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**Provision at the Interface:  
the Māori Mental Health Contracting  
Experience**

A thesis presented in partial fulfilment of the requirements for the degree  
of

Doctor of Philosophy  
in  
Māori Health

at Massey University, Turitea Campus, Palmerston North, New Zealand.

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## Abstract

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New Zealand's mental health performance and monitoring framework is a complex and evolving one. Its initial development occurred at a time when it was taken for granted that mainstream understandings of health and mainstream systems of service delivery would not only be appropriate for all New Zealanders, but would also service the needs of all New Zealanders. Latterly however there has been an acknowledgment that a wholly different understanding of health and health care has existed in this country; the worldview understood and shared by tangata whenua. This thesis uses a theoretical framework devised specifically for this research to investigate the experience of Māori mental health providers as they contract to provide mental health services for the Crown; to ascertain whether Māori mental health providers deliver outside of their contracts; and to examine the role multiple accountabilities play in contracting. The theoretical framework, the "Māori research paradigm net" is inclusive of both the kaupapa Māori and Māori centred approaches, moving beyond the traditional dichotomy that frames Māori health research and allowing the researcher the freedom to select and use the best and most appropriate research tools from both traditional social science research practices, and from Māori culture and tikanga, to answer the research question posed. The thesis concludes that Māori mental health providers deliver mental health services at the interface between two philosophical viewpoints or worldviews: that of the Māori community in which they are located and to whom they provide services; and that of the funder, from whom they obtain resources to enable them to deliver services. As a consequence of working at the interface, Māori providers regularly and routinely work outside the scope of their contracts to deliver mental health services which are aligned with those values and norms enshrined in Māori culture. To adequately acknowledge and validate the beneficial extra-contractual provision which occurs as a result of delivering mental health services at the interface, and prevent less desirable provision, a more responsive contracting environment and a performance measurement framework, which integrates both worldviews and which takes account of the multiple accountabilities that Māori providers manage, is required.

# Acknowledgements

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In 1999, when this thesis was but “a twinkle in the eye”, my world was a very different place; I was a public servant working for the National-New Zealand First Coalition Government, discussions about the health sector required an understanding of acronyms such as HFA, HHS and CCMAU; and my Dad, who instilled in me a pleasure for the written word, was recuperating from liver transplant surgery.

At the time I was tossing around the idea that I might like to do some research to test a theory I had regarding Māori mental health service provision – basically that Māori mental health providers do more than they’re contracted and funded to do. The purpose of this entire 300 page manuscript is to present the results of that theory. I had another theory regarding what would happen if I undertook this research as part of a PhD, but I’ll discuss that later.

It has been said that the significance of a PhD has more to do with what one finds out about oneself, than what one discovers about his or her topic. And of course no journey of self discovery, let alone academic endeavour can ever be achieved alone. To that end, I’ll let the examiners determine the worth of the written words encompassed in the bulk of this manuscript and take these few pages at the front to thank those who helped me on the personal journey that was the PhD.

Of course I owe a huge debt of gratitude to my family who, at times with bemused bewilderment but mostly with outright confidence, love, encouragement (and interminable cups of tea), supported me throughout the PhD. Diane (Mum), Ian (Dad), David, Maiea, Tyler and Levi - my love always. Paul, you especially bore the brunt of the exasperation, frustration and procrastination so I thank you for your steadfastness and commonsense.

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I must also thank the various Ethics Committees for their consideration of the ethics protocol for this research. The project was reviewed and approved by the Massey University Human Ethics Committee (PN Protocol 02/122) and by the Manawatu /Whanganui Human Ethics Committee on behalf of Bay of Plenty, Canterbury and Auckland (M/W 42/02, AKY 03/08/193).

And of course the work presented here could not have been accomplished without the involvement of the participants themselves. Thank you all for agreeing to be part of this research project. I hope I have done justice to the thoughts, opinions and beliefs you shared with me and the time you gave up to have those views recorded. My purpose in pursuing this research was to collect evidence of the extent of the work undertaken by Māori mental health providers, such as those who took part, so that their work might be fully and appropriately remunerated. I hope that the production of this thesis goes some way towards fulfilling that aim.

As for that second theory, it had to do with my Father and the sense of humour we both shared (much to the rest of the family’s chagrin). I remember telling Dad back in 1999 that I was about to embark on a PhD and I recall his wry amusement that a day might actually pass when he might have to append the title of “Dr” to my name. Knowing Dad and his sense of world order, I had a hunch that even if I did get a PhD, despite the achievement that others might see, to Dad I’d still just be his little girl and really there was no need for him to ever refer to me as “Dr Boulton”. While I was able to test the first theory about Māori mental health providers, and have presented it here for the world to see, I never did get the opportunity to test the second theory as Dad died of cancer in 2001, while I was in my second year of study. So, cheated from ever being able to figure out if I was right, all that remains is to dedicate the thesis.

## **Dedication**

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This thesis is dedicated to Ian William Boulton  
22 Sept 1938 – 13 Aug 2001

A promise kept

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## Glossary of Abbreviations

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A and D	Alcohol and Drug
AD&G	Alcohol, Drug and Gambling
AIATSIS	Australia Institute for Aboriginal and Torres Strait Islander Studies in Australia
CAHR	Centre for Aboriginal Health Research
CEO	Chief Executive Officer
CYPFS	Children and Young Persons and their Families Service
DHB	District Health Board
DoC	Department of Conservation
FTE	Full-time equivalent
GP	General Practitioner
HFA	Health Funding Authority
HHS	Hospital and Health Service
HR	Human Resources
IPA	Independent Practitioner Association
MDO	Māori Development Organisation
MHC	Mental Health Commission
MHINC	Mental Health Information National Collection
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NZPHDA	New Zealand Public Health and Disability Act 2000
OSH	Occupational Safety and Health Service
PDN	Psychiatric District Nurse
PHO	Primary Healthcare Organisation
RCMHD	Research Centre for Māori Health &

	Development
RFP	Request for Proposal
RHA	Regional Health Authority
ToW	Treaty of Waitangi
TPK	Te Puni Kōkiri
UK	United Kingdom
USA	United States of America
WINZ	Work and Income New Zealand

## Glossary of Māori Terms

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ao	world
Aotearoa	literally the land of the long white cloud, New Zealand
aroha	love
Auahi Kore	A kaupapa Māori Smokefree Programme
āwhina	help, assist
hākari	feast
hapū	sub-tribe
hauora	health, healthy, health service
He Korowai Oranga	literally a cloak of health, title of the Māori Health Strategy
hīnaki	eel pot, eel traps
hinengaro	mind, heart
hua	outcome (accounting)
hui	meeting, gathering
iwi	tribe, people
kai	food, to eat
kaitiaki	trustee, manager, guardian
kanohi ki te kanohi	face to face
kapahaka	form of modern Māori cultural group performance
karakia	prayer, religious service
kaumātua	elder, elderly men
kaupapa	groundwork, topic, strategy, theme
kaupapa Māori	in a Māori way
kawa	protocol
kete	basket, kit, toolkit

kia tupato	be careful
kina	sea egg, sea urchin
koha	donation, gift
Kōhanga Reo	literally language nest, a Māori language immersion preschool
kōrero	speak, news, narrative
koroua	old man, elder
korowai	cloak, mantle
kuia	old lady, matron
kūmara	sweet potato
mamae	pain, hurt
mana	prestige
manaaki	care for, show respect
manākitanga	entertain, hospitality
manawhenua	local people, having rights over this land
Māori	indigenous people of New Zealand
marae	meeting area of a village or settlement, including its building and courtyards
mātauranga	education, information, knowledge
mate	sickness, death
mate māori	indigenous illness
mihi	greet, greeting
mirimiri	massage, stroke
mokopuna	grandchildren, young generation
ngā	the (plural)
ngahere	forest, bush
ngā hau e whā	the four winds or north, south, east and west
noa	free from tapu
oranga	health, welfare, safety
Pākeha	Non-Māori, European, Caucasian
pono	truth, valid, principle
poroporoaki	farewell, closing ceremony

pōwhiri	welcome, opening ceremony
pūtea	fund, budget
rangatahi	Modern youth
reo	Language (Māori)
ringawera	cook, kitchenhand
ritenga	custom
rohe	territory, zone
rongoā	traditional medicine
rūnanga/rūnaka	assembly
taiaha	weapon, spear
take	topic, subject matter
tamariki	children
tane	husband, male, man
tangata, tāngata (pl.)	person, people
tangata whenua	local people, indigenous people
tangata whaiora/takata	mental health consumer(s)
whaiora	
tangihanga (tangi)	funeral, mourning
taonga	treasure, property
tapu	sacred, forbidden
taua	old woman, matron
tauiwi	foreigner, not indigenous
taurahere	literally to bind together, in this context it means a group from another tribal area who bind together
tautoko	to support
te	the (singular)
Te Whare Tapa Wha	A Māori model of health coined by Dr Mason Durie, literally, a four-sided house
Te Wheke	A Māori model of health devised by Dr Rose Pere, literally the octopus
tika	authentic, realistic
tikanga	protocols, practices, customs

tinana	body
tino rangatiratanga	sovereignty
tuhituhi	write
tupuna, tūpuna (pl.)	ancestor(s)
turangawaewae	Home, domicile
tūrora	sick person, invalid, mental health consumer
wai	water
waiata	song, chant
waiora	total wellbeing
wairua	spirit, attitude
waka	canoe
wānanga (Wānanga)	seminar, series of discussions, also used to denote Māori universities
whaiora	short for tangata whaiora, a mental health consumer
whaikōrero	a formal speech or oration
whakamā	shy, embarrass(ment)
whakapapa	genealogy
whakapiki	increase, promote
whakapiki tangata	enablement, empowerment
whakawhānaungatanga	coming together as a family
whakaurunga	integration
whānau	extended family
whānaungatanga	relationship, kinship
whānau ora	family health
whenua	land

# **Chapter One:**

## **Introduction**

---

### **Introduction to this Thesis**

The major reforms of New Zealand’s health sector in the 1990s resulted in a burgeoning in the numbers of Māori health providers, many of which worked in the area of mental health. Occurring alongside these health reforms was an increased concern with public accountability and interest in measuring the performance of Crown agencies. This thesis examines the experience of Māori mental health providers as they contract to deliver Māori mental health services in a health sector dominated by “western” approaches to contracting and performance measurement. The research investigates whether Māori mental health providers deliver “over and above” their contracted mental health outputs, the reasons why they would work outside the scope of their contracts and the role competing accountabilities and expectations play in the delivery of mental health services.

The origins of this research can be found in the late 1990s when two pieces of research seemed to indicate the Crown’s expectations for Māori health and social service provision were at odds with service delivery on the ground.

### **Origins of the Research**

This research builds upon two case studies undertaken in the late 1990s; a project undertaken by a Māori researcher as part of a Masters in Public Health and my own Masters research in the discipline of Social Science Research. The research projects were independent of each other, sited in different cities and at different universities, and each had different aims and objectives however, they both reported remarkably similar findings with regard to the work of Māori health providers.

The first piece of research was an evaluation of a well child health programme provided by Te Whānau o Waipareira, an urban Māori organisation providing a comprehensive range of health, training and employment and social services. The purpose of the study was twofold: first, to describe, in some detail, the well child health programme; and second, to describe the characteristics of a “by Māori for Māori service” (Crengle 1997). The study was undertaken at a time when “by Māori for Māori services” were beginning to be recognised as an alternative to mainstream service provision for Māori, providing health care in a way that was more acceptable and appropriate for Māori. However as Crengle found:

*There are tensions between providers of by Māori, for Māori health services and the Crown and its agent (the health purchasing agency). The Crown and its agent ostensibly acknowledge Māori health models and Māori approaches to health service delivery and seek to develop by ‘Māori for Māori’ health services. However, the frameworks which are used in the purchase of services, development of contracts and assessment of services are based on Western paradigms. (Crengle 1997, p.158)*

Crengle (1997) identified that whilst the funder recognised the appropriateness of “by Māori for Māori” service provision, the validity of Māori models of health, and indeed the Trust’s own desire to provide a comprehensive range of social services based on Māori models, the frameworks used to purchase and monitor the service did not reflect these approaches.

The second study was my own research undertaken as part of a Master of Arts (Applied) in Social Science Research. In this study I carried out an evaluation of a Māori men’s wellbeing programme run by Te Wātea Society Incorporated, an iwi-based social service organisation operating in the Porirua/Kapiti region of Wellington. Te Wātea provided health, welfare, employment and related social services for Māori whānau in the area and a specific wellbeing programme for at-risk Māori men. In the course of evaluating the men’s programme I found that:

*The inability on the part of funding authorities to deal with Māori providers who offer a holistic service and who deliver intersectoral outcomes restricts the*

*potential of both the providers and the programme participants. ...Programmes such as Te Wātea's can be seen to be contributing not only to health outcomes, but also to broader Māori development outcomes. The difficulty is that the funding mechanisms with which Māori providers currently engage are unable to recognise the contribution these providers make to the wider goal of Māori development. (Boulton 1999, p.90)*

While policies of “by Māori for Māori” service provision recognised the need for different service delivery modes, the contractual framework between the purchasers of health services and Māori health service providers did not necessarily reflect or recognise the reality of Māori health service delivery. The dilemma for mental health contracting highlighted by this finding was sufficiently significant, I believed, as to warrant further research. To that end a set of research questions was developed and funding to undertake this research was successfully sought from the Health Research Council of New Zealand.

## **Research Aims and Objectives**

The broad research questions that this thesis sets out to answer are:

- what is the experience of Māori mental health providers in contracting to provide mental health services for the Crown;
- do Māori mental health providers deliver outside of their contracts; and
- what role do multiple accountabilities play in the contracting environment?

In attempting to answer these broad research questions a further set of lower level questions became apparent namely:

- if Māori mental health providers do deliver more than they are contracted to, are there a set of identifiable drivers which explain why Māori mental health providers do more?
- if Māori mental health providers do deliver more than they are contracted to, does the current contracting model sufficiently recognise and value this additional work?
- is a cultural performance measure required, or sufficient, to acknowledge the extra work done and the environment of delivery?

The research uses a theoretical framework devised specifically for this research to investigate the experience of Māori mental health providers as they contract to provide mental health services for the Crown. Within this theoretical framework, a Māori centred approach using primarily qualitative methods has been employed; methods derived from “Western” research practices but supported and supplemented by Māori methods of engagement, interaction, practice, analysis and dissemination.

## **Thesis Parameters**

In order to address the research questions, the thesis covers a wide range of literature from accountability, performance measurement and contracting from a public sector perspective, through to Māori development and Māori health literature and material from the field of mental health. Because the literature and indeed the topic itself is so broad and diverse a brief explanation about what the research does, and does not cover, is necessary. The research, while concerned with public sector and management concepts of accountability, does not include an examination of clinical accountability, clinical measures of performance, nor clinical performance measurement frameworks. A comparison of Māori understandings of mental health with those definitions found in the DSM –IV<sup>1</sup> is also outside the scope of this research, as is an analysis of how these understandings may impact upon documented prevalence of mental illness in the community. The thesis explores Māori mental health service provision and is concerned with kaupapa Māori mental health providers who are community-based, non-governmental organisations, as opposed to Māori mental health units attached to hospitals. For the purposes of this research and in accordance with the definitions in the New Zealand mental health literature a “kaupapa Māori mental health provider” may exhibit any or all of the following: kaumātua/kuia as an integral part of the service; an emphasis on whanaungatanga; governance based on Kaupapa Māori models; clients who are mostly Māori; local Māori community support; a kaupapa consistent with the wider aims and aspirations of Māori development; Māori tikanga, Māori beliefs, values and practices; and a majority of Māori staff. Time is the final parameter that structures

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<sup>1</sup> The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders used by mental health professionals. DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition), published in 1994 was the last major revision of the DSM. For a more complete explanation of the Manual refer to [http://www.psyweb.com/Mdisord/DSM\\_IV/dsm\\_iv.html](http://www.psyweb.com/Mdisord/DSM_IV/dsm_iv.html)

this research. The research was conceptualised in 2000/2001, with ethics approval and consultation occurring in 2002. The fieldwork was undertaken through August 2003 to October 2004.

## **Thesis Organisation**

The thesis is divided into three main sections. The first section encompasses Chapters 1-3 and provides the background to the study and establishes the context for the research question. Chapter 2 *Māori Mental Health Service Provision within the New Zealand Health Sector* traces the way government organisations have dealt with the issue of Māori mental health and demonstrates that Māori mental health service provision has resulted from the convergence of several factors: a process of deinstitutionalisation; growing numbers of Māori mental health consumers; a desire by Māori to deliver health services to their own people; and a series of health reforms which promoted devolution and contracts for service with NGO providers. Traditional Māori concepts of health and wellbeing and the diverse nature of the contemporary Māori population are introduced before discussing Māori health service provision from 1984 to the present; Government responses to the growing mental health problem; and the main features of the health reforms that occurred from the early 1990s through to the year 2000 and their impact on Māori health planning, funding, purchasing and service provision. The chapter concludes by outlining the key elements of the latest set of reforms; those introduced with the passing of the New Zealand Public Health and Disability Act late in 2000, and comments on their significance for Māori mental health service provision.

Chapter 3 *Accountability, Performance Measurement and Contracting* explores how an international trend towards greater accountability impacted on the wider state sector, and upon the health sector, in New Zealand. The types and forms of accountability in health care are discussed and the primary accountability mechanisms and processes in the mental health sector are presented. The chapter canvasses performance measurement as a mechanism for ensuring accountability and quality, outlining characteristics of performance measures and how performance measurement has been applied in the New Zealand mental health sector. The origins and continued use of contracts for service, particularly in the mental health sector and with Māori mental health providers, is also explored. The chapter concludes by drawing together the

material presented in the two literature chapters to introduce the research questions which guided this project.

The second section of the thesis comprises two chapters which deal with the theory and practice of undertaking social science research. Chapter 4 “*Sitting in an Uncomfortable Chair*”: *Theoretical Approaches in Māori Health Research* is a discussion of the predominant discourses in research and in Māori research in particular. This chapter outlines the theoretical framework that was devised specifically for this research, the “Māori research paradigm net”; a framework which guides the study and provides an interpretive framework for the results. Meanwhile Chapter 5, “*Working Under the Images of our Tūpuna*”: *Research Design and Methods*, introduces the research design and specific methods used in this study. The methods used to collect and analyse the data are outlined as are the various ethical issues which were considered in the course of the study. The themes of accountability to the community, “doing no harm” and contributing positively to Māori development are emphasised as key principles in the conduct of the research.

Chapters 6-10 make up the third and final section of the thesis. Chapters 6 and 7 present the data collected from two separate sets of respondents: Key informants considered to be expert in the area of Māori mental health and mental health providers who are engaged in the delivery of mental health services to tangata whaiora. The analysis of different strands of data such as the contractual and other documentary material, field notes and research journal data is also presented. Chapter 8 *Bringing the Findings Together* draws the various strands of data together to present an analysis of the material as a whole. The main findings from each group of respondents are presented and the different perspectives consolidated into a single and final set of findings.

Chapter 9 *Discussion* reviews the combined findings presented in Chapter 8 in light of the research questions posed at the outset of the research. The chapter begins by characterising the experience of Māori mental health providers as they contract for services from District Health Boards (DHBs) and continues with a discussion about the wider “drivers” that impact upon Māori mental health service provision. The concept of “spheres of accountability” as an explanatory factor in Māori mental health service

provision is then introduced and the implications of service delivery within an environment of multiple spheres of accountability examined. The chapter concludes by reflecting on the research and commenting on the limitations of the study.

Chapter 10 *Conclusion and Implications* presents the three main conclusions of this thesis and the implications for contracting and performance measurement which emerge as a result of these conclusions. The thesis concludes that Māori mental health providers deliver mental health services at the interface between two philosophical viewpoints or worldviews: that of the Māori community in which they are located and to whom they provide services; and that of the funder, from whom they obtain resources to enable them to deliver services. As a consequence of working at the interface, Māori providers regularly and routinely work outside the scope of their contracts to deliver mental health services which are aligned with those values and norms enshrined in Māori culture. To adequately acknowledge and validate the beneficial extra-contractual provision which occurs as a result of delivering mental health services at the interface, and prevent less desirable provision, a more responsive contracting environment and a performance measurement framework, which integrates both worldviews and which takes account of the multiple accountabilities that Māori providers manage, is required. The implications for contracting and performance measurement which emerge as a result of these conclusions have guided the development of a post-doctoral research project which will explore the issues and challenges that funders, planners and Māori providers have in contracting at the district and local level. A brief description of this subsequent project is provided in the Epilogue.

Finally a note on macrons is required. The convention for this thesis is to use macrons to indicate the long vowel sound in spoken Māori language. Macrons are therefore used throughout this thesis except for Appendix 1: *Kaupapa Māori Mental Health Service Specifications*, which is an electronic version of a Ministry of Health document and has retained its original spelling.

## **Chapter Two:**

# **Māori Mental Health Service Provision within the New Zealand Health Sector**

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### **Introduction**

In late 1999 the New Zealand health sector began to experience its fourth major restructuring in fifteen years. The recently-held general election heralded a change from a centre-right National-New Zealand First Coalition Government to a centre-left Labour-Alliance Government. Accompanying the change in leadership was the promise of significant changes to the organisation of health care purchasing and provision (Boulton, Simonsen et al. 2004). The resulting model, named after its governing legislation, the New Zealand Public Health and Disability Act 2000 (NZPHDA) aimed, amongst other things, to reduce the health disparities between Māori and non-Māori and provide a community voice in personal and public health and disability support services. The model was implemented from January 2001 and was therefore being rolled out as this research began.

This chapter traces the way government organisations have dealt with the issue of Māori mental health and demonstrates that Māori mental health service provision has resulted from the convergence of several factors: a process of deinstitutionalisation; growing numbers of Māori mental health consumers; a desire by Māori to deliver health services to their own people; and a series of health reforms which promoted devolution and contracts for service with NGO providers. The chapter begins by introducing Māori and traditional Māori concepts of health and wellbeing and the diverse nature of the contemporary Māori population. The chapter then uses the Decade of Māori Development as a platform from which to discuss Māori health service provision from 1984 to the present. After marking this Decade the chapter continues with a discussion of government responses to the growing mental health problem. It then presents a summary

of the main features of the health reforms that occurred from the early 1990s through to the year 2000 and their impact on Māori health planning, funding, purchasing and service provision. The chapter concludes by outlining the key elements of the latest set of reforms; those introduced with the passing of the New Zealand Public Health and Disability Act late in 2000, and comments on their significance for Māori mental health service provision.

## **Māori**

Māori are the indigenous people of New Zealand. The term indigenous has many definitions and many usages (Cunningham and Stanley 2003) and can be politically charged (Ratima 2001). Key features which unite indigenous peoples include an ancient relationship with a defined territory, ethnic distinctiveness (Durie 2003a) and a shared worldview that places significance upon the idea that humans are intrinsically linked to the natural world (Royal 2003). Indigenous peoples also share the common bond of experiencing “unacceptably large” differences between their health status and that of the non-indigenous populations in developed nations (Ring and Brown 2003, p.404).

Māori use the term *tangata whenua* or “people of the land” to distinguish themselves from the English, French and other nationalities who began colonising the country from the late 1700s. The terms *Pākehā*, meaning non-Māori, European, or Caucasian; or *tauwi*, meaning alien or foreign (Ryan 1999) are variously used to describe those who are not Māori. Colonisation, once begun, swiftly changed the physical and social landscape of New Zealand. The British, who had claimed an interest in the country, were concerned that some form of legal document be drawn up with Māori to confirm their sovereignty over the land. Both Māori and *Pākehā* were interested in identifying the other’s interests, intents and future plans for their respective peoples (Orange 1987).

In 1840 Māori and the British Crown signed the Treaty of Waitangi, an agreement that has come to be known as the founding document of New Zealand (Te Puni Kōkiri 2001). Differences in the Māori and the English versions of the text have resulted in discrepancies between Māori and non-Māori interpretations of the intent of the document to this day. According to the English version, Māori exchanged sovereignty for Crown protection (Durie 2003c), whereas according to the Māori text, tribal chiefs

of the day may have understood they were being offered an arrangement similar to administrative authority or a protectorate (Orange 1987). In the years since its signing, the Treaty has become an integral part of the New Zealand constitutional framework with attempts by recent governments to implement Treaty principles in order to redress past breaches of the Treaty (Te Puni Kōkiri 2001). These principles of partnership, participation and protection have been established by New Zealand Courts, by the Waitangi Tribunal (Te Puni Kōkiri 2001) and by the Royal Commission on Social Policy (1988a). It is these three principles that have guided much of the Crown's public policy in relation to Māori and indeed underpin the most recent Māori health policy documents<sup>2</sup>.

At the time the Treaty was signed Māori were predominantly a tribal people, living on ancestral lands, with close spiritual ties to that land and to their rivers, lakes, seas and forests. Māori of the twenty-first century are now as diverse a group of people as any other, with mixed views on religion, politics, culture, education, health or any other institution of modern life. Contemporary Māori live a host of different lifestyles, from "culturally conservative" through to thoroughly westernised. In coining the term "diverse Māori realities" Durie (1995c) stated that far from being homogenous, Māori are a complex population living in a range of cultural worlds where there is no single reality nor any one definition that will encompass the range of lifestyles Māori lead.

The diverse nature of the Māori population complicates the issue of how to best meet the health needs of Māori in terms of service delivery in the community as no one mode will accommodate all lifestyles and/or all realities. Government attention in the last three decades has focused on addressing how best to meet the health needs of Māori at the policy level, the funding level and through the provision of services. These efforts have aimed to raise the health status of Māori to at least that experienced by non-Māori. However, success in achieving this has been mixed - a situation which may be explained, in part, by the different perspectives Māori and non-Māori have of health, and of the factors that may lead to poor health.

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<sup>2</sup> For a fuller explanation of the Treaty of Waitangi and its application to health policy refer to Durie M. H. Whaiora: Māori Health Development. Auckland: Oxford, 1994

## Traditional Concepts of Health and Wellbeing

A traditional, or contemporary but “culturally conservative”, Māori view of health differs markedly from that of non-Māori, particularly western or Pākehā approaches to health. From a more traditional Māori perspective, health is all-embracing: it encompasses physical (tinana), spiritual (wairua), mental (hinengaro) and family (whānau) aspects (Pomare 1986) as well as relationships with the land, language (Durie 1985) and environment. Durie considers the three principal institutions of land (whenua), family (whānau) and the language (reo) as traditionally being the critical determinants of good mental health (Durie 1985). The alienation of Māori from their tribal land, a focus on the nuclear family, rather than the three-tiered whānau, hapū, iwi structure, and the decline of the Māori language were all considered to contribute towards poor mental health among Māori (Durie 1985).

These “institutions of health”: whenua; whānau; and reo; (Durie 1985, p.65) are embedded in Māori culture and pre-date colonisation and the understandings of health and illness that colonists brought with them to this country. Traditionally Māori had a very close connection with the land and in particular the land where they were born and raised. Māori are a tribal people and connections to the land occur from birth, when the placenta is buried in ancestral land, through to death, when the dead are interred in this same land. The words for placenta and land are the same in Māori, “whenua”, as both provide support, nourishment, security and anchorage (Durie 1985). Consequently, bonds with the land should be strong and the failure to establish an affiliation with tribal land is seen to jeopardise one’s health (Durie 1985). The loss of land through dispossession, war or ill fortune would bring about despondency and grief which in turn could lead to poor health, not only of the immediate family but the wider hapū and iwi (Durie 1985). Meanwhile language was considered the centre of Māori culture. Those without the language are not able to fully understand and enjoy the depth and richness of the culture and for that reason, the loss of language is equated with “incomplete personal development” (Durie 1985, p.67). Whānau, in a traditional Māori sense, embodied a wide and often complex set of relationships. The traditional Māori family, far from being nuclear, encompasses many generations. Individualism or an individual identity is not a concept that sits well with Māori, and being “a person in one’s own right” was considered unhealthy (Durie 1985).

Also intrinsic to a culturally conservative Māori worldview of health and illness are the concepts of tapu and noa. Understanding these concepts is critical for understanding sickness behaviour amongst Māori. Tapu refers to something that is sacred (Ryan 1999) and any person, object or place designated tapu requires dignity and respect. Tapu was used as an “effective social sanction” guiding the relationships between people and their surrounding environment (Durie 1992a, p.2). Noa is the condition or state that balances tapu. While objects or places that are noa (or free from tapu) (Ryan 1999) may be approached and used freely, care needs to be taken to keep these separate from tapu objects. Food, for example, is noa and can contaminate anything that is tapu. Those who believe in the values of tapu and noa will avoid “breaching tapu”, for to do so would, they believe, lead to sickness - “mate Māori” - or even death. Māori may present to mental health providers believing that they have breached certain cultural protocols by breaching tapu or by not according sufficient respect to an event or place (Dyall 1997).

In 1994 Irihapeti Ramsden warned of the implications of not understanding the Māori worldview of health and illness. She noted that while Māori do not question the validity of other cultures’ worldviews, the worldview of Māori culture is constantly questioned. This can lead to Māori being admitted to psychiatric institutions suffering from mate Māori (indigenous illness) and other wairua (spiritually) related conditions for which western science and medicine has little effective treatment. Understanding and knowing one’s culture is therefore considered crucial to overall wellbeing. This view is supported by Māori health providers and practitioners today. The cultural adviser of Te Oranganui in Wanganui has noted that much Māori ill health can be attributed to people’s detachment from their cultural base (Manchester 1998). An evaluation of a Māori men’s well-being programme showed that learning about Māori culture, whakapapa and the traditional role men played in Māori society led to improved wellbeing outcomes for participants in the programme (Boulton 1999).

In contemporary New Zealand Māori, as a population group, experience higher death rates and lower life expectancy than any other ethnic group including Pacific Islanders. Indeed, on average, Māori have the poorest health status of any ethnic group in New Zealand (King 2000c; Ministry of Health 2002b). Ajwani et al. (2003) note that in the

last two decades there has been little (if any decline) in Māori and Pacific mortality rates, despite a steady decline in mortality rates for non-Māori and non-Pacific peoples.

To make any impact on mental health for Māori the “institutions” of Māori health (such as land, language, whānau, tapu and noa); the existence of a “Māori worldview” that is different from that of many New Zealanders; the experience of colonisation; and the diversity of contemporary Māori society must all be given appropriate consideration. The extent to which these factors are regarded and supported by the policies of the current government also has an impact on Māori mental health status.

Only in the last twenty years has there been a wider acknowledgment that mental wellbeing within Māori society is largely determined by a complex mixture of social, economic, political, cultural, historical and spiritual factors (Disley 1997; Durie 1998c). Durie notes that mental health is unlikely to be determined by only one cause or factor and that the foundations of mental health are as likely to be found outside the body as within.

*There is no single cause of poor mental health, nor a single solution. For the most part mental health problems amongst young Māori reflect social, economic and cultural trends and any comprehensive solutions must be similarly broad. (Durie 2003b, p.147)*

Similarly the interplay of these factors will have an impact upon the way Māori access and utilise mental health services. The history of Māori mental health service delivery in New Zealand has largely been a custodial one within mainstream institutions. Ramsden characterises the New Zealand health system as being “monocultural” (Ramsden 1994, p.42), in that the government neither recognised cultural differences as being important to service delivery, nor accepted that Māori could deliver services as well as, or better than, their own agencies or non-Māori health care providers (Te Puni Kōkiri 2000). This was nowhere more so than in the mental institutions and asylums that for so long typified mental health service delivery.

Durie (2001) argues that Māori mental health service delivery has been characterised by three distinct phases of care since the middle of the nineteenth century: institutionalisation; deinstitutionalisation; and “cultural affirmation”. From the mid 19<sup>th</sup> century New Zealand followed the European trend of housing the mentally ill in large asylums or mental hospitals. The purpose of such institutions was seen as two-fold: to protect the public and grant “asylum” to individuals who would not have been well tolerated by society (Durie 2001) and to provide long-term care for those in need. By the 1960s the practice of providing long-term, secure care and support for the mentally ill was gradually being phased out (Disley 1997). Psychiatric hospitals declined in size as mental health consumers were discharged to live, and be treated, in the community. This process of deinstitutionalisation continued throughout the mid 1970s - 1990s and coincided with the introduction of new anti-psychotic drugs and the development of mental health services based on general hospitals (Durie 2001).

Deinstitutionalisation, characterised by the “wholesale discharge of patients into the community” (Durie 2001, p.223) and the rise of community care, resulted in an increased reliance by the government on local communities to support mental health consumers. Durie (1994d) argues that for Māori communities the process of deinstitutionalisation distracted Māori from the proactive goals of Māori development and focused their attentions on providing “ameliorative social services” to fill the gap where the State had failed. However, the increased numbers of Māori mental health consumers living in the community and requiring support, care and treatment also provided an opportunity for Māori organisations, whether iwi, hapū or urban-based, to begin to deliver services to their own people. Deinstitutionalisation could be regarded as one of the catalysts of Māori mental health service provision. However two other developments in the sector were required before Māori mental health service provision could occur: a greater recognition that Māori were best placed to deliver mental health services to their own people; and an infrastructure which would allow the existence of a relationship between the State as a purchaser of services, and community organisations as provider of services.

Before introducing the third phase of mental health service delivery, it is necessary to discuss the Decade of Māori Development, the growing crisis in mental health and the Government’s responses to that crisis: events that span a period from 1984 through to

the late 1990s. This discussion will demonstrate how the Government's recognition of the importance of cultural context to Māori mental health service provision became firmly entrenched in its policy documentation. The discussion will then return to the mid-1980s to examine the health sector reforms and the creation of an infrastructure which allowed Māori providers to flourish.

## **A Decade of Māori Development**

From about the mid-1980s onwards New Zealand “embarked on a process of radical societal change” (Durie 1998a, p.11). In the state sector an extensive series of government-led reforms reshaped and re-ordered the structures, institutions and processes of the public service. These changes were prompted by the desire to improve the efficiency and effectiveness of the public sector (including the institutions that made up the health, welfare and education sectors), reduce public expenditure, enhance the responsiveness of the public sector to its clients and improve managerial accountability (Boston, Martin et al. 1996).

During this period several policy instruments were employed to make requisite changes to the sector. These included devolution of management responsibilities; a shift in focus from inputs to output and outcome measures; tighter performance specifications and contracting out of services (Boston, Martin et al. 1996). Together these instruments came to be known as the New Zealand model of public management (Boston, Martin et al. 1996).

As deinstitutionalisation in the mental health sector continued, questions about the effectiveness of a monocultural health system for Māori were also being considered. Kiro (2001) notes that at a governmental level philosophical debates were occurring about whether New Zealand should pursue a policy of universality for all New Zealanders, or whether some form of positive discrimination for Māori should be introduced. According to Kiro (2001, p.104) “mainstreaming has been government's preferred approach” to dealing with Māori issues. Mainstreaming is a policy of inclusion whereby “mainstream” government organisations and agencies deal with Māori as merely part of the larger population of New Zealand. Mainstreaming presumes that Māori interests are best served by organisations which are responsible for high quality outcomes for Māori as citizens of New Zealand rather than “by virtue of

their ethnicity” (Kiro 2001, p.109). This philosophy was to be challenged in the mid-1980s by the growing demands from within and outside Māori society that Māori themselves should manage and deliver their own programmes and act as guardians for their own people (Royal Commission on Social Policy 1988a).

In 1984, against this backdrop of upheaval in the state sector and ongoing deinstitutionalisation, three significant events occurred for Māori health. The first was the launch of *Rapuora: Health and Māori Women*; a landmark research project into the health and wellbeing of 1177 Māori women. This research was important for several reasons. It represented the first study of its kind into Māori women’s health; it was undertaken wholly by Māori women themselves in the roles of interviewers and field supervisors, with consultants advising on the more technical aspects of sampling and data management; and it received overwhelming support from the community under investigation. In addition to the standard questions on lifestyle and attitude, it included questions that were more significant from a Māori health perspective; namely, questions on the importance of Māoritanga to health and wellbeing. The survey had a response rate of 99 percent, with only 12 refusals in a total of four regions (Murchie 1984). At the launch of the report, the Māori Women’s Welfare League called for a decade which focused on Māori health.

The second event was the Hui Whakaoranga held at Hoani Waititi Marae in Auckland in March of that same year. The hui brought together various health and other government department officials, Hospital Board members and health workers to “listen to Māori people define health in their own terms” (Department of Health 1984, p.4). The hui emphasised the importance of the growing number of Māori health initiatives and asked delegates to consider strategies to maintain the momentum of such initiatives given the disparities in health status between Māori and non-Māori. The emphasis of the hui was on promoting a positive view of Māori health (Department of Health 1984) and it advocated Māori health programmes such as marae and community-based clinics as well as confirming Māori health philosophies and models (Crengle 1999). Further recommendations from the hui included a desire for Māori to be more involved in consultation; that the Māori health workforce be developed and supported; and that consideration be given to reviewing how health resources are allocated (Department of Health 1984). The hui was significant because it presented a view of health and health

care that was different from, and broader than, that embraced by the majority of the population. Culture and socio-economic status were considered to be just as important in determining health as lifestyle choice (Durie 1998c). By showcasing the many Māori community health projects that were emerging throughout the country the hui presented participants with the opportunity to consider the prospect of a health system that could bridge two different conceptual approaches: a system more relevant to “contemporary Aotearoa” (Pomare 1986, p.410).

The third event was the Hui Taumata or Māori Economic Summit at which a decade of Māori development was announced. The Hui Taumata was convened jointly by the Ministers of Māori Affairs and Finance shortly after the fourth Labour government came to power and, according to Durie (2002b), was as much a political initiative to advance privatisation as an initiative to curb a widening economic and social disparity between Māori and non-Māori. Irrespective of motives, the objectives of the Hui were to: reach an understanding of the nature and extent of the economic problems facing New Zealand as they affect Māori people; examine the strengths and weaknesses of the Māori people in the current position; discuss further policies for Māori equality in the economic and social life of New Zealand; and obtain commitment to advancing Māori interests (Durie 1994a).

In essence the Hui Taumata re-invigorated Māori to consider Māori development on their own terms, as much as in terms of how government viewed Māori development. According to Wetere (1994), Māori were left with the expectation that improved wellbeing and economic self-sufficiency was possible, without having to rely on the government. The means of ensuring this greater independence were to be found in the development, investment and regeneration of the traditional institutions of iwi, hapū and tribal resources. Durie (1998a, p.7) argues that tribal development became “the preferred focus for Māori development” and a process of devolution of many government functions to tribal authorities resulted. The premise of devolution was that given adequate access to resources, Māori, relying upon their own structures and organisational groupings as well as the values inherent in their own culture, could provide “certain services to their own people” at least as well as the state (Durie 1998a, p.8). The hui also highlighted the link between health and the position of Māori within society. In particular it was noted that the social, economic and political status of Māori

was directly associated with the status of their health, and, consequently that cultural and political alienation could be regarded as precursors to poor health and increased morbidity (Gillies 1996).

Six themes, central to the philosophy of positive development, emerged from the Hui Taumata and guided the Decade of Māori Development. These were: the Treaty of Waitangi; tino rangatiratanga; iwi development; economic self reliance; social equity and cultural advancement (Durie 1998a, p.8). Although these themes may not have been readily apparent through the following two decades, they were, nevertheless manifest in subsequent responses to a growing crisis in Māori mental health.

### **Māori Mental Health Becomes a Concern**

By the late 1990s, mental health problems were beginning to be recognised as the “number one health concern for Māori” (Durie 1997, p.1) with government agencies coming to regard mental illness as “the major health problem facing the tangata whenua of Aotearoa” (Health Funding Authority 1999b, p.3). Forewarnings about a looming Māori mental health crisis had been evident in the *Psychiatric Report 1988* (Mason, Ryan et al. 1988) and in the review commissioned by the Māori Trustee into the welfare of Māori mental health consumers discharged from psychiatric hospitals (Mason 1991).

*The Psychiatric Report 1988* chronicles the findings of the Committee of Inquiry established to investigate the procedures and processes of psychiatric hospitals throughout New Zealand. In particular the Committee were to investigate the practices of admission, discharge and release on leave for certain types of psychiatric patients, after a series of incidents in which inmates discharged from hospitals had committed homicides or assaults in the community (Mason, Ryan et al. 1988).

In that report, the Committee noted a “disproportionate representation of Māori people in prisons and in psychiatric hospitals” (Mason, Ryan et al. 1988, p.166) and that health services were neither accessible nor culturally appropriate for meeting the needs of Māori. In addition, Māori tended to seek medical advice too late and as a result required hospitalisation, rather than some less intense form of care or treatment (Mason, Ryan et al. 1988).

The report to the Māori Trustee considered whether the Māori Trustee should be a Trustee for ex-psychiatric patients who were living in the community. It noted that not only were Māori over-represented among the “psychiatrically disabled” but that they also appeared to be particularly vulnerable when they left psychiatric institutions (Durie 1994d, p.134). The report concluded that there was a role for the Māori Trustee as an advocate and primary case worker for Māori suffering from a mental disability; however, this recommendation was not followed by the government of the time (Durie 1992b). Practitioners in mental health warned, however, that as the impacts of deinstitutionalisation filtered into the Māori community, so the issue of Māori mental health would gain greater significance (Durie 1992b).

Gauging the exact extent of the “problem” of Māori mental ill-health was complicated by the paucity and inadequacy of Māori mental health data available at that time. Durie (1985) notes that a complete picture of the state of Māori mental health was difficult to obtain. In part this was because of the limitations and inconsistencies that characterise ethnicity data collection in the health field (Disley 1997; Reid and Robson 1998, 2001). For example Te Puni Kōkiri has noted three key changes to the way in which health statistics have been collected and coded since 1995 (Te Puni Kōkiri 1998). These include the adoption by the New Zealand Health Information Service of a new diagnosis coding schedule, and changes to both ethnicity coding for mortality data and the collection of ethnicity data in hospitals to achieve consistency with Statistics New Zealand’s standards (Te Puni Kōkiri 1998).

The evidence of disparities in mental health status between Māori and non-Māori comes primarily from hospital admission statistics; however, hospitalisation data also has its limitations (Te Puni Kōkiri 1993a). Durie (2001) notes that mental health status cannot be accurately determined from hospital admission data alone as there is no clear correlation between prevalence<sup>3</sup> of mental disorders and hospital statistics. In other

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<sup>3</sup> “Prevalence” is the measure of a disorder’s occurrence within the total population over a given period as compared to “incidence” which refers to the number of new cases of a disorder that occur within a population during a given time, usually one year. Disley, B. (1997). *An Overview of Mental Health in New Zealand. Mental Health in New Zealand from a Public Health Perspective*. P. M. Ellis and S. C. D. Collings. Wellington, Ministry of Health: 3-36..

words, admissions to hospitals do not necessarily reflect the prevalence of illness in the community. Despite the limitations of the data, hospital admission figures are used to illustrate trends over time, and to compare the experience of different groups (Durie 1994c).

A report published in 1995 corroborated the findings of *the Psychiatric Report 1988* regarding the state of Māori mental health. *Hauora: Māori Standards of Health III* confirmed that despite an overall decline in psychiatric admissions for the period 1970-1991, the admission rate for Māori to psychiatric hospitals was still on the rise. Furthermore the report noted that Māori were still accessing services at a later stage than non-Māori and as a result were more likely to be seriously ill when they did access a service (Pomare, Keefe-Ormsby et al. 1995).

In 1996 the second Mason Inquiry was completed. That inquiry was convened to investigate the availability and delivery of services that dealt with those mental health consumers who had semi-acute or acute mental disorders (Mason, Johnston et al. 1996). The report from the second Mason Inquiry (the Mason Report) recommended improvements to the mental health sector in the areas of provision and coordination of services, workforce, privacy and child and adolescent services. However it is the recommendations concerning Māori, the creation of a new organisation and increases in funding which are particularly relevant to this research.

The Mason Report noted that Māori made up a significant proportion of mental health consumers and that once admitted to services, they were likely to have poor outcomes, as evidenced by a growing rate of readmission (Mason, Johnston et al. 1996). The report stated that in the context of a “hostile” social and economic environment not only were there insufficient culturally appropriate community services for Māori, but the current services on offer were not designed to meet the needs of Māori (Mason, Johnston et al. 1996, p.137). In effect, the mental health services that had been found so wanting eight years earlier did not appear to have improved. In presentations to the Committee of Inquiry, Māori offered four options to improve the delivery of mental health services; all of these involved the delivery of services by Māori and for Māori. Service delivery options included mental health services run by iwi, services run by a regional organisation, services run by a Māori Mental Health Commission (an

organisation similar in function to a proposed Mental Health Commission) and services run by a Māori National Mental Health Advisory Group.

The Mason Report also recommended the establishment of a new Mental Health Commission “to improve performance and lift the priority given to Mental Health in Zealand” (Mason, Johnston et al. 1996, p.102). The main role of this small, dedicated organisation would be to collate information and report what was “really going on” in the mental health sector (Mason, Johnston et al. 1996, p.108). The report recommended that the Commission be headed by a full-time Chairperson and that two other Commissioners be appointed; one a mental health professional and the other from the wider mental health community. The Commission would require its own separate funding for operations.

The Mason Report noted that funding was an issue that permeated the entire Inquiry. Two recommendations were made with regard to mental health funding. First, expenditure on mental health services (including Drug and Alcohol services) should be increased incrementally over a five year period, and second, all mental health money should be “ring-fenced at both RHA and CHE levels” (Mason, Johnston et al. 1996, p.176); or in other words, at the level of purchaser and public hospital.

The two inquiries, within a decade of each other, demonstrated serious shortcomings in the mental health sector; shortcomings underlined by the publication of Māori mental health admission and readmission rates. Prior to 1970, Durie (1995b) reports that Māori admission rates to psychiatric hospitals were actually consistently lower than for non-Māori. However, since then Māori have experienced higher rates of first admission to psychiatric institutions than non-Māori. Data reported by Te Puni Kōkiri in 1993 noted that Māori rates of admission to psychiatric hospitals and wards increased steadily through the decade 1981 - 1990 (Te Puni Kōkiri 1993b). Indeed, the data collected between these years showed that the rate of admissions for Māori leapt from 400 per 100,000 in 1981 to 600 per 100,000 in 1990. Conversely the rate for non-Māori during the same period remained constant or fell (Te Puni Kōkiri 1993b). Drug and alcohol abuse and psychosis were the major reasons for Māori first admissions, accounting for 32% of all Māori first admissions. Schizophrenia, affective disorders and other

psychotic disorders made up a further 40% of Māori first admissions and 78% of readmissions (Durie 2001).

Despite the inadequacies associated with mental health statistics, a growing disparity between the mental health status of Māori and non-Māori was evident by the late 1990s (Te Puni Kōkiri 1998). By 2001 the Ministry of Health reported Māori as being disproportionately higher users of mental health and related services, such as prisons, alcohol and drug services, and women's refuges (Ministry of Health 2001a). This overrepresentation is, according to Dyall (1996), even more pronounced in those services requiring custodial or intensive supervisory care or intense treatment and rehabilitation services. Unmet and multiple needs arising from whānau dislocation, previous abuse and cultural alienation may explain the disparity.

While no comprehensive national mental health data currently exist, limited mental health data are available from longitudinal cohort studies, public hospital admissions, psychiatric admissions and regional psychiatric epidemiology surveys (Ministry of Health 1999). Fortunately, the government has recently acknowledged the poor state of Māori health data, and, recognising the link between good quality data and effective service delivery, has indicated a commitment to improve the collection and quality of ethnicity data (Ministry of Health 2002b). To that end the Ministry of Health, in conjunction with the Health Research Council, has initiated an epidemiological study aimed at understanding the prevalence of mental health problems in New Zealand populations including Māori. *The New Zealand Mental Health Epidemiology Study Te Rau Hinengaro* includes a survey of households with 13,000 individual interviews. The survey fieldwork was conducted through 2003 and 2004 and the research team are now currently engaged in report writing. The results of the survey will be published in 2006 (The Mental Health Research and Development Strategy 2005).

## **Government Responses to the Crisis**

Until the early 1990s the delivery of Māori health services was predominantly through the mainstream system. Mainstream services were expected to be “responsive to” Māori and reflect Māori perspectives both in their policy and in their practice (Cunningham and Durie 1999). Responsiveness to Māori resulted in the establishment of taha Māori training programmes for nurses (Abbott 1987), the appointment of Māori

to health boards and an expectation that non-Māori would become more “culturally aware” (Cunningham and Durie 1999, p.240). In addition to being “responsive” to Māori, the political philosophy of biculturalism which was being promoted at this time required institutions, government departments and community organisations to consider the Treaty of Waitangi in their operations (Durie 2001) and again, consider how things might be done in a Māori way.

In the last two decades the New Zealand Government’s efforts regarding Māori mental health have tended to focus on three areas: decreasing the level of mental illness, (and in particular reducing the disparity between Māori and non-Māori rates of admission and readmission); accelerating the involvement of Māori in the delivery of services; and encouraging the responsiveness of mainstream mental health services to meet the needs of Māori consumers (Webby 2001). The Government’s key strategies for addressing Māori mental health since the early 1990s and the aims and objectives of the strategies regarding Māori mental health are summarised below:

### ***Ministry of Health***

In 1993 the government revisited its health goals and identified four health gain priority areas requiring particular attention: Māori health, mental health, child health and physical environmental health. These four areas were identified as “needing improvement due either to poor performance compared with other countries or a need to reduce disparity within New Zealand” (Shipley 1996, p.11). To provide direction to the sector on each of these health gain priority areas the Ministry of Health was required to develop accompanying strategic policy documents. In June 1994 the Government launched its national mental health strategy with the publication of *Looking Forward: Strategic Directions for the Mental Health Services* (Ministry of Health 1994). *Looking Forward* was structured around two high level goals and five strategic directions, one of which (Strategic Direction 2: Encouraging Māori involvement in planning, developing and delivery of mental health services), was aimed specifically at addressing issues in Māori mental health. However, the other strategic directions would also affect Māori as they dealt with areas such as the quantity and quality of mainstream mental health service provision, the rights of consumers and infrastructure and workforce issues.

In 1997 the Ministry released the implementation plan *Moving Forward: The National Mental Health Plan for More and Better Services*. The purpose of this document was to link the high-level goals and strategic directions contained in *Looking Forward* to meaningful objectives and targets which would ensure the earlier strategies were implemented (Ministry of Health 1997a). The plan had a four to ten year focus and a stepped approach, i.e. it comprised first steps which were considered high priority and achievable with existing resources, and “next steps” which although desirable, at the time of the plan’s release were not funded.

The strategic directions contained in the Looking Forward document were translated into a series of national objectives. Three objectives specifically targeted Māori mental health; namely

- *National Objective 2.1 - to encourage Māori involvement in planning, developing and delivering mental health services;*
  - *National Objective 2.2 - to increase the responsiveness of mainstream mental health services to the special needs of Māori; and*
  - *National Objective 6.4 - to increase the Māori mental health workforce.*
- (Ministry of Health 1997a)

Issues concerning Māori provider development were dealt with under the National Objective 6.1 (ensuring all mental health services employ sufficient staff with the necessary knowledge and skills to deliver essential services to their identified target groups in the mental health sector). Whilst there was an acknowledgement that Māori may be better able, from a cultural perspective, to provide mental health services for their own people, it was also understood that most Māori mental health consumers were accessing mental health services in the mainstream system. Therefore, the government’s approach was to encourage Māori into service provision yet at the same time try to make the mainstream system more responsive to the particular needs of Māori. During this time, “more and better services” became the catch-cry for the mental health sector.

The Ministry of Health, concerned about the inconsistent and unsatisfactory practices that had been identified in mental health services, undertook a consultation exercise in 1996-97 to develop a set of mental health standards (Durie 2001). In 1997 the *National*

*Mental Health Standards*, a sub-project of the National Mental Health Strategy (i.e. *Moving Forward*) were released. The purpose of the *National Mental Health Standards* was to “establish a level of care and support, which will in time ensure that consumers experience consistent service provision across the country” (Ministry of Health 1997b, p.vii). The aims of the standards were:

- *to promote the mental health of the New Zealand community and where possible minimise the incidence of mental illness and mental health problems;*
- *to ensure that mental health services in New Zealand offer the highest standard of care to those who use them;*
- *to assure the rights of people with mental illness;*
- *to ensure that the unique needs of the New Zealand community are addressed consistently across the nation; and*
- *to promote continuous quality improvement of mental health services in New Zealand through participation of consumers, families, carers, purchasers and providers.* (Ministry of Health 1997b, p.vii)

The standards reflected the special mental health needs of Māori through Standard 1 (Tangata Whenua), and Standard 3 (Cultural Awareness). Standard 1 required all mental health services to provide services appropriate to meet the needs of whānau, hapū and iwi, while Standard 3 required all mental health services to deliver treatment and support which was appropriate and sensitive to the cultural, spiritual, physical, environmental and social values of the consumer and the consumer’s family and community. Therefore the Standards set a benchmark to which all mental health services should aspire, irrespective of whether they defined themselves as a Māori mental health service or not. In hindsight, the Ministry of Health regard the publication of the Standards in 1997 as “a big step forward” in addressing quality improvement (Ministry of Health 2001b). The Standards were revised and updated in 2001 and while they did not alter significantly, the expectations underpinning Standards 1 and 3 were clarified and augmented. Monitoring of the Standards occurs in a number of ways: through self-audits; through regular reporting as specified in a mental health provider’s contract with the funder; and through a system of independent audit and review (Ministry of Health 2001b).

The same year that the Standards were released, leaders within the Māori community were debating and discussing ways to improve Māori mental health. Key amongst these was Durie, who argued that viewing mental illness as a problem that only mental health services needed to address would be to miss the wider role other health services, and society more broadly, played in mental wellbeing. Durie noted that any plans to improve mental health should “reflect a mix of political, cultural, economic, social and clinical strategies operating within a synchronised framework” (Durie 1997).

At the Māori Mental Health Summit in 1997 Durie unveiled his Treaty-based *Puahou* framework. The framework aimed to reverse the growing incidence of mental illness amongst Māori through the application of five inter-related strategies which worked in concert. The five strategies are based upon the Treaty of Waitangi principles of recognition, partnership, options, active protection, and autonomy and included: the development of a secure identity through improved access to the cultural, social and economic resources of te ao Māori; active participation of Māori in society and in the economy; aligning mental health services with primary health care services, mental health services, and services for youth; workforce development; and autonomy and control (Durie 1997).

In his presentation to the Summit, Durie (1997) concluded that while iwi and mandated community organisations have certain obligations to their own people, the responsibility for improving Māori mental health resides with the government. The challenge of reducing the disparities between Māori and non-Māori mental health status lay firmly with the agencies of state who were required to work together more effectively, more collaboratively and in a more co-ordinated fashion. At this time Durie also suggested a separate independent group be established to monitor Government’s progress in Māori mental health.

Since the launch of the national mental health strategy in 1994 Ministry of Health efforts at a strategic level have focused on mental health promotion; on providing a nationally consistent framework for the planning and delivery of services to tangata whaiora and whānau; and on linking and consolidating earlier strategies with the new strategies developed to guide the sector since the passing of the New Zealand Public

Health and Disability Act. These strategic developments are discussed later in the chapter.

### ***Mental Health Commission***

The establishment of the Mental Health Commission was one of the main outcomes from the recommendations of the Mason Report of 1996. On its inception, the Commission was charged with three functions: to monitor the implementation of the National Mental Health Strategy (i.e. *Looking Forward: Strategic Directions for the Mental Health Services*); to reduce discrimination against people with mental illness; and to ensure the mental health workforce was strengthened (Mental Health Commission, 1998).

*The Blueprint for Mental Health Services in New Zealand* represents the Commission's core work and is described as a service development plan, setting out, in the Commission's view, the changes that are required in the sector to realise the objectives of the National Mental Health Strategy. The Blueprint is a five-yearly plan and is reported on annually (Mental Health Commission 1998). Durie (2001) notes that the *Blueprint* represents a shift away from focusing on institutional and provider priorities to the priorities of the consumer. Rather than a focus on "curing" the mental health consumer and eliminating the "disease", practitioners and consumers alike promoted the management of mental illness while achieving a reasonable quality of life. This shift in focus from curing disease to quality of life reflected international trends. For example, in the UK, the main aim of services for people with "mental disorders" was the elimination or reduction of clinical and social disablement and the achievement of optimal quality of life for the sufferers and their carers (Huxley, Hagan et al. 1990). In New Zealand in the 1990s the "recovery" model was promoted as a means of empowering consumers to manage their illness. Two key philosophies underpin a recovery approach: consumer empowerment and zero tolerance for discrimination (Durie 2001).

The Blueprint document outlined a number of areas where changes and improvements in the sector were required to address Māori mental health and it provided some guidelines on how to effect those changes. Key amongst these, and relevant to this research, were the areas of:

- *culturally effective services;*
- *funding and contracting constraints;*
- *inappropriate performance measures; and*
- *meeting the needs of Māori.* (Mental Health Commission, 1998)

The Blueprint also identifies a series of critical success factors for effective mental health services for Māori. These include:

- *effective funding and provision of mental health services for Māori;*
- *the sustainable development of Māori provider organisations; and*
- *the requirement for a Māori mental health strategy to be embedded within wider public and primary health strategies for Māori.* (Mental Health Commission 1998)

Since the second Mason report in 1996 other government departments and agencies have also developed strategies and approaches to deal with the issue of Māori mental health. In 1998, Te Puni Kōkiri, the Ministry of Māori Development, produced a discussion document *He Pou Tarawaho Mo Te Hauora Hinengaro Māori: A Framework for Māori Mental Health*. The purpose of the document was to provide input into the Health Funding Authority's planning process. In 1998 the HFA was the government agency responsible for purchasing health and disability services on behalf of all New Zealanders. In 1999 its budget was \$6.7 billion and it managed over 4,500 contracts (Health Funding Authority 1999a, p.5). The HFA was guided in its purchasing decisions by an explicit set of funding principles, namely: effectiveness; cost; equity; Māori health and acceptability. The Māori health funding principle ensured that funding decisions would acknowledge the Treaty of Waitangi and encourage Māori participation in providing and using services, whereas the equity principle focused on reducing disparities in health status (Health Funding Authority 1999a).

Te Puni Kōkiri's document represented an attempt to enhance the Health Funding Authority's understanding of Māori mental health issues and to identify opportunities to improve the mix and quality of mental health services available to Māori. It also aimed to encourage the HFA to begin the process of specifying the short and medium term goals to fulfil the Government's policy objectives of more and better mental health

services for Māori (Te Puni Kōkiri 1999). Divided into three sections, the discussion document outlines the trends in Māori mental health, summarises Government policy relevant to mental health and discusses how to translate the Government's policy objectives into positive health gains for Māori. The framework outlined in the document attempted to translate the Government's medium-term goals, as identified in the Moving Forward and Blueprint documents, into identifiable and therefore measurable, actions. The document remained an internal discussion piece, for use between Te Puni Kōkiri and the Health Funding Authority; in the following year the HFA released its own long-term strategy document for mental wellbeing and mental health promotion, *Kia Tu Kia Puawai*.

*Kia Tu Kia Puawai*, apart from being a Māori model, emphasised the need for mental health promotion through a community health development approach (Health Funding Authority 1999b). Its purpose was to assist the HFA in its purchasing decisions. It argued that in order to realise their full potential, people needed safe and supportive communities, healthy environments, adequate levels of income and housing and meaningful roles in life (Health Funding Authority 1999b). The document reinforced the links between social, cultural and economic wellbeing and mental health (Health Funding Authority 1999b). Like many other strategic level documents of its time *Kia Tu Kia Puawai* emphasised the need for models of mental health that reflected the needs and expectations of Māori and acknowledged the need to develop an “appropriate paradigm of mental health that contributes to improved outcomes for Māori” (Health Funding Authority 1999b, p.3).

By the late 1990s, the third phase of Māori mental health service delivery, that termed “cultural affirmation” by Durie (2001, p.225), was well underway. This period continues to the present and has been characterised by the growth of a diverse range of mental health service providers, including mental health services for Māori (services, which while catering for Māori do not necessarily operate from within a Māori cultural context) and Māori mental health services (those which start from and are based upon a Māori philosophical premise) (Durie, Allan et al. 1995). This period has been one during which practitioners have begun to acknowledge the role culture has to play in the recovery of Māori mental consumers and where the empowerment of consumers and

their families is regarded as critical to the successful delivery, evaluation and governance of mental health services and systems.

By now, Government strategies and policy documents clearly recognise that to produce positive health outcomes for tangata whaiora, mental health services must be culturally appropriate. Indeed, Durie argued that services that did not take into account the significance of culture for the presentation, assessment, treatment and follow-up of clients were less likely to be effective (Durie 1995b). By the mid 1990s culturally appropriate services, and in particular kaupapa Māori services, had been developed to the extent that they were able to provide a treatment environment based on Māori cultural values, processes and beliefs and were accommodating views and philosophies which were not solely based on western concepts of “good health” (Durie, Allan et al. 1995).

However, the relatively recent development of kaupapa Māori services does not lessen the need for mainstream services, as some Māori consumers may feel more comfortable receiving treatment in a mainstream environment. The diverse nature of the contemporary Māori population means not all Māori will prefer the same service options or delivery modes. Accordingly mainstream services must understand the needs of their Māori consumers and offer culturally appropriate and effective treatment environments. In its principal policy document the Mental Health Commission notes that Māori are entitled to access both the full range of mainstream services and kaupapa Māori services. Both service types must be able to respond in ways which are appropriate to Māori (Mental Health Commission 1998), requiring kaupapa Māori and mainstream mental health services to be attuned to the needs of their consumers.

Kaupapa Māori mental health services, whether part of public hospitals or independent of them, are services which are centred on Māori cultural practices and are usually delivered by Māori staff (Durie 2001). Such services typically include some or all of the following characteristics:

- *management by Māori for Māori;*
- *the incorporation of tikanga Māori;*
- *the involvement of whānau, hapū and iwi;*
- *the use of traditional Māori healing practices;*

- *the provision for cultural assessment cultural practices; and*
- *whakawhanaungatanga.* (Durie 2001).

The growth in the number of kaupapa Māori mental health service providers over the years is consistent with a burgeoning of Māori mental health providers since the early 1990s. In the period leading up to the latest set of reforms Māori health providers increased from around 20 in 1993 to 240 in 2005<sup>4</sup>. This rapid rise in the number of Māori health providers may be explained in part by some key changes to the health sector which occurred in the late 1980s and on through the 1990s; we now return to that time to trace the history of the health reforms.

## **Economic, State Sector and Health Sector Reform**

In the mid to late 1980s the new Labour government embarked on a programme of fundamental economic and state sector reform. Driving the economic reforms were the desire for price stability, a more liberal market economy and a reduction in the role of the state in the economy (Kelsey 1995). The state sector reforms were influenced by rising public indebtedness, a preference for a smaller and more efficient public sector and a political and ideological swing towards “the right” with its concomitant market mechanisms of contracting out, commercialisation and privatisation (Boston, Martin et al. 1996, p.16). These reforms were extensive and wide reaching, affecting nearly every corner of the public sector. In a ten year period the Government enacted legislation which affected the machinery of government (e.g. the separation of policy advice from service delivery functions and the introduction of new population-based Ministries); human resource management (e.g. the passing of the State Sector Act which reconfigured the public service and the Employment Contracts Act which emphasises individual contracts rather than collective agreements); financial management systems (e.g. the passing of the Public Finance Act which brought in comprehensive new reporting requirements for government departments and made Chief Executives of those departments responsible for financial management); and local government. The legislative reforms also introduced an era of greater responsiveness to Māori (Boston, Martin et al. 1996).

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<sup>4</sup> <http://www.Māorihealth.govt.nz/2004/providers.php> accessed 13 May 2005

As part of the wider restructuring of the state sector, the health sector also changed markedly. Once again the driving force behind the health reforms of the early 1990s was primarily economic. The reforms of this time were prompted by the need to control and contain expenditure and to improve efficiency in the use of public health resources (Salmond, Mooney et al. 1994). Until these reforms, Area Health Boards (AHBs) had been the dominant health organisation. They had been established between 1985 and 1989 to provide personal health, hospital and public health care services, with the expectation that they would effectively co-ordinate personal and population-based health services; provide a more integrated approach to health care than the former hospital board; and be responsive to local needs (Scott 1994). Originally, AHBs had comprised between eight and twelve members elected by the resident population once every three years. When concerns about a lack of financial and management expertise on AHBs were expressed in 1988, the Government reduced the size of boards to an average of seven elected members and introduced government-appointed members (Scott 1994).

In many ways the expectations outlined above were not realised. Bloom (2000) notes that AHBs as the planners, purchasers and providers of health services, were seen as insufficiently motivated to change what had become entrenched patterns of service delivery. Area Health Boards were not responsive enough to local needs, and many viewed Māori health perspectives with a great deal of scepticism. Indeed, AHBs varied in the extent to which they responded positively to Māori health concerns (Durie 1992b).

Scott (1994) notes that a capped budget gave Area Health Boards incentives to provide personal services over public services because outputs and outcomes in primary health care could be more clearly identified. Conversely, the system did not provide any incentives for AHBs to purchase or provide the most cost-effective services (Scott 1994). Integration of primary and secondary health services was frustrated by the existence of separate funding streams and no single agency had a strong enough incentive to change the discontinuity that existed between these levels of care (Bloom 2000). It was easier for AHBs to deliver services themselves rather than try to purchase primary care services from other providers (Scott 1994) and the expected integration of

primary and secondary care did not eventuate. This was a major failing of the Area Health Board model (Malcolm and Barnett 1994, p.92).

Two independent studies commissioned in 1986 and 1988 indicated the extent of the changes that were required to make the health sector more efficient.

### ***The Health Benefits Review***

In 1986 the Health Benefits Review Committee was asked by the then Labour Government to report on the underlying rationale for state involvement in health and to recommend broad principles and directions for reform (Health Benefits Review Committee 1986). The report was prompted by a sense that the health sector was at “breaking point”: the “reining-in” of the health vote in earlier years was beginning to bite; access to health care was considered to be easier for the affluent; there was a tendency for the greater share of services to go to those who had less need; and the system was considered to be monocultural, failing to meet the needs of many groups (Health Benefits Review Committee 1986). In reporting on the appropriate role for government in providing, financing and regulating health care two broad options were proposed (Scott 1994). The first option stated the government should remain the dominant funder of health care but that services should be provided on a competitive basis from both private and public providers (Scott 1994). The second option was for the government to have less of a role as a funder and as a provider; rather, most people would insure through private competing insurance companies, with the state acting as a “residual insurer” for those unable to obtain insurance coverage privately (Health Benefits Review Committee 1986, p.106). The Review Committee favoured moving either to a system of competitive Health Maintenance Organisations (one of the residual insurer options) or one where the state remained as a principal funder but contracted for at least some of the services it required. The Committee noted that the State should place more emphasis on achieving greater efficiency in health care through an increased reliance on provider-funder links; that the state should reduce its provider role; and that the State should develop a mix of direct service provision and contracts with providers to purchase services on behalf of users (Health Benefits Review Committee 1986). Tendering of contracts was considered a possibility.

### ***The Gibbs Report***

The 1988 report of the Hospital and Related Services Taskforce, *Unshackling the Hospitals* (hereafter referred to as the Gibbs Report), recommended a restructuring of the New Zealand health sector: in effect, dismantling “a hospital system which, despite the best intentions, is still far from fair in its delivery of services” (Gibbs, Fraser et al. 1988, p.5). The report found the public hospital system to be seriously deficient, with a management structure that was “over-centralised, bureaucratic, inflexible and confused” (Gibbs, Fraser et al. 1988). Furthermore, it highlighted that because public hospitals received their funding through bulk government grants, they did not know the economic value of their output. The report noted that “the process of merely supplying a block grant deprives hospitals of the very information essential to management – the value of what they produce” (Gibbs, Fraser et al. 1988). The Gibbs Report recommended the separation of the Government’s two roles of funder and provider. While the Government would retain these two functions, a clear delineation between the two would allow the creation of a market in which prices would be set through modified competition between hospitals.

Both the Health Benefits Review and the Gibbs Report maintained the Government should continue as the dominant funder of health care in New Zealand; however, both reports also supported greater competition in the provision of health care and greater integration of the funding and provision of care at primary and secondary care levels (Scott 1994).

### ***The Health Sector Reforms of the 1990s***

In 1991 the National Government announced its intention to reform the health sector with the release of *Your Health and the Public Health*<sup>5</sup>. The Area Health Boards were immediately dismissed and replaced with commissioners (Laugesen and Salmond 1994). In 1993 the Government passed the Health and Disability Service Act 1993 which cemented the reforms in place.

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<sup>5</sup> Also referred to as the Green and White Paper after its negotiable and non-negotiable aspects Laugesen, M. and G. Salmond (1994). "New Zealand Health Care: A Background." *Health Policy* 29(1-2): 11-23.:15.

Some of the key elements of these reforms included:

- *the so called purchaser/provider split, which separated the roles of purchasing and provision of secondary health care services;*
- *the establishment of four Regional Health Authorities whose role was to purchase all personal health services for the people of their geographically defined region; and*
- *the reconfiguration of public hospitals into Crown Health Enterprises which were to be run along like businesses (Howden-Chapman and Ashton 2000, p.28).*

The purchasing and provision roles of the 14 AHBs were “split” – the purchasing role to 4 geographically based RHAs and the providing role to 23 profit-oriented Crown Health Enterprises or CHEs. Regional Health Authorities were able to decide how to spend resources and could tender for services with CHEs, primary and community-based health care providers. In turn, separating the functions of purchaser and provider opened up opportunities for community-based health providers to contract directly with RHAs to provide services. Barrett (1997) argues that the 1993 reforms saw a marked increase in the use of contracts for service, this being an effort, on the part of government to promote greater efficiency through competition. Unlike the Area Health Boards which had a vested interest in maintaining their own services, RHAs were to be “technically neutral” so that purchasing decisions would be made on the basis of efficiency and value for money (Durie 1992b, 1998c).

The introduction of competitive tendering and contracts for service had major implications for the voluntary agencies and community based services often referred to as the “third sector”. This group of agencies, many of which were Māori health, welfare and social service organisations, became a key means for the government to deliver its services in the community (Cody 1993). However, these third sector agencies were expected to reconcile their own priorities’ and needs and their accountabilities to their clientele, management teams and boards with those of the Crown as outlined in their service contracts (Cody 1993).

At the time of these reforms, a case was made that the introduction of competition to the health sector would positively benefit Māori by making the health system more

responsive to Māori clients (Upton 1991). Cunningham and Kiro (2001) note that encouraging Māori to participate in the reformed health sector as independent health providers could be seen as evidence of a commitment by the government to tino rangatiratanga or Māori desires for sovereignty. However, while the economic philosophies of privatisation and reduced state provision of services may be reconciled with Māori philosophies of sovereignty and tino rangatiratanga, Pomare and Laing (1994) note that Māori were only being offered a relatively minor management and delivery role in the reformed sector, as opposed to true partnership in decision-making and the formulation of health care policy.

Dyall (1996) argues that the Government's broad policy approach to improving Māori health at this time was to encourage greater Māori participation throughout all levels of the health sector and encourage the development of culturally appropriate practices, procedures and resource allocation priorities which took account of Māori health needs and perspectives. However the way in which this broad approach was translated at the local level varied as Regional Health Authorities developed local responses to local needs and as a result of existing iwi/Māori relationships (Cunningham and Kiro 2001). Māori health policies at a regional level were often a reflection of the political realities that operated in that region; the result was great variability of purchasing arrangements throughout the four regions. For example, the North Health RHA established Māori Purchasing Organisations (MAPO) which were tribally-based and therefore purchased on behalf of the tangata whenua within a particular area; in comparison, the Central RHA established a Komiti Āwhina of Māori advisers which acted as both an internal advice mechanism for the RHA and handled iwi and Māori liaison with providers and consumers of health services (Cunningham and Durie 1999).

Following the election of a National-New Zealand First Coalition government in 1996, further changes to the health sector were implemented in 1997. This government retained the "quasi-market model" introduced in 1993, but the emphasis on competition was replaced by a desire for cooperation (Cumming and Mays 2002). The four Regional Health Authorities were amalgamated into one national purchaser, the Health Funding Authority, to ensure national consistency in access to services (Cumming and Mays 2002). These lesser reforms allowed the continuation of purchaser/provider split, thus maintaining some of the efficiencies gained through the use of contracts for

service; however, the more contentious elements of the 1993 reforms, such as the expectation that Crown Health Enterprises return a profit, were softened (Cumming and Mays 2002).

### ***The New Zealand Public Health and Disability Act 2000 Model***

In 2001 the most recent round of health reforms began. The New Zealand Public Health and Disability Act 2000 (NZPHDA) was enacted by a Labour-Alliance Coalition Government and signalled a return to greater public participation in identifying, and making decisions about, the health needs of local communities. Greater community involvement in health care decisions is one of the main differences between this model and its predecessor; however, several other features of the model differentiate it from the previous structure. The main features of the new model include:

- *a new set of organisational arrangements with the establishment of 21 majority-elected District Health Boards;*
- *a “Health Funding Package” where the size of the health budget is clearly signalled three years at a time; and*
- *a number of high-profile sector-wide strategies driven from central government.*

(Boulton, Simonsen et al. 2004, p.36)

In the NZPHDA model funding for health services is devolved to Boards which are responsible for the purchasing and provision of hospital care and funding community providers. DHBs are governed by 11 member Boards, the members of which comprise a mix of locally elected and ministerially appointed members. In making appointments to a DHB a Minister must endeavour to ensure that Māori membership of the Board is proportional to the number of Māori in the DHB’s resident population, with a minimum of two Māori board members. This is the first time that there has been an explicit policy of minimum Māori representation on health Boards (Cumming and Mays 2002).

The New Zealand Public Health and Disability Act also represents the first time the Treaty of Waitangi has been included in social policy legislation and it is the first time there has been an explicit policy to include Māori input into decision-making on health and disability services. The Act states that DHBs must establish and maintain processes to enable Māori to participate in, and contribute to strategies for Māori health improvement.

The Health Funding Package is the first time a government has committed to a rolling three-year funding path. Prior to the NZPHDA reforms Vote:Health was committed for one year only, with indicative funding identified for the next two years. This indicative funding could be changed in subsequent Budget rounds, therefore there was no guarantee on the level of funding for the health sector in out-years (Ministry of Health 2003). The sector was hindered in its ability to plan ahead and to manage risk in future years. According to the Ministry of Health, the certainty of a three-year funding package provides DHBs with the opportunity to be innovative and prioritise the implementation of the New Zealand Health Strategy and New Zealand Disability Strategy (Ministry of Health 2003).

The New Zealand Health Strategy and New Zealand Disability Strategy both form part of a set of overarching strategies which establish national priorities and provide overall guidance for the health sector. Three strategies in particular set the scene for Māori health service funding, purchasing and provision: The New Zealand Health Strategy; The New Zealand Disability Strategy and The Māori Health Strategy He Korowai Oranga. In particular, He Korowai Oranga represents a new direction in Māori health policy, with a focus on “whānau ora”. This has been interpreted to mean “families supported to achieve their maximum health and wellbeing” (Ministry of Health 2002b, p.1) and represents a shift from an individualistic approach to health and wellbeing to one which is more inclusive of a Māori worldview.

As noted earlier, from the mid 1990s to the present the Ministry of Health has focused on linking and consolidating earlier strategies with the new strategies developed to guide the sector since the passing of the New Zealand Public Health and Disability Act; supporting mental health promotion; and the development of a nationally consistent framework for the planning and delivery of services to tangata whaiora and whānau. Furthermore, as a means of improving mental health and wellbeing the Ministry of Health has begun to advocate for greater, broader-based collaboration within the sector and between government departments.

The release in 2002 of *Building on Strengths: a new approach to promoting mental health in New Zealand/Aotearoa* demonstrated that mental health was beginning to be

viewed by the Ministry as an area that required concerted effort from the health sector, the wider state sector and the community, to effect change. The document outlines a five-year, national approach to mental health promotion, with the goal of enhancing mental wellbeing and reducing inequalities by “improving the social, economic, cultural, political and physical environments” in which people live (Ministry of Health 2002a, p.ix). The document recognises that improvements to mental health and wellbeing require the health, central government, local government and community sectors to work together to create environments that support and build the capacity of individuals to cope with their illness. Māori are identified as a target population in this strategy as they “have more mental health problems than the general population” (Ministry of Health 2002a, p.39) and models of service delivery which are appropriate for the delivery of mental health services to Māori are presented.

In the same year the Ministry of Health released a document aimed at providing a consistent framework for DHBs in their planning and delivery of services to tangata whaiora and their whānau. *He Puawaitanga: Māori Mental Health National Strategic Framework* builds on both *Looking Forward* (the strategic direction document) and *Moving Forward* (the implementation plan) by incorporating the key policy directions contained in those documents and translating them into a series of goals and objectives for DHBs to implement. The focus of the document is on “producing tangible mental health outputs” and acknowledges that for Māori, good mental health requires access to the institutions of Māori society such as land, language and marae, as well as high quality clinical care, efficient health services and access to education, housing and employment opportunities. *He Puawaitanga* acknowledges the truly intersectoral nature of mental health in its widest sense.

## Summary

The New Zealand health system has been subject to significant change over the years as a result of a series of health sector reforms. The mental health sector has experienced a series of “crisis” events which have directed government attention to a growing disparity in the mental health status of Māori and non-Māori. As the health sector has evolved and changed, so too has a process of evolution occurred amongst Māori attitudes and Māori communities. This evolution is apparent in the “cultural renaissance” of the mid-1980s, the demand for more responsive mainstream health

services and equally a desire for services which incorporate a Māori “worldview” and are delivered by Māori for Māori. The simultaneous processes of evolution that occurred in the health sector, and in the area of Māori development, converged in a tangible way with the burgeoning of Māori health and Māori mental health providers in the mid-1990s. While this convergence offered potential for improvements in mental health outcome, evidence of worsening outcomes in Māori mental health persists. Furthermore, despite attempts to develop a more responsive mental health sector, the mismatch between the sector and the Māori worldview remains.

# **Chapter Three:**

## **Accountability, Performance Measurement and Contracting**

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### **Introduction**

In New Zealand a period of state sector and public management reform from the mid 1980s through to the 1990s gave rise to an increased emphasis on both performance measurement and accountability (Boston 1995; Boston, Martin et al. 1996). The overall purpose of these reforms was to improve the performance of the State sector, firstly by removing the functions that were no longer considered to be the business of the state and secondly by ensuring the agencies that were responsible for the remaining functions were structured to deliver their services as efficiently and as effectively as possible (State Services Commission 1996). Accountability and responsibility for performance have been guiding principles behind efforts to improve efficiency and the quality of the public services (Schick 1996).

The health sector was not unaffected by desires for greater accountability, greater efficiency and evidence that funding was making a difference to outcomes. This chapter discusses how an international trend towards greater accountability has impacted on the wider state sector, and upon the health sector, in New Zealand. Types and forms of accountability are discussed and the primary accountability mechanisms and processes in the mental health sector are presented. The chapter discusses performance measurement as a mechanism for ensuring accountability and quality, outlining characteristics of performance measures and how performance measurement has been applied in the New Zealand mental health sector. The origins and continued use of contracts for service, particularly in the mental health sector and with Māori mental health providers, is also explored. The chapter concludes by drawing together

the material presented in the two literature chapters to introduce the research questions which guided this project.

## **Accountability**

The literature notes that during the 1990s there has been a growing emphasis on governmental accountability (Millar, Simeone et al. 2001), on accountability in the management and provision of health services (Bloom 2000) and accountability for achieving desired outcomes in health care (Perrin, Durch et al.). Defining accountability often cannot be achieved without comparing or contrasting the concept with that of responsibility. The two terms are often used synonymously but each refers to a different type of relationship. As Gregory observes, accountability is about “the need to give an account of one’s actions” (Gregory 1995, p.59). Usually in an organisation this would mean giving such an account to a supervisor, to someone “higher up”, in a position of authority.

The idea of direction is important in Gregory’s description of the difference between accountability and responsibility. Whereas accountability is expressed *to* another party, responsibility is accepted *for* the actions, either of oneself or of others (Gregory 1995). To be responsible for someone or something requires a moral decision to be made and implies some degree of “prudence, good judgement and moral probity” (Gregory 1995, p.60). According to Mulgan, responsibility infers the freedom to act, liability for praise or blame and proper behaviour on the part of the person who is responsible. Accountability, as he sees it, is simply an aspect of responsibility and may be considered “relational responsibility”, where one person is responsible to another. (Mulgan 1997, p.2). Thynne and Goldring observe that accountability and responsibility are parts of a whole, noting:

*Officials are responsible within the system to some institution or to some person or persons for the discharge of the responsibilities which they have been allocated. This means they act in the context of a relationship with an institution or person which or who is in a position to enforce their responsibility by calling them to account for what they (and/or their subordinates) have or have not done. Thus this...sense of responsibility requires that officials be accountable for the performance of their official tasks and therefore be subject*

*to an institution's or person's oversight, direction or request that they provide information on their action or justify it before a review authority.* (Thynne and Goldring 1987, p.8)

Emanuel and Emanuel's definition also emphasises the link between responsibility and accountability for actions. Accountability, in their view, is about individuals who are responsible for a set of activities and for explaining or answering for their actions. Accountability includes the procedures and processes by which one party justifies and is held responsible for its actions by another party that has an interest in those actions (Emanuel and Emanuel 1996).

Brown et al (1999) argue that in the area of health care, accountability has assumed a number of different definitions depending upon the perspective and background of those defining the term. For example a political economist might emphasise the importance of accountability for the allocation of limited resources, defining accountability as "answers from agents who control the scarce resources one desires" (Brown, Baker et al. 1999, p.5). However someone with a focus on quality improvement might regard accountability as a means of improving the way care is delivered (Brown, Baker et al. 1999). Brown et al state that "accountability is the extent to which an organisation or individual demonstrates that it is meeting or exceeding its agreed-on objectives" (Brown, Baker et al. 1999, p.7).

At its simplest then accountability is about agreeing on a level of expected performance, agreeing on how that performance is to be judged or defended and then defining who can call for an account and who owes the duty of explanation (Ministry of Health 1996). Accountability and performance measurement are therefore inextricably tied; two halves of a whole, where accountability on one side is the means by which performance is specified, monitored and accounted for (State Services Commission 1999); and performance measurement, on the other side, provides the tools by which accountability can be assessed and judged. Prior to a discussion about this other side, that of performance measurement, the intricacies of accountability in the health sector require further exploration and definition. The following sections identify the three traditional models of accountability; discuss the dimensions of managerial accountability; define

terms used in discussions of accountability and performance measurement; and introduce the concept of strategies of accountability.

### ***Models of Accountability in Healthcare***

Three models of accountability are traditionally identified in the literature (Day and Klein 1987). All these models are relevant to the funding, purchasing and provision of health care services in New Zealand. The models are professional accountability, political accountability and managerial accountability.

Professional accountability is characterised by accountability to one's peers for standards of professional performance and behaviour, rather than to a superior or higher authority. Recent efforts in New Zealand to protect the health and safety of the public by ensuring health practitioners are competent and fit to practise in their professions has seen the passing of the Health Practitioners Competence Assurance Act 2003. This act seeks, among other things, to provide a consistent accountability regime for all health professionals. Many of the professional and regulatory bodies already in existence and responsible for overseeing different groups of health professionals, such as the Medical Council, Nursing Council and Psychologists Board have, with the passing of this Act, had their roles as authorities for their respective professions formalised in the legislation. Professional accountability is regarded as a horizontal model (i.e. accountability occurs across the same level to one's peers), political and managerial accountability are, by comparison, regarded as vertical relationships (Ministry of Health 1996; Hannah 2001).

Political accountability is concerned with elected governments and those with delegated authority giving account to parliament and to the public. In New Zealand the key agencies of accountability at a central governmental level include Ministers, parliament and the courts. Political accountability is equally concerned with the agencies of accountability that exist at a local government level. In New Zealand, District Health Boards comprise a mix of elected and appointed members, at least two of whom must be Māori. Political accountability has particular ramifications for those Māori elected or appointed to District Health Boards ostensibly to represent the needs of the local Māori community.

Managerial accountability is specifically concerned with the oversight and control of agencies who are responsible for implementing the decisions of government (Ministry of Health 1996) and refers to the accountability of departmental managers and Chief Executives to Ministers and to the Government. This dimension of accountability is derived from the need to ensure financial regularity and the efficient and effective performance of functions (Ministry of Health 1996). Managerial accountability was strengthened during the public sector reforms with greater emphasis being placed on the specification of desired departmental outputs and improved reporting and monitoring of performance, particularly with regard to meeting those outputs (Boston, Martin et al. 1996). According to Day and Klein there are three dimensions to managerial accountability:

- *Fiscal or regulatory accountability;*
- *Process or efficiency accountability; and*
- *Programme or effectiveness accountability* (Day and Klein 1987, p.27).

The fiscal dimension refers to accountability which seeks to ensure that funds appropriated for a particular programme or service were in fact used for that service; that the money was spent in the ways which were agreed (Cumming and Scott 1998). Auditing is the primary tool for checking that funds were used properly (Hannah 2001). The process dimension refers to monitoring performance to ensure that services, activities or tasks have been carried out and that funds have been used efficiently. In other words ensuring that the ratio of outputs to inputs is most favourable (Cumming and Scott 1998). The programme or effectiveness dimension involves ensuring that the intended results of a programme are achieved (Cumming and Scott 1998). Evaluations are one method of identifying the effectiveness of a programme, however attributing an outcome solely to the effects of one intervention is problematic. Health outcomes may be affected by economic and social developments outside the health sector, which makes the task of demonstrating the exact contribution of an individual health care intervention to health status difficult (Cumming and Scott 1998).

### ***Defining the Terms***

The terms used in discussions of accountability and performance measurement in health care take on quite specific meanings. It is appropriate that some of the more commonly used terms are defined at this juncture.

“Inputs” are a factor of production used to produce an “output”. Inputs may include staff time, computer equipment, buildings and land. Hence process accountability is concerned with monitoring whether the most outputs possible were produced from the amount of input invested. Donaldson notes that most mental health services are purchased on an inputs basis in terms of Full Time Equivalents (FTEs) in order to track the capacity within the sector (Donaldson 2001).

Outputs are those goods or services that are produced by an organisation. Output measures are traditionally considered in terms of quality, quantity, timeliness and cost. Outputs may also include the management control processes that efficiently or effectively guide an organisation towards meeting its objectives (Donaldson 2001).

Outcomes are the impacts on, or consequences for, a community or individual of the outputs or activities of an organisation. The improvement of health status is regarded as a key outcome in the health sector (Cumming and Scott 1998). The literature has forwarded a number of measures which could be used to determine health status such as mortality and morbidity indicators, quality of life indicators and disability adjusted life year (DALY) indicators (Ministry of Health 1997c; Ministry of Health 1999; Ministry of Health 2003). A health outcome is a *change* in health status of an individual, group or population that is *attributable* to an intervention or series of interventions by health services or processes (Donaldson 2001). Key elements of health outcome are attribution, change and the definition of health which is being used e.g. medical definitions compared to the more holistic definition of health encapsulated in the term “wellbeing”.

### ***Strategies of Accountability***

In 1996 Brown et al. undertook a review of accountability in selected OECD countries. . The purpose of the review was to identify and produce a synthesis of strategies for promoting accountability within the health care sector across the OECD nations. Three accountability strategies were identified: participation and devolution; standards; and reporting. New Zealand uses all three of these accountability strategies in some form and this thesis is particularly concerned with the use of the latter, so it is worthwhile to

understand what is meant by the term “accountability strategy” and the features of each of these.

An accountability strategy is, according to Brown et al., “the structures, standards or processes with the explicit goal of promoting the extent to which health care organisations demonstrate that they meet or exceed their agreed objectives” (Brown, Baker et al. 1999, p.8). Each of the three strategies identified had their own mechanisms (i.e. how the strategy produces the information) and format (i.e. how the information is distributed).

A feature of accountability strategies is the generation of information. Information can be qualitative (primarily descriptive) or quantitative (primarily numeric), but its purpose is to demonstrate that an objective has been achieved. Participation and devolution strategies include the devolution of authority to local boards and the participation by the community in health care priority setting. Both devolution of authority and community participation are aspects of accountability that have recently been reintroduced into the New Zealand health sector by the New Zealand Public Health and Disability Act 2000. According to Brown et al. (1999) these types of strategies increase the amount of information available by seeking input from those affected by the health care system. Formats, or the way that information is distributed, include community forums, surveys, focus groups or even Royal Commissions.

Standards strategies include credentialing, accreditation and the licensing of providers (Brown, Baker et al. 1999). Standards strategies indicate to the public that the provider has met a minimum level of performance and take one of two forms. The first is licensure, a mandatory processes which determines who may or may not provide a service and the second is accreditation which is usually a voluntary process, describing the capability of an organisation to provide high quality services (Brown, Baker et al. 1999). Quality Health New Zealand is New Zealand’s national accreditation body for hospitals and other health and disability services. It has been designated as an auditing authority by the Ministry of Health and can undertake audits to the approved sector standards for the purposes of Ministry of Health certification (Quality Health New Zealand 2005).

Reporting strategies include any mechanism that collects and distributes information on health system processes or performance (Brown, Baker et al. 1999). In the USA the main reporting strategy is the “report card”. While this mechanism is not used in New Zealand, the health sector is becoming increasingly adept at collecting information on health services. Examples of reporting strategies at a provider level include the collection of performance measures which are reported to the DHB and the Ministry of Health, evaluations of health services and the information collected as part of the Mental Health Information National Collection (MHINC) Strategy.

Earlier it was noted that accountability and performance measurement are so intertwined as to be two halves of a whole. Reporting strategies, according to the definition provided by Brown et al. may be regarded as being synonymous with performance measurement. In the New Zealand context, particular standards strategies such as performance audits are, in a sense, being used to assess the performance of Māori mental health providers. It is perhaps timely then to explore what is meant by the term “performance measurement”.

## **Performance Measurement**

Perrin notes that the term “performance measurement” is used in various contexts. In the health sector the term performance measurement may mean different things depending on whether one’s perspective is that of a funder, a purchaser or a user of health care services. In the USA, interest in methods of performance measurement has emerged as a direct consequence of publicly funded health programmes having to account for their performance. In other words, as discussed above, performance measurement may be regarded as a strategy of accountability. Performance measures and performance measurement frameworks may also be used as quality improvement tools if they are used to draw attention to practices which demonstrate the achievement of desired outcomes or which identify areas needing improvement (Perrin, Durch et al.).

The term “performance measurement” refers to predominantly Western-derived performance measurement initiatives. Performance measurement systems and frameworks do not tend to be sensitive enough to account for different perspectives or worldviews, rather they are inclined to measure systems and processes through an identical lens. For the purposes of this research the definition of “performance

measure” is one that has been adapted from Perrin et al whereby a performance measure denotes the specific quantitative (*or qualitative*) representation of a capacity, process, or outcome deemed relevant to the assessment of a programme’s performance (Perrin, Durch et al. 1999, p.20). Performance measurement then, is the

*selection and use of measures of programme capacities, processes and outcomes to inform the public or public agency about the critical aspects of a programme including its effects on the public.* (Perrin, Durch et al. 1999, p.19)

The purposes of performance measurement are to gauge whether progress is being made towards desired goals and determine whether the appropriate activities are being undertaken to ensure the achievement of those goals (Perrin, Durch et al. 1999). The terms performance management and performance monitoring are closely related to performance measurement however should not be used synonymously. Performance *monitoring* refers to a continuing set of performance measurement activities (Perrin, Durch et al. 1999). Performance *management* goes beyond simply measuring performance to look at how to make improvements to performance, for example through the use of incentives.

Throughout the 1990s there was growing interest in performance measurement to better support decision-making (Organisation for Economic Cooperation and Development 1994) and as a basis for accountability reporting (Divorski and Scheirer 2001). The literature notes that there is increasing pressure on western health systems to improve their performance. These pressures come in the form of technological advances and rising consumer expectations, increased concern about medical errors, and a desire to contain health costs and control supply (Hurst and Jee-Hughes 2001). Both the UK and the USA emerged as “leaders” in the use of performance management (i.e. how to make improvements to performance) in the public sector and the literature on performance measurement mainly comes from these two nations (Propper and Wilson 2003) and from work undertaken by the Organisation for Economic Co-operation and Development (OECD).

In the United States the passing of the Government Performance and Results Act 1993, which requires the federal government to measure the performance of all federal

programmes, has resulted in widespread interest in frameworks and systems that can accurately measure, record and report performance data. Performance measurement in the United States is associated with measuring or gauging the performance of health care plans i.e. private insurers of health care, also known as Health Maintenance Organisations (HMOs), and measuring the quality of those plans. Increasing competition among health plans and the rise of managed care have also acted as catalysts for increasing interest in health care performance measures. As health care has become more business-like so health care plans have attempted to maintain a “delicate, dynamic balance” between the achievement of business results and the delivery of appropriate health care to patients (Anderson, Moran et al. 1998, p.2).

Efforts to systematically measure the quality of care, particularly in the United States, began in the late 1980s and therefore may be considered in their “methodological infancy” (Eddy 1998, p.8). One of the most well known performance measurement tools is HEDIS: the Health Plan Employer Data and Information Set. The purpose of HEDIS is to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. Health plans choose whether or not to have their quality of care measured against HEDIS, and whether or not to have the results published (O’Dea, Sundakov et al. 2001).

HEDIS is published by the National Committee for Quality Assurance, an independent, non-profit organisation that accredits managed care organisation (Kenkel 1996). It includes over 75 performance indicators on quality of care, patient access and satisfaction, membership and utilisation as well as finance and health plan management measures (Propper and Wilson 2003). The purpose of collecting this data is so standardised and objective comparisons can be made of different health care plans (Setness 1996). The main criticism of HEDIS is that of all these myriad performance measures that are collected only two are outcome measures or proxy measures of outcome. Most of the indicators report administrative performance or service use as opposed to quality of care (Epstein 1995).

The UK has been developing performance measures since 1983, and over that period has had three different performance management regimes (Organisation for Economic Cooperation and Development 1997). In the UK the market reforms of 1991 introduced

increased competition, improved efficiency and the extension of consumer choice to the health sector; much as the 1991-1993 reforms of the New Zealand health sector did. Further reforms announced in 1997 White Paper, *The New NHS: Modern Dependable*, emphasised long-term agreements with providers, rather than purchasing on short term contracts and encouraged the collection of comparative data on which purchasers of health could base their purchasing decisions (Goddard, Mannion et al. 2000). Furthermore, “a public contract model” of healthcare where the funding of health service providers is conditional upon their demonstrating their effectiveness at meeting consumer needs has not only initiated increased interest in measuring performance (Martin 1998), but also increased interest in collecting accurate performance measures (Rea and Rea 2000).

Competition has been abandoned in the latest regime, although the purchaser/provider split and contracting for hospital services has been retained. The National Health Service (NHS) uses a Performance Assessment Framework (PAF) which covers six areas in which performance is to be assessed. The NHS Plan of 2000 announced the extension of the Performance Assessment Framework to include providers of health services (hospital trusts and primary care groups), in addition to health authorities. The setting of standards, performance monitoring, and performance management was centralised (O’Dea, Sundakov et al. 2001). The six areas of performance the PAF covers include:

- *health improvement (including influence of “non-health” factors);*
- *fair access (in relation to people’s needs, irrespective of geography, socioeconomic group, ethnicity, age or sex);*
- *effective delivery of appropriate health care;*
- *efficiency;*
- *patient/carer experience of the NHS; and*
- *health outcomes of NHS Care (the direct contribution of NHS care to improvements in health status). (O’Dea, Sundakov et al. 2001, p.44)*

It is interesting to note that the PAF distinguishes between “Health Improvement” which reflects areas where NHS may not be the only, or even the main, agency able to bring about improvement and “Health Outcomes of NHS Care” which is meant to reflect those areas in which the NHS can be expected to have a major influence. The

issue of health outcomes, how they can be measured and the difficulties with attribution is discussed more fully in the next section.

### ***Categories of Performance Measurement***

Hurst and Jee-Hughes (2001) note that the first step in the performance measurement process is the adoption of a set of objectives to be measured. “Performance” is then the extent to which the system, organisation or programme is meeting these objectives. The literature identifies a number of types or categories of performance measure as being necessary to assess performance at a programme level. Perrin et al. note that health outcome, risk status, process and capacity are all measures that have been used in the USA. Reliable measures of health outcome have proved difficult to find, primarily because under ordinary conditions of health service delivery, it is difficult to isolate the impact of health care from the impact of other determinants of health status (Hurst and Jee-Hughes 2001). Therefore most of the health outcome indicators used are, for the most part, proxy indicators of outcome. A health outcome, as noted above is “a change in health status brought about by health care, (or indeed health system), activities” (Hurst and Jee-Hughes 2001, p.11). Proxy measures for health outcome are either health status measures (such as mortality and morbidity indicators), or process of care measures which measure health care utilisation. Process of care measures assume that using health services will result in, and correlate highly, with good health outcomes.

Other measures of performance identified in the literature include intermediate outcome measures such as “risk status” as well as capacity measures which measure the ability of a programme or system to provide particular services. Perrin summarises the categories of performance measures in the following table:

**Table 1: Categories of Health Performance Measures**

Health Outcome	Change (or lack of) in the health of a defined population related to an intervention, characterised in the following ways:	
	Health status outcome	Change (or lack of) in physical or mental status
	Social Functioning	Change (or lack of) in the ability of an individual to function in society
	Consumer Satisfaction	Response of an individual to services received from a health provider
Risk Status	An intermediate outcome. Change (or lack of) in the risk demonstrated or assumed to be associated with health status	
Process	What is done to, for, with, or by defined individuals or groups as part of the delivery of services, such as performing a test or procedure or offering an educational service	
Capacity	The ability to provide specific services, such as clinical screening and disease surveillance, made possible by the maintenance of the basic infrastructure of the public health system as well as by specific programme resources.	

Source: (National Research Council 1997), adapted from (Perrin, Durch et al. 1999, p.21)

Benefits and drawbacks associated with the use of performance measures are identified in the literature. Clearly the benefits of performance measures and the main reason for their use is to enable practitioners and policymakers alike to identify whether progress is being made towards desired goals and determine whether the appropriate activities are being undertaken to ensure the achievement of those goals (Perrin, Durch et al. 1999). The process of performance measurement tends to make things concrete, visible and difficult to ignore. According to Anderson et al. (1998) what gets measured tends to get managed effectively and efficiently. However, international literature also notes that among the drawbacks of performance measurement are the difficulties with ensuring the validity, comparability and usefulness of the measures (Eddy 1998; Thomson and Lally 2000).

A further drawback stems from the way performance measurement is used. Often measures are recorded not because they are important, or useful, but simply because they are easy or convenient to record. It is easier for example, to measure efficiency of

a service (how well a service uses its resources to generate units of outputs) rather than effectiveness (how well a service achieves its desired outcomes); and volumes, rather than the contribution (Anderson, Moran et al. 1998). Performance measures in the health sector, particularly in the USA have been criticised for their narrow focus on biomedical interventions to prevent and manage illness (Sofaer, Gruman et al. 2000).

## **Contracting**

Contracts and contracting are terms usually associated with the fields of law and economics however in the last two decades these terms have become commonplace in the New Zealand health sector. In the legal sense contracts are an entity which establishes a relationship, usually between two parties. Martin (1995) notes that there are three key elements to the private law of contracts:

- there are at least two parties to every contract and those parties must possess contractual capacity;
- contracts create rights and duties for the parties only; and
- “consideration” is an essential element of a contract – a contract is a reciprocal transaction between the parties, involving mutual benefit and detriment.

In addition to private law contracts, there are contracts which establish an economic relationship. Martin (1995) identifies three types of economic contracts; spot, relational and classical. Spot contracts are those which occur “on the spot” between willing buyers and sellers and do not require lengthy negotiations or formal documentation, whereas classical contracts refer to those which are usually the subject of formal, binding, legal arrangements and may endure over quite considerable time and involve a number of sale and purchase transaction (Martin 1995). Relational contracts may also endure over a long period of time because they are more in the nature of a “shared relationship”. In these types of contracts there is a recognition that the shared needs of two parties will ensure they continue to do business with each other (Kay 1993). Martin (1995) notes that it is this type of relational contract that characterises many government relationships.

Contracting has become a key tool for purchasing of health care in many countries over recent years. Contracts link financial resources to health service outputs and outcomes; clarify responsibilities and roles with a view to improving accountability; focus service

delivery; and allow adjustments over time and re-negotiations in response to changes in need and other factors (Duran, Sheiman et al. 2005).

Contracts have also become a feature of the health market-place created in New Zealand after a period of extensive reform. Theoretically this marketplace comprises a number of principals and agents who choose, based largely on price, whether or not to enter into contractual relationships (Newberry and Barnett 2001). In the period 1997-1998 some adjustments to the basic health sector structure established with the 1993 reforms were made. The four regional purchasers of health services, the RHAs, were amalgamated into one funding organisation, the Health Funding Authority (HFA). In addition to centralising funding decisions, contracting relationships altered significantly between the funder and providers. Contracts were regarded by the HFA as an important means of encouraging change within the sector. Whereas the RHAs had used contracts as the basis for an “arms-length” relationship with providers, the 1997 Coalition Agreement emphasised greater collaboration between the now funder (as opposed to “purchaser”) and the provider (Health Funding Authority 1999a).

One of the tasks of the HFA was to take the four individual RHA approaches to contracting and performance measurement and develop one national purchasing framework. A national purchasing framework was regarded as having a number of benefits over four distinct mechanisms. It would clarify the roles and responsibilities of providers; assure consumers that the health services they were receiving were safe and of a high quality; allow comparisons between providers and localities; ensure equitable access across the country; facilitate long term contracts with providers; ensure the equitable treatment of providers and encourage changes to the standards to foster innovation (Health Funding Authority 1999a).

Consistent contracting frameworks were regarded as a means of ensuring service quality (Health Funding Authority 1999a). HFA contracts employed measurements of service output as a proxy for improved health gain. While these proxy measures were regarded as being inferior to measures which actually captured changes in the health status of populations, it was recognised that to develop such measures would take some considerable time and effort on the part of the Government. The HFA noted in its 1999 Briefing Paper that further development of contracting methods and technologies for

measuring health gain would be required before outcomes-based contracting could be undertaken (Health Funding Authority 1999a). The HFA also urged New Zealand to look at developing its own solutions to the problem of outcome-based performance measurement, rather than simply importing ideas from overseas.

The health sector experienced a further reform in 2001 with the implementation of the New Zealand Health and Disability Act 2000. Once again the funding and purchasing functions were decentralised (to 21 DHBs), although public health contracts remained with the Ministry of Health and disability funding was devolved gradually. While it could be argued that the competitive nature of contracting for community mental health services has lessened with the 2001 reforms, the contracts themselves are still very much in existence and for the most part remain unchanged since the days of the HFA. Contracting has become a central part of the management of the health system and contracts may now be regarded as tools or mechanisms to ensure the effective and safe delivery of health services (Ashton, Cumming et al. 2002). The introduction of contracts as a means of managing aspects of health care was one part of a broader reform of the health sector that included an emphasis on accountability, efficiency and being more business-like. The emergence of this health marketplace is discussed below.

## **The Emergence of Accountability and Contracting for Services in the New Zealand Health System**

In New Zealand the State Sector Act 1988 and the Public Finance Act 1989 and, to a certain degree the Official Information Act 1982, form the legislative foundation for accountability in the public sector (State Services Commission 1999). The first two pieces of legislation focus on the responsibilities of Chief Executives and to a lesser extent of Ministers while the last is based on the notion that good information and access to it is the basis of good accountability (State Services Commission 1999).

In health systems accountability can be considered at a number of levels: accountability of the medical profession, accountability to the community and to government on behalf of the community (Cheyne, O'Brien et al. 1997: p224). New Zealand's current system of accountability for government agencies includes quarterly performance reports on

purchase agreements, half yearly reports and an annual report on financial results and outputs (Te Puni Kōkiri 2000). An output in this sense refers to the programmes the Minister of Health purchases in a given financial year. Agencies then report on outputs at the end of each financial year. The public sector acts as an owner and a purchaser of services. There is an increasing focus on financial performance and specification of product service and delivery. Budget appropriations are provided to departments and Ministries on the basis of agreed outputs.

This system of accountability had its origins in the state sector reforms of the mid-late 1980s; reforms which it is argued, resulted from the unique convergence of economic pressures and political opportunities (Boston, Martin et al. 1996). The state sector reforms were influenced by rising public indebtedness, a preference for a smaller and more efficient public sector and a political and ideological swing towards “the right” with its concomitant market mechanisms of contracting out, commercialisation and privatisation (Boston, Martin et al. 1996).

The economic and social reforms of this period saw state trading departments corporatised (i.e. turned into profit-focused but still government-owned organisations), or privatised (i.e. sold from public into private ownership), and other government departments restructured (Ashton, Cumming et al. 2002). New accountability mechanisms were introduced with Chief Executives held more tightly to account and responsible for delivering an agreed set of outputs within a certain budget. In the health sector, the Area Health Boards Act 1983 attempted to strengthen and clarify the lines of accountability. The wording of the Act stated that, “an area health board was to have regard at all times to its primary objectives and to the policies of the Minister” (Area Health Board Act 1983, Part 3, Section 38). In addition, Boards were required to sign a performance-oriented accountability agreement with the Minister (Ashton 1992). The Area Health Board Act however, did not adequately resolve the accountability problem. The 1993 reforms were therefore seen as the next logical step to improving accountability (Laugesen and Salmond 1994).

The 1993 reforms introduced several changes to accountability lines. The main change was the introduction of the purchaser/provider split, ultimately created to increase efficiency (Finlayson 2000). Area Health Boards were disestablished and replaced by

four Regional Health Authorities (RHAs). The role of RHAs was to monitor the health service requirements of their populations and purchase services accordingly (Ashton 1999). Ashton (2000) argues that the purchaser/provider split led to improved accountability of providers to purchasers through the service contracts. In addition better information about the mix, level, cost, and quality of services being provided in public hospitals became available (Ashton 1999).

Other changes to accountability lines occurred at the departmental and ministerial level. The Department of Health became the Ministry of Health with a focus on policy development. The Chief Executive of the Ministry was directly accountable to the Minister for Health, as were the public purchasers of health; the Regional Health Authorities. A feature of the 1993 reforms was the addition of a Minister Responsible for Crown Health Enterprises (CHEs) and the vesting of the Crown's interest in CHEs in two shareholding Ministers, the Minister of Finance and the Minister of Crown Health Enterprises. For a short time, political control in the health sector was separated into purchasing responsibilities through the Minister of Health and ownership responsibilities (i.e. ensuring the CHEs operated as successful businesses), through the Ministers of Finance and Crown Health Enterprises (Ashton, Cumming et al. 2002). This situation was reversed in the 1996 Coalition Agreement when the Minister of Health once again became solely responsible for the whole of the publicly funded health sector.

A range of contracting mechanisms developed in this reformed sector. On the provider side the 23 CHEs had to contract with RHAs and the Accident Compensation Corporation (ACC) to provide public health services. Private providers, such as NGOs could contract with the RHAs either directly or through other providers (Ashton, Cumming et al. 2002). These relationships between providers and the RHAs were primarily legal ones, governed by contractual mechanisms, enforceable in courts and subject to New Zealand's general competition law controls in the Commerce Act (Ashton, Cumming et al. 2002). The private law of contract became the primary mechanism of accountability and control in the provision of health services.

The New Zealand Public Health and Disability Act 2000 (NZPHDA) added a further accountability arrangement to the health sector: accountability back to community. The

Labour Party regarded the health system of the late 1990s as being neither accountable to central government nor to local communities. In its 1999 party manifesto Labour noted “the only accountability measures which are regularly reported on or monitored relate to financial rather than health service indicators” (Labour Party 1999). The NZPHDA has sought to strengthen accountability in a wider sense and re-introduce a measure of community accountability lacking in the sector since the demise of Area Health Boards. In addition to being accountable to their respective communities, the 21 DHBs created in this Act are held accountable to the Crown through their strategic plans, annual plans and monthly and quarterly performance reports, and to Parliament through their Statement’s of Intent and annual reports (King 2000b).

The NZPHDA is the most explicit of all the reform models in outlining accountabilities and responsibilities. The reasons for more explicit accountability measures and a return to community accountability may be found in the Act’s purpose statement. The purpose of the Act is to, amongst other things; “provide a community voice in matters relating to personal health services, public health services and disability support services” (NZPHDA 2000 Part 1, Section 3). According to the Minister for Health (King 2000a), the Government’s stated objective is to achieve “an open, accountable and fair health service”. Enshrining these accountability arrangements in legislation indicates a clear commitment to attaining this objective.

Throughout the 1990s competition was regarded as the primary vehicle by which to ensure increased efficiency in the health sector. However, the removal of competition heralded by the passing of the NZPHDA is unlikely to affect public sector expectations of performance developed during the same period. Public accountability for funds, responsibility for performance, effectiveness and the timely delivery of outputs are as important measures of health sector performance in the year 2005 as they were ten years ago.

### ***Accountability and Culturally Relevant Models of Performance Measurement***

Accountability has been tightened up throughout the public sector; there is however, still a need to develop more culturally appropriate measures in health service provision. Whereas standards of performance in the public sector and in the delivery of health

services specifically, is relatively easy to ascertain, performance standards from a Māori perspective may be more difficult to determine and describe. Durie (1995a) is one of the few Māori who has written in the area of performance measurement and performance assessment in health services.

A number of other culturally-appropriate performance monitoring tools and audit tools were developed in the early 1990s for use in assessing the performance of Māori health services. Examples include the CHI Audit Model, a tool developed for public health; the MDI Framework, a disability information framework; He Anga Whakamāna, a disability support services framework; and in mental health the CEI or Culturally Effective Purchasing Framework (Gillies 1996). The CHI Audit Model is a culturally appropriate audit tool developed for the Public Health Commission to monitor contracts with providers. Key features of the model are that it *consolidates* earlier experience, adopts a *holistic* framework, and seeks to be *interactive* (hence CHI) (Gillies 1996). In using the CHI model, purchasers and provider jointly agree on appropriate indicators and providers nominate and develop a set of measures which will be used to evaluate the programme (Gillies 1996).

The Māori Disability Framework is a set of guidelines for use in the management of disability information, while He Anga Whakamāna is a framework for the delivery of disability support services for Māori. Both of these frameworks are underpinned by culturally appropriate philosophies, derived from a Māori worldview, which in turn guide the user of the frameworks. The purpose of the CEI model is to guide purchasing decisions in Māori mental health and highlights the need to balance cultural service inputs, clinical service inputs, outcome measures and other broader socio-cultural issues (Gillies 1996). Gillies (1996) notes that all the models have four elements in common: clinical input; client-focused outcome measures; cultural context; and the integration of health services for positive Māori development. Understanding and consideration of the last two in particular enables health managers and professionals to better identify key areas of concern in the provision of Māori health services. The significance of all of these models however, is that each calls for the negotiation of appropriate health output measures.

The Nationwide Mental Health Service Specifications as they are currently written do appear to recognise the importance of culture and Māori approaches to health and wellbeing. The Service Specification for Kaupapa Māori Mental Health Services notes that health and culture are inextricably linked, that improving the health status of Māori requires Māori solutions and that Māori health improvement must be seen in the context of Māori development generally (Ministry of Health 2001c). The Nationwide Mental Health Service Specifications comprise one aspect of the New Zealand mental health accountability and performance monitoring framework. This and other elements that comprise the framework are the subject of the following discussion.

### ***Accountability, Performance Measurement and Mental Health***

A range of frameworks, regulations, guidelines and acts of Parliament control and prescribe how mental health services are to be delivered in New Zealand<sup>6</sup>. Key accountability mechanisms and structures in mental health include the Mental Health Commission, its Blueprint for Mental Health Services in New Zealand, its yearly reports on the Blueprint and the National Mental Health Sector Standard.

The Mental Health Commission was established as a ministerial committee in 1996 as a direct result of a perceived failing by the wider health sector to adequately address performance issues identified in the mental health sector. In recommending the establishment of the Commission *The Mason Report* noted:

*There is a need for Mental Health to be given a greater sense of commitment and priority by Government, the Ministry of Health and the four RHAs. There need to be incentives, including increased funding, to improve performance, and sanctions if that performance is defective....We believe it is now necessary to establish a new organisation that can act as a catalyst to improve performance and lift the priority given to mental Health in New Zealand. The organisation should provide the necessary leadership for creating a culture of good Mental Health services in New Zealand. For that to be achieved, the organisation will*

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<sup>6</sup> The National Mental Health Sector Standard lists these under the heading “Related Documents” on pages 6-7 Ministry of Health (2001). National Mental Health Sector Standard: He Whariki Oranga Hinengaro. Ministry of Health. Wellington, Ministry of Health.

*need to be independent, well-resourced and have sufficient powers to make a difference.* (Mason, Johnston et al. 1996, p.102)

In 1998 the Commission was established as a Crown Agency in its own right. The three key functions of the Commission as defined in the Mental Health Commission Act and as amended by the New Zealand Public Health and Disability Act 2000, Section 111 are:

- monitoring and reporting to Government on the performance of the Ministry of Health and the 21 District Health Boards in the implementation of Government's national mental health strategy, and the extent to which other Government agencies with responsibilities for delivery of services that affect people with mental illness are implementing the Strategy;
- working with the sector to promote better understanding by the public of mental health, and to reduce discrimination and prejudice against those with mental illness; and
- working to strengthen the workforce, by working with key agencies to lift the image of careers in the mental health sector, and to address mental health workforce training, recruitment and employment issues (Ministry of Health 2005).

The Commission also attempts to identify and promote effective practices and recognise excellence and innovation, believing to do so will assist the sector to grow and develop. Therefore the Commission promotes practices that lead to best possible outcomes for service users, innovation, and continued service improvement and development (Ministry of Health 2005).

The Blueprint for Mental Health Services in New Zealand and the reports on progress on the Blueprint are essentially what Brown et al. would identify as “accountability strategies” for the mental health sector. The Blueprint outlines a series of measures or indicators which are reported on regularly to the Minister of Health, so the Minister can ascertain the progress being made to meet the National Mental Health Strategy.

The National Mental Health Sector Standard 2001 is one of the key documents shaping New Zealand’s mental health sector and can be considered another mental health

“accountability strategy”. The purpose of the Standard is to establish a minimum level of care and support so that, in time, mental health consumers will receive consistent service provision across New Zealand. The aims of the Standard are to: achieve better mental health services; and ensure consistency in the delivery of mental health treatment and support for those who use mental health services (Ministry of Health 1997b; Ministry of Health 2001b).

The 2001 revised Sector Standard comprises 18 standards (down from 20 in 1997) and each standard has a set of related criteria. The standard is the overall goal, is outcomes focused wherever possible and relates to the person receiving the service rather than the service itself (Ministry of Health 2001b). The standard is met when all the criteria are met. Criteria, as outlined in the document, should be measurable elements of performance and will usually relate to the desired outcome or to the performance of staff or the performance of the service. Most criteria are input measures (Ministry of Health 2001b).

Monitoring of the Standard is achieved through self-audits (i.e. audits done by the provider), reporting as specified in the contracts with the funder, and independent audit and review (Ministry of Health 2001b). The Sector Standard sets the level of quality performance expected of all contracted mental health providers.

The key performance monitoring document for the mental health sector is the Nationwide Mental Health Service Framework 2001. The Service Framework is made up of a number of related documents which structure mental health service delivery. The documents include:

- General Requirements for All Mental Health Services;
- Process Descriptions;
- Service Specifications for the range of mental health services;
- The mental health data dictionary; and
- Reporting requirements (Ministry of Health 2001c).

*The General Requirements for all Mental Health Services*

This section begins with a statement on the Treaty of Waitangi, discusses who mental health services are provided for and defines the characteristics of services to Māori

(noting that Māori may receive services from both mainstream and kaupapa Māori mental health services). This part of the Service Framework also outlines the consumer focus and accessibility requirements of services and the standards with which services must comply. The General Requirements section concludes with paragraphs covering information requirements, financial management and audits, and service specification development.

#### *Process Descriptions*

The process descriptions “clarify and provide more detail” on the meaning of particular processes contained in the Service Specifications (Ministry of Health 2001c). Examples of these processes include advocacy, discharge planning, legal compliance management of risk and therapy services. For each of the processes detailed, the scope of the term and its interpretation and application are defined.

#### *Service Specifications*

The Service Specifications outline the range and nature of services that are to be provided to defined groups of people (Ministry of Health 2001c). To that end the document contains Service Specifications for particular types of mental health services, such as Kaupapa Māori Services, Alcohol and Drug Services, Child, Youth and Adolescent Services etc. The Service Specifications themselves differ depending on the nature of the service, but usually include an outline of the services included in that specification (a “service type description”), the key service linkages and accountabilities (i.e. expectations of who the provider should be linking and coordinating with) and may include payment schedules. A copy of the Service Specifications for Kaupapa Māori Mental Health Services is attached in Appendix 1.

The Service Specification for Kaupapa Māori Mental Health Services rather than attempting to prescribe the activities of a Māori mental health service, identifies instead those characteristics that appear to be common to services funded to deliver Kaupapa Māori Mental Health Services (Ministry of Health 2001c). Features of a Kaupapa Māori mental health service therefore may:

- include kaumātua/kuia as an integral part of the service;
- emphasise whanaungatanga;
- exhibit governance based on Kaupapa Māori models;

- serve tangata whaiora who are mostly Māori;
- have a local Māori community that support the service;
- have a kaupapa consistent with the wider aims and aspirations of Māori development;
- operate using Māori tikanga, Māori beliefs, values and practices; and
- include a majority of Māori staff. (Ministry of Health 2001c)

#### *Data Dictionary*

The data dictionary lists the “purchase units” used in the Service Specifications, defines what each purchase unit comprises, lists the units of measure and provides a definition for those units of measure. Purchase units are those items that are purchased from the service and usually include bed days, Full-time Equivalent (FTE) staff, or other “volume” measures. It is these measures that the provider will collate and submit in their quarterly reports to the funder. For example, the purchase unit “MHCS46” in the Service Specifications refers to Kaupapa Māori Mental Health Services – Kaumatua and Taua (Kuia). The definition of this unit is “Provision of Kaumatua and (Taua) Kuia services to support other Kaupapa Māori Mental Health Services”, the unit of measure is in FTEs and the unit of measure definition is:

*Full-time equivalent staff member (clinical or non-clinical) involved in direct delivery of services to consumers. Exclude time that is formally devoted to administrative or management functions e.g. half-time coordination of a community team. (Ministry of Health 2001c)*

#### *Reporting Requirements*

In addition to information on “purchase units”, a Māori mental health service provider has a series of other units or indicators that they might be expected to report on. These can include things such as: the number of consultation or liaison contacts; the number of group sessions; the number of hui held; the number of people supported by the service amongst others. A further series of definitions for these types of indicators is included in this section of the Framework.

#### ***Contracting and Mental Health***

In the community or NGO mental health sector, contracts for service between the funder (the DHB) and the provider are the main mechanism for ensuring the timely and

appropriate delivery of high quality mental health services. Contracts or “Agreements” are generated and managed by the Agreement Administration Team of HealthPAC Dunedin, a national processing centre and information repository (Ministry of Health 2002c). HealthPAC is made up of three teams. The agreement team generate agreement documentation (i.e. contracts for services), enter contract and service details into the Contract Management System (CMS), generate templates for providers and enter performance data when reports are received. The payments team enters invoice data to enable the accurate and timely payment of providers (Ministry of Health 2002c). These two teams are supported by the third team, Information Management, who provide ad hoc reports from then HealthPAC systems.

The Agreement Administration Team is also responsible for maintaining the CMS, a system which, according to the Ministry of Health “manages the whole funding process from drafting and finalising agreements through to monitoring provider performance and service delivery” (Ministry of Health 2002c).

The Agreement Administration Team liaise with DHB contracts managers to produce agreement documents and maintain information about these agreements. Agreements are standard legal documents and include information on the term of the agreement, services purchased, price, volume, payment information (such as schedules and invoice amounts) and monitoring information (Ministry of Health 2002c). Agreements are prepared using generic or master agreements, which contain standard sections and clauses. They normally include the following sections:

- *General Terms and Conditions;*
- *Provider Quality Specifications;*
- *Information and Reporting Requirements*
- *Service Specifications; and*
- *Provider Specific Terms and Conditions.* (Ministry of Health 2002c)

The first three sections include information that is standardised across the mental health sector. Depending on the type of service being provided, the relevant service specification will be added (e.g. for a kaupapa Māori mental health service the relevant specification from the National Framework would be added to the Agreement). The last section, Provider Specific Terms and Conditions, will contain the payment schedule, the

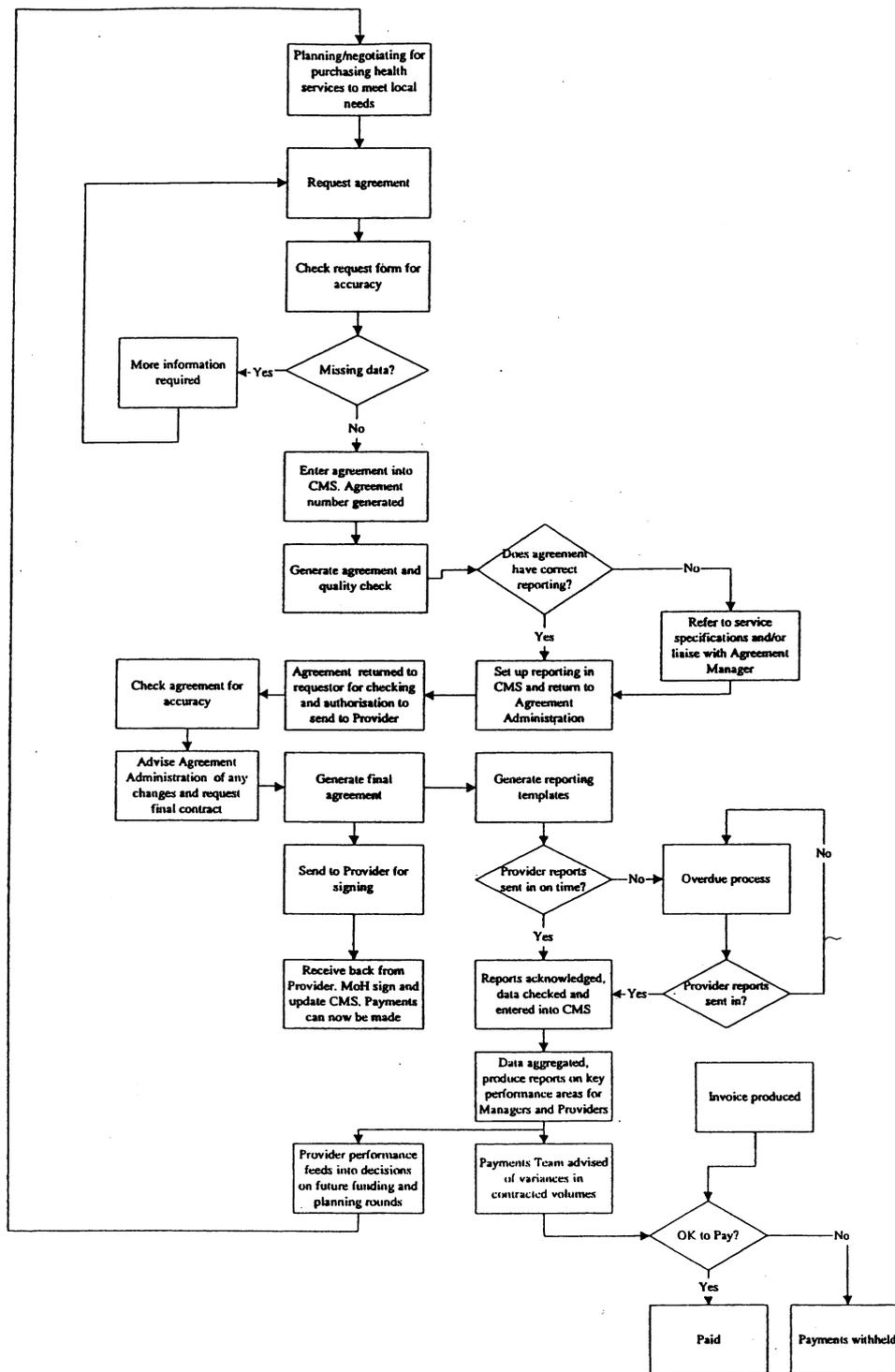
price-volume schedule (the services the agreement is for; the volumes to be purchased; the price per unit, if appropriate; and the total price for each unit), and any changes negotiated to the standard sections of the agreement (Ministry of Health 2002c). Contracts tend to be volume-based (payment based on a maximum number of interventions and funding capped at that level), or paid on a fee for service basis (Lavoie 2004).

The Agreement Administration team are also responsible for the tasks associated with the performance monitoring of providers, including receiving logging and entering data from providers, following up on overdue reports, providing aggregated data reports (such as volumes and variance reports) for contract managers and key stakeholders, and checking the performance monitoring requirements contained in the service specifications (Ministry of Health 2002c).

HealthPAC are able to monitor each contracted service using the Monitoring Module function of the CMS (Ministry of Health 2002c). Monitoring data can be used by both the provider and the contracts manager to check progress against the contract. Reporting templates are generated from the monitoring system and providers can report on these templates electronically via email or by filling out a paper copy. There is an expectation that reporting and data collection should go straight to the Agreement Administration Team rather than to contract managers at the DHB. Only by exception should providers report to the Contract Manager and then the Agreement Administration team must be notified. Once the reports have been submitted, a standard letter is generated to acknowledge receipt of the report, and the information is entered into the Monitoring Module (Ministry of Health 2002c). If reports are overdue, not completed or deliberately withheld, HealthPAC can withhold part of a provider's payment, as per the terms of the standard contract.

The CMS system is able to generate reports for Contracts Managers, however the types of reports that can be generated are mainly volume reports, variance reports, lists of providers who were overdue on their reports and other similar information (Ministry of Health 2002d).

The funding process is outlined in the following diagram:



**Figure 1: The HealthPAC Funding Process**

(Ministry of Health, 2002c)

### Summary

This chapter has demonstrated that in the previous two decades there has been increased emphasis on accountability, performance and the creation of mechanisms to measure both within western systems of health care. In particular, the pursuit of precise

accountability and performance measurement frameworks has led many nations, including New Zealand, to investigate the development of reliable and accurate outcome measures, long regarded as the holy grail of performance indicators. In New Zealand a range of frameworks, regulations, guidelines and acts of Parliament control and prescribe how mental health services are to be delivered with contracts being used as the key mechanism for funding mental health services in the community and for reporting on performance. These contracts tend to be volume-based or paid on a fee-for-service basis and do not as yet, include outcome measures. Nor do contracts encompass more culturally appropriate measures of health service provision, despite the availability of various culturally relevant models of performance measurement. It was the realisation that the contracts used in Māori mental health may not be compatible with the way Māori mental health providers deliver their services that that led to the conceptualisation and development of the research questions which have guided this project.

## **The Research Questions**

This chapter and the chapter before it have established the context in which the research questions for this project emerged. Chapter 2 argued that the growth in Māori mental health providers occurred in a mental health sector that has experienced a series of “crisis” events; in a wider health system subject to significant change through a series of health sector reforms; and in a Māori society which has experienced its own process of evolution, development and cultural renaissance. Chapter 3 has argued that the rise of accountability, performance measurement and contracting in the New Zealand health system are the result of government led quests for efficiency and the quality in the wider state sector. Māori mental health providers have participated in the pursuit of efficiency and quality not so much as stakeholders with an equal share in the outcomes of the crusade but as “camp-followers” who have are compelled to play a part in order to achieve their own objectives; objectives that do not always mesh with those of the government of the day.

The broad research questions that this thesis set out to answer therefore were:

- what is the experience of Māori mental health providers in contracting to provide mental health services for the Crown;
- do Māori mental health providers deliver outside of their contracts; and
- what role do multiple accountabilities play in contracting?

In attempting to answer these broad research questions a further set of lower level questions became apparent namely:

- if Māori mental health providers do deliver more than they are contracted to, are there a set of identifiable drivers which explain why Māori mental health providers do more?
- if Māori mental health providers do deliver more than they are contracted to, does the current contracting model sufficiently recognise and value this additional work?
- is a cultural performance measure required in order to acknowledge the extra work done?

The research questions and the issues these questions sought to explore have in turn determined the methods the study employed. These methods are the focus of Chapter 5. However the broader theoretical framework and methodological approaches which guide the study are derived from the particular perspective I, as the researcher, bring to these questions. The theoretical framework is the subject of the following chapter.

## Chapter Four

### **“Sitting in an Uncomfortable Chair”<sup>7</sup>: Theoretical Approaches in Māori Health Research**

*You know doing a PhD is like sitting in an uncomfortable chair, for how do you [as Māori] reconcile the western paradigm and the Māori paradigm?*

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This chapter explores how Māori knowledge and methods of obtaining that knowledge have become commonplace features of Aotearoa/New Zealand’s research landscape. The chapter discusses the two main theoretical approaches in Māori health research and using Denzin and Lincoln’s (2000a) idea of a paradigm net argues that Māori knowledge and research may itself be considered as a paradigm in its own right. The chapter concludes with a section locating the researcher and the research itself within this Māori paradigm net.

#### **Approaches to Knowledge and “Truth”**

As social science researchers we are concerned with knowledge and the quest for knowledge in order to better understand our society. However, the “truth” of what we discover in the course of our research - and indeed the very way we go about our research - is coloured by who we are; our values, our beliefs and our culture. Patton (1990, p.483) notes that the very question “What is the truth?” may be “intrinsically rhetorical”; however, our beliefs about the nature of truth will affect how we view any research findings.

So the seemingly simple idea of asking a question and finding “the answer” relies in fact on the complex interplay of societal and personal factors that makes us who we are. Our own unique view of the world will influence what is important for us to study, the questions we ask and how we go about collecting our data (our methods). Declaring

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<sup>7</sup> Waiora Port, Inaugural Doctoral Writing Retreat, Hopuhopu, 29 January 2004.

our worldview and our chosen inquiry paradigm not only helps research participants understand how the research might be carried out, but also to what end the research findings may be used. For many Māori researchers, accountability back to their community and the research participants is a foremost concern, therefore it is appropriate at the outset of the study to discuss the inquiry paradigm which drives this research.

### **The “Paradigm Net”**

Denzin and Lincoln discuss (2000b) inquiry paradigms in qualitative research, and use the analogy of a “paradigm net” to explain the effect of the researcher’s personal viewpoint on the research process. They note that every researcher brings to the research her or his own class, ethnicity, gender, culture, history and values; factors that combine to give the researcher their own perspective on the world, their own worldview. This worldview, or paradigm, comprises a basic set of beliefs which guide the action of the researcher and provide an interpretive framework for the research (Denzin and Lincoln 2000b). Using the analogy of a net to describe the concept of paradigm, they note that this ‘net’ contains the researcher’s ontological, epistemological, axiological and methodological principles (Denzin and Lincoln 2000a). The particular contents of this net, and the specific and unique way these contents are combined, will affect the type of research questions asked, how the researcher approaches a research topic and the tools the researcher employs to discover the answer.

Consequently, the research process as a whole may be defined as the interaction of four key activities: ontology, epistemology, axiology and methodology. Davidson and Tolich (1999, p.24) define ontology as “an inventory of the kinds of things that do, or can, exist in the world”. Denzin and Lincoln (2000a) note that ontology raises basic questions about the nature of reality and the nature of human beings in the world. They observe that ontology is concerned with questions such as “What kind of being is the human being? What is the nature of reality?” (Denzin and Lincoln 2000b, p.19).

Epistemology may be described as the philosophical theory of knowledge and how we know certain things. The central concern of epistemology is deciding what counts as legitimate knowledge (Davidson and Tolich 1999). According to Denzin and Lincoln

epistemology asks, “How does the inquirer know the world?” and “What is the relationship between the inquirer and the known?” (Denzin and Lincoln 2000a, p.157).

Axiology or ethics asks “How will I be as a moral person in the world?” (2000a, p.157). Axiology is concerned with the role of values (Cresswell 1998) and researchers need to identify for themselves the values and biases they might bring to the research process.

Finally, methodology is concerned with the examination or analysis of the research question and focuses on how best to gain knowledge about the world (Denzin and Lincoln 2000a). If epistemology is the “science of knowing” then methodology, regarded by Babbie as a subfield of epistemology, may be regarded as the “science of finding out” (Babbie 2001, p.18).

In social science research, two quite different paradigms coexist. These are known as positivism (or logical-positivism), and the interpretive approach (or “phenomenological inquiry”), (Patton 1990) and they differ radically. Positivism uses primarily quantitative and experimental methods to test a hypothesis (Patton 1990) with its emphasis being on deduction and “causal laws” (Davidson and Tolich 1999, p.26). Positivism is characterized as being “objective, value-free and scientific” (Smith 1999, p.164) and has its origins in the natural sciences of physics, chemistry and biology (Davidson and Tolich 1999).

On the other hand, phenomenological inquiry or the interpretive approach attempts to systematically analyse socially meaningful action through detailed observation (Davidson and Tolich 1999). According to Patton (1990) phenomenological inquiry uses qualitative and naturalistic approaches to try to understand human experience holistically and in a context-specific setting. It is concerned with the study of people in their natural setting and emphasises an inductive understanding of how people create meaning in their social worlds (Davidson and Tolich 1999). Whereas positivism claims to be value free and is concerned that the researcher does not “contaminate the data” through personal involvement with the research “subjects”, the interpretive approach emphasises the relationship between what is observed and theory. “Every observation made of nature is impregnated with theory” (Davidson and Tolich 1999, p.29).

Within these two major paradigms, four interpretive paradigms further structure qualitative research in the social sciences. Generally these are known as positivism, post-positivism, critical theory (or critical and feminist post-structuralism) and constructivist-interpretive (or constructivism) (Denzin and Lincoln 2000b; Lincoln and Guba 2000). Ratima describes these approaches as being like points along a continuum, with positivism at one extreme and constructivism at the opposite end (Ratima 2001). Ratima argues that positivism takes the approach that there is only one reality and that this can be objectively researched by a researcher who is independent of those being researched, whereas constructivism claims that multiple realities exist and that knowledge, far from being objective, is subjective and constructed by those who live it. In a constructivist paradigm the researcher and the research participants are “inextricably linked” and the researcher’s own values are clearly exhibited in the research findings and subsequent knowledge (Ratima 2001, p.141). Post-positivism and critical theory rest in the middle of this continuum.

In addition to these four interpretive paradigms, Lincoln and Guba note that several emergent paradigms may interweave, borrow and incorporate perspectives from other paradigms; indeed, on many issues they resemble one or more of the dominant paradigms identified above. They argue that the process of paradigmatic “blurring” is occurring in the social sciences. Elements of one paradigm may be blended into another, to the point where research represents the best of worldviews (Lincoln and Guba 2000).

One such example of an emergent paradigm in health research has grown not out of Western scientific enquiry but out of its own Pacific traditions: it is a Māori research paradigm. However, to substantiate the argument that a Māori worldview or paradigm does exist in health research it is first necessary to consider the development of the Māori research agenda and Māori health research in particular.

## **Determining the Questions: The Reclamation of Māori Knowledge**

The last twenty years have seen the emergence in New Zealand, particularly in the social sciences, of a body of work concerned with reclaiming Māori knowledge, Māori

ways of knowing and the application of Māori values and beliefs to research practice. The reasons for this growing genre of work are varied and may in part be explained by demographic change and a burgeoning renaissance in Māori language, culture and identity. Durie (2004) has argued that the demographic and cultural renaissance experienced by Māori in the previous decade has increased pressure for theoretical and methodological frameworks that incorporate Māori perspectives. The result has been the significant shift within academia to reflect a Māori world view.

Smith (1999) notes that the struggle for Māori to reclaim their own knowledge and right to that knowledge has its foundations in the political upheavals of the 1960s through to the 1980s. Smith uses the terms “indigenous social movement” and the “movement for Māori” to describe the wider platforms of political and social change that occurred at this time as Māori employed various strategies to reclaim their land, language and culture. Landmark events such as Land March of 1974, the emergence of Kohanga Reo movement in 1982 and the Māori Economic Development Conference, Hui Taumata, of 1984 are evidence of a growing concern within Māori society that Māori culture was being subsumed by the more dominant culture of the “colonist” (Smith 1999). Underpinning all these events and many more “radical” activities were the desires of Māori to revitalize, restore and gain a space for, their own language, culture and worldview.

In the 1980s, researchers and practitioners in the education field led the way in reclaiming Māori knowledge, culture and processes and methodologies of “knowing”. Bishop and Glynn (1992) promoted the concept of “research as empowerment”, where research undertaken *with* a community (as opposed to *on* a community) would both positively affirm the lifestyle of the community and improve the life chances of the community and its members. Among the strategies they advocated was a power sharing approach to research. Instead of the traditional research practice of an academic researcher going into a community, conducting research and then leaving, they argue that the researcher needs to enter into a relationship with the Māori community which respects and acknowledges the dignity of all research participants and whereby the community works with the researcher, for the benefit of the community (Bishop and Glynn 1992).

The desire for greater control in the research process was only one of the concerns being voiced by Māori through this period. In the education field anxieties were being expressed by Māori academics and researchers that Māori research was investigating issues of concern to Pākehā, rather than issues that were of concern to Māori, and that research was being used against Māori (Smith 1992). These criticisms were leveled at Māori and non-Māori alike. Research that sought only to describe was regarded as irrelevant. Instead it was believed research should be concerned with encouraging change, should be transformative and should be grounded in the needs and aspiration of Māori communities.

Throughout the late 1980s and into the 1990s, Māori researchers and academics became involved in efforts to reframe “Māori research”, redirecting it away from being merely a tool to describe Māori society and instead using it as a vehicle by which Māori could reclaim their own theoretical and methodological perspectives. During this reclamation process consideration was being given to who should undertake research with Māori (Stokes 1992), what the ethical considerations were when researching with Māori (Cram 1995) and what Māori communities could expect of research (Durie 1992).

A further outcome of the pursuit by Māori to reclaim their own theoretical and methodological perspectives has been the articulation of what constitutes appropriate approaches to researching the lives of Māori people. The history of Māori being researched “upon” is well documented (Te Awekotuku 1991; Cram 1997; Glover 1997). Glover (1997) notes that the observation and measurement of Māori has occurred since the time of first contact with the Pākehā. Te Awekotuku, describing how Pākehā researchers viewed Māori communities, speaks of the many decades of “thoughtless, exploitative, mercenary academic objectification” (Te Awekotuku 1991, p.12); and Cram (1997) argues that the act of observing and commenting on Māori has allowed many Pākehā researchers to build their own careers while largely ignoring any responsibility to contribute to the communities they observed.

In trying to determine the unique features that comprise a “Māori research approach”, at least two ways of considering Māori research have emerged from the social science literature. These approaches are kaupapa Māori research and Māori-centred research. The two are often discussed as being points along a “research continuum”, with that

continuum comprising four types of research in total; namely, research that does not involve Māori, research that involves Māori, Māori-centred research and kaupapa Māori research (Cunningham, 2000). However, Ratima (2001) notes that both kaupapa Māori and Māori-centred research share the common goal of generating and transmitting Māori knowledge and that for the most part the practices each adopts have more common features than differences.

## **Asking the Questions: Approaches to Māori Research**

### ***Kaupapa Māori Research***

Categorically defining kaupapa Māori research remains an elusive goal for many Māori researchers. Powick (2002) notes it is possible to say what kaupapa Māori research is, what it may include, and what it is not, rather than “pin-pointing an exact definition of the approach”. Glover (1997) agrees, noting that kaupapa Māori research can be defined by what it is not rather than by making statements about what it is. To that end Glover argues that kaupapa Māori research is definitely not a positivist approach to understanding the world, as Māori people and Māori worldviews occupy positions of primacy in kaupapa Māori research.

In order to understand what a kaupapa Māori research approach might include it is necessary to know what others have identified as being the features of this type of research. Various examples of kaupapa Māori research approaches appear in the literature. Irwin defined kaupapa Māori research as being:

*research which is ‘culturally safe’, which involves mentorship of kaumātua (elders) which is culturally relevant and appropriate while satisfying the rigour of the research, and which is undertaken by a Māori researcher, not a researcher that happens to be Māori. (Irwin 1994)*

According to Irwin Kaupapa Māori research must contain elements of cultural safety, mentorship, relevance and rigour and it is research that can only be undertaken by Māori. Smith (1995) agrees stating that kaupapa Māori research is research that is by Māori, for Māori and with Māori. Glover (1997) emphasises the intrinsic desire within a kaupapa Māori approach to “to recover and reinstate mātauranga Māori” while Reid

(1999) notes that kaupapa Māori approaches are in direct contrast to universal approaches, and, therefore must be able to address Māori needs or fully recognise Māori culture and value systems

According to Cram et al. kaupapa Māori research is

*a theory and an analysis of the context of research which involves Māori and of the approaches to research with, by and/or for Māori. A Kaupapa Māori approach does not exclude the use of a wide range of methods but rather signals the interrogation of methods in relation to cultural sensitivity, cross cultural reliability, useful outcomes for Māori and other such measures. (Cram, Pihama et al. 2000)*

Henry and Pene (2001) note that kaupapa Māori research “embraces traditional beliefs and ethics, while incorporating contemporary resistance strategies that embody the drive for tino rangatiratanga for Māori people”, and most recently Ranginui Walker commented that kaupapa Māori research is grounded in Māori community and embodies the principal of reciprocity (Walker 2004).

The core of kaupapa Māori research is characterised by several features: a Māori worldview; a desire to affirm Māori knowledge and Māori ways of knowing; an equal relationship with the community being researched; a desire for the outcomes of the research to benefit that community; ethics grounded in Māori philosophies of reciprocity and accountability; and Māori values shaping and directing the rigour and trustworthiness of the data.

Kaupapa Māori research appears to be intrinsically linked to resistance, struggle and emancipation as much as it is to cultural revitalisation, self determination and empowerment. It locates Māori people and Māori communities at the heart of any research process and requires Māori researchers who adopt the approach to incorporate strategies to allow the research to benefit those communities directly. In this approach, the research is not a process distinct from the community, but will inform, support and enshroud that community during the research and long after it is completed.

### ***Māori-centred Research***

In contrast Māori-centred research, while still promoting an agenda of change and transformation, apparently does not demand of its proponents such a whole-hearted capture by the community. The term “Māori centred” was coined at the Hui Whakapiripiri in 1996 by Mason Durie to distinguish a particular approach to health research that differed from western medical models. At that time he noted that Māori health research differed from medical research and other health research in being primarily concerned with the health of Māori people and in that respect took “full cognisance of Māori culture, Māori knowledge and contemporary Māori realities”.

Durie (1996) noted three developments in particular that have accelerated a Māori-centred approach in Māori health research:

- the world-wide move by indigenous people towards self-determination and greater autonomy;
- New Zealand’s reaffirmed commitment to the Treaty of Waitangi in the 1980s and the subsequent inclusion of the Treaty in various pieces of legislation and in the policy frameworks adopted by Ministries; and
- the recognition by 1980 that Māori worldviews and Māori understandings of knowledge were unique and distinctive.

According to Durie (1996) world-wide efforts by indigenous peoples towards self-determination have resulted in debates about intellectual ownership, community control, participation and partnership in research. As Māori have struggled to assert their rights to determine their own future in their own ways, so too have other indigenous nations struggled with the same issues. In the area of health research Māori have voiced their demands for greater partnership. It is from these struggles and debates that new ways of approaching health research have emerged.

In the 1980s the Treaty of Waitangi became a visible part of New Zealand’s policy landscape with expectations that health institutions and programmes would reflect the principles of the Treaty and acknowledge Māori as the indigenous people of New Zealand (Durie 1996). The environment created from these expectations, particularly in

the decade of Māori Development, supported forays by Māori into health provision as well as into health research. As Māori became more involved in health, health service provision and health research there was a growing realisation that Māori worldviews were distinctive. This in turn prompted Māori to develop models which would assist in conveying their perspective to non-Māori working in the field. The development of health research models, such as a Māori centred approach, was a means of articulating Māori ways of knowing to a wider audience.

Like kaupapa Māori research, Māori-centred research deliberately places Māori people and the Māori experience at the centre of the research activity (Durie 1996). However, unlike kaupapa Māori research the locus of control is not with the community. This distinction was identified by Cunningham as the term 'Māori-centred' was further developed into a taxonomy of Māori research; a taxonomy based primarily on the degree of Māori involvement and control in a specific research project (Cunningham 2000). According to Cunningham, Māori-centred research has several defining characteristics: namely, that Māori are more likely to be involved at all levels of the research (i.e. as participants, researchers and analysts); that Māori data will be collected; that Māori analysis is applied; and, as a result that Māori knowledge is produced (Cunningham 2000). Māori-centred research is not value-free; instead the values that permeate the research are culturally determined. The ultimate aim of Māori-centred research is the enhancement or improvement of the Māori position (Cunningham 2000).

Key principles central to a Māori-centred research approach include "whakapiki tangata (enablement or empowerment), whakaurunga (integration), and Mana Māori (Māori control)" (Durie 1996, p.6). The principle of enablement applies to researchers and participants alike. It means that as a consequence of participating in a research activity, either a community's health status should improve or it should be better positioned to take control of its own health or both (Durie 1996). Moreover, the way these improvements are measured should be meaningful to the community and not be imposed from without.

Whakaurunga or integration refers to the integration of the research approach with a Māori worldview. Māori health research needs to be aware of the links between socio-

economic status, culture, history and health. A Māori-centred approach takes an expansive view of health; a holistic view; it seeks to understand a condition or situation in light of these interwoven determinants of health.

The concept of Mana Māori is related to tino rangatiratanga and Māori self-determination. In Māori-centred research Mana Māori refers to the importance of control in the research process, of responsibility for caring for the data and of guardianship of the knowledge the research generates. Mana Māori ensures any Māori-centred research programme is run ethically and in keeping with Māori customs and values.

Kingi (2002) postulated a series of research principles to provide a theoretical framework for research in Māori mental health. These principles provided the theoretical underpinning for his study and were derived from the writings of a number of academics and Māori health researchers. He argued that it was possible to undertake research which adopts a Māori-centred approach from *within* a kaupapa Māori paradigm. His six principles are:

- That the investigation should reflect a Māori world view and be conducted in a manner consistent with those views. Māori values, traditions and cultural practices should underpin the process;
- That the investigation while meeting rigorous academic standards, should encourage gains in Māori mental health;
- That Māori research methodologies should be used as appropriate, however this does not preclude other methodologies, providing they are not inconsistent with the values and methods of kaupapa Māori research;
- That Māori must be actively involved in the research process, in a spirit of partnership between researcher and participants;
- That the manner in which the information is stored and protected is important, particularly the safeguarding of information of cultural significance; and

- That to be of value, research information must be made available to Māori and mechanisms developed to ensure Māori access to the research findings. (Kingi 2002)

These six research principles resonate with my own values in conducting this research. However, where Kingi argued his research adopts a Māori-centred approach from *within* a kaupapa Māori paradigm, in this research elements of kaupapa Māori and Māori centred research overlap and inform each other. In this thesis I assume that a Māori research paradigm, a basic set of beliefs which the researcher brings to the research, can be articulated for this particular research project. The paradigm can be inclusive of both the kaupapa Māori and Māori centred approaches to health research without detracting from the ideals and values of either. The two approaches are neither exclusive nor superior to the other, but merely parts of a greater paradigm that is Māori research.

### **The Case for a Māori Research Paradigm**

Māori have a facility for acquiring structures, concepts and tools and turning them to their own use. Metge (1995) notes that Māori have taken possession of many aspects of the social and cultural arrangements brought to Aotearoa/New Zealand by English and European settlers, modifying them to fit into Māori contexts, re-orienting them to serve Māori goals and in doing so, making them their own. Some may consider this to be a form of “appropriation”, however according to Metge not all appropriation is necessarily “bad”. While she cautions against the form of appropriation that occurs without authority, she notes that cultural borrowing and cross-fertilization is both legitimate and creatively exciting. Metge argues that not only did Pākehā law and policy makers give their approval for the adaptation of the various social and cultural arrangements; often they positively encouraged Māori to do so. Where such “appropriation” occurs with authority and approval, new applications and understandings can arise.

In addition to structures and concepts, Māori have also adapted technologies and techniques in order to pursue their development as a people. In his book on researching family history, Royal (1992) describes how new technologies have become available to Māori since the arrival of Pākehā. Technologies such as printing presses, photographic

equipment and audio tapes have allowed Māori to collect and capture information in new ways. These new technologies, he argues, have challenged, and continue to challenge, Māori concepts of knowledge, learning and teaching and cultural ownership and possession.

Jahnke and Taiapa note that research, as a concept, is universal and not the sole preserve of the Western world. Research is driven by a desire to “improve ways of life” and is influenced by the very world in which the enquirer was nurtured and raised (Jahnke and Taiapa 1999). Durie (2004) argues that creative and inventive capacity forms the core of an indigenous knowledge system and, while it is valued for its traditional qualities, the potential modern applications and uses of indigenous knowledge cannot be underestimated.

The entry of Māori into the traditional fields of inquiry and knowledge generation has challenged the thinking and practices of those already engaged in these fields and in many cases broadened their understanding of knowledge and knowledge acquisition. At the same time, as a dynamic and vibrant people, Māori have adopted traditional methods and processes for gaining knowledge and added them to their own “kete” of tools and skills.

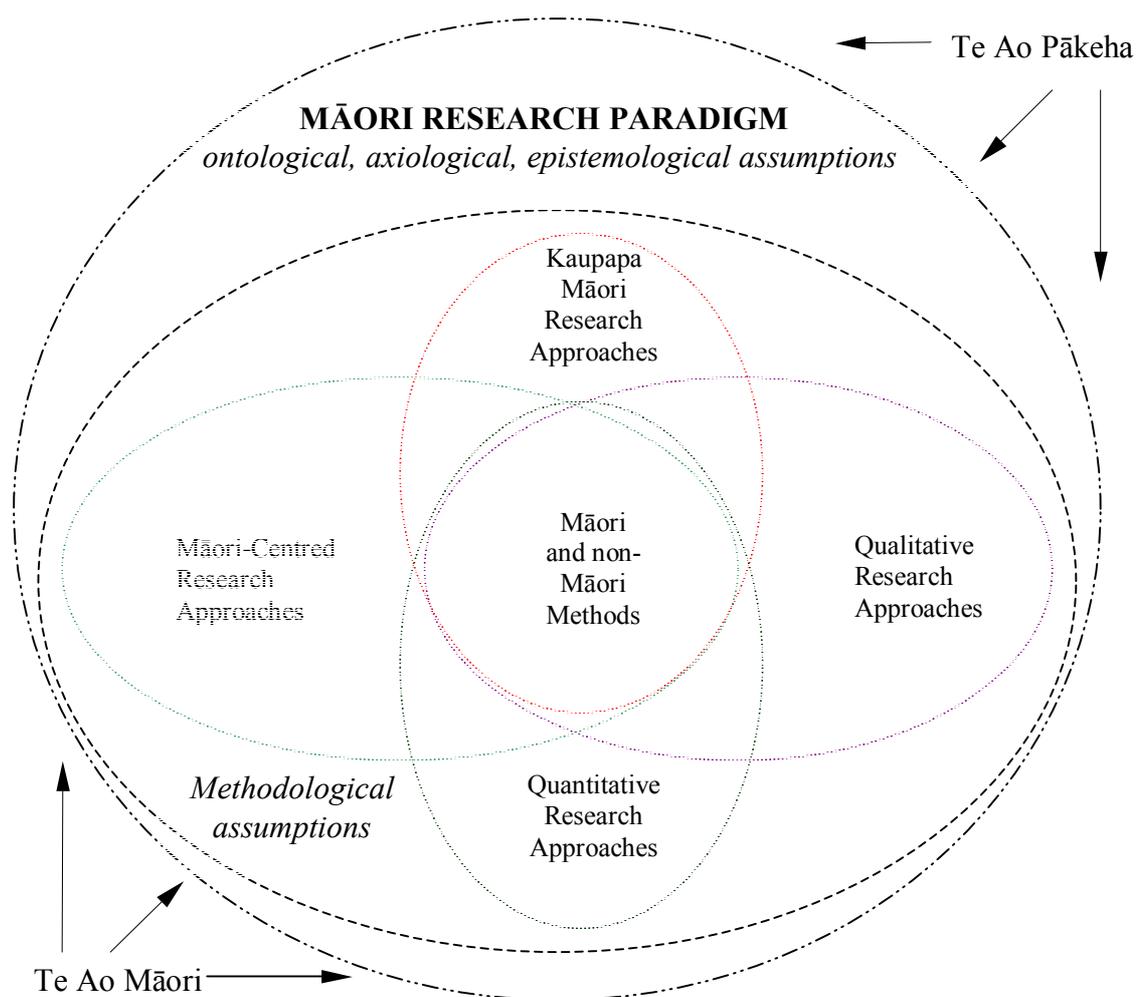
The following diagram expresses the location of my research project within the wider world of social science research knowledge and activity and Māori knowledge. As noted above, the paradigm or basic set of beliefs which the researcher brings to the research guides the actions of the researcher and provides an interpretive framework for the research (Denzin and Lincoln 2000b). Considered as a net, it contains the researcher’s ontological, epistemological, axiological and methodological principles (Denzin and Lincoln 2000a). Few would dispute the validity and legitimacy of Māori ontological and epistemological perspective since it is based on a world-view that continues to exist and is experienced by living people (Tomlins-Jahnke 1996). In addition, Māori bring their own values and methods to the process of inquiry; axiological and methodological principles that are unique to a Māori worldview.

Figure 1 represents the Māori research paradigm “net” which guides this research project and provides an interpretive framework for the results. The net is located within

two worlds, that of te Ao Māori and te Ao Pākehā. It is a permeable structure, allowing ideas and concepts to diffuse in from both worlds and allowing results to disperse out to both worlds. Contained within the paradigm net are specific research approaches. These are a kaupapa Māori approach, a Māori-centred approach, a qualitative approach and a quantitative approach. Researchers within a Māori research paradigm may adopt one of these approaches or a combination of approaches. Each approach brings its own “toolkit” of methods to the research; methods may be used in any combination within the rubric of Māori research.

By adopting the concept of a “paradigm net”, this research builds on and moves beyond the traditional dichotomy that frames social science research; that of positivist versus interpretivist approaches, and the kaupapa Māori/Māori-centred dichotomy which colours Māori health research. The concept of the paradigm net allows the researcher the freedom to select and use the best and most appropriate research tools from both traditional social science research practices and from Māori culture and tikanga -from the world of Māori and the world of Pākehā - to answer the research question posed.

Durie (2004) has recently coined the term “research at the interface” to describe the practice many indigenous scientists and researchers have adopted of accessing both indigenous knowledge and scientific knowledge for the betterment of their people. He notes that while the relative validity and superiority of scientific compared with indigenous knowledge was hotly contested in the past, indigenous researchers are now beginning to use the interface between the two as a “source of inventiveness” (Durie 2004, p.9).



**Figure 2: The Māori Research Paradigm**

The paradigm net outlined above could be considered a pictorial representation of “research at the interface”. Durie (2002a) argues that a continuum exists between scientific method that is culturally indifferent at one pole, and indigenous knowledge that relies entirely on indigenous knowledge at the other. Between these poles exists research that is culturally sensitive and that employs indigenous methods in parallel with scientific methods. Whether the relationship between Māori worldview and science is linear, as Durie theorises, or overlapping spheres, as presented in the idea of a paradigm net, the key issue is that my own particular background, values and culture as well as my academic experience and societal reality not only define who I am, but dictate how this research was conceived, constructed and executed.

The research for this thesis was always going to occur “at the interface” as its purpose is to understand the different perspectives Māori providers and agencies of government bring to mental health service provision. A prerequisite was that it always had to be congruent with the worldview of the Māori health providers and the manner of health provision under study. This congruence occurs because my own worldview is similar to that of the research participants and because the ethical and cultural mores which underpin this research are also those governing relationships and interactions within Māori society.

## **Ethical Considerations and the Practice of Conducting Research with Māori**

The ethical framework which guides this research is a modified version of that offered by Mead (1996) and later discussed by Cram (2001). These guidelines aim to protect and respect the rights, interests and sensitivities of the people who participate in the study (Mead 1996). For this research they also ensure the safety of all participants, from the researcher through to the respondents and even those who transcribed the interviews.

The seven ethical guidelines are

- aroha ki te tangata - a respect for people

This guideline enshrines the ideas of respecting people’s knowledge; their contribution to the study, as well as respecting their location, land and home. As a researcher one often encroaches on another’s life, even if only fleetingly. For this research project, interviews with Māori providers were often in their place of work. These were almost always within in their tribal land. Respecting the people also meant respecting and having regard for the ‘space’ being occupied during the course of the research.

- kanohi kitea - to present yourself face to face

Much has been written about the Māori preference for conducting business face to face, at least until one is known. Presenting yourself in person is also a form of accountability; you are prepared to stand by your work and be known to those from whom you have come to request knowledge. It is important to keep returning and presenting that face throughout the course of the research and beyond its completion.

- titiro, whakarongo, kōrero – look, listen, then speak

This guideline encourages the researcher to listen and observe rather than to leap in straight away as if one were an “expert”. It is particularly apposite for those Māori researchers “beginning their cultural journey” and who may have little expertise with tikanga, language or culture (Cram 2001, p. 44).

- manaaki ki te tangata – share and host people, be generous

This, in addition to relating to sharing of time and resources, also refers to the sharing of knowledge and may be a two way process between the researcher and the participants. In a more literal sense it can also refer to the use of koha to acknowledge a participant’s contribution to the research

- kia tupato – be cautious

Here, being cautious refers to being culturally safe and understanding that in undertaking research with Māori, a Māori researcher is automatically researching from an “insider” perspective (Cram 2001, p.46). This guideline exhorts us to acknowledge our position as insiders, as part of the community we seek to study, and therefore protects us from putting ourselves or the research participants in the position of either being researched upon as the “other” (Cram 2001, p.47).

- kaula e takahia te mana o te tangata – do not trample over the mana of the people

This guideline is linked to aroha ki te tangata above and reminds us to value and respect the knowledge that is passed to us. It also compels a researcher to consider whether the research is worthwhile from the perspective of the Māori community and what benefits might accrue to Māori from the research.

- kaula e mahaki – don’t flaunt your knowledge

Simply put, this reminds the researcher to remain humble and to recognise that our knowledge is just one type of knowledge. Cram (2001) notes that we do not gain access to communities because of our knowledge; rather, access is granted by people in those communities willing to be involved in the project because they are related to us, or they have faith in us because we are Māori. Again the guideline emphasises that the

knowledge generated from the interaction with the community must be returned to that community.

In addition to these seven guidelines I would add a further guideline regarding accountability and responsibility. Mead (1996) talks about the commitment to report back to the people being part reciprocity, part accountability. This theme of accountability and obligation to the community flows throughout this entire thesis. It is one of the main reasons why Māori providers work in the way that they do; it is strongly emphasised by Māori researchers as a key condition for culturally competent research; and it is an important part of my own personal ethical code of conduct as a Māori woman of Ngai te Rangi, Ngati Ranginui and Ngati Pukenga. At the end of the day I have an obligation to present the findings of the research back to those who participated in the project and to the wider Māori community. As Mead (1996) notes the final reporting will close off the activity, but not the relationship. That will endure.

## **Summary**

This chapter has introduced the two main theoretical approaches to Māori health research: kaupapa Māori research and Māori-centred research and briefly summarised the features of each. I have argued that both approaches may be viewed as components of a larger Māori research paradigm. The Māori research paradigm, in addition to containing ideas, concepts and tools from te ao Māori also contains ideas, concepts and tools from the Pākehā world; tools which Māori have adapted and now use freely as they conduct research. My research occurs within this larger Māori research paradigm and takes a Māori-centred approach. The particular methods and tools of that approach are discussed in the next chapter.

## Chapter Five

### **“Working Under the Images of our Tūpuna”<sup>8</sup>: Research Design and Methods**

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#### **Introduction**

This chapter introduces the research design and specific methods used in this study. The chapter begins by noting that within the framework of the paradigm net, a Māori-centred, qualitative research approach is adopted for the project. The methods used to collect and analyse the data are outlined as are the various ethical issues which were considered in the course of the study. The chapter concludes by noting that the dual obligations of “doing no harm” and contributing positively to Māori development not only underpinned the study, but were key principles in the success of the project.

#### **A Māori-centred, Qualitative Research Approach**

The Māori research paradigm net guides this research project and provides an interpretive framework for the results. The net is located within two worlds, that of te Ao Māori and te Ao Pākehā and contained within it are specific research approaches including the kaupapa Māori approach, the Māori-centred approach, the qualitative approach and the quantitative approach. For this research primarily qualitative methods have been employed; methods derived from “Western” research practices. However, these methods have been supported and supplemented by Māori methods of engagement, interaction, practice, analysis and dissemination; a Māori-centred approach. According to Davidson and Tolich the very tools we use to “investigate

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<sup>8</sup> This comment was made by the Manager of an iwi-based Māori mental health service where staff in that office work under the photos and portraits of tūpuna. I was struck by the fact that this is a very visual representation of accountability for Māori. I use it here as a reference to my own accountability back to the research participants, which is a critical component of this work.

reality” are themselves dependent upon epistemological justifications (Davidson and Tolich 1999, p.25). In other words how we go about discovering the truth will be determined by what we ourselves regard as legitimate knowledge. Jackson (1996) argues that the methodological approach employed in a study determines the method(s) used. In addition however, Denscombe (2003) notes some element of choice in the methods used to collect data is possible in social research. While the choice of methods may in part be determined by the research approach adopted, issues of practicality (resources, access to the data) and researcher preference also play a role in the methods selected to collect information. A feature of the Māori-centred research approach is that both contemporary mainstream *and* Māori methods and tools may be used to produce and analyse the data.

The study used qualitative methods as the primary means of information gathering. From traditional, western research theory and practice, we know that qualitative methods are appropriate when studying topics about which little or nothing is known, or when a researcher is attempting to gain an understanding of a field of study (Minichiello, Sullivan et al. 1999). Bowling (1997) notes that qualitative research is seen to have demonstrable advantages over quantitative methods in situations in which there is little pre-existing knowledge. Qualitative methods are considered to be particularly useful for studying people in their natural social settings and to collect naturally occurring data (Bowling 1997). Unlike quantitative research which is underpinned by experimental and positivistic approaches (ie: research which proves a hypothesis), qualitative research emphasises description, rather than explanation. The strength of qualitative research is that reality is represented through the eyes of the research participants themselves (Henwood and Pidgeon 1993). Qualitative research methods are most appropriate for this study as it is in an area about which little is known, namely the use of performance measures in Māori mental health. In addition, understanding the “reality” or environment within which Māori mental health providers deliver services, and the expectations communities have in terms of provider performance, were both crucial objectives of the research.

This thesis employs a Māori-centred, qualitative research approach utilising conventional methods of data collection and analysis in conjunction with Māori values, practices and methods of eliciting information. The specific methods used and the

interaction between western and “Māori” research methods are described more fully in the following sections.

## **Selection of Research Participants**

Two categories of research participant were interviewed in this study: key informants and staff and managers from Māori mental health provider organisations.

### ***Key Informants***

The literature review undertaken at the outset of the research revealed that very little is known about how cultural elements are incorporated into performance measurement, or indeed whether cultural factors should be included in performance measurement systems at all. That cultural imperatives may have a place in performance measurement is an issue rarely raised in the literature. While the New Zealand literature acknowledged the importance of culture in terms of treatment of tangata whaiora, there was only a small body of work making the links between mental health service delivery in a “culturally whole manner” and effectiveness of service provision for Māori. The use of “cultural” measures of performance in healthcare delivery appeared to be almost absent from the overseas literature reviewed.

The first phase of field work therefore involved questioning experts about the usefulness and applicability of cultural performance indicators in the delivery of Māori mental health services and indeed what role cultural performance measures might have. My intention in interviewing these experts was to gain an understanding of the performance measurement framework used in New Zealand’s mental health sector, how it was developed and its characteristics. In addition to generic questions about performance measurement, I was seeking information about the relevance or otherwise of “cultural” performance indicators, current public sector contracting and performance monitoring processes and the form of accountability expected of Māori mental health providers. I also wanted to know whether the commonly held belief that Māori mental health providers did more than they were contracted to do was in fact supported by evidence and if so what form this additional “work” took. Why this extra work was done was also of interest. The information that was being sought therefore determined the range of key informants selected.

Key informants were initially identified through reading New Zealand mental health and Māori mental health literature, including key government documents, my own knowledge of the sector and snowball sampling; a technique where initial respondents are asked to suggest others who they know who are in the “target group”, who could be contacted and asked to participate in the research (Bowling 1997). In the case of this research, an initial group of key informants was identified and those respondents were asked if there were other experts in the field who they thought would be valuable to interview. If they were not already included on the initial list, a decision was made in concert with advice from supervisors as to whether these people should be contacted and asked to participate. Key informants came from various backgrounds and disciplines and comprised Ministry of Health and other policy officials (n=4), District Health Board Managers responsible for Māori and/or Mental Health (n=5), Māori mental health provider managers (n=3), mental health workers (n=5), and academics (n=3). All the key informants were Māori.

### ***Māori Mental Health Providers***

The second group of informants comprises community-based mental health providers. In selecting the number and type of providers for the study, two concerns were uppermost. The first concern was the Health Research Council’s criticism of an earlier proposal in which the study was described as “overambitious”. The second concern was to find a balance between a manageable number of providers to interview and a “representative” sample of providers. My original plan was to interview providers in four areas: Auckland, Canterbury, Manawatu and Tauranga in the Western Bay of Plenty. These sites were chosen because they represented areas with fairly large Māori populations and represented major cities and provincial towns, as well as a North Island/South Island mix. In addition, being physically located at Massey University Palmerston North, while having whakapapa links to Tauranga were important considerations for the recruitment of providers.

Initially I had hoped to select Māori mental health providers using a national Māori mental health database, which I expected would be administered by the Ministry of Health. Unfortunately at the start of this study, no complete national database existed, although the Ministry of Health did have some information about mental health providers and regional Health Funding Authority lists were available. Using these lists,

together with a database developed by Te Rau Puawai<sup>9</sup>, I compiled as complete a list as possible of Māori mental health providers in each of the four regions in order to submit an ethics application (hereafter referred to as the Ethics list). It was during the ethics application process that Te Rau Matatini<sup>10</sup> compiled a complete accurate and up-to-date list of all Māori mental health providers nationwide. This database is available on line at <http://www.matatini.co.nz>.

## **Consultation and Affirmation of the Research Question**

*The man or woman who travels alone will be cold and lonely. The one who travels with a group will have their warmth and support on the journey. (Stokes 1992, p.11)*

Prior to the field work component of the research I undertook an extensive consultation phase with Māori mental health providers and experts (some of whom went on to become key informants) in each of the four field work areas. Irwin refers to this phase as “negotiating entry to the field” and notes that for her as a Māori researcher it was a significant methodological issue, testing her “Māoriness”, her cultural integrity and authenticity (Irwin 1994, p.35). Irwin identified that for her study, also undertaken as part of her doctorate, many communities would need to be approached and negotiations would involve complex cultural and political situations. Similarly, I felt that for my own doctoral study, my “Māoriness” would be scrutinised, my cultural integrity appraised and my motives questioned. My study would involve Māori mental providers giving up much of their time, energy and knowledge at a point in time when mental health was already under the microscope.

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<sup>9</sup> Te Rau Puawai is a joint scholarship programme between the Ministry of Health and Massey University aimed at increasing the numbers of professionally trained Māori mental health workers. Information about the programme can be found at <http://te-rau-puawai.massey.ac.nz>.

<sup>10</sup> Te Rau Matatini is a national Māori mental health development organisation funded by the Ministry of Health. Its main aim is to ensure tangata whaiora have access to a highly qualified Māori Mental health workforce by contributing to national and regional Māori mental health workforce policy development. Information about the programme can be found at <http://www.mataini.co.nz>.

There were a number of reasons then, why the consultation and negotiation stage of the research was crucial. Firstly, the purpose of getting out into the regions was to meet with providers and introduce both myself and my study to them. As a young and emerging health researcher I did not have a wide understanding of the Māori mental health field or the key players within that field. I was not personally known to many of the key informants, nor providers who participated in the study, although the Māori world being as it is, connections were often able to be made.

Secondly and perhaps more importantly, as a Māori researcher I felt it was culturally appropriate for me to introduce myself to Māori providers in each of the four regions in terms of my whakapapa. A number of Māori researchers have acknowledged the importance Māori place in working with someone they know (Dewes 1975; Bishop and Glynn 1992; Smith 1999; Glover 2002). The concept of *he kanohi kitea* or the “face that is known” embodies the preference Māori have for working with people they either know or have been introduced to by someone they know and regard highly. This preference made getting out to the regions and making the whakapapa connections imperative rather than optional. Indeed it was because of a desire to reconnect with iwi hapū and whānau in Tauranga, my turangawaewae, that Tauranga was selected as one of the research sites.

Thirdly the process of travelling in the regions to introduce myself and my research was also a time of gaining support for the topic and validation that the research was important to Māori and Māori providers. While I knew from my own personal experience and contacts that the topic was of value in a local sense, it was useful to know that other providers around the country were interested in the same issues. Gaining support from others involved in Māori mental health service delivery affirmed the value of the research question.

### ***Inexperience is the Mother of Innovation***

An innovative feature of the consultation process was to travel to three of the four sites with a fellow Māori doctoral student and colleague also undertaking doctoral study in the area of Māori mental health. This colleague had considerable experience as a contract researcher and had recently been part of a very successful research project involving tangata whaiora. Her field experience in terms of making initial contact with

potential research participants was just one of the many skills I hoped eventually to learn.

As alluded to briefly above, Māori have a preference for working with someone they know. Dewes (1975) states that it is a common practice in establishing contact amongst Māori to ask someone local, known and trusted by their networks, to set up the first face to face contacts. It was my belief that as a researcher I would have access to key informants in their professional roles with little difficulty. Having worked in a professional capacity for the public service prior to undertaking the PhD, I understood that making oneself available to researchers contributed to the “public good”, therefore I was confident that if approached appropriately, these professionals would make the time to be involved as participants. For many of the government officials, health managers and academics, first contact was made through letters of introduction, on Massey University letter head and bearing not only my contact details but also those of my supervisors (Appendix 2). These letters were followed up by phone calls and/or emails, and upon confirmation of their interest in this research an interview time was scheduled.

While I was confident in my approach with key informants, I was more circumspect with approaching the community based Māori mental health providers as indeed was my colleague. We decided relatively early on to work together for our respective consultation phases wherever our study areas overlapped. Realising our relative youth and inexperience as both researchers and more importantly as Māori researchers, our primary reason for travelling and working together during this consultation phase was to offer each other support and what Stokes identifies as the highly valued elements of “cooperation, reciprocity and mutual assistance” (Stokes 1992, p.1). In the same paper Stokes exhorts Māori researchers to work in pairs, as in the traditional manner, of kaumatua and apprentice. Stokes argues that it is “unwise and unfair” to expect a new Māori researcher or new graduate to undertake a complex task such as research without support from a more experienced researcher (Stokes 1992, p.17). While I was fortunate to rely upon the experience of my supervisors “back at the University” for matters academic, in the field when initiating contact with providers and other research participants, it was my colleague who was able to offer the benefit of their experience both of the mental health sector and of working and researching with Māori.

In Tauranga however I was accompanied during my consultation and negotiation phase by my mother who variously acted as mentor, advisor, wise counsel and support. My mother had grown up in Tauranga and while we reside outside our iwi rohe now, she was able to recall people and make whakapapa links during our meetings with providers. Many Māori authors have discussed the importance of establishing a relationship of trust and accountability when working with and particularly researching Māori communities. A long legacy of “researching on” Māori has resulted in what Linda Smith describes as “a deep distrust and suspicion of researchers by Māori communities” (Smith 1991, p.8). Having my mother there, with her wide knowledge of our family and its history helped to quickly break down the barriers the providers might have naturally thrown up upon hearing of yet another researcher wanting to undertake research about “them”. As a result of being able to discuss shared whakapapa and shared childhood experiences with my mother, providers accepted me as a researcher with ease and a relationship of trust was established very quickly. Māori communities being as they are, we were actually able to find whakapapa connections to all of the Tauranga providers we approached to participate in the research.

A second reason for working with my colleague was that we both subscribed to Koro Dewes’ view that Māori prefer to work with someone they know or have been introduced to by someone who is highly regarded. I was fortunate in that my colleague had for a number of years managed a mental health service in Christchurch and therefore had quite extensive knowledge of the providers in the area. She was also highly regarded by those self same providers and was willing and able to introduce me to her former colleagues. Through her connections and reputation I was able to meet a range of providers and key informants in Christchurch during the initial consultation stage who later went on to participate in the research.

Our final reason for working together was a common desire to recruit participants from Auckland; an area neither of us knew. Nor did we know many of the key players very well. In combining our Auckland consultation we were able to provide each other with “whānau” support as we entered the area “cold”. Practical benefits such as having one person navigate and another negotiate Auckland’s roads was a positive and serendipitous spin-off.

### *Consultation Hui*

The process of meeting with Māori providers took place over several months and in a number of stages. Purposive sampling (a deliberately non-random method of sampling) of the Ethics List was used to find potential research participants. Purposive sampling, because it involves the researcher making decisions about who will be contacted, has a high risk of bias as a sampling method. However, it is advantageous to use purposive sampling where the researcher has specific knowledge about the population and/or where only certain groups or individuals have the required information (Minichiello, Sullivan et al. 1999). Purposefully-selected providers were contacted, usually by phone or by email and asked if they would be interested in hearing about the research in a “face-to-face forum”. If they agreed, my colleague and I would coordinate our meetings so as to be in the same area at the same time. Often we were approaching the same providers to participate in our respective projects; however I was keen to interview provider staff, whereas my colleague was interested in interviewing tangata whaiora.

Hui with providers to introduce our respective research projects and recruit participants was usually a semi-formal affair, following Māori protocols wherever practicable. Usually a kaumatua would welcome us with a brief whaikorero and we would be given the opportunity to respond. As Māori women it was not appropriate that we respond to a formal whaikorero and, for a number of reasons (primarily cost and the implausibility of having someone who could drop their work and accompany us), we were unable to travel with a kaumatua who could respond on our behalf. The fact that we did travel without the support of a kaumātua was remarked upon on more than one occasion and certainly gave us pause for thought. Without a kaumatua to reply more formally, we usually responded with a short mihi each, in essence introducing ourselves and our whakapapa. We would then be introduced to the staff and any tangata whaiora that had come to the hui and in closing the more formal part of the hui prior to eating, a brief prayer would be offered.

The eating of kai signified the transition between the formal and informal parts of the meeting. We usually brought food with us as a koha, which augmented that provided by the hosts. Following the kai, the hui was turned over to my colleague and me at

which time we outlined our respective projects, the level of involvement required by participants, the timelines and our expectations. Any questions about the research were answered at this point. Having outlined the research, people were asked whether they would like to participate in either research project and where possible, dates for future follow-up were made. In one particular case, a provider was interested enough in the research to ask to be interviewed then and made the contract and performance monitoring documentation available to me at the conclusion of the interview.

## **Participant Recruitment**

While the purpose of the consultation phase was primarily to meet providers, some key informants were also identified during the course of these meetings. The process of recruiting key informants was simply, after identifying them, to invite them to participate in an interview at an appropriate venue and at a convenient time. Depending on the circumstances this invitation may have been done “on the spot” but was followed up by either an email or letter to confirm the details. Copies of the Information Sheet, Consent Form and if, requested, Interview Schedule, were included in the letter or as email attachments. These documents and the form which participants filled out to confirm their interest in the research comprise Appendices 3-6.

The recruitment of providers was initiated at the consultation hui. During the consultation phase I met with a number of providers to explain the research, outline the type of provider that I was looking for (ie: iwi, hapū or community-based Māori health providers) and gauge the level of interest in this research, among their community. While all the providers contacted during this consultation phase expressed an interest in the research, the group of providers that finally participated in the project was different from the initial group of providers contacted. This is the result of two factors.

First, in attempting to find providers to participate in the research I had used a combination of methods (the Ethics List derived from Māori mental health databases and my colleagues’ insider knowledge of various key players and organisations, particularly in Canterbury). The combination of methods employed meant not all those providers that were contacted were suitable candidates for the research. For example at least two were Māori mental health services within hospitals as opposed to being

community-based services. Two other providers did not have any current mental health contracts.

Second, and perhaps more importantly between the consultation phase and the field work phase, staff with whom I had built a relationship had left that service. During the consultation phase I had worked hard to build rapport and trust with key staff members and in particular service managers who would assist with the research. In no less than four Māori health providers, the managers of those services left in between the period of consultation (which began with the first provider hui in July 2003) and when the bulk of fieldwork with providers was undertaken (June 2004). One such staff member was the manager of a hospital-based service and while it had already been determined that this service did not fit the research criteria, the fact that the manager went on to other work in the health sector demonstrates the fragility of the Māori mental health workforce.

When these key people left the services my alternatives were to start from scratch with their replacements in terms of consultation, explaining the research and building up trust or not include that provider in the research. The result was that in these four cases, one was happy to continue with the research process started, two as mentioned above were deemed as outside the parameters of the research and the final service, while interested, declined to participate at that time citing the pressures of organisational restructuring and work towards certification.

The final group of providers who participated in the research then came from only three of the four originally selected sites, namely Tauranga, Manawatu and Canterbury. Unfortunately due to the constraints noted above, no Auckland-based providers participated as providers; however a number of the key informants were managers or staff members of Auckland-based Māori mental health providers. The final set of providers who participated in this study is an invited, self-selected sample.

## **Data Collection**

The research uses multiple methods to collect information, including unobtrusive methods (the collection and subsequent analysis and synthesis of current contracting and performance frameworks, document analysis and analysis of written interview notes) and semi-structured interviews with key informants and providers. The

combination of research methods is known as *triangulation*. As a process, triangulation is employed by researchers to ensure the credibility of qualitative data and to test the validity of the information gathered. Polit and Hungler note that the purpose of triangulation is to provide a basis for convergence on the truth, where “true information” can be sorted out from “error information” (Polit and Hungler 1995, p.362).

Four types of triangulation may be identified in the literature, namely theory triangulation; investigator triangulation; data triangulation and methodological triangulation (Bowling, 1997; Polit and Hungler 1995). Methodological triangulation (ie: use of multiple methods to study a single problem) is commonly used by researchers to strengthen a study design, or to ensure the validity of results (Patton 1990). Using multiple methods enables researchers to capture both individual and group experiences (Cassel and Symon 1994). In addition to the methodological triangulation described above, this research also employs data triangulation where the data is collected at different times and places and from different people or groups (Berg 2001; Bowling 1997). The research includes two distinct data collection and analysis phases and a third phase in which the results of the research are presented back to participants and disseminated more widely to the Māori and research communities. The process of data triangulation is discussed in more detail below.

### ***Phase 1 - Key Informant Interviews***

The first phase of the research involved undertaking qualitative interviews with key informants. Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable and able to be made explicit (Patton 1990). The purpose of this research is not only to know what Māori think of current performance measurement and contracting frameworks but by capturing their perspectives, use this knowledge to improve those frameworks. Face-to-face, in-depth, semi-structured interviews were undertaken with key informants as one means of capturing this knowledge.

There are a number of advantages to face-to face interviewing, both from a western perspective and from a “Māori-centred” perspective. Rice and Ezzy’s description of a good interview being “like a good conversation” best characterises the type of interview

I was striving to conduct with both key informants and providers (Rice and Ezzy 2002, p.51). Rice and Ezzy (2002) note that in good in-depth interviews, the good interviewer works hard at listening, as careful listening allows the interviewer to ask questions which make the respondent think and in turn, expose what they do and how they do it. Stokes, in writing about Māori research states that the researcher who has learned to listen quietly will “learn more and so be more effective” (Stokes 1992, p.11). From a Māori-centred perspective the face-to face interviewing resonates with the cultural imperative to undertake exchanges between people *kanohi ki te kanohi*; literally face to face. Face to face interviewing has found favour amongst a number of Māori researchers in the past not only because of the personal nature of the method but also because of the importance Māori place on the researcher being accountable to the research participants (Milroy 1996). In order to be true to both the intent of the research, and to myself as a Māori researcher, face to face interviewing was not only methodologically the best way to collect data, but in keeping with the values of the project.

The semi-structured interview was again used for the benefits the method brought to the project. Using an interview schedule yet being flexible about that schedule allowed respondents to develop and work through their own ideas and speak widely on issues (Denscombe 2003). The use of the semi-structured schedule allowed previously unthought-of connections and themes to emerge and resulted in a very rich dataset. Bowling (1997) notes that in semi-structured interviews, interviewers are able to probe fully for responses, more information of greater depth can be obtained and response rates are generally higher than with postal or telephone interviews. According to Polit and Hungler (1995), the semi-structured interview is best used when the researcher wants to be sure that a given set of topics is covered in the interview, so that themes across interviews can be tracked, yet is open enough to allow for outlying views to be expressed.

An interview schedule, based on the literature review and consisting of a range of open-ended questions, was devised and tested on a former Māori mental health worker in April 2003 for clarity and ease of understanding. Minor amendments were made to the schedule so that it could be administered more easily at the interview. The final schedule comprised twelve main questions used to “guide the interview” although

questions could be dropped and new ones added at my own discretion, depending on the expertise and knowledge of the key informant. The use of a base interview schedule did however ensure some level of consistency across interviews. Key informant interviews took place between August 2003 and February 2004. From these interviews, other key informants were identified which required a further round of “mop-up” interviews in June and July of 2004. In all a total of twenty individuals were interviewed including the pilot interview.

Key informants interviews took place in a venue that was agreeable to the participant. Often this required traveling and meeting with key informants in their place of work, however some interviews were done in my office at Massey and yet others done in the key informants' home. Interviewing usually took between 45 and 90 minutes and began with an introductory phase where I introduced myself and my whakapapa as well as the research. Grbich refers to this time prior to the interview proper as the “settling-down” time, where the nature and purpose of the research and the interviewee's rights may need to be recalled (Grbich 1999, p.98). Indeed it was during this part of the interview I ran over the information sheet and consent form, ensuring that the latter was signed prior to the start of the interview. Once this breaking of the ice” had been achieved the interview proper began. During the interview key informants were asked about their understanding of performance measurement and performance standards and how these are promulgated, applied and implemented within the public service and in health. They were also asked about how the performance of Māori health providers is assessed, what criteria should be used when assessing the performance of Māori health providers, and what role a ‘cultural’ performance measure might have in an overall performance measurement system. At the conclusion of the interview key informants were given the opportunity to clarify anything about the research and asked whether they could suggest other experts in the fields of Māori mental health and performance measurement whose knowledge and expertise might benefit the study. Key informants were given a card and koha in acknowledgement of their gift of their time and the interview was concluded.

Interviews were taped (with permission), and transcribed as soon after the interview as possible. Transcribing was done on both analogue and digital transcribing equipment, by three separate people. Each of these people was required to sign a transcriber

confidentiality form to ensure the confidentiality of the material collected (Appendix 7). Transcriptions were sent back to respondents for checking, either in hard copy form, or electronically. While this was an important part of remaining accountable to the participants, only one of the key informants made extensive changes to their script. Changes, when made at all, included correcting names and grammar. Transcripts and tapes were identified by code only; all identifying information was removed after the transcripts had been checked by participants. Codes were kept in a locked drawer, separate from the tapes and the transcripts, at my office at Massey University.

A preliminary analysis of the interviews was undertaken prior to the second stage of fieldwork, the interviews with providers. This preliminary analysis resulted in the creation of a table which outlined in summary form, the major reasons key informants gave as to why Māori mental health providers might deliver over and above their contracted outputs (Appendix 8). This table was used in the second phase of the research: interviews with providers.

### ***Phase 2 – Interviews with Providers***

The second data collection phase of the research involved interviews with Māori community-based mental health providers who held one or more mental health contracts with the Ministry of Health, DHB or other funder (eg: MDO).

Once again face-to-face, in-depth, semi-structured interviews were undertaken with providers. However unlike the key informant interviews which tended to be conducted solely with the researcher and the individual key informant, providers were informed prior to the interview that group interviews were more than welcome. Interview schedules were sent out to the providers ahead of time, so that they had the opportunity to prepare responses and the number of people at the provider interviews was then left to the provider to determine. For example, in the case of one provider, a manager and a member of the Board participated in the same interview, while at another provider, the manager and two staff members participated in the same interview. My rationale in allowing the opportunity for group interviews was to take as little time as possible from the providers, who I knew to be busy with their own work. I was very thankful to those providers who did agree to participate and therefore wanted to make the burden of being interviewed as painless as possible. Using group interviews had both positive and

negative points. On the positive side these interviews tended to be more dynamic, vibrant and wide ranging in their scope. By the same token however these more dynamic interviews were also the most difficult to transcribe.

The provider interview schedule was derived from the literature and from the preliminary analysis of the key informant interviews. A “test” interview schedule for providers was used in the first provider interview completed in August of 2003. This interview was undertaken early in the fieldwork (indeed key informant interviews were only just starting), because the provider volunteered to be interviewed at the consultation hui (as discussed above). Because the provider was so keen, and because I had the time, I decided to strike while “the iron was hot” and go ahead and conduct the interview, using a then draft schedule. This schedule became the basis of the provider interview schedule used in the remaining interviews.

The schedule comprised thirteen main questions and, as with the key informant interview schedule, questions could be dropped and new ones added as necessary. In addition to the interview schedule all providers, apart from the first provider interviewed in August 2003, were also asked to comment on the table derived from the preliminary analysis of the key informant interviews (ie: reasons as to why Māori mental health providers might deliver over and above their contracted outputs). Providers were asked whether they agreed or disagreed with the reasons key informants had given, what if anything they would add and whether any reasons had been omitted.

Provider interviews, with the exception of the August 2003 interview, took place between June and October 2004. In all a total of seven providers, comprising a mix of some 15 staff and board members, were interviewed. Providers were asked whether there were any tangata whaiora or whānau members who may have wanted to participate in the research. I had made sure in my ethics application to note that tangata whaiora may be participating interviews and had given consideration to the processes and procedures necessary to ensure the safety of all participants. However no tangata whaiora volunteered to participate and as a result these processes and precautions were never invoked. Provider interviews invariably took place at the provider’s place of business. According to the type of provider, this might have been a health centre on, or attached to a marae, a converted private residence in town, or in an office block.

Provider interviews lasted between 45 minutes and 2 hours and usually began with morning tea, which I brought with me. During the morning tea I would reiterate the research, its purpose and answer any questions that the provider might have. I found this time to be particularly valuable, both for making whakapapa and other connections as well as allowing people to relax and become mentally prepared for the interview.

Provider interviews commenced with a review of the information sheet and consent form (Appendix 9). Providers were asked their understanding of how their performance was measured; whether these measures or their contracts adequately captured the extent of their work; what additional work they did do and why; and how they thought the current situation might be improved. Finally providers were asked about their accountabilities and how they knew when they were being successful as Māori health providers (Appendix 10). Providers were also given the opportunity to ask any questions they might have about the research. At the conclusion of each interview, participants were given a card and a koha.

Interviews were taped (with permission), and transcribed as soon after the interview as possible. All the tapes, research notes and hard copies of the transcriptions were kept in a locked cabinet at my office at Massey University. A protocol outlining the process for storing, retrieving, destroying and/or returning interview information (including tapes) based on the National Ethics Committee regulations governing research data was developed for participants. An example of this protocol is attached as Appendix 11.

In all a total of 35 key informants and staff and management of Māori mental health providers were interviewed for this research. In a process of triangulation the data collected in these interviews was compared with the thematic analysis undertaken of the contract and performance monitoring documentation and with the journal and field notes. This process of analysis is described in detail below.

### ***Analysis***

The analysis involved a number of stages: i) analysing the information collected in the key informant interviews, ii) analysing the information collected in the provider, interviews, iii) analysing the contractual and other documentary material collected, iv)

analysis and inclusion of field note and research journal data; v) analysis of the material as a whole. The data collection and data analysis has been developed in an iterative process allowing for theory development which is grounded in empirical evidence collected. As described briefly above, as key informant material was collected, a preliminary content analysis was undertaken in order to formulate the questions for the provider interview schedule. The preliminary findings regarding “reasons for overprovision” were also used during interviews with providers in table form. As provider material was collected and analysed, themes and theories were developed and noted in the research journal for further analysis at the conclusion of the fieldwork.

Content analysis was the primary analytical process used with the interview transcripts. Content analysis (Patton 1990; Crabtree and Miller 1992; Yin 1994), allows for a careful description of the data and the development of categories in which to place processes and behaviours. In content analysis the data are organised around key themes and further examined to see how well the data fits or fails the categories. Because data are analysed as they are collected (i.e. after transcription) theories or patterns may be developed and further explored in successive cycles of data collection and analysis. It is also possible to examine data at this stage for potential sources of bias and inconsistencies which can be selectively explored in the following collection phase.

The interviews with key informants and providers were initially analysed by defining broad categories derived from the interview schedule, reflections on the literature and, in the case of provider interviews, the interviews with key informants. Interview notes were reviewed and coded according to these categories and new themes were sought. Previously coded interviews were re-coded as new themes emerged. The themes arising were then interpreted and the notes from each interview reviewed in light of the interpretations, to see if anything had been omitted.

Coding and analysis of data was done both manually and using NVivo, a specialist software package for qualitative data analysis. NVivo is particularly helpful when dealing with large transcripts and managing large quantities of qualitative material. It is also invaluable for fast and accurate retrieval of previously coded material. The majority of the interview transcripts were coded, stored and managed in NVivo. The remainder of the transcripts were coded and managed manually.

The analysis of the contract and performance measurement documentation was done manually, again using thematic content analysis. Documentary material was accessed from six of the seven providers that participated in the research. Of the seven providers, one declined to release any documentary material, citing commercial sensitivity, while a further service provided performance monitoring material, but declined to release contractual material, again citing commercial sensitivity issues. Providers were asked to provide a current mental health contract for the purposes of this research and it was up to the provider to choose which contract to make available. Some of the smaller providers only had one mental health contract with a funder, while other larger providers simply selected one of the range of contracts they had, for use in this research.

The coding frame for this material was derived from interviews with providers as well as by a preliminary analysis of the contracts themselves. Contracts were analysed by type of contract, type of language used (including jargon), complexity and ease of use, while performance monitoring documentation was reviewed primarily for examples of monitoring information collected and the types of information reported in the narrative section.

Interview transcripts were also analysed against the field notes and entries in the research journal. Field notes were written up immediately after each interview and contained information about how well I regarded the interview to have been conducted. For example field notes may have included my perceptions on how comfortable the participant was in answering the schedule, areas to explore in subsequent interviews or even areas of weakness in my own interviewing technique. Field notes also contained extra material that may have been said after the tape had been switched off, but which was still relevant to the research and my own reflections on the content of the interview that had just been carried out. The research journal contained similar information as my field notes as well as factual material about interview times, locations and during the course of the provider interviews, material about the service itself. The research journal was also used to note undertakings I had made to any of the participants which needed to be followed up at a later date. Both the field notes and the research journal material augmented the interview data and were analysed for additional themes or insights into the research. An example of a journal entry is contained in Appendix 12.

Once the initial analysis had been completed findings were fed back to the participants for comment. The feed back stage was a crucial part of the study as it fulfilled a number of functions. It allowed the participants to remain involved in the research and preserved a sense of ownership in the results. It also afforded participants the opportunity to provide comment, clarification, or additional information on the research. Finally the feed back stage provided an opportunity to regard the analysis with “fresh eyes”.

A critical component of the research is the production of a Māori analysis of the data. While much has been written about Māori methods, ways of collecting data that are appropriate and take cognisance of Māori cultural beliefs and norms, only a few contemporary Māori thinkers and researchers have attempted to characterise the elements of a “Māori analysis” (Durie 1998b; Reid 1999; Cunningham 2000), despite there being many Māori researchers, myself included who would argue that it is a uniquely Māori analysis that they bring to their research findings. It would be fair to say that as more Māori become involved in research, so our understanding of what constitutes a Māori analysis deepens. At its simplest, Māori analysis involves the use of Māori frameworks and models to analyse the data that has been collected. A Māori analysis occurs within a Māori philosophical framework and has as its ultimate goal the improvement and development of Māori. In direct contrast to research “on” Māori which is characterised by being descriptive, offering few insights for Māori (Stokes 1992), belittles Māori history and knowledge (Bishop and Glynn 1992), and rarely benefits research participants (Jahnke and Taiapa 1999), a Māori analysis celebrates the diversity and unique nature of the Māori culture, and applies a Māori “lens” to the research findings. According to Reid, a Māori analysis places Māori experience at the centre of the theoretical base. It wholeheartedly accepts Māori and our processes as the reality (Reid 1998). Durie has noted that

*analysis based on frameworks relevant to Māori must be a fundamental goal of Māori research... it recognises that the design of research and the interpretation of data are not themselves mechanical tasks but are very much shaped by context values and assumptions. (Durie 1998b, p.422)*

In conducting a Māori analysis, findings are reviewed from a perspective that acknowledges and validates Māori ways of knowing, Māori ontology and epistemology. The term “Māori analysis” in this sense indicates that Māori language, culture, concepts, belief and knowledge form the basis of the analysis. The production of a Māori analysis validates Māori knowledge and the perception that there is a uniquely Māori way of viewing the world (Smith 1999).

## **Information Dissemination**

A key feature of Māori research is the need to keep the participants informed of how the research is progressing and to report back the results of the research as quickly as possible. Smith notes that the commitment to report back is partly a tangible demonstration of “the commitment to reciprocity and partly a matter of accountability” (Smith 1996, p.29). According to Jahnke and Taiapa (1999) the notion of accountability back to Māori as a collective has its roots in Māori attitudes to knowledge and the accessing of that knowledge. Bishop and Glynn (1992) note that at the conclusion of any study researchers should be available to report back to participants in a culturally appropriate manner. The value of this task should not be underestimated they argue, as it has significance in terms of acknowledging formally the contribution made by all participants as well as highlighting the importance of the research to the community.

For this research project feedback occurred both in oral form and in written form, as encouraged by Durie (1992). Research participants have had regular informal updates of how the research is progressing, usually by phone or email and the opportunity to feedback on their own transcripts. Two formal feedback sessions have been incorporated into the research design including reporting on preliminary results after the key informant interviews were undertaken and a series of hui to feed back the final results to providers.

In addition to feeding back the research findings to all those who participated in the study, and in keeping with the ideals of remaining accountable to the wider Māori community, the results of the research will also be disseminated as widely as possible to iwi, hapū, whānau and Māori. There are a number of specific groups to whom the results of the research will be targeted and the means of disseminating the research

results will differ accordingly. For example information will be disseminated to Māori academics and health researchers via the usual channels of e-mail networks, seminars, journal articles and conference presentations. It is intended that the results of this research inform public policy, therefore the results of the research will be made available to Te Puni Kōkiri, the Ministry of Health and District Health Boards. Dissemination to the Māori mental health community will involve informing organisations such as Te Rau Matatini and Nga Ngaru Hauora to the research findings and offering copies of the research to interested parties. Information regarding the research findings may also be disseminated to the wider Māori community through Te Puni Kōkiri regional offices and through newspapers and newsletters such as Kōkiri Paetae and Pū Kaea.

### **Rigour in the Research Process**

One of the main issues in any research project is how to ensure the “truthfulness” of the data that is collected and presented. In the area of health research in particular, qualitative research is often criticised for lacking “scientific rigour” (Mays and Pope 1995, p.9). Whereas in quantitative research rigour is assumed by how well a study can be reproduced or the generalisability of research findings, in qualitative research the concern lies with ensuring the data and the analysis is credible and transferable. The concept of rigour takes on a “postmodernist” aspect when applied to Māori health research as it may be considered as a moral and ethical task, focused on emancipation or political action (Rice and Ezzy 2002). In this context rigour must also be concerned with culturally congruent practices of data collection and analysis and the commitment that undertaking the research will contribute in a positive manner to broader Māori development goals.

Mays and Pope (1995) note that aside from adopting a basic research strategy that is systematic and self conscious, researchers should seek to achieve two goals in qualitative research: first to create an account of method and data which can stand independently, so that another trained researcher could analyse the same data the same way and come up with essentially the same set of conclusions; and second to produce a plausible and coherent explanation of the phenomenon under study. Mays and Pope note a number of lower order methods which researchers can employ in order to achieve

these loftier goals. Some of these were employed in this study to ensure rigour was achieved and maintained.

This study used systematic, non-probabilistic sampling to purposefully identify specific groups of people who possessed particular characteristics relevant to the phenomena being studied: in this case Māori mental health. This form of sampling is regarded by Mays and Pope (1995) as an alternative to statistical sampling and allows the researcher to deliberately select key informants with access to important sources of knowledge. While the resulting sample might not be statistically representative, the sample drawn has direct relevance to the research questions.

Keeping a research journal and research notes was an important means of tracking decisions made throughout the ethics process and field work stages of the research (Mays and Pope 1995). Research notes were used to document the process of analysis and were reviewed as the research progressed. To ensure the validity of the findings, data pertaining to performance measurement and contracting was obtained both through interviews and by the collection and analysis of documentary material. Transcripts and draft finding and analysis chapters were sent back to participants for comments and review.

In terms of maintaining the rigour and integrity of the research as a piece of Māori health research, particular protocols and processes were required of the study. In Māori research ensuring rigour in the process of collecting the data is as important as ensuring the validity of the findings themselves. To that end the study adopted culturally congruent processes wherever practicable, such as the use of a pre-consultation phase, the decision to travel to research sites with either a colleague or whānau, and the commitment to undertake face-to-face dissemination of the results of the research. In addition the research was guided by a series of ethical considerations. These are detailed below.

## **Ethical Considerations**

The nature of this research was such that even from the very early developmental stages of the project, a number of ethical concerns had to be considered for the project to reach a successful conclusion. In an earlier chapter I outlined the critical personal principles

which would underpin this research project. To reiterate these were to undertake a project which contributed positively to Māori development; to undertake a research project with integrity; and to undertake a project in which the safety of all involved was ensured.

Carrying out the research would involve investigating the views and perceptions of at least two vulnerable populations in the health sector, namely Māori and tangata whaiora. I qualify the use of the term “vulnerable” to describe Māori in the sense that Māori have had a long history of being researched, of gaining little from that research and of being rightly suspicious and dubious of the benefits that would accrue to them of research. Mental health consumers similarly are all too aware of research *about* them, which has either not included consumers as participants, or in instances where consumers have been participants, discounted and dismissed consumer voices and experiences (Peterson 1999).

I was therefore very conscious of the need to consider the range of ethical challenges that might be raised during the field work stage of the research. In the process of developing an ethics protocol I was guided by a range of publications and policies developed to assist researchers manage the ethical issues raised in research with Māori and in research in the health sector more specifically (Manatu Māori 1991; Health Research Council of New Zealand 1997; Health Research Council of New Zealand 1998; Te Pūmanawa Hauora 1999). I was also guided by the efforts of those Māori researchers who had gone before and written about their experiences in working with Māori and Māori communities. For example the seven guidelines of Māori research ethics derived from Linda Mead’s thesis (Cram 2001) discussed in the previous chapter have been a practical guide in my interaction with the research participants. At another level these seven guidelines are intertwined with the principals that form the theoretical basis of the thesis; those of positive Māori development. The key ethical issues I considered when drafting the ethics protocol were i) my role as the researcher, ii) ensuring informed consent, iii) managing issues of privacy and confidentiality, (including access to and ownership of the data) and iv) a commitment to do no harm (particularly with respect to tangata whaiora and their whānau).

### ***The Researcher's Role:***

As a Māori researcher, undertaking research with mainly Māori participants, my role and my responsibilities were governed by tikanga Māori as well as good research practice from a western point of view. In meeting with potential research participants, particularly during the consultation phase, it was important to clarify the expectations I had of participants, as well as what participants might expect from me. My accountability back to participants and to the Māori community more widely, was explained and tangible examples of how this accountability would be manifest were given. Establishing a relationship of trust early on with all research participants, but in particular with the Māori mental health providers, was crucial to the research. Whereas interviews with key informants may have been easier to arrange and conduct (ie: it may have been easier to discuss government policies and practices), I was conscious that Māori providers may have been less inclined to want to participate this project for a variety of reasons (not the least being workload). Therefore it was imperative the nature, purpose and likely time commitment required was clearly articulated to the research participants. In addition, I felt it was important to provide participants with information on my background, motivation and organisational affiliation in order to assist participants to make an informed choice about being involved in the research.

In accordance with the Māori-centred research design, participants were encouraged to share in the research process wherever possible. Because the research was a university-based, academic exercise in the first instance, rather than a community-led and driven project, opportunities to share control of the project were limited. However providing participants with transcripts of their interviews to check and amend and giving them the opportunity to comment on relevant chapters of the thesis were some of the ways in which I hoped to make the process an inclusive one.

### ***Informed Consent:***

Informed consent is a cornerstone of the research. Wilkinson (2001) notes that informed consent is required because it best respects the autonomy of the subjects and because it protects the subjects. For these reason, both oral and written consent was obtained from the participants where-ever possible and appropriate. Informed consent requires that, in consenting, participants are aware of the purpose of the research, their role in it, the reason for their selection, the protection they would receive as research

participants and how the data would be used. It was made clear at the outset that any information participants provide must be voluntarily given and that they had the right to remove themselves from the research at any stage.

***Managing Privacy and Confidentiality:***

A written guarantee of confidentiality was provided to the Māori health providers prior to the interviews as part of seeking their consent to participate. All identifying information including names was removed from the raw data and codes were used to ensure that the identification of individuals was possible only by reference to a master index which was stored separately from the raw data. All reasonable care was taken to ensure that the data collected is stored securely, in a locked cabinet. The procedures for accessing the data, including tapes and hard copy transcripts have been outlined above as too have the procedures for the storage and eventual destruction or return of the research material. Participants are able to access their raw data at any time. The thesis which is produced from the raw data remains the property of Massey University.

***A Commitment to Do No Harm:***

Perhaps the most pressing issue for any researcher in mental health, and especially Māori mental health is to ensure that no harm is done to the research participants and at the same time ensure the safety of the research team. This was certainly a key concern of the Ethics Committees that considered my ethics application and a lot of effort went into assuaging the committees' fears regarding undertaking research with tangata whaiora. In particular the Committees' concerns centred around "physical and psychological risk to participants and third parties".

The risk of physical violence with this research were minimal, however I did acknowledge there was the chance, although slight, of tangata whaiora suffering some psychological trauma if they agreed to participate in the project. In the end, no tangata whaiora opted to participate in the research, however strategies to minimise risk were incorporated into the project's research design. Strategies included offering tangata whaiora the opportunity of bringing a support person to the interview; making contact numbers of support services available; and making information about the agencies able to deal with specific mental health service complaints available (e.g. services consumer representatives, health advocacy services, local DHB or Ministry of Health).

For my own psychological health my supervisors were available for debriefing following each interview and I had access to further debriefing from my kaumatua, an expert in Māori mental health. In acknowledgment that the interview transcript could contain disturbing material (McCosker, Barnard et al. 2001), those undertaking the transcribing were also debriefed following each interview transcription.

### ***A Contribution to Māori Development***

One further ethical obligation has been uppermost in my mind throughout the various stages of undertaking this research: from prior to the initial drafting of the research proposal, through to applying for ethical approval, in undertaking the fieldwork, in analysing the data and in reporting my findings, and this is to contribute in a positive manner to Māori aspirations for their own development. Remaining true to the latter obligation has required a significant time commitment, one which was underestimated at the outset of the research. However the rewards, in terms of the richness of the data and the relationships that have been forged, certainly cannot be underestimated. It was originally intended that this research inform Māori mental health providers of the scope of their work and reflect back to them the contribution they in turn make in Māori mental health and in Māori development more widely. The comments received already from those who have participated in the research, when commenting on the interim findings and on draft chapters, indicate that this research has resonance in the sector. It remains to be seen how the completed research report might inform Māori mental health providers' aspirations, goals and objectives.

### **Summary**

This chapter outlined the general research approach and specific methods used in this research project. In particular the chapter detailed some of the issues which arose as a result of trying to undertake research in a very changeable, yet dynamic part of the health sector. The difficulties encountered in recruiting a core set of providers indicate that the Māori mental health workforce is at once, both fluid and fragile. It was therefore a privilege to have been able to access so many enthusiastic and passionate people in the course of undertaking this research. The chapter has drawn to a close by outlining how the privilege extended to me by the participants has in turn been

honoured; through the dissemination of information and through the ethical principles which guided the research.

## Chapter Six

### **“Putting in a Dime to Get a Dollar Song”<sup>11</sup>: Findings from Key Informant Interviews**

*You got a hundred percent success rate in terms of maybe ten whaiora when the contract expects you to have forty outputs. It’s kinda like putting in a dime and expecting you to sing a dollar song that pleases only the ones who put the dime in and not the ones who are listening*

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#### **Introduction**

This chapter presents the findings from the key informant interviews. The views presented here are as wide ranging and varied as the key informants themselves. Twenty key informant interviews were undertaken, with respondents comprising Ministry of Health (MoH) officials, other government officials, District Health Board (DHB) staff, academics, independent contractors working in Māori mental health, staff and managers of Māori mental health providers and staff of a Primary Health Care Organisation (PHO). The chapter is structured according to the main topics of inquiry derived from the interview schedule as well as major themes that emerged from the interviews themselves. The chapter begins by presenting key informant views on what is meant by performance measurement; what the current measures are and how these were developed; and how the performance of Māori mental health providers is measured.

The chapter then presents the respondents’ views on the adequacy of these performance measures and of the contracts between providers and funders. The additional work that Māori mental health providers do and reasons for undertaking this additional work are

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<sup>11</sup> Key Informant Interview 25 February 2004.

outlined before presenting respondents' views regarding possible improvements to the performance measurement and contracting system. Views on how the performance of Māori mental health providers should be measured and perspectives on accountability are presented at the end of the chapter. The chapter concludes by summarising the main findings from the key informant interviews.

Within the chapter the terms key informant, informant, respondent and participant are used interchangeably. To ensure the anonymity of views, codes have been used to refer to each different key informant; thus, quotes are followed by the informant's code (e.g. KI01), with the number after the colon (e.g. KI01:12) referring to the relevant page in their interview transcript.

## **Understandings of Performance Measurement in Māori Mental Health**

At the start of the interview and to introduce the topic, key informants were asked to describe what they understood by the term “performance measurement” as it is applied in the health sector and what types of things the Crown, or Government was interested in measuring when it came to the work of Māori mental health providers. This produced a range of responses regarding informants' understanding of the term “performance measurement”, reflecting the nature of the respondents' profession, their role within that profession and their familiarity with performance monitoring. Respondents noted that, at its most basic, performance measurement is the tool by which the Government can ascertain whether it is receiving value for money (KI10:14, KI05:22). One respondent who worked at a governmental level noted:

*If we talk about performance measures in relation to contracted services and where Māori providers are concerned, they can be quite useful because they provide a clear guideline for what it is they, Māori providers, are accountable or responsible for in terms of the contract. They are clear about what areas of health they have responsibility for and those measures they are accountable for in terms of delivery of services, back to whoever is funding those services. They're useful in that way. KI06:2*

By comparison, when asked to comment on what the term “performance measurement” meant a respondent working in the community stated:

*We have an expectation from the department to fulfil certain things. When we give a report every quarter ... we have to state numbers, we have to state how many face to face we see ... All of those things which are okay to a point ... they indicate how often we see whānau, what for, but in terms of measuring whether... the outcome's good or bad, we don't have a measurement from them [the department] or an expectation from them. Internally in our own organisation we have more than that. We would be more concerned about whether there's been an improvement since we first met them. So our measurement would be based on whether they ... want to see us more, whether they broaden out to other issues. Quite often they'll talk about relationships with other friends, they'll talk about things that are happening in their lives. They're more intimate with us and that's the measurement, an internal measurement, we will identify whether they're more intimate with us as workers. KI04:1*

Another respondent had a similar perspective regarding measuring the health and wellbeing of tangata whaiora noting:

*Performance measurements to me perhaps, given my background, is more giving the person a good sense of wellbeing once they've used the services of any health provider but in particular for mental health it was ensuring that ... people did have a good sense of wellbeing and confidence no matter what the diagnosis. Yeah. But that was pretty hard to measure because sometimes a good sense of wellbeing is just telling somebody to go home too. Sometimes a good sense of wellbeing means having a job. Sometimes a good sense of wellbeing was understanding te reo. So performance measures had to be agreed to by whomever you had the contract with and whoever was developing policy because ... to get those performance measures could also mean using a huge amount of resources to get to that point. KI02:2*

According to most key informants the government was likely to be interested in “inputs” and particularly in quantitative measures such as how many staff a provider has

and the number of things a provider has agreed to do in their contract (KI06:2). Input measures are regarded as easy to use and easy to collect. One informant observed that funders will have great difficulty in replacing input performance measures, simply because input information is so easy to collect (KI06:4).

*The emphasis is on ... volumes and measures of input and that might be in terms of ...number of people, the number of particular procedures applied to somebody, treatment or whatever, the number of FTEs, the number of bed days .... Outcomes is a very limited part of health sector contracting at the moment and whilst there are some contracts that I've seen, you know 'what did you achieve, what was the gain as a result of your interaction at the time with whānau', it's predominantly input-based and volume-output based, rather than outcomes. KI08:1*

A key concern noted by one respondent was while there were plenty of input measures (such as the number of Full Time Equivalents employed) and output measures (such as the number of contacts or meetings), there are no output measures of any significance, nor any outcome measures which the mental health system can use (KI05:17). Another respondent noted that there were in fact very few effective performance measures for Māori mental health providers.

*In terms of the contract environments ..., the Māori contracts, there are no, well ... there are virtually no, what I would consider effective performance measures. There are volumes that they report on ... there are some outputs that they report on and ... things like number of hui held, number of ... number of beds occupied, number of referrals made maybe to secondary services ... and I think probably the closest you'd get to some sort of performance measures might be what you would consider an intermediate indicator, something like the number of referrals into secondary care, which might be an indicator of well managed care in the primary sector. KI11:1*

## **The Development of the Current Measurement Framework**

Respondents were asked a series of questions designed to discover the origins of New Zealand's mental health performance measurement framework, including how the measures were developed, whether there are differences in how performance is

measured at a central government level and how the performance of Non-Governmental Organisations (NGO), such as Māori mental health providers, is measured.

Very few key informants were able to discuss with certainty the derivation of the New Zealand's mental health performance measurement framework and even fewer commented on performance measurement at a central government level compared with the performance measurement of NGOs. However one respondent was able to outline the performance measurement framework in use in the mental health sector in some detail. That informant noted that the origins of the current system have as much to do with key people working in the health sector, as with specific windows of opportunity that arose during periods of health reform.

*I actually think a lot about the process was about key people who really wanted mental health to get its place in the sun. The key processes around that like the Mason Report etc. So that I'm not sure whether we would say the government intended to set out to develop the mental health sector or the mental health performance measures. I think it has related hugely to some very key players who believed in the sector and unfortunately some crises that ... helped their lobbying perhaps. So from that it was saying 'well how will we know we've made a difference? How will we know, we've made progress? If the Government is going to invest additional money, what information will the Government get back to justify that expenditure?' So ... I think that's actually been quite a robust process overall. KI03:2*

It became clear through this interview that measuring performance in the mental health sector occurs at a number of levels and for a range of reasons. At one level the Government is concerned with tracking how the money appropriated to the sector is being spent. This is the input focus.

*It's a very input-based system and to a degree I can absolutely understand and accept why that happened when I look at ... the Health Funding Authority. Their desire was to see how ... performance against the Blueprint could be tracked and the best way to see that was to see people on the ground, able to deliver the services. So it was something that was very important for that time. KI03:1*

At another level, the Government as the funder is concerned with ensuring Māori mental health providers comply with their contractual obligations and deliver what they have been paid or funded to do.

*Some of the other ... reporting requirements that are in contracts ... may not actually relate to anything and nobody does anything with it. They are mainly ... contractual requirements and there may be some other things ... a lot about numbers, a lot about volumes, FTEs, staff, what their qualifications, whether they're clinical or non-clinical. The narratives, any narrative reports are very important to check them out. KI03:6*

At yet a third level the Government is concerned that all mental health providers, including Māori mental health providers, are delivering a high quality service. The quality audit is the main tool employed for this purpose.

*... [providers] would be measured during an audit programme and we've had over the past two years audit programmes that I think would now have included all of our community Māori mental health providers and a good deal of other non-Māori providers to say 'at a quality level, are you meeting the terms of your contract, can you describe to us that you're indeed a kaupapa Māori service?' KI03:5*

Audits include a range of quality measures; however, one respondent noted that these measures are very generic and based on western concepts and values.

*The performance measures are ... generically based, so ... they're measured on the clinical component quite strongly, the management component, and the management component is using western paradigms not, it doesn't account for any kind of indigenous management practices. And the other one would be the sort of HR, financial areas and then there's these sort of add on cultural components which are more around things like ... 'How's the provider implementing the Treaty of Waitangi?' But there's nothing behind that that says these are the components that must be demonstrated. It's just a broad question because I don't think they know either. And you might get also things like 'How's the provider involving whānau? What are the relationships between the provider and local iwi?' so they're more systemic kind of issues. I don't*

*remember much about Māori models ... in terms of delivering the service, but I would say that ... the cultural component is probably like about 10% and then the rest is mostly mainstream sort of indicators. KI09:5*

The same respondent indicated that one of the government's key concerns in terms of provider performance was managing risk:

*Risk is a biggy ... mitigating risk, yeah. That's a big one and that's probably ... public pressure that brings that about ... especially around issues to do with homicide or suicide or serious assaults and that sort of interface between justice and ...[the] court ... Mental health would be one of the few areas where that interface is so close. KI09:2*

## **How the Performance of Māori Mental Health Providers is Measured**

Participants were asked to identify how the performance of Māori mental health providers is measured by the Crown or funder and whether the performance of Māori mental health providers should be measured in the same way as mainstream services.

Respondents noted that there are several ways of measuring the performance of Māori mental health providers, some of which are more formal than others. For example performance can be assessed through the contracts providers have with funders; through performance monitoring returns; or through an audit process, where part of that process involves talking to clients and observing the provider in their day to day work (KI02:5).

*There's a standard contract and all they do is underneath the standard contract, they put this stuff [points to Nationwide Mental Health Service Framework 2001]. So in here you've got a description of what you have to provide for a residential service. And all they do is they take that out, put it into the contract and they might put some more detail in there and then that ... forms the contract. And then ... for each of those services you've got a measurement. KI13:8*

*I mean ultimately it's the DHB ... who are responsible for ... that sort of quality control or contract compliance. And ... we're only just entering ... the arena of*

*quality control basically. I mean, we've had it in the hospitals for a while under accreditation, we've had it in ... the residential care area, beds, you know? Like inpatient beds if you like ... So all of the rest homes and stuff like that are going through that ... but eventually it will roll out to all of the primary care sector and other providers. And so this ... is the first time that there has been a DHB external audit ... of Māori providers. They've had other audits through various, ... other contract funders but ... we're just starting to get our heads around what all of this means really. And its had huge implications for our Māori provider network because its shown up quite a few gaps in service delivery and contract compliance. KI11:3*

Some respondents noted that Māori tend to take a more outcomes-focused approach to service delivery, whereas funders are more concerned with outputs.

*I mean all they collect is quantitative data. They do not collect qualitative data. Now for our own Trust we collect qualitative data here, because we need to know whether we are actually making a difference to people's lives or whether we are just mechanically going about delivering a service because if that's what we're doing there's no point in us being here. KI20:2*

The difference in emphasis between a focus on outcomes and one on outputs may result in Māori mental health providers appearing to have “failed” in delivering on their contracted outputs.

*Contracts have an expectation of output ... You're a successful provider if your output is this high in numbers ... Whereas ... Māori often fail in their contracts because they have an inherent interest in outcome and are outcome focused. However, if you are outcome focused for Māori then you're gonna cost somebody mega bucks. And if you cost someone mega bucks even though you've got a hundred percent effectiveness in your outcome, you are a failure in the eyes of the contractors because you got a hundred percent success rate in terms of maybe ten whaiora when the contract expects you to have forty outputs. KI12:5*

One respondent was very concerned at the funders' reliance upon, and seemingly inappropriate use of, audits to track the performance of Māori mental health providers,

rather than regular performance monitoring and monitoring of progress against a contract.

*The trouble is many Māori NGOs in particular, are very concerned about the number of audits they face compared with non-Māori, they have two, three, four times a year. Ridiculous. See one of the things that the system has failed on is the distinction between ... normal performance monitoring of the contract and the function of audit. They're entirely different things. What we tend to do in the health sector, in the past anyway, is to use the audit as both ... it's an examination of your ... total activity ... and whether or not it fulfils whatever criteria that you've set for an organisation of that sort. The ... performance monitoring is something to do with the contract itself, 'a' contract, whether or not you're actually providing what was expected within that contract. It's very specific. KI05:20*

Less formal measures were also identified and include the profile of the provider in the community and what is said of providers by their peers.

## **Adequacy of Performance Measures and Monitoring Returns**

Many respondents identified that the performance measures currently in use in Māori mental health were inadequate. The reasons they gave varied. One respondent noted that the measures were not particularly useful as they were “generic” (KI06:3), designed to be broad so they could be used across a myriad of different mental health service types. Another respondent noted that the measures did not capture the work of Māori mental health providers because “Māori work in fundamentally different ways”. In addition, the informant noted that Māori consumers access services differently, for different outcomes. Whereas for DHBs it is the clinical component of a Māori mental health service that is important, for many tangata whaiora it is the cultural aspects which draw them to a particular service (KI17:4). Yet another informant noted that it is precisely because of the additional services that a Māori mental health provider is willing to offer that tangata whaiora are able to cope when they become unwell:

*What we did is we broadened the little piece of mental health to include all those other things that have such impact on this piece here to actually eliminate or minimise those things that happen for our people when they're unwell. If you*

*look after all that, education, vocation, socialisation, you know, the cultural side of things [then] this bit becomes smaller and smaller and smaller, and becomes bearable. It becomes manageable. It might not fully go away but it's bearable and it's manageable. KI20:2*

Some Māori working in Māori mental health recognise that simply describing or listing the additional work done by providers in the narrative part of the performance monitoring return is insufficient and that what may be required is a separate formal report to DHBs to apprise them of the extent of the extra work that is being undertaken.

*It's not enough to do it [describe the additional work done] through the reporting process. Document it and regular meetings over and above that. Say to our funders, 'you need to do something because if you don't, this is what's going to happen, ... you need to either fund us extra for doing that or you need to tell us where to go to get that support.' KI18:10*

There is also a perception that neither the funders, nor the MoH have an accurate idea of the scope of the work of Māori mental health providers or the quality of their work as the reporting system was solely concerned with quantities and volumes.

*At that point they still didn't have a system which would be able to identify either way and to be quite honest we were also told that when they got our reports every quarter they took no notice of it. You could tell because they didn't actually give a feedback or didn't actually know. 'Yeah, we've met that and that's it. They never ever questioned it or .... said 'hey we're concerned about this'. They're starting to now, have a look at that, but basically they have no idea really of the amount of work ... You could see by the reports that we gave back, or certainly the numbers, it was more about number crunching. Hours and contacts and stuff like that but never anything about the quality of what ... we did. We just carried on, rolled over to the next contract. KI04:6*

Another informant noted that the current performance measurement system was not sophisticated enough to measure the time required when working with tangata whaiora.

*If you think of how Māori process ... there's no time limit. I mean, try going to a pōwhiri, they can take anything from five minutes to twenty hours you know?*

*I mean if you've been through that Māori process and what's happening within that process, you can't put a time limit on what should be happening. KI07:13*

*We had a whānau group come from Whakatane a few weeks ago. They came at ten for an hour they said. Seven o'clock that night we were still there ... how do you document that as a statistic. One whānau hui? ... They don't even want to know how many hours but for us that was connectedness for us as a service to that family ... And to think they travelled all the way from Whakatane to come and, and kōrero with us. It was hugely humbling for us, to have that big whānau, you know when I saw them arriving, all of them and then they shared their mamae, it was just so moving. But how do you document that? One hui. No one will ever know the relationships that have been developed there and understanding of what has happened in their family and their iwi. KI20:21*

One key informant noted that the reason current performance measures are inadequate is because they do not take a broad or holistic approach to mental health.

*Because ... they're too concrete and too siloed ... so they don't have a holistic view. They don't look at all of the components that are essential to somebody's mental wellbeing. Housing, employment, you know. Having the ability to pay bills. You know, whether or not children are in school or alternative education. Just about everything, counselling, relationships, yeah. That's the thing you see - mental health is so broad and so huge that it's not like having a broken arm. KI09*

### ***Evolution and Statis***

A number of respondents noted that the sector has moved and evolved since the development and promulgation of the current performance measures. They note that given these changes, it may be time to revisit these performance measures, and update the definitions that sit alongside those measures.

Another informant noted that there is now a disjuncture between high level policy on the one hand and how Māori mental health services are funded on the other.

*Many of the contract requirements for mental health don't go anywhere near measuring effectiveness, they simply measure volumes and they tell you so little*

*about the home visit, they tell you so little about what is done in the process. There should be room for flexibility within ... it should be possible to shift the focus on activity or output and move towards outcomes. Now that was in the coalition government before last, that's what they were going to do. When NZ First and National had a coalition they were moving towards outcome measures. If you've been talking about it for a while and again, it's a pretty slow moving wheel and I think Māori providers are caught up in that lag ... So in some ways it's a bit deceptive that they are given to understand those world views are important except that when it comes down to paying you for what you do, another framework is used. So you can see there's a disjunction between philosophy and practice, a disjunction between policy on the one hand and fee for service on the other. KI15:7*

*Those measures were put together to start off with and because of the sector changes, then ... that hasn't been a priority to revisit those performance measures. I mean, and that's evident by the kōrero that comes from the providers around those issues of, 'what do we, what did that mean again? ... what does the definition mean?' So we need definitions for the definitions. KI18:8*

Two informants commented on a growing recognition by the Ministry of Health to develop performance indicators that “take into account Māori measures of service” (KI06:5) and which record information relevant to Māori service delivery and day-to-day practice. These indicators report items such as “hui” and “whānau meetings” (KI04:16) through to whether the whānau has any issues of a “spiritual or wairua nature” (KI06:5).

Health outcomes, measures of quality and consumer satisfaction were identified as areas where the Ministry of Health is keen to develop more meaningful indicators for Māori mental health providers.

*The emphasis now is on consumer satisfaction and quality of services ... trying to focus on [the] consumer and in so doing, including the consumer in the development of the services. It's interesting, there used to be a really clear delineation between quality driven and quantitatively driven indicators but I*

*find that more and more of the stuff that I read today a lot of the quantitative stuff is what I used to identify as quality only. Enabling consumer input including iwi/Māori into the planning and delivery of health services has had a huge impact in indicator development and measuring satisfaction with the service is an example of the new quality driven indicators, cultural responsiveness is another. KI06:2*

One respondent felt that several performance measures for Māori mental health providers exist and are adequate but these measures need to be augmented with an understanding of the context in which Māori mental health providers worked; in other words some “big picture” information.

*I think a number of the performance measures do adequately measure Māori mental health providers but always when you're a contract manager and anything like that you need to see the bigger picture. KI03:15*

## **Adequacy of Service Contracts**

Service contracts are the main mechanisms through which funders, usually the Ministry of Health or DHBs, establish the parameters of their relationship with Māori mental health providers. Contracts outline what services will be funded, at what rate and for how long. Several respondents observed that the contracts DHBs are currently using are outdated and do not adequately capture the work done by Māori mental health providers:

*Now I'm suggesting the NGO sector as they are currently constituted are not satisfactory, the contracts are no ... good. They are old anyway, probably five years old. There's been no recognition of the ways of care for Māori and of course they're underpaid as a result ... They're still operating under contracts that were five, are in many cases up to five years old, perhaps not even that long with some of the providers, but nevertheless out of date. And they've never been able to catch up and they won't be able to catch up unfortunately and the net result of course is that they'll go under. KI05:4*

This same respondent noted that the reason the contracts are out of date was because many of them were rolled over in the last set of health reforms:

*Simply, because there was a change from the RHA to the HFA and from the HFA to the DHB. When you have changes of that magnitude ... you've got to roll them through. And so what's happened is that all these contracts have been rolled over and even the ones that have just been transferred from the Ministry to the DHBs most of those have been rolled. So you end up with the old rates as well as the old specifications. KI05:5*

Another respondent noted that many of the mental health contracts that had been developed during the time of the HFA were done so by people who were trained in law, rather than experts in health services or more specifically, health service delivery at a community level.

*You know even at the HFA days, cause I was a ... Contracts Manager there, and, those contracts, you know, the definitions were just something you put together and you had a mix of clinical expertise in there, but a lot of the people who put the contracts together were, you know, graduates out of University or, you know, Law School and had no real understanding of how it worked at the grass roots. KI18:8*

Respondents indicated that while the sector is not as competitive as it once was (the latest set of reforms re-introducing a philosophy of collaboration into the health sector), providers are still unable to negotiate mental health contracts with DHBs that reflect the work that they do. One respondent in particular commented on the level of frustration that Māori mental health providers feel they are tied into contracts that remain static and inflexible. The respondent commented that it is not only Māori providers who feel the effects of these contracts, but tangata whaiora and their whānau (KI17:5).

Another key informant noted that, in the past, contracts have tended to focus more on the clinical aspects of mental health, without equal weight being given to the cultural aspects of service delivery.

*When we first started, our first contract out, we had to hone in more about the psychological side, talked mainly about depression. It had to be focused more at the mental health according to a Pākehā standard of mental health. That was what our original contract did. KI04:6*

Several informants noted that the contracts themselves are not “user-friendly” nor do they necessarily assist the provider to determine the exact scope of their work.

*It's easy to look at the contracts and see what they say in writing but ..., contracts these days, to tell you the truth, the wording of the contracts are ... very general, very broad in terms of service specs and even the performance measures are a little, you know. But ... there's a continuing discussion around performance measures and the definitions of what they mean by, 'you need to do this and you need to do that.' And a lot of the providers complain that every month, unless they've got another list of defining the definitions, then often they go, 'oh, well what was that one about again?', because the wording isn't ... it's not user friendly, it's not plain English. And so, they're having to, every month, or every quarter, to revisit exactly what that particular measure means. KI18:8*

There was a perception amongst some respondents that DHBs had a much closer relationship with their communities, than for example, the Ministry or the Health Funding Authority (HFA) and a better understanding than past funders about the provision of Māori mental health services in the community. DHBs were therefore considered to be well placed to improve the contracts between themselves and those providers (KI18:9).

One respondent's view was that because the contracts do not reflect the nature of the work Māori mental health providers undertake, or the way in which they work, Māori mental health providers may consciously choose to work around or outside the scope of their contracts. The respondent noted that it was up to the DHB to ensure contracts better reflected Māori mental health service provision practice.

*I think many providers just do what they want to do irrespective of what the contract says and they've tried to mould their whānau ora development thing based on what they believe it should be and then ... they try and satisfy the contracting requirements. I think it's really the responsibility of DHBs to recognise that and try and develop the framework within the funding mechanisms. KI07:15*

## **Additional Work, Effort or Services Provided**

Many respondents agreed that Māori mental health providers did engage in work that was completely outside the scope of their contract and for which they were not funded. Examples cited included transporting tangata whaiora, bringing in other skills and expertise and providing kai for hui.

*I mean most people use their own transport to either get them to the service or get them home. There were things about leaving people in the bed for two or three days when in fact you're only paid for a certain number of nights in a bed. There were certain things like bringing our ... Ministers even they didn't get paid for coming in. Our chaplains and Māori chaplains, even bringing in people, hauora Māori, you know? Mirimiri and all that. Our own traditional healers .... The way that we gave medication, the way that we talked to people, all that sort of thing took time. You weren't there for five minutes and then you moved on after five minutes. The time that you took to work with a person ... [you] may have gone the extra mile and people weren't paid for that but it had a dividend. KI02:9*

*Now the other thing of course is ... and you will find it today for example, is if a Māori goes out, from the community mental health team, out to home to deal with a person has a mental illness, that person, clinician is dealing with a broken arm, a snotty nose, a cold, the whole ... works. In other words the treatment of the whole family. And that is not allowed for in the contract, but they've got to do it ... because it's part of being Māori. KI05:6*

*Assisting people with their financial ... you could find that there are some basics that people need in order to stay well and that's housing and money and so, often our workers will try and ensure that people have those sorts of things and that means that sometimes they work outside of the contract that they have. But also recognise that some of our family members don't live in isolation ... so they will be dealing with other family members too while dealing with the particular person that they're concerned with. Because it's the wider network that often helps to maintain the illness for some of those out there. KI13:13*

*Other things around some of our practices like whanaungatanga, koha, those sorts of things, manākitangi, those things. I mean that's just part of our practice ... they're not necessarily factored in ... And often you also, not only are you working with the individual you're also welcoming the whole whānau. It could be anything from two to twenty two all at one time. KI14:13*

The additional time required working with tangata whaiora and their whānau was also cited as additional to the contract, particularly where providers had price per volume contracts with the funder.

*It's just a completely different way of delivering a service ... The time frames are ... really extended often. Like you can't just bowl in, do your ten minute consultation, and out again. It just doesn't work like that. KI11:6*

There was an acknowledgment amongst respondents that Māori processes themselves are resource intensive, so working in a kaupapa Māori way as a Māori mental health provider automatically meant these resources could be strained.

*So I'd say that our Māori processes are resource intensive in that they, there's, we often have to bring people in. If we don't have the knowledge then we have to bring our kaitiaki in to provide us with that knowledge and ... you know, those koroua and kuia and that will come in and we go out and pick those people up to do ... that stuff for us. If there's someone that needed to be seen in the intensive care unit and our koroua wasn't there then we'd have to go and get someone else to go in for her. KI13:18*

## **Reasons for the Additional Work**

### ***Community Expectation***

A number of respondents noted that the reason Māori mental health providers might do more than they are contracted to is because of the expectations placed upon them by their community.

*There's also the expectation by their hapū. I still get phone calls up here, 'my mokopuna needs to go and get physio checks can you come pick us up?' And I say 'Aunty I don't do that, you go to a neighbour, who's got the car ... you're*

*going to hop in the car and going to the GP clinic down the road' you know?  
So there's the expectation from our people. KI07:13*

The sense of community expectation may be particularly strong amongst iwi or hapu-based Māori mental health providers. Often the staff and management are related to the consumers and whānau they are treating:

*We love our people. Everyone that's in this service that you talk to, it is about our people because that could be our sister, our mother, our brother, our cousin and in many cases sometimes it is. It could be us in the future. KI20:12*

*There is the additional, often obligations because ... most of the workers here certainly in this region, are iwi, so they belong to the service group that they are delivering services to. There's a whole lot of whānau sort of expectations stuff that is very difficult for them to work their way through. So they get caught up in all of that stuff around, 'well we need ... to go to the supermarket, and what about so and so who has just lost his job and what about...' you know? So there's all of that additional work that is about belonging to and being responsive to the whānau and the whānau community. KI11:6*

*I think that your drivers are way different, yes. And it's likely that you're related to the person in the whānau that you're dealing with. It's a small Māori world. There are a lot of pressures. The expectations by our people are huge. You know, 'well why didn't you do that?' Generally money is seen as, well that's a side issue because you know ... what about aroha, what about tika, pono? So there's a lot of I think tension that occurs, expectations run high. KI09:11*

### ***Community Need***

In addition to community expectation whether implicit or explicit, Māori providers might go beyond their contract because they have identified a particular need within the community, or the community itself has identified the need and again, expects the provider to address this need.

*It's their community need, very strongly identified need and that's what their consumers want. And so that's what they deliver. And its completely contrary*

*to anything that's in their contract ... So their energy is elsewhere and you know, I guess we, at [name of MDO] we take a hard line on that and we say 'excuse me you are funded for this, yes we appreciate that you know, this is a huge community need ... do some work on putting a paper together to the Ministry for extra funding for that component of your service but ultimately you need to be meeting your existing targets.'* KI11:6

### ***Maturity of the Service***

A number of key informants commented that, particularly in the period where 'by Māori for Māori' services were a relatively new phenomenon, Māori services within hospitals and new or emerging community services were more liable to work outside their contracts.

*Then we had to have our fundraising tangihanga because some of the people would die there and because they'd been there for such a long time their whānau were not in a position to come and take them away, they did not have the money and so for the staff they had to take on that role of being the whānau to look after these people to make sure they had a proper funeral you know. So you could say we certainly delivered more because there was nothing ever given in the first place.* KI10:18

One respondent indicated that the relative youth of Māori providers did not seem to be taken into consideration by funders, or acknowledged by the sector more widely. Given their relative youth the informant noted it was hardly surprising some providers struggled to meet contractual obligations.

*I think that when I have seen Māori services that are maybe struggling or not quite getting there but they're on their way, you've also got to think about the context. DHBs, not in their current form but ... they've existed for [many years]... and they've still not got it right. We've had maybe ten years, fifteen at tops, of developing health services, yet they expect us to be at the same level ... so there's no acknowledgement of stages of development, how you make systems sustainable ... I just think there is very little recognition of the fact that actually we've really only been in this game this long.* KI09:8

### ***Strategic Development***

One respondent noted that most Māori providers have dual obligations and are constantly trying to fulfil both sets of obligations at the same time and with the same funds. In addition to delivering a mental health service for the funder the respondent noted that Māori mental health providers might also have a broader strategic objective of iwi or hapū development.

*It's about ... having a dual agenda really, or a dual kaupapa. One of them is to the Crown and to the contract and the other one is a completely 'nother set of objectives which is around whānau, hapū, iwi development if you like ... or for some other people its around tikanga, you know around being responsive or responsible about your principles and around your tikanga. For other people it's around an agenda of tino rangatiratanga. So a sort of a self-development kaupapa. KI11:7*

Operating with dual agenda means Māori mental health providers have particular protocols which they must adhere to and which may impact upon how they deal with their consumers. The maintenance of harmonious relationships with rūnanga, iwi and hapū also places additional responsibilities upon providers.

*The other thing is just purely around relationships. It's ... like there is this flexibility in terms of being responsive to your community. Like people roll in, up the stairs and go and see somebody just because they know they can? Whakawhanaungatanga stuff. Yeah ... and all of that takes time... Like you ... don't have, 'I'm sorry you can't see the CEO', generally ... I think the other part of it is ... why we get ... pulled in all sorts of directions in terms of provision, is that so much more is expected of Māori providers by their communities, by their whānau and hapū and iwi, you know?... Oh we're expected to be just a helluva lot better ... [than a mainstream provider]. And certainly we're expected to be a lot more responsive, we're expected to be excellent, we're expected to be, to actually do more ... So ... if you refuse to transport somebody its usually ... a huge sort of problem. KI11:13*

The dual agenda also encompasses an element of “reciprocity”. As identified by one informant, were it not for the tangata whaiora, Māori mental health services would not be required.

*Caring is 24/7 to the best of one’s ability. Knocking off at 5, and leaving the contact of a family ‘til the next morning is not a caring attitude at all. It’s a ... individual who works for their almighty dollar, and nothing else. There is a lack of appreciation that it’s because you have patients that you have a position, its cos you have whaiora that you have a position. And so therefore there’s a reciprocal in terms of the whaiora depends on you but so do you depend on having whaiora. And the whānau of that whaiora, for instance. KI12:2*

### ***A Māori Worldview***

One of the explanations offered as to why Māori mental health providers may do more than they are contracted to is because it is in their very nature as Māori.

*It’s actually ... much more intrinsic ... There is a component of that and I can think of several examples. Like for instance the whole thing about kai. And how you conduct meetings and ... that added extra stuff would mean that there are cost factors ... there are ... time factors, there are human resource issues around that cos you, you have to drag a worker in because your manager can’t kōrero Māori and so can’t do the mihi. Yeah, all of that stuff. So yeah there is a component of that. KI11:11*

*From my knowledge and experience I’d say that’s true [that Māori do more than they are contracted to]. And it’s ... the processes that we use, the Māori processes that we use and the practices are often ... more resource ... intensive and then secondly it’s our value system and so if you’re a kaupapa Māori system then our value system is around people. It’s a people value system and so we don’t tend to discriminate between asthma and schizophrenia and ... so I think it’s the value system that ... in some ways ... that kaupapa Māori tag works against us because you open yourself to the fact that you have to provide a service to a lot of people that [you] actually aren’t funded to provide the service for ... So I think they do do more than what they are funded to do. KI13:13*

## ***Whānau***

Another reason offered to explain why Māori providers do more, or are seen to work outside the scope of a contract, is because they do not take an individualistic approach to health. Health of individuals is directly related to the health of the collective, and in the view of Māori providers it would be meaningless to deal with an individual in isolation from their wider familial connections.

*Western medical practices are based on a medicated model of treatment and it doesn't take into account the individual part of the collective ... that whaiora is a part of a whānau, hapū and an iwi. Now the western medicated model actually owns the whaiora. The whaiora is not considered a part of a whānau, hapū, iwi. If they've got what is termed a mental disability, a mental illness then the psychiatrist will own and have power over [them].* KI12:1

*We don't just deal with the individual we deal with their whānaus [sic] so, which is quite different. For example with mental health quite often they're affected, the whole family and I've gone in and talked to the whole family. So you're not only, just, your immediate client but ... the rest of the family become very important, if not more important, because they are the ones that are carrying that member throughout the whole family. And that's the difference. We work with the rest of the family as well. So we've certainly got our work cut out for us and that's not added in the contracts.* KI04:19

## ***A Holistic Approach***

Nor do Māori mental health providers take a segmented approach to health care, delivering only “mental health services” as defined by medical models. Respondents noted that Māori take a holistic approach to healthcare.

*I think Māori providers because they see things in a more holistic way, that ... they're making the connections. Most Māori providers won't say 'I am just seeing you for this interaction and I will ignore the rest of your environment'. They're saying 'I'm seeing you here for this purpose and I note all the other things'.* KI03:7

*So I think the reason that they address the wider issues and don't focus only on the terms of the contract is because they're not very good at unbundling the terms of the contract from the person they're talking to. It's the holistic view, they intuitively respond to. I don't think that's necessarily about being Māori because a number of other providers do that as well. They're not very good at seeing something in isolation. Health professionals are very good at it.*  
KI15:12

*We don't work like the segment of a pie ... A psychiatrist will look at mental illness and a diagnosis. He will prescribe medication. We look at the whole person and ... look at well, 'what's happening within your circle that's making you go like this', you know? So we ... don't deal with just one. You can't otherwise you're missing a link, you know? That's my philosophy and that's how I work. Yeah. We don't look at the segment. They have a psychologist to look at that area, they have a social worker to look at that area, they have a psychiatrist that looks at that area, the PDN that follows up is over there, you know and the Māori health worker comes along and does all that anyway.*  
KI01:3

*If you say that Māori providers do more than is expected of them then you're absolutely right and why I say you're right is because Māori working in that field work in the whole person. The non-Māori view of mental health is some block in the brain and they don't take into account in terms of that brain not functioning properly being associated with any other part of the body ... Māori cannot isolate the biological body from its spiritual dimensions. Now those spiritual dimensions are what we term hinengaro and wairua.* KI12:1

### ***Tikanga***

Māori providers might also do more because they are bound by “a whole other set of rules that others don't [sic] and that's called tikanga” (KI17:5). These rules compel Māori providers to do additional work, to carry out additional tasks and to care for people in a different way from that of mainstream providers. Another respondent, in discussing this point noted:

*You look at our kaumātua, why do they go the extra mile when they're supposed to be retired? Where have we had our learning from? You know. Who's gone in front of us? Who have set the patterns before us? We haven't created it, it's not new, from here. You know, this has been a part of our culture, part of our heritage. It's been handed down to us. We always go the extra mile. Why? Because the other ones in front of us did that as well. So it's not just mental health it's across the board. KI01:12*

Another respondent agreed noting that the reason Māori mental health providers do more can be found in Māori values and the values of one's ancestors.

*You know why do we do it? ... let me answer it this way ..., what is the tikanga of our service and our whānau here? That's how I answer it. What is the tikanga? Because tikanga is based on manaaki, it's based on aroha, its based on wairuatanga. Now I can't see any of that sort of terminology in DHB/Ministry documentation. And those other things that our tūpuna got brought up on. They don't get brought up on being financially secure, and you know being able to measure ... working capital ratios and liquidity ratios. KI08:12*

This explanation is closely linked to the comments of another respondent who observed that Māori mental health providers not only did work that was additional to their contracts, but that their method of working was completely different to that of mainstream providers and in fact unique to Māori.

*It's that wairua stuff eh? That's the big difference. Westernised, western world don't have that. They don't know how to deal with that, they don't understand it. So there's another difference ... The different way is the whanaungatanga stuff, that unity, the family unity. Looking after the whole spiritual side and the spiritual side is not just religion ... Acknowledging the whole rather than segments of the pies. Allowing them to be people not patients, they're a person first, you know, who happens to be Māori and whatever else follows, with a lot of guidance. You know we do manaaki really good...Manaaki, tautoko, awhina, aroha all that stuff. KI01:5*

## ***Service Equity***

Other respondents noted that Māori will try and do more as a means of balancing the inequity between mainstream and kaupapa Māori services.

*They also know that Māori health systems have had to run on with the smell of an oily rag, for example rongoā/traditional health services. So they work harder, they try and produce more, as if to balance up that inequity ... Contracts are flexible and dynamic in my view. Where you identify a need or gap in the service and the dollars required, you may expect that issue would be funded. But generally it doesn't happen and I think that's one of the strong reasons why we find Māori health providers moving out beyond their brief and squeezing dollars out of existing funding to fund those gaps in the service. KI06:6*

*This organisation here for example was funded at half the national rate per bed day for the same service that mainstream service providers were delivering at. We currently have a programme that ... is intended to deliver a screening programme to identify ... at risk diabetes. Now we know that the major target will be Māori. Now there's currently \$1.5m that's been allocated to this particular programme, 7% of it is tagged for Māori service provision but ... the reality is that most of that money should ... be tagged for Māori service delivery. KI08:7*

*We receive \$68,750 for our registered nurses. The actual national price is \$95,000. We've got only two nurses at \$95,000 ... [but] Māori services are so desperate to get a foot in the door and get services up and running quite often they've already got staff working in those positions unfunded ... but we didn't know what the price was. We didn't know what the national price for minimum secure beds was and it wasn't until we went to a meeting one day and they were talking about the national price. And I realised that we were paid ... two thirds of the national price. KI20:8*

## ***Other Explanations***

A number of other reasons were proffered to explain why Māori providers do more than they are contracted to. One of these included having a passion and commitment to work in this area.

*Passion. See my job wasn't, it wasn't a job. It was a passion and I was just lucky to get paid for it. That was me. And so part of that burn out, part of that extra mile is because I had the passion. I just loved it. I still do. KI01:12*

Another provider indicated passion for the job was not the sole preserve of Māori or Māori mental health workers; however, the culture of an organisation can encourage people to do more than they are contracted, paid or expected to do.

*A lot depends on the culture of the service. You think about it. Most people go and work in health services because they want to do something, they like working with people. They like feeling good for what they do and if there was an appropriate culture that is supportive of that, and you get recognised in some way, then we will give more, I will come along and say, take this group of clients down if there's no one else. I will come in and have a meal because that's the art of enjoying what the job's about ... If you have a culture that does not value you and reward you in some way you find that you will become very punitive ... So it's not necessarily the provider, but the culture that exists within it. And you'll hear a lot of Māori health workers say 'I'm sick of that provider, I'm not doing any more. They don't value me, they won't pay' and then that's when health workers start focusing on money because that's the only value that therefore becomes the visible one, that's recognised ... if someone came back and said 'look you're really doing a good job and I really thank you for doing it', you will feel good, they will keep on doing it. KI10:11*

### ***Implications/Consequences of Additional Work***

One of the implications of doing more than one is contracted to is the potential to expose providers and staff to an element of risk or an unsafe environment.

*We need to make sure, keep very much to what we're supposed to be doing and don't do any more and if you do do any more, that you make it clear to your funders that you're doing outside ... 'this is what we should be doing, this is what we're doing'. There are some really big issues around that in risk, around us doing more than what we're supposed to. We need to do that because ... we can't not do anything at the moment, but funders need to address these issues urgently. KI18:10*

A further consequence of doing more than one is contracted to is burnout of staff.

*I think part of the issue is ... that I keep saying to staff and providers, 'you need to prioritise, otherwise you'll burn people out' and that's not safe, that's not safe practice if you've got ... workloads of eight whānau cases with really high and complex needs, how the hell can you meet their needs? But they just bend over backwards. Like people are on call, you know, people make themselves available after five o'clock? And I keep saying 'that is not safe, don't do it!' and they're saying to me 'oh no you're just a ... ball-head.' ... But I still ... keep saying to them 'what happens to your own whānau if you keep doing that? At some point we need a balance and, and you can't always be there ... you know? You're not the be-all and end-all.' But that's my perspective. Other people say 'that's great, go for it, we expect it of you.'* KI11:16

## **Possible Improvements to Current Practice**

Key informants were asked to identify ways in which the work of Māori mental health providers could be better acknowledged and validated. Informants identified that improvements needed to be made at a number of levels. Responses, where possible, have been grouped according to the main themes or levels that emerged from the interviews. The levels include:

- Structural or systems (whole-of-Government approaches to funding, joint contracting and “one-stop shops”);
- Relationships (DHB-Iwi, DHB-provider, provider-provider collaborations); and
- Tools and frameworks (including outcome measures).

### ***Structural or Systems Approaches***

Several respondents observed that neither the policy-makers nor the funders were keeping up with Māori providers.

*We have to basically say ... to government and these government agencies 'pull your weight, pull yourselves together. This time don't try and change our contracts. Change your way to suit our contracts'.* KI04:9

One informant noted that while the Government recognises Māori have their own philosophy of health (a recognition made explicit in the Government's Māori Health

Strategy He Korowai Oranga), the Government has yet to consider the implications for mental health performance measurement of adopting this strategy:

*In accepting the Māori health strategy, what are the implications arising out of that strategy that should be reflected in the contracts for mental health services? ... So you need a multi-level change here. And one is the commitment to the philosophy and then a commitment to translate the philosophy into service specifications. And then a commitment to translate service specifications, those indicators, relevant indicators of service specifications into contracts for Māori health providers. So there are a number of levels there. You've got the Ministry taking one level and then ... you've got DHBs who will be doing on-going work on service specification and contractual arrangements. You've got commitment there. Could they do it without Ministry intervention? I think they could do it tomorrow if they wanted to. KI15:8*

One suggested way of improving the situation was to encourage a more streamlined approach to contracting and joint contracting between agencies, so that providers have a minimum of contractual and reporting deadlines.

*I would like to see, and I understand absolutely the appropriations model, but we've been trying to work with one of the government agencies to have joint contracting so we can say ... I believe ... no provider should have more than three reporting requirements. Maximum, absolutely maximum of five ... in their contract. So they would say 'what do we need to know that will really tell us we're doing a difference?' That you have more than one funding stream lined up ... Some of the ones I've been involved with in the past have had pages of reporting requirements or they've had audit after audit into a small service. KI03:10*

While joint contracts between different government departments was mooted as one possible solution to reducing the compliance burden of smaller Māori mental health providers, barriers such as a lack of trust and patch protection on the part of government agencies might hinder the development of these types of contracts.

*See I think it's easy, but I actually think at an intellectual level it's easy and a contract is merely a mechanism. The key thing that stops it happening is trust ...*

*It is the agreement to reach that contractual mechanism of all the parties it's the hard bit but if everybody would give up a little bit and say we can do it, its fine but at the moment we have ... Education for example having a contract around early childhood, and we have Health having contracts, we have Child Youth & Family and goodness knows who else gets funding ... it's that trust question, that is the biggest barrier and ... all throughout all these things it's the barrier, for providers, it's the constant changing, we don't know who those faces are. You know? The funding faces. KI03:10*

Another solution identified by respondents is to adopt whole-of-government approaches in mental health.

*What we're trying to get the ... Crown or the DHB to look at is whole-of-Government funding but that's ... way down the track. Family Start's probably the best example of whole-of-Government funding ... And it's a significant amount of money ... it's very good funding. So that would be an example of a whole-of-Government approach where we're getting Government agencies [to] contract, at pooling funding and contracting ... across agencies with only one or two contracts. At the moment we've got CYFS contracts, we've got ... education contracts, we've got TPK contracts, that this level of reporting against those contracts is horrific ... And if you're a small provider that's ... started on the back foot anyway, its often really struggling with some of the report stuff. It's quite difficult. So we want to simplify the reporting, the contracting and the funding, and pooling the funding so that we actually get a bit more integrated service stuff happening as well. But we also get Crown agents talking to each other about individual whānau or about whole ... population approaches to things. KI11:17*

Rationalisation of Māori mental health providers was regarded by one respondent as one way of making the limited mental health dollars go further and by extension retaining only the most effective providers:

*The best way forward with this is to rationalise the NGO service ... I mean you can't continue, and we've got, a hundred different NGOs there are now, a couple of hundred Māori NGOs. Some of them are very, very small and some of*

*them are quite ineffective and they are below critical mass. Now, unless you address that problem, you'll never get over the problem because there's no more money. You can reprioritise, do other things less and put more money into the NGO, the Māori NGO and so on. But in the end I think you've got to look at whether or not a particular size is effective and if it's not you get rid of it or you amalgamate it, or do something like that. You can't pour more money into it or, or generate more below-critical mass providers because they feel like doing it. So there's a degree of rationalisation that's got to creep into the thing.*  
KI05:24

Another “structural” approach proposed by one respondent was to develop more “one stop shops”. The respondent argued that this would promote consistency and be more likely to result in tangata whaiora having all their needs met.

*So they can't get this idea that actually we would be far better to have one stop shops for our people. So that you get consistency. So you're less likely for people to fall through the gaps. You know there's a whole lot of reasons why it would be much better to have those integrated one stop shop processes occurring. I mean often, you know, you have to say to someone 'well I'm seeing you for this piece, but I'm sorry you'll have to go there if you've got an alcohol and drug problem cos we don't do that here'. But they don't go and then you don't see them again. They don't want to tell their story 500 times. And you know like it's already been a huge process in terms of all that whakamā, telling their kōrero all of those things and now you're telling me that they have to go somewhere else do the same to a complete stranger? ... it's not going to work that way.* KI09:14

### ***Investing in Relationships***

#### *DHB – Provider*

One respondent noted that funders currently undervalue community based services. Only by actually viewing the work of Māori mental health providers on a day to day basis will funders truly appreciate the extent of the work they do and more importantly how these providers are regarded and valued by the communities in which they operate. To that end the respondent suggested that staff in the Funding and Planning Sections of

DHBs should go out on “placements” with Māori mental health providers to see their work first hand. In that way DHB staff would gain an understanding of “what its like to deal with people coming off the street and wanting something then and there” (KI18:11). Greater linking, liaison and experience of “grass roots” were identified as necessary to improve the relationship between Māori mental health providers and the funders.

*These people who write up these contracts, they write it up from their ivory towers they'd never ever, ever been in a situation where they themselves understand the psyche at the flax roots level where that contracts gonna land up providing a service to. And they ask unrealistic things from their ivory towers of people with the hands on. And don't feel any impact or guilt or conscience about or consciousness about whether or not the person did the best of their ability to apply that contract. KI12:8*

*The advantage ... is that DHBs are in much closer contact with their providers and to a large extent the innovation will depend on the relationship between providers and the DHB and a readiness to explore other options. So the lack of movement in some ways is a reflection of the relationship between DHBs and their providers. If that relationship was working very well then this dilemma that you're highlighting ... would've been recognised some time ago ... and by now the relationship would've learnt a new approach. So I think the key to it has got to be in the relationship that providers have with the DHB. And at present the relationship is dominated by the notion of compliance rather than the notion of development. KI15:8*

One respondent noted that contract negotiations, which took account of a provider's view, would improve the accuracy of what was being purchased on the Crown's behalf.

*I think there's a ... way in which you can you can meet in the middle of the room. You can have your Māori processes, you can have your Māori processes and satisfy contractors requirements. There is a way of doing that. It's at the negotiation levels ... Prior to the contract. It's at the negotiation level prior to the contract where you agree. KI12:10*

One respondent indicated that what was required was for someone to undertake an economic exercise which costs out the work of a Māori mental health provider and which puts a dollar value on the extra work done (KI17:5). However many would argue that the very act of attaching a dollar value to tikanga sullies and compromises tikanga; therefore, Māori providers are reluctant to go through such an exercise.

#### *DHB – Iwi*

The DHB-Iwi relationship was considered an important vehicle for improving Māori health and Māori mental health. One respondent indicated that the latest set of reforms not only requires DHBs to consider their relationship with manawhenua but that they now have a responsibility to engage with iwi, to provide direction, and ‘contribute in a very real way around service development’ (KI07:2).

*Iwi providers, say [name of iwi] for example ... they have two roles. They have their role as a contractor with the DHB but their parent organization, the rūnanga, is a Treaty partner and there is an opportunity there to talk to the Crown, as distinct from the DHB. And talking to the Crown, might be talking of this whole idea at a policy end about either whole of government contracting or contracts that reflect Māori perspectives. So I think the iwi providers have another avenue of redress that they don't use efficiently. And that would take them in this case, directly to the Ministry of Health. I don't know whether anyone's done that, but it's an avenue that's particularly open to, it won't be open to a lot of providers but if iwi are Treaty partners then there is a route there. KI15:9*

*It's my view that iwi are up to play on fish, foreshore and seabeds. But when it comes to health, they're not all that well informed, even though the legislation requires the DHBs to have an effective relationship with iwi. Maybe that's a DHB problem. But without effective iwi influence in DHB planning and service delivery little headway can be achieved for improving health of Māori. KI06:9*

#### *Provider-Provider*

One respondent noted that small communities are identifying, and where possible implementing, new and collaborative ways of working as a means to overcoming the

contractual barriers that exist to improving mental health service delivery on a local basis.

*... the talk now is that we come together as a community and we start to have a look at our future contracts jointly. So that we could have a look at a much more complex and bigger project that would include a few of us rather than small pockets of funding going to smaller organisations. We're already talking now, we've got, for example we've partnered up with [an IPA] and they have a mental health component there. They have a nurse that actually works with the GPs, so that mental health can get into the GP services. Now that's an aspect of it. And she comes up with the same issues that we have. Basically there's a whole lot of things around them before you even get to the issue of their health status. And there's another organisation here that provides day programmes for mental health ... that want to ... have a look at other things, needs for those people. There have been other attempts to look at respite care in [a suburb] and so on. Very costly. And very difficult to do unless you're well skilled at that job. There's another organisation [name], that deals with the sexual abuse, counselling and rape crisis and so on. So all of these join together we should be able to come up with something ... a lot better in terms of what we could offer to this community. KI04:7*

Another respondent indicated that collaboration between providers is essential given the size of many providers. The respondent commented that because many Māori mental health service providers are so small, sharing some of the infrastructure required to run a business would lead to a more sustainable relationship with the sector.

*I think that we're doing an amazing job, but lots of very small providers. And I think that that's problematic just from the point of view of critical mass and economies of scale and for things being sustainable. And I think that for our own sakes we often would be better to form coalitions or whatever you want to call them to make things more sustainable so you ... can do your service delivery the way that fits best with the kawa, but you could share infrastructures around payroll and you know those kind of very functional components of running a business, instead of trying to replicate them all over the place at a huge cost. KI09:9*

Collaboration amongst providers was seen as one way of reducing provider workload, without compromising the level of service to tangata whaiora and their whānau.

*Some of the choices that Māori providers may make may be that they say 'we have to solve everything else' rather than saying 'can we partner with another provider, can we all work together' which I think is a whānau ora model, if you like. 'So that we can actually grow our service by collaboration and partnership with other providers because it will make it better'. We can't all be an expert on housing, social welfare, health and any of the other things, we can't do it on our own particularly if you're a smaller provider you may be tempted to and if you're a community support worker and you're involved with activities of daily living around a person then you have to be very astute in understanding what's happening for the rest of that person's environment.*

KI03:8

Ensuring each provider remained an autonomous entity, secure in their own tikanga and tino rangatiratanga was identified as critical to achieving successful collaborations.

*If you are strong in your tino rangatiratanga then you know who you are and ... you will behave in terms of your Māori values and you will understand your role to manaaki, you will understand your role to assert appropriately your tino rangatiratanga and you will work out that, to me, that would be the strength that would give you the ability to collaborate rather than the ability to protect your patch if you like. Because it's about leadership and that's what tino rangatiratanga is all about, is actually understanding your place to stand, your mana, your strength and how you would do all those things and so I'd say it's the greatest motivator for collaboration. KI03:8*

One respondent noted that the reformed sector is allowing providers to come together and discuss issues more, rather than see each other as competitors. This in turn has resulted in Māori providers starting to identify the gaps in service in their own region.

*The other thing that's ... it's getting better locally, is we've got the continuum of Māori providers who are so separate it's not funny. And part of that is about the contestable funding environment ... but ... what's happening that's really good now is that through hui that we've been having there's a real*

*acknowledge[ment] ... [name of service] does Māori mental health residential care of children. They don't need any more of that ... [name of service] does Well Child through to kaumātua, kuia checks. Kia ora we don't need any more of that but do we need to build the capacity of that provider...there's the alcohol and drug' you know? So there's ... there's a continuum of care developing. They're starting to identify their gaps and ... a big gap for us here is te reo Māori, and ... Māori workforce for mental health service ... [both] health professional[s] and [those skilled in] Māori culture. KI07:18*

### ***Tools and Frameworks***

Improving contracts, improving the way they are monitored and the appropriate application of audits were deemed to be ways in which DHBs could not only improve their relationships with providers but also discover the extent of work undertaken by providers in their area.

*So contracts ... can be really helpful as a descriptor but we have to make them just describe those things and allow people to blossom. I don't like the focus in a contract purely on volumes. I think you need that period for people to say 'okay where are we going, what can we do with this mix of staff', but if you look at 1 FTE mental health community support worker, if they must see more than 20 clients and doing the job really as I believe it ought to be, how can you do that? So it gives you a relativity. One worker say, 20 clients, time for admin, time for training and development, that's a maximum really, 15 is a bit more comfortable. So there's still a lot of development that the sector needs, to be able to grow really and the funding environment isn't there to grow in. KI03:9*

*I would include in the contract fiscal acknowledgement that Māori whānau have people in their whānau or in their Māori community who are repositories who hold the repositories of old knowledge. Even ancient wisdom on all these issues. I would ensure that the Māori providers were contracted to include rongoā healing in their practice. I would ensure that contractors take into consideration manaaki tāngata. That Māori providers need to manaaki whānau. Manaaki them with quality information. Manaaki them with tangible stuff like food. Manaaki them with tangible stuff like practical ... information, practical advice on the where to's from here. That contractors' take into*

*account the time factor, the Māori time factor. And we know that the Māori time factor is when the time is right it's not when the clock says five o'clock. It's when the time is right and we know when the time is right ... Environment is a really important factor and Māori providers are expected to provide a Māori environment. Now contracts don't allow them to do that. KI12:6*

*You don't use the audit process necessarily because an organisation is a Māori organisation or it's had a failing in the past which automatically will be audited, and audited and audited on an ongoing basis. It doesn't make sense. And in fact if the performance monitoring thing is in place in the way that it should be it wouldn't be necessary except for fraud or criminal offences. KI05:22*

Developing a contract that includes quantitative and qualitative data was identified as another possible way of improving the current performance measurement framework.

*It shouldn't be compliance driven, I mean compliance driven ain't going to work. Outcomes-driven in my view isn't going to work because ... the outcome indicators are just, the time lags are too slow, and the ability to identify, in fact I think there are a series like, outputs or intermediate outcomes if you want, that you can look at ... I mean process indicators, how did you go about doing this? So you see that you've got some honesty in the process, is really important alongside some of the more quantitative indicators. Qualitative stuff, it makes it happen. It really does. If we join those two together then I think it could be very, very valuable. KI03:10*

Incorporating a time component into the reporting requirements would be also be one method of acknowledging that kaupapa Māori mental health providers operate differently.

*I think that the best way to do it is to work together where possible and that could very well be that that's separate at times, but that there's a respect and acknowledgement by mainstream of the Māori way of working and that extends to acknowledging that it may take four hours to engage with one person as opposed to the 15 minute timeframe and vice versa you know? KI07:5*

## How Should the Performance of Māori Mental Health Services Be Assessed? /Is a Parallel Measure Required?

Participants were asked consider what they thought was the best way to measure the work of Māori mental health providers, and whether a separate and specific measure to gauge the additional services a provider delivers was warranted or whether some kind of “cultural performance indicator” would be appropriate.

Early on in the interviews it became apparent that a generic “cultural performance indicator” was an undesirable and untenable proposition. There were two reasons for this. Firstly, respondents noted that attempts to define what might be included in such an indicator would be fraught. Each iwi and hapū would have their own values which would need to be enshrined in such an indicator. No one “cultural performance indicator” would fit all; rather, individual measures for each iwi, hapū or even whānau would be required. On a purely practical basis alone, managing a suite of indicators of this size would be daunting.

Secondly, if a generic “cultural performance indicator” was devised and used, it would raise the questions of who would monitor its use and whether it had been used correctly. Obviously it was inappropriate for cultural performance to be measured by the Ministry of Health, a crown funder or even a mainstream auditing body, in spite of such a measure being tied directly to funding. The only appropriate group qualified to measure “cultural performance” at a local provider level would be iwi and hapū themselves. Again, at a purely pragmatic level, auditing these measures would be problematic.

*Oh, a cultural performance measure. I don't ... [think it's a good idea] because again the person or the people monitoring it may not have a cultural appreciation ... an actual cultural performance measure again could be used by people. I mean our reality we have [name of iwi], 25% of the Māori population, we have [name of taurahere group], we have a variety of taurahere groups. How we do marry all of those things? There may be some differences in tikanga, there will be differences in strategy based on urban Māori as against manawhenua. KI03:18*

Nevertheless, a number of respondents were clearly of the opinion that an additional measure or set of measures to assess the performance of Māori mental health providers would be useful. They argued that the health sector does recognise that Māori health providers deliver a service substantially different from that of mainstream mental health services. Were this not the case there would not be two modes of service delivery. Therefore, respondents argued it was inappropriate to judge the work of Māori health providers by mainstream or universal standards alone. Indeed one respondent noted performance monitoring and funding should be moving towards an outcomes focus, where those outcomes are Māori specific.

*No I think ... the additional measure is ... what is needed, but that they should be universal and Māori specific. Not necessarily cultural but the cultural would be part of it. I mean if you're looking at a good outcome, a good outcome includes cultural indicators as well as physical indicators as well as mental indicators .... so I think the contract shouldn't be prescriptive in the sense of saying 'we're paying for these components'. But it should try and be fairly prescriptive on why a Māori client is coming to a Māori health provider, what are the outcomes you would expect? And the cultural thing is obviously a strength in cultural identity, something you would expect as a result of the treatment. To get to that outcome you need to have cultural inputs on the way. KI15:15*

Recognising that these outcomes may take some time to develop and validate, the respondent suggested an interim solution:

*The other way ... is looking for an interim solution until the ... the big picture is built up. Go for the interim solution. The interim solution says we endorse Māori health perspectives and that's why we want Māori health providers so they can deliver mental health services within that context. We don't have a ... contracting mechanism yet that will adequately measure that but we're working towards it. In the mean time, we recognize that there's a gap between what is contracted, the service we're contracting and the Māori perspective and so we will load the contract with what we will call in the mean time a transitional fee, and the transitional fee is transitional in the sense that it is expecting a different basis for contracting will arise. KI15:15*

Other respondents agreed that two separate measures were appropriate - those that were relevant to all health providers and those that specifically measured health improvements from a Māori perspective.

*I think there's two components to it. That there is the performance which ... is about delivering an effective health service. And I think everyone needs to be measured the same around that stuff, and then there is the accountability back to iwi, which is about measuring their performance ... from a cultural perspective if you like, or cultural standards ... [and] I think whānau/hapū/iwi need to measure it, so that first of all, one of the things that we're asking our iwi delegates on our various strategic hauora boards is 'what is your, what outcomes do you want to see measured for your health providers? What is ... if you like, what is whānau ora and how do we measure that? And what is important from a local perspective, if you like, from an iwi perspective if you're measuring cultural performance?' And that's ... different for every iwi.*  
KI11:19

This respondent went on to note that “locality specific” measures would be appropriate, but these measures had to be devised by the community, hapū or iwi themselves.

*Yeah but I think that [measure] has to be locality-specific. I don't think we're going to get national stuff that's going to keep everyone happy on that stuff and that's about ... being iwi-centric ... we've already got national sets of standards that we do all the clinical stuff, all the cultural stuff has to be specific to locality and iwi cos ... there'll be different needs and that's for those communities to decide and often its, the decision is made through their hauora delegates ... at a governance level.* KI11:19

One informant noted that the same basic framework could be used for both Māori and mainstream services but that it would have to be modified for Māori consumers. The modifications would need to be extensive and underlying the framework would be a completely different set of values.

*You could use the same framework but it would have to be modified. We would have to develop measures that are suitable. You could use the same process and approach. But whatever you use has to be populated with the appropriate*

*values and beliefs. So if it's a framework that is Māori, the systems then obviously will be different from the norm of mainstream. It will be built, planned and developed in a Māori way. Its processes will be Māori, systems Māori and its health outcomes will be based on Māori practices and principles.*

KI06:7

Another respondent used the analogy of a set of train tracks to explain a dual system of measurement:

*The analogy that ... I think about ... is like two rail way tracks. OK. You have two railway tracks separate from each other joined by a whole lot of sleepers and the sleepers are cushioned by a whole lot of scoria and metal and stuff and yet it takes two of those tracks to carry the weight of a huge train. Alright. If one track was Pākehā and the other track was Māori, they don't touch each other, they're separate from each other, but they connect via the sleepers. The sleepers were policies, they were proper policies and the scoria and the stone that support those ... policies are the resources, the money and they were properly packed because you can't have too much resources on one side and not on the other. They have to be ...equally ... be parallel to carry the train. That huge, massive beast with all the weight that it carries of all the ethnic minorities that are in this country. If one track wasn't properly resourced, then that train is going to derail. And that's where it is at the moment. Totally derailed. And um, and if that is an analogy about working separate, then that'll be an analogy that's acceptable because if there is anything they want to fly it's a flag of separatism. When we're saying that ... we're not talking about alternative, we're actually talking about working alongside, but respecting difference. KI12:14*

Finally some of the respondents indicated that mainstream services also have a responsibility to become more responsive to the needs of their Māori consumers:

*But the other thing I think about all of that is ... just that some of the most useful work is still to be done, if we're looking at contracts and looking at being responsive and measuring cultural compliance, or some sort of cultural standard, is that the work needs to happen in mainstream because if we can*

*shift, and that's around the inequalities stuff, if we can shift mainstream services so that they are more responsive as well ... We were just looking today at the pool of funding. We've got ... 135 million or something that comes in to this DHB. About 4.5 million of that is targeted to Māori services, to Māori providers. Now it's a pittance ... its minute basically. And what we want to try and influence is the other hundred and twenty million and how those services are provided and contracted. And that ... that's the only way we will shift Māori health outcomes I think. KI11:23*

## **Accountability**

Respondents were asked to consider the accountability of Māori mental health providers in two ways; accountability to the Crown and accountability back to whānau, hapū, iwi and community.

Regarding accountability to the Crown, one respondent commented that the accountability mechanisms were intrinsically “western”:

*So the accountability tie with the funding means that you have to meet these standards and if you look at those standards and if you look at these documents here, a lot of it is around a delivery mechanism that is largely a western-oriented delivery mechanism and has to comply with western medical practices and I think that's part of the problem that we have in either trying to harmonise that or allow the Māori flavour to flow over the top ... unfortunately I don't see that changing as long as the pūtea comes from the government there will always be those constraints on how the funding is used. KI13:12*

According to the respondents, accountability to one's own community is a huge issue for Māori (KI17:6) and often can not be separated from personal integrity (KI01:17) or being responsible for all tangata whaiora irrespective of iwi or hapū. There are numerous forms of accountability in Māori society which, informants noted, Māori mental health providers had to consider and work with in their day to day service delivery.

*Māori intermingle at the hapū/iwi level and if you fail in your duties simply because you don't go above and beyond when you know you have the capacity*

*to, or the capability, maybe not the resource capacity but the capability, you have this feeling of accountability to the whole Māori race and so you go that extra mile to make you feel good as a Māori having done your best for a Māori client. KI12:2*

Accountability to one's own people may be a positive motivating force that compels Māori mental health providers to strive for excellence in service delivery.

*Every Māori that comes through the door is holding us accountable and their iwi. And so that is a key accountability for us ... the contract really is irrelevant, our accountability is to iwi/Māori. There is an expectation out there and for us to exceed that expectation whether it be the Board's or iwi/Māori or that individual's. KI20:15*

In contrast, the accountability back to community may drive Māori mental health providers to do more, not because they are striving for excellence, but because they fear failing in the eyes of their community.

*There's this accountability clause you know? We have a fear, a natural fear, that we're going to be judged unfairly by all community, but worse, from our own. And we go above and beyond for our own and, and that's because we know eh? We absolutely know. We could have a whaiora non-Māori and a whaiora-Māori in our service and we'll go above and beyond for the whaiora Māori cause we know their, of what their Māori expectations are of us ... nobody could make a better rod for our backs than we make for our own. Nobody. KI12:3*

One of the most important forms of accountability for Māori is *kanohi ki te kanohi* or showing your face, face to face with another. However equally effective in holding Māori accountable to each other are the mechanisms of the *hui* and the *kumara vine*.

*... you see Māori hui are a platform of accountability, every hui we have is a platform for accountability. You'll never know what a Māori is gonna raise at a hui. And let us never change that. Never change that. And we shouldn't underestimate the kumara vine of Māori either ... the kumara vine of Māori is a powerful, powerful form of accountability. See some will say it's gossip, it's ...*

*just gossip. However, the kumara vine of Māori if it gets to the right ears ... if it got to the right ears that's the person that calls the hui and says 'well, this was heard on the side of the room. However, because there's a rippling effect or an impact, I wanna raise these issues directly.' And you see the Māori form of accountability is kanohi ki te kanohi. KI12:12*

A further type accountability for Māori is whakamā or shame.

*... whakamā is a form of Māori accountability. It is a form of Māori accountability. But you see that whakamā has been eroded by government contracts because you're not eyeball to eyeball with anybody. We're not kanohi ki te kanohi on your contracts. Those who ... hold you to account, they don't know you, wouldn't know you from a brass razoo. All they know is they have a contract. Signed. And how do they measure it? They measure it this way because this is the way Canada measures it. Or this is the way [the] USA measures it ... and not the way in which tangata whenua would measure it. KI12:9*

Whakapapa was also cited as a form of accountability among Māori providers.

*Because I'll tell you, another thing, we know, our whakapapa is so tight. It doesn't matter what tribe you come from in this country, our whakapapa is so tight and our country so small, there will bound to be somebody who knows somebody that's gonna call you into account. KI12:17*

### ***Managing Multiple Accountabilities***

Respondents were asked their views on the different and multiple levels of accountability experienced by Māori providers. Respondents were reminded that Māori mental health providers were accountable to the Crown, through their contracts and that they would also be likely to experience a sense of accountability back to their own community.

All the respondents agreed that Māori mental health providers are accountable to a number of stakeholders, with one respondent noting that “Māori have to put up with [multiple accountabilities] all the time” (KI06:10). Respondents indicated that in addition to being accountable to the Crown and to their own Board of Governors or

Board of Trustees, Māori mental health providers were also accountable to their clients, the tangata whaiora in their care and by extension, to the whānau of those tangata whaiora and their communities.

*I think it's hell for them really trying to balance all those competing demands and I think they do a truly amazing job most of the time in balancing that and not saying one group you know has higher priority or higher input. But say 'we've got a number of, I think, competing demands that create a tension but at the end of the day we are here to make it better for our tangata whaiora and their whānau who are members of our Māori community and the wider community'. It's not easy. KI03:18*

*I still get back to the way that they provided the service was quite unique in terms of they were accountable to kaumātua, they were accountable to their community, they were accountable to their own Trust. KI02:5*

A number of respondents noted that Māori were used to managing multiple accountabilities and that while it makes service delivery “extraordinarily difficult” they manage it “hugely well because I think that that’s kind of the lifestyle that Māori are used to” KI03:20.

*And we have never, ever been concerned about multiple accountabilities, that's not new to us. That's not new to us at all. Well, multiple accountabilities is ... like me for instance. I've got multiple accountabilities. I'm accountable to, to [DHB], I'm accountable to [Rūnanga] who signed a memorandum of understanding with them and I'm accountable to every Māori I see out there and I'm accountable to my peers in here. I'm accountable to every Māori on every marae I walk on. There's an accountability and as well as that I become a resource. You know all of us Māori, we our backs become the bridges between our people and whatever organisation that we're in. KI12:17*

Respondents also indicated that accountability arrangements for Māori health providers can prove even more complex noting that with each stakeholder, different types of accountability might exist. For example one key informant noted that Māori mental health services within a DHB may be accountable to the Director of Mental Health and to the Director of Māori Health, but as a Māori service there is also a sense of

accountability to a DHB's Manawhenua group. For each of these key stakeholders there might be different and multiple types of accountability, from cultural through to clinical or financial.

In terms of primacy of accountability in relationships, or who if anyone was the main group that provider should be accountable to, a respondent noted:

*I would hope it's their governance group and I don't say that as the governing body who leads them, it's their Māori governance group. So that includes the community, it absolutely must include kaumātua and taua support because they, they are the source of the perceived wisdom. Certainly I know here we find it very challenging and very empowering. The ability to reflect, at least to have that source of a cultural governance model alongside any other structure or governance to create the vision ... but again the clients are part of what I see that governance model is, because no service has a right to exist and no tangata whaiora or anybody else has to go to the service. So to me that's quite important. Nothing that the funder does actually is going to do that, sorry.*

KI03:19

Another respondent indicated that the concept of accountability contains an element of reciprocity also. While a Māori community might need a mental health service, by the same token, the Māori mental health service also requires the support of its community to be effective. So accountability is regarded as a relationship that flows both ways.

*It's a reciprocal relationship really. They need you, you need them absolutely equally in a lot of ways and you know, you want to make the service relevant to the people who can access it. But I mean that's the other thing you see. The service is ngā hau e whā, but you accept that you're in the rohe of say Rangitāne ... and so ... the tikanga and kawa that operates should be Rangitāne. But the way you deliver the service in terms of ngā hau e whā is accepted as well. So I think that if you can get that mix right and you get this tautoko from the local hapū and ... iwi then I tell you what, it's magic. KI09:17*

## Summary

The findings from the key informant interviews indicated a range of views on the origins, usefulness and applicability of the system currently used to monitor the performance of Māori mental health providers. Few respondents were able to comment on the derivation of the current performance measurement system; however, most agreed that the Crown and Māori mental health providers have different measures by which they judge performance. Respondents observed that whereas the Crown tends to be focused on measuring inputs and outputs, Māori judge their performance by measures more akin to “outcomes”. A number of respondents indicated that current performance measures are not adequate for measuring the work of Māori mental health providers and that while these providers had grown and evolved, neither the measures nor the contracts by which they are held accountable appear to have changed since the time of the HFA. Contracts neither enabled Māori mental health providers to work in a “kaupapa Māori manner”, nor reflected the scope of the work done.

Respondents agreed Māori mental health providers did more than they were contracted to and identified a number of reasons for this additional work. The reasons can be broadly grouped into the following categories:

**Community Expectation or Need:** Māori providers are part of their community and relationships between themselves and their community members place certain expectations on the provider to do more. In addition the provider may attempt to meet an identified need in the community that is outside the scope of their contract.

**Immaturity or lack of experience:** Overprovision is a feature of the more immature service. The relative youthfulness of some Māori mental health providers may result in their “chasing” every contract. Inexperience may also mean Māori mental health providers believe they have to “deliver the world”. With maturity this perception may change and providers may learn to become more strategic in their selection of contracts to tender for.

**Strategic Development:** Overprovision occurs because iwi and hapū-based providers in particular view health delivery as merely one aspect of the larger goal of iwi development. Their philosophy is that development as an iwi must occur in conjunction with raising the health status of iwi members.

**A Māori Worldview:** Overprovision occurs because the worldview of Māori mental health providers differs from that of other mental health providers, requiring different approaches, resources and processes. Features of a Māori worldview identified by key informants include a whānau approach, a holistic approach and being governed by tikanga.

**Service Equity:** Overprovision is regarded as necessary in order to deliver a service which is at least equivalent to one delivered by non-Māori providers.

Respondents indicated several ways they thought the performance monitoring and contracting framework could be improved to more accurately reflect and acknowledge the work of Māori mental health providers. The suggestions proposed include streamlining contracting to minimise reporting requirements; the use of joint or whole-of-Government approaches to contracting; rationalising mental health services, especially by having smaller Māori mental health providers share infrastructure, payroll and HR systems; encouraging and enabling greater provider collaboration; and improving the contracts themselves and the contract negotiation process. Several respondents also emphasised the importance of personal relationships and face to face contact with staff and managers at the DHB.

A number of respondents argued the need for two sets of measures of performance in Māori mental health: a universal set of measures and one which was able to measure the specific features of a “high-quality” kaupapa Māori mental health service.

Respondents indicated that accountability for Māori mental health providers usually means managing multiple accountabilities and multiple expectations on a daily basis. The accountability measures used by the Crown and funders are not necessarily the same as those by which Māori mental health providers hold themselves accountable to their communities or to tangata whaiora. Forms of accountability for Māori mental health providers include hui, face to face meetings, whakamā and community perception.

## Chapter Seven

### “Making the Invisible Visible”: The Work of Māori Mental Health Providers

*What Māori do, they do out of aroha, tika and pono. These concepts are invisible, just as the extra work they do is invisible. It is not specified in any job description.*<sup>12</sup>

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#### Introduction

This chapter presents the findings from the provider interviews and provider document analysis. In particular it presents information gleaned from the contracts and performance monitoring material the providers volunteered for this research. The chapter briefly describes each of the seven providers who took part in the research; the types of mental health contracts the provider had; who the contracts were with e.g., Ministry of Health (MoH), District Health Board (DHB) or Māori Development Organisations (MDOs); and the organisations’ underlying philosophies and values. The chapter is then structured according to the main topics of inquiry derived from the interview schedule: these in turn are based upon the findings from the key informant interviews and the literature. These topics include: how performance is measured; the adequacy of contracts and current performance measures; what additional work Māori mental health providers do and why they do it; how current contracting and performance measurement practices might be improved; and provider views on accountability and success. The chapter concludes by summarising some of the key points raised in the provider interviews and in the analysis of the provider’s documentary material.

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<sup>12</sup> Mary-Anne Baker Ngapuhi, Ngati Wai, Inaugural Doctoral Writing Retreat, Hopuhopu, 31 January 2004.

To ensure anonymity, each Māori mental health service that participated in the research was assigned a unique code (e.g. MHP02) and each person interviewed at that service has a code that corresponds to that service (e.g. MHP02A, MHP02B or MH02C). Documents from a particular provider, such as contracts, performance monitoring reports or corporate profiles are also identified by the provider code and then a letter (e.g. MHP02 Document A). Usually a number follows the respondent or document code (e.g. MHP02A:12); this refers to a page number either of a transcript or in the case of a document, a page in that document. One joint interview was not transcribed, so quotes are taken directly from the tape; in this case the number refers to the corresponding position on the tape counter.

## **Provider Characteristics**

Seven providers participated in the research. As stated earlier, Māori mental health providers were asked to participate in two ways; by agreeing to be interviewed (interviews could be with a member of the management team, a staff member, a Board member or any combination of these) and by providing examples of contracts, performance measurement material and any other documentation which would show the extent of the work undertaken by the provider. The providers differed in size, organisational type, contract type and how they went about providing their service. However, all displayed a common commitment to improving the “wellness” of their clients, most of whom were Māori. The following section provides a brief outline of each of the services that participated, based upon interview material and any documentary evidence provided.

**Provider MHP01** is a relatively young service located in the South Island. It provides an activity centre for tangata whaiora in the community. The service is a Trust which has been running since 1999 and offers a range of programmes aimed at training tangata whaiora living in the community and teaching them “life skills”. Programmes include wood, stone and bone carving, cooking and life skills classes as well as te reo lessons. A computer lab is also available. Decisions on the types of programmes and activities offered are made by the tangata whaiora, with programmes reviewed, and if need be changed, every six weeks. In addition to the activity centre (a DHB contract), the service also has a further contract with the DHB to provide a community support

worker and a destigmatisation contract with the Ministry of Health as part of the “Like Minds Like Mine” Project. The community support worker contract involves one full-time worker who offers advice to tangata whaiora who have left the hospital and are living in the community. The destigmatisation contract involves tangata whaiora meeting with various sections of the community and government organisations (e.g. Work and Income New Zealand, the Police) and talking about the discrimination involved with mental illness. According to interview data the service is described as a Māori service and is governed by a voluntary Board (MHP01A:6).

**Provider MHP02** is a kaupapa Māori alcohol, drug and gambling (AD&G) service located in a provincial town in the North Island. The AD&G service is just one of a range of services provided by an iwi-based Charitable Trust. The Trust describes itself as “the health, social service, education and disability support service provider arm of a local mandated iwi authority” (MHP02 Document B:3). The Trust was established in 1993; however, the AD&G service began only four years ago in 2001. The AD&G contract involves screening; early and brief intervention; comprehensive, personal, therapeutic and cultural assessments; education; and referrals. Counselling, and health education and promotion with particular reference to gambling are also provided. The contract has recently been augmented with the inclusion of a Rangatahi Social Worker who works with youth aged 10 to 24. The Social Worker component of the contract includes the tasks of early intervention, advocacy, mentoring, coordination with other services and working with whānau. In addition to the Social Worker, staff include a Clinical/Team Manager, three A&D counsellors, a mirimiri practitioner and Kuia and Kaumātua who provide the cultural assessments. The beliefs upon which the service is based are derived from those that underpin the operation of the Trust as a whole. These beliefs include values such as manaakitanga and care of the environment, through to a respect for the Treaty of Waitangi and the four cornerstones of health (or whare tapa whā). The Trust is governed by a Board of Trustees which meets monthly in conjunction with the tribal Council of Elders.

**Provider MHP03** is also a Trust located in a provincial North Island town. Established in 1982, it is possibly one of the oldest health and social service organisations in New Zealand. This marae-based provider is a kaupapa Māori service, adhering to the tikanga

of the local iwi and utilising the whare tapa wha model of wellness<sup>13</sup>. The provider notes that the purpose of the trust is to “help Māori maintain a reasonable standard of living that will allow them to be part of the activities that Māori participate in. This is achieved by offering a holistic range of services rather than a fragmented approach to health and wellbeing” (MHP03 Document D). While it is a kaupapa Māori service, some 5% of the clients during any period are non-Māori. At the time the research was undertaken the service had a community mental health support work contract directly with the Ministry of Health and was subcontracted by another local Māori mental health provider to deliver mental health needs assessment. The work of the provider involved educating tangata whaiora about their illness, medication, triggers and possible prevention strategies; developing care plans for, and advocating on behalf of, tangata whaiora and their whānau; cultural needs assessment and case management for tangata whaiora and their whānau; and liaising with marae, iwi, community groups, and other health and social service providers. The service employs three full-time and 25 part-time staff. The Board are all Māori and must be able to demonstrate whakapapa connections to the local iwi.

**Provider MHP04** is, in comparison to others that participated in the research, a relatively large kaupapa Māori service provider based in a South Island city. The provider has been established as a trust in its own right; however, it forms one of the service arms of the local Runaka. The Runaka itself was established in 1936 and is “run along extremely traditional lines” (MHP04B:1). The services the provider offers includes support workers, needs assessment service and residential units. The Support Workers Service is a community based support service for tangata whaiora either in institutions or those out in the community but under the care of a case manager. Funding for this service is by Full Time Equivalent (FTE) positions. The needs assessment service, also funded by FTE, involves assessing and reviewing client needs and coordinating services for the client and with the family. Outreach needs assessment is offered in two other towns apart from the home base. Where appropriate, tangata

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<sup>13</sup> The Whare Tapa Wha model of health, first coined by Durie in 1984, compared health to the four walls of house, with all four being necessary to ensure strength and symmetry. The four walls or dimensions of health include taha wairua (spirituality), taha hinengaro (thoughts and feelings), taha tinana (the physical side and taha whānau (family).

whaiora may be referred from needs assessment to the support workers service. The residential units or “whare” include three residences in two locations. In one town there is an eight-bed, 24 hour/7 day a week residential unit for people experiencing long-term psychiatric illness. This whare is run in a kaupapa Māori manner, but it is open to any mental health consumer. In another town there are a further two houses which operate 24 hours a day, 7 days a week and offer six rehabilitation beds and two respite beds. All the supported accommodation is funded per bed night. In order to offer these services the provider holds contracts with three separate DHBs. The underlying values which guide this service appear to be those traditionally fostered by iwi, namely whanaungatanga, manaakitanga, awhi and aroha.

**Provider MHP05** is a relatively new provider of Māori mental health services in Canterbury. In 2000 it developed a mental health component for an organisation running anger management programmes for men. In 2002 that organisation decided it did not want to pursue a mental health component, so its members consulted with the community to determine whether the mental health programme it was offering could be viable in its own right. According to interviews with the staff and management, the community support and developmental work that had already been done allowed the provider to tender successfully for a one year contract to deliver mental health services. By becoming a provider in its own right the service is not constrained by another organisation’s “kaupapa”; consequently ongoing development could occur in a way that “was more conducive to what Māori required” (MHP05A:2). The provider was audited in 2003 and its contract renewed for a further 2 years. The current contract with the DHB is to provide Kaupapa Māori mental health services to adults, tamariki and rangatahi. The contract includes one clinical and one non-clinical FTE for the adult services and two FTEs for the tamariki and rangatahi services. The service offers mental health assessment, therapeutic counselling, advocacy, mentoring, education and training from a kaupapa Māori perspective. The provider is guided in its work by a set of values derived from the Waka Framework, a framework developed by Te Wānanga o Raukawa. It is only the provider participating in this research that had its values and/or philosophy of service delivery enshrined in its contract with the funder.

**Provider MHP06** is a hapū-based provider in a provincial North Island town. While the provider has been delivering a range of hauora services since 1994, its history has

been chequered. According to interview data, the provider has suffered from poor management practices in the past, almost resulting in the closure of the service in 2003 (MHP06A:1). Since then, several organisational and managerial changes appear to have halted the decline in the provider's fortunes. The provider is an incorporated society and has recently developed a new business plan for the years 2004-2006 (MHP06 Document D); has updated its Policy Procedure and Quality Manual (MHP06 Document E); and has successfully tendered for new health contracts from the local DHB. The provider has one mental health subcontract with the local Māori Development Organisation to deliver kaupapa Māori alcohol and drug services. The provider is charged with providing "a Māori community or outpatient-based alcohol and drug assessment, treatment and consultation/liaison service within a kaupapa Māori framework" (MHP06 Document A:2) and the contract includes one FTE, currently occupied by a trained Social Worker and Counsellor. The provider is governed by a board which reports to the Rūnanga and is guided in its operation through a number of principles outlined in its incorporation documents (MHP06 Document C). These guiding principles include tino rangatiratanga, kaitiakitanga, mana, tikanga and mana whenua.

**Provider MHP07** is a community-based provider in a provincial North Island town. The provider had its origins in a half day GP service for Māori in 1997. As its client base grew, so too did the demand for services, so that in 1998 the provider was awarded its first mental health contract. Now, according to interview data, the provider is one of the largest Māori health providers, within its region, providing mental health services (MHP07A:1). The provider has mental health contracts with the Ministry of Health and local DHB including contracts for Mental Health Needs Assessment, Mental Health Advocacy Service, Mental Health Child and Adolescent Service, Mental Health Adolescents Home based Service and Mental Health Rangatahi Service. Its Board comprises 6 trustee Board members affiliated to one or all of the local iwi and two professional advisors (MHP07 Document B:3). The provider delivers kaupapa Māori services based on a set of fundamental principles and core values which are outlined in the provider's profile document (MHP07 Document B:2) and include values such as tino rangatiratanga, whakapapa, whanaungatanga and aroha. The following table outlines the key characteristics of the providers participating in this study.

**Table 2: Characteristics of Participating Māori Health Providers**

<b>Organisational Type</b>	<b>Type of Provider</b>	<b>Location (DHB)</b>	<b>Mental Health Contract Type</b>	<b>Contracts With</b>
Trust	Community based	Canterbury	<ul style="list-style-type: none"> <li>▪ Community Support Worker</li> <li>▪ Activity Centre</li> <li>▪ Like Minds (Destigmatisation)</li> </ul>	Ministry of Health Local DHB
Charitable Trust	Iwi based	Midcentral	<ul style="list-style-type: none"> <li>▪ Kaupapa Māori Alcohol, Drug and Gambling Services</li> </ul>	Local DHB
Trust	Hapū based	Bay of Plenty	<ul style="list-style-type: none"> <li>▪ Kaupapa Māori Day Programmes</li> <li>▪ Kaupapa Māori Mental Health Needs Assessment</li> </ul>	Local DHB Māori Provider
Trust	Iwi based	Canterbury	<ul style="list-style-type: none"> <li>▪ Support Workers</li> <li>▪ Needs Assessment</li> <li>▪ Residential</li> </ul>	Local DHB and two other DHBs
Trust	Community based	Canterbury	<ul style="list-style-type: none"> <li>▪ Adult Mental Health (clinical)</li> <li>▪ Adult Mental Health (community)</li> <li>▪ Tamariki and Rangatahi Mental Health</li> </ul>	Local DHB
Incorporated Society	Hapū based	Bay of Plenty	<ul style="list-style-type: none"> <li>▪ Kaupapa Māori Alcohol and Drug Services</li> </ul>	MDO
Trust	Community based	Bay of Plenty	<ul style="list-style-type: none"> <li>▪ Kaupapa Māori Needs Assessment</li> <li>▪ Child and Adolescent Mental Health</li> <li>▪ Consumer Advocacy</li> <li>▪ Home-based Service</li> </ul>	Local DHB

## How Performance is Measured

Providers were asked what types of mental health contracts they had, who these contracts were with (e.g. MoH, DHBs, MDOs) and what performance measures were included in the contracts. While most providers had contracts to provide mental health services on behalf of their local DHB, some had contracts directly with the Ministry of Health (for example public health contracts such as the destigmatisation contracts run as part of the “Like Minds Like Mine” programme), and one provider subcontracted with a Māori Development Organisation to run mental health services in their locality.

### *Contract and Performance Measurement Documentation – MoH and DHB*

Where providers have contracted with a DHB or the MoH, standard contract documents are used (the template described in Chapter 3 with examples in Appendix 1). These standard contracts, in addition to the section entitled “Provider Specific Terms and Conditions”, include sections on the reporting requirements, the frequency of reports and copies of the Service Specifications for that particular service. For each service funded within a contract, a provider must report on a standard set of performance measures or “reporting units” using templates supplied by the funder. These templates are known as Performance Monitoring Returns and comprises two sections: a table concerned with counts and volumes; and a page headed “Additional Information” where the provider can narrate any pressing issues or concerns. In the instructions accompanying these templates, providers are informed that the purpose of the Additional Information section

*is to advise us [the funder] of any issues you have, other information you would like us to know or any queries you may have. Every endeavour will be made to respond to any issues that you raise. You may also use this section to explain some aspects of the reported data if you believe further clarification is necessary.* MHP03 Document E:3

A typical Performance Monitoring Return for a DHB-funded service may appear as follows:

7. Kaupapa Māori Alcohol and Drug Service Purchase Unit: MHCS02C Kaupapa Māori Alcohol and Drug Services (non-Clinical FTEs) Purchase Unit Measure: Non Clinical FTE				
Reporting Unit	Start Date	End Date	ID	Actual Data
Number of completed support needs assessments			3853	
Number of consultation/liaison contacts			4251	
Number of consultation/liaison training sessions			3852	
Number of day attendees			3864	
Number of face to face contacts (Group)			3892	
Number of face to face contacts with individuals/families			3905	
Number of group sessions delivered			3849	
Number of people supported by services at end of period (NZ Māori)			85962	
Number of people supported by this service during month (NZ Māori)			85969	
Average length of stay			3137	
Number of day places available			3885	
Number of FTE staff (Non clinical)			57462	
Number of FTE staff (other Clinical)			85983	
Number of FTE staff (Senior Medical)			85982	
Number of suicides of current clients			3816	

**Figure 3: Example of a Kaupapa Māori Alcohol and Drug Service Specification**

## ***Contract and Performance Measurement Documentation - Other Funders***

In the two cases where providers subcontracted with another larger Māori mental health provider in their area or with the MDO, memoranda of agreements and contracts were used to establish the relationship between the funder and the provider. Within the memoranda and contracts, as with DHB contracts, schedules outlined the specific services to be provided. Reporting requirements were also outlined in these documents. Schedules and performance reports appeared to be based upon those used by DHBs, using the same types of language and the same kinds of reporting units. As an example, one contract between a provider and an MDO contained the following note in the Schedule, headed “Schedule A2 Kaupapa Māori Alcohol and Drug Service”:

*Based on the Ministry of Health service type description for: Nga Huihinga Tangata o Roto I Nga Mahi Whakawaia Tarutaru Kai Waipiro, Kaupapa Māori Alcohol and Drug Services. MHP06 Document A:11*

In addition, in that same contract, the reporting requirements included:

- *Number of first contacts with individuals/whānau (face to face or other method e.g. telephone)*
- *Number of follow-up contacts with individuals/whānau (face to face or other method e.g. telephone)*
- *Number of group sessions*
- *Number of face to face contacts (group)*
- *Number of consultation/liaison contacts*
- *Number of consultation/liaison training sessions*
- *Number of completed support needs assessments*
- *Number of people supported by services*
- *Number of full time equivalent staff*
- *Number of FTE staff (clinical)*
- *Average length of stay*
- *Number of suicides of current clients*
- *Number of clients on receiving support at end of the quarter*
- *Number of clients service delivered to during the quarter. MHP06, Document A:15*

However, in addition to providing the volume data, the Māori Development Organisation specifically asked that the provider, also:

*provide a quarterly narrative report that includes:*

- *Staff training undertaken*
- *Highlights, issues or concerns and any trends within the quarter*
- *Progress made in implementing the National Mental Health Standards*
- *Progress made in developing, implementing and reviewing the quality plan.* MHP06, Document A:15

In contrast to the MDO contract the memorandum of agreement between two mental health providers appeared to use plainer language; however, the reporting requirements were identical to those used by the Ministry of Health and DHBs. This might be because this information is collated by the funder on behalf of the sub-contracted provider and reported to the DHB as part of the funder's own reporting requirements.

### ***Provider Views***

When asked how performance was measured, providers overwhelmingly indicated that it was “the numbers” or “ticking the box” that was important to the funder.

*At the end of the day ... they're numbers driven you know? How many people did we get through? You've got eight beds, are there eight people in them? Are those beds occupied 24/7, 13 months of the year? .... That's what they're driven by....at the end of the day.* MHP04B:3

*It's like, we look at the holistic picture in terms of mental health. And the way I see it, Ministry of Health, DHB, all they look at is numbers, numbers, numbers.* MHP07A:3

*Basically we are required to report to them on a quarterly basis and they provide us with a reporting template and that really involves data collection of information that they want recorded. And so it's just a matter of staff fill out*

*weekly .... stats sheets and then they are combined at the end of every month and then every three months. And they go in .... the quarterly report that goes to the um, well goes to Dunedin for the DHB. MHP02A:2*

Given that providers are sent a standard template which records counts in order to report back to the funder it is perhaps not surprising that the interviewed providers regarded “the numbers” as the crucial performance indicator for the funder. However, providers are also given an opportunity to raise other issues of concern in the narrative, or “Additional Information”, section of the performance monitoring reports. When asked about more descriptive means of reporting performance providers confirmed that they did fill out the Additional Information section of the reports, but that they rarely received feedback on these narrative reports.

*Well the only thing that in any of the monitoring terms .... is they have an issues page where you can raise issues. Now whether anything is done with those issues, you'd really have to talk to the DHB. As a scenario we might say we haven't reported this but .... look, 95% of our tangata whaiora are reporting housing issues. Now whether that is actually picked up at the DHB level and in turn, do they talk to the Minister of Housing .... we don't know. MHPO4B:4*

Some providers also mentioned that audits were a type of performance measure, in that they were used to check on the quality of care or quality of service a provider might be delivering.

*The internal processes are around quality control and quality improvement mechanisms. So we have things like .... clinical auditing of the client notes, we have case reviews ... and everyone takes part in those reviews, and that ensures that the care that we are giving to tangata whaiora is appropriate. We have peer supervision and .... then we have audits, like, we have, the Community Nurse Clinician .... comes in and she does random audits of notes. MHP02C:3*

However, while these audits were regarded as another performance measure, one provider noted that the audits were very much based upon “western” or mainstream indicators of quality:

*I guess they come in and audit us, well they have us audited anyway, so yes there is a quality component to the agreement and its all mainstream. There is nothing in there about kaupapa – it's all mainstream. MHP03A:4*

## **Adequacy of Performance Measures and Monitoring Returns**

Providers were asked whether they thought the current performance measurement tools used by funders (i.e. the Performance Monitoring Returns comprising reporting units and the Additional Information section) adequately captured the extent of the work they did. A range of responses was received. Most providers agreed that the performance measures were inadequate - in particular the funders' reliance on numbers as a de facto means of indicating improvements in client wellness.

*If we talk about the ... reporting template, although they allow you to write ... whatever you like about certain issues there's something in it that tells us that's not the right template for reporting. I know my mental health team have ... a lot of difficulties with that, but you know at the end of the day, we just stay with it – that's what it is. MHP07A:4*

*I don't think that they are actually getting the true picture of, like, what's happening in the mental health area because they're only really kind of seeking limited information and at the end of the day, its really just kind of output driven, how many people you have through and all that kind of stuff. Sometimes you get the feeling that that's all they care about, how many get spitted in and get churned out. MHP02A:5*

This same respondent observed that the reporting mechanisms were “quite odd” particularly as it was not until the provider's contract was renewed some three years later that a glossary of terms including definitions and specifications for the measures was ever sent to the provider.

*... The first three years it was kind of a matter of us trying to figure out what it meant by what a group session was, or .... what was the difference between ... the number of people supported at the end of the period .... as opposed to the*

*numbers of people supported during the month. So we were kind of left in the dark in that regard. MHP02A:3*

The inadequacy of the monitoring returns was highlighted by another provider. In the Additional Information of their performance monitoring return for September 2002, the provider noted:

*I believe the reporting system has a lot to be desired. There is nowhere in this report that I am able to record the total client contacts with clients during the month. MHP03 Document E:10*

One provider noted that neither the contracts nor the performance measures were actually *intended* to measure the amount or range of work undertaken by Māori mental health providers, stating:

*Well they're not designed to actually. They're designed to capture the numbers .... They are designed to ensure that ... what we signed up for, we signed up for five things, we do five things. So they are designed to measure that .... We report back what they want. We tick their boxes. MHP04B:5*

Another provider commented that simply reporting the numbers would never allow the funder to have a true insight into the work of Māori mental health providers.

*They don't see the results. They can't visually see, which is really difficult to put into words, to write about, they can not visually see what we see on a day to day basis. It's just pure numbers [to the funder]. They don't see the growth, they don't see the empowerment. MHP01A:3*

Another provider, who agreed that simply reporting “quantitatively” does not demonstrate to the funder the extent of the work done, indicated that they were working on ways of reporting more qualitative information to the funder as part of their regular performance monitoring.

*Showing them in terms of quality so rather than a quantitative measure, there's a qualitative measure, that in fact, this is how many hours that we do spend with*

*our clients. So that a contact is not always about being 45 minutes, or being 60 minutes. That one contact may be three hours because of these reasons. So we're trying to see how we can have our work measured qualitatively as opposed to quantitatively. MHP05B*

Respondents, when prompted, were able to identify specific areas where the current performance measures were inadequate. These included:

- no provision to report the efforts of providers to make linkages and networks in the community (MHP02A:3);
- no provision to record actual time spent with tangata whaiora and whānau, whether face to face or on the telephone (MHP02A:4, MHP02B:3 and MHP04B:3); and
- nowhere to record holistic approaches to dealing with mental illness (MHP02C:5 and MHP03A:7).

One provider noted that the funder was too reliant upon numbers as an indicator of success and did not take into account the broader context in which Māori mental health providers worked. The respondent gave the example of a service where instead of ten clients in one reporting period, a provider only saw five. According to the funder, the provider has obviously failed in meeting their obligations to see the requisite number of clients; however the funder is unaware of any contextual information which may explain why a provider could only deal with five clients. It is for exactly these instances, the provider noted, that many providers keep a separate set of records (MHP07A:10).

*The disadvantages are that there's a lot of other work that we do as Māori that isn't accounted for so we slowly are building a database that highlights these things. Like, the number of hours we work with clients ... they don't want to know that and ... you can only start counting a client when that client's actually accepted by the service ... But we as Māori spend a lot of time chasing people up ... to even get to have that initial kanohi ki te kanohi ... we'll do that for two or three months. We have a very good paper trail that shows how much effort we make in getting hold of people. Recording of telephone calls, letters sent when people don't arrive for appointment times, letters to the referrer to know*

*where we're at in the progression of trying to make contact. So all of those things take time, but you can't record them. They are not recorded, actually recorded 'til that person becomes a client. Then you only count the person.*  
MHP05A:78

In many instances, the extra work done by providers is recorded on the Additional Information page of the performance monitoring report.

### ***Uses of the Additional Information or Narrative Section***

The narrative section fulfilled three functions for providers. First, it was used to record the additional work which providers felt was important enough to be formally reported to the funder but which was inadequately captured by the “ticking of the boxes”. Secondly, it was used by providers as a means of communicating with the funder or with those who collated the statistics. Finally, I believe the narratives are used by the providers themselves as a means of recording information that is important to them as Māori providers and which, if not captured on these forms, might be lost. Examples of all these functions were evident from an analysis of the performance monitoring reports.

Appendix 13 *Narrative Report for Provider MHP05* is an actual narrative report submitted to the funder by one of the provider who participated in this study. It shows that the provider has, in the words of its writer “taken the initiative” to provide additional figures on the number of tangata whaiora who accessed the service but were not current clients, or not yet current clients. This was additional information that they felt the funder would be interested in receiving. The provider also used the narrative section to indicate the levels of staff training that had occurred in the three-month period.

Another function of the narrative is to communicate directly with the funder, usually to seek clarification on some point. One provider recounted an experience in which attempts were made through the reporting template to inform the funder of changes in the funder's own reporting system.

*...Our contracts were all separate and then we had different templates and then they all got put together and then we got one reporting template. I think I had*

*to, twice, for the first two quarters, keep telling them that the kaupapa Māori alcohol and drug report was inside the main report, cos they kept writing to me saying I needed it, where is it? MHP02A:4*

Appendix 14 *Narrative Report for Provider MHP03* shows how a narrative report may be used by providers to communicate directly with, in this instance, the funder, or those collating the statistics (if this distinction is recognised). In this set of reports, covering the three month period April 2003-June 2003 the provider repeatedly requests clarification on the time span of a particular reporting unit. After two consecutive reports in which clarification is sought, the provider, in the third report, seeks a reassurance that the reports have arrived safely.

Appendix 15 *Narrative Report for Provider MHP01* shows a narrative report containing substantial additional information, some of which may be of use to the funder, but some of which could be deemed outside the funder's sphere of interest. However, this narrative provides a written record of the issues the provider was grappling with at that time (ensuring client safety, changes in staff and team dynamics), the successes of the past quarter (ongoing whānau training, tangata whaiora employed on service contracts, an article about the service to appear in an upcoming publication), and plans future development (need for larger premises and possible increase in funding).

Some providers mentioned the lack of feedback on these reports as an area of concern. This will be discussed more in a later section dealing with possible improvements to current practice.

## **Adequacy of Service Contracts**

Several providers chose to comment on the adequacy of their contracts as well as the performance measures contained within them. A common issue amongst providers appeared to be the lack of any real negotiation when contracts were being drafted and discussed. One provider observed that, in the past, providers had real input into the content or value of contracts:

*At those times, we had the opportunity to have input. We had the opportunity, or ... put it this way, in the early stages when the Regional Health Boards, or*

*you know, those Midland Health Boards, when they were in, we had the opportunity to have input into contracts. We had the opportunity to talk about dollars and that lasted for about .... like two years and then after that it was here's a contract we want you to do, this is the specs, this is the money. If you want it you can do it, if you don't tough. And that's really how it's been ever since. MHP07A:3*

Another provider agreed that the process was very one-sided with all the power appearing to reside with the funder:

*Basically it [deciding the performance measures] was not through a shared or partnership process. Basically, they just do the contract and once you've signed the contract up, a month or two later you get an email or sent a hard copy with the reporting template and you just fill it out. MHP02A:3*

Another issue that was raised in the interviews was that the contracts themselves were too narrow. Māori providers found it difficult to deliver exactly according to the wording of the contract.

*... [the contract's] no, too narrow. You know, it should be done, I believe that's what we're here for ... the kaupapa is Māori health, the wellbeing of our people holistically. That's our statement so the yeah, the contracts are not broad enough, they're not. MHP06A:12*

## **Additional Work, Effort or Services Provided**

All the providers agreed that they did additional work or provided services over and above those specified in their contracts. In explaining the types of activities which constituted this extra work some providers indicated that they were simply interpreting their contracts in an innovative manner, others noted that the work was a necessary component of delivering a kaupapa Māori service, while others agreed that the extra work was completely outside the scope of their contract.

The types of additional work tended to fall in to one of three categories: additional work undertaken in order to deliver a culturally appropriate and tika Māori mental health

service (according to a provider's own understanding of what constitutes a culturally appropriate service); additional work done, usually for the benefit of the tangata whaiora, from an obligation or sense of duty to the client; and additional work done to improve the service, improve service resources or improve staff capabilities.

### ***Delivering a Culturally Appropriate Service***

Several providers noted that most of the additional work was associated with delivering a culturally appropriate service. All the providers who participated in the research described themselves as kaupapa Māori services. From their perspective, being a kaupapa Māori service placed additional obligations, responsibilities and expectations upon them. Examples of additional work required of them as kaupapa Māori providers included taking tangata whaiora to whānau tangi or even attending the tangi of tangata whaiora (MHP04B:5), helping to trace whakapapa links (MHP02C:2), arranging activities such as kina expeditions or fishing to encourage whanaungatanga, and “cultural learning” such as waiata, reo and kapahaka (MHP03A:10).

Significantly, delivering a culturally appropriate service often required a greater time commitment from the provider and the staff:

*I mean, we can spend two or three days on end with a client and we're talking just, the person's not here for an hour. We're talking they are here eight, ten, twelve, fourteen hours in this building. MHP04B:5*

*It's just the way we are. That's what I found. I mean, I've never ... had a staff member who has said to me 'I stopped at four o'clock because that's all I get paid to'. I've never had that. I've seen staff work after time. End of the week they'll come in and we talk about it, you know, and I'll say, 'take a couple of hours off next week'. You know, something like that. But they will do what they have to do. We've had this conversation with DHB, or with their representatives, for a long time, you know and they agree. They know it's happening, but they won't do anything about it. And I think it's part of the make up of a Māori – you just carry on doing it. MHP07A:7*

Methods of service delivery or “therapy” may also be different in a kaupapa Māori service compared to a mainstream service, requiring greater planning, greater time commitment and a greater emphasis on volunteers and community support.

*The thing is that we use our environment. We go up to the ngahere which is just up the road and then we go to the beach you know? So how do we get there? We find our way there ... We have people, other tangata whaiora coming out and teaching how to make taiahas and all of those types of things. I think what’s additional too is that they don’t ask where we hold these things. I always say marae-based and they are held on the marae, so therefore the hapu is involved automatically. So that’s additional to our service. Actually I see it all as bonuses and I don’t think the Ministry of Health is really interested cos I put it in my records. MHP03A:8*

*The [name of intervention] was something I designed for tane cos what I discovered was that a lot of our tangata whaiora, especially our tane, don’t even go out fishing. So this way was about ... bringing them back onto the marae, so it’s a marae-based programme and it’s about getting them kind of feeling comfortable within the marae, learning about waiatas and karakias and also learning about how to make a hīnaki, a traditional one, and also a contemporary one. Our kaumātua likes using number eight wire, so they can have a choice, they can make two. And then what we would do is once they’ve made that we’ll go out to [local] lagoon and stay there the night in a DoC house .... I haven’t yet [implemented the programme]. Well there’s lots of things I need to do. I have to look at policies about us working outside of those hours. I have to look at safety, how many numbers need to be around, you know, OSH, you know. There’s so many rules and regulations and can I, will I be able to implement it? MHP02B:13*

### ***Additional Services***

Transporting tangata whaiora was the most commonly cited “additional” service that providers offered their clients but were not specifically contracted to do. Examples of transporting clients include taking them to the dentist (MHP01A:3), taking them to the food-bank (MHP02C:4) and getting them to and from the service itself (MHP03A:6).

*And then you know we might have to run them in somewhere or, so, run them in to the Hospital or whatever or different things like that. That sort of extra work you know? That sort of stuff. MHP06A:6*

*And then there's looking at picking them [tangata whaiora] up. We go out and we pick them up. We have to, we actually went out and sought funding to buy us a van to go pick them up. And it's not about making them dependent on us, it's actually 1) a lot of them don't have transport; 2) give a break to whānau; 3) get the tangata whaiora out to actually socialise. Some are quite happy to stay home sometimes. So that's where transport comes in .... transport is actually the whole kaupapa of the thing. When you, if they haven't got it, you're actually looking after their wairua. You're actually looking after their physical tinana, by physically going to get them. You're actually looking after their hinengaro and you're actually looking after their whānau. And that's whare tapa whā. MHP03A:6*

However, another commonly cited example was where the provider acted as a “lead carer” and organised services to support a tangata whaiora, or worked directly with agencies in a brokerage capacity to access services.

*We take part in the process of strengthening family, which we're not contracted to do, but we often, for our tangata whaiora, take on the role of lead provider. So we coordinate their care for them and that might be working across a wide network of people, bringing them all together. And we've had some very successful outcomes from that. MHP02C:5*

*Housing is obviously a big issue ... I know we had one tangata whaiora and for three days back to back we couldn't find anywhere for him to live. He was going to get kicked out of [the] Mission you know so there was three staff sort of tied up for three days ... cos that's what you try and do. You can't have a guy living on the street. Well you can, but we chose not to. MHP04B:4*

### ***Additional Responsibilities and Tasks***

Examples of additional work done in order to improve the service, improve service resources or train staff included the development of Māori resources to use with tangata whaiora (MHP01A:3), taking te reo classes outside work hours so that staff are able to kōrero Māori during their work (MHP03B:18) and working outside one's job description to ensure a planned activity goes ahead. One respondent noted that although her job description stated that she was employed to network and liaise with the DHB, if there were no one to run the afternoon's cooking class, she would do so rather than let tangata whaiora down (MHP01A:3). Additional tasks also included ensuring that organisational systems were all of the highest quality.

*It [the contract] doesn't reflect the level of compliance that we have to do in terms of like, the quality improvement systems that we have in place. The work we have to do to comply with like, the mental health standards and all the policies and procedures that we have to develop and update and maintain and that in terms of making sure that we are providing a good service. MHP02A:4*

*I have probably over this last month, cos I've had to ... get involved with the policies. We've had to go over and do really, the whole policies. So that's been kind of something that's taken me away from tangata whaiora too ... so I guess it's the commitment you have to do all the mahi that you've got to do and ... like the policies and things I think that they needed to have an amount of time where we just spent time on, but then what do you do with your tangata whaiora? MHP02B:11*

## **Reasons for the Additional Work**

### ***Cultural Imperatives***

Some respondents commented on aspects of Māori culture or Māori values that compelled them to undertake more or additional work. Indeed the most common reason given by providers to explain why they would do additional work or provide additional services was “because we are Māori”.

*We just go that extra mile. It's the kaupapa that drives you, it's not actually the business. Certainly we have a business which is mental health, but the kaupapa is the thing that will drive you 'til you drop to your grave. And its about the kaumātua, it's about the history that's attached to the Rūnaka, it's about the kaupapa, it's about whakapapa, it's about who we are. It's that what makes us unique. MHP04B:6*

In the interviews the reason “it’s because we’re Māori” or “we do it because we are Māori” was queried further. What became apparent was that this seemingly simple statement disguises cultural imperatives that compel the provider to deliver the service in the manner they do and sums up a unique way of practising for each provider. In other words, each provider was attempting to deliver a contracted mental health service from within their own unique understanding of Māori health and wellbeing and from a philosophical view grounded in Māori culture. It is this distinction which differentiates the kaupapa Māori provider from the mainstream provider.

*I mean, you know one of the things that we have difficulty with is that mainstream and kaupapa Māori are very different. Now I was .... over there cos we're getting a new Community Mental Health Team. So we just had a bit of a kōrero, you know .... I asked one of the adolescent staff, Community Health Worker, I said 'how's your work going, how's your workload?' And she said to me 'at the moment I'm dealing with three intense', and I said 'yeah ok, what do you mean intense?' And she more or less explained that she's been referred person A, she goes out to see person A and the whole whānau is involved, then she spends quality time with them and ... has to go back at night because the father is at work and, you know do it all again. Those sorts of things? It's never taken into account by the DHB or the Ministry you know? MHP07A:5*

*For some reason I think that in Tauīwi, you're ... governed by so many rules and so many practices that you think that you ... can't practise outside that. I guess that it's just the holistic framework that you work from. It's about, it is about whānau. And it's about ... your sense of identity. You identify with each other, whereas I think some Tauīwi don't have that. It's very individualistic .... and I think when you work in an iwi or Māori provider you're here .... cos you*

*want to be, you're not here cos you're going to get rich doing this sort of work ... you're here because you want to be and I think that's the difference.*

MHP02C:7

Trying to deliver a contracted mental health service from a Māori worldview of health and wellbeing resulted in providers emphasising different values in their practice. For one provider, service delivery was structured around the importance of whānau, for another the importance of whakapapa, while yet a third provider described the importance of manaakitanga (MHP04A). In explaining the importance of whānau and whanaungatanga, one provider noted:

*I come to work everyday because our whānau are out there .... It's their marae, It's my marae. It's our kawa, it's our tikanga and there are no hours in tikanga, there are no hours in kawa .... It's understanding the wairua, the spirituality of Māori .... it's in our reo, it's in our taonga, it's everywhere – that's where the western world doesn't understand. That we have a perfect model; we have whanaungatanga, just jump on our waka! MHP01A:4*

The importance of whānau being supported, compared to simply dealing with one “client”, means the way Māori mental health providers work may be slightly different.

*As a Māori service we don't, we might start with one client but because we're whānau driven you end up with the whole whānau ... And the whole focus of that is about the whānau taking hold of what they need to do for themselves. So [name] might end up with one rangatahi, I might end up with the mother, [name] might end up with the father. Together we're all working to have that ... family to take hold. MHP05:220*

A different provider agreed that the reason Māori mental services delivered over and above their contracted outputs was because of their tangata whenua approach.

*You naturally do it because [you're] Māori and that's just the way you do things and you're tangata whenua, then you have that tangata whenua approach. MHP02A:8*

### ***An Holistic View of Health***

A further explanation of why Māori providers might take on extra work, or deliver over and above their contract is because they are delivering mental health services from within a “whole of health” approach to wellbeing, rather than delivering mental health in isolation from other health needs.

*I guess that we see the care of tangata whaiora in a holistic framework and when you're passionate about making, having a truly successful outcome for Māori, then you do it because it's something inherent in you. You don't think about it. Like, when I think about those things that we do now, it's not something I think about everyday, it's just if someone rings in and they need help, then they need my help and I go and do it. MHP02C:6*

Delivering mental health services in this way may mean that innovative and alternative methods of therapy are employed.

*We do things like cooking because we identify some of our tangata whaiora, do not know how to cook basic, basic meals. So ... we have once a month now, we have a shared kai. The tangata whaiora choose their menus ... we all bring something, for that and we all, they actually cook the meal and we actually have a nice table setting. So they learn all about, cos they didn't know, like to have a nice, knives and forks on tables. So it's kind of all that kind of thing ... so their groceries are starting to change. They've been able to buy things that aren't so expensive to be able to make. MHP02B:4*

### ***Expectations***

Some respondents indicated that the expectations placed upon them by iwi, hapū, whānau and Māori compelled providers to take on extra responsibilities within their service and extra work outside their service. Clearly what distinguished Māori providers from merely being mainstream providers with Māori clientele were the extra lengths that Māori providers were expected to go to for tangata whaiora.

*Just say for argument's sake eh, you say 'oh no, I'm going home at five.' So and so will tell so and so and all of a sudden you're going to be a useless*

*provider. I've had it before you know .... I mean I've heard our people talk about mainstream providers, 'oh they're hopeless', you know? 'They're sitting here talking to you and all of a sudden they're gone cos its knock off time', you know, that sort of thing. So yeah, there is a ... accountability aspect to our people, cos they're the biggest critics of the whole lot.... They have expectations about all Māori providers and especially the hapu-based ones. MHP07A:7*

One respondent noted that, in addition to running her service, she was also a member of the local DHB's Manawhenua group, a member of a Primary Health Organisation's development group, represented Māori interests on the DHB's Rural Committee and was involved in an advisory capacity with other health-related organisations such as the Hilary Commission. She noted that this is simply "what Māori do". In addition, she commented that to turn down offers to be involved in a consultative or advisory capacity due to pressures of work would not be tolerated by the Māori community. Were the Māori community to hear that such a position were turned down, that person's reputation and standing in the community would be forfeit, or in her own words "it can backfire on you to not be involved in everything" (MHP04A, personal communication).

The expectations and obligations compelling Māori to "go that little bit further" may not be explicitly stated, or even voiced.

*So now to give you another scenario ... if you turn around and go mainstream and we know this, some of our staff have been mainstream. So what happens is you go in there, 'four-thirty, oooh knock-off time, oooh we've got to go'. You know? 'If it's bad .... refer it to the crisis team, oh see you tomorrow'. See, we don't do that, you know? We, Māori family, we've got to stay there. And our staff knows that. We're not asking them to do it, you know, we're not asking them to do that, but their heart tells them they have to do that and that's the difference you see? MHP07A:5*

## **Possible Improvements to Current Practice**

Providers were asked to think about the ways in which current contracting practice and/or performance monitoring practice could be improved to better reflect the work done by Māori providers. Responses described three types of improvements: improving

performance monitoring reports, or reporting expectations; enhancing relationships between funder and provider; and upgrading or updating the contracts themselves.

### ***Improvements to Reports***

Suggested improvements to the reporting system ranged from revamping the reporting template (MHP04B:9) to cutting back substantially on the burden of paper-based reports (MHP06A:9). One provider in particular noted that the burden of paper work (including keeping up to date with monitoring reports) took a person's time away from the client.

*But I just wonder sometimes about the amount of work we have to do, in paper work, cause you virtually can be tied up for a major part of the day just in paper work. And where we, where we should be seeing clients, patients and spending more time with patients and helping them, because just think the way they're run, there's just too much paperwork. MHP06A:12*

Respondents suggested that improvements be made to the reporting template including changing the way client hours are recorded and making changes that would capture the different worldview Māori providers bring to their delivery of health services.

*Where I was talking .... before about the issues when we talked about the numbers .... that's just part of the contract, but there needs to and I'm not sure how that can be reflected, that it's about .... an acknowledgment of those support pillars that makes up who we are and if one area is out of kilter, in our role as hinengaro, is that those emotions and mind .... but it also comes into the spiritual and comes into the physical person. So it's an acknowledgement of, that we are dealing with more than just one aspect of that person .... Because that's what Māori organisations have been trying to say for years. Capture the emotion of a culture and it makes them who they are and how do you put that in a box? MHP04B:9*

### ***Changes to Current Contracting Practice***

Several suggestions were made of ways in which funders could improve the way they manage their contracting practice, from actually negotiating with providers rather than presenting them with a fait accompli, to understanding local needs and reflecting these

in contracts wherever possible. Providers also suggested improvements to the contracts which would better acknowledge and validate their work.

One provider indicated that when a new contract is drafted they would like to be able to sit down and negotiate meaningful measures (whether they be outcome or output), with the funder.

*Like what, if just say for arguments sake, if a new contract came out, that I believe that we should be sitting ... at the table and talking about how we provide the service, not how we're told to provide it. And ... that would be good if we could do that then they can put it into words we both understand, you know? Because I always believe that it's an outcome situation that we look at.*

MHP07A:11

Another provider indicated a wish to negotiate access to high quality, external clinical supervision as part of their contract. To date, they have not been successful in their negotiations.

*Well my Board has tried to include supervision in our contract but we have had no joy. So to get a really good quality supervisor you have to pay big money. So we try to get the best people that we can in their own time. And you know to me that's all part of having a quality service is access to good supervision.*

MHP03A:13

Another respondent suggested that it was the mental health contracts themselves that needed to be overhauled so that they were flexible enough to allow for local differences and local needs:

*I really think that, like, the mental health is a silly kind of contract because the contract actually covers any kind of mental health you could be involved in. So, you get to page 150 or whatever and you get to the service specs that are relevant to you. Plus they're standardised at a national level, so I really think they need to have a bit of flexibility in terms of the local level ... because there may be issues that are a bit different, in terms of mental health, in the Mid-*

*Central region than opposed to the Canterbury region or something like that*  
MHP02A:9

A respondent working at the same service also wished to see changes in the contracts themselves.

*So, I guess, that also that contracts need to be looked at, they need to reflect iwi. You know, at the moment DHBs put out contracts and they go, 'ok, we've got some money for an A and D.' They don't care who gets it and like, we go from, we used to go from [a town] right down to [another region]. Well hey, we're crossing all sorts of iwi boundaries, so whether you like it or not, you're gonna get your iwi politics .... I think that DHBs need to be aware of iwi boundaries and contract accordingly .... it really would save a lot of angst and that doesn't mean to say that iwi has to get over there ... they could refer appropriately. Yeah, and that's my biggie for me, with contracting, is they really do need a different set up, even boundaries. Because we all work differently and we have our own tikanga, kawa and ... it's very hard to go into another area and take that with you cos they've got their own* MHP02C:10

Providers believed that the process of negotiating contracts could be improved, so that negotiations were more about agreeing on common desired outputs, as the following statement highlights:

*So, I mean, I'd like to see that, you know, before your contracts end that they contact you about six months beforehand and you come together and you discuss it and you develop the outputs together and that the outputs better reflect what you're actually doing over and above just the numbers game. And of course there's always the funding issue 'cos we always want more money. I think that that's a way that they could be enhanced and made more relevant, I mean, there'll be standard clauses that ... will apply in all contracts and that's fine, but I just think in terms of the actual service specification component, that's the bit that they should really come out and negotiate more .... so that you are developing it together.* MHP02A:9

### ***Relationship Building***

Some respondents indicated dissatisfaction with the lack of feedback received from the funder in response to quarterly performance monitoring reports. For example:

*So you don't actually get any feedback in the sense that [of] how you've been going and that. But having said that, I'm noticing that is starting to happen now that the contracts are with the DHB. With the Ministry of Health, I mean, you could've just made figures up basically and put them in and made your narrative up too, for that matter. MHP02A:5*

Another provider observed:

*We report back what they want, we tick their boxes. I know that the likes of the funding managers do have an oversight and I'm well aware of that. It's a bit cynical, but as I said at the very beginning, there doesn't seem to be a process to acknowledge those issues that are raised. I know that [another service] has issues pages of three or four pages long. The thing is though, I think, she said naively possibly, that I don't think that feedback would be that hard to give, you know? Maybe that is very naive for someone to say 'yes, I've read what you've written.' It's about relationships. MHP04B:19*

One respondent, while expressing doubts that the contracts per se would ever change, did suggest that those involved in contracting and funding Māori mental health services could take a more active role, noting:

*I don't think contracts will change but I think that for a better understanding of Māori working with mental health, Māori that are up top, corporate within the DHB should spend more time within an organisation. MHP01A:4*

One provider reported the beginnings of a positive working relationship with a funder, noting:

*The mental health manager from the DHB, she's actually been down and met with the staff and talked to the staff about what they do and as she's doing her*

*kind of planning, she invites all the mental health agencies together to kind of see what the needs and that are for the forthcoming year. So there has been a bit of a shift, so we are really just starting to see the effects of that coming through now.* MHP02A:5

### ***Other Suggestions for Improved Service Delivery***

An interesting suggestion for improving the way Māori mental health providers operate came from one of the hapu-based providers. The informant suggested providers in small towns become specialists in their own area of Māori mental health service delivery rather than trying to deliver every kind of health service. Currently, some Māori health providers contract for and provide other health services (e.g. Well Child, Auahi Kore, asthma services). The respondent noted that it was too “overbearing” for the provider to “try and run a mini-hospital on a very mini budget.” Instead the respondent argued:

*If we had specialists here, where our people knew that we ... could go to [another hapu] for heart, we could go here you know, for, mental health, for drug and alcohol, somewhere else. But ... each Hauora knows where those specialist areas are and they can refer people on. Say ‘well yes, you need to go here.’* MHP06A:12

## **Accountability**

### ***Accountability Relationships***

When asked who they were accountable to, respondents replied that the key accountability relationships were with the funder, iwi/hapū/Māori (usually through a board of governance or through the organisation’s trustees), and tangata whaiora. While most acknowledged it was the funder-provider accountability relationship that was the most important on a day to day basis, the relationship with the community was probably more enduring.

Several providers indicated that accountability to the funder was the most important relationship simply because without the dollars, the service wouldn’t exist.

*Accountable to the hapu, the [MDO], to the trust, the DHB. Probably, DHB and [MDO] are equal and then the hapu ...why I say that is because that's where our funding comes from and if we don't have funding then we've virtually got no ... Hauora. MHP06A:14*

*Well, I guess, I mean, contractually you're accountable to the DHB or you're accountable to whoever funds you, so you've got that. But you're also accountable to your own Board of Governance and through them ultimately to your beneficiaries. But at the end of the day, if you don't do what you are contractually required to do and you lose your contract, then there's little point being accountable to your Board of Governance cos you don't have kind of an organisation to be accountable to. MHP02A:13*

However, some providers regarded the dual accountabilities to funder and to community as being slightly more balanced.

*Although we're accountable to the DHB first, I'd like to think that we're accountable to our people first and then to the DHB. Well I guess, because the dollars come from the Ministry, you've got to be accountable to them. Which we are and of course we're accountable to our people. MHP07A:14*

*Well, to our funder specifically for a start because they own the funding ... That's the reality, they pay the bills. But we are a Māori organisation so we are accountable to wider community, to our Runaka, to our kaumātua, to our takata whaiora, you know, whānau. And that's not in any order. MHP04B:15*

### ***Forms of Accountability***

The form of accountability differed according to each accountability relationship. For example, providers indicated that accountability to the funder was a formal relationship and demonstrated through the timely submission of monthly or quarterly performance monitoring reports.

Accountability to iwi/hapū/Māori occurred both formally and informally. More formal accountability arrangements included preparing written reports for monthly board

meetings, oral presentations to the Board, reports to Rūnanga and fronting up at hapū hui. Informal accountability may include community feedback, or indeed, not receiving any bad reports from community members.

*... 'cause we meet monthly with our Rūnanga and we give monthly reports of how [we are] doing. We ask the iwi, are there any things in health or social services that they have picked up where we may not have, and how can we work together to do that? We have a joint venture with our iwi on health matters and it's a joint venture tied up with the hospital. So we're actually quite, a very fortunate organisation .... because we have one iwi. We're based with one iwi, on their whenua and there's no complications there you know? MHP03A:10*

*We report to our Runaka, which we have a monthly meeting where over probably anywhere from 80 to 120, 140, Māori and community-based organisations attend. For those groups who either are Māori or who want to work constructively and effectively with Māori so .... [staff] report back in a monthly format...and we don't do it every month because we also have a lot of written reports from other community groups that are coming. All our staff attend those meetings, all the Runaka know who our staff are .... so everyone knows who you are. MHP04B:16*

*Yeah and I guess in terms of accountability in Māori is like you're actually doing the service out in your communities and they're seeing you doing it. MHP07A:15*

*If we had feedback from our [staff] ... that there's an issue brewing in the community, then we might bring in [kaumātua] and [kuia] and we all might have a kōrero and say 'look, all the reports over the last six months have been saying ABCD, the feedback from the community is ABCD, I think we've got an issue brewing.' So there's that informal, but formal process. MHP04B:16*

The difference in forms of accountability is illustrated by the following comment from a hapu-based provider:

*It's because the Māori style is more kōrero than, than actual tuhituhi, you know? ... so you tend to get ... a varying range of comment. Whereas with more structured government departments ... it's black and white, it's .... more contractual. But a hapu to me is a different, it's a different way. MHP06A:16*

### ***Managing Multiple Accountabilities***

Many of the providers appeared to be comfortable with the concept of multiple accountabilities and many different relationships, formal and informal, with their many stakeholders. The reality of having multiple accountability relationships is summed up in the following remark:

*Well, being Māori, we're used to wearing ten hats and doing ten different things at once. So, I mean, I guess for some staff or ... some Māori providers, you know, get ... mixed up where their accountabilities should be. I mean, for me as a professional with a legal background, it's always clear cut where I'm accountable to. So ... you put them in your compartments, you're accountable to the DHB contractually, you're accountable to your Board of Governance for what you do at an operational level, you're accountable to your clients in the sense that ... you've got to provide them a service and the best service that you can. So that, for me, that's kinda where the boxes ... fit. And I guess at the end of the day, you're kind of accountable to your colleagues and yourself as well. Because you've got to do your share of the work load and you can't drop back and expect other colleagues and that to pick it up. MHP02A:15*

### ***Success***

Responses to the question “how do you know when you're successful” were surprisingly similar amongst the various providers and could usually be grouped into one of several categories: positive feedback (from community, tangata whaiora, other stakeholders and peers); visible improvements in tangata whaiora; meeting an external benchmark for example, accreditation; and contract renewal.

### ***Positive Feedback***

According to one respondent “you know when you're successful when you have good relationships with Māori and or with Rūnanga” (MHP04A). However, positive

feedback of any type and from any quarter is considered an indicator of success for many providers. In response to the question another respondent remarked:

*Our community says it .... there is a process from the wider community. As I say [to] all the staff here, I'm not just talking [this place], all across the country because of who they are, they are attached to their communities, so they do get feedback. So there's the informal feedback ... their own community, iwi, Board, sport, whatever networks. There's that feedback. MHP04B:20*

Positive feedback may come from the funder:

*The Chairman of the .... District Health Board was there and she made a remark to me. She's heard you know, about the good work we're doing you know, and I said oh that's nice, I hadn't read it anywhere. And she says to me, no she's heard it. She's heard it time and time again. Yeah that sort of thing. MHP07A:16*

Contract renewal and being asked by funders to tender for RFPs represent a specific kind of positive feedback; indeed for many providers they are an indication of success.

*When your contracts get renewed that's pretty much a strong indication [of success]. MHP04B:20*

*When it [the DHB] comes up with the contracts again and we're accepted we most probably have done a good job. MHP03A:14*

*Even in terms of RFPs coming in, you know? That actually sends a message to me that, they, outside, believe that ah, we have the experience or whatever to actually you know, put in a RFP or even perform a contract. Those are the sort of things I look for. MHP06A:16*

Positive feedback may also come from peers:

*When other Māori organisations come and see you and want to see how you do your business, even mainstream as well. When other organisations are setting*

*up services themselves and they come and talk to you. When other organisations come to you and say 'well can we do a joint venture together, can we apply for a contract together', I think those things indicate that you are succeeding in what you are endeavouring to do. MHP02A:18*

Providers indicated that feedback from tangata whaiora was usually captured through client satisfaction surveys and evaluation forms. However, often simply having clients come in to use the service was an indication of success “because it shows that not only they support it, but they believe in it and they are happy to use it” MHP02A:18.

### ***Visible Improvement of Tangata Whaiora***

Many providers judged their success by the wellness of their clients and whether tangata whaiora were using their services less regularly. For example, one provider commented that success could be measured by the fact that:

*[they're] going to the gym .... their cleanliness, their changes, pride ... some of our whānau on the methadone programme wanting to wean themselves off .... their wellness in educating, well the drama group, enhancing who they are, where they want to be .... being able to stand and speak in a public forum. MHP01A*

Another provider remarked:

*I guess the greatest success is when you've actually had a client come in the door that's had an alcohol and drug problem and they leave not cured, but they leave on a positive road to recovery and you have the whānau come in and say how that person has changed since they've been coming in and getting help. MHP02A:7*

Another provider, also delivering a kaupapa Māori Alcohol and Drug programme, agreed significant change amongst tangata whaiora was not only possible but a very real indicator of success.

*For me, the outcomes are that they've had a good service, they've cut down on their drinking or stopped, or drug use. That they're more whole, supported, you*

*know, the whānau is collectively healthier .... and we can actually get them to that little spark, that dream has now become a reality. MHP06C:10*

Other respondents offered similar examples of how being a “successful service” means bringing about positive changes in the lives of tangata whaiora.

*That the tangata whaiora are going off finding jobs. They ... have interests in other things like, other courses. They're starting to look at their future because what we do find is that they are not looking at their future, they are very much in the day, their heads aren't in a place where they can think about their future, so once they start kind of thinking 'oh well, that's what I'd like to do', yep .... moving, they've kind of like decided .... so they're making decisions based on what they want to do. MHP02B:9*

*They [tangata whaiora] go away and rejoin their communities. They no longer need our services. They're out of respite, they're out of rehab, you know?.... When they can say 'I'm fine' .... it's when they are healthy. And our staff know when they are, they know when they're unhealthy. And they get a whare or they get a car, or they get funds that you and I take for granted. We've had people who are mentally unwell or people who are in different circumstances and that makes you realise what we take for granted is things that are huge to them. MHP04B:20*

### ***Meeting an External Benchmark***

Finally, success for providers can also mean meeting a certain benchmark, whether set by Māori communities or by the health sector.

*It's successful when we got accredited. For us that said that we've got all our systems and processes and policies in place, where we are responding to the needs of our community and our clients. It was successful – we got one of the top DHB audits in the country when we were audited. So for us, that says that at a contractual level we're successful in that respect. MHOP02A:17*

## Summary

The findings from this phase of the research indicate a strong consensus regarding the failure of current performance measurement templates and contracts to accurately reflect the work of Māori mental health providers. The findings show that performance monitoring reports concentrate on the collection of numeric data and while many providers include additional qualitative and contextual information in the narrative section of the reporting template, feedback on this information was rare. Providers indicated several areas where the reporting templates were inadequate; however, the reliance on “numbers” to gauge the effectiveness of a particular programme or intervention was considered to be the greatest weakness of the reporting system.

Providers indicated several concerns with their contracts, including the lack of real negotiation when contracts were being discussed and the narrow focus of mental health contracts. All the providers interviewed noted that they did work outside the scope of their contracts. The areas of work carried out could be categorised as: that undertaken to deliver a culturally appropriate service; that done for the benefit of tangata whaiora; and extra work to improve the service, resources or capabilities of staff. Reasons for this “extra-contractual provision” included cultural imperatives, i.e. “we do it because we are Māori”; that it results from an holistic approach to mental health and wellbeing; and because of the expectations placed upon providers by iwi, hapū, whānau and Māori communities.

Providers indicated three areas where improvements would better reflect and acknowledge the work of Māori mental health providers and which would enable Māori mental health providers to deliver their services more effectively. These included improvements to the performance monitoring tools, such as the performance monitoring templates, through to improvements in contracting practice and building up relationships between funders and providers.

Regarding the concept of accountability, the research found that Māori mental health providers were well aware that they juggled multiple and at times competing accountabilities; however, the forms taken by this accountability differed according to the accountability relationship. The research also found that most providers could

identify when they had been successful and that measures of success included receiving positive feedback from the community, peers or funders and from visible improvements in tangata whaiora, through to contract renewal and meeting external benchmarks.

# **Chapter Eight:**

## **Bringing the Findings Together**

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### **Introduction**

The previous two chapters presented the data collected from two separate sets of respondents: key informants considered to be expert in the area of Māori mental health and mental health providers who themselves are engaged in the delivery of mental health services to tangata whaiora. The analysis of different strands of data such as the contractual and other documentary material, field notes and research journal data was also presented. The purpose of this chapter is to draw these various strands of data together to present an analysis of the material as a whole. The main findings from each group of respondents will be presented and the different perspectives consolidated into a single and final set of findings. The chapter is structured once more according to the main topics of inquiry derived from the interviews and any new themes that arose as a consequence of drawing upon other sources of data. The implications of this final set of findings will be discussed in the following chapter.

### **Understandings of Performance Measurement and the Development of the Current Measurement Framework**

Key informants were asked a series of questions about their understandings of the term “performance measurement” including: how the term is applied in the health sector; whether there are differences in how performance is measured at a central government level compared with at the level of the non-governmental organisation (NGO); and how mental health performance measures were developed. A review of the literature undertaken to ascertain the origins of the performance measurement framework currently used in the mental health sector also informs this analysis.

Key informants expressed a range of views on the origins, usefulness and applicability of the system currently used to monitor the performance of Māori mental health providers. Few respondents were able to comment on the derivation of the current performance measurement framework; however it would appear from the interviews and the literature that the current framework has been developed incrementally over a series of years and through a series of structural changes in the health sector. In particular, the current mental health service specifications appear to have been developed by combining service specifications used by four separate purchasing agencies (the Regional Health Authorities) into one national document. Likewise, in many cases the mental health contracts in use remain unchanged since the time of the Health Funding Authority. The findings from the key informant interviews indicate that the current performance measurement framework utilises a complex and inter-related set of tools and mechanisms to ensure mental health services are delivered in a timely, high quality and cost-effective manner. These tools and mechanisms include the National Mental Health Standards, the Nationwide Mental Health Service Framework, District Health Board (DHB) contracts with mental health providers and independent audits of mental health providers.

## **How Performance is Measured**

In responding to the question “how is the performance of Māori mental health providers measured?” respondents emphasised different ways of measuring performance and different measurement mechanisms or processes. Contract compliance was considered to be an important indicator of performance for many key informants. Other ways in which performance is regularly measured and monitored is through the performance monitoring returns reporting templates or - inappropriately according to one key informant - through the audit process. The key informant concluded that the use of audits as a regular performance measurement tool was inappropriate. The purpose of an audit is not to measure contract compliance but rather to examine an organisation’s *total activity* and whether or not it fulfils the criteria set for that organisation. The informant noted that some providers might experience audits “two, three, four times a year” which was regarded as being “ridiculous” (KI05).

Providers also indicated that meeting the terms and conditions of their contract was an important performance measure. Adherence to the contract was achieved by regular

reporting using standardised reporting templates which were often generated for the provider by the funder, be they the Ministry of Health, DHB or other funder. There was a great degree of consensus amongst providers that funders were clearly interested in “numbers” or “volumes”, rather than additional qualitative or contextual information. Providers who indicated that audits were a type of performance measure also noted that audits were based on “western” indicators of quality, rather than what could be termed kaupapa Māori indicators of quality.

### **Adequacy of Performance Measures and Service Contracts**

Results from the key informant interviews, provider interviews and analysis of documentation indicate that a standard contract document is used by DHBs, and this is “tailored” to the provider by attaching the appropriate service specification(s) from the Nationwide Mental Health Service Framework to the provider’s contract. Key informants and providers both commented on the inadequacy not only of these contract documents, but of the contract negotiation process as a whole, citing the process as being very one-sided with little real negotiation or input by the provider into the terms of the contract. Respondents considered contracts to be inadequate because there were inflexible, difficult to interpret and use, weighted towards clinical aspects of health care without equal weight being given to cultural aspects, and unable to take account of the nature of the work required to treat tangata whaiora.

There was general consensus amongst key informants and providers that neither the performance measures nor the contracts for service were adequate or sophisticated enough to capture the extent of the work done by Māori mental health providers. One key informant went against the consensus opinion stating that several performance measures did assess Māori mental health providers. The informant went on to note that these measures need to be augmented with an understanding of the context in which Māori mental health providers worked, or the “the bigger picture” (KI03).

The majority of respondents observed that because the current performance measurement framework was inadequate, much of the work done by providers remained invisible to both funders and to the Ministry of Health. The inability of the system to ascertain the range of work done by Māori mental health providers was attributed to a number of factors: that the system was purposely designed to be generic so it could be

used across the whole range of mental health service types; that as a result it was incapable of measuring a holistic mode of service delivery, let alone a mode of service delivery based on a different worldview; that the system had not evolved at the same rate or in the same direction as Māori mental health providers; and that the system was simply out-dated.

The perception of providers that the data collected by funders are inadequate has resulted in many providers keeping a separate set of records about their service. These records may contain a range of information which establishes the context in which an intervention occurred, the length of time the intervention or therapy took and the range of people involved, as well as any observations about outcome or changes in health status resulting from an intervention or therapy. Many providers also include this more contextual information in the “Additional Information” section of their narrative reports to funders. None of the providers interviewed reported ever receiving feedback on this additional information.

### **The Additional Work Done by Providers**

Both key informants and Māori mental health providers identified a range of activities which were outside the scope of their mental health contracts. Whilst some providers noted the additional work was the result of interpreting their contracts in an innovative manner, others were clear that at times the work they attended to was simply additional to, or outside of, the scope of their contract. The types of additional work or service provided can be grouped into the following broad categories:

- Work undertaken to deliver a culturally appropriate service;
- Work done for the benefit of, or out of a sense of obligation to, tangata whaiora; and
- Work done to improve the resources, staff or service itself.

Delivering a culturally appropriate service did not necessarily mean that “extra” work was done. It could mean that extra time was taken, that additional protocols were observed or that more people were involved in a therapy or intervention. For example, instead of one face-to-face meeting with one tangata whaiora that lasted for half an hour, delivering a culturally appropriate service might require an all-day hui at a marae for that tangata whaiora and their whānau, an official pōwhiri, hākari before the

business at hand could be attended to, then poroporoakī. This activity might include all the staff at the service as well as members of the marae committee, ringawera and kaumātua.

Many providers cited the examples of transporting tangata whaiora to the service, to tangi or to other appointments, as additional work. Assisting tangata whaiora to trace their whakapapa, to gain access to Māori institutions such as Marae and Rūnanga or to negotiate access to their hapū or iwi were also considered additional to their contract. For many Māori mental health providers this sense of obligation is a key driver in compelling them to “go the extra mile” as will be discussed in the next section.

A significant component of the additional work that providers identified was work to improve the skills of their organisations and staff. During the interviews several providers mentioned the importance of networking and of keeping in touch with their communities. Others noted the additional training or education they were undertaking and cited examples such as te reo Māori courses or hapū-run hui on tikanga, kawa, whakapapa and hapū history. Such courses were seen as imperative not only in order to offer culturally appropriate services, but also to offer services that were appropriate to the local community. Providers also included as additional tasks training in data system creation and management, quality system processes, and learning about service policies and procedures.

## **Reasons for Extra-contractual Provision**

The table on the next page outlines the reasons for extra-contractual provision as identified in the key informant and provider interviews, and the following section discusses each of the reasons raised in the findings in more depth.

**Table 3: Reasons Cited by Respondents for Extra-Contractual Work or Services Provided**

Reason	Worldview	Strategic Development	Community Expectation or Need	Service Equity	Overstating Capacity	Inexperience or Immaturity	Passion
Description	Worldview differs from that of other health providers and the dominant system	Iwi/hapū providers view health service provision as one aspect of a larger goal of iwi /hapū development	Māori providers are bound to their community with obligations and responsibilities to that community	Overprovision is regarded as necessary to deliver a service which is at least equivalent to one delivered by mainstream	Deliberately over stating what a service can achieve during a bidding process in order to secure a contract	Lack of experience means providers chase every contract and believe have to “deliver the world” .	Desire to work in mental health and change people’s lives for the better
Elements/features	Whānau approach Holistic approach Hauora approach Governed by Tikanga	Whānau, hapū or iwi focus Governed by obligations and responsibilities	Whānau, hapu or iwi focus Governed by obligations and responsibilities Health Needs focus	Equity focus	Contract a means to an end, usually linked to wider focus	Immaturity of service or of management With maturity providers become more considered	Love of people and profession

### *Worldview*

Key informants and Māori providers tended to emphasise different reasons for undertaking work outside the scope of their contract, however both sets of informants agreed that there was a “cultural imperative” which compelled them to undertake such activity. The combined findings indicate that iwi and hapū-based Māori mental health providers appear to be operating within a different worldview or different frame of reference from that of the mainstream health system. Often the values, core beliefs and protocols governing how the provider operates will differ, not only from any mainstream provider, but from any other Māori health provider. This is because these values, the values that guide the provider in their work in the community, are inherently tied into the tikanga of the iwi or the hapū which has manawhenua status in that community. It is the hapū or iwi that mandates the provider to operate in that locale and it is the tikanga of that iwi or hapū that underpins all the work that provider does. This is the cultural imperative that compels Māori mental health providers to engage in extra-contractual work.

In analysing the combined findings, several features of a distinctly Māori worldview became apparent. The features of a Māori worldview approach in Māori mental health service provision are categorised as follows: being governed by tikanga, the use of hauora practices, adopting a holistic approach and focusing on whānau ora.

#### *Governed by Tikanga*

Iwi and hapū-based Māori mental health providers are governed by the tikanga of the iwi or hapū which gives them the mandate to operate in a particular area. Tikanga determines the boundaries, obligations, rights, duties and responsibilities to which a Māori mental health provider must adhere. One provider in particular noted that the work that they did was intrinsically tied to “the history that’s attached to the Runaka”, to “the kaupapa” and to who they are (MHP04B). Usually these obligations and responsibilities are endowed with an element of reciprocity: should the provider need the skills, expertise or support of the iwi or hapū they will be there. Evidence of this reciprocity was provided by the examples given of kaumātua and kuia support for the providers in their work with tangata whaiora, e.g. the men’s fishing course (MHPO2);

and by broader hapū support, e.g. the use of the marae and surrounds for running workshops with tangata whaiora (MHPO3).

#### *Use of Hauora Practices*

For the purposes of this research the term “hauora” is used to describe a range of practices and therapies which would not perhaps, in a western sense, usually be associated with the care of mental health consumers, but in traditional Māori culture are entirely appropriate. Providers who took part in this research indicated that the therapies they used included mirimiri, rongoā and karakia as well as “group therapy” sessions which involved participating in a traditional art form (taiaha, kapahaka and the weaving of hinaki) or in learning about the ngahere and wider environment.

#### *A Holistic Approach*

The combined findings from the research indicate that these Māori mental health providers, like Māori providers in other areas of health, take a holistic approach to the care of tangata whaiora and to the delivery of mental health services. A holistic approach in terms of this research meant that Māori mental health providers would deal not only with the mental health needs of tangata whaiora, but with their other health needs if they had any, or with other aspects of their broader social wellbeing. In a holistic approach, mental health is not viewed in isolation from other areas of health, nor in isolation from broader socio-economic determinants of health. Dealing with these other wider determinants, (e.g. other health needs, housing needs, education and employment concerns) will naturally incur an investment of time that other, mainstream mental health providers are not expected, nor asked, to make. Both sets of informants agreed that Māori mental health providers will consider the wider environment in treating tangata whaiora and teach them skills to cope in that wider environment. Such skills may include cooking or even grocery shopping.

#### *A Whānau Ora Focus*

The Māori mental health providers who participated in this research indicated that caring for the tangata whaiora naturally meant caring for the whānau. While it might be an individual who initially presents to a service, these providers noted that to deal effectively with the tangata whaiora, the whānau of that tangata whaiora had to be involved in any therapy or intervention. Several Māori mental health providers noted that dealing with the whānau as well as with the tangata whaiora meant that sometimes

they had to step outside the scope of their contract to deliver a service to an entire family or arrange their contracts in such a way as to give themselves the freedom to work across age groups and family members.

### ***Strategic Development***

One of the reasons for extra-contractual provision was that iwi and hapū-based mental health providers viewed mental health service provision as simply one aspect of a larger goal of iwi or hapū development. One respondent in particular commented that obtaining a mental health contract and becoming established as a mental health provider was considered a form of tino rangatiratanga. As mental health services in their own right, providers had the opportunity not only to attend to the health needs of their community but also to develop their own skills and expertise, and this in turn would contribute to the skill base of the hapū or iwi and to the development of the hapū and iwi as a whole. In taking on this role, respondents noted that Māori mental health providers were then left in a position where they experienced “dual obligations”: to the Crown to deliver a mental health service; and those to hapū and iwi. Managing both sets of obligations was considered crucial to the success of the service.

### ***Community Expectation or Need***

A further explanation for extra-contractual provision was that Māori mental health providers felt obligated to offer extra services due to a high degree of community expectation, or that the community in which they worked had identified a need and requested that the provider meet that need. Both key informants and Māori mental health providers reported that the expectations of communities meant that providers were naturally expected to deal with everyone that came through the door and to take as long as was required to deal with that client’s issues. As one provider reported this could mean that staff had to work additional hours beyond “knock-off time”. Respondents reported a clear expectation on behalf of the community that Māori mental health providers would do everything in their power to effectively treat tangata whaiora.

Key informants also raised the issue of community need as a reason for extra-contractual provision. Māori mental health providers may be asked by the local community to address a specific need in the community, even though it is outside the scope of their contract. One example given was that a mental health provider might be

asked to use alternative therapies, such as mirimiri, when they did not have a contract to provide this service.

### ***Service Equity***

Some providers believed they need to deliver “over and above” their contracted outputs in order to deliver a service at least equivalent to that of the mainstream. The perception was that Māori mental health providers have for many years been under-funded and “run on the smell of an oily rag” in comparison to mainstream services. As a result many Māori providers are now seen to “work harder” and “try and produce more, as if to balance up that inequity”. While this research did not set out to compare the funding of Māori mental health providers and that of mainstream mental health services, at least two respondents provided examples of instances where DHB contracts with Māori mental health providers included lower prices than the national rates. The type of information and analysis required to ascertain whether Māori mental health providers were being paid at a lesser rate than mainstream providers is outside the scope of this research. However what can be said is that the perception that Māori providers must do more to “balance up” an inequity is clearly a reason for extra-contractual provision. Furthermore the perception that inequity exists between Māori and non-Māori mental health services may be as damaging to the sector as any actual evidence that it does exist.

### ***Overstating Capacity and Inexperience/Immaturity***

The last two reasons given for Māori mental health providers working was outside the scope of their contract are closely related. Respondents indicated that some Māori mental health providers in the past have very consciously over-stated what their service can achieve during a bidding process in order to secure a particular contract. This is done because it is deemed necessary and often because of a desire to secure a Māori mental health component for a service which is dealing with another area (e.g. public health or health promotion). Respondents also indicated that this process of over-stating capacity was more common in the early days of Māori service provision. At least one respondent indicated that the more mature, or experienced, Māori mental health providers are more likely to stay within the confines of their contract and do no more than is required of them. Extra-contractual provision was viewed by this respondent as evidence of inexperience or immaturity in the field.

As Māori providers become more experienced and adept at delivering their service some aspects of extra-contractual provision are likely to change. It is less likely for instance, that Māori mental health providers will pursue every contract or Request for Proposal (RFP) offered by the Ministry of Health or the DHB. Evidence that Māori are becoming more strategic in their contracting was apparent as a number of respondents talked about greater collaboration between providers, pan-hapū approaches to health service delivery and providers uniting to tender jointly for RFPs.

### ***Passion***

“Passion” for the job, for tangata whaiora, for making a difference in the lives of tangata whaiora and their whānau led mental health workers to “go the extra mile” for their clients. In doing so, mental health workers risked burning themselves out or compromising their own safety. A passion for working in mental health may not be the sole preserve of the staff of Māori mental health services. Mainstream services are also likely to have passionate staff working harder and longer to achieve positive outcomes for their clients.

## **Possible Improvements to Current Practice**

Key informants and providers offered several suggestions about how to improve the current performance measurement system. These can be broadly grouped into the following categories:

- structural or systems changes;
- improving relationships; and
- improving the tools of performance measurement (i.e. the reporting templates, measures and contracts).

One of the structural changes mooted was to change the way the government currently contracts with Māori mental health providers, from individual contracts between one agency (or funder) and a provider, to joint contracting or “whole of government” contracting arrangements. According to respondents, the benefits of such an approach would include: minimising the reporting burden on providers, thus allowing them to spend more time delivering their service; increased service integration; a greater focus on population approaches to health; and savings on administration and overhead costs.

The creation of more “one-stop-shops” and the rationalisation of the NGO sector were other structural level improvements suggested by informants.

Many respondents emphasised the need to improve relationships between providers and funders (particularly DHBs), between DHBs and iwi and between providers themselves, not only as a means of improving the responsiveness of the performance measurement framework, but also as a means of improving the health status of Māori. Relationships between the DHB and providers were regarded as particularly one-sided by both sets of informants. The lack of feedback received on monitoring reports, the lack of any real negotiation during contract negotiations and the lack of visibility of DHB staff in the community were all cited as evidence of the funder under-valuing community-based services and the work of Māori mental health providers. Furthermore, poor relationships between the funder and the provider did not contribute to an accurate understanding of what was being purchased or provided.

One informant noted that relationships between DHBs and iwi had the potential to improve Māori health status if such relationships are used effectively. Many key informants commented on the collaboration and co-operation that is occurring between Māori mental health providers and Māori providers in other fields of health and other social service sectors. While Māori have identified some opportunities for partnership and collaboration, at least one respondent indicated that more opportunities exist, especially in relation to DHB-iwi partnerships. This respondent argued that, with the introduction of the New Zealand Public Health and Disability Act (NZPHDA) model, a platform now exists for DHB and iwi to relate to each other as Treaty partners rather than simply as funder and provider. A number of respondents commented on other changes resulting from the new legislation and reform of the sector. For example some noted that the new environment allowed for greater cooperation amongst providers while another informant commented that DHBs were in much closer contact with providers than funders in the past had been.

Most respondents commented on the need to change either the contracts, the reporting templates or both as a means of improving the performance monitoring system. Possible changes to the reporting templates included augmenting the performance

measures with outcomes information; the ability to record time; and the ability to add more contextual information. Changes that respondents indicated would be useful in contracts included the opportunity to “fiscally acknowledge” knowledge, skills and expertise other than the medical expertise, and increased flexibility of contracts to allow for local difference and local needs. Many respondents argued the need for greater and “real” negotiation of contracts.

One respondent noted that contract negotiations and the contracts themselves needed to acknowledge and recognise the political boundaries that occur in Māori society. Often these boundaries are not the same as DHB boundaries however, the reality for Māori mental health service providers is that service delivery across iwi rohe is a very real issue that they are expected to manage without extra resources or time. Another respondent noted that strategically, Māori may want to consider regional groupings, inter-hapū and inter-iwi specialisation as a way of getting a wide range of services in one rohe.

### **How the Performance of Māori Mental Health Providers Should be Assessed and the Need for a Parallel Cultural Performance Measure**

Key informants were asked to consider at a high level, how the performance of Māori mental health providers should be assessed and whether there was a need for a cultural performance measure. The results of the key informant interviews indicated that the development and application of a cultural performance measure was problematic on two counts: first, because trying to define what might be included in such an indicator would be difficult, and second, because monitoring such a measure would also be problematic. The difficulties associated with definition arose from the fact that no single cultural performance measure would be appropriate for every iwi or hapū. Each iwi and hapū would need to define for themselves the cultural measures that were important: therefore, in monitoring those measures it would be inappropriate for any organisation other than those iwi and hapū to assess how well a provider had performed. From a purely pragmatic perspective managing and auditing a suite of cultural performance measures would be problematic.

Despite the difficulty associated with developing a cultural performance measure, a small group of respondents argued that what was required to validate and acknowledge the work of Māori mental health providers was a parallel set of “Māori specific” measures in addition to the universal measures currently in use. These Māori specific measures would take account of a Māori worldview, would be able to measure “whānau ora”, would be localised and context specific and would be devised by iwi, hapū, whānau and Māori communities.

Māori mental health providers were not asked to consider whether a cultural performance measure was appropriate but rather were asked how their immediate environment, the contracts and the reporting templates might be made more effective. Their responses have already been summarised above.

## **Accountability**

Key informants and providers agreed that Māori mental health providers had a range of formal and informal accountability relationships with a variety of stakeholders including the funder, iwi/hapū/Māori and their local community and tangata whaiora. Both groups of informants also acknowledged that accountability to one’s community was a significant issue for Māori mental health providers. Accountability to their community could be a positive motivating force, driving providers to excel at their work. However, being accountable to one’s community could also mean Māori mental health providers operated with the constant fear of failure or of letting their community down. The literature identifies a range of accountability mechanisms between Māori mental health providers and the Crown. These “western” mechanisms include contract compliance, regular reporting, adherence to the National Mental Health Standards and a range of clinical and professional accountability measures. The way in which Māori mental health providers are held accountable to their community differs markedly from how the Crown holds the provider accountable. The forms of accountability by which Māori communities hold providers accountable include whakamā; kanohi ki te kanohi; hui and whakapapa.

Both key informants and Māori mental health providers agreed that providers are accountable to a range of stakeholders and that managing these multiple accountabilities, while at times challenging, was something Māori providers were used

to. One respondent commented on the layers of accountability that are a feature of Māori mental health service provision. Accountability in Māori mental health service provision is complex: in addition to multiple accountabilities, many Māori dealt with DHBs at different levels and therefore were accountable in different ways. For example, as a manager of a mental health provider contracted to the DHB to provide a service, a person might have one set of accountabilities; as the Chair of the local Rūnanga, that same person might have a quite different set of accountabilities to the DHB; as a member of the DHB, still another set of accountabilities is apparent.

There was no agreement about which accountability relationship, of the many they managed, was the most important to Māori mental health providers. Some respondents indicated the accountability to the funder (as the holder of the purse-strings) was the most important set of accountabilities, while other respondents indicated that accountability to the provider's governance board, and by extension the community and tangata whaiora, was the most important relationship.

## **Success**

Māori mental health providers were asked at the conclusion of the interview how they knew when they were successful or how they judged their success. Three types of success were mentioned: positive feedback from the funder, peers, the community or clients; the visible improvement of tangata whaiora; and meeting an external standard such as gaining accreditation. Once again providers noted the importance of positive relationships with their funders, with the Rūnanga and with their own communities; they considered a positive relationship with any of these groups as an indicator of success. Improvements in tangata whaiora or in their lifestyle may have been captured or recorded through a formal survey but this was not always so. Often, changes in tangata whaiora were noticed gradually as providers built up relationships with their clients. Providers also considered contract renewal to be an indicator of success.

## **Summary**

The combined findings indicate that Māori mental health providers and key informants have similar views regarding the adequacy of current performance measurement frameworks, reasons for overprovision, suggested improvements to the system and issues of accountability. Analysis of the contract and performance documentation

supported the interview data and in many cases illustrated the specific areas of concern respondents had raised. The implications of these combined findings for policy, for funders and for Māori mental health providers will be the focus of the next chapter.

## **Chapter Nine:**

### **Discussion**

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#### **Introduction**

This chapter discusses the combined findings presented in the previous chapter in light of the research questions posed at the outset of the research. The broad research questions this thesis aimed to answer were: what is the experience of Māori mental health providers in contracting to provide mental health services for the Crown; do Māori mental health providers undertake work, or provide services, outside the scope of their contracts; and what role do multiple accountabilities play in contracting? The chapter is structured so that each of these broad research questions is addressed in turn.

The chapter begins by characterising the experience of Māori mental health providers as they contract for services from District Health Boards (DHBs). The research found that Māori mental health providers' experience of contracting was influenced by the perception that the performance measurement framework was inadequate. The chapter continues with a discussion about the wider “drivers” that impact upon Māori mental health service provision noting that in order to understand contracting and the contracting process between Māori mental health providers and the Crown, an understanding of the higher level environmental and contextual factors which drive the purchase and provision of health service in New Zealand is crucial. The research indicates that contracting practice in the area of Māori mental health almost appears to exist within a “contextual vacuum”. The reality however is that there is a set of drivers which impact upon the contracting environment and which providers and funders must take cognisance of if improvements to the practice of contracting are to occur.

The concept of “spheres of accountability” as an explanatory factor in Māori mental health service provision is then introduced. An argument is forwarded that these

multiple, variable and at times competing, spheres of accountability or influence act as “push and pull” forces on a provider; forces which a provider must manage on a daily basis. The implications of service delivery within an environment of multiple spheres of accountability are examined. The chapter concludes by reflecting on the research and remarking on the limitations of the study.

## **Characterising Māori Mental Health Providers’ Experience of Contracting and the Contracting Process**

The current mental health performance measurement framework comprises a complex and interrelated series of policies, guidelines, standards, service specifications, input, output and contracting data. The framework was not designed in a systematic fashion from “blank canvas”, but rather has been built up incrementally as reform after crisis after reform has altered the health sector. The piecemeal evolution of a performance measurement system is not uncommon among health care systems. Anderson et al. note that most health care processes were never designed in a systematic fashion, but rather grew in time into their current state (Anderson, Moran et al. 1998, p.44). The difficulty with such a system is that it may have a number of weak links; weaknesses which become an integral part of the system.

One of the research questions this thesis aimed to address was what is the experience of Māori mental health providers in contracting to provide mental health services for the Crown? This section of the discussion explores the issues respondents raised in regard to Māori mental health contracting and discusses the “weak links” identified not only in the contracts but in the performance measurement framework overall.

### ***Contracting and Māori Mental Health***

Contracting represents one component of an overall performance measurement framework which the Crown employs to ensure that any funds it makes available for service provision are spent wisely and appropriately. Other components of the mental health performance measurement framework include the performance monitoring reports and reporting templates, Nationwide Mental Health Service Specifications and the National Mental Health Standards. Almost without exception, the respondents who participated in this research reported that the current contracting system does not inadequately capture the extent of work done by Māori mental health providers, nor

does it adequately acknowledge or validate that work. Respondents regarded the contract documents as narrow, inflexible, difficult to interpret and use, weighted towards clinical aspects of health care without equal weight being given to cultural aspects, and unable to take account of the nature of the work Māori providers undertake in order to treat tangata whaiora. Contracts typically are old and composite, having been developed and added to during successive years of reform. Ashton et al. (2002) note that due to the extent of the changes that occurred in the health sector throughout the 1990s, the contracting environment which developed at that time was an unstable one. Different approaches emerged in each of the four RHAs, with national consistency in contracting only emerging over a period of time. The contracts that are in use today are those developed during this period of reform. They are not particularly user-friendly documents, as they are full of jargon and legalese. The contracting process itself was considered by respondents to be one-sided with little real negotiation or input sought from the provider.

At a local level much can be done to improve the contracts, to incorporate local or regional differences, to establish better working relationships between the provider and the funder and to improve the contract negotiation process. Māori providers reported that contracts took no account of the context in which a service was being delivered and that often the measures within the contracts were not meaningful to them or to the wider community within which they worked. The creation of consistent contracting frameworks was pursued in an effort to ensure equity of access to services (Health Funding Authority 1999a). While this is a laudable and worthwhile goal, the quest for consistency should not be pursued at the expense of responsiveness to local imperatives. Epstein (1995, p.60) has noted that regionally defined performance measures or “indicators of quality” are particularly useful in addressing local priorities and that as a result performance measures should be updated regularly. The development of performance reports he argues, must be a dynamic one.

Understanding the local context in which a provider works is the responsibility of the Funding and Planning Unit of a DHB and by extension the DHB itself. The New Zealand Public Health and Disability Act 2000 (NZPHDA) outlines the relationship DHBS are to have with central government and with the community. The Act established 21 DHBS charged with “purchasing, providing or otherwise arranging for

the provision of services for a geographically defined population” (Health Reforms 2001 Research Team 2003, p.5). The Act places a large emphasis on local input into decisions about health care, health needs and health services. Specific objectives of DHBs include:

- *to improve, promote and protect the health of people and communities;*
  - *to reduce health disparities by improving health outcomes for Māori and other population groups;*
  - *to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides or for whom it arranges the provision of services; and*
  - *to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services.*
- (2000) Part3 Section 22 paragraphs a,e,g, and h

In addition one of the functions of a DHB as outlined in the Act is

*to actively investigate, facilitate, sponsor and develop co-operative and collaborative arrangements with persons in the health and disability sector to improve, promote and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities.*

(2000) Part 3 Section 23 paragraph 1b

The Act clearly states that DHBs have obligations to improve the health of people and communities, particularly Māori, while having regard to, and by taking cognisance of, the interests of the local people. It is well within the spirit of the Act for DHBs to use contracts with providers to pick up on local variation, include more meaningful measures and reflect back to Māori an understanding of the context in which they work. To do so in a formal document, through an additional schedule which both parties sign, would acknowledge the unique aspects of Māori service delivery which differentiate it from mainstream services, as well as the unique aspects of service delivery particular *to that service*, which differentiate it from other Māori mental health providers in the community.

At the end of the day the Crown may view a contract as nothing more than a simply a mechanism by which two parties come to an agreement about the purchase and receipt of a set of services or products; the concept of the willing buyer and the willing seller (Martin 1995). For Māori, it would appear that the relationship that envelops that contract is as important as the document or the agreement itself. Māori providers were concerned that contracts are not so much negotiated as rolled over and that when offered to providers, were done so with an expectation that they would automatically be accepted.

The dissatisfaction over contracting processes expressed by Māori mental health providers in this research builds upon the findings of earlier research undertaken by Te Puni Kōkiri into provider views of government funding. The Te Puni Kōkiri (2000) research found that policies for contracting services had been developed on an ad hoc basis and that providers were frustrated with rigid contracting processes, under-funding and the lack of developmental assistance from government agencies. This research has demonstrated that in Māori mental health service provision the narrow focus of mental health contracts does not enable Māori mental health providers to deliver a culturally appropriate service to their clients. As a result “extra-contractual” provision, or the provision of activities, services and work outside the scope of the contract, is often undertaken so that culturally appropriate service delivery can be maintained.

Lavoie (2003) reported on research which compared the contracting experiences of indigenous primary health care services in Canada, Australia and New Zealand. That research noted that while the reforms of the early 1990s created opportunities for Māori participation in service delivery, these opportunities have continually fallen short of facilitating the implementation of a kaupapa Māori approach to health. Service delivery by Māori providers is constricted by narrowly focused, highly defined contracts. Whereas the Crown has “repeated its commitment” to the Treaty principles of partnership, participation and protection (Royal Commission on Social Policy 1988a), these values are barely reflected in the current contractual environment (Lavoie 2003, p.82). Lavoie concludes that contracts are being used as “patches” to current health system delivery, serving an equity ideology as opposed to a true Treaty partnership (Lavoie 2003).

The research undertaken for this thesis supports Lavoie's 2003 findings. Respondents reported the contract process as one-sided, with no true negotiation, despite a "repeated commitment" to the principle of participation. Furthermore this research has found that the unique aspects of Māori mental health service delivery which differentiate it from mainstream service delivery are not recognised nor acknowledged in current contract documentation, again in spite of a "repeated commitment" to the principle of partnership. Each provider has a specific set of values and principles which guides its work. These principles are usually not incorporated into the contracts, rendering those values and principles invisible. Lavoie (2004) notes that further research is required to assess the impact of competitive as opposed to relational contractual environments in providers' ability to deliver effective service and how different contractual arrangements may favour or impede the implementation of indigenous models of health service delivery.

### ***Performance Measurement***

Māori health providers and key informants talk about performance measurement in quite different ways. Clearly for the Government, performance measurement is about accounting for *where* mental health dollars have been spent so that some judgement can be made about how *wisely* this money has been spent. Government identifies how much money has been spent through a range of "input" measures and what products or services this amount of money has purchased in terms of "outputs". A calculation can then be made on whether the number of products and services bought at a particular price represented value for money and the efficient and effective use of tax dollars. Performance measurement then occurs at a level removed from the consumer, from tangata whaiora. It becomes a mechanistic task of collating a series of indicators and reporting the results in a briefing paper or on a balance sheet.

By comparison performance measures and performance measurement for Māori occur at, and are viewed on, a very personal and intimate level. Māori providers discuss performance measurement in terms of relationships, experiences and interactions with tangata whaiora and in terms of success with whānau, hapū, iwi and Māori communities (with whom they are often fundamentally tied). Performance measures for Māori are not as clear cut as a set of numbers to report (number of face to face contacts, number of

group sessions, number of bed nights), rather they are different for each and every individual tangata whaiora. So a performance measure, or a measure of success, for one provider may be getting a tangata whaiora to stop drinking or stop taking drugs, for another it may be getting a tangata whaiora engaged in higher education and for yet a third it may be assisting a tangata whaiora to live back out in their community.

The level of intimacy between the provider and their consumer means the performance measures by which providers hold themselves accountable are not objective. The more formal reporting measures desired by funders are given less weight and are perceived as being less relevant. The measures are not deemed useful in a practical sense in that they do not reflect the changes that may occur in a person as a consequence of being with the service. The perception by providers of their limited utility means the recording process is regarded as merely a “tick the box exercise” that must be performed in order to receive funding, meet contracted targets or secure a contract renewal.

This kind of behaviour may be considered a form of “sub-optimisation” and occurs where there is a lack of congruence between local incentives and the global objectives of the organisation, or in this case between the providers’ incentives and the objectives of the funder (Goddard, Mannion et al. 2000, p.103). Another form of sub-optimisation includes the misrepresentation of data. The chances of misrepresentation are increased where performance data is used to hold staff directly accountable for poor performance (Goddard, Mannion et al. 2000). Strategies to mitigate the dysfunctional consequences of poor performance measurement identified in the literature include constantly reviewing performance measurement systems, measuring client satisfaction and maintaining a careful audit of data (Goddard, Mannion et al. 2000). While several providers did use client satisfaction surveys on a regular basis, the onus for reviewing performance measures and carrying out regular and appropriate auditing lies with the funder.

The findings from this research indicate that Māori mental health providers tend to focus and concentrate on, and put their energies into, changes in the tangata whaiora or in their lives, rather than on the indicators contained in the reporting template. In essence it would appear that providers are using proxy outcome measures to gauge their own performance. There is no universal definition of “health outcome” or “health

outcome measures” but a definition which has gained acceptance in New Zealand is that an outcome is “the identifiable result of an intervention or series of interventions on the health of an individual or group of individuals” (Kingi and Durie 2000, p.4). The most recognised of these health outcome measures include HoNOS, Short Form 36 and in the New Zealand context, Hua Oranga, a consumer-focused Māori mental health measure for use in clinical and care situations (Kingi and Durie 2000, p.20).

If we use the accepted definition that an outcome is the identifiable result of an intervention or series of interventions, then what Māori providers have identified in this research as measures of performance or success must be considered as measures of outcome. Research undertaken by Te Puni Kōkiri (2000) found that in general, Māori providers’ expectations are that progress and performance are measured in terms of client-focused outcomes, not outputs. The providers noted that contractual arrangements should identify a means to measure improvements in the lives of service users rather than provide information about the number of “case management interventions and internal activities” (Te Puni Kōkiri 2000, p.37). Unfortunately the New Zealand mental health sector is not yet geared to the systematic collection of mental health outcomes (Hua Oranga is in its third year of validation) and is some considerable way off funding for outcomes.

This poses the problem of how best to acknowledge, validate, and fund the work of a group of health service providers that can lay claim to not only producing health outcome data, but to producing positive health outcomes in their communities.

The literature indicates that simply reporting health outcome measures by themselves is an insufficient method of monitoring the effectiveness of a given programme in achieving its health goals (Perrin, Durch et al.). There are three reasons for this. Firstly outcomes are often influenced by factors other than the activities associated with a particular programme; secondly there is an impractical delay or “lag” in observing certain outcomes of interest; and thirdly some important outcomes are quite rare and will be seen very infrequently. As a result, Perrin et al. argue that performance monitoring should employ a “multimeasure” approach using a mixture of intermediate outcome, process and capacity measures in order to determine the effectiveness of a programme or service (Perrin, Durch et al., p.24).

Their and Gelijns (1998) agree that where outcome measures are not sufficiently evolved, process measures must be relied on. However they note that it is important not to standardise these measures and thus remove variation from the process, but to recognise and incorporate variation as part of the performance measure. Performance measures must be flexible enough to incorporate different styles and ways of delivering a service. The literature would seem to indicate that where there is an absence of adequate outcome measures, a performance measurement framework which uses a range of measures, which is flexible and responsive to differences in style and to local conditions, is an acceptable alternative. Such an approach, were it adopted by the New Zealand mental health sector, might also provide a more accurate indication of the effectiveness of Māori mental health service provision.

### ***The Wider Performance Measurement Framework***

The Nationwide Mental Health Service Specifications as they are currently written not only claim to recognise the importance of culture and Māori approaches to health and wellbeing they also recognise that the delivery of kaupapa Māori services requires additional elements than those that would be expected from mainstream mental health services. For example the Service Specification for Kaupapa Māori Mental Health Services notes the importance of kaumātua/kuia as an integral part of the service; that the local Māori community supports the service and that the service operates using Māori tikanga, Māori beliefs, values and practices (Ministry of Health 2001c). The Nationwide Service Specification for Kaupapa Māori Mental Health Services also recognises that Māori mental health providers incorporate two distinct elements of service provision into their programme delivery: one that any mainstream mental health service could offer and a kaupapa Māori element that may require “extra resources, time or Māori practices that are different from other mental health services” (Ministry of Health 2001c).

Given that the specifications themselves recognise that kaupapa Māori mental health services may require additional resources, time, or different practices, why is there a perception amongst mental health providers that the contracts and the performance measures they contain are inadequate? The answer may lie in the mismatch between the intent of the Kaupapa Māori Service Specifications, the way the reporting templates

record the work that is done, the types of indicators used, the use that is made of the data or the way in which DHBs contract for service.

The reporting templates, as discussed earlier, collect “purchase units” and a series of other performance indicators (e.g. number of people supported, number of hui held). Both of these performance indicators require information in numeric form (as counts) reported quarterly. There is no provision or scope in the reporting templates for reporting the amount of time that was required to support each tangata whaiora and/or their family, despite the acknowledgement in the specification itself that Māori cultural practices may require more time. There is also no provision in the reporting templates, other than in the narrative section, to report qualitative data or outcome information.

Māori mental health providers stated that in addition to filling out the numeric information required of them by the funder, many take the opportunity provided by the narrative section to report qualitative information and evidence of improved health outcomes amongst their tangata whaiora and wider community. Many providers also commented that despite filling out the narrative report, they receive no feedback on this information. The process for the collection, storage and use of performance monitoring information is outlined in Chapter 3. In essence, providers fill out the required template and email it back to HealthPAC in Dunedin, where the information is inputted into the Contract Management System (CMS). The CMS system is an example of a “reporting accountability strategy” or a mechanism that collects and distributes information on health system processes or performance (Brown, Baker et al. 1999, p.9). While it has the capacity to collect a great deal of information, its primary purpose is not one of “distribution”. Given the process of reporting and storing information it is not surprising that Māori mental health providers do not receive feedback on their performance monitoring reports. The system used to generate reporting templates and collect report information has not been established to collect this type of narrative information. Rather the purpose of the Contract Management System is to track that providers have reported on a set of specified outputs and once it has been confirmed these reports have been furnished on time, to authorise the release of funding.

It is the CMS system which generates the reporting templates that request providers use the Additional Information section for the express purpose of advising the funder “of

any issues you have, other information you would like us to know or any queries you may have”. According to the template “every endeavour will be made to respond to any issues that you raise”. As providers reported, they did not receive any feedback on the issues reported in this section of the template. The reason for this is that these reports proceed directly to HealthPAC not to the Contracts Manager at the DHB. There is currently no process, nor protocol, to forward the narrative reports received by HealthPAC Dunedin to the individual Contracts Managers at the various DHBs. In light of this the importance of establishing and fostering a relationship with providers on a one-to-one level can not be underestimated. Providers cannot assume that because they are furnishing detailed narrative reports as part of their performance monitoring returns that Contract Managers are aware of their particular issues or concerns, or issues of concern in the community. Contracts Managers will not be aware of a provider’s specific areas of concern if the only place these are raised is in the narrative report. Both funders and providers should be meeting regularly to discuss potential problems before they flare up in the community.

### ***Extra-contractual Provision***

For many providers, the regular and repeated provision of services which are outside the scope of the contract appears to be a normal part of contracting in Māori mental health. The reasons for undertaking work or activities outside the scope of the contract included: a Māori worldview; strategic development; community expectation or need; service equity; overstating capacity; inexperience or immaturity; and passion. By far the most significant reason for respondents in this research appeared to be that of “worldview”. It is the particular worldview of the Māori mental health provider that differentiates their service provision from that of any other provider of mental health services, both mainstream and Māori. While Māori providers may share a common worldview, or a commonality of view at a philosophical level, it is unlikely that any two Māori mental health providers will have exactly the same set of core beliefs and guiding principles at a working level. These working beliefs may be referred to as the “kawa” of the organisation. A number of features of a distinctly Māori worldview were identified in the research, these include being governed by tikanga, the use of hauora practices, the adoption of a holistic approach and a focus on whānau ora. The implications of each of these features for mental health contracting are discussed below.

### *Governed by Tikanga*

Iwi and hapū-based Māori mental health providers are governed by the tikanga of the iwi or hapū which gives them the mandate to operate in a particular area. Tikanga determines the boundaries, obligations, rights, duties and responsibilities to which a Māori mental health provider must adhere. Tikanga is not something that can be enshrined in contracts between funders and providers, nor should it be. However contracts do need to recognise that Māori mental health providers are bound by another set of “rules” beyond those which apply universally to all health services. DHBs will need to be mindful and respectful of local kawa, tikanga and customs if they are to understand aspects of Māori service delivery. The “rules” of tikanga may compel Māori mental health providers to take extra time when dealing with a client, to observe specific protocols or to involve other people expert in things Māori in particular therapy or intervention. Contracts and the contracting process need to be flexible enough to support practices based on tikanga Māori.

### *The Use of Hauora Practices*

Cunningham and Kiro (2001) have noted that hauora is not simply the Māori word for health, rather that health and hauora are significantly different concepts. For the purposes of this research I have used the term hauora to describe a range of practices and therapies which would not perhaps, in a western sense, usually be associated with the care of mental health consumers, but in traditional Māori culture are perfectly appropriate. A hauora approach to the care of tangata whaiora includes using a range of healing activities from the spiritual, through the physical and even the ecological. Durie (1994d, p.19) refers to these traditional healing practices as being “eclectic”, but based on “an understanding of human behaviour within the context of tribal survival, communal living and limited resources”. At least five categories of healing activity were common in traditional Māori society. These were:

- *Ritenga and karakia (incantations and rituals);*
- *Rongoā (medicinal, based on flora);*
- *Mirimiri (massage);*
- *Wai (the use of water); and*
- *Surgical interventions (Durie 1994d).*

The ongoing application of these traditional practices in caring for tangata whaiora would indicate that Māori communities and consumers value and support their use. However in order to continue to deliver these therapies the relevant skills and knowledge must be passed on and the appropriate amount of time made available to practice these activities. Durie (unknown date) notes that just as expertise is required for mental health treatment from a medical point of view, so too is a degree of competence necessary for introducing cultural concepts, knowledge and practices into Māori mental health services. The performance measurement framework as a whole needs to ensure that both cultural competence and clinical competence are remunerated and acknowledged appropriately as both are required by Māori mental health providers for their services to be effective.

#### *A Holistic Approach*

Ratima (2001, p.29) in discussing Māori health from a public health perspective noted that “in comparison to Western understandings of health, Māori concepts of health place greater emphasis on holism and are distinct in incorporating a spiritual dimension and a focus on cultural integrity”. Various models of Māori health have been advanced over the years in order to demonstrate the perspective Māori bring to health and health care (Royal Commission on Social Policy 1988b; Durie 1994b; Pere 1997). Many of these are now well known amongst non-Māori and can be recited almost by rote. The respondents in this research noted that while a holistic approach is utilised by Māori mental health providers when dealing with tangata whaiora, contracts are not able to recognise certain dimensions of this approach, nor do the performance measures currently exist to monitor the use of such an approach. As a result some of the work undertaken by Māori mental health providers may remain invisible to those who monitor performance and to the funders.

#### *A Whānau Ora Focus*

As Durie (1985) has noted, in a traditional understanding of society, Māori are not seen as individuals but as part of a greater collective, whether that be a whānau, hapū or iwi. Even today Māori mental health providers bring a whānau perspective to their dealings with tangata whaiora. There was recognition that whānau are not always those with kinship or whakapapa ties (Milne 2002) as tangata whaiora might consider other tangata whaiora their whānau. Family in its widest sense is recognised as a vital source of

wellbeing (Simpson and Tapsell 1999). This research found that focusing on whānau ora meant that at times providers were required to work outside the scope of their narrowly defined contracts to deliver a service to an entire family or arrange their contracts in such a way as to give themselves the freedom to work across age groups and family members. This seems to demonstrate that the contracts may actually be working against providers as they attempt to deliver mental health services in a particular way, to a particular group in the community. It may also indicate that the contracts themselves are not keeping up with innovations occurring at the community level.

Research undertaken by Te Puni Kōkiri (2000) indicates that Māori health and social service providers often play an intermediary role between the government and their communities, and are very aware of the particular needs of the community in which they work. Māori providers are often accountable to their local community either informally through their work in that community, or more formally through governance structures (Te Puni Kōkiri 2000, p.25).

This research supports the findings of the earlier Te Puni Kōkiri study and demonstrates that Māori mental health providers also enjoy a very close link with their communities. Often this link is one of whakapapa, particularly with iwi and hapū-based providers. In such cases, neither Māori mental health providers, nor the Māori mental health workers that are employed by them, are distinct from their communities. As a result providers find it difficult to distance themselves from requests for assistance, or to turn those in need away, despite the fact that those needs might not necessarily fall under the rubric of “mental health.” The obligations towards, and responsibility to, the wider community that Māori mental health providers feel is not necessarily an obligation or responsibility shared by other health providers. Failure to manage these obligations can pose a number of risks to the provider and to their staff in terms of staff burn-out, failure to perform and loss of contract, as well as failure to deliver to an expected level by the community. Māori mental health providers need to consider “managing down” the expectations placed upon them by, in many cases, their own people. At the same time however the performance measurement framework needs to acknowledge Māori mental health providers work with multiple obligations and accountabilities, a point that is discussed in more detail later in this chapter.

It is the contention of this thesis that many of the extra-contractual activities undertaken by Māori mental health service providers are desirable and beneficial to the community as a whole. While the extra-contractual activities may not fall under the rubric of mental health in a strict sense, this is not to say that the wider community does not benefit from this work being undertaken. Much of this activity contributes to Māori development goals and objectives such as building capacity and capability in the community or strengthening whānau and hapū. Halting such activity would be injurious to greater Māori development. If this contention is accepted, then the question remains how best to fund activity which contributes to health in its broadest sense, to Māori development and to the public good.

In the New Zealand context, the interrelated nature of the performance measurement system means it can not easily be dismantled nor readily overhauled. To alter one part (e.g. changing the reporting templates for Kaupapa Māori services), would create a ripple which in turn would affect other aspects of the framework, such as the service specifications for all other mental health services, the pricing mechanism which underpins of those service specifications and eventually impacting upon the mental health vote. This is not to say that the status quo should remain unchanged.

The Government has recognised and reaffirmed in its Māori health policy document, He Korowai Oranga, that health services which practise Māori views of health are not only desirable but should be actively encouraged. The purpose of He Korowai Oranga is two fold: the first to affirm Māori approaches by supporting Māori models of wellness and Māori-led initiatives to improve their own wellbeing (Ministry of Health 2002b). In essence two modes of service delivery are offered by the health sector with Māori consumers being able to choose which mode of service best meets their needs. However it is not enough to develop and promulgate a policy of “by Māori for Māori” service provision without placing the appropriate funding, purchasing and performance monitoring systems around it. The Government has also recognised this, noting that the second purpose of He Korowai Oranga is to improve Māori outcomes by “a gradual reorientation of the way that Māori health and disability services are planned, funded and delivered” (Ministry of Health 2002b, p.3). This research suggests that the time is

ripe for consideration to be given to how funding might be better realigned to take advantage of the work of Māori providers.

## **Environmental and Contextual Drivers**

The discussion above identifies a series of reasons which may account for the extra-contractual provision undertaken by Māori mental health providers. However, underpinning these reasons for extra-contractual provision are a set of higher-level environmental and contextual factors which drive the purchase and provision of Māori mental health services in New Zealand. The environmental drivers or influences include: the philosophical viewpoint or worldview of players in the sector; policy drivers (both operational and strategic policy); resource pressures (including financial and human resources); and drivers or pressures which occur as a result of the recent reform of the sector. These may all be considered as drivers external to the provider.

In addition to these external environmental drivers, there are two further contextual drivers. One of these contextual drivers may be considered to be internal as it is concerned with the expectations and obligations the provider places on their own service delivery. This internal driver is also associated with the viability of the service as a business and issues of competency in both management and governance. This driver is closely related to, and overlaps with, the obligations and responsibilities the provider has to their community, an issue raised later in the chapter in the discussion on accountability. The second contextual driver is locality specific. Locality specific drivers are those which occur as a result of the unique geographic, social or political characteristics of the area in which the provider is located.

The following table lists the environmental and contextual drivers which became apparent in the course of this research. It is by no means an exhaustive list of the pressures or forces which exist in the mental health sector. The drivers listed in this table emerged through an analysis of the data and appear underpin many of the reasons respondents gave as to why Māori mental health providers regularly work outside the scope of their contract. It is also important to note that each provider's experience of these drivers will be different, with some drivers being more influential than others, or playing a greater role at a particular time than others.

**Table 4: Environmental and Contextual Drivers in Māori Mental Health Service Provision**

Driver	Description of Driver	Features of the Driver
Philosophical	The particular principles and values which underpin the funding, purchasing and provision of services	<ul style="list-style-type: none"> <li>▪ The values and principles that underpin the work of the provider may be quite different from those of the funder</li> </ul>
Policy	Two types of policy exist: Government's strategic policy for Māori health and the operational policy for funding and monitoring health service provision	<ul style="list-style-type: none"> <li>▪ Mismatch between strategic policy and operational policy (i.e. between He Korowai Oranga and DHB practice)</li> </ul>
Resource	Financial resources available to the sector Human resources or labour force	<ul style="list-style-type: none"> <li>▪ Financial resources are finite</li> <li>▪ The pool of skilled labour may be restricted in certain areas</li> </ul>
Reforms	The sector is consolidating after a series of reforms	<ul style="list-style-type: none"> <li>▪ Inexperience exists in the funding, purchasing and the provision of services</li> </ul>
Internal	The provider's own self-identified expectations of how the service should be delivered	<ul style="list-style-type: none"> <li>▪ Provider may be overambitious</li> <li>▪ Expectations may outstrip skills and resources available</li> <li>▪ Viability</li> <li>▪ Competency</li> </ul>
Locality	Features of the specific environment in which the provider is located	<ul style="list-style-type: none"> <li>▪ Difference between a large and a small DHB and the expertise that DHB has and can attract</li> <li>▪ Workforce and expertise a provider can attract</li> <li>▪ Iwi and hapū politics</li> <li>▪ Variations in the number of consumers and therefore the viability of services</li> </ul>

The relationship of these drivers to the Māori mental health providers that participated in this research will in many cases be self-evident however a brief explanation of each of these drivers is presented below.

### ***Philosophical***

The philosophical driver is concerned with the particular principles and values which underpin the funding, purchasing and provision of services. As noted above there is a clear mismatch or dissonance in the philosophical principles which drive funding and purchasing and those which underpin Māori mental health service provision. Funders

and providers might share some of the same long-term goals, such as more and better mental health services (Ministry of Health 1994) or more and better mental health services for Māori (Ministry of Health 1997a), however the means by which these goals should be achieved may differ markedly. For example, from a Māori philosophical viewpoint achieving more mental health services in a community may arise through the delivery of more primary health services as mental health is not dealt with in isolation from other aspects of health. It may mean the creation of “one-stop-shops” which take a “whole of health” approach. It may even, at a more extreme level mean one-stop social service shops, as in a Māori worldview, the treatment of ill health is neither separate nor distinct from wider socio-economic, emotional or spiritual elements.

### ***Policy***

The NZ Health Sector has adopted the concept of “whānau ora” as central to the achievement of the goals within the Māori Health Strategy (Ministry of Health 2002b) and, implicitly, the New Zealand Health Strategy and New Zealand Disability Strategy. Whānau ora, as a concept, moves us forward from the idea of ‘hauora’ which has been well articulated through a number of Māori Health models such as Te Whare Tapa Wha (Durie 1998c) and Te Wheke (Pere 1997)<sup>14</sup> and emphasises diversity, community, interdependence and a recognition that health must take account of social constructs, not just physical symptoms (Ministry of Health 2002b).

While the concept of whānau ora is articulated and accepted at a national level, this research has found that a tension remains between acceptability and articulation of a Māori concept in policy terms and the practical implementation of that concept within a health system whose processes and institutions have been designed around a predominantly western view of health i.e. individualised, sectoral, and largely clinically oriented. In 2002 the National Health Committee noted that in developing Māori health policy the sector has experienced enormous variability and a lack of consistency in its responsiveness to Māori health. Furthermore the Committee goes on to state that while in the reformed sector DHBs may be more responsive to local needs, the lack of

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<sup>14</sup> Te Wheke was first discussed by Pere in 1984 and uses the analogy of the octopus to describe the main features of health from a Maori family perspective. Each of the eight tentacles symbolise a particular dimension of health while the body and head represent the whole family unit. Waiora or the total wellbeing of the family is represented by the eyes of the octopus.

consistency evident in the sector may lead to unacceptable variations in responsiveness to Māori. This in turn could threaten the very real health gains Māori have made to date and limit future Māori health development (National Health Committee 2002, p.21).

This research has found that incremental changes such as the development of a Kaupapa Māori Service Specification, have been made to the performance measurement system to “allow for” initially, a different mode of service provision (that of by Māori for Māori). More recently however attempts to incorporate a Māori worldview to the performance measurement system have been confined to piecemeal changes to contracts for service depending upon the DHB or the contracts manager. Change does not appear to have been systematic, considered or consistent. Nor, according to respondents, has the health sector been able to keep up with Māori providers’ desire to include Māori worldviews into the sector in a more integrated manner.

Interim data from the Health Reforms 2001 project supports this finding. The Health Reforms 2001 project has found that DHBs are struggling not only with the concept of whānau ora, but also how whānau ora might be delivered in the community. Many respondents noted that adopting a whānau ora approach requires DHBs and mainstream providers to revisit and rethink the way in which services are currently delivered to Māori (Health Reforms 2001 Research Team 2003). Specifically the research found that so-called “Pākehā” approaches to services, those focussed on delivering care to the individual, need to be revisited in light of the “whānau ora” framework enshrined in He Korowai Oranga.

### ***Resource***

There are only a limited amount of financial resources available for mental health care and for the health sector more widely. Similarly, there is a finite pool of skilled human resource upon which the sector can draw. How these resources are used and which services should receive priority is an ongoing and seemingly irresolvable debate. In Māori mental health service provision the resource drivers impact upon providers in two ways. From a purely financial perspective if resources are not available in the health sector to fund a certain intervention or therapy Māori mental health providers will find other means of funding that intervention. The providers that participated in this research employed a number of strategies to “find” additional money or offer particular

therapies or interventions. These included “shifting” resources within a contract or a series of contracts to fund that therapy; finding the money to pay for the therapy in another sector; volunteering their own time in order to offer that therapy; or contracting out their skills and expertise and using that income to fund a therapy.

The second impact resource drivers has on Māori mental health service providers is that often these services are not able to compete with the DHBs or even mainstream services in terms of the financial remuneration or conditions they are able to offer their staff. A number of providers commented that they could not expect to compete with DHBs, and at least one respondent noted the disparity between the price a Māori mental health provider received to pay for a registered nurse compared to the actual national price. The demand for skilled Māori mental workers is such that the community finds it difficult to fill positions and turnover is high. Māori mental health providers often rely on whakapapa links to bring people home to work in their communities and to keep them there once they have returned home.

### ***Reforms***

The reforms of the early 1990s created a contracting environment in which providers and funders were to operate “at arms length” and retain a degree of independence from each other. The reality of Māori mental health service provision however is that Māori providers require a closer relationship with the funder than simply that of principal and agent. Respondents in this research indicted that funders need to see Māori mental health service provision in action to understand the nature of that service provision. They also called for greater involvement in the contracting process, real negotiation of contracts and a deeper and more meaningful working relationship with the DHB.

A further consequence of the process of reform that has characterised the health sector in the last 15 years is that both Māori providers and indeed DHBs in their current configuration are relatively immature and inexperienced. Māori providers are “youthful”, in that they have only really existed since the 1980s. In twenty years their capacity, capability and expertise have grown at a rapid rate however, the speed with which the sector has also changed has also been rapid. Māori mental health providers would benefit from a period of stability in which to consolidate the gains made to date. Similarly, DHBs as funders are a “new” player in the health sector and would also

benefit from a period of stability in which they could become familiar with the needs of their particular area and population of that area.

### ***Internal Drivers***

There are a number of internal drivers which underpin the reasons Māori mental health providers undertake extra-contractual work. In comparison to the rest of the health sector, and especially in comparison to primary care providers such as General Practice services, Māori mental health providers are relatively youthful and inexperienced in the business of health service provision. There is no denying that Māori have been able to tend to, and care for, their people since time immemorial, however in terms of running a mental health provider as a business in the community, this aspect of health care has only really opened up to Māori in the last 20-30 years. Māori mental health providers need time to grow, to mature and develop the confidence and skills to work with funders on a more level playing field.

Issues of viability, competency and skill base are crucial particularly among smaller and more isolated providers. Māori mental health providers need to consider ways in which they can collaborate with other providers and make the most of the opportunities available for collaboration and cooperation. Evidence of increased collaboration at a local and regional level was apparent in this research. By establishing strong partnerships with other providers at an iwi or regional level providers may be less likely to try and act in every capacity for tangata whaiora. Māori mental health providers must also be aware that in supporting tangata whaiora in their journey to wellness, those who have the skills, knowledge and expertise tend to be called upon time and time again and in doing so run the risk of burning themselves out. This is a critical area to manage as these experts are themselves a finite resource that must be nurtured.

### ***Locality***

Locality drivers for extra-contractual provision may include the expertise that can be attracted to a specific area, variations in viability of services due to the number of tangata whaiora in an area and issues to do with iwi and hapu politics. Respondents noted that the politics that occur in an iwi or a hapū may be played out in the course of a provider's day to day work. The management of iwi and hapu politics is an element

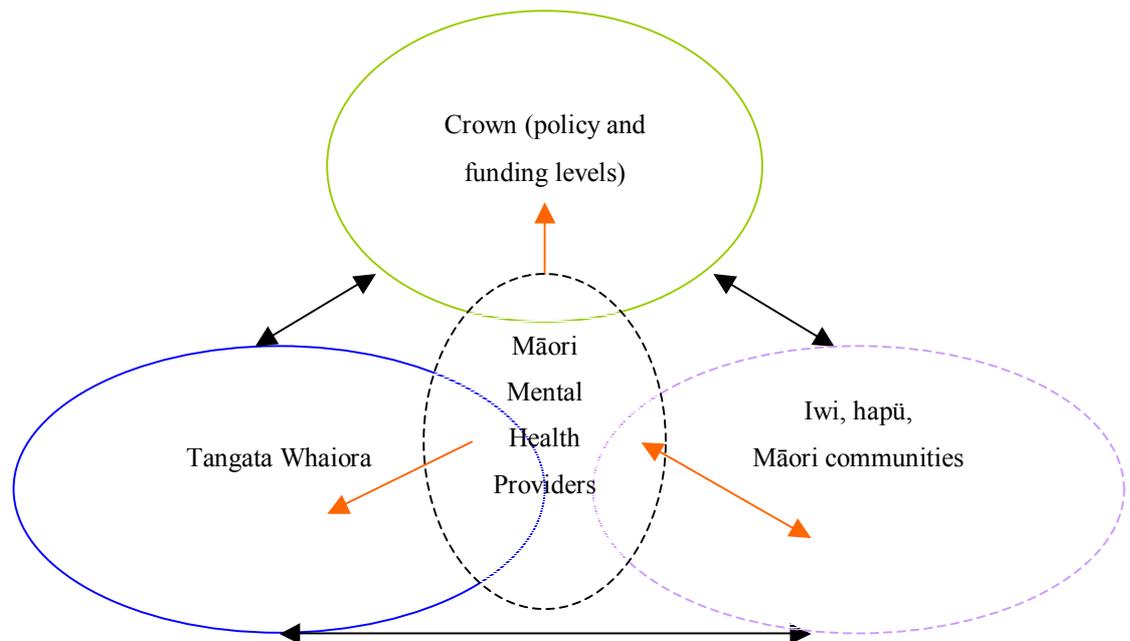
which mainstream mental health providers do not need to consider as part of service provision.

The drivers described above represent a set of higher level pressures which act upon Māori mental health providers, compelling them to work outside the scope of their contract. Currently neither the contracts nor the performance measures contained within them acknowledge the existence of these higher-level drivers. Contracts are expected to be discharged in an environment that is unaffected by outside pressures, almost as if service provision were occurring in a contextual vacuum. The reality for Māori mental health providers is that there are multiple pressures and multiple drivers. Changes to the contracts or to the service specifications may lessen the impact of some of these drivers upon the provider; however most of the drivers identified are so broad that making adjustments to a contract or to the service specifications will be insufficient. What is required is that DHBs recognise and address the contracting process and the environment in which this occurs. This may require a whole scale change in the way contracting and performance measurement is approached in Māori mental health, so that the contracting and performance measurement frameworks acknowledge the reality of Māori mental health service provision and the multiplicity of pressures upon that provision.

## **Accountability and Spheres of Influence**

At any one time there are four major “spheres of influence” which exert pressure upon the provider and which impact upon how the provider carries out their work on a day-to-day basis. These spheres influence what specific services will be provided, or what form the provision will take. Each sphere of influence represents a specific group or entity and in addition to the influence that each is able to exert, each sphere requires the provider to be accountable to them in one form or another. The spheres of influence include tangata whaiora; the community (whether it is an iwi, a hapū or a Māori community); and the Crown at both the policy and funding levels. In addition to these three spheres, the provider also acts as a sphere of influence as it puts pressure on itself to provide certain services in a particular way, in keeping with its own internal expectations and obligations.

The following diagram illustrates the spheres of influence that exist in Māori mental health service provision and the relationships between spheres and the provider. In the diagram, accountability relationships are represented by the red arrows and other relationships which may exist between the spheres by the black arrows. Spheres are represented by dotted lines to indicate that an interface between the spheres of influence, including the provider, occurs.



**Figure 4: Spheres of Influence in Māori Mental Health Service Provision**

The purpose of the diagram is to demonstrate that each sphere has its own set of expectations which it attempts to have met in the sector *through the provider*. Tangata whaiora for example expect that they will be cared for, treated and assisted in their journey to recovery through their interface with the provider. Communities equally expect that their people and their whānau will be supported, cared for, and treated by providers but also that this will be done in a way that is congruent with their tikanga and values. The funder through its interface with the provider expects that an appropriate quantity and quality of mental health services will be delivered at a community level.

Other relationships between spheres occur in Māori mental health service provision and these are represented by the black arrows. For example the Māori community will have a relationship with the Crown as a funder through the health needs assessment and

annual planning cycles as well as a more strategic relationship with the DHB at a governance level. The community has a further relationship with the Crown as they are both the audience at which strategic policy documents, such as He Korowai Oranga, are aimed and the population group the policy seeks to affect. Tangata whaiora too have a similar relationship with the Crown in terms of being the key population group at which the national mental health strategy is targeted.

The influence that each sphere is able to exert on the provider is variable and idiosyncratic. In other words, the degree of influence or pressure is not always constant over time and the type of pressure that is exerted is peculiar to each sphere. Pressure from a funder may only be felt at times of contract negotiation, renegotiation or when performance reports are due, whereas tangata whaiora may exert pressure at any time depending upon the nature of their illness or the degree of severity. The type of pressure each sphere places upon a provider ranges from financial and resourcing pressures (providers are compelled to provide a particular service in a particular way so as to obtain certain funding), through to the pressure to provide a service which is culturally appropriate and congruent with local tikanga. The DHB, tangata whaiora and the Māori community all have competing expectations of the Māori mental health provider. However the provider has only one set of resources to manage these competing expectations. Fortuitously, for the most part, these competing expectations tend to overlap and most providers are able to deliver a service which fulfils the expectations of all the stakeholders. When this occurs, there is no cause for concern. In the event that these expectations do not coincide, the provider may decide to step outside of their contract to meet these expectations or adjust their mode of service delivery. In a worst case scenario, where competing expectations are not managed, a provider may fail to meet its contracted objectives.

That different spheres of influence and expectations exist is not immediately apparent or obvious to any of the stakeholders or to the sector more widely. For example, when considering Māori mental health in contracting terms the most obvious relationship may be that between the provider and the funder. When considering Māori mental health in terms of service provision however, the most obvious relationship may be that between the provider and the tangata whaiora. What this diagram attempts to illustrate is that providers experiences multiple pressures in the activities of contracting for and

delivering mental health services, not the least of which are the pressures placed upon providers by their own communities.

Whereas the contract represents a major financial arrangement between the provider and the funder, for the provider themselves this might not be the most important accountability relationship in the long-term. The accountability relationship between the funder and the provider is characterised by the following features: it occurs at a very formal level; it is a relationship which providers are called to account for most frequently, through quarterly reporting; it is the relationship that is highlighted most often and about which most is known. However, there was no consensus in this research that the financial accountability relationship with the funder was the prime accountability relationship.

Accountability entails a series of duties and obligations (State Services Commission 1999) which themselves imply an acceptance that there are external reference points that must be taken into consideration when choices or decisions, in this case about service provision, are being made. Accountability for Māori mental health providers goes beyond being accountable to the government of the day or to the funder. This research has demonstrated that for many Māori mental health providers the relationship between themselves and their local community is as important as those with the funder or client, particularly if the provider is an iwi or hapū-based one. Furthermore the relationship and accountabilities between a provider and their community is usually a reciprocal one. While the provider has a set of duties, obligations and responsibilities to the community, so too is the provider able to call upon the skills, expertise or support of the iwi or hapū if required. This relationship of reciprocity is not replicated with any of the other spheres of influence, nor is it taken into account when contracts are negotiated. This relationship and the influence it has on service delivery remains clearly outside the contractual considerations of the funder. Contracts and the contracting environment do not make allowances for the additional expectations and accountabilities placed upon providers by their communities.

According to the literature accountability in health care is a manifestation of the relationship between those responsible for the financing health care (DHB), organising health services (DHB), delivery of health care (Māori providers) and those who pay for

and receive it (*tangata whaiora*). The challenge in accountability relationships is to ensure the incentives facing the organisation responsible for ensuring accountability (the agent) are aligned with the incentives of the group receiving care (principal) (Brown, Baker et al. 1999). This research has demonstrated that in Māori mental health service provision these incentives are not always aligned. Some providers indicated that their accountability to the community is the most important relationship as they must face up to their community on a day to day basis. The fact that the services are often located on or next to the marae means that there are daily reminders for Māori health providers of their obligations and responsibilities to their community; a community often-times comprising whānau members. By comparison the Māori mental health providers that participated in this research noted that they rarely saw DHB staff including contracts managers until it was time to renew contracts and face to face contract negotiations were required.

Providers are held accountable by each of these spheres as demonstrated by the red arrows. The direction in which the accountability occurs (Gregory 1995) is also represented. For example, Māori mental health providers are accountable to their communities for the provision of services but the element of reciprocity means that Māori communities are equally responsible for their providers and can be called upon to support providers as the need arises. As respondents noted the types of support Māori mental health providers may rely on from their wider community include skills, knowledge and expertise in things Māori, assistance with powhiri and other formal functions and in the use of venue such as marae. Māori mental health providers, like other Māori businesses, have “multiple responsibilities and levels of accountability” (Durie 2003b, p.248). Accountability to the funder, a feature of a contracting environment, is not the only level of accountability. A Māori provider also has accountabilities to its Board and to the Māori community more generally. Even when there is no “legal” obligation placed on providers to report to their communities (Durie 2003b), the accountability associated with being a Māori provider in a Māori community will ensure such reporting back occurs.

The research found that in addition to the various Crown/funder accountability mechanisms that Māori mental health providers must contend with (in particular the quarterly performance monitoring reports, audits and contract conditions) Māori

providers were also being held to account against another accountability framework which employs a completely different set of accountability measures. The findings from this research indicate Māori mental health providers are held accountable to their communities through a number of mechanisms. Some, such as regular reports to the Board or Rūnanga would be familiar to any other mainstream health service provider or business. Other forms of accountability such as hui, whakamā, kanohi ki te kanohi are culturally based and are not experienced by mainstream mental health providers.

The recognition of a Māori cultural framework that has accountability back to their community is important for Māori providers (Te Puni Kōkiri 2000). A Māori cultural framework would need to take account of the multiple accountabilities that Māori mental health providers manage as well as the different “forms” this accountability takes. Current accountability frameworks rely on Board reports, reporting on outputs or contract compliance. In order to fully recognise the unique features of Māori service delivery, the elements and forms of Māori accountability which accompany Māori service delivery, and indeed Māori business practice, also need to be recognised.

## **Vulnerability of the Sector**

The current configuration of the mental health sector, where the provision of mental health services can be undertaken at the community level through a contractual arrangement between a funder and a provider of services, is a relatively recent organisation of mental health service delivery. Because of this the sector has some weaknesses and a degree of vulnerability which, after a series of major reforms, is only to be expected. This research has highlighted the fragile dichotomy of Māori mental health service provision. On the one hand there is a strong desire in the community and among mental health providers to work with tangata whaiora and their whānau, to support them in achieving their aims and ambitions for health and wellbeing. Māori mental health providers, relatively new to service provision, are having to prove themselves on multiple levels in order to deliver mental health services in the community competently, effectively, successfully and in a culturally congruent manner. On the other hand DHBs, driven by their responsibility to achieve improvements in health outcome for a geographically defined population, are seeking to purchase services from the community. DHBs themselves are relatively inexperienced as funders of mental health services and rely heavily on the ability of Māori mental health

providers to deliver appropriate, timely and efficient services, so that the broader objectives of improvements in health outcome might be realised.

The fragility of Māori mental health provision was illustrated in this research on several occasions. It was apparent by the fluid nature of the Māori mental health workforce, particularly by the changes in management that occurred, and continues to occur amongst the mental health providers that participated in this research. It was also apparent in the way that those who did work in mental health were called upon time and time again to use their skills and expertise in other related fields. Many of those who participated in this project were experts in mental health service delivery; however their skills were also in high demand as auditors of services, as consultants on Māori health more widely, as lecturers on Māori health. In addition to a multitude of professional roles these people also fulfilled many roles in the community as members of Rūnanga or marae committees. The fragility was also apparent in the very nature service provision.

Māori mental health providers have demonstrated that if they are to remain viable, they must be flexible, adaptable and rapid learners. Many of those who participated in this research commented that they were poised to adopt a “whole-of-government” approach to contracting, or joint contracting as a means of advancing Māori mental health and whānau ora more widely. Many commented that they were ahead of the DHB in readiness to accept more intersectoral approaches to contracting. Such approaches to service delivery were not regarded as new, but rather a formalisation of the way services were already being run. Innovation, adaptation and opportunism are often features of a successful Māori mental health provider. These qualities should be supported, as they can only serve to strengthen the sector.

## **Reflections on the Research**

This research commenced with some broad questions about Māori mental health service provision, performance measurement and accountability. The data gathering and analysis phases of the research opened up other avenues for investigation and led the research in a slightly different direction than had been intended at the outset. This research was initially driven by the knowledge that some Māori health providers did more than they were contracted to (Crengle 1997; Boulton 1999) and my own

perception that this additional work was not being adequately acknowledged. The initial set of interview questions devised for key informants therefore included a set of questions around the usefulness of a cultural performance measure which would acknowledge that extra work. In the course of undertaking this research, it became apparent that understanding the reasons Māori mental health providers undertook extra-contractual work was *as important a factor* as acknowledging the extra contractual work itself. It also meant that the solutions to acknowledging and validating extra-contractual service provision required much more complex responses than the glibly titled “cultural performance measure” envisioned at the beginning of the project. As the research progressed, the focus therefore changed subtly from attempting to define or categorise cultural performance measurement to attempting to understand the drivers of extra-contractual service provision. In identifying the drivers, influences and pressures which compelled Māori mental health provider to work outside of the scope of their contract on a regular basis, the need for a multi-level response to adequately acknowledging and therefore validating that work became clear.

This research has identified that there are a number of areas where Māori mental health providers do more than they are contracted to, or work outside the scope of their contract in order to deliver mental health services that are aligned with their own cultural and community norms. The research did not however, specifically investigate where Māori mental health providers might be under-achieving on their contracts or their expected performance output targets. The research findings presented in this thesis indicate that Māori mental health providers and DHBs may enter into contracts with each other for different purposes, to meet different ends and with differing expectations. The research has shown that there are outputs and services which Māori mental health providers deliver which are outside of the scope of the contracts. Equally, it is possible to theorise that there will be specific tasks in contracts, performance outputs or expectations that DHBs have of Māori mental health providers that providers may not be meeting. DHBs are unlikely to be concerned if Māori mental health providers are able to deliver more than they are expected or contracted to, for a set sum. However, gaps in service provision will be cause for concern on the part of funders and policy-makers alike. Identifying exactly where these areas of overlap and mismatch occur requires further research. To that end, identifying areas of “under-provision” will be a focus of the post doctoral work outlined in the Epilogue.

A theoretical and interpretive framework that actively positioned both the research project and the researcher at the interface between the worlds of scientific knowledge and indigenous knowledge, between te ao Māori and te ao Pākehā was consciously chosen for this research. The study sought to understand a phenomenon which, while occurring in a predominantly “western” health system occurred because of the introduction of indigenous practices into that system. This research used an interface “lens”, a lens which operates at the interface between two different worldviews, which is able to distinguish the unique features and characteristics of each, to characterise the experience of Māori mental health providers as they contract for services. Methods and tools from both the Māori and the non-Māori world were used to collect data and a Māori centred analysis was applied to the data collected. Ironically, but perhaps unsurprisingly, this research, which was theoretically positioned at the interface found that Māori mental health providers themselves also operate at this interface between the two worlds and the two worldviews.

### ***Limitations of the Research***

In the process of reflecting upon the research it is also appropriate to consider the limitations of the study. First, this study focused on the experience of Māori mental health providers during a particular period in time: August 2003 to October 2004. As has been demonstrated in the literature, New Zealand’s health sector has been in a state of change since the mid-late 1980s, with the implementation of the latest set of reforms, those introduced by the New Zealand Public Health and Disability Act 2000, forming the backdrop to this study. Therefore this research must be considered in terms of the context in which it took place and with the understanding that the sector has since evolved further.

Second, the research was not intended to produce generalisable findings or achieve representative coverage, but rather was a study of a selected group of providers. Having said this, it is likely these findings will resonate with providers in other localities and regions within New Zealand. Nor are the findings generalisable to other indigenous populations without a specific reference to the context in which those other indigenous providers operate. One of the intentions of the post doctoral research work which arises from this research (discussed in the Epilogue), is to explore the transferability of these findings to other indigenous peoples in their specific contexts and environments.

A further limitation is that due to a delay in securing ethics committee approval for the Auckland region, the number of providers I originally hoped to include in this research was reduced and resulted in a key provider being unavailable for the research. A further limitation of the research relating to the collection of data occurred because some providers denied access to contractual and performance monitoring information due to commercial sensitivity and confidentiality issues. This resulted in fewer than expected contracts and performance monitoring reports being analysed.

A final potential limitation of the research is that funders were not re-interviewed after all the data had been collected and analysed, for their views on the results of the research. Seeking the perspectives of the funders on the combined results of this research while valuable, would have added considerably to the research timelines. After discussion with my supervisors, it was decided not to re-interview DHB funders and planners immediately after the provider data was collected, rather these interviews would form a component of the post doctoral study.

## **Summary**

This chapter has demonstrated that there is agreement that the framework currently used to measure the performance of Māori mental health providers is inadequate on a number of levels. The inadequacy of the performance measurement framework is in part due to its inability to reconcile two different worldviews or philosophical viewpoints which operate concurrently in the sector. As a result of the inadequate nature of the performance measurement framework Māori mental health providers are regularly engaging in overprovision, different provision or even inappropriate provision in order to deliver mental health services which are aligned with those values and norms enshrined in Māori culture. In addition to the reasons provided by respondents for extra-contractual provision, the chapter demonstrated that there are a set of environmental and contextual drivers which provide further impetus for Māori providers to work outside of their contract. The contracting setting does not take account of this set of higher level drivers, nor of the multiple and competing spheres of accountability which characterise Māori mental health service delivery. Rather the delivery of services and the fulfilment of contractual requirements are assumed to occur “in a vacuum”. The reality however, is that Māori mental health services are delivered

despite the inadequacies of the system because the providers themselves manage the many pressures, drivers and accountabilities which exist, acting as the interface between their own communities and the DHBs who represent the wider health sector.

## Chapter Ten:

# Conclusions and Implications

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New Zealand's mental health performance and monitoring framework is a complex and evolving one. Its initial development occurred at a time when it was taken for granted that mainstream understandings of health and mainstream systems of service delivery would not only be appropriate for all New Zealanders, but would also service the needs of all New Zealanders. Latterly however there has been an acknowledgment that a wholly different understanding of health and health care has existed in this country; the worldview understood and shared by tangata whenua. The starting point for this research was to investigate contracting and the contracting process between Māori mental health providers and health funders as agents of the Crown. Three conclusions can now be drawn as a result of undertaking this study. First, Māori mental health providers deliver mental health services at the interface between two philosophical viewpoints or worldviews: that of the Māori community in which they are located and to whom they provide services; and that of the funder, from whom they obtain resources to enable them to deliver services. Second, the contracts which establish the relationship between the provider and the funder are not responsive enough to take account of the unique perspectives, processes and practices Māori mental health providers bring to mental health service delivery, nor the pressures put upon them in the course of that delivery. Making a contract more responsive to Māori mental health providers, while going some way to acknowledging their work, will be insufficient to acknowledge the context in which that work occurs. Rather than changing the contract to make it more responsive, it is the contracting process *as a whole* that needs to be altered. Third, in order to adequately acknowledge and validate the beneficial extra-contractual provision which occurs as a result of delivering mental health services at the interface, and prevent less desirable provision, a performance measurement framework, which integrates both worldviews and which takes account of the multiple accountabilities that Māori providers manage, is required.

## Provision at the Interface

One of the very clear findings from this research is that in order to understand the contracting process for Māori mental health providers one also has to be mindful of the higher level environmental and contextual factors which drive the purchase and provision of health service in New Zealand. One such driver is the philosophical basis or worldview which underpins decisions about what to fund and how to fund. This research has demonstrated that in the New Zealand context, a dissonance exists between the strategic policy intent of the government, the operational policy and procedures of the funder and the philosophical viewpoint of the provider.

The government's most recent acknowledgment of the existence of a different worldview is evident in the Māori health policy document: He Korowai Oranga. This document recognises that whānau are the foundation of Māori society; they are the principal source of strength, support, security and identity for Māori; and they are central to the wellbeing of Māori both individually and collectively (Ministry of Health 2002b). While the recognition of a Māori worldview in which whānau are central to health and wellbeing is clearly articulated at a strategic policy level, this recognition has not been translated into operational policy at the funding or monitoring level. Attempts to date to incorporate a Māori worldview into the existing mental health performance measurement framework, primarily through the development of kaupapa Māori service specifications, have not significantly advanced the health status of tangata whaiora nor assisted Māori mental health providers to deliver the best service they can to tangata whaiora. Indeed a fissure has clearly been found to exist between the government's high level strategic intent as outlined in He Korowai Oranga, the District Health Boards' understanding and operationalisation of this intent through its contracts with providers, and the Ministry of Health's performance monitoring framework.

Māori mental health providers are delivering services at the interface between the Māori world and the non-Māori or Pākehā world. In doing so they strive to bridge two very different worldviews; a Māori worldview which is governed by tikanga, uses hauora practices, adopts a holistic approach and focuses on whānau ora and a non-Māori worldview which has no need to take account of Māori tikanga, is based predominantly on good clinical practice, still compartmentalises health, and remains strongly focused

on the health of the individual. Unlike mainstream mental health services which may choose the degree to which they include elements of Māori culture and what elements they wish to include, the inclusion of cultural imperatives in a Māori mental health service is an absolute obligation placed upon Māori mental health providers by their communities, their clients and indeed themselves. These cultural imperatives are not simply added on; they form an integral part of the entire service. The government has acknowledged that Māori mental health services provide a different and unique service, which is desirable and valued. This research has demonstrated that the generic models of contracting and performance measurement are ill-equipped to accurately monitor, assess or measure Māori mental health service provision. This mismatch needs to be rectified.

### **Responsive Contracting versus a Responsive Contract**

Almost without exception, the respondents who participated in this research identified that the current contracting system for Māori mental health providers is inadequate. Contracts implicitly contain expectations that certain services or activities will be produced or undertaken and certain outputs met. However, this research has shown that at times, Māori mental health providers will provide services and produce outcomes for which they have not been funded, or fall short of delivering the requisite number of outputs purchased by the DHB.

The products, services and activities which DHBs are purchasing, and those which Māori mental health providers are delivering do not always coincide. While for the most part, the products, services and activities being purchased and provided have tended to overlap; neither the funder nor the provider is getting exactly what they want, or expect, from mental health contracts. Contracts are currently negotiated and awarded as if they were able to be discharged in a contextual vacuum. The reality is somewhat different as Māori mental health providers are influenced by multiple drivers or pressures.

Extra-contractual provision has been shown to occur as a result of two factors. First there are a set of high-level environmental and contextual drivers which influence how funders approach contracting for mental health services in the community. Second providers are attempting to manage the multiple influences, pressures, expectations and

accountabilities placed upon them by themselves, funders, communities and tangata whaiora. The inter-play between the higher level drivers and the lower-level expectations and accountabilities compel providers to work outside the scope of their contract. Currently neither the contracts nor the performance measures contained within them acknowledge the existence of these higher-level drivers, let alone the multiple accountabilities providers manage daily. In order to address the issue of extra-contractual provision both sets of pressures must be considered. Hence, simply the revising the contracts, developing cultural performance measures, or altering the mental health service specifications will not remedy the situation in the long-term. Changes to the contracts or to the service specifications may lessen the impact of some of these drivers upon the provider; however most of the drivers identified are so broad that simply making adjustments to a contract or to the service specifications will be insufficient. A whole scale change in the way contracting and performance measurement is approached in Māori mental health is required; moving to *responsive contracting* not just a responsive contract. Responsive contracting is a state in which the contracting and performance measurement frameworks acknowledge the reality of Māori mental health service provision and the multiplicity of pressures upon that provision. Responsive contracting would include: an approach consistent with, and reflective of, the Treaty of Waitangi; recognition of the local context in which services were being delivered; recognition of local needs; true negotiation of contracts; closer, more personal, and face-to-face relationships between DHB contracts managers and provider; regular feedback on issues and concerns raised by providers; a mechanism for ensuring issues raised by Māori mental health providers are considered at the DHB level. In essence the contracting process would be located at the same place as service provision: at the interface between the two worldviews.

### **An Integrated Performance Measurement Framework**

Having recognised that Māori mental health provision occurs at the interface and that a responsive contracting approach located at the interface is required to better manage the extra-contractual work that occurs in Māori mental health service delivery, attention must be turned to the issue of competing accountabilities and the contention that some of the work undertaken by Māori mental health providers contributes more to broader Māori development goals and objectives, than to the Crown's goals for mental health.

This research has demonstrated that accountability for Māori mental health providers goes beyond being accountable to the government of the day or to the funder. For many Māori mental health providers the relationship between themselves and their local community is as important as those with the funder or client, particularly if the provider is an iwi or hapū-based one. Māori mental health providers must contend with multiple accountabilities and different performance assessment frameworks yet their funding is dependent upon their success in managing only one of these accountability relationships: that which exists between the provider and the funder. The Crown/funder accountability framework, linked directly to funding, takes no account of less formal, yet equally stringent, accountability framework employed by Māori communities. Māori mental health providers are squarely placed between the two. The challenge for the sector is to develop an integrated, dual-worldview performance measurement framework which both recognises the multiple accountabilities of Māori mental health providers and funds Māori mental health providers appropriately. As with responsive contracting, such a framework would need to be positioned between, and take cognisance of, both worldviews in operating in the mental health sector.

## **Implications of these Conclusions**

A number of obvious implications for contracting and performance measurement emerge as a result of these conclusions:

- Locating the contracting and performance measurement foci at the interface will be necessary;
- ‘Perspective’ and personnel are likely to be critical to successfully undertaking contracting and measuring performance at the interface;
- A broader set of activities will likely be identified in mental health contracts which will require specification and resourcing;
- This broader range of activity may require both quantitative **and** qualitative measures;
- Multi-perspective monitoring may be required to recognise the multiple accountabilities that Māori providers manage. Tools which use a triangulated approach to performance monitoring are currently being developed (Kingi and Durie 2000).

These implications have guided the development of a post-doctoral research project funded by the Health Research Council. The post-doctoral research will continue the momentum generated by this doctoral research and will explore the issues and challenges that funders, planners and Māori providers have in contracting at the district and local level. Part of the research will involve developing a practical tool to improve the existing contracting environment in a defined geographic area and which will allow Māori providers to deliver at their optimum. A brief description of this subsequent project is given in the epilogue.

## **Epilogue:**

### **Ongoing Research**

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In November 2002 the Māori Health Strategy, He Korowai Oranga, was added to the New Zealand Health Strategy and the New Zealand Disability Strategy to create triumvirate of government strategies that established “the platform for the Government’s actions on health” (King 2000c). The overall aim of He Korowai Oranga was “whānau ora”; a term which quickly became part of the New Zealand health sector lexicon. While arguably the term gained a general and popular usage amongst health professionals, managers and funders, little thought was given as to the how the values and ideals enshrined in the term would play out in the day to day practice of health service funding, purchasing, contracting and performance monitoring.

The findings presented and discussed here indicate that further research is warranted into whether the current contracting environment can deliver whānau ora health gains for Māori. Currently we do not have an accurate picture of whether DHBs are purchasing the “right” services from Māori providers or even whether they are paying the right price for the services they are purchasing. From the perspective of Māori providers, we need to understand more about the contracting processes and the particular issues Māori providers face as they contract for whānau ora. At the moment we possess only a rudimentary understanding of whether current contracting and performance monitoring frameworks work with, or against, Māori providers as they strive to deliver the best health outcomes for Māori.

To that end, in May 2005 I was awarded an Health Research Council postdoctoral research fellowship and strategic development grant to build upon and extend the work contained in this thesis. The primary aim of the postdoctoral research is to explore the issues and the challenges that funders, planners and Māori providers have in contracting at the district and local level. Part of the research will involve developing a practical

tool to improve the existing contracting environment in a defined geographic area and allow Māori providers to deliver at their optimum.

The research aims to bring both local and international strands of research together in a way that moves the New Zealand health sector forward, promotes appropriate Māori health services that deliver whānau ora, and leads to improvements in contracting for Māori health. The research adopts an applied/action research orientation (within a Māori centred approach) in order to influence the way in which the DHB behaves and where necessary inform and transform understandings, processes and practices. Hutt Valley DHB (HVDHB) has agreed to take a collaborative research approach to improving the contracting system for whānau ora services. Their agreement to participate in this research is to be commended, as is their decision to allow the principal investigator full access to DHB systems and information; within the usual confidentiality environment enjoyed by employees. The research will examine whether it is possible within existing contractual arrangements to purchase for whānau ora services. If the answer to this initial question is, “No”, then the research will attempt to develop a conceptual framework and tools to modify the system to respond to whānau ora as a Māori construct.

## **Research Design**

The research design of this project takes a Māori-centred approach. Within the Māori-centred approach the research will adopt an action research orientation. Action research in the sense of this project dovetails into the aims and objectives of a Māori-centred research approach. The emphasis with action research is on improving and transforming and social situations. Bowling notes that action research is undertaken by participants to improve their practices and to improve their understandings of themselves (Bowling 1997). In an action research participants are not subjects to be studied, rather they are active participants in the research process, empowered to act on their own behalf (Bowling 1997) and transform their own settings. Similarly, in a Māori centred research approach Māori will be involved at all levels of the research, as participants, as researchers and as analysts (Cunningham 2000). Information is gathered with the view to applying the findings in a practical sense to further Māori knowledge.

### ***Three Streams of Knowledge***

This research will explore the issues and challenges that funders, planners and providers have in contracting for “whānau ora” at the district level. The project uses an applied, action research approach to positively influence purchaser and provider performance in a contractual environment which has been described as “highly fragmented” and “bearing a weak resemblance” to the official government policy (Lavoie 2003).

The research project involves bringing three streams of knowledge together. First, knowledge from two research projects I have been involved in will be further analysed. Second, new data will be collected directly from the HVDHB and from contracted providers. Third, the knowledge and experience of Canadian researchers who have undertaken a comparison of the contracting environment for indigenous providers in NZ, Canada and Australia will be accessed. These researchers will also provide a valuable indigenous peer review. A synthesis of these knowledge streams in the context of the NZ health system’s strategy for Māori Health (He Korowai Oranga) and a Māori Health Model (Te Whare Tapa Wha) will be undertaken. An analytical framework which describes the parameters within which the DHB *purchases* ‘whānau ora’ will be produced. Similarly, an analytical framework which describes the parameters within which providers of health services *deliver* ‘whānau ora’ will be produced. These frameworks will allow for comparisons and contrasts to be determined and brought to light. Having developed these two frameworks, an overarching template, which combines and brings together both frameworks and perspectives, will be developed.

An important element of this research will be interaction with the University of Manitoba, and indigenous providers in Canada. The University of Manitoba hosts one of the ACADRE programmes funded by the Canadian Institutes of Health Research. The ACADRE Programme is a network of supportive research environments across Canada that facilitates the development of Aboriginal capacity in health research. The Centre for Aboriginal Health Research will be involved in, and contribute to this research by the provision of international, indigenous peer review. They will also host me in Canada during my post-doctoral studies.

*Knowledge Stream One – Analysis of the existing research (Boulton’s PhD and the Health Reforms 2001 Evaluation)*

The Health Reforms 2001 project is a three-year formative evaluation study running in parallel as the reforms are implemented from 2001 to 2004 (Health Reforms 2001 Research Team 2003). The research identifies features of the New Zealand Public Health and Disability (NZPHD) model and government goals for the sector; identifies stakeholder goals, concerns and issues; documents the activities of the Ministry of Health and DHBs as they implement the model; and identifies innovation and draws conclusions about the strengths and weaknesses of the model (Health Reforms 2001 Research Team 2003). The project comprises four concurrent streams of work and 11 themes across these streams. Stream one collates the expectations and experiences of the model with regard to the themes identified as of interest in the research, stream two examines five DHBs in greater depth; stream three documents the policy context in which the reforms are embedded, and stream four compares this model with the previous Area Health Boards, Regional Health Authorities and Health Funding Authority models. By the conclusion of the project in 2005, a considerable amount of data will have been collected regarding the contracting process, funding and purchasing, implementation of He Korowai Oranga and the experiences of Māori health providers in the reformed sector. The information gathered during the project is a rich and unique source of background information garnered from a wide variety of Māori health providers and DHBs across the country. Stream one of the postdoctoral research involves undertaking a content analysis of this data in order to establish a context in which the case studies will be carried out. The research team are familiar with content analysis as a tool, following the methods of (Lupton 1999) and (Fielding 1993). Content analysis requires the investigator to be thoroughly familiar with the data collected from the field including field notes, transcriptions of interviews (Bowling 1997).

In this stream of the research a subset of existing transcripts from the Health Reforms 2001 dataset will be re-coded and re-analysed using NVivo software. Re-coding the material, based upon a new research question and the background information required for this new research project will be essential. Only a subset of transcripts that have direct relevance to this research project will be used. These include transcripts from Funding and Planning managers, Māori managers and Māori providers. Once the

analysis has been completed the results will provide background material and a context in which to carry out the second stream of research: the case study.

*Knowledge Stream Two – Case Study using an Action Research Approach*

According to Hill and Capper action research starts from the notion that research should do more than simply understand the world: it should try to help change it (Hill and Capper 1999). Action research is a research approach that embraces the principles of participation and reflection as well as the empowerment and emancipation of people and groups interested in improving their social situation or condition (Berg 2001). Action research is an appropriate methodology where reflection upon results is required and where all individuals involved in the research (from the researcher through to the research participants) are deliberate, contributing actors to the research (Berg 2001). Grbich identifies three forms of action research: directed, participatory and post-modern (Grbich 1999). Although the three forms tend to overlap, post-modern action research may be distinguished by its focus on communication, participation and inclusion in an attempt to restructure and transform settings and relationships (Grbich 1999). The postdoctoral research will take a post-modern action research approach, with the aim of transforming relationships between the research participants and the contractual environment itself.

Stream Two of the research project will involve working with the HVDHB and service providers at a district level to investigate more fully some of the issues around implementing national policies through local contracts, contracting for outcomes and how to achieve optimum results in a contract negotiation when parties may operate from different worldviews. After discussions with the Funding and Planning Team of the Hutt Valley District Health Board a list of possible research questions has been identified. These questions include:

- in the contracting environment what are the contracting challenges that providers face in trying to deliver whānau ora;
- how might the current process be improved to allow Māori providers to deliver at their optimum as Māori;
- how might this current processes be improved so that mainstream services are encouraged and able to deliver appropriate services to Māori?

*Knowledge Stream Three – the Collection of New Data:*

In order to answer these questions new data will be collected from the Funding and Planning Team of HVDHB; Māori providers who have contracts with the DHB; mainstream providers with DHB contracts who deliver services to Māori; and key informants from within, and outside the DHB itself. The method to be used is a generalised case study approach (Yin 2003) with HVDHB being the case under study, including a set of service providers who contract for services. The largely qualitative dataset will be collected through taped interviews and field notes taken by the principal investigator. Together with the synthesis described in Stream 1 above, the findings from both streams will be used in the final stage of the research, to develop the overarching contracting template.

***The Case Study - Hutt Valley District Health Board***

Case study research is used to contribute to our knowledge of individual, group, organisational, social, political and related phenomena (Yin 2003). Case studies may be exploratory, descriptive or explanatory (Yin 2003) and may include multiple cases or one single case. The value of case study as an approach is its usefulness in studying complex social settings and the dynamics of a single case (Bowling 1997). In this instance the case that has been selected is the Hutt Valley DHB and in particular the complexities and dynamics of contracting for whānau ora with Māori and mainstream providers of health services. The contract negotiation process between the DHB and the providers will be studied from the perspective of the DHB. The aim of the study is to review the DHB's funding and planning processes and align these processes more closely with the Government's stated aims as outlined in He Korowai Oranga and He Whakatataka. The case study will be conducted over a three-year period and involves a number of stages.

*Stage 1: Familiarisation with Hutt Valley DHB funding and contracting processes*

This stage requires information gathering from a number of sources - MoH policies, DHB internal policies and procedures, manuals and guidelines. Interviews with members of the Funding and Planning Team to ascertain actual practice will be conducted. Observations of contract negotiations with Māori health providers will then be carried out.

*Stage 2: Development of contracting template for Whānau Ora*

Analysis and synthesis of the three data types will be carried out and an analytical framework which describes the parameters within which the DHB purchases, and contracts for, ‘whānau ora’ will be produced. Similarly, an analytical framework, which describes the parameters within which providers of health services deliver ‘whānau ora’, will be produced. Having developed these initial frameworks, an overarching template to assist the Funding and Planning Team in their negotiations with providers will then be developed.

*Stage 3: Assessing the template’s effectiveness*

In the third year the template will be used alongside existing contracting processes, in a “dry run” and assessed for its ease of use, usefulness and applicability. The practical application of the template during the contracting process will allow the research team to assess the workability of the template, gather feedback from DHB Funding and Planning staff and further refine and amend the template as necessary and according to an action research approach.

Confidentiality of documentation, contracting processes and content will be a crucial component of this project and a standard confidentiality agreement regarding disclosure, storage, and disposal of information and/or documentation will be signed prior to commencing the research. In addition the project will be bound by both Massey and National Codes of Ethical Conduct.

***Analytical Methods***

This research will collate a large amount of qualitative information directly from respondents on their intentions, experiences, and expectations. The research will also gather a large amount of written information in the form of policies, contracts, service specifications, service plans. These data will be analysed using software (NVivo) which allows the analysis of data in these forms. Conveniently much of the written information is available electronically. Interviews will be summarised and transcribed – experience from the Health Reforms 2001 research project has shown that transcription summaries are a more efficient method for handling data. Content and thematic analysis will be undertaken and reviewed by the project supervisors including Dr

Cumming and Professor Cunningham as well as other colleagues within the Research Centre for Māori Health & Development such as Professor Mason Durie.

*Analytical Peer Review – Indigenous Health Research Winnipeg*

An innovation for this research will be the facilitation of an international, indigenous peer review. Two concurrent processes led out of the Research Centre for Māori Health & Development (RCMHD) will contribute to the international indigenous peer review of this project. In the first instance the RCMHD has a relationship with AIATSIS – the Australia Institute for Aboriginal and Torres Strait Islander Studies in Australia. Through this organisation access to indigenous knowledge and critical peer review of findings may be facilitated. In Canada the RCMHD are developing a relationship with the University of Manitoba who have indicated their desire to work with us, and AIATSIS, in developing an international indigenous peer review collaboration for our respective health research. We are developing this group, and suitable processes, as an enduring peer review network for our collaborative research programme.

Secondly the Centre for Aboriginal Health Research at the University of Manitoba (CAHR) Winnipeg is particularly supportive of this research project as it has a similar interest in health services research and indigenous health research and strong links with both urban and on-reserve health services. I have received positive feedback from the CAHR for this proposal and offers of support for hosting part of the research in Manitoba and with First Nations peoples. One area of overlap between the postdoctoral research and the work of the CAHR, and where the CAHR could offer a critical peer review would be in assessing performance in contracting, as such assessments are routinely undertaken by the purchaser (the First Nation and Inuit Health Branch of Health Canada).

## **Relevance to Health**

“Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi” has been identified as one of seven underlying principles that the government sees as fundamental in the New Zealand Health Strategy and “Māori development in health” is one of ten strategic goals within that strategy. This research operationalises both of these principles/goals through the adoption of a Māori-focused design and methodology.

The investment in the health system and services in NZ is more than \$8000 million per annum. Māori health outcomes continue to lag behind those of Pākehā, and in many examples also behind those of Pacific people. While health services are only part of the contribution to health outcomes, they are an extremely important part, one which has yet to provide optimum delivery to Māori. Any contribution to improved health outcomes generated by system improvements will capitalise on the already significant investment by the government and taxpayers. This research proposal focuses on the health system in order to identify its consistency with, and ability to facilitate, whānau ora.

This study will contribute to the New Zealand health sector by investigating an area that has received little or no attention in the past, namely the link between policy development, policy implementation at district level, and the use of contracting for achieving gains in Māori health. This research will identify the issues and challenges to contracting for whānau ora (an indigenous philosophical approach to health and wellbeing) in a health system that is predominantly western in its structure and processes. The research will take a systematic and methodical research approach to improving the contracting processes for Māori health service providers through the use of a single case study uniquely located within a DHB. The knowledge generated will allow HVDHB to understand the relationship between its processes and the achievement of improved outcomes for Māori health. The outcomes of this case study in HVDHB will also have relevance not only to the wider DHB community but to other agencies charged with taking an intersectoral approach to health and social service delivery and responsible for whānau ora in its widest sense, e.g. housing and social agencies.

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# Appendices

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## ***Appendix 1: Kaupapa Māori Mental Health Service Specifications***

### **NATIONWIDE SERVICE SPECIFICATION – MENTAL HEALTH SERVICES**

#### **SERVICE SPECIFICATIONS FOR KAUPAPA MĀORI MENTAL HEALTH SERVICES**

This Service Specification forms part of Part 3 of the Agreement.

For the purposes of this Service Specification, the term 'Tangata Whai Ora' has the same meaning as 'Service User' as defined in Section A of Part 1 of the Agreement.

### **1 NGA HUIHUINGA TANGATA / INTRODUCTION**

There are a number of strategies required to improve the mental health status of Māori. These include a recognition:

- that health and culture are inextricably linked;
- that improving the mental health status of Māori requires Māori solutions;
- of Māori ownership and Māori delivery of services. Māori health improvement must be seen in the context of Māori development generally.

The funding of Kaupapa Māori Mental Health Services delivered by Māori recognises that:

- culture can be the platform for seeking and maintaining wellness;
- the development of Kaupapa Māori Mental Health Services is a Māori-led initiative for a Māori problem;
- it is likely that Kaupapa Māori Mental Health Services will not sit in isolation from its own Māori community and will likely work to integrate with other services and sectors for the good of the Tangata Whai Ora and whānau/family/informal carer.

To align the strategies that will improve the mental health status of Māori to the funding of services requires us to work in partnership with Māori. This also acknowledges that Māori have a special relationship with the Crown as Treaty of Waitangi partners.

This Service Specification will be subject to ongoing review, and therefore should not be considered as “set in concrete”, but rather a document that will evolve to reflect service developments as these occur.

## 2 TE TIRITI O WAITANGI / THE TREATY OF WAITANGI

The Treaty of Waitangi is the first point of reference in the development of social policy and strategies that will impact on the tangata whenua/whaanau member/Service User populations. As the founding document of New Zealand, the Treaty predicated the relationship between the Crown and tangata whenua and the way in which the partnership might influence the health sector to protect the interests of Māori.

Article One of the Treaty requires active consultation by the Crown with tangata whenua on issues of public policy and service provision.

Article Two establishes the principle of tino rangatiratanga, autonomy, self-determination, and justification for Māori communities and organisations so that Māori can manage their own property, resources and assets. The principle of autonomy has been defined by the Waitangi Tribunal as:

*The right to manage their own policies, resources and affairs (within rules necessary for the operation of the state).*

Translated to the mental health sector, Article Two of the Treaty acknowledges tino rangatiratanga through the specification of unique Māori services that provide opportunities to create and implement strategies to improve Māori mental health.

**Article Three** of the Treaty guarantees Māori the same rights of citizenship and privileges as other New Zealanders, including the rights of equal access to mental health services and to equal health outcomes. Clearly, rights conferred under Article Three of the Treaty are not being achieved in mental health gains.

## 3. KAUPAPA MĀORI HINENGARO ORANGA / KAUPAPA MĀORI MENTAL HEALTH SERVICES

The Kaupapa Māori Mental Health Services that this Service Specification describes, is a clinical service (it may also include non-clinical services) that has an underlying Māori kaupapa which distinguishes it from other mental health services.

### 3.1 He Aha Te Kaupapa Māori Hinengaro Oranga? / What is a Kaupapa Māori Mental Health Service?

This Service Specification does not set out to detail all of the elements that may describe what is meant by Kaupapa Māori. To do so would be contrary to what Māori have said at a hui held to discuss this subject and would require taking into account the differences that may exist between different iwi and possibly between different hapu. It would also require input from Māori with a level of expertise of tikanga Māori to provide this knowledge. Instead, this Service Specification attempts to identify those characteristics that appear to be common to those services that are funded to deliver Kaupapa Māori Mental Health Services.

Kaupapa Māori is the term used to refer to the culturally derived philosophy that underlies and is woven into all aspects of services described within this Service Schedule and which assumes that wellness for Māori is the end goal of the service.

"Te Ara Ahu Whakamua" generally agreed that a Māori person who has wellness exhibits the following characteristics or qualities:

- a sense of identity;
- self esteem, confidence and pride;
- control of their own destiny;
- a voice that is heard;
- intellectual alertness, physical fitness and spiritual awareness;
- personal responsibility, co-operative action;
- respect for others;
- knowledge of te reo Māori and tikanga Māori;
- economic security and independence;
- whaanau support.

### **3.2 Nga Ahuatanga o te Kaupapa Māori Hinengaro Oranga / Characteristics of a Kaupapa Māori Mental Health Service**

Kaupapa Māori Mental Health Services are distinguished by the kaupapa that they operate to, and a set of cultural characteristics that they possess that are generally not found in other mental health services. Kaupapa Māori Mental Health Services describe a service that has two key elements, the kaupapa Māori element and the element that describes mental health services generally. The kaupapa Māori element may require extra resources, time or Māori practices that are different from other mental health services

Kaumaatua are an integral part of Kaupapa Māori Mental Health Services, and it is expected that they play a key role in the delivery of those services. Another key characteristic of Kaupapa Māori Mental Health Services is an emphasis on whaanaungatanga, that is, the building and strengthening of kinship and support relationships. The Tangata Whai Ora and

whaanau/family are received as part of the kinship that comes with being Māori. They are an extension of the whaanau that is the service, provide a sense of belonging and a place where they know Māori values are to the fore, where the service is focused on people and is safe for them. These characteristics are included below.

Common characteristics of Kaupapa Māori Mental Health Services are:

- kaumaatua/kuia are an integral part of the service;
- there is an emphasis on whaanaungatanga;
- the governance and mission of the Service is based on a Kaupapa Māori model;
- Tangata Whai Ora are mostly Māori;
- the local Māori community supports the service;
- the kaupapa of the service is consistent with wider aims and aspirations of Māori development;
- the service operates using Māori Tikanga, Māori beliefs, values and practices
- the majority of staff are usually required to be Māori.

Although it would be expected that the above common characteristics will be a part of all Kaupapa Māori Mental Health Services, the type and nature of the specific service being provided will determine the importance and proportion of each characteristic or component within the service. The kaupapa Māori aspect of the service may also vary from region to region in accordance with the need to reflect the particular kawa/tikanga of an area..

#### **4 TE MARU MĀORI / A MĀORI UMBRELLA FOR DELIVERY OF SERVICES**

Kaupapa Māori Mental Health service providers must ensure that the service is delivered in a way that reflects a holistic approach to the delivery of services, and provides an environment that promotes cultural safety for the Tangata Whai Ora and whaanau/family and for those delivering the services. It will also allow Tangata Whai Ora who receive the services to make the necessary linkages with whaanau/family or other people or services as needed.

The framework that provides the umbrella for safe service delivery will be one that encompasses the Māori approach to health, an approach that is holistic. This has been best described in the Te Whare Tapa Wha model which is one of a number of Māori models of health and well being.

The Te Whare Tapa Wha comprises of:

- Te Taha Wairua which reflects spiritual health, including the practice of tikanga Māori;
- Te Taha Tinana which refers to the physical aspects of health as well as the physical symptoms
- Te Taha Hinengaro which refers to the emotional and mental wellbeing of each individual, whānau and hapu member;

- Te Taha Whānau which supports the importance of whānau and the environment
- in which individuals and whānau live, including the cohesiveness of the whānau
- unit and the collective unity derived from membership within the whānau environment.

As part of this service it is expected that the provider will determine how the above model of care can be delivered in a holistic manner that takes into account the requirements of the Mental Health Act.

While this service is expected to deliver mental health services in an holistic manner to all service users, it is also expected that where tamariki/rangatahi access services from other sectors (e.g. education, social welfare), all services will be delivered in a co-ordinated way. This will be achieved through participation in Strengthening Families interagency case management processes or other similar forum.

## **5. NGA TAUMATA I WHIRIWHIRINGA I ROTO I TENEI KAUPAPA / SERVICES INCLUDED IN THIS SERVICE SPECIFICATION**

This Service Specification lists and describes the current range of Kaupapa Māori Mental Health Services. We require providers to work collaboratively and co-operatively to ensure that the full range of services are provided in an effective and complementary manner, which focuses on the needs of Tangata Whai Ora. It is also expected that all health services offered to Tangata Whai Ora are delivered in an environment and manner appropriate to them.

It is unlikely that any single provider will provide all of the service types described in this Service Specification. Descriptions of the service types included in this Service Schedule are outlined in the tables titled "Service Type Descriptions". Specific requirements associated with each service type are listed in the relevant part of the Service Schedule in Part 3 of this Agreement.

Kaupapa Māori Mental Health service providers are expected to provide a combination of effective Māori mental health specific services that will assist the Tangata Whai Ora to live an ordinary life with access to a typical range of life experiences and choices, and to assist the recovery process.

The current range of Kaupapa Māori Mental Health Services, the reporting clusters, purchase units and purchase measures associated with each service type, are outlined in the table below.

Details of the specific reporting requirements for each reporting cluster are contained in the Service Specification titled Reporting Requirements for Mental Health Services.

<b>Nga Kaupapa o nga Mahi / Service Type</b>	<b>Purchase Unit ID</b>	<b>Purchase Measure</b>	<b>Reporting Cluster</b>	<b>Service Unit Types Included in this Agreement</b>
Kaupapa Māori Mental Health Services - Kaumatua and Taua (Kuia) Services	MHCS46	FTE	R	
Nga huihinga taangata o roto i a nei kaupapa Kaupapa Māori Mental Health Services - Adult Community Teams	MHCS19 MHCS19 C	Clinical FTE Non-Clinical FTE	A + G	
Nga huihinga taangata o roto i nga mahi whakawaia kai tarataru kai waipiro Kaupapa Māori Alcohol and Drug Services	MHCS02 A MHCS02 C	Clinical FTE Non-Clinical FTE	A + G	
Nga roopu Māori manaaki i nga tamariki, rangatahi katoa Kaupapa Māori Mental Health Services - Tamariki and Rangatahi	MHCS39	FTE	A + G	
Nga roopu Māori whakamarama i nga kaupapa o te hau ora Kaupapa Māori Mental Health Services - Consultation/Liaison Service	MHCS40	FTE	A	
Nga kaupapa Māori whaka piri i te oranga ki runga ki nga mauiui Kaupapa Māori Mental Health Services - Crisis Intervention	MHCS41	FTE	A + G	
Nga kaupapa Māori o nga rangi katoa Kaupapa Māori Mental Health Services - Day Programmes	MHCS42	FTE	L	
Nga kaupapa Māori kaitiaki i nga iwi wairangi/haurangi Kaupapa Māori Mental Health Services - Dual Diagnosis with Alcohol and Drug problems	MHCS43	FTE	A + G	
Nga kaupapa Māori wawaotanga o nga iwi tino mauiui ana Kaupapa Māori Mental Health Services - Early Intervention	MHCS44	FTE	A + G	
Nga moenga mo te kaupapa Māori hinengaro i roto i nga hohipera Kaupapa Māori Mental Health Services - Inpatient Beds	MHIS08	Available bed days	B	

A separate Service Specification has been developed for Kaupapa Māori Residential Mental Health Services.

## **6 NGA AHUATANGA O NGA TAANGATA / GENERAL CHARACTERISTICS**

### **6.1 Tangata Whai Ora / Eligible People/Service Users**

The Government's National Mental Health Strategy requires that Mental Health Services are delivered to the 3% of people who are most severely affected by mental illness in any one month. Therefore, the priority groups for this service specification are Māori Tangata Whai with serious mental health needs that fit within the population groups noted below.

(Also refer to the section "Who are the services for" in the Service Schedule titled General Requirements for All: Mental Health Services Including Kaupapa Māori Mental Health Services).

Kaupapa Māori Mental Health Services are to be provided for:

- the Tangata Whai Ora with a mental disorder (as defined in DSM IV, or other generally recognised diagnostic classifications), including drug and alcohol problems, which has a significant impact on that person's ability to function or which is at risk of doing so;
- people seeking information about mental ill-health, its treatment and prevention, support of Tangata Whai Ora with mental illness, or recognition of problems of mental health. The Service is therefore available to whānau members and/or other significant people identified by the Tangata Whai Ora. These people will ordinarily be involved in processes in relation to the Tangata Whai Ora, and are able to access services as set out in these specifications unless good reason exists for them not to be involved.

While mental health services should be focused on a Tangata Whai Ora with a serious mental illness, further development is required in primary and public health on the promotion of mental wellness, active measures to prevent the development of problems and earlier detection and intervention for mental health problems. The document 'Kia Tu Kia Puawai' is an acknowledgement of the need to develop strategies in primary mental health and signals the intent for future development in this area.

### **6.2 Mo wai enei kaupapa? For whom are these services?**

The Tangata Whai Ora include:

- tamariki/children aged 0-14 years;
- rangatahi/adolescents aged 15-19 years with some flexibility based on emotional, physical and social maturity to accept those rangatahi/adolescents older than these age limits, should their needs be deemed appropriate and suitable alternatives are not be available;
- rangatahi/adolescents should be given the option of pakeke/adult services with appropriately skilled clinicians if no suitable adolescent inpatient service is available. In large centres if inpatient treatment is urgently required and no suitable rangatahi/adolescent inpatient

service is available, referral to the pakeke/adult service may be required. This should occur in accordance with prearranged protocols that address priorities of needs and possible joint care of consultation arrangements. Where this is necessary, the pakeke/home services provided will reflect the special needs and safety of these rangatahi/adolescents with respect to facilities, staffing, treatment and provision for parents/whānau;

- The needs of rangatahi/adolescents between 18 and 19 years may fall into either Rangatahi Mental Health Services or Adult Mental Health Services. The most appropriate services to meet these needs are to be determined clinically;
- pakeke/adults aged 18 years or over;
- kaumatua or older people or kuia and koroua over the age of 55 years.

The above age-groupings are based on those identified by the Public Health Group for the Ministry of Health following a consultation process with Māori in 1998.

## **7 E KORE ENEI TAUMATA E MO NGA TANGATA E URU ANA KI TE RARURARU/ EXCLUSIONS**

### **7.1 Diagnostic Criteria**

These services will not be available to people whose problems are solely:

- violence and anger;
- intellectual disability (includes post-head injury) with or without behavioural problems;
- learning difficulties;
- criminal activities (antisocial behaviours);
- parenting difficulties;
- alcohol and drug abuse (except if accessing the Kaupapa Māori Alcohol and Drug service);
- conduct disorder.

### **7.2 Nga Kaupapa O Nga Mahi / Service Types:**

The following services are excluded from this service description:

- relationship services;
- family/Tangata Whai Ora health counselling services;
- parenting services;
- psychological evaluations for educational requirements.

## **8 NGA HUARAHI E HOUO AI NGA KAUPAPA / KEY SERVICE LINKAGES AND ACCOUNTABILITIES**

This Service Specification identifies the key components of a comprehensive Kaupapa Māori Mental Health Service. Where one provider is not providing all of the service types it is critically important that the services and their providers work together in a co-ordinated and planned manner to ensure:

- Tangata Whai Ora and their whaanau have equitable access to the full range of services;
- disputes between providers concerning service coverage are resolved without adversely affecting any Tangata Whai Ora. While no one provider is likely to provide all the services it is critically important that the services and their providers work together to ensure the best combination of the available resources;
- the efficient and effective use of each service and the easy flow of Tangata Whai Ora and their whaanau between services and through the service as a whole.

## **9 NGA KAUPAPA AWHINA / CLINICAL AND FINANCIAL SUPPORT SERVICES**

Access to a number of clinical and financial support services is required. These may include, although are not limited to:

- laboratory diagnostic services;
- pharmacy services;
- anaesthetic services;
- medical intensive care;
- commercial support services.

Service providers must ensure that the necessary relationships are established with providers of these services to ensure their availability to Tangata Whai Ora as required

## **10 DUPLICATION OF SERVICES**

Tangata Whai Ora will generally not receive services from two services of the same service type, and will similarly not be receiving services from two services with broadly overlapping processes. For example, a Tangata Whai Ora would be unlikely to access both a day hospital programme and a non-residential home based support service.

• **SERVICE TYPE DESCRIPTION FOR KAUPAPA MĀORI MENTAL HEALTH SERVICES - KAUMATUA AND TAU (KUIA)**

<p><b>Kaupapa Māori Mental Health Services - Kaumatua and Taua (Kuiā)</b></p> <p><b>MHCS46</b></p>	<p><b><u>Mahia/Function:</u></b></p> <p>The goal of these services for Māori is to improve cultural safety and quality of care for Māori Service Users of mental health services including drug and alcohol services, and to assist in the development and enhancement of services for Māori, by:</p> <ul style="list-style-type: none"> <li>• developing the knowledge and skills of Māori staff presently working within the service;</li> <li>• encouraging new Māori staff to work within the service through an active recruitment and training programme;</li> <li>• ensuring Māori involvement in policy making and strategy development for mental health services at all levels;</li> <li>• strengthening liaison between mental health services and local Māori groups;</li> <li>• helping non Māori staff to develop appropriate ways of working with Māori clients.</li> </ul> <p>Mental health services will work towards developing mechanisms that provide for practical partnership and strong working relationships. This will ensure that the mental health service is effective in meeting the needs of Māori.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b></p> <ul style="list-style-type: none"> <li>• The involvement of kaumatua and taua is essential if excellence is to be achieved in any Māori initiative. Their wisdom and guidance will ensure accountability to Māori. The kaumatua and taua will represent and lead on formal occasions within the mental health service, and may take care of manuhiri (visitors). They will arrange or facilitate hui and Māori formalities within the mental health service. They will provide interpreter services from time to time, or make arrangements for the provision of these.</li> <li>• The kaumatua and taua will provide advice and support to staff of the mental health service regarding all things to do with tikanga Māori. In particular, they will support staff of specialist and developing services for Māori. They will facilitate training of Māori and non Māori staff in tikanga Māori.</li> <li>• The kaumatua and taua will ensure that protocols are developed and observed with regard to cultural safety in general mental health services. Their status will enable them to advocate for Māori and challenge practices that are inappropriate for Māori, particularly in the spiritual and tikanga areas.</li> <li>• They will advise on policy and practices concerning: <ul style="list-style-type: none"> <li>• care of the tupapaku (deceased) and tangihanga (funeral);</li> <li>• cultural support for Māori clients and whanau;</li> <li>• inter-iwi relationships;</li> <li>• promotion of the concept of the four cornerstones of health;</li> <li>• cultural assessment;</li> <li>• interpretation of good clinical practice from a Māori perspective.</li> </ul> </li> <li>• The taua will have a special role with respect to issues concerning women, and Māori women in particular.</li> </ul> <p><b><u>Tangata arahi i te kaupapa/Service provided by:</u></b></p> <p>The kaumatua and taua services will be provided in such a way as to ensure relevant skills and expertise are available to the mental health service. It is</p>
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	<p>expected that one full time equivalent kaumatua and taua position will be filled by several people who are employed in this service on a part time or contract-for-service basis. The roles of these people will be negotiated between them and the mental health service. Kaumatua and taua of this service will be recognised as spokespersons for their Māori communities, and so will be tangatawhenua.</p>
<p><b>Kaupapa Māori Mental Health Services - Kaumatua and Taua (Kuia)</b>  (cont.)</p>	<p><b><u>Linkages With Other Services:</u></b>  These Māori services will develop effective working relationships with other Māori mental health providers, including Alcohol and Drug Services, and in some cases the positions will be considered to be regional, with the kaumatua and taua providing services to a specified number of providers. Effective channels of communication and good relationships will be maintained with local iwi, and with Māori mental health workers of other providers. Workshops will be held with these services to develop protocols and working relationships.</p>

**SERVICE TYPE DESCRIPTION FOR NGA HUIHINGA TANGATA O ROTO I A NEI  
KAUPAPA/ KAUPAPA MĀORI MENTAL HEALTH SERVICES - ADULT COMMUNITY  
TEAMS**

<p><b>Nga huihinga tangata o roto i a nei kaupapa/ Kaupapa Māori Mental Health Services - Adult Community Teams</b></p> <p><b>MHCS19</b> <b>MHCS19C</b></p>	<p><b><u>Mahia/Function:</u></b> To provide a Māori clinical and cultural community or outpatient based assessment, treatment and consultation liaison service within a kaupapa Māori framework for pakeke/kaumaatua/Tangata Whai Ora who have a diagnosed mental illness.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b> These Kaupapa Māori services will be mutually integrated with other mental health services. The service may include, but will not be limited to:</p> <ul style="list-style-type: none"> <li>• specialist clinical and personal assessment including cultural assessment (see Process Description “Assessment”) and diagnosis;</li> <li>• the provision of and monitoring of medication/rongoa (including such new agents as are approved for use, in accordance with funding and safety protocols) and other treatments (for example, mirimiri/massage) in accordance with a documented comprehensive clinical and cultural management plan with identified desired clinical and cultural outcomes;</li> <li>• ongoing monitoring of clinical and cultural symptoms and regular review of progress and treatment at specified intervals and undertaking discharge planning;</li> <li>• the provision of or access to kaumatua and kuia, a Māori environment, rongoa Māori, tohunga, speakers in te reo Māori in accordance with the needs/requests of Tangata Whai Ora;</li> <li>• the provision of tikanga Māori that relate to the kawa and kaupapa of the service. This may include powhiri, mihimihi, hui, karakia, waiata or poroporoaki;</li> <li>• maintaining key links with tangata whenua and key Māori organisations/roopu;</li> <li>• attention to matters in relation to early intervention, maintenance of health, relapse prevention, problem prevention and promotion of good mental health;</li> <li>• provision of clinical and cultural consultation and liaison services to whanau, other mental health services, Māori and other primary care providers and other relevant health or social services agencies.</li> </ul> <p>Provision will be made for referral/access to specialised assessments and intervention for particular Tangata Whai Ora groups, including:</p> <ul style="list-style-type: none"> <li>• Tangata Whai Ora with eating disorders;</li> <li>• Wahine during antenatal or postpartum period;</li> <li>• Tangata Whai Ora with combined problems of mental illness plus drug and alcohol use, or intellectual disability, or brain injuries;</li> <li>• Tangata Whai Ora who are profoundly hearing impaired</li> </ul> <p>Where possible, care will be provided in conjunction with primary health services. At the least, there will be documented clear communication with any primary health providers regarding the treatment plan and progress, and its completion, unless specifically refused by Tangata Whai Ora.</p> <p>Clinical and cultural training, advice and supervision will be provided to Māori or other primary health workers to support the assessment/treatment/management of Tangata Whai Ora in community settings.</p> <p>Care will be co-ordinated by a specified person (key worker/case manager) with a number of staff from varying backgrounds being available to contribute to care in</p>
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	<p>accord with identified needs.</p> <p><b><u>Tangata arahi i te kaupapa/Service provided by:</u></b>  Services will be provided by a multi-disciplinary team including, kaumatua, specialist psychiatrists, registered nurses, psychologists, occupational therapists, social workers, cultural advisors and/or Māori mental health workers, Tangata Whai Ora and any other professional staff in accordance with the needs of the Tangata Whai Ora served.</p> <p><b><u>Putanga/Access:</u></b>  Access may be from any source, including from a Tangata Whai Ora directly or upon referral from mental health services, inpatient services, primary practitioners (including GP's), whanau, caregivers, and community members.</p>
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**SERVICE TYPE DESCRIPTION FOR NGA HUIHINGA TANGATA O ROTO I NGA MAHI  
WHAKAWAIA KAI TARUTARU KAI WAIPIRO/  
KAUPAPA MĀORI ALCOHOL AND DRUG SERVICES**

<p><b>Nga huihinga tangata o roto i nga mahi whakawaia kai tarutaru kai waipiro/ Kaupapa Māori Alcohol and Drug Services</b></p> <p><b>MHCS02A MHCS02C</b></p>	<p><b><u>Mahia/Function:</u></b></p> <p>To provide a Māori community or outpatient based alcohol and drug assessment, treatment and consultation/liaison service within a kaupapa Māori framework.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b></p> <p>Community based assessment, clinical, cultural and treatment services that provide, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Screening and early or brief intervention;</li> <li>• Comprehensive personal and therapeutic assessments (includes cultural assessments);</li> <li>• drug and alcohol counselling and treatment (both individual and group);</li> <li>• whanau support and other cultural interventions;</li> <li>• facilitation for access to community based initiatives, dual diagnosis, detoxification, residential and methadone services;</li> <li>• referrals to other speciality mental and health services for personal, clinical and cultural assessment and treatment (for example, honoa);</li> <li>• clinical and cultural consultation/liaison services to, mental health services, general practitioners and primary health services, schools and other key referral sources;</li> <li>• access to kaumatua, a Māori environment, rongoa Māori, tohunga, te reo Māori speakers or other cultural needs in accordance with the needs/requests of Tangata Whai Ora;</li> <li>• tikanga Māori that relate to the kawa and kaupapa of the service. This may include powhiri, mihimihi, karakia, waiata, hui, or poroporoaki;</li> <li>• maintenance of key links with tangata whenua other key Māori organisations/roopu.</li> </ul> <p>Each Tangata Whai Ora will be offered the clinical and cultural interventions that are appropriate according to their assessed needs in terms of their drug and alcohol use, related problems and readiness for change. This may include referral to other services or agencies.</p> <p><b><u>Putanga/Access:</u></b></p> <p>Access may be from any source, including from the Tangata Whai Ora directly, or upon referral from mental health services, primary practitioners, whanau, schools, caregivers, and community members, and from inpatient or residential services.</p>
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**SERVICE TYPE DESCRIPTIONS FOR NGA ROOPU MĀORI MANAAKI I NGA TAMARIKI,  
RANGATAHI KATOA/  
KAUPAPA MĀORI MENTAL HEALTH SERVICES - TAMARIKI AND RANGATAHI**

<p><b>Nga roopu Māori manaaki i nga tamariki, rangatahi katoa/ Kaupapa Māori Mental Health Services - Tamariki and Rangatahi</b></p> <p><b>MHCS39</b></p>	<p><b><u>Mahia/Function:</u></b></p> <p>These Māori services will provide a clinical community-based, comprehensive assessment, treatment, monitoring and support service for tamariki, rangatahi and their whanau/parents within a kaupapa Māori framework.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b></p> <p>These Māori services will be mutually integrated with other mental health services. The service may include, but will not be limited to:</p> <ul style="list-style-type: none"> <li>• specialist clinical and personal assessments including cultural assessments (see Process Description “Assessment”) and diagnosis;</li> <li>• provision of appropriate family therapy and counselling services and other treatment (for example, mirimiri/massage, rongoa/traditional medicine et cetera) in accordance with a documented comprehensive clinical and cultural management plan with identified and desired clinical and cultural outcomes. This includes provision and monitoring of pharmaceutical interventions (including such new agents as are approved for use, in accordance with funding and safety protocols);</li> <li>• ongoing monitoring of clinical and cultural problems/symptoms and regular review of personal progress and treatment at specified intervals and planning for discharge;</li> <li>• the provision of or access to kaumatua, a Māori environment, rongoa Māori, tohunga, speakers in te reo Māori etc, in accordance with the needs/requests of tamariki/children and rangatahi/adolescents or their maatua/parents;</li> <li>• the provision of tikanga Māori that relate to the kawa and kaupapa of the service. This may include powhiri, mihimihi, hui, karakia, waiata, poroporoaki;</li> <li>• maintenance of key links with tangata whenua and key Māori organisations/roopu;</li> <li>• attention to matters in relation to early intervention, maintenance of health, relapse prevention, problem prevention and promotion of good mental health and mental health education;</li> <li>• provision of consultation and liaison services to Kohanga Reo/Kura Kaupapa, schools, primary care providers and other relevant agencies providing services to tamariki/children and rangatahi/adolescents and their whanau/parents;</li> <li>• provision of consultation/liaison services and linkages with the Department of Child Youth and Family, SES, child health services, paediatric services, primary health services and other lead agencies.</li> </ul> <p>Provision will be made for referral/access to specialised assessments and intervention for particular tamariki/children and rangatahi/adolescents groups, including:</p> <ul style="list-style-type: none"> <li>• tamariki/children and rangatahi/adolescents with attention deficit hyperactivity disorders;</li> <li>• tamariki/children and rangatahi/adolescent with eating disorders;</li> <li>• tamariki/children and rangatahi/adolescent with combined problems of mental illness plus drug and alcohol use, or intellectual disability, or brain injuries.</li> </ul> <p>Unless specifically refused by rangatahi/adolescents or whanau/parents, care will be provided in conjunction with primary health services. At the least, there will be documented clear communication with any primary health providers regarding the treatment plan and progress, and its completion, if approved by rangatahi/adolescents</p>
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	<p>or whanau/parents.</p> <p>Training, advice and supervision will be provided to Māori and other primary health workers to support the assessment/treatment/ management of Service Users in community settings.</p> <p>Care will be co-ordinated by a kai awhina/key worker, with a number of staff of varying backgrounds being available to contribute to care in accordance with identified needs.</p> <p><b><u>Tangata arahi i te kaupapa/Service Provided By:</u></b>  A multi-disciplinary team including specialist child and adolescent psychiatrist, kaumatua, rangatahi workers, registered nurses, psychologists, occupational therapists, social workers, child psychotherapists/therapists, cultural advisors and/or cultural workers and other professional staff in accordance with the needs of tamariki/ children and rangatahi/adolescents and their whanau/parents.</p> <p><b><u>Putanga/Access:</u></b>  Access may be from any source, including from parents directly or upon referral from primary practitioners, whanau, caregivers, and community members, and from inpatient services.</p>
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**SERVICE TYPE DESCRIPTIONS FOR NGA ROOPU MĀORI WHAKAMARAMA I NGA  
KAUPAPA O TE HAU ORA /  
KAUPAPA MĀORI MENTAL HEALTH SERVICES - CONSULTATION/LIAISON SERVICE**

<p><b>Nga roopu Māori whakamarama i nga kaupapa o te hau ora/ Kaupapa Māori Mental Health Services - Consultation/Liaison Service</b></p> <p><b>MHCS40</b></p>	<p><b><u>Mahia/Function:</u></b> Provision of liaison and specialist Māori advice and information to other services, teams (which retain responsibility for care) in regard to care for specific Tangata Whai Ora who are in their service, or in relation to the more general circumstances of care for groups of eligible Tangata Whai Ora, for whom specialist advice is thought to be required.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b> This includes:</p> <ul style="list-style-type: none"> <li>• provision of specialist Māori consultation and liaison services to non Māori mainstream services to ensure the appropriate assessment and treatment of Māori Tangata Whai Ora in such services;</li> <li>• attendance and or availability to attend cultural/Māori meetings or go to locations (for example, urupa/cemetery, marae/tribal complex, awa/river, maunga/mountain, moana/ocean, et cetera), for the purpose of personal considerations, consultations or advice regarding appropriate cultural assessment, treatment and support for Tangata Whai Ora and their whanau/families;</li> <li>• the availability for ongoing advice and information in regard to aspects of care for Tangata Whai Ora and their whanau/families;</li> <li>• assistance in facilitating further interventions or refer to appropriate tangata/roopu/agency/service;</li> <li>• provision of or access to kaumatua, a Māori environment, rongoa Māori, tohunga, te reo Māori speakers or other cultural needs in accordance with the needs/requests of Tangata Whai Ora;</li> <li>• provision of tikanga Māori that relate to the kawa and kaupapa of the service. This may include powhiri, mihimihi, karakia, waiata, hui or poroporoaki;</li> <li>• provision of clinical and cultural education to whanau, other Māori health services regarding mental illness/wellness and treatment including psycho-pharmacology, rongoa/traditional medicine, wairuatanga/spirituality.</li> </ul> <p><b><u>Tangata arahi I te kaupapa/Service Provided By:</u></b> Services will be provided by specialist Māori staff/kai awhina, including kaumatua, registered nurses, psychologists, occupational therapists, social workers, cultural advisors and/or cultural workers and any other Māori workers/kai awhina in accordance with the needs of the Tangata Whai Ora.</p> <p><b><u>Putanga/Access:</u></b> Access may be from the Tangata Whai Ora or his/her whanau directly or upon referral from community mental health services, inpatient services, speciality mental health services, Māori health providers, primary practitioners, and community members.</p>
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**SERVICE TYPE DESCRIPTIONS FOR NGA KAUPAPA MĀORI WHAKA PIRI I TE  
ORGANA KI RUNGA KI NGA MAUIUI /  
KAUPAPA MĀORI MENTAL HEALTH SERVICES - CRISIS INTERVENTION**

<p><b>Nga kaupapa Māori whaka piri i te oranga ki runga ki nga mauui/ Kaupapa Māori Mental Health Service - Crisis Intervention</b></p> <p><b>MHCS41</b></p>	<p><b><u>Mahia/Function:</u></b></p> <p>To provide rapid clinical and cultural assessment and intervention for eligible Tangata Whai Ora in crisis, in a highly mobile fashion and at the point when the crisis is occurring.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b></p> <p>Crises are urgent, unplanned situations which require immediate therapeutic assessment, treatment or advice. Crisis intervention includes:</p> <ul style="list-style-type: none"> <li>• personal, clinical and cultural assessment (see Process Description);</li> <li>• development of a prompt and personalised treatment plan;</li> <li>• documentation of personal, clinical and cultural assessment and the treatment plan;</li> <li>• performance of any tasks necessary in relation to compulsory processes of Mental Health (Compulsory Assessment and Treatment ) Act 1992 (including the tasks of duly authorised officers, assessing psychiatrists and responsible clinicians);</li> <li>• implementation of immediate treatment plan and interventions, including facilitating access to acute/ICU inpatient services, crisis respite, referral to other services for immediate or ongoing treatment (for example, whakarite/absolution);</li> <li>• provision of clinical and cultural advice, information and support to other caregivers and family as appropriate;</li> <li>• provision of or access to kaumatua, a Māori environment, tohunga, te reo Māori speakers or other cultural needs, in accordance with the needs/requests of the Tangata Whai Ora.</li> </ul> <p>Ninety per cent of requests for assistance for people under the Mental Health (CAT) Act 1992 result in assessment by an officer duly authorised under the Act within four hours of the request.</p> <p>The service will be mobile and will be able to be provided at the location of the crisis. Where necessary, the service will arrange for or provide transport of the Tangata Whai Ora to the nearest acute treatment facility. Ninety per cent of people assessed as needing acute inpatient assessment and treatment will be admitted to an acute hospital service within six hours of the assessment.</p> <p>Interventions will be appropriate to the age, gender and culture of the individual concerned, and will be no more restrictive than necessary in each situation.</p> <p>There will be effective liaison with police, general medical practitioners, residential providers and ambulance services, with formal protocols agreed to by relevant parties about when each will be involved and to what extent, where appropriate.</p> <p>Crisis intervention is fully available 24-hours, 7 days a week.</p> <p>Access to crisis respite service (see below) is facilitated through the crisis team or agreed alternative mechanisms. Caseloads range from 10-35 depending on the level of support the Service User requires.</p> <p><b><u>Key Processes:</u></b></p> <p><i>Services Users accessing these services can expect, as a minimum, to be able to access all of the following processes:</i></p>
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	<p>Advocacy, Assessment, Case Management, Discharge Planning, Early Identification, Legal Compliance, Management of Risk, Peer Support, Service Handover, Support, Therapy, Treatment and Rehabilitation.</p> <p>These processes are described in the Service Specification titled "Process Descriptions".</p>
<p><b>Nga kaupapa Māori whaka piri i te oranga ki runga ki nga mauiui/ Kaupapa Māori Mental Health - Crisis Intervention  (cont.)</b></p>	<p><b><u>Tangata arahi I te kaupapa/Service Provided By:</u></b> Services will be provided by a multi-disciplinary team including specialist psychiatrists, kaumatua, registered nurses, psychologists, occupational therapists, social workers, cultural advisors and/or cultural workers and any other professional staff in accordance with the needs of the Tangata Whai Ora. Where appropriate, arrangements will be made to ensure two clinicians attend a call out.</p> <p><b><u>Putanga/Access:</u></b> Access may be from any source, including from the Tangata Whai Ora directly or upon referral from Māori health services, primary practitioners, whanau, caregivers, and community members.</p>

**SERVICE TYPE DESCRIPTIONS FOR NGA KAUPAPA MĀORI O NGA RANGI KATOA/  
KAUPAPA MĀORI MENTAL HEALTH SERVICES - DAY PROGRAMMES**

<p><b>Nga kaupapa Māori o nga rangi katoa / Kaupapa Māori Mental Health Services - Day Programmes</b></p> <p><b>MHCS42</b></p>	<p><b><u>Mahia/Function:</u></b></p> <p>To assist Tangata Whai Ora to improve their life skills, strengthen their sense of identity and knowledge and understanding of their Māoritanga and overcome whaanaungatanga/social isolation.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b></p> <p>Kaupapa Māori day activity services are a community-based service based on Māori kaupapa.</p> <p>Attendance may be long term.</p> <p>Kaupapa Māori day activity services will promote normalisation and community involvement by including activities relating to the kaupapa of the service and activities away from the centre.</p> <p>Tangata Whai Ora will be given as much responsibility as they are able to take for determining the content of the programme and the management of the service.</p> <p>The service will provide a flexible and varied programme of activities determined largely by Tangata Whai Ora, and will provide a safe environment for mutual support, information exchange and socialisation.</p> <p>The style of the service will be such that:</p> <ul style="list-style-type: none"> <li>• there is an emphasis on whanaungatanga (building a sense belonging to a family) and a kaupapa that supports and nurtures activities focused on tikanga Māori, of supporting the strengths of the Tangata Whai Ora and their whanau and significant others;</li> <li>• kai awhina/mental health workers will work together with the Tangata Whai Ora to reach desirable outcomes for all. Wherever possible, relevant staff will be Māori mental health workers;</li> <li>• there will be provision of or access to kaumatua, a Māori environment, rongoa Māori, tohunga, te reo Māori speakers or other cultural needs, in accordance with the needs/requests of the Tangata Whai Ora;</li> <li>• there will be the provision of tikanga Māori that relate to the kawa and kaupapa of the service. This may include powhiri/whai korero/karanga, mihimihi, huihui, karakia, waiata or poroporoaki.</li> </ul> <p>The services will lead to the following outcomes for Tangata Whai Ora:</p> <ul style="list-style-type: none"> <li>• improved participation in community life;</li> <li>• a strengthening of their identity and improved knowledge of aspects that relate to tikanga Māori;</li> <li>• maintenance and development of pre-vocational skills;</li> <li>• greater stability of lifestyle.</li> </ul> <p><b><u>Key Processes:</u></b></p>
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	<p>Services Users accessing these services can expect, as a minimum, to be able to access all of the following processes:</p> <p>Advocacy, Assessment, Case Management, Discharge Planning, Legal Compliance, Management of Risk, Peer Support, Service Handover, Support, Therapy, Treatment and Rehabilitation.</p> <p>These processes are described in the Service Specification titled "Process Descriptions".</p> <p><b><u>Putanga/Access:</u></b></p> <p>Referral from mental health team or community support services in accordance with an agreed management plan.</p>
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**SERVICE TYPE DESCRIPTIONS FOR NGA KAUPAPA MĀORI KAITIAKI I NGA IWI  
WAIRANGI/ HAURANGI /  
KAUPAPA MĀORI MENTAL HEALTH SERVICES – DUAL DIAGNOSIS WITH ALCOHOL AND  
DRUG PROBLEMS**

<p><b>Nga kaupapa Māori kaitiaki i nga iwi wairangi/haurangi/ Kaupapa Māori Mental Health Services - Dual Diagnosis with Alcohol and Drug Problems</b></p> <p><b>MHCS43</b></p>	<p><b><u>Mahia/Function:</u></b></p> <p>To provide a specialised service that provides interventions to assist (directly or indirectly) the Tangata Whai Ora with combined problems of mate hinengaro/mental illness and kai tarutaru/substance abuse.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b></p> <ul style="list-style-type: none"> <li>• A range of service components are provided, including:</li> <li>• clinical and cultural assessment and treatment of substance abuse disorders and mental illness where a specialist Māori service is required;</li> <li>• clinical and personal co-ordination of treatment to ensure joint care management between Māori mental health and Māori alcohol and drug services;</li> <li>• family/whanau support;</li> <li>• Tangata Whai Ora self help/mutual support opportunities and access to rangatahi/ adolescent services;</li> <li>• alcohol and drug education, consultation and advice to other mental health and alcohol and drug services to assist those services in the ongoing care of Tangata Whai Ora under their care;</li> <li>• the provision of or access to kaumatua, a Māori environment, rongoa Māori, tohunga, te reo Māori speakers or other cultural needs, in accordance with the needs/requests of the Tangata Whai Ora;</li> <li>• the provision of tikanga Māori that relate to the kawa and kaupapa of the service. This may include powhiri, mihimihi, karakia, waiata, hui, or poroporoaki.</li> </ul> <p><b><u>Key Processes:</u></b></p> <p><i>Services Users accessing these services can expect, as a minimum, to be able to access all of the following processes:</i></p> <p><i>Advocacy, Assessment, Case Management, Discharge Planning, Early Identification, Legal Compliance, Management of Risk, Peer Support, Screening, Service Handover, Support, Therapy, Treatment and Rehabilitation.</i></p> <p><i>These processes are described in the Service Specification titled "Process Descriptions".</i></p> <p><b><u>Tangata arahi i te kaupapa/Service Provided By:</u></b></p> <p>Kaumatua, cultural workers and specialist clinical staff with appropriate health qualifications, skills and experience in meeting the needs of Tangata Whai Ora with substance abuse disorders and psychiatric illness.</p> <p><b><u>Putanga/Access:</u></b></p> <p>Referral from community/whanau or inpatient mental health service key worker.</p>
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**SERVICE TYPE DESCRIPTIONS FOR NGA KAUPAPA MĀORI WAWAOTANGA O NGA IWI  
TINO MAUIUI ANA/  
KAUPAPA MĀORI MENTAL HEALTH SERVICES - EARLY INTERVENTION**

<p><b>Nga kaupapa Māori wawaotanga o nga iwi tino mauiui ana/ Kaupapa Māori Mental Health Services - Early Intervention</b></p> <p><b>MHCS44</b></p>	<p><b><u>Mahia/Function:</u></b> To provide a Māori service specifically for rangatahi/adolescents to pakeke/adult experiencing a psychotic illness or other tino mate hinengaro/serious mental health problem for the first time. The service aims to shorten the course and decrease the severity of the illness, thereby minimising the complications that may arise.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b> Components of the service will include:</p> <ul style="list-style-type: none"> <li>• clinical, cultural and personal assessment and treatment;</li> <li>• personal case management and service co-ordination;</li> <li>• clinical and cultural consultation and liaison with other health services;</li> <li>• clinical and cultural liaison with other services/agencies to facilitate assistance with income/employment/education/ housing requirements</li> <li>• clinical and cultural training and education (of the individual concerned plus relevant family/caregivers) in regard to symptoms, treatment, and maintenance of health and well-being;</li> <li>• family/whaanau support;</li> <li>• rangatahi/adolescent and pakeke/adult self-help/mutual support opportunities, facilitated access to rangatahi/adolescent services/programmes.</li> </ul> <p>Attention will be given to (amongst other things):</p> <ul style="list-style-type: none"> <li>• developing and maintaining positive interpersonal relationships;</li> <li>• personal safety;</li> <li>• alcohol and drug misuse;</li> <li>• provision of, or access to kaumatua, a Māori environment, rongoa Māori, tohunga, te reo Māori speakers or other cultural needs in accordance with the needs/requests of rangatahi/adolescents or pakeke/adults;</li> <li>• provision of tikanga Māori that relate to the kawa and kaupapa of the service. This may include powhiri, mihimihi, karakia, waiata, hui, or poroporoaki.</li> </ul> <p><b><u>Key Processes:</u></b> <i>Services Users accessing these services can expect, as a minimum, to be able to access all of the following processes:</i></p> <p>Advocacy, Assessment, Case Management, Discharge Planning, Early Identification, Legal Compliance, Management of Risk, Peer Support, Screening, Service Handover, Support, Therapy, Treatment and Rehabilitation.</p> <p><i>These processes are described in the Service Specification titled "Process Descriptions".</i></p> <p><b><u>Tangata arahi i te kaupapa/Services Provided By:</u></b> Services are provided by a multi-disciplinary team including specialist psychiatrists, kaumaatua, alcohol and drug counsellors, rangatahi workers, registered nurses, psychologists, occupational therapists, social workers, cultural advisors and/or cultural support workers and other professional staff in accordance</p>
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	<p>with the needs of the Tangata Whai Ora served.</p> <p><b><u>Putanga/Access:</u></b> Access may be from any source, including from rangatahi/adolescents or pakeke/adults directly, or upon referral from primary practitioners, whaanau, caregivers, and community members, and from inpatient services.</p>
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**SERVICE TYPE DESCRIPTIONS FOR NGA MOENGA MO TE KAUPAPA MĀORI  
HINENGARO I ROTO I NGA HOHIPERA / KAUPAPA MĀORI MENTAL HEALTH  
SERVICES - INPATIENT BEDS**

<p><b>Nga moenga mo te kaupapa Māori hinengaro i roto i nga hohipera/ Kaupapa Māori Mental Health Services - Inpatient Beds</b></p> <p><b>MHIS08</b></p>	<p><b><u>Mahia/Function:</u></b></p> <p>To provide a Kaupapa Māori inpatient service for Tangata Whai Ora that strengthens their identity and knowledge of tikanga Māori, enhances skills, their functional independence and has a focus on recovery.</p> <p>The service is for Tangata Whai Ora who are assessed as requiring inpatient rehabilitation because of diagnostic and treatment complexity, insufficient response to treatment and a continuing need for a high level of ongoing supervision and support.</p> <p><b><u>Te taumata o te kaupapa/Nature of the Service:</u></b></p> <p>A kaupapa Māori goal oriented, recovery focused, skill development inpatient programme, which increases the Tangata Whai Ora's ability to:</p> <ul style="list-style-type: none"> <li>• Manage their own illness;</li> <li>• map, process, activate and achieve life goals;</li> <li>• develop positive relationships and a view of their self and strengthen identity;</li> <li>• further develop whanau/other relationship;</li> <li>• develop problem-solving skills.</li> </ul> <p>Personal, clinical and cultural plans will be developed in accordance with formally assessed needs. Clinical and cultural progress against plans and identified goals will be reviewed at specified intervals, with modification of plans accordingly.</p> <p>Plans will aim to:</p> <ul style="list-style-type: none"> <li>• meet individual cultural needs;</li> <li>• provide wairuatanga/spiritual sustenance;</li> <li>• assist whakawhaanaungatanga/reintegration into the community;</li> <li>• maintain cultural links particularly with own papakainga/marae and Māori linkages;</li> <li>• provide access to learning and experiences of Māori culture;</li> <li>• maintain and strengthen family/whanau links;</li> <li>• educate Tangata Whai Ora and their whanau/caregivers about illness, symptoms and the management of symptoms.</li> </ul> <p>The emphasis will be on implementation of the treatment plan and reintegration into the community. A comprehensive range of community and hospital based rehabilitation options will be available including:</p> <ul style="list-style-type: none"> <li>• provision of or access to kaumatua, a Māori environment rongoa Māori, tohunga, te reo Māori speakers or other cultural needs, in accordance with the needs/requests of Tangata Whai Ora;</li> <li>• provision of tikanga Māori that relate to the kawa and kaupapa of the service. This may include powhiri, whaikorero, karanga, mihimihi, karakia, nga moteatea, huihui, waiata or, poroporoaki;</li> <li>• psychological treatments;</li> <li>• social treatments;</li> <li>• occupational therapy;</li> <li>• recreational activities;</li> <li>• social skills training;</li> <li>• domestic skills training/budgeting;</li> </ul>
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	<ul style="list-style-type: none"> <li>• assertiveness and self esteem building;</li> <li>• pharmacotherapy and bio-medical interventions.</li> </ul> <p><b><u>Key Processes:</u></b>  Tangata Whai Ora accessing these services can expect, as a minimum, to be able to access all of the following processes:  Advocacy, Assessment, Case Management, Discharge Planning, Hotel Services, Legal Compliance, Management of Risk, Peer Support, Service Handover, Support, Treatment and Rehabilitation.  These processes are described in the Service Specification titled "Process Descriptions".</p> <p><b><u>Tangata arahi i te kaupapa/Services Provided By:</u></b>  Refer to "Treatment and Rehabilitation Services" section of Process Descriptions.</p> <p><b><u>Putanga/Access:</u></b>  Referral from inpatient services or community clinical rehabilitation service.</p>
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## *Appendix 2: Letter of Introduction*



# Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Te Pūtahi-ā-toi  
School of Māori Studies  
Private Bag 11 222,  
Palmerston North  
New Zealand  
T: 64 6 356 9099 extn 7236  
F 64 6 350 5634  
<http://Māori.massey.ac.nz>

<date>

<name>

<address 1>

<address 2>

Tena koe

My name is Amohia Boulton and I am an HRC Training Fellow undertaking a PhD in Māori mental health at Massey University, Palmerston North. My research looks at the reasons Māori mental health providers provide services over and above those that they have contracted to deliver and the difficulties associated with delivering these extra services. I also want to explore whether current contracting models sufficiently recognise and value the work of Māori mental health providers and whether some sort of “cultural performance measure” is required in order to acknowledge the additional work undertaken.

The study involves two phases. The first involves interviews with experts in Māori mental health and public servants about models of contracting in the mental health sector. In particular the interviews will find out about current contracting arrangements with Māori mental health providers. In the second phase I will interview Māori providers about whether they deliver services additional to those in their contracts, why they do this and in what ways this extra work may be acknowledged. It is hoped that providers in Auckland, Tauranga, Manawatu/Wanganui and Christchurch will agree to participate in the study.

The purpose of my letter is to ask whether it would be possible to meet with you to discuss my research project and, if you agree, to interview you as an expert in Māori mental health.

I will be in Wellington next Wednesday, August 13<sup>th</sup> and would appreciate meeting with you if you are free. Regardless of whether you agree to be interviewed or not, I would still like to present my research to you and introduce myself.

If you do agree to be interviewed, the interview itself will take between one and one and a half hours.

Heoi ano

Amohia Boulton  
HRC Training Fellow

### Appendix 3: Confirmation Sheet



# Massey University

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F 64 6 350 5634  
<http://Māori.massey.ac.nz>

## Measuring Cultural Performance in Māori Mental Health Confirmation Form for Research Participation

By completing this form you are indicating that you are interested in finding out more about the research “**Measuring Cultural Performance in Māori Mental Health**” a study being undertaken by Amohia Boulton as part of a PhD in Māori Studies. Before you make the final decision to be interviewed, you will be given an opportunity to have your questions or concerns about the research addressed.

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone (if any) \_\_\_\_\_

1) What is the best way for the researcher (Amohia Boulton) to make contact with you? Eg: telephone, fax, letter, in person?

\_\_\_\_\_

2) If you agree to be interviewed, where would you like this interview to take place? I will cover reasonable transport costs to get you to any of these venues. (Please tick)

Anywhere in (*name of city inserted here*)

At a room at the (*appropriate provider inserted here*)

Amohia’s office at Massey University, Palmerston North Campus

Your home or supported house

Other – please provide a suggestion in the space below

3) What week day and time of day is most suitable for you?

\_\_\_\_\_

Thank you for completing this form. Amohia Boulton will make contact with you sometime in the next two weeks to discuss the research. If you agree to be interviewed Amohia will also discuss whether you require transport to and from the interview or reimbursement for any child

care costs to enable you to be interviewed. Before you can be interviewed you will be asked to sign a written form, consenting to the interview.

Please return this form in the stamped-addressed envelope provided to: Amohia Boulton, School of Māori Studies, Massey University, Private Bag 11 222 Palmerston North.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/122 and by the Manawatu/Whanganui Human Ethics Committee on behalf of Bay of Plenty and Canterbury. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email [S.V.Rumball@massey.ac.nz](mailto:S.V.Rumball@massey.ac.nz), or you may wish to consult with your professional organisation.

*Appendix 4: Consent Form*

# Massey University

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 Private Bag 11 222,  
 Palmerston North  
 New Zealand  
 T: 64 6 356 9099 extn 7236  
 F 64 6 350 5634  
<http://Māori.massey.ac.nz>

## Measuring Cultural Performance in Māori Mental Health Consent Form for Research Participants

I \_\_\_\_\_ (participant) give my consent to  
 \_\_\_\_\_ (print name)

be interviewed as part of the research being undertaken by Amohia Boulton (**researcher**) on the subject: **Measuring Cultural Performance in Māori Mental Health**. I understand that Amohia Boulton is completing this research as part of her PhD in Māori Studies through Massey University, Palmerston North. I have been given written information on

- |                        |  |
|------------------------|--|
| - The research project | - The researcher                       |
| - The study            | - The significance of the research     |
| - The interview        | - Confidentiality                      |
| - Participation        | - How the findings will be distributed |

I have had the opportunity and sufficient time to consider the implications associated with undertaking this interview. I am aware that I may withdraw from this research up until the final writing up of the thesis. I therefore voluntarily agree to be interviewed.

\_\_\_\_\_  
 (Participants signature) Date \_\_\_\_\_

I agree for my interview to be taped.

\_\_\_\_\_  
 (Participants signature) Date \_\_\_\_\_

\_\_\_\_\_  
 (Researchers signature) Date \_\_\_\_\_  
 A copy of the consent form is to be kept by the participant

I understand that I will be sent a transcript of my interview, and asked to check and return it within four weeks of receiving it.

I wish to receive the transcript for checking.

YES  NO

I would like to be provided with a full report on the completed research.

YES  NO

I would like to be given the interview audiotape on completion of the research

YES  NO

Amohia Boulton School of Māori Studies, Massey University, Private Bag 11 222 Palmerston North, telephone 06 350 5799 x7541, or 0800 Hauora, email [A.F.Boulton@massey.ac.nz](mailto:A.F.Boulton@massey.ac.nz)

**Thank you very much!**

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/122 and by the Manawatu/Whanganui Human Ethics Committee on behalf of Bay of Plenty and Canterbury. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email [S.V.Rumball@massey.ac.nz](mailto:S.V.Rumball@massey.ac.nz), or you may wish to consult with your professional organisation.

## *Appendix 5: Key Informants Information Schedule*



# Massey University

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F 64 6 350 5634  
<http://Māori.massey.ac.nz>

### **Measuring Cultural Performance in Māori Mental Health Information Form for Key Informants**

Ko Mauao te maunga, ko Tauranga Moana te moana, ko Ngai te Rangi raua ko Ngati Ranginui oku iwi, ko Pirirakau toku hapū, ko Poutu-te-rangi te marae, ko Bidois te whānau, ko Amohia Boulton toku ingoa

#### **Research Project**

This study investigates the reasons Māori mental health providers provide services over and above those that they have contracted to deliver and the difficulties associated with delivering these extra services. The study will also explore whether the current contracting model sufficiently recognises and values the work of Māori mental health providers and whether a “cultural performance measure” is required in order to acknowledge the additional work undertaken.

#### **The Researcher**

This research is being carried out by Amohia Boulton to fulfil the requirements of a PhD in Māori Studies, which she is undertaking through Massey University, Palmerston North.

Amohia’s primary supervisor for this study is Chris Cunningham, Director of Te Pumanawa Hauora (Māori Health Research Unit), Massey University Palmerston North. Amohia’s Secondary supervisor is Jackie Cumming, Director of the Health Services Research Centre, Victoria University of Wellington.

#### **The Study**

The study involves two stages. In the first stage experts in the area of Māori mental health and public servants will be interviewed about models of contracting in the public service and the health sector. In particular the interviews will find out about current contracting arrangements with Māori mental health providers. In the second stage Māori providers, and where possible tangata whaiora, will be interviewed about whether they deliver services additional to those in their contracts, why they do this and in what ways this extra work may be acknowledged. It is hoped that providers and tangata whaiora in Auckland, Tauranga, Manawatu/Wanganui and Christchurch will agree to participate in the study.

#### **The Significance of the Study**

Mason Durie has noted that mental health is the number one health concern for Māori. Māori mental health and the provision of high quality health services for Māori are both priority areas identified in the Government’s most recent strategic health documents. The results of this research will advance our understanding of the critical operational issues that confront Māori providers. Such understanding and knowledge will build upon the hard-won gains made by Māori providers in the delivery of services specifically catered to meeting the needs of Māori. In addition, understanding what drives providers to deliver the services they do will allow the Government to better use the contracting process to ensure improved outcomes for Māori.

### **The Interviews**

People who agree to participate in the research will be interviewed for approximately 1-1½ hours. These interviews will be audio taped. Written informed consent will be obtained from willing participants prior to the interview. The interview will take place at a mutually arranged venue and time and will be conducted by Amohia Boulton, the researcher. Once completed the interviews will be transcribed (written up) by a transcriber. All personal information including people's names will be removed.

### **Confidentiality**

All information obtained in this research will be treated in confidence. To ensure confidentiality pseudonyms (aliases) will be used instead of real names. Access to any data during the study will be restricted to the researcher, Amohia Boulton, the supervisors and an external transcriber, all of who will treat the research with confidence. All research information will be locked in a filing cabinet at the researcher's place of employment, Massey University, Palmerston North. Amohia Boulton will be the only person with access to this. On completion of the research participants will be offered the audio-tape, otherwise data will be locked and stored for a minimum of five years and will then be destroyed by the researcher.

### **Participation in this research**

Participation in this research is entirely voluntary.

Participants have the right to withdraw from the research at any time until the final writing up of this thesis without fear of recrimination or discrimination in their future health care.

Participants are free to invite a support person/persons or their whānau to the interview.

Transport is available to and from the venue and child-care costs will be met if this is required.

### **Distribution of Findings**

The research will be submitted for examination and lodged as a thesis at Massey University Palmerston North. A summary report on the findings of the research will be sent to all the research participants, individuals, and providers alike. In addition a full report on the research will be available upon request. The research report will also be disseminated to the Ministry of Health, the Mental Health Commission, Te Puni Kōkiri, District Health Boards and other relevant government departments. Copies will be made available to other Māori health researchers, Māori academics, Māori PhD students and local consumer groups. Consideration will be given to presenting this research at an appropriate conference. Further dissemination of the results is possible through journal articles.

### **Further Information**

If you require further information or have any issues with this research please feel free to contact either:

Amohia Boulton  
School of Māori Studies  
Massey University  
Private Bag 11 222  
Palmerston North  
Ph (06) 350 5799 x 7541  
Fax (06) 3505606

Chris Cunningham  
School of Māori Studies  
Massey University  
Wellington Campus  
2<sup>nd</sup> Floor, No Name Building  
Ph (04) 380 0620  
Fax (04) 380 0626

Jackie Cumming  
Health Services Research Centre  
Victoria University of Wellington  
PO Box 600  
Wellington  
Ph (04) 463 6565  
Fax (04) 463 6568

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/122 and by the Manawatu/Whanganui Human Ethics Committee on behalf of Bay of Plenty and Canterbury. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email [S.V.Rumball@massey.ac.nz](mailto:S.V.Rumball@massey.ac.nz), or you may wish to consult with your professional organisation

Thank you for your interest in this research.

## *Appendix 6: Key Informants Schedule*



**Massey University**

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

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<http://Māori.massey.ac.nz>

### **Interview Schedule for Key Informants**

**Question 1:** My research is about performance measurements and standards, as they apply in Māori mental health. Broadly, can you tell me, what is your understanding of the term “performance measurement” as it applies to the health sector?

**Question 2** Given the above response, how is performance in the mental health sector currently measured by the Crown/government? What things is the Crown interested in measuring and why?

**Question 3** How has the government developed mental health performance measures?

**Question 4** Is there a difference between how the performance is measured at a central government level compared to how the performance of agencies that contract to provide services is measured? If so what are the differences?

**Question 5** Looking specifically at Māori mental health services now, Māori mental health providers are an example of agencies that contract with the Crown to provide services. What is your understanding of how the performance of Māori mental health providers is measured?

**Question 6** With regard to Māori mental health providers, what things is the Crown interested in measuring and why?

**Question 7** Should the performance of Māori mental health services be measured the same way as mainstream mental health services?  
Explain why/why not.

**Question 8** A number of researchers have noted that Māori mental health providers often deliver more than they are contracted to. Do you agree with this statement and if so, what are these extra things they do and why do you think they are doing more?

**Question 9** Do you think the performance measures currently used by government adequately measure the activities of Māori mental health providers? Explain why/why not.

**Question 10** What is the best way, in your opinion, to measure and acknowledge the additional work undertaken by Māori mental health providers?

**10A** For example what do you think about developing a separate and specific measure to gauge the additional services a Māori mental health provider delivers?

If you agree, what types of things would be measured?

**10B** Or do you think there is a need to develop a so-called “cultural performance” measure?

If you agree, what types of things would be measured?

**Question 11** Māori mental health providers operate in an environment in which they are accountable to the government as well as to their own community, iwi, hapu or whānau. Do you think the multiple accountabilities Māori mental health providers operate under have an effect on how they work or the types/ range/ extent of work they do?

Please give examples

**Question 12** What sort of impact do the multiple accountabilities discussed above have upon the performance of Māori mental health providers?

Please give examples

**Finally is there anything you would like to ask me about the research?**

---

Thank you for your time today. If you would like a copy of the summary report or the full report, please give me an address that I can post them to.

If you have any questions or queries about the research, please feel free to contact me.

Amohia Boulton, School of Māori Studies, Massey University, Private Bag 11 222, Palmerston North. Telephone (06) 350 5799 x 7541 or 0800 Hauora, Fax (06) 3505606, email [A.F.Boulton@massey.ac.nz](mailto:A.F.Boulton@massey.ac.nz)

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/122 and by the Manawatu/Whanganui Human Ethics Committee on behalf of Bay of Plenty and Canterbury. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email [S.V.Rumball@massey.ac.nz](mailto:S.V.Rumball@massey.ac.nz), or you may wish to consult with your professional organisation.

## *Appendix 7: Transcriber Confidentiality Form*



# Massey University

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F 64 6 350 5634  
<http://Māori.massey.ac.nz>

### **Measuring Cultural Performance in Māori Mental Health Transcriber Confidentiality Form**

I \_\_\_\_\_ (**Transcriber**) agree that the information I am about to transcribe as a result of interviews for Amohia Boulton's research entitled **Measuring Cultural Performance in Māori Mental Health**, is strictly confidential.

At all times the research information (tapes and transcripts) will be inaccessible to other persons. I understand that the research data will be stored on floppy disk, CD and on hard drive. The researcher has assured me that she will debrief me following each interview transcription to address any issues that may have risen for me as a consequence of transcribing the interview tapes.

I agree to the conditions of transcribing Amohia Boulton's research and understand that the research is a requirement for the completion of a PhD in Māori Studies, which is being supervised by Dr Chris Cunningham, Director, Te Pūmanawa Hauora, Massey University, Palmerston North.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Transcriber)

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Researcher)

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/122 and by the Manawatu/Whanganui Human Ethics Committee on behalf of Bay of Plenty and Canterbury. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email [S.V.Rumball@massey.ac.nz](mailto:S.V.Rumball@massey.ac.nz), or you may wish to consult with your professional organisation.

## ***Appendix 8: Preliminary Findings***

**Table 9-A:** Preliminary findings from Key informant interviews indicate that Māori providers do do more than they are contracted to and the reasons generally fit into one of five categories

<b>Hauora</b>	Worldview is different from that of other providers, operating from a completely different worldview, where hauora rather than health is delivered.
<b>Overstating capacity</b>	Overstating what a service could do in the bidding process, so that a lot more work had to be done in order to deliver on the contract's outputs
<b>Iwi-development</b>	Iwi providers in particular view health delivery as merely one aspect of the larger goal of iwi development. Their philosophy is that development as an iwi must occur in conjunction with raising the health status of iwi members.
<b>Inexperience</b>	Lack of experience in contracting for health services may mean some providers chase every contract and/or believe they have to “deliver the world”. With maturity this perception may change and providers may learn to become more strategic their selection of contracts to tender for.
<b>Responsiveness to Client Demand</b>	Client driven. Māori providers are very close to their community/are part of their community and relationships between themselves and their community members can not be ignored.

## *Appendix 9: Provider Information Sheet*



**Massey University**

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F 64 6 350 5634  
<http://Māori.massey.ac.nz>

### **Measuring Cultural Performance in Māori Mental Health Information Form**

Ko Mauao te maunga, ko Tauranga Moana te moana, ko Ngai te Rangi raua ko Ngati Ranganui oku iwi, ko Pirirakau toku hapū, ko Poutu-te-rangi te marae, ko Bidois te whānau, ko Amohia Boulton toku ingoa

#### **Research Project**

This study investigates the reasons Māori mental health providers provide services over and above those that they have contracted to deliver and the difficulties associated with delivering these extra services. The study will also explore whether the current contracting model sufficiently recognises and values the work of Māori mental health providers and whether a “cultural performance measure” is required in order to acknowledge the additional work undertaken.

#### **The Researcher**

This research is being carried out by Amohia Boulton to fulfil the requirements of a PhD in Māori Studies, which she is undertaking through Massey University, Palmerston North.

Amohia’s primary supervisor for this study is Chris Cunningham, Director of Te Pumanawa Hauora (Māori Health Research Unit), Massey University Palmerston North. Amohia’s Secondary supervisor is Jackie Cumming, Director of the Health Services Research Centre, Victoria University of Wellington.

#### **The Study**

The study involves two stages. In the first stage experts in the area of Māori mental health and public servants will be interviewed about models of contracting in the public service and the health sector. In particular the interviews will find out about current contracting arrangements with Māori mental health providers. In the second stage Māori providers, and where possible tangata whaiora, will be interviewed about whether they deliver services additional to those in their contracts, why they do this and in what ways this extra work may be acknowledged. It is hoped that providers and tangata whaiora in Auckland, Tauranga, Manawatu/Wanganui and Christchurch will agree to participate in the study.

#### **The Significance of the Study**

Mason Durie has noted that mental health is the number one health concern for Māori. Māori mental health and the provision of high quality health services for Māori are both priority areas identified in the Government’s most recent strategic health documents. The results of this research will advance our understanding of the critical operational issues that confront Māori providers. Such understanding and knowledge will build upon the hard-won gains made by Māori providers in the delivery of services specifically catered to meeting the needs of Māori. In addition, understanding what drives providers to deliver the services they do will allow the Government to better use the contracting process to ensure improved outcomes for Māori.

### **The Interviews**

People who agree to participate in the research will be interviewed for approximately 1-1½ hours. These interviews will be audio taped. Written informed consent will be obtained from willing participants prior to the interview. The interview will take place at a mutually arranged venue and time and will be conducted by Amohia Boulton, the researcher. Once completed the interviews will be transcribed (written up) by a transcriber. All personal information including people's names will be removed.

### **Confidentiality**

All information obtained in this research will be treated in confidence. To ensure confidentiality pseudonyms (aliases) will be used instead of real names. Access to any data during the study will be restricted to the researcher, Amohia Boulton, the supervisors and an external transcriber, all of who will treat the research with confidence. All research information will be locked in a filing cabinet at the researcher's place of employment, Massey University, Palmerston North. Amohia Boulton will be the only person with access to this. On completion of the research participants will be offered the audio-tape, otherwise data will be locked and stored for a minimum of ten years and will then be destroyed by the researcher.

### **Participation in this research**

- Participation in this research is entirely voluntary.
- Participants have the right to withdraw from the research at any time until the final writing up of this thesis without fear of recrimination or discrimination in their future health care.
- Participants are free to invite a support person/persons or their whānau to the interview.
- Transport is available to and from the venue and child-care costs will be met if this is required.
- If you are a Māori mental health provider, please note your participation in this research will not affect your future employment.

### **Distribution of Findings**

The research will be submitted for examination and lodged as a thesis at Massey University Palmerston North. A summary report on the findings of the research will be sent to all the research participants, individuals, and providers alike. In addition a full report on the research will be available upon request. The research report will also be disseminated to the Ministry of Health, the Mental Health Commission, Te Puni Kōkiri, District Health Boards and other relevant government departments. Copies will be made available to other Māori health researchers, Māori academics, Māori PhD students and local consumer groups. Consideration will be given to presenting this research at an appropriate conference. Further dissemination of the results is possible through journal articles.

### **Further Information**

If you require further information or have any issues with this research please feel free to contact either:

Amohia Boulton  
School of Māori Studies  
Massey University  
Private Bag 11 222  
Palmerston North  
Ph (06) 350 5799 x 7541  
Fax (06) 3505606

Chris Cunningham  
School of Māori Studies  
Massey University  
Wellington Campus  
2<sup>nd</sup> Floor, No Name Building  
Ph (04) 380 0620  
Fax (04) 380 0626

Jackie Cumming  
Health Services Research Centre  
Victoria University of Wellington  
PO Box 600  
Wellington  
Ph (04) 463 6565  
Fax (04) 463 6568

Thank you for your interest in this research.

## *Appendix 10: Provider Interview Schedule*



# Massey University

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Te Pūtahi-ā-toi  
School of Māori Studies  
Private Bag 11 222,  
Palmerston North  
New Zealand  
T: 64 6 356 9099 extn 7236  
F 64 6 350 5634  
<http://Māori.massey.ac.nz>

## Interview Schedule for Providers

- Question 1:** Please describe your background and your involvement in Māori mental health
- Question 2** Can you tell me a little bit about the history of your organisation?
- Question 3** What contracts do you currently hold with the DHB?
- Question 4** How is your performance measured with regard to these contracts (particularly the mental health contracts)?
- Question 5** What outputs or outcomes are you contracted to deliver and how do you know if you have delivered these?
- Question 6** Do you think these contracts, and the performance measures explicit within them, adequately capture and measure the extent of the work you do?
- Why?
- Why not?
- Question 7** Based upon your response to the previous question, do you believe you and your organisation do more than you are contracted to and if so what types of things do you do in addition to your contract?
- Question 8** Why do you do this extra work you have identified?

- Question 9** How could these contracts be improved to better reflect the work that you and your organisation does? Can they be improved or is there another way of assessing your performance?
- Question 10** As a Māori health provider who are you accountable to?
- Question 11** Based on your response to the previous question what form does this accountability take? In other words, how do you report to those you are accountable to?
- Question 12** Based on your earlier answers, how do you manage any differences that may exist between being accountable to Māori and accountable to the Crown?
- Question 13** How do you know when you and your organisation have been successful?

**Finally is there anything you would like to ask me about the research?**

---

**Thank you for your time today. If you would like a copy of the summary report or the full report, please give me an address that I can post them to.**

If you have any questions or queries about the research, please feel free to contact me.

Amohia Boulton, School of Māori Studies, Massey University, Private Bag 11 222, Palmerston North. Telephone (06) 350 5799 x 7541 or 0800 Hauora, Fax (06) 3505606, email [A.F.Boulton@massey.ac.nz](mailto:A.F.Boulton@massey.ac.nz)

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 02/122 and by the Manawatu/Whanganui Human Ethics Committee on behalf of Bay of Plenty and Canterbury. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email [S.V.Rumball@massey.ac.nz](mailto:S.V.Rumball@massey.ac.nz), or you may wish to consult with your professional organisation.

## *Appendix 11: Appendix on Data Storage*



**Massey University**

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Te Pūtahi-ā-toi  
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Private Bag 11 222,  
Palmerston North  
New Zealand  
T: 64 6 356 9099 extn 7236  
F 64 6 350 5634  
<http://Māori.massey.ac.nz>

<date>

<name>

<address1>

<address2>

Tena koe

Thank you for agreeing to participate in the research project: **Measuring Cultural Performance in Māori Mental Health** which is being undertaken as part of my PhD in Māori Studies through Massey University, Palmerston North.

Please note that any audio-tapes of interviews undertaken with you or your staff will be kept by Te Pūmanawa Hauora for a minimum of 10 years, as per Ethic Committee requirements. Te Pūmanawa Hauora undertakes responsibility for the guardianship of these tapes, which will be stored in a locked cabinet for the duration of the research. Upon the completion of the research the tapes will be moved to locked cabinets in a secure Archives Room in the School of Māori Studies, Turitea Campus.

Should you wish to access your tapes you should, in the first instance, contact the Administrator at Te Pūmanawa Hauora, quoting the following project title:

**PR56660 A Model for Understanding Cultural Performance Standards in  
Māori Mental Health**

and ask for the tapes labelled with your organisation's unique identifier **MHP07**. The contact details are:

The Administrator  
Te Pūmanawa Hauora  
Massey University  
Private Bag 11 222  
Palmerston North

Amohia Boulton  
Te Pūmanawa Hauora  
Massey University  
Private Bag 11 222  
Palmerston North

Thank you once again for giving your time to this project. I look forward our continued work together.

Heoi ano

Amohia Boulton  
Doctoral Research Officer

Appendix 12: Journal Entry

KEY WORDS

DATE 16/6/04 NAME \_\_\_\_\_  
ORG/BUS \_\_\_\_\_  
PLACE \_\_\_\_\_ after 1/V

post 1/vm

good 1/v? was pretty prepared and printed out a list of performance measures for the alcohol + drug programme (note all numbers based)

\*

things to follow up - are these bulk or price/volume contracts (forget to ask) also any written material on service?

while \_\_\_\_\_ was clear the contract was confidential happy to talk about extra work done over + above.

\* note wants to see final report + should do formal round of feedback.

*Appendix 13: Narrative Report for Provider MPH05*

**MPH05**

**ADDITIONAL INFORMATION**

In the past three months we have received no less than 38 new referrals. The majority of these referrals have come via

For the purposes of Performance Monitoring Returns we are expected to provide information relating to, and restricted to, "current clients" or in other words "accepted tangata whai-ora". We have taken the initiative to also collate hours/data for "not current clients" or new referrals yet to be accepted.

Below is a table highlighting the amount of hours and types of contact which take place when following up new referrals. We endeavour to follow up every new referral received by way of telephone contact, correspondence, and face to face contact.

*Monthly Follow up of New Referrals (Not Current Clients) HOURS*

	January	February	March
<b>Clinical Adult</b>	0.50	17.25	26.00
<b>Clinical Tamariki-Rangatahi</b>	0.00	5.50	9.50
<b>Non-Clinical</b>	2.50	2.50	17.50

*Monthly Follow up of New Referrals (Not Current Clients) CONTACTS*

	January	February	March
<b>Phone Contact</b>	4	15	17
<b>First Face to Face</b>	0	1	13
<b>Follow up Face to Face</b>	0	1	2
<b>Group (Face to Face)</b>	0	0	8
<b>Consultation/Liaison Contact</b>	1	10	10

Members of our staff have undertaken study/training in the past three months. An overview of this training are as follows:

Adult Clinical

*Child Advocacy Training (2days) 22-23 March 2004*

Tamariki-Rangatahi Clinical

*Interactive Therapy Drawing (2 days) 25-26 March 2004*

Non-Clinical

*Te Atawhaingia Pa Harakeke (4 days) March 29 – 1 April 2004*

- Parenting Programme – Parent and Tamaiti arm. Court approved.

*2 x Staff Tikaka Hauora at Hospital (5 days) 10-12 March 2004 & 7-8 April 2004*

- Tikaka Hauora is the recommended training for Maori Mental Health Workers
- Delivery through (Pakeke)
- Clinical Teaching and Tutorial Programme ie
- Areas covered included but were not restricted to:  
History of Psychiatry, Psychologist & Assessment, Psychosis, & Mood Disorder to name a few.

*Appendix 14: Narrative Report for Provider MHPO3*

MHPO3 DOCUMENT C

Narrative Report

APR 03

Kia ora

Just one clarification required,  
"Number of people supported by services at end of period?" Does this mean year to date?  
Please get back asap.

Na

MHPO3 DOCUMENT C

Narrative Report

MAY 03

Kia ora

I'm not sure if you received my last report (April), however will send a copy as I asked for clarity re – "number of people supported by services at end of period" Is "end of period, year to date?"

Noho ora mai, na

MHPO3 DOCUMENT C

Narrative Report

JUNE 03

Kia ora

- Please acknowledge if you have received this report.
- is our employee for this service.

Naku noa. Na

Service Manager

*Appendix 15: Narrative Report for Provider MHPO1*

21/10/02

MHPO1

DOCUMENT D

Tēnā Koutou Katoa,

My gosh the year is almost over what have we been doing

#### Attendance/ Service Provision

The days at the Activity Centre are extremely busy the client base has risen by 60% that's not counting our regulars. We have changed office location due to the increase of clients, the reason that this was done is a safety issue, and I felt that the safety of the Activities Coordinator was at risk with the increase of clients. So is now operating from one building.

All programmes are active every six weeks they are viewed.

All programmes running at present are tangata whai ora driven at present nine are employed on service contract that's exciting in it's self.

#### Whanau Training

Whanau training is once a month based around tikanga all whanau have an input in to developing the programmes

The first Monday of every month we have a whanaungatanga day this is open to the Māori community and all sector bases.

Two computer sessions morning afternoon at the moment are designing their Web Site.

provides a very unique service where we are able to operate under the Whanaungatanga model by incorporating all aspect of the contacts by interweaving Public Health with the contact from the DHB this is well reconsigned in the community as well as by the stakeholders.

With the increase of our client base I envisage that I will be putting a new proposal together for more funds for the activity centre, we broke all records one day 106 people in one day, having said that there are days that are quite but steadily on the increase, if this should continue on to rise we may have to look at another building in another part of town

will be doing an article on early next year

In summary, due to the changes in team dynamics over the past months, we have had to re stabilise. This has happened extremely well thanks to the Whanaungatanga environment with the team and we are ready to 'take off' and continue to spread the word of our services