Te ORA submission to the Mental Health and Addiction Inquiry

Te ORA, the Māori Medical Practitioners Association acknowledges the work of the Mental Health and Addiction Inquiry and respectfully forwards this submission.

Te ORA is the professional body representing approximately 350 Māori medical practitioner across general medical practice and the specialties. Our members include students and doctors. We work as clinicians, researchers and teachers. We support members in their working lives, assist younger colleagues through professional training, work with the Medical Council of New Zealand and the Council of Medical Colleges to develop cultural competency programmes for New Zealand (and Australian doctors) and we run and attend annual scientific meetings and international indigenous conferences for medical practitioners. Te ORA’s vision is to provide Māori medical leadership to the health sector to effect Māori health development.

Te ORA is particularly cognisant of mental health needs in the Māori that are the result of:

* a history of colonisation, land loss, cultural and economic marginalisation of Māori tribal communities over the years and loss of any sense of self determination[[1]](#footnote-1)
* a culturally hostile societal infrastructure where *te reo Māori me ōna tikanga*, have not attained the status where Māori individuals can ‘be ourselves’ and ‘do our own thing’ as indigenous peoples, having our cultural identity and the connection with the spirituality of ancestral places being marginalised[[2]](#footnote-2),
* an inequitable socio-economic environment where Māori, like others in a similar environment, continue to be failed by the education system, under-employed, more likely to be imprisoned and socially isolated from the ‘social determinants of resilience’[[3]](#footnote-3)
* Culturally incompetent mental health workers and institutional racism in mental health services

We are supportive of, as others will be, the longer term strategies around funding mental illness prevention and mental wellbeing promotion, bolstering the capacity and capability of mental health treatment services and indeed, the very long term objective of addressing the social determinants of mental health by a redistribution of the resources of our society. We believe however, that there are short term outcomes to be gained in the mental health services that are afforded Māori whānau that should be urgently prioritised and we proffer the view that:

***Early intervention services, whose workers and the philosophy of which resonate with Māori ideology, are likely to be able to stem the capacity-strain placed upon the mental health system by Māori with mental health distress, and the cultural capability issue inherent in the New Zealand workforce.***

**What’s currently working well?**

The short answer is “Not much”.

People in Māori communities do very poorly with regard to mental health. Prevalence of mental health disorders are generally not too dissimilar across ethnic groups,[[4]](#footnote-4) but a larger proportion of people from Māori communities present with mental health problems to their general practitioner,[[5]](#footnote-5) and Māori women have twice the consultation rate of non-Māori women.Anxiety, substance abuse and depression are the main problems, and despite 75% of disorders being moderate to severe, Maori had very low access to primary or secondary services.[[6]](#footnote-6) General practitioners admit to underdiagnosing mental health problems among Māori, particularly depression.[[7]](#footnote-7) Awareness of the lower presentation rates,[[8]](#footnote-8) under-diagnosis, under-investigation, lower referral rates and under-treatment[[9]](#footnote-9) in primary care would point to the likelihood of this being exactly the same for mental health issues.

Māori have more acute inpatient admissions than others,[[10]](#footnote-10) have twice the relative risk of being admitted into an inpatient psychiatric unit with a diagnosis of schizophrenia or major depressive disorder, [[11]](#footnote-11)are readmitted more often after discharge,[[12]](#footnote-12) are more likely to be secluded in hospital[[13]](#footnote-13) and those of us with psychotic illness are overly incarcerated in prison forensic units.[[14]](#footnote-14) Using prioritised ethnicity, Te Rau Hinengaro, notes that Māori have the highest 12 month prevalence of ‘any mental health disorder’, ‘serious disorder’ or ‘mental health visit’ even after adjusting for age, sex, educational qualifications and household income.[[15]](#footnote-15) It also reports the national age standardised rate of suicide for Māori being almost twice that of ‘Others’ and four times, when considering those who were not previously known to mental health services and the Ministry of Health (2015) confirm that this is unchanged.[[16]](#footnote-16)

**What isn’t working well?**

As outlined above, ‘*mental health in Māori communities* *isn’t working well’* and neither are the services that support New Zealanders working well for Māori. We do acknowledge that poor mental health outcomes in New Zealand are across the board. But we simply note that in Māori communities, mental health outcomes are devastating. Further, we note that despite such significant differences in mental health status, we do not have any dedicated and adequately resourced focus on research that might mainstream services to understand the significance of these differences in mental health status, access to and experience of services and why the services provided often do not adequately treat the problem(s) that clients present with.

We make mention of the capacity problems experienced by the mental health services where demand has soared with people accessing mental health services increasing by 7% in the two years to 2016.[[17]](#footnote-17) This significant increase in demand sees 20% of the population having a diagnosable mental health illness in the 2017 year.[[18]](#footnote-18) In a systematic documentation of mental health service problems, the 2016 ActionStation *People’s Mental Health Report, [[19]](#footnote-19)* noted that mental health and wellbeing in New Zealand is undermined by:

* poverty
* discrimination,
* the effects of colonisation
* high levels of domestic and sexual violence

It noted

* poor access to services
* long wait times
* limited treatment options in primary and community
* high use of compulsory treatment and seclusion practices
* ineffective responses to crisis situations
* underfunding of services in the face of rising demand
* mental health workers who felt overworked, under-resourced and stressed

Later that year the Office of the Auditor-General’s *Mental Health: Effectiveness of the planning to discharge people from hospital* Report[[20]](#footnote-20) which, noted that the problems outlined by ActionStation had led to an inappropriate discharging of patients ignoring *“broader needs, such as getting help with housing, finances, or support from their employer or family”*.

In addition, we see that there is a capability problem in mental health services and the lack of culturally appropriate services for Māori and appropriate training of mental health professionals has been noted.[[21]](#footnote-21) Although there has been a long and active promotion of a Māori cultural base in the provision of mental health care by psychiatrist and academic Professor Sir Mason Durie,[[22]](#footnote-22),[[23]](#footnote-23),[[24]](#footnote-24) it seems that, apart from one paradigm-challenging example of a traditional healer-psychiatrist collaboration[[25]](#footnote-25) and a few innovative local Māori primary mental health care initiatives,[[26]](#footnote-26) there is little evidence of systematic change.

The NZ mental health system is simply not equipped to deal with the increasing number of Māori who present with various forms of distress that is exacerbated by deprivation, racism, cultural marginalisation and social isolation. Neither is the alienation of Māori from mental health services helpful, despite those service being mostly culturally incompetent. Discrimination is known to be bad for psychological well-being,[[27]](#footnote-27) and New Zealand researchers have openly subscribed to the concept that Māori experience of ‘racism’ is responsible for a wide range of inequitable health outcomes including mental health.[[28]](#footnote-28) [[29]](#footnote-29),

**What could be done better?**

We understand that health inequities arise through inequitable access to the determinants of health, unequal access to and through health care and the differential quality of the care received.[[30]](#footnote-30) At the same time however, we note that this maldistribution is an expression of racism and colonisation, where the social determinants of health continue to be differentially distributed in NZ by ethnicity and especially, by indigeneity. Finally, that the history of institutional racism has predicated against kaupapa Māori services ever attaining any form of sustainability.

In respect of the latter two we note:

* the lack of service available to those in early stages of distress where simple intervention might suffice
* the mainstream (and therefore non-Māori) focus of mental health services and their particular therapeutic and pharmaceutical approaches to becoming well again
* the lack of resilience development in children of marginalised communities and in early childhood education that might help fill that gap
* that we have no wish to medicalise mental health distress and that we recognise this distress as a reasonable response to adverse social and cultural states of being

Children need safe and loving attention in their upbringing,[[31]](#footnote-31) and a lack of that attention and exposure to adverse events in early childhood leads to poorer mental health outcomes.[[32]](#footnote-32),[[33]](#footnote-33) We do poorly in New Zealand with regard to both a poor experience of an early life where poverty, poor housing, and preventable illness are rife, and possibly a lesser experience of childhood where good parenthood and good parenting is challenged by those things. But it is clear that healthy pregnancies,[[34]](#footnote-34) early childhood education[[35]](#footnote-35) and school systems[[36]](#footnote-36) are able to enhance ‘social and emotional learning’.

Therefore we would like to see:

* The development of community-based open access mental health centres
* The centres are staffed by professional mental health workers (many of whom are Māori) whose extra training in an appropriate therapeutic approach to Māori mental health is paramount
* That these centres are also well staffed with ‘community support and advocacy workers’, who also have extra training in an appropriate therapeutic approach to Māori mental health, and who can ensure that Māori individuals and whānau are supported to access resources they have rights to
* That whaiora/tūroro are seen and treated within the context of their whānau and the community in which they live
* That these centres are funded separately from DHB control where money is incessantly invested in hospital systems and the very unwell patient
* That there is a national approach to ‘community mental health’ and that the philosophical approach to provision of mental health service is consistent with Māori values.

We would also like to see:

* A purposeful re-development of early childhood education for deprived and for Māori and Pacific communities such that the ethos of that education concentrates around ‘developing the ‘social and emotional’ learning of children in the context of their community of residence and their cultural needs.
* A primary education that likewise prioritises the development of socio- emotional skills and coping skills providing mentorship, coaching and guidance across a range of sporting and cultural activities.
* A secondary education system that gets rid of its teaching of compliance and conformity and the need to learn appropriate skills for a job, alongside the development of age appropriate lessons in how to deal well with life’s challenges like sexual behavior and alcohol and substance use, bullying, intimidation, social media being a happy and fulfilled individual in a whānau and a cultural community seems a good place to start.

We have concentrated in this submission on changes in the nature of ‘early intervention’ services available to Māori (and other New Zealanders) and changes in the education system for two reasons. Firstly, the services changes in mental health care mooted by us are being actively explored by the Ministry of Health’s Fit for the Future initiative[[37]](#footnote-37) and we should expect researched outcomes from this in the short term. Secondly, the other way to intervene early on in the life course is via education, another sector undergoing major change by this recently new Government. Wee seek to take advantage of that changing sector as well. This concentration on these two elements is not to suggest that welfare, housing, economic development, justice and other elements of the New Zealand landscape do not need similar attention.

We thank the Mental Health and Addiction Inquiry team for their attention to this piece of work and wish you well.

Ngā maanakitanga

Nāhaku noa, nā

David Tipene-Leach

Chair, Te ORA

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