ENDORSED BY DISTRICT HEALTH BOARDS IN THE
NORTHERN REGION OF AOTEAROA
MAY 2004

WHANAU ORANGA HINENGARO

NORTHERN REGION MAORI MENTAL HEALTH AND ADDICTIONS PLAN

Prepared for the
Northland, Waitemata, Auckland and Counties Manukau
District Health Boards

Tawhiti rawa tou haerenga ake te kore haere tonu

Nui rawa ou mahi te kore mahi nui tonu

You have come to far, not to go further

You have done too much, not to do more

Acknowledgements

The Northern Region District Health Boards would like to acknowledge the contribution of all of those involved in creating this regional plan. Thank you for your gifts of knowledge and information.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Current evidence shows that outcomes are sharply divided along ethnic lines and that Maori experience disproportionately more readmissions and poorer long-term recovery. Specifically, in Northland/Auckland's DHBs evidence shows that Maori have the highest rate of hospitalisation for psychiatric disorders out of all ethnic groups. Maori are seen accessing services later and with greater severity at the point of entry[i].

The Mental Health Commission's Blueprint for Mental Health Services (1998)[ii] outlines key issues for Maori as; increasing concerns about poor mental health status, access, culturally effective services, funding contract restraints, workforce development, inappropriate performance measures, discrimination and recovery. In respect to access, the Blueprint identifies that at any given time 6 % of Maori should be able to access Mental Health Services.

Mental health services are contracted to focus services to 3 % of the population with severe mental health disorders (6 % for Maori). This plan focuses on 6 % Maori population with severe mental health needs and NGO/Iwi service development. This plan also recognises the opportunity for Maori mental health gains in areas of Public Health and Primary Health Care.

It is important to recognise the roles, responsibilities and issues of different groups that contribute to improving Maori mental health services. These include the Ministry of Health (Facilitate Intersectoral Collaboration), Public Health Services (Health Promotion and Prevention), Primary Health Care (Mild to Moderate Mental Illness), Mental Health Services (Severe Mental Illness) and NGO/Iwi Services (Support Services).

Of particular relevance to primary health care services is the 17% of the population with mild to moderately severe mental health problems. It is well recognised internationally that the mental health needs of most people in this group must be met in a primary care setting.[iii] However the infrastructure of the primary health sector requires further development so as to be prepared for mental health responsibilities.

On the other hand, mental health contract specifications are presently inconsistent with holistic Maori models of wellness that are widely practiced by the Maori mental health workforce. Service specifications would be greatly enhanced by the addition of outcome measures for Maori health gain.

This is indeed the prime foci of the Government's new National Maori Health Strategy, He Korowai Oranga, which does impact upon, and permeate, this plan. The overall objective of 'Whanau Ora' is embedded in this plan.

He Korowai Oranga (2002), Whakatataka (2002), the Blueprint (1998), and the Ministry of Health's 2002 publication on Primary Mental Health all advocate for services to contribute to Maori wellness, within the context of whanau, hapu and iwi development. This includes understanding and implementing Maori aspirations around workforce development, building effective linkages between primary, secondary, tertiary and Maori/iwi providers, integrated and intersectorial initiatives and responsiveness frameworks.

This plan endorses the above strategies and promotes those approaches that strengthen Oranga hinengaro for Maori and reduce the number of Maori who experience mental health problems.[iv] A set of structured milestones and related actions is provided to help the northern region DHBs to deliver effective mental health services to Maori. The plan outlines the strategic directions for the next five years in respect to current and future regional mental health planning processes.

This Whanau Oranga Hinengaro, Northern Region Maori Mental Health and Addictions Plan proposes that the Mental Health sector will:

- plan and improve integration and whanaungatanga (relationships and networking) between funders, providers, tangata whaiora and their whanau
- engage in development and implementation of responsiveness frameworks for the entire sector (funders and providers)
- start to cost and budget better value-for-money services which aim to do no harm and do make a difference
- develop ways to improve capacity and capability of the mental health sector.

BACKGROUND

TE TIRITI O WAITANGI

The Government wishes to implement a series of rational, practical, affordable actions that help undertake its key responsibilities as a partner to Te Tiriti O Waitangi for the mutual benefit of all New Zealanders. In the health sector, the Government provides for Maori to have an important role in implementing Maori health strategies and requires that the Crown and Maori will relate to each other in good faith with mutual respect, co-operation and trust.

In particular, Maori should be actively involved in defining and prioritising their health needs and directly aided to develop the capacity to deliver services to their own communities, as defined in Section 4 of the New Zealand Public Health and Disability Act 2000. Therefore, the four northern district health boards and the three MaPO are committed to ensuring Maori achieve the best possible levels of Oranga hinengaro and mental health and wellbeing.

METHODOLOGY

In 2002, the Northern District Health Board Support Agency (NDSA) on behalf of the northern region's four district health boards (Northland, Waitemata, Auckland and Counties Manukau) commissioned the preparation of a Northern Region Maori Mental Health Action Plan as part of a strategy to develop a northern region infrastructure in mental health.

The plan has been developed in consultation with the Ministry of Health, the four district health boards in the northern region, the NDSA, Maori and non-Maori providers and most importantly tangata whaiora and their whanau.

A team was established to develop the plan in 2002. The original project team consisted of:

- the ADHB Funding Manager, Mental Health;
- the NDSA Manager, Mental Health;
- the four DHB General Managers, Maori Health;
- the three MaPO Project Managers, Mental Health;
- an NGO Representative; and
- a Consumer Representative.

The Project Team developed the methodology for consultation with the key stakeholders. Specifically, the methodology included:

- a review and analysis of key national, regional and local strategic documentation;

- consultation with key stakeholders including the Ministry of Health, the four northern region district health boards, the NDSA, Maori and non-Maori providers and tangata whaiora and their whanau; and

- a review and analysis of utilisation data provided by the four Auckland district health boards and the NDSA.

The review and analysis of strategic documentation was undertaken in October 2002. The consultation with key stakeholders was conducted over a twelve-week period from November 2002 to January 2003.

Before the consultation was conducted, the project team developed a standard set of questions for funders, providers and tangata whaiora and their whanau. The questions used to inform all of the interviews and hui included:

- How can tangata whaiora stay well, what do I need?

- What supports and information should my whanau have to help me nurture and care for my wairua and my hinengaro?

- But if others or I can sense that I am becoming unwell, what different supports and information do we need to keep my wairua and my hinengaro from becoming more damaged or more hurt?

- And if I were to need active intervention and the use of secondary and tertiary services, what would I need to manaaki and awhi my wairua and my hinengaro?

- What would I need for my whanau to regain control and to restore our mana, our rangatiratanga and our whanau ora?

Interviews were held with a selection of funding managers (Maori and non-Maori), DHB mental health provider managers (Maori and non-Maori) and (Maori and non-Maori) NGO providers. Three hui were held with Maori providers (Waitangi, Whangarei and Auckland) and two hui were held for tangata whaiora and their whanau (Whangarei and Auckland).

Following the completion of the interviews and hui, the data was coded and analysed to identify the key themes. The key themes were analysed to inform the strategic framework outlined in this action plan.

OUTLINE OF MAORI MENTAL HEALTH NEEDS

The following section draws together a wide range of information in order to develop strategic themes and key priorities for Maori mental health in the northern region. The information includes:

- a summary of demographic information available;
- prevalence of mental health amongst Maori; and
- an outline for effective services for Maori drawn from policy frameworks and the consultation process. (A summary of these are available in the appendices)

It is recognised this information is limited and that an in-depth Maori mental health needs analysis is required to determine future needs and better inform future planning.

DEMOGRAHIC PROFILE

According to the 2001 census, Maori made up 14 % or 523,000 of the total New Zealand population.

At the last census, around 171,000 or 33 % of the Maori population resided in the Northland/Auckland region.

	NDHB	ADHB	WDHB	CMDHB	Total
Maori	40,722	29,139	39,696	61,392	170,949
Total Population	140,088	367,740	429,747	375,510	1,313,086
% of Maori out of total DHB population	29%	8%	9%	16%	13%

Table 1: The Maori population distribution across Northern/Auckland DHBs

There is a higher ratio of Maori to non-Maori population living in Northland and Counties Manukau than in Auckland and Waitemata.

Age distribution spread indicates that 46 % of the Maori population is less than 19yrs, 51 % between 20yrs and 64yrs with only 3 % above the age of 65yrs.

National life expectancy for Maori is the lowest of all ethnic groups at 67yrs for male and 72yrs for females compared with Pacific people at 69yrs and 76yrs and others being 77yrs and 82yrs.

High numbers of Maori across the Northern/Auckland DHBs live in areas classified as most deprived (deciles 7 to 10). Conversely few Maori live in the least deprived areas (deciles 1 to 4).

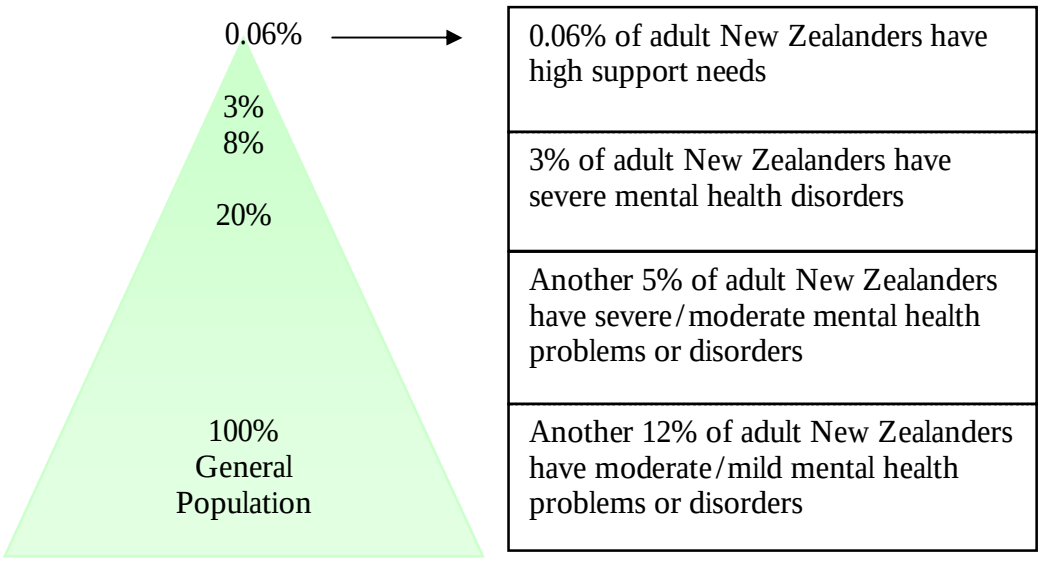
The graph below indicates the highest concentration of deprivation is in Northland and Counties Manukau. Deciles are 10 % groupings at the total NZ level, with the same cut-off points used for each area. For this table, groups are combined in pairs apart from 9 & 10 (most deprived areas) for ease of reading table.

Locality	**NZDep96 deciles* (%). 10 = most deprived**					
	1-2	3-4	5-6	7-8	9	10
Northland	**7**	**13**	**18**	**25**	**15**	**21**
North Shore/Rodney	**35**	**34**	**21**	**9**	**1**	**1**
West Auckland	**21**	**2**	**23**	**27**	**7**	**2**
Central Auckland	**25**	**19**	**19**	**18**	**9**	**10**
Counties Manukau	**10**	**15**	**13**	**17**	**13**	**21**
Waikato	22	18	19	22	13	12
Bay of Plenty	21	16	19	21	14	15
Tairawhiti/Hawkes Bay	17	16	19	22	13	18
Taranaki	12	23	24	22	12	17
Wanganui/Manawatu	13	19	23	22	13	10
Wellington	15	19	17	17	7	9
Nelson/Marlborough	12	21	27	26	6	2
Canterbury/ West Coast	18	23	22	19	8	4
Otago/Southland	12	24	22	21	9	5
All New Zealand	20	20	20	20	10	10

Table 2:[v] All New Zealand by NZDep96 decile - percentage within each locality. 1996

PREVALENCE OF MENTAL HEALTH AMONGST MAORI

Estimated prevalence of mental health problems among adult New Zealanders is demonstrated in the picture below. Also, at any given time 5 % of children and young people need to access specialist mental health services.



(Adapted from Minister of Health 2003. Implementing the New Zealand Health Strategy 2003. The Ministers Third Report On Progress On The New Zealand Health Strategy. Wellington, Ministry of Health. Page 58.)

The major subgroups of mental illnesses include:

- Attention Deficit Disorders
- Conduct Disorders
- Mood Disorders
- Substance Use Disorders
- Anxiety Disorders
- Schizophrenia and other psychotic disorders
- Personality Disorders
- Dementias

There is not enough accurate data on the rates of mental health problems for Maori. However, a nation wide community prevalence study, The New Zealand Mental Health and Wellbeing Survey, Te Rau Hinengaro, will show knowledge in this area. This will enable needs based approaches for services[vi] and to align funding so that it reflects the access need of 6 % for Maori not 3 % of the population with severe mental health disorders.

Historical data from 1993, based on inpatient activity only, suggested major differences in the way Maori used mental health services. Maori are seen accessing services later and with greater severity at the point of entry and tended to stay for shorter periods of time.[vii]

Admission rates for Alcohol Induced Psychosis and Drug Induced Psychosis for Maori are approximately five times that of Non-Maori. Diagnostic issues highlighted with Schizophrenia account for 17 % of first admissions and 45 % of readmissions. Readmission rates were significantly higher especially for Maori men and a third of Maori Men were admitted under compulsion. Maori comprise 50 % of inpatients at Forensic Units.[viii]

Maori have multiple and complex high support needs (head injury, history of criminality, issues with employment, accommodation, co-existing substance abuse, significant risk issues and issues with primary support).[ix]

Anecdotal evidence indicates that clinicians struggle with diagnosis (depression and schizophrenia) and this delays treatment. Also, they tend not to ask about depression symptoms and struggle with the interface between symptom complex and risk behavior.[x] There is a tendency to blame individuals for their predicament rather than see needs as part of the illness complex.

The following points outline the key issues in terms of mental health statistics.

Deprivation

There is a significant body of evidence that clearly indicates that deprivation impacts on the mental health status of a population. A study in South Auckland indicated that mental health clients living in deprivation decile 9 and 10 were over represented in mental health services compared to an under representation of mental health clients from less deprived areas. The table below illustrates that Maori clients represent a higher proportion of those needing high levels of support services across DHBs.

	% Maori	% Of the Population
Northland		29
Auckland Central	14.5	8
Waitemata	18.4	9
Counties Manukau	29	16

Homelessness

While homelessness is clearly identified as a component of deprivation, this is a significant issue that warrants further discussion.

The Ministry of Social Development's (MSD) recent research into Mental Health and Independent Housing estimated that around 8000 (17 %) consumers/tangata whaiora using mental health services from District Health Boards (DHBs) experienced housing difficulties, while the number of literally homeless consumers/tangata whaiora or those living in temporary or emergency accommodation could be as many as 2000 (4%).

This report writes that more important are the findings of the research about the nature of the housing difficulties that are faced by consumers/tangata whaiora. The principal areas of difficulty identified related to the cost and affordability of housing, lack of choice in housing options and discrimination. Therefore, intersectorial integrated initiatives are a priority, along with strong messages regarding a "zero tolerance for homelessness".

Co-existing Substance Abuse

In New Zealand people with alcohol disorders were 1.9 times more likely than those without to have another mental disorder. The association between alcohol and other disorders was by far the strongest for antisocial personality disorder (odds ratio 12.7) and drug abuse/dependency (odds ratio 7.2). Other disorders that showed elevated levels of risk when associated with alcohol included major depression, dysthymic disorder, and schizophrenia.[xi]

Alcohol dependence or abuse is the leading cause of admission to psychiatric institutions for Maori men, and the second most common cause of admission for Maori women.[xii.]

Current research identifies that cannabis is a widely used illicit drug amongst some groups in the Maori community.[xiii] The risk of experiencing psychotic symptoms may be higher among those who are vulnerable because of personal or family history of psychosis. There is also suggestive evidence that heavy cannabis use may exacerbate schizophrenia in vulnerable individuals and that heavy cannabis use among young people should be regarded as a marker for other significant mental health problems.[xiv]

Further research on the prevalence and incidence of cannabis use in the Maori community and its effect on mental health and wellness is required. Another drug that requires further research is "P", “Burn” or "Pure" which is New Zealand’s name for high purity methamphetamine.[xv]

Clinically, evidence demonstrates that, in extreme cases overt psychosis may be discernible for several days and cause symptoms lasting several weeks. Symptomatically this can be indistinguishable from schizophrenia. Moreover, long-term effects of methamphetamine use are pronounced and the propensity of methamphetamine users to become paranoid and/or fearless could lead to violent and self-protective behaviours, even when there is no threat to the user. Indeed, Police investigations into a number of recent high profile homicides have identified that the use of methamphetamine has being linked to the crime.[xvi]

Currently little data is available on methamphetamine hospital admissions. In order to increase knowledge of methamphetamine and the prevalence of the methamphetamine problem in New Zealand a number of better information gathering systems are being developed. As mentioned above, further work is needed regarding patterns of use, as there is anecdotal evidence that there is disproportionate use amongst some Maori communities.

Intellectual disability and psychiatric disorders.

An literature review prepared for the National Advisory Committee on Health and Disability (2003) outlined a prevalence survey in New Zealand[xvii] stating that the proportion of Maori was higher (11.3%) than would be expected on the basis of the population at the time (7.9%).

According to the most recent figures available (1996/97), the total numbers of “people with intellectual disabilities requiring assistance”, is twice as many as predicted from the 1971 survey (Health Funding Authority, Ministry of Health undated).

The review concluded that there are practical difficulties and variations in results of prevalence studies of intellectual disability. People whose disabilities may require less support or more intermittent supports are less easy to identify in prevalence studies.

Nevertheless a proportion of this group is more likely to be negatively affected by environmental stressors such as poverty and unemployment. They are also more likely to experience mental illness and to have problems with alcohol or other drugs. They are also less likely to access appropriate disability services. [xviii]

Suicide

Suicide is inherently linked to mental health status. Recent decades have witnessed increases in Maori youth suicide rates. NZHIS Health statistics (2000 Provincial results)[xix] concluded that suicide deaths have reduced in non-Maori, but have remained almost the same in Maori. In 2000, the rate of suicide in Maori was 13.1 per 100,000 compared with 10.7 per 100,000 in non-Maori.

Mental disorder, most commonly depression, appears to be the most important risk factor for suicide and suicide attempts. There are additional risk factors, which apply only to Maori and other indigenous youth. These are the risk factors relevant to cultural alienation, the impact of history through intergenerational modeling and behavioral transfer, and confusion over identity. Thus, working to reduce Maori youth suicide is a key direction. It is also in recognition that Maori youth are precious and vital to our collective survival as Maori.[xx]

An identified research gap is the Maori experience of family/whanau in today's society as anecdotal evidence identifies cultural diversity as an issue for tangata whaiora and whanau.[xxi]

EFFECTIVE SERVICES FOR MAORI

To work effectively with Maori it is necessary to know and understand the components that contribute to our wellbeing. This includes knowing how Maori culture is defined and the values, beliefs and behaviors that are part of that identity.

Professor Mason Durie (1994)[xxii] articulates mental health for Maori as being holistic in that mental health is that which nurtures:

- spirituality (taha wairua)
- family (taha whanau)
- psychological/mental/emotional wellbeing (taha hinengaro)
- religion (taha haahi)
- physiology (taha tinana)
- environment (taha turoa)
- social responsibility (taha tikanga)
- old world (te ao tawhito)
- new world (te ao pakehatanga)
- self (taha tangata)

Services must integrate clinical treatment with Maori development. Mason Durie[xxiii] (1998 pg 57) lists five principles for funding culturally effective services. These include choice, relevance, integration, quality and cost effectiveness.

The Blueprint (1998 pg 60) outlines the key areas for essential service components and the range of components that must be incorporated into all mental health services to meet the needs of Maori. This is to be aligned to the National Mental Health Standards and continual quality improvement programmes. These are:

- cultural assessment, to ensure the most appropriate and effective services are available to Maori,

- whanau and tangata whaiora participation, to foster whanaungatanga which is emphasised as the basis for healing,

- Maori language, to be used in the expression of Maori beliefs and values as integral to the healing process for Maori,

- Tikanga Maori, which provides an environment for Maori to acknowledge their beliefs and values as integral to the healing process,

- having a full range of choices for treatment processes, both cultural and clinical methodologies, process, approaches and treatments thus acknowledging the positive impact culturally based treatments have on the healing process,

- workforce development to include health professionals, clinicians, managers and decision makers to create an environment and service standards that are more suitable for dealing with tangata whaiora and whanau,

- performance measures that are relevant to Maori and go beyond the immediate clinical parameters and encompass the wider measures of good health for Maori.

The major challenge for the DHBs is to provide adequate, appropriate and effective services with limited resources to a population that has multiple and complex high support needs. Maori not only need to have more mental health services provided for them, they need to be able to choose whether they use mainstream services or kaupapa Maori services or both of these.

As mentioned previously, access is a key issue for Maori. There is three main issues regarding accessing of services. Firstly, the groups that do not access any services; secondly, those that have delayed access to care (also associated with misdiagnosis) and thirdly, people who access primary, secondary and tertiary care but 'bounce' around the services.

Therefore, the priorities of this plan include focusing on points of entry, adopting early intervention approaches, improving access to service's and the monitoring of access rates for Maori. This is further extended to the development of service delivery models, which align with Maori health wellness paradigms and ensuring they are appropriately resourced. Also, ensuring Secondary Maori Mental Health Services target the hard end of the spectrum (0.06 % of adult New Zealanders who have high support needs), as this is the clinical reality.[xxiv]

This highlights the area of workforce development and the need to link into national programmes. This includes recruitment and retention of Maori staff into the mental health sector; increasing the clinical skill base of the Maori providers and enriching the cultural responsiveness of mainstream providers, thereby promoting holistic paradigms of wellbeing; and increasing capacity and capability for Maori influence and leadership. This will include future development of kaupapa Maori services regarding Maori clinical leadership and direction.

Also, further discussions regarding the funding and management of Maori specific mental health services needs to occur. There is a range of options including maintaining the status quo through to the transfer of Maori Specific Mental Health Services to a Maori Operational Group, with Maori General Manager leadership and management. These options need further exploration by each DHB.

Additionally, a key recommendation from the Mental Health Commission 2002 review of Auckland service's, was the need to establish a Service Coalition to coordinate services within and across the three DHB districts' in Auckland.

In support of this recommendation, this plan proposes the establishment of a Regional Maori Mental Health Forum that links to the Network North Coalition. The purpose is to ensure a robust infrastructure so as to be able to provide advice regarding strategic planning for mental health services in the Auckland region. This includes service development priorities, the allocation of funding to mental health services by DHBs and the impact on Maori whanau, hapu and iwi.

STRATEGIC FRAMEWORK

VISION

- To provide an integrated range of mental health services for tangata whaiora and their whanau so that they may achieve whanau ora.

STRATEGIC THEMES

- Focusing on wellness
- Promoting holistic models of wellbeing that integrate clinical excellence and cultural responsiveness
- Ensuring the provision of high quality, clinically safe, culturally effective and efficient services
- Fostering collaboration within the mental health sector, the health sector and across other sectors

STRATEGIC PRIORITY AREAS (3-5 YEARS)

- Mental Health Services for Maori
- Capacity and capability development
- Information, research and analysis
- Quality and risk management
- Resourcing

HIGH LEVEL KEY RESULT AREAS

- By 2006, every funded provider will be able to initiate Maori cultural assessments for at least 60% of the Maori people accepted into their service, within seven days (except where the person has already had such an assessment within the previous 6 months). These assessments will include the person's whanau, and be based on both clinical and Maori models of care, assessment and treatment (including traditional Maori healing).

- By 2007, at least 50% of the staff of all providers will have received training in cross cultural communication with Maori, with a view to reducing cross cultural misdiagnosis and improving health outcomes for Maori.

- The reduction of the negative impacts of mental illness and disorders for Maori is a priority, so the establishment of a network of Maori recovery programmes for tangata whaiora across the region will have occurred by 1 July, 2007.

STRATEGY ONE - PRIORITY MENTAL HEALTH SERVICES FOR MAORI

Objective: To develop regional and local strategies that improves clinical excellence and cultural responsiveness in the following priority mental health services for Maori: Maori Specific Services, Whanau Services, Specialist Services, Alcohol and Drug Services and Dual Diagnosis Services.

ACTION	MEASURE	LED BY (Will include NGO Sector)	BY WHEN
Maori Specific Services:			
Identify a developmental pathway for clinical care integration.	Pathways identified.	CMDHB	June 06
Identify and implement change management strategies to improve early access rates to best practice clinical care.	Change management strategies identified and implemented.	DHBs	Dec 08
Identify and develop change management strategies that improve access to services for the rural population.	Change management strategies identified and implemented.	DHBs	June 08
Identify pathways for traditional Maori healing development.	Developmental pathways identified.	DHBs	June 07
Investigate options for funding and management of Maori Specific Mental Health Services within a Maori Operational Group.	Pathways identified.	DHBs	June 07
Whanau Services:			
Develop comprehensive clinically excellent and culturally responsive services for children and young people. These include: • Suicide prevention • Improved diagnosis of ADHD in youth • Initialisation of early psychosis intervention teams with a youth focus • Developing an inter-sectorial approach to managing conductive disorders	Early intervention approaches identified and implemented. Early psychosis intervention teams implemented. Joint projects established.	DHBs	Dec 08
Develop integrated initiatives that have an inter-sectorial approach to address homelessness. (For example, consistent processes between WINZ, Housing NZ and Mental Health Services)	Joint projects established.	DHBs	June 07
Develop and implement screening tool for risk factors for mental disorders, Substance abuse and Dependence.	Screening tool identified and implemented.	DHBs	June 07

ACTION	MEASURE	LED BY (Will include NGO Sector)	BY WHEN
Specialist Services:			
Identify and implement change management strategies to improve early access rates to best practice clinical care.	Change management strategies identified and implemented.	DHBs	June 08
Develop tangata whaiora based initiatives.	Initiatives identified and implemented.	DHBs	June 06
Develop consistent cultural assessment tools	Cultural assessment tools implemented	DHBs	June 05
Increase collaboration between DHB and NGO.	Joint projects established.	DHBs	June 06
Identify intensive community support needs.	Intensive community support needs analysis completed.	CMDHB	June 05
Develop service delivery models, which align with Maori health wellness paradigms. (For example ACT).	Pathways identified.	CMDHB ADHB WDHB	June 06
Increase capacity and capability of Secondary Maori Mental Health Services to target the hard end of the spectrum (0.06 % of adult New Zealanders who have high support needs).	Pathways identified and implemented.	DHBs	June 07
Alcohol and Drug Services:			
Develop integrated initiatives that have an intersectoral approach to address cannabis and "P" drug use	Joint projects established.	DHBs	June 06
Identify and develop change management strategies that improve access to services for the rural population.	Change management strategies identified and implemented.	DHBs	June 06
Dual Diagnosis:			
Develop integrated therapeutic approaches to support people with co-existing disorders, and increase access to such services	Integrated therapeutic approaches implemented.	DHBs	June 07
Develop dedicated dual diagnosis workers within a range of team environments.	Number of dual diagnosis workers increased.	DHBs	June 08
Develop an early intervention model.	Model implemented within services.	DHBs	June 08

STRATEGY TWO - CAPACITY BUILDING AND CAPABILITY DEVELOPMENT

Objective: To develop the capacity and capability of whanau, hapu, iwi and mental health services by promoting holistic models of wellbeing that integrate clinical excellence and cultural responsiveness.

ACTION	MEASURE	LED BY (Will include NGO Sector)	BY WHEN
Whanau Participation:			
Develop strategies to maximise the role of whanau in the delivery of services to tangata whaiora with a particular emphasis on customised 'whanau inclusive packages of care".	Whanau-inclusive packages of care developed.	WDHB	June 06
Kaupapa Maori Provider Development:			
Identify a developmental pathway for Kaupapa Maori Providers to increase their clinical input (including clinical expertise and paradigms) to enrich the care of tangata whaiora and their whanau.	A plan for Kaupapa Maori Providers to provide clinical services is developed.	ADHB	June 06
Undertake a review of Kaupapa Maori Providers to identify ongoing viability and sustainability requirements.	Review completed with a plan to maintain viability and sustainability.	MaPO	June 05
Mainstream Provider Development:			
Develop and implement a Treaty of Waitangi responsiveness framework.	Framework completed.	Tumu Whakarae	June 05
Develop the capacity of the Regional Co-Ordination Service to competently and appropriately assess the accommodation and support needs of Maori.	RCS develops Maori capacity.	MaPO	Dec 05
Maori Workforce Development:			
Identify priority development plans that are consistent with National workforce programmes (such as Te Rau Matatini) and other regional plans.	Priority areas identified.	DHBs	Dec 05
Non-Maori workforce Development:			
Identify priority development plans that are consistent with National workforce programmes (such as Te Rau Matatini) and other regional plans for the non-Maori workforce for the four districts.	Priority areas identified.	ADHB	Dec 05

STRATEGY THREE – INFORMATION, RESEARCH AND ANALYSIS

Objective: To have robust in-depth information and analysis related to Whanau Hinengaro Oranga, Maori mental health needs so as to better determine future needs and planning of services.

ACTION	MEASURE	LED BY (Will include NGO Sector)	BY WHEN
Ethnicity Data Collection:			
Expand 'Train the Trainer' programmes for ethnicity data capture to all mental health services, in alignment with national protocols for collection, recording and analysis of ethnicity data collection.	Training rolled out across all mental health services.	DHBs	June 05
Information collection and analysis for planning:			
Develop a plan to improve the collection of contract reporting information.	Plan completed	NDHB	June 05
Identify initiatives and possible further studies from current national prevalence study (Te Rau Hinengaro) within the northern region to ensure a needs-based approach to service planning.	Initiatives and further studies identified.	WDHB	Dec 06
Extend current work regarding the collection of data for hospital admissions for the drug 'P' methamphetamine, so as to provide accurate data regarding prevalence and patterns of use.	Dataset completed and implemented across the northern region.	CMDHB	Dec 06
Undertake a detailed quantitative and qualitative review of utilization within the northern region.	Review completed.	DHBs MaPO	Dec 06
Information Sharing:			
Develop a regional framework of Maori health information collected so that trends and gaps are communicated to the sector.	Information communicated.	DHBs	Dec 06
Research:			
Develop and implement a comprehensive Maori needs analysis methodology.	Methodology completed.	MaPO	Dec 04
Increase capacity and capability of Maori researchers and research proposals so as to be funded/linked with the Health Research Council.	Increase the number of research proposals funded by HRC within the northern Region.	DHBs	Dec 08

ACTION	**MEASURE**	**LED BY** (Will include NGO Sector)	**BY WHEN**
Undertake kaupapa Maori research that contributes to Maori health gain priority areas and reducing inequalities.	Research funded and completed.	DHBs	Dec 07
Undertake research on the prevalence and incidence of cannabis use in the Maori community and its effect on mental health and wellness.	Research funded and completed.	DHBs	Dec 06
Undertake research on the prevalence and incidence of 'P' Methamphetamine use in the Maori community and its effect on mental health and wellness.	Research funded and completed.	DHBs	Dec 06
Undertake research that explores the Maori experience of family/whanau in today's society.	Research funded and completed.	DHBs	Dec 06
Design, conduct, analyse and disseminate high quality research on priority areas for Maori mental health in northland and Auckland through partnerships with tangata whaiora and their whanau.	Research funded and completed.	DHBs	Dec 06
Outcome Measures:			
Develop appropriate Maori clinical and non-clinical outcome measures and performance indicators (aligned to the National work programme) for all providers.	Measures developed.	Tumu Whakarae	Dec 04
Include Maori clinical and non-clinical outcome measures and performance indicators in all provider contracts.	Indicators developed.	DHBs	June 05

STRATEGY FOUR – QUALITY AND RISK MANAGEMENT

Objective: To ensure the provision of high quality, clinically safe, culturally effective and efficient services.

ACTION	MEASURE	LED BY (Will include NGO Sector)	BY WHEN
Planning:			
Establish a Regional Maori Mental Health Forum that links to the NDSA, Network North Coalition to provide advice on strategic planning for mental health services in the Auckland region.	Group established.	DHBs	Dec 04
Ensure robust planning systems and processes for Maori mental health are in place to integrate Maori planning, funding and monitoring into the current planning systems and processes of the NDSA.	Systems and processes established.	ADHB	Dec 05
Ensure Kaupapa Maori and mainstream providers have best practice systems and processes in place to ensure high quality clinical and cultural responsive services. (To be linked to the national mental health standards and continual quality improvement programmes).	98% Kaupapa Maori Mental Health and mainstream providers can evidence a best practice system.	MaPO	June 05
Establish a regular programme of monitoring and evaluating provider effectiveness, with emphasis on access rates.	Framework for monitoring and evaluation programmes implemented.	MaPO	June 05
Develop and implement a satisfaction survey for tangata whaiora.	Survey implemented in services.	DHBs	Dec 04

STRATEGY FIVE – RESOURCING

Objective: To ensure the provision of high quality, clinically safe, culturally effective and efficient services that demonstrate Maori health gains and reduce inequalities in health.

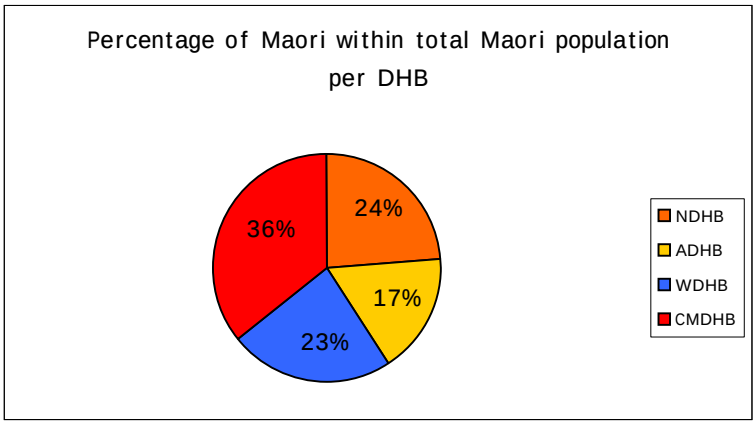
ACTION	MEASURE	LED BY (Will include NGO Sector)	BY WHEN
Blue Print Funding:			
Work with the Mental Health Commission to determine new Blueprint benchmarks for Maori and integrate the benchmarks into the annual planning process.	Benchmarks reflect Maori Mental Health Gain Priority in the Northern region.	DHBs	Dec 04
Ensure Blueprint benchmarks are achieved by Maori	Benchmarks reflect Maori Mental Health Gain Priority in the Northern region.	DHBs	Dec 08
Equitable Funding:			
Investigate and address regional and local funding inequities (with a particular focus on the pricing framework and models)	Pricing Framework developed and adopted	DHBs MaPO	June 05
Work towards equitable funding for Mental Health Providers whom provide services within the Northern region	Pricing Framework developed and adopted	DHBs MaPO	Dec 06

APPENDICES

DEMOGRAPHIC PROFILE

Maori make up fourteen percent (14%) of the total population in New Zealand (2001)[1]. By the year 2021, this is estimated to rise to eighteen percent (18%). The total population of Maori in the Auckland/Northland region is 170,949, thirteen percent (13%) of the whole region.

Thirty-six percent (36%) live in Counties Manukau DHB, twenty-four (24%) in Northland DHB, twenty-three (23%) in Waitemata DHB and seventeen (17%) in Auckland DHB.

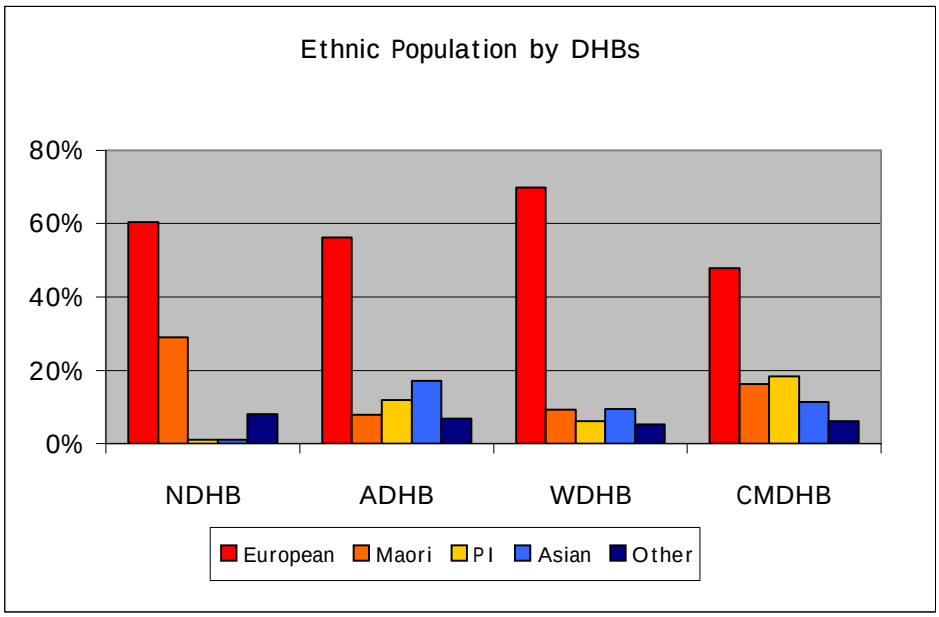


Twenty-five percent (25%) of Maori in New Zealand live in the Auckland/Northland region. The ethnic distribution in the region is shown in the table below. Northland is twenty-nine percent (29%) Maori, Counties Manukau sixteen percent (16%), Waitemata nine percent (9%) and Auckland eight percent (8%).

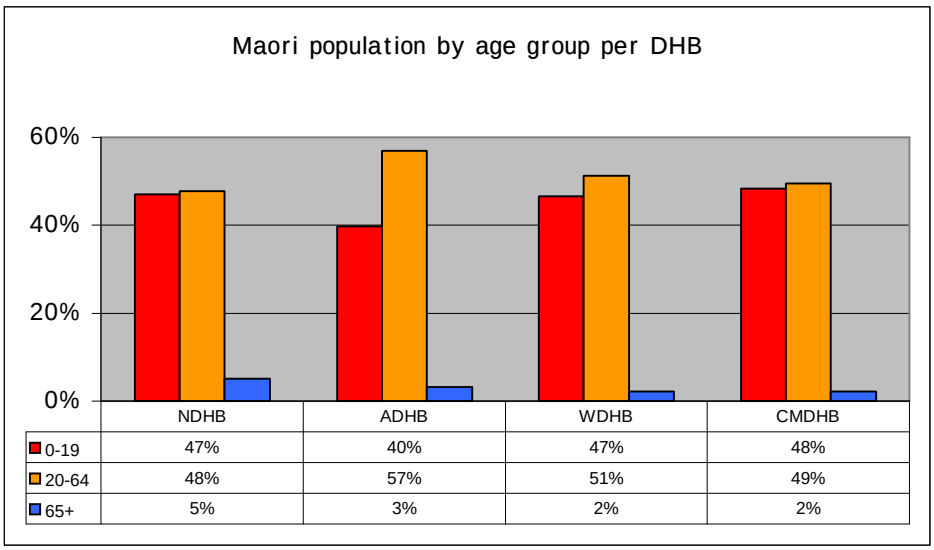
	NDHB	ADHB	WDHB	CMDHB	Total
Maori	40,722	29,139	39,696	61,392	170,949
Total population	140,088	367,740	429,747	375,510	1,313,086
% of Maori out of total DHB population	29%	8%	9%	16%	13%

[1] Unless otherwise stated, all figures are 2001 projections from the 1996 Census, the most up to date ethnic splits available. Please note, these population figures do not include undercount or those temporarily overseas and therefore are conservative estimates.

The graph below shows the Maori population (orange) compared to other ethnic groups in each DHB. There is a greater percentage of Maori in Northland than in any of the metro DHBs.



The following graph shows the age breakdown of the Maori population. The majority of the population in each DHB is aged between 20 and 64. In Northland and Counties Manukau this group is only slightly larger than the 0-19 population indicating a more youthful population than in Waitemata and Auckland. There are only a very small percentage of Maori over 65 years. Overall, 46% of the Maori population is between 0-19, 51% between 20-64 and only 3% over 65+.



	NDHB	ADHB	WDHB	CMDHB
0-19	47%	40%	47%	48%
20-64	48%	57%	51%	49%
65+	5%	3%	2%	2%

CURRENT POLICY SUMMARY

The following summarises the key themes identified from the analysis of key national, regional and local documentation:

- Focus on recovery
- Strategic partnerships and alliances (intersectorial and intrasectorial relationships)
- Consultation with tangata whaiora and their whanau
- Addressing inequalities in access
- Workforce development
- Improving iwi, hapu and whanau wellbeing
- Creating choice for Maori between kaupapa Maori and mainstream services
- Strengthen kaupapa Maori services
- Contribute to the development of resilience and life skill development
- Expanding the role of primary mental health care providers
- Equitable funding
- Focus on prevention and early detection

CONSULTATION SUMMARY

The following summarises the key themes identified during the consultation process with funders, providers (Maori and non-Maori) and tangata whaiora and their whanau about the mental health needs of Maori in the northern region:

- Focus on waiora (wellness) and mental health promotion, prevention and education
- Recognise the role of tohunga, kaumatua and rongoa Maori
- Minimise institutionalisation for tangata whaiora and their whanau
- Support mainstream enhancement in areas of priority (e.g. acute services)
- Support the development of kaupapa Maori services[2] across the continuum
- Support Maori workforce development
- Provide services in local communities (services that move around people rather than people around services)
- Provide greater support to whanau and local communities to enable them to support tangata whaiora
- Work across sectors to maximise health outcomes
- Improve the collection, storage and use of information
- Improve co-ordination and co-operation within and across services
- Improve funding and planning systems and processes within the mental health sector

[2] Note that the definition of "kaupapa Maori services" is "Maori governed and Maori managed"

GLOSSARY

Maori	English
Aroha	Desire to work responsibly with/for each other
Hapu	Sub-tribe (also, to be pregnant)
Hinengaro	Emotional well being, mental health
Humarie	Be sensitive, calm, reliable
Iwi	Gathering of subtribes, people from the whenua (also, means human bone)
Kaiawhina	Helpers. In health, usually considered to a nurse or social worker
Kawanatanga	Governance
Mana	Authority
Manaaki	Take generous care of each other, anticipate each others concerns and situation
Manaakitanga	Hospitality and care
Oranga	Wellness
Pono	Honest, open work that shows integrity
Rangatiratanga	Self identity
Rongoa	Medicinal, remedy, cure,
Tangata Mauiui	Patients
Tangata Whaiora	Maori people seeking wellness, mental health consumers
Tinana	Physical body or being
Tikanga	Process and the action of implementing cultural customs and protocols
Tupuna	Ancestors
Turangawaewae	Place of standing, normally said to be the place from where one's personal ancestors originate
Wairua	Spiritual
Whaiora	Consumer or user of health services
Whakaiti	Humble one's self so the message can be heard
Whanau	Extended family (also, to be born)
Whanaungatanga Whakawhanaungatanga	Build the relationships necessary, to truly honor others, relationship-ness
Whenua	Land, ground, earth, country, placenta

BIBLIOGRAPHY

Alcohol Advisory Council of New Zealand, Kaunihera Whakatupato Waipiro o Aotearoa and The Ministry of Health, Manatu Hauora, (March 2001). National Alcohol Strategy 2000 –2003. The Alcohol Advisory Council of New Zealand, Kaunihera Whakatupato Waipiro o Aotearoa, Wellington, New Zealand and The Ministry of Health, Manatu Hauora, Wellington, New Zealand. Sourced at http://www.moh.govt.nz

Bray, Anne (2003) Demographics and characteristics of people with an intellectual disability Review of the literature prepared for the National Advisory Committee on Health and Disability to inform its project on services for adults with an intellectual disability. Wellington. National Advisory Committee on Health and Disability National Health Committee. Sourced at: http://www.nhc.govt.nz

Bushnell J, Carter H, Howden-Chapman P. A review of the epidemiology of substance use disorders in New Zealand. Wellington: Ministry of Health; 1994. Unpublished. Sourced at: http://www.rnzcgp.org.nz/alac/info/Co%20morbidity.pdf

Counties Manukau DHB (2001) Counties Manukau Health Profile.

Lawson – Te Aho, k. (1998) A Background Document to Support Kia Piki Te Ora O Te Tamariki. A Review of Evidence. Wellington Te Puni Kokiri, Ministry of Maori Development. Sourced at: http://www.moh.govt.nz

Ministry Of Health (1998) Blueprint For Mental Health Services. What New Zealand Needs. Wellington Ministry Of Health.

Ministry Of Health (2003) Health and Independence Report Director-General's Annual Report On The State Of Public Health. Wellington Ministry Of Health.

Ministry Of Health (2002) He Korowai Oranga, Maori Health Strategy. Wellington Ministry Of Health.

Minister of Health (2003). Implementing the New Zealand Health Strategy 2003. The Ministers Third Report On Progress On The New Zealand Health Strategy. Wellington, Ministry of Health.

Ministry of Health (2002) New Zealand Primary Mental Health A review of the opportunities. Wellington, New Zealand. Sourced at: http://www.moh.govt.nz

Ministrial Action Group on Drugs (2003) Methamphetamine Action Plan. Sourced at: http://www.ndp.govt.nz/pubs/MethamphetamineActionPlan.pdf

Morrison AA, Beasley DMG, Williamson KI. (1976) The Intellectually Handicapped and their Families: A New Zealand survey. Wellington: Research Foundation of the New Zealand Society for the Intellectually Handicapped. Cited in Bray, Anne (2003) Demographics and characteristics of people with an intellectual disability Review of the literature prepared for the National Advisory Committee on Health and Disability to inform its project on services for adults with an intellectual disability. Wellington. National Advisory Committee on Health and Disability National Health Committee. Sourced at: http://www.nhc.govt.nz

van Altvorst, S. (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui. Auckland. NZ. March

Wells J, Bushnell J, Joyce P, Oakley-Browne M, and Hornblow A. Problems with alcohol drugs and gambling in Christchurch New Zealand. In Abott M.W. (ed) Alcohol, drug dependence and disorders of impulse control. Auckland: Mental Health Foundation; 1992. Cited at: http://www.rnzcgp.org.nz/alac/info/Co%20morbidity.pdf

http://www.ndp.govt.nz/cannabis/cannabis.pdf

http://www.mhrds.govt.nz

ENDNOTES

i Ministry Of Health (2003) Health and Independence Report Director-General's Annual Report On The State Of Public Health. Wellington Ministry Of Health.

ii Ministry Of Health (1998) Blueprint For Mental Health Services. What New Zealand Needs. Wellington Ministry Of Health.

iii Ministry of Health (2002) New Zealand Primary Mental Health A review of the opportunities. Wellington, New Zealand. Sourced at: http://www.moh.govt.nz

iv Dr. Sylvia van Altvorst (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui, Auckland, March.

v Counties Manukau DHB (2001) Counties Manukau Health Profile Page 8

vi http://www.mhrds.govt.nz

vii Minister of Health 2003. Implementing the New Zealand Health Strategy 2003. The Ministers Third Report On Progress On The New Zealand Health Strategy. Wellington, Ministry of Health. And Dr. Sylvia van Altvorst (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui, Auckland, March

viii Dr. Sylvia van Altvorst (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui, Auckland, March

ix Dr. Sylvia van Altvorst (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui, Auckland, March

x Dr. Sylvia van Altvorst (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui, Auckland, March

xi Wells J, Bushnell J, Joyce P, Oakley-Browne M, and Hornblow A. Problems with alcohol drugs and gambling in Christchurch New Zealand. In Abott M.W. (Ed) Alcohol, drug dependence and disorders of impulse control. Auckland: Mental Health Foundation; 1992. And Bushnell J, Carter H, Howden-Chapman P. A review of the epidemiology of substance use disorders in New Zealand. Wellington: Ministry of Health; 1994. Unpublished. Cited at: http://www.rnzcgp.org.nz/alac/info/Co%20morbidity.pdf

xii Alcohol Advisory Council of New Zealand, Kaunihera Whakatupato Waipiro o Aotearoa and The Ministry of Health, Manatu Hauora, (March 2001). National Alcohol Strategy 2000 –2003. The Alcohol Advisory Council of New Zealand, Kaunihera Whakatupato Waipiro o Aotearoa, Wellington, New Zealand and The Ministry of Health, Manatu Hauora, Wellington, New Zealand. Sourced at http://www.moh.govt.nz

xiii http://www.ndp.govt.nz/cannabis/cannabis.pdf

xiv http://www.ndp.govt.nz/cannabis/cannabis.pdf

xv Methamphetamine Action Plan. Ministerial Action Group on Drugs 2003. Cited at: http://www.ndp.govt.nz/pubs/MethamphetamineActionPlan.pdf

xvi Methamphetamine Action Plan. Ministerial Action Group on Drugs 2003. Cited at: http://www.ndp.govt.nz/pubs/MethamphetamineActionPlan.pdf

xvii Morrison AA, Beasley DMG, Williamson KI. (1976) The Intellectually Handicapped and their Families: A New Zealand survey. Wellington: Research Foundation of the New Zealand Society for the Intellectually Handicapped. Cited in Bray, Anne (2003) Demographics and characteristics of people with an intellectual disability Review of the literature prepared for the National Advisory Committee on Health and Disability to inform its project on services for adults with an intellectual disability. Wellington. National Advisory Committee on Health and Disability National Health Committee. Sourced at: http://www.nhc.govt.nz

xviii Bray, Anne (2003) Demographics and characteristics of people with an intellectual disability Review of the literature prepared for the National Advisory Committee on Health and Disability to inform its project on services for adults with an intellectual disability. Wellington. National Advisory Committee on Health and Disability National Health Committee. Sourced at: http://www.nhc.govt.nz

xix http://www.nzhis.govt.nz/stats/suicidefactsheet.html

xx Lawson – Te Aho, k. (1998) A Background Document to Support Kia Piki Te Ora O Te Tamariki. A Review of Evidence. Wellington Te Puni Kokiri, Ministry of Maori Development. Sourced at: http://www.moh.govt.nz

xxi Dr. Sylvia van Altvorst (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui, Auckland, March

xxii Dr. Sylvia van Altvorst (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui, Auckland, March

xxiii Mental Health Commission, (1998) Blueprint for Mental Health Services in New Zealand, How Things Need to Be' Wellington, New Zealand

xxiv Dr. Sylvia van Altvorst (2004) Maori Mental Health. PowerPoint Presentation. Tumu Whakarae, Maori Managers, National Hui, Auckland, March