

**MENTAL HEALTH IN
PRIMARY HEALTH CARE**
TRM/03/05

Holdaway, M.

**Published in October 2003 by
Te Rau Matatini**

**Te Pūtahi-ā-Toi, Massey University
Private Bag 11222, Palmerston North, New Zealand**

ISBN: 0-9582444-4-8

**This document is available on the website of Te Rau Matatini:
<http://www.matatini.co.nz>**



TE RAU MATATINI
AOTEAROA MĀORI MENTAL HEALTH WORKFORCE DEVELOPMENT

CONTENTS PAGE

1.	Introduction.....	3
1.2	Te Rau Matatini	4
2.	Te Rau Whakawhānui: Māori Primary Health Care Workforce Development	6
3.	Te Rau Whakawhānui Primary Care Provider Profile	8
3.1	Pilot Site Primary Healthcare Providers	8
4.	Survey findings.....	10
4.2	Age Group.....	10
4.3	Primary Health Care Workforce Roles	10
4.4	Primary Health Care Career Duration.....	10
5.	Training Needs Assessment Findings.....	10
5.1	Professional Training	11
5.2	Training and Ongoing Educational Programmes.....	11
5.3	Importance of Competence in Both Clinical and Cultural Expertise	11
6.	Key Training Needs: Focus group interviews	11
6.1	Workforce Development.....	12
6.2	Cultural Competency	13
6.3	Intersectoral Issues.....	13
6.4	Organisational Development	14
7.	Te Rau Whakawhānui Training.....	15
8.	What Works in Primary Care?	15
8.1	Background.....	15
8.2	Models within primary care	16
8.3	General practitioner-led services.....	16
8.4	Nurse-led services.....	17
8.5	Integration of primary and social care	18
8.6	Management of links between primary and secondary care	19
8.5	Shared Care.....	19
8.6	New roles	20
8.7	Knowledge skills and training	21
8.8	Funding	22
8.9	Strategies for building and sustaining capacity	22
	References	23

1. Introduction

In New Zealand, interest in Early Intervention has been guided by the work of EPPIC a pioneering Early Intervention for Psychosis Service set up by Pat McGorry in Melbourne (McGorry et al., 1996). On the topic of Early Intervention Services, the New Zealand Blueprint for Mental Health Services (MHC,1998) states:

All services working with people who have developing mental illness need to practice early intervention strategies aimed at not only preventing or limiting relapses but also at reducing and preventing the development of high support needs or disability.

Early intervention is fundamental in preventing progress towards a full-blown disease, in controlling symptoms and improving outcomes. Māori are over-represented in services, especially forensic services where 33% of those treated are Māori.

1.1 Māori and first-episode psychosis

Current needs of Māori within mental health services have been clearly highlighted within the Blueprint for Mental Health Services (MHC, 1998). The Blueprint lists a range of components that must be incorporated into all Mental Health Services to meet the needs of Māori, (see page 61; 91-95). Two key concerns are late intervention for Māori and the lack of effective and, or appropriate services for Māori. Māori have a younger age profile than non-Māori. In the 1996 Census 23.6% of the total 0-14 years age group and 19.7% of those aged 15–17 identified as Māori (Ryan, 1998). This means an increasingly large proportion of people entering the high-risk age group for psychosis are Māori. In addition, Māori access mental health services at a much later stage in their illness and consequently are more likely to be seriously ill by the time they present to a service. Māori are also more likely to be admitted into psychiatric institutions as a result of compulsory admission for assessment and treatment (MHC, 1998: 62). Both delayed access to treatment (Norman & Malla, 2001) and trauma associated with first episode psychosis (McGorry et al., 1991) are risk factors for poor treatment outcomes.

An important means of dealing more effectively with the high admission and readmission rates is through the introduction of early intervention programmes and services... Early intervention through Community Mental

Health Centres which are able to offer expert diagnostic services within an appropriate cultural context could have a significant impact on late and compulsory admission rates by developing more, appropriate management plans. (MHC, 1998, p. 63)

Mental disorders are associated with significant physical and social disability and increased mortality. A WHO analysis of the global disease burden shows mental health disorders make up five of the 10 leading causes of disability world wide, and that the proportion of the global disease burden attributable to mental disorder is likely to increase by 50 percent between now and 2020 (Ustun, Sortorius, 1995), New Zealand is no exception.

This project aims to extend the capacity of primary health care professionals and community support workers, to become more informed and involved in early recognition of mental health problems and mental disorders. Anxiety disorders, along with depression and substance abuse, comprise a group of disabling conditions whose presentation is often assumed normal. They frequently escape the notice of primary health professionals. Early recognition of these disorders will help facilitate early intervention. This reduces distress, disability and burden of illness, and has the potential to reduce the need for secondary mental health services.

Early intervention is fundamentally about enhancing the capacity for early recognition of mental health problems and mental disorders by primary care services. This means identifying and providing appropriate responses for people with the early signs and symptoms of a developing disorder such as, anxiety, depression, or substance abuse. Frequently these people and/or their families often have not recognised their emerging symptoms or sort appropriate help.

1.2 Te Rau Matatini

This report presents the initial findings from the training needs assessment for the Māori primary health care workforce project conducted by Te Rau Matatini. The information was gathered to inform the development of a training package to increase the capacity of Māori working in primary care to provide early intervention in mental health problems and mental disorders.

Te Rau Matatini is a national Māori Mental health workforce development programme funded by the Ministry of Health. Although based at Massey University's School of Māori Studies (Turitea campus), the programme is governed by an independent Trust Board with the primary purpose of promoting Māori workforce development in the mental health sector. Te Rau Matatini currently manages nine related projects, one of which (Te Rau Whakawhānui) is reported in this publication.

Established in December 2001, Te Rau Matatini is one of a number of initiatives funded by the Ministry of Health to strengthen the Māori mental health workforce as expressed in *Tuutahitia te wero: Meeting the challenges, Mental Health Workforce Development Plan 2000–2005* (Health Funding Authority, 2000).

The Ministry expects that through the national organisation selected to oversee the Programme, Te Rau Matatini will:

- provide sector leadership and advocacy for Māori mental health workforce needs
- analyse Māori mental health workforce needs such as kaupapa Māori provision, bicultural and mainstream services
- foster a strategic and coordinated approach to workforce issues
- create/encourage/foster links with other mental health sector workforce development initiatives
- monitor and evaluate the impact of training and unmet training needs
- create strong operational links to the Māori mental health sector, including service users, service providers, other mental health workforce agencies, education providers and central agencies such as the Ministries of Health and Education, the Mental Health Commission, the relevant colleges, professional bodies, and standard-setting bodies
- establish effective links with Māori including support of Iwi and Māori providers, and
- determine appropriate education and training goals, modalities and materials, and deliver or arrange delivery of education and training.

2. Te Rau Whakawhānui: Māori Primary Health Care Workforce Development

The overall purpose of the Māori primary workforce development pilot project is to increase the capacity of Māori primary health workers to provide early recognition and intervention in mental illnesses. Primary health services provided by Māori are developing throughout New Zealand and are a key point of referral to secondary mental health services. It is therefore important that these services are able to address mental health concerns by ensuring that their staff, including registered nurses and community health workers, are able to assess, screen, detect, and refer to appropriate services, people with mental health problems or mental disorders. Secondly in order for these services to be effective they need to develop stronger links with specialist mental health services. Underlying the project are twin concerns about late interventions for Māori, and the ability of mental health services to treat only a fraction of people who have mental health problems or disorders.

Early Intervention takes place when people are displaying the early signs and symptoms of a mental health problem such as anxiety or depression or mental disorder, or developing or experiencing a first episode of mental illness such as schizophrenia. Its focus is primarily on the individual who is experiencing problems, although the ongoing contribution of promotion and prevention interventions are fundamental to its effectiveness.

Early intervention relies on strategies for identifying the early signs and symptoms of mental health problems and mental disorders. It also requires immediate access to treatment strategies that are effective and appropriate for the people experiencing an at-risk mental state or the early stages of disorder. It is essential that interventions do not, in themselves, exacerbate the course or burden of mental health problems or a mental disorder. Strategies for early intervention become more disorder-specific as the signs and symptoms of the specific mental disorder become evident and in the instances of first episodes of mental disorder. Partnerships with consumers and whānau are vital for determining what comprises good practice in early intervention.

A literature review focussing on promotion, prevention and early intervention for mental health, workforce development and training needs for mental health, mental health services for Māori, and various policy documents on mental health both national and international, has been completed and has helped develop the foundations of our training package.

Two provincial primary healthcare sites (including one general practitioner provider) and a metropolitan site agreed to participate in the pilot training. An assessment of training needs was conducted in the sites, and this data combined with the data gathered from the literature review, informed the development of the training package which is currently being delivered at the pilot sites.

We have begun scoping phase two of the project, which will revolve around Māori Midwifery and Early Childhood services (i.e. Plunket), and Emergency Department services within District Health Boards (DHBs).

The overall expected outcome of the Māori primary workforce development pilot will be to meet the expressed professional development needs identified by Māori primary health care workers at the pilot sites, to up-skill the capacity of pilot services to recognise the early clinical/cultural features of a mental health problem and or mental disorder, and to enhance the links between primary and secondary services to enable timely and appropriate interventions. The pilot is expected to:

- increase the capacity to identify and recognise mental illness among Māori health workers in primary care settings
- increase the capacity for timely and appropriate consultation, or liaison with, or referral to specialist mental health services
- establish a national training standard as a baseline for future professional development of Māori primary health care services
- identify and clarify key areas of need for future development of mental health expertise among Māori primary health care services, and
- enable recommendations to be made for future primary care training.

3. Te Rau Whakawhānui Primary Care Provider Profile

The following section presents a profile of the Providers, details their current contracted services, and summarises the findings from both the survey and the focus group discussions undertaken to assess training needs.

3.1 Pilot Site Primary Healthcare Providers

As noted in the introduction two provincial primary healthcare sites (including one general practitioner provider) and a metropolitan site agreed to participate in the development of this project. The first two sites were both in provincial towns: one in Levin, Te Runanga O Raukawa, and the other in Whanganui, Te Oranganui.

Te Runanga O Raukawa Inc operates from Otaki, Levin, Palmerston North and Feilding.

The mission of Te Runanga O Raukawa Inc is:

to serve the best interests of, and be accountable to the hapu and affiliated Iwi of Ngati Raukawa ki te Tonga, as tangata whenua in the rohe "Mai i waitapu ki Rangataua, mai i miria te kakara ki Kukutaauaki". This includes members of the Iwi residing outside of the defined rohe.

They are currently contracted to provide the following health and disability services:

- Whānau Tamariki Ora Well Child and Support Service
- Disability Support Service
- Ngā Oranga O Te Rae Mental Health Support Service
- Alcohol and Drug Support Service
- Child Adolescent and Family Support Service
- Day Activities
- Contraception Service
- Whiti Ora Smoking Cessation Programme
- Hearing Assessment Service, and
- Mobile Nursing Service (Disease State Management).

Te Oranganui Iwi Health Authority operates from Whanganui, Ngāti Apa, Otaihape, Nga Rauru.

The underlying philosophy of Te Oranganui Iwi Health Authority is that:

Tino Rangatiratanga is the spiritual health that will ultimately provide holistic wellness for whānau, hapu & iwi and other peoples residing in the region.

To acknowledge the traditional social organisation of hapu and iwi as most ideal structures for service delivery to whānau, hapu & iwi. Inherent in these structures is the diversity & uniqueness of Tikanga & Kawa.

Te Oranganui currently provides the following health and disability services:

Te Korimako Community: Whānau ora: health promotion and prevention; Tamariki ora: well child checks; Te ha ora: quit smoking programme; Te pataka kai ora: nutrition and physical activities; hospital liaison patient visits and support Arohata services; independent living for the intellectually and physically disabled; and ACC home-based rehabilitation.

Te Waipuna Medical Centre incorporates several primary care services, including: General practitioner clinics; practice nurses clinics; midwifery and maternity support; rongoa Māori; a diabetic clinic; and a 50+ well health programme.

Hinengaro Hauora Māori Mental Health: 24 hour on call; community support; residential care; day activities programme; alcohol and drug counselling; rangatahi counselling; assessment and service coordination; whānau awareness and education; destigmatisation; interface between primary and secondary services. The service is staffed by registered nurses and includes a duly authorised officer.

Te Puawai Whānau Family Start: Advocacy and housing; home visits; family planning; budgeting; custody and access; building whānau and community networks; PAFT (parents as first teachers), legal matters.

Te Whānau O Waipareira Trust, the metropolitan site, operates from Henderson and covers mainly West Auckland. Their mission statement is:

To be a public forum for the people of Auckland, concerned with ensuring that facilities and resources are better utilised to benefit and assist the community.

Promoting economic, social and community development.

Their services include:

GP clinic; tamariki ora; maternity support; mobile nursing; disease management nurses; mental health education and support; addictions counselling; kai and nutrition education; cervical screening; health promotion, and home-based support services. Also included is the Waipareira Pasifica Family Start programme, which will also participate in the training.

4. Survey Findings

This section provides a summary of the survey findings from the pilot sites¹.

4.1 Gender

The majority of respondents across the sites were female.

4.2 Age Group

The majority were between 30 and 49 years old.

4.3 Primary Health Care Workforce Roles

The most common work roles from the pilot site survey were Māori health workers, community support workers, and community health workers who as a combined workforce constituted the largest group of workers across the sites. The second largest group was made up of practice nurses, disease state management nurses and rural nurses.

4.4 Primary Health Care Career Duration

When asked about the length of time they had spent in their current roles, the majority of respondents had been in their present role for 2–5 years and the remainder for 10–20 years.

5. Training Needs Assessment Findings

The following section provides findings from the training needs assessment conducted at the three pilot sites.

¹ Percentages were not used due to the small numbers of participants involved in the survey.

5.1 Professional Training

The registered nurses felt their clinical training had prepared them adequately or well for the demands of their current position. However, many felt that in terms of working with Māori in NGOs, their prior training (i.e., polytechnic), had not adequately prepared them for the demands of their current roles, i.e., working with Māori families/whānau, only 2 of the 8 registered nurses had had experience in mental health.

5.2 Training and Ongoing Educational Programmes

All three pilot sites had a number of different training/ongoing educational programmes including PAFT training, strengthening families, tikanga training and decolonisation courses, but no courses in mental health and /or early intervention in mental illness.

5.3 Importance of Competence in Both Clinical and Cultural Expertise

The concept of dual competency was seen as very important although some concern was raised about how to *blend the two different cultures i.e., clinical and tikanga Māori*. The concept of dual competency can raise some ethical dilemmas for current staff and it is acknowledged that an important component in ongoing training and development is to provide the knowledge and skills required to practice in both an ethically and culturally safe way. It is also important that with dual competencies we include a process whereby we implement appropriate models of supervision.

Another issue raised by health professionals was the extra time and resources needed to develop *cultural skills on top of clinical skills and how would this work*.

6. Key Training Needs: Focus Group Interviews

Focus group interviews were conducted at all sites with both registered nurses and community support teams. When specifically asked what their ‘primary training needs’ were, common themes included the general need for continuing education, ongoing training, or extension of professional skill base in both the clinical and the cultural domains of mental health work.

In terms of clinical training needs, mental health and clinical assessment were identified as areas of need, as was training in working with families with drug and alcohol issues; this was seen as especially necessary for the well-child support workers.

There was also a desire to understand *what is out there and what do they do and what is the most appropriate service* to meet the client needs. Many participants want to help, and recognise they are *...in a position to do so and are often the first to notice when things are going wrong but do not know what to do.*

6.1 Workforce Development

As all the participants were not primarily mental health focussed, enhancing mental health knowledge and skills of staff was seen as a vital first step: *we could deal with minor mental health if we knew how and had the right team.* All participants were very well aware of the current levels of mental illness within their whānau... *there is lots of depression in our families what can we do they have learnt to live with it ..and we miss what we could be doing.*

Participants want the knowledge and skills to help their whānau. They want the skills to be able to recognise the early warning signs, and the knowledge of when to refer and to whom, i.e., the most appropriate service for their whānau and the knowledge to work effectively with their whānau.

While participants currently accept there is a high tolerance of poor mental health, they are highly motivated to change not only their own tolerance level but also that of the communities in which they work: *we accept that this is how it is we must not accept this' It is me knowing how to advocate for my families and what resources are available.*

Many community health workers expressed a desire to have a nationally recognised certificate/diploma, and wanted recognition of prior learning considered. They want their training to be portable and transferable.

6.2 Cultural Competency

Although all the services have ongoing cultural training, all participants felt there was a need to develop Māori models of practice that were culturally relevant and appropriate for the services being developed, *we must work in a process that is safe for Māori.*

Many of the services have ongoing training with Māori providers such as Te Korowai Aroha, and are currently using Māori models of practice. As outlined above a key issue for many Māori staff is the lack of knowledge and skill required to work for Māori providers and whānau.

They also recognise the importance of understanding culture differences in the presentation of symptoms: *is this just them this is how they are or is there something wrong.* One of the problems for early intervention is the ability to define what actually constitutes a problem, i.e. what health workers should be worried about and what is normal for the client and the whānau.

The inclusion of Kaumatua in many services now to support staff and whanau is an important move forward in keeping Maori safe in our Mental health services. The use of Kaumatua in our pilot training was applauded by all participants and was viewed as being both supportive and making them feel safe.

6.3 Intersectoral Issues

A major issue for community support/health workers was the lack of recognition or respect *for our knowledge and skills from mainstream and others. They don't value our opinions.* Community health workers see an urgent need to develop intersectoral relationships and a team approach in order to improve outcomes for their whānau. They felt there was little or no sharing of information across the sector; many felt that once they had referred the whānau on, even if it was simply to their GP, they heard no more about the case. There was no feedback to the community support teams and often their families just *fell through the cracks. We need the skills and knowledge to change opinions in other sectors of health professions.* Many felt that to gain recognition and respect they needed the knowledge and skills to communicate effectively and efficiently across the sector and across professions.

They are very supportive of working towards a team approach, but felt *they were committed but other agencies and services aren't*. Participants also noted that there was very little sharing of information within services and across providers, although they were very keen to be part of the ongoing service development they felt their voices were not always heard.

6.4 Organisational Development

Participants expressed the need for support from management to fund ongoing training and development, and to support ongoing education through relief time. However, workload was seen as one of the main barriers to ongoing training and education. Most participants expressed a desire to up skill in the area of mental health but stated, *time is the biggest problem. We don't have time to do screening*. Another issue was the perceived lack of services and, or the very long waiting time *being aware is one thing but there are no services to back you up, and there is up to two months to get an appointment. There is not enough time to do the simplest things and not enough support*.

The lack of time and support were also seen as key issues by many registered nurses, especially those working as practice nurses. Some registered nurses, while recognising the importance of early intervention and the key role played by primary care providers, saw early intervention in mental health as a role for a practice nurse with an interest in mental health, i.e. the development of a new role within primary care services.

There was much enthusiasm from all those involved in the project, they were very keen to have the knowledge, skills, and information to put early intervention into practice, but competing demands in the primary care setting, such as limited time, frequent co-morbidity and the stigma associated with mental illness were all seen as major barriers to the implementation of any programme, especially by the practice nurses.

7. Te Rau Whakawhānui Training

Te Rau Whakawhānui training-needs assessment data have been used to guide Te Rau Matatini in promoting and developing training in early intervention to meet the needs of Māori working in the primary care sector. A developing Māori primary care workforce requires professional training in both clinical and cultural areas to meet the needs of a diverse and diversifying Māori population.

In maintaining consistency with the overall Te Rau Matatini framework, Te Rau Whakawhānui will endeavour to promote best practice in Māori primary health care service training. The project's ultimate aim is to contribute to best health outcomes for Māori primary health service consumers, and to achieve this Te Rau Matatini aims to strengthen the Māori primary health care workforce by encouraging a workforce committed to best practice based on the highest clinical standards, underpinned by indigenous values and concepts of healing. While some Māori primary health services are currently strong in clinical aspects of service delivery, others are strong in the cultural aspects of Māori primary health care work. The fundamental goal is to promote dual competency within the Māori primary healthcare workforce, thereby integrating both arms in the provision of best practice for Māori consumers in the wider primary care/mental health sector.

During July and August 2003 pilot a training-package was developed², informed by the survey data and focus group interviews, the literature review and advice from the Te Rau Whakawhānui Advisory group. These packages will be piloted and evaluated in three sites. Findings will help inform future training developments within the national Māori mental health workforce development area

8. What Works in Primary Care?

8.1 Background

Changes in legislation together with the current health reforms mean primary care practitioners and community health workers will have an increasingly important role

² See appendix 1

in the delivery of mental health care, and therefore need to develop innovative methods to fulfil this role. The literature discusses different structural models of primary care mental health services provision. Many of the issues raised in the literature are consistent with the initial findings in this project.

8.2 Models within primary care

Both internationally and nationally there is no clearly defined model for the provision of primary care mental health services. Each service, each practice, and each clinician/community health worker, develops skills and services to meet the needs of local populations. This is the strength, and the weakness, of primary care. Nevertheless, some themes emerge from the literature and the initial findings from this project.

8.3 General practitioner-led services

Traditionally, the general practitioner has led the provision of services for people with mental health problems and acted as gatekeeper to secondary services (Strong, 2000). While the success of this relies on GPs' ability to recognise and appropriately manage mental health problems, up to 50 per cent of clients/patients who present with depression and other mental health problems fail to have their symptoms recognised by the GP (Bushnell et al., 2001).

In New Zealand, in contrast to most other countries providing socialised health care, primary care is run as a private business with costs to patients. This may have an impact both on what sort of problems patients disclose to their GP, and the response of the GP to the patient who does disclose psychological difficulties (Bushnell et al., 2001). The major problem is current funding for general practitioners while GPs are funded for a 10-minute consultation, discussion of mental health issues may extend such a consultation to 30-60 minutes.

As well as the funding problem, another difficulty with early intervention services for Māori is just how easy it is to miss or misinterpret the signs of first-episode psychosis:

There is therefore a need for practitioners, whether they be Māori or not, to understand Māori phenomenology. Without an understanding of the phenomenology, on one hand we may infer there is nothing wrong with this

person, on the other hand we may infer there is too much wrong with this person, we can mistake a normal auditory experience with a 'hallucination', or mistake tangential thinking for allusive thinking (Durie, 2001).

Lack of funding is but one of a number of significant existing barriers to provision of effective primary mental health care. Other barriers include patient awareness and attitudes (stigma), GP/primary care clinician awareness and skills in detection and effective treatment, and lack of access to effective psychological interventions in primary care. GPs describe the cost and time barriers as actually having increased over the past decade.

8.4 Nurse-led services

Internationally, practice nurses have become increasingly involved in providing services for people with mental health problems in primary care, where they work as part of an integrated nursing team with community nurses, nurse practitioners, and midwives. Practice nurses have been successfully trained in the assessment and management of depression and problem solving in severe depression (Wilkinson et al., 1993), and are frequently involved in chronic disease management programmes and in the running of clinics. They have been shown to improve the health outcomes of people with both asthma and diabetes (Charlton et al., 1993; Parnell et al., 1993). Such nurse-led clinics offer systematic assessment, treatment, management of medication side effects, and assertive follow up with outreach to people.

Although most general practices in New Zealand have a practice nurse, their potential is probably underdeveloped. Interest in extending involvement in mental health care and in gaining further training about mental health among the practice nurses surveyed confirm the potential for improving the general practice-based delivery of mental health by extending the role of practice nurses. However, such nurses must be adequately prepared and trained. The low number of patients with mental health problems in some practices means that even with extensive training nurses would be unlikely to have sufficient contact with patients and families to be fully confident in this role (Gardner, 1999). Practice nurses would need to be supported by specialist mental health teams. Current difficulties in contacting the mental health team acts as a barrier to teamwork. An increase in the number of mental health specialists

working in the community would help reduce such barriers. Within the Te Rau Matatini projects we will also be working towards this goal.

There are currently several Mobile Māori DSM (Disease State Management) Nursing Services underway in New Zealand. These services provide an innovative and cost-effective way to reach communities and meet health needs across all sectors. Complimenting the work of other medical professions such as allied health, these services include promotion prevention, and early intervention, as well as management of disease. Recently the first Māori Nurse Practitioner was certified by the Nursing Council of New Zealand.

There is now the potential for these nurses and nurse-led PHOs (Primary Health organisations) to take on the management of primary mental health services. Given the limited availability of GPs in rural areas, nurses clearly have an important role in primary mental health, and this needs to be explored.

The role of the mental health nurse within the community also needs to be better understood because it is the community mental health nurses who are generally the main health supporters of many people with mental illness who live in the community (White, Roy & Hamilton, 1997).

Māori community health workers, who make up the bulk of the workforce in Māori services, will also have a key role to play in the development of primary mental health services and this role also needs to be defined.

8.5 Integration of primary and social care

Both the Blueprint for Mental Health Services (MHC, 1998) and the New Zealand Health Strategy (MOH, 2000) address the integration of services across health and social care. The Government has also placed a significant emphasis on partnerships to solve the problems of resources, communication, and coordination in health and social care. There are advantages to this greater integration of social care with health care as it should allow longer term planning of services with social inclusion and may also improve their efficiency. Māori primary care services have led the way in the development of innovative services and models of service delivery that best meet

local needs. These services are based on the aspiration of Māori for strong and vibrant communities that have initiative, capacity and self-direction.

8.6 Management of links between primary and secondary care

The link between primary and secondary care is of key importance in delivering mental health services. Traditionally, the link consisted largely of a referral letter from a general practitioner to a psychiatrist and vice versa. The Blueprint for Mental Health Services has acted as a catalyst for the further development of models that will integrate mental health services across primary/secondary care. Internationally, Cohen and Paton (1999) have identified four possible models of joint working between primary and secondary mental health services based within community mental health teams. A recent evaluation of early intervention for psychosis services in New Zealand (Turner et al., 2002) noted that the primary barrier to implementation of best practice for Early Intervention for Psychosis is resource constraints that impede most innovative community care initiatives. There needs to be further research to identify those services that work well and define how best to support such innovative programmes.

8.7 Shared Care

A recent evaluation of Early Intervention for Psychosis Services in New Zealand (Nelson et al., 2002) noted that large centres, i.e. Auckland, Wellington, and Christchurch, where there is a population base to support specialist services, have developed comprehensive services based on the EPPIC model (McGorry et al., 1996) and the IMHC approach of Ian Falloon (Falloon & Fadden, 1993). However, most services have taken the best pieces from all available approaches and adapted them to their local needs. They reported many areas where enthusiastic Early Intervention Staff were frustrated at the lack of resources support/understanding from others unfamiliar with the principles of Early Intervention.

Many services commented that they were unable to carry out the Early Intervention work they would have liked due to resource constraints. There were no systematic reviews of the outcomes undertaken.

With the emergence of PHOs, consideration needs to be given as to how shared care between adult mental health services and Māori providers might work. Given the over-representation of Māori in mental health services, future programmes need to consult with Māori consumers, Māori providers, and Māori mental health teams to ascertain whether their involvement in shared care would be beneficial and desirable. Given that the largest Māori clinical occupation is nursing, consideration should also be given to nurse-led shared care programmes (Nelson et al., 2003).

For a fully integrated approach, the future development of shared services should ensure that people with mental illness, minor or serious, can access the most appropriate service for their needs at any specific time, and ideally any transition between services should be seamless. The complexity of current programmes has in the past made this difficult.

Establishment difficulties and the complexity of programmes require a new and different relationship between services. Key points to be considered are the development of information systems, the development and implementation of training programmes, and the development of follow-up procedures so that clients are not lost in either system.

8.8 New roles

Some research suggests that new positions be created in the liaison area, where workers have a critical role in preparing and supporting people moving between services. As noted earlier this was an issue raised within the current project, particularly as most staff felt they were already working to capacity, and that research was necessary to understand the detail of their current role and gather further information about workloads of staff in these positions. Many agreed that in order to develop early intervention services new roles will need to be created within primary care.

In DHBs and NGOs where the population base does not justify the establishment of a comprehensive early intervention for psychosis service, it is suggested other more innovative models of practice be explored, e.g. the development of the 'first contact care' where a nurse/community health worker is employed as part of the primary care

team to ensure quicker access to more effective treatment for people with mental health problems. These health professionals will participate in the provision of information, assessment, screening and onward referral where appropriate. They will also be trained to deliver some brief evidence-based techniques such as anxiety management.

Many community health workers with both Family Start, and Whānau Ora contracts maintain they already do this. But for these services to be more effective the community health workers need to have strong links to secondary services. This will ensure opportunities for appropriate training and supervision, tasks that are vital for effective and safe service.

International literature suggests that for these services to be effective they should employ graduate psychologists (Cohen, 2003). Given the very limited number of Māori psychologists currently in the New Zealand workforce, specifically in Māori led services, this is currently not an option, but it does not preclude further training for both registered nurses and community health worker in clearly defined mental health scopes of practice.

In June 2002 the Health Practitioners Competence Assurance Bill (HPCA) was tabled in the House. The HPCA is intended to replace the 11 out-of-date statutes with a single Act. It provides an important opportunity to develop a more flexible workforce while still assuring the competence of individual practitioners.

The key to flexibility in the HPCA is the development of ‘scopes of practice’ by registration authorities. Scopes of practice are the services a practitioner is competent to offer and the boundaries within which these services can be offered. Conditions, such as the requirement to practice under supervision, may also be placed on an individual practitioner. There will be overlaps between the scopes of different professions, reflecting the changing nature of service delivery.

8.9 Knowledge skills and training

If there is to be meaningful collaboration within and across services, training programmes need to incorporate cultural and clinical skills as well as issues of

working relationship. Issues of building trust both with clients and within and across services will also provide consumers with some confidence in the nurses' and community health workers' skills and knowledge.

There are substantial problems both defining and implementing consistent education and training plans in primary care. Workloads in primary care have expanded substantially, without a corresponding increase in resources to meet these loads. Staff time is fully employed with user contact, and there is little or no time left for training.

8.10 Funding

Most programmes are not fully funded, and services meet the many hidden cost through a variety of ways, not least being that to meet clients' needs staff committed to the service work well beyond their contract with little recognition and/or remuneration to deliver those services they feel are required.

8.11 Strategies for building and sustaining capacity

Although workforce development focuses on improving the skills and knowledge of staff within organisations, on its own it is unlikely to bring about sustainable change. It is therefore important to see this project within the overall framework of Te Rau Matatini, which has been developed to ensure;

- a cohesive and strategic direction consistent with Māori and national goals, and
- consistency and internal coherence across all Te Rau Matatini projects and activities.

The development of strategic plans and policies to support Māori mental health workforce development, and resources both financial and human, will enhance our ability to meet the goals set out in this project. Overall great enthusiasm and energy was displayed by all participants for this new initiative and there was an overwhelming demand for information on how to put early intervention into practice.

9. References

- Bushnell, J., Dowell, A., Friedle, K., McLeod, D., McMurry, K., & Salmond, C. (2001). The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe). *New Zealand Medical Journal*, 114, 11—13.
- Cohen, A. (Ed.). (2003). *Primary solutions: An independent policy review on the development of primary care mental health services*. London: The Sainsbury Centre for Mental Health.
- Durie, M. H. (1998). *Whaiora: Māori health development* (2nd ed.). Auckland, New Zealand: Oxford University Press.
- Durie, M. H. (2001). *Mauri Ora: The dynamics of Māori health*. Auckland, New Zealand: Oxford University Press.
- Durie, M. (2001). *A mental health intervention framework*. A paper presented at the Early Intervention in Psychosis National Training forum Wananga Tokomaru Bay Gisborne
- Edwards, J., & McGorry, P.D. (2002). *Implementing early intervention in psychosis: A guide to establishing early psychosis services*. London: Martin Dunitz Ltd.
- Fallon, I., & Fadden, G. (1993). *Integrated mental health care*. Baltimore: Johns Hopkins University Press.
- Gardiner, S. (1999). Practices nurses in *mental health: A changing role*. *The Journal of Primary Care Mental Health*, 2, 11—12.
- Health Funding Authority. (2000). *Tuutahitia te wero: Meeting the challenges. Mental Health Workforce Development Plan 2000–2005*. Christchurch, New Zealand: Health Funding Authority.
- Mental Health Commission. (1998). *Blue print for mental health services in New Zealand: The way things need to be*. Wellington, NZ: Mental Health Commission.
- Ministry of Health. (2000). *The New Zealand health strategy*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2002a). *He Korowai Oranga: Māori health strategy*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2002b). *Te Puāwaitanga Māori mental health national strategic framework*. Wellington, New Zealand: Ministry of Health.

- McGorry, P.D., Chanen, McCarthy, E., Van Reil, R., McKenzie, D., & Singh, B.S. (1991). Post-traumatic stress disorder following recent onset psychosis: An unrecognised postpsychotic syndrome. *Journal of Nervous & Mental Disease*, 179(5), 253—258.
- McGorry, P. D., Edwards, I., Mihalopoulos, C., Harrigan, S. M., & Jackson, H.J. (1996). EPPIC: An evolving system of early detection and optimal management. *Schizophrenia Bulletin*, 22(2), 305–326.
- Norman, R.M., & Malla, A.K. (2001). Duration of untreated psychosis: A critical examination of the concepts and its importance. *Psychological Medicine*, 31(3), 381–400.
- Ryan, E. (1998). *Māori mental health services: A proposal for change*. Wellington: Māori Health Commission.
- Strong, S. (2000). Gateway to mental health. *Nursing Times*, 96, 24–26.
- Ustun, T. B., & Sartorius, N. (Eds) (1995). *Mental illness in general health care*. John Wiley & Sons.
- White, K., Roy, D., & Hamilton, I. (1997). ABC of mental health and community mental health services. *British Medical Journal*, 314, 1817.

**Te Rau Matatini
Whakawhānui Training Package**

**Primary Māori Mental Health
Pilot Project**

Te Rā Tuatahi

0830hr

Pōwhiri

Karakia

Mihimihi/Whakawhānaungatanga

1000hr

Wā Kai

1015hr

Setting the Scene - National Direction & underpinning documents

Treaty of Waitangi

Ottawa Charter

He Korowai Oranga

Te Puāwaitanga

Blueprint For Mental Health Services

Primary Māori Mental Health Care Services

Puāhou

1100hr

Base Understanding 1.1

Māori Mental Health Concepts

Personal (life)

Practice (experience and training)

The continuum of care (Primary, Secondary and Tertiary)

Overview of Māori Models

Te Whare Tapa Whā

Te Wheke

Ngā Pou Mana

Pōwhiri Poutama

Pounamu

Pounamu as an assessment tool

Group Activity

Kaimahi to map back their case studies they brought, back to a Māori model of practice (own choice).

1230-1300hr

Wā kai

1310

Early detection

1.2

What am I looking for? (BATOMI)

How would I know?

Early Intervention Strategies

Tangata Whaiora and Whānau Access to Services.

Group Activity

From your case study identify the formulation of issues into a chosen Māori model framework, for example (Presenting

Issues, Key Features, Coping Strategies, Whānau, Social, Safety, Other Contributors and Cultural related features)

1400hr	Early Intervention What do I do next? Who do I contact? How do I do that? Group Activity Feedback Assessment formulation (Using the Māori model as a guide for the Assessment Tool) Feedback Assessment model & any proposed Treatment Strategies to wider roopu
1500hr	Wā kai
1520hr	Scope of mahi as a Community Support Worker 1.3 Understanding one's role and the scope of responsibility with: (a) Mental Health Workers (b) Other related services (c) Developing relationships that are complementary Key Legislation <i>Mental Health Act 1992</i> <i>Privacy Act 1993</i> <i>CYPFA Act 1989</i> Understanding the implications from two perspectives (Tikanga and Professional / 'ethical' and safe practice) Group activity – based on Case study and earlier 'assessment' mahi: Formulate Referral Process to appropriate area of 'expertise'
1630hr	Overview Feedback of mahi Evaluation of day Kōrero
1700hr	Karakia Whakamutunga

Te Rā Tuarua

0830hr	Karakia Whakawhānaungatanga	
0900hr	Recovery - Principles - Kōrero Tāhuhu	2.1
1030hrs	Wā kai	
1040hrs	Community Support Worker’s Role(s) and Responsibilities to the Recovery process Understanding one’s role and the scope of responsibility with: - Tangata Whaiora and their recovery process	
	Whānau Matrix - Whānau and the relevance of whānau concepts, values, beliefs in working with tangata whaiora	
1200	Wā kai	
1230	Supervision Understanding supervision <i>Group activity – Māori processes, forms of supervision identified and understood</i>	2.2
	Alerts e.g Counter-transference and Transference, effects of being part of ‘applying’ legislative actions Addressing ‘alerts’ appropriately – Whakawhitiwhiti kōrero	
1500hr	Wā Kai	
1515hr	Overview Evaluation Handout Feedback of training components Feedback from Kaimahi re: training	
1600hr	Poroporoakī Farewells Karakia Whakamutunga	
1630hr	Kua mutu	

Book of Readings One – pre-course material includes:

- Ottawa Charter
- Puāhou (Mauri Ora, 2001,255-283)
- Services for Māori with Episode Psychosis (p64-69 in “Evaluation for Psychosis Services in New Zealand: What works?”)
- Culture-Bound Syndromes (Mauri Ora, 2001, p24-25)
- Everyday People and Mental Illness
- Education on Aspects of Mental health
- Cultural contributors to Māori Recovery (Kia Mauri Tau, MHC, 2002)
- Communication
- Recovery Competencies
- Boundaries & Ethics of Practice for Kaimahi Māori in the Field of Health (Maynard Gilgen, 9 June 2002)
- Supervision: A Working Alliance (Brigid Proctor)
- Notes For Supervisors

Book of Readings Two – course & post course material includes

Introduction

1. Te Puāwaitanga Māori Mental Health National Strategic Framework (MOH, 2002)
2. Blueprint for Mental Health Services in New Zealand (MHC, 1998)
3. Te Pae Māhutonga. A Model for Māori Health Promotion (Durie, 1999)

Module 1.1

1. Guidelines for Assessing & Treating Anxiety Disorders (NHC, 1998)
2. Guidelines for Treatment & Management of Depression by Primary Healthcare Professionals (NHC, 1998)
3. Māori Models of Health
4. Māori Models of Health Presentation handout

Early Detection 1.2

1. B.A.T.O.M.I. Assessment Format
2. Mauri Atawhai Whānau and Community (Durie, 2001) in Mauri Ora: The Dynamics of Māori Health
3. Promoting Prevention and Early Intervention for Mental Health (A Monograph, 2000, p. 58 – 70)
5. Early Intervention in Psychosis. Guidance Note (MHC, 1999, p. 1 –24)

Scope of Mahi as a Community Support Worker 1.3

Key Legislation

1. Mental Health Act 1992
2. Children Young Persons and their Families Act 1989
3. Privacy & Health (Consumer 412 March 2002)
4. MHC Frequently Asked Questions
5. Child, Youth and Family. Care and protection of children

6. The Application of Tapu & Noa to Risk, Safety & Health (Durie, 16 Nov 2000)

Recovery Definitions, Strategies & Principles

1. Cultural Assessment Processes for Māori. Guidance for Mainstream Mental Health Services (MHC, 2001)
2. Teaching Notes on Recovery Principles and Strategies
3. DSM-IV Classification Axes I and II
4. Mental Health Database (Health Ed, 2003)

Handouts

Pounamu Model Package

Amphetamine Pamphlet

Kaimahi Participants

Kaimahi to bring a case study and a cultural assessment tool they are working with.

Registration & Information Sheet (to be completed by kaimahi prior to training) to include:

- **Experience with Māori Mental Health (personal or professional)**
- **Knowledge and Insight into Māori Mental Health**
- **Expected Outcomes from Wānanga**

Team Leaders

Team Leaders to bring:

- relevant information about mental health services and resources in their respective area (inclusive of social services, day programs and learning centres).
- copies of He Korowai Oranga, Puāwaitanga.

Appendix One

Programme outline and framework for Te Rau Whakawhānui, Māori Primary Mental Health Care Training Project **Background Information**

The Associate Minister of Health Hon. Tariana Turia launched Te Rau Matatini on March 8, 2002. As a national Māori mental health workforce development programme, Te Rau Matatini ultimately aims to ensure that Māori tangata whaiora / service users have access to a well trained and prepared Māori workforce in services offered by DHBs, NGOs, Iwi and Māori communities; and build a Māori health workforce that can demonstrate excellence in both cultural and clinical domains.

Te Rau Whakawhānui is a training project that has been developed to help meet the above aims of Te Rau Matatini.

Te Rau Whakawhānui, Māori Primary Health Care Training Project **Purpose**

The overall purpose of the Māori primary health care training project is to increase the capacity of Māori primary health workers to identify early warning signs of possible mental health illness (early detection) and therefore able to facilitate early intervention processes to address possible mental health illnesses. Emphasis will be given to enhancing existing skills and expertise in both clinical and cultural aspects of Māori mental health prevention and early intervention and where possible the integration of such in practice.

Paper outlines

Module 1) Knowledge

Module 2) Process of care

Module 1) Knowledge

General aim and rationale

This paper provides an overview of Māori mental health knowledge, prevention and early intervention in order to support the work of Māori primary health workers. Essential to the paper is being able to provide early intervention and an understanding of referral processes in mental health practice as well as an understanding of policy and legislation that impacts on this practice. Emphasis will be given to enhancing existing skills and expertise in both clinical and cultural aspects of Māori mental health, and where possible the integration of such in practice.

1 Learning outcomes and Performance criteria

Following satisfactory completion of the module staff will be able to:

- 1.1 Understand Māori mental health concepts from personal and practice perspective
 - Concepts of Māori mental health for development of personal practice are identified and discussed
 - Understanding of Mental health and tikanga Māori practices for Māori mental health are discussed
 - Māori models of health and wellbeing are identified, understood and applied

- 1.2 Gain an understanding of appropriate health detection and referral processes for Māori mental health
 - Health detection and intervention principles for Māori mental health are developed
 - Identification and recognition of mental health illness and behaviour
 - Appropriate referral processes including legal and ethical considerations are applied both theoretically and practically
 - Understanding of the health and mental health services being provided in the community for Māori mental health and being able to access them

- 1.3 Understand the role and scope of the worker within a Māori mental health team
 - Mental Health Act and its associated principles are understood
 - Policies and procedures governing the privacy and confidentiality issues that may arise are identified and understood
 - In jury prevention and other safety issues relevant to working with tangata whaiora are identified
 - An understanding of community, government policy and mental health legislation that facilitate practice is incorporated into practice
 - Community development is identified and examined

2 Content

Whakawhānaungatanga-the identity of self
Mental health key concepts
Tikanga Māori protocols and practices for Māori mental health

Māori models and concepts of health
Using Māori models of health to conduct a client assessment appropriate to Māori mental health
Early detection and referral processes
Mental health illnesses and behaviour
Legal and ethical issues
Policies and legislation
Mental Health Act
Community development

3 Teaching and learning styles

Kaumatua and guest facilitators presenting
Discussion and participation
Drawings/ waiata
Group work
Reflective practice and discussions of practical experiences
Book of readings

4 Assessment

An oral presentation on an aspect of working with whānau within their practice
Participation in discussions/ group work

5 Resources

Key definitions of mental health concepts-handout
Key illnesses/ presentations-handout
Signs and Symptoms-handout
Māori related issues -handout
Te Whare tapa whā-handout
Te Wheke-handout
Poutama-handout
What models do they know and how do they apply them
How do you work-processes
Client assessments-BATOMI-handout
Cultural assessments-handout
Community agencies-pānui
Referral processes-What is available in this area
Mental Health Act-handout
Community development-handout
Ottawa Charter

Module 2) Process of care

General aim and rationale

This paper provides an opportunity to apply theoretical knowledge gained in module one in relation to the care provided to tangata whaiora that has relevance to Māori mental health workers and their work settings. The focus of this paper is also to discuss supervision and mentoring in order to support your role. Essential to the paper is being able to work in partnership with Māori mental health tangata whaiora and whānau in the recovery process. Emphasis will be given to enhancing existing skills and expertise in both clinical and cultural aspects of Māori mental health, and where possible the integration of such in practice.

2 Learning outcomes and Performance criteria

Following satisfactory completion of the module staff will be able to:

- 2.1 Understand working with whānau and tangata whaiora in the recovery process
 - The relevance of whānau concepts, values, beliefs protocols and norms are explored and applied to Māori mental health practice
 - The application of whānau concepts to working with tangata whaiora
 - The role of self awareness in relation to dealing with others is explored
 - Recovery process understood and applied

- 2.2 Understand the supervision processes for safety and practice issues
 - Specific Māori supervision approaches are identified and understood
 - Specific clinical supervision processes are identified and understood
 - Understanding the role and scope of the worker within a Māori mental health team is explored
 - Mental health Act and its associated principles in relation to your work is understood

3 Content

- Supervision
- Self care
- Community agencies
- Health risks and safety issues
- Working with Māori whānau
- Self-awareness exercises
- Recovery process

4 Teaching and learning styles

- Kaumatua and guest facilitators presenting
- Reflective practice and discussions of practical experiences
- Group work

5 Assessment

- Develop a care plan using a Māori model of health for a tangata whaiora and their whānau
- Participation in discussions/ group work

6 Resources

Pānui on national mental health and Māori mental health groups:
Supervision information-handout
Recovery toolkit