

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.



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

Lorraine Eade

*Te Kura Hinengaro Tangata: School of Psychology
Massey University, Turitea, Palmerston North*

February 2007



Thesis submitted in partial fulfilment of a Master of Arts (Psychology)

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)</i>	
<i>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)

Acknowledgements

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.

To my thesis supervisors, Dr Mandy Morgan and Dr Paul Hirini, thank you for your patience, guidance and support.

To Te Rau Puawai, your awahi and tautoko is truly appreciated. Nga mihi mahana ki a koutou.

Finally and most importantly, to my husband Dave and our three beautiful children, Shane, Joey and Mana. You have made this journey so much easier. I am truly blessed.

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.

Chapter Two - Methodology

Theoretical Approach

The research methodology involves two separate theoretical approaches, Kaupapa Maori and grounded theory.

Maori have been concerned for some time over westernised approaches to research that affects or purports to affect Maori. Maori have often been the 'researched' and not the 'researchers'. In the end Maori are sick of being blamed for the existing inequities and inequalities that are defined within a non-indigenous research framework. Cram (2001, p. 432) notes that when research blames individuals, then the onus and responsibility is based on individual change as opposed to changes in wider society. Cram (2001, p.433) also suggests that non-indigenous researchers use a top down approach as opposed to a bottom up approach to research. This in turn has consequences of not clearly hearing the voices of those that the researcher is asserting to represent.

Bishop (1999) identifies a level of self interest by non-Maori researchers, who undertake Maori research but within their own cultural paradigm. The question that poses itself is, is it a requirement for cultural paradigms to align through a research process. Non-Maori researchers bring their own values, assumptions to any research project based from their own cultural paradigm, as do Maori researchers. This could limit or impact communication and understanding of the subjects' voices. Therefore it is reasonable to consider whether non-Maori researchers can assert to

‘know’, as an outsider attempting to look in on, and analyse Maori issues from a non-Maori perspective. Cram (2001) and Bishop (1998) summarise that if there is any opportunity for a misrepresentation of Maori knowledge and meaning, then there is a risk of the research being adopted as an authoritative, accepted and validated perspective. Consequences of these misrepresentations in terms of policy implementation and service developments are that their goals are at risk of being unachieved or rejected by Maori if they don’t necessarily align to their realities. Arguably Maori are then blamed for the additional failures that result from well intentioned but flawed research processes.

In recent decades this has raised concerns over who has control over Maori research processes, outcomes and the distribution of knowledge. The Health Research Council and Ministry of Health Ethics Committees now requires researchers to consider and identify clearly what level of consultation, support and endorsement is required from and with Maori. They have recognised the consequences of research and developed guidelines to assist fledgling and experienced researchers ensure their intended research can do no harm to Maori.

Kaupapa Maori research is about benefiting not the researcher or the mainstream agenda, but research participants and community. Historically Maori had means of accessing knowledge, and this validated knowledge was passed down from generation to generation. Kaupapa Maori research is aligned to a similar framework.

Kaupapa Maori research methodologies position researchers to implement tino rangatiratanga (*self determination*) over the research process. Iwi and Maori

communities will determine the value of the research.

Cunningham (2000) provides a useful taxonomy that describes research approaches for Maori into four separate types:

Research not involving Maori	Research where Maori participation or data is neither sought nor considered relevant; Research whose results are thought to have no impact on Maori.
Research involving Maori	Research where Maori are involved as participants or subjects, or possibly as junior members of a research team; Research where Maori data is sought and analysed; Research where Maori may be trained in contemporary research methods and mainstream analysis.
Maori-Centred Research	Research where Maori are significant participants, and are typically senior members of research teams; Research where a Maori analysis is undertaken and which produces Maori knowledge, albeit measured against mainstream standards for research.
Kaupapa Maori Research	Research where Maori are significant participants, and where the research team is typically all Maori; Research where a Maori analysis is undertaken and which produces Maori knowledge; Research which primarily meets expectations and quality standards set by Maori.

The overarching difference between all four is that the power and control lie predominantly with the mainstream agencies excepting Kaupapa Maori research. A Kaupapa Maori research methodology is seen as implementing tino rangatiratanga within Maori cultural context and practice.

It legitimises and validates Maori voice, knowledge and experiences.

Durie (1996) identifies three competencies required to undertake Kaupapa Maori research, they are:

- (a) competence in health research
- (b) competence in understanding and managing Maori knowledge
- (c) competence in operating within Maori society

Linda Smith (1999) identified a list of seven Kaupapa Maori practices for Maori researchers to consider and examples of which were addressed as part of this research methodology:

1. Aroha ki te tangata (respect for people): Tangata whaiora and Kaupapa Maori Mental health workers were the core participants for this research. In respecting their positions (that we are all on equal footing, and that there are no power imbalances) in relation to the kaupapa, interviews were held at a location that suited the subjects, not the researcher. The timing of interviews whether weekdays, weekends, during the day or night was also at the behest of participants. The important objective was to allow participants to identify their own space and the researcher to meet with them on their terms. The researcher is not the important focus here, it is the participants, since without their input there is no research. Acknowledging that the Wairau rohe (district, boundary) is not as blessed as other Maori communities in relation to Te Reo me ona Tikanga Maori, kaumatua (Maori elders) and interpreters

were available to support the process. However participants did not require this support for a number of reasons.

2. Kanohi kitea (face to face approach): All interviews were conducted face to face. The researcher knew some of the participants, with other participant relationships having to be established. In some instances this meant meeting with the participant before the interview proper to establish a relationship and gain the trust of the participant, and giving the opportunity for the participant assess the researcher. It is important to build and maintain these relationships throughout the research process.
3. Titiro, whakarongo ... korero (look, listen.. speak): The researcher listened carefully so that she was in a position to capture the content and meaning behind the korero, examine the body language that presented itself and when required respectfully exploring issues further.
4. Manaaki ki tangata (share and host people, be generous): The Researcher, participants, Maori community and the primary health sector will learn from this research. It is a reciprocal mutually beneficial process. At the completion of the thesis, there will be further work and responsibility for the researcher in assisting Iwi and the Primary Health Organisation consider the opportunities and knowledge presented to improve service delivery. Tangata whaiora were given a small koha to acknowledge their contribution to the research process.
5. Kia tupato (be cautious): This aligns to being politically and culturally safe, alongside the importance of considering the researchers insider/outsider status. In this instance, Ngati Rarua and Ngati Toarangatira were engaged early into the research process. The researcher outlined the intent of the research and

gained their support. Support was also gained from the mainstream mental health service (*Witherlea*) and the only Kaupapa Maori mental health provider in Marlborough, Te Rapuora o Te Wai Harakeke. The first presentation at the conclusion of the research process will be to present findings to the tangata whaiora, followed by Ngati Rarua and Ngati Toarangatira. Kaumatua support has been available throughout the process in terms of tikanga for those participants that required tikanga to be observed. The researcher can be considered as both insider and an outsider. An insider in terms of being Maori, manawhenua, involved in the mental health sector, whanau members having a mental illness, embedded and accountable to the community. An outsider in terms of being a post graduate Massey student, from a different tribe from those interviewed, and a District Health Board employee.

6. *Kaua e takahia te mana o te tangata* (do not trample over the mana of the people): In this instance, especially for tangata whaiora, the researcher's intent is to clearly reflect tangata whaiora experiences and meaning to those experiences. Tangata whaiora have contributed significantly. Personal and sometimes emotionally distraught experiences have been shared, so there is a clear responsibility to reflect and report their meanings. This research is about improving services to tangata whaiora.
7. *Kaua e mahaki* (do not flaunt your knowledge): This entails a humble approach and not being whakahihi (a show off). The research will be shared with tangata whaiora, Maori mental health providers, Iwi, Maori community and the Primary Health Organisation Kimi Hauora Wairau.

In a Kaupapa Maori framework it is generally accepted that the researcher can embed themselves in the research without having the level of objectivity in westernised processes. The researcher is of Ngati Rarua and Ngati Toarangatira descent, is entrenched in the community, supports iwi in their kaitiaki and manaaki role as manawhenua and therefore has a personal investment in the research. Accordingly this research project is not about the completion of a Masters thesis, its about a product that hopefully will add value to tangata whaiora, their whanau, the wider Maori community and the primary care sector. It is aimed at exploring tangata whaiora experiences and providing some guidance on how our primary healthcare sector can improve service delivery, thereby benefiting the whole Marlborough community.

It is not within the scope of this research project to fully implement a grounded theory approach and a theory will not be produced as part of this research project given its exploratory nature. The three consistent components of any qualitative research approach is data, analysis and interpretation, resulting in written or verbal reports. Grounded theory is not a quantitative approach where relationships between variables are tested.

Grounded theory does not test a hypothesis as such, theory emerges. It is "*generated by (or grounded in) an interactive process involving the continual sampling and analysis of qualitative data gathered from concrete settings, such as unstructured data obtained by interviews, participant observations and archival research*" (Strauss & Corbin 1990).

In other words, it is a grounded theory researcher's objective to understand what is happening, its meaning behind events and the roles that each individual undertakes. Gathering this data is through observation, conversation and interview. Corbin and Strauss (1990) identify this as theory being discovered, developed and verified through a substantive and systematic process of data collection and analysis.

Grounded theory processes summarised is as follows:

1. Data is collected from a multitude of techniques including interviews, existing literature, focus groups or observation.
2. Note taking is conducted in the form of interview notes, observation notes or transcripts.
3. Coding is the process of analysing the data. Theory is considered to be hidden in the data gathered waiting to be discovered. From the note taking, categories, concepts and properties are identified along with their interrelationships and interactions. There are three types of coding, open coding, axial coding and selective coding. When examining data, open coding involves the naming and categorizing of phenomena. It's about asking the question - what's this all about? In axial coding, after the open coding process has been completed, data is put back together in new ways by making connections between categories. It involves relating causal conditions that lead to the occurrence or development of the phenomenon, context in terms of looking at what is influencing the action or strategy, intervening conditions that is an expansion of context to consider mediating and moderating variables, action strategies that look at what an individual does in response to

the phenomenon and intervening conditions and finally the consequences of the action strategies. Following completion of axial coding the researcher will choose a core category, identify how this is related to other categories, examine and validate the relationships. This is called selective coding. While coding, constant comparisons are made between data and between data and categories. The researcher has a number of questions when examining the data sentence by sentence or observing a situation, such as what is happening?, what are the interactions?, what were the consequences?. Theory does emerge, and when this does emerge the researcher compares the data to the proposed theory. The results from the comparison are written in the margins of interview notes as coding. It is important to note that this process occurs after each interview in order that the researcher can examine and explore newly discovered categories at their next interview.

4. Memoing is done throughout the whole process. When coding and analysing the notes, certain suggestions about the data will be made. There may be links between categories and as these categories and properties emerge, the researcher will identify these in a memo.
5. Once the memoing process has been completed the researcher will group memos into similar types.
6. The researcher will then commence writing from the memo's, which form the framework of the theory.

For the purpose of this research project, only selected elements of grounded theory have been used. These include data collection (*in this instance through semi-structured interviews*), note-taking (*interview transcripts and transcript notes of key*

points), coding (*identifying key themes and interactions for further investigation*), constant comparison (*comparing themes interview by interview*) and finally the development of core subject categories.

Elements of grounded theory have similarities to a Kaupapa Maori theory approach given that both are driven from bottom up instead of a top down research processes. In terms of theoretical sensitivity, in grounded theory there is an acceptance and endorsement of the personal qualities that a researcher brings to the process in terms of insight, the ability to give meaning, understanding and interpretation of the data. Theoretical sensitivity is enhanced through the use of specific techniques for the researcher such as the use of questioning, comparisons, analysis of single words, phrases or sentences so that there remains an ability to identify variables and their relationships. This is in addition to the professional sensitivity that is gained through for example, ones employment, or that of the knowledge gained through literature and readings. Of similarity to a Kaupapa Maori approach is that the researcher brings all of this knowledge and experience to the process and that is acceptable. One of the attractions in grounded theory is that it is designed to help make sense of a situation and or experience. Its about understanding the actions of individuals which in relation to this exploratory study is tangata whaiora access to primary healthcare.

Ethics Approval

Ethics approval was sought and gained from the Massey University Ethics Committee and the Upper South Ethics Committee (URA/05/10/122).

Semi- Structured Interviews

Two semi-structured interviews were created. One was specifically for tangata whaiora to explore their experiences in accessing general practitioner services in Marlborough, and the second was for Kaupapa Maori clinicians to contrast their view in terms of access. A semi-structured interview framework fits well within a qualitative framework giving the flexibility to ask subsequent questions during the interview and for ensuing interviews. They are structured guided conversations about individuals' thoughts around a particular topic.

Both frameworks used open-ended questions and Likert scales. As interviews progressed there was flexibility in the questionnaire format to explore categories further.

Questions asked in the tangata whaiora semi structured interview were as follows:

1. When you first noticed that you might be unwell with a mental illness, what were your initial thoughts on where you would go to seek help? Why?
2. Did you actually seek the help you needed from this first point of contact? If yes, what help did you get? If no, where did you go next for help?
3. If you didn't seek help, how did you eventually access the mental health service?
4. At anytime did you see your/a GP with the specific aim of discussing your mental health symptoms? Tell me about your experience.
5. If you didn't go to your/a GP to discuss your mental wellbeing, why wasn't

this an option?

6. Prior to the onset of your mental illness, how often did you visit your GP?
7. Is there anything that would make it easier for you (*and others*) to visit the GP to address your mental health needs.

Questions asked in the kaimahi interview were as follows:

1. What are your thoughts or local experiences of how Maori access specialist services through the primary care sector?
2. Do you think Maori face barriers in accessing primary health services? If so, what are your thoughts on what those barriers maybe? If no, what are your thoughts on why Maori access specialist mental health services at higher acuity levels?
3. As a practitioner, how do you think the primary care sector can improve access for Maori?

Information Sheets and Consent Forms

Information sheets and consent forms were provided and signed off by all participants. Options were provided to have an interpreter and kaumatua available if required.

Given the small community, assurance was given in the information sheet that participant contributions would be anonymous and that they would not be identified in the final report. However, given that Marlborough is a small community and some of the experiences quoted in the research might be traceable back to tangata whaiora,

identifiable quotes were provided back to tangata whaiora for their approval prior to inclusion.

Participant Eligibility

For tangata whaiora, to be eligible to participate in the study, participants had to be of Maori descent, over the age of 18 years, and have a Witherlea Case Manager assisting in their recovery. Exclusions were any tangata whaiora who had been in an inpatient setting within the last 12 weeks. Not all first episode tangata whaiora experiences in the primary care setting relate specifically to the Marlborough region as many have moved back to be closer to whanau when they became ill.

In terms of the Kaupapa Maori Mental Health clinicians, it was deemed important to have a mainstream service perspective and that of a Kaupapa Maori non government organisational view.

Eligibility criteria were that you needed to be of Maori descent, over the age of 18 years and have been working in the Maori mental health sector for at least two years. Given that the Marlborough region only has four full time equivalent Maori mental health staff, the eligibility criteria for one participant was extended as clinician identified as Pacific Island and Croation, however has been working within Maori mental health services over a five year period both mainstream secondary service and Kaupapa Maori NGO. Participants were also offered kaumatua support and interpreter services.

Participant Support

Tangata whaiora were invited to bring along whanau or kaumatua support to the interviews. If they did not have this support available, then at their request the researcher was able to ensure a kaumatua was available to support the process. Tangata whaiora were also offered to have their interview conducted in Te Reo Maori with interpreter services available. No participants undertook to have whanau, kaumatua support or interpreters at the interviews.

Participants in the Study

Three Kaupapa Maori Mental Health clinicians were also interviewed; two male and one female. Ages ranged between 46 and 55 years of age. Two interviews were held at the Kaupapa Maori Day Activity programme, and one interview was held at the District Health Board office.

Tangata whaiora were recruited through the Kaupapa Maori clinician at the Witherlea Mental Health service. Six tangata whaiora were interviewed, three male and three female all between the ages of 28 and 52 years of age.

Tangata whaiora interviews were held at a location that suited them. This included at their homes, Kaupapa Maori Day Activity programme, Witherlea Mental Health Service, and District Health Board office.

Tangata whaiora were given the option of whether they were audio taped or the researcher took notes by hand. All interviews were transcribed or noted by the researcher and sent back to the interviewee for correction, amendments or additions

prior to information being used.

Tangata whaiora were given a small koha of \$30 in the form of gift vouchers, as an acknowledgement of their contribution to the research.

Limitations

There are several limitations to this research project as follows:

1. First episodes of mental illness were not necessarily located in the Marlborough region.
2. Tangata whaiora noted memory loss when recalling their first episodes of mental illness.
3. Some tangata whaiora identified that they did not access their GP at all historically and currently do not talk about their mental illness with the GP.
4. Marlborough General Practitioners were not interviewed as part of the research project.

Chapter Three – Tane Tangata Whaiora (Maori Male Service User) Experiences

For the purposes of the following chapters, the analysis has been separated into three distinct areas. Tane tangata whaiora (*male service users*) experiences, wahine tangata whaiora (*female service users*) experiences, and Kaupapa Maori clinician views.

The pivotal reason behind the gender separation is that while there are overall consistencies in terms of experiences, initial analysis suggested that male pathways into specialist services and historical and existing utilisation of GP services significantly differed from female experiences.

The Kaupapa Maori clinician views come from an outsider view observing and supporting tangata whaiora on their road to recovery.

References to tangata whaiora in this chapter, relate to tane (male) only.

Pathways into Secondary Services:

Tangata whaiora were asked that when they first noticed they might be unwell with a mental illness, what were their initial thoughts on where they would go to seek help and why.

“Didn’t access the GP”

“I just got taken to the Police. They put me in a cell there and then took me to mental

health”

‘When I first became unwell I went straight to Ward 12”

Tangata whaiora had mixed experiences in relation to their first episode of mental ill health. Taking into consideration their difficulties in recalling first episode experiences of mental illness, tane identified that General Practitioners (GPs) were not the first port of call. Their pathway into the service was either through the judicial system or direct to the specialist mental health service, which resulted in their view a loss of control. Two tangata whaiora were unaware that they had a mental illness at the time of their admission.

Cost

Two tangata whaiora noted cost as one of the biggest barriers in accessing primary healthcare services. However, one tangata whaiora identified that cost was not a barrier to access the GP and that if he needed to go he would attend. Even with outstanding monies owed to the general practice, payment of consultation fees was not a barrier.

“Cost a little bit. It’s not too bad”

“It could be cheaper than what it is now. It’s about \$38 for me to see my Doctor”

“It costs more to go to the GP

Inherent in all of the responses were that tangata whaiora will not attend the GP unless the level of acuity is high. This naturally has an impact on the ability to prevent illness and implementation of early intervention strategies.

Fear

One tangata whaiora identified a fear in going to the General Practitioner and a possible referral to the mental health admissions (inpatient) unit. Even though, there is close liaison between primary and secondary based mental health services, there is a concern that the GP could refer direct to admissions. Consequently this is another contributing reason why tangata whaiora address only physical needs in a general practice setting.

There is a genuine fear from all tangata whaiora of ending up in an admissions unit and the consequences that follow. This is evidenced by the following comments.

“If I say anything, I might get put in hospital again”

“I hated having that needle. The medication would zombie me out. I’d come out of the unit and not be able to talk. Would be like a three week old baby”

Some of this fear relates to the loss of control, lack of communication or understanding of why tangata whaiora were admitted.

“Involuntary. I don’t even remember them telling me, cause I remember being there for weeks and not knowing why I was there”

“I was in the unit for several weeks not knowing why. There was paranoia, they were trying to kill me, inject stuff into me. I fought off the male nurses. They might have told me but I might not have comprehended it”

Tangata whaiora clearly demonstrated they were fearful at the prospect of being admitted to acute inpatient services on the basis of their previous experiences.

General Practice Knowledge and Expertise in Mental Health

There is a clear perception amongst male tangata whaiora that general practice is not the most appropriate setting to treat their mental illness.

“I’ve never talked to my GP about my mental illness”

“I just go to the GP for my physical health”

There are several contributing factors that advance their perception of primary health care. One is around opinions relating to general practice qualifications and knowledge to assess and treat mental illness. This is complicated by the fact that tangata whaiora have access to the Witherlea service, a secondary based specialist mental health service. Therefore the service is free and there are more resources in terms of a multi disciplinary team that can provide the necessary time to assist in their recovery.

” Witherlea are more probably qualified to talk about it”

“I go to Witherlea for my mental health”

For one tangata whaiora there is a hesitancy to approach either the GP or the specialist mental health service, and whanau/family are their preferred first contact for support and assistance with their mental health.

“I go to my family first before the GP or Witherlea”

There is also the view that GPs will not provide the treatment that you’ll require.

“GPs give panadol, tell you to drink lots of water and rest.”

Underlying this statement is the lack of confidence in GP assessment, diagnosis and treatment of mental illness.

Relationship with the General Practitioner

If tangata whaiora have had a long term primary care relationship with their GP, there is an increased ability to communicate with them, and more confidence in their ability to understand their illness and how it impacts on their lives.

“My GP is good with me. I’ve been with the same GP, father and daughter all my life”

“I’ve had the same one all my life. It does make a difference. Didn’t feel as

comfortable with the locum”

“I wouldn’t go to another GP now because he might be different – because he knows more about me than a new GP would. Been with this GP since 1998”

One tangata whaiora did not have a GP at the time of his interview. He identified that while he knew that he required a GP, he’d wait until he became physically ill to arrange it. He specifically identified that historically he has never spoken to his GP about his mental illness given that he had access to Witherlea.

Frequency of General Practice Visits

Males do not like to visit their General Practitioner for physical or mental health. There is a tendency to avoid general practice consultations unless the acuity is high.

“I’ve only had one visit in four or five years”

“Really don’t remember. Haven’t been for quite a while:

“I never go to the GP unless I’m really sick.”

“I don’t go to the GP unless I’m really worried about my health, every two or five years”

Given the poor status of Maori health, tangata whaiora are at higher risk given

research evidence that mental health service users have a mortality rate higher than the general population who do not have a mental health illness. There is no current research evidence that identifies mental health service users' mortality rates, comparing Maori and non-Maori.

General Practice Waiting Times

At a general consultation timeframe of 10 to 15 minutes, tangata whaiora did not have many concerns around the general practice waiting times for an appointment, which can often be longer than the 10 to 15 minute consultation timeframe. Partly this was because when tangata whaiora wanted to open up and spend the time communicating their mental wellness/illness then their preference is to discuss this with the specialist mental health service.

“My GP’s okay but at night time I have to wait a bit longer”

Another reason for their lack of concern about waiting times is that tangata whaiora do not access their General Practitioner very often.

General Practice Reception

One tangata whaiora noted that the receptionist can be rude at times, especially around payment. Consequently, if there are outstanding debts owed by tangata whaiora, then there is hesitancy and a sense of embarrassment in returning to the GP in case they receive a similar reception. This can also prevent access.

General Practice Waiting Room

Waiting room environments can cause a level of concern. For those tangata whaiora with a mental illness, waiting room environments and the length of time spent in the waiting room can cause them to become more anxious while they wait.

“The waiting room environment is dirty. People coughing everywhere and blowing their noses and picking up a magazine and putting it back down and someone else picks it up and picks up their germs”

Understandably for tangata whaiora with general anxiety disorders (GAD), the waiting room environment could cause an escalation in somatic symptoms. Even without GAD tangata whaiora feel a level of discomfort waiting for long periods of time in waiting rooms with the possibility of picking up additional illnesses.

Current General Practice Utilisation

Tangata whaiora were asked about whether there were any changes from their care prior to and after their mental illness diagnosis. This question was difficult for tangata whaiora to answer since they very rarely attended their General Practice unless the level of acuity was high

“I try, to never go to them eh”

For two tangata whaiora there was also a level of memory loss, which was quite substantive in one instance, so they could not recall previous history. Therefore overall they did not see any difference in visits prior to and post their mental illness

diagnosis. This could also be attributed to the care provided by the Witherlea mental health service.

Support Mechanisms

Some tangata whaiora take support to their GP visits including whanau, Community Support Workers and/or their Case Managers.

“Have someone to go to the GP to help explain to the Doctor but I go to Witherlea by myself”

Tangata whaiora talked about having support available to help communicate with the GP. However, taking support along to their doctor’s visits did not necessarily mean they were more likely to engage in discussions around their mental health. Notably, a communicator/translator isn’t deemed necessary for secondary care services.

Transportation

Transportation can be an issue in accessing services. The three tangata whaiora interviewed did not have vehicles of their own. Tangata whaiora lived central to the Blenheim Township therefore transportation to a GP practice was not an issue of concern for them.

“Had to walk to A & E, about half an hour walk and then you have to wait”

The mode of transport is primarily walking or cycling. In some instances this has benefits not only in terms of their physical health, but also to their ability to

financially survive on a sickness benefit without the added burden of motor vehicle costs.

Relationship with Witherlea Mental Health Service

Tangata whaiora prefer to use the Witherlea Mental Health Service for all of their mental health needs. This is deemed a positive relationship where the staff are known to tangata whaiora, the appointments are not rushed and there is no cost associated with the service. They experience improved levels of understanding from the specialist services around the illness and how best to meet their needs. This has created a level of trust and comfort in the service.

“I go to Witherlea for my scripts and meds. They are the specialist services. They know what I’m like. Better communication and relationship”

“Feel safer at Witherlea”

“Witherlea is more accessible than the Doctor. Know nearly everyone there but not at the GP office”

“Its cheaper to go to Witherlea”

“Witherlea does me for 3 or 7 months. You can have a joke with them. They know me”

“I feel more comfortable talking to Witherlea because they have time. If I need to talk

to someone, if I need half an hour or an hour then they give me that time”

However for one tangata whaiora, there still remains a level of hesitancy and mistrust with Witherlea and a reliance on whanau/family first.

“Had some brilliant nurses. Our relationship is okay. I only tell my family when I’m sick. Don’t even tell Dr _____, (at Witherlea). I don’t trust them”

In this instance there is recognition of an improved relationship with specialist services compared to primary health services, but a level of mistrust remains.

Relationship with Maori Mental Health Staff

Generically being able to have service provision relationships with Maori mental health workers was viewed as positive and made a difference in terms of the ability of tangata whaiora to communicate with and access services.

‘I rely on _____ first for mental health, and he’s Maori second. I need him more than anyone else”

This comment related specifically to Maori mental health staff within a mainstream setting. There is an increased level of comfort and acceptance due to the professional expertise the individual holds and confidence in his abilities to care for the tangata whaiora increases due to his Maori descent.

Relationship between primary and secondary based mental health services

There appears to be good communication between primary and secondary based mental health services.

“My GP knows that Witherlea cares for me”

Tangata whaiora are aware that the GP and Witherlea communicate and share client notes in order to provide a comprehensive care plan for the client. Information sharing between the two services does not trouble tangata whaiora even though their level of trust in the primary health care services is not as strong as primary health care providers.

Whanau /Family Supports

Undoubtedly family/whanau can be great sources of support. However in some instances this can border on creating a level of dependency as opposed to empowerment. It can also take away the individuals control over their own recovery path.

“She’s still trying to tell me what to do. If I swore at her, she’d ring up Witherlea and five or more would come down and try to take me to Nelson.”

Even when tangata whaiora have made attempts to implement positive changes, whanau can be a barrier to recovery without even realising it and with the best of good intentions

“You know I gave up smoking while I was in hospital and I’d smoked ever since I was 13. My sister came and said ‘Do you want a smoke’ and I said ‘No, I’ve given up’ and she said ‘You’re too sick to give up’ and she gave me a carton of smokes”

“I came back to Blenheim but wanted to go down the Pa, not be in town. Mum told everyone my business but I wanted my privacy. Mum even told Social Welfare that I didn’t need that much money. I said to Mum ‘I’m going to get a flat’ and she said ‘No you’re too sick”

“Mental Health cost me a lot, there was this bitch of a nurse and her and my Mum would sit down and talk for ages, over about four years – they never asked me a thing – I hated it, they made decisions for me”

In these examples whanau/family were trying to support what they believed was the best interests of the tangata whaiora. However their efforts had the opposite effect and in these cases whanau became barriers to recovery, and supported the loss of autonomy suffered by tangata whaiora.

Summary

Male tangata whaiora experiences demonstrate a number of barriers in terms of accessing general practice services, many of which are consistent and identified in earlier research or encapsulated in government strategy and action plans. However a number of new themes have emerged, the concept of fear, the reliance on specialist mental health services (including Maori mental health staff), the provision of

adequate waiting room environments, the importance of first contact reception services, and finally effective communication on several fronts.

Chapter Four – Wahine Tangata Whaiora (Maori female service user) Experiences

Pathways into Secondary Services

The pathways to secondary services differed between tane and wahine. Two female tangata whaiora accessed primary health care services in some form prior to accessing secondary based services.

“Not sure if first visit was to a Doctor or Psychiatrist. Think it was a Doctor. When I think back on it GPs didn’t help at all. They were mainly a referral agency. They said ‘No she needs to go to psyche services’”

“No it wasn’t my GP. I was overseas and got sent two and a half hours away to see an American Psychiatrist. He said go home and see your GP, go back to NZ, don’t stay. So when I got back I went straight to my GP and at the time he said ‘right you need hospitalisation’ and I did. I did see a GP pretty well straight away when I came home”

One identified that when she first became ill she didn’t realise what was going on or how sick she had become.

Cost

Tangata whaiora identified that there are barriers in terms of the cost of GP visits and that reduced fees would assist in them accessing Primary Health services. Costs did not only include the consultation fees, but also the writing of scripts and pharmaceutical charges. Tangata whaiora expressed a sense of unfairness at the fees

charged for services outside of a consultation visit. In addition, if you are ineligible for a Community Services Card then there are further barriers in terms of cost.

“Cost is a big thing”

“Scripts cost me about \$10 from the chemist. I still have to pay for the actual medication when I purchase it. See I haven’t got a CSC [community services card]. I don’t qualify. CSC makes a difference to your prescription costs, visit costs and charges for medication at the pharmacy”

“It has been a factor in me not going to the doctor as often as I should”

“\$15 for prescriptions, \$10 to get a form signed, just a social welfare or parking permit where he just has to squiggle his signature”

Overall cost is seen as a barrier to access the GP and had consequences for limiting the frequency of tangata whaiora visits. However, cost doesn’t seem to limit access to a GP when it is needed.

General Practice Knowledge and Expertise

Tangata whaiora expressed the view that general practitioners are not seen as having the skills, knowledge and expertise to appropriately assess and treat mental illnesses. There is a clear perception that this is the realm of secondary mental health services. Given that the tangata whaiora involved in this exploratory study are all case managed by Witherlea mental health service, and have moderately severe to severe mental

health disorders, this is a reasonable assertion from their vantage point. They gave, minimal consideration to the possibility of their GP taking over their future case management. Tangata whaiora still considered that primary health care providers do not have the mental health expertise required.

“GPs are not the place to go for mental health. Mental health is not their job and they don't have the expertise for it”

“Tried years ago talking to my GP but it didn't work. He didn't know how to deal with it when I spoke to him. Only go now to get my scripts”

“Personally when you first get sick, you should probably go to the GP. But if I knew someone who had the same symptoms as me, I'd refer them direct to Witherlea”

“Yeah but of course it's not his special area”

This perceived lack of knowledge prevents tangata whaiora from accessing the GP service, even if it is only for a mental health assessment.

“I very seldom would make a specific appointment to discuss mental health. I would always. I mean maybe I should, but I go ... as I say that's when cost comes into it. Like I've gotta go every 3 months anyway for medication but there's always other things that crop up as well “

One tangata whaiora had recognised a change in GP knowledge of mental health over

time and now had confidence that the GP was able to cater for her needs.

“GPs have the skills to look after me now”

While visiting the General Practitioner for her normal medications, the doctor had said *‘I think you’re a wee bit down’*. He didn’t think that she was depressed but ‘down’.

“and that he actually said to me ‘Its not a long term solution’. That’s what he said, and yeah, and because I made sure, I was determined not to burst into tears even though I was feeling suicidal, he actually said to me ‘I think you’re a bit down’ but that’s all. He didn’t think I was depressed, he thought I was a bit down. And I said well actually I’ve been feeling suicidal but I was determined not to cry you see so maybe I didn’t come across as someone as ill as I actually was”

Relationship with the General Practitioner

For all tangata whaiora the key to their accessing a general practice service was in the relationship that was developed with their GP. From a tangata whaiora perspective it makes a substantive difference in the level of care provided if you have been with the GP for a number of years. Two tangata whaiora families had been with their GP for several generations. Such a long term relationship allows the time necessary for the GP to get know the tangata whaiora, for the tangata whaiora to form trust in the relationship and have the confidence to clearly communicate concerns. They are more likely to receive the assistance needed.

“Yeah because he cared for me since I was a baby and the whole family. So that did make a difference of course”

“Comfortable because I knew _ and he knew me, I have a long history because he delivered me”

“Look he was wonderful and like I knew him and I’ve know him for years and he has always been so you know what he’s gentle and he’s kind and he’s understanding, he doesn’t judge you or anything”

However, two of the tangata whaiora, having been with their GP for two generations, transferred to another GP because of the extensive waiting times for their appointment and the anxiety that this often caused. This made it clear that even long term, trusting relationships could be disrupted by other factors.

General Practice Attitudes

Tangata whaiora were varied in their descriptions of GP attitudes. The majority of these were positive.

“He doesn’t judge you or anything”

However, there were occasional negative experiences where tangata whaiora felt the service providers had bordered on being insulting and impolite. These incidents left lasting impressions that can subsequently impact on communication and effectiveness

of the consultation.

“And I think sometimes I have had some, its not so much a barrier and I’ll probably keep going to him but as I said because its now really hard to change. I do know some who come up with those same kind of inappropriate comments I haven’t found very funny and I know its once again half humour and half meaning it and I felt not respected when those comments come up. And it is a barrier in some ways because I feel it out in that waiting room, I think hmm what’s going to happen in there today”

Tangata whaiora simply want to be treated with respect and without discrimination.

“Probably with this particular GP may not, his heart may not be in his job. He finishes at 4 pm, he has the school holidays off and he’s just not gonna be a slave to his job and that’s just a lot of the young modern doctors”

The above quote implies a non-caring attitude or lack of full commitment of the GP.

The GP isn’t going to go out of his way or the extra mile for his practice or patients.

General Practice Service Provision

There is a level of variety in what the GP will provide in terms of addressing mental health issues. It appears that their predominant role is the renewal of medication prescriptions, which is normally done in consultation with Witherlea Mental Health Service.

“The GP does my prescriptions”

“Now my medication lasts me for three months, so then I’m supposed to go and see my GP, but normally I probably go and see him about once a year, twice a year maybe”

Really the only reason I go to the GP other than if I’m physically sick is to get another script for my meds. They’ll ask you how you are going and are you okay but that’s about it”

In comparison to male tangata whaiora, wahine appear to be more comfortable in accessing primary health care services even if it is only to renew medication.

Due to other chronic conditions one tangata whaiora was seeing her General Practitioner on a regular basis.

Tangata whaiora were encouraging, identifying that in the main, GP’s service provision is satisfactory, even though there could be some communication improvements.

“Very caring GPs, very considerate, very helpful, yeah and good”

“Had mainly positive experiences with GPs. The only negativity is around paranoia sometimes”

“I did years ago try talking to my GP but it didn’t work. He didn’t know how to deal with it when I spoke to him”.

Consultation Timeframes

It is important for GPs to be flexible around the consultation timeframes for tangata whaiora to be able to communicate their mental and physical health issues.

“He’s very good too and he doesn’t rush me, so there’s not much difference between now and before”

“My new doctor is very good but you tend, you get a shorter time to wait for him, but a shorter time to be with him. And it can be a bit anxiety provoking wondering whether I can actually get through everything that I need to talk about including my mental health. Once I’ve talked, even just writing out my prescriptions and talking about my asthma and chest infections there’s hardly any time to talk about my mental health”

“I suppose what would make it easier would probably be for me to set aside one whole appointment, instead of just trying to cover so much in quarter of an hour”.

Tangata whaiora contrast the level of care they receive between the GP and the Witherlea mental health service. The constraints of a GP setting does not necessarily allow the consultation timeframes that tangata whaiora need. While there is recognition that GPs are concerned about their patients health, they are unable to give the time needed, to fully accommodate a mental health consultation. However, tangata whaiora prioritise their appointment time and tend to physical health issues before mental health issues.

General Practice Waiting Times

Longer waiting times cause a level of anxiety and distress, which can result in tangata whaiora changing GPs., This is despite the fact that long term intergenerational services have been provided to the whanau/family.

“I know once you get in there he gives you his full attention, and he’s got a wonderful manner but some people, and myself found it a bit distressing at times you know that two hour wait”

“I’ve got to say, around here it seems to be a bit unfair to Doctor ___ because he um, there used to be a two hour wait for him. I don’t know if there still is, so I had to sort of change doctors”

There is also a level of concern around appointment timeframes and the ability to access services on the same day. For tangata whaiora living in rural areas this poses additional challenges.

“If you go to a GP, you have to make an appointment which sometimes is the next day, unless you go straight to hospital which makes it really hard if you live in Picton”

General Practice Reception

Tangata whaiora had no major concerns around first contact reception responses. One tangata whaiora spoke very positively of the relationship she had established with GP receptionists.

“They’re pretty good when I ring up and I know when I’m not too good. One of them in particular will actually say ‘we’ll you’ll have to come in and they find me a spot on that day. The other one will just sort of say ‘no he’s fully booked today you’ll have to come in tomorrow unless you feel its really really urgent’ and I wouldn’t say if it wasn’t and I’d say yes I do need to see him today”

Inherent in the relationship with the receptionist is the flexibility and ability to accommodate last minute appointment requests.

General Practice Waiting Room

The waiting room environment causes anxiety and distress for a number of reasons. Tangata whaiora did not say that they left the waiting room without having the consultation with the GP, however the all three tangata whaiora identified differing levels of anxiety caused in the waiting room.

“I used to get anxious previously when there were lots of people around but not in the past four or five years as I only have a mild form. I used to walk around a bit though.

I wanted to leave and became impatient and felt the need to go”

“The waiting room makes me feel uneasy. Some situations make me anxious”

“Well I guess that is sort of, noise and kids running around and um, I often feel anxious. I start to feel anxious and wondering when my turn is coming and”

Inevitably, the noise, the number of people, the young children, accompanied by the existing illness, all cause a level of anxiety while waiting in the GP waiting room.

Transportation

Female tangata whaiora did not identify transportation as a barrier to accessing a GP service. This may be due to the locally centred General Practice services. Tangata whaiora were prepared to utilise the local taxi service if this was required to access services.

Current General Practice Utilisation

Use of Primary Health Care services had not changed dramatically for tangata whaiora at the time of the interview. They continue to access the GP predominantly for their physical health needs. If there are any scripts required for their mental health, then this is usually tacked on at the end of a physical health visit.

Relationship with Witherlea Mental Health Service

The purpose of the thesis is to explore tangata whaiora experiences with general practice services. The specialist mental health service clearly influences the perception and opinions of tangata whaiora in terms of GP services.

Several key themes surfaced in relation to tangata whaiora preference for the specialist mental health service to cater for the mental health needs. These can be summarised as follows:

Tangata whaiora consider that the specialist skills, knowledge and experience that Witherlea hold as a specialist mental health service far outweigh those within the primary care sector. There is a level of confidence in the service provision.

“I wouldn’t go to the doctors again, if I had the option I’d go straight to Witherlea”

“But I also have access to Witherlea House. Like if I’m really bad and I’m not going very well, then I go and see__ and can bring supports with me”

Once again, the relationships established with Witherlea are deemed positive with improved levels of communication.

“We have a good relationship, they know about my illness and I feel more comfortable in talking to them because they have the time.”

Appointment and consultation timeframes are not restricted at Witherlea. There is a level of flexibility that allows for increased service provision if needed.

“If I need to talk to someone, if I need time half an hour, an hour then they give me that time”

Wetherlea are able to show a level of empathy and caring in their day-to-day practice. This also links to the flexible timeframes available as an enabler for improved quality of care.

“And GPs don’t seem like they really care, like the mental health people do”

In times of crisis, even though the appointed Case Manager may not be available, Wetherlea are able to provide the necessary experienced and qualified back up to support tangata whaiora. Knowing that this level of support is available provides a level of comfort appreciated by tangata whaiora.

“They’re always there and are very supportive. Even if its not my existing Case Manager, they always have someone on call. Last year when I thought I was becoming unwell, they were right there for me”

Wetherlea is a free service. There is no cost for tangata whaiora to see their staff whether Psychiatrist, Case Manager, Psychologist or Occupational Therapist. In fact in some instances there are cost savings for tangata whaiora.

“Yep cause I can see ___ and she’ll give me a prescription and not charge for it. But I don’t always do that.... that’s not a regular thing.

She gives me a script and not charge. Saves me at least \$10”

This clearly demonstrates the comparison tangata whaiora make between primary healthcare services and specialist mental health services, and the added value they receive from specialist services.

Tangata whaiora and whanau stigma

Stigma is attached to both tangata whaiora and whanau preventing them from fully participating in society on a full and equal footing. The negative labels attached to a mental illness can result in social exclusion and fuel discrimination, which is why having a mental illness is kept hidden at times. While tangata whaiora acknowledge the unintentional stigma from family/whanau, there is also the internal stigma they carry in terms of their mental illness.

“I also got embarrassed towards the end. I get nervous. I’m a very nervous person. I was thinking that I was a bit of a loser”

“Um I think it must have been my own internal stigma and with a feeling that Mum perhaps was a bit ashamed”

One tangata whaiora was asked to return to Marlborough to be with family when she noticed that she was not feeling well. The tangata whaiora arrived home and feeling unwell advised her parents that she needed to go to an inpatient mental health service.

Her father’s response was:

“We shall not permit it”

And her mother's response was:

"There are worse things"

In the tangata whaiora view, this response was due to their age and that they were from a generation when there was a huge stigma around mental illness and lack of education around mental health issues. They believed that mental illness is best kept within the whanau/family where it could be dealt with internally. They also believed there were more terrible things that could happen than a mental illness, so they expected that the tangata whaiora would simply get over it.

Support Mechanisms

The importance of support mechanisms cannot be understated. When one tangata whaiora became unwell, her mother decided to accompany her to the GP who was a family GP and had cared for the whanau for some time. This was the turning point where the GP diagnosed the depression, made a referral to Witherlea Mental Health Service and subsequent treatment/medication and support were provided. Having her mother attend the consultation, recognise the severity of the illness and support the subsequent treatment provided relief and an endorsement of family/whanau acceptance of the illness.

Tangata whaiora also recognised the impact of their mental illness on their partners and family/whanau. They had a desire to avoid imparting stress to their whanau.

"I kept saying to him, I'm going to have a breakdown, I'm having a breakdown and I

was being mean and I was racing around, driving erratically, doing all this crazy stuff, its hard on him”

However, there remains a level of uneasiness about accessing the GP even when tangata whaiora are accompanied by whanau support. Whanau support does make a difference and alleviates some of the pressure for tangata whaiora.

“Extremely uncomfortable only because of my nerves. Even when whanau came along it was a wee bit better but still uncomfortable” (in terms of visiting a GP)

Relationship between primary and secondary based mental health services

Tangata whaiora are confident that there is close communication between the GP and the Witherlea Mental Health Service. Their only concerns were whether they were left out of the communication loop in relation to their own recovery plan, not wanting to be caught in the middle of any disputes, and not entirely agreeing to the treatment plan.

“He’s a little bit weary, he actually says things like ‘I don’t want to get into a political fight with Witherlea cause there was a little tussle about my medication with somebody chopping it and somebody in Witherlea chopping it back and they did it too severely and you know it didn’t work and so he gave me a little bit back and was worried if he’d upset Witherlea. But theres been quite a bit of that, back and forth”

“They did receive copies of consultations up there, a copy would be sent to him. He’d just say ‘I’ve had a few letters’ and once he did say to me ‘yes there is a plan – we do have a plan’ that was a few months ago’

“He doesn’t like my medication for my mental health”

In general however, there were no major concerns around the interface between primary and specialist mental health services.

Tino Rangatiratanga

In terms of recovery pathways it is important that tangata whaiora lead their own recovery. Tangata whaiora say that during their illness there has been a loss of control and decision-making, which has impacted on their recovery.

“So he said to me ‘we’ve got a plan’ my doctor, as he’d like me to come off them.

And I will come off some, but I’d like it to be, to feel myself more in control of it”

In some instances it would be beneficial for recovery based training and education programmes to be provided to the primary health care sector.

Chronic Illnesses and Care Plus

For those tangata whaiora with a number of health issues, there are additional barriers to primary healthcare. These include issues such as adequate consultation timeframes, cost, transportation. None of the tangata whaiora interviewed whether male or female, were registered on the Care Plus programme even though they may be eligible.

“but what I’ve noticed people with chronic illnesses, myself and I’ve got a friend with a chronic illness (you know a number of things) that they’re less likely to take you on as a patient and um, I mean my doctor actually said to me ‘nobody else would take you on. It’s getting much harder to change your doctor now in our practice yeah, particularly if you’ve got a chronic illness”

“He said you are a case for Care Plus but nothing has happened and yeah. Cause he said to me, sometimes I think he’s actually got quite irritated. I think there’s a stage for people with chronic illnesses where maybe GPs feel that they actually can’t do much more. You know”

“I don’t know who’s on it. I’ve heard people talk about it but they’ve not actually ... yeah he said to me ‘you’d be eligible’ my doctor, he said you can get a discount for one, one free one and a discount for two and then you would see me every two months”

With a chronic condition there are cost savings to be made if tangata whaiora were registered with the Care Plus programme. This could improve tangata whaiora access to services and provide the additional consultation timeframes required.

Summary

Female tangata whaiora experiences also demonstrate a number of barriers in terms of accessing general practice services. Once again, many of these are consistent with what we already know. However, in addition wahine talked about the additional extra costs incurred in a GP visit, the lack of respect sometimes given to them by the primary care sector, the stronger preference for specialist mental health services,

the internal stigma about one's own illness, the provision or lack of Care Plus, the environmental issues and finally the importance of participating and leading the decision making around ones care.

Chapter Five - Maori Mental Health Clinicians

Three Maori Mental Health Clinicians (MMHC) were interviewed in the current study. Altogether they had over twenty years experience in the mental health sector among them.

Referral Pathways

MMHC confirmed that most Maori males access specialist services in a violent way and when most unwell. MMHC are more likely to see Maori males in a Police Station setting, predominantly due to their externalising behaviours. When Maori present as unwell they can appear intimidating to others especially if they are physically larger. Aggressive behaviours were identified as one of the primary health care barriers because GPs can be hesitant in engaging tangata whaiora.

“But when they go through the Police Cells its crisis it goes into. They go through crisis and it’s them who will contact us to bring us on board with them if they need to.

We have had some referred to us through probation”

MMHC report that postnatally depressed clients usually come through GP referrals and the rest attend to appear in crisis and usually at their first presentation. Often the majority are psychotic, with depressive psychosis. They often get a label of anti-social disorder mainly due to the aggressive nature of their behaviour. This is similar for non-Maori men.

Whanau/Families are another referral point, seeking support and assistance from services when their whanau member mental illness causes concern.

Cost

MMHC identified that cost is the most restrictive barrier. If tangata whaiora owe money to the GP they are reluctant to go back. Consequently Maori tend to carry their illness until they are very unwell and unable to cope. Emergency services are then necessary.

The cost of GP visits and medications are sometimes simply unaffordable. Tangata whaiora would rather put kai (food) on the table and be unwell than pay for doctor's fees. In addition, some of the medications are quite expensive therefore tangata whaiora are not always up to date with their medications.

Wetherlea Case Managers will work with Work and Income New Zealand (WINZ) to set up systems where tangata whaiora disability allowances are paid directly to the GP or Pharmacist. However, if the WINZ staff changes then the disability allowances can be stopped. MMHC reported that some WINZ staff feel that setting up direct payments is creating dependence. But when MMHC explain the difficulties in putting \$3 or \$4 away each week to pay for medical costs, when they only receive \$200 a week to live on, then most are happy to reset the automatic payments. Tangata whaiora often go into debit and MMHC reported that drip feeding disability payments direct to the tangata whaiora and not the GP or Pharmacist can become a barrier. Once this is addressed then access due to cost is not an issue.

“Because I find that WINZ is not too bad at trying to sort something out with their medication.

At times, due to these costs, tangata whaiora are unable to afford their medications and as a consequence their level of acuity increases.

“A lot of times they can't afford to get their meds out, so they do without them and then were on this trial of them becoming ill, going right back down because they won't tell you, they won't tell you that they haven't go their meds because they didn't have any money to go and get them out, they won't say. You'll be saying 'have you been taking your medication today' because you can see the decline and they say 'yep, yep, yep' and then they start getting worse”

In rare instances where there are no further avenues available for tangata whaiora to receive their medications MMHC will personally pay for medications.

“I know I had one case where I paid for the meds. Because she just couldn't, her bill was just too high at the chemist, because she had had been into WINZ so many times, she just couldn't afford to get any, they wouldn't give her any more money. So I ended up just getting her meds, I just went and paid for them”

Even though to access primary healthcare is at a cost, the Witherlea mental health service on rare occasions has taken a generalist role and also accommodated tangata whaiora physical health needs.

“Tangata whaiora income is limited and they normally won’t go the GP unless they’re near on death’s door, so in some instances our Psychiatrist will cater for their physical needs but very rarely now as the service is trying to promote GP care when its clinically viable”.

General Practice Knowledge

MMHC felt that GP’s did not see tangata whaiora with moderately severe to severe mental illnesses very often and believed that further education was required to assist them in gathering information for appropriate referrals to secondary based specialist mental health services. MMHC suggested that GPs have difficulty in identifying prodromal features and if they were oriented to a specific mental health area, they would be likely to miss other mental health symptomologies and diagnosis.

MMHC accepted that GPs pick up depression effectively and identify those Maori with acute psychosis however they are unable to identify signs and symptoms associated to the wider DSM-IV diagnosis.

“Sometimes they can’t pick up prodromal features. If health professionals have a bent on a certain mental health issue then they can miss others. GPs pick up depression really well and those that are really psychotic but not the subtle things”.

“Usually they get a label of anti-social disorder mainly due to their aggressive nature, which is similar to non-Maori”.

Power Differentials

MMHC also spoke about observing the power differentials between tangata whaiora and the GP. Tangata whaiora can feel that they're wasting their GPs time because the GPs are professionals, highly educated, affluent and know what is best.

“GPs need to be more interactive and see a different level of functioning. Clients can be robotic, sit quietly waiting for the GPs to talk. We are all trained as young kids to sit and listen to what the Dr said”.

“There's an inferiority there”

This can be intimidating for tangata whaiora so they often don't speak up and have a tendency to either misrepresent their symptoms or not disclose them at all.

There is also the belief that 'the doctor knows best' which leads tangata whaiora to avoid querying what the doctor has been advising or prescribing. The tangata whaiora will affirm that they understand without fully comprehending what the GP is saying. MMHC have had to often attend appointments to help tangata whaiora and act in an interpreter role so tangata whaiora understand changes to their medication.

Physical symptoms have priority over mental health symptoms for GPs. Some of this is about the tangata whaiora own insight, and there is a level of failure within tangata whaiora themselves. When questioned, tangata whaiora have said that they forgot to ask about their mental health issues. Whether this happens consciously or

unconsciously MMHC felt there was a feeling of inferiority that stifled communication between tangata whaiora and GPs.

General Practice Relationships

Where the tangata whaiora has a collaborative and long term relationship with the GP, or among some older GPs, the power may be equalised and this gives tangata whaiora the confidence to verbalise their symptoms. If the GP ‘birthed’ the tangata whaiora and continued care throughout their adult life, then the access issues aren’t as serious because there is a level of trust and respect in the relationship. Without that level of connection or relationship with the GP access to quality of care is compromised.

General Practice Waiting Times

There was an acknowledgement that tangata whaiora who have to sit and wait for the GP consultation for an extended period of time become anxious.

“No they won’t, a lot of them won’t but a lot of it you pick up just through their actions because of what they’re doing, while they’re sitting there for five minutes and they can’t keep still and then they jabber without realising what they’re doing, the assessment is being done through what they’re doing.”

Tangata whaiora can become wound up and anxious in the waiting rooms. Adrenalin starts to affect their behaviour. If they could go directly into the consulting room, or see their Practice Nurse first so that blood pressure, blood sugars, weight assessments or other physical assessments can be completed first, then that might alleviate the anxiety and provide more time to discuss symptomology with the GP.

MMHC will limit the stress caused by the waiting period (*not only in a general practice setting*) using a number of different techniques.

“Tangata whaiora can become paranoid and volatile while waiting for the GP due to past experiences. The level of time spent in the waiting room, the hustle and bustle of movement and noise can make it worse. In some instances I’ll ring the GP and advise that we’re attending at such and such a time and would appreciate a limited waiting time because of the patient’s illness. Most GP’s will accommodate this, especially if they know the tangata whaiora well. At a local level one of the tangata whaiora on my caseload has a WINZ Manager who now knows that when he has an appointment, to either see him when he arrives, or escort him to an empty office to wait until he is available.”

General Practice Receptionists

As the first point of contact for General Practice services, the receptionists conduct in handling outstanding accounts can prevent access. Some receptionists are more business like, and if tangata whaiora owe money, they may be shamed by the receptionist. If tangata whaiora debt is raised at reception, some receptionists will say that the GP is not prepared to see the tangata whaiora again because of outstanding accounts, or they’ll ask how the tangata whaiora is going to pay for it.

“No she said ‘well he’s got a bit of an account here, I won’t be a minute’ she goes and talks to the GP who comes back and says ‘well we really have to get this account

sorted you know' So they're really not keen on taking him, until you do something about that".

"I mean our people are not – its sort of something that gets put on them and its totally.. I've known those that would walk out and not go back in. So you've got those walking out there and you're trying to you're out well how are you going to get their meds, but, you go in see the Dr, talk to the Dr and try and sort it out with the Dr and then you go and look for them and bring them back in. So that takes a heck of a lot of work even trying to get them back in there."

Receptionists may be very efficient, and if they could offer a glass of water or cup of tea it would be helpful. Receptionists could also advise the tangata whaiora on the estimated waiting length time so they could come back if it's longer than half an hour.

Consultation Timeframes

From the MMHC point of view, the length of consultation is rushed at 15 minutes. Often this is an inadequate time to communicate all of your health issues.

Tangata whaiora are unaware of how to maximise their quarter of an hour consultation, because they may go for one issue, when they have several health concerns, even basic health checks. A Mental Status Examination can take up to 1.5 hours, and GPs simply don't have the time or necessarily the skills to conduct these.

Practice Room Environments

The waiting room environment can be uncomfortable for tangata whaiora. Chairs can be uncomfortable especially if you're a large Maori. The practice rooms are often

not large enough to accommodate whanau support. MMHC report that some waiting rooms are almost like a bus stop where you take a number and wait your turn, which leaves tangata whaiora feeling depersonalised.

Tangata whaiora can get anxious and their condition will escalate requiring MMHC intervention.

“Yeah. A lot of times I’ve had to talk them down and take them out for a walk and then go back again. And its really hard for them, it’s really hard for them when things like that are happening to them. I find when they go to Witherlea in the waiting room there, there a bit more settled there because they know that that they’re okay there, there’s not going to be a heap of others there and those people that are there, especially with _____ being there is the best thing that could have happened in that place, they know that they’re okay because he’s there and they’re safe or I’m there, they’re safe. It’s different from being in a GP waiting room, when everyone’s just coming in and out all the time”

Witherlea Mental Health Service

In themselves GPs may hold the view that Witherlea do the majority of mental health care so they prioritise the physical symptoms. There is a flow on about accessing Kaupapa Maori services, as GPs feel mainstream services are better equipped to deal with these issues.

“Witherlea has developed a good relationship with GPs, which is why the bulk of all our referrals come through from this sector. There are not very many that are

inappropriate referrals. For Maori who have lived in the region for some time and have already got a GP then the referral mechanism works well. However, due to the viticulture industry there are a larger number of Maata Waka coming to live in the area, they are often transient and don't have a GP. A lot of Marlborough GPs are not taking on additional patients anyway, and if a Maori presents that is not well dressed then a practice can sometimes make assumptions around their ability to pay their fees. And the practice will say to them, no sorry we're not taking any more patients'.

Mindset changes need to occur with tangata whaiora and whanau about the services that the primary healthcare sector can provide, and reduce the reliance on specialist services for some clients.

“There remains a perception from many tangata whaiora that you only go to the GP for your physical health needs, and you come to us for mental health. We are trying to change that culture and the Primary Care Liaison nurse has been supporting clients transfer from and discharged from our service into GP care. The difficulty with that is that when clients are discharged, then they lose some of their supports such as the Community Support Workers, Respite, Marae Day Activity programmes”

Tangata whaiora relationship with Witherlea Case Managers

In some instances tangata whaiora have communication difficulties with Witherlea Case Managers. There remains a level of shyness in talking with them. However

when MMHC work alongside Witherlea Case Managers there is a higher level of disclosure.

“And its just them and .. its really quite sad where our people are at. But yeah it does happen. I mean even with Witherlea with some of the Case Managers, some of them are very whakama about talking to them about everything and anything and I try as much as I can to get alongside them at Witherlea when they’re doing the assessments .. and yeah it makes it easier for the tangata whaiora and for them”

MMHC recognise that from a tangata whaiora perspective, Witherlea is the place to go for their mental health, not a General Practice setting.

“And because they know that’s where they specialise, is with their mental illness and they seem to know that and they pick that up. And I said ‘yes he does, yes he does, yes he does do your meds for you’. Then it was ‘we’ll how come I have to go to Witherlea . I said because ‘that’s where your specialist is’. I don’t think he knew what I was talking about but I sat him down and explained it to him”.

“Yes they do and I don’t know why that is because even with their meds, I took one the other day to go and get his meds, and he said ‘ why do I have to go to Dr So and So, I should be going to Witherlea, because those are my head meds’ I said to him ‘because you are under your GP, your under that Dr’ and he said ‘but he doesn’t look after that”

“There remains a perception from many tangata whaiora that you only go to the GP for your physical health needs, and you come to us for mental health. We are trying to change that culture and the Primary Care Liaison nurse has been supporting clients transfer from and discharged from our service into GP care. The difficulty with that is that when clients are discharged, then they lose some of their supports such as the Community Support Workers, Respite, Marae Day Activity programmes”

MMHC reported that Maori don't necessarily have an understanding of the difference between the primary and specialist service sectors. In their view, specialist services could include access to rongoa services.

MMHC suggest that mindsets need to change, that the GP is only their for tangata whaiora physical health.

Witherlea/General Practice Interface

As identified previously, there is a level of exchange in information between Witherlea and the GPs to ensure both parties have on file, changes to any medications tangata whaiora are currently taking, for example. In some instances there can be a double up if the communication channels are not running well.

“Recently a tangata whaiora had two sets of bloods taken, where as if the GP practice had advised Witherlea they had done so, a further blood analysis would not have been conducted. This can get confusing for tangata whaiora as well so this area could be improved”

Overall, in comparison with other centres MMHC felt that the relationship and communication between Witherlea and the GP sector is effective, which is beneficial for service provision to tangata whaiora.

Whakama/Shyness

In some instances Maori maybe whakama and play down their symptoms both in a primary and secondary care setting.

“Yes I do. Because they, they are all whakama. They don’t know how to go there and talk about what is happening to them. When they’re going through depression they don’t know how to tell the Dr what’s happening to them. I often go and sit with them, I go to the Dr with them and they just don’t know what to say and don’t know what to do”

Being whakama impacts on tangata whaiora ability to communicate and articulate their symptoms to the GP.

Fear

The issue of fear was raised by male Maori and reported previously. It also arose in interviews with MMHC. This is another barrier to access in terms of the consequences of tangata whaiora disclosure and openness.

“A lot of it brings a lot of fear to them, they are afraid that if they say something that they’re gonna go and get locked away”

The clinicians described the concept behind the fear that tangata whaiora carry with them as follows:

“For Maori males Police are often called and there could be a stand off, there is a level of safety for all parties. When transferring to the inpatient unit you could have 5 in the car, two people either side of the tangata whaiora who could be mechanically restrained and two in the front. Sometimes they are medicated but when they get to the inpatient unit this makes their symptoms lessen which could result in an early discharge. For first time presentation there are security issues if through the Police system. It’s not a pleasant experience transferring to the inpatient unit when you’ve had to use an injection, sometimes the tangata whaiora is violent, can defecate and urinate during the trip. It doesn’t happen often but can. For Maori they might and can go over in the paddy wagon. This can be a long and drawn out process. If the tangata whaiora has had to wait for a slot to see the GP, some will make a space straight away and some won’t but by the time it gets sorted it could be dark, you’re in the back of a paddy wagon, restrained, cold, isolated and noisy. Length of stay is also an issue especially in seclusion, and with the amount of antipsychotics to bring them down with the side effects of sedation, numbing, dribbling, then there is that fear”

“Many tangata whaiora have the traditional ‘white jacket’, ‘bad experience and memories’ of what happens when they are unwell. Given inpatient experiences at the old Ngawhatu site, many believe that if you go to see your GP because you are unwell, you could end up back at Ngawhatu and most of the tangata whaiora remember the negative experiences they had at Ngawhatu. Some whanau and

tangata whaiora report that the new Acute Inpatient Unit doesn't hold the same stigma that Ngawhatu had given it looks like any other ward and is more visually pleasing. To go to the GP, get bundled up in the back of a car/van, being restrained, whether they hurt anyone when they were unwell, the car ride to Nelson, sometimes not even been able to remember some of the events before you get to the unit can be distressing. These negative experiences cause a level of fear and anxiety when tangata whaiora visit the GP."

"And I really think we as Maori need to do something about that for our Maori people because it's absolutely scary for them sitting their waiting to see a GP. Sitting there waiting to see a Psychiatrist cause they're so suspicious about what's going on they're not knowing what to expect when they go in the room. Its like a, its such a fear for them, its like the fire of hell is there to take them... they are so freaked out, I couldn't, that's one thing I couldn't get over in my mahi is how frightened they are, I just couldn't comprehend why these people were so scared".

For male tangata whaiora these can be very traumatic experiences and the above descriptions give the reader some insight into the level of fear disclosure of mental illness can cause tangata whaiora.

Whanau

Whanau can attempt to hide tangata whaiora unwellness at a whanau, hapu and iwi level. Clearly there is a level of stigma and discrimination within the whanau.

“And they can become very suspicious of that one too, they’re whanau member as they see them coming, picking up and getting better but the whanau member will go and do something that’s quite natural but to them its not and then its ‘I think you better come and take a look’ and there’s a lot of suspicion in it and its really quite hurtful to that whanau member”

They are also considered at times unintentionally to be a barrier to tangata whaiora recovery.

“Whanau themselves are barriers”

This is acknowledging the good intentions of whanau as pivotal supports. However, these good intentions do not necessarily help tangata whaiora and at worst they become a barrier to recovery.

Tangata Whaiora Tino Rangatiratanga

MMHC reported that some tangata whaiora are better educated and can advocate for themselves, while others, even with whanau support cannot. They felt that the current system is draconian, and that tangata whaiora should have a sense of control in their lives and at times the system doesn’t support this.

It is also often difficult to shift professionals’ decisions around healthcare. MMHC believe that if whanau and tangata whaiora want to explore other medications that are within the gambit of efficacy then this should be accommodated.

Care Plus

One Clinician reported that there were a number of tangata whaiora in his existing caseload who would be eligible for Care Plus. A large percentage of his clients have chronic illnesses alongside their mental illness. However it seems that the promotion of Care Plus has not reached key target groups.

“But given a quota system applies, I’m not sure whether tangata whaiora are advised or encouraged to participate. Our Primary Care Liaison position is also working on this”.

Stigma

Mental health stigma remains widespread within our community whanau and tangata whaiora. MMHC provided an example of the internal and whanau stigma:

“one of the tangata whaiora who has been well for some time now, felt a huge amount of support, comfort and whanaungatanga when he attended the Kaupapa Maori Day Activity programmes. He felt comfortable using the AA approach introducing himself, identifying that he was unwell, and then participating in the events. For his whanau in Blenheim he had no problem explaining his illness and was able to front about the impact and what this meant. However when he travelled north, he wouldn’t talk to his wider family about the illness. It wasn’t only until recently that he felt comfortable doing that, with his mother identifying this as a turning point in his recovery. Some tangata whaiora do feel a sense of shame/whakama that they have become unwell.”

Summary

MMHC added further detail to the complexity and reality of day to day barriers experienced by tangata whaiora both male and female. They articulate the core barriers to access but also offer opportunities to provide solutions. MMHC also added value to the discussion around power differentials between health professionals and tangata whaiora and how this impacts on their ability to communicate effectively.

Chapter Six - Discussion

This research is based on exploring tangata whaiora experiences in accessing primary health care services, with a specific focus on general practice. What it has demonstrated in a relatively small sample is a wide diversity in experiences, yet if taken in a wider context, are a number of similarities in those experiences. This discussion will focus on the major issues arising from the study and identify some opportunities for development at a local level.

Some male tangata whaiora could not recall exact events leading up to their first episode of mental illness. Acknowledging that for some tangata whaiora these episodes occurred up to twenty years ago, the memory loss that occurred may have been due to the diagnosis itself, medical interventions implemented over a sustained period of time or self-induced drug taking. The memory loss continues to cause a level of stress particularly for male tangata whaiora for two reasons. Firstly, given their point of entry was directly to specialist services and for some this involved law enforcement agencies, they were physically restrained and medicated in vehicles through a 1.5 hour transfer, they are unable to recall whether they were violent to, or harmed others. Secondly, their memory loss has impacted on their ability to recall personal memories and events prior to their mental health illness. The level of sadness was evident for those who had difficulty in recalling personal relationships and childhood history. Memory loss for female tangata whaiora was not identified as a major issue or concern, which could be for a number of reasons. Given none of the female tangata whaiora interviewed had referrals through the justice system or

identified a level of aggression with their first presentation so, they may not have had to experience the level of medication or trauma through justice pathways.

In terms of accessing General Practice (GPs) services, not all tangata whaiora realised that they were mentally unwell. This makes a significant difference in relation to accessing primary care services and why the points of entry may differ. A stronger mental health promotion focus within the GP practices would be beneficial on several fronts. Firstly, changing attitudinal mindsets that GP services are in fact the places to go for mental health assessment, diagnosis and treatment. This is one of the biggest barriers identified by tangata whaiora, therefore challenging this mindset and promoting earlier access and intervention for mild to moderate mental health disorders could prevent the escalation of illness. Included in any promotional strategy should be identifying at what point one should seek help. Secondly yet more broadly, it is evident that Maori do not access primary health services at the same rate as non-Maori. Promotional activities that encourage and support Maori to access primary care services at an earlier onset of any health condition should be encouraged. Finally and unfortunately mental health stigma and discrimination is still present within our community therefore in association with public health strategies, local initiatives within a practice setting could increase the anti stigma and discrimination messages.

A GP as first point of contact was the case for only two of the six tangata whaiora. It appears that access to GP services is not a major issue; it's the perception of the services that a GP will provide. Consistently tangata whaiora views were that GPs are not considered to be knowledgeable, qualified or have the expertise in mental

health assessment, diagnosis and treatment. GPs are seen as treating physical ailments only even though they provide referrals to a specialist mental health service or renew medications in collaboration with specialist mental health service. If tangata whaiora are also taking drugs this makes it difficult to correctly diagnosis. Several studies have confirmed the number of mental health diagnoses that are missed in the GP sector. One of the opportunities for the Marlborough district is to design a Primary Mental Health Plan that will improve GP training and education, the utilisation of screening and assessment tools, best practice treatment interventions and longer term case management. A training package could also include effective communication with tangata whaiora, targeted for Practice Managers, Receptionists, Practice Nurses and General Practice. Underpinning the training could be standard core competency development including as a grounding anchor, recovery based training. The combined training should address concerns tangata whaiora and Maori mental health clinicians raise around feeling inferior and power imbalances with health professionals.

GP consultation timeframes are a restraint for communication. One tangata whaiora writes a list of all the issues she would like covered in her consultation. If there is any time left at the end of the consultation then mental health issues are covered. Tangata whaiora also note concerns in being able to engage adequately around mental health issues in a ten to fifteen minute consultation timeframe. Acknowledging that GP services are also commercial businesses, it is understandable that to maintain viability additional fees may have to be charged over and above the normal consultation timeframe. Several consequences arise out of this. Firstly, tangata whaiora prioritise their visits to the GP services for physical health concerns and rely

on the specialist mental health service to cover their mental health needs. That is currently the status quo if you meet the eligibility criteria for specialist mental health services. Secondly, some tangata whaiora who do not receive the assessment, diagnosis and treatment they need in the GP sector therefore present to specialist services when their acuity levels are high. Thirdly, for those tangata whaiora who do not meet the access criteria for specialist services, their mental health needs are not met or addressed. Two opportunities arise for improving consultation timeframes. Firstly, ensuring those tangata whaiora who would be eligible for Care Plus are accordingly registered. This will provide a co-ordinated approach for chronic care management. Secondly, if GP's know their patients well enough and past appointments have taken over the average consultation timeframe, extended appointments could be made.

While female tangata whaiora had no problems in accessing a GP, for male tangata whaiora they clearly and descriptively reported that they very rarely see a GP (*one tangata whaiora had no GP*) and will only do so if they are acutely physically unwell. This is not a unique experience for male tangata whaiora. Overall across the total male Maori population, males do not seem to access primary health services at the same rate as non-Maori. To reduce barriers to accessing primary health care services and therefore change the disparities that currently exist will require additional investment of health resources and strategies that are specifically designed to meet male Maori needs.

GP communication with tangata whaiora could also be enhanced. It certainly makes a difference if tangata whaiora have been a patient of the GP for several years

(*sometimes generations*) and a trusting non-judgemental doctor-patient relationship has been formed. For these tangata whaiora, they are able to talk about their mental health issues, they feel the GP has a higher level of understanding around their mental and physical health issues, and there is often a level of flexibility around the consultation timeframes. For those tangata whaiora without this type of relationship, there is difficulty in being able to effectively communicate and engage with the GP. Even when there is effective engagement, describing symptoms can be a hurdle. This needs to be completed or translated in a terminology understandable by the GP and the specialist service (*if referral required*) so that recognisable symptoms are not missed. Even when natural supports such as friends and whanau, specialist mental health staff or Kaupapa Maori mental health staff accompany the tangata whaiora to GP consultation, there is a level of encouragement and interpretation required to assist tangata whaiora communicate their mental and physical health issues to the GP. Even basic eye contact with tangata whaiora would make a difference in the level of communication instead of no eye contact while reading patient files. This is an indication that we are experiencing a new era of primary health care provision. As the older GPs retire and are replaced with young GPs who need to run commercially viable practices, inevitably this will increase pressure to maintain or provide shorter consultation timeframes. Consequentially tangata whaiora ability to communicate and engage effectively will be impeded. A suggested pathway forward to address this concern is to ensure those tangata whaiora eligible for Care Plus are provided with this service. In addition, tangata whaiora, (*in fact all PHO patients with multiple health issues*) should be encouraged to write down what health issues need to be addressed in the consultation timeframe and prioritise

this accordingly. This will make the best use of the consultation timeframe available and hopefully reduce fees for additional consultation time.

A number of tangata whaiora reported GP attitudes that they viewed as negative during the consultation. Recognising the power differentials in the Doctor/Patient relationship, tangata whaiora appreciate being treated with respect and dignity. As indicated previously, tangata whaiora are reluctant to talk about their mental health symptoms within a consultation. A perceived level of inferiority in relation to a well-educated and articulate health professional who is often pressed for time adds undue pressure to the consultation. GPs need to take the time to listen to tangata whaiora concerns, be non judgemental and show a caring and professional attitude. For example, when tangata whaiora take the time to research their mental illness and associated pharmaceutical efficacy, then this should be explored within the consultation and not ignored. These issues were identified specifically by those tangata whaiora who did not have a long term relationship with their GP.

In terms of the Primary Care Strategy, cost is one of the major barriers that is being addressed at a national and local level. Tangata whaiora acknowledge that reducing consultation costs would certainly assist access. However, overall there are a number of additional costs over and above the consultation fee that add to the financial burden of mental health care. Tangata whaiora report that even though they maybe eligible for Care Plus given associated chronic diseases, there has been no follow up or registration on the Care Plus programme. One tangata whaiora reports that some GPs are less likely to take you on as a patient if you have a number of chronic illnesses. Extra costs include fees of \$15 for writing a prescription for

renewal of medication and \$10 to sign forms for Work and Income. When pharmacy and medication costs are taken into account, visits to the GP sector can be financially resource intensive for tangata whaiora on limited incomes. In addition, if tangata whaiora are not eligible for a Community Services Card then there is an increase in costs across the primary care continuum. A number of tangata whaiora are reluctant to return to the GP setting if there are financial debts owing. And a number of GPs are not willing to see tangata whaiora until their outstanding debts have been addressed. In these instances, their mental illness will exacerbate until they cannot cope and require specialist intervention. Similar situations arise for those tangata whaiora who cannot afford their medication. There are opportunities for our local PHO in association with Work and Income to set up a direct credit system with tangata whaiora to pay a small weekly amount (*based on previous year utilisation*) that will cover these costs on an annual basis. This has the added benefit of avoiding debts becoming a barrier to access. In addition, GP Practices need to clearly identify their fees and associated costs so that tangata whaiora are not surprised by the extra costs charged.

The GP reception area is tangata whaiora first contact and first point of entry in accessing the GP. Tangata whaiora see the receptionists initially as a triage system. If the GP is fully booked, receptionists will talk with tangata whaiora to discuss the level of urgency in securing a consultation and support access. In general tangata whaiora report that the receptionists are very helpful and friendly. However, if there is an outstanding debt owed to the practice, and an open reception area combined with the waiting room, then the tangata whaiora financial position can be overheard by others causing a level of embarrassment. While it is not an easy subject to

approach, the communication of outstanding debt and the resolving of these issues has, and will continue to be, a barrier to access. The GP Practice needs to talk with tangata whaiora outside of the general reception area and address the issue in a confidential manner.

The GP waiting room environment and associated waiting times to see the GP are other issues raised. Tangata whaiora report a level of anxiety waiting to see the GP. The anxiety involves estimating and counting the number of patients in front of you and how long you may have to wait. It includes tangata whaiora thinking about what they will say when they enter the GP consultation room, in terms of rehearsing the communication of symptoms and problems to be addressed. Tangata whaiora have identified that being in a waiting room where there are lots of people, noise, young children and individuals with communicable illnesses increases their level of anxiety to the point of wanting to leave the premises. If tangata whaiora take natural supports, or their appointed Case Managers or Community Support Workers, this can alleviate the anxiety. Therefore the receptionists need to advise tangata whaiora by phone of the number of patients ahead of their appointment time so it minimises the waiting period can easily rectify these concerns. Alternatively having the Practice Nurse see tangata whaiora prior to the GP and complete all the physical assessment first will alleviate the anxiety and provide more consultation time to discuss their mental health.

The GP waiting room environment could also be enhanced. Many Primary Health Care practices have promotional and information material available in the practice setting. To provide a level of comfort to tangata whaiora, including Maori health

promotional messages would add value. In terms of tangata whaiora, (*in fact all physical and mental health patients*) including a water dispenser in the waiting room would reduce anxiety levels. This basic hosting function will accommodate a larger number of patients. Waiting rooms also need to be large enough to accommodate natural supports.

Transportation is not viewed as a barrier to accessing GP services given that the majority of practices are centrally located. However, after hours services are based at Wairau Hospital and pose an issue for those without a vehicle as it takes thirty to forty minutes to walk to the after hours service from the central business district. Tangata whaiora can be supported to GP consultations during normal working hours, either by their Community Support Worker, Case Manager or Kaupapa Maori Community Support Worker therefore transportation is not an issue. However for rural localities such as Picton, these services are not as responsive.

Male tangata whaiora reported a level of fear in terms of accessing general practice services when they are mentally unwell. Fear is a normal response or aversion to a perceived risk or threat and it can underlie tangata whaiora behaviour in terms of access to health services. For male tangata whaiora who were admitted to acute inpatient services through the judicial system or physically restrained and medicated, these are very frightening, scary and traumatic experiences that tangata whaiora do not want to replicate. The fear and suspicion reported is based on, the chance that they could be admitted to the acute inpatient service and once this occurs there is an individual loss of control and autonomy in their care. Additionally the medication that can accompany the admission has negative impacts (*the 'zombie' effect*) from the

tangata whaiora point of view. Finally, tangata whaiora are taken away from their natural supports. Female tangata whaiora more readily accepted the need for admission with their fears more centred on a sense of failure. Maori male are addressing their fears by avoiding primary health care practice and being treated for their mental health by the specialist mental health service. However, if we are to realise the Primary Health Strategy, then the fear of referral through GP practices to the acute admissions unit needs to be addressed. This should be accomplished through joint primary and secondary individual treatment plans for tangata whaiora.

As a natural support whanau/family obviously play a pivotal role in tangata whaiora care and recovery. However tangata whaiora report that whanau can also be a major barrier to recovery and at times either cause or aggravate their mental illness. Whanau support and attitude towards their loved ones mental illness can border on being discriminatory. Tangata whaiora are viewed as being less capable of and competent at living independently, and as unable to make decisions. Whanau have been known to take over control of tangata whaiora care, which has caused power differentials and relationship problems. Due to the stigma that surrounds mental illness, whanau have attempted to hide their loved ones mental illness so as to protect their loved one from specialist mental health services subsequent admission and protect their whanau, hapu and iwi reputation. This has three major effects; firstly it reduces tangata whaiora self worth and self esteem by promoting negative attitudes that a mental illness is 'the' worst illness to have; secondly it increases and spreads community stigma and; finally it promotes the view that once diagnosed with a mental illness you're never going to get better.

Whanau/family support and education around mental illness is provided locally. However the stigma remains and further in depth analysis of how to improve whanau understanding would be beneficial.

Tangata whaiora have described carrying their own internal stigma because of their mental illness. Descriptions of being a 'loser' and a 'failure' became apparent in the earlier stages of their mental illness. The attitudes of others in relation to their mental illness continued to endorse this perception. Being 'whakama' or 'ashamed' of their mental illness reduces the ability to effectively communicate with others. Aligned with the whanau discrimination and tangata whaiora self fulfilling prophecies of self worth, these feelings obviously impede the recovery pathway.

Of interest, none of the tangata whaiora identified culturally inappropriate primary health services as an issue. Through the colonisation process the Marlborough region has suffered significantly as manawhenua iwi casebook reports to the Waitangi Tribunal identify and whether it is due to the loss of whenua (land), Te Reo me ona Tikanga Maori (Maori language and customs) would require further research. Alternatively, this could be due to the expectations and acceptance of primary health services, predominantly delivered by non-Maori in a region where 11% of the population are Maori, or the use of Te Rapuora o Te Wai Harakeke, a local Maori mental health provider who in conjunction with local practices provide an essential support system to tangata whaiora who require support to access GP practices.

In separating out those tangata whaiora with mild to moderate disorders who are cared for in the primary care sector, there is sufficient evidence that there are existing access

issues in the primary care sector that provide barriers to accurate assessment, diagnosis and treatment of mental illness.

However, for those tangata whaiora who have moderately severe to severe mental illness there is a distinct advantage in being managed by specialist mental health services. Tangata whaiora see the benefits of being case managed by specialist mental health services on several fronts.

Specialist mental health services are able to provide significant supports in terms of an overall appointed Case Manager, access to Crisis Services, Kaupapa Maori services, Psychology and Psychiatry services. With a multidisciplinary team a menu of supports is available to support recovery.

The majority of specialist services are not restricted by time limits. If half an hour is needed, then that is what will be provided. This has improved the relationship between tangata whaiora and specialist services and to a certain extent by default it has produced a non-reliance on primary health care services. The specialist service is seen as having 'the' expertise in mental health. They are the 'head meds' service where GPs are seen for physical care. Specialist services 'know' the tangata whaiora, know their illness, have an overall recovery plan and if tangata whaiora require support, then they know the specialist service will be there. Tangata whaiora feel 'safer' being in their care. The services are easily accessible, there is no cost to the service and there is a level of overall comfort in the services provided.

Summary

Tangata whaiora have shared their personal experiences of access to primary health care services in Marlborough that have highlighted several opportunities to improve Maori tangata whaiora access to primary health services. The changes envisaged will not only benefit Maori, but non-Maori tangata whaiora. Accordingly this can be encapsulated in Kimi Hauora Primary Mental Health and Maori Health planning processes.

The core messages threaded throughout the interviews is that to improve primary mental health services, two basic principles of delivery are required. Treat tangata whaiora with the respect and dignity they deserve and have recovery as the core anchor. With these two basic principles at the forefront, the additional barriers identified by tangata whaiora will be much easier to address.

Glossary

Hapu	Sub tribe
Iwi	Tribe
Kaimahi	Worker
Kaumatua	Old man, elders
Kowhaiwhai	Scroll decorative pattern work on rafters
Mihimihi	Greetings
Maori Tangata Whaiora	Maori users of specialist mental health services
Pakeha	European, non-Maori.
Rohe	Boundary, district
Taane	Male Maori
Te Rau Puawai	Massey University Maori Mental Health Scholarship Programme
Te Reo me ona Tikanga Maori	Maori language and customs
Tino Rangatiratanga	Self autonomy
Wahine	Maori woman
Whakama	Shyness, embarrassment
Whanau	Family

References

- Abas, M., Vanderpyl, J., Robinson, E., & Crampton, P. (2003). More deprived areas need greater resources for mental health. *Australian and New Zealand Journal of Psychiatry*, 37(4), 437-444.
- Bishop, R. (1998). *Whakawhanaungatanga as a research process. Proceedings of Te Oru Rangahau Maori Research and Development Conference*. Paper delivered to Te Oru Rangahau Maori Research and Development Conference (pp. 130-135).
- Bishop, R. (1999). Kaupapa Maori research: An indigenous approach to creating knowledge. In Maori and Psychology Research Unit (Ed.), *Maori and Psychology: Research and practice* (pp.1-6). Hamilton, New Zealand: Department of Psychology, University of Waikato.
- Bridgman, G., & Dyall, L. (1993) *Nga ia o te oranga hinengaro Maori: Trends in Maori mental health*. Wellington, New Zealand: Te Puni Kokiri.
- Caccioppoli, P., & Cullen, R. (2005). *Maori Health*. Auckland, New Zealand: Kotahitanga Community Trust.
- CBG Research Ltd. (2006). *Review of the Implementation of Care Plus*. Wellington, New Zealand: Ministry of Health.
- Coster, G., & Gribben, B. (1999). *Primary care models for delivering population based health outcomes: Discussion paper for the National Health Committee*. National Health Committee.
- Cram, F. (2001). Rangahau Maori: Tona tika, tono pono – The validity and integrity of Maori research. In M. Tolich (Ed.), *Research Ethics in Aotearoa New Zealand* (pp 35-52). Auckland, New Zealand: Pearson Education.
- Cram, F., Smith, L., & Johnstone, W. (2003). Mapping the themes of Maori talk about health. *The NZ Medical Journal*, 116 (1170).
- Cunningham, C. (2000). A Framework for addressing Maori knowledge in research, science and technology. *Pacific Health Dialogue*, 7 (1): 62-9
- Durie, M.H., Allan, G.R., Ratima, M.M., & Waldon, J.A. (1995) *Maori Providers of Mental Health Services: A report prepared for the Central Regional Health Authority*. Palmerston North, New Zealand.
- Durie, M.H., & Kingi, T.K.R. (1997). *A framework for measuring Maori mental health outcomes*. Palmerston North, New Zealand: Massey University, Department of Maori Studies.
- Edmonds, L.K., Williams, S., & Walsh, A.E.S. (2000). Trends in Maori mental health in Otago. *Australia and New Zealand Journal of Psychiatry*, 34(4).

- Gribben, B. (1999). Ethnicity and Resource Use in General Practice in West Auckland. *Healthcare and Informatics Review on Line*, 1 (1).
- Harcourt, B.J., (2000). Mental Health Services 'by Maori for Maori'; potential barriers that could impede. Hamilton, New Zealand. Hauora Waikato Group.
- Harris H., Tobias M., Jeffreys M., Waldegrave K., Karlsen S. & Nazroo J. (2006). Racism and health: The relationship between experience of racial discrimination and health in New Zealand. *Social Science in Medicine*.
- Health Committee. (1992). *Barriers to Health care: A report presented to Te Runanga o Raukawa*. Te Runanga o Raukawa, Otaki. Cited in: Durie, M.H., Allan, G.R., Ratima, M.M., & Waldon, J.A. (1995). *Maori Providers of Mental Health Services A report prepared for the Central Regional Health Authority*. Palmerston North, New Zealand.
- Health Funding Authority. (2000). *Eight Priority Areas for Maori Health 1999/2000; Report One*. Maori Mental Health Operating Group, Health Funding Authority.
- Health Funding Authority. (2000a). *Tuuhaitia te Wer; Meeting the Challenges, Mental Health Workforce Development Plan 2000 – 2005*. Christchurch, New Zealand: Health Funding Authority.
- Holdaway, M. (2003). *Mental Health in Primary Health Care*. Palmerston North, New Zealand: Te Rau Matatini.
- Horsburgh, M., & Lamdin, R. (2004). Maori health issues in an interprofessional learning context. *Journal of Interprofessional Care*, 18 (3).
- Houlahan, M. (2005, May 30). Maori staff initiative welcomed. *The Press*. Page A7.
- Kimi Hauora Wairau. (2005). *The Mobile Health Service Survey 2005: Services to Improve Access*. Marlborough, New Zealand: Kimi Hauora Wairau.
- Kimi Hauora Wairau. (2006). *Maori Health Plan*. Marlborough, New Zealand: Southlink Health.
- Kypri, K. (2003). Maori/non Maori alcohol consumption profiles: implications for reducing health inequalities. *New Zealand Medical Journal*, 116 (1184).
- Lapsley, H., Nikora, L.M. & Black, R. (2002). *Kia mauri tau: Narratives of recovery from disabling mental health problems*. Report of the University of Waikato, Mental Health Narratives Project. Wellington, New Zealand: Mental Health Commission.
- MaGPie Research Group. (2003). The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPie). *The New Zealand Medical Journal*, 116 (1171).

- MaGPIe Research Group. (2005a). Do patients want to disclose psychological problems to GPs. *Family Practice*, 22 (6) 631-637.
- MaGPIe Research Group (2005b) Mental disorders among Maori attending their GP. *Australia and New Zealand Journal of Psychiatry*, 39 (5), pp 401.
- MaGPIe Research Group. (2005c). GP perceptions of barriers to their provision of mental health care. A report on mental health and GP investigation. *New Zealand Medical Journal*, 118 (1222).
- Malcolm, L. (1996). Inequities in access to and utilisation of primary medical care services for Maori and low income New Zealanders. *New Zealand Medical Journal*, 115 (1167) pp 356-359.
- Malcolm, L. (2002). Major inequities between DHBs in referred services expenditure: a critical challenge facing the primary health care strategy. *The New Zealand Medical Journal*, 115 (1167).
- Health Funding Authority,. (no date). *Health Funding Authority Eight Health Gain Priority Areas for Maori 1999/2000. Report One: Mental Health*. Wellington, New Zealand. Maori Health Operating Group, Health Funding Authority.
- Marlborough District Council. (2006). *Long Term Council Community Plan 2006-2016*. Marlborough, New Zealand: Marlborough District Council.
- Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: The way things need to be*. Wellington, New Zealand: Mental Health Commission.
- Mental Health Commission. (2004). *Occasional Paper No 5: Physical Health of Service Users ... Who Cares?* Wellington, New Zealand: Mental Health Commission.
- Mental Health Commission. (2005). *Briefing for the Incoming Minister of Health – Commissioners Ruth Harrison, Bob Henare OBE, Mary O’Hagan*.
- Ministry of Health. (2000). *The New Zealand Health Strategy*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2001). *Primary Health Strategy*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2002a) *He Korowai Oranga: The Maori Health Strategy*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2002b). *Te Puawaitanga Maori Mental Health National Strategic Framework*. Wellington, New Zealand: Ministry of Health

- Ministry of Health. (2003). *DHB Toolkit Mental Health*. Edition 2. Wellington, New Zealand: Ministry of Health
- Ministry of Health. (2004a). *Service development toolkit for mental health services in primary health care*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2004b). *A Portrait of Health: Key results of the 2002/03 New Zealand Health Survey*. Wellington: New Zealand. Ministry of Health.
- Ministry of Health. (2005). *Te Tahuhu: Improving Mental Health 2005-2015, The Second New Zealand Mental Health and Addiction Plan*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2006a). *Kia Puawai Te Ararau. National Maori Mental Health Workforce Development 2006-2010*. Kaitoro Publishers, Hamilton, New Zealand.
- Ministry of Health. (2006b). *Suicide Facts: Provisional 2003, Monitoring Report No 1*. All ages statistics Public Health Intelligence. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2006c). *Tatau Kahukura. Maori Health Chart Book: Public Health Intelligence Monitoring Report No. 5*. Wellington, New Zealand: Ministry of Health.
- Mulder R. (2003). Psychiatric illness in primary care: whom should we treat. *New Zealand Medical Journal*, 116 (1171).
- Oakley Browne, M.A., Wells, J.E., & Scott, K.M (eds). (2006). *Te Rau Hinengaro: The New Zealand mental health survey*. Wellington: Ministry of Health. Pp 149 -156.
- Raymont, A., Lay-Yee, R., Pearson, J., & Davis, P. (2005) NZ General Practitioners characteristics and workload: The National Primary Medical Care Survey. *The New Zealand Medical Journal*, 118 (1215).
- Reid, J., (2005). Mental health treatment at the New Zealand General Practice. *New Zealand Medical Journal*, 118 (1222).
- Robson, B. (2004). *Economic determinants of Maori health and disparities: A review for Te Ropu Tohutohu i te Hauora Tumanui (Public Health Advisory Committee of the National Health Committee)*. Wellington School of Medicine and Health Sciences & University of Otago.
- Rodenburg, H. (2003). *Mental health care within a primary care environment: Implications for policy, service delivery and PHO's*. A GP perspective for discussion. The Royal New Zealand College of GPs.
- Smith, L.T. (1999). *Decolonising Methodologies: Research and Indigenous Peoples*, Zed Books, New York and Otago University Press, Dunedin.

- Strauss, A., & Corbin J. (1990). *Basics of Qualitative Research – Grounded Theory Procedures and Techniques*. London: Sage Publications.
- Te Puni Kokiri. (2000a). *Progress towards closing social and economic gaps between Maori and non-Maori*. Wellington, New Zealand: Te Puni Kokiri.
- Te Puni Kokiri (2000b) *Whakapakari: Tikanga Oranga Hauora*. Number 4. Wellington, New Zealand: Te Puni Kokiri.
- World Health Organisation . (1978). Retrieved 25th April 2005, from http://www.euro.who.int/AboutWHO/Policy/20010827_1
- World Health Organization. 2001. *World Health Report 2001: Mental health: New understanding, new hope*. World Health Organization.