The Regional Pacific Model of Care and Mental Health and Addictions Service Framework 2010
This report was prepared by Health & Safety Developments Ltd. on behalf of the Moana Pasefika Working Group and the Northern District Support Agency Ltd. This document is available on the Network North Coalition Northern website: http://networknorth.org.nz

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Executive Summary

The Northern DHB Support Agency (NDSA) on behalf of the Auckland metropolitan District Health Boards (DHBS) and Moana Pasifika has undertaken a project to develop a regional Pacific Mental Health and Addictions Service Framework (Pacific Service Framework).

The Pacific Service Framework is intended to guide mental health and addiction service planning, funding and delivery and to assist with achieving increased levels of consistency across services in the Auckland region, where this will better serve Pacific consumers and families. Any regional or local implementation of the framework will be dependent on prioritisation, available funding and ongoing implementation under local DHB or regional plans.

The Framework was developed between October 2007 and June 2008 by stakeholders in Auckland region Pacific mental health and addictions services via a process managed by Health & Safety Developments. The development process included:

- Review of selected literature
- Review of services provided and access data
- Development of a draft Framework and region-wide consultation on the draft framework
- Preparation of a final Pacific Mental Health and Addictions Service Framework.

The Pacific Service Framework incorporates the principles which inform effective mental health and addictions services for Pacific peoples, drawing on a number of sources including expertise of Pacific stakeholders, Pacific models of care and models of health belief, Pacific research, relevant national policy documents and other relevant literature. The Pacific Service Framework also draws on relevant national policy and planning documents and reflects national mental health and addictions sector standards.

The Pacific Service Framework applies directly to those mental health and addictions services, both in primary and secondary care, which are designated specifically to meet the needs of Pacific peoples residing in the Auckland region. The Framework applies to the whole system of mental health and addictions care acknowledging that a continuum of care is required.

Diversity is a defining characteristic of the New Zealand Pacific population. Therefore to be acceptable and effective, the Pacific Service Framework is broad and principles-based, rather than overly prescriptive as to practices and protocols, to allow services to be responsive to the diverse needs of Pacific peoples.

Shared Pacific values and beliefs about health and wellbeing provide the foundation for the Pacific Service Framework. Shared values
underpinning the Framework include: love, respect, humility, caring, reciprocity, spirituality, humour, unity and belief in the importance of family.

There are two fundamental beliefs that Pacific people share:

- An holistic notion of health i.e., inclusive of spiritual, physical, emotional and mental dimensions
- Health as a family concern rather than an individual matter

Theses fundamental beliefs constitute overarching principles in service provision for Pacific peoples and are reflected as key principles within the Pacific Service Framework. These fundamental beliefs incorporate: a relationship focus (including acknowledgement of community), and the use of Pacific language and cultural practices.

The Pacific Service Framework is intended to support professionals, organisations and service systems to demonstrate cultural competence, i.e., to integrate cultural practices and concepts into health service delivery across the whole system of care.

While there is broad agreement in relation to services for Pacific adults, there are questions and issues in relation to services for the increasingly culturally diverse and mostly New Zealand-born young Pacific population. The question of ethnic/cultural identity is complex for the young New Zealand Pacific population which raises issues regarding cultural competence in relation to this group. There is a need for further exploration of the needs of this group to ensure that services are effective. The Pacific Services Framework acknowledges the need to support the development of youth-specific services (likely to be multi-cultural/mainstream in focus) and ensure that Pacific specific services retain a family focus inclusive of the needs of young people.

National, regional and local strategies and plans strongly support further development of Pacific specific services based on a clear model of care or service framework. Issues of access, including workforce development, understanding the diversity of the Pacific population, estimated population growth, and prevalence of mental health and addiction issues highlight the urgency of establishing a Pacific Service Framework as a means of facilitating Pacific service development.

Available access and utilisation data for services and stakeholder feedback strongly indicate a need for the establishment of increased capacity across the service continuum with particular focus on health promotion, destigmatisation and early intervention services, especially primary care.

Currently DHB-based services for Pacific peoples are configured differently in each DHB and there is no apparent rationale for this.
Given the somewhat artificial construct of DHB boundaries within the Auckland metropolitan region (ie, families and workforces seldom live entirely within one DHB area) there may be merit in furthering a more consistent approach to service delivery and this could be assisted by the adoption of the Pacific Service Framework.

The Pacific Mental Health and Addictions Service Framework is shown in summary form as Figure 1.
The Project

In October 2007 the NDSA on behalf of the Auckland metropolitan DHBs and Moana Pasifika initiated a project to develop a regional Pacific Mental Health and Addictions Model of Care (Pacific Model of Care). The intention was that an Auckland regional Pacific Model of Care would provide a framework to guide planning, funding and service delivery helping to configure mental health and addiction services. It was further intended that a regional Pacific Mental Health and Addictions Model of Care would assist with achieving increased levels of consistency across services in the Auckland Region.

Health & Safety Developments Ltd was contracted to manage the project. All Pacific mental health and addictions services within the Auckland region were invited to participate.

A project steering group monitored and guided the project. A list of the steering group members can be seen in Appendix 1. This group comprised the Moana Pasifika Working Group and representatives of NDSA and Health & Safety Developments. A reference group comprising key regional stakeholders was provided via the Regional Pacific Service Development Forum.

The timeframe for the project was 31 October 2007 – 30 June 2008.

Project goal and deliverables

The overall goal of the project was to develop a Pacific Model of Care[^1] for the Auckland region.

The following deliverables were required from the project:

1. A summary of literature relevant to existing national and international mental health and addictions service delivery models for ethnic groups.
2. A summary of current service delivery by Pacific Mental Health and Addictions services across the Auckland region.
3. A summary of access rates by Pacific peoples to Pacific Mental Health and Addictions services and analysis of this in relation to census population data for each DHB locality (i.e. Auckland, Counties Manukau, and Waitemata DHB).
4. Identification of the target population for Pacific services which is inclusive of a whole of population approach ie inclusive of young people and families.
5. A proposed Pacific Model of Care including philosophy and principles of service delivery, service types and configuration and continuum of care issues, inclusive of primary care and Pacific social services as far as possible.
6. A summary of areas of service and service-related development that could be aligned at a regional level.

[^1]: Note: with agreement from the project steering group this term was replaced during the course of project with Pacific Mental Health and Addictions Service Framework
This report provides a brief outline of the project process and presents a regional Pacific Mental Health and Addictions Service Framework and a discussion of areas for service development.

A summary of service delivery and utilisation data was provided in a separate confidential appendix to NDSA and the steering group, but key findings have been discussed in this report and inform the framework.

Access rates are discussed in the literature review. Data and discussion on the target population are provided in the literature review and have been incorporated into the Framework below. A summary of areas of service and service-related development that could be aligned at a regional level have been incorporated into the Regional Service Framework outlined below and briefly outlined in the Discussion section.

**Project processes**

Services identified and invited to participate

The project was identified as a priority at the May 2007 Regional Pacific Service Development Forum and subsequently funding was agreed. The project was introduced at the Regional Pacific Service Development Forum in November 2007.

A total of 12 providers of Pacific Mental Health and Addictions services in the Auckland metropolitan DHB catchment areas were identified via the project steering group and were invited to participate in the project. The list of services invited to participate is outlined in Appendix 2. The NDSA wrote to service providers in December 2007 informing them of the project and inviting their participation.

**Literature review**

Literature was sourced via the following:

- Web-based searches on key terms: model of care; Pacific model of care; model of service delivery; service delivery model; Pacific mental health; Pacific addictions
- Searches of key websites including: Ministry of Health, Mental Health Commission, Te Pou, ALAC, ADHB, CMDHB, and WDHB
- Information provided by members of the project steering group and other project participants
- Bibliographies from relevant publications

Additional literature was sourced via suggestions from the project steering group.
Literature was selected for relevance to the project goals and analysed and compiled into a summary to inform development of the Pacific Mental Health and Addictions Service Framework as appropriate.

**Review of services provided and access data**

All identified services were asked to provide the following data:

- Number of clients accessing service for the period 1 July 2007 – 31 December 2007 (i.e. individual clients who have accessed service one or more times regardless of the number of times seen or contacted)

Additionally, the following breakdown of the above data was requested:

- Age group (number of clients in each age group as follows: i. 0-18 years of age; ii. 19-64 years of age; iii. 65+ years of age).
- Gender (number of male, and female clients).
- DHB of residence/last known residential address (number of clients seen by DHB area as follows: Waitemata, Auckland, Counties Manukau, Other).
- Ethnicity (number of clients by different ethnic grouping, e.g. Samoan, Tongan, Niuean Cook Island, other Pacific – please specify, non-Pacific).
- Type(s) of service (Residential, CSW, de-stigmatisation, etc).

Each service was contacted for a follow-up interview. Attempts were also made to obtain service reports provided to DHBs and/or Ministry of Health.

Comprehensive service access data were unavailable. A general discussion of access data has been compiled and analysed in relation to census data within the literature review and considered in the development of the Pacific Mental Health and Addictions Service Framework.

**Development of Draft Pacific Mental Health and Addictions Service Framework**

A draft Pacific Mental Health and Addictions Service Framework was prepared for input and discussion with the project steering group, the project reference group and the DHB Pacific Mental Health and Addictions stakeholder groups.

Feedback from these groups was integrated and presented back for final feedback to the project reference group. This report presents the final version of the Pacific Mental Health and Addictions Service Framework.

[2] Access data that were made available by providers have been compiled into the summary of service delivery which is provided separately to NDSA and the Steering Group.
Process limitations

The following limitations are noted:

- Two services formally opted not to participate in the project, citing pressures related to ongoing service delivery commitments that limited their availability to participate.
- Six (50%) services were not able to provide the data requested. While lack of utilisation data did not unduly compromise the development of the Framework the obtaining of utilisation data is likely to be an issue for resolution between DHBs, NDSA and providers in the future.
The review of literature was undertaken to assist with answering the following key questions:

- What is a model of care?
- What are the essential components of a Pacific model of care?

**Who are “Pacific peoples”?

There are seven main ethnic groups in the Pacific community in New Zealand, originating from countries in the Pacific, each with their own unique culture and language (Pulotu-Endemann et al, 2004).

The term ‘Pacific peoples’ encompasses a variety of Pacific Island nations and communities who are linguistically, culturally, and geographically distinctive from each other (Health Research Council, 2005; Tiatia & Foliaki, 2005).

**It is a common joke in Pacific circles that there is no such thing as a ‘Pacific person’ outside of New Zealand. Yes, there are Tongans, Samoans and Niueans, however, it is only when people arrive at Auckland airport that these Tongans, Samoans and Niueans become known as ‘Pacific peoples,’ and that the identity label ‘Pacific’ has meaning**

(Ministry of Pacific Island Affairs, 2001:3)

While much of the literature points to the commonalities shared by Pacific peoples in terms of values and beliefs, there is equal caution that the distinctiveness of Pacific peoples cannot be overlooked. Tiatia & Foliaki (2005) outline the following commonalities:

- Belief in Christianity
- Mythology
- Communal land ownership
- Genealogical based identity
- Extended family accountability
- Beliefs that wellbeing and illness are linked to obligations to extended family being met or not being met.

It is widely acknowledged that there is such diversity within the Pacific that there is a range of views about what it is to be a Pacific person. Correspondingly there are multiple world views and diverse perceptions of illness, treatment and prevention as well as diverse belief systems including cultural and religious factors which influence behaviour and attitudes towards wellbeing (Finau & Tukuitonga, 2000 cited in Ministry of Health, 2008).

**Key Findings**

A key implication for the project in question is that to be acceptable and effective, a Pacific Service Framework needs to be broad and principles-based, rather than overly prescriptive as to practices and protocols, to allow services to reflect the diversity of Pacific peoples and be responsive to their needs.
Pacific peoples approaches to health and wellbeing

Pacific peoples view mental health as an intrinsic component of overall health. Pacific cultures do not have words that translate easily into ‘mental illness’, and mental health is considered to be inseparable from the overall wellbeing of the body, soul and spirit. (Ministry of Health, 2008b:9)

There are two fundamental beliefs that Pacific people share:

• An holistic notion of health (Bathgate 1994 cited in Ministry of Health 2008c)
• Health as a family concern rather than an individual matter (Laing and Mitaera 1994; Tukuitonga 1990 cited in Ministry of Health 2008a).

It is also noted that views may vary widely between Pacific New Zealand-born and Pacific migrant peoples (Ministry of Health 2008b)

Key Findings

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What is a model of care?

The term model of care[3] is not consistently defined. Queensland Health (2000) undertook a comprehensive review of literature and concluded that no consistent definition of a model of care was apparent. Queensland Health defined a model of care as follows:

“A model of care is a multifaceted concept, which broadly defines the way health services are delivered. It can therefore be applied to health services delivered in a unit, division or whole of District (p4).”

It can be useful to think about a model of care more broadly as a framework which incorporates the philosophy, principles and mechanisms for providing a continuum of care (promotion, prevention, early intervention, treatment and recovery/support) to a target population. The framework provides a means of summarising and comparing interventions with similar goals and comparable target groups (Christensen et al, 2006).

Christensen et al (2006) note the following big five considerations in relation to any model of care: quality, access, continuity, cost and workforce.

[3] During the course of this review of literature it was decided, that the project should not focus on developing a Pacific model of care but should more properly focus on developing a Pacific Service Framework which could be inclusive of the numerous Pacific models of care which already exist.
The Mental Health Council of Australia (2006) presents a summary of best practice models in mental health care citing Australian and New Zealand-based examples and noting that there are principles and practices common to these best practice models. Among these identified principles the following are of particular note:

- Developing partnerships between consumers, family and/or carers, non-government agencies, private and government providers, and community-based and clinical services
- Addressing needs holistically
- Avoiding siloed approaches and thinking
- Incorporating a range of paid roles that are not clinical, such as system advocates and peer support.

**Key Findings**

These principles align well with Pacific approaches and would readily be accommodated within a Pacific Service Framework

**Pacific models of care**

There are a number of summary accounts of Pacific models of care in the literature. Those highlighted include:

- **Faletui.** Generated from Samoan-specific Wellington-based qualitative mental health research. The Samoan term fa’aafaletui relates to a method for holding a discussion on a particular matter (Tamasese et al. 1997 cited in Novak 2007; Pulotu-Endemann et al, 2007)
- **Fonofale Model.** Described as a Samoan health belief model, the model is based on the traditional Samoan meeting house. The roof represents cultural values and beliefs, the foundation of the house represents the family. The four posts that hold up the house are physical, spiritual and mental and social dimensions of health. The house is set in the wider context of environment and time. (Pulotu-Endemann et al, 2007; Niumata-Faleafa et al, 2005; Agnew et al 2004, Lui, 2001; Mental Health Commission, 2001).
- **Strands of Pandanus.** In this model the weaving of the strands of the Pandanus mat provides a metaphor for weaving together the strands in the care of a mental health consumer. The durability of the mat depends on how well the strands were woven together (Pulotu-Endemann et al, 2007).
- **Te Vaka Atafaga Model.** This model defines health from a Tokelau holistic perspective; using a metaphor based on the traditional long distance outrigger sailing vessel ‘Vaka Atafaga’ (Pulotu-Endemann et al, 2007).
- **Popao model.** Described as Tongan cultural recovery tool draws on the metaphor of the popao (outrigger sailing vessel) and its journey and enables consumers and professionals to conceptualize and communicate about their goals, tasks and
roles to develop a shared understanding of the treatment process. There is particular and explicit emphasis on consumer strengths (WDHB Hospital Advisory Committee Meeting notes 10/10/07; personal communication with Manu Fotu, February 2008).

- Soifua Maloloina. This model is named for the Samoan term for good health or literally translated “life wellness”. It is based on an holistic view of health where the person is in tune with his or her environment as well as with other people and God. Maintaining good, safe and balanced relationships between a person and God, the person and land (environment), and the person and other people is necessary to achieve good health (Lui, 2001).

While it is acknowledged that these models are diverse, there are evident commonalities, in particular the emphasis placed on the holistic context of care, the importance of the spiritual alongside the physical (Agnew et al 2004). Additionally most Pacific models incorporate key concepts such as the relation/connectedness between the individual, family, and community (Novak, 2007; Agnew et al 2004).

Drawing on his own research and that of Agnew et al (2004), Novak (2007) notes that Pacific models are more health belief type models rather than service planning or delivery models. They inform service delivery but are not in themselves models of service delivery. The models do not easily inform questions such as ‘at what level of the continuum should services be focused for Pacific people’ or ‘should services be focused at one part of the continuum to the detriment of others’.

Similarly Agnew et al (2004) note that Pacific models of service delivery exist in implicit rather than explicit forms and suggest that services need to develop written expositions of how the models might be framed taking into equal account cultural, clinical and service management issues. This view is supported by Pulotu-Endemann et al (2004) who note:

> While models of care require close examination, constructs to support end delivery will also need to be discussed. This includes matters relating to organisational infrastructure, governance and workforce capability (p9).

Pulotu-Endemann et al (2004) summarise the key features of service delivery which require change to align with Pacific values and beliefs. These are shown in Table 1.
Table 1: Key features of service delivery which requires change to align with Pacific values and beliefs (Source: Pulotu-Endemann et al, 2004)

<table>
<thead>
<tr>
<th>Non-Alignment of Services to Pacific People</th>
<th>Alignment of Services to Pacific People</th>
</tr>
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<tbody>
<tr>
<td>Services are acute and crisis focused</td>
<td>Services are wellness focused</td>
</tr>
<tr>
<td>Lack of appreciation of the holistic perspective</td>
<td>Services work from an holistic perspective</td>
</tr>
<tr>
<td>People have to come to the service</td>
<td>Services come to people in their communities</td>
</tr>
<tr>
<td>Consumers’ families are marginalised</td>
<td>Consumers’ families are included</td>
</tr>
<tr>
<td>Services not culturally friendly</td>
<td>Culturally friendly services</td>
</tr>
<tr>
<td>Emphasis on medication</td>
<td>Embrace traditional healing</td>
</tr>
<tr>
<td>People looking after mentally ill family members are not always supported</td>
<td>Support for people looking after mentally ill family members</td>
</tr>
<tr>
<td>Services are based around hospital/ institutional delivery</td>
<td>Services focus on delivery in the community</td>
</tr>
<tr>
<td>Needs are determined according to diagnosis</td>
<td>Needs are determined according to the assistance that a consumer requires to live well with their mental illness</td>
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</table>

**Key Findings**

While there are a number of Pacific models of care which share common principles, these do not constitute models of service delivery and therefore a regional Pacific Service Framework could fill this gap while acknowledging existing Pacific models and approaches.
Family
The importance of family for Pacific peoples is consistently emphasised in the literature\[4\]. It is from family that a Pacific person derives a sense of identity and the understanding of family obligations to look after each other. The mental health of a consumer and the mental health of family are inextricably linked. It is therefore imperative to work with family in supporting a consumer’s recovery (Pulotu-Endemann et al, 2007). The family is part of the healing process (Mental Health Commission, 2005).

This view aligns with the Māori perspective whanau ora and recognises that health and wellbeing are influenced and affected by the collective as well as the individual (Ministry of Health, 2002). It is noted that every Pacific family is different and traditional models of family leadership, values and practices can differ. These factors must be taken into account when working with Pacific families, and services must be sufficiently flexible to incorporate these variations (Pulotu-Endemann et al, 2007; Suaalii-Sauni & Samu, 2005; Agnew et al, 2004).

Community
For Pacific peoples, the importance of community, i.e. the connectedness between the individual, family, and community and the importance of community connection in relation to recovery from mental health and addictions is well documented (Novak, 2007; Pulotu-Endemann et al, 2007; Robinson et al, 2006; Agnew et al, 2004).

Tiatia and Foliaki (2005) note that traditional Pacific cultural values evolved in village/island environments where co-operation and communalism was necessary for survival. The values generated by a Pacific society are inclusive of:

- Co-operation with the group
- Loyalty to the group
- Conformity to the group
- Respect for the group
- Acknowledging and respecting status within the group.

In Pacific cultures, ways of thinking and doing are often driven by what is perceived to be acceptable to the community. Strength and confidence are drawn from communal beliefs.

**Language**

Language is considered a treasure and is of course a key means of communication.\(^5\) It is noted that provision of service in the language of the consumer and family is a key means of providing access to services and reducing health inequities for underserved groups (Ministry of Health, 2005a).

Working with Pacific consumers and their families requires access to workers with language competency (Pulotu-Endemann et al, 2007).

**Tapu**

Tapu encompasses and signals the cultural, spiritual and relational markers and boundaries for working with Pacific mental health consumers and their families. Tapu is about sacred bonds between people. For Pacific people these bonds stem from their stories of creation and the cosmic and spiritual relationships between them, their environment and their gods. All Pacific cultures believe that there is a connection between a breach of tapu and mental illness. (Pulotu-Endemann et al, 2007; Suualii-Sauni & Samu, 2005; Tiatia & Foliaki 2005; Agnew et al, 2004).

Spirituality is a key component in Pacific models of care and exists alongside the physical, mental and social aspects of a person’s wellbeing. The spiritual can encompass both Christian and ancient cosmological senses and co-exists each in its own sphere. (Suualii-Sauni & Samu, 2005; Agnew et al, 2004). In Pacific mental health and addictions practice, spirituality is incorporated as part of the treatment process (Robinson et al, 2006; Suualii-Sauni & Samu, 2005).

Traditional healers and Christian pastors are sometimes called on to assist Pacific families where a family member is mentally unwell (Suualii-Sauni & Samu, 2005).

**Holistic approach**

> The Pacific way of working means working with the whole person and whatever they bring to the table and helping them with the confidence to deal with it. (Robinson et al, 2006: 6)

A holistic view of wellbeing is central to Pacific cultural practices and belief systems (Pulotu-Endemann et al, 2007; Robinson et al, 2006; Agnew et al, 2004; Pulotu-Endemann et al, 2004).

For Pacific peoples, mental wellness encompasses family, community, and the spiritual, physical and emotional dimensions of wellness. There is therefore the requirement for health care to adopt a holistic approach.\textsuperscript{[6]} Often this approach does not align with the interpretations of mental illness that underpin New Zealand’s mental health system. These differences create conflict and contribute to Pacific peoples’ under-utilisation of mental health services. (Pulotu-Endemann et al, 2004).

Pacific services endeavour to embody an holistic approach to service delivery, despite the tensions that this can involve (Alofi, 2007; Robinson et al, 2006; Mental Health Commission, 2005; Niumata-Faleafa & Lui, 2005; Annandale & Instone, 2004; Pulotu-Endemann et al, 2004).

Values

Alofi (2007) draws on a number of Pacific publications in her summary of the most common traditional Pacific peoples values. These are reported as:

- Love
- Respect
- Humility
- Caring
- Reciprocity
- Spirituality/Christianity
- Humour
- Unity
- Family

As noted above Tiatia & Foliaki (2005) highlight that many Pacific values have their genesis in community/group membership.

Agnew et al (2004) note that mental health and addictions service delivery reflects Pacific values. As examples they highlight the roundabout rapport building approach, understandings of spirituality, the cultural value of group therapy.

Key Findings

Pacific values and themes within the literature highlight that an overarching principle is that service provision needs to be holistic, i.e., inclusive of spiritual, physical, emotional and mental dimensions and that this approach will incorporate explicit Pacific values, a family focus, a relationship focus, and use of a Pacific language and cultural practices.

Cultural competency

Pacific cultural competency is defined as:

“the ability to understand and appropriately apply cultural values and practices that underpin Pacific people’s worldview and perspectives on health.” (Tiatia & Foliaki, 2005: 5)

Pacific cultural competence is vital for improving quality of care for Pacific people. There are a number of relatively recent publications dedicated to discussion and explanation of Pacific-specific cultural competency in relation to mental health and addictions practice.[7] Consistently the themes of language, family, tapu relationships and organisational policy[8] are identified as areas where professionals, organisations and service systems need to demonstrate cultural competence.

Cultural competence is necessary at the individual practitioner level as well as at the organisational and systems-wide level. Organisational competency is attained through the employment of culturally skilled Pacific persons (Tiatia and Foliaki, 2005).

Tiatia (2008) notes that at a systems-wide level, cultural competence is the capacity of a health system to improve health and wellbeing by integrating cultural practices and concepts into health service delivery. For Pacific this means that systems demonstrate the ability to integrate or acknowledge Pacific values, principles, structures, attitudes and practices in the care and delivery of service to Pacific clients, their families and communities.

Suaalii-Sauni & Samu (2005) note that cultural competency is complex and is not usefully viewed in terms of one size fits all. It is also noted that the evidence-base for Pacific cultural competency is largely based on contributions from key groups and individuals with experience and expertise in the mental health and addictions sector (Tiatia, 2008; Pulotu-Endemann et al, 2007).

A key source of expertise in cultural competency is derived from Matua. The value of Matua or cultural experts/advisors and the need to have Matua institutionally recognised in the current Pacific mental health sector is supported (Pulotu-Endemann et al, 2007).

Acculturation

Tiatia (2008) also acknowledges the issue of diversity within Pacific populations and specifically the issue of acculturation and the varying degrees to which this has occurred. Drawing on the work of Southwick (2001) she argues that acknowledging and assessing acculturation is just as important as the need for appropriate advice and services. The inference is that this is a further aspect of cultural competence relevant to providing services for Pacific peoples. This aspect of cultural competence is particularly relevant to young people.

Young people

The New Zealand Pacific population is young with almost 50% under 20 years of age. The burden of mental illness is greater in the young Pacific population as compared with the older generations and those under 20 are significantly under-represented as users of mental health services (Ministry of Health 2008b: 7).

The young Pacific population is ethnically diverse, for example more than 50% of the Pacific children born in New Zealand from 2001 to 2004 were listed as being of more than one ethnicity (Callister & Didham, 2007 cited in Ministry of Health 2008b).

The question of ethnic/cultural identity is therefore complex for the young New Zealand Pacific population which raises issues regarding cultural competence in relation to this group. For example, Suaalii-Sauni & Samu (2005) note that the emphasis on certain themes outlined in their research is challenged in relation to cultural competency when working with young Pacific peoples. Likewise Polotu-Endemann et al, (2007) note that cultural markers for young Pacific may go beyond ethnic markers and there is inevitably tension which arises from this.

The key debates appear to focus on cultural identity in relation to issues such as mixed ethnicity and differing levels of acculturation, given the very different life experience of young people born and raised in New Zealand. Questions are raised as to the significant differences in the ways young Pacific peoples perceive themselves and the importance placed upon their Pacific identity (Tiatia & Foliaki, 2005).

These debates are in progress and unlikely to be resolved in the short term. Key points noted in the literature are:

- Pacific models of care tend to privilege the Pacific island-born adult perspective and this requires further examination in relation to the appropriateness of these models and in development of cultural competencies for working with young people (Polotu-Endemann et al, 2007; Suaalii-Sauni & Samu, 2005; Agnew et al, 2004).
- Pacific young people appear to prefer to be viewed as New Zealand young people. They face similar issues to other young New Zealanders but appear to face more challenges in maintaining good health and wellbeing (Ministry of Health, 2008c).
• A majority of young Pacific people in New Zealand are growing up in areas of high deprivation (Ministry of Health, 2008c).
• Pacific children and young people cannot be defined in isolation of their families. This interdependency is crucial to the totality of the Pacific child and young person (Action for Children & Youth Aotearoa, 2003; cited in Leger, 2005).
• There is some ambivalence expressed by young Pacific people in relation to use of some Pacific health services. Some fear that confidentiality will not be maintained (Leger, 2005).
• There appears to be reluctance on the part of Pacific young people to use conventional health services, therefore consideration needs to be given to developing youth services (eg a One Stop Shop model) that are inclusive of the needs of young Pacific (Ministry of Health, 2008c; Leger, 2005) or on Pacific specific services that are effective for the young Pacific population (Ministry of Health, 2008c).
• Cultural barriers to Pacific peoples accessing child and adolescent mental health services include lack of culturally appropriate resources/specialists and services (Ramage et al 2005, cited in Ministry of Health, 2008b).
• Ethnic matching may be less important for young people (Leger, 2005; Agnew et al, 2004).
• Pacific interventions may be more acceptable and effective for Pacific adults but less so for Pacific youth (Tiatia, 2008).

**Key Findings**
The development and application of a Pacific Service Framework must take the above issues into consideration

**Strategic context**

There are a number of national, regional and local strategic plans that inform the development of a Pacific Model of Care. Nationally, Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan (Ministry of Health, 2005b) and Te Kökiri: The Mental Health and Addiction Action Plan 2006–2015 (Minister of Health, 2006) provide overall strategic direction. Te Hononga 2015 Connecting for greater well-being (Mental Health Commission, 2007) builds on the foundations laid by these documents, providing a picture of 2015 after the challenges and actions have been met and implemented.

These national documents reinforce the importance of meeting the unique needs of specific population groups and clearly signal the requirement for services to foster the wellbeing of Pacific peoples in New Zealand and be responsive to Pacific peoples. For example:

*Build responsive services for people who are severely affected by mental illness and/or addiction, with immediate emphasis on improving the responsiveness of services for Pacific peoples.*
(Minister of Health, 2006:27)
It is noted that responsive services focus on recovery, reflect relevant cultural models of health, and take into account the clinical and cultural needs of people affected by mental illness and addiction.

The Mental Health Commission (2007) presents a vision of connectedness of services and systems in 2015 that offer more flexibility than our current configuration, outlining values, concepts and principles that appear to be highly compatible with Pacific approaches to wellness. The crucial influence on wellbeing of identity, spirituality and social and cultural connections is explicitly recognised. Values such as connectedness, collaboration and a focus on family are emphasised.

Everyone is connected to other people – whether to families, friends, communities, work colleagues, service providers or others. In 2015, the significance of these connections will be acknowledged. Services will work towards achieving and practising whanau ora/family wellbeing, and people will be supported to develop and maintain their networks with those important to them. (Mental Health Commission 2007: 25)

The Mental Health Commission (2007) envisages that services will connect with different communities and groups in different ways, according to the views, beliefs and protocols of these groups and that funding will be appropriate to the models of delivery. Pacific cultural service models are explicitly mentioned.

The need for much greater integration of services, for example primary and secondary services is also noted.

Regionally, the Northern Regional Pacific Mental Health & Addictions Plan 2003/05 (CMDHB on behalf of the four Northern region DHBs), is currently under review but provides broad direction.

The plan signals that acknowledgement of the perspectives of Pacific peoples necessitates new approaches to treatment and service delivery. It is noted that the development of new approaches impacts widely on a range of stakeholders.

The plan highlights the need for consideration of the following key issues:

- The Pacific view that mental health and wellbeing also encompass other aspects of health, social, cultural and spiritual wellbeing
- The young Pacific population
- The impact of socioeconomic factors
- The diversity of the New Zealand Pacific population for example: New Zealand-born versus Island-born people, and people of mixed ethnicity

The Northern Region Mental Health & Addictions Services Strategic Direction 2005 – 2010 (NDSA and Network North Coalition (2004) supports the direction signalled in the Northern Regional Pacific Mental Health & Addictions Plan 2003/05.
A number of District Health Board plans support, either directly or indirectly, the development of a Pacific Model of Care. These include:

- **Mental Health & Addictions 3 Year Financial Plan 2007-2010** (CMDHB, 2007).
- **Pasefika Lotu Moui Health Programme** (CMDHB, 2006b).
- **Counties Manukau Primary Health Care Plan “Moving forward together”** (CMDHB, 2003).
- **Waitemata District Health Board DISTRICT STRATEGIC PLAN 2005-2010 Making a Healthy Difference FINAL, WDHB (2005).**
- **Health Improvement Plan 2006 to 2010. Auckland District Health Board District Strategic Plan to 2010. ADHB (2006)**
- **Mental Health and Addiction Services District Service Development Plan 2006–2011 DRAFT. ADHB.**

As an example, *Tupu Ola Moui: Counties Manukau District Health Board Pacific Health and Disability Action Plan 2006-2010* emphasises the importance of consideration of a Pacific perspective of health and the implications of this for health service delivery:

> The Pacific perspective of health is often described as a balance between an individual’s spiritual, mental and physical health and wellbeing. This is defined within a context of relationships with immediate and extended family, village, district, country. This social and collective context of relationships reflects the important points of reference for Pacific self identity and wellbeing. (Counties Manukau District Health Board, 2006c: 6)

Tupu Ola Moui cites Sheehan (2005) referring to the following critical success factors in delivering effectively to Pacific populations:

- **Leadership**: Building leadership capacity in Pacific communities to take an active partnership with the health sector to improve their own health
- **Community Identity**: Understanding the changing definitions of Pacific communities and the consequent change of health needs – models that encompass ethnic specific, traditional vs contemporary needs
- **Effective Collaboration**: collaboration between funders, providers and key community leadership
- **Structural Cohesiveness**: consistent messages at all levels of the system i.e. funders, providers, individual health professionals
- **Strengthened Pacific health capacity**: strengthening and developing Pacific workforce both in the health sector and within the community to support action

The Pacific perspective of health and the identified critical success factors for Pacific service delivery provide direction for a regional Pacific Model of Care.
Waitemata District Health Board DISTRICT STRATEGIC PLAN 2005-2010 Making a Healthy Difference (FINAL 28 September, 2005) supports implementation of the regional strategies at the local district level to improve service responsiveness to the specific mental health and cultural needs of people with severe mental illness. There is explicit recognition in the plan regarding the need to address the factors that contribute to inequalities, and to work in partnership with Pacific communities and families as well as other sectors. Support for development of Pacific models of care is specifically noted in relation to public health initiatives.

The Mental Health and Addiction Services District Service Development Plan 2006–2011 DRAFT (ADHB) recognises the need to develop the capability of specific services to meet the needs of Pacific peoples.

This plan emphasises the need to address the determinants of health, the performance of mainstream health services and the development of Pacific health providers. It is noted that in accordance with the wishes of Pacific peoples health services for Pacific should take a whole family approach and advocates for consideration of a settings-based approach to health services. A settings-based approach focuses on supporting improved health knowledge, access to health services and lifestyle choices through the church environment for those communities where a high proportion of Pacific people live and work. The example of the Healthy Village Action Zone being developed by the ADHB Pacific Health Team is cited.

Overall there is considerable support within key national, regional and local health planning documents for enhancement of culturally-specific approaches to health care. Pacific peoples are well recognised as a priority group. A number of these key documents specifically cite the need for development of Pacific models of care. Additionally, many documents cite the need to involve communities in health care development and delivery and to take holistic and family-based approaches to delivery of care.
Access and target population

Comprehensive access rate data has been difficult to obtain and highlights that access data recording and reporting requires significant improvement. Nationally, the Pacific population is estimated to increase by 2.4 percent a year from 300,000 in 2006 to 480,000 in 2026[9]. The following provides an outline of the Pacific population in the Auckland region by DHB, provides an estimate of prevalence, and a discussion of access to services.

The Pacific population of the Auckland region

Based on a Pacific population of 202,100 in 2006 it is estimated that by 2026 there will be over 320,000 Pacific people in the Auckland metropolitan area, with the greatest increases being expected in Manukau City followed by Waitakere City.

Counties Manukau DHB

The Pacific resident population of Counties Manukau is nearly 93,000 or 19% of the total population. The majority (86,619, 93%) of Pacific peoples live in Manukau City, with smaller numbers in Papakura (4,377, 5%) and Franklin (1,986, 2%). Of the Pacific peoples resident in Counties Manukau, approximately 45,700 (49%) are aged 0-19, 42,000 (45%) are aged 20-59, and 5,400 (6%) are aged 60 or more.

Auckland DHB

The Pacific resident population of Auckland is just over 50,000 or 11% of the total population. Of the Pacific peoples resident in Auckland, approximately 22,200 (44%) are aged 0-19, 24,200 (48%) are aged 20-59 and 3,700 (8%) are aged 60 or more.

Waitemata DHB

The Pacific resident population of Waitemata is just over 35,000 or 7% of the total population. The majority (28,320, 80%) of Pacific peoples live in Waitakere City, with smaller numbers in North Shore (6,537, 19%) and Rodney (1,830, 5%). Of the Pacific peoples resident in Waitemata, approximately 16,700 (48%) are aged 0-19, 16,600 (47%) are aged 20-59 and 1,900 (5%) are aged 60 or more.

The census detail on Pacific populations is outlined in Table 2 below.

| Table 2: Pacific population by age group and DHB area within the Auckland region |
|---------------------------------|-----------|-----------|-----------|-----------|-----------|
| DHB                | 0-19 No. | 20-59 No. | 60 plus No. | Total No. |
| Counties Manukau    | 45,702   | 41,895    | 5,376      | 92,973    |
| Auckland            | 22,176   | 24,222    | 3,768      | 50,166    |
| Waitemata           | 16,701   | 16,599    | 1,896      | 35,196    |
| Total               | 84,579   | 82,716    | 11,040     | 178,335   |

[9] 2006 Census
Using 2001 Census national figures, the Ministry of Health (2005a) reports that the proportion of Pacific Island-born versus New Zealand-born Pacific peoples varies according to age group, with 84% of Pacific children aged 15 or younger being New Zealand-born compared with 65% of 15-24 year olds, 28% 25-64 year olds, and just 4% of 65 plus year olds.

Pacific peoples living in New Zealand represent around 22 different cultures and speak an even greater number of languages… The socio-cultural fabric of New Zealand’s Pacific populations is diverse, complex and heterogeneous. Differences also exist between, and even within cultural groups with regard to cultural norms, customs, languages, values and lifestyles. …there are also distinctive differences between those Pacific people born in their island of origin and those born in New Zealand. (Ministry of Health, 2005a: 1)

Prevalence rates for Pacific peoples in New Zealand

It is estimated that people of Pacific ethnic origin have higher prevalence rates of mental health and addictions problems than other ethnic groups, except for Māori (see Table 3 below for more detail). It appears that these higher rates are due to the youthfulness and relative socioeconomic disadvantage of the Pacific (and Māori) population (Oakley Browne, Wells and Scott, 2006).

<table>
<thead>
<tr>
<th>12 month prevalence</th>
<th>Pacific</th>
<th>Maori</th>
<th>Other ethnicities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental disorder</td>
<td>24.4%</td>
<td>29.5%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Bi-polar disorder</td>
<td>2.7%</td>
<td>3.4%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>3.2%</td>
<td>6.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Major depression</td>
<td>3.5%</td>
<td>5.7%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Suicide plans</td>
<td>1.0%</td>
<td>0.9%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0.8%</td>
<td>0.7%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Using the census population figures outlined above for 20-59 year olds and the prevalence of mental health disorders in Table 5, it is estimated that there will be over 20,000 Pacific adults across the Auckland region with a mental disorder, including approximately 10,200 in Counties Manukau, nearly 6,000 in Auckland and 4,000 in Waitemata in any year. These figures and further breakdowns are outlined in Table on page 31.
Table 4. Estimated prevalence of mental health and addictions problems by DHB (Adapted from Browne, Wells and Scott, 2006)

<table>
<thead>
<tr>
<th>Mental Health and Addictions Problems</th>
<th>Counties Manukau</th>
<th>Auckland</th>
<th>Waitemata</th>
<th>Total Auckland region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental disorder</td>
<td>10,222</td>
<td>5,910</td>
<td>4,050</td>
<td>20,183</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>1,1341</td>
<td>645</td>
<td>448</td>
<td>2,233</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>1,341</td>
<td>775</td>
<td>531</td>
<td>2,647</td>
</tr>
<tr>
<td>Major depression</td>
<td>1,466</td>
<td>848</td>
<td>581</td>
<td>2,895</td>
</tr>
<tr>
<td>Suicide plans</td>
<td>419</td>
<td>242</td>
<td>166</td>
<td>827</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>335</td>
<td>194</td>
<td>133</td>
<td>662</td>
</tr>
</tbody>
</table>

Note: It is important to note that these are estimates only, but the figures provide a guide for service capacity required within the Auckland region and each DHB area to meet the needs of Pacific people.

Access to mental health and addictions services by Pacific peoples

There are well-documented disparities in rates of access to mental health and addictions services between Pacific people and other ethnic groups (Ministry of Health, 2005a[10]; Oakley Browne, Wells and Scott, 2006; Novak, 2007). Analysis by Oakley Browne, Wells and Scott (2006) indicates that barriers to access for Pacific people (and Māori) are not explained by youthfulness or socioeconomic disadvantage. Anecdotally, Pacific people usually access mental health services via primary care, but delay seeking assistance until the issue is more severe, thus requiring more intensive treatment.

The Ministry of Health (2005a) notes that:

*The increasing number of Pacific peoples now accessing mental health services is an indication that unemployment, low income, poor housing, the breakdown of extended family networks, cultural fragmentation, and rising alcohol and drug problems are having an increasing impact on the mental health of Pacific peoples. Quantifying the extent of mental illness among Pacific peoples is complex, however, particularly because traditional Pacific perceptions of mental illness are frequently at variance with Western clinical understanding. For instance, the Western notion of chemical imbalance is not readily acknowledged or understood by Pacific cultures. In turn, Western clinicians may not readily acknowledge or understand the spiritual nature of Pacific explanations of mental illness (p1).*
Table 5 below reports findings from a study (Browne, Wells and Scott, 2006), which indicate that the percentage of Pacific people with a mental health disorder who made contact with a service for mental health reasons is well below that of other ethnic groups.

<table>
<thead>
<tr>
<th>12 month period</th>
<th>Pacific</th>
<th>Maori</th>
<th>Other ethnicities</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of people with a mental health disorder who made contact with a service for mental health reasons</td>
<td>25.4%</td>
<td>32.4%</td>
<td>41.1%</td>
</tr>
</tbody>
</table>

The findings from the data received from Pacific service providers strongly support a view that access is low and generally delayed until problems are more severe compared to people of European descent. Counties Manukau DHB (Lindsay, 2007[11]) compiled mental health and addictions utilisation data for 2005 which showed that 1,180 Pacific people living in Counties Manukau were seen by a DHB mental health team (not necessarily a Pacific service)[12]. Non-Government Organisation (NGO) data were not included in the analysis due to significant known under-reporting of the data. Breakdowns by gender, age and ethnicity were provided. Of the 1,180 clients, approximately 28% were seen by a Community Team and 25% by a Pacific Island Team. While 13% were seen by an Inpatient Team, 11% by a Child Adolescent and Family Team, 10% by an Alcohol and Drug Team and 4% by a Forensic Team. A smaller number of clients were seen by a range of other teams. These figures indicate that Counties Manukau Pacific communities are accessing mental health and addictions services at lower than expected levels. Data from other DHBs were not available.

**Access to primary health care by Pacific peoples**

Primary health care provides an important access point and service delivery means for mental health and addictions services for Pacific peoples. Pacific peoples have a high rate (close to 100% of the resident pop.) of enrolment in Primary Health Organisations (PHO) within the Auckland region.

Langimalie Health Clinic, a Pacific PHO in Auckland DHB has over 4,700 Pacific enrolments making up 97% of its total enrolled population. TaPasefika, a Pacific PHO in Counties Manukau has over 15,000 Pacific enrolments and high percentage (68%) of Pacific enrolments. Two other Pacific PHOs within Counties Manukau, Total Healthcare Otara and Procare Network Manukau have the highest number of Pacific enrolments with over 43,000 and 41,000 people respectively. The numbers of Pacific people enrolled in PHOs in each DHB area are shown in Appendix 3.

[12] Note: These figures were for Counties Manukau residents accessing services within Counties Manukau DHB and/or another DHB area, predominantly from Counties Manukau located or metro Auckland (i.e. regional) services.
The Hughes, O’Brien, Moir, Thom, and Firkin (2006) report entitled, *A Stocktake of Primary Mental Health Care Initiatives and Workforce in the Northern District Health Boards Region on behalf of the NDSA* highlighted a wide range of mental health initiatives within primary health care. These include health promotion (including community development and promoting lifestyle change and healthy lifestyles through exercise and nutrition programmes), school outreach, shared care between primary and secondary services, transfer of care, improved detection and effective treatment for mild to moderate mental disorder and improved access to primary health care services for secondary mental health service consumers. In relation to Pacific-specific activity the focus reported in the Hughes et al (2006) report was on a pilot being lead by TaPasefika and funded by the Ministry of Health. Other Pacific PHOs provided a varying degree of mental health activity.

**Workforce development important factor in improving access**

Nationally, the need to increase the Pacific mental health workforce was first highlighted in 1997 and re-iterated in 2002 (Ministry of Health, 2005a). In a recent report published by Te Pou (Southwick and Solomona, 2007), three key issues have been identified that need to be addressed to improve recruitment and retention for the Pacific mental health workforce as follows:

- Education and training supply issues such as poor graduation rates within the health professions by Pacific students
- Infrastructural barriers such as small NGO providers with limited FTEs and management support structures
- Pacific communities supply issues such as a lack of knowledge and awareness of the range of mental health services and therefore a lack of interest in seeking employment in this sector

**Affiliation and participation in church communities by Pacific peoples**

Churches play a prominent role in the communal life of most Pacific peoples with over 80% of Pacific peoples identifying with a religious denomination and being actively affiliated to churches (Ministry of Health, 2005a). Further, the Ministry of Health notes that “Elders of those churches provide Pacific community leadership, and the churches themselves provide the primary infrastructure in which migrant Pacific peoples can transplant the culture of their respective islands of origin (p15).” In summary, the church acts like the village structure by providing a range of social, cultural and spiritual supports, including the maintenance of family connections, language, customs and valued traditions, advocating for new immigrants, and providing a ‘place to stand’ and a refuge from racism.

DHBS are recognising the importance of building relationships with churches as means to improve Pacific health and wellbeing, including

[13] Note: The level of church affiliation and attendance varies between different Pacific ethnicities.
mental health and addictions. For example, CMDHB has formally acknowledged the important role churches play in the wellbeing of Pacific communities by establishing the Pasefika Lotu Moui Health Programme – Operations Plan 2006-2010 (Counties Manukau District Health Board, 2006b). The focus of the Operations Plan is on a range of priority health issues for Pacific peoples. Mental health and addictions is a component of this plan in terms of CMDHB facilitating linkages between providers and LotuMoui churches to ensure that churches have access to up-to-date and accurate information on priority conditions including mental health. This is further extended by a goal that “Lotu Moui churches will have increased knowledge and awareness relating to mental health priorities and services including other cross-sectoral issues that impact on health (p 24)” and a commitment to organise and run various forums and community education sessions on mental health, addictions and gambling.

Several authors have noted that in New Zealand, traditional support structures and customary expectations are changing for Pacific peoples, and new subcultures – particularly youth and young adult urban cultures – are emerging.[14] Further, Pacific models of care privilege the Pacific island-born adult perspective [and researchers noted that] a number of participants argue for the need to include New Zealand-born Pacific youth issues and perspectives within these models.[15]

**Key Findings**

Issues of access, including workforce development, understanding the diversity of the Pacific population, estimated population growth, and prevalence of mental health and addictions issues highlights the urgency of establishing a Pacific Service Framework as a means of facilitating Pacific service development.


Overview of the Framework

This Framework attempts to incorporate the principles which inform effective mental health and addictions services for Pacific peoples, drawing on a number of sources including expertise of Pacific stakeholders, Pacific models of care and models of health belief, Pacific research, relevant national policy documents and other relevant literature. Recent publications by Pulotu-Endemann et al (2007) and Agnew et al (2004) have provided key reference material. These publications are based on extensive research and consultation with Pacific communities. The Pacific Service Framework also draws on key national policy and planning documents and reflects national mental health and addictions sector standards.

Recognising that there is not just one right way to provide services this Framework is not intended as a one-size fits-all prescription for service provision to Pacific peoples. Nor does it preclude or supersede existing and evolving Pacific models of care and/or other ethnically specific approaches. In reality this regional Framework is derived from the essential principles of existing Pacific models. The intention is that the principles outlined are sufficiently broad and inclusive to enable services to utilise a range of effective approaches in consideration of the needs of the person and family, and context and environment. It is intended that this Pacific Service Framework will guide service planning and delivery and will be applied on a basis of sound cultural and clinical judgement.

The Pacific Mental Health and Addictions Service Framework is described below and presented as a Figure on page 41.

Purpose of the Framework

The Pacific Mental Health and Addictions Service Framework is intended to guide planning, funding and service delivery of mental health and addictions services for Pacific peoples within the Auckland metropolitan area (i.e. for populations served by ADHB, CMDHB and WDHB).

Scope of the Framework

The Pacific Mental Health and Addictions Service Framework applies directly to those mental health and addictions services, both in primary and secondary care, which are designated specifically to meet the needs of Pacific peoples residing in the Auckland metropolitan area.

The term ‘Pacific peoples’ encompasses a variety of Pacific Island nations and communities who are linguistically, culturally, and geographically distinctive from each other. Cook Island Māori, Fijian,
Niuean, Samoan, Tokolauan, Tongan and Tuvaluan peoples are the seven main ethnic groups in the Pacific community in New Zealand. The diversity of these groups is acknowledged and it is intended that the Pacific Service Framework is sufficiently broad to allow for this diversity while recognising the principles and practices shared by these groups.

Pacific peoples in New Zealand include those that are:
- Island-born and raised
- Island-born and New Zealand raised
- New Zealand-born and raised.

Services for Pacific peoples in the Auckland metropolitan area are those mental health and addictions services that are:
- By Pacific, for Pacific services (i.e. services with Pacific governance)
- DHB, PHO and NGO services based on Pacific approaches/models delivered by a predominantly Pacific workforce for Pacific communities

Problem Gambling services are included as part of addictions services. The Pacific Service Framework applies to all processes within the following areas of service-related activity:
- Service planning
- Service funding
- Service delivery
- Service reporting
- Outcome measurement
- Service evaluation.

The Pacific Service Framework pertains to services for all age groups, however the evolving needs of young Pacific people are acknowledged and discussed below in the section Implications for Service Development.

The Framework Objectives

The overall objectives of the Pacific Mental Health and Addictions Service Framework are to:
1. Outline the shared principles which are embodied in Pacific mental health and addictions service planning and delivery in the Auckland metropolitan region.
2. Describe the range of mental health and addictions service types required to meet the needs of Pacific peoples in the Auckland metropolitan region.
3. Account for the interplay between the unique qualities of Pacific mental health and addictions service delivery and the generic principles of service delivery which apply to all New Zealanders.
4. Describe the mechanisms to support delivery of the required service types.
5. Support regional consistency of service provision where possible and local implementation for local population differences.
6. Provide guidance for mainstream mental health and addictions services to support service provision that is responsive to the needs of Pacific families and communities.

Values and Principles
Services included in the scope of the Pacific Service Framework embody the following:

Pacific values
The key values underpinning this Framework include: love, respect, humility, caring, reciprocity, spirituality, humour, unity and belief in the importance of family.

Holistic approach
The overarching principle is that in accordance with Pacific approaches to health and wellbeing, service provision is holistic, i.e. inclusive of spiritual, physical, emotional and mental dimensions. This incorporates the following:
• Family focus: the family is the basic unit to which services are provided (i.e. biological and adopted, nuclear and extended), in recognition that this is key to the recovery of Pacific consumers. The Framework is sufficiently flexible to incorporate exceptions to this, for example some consumers may define family in other terms or prefer individualised care.
• Relationship focus: services have a strong focus on relationships, recognising the importance of relationships with self, God, family and community. Maintenance of strong relationships with the communities of consumers and families recognises the importance of the collective in relation to Pacific identity. Pacific community leaders are actively involved in services. Communities can be defined by ethnicity, geography, church-based or other group identity.
• Pacific language and cultural practices: competence in communicating (both verbally and in writing) with Pacific families and communities in their languages is a requirement within this Framework. Service provision reflects Pacific ways of thinking and doing. This includes working according to Pacific protocols, a focus on respect, a focus on meeting face-to-face, developing rapport in a Pacific way, going the extra mile, using humour, taking an unhurried approach. Services observe and incorporate customary cultural and spiritual practices related to tapu and breaches of tapu. Traditional Pacific health practices are acknowledged. Supervision and mentoring practices within services support a high level of expertise in cultural practices.

For further information on the values and principles of the Framework refer to Seitapu Pacific Mental Health and Addiction Cultural & Clinical Competencies Framework (Pulotu-Endemann et al, 2007)
**Recovery approach**
There is a focus on the ability to live well in the presence or absence of mental illness and/or addiction, emphasising the active role of people with mental illness and addictions in improving their lives. Living well is defined by consumers and families. The needs and rights of consumers and families are the first priority. Hopefulness is encouraged and people are supported to develop meaningful life roles. The need to eliminate the stigma associated with mental illness and addiction is acknowledged as a priority. The Recovery approach is inclusive of clinical treatment, support services and other rehabilitative care.

**Strengths-based approach**
There is an emphasis on building on individual, family and community strengths.
Mechanisms to support the delivery of the Pacific Service Framework

This Pacific Service Framework applies to the whole system of mental health and addictions care. At a whole system level a continuum of care is required including:

- Health promotion, destigmatisation and mental illness and addiction prevention
- Early intervention and Primary care
- Crisis intervention
- Acute in-patient care
- Community clinical services
- Community residential rehabilitation/support
- Community support services
- Day activities/employment and educational rehabilitation/advocacy/peer support and research and development.

The following mechanisms support delivery of the Pacific Service Framework:

1. Planning and funding: Processes reflect the principles outlined in this Framework. This requires that:
   - Pacific peoples, including community leaders, are involved in service planning and in funding decision-making.
   - The specific elements that are required to effectively deliver the Pacific Service Framework are stipulated in service specifications.
   - Funding levels are sufficient to deliver services in accordance with these principles. For example, expected service volumes and outputs match the nature of family-based holistic intervention.
   - Service planning is considerate of the need to provide a continuum of care for Pacific communities living within the Auckland metropolitan area.

2. Service delivery: Structures and processes reflect the principles outlined in this Framework. This requires that:
   - Philosophies of care reflect Pacific values
   - The norm is that intervention is family-based
   - Services address the needs of the whole person and their family and are actively linked with other services and groups to support this
   - Services are delivered in the preferred language(s) of the family
   - Services are provided according to Pacific cultural practices, protocols and beliefs. This is evident in service policies and protocols and in the physical environment.
   - Guidance and support is provided by cultural experts such as Matua
   - Strong relationships are developed and maintained between services and Pacific communities
   - Pacific community leaders are actively involved in services
• Service staffing configuration reflects the skill base required to deliver the Pacific Service Framework (ie, services can demonstrate ability to provide the cultural and clinical competence required)

3. Reporting: Reporting requirements match the services provided under this Framework. For example reporting requirements:
- Reflect the nature of family-based, holistic intervention
- Include feedback from families and community representatives
- Describe processes and mechanisms to ensure cultural and clinical competence at an organisation level and practitioner level
Implications for service development

It is acknowledged that service development priorities will change over time, as will the relevance of this Pacific Service Framework. At this time, based on the available literature and on the feedback provided by a range of Pacific stakeholders, key areas of service development are health promotion, destigmatisation and early intervention services (especially primary care). The stigmatising of mental health and addictions issues and the lack of knowledge regarding mental health services within Pacific families and communities is noted repeatedly. An important argument is made for investment in these areas as there is little point in developing excellent secondary mental health and addictions services which Pacific communities will not access due to stigma and lack of knowledge of service options.

A further area for consideration is development of services for young people. Literature and stakeholder feedback at this time suggests that Pacific young people generally identify strongly with youth culture and may not identify as strongly with the principles and practices embodied in the Pacific Service Framework.

The Pacific Service Framework acknowledges that there is a distinction between services for young people and services for families. Services for Pacific young people are currently evolving with an increasing focus on youth culture and provisions of one-stop-shop type services that also provide services for all young people. For this reason, the Pacific Service Framework does not directly apply to these services, but may be useful in terms of guiding cultural responsiveness in youth services and ensuring linkages to family focused services. The Pacific Service Framework focuses on services for families that in some circumstances will naturally include Pacific young people. Again, linkages between family focused services and youth services are important. The distinction between services for Pacific young people and Pacific families is represented in the figure below (and incorporated into the overall Pacific Service Framework diagram – see Figure 2 on page 41).
Discussion

The Pacific Model of Care project and the resulting Pacific Service Framework outlined above has been developed using a process of stakeholder liaison (Regional Pacific Service Development Forum convened by NDSA, discussions with DHB Pacific stakeholder groups, and other discussions with key stakeholders, including consumers), drawing on a literature review, a review of current service delivery and guidance from a project steering group (i.e. the Moana Pasifika Working Group).

Key findings from the literature review, overview of current services and stakeholder discussions in relation to the proposed Regional Pacific Service Framework include:

• Any Pacific Service Framework to be acceptable and effective, needs to be broad and principles-based, rather than overly prescriptive as to practices and protocols, to allow services to reflect the diversity of Pacific people and be responsive to their needs.

• There is a diverse range of Pacific models of care already in existence and services for Pacific must reflect and effectively respond to the range of health beliefs and approaches that are evident in the New Zealand Pacific community.

• While there are a number of Pacific models of care which share common principles, these do not constitute models of service delivery and therefore a regional Pacific Service Framework could fill this gap while acknowledging existing Pacific models and approaches.

• Pacific values and themes within the literature (and supported by stakeholder discussions) highlight that an overarching principle is that service provision needs to be holistic, i.e., inclusive of spiritual, physical, emotional and mental dimensions and that this approach will incorporate: explicit Pacific values, a family focus, a relationship focus, and use Pacific language and cultural practices.

• Development of a Pacific Service Framework to inform service development and provision across the whole system of care should assist with ensuring cultural competence in mental health and addictions care, particularly at a system level, which currently appears to be a gap.

• The development and application of a Pacific Service Framework must take the debates around provision of services to young people into consideration and be supportive of the development of youth-specific services (likely to be multi-cultural/mainstream in focus) and Pacific specific services that retain a family focus inclusive of the needs of young people.

• National, regional and local strategies and plans support further development of Pacific specific services based on a clear model of care or service framework.

• Available access and utilisation data, and stakeholder feedback strongly indicate a need for the establishment of increased capacity across the service continuum with particular focus on health promotion, destigmatisation and early intervention services (especially primary care).
Attempts to understand the Pacific service continuum in terms of the current configuration and consumer utilisation were limited. Utilisation data were requested from 12 Pacific mental health and addictions services and obtained from 6 services (including the 3 DHB services, the regional DHB addictions service and 2 other providers). Representatives from 10 of the 12 services were interviewed and some data on service configuration have been compiled and are briefly summarised below.

- Primary care provision of Pacific specific mental health and addictions services appears to be limited, but there are some promising linkages being established with secondary services reported by providers.
- NGO providers generally provide Community Support Work-type services although some providers deliver health promotion and destigmatisation services, and consumer support, family support, counselling, and residential services.
- Addictions services are provided regionally and as with mental health services appear to have limited capacity in relation to population estimates of mental health and addictions prevalence.
- Currently each of the Pacific mental health DHB-based services in the Auckland metropolitan region appears to be configured differently with each of the service teams in each DHB comprising different roles. This appears to contrast somewhat with mainstream services which over time have become more consistent in terms of configuration and function in each DHB.
- The findings of this project have not determined any specific rationale for these differences within the DHB services. Rather the differences appear to reflect opportunities that have arisen within the respective DHBs over time. It is also unclear how these different configurations impact on Pacific consumers and families.

Given that Pacific mental health and addictions services are relatively new; these differences are perhaps not surprising. However, given the somewhat artificial construct of DHB boundaries within the Auckland metropolitan regions (ie, families and workforces seldom live entirely within one DHB area) there may be merit in furthering a more consistent approach to service delivery and this could be assisted by the adoption of a regional service framework. A consistently applied service framework may assist consumers, families, the Pacific workforce and other professionals to more easily understand the Pacific approach to mental health and addictions service delivery.

Importantly, issues of access, including workforce development, understanding the diversity of the Pacific population, estimated population growth, and prevalence of mental health and addictions issues, highlights the urgency of establishing a Pacific Service Framework as a means of facilitating Pacific service development.
Appendices and References

Appendix 1

Steering Group Members

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaka Tautua Trust</td>
<td>Manu Fotu</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>Johnny Siosi</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>Bruce Levi</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>Lita Foliaki</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
<td>Dr Siale Foliaki</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
<td>Kirk Mariner</td>
</tr>
<tr>
<td>Auckland DHB and Waitemata DHB</td>
<td>Dr Francis Agnew</td>
</tr>
<tr>
<td>TaPsefika PHO</td>
<td>Siobhan Mattich</td>
</tr>
<tr>
<td>NDSA</td>
<td>Emma Wood</td>
</tr>
</tbody>
</table>
## Appendix 2

### Services invited to participate in the project

<table>
<thead>
<tr>
<th>District Health Board</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB and Counties Manukau DHB</td>
<td>Vaka Tautua Trust</td>
</tr>
<tr>
<td>Auckland DHB</td>
<td>Lotofale</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
<td>Faleola Pacific Mental Health Services</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
<td>Ta Pasefika Health Trust</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
<td>PIDAS</td>
</tr>
<tr>
<td>Counties Manukau DHB</td>
<td>PacifiCare Trust</td>
</tr>
<tr>
<td>Counties Manukau DBH Regional</td>
<td>Penina Health Trust</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>West Auckland Pacific Island Health Fono Inc</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>Malaga A Le Pasifika Service</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>Isa Lei Pacific Community Mental Health Services</td>
</tr>
<tr>
<td>Waitemata DHB/Regional</td>
<td>TUPU Pacific Mental Health Alcohol and Drug Services</td>
</tr>
<tr>
<td>Waitemata DHB and Counties Manukau DHB</td>
<td>Challenge Trust</td>
</tr>
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</table>
### Table 6. Enrolment figures for PHOs by DHB within the Auckland region as at April 2008 (Source: Ministry of Health, 2008)

<table>
<thead>
<tr>
<th>PHO</th>
<th>Total Enrolled</th>
<th>Pacific Enrolled</th>
<th>% Pacific with PHO</th>
<th>% of Total Pacific Enrolled within the DHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Health Trust</td>
<td>76,847</td>
<td>1,096</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Mangere Community Health Trust</td>
<td>10,106</td>
<td>6,510</td>
<td>64%</td>
<td>6%</td>
</tr>
<tr>
<td>Peoples Healthcare Trust</td>
<td>5,379</td>
<td>653</td>
<td>12%</td>
<td>1%</td>
</tr>
<tr>
<td>Procare Network Manukau Limited</td>
<td>244,177</td>
<td>41,229</td>
<td>17%</td>
<td>36%</td>
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<tr>
<td>TaPasefika Health Trust</td>
<td>22,509</td>
<td>15,270</td>
<td>68%</td>
<td>13%</td>
</tr>
<tr>
<td>Te Kupenga O Hoturoa Charitable Trust</td>
<td>34,912</td>
<td>5,590</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Total Healthcare Otara</td>
<td>80,124</td>
<td>43,357</td>
<td>54%</td>
<td>38%</td>
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<tr>
<td><strong>Sub-total</strong></td>
<td><strong>474,054</strong></td>
<td><strong>113,705</strong></td>
<td><strong>24%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td>Auckland PHO Limited</td>
<td>43,685</td>
<td>5,242</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>AuckPAC Health Trust Board</td>
<td>37,954</td>
<td>13,145</td>
<td>35%</td>
<td>21%</td>
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<tr>
<td>Procare Network Auckland Limited</td>
<td>304,985</td>
<td>28,421</td>
<td>9%</td>
<td>45%</td>
</tr>
<tr>
<td>Ta Langimalie Health Clinic Tongan</td>
<td>4,927</td>
<td>4,757</td>
<td>97%</td>
<td>8%</td>
</tr>
<tr>
<td>Health Society Incorporated</td>
<td>44,702</td>
<td>11,004</td>
<td>25%</td>
<td>18%</td>
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<tr>
<td><strong>Sub-total</strong></td>
<td><strong>436,253</strong></td>
<td><strong>62,569</strong></td>
<td><strong>14%</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td>Coast to Coast PHO</td>
<td>13,880</td>
<td>166</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Harbour PHO Ltd</td>
<td>149,853</td>
<td>2,284</td>
<td>2%</td>
<td>8%</td>
</tr>
<tr>
<td>HealthWest</td>
<td>131,764</td>
<td>16,314</td>
<td>12%</td>
<td>58%</td>
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<tr>
<td>Procare Network North Limited</td>
<td>100,079</td>
<td>2,723</td>
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<td>10%</td>
</tr>
<tr>
<td>Te Puna PHO Limited</td>
<td>11,349</td>
<td>1,084</td>
<td>10%</td>
<td>4%</td>
</tr>
<tr>
<td>Waiora Healthcare Trust</td>
<td>27,808</td>
<td>5,372</td>
<td>19%</td>
<td>19%</td>
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<tr>
<td><strong>Sub-total</strong></td>
<td><strong>434,733</strong></td>
<td><strong>27,943</strong></td>
<td><strong>6%</strong></td>
<td><strong>100%</strong></td>
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<tr>
<td><strong>Total Auckland region</strong></td>
<td><strong>1,345,040</strong></td>
<td><strong>204,217</strong></td>
<td><strong>15%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Appendix 4

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Counties Manukau District Health Board on behalf of four northern district health boards. 2003. The Northern Regional Pacific Mental Health and Addictions Plan 2003/05. Auckland, New Zealand.

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