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Seeking Solutions to Being Restricted

A Māori-Centred Grounded Theory of
Māori, Mental Illness and Health Services

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ABSTRACT

The status of Māori mental health in New Zealand has increasingly deteriorated, despite radical changes to mental health service delivery and modern improvements in treatment. The question posed in this doctoral research is: ***What is occurring amongst Māori with mental illness and mental health services?***

The research applied qualitative methods. Glaserian grounded theory, informed by a Māori centred approach, was utilised and further supported by the concepts of mana Māori (control), whakapiki tangata (enablement), whakatuia (integration), and Māori ethical principles. Thirty Māori participants between the ages of 20 and 65 years were interviewed; 24 were interviewed individually and the remaining participated in a focus group of six Māori women. Participants identified as Māori with lived experience of mental illness and mental health services. The cohort also included whānau members and Māori practitioners who were interviewed during the process of theoretical sampling. Thirty interviews were audio recorded and field notes were taken. A systematic process of data collection and data analyses occurred using a range of methods as part of the Glaserian grounded theory method. This included coding, memoing, the constant comparison of data and theoretical sampling, all of which helped to reach the saturation of data. The goal was to discover what the main problem was for Māori participating, and how they resolved it. The outcome from this research was the development of a middle range substantive theory titled *Seeking Solutions to Being Restricted*.

The core category, *Being Restricted*, is recognised as the main problem Māori, in this study, grappled with in regard to their mental health and wellbeing. This includes subcategories with a number of properties: *the turning point, being apprehended, physical compromise for mental stability and addressing wairua*. The basic social psychological process, *Seeking Solutions*, was influenced by Māori aspirations for hope and change. This process explains various behaviours where Māori are fighting for their goals and desires to be met or they are having to adapt to a mental health system in order to acquire their

goals. Together, the core category and the basic social psychological process represent the theoretical proposition that Māori with experience of mental illness and mental health services are *Seeking Solutions to Being Restricted*. From the findings of this study, recommendations are provided to address Māori being restricted. The implication of this study is that if mental health professionals and mental health services continue to contribute to an oppressive approach to Māori, there will be an increasing disadvantage to the mental health of Māori.

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GLOSSARY

Ahu	Tend or foster
Aroha	Compassion
Atawhai	Show kindness to
Awhi	Embrace
Hapū	Subtribe
Hinengāro	Emotional and mental state
Iwi	Māori tribe
Kaikarakia	Minister
Kaimahi	Worker
Kaitiaki	Guardian
Kaiuru	Participants
Kaumātua	Elder Māori male
Kaupapa	Method, purpose
Kuia	Elder Māori female
Mākutu	Curse
Mana	Pride, identity
Manaaki	Hospitality, care
Māori	Indigenous people of New Zealand
Marae	Māori meeting house
Mataurangā Māori	Māori knowledge
Pākehā	European people
Porangi	Lightness and darkness of day and night
Rongoa	Māori medicine
Tamariki	Children
Tangata	Person, people
Tangata Whaiora	People seeking wellness
Tangata Whenua	Traditional people of the land
Tapu	Sacred
Taurima	Treat with care
Tautoko	Support
Te Reo	Māori language
Tikangā	Māori customary practice
Tinana	Body, physical

Tino Rangātiratangā	Self determination
Tohungā	Māori healer
Tupuna	Ancestor
Turangāwaewae	Place of belonging
Wairangi	Turbulence spirituality
Wairua	Spirit, spirituality
Whakapapa	Genealogy
Whakapiki	Enhance, empower
Whakatuia	Integrate, interconnect
Whakawaatea	Cleanse
Whānau	Kin, extended family relationships
Whāngai	Nourish, bring up
Whenua	Traditional land

CHAPTER ONE – INTRODUCING MY JOURNEY

I te mate te taongā ke mate te wairua. Ka mate te wairua ka mate te tinana.

When the treasure dies, the spirit dies, and when the spirit dies the body dies.

(Nuki Aldridge, Ngāpuhi, Huygens, Murphy, & Healy, 2012)

1.1. Background to the Thesis

Ngā mihi mahana kia koutou katoa, Ngā uri ahau o te Tai Tokerau, Ngāpuhi me Te Rarawa ngā Iwi, Maria Baker tāku ingoa.

When I started my career as a Māori mental health nurse in the 1990s I came to learn about a Māori whānau and the impact of mental health services upon them. I often heard of a verbal theory held by senior Māori mental health nurses in the Auckland and Northern regions of New Zealand that was informed by the loss of two men from a whānau named Watene. The theory grew over time and its principle purpose was to ensure professional vigilance with any relatives from the Watene whānau that might come through mental health services. I had little idea of the actual history to the theory but, as a Māori mental health nurse, I was mentored to ensure the importance of whakapapa links as paramount in any assessment process with Māori amongst tangata whaiora coming through mental health services. Such vigilance included the need to comprehend any links with the Watene whānau, because of their negative experiences with medication (e.g. Haloperidol: antipsychotic medication) and mental health services. It would be much later in my career that I learnt of Michael and Manihera Watene and how they had been mistreated whilst in care of psychiatric hospitals in the 1980s. Michael Watene died in Oakley Hospital following a high dose of medication given over a short period of time, and Manihera Watene died following an aggressive restraint procedure by staff (Department of Health, 1983; Department of Health, 1991).

The story of these two Māori men exposed the visibility of what would later be termed as continual poor practice of Māori in mental health care. The stories behind the experiences of these two men were evidence of psychiatric institutional attitudes toward Māori males who were labelled as scary, violent and unapproachable.

I am unsure if the Watene whānau received an apology from the Director of Mental Health for the deaths of Michael and Manihera. However, following these cases, the Department of Health called for an independent review of services and recommended a radical change to how mental health services should be delivered to Māori people. The losses of the Watene whānau proved to be a catalyst of hope to improve Māori experiences of mental health services and their overall wellbeing (Mason, Bennett & Ryan, 1988).

Michael Watene was a 25-year old Māori man who had appeared in Whangarei Court for offensive behaviour and imprisoned at Mt Eden Prison for seven days. Whilst in his cell he was noted to have been behaving unusually because he was barricading himself in the cell for fear that people were after him. Michael was assessed by the mental health service, where he was noted to be sullen and withdrawn, and so he was committed to a psychiatric hospital for assessment and treatment. Upon admission, he was quickly secluded and remained secluded throughout his eight-day stay. He was seen by the doctor who considered Michael to be suspicious, tense and uncommunicative with staff. Further reports from staff were that he was dangerous and unpredictable. No physical examination was conducted due to concerns that he was too aggressive. The doctor gave him unmodified Electroconvulsive Treatment (ECT) on a mattress on the floor, because of the supposed difficulties in giving Michael any anaesthetic or muscle relaxant (Department of Health, 1983). Over the following days Michael was given more ECT (both unmodified and modified) and increasing doses of medication. Following his fifth ECT session, and with little supervision by staff, he died in his room.

The postmortem findings confirmed Michael died of cardiac arrhythmia due to ECT or, more likely, due to the high dose (660mg) of Haloperidol given in the

four-day period (Department of Health, 1983). At the time, the then treatment regime of Haloperidol would be given in doses of 6-10mg per day due to its potency. Yet, it was accepted to administer Haloperidol in regular intervals as part of a rapid tranquilisation process. The initial level of Haloperidol was 10-20 mg four times a day and in the last three days of Michael's life, Haloperidol was increased to 20mg two hourly.

The official inquiry initiated into Oakley Hospital following Michael's death identified a range of concerns regarding the care he was provided, which included:

- the blanket prescription of medication and discretion of its administration left to nursing staff;
- the brief and inadequate clinical assessments and examinations that were conducted which provided little basis for the treatment that was given;
- no information was gathered from whānau or from people outside of the institution who knew Michael; and
- there was no attempt to communicate with Michael, and no explanations were given to him about why he was in hospital (Department of Health, 1983).

In addition to the placement of Michael in seclusion over the eight-day period, there was a lack of medical oversight and a failure to regularly review the medication regime and adjust the dosage. Of particular concern was the use of paraldehyde in what looked like a form of coercion following ECT, and the high doses of Haloperidol (over 100mg daily) from which emerging evidence, at that time, had been shown to be associated with sudden deaths of clients elsewhere that was unknown to the medical team (Department of Health, 1983).

Manihera Watene was 23 years old when diagnosed with schizophrenia following his first admission to a psychiatric hospital. For the following decade, he rotated between psychiatric hospitals – for inpatient and outpatient treatment – and prison for varying offences. In 1989, it was alleged Manihera

possessed a weapon, assaulted a police officer, resisted arrest, acted disorderly, and trespassed on property; all symptoms associated with Manihera's poor control of his mental illness and his use of substances.

As a result of the court case in July 1989, an order was made under Section 118 Criminal Justice Act (1985) to send Manihera to psychiatric hospital for treatment. During the treatment period, a doctor decided that Manihera could receive treatment at home; but when the community outreach team visited his home he was not there as agreed which provoked a cause for concern by the hospital. Manihera was returned to the ward four days after being absent without leave and was recommenced on treatment.

Although nursing staff reported Manihera as settled over the following five-day period, he had approached staff seeking extra medication but was declined. Manihera's experience in care continued to be difficult. In an incident prompted by a client screaming on the ward, Manihera became agitated and assaulted a staff member, following which he was forcibly restrained, taken into the seclusion room and injected with Droperidol (antipsychotic medication).

It was the force of being wrestled to the ground and held down by staff that contributed to Manihera's death. Similar to Michael Watene, an official inquiry conducted into Manihera's death revealed a number of issues regarding the care provided, such as:

- the lack of focus on Manihera's needs;
- nobody had really determined if he was a risk to others; and
- there had been little information obtained through his whānau or others to inform a comprehensive treatment plan.

Manihera had asked for extra medication prior to the incident and was refused; yet he was known to have taken medication regularly as an outpatient in the past. Further, there were no defined methods of restraint and the actions that killed Manihera were heavy-handed and uncontrolled, and with it a delay in providing lifesaving treatment by the staff.

An observation made of Manihera was that he had responded well to Māori staff. The committee of inquiry noted that the four staff members involved in his restraint were non-Māori, which prompted reflections about whether a different outcome could have been reached if the staff were Māori. This is important, as the cause of Manihera's death was most likely the restraint procedure conducted by the staff (Department of Health, 1991).

*Haere korua ngā tungāne, Haere ki te ripo, Haere ki te whare ariki, ki te ao
taungāhuru, Ki te ao turoa, haere korua, haere korua, haere korua.*

*Farewell to Michael and Mansell, Go to the house of your ancestor, away from this
challenging world, farewell to you both, rest, farewell, farewell.*

The Watene cases have remained in my mind since the 1990s. This is because of the presence of the underlying assumptions that remain in the mental health system regarding Māori, that often inform the inadequate engagement and care carried out within mental health services.

Michael Watene and Manihera Watene did not have involvement of whānau in their care. Instead, staff were scared of both of these young men based on their physical presentations, and when they arrived at the hospital they were subsequently labelled dangerous and violent. There was an assumption made that being Māori, male, mad and violent, attributed to their demise. Unfortunately, the health professionals did not consider whether the Watene's may have been frightened or confused. In Michael's situation, instead of exploring ways to engage with him he was isolated. In regard to Manihera, there was previous evidence that he responded well to Māori staff, but it is unknown if any Māori staff member engaged with him. It was apparent that staff were prepared to fight with both Māori men and use force upon them as a system of control. When Michael and Manihera resisted the unexplained actions of staff their response provoked and reinforced the impression that these actions only proved how dangerous they were.

1.2 Current Situation

Serious mental illnesses such as bipolar disorder, schizophrenia, depression, anxiety, substance use disorders and stress related disorders are disproportionately high amongst Māori (Ministry of Health, 2016); alongside concerning rates of self-harm and suicide (Ministry of Health, 2016). The reasons for the state of Māori mental health are complex. Even though mental health service delivery transformed in the 1980s, with the introduction of Māori models of practice and Kaupapa Māori mental health services, the hospitalisation rates and general disparities amongst Māori have worsened (Baxter, 2008; Ministry of Health, 2016).

Data, based on mental health service use, informs there has been an increase in the use of mental health services by Māori. But such data gathered by health services is not an accurate measure of mental health need within a population. Especially, given the challenges and limitations with obtaining meaningful information pertaining to Māori. The admission to acute mental health units and community based mental health services is only one part of a wider spectrum of mental health care, and the provision of interventions to help those who are mentally unwell. Due to the limitation of research that explains the differences between mental health conditions, the Māori mental health and addiction need remains speculative.

It has been decades since the Watene cases, and there is still much more that needs to occur to improve the way mental health services respond to Māori to improve Māori mental health outcomes. In completing this doctoral study, it is an aspiration that the findings will help further tell the experiences of Māori with experience of mental illness and mental health services and what is occurring for them.

The purpose of this study was to discover what was occurring among Māori with mental illness and mental health services, and to identify beneficial solutions. A Māori centred grounded theory research design was developed, with ethical approval (NTX/12/02/006, Appendix A) for the study gained in Te Tai Tokerau (Northland). Thirty Māori (aged 20 to 65 years of age) with

experience of mental illness and mental health services contributed to this study.

1.3 Thesis Chapters

The layout of this thesis follows a format typical of a Glaserian Grounded Theory Study, and commences at **Chapter One**, which has introduced the Watene case and the background of the thesis journey. **Chapter Two** provides a review of Māori mental health literature which supports the justification for this research. **Chapter Three** discusses the research design, methodology and methods used in the study. It commences with a perspective on why research with Māori is important. This is followed by a discussion on the Māori centred research design and the grounded theory method used to understand the sociological world in this field. **Chapter Four** demonstrates the application of the research design. It includes the aim of the study, the research question, the consultation process, the setting and support received, as well as the recruitment process. It then engages the reader in the grounded theory style by revealing how the raw data and its analyses occurred supported by examples of coding and memos. **Chapter Five** presents the findings section of the study explaining the substantive Māori centred grounded theory developed. This includes the explanation of *being restricted* through its subcategories of turning point, being apprehended, physical compromise for mental stability, addressing wairua and the basic social psychological process of seeking solutions. **Chapter Six** extends upon chapter five with a discussion that builds on the fore mentioned subcategories, and the basic social psychological process with recommendations. **Chapter Seven** provides a final perspective to the thesis and brings it to a close whilst acknowledging the limitations of the study. The thesis then ends with a representation of key recommendations placed into five tables, for the purpose of contributing toward the change needed for the mental wellbeing of Māori, and the improvement of mental health care to Māori.

1.4 Concluding Comments

The Watene case had left unanswered questions for me as a Māori mental health nurse. Over two decades later, the questions for me continue to be:

- Why are increasing numbers of Māori treated as aggressive individuals?
- Why do high numbers of Māori become restricted by the high use of the Compulsory Assessment and Treatment legislation?
- Why do Māori receive high doses of medications, and high levels of seclusion and restraint in mental health services?

This research journey has enabled me to explore elements of these questions and prompted reflections of racial bias embedded in mental health services. It has allowed me to reflect upon whether Māori are unnecessarily being oppressed and to consider if the government response to the health needs of Māori is indeed by an application of action that intends to take their power away. The next stage of this thesis builds the concerns of Māori through a review of the available literature, highlighting the extent to which mental illness is impacting Māori.

CHAPTER TWO - LITERATURE REVIEW

2.1 Introduction

Māori have poorer mental health than other people in New Zealand; including having higher rates of mental illness and mental distress than non-Māori (Gluckman, 2017). In this chapter, I summarise the mental health status of Māori according to the information available from small sample studies, and national statistics from mental health services. The mental health of Māori people in New Zealand overall has not been an area of inquiry that has been studied systemically. As a result, the literature that was available and utilised in this review is captured from the information generated through evidence of small sample studies and mental health service use; rather than a broad national database or information about the conditions of Māori and their mental health. *Te Rau Hinengaro* was the first national survey of mental illness in the New Zealand yet since then, studies have not provided a comprehensive picture of Māori mental health. Information generally on indigenous mental health is also scarce (Valeggia & Snodgrass, 2015).

This chapter presents a literature review drawing on the most recent information available. National and international literature, and grey materials such as government and non-government documentation, reports and texts were reviewed. Databases searched included Google Scholar, CINAHL, MEDLINE and Web of Science; with search terms such as Māori, mental illness, mental health, health and wellbeing, psychiatry, mental health services, health services, indigenous health and mental health. The inclusion criteria focused on Māori and indigenous experiences initially within the five to ten year timeframe. However, the literature search highlighted a brevity of research based information within this timeframe. Due to this limitation it has been necessary, in some parts of this chapter, to draw on older information. Whilst it is acknowledged some of the presenting information has its inherent limitations, it does help in regard to understand the presenting issues experienced amongst Māori, and of the range of mental health issues and the responses by mental health services.

2.2 Brief History of the Mental Health of Māori

The mental health of Māori was once better than non-Māori in New Zealand. Early Pākehā explorers to New Zealand had recorded that it was rare to see mental illness amongst Māori. They went further to state that if there were recognisable differences amongst Māori, it had little implications for Iwi as the person would be well cared for by Māori rather than be differentiated as being anything other than part of their community (Tregear, 1904; Morrell, 1958).

Historically, Māori held spiritual beliefs about a person's mental and emotional wellbeing. If it was considered there was the presence of imbalance in their emotional or mental wellbeing, it was thought the person was pōrangī or wairangī. An explanation by Kaumātua Hone Kaa describes these terms as 'a state of being that was in turbulence.' Kaa stated that Māori sought from tohunga (cultural healers) a spiritual resolve to remedy any mental or emotional health problems.

Pōrangī means the lightness and darkness as day and night, it is the degree to which one is in the darkness or the light, which is determined by those around you. The term wairangī is to do with water, it is a turbulence about that, turbulence about the wairua or the mauri, it's not just utilised for the head, it can be used for the total person. In any situation Māori sought the advice of the tohunga and talked to him about these. In many cases the tohunga would already know about the person being in that state prior to being brought to them. The tohunga would work out the best incantations he required in order to put to a sense of normality. (Hone Kaa in Television New Zealand, 1984)

The first mental health legislation supported the establishment of asylums in New Zealand. These were implemented by the then colonial government post-1840 (Treaty of Waitangi). Mental health policy, public administrative systems and legislation were established by representatives from civil control and order (e.g. police, court) partnered with medical officers to provide mental health care in New Zealand for all New Zealanders (Brunton, 2001). This shaped a mental health system that was ruled by the values of the settlers (Brunton, 2001) and

in turn socialised the association between insanity with law and order, and reinforced Crown responsibility for the mentally unwell.

As Māori people increased their contact with Pākehā, the number of Māori people in asylums and mental hospitals slowly increased. Although small in numbers, Māori presented to the early mental health services with the stresses associated with conflicts they had experienced with Pākehā over the alienation of their lands and connected to their holding onto their spiritual beliefs that were tapu (Barry & Coleborne, 2011). The committal of Māori to mental hospitals became more frequent in the 20th century as the colonial rule of Pākehā increased (Labrum, 1992).

As asylums increased in operation, public opinion of insanity and mental health care of people were openly judged and played out in newspapers (Labrum, 2012). Emotive reports about suffering insane people were used to arouse public opinion, by the same token foster public sympathy and publicise political agenda (Brunton, 2001). Newspaper excerpts concerning Māori were often captured under titles that in modern terms would be viewed as discriminatory, what they did, was deliberately prompt public opinion to categorise Māori as insane. Some titles included; “Reprehensible dealings with a Māori Lunatic” (Puckey, 1880), “The Mad Māori” (Colonist, 1899), “The Mad Māori fights for Liberty” (Auckland Star, 1924). These terms were part of everyday language then, where it was common for Māori to be written into constructs with underlying perspectives that if Māori were acting a certain way, they indeed were mentally unwell, with police apprehension and asylum admission as parallel processes. The following excerpt is a further example;

The wild behaviour of a stalwart Māori who had gone demented caused consideration consternation on Para Bay Road on Saturday. So much so that the alarmed inhabitants telephoned for police assistance. Constable power was dispatched but when the maniac caught sight of the man in blue he made a wild rush for the river. Then ensued a severe struggle and it took three men to put the handcuffs on the Māori. The latter was brought into Whangarei and after examination by two doctors

was committed to the mental hospital where he left by today's train in a straight jacket and under police escort" (Auckland Star, 1924).

The tendency to model behaviour on non Māori patterns of abnormal behaviour (Beaglehole, 1939) was the system to ensure a monopoly over a person's function and behaviour during this era, which not only determined good from bad, in this case it determined sane from the insane.

Public hospitals were accessible to Māori, unlike parts of America where Black Americans were segregated or refused entry (Grob, 1973). The first point of contact prior to the admission of Māori to mental hospitals was often with Police (Barry & Coleborne, 2011). A feature embedded by the Crown that has endured its presence into the 21st Century admission trends of Māori entering modern inpatient mental health units.

During 1920's to 1930's the incidence of Māori mental illness was considered low in comparison to non Māori. The number of Māori first admissions to mental hospitals during 1925 – 1935 was 230 (131 males and 99 females). Manic depression seemed high in Māori females and schizophrenia high amongst Māori males, although its incidence was comparable with non Māori (Beaglehole, 1939). It was projected that as Māori lived rurally their access to psychiatric services was irregular (Sachdev, 1990). Although, earlier records from the Auckland Asylum showed Māori were taken to the asylum from rural areas outside of the area. Most likely due to the increased contact they had with Pākehā and the introduction to their non Māori perspectives about illness and treatment (Barry & Coleborne, 2011).

A spike between 1930-1933 recorded Māori psychiatric hospital admissions, assumingly due to the Great Depression, a time of social and economic poverty and hardship (Foster, 1962). Although, there were suggestions Māori were becoming psychologically confused because of the continual imposition of non Māori standards that had caused Māori to be "living unhappily on the margin of two races and two cultures" (Sutherland, 1938).

Māori fought in the Great War (WWI, 1914-1918) and the Second World War (WWII 1939-1945), and both campaigns had a great loss of life, with many

returned soldiers never fully recovering from their ordeals (Ministry of Culture & Heritage, 2014). On the return of Māori soldiers to New Zealand, the Crown made efforts to obtain what they considered was surplus Māori land for the purpose of settling non Māori returned soldiers as a priority (Hearn, 2006). In the end, the most prosperous and attractive lands were obtained by Pākehā with Māori forced into marginal lands and needing to move to urban towns for employment (Hearn, 2006). Psychiatric hospitalisation of Māori post WWII did increase slightly, but the impact upon the mental health of returned Māori soldiers wasn't understood, until generations after (Awatere, 1984). It has only been in recent times, there is a recognition of Māori who participated in these campaigns, had experienced an increased vulnerability to stress post battle (MacDonald, C., Chamberlain, K., & Lon, N, 1997; Papuni, 2004; Soutar, 2009).

Māori admission rates to psychiatric hospitals were low in comparison to non Māori until the mid-1960s. By 1970, non-Māori admission rates to psychiatric hospitals declined and Māori rates increased. The rate was high for Māori males in the 20-29 year age group, with a slight increase in admissions seen in the over 60 years of age group. First admission rates to psychiatric hospitals (referred to as 'first admissions') for Māori surpassed non-Māori rates for all age groups by 1974. Since this time, high rates of mental illness have existed and the disparities for mental health between Māori and non-Māori have continued to widen (Durie, 2001).

Between 1984 and 1993 the rates for first admissions of Māori men and women remained steady. Drug and alcohol use were given as reasons for some (32%) of these first admissions. Readmission rates to hospital were a specific concern showing that continued treatment in the community was ineffective, evidenced by the increased readmission rates for Māori men (64%) and Māori women (28%). By 1993, Māori admission rates were two to three times more than non-Māori. Serious mental illnesses such as schizophrenia, affective disorders and other psychotic disorders made up 40% of Māori admissions and 78% of readmissions. In 1994, Māori admissions made up almost 14% of first admissions and 18% of readmissions to hospital. Alcohol

dependence was a leading cause for first admissions, whilst schizophrenia and psychoses were common diagnoses of Māori being readmitted to hospital (Te Puni Kokiri, 1996).

By the late 1990s, Māori mental illness was declared as the number one Māori health issue (Durie, 1997). This status had been predicted in an earlier committee of inquiry report that investigated the impact of mental health services upon Māori (Mason et al., 1988). In the Mason Report, the prediction was there would be a disproportionate representation of Māori people in psychiatric hospitals, especially if the services continued to provide culturally inappropriate services. In the period from 2000 onward, the rates of Māori hospitalised for substance disorders, schizophrenia, psychoses and bipolar disorders increased (Baxter, 2007), mostly in the 25-44 year age group followed by 16-24 year age group, especially so amongst Māori men (Baxter, 2008).

Māori men were significantly more likely to receive schizophrenia as a diagnosis than most other mental illnesses (Kake, Arnold & Ellis, 2008; Te Puni Kokiri, 1996) than non-Māori. Racial bias had an impact on this increasing statistic and is a matter that requires further research. An increase of Māori comorbidities (coexisting substance use and medical health problems) also reached a critical point in the late 1990s, requiring all health services to review how they could improve on their response more broadly to the increasing Māori health and social need (Durie, 2001).

The first epidemiological study to understand the prevalence of mental health problems in New Zealand, including Māori, was *Te Rau Hinengaro* (New Zealand Mental Health Survey) (Baxter et al., 2006). *Te Rau Hinengaro* involved surveying 12,992 people using face to face interviews and included 2,595 Māori people. It provided evidence of 12-month prevalence rates for Māori and reported that Māori had a 19.3% prevalence for anxiety, 11.4% prevalence for mood disorders, and a prevalence of 9.1% for substance use disorders. Māori also had a lifetime prevalence of 31.3% for anxiety, 26.5% for substance use, and 24.3% for mood disorders (Baxter et al., 2006).

Baxter (2007) also reported depression being most common among Māori in the 12-month period prior to *Te Rau Hinengaro* (6.9%), and in lifetime prevalence (15.7%). Bipolar disorder was reported to be present in 4.6% of Māori in the previous 12-month period and 8.3% in lifetime prevalence. The age of onset for a mood disorder was predicted to be 25 years for bipolar disorder and 34 years for depression (Baxter et al., 2006). Moreover, Māori experienced a marked impairment in social and occupational functioning in respect to both of these mood disorders (Baxter, 2008).

The pattern of co-morbidity of substance use disorders among Māori was found to be high. One in three (31.2%) who had a primary alcohol disorder also suffered a drug abuse issue, and over half (58.3%) who had a primary drug use disorder had a co-existing problem with alcohol (Wells, McGee, Baxter, & Agnew, 2006).

The increasing substance use among Māori continued to be identified as a major health and social issue with one in 11 Māori reported to have experienced an alcohol disorder in a 12-month period, while one in 25 a drug disorder. One in four Māori experienced an alcohol issue, while one in seven experienced a drug disorder (mainly marijuana induced) during their lifetime (Todd, 2010).

Māori recognised both the impact of substance use and its effects on their personal health, and the wellbeing and sustainability of their whānau, including the influence on relationships within their whānau (Baxter, 2008). At the time of *Te Rau Hinengaro*, it was understood Māori also experienced a high level of unmet needs when accessing mental health services. Additionally, only half of Māori people with moderate to serious mental illness had contact with mental health services in comparison with two thirds of non-Māori (Oakley Browne, Wells, & Scott, 2006).

2.3 Suicide and Self Harm

Suicide (the act of deliberately taking one's own life) and suicidal behaviours (suicidal ideation, plan and attempts) with potentially life-threatening consequences can accompany many emotional challenges in life. Between the 1950s and the 1990s, the suicide rate amongst Māori was less than non-Māori. For Māori, there was half the risk of what non-Māori men were experiencing, and for Māori women one third the risk of non-Māori women (Skegg, 2005). In 2007 the reporting on suicide statistics began. The current Māori suicide rates are now recognised as the highest in New Zealand (Ministry of Health, 2016b). Māori male suicide deaths particularly are disproportionately represented, with the highest cohort 20-24 years of age followed by 40-44 years of age. Māori suicide rates are near twice as high as non-Māori. Disparities are great for both males and females. Māori females are more than twice as likely as non-Māori females to take their lives, and for Māori males, suicide was the third leading cause of death (Ministry of Health, 2016b).

The hospitalisation rates for intentional self-harm for women is twice as high as for men. Nevertheless, Māori males have about 1.5 times greater likelihood compared to non-Māori males to be hospitalised for intentional self-harm. Young people in the 15-24 years age group had the highest rate of hospitalisation for intentional self-harm. Māori males in the 15-24 years and 25-44 years age groups had significantly higher rates of hospitalisation for intentional self-harm than non-Māori males in the same age groups (Ministry of Health, 2016b).

2.3.1 Rangatahi Suicide

Māori youth suicides are the highest in the Organisation for Economic Co-operation and Development (OECD) (Ministry of Health, 2016). A Suicide Mortality Review Committee (2016) investigated data from completed suicides between 2007 and 2011. Rangatahi (Māori youth), aged 15-24 years, had the highest suicide rate in New Zealand, with 2.8 times the rate of non-Māori youth. In the socio-cultural analyses of Māori youth who died by suicide, half had lived in the most socially deprived areas of New Zealand. One in five had been

exposed to family violence as children or had experience of a violent relationship as young adults, and 14% had disclosed sexual abuse (Suicide Mortality Review Committee, 2016).

Globally, suicide is a problem amongst indigenous youth whose people have been colonised. American Indian, Alaska Native, Canadian First Nations, Aboriginal and Torres Strait Islander youth all have suicide rates higher than non-indigenous youth in their respective countries (Advisory Group on Suicide Prevention, 2003; Australian Indigenous HealthInfoNet, 2015). The effects and presence of oppression and deprivation as a result of colonisation is one argument that proposes it has negatively affected the mental health and wellbeing of indigenous young people (Valeggia & Snodgrass, 2015).

2.4 Annual Health Survey

The New Zealand Health Survey (Ministry of Health, 2015) provides regular national level information and a snapshot of health behaviours, health status and access to health care for both adults and children. In this survey, 'psychological distress' means high or very high levels of psychological distress according to the K10 screening scale (that is, a score of 12 or more) in the past four weeks. About seven percent of adults (13,781 total number of participants) in this survey experienced psychological distress in the four weeks before taking part in the survey, although the prevalence varied by sex, age, ethnic group and neighbourhood deprivation.

In the Māori sample (n=2,770), one in nine Māori adults (11%) had experienced psychological distress in the past four weeks. After adjusting for age and sex differences, Māori were 1.5 times likely to have experienced psychological distress than non-Māori adults. The prevalence of psychological distress was higher in the most socioeconomically deprived areas, and those living in the most deprived areas were 3.1 times more likely to have experienced psychological distress. Māori adults were about 1.5 times as likely as non-Māori adults to report a high probability of having an anxiety or depressive disorder. It was also higher for Māori males, who were twice as

likely as non-Māori males to report a high probability of having an anxiety or depressive disorder (Ministry of Health, 2015).

2.5 Determinants of Māori Mental Health

There are processes of social differentiation that affect Māori health and social outcomes in New Zealand's society, often reflected in socioeconomic circumstances. This is where Māori are less likely to have a formal educational qualification; less able to secure employment and therefore have less income in the household; are less able to access transport; and less able to own their homes in comparison to other New Zealanders (Statistics New Zealand, 2013). These inequities are an indication of the scale of socioeconomic differences present in New Zealand and show that problems associated with relative deprivation are more common with Māori (Howden, Chapman & Tobias, 2000).

Further reflected amongst people with mental illness generally, Māori disproportionately present with both mental illness and negative socio-economic factors (Edmonds et al., 2000; Baxter, 2008; Ministry of Health, 2011). Although it is unclear the exact nature of the propensity for Māori to develop mental illness and substance use disorders as a result of their socio-economic situation. From a social stress perspective, a person will physiologically respond to the external demands of one's environment (Selye, 2013). Whilst people perceive stress differently, it is the social nature of stress (stressors) that has the potential for engendering psychological stress in people. Stress creates demands of a person who may or may not be able to effectively cope, as do social and environmental factors influence stress and the way they respond to it (Selye, 2013). It is suggested socioeconomic conditions do influence stress inducing a range of determinants that may lead to additional problems and contribute to physical and mental illness or both (King, Smith & Gracey, 2009).

Studies in an urban community, with a high Māori population, made links with a significant rise in compulsory admission rates of Māori to an inpatient mental health unit with greater levels of deprivation and subsequent differential access

to health services (Abas et al., 2003; Wheeler et al., 2005). In a separate study (Blakely et al., 2003), deprivation was considered to be linked to self-harm and completed suicides, especially for 18-24 year old men. The explanations about the associations between mental illness and socio-economic deprivation being causal are unclear. But the patterns of socioeconomic deprivation in the evidence suggests a rise in stressors from marginalisation and poverty, from constrained social and environmental factors, and limited access to health services, which overall contribute to a vulnerability of Māori to mental illness. In another study, in a prison context, the socioeconomic factors were considered to contribute to the over representation of Māori and Pacific people in prison, and similarly with elevated rates of mental illness (Simpson et al., 2003).

There is little research that relates to the extent of material disadvantage to Māori mental health or if it could be viewed as a precipitating factor in the development of Māori mental illness. Although the connections between deprivation and mental illness is possible, further explanations are required to determine how (or if) there is a socioeconomic association with mental illness and suicide in Māori, given the high rates of these conditions (Ministry of Health, 2016).

In comparison, when deprivation factors are factored in non-Māori populations, disparity between Māori and non-Māori still exists (Robson & Purdie, 2007). Drawing on the negative correlation between socio economic conditions and mental illness poses a double-edged sword. One perspective is that there may be a social causation to mental illness where factors such as poverty and limited access to resources over time may lead to a greater vulnerability to mental illness (Read et al., 1999). Mental illness provokes a cycle of entrapment, as Māori become unfortunate victims as a consequence of their circumstances whereby they may become depressed or mentally stressed (Keelan, 1997). The converse perspective is that mental illness has the potential to marginalise people (Barnett & Barnes, 2010), and people become subjected to the worse access to conditions necessary for their health, such as suitable housing, adequate income, access to health services and

opportunities for developing positive social coping behaviours (Ministry of Health, 2008a).

Either way, systematic disparities exist for people with mental illness and people who experience high levels of social disadvantage (Howden-Chapman & Tobias, 2000). The multiple factors that contribute to the disparity between Māori and non-Māori show there is differential access to the determinants of health for Māori, including access to education, employment and income. There are also exposures that lead Māori to evidential differences in illness, such as tobacco use, poor living conditions and substance use, as well as the differential access to health services and the differences in the quality of care that Māori receive once in health services (Reid & Robson, 2007; Wilson & Barton, 2012). Māori are more likely to experience discrimination through institutional and interpersonal racism (Harris et al., 2012; Reid & Robson, 2007). It is the systemic structures and processes that sustain the socioeconomic position of Māori and, by association, leads to poor mental health, which in turn requires effective and sufficient resources to address Māori mental health needs (Abas et al., 2003).

Prevalence rates show Māori tend to exhibit a greater severity of symptoms such as suicidal ideation and self-harm (Ministry of Health, 2016), of mental illness and substance use than any other group (Baxter et al., 2006). While socio economic status contributes to Māori and non-Māori differences, where there is no difference between Māori and non-Māori socio economic circumstances, it is suggested that ethnicity may be a distinctive factor to illness and health (Durie, 2005).

Trauer et al. (2006) revealed Māori with less deprivation were still more likely to have higher levels of mental illness and lower levels of functioning than other Māori living in areas of greater deprivation. Reid et al. (2000) explained that ethnic disparities may occur from the groups' characteristics or, in this case, Māori themselves, as they may be predisposed to certain illnesses that might be influenced by customary beliefs or practices. A further explanation of ethnic disparities is the manner that others react and respond to Māori as not being

different from the majority (that is, they are the same as them), re-emphasising the exposure of Māori to racism and cultural bias. Together, these factors potentially influence Māori mental illness, mental health and wellbeing.

2.6 Māori and Mainstream Mental Health Services

The New Zealand Government has the responsibility for the delivery of mental health services. Health service contact by Māori and non-Māori has increased as the severity of mental health problems have increased. Mental health services are delivered mainly through district health boards (DHB) and non-government organisations (NGO). Between 2001 and 2015, the rate of Māori seen by DHB services increased by 59.8% in comparison to non-Māori (33%) (Ministry of Health, 2016a). Further, the proportion of Māori seen by NGO was higher (28%) than non-Māori (12.78%) and the number of Māori seen in a kaupapa Māori setting was even higher (Ministry of Health, 2016a).

It is often part of the promotion of health that the access to health services will be of benefit to Māori, so they can access the care that is needed and offered by health services. Yet, barriers to health care were identified in relation to personal issues, such as the inability of Māori to access primary health care, and being misunderstood by health professionals when seeking help (Baxter, 2008; Ministry of Health, 2008a). Concerns from Te Rau Hinengaro highlighted Māori with moderate to serious mental health and substance use disorders had less access to mental health specialist assistance than non-Māori suggesting an increase in risk for serious health conditions to develop and an inherent challenge in the current system of health care (Baxter et al., 2006).

2.6.1 Restricted Practices in Mainstream Mental Health Services

Restricted practices in DHB mental health services are viewed as being justifiable as part of a service that provides much needed mental health care to people even when actions occur against a person's will. Restricted practices involve involuntary admission to acute mental health units; the use of the Mental Health Act; restraint and seclusion (Kumar, Ng, Simpson, Fishcher & Robinson, 2008). From the 1970s to the 1990s the rate of compulsory inpatient care was highest amongst Māori (Te Puni Kokiri, 1996). Since the introduction of the current Compulsory Mental Health Assessment and Treatment Act (1992), the overall rate of restricted practice and care in New Zealand has increased, yet shifted to the community (Ministry of Health, 2014).

Māori are four times more likely to be subject to being treated under a community treatment order (Mental Health Act) than non-Māori (Ministry of Health, 2014, 2017a). Section 29 enables a compulsory community treatment order to be used as a legal tool that authorises and regulates the use of involuntary or compulsory mental health care outside of inpatient mental health units in the community setting (Light et al., 2014). New Zealand's use of compulsory treatment orders is high by international standards, and greater than other developed countries (for example, Australia, England, Scotland and Wales) (Gordon & O'Brien, 2014). Many oppose compulsory treatment and are appalled by an over emphasis of control, restraint and threat by the mental health system. The Ministry of Health completed a review of the Mental Health Act in relation to New Zealand Bill of Rights Act (1990) and obligations under international conventions. Following a national consultation process, respondents felt the Mental Health Act was inconsistent with the Bill of Rights Act (1990) in regard to the ability to override a person's right to refuse treatment, as well as being inconsistent with the Health and Disability Services Consumer Code of Rights right to informed consent. The vast majority of the 40 individuals and 27 groups who responded to the consultation recommended the Mental Health Act improve in promoting and protecting human rights (Ministry of Health, 2017b).

In due course, these restrictive practices have contributed to poor relationships between people and mental health professionals, and lead to a mistrust of the mental health system (Kisely, S. R., Campbell & Preston, 2005). Succinct studies in New Zealand have explored Māori views of the impacts of compulsory treatment orders (Baker, 2015; Gibbs, Dawson & Forsyth et al., 2004; Newton-Howes, Lacey & Banks, 2014). These studies provide insights and context to the experiences of Māori against the increasing rate of compulsory mental health treatment. They show Māori tolerated compulsory treatment in the community, because it was an alternative to inpatient care (Baker, 2015). There was an accommodation of mental health service treatment as it was thought to have improved social and clinical outcomes. The positive feedback included access to services, a sense of security or safety felt, with attributions of having the compulsory order providing access to treatment for their wellbeing. The negative feedback included the person's lack of choice about medication and treatment, their place of residence, and the necessity for travel. For some, there was no guarantee to getting access to necessary resources to live within the community following acute inpatient unit admission (Baker, 2015).

There is a predominant western medical approach to the management of community mental health care in New Zealand and when a person is placed under the Mental Health Act, the treatment is predominantly in the form of medication (Ministry of Health, 2017b). There seems to be an attempt to hospitalise the communities in which Māori reside by extending the use of the Mental Health Act from their time in acute inpatient care to community based care. This is managed by enforcing the care of Māori under a community treatment order. Community mental health care of Māori is dominated by patterns of psychiatric control that promotes a western medical model of illness for the community and Māori. This is demonstrated in the increasing rates of community treatment orders under the Mental Health Act of Māori (Health and Disability Commissioner, 2017). People who were admitted to a mental health unit or treated under compulsion in the community were powerless and continuously exposed to coercive actions by health professionals (McKenna, Simpson & Laidlaw, 1999). More research is needed to understand the impact

of coercive and involuntary measures for Māori (Elder & Tapsell, 2013). When Māori are in mental health services, the care tends to be dominated by the dominant culture and structures, which perpetuates the oppression of Māori and marginalises them further (Reid & Robson, 2007).

Māori have felt disrespected, not listened to and often feel they are worse off as a result of the treatments they have received in mental health services (Fenton, 2000; Lapsley et al., 2002; Liebrich, 1999; Wharewera-Mika, 2012). When there is a lack of recognition of Māori cultural heritage, Māori feel their spirituality is disregarded and that the mental health service alienates them from their cultural identity (Lapsley et al., 2002; Semmons, 2006).

Māori have experience of being given unnecessarily high doses of medication administered in mental health services. Their concerns have identified significant side effects (such as dribbling, dizziness, numbing, restlessness, inability to walk or talk, loss of short term memory), over sedation, extreme weight gain and an impaired ability to conduct normal activities in daily life (Eade, 2007; Fenton, 2000; Lapsley et al., 2002; Liebrich, 1999; Pere, 2006).

Acute inpatient mental health units are of particular concern, although surroundings of acute units have changed over the years. The main barriers in acute care remain the same for Māori as they have done historically. These barriers are demonstrated by higher rates of restraint, seclusion and the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 upon Māori, and high doses of medication (Fenton, 2000; Lapsley et al., 2002; Procter et al., 2013; Wharewera-Mika, 2012).

The concerning issue amongst Māori is the stereotypical view and impression of Māori males that exists in mental health services. It is the impression that when Māori males are seriously mentally unwell, they are labelled violent, aggressive or bad, which in turn perpetuates Māori men being treated with high doses of medication, restraint and long spells in seclusion (Eade, 2007; Lapsley et al., 2002; Matonga, 2010). Māori access to mental health services

may come via the police or compulsory committal processes, where there is almost an expectation for physical restraint to be used due to the Māori person's intimidating physical presence (Eade, 2007; Te Pou, 2014).

Against the context of mental health treatment of Māori, there is little recognition that Māori may be fearful of mental health services or police. There is no recognition that fear motivates Māori to externalise themselves through various defensive behaviours of which they are forcibly detained and treated in an alien environment (Adams cited in Liebrich, 1999; Eade, 2007). When Māori access mental health services through the criminal justice system, it continues to be a consequence of having late access to treatment for mental health issues and evidence of poor primary care (Barnett & Barnes, 2010).

There is a significant difference when Māori have access to Māori healing techniques, Māori health professionals and Kaupapa Māori mental health services. Health providers who create Māori cultural settings and employ Māori mental health professionals and traditional healers provide an effective cultural model of care to assist Māori with their recovery (Lapsley et al., 2002; Pere, 2006; Wharewera-Mika, 2012). Māori health units within mainstream services or standalone organisations enable Māori mental health professionals to provide whakawhanaungatanga (process of making connections and relationships), karakia (prayer), waiata (song) and a safe place to talk and share, with a range of cultural practices and activities to learn, and to identify cultural supports and promote pride in one's Māori identity. Each of these practices enables stronger connections to whakapapa (genealogy) and whānau (family) (Lapsley et al., 2002; Pere, 2006; Wharewera-Mika, 2012).

The way mainstream mental health services are delivered instigates barriers that hinder Māori from effectively utilising them. This is evident by the differing pattern of mental health service use between Māori and non-Māori, where non-Māori receive higher quality health service access than Māori, and Māori males have high rates of compulsory (enforced) service access and care (Abas et al., 2003; Edmonds et al., 2000; Gibbs, et al., 2004; Ministry of Health, 2016; Wheeler et al., 2005). The situation is further compounded by the state of poor

Māori mental health outcomes with treatment methods that have minimal evidence of therapeutic or cultural efficacy amongst Māori (Pharmac, 2006; Wheeler, Humberstone & Robinson, 2008).

In 2008, Baxter indicated little change had occurred in the way mainstream health services delivered care to Māori with mental health needs. Perhaps the very nature of mental health issues makes it difficult for Māori to seek or receive optimal health care (for example, because of the severity of symptoms and its impact upon their confidence, assertiveness and communication when seeking health care).

The increasing patterns of Māori use of health services highlight the role health professionals can have in the treatment of mental illnesses, although there is a need to understand the routes or pathways to care that would best assist Māori to meet their mental health needs (Durie, 2001; Robson & Harris, 2007). There is a need to understand why the unequal access to, and the receipt of, certain treatment methods for Māori occurs. Little research has been conducted about Māori experiences in terms of their access to, and effectiveness of, health services for their mental health needs.

From the 1970s to 2016, Māori had the highest mental health rates in New Zealand. The widening disparity between Māori and non-Māori has been persistent and is structural, with continual effects on Māori, making mental illness as a disparity even more serious. Mental health service use is one indicator to the prevalence of mental illness, as it provides an impression about the need of a population in regard to their access to and use of public mental health services in New Zealand.

2.7 Indigenous Peoples

Indigenous peoples are recognised as the first peoples of a land, who are best known for their specific social, cultural and economic situations, that distinguish them from other communities. They are the descendants from native groups of people who inhabited a country or a region, often from which, they have been impacted on by the invasion of others and subsequent

colonisation. Although, their lands were never ceded, there are continual reminders, from the process of invasion and colonisation that has remained across generations. Indigenous peoples self-identify through their culture and their own historical significance. One of the most important factors in the history of indigenous peoples has been the negative impacts of colonisation, and the necessary adaptations indigenous peoples have needed to make in order to cope (King, Smith & Gracey, 2009).

Indigenous peoples tend to have higher rates of serious mental illness and addiction related harm, they tend to self-harm and complete suicide more, and be compulsorily treated by mental health services. Non-indigenous peoples experience these health conditions as well, yet in most countries where there are ethnic disparities between European and indigenous people or minority groups, mental illness and addiction related harm are the worse amongst the indigenous communities (Bhui et al., 2003; Keyes et al., 2012). Indigenous peoples, Blacks, ethnic minority groups, generally non-European groups, also tend to be disproportionately placed under the Mental Health Act in their respective countries for treatment against their will, than those of the dominant racial group (Mfoafo-M'Carthy, 2014).

The indigenous peoples of the Americas and Australia share similar commonalities with Māori of being colonised by a settler group and subsequently marginalised within their own country. Without ignoring the significant and unique historical and cultural differences amongst indigenous peoples, there appears to be higher levels of mental distress amongst indigenous people. With common histories of accumulated loss and grief caused by colonisation, there are longstanding impacts upon indigenous people's spirituality that manifests in mental and physical illnesses.

Indigenous theoretical propositions go some way to explain why the impacts of colonisation still, to this day, are relevant to the mental health and wellbeing of indigenous peoples. Duran (2006), an indigenous psychologist, identified the soul wound, a process of intergenerational post-traumatic stress that occurred in Native American communities that is passed down through the generations. He identified that trauma that had not been dealt with in the past

became more severe each time it was passed onto a subsequent generation. This perspective about the impact on or loss of wairua has also been associated with mental distress amongst Māori (Clements, 1932).

Brave Heart and DeBruyn (1998) developed a theory of historical trauma following the analyses of literature on intergenerational post-traumatic stress. By comparing the experiences of historical loss and the intergenerational transmission of trauma from the loss of land and culture with Native Americans, they identified the transference of trauma across generations, through biological, psychological, environmental and social means, resulting in a cross-generational cycle of trauma (Sotero, 2006). Theories, such as this one, about indigenous peoples' spiritual wounds and ancestral hurt, suggest prolonged tensions that exist across generations since colonisation are now manifesting in the presentation of high rates of depression, various mental illnesses, substance use, self-harm and suicide. The mass losses of whenua amongst Māori and the effects upon their latter generations in regard to socioeconomic determinants, more importantly the impacts upon Māori mental health is an area for further research. There may be varying factors that impacted Māori, and the magnitude of historically traumatic events and their responses to them.

It is likely that Māori, as the indigenous people of New Zealand, are also experiencing historical trauma and soul wound. This is shown by the high rates of mental illness and addiction due to the losses caused by colonisation. There are also issues in Australia with the increase in mental distress and suicide among Aboriginal and Torres Strait Islander people (Australian Indigenous HealthInfoNet, 2015). Similarly, for the Native American people, social and economic disadvantage has been connected to the historical loss of land, the damage to traditional social and political structures and languages, the impacts from the removal of children, high incarceration rates and intergenerational trauma (Mitrou et al., 2014; Parker & Milroy, 2014). Indigenous Australians experience higher levels of morbidity and mortality from mental illness, psychological distress, self-harm and suicide than other Australians. Similar to Māori, Native Americans, Aboriginal and Torres Strait people have the worst

rates of mental distress, substance use and suicide in the world (Abuse, 2010; Durie, Milroy & Hunter, 2009).

The delivery of mental health services to indigenous peoples is also of concern. Stigma and the lack of awareness about the need for culturally safe and appropriate mental health care for indigenous peoples, by mental health services has created barriers to help seeking and service use by indigenous people with mental illness and addiction issues.

With delays in health service contact, when help is sought for mental health needs, there is an issue about the quality of care that is provided and then received by indigenous peoples and the subsequent compulsory admissions to acute inpatient units (Harris, Edlund & Larson, 2005; Morgan et al., 2005). Non-western peoples experience common barriers of being restricted, when indigenous peoples interact with monocultural mental health services, they are significantly controlled by western medical systems more so than any other group (Durie, 2001).

2.8 Kaupapa Māori Mental Health Services

It is important to recognise the development of Māori models of practice and the impact these have had on the delivery of mental health services known as Kaupapa Māori mental health services. Durie (1984) introduced a framework for understanding Māori health perspectives called Te Whare Tapa Wha. The model proposes four dimensions of health, and compares them to the four sides of a whare or house: Taha wairua (spirituality) Taha hinengaro (thoughts and feelings), Taha tinana (physical health) and Taha whānau (family). The concept of health and wellness is conceptualised as an interaction of each wall in a house. Each wall is unique, but relies on the balance and connection with the other walls to ensure a solid foundation overall. Pere (1991) produced Te Wheke the Octopus to similarly illustrate the major features of health from a Māori perspective. The aim of these models were to strengthen the understanding that for Māori, there is a preference for holistic health models and approaches in their health care.

Kaupapa Māori mental health services were established in the 1980s with the principle aim of introducing a Māori perspective into clinical mental health services, because increasing numbers of Māori were engaging with mental health services (Durie, 1998). It was one of the most transformational changes to health services over the past 30 years in New Zealand (Durie, 2011, Baker, 2012).

Māori and non-Māori were instrumental in forming and shaping the development and delivery of Kaupapa Māori mental health services (Durie, 1997, 2001). They incorporated Māori values, beliefs, and management styles into the clinical treatment environments of mental health services. Characteristics of these services included being managed by Māori, targeting Māori within mental health services; incorporating tikanga Māori, whānau, hapū and Iwi; use of traditional Māori healing practices; cultural assessment, cultural practices and whanaungatanga (Keelan, 1997).

Whaiora was the first Māori mental health unit established in New Zealand, within Tokanui psychiatric hospital based in Te Awamutu (Durie, 1997). It was born from a need for a bicultural approach for both Māori staff and tangata whaiora, in a mainstream mental health service setting. Whaiora, following a three-year developmental period, opened in 1984 (Elliot, 2012). It was deemed a 'cultural therapy unit' or Māori treatment centre (Diamond, 2005; Te Mata o Te Tau, 2008), informed by Māori culture (kawa), traditions (tikanga), knowledge (mātauranga) and language (reo) and based upon whānau (Baker, 2012). Te Roopu Awhina o Tokanui (Māori staff) together with Medical Superintendent Dr Henry Rongomau Bennett (first Māori psychiatrist) and Dr Jennifer Rankin (Māori registrar) were strategic in the development of this unit (Durie; 1997, Kingi, 2005; Rankin, 1988). It provided a 20 bed kaupapa Māori inpatient unit staffed by Māori and non-Māori that offered short term rehabilitation to Māori tangata whaiora (Elliot cited in Raumati, 1994). Designed to strengthen the cultural, tribal and family links to whānau, it also assisted to enhance the mana of Māori clients (Sachdev, 1989).

In Auckland, following the investigation into the death of Micheal Watene recommendations stressed the need of mental health services to take into

account Māori cultural beliefs and Māori models of health care (Durie, 2001). Whare Hui was the first of three Māori mental health services in central Auckland. Whare Hui provided for a six-month activity established at Carrington psychiatric hospital, led by Nellie Hippolite a Māori psychiatric nurse. Her role involved counting the number of Māori clients admitted into Carrington hospital (Baker, 2014). This activity provided statistical evidence to support the establishment of a Kaupapa Māori mental health unit, Whare Paia, at Carrington Hospital in 1984. Māori staff set up Whare Paia in a vacated ward within the Carrington hospital grounds, taking in Māori and Pasifika tangata whaiora who were transferred from the male forensics ward (Male 3) (Howden-Chapman, 1988).

Unfortunately, the outcomes of Whare Paia were tarnished by controversy in relation to poor care of tangata whaiora and staff politics that led to its closure. It was thought that the attainment of tino rangatiratanga (self-determination) of a unit within a mainstream mental health system (that is, the Auckland Area Health Board) underpinned the contradictory philosophies between Māori staff and non-Māori management (Durie, 1998). The political agenda of staff, in addition to being untrained, contributed to a compromise of care and an assault of tangata whaiora hastening the demise of the unit (Gregory cited in NZ Parliamentary Debate, 1988).

Manawanui was the third Māori mental health unit opened in the Carrington Hospital grounds subsequent to Whare Paia. It had a purpose-built marae and inpatient service, which closed in 2003. Manawanui continues to provide community based Kaupapa Māori mental health service from the purpose-built Marae built in the greater Auckland region (Lambrecht, 2017; Wirihana, 2008).

Further south of Auckland, in 1988, a community health worker and Māori coordinator were appointed at Kingseat Hospital to aid in meeting the needs of Māori. Concerns expressed by local kaumātua about Māori mental health need led to the establishment of Rapuora in 1990. However, amidst the commencement phase of the country's psychiatric hospital deinstitutionalisation phase (mid 1990s), Rapuora closed. With contributions by Māori mental health staff scattered throughout the services, the

establishment of one of the first kaumātua led Kaupapa Māori mental health services (titled Rapua te Oranga Hinengaro) occurred in the South Auckland community in 1994.

Te Whare Marie Kaupapa Māori mental health unit was established in 1989 at Porirua Hospital (Neilson-Hornblow, 2009). Māori and non-Māori provided support to the establishment of Te Whare Marie, which included the local community of Wellington, Te Kaunihera o Ngā Neehi Māori (the National Council of Māori Nurses) and Wellington Polytechnic. It was felt that an affirmative action policy was required to transform the systems in the hospital to incorporate Māori values (Williams, 1987). During the early developmental phase, support was provided from colleagues at Tokanui Hospital with Whaiora, Bob Elliot and Te Roopū Āwhina o Tokanui providing mentorship to the staff in Wellington whilst they were exploring the development of Kaupapa Māori mental health services. Te Whare Marie now provides a community based Kaupapa Māori mental health service in the greater Wellington region.

In other places, health services were increasingly becoming more sensitive to Māori values during the 1980s. Hospital Boards appointed bicultural Māori staff, and practitioners were establishing working relationships with traditional healers. Hospitals and mental health units supported whānau of Māori clients to be admitted with the tangata whaiora (Durie, 1998).

2.8.1 Māori Health Reforms

The government established policies and programmes to advance Māori development for cultural advancement, economic and Iwi development, service development, social equity and inclusion. By reducing state delivered programmes, devolution of resource into the community meant that support for Iwi and independent Māori provider development was possible. This helped foster strategies to enhance Māori perspectives, values and worldviews, especially within health services and programmes (Durie, 2005).

The 1990s was an era where mental health services were transitioned from a model of remote psychiatric institutional care to a model of care based within the community. It drew witness to one of the largest growth periods of Kaupapa Māori mental health services both in mainstream health services and in

communities. The deficiencies in mental health service delivery that led to a number of service inquiries (for example, Mason Reports, 1988, 1996; Ministry of Health, 1994) provided the catalyst to significant policy changes that reshaped mental health legislation, paved the way for deinstitutionalisation (Brunton, 2015) and ring-fenced financial investment in Māori mental health service and workforce development (Mental Health Commission, 1998). The findings from the reviews of mental health services revealed a high prevalence of mental illness amongst Māori, with increasingly high first admissions and readmissions to mental health services. The reviews also revealed mental health services were monoculturally focused on clinical treatment, with systems that had cut Māori off from their whānau and culture (Ministry of Health, 1994).

Part of the new model of care to emerge in Māori communities, occurred with Iwi Hauora providers establishing Kaupapa Māori Iwi community support programmes (Northland, Auckland, Waikato, the Bay of Plenty, the Central region and the South Island). These Iwi community support programmes helped to extend additional support to Māori tangata whaiora and their whānau in their homes, often focusing on psychosocial, whānau and cultural elements that were amiss from mainstream mental health services.

Collectives of Māori mental health providers, tangata whaiora and whānau also established networks to facilitate support amongst Māori which provided further impetus for regional Māori mental health strategic developments (for example, Miria te Hinengaro in the Midlands region). These collectives of Māori helped shift the paradigm to more Māori models of practice (Durie, 2001).

The Mental Health Commission was one of the best advocates for Māori and Kaupapa Māori mental health service development in its time. Established as a watch dog by the government to monitor the implementation of the national mental health strategy (Mental Health Commission, 1998), it aimed to reduce the discrimination against people with mental illness and promote mental health excellence. The Commission established the Blueprint policy which prompted transformational change, particularly in its emphasis on meeting Māori mental health need. It was hoped that with the prioritisation of more and

better services for Māori this would ensure effective mental health outcomes and services for Māori (Mental Health Commission, 1981). Guidance from the blueprint on how mental health services should be delivered to Māori, targeted funders and providers covering areas such as better access to mental health services; culturally effective services; aligning service contracts with aspirations of Māori healing and wellbeing; increasing the Māori workforce; suitable performance measurements and providing choice for kaupapa Māori and culturally effective mainstream mental health services (Mental Health Commission, 1998).

The policy promoted that for services to be effective for Māori, Te Whare Tapa Whā as the holistic model for Māori health was required to be applied and reflected in the care and support of Māori with clinical treatment. It was viewed that Māori should have a choice of either mainstream or Kaupapa Māori mental health services or both at the same time. However, by making either choice, Māori would be guaranteed to have their needs met as well as have their cultural identity strengthened with access to forms of Māori healing or wellbeing (Mental Health Commission, 1998).

Seven components were recommended for mental health services to meet the needs of Māori (Table 1). These consisted of cultural assessment, whānau and tangata whaiora participation or inclusion in mental health service care; the recognition and support of Te Reo Māori me ōna tikanga as part of the healing process; the inclusion of culturally based treatments or approaches along with clinical treatment; access to a Māori health workforce and improved performance measurements (Mental Health Commission, 1998).

Table 1: Seven Components to Meet the Needs of Māori in All Mental Health Services

Component	Description
Cultural assessment	Cultural status and needs of Māori are assessed, enabling Māori values, tikanga and healing practices to be incorporated into the care and support of tangata whaiora.

Participation	Whānau and tangata whaiora participation is required at any stage of mental health service contact or involvement.
Te Reo Māori	Tangata whaiora should have choice to converse in or have access to te reo Māori to enable an expression of Māori values and beliefs as an important part to the healing process.
Tikanga	Māori protocols, rituals are important to acknowledge and embed. A conducive mental health service environment and approach to tikanga recognises Māori values, beliefs, and wairua as integral to the healing process.
Optimum treatment	Culturally based treatments, healing processes and rongoa should be as accessible as optimum mainstream clinical treatments and recovery approaches available.
Māori workforce	The mental health workforce need to culturally match Māori by Māori participation as health professionals, clinicians, managers and decision makers.
Performance measures	Performance measures need to ensure measures that represent good health for Māori. Te Whare Tapa Wha is suggested to be incorporated into performance measures.

Note. From Mental Health Commission (1998).

The components indicated in Table 1 above, indicated that Māori with a mental illness could have choice to obtain treatment as they wished (Durie, 2001). For this reason, all mental health services were expected to address Māori cultural needs and establish links with Māori networks, including traditional healers. This included assessment processes being able to take into account cultural values and in order to deliver an effective service to Māori, the recruitment and retention of a Māori health workforce. Kaupapa Māori mental health services were recommended, either as an independent service or as part of DHB or mainstream mental health services, centred on Māori cultural practices and delivered by Māori staff. By the mid-1990s there were an estimated 13 Kaupapa Māori mental health services (Mental Health Commission, 2000). In 2015, at least each DHB region had a Kaupapa Māori mental health service of some type providing support to Māori.

Since Kaupapa Māori mental health services were established in the 1980s there have been successes in developing new services and processes to be more compatible for Māori. Conceptually Kaupapa Māori mental health services are thought to provide a better cultural match between Māori and health interventions. Most are located in the community and some are delivered by secondary care mainstream mental health services, which can be challenging given the systemic processes of mainstream mental health service infrastructures do not take into account the indigenous framework required of such services. Given the number of Māori entering mainstream mental health services some may view Kaupapa Māori mental health services inside DHB would offer the greatest contribution if they gained easy access to these (Cunningham, 2015).

Yet, the integration of Kaupapa Māori mental health services within secondary care mainstream mental health services can hinder its specifically Māori holistic approach and lead to the minimisation of its overall purpose (Mar, 1999). In fact, funders have not understood nor valued Kaupapa Māori service provision, and lacked the vision and the funds to invest into the further establishment of sustainable infrastructures and facilitate a whole of government approach (Mental Health Commission, 2007). Contractual disparities, differences in worldviews of Māori, funders and mainstream services are part of the key challenges for the integrity of Kaupapa Māori mental health services (Boulton, 2005). The greater control of resources and their use are also part of the continual challenge as Kaupapa Māori mental health services seek opportunities to evolve further into Māori communities and attain the sustainability of the service (Boulton, 2005).

Though the growth and expansion of Kaupapa Māori mental health services over the years would suggest there is not an issue with considering culture in mental health care, with the increasing Māori mental health need, it remains important Māori cultural concepts are visible in health services. This will provide the foundation for whānau, to ensure Māori models of practice and tikanga approaches are available to Māori, and are widely accepted as fundamental to Māori mental health service provision, and consistent with Māori aspirations and previous government policies. The challenge remains

for Kaupapa Māori mental health services to maintain the gains achieved thus far and to contribute to Māori aspirations into the future (Brannelly, Boulton & Te Hiini 2013).

2.9 Concluding Comments

This chapter has provided a summary of the available literature focusing mainly upon the mental health of Māori. There is a clear disparity in the amount and quality of literature (data) pertaining to the mental health of Māori. A subtle comparison to the mental health issues experienced by other indigenous peoples was applied. However, until national systemic data is consistently available, information about the mental health of Māori can only be drawn together from a variety of sources to provide for a generalised understanding of the mental health of Māori in New Zealand.

CHAPTER THREE – METHODOLOGY

3.1 Introduction

This chapter discusses the research methodology and methods used in this doctoral study. The aim is to present key features of the methodological design. It commences with a perspective of why research, for Māori, must include working beside us rather than posing research on us. Then the Māori centred research design and the grounded theory method used to understand the sociological world in this subject area is presented. This is followed by a background on classic Glaserian grounded theory (data collection, coding, constant comparison, memoing, rigour and theory).

3.2 Māori Repositioning Research

Research is a way to find out something that is unknown; yet historically research has been conducted on indigenous peoples, not with or beside them. Embedded in a colonial context, research can be juxtaposed by power and control between the original people of a land and the dominant western representatives that were oppressive to Māori (Belgrave, 2014; Smith, 2005). Information about indigenous peoples was often collected, classified, and re-presented back to non-Māori in a way that indigenous peoples were thought of as exotic, unique and different from Pākehā (Smith, 1999). The consequences of these processes fostered significant and negative racial assumptions and biases about Māori, which have remained embedded in societal structures, and have later impeded generations of Māori, especially in mainstream constructs (Smith, 1999).

Māori knowledge and ways of being were relegated to a domain of little importance in comparison to mainstream knowledge and critics (Smith, 1999; Waitangi Tribunal, 2006). Thankfully, colonisation did not entirely erode Māori tradition (Cram, 1993), as Māori sustained their knowledge and customary practices through the generations and retained a uniquely Māori way of looking at the world (Smith, 1992).

Māori theory and knowledge is important for the interpretation and predictions about the world in which Māori live, reinforcing the point for the need to have a sense of reality as informed by Māori (Denzin & Lincoln, 2000). It was vital to focus this study in a Māori centred way, by attending to the issues and needs of Māori from their perspectives whilst being appreciative of their lives and experiences as Māori, and also of their current reality (Mataira, 2003).

Dr Linda Tuhiwai Smith's (1999) seminal work prompted a catalyst of change for Māori and research, fostering Māori aspirations and achievements in research and evaluation from decolonising methodologies, and deliberately shifting the influences of power in research to Māori control. The value added from a Māori way of being, of Māori language and culture, are important matters in research for Māori. There must be the ability to generate goals and actions that reposition methods on matters of importance from a Māori worldview. Research should make it possible to reveal and reaffirm knowledge and interpretations from traditional and contemporary Māori worldviews. Māori research ensures a principled approach and focus on being Māori, that purposely connects with Māori philosophy and values, and takes for granted the validity of being Māori and Māori knowledge (Smith, 1999).

Worldview is attained through principles people acquire and utilise to construct a sense of reality, so they can interpret and make sense of the world around them. Worldview provides people with a sense of location and identity, with a set of values that generate and guide behaviours (Smith, 1999). A Western worldview is representative of knowledge, systems and values that are characteristic of non-Māori (Smith, 1999). Researchers from a Western worldview tend to draw on their own assumptions to understand what is happening. They may assume to know all that is possible to know about Māori based on brief encounters with them and descriptive data about Māori. The application of research practices from Western worldviews have, in the past, denied the validity of indigenous people's claims to their existence, lands and right of self-determination, and to the survival systems of living within one's environment (Smith, 1999).

Research about Māori has tended to be descriptive, often separating Māori from their cultural, social, spiritual and spatial contexts. For example with the topic of Māori rates of mental illness, although prevalence and determinants are informative, little is known about how Māori cope, let alone what solutions or actions are needed for their status to change (Cram, 2001). Grounded in the lives and experiences of Māori (Mataira, 2003), a Māori research approach challenges the deficit systems within which Māori are located by non-Māori paradigms, similarly attributed to with Māori and mental illness (Pihama et al., 2004).

The motivation to conduct research by Māori is partially due to the dominant worldview that provokes a gaze that identifies, positions and juxtaposes Māori with non-Māori, with little consideration of their tangata whenua status, language, whenua or tikanga. Furthermore, the dominant non-Māori perspective in research portrays Māori in a way that is devoid of an indigenous history, spirituality, and disregards overall the impact the research will have upon Māori thereafter.

Research is not new to Māori, and Māori are not entirely against non-Māori theories or methods (Smith, 1999). There is still caution as the impact of colonisation has disrupted Māori knowledge systems and mainstream constructed research has often replicated old colonial measures that continue to justify the oppression of Māori (Walker, 2004). Research has had a bad name within Māori communities and is not about the notion of research; rather how research has been conducted, including the approach of the researcher. It is also about Māori having the research done to them rather than working in partnership between Māori and the researcher (Cram, 1993; Smith, 1999).

Māori research critically analyses situations and captures data about Māori in a way that makes sense to Māori people (Te Awekotuku, 1991). It is realised that Māori are not homogenous (Hemara, 2000, Smith, 2005); yet by ensuring the perspectives in research are capable of embracing a Māori worldview, it privileges Māori values, attitudes and practices (and their diversity), which

indeed will enhance the development of Māori and their knowledge systems (Smith, 2005). Māori research also appreciates that embedded in Māori data are other stories Māori wish to tell which question the nature of Western ideals and practices and serve to ensure their story is told – rather than a story being told by non-Māori (Smith, 1999).

3.3 Design

The design of this doctoral research was a qualitative choice. I applied a Māori centred approach with Glaserian grounded theory method, to foster insights into the intimate experiences of Māori with mental illness and mental health services (Flick, 2009). Admittedly, using a Māori centred approach with grounded theory suggests juxtaposition in the application of two differing methods to show how they are the same or different. In one way, this study could be viewed as a deliberate bicultural approach, essentially Māori philosophical and value laden approaches to benefit the contemporary aspects of ngā kaiuru (participants) and the academic requirements of this study. The other is that Māori are diverse and contemporary (Durie, 2001), and a research design and methodology that considers similar elements would be viable for this study.

3.4 Māori Centred Research

It is important to discuss further the notion of a Māori centred design to research. Māori centred research design deliberately enables the exploration, discussion and analyses of information according to what is meaningful to Māori. It includes Māori values, attitudes and practices throughout the research process (Cunningham, 2000) by positioning Māori experiences and philosophies at the centre of the research with the aspiration of contributing to strategies that will support them (Durie, 2001). Māori centred research requires Māori input at all levels of a research study. In this case, as an emerging Māori researcher, I was well supported by two Māori academic supervisors, and Māori experts and kaumātua during the tenure of this study (Smith, 1999). Some of the key principles of this Māori centred research approach included:

- *Mana Māori* which pertains to Māori autonomy, control and determination, similar to tino rangatiratanga, with the protection of information generated from the research.
- *Whakapiki Tangata* focuses on enablement and empowerment of kaiuru (participants), by upholding the dignity of individuals and the collective, and ensuring processes are protective and accountable to them (Forster, 2008).
- *Whakatuia* appreciates an integrated holistic Māori world view (Durie, 1998) and incorporates cultural notions of relationships and interconnectedness with spiritual, physical and environmental domains (Forster, 2008; Wilson, 2004).

Māori centred research design honours Te Tiriti o Waitangi and ensures the obligations under which have direct relevance to Māori, whilst adhering to mainstream academic requirements of Massey University. These include te reo me ona tikanga (language and customary practices), he kanohi kitea (the seen face) and whanaungatanga (relationship building).

The responsibility of a Māori centred approach is to produce knowledge and theories that explain the nature and condition of the lives as Māori view them (Cram, 2001; Smith, 1999; Tomlins Jahnke, 2002; Wilson, 2004). In combination with other methods, a Māori centred approach ensures a Māori worldview or ways of being are fore-fronted, maintained and evident in the research (Smith, 1999). Mane (2009) contended Māori centred research is best defined by Māori as it is by those Māori who are well positioned to speak from within their institutions. It is then that the researcher is guided by those Māori communities to also follow tikanga as determined by the community, and will include the use of karakia (prayer), mihimihi (greetings), korero (talk), whanaungatanga (relationship building).

Centring the research upon Māori assumes Māori people, their language and culture will occupy the research in its entirety (Durie, 1997; Tomlins Jahnke, 2002); in addition to shaping the sense-making process, ensuring it has a valid alignment to Māori values, tikanga and perspectives as they emerge (Smith,

1999). A Māori centred approach informed this research by revealing the voices and perspectives of Māori. By utilising a cultural lens, it helped to elicit what was important to them, and the strategies they used to overcome their problems.

3.5 Method

3.5.1 *Grounded Theory*

A Glaserian, or classic grounded theory, was the method used to unpack, understand and analyse the data in this study (Glaser & Strauss, 1967; Glaser, 1978). Classic grounded theory was used as a systematic method to produce an inductive theory about the substantive area of Māori mental health. Highly structured, yet flexible, a classic grounded theory can bring together theories and propositions from data rather than from *a priori* assumptions of existing theoretical frameworks (Smith, 2005), which views the generation of a data-driven sociological inquiry.

This method enables the use of empirical data to conceptualise what is going on among a group of people, to find out what their main problems are, and what processes they are using to resolve or cope with these issues. To understand this further, the aim is to generate a conceptual theory to explain the actions of people. In this study, classic grounded theory method enabled the exploration of Māori, mental health and illness, and Māori experiences of health services in meeting their needs. The appealing aspect of this method is its ability to support both qualitative and quantitative data in the generation and verification of a theory (Glaser, 1978). The dictum of 'all data is data' is one of the definite benefits of grounded theory, especially when literature and information for and about Māori is not necessarily considered academic. Thus grounded theory appreciates the different forms of data (on the same subject) that can be utilised to build a picture with Māori in this substantive area of Māori mental health and undertake the process of comparative data analyses (Glaser, 1978).

Symbolic interactionism is the theoretical foundation of grounded theory, and is appropriate where social action becomes the key focus of research (Blumer, 1986). The core purpose of a grounded theorist (the researcher) is to consider the social processes that take place with people, inclusive of their subsequent actions, responses, meanings and decisions, and how these influence their active participation and the derived meanings (Charon, 2009). The method is based upon the idea that theory can be inductively generated from data captured from the observation of people, their behaviour(s) and what they say. People's meanings are derived from their interactions and interpretations of their experiences, and are not imposed upon by the researcher. This is appealing, especially amongst Māori, as korero that reveals cultural dynamics may not be explicit. Therefore, active attention can be provided to attribute to a robust analysis of what is going on. Grounded theory encourages open-ness and flexibility that supports a researcher to process ideas and perspectives as they arise from within the korero (discussions) between the researcher and person(s), enabling the researcher to follow through with hunches with the next person(s), as the interviews progress.

3.5.2 Background to Grounded Theory

Grounded theory is 50 years old (1967) and was developed by American sociologists Barney Glaser and Anselm Strauss. It was formed to reveal the ways people managed their problems, and to generate theories relevant to a researcher's field of interest (Glaser & Strauss, 1967). The term 'grounded theory' purports its intention by its title, in that theory is established from the basis of its subjects, so that it is 'grounded' from within the data and the sociological world that is under study.

With an inductive approach, the generation of theory and the conduct of social research forms two parts of the same process (Glaser, 1978). The aim is not to prove or describe the subject or field under study, but to interpret and understand relevant human behaviour (Glaser & Strauss, 1967). In doing so, a conceptually abstract explanation is offered about the latent patterns of behaviour (in response to an issue or concern) in the social setting under

study. We then understand what is happening in that social setting according to its people (Glaser, 2003). The overall purpose is to reveal the real world of people, to understand what their main struggles are and how they are coping to deal with those struggles. The difference between grounded theory and other forms of qualitative research is its emphasis upon the ground-up approach to developing theory (Strauss & Corbin, 1998); rather than specific description, it is drawn from a continual interchange between data collection, and constant comparative analyses (Glaser & Strauss, 1967).

3.5.3 Philosophical Influences Underpinning Grounded Theory

The motivation behind grounded theory and its methods stem from attributes drawn from various methods (Glaser & Strauss, 1967; Glaser 1998; Nathaniel, 2011); quantitative and qualitative research (Glaser & Strauss, 1967), symbolic interactionism (Nathaniel, 2011) and psychoanalyses (Gynnild, 2011). All of which shaped Glaser and Strauss' development of grounded theory (1967) whose intention was to fill the gap between theory and empirical research.

Symbolic interactionism and pragmatism are often argued as being philosophically inherent to grounded theory (Schreiber & Stern, 2001). Glaser accepted these features assisted to inform the method but felt these did not provide the philosophical foundation to classic grounded theory (Glaser, 2005), rather they guided data analyses (Wuest, 2012). It is important to consider what influences the methodology or methods and its underlying philosophical foundation as these contribute to the ontology and epistemology of the methodology that holds it together. The complexities exist in how the structured, logic and cohesion came to form the grounded theory method, through its steps and procedures of data gathering, coding and analysis, language, images, relationships and meanings (Nathaniel, 2011).

Glaser (2005) said grounded theorists should not be overly concerned by symbolic interactionism, as grounded theory is based in a concept-indicator model taken from psychological research, from which constant comparative methods were added to conceptualise categories and properties of data (Glaser, 2005). Even though there are differences of opinion, there is an

appeal with symbolic interactionism and pragmatism by many researchers in the means to capture people's behaviours as a primary interest for social change and better health outcomes. Thus, appreciating the meanings and worldviews of people, their social relationships and behaviours as part of the overall research process (Abrams & Curran, 2009; Karatalova- O'Doherty, Stevenson & Higgins, 2012; Wilson, 2004).

To further elaborate, at the Chicago School of Sociology in the early 1900s, social psychologist George Herbert Mead established the foundation to symbolic interactionism. Mead was influenced by pragmatism (John Dewey and William James); a perspective that people went through a continual process of adaptation in a constantly changing social world. Propositions of pragmatism which informed symbolic interactionism included:

- Truth being actively created, as people act toward the world;
- People basing their knowledge of the world on what has proven to be useful to them;
- People defining social and physical objects they encounter, according to the way they use them; and
- Understanding people is to understand what they do in their world and how they interpret that world (Ritzer, 1992).

Mead (1962) contended that an inner conversation (I, me and self) in each person occurred continually, as they engaged in a social interaction. This reflects a person's mental processes and interaction within their contexts, rather than acting without considered thought to a situation. Herbert Blumer (1969) refined Mead's propositions, adding that the character of relationships amongst people had the ability to construct and share meaning.

- People act toward things on the basis of the meanings these things have for them;
- Meanings are derived from or arise out of the social interaction a person has with other people; and

- These meanings are handled in, and modified through interpretative processes used by a person when dealing with the things he or she may encounter (Blumer, 1986).

From Mead's and Blumer's propositions, the philosophical stance of symbolic interactionism is now used to understand the world that is under study, in regard to the person(s) actions and interactions in that world. By doing so, meaning is generated through the interaction with others. Symbolic interactionism guides researchers to assume that meaning is made and constantly changed through interaction and becomes embedded in a social context. Both meaning and social context influence the ways that people are enacted. Pragmatism supports seeking out revised understandings of a situation for the purpose of useful change with reflexive confirmation and use of applicable existing knowledge. Pragmatism and symbolic interactionism are useful principles to a grounded theory approach (Denzin, 2008).

3.6 Classic Grounded Theory

Since the development of grounded theory, it has been adapted creating a variety of ideas about its philosophical foundation (Nathaniel, 2011) and methods (Charmaz, 2005; Clarke, 2005; Strauss & Corbin, 1998). Emergence or forcing of the data became the subject of contention between the originators Glaser and Strauss. Glaser (1992) maintained an adherence to an emergence model of discovery of theory generation and Strauss, in partnership with Corbin, emphasised procedures and analytical tools for applying grounded theory (Strauss & Corbin, 1998).

Classic grounded theory was the method used in this study. Its aim has been to produce theory completely grounded in data, and to provide an understanding of what is really going on (Glaser & Strauss, 1967). This was an important element for me in this study, to ensure that the concerns of kaiuru and their ways of knowing were prioritised. The other factor was my previous experience in the field of study. I wanted to step back from what I knew, as much as possible, to refrain from introducing constructivist elements during

data collection and analysis. The classic grounded theory approach supports the concept that everything must earn its way into a theory through constant comparison of data, rather than being imported from other sources.

3.7 Data

Researchers will collect their own data in various ways; the main perspective is that all data is relevant in a grounded theory study. Interviews, film, television, documents, discussions, newspapers, magazines, survey data, websites, anything that is available to the researcher, is viewed as data where something is going on that patterns actions and interactions (Glaser, 1998; 2005). Although there is this generosity of data, qualitative interviews are the most common methods to obtain information (Nathaniel, 2011). To understand what is going on amongst people and how they resolve their concerns, people remain the best source of information.

Numbers of interviews may depend on the research (Thomson, 2011), its scope, and the researcher's experience which might require more interviews or alternative data sources than most other types of research. In the case of interviews in a grounded theory study, there is no set number as the researcher focuses on gaining theoretical saturation (Glaser & Strauss, 1967). The additional advantage is the continual comparison with any data.

Open ended interviews in grounded theory are preferred as they prove to be data rich, with people free to 'spill' their concerns about what is going on (Glaser, 1998). By posing a 'grand tour' question, the researcher invites the person(s) to discuss what is relevant to them (not the researcher) about the topic area in their terms. Such a question is phrased in the most open-ended manner possible, for example: What does *oranga hinengaro* mean to you? Through theoretical sampling, grand tour questions become increasingly more specific as the theory emerges. Even as data collection becomes more selective, as a theory emerges, questions continue to be asked in the least leading manner possible. Formulation of subsequent questions are based on the person(s) reply to the previous question. Through a process of *korero*, of

non-structured interviewing and listening in the interview, constructivism is minimal. Each interview provides the researcher a selection of data on which to build.

3.8 Coding

The raw qualitative data gathered is studied and coded as a way to generate an emergent set of categories and properties which fit, work and are relevant for integrating into a theory. To achieve this, an examination occurs of the data in every possible way (open coding) (Glaser, 1978). By doing so, actions or events found within the data are named, often labelled with the words of the person(s) that are found in the data themselves. This renders the substantive (specific subject area) data into a multitude of codes that are later reorganised, and reordered into a representative whole. This is a process of emergence as generating codes and categories occur directly from the data (Glaser, 1978; 1992) as a means to open up the inquiry for the researcher (Strauss, 1987). It is a game of believing everything and believing nothing occurs, leaving the researcher as open as the coding itself. Data should not be viewed through a predetermined framework; rather, data interpretation and category development should be driven by conceptual concerns in the data (Glaser, 1978). To ensure the methods govern open coding, it is suggested the researcher frequently reflect and ask a prescribed set of questions of the data:

1. What is this data a study of?
2. What category does this incident indicate?
3. What is actually happening in the data? (Glaser, 1978).
4. What basic social process is at work in this particular situation? (Wilson, 2004).

By asking these questions, the researcher is kept theoretically sensitive to the data, transcending to analyse, collect and code the data, to focus on the patterns amongst the incidents (Glaser, 1978). The next stage is to analyse the data line by line, constantly coding each sentence to yield a cluster of categories. From the codes, categories will emerge in different ways to add to

an understanding about the properties and inter-relationships. Each category will have properties whose descriptions will be added to by studying the data until a point is reached when further data adds no more detail. The category is now 'saturated' (Glaser, 1978). Relationships between categories will emerge, with a core variable identified to organise and hold the data together (core category) and reveal the process used to resolve a social problem or phenomena (basic social process).

There are two types of basic social process, basic social psychological process (BSPP) and a basic social structural process (BSSP). The substantive theory takes shape throughout the process. Findings are checked against the data by a process called the 'constant comparative method', which is a way of combing through the material to extract as much detail as possible. This permits the researcher to check emerging hypotheses, which leads to the development of substantive theory.

3.8.1 Constant Comparison

Fundamental to grounded theory is an adherence to the inductive nature of the analytical process. The primary strategy with the integration of coding and analysing stages of this method is one which is consistently applied, better known as constant comparison. This technique involves contrasting data first against itself, then against original data, and finally against theoretical and conceptual claims, which facilitates the emergence of knowledge to provide relevant predictions, explanations, interpretations and applications (Glaser & Strauss 1967). Simply, the process of constant comparison involves four steps: the analyst compares (1) incident to incident; (2) the concept to more incidents; (3) concept to concept; and (4) outside comparison (for example, anecdotes, stories and literature) (Glaser, 1978). As the theory grows with coding, it gets saturated, delimited and reduced to an abstraction that rings true to both the world of the person and to people outside their world (Glaser, 2005).

3.8.2 Coding Families

Glaser (1978) identified 18 different coding families to guide the grounded theorist with systematically linking their categories of data to each other and to enhance the level of abstraction. The coding process reinforces the importance of the notion of conceptualisation after the analysis, which is assured if grounded in the data. The coding families are not exclusive yet provide a means for the researcher to sensitise and theoretically render empirical patterns in the data (Glaser, 1978). I utilised a blend of coding families in this study included the six C- family (possible causes, contexts, contingencies, consequences and conditions is central to the analysis of social events) and an interactive process family (stages, phases, progression and interaction between categories and concepts) as a framework for the stimulation of concept formation and theory generation (Glaser, 1978).

3.8.3 Memoing

Memoing is the theoretical writing up of ideas that focus on the relationships between codes and their properties. A memo can be a sentence, a paragraph or more that captures the researcher's ideas and raises the data to a conceptual level, or presents hypotheses about connections between categories and begins to locate the emerging theory (Glaser, 1978). A key element of grounded theory analysis is the researcher's creativity (Glaser, 1978; Strauss & Corbin, 1992) with maps or graphing being alternative ways of analysing and organising the data analysis and viewing it in alternative ways.

Over time, memos produce a range of reflections about incidents already seen as patterns during coding, and how a code may compare to other codes as the properties are conceptualised (Glaser, 1978). The emergent momentum facilitates a theoretical sense making process where the researcher deliberately pauses to reflect on the data whilst relating and integrating the codes and their properties. The memos are then used to guide theoretical sampling, and future sorting and integration of the data.

3.8.4 Rigour

The theory generated must be relevant to the problem area, it must fit the data and it must work – that is, produce explanation, understanding and be predictive. It is an inductive methodology in which theory is grounded in the qualitative data. This does not prove the theory is correct; rather that the theory is a set of integrated hypotheses. It is not the final word on the subject but a step on the pathway of development of fuller understanding. Theory, in any research area, is expected to be integrated and this is based on the belief that the social world is integrated and it is the job of the researcher to discover this and render it into theory (Glaser, 1978).

3.8.5 Theory

Grounded theory is identified as substantive or formal grounded theory (Glaser & Strauss, 1967). A substantive grounded theory that is grounded in research in one particular substantive area applies only to that specific area. On the other hand, formal grounded theory is defined as a theory developed from a substantive grounded theory's core category's general implications, and generated from, as wide as possible, other data and studies in the same substantive area and in other substantive areas (Glaser, 2007). Glaser and Strauss (1967) and Glaser (2007) suggest formal grounded theory is seldom done in sociological research because most formal theories are not grounded and, therefore, not trusted by either sociologists or laymen when they face real-life circumstances (Glaser & Strauss, 1967).

3.9 Concluding Comments

In Chapter Three, I have presented the Māori centred grounded theory methodology and methods used in this study. It provides the foundation for, and the importance of, Māori research completed by Māori to produce knowledge and theory to explain the nature and conditions of the lives of Māori as they view it. The combination of the grounded theory method enabled the exploration of Māori, mental health and illness and Māori experiences of health services in meeting their needs. These methods are discussed further in Chapter Four.

CHAPTER FOUR – RESEARCH METHODS & APPLICATION

4.1 Introduction

This chapter demonstrates the application of the research design, methodology and methods in this study. The focus is on the implementation of Māori centred grounded theory, the aim of the study, the research question, consultation, the setting and the support received for the study and ethical approval. In this chapter, I demonstrate how the process of this study came to be, and what the response was from the general public and kaiuru (participants). This includes the recruitment process with written consent, and the importance of koha and examples from the study during data collection and analyses.

4.2 Preliminary Consultation

At the outset, a pre-consultation process occurred to encourage korero (conversations) with a range of people to ascertain if there would be support for this study. Conversations occurred with a variety of health professionals, mainly Māori mental health professionals from Auckland, Tauranga and Northland regions, in addition to Te Rau Matatini National Māori Health Workforce development organisation and the General Manager Northland District Health Board (DHB) Mental Health and Addiction services.

Discussions were held with Northland DHB Te Kaunihera and the Chief Medical Officer. The purpose of these discussions was to gauge support for the research and to enable it to be conducted in Northland and meet local services ethical requirements (Appendix B). Following Health and Disability Ethics Committee Northern approval (NTX/12/02/006 Appendix A) further discussions occurred with Northland DHB and key stakeholders to ensure their buy in and engagement with local Māori.

4.3 The Setting for the Study

The study was primarily conducted in Te Tai Tokerau (Northland). It is my tūrangāwaewae and has a high population of Māori residing within the region. Te Tai Tokerau is located in the upper region of the North Island of New Zealand. A number of hapū and Iwi reside within the region, and it has one of the largest Iwi Ngāpuhi in New Zealand (Statistics New Zealand, 2013). Important tribal affiliations to the area include Ngāti Kuri, Te Aupouri, Ngai Takoto, Ngāti Kahu, Te Rarawa, Ngāti Hine, Ngāti Wai and Ngāti Whatua ki Kaipara.

Just over 150,000 people were resident in Te Tai Tokerau (Statistics New Zealand, 2013) at the time of this study. Of those who identified as Māori, there were over 55,000 with most (49%) living in the Far North District, 42% in Whangarei, and 7% in Kaipara (Mills, 2014). The socioeconomic status in Te Tai Tokerau is one of the poorest in Aotearoa and, sadly, many Māori hold lower levels of education, employment, income and standard of living than non-Māori (Northland DHB, 2014a).

The situation with Māori in this region regarding mental health is concerning. According to mental health service data, Māori are over-represented in mental health services relative to non-Māori (Ministry of Health, 2016). Māori are more likely to have a serious mental illness diagnosis, and have an acute inpatient unit admission under the Mental Health (Compulsory Assessment and Treatment Act (1992). They also have more readmissions and a higher prevalence of seclusion and restraint by mental health staff whilst in the inpatient mental health unit (Northland DHB, 2014b).

Evidence shows Māori access rates to mental health services have increased by 3% since 2011 (Northland DHB, 2014). They have a higher number of admissions and readmissions to the acute inpatient unit than non-Māori. Māori between the age of 20 and 30 years accounted for a total of 14% of all inpatient bed nights, but only comprise 9% in community services. Māori males between 20 and 30 years of age are the highest users of mental health services in Northland (Northland DHB, 2014b).

Between 2011 and 2013, the rates of hospitalisation for Māori with mental illness was almost twice that of non-Māori. Māori women were mainly hospitalised for schizophrenia, with on average 114 admissions per year – their admission rate is four times that of non-Māori females. They are also admitted at higher rates for mood and substance use disorders, but less so for anxiety and stress-related issues (Ministry of Health, 2016b). The overall admission rate for Māori men is twice that of non-Māori men. They were commonly admitted for schizophrenia at three times the rate of non-Māori, with 183 admissions per year on average. The admission rate for mood disorders was almost 60% higher than non-Māori (Ministry of Health, 2016b). In Northland, the Compulsory Mental Health Assessment and Treatment Act (1992) (also called the Mental Health Act) is used at higher rates than in other regions in New Zealand. During 2012-2013, almost 60% of Northland Māori in mental health services were treated under Section 29 of the Mental Health Act 1992 for compulsory treatment in the community compared to just less than 42% of non-Māori (Ministry of Health, 2016b).

These trends could be interpreted in several ways. Perhaps Northland mental health services are proactive in the community and services are accessible to Māori, or there may be a high predisposition to mental health issues experienced by Māori, especially men in Northland. Either way, an increased demand for mental health services by Māori is noted (Northland DHB, 2014b).

Support for the study was received from Northland DHB, specifically Te Kaunihera o Kaumātua, Chief Medical Officer, Māori mental health and mainstream mental health services. In addition to Te Tai Tokerau Primary Health Organisation and Manaia Primary Health Organisation with Te Rau Matatini Māori Health Workforce Development Organisation who overall provided support for the study.

4.4 Ethics

Health Disability Ethical Committee (Northern A) provided ethical approval for this research on the 19th March 2012 (NTX/12/02/006). Academic and cultural support was gratefully received from Dr Fiona Te Momo – Ngāti Porou, Senior Lecturer of Massey University and Dr Denise Wilson, Ngāti Tahingā, Tainui,

Professor Māori Health of AUT University. Both supervisors are Māori, they have conducted research with Māori, and they have supported Māori researchers in Māori centred studies.

The Māori centred approach to this study enabled Māori philosophical perspectives and the application of tikanga Māori. Ensuring processes and procedures were tika (correct), and people connected to the study were empowered, with some inclusivity of myself, as the researcher, in that we both (kaiuru and researcher) were culturally safe and protected during the study (Mead, 2003). Throughout the data collection and engagement processes of this study, a whakataukī (Māori proverb) resonated:

Ko tou rourou Ko taku rourou Ka ora ai te Iwi

(With your basket of knowledge and my basket of knowledge it will benefit the Iwi)

The inspiration from this whakataukī set a context for the relationships and interactions as I met with various people throughout this study, offering a sense of duty and respect that anything people would give would have value. There were various Māori ethical values and practices also imperative to this study, including the following seven cultural principles;

- Aroha ki te tangata: ensured the upmost respect of people, where they came from and enabling they were confident with their own space and to meet on their own terms.
- Kanohi kitea: the honour of meeting people face to face and the mana this generates.
- Titiro, whakarongo, korero: the need to be cognisant of my position and to observe fully by listening first and only then understanding when I have the right of place to speak.
- Manaaki ki te tangata: drawn from the principle of manaaki, is the expectation to share, host and show generosity.
- Kia tūpato: to act with care, whilst being politically astute, culturally safe and reflective about my status.
- Kua e takahia te mana o te tangata: in hospitality, not to trample on the mana of people or the korero provided,

- *Kaua e mahaki*: not to flaunt my knowledge but to find ways to share it. (Cram, Kennedy, Paipa, Pipi & Wehipeihana, 2015; Smith, 1999; Te Awekotuku, 1991).

4.4.1 Ethical Considerations

Ethical principles imperative to research included informed consent, privacy and confidentiality. Informed consent ensures people have the autonomy to voluntarily participate in research and, when doing so, they are fully aware of any implications (Hudson et al., 2010). Privacy and confidentiality require information provided by people to be kept confidential, and anonymity ensures no harm occurs to others. All interview information gathered were stored in a locked cupboard in my study and, thereafter, will be located at Massey University for 10 years and destroyed after this time. Informed consent processes and maintenance of anonymity will be discussed further on in this chapter.

4.5 Recruitment

The confirmation of ethical approval with a pānui (Appendix C) and information sheet (Appendix D) were developed to help provide information to people about the study. It was titled: *What is occurring with Māori, mental illness and health services?* and included information about the inclusion criteria. Participants needed to identify as Māori, be an adult (aged 18 to 65 years of age), resident in Northland, and have experience of mental health issues and of utilising health services. The pānui promoted the study and provided initial information, including a brief introduction of myself, and of my two supervisors Dr Fiona Te Momo and Professor Denise Wilson. The pānui also informed the reader that the study had ethical approval, and if they chose to participate, a recorded interview could be arranged. It included information about the process of written informed consent (Appendix E), confidentiality, voluntary participation for the interview and the distribution of findings when the study was complete.

During the consultation period and after discussion with local people in Northland about the best way to recruit people, I utilised a range of methods to share information about the study. I placed an advertisement in three local newspapers (Northland Age, Bay Chronicle and Northern News) which ran for a two-week period (Figure 1). I shared the pānui and information sheet amongst networks of health professionals, mainly by email. They then passed the information onto others and asked tangata whaiora if they would be interested to participate. Presentations about the study were held at Northland DHB Māori health and mental health services, as well as Te Tai Tokerau and Manaia Primary Health Organisations, Ngā Morehu Whaiora (Consumer Led Organisation), Hauora Hokianga and Te Mana Oranga (Māori Mental Health NGO).

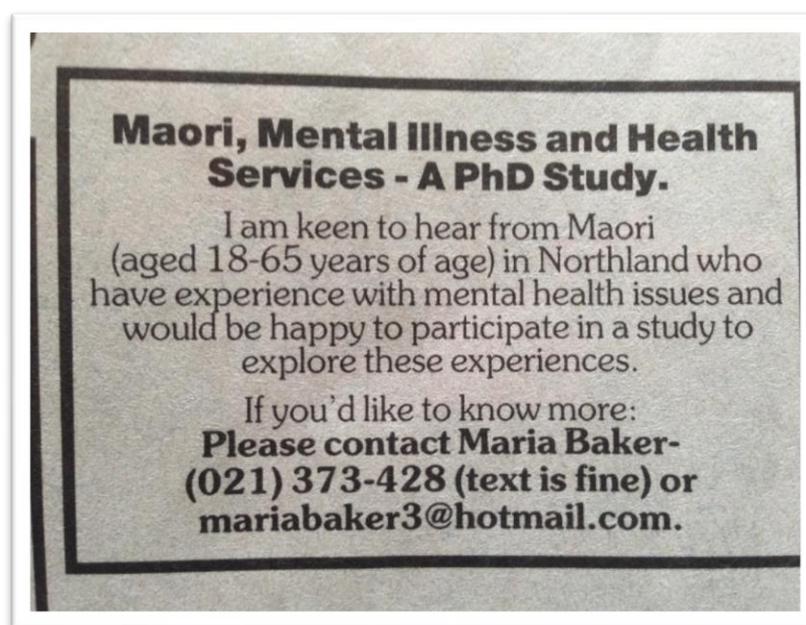


Figure 1: Copy of advertisement about the study in Northland Newspapers

The interest from local Māori was incredible in response to the advertisement in the newspapers. People whom I did not know texted, phoned and emailed me, wanting to talk about my advertisement and study. The first few contacts received were mainly from Māori with whānau experiences of loved ones with

mental illness and health services. They wanted to share their experiences as whānau.

I am 25 and I have had a wild adventure with mental illness in my family. I have a father with bipolar and a sister I would love to share with you my experience, you can call me or text me. (Text message received from person)

Māori with personal experiences of mental illness or health services also contacted me. Often they would text, while a few phoned and emailed. They would start by introducing themselves, stating they had seen my advertisement, and they then identified having had mental health experiences or a named mental illness.

Hi, my name is X, I live in X, I have experience with mental health issues, and there is a need to sort out local health services. One minute you're offered a pill, the next time you go to see them you are offered something else. Can you meet me? (Text message received from person)

Whilst the advertisement was gathering local interest, pānui and information sheets were sent via email amongst people who had received it, generating a snowball effect. Emails and phone calls were received from people motivated from this process and wanting to know more about the study. Varying discussions occurred as a result of this recruitment process, and new connections made with people who had an interest in mental health, Māori and mental health services. Not all people who made contact were able to fulfil an interview for differing reasons. Some cancellations made by people on predetermined times to meet were unfortunate, and while renegotiations were made to find more suitable times and places, for some the timing just was not right to fully participate in this study. For those I was able to meet, there was great generosity, especially inviting me, as a stranger, into their homes, and in the sharing of their intimate and whānau experiences.

4.6 He Tangata He Tangata He Tangata

Thirty people were recruited who contributed their perspectives to this study, they all identified as Māori, 53% (n=16) were female and 47% (n=14) were male, they were between 20 and 65 years of age. The majority had whakapapa

links to Northern Iwi of Ngāti Kuri, Te Aupouri, Ngāti Kahu, Ngai Takoto, Te Rarawa; Ngāpuhi nui tonu and Ngāti Whatua, with one related to Ngāti Porou (Gisborne). Of the 30 kaiuru, 67% (n=20) had lived experience of mental illness and mental health services, 20% (n=6)¹ were whānau with experience of supporting a loved one with mental illness, and 20% (n=6) were Māori practitioners who focused specifically on Māori with mental health and addiction issues. Those with lived experience of mental illness and mental health services, at the time of the study were unemployed. Half (50%) of whānau participants and all Māori practitioners were employed. The excerpts of kaiuru (participants) korero (discussion) are shared throughout this thesis. To maintain their confidentiality, yet honour their mana (status), I utilised Māori terms to protect their identities in their contributions. Kaiuru with lived experience of mental illness are identified with Māori names of birds; whānau by Māori colours and Māori practitioners by Māori native trees (Table 2).

Table 2: Pseudonyms Utilised to Represent Kaiuru Contributions

Kaiuru				
Lived experience			Whānau	Māori Practitioners
Kotare	Piwakawaka	Pukeko	Kahurangi	Kowhai
Kotuku	Kahu	Kereru	Kakariki	Puriri
Tui	E Kara	Ruru	Karaka	Manuka
Miomiro	Karoro	Kaka	Whero	Rimu
Porete	Kiwi	Kokako	Mawhero	Totara
Moa	Weka	Takahe	Waiporoporo	Titoki
		Karoro		

4.7 Recruitment Process and Written Consent

In the first contact with people, it was important to demonstrate manaaki (care and hospitality) and whanaungatanga (relationship building). When people contacted me I immediately phoned them to acknowledge their interest. My approach was one of whakawhanaunga (relational), to connect with them, to share about who I was, where I was from and why I was doing this study. Gratitude was also expressed for their interest. Once the initial introduction

¹ NB: Two also had lived experience of mental illness as well as whānau experience.

was complete and the person was willing, an invitation to meet kanohi ki te kanohi (face to face) was made. Then an agreeable time, date and place for the interview was established with each person. The venues for the interviews varied and included people's homes, Marae, local halls, restaurant, cafe and rooms situated in health services and at consumer-led services.

Upon arrival to the venue, further whakawhanaunga was conducted, especially at the first time of meeting kanohi ki te kanohi (face to face). He kanohi kitea (seen face) is important in engaging well with Māori, it is one thing to korero (talk) on the phone or by email but the seen face is where the connections are established and required for korero. Time was needed at the initial stages of the korero about no hea (persons origins), ko wai (person's identity) and to warm up to the korero (discussion) ahead. Karakia (prayer) was offered or supported, each person's response varied. Often, I took kai and refreshments with me or it was made available (for example, restaurant or café), which was as important for the process of whakanoa (removing tapu to make common) either following whakawhanaunga (relationship building), mihimihi (greeting) or at the end of the interview. It depended on each person's preference when the sharing of kai (food) and inu (drink) were to occur.

Once mihimihi and whakawhanaunga were complete, I then reintroduced the purpose of the study to the person(s). I gave the person a copy of the pānui, information sheet orientating them to the information enclosed. I then asked if they had any questions and if they still wanted to participate. All participants read the informed consent form that was provided and we discussed the information. Attention was drawn to the person's right to decline answering questions or to withdraw from the study at any time. Each person signed a consent form, which was stored securely in a locked cabinet in my office following the interview. Interviews took anything from one to three hours, with one taking five hours (over 2 separate interviews), taking into account tikanga, whanaungatanga and whakanoa.

There are no set number of interviews recommended in grounded theory, what is important is the data captured assists with theoretical saturation (Glaser &

Strauss, 1967). In this study interviews occurred mainly on a one to one basis with individuals. One interview involved the person's whānau member present and I conducted one focus group of six people, which contributes to theoretical saturation.

I had recognised early on in the study the possibility that information shared in the interviews may trigger memories of a sensitive nature and upset the person during the interview (Pere, 2006). All care and respect for the person was adhered to, noting that anything shared was to be kept confidential and that he/she could ask for a break during the interview or withdraw from the study.

Some kaiuru became upset during their korero, necessitating a break in their interview. For one person, I asked if they wanted to stop altogether. What I found typical was people retrospectively reflecting on their past, where some of the challenging issues associated with their experiences were deliberately and voluntarily shared with me. At no time was there a need to bring someone else (for example, whānau or key worker) into the interview to awhi the person. However, I would constantly check with kaiuru to see if all was okay.

4.8 Koha

The concept of koha is based on an exchange of reciprocity; along with awhi and manaaki, it is a cultural practice of recognition, of giving and receiving (Mead, 2003). I was fortunate to have received a Health Research Council Māori Health Research PhD Scholarship, so I was able to access monetary koha for people in recognition of their participation in this research. At the end of the interview, each person received a koha with an individualised card of thanks as an expression of the respect and value placed on their contribution to this study. My responsibility as an emerging Māori researcher is to show manaaki in this way. Koha was also made available to kaumātua for their ongoing guidance and wisdom, and for some venues and services who helped me during this study.

4.9 Data Collection and Analysis

Interviews conducted with people were the main collection method in this study. An open-ended request (for example, “Tell me about yourself”) to talk about their experiences caused them to reflect back to the first time they had experienced new, different and challenging thoughts and emotions. Within their korero, they described stories constructed from their past experiences of mental illness and health services, up to their present contexts and the strategies they had actioned during these experiences.

Most people were audio-taped, and for a few field notes were their primary records – all of these I transcribed. The audio recordings were useful. I had learnt from my previous study (Baker, 2008) that audio helped to build the overall picture of the person’s korero (discussions) and I could replay it if I needed to prompt my analyses in the coding stages and capture the basic problems and social processes that were used. The transcribed interviews were pasted into an individual scrapbook. This helped me to set about coding in an open and selective way and helped with writing up reflections in words and diagrams through the process. Figures 2 and 3 (p. 65) show two excerpts from the open and selective coding process in the scrapbooks: one from a person with personal experience, the other person provides his/her whānau perspective and experience.

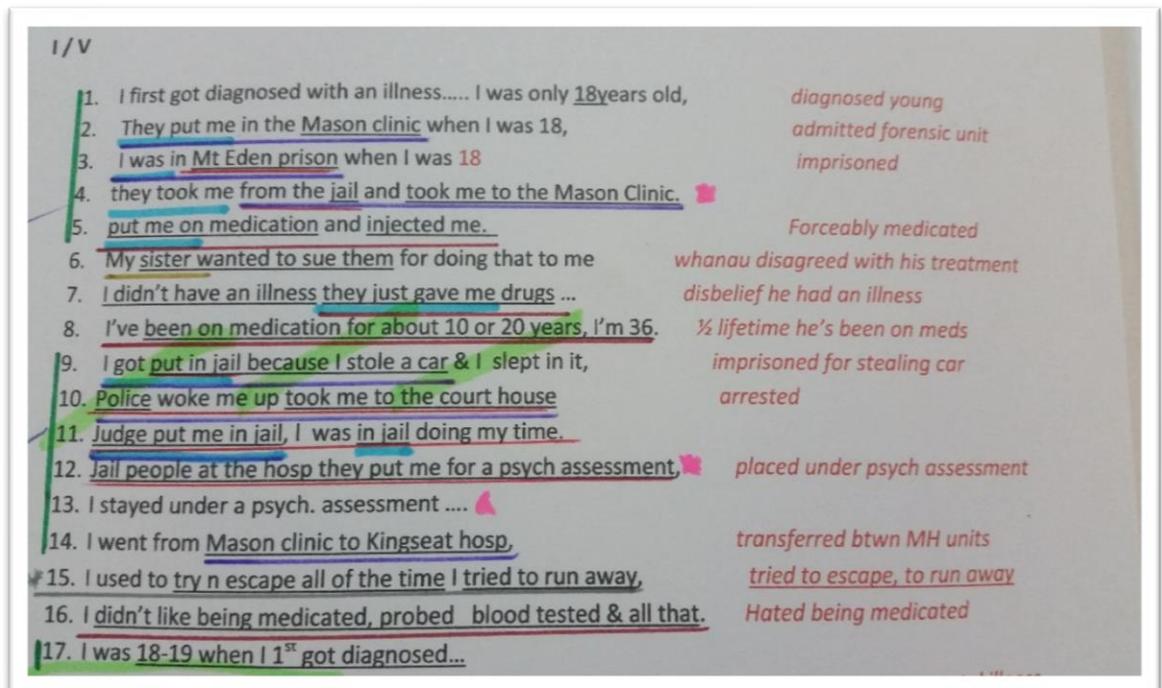


Figure 2: Excerpt from coded interview from a person with personal experience of mental illness in scrapbook

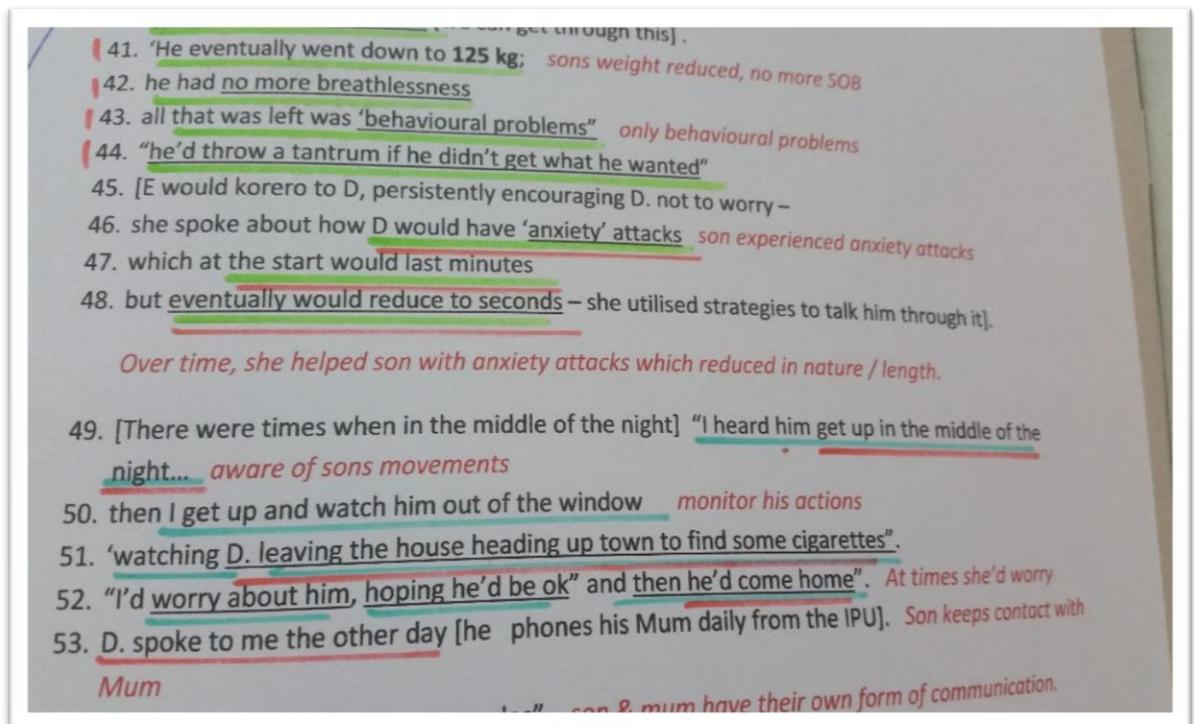


Figure 3: Excerpt from coded interview from a person with whānau perspective in scrapbook

Data were gathered at each interview and theoretical sampling helped to inform the questioning and considerations for subsequent interviews. Simultaneously, constant comparison of data with other data occurred which encouraged enrichment of meanings and processes to further explore and confirm emerging codes, concepts and categories (Glaser & Strauss, 1967). It helped to write memos, notes and to draw pictures during this process to aid in the analyses which provided an understanding of what Māori were going through, how they were coping and some of the strategies they used. Table 3 provides an example of a selection of codes and the emerging thoughts in the memo.

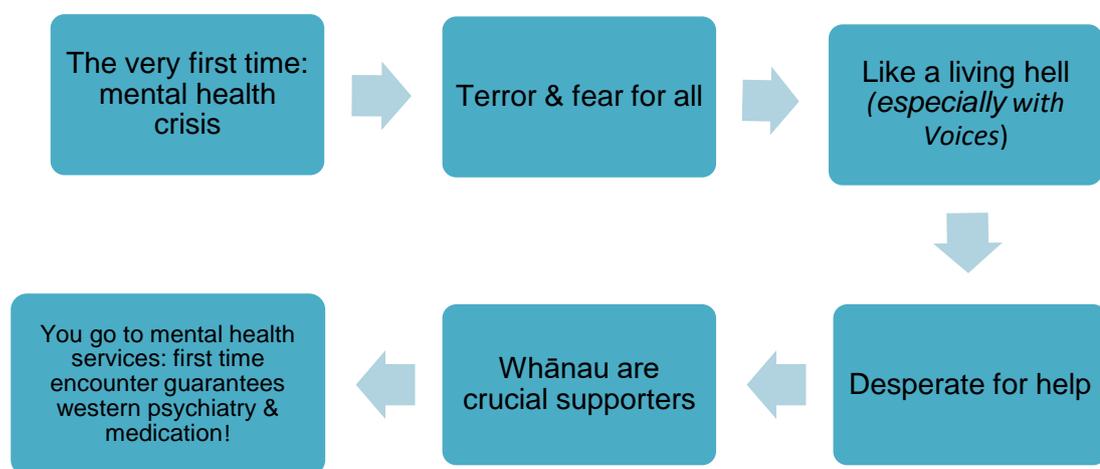
Table 3 : Selected Codes and One Working Memo

Codes	Notes (memo) & Picture
<p>They put me in (forensics unit)</p> <p>They took me</p> <p>Put me on medication</p> <p>I got put in jail</p> <p>Took me to court</p> <p>Put me up for a psych. assessment</p> <p>The put me in a boarding house</p> <p>They said, “You will be put on medication and this and this”</p> <p>Within the law they took me</p> <p>I ended up staying in the unit</p> <p>Took me to the ward</p> <p>They sent him away</p> <p>I never saw him for ages</p> <p>They came and took her away</p> <p>They used to take him away</p>	<p>They have the power to take you and to put you in an institution and to place you on medication. They are the authorities, police and mental health professionals. They will use the law to take people to put them in jail, in a forensics unit and in mental health unit. There is no personal say in the matter!</p> <p>The whole korero is about what was done to them by others, where they took them, where they put them and what they put them on. Each story or example was associated with the ‘putting in’ and the taking away by someone else to another place – meant for their benefit!</p> 

Note: Findings from study

During the comparative analyses, concepts emerged from the data, so I separated these onto post-it pad notes, which were made into posters that I placed on my wall to see how they linked together and to identify the relationships between them. As the process progressed, more concepts and categories emerged contributing to a wall of post-it pad notes and lines between each to show its relationship.

Figure 4: Turning Point: An example of post it pad note poster



Note: Findings from study

4.10 The Poutama Model

I previously used the Poutama Model (Figure 4, p. 66) in my master's thesis study (Baker, 2008) and, as a model to assist with data analysis in a grounded theory study, Wilson (2004) describes it best. The model provided a process to develop a substantive grounded theory informed by a Māori centred approach. Poutama is symbolic of a staircase; traditionally it represents the journey of Tane nui a Rangi who scaled the heavens in the pursuit for higher knowledge (Tangaere, 1997). This contemporary use of the poutama is common in the pursuit of knowledge by centring on Māori, tikanga (customs) and mātauranga (knowledge) (Tangaere, 1997). In Wilson's Poutama there are six steps that incorporate a Māori centred perspective and demonstrate the simultaneous coding and comparative analysis typical of grounded theory.

These steps commence with data collection ascending upward to open coding, then selective coding, theoretical coding and substantive coding, until the top step is reached with the eventual emergence of a substantive Māori centred grounded theory. The Poutama portrays the continual observation and performance of key activities that are associated with the researcher analysing the data. Upon each step, a person is expected to reflect on the data's continual transformation that occurs while being coded and sorted during each phase.

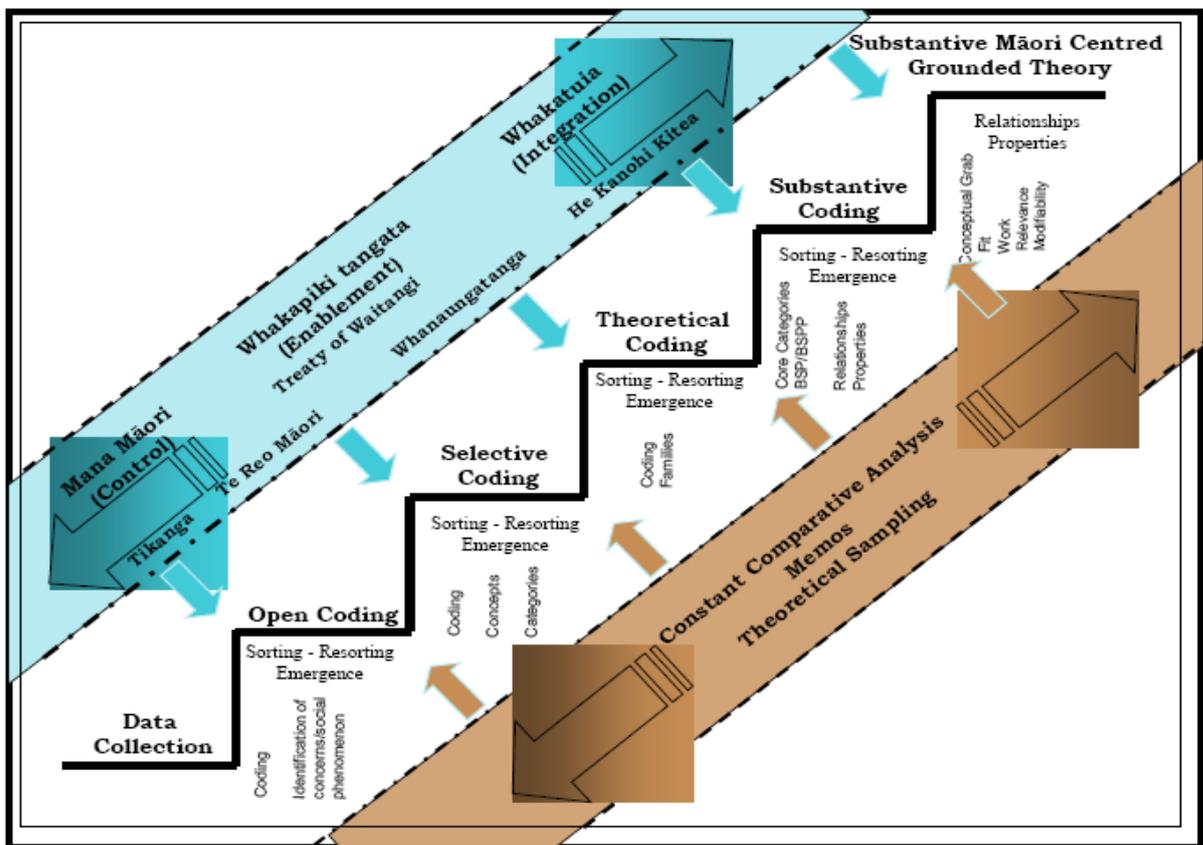


Figure 5: Poutama model

Note. Reproduced with the permission of Wilson (2004).

On the blue horizon to the left of Figure 5, guiding the poutama, are the pertinent principles associated with a Māori centred approach to research, mana Māori (Māori control), whakapiki tangata (enablement or empowerment) and whakatuia (integration). In addition, Wilson (2004) has included the Māori principles of tikanga, te reo Māori, whānaungatanga and he kanohi kitea to

appreciate the important practices and processes that are important to Māori. Te Tiriti o Waitangi is also included to honour the obligations to Māori, and to stay cognisant of the evidence that has continued to form as part of the process since Te Tiriti o Waitangi, and to consider the impact of colonisation for Māori in relation to the consequences of research upon Māori. This poutama encourages a Māori centred dogma that accepts the researcher returning to prior achieved steps to revisit and revise data by descending and then re-ascending the steps until the emergence of a substantive grounded theory.

4.11 Data Analyses

Data analyses involved constant comparative method of the interview transcripts (Glaser, 1967) as earlier discussed. The method of coding allowed the data to be broken down, conceptualised and reconstructed in new ways, whilst enabling myself (as the researcher) to understand the experiences of ngā kaiuru from their viewpoints. In taking this perspective, the thoughts and actions of Māori were established. Table 4 illustrates some codes or experiences as told in the person’s words in relation to his/her first experiences of mental health issues, and with being locked up.

Table 4: Selection of Codes Regarding First Experience and Being Locked Up

Selection of codes regarding first experience	Selection of codes regarding being locked up
I was freaking out I was scared First, we knew of it was the behaviour I was 18 I was scared Feels like I'm being molested Felt like I was being possessed Bad experience I was in a nightmare At first, I was scared It was scary I'd be scared all the time I was scared, I was unhappy First break down First episode was at 16 years	Locked up in a psychiatric hospital Left me there for about 3 years I was helpless Police intervened Ended up in hosp. I took him to (service) I went to see a friend I would end up in jail Being locked up is part of it I was locked up Been there ever since Sticking him in psychiatric hospital We were there when the police came I went to psychiatric hospital

Selection of codes regarding first experience	Selection of codes regarding being locked up
I felt like I was being taken over It was enough to frighten me I thought I was going to die She got scared of me They were frightened of me I was scared – he was this other person I was in a nightmare time First started happening to me Started seeing things they weren't pretty I was hearing voices	Sent me there I went away, and I would be up all night Under a psychiatric assessment Locked in a room Lots of stress You go into a psych ward They just lock you up

Note Findings from Study.

In the beginning of the data analyses, open coding enabled a level of abstraction to help identify concepts and to summarise the meaning of a series of statements made by kaiuru. Theoretical sampling was utilised to inform the constant comparative analysis of the data. During the iterative process, I needed more information to fully understand the emergent patterns associated with “wairua”. A decision was made to interview Māori practitioners who worked with Māori with mental illness to enable a better understanding of the conditions and dimensions about what was occurring spiritually amongst Māori with lived experiences and whānau experiences with mental illness and mental health services. As an outcome, the subcategory *addressing wairua* was formed. Table 5 provides an example of my coding and memoing regarding the concept of wairua and how the wairua needs of kaiuru were identified.

Table 5: Working Memo about ‘Wairua Needs’ of Kaiuru

Kaiuru codes	Māori practitioners’ codes	Excerpts from Māori practitioners	Working Memo
In the system Locked up They use force to apprehend System is detrimental Absolutely angry My mum was scared of it Thought it was mākutu Mum thought I was Matekite Hear voices of my tupuna I always could see things My wairua was ignored Old Māori beliefs Daily struggle Karakia	Wairua is diminished Caught up in the system Medication blocks the wairua Pouritanga Reconnecting to whānau, whenua for healing Limited control Māori struggle Spiritual connection Māori healing Māori connect better with Māori Medication harming Māori Guardian of wairua Wairua is everywhere	“You have that clash, Māori have been drawn so much into the medical side, and they are programmed to do this and that. I was with a whaiora the other day, been on medications all of his life. To me his whole ahua had been trodden on.” (Rimu) “We created an environment for Māori. We used the wharenuī, we used the whānau. We would spend a lot of time with them. We’d go to the water. It would take us several weeks to get someone into the right place. Back then we had control over the environment. We were able to attend to those spiritual things and able to work much closely with their person and their whānau. Now it’s more challenging with mainstream.” (Manuka)	What are the key properties? Māori are saying their wairua is impeded by mental health services & medication. Is part of being restricted also about being compromised spiritually? Māori are seeking ‘spiritual’ solutions to also help with their resolve mentally.

Note Findings from Study.

It was through the application of constant comparison, that a number of subcategories and concepts, with a number of indicators and properties were identified and linked. When no new insights about a concept were generated, the concept was considered theoretically saturated. Coding involved the formulation of categories, which are to stand alone as a conceptual element of the theory (Glaser & Strauss, 1967). The process involved searching for meaningful units of data that could stand on their own and were associated with the overall purpose of the study. Through coding, the data were grouped into final categories that represented key cultural and psychosocial issues and patterns that were analysed by comparing them with one another, so relevant themes that addressed the research question could emerge.

Coding was conducted until saturation was reached. This enabled a full explanation of the category and process, and ensured there was no new information or meanings to be discovered from the ongoing analytical process (Glaser & Strauss, 1967; Glaser, 1978). As previously mentioned, to determine the importance of data, four reflective questions aided theoretical sensitivity:

1. What is this data a study of?
2. What category does this incident indicate?
3. What is actually happening in the data? (Glaser, 1978).
4. What basic social process was at work in this particular situation? (Wilson, 2004).

Table 6 (p. 72) provides an example of the use of these reflective questions following an interview with kaiuru who had supported two whānau members with experience of mental illness. The reflective questions helped to determine what the main concern was in this situation (Glaser & Strauss, 1967).

Table 6: Example of analysis following an interview from a whānau perspective

Prompters to data analyses	Memo from interview
<p>What is this data a study of?</p> <p>What category [or property] does this incident indicate? and</p> <p>What is actually happening in the data? (Glaser, 1978)</p> <p>What basic social process was at work in this particular situation? (Wilson, 2004)</p>	<p>This memo captures one person and focuses on her experience as a whānau member (with a parent and sibling). It revealed her helping, where she could, to awahi her whanaunga and their mental health experiences. The two situations differed:</p> <ol style="list-style-type: none"> 1. She initiated contact with mental health services for her parent. The consequence of this was medication and an admission to an inpatient mental health unit. Since then, whānau members, acknowledge her for doing this, and being the support for her parent. She is contacted by whānau, to ascertain the parent's progress. She is now the monitor of his status (she monitors him, keeps an eye on him). 2. Her parent initiated contact with mental health services for her sibling, the consequence was also medication and an admission to an inpatient mental health unit. The difference here is that the parent initiated the contact, but subsequently pulled the sibling out of mental health services, as the service did not listen to her about the giving of medication. <p>In both situations, the consequence of contacting mental health services is: medication and an admission to an inpatient mental health unit.</p> <p>One situation, the intervention is acceptable and recognised by whānau as the right thing to do at that time. The second situation, the intervention has caution wrapped around it, due to the sibling's youthfulness and the whānau dislike for medication. At the same time, in this second situation mental health services did not engage the whānau, even though whānau were physically present during the admission. They were left out! Medication was given to the whānau member – even when the parent said, "Hey I want to be told and involved in her treatment options". This did not happen; the parent was concerned about the consequence of the medication given to the child – so the parent pulled her away from the service.</p> <p>This shows whānau finding means and ways to help their loved one deal with mental health issues at the time. They do look for help, they will make contact with mental health services. But, they struggle when the mental health service takes over. It is portrayed as a separate entity, with its own ways and rules imposed upon their loved one. It is about what whānau will do when a loved one is unwell. They will do what they think is right; they will do what they can. They will not leave their loved one alone, they will go to them, to be nearby them no matter what it takes. They will say what they don't like and what they do want for their whānau member. Even if it means, challenging the institution where the whānau member is engaged or resident within.</p>

Employing the coding families to analyse the variables helped identify what the main problem and basic process were in regard to Māori experience of mental illness and mental health services. This involved a consideration of which variables indicated cause of their particular situation and which variable indicated consequences. I had also included Wilson's (2004) query of what basic social process was at work in this particular situation.

Typical of a Glaserian (classic) grounded theory, one category had formed through the saturation of data (Glaser, 1978). The core category is identified as the main problem amongst the participants, that reoccurs, yet helps to organise and hold the data together. In the constant comparison methods, the core category *Being Restricted* had real grab for what was occurring amongst Māori in this study.

A basic social process explains the variation in behaviour and provides for the organisation and integration of a grounded theory (Glaser, 1996). Rigour is established when grounded theory meets the criteria of fit, transferability, and when there is a strong probability the research findings have meaning to others in similar situations. Fit refers to the relationship of the core category to the social problem and its ability to account for most of the variation in the behaviours used to address the problem (Glaser, 1978). Relevance and work are defined as the relevance to the core category to the data, and the ability of the category to work the other concepts so that there are interconnections (Glaser, 1978, 1992).

In the next chapter, further discussion is had on the core category and subcategories. The core category of *Being Restricted* was identified with its subcategories of *turning point*, *being apprehended*, *physical compromise for mental stability* and *addressing wairua*. *Seeking Solutions* was affirmed as the basic social psychological process Māori with mental illness and mental health services, utilised to overcome their main problem of *Being Restricted*. *Seeking Solutions* provides for a theoretical summary of what Māori are doing to overcome *Being Restricted*. It provides a perspective that Māori are influenced by the desire for change and, underpinned by a sense of hope, are acting in

ways to fight the mental health system, or to adapt to parts of it in order to achieve their aspirations.

4.12 Concluding Comments

Grounded theory has the ability to provide a snapshot of what people do, what their primary concerns are and how they deal with their concerns. Glaser and Strauss (1967) cautioned grounded theorists to be wary of their own ideology, due to the potential for directing the examination of data and its eventual emergence of theory. Yet, to understand the cultural nuances from where the data is collected, is to afford it the genuine meanings that are relative of the people in the study and their possible ways of thinking. By centring this grounded theory research on Māori, and as an emerging Māori researcher with some knowledge of the context of this study, the methodology and methods helped to provide another translation and context of the information that was gathered without forcing the data (Tarrozzi, 2013). Essentially, an opportunity was provided for an inductive process and methodology whereby theory was grounded in the qualitative data that mattered to the people in this study.

CHAPTER 5 – FINDINGS SECTION

5.1 Introduction

The manner in which this chapter is presented, aims to provide immediate engagement with the reader, of a Māori-centred grounded theory approach. The presentation is one which is focused on the findings of the study and this thesis by explaining the substantive Māori-centred grounded theory - *Seeking Solutions to Being Restricted*. Commencing with the core category of *being restricted*, identified as the main problem Māori struggled with in this study and explained across four main subcategories (Figure 6).

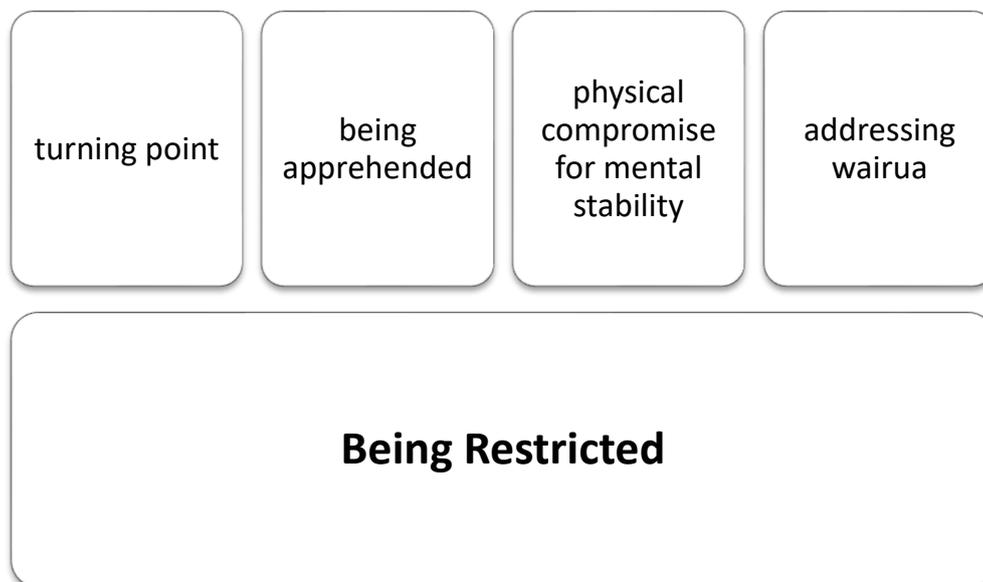


Figure 6: Four subcategories that make up Being Restricted

The first subcategory, the *turning point*, outlines the personal meanings and ways Māori made sense of their situations at the first onset of a mental health crisis. Seeking help from mental health services incurred *being apprehended* and *physical compromise for mental stability*. The second subcategory, *being apprehended*, outlines the experiences of Māori being taken or sent away, distanced from their whānau and locked up; thereafter a lack of control continues when engaged with mental health services. *Physical compromise*

for mental stability is the third subcategory and highlights the dominance of psychiatric medication with Māori as part of mental health treatment, which compromises their physical and spiritual wellbeing.

Seeking Solutions shows Māori *addressing wairua* as the fourth subcategory which highlights the importance of a person's wairua in the healing for Māori, and that regardless of where Māori are located they will seek strategies to heal their wairua. *Addressing wairua* provides perspectives of Māori practitioners who help Māori to address their wairua and the challenges in doing so when employed in mainstream mental health services. The basic social psychological process of *Seeking Solutions* highlights various behaviours amongst Māori that have been influenced by hope and change in this study. It involves a blended process of seeking help from mental health services, whānau, and Māori practitioners. It also identifies the double bind that underlies how Māori seek solutions, specifically having to fight for change or adhere to the mainstream mono-cultural system when solutions are sought from mental health services.

The first presentation in this chapter discusses the four subcategories of the *turning point, being apprehended, physical compromise for mental stability, and addressing wairua*, and their respective properties.

5.2 Turning Point

This section explains the subcategory *turning point* with its properties of confrontation, varied explanatory beliefs, mental and emotional struggle, internal hell and locked into memory (see Figure 7, p. 77). The *turning point* is the first-time experience of a mental health crisis; it is confrontational and remains stored in a person's memory as the first time they became unwell. It is further prompted by subsequent episodes of mental illness.

I had a major panic attack, I thought I was going to die. That was the first concrete evidence that there was anything wrong. My life has never been the same since. It's like the lid came off Pandora's Box and [I've] not been able to stuff everything back in. (Kereru)

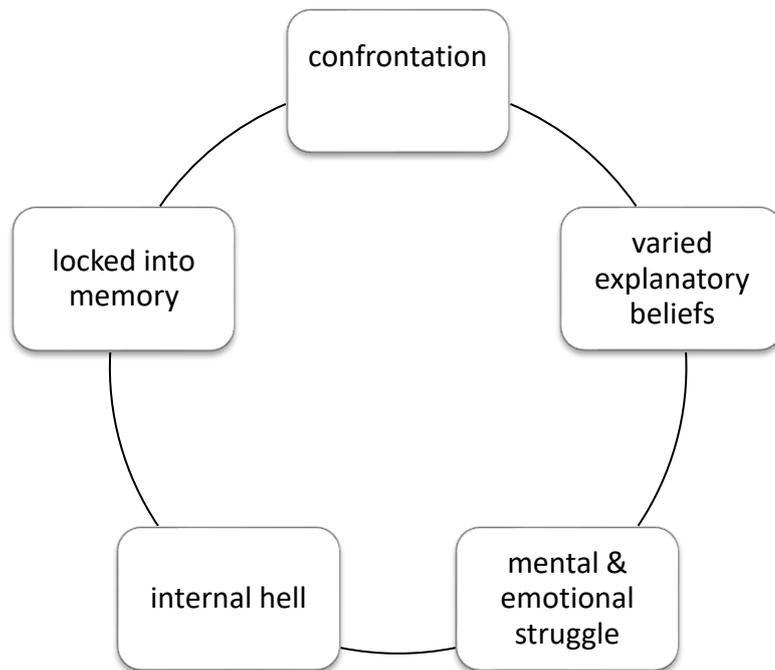


Figure 7: Turning point

The *turning point* confronts whānau, as their loved one’s personal experiences and behaviours exhibit some of the most challenging thoughts and feelings never witnessed before. These are manifested by uncharacteristic behaviours, unusual talk and radical changes which tell whānau things are not right with their loved one.

Couldn’t even talk to her, she was talking like she had a demon in her or something, she had those crazy as eyes. (Kakariki)

Then he came to me with his black eyes at the [mental health] unit. (Whero)

Subsequently it is the people who are close by a person experiencing the *turning point* that will want to stay close. By doing so, they show their aroha (compassion) and manaaki (care). The following example depicts an appreciation for the closeness of a whānau member in helping a person to

cope with the unusual experience and, in doing so, being comforted and reassured.

My mum would have to rock me to sleep I'd be so scared, I'd be scared all the time, my head felt like it was going to open up and things would come out of it. Every time I closed my eyes I could see ugly faces. (Miromiro)

5.2.1 Varying Explanatory Beliefs

Varying explanatory beliefs about why the *turning point* eventuated were held by kaiuru. This included an accumulation of interpersonal and life's challenges, the impacts of social determinants, trauma and substance use.

She was becoming unwell when she was a young woman, some of that nature stuff you know, hormones, as soon as she had her periods she went pōrangī. (Waiporoporo)

I was doing too much work at the time. I was probably doing 18-20 hours a day six days a week. I had stuff-all sleep and used to drive for miles too. I parked the van up and just lost it. (Kotare)

Engagement with mental health services, at the *turning point*, meant personal experiences reframed into mental illness defined terms and concepts, providing for a rationale of what occurred. Reframed as a mental health crisis, which was thereafter situated in the common schema of making reference to an illness model and one of disturbance.

I didn't know I had been experiencing a psychosis or a neurosis or whatever any of those things were called then. All I knew was I was living a nightmare, it wasn't until after mental health services did I start calling it a mental illness. (Pukeko)

5.2.2 Mental and Emotional Struggle

It can be especially difficult to understand what has occurred mentally and emotionally when the internalised struggle overwhelms the person's wairua, with feelings of being taken over and of spiritual possession.

It felt that I just went overboard. I locked myself away in my head, and yet I thought I was trying my best. But really, emotionally I was just knackered. I just started crying. I just couldn't control it or me. (Kokako)

It felt like they were trying to rip my legs out of my body, I had this burning feeling all in my head, it was scary. I was trying to tell my friends there's something not right, there were evil things on the side. I couldn't breathe, strangling me. I could see this thing with six arms attacking me spiritually and that started it. It was like thoughts I had weren't mine. It was like I was possessed. Oh, so many thoughts. [It was] like heaven and hell – it was scary. I wouldn't wish that on my own worst enemy. I started hearing things and I would start seeing black shadows that would stick to my eyes. Every time my eyes would move, it would get darker and darker and everywhere my eye moved it just was not nice. (Miromiro)

5.2.3 Internal Hell

Confusion and disorganisation caused by compelling thoughts, feelings and emotions, the person feels caught in a mental health crisis, alike an internal hell, preoccupied by voices, or unusual feelings and emotional isolation leaving the person with little capacity for self-control. This state of being is especially so for voice hearers where mental arguments are held with invisible forces that are hard to resist. They are pulled into an unfamiliar situation that challenges the person and his/her perspective of reality. This overwhelming battle adds to the ever-challenging tension in the person's state of confusion and frustration, and so contributes to the feeling of powerlessness.

I started hearing people arguing with me, I remember that there were times I heard people call me a (swear word) and I didn't understand. But in my head, I would argue with what I now know were voices but I didn't know that then. I'd get really angry because in my head they were calling me a X. Why did they not want me there? Why were they angry with me? I couldn't control it and then my body started moving in all sorts of funny ways I didn't know how to stop it. I remember my roommate saying, "Stop making that noise. I'm trying to get some sleep." I didn't know what to do, I was so scared. (Kotuku)

Voices are often negative and derogatory in nature, pulling a person into an isolating world of mental conflict to which only the voice hearer is privy. This may manifest physically where the person will attempt to externalise parts of the haunting voices so as to relieve oneself of the mental and emotional distress, though often with little resolution.

I used to hallucinate a lot, I didn't know what the hell was happening. When I started hallucinating, it wouldn't stop sometimes, and I would whack [bang] my head trying to relieve it all. I was hearing and seeing things. It wasn't clear, sort of a mumble in my head. It was enough to frighten me. (Weka)

There can be little appreciation for the connection between a person's mental status and his/her disengaging actions with people around him/her. This can be complicated by already strained interpersonal and whānau relationships, which can be contributed to confrontation.

I had a nervous breakdown as I had problems in my relationship and it put me in the mental health system and I've been there ever since. (Weka)

I have suffered from battered women's syndrome and post-traumatic stress from years of being bashed. (Pukeko)

5.3 Summary

Turning point experiences are traumatic, forever locked into the memory of a person about their first-time mental health crisis. It can be triggered each time a person has contact with acute mental health services or there are glimpses of mental or emotional struggles that emerge again. It can take time from the turning point to understand mental illness and to deal with the adjustments a person is required to make in order to cope. Adaptation is needed if a person is to manage and move forward to recreate his/her life. Often compromises are made around other people's perspectives and expectations. In varying ways this can motivate a person's personal recovery to mental illness. Transforming the *turning point* into something useful occurs by talking about it, recognising

the experience and the opportunity to share feelings related to it. Connecting a person's current status and recovery with the turning point may help to separate the past traumatic event that initiated the identification of a mental illness from the present and to consider the learning from it for the future.

5.4 Being Apprehended

Māori are frequently sent to mental health services, often by force yet with good intentions by others. Being apprehended typifies the Māori experience of the type of restrictive care provided by mental health services. *Being apprehended* is associated with the police, the legal system and the mental health services, all working in tandem to take or send Māori away. This section explains the subcategory *being apprehended* along with its properties of being taken and sent away, being locked up, and lack control (see Figure 8).

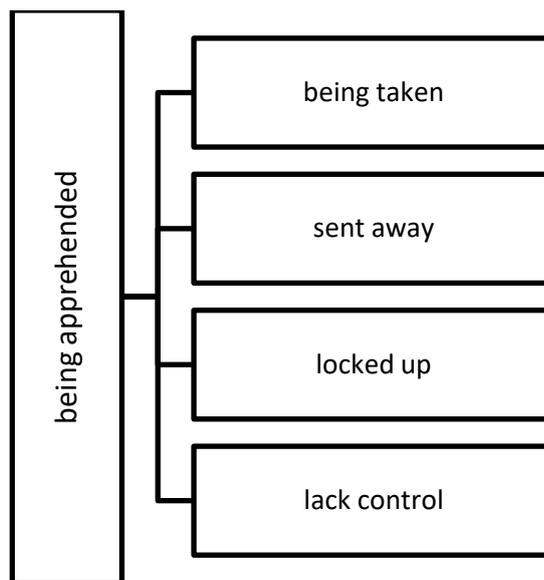


Figure 8: Being apprehended

I couldn't stop myself from crying and I ended up being taken to the local hospital. They asked, "Have you been taking drugs?" I said, "No." "Have you been drinking?" I said "No." I asked them, "Are you going to hurt me?" They said, "No." Then they gave me an injection and I went to sleep that night. The next day I was really quiet in my head and everything was just calm I couldn't believe it. (Kotuku)

Stories from the past of mental health institutional care reinforces the perspective that there is a basis of control that is taken over from Māori. Yet, it is surprising to whānau that their loved ones are overpowered by mental health services, as it is not something whānau condone or are really aware of when they seek help for their loved one from mental health services.

He had years of shock treatment, he was bashed in there, all that sort of stuff. I don't think he was that bad, but he was earmarked as bad. One of the stories was he was on the concrete floor all night, kicked and you know. (Kahurangi)

He was admitted to [mental health institution] for six weeks. They were nothing but a bunch of bouncers. He had smoke burns burnt into him. So, I made a decision to get him out, and the kaumātua supported me. (Whero)

5.4.1 *Being Taken or Sent Away*

Being taken or sent away is inadvertently initiated by whānau when help is sought from mental health services for their loved ones. Often, the outcome of seeking help from mental health services will result in Māori being detained or locked up in a mental health unit for extended periods of time. It involves having to stay in the facility and losing almost all freedom.

Mum was being taken away by the authorities, that time she was sent away for about six months. (Waiporoporo)

That's when they got a hold of mental health services and they took me to the mental health unit. I was there for about a month. My wife was upset that I had been secluded whilst I was in there. (Kotare)

There's a law and that people in there, if they want freedom, they have to do certain things before they are allowed to leave. They have to stay there; I was in a hurry to get out of that place before it happened to me. That's sad aye, they got a lot of our own people in there, but they're not allowed out indefinitely. (Weka)

Whānau seeking professional help does not necessarily suggest power dynamics shift between person and whānau. Regardless of the length of time of engagement with mental health services, whānau experience a sense of powerlessness when their loved one is engaged in mental health services. Whānau tend to be left out of consultations by mental health professionals, and mental health services often will determine the availability of solutions for their loved one based on a western medical model of treatment.

Mental health services would have discussions without whānau involved and they'd determine solutions for him. It wasn't until psychiatrist [name removed] did I get an understanding about medications. Because of his illness, he was on high doses of an injection. (Whero)

Accumulated stress can be caused by engagement with mental health services which can influence the relationship between mental health services and whānau. In turn, whānau will fight the mental health system by resistance, especially when their aspirations for their loved one are constantly minimised by the over importance of the mental health service's viewpoints on what is best for their loved one.

Mental health professionals turned up to my house to talk to me. I was looking for a punch line, so I trespassed them – they didn't listen to anything I said. There was a suggestion of a partnership between rongoa and the non-Māori medicines; they knew how I felt about their medications. But really, they were there to reinstate the Pākehā medications regardless of what I had to say. (Mawhero)

Being taken or sent away to mental health services causes disruption to whānau, particularly in their relationships. Whānau who were physically

distanced from each other due to the policy and culture of individualism in healthcare facilities provoked long-term relationship problems of disconnection.

I remember Dr X and the police they took him away, and each time they did it we wouldn't know when he'd be back home again. In the end, he was institutionalised and away from us for years. (Kahurangi)

One of the most challenging experiences was for parents when they were taken away from their tamariki or their tamariki were taken away from them due to their mental health situation. Separation caused by being sent away impacted the whole whānau, where for some there were hurtful consequences from separation in the parent and child relationship.

That was one thing I hated in becoming sick was the kids being taken off me all the time, they thought I would hurt them, or hurt someone else. I never did. (Tui)

Conversely, the impact upon young whānau members who were witness to parental emotional and mental struggles would also be one of the most challenging life experiences. Particularly so from the child's perspective who may not understand what was occurring at the time or what to expect from the parent which fostered latent perspectives about mental illness and mental health services.

I had one son who saw everything, he has this vengeance toward mental health services, and I said to him this is not your walk. (Pukeko)

I never let my kids hear an argument not like I did. I heard everyone, I heard every scream, I heard every lie that my mother said to my father whilst she was unwell. (Waiporoporo)

5.4.2 Being Locked Up

Being taken or sent away involved apprehension by police and mental health services. *Being locked up* is part of a continual cycle of control over Māori where they are 'locked up' in institutions, distancing them away from whānau and familiar surroundings. The foreign environment of mental health units further isolate Māori. For many this process engenders a lack of trust in the health system and in those who initiated the entry to the mental health service. When there is police apprehension to mental health services, mental health professionals are seen as the legal agents who pursue people in their homes and communities.

When I get unwell I usually stay in the ward for about a week. I've been there twice now, but usually my Mum has to come and rescue me so I can get out quick. Mum has always said she doesn't like me in there because you don't really know what they are go to do to you while you're there. (Kiwi)

Mental health professionals would keep coming to my house, knocking on the windows, turning up daily looking for my son. One day they came over, and I hid in the house, I saw them wandering to the back of the house. They came in the night too. (Whero)

They can put you back in the hospital if they think you are unwell. I've been away from the mental health unit for three years, only because I do as I am told. (Takahe)

Being locked up is a form of punishment for some wrong doing and trouble. In these circumstances, the person or his/her whānau will have little say in the decision-making processes. Physical force and restraint can be applied by mental health professionals to elicit compliance with the mental health system and, as a result, hinder the person's physical, cultural, social and spiritual freedom.

They held me down, they kept me down and they gave me an injection to whip me around, I couldn't do anything. (Ruru)

I did something wrong so they put me in [name removed] prison when I was 18. They took me from there to forensic unit and put

me on medication. I stayed there for a while, then I was taken back to prison and then back to the psychiatric hospital. (Takahe)

Fear of being held in a psychiatric hospital and the desire to gain freedom and control motivates a person's attempts to escape – often involving a willingness to take desperate measures to be free. While mostly unsuccessful, the escapes will result in Māori being recaptured, apprehended, and placed in a secure facility for treatment.

I was freaking out, I was trying to jump the fence, and I was thinking they were going to lock me in jail. I thought it was a jail, they were dosing me up with medication. They were giving me an injection in my butt and I turned around and said, "No! I don't want it." (Tui)

I kept on getting into trouble [and] that's why I ended up in the lock up unit because they said I had a history of AWOL [absent without leave], you know taking off all the time. I just wanted to run off. I kept taking off and they locked me up completely that time. (Piwakawaka)

What follows is that Māori are made to adapt to the expectations set by others and to conform to routines through increasing contact with mental health services. They will understand in time that being apprehended is part of the mental health treatment process. However, for some the 'unwritten' terms of conformity are learned the hard way; with the inevitable expectation that it would be better to socialise to the Western medical and biological approaches to treatment or else they indeed will be re-apprehended.

You have to be compliant with the doctor and the nurses, if you go along with them they'll be happy with you. Just agree with the doctors as much as possible. (Ruru)

The institutional framework is the same as a prison, the mental health unit is like a prison state which is evil, and it takes your spirit and your freedom. (Kaka)

Transactional care by mental health services is aided by mental health professionals who act in ways to ensure Māori engage in the service. This

initially may alter Māori attitudes toward mental health services believing they are acceptable to Māori, particularly if they held prior discriminatory attitudes.

At first, I was scared. I thought, “OMG [oh my god]! They’re going to send me to a loony bin. Oh no, I’m going to be one of those nutcases. But not even [no], they were really awesome. The support of the team was awesome, they were really kind, and they gave me medication. (Miromiro)

However, Miromiro’s experience is not always the case. Mental health professionals may show little interest in Māori nor understand their goals, giving importance to the mental health system and its dominance in care. This will often result in Māori disengaging with the mental health professional and thinking less of the mental health service.

I got in contact with my support worker but I didn’t feel she was going to help me at all. She tried too, but it’s like I got this feeling – you know I asked myself, “Are you bothered to be here?” So I felt uncomfortable, as I still go through stuff .(Piwakawaka)

5.4.3 Lack Control

Lack control is multifaceted, involving limits on freedom and compulsory medical treatment mandated by the Compulsory Mental Health Assessment and Treatment Act (1992). Health professionals are the agents of control who expect Māori to socialise to and comply with multiple expectations within the mental health system. For Māori living with emotional and mental turmoil this lack of control and freedom perpetuates a sense of powerlessness. This leads to their having to reframe being restricted in a way that aligns with and accommodates the mental health system and the treatment that they receive.

That was me locked up again. I had this real hatred about what could go on in mental health services, and now well I have had to embrace it and so I started to go to them, and I have found they are not as harsh on me like they were before. (Koreke)

I was having panic attacks, my whānau had rang me with some bad news. So I rang X can I go to hospital? I wouldn’t have done

that before. So they organised for me to go to respite, I was there for a week. (Weka)

Mental health care becomes synonymous with being taken or sent away, admitted to inpatient mental health units, detainment, and loss of control and freedom. The control exerted by mental health services occurs in acute inpatient mental health units and increasingly in the person's community with compulsory treatment orders. Such orders ensure Māori continue treatment according to terms set by mental health services.

They took me to the IPU (inpatient mental health unit), they didn't lock me up in a room, and they spoke to me and said we want you to stay here. I ended up staying there for seven months. They put me on the same medication but probably increased it, and gave me blood checks. That was strange I didn't understand what that was about. (Takahe)

I remember being taken by the cops, one person on that side and the other on the other side. You are treated like a criminal. I remember being in the cop car. I remember thinking why do they have to bring the police? I get to the unit, and there's X, and I think far out, this is unnecessary, why on earth do the cops have to come and fetch me to throw me into that place? (Tui)

5.4.4 Summary

The control exerted by mental health services is continual and longstanding. Māori are frequently sent to mental health services, often by force, yet intended by others for their own good. *Being apprehended* typifies the Māori experience of the type of confined care that is provided by mental health services. *Being apprehended* is associated with the police, the legal system and the mental health services, all working in tandem to take or send Māori away.

To conclude this section, the role of the state via legislation and mental health services is utilised to place constraints upon Māori with intent for their mental wellbeing. By being taken or sent away to mental health services, Māori are distanced from the familiarity of whānau and home. Impeded freedom by the formal structures and constraints of mental health systems disrupt the ability

of Māori to act freely. *Being apprehended* contributes to being restricted by mental health services for the realisation of one's mental health. It is this that perpetuates the stigma of the mental health system toward Māori.

I hardly see the psychiatrist, when I do they just ask me questions. They keep me on a CTO [compulsory treatment order] for some reason. I have been on it for two years. I think so they can put me back in the hospital if they think I am unwell. (Koreke)

The funny thing was every time I went to hospital I had my bag packed especially when I knew the police were coming. I used to think why do they have to bring the police? The last time I went, I knew I needed to go, but they still sent the police, man that annoys me. (Tui)

5.5 Physical compromise for mental stability

This section extends from *being apprehended* and explains the subcategory *physical compromise for mental stability*, the consequence of being restricted in mental health services with properties of being drugged up and physically compromised (Figure 9, p. 89). Bargaining for change and whānau watch are part of the basic social psychological process Māori undertake to seek hope and to change the physical compromise caused for mental stability.

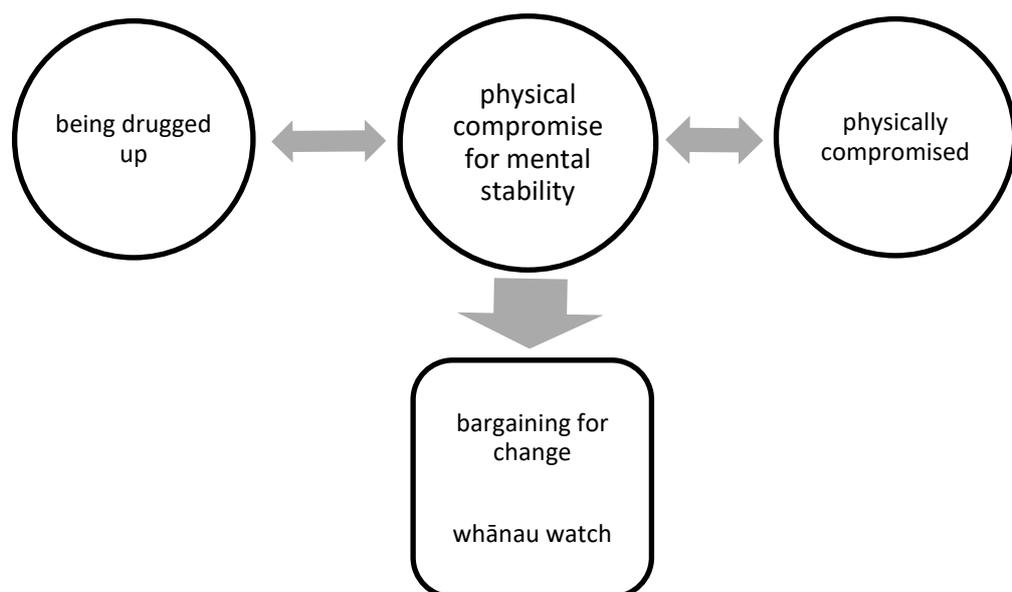


Figure 9: Physical compromise for mental stability

When Māori seek solutions from mainstream mental health services, psychiatric medication is the dominant intervention promoted for their mental wellbeing. Māori are given, and for most forced to take, medication as part of their treatment by mental health services. From the *turning point* to the first encounter with mental health services, most people are naïve to taking the foreign chemicals of psychiatric medication that are considered beneficial for mental and emotional wellbeing.

I never used to take pills before I had contact with mental health services, he (nurse) gave me some pills to settle me down at night but it just zonked me out. (Ruru)

I was so drugged up on quetiapine, I was taking five at once or maybe more. I was in the unit [first admission], I think I was 18 -19. I was drowsy as, like always tired and in and out of consciousness. Anyway, I don't know what happened but one of the days they didn't give me as much quetiapine, and it was like I woke up. The day before that I was sitting there staring into nothing for ages – you know like one of those loony people you see at those places. Then I realised I'm one of those, it freaked me out, I'm really here, this is really happening to me, I knew they were helping me, but being zonked all the time wasn't right. (Miromiro)

5.5.1 Being Drugged Up

Being young and experiencing a mental health crisis for the first time might suggest some caution when it comes to treating a person with medication. Yet whānau were stunned at the ease with which medical professionals gave medications to young Māori, especially when they were still rangatahi and it was their first mental health crisis.

My son was 16 when he was admitted to the mental health unit. He didn't take to being there, and I was in the foyer when I saw him being taken away into a room. I was asked to come back the day after. What I didn't realise was they had taken him into the room and then injected him. I asked to see him, when I arrived to the unit the day after but I was told to come back. I found out later

he was still sleeping the effects of the medication off. He would be like that for the next three days. (Whero)

Being drugged up is a feature of Māori being detained in mental health services for treatment. This happens whereby medications are the first line treatment and administered without consent, leaving them sedated, for some days at a time. *Being drugged up* becomes part of the negative imagery associated with being in a mental health service.

Whānau often advocate and make requests to mental health services to not overmedicate their loved ones. This request tends to be unheeded by mental health professionals who continue to administer medications that often result in the person being “drugged up”.

Mum had said, “Do not over medicate her.” She was only young and we didn’t want to see her drugged up. When they kept giving her medication, my Mum was furious. They weren’t listening to her and it felt like we were losing her. (Kakariki)

As a parent I wasn’t informed, I said do not medicate him but they did so anyway. There is no guarantee medication will work, and he was always overwhelmed by it. (Karaka)

Being drugged up becomes an additional condition for Māori on psychiatric medication, who have limited power in the decision-making process regarding medication. This reflects the dominance of the legal system and mental health services with prescribed medications. Indeed, many of the medications they were receiving they had not heard of. The medications are viewed as not good, yet Māori are made to take them. The concerns about medications relate mostly to the physical health consequences and the significant side effects that make Māori ill.

Some of the medications, are not very good for you, you get lots of side effects from it, they drug you up, and you won’t be able to do much. They put you on high doses of medication, but you gotta keep taking it. (Takahe)

I am putting you on medication, and I'm putting you on this and this. With the law, they put us on these psych meds, because they [mental health services] can. (Weka)

Opinions amongst kaiuru were easily shaped about the types of medication, what it can do, its purpose, and with information gained from others who had similar medication regimes. There were alarming concerns about how the medicines are perceived and what they are associated with.

I was told I was on drugs that powerful that people could use them like date rape drugs or something like that, I was shocked, that's what I heard from other patients, no wonder I felt out of control and sick all the time. I went to the doctor to find out if that was true, and to ask why I was on them. (Kaka)

5.5.2 Physically Compromised

Physically compromised refers to the discomforts and side effects of the medications Māori experience. Being *physically compromised* is a direct consequence of being apprehended, taken and locked up in mental health facilities and by being managed in the community. Additionally, being aided by medications designed to improve the wellbeing of Māori affected by mental illness. Kaiuru and whānau believed the ill effects associated with taking the medications is due to chemical toxicity. Regardless of the discomfort and side effects experienced by Māori, medications continued to be administered. These psychiatric medications are known to cause sedation, gastrointestinal upsets, weight gain, blurred mental clarity, and other adverse reactions, all of which kaiuru had variable experiences.

She was up at the ward, she was dribbling when they were giving her pills. She didn't know what they were giving her either. She didn't want to take them because she was shaking, her lips and her mouth were shivering. But they gave the pills to her anyway. You know it's like you are stuck in there, you don't know what you are taking but because you are there you have to take it. (Kahu)

The pills that my doctor says I have to take make you feel crook [unwell] all the time, you know physically. It's like horse

tranquilisers. You end up feeling like crap for the rest of the week.
(Kokako)

The pills mental health services give us are toxic. They make you fat, sluggish, and really don't help with your concentration. (Puriri)

High doses and multiple types of psychiatric medications given simultaneously are common approaches by mental health services to Māori. This method of treatment impacts Māori physically and contributes to further restriction of the person's mental, emotional and spiritual wellbeing.

You can't function when you are in a state of mind that has been over medicated, you are locked into a certain being, and all your thoughts and especially your feelings get blocked. (Kaka)

I find it very difficult even for those that have been referred, it's like the medication is blocking the wairua from moving. The effect or the side effects of that medication is dulling them. They take it for mental stabilisation, but not knowing really that their wairua is actually being removed in that sense. (Rimu)

5.5.3 *Bargaining for Change*

Bargaining for change is part of the basic process of seeking solutions for change to the physical compromise experienced for mental stability. It entails the confidence to negotiate a change of medication whilst in the mental health system. To do so Māori require an awareness of the rules of engagement with mental health services when medication is concerned. It is the power of the doctor in the mental health system and their driving preference for wanting certain aspects from a person when on medication, that will override any decisions if a change is desired by Māori.

They say if you want to come off your medication you have to speak to your psychiatrist as he will need to supervise it. I am on Lithium, I know when I get my highs and my lows, but I worry about the long-term effects this drug and the other drugs I have had over the years to my tinana [physical body]. There have been times I have battled to get my meds sorted, sometimes it works and lots of times it doesn't. (Karoro)

Bargaining for change can depend upon the length of time in the mental health system and the understanding from a mental health professional about the person's needs balanced by his/her preference for a reduction in medication.

Now I am taking Olanzapine, I was given 10mg but I asked to lower it down because I didn't think I needed so much. I still think they are drugging me up. They were like we can give you this and that I said, "no I just want to stay on the same pill, but I want it reduced down to the lowest you can get", so eventually it went down to 5mg. (Porete)

I wrote a poem, that I divorced my depression and threw away my pills when my mountains became hills, and I gave it to the doctor. He loved it but he said he didn't know about the pill part and I said to him I will take one each time, if I take two, it makes me loopy, and the doctor agreed with me. I don't cry when I go down town and I don't get terrified when I go shopping, and I tell him I am walking my depression off. If I have any issues, I talk to him, and he will give me a sleeping tablet if I need it, so I take it and then I feel better. He's been watching me for a long time, those pills I hate them, he's given me lots in the past and now we work it out together now. (Pukeko)

Understanding how the mental health system operates whilst under the Mental Health Act, inclusive of its requisite of assessments and general processes are also of benefit. Comprehending such is needed if Māori are to show that medication prescribed has its place but it is not always needed as the dominant contribution to a person's wellbeing.

I challenged the system. I don't take medication now, but it was a long journey to get to where I am now. When I was under the Mental Health Act, I was pleasant. Because it's the law, if I don't take my medication, they have to reassess me. So they reassessed me, and I would make sure to take enough to meet the therapeutic threshold. Over time I would reduce it, I would see the psychiatrist and I was doing ok, I would tell him I was reducing it. He'd say "Oh!" And then another assessment would occur. They'd finish the assessment and realise I had insight into my situation. And actually, I was doing other things in my life too which was helping me. Then I would continue to reduce the meds, and go

back to see the psychiatrist and then say I'm not taking it now. So it was a little frustrating for the doctor but not for me. As it allowed me to have a period of no to minimal meds and work on myself using other things. (Kaka)

It did not matter how long a person was engaged with the mental health system or the mental health professionals, there was constant frustration in having to take medication. If a person resists or says something to mental health professionals about his/her frustrations over medication, it is often interpreted as an act of resisting the system or aggression, which is reported to the authorities to enact the control processes of the mental health service. The consequences of these challenging actions by Māori is that for some it meant they were apprehended and taken back to mental health services.

They put me on a high dose of medication, you know you gotta keep taking it. I got into trouble because I threatened a nurse, well I more or less told her off that she was giving me an injection. She used to give it to me in the arm, and for some reason she wanted to give it to me in my leg, and it was sore. Anyway, I said hey you are giving it to me too early anyway. She was about four days early too. I said, "Why are you giving it to me early?" So, I told her off, well then I ended up in jail for talking like that to her, and then I was taken over to the mental health unit. (Takahe)

Feeling like you are part of an experiment was the impression given by many Māori in this study who had been medicated by mental health services or as whānau had supported their loved ones in mental health services. For some, it felt like they had been given multiple types and doses of medication over their time with physical effects which made them feel like death.

One medication I can't remember what it was, I couldn't even speak, and I couldn't even remember my name. I was in that state for three months, I was basically a zombie, people would say X, I was like (blank). I couldn't even think I was, "Ha! I think I'd heard that name before." I'd get close to knowing oh that is me, then I would forget. Yeah it was horrible, quite a horrifying experience. (Piwakawaka)

There were various experiences with medications. Amongst those who had more than a decade of experience with mental health services, they felt the contemporary or newer medications were no different than the older medications. They were prescribed high doses of the newer medications yet were now more than ever compromised by physical and medical problems, which they had never experienced before. For most the psychiatric treatment was worse than the mental illness.

I have been on a few, that risperidone used to give me nose bleeds. I started off rough with Clozapine because of the side effects and stuff. I was put into ICU, actually I ended up there a couple of times in the hospital. My lungs felt like they didn't want to move, and I was having this mean chest pain. Oh man, it was one of the most frightening moments in my life. I don't know why they changed me, I was on Olanzapine before then, that was ok and I thought was way better. Now I have to watch everything I do with this Clozapine. (Weka)

Clozapine was viewed as the wonder drug for people diagnosed with schizophrenia and many were encouraged to come off conventional antipsychotics to shift onto this new atypical medication. However, the physical health overhaul required to transition to this medication challenged each person in regard to the stress of untold blood tests and medical monitoring. Once the drug was instituted there were new physical comorbidities which meant needing to manage other health issues and take other medicines.

Before I was started on Clozapine, I was on Modecate injection, I was doing okay. But the doctor said we have a new drug called Clozapine it was discovered in the US and it had been in New Zealand for 10 years. I said, "What does it do?" He said, "It's classed as the wonder drug." He said, "We have to put you on a high dose." So I had to put up with being monitored for weeks on end, couple times I got crook, there were untold blood tests. I became to understand the chemical drug, now it's in my system, I can't get off it now my body is used to it. I am no expert but I have gone through a hell of a lot of medications and in any case, it does not sit well with me, I'd rather not be taking them. Now I have diabetes too, I reckon as a result of this Clozapine, now I have to take more pills and also watch what I eat and keep healthy. (Moa)

Physical health problems and the fear of early death are the complications of medications. Further fears are formed by personal, peer and whānau experiences with medications; including adverse side effects and the deaths of people they knew taking the same medicines.

She died when she was on that Clozapine. Yeah, I'm on Clozapine too now, it scares me a little bit. I can only get to sleep now with a sleep apnoea machine. I try to keep fit, I exercise with my key worker, I don't drink alcohol, I smoke tobacco but am trying to cut down. I don't want to die young, I wonder sometimes how long I will live. (Takahe)

I have been in the mental health system for years, and I have seen so many of mates kaput, you know die as a result of the medication they're on. Especially that Clozapine stuff, it freaks me out. (Karoro)

Death was a common danger associated with medications. Although side effects such as over sedation and weight gain were linked to other medications, their emphasis about Clozapine was of sudden deaths amongst Māori. Māori practitioners who worked with Māori in mental health services concurred with kaiuru (lived experience) and emphasised the complexity and fear held about these medications.

I take Clozapine, it's been pretty rough. When I first took it, I almost passed away, the doctor said it was one of the side effects that did that to me, man it was one of the scariest things that has ever happened to me. (Weka)

Our people go on wonder Clozapine! And so called miracle drug and I think I have taken 3 young boys home [to bury] because of heart attacks whilst on that drug, all were under 40 years of age too. There is no accountability, the system has immunity. (Puriri)

We lost X last year, he used to be fit young man, he went on that Clozapine and he seemed to be ok mentally, but physically he was a mess. He died of a heart attack at 38. (Manuka)

The desire to stop medications is common, but to do so means escaping the hold of mental health services. For many who took the time away from mental health services, each time services were reengaged, medications were the primary focus of the person's mental health care.

I was on medication but when I went away from their services I stopped taking it, they caught up with me again and put me back on medication. I didn't agree with them, when they put me on medication. (Takahe)

Finding a balance with taking medication can take a person years of trials and error, yet it still outweighed the emotional and mental turmoil a person experienced from medication.

It took me 5 years before they got the medications right, they experimented with this medication and that because I was told not everyone's the same, so it takes a while before you get something that works well. Every time I don't feel ok they up the meds, and every time they do it I feel crook as, sometimes I think, maybe I shouldn't. (Tui)

Few felt taking medications contributed to their general wellbeing and recovery. It did help with one kaiuru in his/her ability to acquire employment, and other kaiuru to maintain a good sleeping pattern.

I was on different medication and it was hard to focus on the things that I was doing at the time. Over the years I have found the medication that is right for me so that my voices are gone. I have to have my injections, I'm on Haloperidol, the dose I'm on its been good for me, it's allowed me to do my job and my work when I need to. (Kotuku)

Yep the ones I take at night now are good. Lucky I take them at night so I can sleep through them. But sometimes it just zaps me, the old brain ticks over a little fast, so it turns it off a bit. (Kokako)

5.5.4 Whānau Watch

Whānau watch over mental health services to advocate for their loved one's needs. This is a component of *seeking solutions* enacted by whānau who were assertive and confident to challenge mental health services, given their control over Māori. It was important to seek answers for why their whānau member was so unwell when being treated by the mental health service.

I remember going to the hospital and asking them what is my son on? And the doctor said oh they are to help him to stay well. I thought really, because they seem to be making him unwell.
(Mawhero)

Motivated by the distress of seeing how unwell their loved one was in mental health services, whānau would take matters in their own hands to seek solutions for change. Pleas of help were made to whānau by loved ones, subject to having to undergo the treatment and being physically unwell. For many, this caused whānau to hold feelings of regret in the knowledge it was they who had taken their loved one to the mental health service for treatment and then discovered that the treatment was making their loved one worse.

I said to Mum I don't want to be here, get me out of here. They were giving me pills all the time, I felt like I was being experimented on, is that treatment? (Kahu)

The doctor said one of the times they took him to the hospital it took five people to hold him down to sedate him, I think the doctor and them [mental health services] were scared of him, I felt aroha for him. (Kahurangi)

When concerns were not addressed about how a loved one was medicated whilst in care, whānau would challenge the mental health system about the amount of medication given.

Mum didn't like it, she said right and hauled her out. Mum pulled her out of there, she said Nah! They're not listening to me, I told you not to give so much medication, and they weren't listening so we took her away. (Kakariki)

Whānau would communicate to mental health services clearly what their thoughts were about medications and, in some cases, would request mental health services to not over medicate their loved ones. When the mental health service carried on medicating them, whānau felt let down by the system they sought help from.

My son needed a rest and so we went to mental health services to get help. I asked them not to give him medication. It made me angry they were giving him medication and I told them not to, because it is no good for them. (Whero)

A strategy to wean a loved one off their medication was commonly thought of by whānau to be informed by compassion and that it would benefit the person's holistic wellbeing; especially, when the loved one had extreme weight gain, and subsequent physical health problems due to the medication.

It makes me cry thinking of it. He was 271 kg as a result of all the medication they were giving him. He was breathless all the time, he had to have other medications for his blood pressure, heart because of the impact of the mental health medications. One night I heard him snoring and I got up to have a look and there he was standing in the hallway in the middle of the night trying to stand up and sleep. That was the only way he could get some rest, I cried and hugged him. That's when I decided to do something about it. (Waiporoporo)

Whānau would go to great extremes to support their loved one to come off the medication believing it would help them regain an improved sense of physical wellbeing. Whānau would do so by instituting kai, exercise, rest and activities all in the hope of benefitting their loved one's wellbeing.

I weaned him off his medications, I did it safely, and I felt confident about what I was doing. It took us months slowly reducing his medications and introducing kai, exercise, rest and activities during the day. With lots of encouragement he went from 271kg down to 125kg, he had no breathlessness, all that was left were some behavioural problems. (Whero)

My sister took me over to Australia to wean me off the pills. I was 112kg and when I came back I was 75kg. My mind was clear, I could think properly, everyone looked fat to me when I came home, with all those medications, kai and that. (E Kara)

As challenging as the physical health changes could be for the loved one, few whānau appreciated these side effects were part of the compromises that were going to be made to having their loved one in their lives and for having a settled life with them in it.

She was on medications she put on a bit of weight, sometimes she was kind of like a zombie too, but she was calm, nice even. It was difficult at that time to get her treatment because she was so good in holding it together for the doctor. (Mawhero)

Māori health professionals worried about the way Māori were treated with medication and the overall impact on them. They were aware some of the ill effects from medication seemed to far outweigh the possible benefits of the treatment. They also believed the medication dulled the wairua of Māori, consequently making it challenging to work with Māori in a therapeutic way that reached their wairua for healing.

People have to have an opportunity to speak, if they are over medicated its dulling more than their senses and their ability to korero. I find it's their wairua we cannot get access to because of the medication they are given. It's hard to do this work with them when it is so needed. (Rimu)

Another perspective was that in the area of wairua work and with people wanting to come off their medication, during their wairua healing, medication would eventually not be required and the person would be able to determine his/her own choices for medication.

He just come out of a mental hospital, you could see it, and he was like a zombie. We made contact with him, we came home. A week later, we got a phone call, we asked him to come over. What we

did was release his wairua each time he came, he's been coming for the last six months. Yesterday when he came he's not on any medication, he just kept coming and we kept talking to him. He doesn't take anything. We helped to lift and clear him. Now he does his own healing, he listens to his tūpuna, he paints and carves. He's on a new journey and on the right track now. (Kowhai)

5.5.5 Concluding Comments

To conclude, this section presented the consequences of being restricted by mental health services with two properties of being drugged up and physically compromised. Bargaining for change and whānau watch are part of the basic social psychological process of seeking solutions Māori apply in order to counteract being physically compromised for mental stability.

5.6 Addressing Wairua

This section presents *addressing wairua* as actions by Māori seeking solutions to acquire a more holistic state of wellbeing and to counteract the negative effects of being restricted by mental health services (Figure 10).

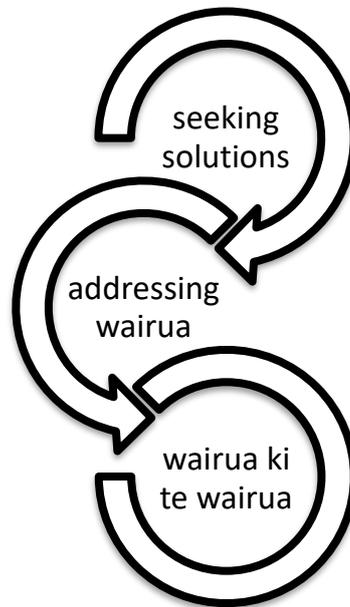


Figure 10: Addressing wairua

Māori who seek help from mental health services were restricted and had a predominantly biomedical experience. There is little to no appreciation by mental health services for the need to be *addressing the wairua* of Māori or to provide for a holistic service that ensures a person's spirituality.

I think it's our spirituality, it is misunderstood by non-Māori that's how I see it, it is a differing way to look at me, and it is a whole different aspect. The non-Māori person would think oh she's a bit loony-toons. The Māori way of seeing me and who I really am, it is about spirituality, it's about my wairua. (Puriri)

Wairua is viewed as the sensibility aspect of Māori where the Māori person yearns for inner harmony and comfort. From a Māori perspective, this is achieved through the connection to one's whakapapa, whenua and ancestral knowledge.

Having no sense of belonging plays a big part on a person's wairua. If you look at a lot of youth, they're disconnected from their

whenua, don't know who they are or who their whānau are as they have no connection with them. They are out there floundering around, with no sense of belonging. (Kowhai)

Māori living away from ancestral lands and kin can be challenged with obtaining the traditional land based spiritual connections needed to find inner spiritual solace. Yet, attempts will be made by Māori and Māori practitioners in *addressing wairua* to make deliberate connections with Māori as part of a healing process.

She was living in X and she was trying to find her wairua. I said who is your kaumātua? She said X I said are you close to him? She said yes. I said you go back and have a korero with him. She talked about wanting to climb the maunga. I said you go and have a korero. And get him to take you under his wing. Let him take you through the processes that you are searching for. When Māori are from a certain area, where there is kaumātua that knows the area well. Then that's their connection to their tūrangāwaewae and their whakapapa. It is this that gives them more of an in-depth understanding of who they are than what they would get from a Māori from another rohe. (Rimu)

Whānau are the facilitators necessary for *addressing wairua*; whānau will comfort loved ones in distress, reassure them and provide spiritual safety. They will seek out those who hold the trusted knowledge and skills amongst Māori about *addressing wairua* to see their loved one or for their own counsel.

He used to say, they're here they are going to take my soul. I'd say no they can't take your soul, although it was scary, I would stay strong for him spiritually. (Whero)

At one stage, they tried to have her holistically healed, the whānau went down the line to see this person to have her healed spiritually. (Waiporoporo)

Traditional Elders, kuia and kaumātua will guide what and who is needed for *addressing wairua* of people, and will guide whānau members' wairua, especially when they are confronted by the concept of mākutu.

We hadn't seen anything like it before, I had some knowledge about mākutu which came from my Mum, we tried to manage it, but my Mum was scared of it. We ended up getting Mum to bring someone in to see him. (Kakariki)

Some of the old Māori said he had a mākutū on him, and because he wouldn't acknowledge it that's why he was sick. (Kahurangi)

These Māori Elders will provide a perspective from a generation who revered traditional knowledge and spiritual relationships that helped to inform the beliefs and necessary actions for meeting the wairua needs of Māori.

I remember back in my days I was still a kid, my mum and dad they used to go out to where they had a Māori faith healer. A lot of people went to her for their healing. She used to live in a little house on the hill. She was classified as a Māori healer, a tohunga in her own right. Don't ask me what went on in there because I couldn't answer that. As kids, they never let on to us. That was their place, and back then Māori always looked for healing. That's where a lot of them went to. (Rimu)

It was from the ancient Māori source of knowledge about mākutū (curse) that the information about a regression of tapu (sacredness) came forth. This understanding frightened some in the study, especially when loved ones presented in ways that were reminiscent of the stories about mākutū.

You couldn't talk to her, she was talking like she had a demon in her or something, she had those crazy as eyes, and we didn't know what to do. (Mawhero)

There are Māori practitioners who *address wairua* through the provision of karakia and methods in such a way that a practice of whakawaatea occurs to help address the wairua of a person. This would include connecting with the person, honouring who he/she is and what he/she brings in a way that connects to his/her wairua.

When mental health clients come to me, I would help cleanse, I would clear their wairua. Whatever we do, it all has a spiritual connection. It is not separate, wairua is not seen out here, it's here inside me, it is connected to us, and that's how we connect. The more you understand that, the more it works. (Kowhai)

For those kaiuru who received wairua healing, it was an experience many had never had before the *turning point*. There was a sense of peace and a feeling like they had been rid of their distressing feelings, alike something had been lifted from them.

She did an exorcism on me, she came down and did some prayers and stuff like that. I felt a big weight had lifted of me, I was so happy when the karakia was finished, it was such a beautiful thing, I thought oh my thoughts were my own again, I felt good after that. (Miromiro)

By *addressing wairua*, the mental and emotional wellbeing of the person is relieved, there is a lifting of the distress from the person with positive calming effects. For some this meant an interpretation of wairua healing through contemporary means for the primary purpose of relieving mental and emotional distress.

Aunty came home, and she got us going to this church, where they lay their hands on them and then those things came out. You can't see things but they worked, it didn't work straight away, but it worked for my sister. (Kakariki)

For whānau who did not seek help to address wairua, and solely sought solutions from mental health services, there was often regret and a persistence of the belief that the wairua of the person was what was needed to be addressed in order to resolve the mental distress and to heal the whole person.

You just know something was not right, you know we didn't actively seek out a healer because of what Nan was taught, but I always felt it had something to do with his wairua. (Karaka)

You have all these clashes of Māori and non-Māori. Once Māori has nowhere else to turn to for their wairua, then they come up in the system that's when they get medication, it may settle them down but their whole ahua is diminished. (Titoki)

Māori who conduct the actions to address wairua, their reputations and outcomes speak for itself; they are people who are known and revered by Māori who have attended to the wairua of others. This Māori practitioner is reputable by word of mouth, often in examples of practice or stories shared amongst whānau and Iwi as people who have helped them in similar situations to address their spiritual needs. They may be located as kaimahi in employed cultural positions, but mostly they are viewed and known as healers, kaikarakia or tohunga in Māori communities.

There is a tohunga he works in the wairua, he's from X, and now and again he is called out to do a cleansing. He works with wairua. I've known this because he's come up and done work at home. But having said that it's your belief. It's your belief that he has this wairua that can move you to a better situation. (Titoki)

Working to address wairua requires the Māori practitioner to believe in the power of *wairua ki te wairua*, the ability of wairua to be connected to wairua of people and place. Part of the Māori healing resolve is to be able to facilitate the connecting of wairua, and to recognise wairua whilst comprehending Māori principles important to life. The knowledge, skills and commitment required of Māori who work with wairua is informed by the belief in and the provision of spiritual work that is connected to the creator; in addition to being able to seek solutions beyond what the person physically presents with.

Whatever we do, it all has a spiritual connection. It is not separate, wairua is not seen out here, it's here inside me, it is connected to us, and that's how we connect. The more you understand that, the more it works. (Kowhai)

There is a connection that you must make with them. You can take them through a process, of whatever it may be. To ensure that you can see where they are actually, and to find how they would connect with you best. (Rimu)

Wairua ki te wairua, is the fulfilment of a connection in the relationship between the person's wairua and that of the Māori practitioner. When wairua is mirrored in the other person it is suggested to show that the relationship is spiritually attuned and will provide for the positive spiritual construct for the healing of the person to occur. The difference with working to address wairua is in the depth Māori are willing to go to in order to reach the complexity of the issue at hand and to find some meaningful way to help settle the person.

What I've noticed from the work with Māori is they find there is a difference working with a Māori kaimahi than a non-Māori kaimahi. Because non-Māori hasn't got the wairua to get across to Māori in a deep way. With a Māori kaimahi – they start with the whakapapa, they go through the whakapapa, the wairua and everything. Then you see the person start to settle. They find that their whole wairua starts to settle because they've been recognised by their own. (Manuka)

It may indeed be the person's whānau, whakapapa, whenua or tupuna that is considered to be the origin of the issue in which the person is presenting with, that is manifested in the person's mental health. Therefore, from a wairua perspective, what is important for the person's healing is also important for the healing of the whole whānau. Māori practitioners do require access to the whānau to get to the depth of the presenting issue and for *addressing wairua* in the whānau which in turn should aid the person.

The family came to me and I said I want to see the whole family. They came, it was the mother. The mother had the mental [health] issue and it was passed down from the mother to the children. I took wairua from the mother. The same wairua in the mother was in the children. I went in and took that wairua from tupuna, it went right back to a prior generation. When I took the wairua from her, she could walk again. I said please get in contact with me. They did, they came back and I checked them all. The boy that was ready to commit suicide he said, "Whaea I've never felt so good." I said to the mother. "How you feeling?" "Oh much better, than I have ever have." (Kowhai)

Spiritual belief and knowledge of Māori practitioners that work in and with wairua are informed by traditional and contemporary perspectives. The Māori practitioner will reason that the wairua brings an order and provides meaning to people's lives and a sense of being. When there are challenges with the wairua, it has an effect and will influence the mind and the body in the way it operates and functions. There is an ability to reverse or remedy spiritual issues from the past, which belong in the realms of Māori healers who are skilled, and dedicated to work in and with wairua.

We went onto the whenua, through the process I took the curse of the family as well as the whenua. This is unconditional, I had my karakia and made sure I was 1:1 with them. It came to me straight away and I lifted it. I went right back to that past life and I lifted the curse from that life time. Bring it in to this lifetime. The children in this immediate family had mental health issues, one with deep depression. There has been a big improvement. It has helped the families. Two of the children are out of mental health services and are now in work. (Titoki)

Working to *address wairua* whilst situated in a mental health system can be one of the most challenging when medico-legal aspects dictate the treatment focus of Māori. This is particularly so for mental health service employed Māori practitioners who will provide, as much as possible, the best approach to address wairua.

Because we are in the system, they say not to do anything black magic or if it doesn't mean taking a pill then we're not to do it. But we do support our whānau, we say to them, go home and get your kaumātua. Or our kaumātua will come and talk to you and so I will go to the whānau. (Puriri)

We haven't got all of the controls in the environment. We still use some of the medications. We don't have much of a choice! Not there is a choice! We don't have enough control over the environment to supplement them with what they need spiritually. (Manuka)

There is a concern that psychiatric medications will dampen the wairua of Māori. In doing so it will make it challenging for Māori practitioners to address wairua and to bring about a sense of spiritual balance needed for the person's recovery and full potential.

To deal with a Māori with a mental health issue today – I find it very difficult even for those that have been referred from the mental health to us. It's like the medication is blocking the wairua from moving. The side effects of that medication is just dulling the person. (Manuka)

The medication blocks them, you get stunned, and it stuns the ability to handle normality of what's going on with your life. You get that slow look on your face. It slows things down when it shouldn't. Only because of where the medication goes. Consequently, you can't adequately address some of these things that you need to with people because of the (meds). You can't get in touch with the parts that you need to. (Puriri)

Māori practitioners have the ability to engender protection that ensures that the wairua solutions sought do not place a person at risk. Because of the diversities of Māori today, some of the solutions avail may not always receive constructive criticism let alone healing recognition. The difficulty here is that spiritual meaning may arise from a range of sources for Māori today, and the

experiences of those who indeed receive spiritual healing from contemporary sources will be hidden because mainstream society will not recognise them or thinks little of them.

We say to people go to see your kaumātua, but even then we have to be careful, we say to them you are still under our service, and I will come along and watch to see what they are doing. As soon as I see anything bigger than cup of water, I say nah we're going back.
(Puriri)

The overall responsibility for *addressing wairua* lies with Māori themselves. Whānau, hapū and Iwi are the kaitiaki of mātauranga Māori pivotal to addressing wairua. The continual survival of Māori knowledge is required to address wairua and it depends upon Māori for its protection, propagation and transmission. If that commitment is absent, then there is no amount of support that will preserve and hold onto the knowledge and skills required to understand wairua or ensure the resourcing needed to address wairua needs among Māori.

We'd need the ability to influence the environment people are going back to or living in. We would need some more support to be able to utilise the facilities, such as the Marae, things that we have had for longer periods of time rather than from 8-5pm. We'd need a little more training to increase understanding of people that work here. We can still use the environments like the sea, the ngahere, the whenua we can still use those, but we need more control. (Rimu)

5.6.1 Summary

Addressing wairua is principally the pursuit of a solution for the spiritual strength, and the connectedness with culture that plays a major part in the approach to healing for Māori. The western approach includes the western medical model in mental health services which deals largely with observable symptoms. Although mental health services have taken on biopsychosocial aspects, the absence of Māori approaches to wellbeing means that the wairua of people is rarely taken into account (Marsden, 2003). Māori in this study sought solutions for their overall wellbeing and, regardless of contact with

mental health services and the experiences associated, Māori with lived and whānau experiences sought solutions to address their wairua by reaching into the Māori world. This is where the knowledge and beliefs that belong to Māori and to the appreciation of wairua lay. It is, however, the access to Māori practitioners who are dedicated to working with and in wairua with Māori that will make the difference for Māori to be able to address their wairua and to heal.

5.7 Seeking Solutions

This section presents the basic social psychological process of seeking solutions, a concept Māori in this study became accustomed to actively doing in their experience of mental illness and mental health services. As previously discussed, seeking solutions involved bargaining for change and whānau watch when Māori were engaged in mental health services. In addition, to addressing wairua to find a resolution for healing. During the study, when asked how people coped, they shared of moving forward beyond their experiences through activities that sought solutions to give them hope and to achieve change.



Figure 11: Seeking Solutions

Much of this thesis has focused on the experiences of Māori in mental health services as a dominant foci. The main problem of kaiuru of *being restricted* has highlighted the attention upon illness, sickness and mental health, mainly due to the current health system that supports a set of norms that are established by western bio medical science.

How are you ever going to get well if you think you are always sick? I've got this label – I've got to be sick. It works, it really does work – you don't get well. I consider myself lucky as a mental health consumer in that I got a good education, had a couple of successful careers, that's made the difference as I have had confidence in the past. A lot of our people who are not well have never had those experiences. If you've never had them, then how are you going to get them? You have no idea, not a clue, you don't know what you are aiming for, especially if you are in the sick role all the time. I remember when I was thinking that for years, I'm trying to think where the goal posts are, because they keep on moving. Then it was really confusing, in and out of reality you know. (Kereru)

The solutions sought in mental health services toward getting well were challenging for Māori and complicated when their diagnoses were ever changing due to the impressions of doctors. Finding a definite diagnosis took multiple contacts by Māori with mental health professionals and years in the making, causing frustrations in understanding the symptoms and meanings associated with the condition.

I didn't understand what it was at the time, it took me a couple of years... after the secure unit I went into rehab, I had to do classes about early warning signs and stuff... I found out I had schizophrenia I didn't get prodded or poked, I was about 25 when I was finally diagnosed with schizophrenia. (Weka)

The existence of the beliefs of others had some influence on the solutions Māori had access to, which has made it difficult for Māori to flourish in their community (Baker, 2015). Especially up against the generalising behaviours of and in the public, that foster negative stigma about people living with mental illness.

You've got a mental illness. At first, I'd say who told you that? I thought, moving here, I'd escape all that. You see I hadn't dealt with it. I was stuck right in it, with everyone around me. It went out

like this, watch out for X! She's got a mental illness. That's what they were saying. I counteract it by stopping to go over to people's places, swearing at them when I get angry. Because that's what they're expecting me to do. No wonder they think I'm a nutty witch, when I see people do that - they don't have a mental illness. I just think it's uneducated. We don't need to behave like that. You actually get your point across more by speaking nicely and I've seen it through the older people, how they speak - you don't even want to be spoken to like that. You've hurt them. For them to speak to you like that, no swearing, just to the point. I'm trying, it's hard to keep up with it, and to keep myself constrained. (Tui)

Still, there was much optimism amongst kaiuru who wanted to resist the western medical model of mental illness as a deficiency. Although, their various problems were not denied, tangata whaiora and whānau held out the pursuit to live life as best as possible beyond that, when they were engaged with mental health services.

Seeking solutions involved fostering hope in the pursuit of people to meet their full potential with mental illness and when engaged with mental health services. It highlighted elements that influenced how Māori had been engaged with mental health services. Also making the connection with how mental health services and resources could be bearable, through certain characteristics of a mental health workforce. It showed the differences with Māori mental health professionals and Kaupapa Māori mental health services, in being more holistic than mainstream mental health services.

Kaiuru with lived and whānau experiences of mental illness and mental health services needed to believe there would be a sense of recovery, and that people could indeed live a life beyond the effects of mental illness and experiences with mental health services. The seeking of solutions that reduced the cultural bias in the encounter with mental health services to make hope possible for Māori, was possible via a Māori mental health workforce who contributed a specifically Māori cultural focus, or a Kaupapa Māori mental health approach. The distinction between mainstream and kaupapa Māori changed people's attitudes toward a more holistic model of care, and provided further possibilities that Māori were appreciative of regarding their cultural identity and overall wellbeing.

When [the] cultural advisor came on board she would take me out, teach me things. It was a Māori female who taught me karakia, it was about facing north, east and stuff, [we would] go for walks, and she gave me some stone which I carved. We'd talk about Māori stuff, it was inspiring to me and the way I was at the time. (Kereru)

It did not matter that Māori had little knowledge or experience with knowing their Māori whakapapa, or if they had not understood Te reo me ona tikanga prior to being supported by Kaupapa Māori mental health services or Māori health professionals. The direct Māori approach increased the methods to recognise the importance of being guided in the access to mātauranga Māori, for a sense of wellbeing that was connected to their Māori identity.

I was brought up Pākehā, knowing I was Māori but not knowing what it meant. One of the lost generations, yes that was a turning point for me, when I came back from [Māori services] there. I did a whakairo course, half was art and the other half was history and tikanga. XX was the tutor, it changed my life. That was the turning point – it was connecting with the Māori side of me. The wairua, tupuna feeling that made a connection and an identity. (Karoro)

Kaupapa Māori mental health services included a philosophy and approach that ensured there was support of people with their whānau as a whole unit. By utilising the Kaupapa Māori mental health team, tangata whaiora and whānau were able to benefit from the pool of skills, knowledge and attributes of its members as they required. Whilst other health services helped people individually, there was a conscious socialisation of beliefs about the Māori way of helping the whole whānau that would also help the person.

I've been part of Kaupapa Māori mental health service that was one service that was consistent with us. I think the thing that helped me and my family was they all got involved with me. Wasn't just the nurse, it was the whole team. They all got involved with me, one person had a key role but other people would awahi. That helped me and my wife, because it by helping me it was helping my wife. It was good. (Kotuku)

Seeking solutions through Kaupapa Māori mental health services ensured a Māori person's sense of belonging and connections were intact. This strengthened Māori and aided in their ability to communicate with and trust

others. The comfort in this cultural context was significant to Māori in their continual contact with mental health services and their recovery.

I found it good here with this NGO (tangata whaiora led), the first time I stepped into here – I was welcomed and they did their introductions and I did my introductions. As soon as I got into the door I felt like I was in a house with whānau – that where I got that whānau feeling – since then I've got that every time I have been here. I feel safe with the team, I feel I can communicate, I feel I can trust. They have the whānau feeling otherwise I wouldn't be here. I feel that comfortable with them. (Moa)

By *seeking solutions* with Māori health professionals and Māori mental health services, there were explicit changes to the wellbeing of Māori. This included the building of Māori personal capacities and capabilities, as well as that of their whānau to strengthen their cultural knowledge and their sense of identity.

I am way stronger now as a result of (Kaupapa Māori mental health service). If it had not been for (Kaupapa Māori mental health professional) I would not have achieved what I have in my recovery and my whānau would not be as confident either about my abilities to care for myself. (Puriri)

Adequate support in the community was integral to ensuring an acceptable standard of living and a sense of livelihood in one's community. There were facilitated connections in communities, where there was help with activities of daily living, and support for the person to achieve his/her goals. There were leisure and recreational options and time out opportunities, which helped reduce isolation and increase socialisation in the community.

Having a flat from mental health, friends were around me (they) were also with mental health and to have them there. He's like a genius and he just needs to sit down and talk to you, how do you feel today? So it helped me as I was finding my own way to get back in the world. (Pukeko)

I have a CSW [community support worker]. They take me grocery shopping, go for weekly walks. It gets me out of the house, I can talk to my case worker, when the weather's good we go to the beach we go diving, and we go fishing. It's something to look forward to, I like

fishing, and I've got a fishing rod and all of that stuff. It's better than being stuck at home when you can be at the beach on a summer day, when it's hot keeping active. One thing that can help you through mental illness is by keeping active, keep enjoying yourself, enjoying life. (Takahe)

The Māori community support workforce acted as a protective buffer for Māori in dealing with complex systems, especially where they struggled with knowing how to effectively communicate their needs to agencies. By acting as the go between and navigating the various barriers that exist in government systems, Māori were able to access the resources desired with the help of community support workers.

My fall back person is my CSW [community support worker] and Dr X they are the people that I can hook into. The CSW, she rings me if I need to go to WINZ, I still have an anger in there that kills it when I get nervous. I'm learning to control that and some of the pills the doctor gives me just like a relaxer to keep my calm, there's a booster one when I go to WINZ. If I'm hanging around waiting, I have this nervous tension that gets in, mainly because I got black listed from the X branch, I went in there I was still dopey on the heavy drugs. I was told to come in for a food grant oh I don't know, what sort of food you looking for? I don't even know, this is the first time I've come in for a food grant. [The WINZ person said] "Oh well it's hard as you can only have KFC 3x days a week." And I just lost it, there was this table and next minute (sirens). (Weka)

5.7.1 Hope and Change

There were meanings of hope held by Māori in this study which included aspects of self-determination, personal confidence and connectedness with whānau through relationships. Māori wanted to lead normal lives, this included the view that employment attributed to a normal adult life. Some had employment experience prior to their *turning points* and being diagnosed, but few had been employed since. The barrier to gaining employment was the stigma associated with a mental illness, and the perspectives of both mental health services and potential employers that the person with a mental illness needed to be protected or assumptions that the person was incapable of holding a job down because of their condition.

About 4 years ago I met this doctor. He said to me, and he put his arm around me and said, "You were real quick" (this was a court hearing), and I said, "Yes, I even spoke for myself, cause the lawyer wasn't there." He goes, "X When are you going to realise that you are an invalid for life?" I looked at him and I said, "What? I'm not an invalid! I can work." That's what stuck with me. That I am classified as an invalid! (Tui)

Kaiuru held their own aspirations of self-improvements, including increasing their educational knowledge and gaining qualifications to increase their possibilities for employment.

Now to find a job, just something and I will go from there. I have qualifications in Tourism that I have graduated from. But I've gone off that, I want to study and do something else, don't know what, maybe I get a part time job. (Miromiro)

Mental health peer support and consumer advocacy roles were viewed as significant roles and potential employment opportunities for kaiuru. It was felt that their personal experiences could be useful to share and to help others who might experience similar experiences.

I was even thinking about working in mental health, coz I've been there and done that. I mean I still go through things. I don't let it get me down. Just to you know!! Like I've been in your shoes you'll be ok! (Piwakawaka)

The ability to contribute to change in mental health services promoted purpose and satisfaction in knowing that personal experience of mental health services could in fact benefit others and impact the way mental health services were delivered.

We had a lot of things coz I was made a consumer rep. I was the one that spoke up about having a pre-discharge area. I used to [go] around to the other wards, to see what the guys were doing and stuff. I would jot down he's doing his washing or he's still asleep in bed and then I took it all to the doctor. One day one of the guys played up and what happened was they said it's not fair he has to stay in the cell, so we're changing things around so we're going to take you guys up on your offer coz he was locked up in the cells too long. So they took us up on our offer they made us a pre-discharge

area, by then we were already leaving, but it did change, you know some of those guys have been in that place for years! (Weka)

A key part of the process of *seeking solutions* is to counteract the effects associated with mental illness and mental health services, by living life to the best of one's abilities. This often meant a simple appreciation of the essential routines of daily living, of attending to chores to maintain a household, of the necessities to help with whānau responsibilities and to fill the day with activity.

So I am up, showered, kids off, breakfast, lunch, they're off to school, do my housework. Get books from the library read, look in the paper see what courses are going. (Tui)

Having chickens and having a cat, you have to get up in the morning and feed them, collect the eggs. Having a garden is all therapy for staying well. (Kereru)

5.7.2 Concluding Comments

Seeking solutions is the crucial process for Māori with mental illness and mental health services who are being restricted. Bargaining for change and whānau watch are properties of seeking solutions, as Māori cope with the challenges in mental health services and with psychiatric medication. Seeking solutions includes addressing wairua and reaching into Te Ao Māori, where representatives, such as a Māori health workforce, Māori models of practice and Kaupapa Māori mental health services are present. The ideal that the solutions are informed by hope and driven for change provides for an understanding of how Māori are coping with difficult circumstances of being restricted by mental health services.

5.8 A MĀORI CENTRED GROUNDED SUBSTANTIVE GROUNDED THEORY

Seeking solutions to being restricted is the substantive Māori centred grounded theory of Māori, mental illness and mental health services. At the first onset of a mental health crisis, the *turning point* represents a confrontational interaction between Māori and the mental and emotional struggles they or their loved ones experience. Invariably, Māori will recall the reasons their *turning point* occurred against the mental and emotional struggles and often internalised hell. There is no forgetting the first episode or first onset mental health crises experience as it is locked in the memory of the person and his/her whānau. Fear from the first time is often provoked by subsequent relapses in the person's mental wellbeing.

The experiences of Māori in this study show that seeking help from mainstream mental health services incurs an oppressive approach. The power of control is intertwined within the mental health system, enacted by mental health professionals and enforced under the current mental health legislation. When mental illness is found among Māori then mental health services will give priority to restricting them for their treatment.

As Māori increasingly have contact with mainstream mental health services, there will be a subsequent alienation caused by being restricted, an implication that incurs as Māori are *being apprehended* for being mentally unwell. *Being apprehended* involves being taken and sent away by or to mental health services, supported under the legal system for the person's own good. Being locked up is also a part of the Māori experience when they encounter mental health treatment. This contributes to and maintains an insidious cycle of control that involves police apprehension, the use of the Mental Health Act and being locked up in mental health services.

This continual cycle of control enforced upon Māori in turn fosters a culture of fear, and an extreme lack of control that profiles mental health treatment as punishment. The consequence of *being apprehended* by mental health services is Māori are often distanced away from their whānau and their home,

giving cause for concern about the negative impact it can have on relationships, and roles associated with parenting, and as whānau members. With continual distances and for some long term separations, this separation can cause major break downs in whānau relationships.

The consequence of *being restricted* and *apprehended* by mainstream mental health services, is that Māori are *physically compromised* for mental stability with psychiatric medication as the dominant treatment approach. The impact of psychiatric medication is best explained as being drugged up and physically compromised. Physical side effects, medical adverse reactions and sudden deaths all raise serious concerns about how Māori are prescribed medications and treated by mental health services. It is here whānau will watch over mental health services to advocate in their loved one's interests. If unhappy, whānau will take action to remove their loved one from mental health services.

Bargaining for change is part of *seeking solutions* for change from the physical compromise caused by medication, it is a process that requires confidence by the person under treatment to negotiate a change of regime from mental health professionals.

Further consequences of Māori in mental health services, is the compromise of their spirituality. *Addressing wairua* involves Māori *seeking solutions* to achieve mental wellbeing and balance. Māori will deliberately seek solutions from the Māori world to achieve balance. This is aided by whānau who will facilitate access to wairua support and Māori practitioners who work in and with wairua to address wairua needs.

The basic social psychological process of *seeking solutions* explains how Māori are coping with mental illness and mental health services, acknowledging their main problem of *being restricted*. *Seeking solutions* identifies Māori having to rise above the impacts of *being restricted*. They are holding out hope for change to occur, they are taking control when out of hospital, and seeking Māori resources with processes to help heal and grow. With the imbalance of the mental health system overpowering Māori by using the Mental Health Act and medication, for hope and change to be instilled in mental health services for Māori and any process to meet their mental health

needs, mental health services will need to shift its focus, to centre upon the needs and preferences of Māori.

Currently, the mental health system is failing Māori because its environment and treatment approach is ill equipped to be conducive to a healing approach that involves wairua, whānau involvement and the transfer of control over to Māori regarding their treatment options. Māori mental health professionals and Kaupapa Māori mental health services are showing the need to work outside of the western medical and controlled treatment framework.

Table 7: Seeking Solutions to Being Restricted

Core category	Basic social process	Subcategories	Properties	Theoretical proposition
The main problem Māori grapple with is Being Restricted	Māori cope by Seeking Solutions	Turning Point	<ul style="list-style-type: none"> • Confrontation • Varying explanatory models • Mental & emotional struggle • Internal hell • Locked into memory 	<ul style="list-style-type: none"> • The onset of mental health crisis is crucial <i>turning point</i>.
		Being Apprehended	<ul style="list-style-type: none"> • Being taken • Sent away • Locked up • Lack control 	<ul style="list-style-type: none"> • Māori have greater chance of <i>being apprehended</i> for being mentally unwell.
		Physical Compromise for mental stability	<ul style="list-style-type: none"> • Being drugged up • Physically compromised • Bargaining for change • Whānau watch 	<ul style="list-style-type: none"> • Māori are likely to be compromised by psychiatric medications.
		Addressing Wairua	<ul style="list-style-type: none"> • Address wairua • Wairua ki te wairua 	<ul style="list-style-type: none"> • Māori will pursue spiritual strength and healing regardless of location.

CHAPTER SIX DISCUSSION

6.1 Introduction

This section presents a discussion to the substantive Māori centred grounded theory *seeking solutions to being restricted*. It commences with a discussion on the unjust loss of social control experienced by Māori in mental health services. Then leads into dialogue about the subcategories of *turning point, being apprehended, physical compromise for mental stability, addressing wairua* and the basic social psychological process of *seeking solutions*. Each of these segments are then supported by a range of recommendations informed by the findings of this study.

6.2 Discussion

This thesis commenced with my perspective as a Māori mental health nurse, whose early career practice had been influenced by the mentorship of senior Māori mental health nurses. Those senior Māori mental health nurses had created a practice informed theory about how best to work with Māori with mental illness. The theory included the need to be vigilant with any whānau from the Watene whānau who might present to mental health services and aimed to prevent the unnecessary and negative impacts on Māori from mental health care. The theory was informed, in particular, by the demise of Michael and Manihera Watene, two Māori men who died whilst in the care of mental health services in Auckland, New Zealand.

In comparison with non-Māori, the disparities in mental illness, addiction, self-harm and suicide deaths of Māori people has increased significantly since World War II. By the late 1990s Māori rates of mental illness were considered the number one Māori health issue (Durie, 1997). Since then, Māori have disproportionately been impacted by high rates of mental illness and restrictive care in mental health services.

By a process of reviewing the current literature for this study, it was identified that data on Māori mental health issues and treatment was insufficient and dated; although, the existing data revealed that a proportion of the Māori

population are suffering significant mental health disparities compared with non-Māori. This research has provided valuable insights into the lived experience of Māori with experience of mental illness who have been in contact with mental health services and of whānau members who are supporting their loved ones with mental illness and have been in contact with mental health services. In addition, the perspectives of Māori practitioners who provided care to Māori with mental illness have also been given voice.

This substantive theory was developed following a Māori centred Glaserian grounded theory study with 30 Māori participants aged 20 to 65 years of age. Resident in Te Tai Tokerau, Northland, New Zealand, the participants who had lived experience of mental illness and mental health services at the time of the study were unemployed. They had held varying diagnoses of serious mental illness and had been in contact with mental health services.

The substantive theory explains what is occurring amongst Māori with mental illness and mental health services. The main sociological problem that has contributed to the problem experienced by participants in this study is *being restricted*. This problem consists of the *turning point*, in contact with mental health services Māori *being apprehended*, taken or sent away, to be treated by psychiatric medication that provokes a *physical compromise for mental stability*. This experience provokes *whānau to watch* and for Māori to seek a resolve by *addressing their wairua*.

The basic social psychological process Māori used to manage the problem of being restricted was *seeking solutions* which identified the importance of hope and change, as implicit and explicit motivators to the fight or adherence to the mental health system. This theory conceptualises the sensitivity to the problems Māori are facing in regard to mental illness and mental health services and informs mental health policy makers, services and mental health professionals of the need to engage in specific activities to reduce the restrictions Māori are experiencing in mental health care. In due course, mental health professionals will be challenged as their models of care are identified as contributory to the disadvantage Māori are experiencing. Alongside this is the denial of spirituality for the wellbeing of Māori and the necessary supports

for whānau as a significant shift in mental health services. The improved practices of mental health professionals and culture in care are needed to address Māori mental health needs.

6.3 Unjust Loss of Social Control

From the experience of Māori in this study, the findings show that the main problem of participants was centred on the social control that occurs in the mental health system with its oppressive methods. It seemed that the way Māori were viewed by mental health professionals was one that was often connected to adverse risk or as high risk which Harris, Cormack and Stanley (2013) would affirm as an element of racism and a negative health determinant. There is a sense that the social control of the mental health system is increasing and has expanded from inpatient acute care to treatment in the community. The consequences of Māori being restricted by the system through the actions of mental health professionals is aided by the Compulsory Mental Health Assessment and Treatment Act (1992). With this method of approach there are also systemic and chemical forms of control used. The functioning of this social control suggests that some mental health practitioners may approach Māori in more punitive than therapeutic ways. In this research, high levels of restrictions were placed upon Māori stripping them of their autonomy and agency to participate in their care and to choose in the treatments that were used and made available. It is the view that the mental health system in New Zealand is overtly contributing to an institutionally racist approach for addressing Māori health issues (Came, 2014; Harris et.al; 2013).

According to Feagin (2013), who interviewed 300 white Americans on their racial views on public policy states, systemic racism is reproduced through generations of people. That is, when conditions include substantial control by non-indigenous peoples and there is a sustained positioning of their power evident in organisational structures, institutional and ideological processes, there will be a power imbalance that will continue to sustain racial inequalities. As each new generation inherits the established culture and structures of the past mental health systems then disadvantage will continue to contribute to indigenous peoples' conditions. Whilst some improvements may have

occurred over time with the introduction of Māori health models and Kaupapa Māori mental health services (Durie, 2011), systemic racism has been retained in mainstream institutions to oppress Māori and perpetuate a racial bias against Māori. The result is seen in high rates of Māori mental illness and across rates of restrictive practices (high seclusion, restraint and Mental Health Act use).

In this study, the meaning of being restricted for Māori was about being confined and kept away from familiar locations and whānau. Māori were kept away from seeking the solutions to acquire the holistic health and wellbeing they desired, which included spiritual strength and healing. Indigenous peoples in the Americas and Australia have similar experiences with western health services failing to acknowledge the importance of their traditional place, people, culture and spirit as part of a holistic health approach (Durie et al., 2009). This then suggests that the powerlessness experienced by the tangata whaiora in this study, is relative to the racial oppression informed by western non-indigenous perspectives of mental health services and wellbeing.

When Māori experiences are misrepresented by processes that displace Māori lived experiences and meanings (Smith, 1999), these experiences are further disadvantaged in a mental health system that gives no value to culture or spirituality. This could be further explained by the constant comparison of Māori with non-Māori, as if the best benchmark sought for Māori mental wellbeing is one that is comparable to non-Māori wellbeing. With the inequalities in mental health service provision, and the subsequent Māori health outcomes from being in the mental health service, there are significant issues in mental health services with institutional racism (Harris et al., 2005). The following discussion aims to discuss and summarise the components of this theoretical model. Each section presents a discussion on each category and a range of recommendations for Māori, mental health professionals, mental health services and policy makers. I have included a component about whānau, as their perspectives were commonly weaved through the findings of this study.

6.4 Turning Point

The *turning point* is the first-time experience of a mental health crisis, it is confrontational and remains stored in a person's memory about the first time they became unwell. The impact of mental illness upon a person and his/her whānau is intense, with the person often feeling scared, socially isolated and devastated by the disruption caused to his/her life. The experience can be traumatic, for some it may be attributed to similar effects like an acute or posttraumatic stress disorder (Jackson, Knott, Skeate & Birchwood, 2004).

Engagement with mental health services, at the *turning point*, meant that the personal experiences of Māori were reframed into mental illness defined terms and concepts, providing for a rationale of what occurred. What is important to note though about the *turning point* amongst Māori is the vivid recall they possess of their experiences and the impact this has on latent feelings about mental illness and mental health services. The first mental health crises will mark a *turning point* for Māori with lived experience and whānau experience of mental illness. It is an occurrence in time that for some has remained a life time difficulty to comprehend how it eventuated. When there were feelings and thoughts that were extremely different, it provoked fear and isolation. In this study, people that heard voices felt out of control with an inability to resist being drawn into their internal hell. For most Māori in this study, having access to supportive whānau members helped greatly ease the impact of the experiences of the *turning point*.

Talking about the first onset of a mental health crisis and learning from it can transform the *turning point* experience into something useful; albeit challenging to fully acknowledge the reality of it at first. There can be a sense of loss that may invariably affect people, with disruptions to lives and sometimes to relationships leading to estrangement, wherein people may have grieved for what they perceived they had lost (Lapsley et al., 2002). From a mental health service perspective, it is important to acknowledge that Māori face a major task when seeking professional help for a mental health issue – it is never easy. Mental health professionals are encouraged to enhance their awareness of the difficulties Māori have with seeking solutions from mental health services and

how to negotiate these when Māori access mental health services for the first time. There is little point in responding to Māori unless the mental health professional accepts that a process is needed for each person and his/her whānau collectively, so that he/she will understand in general what he/she will be facing and what the available options will be when engaged in the mental health system. This is not something new as Māori have been advocating for this approach for a long time (Durie, 2001).

Caution is needed with determining what the problem is in the early course of the mental health experience. As this is in recognition of the fine line between mental illness, accumulative stress and life crises, of which the latter does not always require the western illness model to figure it out. Mental health professionals may do well to work through the early stages of the *turning point* in partnership with Māori by being supportive and available to them when the person emerges through their experience, helping them through it as it ends or progresses. Furthermore, realising that a person's reactions will change as they begin to understand or see a pattern in what is occurring (Lapsley et al., 2002). Mental health professionals are encouraged to acknowledge and not judge whānau who will act in an attempt to understand the situation with their loved one. Whānau will require their own solutions to deal with the stress at the *turning point* and often will need their own practical help to carry on.

6.5 Recommendations

These recommendations are offered to mental health professionals and for mental health services as drawn from the findings of this study and to address the issue of the *turning point* amongst Māori.

6.5.1 Mental Health Professionals

- Establish meaningful relationships with tangata whaiora and their whānau to reflect and talk about their *turning point*.
- Undertake a process of self reflection of their own practices toward Māori.

- Recognise the potential for grief and loss that tangata whaiora and whānau may experience as a result of the mental health crisis and mental illness.
- Recognise the potential for acute or posttraumatic stress secondary to the *turning point*.
- Identify and work with the difficulties Māori may experience accessing mental health services.
- Provide support and be readily available to tangata whaiora and whānau as the mental health crisis progresses.
- Recognise whānau are part of the treatment decision making process.

6.5.2 Mental Health Services

- Establish a system that fosters mental health professionals to work in partnership with tangata whaiora and whānau collaboratively from the *turning point*.
- Establish and implement whānau centred strategies that provide a range of solutions to tangata whaiora and their whānau to deal with the stress from the *turning point*.
- Ensure practice development opportunities are available to mental health staff including working with Māori experiences of grief and loss, trauma from a Māori perspective, tangata whaiora and whānau strategies in mental health crises.

6.6 Being Apprehended

The category of *being apprehended* is the key outcome of Māori seeking help from mental health services. This category is primarily focused on retaining Māori in the mental health system for the sole expectation of treatment. Little discussion occurred amongst this group of participants about improvements over any course of enforced treatment they had experienced.

This raises the perspective that there is an authoritarian attitude toward mental health care in New Zealand. This attitude of control is embedded into the mental health system and has been evident since the asylum era in New Zealand that is supported by the Crown and Mental Health Act legislation. With early mental health laws, it was common practice to publically profile cases of the mentally ill through newspapers; this provoked a public narrative and socialisation of beliefs about mental illness that connected mental illness with the police and the law. This association built a focus on the mentally unwell as being part of a community that wished to achieve normality through a practice of law and order (Hill, 2008). Such stigma has produced a confused health system, whereby in its benevolent role of health care is woven the legal powers of a court and policing system that has become an accustomed practice when it comes to contributing to the policing of Māori for their mental health treatment.

The Ministry of Health (2014) had its concerns regarding high rates of Māori being treated under the Compulsory Mental Health Assessment and Treatment Act (1992) (both as inpatients and especially in the community) and subsequently requested an investigation and sought solutions to reduce the apprehension rates of Māori in mental health services. Though Māori experience some of the most appalling social determinants to health, these do not entirely explain the high rates of Māori being apprehended by mental health services. Instead, the attention taken by the Ministry of Health has reverted to the systematic processes and the institutional racism in New Zealand's mental health services that have progressively disadvantaged Māori (Reid & Robson, 2007).

The persistence of racial bias in relation to Māori, especially Māori men, has attributed to the disproportionate representation of Māori in mental health services and Māori being treated under the Compulsory Mental Health Assessment and Treatment Act (1992) (Ministry of Health, 2014). Outside of health, it is considered that Māori people are actively policed rigorously for other matters as evident throughout the history of New Zealand (Hill, 2008; Tauri & Morris, 2003).

Mental health professionals and services have been highly discriminatory toward Māori, often using restrictive controls and psychiatric medication even when they have unpleasant and dangerous side effects. Not surprisingly, Māori will choose to escape mental health services or stop contact because of their dissatisfaction with the care received, especially from the impacts of the enforced medication. Mental health professionals will want to develop a therapeutic relationship with Māori people. But once there is coercion in the treatment pathway, there will be a major problem regarding how Māori people will feel about trusting mental health professionals and mental health services, which in turn will influence the treatment relationship (Drury & Munro, 2008). Adding to this are the attitudes of mental health professionals toward Māori, some of whom will hold bias, some believing all Māori are aggressive (Te Pou, 2014). The attitudes of mental health professionals will influence their practices toward Māori as being more likely to institute punitive responses to their treatment.

Transactional care by mental health services is aided by mental health professionals who act in ways to ensure Māori engage in the mental health service. Accumulated stress can be caused by the ill engagement with mental health services which will further influence the relationship between mental health services and whānau. The result is often Māori wanting to disengage with the mental health professional and thinking less of the mental health service. There is encouragement of mental health professionals to review their beliefs about Māori and the propensity that they will be more predisposed to mental illness (Johnstone & Read, 2000). In addition to challenging the preferences of clinicians who are using mechanisms under the Compulsory Mental Health Assessment and Treatment Act (1992) to pursue their clinical

goals (Romans, Dawson, Mullen & Gibbs, 2004) rather than the goals centred on Māori needs and aspirations, there is a need for a strategy to transform the perceptions of mental health professionals about Māori and mental illness. This calls for a workforce development approach to transform beliefs. Came and Griffith (2017) believed that to tackle racism requires specific anti-racism interventions, through the integration of new knowledge and skills into health professionals' practice. A strong strategy would be to critically review the place of institutional racism in mental health services, and to develop models of practice that empower Māori rather than isolate, restrict and disempower them. Cultural competencies for mental health professionals do have the potential to reduce disparities experienced by Māori in mental health services. It is important mental health professionals understand and not ignore Māori perspectives of health and healing, and the involvement of whānau, the importance of those relationships and the place of wairua in recovery.

The main concern amongst Māori was about *being restricted* and part of this was about being forced away from familiar surroundings and whānau. Māori took the distancing personally and many were hurt by it. Subsequent issues included Māori being distanced culturally and spiritually, being apart from whānau and their way of life. If continual, there was potential to turn into a form of alienation which could be too easily accommodated as an accustomed approach and practice of the mental health system.

6.7 Recommendations

These recommendations are offered to mental health professionals and for mental health services as drawn from the findings of this study and to address the issue of *being apprehended*. This section highlights the need for further research and an improvement in policy to address the issues of mental health care to Māori being synonymous with being taken or sent away, as part of this overall category.

6.7.1 Mental Health Professionals

- Understand the continual impact of mental health services upon Māori and the subsequent disparities experienced.

- Identify and critically work through racial bias about Māori and mental illness.
- Develop and implement cultural competencies and models of practice that empower Māori rather than isolate, restrict and disempower them.

6.7.2 *Mental Health Services*

- The recognition that there is a need for the transformation of mental health services from an oppressive system that restricts Māori to one that empowers Māori tangata whaiora and their whānau.
- Develop mental health systems so whānau relationships are maintained, especially when tangata whaiora are in receipt of acute mental health care.
- Implement practice development opportunities for staff so they possess the skills and knowledge to provide alternative methods of working with Māori rather than compulsion under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and restrictively.

6.7.3 *Research*

- Research is required to determine racial bias regarding the increasing rate of Māori (especially Māori men), diagnosed with serious mental illnesses such as schizophrenia, in mental health services and under the Mental Health Act.
- Updated research is required to fully comprehend the impact of disparities upon Māori mental health.

6.7.4 *Policy Makers*

A range of strategies to:

- Eliminate institutional racism in mental health services by engaging in activities that target the disparities of Māori in mental health services.
- Reduce the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 as a mechanism for treatment by clinicians on Māori.

- Support the development of models of practice and care that empower Māori rather than isolate, restrict and disempower them.
- Critically review mental health services and their impact on retaining Māori for the sole purpose of treatment continuation.

6.8 Physical Compromise for Mental Stability

When Māori seek solutions from mainstream mental health services, psychiatric medication is the dominant focus promoted for their mental wellbeing. In this study, mental health services were highly criticised for their dominant medical model and overzealous approach in treating Māori with psychiatric medication. Māori and whānau with lived experiences were confronted by mental health services that focused on dealing with symptoms by using medicines to chemically restrict them.

It is appreciated that each person will hold his/her own health beliefs and experiences when it comes to whether or not they are willing to accept medication (Day et al., 2005). Thus, there is a requirement for mental health professionals to understand that Māori may have other meanings assigned to medicines and that cultural obligations and whānau will influence their beliefs and medication practices (Nikora, Hodgetts, Carlson, Tongi & Li, 2010).

From the *turning point* to the first encounter with mental health services, participants in this study were naive to taking the psychiatric medication that were considered beneficial for their mental and emotional wellbeing. Whānau members were stunned at the ease with which medical professionals gave medications to young Māori, especially when it was their first mental health crisis. Participants felt the dominance of the legal system and mental health services was always evident when it came to prescribed medications, and had not even heard of many of the medications they were receiving.

From the current literature, there is little argument that Māori are prescribed higher doses of medication in comparison to non-Māori in mental health services (Pharmac, 2006; Wheeler et al., 2008). Any clinical assumptions about the biological variances between Māori and non-Māori, and their acuity as attributed to the higher doses of medicines given to Māori needs to be

seriously reviewed (Gibbs et al., 2004; Kumar et al., 2008). There is no scientific evidence in New Zealand to indicate biological differences with medications used in mental health services between Māori and non-Māori; yet there are more marked differences in the morbidity and mortality rates of Māori.

There exists knowledge of premature mortality where people who experience mental health problems and who are in contact with mental health services are dying prematurely. In general men and women using mental health services are at more than twice the risk of death when compared to the New Zealand population after adjusting for age. Men and women with psychotic disorders have even higher mortality, three times that of the whole population. For Māori mental health service users, their mortality rate is one third greater than that of the whole Māori population, with women worse off than men assuming the same age structure (Cunningham, Sarfati, Peterson, Stanley & Collings, 2014).

In the current study, concerns were expressed about how young Māori were given high doses of medication upon their first onset of a mental health crises. No New Zealand research could be found that has been conducted with young Māori people given high doses of medication. This matter requires more exploration to further understand the concern. Overall, a systemic review is needed of how Māori are treated with medications and in mental health services.

It did not matter how long a person was engaged with the mental health system or with mental health professionals, there was constant frustration amongst Māori in having to take medication. Feeling like they were part of an experiment was the impression given by many participants who had been medicated by mental health services or as whānau who had supported their loved ones in mental health services. Amongst participants who had more than a decade of experience with mental health services, they felt the contemporary or newer medications were no different than the older medications. There may be an inclination to taking medication not because of its therapeutic benefits, but because of the relationship with the medical professional who has oversight or responsibility for prescribing or supporting the person (Day et al., 2005;

Fenton, 2000; Gray, R., Rofail, Allen & Newey, 2005). Even so, when under the Compulsory Mental Health Assessment and Treatment Act (1992) there is a tendency to just accept what is happening (adhering to the system) so the person can get more out of the mental health system faster (Fenton, 2000).

Often noncompliance to prescribed medication is associated with increased involuntary admission to mental health services (Day et al., 2005), which was evident amongst this group of participants. If Māori were forcibly detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 it was easy to associate the giving of medication as a form of punishment and it was often recalled in these experiences that medications were always a negative occurrence.

When concerns were raised about psychiatric medications, the person and whānau's judgement was seriously tested by mental health professionals who would question their intentions. It was here that the question of where the power balance existed was raised. Was it with the mental health professionals, the person and whānau or was it that by having a mental illness, it stigmatised Māori and impacted on what credibility the mental health professional placed on the person's desires pertaining to their medication (Happell, Manias & Roper, 2004). Whilst medication may satisfy some people in regard to symptoms experienced, alone these did not entirely appease Māori as it only affected the physical symptoms and did not address their cultural or spiritual needs. Being physically compromised was a direct consequence of *being apprehended*, taken and locked up in mental health facilities, aided by medications designed to improve the wellbeing of Māori affected by mental illness.

Māori expressed having had intolerable side effects from the medication and that achieving the right dose and type of medication took years, although they still hated taking them. The newer medications (second generation antipsychotics) were available to Māori in this study (Wheeler et al., 2008); yet grave concerns were held of atypical antipsychotic medications for their adverse reactions (Medsafe, 2002 & 2003). There have been genuine concerns in relation to the increasing evidence and association of atypical

antipsychotic and medical conditions experienced by consumers. For example, increased weight gain; impaired glucose metabolism causing new onset of diabetes mellitus (Medsafe, 2002 & 2004) pulmonary embolism (Medsafe, 2001 & 2007) and myocarditis and cardiomyopathy (Hill & Harrison-Woolrych, 2008), especially in association with Clozapine (Medsafe, 2001, 2003, 2008; Novartis, 2014), in addition to gastrointestinal obstruction and impairment (Medsafe, 2006). Significant physical effects such as sedation, gastrointestinal upsets, weight gain, blurred mental clarity, adverse medical experiences and the knowledge of other friends' sudden deaths had an influence on the attitudes of Māori toward ongoing treatment. This was one of the reasons why medication was stopped or there was an attempt to escape the mental health service entirely. In this study, concerns were raised of sudden deaths of Māori who were taking Clozapine. Evidence elsewhere suggests this to be possible and probable from the consequences of medication (Ministry of Health, 2008). Unfortunately, the information on the issue of sudden deaths of Māori is unavailable. There was serious concern that if there remains little recognition of the dangers of death associated with psychiatric medication and with little focus given to Māori, the medications they are prescribed in mental health services, will continue to physically compromise Māori for mental stability. There is a need for an authority to be established to ensure vigilance in monitoring and reporting the status of and impact upon Māori in regard to psychiatric medication. Additionally, a study on the administrative data that looks at Māori mental health ICD codes, mortality, cause of death and prescribing information to see if there is a difference in deaths is also warranted. Rather than promoting warning messages of psychiatric medication, any deaths of Māori being treated with Clozapine or other psychiatric medication requires an immediate formal inquiry of review to ascertain the enormity of the issue. Furthermore, strategies need to be developed to ensure Māori who are prescribed any psychiatric medications (with their whānau) are fully aware of the consequences whilst being treated by mental health services.

6.9 Recommendations

These recommendations are offered to Māori, mental health professionals and mental health services as drawn from the findings of this study and to address the issue of *physical compromise for mental stability*. This section also highlights the need for further research and an improvement in policy to address the issues that are associated with the use and outcome of psychiatric medication with Māori.

6.9.1 Māori

- Māori accessing mental health services and receiving psychiatric medication to be vigilant of the potential impacts of medications and their right to seek a review of treatment.
- This includes the need for improved health literacy of medications and the right to request a review of or to decline treatment.

6.9.2 Mental Health Professionals

- Monitor and review the treatment and medication of tangata whaiora.
- Increase the monitoring of psychiatric medication of Māori and provide strategies to address the physical compromises they are experiencing (side effects and serious medical conditions).

6.9.3 Mental Health Services

- Establish systems that critically review the use and prescribing of psychiatric medication to Māori and its impacts.
- Increase the monitoring and management of psychiatric medication of all Māori tangata whaiora.

6.9.4 Policy Makers

A range of strategies to:

- Critically review the use and the prescribing of psychiatric medication to Māori and its impacts in mental health services.
- Institute a mechanism (for example, a register) to monitor all Māori being treated with Clozapine and other atypical antipsychotic medication.
- Establish a mental health mortality review committed that would investigate all unexpected deaths of Māori who were taking Clozapine or atypical antipsychotic medication.
- Prioritise Māori mental health given the disproportionate health and social issues, and potential for poorer physical health.

6.9.5 Research

- Further data is required on Māori sudden deaths on Clozapine and other psychiatric medications.
- The attitudes and beliefs of mental health professionals toward Māori, specifically how such attitudes and beliefs inform how they prescribe for Māori.

6.10 Addressing Wairua

There is little to no appreciation by mental health services for the need to address the wairua of Māori or to provide for a holistic service that ensures a person's spirituality. Yet, attempts will be made by Māori and Māori practitioners in *addressing wairua* to make deliberate cultural and spiritual connections with Māori as part of a healing process. The category *addressing wairua* with concepts of the *pursuit of spiritual strength* and *working with wairua* reveal perspectives of Māori in regard to the need for the healing of a person's wairua. Wairua to Māori is the human soul (Mead, 2003); it is also a generalised term used to describe the spirituality of Māori. Addressing wairua holds a connection to a depth of understanding that traditional Māori once held, and the desire of contemporary Māori people seeking wairua healing.

From birth, each person possesses their own wairua, bound to them during their lifetime (Mead, 2003). Wairua provides an inbuilt mechanism that has the ability to warn a person of impending danger through visions and dreams. It is in this wairua context where often there is an acceptance of auditory voices and visions, although the wairua is viewed as being vulnerable to being subject to attack from others (Best, 1978).

Accessing tohunga was the common custom of the past. Tohunga were a resource whom Māori would seek solutions from for their challenges. Tohunga were often thought of as experts. According to Marsden & Henare (1992) the tohunga was the person chosen or appointed by the gods to be their representative and agent by which they manifested their operations in the natural world of power.

All Iwi had tohunga who were trained in whare wananga in the intricate aspects of the law of tapu and the important elements in tikanga (customary practice). Tohunga would apply or remove tapu (sacred state of being set apart) from places, people or activities for special reasons (Keene, 1977; Marsden & Henare, 1992). Their focus was to re-establish the balance between tapu and noa (Durie, 1998) as a high level of tapu was regarded as dangerous. It was the role of the tohunga to reduce the level of tapu until it was noa or safe (Mead, 2003). Once the balance was reached then life was back to normal again, health was restored and the crisis was over (Marsden & Henare, 1992).

The Tohunga Suppression Act (1907) forced Māori healers underground, a consequence of why the knowledge of rongoa and karakia amongst some Māori has been disregarded (Durie, 1998). Notwithstanding the impact of this legislation, in some regions Māori wairua healing, Māori healers and the attention required of wairua had sustained the ravages of colonisation through the passage of knowledge down through the generations of certain whānau.

They cut out tohungatanga, the tohunga suppression act took away the very ngākau of our teachings as a consequence. If you look at our mental health as a people; a couple of generations of any teaching that was embedded in wairua is almost entirely lost. A lot of my teaching comes from Papahurihia (Waima). His teachings were passed down through our whānau. (Rimu)

There are potential challenges in reconnecting to the depth of knowledge about the traditional practices of Māori when it comes to addressing wairua. In the 21st century Māori continue to believe in the importance of wairua and will seek answers to their situations, hoping for strategies to help heal the wairua of themselves as Māori.

In this study, there were Māori practitioners who addressed wairua through the provision of karakia and methods in such a way that a practice of whakawaatea occurred to help address the wairua of a person. For Māori who conduct the actions to address wairua, their reputations and outcomes speak for itself, they are people who are known and revered by Māori who have attended to the wairua of others.

What it means to address wairua requires the Māori practitioner to believe in the power of wairua ki te wairua, the ability of wairua to be connected to wairua of people and place. Part of the Māori healing resolve is to be able to facilitate the connecting of wairua, and to recognise wairua whilst comprehending Māori principles important to life.

Māori in this study sought solutions for their overall wellbeing and, regardless of contact with mental health services and associated experiences, Māori with lived and whānau experiences sought solutions to address their wairua by reaching into the Māori world. It is, however, the access to Māori practitioners who are dedicated to working with and in wairua with Māori that will make the difference for Māori to be able to address their wairua and to heal.

By doing so, Māori are posing that it is the wairua that is in trouble when a loved one experiences a mental health issue. It is a member of the whānau who will usually raise the concern that the wairua of a person is in trouble and this is why the person is unwell. The wairua is viewed as the basis of all emotion and thoughts, and so when a person demonstrates unusual emotions and thoughts the innate response by Māori is to enquire about the person's wairua (Mead, 2003).

The impact of the lived experience of mental and emotional turmoil, can be so compounding for a person, it can conjure feelings of losing one's soul or feeling that their soul is being taken away by another force. This is where whānau are needed to comfort their loved one, to reassure them this will not occur and spiritually ensure they are safe.

Mākutu was raised in this study and in the past it was understood by Māori to be one source of disease and death (Te Hiroa, 1910) caused by sorcery (Mead, 2003), a curse or calling up of spirits by means of incantation to cause a person harm or disaster of a supernatural kind (Blake-Palmer, 1954; Durie, 1998; Te Hiroa, 1910). If a person had caused offence or had done wrong to another person or place it could bring about sickness or death (Marsden, 2003).

The knowledge and practice of mākutu were confined to specialist tohunga whose knowledge and skills were hidden from commoners (Marsden, 2003). The fear inspired by the dread of mākutu would help tohunga to govern the tribe (Te Hiroa, 1910). The rituals conducted by tohunga varied, although it was thought some type of personal material was needed to enact the deed of mākutu (Te Hiroa, 1910). Tohunga would counteract these effects by seeking the origin of the person's troubles and facilitating a cure.

The interpretation of symptoms by Māori were invariably considered supernatural features of what the person was experiencing, which was against the norm at the time and looked upon with fear (Te Hiroa, 1910). Although the person could self-diagnose the problem, it was important to gain access to a tohunga to verify the existence of mākutu. By evaluation, the tohunga would elicit from the person if they had transgressed tapu or Māori lore's, and in consultation with the gods the tohunga would make her or his diagnosis (Blake-Palmer, 1954; Te Hiroa, 1910).

It was thought that a person under mākutu could go into a deep trance. They might speak in tongues or express knowledge of which they were previously unfamiliar with. They may also show facial changes by grimacing and an intensity in their eyes (Fielding Star, 1920). It was stories informed by similar circumstances through generations of whānau that frightened some in this

study, especially when loved ones presented in ways that were reminiscent of those whānau examples of mākutu.

Māori were viewed as a tapu (sacred) people with many laws, customs and rules of conduct based on rules of tapu affecting man, the land and all things. Māori used karakia and practiced rituals to secure one's safety from mākutu. Today there seems a hidden silence about mākutu and its existence amongst Māori, although the silence lifts when a reason for the origin of illness, ill fate or situation is sought because there is little explanation for what has occurred (Taylor, 2007). The fear of mākutu reigns, for a small group of Māori living with mental illness. One study found that the thought of having an mākutu was more detrimental than identifying with having a mental illness (El-Badri & Mellsop, 2007).

Western perspectives of traditional Māori beliefs have portrayed mākutu as nothing but superstition, and in the area of health it is viewed as being of doubtful diagnostic significance (Durie, 1998). Durie (1984) and Pere (1991) introduced holistic health models which have provided an understanding of Māori health perspectives. In *Te Whare Tapa Whā* (Durie, 1984) and *Te Wheke* (Pere, 1991), wairua is viewed as the most essential component for health, superseding the physical dimension. Yet, western health perspectives continue to separate the mental, physical and spiritual realms of people, and though Māori concepts of illness inclusive of wairua maybe recognised, wairua needs of Māori are not well addressed by health services.

Addressing wairua in mental health services is juxtaposed by two different systems of knowledge, Māori knowledge and western medicine. This is why the wairua of Māori is not addressed well by mainstream mental health services. The prevailing risk of viewing Māori only in physical and medical terms will only result in Māori being viewed as a psychiatric problem and all other matters of importance will be neglected. Within the Māori world there remain the stories of people seeing, hearing, predicting, all of which are culturally acceptable and manageable with spiritual guidance (Bidois, 2012; Bush & Niania, 2012). Māori spiritual issues within the health context are considerable yet they are often overlooked, unless there is easy access to

skilled Māori practitioners or Kaupapa Māori mental health services (Bush & Niania, 2012).

The mental health service needs to have systems to appreciate the importance of wairua having a place within the mental health care of Māori without restrictions. This includes mental health professionals accessing experts such as professional spiritual healers (Carey & Del Medico, 2013; Johnstone & Read, 2000).

Māori practitioners in this study contended that the issues of Māori mental health as stimulated by a person's wairua are due to having been impeded by the impacts of colonisation, indicating the dire need for spiritual support amongst Māori. In turn, Māori practitioners will play a vital role in addressing the wairua needs of Māori, as they will draw on aspects of spirituality to heal people holistically (Mark & Lyons, 2010). But there are concerns of what will happen to Māori with mental illness and their whānau if there is little access to Māori practitioners or healers skilled in addressing wairua that Māori require. To understand the scale of this, further research is needed to comprehend the extent to which Māori healers and healing are needed for Māori with mental health issues and to build a strategy to ensure this healing resource is easily available to Māori.

6.11 Recommendations

These recommendations are drawn from the findings of this study about how to improve the approach to address the wairua needs of Māori. There are implications for mental health professionals and mental health services given alongside the discourse of mental health services and the domination of medication in the treatment focus of those with mental illness.

6.11.1 Mental Health Professionals

- Attain skills and knowledge pertinent to ensure Māori cultural and spiritual needs are incorporated into the care and treatment of tangata whaiora.

6.11.2 Mental Health Services

- Establish systems and processes to ensure spiritual needs of Māori are facilitated and addressed.
- Ensure access to Māori practitioners and spiritual healers skilled in addressing the wairua needs of Māori.

6.11.3 Research

- Further research to identify the resources required to address the spiritual needs and healing of Māori with mental health issues.

6.12 Whānau

The whānau is a key source of Māori well-being and connectedness. A common Māori expression to describe the integration of whānau uses the metaphor of the harakeke, or the flax bush. 'Kua tupu te pa harakeke' is translated as 'the harakeke is growing'. The centre shoot, or 'te rito' of the flax bush is protected by the wider flax bush. The centre shoot represents children, and the bush represents adult whānau members. The pa harakeke metaphor assumes within whānau there will be individual and whānau security, protection, and wellbeing; with each person supporting each other and securing their position in the whānau (Munford & Sanders, 1999). According to Metge (1995) there is the duty to care within whānau that is expressed in the Māori language via words such as ahu (tend, foster), atawhai (show kindness to, foster), awhi (embrace, foster, cherish), manaaki (show respect or kindness to), taurima (treat with care, tend) and whāngai (feed, nourish, bring up). All of these words imply meeting the physical needs of whānau members as well as the need of whānau to be nurtured mentally and spiritually. This duty of care for each other includes the responsibility laid down from previous generations to teach the younger generations the right way to live a life and to hand on knowledge that belongs to and will benefit the whānau as a whole. Given its central importance to Māori, whānau is recognised by New Zealand's Government as vital to the economic and social wellbeing of all Māori (Families Commission, 2009; Ministry of Health, 2002b). Significant

whānau and relational networks exist outside the immediate household. The exchange of social and economic resources between whānau members and members of different households can significantly affect the achievement of whānau wellbeing (McKenzie & Carter, 2010; World Health Organisation, 2012). Extended whānau networks can be complementary to (or replace) the public services that are supported by Government social policies. The existence of an extended whānau and whānau members' ability to provide care and support for one another is a key assumption of a great deal of whānau based policies. It is important, therefore, to have an understanding of these networks.

Two models of whānau dominate the current literature, they are whakapapa and kaupapa whānau (Lawson-Te Aho, 2010). Whakapapa whānau are connected through a common ancestor. Kaupapa whānau are people connected to each other to fulfil a common purpose or goal. Māori want to be able to determine how whānau are identified and what the priorities are for their own development (Te Puni Kokiri, 2005, cited in Lawson-Te Aho, 2010). With this in mind, there are variances of whānau that will consider both whakapapa and kaupapa whānau as being valid. Leaving it to the individual person to define his/her own whānau within their broader relationship categories. While whānau wellbeing is a complex concept, at its simplest it is having a happy and healthy whānau. Whānau wellbeing, or whānau ora, is based on the central role of Māori cultural values (Lawson-Te Aho, 2010). In exploring and defining whānau ora, Lawson-Te Aho (2010) said "the mental, emotional, physical and spiritual state is shaped, maintained and contained in context of whānau relationships" (p. 11). Therefore, when an individual is not well, a whānau is not well. Conversely when a whānau is not well, individuals are adversely impacted. Whānau ora is a state of collective wellbeing that is integrated, indivisible, interconnected and whole. Each whānau attaches different meanings to whānau wellbeing than do other whānau, and each may adjust what it means to them over time. Therefore, whānau wellbeing is best shaped and given meaning by Māori who are most affected by it (Whānau Ora Taskforce, 2009). The role of whānau is an essential aspect of Māori wellbeing; as the foundation to Māori society (Ministry of Health, 2002b), whānau can

provide for a source of strength and support essential to Māori mental wellbeing (Huriwai et al., 2001; Munford & Sanders, 1999). Since the shift from psychiatric institutional care to more community based models of mental health services and care, whānau have increasingly been expected to provide crucial support to their loved ones with lived experience of mental illness. The added expectations upon whānau as primary caregivers of loved ones with serious mental health and addiction related issues, has tended to go unrecognised by mental health professionals and health services (Laird, Smith, Dutu & Mellsop, 2010).

Mental health professionals have been encouraged to involve whānau with the people they are supporting, and evidence shows where whānau are actively involved in a person's mental health care, there are positive treatment outcomes for the person and better relationships with whānau (Gibbs et al., 2004; Mental Health Commission, 1998). Whānau rarely had experience of mental illness, as the notion of it is perceived within a western construct with which whānau find difficulty to relate. There is a whānau instinct to care for their whānaunga if they are demonstrating new, different and challenging emotional and thought processes. They are motivated to be nearby their loved one during the experience so they can support them as best they can. By being physically nearby their whānaunga, with support from other members of their whānau, they are able to show their aroha, manaaki and desire to help their whānaunga the best way they can. The first experience of a mental health crisis of a loved one's *turning point*, in this study, was one of the most confronting experiences for whānau. Whānau in this study talked about their motivation to be nearby their loved one either during or after the experience so they could support them as best they could. This meant whānau left their homes to stay nearby their loved one who was engaged in mental health services, with some whānau members making desperate measures economically and personally in the interests of their loved one to be nearby them. Whānau actively sought out reasons and solutions within their personal support networks to seek solace and advice. Overall, whānau will seek solutions for their whānaunga within their whānau networks first, often searching for reasons why their whānaunga is experiencing what they are.

This often entailed a process of deep reflection, challenge and learning to locate the underlying reason for the experience of their whānaunga and thus the best considered approach based on Māori values. In the end, in this study, most whānau eventually sought help for their loved one from mental health services.

During the acute phase of mental illness Māori have reported feeling isolated and alienated from their whānau. Once recovered, there is an appreciation for whānau when Māori are reconnected with them following their episode (Waitoki, Nikora, Harris & Levy, 2015). There was an impact in the home and on the life of the whānau, especially where there were tamariki concerned and whānau were unwell, which required the need to manoeuvre around and cope with the behaviours portrayed by their loved one. Whānau members and extended whānau arrangements were crucial in providing the extended support needed to ensure stability, routine and security in the home. One of the most challenging experiences that parents, especially mothers in this study, experienced was when they were taken away from their children or the children were taken away from them. Losing the right to care for one's children was a reality for some and a constant threat to loved ones with mental illness. In a New Zealand study of Māori diagnosed with bipolar disorder, the mothers were in constant fear of losing their children, whilst some had their children taken from them or were told not to have children. Māori men were equally concerned about losing their children or were unable to provide for their whānau (Waitoki et al., 2015). There was also a converse impact for children who witnessed their parents' experiences of untoward behaviours, and experienced the negative consequences from the forced separation caused by their parent being apprehended and sent away.

Whānau participants in this study held feelings of regret in the knowledge it was they who had taken their loved one to the mental health service for treatment and then discovered that the treatment was making their loved one worse. Whānau would communicate to mental health services clearly what their thoughts were about medications and, in some cases, they would request mental health services do not over medicate their loved ones. When concerns were not addressed about how a loved one was medicated whilst in care,

whānau would challenge the mental health system about the amount of medication given.

Whānau tend to be left out of consultations by mental health professionals, and mental health services often will determine the availability of solutions for their loved one based on a medical model of treatment. A study completed in New Zealand mainstream mental health services identified whānau, especially the needs of children of parents with mental illness, were neglected by the health services responses to the parents' mental health issues (Pfeiffenberger et al., 2016). This was particularly so when the parent was assessed during an episode of acute mental illness where the immediate care and protection of the child should be paramount.

When the experience of mental health services were dissatisfying, whānau fought the mental health system. They removed their loved one from the service and/or challenged the mental health service, especially when concerns were raised about their wellbeing and the use of medication.

Mental health professionals who made it clear to whānau of what to expect of mental health services and included whānau were appreciated as opposed to those who did not, dominated the decision-making process for the person, and left whānau out. The resistance viewed amongst whānau, of fighting the mental health system, meant fighting for an improved level of care for their loved one, and their desires for a more holistic approach, including their loved one's interests, their life and their whānau. Personal and whānau meanings of separation had a strong influence on the interactions between the loved one and whānau. With periods of extended separation between the loved one and his/her whānau, it required differing methods of building relationships because the loved one had been taken away, or was institutionalised for extended periods of time. Often it meant that the separation from whānau, needed the relationships to be mended to bring about meaning and closeness between the loved one with the experience of mental illness and his/her whānau. Yet, the desire to be nearby and to have better contact and communication with, and amongst, whānau members were goals of all participants.

Whānau members often sought solutions to the problem that purposely addressed taha wairua of the person. Sometimes this incurred looking to see if the source of the problem lay within the whānau. People with knowledge of taha wairua whom were informed by mātauranga Māori and healing were sought from varying places to provide counsel and guidance. General methods utilised and applied were korero, karakia, and whakawātea by tohunga, kuia or kaumatua, with outcomes of Māori feeling an immediate calming effect upon them. For some whānau, these Māori informed solutions raised issues of historical matters that had not been resolved, and laid dormant within their whakapapa. Conversely, some whānau were restricted by their fears of the source of their loved one's issues being wairua bound in part due to the impact of the Christian infused values of a colonised people with beliefs of evil and wrongdoing being the underlying cause to their loved one's experience. With such fear, it provoked some whānau to be estranged from a taha Māori approach and thus impeded the depth of attention to address wairua or the issues that lay within the whānau as a whole. For these whānau, the western medical model of mental health services provided for Pākeha solutions that were deemed more plausible to seek.

Māori in this study valued their whānau, and the connection through them to their cultural identity. When Māori perceived there was a distancing from their whānau, their wellbeing was also compromised. Mental health services were criticised for not considering whānau. It seemed that in this study, mental health professionals had little understanding of the distress to whānau, let alone to the situations where parents and children were either removed or displaced by the mental health system.

Some whānau shared the desire of wanting to keep close and in this regard it was difficult to do so as mental health professionals and services prevented ready access to most whānau members, or mental health services sustained the distancing of the person by staying focused on the individual. This is a breach of right four under the Health Disability Code of Health and Services Consumers rights where services users have the right of support persons with them.

There was also some ambivalence toward mental health treatment. On one hand whānau needed support for their loved ones' mental health; yet they were often sent away in the promise of treatment. On the other hand, the distance through the loved one being sent away from whānau meant a distance also from parenting roles and bonds and/or overall relationships amongst whānau.

To appreciate how whānau come to terms with their loved one's mental illness and in order for the response by mental health services to be beneficial to Māori, there is a need to consider how best to support and include whānau from the *turning point* and through subsequent engagement. Further, it should be realised that whānau may seek a negotiation process to bargain the care of their loved one, especially when it comes to medications.

Whānau will make decisions and take matters into their hands, especially when they are concerned their loved one is being over medicated. There is a desire for mental health professionals to walk beside the whānau so they understand the system and help them process the raw emotions that come with their distress. To work well with whānau, mental health professionals require strategies that appreciate the cultural and spiritual preferences of Māori in care.

It is important not to over-generalise whānau as they will differ widely in their knowledge of mental illness, and in their capacity to support a loved one. Each whānau will require their own strategies to understand and manage the support process. Some will require support to develop new communication skills so they can effectively talk with their loved one, and relate well with them going forward.

In many cases, frustration experienced by whānau could well be addressed if mental health professionals could spend more time with them. Blaming mental health services is common when whānau are overwhelmed and the expectation for the level of care of their loved one does not meet their expectations. It is pivotal for mental health services to have the right resources and strategies that are able to be tailored to Māori whānau to enhance their knowledge and capability to engage in interactions. Working with whānau requires a shift away from an individualised focus, common in mental health

treatment, and an investment in a shift toward authentic whānau centred practice (Ministry of Health, 2012). Evidence from Waitoki et al. (2015) showed Māori were more productive when they were connected to their whānau via strong relationships. In addition to viewing whānau as a source of connection, strength, support, security and identity, raising the importance of whānau is central to the wellbeing of Māori – individually and collectively.

6.13 Recommendations

These recommendations are drawn from the findings of this study about how to improve the approach to working beside whānau of Māori. The recommendations are specifically focused towards mental health professionals and mental health services.

6.13.1 Mental Health Professionals

- Increase knowledge and strategies to counteract the separation mental health services cause to whānau, especially to the parent-child relationship.

6.13.2 Mental Health Services

- Establish whānau friendly services that foster the ability and ease of whānau to be nearby and included with their loved one.
- Establish pathways or models of practice whereby whānau are included from the *turning point* and at any engagement with mental health services.
- Encourage mental health professionals in practice development opportunities that ensure they walk beside whānau and are competent to do so effectively.

6.14 Seeking Solutions

Seeking solutions is the basic social process, a concept Māori in this study became accustomed to actively doing to overcome being restricted in their experience of mental illness and mental health services. By *seeking solutions*, there were differences shown with Māori mental health professionals and

Kaupapa Māori mental health services, in being more holistic in their responses to Māori than mainstream mental health services. Te Ao Māori (Māori world) provided for a more holistic approach to health and wellbeing that better aligned with the philosophy of recovery. If Māori had a previous history of trauma, the pain could be recreated through the experiences in mental health services (Kidd, Butler & Harris, 2014); therefore, *seeking solutions* that helped them heal were most important.

Participants with lived and whānau experiences of mental illness and mental health services needed to believe there would be a sense of recovery, and that people could indeed live a life beyond the effects of mental illness and experiences with mental health services. The seeking of solutions that reduced the cultural bias in the encounter with mental health services for Māori was possible through a Māori mental health workforce who contributed a specifically Māori cultural focus, or a Kaupapa Māori mental health therapeutic approach.

It did not matter that the Māori participants may have had little knowledge or experience with knowing their Māori whakapapa, or if they had not understood te reo me ona tikanga prior to being supported by Kaupapa Māori mental health services or Māori health professionals. *Seeking solutions* through Kaupapa Māori mental health services ensured a Māori person's sense of belonging and connections were intact, and by doing so there were explicit changes and an improvement to their overall wellbeing.

Māori are alike other indigenous and first nations peoples when it comes to a preference for healing that is holistic and reconnects to their culture. Through the use of healing traditions indigenous peoples tend to seek solutions to regain balance in their spiritual, emotional, mental and physical health whilst sharing their cultural interactions with other peoples (Hunter et al., 2006).

According to a study of indigenous practitioners, culture is the primary vehicle for delivering required healing to indigenous peoples. The overarching principle in culturally appropriate approaches is that culture is medicine which means that connecting with one's culture has both protective and therapeutic

value, promoting both resilience to and recovery from health issues (Bassett, Tsosie & Nannauk, 2012).

Indigenous means of treatment through culture may include any or all of the following: language, traditional foods, ceremonies, traditional values, spiritual beliefs, history, stories, songs, traditional plants, and canoe journeys. The integration of traditional and holistic healing practices into mainstream treatment interventions are to be recommended when working with indigenous people (Bassett, et. Al, 2012). Connecting Māori with their culture will indeed promote better Māori mental health outcomes (NiaNia, Bush & Epston, 2016).

6.14.1 Hope and Change

A key part that helped inform the process of seeking solutions was done by living life to the best of one's abilities, of having aspirations for self-improvement, whilst holding on to a sense of hope and wanting change for the better. Māori participants in this study held their own definitions of recovery. This included the desire to contribute to mental health services by sharing their personal experiences of mental illness and mental health service delivery to effect change. However, the barrier to gaining employment was considered to be associated with the stigma of mental illness, and the perspectives of both mental health services and potential employers that the person with a mental illness needed to be protected or assumptions were made that the person was incapable of holding a job down because of his/her condition. Aside to this struggle, Māori sought solutions to cope with *being restricted*.

CHAPTER SEVEN CONCLUSION

7.1 Introduction

This section will bring the thesis to a close and provides a final perspective on the outcomes of this research, finishing with limitations of the study and re-presenting the recommendations offered from the findings of the study in four tables (Tables 8-12, pp. 158-116).

7.2 Discussion

Through the use of Māori centred grounded theory methodology, data collected amongst 30 Māori participants was used to identify the substantive theory of *Seeking Solutions to Being Restricted*. The substantive theory saw participants with experience of mental illness and contact with mental health services move from a *turning point* of first mental health crises through to *being apprehended* by mental health services. The impacts included being sent away, of being *physically compromised for mental stability*, to *addressing wairua*, and *seeking solutions to being restricted* through concepts of hope and change.

This research has served to increase the awareness of the personal and complex issues Māori are facing as a result of seeking help from mental health services, albeit within a small rural community of Te Tai Tokerau (Northland) in New Zealand. Nevertheless, this perspective provides new insights into Māori experiences of mental illness and mental health services by adding a better understanding of the issues pertinent to Māori.

This research has provided an understanding about the power of the barriers that exist in mental health services when Māori seek solutions for their mental health care. Māori with mental illness and who are in contact with mental health services are encountering negative barriers in regard to their ability to meet their aspirations and improve their overall mental wellbeing. The criticism of the mental health system rests on how the western medical model dominates the treatment approach and how legal controls are increasingly placed upon

Māori. There is a collective failure of mental health services to provide appropriate care and services to Māori as they desire. New Zealand's health system is rife with institutional racism (Came & Griffith, 2017; Harris et al., 2005) where there is a clear difference in the access to resources, services and opportunities of society, and what is available for Māori in comparison to non-Māori. The examples from this study that reinforce the inequalities in mental health outcomes have identified a less likelihood of Māori receiving appropriate levels of care in mental health services as reinforced through the high rates in New Zealand of restrictive practices such as seclusion, restraint and the use of the Mental Health Act upon Māori. In addition to high doses of psychiatric medication, the consequences of Māori being physically compromised for mental stability, the separation from whānau, the inability to address wairua and the constant need to seek solutions from the Māori world and outside of mental health services, all serve to reinforce issues of inequality.

The attitudes of some mental health professionals toward Māori has amounted to a discrimination of health care that is contributing to the disadvantage of Māori, rather than helping them to achieve their mental wellbeing and full potential. Inequalities in mental health outcomes of Māori can be prevented and eliminated. To do so, there is a need for a radical overhaul and a systems approach to improve mental health services for Māori and for Māori leadership to ensure the needed changes in mental health service delivery occurs.

Before any change can commence in mental health services for the benefit of Māori, it is a priority for mental health leaders, mental health professionals and services to accept that institutional racism does exist in mental health care in New Zealand, and acknowledge it is hindering Māori mental health outcomes. This is an important step if mental health professionals are to understand and tackle the cause of racial inequalities (McKenzie & Bhui, 2007). Key decision making needs to be shifted to Māori with the authority and funds to ensure the changes needed for the improvement of Māori mental wellbeing occurs in New Zealand.

As an outcome of this research, there is a number of considerations and recommendations identified for Māori, mental health professional practice,

mental health service delivery, policy and research that arise from the study findings. These are presented as recommendations to address the *turning point, being apprehended, physical compromise of mental stability, addressing wairua, and seeking solutions* (Tables 8-12).

Targeting Māori mental health in response to the trending issues accompanied by national health policy had been instigated at least 25 years ago. There was transformational change in mental health service delivery by way of Kaupapa Māori mental health services and Māori-centred models of practice (Durie, 2009). But it is evident that more is needed immediately to improve Māori mental health status, and the mental health system's response to Māori mental health need is only one method of improvement.

Whilst national policy has its place in authorising the redress to Māori mental health requirements, there is a need for an overhaul of systems, for new mechanisms and resource to be allocated to Māori for the transformation of health care to occur if there is to be an improved state of Māori mental health.

This research extends upon the understanding of Māori experiences of mental illness and contact with mental health services. The findings make a contribution to the existing literature on Māori experiences of mental illness and mental health services and provides a view of the challenges experienced.

With the disproportionate rates of Māori with mental illness and restrictions in mental health services on the increase, this research provides a platform for additional studies into effective strategies to help meet the mental health needs of Māori, whilst advocating for more in depth studies to investigate the mental and overall health needs of the Māori populations. For example:

- Strategies that will address the inequities of Māori mental health.
- Whether the diagnoses of serious mental illnesses (e.g. schizophrenia, bipolar disorder) are more culturally biased amongst Māori.
- Effective therapy for Māori mental health and the impacts of models of care to Māori.

7.3 Limitations of the Research

This doctoral study primarily occurred in Te Tai Tokerau (Northland) which has a context that may differ from other regions in New Zealand. While caution is advised in using the findings outside of the study context, they do provide a powerful insight into Māori and their whānau when they come into contact with mental illness and mental health services; alongside the views of Māori practitioners who are working to address wairua of Māori in contact with mental health services.

7.4 Concluding Comments

To conclude, this thesis has provided a perspective of the restrictions experienced by Māori with mental illness and mental health services. There is hope this theoretical model of *Seeking Solutions to Being Restricted* will provide insight to Māori mental health through giving visibility to the issues Māori are experiencing whilst they are trying to manage their problems, and the reasons to why they are seeking the solutions they are to address their wellbeing and live their lives successfully. The following Tables 8-12 (pp. 158-161) summarise the recommendations from the discussion chapter as offered by the findings in this study.

Table 8: Suggested solutions to turning point

Core Category	Subcategories and theoretical proposition	Strategies to address being restricted
<p>Being Restricted</p>	<p>Turning point The onset of a mental illness is a crucial turning point.</p>	<p>Mental Health Professionals</p> <ul style="list-style-type: none"> • Encourage tangata whaiora to reflect and talk about their <i>turning point</i>. • Undertake a process of self reflection of their own practices toward Māori. • Recognise the potential of grief and loss tangata whaiora and whānau may experience as a result of the mental health crisis and mental illness. • Recognise the potential for acute or posttraumatic stress secondary to the <i>turning point</i>. • Identify and work with the difficulties Māori may experience accessing mental health services. • Provide support and be readily available to tangata whaiora and whānau as the mental health crises progresses. • Recognise whānau are part of the treatment decision making process. <p>Mental Health Services</p> <ul style="list-style-type: none"> • Establish a system that fosters mental health professionals to work in partnership with tangata whaiora and whānau collaboratively from the <i>turning point</i>. • Establish and implement whānau centred strategies that provide a range of solutions to tangata whaiora and their whānau to deal with the stress from the <i>turning point</i>. • Ensure practice development opportunities are available to mental health staff that include working with Māori experience of grief and loss, trauma from a Māori perspective, tangata whaiora and whānau strategies in mental health crises.

Note Findings from Study.

Table 9: Suggested solutions to being apprehended

Core Category	Subcategories and theoretical proposition	Recommendations to address being restricted
<p>Being Restricted</p>	<p>Being apprehended</p> <p>Māori have a greater chance of being apprehended for being mentally unwell.</p>	<p>Mental Health Professionals</p> <ul style="list-style-type: none"> – Understand the continual impact of colonisation upon Māori and the subsequent disparities experienced. – Identify and critically work through racial bias about Māori and mental illness. – Develop and implement models of practice that empower Māori rather than isolate, restrict and disempower them. <p>Mental Health Services</p> <ul style="list-style-type: none"> – New models of care to transform mental health services from an oppressive system to one that empowers Māori tangata whaiora and their whānau. – Develop mental health systems so whānau relationships are maintained, especially when tangata whaiora are in receipt of acute mental health care. – Implement practice development opportunities for staff so they possess the skills and knowledge to provide alternative methods of working with Māori rather than compulsion under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and restrictively. <p>Research</p> <ul style="list-style-type: none"> – Research is required to determine racial bias regarding the increasing rate of Māori (especially Māori men), diagnosed serious mental illnesses such as schizophrenia, in mental health services and under the Mental Health Act. – Updated research is required to fully comprehend the impact of disparities upon Māori mental health. <p>Policy Makers</p> <p>A range of strategies to:</p> <ul style="list-style-type: none"> – Eliminate institutional racism in mental health services. – Reduce the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 as a mechanism for clinicians. – Support the development of models of practice and care that empower Māori rather than isolate, restrict and disempower them. – Critically review mental health services and their impact on retaining Māori for the sole purpose of treatment continuation.

Table 10: Suggested solutions to physical compromise for mental stability

Core Category	Subcategories and Theoretical proposition	Recommendations to address being restricted
<p>Being Restricted</p>	<p>Physical compromise for mental stability</p> <p>Māori are likely to be compromised by psychiatric medications.</p>	<p>Māori</p> <ul style="list-style-type: none"> – Māori accessing mental health services and receiving psychiatric medication to be vigilant of the potential impacts of medications and their right to seek a review of treatment. <p>Mental Health Professionals</p> <ul style="list-style-type: none"> – Mental health professionals to realise whānau will take an interest in the treatment and medication of tangata whaiora. – Mental health professionals to increase the monitoring of psychiatric medication of Māori and provide strategies to address the physical compromises they are experiencing (side effects and serious medical conditions). <p>Mental Health Services</p> <ul style="list-style-type: none"> – Establish systems that critically review the use and prescribing of psychiatric medication to Māori and its impacts. – Increase the monitoring and management of psychiatric medication of all Māori tangata whaiora. <p>Policy Makers</p> <p>A range of strategies to:</p> <ul style="list-style-type: none"> – Critically review the use and the prescribing of psychiatric medication to Māori and its impacts in mental health services. – Institute a mechanism to monitor all Māori being treated with Clozapine and other atypical antipsychotic medication. – Review all unexpected deaths of Māori who were taking Clozapine or atypical antipsychotic medication. – Prioritise Māori mental health given the disproportionate health and social issues, and potential for poorer physical health. <p>Research</p> <ul style="list-style-type: none"> – Further data is required on Māori sudden deaths on Clozapine and other psychiatric medications. – Research on the attitudes and beliefs of mental health professionals toward Māori, specifically as to how this informs how they prescribe for Māori.

Note Findings from Study

Table 11: Suggested solutions to addressing wairua

Core Category	Subcategories and Theoretical proposition	Recommendations to address being restricted
Being Restricted	<p>Addressing wairua</p> <p>Māori will thrive for solutions to address their wairua.</p>	<p>Mental Health Professionals</p> <ul style="list-style-type: none"> – Attain skills and knowledge pertinent to ensure Māori cultural and spiritual needs are incorporated into the care and treatment of tangata whaiora. <p>Mental Health Services</p> <ul style="list-style-type: none"> – Establish systems and processes to ensure spiritual needs of Māori are facilitated and addressed. – Ensure access to Māori practitioners and spiritual healers skilled in addressing the wairua needs of Māori. <p>Research</p> <ul style="list-style-type: none"> – Further research to identify the need and the resource required to address the spiritual needs and healing of Māori with mental health issues.

Note Findings from Study

Table 12: Suggested solutions to help whānau

Core Category	Focus	Recommendations to address being restricted
Being Restricted	Whānau	<p>Mental Health Professionals</p> <ul style="list-style-type: none"> – Increase knowledge and strategies to counteract the separation mental health services cause to whānau, especially to the parent-child relationship. <p>Mental Health Services</p> <ul style="list-style-type: none"> – Establish whānau friendly services to foster whānau to be nearby and included with their loved one. – Establish pathways or models of practice whereby whānau are included from the turning point and at any engagement with mental health services. – Encourage mental health professionals in practice development opportunities that ensure they walk beside whānau and they have the competencies to do so effectively.

Note Findings from Study

References

- Abas, M., Vanderprl, J., Robinson, E., & Crampton, P. (2003). More deprived areas need greater resources for mental health. *Australian and New Zealand Journal of Psychiatry*, 37(1), 437-444. doi:10.1046/j.1440-1614.2003.01206.
- Abrams, L. S., & Curran, L. (2009). And you're telling me not to stress? A grounded theory study of postpartum depression symptoms among low income mothers. *Psychology of Women Quarterly*, 33(3), 351-362. doi: 10.1111/j.1471-6402.2009.01506.
- Abuse, S., & Mental Health Services Administration. (2010). *Results from the 2009 national survey on drug use and health: Volume I. Summary of national findings*. HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration. USA.
- Advisory Group on Suicide Prevention. (2003). *Acting on what we know: Preventing youth suicide in First Nations*. Ottawa, Canada: Health Canada.
- Auckland Star (1924). A Mad Māori fights for liberty. 14 October 1924, p 4. Retrieved 11 October 2014 from Alexander Turnbull Library, Wellington: <http://paperspast.natlib.govt.nz/cgi-bin/paperspast?a=d&cl=search&d=AS19241014.2.23&srpos=52&e=---10--51---0Māori +Asylum-->
- Awatere, D. (1984). *Māori sovereignty*. Broadsheet.
- Baker, M. (2008). Te Arawhata o Aorua. Bridging of two worlds. Unpublished Master's thesis. Massey University, Albany, New Zealand.
- Baker, M. (2015). *He Korero He Kai i te Rangatira*. Wellington, New Zealand: Te Rau Matatini Ltd.
- Baker, R. (2012). Reflection from a registered nurse. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to mental health services in the Waikato, 1910-2012* (pp. 115-116). Hamilton, New Zealand: Half Court Press.
- Baker, R. (2014). Oral History Transcript, Tuia Te Ao Marama. Māori Mental Health Nursing Website.
- Barnett, H., & Barnes, A. (2010). *Walk a mile in our shoes: He Tuara, Ngā Tapuwae Tuku Iho Ō Ngā Mātua Tūpuna*. Wellington, New Zealand: Mental Health Foundation of New Zealand.

- Barry, L., & Coleborne, C. (2011). Insanity and ethnicity in New Zealand: Māori encounters with the Auckland Mental Hospital, 1860—1900. *History of Psychiatry*, 22(3), 285-301.
- Bassett, D., Tsoisie, U., & Nannauck, S. (2012). “Our culture is medicine”: Perspectives of native healers on post trauma recovery among American Indian and Alaska Native patients. *The Permanente Journal*, 16(1), 19.
- Baxter, J., Kokaua, J., Wells, J. E., McGee, M. A., & Oakley Browne, M. A. (2006). Ethnic comparisons of the 12-month prevalence of mental disorders and treatment contact in Te Rau Hinengaro: The New Zealand mental health survey. *Australian and New Zealand Journal of Psychiatry*, 40(10), 905-913. doi:10.1111/j.1440-1614.2006.01910.
- Baxter, J. (2007). Mental health: Psychiatric disorder and suicide. In B. Robson & R. Harris (Eds.), *Hauora: Māori standards of health IV. A study of the years, 2000- 2005* (121-138). Wellington, New Zealand: University of Otago.
- Baxter, J. (2008). *Māori mental health needs profile. A review of the evidence*. Palmerston North, New Zealand: Te Rau Matatini.
- Beaglehole, E. (1939). Culture and psychosis in New Zealand. *The Journal of the Polynesian Society*, 48(3 (191)), 144-155.
- Beaglehole, E. (1946). *Some modern Māoris*. Wellington, New Zealand: N.Z. Council for Educational Research.
- Beaglehole, E. (1975). Postscript: the Māori now. *The Māori people in the nineteen-sixties*, 351-355.
- Belgrave, M. (2014). Beyond the Treaty of Waitangi: Māori tribal aspirations in an era of reform, 1984–2014. *The Journal of Pacific History*, 49(2), 193-213.
- Best, E. (1978). *Spiritual and mental concepts of the Māori*. E.C. Keating, Government Printer: Wellington, New Zealand.
- Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK. *British Journal of Psychiatry*, 182, 105-16.
- Bidois, E. (2012). A cultural and personal perspective of psychosis. *Experiencing psychosis: Personal and professional perspectives*, 35-43.

- Blake- Palmer, G. (1954). Tohungaism and Māku. *The Journal of the Polynesian Society*, 63(2), 147-164. Retrieved from <http://www.jps.auckland.ac.nz/document/?wid=2709>
- Blakely, T. A., Collings, S. C. D., & Atkinson, J (2003). Unemployment and suicide. Evidence for a causal association. *Journal Epidemiological Community Health*, 57, 594-600.
- Blumer, H. (1986). *Symbolic interactionism: Perspective and method*. CA, State: University of California Press. USA.
- Boulton, A. (2005). Provision at the interface: The Māori mental health contracting experience. Unpublished doctoral thesis, Massey University, Palmerston North, New Zealand.
- Brannelly, T., Boulton, A., & Te Hiini, A. (2013). A relationship between the ethics of care and Māori worldview—the place of relationality and care in Māori mental health service provision. *Ethics and Social Welfare*, 7(4), 410-422.
- Brave Heart, M. Y. H., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaskan Native Mental Health Journal*, 8(2), 60-82.
- Brunton, W. A. (2001). *A choice of difficulties: National mental health policy in New Zealand, 1840-1947*. Unpublished doctoral dissertation, University of Otago, Dunedin, New Zealand.
- Brunton, W. A. (2015). 'At variance with the most elementary principles': The state of British colonial lunatic Asylums in 1863. *History of Psychiatry*, 26(2), 147-165.
- Bush, A., & NiaNia, W. (2012). Voice hearing and pseudo seizures in a Māori teenager: An example of mate Māori and Māori traditional healing. *Australasian Psychiatry*, 20(4), 348-351.
- Came, H. (2014). Sites of institutional racism in public health policy making in New Zealand. *Social Science & Medicine*, 106, 214-220.
- Came, H., & Griffith, D. (2017). Tackling racism as a “wicked” public health problem: Enabling allies in anti-racism praxis. *Social Science & Medicine*. Retrieved from doi: 10.1016/j.socscimed.2017.03.028.
- Carey, L. B., & Del Medico, L. (2013). Chaplaincy and mental health care in Aotearoa New Zealand: An exploratory study. *Journal of Religion and Health*, 52(1), 46-65.

- Charmaz, K. (2005). Grounded theory in the 21st century: A qualitative method for advancing social justice research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., 503-536). Thousand Oaks, CA: Sage Publications.
- Charon, J. M. (2009). *Symbolic interactionism: An introduction, an interpretation, an integration*. Prentice Hall, Englewood, UK: Pearson College Division.
- Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage Publications.
- Clements, F. E. (1932). Primitive concepts of disease. *American Archaeology and Ethnology*, 32(2), 185-252.
- Colonist (1899) The Mad Māori. Colonist 16 June 1899, p3. Retrieved from Alexander Turnbull Library, Wellington: Retrieved October 14 2015 from <http://paperspast.natlib.govt.nz/cgi-bin/paperspast?a=d&cl=search&d=TC18990616.2.17.14&srpos=5&e=-----10--1----0Māori +Asylum-->
- Cram, F. (1993). Ethics in Māori research: Working paper. Department of Psychology, University of Auckland, New Zealand. Retrieved October 14 2015 from <http://researchcommons.waikato.ac.nz/bitstream/handle/10289/3316/cram?sequence=1>.
- Cram, F. (2001). Rangahau Māori: Tona tika, tona pono—the validity and integrity of Māori research. In M. Tollich (Ed.), *Research ethics in Aotearoa* (35-52). Auckland, New Zealand: Longman.
- Cram, F., Scott, A., Phillips, H., Tipene-Matua, B., Parsons, M., & Taupo, K. (2004). A parallel process. Beginning a constructive conversation about a Māori methodology. *Journal of Bioethical Inquiry*, 1(1), 14-19.
- Cram, F., Kennedy, V., Paipa, K., Pipi, K., & Wehipeihana, N. (2015). Being culturally responsive through Kaupapa Māori evaluation. *Continuing the journey to reposition culture and cultural context in evaluation theory and practice*, 289-312.
- Cunningham, C. (2000). A framework for addressing Māori knowledge in research, science and technology. *Pacific Health Dialog*, 7(1), 62-69.
- Cunningham, C. (2015). Psychosocial factors in healthcare for Māori. *Psychosocial Dimensions of Medicine*, 208.

- Cunningham, R., Sarfati, D., Peterson, D., Stanley, J., & Collings, S. (2014). Premature mortality in adults using New Zealand psychiatric services. *The New Zealand Medical Journal (Online)*, 127(1394), pages.
- Day, J., Bentall, R. P., Roberts, C., Randall, F., Rogers, A., Cattell, D., Power, C. (2005). Attitudes toward antipsychotic medication. The impact of clinical variables and relationships with health professionals. *Archive General Psychiatry*, 62, 717-724.
- Denzin, N. K. (2008). *Symbolic interactionism and cultural studies: The politics of interpretation*. John Wiley & Sons.
- Denzin, N. K., & Lincoln, Y. (2000). *Qualitative research*. Thousand Oaks, CA: Publisher.
- Department of Health. (1983). *Report of the Committee of Inquiry into procedures at Oakley Hospital and related matters*. Auckland, New Zealand: Author.
- Department of Health. (1991). *Report of the Committee of Inquiry into the death at Carrington Hospital of a patient, Manihera Mansel Watene and other related matters*. Auckland, New Zealand: Author.
- Diamond, P. (2005). How Māori culture can improve mental health. 200(3411).
- Drury, N., & Munro, T. A. (2008). Crisis engagement in mental health: A New Zealand Māori contribution. *International Journal of Mental Health Nursing*, 17(5), 317-325.
- Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native people*. Colombia, New York: Teachers College Press.
- Durie, M.H. (1997) Māori Cultural Identity and Its Implications for Mental Health Services, *International Journal of Mental Health*, 26:3, 23-25, doi: [10.1080/00207411.1997.11449407](https://doi.org/10.1080/00207411.1997.11449407)
- Durie, M. H. (1998). *Whaiora. Māori health development* (2nd ed.). Melbourne, Australia: Oxford University Press.
- Durie, M. H. (1989). The Treaty of Waitangi and health care. *The New Zealand Medical Journal*, 102(869), 283-285.
- Durie, M. H. (2001). *Mauri ora: The dynamics of Māori health*. Melbourne, Australia: Oxford University Press.
- Durie, M. H. (2003). Providing health services to indigenous peoples: A combination of conventional services and indigenous programmes is needed. *BMJ: British Medical Journal*, 327(7412), 408.

- Durie, M. H. (2005). *Ngā Tai Matatū*. Melbourne, Australia: Oxford University Press.
- Durie, M. H. (2009). Māori knowledge and medical science. *Psychiatrists and traditional healers: Unwitting partners in global mental health*, 237-249.
- Durie, M. H., Milroy, H., & Hunter, E., (2009). Mental health and the Indigenous peoples of Australia and New Zealand. In L. J. Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 36-55). Vancouver, Canada: UBC Press.
- Durie, M. H. (2011). Indigenous mental health 2035: Future takers, future makers and transformational potential. *Australasian Psychiatry*, 19(sup1), S8-S11.
- Eade, L. (2007). *Marlborough Māori experience in accessing mental health services via primary health care: An exploratory study*. Unpublished master's thesis, Massey University, Turitea, Palmerston North, New Zealand.
- Edmonds, L. K., Williams, S., & Walsh, A. E. S. (2000). Trends in Māori mental health in Otago. *Australian and New Zealand Journal of Psychiatry*, 34(4), 677-683.
- El-Badri, S., & Mellsop, G. (2007). Stigma and quality of life as experienced by people with mental illness. *Australasian Psychiatry*, 15(3), 195-200.
- El-Badri, S., & Mellsop, G. (2011). Clozapine use and outcomes among patients with treatment resistant schizophrenia. *Australasian Psychiatry*, 19(5), 410-414.
- Elder, H., & Tapsell, R. (2013). Māori and the Mental Health Act. *New Zealand's Mental Health Act in Practice*, 249-267.
- Elliot, B. (2012). Whai Ora cultural unit, Tokanui Hospital, Te Awamutu 1984-1998. In C. Coleborne & Waikato Mental Health History Group (Eds.), *Changing times, changing places. From Tokanui hospital to mental health services in the Waikato, 1910-2012* (pp. 113-114). Hamilton, New Zealand: Half Court Press.
- Families Commission. (2009). *Whānau strategic framework 2009–2012*. Wellington, New Zealand: Author.
- Feagin, J. (2013). *Systemic racism: A theory of oppression*. London, UK: Routledge.

- Fenton, L. (2000). *Four Māori korero about their experience of mental illness. Mental Health Commission Recovery Series*. Wellington, New Zealand: Mental Health Commission.
- Fielding Star. (August,1920). *Demonism, experiences among Māori exorcising of evil spirits, sensational episodes described* (p. 4). Retrieved September 14, 2013, from www.paperspast.natlib.govt.nz/cgi-bin/paperspast?a=d&d+FS19200830.2.32&l=mi&e
- Flick, U. (2009). *An introduction to qualitative research* (4th ed.). London, UK: Sage.
- Forster, M. (2008). Te hoe nuku roa: A journey towards Māori centered research. *Ethnobotany Research and Applications*, 1, 047-054.
- Foster, F.H. (1962). *Māori patients in mental hospitals. Special report No. 8*. Wellington, New Zealand: Department of Health.
- Giba, E., & Lincoln, Y. (2005). Paradigmatic controversies, contradictions and emerging confluences. *The Sage handbook of qualitative research* (3rd ed). London, UK: Sage.
- Gibbs, A., Dawson, J., Forsyth, H., & Mullen, R. (2004). Māori experience of community treatment orders in Otago, New Zealand. *Australian and New Zealand Journal of Psychiatry*, 38(10), 830-835.
- Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1992). *Emergence vs. forcing: Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (2005). *The grounded theory perspective III: Theoretical Coding*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (2003). *The grounded theory perspective II: Descriptions remodeling of grounded theory methodology*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (2007). Doing formal theory. In Initial, Surname (Ed.), *The Sage handbook of grounded theory* (Part II, pp. 97-113). Mill Valley,CA: Sociology Press.

- Glaser B. G., & Strauss A. L. (1967). *The discovery of grounded theory. Strategies for qualitative research*. Chicago, IL: Aldine Publishing Company.
- Gluckman, P. (2017). *Toward a whole of government / whole of nation approach to mental health*. Auckland, New Zealand: Office of the Prime Ministers Chief Science Advisor.
- Gordon, S. E., & O'Brien, A. (2014). New Zealand's mental health legislation needs reform to avoid discrimination. *New Zealand Medical Journal*, 127, 55-65.
- Gray, R., Rofail., D., Allen., J., & Newey, T. (2005). A survey of patient satisfaction with and subjective experiences of treatment with antipsychotic medication. *Journal of Advanced Nursing*, 52(1), 31-37.
- Grob, G. N. (1973). Class, Ethnicity, and Race in American Mental Hospitals, 1830–75. *Journal of the history of medicine and allied sciences*, 28(3), 207-229.
- Gynnild, A. (2011). Living the ideas: A biographical interview with Barney G. Glaser. *Grounded theory: The philosophy, method, and work of Barney Glaser*, 237-254. Florida, CA: Brown Walker Press.
- Happell, B., Manias, E., & Roper, C. (2004). Wanting to be heard: Mental health consumers' experiences of information about medication. *International Journal of Mental Health Nursing*, 13, 242-248.
- Harris, K. M., Edlund, M. J., & Larson, S. (2005). Racial and ethnic differences in the mental health problems and use of mental health care. *Medical Care*, 43(8), 775-784.
- Harris, R., Cormack, D., Tobias, M., Yeh, L.-C., Talamaivao, N., Minster, J., & Timutimu, R. (2012). The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Social Science & Medicine*, 74(3), 408-415. doi:10.1016/j.socscimed.2011.11.004.
- Harris, R. B., Cormack, D. M., & Stanley, J. (2013). The relationship between socially-assigned ethnicity, health and experience of racial discrimination for Māori: Analysis of the 2006/07 New Zealand Health Survey. *BMC Public Health*, 13(1), 1.
- Health and Disability Commissioner. (2017). *Mental health and addiction services: HDC monitoring and advocacy*. Presentation to Directors of Mental Health Nursing, 14th November 2017, Wellington, New Zealand.

- Health Funding Authority. (1999) *Kia Tu Kia Puawai*. Wellington, New Zealand: Health Funding Authority.
- Hearn, T.J (2006). Social and Economic Change in Northland 1900 to 1945: The role of the Crown and the place of Māori. The Northland Enquiry. Wai 1040 A Report commissioned by the Crown Forestry Rental Trust.
- Heart, M. Y. H. B., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, 8(2), 56.
- Hemara, W. (2000). *Māori Pedagogies: A View from the Literature*. New Zealand Council for Educational Research, Education House, PO Box 3237, Wellington, New Zealand.
- Hill, G. R., & Harrison-Woolrych, M. (2008). Clozapine and myocarditis: A case series from the New Zealand Intensive Medicines Monitoring Programme. *New Zealand Medical Journal*, 121(1283), 68-75.
- Hill, R. (2008). Māori, police and coercion in New Zealand history. In D. Keenan (Ed.), *Terror in our midst? Searching for terror in Aotearoa New Zealand* (pp. x-x). Wellington, New Zealand: Huia Publishers.
- Howden-Chapman P. (1988). The demise of Wolfe Home: A case study of the closure of an inpatient alcoholism unit. *Community Health Studies*, XII(4), 453-460.
- Howden-Chapman, P., & Tobias, M. (2000). *Social inequalities in health: New Zealand 1999*. Wellington, New Zealand: Ministry of Health.
- Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika. Guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Auckland, New Zealand: Health Research Council of New Zealand.
- Hunter, L. M., Logan, J., Goulet, J. G., & Barton, S. (2006). Aboriginal healing: Regaining balance and culture. *Journal of Transcultural Nursing*, 17(1), 13-22.
- Huriwai, T., Robertson, P. J., Armstrong, D., Kingi, T. P., & Huata, P. (2001). Whānaungatanga – A process in the treatment of Māori with Alcohol and Drug Use related problems. *Substance use & misuse*, 36(8), 1033-1051.
- Huygens, I., Murphy, T., & Healy, S. (2012). Ngāpuhi speaks. *Whangarei, Network Waitangi Whangarei, Te Kawariki*.

- Jackson, C., Knott, C., Skeate, A., & Birchwood, M. (2004). The trauma of first episode psychosis: The role of cognitive mediation. *Australian and New Zealand Journal of Psychiatry*, 38(5), 327-333.
- Johnstone, K., & Read, J. (2000). Psychiatrists' recommendations for improving bicultural training and Māori mental health services: A New Zealand survey. *Australian and New Zealand Journal of Psychiatry*, 34(1), 135-145.
- Take, T. R., Arnold, R., & Ellis, P. (2008). Estimating the prevalence of schizophrenia amongst New Zealand Māori: A capture recapture approach. *Australian and New Zealand Journal of Psychiatry*, 42(11), 941-949.
- Kartalova-O'Doherty, Y., Stevenson, C., & Higgins, A. (2012). Reconnecting with life: A grounded theory study of mental health recovery in Ireland. *Journal of Mental Health*, 21(2), 135-143. doi.org.ezproxy.massey.ac.nz/10.3109/09638237.2011.621467.
- Keene, F. M. M. (1975). *Tai Tokerau*. Northland, New Zealand: Keene.
- Keelan, W. (1997). *Māori Service Auckland Healthcare*. Paper presented at Oranga Hinengaro Māori, Māori Mental Health Summit, Wellington, New Zealand.
- Keyes, K. M., Martins, S. S., Hatzenbuehler, M. L., Blanco, C., Bates, L. M., & Hasin, D. S. (2012). Mental health service utilization for psychiatric disorders among Latinos living in the United States: The role of ethnic subgroup, ethnic identity, and language/social preferences. *Social Psychiatry and Psychiatric Epidemiology*, 47(3), 383-394.
- Kidd, J., Butler, K., & Harris, R. (2014). Māori mental health. In; N. Proctor (ed) *Mental Health Nursing: A person centred approach*. Port Melbourne, Vic: Cambridge University Press
- Kingi, T. K. (2005). *Māori mental health: Past trends, current issues, and Māori responsiveness*. Wellington, New Zealand: Massey University.
- King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *The Lancet*, 374(9683), 76-85.
- Kisely, S., Campbell, L. A., & Preston, N. (2005). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database Systematic Reviews*, 3.
- Kumar, S., Ng, B., Simpson, A., Fischer, J., & Robinson, E. (2008). No evidence for restrictive care practices in Māori admitted to a New

- Zealand psychiatric inpatient unit: Do specialist cultural teams have a role? *Social Psychiatry and Psychiatric Epidemiology*, 43(5), 387-391.
- Labrum, B. (1992). Looking beyond the Asylum – Gender and the process of Committal in Auckland. 1870-1910. *New Zealand Journal of History*, 26(2), 125-144.
- Laird B., Smith, S., Dutu, G., & Mellsop, G. (2010). Views and experiences of family/whānau carers of psychiatric service users on diagnosis and classification. *International Journal of Social Psychiatry*, 56(3), 270-279. Retrieved from <http://www.sagepub.co.uk/journals.doi>:
- Lambrecht, I. (2017). The Distress of Makutu: Some Cultural–Clinical Considerations of Māori Witchcraft. In *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* (pp. 549-563). Palgrave Macmillan, London.
- Lapsley, H., Nikora, L. W., & Black, R. M. (2002). *"Kia Mauri Tau!" Narratives of recovery from disabling mental health problems*. Wellington, New Zealand: Mental Health Commission.
- Lawson-Te Aho, K. (2010). *Definitions of whānau: A review of selected literature*. Wellington, New Zealand: Families Commission.
- Leibrich, J. (1999). *A gift of stories: Discovering how to deal with mental illness*. Wellington, New Zealand: Mental Health Commission.
- Light, E. M., Robertson, M. D., Boyce, P., Carney, T., Rosen, A., Cleary, M. & Kerridge, I. H. (2014). The lived experience of involuntary community treatment: A qualitative study of mental health consumers and carers. *Australasian Psychiatry*, 22(4), 345-351.
- McDonald, C., Chamberlain, K., & Lon, N. (1997). Race, combat, and PTSD in a community sample of New Zealand.
- McKenna, B. G., Simpson, A. I., & Laidlaw, T. M. (1999). Patient perception of coercion on admission to acute psychiatric services: The New Zealand experience. *International Journal of Law and Psychiatry*, 22(2), 143-153.
- McKenzie, K., & Bhui, K. (2007). Institutional racism in mental health care. *British Medical Journal*, 334, 649--650.
- McKenzie, S., & Carter, K. (2010). 'Measuring whānau: A review of longitudinal studies in New Zealand'. *MAI Review*, 3. Retrieved 15 May 2015 from <http://www.review.mai.ac.nz>.
- Mane, J. (2009). Kaupapa Māori: A community approach. *Mai Review*, 3(1), 9.

- Mar, M. (1999). *Approaches to establishment and sustainable development of Māori mental health services*. Paper presented at Health Informatics New Zealand Conference, Wellington, New Zealand.
- Mark, G. T., & Lyons, A. C. (2010). Māori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science & Medicine*, 70(11), 1756-1764.
- Marsden, M. & Henare, T.A. (1992). *Kaitiakitanga: A definitive introduction to the holistic world view of the Māori*. Wellington, New Zealand: Ministry of the Environment.
- Marsden, M. (2003). The woven universe. In. Te Ahukaramu Charles Royal (Ed.), *Selected writings of Reverend Māori Marsden*. Auckland, New Zealand: The estate of Rev. Māori Marsden.
- Mason, K. H., Bennett, H., & Ryan, E. (1988). *Report of the committee of inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients. The Mason Report*. Auckland, New Zealand: Publisher.
- Mataira, P. (2003). *Māori evaluation research, theory and practice: Lessons for native Hawaiian evaluation studies*. Retrieved 20 May 2016 from www.ksbe.edu/pase/pdf/EvaluationHui/Mataira
- Matonga, A. (2010). *An examination of mental health service delivery changes for Māori since the Mental Health Foundation Report in 2004*. Unpublished masters thesis, Massey University, Albany, New Zealand.
- Mead, H. M. (2003). *Tikanga Māori: Living by Māori values*. Wellington, New Zealand: Huia Publishers.
- Medsafe. (2001). *Extract of minutes of the 105th MARC Meeting*. Wellington, New Zealand. Retrieved 14 May 2015 from <http://www.medsafe.govt.nz/profs/adverse/minutes105.htm#46073>
- Medsafe. (2002). *Prescriber update*, 23(1).
- Medsafe. (2003). *Prescriber update*, 24(1).
- Medsafe. (2006). *Extract of minutes of the 125th MARC Meeting*. Wellington, New Zealand. Retrieved 14 May 2015 from <http://www.medsafe.govt.nz/profs/adverse/Minutes15.htm#4.1.1>
- Medsafe. (2008). *Extract of minutes of the 135th MARC Meeting*. Wellington New Zealand Retrieved 14 May 2015 from <http://www.medsafe.govt.nz/profs/adverse/Minutes135.htm>

- Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand. How things need to be*. Wellington, New Zealand: The Mental Health Commission.
- Mental Health Commission. (2007). *Te Haererenga mo te Whakaoranga 1996-2006: The journey of recovery for the New Zealand mental health sector*. Wellington, New Zealand: Mental Health Commission.
- Mental Health Commission. (2012). *Blueprint II: How things need to be*. Wellington, New Zealand: Mental Health Commission.
- Mental Health Commission. (2012). *Improving mental health and wellbeing for all New Zealanders. Making change happen. A companion document to Blueprint II*. Wellington, New Zealand: Mental Health Commission.
- Metge, J. (1995). *New growth from old: The whānau in the modern world*. Wellington, New Zealand: G.P. Print.
- Mfoafo-M'Carthy, M. (2014). Community treatment orders and the experiences of ethnic minority individuals diagnosed with serious mental illness in the Canadian mental health system. *International Journal for Equity in Health*, 13(1), 69.
- Mills, C. (2014). *Highlights from Census 2013: Northland Health*. Whangarei, New Zealand: Northland District Health Board.
- Ministry of Culture & Heritage (2014). Māori and the First World War. Retrieved 15 November 2016 from Māori and the First World War'.URL: http://www.nzhistory.net.nz/war/Māori_in-first-world-war/introduction, (Ministry for Culture and Heritage), updated 27-Aug-2014.
- Ministry of Health. (2001). *Prescriber update. No. 20 February 2001*. Retrieved 14 May 2015 from http://www.medsafe.govt.nz/profs/PUarticles/PDF/Prescriber%20Update_Feb01.pdf
- Ministry of Health. (2002a). *Prescribers update, 23(1), April 2002*. Retrieved 14 May 2015 from http://www.medsafe.govt.nz/profs/PUarticles/PDF/Prescriber%20Update_Apr02.pdf
- Ministry of Health. (2002b). *He Korowai Oranga – Māori health strategy*. Wellington, New Zealand: Author.
- Ministry of Health. (2008a). *Te Puāwaiwhero - The second Māori mental health and addiction national strategic framework 2008-2015*. Wellington, New Zealand: Author.

- Ministry of Health. (2008b). *Clozapine and achy breaky hearts (myocarditis and cardiomyopathy)*. Retrieved 5 May 2015 from <http://www.medsafe.govt.nz/profs/PUArticles/Clozapine.htm>
- Ministry of Health. (2012). *Rising to the challenge: The mental health and addiction service development plan 2012–2017*. Wellington, New Zealand: Author.
- Ministry of Health. (2014). *Office of the Director of Mental Health annual report 2013*. Wellington, New Zealand: Author.
- Ministry of Health. (2015). *Annual update of key results 2014/15: New Zealand health survey*. Wellington, New Zealand: Author.
- Ministry of Health. (2016a). *Mental health and addiction: Service use 2014/15*. Wellington, New Zealand: Author.
- Ministry of Health. (2016b). *Suicide facts: Deaths and intentional self-harm hospitalisations: 2013*. Wellington, New Zealand: Author.
- Ministry of Health. (2016c). *Office of the Director of Mental Health annual report 2015*. Wellington, New Zealand: Author.
- Ministry of Health. (2017a). *Office of the Director of Mental Health annual report 2016*. Wellington, New Zealand: Author.
- Ministry of Health. (2017b). *The Mental Health Act and human rights. A discussion document*. Retrieved 8 October 2017 from <https://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-and-human-rights-assessment>
- Mitrou, F., Cooke, M., Lawrence, D., Povah, D., Mobilia, E., Guimond, E., & Zubrick, S. R. (2014). Gaps in Indigenous disadvantage not closing: A census cohort study of social determinants of health in Australia, Canada, and New Zealand from 1981-2006. *BMC Public Health*, 14(1), 201.
- Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., & Murray, R. (2005). Pathways to care and ethnicity. 1: Sample characteristics and compulsory admission. *The British Journal of Psychiatry*, 186(4), 281-289.
- Morrell, W. P. (Ed.). (1958). *Sir Joseph Banks in New Zealand from his journal*. Wellington, New Zealand: A.H. & A.W. Reed.
- Munford, R., & Sanders, J. (1999). *Supporting families*. Wellington, New Zealand: Dunmore Press.

- Nathaniel, A. K. (2011). An integrated philosophical framework that fits GT. In V. B. Martin & A. Gynnild (Eds.), *Grounded theory, the philosophy, method and work of Barney Glaser* (pp. 187-200). Florida, CA: Brown Walker Press.
- Neilson-Hornblow, C. (2009). Three Key Elements: Mental Health Delivery towards Māori . *Whitireia Nursing & Health Journal*, (16), 54.
- New Zealand Parliamentary Debate. (1988). *New Zealand Parliamentary Debate Record. Tuesday October 11, 1988*. Retrieved 11 March 2014 from New Zealand Archives.
- Newton-Howes, G., Lacey, C. J., & Banks, D. (2014). Community treatment orders: The experiences of Non-Māori and Māori within mainstream and Māori mental health services. *Social Psychiatry and Psychiatric Epidemiology*, 49(2), 267-273.
- NiaNia, W., Bush, A., & Epston, D. (2016). *Collaborative and Indigenous mental health therapy: Tataihono-Stories of Māori healing and psychiatry*. City, Country: Taylor & Francis.
- Nikora, L. M., Hodgetts, D., Carlson. T., Tongi., L., Li., W. W. (2010). *Māori, Tongan and Chinese households: Medications and elder care*. Proceedings of the 4th International Traditional Knowledge Conference, 6–9 June 2010, Auckland, New Zealand. Retrieved from <http://www.traditionalknowledge2012.ac.nz>
- Northland District Health Board. (2014a). *Māori Health Annual Plan 2014-15*. Retrieved 11 February 2014 from <http://www.northlanddhb.org.nz/Portals/0/Communications/Publications/Māori Health Plan 2014-15 FINAL.pdf>
- Northland District Health Board. (2014b). *Mental health & addiction services: Service utilisation and performance report for 2013-2014*. Obtained from Kevin Waugh October, 2014.
- Novartis New Zealand Ltd. (2014). *Data sheet*. Retrieved November 22, 2014, from <http://www.medsafe.govt.nz/profs/datasheet/c/Clozariltab.pdf>
- Oakley Browne M. A., & Wells J. E., (2006). Health services. In M. A. Oakley Browne, J. E. Wells, & K. M. Scott (Eds), *Te rau hinengaro: The New Zealand mental health survey* (pp.115-138). Wellington, New Zealand: Ministry of Health.
- Papuni, J. R. M. (2004). *'We answer the call to arms': war experience and its toll on the spirituality of the Māori soldier post-WWII*. A thesis submitted

in partial fulfilment of the requirements for the degree of Master of theology. The University of Auckland.

- Parker, R., & Milroy, H. (2014). Aboriginal and Torres Strait Islander mental health: An overview. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, 2, 25-38.
- Pere, L. M. (2006). Oho mauri: Cultural identity, wellbeing, and tangata whaiora/motuhake. Unpublished doctoral thesis, Massey University, Wellington, New Zealand.
- Pere, L., & Barnes, A. (2009). New learnings from old understandings. Conducting qualitative research with Māori. *Qualitative Social Work*, 8, 449.
- Pere, R. R. (1991). *Te Wheke. A celebration of infinite wisdom*. Gisborne, New Zealand: Ao Ako Global Publishing.
- Pfeiffenberger, A. S., D'souza, A. J., Huthwaite, M. A., & Romans, S. E. (2016). The well-being of children of parents with a mental illness: The responsiveness of crisis mental health services in Wellington, New Zealand. *Child & Family Social Work*, 21(4), 600-607.
- Pharmac. (2006). *Research report: A qualitative investigation of the impact and barriers to use of antipsychotic medication by Māori tangata whaiora in Aotearoa*. Wellington, New Zealand: Pharmac.
- Pihama, L., Smith, K., Taki, M., & Lee, J. (2004). A literature review on kaupapa Māori and Māori education pedagogy. *Prepared for ITP New Zealand by The International Research Institute for Māori and Indigenous Education (IRI)*.
- Puckey, W.G (1880). New Zealand Herald. Reprehensible Dealings with a Māori Lunatic. 4 March 1880, p6. Retrieved from Alexander Turnbull Library, Wellington: Papers Past | Newspapers | New Zealand Herald | 4 March 1880 <https://paperspast.natlib.govt.nz/newspapers/new-zealand-herald/1880/3/04>
- Rankin, J. F. A. (1986). Whai Ora – a Māori cultural therapy unit'. In M. Abbott & M. Durie. (Eds). *The Future of Mental Health Services in NZ: Māori Perspectives*. Auckland: Mental Health Foundation.
- Raumati G. (1994). *Mental health services and health education and promotion. Report for the Piki Te Ora Joint Venture Board*. Retrieved February, 13, 2011, from www.moh.govt.nz

- Reid, P., & Robson, B. (2007). Understanding health inequities. In B. Robson & R. Harris (Eds.), *Hauora: Māori standards of health IV: A study of the years 2000-2005*, (pp. 3-10). Wellington, New Zealand: Te Roopu Rangahau Hauora a Eru Pomare, University of Otago.
- Reid, P., Robson, B., & Jones, C. P. (2000). Disparities in health: Common myths and uncommon truths. *Pacific Health Dialog*, 7(1), 38-47.
- Ritzer, G. (1992). *Contemporary sociological theory* (3rd ed.). New York, NY: McGraw-Hill.
- Robson, B., & Purdie, G. (2007). Mortality. In B. Robson & R. Harris (Eds.), *Hauora: Māori standards of health IV. A study of the years 2000–2005* (pp. 33-61). Wellington, New Zealand: Te Rōpū Rangahau Hauora a Eru Pomare.
- Robson, B., Cormack, D., & Cram, F. (2000). Three social and economic indicators. In B. Robson & R. Harris (Eds.), *Hauora: Māori standards of health IV: A study of the years 2000-2005* (pp. 21-32). Wellington, New Zealand: Te Rōpū Rangahau Hauora a Eru Pomare.
- Romans, S., Dawson, J., Mullen, R., & Gibbs, A. (2004). How mental health clinicians view community treatment orders: A national New Zealand survey. *Australian and New Zealand Journal of Psychiatry*, 38(10), 836-841.
- Sachdev, P. S. (1989). Mental health and illness of the New Zealand Māori. *Transcultural Psychiatric Research Review*, 27, 85-111.
- Schreiber, R. S., & Stern, P. N. (Eds.). (2001). *Using grounded theory in nursing*. New York, USA: Springer Publishing Company.
- Selye, H. (2013). *Stress in health and disease*. Oxford, UK: Butterworth-Heinemann.
- Semmons, W. V. (2006). *Ko au te wahine Māori: A phenomenological study of Māori women diagnosed with a mental illness and their experiences of pregnancy and childbirth*. Unpublished masters thesis, Massey University, Palmerston North, New Zealand.
- Simpson, A. I., Brinded, P. M., Fairley, N., Laidlaw, T. M., & Malcolm, F. (2003). Does ethnicity affect need for mental health service among New Zealand prisoners? *Australian and New Zealand Journal of Psychiatry*, 37(6), 728-734.
- Simpson, B. (2009). Pragmatism, Mead and the practice turn. *Organization Studies*, 30(12), 1329-1347.

- Skegg, K. (2005). Self-harm. *The Lancet*, 366(9495), 1471-1483.
- Smith, L. T. (1999). *Decolonizing methodologies: Research and indigenous peoples*. London, UK: Zed Books.
- Smith, L. T. (2005). On tricky ground. Researching the Native in the age of uncertainty. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (pp. 85-107). Los Angeles, CA: Sage Publications.
- Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice*. Vol 1: (1) (pp.93-108).
- Soutar, M. (2009). *Nga Tama Toa: The Price of Citizenship: C Company 28 (Māori) Battalion 1939-1945*. David Bateman.
- Statistics New Zealand. (2011). *Quick stats about Māori and Northland*. Retrieved from <http://www.stats.govt.nz/Census/2006/2006CensusHomePage>
- Statistics New Zealand. (2013). *2013 Census quick stats about Māori*. Retrieved from <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-Māori-english/population.aspx>
- Strauss, A. (1987). *Qualitative analysis for social scientists*. New York, NY: Cambridge University Press.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications.
- Suicide Mortality Review Committee. (2016). *Ngā Rāhui Hau Kura: Suicide Mortality Review Committee Feasibility study 2014–15. Report to the Ministry of Health, 31 May 2016*. Wellington, New Zealand: Author. ISBN 978-0-908345-18-2.
- Sutherland, I.L.G (1935). *The Māori Situation*. Wellington. Harry Tombs.
- Tangaere, A. R. (1997). Māori health development in learning theory. In Pt. Whāiti, M. McCarthy & A. Durie (Eds.). *Mai i Rangiātea: Māori wellbeing and development* (pp. 46-59). Auckland, New Zealand: Auckland University Press.
- Tarozzi, M. (2013). Translating and doing grounded theory methodology. Intercultural mediation as an analytic resource. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 14(2).

- Taskforce on Whānau Centred Initiatives. (2010). *Whānau Ora: Report of the Taskforce on Whānau - Centred Initiatives*. Wellington, New Zealand: Ministry of Social Development.
- Tauri, J., & Morris, A. (2003). Re-forming justice: The potential of Māori processes. *Restorative Justice: Critical Issues*, Chapter 4, 44-53.
- Taylor, G. (2007). *Beware of the mākutū*. Waikato Times, 01/12/2007, pE5.
- Te Awēkotuku, N. (1991). *He tikanga whakaaro: Research ethics in the Māori community*. Wellington, New Zealand: Manatu Māori.
- Te Hiroa, T. R. (1910) *Medicine amongst the Māoris, in ancient and modern times*. Unpublished MD thesis, University of New Zealand, Otago Medical School, Dunedin, New Zealand.
- Te Mata o te Tau. (2008). *Matariki. A monograph prepared by Te Mata o te tau, the academy for Māori research and scholarship*. Palmerston North, New Zealand: Massey University.
- Te Momo, F. (2012). *Personal communication*, 23 February, 2012. Doctorate Supervision Session. Massey University, Auckland, New Zealand.
- Te Pou. (2014). *Supporting seclusion reduction for Māori: "Taiheretia tātou kia puta te hua" – Publication written by Te Ao Māramatanga (College of Mental Health Nurses) Māori Caucus*. Auckland, New Zealand: Te Pou o te Whakaaro Nui.
- Te Puni Kokiri. (1996). *Nga ia o te oranga hinengaro Māori. Trends in Māori mental health 1984-1993*. Wellington, New Zealand: Te Puni Kokiri. Ministry of Māori Development.
- Television New Zealand. (1984). *Koha*. Hosted by Dame Mira Szaszy.
- Thomson, S. B. (2011). Sample size and grounded theory. *Journal of Administration and Governance*, 5(1), 45-52.
- Todd, F. (2010). *Te Ariari o te Oranga: The assessment and management of people with co-existing mental health and substance use problems*. Wellington, New Zealand: Ministry of Health.
- Tomlins-Jahnke, H. (2002). Towards a secure identity: Māori women and their home place. *Women's Studies International Forum*, 25(5), 503-513.
- Trauer, T., Eagar, K., & Mellsop, G. (2006). Ethnicity, deprivation and mental health outcomes. *Australian Health Review*, 30(3), 310-321.

- Tregear, E. (1904). *The Māori race. Archibald Dudingston Willis*. Wanganui, New Zealand. Retrieved 11 October 2014 from <http://nzetc.victoria.ac.nz/tm/scholarly/tei-TreRace-t1-front-d7.html>
- Valeggia, C. R., & Snodgrass, J. J. (2015). Health of indigenous peoples. *Annual Review of Anthropology*, 44, 117-135.
- Waitangi Tribunal. (2006). *The Kaipara Report, Waitangi Tribunal Report*. Wellington, New Zealand: Wai 674. Legislation Direct.
- Waitoki, W., Nikora, L. W., Harris, P. E. T. K., & Levy, M. P. (2015). Reconnecting whānau: Pathways to recovery for Māori with bipolar disorder. In *International Indigenous Development Research Conference 2014* (pp. 147-154). Ngā Pae o te Māramatanga, Hamilton, New Zealand.
- Walker, I., & Read, J. (2002). The differential effectiveness of psychosocial and biogenetic causal explanations in reducing negative attitudes toward “mental illness”. *Psychiatry*, 65(4), 313-325.
- Walker, R. (2004). *Ka Whawhai Tonu Matou: Struggle without end*. Auckland, New Zealand: Penguin.
- Wells, J. E., McGee, M. A., Baxter, J., Agnew, F., & Kokaua, J. (2006). Onset and lifetime use of drugs in New Zealand: Results from Te Rau Hinengaro: The New Zealand Mental Health Survey 2003–2004. *Drug and Alcohol Review*, 28(2), 166-174.
- Wharewera-Mika, J. (2012). *Ahakoā te momo mate, whakanuia tāngata.” Mental health inpatient services: Māori needs when extremely distressed*. Unpublished doctoral thesis, University of Auckland, Auckland, New Zealand.
- Wheeler, A. J. (2008). Treatment pathway and patterns of Clozapine prescribing for schizophrenia in New Zealand. *Annals of Pharmacotherapy*, 42(6), 852-860.
- Wheeler, A., Humberstone, V., & Robinson, E. (2008). Ethnic comparisons of antipsychotic use in schizophrenia. *Australian and New Zealand Journal of Psychiatry*, 42, 863-873. doi: 10.1080/00048670802345482
- Wheeler, A., Robinson, E., & Robinson, G. (2005). Admissions to acute psychiatric inpatient services in Auckland, New Zealand: A demographic and diagnostic review. *The New Zealand Medical Journal*. 118, (1226), 1-9.

- Williams, W. H. (1987). *Out of mind out of sight: The story of Porirua Hospital: Porirua Hospital Centennial 1887-1987*. Porirua, New Zealand: The Hospital.
- Wilson, D. L. (2004). *Ngā kairaranga oranga - The weavers of health and wellbeing: A grounded study theory*. Unpublished doctoral thesis, Massey University, Wellington, New Zealand.
- Wilson, D., & Barton, P. (2012). Indigenous hospital experiences: A New Zealand case study. *Journal of Clinical Nursing*, 21(15-16), 2316-2326. doi:10.1111/j.1365-2702.2011.04042.
- Wirihana, R. (2008). Utilising mātauranga Māori to improve the social functioning of tangata whaiora in Māori mental health services. In Levy, M., Nikora, L.W., Masters-Awatere, B., Rua, M.R., Waitoki, W. Claiming Spaces: Proceedings of the 2007 National Māori and Pacific Psychologies Symposium, 23-24 November, Hamilton : Māori and Psychology Research Unit.
- World Health Organisation (2012). *The European Health Report. Charting the way to wellbeing*. Geneva: World Health Organisation.
- Wuest, J. (2012). Grounded theory: The method. In P. L. Munhall (Ed.), *Nursing research, a qualitative perspective* (5th ed., pp. 225- 256). Sudbury, Massachusetts: Jones & Bartlett Learning.

APPENDICES

Appendix A: Ethical Approval



Northern X Regional Ethics Committee
Private Bag 92522
Wellesley Street
Auckland 1141
Phone: (09) 580 9105
Fax (09) 580 9001
Email: northernx_ethicscommittee@moh.govt.nz

19 March 2012

Ms Maria Baker



Dear Maria

Re: Ethics ref: **NTX/12/02/006** (please quote in all correspondence)
Study title: Māori, Mental Illness and Health Services: A Māori-Centred Grounded Theory. PIS/Cons v#?
Investigators: Ms Maria Baker (Principal), Dr Fiona Te Momo (Supervisor) Associate Professor Denise Wilson (Co-Supervisor)
Locality: Northland DHB

We thank Dr Fiona TeMomo and yourself for attending the meeting via teleconference when the Northern X Regional Ethics Committee considered your re-submission on 13 March 2012.

The Committee is satisfied with the new information supplied. The researcher has addressed our main concern and provided more details on analytical methods used for the study. It is noted that the information gathered for the study will help the researcher to have a better understanding of the grounded theory approach and provide a basis for further research.

This study has received ethical approval from the Northern X Regional Ethics Committee. A list of members of the Committee is attached.

Approved Documents

- Information sheet/Consent Form version [?] -
 - Please insert the version number and date (on footer) of both documents and provide a final copy to the Committee.
 - It is suggested that provision be made for the documents to be translated into Maori (if you think it necessary).
- General notice to recruit (please insert version number and date)
- Sample Questions Interview Schedule

The following documents have been received and reviewed:

- Letter of support from Northland DHB Kaunihera Kaumatua dated 22 December 2011
- Letter of support from Director, Te Rau Matatini dated 22 December 2011
- Letter of support from Frank Wiki dated 23 January 2012
- Locality assessment from Northland DHB
- Locality assessment from Te Tai Tokerau PHO
- Locality assessment from Manaia PHO

This approval is valid until 30 June 2016, provided that Annual Progress Reports are submitted (see below).

Access to ACC

For the purposes of section 32 of the Accident Compensation Act 2001, the Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out. Participants injured as a result of treatment received in this trial will therefore be eligible to be considered for compensation in respect of those injuries under the ACC scheme.

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by **19 March 2013**. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Requirements for the Reporting of Serious Adverse Events (SAEs)

SAEs occurring in this study must be individually reported to the Committee within 7-15 days only where they:

- are *unexpected* because they are not outlined in the investigator's brochure, and
- are not defined study end-points (e.g. death or hospitalisation), and
- occur in patients located in New Zealand, and
- if the study involves blinding, result in a decision to break the study code.

There is no requirement for the individual reporting to ethics committees of SAEs that do not meet all of these criteria. However, if your study is overseen by a data monitoring committee, copies of its letters of recommendation to the Principal Investigator should be forwarded to the Committee as soon as possible.

Please see www.ethicscommittees.health.govt.nz for more information on the reporting of SAEs, and to download the SAE Report Form.

Statement of compliance

The committee is constituted in accordance with its Terms of Reference. It complies with the [Operational Standard for Ethics Committees](#) and the principles of international good clinical practice.

The committee is approved by the Health Research Council's Ethics Committee for the purposes of section 25(1)(c) of the [Health Research Council Act 1990](#).

We wish you all the best with your study.

Yours sincerely



Cheh Chua
Administrator
Northern X Regional Ethics Committee

cc: Dr Fiona TeMomo

Appendix B: Northland Locality Assessment

NAF-2009-v1 Page 1

Locality Assessment by Locality Organisation

Refer to pages 13–15 of Guidelines for Completion of the National Application Form for Ethical Approval of a Research Project (NAFG-2009-v1).

2011-12

Locality organisation sign off

Ethics committees review whether investigators have ensured their studies would meet established ethical standards if conducted at appropriate localities. Each locality organisation is asked to use the locality assessment form to check that the investigator has also made the appropriate local study arrangements.

Ethics approval for study conduct at each site is conditional on favourable locality assessment at that locality.

Please note that the locality organisation may have additional requirements to be met before a study may commence at that locality.

Part One: General

To be completed by the principal investigator for this locality.

Full project title:

Māori, Mental Illness and Health Services: A Māori-Centred Grounded Theory Study

Short project title:

What is occurring among Māori with mental illness and health services?

Locality to be assessed:

Northland

Brief outline of study:

Variations and differences in mental and substance use disorders exist for Māori. From 16 to 44 years of age Māori experience higher rates of anxiety, mood and substance use disorders (Baxter, Kingi, Tapsell, Durie & McGee, 2006), suicidal ideation and attempts (Beautrais, Wells, McGee & Oakley Browne, 2006), and schizophrenia than non-Māori (Kake, Arnold & Ellis, 2008). Māori are also more likely to have two or more coexisting health conditions with their mental or and substance use disorder, such as chronic pain, cardiovascular and respiratory disease (Scott, 2006).

Disparities in health service access and optimal treatment between Māori and non-Māori for mental health and substance use needs exists. Evident by the differences in service contact and quality of care (Durie, 2001; Crengle, Lay-Yee, Davis & Pearson, 2005; Baxter et al., 2006) in addition to Māori not accessing health services in proportion to their mental health need.

Socioeconomic factors contribute to delayed access to health care services and subsequent enforced courses of treatment for Māori (Abas, Vanderprl, Robinson & Crampton, 2003; Gibbs, Dawson, Forsyth & Mullen, 2004; Wheeler, Robinson & Robinson, 2005), as well as self-harm and suicide in 18 to 24 year old men (Blakely, Collings & Atkinson, 2003).

The reasons for the state of Māori mental health are complex. There are accounts of serious interference to the lives of Māori personally, occupationally and to their relationships with whānau.

Baxter (2008) pointed out that health service delivery had not changed for Māori as hospitalisation rates and disparities continued to increase since the 1980's. The access and responsiveness of care to Māori needs improving because of their ongoing and unmet mental health needs, including the need for optimal health care.

This study will explain what is occurring among Māori with mental illness and health services, and to identify strategies for improved access to appropriate health services.

Principal investigator (for this locality):

Maria Baker

Contact details:

Other local investigators (list all at this site):

Nil

Contact details:

Nil

Part Two: Locality Issues

To be completed by the principal investigator for this locality and signed by the authorised locality representative. (See the Guidelines (NAFG-2009-v1) (pages 13–15) for more information and examples.) Identify any local issues and specify how these issues will be addressed.

1. **Suitability of local researcher**
 For example, are all roles for the investigator(s) at the local site appropriate (for example, has any conflict the investigator might have between her or his local roles in research and in patient care been adequately resolved)? Yes No

2. **Suitability of the local research environment**
 - a) Are all the resources (other than funding that is conditional on ethical approval) and/or facilities that the study requires appropriate and available (for example, is staffing adequate? Is this site accessible for mobility-impaired people where necessary)? Yes No

 - b) Have all potentially affected managers of resources such as patient records or laboratory managers been notified? Yes No

3. **Have issues such as cultural issues specific to this locality or to people being recruited at this locality been addressed?** Yes No

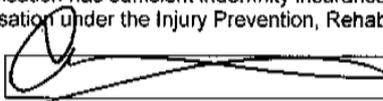
4. **Have the local investigator contact details and other important contact details been provided to the locality organisation for checking?** Yes No

Part Three: Declaration by locality organisation

I am authorised to complete locality approval on behalf of this locality organisation. I understand that I may withdraw locality approval if any significant local concerns arise. I agree to advise the principal investigator and then the relevant ethics committee should this occur.

(Questions 1–4 at Part Two above must be completed prior to signing.)

I confirm the organisation has sufficient indemnity insurance to compensate participants for harm that does not qualify for compensation under the Injury Prevention, Rehabilitation and Compensation Act 2001.

Signature:  Date: 22.12.11

Name: Dr Gloria Johnson Position: Chief Medical Advisor

Contact details: Northland District Health Board, Private Bag 9742, Whangarei 0148



22 December 2011

To Whom It May Concern

Re: Short Project Title: What is occurring among Maori with mental illness and health services?

This letter is to confirm the Kaunihera Kaumatua have expressed approval through the Locality Assessment process for the above study.

This study was approved on 22 December 2011 under Reference No: 2011-12

Yours faithfully

A handwritten signature in black ink, appearing to be 'Te Ihi Tito', written over a horizontal line.

Te Ihi Tito
Kaunihera Kaumatua

Appendix C: Panui



School of Health and Social Services
Private Bag 102904
North Shore City 0745
Auckland.

HE PANUI TENEI

What is occurring with Māori, mental illness and health services?

Are you a Māori adult (aged 18 to 65 years of age) & living in Northland?

Have you had experience of mental health issues and of utilising health services to help with this?

I am doing a study with Māori adults, to explore their experiences of health services when they need help for their mental health.

If you are interested in being interviewed and you would like to know more information. Please phone, email or text:

Maria Baker on phone [REDACTED] or email [REDACTED].

This study has received ethical approval from the Health and Disability Ethics Committee (Northern X).
Ethics Reference Number: NTX/12/02/006
Version No 1. Date: 19th March 2012

Appendix D: Participant Information Sheet



School of Health and Social Services
Private Bag 102904
North Shore City 0745
Auckland.

Participant Information Sheet

What is occurring with Māori, mental illness and health services?

*Ko Whakaterere me Maungapohatu nga Maunga; Ko Waima me Te Karae nga Awa;
Ko Hokianga nui a kupe te Moana; Ko Mahurehure me Ihutai nga Hapu; Ko Ngapuhi
me Te Rarawa nga Iwi; Ko Maria Baker taku ingoa.*

Tena koe te tuakana

I am a PhD student at Massey University, Auckland. I am conducting a research study under the supervision of Dr Fiona Te Momo (Ngati Porou) and Associate Professor Denise Wilson (Ngati Tahinga). My background is nursing; I have worked mainly in mental health and Māori health settings. I am interested in interviewing Māori adults who have experiences of mental illness, and using health services to help them resolve these health issues.

I would like to invite Māori (18-65 years of age) who have experience of mental illness and health service use to participate in this study. If you choose to participate, an interview will be arranged and conducted by myself. It should take less than 2 hours although we might split the interview up into two sessions depending on your preference. Some of the questions that I might ask may include some of the following (such as but not limited to);

- What does mental health mean to you?
- Tell me about the things you use to cope with your mental health condition?
- Are there people or health services that help you? Talk to me about these.
- Tell me about the first time you needed to see a health professional about your mental health?
- What influences you to seek help from health services?
- What are your expectations of health services?
- Describe your experiences of your General Practitioner (GP / PHO).
- Describe your experiences of mental health services.

The interview will be audiotaped and the data transcribed with all personal information including names being removed. Written informed consent will be obtained from people willing to participate in this study prior to each interview; it will include a discussion of the purpose of the study and your rights including withdrawal from the study.

Confidentiality

All information obtained in this study will be treated with absolute confidentiality. To ensure confidentiality pseudonyms (using codes) will be used instead of real names and any other information that may lead to identification will be removed. Access to any data during the study will be restricted to me and my supervisors (Dr Fiona Te Momo and Dr Denise Wilson). All research information will be locked in a filing cabinet. My supervisors and I will be the only people with access to this. On completion of the study, the data will be locked and stored for a minimum of ten years, and then destroyed by the Massey University School of Health Sciences.

Participation

Participating in this research is entirely voluntary. Your participation will involve a korero with me about your experiences as mentioned. Participants have the right to not answer any questions and to withdraw up until two weeks after the interview has been completed.

Distribution of Findings

The findings of the study will be submitted as a thesis and for examination to Massey University's School of Health Sciences at Albany, Auckland. A summary report of the findings of the study will be made available at the end of the project for all participants and supporters if they wish to receive a copy. The findings will also be published in professional journals and presented at conferences. No information about identifying individuals will be presented.

Further Information

If you require information or have an issue with this research please feel free to contact either:

<p>Maria Baker School of Health Sciences –Auckland Massey University Private Bag 102904 North Shore City 0745 Auckland.</p> <p>Phone: [REDACTED] Email: [REDACTED]</p>	<p>Dr Fiona Te Momo School of Health and Social Services Massey University Private Bag 102904 North Shore City 0745 Auckland.</p> <p>Phone: (09) 414 0800 ext. 9043 Email: F.Temomo@massey.ac.nz.</p>
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This study has received ethical approval from the Health and Disability Ethics Committee (Northern X).
Ethics Reference Number: NTX/12/02/006
Version No 1. Date: 19th March 2012

Appendix E: Participant Consent Form



MASSEY UNIVERSITY

School of Health and Social Services
Private Bag 102904
North Shore City 0745
Auckland.

Participant Consent Form

What is occurring with Māori, mental illness and health services?

This consent form will be held for a period of ten (10) years.

I(participant)

Confirm that I have read the Information Sheet and I have had the details of the study explained to me. I have had the opportunity to discuss this study and to have my questions answered to my satisfaction, and I understand that I may ask further questions at any time. I have had the opportunity to have access to whānau support or a friend to help me understand this study also. I understand that taking part in this study is my choice and that I may withdraw from the study at any time, and this in no way will affect my future health care.

Iconsent to participate in this study under the conditions set out in the Information Sheet and:

1. I agree to the interview being audio taped.
2. I agree to the information shared in the interview being for the findings to be published in a research thesis and in peer reviewed journals and presented at conferences.
3. I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports about this study.
4. I understand that I can withdraw from this study up until two weeks after my interview.

I wish to receive a summary of the findings of this study (please tick)

Signature:

Date:

Full Name - printed

This study has received ethical approval from the Health and Disability Ethics Committee (Northern X).
Ethics Reference Number: NTX/12/02/006
Version No 1. Date: 19th March 2012

Appendix F: Permission: Te Poutama.

Kia ora Maria

I give you permission to reproduce Te Poutama in your thesis and any publications arising from your thesis. I just ask that you reference it appropriately.

Ngā mihi mahana Denise

Denise Wilson

Professor Māori Health, Co-Director Taupua
Waiora Centre of Māori Health Research

Associate Dean Māori Advancement, Faculty
of Health & Environmental Sciences
Auckland University of Technology

Visiting Professor, Oxford Brookes University

P 09 921 9999 ext 7392 **M** 027 407 0022 **E** dlwilson@aut.ac.nz **W** aut.ac.nz