental health services



## **Introduction**

**The Northern Region Pacific Mental Health and Addiction Plan** project was developed to inform funders, planners and providers about the Mental health needs of Pacific people in the Auckland region. This project will also inform and influence the Northern Regional Mental Health Plan 2002/03 report to be released early 2003. It is another step forward for District Health Boards in the Greater Auckland and Northland regions in fulfilling their responsibilities to the priorities set out by the government regarding Mental Health services.

### **Purpose**

The Plan will identify the key directions and focus areas for Pacific Mental Health development in the greater Auckland and Northland regions over the next 3-5 years.

### **Background**

Over the past ten years, substantial effort has gone in to developing Pacific Mental Health services in order to improve the health of the Pacific people. It is timely to now consider the appropriate service delivery models, workforce implications, future planning assumptions and priorities for the next three years to inform planners, funders, service providers service users and communities. Data gathered during the project has provided information on which to plan future developments.

The growth of the Pacific Health sector and in particular the Pacific primary care sector will provide opportunities to develop innovative and exciting responses to Pacific peoples mental health needs and through doing so will deliver improved outcomes for Pacific peoples in these regions.

### **Approach**

The approach involved gathering information from a wide variety of sources, analysing progress against the various strategies and plans currently in place, interviewing stakeholders and several brainstorming sessions with key groups.

Inherent in this process is the consideration of cultural competency and appropriate application of cultural models. Several Pacific models of research and theory have been utilised during this project.

#### **These three models are:**

- Kakala model by Professor Konai Helu Thaman
- Tivaevae model by Maua Hodges





- Faafaletuli model by K.Tamasese, C.Peteru, C.Waldegrave

These three models outline in detail the process of Identification, Collection and Analysis of information, moreover the Faafaletuli model describes how information must be viewed from three different perspectives, firstly the view of people from the mountain, secondly the view of people on the tree and thirdly the view of the fisherman from the canoe.

The “Fonofale” model was also consulted with the approach of this report and it is further elaborated in the section on Pacific perspectives on mental health.

To ensure this project engaged a wide representation of the sector, information was provided and feedback sought from the Pacific Regional Network, Pacific Sector Reference Group, ALAC, NDSA, CMDHB Pacific Committee, Pacific Regional Funding Team and Pacific providers.

Pacific Communities were informed via existing links and networks. This project also consulted with the service users group for the Auckland region via the Pacific consumer members.

The draft document was widely distributed among stakeholders before being finalised.

### **What Guides Us?**

This plan has been developed based on a set of key policy principles and goals guiding the health sector. These are summarised below.

### **The Pacific Health and Disability Action Plan 2002**

This plan identifies the strategic direction and actions to improve health outcomes and participation of Pacific peoples with a view to reducing inequalities between Pacific and non-Pacific peoples.

It identifies 6 Priority areas. The following goals which particularly guide the development of this plan are:

- to improve and protect the health of Pacific youth (15-25 years) (Goal 2)
- to encourage and support healthy lifestyles (Goal 3)
- create new and improved ways of delivering mental health services (Goal 4.7)





- to address the workforce development issues facing mental health) (Goal 5.4)
- to develop Pacific research capacity that will inform policy planning and service development (Goal 7)

### **Primary Mental Health, A review of the opportunities 2002. Mental Health Directorate, Ministry of Health**

This document identifies the following recommendations:

- Primary Health Care providers will be expected to incorporate a substantial mental health component in to their work in a systematic way
- Primary Health Care providers should lead the role in delivering mental health services to people with mild to moderate mental health problems over the medium term
- The capitated funding formula for primary health care will need to be adjusted to include primary mental health
- There will be the development of tools and guidelines to ensure best practice
- Specialist mental health training to GP and nurses in primary care providers will be a priority
- More integrated and collaborative models for service delivery in the community and primary health care setting require development

### **The Pacific Mental Health Services and Workforce - Moving on the Blueprint - Mental Health Commission 2001**

This document is the first comprehensive paper on Pacific Mental Health services and workforce capacity.

It recommends that additional work needs to be undertaken in the following areas:

- Pacific mental health framework development
- Pacific provider development
- Pacific workforce development
- Increasing cultural responsiveness of mainstream services to Pacific peoples
- Promoting and implementing anti-discrimination work among Pacific peoples
- Partnerships with Pacific service users



- Information and research needs in relation to Pacific mental health

### **The New Zealand Health Strategy 2000.**

The New Zealand Health Strategy identifies the Minister of Health's priority areas and aims to ensure that health services are well targeted to ensure the best health outcomes for the New Zealand population.

The goals which particularly apply to Pacific mental health development are:

- ensuring accessible and appropriate services for Pacific peoples (Goal 2)
- better mental health (Goal 7)

### **The Blueprint for Mental Health Services in New Zealand - Mental Health Commission 1998**

The "Blueprint" is seen as one of the foundation documents for Mental Health development. It takes a recovery approach to mental health service delivery and is based on the assumption of 3% of the total population needing to access specialist mental health services.

The Blueprint identifies the following priorities for Pacific Mental health development:

- Development of a Pacific workforce
- Development of models of service delivery which work for Pacific peoples

All of these policy documents identify the common themes of reducing inequalities, improving outcomes and identifying Pacific health as a priority.



## Contextual Overview

### Pacific Health Status

Pacific health disparities are well documented and include:

- life expectancy rates 68.8 years for males and 76.2 females compared with 76.6/81.8 respectively for non Pacific/non Maori
- fertility rates 3.2 expected children compared with 1.8
- Pacific children under 1 year have a 50% rate of admission to hospital

The latest figures from the NZHIS identify that Pacific people in comparison to any other New Zealander are: -

- ▶ twice as likely to:
  - live in areas of socio-economic deprivation
  - be unemployed
  - be in prison
  - visit a GP more than twelve times a year
- ▶ more likely to:
  - live as a part of a family with children
  - be on the benefit
  - earn less than \$ 10,000 per year
  - leave school with no qualification
  - consume alcohol at greater quantities
  - visit a Public hospital
- ▶ almost twice as likely to:
  - smoke
- ▶ less likely to:
  - visit Private Hospital, Social worker or Psychologist



In 1998 the Report from the National Health Committee indicated that the health of Pacific people in New Zealand has improved, however many areas for Pacific people continue to have poor outcomes. Pacific people continue to have the highest rates nationally of meningococcal disease, measles, rheumatic fever, rheumatic heart disease and obesity. There is also an increasing rate of SIDS and hospitalization of children for pneumonia, asthma and ear infections. Pacific adults continue to have high rates of diabetes, liver cancer and tuberculosis.

Pacific people in the Greater Auckland/Northland region tend to live in areas classified as being of high deprivation - 80% live in areas with an NZDep96 decile rating of 9 or 10.

As a socially disadvantaged group, Pacific peoples are likely to be more vulnerable to mental stressors and some disorders. Pacific peoples experience high levels of discrimination and inequity. It has been recognised that strategies are needed that remove discrimination and promote true equity and self-determination opportunities for Pacific peoples across all levels of social institution - political, social, educational, religious, cultural and family (Ministry of Health 1997c: 469).

Information on Pacific Mental health status is poor. Most of the key evidence about Pacific people's mental health is drawn from institutional statistics, primarily admissions to psychiatric facilities. The sparse data available on Pacific mental health status suggests that there is a low incidence of many conditions of mental illness among Pacific people (Health Funding Authority 1999). Pacific people appear to have low first admission rates to psychiatric hospitals, public hospital psychiatric units and institutions licensed under the Alcohol and Drug Addiction Act (Public Health Commission 1995). Pacific youth suicide also appears to be low, although health workers in Pacific communities regard suicide and self-harm attempts among young Pacific people as under-recorded, and a serious mental health issue.

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

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



## **Pacific Health Sector**

The Pacific Health sector has developed over the past 10-15 years to include a wide range of health services from health promotion, health education and primary care services to specialist alcohol and drug and mental health treatment services.

The growth of 'by Pacific for Pacific' services has been substantial and the development of Pacific Primary Health Organisations will provide unique opportunities for innovative and exciting Pacific health developments.

Pacific Provider Development has contributed to the development of the sector and the workforce and aims to:

- support Pacific providers development consistent with the local DHB's strategy for Pacific health
- consolidate existing provider structures
- support providers for effective delivery of health services
- build a highly skilled pool of Pacific peoples in the health and disability workforce

Pacific providers are defined as:

- owned and governed by Pacific people
- responsive to the Pacific community
- staffed by predominantly Pacific staff
- provide health services for Pacific people
- effective in meeting the health needs of Pacific people (clinically and culturally competent)
- having a focus on population health, health outcomes and the wider determinants of health

## **The people we serve**

### **Pacific peoples in New Zealand<sup>3</sup>**

Pacific peoples comprise of 6% of the total New Zealand population and constitute one of the fastest growing ethnic groups in New Zealand. By 2051 Pacific people are expected to comprise 12% of the population, with Pacific children comprising one in five children.

One in sixteen or 231,081 people in New Zealand were of Pacific ethnicity at the 2001 Census. Half of those Pacific peoples were Samoan with the next largest groups being Cook Island, Tongan, Niuean, Fijian, Tokelauan and Tuvaluan. Sixty percent (60%) of the population is New Zealand born.

<sup>3</sup>NZIS. 2001





Manukau city has the largest Pacific population with 1 in 4 people being of a Pacific ethnicity followed by Auckland and Waitakere. Seventy percent (70%) of the total Pacific population in New Zealand live in the Auckland region. The median age of Pacific peoples is 21 years while 2 out of 5 people are aged 15 years and under and only 3% aged 65 years and over.

The median annual income for adults of Pacific ethnicity was \$14,800.

### **Pacific peoples in the Greater Auckland/Northland region**

Seventy percent of the total Pacific population in New Zealand live in the Greater Auckland Northland region. The ethnic distribution in the region is shown below. The Pacific Population makes up twelve percent of the total Northern Region population behind the Maori (12%) and European (63%) population.

Note: The data shown below represents more than the actual population because it is non-prioritised. This means that people with more than one ethnic background were able to tick more than one ethnic group, and were then in counted in all ethnic groups ticked.

The Pacific population is distributed between the DHBs is shown below.

<b>DHBs</b>	<b>CMDHB</b>	<b>ADHB</b>	<b>WDHB</b>	<b>NDHB</b>	<b>total</b>
Pacific Population	82,422	51,246	32,967	3,162	169,797
Total Population	405,489	385,362	455,625	147,687	1,393,749

- Forty percent of the total Pacific people in the Northern Region lives in the CMDHB geographical area
- Thirty one percent lives in the ADHB geographical area
- Twenty percent lives in the WDHB geographical area
- Two percent lives in the NDHB geographical area

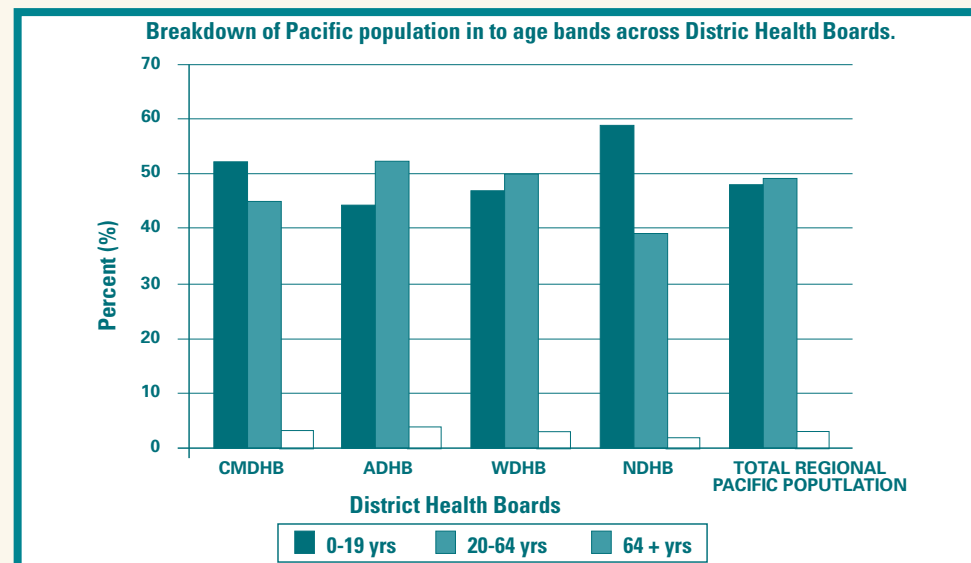
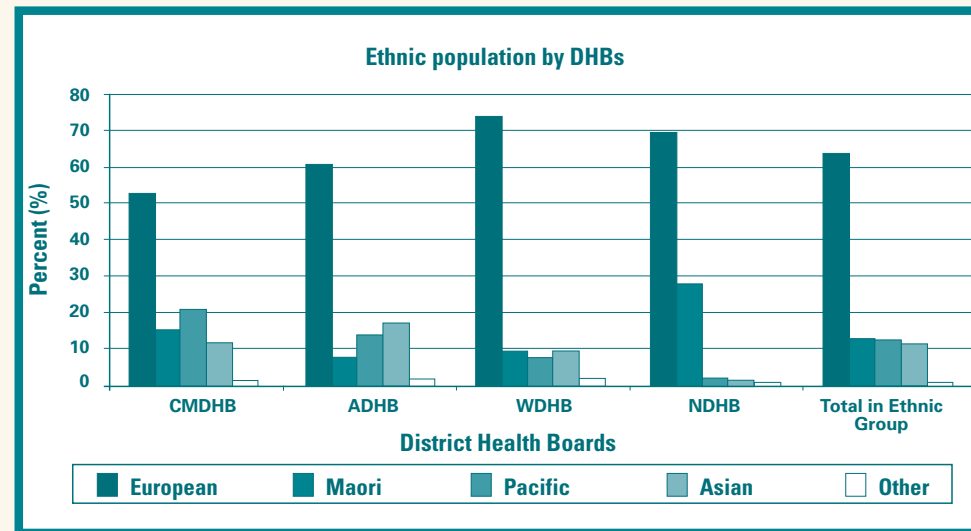
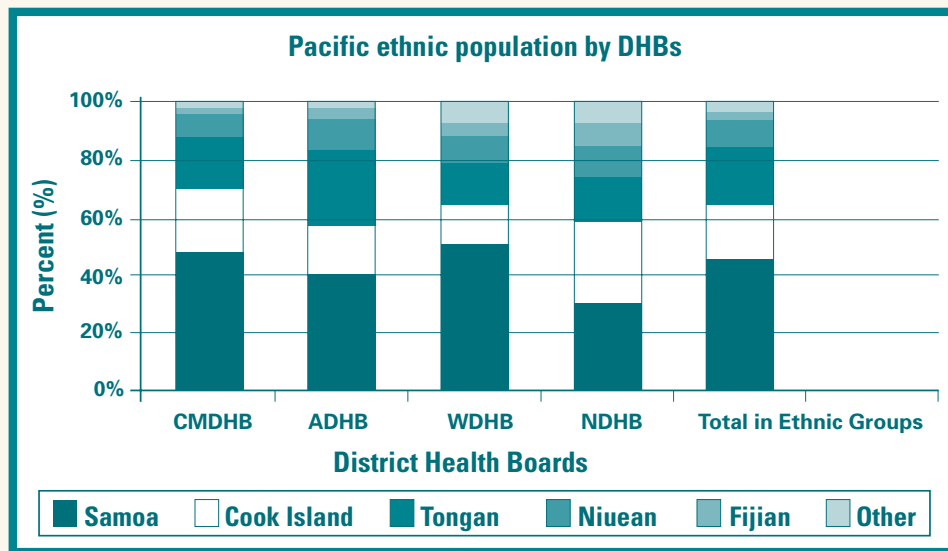
The Pacific ethnic groups in the region are described graph below. The Samoan population continues to be the largest Pacific ethnic group for the Auckland region with 45.7 percent. This follows by the Tongan (19.5%), Cook Island (19.1%), Niuean, (9.7%) and Fijian (2.6%).





The age distribution of Pacific population per DHB is shown on the right.

Counties Manukau and Northland District Health Boards' Pacific populations are youthful with over half of their population being under 20 years of age. All District Health Boards show small numbers of Pacific peoples in the 65 years and over age group. This identifies the shorter life expectancy for Pacific peoples.



## Pacific Mental Health Today

The following tables show Pacific mental health Services funded by northern regions DHBs. A number of other mainstream services may also deliver a Pacific component of care by designated Pacific people.

### Pacific Mental Health and Alcohol and other Drug Providers in the Auckland region

Provider	Service Provided	Lead DHB
<b>Faleola Mental Health Services</b>	The Faleola Service provides clinical care for the adult Pacific population of the South Auckland catchment area. Located in Great South Road, Papatoetoe. It supports mainstream services by providing Consultation and Liaison service to the youth and older adult services. Faleola also provides its own crisis service coverage from the hours of 0830hrs to 1630hrs.	<b>CMDHB</b>
<b>Pacificare Trust</b>	Pacificare Trust is a regional non-government organization for the Auckland area. Situated in the Old Papatoetoe town Centre it provides a range of services. Pacificare Trust provides the only Pacific Residential services for the Auckland region. It also provides Community Support Service, family counseling, youth service, recreational service and health promotion services.	<b>CMDHB</b>
<b>Penina Pacific Health Limited</b>	Penina was set up in 2001 contracted by the CMDHB to provide Family Support Services to the Adult population of the South Auckland area. Penina has also been contracted by the WDHB to provide level 4 plus step down bed for the Forensic services in the Auckland region.	<b>CMDHB WDHB</b>
<b>Pacific Alcohol and Drug Services</b>	PIDAS is a Pacific regional drug and alcohol service covering the Auckland region. Located in Albion Road, Otahuhu it provides relationships counseling, community education, report, group sessions, community networking and training. The service is provided to all Pacific ethnic groups of all ages. PIDAS also provides service for people with gambling problem.	<b>CMDHB</b>
<b>Lavea'i Trust</b>	Lavea'i is a drug and alcohol service providing community counseling and education to the Pacific population of the South Auckland area. It also provides counseling in the area of family relationships and violence. Lavea'i Trust is located in the old Papatoetoe town centre.	<b>CMDHB</b>
<b>Lotofale Mental Health Services</b>	Established in 1995, it has developed from providing Community Support Services to including a clinical service in 2003 with the addition of medical staff onsite. Lotofale provides Consultation and Liaison service to ADHB mainstream services. It also provides fanau support and advocacy for the Pacific communities.	<b>ADHB</b>



Provider	Service Provided	Lead DHB
<b>Malologa Trust</b>	Malologa Trust is situated in the Point Chevalier town centre. Started in the year 2002 as a non-government organization, its main function is to provide Community Support Services to the adult population of the Central Auckland catchment area.	<b>ADHB</b>
<b>Isa Lei Mental health Services</b>	Isa Lei became operational in 1999 to provide cultural/clinical services for the Pacific people of the Waitemata catchment area. Situated in Lincoln road, Henderson Isa Lei developed its Cultural Arm initially with staff dedicated to this role to provide consultation and Liaison services to mainstream adult, youth and older adult mental health services. In 2000, its Clinical Arm became fully operational.	<b>WDHB</b>
<b>Tupu</b>	Tupu is a regional drug and alcohol service. It provides both Alcohol and drugs counseling and Dual Diagnosis to the Pacific people of the region. Tupu is located in Kingsland.	<b>WDHB</b>
<b>Tagaloa</b>	Tagaloa is the Pacific cultural team located at the Mason Clinic catering for the cultural needs of Pacific clients in the Forensic services. It also provides liaison services to other Pacific clinical and cultural services.	<b>WDHB</b>
<b>Pasifika Health Fono</b>	Pasifika Health Fono (Primary Care Provider) operates a CSW service for the Waitemata area. This service also provides liaison and support to the Pacific mental health clinical team and also to mainstream services.	<b>WDHB</b>



### Pacific Mental Health Services Expenditure

The Expenditure on Pacific mental health services for the northern region was approximately 8.4 million for the year 2002. Future work is required to determine equitable and appropriate funding for future services.

	<b>CMDHB</b>	<b>ADHB</b>	<b>WDHB</b>	<b>NDHB</b>
Community Support Work	10.4	9	7	-
Residential Rehab Service	10	-	5	-
Social and Recreational Services	2	-	-	-
Child and Youth	8.2	3.2	1.7	-
Adult mental health services	14.8	18.2	14.4	.3
Older Adult mental Health Services	1.1	-	1.6	.7
<b>Total FTE</b>	<b>46.3FTEs</b>	<b>30.4FTEs</b>	<b>29.75FTEs</b>	<b>1FTE</b>

The table on the left illustrates the numbers of FTEs that were contracted to Pacific providers in both Pacific services in mainstream and Non Government Organisations.

There were 107.3 FTEs contracted out for Pacific mental health in the Auckland region totaling at 8.4 million dollars for the year 2002.

In some areas like Child and Youth and Older adult services where there are no “by Pacific for Pacific” Mental health services, there are small numbers of Pacific staff working with in mainstream services. The positions held by these Pacific staff members in mainstream services are not necessarily designated as Pacific FTEs and the number of Pacific staff is not necessarily the same as the number within the contracts.

Current (02/03) Crown Funding Agreements with the DHBs do not all specify the number of Pacific FTEs.

*Source: NDSA records of contracted Pacific mental health expenditure prior to transfer from Health Funding Authority to Ministry of Health. (June 2001)*



## Key Issues for the Northern Regions Pacific Mental Health

### 1. Access to services: -

It is impossible to provide all services to all people in the country but it is important that all people have access to appropriate services that meet their needs. To improve access for Pacific communities to mental health services as required by the Government Mental Health Strategy, more services are needed. This issue must be addressed from government level to Pacific mental health providers.

In the northern region, Pacific people are utilising the mental health services less than any other ethnic group ( NHIS 2003). This is related to a number of reasons including lack of “for Pacific by Pacific services” and the lack of responsiveness of mainstream services to the mental health and cultural needs of Pacific people.

The need to increase and develop “for Pacific by Pacific” services and improve the responsiveness of mainstream services are essential to meeting the current and future demand for the Pacific population. The level and type of services needed should meet the high admissions of Pacific people to Acute Inpatient Units and Forensic services. Currently, there is no “by Pacific for Pacific” mental health services in the region for Pacific youth despite half of the total Pacific population are under the age of twenty.

Pacific services must improve their information systems to collect and capture data that improve the low access of Pacific people to mental health services. Business plans and processes should be aligned with Pacific mental health priorities.

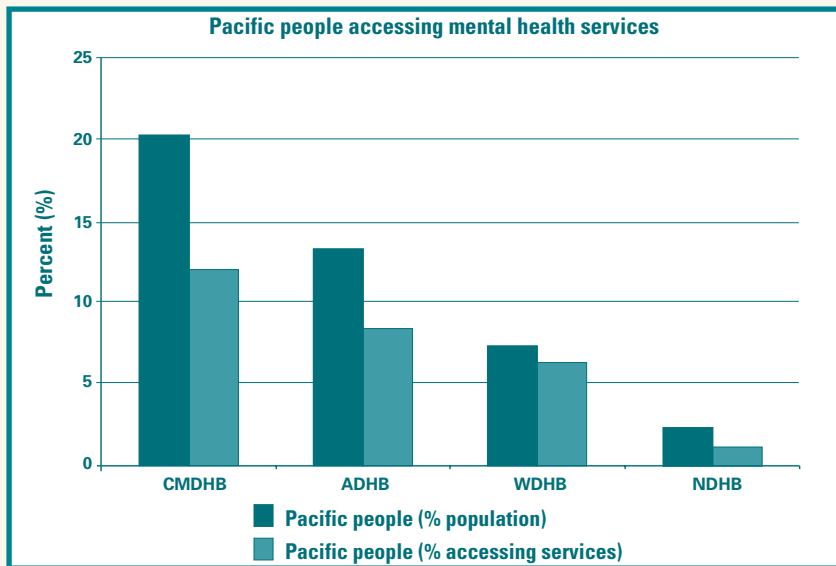
Particular focus are placed in the area of : -

- Primary Mental Health Care
- Youth
- Family support services
- Recovery services

Where services are most needed by the Pacific communities.

The Blueprint suggested that ethnic specific services are likely to be viable where there is enough capacity of a specific ethnic group. In areas like Northland where there is small number of Pacific population, mainstream services must commit in reassuring that their services are acceptable to the Pacific communities. This is achieved by encouraging of Pacific staff





members to apply their knowledge of their culture to their work but also training of non Pacific staff in understanding the relationship between Pacific culture and mental illness, different paradigms for Island and New Zealand born children and the discrimination and shame associated with mental illness amongst the Pacific communities.

**Focus areas are: -**

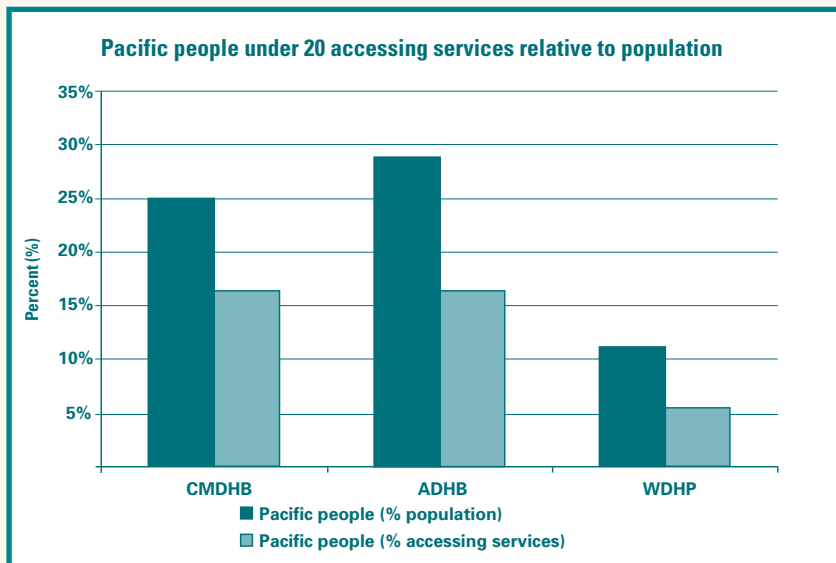
- Crisis and Early Intervention teams
- Child and Youth services
- Intensive Clinical Treatment teams

**Pacific peoples in the Greater Auckland/Northland region accessing mental health services**

The data on access by Pacific people to mental health services in the northern region has been drawn from the Mental Health Information National Collection (MHINC) database managed by the New Zealand Health Information Service (NZHIS) for the one year period July 2001 to June 2002 (inclusive).

As illustrated above left, the number of Pacific people accessing mental health and addiction services in the northern region is less than an equitable percentage of the total number of people accessing these services.

The chart below left, shows the percentage of the child and youth population that is Pacific, and the percentage of people accessing services that are Pacific people. Access to community services by Pacific people is less than would be expected given the Pacific populations of each DHB.







## **2. Partnerships**

Often discrimination and stigmatisation of mental illness can minimise opportunities for people with mental illnesses. Developing a working relationships with the communities can reverse this and allow people with mental illnesses to live a fulfilling life. Not only that these relationships empower and lift the self esteem of people with mental illnesses but also helps to maintain positive and right attitude in the community towards people with mental illnesses.

Recovery is differently for everyone, but for Pacific people as it describes in the Fonofale model, Mental health (Recovery) is maintained or achieved when Physical, Spiritual, Emotional and Family is in harmony. It is then logical to form partnerships with people that helps to achieve these aspects of life.(Pacific Mental Health Services and Workforce. Moving on the Blueprint. 2001)

Pacific services providers must not form working partnerships with their clients only but also assist their recovery by forming working partnerships with employers, landlords, education programs and institutions and other social and government agencies.

## **3. Workforce**

The need to develop capacity and capability for Pacific mental health workforce is an important part of reassuring that the need of Pacific community is met. It is important that the numbers of staff are not only increased but also Pacific staff need to be clinically and culturally competent in their service delivery. (Blueprint 1998)

The “Northern Regional Mental Health Plan. 2002/03” draft document is in progress, which identifies Pacific workforce as a priority for development. (Northern Regional Mental Health Action Plan 2002/03).

For Pacific mental health, Workforce Development is high priority not only for by Pacific for Pacific services but mainstream services. The growing inequalities between Pacific people and European New Zealanders indicates the need for more and competent Pacific staff. This also indicates the need for mainstream workforce to be more responsive and to understand the need of Pacific people and cultural values that influences the mental health of Pacific people.

Figures showed by the Mental Health Commission report, Pacific Mental Health and Workforce. Moving on the Blueprint 2001, Pacific mental health workforce is under represented throughout the mental health system, Pacific people who are experienced in key areas like Business Health Management, Policy development and Planning and Funding are needed. The New Zealand Health Workforce Discussion Document 2002 Stated that:



Intersectoral community partnerships, population-based health planning and funding and planning for more Pacific health practitioners are three strategies that the government has identified to assist Pacific peoples.

The recent release of the Mental Health (Alcohol and Other Drugs) Workforce and Development Framework document maps out the roles of stakeholders in mental health workforce development. This is particularly helpful in setting clear responsibilities to stakeholders from government agencies to provider arms in being accountable to reassure the fulfillment of their roles.

<b>Occupational Groups</b>	<b>CMDHB No</b>	<b>ADHB No</b>	<b>WDHB No</b>	<b>Total</b>
Nurses	8	8	16	32
Community Support Workers	11	11	5	27
Residential Workers	21	-	-	21
Social Workers	12	2	2	16
Managers	4	1	4	9
Consumer advisors	2	-	-	2
Administrators	10	2	9	21
Youth Worker	1	-	-	1
Occupational Therapist	1	1	1	3
Psychiatrist / Registrar	1	-	1	2
Family Counsellors	2	-	-	2
Clinical Psychologist/ Intern	-	3	1	4
Psychiatric assistant	-	2	8	10
Matua	1	1	1	3
Alcohol and drug workers	5	-	9	14
Cultural advisers	-	3	2	5
Care Co-ordinators	-	-	5	5
Work skills Co-ordinator	-	-	1	1
Traditional Healer	1	-	-	1
Training co-ordinators	1	-	1	2
<b>Total Pacific MH Workforce/DHB</b>	<b>81</b>	<b>34</b>	<b>66</b>	<b>181</b>
<b>Total MH Workforce/ DHB</b>	<b>439</b>	<b>588</b>	<b>1048</b>	<b>2075</b>

### **Pacific Mental Health Workforce**

The Pacific mental health Workforce data recorded in this section was collected from all Pacific mental health services (DHBs and NGOs) and mainstream mental health services in the Auckland region.

The table on the left illustrates the occupational distribution throughout the Auckland region.



The table below shows the numbers of some key occupations from the last Northern DHBs provider arm report. (NDSA 2002) The number presented below is exclusive of Non Government Agencies, therefore the actual total number mental health workforce in the region may be greater than what is shown here.

Occupational Groups	CMDHB	ADHB	WDHB	total
Nurses	167	231	422	820
Social Workers	38	41	167	246
Occupational Therapist	21	30	26	77
Psychiatrist/Registrars/MOSS	56	56	79	191
Psychologist	18	50	30	98
Psychiatric Assistant	53	31	103	187
Managers	-	19	28	47
Administrators	32	50	83	165

### Ethnicity of Pacific Staff

#### CMDHB

Ethnicity	Tongan	Samoan	Cook Is	Tuvaluan	Fijian	Tahitian	Niuean	total
Number	10	42	16	1	2	1	9	81
Percentage of total	12.3%	51.8%	19.8%	1.2%	2.5%	1.2%	11.1%	100%

#### ADHB

Ethnicity	Tongan	Samoan	Cook Is	Tokelauan	Niuean	Total
Number	10	14	6	1	3	34
Percentage of total	29.4%	41.2%	17.7%	2.9%	8.8%	100%



**WDHB**

<b>Ethnicity</b>	<b>Tongan</b>	<b>Samoaan</b>	<b>Cook Is</b>	<b>Tuvaluan</b>	<b>Fijian</b>	<b>Niuean</b>	<b>PNG</b>	<b>total</b>
Number	12	31	6	2	6	8	1	66
Percentage of total	18.2%	46.9%	9.1%	3%	9.1%	12.1%	1.5%	100%

**Total Number of Pacific staff in all DHBs**

<b>Ethnicity</b>	<b>Tongan</b>	<b>Samoaan</b>	<b>Cook Is</b>	<b>Tokelauan</b>	<b>Fijian</b>	<b>Niuean</b>	<b>Tahitian</b>	<b>Tuvaluan</b>	<b>PNG</b>	<b>Total</b>
Total No. DHBs	32	87	28	1	8	20	1	3	1	181
% of total DHBs	18%	48.6%	15%	.6%	4.6%	10%	.6%	1.7%	.6%	100%

**Gender of Pacific Mental Health Workers**

<b>Gender</b>	<b>CMDHB</b>	<b>WDHB</b>	<b>ADHB</b>	<b>Total all DHBs</b>	<b>Percentage</b>
Male	40	30	19	89	49%
Female	41	36	15	92	51%

**Number of staff in particular areas**

	<b>CMDHB</b>	<b>ADHB</b>	<b>WDHB</b>	<b>Total number</b>	<b>Percentage</b>
Child and Youth Mental Health	9	4	-	13	7.2%
Adult Mental Health	63	30	55	148	81.8%
Older Adult Mental Health	1	-	2	3	1.7%
Dual Diagnosis Alcohol and other drugs	8	-	9	17	9.4%
Inpatient Services	8	8	22	38	21%
Community Services	79	26	30	135	74%
Forensic Services	-	-	14	14	7%
Clinical staff	27	13	30	70	39%
Non Clinical Staff	54	21	36	111	61%



### Summary of Qualification for Pacific Staff

The data shows above indicate the serious lack of Pacific staff in the Mental Health sector. It indicates a lack of Pacific qualified staff throughout the mental health system. Specifically there is serious lack of Pacific staff in some occupations. There is a lack of Pacific Psychiatrist throughout the region where Pacific services have no options but to employ non-Pacific Doctors to enable a clinical service to be operational.

	CMDHB	ADHB	WDHB	TOTAL
Nursing Degree/Diploma	8	8	16	32
OT Degree/Diploma	1	1	1	3
SW Degree/Diploma	12	2	2	16
Clinical Psychologist Intern	-	3	1	4
Certificate/Diploma in Mental Health	20	13	8	41
Psychiatrist/Registrar	1	-	1	2

There is a major shortage of Pacific youth workers despite the growing number of Pacific youth. There is also lack of Matua and Cultural advisors. There is also a large number of Pacific support staff particularly in the CMDHB area.

### Participation in Pacific Mental Health Training

Information was gathered from two main sources, the Ministry of Health and service providers (DHB and NGO). The intention was to pinpoint whether Pacific staff are participating in some form of training, and any impediments to participation. Questions were asked to determine the following:

- the awareness of Pacific services of what initiatives available to them
- what level of staff are currently participating in some form of training
- barriers to Training and Development
- training available from the service to other services

Pacific mental health service managers were asked to indicate on how much they know about the range of training initiatives available. The results were:

- Pacific MH services are aware of up to eighty five percent of the initiatives shown below
- Pacific MH services in mainstream have up to 70 percent of staff engaging in some form of formal training, while non government organisations have up only to 25 percent of staff engaged in formal training
- There is a lack of integration of training opportunities
- Non-government organisations identified lack of funding as the main barriers together with lack of staff numbers to cover off duty staff.
- Other respondents reported that barriers to training included funding shortages to back fill for staff who are on





study leave in some mainstream Pacific mental health services

- Some staff indicated that commitment to other aspects of life, like families impeded access to training
- Pacific mental health services in mainstream have more capacity to provide training to other services/groups e.g. Nursing and Social Work schools, Inductions for DHB staff, schools, and students
- Both DHB and NGO Pacific mental health services have few incentives for their staff.

#### **4. Information Research**

##### **Information for the public**

Pacific people need access to clearly communicated information about how to stay mentally healthy, how to recognize mental health problems and where to go to get help. When suffering from a mental health problems and recovery options, they need clear information about what maybe wrong, treatment choices and about any treatment they may use.

##### **Information for Planning and Evaluation**

There is a shortage of good information to inform:

- planning for Pacific mental health service development
- strategies to improve the quality of Pacific and mainstream services
- strategies to improve workforce availability and cultural competence

In order to improve planning, funding and delivery of services for Pacific people, we will need to routinely collect data in order to:

- Identify the level of funding for Pacific community services relative to other community services
- Identify the diagnoses and characteristics of Pacific people using mental health services
- Identify service use for Pacific people (for comparison with local populations)
- Identify outcomes for Pacific people using Pacific and mainstream mental health services (for comparison with others in the population)
- Identify the existing Pacific workforce in both Pacific and mainstream services





## Research

### Aim

To foster research and development that will assist in planning and improved delivery of mental health services to the Pacific Islands community.

- To build a Pacific Mental Health research workforce
- To date there has been little data on which to base services of planning and little (or no) information on the outcomes for Pacific consumers of being under services. We know little about what works well in Pacific Services and makes it uniquely Pacific service.

Research is an encouraged part of university culture and DHBs appear to be not well equipped or willing to undertake research or to foster a research and development culture of inquiry.

The challenge is to build a Pacific Mental Health research network. Current initiatives involve Whitireia Polytechnic, University of Otago, University of Auckland and Auckland University of Technology.

To promote and build career pathways in mental health research for Pacific people the Ministry of Health has provided annual Pacific Mental Health Workforce Awards and Pacific Health Workforce Awards. (Northern Regional Mental health Action Plan. 2002/03)

The Health Research Council of New Zealand provides:

- Summer studentship for undergraduate student interested in research
- Pacific Health Research Awards to postgraduate Masters and Doctoral students
- Other research Training and Funding opportunities, which include post doctoral awards

The Mental Health Research and Development Strategy (MHRDS) committee administers a ring- fenced budget from the Ministry of Health to fund research. A current project being funded is a Pacific specific tender which explores the models of Pacific Mental Health Services Delivery in New Zealand.



## 5. Quality of Services

There is currently a lack of regional consistency in the quality of Pacific mental health services provided and in the appropriateness of mainstream services for Pacific people. There is no standardised and agreed 'best practice' for Pacific mental health, and providers have different systems in place to ensure Quality. There is no consistent approach to monitoring and evaluating Pacific Mental Health service providers.

There will be little improvement in the mental health of the Pacific communities if staff are not skilled enough (both in terms of clinical skills and competence in recognising cultural values) to intervene. As identified under workforce, there is no consistent and integrated approach to ensuring cultural competence through training for Pacific and mainstream services. The Government has, however, provided the following initiatives to assist Pacific Mental health providers:

- The development of Pacific Mental Health and Workforce. Moving on the Blueprint 2001
- Training delivered by the Alo Itauga o Tagaloa
- The development of The Pacific Health Education and Research programme at the Whitireia Polytechnic
- Pacific Providers Development Funds. Ministry of Health and HRC scholarship programme
- The Auckland School of Medicine Maori and Pacific Studies Programme
- The development of The Pacific Health and Disability Action Plan 2002

In addition to this, the Pacific Branch for WDHB and CMDHB has started Cultural Competency Training in 2002. This training is intended to develop a standard of practice for cultural competency in mental health.

There is limited information provided to service users, families and communities on what to do when you are unwell, how to stay well, what services are available.

Pacific service user and family networks and Pacific multi-stakeholder networks are not yet well established and therefore largely unable to feed into local and regional networks, service monitoring, evaluation and planning in order to enhance planning for service development. Family and services users will need to be encouraged to participate in the monitoring, evaluation and planning of Pacific mental health services.



## **6. Model of Service delivery**

The current service delivery model of the Mental health sector has not proven to be effective nor appropriate for the Pacific people, therefore a Model of service delivery that works for Pacific people must be developed and in collaboration with Pacific communities (Blueprint for Mental health Services in New Zealand 1998). A model to be developed has to be aligned with the traditional and the evolving family and society structures and values of the Pacific communities in New Zealand. The Pacific approach to mental health, international models and approaches to primary care delivery are described below.

### **Pacific Models of Service Delivery**

The following section is an extract from the document “Pacific Mental Health Services and Workforce”. Moving on the Blueprint. 2001 (Mental Health Commission)

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

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



### **The Fonofale model of health**

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

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

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

#### **The roof**

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



## The foundation

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

## The pou

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

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

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

- Environment** - this dimension addresses the relationships and uniqueness of Pacific people to their physical environment. The environment may be a rural or an urban setting.
  
- Time** - this dimension relates to the actual or specific time in history that impacts on Pacific people



**Context**

- this dimension relates to the where/how/what and the meaning it has for that particular person or people. The context can be in relation to Pacific Island-reared people or New Zealand-reared people. Other contexts include politics and socio-economics

**The concept of recovery from a Pacific perspective**

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

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

*With the important role of the extended family in the lives of Pacific Islanders, cousins often become their friends, the elders become their leaders, and the extended family as a whole, becomes the community. Pacific Island cultures are different from almost every other culture in New Zealand because the extended family plays such 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.*

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



Pacific mental health service users have given a strong message that having access to a service run by a Pacific organisation and/or with Pacific staff is fundamental to their recovery. Importantly, Pacific consumers can more easily identify with Pacific staff who bring Pacific cultural understandings and belief systems to the service (Malo 2000: 13). It also helps families to better understand mental illness when they can communicate in their own language with the service, and be comfortable in a supportive cultural environment.

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

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

- a high degree of stigma associated with experiencing mental illness in both Pacific and other communities
- poor access to mainstream mental health services
- late presentation leading to high rates of committal under the Mental Health (Compulsory Treatment and Assessment) Act and incarceration within the forensic mental health services
- a lack of services specifically designed to meet the needs of Pacific people whose language and cultural beliefs make successful engagement difficult. This is especially evident in the area of child, youth and family
- a lack of a sufficiently large and appropriately skilled Pacific mental health workforce
- the lack of an acknowledged, credible model for addressing the challenges facing Pacific communities in relation to their mental health

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



### **International Experience**

The literature and information on successful international models<sup>4</sup> for mental health service delivery and best practice suggest the following characteristics for successful mental health services:

- work in partnership with consumers, recognizing their strengths and expertise in resolving their own difficulties
- actively engage and support families
- actively engage and develop communities and community resources to contribute to the recovery of people with ongoing illnesses
- deliver very flexible, highly person/family-specific services
- use approaches that reflect best practice – both from the perspective of the professionals and that of consumers and families
- work closely alongside Primary Care Services, providing support and advice to primary care practitioners as well as direct involvement in service delivery
- operate with a philosophy of “least restrictive environment”, delivering services in the community and using inpatient care only as a rare back-up when absolutely necessary
- work together as a whole, well integrated system of care
- work in an integrated fashion with other health and social services
- recognize the relationship between socio-economic circumstances and mental health/reliance on mental health services to support economic development for people socio-economically disadvantaged as a result of their ongoing illness

<sup>4</sup>Drawn from a literature review and information from a range of integrated mental health systems including Queensland, Australia. Clondalkin, Ireland. Trieste, Italy. Helsingborg, Sweden. North West, Wales. Dane County, Wisconsin, Massachusetts, Keene, New Hampshire, Sacramento County, USA. Franco Basaglia Institute, Brazil. Kerala, India. and Nepal.



### **Primary Care**

The Primary Health Strategy released by the Minister of Health in February 2001 describes a future model for primary mental health care that includes, through the establishment of Primary Health Organisations (PHOs):

- and Nepal. working with local communities and enrolled populations
- identifying and removing health inequalities
- offering access to comprehensive services to improve, maintain and restore peoples' health
- coordinating care across service areas

The intent is that there will be a multi-disciplinary approach to primary care involving nurses, doctors and a range of other community workers. Specifically, the skill mix of primary health care providers will include the ability to effectively respond to the majority of mental health problems which can be managed in primary care settings. Primary Health Organisations with enrolled populations will work with other sectors to effect change in social, economic and cultural impacts on the community's health problems. They will build effective linkages with mental health service providers to ensure coordination of care. Assistance for primary health providers from specialist services will include decision support, evidence based guidelines, responsiveness in offering appropriate support and collaboration in chronic illness management.

The first PHO to be established was TaPasefika, a Pacific PHO in Counties Manukau, involving South Seas Health Care and Health Pacifica primary care providers. There are two other Pacific primary care providers in the Auckland region. Together the four primary care providers have registered regular clients of 36,500 and additional casual clients of 9,000. There are 28 doctors (5 fulltime) and 37 nurses out of 144 staff members throughout the Auckland region.





## Proposed Pacific Mental Health Model of Service Delivery

Drawing on the strengths within Pacific communities, families and primary healthcare provision, Pacific people are ideally placed to take a lead in developing effective mental health services that weave together the best of Pacific and international approaches to mental health preservation and recovery.

It is timely for Pacific people to take ownership and responsibility in planning for the mental health of their community. In this section we are exploring the ideas and visions for the future developments aimed at improving the health of our Pacific people. If we are to empower our people to take responsibility for their own health and take ownership of their goals in life<sup>5</sup>, then the ideas expressed in this section will need to be developed and refined by the Pacific community, working together.

In this section is a systematic structure of service integration that we believe will effectively address not only the mental health but the overall health of the Pacific people. This plan is based on many factors including Pacific mental health history, Pacific models of service delivery, current data, anticipations of the future Pacific population and international experience. The approach is based on the linking of Pacific mental health services to Primary Health Care and Preventative services. It is intended to encompass early intervention, treatment of mental illness, recovery and rehabilitation, including alleviation of stigma and improved health for people with severe mental illnesses.

It is expected that services delivered will deal with the cornerstones of the life of Pacific people, integrating, the values, culture, religion and other Pacific paradigms that can affect Pacific peoples health.

Developing the services described in this section will require the Pacific community to work together, and coordinated support from all levels of the mental health system, from individual clinician through to Government.

The diagram below illustrates the proposed approach to a Pacific Mental Health System. The mental health system shown in the diagram sees the Primary Care Team as the primary point of contact. In future, many problems would be resolved by people within that team with mental health expertise, such as primary mental health nurses. The Pacific Specialist Mental Health and Addictions Services (including Youth Services and Family Services) would provide back up advice to the Primary Care Team. When this advice is insufficient, the Pacific Mental Health and Addictions Services would become directly involved, always with a view to Primary Care resuming primary responsibility for ongoing problems as soon as appropriate. The Pacific Mental Health and Addictions Services would work closely with the Primary Care Team and are preferably co-located with that team.

<sup>5</sup>As emphasised in the *Pacific Mental Health Services and Workforce Moving on the Blueprint 2001*

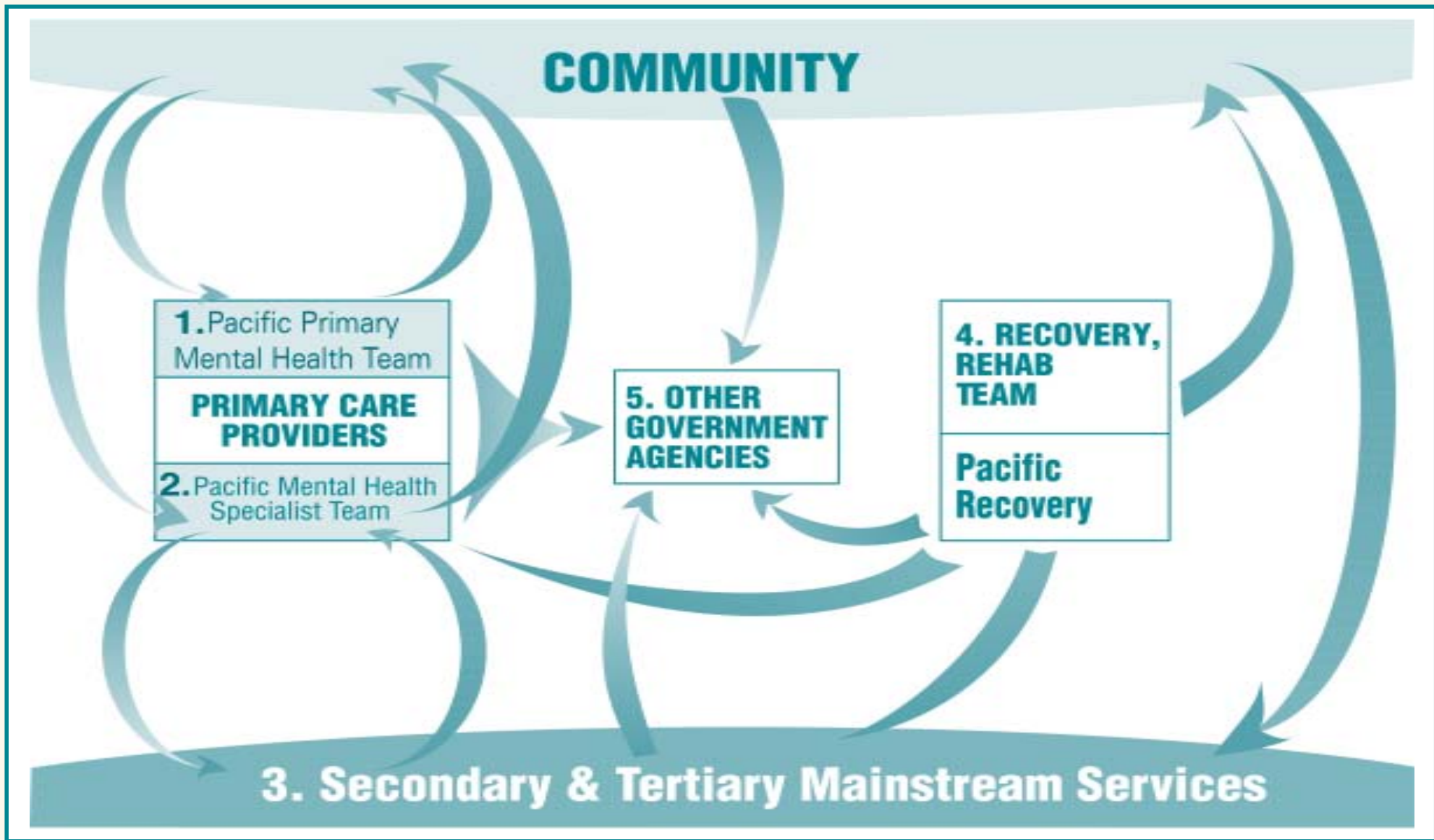




When a person has very high treatment needs, other secondary/tertiary mental health services (e.g. inpatient care, out of hours crisis services, dual disability team, etc.) would be accessed through the Pacific Mental Health and Addictions Services. During use of these services the Pacific Mental Health and Addictions Services would remain actively involved with the person and the secondary/tertiary service in planning care.

When a person has very high support needs in order to recover a life in the community, recovery services could be accessed through the Pacific Mental Health and Addictions Services. There would be specific Pacific Recovery Services as well as mainstream services. These services would take responsibility for linking in with appropriate community supports and working with the service user and their family to help establish a full life in the community. Clinical treatment for this group of people would continue to be offered by the Pacific Mental Health and Addictions Services and/or Primary Care Team, who would be very responsive to the Recovery Services and service users involved with them.

Recovery services would work to strengthen supports for service users in the community and to assist service users to access the full range of community resources, including those supplied by other Government agencies and those provided by mental health support/rehabilitation services.





## Key Directions and Objectives 2003 - 2005

**Key directions identified for Pacific mental health over the coming three years were:**

1. Pacific Primary Mental Health
2. Improved access to mental health services and to alcohol and other drug services
3. Partnerships
4. Workforce
5. Information and Research
6. Quality

The table that follows details three-year objectives that relate to each of the above priority areas.

Goals	Objectives
To develop Pacific primary Mental health services	<ul style="list-style-type: none"> <li>▶ To develop a model for Pacific primary mental health services</li> <li>▶ Implement a pilot for Pacific primary mental health services</li> <li>▶ To develop mental health expertise for Pacific Primary care staff</li> </ul>
To improve access for Pacific peoples to Mental Health services	<ul style="list-style-type: none"> <li>▶ To expand and develop 'by Pacific for Pacific' Mental health services with a particular focus on:               <ul style="list-style-type: none"> <li>• Pacific primary mental health care</li> <li>• Pacific youth services</li> <li>• Pacific family support services</li> <li>• Pacific 'recovery' service</li> <li>• Pacific Clinical Team</li> <li>• Regional Alcohol And Other Drugs Services</li> </ul> </li> <li>▶ To support the growth and development of Pacific Mental health services with an emphasis on:               <ul style="list-style-type: none"> <li>• information systems</li> </ul> </li> </ul>



Goals	Objectives
	<ul style="list-style-type: none"> <li>• business processes</li> <li>▶ To ensure that mainstream mental health services who provide services to significant Pacific populations are more responsive and culturally competent, including awareness of family structure and dynamics. Priority areas for focus are:               <ul style="list-style-type: none"> <li>• Crisis and early intervention teams</li> <li>• Child and youth services</li> <li>• Intensive clinical treatment teams</li> </ul> </li> <li>▶ To ensure equitable access for Pacific peoples to specialist mental health services across the region</li> </ul>
<p>To develop partnerships with organisations, communities, families and service users, which will maximise opportunities for Pacific peoples involved with Mental Health and Alcohol and other Drug services.</p>	<ul style="list-style-type: none"> <li>▶ Work with Pacific communities to reduce stigma and provide support and the promotion of healthy lifestyles</li> <li>▶ Work with employers, housing providers and local communities to enhance opportunities for Pacific peoples</li> <li>▶ Develop partnerships with agencies and organisations to develop opportunities and improve outcomes with a focus on Education, Housing and Social Service providers</li> <li>▶ Develop close working relationship between the Alcohol and other Drug and mental health services.</li> </ul>
<p>To develop a competent and qualified Pacific Mental health workforce that will meet the needs of Pacific peoples</p>	<ul style="list-style-type: none"> <li>▶ Introduce recruitment and retention strategies to increase the range and number of Pacific Mental health workers both clinical and support staff in the following areas:               <ul style="list-style-type: none"> <li>• Psychiatrists</li> <li>• Nurses</li> <li>• Recovery staff</li> <li>• Child and youth workers</li> <li>• Alcohol and Other Drug service workers</li> <li>• Managers</li> </ul> </li> <li>▶ To ensure all mental health services providing service to Pacific</li> </ul>





Goals	Objectives
	<p>peoples develop skills and understanding of Pacific primary care, dual diagnosis in relation to Pacific service users and Pacific health issues</p> <ul style="list-style-type: none"> <li>▶ To establish a Pacific Mental health workforce plan including database</li> </ul>
<p>To ensure that information and research on Pacific Mental health will inform policy planning and service development</p>	<ul style="list-style-type: none"> <li>▶ To collect, collate and analyse ethnic specific information for policy and service development</li> <li>▶ To develop a Pacific mental health research capacity which will focus on the effectiveness of Pacific and mainstream mental health models</li> <li>▶ To disseminate information to Pacific communities, service users and families on Pacific Mental health issues</li> </ul>
<p>To improve the Quality of Mental Health services</p>	<ul style="list-style-type: none"> <li>▶ To ensure Pacific providers reflect 'best practice' and have systems in place to ensure Quality.</li> <li>▶ To develop cultural competency standards and training programs for Pacific and mainstream services with an emphasis on service provision and workforce</li> <li>▶ To develop information for service users, families and communities on what to do when you are unwell, how to stay well, what services are available</li> <li>▶ To develop Pacific service user and Pacific family networks which will provide input into service monitoring, evaluation and planning</li> <li>▶ To implement monitoring and evaluation systems for all Pacific Mental health providers</li> <li>▶ To ensure Pacific representation and input into regional and local stakeholder networks.</li> <li>▶ To collate all existing groups and organisations of Pacific providers with a mental health and/or alcohol and other drugs focus in a single data base</li> </ul>





## **Future Work**

This report describes the broad directions for development of Pacific mental health and addiction services over the next three to five years. In order to ensure that these developments are achieved, the following additional work will be needed:

- Formation of a formal Pacific Regional Network to consult on the implementation of this plan
- Estimation of Resources/ Funding needed for Pacific mental health in the region for closing the gap against the Blueprint benchmark over the next 10 years
- Annual Planning with stakeholders on Pacific Mental Health and Addiction Service developments in line with priorities detailed in this document
- Ongoing Pacific representation in all formal planning and funding structures.
- Development of a regional approach to planning, configuring and delivering Pacific mental health services



## References

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- *A National Work Plan for Child and Youth mental health services 2000*
- *Blueprint 1998*
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- *“Looking forward.” Strategic Direction for the Mental Health Services 1994*
- *“Making Links.” Guidelines on services co ordination for children and young people with severe mental health problems 1997*
- *Meeting the challenges Mental Health Workforce Development Plan 2000-2005*
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- *Mental Health in New Zealand from a Public Health Perspective 1997*
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- *“Moving Forward.” The National Mental Health Plan for More and better services 1997*
- *National Alcohol Strategy 2000 to 2003*
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- *“New Futures” - A Strategic framework for specialist mental health services for children and young people in New Zealand*
- *New Zealand Health Strategy Discussion Document 2000*
- *Northern Region Mental Health Plan 2002/2003*
- *Pacific Health and Disability Action Plan 2002*
- *Pacific Mental Health and Workforce. Moving on the Blueprint 2001*
- *Primary Health Care Strategy 2001*
- *Primary Mental Health. A review of the opportunities 2002*
- *The Mental Health of Pacific Peoples in New Zealand 2002*
- *The New Zealand Health Workforce 2002 Framing Future Direction Discussion Document (HWAC)*



**District Health Board Documents**

**Counties Manukau District Health Board**

- Counties Manukau Health Profile 2001
- Healthy Futures A Strategic Plan Summary for Counties Manukau Draft 2002

**Auckland District Health Board**

- Pacific Island Mental Health Services Annual Business Plan 200/2003

**Waitemata District Health Board**

- Waitemata Strategic Plan 2002
- A Picture of Health and Health Care for Waitemata Residents

