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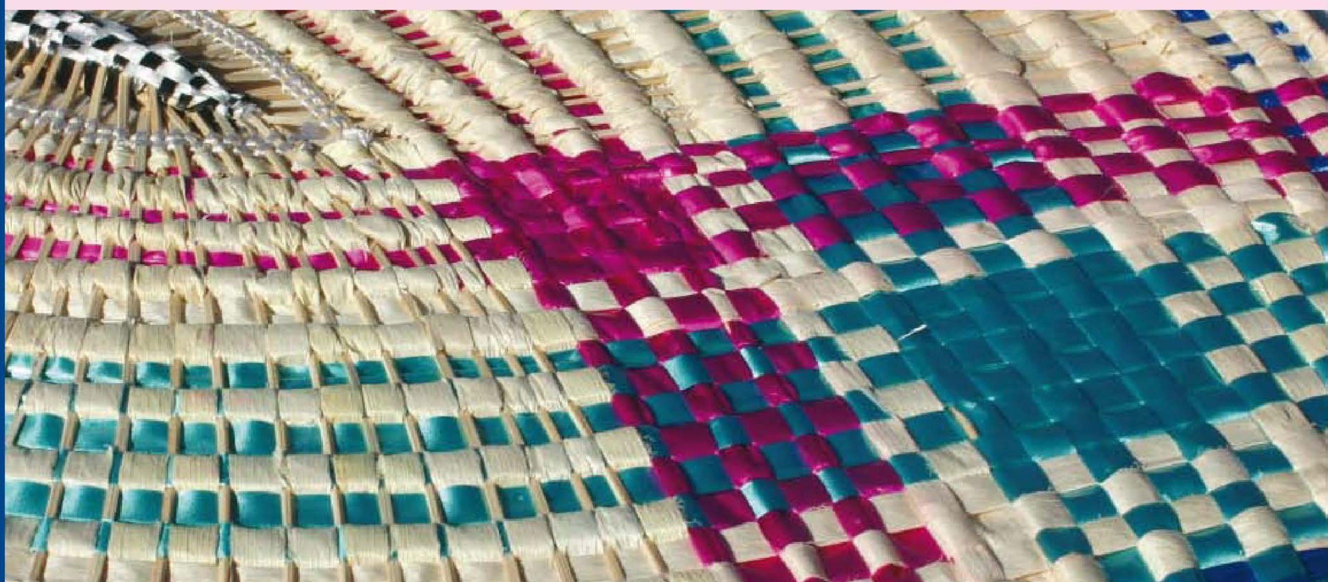
MINISTRY OF HEALTH
MANATŪ HAUORA

PACIFIC PEOPLES AND MENTAL HEALTH

A paper for the PACIFIC HEALTH AND DISABILITY ACTION PLAN REVIEW



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MSC0030122_0003

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Foreword

Talofa lava, Malo e lelei, Kia Orana, Taloha Ni, Fakalofa Lahi Atu, Ni Sa Bula Vinaka, Talofa, Kia Ora, Greetings

This is one of a series of papers prepared for the review of the Pacific Health and Disability Action Plan and represents another step towards the development of a Pacific health evidence base. The *Pacific Health Chart Book* in 2004 brought together much of the available data and identified indicators that could be used for monitoring Pacific health. Its development also highlighted the comparative inaccessibility of quality information about Pacific health. These papers bring together much of the published information relevant to Pacific health and a more complex picture is emerging about the significant influence of determinants and risk factors on Pacific health; and the role of the health system in addressing Pacific health need. The evidence from the papers confirms the importance of action in two directions to achieve Pacific health gain and reduce inequalities: one, intersectoral action to improve the determinants of health status and two, improved health system responsiveness to Pacific peoples to reduce inequalities.

With the publication of *Te Rau Hinengaro: The New Zealand Mental Health Survey* in 2006 detailed information about the prevalence of mental health illness became available for the first time. This indicated that Pacific people carried a higher burden of mental disorder than previously thought. Te Rau Hinengaro also confirmed that Pacific peoples are low users of mental health services, as they are of drug and alcohol services and problem gambling services. The Ministry is working with Te Pou o Te Whakaaro Nui the National Centre of Mental Health Research, Information and Workforce to further develop and expand the evidence base about Pacific peoples' mental health. The next step is applying this information to improve health system responsiveness and performance for Pacific peoples as well as health promotion activities to support lifestyle and behavioural change.

Dr Debbie Ryan
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Executive Summary

Pacific people carry a higher burden of mental disorder than New Zealanders in general, with a 12-month prevalence of 25.0 percent compared with 20.7 percent of the total New Zealand population. Even if their disorder is serious, Pacific people are much less likely to access mental health services (25.0 percent compared with 58.0 percent of New Zealanders overall).

Evidence suggests that Pacific people who migrate to New Zealand at an early age have a higher prevalence of serious mental disorder than other migrant or New Zealand-born groups, along with the lowest use of mental health services. New Zealand-born Pacific people have a higher prevalence of disorders than Pacific migrants, but also seek help from mental health services more often.

Almost half of New Zealand's Pacific population is under 20 years of age, and this young population is increasing rapidly. It is mostly young Pacific people, rather than older Pacific people, who carry the burden of mental disorder, particularly severe forms of mental illness. For Pacific under-20-year-olds rates of use of mental health services are significantly low.

In 2005/06, Pacific people had the lowest access rate of all ethnic groups in this age range. Although information on Pacific youth and adult (16 years and over) mental health has improved, there is still a notable lack of evidence on the prevalence of disorder among Pacific children (15 years and under).

The risk of suicidal ideation, planning and attempts varies with ethnicity. Pacific people, particularly those aged 16–24 years, have the highest rates of suicide planning and attempts. Suicide mortality rates, however, do not reflect this discrepancy, with rates for Pacific people being lower than or similar to those for other ethnicities.

Pacific people have higher rates of substance-related mental health disorders than the New Zealand population overall. There is particular concern at the prevalence of binge drinking behaviour, which is higher than for the general population. As seen for other services, use of drug and alcohol services by Pacific people is very low: 27 percent less than the national average.

Gambling prevalence surveys have identified Pacific peoples as being the most at-risk ethnic population group for developing problem gambling behaviour. Pacific people appear to have low levels of help-seeking behaviour for gambling problems, although this has recently begun to improve with the introduction of Pacific-specific help services.

Although the evidence base relating to the mental health of Pacific peoples is growing, there are still pressing information and research needs, particularly in relation to the mental health of Pacific children. A range of strategic initiatives and action plans are already in place aimed at addressing the mental health needs of all New Zealanders. The challenge is to ensure that the implementation of these policies is sufficiently inclusive and responsive to the mental health needs of Pacific peoples.

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Introduction

This paper stands alone, but also forms part of a series of papers prepared for the review of the *Pacific Health and Disability Action Plan* (Ministry of Health 2002). Other papers cover the topics of: Pacific child health; Pacific youth health; promoting healthy lifestyles and preventing chronic diseases among Pacific peoples; Pacific peoples and health services; improving the quality of care for Pacific peoples; and Pacific peoples' experience of disability.

This paper brings together the available information and evidence about Pacific peoples' mental health. It provides background about Pacific perspectives on mental health before profiling the prevalence of disorders and patterns of use of services. The issues facing migrants and children and young people are then discussed, followed by a discussion of suicidal behaviours and addictions. The resources currently available to Pacific peoples' mental health are described. Finally, conclusions and recommendations are presented.

Background

It has been estimated that, at any one time, 20 percent of the New Zealand population have a mental illness and 3 percent have a serious mental illness (Andrews 1991). The national survey *Te Rau Hinengaro: The New Zealand Mental Health Survey*[1] was undertaken as part of meeting New Zealand's commitments as a member of the WHO World Mental Health Survey Consortium. The survey results, published in 2006, provide detailed information on mental illness prevalence for Māori and Pacific peoples, as well as for the general New Zealand population. *Te Rau Hinengaro* is particularly valuable because its data and findings are New Zealand-specific, accurate for Māori and Pacific populations, and part of a large international data set.

The Ministry of Health's work to address the needs of New Zealanders who experience mental illness is guided by several strategic documents and action plans. These include *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan* (Ministry of Health 2005c). An action plan to implement *Te Tāhuhu, Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015*, was released in August 2006 (Minister of Health 2006). In December 2005 the Ministry published *Tauawhitia te Wero – Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006–2009*, which provides a framework for the development of the mental health and addiction workforce over the next four years.

In addition, the *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998) details the resources (FTEs and beds) the Mental Health Commission considered necessary, to implement the service developments presented in *Moving Forward: The national mental health plan for more and better services* (Mental Health Commission 1997). The targets set out in the *Blueprint* are still used in service planning and evaluation.

1 The survey and report will generally be referred to as Te Rau Hinengaro in this paper, or cited as Oakley Browne et al 2006. In most cases these should be read as a reference to Chapter 10: Pacific People.

Information sources

Until recently there has been little information available about Pacific peoples' mental health in New Zealand. The *Pacific Health and Disability Action Plan* did not include mental health as a priority, but did include two objectives related to Pacific peoples' mental health:

- to create new and improved ways of delivering mental health services
- to address workforce development issues facing mental health.

Tupu Ola Moui: Pacific Health Chart Book 2004 (Ministry of Health and Ministry of Pacific Island Affairs 2004) was the first comprehensive review of Pacific health since 1996. It used an indicator approach to focus on issues of particular importance to Pacific peoples, and also provided a stocktake of Pacific population health needs. *Tupu Ola Moui* showed that, compared to the rest of New Zealand, Pacific peoples have poorer health status, are more exposed to risk factors for poor health, and experience barriers in access to health services.

More information has become available with the publication of *Te Orau Ora: Pacific Mental Health Profile*[2] (Ministry of Health 2005b) and *Te Rau Hinengaro in 2006. Te Rau Hinengaro*, in particular, provides information about the prevalence of mental disorders, patterns of onset and the impact for adults in New Zealand, and patterns of health service use by people with mental health problems. The survey results will form a sound base for the future development of mental health services (Ministry of Health 2006a).

Te Orau Ora (Ministry of Health 2005b) was developed to provide information on the mental health status of Pacific peoples in New Zealand. The information in *Te Orau Ora* attempts to better represent Pacific numbers within the Mental Health Information National Collection (MHINC) data and is intended to assist the planning of service provision.

A Pacific perspective on mental health

Pacific peoples currently make up 6.9 percent of the New Zealand population, and between 2001 and 2006 the Pacific peoples ethnic group was the second fastest growing ethnic group in New Zealand (Statistics New Zealand 2007b). Pacific peoples are diverse and heterogeneous – each Pacific nation has its own set of cultural beliefs, customs, languages, values and traditions. There are also differences within each Pacific community in New Zealand, particularly in relation to levels of acculturation, which may be reflected in variations in perceptions of mental health. However, there are underlying shared pan-Pacific socio-cultural approaches that allow a discussion of mental health from a Pacific perspective.

The traditional Pacific belief related to mental health is that disturbed behaviour is a manifestation of an external spiritual force, especially ancestral spirits who have taken possession of the person because the person or the person's family have broken a certain custom or offended the spirits in some way. There is a common belief across Pacific cultures that ancestors have a constant spiritual and physical communication with current generations.

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.

The Fonofale model of health was developed to explain key features that Pacific peoples consider important for maintaining good health, and which are distinct from approaches to health within

2 Hereafter referred to as Te Orau Ora.

mainstream New Zealand culture (Mental Health Commission 2001). In the Fonofale model, these components include cultural values and beliefs, seen as a shelter for life, with family forming the foundation. Connecting culture and family are four inter-related dimensions – spiritual, physical, mental and 'other' – which together contribute to an individual's wellbeing. 'Other' refers to factors that can directly or indirectly affect health, such as gender, age, social class, employment, education and sexual orientation. The Appendix presents the Fonofale model of Pacific Island health in full.

Pacific Prevalence Rates

Historically, very little was known about the prevalence of mental disorders in Pacific peoples living in New Zealand. Prior to 2006, mental health surveys in New Zealand had included too few Pacific people to generate reliable prevalence estimates for major mental disorders (Oakley Browne et al 1989). Much of the evidence about the prevalence of mental illness in Pacific peoples came from institutional statistics, which tended to underestimate the true prevalence of mental disorder (Ministry of Health 1997a). This lack of information about the mental health status of Pacific communities was seen as limiting planning for the needs of these communities (Ministry of Health 2005b).

Te Rau Hinengaro was the first national epidemiological study undertaken on mental health in New Zealand, and provided reliable estimates of the prevalence of major mental disorders for Pacific peoples and New Zealanders overall. The survey also provided information about the patterns of use of health and other services by people with mental health problems. *Te Rau Hinengaro* sampled almost 13,000 people aged 16 years and over and living in private residences in New Zealand.[3] In order to obtain reliable prevalence estimates, Pacific peoples were oversampled, with the 2374 Pacific people interviewed making up approximately 18 percent of the total sample, compared to Pacific peoples comprising around 7 percent of the total population (Oakley Browne et al 2006: Chapter 12: Methodology).

Before *Te Rau Hinengaro*, what evidence there was suggested that Pacific prevalence rates were generally low compared to international figures (Ministry of Health 2005b; Allen and Laycock 1997). In the absence of community data, admission rates to inpatient facilities were used to estimate the burden of mental disorder in the Pacific population. However, up until 1999 usage rates of mental health services by ethnic groups were seriously undercounted due to poor recording of ethnicity in official admissions data. This led to inaccurate reporting of mental health service use among Pacific peoples, contributing to the perception that Pacific peoples do not use mental health services as much as other people.

The artificially low prevalence rates that were the outcome of relying on admissions data reinforced the widely held view that Pacific peoples experience lower rates of mental illness than other groups in New Zealand. There was also a suggestion that Pacific peoples might be resistant to the effects of many factors that are commonly viewed as stress factors for mental disorder in other communities (Ministry of Health 2005b; Graves and Graves 1985). *Te Rau Hinengaro* has proved these historical assumptions to be incorrect.

Intra-Pacific comparisons

The oversampling of Pacific peoples in *Te Rau Hinengaro* also enabled comparisons between Pacific Island groups. The majority of Pacific participants were Samoan (49.2 percent), Cook Island Maori (20.7 percent) and Tongan (16.5 percent). Each of these three groups had similar age and gender profiles. The remaining Pacific peoples (13.5 percent) were grouped into an 'Other' Pacific group because there were insufficient numbers for each Pacific ethnicity to be analysed individually. Most people in the 'Other' Pacific group were Niuean, with smaller numbers of Tokelauan and Fijian people.

Te Rau Hinengaro found that Cook Island Maori had the highest 12-month prevalence (29.3 percent) of mental disorder, followed by 'Other' Pacific peoples (25.5 percent), Samoans (24.5 percent) and Tongans (19.6 percent). The results were not statistically significant, but the pattern was consistent throughout individual disorder groups (Oakley Browne et al 2006).

3 It therefore did not include children, or people residing in prisons or medical institutions.

Differences in the levels of prevalence between Pacific Island groups and within each group may be influenced by variations in factors such as migration experience, socioeconomic status and education levels. Further analysis is planned to investigate the effects of these potential influences.

Prevalence of mental disorders

The *Te Rau Hinengaro* data indicated that 46.5 percent of Pacific people had experienced a DSM-IV CIDI 3.0[4] mental disorder at some stage during their lifetime, compared with 39.5 percent of the overall New Zealand population. Over the preceding 12 months, 25 percent of Pacific peoples had experienced such a disorder, compared with 20.7 percent of the total New Zealand population.[5]

Four aggregated groups of mental disorders were assessed in the survey: anxiety disorders, mood disorders, substance use disorders and eating disorders. The prevalence rates for individual disorders within these groups[6] can be found in Oakley Brown et al 2006. The 12-month and lifetime prevalence rates of the four disorder groups for Pacific peoples and the overall population are given in Table 1.

Table 1: Period prevalence of mental disorders

	Lifetime prevalence (%)		12-month prevalence (%)	
	Pacific	Overall NZ	Pacific	Overall NZ
Any disorder	46.5	39.5	25.0	20.7
Anxiety	27.7	24.9	16.2	14.8
Mood	19.0	20.2	8.6	7.9
Substance use	17.7	12.3	1.5	0.5
Eating	4.4	1.7	5.3	3.5

Source: Oakley Browne et al 2006

4 DSM-IV is the standard abbreviation for the Diagnostic and Statistical Manual for Mental Disorders (4th ed). The CIDI (Composite International Diagnostic Interview) is a comprehensive, fully structured diagnostic interview for the assessment of mental disorders. By means of computerised algorithms, it provides lifetime and current diagnoses according to the accepted definitions of DSM-IV (American Psychiatric Association 1994).

5 The CIDI 3.0 generates DSM-IV diagnoses by determining whether the person has ever in their lifetime met criteria for the disorder, then determines the last time the person had an episode or key symptoms of the disorder. *Te Rau Hinengaro* collected data on lifetime prevalence (the proportion of people known to have met criteria at some time in their lives before the interview) and 12-month prevalence (the proportion of people who have ever met criteria for a disorder and who have experienced an episode or disorder or key symptoms in the 12 months before the interview).

6 For example, anorexia is an eating disorder, and depression is a mood disorder.

Pacific peoples were also more likely than the total New Zealand population to experience more than one mental disorder. Table 2 shows the period prevalence and number of mental disorders experienced by the Pacific and total New Zealand samples.

Table 2: Number of mental disorders and period prevalences

	Lifetime prevalence (%)		12-month prevalence (%)	
	Pacific	Overall NZ	Pacific	Overall NZ
Any disorder	46.5	39.5	25.0	20.7
One disorder	23.4	20.0	16.6	13.0
Two disorders	12.4	9.9	5.1	4.4
Three disorders	10.7	9.7	3.3	3.3

Source: Oakley Browne et al 2006

Prevalence of disorders by age and gender

The *Te Rau Hinengaro* results indicate that younger Pacific people are more likely than older Pacific people to experience a mental disorder that is classified as serious. This is consistent with findings for the overall New Zealand population (Oakley Browne et al 2006).

The survey found that 26.7 percent of Pacific females were classified as having a DSM-IV mental disorder in the last 12 months compared with 22 percent of Pacific males, but this result was not statistically significant. There was also no statistical difference between Pacific males (5.4 percent) and Pacific females (6.4 percent) who reported having a serious disorder.

There were, however, some statistical differences between Pacific women and men in the prevalences of individual disorders. Pacific females had higher prevalences than Pacific males of certain anxiety disorders, major depression and eating disorders. Pacific males, on the other hand, had substantially higher prevalences of substance use disorders than Pacific females.

Pacific Patterns of Use of Services

People use health services to meet real or perceived needs for preventive, curative or rehabilitative care. However, the rate of use of health services often depends on an individual's knowledge of, and access to, those services. People may be unaware that they are at risk of health problems, or that health services could improve their condition. There may also be barriers to access, including cost and cultural discomfort with health care institutions. Identifying and reducing the gaps between need and use ('unmet need') should lead to better health outcomes for Pacific peoples, as for the rest of New Zealand.

Use of treatment from mental health services

Te Rau Hinengaro shows only small differences in the prevalence of serious mental disorder between Pacific peoples (5.8 percent) and the total population (6.4 percent). However, Pacific people with the most serious disorders are less likely to receive treatment from mental health services. The survey found that of Pacific people who had experienced a serious mental disorder, 25 percent had received treatment from mental health services in the past 12 months, compared with 58 percent of all people with serious disorders. Of people who had experienced a moderate mental disorder, 26.5 percent of Pacific peoples had received treatment in the past 12 months compared with 36.5 percent overall (Oakley Browne et al 2006). The *Te Rau Hinengaro* figures support previously documented evidence that the rate for Pacific peoples in New Zealand receiving mental health treatment is 35 percent lower than the rate for the total New Zealand population (Ministry of Health 2005b).

When comparing across ethnic groups for any visit for a mental health reason, *Te Rau Hinengaro* found that 25 percent of Pacific people with a disorder made a mental health visit, compared to 33 percent of Māori and 41 percent of all other New Zealanders. Adjustment for age, sex, educational qualifications and equivalised household income led to minimal changes in these percentages. This suggests that there is some reason for Pacific peoples not using mental health services that cannot be explained by their demographic characteristics (Oakley Browne et al 2006).

Approximately 40 percent of Pacific clients were referred to mental health services by a general practitioner. A further 20 percent of Pacific clients – a rate 66 percent higher than the national average – were referred by police or the courts (Ministry of Health 2005b). The levels of use by Pacific peoples of mental health services in a variety of mainstream (non-forensic) treatment settings are outlined below.

Primary mental health initiatives

Preliminary findings from an evaluation of the first 26 mental health initiatives, introduced to support the implementation of the Primary Health Care Strategy are that there are obvious gaps in service provision for Pacific peoples. The evaluation highlighted the need for primary mental health care to include health promotion and destigmatisation as service components because of the way in which mental health issues are perceived by some Pacific people and communities. Treatment options also need to accommodate a wide range of beliefs about mental health. Further work to increase the Pacific workforce may help to address some of these gaps (Ministry of Health 2007e).

Community mental health services

In 2001/02 Pacific people used mental health services delivered by community mental health teams, rather than in a hospital setting, less often than the total population (1413 per 100,000 compared to 1826 per 100,000) (Ministry of Health 2005b).

Alcohol and other drug services

Overall, Pacific peoples are less likely than the total population to use alcohol or other drug services. However, Pacific people aged 15–19 years appear to use these services as much as other New Zealanders of the same age (Oakley Browne et al 2006).

Acute inpatient services

Hospital-based mental health services for people in crisis who may need urgent diagnosis, care and treatment are referred to as acute inpatient services. Pacific peoples are more likely to use acute inpatient services (198 per 100,000) than the total population (170 per 100,000). In 2001/02 Pacific men used acute inpatient services at a rate 40 percent higher than Pacific women, who were more likely to use community mental health services (Ministry of Health 2005b).

The average length of stay in an inpatient unit per episode of illness for Pacific people is approximately four days longer than for the general New Zealand population (Ministry of Health 2005b). Furthermore, Pacific peoples generally incur higher costs per head in mental health than both Māori and European/Others (Gaines et al 2003).

Use of forensic psychiatry services

Forensic psychiatry services are defined as 'mental health services delivered by a multidisciplinary team to mentally ill offenders, alleged offenders, or those who pose a high risk of offending' (Ministry of Health 2005b). Pacific peoples are overrepresented as users of forensic mental health services in community and inpatient settings, making up 9 percent of all users of these services in 2005 (Ministry of Health 2007a).

The over-representation of Pacific peoples in inpatient and community forensic mental health services is a matter for concern (Ministry of Health and Ministry of Pacific Island Affairs 2004). It may well be linked with under-representation of Pacific peoples in other areas, such as community mental health services. This highlights the need for more assertive development of programmes specifically targeting Pacific peoples (Ministry of Health 2005b).

Ten percent of those using forensic mental health services provided within prisons, are of Pacific descent. However, this reflects the fact that 10 percent of the overall prison population are Pacific peoples rather than any over-representation in service use (Ministry of Health 2007a).

Intra-Pacific use of services

Te Orau Ora reported that 43 percent of Pacific clients of mental health services are Samoan, 20 percent are Cook Islanders, and 11 percent are Tongan. Many of the smaller Pacific ethnic groups appear to be over-represented in mental health services. Fijians, for instance, represent 3 percent of the Pacific population but make up 7 percent of all Pacific mental health services clients. Similarly, 18 percent of Pacific mental health clients are Pacific clients from the smaller Pacific nations, yet people from these nations represent only 13 percent of the Pacific population in New Zealand (Ministry of Health 2005b).

Future need

Estimates of future Pacific mental health service need suggest that over the next two decades a higher proportion of Pacific peoples are likely to be at risk of developing a mental illness. Due to the young age structure of the Pacific population, more Pacific peoples will soon be entering the age groups where this risk of mental disorder is highest. The greatest demand is expected to be in the 10–30 years age range, because this group is increasing at the fastest rate and those are the years within which first-time mental illness is most likely to occur (Ministry of Health 2005b).

Migrant Issues

Although the majority of Pacific people are born in New Zealand and 90 percent of the Pacific population speak English, 42 percent of Pacific people were born outside New Zealand (Statistics New Zealand 2002). Prior to *Te Rau Hinengaro*, no New Zealand-based studies had been undertaken on the prevalence of mental disorder among Pacific immigrants. *Te Rau Hinengaro* found that the 12-month prevalence rate of any mental disorder for New Zealand-born Pacific peoples was 31.4 percent, compared with only 15.0 percent for Pacific peoples who had migrated here at the age of 18 years or over.

Table 3 shows a pattern of prevalence whereby New Zealand-born Pacific peoples and those who migrated at an early age (under 12 years old) have a high prevalence of mental disorder, regardless of the specific diagnosis, compared with those who migrated at older ages. Furthermore, age at the time of migration is related to the prevalence of serious disorder: 6.8 percent of New Zealand-born Pacific peoples have a serious mental disorder, compared to 3.7 percent of Pacific peoples who migrated at age 18 or over (Oakley Browne et al 2006).

However, for use of services, while New Zealand-born Pacific peoples remained the highest users, the lowest service users were Pacific peoples who migrated at an early age (Oakley Browne et al 2006). Over 13 percent of New Zealand-born Pacific people had visited a mental health service in the previous 12 months, whereas less than 2 percent of Pacific peoples who had migrated to New Zealand under the age of 12 visited a mental health service. This means that a high proportion of a group who have some of the highest prevalences of mental disorder are unlikely to seek any help for their illness.

Table 3: Prevalence of disorders and service use, by age of migration

	NZ-born (%)	Under 12* (%)	12 to 17* (%)	18 + years* (%)
Any disorder	31.94	32.15	20.70	15.92
Mood	11.58	13.21	7.85	4.23
Anxiety	20.48	18.78	15.43	10.70
Substance	8.14	4.55	1.91	3.20
Serious disorder	6.80	8.13	5.88	3.73
Mental health visit	13.36	1.58	10.80	3.64

Source: Oakley Browne et al 2006

* Age at migration

One proposed explanation for the difference in rates of mental disorder between Pacific-born and New Zealand-born Pacific people is that traditional Pacific belief systems and lifestyles (which include extended family living and strong social support) provide a safeguard against mental illness. This safeguard may diminish as Pacific peoples in New Zealand become more acculturated. Accordingly, acculturation may be associated with rising rates of alcohol and drug abuse and mental illness, especially if accompanied by low socioeconomic position and associated stresses.

Reasons for this possible trend might include:

- a growing divergence between New Zealand-born and Pacific-born peoples about what the mental health needs of Pacific peoples are and the best methods for meeting those needs
- a weakening of the position of the church in New Zealand's Pacific cultures
- a weakening of the extended family structure by economic forces, with the second generation of New Zealand-born Pacific peoples growing up in relative poverty, and with a weakened cultural base
- 'complexification'[7] of ethnicities through increasing ethnic intermarriage.

7 As used by Callister and Didham 2007

Child and Youth Mental Health

Children (14 and under) make up over two-thirds of the Pacific peoples ethnic group, which is the highest among all the main ethnic groups in New Zealand (Statistics New Zealand 2007b). As Table 4 shows, the number of Pacific children is projected to increase at a rate much higher than the number of children of other ethnicities.

Table 4: Projected population growth, ages 0–14 years, 2001 to 2021

	2001	2021	Change (%)
Pacific	100,000	139,000	39
Māori	216,000	230,000	6
NZ European	653,000	521,000	-20

Source: Statistics New Zealand 2005

At the time of the 2006 Census, over 48,000 Pacific people living in New Zealand were aged between 15 and 24 years, or 18.2 percent of the total Pacific ethnic group at that time (Statistics New Zealand 2007a).

Pacific children and youth are more ethnically diverse than Pacific adults, which is one of the outcomes of increasing ethnic intermarriage by Pacific peoples in New Zealand. Over half of the Pacific children born in New Zealand from 2001 to 2004 were listed as being of more than one ethnicity (Callister and Didham 2007).

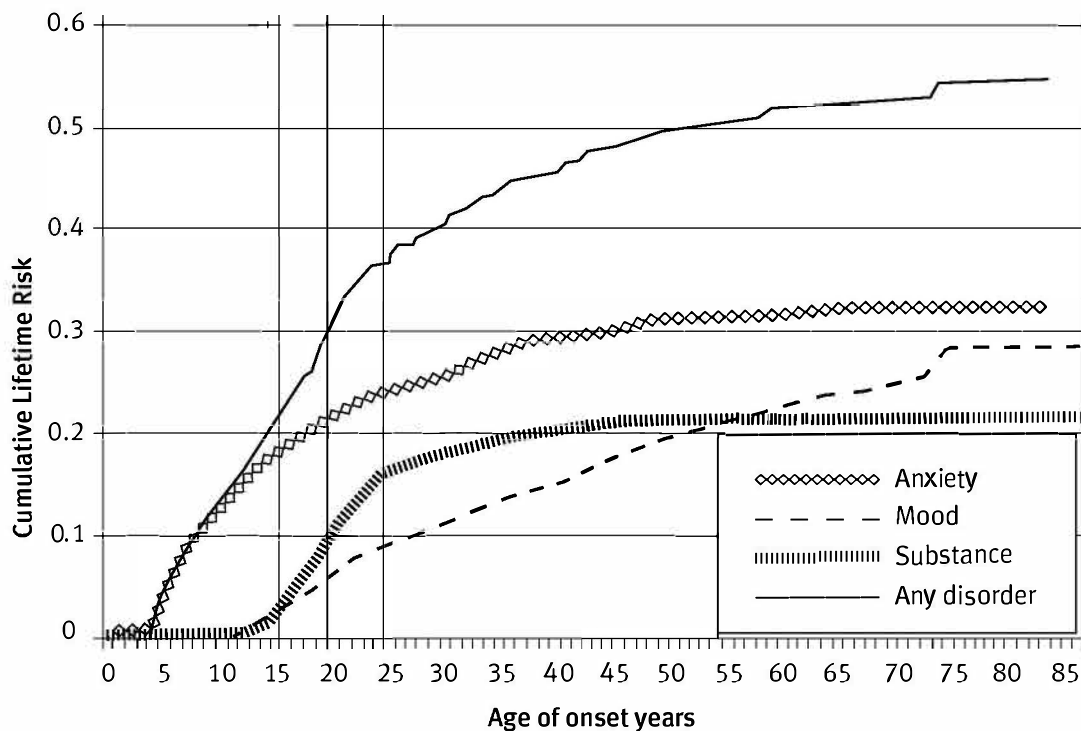
Prevalence for youth

There has been no mental health epidemiological survey that sufficiently includes a Pacific child population, although information on the prevalence of mental disorder among Pacific youth is now available from several sources.

Te Rau Hinengaro results indicate that Pacific youth aged 16–24 years are more likely than older Pacific people to experience a mental disorder. They are also more likely than older Pacific people to experience a mental disorder that is classified as serious. However, Pacific youth aged 16–24 years had only slightly higher 12-month prevalence of any disorder (29.0 percent compared to 28.6 percent), and of serious disorder (7.5 percent compared to 7.2 percent), than the total New Zealand population in this age group (Oakley Browne et al 2006).

The onset of anxiety and substance abuse disorders in Pacific peoples often occurs during their youth. Figure 10.1 in *Te Rau Hinengaro* (copied below as Figure 1) shows that nearly half of all Pacific people who will suffer an anxiety disorder will have developed the first symptoms by 15 years of age. By 20 years of age this figure will be around two-thirds, and nearly half of the Pacific people who will develop substance disorders will also be showing their first symptoms. By 25 years of age nearly all Pacific people who will have a substance disorder, and most of those who will have an anxiety disorder, will have shown the first signs of their disorder (Oakley Browne et al 2006).

Figure 1: Cumulative lifetime risk for Pacific peoples, by disorder



Source: Oakley Browne et al 2006

The Youth2000 survey found that 20 percent of Pacific secondary school students reported suffering depressive symptoms that were considered to be serious and in need of professional assistance. A significantly higher proportion of these students were female than male (Adolescent Health Research Group 2003). By comparison, 16.2 percent of Māori students and 11.7 percent of NZ European students reported experiencing such symptoms (Adolescent Health Research Group 2004).

Use of services by children and youth

In a 2003 stocktake of child and adolescent mental health services, Pacific peoples made up only 2.9 percent of all mental health clients aged 0–19 years (Ramage et al 2005). At that time, Pacific peoples made up 8.5 percent of the total New Zealand under-20 population, so Pacific children and youth were significantly under-represented as users of mental health services.

Consistent with findings for adult Pacific peoples (Oakley Browne et al 2006), Pacific children and youth have also been shown to be comparatively low users of mental health services.

The Ministry's current target access rate for use of mental health services by children and young people (0–19 years) is 3 percent, measured annually.[8] In 2005/06 the national average access rate for this age group was 1.89 percent (Ministry of Health 2007d). The average access rates by ethnicity are given in Table 5.

Table 5: National average access rates to mental health services, 0–19 years, by ethnicity

	2002/03 access rate %	2005/06 access rate %
Pacific	0.76	1.04
Māori	1.64	1.73
Other	1.84	1.90

Source: Ministry of Health 2007d (Table 6)

The access rates presented in Table 5 show that although an increasing proportion of Pacific children and youth are accessing mental health services, their use rates still fall well behind those of children and youth of non-Pacific ethnicities. Pacific peoples are therefore not accessing services at a rate that reflects their need (Ministry of Health 2007d). The 2003 stocktake identified a number of cultural barriers to Pacific peoples accessing child and adolescent mental health services, including lack of culturally appropriate resources/specialists and services, which need to be addressed in order to decrease the disparity in service use between Pacific people and the rest of the population (Ramage et al 2005).

8 Access rates are the number of clients from each ethnicity as a percentage of their total ethnic group aged 0–19 years (ie, 559 Pacific clients out of a total Pacific 0–19 years population of 99,990).

Suicidal Behaviours

Suicide and suicidal behaviours are often associated with mental illness and significant emotional distress (Beautrais et al 2005). The *New Zealand Suicide Prevention Strategy 2006–2016* defines suicide as 'the act of intentionally killing oneself' (Associate Minister of Health 2006b). Classification of a death as suicide is subject to a coroner's inquiry and can be officially deemed suicide only once an inquest is complete.

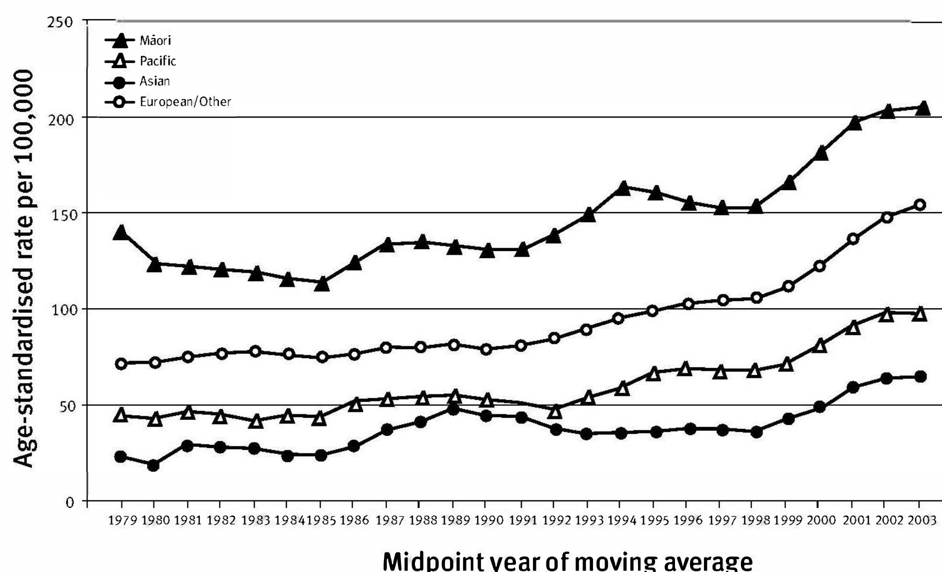
Prevalence

There is a high incidence of risk factors for suicide[9] among Pacific peoples in New Zealand, but the evidence on relative prevalence of suicidal behaviours is inconsistent, with some indicating higher prevalence and some pointing to rates similar to those for Europeans and lower than for Māori.

Te Rau Hinengaro identified that Pacific people, particularly those aged 16–24 years, have the highest rates of suicide planning and attempts (Oakley Browne et al 2006). The estimated lifetime prevalence of suicidal ideation[10] for Pacific peoples was 16.9 percent, compared with the overall population rate of 15.7 percent. The estimated lifetime prevalence of suicide attempts for Pacific peoples was 4.8 percent, which was marginally higher than for the overall population of 4.5 percent. The estimated Pacific 12-month prevalence for suicide attempts was 1.2 percent, which was three times the rate for the general population of 0.4 percent (Oakley Browne et al 2006).

However, these higher rates of ideation and attempts do not appear to translate into higher rates of hospitalisation for self-harm or completed suicide among Pacific peoples compared to other ethnicities. Hospital admissions of Pacific peoples for self-inflicted injury are consistently lower than for Māori or European people. As shown in Figure 2, the rate of hospitalisation for intentional self-harm shows an increasing trend for all population groups, including Pacific peoples (Ministry of Health 2006b).

Figure 2: Age-standardised intentional self-harm hospitalisation rates, by ethnicity, three-year moving averages, 1978–2004



Source: Ministry of Health 2006b

9 See the 'Groups at high risk' section below.

10 Thinking about suicide.

Completed suicide among Pacific peoples in New Zealand is difficult to study at a population level because the numbers are statistically small. However, recent evidence suggests that Pacific peoples commit suicide at a rate of 8.3 per 100,000 Pacific peoples, compared with 14 per 100,000 for New Zealand overall (Ministry of Health 2006c).

A recent Public Health Intelligence report tracks suicide mortality trends from 1981 to 2004 (Blakely et al 2007). All ethnic groups saw a peak in suicide rates in 1996–99. Males in all ethnic groups had the highest rates of completed suicide throughout. People of Māori ethnicity had the highest increases in suicide rates, and these were also consistently higher than their European/ Other counterparts. No clear trend of inequality between Pacific males and European/Other males was found. Suicide rates declined from 1996–99 to 2001–04 for all sex-by-ethnicity groupings except European/Other females.

Groups at high risk

Young people's mental health, including suicidal behaviour, is of particular importance to Pacific communities given their youthful age structure. As for all ethnic groups, suicidal behaviours affect younger Pacific people more than older age groups. For Pacific people aged 15–19 years, suicide rates are 16 per 100,000 compared to 8.3 per 100,000 for all Pacific ages and 22.5 per 100,000 for non-Pacific people of the same age (Ministry of Health 2005b).

The rates of completed suicide among New Zealand young people of all ethnicities reached a peak in the mid-1990s and then began to decline. Although the suicide mortality rates for young Pacific people are lower than for young Māori people, Pacific rates are similar to those for young European people.

The Youth2000 survey reported that 28 percent of Pacific students had thought about killing themselves in the past year and 14 percent had attempted suicide in the past year (Adolescent Health Research Group 2003). These figures were higher than for both Māori (26 percent and 11.5 percent) and NZ European (22.6 percent and 5.7 percent) students (Adolescent Health Research Group 2004).

Generally, more deprived areas have higher suicide rates than the least deprived areas. For example, from 2001 to 2003 the least deprived areas of New Zealand had a suicide rate of 8.8 per 100,000 population, compared to 13.2 per 100,000 population in the most deprived areas. It might be assumed that Pacific people would follow this pattern because they tend to be geographically clustered within low socioeconomic areas. However, the suicide rates for Pacific 15–19-year-olds in the low deprivation (richest) areas were at least twice those for Pacific 15–19-year-olds living in the very high deprivation (poorest) areas (Ministry of Health 2005b).

Suicide prevention

The *New Zealand Suicide Prevention Strategy 2006–2016* (Associate Minister of Health 2006b) aims to reduce the rate of suicide and suicidal behaviour and the harmful impact of suicide and suicidal behaviour on families, whanau, friends and the wider community, as well as to address the greater incidence of suicide and suicidal behaviour in some population groups.

The National Depression Initiative (NDI) was launched in 2006 as part of the implementation of the Suicide Prevention Strategy. The NDI is a Ministry of Health project aimed at raising awareness of depression in order to aid early recognition, appropriate treatment, and recovery (Associate Minister of Health 2006a). A new mass media campaign has begun under the NDI to raise awareness among all New Zealanders of how to respond to depression.

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The development of the NDI involved a benchmark survey of existing levels of awareness about depression, and compared the results between the total population and Māori and Pacific peoples. This report showed that Pacific peoples were less aware of the difficulties faced by people with depression, including increased risk of suicide, and of the prevalence of the disorder. They were also less aware of and less likely to seek professional treatment for depression, although were more likely to seek support from family, friends and church (Wyllie et al 2005).

Alcohol and Other Drugs

The use of alcohol and other drugs can have detrimental effects on physical and mental health. People showing the most extreme behaviour patterns in using these substances are diagnosed as having substance disorders, which are DSM-IV defined mental disorders.

Patterns of substance use

The report entitled *The Way We Drink: The current attitudes and behaviours of New Zealanders towards drinking alcohol*, undertaken for the Alcohol Advisory Council (ALAC) in 2004, found that the drinking behaviour of Pacific people tends to be at one of two extremes. Pacific adults are more likely to be non-drinkers (46 percent compared with 19 percent of the total population), but those Pacific adults who do drink are more likely to have consumed more than 10 glasses on the last drinking occasion (27 percent compared with 8 percent of the total population) (BRC Marketing and Social Research 2004).[11]

In the late 1990s ALAC also commissioned reports into the place of alcohol in the lives of people in different Pacific communities in New Zealand. The summary report (Alcohol Advisory Council 1997) noted that Pacific peoples did not recognise the term 'binge drinking' but they did recognise the behaviour. Researchers were told that 'when Pacific people drink, the intention is to drink until the alcohol is finished or until a person can drink no more' (Alcohol Advisory Council 1997: 8). Pacific peoples who participated in the research were also found to be more concerned with and aware of the social–behavioural issues of drinking too much rather than the health risks.

The sample sizes in national surveys have generally not been large enough to allow separate analysis of Pacific peoples' drug use, so it is difficult to obtain robust comparisons between ethnic groups of the use of drugs other than alcohol. Collating data from different sources does allow a partial picture to be seen for marijuana, which is the third most widely used illegal drug in New Zealand (Ministerial Committee on Drug Policy 2007). One-third of respondents to the Pacific Alcohol, Drugs and Gambling Survey 2003 reported that they had tried marijuana at least once, and 17 percent had used the drug in the last 12 months (PRDS and SHORE/Whariki 2004). This compares with 13.7 percent of all New Zealanders who reported during a 2003 national drug use survey that they had used marijuana in the last year (Ministerial Committee on Drug Policy 2007).

Prevalence of substance disorders

A substance disorder can be either abuse or dependence. Substance abuse implies a pattern of substance use that results in 'recurrent and significant adverse consequences' in a person's life; for example, failure at work or school or interpersonal or legal problems. Substance dependence is the experience of three or more physical and social symptoms, including tolerance, withdrawal, persistent desire to use, inability to reduce use, giving up other activities, or continuing use despite knowledge of the health consequences (Oakley Browne et al 2006).

The most recent evidence on the prevalence of substance disorders in New Zealand comes from *Te Rau Hinengaro*. As shown in Table 6, *Te Rau Hinengaro* found that Pacific peoples experience higher levels of substance disorders, in particular in relation to alcohol, than do the general population (Oakley Browne et al 2006).

11 The Pacific youth health paper also reflects on alcohol and drug use behaviours among Pacific people.

Table 6: 12-month prevalence of substance disorders

	Pacific peoples (%)	All New Zealand (%)
Any substance disorder	4.9	2.7
Alcohol abuse or dependence	4.2	2.2
Marijuana abuse or dependence	1.3	1.0

Source: Oakley Brown et al 2006

Te Rau Hinengaro also demonstrated that comorbidity of substance disorders is common, particularly in the overlap of alcohol and drug dependence. Twenty-two percent of Pacific people experiencing alcohol dependence also reported drug abuse symptoms in the past 12 months, but relatively few (11.2 percent) met criteria for drug dependence, compared with 39.1 percent of the total New Zealand population.

For Pacific people with drug use disorders, even greater proportions had alcohol use comorbidity. Forty-seven percent of those with drug dependence also reported alcohol abuse symptoms in the past 12 months, and 51.7 percent of those with drug dependence were also alcohol dependent, a pattern similar to that for the overall New Zealand population.

Service use patterns

Pacific peoples' use of alcohol and other drugs services is low. In 2001 Pacific peoples used these services at a rate of 293 people per 100,000 population, while the overall New Zealand rate was 423 per 100,000. After adjusting for age and deprivation, Pacific peoples are 27 percent less likely than the total population to use alcohol or drug services. Use is particularly low for Pacific women and for older age groups, possibly reflecting access barriers and/or cultural discomfort with the available services (Ministry of Health 2005b).

In areas of very high socioeconomic deprivation, 22 out of every 10,000 Pacific peoples, compared with nearly 62 per 10,000 of the total New Zealand population, used an alcohol or drug service each year during 2001 and 2002. However, in areas of low deprivation (relative wealth), 37 per 10,000 Pacific peoples used alcohol services, which was 70 percent higher than the rate for areas of highest deprivation. This is counter to trends for New Zealand overall, where service use was generally highest in the most deprived areas (Ministry of Health 2005b).

About 14 percent of Pacific clients seen by mental health services were also seen by an alcohol or drug service – the same rate of dual diagnosis as for the general population (Ministry of Health 2005b).

Problem Gambling

In the Pacific Alcohol, Drugs and Gambling Survey 2003, 39 percent of Pacific men and 38 percent of Pacific women reported they had gambled at some time in their lives, with 21 percent of those who had ever gambled having done so in the past week (PRDS and SHORE/Whariki 2004). The 2003 survey also found that the most common forms of gambling, apart from buying Lotto tickets, were betting on horse races for Pacific men and playing housie for Pacific women, as shown in Table 7.

Table 7: Types of gambling activities undertaken by Pacific peoples[12]

	Men (%)	Women (%)
Lotto	30	25
Bet on horse racing	30	-
Housie	-	37
Pokies	16	22
Casino	12	17

Source: PRDS and SHORE/Whariki 2004

The above figures refer to any gambling, not specifically to problem gambling. In New Zealand, problem or pathological gambling is often classified as a 'disorder of impulse control', as outlined in DSM-IV. Although this somewhat medicalised model continues to be used by clinicians and researchers, it has been widely questioned by those who prefer a broader epidemiological model that includes the impact of the environment in which gambling takes place (Productivity Commission 1999).

'Compulsive' and 'excessive' gambling are also commonly used terms, with the former being coined by Gamblers Anonymous, borrowing the term from the disease model of alcoholism, and the latter based on the idea of a continuum of problem gambling behaviour from social to heavy to problem to pathological. The term 'problem gambling' has become favoured as a more inclusive umbrella term for compulsive, excessive and pathological gambling because it is wider in its concept, so does not suggest a discrete condition and allows for the incorporation of environmental factors and effects (Abbott and Volberg 1999).

Niumata and Perese (2000) have emphasised the difficulties of defining 'problem gambling' in a Samoan context, but conclude that gambling became a problem for Samoans when they were 'losing discretionary money, as well as money allocated for bills and family obligations, and when they were spending time away from children, family and community [in particular, church]'.

New Zealand has seen a significant rise in gambling overall, with a parallel rise in the number of people seeking help for problem gambling. Niumata and Perese (2000) identify a need for more culturally appropriate research on problem gambling among Pacific peoples that recognises the diversity of Pacific ethnicities in New Zealand.

12 Some people may have reported more than one type of activity, so the percentages do not total 100.

Prevalence of problem gambling

In 1991 and 1999 national prevalence surveys on problem gambling were conducted in New Zealand. Results from these surveys indicated that adult Pacific people are the most at-risk population group for developing problem gambling in New Zealand (Abbott and Volberg 2000). The 1999 Gaming Survey (Abbott and Volberg 2000) estimated that Pacific peoples accounted for some 14 percent of all current probable pathological and problem gamblers, when they make up just 4.4 percent of New Zealand's adult population. Abbott and Volberg also showed that being of Pacific ethnicity remained a risk factor even when all other risk factors were controlled for in multivariate analysis.[13]

Analysis of the problem gambling data from the 2002/03 New Zealand Health Survey found that although Pacific peoples participate in gambling at a lower rate than the national average (53.9 percent compared to 69.4 percent), they have significantly higher rates of problem gambling than the rest of the population (3.8 percent compared to 1.2 percent) (Arnold and Mason 2007).

There has been a proliferation of electronic gaming machines, commonly known as 'pokies', both within (CGMs[14]) and outside (NCGMs[15]) casinos throughout New Zealand (Ministry of Health 2004). This continuous form of gambling is usually seen as the most addictive (Abbott and Volberg 2000).

In 2006 NCGMs were cited as the primary mode of problem gambling for most new Gambling Helpline callers and face-to-face ('full') clients, regardless of their ethnicity (Ministry of Health 2007c). Table 8 shows that for Pacific full clients of both genders, the proportion who reported CGMs as their primary mode of problem gambling was much higher than for Māori and European ethnic groups. When added to the number of full clients reporting NCGMs as their primary mode of problem gambling, the total figure for electronic gaming machines of any type is slightly higher for Pacific peoples than for other ethnic groups (Ministry of Health 2007c).

Table 8: Electronic gaming machines as the primary mode of problem gambling, by ethnicity and gender

	Pacific (%)		Maori (%)		European (%)	
	Male	Female	Male	Female	Male	Female
CGMs	36.1	30.5	15.7	10.5	11.6	18.9
NCGMs	44.4	66.1	62.2	85.6	66.7	74.6
Total	80.5	96.6	77.9	96.1	78.3	93.5

Source: Ministry of Health 2007c

Pacific peoples have been reported as having the highest expenditure on gambling. In 1999 adult Pacific peoples' average monthly gambling expenditure ($62) was significantly higher than the average monthly gambling expenditure ($41) of the total New Zealand adult population (Abbott and Volberg 2000). Problem gambling behaviour has been shown to devastate the family, adversely affecting marriages, parent–child relationships, and the psychological development of children (Faleafa 2000). Research has also estimated that for every problem gambler, five to seven other people within their families/aiga and social networks are affected (Productivity Commission 1999).

13 That is, the higher prevalence was not explained by factors such as age, employment, education or family income.

14 Casino Gaming Machines.

15 Non-Casino Gaming Machines.

Use of services

The high risk of Pacific peoples' involvement in gambling is further exacerbated by the low levels of use of help services and an absence of help-seeking behaviour among the Pacific population. Gambling research has also identified low levels of Pacific presentation to treatment services (Australian Institute for Gambling Research 1998). This reflects international findings among other ethnic minority populations around the world.

The 1998/99 clinical report of the Compulsive Gambling Society of New Zealand is reported as stating that although Pacific peoples have been identified as being six times more likely to develop problem or pathological gambling than European/Pākehā, they have a low rate of use of the Compulsive Gambling Society's help service (Problem Gambling Committee 2003).

Gambling Helpline service use data from 2006, analysed by the Ministry of Health (Ministry of Health 2007c), suggests that initiatives specifically targeting Pacific peoples, such as the dedicated Pasifika helpline, are beginning to have an effect. Although the overall number of people seeking help with gambling problems decreased significantly between 1999 and 2006, the same period has seen an increase in the number of Pacific people seeking assistance, with over 10 percent of callers now of Pacific ethnicity. Over half of new Pacific full intervention clients in 2006 were men, which was consistent with all other ethnicities except Māori (Ministry of Health 2007c).

The overall decline in problem gambling service users during 2005/06 is thought to be associated with the smokefree legislation, a stricter regulatory environment for gambling venue operators, and the impact of established public health and mental health services (Ministry of Health 2006a).

There are anecdotal reports and increasing clinical data suggesting that there is a growing number of people with a gambling problem and a co-existing substance misuse problem or a mental health disorder. There are also significant numbers of people in social service and criminal justice settings being identified as having a gambling problem who, for a variety of reasons, have been less likely to use dedicated problem gambling services.

Strategies and resources

Pacific peoples are able to receive treatment for or assistance with their mental health needs in both specific-Pacific and mainstream services. There are a number of important strategic initiatives in place to support New Zealanders who experience mental health disorders, including:

- the Health Targets[16]
- the *Primary Health Care Strategy* – primary mental health service development (Minister of Health 2001)
- *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan* (Ministry of Health 2005c)
- *Te Kōkiri – The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health 2006)
- *Tauawhitia te Wero – Embracing the Challenge: National Mental Health and Addiction Workforce Development Plan 2006–2009* (Ministry of Health 2005a)
- *Blueprint for Mental Health Services in New Zealand: How things need to be* (Mental Health Commission 1998)
- the National Drug Policy review
- *New Zealand Suicide Prevention Strategy 2006–2016* (Associate Minister of Health 2006)
- the National Depression Initiative.

The Mental Health Commission (2001) noted that poor regional planning, co-ordination and collaboration had made it harder and more expensive to deliver mental health services to Pacific communities. It also noted the difficulty of achieving effective service co-ordination, given the often transient nature and high mobility of the Pacific population. Over time, with increased population, there is likely to be growth in ethnic-specific services. These may include services operating under the umbrella of general health services (Ministry of Health 2005b).

Workforce development

As noted by the Mental Health Commission (2004), there is a shortage of experienced Pacific clinicians in mental health occupations. Currently only 0.4 percent of psychiatrists and other medical practitioners working in mental health and addiction services are Pacific people (Ministry of Health 2005a).

Between 1996 and 2001 there was a 26 percent increase – to nearly 1200 people – in the total Pacific mental health workforce. This workforce comprises professional occupations such as psychiatrists and psychiatric nurses, and other occupations such as social workers, counsellors, caregivers and administrators. Of the Pacific people who worked in mental health occupations in 2001, only 5 percent were specifically mental health professionals (excluding psychiatrists). The majority of the Pacific mental health professionals are psychiatric nurses. Between 1996 and 2001 there was a 27 percent increase in the number of Pacific psychiatric nurses (Ministry of Health 2005b).

16 The Health Target indicator for improving mental health services is that 90 percent of all long-term clients will have up-to-date relapse prevention plans (Minister of Health 2007).

The stocktake of child and adolescent mental health services identified a total of 64 Pacific staff currently working in these services. DHBs reported employing a total of 34 Pacific staff in this type of service, with the 30 remaining staff working in community services throughout the country (Ramage et al 2005).

Tauawhitia te Wero (Ministry of Health 2005a) provides a framework for the development of the mental health and addiction workforce. It also establishes a high-level umbrella plan providing national direction on key issues for all other workforce planning in the mental health and addiction sector. Of the overall funding dedicated to Pacific mental health service providers in 2005/06, $0.6 million was allocated to workforce development.

Within the framework set out in *Tauawhitia te Wero*, the Pacific research organisation PAVA, in collaboration with the National Centre of Mental Health Research and Workforce Development, was contracted by the Ministry of Health to complete a series of Pacific mental health and addictions workforce development initiatives (Annandale 2007).

The initiatives included:

- a feasibility study on establishing a Pacific mental health workforce development organisation
- investigation of issues relating to the recruitment and retention of Pacific people in mental health occupations
- research aimed at identifying Pacific mental health workforce development training needs
- a study on Pacific mental health infrastructure and organisational development
- the implementation of a Pacific mental health and addictions community mental health worker training programme
- the development of a set of Pacific mental health clinical and cultural competency standards.

The key recommendations to come out of this suite of work related to:

- establishing a dedicated Pacific mental health workforce development organisation
- greater collaboration and partnership between the Ministry, providers and DHBs, particularly in relation to funding approaches
- the need for further research in the area
- infrastructural and organisational development training for providers (eg, in governance and human resources skills)
- leadership development
- co-ordination with educational institutions to review current Pacific programmes (Annandale 2007).

The Ministry of Health has established the Pacific Mental Health Workforce Awards as a way to encourage Pacific peoples into the mental health workforce. The awards cover course fees and study-related expenses up to a total of $10,000 per year and are administered by the Health Research Council. Award recipients are enrolled in qualifications that add value to the Pacific mental health sector, such as social work, psychiatry and mental health nursing (Health Research Council 2007). Since its inception in 2003, this awards programme has supported over 120 Pacific students to further or complete their studies in mental health-related fields, with a pass rate of approximately 88.5 percent of its recipients compared to an average pass rate of 44 percent of Pacific students in all tertiary courses (Ministry of Health 2007b).

Resource allocation

The total annual funding of mental health services specifically for Pacific peoples in 2005/06 was $11 million.[17] Of this, 68 percent was allocated to community and residential services for all ages, 16 percent to child and youth services, 9 percent to family/carer and home-based support, and 5.5 percent to adult alcohol, drugs and problem gambling services. This funding provided for 116 full-time (worker) equivalents (FTEs) contracted among 19 Pacific providers of mental health services for Pacific peoples around New Zealand. The Pacific-specific child and youth mental health funding in 2005/06 was $1.6 million, or around 1.6 percent of the total of over $100 million allocated to child and youth mental health[18] (Ministry of Health 2007d).

People with mild to moderate mental health disorders such as depression, anxiety and addictions are often treated in primary health care settings. Such treatment is funded through general mechanisms for funding primary health care, rather than explicit allocations for mental health services provided in primary health care settings. This method of funding will continue in the future, with some additional targeted funding for mental health service development under the Primary Health Care Strategy. This funding path has ongoing funding allocated of just over $7 million (GST exclusive) (Ministry of Health 2006a). Through a request-for-proposals process run over 2004/05, 40 Primary Health Organisations have been funded to implement their proposed primary mental health demonstration initiatives. An evaluation of the overall approach is also being funded. The evaluation and the initiatives are due to be completed by 30 June 2008 (Ministry of Health 2006a).

17 Except for child and youth, 2005/06 funding data provided by the Mental Health Group of the Ministry of Health.

18 Many Pacific children and young people will be seen in mainstream settings.

Conclusion

This paper has brought together the available evidence and information about Pacific peoples' mental health. Without *Te Rau Hinengaro*, the evidence would have been very sparse. This highlights an important concern, common to all the papers, about the need to collect and report ethnic-specific data about prevalence, incidence and service delivery.

Prevalence of mental illness

Recent information and evidence has contributed to a better understanding of Pacific peoples' mental health. *Te Rau Hinengaro* identified that Pacific peoples experience higher rates of mental illness than New Zealanders overall. The 12-month prevalence of Pacific peoples experiencing a mental disorder was 25 percent, compared with 20.7 percent of the total New Zealand population. Further research and investigation is required to understand this disparity.

There are only small differences in the rates of serious mental illness between Pacific peoples and New Zealanders overall (5.8 and 6.4 percent, respectively). Young Pacific people experience more severe forms of mental illness than older Pacific people, which is similar to the experience of the total youth population compared to the New Zealand adult population.

The higher than previously thought prevalence of mental disorders among Pacific peoples, alongside the holistic model of health held by many Pacific peoples, means that greater consideration for mental health issues should be included when addressing Pacific peoples' health needs.

Use of services

The finding of *Te Rau Hinengaro* that Pacific people with serious mental disorders are much less likely to receive treatment from mental health services (25 percent compared to 58 percent of New Zealanders overall) is of concern. Pacific peoples' length of stay in inpatient hospital care is longer than for New Zealanders overall, and Pacific peoples generally incur higher treatment costs per head in mental health care than either Māori or European New Zealanders. Pacific peoples are over-represented in inpatient and community forensic mental health services. This is a concern, and may be linked with the low usage of mainstream mental health services. The potential implications of low mainstream service use by Pacific peoples are a matter for further investigation.

More analysis and research on the quality of care for Pacific people with mental health disorders is required, along with strategies to respond to evident disparities. This work needs to involve Pacific communities as well as mental health professionals.

There are a number of recent national mental health initiatives that should be contributing to improvements in Pacific peoples' mental health and use of services. Collection and reporting of ethnic-specific data is required to monitor their outcomes and effectiveness, and to ensure that Pacific peoples' needs are not lost sight of among national targets and achievements.

Migrant issues

Pacific peoples who migrate to New Zealand aged 18 years or over have significantly lower rates of mental illness than Pacific peoples born in New Zealand (15 and 31.4 percent respectively). However, migrant Pacific peoples are less likely to visit a mental health service than New Zealand-born Pacific peoples.

The role of culture is likely to be important, and further research may inform approaches to preventing and treating mental health disorders among New Zealand-born Pacific peoples, and to removing barriers to migrants' use of mental health services.

Child and youth mental health

Pacific peoples under the age of 20 who used mental health services in 2003 made up 2.9 percent of the total clients in that age range – a significant under-representation of the Pacific child and youth population. The low access rates by Pacific people under 20 against *Blueprint* targets reinforces the cause for concern.

Planning for mental health services needs to consider Pacific peoples' demographics and the needs of a rapidly increasing child and youth population. The level of unmet need created by the low service access rates cannot be determined accurately until clear data is available on the prevalence of mental disorder among young Pacific peoples, which is especially lacking for Pacific children (under 15 years).

Suicidal behaviour

Evidence is mixed on the relative prevalence of injury and death as a result of self-harm, with the most recent data showing that Pacific peoples do not experience disproportionately high rates of suicide mortality or hospitalisation for self-inflicted injuries. However, levels of suicide ideation and suicide attempts are higher among Pacific peoples than in the general population. Pacific peoples also have a higher-than-average prevalence of risk factors for suicidal behaviour, in particular the high proportion of young people in the population.

Further research relating to suicidal behaviours is required to investigate the prevalences among different Pacific ethnicities, cultural approaches and attitudes to suicide, potential protective factors for non-completion, and whether there are differences for New Zealand-born and migrant Pacific peoples.

Substance disorders

Pacific peoples have slightly higher rates of alcohol and marijuana abuse or dependence than the New Zealand population overall. In particular, drinking behaviours, attitudes towards alcohol and low awareness of its health effects are of concern. Reliable information on Pacific peoples' use of drugs other than alcohol is not readily available. Pacific peoples' use of drug and alcohol services is very low.

Problem gambling

Gambling prevalence surveys undertaken in the 1990s identified that Pacific peoples are the most at-risk ethnic population group for developing problem gambling behaviour. Pacific peoples also had the highest expenditure on gambling. Low levels of use of help services and an absence of help-seeking behaviour for problematic gambling among the Pacific population were also reported. On a positive note, the most recent figures suggest that the access of Pacific peoples to services is now increasing. However, there is still a need to establish the extent to which prevalence data has changed over time and the impact of recent environmental changes for Pacific peoples.

Strategies and resources

Te Rau Hinengaro has shown mental health disorders to be more of an issue for Pacific peoples than was previously thought, and has highlighted inequalities compared to the general population, especially in relation to service use. This new evidence reinforces the need to ensure that Pacific peoples' mental health needs are appropriately recognised and responded to as part of the delivery, monitoring and reporting requirements for existing strategies and action plans, such as those listed in the previous section, and new initiatives as they are developed and implemented.

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Looking Forward

The overarching message arising from this paper is a need to improve information and evidence in this area, in order to inform policy development and enhance the focus of national initiatives on Pacific peoples.

Building a strong evidence base is important to establishing an understanding of Pacific peoples' mental health and likely needs now and in the future. The following actions are planned or underway to increase this understanding, as well as to build the Pacific mental health workforce and strengthen service delivery to Pacific peoples.

Research

Le Va, the Pacific Islands Mental Health unit within Te Pou[19], is developing a mental health research agenda. The Ministry will provide Te Pou with a copy of this paper and a recommendation that the following areas arising from this paper be included in that agenda:

- further investigation and analysis in those areas of mental health, including service use, where Pacific peoples' profiles and patterns of use are sufficiently different to those of other New Zealanders
- exploration of Pacific family and community attitudes towards mental health, and the influence of traditional beliefs and attitudes
- profiling the impact of Pacific peoples' demographic characteristics on mental health service use patterns.

19 Te Pou o Te Whakaaro Nui (Te Pou) is the National Centre of Mental Health Research, Information and Workforce Development.

20 MHSMART stands for Mental Health Standard Measures of Assessment and Recovery Initiative which looks at the use of outcome measures in mental health services.

Workforce development

Te Pou is currently developing an action-focused strategic plan for Pacific workforce development. This is likely to include a stocktake of Pacific mental health workforce numbers, work on leadership and management and developing a Pacific core competency framework.

The Werry Centre[21] manages the Mental Health Placements programme which seeks to support DHBs and NGOs offer mental health clinical placements to students who have an interest in child and adolescent mental health. In 2007/2008, there is priority being given to placements for Pacific students. The Werry Centre is also developing and implementing recruitment strategies, both in the medium and long term, for Pacific mental health workers, also with a focus on child and youth services.

Service development

The Werry Centre is developing guidelines for Pacific (and Māori) youth consumer participation in both mainstream and ethnic-specific mental health services. The Centre is also designing appropriate models and processes to support the development of Pacific (and Māori) family consumer advisor roles and advisory groups to work with DHB and NGO services around service design and delivery.

Te Pou is responsible for developing an online resource about mental health service development initiatives. This project will collect and present snapshots of innovative and effective initiatives as a means of sharing and further developing new and best practice in mental health service provision. It is recommended that this resource include examples from Pacific-specific service providers.

Data collection

There is mandatory collection of ethnicity data by all mental health providers, DHBs and the Ministry of Health through the MHINC[22]. The Ministry also collects and reports achievements for Pacific peoples against national measures such as the Health Targets and access rates. There is a need for consideration of how to communicate and use data gathered from these sources effectively.

Other

This paper has also raised the need in the New Zealand mental health sector for:

- development of resources outlining what services and resources are available for Pacific consumers in various regions
- health promotion activities within the Pacific community to include information about drug, alcohol and gambling services, the dangers of addictions, and services available
- the needs of Pacific families and communities to be considered and addressed in order to help provide a safe environment for discussion, information sharing and mutual support
- further information about mental disorders experienced by all children, including Pacific children.

21 The Werry Centre is the Child and Adolescent Mental Health and Addictions Workforce Development Centre.

22 MHINC is the Mental Health Information National Collection, the main source of mental health service data.

Appendix: The Fonofale Model

The Fonofale model of health

The Fonofale model was created by Fuimaono Karl Pulotu-Endemann as a Pacific Island model of health for use in the New Zealand context. The Fonofale model is named after Fuimaono Karl's maternal grandmother, Fonofale Talauega Pulotu Onofia Tivoli.

A description of the Fonofale model first appeared in 1995 in the Ministry of Health report Strategic Directions for Mental Health Services for Pacific Island People. However, the model's development dated back to 1984, when Fuimaono Karl was teaching nursing and health studies at Manawatu Polytechnic. The model underwent many changes prior to 1995.

The Fonofale model incorporates the values and beliefs that many Samoans, Cook Islanders, Tongans, Niueans, Tokelauans and Fijians had told Fuimaono Karl during workshops relating to HIV/AIDS, sexuality and mental health from the early 1970s to 1995. In particular, these groups all stated that the most important things for them included family, culture and spirituality. The concept of the Samoan fale, or house, was used as a way to incorporate and depict a Pacific way of what was important to the cultural groups as well as what the author considered to be important components of Pacific peoples' health. The Fonofale model incorporates the metaphor of a house, with a roof and foundation.

The roof

The roof represents cultural values and beliefs that is the shelter for life. These can include beliefs in traditional methods of healing as well as western methods. Culture is dynamic and therefore constantly evolving and adapting. In New Zealand, culture includes the culture of New Zealand-reared Pacific peoples as well as those Pacific peoples born and reared in their Island homes. In some Pacific families, the culture of that particular family comprises a traditional Pacific Island cultural orientation where its members live and practise the particular Pacific Island cultural identity of that group. Some families may lean towards a Palagi orientation where those particular family members practise the Palagi values and beliefs. Other families may live their lives in a continuum that stretches from a traditional orientation to an adapted Palagi cultural orientation.

The foundation

The foundation of the Fonofale represents the family, which is the foundation for all Pacific Island cultures. The family can be a nuclear family as well as an extended family and forms the fundamental basis of Pacific Island social organisation.

The pou

Between the roof and the foundation are the four pou, or posts. These pou not only connect the culture and the family but are also continuous and interactive with each other. The pou are:

Spiritual – this dimension relates to the sense of wellbeing which stems from a belief system that includes either Christianity or traditional spirituality relating to nature, language, beliefs and history, or a combination of both.

Physical – this dimension relates to biological or physical wellbeing. It is the relationship of the body – which comprises anatomy and physiology – to physical or organic substances such as food, water, air, and medications that can have either positive or negative impacts on the physical wellbeing.

Mental – this dimension relates to the health of the mind, which involves thinking and emotion as well as behaviours expressed.

Other – this dimension relates to variables that can directly or indirectly affect health such as, but not limited to, gender, sexual orientation, age, social class, employment and educational status.

The fale is encapsulated in a cocoon whose dimensions have direct or indirect influence on one another. These dimensions are:

Environment – this dimension addresses the relationships and uniqueness of Pacific people to their physical environment. The environment may be a rural or an urban setting.

Time – this dimension relates to the actual or specific time in history that impacts on Pacific people.

Context – this dimension relates to the where/how/what and the meaning it has for that particular person or people. The context can be in relation to Pacific Island-reared people or New Zealand-reared people. Other contexts include politics and socio-economics.

Source: Mental Health Commission 2001: 6-7

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