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*Marlborough Māori experience in accessing mental health
services via primary health care: An exploratory study.*

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Table of Contents

Whakatauki (<i>Proverb</i>) _____	5
Acknowledgements _____	5
<i>Chapter One - Setting the Scene</i> _____	6
National and Maori health policy: A background _____	6
Defining primary health care? _____	7
The important role of primary health care. _____	10
Maori mental health and secondary mental health services _____	10
Maori access to primary health care _____	14
Defining primary mental health care _____	18
Maori access to primary mental health care _____	19
A general practice view _____	24
Access barriers _____	27
Why explore Marlborough Maori tangata whaiora access to Primary Health Care? _____	31
<i>Chapter Two - Methodology</i> _____	35
Theoretical Approach _____	35
Ethics Approval _____	44
Semi- Structured Interviews _____	45
Information Sheets and Consent Forms _____	46
Participant Eligibility _____	47
Participant Support _____	48
Participants in the Study _____	48
Limitations _____	49
<i>Chapter Three – Tane Tangata Whaiora (Maori Male Service User) Experiences</i> _____	50
Pathways into Secondary Services: _____	50
Cost _____	51
Fear _____	52
General Practice Knowledge and Expertise in Mental Health _____	53
Relationship with the General Practitioner _____	54
Frequency of General Practice Visits _____	55
General Practice Waiting Times _____	56
General Practice Reception _____	56
General Practice Waiting Room _____	57
Current General Practice Utilisation _____	57
Support Mechanisms _____	58
Transportation _____	58
Relationship with Witherlea Mental Health Service _____	59

Relationship with Maori Mental Health Staff _____	60
Relationship between primary and secondary based mental health services _____	61
Whanau /Family Supports _____	61
Summary _____	62
<i>Chapter Four – Wahine Tangata Whaiora (Maori female service user) Experiences</i> _____	64
Pathways into Secondary Services _____	64
Cost _____	64
General Practice Knowledge and Expertise _____	65
Relationship with the General Practitioner _____	67
General Practice Attitudes _____	68
General Practice Service Provision _____	69
Consultation Timeframes _____	71
General Practice Waiting Times _____	72
General Practice Reception _____	72
General Practice Waiting Room _____	73
Transportation _____	74
Current General Practice Utilisation _____	74
Relationship with Witherlea Mental Health Service _____	74
Tangata whaiora and whanau stigma _____	77
Support Mechanisms _____	78
Relationship between primary and secondary based mental health services _____	79
Tino Rangatiratanga _____	80
Chronic Illnesses and Care Plus _____	80
Summary _____	81
<i>Chapter Five - Maori Mental Health Clinicians</i> _____	83
Referral Pathways _____	83
Cost _____	84
General Practice Knowledge _____	86
Power Differentials _____	87
General Practice Relationships _____	88
General Practice Waiting Times _____	88
General Practice Receptionists _____	89
Consultation Timeframes _____	90
Practice Room Environments _____	90
Witherlea Mental Health Service _____	91
Tangata whaiora relationship with Witherlea Case Managers _____	92
Witherlea/General Practice Interface _____	94
Whakama/Shyness _____	95

Fear	95
Whanau	97
Tangata Whaiora Tino Rangatiratanga	98
Care Plus	99
Stigma	99
Summary	100
Chapter Six - Discussion	101
Summary	113
Glossary	114
References	115

Whakatauki (Proverb)

He manga wai koia kia kore e whitikia

It is a big river indeed that cannot be crossed. (Make light of difficulties and they will disappear)

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The kowhaiwhai design on the front cover is the mangopare (hammerhead shark).

For Ngati Rarua and Ngati Toarangatira the mangopare reflects the stamina, endurance, tenacity and indomitable spirit of whanau, hapu and iwi. The mangopare and whakatauki were specifically chosen to acknowledge the hardships and challenges tangata whaiora face everyday on their road to recovery. To nga tangata whaiora who participated in this research project, you are true hero's. Thank you for gifting your experiences and knowledge in the hope of benefiting others.

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Chapter One - Setting the Scene

National and Maori health policy: A background

The New Zealand government has clearly recognised the disparities between Maori and non-Maori health (Te Puni Kokiri, 2000a; Te Puni Kokiri, 2000b; Ministry of Health, 2002a). This has contributed towards a number of health strategies and policy development designed to improve Maori health. The *New Zealand Health Strategy (2000)* is the government's overarching health strategy, which acknowledges a special relationship between Maori and the Crown under the Treaty of Waitangi. It identifies Maori health as one of its key priorities and several subsidiary strategies have been launched to assist meet its national objectives for achieving Maori health gain.

Four subsidiary strategies play a pivotal role in terms of Maori mental wellbeing. The key objectives outlined in *He Korowai Oranga – The Maori Health Strategy (2002)* are to improve access to appropriate services for Maori, improve Maori health outcomes and support Maori health provider development. *Te Puawaitanga Maori Mental Health National Strategic Framework (2002b)* suggests that opportunities need to be maximised for intra and intersectoral co-operation. These include objectives to improve training for General Practitioners and other health workers providing primary health care to Maori tangata whaiora (*users of mental health services*), with a focus on depression, anxiety, youth suicide and addictions. *The Primary Health Care Strategy (2001)* aims to build a strong primary health care system that will improve the health of all New Zealanders and in particular will focus on reducing inequalities in health. *Te Tahuhu – The Second New Zealand Mental*

Health and Addiction Plan (2005) has, as one of its ten challenges, a stronger emphasis on primary health care. This challenge aims towards “*building and strengthening the capability of the primary health care sector to promote mental health and wellbeing for tangata whaiora*”, and for the New Zealand health system to “*continue to broaden the range, quality and choice of mental health and addiction services accessible for Maori*”. (p.13,14).

In essence, when reviewing and summarising these strategies in relation to Maori mental health and primary healthcare provision, the aims of the strategies centre on improving Maori access to services, and providing services to Maori that meet their health needs. This necessarily aligns to building both Maori and non-Maori capacity of the primary and secondary healthcare workforce.(Ministry of Health, 2006a; Health Funding Authority, 2000).

Defining primary health care?

Before defining primary health care, it is important to recognise that the new millennium brought about a new vision for primary healthcare services. The *Primary Health Strategy (2001)* aims to achieve a different approach to primary health care, through a number of mechanisms. The strategy recognises that there needs to be a greater emphasis on population health, health promotion and preventative care. There is an expectation of having a wider range of professionals involved, not necessarily relying solely on general practice services. The strategy also looks at encouraging multidisciplinary approaches to decision-making to improve health service delivery. Other anchoring objectives are improving accessibility, affordability and appropriateness of services and last but not least, improving co-ordination and

continuity of care. The establishment of primary health organisations (PHO's) is seen as pivotal to the growth of a more co-ordinated and collaborative approach across a range of primary health services. A PHO is a group of providers whose job it is to look after all the people enrolled with them. The group will always include a GP and may also include some or all of nurses, Maori providers, Pacific providers, pharmacists, dieticians, mental health workers, community health workers and dentists working as a team. One of the minimum requirements of a PHO is a obligation to examine their enrolled populations needs who have poor health or are missing out on services to address their needs. PHO's need to demonstrate that they are working with other providers within the region to improve service co-ordination and quality of care. This approach is aimed at reducing inequalities, improving the health and maintaining the wellness of their patients, improving access to their services and to improve continuity of care for consumers across the continuum of care (Ministry of Health, 2001).

The Declaration of Alma-Ata provided the definition of primary health care as:

Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self reliance and self determination. It forms an integral part of the country's health system of which it is the central function and the main focus of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the

community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process. (World Health Organisation, 1978).

In the late 1990's, New Zealand's National Health Committee developed a more user friendly definition of primary health care as: *"Local, first contact care for people that is accessed by self referral. It comprises a range of services, range of health practitioners, designed to keep people well, from health promotion and screening to diagnosis and treatment of medical conditions"* (Coster & Gribben, 1999, p.6).

In 2001 with the launch of the *Primary Health Care Strategy*, the Ministry of Health, expanded the description of primary health care as the central function of our health system. Primary health care is *"universally accessible to people in their communities; involves community participation; integral to and a central function of New Zealand's health system; and the first level contact with our health system"*.

Primary health care is predominantly community based and comprises a range of services from health promotion and screening through to diagnosis and treatment of medical conditions. Primary health care is not provided solely by General Practitioners (GP's), it also includes services such as (*but not limited to*) mobile nursing services, community health services (for e.g. plunket,), Maori health services, pharmacy services, maternity, family planning, sexual health services, dentistry and complementary or alternative therapies (for e.g. traditional medicines such as Rongoa Maori). These services are provided by a wide range of community based health practitioners and support workers.

This current research explores tangata whaiora Maori access to Primary health care services with a focus on General Practitioners.

The important role of primary health care.

Gribben and Coster (1999) found that primary health care is pivotal and early access has been found to decrease hospitalisations. Therefore primary health care is important in advancing contemporary and future health gains for the Maori population. Horsburgh and Lamdin (2004) note that if our health system was more effective Maori would not become as ill and/or die from conditions that could be prevented with earlier intervention. They suggest that 25% of hospitalisations for Maori could be avoidable, if Maori received the treatment they needed at the primary health care level.

Maori mental health and secondary mental health services

A mental health needs assessment conducted by the Health Funding Authority (2000) outlined a number of studies that recognised the desperate state of Maori mental health. The assessment concluded that Maori are at greater risk for all types of mental health problems and disorders, with higher suicide rates, higher level of first admissions, and unfortunately the high numbers of Maori using mental health forensic services is cause for concern.

It is well known that non-Maori were more likely than Maori to be admitted to psychiatric hospitals. However in 1993, admissions for Maori were nearly double that of non-Maori (Te Puni Kokiri 2000a, p.25). In 1960, there were 88 Maori and 119

non-Maori admissions to psychiatric hospitals per 100,000, yet in 1993 there were 191 Maori admissions and 104 non-Maori admissions (Bridgeman & Dyall 1993). Maori male readmission rates have increased 65% from 1984 to 1993, and there has been a 49% increase in Maori female first admission rates for drug and alcohol abuse and psychosis. Maori have substantially higher rates of presentation to crisis, acute and forensic services than non-Maori (Bridgeman & Dyall 1996, p. 45). Maori hospital admission rates are 40% higher than for non-Maori and Maori are more likely than non-Maori to suffer from alcohol and drug disorders (Ministry of Health 2003, Te Puni Kokiri 2000a,).

More recently eight District Health Boards participated in the CAOS (*Classification and Outcome Study*) project, which has continued to endorse disparities between Maori and non-Maori. This study aimed to establish and assess a casemix classification system that would inform future planning, purchasing and delivery of mental health services in New Zealand. A casemix classifies episodes of care that are clinically similar, and in terms of the resources used in providing a service to the client (Health Research Council 2003). This study found that for adult episodes of care in hospital settings, there were a higher proportion of Maori and Pacific Island consumers relative to other ethnic groups in the distribution of inpatient episodes.

Once Maori are in the mental health 'system' Maori also appear to have higher re-admission rates than non-Maori. Durie & Kingi (1997) identified that:

Readmission rates are estimated to be 40% higher than that of non-Maori. High rates of first admissions for Maori youth are linked largely to Alcohol and Other

Drugs. Current evidence also suggests that Maori tend to access mental health services at a later stage than non-Maori. This implies that treatment will often be sought at an acute stage of illness, thereby requiring ongoing, and often expensive treatment. The resulting health outcomes are therefore likely to be less effective and may in part explain high rates of readmission. (p.10)

Clearly this demonstrates the number of Maori requiring specialist interventions has had an alarming growth in the last fifty years.

He Tatau Kahukura (Ministry of Health 2006c) provides further recent evidence of Maori intentional self harm and suicide mortality. For all age groups, Maori males had significantly higher rates of hospitalisation for intentional self-harm than non-Maori males. For both Maori and non-Maori, young people (15-24 years) had the highest rate of hospitalisation for intentional self harm. Maori had higher suicide mortality rates than non-Maori and males of both ethnicities had significantly higher suicide mortality rates than their female counterparts. For Maori the age group with the highest suicide rate was young people (aged 15 – 24). For non-Maori, adults aged 25 to 44 years had the highest suicide rate.

Even though overall there was a reduced suicide rate compared to 2002, the age-standardised rate of suicide remains higher for Maori than non-Maori. For Maori males 21.1 – Maori females 6.4 per 100,000 population, compared to non-Maori males 15.6 – non-Maori females 5.9 per 100,000 population (Ministry of Health, 2006b).

Given Maori growth in secondary care presentations, of notable interest is that the majority of referrals into secondary services for Maori do not derive from the primary care sector.

For Maori mental health inpatients, the majority of referrals to first admission inpatient units derive from welfare and law agencies (38%), which far outweighs non-Maori (27%) whose major referrals derive from psychiatrists or General Practitioners (Bridgeman & Dyll 1996). A recent Otago study also found similar distinct differences in referral pathways in that while Maori admissions were four times higher than non Maori, the majority of these referrals to their services derived from welfare agencies, the justice sector or from family, whereas non Maori referrals came from psychiatrists, doctors or outpatient services (Edmonds, Williams & Walsh 2000). This research suggests that Maori are not using the primary care sector for assessment and treatment and therefore presenting at higher acuity levels than non-Maori.

Once again the consequences are reiterated by Durie, Allan, Ratima & Waldon (1995) who support the view, that the link to the provision of adequate primary health care may not be forthcoming for Maori.

Of mounting concern are the disproportionately high numbers of Maori who are committed under the Mental Health Act for assessment and treatment. Psychiatric admissions and particularly committals under the Act, represent a late form of intervention suggesting that Maori are less likely to have received

adequate primary health care so that hospitalisation becomes an inevitable consequence of poor mental health. (p.4).

As we know access to primary health services is pivotal to ensure early assessment, diagnosis and treatment.

Robson (2004 p.3) also suggests that even though Maori have overall higher health needs, they are not accessing health services as the need would imply. While this is indicative of a wider range of health services it is especially so in the mental health and primary health sectors.

The evidence strongly suggests that, Maori access mental health secondary based services later and with more severe conditions at point of entry than non-Maori. There are disparities between Maori and non-Maori in relation to access and pathways to mental health services. One of the key factors in addressing this is supporting the primary health care sector in improving access to services and subsequent treatment.

Maori access to primary health care

The inverse care law applies in New Zealand for Maori. That is, those populations in greatest need are those less likely to receive the services they need (Malcolm, 2002; Caccioppoli & Cullen, 2002; Abas, Vanderpyl, Robinson & Crampton, 2003).

The New Zealand Health Survey (Ministry of Health, 2004b) identified that 77% of Maori adults compared to 81% of pakeha (European) adults had visited their GP in the previous 12 months. Sixty percent of Maori (compared to 66% of pakeha) had

received a prescription in the previous 12 months. Of those, one in five, compared to one in seven for pakeha, did not pick it up from the chemist.

The survey goes further to identify that Maori males were most likely to have seen more than one GP in the last twelve months, followed by European/Other, Pacific and Asian males, although these differences were not significant. European/Other and Maori females were significantly more likely than Pacific and Asian females to have seen more than one GP. There maybe several reasons for this, for example, Maori are not registered with a specific General Practitioner, Maori are not concerned about which GP they access, Maori are accessing after hour GP services or Maori are shifting between GP practice geographical areas. European/Other males were significantly more likely to have visited a GP in the last 12 months than Maori and Asian males. This has implications for Primary Health Organisations as they begin to understand and plan for their enrolled population health needs.

Similar findings are reported in *Tatau Kahukura – Maori Health Chart Book* (Ministry of Health, 2006) which identifies that while Maori adults were as likely as non-Maori adults to report having a usual health practitioner they were significantly less likely to have seen a General Practitioner in the last 12 months than non-Maori males. Given the high rate of Maori male admissions to acute mental health services, improving access to Maori males should be a priority. The contrast between self reported unmet need from a GP in last 12 months (16.6% Maori males, 23.6% for Maori females, 10.9% for non-Maori males, and 13.6% for non-Maori females. p.61) is indicative that Maori are leaving general practice settings without having their

health needs addressed. Both Maori and non-Maori adults had similar prevalence of self-reported mental disorders.

Maori males were significantly more likely than European/Other and Asian males to not collect one or more of their prescription items in the last 12 months. The New Zealand Health Survey clearly identifies that Maori are not utilising primary health care services at the same rate or frequency than non-Maori. In *Tatau Kahukura – Maori Health Chart Book*, females in both ethnic groups were more likely not to fill their prescription than males, although this difference was only significant for non-Maori. This indicates that even when Maori access a GP and work through the initial barriers such as cost and transport, they may not be able to meet the cost of pharmaceuticals. Therefore the condition is not being treated and could result in hospital admission.

The prevalence of having a serious mental disorder and either potentially hazardous drinking or regular marijuana use was also similar for Maori and non Maori (Ministry of Health 2006c). However Kypri (2003 p. 1-3) identifies that relative to Maori, non-Maori drink more frequently but on average 40% less alcohol per drinking occasion. The MaGPIe research (2003) also indicates higher rates of alcohol consumption on each drinking occasion for Maori.

Gribben (1999) conducted a study in relation to ethnicity and resource use in West Auckland and he supported the view that Maori do not receive primary care resources at the rate expected for the morbidity they demonstrate. He concluded that Maori and Pacific Island patients have the highest burden of chronic illness yet after age

adjustment receive fewer prescriptions, less in pharmaceutical subsidies, fewer laboratory tests, less in laboratory subsidies, and fewer consultations per annum.

Malcolm (1996) suggests that Maori continue to have low expectations of primary medical care, delaying or deferring treatment. This inevitably results in higher acuity levels and or emergencies requiring hospital admission. He observes that Maori and low income populations do not receive the medical care they need from the primary care sector as compared to the average New Zealander. He advocates that access issues are the reason why Maori over utilise secondary inpatient services. If Maori do not expect to have their health needs met when attending their GP then it is unlikely that they will access the primary health service.

While controversial in their views, Caccioppoli and Cullen (2005) endorse concerns around access to primary health services. They identify their impatience with the lack of progress and failure of the existing health system in addressing Maori health. While providing some thought provoking opinions on why the health system fails Maori they also offer remedial solutions for consideration. There is an apparent frustration from the authors that Maori do not need to die prematurely.

With the introduction of the *Primary Health Strategy* (2001) over the next few years the Ministry of Health should be in a position to determine and celebrate whether any significant gains have been made to Maori health since the implementation of the strategy. There clearly needs to be more focus on the 'action' in Maori health as opposed to the rhetoric.

Defining primary mental health care

Primary health care plays a fundamental role in caring for people with a mental illness. In 2004, the Ministry of Health launched the *Service Development Toolkit for mental health services in primary health care*. The toolkit specifies the role for primary health care practitioners in the provision of mental health services is to ensure that individuals return to their full level of functioning by identifying and subsequently managing the mental health issue (Ministry of Health, 2004a, p. 32). It is supposed to be that component of primary health care that addresses a person's and their family/whanau psychological distress and illness (Ministry of Health, 2004a, p. 54).

At its most basic level, any individual accessing a primary health care service with concerns around their mental health, should be able to have their mental health needs identified and assessed, and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if needed.

The role of a primary healthcare provider is to recognise that there is a mental health issue, provide self-help information, support and appropriate treatment/therapy to assist a person to rapidly resolve the issue and to support them to maintain and build their links with their important community resources. (Ministry of Health, 2004a, p.31)

The Mental Health Commission (1998) blueprint for mental health services, estimated prevalence of the New Zealand population who have mental health problems is, that at any one time 20% of our population will experience mild to high support needs.

Specialist mental health services (*predominantly those services provided by hospital based services*) are funded to support the 3% of our population who suffer from severe mental health disorders (*that is hospital, outpatient and community mental health support services*). A further 5% who have moderate disorders are cared for by primary health care services who often work in liaison with mental health services. The remaining 12% are serviced by primary care, natural supports (*family, partners, close friends*) and social service agencies.

There has been clear support and direction from the Ministry of Health for primary health care practitioners to take the lead role in the provision of mental health services for people with mild to moderate mental health problems.

Maori access to primary mental health care

Internationally it is recognised that General Practitioners often fail to identify mental health symptoms. The World Health Organisation study identified that 24% of people presenting have a major psychiatric disorder and a further 9% present with a sub threshold disorder and yet diagnosis of mental health problems are frequently missed in primary care consultations. (WHO, 2001)

These findings are similar in a New Zealand setting. The MaGPie Research Group (2003) found that one third of people attending their GP had a diagnosable mental disorder in the previous 12 months. The three most common disorders being anxiety disorders, depression and substance abuse disorders. GP's were accepting of the low rates of identification of mental illness in primary care, and GP's thought that about

half their patients had some type of psychological problems in the past year although they considered that these were moderate or severe in about only one in ten.

Rates of mental disorder for Maori are higher than that of non Maori in the General Practice setting. In all of the three common disorders found in the 2003 analysis (*anxiety disorders, depression and substance abuse*), Maori had higher rates than non-Maori. It was specifically concerning that Maori women were twice as likely as non-Maori to have a diagnosable mental health disorder. Although there were differences between Maori and non Maori in terms of social and material deprivation, higher rates of mental disorder among Maori attending GPs compared to non Maori couldn't be accounted for by those differences alone (MaGPie Research Group, 2005b).

The Mental Health Commission blueprint has also recognised that Maori have high needs therefore require better access to services. They suggest that the target for access to specialist mental health services for Maori should be double that for the general population, that is 6% as opposed to 3%, partly in recognition that Maori present at higher acuity levels and through referral sources other than primary health care (Mental Health Commission, 1998). Therefore one could assume that improved access for Maori to primary care services should also be double that for non-Maori.

Te Rau Hinengaro (2006) is the first national survey undertaken by the Ministry of Health to ascertain how many people experience problems with their mental health. Generically the survey found that for all populations, access to address mental health conditions is low. However the survey acknowledges and endorses research findings

of the last two decades, that Maori and Pacific peoples do not access mental health services in relation to other population groups. The survey provided some interesting findings:

- 50.7% of Maori experienced at least one mental health disorder over their lifetime.
- 29.5% of Maori had at least one disorder in the past 12 months. In comparison, Pacific People were 24.2%, and Other groups at 19.3%.
- 18.3% of Maori had at least one disorder in the last month.
- In terms of accessing service providers to assist with their mental health, 14.6% were seen by specialist services, non-healthcare providers saw 9.1%, and 20.4% were seen by general medical services.
- 52.1% of Maori, who had serious disorders had no contact with health services.
- 74.6% of Maori with moderate disorders had no contact with health services.
- 84.3% of Maori with mild disorders had no contact with health services.

Included in the survey and across all populations researchers asked questions in relation to why participants delayed seeking help for their mental health problems. Fifteen possible reasons were given, with the top three most frequently endorsed reasons being that participants wanted to handle the problem on their own (79.3%), they thought the problem would get better by itself (63.2%) and that the problem didn't bother them very much at first (48.9%). Interestingly cost was not cited as one of the top three reasons. *Te Rau Hinengaro (2006)* illustrates that three quarters of Maori with mild to moderate mental health problems are having no contact with health services, and over 50% with serious mental health problems had no contact

(Oakley Browne, M.A, Wells, J.E., & Scott, K.M (eds) 2006). This further solidifies evidence that the existing health system is not meeting the needs of Maori

There is some synergy here with the NZ Health Survey (2002/2003) findings which identified that only 5% of people attended a GP for a mental health problem. There is also some correlation here with the 5% threshold as identified in the blueprint, although this doesn't take into account shared care arrangements between specialist mental health services and primary health services, or those with mild mental health disorders. The most common reasons for GP visits are short-term illnesses or temporary conditions, a routine check up or health advice, a chronic condition or disability, or an injury or poisoning (Ministry of Health, 2004b). This suggests that the GP sector is not viewed as the place to discuss mental health problems. This is supported to some extent by the MaGPIe Research group (2005a) who identify that overall 29.8% of all patients and 26.9% with current symptoms did not report their self-perceived psychological problems to their GP. Two of the reasons they identified as not discussing these issues with their GP was that the GP was not the right person to speak to (33.8%), and that mental health problems should not be discussed at all (27.6%).

The Mental Health Commission (2005) acknowledges that GPs are the first port of call for most people with mental illness and that there are benefits for early intervention and treatment. However, it is not evident that GPs are the first port of call for Maori, particularly given our referral pathways into secondary specialist mental health services.

A recent recovery narrative study (Lapsley, Nikora & Black 2002 p. 79-83) supports the Mental Health Commission view in terms of expectations for diagnosis, treatment and referrals to specialist services if required. The study also found that:

- a good relationship with GPs or other professionals was an important factor in their recovery.
- Tangata whaiora had virtually no complaints about GP interventions, (*however there was no indication on the extent that tangata whaiora utilise GP's for mental health*).
- Contacts with GPs did not lead to people feeling powerless, trapped or deprived of rights.
- The most substantial issue relating to GP contacts was around medication and its side affects.

While there is data available in the secondary care sector in terms of Maori utilisation of services through the national Mental Health Information Collection system, there is no accurate data on the rates of mental health problems within specific ethnic groups and particularly for Maori and Pacific people in the primary healthcare system (Ministry of Health, 2003). Research is limited in this area, and one would hope that as PHO's develop under the Primary Health Strategy, additional information systems will be developed to capture this data.

The Mental Health Commission (2005) also recognised some of the gaps within the GP sector that could assist improve service delivery. Particularly if public funding was available for psychological interventions and therapies, then a range of treatments

and supports could be provided. This is a challenge to the sector, which will require additional resources to improve its services to tangata whaiora.

While this section is specifically around tangata whaiora access to primary mental health care, the physical health status of tangata whaiora should not be understated. At least 45% of tangata whaiora have a concurrent physical illness and the relation to chronic conditions such as heart disease, diabetes, cancer, and respiratory diseases provides additional challenges for tangata whaiora. In comparison with the general population, male tangata whaiora live 14 years less and female tangata whaiora 6 years less (Mental Health Commission, 2004). While there has been no specific research on Maori tangata whaiora, in comparison to non-Maori tangata whaiora, one could suggest the average life span would be even less.

A general practice view

The General Practice sector also recognises the barriers to providing improved mental health services. The MaGPie Research Group (2005c) note that GP consultation timeframes with tangata whaiora/service users take longer. This inevitably upsets the appointment schedule with other patients having to wait for longer periods of time. GPs subsidise these longer consultation timeframes by either not charging or writing off consultation fees. In addition, Rodenburg (2003 p.2-3) states that the sector recognises that there are perceptions held by their patients in relation to primary mental health care and that seeing a GP for this needs to be promoted further. Of interest, GP's recognised that there is an increased detection of mental health problems if there is an established long-term relationship between patient and the GP. However, given the short consultation timeframes of 10 – 15 minutes, establishing a

relationship based on trust and respect could take several years for new patients. This could contribute towards Maori utilising a higher number of GPs than non-Maori as identified in the New Zealand Health Survey (2004).

Reid (2005) also suggests that payment mechanisms are disincentives to provide thorough and comprehensive screening and treatment for mental health patients. GP's have to run viable commercial practices. He identifies a level of improvement with the establishment of the Primary Health Strategy (2001) and implementation of reduced consultation fees, including the introduction of Care Plus for those clients with chronic disorders, acute medical or mental health needs or a terminal illness.

Care Plus aims to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users (CBG Research, 2006). The eligibility criteria, by which a number of tangata whaiora could be eligible, is that you have two chronic health conditions, or had at least six visits to a GP in six months, or have had two mental health related admissions to inpatient units in the last twelve months, or have a terminal illness, or are on active review for elective services. Care Plus had been operating for 22 months and only 39% of the predicted eligible Care Plus patients were enrolled with Primary Health Organisations that had commenced the programme. In addition, Maori had higher volumes on the Care Plus programme relative to their population (CGB Research, 2006), which is understandable given the greater health need.

However this is only the start of a difficult journey, GP's also need to be supported in the provision of continuing education and the necessary tools to adequately assess, diagnose and treatment for tangata whaiora.

Of concern from the GP sector is the full implementation of the Primary Health Strategy. If a directive was given to address the MaGPIe research findings, it is clear that the primary health care resources and sector would be overwhelmed (Mulder 2003). Given on average, in the South Island, GPs work 3.9 days per week and see 104.2 patients per week (or 26.4 patients per day), in addition to undertaking after hours work, and some evening and weekend work, the practicalities of enabling longer consultation timeframes for tangata whaiora would be a challenge (Raymont, A., Lay-Yee, R., Pearson, J., & Davis P., 2005).

However there are opportunities. GPs see that the barriers of cost and time could be overcome. GP's could be provided with adequate education and back up from specialised services to assess, diagnose and treat conditions at an earlier stage. Specialised services could be providing responsive back up to the GP sector, and there could be a greater alignment of resources between primary and secondary services (Rodenburg 2003).

What becomes evident is the requirement of a reality check for the General Practice sector. New Zealand does not have the current workforce to fully address findings from the MaGPIe study. Reid (2005) identifies an estimated national shortage of 1400 GP's. The existing workload and expectations of General Practitioners are already considerable, therefore additional investments will be required not only for

mental health training and development, but also for adequate consultation timeframes.

Access barriers

There are many reasons why people do not request help from their General Practitioners.

Cost remains a major issue. The New Zealand Health Survey (2002-2003) identified that overall the most common charge for GP visits is between \$31 and \$40. One in 10 adults (9.3%; 8.3 – 10.3) were not charged for their last GP visit, while one in 20 adults (5.0%; 4.4 – 5.7) were charged more than \$50. Females were significantly more likely than males to not be charged for their last GP visit, while males were significantly more likely than females to be charged \$50 or more (Ministry of Health, 2004b). Robson (2004) identified that cost is the most frequently reported reason for not taking children to a general practitioner.

Consultation timeframes are on average 10-15 minutes per patient. Cram et al (2003) identify that Maori may have difficulty in opening up and communicating health problems. A 15-minute consultation timeframe does not give the necessary time for mihimihi to commence the formation of a relationship. It is not unknown for some GP's to charge per 15-minute consultation, therefore a 45-minute consultation could cost up to \$135.00.

Communication and rapport between doctor and patient is increasingly regarded as central to the practice of primary healthcare. Maori find it difficult to talk about and

address their health problems with health professionals in general (Cram et al, 2003). As noted previously a longer-term relationship between GP and patient can improve communication and increases detection of mental health problems.

However even if the relationship was developed, Durie et al (1995 p. 4) cites a tribal study identifying that there remains a reluctance to talk about mental health problems with any medical practitioner, even if the practitioner is Maori.

Racial discrimination has also been found to impact on access to services. Harris, Tobias, Jeffreys, Waldegrave, Karlson and Nazroo (2006), found that racial discrimination in New Zealand is disproportionately experienced by non-European ethnic groups particularly Maori, and that there is a strong association between racism and various measures of poor health.

Frequency of visits can also be related to cost. From the NZ Health Survey, overall, the mean number of GP visits among adults who had seen a GP in the last 12 months was four visits. When asked why they had not seen a GP when they needed to, the most common reasons were: *'costs too much'*, *'didn't want to make a fuss or couldn't be bothered'*, *'couldn't get an appointment'*. When adults who were dissatisfied with their last GP visit were asked why, the most common reasons were *'costs too much'*, *'Doctor did not spend enough time or wasn't thorough enough'*, *'Doctor gave wrong treatment or didn't give any treatment or only prescribed drugs'*, *'didn't like doctors manner or couldn't talk to doctor or doctor wouldn't listen'*.

Tatau Kahukura Maori Health Chart Book (2006 p. 64-65) also identifies reasons why Maori males did not access the GP. They were cost, not wanting to make a fuss, couldn't be bothered, couldn't get an appointment soon enough or at a suitable time, health need was after hours and couldn't spare the time. Maori females top three reasons for not seeing a GP were cost, could not get an appointment soon enough/at a suitable time/it was after hours, didn't not want to make a fuss/could not be bothered.

Difficulty with access to transport was slightly higher for Maori; when Maori were analysed separately approximately a quarter reported problems accessing services; Maori were less likely to use a mobile service than the population overall.

Ministry of Health (2004a) identified three major barriers to the provision of effective primary mental health services. They were the cost to the GP, the cost to the Service User and GP confidence/competence. Should a GP consultation take longer than the allocated timeframe, unless the patient is charged an additional consultation fee, then GP will lose income. GP confidence/competence surrounds the level of training, skills and knowledge around diagnosis and subsequent treatment.

There is a lack of information in terms of Maori accessing the primary care sector but the Health Funding Authority (2000 p. viii) did find a local study comprising of Maori women with post natal depression with the three major barriers in terms of accessing the primary care sector for help, were; lack of information, trust and inability to communicate.

Maori researchers acknowledge the importance of accessing culturally safe mental health services for Maori and failure to provide this prevents access. Being whakama is considered one of the greatest barrier to accessing mental health services (Harcourt 2000). It's not an easy issue to address. Maori simply do not have the current workforce to contribute towards the provision of culturally appropriate services. Nationally only 2.4% (71) of registered General Practitioners are Maori and only 7.1% of Registered Nurses and Midwives are Maori (Houlahan 2005 p. A7).

The Ministry of Health (2004a) service development toolkit provides the most comprehensive view of access barriers and the following three components at individual, community and provider level are useful.

At an individual level, often tangata whaiora are not aware that they may have a mental illness or may interpret the unwellness as a cultural diagnosis. Even if there is some recognition of being mentally unwell, tangata whaiora are not sure where to seek help. Some do not have the time to attend appointments and the financial cost associated to seeking help provides further disincentives. Tangata whaiora will prioritise their time to seek assistance against other priorities in their life, work, family, social events etc. If the patient had negative experiences previously, they are not likely to present again. In addition there is a level of internal stigma and embarrassment about being unwell and that they should be able to cope on their own.

At a community level there is an abundance of stigma, which in turn leads to discrimination. The community is not well educated in mental illness or wellness,

there is a level of mistrust and lack of confidentiality in community settings, and finally the number, range and quality of mental health services is not well known.

At a provider level, staff need support and training around co-existing disorders, working biculturally, best practice for interventions and mental health generally. Further knowledge and experience in the mental health would be beneficial, as would reducing the stigma, prejudices and stereotypes that staff may hold.

Why explore Marlborough Maori tangata whaiora access to Primary Health Care?

While political debate ensues around the race versus need based provision of government funded services, in both categories it can be clearly demonstrated that health disparities exist and perhaps will continue to exist between Maori and non-Maori. The current health systems are failing Maori and there are opportunities available from a local perspective to support improvement of services to Maori in an attempt to reduce mental health disparities.

The Marlborough region is quite distinct with seven mana whenua iwi, Ngati Rarua, Ngati Toarangatira, Rangitane, Te Atiawa, Ngati Apa, Ngati Kuia and Ngati Koata. Maori comprise 11% (4352) of the Marlborough population (39,561), 8% are manawhenua (349), and 92% (4003) are iwi from outside of the district. However, the Marlborough Maori population is expected to grow by 80% between 2001 and 2021, the highest predicted Maori growth rate in New Zealand (Marlborough District Council, 2006).

Utilising the blueprint assumptions 870 Marlborough Maori will require support with their mental wellbeing. At the 3% access minimum this means that 130 Marlborough Maori would be using a combination of our secondary based mental health services and general practice, 217 using our general practices and 522 using a combination of general practice and social support agencies. Given that the blueprint suggests that for Maori the access rate should be doubled, up to 1740 Maori could require health service provision from the GP sector.

Utilising *Te Rau Hinengaro* findings, 2206 of Marlborough Maori will experience a mental health disorder over their lifetime, 1284 have experienced at least one disorder in the last 12 months, and 796 will have experienced a disorder in the last month (Oakely Browne et al, 2006).

There are eight GP practices in the Marlborough region, served by 27 GPs. Only one General Practitioner identifies as Maori. There are no specific primary mental health services delivered in the Marlborough region other than existing General Practice service delivery.

In 2005 the Marlborough Primary Health Organisation, Kimi Hauora Wairau conducted '*The Mobile Health Service Survey 2005*' (Kimi Hauora Wairau, 2005), which was initiated to gain rural residents attitudes to a mobile health service as part of the Services to Improve Access funding. The survey concluded that while the sample size in the survey was small and drawing definitive conclusion for some questions problematic, it recognised that Maori were more disadvantaged than the population overall.

The Kimi Hauora Wairau Maori Health Plan is ambitious in its intent but identifies a passion for addressing a wide variety of Maori health needs. The opportunities for mental health improvement are limited within the plan given its three-year timeframe (Kimi Hauora Wairau, 2006).

Care Plus uptake for Marlborough Maori is at 7.14% (61 Maori registered) which is relatively low given Maori comprise 11% of the population and with higher health need (P. Ballinger, personal communication, 29th January 2007). This is not consistent with the national review of Care Plus that found that overall more Maori are registered on the programme relative to their population (CGB Research Ltd, 2006). Current Marlborough GP practice fees for patients aged 25 to 44 years of age with a Community Services Card ranges from \$32 to \$35 per consultation, and without a Community Services Card the charges range from \$50 to \$65. For patients in the 18 to 24 years of age, consultation fees range from \$23 to \$33 per consultation (Kimi Hauora GP Schedule of Fees January 2007).

Kimi Hauora Wairau has a responsibility to address Maori primary mental health and this research could assist in meeting those responsibilities. Based on Kimi Hauora Wairau commitment in improving Maori health and the growing number of Maori within the Marlborough region requiring effective and efficient primary mental health care services, the timing and landscape is ripe for development.

In addition, the researcher is of Ngati Rarua and Ngati Toarangatira descent and has a responsibility to utilise existing skills and knowledge to awhi and support iwi improve

existing service provision to Maori. There is no existing local research that might inform Kimi Hauora Wairau in relation to the development of a primary mental health plan.