Evaluation of Tu Meke PHO's Wairua Tangata Programme: a primary mental health initiative for underserved communities

Sally Abel PhD;[1] **Bob Marshall** PhD;[1] **Donny Riki** BASS (psychotherapy);[2] **Tania Luscombe** BAgEcon, DipTchg[2]

[1] Eastern Institute of Technology, Hawke's Bay

[2] Wairua Tangata Kaiwhakaora Hinengaro/Lead Practitioner, Innov8 Group Ltd

ABSTRACT

BACKGROUND AND CONTEXT: New Zealand's primary mental health initiatives (PMHIs) have successfully filled a health service gap and shown good outcomes for many presenting with mild to moderate anxiety/depression in primary health care settings. Maori have higher rates of mental health disorders and complexity of social and mental health needs not matched by access to PMHIs.

ASSESSMENT OF PROBLEM: The Wairua Tangata Programme (WTP), a Hawkes Bay PMHI, aimed to provide an integrated, flexible, holistic, tikanga Maori–based therapeutic service targeting underserved Maori, Pacific and Quintile 5 populations. External evaluation of the programme provided formative and outcome feedback.

RESULTS: The WTP reported high engagement of Maori (particularly women), low non-attendance rates, good improvements in mental health assessment exit scores, strong stakeholder support and service user gratitude. GPs reported willingness to explore mental health issues in this high needs population. Challenges included engaging Pacific peoples and males and recruiting from scarce Maori, Pacific and male therapist workforces.

STRATEGIES FOR IMPROVEMENT: Effectively meeting the target population's complex social and therapeutic needs required considerable programme flexibility, referral back into the programme and assistance with transitioning to other therapeutic or social support services. Referral criteria required adaptation to accommodate some sectors, especially youth. A group programme was developed specifically for males.

LESSONS: A holistic PMHI programme delivered with considerable flexibility and a skilled, culturally fluent team working closely with primary care providers can successfully engage and benefit underserved Maori communities with complex social and mental health needs. Successful targeted programmes are integral to reducing mental health disparities.

KEYWORDS: Primary health care; mental health; Maori; medically underserved areas; evaluation.

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CORRESPONDENCE TO:
Sally Abel
Senior Research Fellow, Eastern Institute of Technology, PB 1201, Hawkes Bay Mail Centre, Napier 4142, New Zealand
sabel@eit.ac.nz

Background

In New Zealand, over a third of general practice patients are reported to have a diagnosable mental disorder, most commonly conditions relating to anxiety, depression and substance use.[1] Major time constraints can militate against GPs counselling effectively within the context of the general practice setting,[2] yet private therapy is costly and community-based secondary care services, although free, are very stretched and have long waiting lists.[3] The Ministry of Health (MoH) funded primary mental health initiatives (PMHIs), which commenced in 2004, allowed primary health care providers around the country to establish programmes suited to their patient population that could address mild/moderate anxiety or depression and prevent progression into more complex (and costly) conditions. An evaluation of the first round of PMHI programmes found that a number of different models of care were developed, including some Kaupapa Maori programmes; programmes were viewed very favourably by primary health care providers and their patients; and some important service-user outcomes were demonstrated.[3]

The PMHIs (both mainstream and Kaupapa Maori) were intended to be responsive to Maori and an aim of their evaluation was to assess whether they were reducing mental health disparities and improving health outcomes.[3] Maori have higher rates of mental health disorders that are not matched by access to mental health interventions.[4] In addition, NZ GPs are less likely to diagnose depression in Maori patients than in non-Maori patients.[5] The PMHI evaluation found that Maori comprised 17.5% of service users in the programmes evaluated, slightly higher than the 15% in the general population, and Kaupapa Maori and some mainstream PMHI programmes were considered responsive to Maori. However, many providers experienced difficulty providing Maori-focused programmes and recruiting a Maori workforce, and the evaluators noted that there remained a relative underutilisation of PMHI services by Maori, given their higher prevalence of mental health conditions. Evaluation feedback from Maori PMHI service users also highlighted the multiple everyday life stresses they faced and the sheer complexity of their mental health issues.[3]

This paper reports on an evaluation of a primary mental health initiative in Hawkes Bay that was developed a little later than the above-mentioned programmes. The Wairua Tangata Programme (WTP) specifically targets Maori, Pacific and NZDep Quintile 5 communities using a holistic tikanga Maori–based approach, and has shown some success at engaging and improving outcomes for this historically underserved population. The aims of the evaluation were to provide formative feedback to the implementation team and, through the collection and analysis of process and outcome data, to determine the success of programme outcomes. The paper reports on results from the programme's first year with further follow-up results and comments.

WHAT GAP THIS FILLS:

What we already know: Primary mental health initiatives (PMHIs) have shown successful outcomes for many presenting with mild to moderate anxiety/depression in the primary health care setting, but appear to be underutilised by Maori who have higher rates of these conditions.

What this study adds: A holistic PMHI programme delivered with flexibility and a skilled, culturally fluent team who work closely with primary care health practitioners can successfully engage and benefit underserved Maori communities with complex social and mental health needs.

Context

The WTP was established in 2008 by Tu Meke First Choice PHO (TMFCPHO), which at that time serviced a high needs population of 13 712 people (including 47% Maori and 11% Pacific) resident in Hastings and Flaxmere, Hawkes Bay. TMFCPHO was one of the three Hawkes Bay PHOs that have since been amalgamated into one, Health Hawke's Bay: Te Oranga Hawke's Bay. The WTP was funded through the second round of MoH PMHI contracts. Its target population was 18–60-year-old Maori, Pacific residing in an NZDep Quintile 5 area. Access was by GP referral and, as was required by the MoH contract, a mental health assessment tool was used prior to entry and on exit from the programme. The Kessler-10 (K10) assessment tool was chosen from a range of options, although none had been validated for Maori. The K10 criterion for admission was a score of 20–29 (mild–moderate depression and/or anxiety) out of a possible 50. Those referred to the programme received an initial therapeutic programme of four to six (more or less) sessions of counselling or psychotherapy and the services of a social worker if required. The service was free of charge.

Initiation of the programme was driven by the PHO management and general practitioners. The programme design was developed by a predominantly Maori team who were mindful of early evaluation feedback about the successes and weakness of other initiatives around the country.[6] A popular modality used in other PMHIs was cognitive behavioural therapy (CBT). Although one early commentator argued that this cognitive approach may not work well for Maori,[8] recent research on how CBT might be adapted to be responsive to Maori looks promising.[7] However, the WTP team decided on a more holistic approach with spiritual and whanau dimensions.

The programme was embedded in a Maori framework and ethos that embraced all comers. Practice guidelines embraced a holistic view of the person founded on Te Whare Tapa Wha model[9] and on a parallel Pacific Fonofale model (developed by Traci Tuamaseve, Trail Media, Flaxmere). Key features considered important and integral to the programme were:

- an integrated model at both structural and therapeutic levels
- considerable flexibility in a range of domains (e.g. venue, time, style of engagement and personnel) to enable appropriate responsiveness
- a polymodal, systemic, strengths-based therapeutic approach
- tikanga Maori–based practice, including whakawhanaungatanga (acknowledging relationships), whakawatea/whakanoa (creating a sense of safety), whakapapa/pepeha (reclaiming ancestral origins), waiata/haka composition (expression of new beginnings) and decolonisation techniques (dealing with the sense of historical injustice)
- inclusion of whanau, when appropriate
- prompt, face-to-face engagement with the programme and therapist.

Tikanga Maori–based practice is delivered from a contemporary understanding of a traditional Maori worldview that provides a context to remember, reclaim and reaffirm the empowering elements of Maori cultural heritage. The practice provides spaciousness that aims to counteract the negative effects of colonisation and proactively provide the potential to expand, transform and heal.

The programme was led by an experienced Maori service development manager and a Maori therapist, the lead practitioner, with a programme advisory team and support from the PHO management and board. The therapeutic team comprised the full-time lead practitioner, a part-time Pacific social worker and a number of therapists or counsellors who were contracted part-time to the programme. The selection of therapists, most of whom were Pakeha women, was based on both cultural competence and appropriate professional scope of practice. Cultural supervision was provided by the lead practitioner. The social worker assisted service users with a range of practical problems, including liaison and advocacy around access to benefits and services, assistance with budgeting and food, and transport to therapy and other services. The team liaised closely with PHO clinical staff, providing programme information and training, including cultural competency, where necessary. Some data not required by the contract but considered necessary to monitor for meaningful and positive outcomes (such as attendance rates, onward pathways and a satisfaction survey) were collected.

Assessment

Evaluation method

The Eastern Institute of Technology Hawke's Bay was commissioned by the PHO to undertake an evaluation of the WTP in early 2008. The evaluation objectives were to describe the service-user population and their use of the service, report on effects of the therapeutic treatment in terms of changes to K10 scores, and assist programme improvement by identifying implementation process issues. As no service users were interviewed personally, the Central Regional Ethics Committee confirmed that the evaluation did not need ethics approval or expedited review.[10]

The evaluation covered the first 15 months of the programme: 1 April 2008 to 30 June 2009. A mixed methods approach was used to provide a picture of formative issues and programme processes and outcomes.[11] Qualitative data were obtained from in-depth interviews or focus groups with key informants, the formative evaluator's notes on team meetings, and document review. Open-ended interview questions focused on participants' views of programme progress, what they considered key programme strengths and difficulties, and what recommendations they had for improvement. In the early phase, 13 key people were interviewed as part of the formative evaluation. Face-to-face key informant interviews or small focus groups were then undertaken midway (n=15) and at the end of the first 15 months (n=21), with many people interviewed on both occasions. Those interviewed at least once included therapists (6), social worker (1), community worker (1), general practitioners (GPs) (10), nurse (1); admin/management staff (6). The 10 GPs interviewed had made 72% of all GP referrals to the programme. Quantitative data were obtained from the programme database. This comprised service user demographics, patterns of service use and K10 pre- and post-treatment scores. In addition, service-user satisfaction surveys, which comprised both quantitative and qualitative components, were analysed. For this paper, some descriptive quantitative data for the programme's second MoH contract (July 2009 to June 2010) have also been included and compared to the previous period.

Table 1. WTP quantitative outcomes

Referrals	2008–2009 % (n)	2009–2010 % (n)
Maori	65% (138)	71.5% (236)
European	23% (49)	25.8% (85)
Pacific	3% (6)	1.5% (5)
Other	9% (19)	1.2% (4)
Females	75%	74%
Males	24%	26%
No. of packages of care	257	330
No. of therapeutic sessions	1228	1860
Average sessions per package of care	4.8	5.6
No. of social worker interventions	204	262
Attendance rates	86.4%	84.5%
Did not attend (DNA) rates	10.2%	5.3%
Late cancellation	3.4%	10.2%
Kessler 10 score—reduced	87%	83%
Kessler 10 score—increased	5%	8%
Kessler 10 score—no change	8%	9%

Outcome evaluation results

Quantitative data

The quantitative data (Table 1) indicated that the programme successfully reached most of its target population, with particularly high engagement of Maori women, high appointment attendance rates and improvement in average exit K10 scores, the latter being slightly higher than the 80% average shown in the national evaluation.[3] The low non-attendance (DNA) rates recorded are considered very good for therapy in the primary health setting,[12,13] and are likely to be particularly so for this demographic group. All the above measures were demonstrated to improve over the two-year period. The engagement of Pacific peoples and men, however, was low and remained so despite efforts at improvement.

Entry K10 scores tended to be considerably higher than the admission criteria. In the first 15-month period, the average score was 33.4, with 73% of users having a score of 30 or more. Although exit K10 scores averaged 25.3, a highly significant (p<0.001) improvement, this was still in the mid-range of scores denoting a mild/moderate depression or anxiety.

In the first 15-month period, the majority (79%) of service users were diagnosed with some form of depression (depression, moderate depression, reactive depression, postnatal depression). Other diagnoses included anxiety, post-traumatic stress disorder, stress, grieving and relationship problems. Anecdotal reports of high levels of distress and comorbidities were confirmed by the K10 scores, stakeholder interview data and the programme database, with 71% of service users having physical and/or mental comorbidities recorded. Those who required more than the standard package of care were either referred back into the programme (4%) or on to other services (20%).

Service user feedback

Service users completed a short satisfaction survey approximately six weeks after exiting the programme. Results must be viewed knowing that this was undertaken over the phone by a therapist and thus responses may be more positive than if collected by an independent person. Within the first 15-month period, 113 of the 170 people who had exited the programme at least six weeks before had provided feedback via the survey. Table 2 details responses to the closed response questions. Some did not answer all questions and percentages are of those who responded. They show that a significant majority of those providing feedback responded positively to all questions.

Table 2. WTP satisfaction survey responses six weeks post-exit

	Yes n (%)	No n (%)
As a result of the counselling/therapy programme do you generally feel:		
More content and happier in yourself?	88 (84%)	17
Healthier from a spiritual point of view?	73 (73%)	27
Stronger in yourself as a Maori or other cultural group you identify with?	67 (72%)	26
As a result of the counselling/therapy programme are you:		
More able to set goals for yourself?	86 (81%)	20
More able to think and feel positive?	82 (77%)	24
More able to manage unwelcome thoughts and feelings?	72 (67%)	35
More committed to having good physical health?	73 (72%)	28
More able to communicate with your whanau?	95 (88%)	13
More confident in your relationships with other people?	87 (81%)	20
Were you happy with our service?	105 (98%)	2

Responses to the small number of open-ended questions gauging satisfaction with the service were very positive, with strong appreciation expressed for the kindness and support of the therapists and social worker, the availability of Maori therapists, the fact the service was no cost, the flexibility around venue and the ability to involve whanau members.

Stakeholder feedback

Stakeholder interviews showed strong confidence in the WTP team and good relationships between the team and primary care practices. General practitioners felt many of their patients did not seek help unless their situation was serious and, whilst previously they might have avoided probing a problem in the 15-minute consultation, they reported an increased willingness to pursue a patient's depression or anxiety because of their confidence in the programme now available to them. Some changes in GP prescribing practices occurred, with several reporting they used medication less frequently or delayed use to see if therapy was useful. General practitioners also reported seeing important and significant changes in many of their referred patients, such as visible reductions in anxiety and distress and, in some cases, major lifestyle changes.

Both GPs and therapists expressed ambivalence about the cultural and social appropriateness of the K10 assessment tool for this high-needs Maori community, but it was considered useful to the extent that entry and exit scores could be compared. Participating GPs, who were very experienced in this community, reported, however, that they preferred their own clinical judgment to the K10 score when assessing the appropriateness of the referral. Therapists trusted their judgment and liaised closely with them. The WTP commitment to accepting those with K10 scores higher than the referral criteria meant there was no temptation for GPs to adjust scores downward in order for the person to be admitted to the programme, as anecdotal comments suggest may have occurred elsewhere.

Strategies for quality improvement/change

This section describes quality improvement strategies adopted by the team to address issues identified through formative evaluation feedback and internal review. To effectively meet the complex needs of many referred, more than the standard package of care was often required. This was achieved through referral back into the programme for another package of care or transitioning on to other therapeutic or social support services. The latter required the programme manager to seek alternative funding options and liaise with a range of agencies (e.g. Work and Income NZ, Ministry of Social Development and Accident Compensation Corporation). The team found the requirement of GP referral to the programme limited entry for those who did not use GP services, so direct access through whanau or self-referral was initiated in the second year.

Rangatahi/youth under 18 years were initially not eligible for admission to the programme, but the holistic therapeutic model placed importance on the integrity of the whanau so strategies such as including rangatahi in whanau sessions and liaising with existing youth services were explored as necessary. In the second year, those aged 12 years and over became eligible for referral to the programme and were seen by either the programme's therapeutic team or the team of a contracted dedicated youth service.

Key informants considered reasons for relatively low Pacific referral rates were complex, but included Pacific community sensitivity around confidentiality, unfamiliarity with seeking help from outsiders, low usage of GP services through which referral occurred, GPs not recognising need because of cultural or language barriers, and the lack of a Pacific therapist. To optimise effective engagement with those referred, the team involved the Pacific social worker in first sessions if appropriate.

Reasons for low male referral rates were seen to be a combination of men being reluctant to access therapy and the shortage of male therapists. A male therapist was later recruited and a men's group programme, Tane Toa, funded from an alternative source, was started in the second year.

The scarcity of available Maori, Pacific and male therapists was an ongoing issue. To increase the pool of male and Maori therapists for the programme, a mentoring system was developed with senior psychotherapy students from the regional Eastern Institute of Technology. Ensuring availability of Maori and male therapists remained a priority and, at the time of writing (September 2011), the therapeutic team comprises five therapists; three are Maori, one of whom is male.

Discussion

Programme data showed that the WTP successfully reached and maintained engagement with many of the historically underserved target population. In addition, it showed successful outcomes for many of those finishing the programme, with ongoing referral if necessary.

Key features which differed from many mainstream PMHIs included the use of tikanga Maori to build rapport, enhance feelings of safety and strengthen cultural identity; the emphasis on culturally competent personnel; the availability of a social worker; flexibility around venue and time; and the inclusion of family/whanau if wanted. Issues identified through the formative evaluation, for which quality improvement strategies were developed, were generally specific to high needs, underserved populations.

Many of the WTP's reported successes (improvements in K10 scores, stakeholder support and service-user gratitude) and difficulties (low recruitment of Pacific peoples and men and lack of available Maori, Pacific and male therapist workforce) were a feature of other PMHIs around the country.[3] However, high Maori engagement, low non-attendance rates and high percentage improvements in K10 exit scores for this population are distinctive WTP features.

Two possible explanations might account for the high entry K10 scores and, although significantly reduced, relatively high exit scores. Firstly, that those referred were the more distressed of a population in which high levels of distress and anxiety are perhaps the norm. Secondly, as key informants in both this and the national PMHI evaluation[6] have suggested, that the assessment tool might not be as meaningful or culturally appropriate for this population. Despite ambivalence about the tool, both GPs and therapists were happy with the referral process and service users who required more or ongoing therapy or support were assisted on to other services. An evaluation recommendation, however, was that the K10 entry criteria be reassessed.

Perhaps more relevant markers of success for this population were the low DNA rates, GPs' confidence in the programme and reported observed improvements in their patients. Of note was GPs' greater willingness to pursue mental health issues in this high needs population and reported changes in their prescribing practices.

Lessons and messages

A key message to take from the WTP programme is that a holistic, tikanga Maori–based programme delivered with considerable flexibility and skilled, culturally fluent programme management and therapeutic teams who work closely with primary care providers can successfully engage and benefit underserved communities with complex social and mental health needs. The complexity of need and high prevalence of comorbidities amongst Maori service users are consistent with national data[14] and, given Maori have higher unmet need for general practitioner services than the general population,[15] alternative referral pathways to

PMHIs and a dedicated specialist team, such as the WTP, appear necessary to ensure services to this population.

The PMHIs have clearly increased services to, and shown benefits for, the general population, including Maori, and new developments, such as screening tools[16,17] and brief interventions in the primary health care setting,[18] continue to be assessed. While the general view is that Maori probably benefit best from having both Kaupapa Maori and mainstream PMHI models available,[3] the challenge is to ensure that new developments do not disproportionately benefit some groups over others and increase mental health disparities. A recent NZMA position statement, supported by mounting research evidence, has prioritised a focus on reducing health disparities in New Zealand.[19] This signals to PMHI funders and providers the importance of ensuring that new and existing services are at least as effective for Maori and others in underserved communities as the general population and that successfully targeted programmes, like the WTP, which are developed around the specific needs in these communities, are sufficiently resourced.

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COMPETING INTERESTS
Donny Riki is the WTP lead practitioner and Tania Luscombe is the WTP project manager.

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