Te Tau Ihu Māori Mental Health outcomes and tangata whaiora experiences in Te Wahi Oranga (Nelson Acute Mental Health Inpatient Unit).

An exploratory study.

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Abstract

There are significant differences between Māori and non-Māori mental health in New Zealand. Māori have higher prevalence of serious mental health disorders than non-Māori, yet in comparison to non-Māori, Māori are less likely to access health services; are less likely to be referred to specialist mental health services by General Practitioners (GPs) and more likely through law and welfare agencies; are more likely to be involuntarily admitted; have higher admission (and readmission) rates, are more likely to be diagnosed with psychotic disorders on admission; and have higher suicide and mortality rates.

The aim of this research was to explore outcomes for Māori in Te Tau Ihu (Nelson/Marlborough), New Zealand and understand Māori tangata whaiora (service users/patients) experiences from admissions through to discharge from a mental health acute inpatient unit in Te Tau Ihu. First, five years of inpatient data was collated to identify whether there were similarities between Te Tau Ihu Māori and Māori nationally in terms of admission rates, readmission rates, seclusion practices, length of stay and diagnostic data. Second, using a narrative inquiry approach embedded within a Kaupapa Māori framework, 13 tangatawhaiora were interviewed.

This research has found that there are some similarities between Māori in Te Tau Ihu and Māori nationally in terms of the higher number of admissions and first time re-admissions, higher rates of psychotic disorders and seclusion. However, Te Tau Ihu Māori compare more favourably in terms of lower two or more subsequent re-admissions, and there is minimal difference between Māori male and female admission rates.

In terms of tangata whaiora experiences, there are consistencies with other studies around concerns with medication, stigma and discrimination, lack of respect, boredom, fear and safety, and relationships with staff. There are also new learnings in terms of the complex relationship with medication, the importance of food and music as a relationship enabler, the strength of having Māori staff on the unit and a call for more therapeutic interaction.

The findings endorse the need for more comprehensive care planning based on Te Whare Tapa Whā (mental, physical, family, spiritual dimensions) to better support tangata whaiora.

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Acknowledgements

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Glossary

Atua	Māori gods or spirits
Inpatients	Service users/Tangata whaiora admitted to an acute mental health inpatient unit.
Kai	Food
Kaupapa	Strategy, policy or cause.
Kaupapa Māori Health Services	Common characteristics of Kaupapa Māori 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 Maori.
Maata waka	Iwi groups living outside of their traditional rohe (boundary).
Mākutu	To inflict physical and psychological harm and even death through spiritual powers, bewitch, cast spells.
Mana	Prestige, authority, control, power, influence, status, spiritual power, charisma - *mana* is a supernatural force in a person, place or object
Manawhenua	A set of customary land rights of a hapū or iwi which denotes their ownership, control and sovereignty over a defined area of land.
Mental Health Disorder (admission to acute inpatient services)	Under the Mental Health (Compulsory Assessment and Treatment) Act 1992 a mental disorder is defined as an: *abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it— (a) Poses a serious danger to the health or safety*

of that person or of others; or (b) Seriously diminishes the capacity of that person to take care of himself or herself;— and mentally disordered, in relation to any such person, has a corresponding meaning.

Pākehā	Term used for New Zealanders who are of European descent. The term is used in this thesis from a more historical lens to describe European contact pre 1840 to the 1980's. Recently the word has been used to refer inclusively to either fair-skinned persons or any non- Māori New Zealander, and Non-Māori is used between 1980's to 2012.
Primary Mental Health Services	The assessment, treatment and, when needed, the ongoing management of people with mental health and/or addiction issues in the primary care setting. It encompasses promotion, prevention, early intervention and ongoing treatment for mental health and addiction issues.
Recovery	Recovery is defined as the ability to live a meaningful and satisfying life in the presence or absence of mental illness or addiction.
Rohe	The territory or boundaries of iwi.
Service Users Tangata Whaiora Tangata Whai ora	A person who is obtaining treatment of support for a mental disorder, also known as psychiatric or mental illness. Where possible, tangata whaiora has been used to indicate Māori; and service users for non-Māori.
Tapu	Be sacred, prohibited, restricted, set apart, forbidden, under *atua* protection.
Te Ao Māori	Māori world view, which includes for example, Te Reo Māori, Tikanga, Marae, Wahi Tapu, access to whānau, hapu and iwi.
Te Tau Ihu o Te Waka a Maui	Top of the South encompassing Tasman, Nelson and Marlborough districts. The prow of Maui's waka. The shortened version is Te Tau Ihu. This is also used interchangeably with Nelson Marlborough.
Te Wahi Oranga	The acute mental health inpatient unit based in Nelson.

Tika	What is just, fair and correct.
Tikanga	Tikanga can be described as general behaviour guidelines for daily life and interaction in Māori culture. Tikanga is commonly based on experience and learning that has been handed down through generations. It is based on logic and common sense associated with a Māori world view.
Wahi tapu	Sites of historical and cultural significance.
Waka	Canoe, vehicle, conveyance.
Whakapapa	Whakapapa links all animate and inanimate, known and unknown phenomena in the terrestrial and spiritual worlds. Whakapapa therefore binds all things. It maps relationships so that mythology, legend, history, knowledge, tikanga (custom), philosophies and spiritualities are organised, preserved and transmitted from one generation to the next. Whakapapa is the core of traditional mātauranga Māori (Māori knowledge). Whakapapa means genealogy.
Whānau	Family. In a Māori worldview this also includes the extended family.

Chapter One: Introduction

1.1   Introduction:

There are a number of disparities between Māori and non-Māori including access to health services, pathways to mental health services, estimated prevalence rates and suicidal behaviours. In 2007, I undertook a study on Marlborough Māori accessing mental health services through their general practitioners. Two of the male tangata whiaora interviewed delayed seeking an appointment to see their GP for fear they might end up being admitted to the acute mental health inpatient unit in Nelson. This then stimulated an interest to better understand what experiences they had in the unit which resulted in this type of avoidance behaviour.

1.2   Thesis Aims:

This study is about extending the Master of Arts thesis findings,   so that any additional research might add value to whānau, hapu and iwi. This thesis addresses two broad aims. Firstly, to compare Te Tau Ihu (Nelson/Marlborough/Tasman) Māori experiences in the Nelson acute mental health inpatient unit, (including length of stay, seclusion rates, admissions, readmissions, and diagnosis) with Te Tau Ihu non-Māori, and with Māori nationally. Secondly, to take a narrative inquiry approach to tangata whiaora experiences in an acute mental health inpatient setting.

1.3   Research Questions:

There are two research questions for this thesis.   Firstly, how does Te Tau Ihu Māori mental health in an acute inpatient setting differ from non-Māori and Māori nationally? Secondly, what are tangata whiaora experiences in a Te Tau Ihu acute inpatient unit.

1.4   Chapter Summaries:

The journey of this thesis covers 13 chapters.

Chapter Two positions the research from pre-Pākehā times, including an example of the commencement of Pākehā tactics to take Māori lands. The impact of colonisation and how this has affected Māori is discussed briefly to set the context for the ramifications to Māori wellbeing.   The chapter also identifies my responsibility as a Ngāti Rarua and Ngāti Toarangatira iwi member in terms of completing research that will hopefully add value to

whanau, hapu and iwi.   A brief explanation is given of the eight manawhenua[1] in Te Tau Ihu and contemporary health developments within the rohe.

To understand where Māori mental health is positioned now requires some reflection on how mental health services have developed within New Zealand.   Chapter Three examines national legislative and policy developments from 1846 through to contemporary times. This is then aligned to facility and service development occurring within the Nelson community. An example is given of a Ngāti Rarua tupuna (ancestor) who was confined to the asylum, with her descendants identifying that her illness was associated to the stress of losing her lands. A review of the Nelson Lunatic Asylum Report Book from 1864 to 1892 was also undertaken in which there were minimal Māori admissions. Several of these admissions were tupuna who were sent back to Nelson after the Taranaki land war period.

Chapter Four looks at Māori health in general, and compares personal health indicators between Te Tau Ihu Māori, and Māori nationally. It shows that the personal health of Te Tau Ihu Māori is generally better than Māori nationally, and asks whether Te Tau Ihu Māori also have better mental health.

Chapter Five extends the previous chapters' findings, and looks at the role of primary care services in relation to mental health, including a discussion of the access barriers for Māori. This chapter begins by using Te Rau Hinengaro (National Mental Health Survey) findings for estimated prevalence and aligning this to Te Tau Ihu Māori population.

Specialist mental health secondary care services are covered in Chapter Six. This is a national view of findings relating to Māori. This identifies the disparities between Māori and non-Māori, and shows that these are similar to findings in other indigenous populations.

The first research aim is covered in Chapter Seven. How does Te Tau Ihu Māori mental health in an acute inpatient setting differ from non-Māori and Māori nationally? Five years of acute mental health inpatient data are analysed, alongside information from the Mental Health Information National Collection database, and the Ministry of Health.

Chapter Eight looks at cultural identity and best practice. Cultural identity in terms of whether the strength of one's own identity can impact on mental well being. Best practice is

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[1]   A set of customary land rights of hapū or iwi which denotes their ownership, control and sovereignty over a defined area of land.

considered in terms of suggestions of how services can enhance their service delivery to Māori. Once again, there are similar experiences for Māori, to other indigenous populations and this is noted within the chapter.

Chapter Nine is brief but important enough to warrant its own chapter as it forms the basis of proceeding chapters of tangata whaiora experiences. This chapter identifies the key issues service users/tangata whaiora experience within an acute inpatient setting.

The methodology for the second research question looking at tangata whaiora experiences in an acute inpatient unit is covered in Chapter Ten. A narrative inquiry approach is undertaken within a Kaupapa Maori framework. Thematic analysis is used across the interviews.

In Chapter Eleven, tangata whaiora experiences are shared using Te Whare Tapa Whā (Durie, 1998). Te Whare Tapa Whā covers the four cornerstones of wellbeing, mental, physical, spiritual and family as a framework to presenting key themes arising from the tangata whaiora narratives.

Chapter Twelve discusses the findings from the thematic analysis, and the thesis concludes in Chapter Thirteen, including recommendations for the future.

1.5 Conclusion:

This thesis provides an overview of mental health and tangata whaiora experiences within Te Tau Ihu. It provides some recommendations for strengthening service provision to Māori, which will take leadership at a local, regional and national level to effect change.

Chapter Two: Te Tau Ihu o Te Waka a Maui (Te Tau Ihu)

2.1   Introduction

Te Tau Ihu o Te Waka a Maui translates as the prow (Te Tau Ihu) of Maui's waka (canoe) and encompasses the Nelson, Marlborough and Tasman districts. The name refers to the actions of Maui as he fished up the North Island from his waka (the South Island – Te Waka a Maui). Te Tau Ihu is embedded in a rich and diverse iwi history, of which a brief description is helpful to provide context around the rationale for the research.

2.2   Manawhenua iwi of Te Tau Ihu o Te Waka a Maui

In the early 1820s Te Tau Ihu was occupied by Kurahaupo iwi of Rangitāne, Ngāti Kuia and Ngāti Apa. In the mid 1820s this occupation was disturbed by a number of Te Rauparaha led taua (war expeditions) who took utu (revenge) against Kurahaupo for insults to Te Rauparaha and Ngāti Toarangatira. The iwi involved in the taua were Ngāti Toarangatira, Ngāti Rārua, Te Ātiawa, Ngāti Tama and Ngāti Koata. The full settlement by the taua took place over a period of 20 years. Whether by raupatu (to strike or kill many), take whenua (right or reason to the land), customary occupation and use, or arrangement of strategic marriages, these same eight iwi have solidified their positions and are considered manawhenua[2] of Te Tau Ihu (Waitangi Tribunal 2007).

2.3   Pākehā Settlement and Land Disputes

However, during this period of time the Pākehā settler community, and in particular the New Zealand Company, were attempting to secure land holdings for incoming migrants. The first nationally well known land war between Māori and Pākehās was the Wairau Incident[3] at Tuamarino[4] in June 1843. As the New Zealand Company did not have enough lands to provide for incoming migrants in Nelson, the New Zealand Company attempted to take lands in the Wairau (Marlborough) district without negotiation, payment or permission of Ngāti Toarangatira. The account below is given by my tūpuna Rore Pukekohatu who is of Ngāti Rārua and Ngāti Toarangatira descent and present at the time of the incident:

> *I was an eye witness of, you may say, all that occurred, and being fully 16 or 17 years old at that time can well recall all the particulars. Surveyors with their men had come from Nelson, and were engaged in several parties in laying out the ground, about here, and Blenheim, and elsewhere. Rauparaha and Rangihaeata, who were then in*

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[2] A set of take whenua or customary land rights of hapū or iwi which denotes their ownership, control and sovereignty over a defined area of land.
[3] Originally known as the Wairau Massacre or Wairau Affray.
[4] Now known as Tuamarina.

the island of Mana, having been informed of this, came over and on their arrival at once gave the survey parties to understand that they (the survey parties) must stop their work, that the land they were surveying did not belong to the Pakeha, but was Māori property, that the materials, wood and raupo, with which they (the survey parties) had built their whares, had been taken off Māori ground, and consequently was not theirs to use, that therefore they (the Native Chiefs) intended, by way of asserting the Māori right to the land, and notifying the absence of any claim whatever of the Pakeha to it, to burn down the whares, but in doing so would be careful that nothing belonging to the Pakeha should be destroyed or injured.

The Māori chiefs then, having first removed from the whares everything belonging to survey parties, had them burnt. The survey parties then left for Nelson, and afterwards came Wakefield with a number of people who had been brought in a man-of-war, the Victoria, which anchored off the mouth of the river. They came in three boats up the river, one a barge boat and the other two whale boats to where Mr Cheeseman's house is now. Here I and my father and some other Māoris were cutting wood in the bush. It was in the afternoon that they came. The principal persons among them were Wakefield, Thompson the magistrate, Brooke the interpreter, and Tuckett the head surveyor. There seemed to be between 50 and 60 people in all, and they were all armed. At their request we got some food ready for them. They asked where Rauparaha was. We told them at a place close to Massacre Hill that now is, but on the other side of the Tua Marina. They do not seem to believe this, for they began searching for Rauparaha in a large canoe we had there, that had high bulwarks and a deck. They remained there in tents, but I and my father went off in the evening to where Rauparaha was, who had previously been informed of all that had taken place. He had with him Rangihaeata and about 30 other Māoris his immediate followers.

The next morning, very early, Wakefield and all his people arrived. They had come in their three boats to as far as about half a mile from Massacre Hill, and then quitted their boats and walked. On their saying that they wanted to speak to Rauparaha, a large canoe was placed by the Māoris for them to crossover, a canoe so long that its length reached from one side of the Tua Marina to the other. Then Wakefield, Thompson, Brook, Tuckett, and one or two others with two policemen crossed over, and came to where Rauparaha and Rangihaeata were.

A conversation then ensued, Brook interpreting. Rauparaha was informed that he must go to Messrs Clarke and Payne. He said he should not go - that if Mr Clarke had

anything to say to him, let Mr Clarke come to him. He was then told he would be made to go - by force, and on an intimation from Thompson the Magistrate, a Policeman showed him a pair of hand cuffs, which he was informed would be put upon his wrists. His answer to this was to the effect that they had better try. During this time that Brook was interpreting all this, an old Māori whaler, called Tom, who understood English well, declared several times that Brook was interpreting falsely what Rauparaha was saying giving to it an offensive menacing construction that was wrong. After Rauparaha had used the expression - "they had better try" - Wakefield and those with him left and went back to the other side.

Very soon afterwards, the old Māori whaler, Tom, cried out that the Pakehas were going to fire, and would do so after giving warning three times . And such was the fact heard the order given, and saw the guns levelled by the Pakehas, who were in a line on the bank on their side of the Tua Marina. Two Māoris were shot dead, they were in such a position that they were both killed with one bullet. The Māoris lay down on the ground to escape the fire, and did not return it till they saw the Pakehas crossing over on the canoe. They then began, and several Pakeha on the canoe fell.

The Pakehas then began to retreat, and to ascend the hill. The Māoris followed after, and soon the Pakehas held up a white handkerchief, on which the Māoris stopped firing, but immediately afterwards a Māori cried out that Rangihaeata's wife had been killed; she was Rauparaha's sister as well. On which Rangihaeata said there should be no mercy or terms now, and then the massacre was committed.[5]

From this single example, Boast (2003) identified that there were ramifications for Ngāti Toarangatira even though Governor Fitzroy in 1844 identified that the Pākehā were in the wrong. Boast (2003) explained the immediate impacts which included a departure of a large number of iwi members to Wellington; the kidnapping of the Ngāti Toarangatira Chief Te Rauparaha, and his subsequent confinement in Auckland (designed to minimise his influence/actions); the confiscation of the tribe's weapons and ammunitions; and the shifting of commerce and trade from Ngāti Toarangatira strongholds in the Port Underwood to Nelson. By 1847 the environment was ripe for Governor Grey to complete the Wairau Purchase which covered 608,000 acres. Iwi were simply disenfranchised from their own lands. It is important at this point for the reader to take the time necessary to consider what

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[5] www.marlboroughonline.co.nz/index.mvc?articleid+294.

the ramifications of this single example might mean to Ngāti Toarangatira and their descendants' wellbeing.

Briefs of Evidence presented at Te Tau Ihu Waitangi Tribunal Hearings (which commenced in the late 1990s) clearly evidenced a range of Treaty breaches[6], and each of the eight manawhenua iwi took the opportunity to identify the impacts. These included the intergenerational effects on their health.

2.4   Colonisation Impacts

A centrifugal approach would suggest that not only for Ngāti Toarangatira, but for all Iwi within Aotearoa, consequences of colonisation through the loss of tribal land, assimilation policies, and legislation that supported the transfer of power and resources to Pākehā, are apparent in the disparities we now face between Māori and non-Māori.

The Honourable Tariana Turia, Minister of Māori Affairs once described the trauma suffered by Jewish survivors in the holocaust of World War II, as similar to that of Māori and other indigenous populations as a result of colonialism.[7] This caused outcry at the time and resulted in the New Zealand Prime Minister ruling that the term 'holocaust' must never be used again in a New Zealand context.[8] Durie (2003. p 272), describes the loss of Māori land, voice, culture, population and dignity as 'cataclysmic'. Quince (2007), describes it as decimating entire generations of Māori and Sorrenson (1956) talks about mana[9] Māori being destroyed. In 1768 there were an estimated 240,000 Māori in New Zealand. After pākeha settlement by 1867 the Māori population dropped to 60,000 through inter tribal wars, pākeha land wars, and pākeha diseases (Sorenson 1956).

Land wasn't owned by the individual, it was a tribal collective resource handed down the generations (Walker 1987). There is a Māori proverb that says "Te toto o te tangata he kai. Te oranga o te tangata he whenua", the translation of which means "the lifeblood of a person is derived from food, the livelihood of a people depends on the land". Land provided for the wellness of the tribe. For example, it provided sustenance in terms of its food supplies; weaving materials in terms of clothing, mats and baskets; timber for waka (canoe) and other natural resources for tools and weapons. Ngaruru (2008, p 2) articulates a Māori world view around the importance Māori associate to their lands:

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[6] For further detail see Waitangi Tribunal Wai 785 Briefs of Evidence.
[7] NZ Herald 31/8/2000 'What Tariana Turia said in full'
[8] NZ Herald 6/9/2000 'Holocaust apology puts Minister in Hot Water'.
[9] Prestige, authority, control, power, influence, status, spiritual power, charisma

whenua is a significant part of our well-being. We have a physical (environmental), spiritual (mauri), psychological (ora) and cultural attachment similar to that of any other country's Aboriginal people. Land gives identity and identifies cultural and customary difference.

Land is a source of identity for Māori. When Māori stand and introduce themselves 'ko wai au' (who am I), this inevitably includes identification of their whakapapa (family geneaology), their mountain and the rivers they link to. Associated to those tribal lands are wahi tapu (sacred sites), and tribal histories, therefore there is a very strong spiritual connection to the land (Mead 2003).   This is why the lands were so heavily protected against invasion from other tribes, and deceitful government policy and actions.

So think about what it meant for Māori as they continued to lose their lands, and the impact this had on 'ko wai au' (who am I).

In addition,   commercially as settlers arrived in the Nelson area,   Ngāti Rarua were supplying produce and trade at Auckland Point in Nelson.   Governor George Grey confiscated 371 acres at Te Maatu in Motueka for the Anglican Church with no payment given to the owners of the land. [10]   This had an immediate impact on not being able to produce goods for their own whanau and for trading purposes.   Māori were also heavily involved in the fishing industry.   By the 1850's, one third of the sailing ships at Port Nelson were owned by Māori and these ships were also servicing Australia.[11]   Overtime, Māori were displaced and marginalised within the fishing and shipping industry (Mermon and Cullen, 1992).   There was over a century of government suppression of the Māori language which became close to extinction (Walker, 1987) before a concerted effort to revive it in the 1980s through the Kohanga Reo (Māori language nests) movement.

From a health lens,   Robson and Harris (2007), discuss that colonisation established new systems that determined how resources were allocated and therefore who would benefit. They suggested that over time,   inequities in health outcomes between Māori and non-Māori were created through a system built and still controlled by Pākehā/non-Māori.   The disclocation of most indigenous people from their land has contributed to poorer health, and if we are seeking a difference in outcome, the most effective programmes are those that acknowledge the impacts of land loss, the removal or marginalisation of children from their

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[10] www.nrait.co.nz
[11] www.nrait.co.nz

families and culture, and the marginalisation of advantages by the coloniser (Cunningham and Stanley 2003).

In terms of this, historical trauma is about exposure to a traumatic event that continues to affect subsequent generations, emotionally and psychologically (Hill et al 2010, Mullan-Gonzaelez 2012, Walters 2012).

Braveheart (2005), links historical trauma to the 'contemporary' space, and describes it as the '*cumulative emotional and psychological wounding across generations, including ones own life span because everything up to a minute ago is history'* (p.3).

Certainly the New Zealand experience of colonisation supports the 'series of events'. As such, Māori social and health problems can be attributed to historical trauma as Farelly et al (2005) suggest, that Māori developed coping mechanisms to deal with the trauma including a number of negative behaviours (Tuhiwai-Smith & Reid 2000).

Intergenerational trauma arises out of historical trauma and is transmitted through to secondary and subsequent generations.   Sotero (2006), conceptual model of historical tauma aligns to Māori experiences of subjugation, that is,   segregation/displacement (development of Māori reserves); the physical and psychological violence (both acute and chronic);   economic destruction (loss of resources and legal rights);   and cultural dispossession (loss of cultural roles such as Tohunga,   and the loss of language). Transmission of trauma responses by the first generation to subsequent generations includes physical responses, e.g diabetes, infectious diseases etc;   social responses such as increased suicide rates, domestic violence, unemployment;   and psychological responses such as post traumatic stress, depression, anxiety disorders etc.   This ultimately results in a breakdown of our overall wellbeing.

Intergenerational historical trauma and oppression is now being recognised within the mental health field (Wharewera Mika 2012), however it is often misunderstood and therefore not treated appropriately (Walters 2006).   Braveheart (2005) suggests that to heal historical trauma we need to confront the trauma,   embrace and understand that history, release the pain, and then transcend the trauma from 'victim' to 'survivor'.

While this thesis does not investigate a direct link between land loss and mental illness, it is nonetheless important to provide some context on how colonisation has impacted on Māori wellbeing.

2.5   Researcher Positioning

The Tukituki Patu Aruhe battle in the mid 1820s (one of the reasons for the taua/war party to descend upon Te Tau Ihu and avenge an insult to Te Rauparaha) resulted in an arranged marriage between Te Rauparaha's nephew Te Kanae of Ngāti Toarangatira and Mere Te Rapu, daughter of the local Rangitāne Chief Ihaia Kaikoura. The children of these arranged marriages were referred to as '*takawaenga*' and their role was to maintain intertribal stability. Te Kanae and Mere Te Rapu lived at Wairau, their daughter Hera Titahi (Sarah) married Te Hiko te Oka of Ngāti Toarangatira. They had two children, Hanikamu Te Hiko and Mere Te Hiko. Through another arranged marriage Mere Te Hiko married Hapareta Rore Pukekohatu (aka Alf Rore) who was the last recognised Ngāti Rārua Chief of the Wairau rohe (district). Mere and Hapareta were unable to have children of their own and legally adopted my grandmother Mere Te Aka (who was the granddaughter of Hanikamu Te Hiko). There are also close whakapapa ties with Ngāti Tama as Hanikamu Te Hiko married Ngawaina who was the daughter of Paremata Te Wahapiro of Ngāti Tama/Ngāti Toarangatira descent and Ngamianga (who was given in marriage to Paremata by a Ngai Tahu Chief Taiaroa from Otakou).

Therefore I have certain responsibilities to Iwi and the wider community within Te Tau Ihu and over the previous 20 years this has encompassed a number of roles with Wairau Pa Marae; trustee roles with Ngāti Rārua Iwi Trust and Ngāti Toarangatira Manawhenua Ki Te Tau Ihu Trusts; directorship roles on Iwi Professional Services; and Te Tao Tangaroa fishing companies and Manager for Ngāti Rārua Iwi Trust. From a health perspective, roles have included membership on the Marlborough Māori Advisory Komiti (to the then Nelson Marlborough Health Services), the establishment of Te Hauora o Ngāti Rarua Ltd health services, representing Ngāti Toarangatira interests on Poumanawa Oranga (Māori Development Organisation[12]) and establishment of the Iwi Health Board. More recently, in completion of a Master of Arts degree, the kaupapa (in this context kaupapa means 'subject') for the thesis was exploring Marlborough Māori experiences in accessing primary mental health care services[13]. The findings from this research were then used in ensuring that recent Primary Mental Health Initiative funding contracts included a separate pathway to General Practice extended consultations and individual packages of care for Māori.

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[12] Maori Development Organisations were established to assist strengthening the Māori Health and Disability Sector, the emphasis on better integration and co-ordination of care; and assisting Māori health development. Ko Te Poumanawa Oranga service coverage area was Te Tau Ihu (Nelson/Marlborough), and their membership included all eight Māori health providers,   several iwi, and other interested Māori health and social service providers (non District Health Board funded).

[13] Primary mental health is the assessment, treatment and ongoing management (where required) of people with mental health and/or addiction problems within a primary care setting.

This study is about extending the Master's of Arts thesis findings, so that any additional research might add value to whānau, hapu and Iwi.

2.6 Contemporary Te Tau Ihu

In terms of understanding contemporary Te Tau Ihu, it must be noted that the demographic landscape has changed over the last 180 years. Manawhenua comprise the minority of Te Tau Ihu Māori population, the balance being made up of maata waka[14]. Nelson Marlborough District Health Board (2007), estimates that between 75-80% of Te Tau Ihu Māori are affiliated with iwi who are outside of the traditional boundaries of Te Tau Ihu.

The higher number of Māori resides in the Marlborough district, followed by Nelson and then Tasman. From the 2006 Census, the total Māori population for Te Tau Ihu is 10,953 which is around 8% of the total population, but this is expected to increase to 30% by 2016. While just over 90% of all Māori live in the North Island (Te Rau Matatini 2008), only 10% of the Māori population live in Te Waipounamu (South Island). Te Tau Ihu Māori are more heavily skewed in living in higher deprivation[15] areas than non-Māori. Of most concern is in the Nelson City area where 48% of Māori live in deprivation areas 8, 9 and 10.

Waitangi Tribunal Hearings have been concluded, findings released, with Iwi currently negotiating settlement with the Crown in terms of cultural and economic redress relating to Crown breaches of Te Tiriti o Waitangi.

Understanding health in this context is useful, as Māori are the minority population in Te Tau Ihu.

2.7   Two decades of Māori Health Development

There are several 'by Māori for Māori' health services provided within Te Tau Ihu. The establishment of specific Māori-based services commenced in the 1990s under the Central Regional Health Authority and Nelson Marlborough Health Services, as did the drive to ensure that an avenue was available to provide advice and guidance to hospital based services being responsive to Māori. Subsequently, over the last two decades eight Māori health providers have been established and deliver a range of whānau ora (family wellbeing), disability, health promotion and community mental health and addiction services. The

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[14] Iwi groups living outside of their traditional rohe (area).
[15] The New Zealand Deprivation Index has a rating of 1 to 10. Deprivation area 1, represents those areas with the least deprived scores through to Deprivation area 10 which has the most deprived score. Dimensions of deprivation are measured on income, home ownership, support, employment, qualifications, living space, communications, and transport.

providers' base locations are fairly well positioned geographically. For the Tasman district, these include Te Āwhina Marae and Te Amo Health. For Nelson, Whakatū Marae, Te Korowai Trust and Te Kahui Hauora o Ngāti Koata; and for the Marlborough District, Mata Waka, Te Hauora o Ngāti Rārua and Te Rapuora o Te Wai Harakeke.

2.8 Summary

It is important to provide this context, as it provides a very brief overview of Iwi in Te Tau Ihu, an example of how Crown actions (or inactions) impacted on Māori wellbeing.   Colonisation was not a single event that occurred in 1840. Māori through the generations have been and continue to be affected.   Finally, the Chapter describes how I am positioned within the research including that unwritten responsibility to assist Iwi and Māori development within Te Tau Ihu. This then sets the scene for choosing an area of research that aims to better understand the experiences of Māori in an acute inpatient unit setting.

The next Chapter will review mental health policies and development from the 19th century to contemporary times, and will also include a local perspective on events.

Chapter Three: Mental Health 'facility', legislative and government policy developments

3.1 Introduction

In the last 160 years, those who required hospital admissions for their mental illness, had differing experiences based on the policy relevant to that timeframe. From the stark early days of placements in gaols (jails) with criminals, to the current new wave developments of primary mental health, this chapter will explore the legislative framework of mental health service provision, and align this to local developments within Te Tau Ihu. Māori involvement (as expected) has been sparse over this time, therefore there are 'threads' of information that provide some context from a Māori viewpoint.   This chapter briefly aligns to Durie's (2008) mental health and transformation of care and system changes that have occurred over the last 170 years. New Zealand has shifted from an institutionalised approach (containtment at psychiatric hospitals and asylums), to deinstitutionalisation (replacing long stay psychiatric hospitals with less restricted mental health services based in the community), to community care (developing a wider range of services based in the community that support people living more independently), and now primary care (strengthening primary care capacity and capability in primary mental health) is taking a higher profile. Durie (2008) envisaged that Whanau Ora (family empowerment to address their overall wellbeing, across a number of dimensions) would be the next stage of transformation.

3.2 Synergies between Māori land and location of asylums

Research indicates there is not a huge range of material relating to Māori experiences of mental illness and mental health service provision, (Brunton, 2001, p. 36) and it has been difficult to source any material relating to Iwi or Māori involvement in mental health within Te Tau Ihu before the early 1980s.

As stated previously in Chapter One, there were eight iwi resident across the Marlborough, Nelson and Tasman districts in 1840. Pākehā contact had occurred previously, leading up to the New Zealand Company's first settler ships arriving from Britain in 1842; however, the majority of land remained under the ownership of iwi. The New Zealand Company had a reputation for dubious land purchases from Māori. In Nelson, this was no different. Properties for government public purposes such as hospitals, cemeteries, schools, parks and so on were required to be set aside as government reserves by the New Zealand Company, prior to the rest of the town sections being allocated to settlers or for Māori. Whichever lens you use, asylums, gaols and mental hospitals were built on land originally belonging to iwi, and iwi

were disenfranchised from their lands. As discussed in the previous chapter, Māori experienced significant economic, social and cultural change and this impacted on their health and overall wellbeing.

3.3   1846 to 1864 Mental Health developments in Te Tau Ihu

The 1846 Lunatics Ordinance provided the first basis for compulsory detention in New Zealand prisons. As a sign of the times, those people who were experiencing mental illness were housed in the same facilities as those with disabilities or who were criminal offenders (Brunton, 2001, p. 60). It is unknown whether this ordinance resulted in Māori being detained locally. However, there was some indication in 1848, (perhaps the first written report of a local Māori experiencing mental health symptoms) when the Nelson Examiner reported on 22 April that a Māori from Wakapuaka is 'allowed to be at large in the place, subject [sic], as he undoubtedly is too pitiful, and what may prove dangerous aberration of the mind'. It is not known what happened to this individual.

Aligned to the Lunatics Ordinance, in 1850 a local Gaol opened in Shelbourne Street, Nelson and this was used to house 'lunatics' and prisoners (Webby, 1991). According to Mitchell (2008) there is evidence that not only was a Pākehā cemetery located on this site, it was also the site of a Māori urupa. Lunatics were however occasionally admitted to Nelson Hospital before 1854 when local doctors agreed that the hospital should be furnished with proper accommodation for the insane (Brunton 2001 p 69). The first 'Lunatic Asylum' was opened in Nelson in 1861 (Webby, 1991).

Ramari Herewini was of Ngāti Rārua descent and was admitted to this asylum. She is likely to have been admitted prior to 1864, as she is not mentioned in the 1864 to 1892 admission registers; and McKay's Compendium identifies that Ramari was in the Nelson asylum during the Whakarewa[16] land confiscations. During Governor Grey's acquisition of the Whakarewa block in Motueka in 1853/1854, Ramari challenged and protested the Crown's 'acquisitions' of Iwi lands (MacKay 1871-1872). Mitchell and Mitchell (2004) identified that:

> Ramari Te Kauri (Mrs Herewini) and her family were evicted from their occupation reserve land taken to provide for the school. Mrs Herewini may have been inclined towards episodes of psychiatric illness but her descendants believe that through stress of being forcibly removed from her family's lands and cultivations, she had to be confined to the Lunatic Asylum at Nelson.

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[16] Whakarewa involved the alienation of 918 acres of Native Reserve lands in Motueka to Governor Grey, who granted this land to the Anglican Church in 1853.

Ramari never gave up the fight to regain Whakarewa and was vocal in late 19th century land court hearings. As her descendants have indicated there was significant stress and trauma associated to losing her lands.   She did not give up and neither did her direct descendants who through the generations took active roles in seeking the return of these lands.   Brunton (2001) identified that psychiatry and asylums arose out of default due to the social problems in the mid 19th century including poverty and non-productive members of society. In this instance, one could suggest that Ramari became a 'social' problem due to her resistance to the loss of her lands. In addition, under the Lunatics Ordinance, it was expected that the financial responsibility for a patient's care was the individual's or their relatives'. When an individual had no financial resources, then the State would pay for their care (Brunton 2001 p 22).

On 29 December 1869, the Appendices Journals to the House of Representatives (1869) records Ramari Herewini (post discharge from the asylum) giving the following evidence:

> My name is now Herewine (Selwyn). My land was called Matakino-kino (now sections 1 to 9, also 10 & 11 Rewaka, this side of Motueka). It was mine before I was ill. It was land of my forefathers. I lived there till I went to Nelson.

Again, 15 years later, the Appendices Journals to the House of Representatives (1884), records Ramari petitioning government for the return of Whakarewa lands. This petition in 1884 identified that:

> Petitioners wanting Whakarewa land returned (given by Natives for school site and for children to cultivate, may be returned to them as there is no school and the land is lying idle.

Nearly twenty years later Tapata Harepeka gave evidence supporting Ramari's cause (Royal Commission 1905):

> When Mr Baker's school ceased, Ramari Herewini, one of the owners of the land informed the Bishop that the school had ceased and she wanted the land returned. That was when Bishop Suter bade farewell to Mr Baker on his leaving the district.

Tapata was then asked 'was that the woman who had gone to the asylum because she was ill', to which Tapata's response was in the affirmative.

Ramari Herewini's case is an example of a woman who is likely to have had a biological basis to her mental health condition, and with the stress associated to losing her lands, this probably exacerbated her condition. Ramari was forcibly removed from her own land, protested accordingly and eventually ended up in the asylum. In addition, the rentals from the land forcibly taken was managed by the Native Trustee, and these rentals paid for Ramari's care while in the asylum 'for that maintenance during my illness', *(Appendices Journals to the House of Representatives 1970)*. Asylums in the early days were predominantly holding cells, very little was attempted in the way of treatment locally (Brunton 2001 p 98), and given the injustice that occurred to Ramari in terms of land evictions, the utilisation of her own income, and continued battle to have lands returned, one can certainly understand the impact on her mental wellbeing.

There were other Māori who were admitted to the asylums in those early years, but they were few and far between. Prior to the opening of the first Lunatic Asylum in Te Tau Ihu in 1861, there were a number of *'lunatics'* confined (special wards housed lunatics in the Nelson general hospital 1854 to 1864 as well as the Taranaki buildings [which were also based in Nelson*]*) which were originally used for refugees from the Taranaki wars, Brunton (2001).

In 1861 there were five admissions, only one of whom was Māori. All of the confinements in those early years were aged between 28 and 49 years of age (National Archives 1861-1877). Emily Tari, at the age of 29 was committed on 29 May 1857. The Nelson Government Gazette in 1863 identified that there were six female lunatics, one who was Māori and who had been discharged. Whether this is Emily Tari is unknown. In 1864, females were shifted to the Taranaki buildings in Waimea Road (Webby 1991).

3.4   1864 to 1910 Mental health developments in Te Tau Ihu

The Nelson Lunatic Asylum Report Book from 1864 to 1892[17] had a total of 591 admissions, of which only seven were Māori, three of the seven being of manawhenua descent and these individuals held land rights within Te Tau Ihu. The total number of Māori over a 28 year period is low at 1.18% of total admissions. Five of the Māori admissions were sent from Taranaki to the Nelson Lunatic Asylum by the New Plymouth Resident Magistrate, including Eurangi who held land interests in Te Tau Ihu. This was subsequent to the Taranaki Land Wars where a number of Te Ātiawa/Ngāti Awa returned to support the cause. Eurangi definitely held land

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[17] The Nelson Lunatic Asylum Report Book 1864 to 1892 was sourced at the National Archives.   Admission references for Tamati Parana, Eurangi, Riri Te Ra, Frederick Charles Whitiwa, Hemi Kuki and Rangi Te Ao derive from this source.

interests in Te Tau Ihu, and it is possible given the close whakapapa links, that the remaining Māori also held some form of customary interest in Te Tau Ihu.

Tamati Parana was admitted on 30 October 1873. Tamati was of Ngāti Awa descent and held land interests in Marahau. Tamati was discharged by order of the Superintendent on 30 December 1873, therefore was confined for a two-month period.

In 1876, a new asylum was opened in Waimea Road of approximately eight acres based at Braemar (Webby 1991). Six years later, Rangi Te Aio was transferred from gaol at New Plymouth to the asylum and died two years later of natural causes while in the asylum.

In 1884, Eurangi of Hawera was admitted and he died eight months later of natural causes in the asylum. He was buried the day after his death on 15 October 1884 at Wakapuaka.

In 1885, Riri o Te Ra was admitted and he also died seventeen months later while in the asylum due to exhaustion from general paralysis. In the same year, Frederick Charles Whitiwa was admitted, and in 1886 Hemi Kuki (*both from New Plymouth)*. Within the register of admissions there is no discharge or death data for Frederick or Hemi.

Given the higher number of Māori in the asylum were from New Plymouth subsequent to the Taranaki land wars (*between Te Atiawa and the Crown*) once again the loss of land, the fight to retain these lands with substantive loss of lives, could have been a contributing factor on their mental wellbeing.

The Lunatics Act 1882 was the first piece of legislation for detaining people with mental illness in New Zealand. The wording would not pass the political correctness test in contemporary times as it included, 'lunatics', 'idiots' and 'imbeciles', but it did provide the opportunity to separate those with mental illness from the prison system clientele.

There is limited research material available in relation to mental health within Te Tau Ihu from a wider Iwi perspective. At the 1901 Māori Land Court hearings, Iwi collectively met to discuss a number of issues. A number of leading chiefs identified their concerns regarding the impact of alcohol on their tribes (*The Colonist*, 1901). These included Tapata Herepeka of Ngāti Rārua. The concern predominantly focussed on halting the widespread uptake of alcohol to curb the effects it was having on whānau, hapu and Iwi. The Colonist (1901) also identified that in the Wairau a special bylaw had been passed by Iwi of the Wairau Pa that any Māori found in the Pa under the influence of alcohol was fined five shillings.

Dow (1999), identified that in 1901 South Island iwi made up only 6% of the total New Zealand Māori population. Thus there may have been uneven distribution of medical services for Māori. Administrators of the Nelson Native Reserve Fund used its revenue for the payment of Native Medical Officers. The extent of mental health problems is not known from Native Medical Officer reports, nor the extent of resources used for admissions in the asylum.

A change in legislation through the Mental Health Defectives Act 1911 included persons of unsound mind, persons mentally infirm, idiots, imbeciles, feeble minded and epileptics. The word 'lunatic' for the first time did not appear in the legislation. A mental 'defective' was categorised as a person who because of his mental condition required oversight, care or control for his own good or in the public interest. In those earlier days there was a merging of care for individuals with intellectual impairments and mental illness, and the Nelson institutions for a long period of time were no different. Subsequent to this legislative change in 1912 there was an official change of name from the Nelson Lunatic Asylum to the Nelson Mental Hospital.

3.5   1920 to 2000 Mental Health Developments

In 1920, the Education Department purchased an Industrial School Building at Ngawhatu in Stoke, Nelson (Webby 1991). The original building at Ngawhatu was known as the St Mary's Orphanage which burnt down in 1903 and was rebuilt and used by the Education Department as a training school for delinquent boys (Nelson Provincial Museum). In 1922, there was a transfer of most of the adult population to Ngawhatu from Nelson Mental Hospital. It was at this time that most of the earlier archival records were lost (Webby 1991).

In terms of prevalence estimates, Sacdev (1989) cites Beaglehole and identified that for the period 1925-1935, the crude rates per 100,000 population were 31 for Māori and 58 for Pākehā, and during this time the incidence of psychosis was lower for Māori.

In 1928 the first four villas were built in the valley above the main building at Ngawhatu and ten years later six more villas were built. This paved the way in the early 1930s for the Braemar complex to be condemned. Given the limited reference to Māori from the inception of the first Lunatic Asylum right through to the mid 1980s, the only indication of 'Māori' consideration was the names of the female villas being given Māori native tree names. Historically this is understandable given that Māori voice was tangential to most government planning processes.

Moving through to the early 1950s, Sacdev (1989) identifies that the crude first admission rates to psychiatric hospitals for Māori nationally during 1953 – 1957 were 68 per 100,000, reaching 178 per 100,000 by 1969. And in 1983 crude first Māori admission rates were 194 per 100,000. From 1925 to 1935 the crude rate was 31 and by the 1950s it had already doubled for Māori. Foster (1960 pg 30, 31) identifies the growth in Māori admissions by 10%, one in six first admissions for Māori were voluntary, but more than half of Pākehā admissions were voluntary, and Māori patients' length of stay was longer.

In 1954, the Mental Health Defectives Act was changed by the Mental Health Amendment Act 1954, which for the first time recognised the need for voluntary committals and the introduction of mental hospital housing/villas outside of an inpatient setting. This was another turning point in our psychiatric history with the separation of those with intellectual disabilities and mental health disorders into different institutions.

There were certainly challenges for the sector in the early 1960s. The Minister of Health stated (Board of Health 1960 p. 4)

> the Mental Hygiene Division has been understaffed, overworked and has had a very trying type of patient to look after, and there has been a tendency for staff to be lost for these reasons.

Some might suggest that there have been minimal changes over the past 50 years. Stigma was apparent for those who worked within the sector to the extent that the Board also recommended pay parity for psychiatrists whether they worked in the Mental Hygiene Division or the Hospital Board. Even then there was acknowledgement that resources were inadequate to meet the demand of mental illness within their communities.

A census of mental health patients taken in 1966 (Department of Health 1968), identified that at Ngawhatu there were 326 males and 322 females. Most of the patients (50%) had been in hospital for 20 years or more, with 25% of patients being over the age of 65, and 32% being aged 45 to 64 years. The main diagnostic groups were mental deficiency at 51%, schizophrenia at 27% and senility at 8%. At the same time in Braemar there were 120 males and 103 females, with 96% of the patients having a diagnosis of mental deficiency. Age ranges differed significantly with only 1% over the ages of 65, 4% in the range 45 to 64 years of age, but 56% of patients were under 15 years of age, and 30% 15 to 44 years of age.

The Mental Health Act 1969 replaced the Mental Health Act 1911. In essence, this legislation covered both committal and voluntary treatment and provided more clarity around those with a mental illnesss, those with intellectual disabilities and those who were infirm (arising from age or deterioration or brain injured). This Act in essence was the driver for the development of community care in less restrictive settings.

In 1972 there was a transfer of responsibility from the Department of Health Division of Mental Hygiene to Hospital Boards. This signalled the commencement of the community care era, where there were expectations of a separation of care from treatment. To accommodate this shift, a number of community based services were required in tandem with mental health inpatient services being provided within a general hospital setting. The commencement of this 'separation' is best reflected in a comment from the Ngawhatu Assistant Head Nurse in the early 1970s:

> … the most important worthwhile aspect however, is the emergence of the patient as the most important person in the change. No longer a statistic, no longer a passive recipient of medical and nursing care, but a person with a background, an illness and one hopes a bright future. The nurse's job with this important person is therefore obvious, with nursing skill and technique, with understanding, with encouragement, this person, where able must be cared for, made well, or in the apparent good health and returned to their homes and the community expeditiously. (National Archives New Zealand 1969-1971)

This statement recognises respect of the individual in terms of supporting and assisting them on their recovery journey. However, in practice there may have been challenges in implementing the intent. Thirty-two years later, in 2004, four former Ngawhatu patients lodged formal complaints of abuse while in the institution, including allegations of experimentation on patients[18]. The patients claim that they were victims of sexual and physical abuse from staff members and were given electric shock therapy as punishment. By 2007, a further five patients had lodged complaints, all of which stemmed from the 1960s and 1970s era[19].

In the early 1970s, there was some record of improving awareness of Māori culture, where a combined hospital group which also included members from the public, performed at certain events. After pouring through National Archives and the Nelson Provincial Museum Records it was pleasing to note that after 100 years of the provision of acute mental health inpatient

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[18] Nelson Mail (June 29, 2007). *Ngawhatu Part of Damning Report.*
[19] The Dominion Post. (1st October, 2007). *Disabled man lodges $200,000 sex claim.*

services/gaol/asylums etc, a record was found where attempts were finally being made to understand (albeit small) Te Ao Māori (Māori worldview).   The minimal impetus to directly address the rising Māori mental health utilisation of services is understandable given the Health Act 1956 had no reference to Māori,   and the only reference in the Mental Health Act 1969 was in relation to administering Māori patient's estates through the Māori Trustee.

The Department of Health conducted a survey of patients in psychiatric hospitals in 1974, and there was a change in the number of patients at Ngawhatu. There were 549 patients compared to 648 in 1966. There remained a blend of mentally 'subnormal' (338) and psychiatric (211) patients.

The change to a more community-focussed service resulted in a number of Ngawhatu villas not being used. In 1985 Whakatū Marae was the recipient of Toitoi Villa from the then Nelson Hospital Board, which is still utilised today[20].

Around the 1980s, Ngawhatu was predominantly made up of long stay patients, and 56.3% were intellectually handicapped (Dowland & McKinlay 1985). It was in this decade that the provision of culturally responsive services for Māori came to the fore. Dowland and McKinlay (1985) did not identify Ngawhatu's position in relation to her four identified levels of cultural diversity but certainly highlighted those institutions such as Carrington and Tokaanui where gains were being made in providing culturally appropriate responses.

The Mental Health (Compulsory Assessment and Treatment) Act was introduced in 1992. This provided a new definition of mental disorder, solidified the importance of the community care approach, focussed away from detention to assessment and treatment, had an appeal and review process, acknowledged the importance of cultural factors in diagnosis and treatment, and introduced more focus on patient rights.

Accordingly, planning commenced on devolving services out into the community. The Central Regional Health Authority (1996), commenced a consultation process with local communities. Māori within Te Tau Ihu had concerns that the Māori Liaison Service should be invited to contribute towards the assessment process, and that providers in the community would need operational and financial skills to ensure the success of Community Residential Services. Māori also held concerns about the role of whānau, and the impact devolvement would have

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[20] Nelson Evening Mail, 20th September 1984.

on whānau caring for tangata whaiora. There was an indication at that time that a monitoring programme for Māori receiving home or marae-based care would be introduced.

Devolvement had occurred in July 2000 when patients were transferred to the new unit at Tipahi Street and/or community residential providers, and the existing Ngawhatu Hospital was purchased by the McCashin family of McCashin Breweries. During the devolvement process a number of community non government organisations were established to assist with the mental health community supports. This included services such as community housing, home based supports and day activity. It was also around this time that the Central Regional Health Authority commenced working with the community to develop Māori mental health and addiction services.   As such, for all Māori health providers (and many non-Māori health services), there was and continues to be an expectation that services are delivered within a Kaupapa Māori framework,   including models of health that were developed and designed by Māori.   These models are holistic in their approach and do not simply focus on a health issue, but the overall wellbeing of the individual, and their whanau. To improve Māori health, providers address elements within the model to make the gains needed.   There are a number of models, however Te Whare Tapa Wha, Te Wheke, and Te Pae Mahutonga are probably the most well recognised.

Te Pae Mahutonga was developed by Professor Mason Durie and is based on the Southern Cross star constellation. It is made up of six stars aligned to elements of a modern health promotion framework.   The stars are Mauri ora (cultural identity),   Waiora (physical environment),   Te Oranga (participation in society),   Toiora (healthy lifestyles),   Nga Manukura (community leadership) and Te Mana Whakahaere (autonomy).

Te Wheke was developed by Rose Pere and is based on an octopus (te wheke) and its eight tentacles, all of which contribute to wellbeing.   The eight tentacles include Wairuatanga (spirituality),   Mana Ake (unique identity of individuals),   Mauri (life force in people and objects), Hā a koro ma a kui ma (breath of life from forebearers), Taha Tinana (physical wellbeing), Whanaungatanga (extended family), Whatumanawa (the open), Hinengaro (the mind).   The head of the octopus represents the individual and the family unit.

Te Whare Tapa Wha was also developed by Professor Mason Durie. The framework is based on the premise that there are four walls to a wharenui, and if any of those walls are damaged or unbalanced, the consequences of this affect the stability of the entire wharenui (or one's wellbeing). To maintain tangata whaiora wellness, services need to focus on all four

walls of the wharenui that is te taha hinengaro (psychological health), te taha wairua (spiritual health), te taha tinana (physical health), and te taha whānau (family health).

However, regardless of embedding Māori models of care within services, the increasing trend of hospitalisation rates continues. Between 2003 and 2005 the mental health hospitalisation rate for Māori females was 570.8 (95% confidence intervals) per 100,000 and 745.4 for Māori males. Combined for both Māori males and females the rate is 658.1 per 100,000. In comparison to non-Māori, their rate is significantly lower. Non-māori females were 379.2 per 100,000, and non-Māori males 348.7, a combined rate of 364 per 100,000 (Robson and Harris 2007).

3.6   Contemporary Government Policy

The New Zealand government has clearly recognised the disparities between Māori and non-Māori health. This has contributed towards a number of health strategies and policy development designed to improve Māori health. The *New Zealand Health Strategy (2000),* is the government's overarching health strategy, which acknowledges a special relationship between Māori and the Crown under the Treaty of Waitangi. It identifies Māori health as one of its key priorities and several subsidiary strategies have been launched to assist meet its national objectives for achieving Māori health gain.

Four subsidiary strategies play a pivotal role in terms of Māori mental wellbeing. The key objectives outlined in *He Korowai Oranga – The Māori Health Strategy (2002.a)* are to improve access to appropriate services for Māori, improve Māori health outcomes and support Māori health provider development. *Te Puawaitanga Māori Mental Health National Strategic Framework (2002.b,* suggests that opportunities need to be maximised for intra- and intersectoral co-operation. These include objectives to improve training for General Practitioners and other health workers providing primary health care to Māori tangata whaiora (*users of mental health services)*, with a focus on depression, anxiety, youth suicide and addictions. Its follow up policy, *Te Puawaiwhero the Second Māori Mental Health and Addiction National Strategic Framework (2008),* was strengthened from the New Zealand National Mental Health Survey (*Te Rau Hinengaro)* findings and used this evidence to suggest planners, funders and service providers needed to prioritise Māori mental health and addiction development. *The Primary Health Care Strateg*y (*2001)* aims to build a strong primary health care system that will improve the health of all New Zealanders and in particular will focus on reducing inequalities in health. *Te Tahuhu – The Second New Zealand Mental Health and Addiction Strategy (2005)* has, as one of its ten challenges, a stronger emphasis on primary health care. This challenge aims towards '*building and strengthening the capability*

of the primary health care sector to promote mental health and wellbeing for tangata whaiora', and for the New Zealand health system to '*continue to broaden the range, quality and choice of mental health and addiction services accessible for Māori*.'

In essence, when reviewing and summarising these strategies in relation to Māori mental health and primary healthcare provision, the aims of the strategies centre on reducing barriers for Māori in terms of accessing services, and improving the quality of services provided. This necessarily aligns to building both Māori and non-Māori capacity workforces (Ministry of Health 2000 p. 47 & Ministry of Health, 2006 p. 47).

3.7 Summary

This chapter briefly signalled the transformation of care and system changes, described by Durie (2008). In summary, this includes institutionalisation, deinstitutionalisation, community and primary care. The primary mental health care stage is relatively new and will be dealt with in further chapters. While Whānau Ora[21] can be considered the fifth and final stage in terms of system changes, the policy is relatively new in its infancy. Whānau Ora provides scope for whānau to truly be at the centre of care, with whānau taking the lead role in determining the services that support their whānau wellbeing.

What we can see from the Nelson Lunatic Asylum Report Book of 1864 to 1892, is that there were only seven Māori admissions over a 28-year period, and this comprised 1.18% of total admissions. Some of these tūpuna were deported back to Te Tau Ihu during the Taranaki Land Wars and, as for Ramari Herewini's vocality in trying to retain her land rights, one could understand the impact fighting for the retention of your land has on mental wellbeing. As identified, there has been a reversal of need between Māori and non-Māori. Historically non-Māori had higher utilisation rates, unfortunately we find now that Māori utilise inpatient services more frequently than non-Māori.

In the 19th century, land confiscations, land evictions and the fight to retain land interests could have been major factors in Māori admissions at that point in time.

New Zealand's legislation framework has determined the growth and changing models of care for mental health, and this has been reflected at a local level. From the 19th century right

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[21] Whānau Ora is now government policy introduced in 2010 driven by a focus on outcomes. The aim is that whānau will determine their own pathways, they will be empowered to do so with providers/agencies working inclusively by supporting whānau in terms of self management, healthy lifestyles, participating fully in society, economically secure, successfully involved in wealth creation, being cohesive, resilient and nurturing.

through to the 21st century Nelson has had facilities to house the most acutely unwell, with a rich history surrounding their development.

The previous chapters have set the historical context of Māori and mental health in Te Tau Ihu. The next chapter will start to explore Māori health status and compare whether Te Tau Ihu Māori health is statistically aligned to Māori health nationally. This will then set the scene for further exploration around Māori mental health.

Chapter Four : Hauora Māori

4.1   Introduction

This chapter will compare Māori health status nationally to that of Te Tau Ihu Māori, and where available contrast with non-Māori health status. It will identify the role of primary health care and its importance in terms of earlier intervention. The interface between physical and mental health conditions will be noted, and the chapter will also offer reasons for the disparities between Te Tau Ihu Māori and Māori nationally.

4.2   Māori health disparities and gains

Nationally, the age-sex-standardised all-cause mortality rate for Māori was twice that of non-Māori (434 per 100,0000 and 213 per 100,000 respectively [95% confidence interval]). The Māori/non-Māori rate ratio was highest in the 45 to 64 age group and lowest in the 1-4 year age group (Robson & Harris 2007 p 33). There are clear disparities between Māori and non-Māori mortality rates. Within the health sector reducing inequalities was a major governmental focus and Māori were at the forefront of the most discouraging statistical data available. This chapter will highlight many of these disparities which emphasises that either more investment is needed or we need to do things differently, to improve Māori health.

Robson (2004), suggests that a wider global effort is still required to eliminate health disparities with a focus on the root causes. She identifies an example of cardiac interventions which were predominantly received by non-Māori, that colonisation and racism underpin health inequalities.   Racism in terms of how the majority culture perceives the reasons for Māori health inequalities.   Colonisiation in terms of the transfer of power, how resources are then allocated; and how health systems and services are developed.

At the same time, it is just as important to acknowledge the significant gains that have been made in the past few decades in Māori health. These include specific gains in the number of Māori health professionals, establishment of Māori Development Organisations; Māori Integrated Care Organisations; development of Māori health providers delivering by Māori for Māori health services; and Māori leadership influencing health policy development at a local, regional and national level. In most instances, this has had a positive effect on Māori health gain, but still disparities remain between Māori and non-Māori.

4 .3   Primary health care

The Ministry of Health (2001 p.1) defines primary health care as '*universally acceptable to people in their communities, involves community participation, is integral to and a central function of the New Zealand health system, and is the first level contact with our health system.*' In essence, primary health care is 'first point of contact' health services. The expectation under the Primary Health Care Strategy is that all primary health care services will include services that improve, maintain and restore people's health. Generically, this is the high-level intent of the strategy and aligns to the World Health Organisation definition of primary health care. Māori need to access general practice or primary health care services to seek help at the early onset of their health condition. If not, it is more than likely that their condition will escalate to higher levels of acuity, necessitating hospital or specialist intervention, or death.

Primary Health Organisations are responsible for delivering and co-ordinating primary health care services to its enrolled population and within a specific geographical service coverage area. This includes not only the traditional view of primary care, that is, General Practitioners and Practice Nurses, but also includes Māori health providers, health promotion workers, pharmacists, dieticians, in fact all those providers involved in first contact health service provision. Primary Health Organisations are required to target those populations with the highest health needs first, to improve access, reduce costs and inequalities in health.It is widely accepted that early access to primary health care decreases the need for hospitalisations (Abus, Vanderpyl, Robinson & Crampton 2003.; Davis, P 1997; & Horsburg and Lamdin 2004).

Māori as a population group have on average the poorest health status compared with the rest of the New Zealand population (Ministry of Health 2004). However, is there any difference between Māori in Te Tau Ihu and Māori nationally? The following provides a few examples and snapshot views of comparative Māori health status between Māori in Te Tau Ihu, non-Māori in Te Tau Ihu, and Māori nationally.

4.4 Te Tau Ihu Māori health status compared to Māori nationally and non-Māori Nelson Marlborough population.

The following table outlines a brief comparison between Te Tau Ihu Māori, Nelson Marlborough non-Māori, and Māori nationally on a range of indicators (Nelson Marlborough District Health Board 2007[22]).

Māori Health Comparisons					
Indicators	**Nelson Marlborough non-Māori**		**Te Tau Ihu Māori**	**Māori Nationally**	
Average life expectancy male	76.1 years	⬆	**73.5 years**	68.6 years	⬇
Average life expectancy female	81.3	⬆	**78.2 years**	73.3 years	⬇
Percentage of population 15 years and over who smoke male and female.	19.1%	⬇	**44.2%**	47.2%	⬆
Percentage of population overweight male and female	33.4%	⬇	**41.2%**	35.8%	⬇
Percentage of population obese male and female	17.5%	⬇	**22.5%**	28.3%	⬆
Cancer rates per 100,000 female population	329	⬆	**226**	398	⬆
Cancer rates per 100,000 male population	452		**34**[23]	394	
Cardiovascular disease aged standardised rates female	7.4	⬆	**6.3**	10.6	⬆
Cardiovascular disease aged standardised rates male	8.7	⬇	**11.8**	13.6	⬆
Age standardised diabetes rates self reported aged 15 years and over. (95% confidence interval)	3.1	⬇	**5.5**	8.0	⬆

Table 1Māori Health comparison Te Tau Ihu Māori against non- Māori and Māori nationally

Te Tau Ihu Māori can expect to live five years longer than Māori nationally. However, compared to the NMDHB non-Māori population, Māori females' life expectancy is 3.1 years less than non-Māori females, and for Māori males it is 2.6 years less than non-Māori males.

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[22] Note that the NMDHB 2007 Document Review does not identify confidence intervals. The Average Life Expectancy indicators were not referenced in the document other than table reference 'Source: Wellington School of Medicine' The Age Standardised diabetes rates were sourced from Public Health An Indication of New Zealanders Health Needs therefore confidence intervals have been identified. The remaining indicators were sourced from PHI Online Public Health Intelligence New Zealand Charting our Health. PHI Online website is no longer available and an interloan library request was unable to source this document.

[23] Note that the NMDHB 2007 Document Review identifies 34 per 100,000, however this is likely to be a typographical error.

In terms of smoking behaviours for Te Tau Ihu Māori population 15 years and over, there are slightly fewer Māori who smoke when compared to the national average for Māori. However, the disparity between Te Tau Ihu Māori and Nelson Marlborough non-Māori population is quite significant, with 25% more Te Tau Ihu Māori population smoking in comparison to Nelson Marlborough non-Māori.(NMDHB 2007 pg 15).

Te Tau Ihu Māori are more overweight than Māori nationally but Te Tau Ihu Māori are less obese than Māori nationally[24]. Once again the disparity between Te Tau Ihu Māori and the non-Māori population is apparent in relation to being overweight or obese, with 7.8% more of Te Tau Ihu Māori being overweight and 5% of Te Tau Ihu Māori being obese, than that of the Nelson Marlborough non-Māori population. When it comes to physical activity, Te Tau Ihu Māori 15 years and over are less regularly physically active than the national Māori average (NMDHB 2007 p 16,17).

Te Tau Ihu Māori have significantly lower cancer registration rates per 100,000 population than the national Māori average. When contrasted to the non-Māori Nelson Marlborough population, Te Tau Ihu Māori females and males have a significantly lower cancer registration rate than the Nelson Marlborough non-Māori population counterparts (NMDHB 2007 p 19). However, Robson & Harris (2007 p 103) identified that Māori are at significant higher risk of death from cancer after diagnosis than non-Māori.

In terms of cardiovascular disease, (heart disease and stroke) it is the most common cause of death among Māori accounting nationally for a third of all Māori deaths (Robson & Harris 2007 p 33). Te Tau Ihu Māori prevalence rates are lower than the national Māori average (NMDHB, 2007 p 21). Te Tau Ihu Māori females compare favourably with Māori females nationally and non Māori in Nelson Marlborough. Te Tau Ihu Māori males compare favourably with Māori males nationally, but not with non-Māori males in Te Tau Ihu.

Diabetes caused 7% of Māori deaths nationally. Te Tau Ihu Māori age standardised diabetes rate indicators are lower than Māori nationally by 2.5, but higher than Nelson Marlborough non-Māori by 2.4 (NMDHB p 24).

What this briefly shows is that across several health indicators, Te Tau Ihu Māori health is better than Māori nationally. Te Tau Ihu Māori did not compare favourably in comparison to non-Māori in Nelson Marlborough, with the exception of cancer registration rates.

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[24] Body mass index (BMI) is calculated by an individuals weight in kilograms, divided by their height in metres squared. Overweight is classified as having a BMI of between 25.0 and 29.9. Obese is classified as having a BMI of over 30.0.

4.5   Why are Te Tau Ihu Māori healthier than Māori nationally?

There could be a number of reasons that contribute towards Te Tau Ihu Māori being 'healthier' than Māori nationally, if taken from a determinant of health position.

Income and poverty are considered the most important determinants of health (National Health Committee 1998), and there is a clear correlation between income and health (Robson and Harris 2007 p 23). Thirty three percent of families in New Zealand containing a Māori member experienced low living standards in comparison to non-Māori (21%) (Ministry of Social Development 2006). Employment and occupation are related to income and social inclusion. Redundancy and unemployment are associated with poorer health outcomes (Robson and Harris 2007 p 23).

The following table outlines a determinant of health comparison between Te Tau Ihu Māori, and Māori nationally (NMDHB 2007)[25].

Indicator	Te Tau Ihu Maori	Maori nationally	
Unemployment, age standardised rates for 15 years and over	4.0	6.9	⬆
Number of Māori over the age of 15 years with no educational qualifications	38.1%	39.9%	⬆
Number of Māori with university degrees	5.6%	7.1%	⬆
Number of Māori per bedroom.	Ave 1.09 1.05 Tasman 1.09 Nelson 1.02 Marlborough	1.09	⬆
Number of Māori who speak Te Reo Māori	16%	23%	⬆

Table 2 Determinant of Health Comparison

For Te Tau Ihu Māori there is less unemployment where the age standardised rates for 15 years and over are 4.0, while for Māori nationally it is 6.9. However, there are pockets of higher need within Te Tau Ihu where Nelson Māori had an unemployment rate in 2006 of

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[25] Note that the figures quoted in the Nelson Marlborough District Health Board Document Review were based on Statistics New Zealand 2006 Census.

9.0%, 5.3% for Tasman Māori and 4.8% for Marlborough Māori[26], with the national Māori average estimated at 9.59%[27]. There are also disparities between North and South Island Māori unemployment with an estimated South Island Māori unemployment rate of 5.99%, and a North Island Māori unemployment rate of 11.2%. Te Tau Ihu Māori experience less unemployment than other Māori nationally.

Education is important, as it contributes towards determining an individual's social and economic status, and therefore their health. For Te Tau Ihu Māori aged 15 years and over, 38.1% did not have any educational qualifications, whereas for Māori nationally the percentage is 39.9%. However, Te Tau Ihu Māori have a lower percentage of university degrees at 5.6%, whereas for Māori nationally it is 7.1% (NMDHB, 2007 p 10).

In terms of housing, the locality, physical quality, level of overcrowding and the cost of housing all impact directly on health. For Te Tau Ihu Māori the 2001 Census identified that there were 1.05 people per bedroom for the Tasman district, 1.09 for the Nelson district and 1.02 for the Marlborough district. In comparison, Māori nationally report 1.09 people per bedroom. Other than the Nelson district, Te Tau Ihu Māori experience less overcrowding than Māori nationally.

There is increasing evidence that social cohesion and social connectedness enhance health (Kumar & Oakely Browne, 2008). Ethnicity is strongly associated with underlying socioeconomic status (National Committee 1998), and cultural factors can have both a positive and negative influence on health. In the 2006 Census, the number of Te Tau Ihu Māori who speak Te Reo Māori (16%) is less than the national Māori percentage (23%).

Using the determinants of health there were similarities between Te Tau Ihu Māori and Māori nationally in terms of the number of Māori who have no educational educational qualificiations. However, Te Tau Ihu Māori compare more favourably to Māori nationally in terms of employment and housing; and Māori nationally compare more favourably to Te Tau Ihu Māori in terms of university degrees and Te Reo Māori speakers. Therefore using health determinants to explaning why Māori health in Te Tau Ihu is better than Māori nationally has not been definitive.

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[26] www.stats.govt.nz/census/census-outputs/tables/detailed/place//territorial-authority.
[27] www.stats.govt.nz/census

4.6   Te Tau Ihu Māori Mental Health and co-existing physical health conditions

A general view of Māori health is required, as there is a strong relationship between between mental health and co-existing physical health disorders. Te Rau Hinengaro was the first New Zealand mental health survey with the objectives of describing prevalence rates, patterns of and barriers to health service utilisation and the level of disability associated with mental disorder (Oakley-Browne, Wells & Scott, 2006). In terms of co-morbidity, Te Rau Hinengaro confirmed the interface between mental disorders and chronic physical health conditions such as chronic pain, cardiovascular disease, high blood pressure, respiratory conditions and diabetes.   The survey found that chronic conditions were common not only in Māori who experienced a mental disorder, but also in Māori generally. This is important given previous evidence on health disparities between Māori and non-Māori. Even without a mental disorder 33.3% of the Māori sample experienced chronic pain, 26.0% respiratory conditions, 11.0 % high blood pressure, 6.2% cardiovascular disease, 4.8% diabetes and 4.7% cancer. For those Māori who did experience a mental disorder in the previous 12 months, in all chronic condition areas the rates are higher, as 46.4% also suffered from chronic pain, 31.2% from respiratory conditions, 12.0% from high blood pressure, 8.7% from cardiovascular diseases, 6.5% from diabetes and 6.0% cancer.

These findings consolidate the importance of addressing the physical health of service users/tangata whaiora. The Mental Health Commission (2004a), cites international studies which found that service users die at 2.5 to 4.3 times the rate of the general population. Male service users tend to live 14 years less and female service users six years less than their counterparts. These were international studies, and given the existing prevalence rates identified through Te Rau Hinengaro (2006), it would be interesting to investigate whether there are any disparities between Māori and non-Māori tangata whaiora.

More recently McCabe & Leas (2008), cited an Australian study that suggested the rate is even higher, with those individuals with a severe mental illness living between 25 and 30 years less than people in the general population. Of those physical illnesses, cardiovascular disease was the leading cause of death and physical impairment. The study went further to suggest that service users have a high rate of misdiagnosis and high under-diagnosis of major physical illnesses. Lawrence, Jablensky, Holman and Pinder (2000), also reported that the mortality rate for Aboriginal and Torrest Strait Islanders is 3.75 times higher than the mortality rate of the general community, but among service users of mental health service, there was a 40% higher mortality rate if you were of Aboriginal or Torres Strait Islander descent.

4.7   Summary

This Chapter demonstrates that for Te Tau Ihu Māori, the evidence shows that on several indicators Te Tau Ihu Māori health is better than Māori nationally. However, the disparities still continue between Te Tau Ihu Māori and non-Māori, therefore the challenge remains to improve the quality of all health service provision to Māori, which in turn should lead to a reduction in disparities. Given these findings, the next two chapters will explore Māori mental health (both primary and specialist mental health) nationally to understand the contextual environment before the first research question is posed.

Chapter Five: Mental health in a primary care setting

5.1   Introduction

Primary mental health care is pivotally important as a first point of contact, and to intervene early when patients are experiencing mild to moderate mental health problems. The MaGPie Research Group (2003) found that one third of people attending their General Practitioner had a diagnosable mental disorder in the previous 12 months, and Te Rau Hinengaro found that 29.5% of Māori had at least one mental illness disorder in the past 12 months. If mild to moderate mental health problems are not addressed at primary care level then there are risks of the condition escalating and requiring specialist intervention.

With the statistical data presented,   aged standardised rates and confidence intervals have been identified where this information was available.

5.2   The purpose of primary mental health care

The role for primary health care practitioners in the provision of mental health services is to ensure that individuals return to their full level of functioning by identifying and subsequently managing the mental health issue (Ministry of Health, 2004a, p 21). It is supposed to be that component of primary health care that addresses a person's and their family/whānau psychological distress and illness (Ministry of Health, 2004a, p 59).

5.3   Māori mental health estimated prevalence

The Mental Health and General Practice Investigation (MaGPIe) team (2003) found that the three most common disorders were similar to Te Rau Hinengaro findings, depression, anxiety disorders and substance abuse disorders. However, they also found that rates of mental disorder among Māori general practice attendees were higher than among non-Māori (even post-adjustment for socio-economic deprivation), with Māori women twice as likely as non-Māori women to have a diagnosable mental disorder. In a general practice setting, Māori overall had higher rates of anxiety, depression and substance abuse. Symptoms among Māori were also considered more severe and the findings were not explained by Māori/non-Māori differences in age and socio-economic status. It is therefore of some concern that even though there were higher rates and severity with Māori general practice attendees, referral rates to secondary mental health services are lower than for non-Māori (Mental Health Commission 2008).

Te Rau Hinengaro (2006) found for Māori, anxiety disorders were the most common disorders experienced over a 12-month period (19.4%), followed by mood disorders (11.4%) and substance use disorders (8.6%). In terms of co-morbidity, for those Māori with a mental disorder in the previous 12-month period, 7.6% had at least two mental health disorders and 5.5% had three or more mental health disorders.

As stated in the previous chapter there are a number of health indicators where Te Tau Ihu Māori compare more favourably than Māori nationally. However, there are currently no Te Tau Ihu mental health prevalence studies for comparison purposes. In the absence of such information, Te Rau Hinengaro prevalence findings are used and extrapolated to Te Tau Ihu Māori population. The following crude estimates apply:

Twelve Month Prevalence Mild to Serious Mental Health				
Te Tau Ihu Māori Population (10,953) (2006 Census)	Well Population	Mild at 8.7%	Moderate at 12.6%	Serious Mental Health at 8.2%
Tasman (3063)	2159	267	386	251
Nelson (3615)	2550	314	455	296
Marlborough (4275)	3015	372	538	350
Total	7724	953	1379	897

Table 3 Te Rau Hinengaro Mild to Serious Mental Health Estimate[28]

Using the 2006 New Zealand Census population data, an estimated 2,332 (1,379 + 953), of Te Tau Ihu Māori may have required intervention for their mild to moderate symptoms. There is currently no information system available through the two local Primary Health Organisations that can capture data (specifically mental health symptomology), other than those Māori accessing the recently established Primary Mental Health Initiatives[29]. Therefore, at this point the best estimate of prevalence are Te Rau Hinegaro's findings.

5.4 Māori access to primary mental health services

Te Rau Hinengaro (2006) found that in comparison with the 'other'[30] population, Māori had a higher proportion of mental health disorders, and those who did experience a mild to serious disorder in the previous 12 months, just under one third sought contact with a service provider. Of those Māori who experienced a moderate disorder, 74.6% had no contact with a

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[28] Note that Te Rau Hinengaro uses 95% confidence intervals. The 95% CI is the interval that would be expected to contain the true population value 95% of the time.

[29] Primary Mental Health Initiatives were established in both PHOs in 2008, and volumes funded are small in comparison to the estimated need.

[30] All ethnicities other than Māori and Pacific peoples.

health provider, and if the disorder was mild 84.3% had no contact. This is an important finding for Māori primary mental health development as it clearly articulates an unmet need and requires further investigation into why Māori are not seeking earlier intervention. It goes some way to explaining why Māori enter secondary services at acute levels.

5.5   Barriers to accessing health care in the community

There are a range of barriers to access health care in the community.   These include the cost of the general practice consultation,   debts that may have already been incurred at the general practice, dignity and pride, access and transport,   beliefs and values, language, ethnicity and gender, work hours, transient lifestyls, residency status, fear of being identified, and the clinical setting (CBG Research, 2005).

In terms of cost, Barnett and Barnett (2004) found that patients were dissatisfied with the fees charged by their General Practice service and will delay care due to cost.   Raymont (2004) analysed the cost barriers from the New Zealand Health Survey and found that Māori were more frequently than non-Māori to forgo visits to their general practitioner and/or collect their prescriptions due to cost.   He summarised that with the introduction of the Primary Health Care Strategy, by 2002 the health system was insufficient to provide equal access to primary health care for Māori, Pacific, those on low incomes and those who were in poorer health.

These findings align to Jansen, Bacal and Crengle (2008), who identified two types of costs for primary health care.   The first being direct costs such as the general practice consultation charges and items such as prescriptions and pharmaceuticals. The second type of costs were indirect, and these covered items such as transport to the general practice, having to pay for childcare,   and lost wages having to take time off to visit the general practitioner. Jatrana and Cramptom (2009) identify that financial barriers to primary still exist for a substantial subgroup of the population and these subgroups are more likely to delay accessing care because of cost barriers.   These sub populations included young adults aged 15-24 and 25 to 44, female, never married,   those in the middle income tertile, those reporting the worst health status, Māori, Pacific, those in lower income tertiles, people living in the most deprived areas, those in poverty, those reporting high and very high levels of psychological distress, and those with more than two co-morbid diseases. In other words, high need populations.

When it comes to mental health problems,   not all individuals, Māori or non-Māori, will present to primary care services for help with their mental health problems. Te Rau

Hinengaro (2006) found that generically across all populations, the three most frequently endorsed reasons for delaying seeking help and treatment were that individuals wanted to handle the problem on their own (79.3%); or thought the problem would get better by itself (63.2%); and that the problem didn't bother them at much at first (48.9%). In addition, the three most frequently endorsed reasons for not seeking help at all were similar to those reasons for delaying seeking treatment, that is; individuals wanted to handle the problem on their own (43.5%); the problem went away by itself and the individual didn't really need help (37.3%); and finally they thought the problem would get better by itself (31.8%).

Of specific interest is that even though cost was listed as one of the 16 reasons offered to participants in terms of delaying seeking treatment or not seeking treatment, cost was not a dominant reason. One would expect this would have a higher profile given previous indicators identifying cost as a major barrier to access general practice services and as aligned to the New Zealand Health Survey (2002/03), which asked adults why they had not seen a General Practitioner when they needed to. The most common reasons identified in that survey were cost; not wanting to make a fuss or could not be bothered; couldn't get an appointment soon enough or at a suitable time or it was after hours; and finally that they couldn't spare the time.

When contrasting the two surveys it raises questions whether individuals internalise mental health symptoms and/or alternatively that the stigma around mental health could be prominent enough for individuals to not seek help.

McCabe and Leas (2008) suggest that service users lack the necessary skills and resources to access and use the health system. His study found barriers did include self stigma and the accompanying negative attitudes associated with having a mental illness. Even though it was a small sample, other barriers identified included communication with the GP; difficulties with access; GPs did not listen and service users were often ignored; physical symptoms were often overlooked, as the GP focused predominantly on mental health; there was a level of fear and anxiety with using health services; and service users experienced difficulty in advocating for themselves and in navigating services.

The Mental Health Commission (2008 p 17) completed an analysis on access to mental health and addiction services and found that General Practitioners are the most common source of referral to secondary mental health services. However, when comparing the referral patterns for Māori, Māori were less likely than the 'other'[31] population to be referred by a

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[31] 'Other' population is all ethnicities excluding Māori and Pacific.

General Practitioner to a secondary mental health service (20.7% Māori, 32.2% Other). Māori were more likely to have a self referral/relative referral (20.5%) to secondary services than the 'other' population at (19%). It is interesting to note the disparity in referrals to secondary mental health services, especially when Te Rau Hinengaro prevalence rates for Māori are significantly higher than the 'other' population.

There are a number of barriers in terms of access to general practitioner services as indicated previously. Hart (1971) discussed the inverse care law, identifying that those populations that are in most need of health services are least likely to receive them, and there is current evidence that supports this. Coster & Gribben (1999) and Malcolm (1996), found that the disadvantaged populations in New Zealand have poor access and are underserved when it comes to primary health services and this results in a number of disparities which are currently evident today.

Even when Māori present to general practitioner services there is inequity in the services and treatment offered. A study conducted in west Auckland found that while Māori patients may have the highest burden of chronic disease, after age adjustment they receive fewer prescriptions, less in pharmaceutical subsidies, fewer laboratory tests, and fewer consultations per annum (Gribben, 1999). The National Primary Medical Care Survey study explored Māori experiences in Accident and Medical Clinics (emergency departments included): Māori made up 9% of patients attending the clinics and received fewer tests/investigations than non-Māori (this difference was marked during usual working hours); received fewer prescriptions during usual working hours, and more prescriptions during after hours than non-Māori. Cumming, Sillman, Liany, Poland & Harris (2010), endorsed what we know already around the disparities in access to General Practitioners. The authors confirmed that gender, age and ethnicity all influence healthcare utilisation. Asians and Māori are less likely to visit the GP and have less GP visits per year.

Māori expectations of general practitioner services also differ. Malcolm (1996) identified that Māori have low expectations of primary medical care and often defer treatment, to the extent that health problems generically are exacerbated to higher acuity levels often requiring secondary hospital services. Horsburgh and Lamdin (2004) support this point and suggest that up to 25% of hospitalisations for Māori could be avoided through effective primary health care interventions.

Rodenburg (2003) clearly articulates that mental health has always been a part of primary health care, but acknowledges that there are a number of barriers in terms of utilising general

practice, the two major barriers being cost and time. As identified in Te Rau Hinengaro, cost was not one of the top three reasons for not accessing help for mental health problems. However, the consultation timeframe is a widely accepted barrier (Eade, 2007; Te Puni Kokiri, 2000). Even though the mean length of general practitioner consultation time for Māori patients (all health needs) was less than for non-Māori (13.7 minutes compared to 15.1 minutes), there were higher urgency levels for Māori visits judged as needing attention as soon as possible (43.3%) in comparison to non-Māori at (31.1%) (Crengle, Lay Yee & Davis, 2004). The disparity is high and reiterates that Māori present at higher acuity levels. Crengle, Lay Yee, Davis & Pearson (2005) also examined Māori providers' primary health care services and found that the average length of consultation was higher at 15.9 minutes. This is longer than the 13.7 minutes in the 2005 study.

If we look specifically at mental health need across all ethnicities, Te Rau Hinengaro (2006) found that the average duration of a general practitioner visit for mental health was significantly higher than a 15-minute time slot. The survey found that only 5.9% of patient consultations were less than 15 minutes, 42.1% were between 15 and 30 minutes, 16.1% between 31 and 45 minutes, and finally 35.8% were 46 minutes or longer. Therefore over 50% of general practice consultations to patients that have a mental health problem (and given the data a higher percentage have mental and physical co-morbid conditions) are over 30 minutes duration. This endorses that additional time is given to meet the needs of tangata whaiora within general practice consultations. In addition, the Ministry of Health will need to further invest in primary mental health service development, recognising the need to support the primary mental health care sector, specifically extended general practice consultations.

To further acknowledge General Practitioners' willingness and understanding of the disparities and economic difficulties faced by some Māori families, the NZ Health Survey (2008b) report that Māori men and women were more likely than men and women in the total adult population to report that their last GP visit was free. Malcolm (1996) acknowledges this and identifies that the average practice subsidises poorer patients by charging those who can afford to pay. He identifies that disadvantaged populations have a lower uptake of Community Service Cards than advantaged populations. Barriers remain however, with Māori children and adults significantly more likely than children and adults in the total population unable to see a GP due to cost.

There is also the issue of prioritisation of health needs within the general practitioner consultation. Eade (2007) found that due to the pressure of addressing all tangata whaiora physical and mental health needs within the consultation timeframe, that tangata whaiora

prioritise the issues they want to address, often leaving mental health needs last. There is some alignment here with the New Zealand Health Survey (2002/03) which found that Māori adults were significantly more likely than adults in the total population to have their primary health care provider discuss their smoking, nutrition, weight, exercise, oral health and alcohol use in the previous twelve months. Wider mental health didn't feature highly in both the Māori and non-Māori population sample. This could be reflective of a number of reasons including the competency of the primary care service to recognise, assess and treat mental health issues, the prioritisation of physical health needs being served first at general practice consultations, the stigma associated with mental illness, the ability and willingness to discuss symptoms with the General Practitioner, or the practicality of covering all health issues in a 10 to 15 minute consultation. Only 3.5% of males and 3.8% females interviewed in the sample identified mental health as a reason they visited their GP, which is interesting in itself when compared to Te Rau HInengaro National Mental Health Survey mental health prevalence estimates.

Eade (2007) also identified the differences in service if you have an intergenerational relationship with your General Practitioner. This includes confidence to disclose mental health issues, GP awareness of historical health issues, and developing a sense of trust. Māori have lower levels of trust in health professionals than non-Māori. Rodenburg (2003) goes further and found that if a patient has a long-term relationship with their General Practitioner, there is an increased detection of mental health problems. However, intergenerational general practitioner relationships may not be the experience of most Māori. The New Zealand Health Survey (2004) found that Māori are less likely to see the same GP every time and that the most common reasons in choosing a primary health provider were:

(i)   46.6% said that they were the closest health care provider.
(ii)   28.8% were referred to them by a friend or relative.
(iii)   8.5% said they were willing to spend more time discussing their health.
(iv)   6% said it was cheaper than going to another health care provider.
(v)   5.7% said they were more comfortable talking to someone who understood their culture.

Therefore for over 75% of all ethnicities, location, convenience and 'word of mouth' are the predominant reasons for selection of a general practitioner. They also found that Māori are significantly less likely than adults in the total population to report in the previous 12 months that their health care professional treated them with respect and dignity 'all the time'. This could be attributable to a number of reasons such as, infrequency of health visits; therefore

the non-establishment of a confident stable relationship with a General Practitioner, or presentations 'after hours' to other medical centres. This relationship and engagement with Māori is pivotal in terms of the ability to disclose. Crengle et al (2005) completed a comparison of Māori and non-Māori patient visits to General Practitioners as part of the National Primary Medial Care Survey, and found that overall General Practitioners reported lower levels of rapport with Māori patients.

While Laplsley, Nikora & Black (2002) found that contacts with GPs did not lead to people feeling powerless, trapped or derived of rights, Eade (2007) found that in the Marlborough district, unequal power relationships between general practitioner services and tangata whaiora do exist, where tangata whaiora experience a perceived level of inferiority in communicating with a General Practitioner. Māori male tangata whaiora also reported a level of fear in terms of accessing general practice services when they become mentally unwell for fear of being admitted to the acute inpatient unit in Nelson.

Te Rau Hinengaro looked at Māori participation rating of satisfaction by health professional groupings. For those who did attend a General Practitioner or any other medical doctor, 33.7% were very satisfied with the care received and average duration of visit, 41.0% satisfied, 10% neither satisfied or dissatisfied, 8% dissatisfied and 7.3% very dissatisfied. This means that just under 75% of Māori are satisfied or very satisfied with the care that they received. These findings support a recent recovery narrative study (Lapsley et al 2002) which found that tangata whaiora had virtually no complaints about GP interventions. However, one would question whether the individuals concerned were aware of what level of interventions should be provided based on best practice.

General Practitioners are aware of the challenges. McCreanor and Nairn (2002) completed a discursive analysis of 25 General Practitioners through semi-structured interviews in an Auckland urban area. They found that GPs recognise the poor status of Māori compared to non-Māori, acknowledge the colonisation impact and power differentials, and the central importance of language and communication between the GP and patient. In addition, there has been some debate around General Practice capacity and competency in mental health (Ministry of Health 2004; Rodenburg 2003; Rodenburg, Bos, O'Malley, McGeorge, Love & Dowell 2002), which impacts service provision.

5.6   Access to services through Accident and Emergency

If we briefly examine Accident and Emergency Departments to see whether Māori are presenting at higher acuity and also analyse the referral patterns to specialist mental health service interventions, the National Primary Medical Care Survey in 2005 noted the frequency of visits to the Accident and Emergency Departments for 'mental visits' were 0% for Māori, and 1.4% for non-Māori during the hours of 8.00 a.m. to 6.00 p.m. However, after hours 'mental visits' were 1.5% for Māori and 1.3% for non-Māori. This indicates that Māori are accessing these services outside of 'normal' working hours.

When looking at where patients were referred to from the Accident and Emergency Department, we find that 2.6% of Māori were referred to Psychiatry services (2.0% for non-Māori); no Māori were referred to Psychology services (1.0% for non-Māori), and 3.0 % of Māori were referred to counselling services (2.1% of non-Māori). Māori referral patterns to specialist mental health services are outside of normal working hours, indicating a slightly higher rate of crisis intervention than non-Māori. Of interest is that a slightly higher percentage of Māori were referred to counselling services rather than psychological services.

5.7   Inverse Care Law

As identified previously the inverse care law identifies that those who need health care the most, are less likely to receive it. The inverse care law also works more completely where medical care is most exposed to market forces, and less so where such exposure is reduced (Hart 1971; Gauld 2000; Mercer, Guthrie, Furler, Watt and Hart 2012).   When health services are removed from market forces, there is more opportunity for resources to be targeted to those deprived communities/populations most in need.

New Zealand's health system is publically funded and around 75% of vote health funding goes to District Health Boards to plan, manage, provide and purchase health services within their respective districts.   Therefore New Zealand isn't as strongly influenced from the open market as compared to other countries.   The New Zealand Public Health and Disability Act 2000 acknowledges the principles of the Treaty of Waitangi and one of the Acts objectives is to reduce health disparities by improving health outcomes for Māori and other population groups.   The question is, how well does the system achieve this given there is there is ample evidence that Māori have and continue to receive lower levels of health services and poorer quality of service in comparison to non-Māori (Hirini, Flett, Long, Millar and MacDonald 1999; Gauld 2000; Nidodo, 2007; and Sitaleki 2006). That isn't to say that there haven't been gains made in Māori health over the last 20 to 30 years through a number of government

health reforms, policy changes and public inquiries into mental health (Brunton, 2005), however the inverse care law is still evident.

As Sharpe (2011) identified we need to blend action for equity as part of quality improvement processes, and avoid service development or improvements which only reinforce the inverse care law. Robson and Harris (2007) go further to suggest that the preferential benefit accured to Pākehā are from the systems they have introduced, built and continue to refine and control. In this sense, Sitaleki (2006) identifies the inverse care law as the 'norm' in New Zealand, and that as a health system there has been too much focus on equality to the detriment of equitability. His solution is for affirmative action to address inequities through cultural democracy to reach a level playing field.

5.8   Summary

This chapter solidified that Māori have a higher prevalence of mental unwellness in comparison to non-Māori, and face a number of disparities and barriers in terms of access and treatment. This aligns to the inverse care law, where those populations who are most in need of health care are least likely to receive that care.

Primary healthcare services (*both Māori and non-Māori*) need to be challenged further in terms of removing those barriers to access.

A number of recent developments in primary mental health have given a new impetus to increase earlier intervention and treatment therefore reducing the need for specialist interventions. The next chapter then will consider specialist mental health services from a Māori lens.

Chapter Six: Specialist Mental Health Service Provision

6.1   Introduction

This Chapter will consider findings on Māori mental health in relation to specialist mental health service provision in New Zealand. Māori are at greater risk for all types of mental health problems and disorders, with higher suicide rates, higher levels of first admissions, and unfortunately high numbers of Māori using mental health forensic services.

With the statistical data presented,   aged standardised rates and confidence intervals have been identified where this information was available.

6.2   Māori Mental Health Prevalence and Incidence Data

Using 95% confidence intervals, Te Rau Hinengaro (2006) identified that Māori have the highest prevalence of serious mental health disorders in the previous 12 months, followed by Pacific and then Other (29.5% Māori compared to 19.3% Other). This suggests a higher health burden for Māori as a result of mental disorders. Across all ethnicities Te Rau Hinengaro found that 6.6% of the population would experience a mild disorder in a 12-month period, 9.4% a moderate disorder and 4.7% a severe disorder. However, for Māori the estimates are 8.7% for mild, 12.6% for moderate and 8.2% for serious disorders. The following table outlines an estimate of 12-month prevalence rates extrapolated from Te Rau Hinengaro findings, and applied to the 2006 Māori population of Te Tau Ihu, shows there are an estimated 897 Māori who have serious mental health issues.

Twelve-month prevalence – Māori prevalence estimate rates				
Māori Population (10,953) (2006 Census)	Well Population	Mild at 8.7%	Moderate at 12.6%	Serious Mental Health at 8.2%
Tasman (3063)	2159	267	386	251
Nelson (3615)	2550	314	455	296
Marlborough (4275)	3015	372	538	350
Total	7724	953	1379	897

Table 4 Te Tau Ihu Māori Mental Health based on Te Rau Hinengaro Estimates

The most common disorders among Māori were anxiety disorders (19.4%), mood disorders (11.4%) and substance use disorders (8.6%). However, the most common lifetime disorders

were anxiety (31.3%), substance use (26.5%), mood disorders (24.3%) and eating disorders (3.1%). Note however that there are several limitations to Te Rau Hinengaro survey.[32]

As stated in previous chapters, having co-morbid disorders is common. In the past 12 months, among Māori 55.5% had only one disorder, 25.7% had two disorders and 18.8% had three or more disorders. Māori had high levels of suicidal thinking (3.8%, compared to 3.1% of the Other population), behaviours and suicidal planning (1.3% compared to 0.8% Other), especially among younger people; and Māori were more likely to make a suicide attempt (0.7% compared to 0.3% Other).

Te Rau Hinengaro did not include low prevalence disorders such as schizophrenia; however, Kake et al (2008), using a 'capture recapture' approach on the Mental Health Information National Collection national data set identified that the estimated 12-month prevalence of schizophrenia for Māori was 0.97%, significantly higher than that of non-Māori at 0.32%, even after adjustment for age, case under ascertainment, and socioeconomic deprivation. The study found that Māori men have higher estimated prevalence than Māori women (1.27%); Māori women have higher estimated prevalence (0.70%) than non-Māori males (0.41%) and non-Māori females (0.24%).

6.3   Māori Admission and Access Rates

Historically, it is relatively well known within the mental health sector, that non-Māori were more likely than Māori to be admitted to psychiatric hospitals (Baxter 2008; Bridgeman & Dyall 1993; Durie & Kingi 1997). In 1960, there were 88 Māori and 119 non-Māori admissions to psychiatric hospitals per 100,000, yet in 1993 there were 191 Māori admissions and 104 non-Māori admissions (Bridgeman & Dyall 1993). Māori male readmission rates had increased 65% from 1984 to 1993, and there had been a 49% increase in Māori female first admission rates for drug and alcohol abuse and psychosis. Māori had substantially higher rates of presentation to crisis, acute and forensic services than non-Māori (Bridgeman & Dyall 1996, p. 45). In forensic services treatment for mental disorder is less for Māori in comparison to their Pākehā counterparts (Simpson, Brinded, Fairley, Laidlaw & Malcolm 2003). Māori

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[32] There are several limitations of the survey that need to be noted. For Te Rau Hinengaro, four groups of mental disorders were assessed: anxiety disorders (panic disorder, agoraphobia without panic, specific phobia, social phobia, generalised anxiety mental disorders were assessed: anxiety disorders (panic disorder, agoraphobia without panic, specific phobia, social phobia, generalised anxiety disorder, post-traumatic stress disorder and obsessive–compulsive disorder), mood disorders (major depressive disorder, dysthymia and bipolar disorder), substance use disorders (abuse or dependence on alcohol or other drugs) and eating disorders (anorexia and bulimia). In addition, the survey does not provide estimates of rates of dementia and associated cognitive impairment in older people. People living in institutions (such as rest homes, hospitals, sheltered accommodation, university colleges, prisons and armed forces group accommodation), homeless people and those aged 15 years and under were not included in the sampling frame.

hospital admission rates were 40% higher than for non-Māori and Māori were more likely than non-Māori to suffer from alcohol and drug disorders (Te Puni Kokiri 2000). Abbott and Durie (1986) identified that even a decade ago psychiatric admissions had trebled in less than 20 years. In 1993, admissions for Māori were nearly double that of non-Māori (Te Puni Kokiri 2000). Higher admissions rates are also experienced by other indigenous or minority populations (Snowden & Cheung 1990; Wand, Corr & Eades 2009). If we look at access rates to all specialist mental health services (inpatient and community), the Mental Health Commission (2008) identify that access rates nationally over a twelve month period for Māori were higher (2.8%) than that of Pacific (1.6%) or Other (2.2%).

Once Māori are in the mental health 'system', they also appear to have higher re-admission rates than non-Māori. Durie and Kingi (1997) identified that:

> Readmission rates are estimated to be 40% higher than that of non-Māori. High rates of first admissions for Māori youth are linked largely to Alcohol and Other Drugs. Current evidence also suggests that Māori tend to access mental health services at a later stage than non-Māori. This implies that treatment will often be sought at an acute stage of illness, thereby requiring ongoing, and often expensive treatment. The resulting health outcomes are therefore likely to be less effective and may in part explain high rates of readmission. (p.10)

Abas et al (2003) identified a strong association between deprivation and psychiatric bed utilisation, and that Māori tend to be more economically deprived than non-Māori.

6.4   How do Māori access specialist mental health services?

Given Māori growth in secondary care presentations, of notable interest is that the majority of referrals into secondary services for Māori do not derive from the primary care sector. For Māori mental health inpatients, the majority of referrals to first admission inpatient units derive from welfare and law agencies (38%), which far outweighs non-Māori (27%) whose major referrals derive from psychiatrists or General Practitioners (Bridgeman & Dyall 1996). Other indigenous or minority populations experience similar avenues to specialist mental health services (Parker 2003; Secker & Harding 2002), with aggressive behaviours often identified.

An Otago study also found similar distinct differences in referral pathways in that, while Māori admissions were four times higher than non Māori, the majority of these referrals to their services derived from welfare agencies, the justice sector, or from family, whereas non Māori referrals came from psychiatrists, doctors or outpatient services (Edmonds, Williams & Walsh

2000). Recently, the Mental Health Commission (2008) compared access rates within secondary mental health services, and confirm these differences in referral patterns. Referrals from Police were 8.6% for Māori and 5.1% for 'other' populations. Justice referrals were 6.1% for Māori, and 2.9% for 'other'. Māori had fewer referrals from non-psychiatric hospital services (8.5%) compared to 'other' population (12.8%). Given Māori growth in secondary care presentations, it is interesting that the majority of referrals into secondary services for Māori do not derive from the primary care sector. This research suggests that Māori are not using the primary care sector for assessment and treatment and therefore presenting at higher acuity levels than non-Māori.

The Ministry of Health (2007) undertook a census of forensic mental health service use since 2005. In 2005, Māori made up 40% of the overall prison muster. In terms of the number in forensic inpatient settings, 48% were Māori, and the number of Māori in community based services 45%. There is a high incidence of mental health problems for Māori in the judicial system. The most common primary diagnosis across all ethnicities was schizophrenia. For Māori this meant 75% of forensic inpatient primary diagnosis was schizophrenia.

6.5   Linkages with Primary Health Care

The consequences are reiterated by Durie, Allan, Ratima and Waldon (1995) who support the view, that the links to, and provision of adequate primary health care may not be forthcoming for Māori.

> Of mounting concern are the disproportionately high numbers of Māori who are committed under the Mental Health Act for assessment and treatment. Psychiatric admissions and particularly committals under the Act, represent a late form of intervention suggesting that Māori are less likely to have received adequate primary health care so that hospitalisation becomes an inevitable consequence of poor mental health. (p.4).

Te Rau Hinengaro confirmed that Māori were less likely than the 'Other' population group to make contact with health services for mental health reasons. Nearly a third of Māori with a disorder were classified as serious but less than half of these had any contact with health care services for their mental health problems. One would expect that one of the key points of referral from primary to specialist services would be through General Practice.

There is evidence which reports that other indigenous or minority populations are also unlikely to seek help or make contact with health services for the decline in their mental

wellbeing (Miranda & Cooper 2004; Parkham, Davies, Leese, Phelan & Thornicroft 1997; Secker& Harding 2002;).

6.6   Compulsory Assessment and Treatment Orders

The Director of Mental Health and Chief Advisor (Mental Health) Annual Report of 2005 reports the average rate of compulsory assessment and treatments per month, per 100,000 population, by Mental Health Compulsory Assessment and Treatment Act sections and by DHB. National averages for all ethnicities for Sections 11 (first assessment up to five days) is 11, for Sections 13 (extension of the five days up to a further 14 days) it is 9, and for S14 (4) (if further time is required a compulsory treatment order is made) it is 5. In comparison, Nelson Marlborough District Health Board had 9 Section 11's (per 100,000), 7 Section 13's and 4 Section 14(4), which is below the national average[33].

In terms of Compulsory Treatment Orders, for the period 1 July 2008 to 30 June 2009, the Mental Health Tribunal[34] found that of the applications brought before the tribunal, 30% were of Māori ethnicity (Ministry of Health 2010). Gibbs, Dawson, Forsyth, Mullen & Te Oranga Tonu Tanga (2004) reported that Māori patients felt Community Treatment Orders (CTOs) helped them in their recovery but also impacted their ability to make personal choices, particularly around medication, travel and where they live. Tangata whaiora and whānau wanted to have more involvement around CTO discharge practices, and indications were that to reduce liability against the specialist mental health service (in case anything went wrong in the community), tangata whaiora were retained under the CTO longer than was necessary. Whānau also felt that there needed to be more communication and support from services in terms of assisting and caring for tangata whaiora. Of interest is that tangata whaiora 'especially valued' staff (whether Māori or non-Māori) supporting them to learn more about Te Ao Māori.

McKenna, Simpson and Laidlaw (1999) discuss whether legal status equates with coercion. This study looks at involuntary and voluntary admissions from two acute inpatient psychiatric units in Waitemata. Fifteen percent of the admissions were Māori. Using the MacArthur Admission Experience Survey, questions were asked concerning the degree of influence, control, choice and freedom the service user had in decision-making relating to the admission process. Coercion in this instance is defined as persuasion, inducements, threats and force.

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[33] Note Confidence Intervals were not available for this data.
[34] The purpose of the Mental Health Tribunal is to review applications from service users (*or on its own impetus),* to decide whether a service user is subject to a compulsory treatment order or, whether the service user should have that status removed or continued. The Tribunal also hears complaints, reviews the condition of restricted patients and appoints psychiatrists to carry out certain functions.

The findings were not surprising in that those service users involuntarily admitted felt a stronger sense of coercion than informal patients; loss of autonomy; stronger perceptions of threat and force, and feelings of anger associated to the involuntary admission. The authors cite a range of other studies which also supported the view that service users need to have their views included in any clinical decision-making, and service users needed to be treated with dignity, respect, politeness and concern. They also suggest that Māori over-representation in mental health services is an outcome from a history of colonisation and could be a contributing factor to why Māori report a stronger sense of coercion than others.

6.7   Māori presentations to specialist mental health services

Tapsell & Mellsop (2007) reviewed a number of specialist psychiatric and primary care population studies and found that within the specialist psychiatric services Māori were most likely to present with hallucinations and/or aggression, and less likely to present with depression and/or episodes of self harm. They were overly represented with schizophrenia and Māori were most likely to be involved in acts of aggression and to be secluded.

Cherrington (1994)' completed a comparative study of presenting symptoms between Māori and Pakeha patients diagnosed with schizophrenia. She found that Māori participants presented with higher frequencies of hallucinations and delusions than Pākehā,   and that misprepresentations of behaviour can occur between different cultural groups.   The differences in symptomology are a direct result of the clinicians interpretations of 'normal' behaviour. However, at the same time, she acknowledged that there should be a level of acceptance that within Te Ao Māori these are not necessarily considered to be abnormal.

As an example, Mate Māori and Mate Atua are both defined as a sickness of the gods. This sickness occurs when a transgression against tapu[35] has occurred.   This manifests in the person displaying fit like behaviours, talking incomprehensibly, being physically sick with no apparent cause, hearing or seeing things, being socially withdrawn,   the person's eyes may look unusual,   and the person may sense a spiritual presence.   For many Māori the explanation is that of a breach of tapu, not necessarily a bio-medical explanation of schizophrenia.   Taitimu (2007) explains that Māori held multiple explanatory models for explaining extra ordinary experiences with the four predominant themes being spiritual, psychosocial (trauma and drug abuse), historical trauma (colonisation) and biomedical constructions (chemical brain imbalances).

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[35] Tapu is something that is held sacred, or is prohibited, restricted, set apart, forbidden,and under *atua (god)* protection.

A retrospective file review of 932 people conducted by Wheeler, Robinson & Robinson (2005) for the period 1 January 2000 to 31 December 2000 in three urban Auckland adult inpatient psychiatric units found that 23.4% of those admissions were Māori, double that of the catchment population at 11.4%. Of those Māori admissions, the principal diagnoses were psychotic disorders at 62%, 32% for mood disorders, and 6% for other disorders. Compared to Pākehā counterparts, psychotic disorders were 38%, mood disorders at 45%, and other disorders at 17%. In addition, 72% of all Māori admissions were involuntary, compared to 57% for Pākehā. There is evidence that other indigenous or minority populations also experience higher rates of psychotic disorders (Snowden & Cheung 1990, Secker and Harding 2002).   Tai, Kake and Ellis (2008) estimated the one year prevalence of schizophrenia amongst Māori to be approximately 1%, which was three times the estimate for non- Māori at 0.32% (95% confidence intervals applied).

It is of interest to note that eight District Health Boards participated in the Classification and Outcome Study project. This study aimed to establish and assess a 'case-mix' classification system that would inform future planning, purchasing and delivery of mental health services in New Zealand. A casemix classifies episodes of care that are clinically similar, and in terms of identification of the resources used in providing a service to the client (Gaines, Bower, Buckingham, Eagar, Burgess & Green 2003). This study found that for adult episodes of care in hospital settings, there was a higher proportion of Māori and Pacific Island consumers relative to other ethnic groups in the distribution of inpatient episodes and that the costs of each episode in comparison to 'other' is higher. In a recessional environment it certainly makes sense to provide earlier intervention, thereby reducing or delaying the number of costly inpatient episodes.

6.8   Māori to non-Māori comparison – do Māori experience different care and treatment?

Kumar, Ng, Simpson, Fischer & Robinson (2008) used a small rural sample to investigate restrictive care practice for Māori in a psychiatric unit. They found that Māori are more likely to be prescribed antipsychotics and at higher doses than non-Māori; are less likely to be referred to psychotherapy services; and 31% of Māori were secluded in comparison to 19% of non-Māori. On admission, 49% of Māori admissions were under the Mental Health Act, in comparison to 40% of non-Māori. On a positive note, readmission rates were similar between Māori and non-Māori.

Section 71 of the Mental Health Compulsory Assessment and Treatment Act identifies that seclusion can only occur where and for as long as it is necessary for the safe care of the patient, or the protection of other patients. Therefore seclusion is about the protection of the service user, other patients and by default staff. It is used when there are no other alternatives available. In terms of seclusion, the Mental Health Commission (2004) identified the consequences of this practice, including feelings of helplessness, punishment, depression, anger, frustration, confusion and fear. Seclusion is necessary at times. El-badri & Mellsop (2002) completed a study of the use of seclusion in the Waikato area, and they found that overall 16% of patients were secluded, and 75% of those patients had more than one seclusion episode. Overall they found that 20% of Māori patients were secluded; 22% of other non-Pākehā; and 11% of Pākehā patients were secluded. Those patients with schizophrenia, mania or with substance abuse tended to be secluded more frequently than others.

This somewhat aligns to the findings (Ministry of Health 2010a) who identified that Māori were more likely to be secluded than all other ethnicities. In 2010 there were 6,348 adult inpatients (between the ages of 20 to 65) and 1,065 were secluded. Māori were statistically more likely to be secluded than Pacific and Other populations.   Of the 1,065 adults between the ages of 20 to 65 years of age, 400 (38%) were Maori,   54 (5%) Pacific, and 611 (57%) other.

Nelson Marlborough from the 1 January 2010 to the 31 December 2010 had the second highest number of seclusion events per 100,000 population across 21 District Health Boards.

This is not dissimilar to other indigenous or minority populations who also experience higher levels of compulsory admissions and seclusion rates (Parkham 1997; Secker & Harding 2002).

6.9   Whakamomori - Suicide

Suicide does not just occur when service users are accessing specialist mental health services. Suicides also occur in primary and community settings. In some instances, no contact is made with health services seeking help with their personal circumstances that might drive suicidal behaviours. Service users who are under the care of Specialist Mental Health Services have about 25 times the rate of suicide compared with non-service users. There were 497 suicides recorded in the mortality database for 2008 (Ministry of Health 2010). Forty percent of those people who committed suicide had been in contact with specialist mental health services in the year prior to the date of death (Media Roundtable 2011).

Te Rau Hinengaro (2006) provides interesting comparisons between Māori, Pacific and 'Other' population suicidal behaviours. Prevalances for suicidal ideation are higher for Māori than non-Māori or Pacific. However, for suicidal planning and attempts Pacific people have a higher prevalence followed by Māori, then 'Other' populations.   Given that Māori have a higher prevalence of mild to severe mental disorders in comparison to non-Māori and Pacific populations, Māori are at higher risk of having a mental disorder which is a strong risk factor associated with suicidal behaviours.   In addition, a further exacerbation of risk is that Māori and Pacific populations are less likely to make contact with health services if they do experience mental health issues. For all populations who experienced a disorder in the past 12 months, only 25.4% of Pacific people sought help through a health service, 32.5% of Māori, and 41.1% of the 'Other' population. If Māori do not access health services when they start to become unwell, this is likely to result in poorer health outcomes.

Ministry of Health (2008b) identifies that both suicide rates (Māori and non-Māori) per 100,000 population and self harm hospitalisations have reduced significantly. Male suicide rates were three times higher than female suicide rates in 2006, and female self harm hospitalisations were approximately twice that of males. Still, disparities exist between Māori and non-Māori where Māori age standardised suicide rates were 17.8 per 100,000 population, and non-Māori were 11.0 per 100,000 (95% confidence intervals applied). Suicide rates are higher for those living in Quintile 5 than Quintile 1 and socio-economic deprivation is an indicator of increased risk.   For Māori, the age group with the highest suicide rate was young people (aged 15 to 24). For non-Māori, adults aged 25 to 44 years had the highest suicide rate.

6.10   Intentional Self Harm

He Tatau Kahukura (2006a) identifies that for all age groups, Māori males had significantly higher rates of hospitalisation for intentional self-harm than non-Māori males. Ministry of Health (2008b), identifies that the total Māori age-standardised hospitalisation rate for intentional self harm was 209.6 per 100,000 population. This rate is nearly 1.5 times that of non-Māori at 141.3 per 100,000 population. The age-standardised hospitalisation rate for Māori females for intentional self harm was 258.2 per 100,000 population, compared to 193.8 per 100,000 non-Māori female population. For Māori males the rate was 157.2 per 100,000 compared to 87.8 per 100,000 for non-Māori males[36].

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[36] 95% confidence intervals were applied to He Tatau Kahukura.

The subgroups of the New Zealand population with the highest intentional self harm hospitalisation rates in 2006 were females, Māori (as opposed to non-Māori), those in the life-cycle stage 15 to 24 years and those residing in the most deprived areas (quintile 5). For both Māori and non-Māori, young people (15-24 years) had the highest rate of hospitalisation for intentional self harm.

6.11   Summary

This chapter explores specialist mental health services for Māori from a national perspective. There has been a distinct reversal from the early 1960s where there were more non-Māori admissions per capita to psychiatric hospitals, to current times where there are more Māori admissions.

This chapter has shown that in comparison to non-Māori, Māori have higher prevalence rates of serious mental health disorders, higher seclusion rates, greater use of antipsychotics, higher presentations for psychotic disorders, more involuntary admissions, higher risk of suicidal behaviours, higher prevalence of mental illness, more referrals to psychiatric units from law and welfare agencies, Māori are least likely to be referred through a General Practitioner, Māori feel a stronger sense of coercion, Māori have higher levels of co-morbidity, higher number of presentations for crisis, acute and forensics, higher readmission rates, and after all of this, Māori are less likely to make contact with health services to seek help for their mental wellbeing. This is similar to other indigenous or minority experiences.

This then sets the platform for the first study question. How does Te Tau Ihu Māori Mental Health in an acute inpatient setting differ from non-Māori and Māori nationally?

Chapter Seven: Study One – How does Te Tau Ihu Māori Mental Health in an acute inpatient setting differ from non-Māori in Te Tau Ihu and Māori nationally?

7.1   Introduction

Previous chapters have explored the health status of Māori in Te Tau Ihu with Māori nationally. Te Tau Ihu Māori have an improved level of wellbeing on a number of physical health indicators. This study will compareTe Tau Ihu Māori tangata whaiora with non-Māori in Nelson Marlborough, and Te Tau Ihu Māori with New Zealand Māori nationally who require admission to a specialist mental health unit.

7.2   Background

Prior to Te Rau Hinengaro National Mental Health Survey publication, the Mental Health Commission suggested that the target for access to mental health services for Māori should be double that of the general population, indicating a 6% access rate would be appropriate to meet Māori needs. Te Roopu Awhiowhio (2004)[37] endorsed this view with a goal of having Te Waipounamu (South Island) achieve the 6% level.

The number of services for specialist mental health services are wide and varied. The generic mainstream services[38] across the Tasman, Nelson and Marlborough areas include Child and Youth Adolescent Services, Early Intervention, Day Activity, Home Based Treatment, Forensic, Primary Care Liaison, Inpatient, Alcohol and Other Drug Services, including opioid substitution treatment; Continuing Care, Crisis Team Services, Respite, Home Based Support, Community residential services and Community Support Worker services. The Provider Division (hospital based) service has a Māori mental health team funded for two staff based in Nelson, and two in Blenheim.

There are three Kaupapa Māori specialist mental health community providers. In the Tasman region Te Awhina Marae provide Mental Health Community Support and Alcohol and Drug Counsellors. In Nelson, Te Kahui Hauora o Ngāti Koata provide Alcohol and Drug Counsellors and Adult Community Health; Te Rapuora o Te Wai Harakeke provide Needs Assessment and Service Co-ordination in a district-wide service, a Day Activity Programme,

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[37] Te Roopu Awhiowhio (whirlpool of knowledge rising forth), was the name provided by kaumatua to identify the work of the South Island Kaupapa Maori Mental Health Services Review Project Team in 2003/2004. Te Roopu Awhiowhio included representatives from all six South Island District Health Boards and developed Te Waipounamu Maori Mental Health Strategy 2003-2007.

[38] Both Provider Division Hospital Based services and the Community NGO sector.

Tamariki and Rangatahi services and Community Support Work. In Marlborough, Te Rapuora o Te Wai Harakeke provides Alcohol and Drug Counsellors, Tamariki and Rangatahi services, Adult Community Mental Health, Day Activity Programme, adult planned respite and Community Support Work.

The range of services provides a platform to better understand Māori mental health in Te Tau Ihu.

7.3   Research Question One

The first research question '*How does Te Tau Ihu Māori Mental Health in an acute inpatient setting differ from non-Māori and Māori nationally?'* has four subsidiary questions, as follows:

a) Are there differences between Māori and non-Māori data in Nelson Marlborough/Te Tau Ihu in relation to acute inpatient admissions, diagnosis, age and gender ranges, readmissions, seclusions, and average length of stay?

b) Are there differences between Māori and non-Māori data in Nelson Marlborough/Te Tau Ihu in relation to suicidal behaviours?

c) Are there differences between Māori and non-Māori in Nelson Marlborough/Te Tau Ihu, in terms of access rates to specialist mental health services?

d) How do Te Tau Ihu Māori compare with Māori nationally?

7.4   Methodology:

In answering the above subsidiary questions, data was collected from a number of sources as listed below. Note that the time periods may not be consistent. For example acute inpatient data is over a five-year period, and Mental Health Information National Collection (MHINC) data is over an eight-year period. For the suicide data very low volumes for Māori in Te Tau Ihu are recorded and percentage applications can be misleading. Therefore actual numbers and percentages are used.

7.4.1   Specialist Mental Health Inpatient Data

Five years of data (2005 to 2009) was collected from the Specialist Mental Health Service acute mental healthinpatient service, Te Wahi Oranga. Te Wahi Oranga is a 26 bed unit, two of which are for Children and Youth. The five-year data set was provided in Microsoft

Excel, and was manipulated on a per annum basis to capture the information required for the first research question. Formulas were checked and applied, and a manual count against a hard copy spreadsheet prints out to double check for accuracy.

The data was collected by calendar year and included:

(i)   Ethnicity
(ii)   Age
(iii)   Male/female
(iv)   Seclusion episodes
(v)   Diagnosis
(vi)   Admission and discharge dates per service user.

The data supplied was broken down and segregated into a comparison between Māori and non-Māori in terms of the following categories:

(vii)   The percentage and number of admissions.
(viii) The percentage and number of seclusion episodes.
(ix)   The percentage and number of male admissions.
(x)   The percentage and number of female admissions.
(xi)   The percentage and number of readmissions.
(xii)   The percentage and number of admissions by age.
(xiii) The average length of stay for admissions.
(xiv)   Diagnosis data for each admission.

A comparison was then completed on whether Te Tau Ihu Māori rates differ from the 'Other' population in Nelson Marlborough; Te Tau Ihu Māori and Māori nationally; and suicidal behaviours Te Tau Ihu Māori and Māori nationally (*where such data is available).*

7.4.2   Mental Health Information National Collection
Additional information was gathered from the Mental Health Information National Collection (MHINC) in terms of access rates from Nelson Marlborough District Health Board. This information determines the percentage access rates for Māori and Other, and by age bands.

7.4.3   Ministry of Health
Ministry of Health information was used in relation to suicidal behaviours and mortality rates. Consultation also occurred with the Nelson Marlborough Suicide Prevention Co-ordinator to confirm rates provided by the Ministry of Health for Te Tau Ihu.

7.5 Results

Given the disparities noted in previous Chapters between Māori and non-Māori health generically; and indicatively Te Tau Ihu Māori and Māori nationally, a comparison of five years admissions data was collected and analysed to identify whether Te Tau Ihu Māori mental health utilisation of an acute mental health inpatient unit, were comparable to non-Māori in Nelson Marlborough and Māori nationally.

Appendix A provides a breakdown of mental health acute inpatient admission date for Nelson Marlborough District Health Board for the 2005 to 2009 by each year.

Māori acute inpatient admissions are higher than their population rate. The Māori population rate of Te Tau Ihu is 8%; however, admissions to the acute inpatient unit are 15% of all acute admissions.
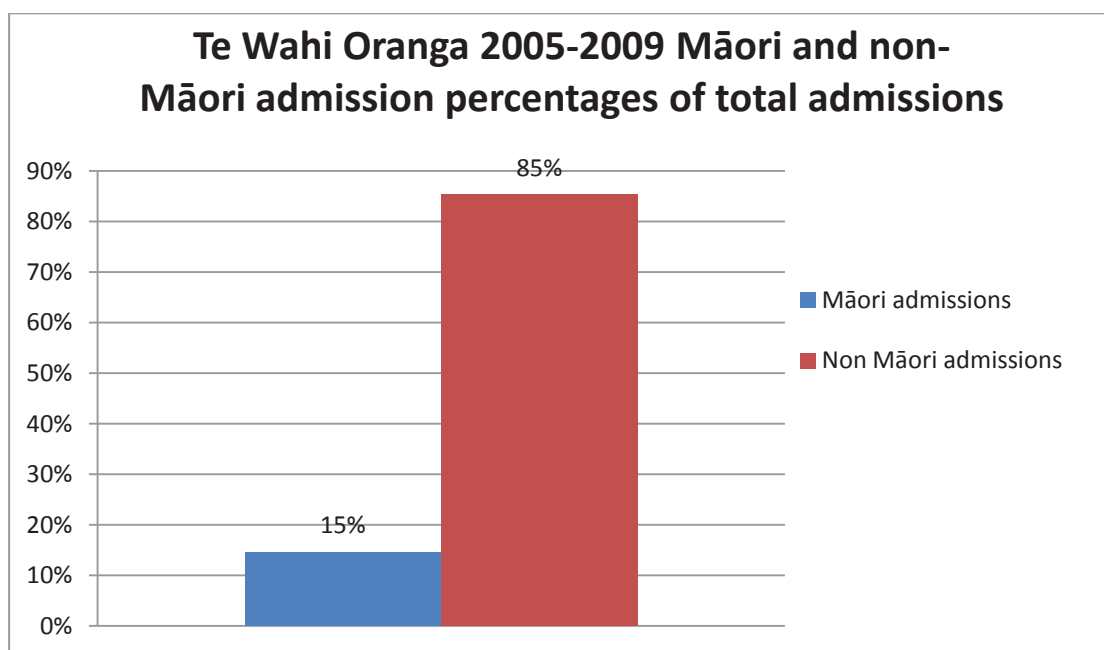
Graph 1 Māori and non-Māori admissions Te Wahi Oranga 2005-2009

For the 0 to 15 year age group, Māori admissions across both male and female (2%) are consistent with non-Māori admissions at 2%. However, when we get to the 15 to 19 year age group Māori admissions for male and female are 13%, and non-Māori at 7%.

Māori admissions are also higher for those aged 20 to 44 years. For Māori females it is 73% of all Māori female admissions, whereas for non-Māori females it is only 49%. For Māori males 78% of admissions are in the 20-44 age range, and for non-Māori males it is 60%. 75%

of all Māori admissions are in the 20-44 age range, whereas for non-Māori it is only 53% of all non-Māori admissions.
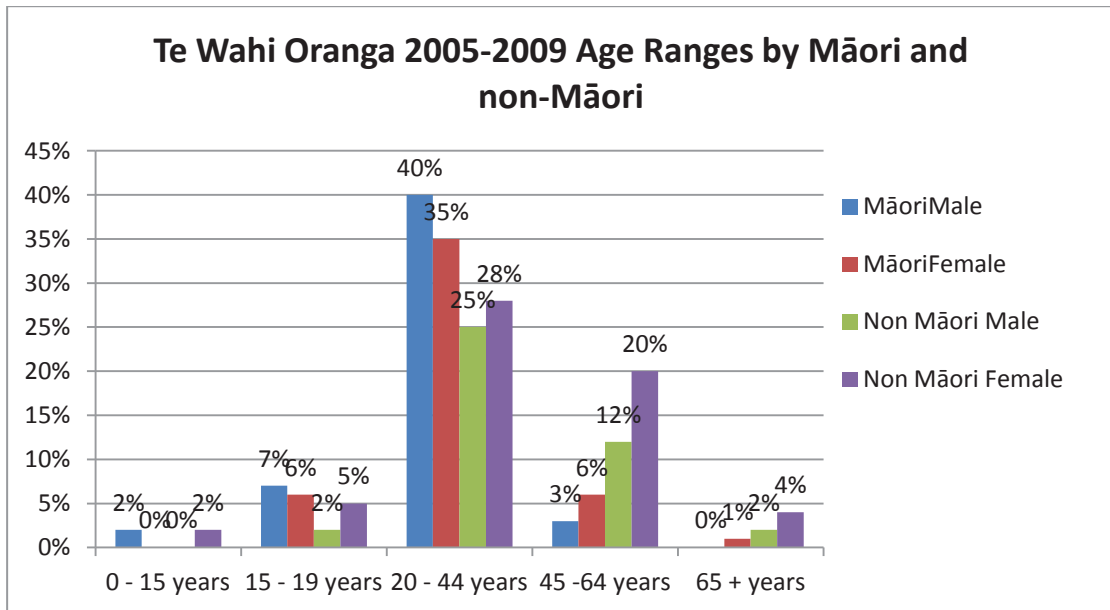
Graph 2 Admissions by age groups 2005 to 2009

Māori admissions for those aged over 65 years across male and female is low at 1%, but higher for non-Māori at 6 %.

Māori male admissions are 51.9% (136) of all Māori admissions, and female Māori admissions are at 48.9% (126) so are relatively consistent across each gender. However, for non-Māori there were more female admissions at 57.5% (880) than male admissions at 42.25% (644).
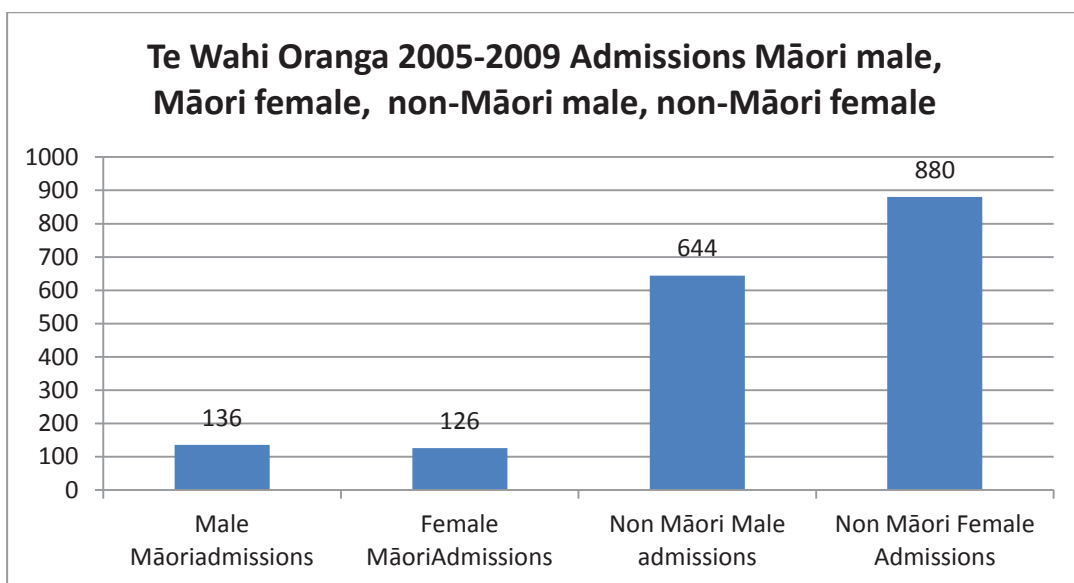
Graph 3 Male compared to Female Admissions by Ethnicity 2005 to 2009

Māori have slightly more readmissions episodes at 34.35% (90), compared to non-Māori at 31.75% (484).

Te Wahi Oranga 2005-2009 Percentage of Readmissions by total Māori and total non-Māori admissions
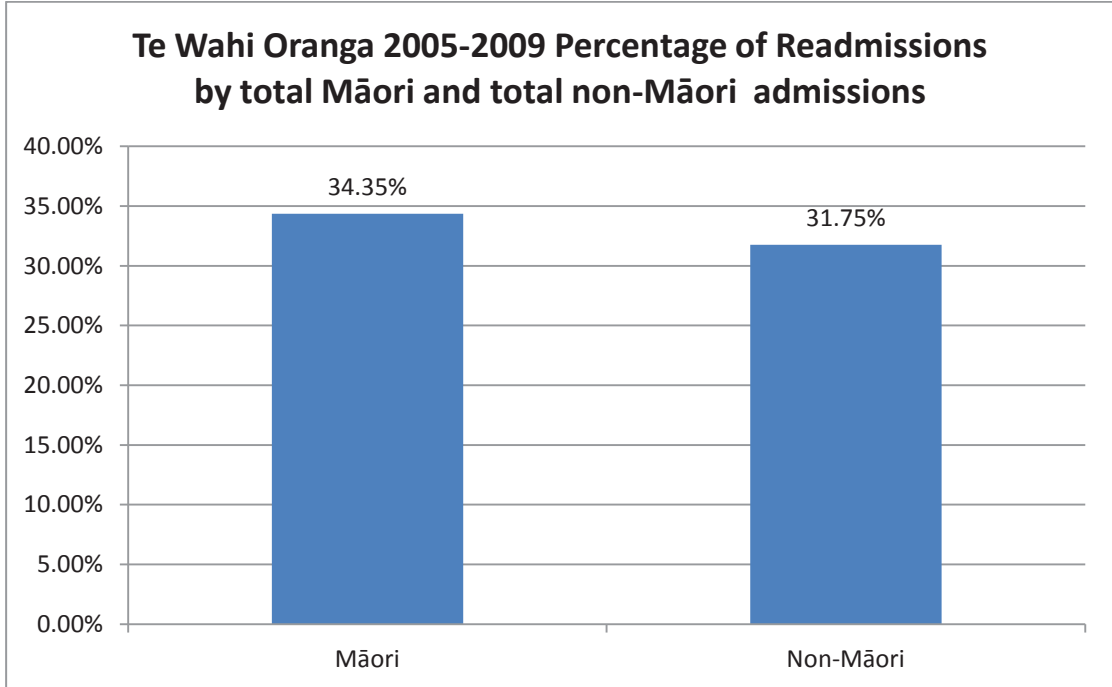
Graph 4 Percentage of readmissions by ethnicity 2005 to 2009

The number of Māori individual services users readmitted (service users admitted more than once in the sample period) is lower at 22.75% (90) than that of non-Māori at 26.04% (275).

Te Wahi Oranga 2005-2009 Percentage of readmissions (two or more) for Māori and non-Māori
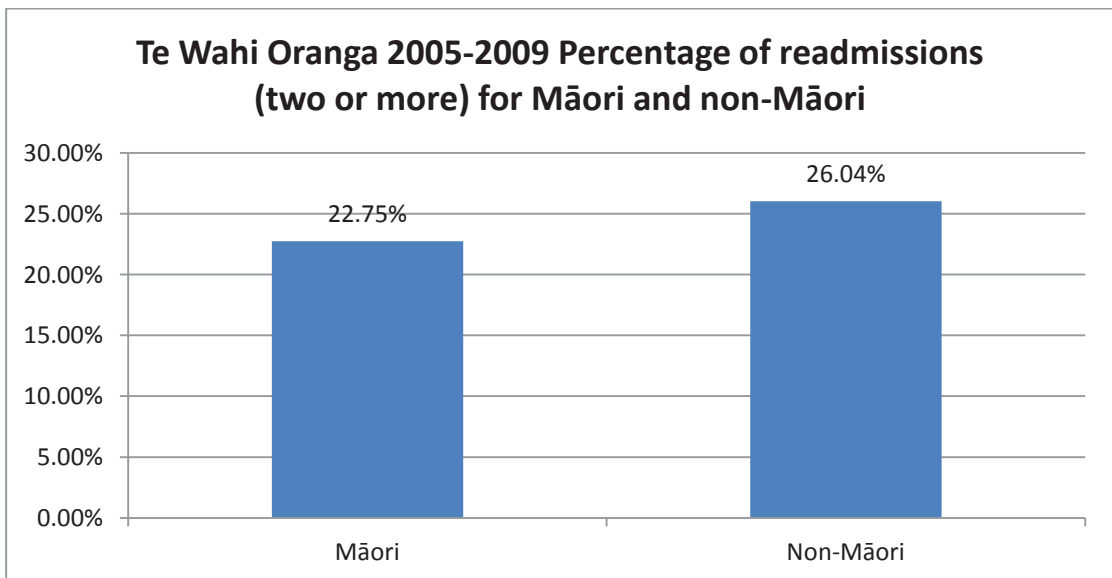
Graph 5 Two or more readmissions by ethnicity 2005 to 2009

Māori do however have higher rates of seclusions at 24.42% (64) than non Māori at 18.96% (289).

Te Wahi Oranga 2005-2009 Seclusion percentages for Māori and non-Māori admissions
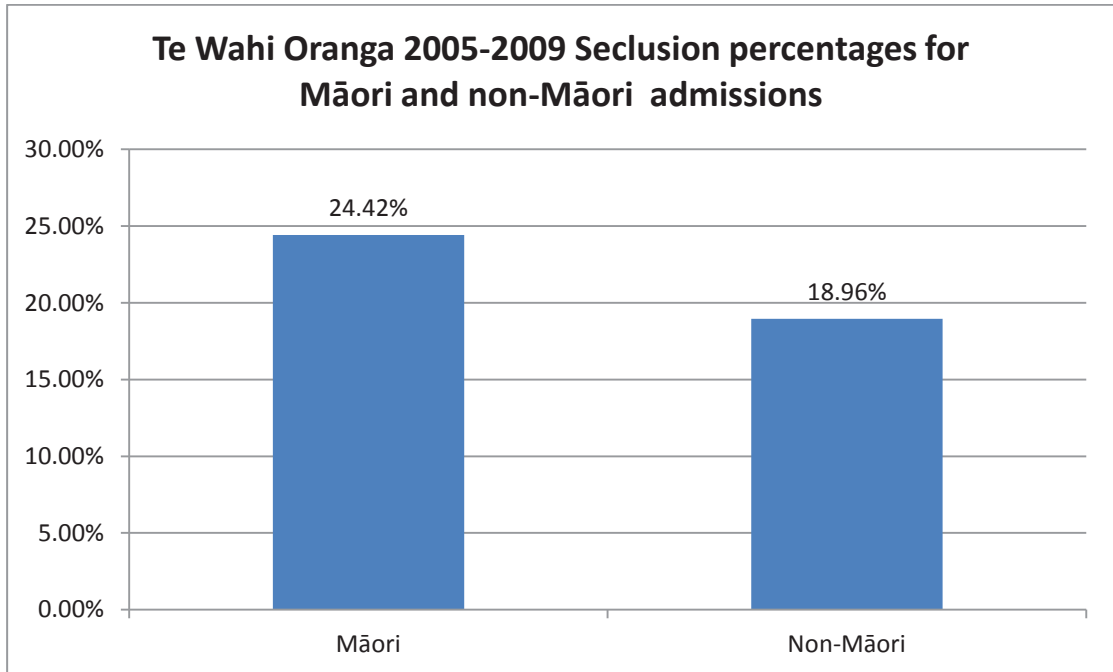
Graph 6 Seclusions rates by ethnicity 2005 to 2009

There are differences in terms of length of stay with Māori staying on average 11.12 days, and non Māori 14.85 days. The average across both ethnicities being 12.98 days.

Te Wahi Oranga 2005-2009 Average length of stay for Māori and non-Māori
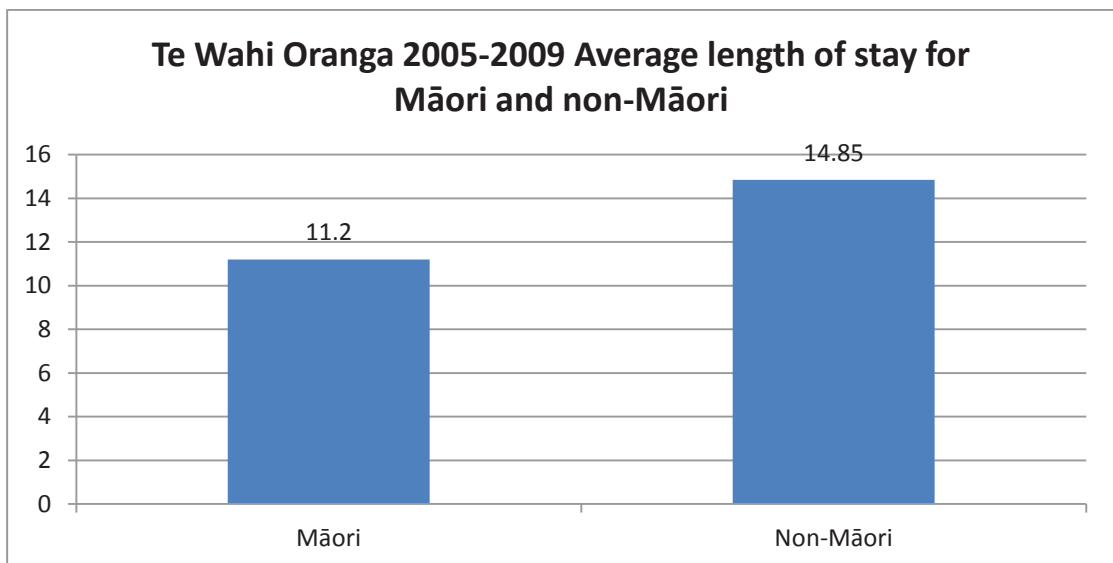
Graph 7 Average length of stay by ethnicity 2005 to 2009

In terms of diagnostic data, there were 62.23% of Māori males that were recorded as having delusional disorders, and for non-Māori males this was just over half of that total at 29.13%. Māori and non-Māori female rates were relatively similar at 15.07% and 16.47% respectively.

For Māori females 36.5% had mood disorders, where non-Māori females were higher at 45.34%. Mood disorders for Māori males were lower at 18.38%, whereas non-Māori males were 29.34%.   Māori females with anxiety disorders were 30.9% but non-Māori females 18.75%. A reversal situation is noted for Māori males with anxiety disorders at 4.41%, while non-Māori males were at 14.75%.
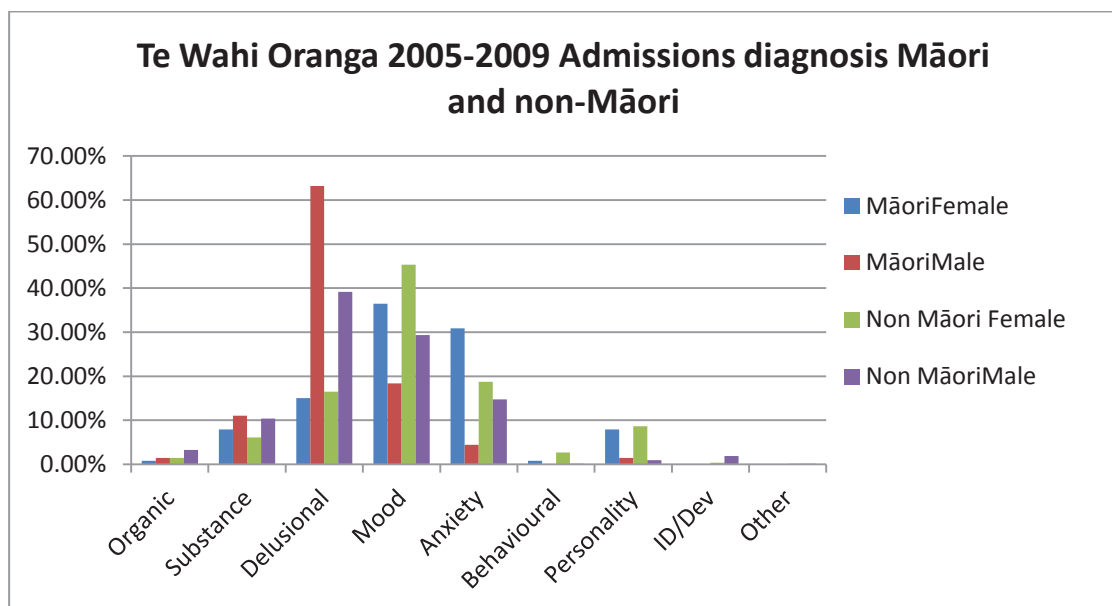
Graph 8 Diagnosis be ethnicity and gender 2005 to 2009

7.6 Mental Health Information National Collection

In the publication for Mental Health Information National Collection (MHINC) data for 2003, there were a total of 14,909 Māori admissions seen within all DHB mental health services, comprising 17.2% of all clients. Māori admissions are lower within Nelson Marlborough at 15% of total admissions during 2005 to 2009. However, Te Tau Ihu Māori comprise only 8% of our population, therefore a 6.66% rate higher than our population base. Māori nationally have a population rate of 14% and with total admissions for 2003 being 17.2% of all clients, the rate is only 3.2% higher than the national population rate.

In the 2002/2003 financial year there were 403 (3.56% access rate) Māori receiving specialist mental health services[39], and by 2009/2010 this had risen to 630 (5.22% access rate). This is

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[39] See Appendix B

an overall increase of 1.72% for Māori. In terms of non- Māori, in 2002/2003 there were 3,770 (3.19% access rate) receiving services, and by 2009/2010 this had risen to 4,327 (3.48% access rate). This is an increase of 0.29%.

7.7 Suicidal Behaviours/Mortality

From 1996 through to 2007 there were 272 suicides in the Nelson Marlborough district. Of that 23 (8.4%) were Māori, similar to that of the Māori population demographic across Te Tau Ihu. [40]

In terms of NMDHB Māori mortality rates, there were 128 completed suicides for the period 2000 to 2006 (12 were Māori). The majority (4 - 33%) of Māori completed suicides were in the 20-24 year age group, followed evenly by those in the 30–34 age; 35-39 age; and 40–44 age groups (2 - 17%). For the 15-19 age group and 25-29 age group there was one completed suicide (8.3%) for the two age groups. Of interest there were no completed suicides for Māori over the age of 45 years[41].

Nelson Marlborough Māori and non- Māori suicide mortality percentage ranges 2000 to 2006, per age group range		
Age Group	**Māori**	**Non- Māori**
10-14	0 %	2 %
15-19	8 %	9 %
20-24	33 %	7 %
25-29	8 %	8 %
30-39	17 %	8 %
40-44	17 %	16 %
45-49	17 %	9 %
50–54	0	8 %
55-59	0	6 %
60-64	0	10 %
65-69	0	7 %
70-74	0	0 %
75-79	0	10 %
80-84	0	3 %
85+	0	3 %
Total percentage	**100% (12)**	**100% (116)**

Table 5 2000 to 2006 Suicide Mortality Rates Nelson Marlborough

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[40] Information request to Ministry of Health, responded 11th July 2011.
[41] See Appendix C

This differs from the non-Māori NMDHB population where 116 completed suicides occurred over the same period, and over 41% of completed suicides were in the 45 years and over age group. While the volumes are small, Māori were at higher risk between the ages of 15 to 44 years of age. This reflects the national data.

When comparing the completed suicides across Māori and non-Māori across the same period we find the percentage figures range variably from 0% through to a high of 17.64%. Te Tau Ihu Māori comprise 8% of the Nelson Marlborough population, and for 2000, 2001, 2003 the completed suicides were aligned to the overall Māori population, in 2004 there were no Māori completed suicides, in 2006 there was less than the Māori population equivalent at 5.26%, and 2002 and 2005 there was near double the Māori population equivalent. Note that the volumes are small, therefore are treated with caution with both actual volumes and percentage rate given.

Te Tau Ihu Māori % of all total completed suicides 2000 to 2006							
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Māori	2	2	3	1	0	3	1
Non-Māori	24	22	14	11	10	17	18
Total completed all suicides	26	24	17	12	10	20	19
% Māori	7.69%	8.33%	17.64%	8.33%	0%	15%	5.26%

Table 6 Te Tau Ihu Māori percentage of total completed suicides 2000 to 2006

Hospitalisations for intentional self harm and age-standardised rates for Nelson Marlborough from 2003 to 2006[42] is as follows in the table below. Note the decreases from 2003 to 2006 for both Māori and non-Māori, even though differences still remain between the two. Within the Nelson Marlborough service coverage area the number of intentional self harm hospitalisations (all ethnicities) for those aged 5 years and over per 100,000 for 2004/2005 were 131.2, whereas the national average was 139.9.

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[42] Age-standardised rates are rates that have been adjusted to take account of differences in the age distribution of the population over time or between different groups (for example, different ethic groups). An age-standardised rate ratio is the ratio of the two rates, taking into account differences in the group size and age structure.

Year	Māori		Non- Māori		Total	
	Number	Rate	Number	Rate	Number	Rate
2006	11	101.2	111	120.4	122	117.7
2005	17	179.4	128	127.9	145	131.4
2004	17	170.6	131	124.2	148	131.1
2003	29	283.0	161	160.1	190	174.8

Table 7: Nelson Marlborough Self harm hospitalistion rates by ethnicity 2003 to 2006

7.8 Discussion: How do Te Tau Ihu Māori compare?

In terms of how this relates to national findings, there are differences between Māori nationally and Māori within Te Tau Ihu. The Nelson Marlborough Māori admissions data has been contrasted for this purpose with findings from several sources to provide a level of comparison, albeit acknowledging the overlapping timeframes.

Nationally, hospitalisation rates for Māori men were 30% higher than Māori women (Robson & Harris 2007 p 128). In Te Tau Ihu across five years admission data, there is minimal difference with 126 female (48%) and 136 male admissions (52%) to the acute inpatient unit Te Wahi Oranga. Māori males have a 4% higher admission rate than Māori females in Te Tau Ihu.

For Te Tau Ihu, the evidence identifies that non-Māori female admissions for mood disorders are higher at 45.34%, where Māori female is 36.50%. There are also a higher percentage of non-Māori male admissions for mood disorders at 29.34% and Māori male at 18.38%.

As expected nationally the leading causes of hospitalisation for Māori were schizophrenia, schizotypal and delusional disorders, followed by manic episode and bipolar affective disorder; substance use disorders; anxiety and stress related disorders; depressive episode and persistent mood disorders; organic disorders and personality and behavioural disorders (Robson & Harris 2007). Māori were over 3.5 times more likely to be hospitalised for schizophrenia and related illnesses and 2.4 times more likely to be hospitalised for bipolar disorder when compared with non-Māori (Robson & Harris 2007 p 131). In short, Māori are over represented in this regard in terms of psychotic disorders (Tapsell & Mellsop 2007;

Wheeler, Robinson & Robinson 2005).   Robson & Harris (2007 p 129) note that schizophrenia and bipolar disorder alone comprise over 50% of Māori hospitalisations for mental disorders. There are similar findings for Te Tau Ihu where 67% (176) of admissions are for delusional and mood disorders.

For Māori in Te Tau Ihu the five leading causes of hospitalisation are: delusional disorders (40%), mood disorders (27%), anxiety disorders (17%), substance disorders (9.5%) and personality disorders (4.5%). For non-Māori in Te Tau Ihu, the leading causes are mood disorders (38.5%), delusional disorders (26%), anxiety disorders (17%), substance disorders (8%) and personality disorders (5.4%). The major differences between Māori and non-Māori in Te Tau Ihu in terms of diagnosis are delusional disorders with Māori 14% higher than non Māori, and mood disorders for non-Māori 10% higher than Māori.

Nationally rates for hospitalisation among Māori women were 3.6 times more likely to be hospitalised for schizophrenia and related illness, and 2.5 times more likely to be hospitalised for bipolar disorder than non- Māori women.   Māori men were 3.5 times more likely to be hospitalised for schizophrenia and related illness, and 2.3 times more likely to be hospitalised for bipolar disorder than non-Māori men. (Robson & Harris 2007 p 132, p 133).

Te Tau Ihu Māori males had a significantly higher diagnosis of delusional disorders at 63.23% where as non-Māori males were 39.13%.   However, there is minimal difference between Te Tau Ihu Māori females at 15.07% and non-Māori females at 16.47% for delusional disorders.

Nationally suicide rates for Māori were 1.5 times higher than non Māori. Māori males had the highest suicide rates followed by non Māori males, Māori females and non Māori females (Robson & Harris 2007 p 133). Māori are at increased risk of psychotic episodes due to *"poorer outcomes"* from within mental health services and primary care (Robson & Harris 2007 p 137).

However, in terms of Te Tau Ihu Māori suicidal behaviour incidence data, Te Tau Ihu Māori compare more favourably than Māori nationally. The Māori suicide mortality rate nationally is 17.2 per 100,000, and for non- Māori it is 11.0 per 100,000. For Te Tau Ihu Māori from 2003 to 2005 the volumes were so small that the Māori mortality rate are not meaningful in a data sense. However the rate for non- Māori in Nelson Marlborough was 9.9 per 100,000

indicating for both measures Nelson Marlborough suicide mortality rates are lower than the national averages[43].

Kumar et al study reviewed 300 consecutive acute admissions between January 2000 to December 2001. This study identified that 31% of Māori were secluded compared to 19% non Māori. Elbadri et al (2002) collected data from the Waikato area over a nine month period in 2000, and found that 20% Māori were secluded, 22% other non-Pākehā and 11% Pākehā. In Te Tau Ihu 24.42% of all Māori admissions included seclusion, and for non Māori it was 18.96% of all admissions. These three studies were provincial studies therefore there is some level of variation. However in terms of a more global national picture [that includes all District Health Boards], the Office of the Director of Mental Health (2010) identified that 25% of all seclusion episodes nationally were Māori, 3% Pacific and 72% Other.

Kumar et al (2008) identified that readmission rates were similar between that of Māori and non-Māori. Te Tau Ihu Māori experience is similar in that 34.35% of Māori were readmitted once, and for non-Māori their rates were 31.75%. However, when it came to being readmitted more than once, Te Tau Ihu Māori were lower at 22.75% than non-Māori at 26.04%.

7.9   Summary

This chapter found that there is some variability between Te Tau Ihu Māori and Nelson Marlborough non-Māori; and between Te Tau Ihu Māori and Māori nationally.

There was a level of consistency with Māori nationally in terms of the higher level of seclusions; higher level of admissions for delusional disorders; higher number of admissions relative to Te Tau Ihu Māori population base; and higher number of first time readmissions.

Te Tau Ihu Māori, however, have a relatively equal number of Māori males and Māori female admissions [where nationally Māori male admissions are 30% higher than female Māori admissions]; have lower than expected second (or more) readmissions than non-Māori; have higher access rates to specialist mental health services than other District Health Board areas; and a lower level of suicidal behaviours compared to Māori nationally.

Comparing Te Tau Ihu Māori and non-Māori findings, there are higher percentage of Māori admissions [relative to the Māori population at 8%], first time readmissions and seclusions. Non-Maori have higher rates of two or more readmissions and have a longer length of stay within the acute inpatient unit. Māori admissions predominantly comprise of the 15 to 44 age

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[43] See Appendix C

group, where non-Māori predominantly are in the 20 to 64 age group.   There are distinct differences across diagnostic data for both Māori and non- Māori populations.

Te Roopu Awhiowhio (2004) identified expenditure on Kaupapa Māori or dedicated[44] Māori mental health services was $5.7 million of the total South Island spend of $170 million on specialist mental health services. At the time of that publication Nelson Marlborough District Health Board had the highest per capita spend on Māori mental health services in the South Island at $130.89. The nearest DHB in terms of capita spend was the West Coast District Health Board with $102.15. The lowest per capita spend was $53.15. NMDHB had increased investment in Kaupapa Māori Services, and this may be one contributing factor towards the improved access rates and quality of specialist mental health service provision. As noted in previous Chapters, Te Tau Ihu Māori compare favourably in terms of the determinants of health (and across a range of health indicators) in relation to Māori nationally.

An area of interest that requires further exploration, is how recognition of ones culture impacts the quality of service provision [and therefore health outcome] to Māori.

The next Chapter will briefly explore cultural responsiveness and consider best practice in relation to working with Māori in a culturally responsive way.

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[44] Kaupapa Māori and Dedicated Māori Services were self-identified by each District Health Boards.

Chapter Eight: Approaches to Cultural Identity and Culturally Responsive Services

8.1   Introduction

Twenty five years ago, Dowland & McKinlay (1985 p 136) took an outsider's look at New Zealand psychiatric institutions and found that the awareness and response to cultural difference was varied into four different levels: where cultural difference was not experienced as an issue; to those where the response was limited to the provision of interpreters; to those where there was use of tohunga or healers, or other culturally appropriate responses as an accepted part of therapy; and finally to those who worked actively with groups on Māori mental health issues. How have services and service delivery changed in the last 25 years? This chapter will briefly explore cultural identity issues and whether this has an impact on tangata whaiora wellbeing. It will also include a synopsis of how or what mental health services might need to consider in terms of providing a culturally effective service that supports tangata whaiora recovery.

8.2   Does cultural identity have an impact on resilience to mental health conditions and wellbeing?

Cultural identity, relates to the distinctiviness and sense of belonging to a group or culture. Alignment can be expressed through history, language, sexuality, religious beliefs, ethnicity, customs, beliefs or traditions.   Clark (2008) suggests that cultural identity defines and classifies an individual and in turn, the individual defines themselves in relation to other cultures. This in turn is about the notion of 'difference' between cultures.

A number of authors agree that culture influences our wellbeing and recovery and having a secure cultural identity can be a protective factor for mental illness and suicidal behaviours (Coupe 2005; Durie 1997, 2007; Lawson Te Aho 1998; Elder 2008), albeit there are mixed views in terms of the level of protection afforded (Pere 2006).

Durie (1996) suggests a secure cultural identity includes self identification with quantifiable involvement in or understanding of whakapapa, Marae, whānau, ancestral lands, Māori language and social connection with Māori people.

What does this mean for a rohe such as Te Tau Ihu, whose iwi have clearly identified through the Waitangi Tribunal process the colonisation impacts on their culture, inclusive of health? While Te Tau Ihu Māori generic health, might be better statistically than Māori nationally, there are still health disparities between Te Tau Ihu Māori and non-Māori.

8.3   Cultural competence

Given that a range of cultures have differing perceptions of mental illness, including what causes mental illness and how it should be treated, this may affect not only their access to services, but the assessment and treatment of their illness. It is pivotal that staff are skilled, or able to access the necessary expertise to provide a culturally appropriate service. The DSM-IV 2000 (p xxxiv) states that 'a clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behaviour, belief or experience that are particular to the individual's culture'. Recognising and accommodating both biomedical[45] and indigenous cultural beliefs of illness to support recovery, and in a culturally appropriate way is required. (Buetow 2004; Cherrington 1991; Coster & Gribben 1999; Dowland & McKinlay1985; Durie 2007; Ihimaera 2004; Kumar et al 2008; Johnston & Read 2000; New Zealand Guidelines Group 2008; Saravanan, Jacob, Deepak, Prince, David & Bhugra 2008).

So what is the level of cultural competence needed? Delphin and Rowe (2008) articulate cultural competence quite well as:

> knowledge and information from and about individuals and groups that is integrated and transformed into clinical standards, skills, service approaches, techniques, and marketing programmes that match the cultural experiences and traditions of clients and that increase both the quality and appropriateness of health care services and health care outcomes (p.183).

It raises the issue of whether our mental health workforces are culturally competent and how that might be assessed.

8.4   What is cultural safety?

Cultural safety is about providing quality care for people from ethnicities different than the majority, and to provide a culturally safe environment. Health service staff and providers need to reflect on their own practice in terms of acknowledging that their own cultural values and

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[45] Biomedical is the application of the principles of natural sciences especially biology and physiology to clinical medicine.

beliefs may differ from that of their patient. This needs to be accommodated in terms of how staff interact with patients (Gray, Hughes and Klein 2003). Whether we like it or not, power differentials exist as Smy, Josewski & Kendall (2010) identify, including the benefits of being aware of these differentials in terms of front line practice. In the end, those who receive care decide what is culturally safe or unsafe, they will simply 'vote with their feet' and decide not to return if they do not feel safe within the service.

8.5   What is cultural assessment?

Cultural assessment involves the incorporation of an individual's culture, relative to their wellbeing, Durie et al (1995), Mental Health Commission (2001), Ministry of Health (2004c). The assessment acknowledges the link between identity, wellness, treatment and recovery, (Mental Health Commission 2004), and is a key tool in planning treatment and rehabilitation. While these assessments can be viewed as 'complementary' to clinical assessment (MHC 2001), they should in fact be one and the same. You should not complete a clinical assessment without a cultural assessment and vice versa, or the assessment could miss some key information that supports tangata whaiora recovery. This could result in misdiagnosis and poor clinical outcomes (Delphin & Rowe 2008). Dual clinical and cultural competencies are required (Ihimaera & Tassell 2004).

A cultural assessment complements a DSM-IV diagnosis (Kingi 2005),   and is only useful if it leads to a comprehensive recovery plan that includes cultural support through the clinical pathway (Best Practice Journal (2011).   The Ministry of Health (2004c) has a framework for what a cultural assessment should contain for Māori, and this includes whakapapa (family history, iwi, hapu), whakawhanaungatanga (relationships, supports systems and the ability to relate), moemoea (dreams, aspirations, personal health, self esteem), Mātauranga Māori (knowledge, experience of a Māori world view), Taha Wairua (values, spiritual base and personal belief systems), Mauiuitanga (physical and medical health and wellbeing).

Cultural assessment processes are an expectation of all mainstream mental health services. The Mental Health Commission developed Cultural Assessment Guidelines in 2001 and reviewed the application of the guidelines in 2004, with mixed results. The sector acknowledged cultural assessment options were available and there was goodwill about the practice of cultural assessment. However, they were not always used, nor were they being used to enhance clinical assessments in mainstream services. The guidelines were not being fully integrated into mainstream standard processes and the review found that cultural assessment implementation predominantly relied on Māori staff and the goodwill of the wider

mainstream service. As it always takes a period of time to embed new processes such as cultural assessments, it would be worthy of conducting an updated review of existing practices across the twenty District Health Boards in New Zealand to see if the landscape has changed.

8.6   Do we have a workforce that understands cultural differences?

Durie (2007) acknowledges that cultural barriers can influence the care provided. Not being able to effectively communicate due to lack of understanding of language or custom is a large contributor towards this. Without an understanding of the cultural dynamics, clinicians can misinterpret spoken and body language. Therefore the importance of cultural competence and safety should not be ignored. This is certainly a worry when reviewing Johnstone & Read's (2000) research where a survey of psychologists and psychiatrist opinions was taken on Māori mental health. There were 692 respondents, of which 38% of psychiatrists and 28.9% of psychologists believed that they did not have enough knowledge in Taha Māori to work effectively with Māori clients. 49% of psychiatrists and 73.2% of psychologists indicated that their training had not prepared them to work effectively with Māori clients. One should also remember that there is a percentage of the workforce are trained overseas. There were, however, a few racially disappointing comments, one of which articulates a strong racist belief and stereotypical viewpoint:

> This questionnaire is worthless! I mean the Māori are always going on about the importance of land etc, so why the hell did they give it away, I feel that they are getting the appropriate services they need, just not using them, medication is the answer – but they just don't take their pills – if cannabis was prescribed I'd bet they'd bloody take that, my effectiveness as a psychiatrist is not depending on the colour of my skin, my culture, nor my understanding of the bloody Māori culture. (p. 142)

Even though the negative comments came from a very small minority, it indicates and is concerning that individuals with these attitudes are practicing in New Zealand. The majority of respondents understood and could describe reasons why Māori were over-represented in psychiatric institutions. Unfortunately, the minority of respondents who held discriminative stereotypic views of Māori leave a sour taste and concern for tangata whaiora/service users in their care.

Even when using clinical assessment tools, a Barker-Collo (2003) study found that within a New Zealand student sample, cultural identity affected performance on scales. They suggested that on measures of psychopathology, different cultures will perform differently

given the differences in perceived normality. This then can skew results and needs to be factored in when developing treatment or recovery plans. Cherrington (1994) and Sachdev (1989) both found that Māori patients referred to cultural themes and/or beliefs when explaining their symptomology. These were not necessarily considered pathological by tangata whaiora in a cultural context, but from a biomedical view they were aligned to hallucinations and delusions.

The clinician-tangata whaiora relationship is pivotal given that the majority of the New Zealand health workforce are non-Māori. If there is, as Cram, Smith & Johnstone (2003) suggest, a cross culture nature of many Māori patient/Pākehā doctor interactions that sets the platform for miscommunication and negative experiences, then existing disparities will continue and may even widen. Interestingly enough, while there is a small beacon of light around the growth of Māori workforce development capacity, only 3.1% of the medical workforce are Māori doctors (Cram 2010).

Rapport is one of the key facilitators for Māori access to healthcare. While there is currently no set requirements to practice sensitively, there is a need for clinicians to be aware of cultural sensitivity, including the process of care delivery (Tipene Leach 2004; O'Brien, Boddy & Hardy 2007; Ministry of Health 2004).

Ihimaera (2004) undertook a study on a pathway to understand taha wairua (spirituality) in mental health services. She distinguishes between culture and spirituality and the importance for clinicians to understand religion and spirituality beyond the DSM-IV framework. Clinicians, however, can struggle in their understanding of how cultural interventions can assist to improve mental health. Selvarajah's (2006) study involved clinicians working at nine mental health units in the Auckland region. Sevlarajah (p 65) suggested that those *'staff professional status, ethnicity and ability to speak more than one language, may influence the staff member's desire to learn more about counselling across cultures'* which synergises with his finding that there is a lack of cross cultural counselling in the Auckland area. Kirmayer, Brass & Tait (2000 p 614) highlight that *'psychiatric practice must be adapted to local cultural concepts of the person, self, and family that vary across Aboriginal communities'*.

It is more than timely that existing tertiary institutions cater and embed dual competencies within their prospectus.

There are an ample range of frameworks designed to enhance cultural competency. Whealin & Ruzek (2008) developed a ten-step framework to enhance cultural competence which

included organisational infrastructure; staff assessment, knowledge and cultural diversity; and service delivery and review. Ihimaera (2004) offers a template of tikanga processes, providing a healing rationale of why tikanga is followed, when it is applicable in a mental health service setting, and the benefits of its application. For example, 'whakapapa' acknowledges significant relationships of kin and non-kin persons, it is applicable in all cultural and clinical interactions, and one of the benefits is that it endorses whānau involvement in all aspects of care. It is a baseline template that could be embedded in tertiary institutions across the wider health sector.

The Takarangi Competency Framework is focussed on staff working within the addictions fields and outlines competencies clinicians need to effectively work with Māori[46]. The framework synergises both cultural and clinical aspects of practice underpinned by 14 essence statements. These statements include aro matawai (assessment and ongoing monitoring), pōwhiri (transactional engagement), mihimihi (structured communication), aroha (empowering action), whakawhanaungatanga (multiple system dynamics), manaaki (honouring and respecting), tātai (effective documentation), tautoko (effective support), ahu whenua (consideration of the use of the environment), ngākau mahaki (unconditional positive regard), te reo (effective communication), karakia (the means by which spiritual pathways are cleared), tuku atu tuku mai (reciprocity), whakawhangahau (celebrating effective transition and service).

Te Pataka Uara[47] is under development predominantly for Whānau Ora navigators and practitioners. This has seven core principles as the framework, whānaungatanga, wairuatanga, matakitetanga, manaakitanga, kaitiakitanga, awhinatanga, and rangatiratanga. *Let's Get Real*[48] is the mental health and addictions overall workforce competency framework. One of the 'seven real skills' is that every person working in the mental health and addiction field contributes to whānau ora for Māori. In this sense, working with Māori requires a range of skills including Te Reo Māori, waiata, karakia, whakawhānaungatanga, Hauora Māori, wairua, tuakiri tangata and manaaki.

Frameworks such as these continue to support the enhancement of providing clinically and culturally responsive services to Māori.

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[46] http://www.matuaraki.org.nz/library/matuaraki/takarangi-competency-framework-workshop-resources
[47] www.matatini.co.nz
[48] www.tepou.co.nz

8.7   Other Indigenous experiences

Virnig, Huang, Lurie, Musgrave, McBean and Dowd (2004 p 201) quote the United States Surgeon General who sums up the status of racial and ethnic minorities unmet health needs which is consistent to a Māori worldview lens:

> racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity.

Lack of cultural competency in dealing with minority racial and ethnic cultures is a contributor towards unmet mental health needs. How could this be addressed?

Parker (2003) suggests that Aboriginal indigenous mental health workers are best placed to support Aboriginal indigenous populations. The rationale being two-fold; firstly the understanding of colonisation and its impact on indigenous populations, and secondly an in-depth understanding of Aboriginal models of wellness that includes mental, physical, spiritual and cultural needs. Wand et al (2009) suggests two further aspects are environment and socio-political factors, and the importance of understanding these factors when working and engaging with Aboriginal patients, their families, communities and culture. Nagel and Thompson (2006) endorse this, articulating that Aboriginal mental health workers operate as '*cross cultural'* brokers, which supports culturally appropriate care. Aboriginals self determining their future directions and addressing Aboriginal socio-economic status is needed (Hunter 1997). Once again there are similarities to Māori populations.

In Canada, Kirmayer et al (2000) talk about cultural discontinuity and the direct link this has to higher rates of depression, alcoholism, suicide and violence. The authors reiterate how close cultural identity is to self esteem and individual identity, the power imbalances affecting service access and provision Peris, Brown & Cass (2008) support this view.   Once again, a more holistic approach is needed with less reliance on a biomedical model, and being more inclusive regarding shared decision making, trust and reciprocity with patients and their families.

8.8   How can mental health services improve their services to Māori?

There are a range of Māori health models that services can, in association with whānau, hapu, iwi and Māori communities embed within their local service. As previously discussed in Chapter 3,   Te Whare Tapa Wha, Te Wheke and Te Pae Mahutonga are the more widely

known models. Once embedded, these services are more likely to be appropriate and acceptable to Māori as Coster and Gribben (1999) and Crengle (1999) suggest.

Whānau are a social network and this is an important facet of Māori health care. Atawhaitia (1991) suggests that Māori people prefer to care for their own in a way that is consistent with Tikanga Māori. Kumar et al (2008 p 441) goes further to identify that these social networks (*in this instance whānau)* influence service utilisation by providing information about services, resources and act as a general support to their recovery. Therefore it is important and makes sense that whānau are involved in the recovery process.

While Te Rau Hinengaro identified Māori rates of co-existing mental health and addiction; and mental health/physical health conditions, some services still operate in isolation of each other. In other words,the services not wanting to address the mental health issues until the addiction issues have been treated. Dyall (1997) suggested that when developing mental health plans, not to separate out Alcohol and Other Drugs from psychosis, given that the major reasons for Māori being admitted were for this specific reason. Mental health plans need to go further than this, and also include a focus on physical health, spiritual, whānau inclusion. This requires that across the primary, community and specialist mental health services, integrated services across the continuum of care are needed. Durie et al (1995) support this and talk about funding culturally effective services, including the integration for mental health services that should not exist in isolation from other health services, along with the importance of intersectoral connections. This is not rocket science. Improving integration enhances tangata whaiora pathways through services, where there are minimal gaps in terms of service provision. This makes a service tangata whaiora centric and not service-provider centric. The difficulty is the ability to implement this approach.

Acknowledging there is a level of congruence between Ihimaera (2007) and Durie (1997) around best practice/strategies for improving Māori health, key considerations are as follows:

(a) A secure and positive cultural identity. As indicated previously,   a secure cultural identity can be a protective factor for mental illness and suicidal behaviours.

(b) Where possible cultural matching between clinician and tangata whaiora.   This enables a better connection and understanding of the issues faced by Māori. Māori clinicians are more likely to implement Māori models of care while working with tangata whaiora.

(c) Reinforcing or re-establishing links with whānau and Māori communities where Māori values, beliefs and practices are the norm. This supports tangata whaiora in terms of strengthening their cultural identity and gaining knowledge around Te Ao Māori.

(d) Actively assist applied Māori mental health practice of tikanga Māori and Māori models of health. Shifting from western models of health which focus predominantly on addressing mental health issues to Māori models of health, which are more holistic in their approach. From admission to discharge tikanga Māori practices such as powhiri (welcome), whanaungatanga (relationships), karakia (prayer) are embedded in the service delivery model.

(e) Improving the quality and quantity of mental health services. The majority of mental health services in New Zealand are non-Māori based. Tangata whaiora are likely to touch several parts of the health system, therefore it is important that there is easier access to a range of services (quantity), and that the quality of services meet the needs of tangata whaiora.

(f) Comprehensive cultural, clinical and social assessment process. It is questionable whether we currently have services that include cultural, clinical and social needs in the assessment process. Having all three provide a more comprehensive view of tangata whaiora needs that will better support their recovery journey.

(g) Early intervention strategies that support early access to services. Early assessment and intervention is important in terms of addressing the mental health problem. Without such, the condition may escalate to the point of needing secondary intervention.

(h) Increasing Māori participation in the planning and delivery of services and of Māori people in society and in the economy in general. This aligns to not only influencing the health system to strengthen service delivery to Māori; but building Māori development across society as a whole.

(i) Increased and ongoing Māori workforce development. Increasing the workforce is an enabler to improving service quality direct to Māori.

(j) Autonomy and control. Tangata whaiora and their whānau can lead and take responsibility for their own health, with the support of service providers.

(k) Whānau wellbeing being pivotal to the wellbeing of Māori people. When working with tangata whaiora, health service providers need to include the wider aspects of whanau wellbeing in their service delivery.

(l) Personalised treatment plans are essential to recovery and should be focussed on tangata whaiora needs, aspirations and goals.

The implementation of the above is often adhoc and mostly led by Māori practitioners.

Within the treatment plan there needs to be acknowledgement of traditional, complementary or alternative medicines/therapies. Recent research in Gisborne, New Zealand (Evans, Duncan, McHugh, Shaw, Wilson & Craig 2008), where 45% of the population are Māori.

Their research found that Māori had a high usage of Rongoa Māori and traditional Māori medicine, hypnotherapy, spiritual healing, imagery and visualisation. Māori used Rongoa Māori four times more frequently than non-Māori.

In addition, services need to encourage cultural governance, lead from the higher echelons of the organisation, operating as a 'family', continually moving forward but with eyes on the past (Buetow 2004).

8.9   Summary

Cultural identity does make a difference in terms of tangata whaiora mental wellbeing, and this is similar to other indigenous cultures. Embedding cultural safety and cultural competence through the continuum of care is still developing and New Zealand has led the way in some aspects. However, there is still a long way to go.   There is a small but developing Māori mental health workforce, and a larger non-Māori workforce that needs support to provide culturally competent services that meet the needs of Māori.
Fortunately, there are a number of Māori frameworks and models of care that are available to support the sector to achieve this.

The next Chapter will briefly review what service user perspectives are of inpatient care with a mix of both national and international literature.

Chapter Nine: Service User Perspectives on Inpatient Care

9.1   Introduction

The existing health environment often talks about patient-centred care, and designing services around service user/tangata whaiora needs and not the service provider. This Chapter will review what service users think about the care they receive in an acute inpatient setting.

9.2   Service user/tangata whaiora views

A number of service user studies report concerns around reliance on medication and the biomedical model (Barker, Shergill, Higginson & Ovell 1996; Barnett & Lapsley 2006; Fenton & Kotua 2000; Langle, Baum, Wollinger, Renner, Uren, Scwarzler & Eschweiler 2003; and Gilburt, Rose & Slade 2008), as opposed to a more holistic approach. However, there is a level of acceptance that medication is often required.

In one study, medication was rated as one of the most important issues but received the lowest satisfaction rating by service users (Langle et al 2003). Concerns include the trialling and testing of medication on a service user until an appropriate drug (*and dose*) suited to the service user is found. Along the way, this can cause side effects, negatively impacting on the service user's wellbeing. In some instances, tangata whaiora feedback is that they were being medically 'controlled' (Fenton & Kotua 2000). There can also be too much jargon around medical terms, as well as a lack of information/communication around the medication itself.

Consistently the issue of staff interactions is noted. A trusting positive relationship with staff resulted in a higher level of satisfaction (Gilburt et al 2008), and vice versa in terms of mistrust. Like any service, there will be staff who are engaging and provide positive experiences for service users, and there will be staff who leave their mark on service users in terms of the negative aspects of their stay. Some service recognised that given the level unwellness admission to the inpatient unit is needed (Barnett & Lapsley 2006). Service users describe that staff can contribute to a lower level of self worth and increase service user experiences in terms of stigma and discrimination (Fenton & Kotua 2000, Barnett & Lapsley 2006). The threat of compulsion or seclusion to control behaviours was noted. Service users, like any other patient, expect to be treated with respect and that their rights and privacy are upheld. This did not always occur. One service user identified (Gilburt et al 2008 p 2) that 'the

staff work hard at trying to stay away from the clients was my opinion. Be in their office as much as they could', which was a key barrier to communication and interaction. In terms of psychiatrists, there is a preference for the relationship and interactions to be based on personal qualities as opposed to professional qualities; and that services provided are timely to meet the patients needs (Barker et al 1996).

Fear, safety and security continue to merge throughout the literature. Lapsley et al (2005), discussed with services users their views of inpatient services. These were described as 'crap', 'terrible', 'worst experience ever' and 'scary'. A range of issues contribute towards this. Firstly, service users identified that they are in an inpatient unit with other unwell service users (Lapsley et al 2005, Barnett & Lapsley 2006) which is not necessarily conducive to one's recovery. Secondly, there are fears for one's personal safety and security of their possessions. Notably there were safety concerns also held for other service users and staff. Thirdly, there are references to the inpatient units resembling a prison, with a lack of control and freedom noted (Barnett & Lapsley 2006, Fenton & Kotua 2000, Gilburt et al 2008), especially around participation in and contribution towards one's own service user's treatment plan (Langle et al 2003, Fenton & Kotua 2000), and coercion in terms of the use of legislative controls and seclusion.

Boredom and lack of activities while in the inpatient unit were identified (Fenton & Kotua 2000, Lapsley et al 2005, Barnett & Lapsley 2008). Having appropriate inpatient facilities can also make a difference in terms of old buildings versus the contemporary, overcrowding, and basic comforts (Gilburt et al 2008).

Service users noted concerns around the discharge process. In some instances discharge occurs without the necessary supports put in place. Alternatively, service users are discharged too early, both of which result in readmissions to the service (Fenton & Kotua 2000, Barnett & Lapsley 2006). At the same time, some tangata whaiora have learned how to play the game and service users can adapt their behaviours with the aim of getting an earlier discharge (Fenton & Kotua 2000).

Wharewera-Mika (2012) conducted a study of an Auckland Acute Inpatient Unit Te Whetu Tawera. The first study centred on admission patterns, and the second on tangata whaiora and whanau needs within an acute inpatient setting. Te Whetu Tawera is a 58 bed facility, and built within this facility is an onsite Marae with its own wharehui, wharekai and associated office space. Te Whetu Tawera has a Māori team within the unit called Kai Atawhai. Wharewera-Mika used a Likert Scale and semi structured interview process with

twenty tangata whaiora and ten whanau participants. In terms of admission processes, she found that tangata whaiora didn't appreciate police intervention; that at times there was a lack of honesty in communications around admission processes and that the level of unwellness could be escalated by this; that there was a level of fear, anger and confusion around the admission process, sometimes brought about my memories of past admissions; and that there is a level of comfort in having Māori staff involved in the admission process.

Tangata whaiora also talked about the level of boredom within the unit; there were mixed views about the food, many had put on weight while in the unit; there were comments about the nurses station and this being perceived as not helping either staff or patients; that assaults within the unit caused additional fear and trauma; restraint practices were an issue; and there was a sense by some tangata whaiora of feeling disrespected by staff. Tangata whaiora identified the positive difference in having Māori staff and a Māori friendly environment within Te Whetu Tawera.

Finally, the issue of culture and cultural competency arises where service users report a lack of understanding on several fronts. In one United Kingdom study the issue was around staff awareness and reaction around voodoo, which ended up being a negative racist experience (Gilburt et al 2008). In three other studies, ethnic minority groups report lower levels of satisfaction with inpatient services, and these populations were less likely to seek help from a mental health professional, more likely to use emergency services, and more likely to be diagnosed with schizophrenia (Parkman et al 1997, Gillespie, Gillespie & Williams 2005, Snowden & Cheung 1990). One can imply that this is linked to their experiences in the inpatient unit, and the cultural awareness and competency of staff. Fenton & Kotua (2000) clearly identified that the cultural needs of Māori were not met in most instances within an inpatient setting. From service user perspectives, the key areas that would support tangata whaiora recovery in an inpatient setting are whānau support and involvement, tangata whaiora self belief and hope; support and interaction with Māori or other Māori tangata whaiora on the unit, Kaupapa Māori mental health services, and personal growth in Te Ao Māori.

9.3　Summary

There is a level of synergy in service users' experiences. Some of the key themes of these experiences involve the development of respectful relationships between staff and service users as part of the therapeutic relationship. This covers issues such as trust, communication and human rights. Service users' perspectives on clinical reliance of medication remain a concern, as is providing a safe and secure environment. Minority ethnic groups have a lower

level of satisfaction within inpatient services, this predominantly being linked to the lack of understanding around their cultural beliefs, values and attitudes.

This Chapter sets the scene for the second research question: *'What are Māori tangata whaiora experiences in a Mental Health Inpatient Unit in Te Tau Ihu?'*

Chapter Ten: Study Two – Tangata Whaiora experiences in a Mental Health Acute Inpatient Unit

10.1 Introduction

Legislation and government policy in relation to mental health service provision and approaches have grown and adapted to changing times. In the latter parts of the 19th century over a 28-year period, there were only seven Māori admissions to the Nelson Lunatic Asylum, which was a small 1.18% of all admissions over that period. Five of those admissions were transfers from the period of the Taranaki land wars. One other admission was for a Ngāti Rarua tūpuna Ramari Herewini who as her whānau have suggested, was so bereft for the loss of her lands, consistently voicing her challenges to authorities that arguably may have led to her admission to the asylum.

For those six tūpuna, their experiences in protecting their lands from the Crown is a possible contributing factor towards their mental wellbeing at the time of their admission.

From the 19th century through to the 21st century we have seen a reversal of fortune for Māori, where Māori admissions to acute inpatient services are now significantly higher than non-Māori.

We have also considered Māori health in Te Tau Ihu in comparison to non-Māori in Nelson Marlborough and Māori nationally. Māori living in Te Tau Ihu across a range of health indicators are healthier than Māori nationally. They do, however, have some way to go in terms of reaching the same levels of health of non-Māori in Te Tau Ihu.

Māori have higher prevalence of mental illness than non-Māori. Te Tau Ihu can expect an estimated 3,229 Māori in our community that experience a mild to serious mental illness within a twelve-month timeframe, which is significant given this is 30% of the Māori population in Te Tau Ihu. Māori do not access services early enough, and the inverse care law (*those who require most health care receive the least and of a lesser standard*), applies here in that those populations that most need health interventions are less likely to receive it. There are a range of barriers in terms of access to services, and Māori are affected by those barriers.

From a specialist mental health view, research indicates that Māori are more likely to be readmitted, more likely to be secluded, more likely to be diagnosed with a psychotic disorder,

more likely to be prescribed antipsychotics, more likely to be involuntarily admitted, more likely to be referred by law and welfare agencies, less likely to be referred by a General Practitioner, more likely to have a range of mental health, alcohol and drug and physical co-morbidities, more suicidal behaviours and self harming events, and yet less likely to seek help than non-Māori. Simply, things have to change for Māori who experience mental illness, and this requires a concerted effort from government strategy and policy, which should be infiltrated right through to frontline service delivery.

The first research question posed in this study looked at how Te Tau Ihu Māori Mental health in an acute inpatient setting differed from non-Māori in Te Tau Ihu, and Māori nationally. A brief comparison with non-Māori living in Nelson Marlborough was also part of the framework. This study found that there was a level of consistency with Māori nationally in terms of the higher level of seclusions; higher level of admissions for delusional disorders; higher number of admissions relative to Te Tau Ihu Māori population base; and a higher number of first time readmissions. Te Tau Ihu Māori, however, had a relatively equal number of Māori male and Māori female admissions; had lower than expected second (or more) readmissions than non-Māori; had higher access rates to specialist mental health services than other District Health Board areas; and lower level of suicidal mortality compared to Māori nationally. Non-Māori also tended to stay in the acute inpatient unit longer than Māori.

As noted previously there are indications that the effects of colonisation have had an effect on the mental wellbeing of Māori over time. Having a secure cultural identity provides a stronger level of resilience to mental unwellness. When it comes to services providing a culturally responsive environment, there has been some positive growth in the last three decades. However, there are still challenges to be met given Māori experiences in both primary and secondary care services, including the provision of a culturally competent workforce.

In terms of an acute mental health inpatient unit, from an experiential base, it is our tangata whaiora who are the experts and hold the key to better understanding what supports, or does not support their recovery. There are consistent themes both within New Zealand and overseas covering the development of positive relationships with staff; less reliance on western biomedical models of care and being more open to the provision of holistic models; providing a culturally responsive environment; ensuring there is a level of safety and security; being treated with respect and dignity; being able to participate in one's own treatment planning; reducing the level of boredom; reducing the level of stigma and discrimination, being more in control of one's destiny; less threatening behaviour in terms of the use of

legislation or seclusion; and ensuring adequate discharge processes which might prevent earlier readmissions.

With all of this in mind, the second research question is around understanding tangata whaiora experiences in a Te Tau Ihu acute inpatient unit. To answer this question, a Kaupapa Māori research methodology will be used. A Kaupapa Māori research methodology enables the research to centre on Māori principles of engagement, recognises Māori methods of creating Māori knowledge, and is driven predominantly by Māori.

10.2 Methodology: Kaupapa Māori Research

Emerging in the late 1970s, early 1980s, Kaupapa Māori research developed from a level of frustration from Māori tired of being exploited by non-Māori research practices. It was time to challenge westernised models of research that continued the colonial power imbalances, 'belittling', 'undervaluing', 'misconstruing' and 'misinterpreting' Māori knowledge (Bishop 1999; McNicholas & Barrett 2007), which resulted in research outcomes being of questionable value to the Māori community itself (Bishop 1998). In addition, the power imbalances and cultural superiority in the westernised approach, are likely to have reduced the level of engagement with Māori participants.

As Edwards, McManus, McCreanor (2005) suggest, this maligned Māori. Māori were weary of being continually researched *(*Tuhiwai-Smith 1999), especially as non-Māori researchers often took a top down approach (Cram 2001). The consequences of this were that the Māori voice was not heard, when the research should have been asserting those views. Māori needed to challenge the accepted norms and assumptions about acquiring knowledge and how it was constructed in relation to Māori (Moewaka-Barnes 2001). Bishop (1998,1999), Cram (2001), and Smith (1999) elucidate these concerns and how universal truths about Māori are developed by non-Māori researchers. McNicholas (2005) expresses Kaupapa Māori Research as a form of freedom from oppression from westernised models. It is an anti-positivist approach, aligned to ensuring that the Māori world view can only be understood from the point of view of individuals who are directly involved. In addition, understanding the 'phenomenon' researched does rely on the researchers own knowledge and world view, which is why Māori involvement and control is critical.

Cunningham (2000) provides a useful taxonomy that describes research approaches for Māori into four separate types: The first type is an approach where Māori data or participation is not sought as part of the overall research framework. In these instances the outcomes and results from this research is not viewed as having an impact on Māori. The second type is

where Māori may be involved in terms of being participants of the research and where Māori data is sought and analysed. Māori may be involved as part of the research team but not in a leading role and they also may be trained in contemporary research methods and mainstream analysis. This second type of research is a concern as Edwards et al (2005 p. 89) articulate 'issues and concerns affecting Māori communities either continue to be dealt with ineffectively, in ad hoc ways, that produce inaccurate findings, or they simply remain unaddressed'. Tillman (1998 p. 222) explains the risks associated with westernised models of research 'an assumption that members of these groups need and want others who are outside of their reality to understand them, define their reality for them, and then make decisions about what is best for them'. In this type of research Māori knowledge is produced based on western methodologies. This may result in the risk of the research outcomes being questioned by Māori as to their value.

The third type is Māori-centred research, where Māori take leadership roles and non-Māori are also involved in the research team. Māori analysis is undertaken and Māori knowledge is produced, however, this is often measured against mainstream standards. The final type is Kaupapa Māori research where Māori lead the research and the research team is typically all Māori. Once again, Māori analysis is undertaken which produces Māori knowledge. The difference with Kaupapa Māori research as opposed to Māori-centred research is that Kaupapa Māori research meets the expectations and quality standards of Māori.

Of these four differing types, a Kaupapa Māori research methodology aligns to Tino Rangatiratanga (self determination) within Māori cultural context and practice. It therefore legitimises and validates Māori voice, knowledge and experiences.   Kaupapa Māori takes a collective approach, where sharing control of research encourages and maximises the engagement, participation and interest of Māori. The research is therefore legitimised within the Māori community itself given the collaborative approach. The aim of Kaupapa Māori research is to seek positive and improved outcomes for the participants and the wider community (Edwards et al 2005, Moewaka Barnes 2000) and accordingly, this plays a central role. Smith (1999) identified the key features of a Kaupapa Māori approach as: it is related to being Māori; connected by Māori philosophy and principles; takes for granted the validity and legitimacy of Māori, including the importance of Māori knowledge and culture; and is concerned with the struggle for autonomy over Māori wellbeing.

There are a number of key principles underlying a Kaupapa Māori approach. Tino Rangatiratanga is the principle of self determination with Māori having control over their own culture, aspirations, knowledge and destiny. Taonga tuku iho is the principle of cultural

aspiration. This is not only about validation and legitimisation of Te Reo Māori, Tikanga Māori and Matauranga Māori, it is also around the strengthening of Ako Māori, the principle of culturally preferred pedagogy. This involves teaching and learning practices of Māori. '*Kia piki ake i nga raruraru o te kainga*' is the principle of socio-economic mediation, therefore the research needs to be of benefit to Māori communities, contributing towards alleviating some of the existing socio-economic disadvantages. Whānau is the principle of the extended family structure. One of the key elements within Kaupapa Māori research acknowledges the importance of relationships on a number of differing levels. In this sense, it can encompass whānau (in the wider sense) at work, sport and play. Kaupapa is the principle of collective philosophy. This in essence should reflect the vision, aspiration and purpose of both iwi and Māori communities. Te Tiriti o Waitangi acknowledges that the treaty provides a basis through which Māori can critically analyse relationships, challenge status quo and affirm Māori rights. Ata is about building, growing and nurturing respectful relationships. Barrett-Ohia (2006), when undertaking research on Māori multiple owned land, identified additional principles required, including reciprocity, chiefly thought and behaviour (whakaaro rangatira), acknowledgement of land owners (mana whenua), unity of thought and action (kaitiakitanga), and things of value (taonga).

The present research project took place as an investigation of tangata whaiora in Te Tau Ihu rohe (Nelson Marlborough). Kaupapa Māori principles have been applied in this context.

In terms of tino rangatiratanga, I whakapapa to Ngāti Toarangatira and Ngāti Rārua (among many others) and am taking the lead in this thesis, supported by the iwi of Ngāti Rārua and Ngāti Toarangatira. Tangata whaiora involved in the research have also had the opportunity to voice and share their stories. The research has inspired taonga tuku iho, providing a sense of pride in being Māori and endorsing the need to provide more culturally appropriate services to Māori in acute inpatient settings. Ako Māori in this instance is tangata whaiora having shared their stories, which in turn teaches others in terms of service improvement. *Kia piki ake i nga raruraru o te kainga*, the research is seen to be beneficial to Māori who access acute inpatient services, with improved service delivery requiring additional Māori staff, but more importantly, improved health outcomes for Māori. Whānau recognise that within this research, encompass tangata whaiora and their immediate or extended whānau.

Kaupapa Māori research principles are generic across all Māori. However, there is also a Kaupapa iwi approach which recognises the differing tikanga across iwi.   What is tika for Ngāti Rārua and Ngāti Toarangatira may not be so for say Tuhoe or Nga Puhi. Therefore the approaches and implementation of the research may differ. For Ngāti Rārua and Ngāti

Toarangatira there was a sense of trust and confidence in the work I have previously produced, however there were still two key expectations to be met. Firstly, given iwi were aware of my limitations in terms of knowledge in Te Reo me ona Tikanga Māori, if any cultural supports were needed (*over and above interpreter and kaumatua services)*, that assistance would be sought direct from iwi. Iwi were aware of the current state of play in Te Tau Ihu in relation to the number of fluent Te Reo Māori speakers and did not foresee any major issues arising. As Mead (2003 p 318) suggests, 'processes, procedures and consultation need to be correct so that in the end everyone who is connected with the research projects is enriched, empowered, enlightened and glad to have been part of it.*'* Tangata whaiora and whānau safety therefore were implicit in iwi approval, hence the offer of cultural support if required. Secondly, iwi expected that the research findings would benefit those Māori in Te Tau Ihu (Nelson/Marlborough) who are living with, or supporting, a whānau member with a mental illness.

10.3   Why the selection of a Kaupapa Māori approach?

Durie (1996) identifies three competencies required to undertake Kaupapa Māori research, that is, having a level of competence in health research, competence in understanding and managing Māori knowledge and competence in operating within Māori society. The Health Research Council and Ministry of Health Ethics Committees now requires researchers to consider and identify clearly what level of consultation, support and endorsement is required from and with Māori. They have recognised the consequences of research and developed guidelines to assist fledgling and experienced researchers ensure their intended research can do no harm to Māori. Being of Māori descent, I am able to fit Durie's (1996) levels of competence. Endorsement and support for the research topic was also sought in the initial phases from Ngāti Rārua and Ngāti Toarangatira. A Kaupapa Māori approach also has the flexibility to adapt, recognising that not all Māori are fluent in Te Reo Māori, or conversant in Tikanga Māori. The research can adapt to the expectations of local iwi and tangata whaiora. As suggested by Bishop (1998), it is generally accepted that Māori are somatically involved in the research process, therefore I am able to 'personally invest' and immerse myself in the research.

Kaupapa Māori research addresses issues of social injustice (McNicholas 2005). As identified earlier, tangata whaiora are the recipients of societal stigma and discrimination. As such, I need to develop a relationship with tangata whaiora that makes them feel comfortable in sharing quite personal stories of their experiences. As Moewaka-Barnes (2000) suggests, the qualitative approach is well suited to Māori as it allows for equity in communication and conversation, that is, the balance of power is shared. The researcher does not come from a

position of 'knowing'. In this instance, I have a policy level of mental health knowledge but no experience in having acute mental health problems that require admission to an acute inpatient unit. In this instance, tangata whaiora are the experts and the balance of power is more evenly shared.

Edwards, McManus et al (2005), researched Sudden Infant Death Syndrome which is also a sensitive subject. They identified that if research activity is likely to have effect on a person's tapu or mana, whether the person is living or dead, then the research should be considered sensitive. Safety of interviewees was paramount in their research design and they paid close attention to both the cultural and emotional aspects of conducting the research. Acute inpatient experiences as a research topic is considered sensitive, where recalling of periods of acute levels of unwellness may impact on tangata whaiora current wellbeing. Given the sensitivity of the kaupapa, Edwards, McManus et al (2005) found that it was important to work with whānau as well as the individual. Predominantly, whānau provide a range of support mechanisms to tangata whaiora that assists with the research process and contributes towards tangata whaiora safety and level of comfort. Secondly, that there is a level of 'reciprocal judgement' from each stakeholder lens. It is important to be up front and acknowledge perspectives. Thirdly, karakia played a central role with some Māori researchers, but not all, therefore it is important to be flexible and prepared. Fourthly, keeping the communication channels open with regular updates on research progress assists keeps the research at the forefront. Finally, there was a reliance on 'care workers' not only at the interview but for overall safety, data gathering, regular team meetings. Other lessons learned included maintaining flexibility and remaining responsive to participant reactions, and keeping a researcher diary so that the researchers can reflect their own processes and practices. This research would encompass these learnings when implementing interviews with tangata whaiora.

Lastly, the principles of a Kaupapa Māori approach are central to the researcher's own view of how research should be conducted. The key foundation being that this research is based on a level of respect between all parties.

10.4   Method

To answer the study question, interviews were conducted with thirteen tangata whaiora using a narrative inquiry approach. Tangata whaiora shared their stories for the purpose of this research. This provided another layer of understanding which places a significant responsibility on me, in terms of accurately reflecting their stories and their experiences in a

way that honours their contribution to the study, and to Māori mental health development generically.

Nelson Marlborough District Health Board has one mental health acute inpatient unit and this is based in Nelson.   There are 26 beds at the unit, two of which are for Children and Youth.

Participants

Tangata whaiora were recruited to the study through three Māori Case Managers within the Nelson Marlborough District Health Board mental health service. The Māori Case Managers were in essence 'recruiters' and 'promoters' of the study. They approached eligible tangata whaiora and provided information on the study. They often transported tangata whaiora to interviews when needed and attended the interviews with tangata whaiora when requested.

To be eligible to participate in the study, participants had to be of Māori descent, over the age of 18 years, and have a Case Manager or General Practitioner (primary or secondary care) assisting in their recovery. In addition, participants had to have been admitted to Te Wahi Oranga within the previous six years. Exclusions were any tangata whaiora who had been in an inpatient setting within the last 26 weeks. Information sheets, consent forms and audio file authorities [Appendix D, Appendix E, Appendix F] were provided and signed by all participants. Assurance was given in the information sheet that tangata whaiora contributions were anonymous and that their personal details would not be included in the final report.

Of the thirteen tangata whaiora were interviewed, seven males and six females. Seven of the participants were from the Wairau (Marlborough district) and six from the Whakatū (Nelson district). All participants were aged between 25 and 60 years of age.

Note that pseudonyms have been used to protect the identity of tangata whaiora.

Kaupapa Māori Principles and the interviews

Linda Tuhiwai Smith (1999) developed a list of seven Kaupapa Māori practices for Māori researchers to consider, which were addressed in developing the method for this research. These principles are *kia tupato* (be cautious); *aroha ki te tangata* (respect for people); *kanohi kitea* (face to face approach); *titiro, whakarongo … kōrero* (look, listen ... speak); *manaaki ki tangata* (share and host people, be generous); *kaua e takahia te mana o te tangata* (do not trample over the mana of the people); and *kaua e mahaki* (do not flaunt your knowledge). In adopting this approach as part of the research framework, I aligned to these principles.

The Upper South Ethics Committee provided ethical approval for these procedures in August 2010. [Appendix G].

Kia tupato aligns to being politically and culturally safe, alongside the importance of considering the researchers insider/outsider status. In terms of process, Ngāti Toarangatira Manawhenua Ki Te Tau Ihu Trust and Ngāti Rārua Iwi Trust were engaged initially to explain the research and seek iwi endorsement of the research. Mr Rangi Joseph [Ngāti Toarangatira, Ngāti Rārua, Ngāti Maniapoto] accepted the role of kaumatua for the research. Engagement was needed with the Māori mental health team within the Nelson Marlborough District Health Board and the Kaupapa Māori Day Activity programmes based in Nelson and Blenheim given that there was the potential for some tangata whaiora to remember traumatic and emotional experiences of their admissions. Therefore it was important to have appropriate support available. An interpreter and kaumatua were available if tangata whaiora requested their support. Tangata whaiora were invited to bring along whānau or kaumatua support to the interviews. No tangata whaiora asked for an interpreter or a kaumatua to be present. In one interview the Case Manager and I, along with the tangata whaiora and their partner were present. This couple's relationship was close in that the tangata whaiora relied on his partner to assist with communicating to others given his level of unwellness.
In terms of *aroha ki te tangata*, tangata whaiora are the experts of their own experiences, and were respected at all times. Timing and locations of interviews were set by tangata whaiora. Localities of interviews were variable. Several interviews were held in tangata whaiora homes, at the District Health Board office, or the Nikau Day Activity Service. Flexibility was needed in terms of locality of interviews, which ensured a higher degree of comfort for tangata whaiora. It was also important to ensure that there were no perceived power imbalances as part of the process, therefore I turned up at interviews casually dressed, and the language/conversation was adaptable to suit tangata whaiora.

Kanohi kitea is essential for Kaupapa Māori research and all interviews were conducted face to face at a location and venue that ensured tangata whaiora were the most comfortable [where possible]. Two meetings were held. Firstly, an introductory meeting to introduce myself, identify the purpose of the research, provide an opportunity for any questions, answers and feedback, but primarily to establish a relationship where tangata whaiora felt more comfortable prior to the interview proper. The second meeting would consist of the interview questions and these interviews took between 30 minutes to one hour. Either the Case Manager or I, undertook the first meeting [dependant on tangata whaiora wishes, and geographical limitations where phone calls were substituted]. Tangata whaiora interviews have been a learning experience in themselves. Nelson Marlborough is a relatively small

community in relation to Māori mental health. In some instances, I had met tangata whaiora previously in terms of my work role as Portfolio Manager for Mental Health and Addictions, but also in terms of whakapapa linkages. Relationships were already established for some of the tangata whaiora. In other instances, new relationships had to be created. This was perhaps the most difficult part of the interview journey. Tangata whaiora engagement and level of ease with any researcher is pivotal to create an environment where tangata whaiora feel comfortable in sharing their story.

Titiro, whakarongo, as far as practicable a 'listening and looking' approach was implemented to enable tangata whaiora free flow of dialogue. This is another sign of courtesy and respect. However, given the sensitivity; prompts were also given as there was a level of hesitancy in some instances to divulge such personal experiences. Two tangata whaiora identified that it was the first time, the first opportunity they had to talk about their experiences at the unit and that it felt 'good' to tell the story. Some tangata whaiora came prepared for the interview and had pre-written details or notes of their experiences they wanted to share. At times language was an issue. Profanities were prolific with a couple of interviews, but were part of their everyday language, therefore have been replicated in part of the analysis.

Manaaki ki tangata, kai was available for each interview and a koha of $50 supplied at the conclusion of each interview. Kai assisted in not only the formation of the relationship, but also provided a level of reciprocity to the process. Koha of $50 each was appreciated by tangata whaiora, and if interviews were held during the Christmas period, a small gift was also given. It was humbling that a small koha could contribute significantly to basic necessities such as the weekly kai budget, and was so deeply appreciated by tangata whaiora. The research is also envisaged to be shared with a wide range of key stakeholders, to share their learnings.

In terms of *kaua e takahia te mana o te tangata*, the purpose of the research is to enhance future service provision to tangata whaiora by understanding their experiences in acute inpatient settings, and sharing the findings to influence service improvements. This research is about tangata whaiora experiences and as much as possible to accurately reflect their views. *Kaua e mahaki*, communications with research participants were conducted from a respectful, humble approach. All interviews were audiofiled and I transcribed each audiofile. Interview transcripts were sent back to the interviewee for correction, amendments or additions prior to information being used. This provided an additional opportunity for tangata whaiora to share their knowledge and stories.

There were challenges in terms of the interviews themselves. Many tangata whaiora could not recall the finer details around their time in the unit. This caused a level of anxiety in terms of memory recall, but given the time lapses between admissions or the interview itself and their level of unwellness at the time, this was understandable. Tangata whaiora related their story and the issues of importance to them, but in many instances prompts had to be used, and responses were not 'stories' in their own right. Some of this was due to my inexperience in narrative interviewing and some due to tangata whaiora comfort in sharing quite personal details. It might not have covered the full spectrum of detail expected initially as part of the process; however, a wealth of information was shared yet at times it felt like a small glimpse of the actual events and experiences tangata whaiora had to live through.

10.5   Narrative Interviews

The use of a narrative approach to the interviews was a natural alignment to a Kaupapa Māori framework. Given the kaupapa of sharing tangata whaiora experiences in a mental health acute inpatient setting, a narrative inquiry approach allowed for rich details and meanings about those experiences being expressed. It is appropriate for this level of research as Parker (2005 p.2&3) identifies 'knowledge is different for the powerful than it is for the oppressed and that those with power are simply unable to see the mechanisms that privilege their own viewpoint over others.' He also suggests that 'historical accounts are always produced from the standpoint of present day practices, usually with the function of legitimising the way we have come to do things or think about themselves.' Eade (2007) indicated there are perceived power differentials between health professionals and tangata whaiora and the aim of this study is for tangata whaiora to tell their stories, from their perspective. It is not often that tangata whaiora viewpoints are sought, and this research provided an opportunity for tangata whaiora to tell their story.

Narratives can come from many sources (Casey 1995). In this instance, the source for the narrative was interviews with tangata whaiora. The study's research topic, '*tangata whaiora experiences in an acute inpatient mental health setting',* which as McQueen & Zimmerman (2006 p 475) suggest is within the parameters of narrative research having a 'broad enough question that can elicit comprehensive narratives and responses from participants', without being too prescriptive. The expectation was that stories would 'flow', and for several tangata whaiora that was case; however, for others prompts were used to illicit responses. To assist the elicitation of stories, 'interview prompts' [Appendix H] were developed, and these were used when needed to draw out further conversations around tangata whaiora experiences.

Green, Strang, Brock & Sawyer et al (2004) quotes Schank & Berman by defining a story (narrative) as a 'structured, coherent retelling of an experience or a fictional account of an experience', with autobiographical memories being 'reconstructions' of past events, rather than 'reproductions' of past events (Garro 1994 p 776). For this research, there was a blending of both 'reconstruction' and 'reproduction'. In some instances, it was difficult to distinguish the level of 'embellishment' [and it is not the role of the researcher to determine what is or is not factual] and how much of this was due to their illness. Where in other instances tangata whaiora were trying to account for exact details of the experience and took time to recount this in detail, and in two instances checked with a family member or Case Manager in terms of accuracy.

Parker (2005 p 82) goes further and identifies that narrative research 'does not discover what the empirical truth is, but rather how someone makes sense of an event that they may have had some difficulty in describing, so it becomes true to them.' Harter et al (2005 p. 338) explains narrative research in a much more simplistic view: 'Story making and story telling help people make sense of their circumstances, cope with their situation and negotiate with others in their environment. It is the 'why' behind our actions.' As individuals, we develop narratives that account for events and those times of uncertainty and change, or as Murray (2000) suggests people try 'to bring order to disorder', that is, making sense of the changes and being able to cope. Narratives are comprised of actions, happenings, characters, settings, discourse or plot – and in terms of narrative format, this is how a story is communicated (Sandelowski 1991).

Interestingly enough, narratives can also be presented as drama sequences (Goffman 1981) or social performances (Murray, 2000). Riessman (2008) also suggests that in difficult situations such as chronic illness (in my view this includes mental illness), individuals will 'stage performances of desirable selves to preserve 'face.'' A few accounts were very thought-provoking, bordering on a sense of disbelief and that the accounts were more reflective of psychiatric hospital settings 30 to 40 years ago.   Surely such accounts could not occur in contemporary times. However, to even consider the former, as to whether the experiences were 100% factual, does not give voice or do justice to tangata whaiora experiences.

Given that the study question includes layers of meaning from a tangata whaiora perspective, this will be linked into the wider cultural context. This is important given that people construct their identity through interactions and experiences with others (Harter et al), and identity is linked to the social contexts within which it occurs (Phoenix & Sparkes 2009). Providing a

contextual perspective in terms of identity and relationships with whānau, staff and other supports is pivotal to better understand the experiences.

A narrative approach also shifts the 'subject' or 'interviewee' into a 'co-owner' and 'co-author' (co-author alongside the researcher) of the story (Harter et al 2004, Parker 2005), and while it is expected that some of the narratives deriving from the interviews will not only have an effect on the reader, as Harter et al (2005) suggests, the co-author/interviewee might also benefit from the experience by having a deeper level of self awareness, reduced level of anxiety, and the building of a new identity. Parker (2005 p 71) notes that this approach aligns to the self and is a story of self identity. There is a level of therapeutic value for tangata whaiora telling their story, and in addition, knowing that others will 'witness' the story can be described as a call for support from others, and/or a validation of the experiences shared (Murray 2000). This did occur as two tangata whaiora had never told their story before, both articulating how beneficial it was to share their experience and be 'heard' for the first time.

The key components of narrative research in relation to this study are to enable tangata whaiora to share their inpatient experience, how it affected them and how they gave meaning or made sense of those events and for tangata whaiora to explain the event in a way that is easily understood by the reader. My roles was to work alongside tangata whaiora as a co-author and provide the space for them to tell their own story.

In terms of health narratives, the outcome is not so much a story about the illness, but how that illness had altered one's life (Garro 1994). All narratives are surrounded by cultural knowledge and social context; however, as Garro suggests, illness narratives can provide insight into concepts about illness and that all important relationship between mind and body. Garro found that for those patients with predominantly physical illnesses, some patients felt that taking prescribed medication that altered their mind was too high a price to pay for control over the symptoms, so the patients found alternative ways to cope and respond to their bodies' needs. Phoenix and Sparkes (2009) talk about when narrators are sharing their stories about their bodies and illnesses, the narrator is telling the story out of and through their body. That is the body is a cause, a topic and an instrument in their story. However, for service users/tangata whaiora with a mental illness a number of medications can 'alter the mind' as well as the body, so they suffer a double 'whammy'. Their story can be told through both avenues.   In this study, I was cognisant of the likelihood that tangata whaiora would share stories of both physical and mental health impacts, and these were included in the narrative prompts as listed in Appendix H .

A narrative approach enables tangata whaiora to tell their story as they can recall, and as it makes sense to them. Tangata whaiora voices are not often heard, and instead of a reliance on non-tangata whaiora views (whether clinician, family, members of the community), an opportunity is given to co-author a piece of research that analysed and summarised local experiences. The language I used in the tangata whaiora information sheet and when talking kanohi ki te kanohi (face to face) with tangata whaiora, was that together we were co-authors but the story was theirs, lead and directed by them.

10.6 Thematic Analysis

After the interviews were completed, determining how the narratives were to be analysed was the next step in the process. The research question aligns to thematic analysis as it takes into account personal experiences as an object of study. This aligns to sharing tangata whaiora voice within the analysis. Thematic analysis was useful in this study as there was a large data set to analyse, and the themes selected were supported by the data gathered. Categories began to 'emerge' from the data. The additional benefit is that thematic analysis is flexible in its approach, without being overly prescriptive, providing guidelines, yet allowing the researcher to manage the data as they feel best represents and answers the research question (Braun & Clarke 2006). The disadvantage is that it can be wide open to interpretation and if using the same data set, different researchers may come up with different themes. There can also be some blurring between codes and themes.

In essence, thematic analysis looks for patterns, consistencies or themes across data. The themes then become the categories for analysis. Themes captured something important about the data, which was then linked back to the research question. Thematic analysis is a qualitative approach, in that the research question is around tangata whaiora experiences, including what that experience meant to them. A more qualitative than quantitative view is helpful in this regard (Newman & Hitchcock, 2011) and there is no problem with the researcher being actively embedded in the data (Braun & Clarke, 2006) recognising that the researcher will select the themes.

Therefore, I followed the six-step by step guide developed by Braun, Clark 2006. The first step in the process was to become familiar with the data. This occurred through the undertaking of all interviews with tangata whaiora, and also the transcribing of those interviews. This enabled more intimacy with the data, having not only witnessed the body language associated to each interview, but understanding the pauses and delays on audio files, reading and re-reading interviews. Step two involved generating initial codes of the data. Patterns were starting to emerge as part of step one, but not in a formal sense. The use of

'post-it' notes and highlighted text started to generate codes across all of the interviews. Step three, involved merging the codes to larger themes, which were more descriptive. Both semantic (explicit and surface meanings of the data), and latent themes (underlying ideas, patterns and assumptions*)*, were extracted as part of the data coding. Step four involved reviewing the themes clustered into a thematic map. Using 'post-its', the themes were able to flexibly shift and re-shift into groupings. In some instances, the themes were explicative across several themes (for example respect and dignity was important while living in the community, and in staff interactions). In step five, the process of reviewing themes and sub-themes commenced. Culling out of themes occurred that were not as applicable to the research question posed. At this point writing commenced. Step six involved developing the writing, using sample extracts to provide evidence of themes, determining what themes were most meaningful, analysing and strengthening detail for inclusion into the thesis.

10.7   Researcher Positioning

Reissman (2004 p 311) suggests that researcher positioning is important because it shapes the production of knowledge. She queries how the 'investigator's social location, subjectivity and frameworks of understanding enter into that investigator's analysis of another's narrative account of illness*'*. However, it is recognised that researchers are co-authors with their subjectivity and actions being embedded in the study itself (Harter et al 2005).

Certainly, I had some clear views around Māori admissions and their experiences in an acute inpatient unit. These predetermined notions come from the completion of a Master of Arts (Psychology), where tangata whaiora were interviewed around access to primary care services; a literature review of Māori mental health wellbeing; my employment as a Portfolio Manager for Mental Health and Addictions; and generic feedback from tangata whaiora and mental health staff over several years. These predeterminations were going to influence the nature of the narrative prompts.

10.8   Kia Tupato (Being careful)

Throughout the research process, I was cognisant of tangata whaiora comments and not literally taking these at face value or as Sandelowski (1991 p 161) suggests, the 'ambiguous nature of truth*'*. There may be underlying forces that generated these comments, or tangata whaiora themselves may want to re-position themselves in the narrative. As Parker (2005) suggests, tangata whaiora may relate the story the way they think the researcher wants to hear it.   As indicated previously there maybe opportunities for improving the level of awareness and the reduction of anxiety (Harter et al 2005).

Two other key areas Parker (2005) suggests to exercise caution is around not stereotyping or categorising individuals as 'good examples', but to focus on how identity scripts are used. Secondly the researcher cannot fully analyse the narrative that truly reflects tangata whaiora thoughts. That is, the researcher has to stick to and analyse the narrative as it presents itself.

From my perspective a Kaupapa Māori approach (with the support of kaumatua) underpins the research from its inception through to its completion. It feels 'natural' to me as we live this approach every day as Māori. The narrative research component is complimentary, the main benefit being that it empowers tangata whaiora to voice their experiences and stories so it makes sense to them. They do not become a 'subject' as such but take a co-author role in the study.

10.9   Lessons Learned

A bridging person who had a direct relationship with tangata whaiora (in this instance the Māori Case Managers) was essential in terms of recruitment to the study. Māori Case Managers were able to communicate with tangata whaiora and provide a level of ease before I made contact to discuss the research study.

My interviewing techniques were 'fledgling'. On reflection, given a trusting relationship with tangata whaiora is needed for them to divulge such personal stories, the face to face interviews could have been held over two sessions. This would have developed the relationship further and also provided additional time for tangata whaiora to consider other aspects of their stories. In addition, it would have been useful if I was able to 'practice' through a mock interview type scenario, to build confidence and hone my skills further.

In applying thematic analysis, a fair amount of time was spent reading and re-reading the interview transcripts. The initial coding of themes was continually related back to the transcripts. A cleared bedroom wall is useful for this purpose as you have a large area of space to transfer 'post it' codes and themes easily.

The narrative prompts were designed to illicit responses around tangata whaiora experiences from admission to discharge. Half way through the interviews, I considered whether questions around cultural identity could have added value to the study. In short it was too late to change the approach given half of the interviews had already been completed.

10.10 Summary

This chapter provided a brief introduction to study two. It outlines the research methodology including Kaupapa Māori,   narrative inquiry and thematic analysis approaches. It concludes by identifying some key lessons learned as part of the research process. This then provides the framework for sharing tangata whaiora stories.

Chapter Eleven: Tangata Whaiora Stories

11.0 Introduction

Developed by Mason Durie in the early 1980s, Te Whare Tapa Wha model provides a Māori framework to understand the four elements that can affect one's wellbeing. A wharenui (Māori meeting house) is the symbol used to demonstrate the four dimensions of overall wellbeing. The model is widely used in New Zealand. It is now embedded in Māori Health policy and is used as an approach in both Māori and non- Māori health services. (Pitama, Robertson, Cram, Gillies, Huria, & Dallas-Katoa 2007).

Te Whare Tapa Wha has been used to analyse and determine themes from tangata whaiora experiences. The rationale being that the wharenui encompasses whānau ora, or the concept of being well. To maintain tangata whaiora wellness, services need to focus on all four walls of the wharenui that is te taha hinengaro (psychological health), te taha wairua (spiritual health), te taha tinana (physical health), and te taha whānau (family health). Working in isolation or considering only one element of the wharenui compromises and impacts on one's overall wellbeing. For example, if a whānau member is recently diagnosed with a psychotic disorder, a service could provide medication that might alleviate the symptomology; however, whānau relationships are likely to be strained as behaviour changes; the illness may also have a consequential impact on employment status and therefore on tangata whaiora self worth. There could also be medication side-effects which directly impact tangata whaiora physical health. Servicing but one element of Te Whare Tapa Wha does not support a recovery approach.

Using this framework provides a platform to better understand tangata whaiora stories. It has provided a level of learning that endorses how important a holistic approach is to supporting tangata whaiora maintain and improve their level of wellness.

Note that pseudonyms have been used for all tangata whaiora who participated in the study to ensure confidentiality.

11.1 An acute inpatient unit

The purpose of an acute inpatient unit is for tangata whaiora who are in an acute stage of mental illness and need a period of close observation; and/or intensive investigation; and/or intervention. Tangata whaiora are often admitted when they are in crisis and cannot function with their usual resources and supports. Historically, acute unit's main interventions were all about medication and containment. However, over the last two decades the landscape has been changing, with Ministry of Health expectations that a range of interventions are provided, including medication, budgeting, social skills, psychological therapies, occupational therapy, recreation activities, connections with cultural linkages, domestic skills, assertiveness and self esteem building.

Nelson Te Wahi Oranga acute inpatient unit has 26 beds [adult (20), child and youth (2), intensive care beds (4)]. Te Wahi Oranga is relatively new, opening in 2001.   Prior to that, Ngawhatu Hospital provided acute care. A number of tangata whaiora have accessed both Ngawhatu and Te Wahi Oranga, and have experienced both the historical and contemporary models of service delivery.

Three tangata whaiora identified that until you have actually lived through the experience of being in an acute inpatient unit, you could not fully understand what it is like. While most acknowledged they want to prevent further admissions, they recognised that if they become unwell again, the acute inpatient unit is the place they need to be:

> *if you've experienced it yourself you know what you're on about … but people who read from books and try to listen to other patients…ugh…you gotta go through it yourself to know what it's all about" [Daniel]*

> *You gotta go through it…you know…you can understand once you've been through it and you come right, why they put you in there….because some people are dangerous. [Murray]*

11.2 Ann's Experience

Ann's story of her first experience of mental unwellness which necessitated admission to the acute inpatient unit is fairly descriptive. Ann is a professional working woman who at the time had a lot going on in her life, healthwise, at work, and at home.   Ann was on pain medication and antidepressants at the time due to an injury that had occurred several years previously. Ann's belief is that the trigger for her mental unwellness was getting her medications mixed up, and the subsequent lack of sleep:

I remember that distinctly thinking..I need to find him, somethings wrong with my head….by the time I did find him which was 20 minutes later at the neighbours I had come up with this..I decided that I was psychic of all things…. And I asked him to come home and spend one hour with me while I explained this new psychic thing that was happening to me. I didn't realise then that I was going mad. And so I put him through all these hoops, not realising that I was going loopy. He did. And he didn't know how to react and we were having some vehicle issues outside at the time and I was convinced that I could fix the car..(laughs)… he couldn't get it to go and it was really weird cause everything was playing into my hands…I'd disconnect the battery and the car would start and things like this..it was very weird. And he decided I needed help so he brought me into town and half way into town I decided to throw myself out of the car. I remember that. And he had to scream the car to a halt while I was trying to get out of the car.

And so we ended up back here where I just wanted to hide from everyone cause part of me realised that something was really wrong…. And I couldn't stop it, I couldn't control it. So I was…I went to bed which is my safe place. I went to bed and [   ] organised a Drs appointment …..and [   ] took me to the Dr. I don't have really clear memory of that. Um….he took me to [   ], and I vaguely remember being in the room. A Dr and a Nurse but I don't remember what happened in there. I do remember [   ] taking me up to the hospital and what happened there..um..we went into A&E and they took us straight into another room where for some reason I decided I was a cat. I was gonna curl up in a ball on the floor….um….then they took me through to another room where there was nothing in it except a bed. And [   ] and I ..our views were both…we both concurred that what I was needed was sleep, that all I had to do was get some sleep and we thought that if we went to the hospital they'd give me something…they'd recognise …they give me something to go to sleep. And once I had a good sleep everything would come right. We just thought theres a bit of wiring gone mad here because I hadn't slept…. I had it all…..I knew I was going mad...but I knew ..well I thought I knew what the cure was, which was to sleep. Um. And apparently were waiting in that room for 8 hours while various Drs come in and out and poked and prodded and took tests.

I remember them talking about urine tests, that I could have a urinary infection. And I was thinking this can't be a urine infection. I'm not a cat and psychic because of (laughs)…and then another Dr came in and wanted to see all my skin to see if there were any rashes that were causing it and they put me through all these different tests. Eventually, apparently 8 hours later they decided to give me something to make me go to sleep, these little yellow wafers. And apparently I went to sleep and [   ] came home here. So apparently when they were trying to contact him he couldn't hear the phone ringing…. Apparently…and I have vague memories of a nurse holding my hand. And I remember all I wanted to do was go home. I kept trying to escape. That was the big problem, I kept just getting off the bed and heading off out the door, heading down the corridor and they'd have to bring me back. And I wasn't violent or abusive or anything like that, I was just determined to get home cause its only around the corner….

And as far as I was concerned there was nothing wrong with me and I hadn't done anything wrong so how could they force me to stay there….. I was convinced that something was going on that would end up having me locked up and I wouldn't get home. And even amongst this, its quite interesting.. I just re read it this morning. '[   ], we will take very good care of you and return you to Blenheim safe and well, [   ] Registered Nurse'. It's a wonder I didn't think I was being kidnapped or something….

And then they put me in the back seat and I had one person on each side of me. Quite big people and we were squashed in this quite little car. And we headed off down the road and I decided in my nutty state that I could cause an accident, I could convince this car to crash itself. And it's so embarrassing telling you this, but it's the truth. But that's where I was at. So I um…I said 'you're about to crash' or something along those lines, and I was really into maintaining eye contact with people and I believed I was talking telepathically to them, I could affect the car and I was mad as a hatter but I didn't know that…and the car stopped and they couldn't restart it. And this just fed my, you know...I can control all this. I was told later that that wasn't what happened and what happened was I was trying to jump over into the front seat.

At the Police station I don't remember getting out of the car or going in, I just remember being in the holding cell …I think I was told it was…and thinking oh my god that's where the guy broke out of the wall cause there's a big patch on the wall and there was a woman in the cell with me but the door was open…cause I let them know if they shut the door I was gonna lose it…then they took me out of there and I was on the floor while they were putting handcuffs on me that were attached to a belt around my waist. And there were lots of police around me. And I remember deciding that if I screamed the house down they wouldn't be able to do this. And I'm not a screamer but I remember clearly just opening my mouth and screaming my head off. And they still managed to get these things….I wasn't swearing or anything I was just ..what…I was hideously upset and that was…and at the time …and at my state of mind that was the only response I could give them.

And um..then I remember being led out to the paddy wagon and thinking looking out towards the street and seeing people looking in, pedestrians walking past and thinking…oh my god how embarrassing people can see me being put in a paddy wagon. And um…they put me in there. I couldn't believe I was in there. I was just blown away and I don't' remember the trip to Nelson. I remember looking out the window at one stage and seeing paddocks and things, and thinking where the hell are they taking me cause no-one had told me where I was going. I remember telling them I wanted [   ] but they turned the intercom thing off so they couldn't hear anything I was saying. And I imagine I was very, quite hysterical by then. That was terrifying to me, I had no idea where I was going.

And um….I don't remember arriving at the unit. I just, I don't know if I blanked out or if I screamed all the way there. I don't remember which is probably a blessing, cause I imagine it wouldn't have been fun. I don't remember arriving at the unit. I remember being in a room that had a bed on the floor, quite a low bed. I remember making the bed and being really really pedantic about how I made it. It had to be perfect. And I remember remaking and remaking the bed that's all I remember doing and having a shower and not even…this is the thing I find strange looking back that I don't remember being scared in there. Or questioning anything that was going on. I think, I don't know where my mind was then but I just accepted that's where I was.

I must have because I don't remember reacting to not feeling safe. I think I just..I don't …oh yes that's right. I remember now, when I got put in the paddy wagon and when they were trying to manacle me in the Police Station I remember ..that's why I don't think I was entirely mad because part of my brain was still functioning, cause I remember saying to the Police 'all I need to do is sleep and co-operate' and I was saying it like a mantra over and over 'sleep and co-operate' even when I was getting into the paddy wagon. Sleep and co-operate. It was going ..yeah..and I was saying this..and I remember saying this when I was in that room. Yes that was my wee mantra to get back to normal, I just had to sleep and co-operate and things would come right. So I wonder whether that mantra was the thing that was making me feel

safe. One little part of my brain must have been still functioning at that level and then…

I think a day later...I don't remember meals or interaction with people or anything in that room. I remember..I think it was a day later that I realised that the door was open and I could walk in and out of the room and into the sort of hallway and um…and I think I must have had a meeting with somebody on that day cause I can vaguely remember a conversation in an office..so maybe that was with [...]. Um….then I was in the acute unit which there was other people there. And that was quite a good time. [...] was coming into visit. I was really excited about seeing him and started to, started to realise where I was and what was happening but once again I didn't feel as if I was locked up. I remember walking out into the little yard, and um..and seeing the big fences and things but not being at all phased about it, not being. I didn't feel I was in jail, or locked up at all..I was just in this state of mind where whatever was happening was fine and I would co-operate and I would get home.

Ann's story covers all four cornerstones of Te Whare Tapa Wha. In terms of Te Taha Hingengaro, Ann is aware that something isn't quite right and that she is becoming unwell. During this period of unwellness she is still able to, at some level, to communicate, negotiate and rationalise with other people. Ann's beliefs in her psychic and telepathic abilities put her and others in physical danger. Ann provided two examples, the first when her partner is driving her into town and she tries to jump out of a moving vehicle, and the second example when she is being transported to the Police station and attempts to jump over to the front seat of the vehicle. In the first of those examples she clearly recalls her behaviour (which was prior to any medical assessment or intervention), in the second example her rendition of events given her level of unwellness were the total opposite to the staff who transported her to the Police station. This may well be an indication that her level of unwellness had escalated over time. Ann was also able to negotiate with the Witherlea Case Manager at Accident and Emergency, and get him to sign a document that was obviously an attempt to allay her fears about what might happen next. Also, while at the Police Station she was able to negotiate keeping the cell door open. Ann talks about her awareness and loss of internal control and sense of reality, and on the other hand she also talks about being in control of objects and the behaviours of others through her psychic abilities. Even when at the Police Station and prior to her one and a half hour drive to the acute inpatient unit in Nelson, Ann is cognitively able to process what's needed to get out of her current situation, with her internal mantra of sleep and co-operate. Sporadically throughout Ann's unwellness episode, there are small windows of clarity amid a growing level of psychosis.

In terms of Taha Whanau, Ann's partner was her first port of call in terms of trying to communicate what was happening to her. Ann's partner was pivotal in organising an appointment with the General Practitioner, and then supporting Ann through her assessment at Accident and Emergency, and throughout her stay at the acute inpatient unit. When Ann

was interviewed for this thesis, she reflected on the worry that her wellness had caused her partner.

While Ann was in Accident and Emergency, in terms of Te Taha Tinana, Ann was tested for a number of physical health conditions. She talks about eight hours of waiting in this department, the different types of tests, and being seen by a number of different Doctors. There is a sense of frustration for Ann in terms of the continued change of health professionals coming and going. Ann also talks about being physically restrained and put in handcuffs which was a negative experience for her. Her only defense mechanism left at this time was her voice. When Ann was taken to Nelson in the 'paddy wagon' she is also restrained within the vehicle and wasn't able to communicate with the drivers of the vehicle. Being shut out in this regard was also frustrating for her. Upon admission to the acute inpatient unit Ann was isolated and put into seclusion. For Ann, seclusion was not a traumatic experience.

In terms of Te Taha Wairua, Ann talks about her level of frustration around not being able to go home from the Accident and Emergency department. She also talks about how upset and embarrassed she was after being put in handcuffs and having the general public witness her transfer to the paddy wagon. Ann was scared about what would happen next, as at this point she is not clear where she is going, for what length of time, and what will happen to her upon her arrival. Once within the unit however, Ann was accepting of her situation and understood that if she wanted to get home to her partner, she needed to behave in a certain way.

This was Ann's first and only psychotic episode. Ann woke up to find herself in a totally new and foreign world.

11.3 Te Taha Hinengaro (Psychological Health)

Medication

In embarking on the interview process, one of my key expectations was that there would be overwhelming negative connotations to the use of medication.   The relationship tangata whaiora have with their medication is much more complex than originally envisaged. Medication plays such a key role in tangata whaiora lives that it is not a simple dichotomy of positivity or negativity. The relationship is intricate, and an interwoven part of their everyday life.

Tangata whaiora do not necessarily like taking medication but accept that it is needed to manage their illness, and that this could be long-term:

> *I need my medication…I tried to go off it twice..both times I got high… You know… and what comes after that is horrible voices… I need my medication. …you gotta take your medication, if you don't….yeah...'... I couldn't keep that mood...I'd get depressed...but with these pills I just relax a lot more…it's made a world of difference.... ..and you…cause when you have your needle you're starting afresh so you've got no inhibitions about anyone or anything… [Murray]*

Of interest, while there was an acceptance of the need for medication, yet very little dialogue around whether there is much choice in the matter. Feedback centred more on medication benefits and/or coping with any side effects:

> *…I can't use my arms….cause they're fucking floppy (laughs)… They're fucking floppy (laughs)..anyway..um… yeah the medication is bad..they need to do more research on it. It's affecting people in many different ways and its..fuck it's not good for you. The side effects…there shouldn't….nobody should be allowed to take medication when your tongue jumps around your fucking neck and your fucking choking on it… Medication is bad…I'm taking my medication. [Lisa]*

> *The drugs had several side effects that I did not at all enjoy; arthritis in my fingers, stiffness in my limbs, can't stop walking around or pacing, rapid weight gain, agitation, unable to keep an erection. So much for therapeutic dosage. A few months later the staff felt sorry for me and suggested that I try a newer drug. I feel glad that I'm not on that shit they had me on, no more iatrogenesis. But the side effect I endure from this risperidone is anxiety. It is a common adverse reaction. Every few days I experience a knot in my stomach and feelings of dread, as if something terrible is about to happen. I feel as if everyone is looking at me or that I am being watched. Sometimes I get the shakes. This is intense and it is disturbing if I happen to be uptown at the time. It lasts as long as two hours. They prescribed more risperidone for it. All it does is intensify the anxiety. [Malcolm]*

The benefits were viewed as improving their overall functioning. This included the ability to communicate effectively with others; reduce unwanted voices; maintain relationships; and provide a sense of peace and wellness.

The side-effects not only comprise the mental and physical, they also include the other two cornerstones of Māori health, spiritual and whānau. 'Unseen' effects such as tangata whaiora relationships with partners, friends, families; not being able to hold down employment due to their illness; and a sense of peace with one's inner self.

With this level of acceptance, tangata whaiora tend to balance the risks of side-effects which can cause a level of anxiety on a number of fronts. Some tangata whaiora talked about the trial and error approach of being prescribed medication until there was a level of equilibrium found, often at the expense of their physical wellness:

> *Well I've been experimented on most of my life and I've been on this medication since about 2007 and I've stayed on it…*[previous medication] *they were knocking me around all over the place. I ended up getting..ballooning up to 170 kilo actually. It didn't take long, I was on .. the Doctor had me on 550 mg of clozapine a day. And as soon as I'd take it I'd just eat and sleep and clozapine if you notice anyone who goes on it, they retain water and it all just..they get really big. And I've knocked it all off..I've knocked off 70 kilo so I'm back to my normal..... Well I find the side effect medication I'm on at the moment… I don't really like it that much but it stops my shakes but that affects your short term memory…yeah…Cogentin. [Nigel]*

> *Cause the lithium…I've actually had a couple of blood tests lately cause its affecting my kidneys….the thing is I had this blood test ..nearly two weeks ago now…and she hasn't even got back to me..I don't know what's happening……like I had this blood test like two weeks ago now…and I don't know…I guess no news is good news..but I still like to know what's going on..with my kidneys and things like that …you know…[Caroline]*

Caroline's story of her blood tests is an example of how important it is for tangata whaiora to also be kept informed around their physical health status. Tangata whaiora recognise the importance of maintaining their physical wellbeing just as much as their mental wellbeing.

The trial and error approach could take several attempts over time, with both interim and permanent consequences. An example of an interim consequence that several tangata whaiora noted was the weight gain which often takes months or years to rectify; or in terms of permanent consequences enduring memory loss. Of note, the way in which tangata whaiora spoke around their medication was attuned to the balance between the lesser of two evils (coping with medication effects, or alternatively the full onset of the illness), with the clear preference to maintain mental wellbeing, if the physical side-effects were manageable. A

number of tangata whaiora described a sense of sadness and grief in relation to the loss of memory, especially when it came to recalling historical details around personal relationships with their partners or children. When the recalling was not specific to personal relationships, but were more around events [e.g. the last time they were admitted] tangata whaiora were more frustrated that they could not remember the detail:

> *Well I can't really…Nelson's a long time ago….I get those needles that take your memory away…. You know and it sits you on your arse for three days and you don't know what's going on..you can't remember nothing ..and when you .. No they got um….I ….I think they've got them in Nelson…but they were just…they were just unreal in Invercargill…you know…but Nelson is …oh hell….I've had one of those needles since then..takes a lot of your memory away…but I can remember in Nelson… Cause I lost all my married life I couldn't remember it, I still can't because of the ..because of my sickness or the needles or something cause I can't remember my ..a lot of my life. I can remember my younger days. [Murray]*

Tangata whaiora are 'copers'. They cope with side-effects. Some with humour with an attempt to laugh it off; some with a planned approach to reducing impact such as physical exercise and diet; and others with being selective on who they approach or see when side-effects are noticeable. One tangata whaiora noted the importance of further research so that side-effects are limited.

Not only is there acceptance, there is also reliance on medication. Tangata whaiora want to retain their wellbeing and rely on their medication to do so. This is then closely connected to tangata whaiora compliance. Through experience, tangata whaiora are aware of the risks of non-compliance and how this can set back their recovery. A perverse relationship exists in that non-compliance by some tangata whaiora not taking their medication had increased their ongoing future compliance. The driver here is that tangata whaiora did not want to return to 'that' level of unwellness again.

However, within the acute inpatient setting there were several stories about physical force being used by staff to medicate tangata whaiora; or inpatient staff being sufficiently forceful in their language to get tangata whaiora to comply. The power imbalance was noted, as was the limitation of tangata whaiora choice.

The medication regime also encompasses routine. There is a commitment to ensuring medication is taken [and on time]. Within the acute inpatient unit, routine was not indicated as a concern. However, tangata whaiora noted that if injections are required to be given by Case Managers out in the community and for whatever reason they fail to connect with tangata

whaiora, this leads to an imbalance of tangata whaiora wellness. Tangata whaiora disliked having to go to the Police Station to have their injections:

> *Well..for a few years I didn't want to..and then I felt …oh I'm alright without my medication…but instead of them asking me…they used to pick me up…just pick me up…you coming to Nelson or get the Police onto you cause I haven't had my needle..instead of just talking to me and saying come on you've got to have your needle….they'd send the Police out and …or take me into jail and give me the needle in there when I should've been up the hospital…you know make you feel like a real criminal [Murray]*

> *Um, they're pretty staunch on their idea that you've got to take medication that can boil down to a Police Officer well you've got two options you can pull down your pants and take the injection or we'll, we'll hold you down and they'll give me an injection. [Malcolm]*

Think about what it means if a Police car turned up at your home, or while you were visiting friends, or even going about your everyday business in the community; and with no choice you are taken to the Police station. The general public might equate someone being put in the back seat of a Police vehicle as someone who is in trouble with the law. Murray identified that it does make him feel like a criminal, where in reality he has a mental illness and should not be treated as if he is a criminal. This type of approach is likely to contribute towards tangata whaiora self stigma, and stigma within the sider community.

Tangata whaiora are experts in their own right when it comes to their medication. Most tangata whaiora were able to identify their medication and dosage, and were knowledgeable around a wider range of medications. One tangata whaiora was unable to remember the full name of her medication, but was able to differentiate between colour and size, as well as describing dosage levels. Tangata whaiora combined knowledge around medication is often shared either on an individual basis or on a collective basis in areas where tangata whaiora congregate. In these instances tangata whaiora can act as educators and informers sharing their own medication experiences with other tangata whaiora.

There was, however, one tangata whaiora who held strong views in relation to the political and commercial nature of pharmaceutical companies, including the historical and contemporary experimentation on tangata whaiora:

> *Medication, well I think it's a form of oppression, medication. It doesn't help you, it gives you side effects and they're very unpleasant. It seems that the prevailing opinion is that all is well as long as one is taking medication. They tend to max out the dosage too. This I feel is a form of exploitation. Some faceless big pharma recieves a lot of taxpayers money because we have been diagnosed and said to be a serious danger*

to someone or self. So much for helping us with our problems. They should be paying us to take their medication! They should be paying us for the iatrogenesis! They should pay for fucking our lives up and for the way society maltreats us. I think there's some type of big pharma influence in the whole mental health industry. It seems to be geared towards the best interests of the shareholders of the big pharma. [Malcolm]

Tangata whaiora like to be in control of their medication regime, be included in conversations where decisions are made around their medication, and more importantly, to be heard in relation to any concerns they have around its effects. The preference is not to be 'told', and they are open to discussion and negotiation around their medications. For those tangata whaiora that did identify conversations with their psychiatrists, these were viewed as positive collaborative discussions where joint decisions were made:

you don't understand mate….and I went those aren't the ones..so in the end they took me back to see the Doctor, okay....They took me to see the Doctor, not the same Doctor another Doctor cause that Doctor was out of town you see what I mean..so then um I went to see another Doctor and stuff like this and I explained to him what pills I take and he goes and "well I don't know why they administered you that [Ariana]

Yep..yes…doesn't make me think too many things at once…and um….yeah not…not feeling out of place or anything like that….medication they've got me on today has been quite good…yeah…and um….I asked my psychiatrist about a week ago…I said can we keep the medication the same as it is…he goes well I'm willing to keep it that way….I said that's good…I said to him its been working okay and told him I'm not having so much troubled thoughts or troubled voices…[Melanie]

Understanding the triggers

Tangata whaiora were clearly able to describe what exacerbated their illness to the extent that they needed to be admitted the acute inpatient unit. In most instances,   they know they are becoming unwell and would prefer earlier intervention while in the community; or have the ability to self admit to the unit when needed:

Yeah I just ah, I was having like delusions and remembering like suppressed memories from since I was a kid, childhood memories, like ah, I started like remembering them and like reliving them again, and realising that that had happened…..But ah, by the time the second one was born, I was having trouble with employment and ended up breaking up and I just got to the point where I couldn't really, um, function properly. Cause at the time I ..couldn't pay my rent and stuff like that [Mark]

My husband had just died. Um so I did the funeral and stuff like that but I just sort of weirded out, cause why,   where to from here, you know, you know everything crushed me at the same time cause I didn't know who was who and stuff like this, cause he was the boss, my husband was the boss, so after he went, who was the boss, me, so I sort of worked through a lot of turmoil in my head about how things

are done and stuff like that, um, so they….yeah they put me in the hospital ward,
cause fucking I weirded out in such a way where I couldn't tell reality through um
today or yesterday you know, everything just caught up on me, it just…..so I was
a bit strange….(laughs) [Ariana]

Tangata whaiora spoke of a range of triggers. These included the normal life stressors and major life adjustments such as financial pressures, breakdown of relationships with partners or whānau, the death of a close friend, spouse or relative, loss of employment, and a busy lifestyle attempting to accommodate too many responsibilities and accountabilities. Some tangata whaiora had medication problems, either non-compliance which for example resulted in hearing voices or experiencing delusions; or there were side-effects which required a reassessment of prescribed medication. One tangata whaiora had suicidal ideation, and two others were re-living past traumatic experiences.

The key strand being that all tangata whaiora knew they were becoming unwell and either needed support from family, primary or secondary care services. In most instances the support sought was gained.

Fear

Fear is being afraid of someone or something that might be dangerous, painful or threatening to you. There were four sub themes of fear identified, personal safety, seclusion, fear of becoming unwell, and fear of the unknown. The provision of a safe unthreatening environment for tangata whaiora should be expected to enable tangata whaiora to recover from an acute episode.

What would be your idea of a unit? To go there to support you to get you back into
the community [Daniel].

The first time that I went in, ……which was many years ago, I had felt quite unsafe
and frightened in the unit [Margaret].

Personal safety

Recovering from an acute episode of mental unwellness, one could rightfully assume that an acute inpatient unit should provide a safe environment. That was not the case in relation to several tangata whaiora stories:

Nah not really safe in there. Um…quite scary for me at the time cause I didn't
know what was going to happen or anything. [Melanie]

> *…cause ….. people used to get dragged away and straight jacketed to go to the unit. It was very scary [Margaret].*

Even in Ann's earlier admission story it showed that while her first few days felt safe for her, there were other times during her stay that she had either witnessed violence or did not feel safe. Of concern is that it was generally accepted by tangata whaiora that violence is part of the norm within an acute unit. All but one tangata whaiora witnessed violent behaviour against individuals or property; was assaulted; perpetrated verbal abuse; or retaliated to acts of violence within the unit. Dealing with these behaviours when you are already acutely unwell is in itself distressing; however, tangata whaiora have developed coping mechanisms to manage and protect themselves within the acute environment:

> *For the amount of people who….like I was there one day sitting next to this fulla who picked up a chair and threw it through the glass…where they all work. [Murray]*

> *Oh assault on another person and um, another guy came running towards the window….yeah so he was going to come through the window, and another guy who tried to hurt someone. And it all happened when I was in the unit. Yeah. [Melanie]*

> *There's nothing to do…and your stuck with people who are really aren't well and they're gonna lose it, they're gonna take it out on whoever is in front of them.[Martin]*

The coping mechanisms include a period of 'sussing' out other tangata whaiora. This is an internal assessment, watching others' behaviours to determine whether they are 'safe'. Tangata whaiora will then decide whether they will communicate or interact, and if so, what approach might be needed. If witnessing damage to property, tangata whaiora will simply isolate themselves from the behaviour, either heading back to their rooms, down a corridor or outside until the behaviour stops. This had two direct benefits; first of all keeping themselves safe and out of harm's way; and secondly, providing space for the person to express their feelings.

Witnessing assaults between tangata whaiora is more stressful than witnessing property damage, and tangata whaiora expressed confidence that staff do the best they can in terms of protecting everyone on the unit. One tangata whaiora was assaulted on several occasions by other patients, and her coping mechanism was to retaliate violence with violence:

> *And then, um, and it, this um, girl physically……, physically, physical contact with the fists (laughs), punched me in the face and then I punched her in the face and then they tried to do me for assaulting her while I was in the unit. [Lisa]*

It is not just physical assaults, there are also experiences of more coercive behaviour with verbal assaults and interference with one's personal property. Tangata whaiora can create weapons to protect themselves if need be:

Ran and then I hid. Yeah. Cause I wasn't sure if they were going to attack me next. Oh down the hallway where the bedroom was down the end.........Yeah and um…they've been a couple of times I took some things into my room and I'll make up my bed, and they'll say why have you got this here…and I said ..just in case I get hurt…and there was this knife..I mean a fork…I said can cause damage with the fork…she said I know you can….and then she wrote it down in my notes…and um…they started watching me to see how I was doing after that….and monitoring me.....Yep…course I'm only little so not a hope in hell I can protect myself. [Melanie]

Initimidation of other tangata whaiora can also occur on the unit. Malcolms description is one of harassment to another tangata whaiora, yet when that tnagata whaiora is physically assaulted, Malcolm shows empathy and the harassment behaviour ceases:

One of the other inmates took a dislike to me. He was about 50, had dyed his hair shocking pink and had nail polish on his fingernails and toenails. I took great delight in torturing him; his room was next to mine. Every time he left the wing I would emerge from my room and lock his door. He would have to go and get a staff member to unlock the door. He got quite shitty about it. He would play Led Zeppelin, the Rolling Stones and Pink Floyd DVD's all bloody day. I stole his DVD's from the t.v. room when he wasn't looking and stuffed them in a rubbish can. He got a hiding from another inmate. I felt sorry for him and stopped locking the door. [Malcolm]

Forming relationships with other tangata whaiora can provide a level of protection by providing additional support and peer pressure to reduce such behaviours.

The issues raised by tangata whaiora elevate the question whether it is appropriate that when tangata whaiora are already acutely unwell, they also have to cope with being a victim of, or witnessing, violent behaviours.

One tangata whaiora explained the hesitancy and nervousness of some staff around Māori males. He implied that staff might not feel safe and this invariably impacts on the care they are provided:

Ah I find a lot of the European ones up there are a bit iffy nervous around Maori, Maori men because of our physical nature. Most of the ones that go up there play league or rugby or whatever um but…the Maori nurses up there they're always talking to us and helping us as much as they can..which they'res not very many of them up there [Nigel] but… there's a nurse up there who I was having problems with and um,

I was trying to apologise to him and he was rarking me up, and I just ses 'we'll fuck you then' and walked off and next thing you know the Police are pulling me out the back and I had to stay out there….and even the Psychiatrist even…… And even like [ ] and them, they couldn't believe what was going on and then after that he took the day off the next day and then he came up to me after and apologised…and I was man enough to say 'Yeah don't let it happen again' (laughs).   [Nigel].

Seclusion

Seclusion involves containing a tangata whaiora in a room that is locked. Tangata whaiora are isolated in a room by themselves, they are unable to exit the room, sensory input is limited, and nursing staff regularly check on them and control aspects of their mobility within the unit. Tangata whaiora are put into seclusion if they are a danger to themselves or others, and there is no other alternative available. In Te Wahi Oranga (Nelson's acute inpatient unit), tangata whaiora call seclusion '*out the back*':

Normally the first night is the hardest cause the Doctors don't, like um, you know how you go into an area like that and you're frightened, scared, angry and all that see…the Nurses check on you every 15/10 minutes, um you hear them, you just can't get any sleep and…And ah it usually takes the next day when you talk to the Doctor you say "I've been up all night, I couldn't sleep" and then they finally give you medication to knock you out so you can finally just sleep while you're there……..… they don't keep me long in there, usually when I go in there it's about three or four days. [Nigel]

A number of different adjectives were described for seclusion; these included '*frightening', 'horrible', 'scary', 'bad energy', 'terrible', 'boring'*. Caroline's story is one of frustration and anger at being isolated in seclusion with a range of negative emotions identified. It is difficult to understand then, how seclusion was beneficial to her recovery:

My first time…um…oh all I remember is um…they took me to the back where I didn't realise....well I didn't really know what was going on…my mind was sort of all over the place..and I remember them telling me that my brother was going to be there…and next thing I knew they put me in like a cell…that put...... Yeah I remember going there…it was all dark and everything cause it was near dark when we got there …and next thing I knew..I was in the cell…and I was just screaming…and just literally just like where's my brother and they left me there…in this it was like a jail cell...... and but they didn't tell me that they were going to put me in there....... They just said your brother's there you'll be fine…you know..and next thing I'm ..I remember walking in with them and I was like what's going on…I didn't know what …what was going on….and I still don't…know today why they did that..... And honestly I was so upset about that I stayed in there all night and I put....practically screamed myself to sleep….and um...woke up in the morning and they let me out into the thingee bit and I …I ended up telling my brother he was an arsehole…...... But yeah and but I don't understand why they put me out the back to start with…it was a horrible horrible horrible experience for me and like even we used to have…we had a meeting..they used to have meetings every morning and one morning I was just still really upset about it and I mentioned it to the people and I said…. why was I put out the back, why did you lock me in the cell…to me it was…It was it was really…really scary..it was

> *really..I was confused..I didn't know what the hell was going on..it was horrible..and ..it upset me for days and I remember talking about..oh I told you…talking about it in the group meeting….and I just thought..fuck this…people need to know..so I just said…I was ..brought in from the back..I don't know why..and then I just started bawling my eyes out…and it was wrong..and I'm angry…and….ra ra ra…[Caroline]*

Caroline's first admission experience was traumatic for her. She did not know what was going to happen to her and was in the unit on the pretence that her family would be present, only to find that she was totally isolated and put into the seclusion unit. Once again out of a sense of frustration the only defence mechanism Caroline had was her voice, and therefore she screamed herself to sleep. What irritated Caroline the most is that she still has no understanding (and staff did not explain) why she was put into seclusion.

Tangata whaiora also described seclusion as the place you go when you compromise the safety of yourself, other tangata whaiora or staff. It is the place *'where dangerous people go'.* It is also considered an area where you are admitted to if staff are not sure whether you are *'safe'.* For those older tangata whaiora who can remember Ngawhatu, they had concerns that the same model of care would be provided if they ended up in seclusion, with one tangata whaiora witnessing another being forcibly removed from the main ward area in a strait jacket. The verbal objections and distress coming from tangata whaiora going into seclusion can emotionally upset tangata whaiora witnessing the event:

> *and I actually watched them the two weeks that I was there and the people they were putting into seclusion were gone for days and then they were coming out and sitting down at the table with us and trying to talk with us then they'd come and get them …and these people just break down …and crying..and they'd be like …I'm not gonna do anything ..I won't do anything…[Mark]*

> *you bang on the doors and you ask for a light for your cigarette and you're treated like…..dangerous …you're put in that category and that's why you should be cause some people are…it's just if you're not that bad and you get put in there…I..I'm used to it..   [Murray]*

Some tangata whaiora talked about the *'jail'/'prison'* elements of seclusion, as it is a loss of personal freedom, choice and control. Especially if you are not expecting to be put in seclusion, where personal visits and access to personal items are restricted.

The length of stay within the seclusion area ranges, some were simple overnight stays, and others two to three days:

> *Usually they put me straight into seclusion. They want my belongings, shoes, socks and belt. Sometimes they require you to wear hospital pajamas. The best thing about*

seclusion is the food! Pies, fish and chips, cheese and crackers, club sandwitches, fresh fruit, orange juice. I have been in seclusion for as long as six days. It is easy to lose track of time in the cells. It is very boring. Sometimes they allow books or magazines. Most of the cells have a shower/toilet area. I once found a lighter hidden behind the toilet. The walls have grafitti scratched into them…..The first thing I do is tear off a strip of the bedding to make a belt with. I pace back and forth but spend most of the time sleeping. Sooner or later they release you from seclusion. [Malcolm]

Fear of the unknown

If you are being admitted for the very first time, there is fear of not knowing what to expect next.

Being a 'first timer' can be very stressful for a range of reasons. First of all, there are pre-conceived perceptions of what an acute unit looks like, what other patients' behaviours will be, based on what they have seen in 'the movies'. After admission, these perceptions are quickly put to rest, but it does cause a level of anxiety prior to admission:

Well, well it can be….going into the unit especially when you're younger and on your own, very vulnerable, it can be a very frightening place. Um…quite scary for me at the time cause I didn't know what was going to happen or anything. [Margaret]

I went up into the attic thinking that someone's got me on camera, starting cutting at these wires and that night, and the next night after there, MCT turned up, Mobile Community Team. I told them to get and don't come back here. And they were talking to each other to stay here and they, stayed until a certain time, and then they said they had to take me to Ngawhatu, that's when the hospital was at Ngawhatu at the time. Yeah and um, and I said oh…oh I'm afraid…and they said don't worry things'll be all right…[Melanie]

Secondly, perhaps for the first time in their life tangata whaiora might not be in control and there are concerns around loss of personal freedom while in the unit, and what the ramifications are in terms of possible commitment under the Mental Health Act:

Yeah….but thinking that I could leave when I wanted too…. And then I was on that 7 day 14 day…and I was so angry…I was so angry ..yep….I had all these…..and I went under the Act… That was really hard…that really pissed me off…you know I'll go in there and have a break and you know..and then I'll go out when I'm ready..that's what I thought..and not even…[Caroline]

Thirdly, 'first timers' are not aware of what interventions might be provided while in the unit and the perception is that they will be put in strait jackets and be over medicalised so they are unable to communicate. Finally, there is a level of angst in terms of not knowing what will

happen to their family, children or partners (how they will cope), employment, while they are in the unit; or if they will be allowed to see their families during their stay:

> *but um….and then I was worried about my bills and stuff like that….my bills and my…and at the time..um my son….was in my [   ] care….and um….I don't really want to say much about that…..but that was pretty hard…[Caroline]*

Fear of becoming unwell

Most tangata whaiora reported that they did not want to become unwell to the extent that they needed to be readmitted to the unit. This drives them to comply with medication, keep active in terms of physical exercise, link into community supports, ensuring earlier intervention when things are not going well, and generally working towards maintaining wellness. One tangata whaiora described not wanting to become admitted, or going to '*that dark place'*, which was a reference to the illness itself. As much as practicable, tangata whaiora will keep well to avoid an admission:

> *yeah I feel like I'm coming out of that horrible place that I was, but I'm still scared that it's gonna happen again…Yeah I did have a lot on my plate but it still just came out of the blue and scared the hell out of me..still scares me..I wake up and think am I going to go mad today…[Ann]*

> *seriously started thinking about what I was going to do when I got out and….and you know..um…and the first time I was in there..I'm never going back there again..and then I went there again and that was really sad…but um…I'd never want…if I can help it would never like to go back in there..[Caroline]*

11.4   Te Taha Wairua (Spiritual Health)

Wairua was acknowledged as a component of recovery. However, not all tangata whaiora referred to it as such, more that it was 'implied'.

Stigma and discrimination

Stigma in this sense, is an attribution of shame or disgrace associated to a person with a mental illness, and discrimination is other people's behaviours in relation to how that person is treated. This can impact on a person's wairua, or spiritual health. Stigma and discrimination are well accepted as one of the major barriers to recovery:

> *I guess also being… I dunno... of people knowing about you going into those sorts of places and you know how they can judge you… I worry about telling people about my illness and that …but I tell people and some of them are really cool… majority are really good about it…. some people I haven't told..I..depends on who I*

meet..who..how..like I've just recently met this guy and um..he's really cool…and he ..I told him about my illness…I even told him about the stay…and um..he's really cool about it and he's…you know…comes and sees me…so that's really nice…it's those ones that think…oh you're weird or something or….know it's just embarrassing…you know..you know you go in the street and you see someone that's been in there..and they go..I know you from ra ra ra …you don't want to be known from in there…sort of thing… guess also being…I dunno..of people knowing about you going into those sorts of places and you know how they can judge you… [Caroline]

In the above example, Caroline expects to be treated differently if she shares her illness with others. She is hesitant to tell others of her illness for fear of their reaction. Tangata whaiora reported two layers of stigma. The first being their own, the second being both discriminatory and exemplary practices of some staff. I had expected a level of whānau stigma but this was not a consistent theme across interviews.

Self stigma exists, to the extent that one tangata whaiora spoke about the mental illness defining who she was as a person. The assumption being that the mental illness significantly impacts and centres her everyday life, including her future. The self stigma also extends to whether tangata whaiora will disclose their illness to others, conscience of the response they might receive and whether they will be 'judged' accordingly. Therefore there is a level of pre-assessment on who might be safe to disclose such information. The level of relief is apparent when support is given without judgement, but it was inferred that these experiences were few and far between. Therefore even if you meet another tangata whaiora in the street [who has also been in the acute inpatient unit], they might not wish to converse about how they met, or how they are feeling, if those conversations could be overheard by others. There is a sense that for tangata whaiora the illness will always be with them. The illness drives the immediate 'here and now' as opposed to tangata whaiora proactively focussing towards the future potential and growth.

Several tangata whaiora spoke of discriminatory practices by some staff. Like any service industry, there will be the 'good' and 'not so good' staff, and mental health is no different. However, with alignment to professional bodies and standards, one would expect that the evolution of mental health service delivery would have wheedled out the more archaic views of some staff in terms of treating all patients with dignity and respect. The discriminatory practices more related to specific comments or the generic feeling tangata whaiora got as part of the interaction. Some of this could be connected to the power imbalances that exist between staff and tangata whaiora, with tangata whaiora describing they felt like '*you're down there and they're up here*':

And I thought, hey I've got my room in here lady…..and she goes…oh you're one of these… [Ariana]

During another admission I was required to lay down on an examining bed after I had been questioned by a psychiatrist. He ran his hands over my belly and remarked; "he's a bit porky"..I felt like giving him the bash, but decided against it. [Malcolm]

However, there were exemplary practices described also, where staff showed respect in their everyday interaction with tangata whaiora. For example, barriers were broken down with the development of an Indoor Soccer team by one of the Māori Case Managers, which comprised a team made up of both tangata whaiora and staff:

I felt I was treated with dignity and respect by the staff. Um I had a, basically had a very good experience there [Margaret]

Boredom

All tangata whaiora spoke of the boredom associated to being in the unit. While there are a range of activities available on site, many of the resources were outdated or of lower quality with tangata whaiora making do with what is available:

A stay in the unit is rather boring. It's very very boring in the unit. It's terribly boring. It's the top of boring boredom than can drive you mad [laughs]. Yes life is very fucking boring in the unit.   They have the OT room and that's open every day or every other day. You can paint or bake something or something like that. Yeah They have a TV, two TV areas, so you can watch TV or DVD's I think they've got an X Box or a Playstation in there as well. So you can ask for the Playstation and that's okay. You don't want to do that all day, every day [laughs]. I reckon they could get new books ….and they're so old, they've got a whole collection of Readers Digests condensed books and they look 1960 or something [Malcolm]

I'm an artist, and so I thought yes I'd paint something but they only had kids paints like they have at kindy and I was thinking….I remember getting quite vocal about that..I can't paint with this crap (laughs). [Ann]

Yeah..nothing much..but ..talking with the other patients…[Jack].

Not having access to the internet, or your personal cellphone also limited your ability to maintain one's usual daily communication activities. While games are available, another tangata whaiora who is of 'like mind' and ready to participate at the 'right time' is needed. Tangata whaiora look forward to outings, as these are based out in the community. One tangata whaiora noted concern that the boredom can sometimes lead to frustration where tangata whaiora will take it out on others around them. Another tangata whaiora spoke of being involved in illegal activities or breaking unit rules to reduce boredom.

Religion

Three tangata whaiora talked about feeling isolated and how important their beliefs, their atua were to them but did not go into too much detail. Religious beliefs were not identified in the majority of interviews; however, one tangata whaiora read the bible on a daily basis:

> *and ah…I've been doing my bible lessons and that, and that helps me, it gives me something to study for the day to [Malcolm]*

> *yeah..I was alone while I was over there….so….but um…you know with loneliness comes something else….you know atua…cause why…I rode with him…so um…yeah…yeah..yeah…[Ariana]*

Te Ao Māori

Unexpectedly, tangata whaiora expectations around the provision of culturally appropriate services were variable. While I had expected a stronger response in this regard, the underlying sense was that tangata whaiora were so used to the existing mainstream health provision, they do not know what options could be made available. They also tend to live in the 'here and now', it being difficult enough to survive out in the community with a mental illness, let alone consider what future Te Ao Māori services are needed within an acute inpatient unit. Added to this, tangata whaiora were on varying levels of knowledge in Te Ao Māori, including levels of comfort in terms of their own 'Māoriness'. However, there was consistent overwhelming support to having a service that is culturally responsive to Māori. That includes having Māori staff, Kaumatua, and Māori programmes on the unit.

One tangata whaiora had been raised by a non-Māori family and first met his birth parents and wider whānau as an adult. When he became ill, he had a level of hesitancy around being supported by Kaupapa Māori services. However, having done so, there was an instant connection to the point where Kaupapa Māori services are now his preference as a first option:

> *was the first sort of thing anywhere that I'd gotten that was sort of for people who were Maori..and I was..yeah I was a bit …I didn't really know what it was gonna be like ..and I was like straight away ..now everywhere I go I always um…if there's an option to have someone like that then I always take it..[Mark]*

Being supported by Māori staff and kaumatua in the inpatient unit was seen as beneficial by the majority of tangata whaiora. This includes non-government organisation (NGO) Kaupapa Māori Mental Health staff who visit the unit regularly to provide individual support. Every Wednesday NGO Kaupapa Māori services attend the unit and provide a Tikanga Māori

programme. This is well supported and one tangata whaiora, who had found employment in the community, returned to the programme to support its continuation. The relationship was reciprocal and from his point of view was about giving back to those who had assisted him in his time of need:

> *No that's where it stopped…I just went over there…there was a Māori name to it..but that was it ..you know ..but there was nothing there, there was nothing there…not even you know…just somebody to care ….that's all I'm saying…like if you've got a Māori in there….like there should be a Liasion where you can actually fund them through and just.. get…get somebody in there like a friend of the whānau …you know…don't have to be your immediate whānau..just a friend you know…where as like I was chasing after all the um….palangi ones or the Pākehā ones and …they just weren't cutting it for me..cause why…they thought I was clever enough to cut if for myself so….you know …um…yeah yeah…just having somebody there that you can confide with…that's all you know..there's kaumatua that need little things to do..and its like every now and then when they get a Māori person over in the unit…they should have somebody that liases on it while they're there…because why…nah it wasn't good for me…cause why…lucky I'm me, I'm my own best friend you know…(laughs) .... And just seeking them like….'hello…kia ora' nah…(laughs)..you know so I think that …what they need..if there's things that should be done over there it should be on Maori terms when Maori are over there…and its like…..especially when they come from this land….to over that land…okay..cause why..its foreign to us…we might have been over there a long time ago…but hey…we make our lifestyle here not over there…[Ariana]*

Ariana identified that even though the Nelson acute inpatient unit is named Te Whare Oranga, that doesn't necessarily reflect a service that is culturally responsive to Māori. She implies that western models of care don't work well for Māori and that it would be useful to have a Māori staff to support tangata whaiora.

Kaumatua were mentioned several times. Having someone who is older, wiser, respected and versed in all things Māori also assists towards tangata whaiora feeling more relaxed while in the unit. It is that instant connection where kaumatua can immediately de-escalate tense situations and make everyone feel at ease. Kaumatua had the ability to adapt to each tangata whaiora Te Ao Māori journey, recognising that tangata whaiora were at differing levels of their journey. Kaumatua were simply there if tangata whaiora needed to talk. There was only one negative comment around kaumatua support and that related to a tangata whaiora being advised they had a 'mākutu' (curse) placed on them. However, the choice of having a Kaumatua support option available remains important:

> *Yes he was wonderful. He was amazing. He was wonderful and he said to me that I could always have alternative care with him. He said that to me, he said if I wanted support I could just….and rather than do the pakeha thing of going there, I could go, if I was, you know, if I was wanting a equivalent of a Māori sort of thing. But that*

didn't happen this time. Nobody said that to me this time….. Probably more people like [...] that you could really like, if you, that if you could just get there first of all and really have a good chat to, and really relate about how you're feeling as a Māori person and look to for support, you know. See if I remember him being very special for that. It was a big thing that really struck me [Margaret]

Tangata whaiora identified that seeing a 'Māori' face can provide an immediate connection and sense of relief. Māori staff are viewed as having a higher level of understanding on what it is to be Māori, including how best to communicate, provide reassurance, how to 'connect', and reduce the sense of isolation. This contributes towards them feeling more comfortable on the unit with a sense of equality and whānaungatanga between Māori staff and tangata whaiora. Tangata whaiora felt that with Māori staff you are not simply able to bluff the truth. Māori staff can see through the façade, so tangata whaiora tend to be more upfront with Māori staff:

It felt like whānau coming visiting….pakehas make you feel wanted, but Māoris make you feel loved. Oh makes all the difference….because you're like a brotherhood..you know…you see em and your face lights up straight away…and he's always happy to see you and..and…and…ah…you know your place…and he knows his place… [Murray]

…like..as soon as I saw a Maori face it was like…..you know…aaah…cool….and [ ] was great….she um….she made me feel ….at home..she made me feel …comfortable there…yeah…she she was really cool…um…and she helped me with my ….my um…think she was the one….that dealt with my benefit and things like that…[Caroline].

Waiata

Tangata whaiora identified how music was a tool to enhance their spirits, and also assisted in connecting with other tangata whaiora within the unit:

and I was sitting in the sun and with people and singing along while they played their guitars, and there was this young guy in there that was playing the bagpipes and that was so cool…. I like bagpipes, and [...] had his guitar and we were all singing…we got a round song going at one stage…Proud Mary and we were singing like in a circle …[Anne]

They have a Wednesday meeting where the staff and all the clients hook up together and our Te Rapuora crowd goes down to unit every Wednesday …..share a few introductions about yourself..sing a few songs, have a good laugh..and that's one thing that I find pretty good eh. Because I've found the last four Wednesdays our meetings have been quite packed. So that's a good sign….. See well that's the thing, things like that …attitudes at the unit now is changing in a positive way… It is now becoming a positive environment rather than a negative environment…. Yeah so….cause yeah when we go down to those Wednesday meetings everyone's pretty much happy and cheerful and wanted to talk [Daniel]

11.5   Te Taha Tinana (Physical health)

Physical wellbeing:

Physical wellbeing is important to tangata whaiora. As indicated earlier in Te Taha Hinengaro section surrounding medication, there are a number of physical side effects tangata whaiora cope with and that don't need to be replicated again here.   The important thing is that tangata whaiora want to be kept informed in terms of any tests related to their physical wellbeing; and to better understand the scope of side affects that may result from the medication they are prescribed.

> *but taha tinana isn't very well taken care of or much of a high priority. The taha medication is the high priority. [Malcolm]*

Kai

Traditionally, Māori are known as hunters and gatherers in terms of obtaining food for their whānau, hapu and iwi. In times gone by, a sign of wealth and mana was the ability to host manuhiri (visitors) with a range of the best delicacies available.   There is an old whakatauki (proverb) '*Nā tō rourou, nā taku rourou, ka ora ai te iwi*',   with its literal translation being 'with your food basket and my food basket, the people will thrive'. In its wider interpretation it means that with collective sharing of knowledge, food and other resources, Māori will maintain overall wellness.   Conversations at mealtimes at the Marae are an important tikanga component where relationships are established and developed. This approach has continued through to contemporary times and is often evidenced within an acute inpatient setting.

Tangata whaiora had a range of comments and stories around the food, which was unexpected in terms of having it feature so highly in the narratives. The quality and abundance of the food was appreciated. Only positive comments were received by all tangata whaiora:

> *They had food all the time..it was good..it was good…and if they didn't have ..you know ..if you didn't have lunch they had like biscuits….and they had fruit..too but you tend to go for the biscuits and …then they'd bring out muffins and scones…and…I was eating all the time….[Caroline]*

Several noted that food acted as a tool to build relationships with others. Eating at the table with other tangata whaiora and staff provided the opportunity to start conversations, learn about other tangata whaiora lives, and form friendships. There could be a level of paranoia

when staff eat at the table, as there was a suggestion that staff were eavesdropping and recording conversations back in tangata whaiora clinical files:

> *Yeah, food was okay I think so ..yeah…because why..I used to save everything out of my plate. Yeah..hard…so I had dishes all over the place (laughs)…and they'd go to me..'oh you can chuck that out and have another one'…and I'd say 'eh…okay'..but this…it was neat cause why, I was building, I was building like you know how you build a friendship over one day, two days, whatever day it is ..an hour…you can build something over one an hour…you can build an impression over an hour…we'll that's what I was doing with them…because why…I…....I needed to know them, I needed to know them before they…before I'd let them in let them in …sort of thing you know [Ariana]*

For those who are given leave from the unit, they can act as 'shoppers' buying a range of treats out in the community on behalf of other tangata whaiora who are not able to leave the unit. As one tangata whaiora explained, this is an exercise as it involves the taking of orders; writing of the shopping list; the finding of transport to a suitable store (or stores) to find the range of treats requested; the receipt of monies from tangata whaiora; the purchasing and distribution of; and the delivery of any change from the individual purchases. Even though a task in itself, it was viewed as an enjoyable one which on receipt of the treats provided pleasure to others and productive in terms of supporting other service users' wellness.

The regularity of meals (three meals a day, plus morning and afternoon teas) was raised in terms of the benefits of knowing when the next meal is due.   The reference being that living out in the community, there is irregularity in mealtimes given some of the financial challenges tangata whaiora often face.   Regular meal times also can provide a sense of security and stability through their admission period.   In addition, there is no responsibility in the purchasing, preparation and cleaning up of meals so meal times are considered more relaxing and less stressful.

Three tangata whaiora spoke about the association between their weight and the food intake. One identified that the regime assisted in better managing her eating disorder. Another two talked about the weight gain during their admission which was viewed as one of the negatives during their stay, albeit there was no identification of whether they attempted to scale back the food intake.

The food provided is healthy and nutritious, and for some considered higher quality than they would normally prepare and serve at home. Two tangata whaiora would regularly steal food and hide it in their bedrooms. This included even small items such as sugar sachets. There was no rationale other than reducing boredom in terms of hoarding food.

Physical Exercise

There is enough national and international research evidence that puts mental health service users at higher risk of poorer physical health status than non-mental health users, so it was pleasing to note that all tangata whaiora talked about their physical health as a priority and were taking action to improve their wellbeing. It is difficult enough living with a mental illness without coping with physical health challenges as well. Female tangata whaiora were more conscious of not putting on additional weight and an example was provided of negotiating medication that limits the potential for weight gain:

> *I enjoyed my swimming…I enjoyed that I don't normally swim..so that was quite cool….um….there was..there was an experience where they were giving me olanzapine but I was on very ….what do you call it…I'm very thing about my weight…and I knew olanzapine put on weight but if you took the wafers..apparently it wasn't so bad if you took the wafers and this particular night I wouldn't take my medication…and …but I didn't want to tell her why…and she was going why don't you want to take it….and I didn't want to tell…her cause …oh you know it's a weight thing..it was just..I felt too embarrassed to say [Caroline]*

Weight management for both male and female can be difficult and tangata whaiora developed a number of strategies to control this, including participation in sporting teams, or passive exercise such as walking. Being supported to continue physical exercise while in the unit is appreciated:

> *Doing lots of walking. Do lots of walking .. um .. I walk up to about 15 kms a week. Helps keep the weight off. And um after Christmas gonna hit the training cause we've got an indoor soccer with um .... So I wanna get my fitness up for that. [Daniel]*
>
> *Yeah he said to me…what exercise are you doing…and I said not much….he goes…I said I can start exercise though….what do you do in the weekend…I said oh nothing much…but I've started to walk into town now…yeah so…that's part of my progress and um…my bit of progress for the programme anyway… And I do aerobics on Friday… And Wednesdays its Tai Chi….[Melanie]*

Tangata whaiora also related the benefits of physical exercise including the direct synergy with their mental health wellness, their overall physical wellbeing and the wider inclusion of physical activities that incorporate their whānau. There is also recognition of healthy eating and reducing alcohol intake:

> *I've lost a bit of weight but its hard ….haven't been doing too bad..just gotta cut my drinking down now..I really want to lose weight…and my drinking's not helping…as well….so…[Caroline]*

And um, we've been going on leaps and bounds with that and he's even got MCT to sponsor it all so its all free and I get all my family involved. [Nigel].

The majority of tangata whaiora used walking as their daily exercise, partly due to the overall enjoyment, and secondly that there was no cost to the activity. There was a sense of pride with tangata whaiora sharing their weight losses as part of the interview process:

Yeah, the weight loss has stayed off too, I haven't put it back on.[Margaret]

Smoking

Smoking within acute inpatient units 20 years ago was encouraged as a form of placating or managing tangata whaiora behaviours. Smoking was a common practice and there was a defined smoking room. During this era, one tangata whaiora described wanting to give up smoking when his sister turned up at the unit *'Do you want a smoke?'* and he replied *'No I've given up.'* Her response *'You're too sick to give up'* and gave him a carton of cigarettes.

Today the unit is smokefree and many of the tangata whaiora do not smoke. Tangata whaiora are well educated in this regard and able to identify how detrimental smoking is to your health:

The other thing I can say though is too, is that a lot of Māori people smoke, and all that kind of stuff. And see I used to too. But that's interesting to think about that because, hopefully I will live a bit longer now, because I haven't smoked, like that would change, that's change for me. No, only about eight months. I stopped drinking a year ago. I don't drink alcohol. Right. But the smoking has been about eight months. You see when I was in the unit, in the unit I smoked heavily and most people smoked there. There's even a special smoking room, you go and sit in the room with your smokes….everybody smoked and I can see what that would do to you, to your physical health, how that would cut back the, you know. I know. Cause I really relied on my cigarettes. Those days. I really did. God yeah, it was part of me, a big part of me. Cigarettes. I used to think there's cigarettes [ ], there's not just [ ], I needed my smoke. I can't believe how much better I feel… [Margaret]

Margaret became more health literate during her illness and as a result has made a number of lifestyle changes. She now exercises, doesn't drink or smoke, and is able to articulate the longer term benefit of these lifestyle changes.

11.6   Te Taha Whānau (Family)

This section is broken down into the three key areas where tangata whaiora identified key relationships; and that is whānau; staff and tangata whaiora.

Whānau

Whānau in this context is considered a mixture of either the nuclear or extended whānau unit. Experiences with whānau were variable. There were some tangata whaiora where relationships with whānau were fractured and contact had not been made (or was in the process of re-developing) for several years; and then there were whānau who were heavily involved in tangata whaiora recovery:

> *My family have rejected me. Black sheep of the family. They don't want to know me. On both sides of the family. That's why I thought stuff you's I'll make my life down south. Cause all my family are up north. That's why I just jumped on the ferry, crossed to Picton, did a bit of hitch-hiking.[Daniel]*

> *I've got [　]boys and I've got a step father, he's English, he's bringing up my boys at the moment, they're living with him. [Melanie]*

In terms of whānau (*including partners)*, several tangata whaiora identified that they were supported by whānau to access crisis response services which may have resulted in admission. Whānau can act as bridges to the admission, persuading tangata whaiora around the benefits. For example, for those experiencing financial pressures a stay in the unit over a two-week period can alleviate some outgoings such as food costs. However, on two occasions whānau were used as 'levers' as pretence to get tangata whaiora co-operation to the admission. As part of this process, if tangata whaiora ended up in seclusion or whānau were not able to stay after admission, they felt they were lied to and abandoned. This caused a level of distrust with staff and also their own whānau. Tangata whaiora are forgiving and given the acceptance that whānau were doing what they thought was best at the time, the relationships were not strained in the longer term.

Whānau also make it easier for tangata whaiora while they are in the unit. This occurs on several fronts. For those whānau who live in Blenheim, two tangata whaiora spoke of their partners driving their campervans and living in the car park outside the unit for the duration of their admission. Seeing whānau every day made a difference to their recovery:

> *I used to stay over there…I used to stay over there and visit him nearly every day…. That's right, either that or sometimes you …you used to want me to sleep in the van [Jacks partner].*

> *He just drove the motorhome over there and stayed over there the whole time I was there …[Anne].*

There is a level of reliance on whānau to look after a range of needs while they are in the unit, this might for example include looking after their accommodation; paying the necessary bills; or caring for their children.

Tangata whaiora also worry about their whānau while they are in the unit. The level of worry is whether whānau are also coping and the pressure the inpatient admission places on them. For example for those residing in Blenheim, it is a one and half to two hour trip to travel to Nelson to visit. There is a cost involved in terms of transportation and possible time off from their employment might be needed. To alleviate pressure, some tangata whaiora are supported by Kaupapa Māori NGO providers who may also visit them while at the unit and provide support to their whānau.

If there is separation from their children, this also causes a level of angst. Tangata whaiora will attempt to make it as easy as they can for their children, one tangata whaiora injecting humour into her communications with her children, speaking at a level they would understand. One tangata whaiora could not describe how hard it was to be separated from her child even though the child was being cared for by a relative. Another tangata whaiora had her two children removed from her care, and remembers clearly how difficult that was after she first became unwell:

> *Can you watch my kids and look after my house and my dog until I get out' and she did…she put everything on hold just to fucking look after my kids and I'll never forget that eh…cause why….that's what I needed somebody so she took that off me and then I could only go over there and funny farm out (laughs)……… I had it all planned before I went eh…and um…yeah…it was just about getting me back to where I was before you know before everything just fucking came undone…yeah as much as I could…why because my two children were looking at me….so um….yeah..and plus I'd been working with caregivers for a long time for specially for my ACC working for them…cause why….um…it was up to me to look after the kids you see …so I had to get ready for it…..and…yeah…its fucking hard eh….but that's what they need tautoko over there…tautoko by you know….your friendly elders, your friendly Maori (Ariana]*

Ariana was reliant on support from her whanau.   There is a deep appreciation and recognition of the sacrifices the whanau made in picking up Ariana's responsibilities at home, even when those whanau had responsibilities of their own.   Ariana acknowledged the stress levels were reduced by having whanau support and therefore she was able to focus on her own recovery.   Having said that, she also concludes her story by identifying that having Māori in the unit would also assist towards the recovery journey.

Tangata whaiora

Making friendships or acquaintances with others can improve your stay while at the unit. As indicated previously, there is a period of assessment where tangata whaiora ascertain who they might engage and interact with. One tangata whaiora assessed another as 'mad like me', comparing other tangata whaiora behaviours to assess how 'unwell' they actually are:

> *Yeah you meet people who are in the same boat as you…..and they seem to help out more.. [Martin]*

> *Yeah they were all good, they were all good to one another. [Jack]*

> *And the other patients and yeah…everything…I was worried someone was gonna say something to me or …but I liked the patients that I kinda liked the patients that no-one else…that were by themselves….. And I found them quite fascinating because yeah there was one guy there who was non stop talking like there were people sitting around him…all day…and yet you walk up to him and start talking and he'd talk back to you ..(laughs)… Yeah yeah…they were funny…but yeah one of them ..one of them had a tendency to walk into the womens side, into the womens dorms.. Which was a bit dodgy (laughs) [Mark]*

The relationship can be symbiotic, both tangata whaiora supporting each other to which reduces that sense of isolation, and at the same time coping with separation from whānau:

> *So it was like that ..meeting her made it a lot nicer experience I didn't feel isolated or alone..we would get together and have cups of coffee and watch the same programme, and sit there cutting pictures out of magazines to do collage things..things that I wouldn't normally do but…for some reason I was really interested and into it. [Anne]*

They also learn from each other in terms of understanding how to work the system. Therefore a number of tangata whaiora have formed solid friendships that have continued outside of the acute inpatient environment. There is a certain level of camaraderie across tangata whaiora, all being in a position of needing help to reduce their level of distress. Music was one natural tool where tangata whaiora came together, joining in the entertainment and resulted in relationships being established or strengthened.

Three tangata whaiora also developed intimate relationships while on the unit. Two of the tangata whaiora are still together today:

> *Randomly, I hooked up with four different female inmates. These things just happened. I wasn't looking for it but I found it. [Malcolm]*

Staff

There were variable responses around staff on the unit, the majority of tangata whaiora remarks being positive. Acute inpatient staff are the main 'intervention' provided, therefore it is pivotal that there is a respectful and trusting therapeutic relationship formed. Tangata whaiora spoke a lot about nursing staff, and to a much lesser extent psychiatrists. These were the two professions predominantly identified. Other staff such as occupational therapists, psychologists and social workers were fairly non-existent in their stories, albeit there were some references to Māori staff.

There were mixed responses around the 'fish bowl'[49] where nursing staff are perceived to spend most of their time. This was viewed more as a separation between tangata whaiora and staff, inhibiting the interaction that tangata whaiora need and more importantly the development of therapeutic relationships:

> *The observation and they've got all their computer screens in there, I decided that they could read our minds and that every thing that we thought in our minds was coming up on their computer screens cause every time I'd look on their computers they would turn it off. (laughs) so that little psychotic thing going wrong,….their reaction was really interesting and once again [   ] and I were talking about that yesterday because they weren't friendly. And I remember looking at them at the time and thinking why aren't you friendly what is the reasoning behind this, cause I would assume if I was working in that situation that I would be friendly..but I got the very strong impression that they were there to support us but not to befriend us. [Ann]*

> *Nah. Still I thought ..you know instead of them sitting in their office is getting out more and being around the patients… the clients…. And cause as far as I'm concerned, the units there to get your life back in order..and then start preparing yourself for when you leave the unit….just talk …you know just hanging with the clients .[Daniel]*

Some tangata whaiora identified a hesitancy to disclose personal information unless they had some form of therapeutic relationship and a level of respect for the staff member. This can take time to build. For those tangata whaiora who have been in the system for some time, they know the unit staff very well, know the 'ropes', and feel more comfortable engaging and disclosing information to staff. For those who are relatively new to the system, there are additional barriers to overcome. For example, one tangata whaiora had difficulty distinguishing between patients and staff and was therefore confused about who to approach for support. Another tangata whaiora, due to his illness, was not sure whether he was

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[49] Office area,   surrounded by glass [waist to roof] in the middle of the acute inpatient unit for easier observation of service users/tangata whaiora.   One tangata whaiora used the term 'Dungeon of Doom' in reference the fish bowls nickname.

physically restrained and given medication. Not being aware of internal processes he did not follow this up with nursing staff to clarify actual events.

A number implied power imbalances between staff and tangata whaiora, with an appreciation of those staff who actively work to reduce that imbalance.   Mark's story is one worth replicating as it identifies the power imbalance;   demonstrates the frustration of being physically restrained; and finally the inability to do anything about the situation:

> *I thought the original one I got appointed..this guy with a [   ]..he was um, he was nasty to me…he actually ah…just treated um…treated me like I was being a nuisance by putting myself in there, cause it was sort of voluntary that I went over.... And he was like …I've got some risperidone and then I got up that morning and he was waking me up and just bitching at me and then I started to walk out and just having dizzy spells and just about falling over and that and I made it to the table and he was like…what are you doing here man….what's wrong with you…and I was like what…it was almost like he was trying to get a reaction out of me...... So I just didn't react. After awhile he, he didn't..he didn't sort of have that attitude but there was ..it was on the first or second night I can't remember now, but um… I do remember like, people coming into my room in the middle of the night and I was like hadn't had this medication before and I was real dozy and ah,   yeah I think they were trying to wind me up then and I remember something ..something being dug into my back and then I remember feeling u…feeling warm like it was bleeding and I remember reaching around cause I was that dozy, and I remember reaching around and swearing at them …and turning around they were like ….expecting a reaction or something …and I just laid there and said ..do what you fucking want…. and um they just left… And then in the morning I woke up….did that happen….or did I just imagine that…I must've imagined that…but I had this mark on my back and I looked at it and it was like… fresh and it looked like it had been bleeding. And I remembered them wiping up the blood...... Well they just….they came in, they dug something in my back and it started bleeding just to try and get me to nut out.. [Mark]*

Mark seems to be querying the reality of the 'night visit' event because of his level of unwellness, even though the next day he had physical evidence that something did occur to his back.   During the 'night visit', Mark accepted the situation and treatment, which then resulted in the staffs departure from his room.

There were also stories about an 'enforcer' type role, with tangata whaiora identifying the same staff member several times. This role related to compliance with medication and behaviour management. One tangata whaiora felt the 'enforcer' was goading him purposely to test what his reaction would be. Other experiences included physical restraint and bellowing of orders in order that tangata whaiora would obey those instructions. The role was generally accepted and to some extent respected:

I thought the original one I got appointed …..this guy with a [   ] ..he was um, he was nasty to me…he actually ah….just treated um….treated me like I was being a nuisance by putting myself in there, cause it was sort of voluntary that I went over….And he was like….I've got some risperidone and then I got up that morning and he was waking me up and just bitching at me and then I started to walk out and just having dizzy spells and just about falling over and that, and I made it to the table and he was like…what are you doing here man…..what's wrong with you….and I was like what….it was almost like he was trying to get a reaction out of me…..so I just didn't react. After awhile he, he didn't…he didn't sort of have that attitude [Mark].

Yeah [   ] cool..I like…you know he's sort of got me a couple of times and rubbed me up the wrong way ..but I thought..ugh I'm not going to take it to heart. Yeah cause I like [   ] eh. He's a hard man. But you need a hard man in the unit for some of the clients that come in like all the ruffians and all of that….but I've got time for [   ] so…I've actually got time for a lot of them now eh cause um..I'm the sort of person that doesn't hold onto grudges …. [Daniel]

He's a nurse and he came and said….you take your medication (deep voice)…he freaked me out eh…oh my god ..and I took them (laughs)…but you know….it was really scary….(laughs)…yeah…so um…that was one of my experiences…[Caroline]

Quite trendy but he's a hard case and I remember getting up one night and walking out into the lounge and he was lying on the sofa with a pillow, he was on night duty and he just looked at me and in the same tone that you would talk to a 5 year old he said 'Anne go back to bed'. And I just turned around and toddled off back to bed but I remember thinking later that's not actually how you speak to a [   ] year old woman so there must be a thesis behind it..[Anne]

Tangata whaiora also spoke of the difference between week and weekend staff.   Weekend staff were viewed as taking a more interactive non-clinical approach, and were more relaxed in their approach.

Psychiatry comments were more attuned to psychiatrist's availability to meet with tangata whaiora and the relationship between tangata whaiora and the psychiatrist. Tangata whaiora felt comfortable in negotiating aspects of their care plan direct with the psychiatrist. One felt embarrassed that due to their medication at the time they were unable to converse at the same level as they normally would. Another felt left out of their care planning when there was more communication with their whānau member instead of the tangata whaiora. Having to wait to see the psychiatrist was noted as a concern but generally accepted that this was the norm:

You go to, your um..Psychiatrist and get an evaluation before you can get in there......And that's hard to get to get an appointment with your Psychiatrist…. [Martin]

Yeah I saw her a few times…um….there were times when I wanted to see her more to get out…but it didn't happen….and sure she was always busy….you know when I

really wanted to see her to try and get out..she was …I won't see her until four hours later…and it was really frustrating..it was a time waiting game there…it was a …waiting game you know you just had to wait until you were seen and sometimes it would be four or five..you know..you want to see them in the morning but you wouldn't see them till 4 o'clock in the afternoon….and it was so frustrating and so…[Caroline]

Tangata whaiora also appreciate a good discharge process where transportation back to their home is organised, the necessary community supports are put in place, connections to services such as Work and Income are arranged, and there is good follow up by their Case Manager.

In the main, there is an appreciation of the acute unit and the work staff do to assist reduce the acuity of their illness. The message from tangata whaiora in relation to all staff within the unit has been consistent and should be transparent across all health professions. Tangata whaiora expect and would like to be treated with respect and dignity and this makes a difference in terms of their recovery. There is no 'us and them'. Be open and transparent in all communications. Tangata whaiora do not like to be discounted, disbelieved, disrespected or discarded. Basically, 'we' have a voice, please respect it:

But um…I was telling him about voices and ah..imagining other ..um spirits coming…like coming down and interacting with me and that, and I can't be sure but I got the impression that he thought I was making it up and I don't really think he took it seriously at all. [Mark]

Tangata whaiora identified that its the right place to be if you are acutely unwell:

I can't really fault it, there was really no disrespect shown at any time we were all treated very professionally and respectfully. We were well looked after, we were well fed, we were supported, I can't actually speak highly enough of the unit I just think that if your in the place that I was in, then that's the best place I could've been..... Yep, it was just what I needed. Just having, having all that list of stuff taken off my shoulders for two weeks and just let my brain settle. I remember walking around the grass in bare feet and just you know…re-earthing and thinking it was so nice just to have my mind be free of all..everything..everything was taken off my shoulders for the period I was there, and it was exactly what I needed. [Ann]

But actually it's a good place, I like it there. I do, I really do [Lisa]

Um, overall the experience from a Maori perspective was that I felt I was treated very well, I felt I was treated with dignity and respect by the staff..[Margaret]

11.7 Summary

Tangata whaiora experiences have demonstrated that an acute inpatient unit has its place, even though some considered it to be confining. If becoming mentally unwell, there is general agreement that the unit is the right place to be. In fact, some tangata whaiora would like the opportunity to self-refer directly to the unit.

A range of experiences were themed into Te Whare Tapa Whā. Tangata whaiora talked about being fearful, their relationship with medication, the staff interactions (or lack thereof), the stigma and discrimination they face, the difference Māori staff can make to their inpatient stay, the friendships they make while in the unit, the peer support they provide to other tangata whaiora, the boredom they face, and the impact on their whānau.

The experiences have been rich and from the quantum of interviews, it has been difficult to do justice to all tangata whaiora stories.

Chapter Twelve: Discussion

12.1 Introduction

This study stemmed from an earlier thesis on Māori access to primary mental health services in the Marlborough region (Eade 2007). The study found that there were a number of barriers tangata whaiora faced in terms general practice meeting their primary healthcare needs. In addition, several of the tangata whaiora interviewed as part of that thesis identified that they do not communicate their level of unwellness to their General Practitioner in fear of a referral to Witherlea Mental Health service, which in turn might result in an admission to the Nelson acute inpatient unit. This prompted the two questions posed in this thesis.

The first question was around exploring whether Māori mental health statistics in an acute inpatient environment were any different from non-Māori in Te Tau Ihu, or indeed Māori nationally. This found that there were similarities in terms of higher rates of Māori admissions, seclusion, diagnosis of psychotic disorders and first readmission rates. There were also a number of dissimilarities in terms of Māori male and female admission rates, second (and more) readmission rates, higher access rates compared to other District Health Boards, and lower suicide mortality.

The second question was around seeking the views of tangata whaiora in terms of their experiences and stories of their stay in an acute mental health inpatient unit. This built on previous international research which echos the concerns around medication, the call for reducing boredom, reducing discrimination, providing a safe and secure environment, reducing seclusion, having staff of their own cultural background providing care, and having therapeutic relationships built on respect and dignity (Barker, Shergill, Higginson & Ovell, 1996; Barnett & Lapsley, 2006; Baum et al (2003); Fenton & Kotua 2000; Langle, 2003; Gilburt, Rose & Slade, 2008). These concerns have also been noted by tangata whaiora within this study. It also added additional learnings around the importance of whānau/family (in the broader sense this includes friends, staff and other tangata whaiora within the unit) in supporting recovery,how tangata whaiora keep themselves safe within the unit, kai/food to not only sustain the body but also as a mechanism to build relationships, the complex relationships tangata whaiora have with their medication regime, the importance of physical health, and the difference having a Māori presence on the unit can make to ones stay on the unit.

12.2   Limitations

From 2005 to 2009, there were on average 33 individual Māori tangata whaiora per annum admitted to the acute mental health unit. Tangata whaiora were recruited through Māori Case Managers within the Nelson and Witherlea Mental Health Service. This raises an issue around sample bias as while a number of tangata whaiora were approached by the Case Managers, the full number of tangata whaiora on the specialist mental health services caseload lists were not. Recruitment therefore depended somewhat on the relationship between the Case Manager and tangata whaiora. The 13 tangata whaiora interviewed represent (on average) 39% of tangata whaiora individuals admitted per annum. Tangata whaiora were aged between 25 and 60 years of age. The stories therefore, are reflective of pakeke experiences as opposed to rangatahi and kaumatua experiences.

In terms of the second research question, first and foremost many tangata whaiora had difficulty in recollecting the detail of their experiences. Whether this is solely down to the medication usage over time is not clear; however, memory loss has impacted on their recall and accuracy of events.

My previous employment role was as Mental Health Portfolio Manager for Nelson Marlborough District Health Board Planning and Funding. There were no concerns raised by tangata whaiora in terms of whether the stories they told might end up being shared back with the acute inpatient service, thereby affecting the services offered to them. To some extent, this was covered by the confidentiality agreement. It is not known whether tangata whaiora felt confident and trusting to provide the full detail of experiences.

An additional limitation is that I have not had experience as a front line clinician in mental health services. Understanding an acute inpatient model of care is lacking. However, the thesis is on tangata whaiora stories, therefore it is more important to focus on tangata whaiora experiences without taking an acute inpatient lens, which may take a more defensive approach to tangata whaiora realities.

My objectivity could also be questioned. The expectation was that a number of findings might emerge, therefore there shouldn't be any 'steering' tangata whaiora into these areas. The use of 'Narrative Prompt' questions enabled me to adhere to a core range of questions to open conversations and/or stimulate thinking, where the flow of narratives were impeded.

Research findings are applicable to Te Tau Ihu (Nelson Marlborough Tasman) area, and may not be reflective of other geographical areas.

12.3   Māori Mental Health in Te Tau Ihu

Clustering all Māori together statistically is useful, as it provides a national view of Māori. However, direct application of a national view does not necessarily mean that this is reflective of Māori at a provincial level. In comparison to Māori statistics nationally, Te Tau Ihu Māori are 'healthier' (Nelson Marlborough District Health Board 2007). Therefore, when discussing Māori health in a general national sense, it is useful for local communities to assess their own position which might not be as dismal (or could be worse) than the national picture. We know that there are areas within Aotearoa with high numbers of Māori population and vice versa. Those populations with higher numbers of Māori also experience higher levels of deprivation which have a direct impact on health outcome (Mare et al; Brabyn & Barnett 2004). Applying a heuristic application of Te Rau Hinengaro National Mental Health survey findings forms a basis for conversations across the mental health and addiction sector in terms of understanding what the prevalence implications at a local level might be. Once again, local assessment is needed as whānau, hapu, iwi and Māori are not homogenous, and the needs across communities may differ.

While there is acknowledgement of the health determinants that affect wellbeing (income, poverty, education, housing, culture and ethnicity, population-based services and facilities and social cohesion), this thesis briefly explored cultural identity and cultural responsiveness with the view to better understanding whether this is an enabler to access and remain within health services for treatment. A direct causal link between colonisation processes and the intergenerational effect on Māori is platformed as a possible underlying reason for the escalation in Māori mental health statistics. This can be viewed two ways. Firstly, while it might be a contributing factor towards the disparity between Māori and non-Māori, perhaps Māori were 'colonised' to a higher level than other tribal rohe (given the loss of Te Reo me ona Tikanga Māori) being so assimilated into non-Māori practices, including accessing health services. Along with being the clear minority within the Nelson Marlborough population, maybe this has positioned Māori to have better health outcomes. Building on that reasoning, there is evidence that having a strong cultural identity is a protective factor for mental illness and suicidal behaviours. If having a strong identity is a protective factor, then does the converse apply in terms of a lack of protection therefore a higher risk of developing a mental illness. If Māori 're-indigenise' and build cultural identity, then perhaps there could be an increased equity of health outcome between Māori and non- Māori.

At the time of this study, Māori mental health in Te Tau Ihu might be better than Māori nationally from a funding investment perspective. In the past fourteen years there has been

significant growth in Te Tau Ihu, both within the specialist mental health service and the community sector. At one point, Nelson Marlborough had the highest kaupapa Māori mental health and addiction spend in the South Island (Te Roopu Awhiowhio 2004). This expenditure across three Māori health providers in each of the Territorial Local Authorities (Tasman, Nelson and Marlborough), alongside dedicated Māori mental health spend within the specialist mental health services, has probably contributed towards improved and easier access to services for tangata whaiora and whānau.

Nationally Māori male admissions can be as high as 30% in comparison to Māori females. In Te Tau Ihu there is minimal disparity on admissions between the two sexes. The female, male population of Te Tau Ihu is similar to that of other centres. Marlborough Māori males comprise 49.7% of the total Māori population, 48.7% in Nelson, 50.19% in Tasman, 50.3% in Canterbury, 48.9% in the Manawatu and 49.2% in Northland[50], so there is no overabundance of Māori females that would support the national Māori male admission data. Does the health system in Te Tau Ihu make it easier for Māori males to access interventions earlier within primary or community care, therefore receiving the support need and their symptomology not reaching acute levels?

Māori do have a higher seclusion rate in Te Tau Ihu. In 2009, Nelson Marlborough had the fifth highest seclusion rate per 100,000 population across all ethnicities, and was the highest of all District Health Boards in terms of the number of individuals secluded (Ministry of Health, 2010). The two main reasons seclusion is used are therapeutic value and managing risk in terms of safety[51]. Seclusion rates can be influenced by senior clinicians, who in some instances may practice defensively to minimise risk. It is unknown whether there is an internal culture within the Nelson acute inpatient unit to use seclusion as a final solution only, or whether there are limitations around staffing capacity or ward design that influence utilisation of seclusion. It could also be attributed to Māori presenting at higher levels of acuity to the service. Are staff cautious when they see Māori and feel physically threatened by their presence? Given that there is minimal evidence on 'therapeutic value' of seclusion, in a climate of economic restraint it would add value to reduce the use of seclusion given international experience that there are savings to be made[52]. For a range of reasons the impetus is to change current practice to 'best practice' and reduce or eliminate seclusion practices (O'Hagan et al 2008; Mental Health Commission 2004). Tangata whaiora stories in

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[50]http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats/AboutAPlace/SnapShot.aspx?id=1000001&type=region &ParentID=

[51] www.likeminds.org.nz/file/newsletter-archive/PDFs/LMLM-Newsletter-33

[52] www.likeminds.org.nz/file/newsletter-archive/PDFs/LMLM-Newsletter-33

this thesis generally support the view that seclusion is an overwhelmingly negative experience.

Māori have a higher rates of delusional psychotic diagnosis that non- Māori. Te Tau Ihu is no different to the national picture. The basis for this could be that either (a) Māori have a higher prevalence of psychotic disorders, (b) Māori are misdiagnosed due to clinicians' lack of understanding around cultural beliefs such as infringement of tapu or mākutu, or (c) Māori presenting at high levels of acuity so it is difficult to diagnose accurately. Regardless, it would be useful if Māori kaimahi were part of the assessment process to alleviate tangata whaiora anxiety and to support the clinician with a cultural assessment. No tangata whaiora spoke about their cultural needs being taken into account as part of a cultural assessment. However, there were no specific prompts around this issue either.

Māori have lower length of stay than non-Māori at 11.2 days compared to non-Māori at 14.85 days in Te Tau Ihu. The National Key Performance Benchmarking Indicator project identified that good practice length of stay was between 14 – 21 days. This benchmark indicator acknowledges how responsive services are, so that tangata whaiora can be supported in the least restricted environment. Lower length of stay could result in higher readmissions if discharged earlier than clinically indicated. Te Tau Ihu Māori have a higher first readmission rate (34.35%) than non-Māori (31.75%), but for readmissions (two or more), Māori are lower (22.75%) than non-Māori (26.04%). However, length of stay can be influenced by the range of community support services available to support the recovery of tangata whaiora once discharged. Examples of influencing factors are whether there are ample community residential rehabilitation beds to discharge to; the acute inpatient unit practices such as discharge planning; and the service user casemix of need. On top of this, those tangata whaiora who have been in the system for some time, identified that they know how to 'play the game' sufficiently enough to get discharged early, so it might not necessarily be that Māori respond to treatment better than non-Māori, but given access to extended whānau, there is better supports at home.

12.4   Tangata whaiora

The next research question looked at tangata whaiora experiences in the Nelson acute inpatient unit. Barker, Shergill, Higginson & Ovell 1996; Barnett & Lapsley 2006; Fenton & Kotua 2000;   Langle, Baum, Wollinger, Renner, Uren, Scwarzler & Eschweiler 2003; & Gilburt, Rose & Slade 2008, Wharewera-Mika 2012,   all identified the main areas of concern for service users.   Internationally, minority ethnic groups overall have a lower level of satisfaction within an acute inpatient setting. There were consistent messages around the

reliance and trialling of medication, even though some recognised it was needed. Other concerns were jargonisation of language; professional interface; interaction and relationships with staff; stigma and discrimination behaviours; the threat of imposing seclusion or compulsion; the lack of respect and patient rights; fear, safety and security; boredom; lack of adequate discharge planning; and culture and cultural competency.   This study found simiarlities with these findings other than the jargonisation of language and cultural competency levels.

Threaded throughout tangata whaiora stories was the reliance of care provision based on a medical model of care. In analysing tangata whaiora stories, Te Whare Tapa Wha was used as the framework to better understand their journeys, providing a more holistic view of overall wellbeing. Using this framework, it became apparent that it is not just the health system that has a role to play in tangata whaiora care. What it does call for though is an integration of health, social, cultural, whānau and spiritual support into an overall comprehensive care plan for tangata whaiora. There is interconnectedness across Te Whare Tapa Wha, tangata whaiora are aware of this and spoke frequently not just about their mental health, but also their relationships, their physical health status and to some extent spirituality.

Tangata whaiora focus on living with a mental illness and its ramifications on a daily basis. To do that, mental health strategic planning and policy development are not high on their agenda unless there is a direct cause and effect. Their focus first and foremost is getting through each day while maintaining their wellness. Keeping well has accumulative benefits in terms of preserving and sustaining relationships with partners, whānau, friends and employers.

Using Te Whare Tapa Wha, the main issues arising from tangata whaiora stories are described here in terms of te taha hinengaro, te taha tinana, te taha wairua and te taha whanau.

12.5   Te Taha Hinegaro

Overall seclusion is a negative experience. When tangata whaiora entered seclusion, it raised the question of how much of their current behaviour is due to being isolated in seclusion, and how much is due to their actual symptomology? How would you feel being put in seclusion if you were 'tricked' into going into the acute inpatient unit , all alone and in a stark, cold environment? How much would that exacerbate your level of unwellness?

Tangata whaiora generally accept that they need medication to better manage the impact of their illness. Given the range of side-effects, in some instances these can be a barrier in themselves to the recovery journey. This raised the question in terms of what opportunities there are to minimise the longer term impacts of medication. How can the biomedical model be more responsive to minimising the side-effects of medication? This could include more regular medication use reviews to ensure earlier intervention if the medication is having a significant impact on 'living'. Are tangata whaiora and their whānau able to have more of a say in terms of the medication regime. Tangata whaiora are well versed in the medication they are taking and the purpose it serves, but is psychiatry ready to be more open to change, listening and communicating with tangata whaiora on a more regular basis? There needs to be better connections between inpatient, community and primary care to support tangata whaiora and whanau.

12.6   Te Taha Tinana

International evidence suggests that those with a mental illness have higher mortality rates than those without a mental illness and that there is a need to strengthen the physical health of tangata whaiora (Vasudev & Martindale 2010; Handiside 2004; Minister of Health 2006). All tangata whaiora talked about their physical health and had a strong sense of awareness of keeping themselves both mentally and physically well. All are being pro-active with activities such as walking, team sports, or smoking cessation. Therefore, having a closer impetus on physical health as part of care planning (general practice and specialist mental health) needs to be embedded into service provision.

12.7   Te Taha Wairua

Stigma, discrimination and boredom are included under Te Taha Wairua because these three areas can impact ones spiritual wellbeing.   Wairua as a spiritual dimension is what makes a person feel uplifted (or vice versa).   Kingi and Durie (2000) developed a Māori mental health outcome measure and included under Te Taha Wairua were, dignity and respect, cultural identity, personal contentment and spirituality.

It is not unfamiliar that those who live with a mental illness experience a level of stigma from those they interact with (Petersen, Pere, Sheehan & Surgenor 2004). At times, this might include some members of their family, work colleagues, friends and acquaintances, those working in the health sector, and the wider general public. Campaigns such as 'Like Minds Like Mine' and the National Depression Initiative featuring Sir John Kirwan have gone some way to demystifying living with a mental illness. However, societal attitudinal change often

takes time. What is less known is the internal stigma tangata whaiora develop which, in their own words, can end up defining who they are as an individual. 'Like Minds Like Mine' have one definition which is reflective of tangata whaiora interviews held as part of this thesis explaining internalised stigma as *'negative thoughts or feeling towards yourself based on the fact you have a mental illness'.* It is due to this internal stigma, alongside the solidifying discriminative behaviours in the community, that tangata whaiora are more accepting of how their lives have panned out. They then self-discriminate, and this has ongoing consequences of tangata whaiora not looking too far in the future. Tangata whaiora may not be willing to sit outside of their comfort zone in terms of seeking employment or education outside of what is expected for someone who lives with a mental illness because it does not align to their individual and societal expectations. To overcome internalised stigma, just as the national Like Minds Like Mine and National Depression Initiative campaigns have achieved with reducing stigma and discrimination, a similar programme at service level should be available to tangata whaiora, whānau and staff, assisting them to identify and recognise the stigma and then how it affects their own behaviours. From there, tangata whaiora could develop strategies to address the stigma, to understand when they are discriminating against themselves, and to challenge their own negative thoughts to help move forward. This would have more success if societal stigma was reduced significantly.

As national and international literature has identified, tangata whaiora expect to be treated with respect. When looking at the Health and Disability Commission Code of Health and Disability Services Consumers' Rights Regulations (1996), several tangata whaiora stories challenged the implementation of these regulations. The code identifies that every consumer has the right to be treated with respect. In most instances within an acute inpatient unit that is the case. However, it only takes those few minority staff who do not do so to have a significant impact on tangata whaiora experiences. If those staff were in an oncology, cardiac or respiratory unit, would their patients be treated with as much disrespect as some of the tangata whaiora interviewed were? Probably not, as mental health is not viewed as the 'roses and chocolates' ward, and the stigma of a mental illness is still pervasive across the health profession (Petersen 2005). The sector needs to up the ante around engaging and developing a respectful relationship with tangata whaiora. Staff need to be held accountable and tangata whaiora need to be encouraged to better understand their rights under the code, including how they can pro-actively complain in a way that does not compromise their continuing care.

The Health and Disability code also protects tangata whaiora in terms of being free from coercion and harassment, expecting services to minimise harm. Tangata whaiora have the

right to be informed and make an informed choice. It must be a tightrope to walk across for clinicians at times in terms of assessing the capacity of tangata whaiora to absorb the information provided when they are significantly unwell. District inspectors have an important role in terms of safeguarding the rights of tangata whaiora under the Mental Health Act, especially in terms of addressing and investigating complaints (Ministry of Health 2012).

Tangata whaiora have the right to feel safe and protected while in treatment, as any patient in any medical ward has the right to. We know, however, that acute inpatient units can be 'unsafe' at times regardless of the ongoing de-escalation, calming and restraint training of staff (Lapsley et al 2005; Barnett & Lapsley 2006). Admission to an acute inpatient unit is a last port of call. Depending on the level of acuity of tangata whaiora, (whether there are other behaviours [e.g. no self care or treatment adherence], what support mechanisms they have at home, and the referring clinician preferences), specialist mental health services will consider alternative options such as crisis respite, peer-led crisis houses or a home-based treatment service. Acute inpatient units are the most expensive service in specialist mental health services, accounting for 31% of their total budget,[53] so given the tight fiscal health environment facing the nation, are there alternative options to be considered? Most tangata whaiora agreed that if they were unwell, an acute inpatient unit is the place to be (regardless of their experiences), so any alternative would have to encompass the same level of confidence.

12.8 Te Taha Whānau

Māori like to kohikohi (gather) together and connect. Two aspects tangata whaiora spoke of is coming together at kai time which provides opportunity to relax and engage with others (Te Puni Kokiri 2010),[54] to manaaki and nurture others, and also for the purposes of having fun and relaxing through music. Traditionally, waiata had a purpose of entertaining, passing on history, knowledge, stories and to express emotions. In an acute inpatient setting it is more about at an individual level reducing anxiety and stress, relaxing the mind and body and with more non-traditional waiata. When doing this as a group activity, it is more about this unwritten understanding, to bond as a group, to recognise that even though tangata whaiora are in an inpatient unit, they can have fun and enjoy each others' company. It is about being part of a unified group, supporting one another through periods of unwellness.

The language for most District Health Boards now is being committed to developing 'patient-centred' services (National Health Board 2011; Nelson Marlborough District Health Board

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[53] From Nelson Marlborough DHB funded acute inpatient service costs 2011
[54] http://www.bpac.org.nz/magazine/2008/august/tikanga.asp

2010/2011). It would then be useful to consider building capacity within the workforce, that is reflective of meeting tangata whaiora need. Tangata whaiora stories around the lack of interaction with staff needs to be addressed. Understandably, there are guidelines in terms of the construction of inpatient units (Ministry of Health 2002), however, the design needs to balance out the slightly archaic approach to have a divide in terms of the observational 'fish bowl' which accentuates an 'us and them' perception. Accordingly, having additional Māori staff within the unit would strengthen tangata whaiora engagement and interaction, as well as their journey through the unit.

Collectively Te Whare Tapa Wha should be inclusive of all care planning. Focussing on one or two aspects only, risks providing a comprehensive response to supporting tangata whaiora achieve wellbeing.

12.9   Future research opportunities

Given the impact on physical health, it would be useful to consider developing a research framework to investigate the mortality rates of longer term service users/tangata whaiora (those who have been within specialist mental health services for two years or longer) by Māori and non-Māori, and then compare this to the general population. The hypothesis being that overall Māori have inequitable general health outcomes compared to non-Māori, including life expectancy. Adding the complexity of having a mental illness, one would expect that Māori tangata whaiora would have a higher mortality rate than non-Māori given the existing disparities.

The medication issue is complex, and it would be useful to better understand the relationship between medication and tangata whaiora. This would include investigating the length of time tangata whaiora have been on medication; the range of side affects (and benefits) tangata whaiora experience over time; the benefits of the medication in relation to maintaining wellness; how tangata whaiora are informed and contribute towards decisions relating to their medication; whether any alternative medications are taken; whether tangata whaiora understand the rationale for and intended benefits of the medication; what level of choice tangata whaiora have in relation to medication compliance; the level of peer support education undertaken by tangata whaiora, and the frequency of medication reviews undertaken.

None of the tangata whaiora raised the issue of whether a cultural assessment was undertaken, or raised concerns around cultural competency levels. Given the expectations of cultural assessment as per the Mental Health Commission guidelines, a national stocktake

across the 20 District Health Boards to identify the percentage of Māori tangata whaiora with a completed cultural assessment would be useful. This would include who conducts the cultural assessments, how cultural assessments are embedded in the overall care plan, what core competency levels are required to conduct the assessment, how many tangata whaiora are offered a cultural assessment but decline this option, what level of cultural interventions and supports are provided while in an acute inpatient unit, and how the assessment is followed up when discharged to community services. An addendum to this research could include the number of Māori staff and cultural interventions that are offered within an inpatient setting. This would then form the basis for more comprehensive individual care planning using Te Whare Tapa Whā as the basis to ensure all four cornerstones (Te Taha Tinana, Te Taha Wairua, Te Taha Whānau me Te Taha Hinengaro) of wellbeing are catered for.

While this thesis didn't focus primarily on colonisation and its impacts from a historical trauma lens and the intergenerational effects, it would be useful for future qualitative studies to question the link from a tangata whaiora perspective in a more focused study.

Tangata whaiora generally accepted that when they are unwell an Acute Inpatient Unit is the place to be. However, when there are minimal alternatives available, choice is limited. Seclusion was raised continuously even if tangata whaiora had not been in seclusion but had witnessed others going into and out of seclusion. Further work in the area of alternative facilities and models of care would be useful, which could explore whether the same level of clinical oversight can be provided, delivered within a Te Ao Māori environment.

Chapter Thirteen: Conclusion

It has been such a privilege to work with tangata whaiora. There has been a great deal of knowledge shared by tangata whaiora, yet there is so much more to be told. I hope that I have reflected their stories in a way that honours and does justice to those experiences. As Daniel said '*you gotta go through it yourself to know what its all about*', and he is right. Four years after the initial interviews, it still feels like a small 'glimpse' into the full spectrum of challenges that tangata whaiora face every day.

We know that there are challenges within Māori mental health. Māori have higher prevalence rates of mental health problems compared to other ethnicities, but we don't access primary or secondary services in a timely way. The health sector needs to challenge itself in terms of better distributing its health resources to the populations who most need care. Taking this one step further, that distribution would involve increasing the capacity of Māori health services who already deliver culturally responsive services to Māori (and other ethnicities). This would result in earlier engagement, assessment and treatment, and improved health outcome. This should result in the government receiving better value for money in terms of their health investment.

On a positive note, Māori mental health service provision has grown over the past two decades. This growth has included an increase in the Māori mental health workforce and the number of Kaupapa Māori mental health services. There is a growing awareness (and in most instances a contractual requirement) within primary, community and secondary services to provide a culturally responsive service to Māori. However there is a gap between the 'awareness' and the 'implementation'. There have been decades of compliance requirements for health providers in relation to Māori health, and Māori are continually reminded of the disparities between Māori and non-Māori. Both have a negative connotation and arguably this approach has made little difference to Māori mental health outcome. To bridge the gap between 'awareness' and 'implementation', we need to better support providers from a quality improvement perspective at a governance, management and operational level.

There are a wide range of tools and resources already available to support a quality improvement approach across the sector in terms of Māori mental health. District Health Boards can lift their game in terms better connecting and investing in these resources for

health providers. Doing the 'same old same old', means that we are likely to be in exactly the same position 20 years from now.

There is potential for Whanau Ora to take a different direction for tangata whaiora and whanau wellbeing. If there is capacity for a range of government agencies to come together, reduce the silo approach to contracting services, and develop a new service model that is truly driven by tangata whaiora and their whanau, then this would align to Te Whare Tapa Wha. Tangata whaiora and whanau would be empowered to address a range of issues relating to their wellbeing, with the service provider taking a cultural motivational support navigational role. This would reduce the number of agencies being involved in their lives, have one key worker (instead of several workers going into their home, who don't necessarily communicate with each other because they work in isolation), who is able to work flexibly, collaboratively and innovatively to meet the wellbeing goals. For example, a whanau ora service model could cover educational aspirations, employment or career path development, mental and physical health issues, the strengthening of cultural identity, finainicial management and growth, housing, parenting supports to name but a few. The important issue is that the goal is set by tangata whaiora and whanau, not a service provider or government agency that have key performance indicators to meet. Many Māori health providers would say that this is how they've been operating since their establishment as Te Whare Tapa Wha is a natural fit. However, this approach is a challenge as they are often restricted by the service specification they are contracted for.

Completing this thesis has been a journey in itself. The best way I can think of finishing the journey and to acknowledge tangata whaiora who participated in the research is this Ngāti Toarangatira karakia:

Ka oho te wairua (when the spirit is awakened)
Ka matara te tinana (when the mind and body is alert)
He aroha ki te aroha (when love is unconditional)
Ka ka te rama (enlightenment flows)

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Appendices

APPENDIX A- SPECIALIST MENTAL HEALTH DATA

2005 to 2009 NMDHB Mental Health Inpatient Admission Data (MHAU - Wahi Oranga)

	MĀORI			OTHER			TOTAL	
Total Admissions	262 (14.66% of all admissions)			1524 (85.33% of all admissions)			1786	
Number of Male Admissions	136 (17.43% of all male admissions)			644 (82.56 % of all male admissions)			780	
Number of Female Admissions	126 (12.52% of all female admissions)			880 (87.47% of all female admissions)			1006	

Age range of individual Service Users	Number of Admissions			Number of Admissions			TOTAL	
	Age	Female	Male	Age	Female	Male	Female	Male
	0-15yrs	1	4	0-15yrs	25	2	26	6
	15-19yrs	15	19	15-19yrs	70	36	85	55
	20-44yrs	92	106	20-44yrs	429	388	521	494
	45-64yrs	16	7	45-64yrs	302	189	318	196
	65+yrs	2	0	65+yrs	54	29	56	29
	Total	**126**	**136**	**Total**	**880**	**644**	**1006**	**780**

	Percent of Admissions (rounded)			Percent of Admissions (rounded)			TOTAL	
	Age	Female	Male	Age	Female	Male	Female	Male
	0-15yrs	0%	2%	0-15yrs	2%	0%	1%	0%
	15-19yrs	6%	7%	15-19yrs	5%	2%	5%	3%
	20-44yrs	35%	40%	20-44yrs	28%	25%	29%	28%
	45-64yrs	6%	3%	45-64yrs	20%	12%	18%	11%
	65+yrs	1%	0%	65+yrs	4%	2%	3%	2%
	Total	**48%**	**52%**	**Total**	**58%**	**42%**	**56%**	**44%**

	MĀORI	OTHER	TOTAL
Number of individual service users	167 (13.65% of total individual service users)	1056 (86.35% of total individual service users)	1223
Readmission episodes	90 (34.35%)	484 (31.75%)	574
Readmitted Service Users	38 (22.75% admitted more than once in the sample period)	275 (26.04%admitted more than once in the sample period)	313
Seclusion used from total admissions	64 (24.42% admissions included seclusion)	289 (18.96% admissions included seclusion)	353

Average length of stay	11.12	14.85	12.98

Diagnosis Group Count			Diagnosis Group Count			TOTAL	
Diagnosis	Māori Female	Māori Male	Diagnosis	Non-Māori Female	Non-Māori Male	Total Female	Total Male
Organic	1 (0.79%)	2 (1.47%)	Organic	13 (1.47%)	21 (3.26%)	14 (1.39%)	23 (2.05%)
Substance	10 (7.93%)	15 (11.02%)	Substance	54 (6.13%)	67 (10.4%)	64 (6.36%)	82 (10.51%)
Delusional	19 (15.07%)	86 (63.23%)	Delusional	145 (16.47%)	252 (39.13%)	164 (16.3%)	338 (43.33%)
Mood	46 (36.50%)	25 (18.38%)	Mood	399 (45.34%)	189 (29.34%)	445 (44.23%)	214 (27.44%)
Anxiety	39 (30.9%)	6 (4.41%)	Anxiety	165 (18.75%)	95 (14.75%)	204 (20.28%)	101 (12.95%)
Behavioural	1 (0.79%)	0 (0%)	Behavioural	24 (2.72%)	1 (0.15%)	25 (2.49%)	1 (0.13%)
Personality	10 (7.93%)	2 (1.47%)	Personality	76 (8.63%)	6 (0.93%)	86 (8.55%)	8 (1.03%)
ID/Dev	0 (0%)	0 (0%)	ID/Dev	3 (0.34%)	12 (1.86%)	3 (0.30%)	12 (1.54%)
Other	0 (0%)	0 (0%)	Other	1 (0.11%)	1 (0.15%)	1 (0.10%)	1 (0.12%)

2005 NMDHB Mental Health Inpatient Admission Data (MHAU - Wahi Oranga)							
	MĀORI			**OTHER**			**TOTAL**
Total Admissions	27			176			203
Number of Male Admissions	11			75			86
Number of Female Admissions	16			101			117
Age range of individual Service Users	**Number of Admissions**			**Number of Admissions**			**TOTAL**
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**

Age range of individual Service Users	**Number of Admissions**			**Number of Admissions**			**TOTAL**	
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**
	0-15yrs	0	0	0-15yrs	3	0	3	0
	15-19yrs	0	1	15-19yrs	10	6	10	7
	20-44yrs	16	10	20-44yrs	44	46	60	56
	45-64yrs	0	0	45-64yrs	38	17	38	17
	65+yrs	0	0	65+yrs	6	6	6	6
	Total	**16**	**11**	**Total**	**101**	**75**	**117**	**86**
	Percent of Admissions (rounded)			**Percent of Admissions (rounded)**			**TOTAL**	
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**
	0-15yrs	0%	0%	0-15yrs	2%	0%	2%	0%
	15-19yrs	0%	4%	15-19yrs	6%	3%	6%	7%
	20-44yrs	59%	37%	20-44yrs	25%	26%	84%	63%
	45-64yrs	0%	0%	45-64yrs	22%	10%	22%	10%
	65+yrs	0%	0%	65+yrs	3%	3%	3%	3%
	Total	**59%**	**41%**	**Total**	**57%**	**43%**	**117%**	**83%**
Number of individual service users	16 (7.88% of all admissions)			150 (78.3% of all admissions)			175	
Readmission episodes	11 (40.74%). 3 people readmitted twice, 1 person readmitted eight times			36 (20.45%). 16 people readmitted nce, five readmitted twice, two readmitted three times, and one readmitted four times.			47	
Readmitted Service Users	4 (25%) admitted more than once in the sample period.			24 (13.64%) admitted more than once in the sample period.			28	
Seclusion used from total admissions	7 (25.92%) admissions included seclusion (5 male/2 female)			37 (13.64%) admissions included seclusion (21 male/15 female)			43	
Average length of stay	11.07			13.44			13.13	

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Diagnosis Group Count			Diagnosis Group Count			TOTAL	
Diagnosis	**Female**	**Male**	**Diagnosis**	**Female**	**Male**	**Female**	**Male**
Organic	0	0	**Organic**	1	2	1	2
Substance	0	3	**Substance**	9	6	9	9
Delusional	0	5	**Delusional**	18	31	18	36
Mood	4	2	**Mood**	40	23	44	25
Anxiety	7	0	**Anxiety**	26	10	33	10
Behavioural	0	0	**Behavioural**	2	0	2	0
Personality	5	1	**Personality**	4	0	9	1
Other	0	0	**Other**	1	0	1	0
ID/Dev	0	0	**ID/Dev**	0	3	0	3

Diagnosis Group Percentage			Diagnosis Group Percentage			TOTAL	
Diagnosis	**Female**	**Male**	**Diagnosis**	**Female**	**Male**	**Female**	**Male**
Organic	0 %	0 %	**Organic**	0.99%	2.67%	0.85%	2.32%
Substance	0 %	27.27%	**Substance**	8.91%	8%	7.69%	10.46%
Delusional	0 %	45.45%	**Delusional**	17.82%	41.33%	15.38%	41.86%
Mood	25%	18.18%	**Mood**	39.60%	30.66%	37.60%	29.06%
Anxiety	43.75%	0 %	**Anxiety**	25.74%	13.33%	28.20%	11.62%
Behavioural	0 %	0 %	**Behavioural**	1.98%	0 %	1.70%	0 %
Personality	31.25%	9.09%	**Personality**	3.96%	0 %	7.69%	1.16%
Other	0 %	0 %	**Other**	0.85%	0 %	0.85%	0 %
ID/Dev	0 %	0 %	**ID/Dev**	0 %	4%	0 %	3.48%

2006 NMDHB Mental Health Inpatient Admission Data (MHAU - Wahi Oranga)								
	MĀORI			**OTHER**			**TOTAL**	
Total Admissions	58			346			404	
Number of Male Admissions	32 (55.17%)			145 (41.9%)			177 (43.8%)	
Number of Female Admissions	26 (44.83%)			201 (58.1%)			227 (56.2%)	
Age range of individual Service Users	**Number of Admissions**			**Number of Admissions**			**TOTAL**	
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**
	0-15yrs	1	1	**0-15yrs**	4	1	5	2
	15-19yrs	0	2	**15-19yrs**	19	7	19	9
	20-44yrs	23	27	**20-44yrs**	92	94	115	121
	45-64yrs	1	2	**45-64yrs**	71	35	72	37
	65+yrs	1	0	**65+yrs**	15	8	16	8
	Total	**26**	**32**	**Total**	**201**	**145**	**227**	**177**
	Precent of Admissions (rounded)			**Precent of Admissions (rounded)**			**TOTAL**	
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**
	0-15yrs	2%	2%	**0-15yrs**	1%	1%	1%	0%
	15-19yrs	0%	3%	**15-19yrs**	5%	1%	5%	2%
	20-44yrs	40%	47%	**20-44yrs**	27%	27%	28%	30%
	45-64yrs	2%	3%	**45-64yrs**	21%	10%	18%	9%
	65+yrs	2%	0%	**65+yrs**	4%	2%	4%	2%
	Total	**45%**	**55%**	**Total**	**58%**	**42%**	**56%**	**44%**
Number of individual service users	34 (58.6% of all admissions)			224 (64.73% of all admissions)			258 (63.8%)	
Readmission episodes	24 (41.38%) 3 people readmitted once 3 people readmitted twice 2 people readmitted three times 1 person readmitted nine times			121 (34.97%) 26 people readmitted once 9 people readmitted twice 4 people readmitted three times 1 person readmitted five times 1 person readmitted seven times 1 person readmitted eight times 1 person readmitted eleven times 1 person readmitted 14 times			145 (35.9%) 29 people readmitted once 12 people readmitted twice 6 people readmitted three times 1 person readmitted five times 1 person readmitted seven times 1 person readmitted eight times 1 person readmitted nine times 1 person readmitted eleven times 1 person readmitted 14 times	

Readmitted Service Users	8 individuals (23.5%) admitted more than once in sample period			49 individuals (21.8%) admitted more than once in sample period			57 (22%)
Seclusion used from total admissions	14 (24.13%) admissions included seclusion (6 female/8 male)			50 (14.45%) admissions included seclusion (17 female/33 male)			64 (15.8%)
Average length of stay	12.01 bed days (697 total bed days divided by 58 admissions)			13.15 bed days (4550 total bed days divided by 346 admissions)			12.5 bed days

Primary Diagnosis	Diagnosis Group Count			Diagnosis Group Count			TOTAL	
	Diagnosis	Female	Male	Diagnosis	Female	Male	Female	Male
	Organic	0	0	Organic	2	7	2	7
	Substance	2	4	Substance	12	8	14	12
	Delusional	6	22	Delusional	32	65	38	87
	Mood	10	4	Mood	77	34	87	38
	Anxiety	4	2	Anxiety	43	25	47	27
	Behavioural	0	0	Behavioural	5	0	5	0
	Personality	4	0	Personality	28	2	32	2
	ID/Dev	0	0	ID/Dev	2	4	2	4
	Diagnosis Group Percentage			Diagnosis Group Percentage			TOTAL	
	Diagnosis	Female	Male	Diagnosis	Female	Male	Female	Male
	Organic	0.0%	0.0%	Organic	1.0%	4.8%	0.9%	4.0%
	Substance	7.7%	12.5%	Substance	6.0%	5.5%	6.2%	6.8%
	Delusional	23.1%	68.8%	Delusional	15.9%	44.8%	16.7%	49.2%
	Mood	38.5%	12.5%	Mood	38.3%	23.4%	38.3%	21.5%
	Anxiety	15.4%	6.3%	Anxiety	21.4%	17.2%	20.7%	15.3%
	Behavioural	0.0%	0.0%	Behavioural	2.5%	0.0%	2.2%	0.0%
	Personality	15.4%	0.0%	Personality	13.9%	1.4%	14.1%	1.1%
	ID/Dev	0.0%	0.0%	ID/Dev	1.0%	2.8%	0.9%	2.3%

2007 NMDHB Mental Health Inpatient Admission Data (MHAU - Wahi Oranga)							
	MĀORI			**OTHER**			**TOTAL**
Total Admissions	44			215			259
Number of Male Admissions	23 (52.27%)			95 (36.67%)			118
Number of Female Admissions	21 (47.72%)			120 (55.81%)			141

Age range of individual Service Users	**Number of Admissions**			**Number of Admissions**			**TOTAL**	
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**
	0-15yrs	0	0	**0-15yrs**	3	0	3	0
	15-19yrs	3	7	**15-19yrs**	9	5	12	12
	20-44yrs	12	15	**20-44yrs**	62	59	74	74
	45-64yrs	6	1	**45-64yrs**	38	27	44	28
	65+yrs	0	0	**65+yrs**	8	4	8	4
	Total	**21**	**23**	**Total**	**120**	**95**	**141**	**118**
	Percent of Admissions (rounded)			**Percent of Admissions (rounded)**			**TOTAL**	
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**
	0-15yrs	0%	0%	**0-15yrs**	1%	0%	1%	0%
	15-19yrs	7%	16%	**15-19yrs**	4%	2%	11%	18%
	20-44yrs	27%	34%	**20-44yrs**	29%	27%	56%	61%
	45-64yrs	14%	2%	**45-64yrs**	18%	13%	32%	15%
	65+yrs	0%	0%	**65+yrs**	4%	21%	4%	2%
	Total	**100%**	**100%**	**Total**	**100%**	**100%**	**104%**	**96%**

Number of individual service users	29 (11.19% of all admissions)	153 (59.07% of all admissions)	182
Readmission episodes	15 (34.09%). 7 people readmitted once, 2 readmitted twice, and one readmitted four times.	68 (31.62%). 20 people readmitted once, 3 readmitted twice, 3 readmitted three times, 2 readmitted four times, 2 readmitted six times, and 1 readmitted 7 times.	
Readmitted Service Users	10 (34.48%) more than once in the sample period.	68 (44.44%) more than once in the sample period.	
Seclusion used from total admissions	12 (27.27%) of admissions included seclusion. (4 female/8 male)	24 (11.16%) of admissions included seclusion. (9 female/15 male)	
Average length of stay	11.52	15.65	

Primary Diagnosis	**Diagnosis Group Count**			**Diagnosis Group Count**			**TOTAL**	
	Diagnosis	**Female**	**Male**	**Diagnosis**	**Female**	**Male**	**Female**	**Male**
	Organic	0	1	**Organic**	1	5	1	6
	Substance	1	2	**Substance**	1	7	2	9
	Delusional	1	13	**Delusional**	23	40	24	53
	Mood	15	6	**Mood**	76	23	91	29

Anxiety	4	1	**Anxiety**	8	16	12	17
Behavioural	0	0	**Behavioural**	3	0	3	0
Personality	0	0	**Personality**	8	2	8	2
ID/Dev	0	0	**ID/Dev**	0	1	0	1
Other	0	0	**Other**	0	1	0	1
Diagnosis Group Percentage			**Diagnosis Group Percentage**			**TOTAL**	
Diagnosis	**Female**	**Male**	**Diagnosis**	**Female**	**Male**	**Female**	**Male**
Organic	0 %	4.34%	**Organic**	0.83%	5.26%	0.70%	5.08%
Substance	4.76%	8.69%	**Substance**	0.83%	7.36%	1.41%	7.62%
Delusional	4.76%	56.52%	**Delusional**	19.16%	42.10%	17.02%	44.91%
Mood	71.42%	26.08%	**Mood**	63.33%	24.21%	64.53%	24.57%
Anxiety	19.04%	4.34%	**Anxiety**	6.67%	16.84%	8.51%	14.40%
Behavioural	0 %	0 %	**Behavioural**	2.5%	0 %	2.12%	0 %
Personality	0 %	0 %	**Personality**	6.67%	2.10%	5.67%	1.69%
ID/Dev	0 %	0 %	**ID/Dev**	0 %	1.05%	0 %	0.84%
Other	0 %	0 %	**Other**	0 %	1.05%	0 %	0.84%

2008 NMDHB Mental Health Inpatient Admission Data (MHAU - Wahi Oranga)										
	MĀORI			**OTHER**			**TOTAL**			
Total Admissions	64			407			471			
Number of Male Admissions	41 (64%)			175 (43%)			216 (46%)			
Number of Female Admissions	23 (36%)			232 (57%)			255 (54%)			
Age range of individual Service Users	**Number of Admissions**			**Number of Admissions**			**TOTAL**			
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**		
	0-15yrs	0	3	0-15yrs	8	0	8	3		
	15-19yrs	9	5	15-19yrs	19	11	28	16		
	20-44yrs	13	33	20-44yrs	120	111	133	144		
	45-64yrs	1	0	45-64yrs	74	48	75	48		
	65+yrs	0	0	65+yrs	11	5	11	5		
	Total	**23**	**41**	**Total**	**232**	**175**	**255**	**216**		
	Precent of Admissions (rounded)			**Precent of Admissions (rounded)**			**TOTAL**			
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**		
	0-15yrs	0%	5%	0-15yrs	2%	0%	2%	1%		
	15-19yrs	14%	8%	15-19yrs	5%	3%	6%	3%		
	20-44yrs	20%	52%	20-44yrs	29%	27%	28%	31%		
	45-64yrs	2%	0%	45-64yrs	18%	12%	16%	10%		
	65+yrs	0%	0%	65+yrs	3%	1%	2%	1%		
	Total	**36%**	**64%**	**Total**	**57%**	**43%**	**54%**	**46%**		
Number of individual service users	42 (65.6% of all admissions)			274 (67.3% of all admissions)			316 (67%)			
Readmission episodes	22 (34%) 5 people readmitted once 1 person readmitted twice 1 person readmitted three times 1 person readmitted four times 1 person readmitted eight times			133 (33%) 55 people readmitted once 13 people readmitted twice 3 people readmitted three times 2 people readmitted four times 1 person readmitted five times 1 person readmitted eight times 1 person readmitted 22 times			155 (33%) 60 people readmitted once 14 people readmitted twice 4 people readmitted three times 3 people readmitted four times 1 people readmitted five times 2 person readmitted eight times 1 person readmitted 22 times			
Readmitted Service Users	9 individuals (21%) admitted more than once in sample period			76 individuals (27.7%) admitted more than once in sample period			85 (26.8%)			

Seclusion used from total admissions	12 (27.5%) admissions included seclusion (2 female/10 male)			93 (22.3%) admissions included seclusion (37 female/66 male)			105 (22.2%)	
Average length of stay	13 bed days (812 total bed days divided by 62 admissions)			16 bed days (6438 total bed days divided by 407 admissions)			15.45 bed days	
Primary Diagnosis	**Diagnosis Group Count**			**Diagnosis Group Count**			**TOTAL**	
	Diagnosis	**Female**	**Male**	**Diagnosis**	**Female**	**Male**	Female	Male
	Organic	0	1	**Organic**	8	5	8	6
	Substance	3	4	**Substance**	18	26	21	30
	Delusional	4	26	**Delusional**	33	68	37	94
	Mood	6	7	**Mood**	102	60	108	67
	Anxiety	9	3	**Anxiety**	35	13	44	16
	Behavioural	1	0	**Behavioural**	11	0	12	0
	Personality	0	0	**Personality**	25	2	25	2
	ID/Dev	0	0	**ID/Dev**	0	1	0	1
	Diagnosis Group Percentage			**Diagnosis Group Percentage**			**TOTAL**	
	Diagnosis	**Female**	**Male**	**Diagnosis**	**Female**	**Male**	**Female**	**Male**
	Organic	0.0%	3.4%	**Organic**	3.5%	3.2%	3.0%	3.3%
	Substance	7.5%	13.8%	**Substance**	8.0%	16.9%	7.9%	16.4%
	Delusional	10.0%	89.7%	**Delusional**	14.6%	44.2%	13.9%	51.4%
	Mood	15.0%	24.1%	**Mood**	45.1%	39.0%	40.6%	36.6%
	Anxiety	22.5%	10.3%	**Anxiety**	15.5%	8.4%	16.5%	8.7%
	Behavioural	2.5%	0.0%	**Behavioural**	4.9%	0.0%	4.5%	0.0%
	Personality	0.0%	0.0%	**Personality**	11.1%	1.3%	9.4%	1.1%
	ID/Dev	0.0%	0.0%	**ID/Dev**	0.0%	0.6%	0.0%	0.5%

2009 NMDHB Mental Health Inpatient Admission Data (MHAU - Wahi Oranga)								
	MĀORI			**OTHER**			**TOTAL**	
Total Admissions	69			380			449	
Number of Male Admissions	29 (42%)			154 (40.5%)			183 (40.7%)	
Number of Female Admissions	40 (58%)			226 (59.5%)			266 (59.3%)	
Age range of individual Service Users	**Number of Admissions**			**Number of Admissions**			**TOTAL**	
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**
	0-15yrs	0	0	**0-15yrs**	7	1	7	1
	15-19yrs	3	4	**15-19yrs**	13	7	16	11
	20-44yrs	28	21	**20-44yrs**	111	78	139	99
	45-64yrs	8	4	**45-64yrs**	81	62	89	66
	65+yrs	1	0	**65+yrs**	14	6	15	6
	Total	**40**	**29**	**Total**	**226**	**154**	**266**	**183**
	Precent of Admissions (rounded)			**Precent of Admissions (rounded)**			**TOTAL**	
	Age	**Female**	**Male**	**Age**	**Female**	**Male**	**Female**	**Male**
	0-15yrs	0%	0%	**0-15yrs**	2%	0%	2%	0%
	15-19yrs	4%	6%	**15-19yrs**	3%	2%	4%	2%
	20-44yrs	41%	30%	**20-44yrs**	29%	21%	31%	22%
	45-64yrs	12%	6%	**45-64yrs**	21%	16%	20%	15%
	65+yrs	1%	0%	**65+yrs**	4%	2%	3%	1%
	Total	**58%**	**42%**	**Total**	**59%**	**41%**	**59%**	**41%**
Number of individual service users	46 (66.7% of all admissions)			255 (66.9% of all admissions)			301 (67%)	
Readmission episodes	25 (36%) 5 people readmitted once 1 person readmitted twice 1 person readmitted 16 times			126 (33%) 31 people readmitted once 12 people readmitted twice 7 people readmitted three times 3 people readmitted four times 2 person readmitted five times 1 person readmitted six times 1 person readmitted eight times 1 person readmitted 14 times			151 (33.6%) 36 people readmitted once 13 people readmitted twice 7 people readmitted three times 3 people readmitted four times 2 people readmitted five times 1 person readmitted six times 1 person readmitted eight times 1 person readmitted 14 times 1 person readmitted 16 times	

Readmitted Service Users	7 individuals (10%) admitted more than once in sample period			58 individuals (22.7%) admitted more than once in sample period			65 (21.6%)	
Seclusion used from total admissions	19 (27.5%) admissions included seclusion (7 female/12 male)			85 (22.3%) admissions included seclusion (41 female/44 male)			104 (23.2%)	
Average length of stay	8 bed days (847 total bed days divided by 69 admissions)			16 bed days (6093 total bed days divided by 380 admissions)			15.49 bed days	
Primary Diagnosis	**Diagnosis Group Count**			**Diagnosis Group Count**			**TOTAL**	
	Diagnosis	**Female**	**Male**	**Diagnosis**	**Female**	**Male**	Female	Male
	Organic	1	0	**Organic**	1	2	2	2
	Substance	4	2	**Substance**	14	20	18	22
	Delusional	8	20	**Delusional**	39	48	47	68
	Mood	11	6	**Mood**	104	49	115	55
	Anxiety	15	0	**Anxiety**	53	31	68	31
	Behavioural	0	0	**Behavioural**	3	1	3	1
	Personality	1	1	**Personality**	11	0	12	1
	ID/Dev	0	0	**ID/Dev**	1	3	1	3
	Diagnosis Group Percentage			**Diagnosis Group Percentage**			**TOTAL**	
	Diagnosis	**Female**	**Male**	**Diagnosis**	**Female**	**Male**	Female	Male
	Organic	2.5%	0.0%	**Organic**	0.4%	1.3%	0.8%	1.1%
	Substance	10.0%	6.9%	**Substance**	6.2%	13.0%	6.8%	12.0%
	Delusional	20.0%	69.0%	**Delusional**	17.3%	31.2%	17.7%	37.2%
	Mood	27.5%	20.7%	**Mood**	46.0%	31.8%	43.2%	30.1%
	Anxiety	37.5%	0.0%	**Anxiety**	23.5%	20.1%	25.6%	16.9%
	Behavioural	0.0%	0.0%	**Behavioural**	1.3%	0.6%	1.1%	0.5%
	Personality	2.5%	3.4%	**Personality**	4.9%	0.0%	4.5%	0.5%
	ID/Dev	0.0%	0.0%	**ID/Dev**	0.4%	1.9%	0.4%	1.6%

APPENDIX B – NMDHB ACCESS RATES

		Age group												
		0 - 19 years			20 - 64 years			Over 65 years			Total		
	Ethnicity	Clients seen	Population	%	Clients seen	Population	%	Clients seen	Population	%	Clients seen	Population	%
2002/03	Māori	149	5,310	2.81%	251	5,613	4.47%	3	384	0.78%	403	11,306	3.56%
2003/04	Māori	121	5,390	2.24%	264	5,748	4.59%	3	426	0.70%	388	11,564	3.36%
2004-05	Māori	109	5,470	1.99%	261	5,883	4.44%	2	469	0.43%	372	11,821	3.15%
2005-06	Māori	101	5,545	1.82%	278	6,015	4.62%	7	500	1.40%	386	12,060	3.20%
2006-07	Māori	126	5,615	2.24%	286	6,130	4.67%	2	540	0.37%	414	12,285	3.37%
2007-08	Māori	144	5410	2.66%	298	6265	4.76%	2	555	0.36%	444	12230	3.63%
2008-09	Māori	207	5465	3.79%	439	6410	6.85%	6	605	0.99%	652	12480	5.22%
2009-10	Māori	179	5485	3.26%	444	6580	6.75%	7	612	1.14%	630	12065	5.22%
2002/03	Other	1141	30,369	3.76%	2500	69,582	3.59%	129	18,054	0.71%	3770	118,006	3.19%
2003/04	Other	1041	30,536	3.41%	2452	70,983	3.45%	108	18,431	0.59%	3601	119,949	3.00%
2004-05	Other	988	30,702	3.22%	2375	72,384	3.28%	98	18,807	0.52%	3461	121,893	2.84%
2005-06	Other	1018	30,765	3.31%	2465	73,535	3.35%	138	19,263	0.72%	3621	123,563	2.93%
2006-07	Other	952	30,678	3.10%	2,592	74,390	3.48%	129	19,858	0.65%	3,673	124,925	2.94%
2007-08	Other	1124	29813	3.77%	2780	72895	3.81%	146	20143	0.72%	4050	122850	3.30%
2008-09	Other	1253	29626	4.23%	3055	73343	4.17%	186	20630	0.90%	4494	123599	3.64%
2009-10	Other	1110	29400	3.78%	3033	73679	4.12%	184	21349	0.86%	4327	124428	3.48%
2002/03	Total	1290	35,679	3.62%	2751	75,194	3.66%	132	18,438	0.72%	4173	129,312	3.23%
2003/04	Total	1162	35,926	3.23%	2716	76,731	3.54%	111	18,857	0.59%	3989	131,513	3.03%
2004-05	Total	1097	36,172	3.03%	2636	78,267	3.37%	100	19,276	0.52%	3833	133,714	2.87%
2005-06	Total	1119	36,310	3.08%	2743	79,550	3.45%	145	19,763	0.73%	4007	135,623	2.95%
2006-07	Total	1,078	36,293	2.97%	2,878	80,520	3.57%	131	20,398	0.64%	4,087	137,210	2.98%
2007-08	Total	1268	35223	3.60%	3078	79160	3.89%	148	20698	0.72%	4494	135080	3.33%
2008-09	Total	1460	35091	4.16%	3494	79753	4.38%	192	21235	0.90%	5146	136079	3.78%
2009-10	Total	1289	34885	3.69%	3477	80259	4.33%	184	21349	0.86%	4950	136493	3.63%

APPENDIX C – SUICIDE STATISTICS – (Source Nelson Marlborough District Health Board Suicide Prevention Co-ordinator)

Suicide Mortality - NMDHB Residents, 2000 -2006, Māori Only

Gender	2000	2001	2002	2003	2005	2006	Total
Female	0	2	1	0	0	0	3
Male	2	0	2	1	3	1	9
Total	2	2	3	1	3	1	12

Age group	2000	2001	2002	2003	2005	2006	Total
15-19	0	0	0	1	0	0	1
20-24	0	0	2	0	1	1	4
25-29	0	0	0	0	1	0	1
30-34	0	1	0	0	1	0	2
35-39	1	0	1	0	0	0	2
40-44	1	1	0	0	0	0	2
Total	2	2	3	1	3	1	12

Suicide Mortality - NMDHB Residents, 2000 - 2006, Total

Ethnicity	2000	2001	2002	2003	2004	2005	2006	Total
Māori	2	2	3	1	0	3	1	12
non-Māori	24	22	14	11	10	17	18	116
Total	26	24	17	12	10	20	19	128

Gender	2000	2001	2002	2003	2004	2005	2006	Total
Female	3	4	5	4	2	7	3	28
Male	23	20	12	8	8	13	16	100
Total	26	24	17	12	10	20	19	128

Agegroup	2000	2001	2002	2003	2004	2005	2006	Total
10-14	1	1	0	0	0	0	0	2
15-19	4	2	1	3	0	0	1	11
20-24	1	4	2	0	0	3	2	12
25-29	2	4	1	0	1	1	1	10
30-34	2	2	3	0	0	2	2	11
35-39	5	3	3	1	2	4	3	21
40-44	4	2	1	1	0	2	3	13
45-49	0	1	0	4	1	2	1	9
50-54	2	0	0	1	1	1	2	7
55-59	2	2	3	1	1	2	1	12
60-64	2	1	0	0	3	1	1	8
70-74	0	2	2	0	0	0	1	5
80-84	0	0	1	1	1	1	0	4
85+	1	0	0	0	0	1	1	3
Total	26	24	17	12	10	20	19	128

Table 1: Suicide deaths and age-standardised rates, by District Health Board (DHB) and ethnicity, 2003-2005

	DHB	Māori		Non-Māori		Total	
		Number	Rate	Number	Rate	Number	Rate
1	Northland	26	24.4	43	14.5	69	18.5
2	Waitemata	12	10.9	134	10.4	146	10.6
3	Auckland	20	21.8	109	9.3	129	10.4
4	Counties Manukau	41	22.9	113	11.4	154	13.6
5	Waikato	28	16.4	88	11.3	116	12.5
6	Lakes	14	17.4	15	7.9	29	11.7
7	Bay of Plenty	25	22.4	66	14.0	91	16.8
8	Tairawhiti	12	22.5	14	18.0	26	21.4
9	Hawke's Bay	21	23.6	43	13.3	64	16.6
10	Taranaki	7	18.3	39	16.4	46	16.4
11	MidCentral	17	24.8	61	15.8	78	17.3
12	Whanganui	10	27.1	19	13.3	29	18.0
13	Capital and Coast	13	16.2	70	9.5	83	10.5
14	Hutt Valley	13	21.3	29	9.2	42	11.8
15	Wairarapa	3	-	25	27.9	28	27.5
16	Nelson Marlborough	4	-	38	9.9	42	10.7
17	West Coast	4	-	6	7.4	10	10.6
18	Canterbury	11	11.6	176	13.6	187	13.6
19	South Canterbury	2	-	16	12.3	18	12.5
20	Otago	5	12.6	65	13.0	70	13.3
21	Southland	8	25.1	37	14.1	45	15.7

APPENDIX D – INFORMATION SHEET

"What are Tangata Whaiora experiences in a mental health acute inpatient unit – a narrative approach".

INFORMATION SHEET

Tēnā koe, tēnā koutou.
Ko Tainui te waka
Ko Tokomaru te maunga
Ko Wairau te awa
Ko Wairau te Marae
Ko Ngāti Rarua, Ngāti ToaraNgāti ra ōku iwi
Ko Lorraine Eade ahau

My name is Lorraine Eade, and I am currently completing a PhD in Philosophy through Massey University's School of Psychology (Te Kura Hinengaro Tāngata). You have indicated an interest in participating in this study, which I hope will lead to celebrating what works well, and improving what doesn't work so well for Māori Māori when they are admitted to Te Wahi Oranga Nelson Acute Mental Health Inpatient Unit.

If you are interested in participating, this will involve three meetings with the researcher. The first meeting is just an introductory meeting. This is so I can explain the research a bit further and to talk about a list of broad topics that might be covered in the research. You can tell me which topics your okay to talk about, and which topics are absolutely off limits! I'll also talk to you about your written consent to participate. You don't need to sign the consent today because you might need to take time to think about our discussion, and/or you might also want to talk to your whānau.

If you are still comfortable in participating, the second meeting is the interview itself and you will need to sign the consent form before we start the interview. This is the meeting where you start sharing your stories around your experiences in Te Wahi Oranga. Your stories have to be audio taped to use a narrative analysis.

The third meeting, is where I will provide you with your written transcripts and a copy of the audio file (if you would like a copy). This provides you the opportunity to provide any further information or clarify aspects of your story.

You are a co-author with the researcher, but this is your story, led and directed by you.

The audio files of our discussions have to be held for a ten year period which will be on a secured computer. I will destroy your written transcripts after the narrative analysis has been completed.

Interviews will be held at a location that suits you. You are most welcome to bring along whānau or kaumatua support to the interviews. If you do not have a kaumatua available within your own whānau at the time of the interview, and you would like to

have one there, then I can arrange for a kaumatua to support our interview. If you would like your full interview to be conducted in Te Reo Māori Māori, an intepreter can also be made available.

To be able to participate in this study you must be of Māori Māori descent; over the age of 18 years, and have had an admission to the acute inpatient unit between 2004 to 2010.

Your stories will be totally anonymous in the final thesis (report), that is any comments you have made, will not have your name attached to them. However, if permission is granted by you, and you would like your name published, then this can be accommodated in the 'Acknowledgement' section at the front of the report.

You will also have the option of receiving the final thesis or a summary version of the final thesis. At the conclusion of the study, I would like to invite all tangata whaiora participants who participated in the research, to a hui where I can share with you the findings of this research. For confidentiality reasons you may choose to attend or decline this invitation and that decision is respected.

After this meeting, the findings of the report will be distributed to a number of organisations that may benefit from understanding how to improve Māori experiences in acute mental health inpatient units. This is likely to include Iwi, Nelson Marlborough District Health Board (NMDHB), Ministry of Health, Mental Health Foundation, Te Roopu Tupu Tahi (Mental Health and Addiction Services Advisory Forum to NMDHB), and Tumu Whakarae (National Directors of Health forum), and the research may be published in academic journals.

You are still under no obligation to accept this invitation. If you do decide to participate, you have the right to:
- decline to answer any particular question;
- withdraw from the study at any time
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- you also have the right to ask for the audio/video tape to be turned off at any time during the interview.

Participants will receive a koha of $50 for contributing to this research project. This is a small reimbursement for any travel costs and to acknowledge the time you have spent sharing your story.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Services Consumer Advocate on **0800 377 766.**

I am currently employed with the Nelson Marlborough District Health Board in the Planning and Funding Division. If you have any questions surrounding this research then please contact me by:

Email : eadel@xtra.co.nz

Phone：   Work (03) 5209860
Cellphone: (027) 210 3924

My Primary Supervisor for this thesis is Dr Christine Stephens, Associate Professor at the School of Psychology, Te Kura Hinengaro Tangata at Massey University. Dr Stephens contact details are as follows:

Private Bag 11-222
Palmerston North
Phone (06) 350-5799 (ext 2081)
Fax (06) 350 5673
Email: C.V. Stephens@massey.ac.nz

My Secondary Supervisor is Dr Rangi Maatamua (Tuhoe) who completed his PhD on *'Te Reo Paho – Māori Māori Radio and Language Revitalisation'.*

Committee Approval Statement
"This project has been reviewed by the Upper South Ethics Committee. If you have any concerns about the ethics of this research, please contact

APPENDIX D – Case Manager Information Sheets

"What are Tangata Whaiora experiences in a mental health acute inpatient unit – a narrative approach"

TANGATA WHAIORA INFORMATION SHEET

A local researcher Lorraine Eade is starting her PhD (Doctorate) through Massey University and wants to provide Nelson Marlborough tangata whai ora the opportunity to tell their stories around their experiences at Te Wahi Oranga (Nelson Mental Health Acute Inpatient Unit).

Lorraine is looking for up to 20 tangata whai ora to participate in the research. The research provides the opportunity for tangata whai ora to share their stories about their experiences in the unit. The aim is to celebrate what works well for tangata whai ora, and what areas could be improved.

The interviews will be held at a venue that suits you, and you are more than welcome to bring along whānau or kaumatua support. The kaumatua for this research is Mr Rangi Joseph (Ngāti Toa/Ngāti Maniapoto), and he is available to support tangata whai ora and the researcher. If you want your full interview conducted in Te Reo Māori Māori, an interpreter can be made available.

To be able to participate in this study you must be of Māori Māori descent; over the age of 18 years, and have had an admission to the acute inpatient unit between 2004 to 2010. Your stories will be anonymous, that is, any comments you have made will not have your name attached to them, unless you want to have your name acknowledged.

If you would like further information or your are interested in participating in the research study, then you have two options. Either you can make direct contact with Lorraine or I can make contact with Lorraine on your behalf to organise an introductory meeting.

Lorraine's contact details are:
Email : eadel@xtra.co.nz
Phone: Work (03) 5209860
Cellphone: (027) 210 3924

Committee Approval Statement
"This project has been reviewed by the Upper South Ethics Committee. If you have any concerns about the ethics of this research, please contact

APPENDIX E – Consent Forms

	Consent Form

	REQUEST FOR INTERPRETER

English	I wish to have an interpreter.	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka Pākehā korero.	Ae	Kao

I have read and I understand the information sheet for volunteers taking part in the '*What are Tangata Whaiora experiences in a mental health acute inpatient unit – a narrative approach*". I have had the opportunity to discuss this study . I am satisfied with the answers I have been given.

I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my *future continuing health care.*

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part.

I know who to contact if I have any questions about the study.

I understand that my interview will be audio-filed.   YES/NO

I wish to receive a copy of the summary and/or final report   YES/NO

I _____ (full name) hereby consent to take part in this study.

Date   _____

Signature   _____

Full names of Researchers   **Lorraine Shirley Eade**

Contact Phone Number for researchers   **(03) 5209860**

Project explained by   _____

Project role   _____

Signature   _____

Date   _____

"What are Tangata Whaiora experiences in a mental health acute inpatient unit – a narrative approach".

AUTHORITY FOR THE RELEASE OF AUDIO FILES

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

I confirm that I have had the opportunity to read and amend the transcript of the interview/s conducted with me by Lorraine Eade for the purposes of her thesis research in Philosophy.

I agree that the edited transcript and extracts from this may be used by the researcher, *Lorraine Eade* in reports and publications arising from the research, being assured that my anonymity and confidentiality will be respected.

Signature: .... **Date:** ....

Full Name - printed ....

APPENDIX G – ETHICAL APPROVAL

Health and Disability Ethics Committees

Upper South A Regional Ethics Committee
Ministry of Health
4th Floor, 250 Oxford Tce
PO Box 3877
Christchurch
Phone (03) 372 3037
Fax (03) 372 1015
Email: uppersouth_ethicscommittee@moh.govt.nz

[handwritten: Talked to Ae Re. 1.57pm 20/9/2010 who agreed to including (03) 372 3087 phone number in]

2 August 2010

Ms Lorraine Eade
81 Vickerman Street
Grovetown
Blenheim

Dear Lorraine Eade

Ethics ref:	URA/10/07/047	(please quote in all correspondence)
Study title:	What are Tangata Whaiora experiences in a mental health acute inpatient unit - a narrative approach.	
Investigators:	**Ms Lorraine Eade**	

This study was given ethical approval by the Upper South A Regional Ethics Committee on 2 August 2010. A list of members of the Committee is attached.

Approved Documents
— Information sheet and consent form version 2 dated 30 July 2010
— Tangata Whaiora information sheet version 1 dated 9 June 2010
— Narrative interview prompts, version 2 dated 30 July 2010
— Authority for release of audio files, version1 dated 9 June 2010

This approval is valid until 30 June 2012, provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations
All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:
— the researcher responsible for the conduct of the study at a study site
— the addition of an extra study site
— the design or duration of the study
— the method of recruitment
— information sheets and informed consent procedures.

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

Annual Progress Reports and Final Reports
The first Annual Progress Report for this study is due to the Committee by 31 August 2011. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

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

Requirements for the Reporting of Serious Adverse Events (SAEs)
For the purposes of the individual reporting of SAEs occurring in this study, the Committee is satisfied that the study's monitoring arrangements are appropriate.

SAEs occurring in this study must be individually reported to the Committee within 7-15 days only where they:
— are *unexpected* because they are not outlined in the investigator's brochure, and
— are not defined study end-points (e.g. death or hospitalisation), and
— occur in patients located in New Zealand, and
— if the study involves blinding, result in a decision to break the study code.

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

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

We wish you all the best with your study.

Yours sincerely

Alieke Dierckx
Administrator
Upper South A Regional Ethics Committee
Email: alieke_dierckx@moh.govt.nz

APPENDIX H – Narrative Prompts

Narrative Interview 'Prompts' – Tangata Whaiora experiences in Te Wahi Oranga (Acute Inpatient Unit) – Tangata Whaiora telling their story.

Lead Question: Tell us about your experiences in Te Wahi Oranga?

Prompts:

1. Did you seek help when you first became unwell? where did you go to get help first? (GP, whānau, friend).

2. Tell us about how you were admitted? What happened? What was it like? (Admission processes and support)

3. How did you get to Te Wahi Oranga? Did someone drive you there? Where were you before you were admitted? (Seeking information on geographical challenges over Whangamoa hills, admission pathway Justice/GP/Home etc).

4. How many times have you been to Te Wahi Oranga? (Readmissions)

5. How long were you in Te Wahi Oranga? (Length of stay)

6. Were you ever in the IPC or Seclusion unit? What was that like? (Seclusion rates)

7. Did you ever have to be restrained? What was that like? (Restraint practices)

8. Tell us about your experiences while in the unit. What really helped you getting better? (Staff, Respect, Kaumatua, Māori Māori health provider support, flexible visiting, Medication, ongoing therapy, visiting hours etc).

9. What didn't go so well while you were in the unit. What might need improvement? (Staff, lack of respect, cultural interventions, being listened too etc)

10. Did you have any physical health problems that also impacts on your overall wellbeing (co-morbidities/co-existing disorders).

11. Tell us about your experiences around the discharge process?