KIA WHAI TE WHAKATEKAINGA O NGA TURORO WAIRANGI

The Effectiveness of Discharge Planning for Maori Mental Health Patients

A thesis presented in partial fulfilment of the requirements
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Cindy Mokomoko
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ABSTRACT

This research evaluates the effectiveness of discharge planning for Maori mental health patients who have been discharged from a 21 bed ward of a provincial hospital. The findings are based on the perspectives of the sample group which is made up of six Maori patients and six mental health staff. The staff participants are a mix of primary and secondary workers. The addition of documentation of discharge planning from patient files adds to the method triangulation. The research is Maori centred set within a whanaungatanga methodology framework using the three guiding principles of establishing and maintaining relationships with whanau of interest, involvement from a holistic cultural base and involving participatory research practices as described by Bishop, (1998:130).

The findings of the research indicate that there are gaps for Maori in the discharge planning services, using the discharge planning guidelines as a measuring tool. It would be a fair comment that there is a high likelihood of similar outcomes of research on discharge planning at other hospitals and wards, which would have similar findings to varying degrees. Deinstitutionalisation in Aotearoa has opened the doors of psychiatric institutions, enabling mental health patients to be discharged earlier and treated in the community. A number of homicides and other violent crimes committed by people with a mental illness in the 1980s highlighted the need for good discharge planning for certain classes of patients who had been discharged back to their communities (Psychiatric Report,1988). This led also to the discovery of an absence of uniformity in policies and practices of discharge planning for mental health patients on a national level. The Ministry of Health had formulated policies in 1993 that were to be used as a framework and guideline for discharge planning for people with a mental illness who had been admitted into services. The discharge planning policies, therefore, are not just for certain classes of people, such as those who come under the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992, but for all people with a mental illness, who are discharged from inpatient services.

From the analysis of the interviews, viewpoints of the participants are reflected in the suggested developments for improving discharge planning services for turoro Maori discharged from mental health inpatient care. This thesis, although with a small sample, has heard the voice of the consumer and is a contribution to Maori mental health research

MIHIMIHI

E nga iwi
E nga mana
E nga reo karanga
E nga ma taa waka hoki,
E nga hau e wha
Tena koutou, tena koutou, tena koutou

Te mihi tuatahi ki ta tatou kaihanga nana nga mea katoa

Te mihi tuarua he nui nga mihi ki nga kuia me nga koroua, nga tangata whenua o tenei rohe, tena koutou

Te mihi tuatoru, anei te mihi aroha i te whakamaharatanga ki oku kuia tupuna me oku koroua no Te Rarawa me Te Aopouri me Ngapuhi whanui katoa, tena koutou

Ka mihi hoki ki nga turoro me o whanau mo o korerorero "kia whai te whakatekainga" tena koutou

Tena koutou, tena koutou, tena koutou katoa.

Ko Whangatautia te Maunga

Ko Karirikura te Moana

Ko Te Ohaaki te Marae

Ko Te Rarawa te Iwi

Ko Cindy Mokomoko ahau.

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Chapter One – Introduction

The accelerating pace of deinstitutionalisation of patients from mental hospitals has highlighted the need for effective discharge planning. For Maori, in particular, devolution of former responsibilities of the State back onto whanau, hapu and iwi, has created challenges.

This thesis evaluates how a small sample of Maori who have a mental illness are faring in the community once discharged from a provincial hospital: in other words, how well discharge planning worked for them. It is a useful start to Maori research into discharge planning, which could lead on to a study with a larger sample conducted over a longer period of time. Ultimately, the aim of the research is to achieve better discharge planning for Maori mental health patients, reduce re-admissions and improve follow-up care and support for patients discharged from the hospital in which the study was done. This introductory chapter sets out the objectives of the research and the contents of the thesis as a whole.

Objectives

The first objective of the research is to measure the effectiveness of discharge planning for Maori mental health patients. This is from the perspectives of the turoro and caregivers. The second objective is to identify discharge planning needs of Maori mental health patients and their whanau or caregivers and to provide suggestions and recommendations for dealing with gaps which have been identified in the discharge planning service. The final objective of this research is to satisfy the requirements of the thesis in order for the researcher to graduate with a masterate in Social Work.

The policy background

I will begin by looking at the background and history of mental health policy in Aotearoa /New Zealand. From its inception, the system was modelled on that of the United Kingdom. The colonial approach towards mental health management in Aotearoa had its roots in a system of law and order rather than health, where patients were accommodated with criminals in jails. There is little account of discharge planning in the early history of psychiatric care in Aotearoa, and even less on this in so far as it affected Maori. This is more than likely due to the fact that patients often spent long years in institutionalised care, and many were never released; also that Maori/non-Maori statistics were not distinguished.

One of the major moves toward deinstitutionalisation in New Zealand was the establishment of *halfway houses* in the 1960s for patient rehabilitation back to the communities. These provided a place for patients to live, working towards possible independence. Bennie, writing about deinstitutionalisation, in 1993, identified that a constellation of social, economic and political forces converged to produce policies of deinstitutionalisation. He readily acknowledged that policies were not highly successful, particularly for people with psychiatric disabilities.

Bennie (1993) concluded from the writings of Mechanic and Rochefort that a combination of an expanding welfare state underpinned by economic growth and at the same time economic restraint, coupled with humanitarian philosophies created a climate for deinstitutionalisation in the mid-1960s. Within this climate, deinstitutionalisation was not a new concept but a tension occurred when it was driven by both humanitarian and cost cutting values.

There has been, in Britain since the second world war, a changing climate of opinion similar to that of the later 18th and early 19th centuries which led to changes in the care of the mentally ill. Medical superintendents of mental hospitals began unlocking wards and discharging patients early. Hoult (1986) suggests that no major catastrophes occurred largely, it is now believed, because the first patients to be released were those with the least acute symptoms and it was only later, when patients with major mental illnesses were released, that problems manifested themselves in such a system. He noted also that American psychiatrists visiting Britain in 1958 discovered that the deinstitutionalisation process was dependent on voluntary status and patient co-operation. The discovery of Phenothiazine drugs by the French in 1952 accelerated the deinstitutionalisation process. Drugs quickly and dramatically settled symptoms of acute psychosis so people were not in apparent need of long hospitalisation. New drugs led also to the alleviation of distressing psychotic symptoms, aiding deinstitutionalisation. Other significant factors that helped the deinstitutionalisation process were the international development of a trend and movement of the care of the mentally ill into the community and the closures of large hospitals (Mason, 1988:135).

Some of the ideology behind deinstitutionalisation of the 1950s and 1960s was that a stigma was attached to mental institutions and it was therefore better for the patients not to be in residence for any longer than was absolutely necessary. Thirty to forty years later, in the late 1990s, a report to the Minister of Health (1996) continued to emphasise the effects of stigmatisation on people who have suffered mental illness. It has been found that, once a person has used the mental health services, it is difficult for them to ever move away from an identity of "psychiatric patient" (Mason, Johnston, & Crowe, 1996:62). Hoult (1986) also suggests that hospitalisation for mentally ill patients was becoming expensive.

For Maori, the stigmatisation of people using mental health services was largely suffered by both the whanau and the patient. The term "porangi " was commonly used, often in jest, to describe Maori using the mental health systems. It has been only within the past decade that there has been more acceptance and understanding of mental illness among Maori, where they are not whakamaa to seek assistance or treatment. One can empathise then, with the need for patients to have as short a stay as possible in psychiatric residency.

The growing belief that mental hospitals have adverse affects on patients was another reason for deinstitutionalisation. Some patients who have had lengthy and repeated terms of psychiatric care can become alienated from friends, family and society. Also, periods of hospitalisation can lead to general dysfunction and a worsening of the illness. The National Advisory Mental Health Council, USA, estimate that "at least 20% of the population suffer from mental disorders and mental health problems which impair functioning and cause significant distress and anguish to sufferers and their families. These conditions are treatable and early intervention can prevent the development of severe illness" (Mason, Johnston, & Crowe, 1996:143).

As the Mason Report (1988:147) identified, nowhere in New Zealand has the development of community services kept pace with the growing need created by the notion of deinstitutionalisation. Mental health patients moving back to their communities need access to appropriate services such as day hospital services; outpatient services; psychiatric district nursing services; crisis services; support services; work schemes; and housing, if they are to make successful transitions. Families, too, need access to such support services. The Mason Report (1988:148) discusses a study that was undertaken to examine barriers to the provision of services, and one of the main conclusions was that the most important barrier was inadequate funding. Other potential difficulties highlighted at that time were a shortage of trained mental health workers; negative public attitudes to psychiatric illnesses; a community un-educated in caring for the mentally ill; lack of co-ordination of information resources; and the lack of research into the effectiveness of community services.

Co-operation, consultation and coordination are central and essential activities needed to address the interfaces and reduce the risks of duplication, gaps and difficulties in maintaining continuity of care. The health and social support services required for people with serious mental illness are often scattered among disparate agencies. These agencies need to co-ordinate their services in order to involve the mentally ill and their families within the community. Both social support agencies and health professionals need to ensure a successful integration of the patient into the home and community.

From as early as the 1940s, and more recently since the 1980s, a move in the mental health system towards patients being rehabilitated back to their communities occurred as a result of changed treatment as well as the need for better services to meet those demands. Early attempts at returning patients to their communities were crude and unplanned by today's standards. Discharge planning has now become a vital and important part of the care plans for any mental health patient discharged from a psychiatric ward or hospital today.

Mental health legislation

The Mental Health Act of 1969 set the foundation for the revised edition of the Mental Health Act (Compulsory Assessment and Treatment) 1992. It appears, from excerpts of the mental health debates, that the Act led to a transition of mental hospitals being no longer under the control of the Department of Health but rather under the control of local hospital boards. With post-war urbanisation, a Maori presence in psychiatric institutions became more marked. Durie (1994:134) states that:

> *Maori under-representation in psychiatric hospitals, the rule prior to 1970, had changed to the extent that Maori rates became two or three times higher than non-Maori, even by 1982.*

Some of the reasons for the increase of Maori within psychiatric hospitals from this time and up until today are complex. However, they could include such things as a greater utilisation of psychiatric facilities, more accurate ethnic statistics, an actual greater incidence of mental illness and urbanisation and its effects (Durie, 1994:143). This led, in the 1970s, to a need for a service that better matched the growing clientele. This led also to a review of the way in which this part of the health service practised the diagnosis and treatment of psychiatric illness.

A major piece of legislation that underpins the welfare and care of the mentally ill is the Mental Health (Compulsory Assessment and Treatment) Act 1992. This Act replaces the Mental Health Act 1969 and redefines the manner and circumstances in which a person may be assessed for treatment. If the need for treatment is established, the Act then instructs health professionals how the compulsory treatment should be provided. The Act emphasises that both assessment of the need for, and the provision of, treatment are expected to be carried out in the least restrictive environment possible. Two additions to the 1992 Act are the recognition of the importance of cultural identity, and a legal framework which fosters the patient's rights. As stated in Bailey and Coates (1992:1)

> *The rights of people with mental health disorder are specified and comprehensive provision is made for the review of clinical decisions*

about a person's mental condition.

The 1992 Act, unlike the Mental Health Act 1969 deals only with compulsory assessment and treatment. It makes no provision for the assessment and treatment of voluntary patients. Emphasis is shifted from determining whether a patient should be detained in a psychiatric hospital to the consideration of whether treatment for mental disorder is required.

The compulsory assessment and treatment periods range from an initial period of five days, to a second, and then, if warranted, a third period of fourteen days which may result in a compulsory treatment order. At any stage, including the initial stage of this process, a patient may be discharged from a hospital or ward. Under a compulsory treatment order, which remains in force for six months from the day it was enforced, such as a community treatment order or an inpatient order where the court is satisfied that a patient can be treated adequately in the community, then it is argued that discharge planning has a major role in the functions of care and treatment. Good discharge planning for patients with mental disorders and who are under the 1992 Act is crucial, can assist them to maintain the level of health needed for community living and, perhaps, help to lessen the likelihood of re-admission. This thesis covers only the effectiveness of discharge plans for people who have entered hospital and received treatment. There are now numbers of people in the community who remain untreated. Since the 1992 Act has come into force, it has been relatively difficult to oblige a mentally unwell person to accept treatment.

In the application of the Mental Health (Compulsory Assessment and Treatment) Act 1992, the court has a role. It must be satisfied that the patient is both 'mentally disordered' as defined in the Act, and that it is necessary to make a compulsory order. The definition ' mental disorder' is not easy to understand and has been the subject of debate among medical and legal practitioners alike. One of the principal difficulties is that of language (Cooper, 1997). The definition does not use the same interpretation that is common to both medical and legal users. Examples are the terms 'disorder of volition' and 'disorder of cognition'.

Under the 1992 Act, 'mental disorder' in relation to any person, means *an* *abnormal state of mind whether of a continuous or an intermittent nature. A state of mind that is characterised by delusions or by disorders of mood or perception or volition or cognition, of such a degree that it poses a serious danger to the health or safety of that person or of others; or seriously diminishes the capacity of that person to take care of himself or herself.*

Cognition has two meanings in mental health literature. One definition refers to *the action of knowing, perceiving and conceiving* as opposed to the other definition, which refers to *emotion of the mind relating to awareness of thought, including understanding and reasoning* (Simpson, 1997). Both these terms are used in the Act to describe disorders. The variations in interpretations cause dilemmas for both psychiatric clinicians and court judges alike.

Without a common interpretation of the language between the Justice and Health systems to begin with, and then a more defined clarification of the sections of the Act, it appears that defining a mentally ill person's treatment may have varying results depending on the interpretation being applied at the time. Making important decisions on clinical assessment, which is a major part of the Act, is the task or responsibility of the Judge. It would be more appropriate for the judge to decide on matters of safety for the patient to ensure no ill-treatment or violation of rights. It could be argued that the District Inspectors who are also mental health professionals such as psychiatrists, should be the most appropriate clinical assessors. As the Act stands to date, judges may over-rule the clinical decision of the psychiatrists. This has the capacity to be confusing for patients waiting to be discharged from the provisions of the Act whether they are Maori or non-Maori.

By contrast, however, the Act also ensures that patients who are discharged, receive the safety of legislated care and treatment. Patients are discharged to residencies that have ample monitoring and support systems. This has the added surety for patients of supervised follow- up care. It is not uncommon for chronic patients to want to move from town to town, at times to avoid treatment. A person who is subject to the provisions of the Act must reside where ordered.

The 1992 Act- culturally effective service delivery

A recognition of both the importance of cultural identity and the beliefs of the patient is critical in their care, and increases their potential for making a satisfactory recovery. This aspect is particularly important to Maori. In a discussion document on Maori mental health it was noted that, while Maori first admissions into hospital for mental illness are about the same rate as that of Pakeha, Maori experience a poorer outcome after their first admission leading to more readmissions and chronocity (Te Puni Kokiri, 1993). Durie (1998:56) maintains that, with the high and disproportionate number of Maori patients admitted to psychiatric hospitals, a great concern not only to Maori, but also to the purchasers of services as well as to the profession itself, is that psychiatric treatment should not carry with it any risks to cultural identity. This means that the Government's strategic direction for the implementation of Maori mental health services proposes objectives that reduce the level of mental illness of Maori so that it is no higher than that of the general community; increases Maori involvement in the delivery of mental health services; and increases the responsiveness of mainstream mental health services to the special needs of Maori (Ministry of Health, 1994).

Past health legislation failed to acknowledge the importance of a patient's cultural or personal beliefs. The 1992 Act emphasises respect for the need to acknowledge and incorporate differing cultural values and beliefs into assessment and treatment of Maori and/or people of other cultures suffering mental disorders. This makes the practice culturally safe. Of major significance in ensuring culturally safe practice, is ensuring that kaupapa Maori staff are involved, or that kaumatua and kuia are available if needed. Mainstream staff, too, need to be professionally trained in cultural safety.

The 1992 Act, which provides a legal framework that enables patients to be treated at home or in their community, is important legislation in respect to deinstitutionalisation. The policy content to address this objective has both positive and negative implications for the patient and their families or their carers. On the positive side, it had been found that in the past, too many people had been placed in mental health institutions and had been kept there for long periods of time. This piece of legislation proposed to safeguard against patients being 'locked up' indefinitely, as well as providing an alternative to institutionalised care. The Hansard Report (1969) includes a comment made by parliamentarian, Mrs McMillan, that:

> *Far too many people are being pushed off to psychiatric hospitals when, in my opinion at least, they should not be in a mental hospital at all. Far too many people, just because they are elderly and have run down mentally and physically, but are not psychiatric cases, are in psychiatric hospitals because no provision has been made by Government for a halfway house for them.*

The 1992 Mental Health Act supersedes the outdated model of mental health care where now the patient is able to be looked after either at home or in the community. In practice, however, clinicians in most centres have struggled with a shortage of suitable accommodation or care for patients under the community treatment order.

Cooper (1979) suggests that:

> *Not all families want, or are willing to accept, responsibility for the patient, and of course some people have little or no contact with care givers at all. In the case of private organisations offering supported accommodation to mental health patients there is no obligation on the owners or managers to accept anyone into their care even if their service may be the most suitable for the patient.*

There is also the issue that some families may have been a contributing cause to the mental illness in the first place, so they are unlikely to be able to provide an environment of wellness. The negative implications of this section of the Act are that the ability to treat patients in a home or a community setting are, in some circumstances, severely restricted due to under-resourcing both of people and families to provide care. With deinstitutionalisation and more people needing somewhere to live in the community there is sometimes a lack of appropriate accommodation. This has an impact on discharge planning and on the varying needs of patients for suitable accommodation.

Procedures for review and appeal about patient's conditions and legal status

Unlike the era of institutionalisation, where patients had no means for review of their mental health status, this section of the Act ensures that now patients are safeguarded by policies. Patients are regularly reviewed, and therefore are not just "left" within hospitals or wards, but are discharged back to their communities as soon as they are well.

The preliminary assessment examination is carried out by a psychiatrist to determine whether or not a proposed patient is mentally disordered, based on the statutory definition. A copy of the assessment which does not contain details of the examination, is then required to be given or sent to the patient who was assessed; any welfare guardian; the applicant who applied for assessment; the patient's principal caregiver; and the patient's usual medical practitioner. The purpose of notification is that any person receiving such a notice has the right to apply to the Court for review of the patient's condition.

West (1997) has identified two aspects of concern arising from this policy on the notification process. These are where the patient objects to others listed being given a copy of the certificate, and where there is no-one independent to notify. Both these issues affect the process of discharge planning. Firstly, although this section of the Act is intended to safeguard the patient's rights, in some cases where mental health authorities would seek to have their treatment kept confidential, the dilemma is that the legal requirements to notify may clash with the request of the patient not to notify. Secondly, where there are no family or care-givers' avenues for appeal, which may thus be restricted to the patient, or to the person who first sought the assessment. West, (1997) exemplifies that:

> *Where no other person is available or willing to complete the form, requests for assessment are in fact made by clinical staff ... A possible conflict of interest arises in these cases where a clinical staff member may be the only other person with the ability to apply for a review.*

In reality, this section of the Act has the potential to either support, or detract from, the wishes of the patient. Policymaking is a process of both theoretical influence and fiscal responsibility. In the present political climate, health care for New Zealanders is at risk. Tyler, (1997) declares:

> *Waiting lists continue to grow, patients are having to meet the cost of*

> *travelling to distant hospitals, families looking after former asylum inmates face big bills and the Crown Health Enterprises continue to slide into the red.*

Scott (1997) seems to state the obvious when he observes that:

> *Shifting the burden of health spending from the Government to the private individual has quite serious consequences in terms of health outcomes. The people in any society that require most health care are the ones who are least able to afford it.*

This is particularly pertinent for Maori, who rate high in unemployment and other social issues in Aotearoa, many of whom would doubtless, be burdened by the added costs of coping with whanau discharged back to their communities.

The Mental Health (Compulsory Assessment and Treatment) Act 1992, is currently the policy that impacts most on mental health patients who are not voluntary, and who are admitted into psychiatric wards or hospitals in New Zealand today. It therefore has a major impact on a patient's discharge. Research shows that compulsory admissions account for a third of all admissions for Maori men, which include those under both the 1992 Mental Health Act and the Criminal Justice Act 1985. It is noted also that the rate of involuntary admission is 154 percent higher for Maori men than Pakeha men, and 55 percent higher for Maori women than Pakeha women (Dyall, 1997:93). During the 1960 to 1990 period it was found that Maori rates of admission to mental health services had increased alarmingly and were slightly higher than Pakeha rates, stabilising for both groups since 1990. By the 1980 to 1990 decade it was found that "Maori were 40% more likely to be readmitted to psychiatric services than Pakeha" (Ministry of Health, 1997:93). Some possible reasons why readmissions occur include; the illness was more serious at the time of first admission; the treatment at the first admission was not culturally appropriate or effective; the discharge was too early; or there was insufficient, or culturally inappropriate, community support on discharge.

Changes within the health system

As this recent legislation has the potential to impact on mental health patients and discharge planning, it is important to look at the radical changes which have occurred in the health system, particularly since 1991. The main structural changes under the National Government were: that four Regional Health Authorities undertook purchaser and provider roles that had formerly been carried out by Area Health Boards; that most large hospitals (Crown Health Enterprises) would operate more along business-market ideologies; that people could take their share of government funding to an alternative health-care plan which provided a compulsory range of core services; and that a "user charge" for medical services was introduced, with low income families and the chronically ill being issued with community services cards that entitled them to subsidies (Ashton, 1992).

These changes were largely motivated by the more market ideology of Libertarianism. Ashton (1992) states that:

> *Market liberals generally argue that health care is no different from other commodities in terms of the expected responses to market mechanisms. Even when ill, individuals are the best judges of their own welfare and should therefore accept responsibility for their own health care. Strengthening market mechanisms through private funding and provision should improve the efficiency of health services.*

At the time of the formulation of the Mental Health Act 1992, the political environment in New Zealand had changed from State Welfare provision "from the cradle to the grave" and had now undergone a series of radical reforms reflecting the neo-liberal ideology of recent governments (Crowe, 1997). The Ministry of Health (1994) recognised that:

> *New Zealand's mental health system does not provide adequate services to the community. Until relatively recently, mental health services were concentrated in specialist institutions which were often remote from the communities and consumers they were meant to serve. Maori were particularly poorly served, as the mental health system cut them off from their whanau and culture.*

For many years there has been discrimination against people with mental illness. The Act appears to be attempting to give redress to the conditions and care of the mentally ill which encompasses a socialist perspective of equality, but the neo-liberal ideology of profit from a market driven economy is the political and economic environment in which the Mental Health Act has to function. This presents a conflict in that, whilst care for the patient at home or in the community is an integral part of the Act, the resources may not be available for those needing them such as the whanau or other caregivers, in the neo-liberal climate.

Discharge planning - Review of the literature

In Aotearoa/ New Zealand, discharge planning is described *as a formal process that leads to the development of an on-going individualised programme of care and support, meeting the objectively assessed needs of a patient on leaving the hospital.* The plan needs to involve the patient, family, whanau, the treatment team and other service providers. A discharge plan is required when a patient leaves any in-patient facility, and is particularly important in the case of patients with mental health disorders who have been in hospital suffering from chronic mental illnesses with residual psychiatric disability (Ministry of Health, 1993:5). Kemp's (1990) article on deinstitutionalisation planning includes a model consisting of four processes involving policy analysis, implementation, discharge planning, and impact and outcome analysis. This research supports the view of Kemp that the four processes are essential for the deinstitutionalisation process. Policy analysis is further described by Kemp as occurring at Government level, where responsibility for overall mental health policy lies.

The implementation plan includes several components and should be individually developed by each group or community which has input and inclusion into the discharge process (Kemp, 1990). Each deinstitutionalisation plan includes a needs assessment with the ideal number and type of facilities the discharged group may need. Following a resource and information-gathering exercise, a coordinated plan should be prepared to match the client's need with available facilities.

In Kemp's (1990) model of discharge planning, a case-manager is assigned to each client to oversee the placement and ensures that all planned services are received or accessed. Emphasis is placed on the patient's identified needs being matched with the services and facilities outlined in the coordination plan prior to the patient leaving the institution. Kemp (1990) suggests that any needs not being met currently should remain in the client's programme, and be planned for, and met, as new services or resources become available.

O'Sullivan and Brady (1986) describe discharge planning *as an individual assessment of the client in preparation for moving that person from the institution into another placement*. Rock (1987) also discusses the management of continued service provision once the individual is in the community.

Kemp (1990) suggests that it is important to discharge planning that consultations should occur with the families or significant people of the patient. Emphasis is placed on the use of standardised assessment and discharge planning instruments, including documentation forms. A range of methods is used to gather information for the purpose of discharge planning, in Kemp's model including face-to-face interviews, phone surveys, or mail surveys. The broad scope of information assists the individual treatment or programme plan for the patient. It is also suggested that the process is consultative and inclusive of the patient, the interdisciplinary team, the patient's family and the patient advocate. It is thought that the individual treatment plan or programme should be put together based on the needs of the patient, and should not be restricted or constrained by existing resources or services.

The Psychiatric Report (1989) Scott (1997) Torrey (1987) and Tyler (1997) have commented on the fact that deinstitutionalisation and the process of moving the patient back into the community is often without sufficient resources to meet the needs of the patient. Maxwell (1983:206) suggests that:

> *People should be involved in safeguarding their own health and their treatment when ill. In the broader local and national community the choices about policies affecting health, and about priorities for the use of scarce resources, should be public ones.*

The researcher agrees with Kemp (1990) that:

> *Any identified needs not being met...should also be identified...be fed back into the coordination plan, and, where system problems are involved, back into the policy analysis. The unidentified, unmet needs of*

> *the individual should remain in their programme plan and be met as new resources are identified or developed.*

Christ, Clarkin and Hull (1994) and Hochberger (1995) agree that discharge planning needs to begin at, or shortly following, admission. Further discussions conclude that discharge planning cannot be extricated from the process of clinical assessment and intervention. In the broadest sense it must inform the entire treatment process. High-risk list items are representations of serious social issues that must be addressed if any after-care plan is to succeed. The high-risk profile for each patient should, therefore, be used to identify those issues that contributed to the current inpatient admission.

A study in America tested the hypothesis that psychiatric inpatients at high risk for presenting difficulties in after care planning could be accurately identified on admission to an inpatient unit. Christ, Clarkin and Hull (1994:269) found that a high-risk screening list permitted early identification of patients who would require immediate and intensive environmental interventions. They believe that such data are critical to psychiatric social work in preventing overstays and in deploying resources with maximum effectiveness.

Hochberger (1995:36) developed a discharge check-list for psychiatric patients returning to the community in Hammonton, New Jersey, and found that it provided a way of ensuring assessment and planning needs for the patient were met as well as acting as a monitoring and accountability tool once the patient was discharged. The model calls for a collaborative team approach, with all professionals involved in planning the successful return of the patient to the community. Six areas pertinent to Hochberger's (1995) discharge check-list are: medications, activities of daily living, mental health after-care, supervised residential care, follow-up physical health care and special education or financial and other needs.

Hochberger concludes that:

> *Psychiatric patients with multiple problems who are to return to the community, present complex planning issues for nurses and other mental health professionals. The discharge checklist provides a way of ensuring assessment and planning to meet these needs through*

> *developing a system that provides accountability for discrete functions and ensures that someone is designated a team leader, often the nurse, to ensure that all professional staff collaborate in assessment, planning, and intervention during inpatient stays to plan for a successful return to the community for the client.*

Discharge into the community for mental health patients has been seen as an important aspect of care, and as a continuous part of the caring process which extends from pre-admission to after care. Durgahee (1996:621) comments that discharge management is a multi-agency concern, and cannot function effectively without inter-agency collaboration. He adds that without pro-active collaboration, patients, professionals and the public at large will tend to be at risk. From the discharge planning literature that is used in this section of the thesis, it is obvious that extensive information gathering is a core requisite to good discharge planning. Coulton (1985) demonstrated that discharge planning is the most time-consuming service provided by medical social workers. The theory is that, if workers are able to predict those patients requiring the most intensive discharge planning efforts, then in those instances, extra considerations are needed for resources and targetted areas of post-discharge care.

From an analysis of the literature presented within this section of the thesis on discharge planning, the common threads that emerge from the writers are that: discharge planning should commence from admittance; that families or support people of the patient need to be involved; a specified check-list would ensure that all aspects of a patient's care plan would be covered; that there needs to be a case-manager or responsible carer assigned to each patient to guarantee that the plans put in place for the patient are carried out, and to provide ongoing monitoring of both patient needs and patient well-being; and that a collaborative approach to service needs and service delivery will assist a successful discharge back to the community for mental health patients.

The researcher would argue that discharge planning needs to include all aspects mentioned above. However, a priority for each patient would be the on-going monitoring of medication, on-going reciprocal communication between the patient and all caregivers, and for Maori, on-going access to cultural services, therapies and rongoa where/if needed. A collaborative approach to servicing the patient has to centre on the mental health needs of the patient who is the hub of the whole programme. Often workers tend to have a "mental" checklist, where if they have completed tasks one, two three and four then the obligation to the patient has been met. This may give the patient the impression that his/her thoughts and opinions about his/her treatment are not valued, or perhaps may not provide an opening for the patient to speak out when s/he has concerns. A more productive relationship between the patient and any care giver is a reciprocal one as previously mentioned, where they both need to be talking to each other. A collaborative approach to discharge planning is an inclusive model where all parties need to be talking to each other. In Aotearoa/N.Z., this is a relatively new way of , as health and social service departments and organisations have mainly worked in isolation. Staff within each organisation will have to break down their own barriers and gate-keeping for fluidity of effective service delivery in the collaborative approach for mental health patients. As identified in *Nga Ia o Te Oranga Hinengaro Maori* (1996:8) "it has become more apparent that culture, mental health and diagnosis of mental illness cannot be separated but are intimately intertwined". To make some improvement in Maori mental health so that it is at least on a par with non-Maori mental health, all stages of care and treatment require attention from diagnosis and admittance to discharge planning and community care. Further comments are made about discharge planning in Chapter Three looking specifically at the measures for discharge planning in Aotearoa.

In this study of the effectiveness of discharge planning for Maori mental health patients, this chapter looks at the history of mental health care in Aotearoa. Up until the move towards deinstitutionalisation as mentioned earlier, psychiatric patients were seen mainly as " long-term and incurable" and therefore the need for discharge planning was minimal. Over more recent years, discharge planning has become more formalised to accompany the move to deinstitutionalisation and the growth of community models. This is the environment in which this research was conducted.

The American experience of deinstitutionalisation

In planning for deinstitutionalisation, New Zealand looked at American models. Dr Fuller Torrey, in Auckland in 1987, addressed a conference in this country, outlining some of those experiences. The first was the assumption that the major problem of mental health care was the lack of a client-centred focus. The reality is that some patients have a disease which makes it difficult for them to function inside or outside an institution. Secondly, the enthusiasm and overselling toward new anti-psychotic drugs did not solve all problems of mental health patients. Thirdly, the placing of patients in the community without adequate out-patient services and care was not well prioritised. Fourthly, the funding for the hospitalised patient did not follow them in the deinstitutionalisation process. Patients were deinstitutionalised, but the funding remained with the hospital, to the point where, in some hospitals, the number of patients decreased but the staff numbers increased. Fifthly, the issue of housing was not addressed, resulting in either inadequate housing, or no housing.

Some other points raised in the American experience of deinstitutionalisation were that no resources went into job rehabilitation programmes for those who could eventually work. It is highly likely that a lack of jobs for those patients who become well enough to work could result in feelings of "uselessness," which, if left long enough, have the potential to perpetuate mental unwellness. A high number of Maori today in Aotearoa are unemployed. A significantly high number of Maori are also in the mental health system. The 1997 Public Health Report on mental health established that there was a paucity of New Zealand publications on the studies linking unemployment and mental health. However, one study found that "the suicide rate among the unemployed in the Wellington Hospital Board area in 1978 was 24.4 times that in the general population, and the rate of admission to hospital after deliberate self-harm was 20 times higher" (Ministry of Health, 1997). The Report shows also that there was a clear rise in suicide during the depression years of the 1930s and again in 1977. For Maori, it has been identified that there is limited research into the actual effects of unemployment on mental health, but Durie (1994:141) suggests that:

> *Health status cannot be measured outside the socio-economic realities of Maori experience. There is abundant evidence that health is directly related to general standards of living as determined by employment, education, income levels, housing, and household configurations.*

Dr. Torrey also spoke about the resistance in the United States of America to a new approach and a client centred focus. Similarly, in Aotearoa there has been a resistance, until relatively recently, to designing appropriate mental health services for Maori. The similarity with the North American example extends further to research in New Zealand where there was a failure to research the quality of life of Maori patients who have left a tradition of institutionalised care in an asylum, and been discharged into the Maori community.

In looking at the American discussion of examples of deinstitutionalisation, it appears that we, in Aotearoa, can learn from some of the experiences. It was found that no resources were allocated for adequate staffing or housing in rehabilitation of mentally ill into their communities. Neither were there any resources or programmes toward eventual employment. Deinstitutionalisation requires adequate funding for a range of comprehensive services for patients being rehabilitated into the community, and adequate funding is essential also to ensure successful transitions. The Psychiatric Report (1988:160) commonly now known as the Mason Report identified that community psychiatric services for Maori also needed to be culturally sensitive, and that an allocation of funding was required to enable Maori staff "to participate in the development of community based health initiatives for Maori people".

This thesis research aims to firstly, identify any gaps that exist which, if closed, may assist and contribute towards improved discharge planning for Maori mental health patients and; secondly, to identify patient and whanau needs. This will be through data analysis and recommendations from the findings. The research focuses on the experiences of discharge planning of a group of Maori mental health patients and a group of staff working with patients at both secondary and primary levels of mental health care.

The outline of the thesis chapters

Chapter one has laid the foundation for the thesis in describing the research question and the objectives of the research. This is followed by an overview of mental health history in Aotearoa. This is to set the scene and show the mono-cultural system, based mainly on British ideologies, that Maori psychiatric patients have had no choice but to enter for psychiatric care over the past hundred and twenty years. It was not until the 1970s that cultural distinctions were considered in both diagnosis and treatment. Although there do not appear to be specific statistics recorded for Maori psychiatric patients at the start of psychiatric care in the mid-1800s, and therefore there are no specific examples of discharge planning, one has to assume that if there were Maori patients, they would have been treated as all other "lunatics" and jailed with criminals.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 is legislation that heralds in a cultural emphasis in treatment which service-providers have a responsibility to accommodate. The framework of discharge planning itself calls for more involvement, not only with the patient but also with whanau members where possible. From these two examples that have been directed from government, there is national recognition that Maori needs are culturally different, and that there is a necessity to accommodate services and treatment to meet these needs. The overall aim is that Maori health will be at least on a par with non-Maori.

The second chapter describes important compositions of foundational roots of health for Maori. These include the lore of tapu and noa, which govern the spiritual, social, cultural and economic circumstances of Maori and to which health from a Maori viewpoint stems. Other aspects and vital facets of health were the importance of, and connection to, the whenua which was more than a place to live. For Maori, land has a direct link to physical and spiritual well-being as well as a spiritual relationship with the tupuna or ancestors. Significant loss of land due to land wars, confiscation and legislation has left many Maori bereft of their heritage and, in many cases, their identity. Land losses and alienation from cultural practices such as tikanga and the knowledge of whakapapa have helped to erode Maori society and have been major factors in poor Maori health, including mental health today.

From the breakdown in Maori society has evolved the breakdown of cultural identity. A section on the broad levels of Maori identity and whanau groupings depicts the scope of knowledge and expertise needed to understand and work with Maori, including mental health patients. From traditional health practices, chapter two looks at the health status of Maori. The Treaty of Waitangi has been interpreted with specific relevance to Maori mental health and shows the commitment that the Government has expressed to effecting an improvement in the mental health status of Maori (Mental Health Commission, 1998:11). The Blueprint (1998:55) expresses "the commitment to providing more and better mental health services for Maori must be translated into tangible and culturally appropriate mental health outcomes and recovery for Maori".

This chapter relates to discharge planning in a holistic way in that it captures the essence of traditional Maori health, and then presents the erosion of culture and health. This provides the reader with a view to some of the possible reasons for the mental health status of Maori today. There are high numbers of Maori in psychiatric care, and therefore high numbers of people who will be discharged from acute inpatient wards or hospitals to their whanau and communities in the deinstitutionalisation process.

The third chapter focuses on the measures for discharge planning which are based on the framework of the New Zealand national discharge planning guidelines. The guidelines are a recent government initiative of the early 1990s in response to a request from the Ministry of Health in 1993 for consistency in discharge planning for mental health patients. The guidelines now provide a uniformity of content to ensure that certain aspects of discharge planning are covered when any mental health patient leaves a ward or hospital. Prior to the 1990s there was no overall standard or consistency of discharge planning among hospitals.

The Psychiatric Report (1988), commonly known as the *Mason Report*, is the result of enquiries surrounding some mental health patients who had been discharged from inpatient care back to their communities and committed violent crimes or murders. The public concerns about inadequate follow-up for the discharged patients highlighted in the Mason Report emphasised the need for a uniformity of discharge planning guidelines.

Discharge planning is about people leaving wards or hospitals and returning to their whanau or communities. Government can change policies, but one also needs to look at the match of services. The range of help that patients are able to access in the region in which this study was carried out, both mainstream and kaupapa Maori, will be described. Although there has been an increase in mainstream services and a small increase of kaupapa Maori services, there is still a large gap in the delivery of Maori mental health services due to inadequate resourcing of staff within both primary and secondary services.

The fourth chapter, on methodology, discusses a kaupapa Maori research framework. My journey in Maori health and mental health is discussed, leading into the research. The steps of preparing the ground for the research, including hui or consultation with kaumatua and kuia as well as consumers, care givers and colleagues was, for me, a major prerequisite to the research. This began a year before the research proposal was submitted. Problems that arose in trying to gain approval from patient participants for the study, were overcome by seeking participants who had already been discharged from the ward rather than those who were about to be discharged. Six mental health workers, both Maori and non- Maori working at primary and secondary levels of mental health care, are also participants. The discharge planning documentation from patient files contributes to the analysis. With the effectiveness of discharge planning coming from the perspective of consumers and staff as well as documentation from the discharge planning section of patient files, the theoretical framework is kaupapa Maori, and is facilitated by the use of method triangulation.

The fifth and sixth chapters discuss the themes that emerged from the hui and interviews with the research participants. The themes in chapter five are, broadly speaking, of the discharge planning process and whether patients or whanau were involved and whether patients had felt they had control as what was to happen after discharge. The section on information in chapter six includes four main issues beginning with an examination as to whether enough information is given to patients and the staff who are caregivers of the discharged person. Another section, on whether the patient or caregiver is given enough information about the discharged patient's medication, resulted in some caregivers having strong opinions that they needed to be informed prior to discharge to help the patient's recovery process. A third section is about information on services, and the fourth section includes dialogue about whether the patient knows his/her caseworker, or whom to contact if they start to become unwell. These are also issues that have been identified by other researchers featured in the literature review on discharge planning. Chapter six also includes korero on the patients' perspectives on resources for discharged patients. The final section in chapter six looks at cultural issues for Maori mental health patients in discharge planning.

Chapter seven brings the essence of the whole thesis together, presenting an overview and analysis of the findings of the research. It is in this final chapter that suggested developments and recommendations for improvement in discharge planning are made.

Conclusion

In conclusion, this chapter has outlined the intent of the researcher, which is to measure the effectiveness of discharge planning for Maori mental health patients from the ward of a provincial hospital. The background to discharge planning of mental health patients is firstly set within a historic framework of early psychiatric care in Aotearoa, which was long-term, institutional and based on western ideologies. For Maori, this meant that there were no cultural considerations in either treatment or discharge. Chapter one broadly traces the deinstitutionalisation process leading to mental health patients being discharged to the communities within shorter timeframes. A review of the literature on discharge planning shows that good discharge planning should be inclusive of the patients and their families. The literature suggests also that the discharge planning should start upon admission of the patient. The research aims to evaluate the discharge planning for Maori mental health patients, identify the gaps in the discharge planning and make recommendations to improve discharge planning to help reduce, or lower, re-admission rates for Maori.

Chapter Two – Foundations of health for Maori

Introduction

This chapter looks at health from a Maori perspective. Within these concepts, mental health is not separate from other aspects of well-being, and therefore the discussion of Maori health is broad. It includes perspectives of spirituality, values, protocols, the importance of whanau, and the significance, for Maori, of their relationship to the land.

Tapu and Noa

The foundations of health, from a Maori viewpoint, have their roots in *Te Ao Tawhito,* the old world. Here, the spiritual, social, cultural and economic circumstances of Maori were governed by the lore of tapu. Marsden (1992:119) defines tapu as :

> *having both religious and legal connotations. A person, place or thing is dedicated to a deity and by that act it is set aside or reserved for the sole use of deity. The person or object is thus removed from the sphere of the profane and put into the sphere of the sacred. It is untouchable, no longer to be put to common use. It is this untouchable quality that is the main element in the concept of tapu....the object is sacred and any profane use is sacrilege, breaking of the law of tapu.*

The three dimensions of tapu included sacredness, prohibition and uncleanness. All three kinds of tapu had to be treated with great care. Tapu was a means of social and behavioural control that maintained harmony, balance and unity of the mind, body, soul and family of a person. Tapu protects and nurtures existing resources of tribal well-being and ensures a continuity between the past, present and the future. This is maintained through a system of tikanga, ture, ritenga, kawa, karakia, and respect (Hui Whakaoranga, 1984).

Buck's (1949:405) discussions on tapu suggest that the ramifications of tapu had such far-reaching effects that it was comparatively easy to ascribe the manifestation of illness to some form or another of violation. An example of a tapu either being placed upon someone for violating a sacredness, prohibition or uncleanness could be lifted only by a tohunga. In Buck's (1949:405) example of the lifting of a tapu, the tohunga had to first find the hara committed which was equivalent to the diagnosing of a disease. The person's case history included their movements and actions prior to the attack or illness. This provided knowledge as to the appropriate cleansing or tapu lifting rituals for each individual. This is known as noa. Shortland (1856:103) also comments that everything not included under the class of tapu, is noa, meaning free or common. Lyndon (1983:31) states that:

> *Man was the centrepoint of life, and as such, could only maintain his wellbeing by surrounding himself with a personal tapu and keeping it inviolate.*

According to Buck (1949:380) chiefs sometimes would name newly-acquired territory or lands after some parts of their bodies and so prevent others from claiming them. The custom that was used to invoke the tapu was termed taunaha. Lyndon (1983:37) and Polack (1976:276) make references to the fact that ignorance of a tapu was no excuse for breaking the law, and appropriate rites of appeasement and propitiation were necessary for each penalty of a violated tapu. Walker (1996:171) expounds upon this point thus:

> *The main focus of Maori medical practice was psychosomatic and spiritual healing. There are stories in traditions of bodily processes being afflicted by mental states. The most celebrated of these pertained to the birth of Tutanekai. His mother Rangiuru went into protracted labour. In the end the midwives called in the tohunga who recited karakia of the most potent kind to facilitate the birth. When that failed, he taxed Rangiuru with having committed a hara where upon she confessed that her husband was not the father of her child. It was Tuwharetoa. The tohunga recited his incantations again and in the appropriate place in the child's genealogy he inserted the name Tuwharetoa. The child was then delivered with ease. The case of Tutanekai's birth is in modern parlance an example of a psychosomatic disorder for which Maori medical practice had an adequate technique-they knew confession was good for the soul.*

Buck, (1949), Lyndon, (1983) and Walker, (1996 suggest that, when the laws of tapu were transgressed, protection was withdrawn from the mauri of an individual. Walker's (1996) example is a clear archetype of a Maori traditional health model of practice incorporating the violating of a tapu and the application of noa towards cultural, metaphysical and spiritual healing.

Other important issues relating to Maori health are the cultural values of whenua, whakapapa, the marae and the tikanga or customs in which the pivotal axis is the whanau.

Te Whenua - the land

The land, more than any other element, is the substance of Maori values. Myths, oral traditions and social relationships are inextricably intertwined with the land. It is the basis of Maoridom and the pivotal feature of identity, linking one with ancestral mountains, rivers and seas, as well as whanau, hapu and iwi. Reinforcing the previous point that myths, oral traditions and social relationships are intrinsically enveloped within the land, personal identity for Maori includes also the environmental features of mountains, rivers, lakes and seas and therefore loss of land is loss of identity. (Durie, 1994:71) states that:

> *A lack of access to tribal lands or territories is regarded by tribal elders as a sure sign of poor health since the natural environment is considered integral to identity and fundamental to a sense of well-being.*

The guardianship, and responsibility for taking care of the land and the environment were vested in the whanau group and passed on from one generation to the next. In relationship to health, land promotes a positive sense of tribal, whanau and individual well-being resulting in a sense of belonging. Another connection which it provides for Maori is that land links the past, and the land is the vital link between one's tupuna and the ongoing living world (Hui Whakaoranga, 1984:17).

Jackson (1988:40) draws a parallel between the need to maintain order and protection for the land by ensuring a balance of the interlinked animal, plant, spirit and human worlds which was an ancestrally defined responsibility. This means that there were certain protocols and responsibilities about such things as hunting, gardening, gathering rongoa from the bush to the more tapu matters such as childbirth. Pere, (1982: 18) also gives credence to a direct relationship between the physical and spiritual wellbeing of Maori being linked to the land, and more importantly, to the ancestors of the land. However, in the history of

Aotearoa, there has been significant loss of land by Maori. Two of the main contributors have been land wars and legislation. The Lands Ordinance Act 1841, and the Native Lands Acts of 1862, 1865 and 1873 did much to reduce Maori land ownership. In addition, the New Zealand Settlements Act and the Suppression of Rebellion Act, in 1863, allowed the government "wide-ranging powers to confiscate tribal lands" (Durie, 1998:119).

Some of the effects of these Acts were the breaking up of communal and collective ownership - the basis of land ownership for Maori; individualising Maori land titles; and the labelling of Maori who fought to defend their land as "rebels" resulting in confiscation of lands and lengthy Land Court hearings which Maori were obliged to attend. Often the costs of attending court were so high that huge debts could only be offset against and exacted from, the lands (Te Hikoi Ki Waitangi, 1985). It was also noted by Poole (1991:62) that the congregating of Maori for court hearings greatly enhanced the efficiency of disease diffusion by their being forced to live temporarily in less than perfect hygienic conditions.

At the turn of the century in Aotearoa 50% of land was either owned by the Crown, or reserved for public purposes, 47% was freehold land under European definition and title and 3% was Maori land, much of it unable to be built upon or developed because of legislation (Te Hikoi Ki Waitangi, 1985). Durie claims that Maori health declined as Maori land ownership declined. With only 3% in Maori ownership in 2000, it is feasible to link a decline in health to a loss of land.

Tikanga Maori

Tikanga Maori, as an aspect of health, is about values and belief systems that focus on maintaining balance and harmony between people and their natural, physical and spiritual world. The Hui Whakaoranga (1984:18) distinguished that Maori values:

> *were socially and culturally integrative in that they fostered open debate and discussion, consensus decision making and patterns of behaviour that acknowledged and promoted the dignity, worth and pride of man, (sic) his whanau and tupuna.*

The teaching of the tikanga around tribal customs, protocols and other important aspects of Maoridom was the responsibility of the elders and the tohunga. Learning of these things, both in the past and in the present is a lifelong experience which occurs through developing very good listening and oral communication skills. Some of the examples of the values passed down through the generations are those of aroha which is love, concern, compassion and hospitality in the widest sense; manaakitanga, meaning caring, sharing, respect and looking after; awhinatanga which incorporates the ideology of helping, relieving, assisting and embracing; and tiaki which means to take care of, to cherish, nurture, and to be a guardian (Hui Whakaoranga, 1984).

Many Maori, through previously identified losses such as land and cultural alienation, have lost also the knowledge and practice of traditional values and beliefs. This could surely be borne out for some, by the high numbers of Maori using health, welfare and justice services (Ministry of Health,1997).

The traditional Maori definition of health is that it is a holistic, embracing concept that emphasises the spiritual, familial, mental and physical aspects of a person. The following whakatauaki captures the essence of the proverb and its interpretation.

E wha nga kokonga o taku whare
Ka hinga tetahi ka hinga taku whare
Te taha wairua
Te taha hinengaro
Te taha tinana
Te taha whanau

There are four dimensions to my house
Should one be weak then my whole house will fall
The spiritual dimension
The mental/ emotional dimension
The physical dimension
The family dimension.

This model which was a culmination of ideas from Maori kaumatua and kuia, Maori health practitioners and the Maori Women's Welfare League in 1982,is described by Durie (1994:70) as Te Whare Tapa Wha. Health was compared to the four walls of a house and included the spiritual, mental and emotional, physical and family wellbeing which are integral for the good health of Maori. Durie says further that:

> *A study of Maori health must follow more than two strands. Tinana is the physical element of the individual and hinengaro the mental state, but these do not make up the whole. Wairua, the spirit and whanau the wider family, complete the shimmering depths of the health pounamu, the precious touchstone of Maoridom.*

A Maori definition of good mental health would include the encompassing and promotion of facilities for each Maori person to foster and maintain their spiritual, mental, physical and familial aspects of themselves. Green (1993:22) states that:

> *Knowledge of family, connections with tribal lands, the environment and Maori language would be considered essential to good Maori mental health.*

The World Health Organisation, in its definition of health, concluded that health was greatly influenced by social and cultural factors and that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (cited in Durie, 1994:69).

Maori views of health in comparison to those expressed by the World Health Organisation are somewhat broader in that they add the spiritual component to a holistic philosophy. A Maori perspective of health, as explained in this chapter, describes how these dimensions are interrelated to form a whole, and are the cornerstones on which good health is formed. When all cultural, social and environmental determinants are met, good health and wellness have a greater base on which to build.

The Whanau, the caregivers

The basic social unit of Maori society is the whanau, with whakapapa the genealogical lineage connecting whanau members. One's whakapapa is the heritage to ancestral lines as well as all that pertains to a particular genealogy, linking the past with the present and the future. Today, whakapapa and knowing one's whakapapa enables us to know who we are and to whom we relate. It enhances our ability to network and create new relationships in an urban environment. Whakapapa is also the link between whanau, hapu and iwi, creating whanaungatanga relationships and obligations. Whanaungatanga is also the element that provides the strength, warmth, support and understanding in family relationships and dynamics. Durie (1994:1) declares that:

> *Whanaungatanga is the process by which whanau ties and responsibilities are strengthened. It is based on the principle of both sexes and all generations supporting and working alongside each other. Maori have recognised that whanaungatanga cannot be a passive process; active planning and development are necessary if whanau are to play a continuing and significant role in the future.*

Within the whanau, individuals are seen not only as members of the whanau and hapu, but as human manifestations of their tupuna with certain functions, roles and obligations to fulfil during different stages of the life-cycle. In pre-European days of Maori settlement in Aotearoa, the main function of the whanau was procreation and nurturing of the young. These were foundational values of Maori society. Today, however, as a result of land alienation and urbanisation among many other things, many Maori do not have same support structures of the past, which included care and guidance from the wider whanau and papakainga or village settlement. Cultural alienation and cultural unawareness are also factors which may tend to isolate even further. Durie (1990:111) identifies that:

> *A trend that has swept the western world over the last decade and a half has been that individuals should be self-sufficient, autonomous, independent, self-directed and governed principally by what is best for them as individuals. Such qualities are often equated with mental health, but a Maori with those qualities is extremely unhealthy...independent living is very unhealthy in Maori terms... it fails completely to acknowledge where someone has come from and where*

> *their strength lies.*

Cultural Identity

There are many factors that influence health today which are outside the current health system. Unemployment, housing, socio-economic status, educational achievement and exposure to modern life-style diseases are some of the determinants. It could well be argued that one of the major considerations must be the whanau itself and the varying degrees of loss due to lack of cultural identity. Durie (1998:57) states that:

> *Cultural identity is conceived as an amalgam of personal attitudes, cultural knowledge, and participation in Maori society. Particular attention is focussed on self-identification, knowledge of whakapapa participation in marae activities...involvement with whanau,...access to whenua tipu, contacts with other Maori people and use of Maori language.*

A study being undertaken by Te Hoe Nuku Roa, Massey University, involves Maori families in the four regions of Auckland, Tairawhiti, Manawatu-Whanganui and Wellington, initially for ten years. It has enabled the identification of four cultural profiles or categories for Maori. These are a *secure identity*, a *positive identity*, a *notional identity* and a *compromised identity* (Durie,1998:58). Those with secure identity have a strong sense of self-identification as Maori and are often involved in marae participation, a knowledge of their whakapapa, their ancestral lands and tikanga and te reo Maori. The positive identity Maori have lower levels of involvement whilst according to Durie, the Maori with notional identity have no access to things Maori, nevertheless do identify as Maori. Finally the fourth grouping, described as compromised identity, reflect non-identification as Maori, in spite of having considerable access to te Ao Maori or the Maori world.

My own experiences and analysis of whanau groupings

Working within the community of Tauranga Moana over a ten year period, in both primary and secondary Maori health care, I have observed three main whanau groupings. Firstly, those who are strong in their cultural identity (Durie's secure identity); secondly, those who are discovering and reclaiming their cultural identity; and thirdly, those who are still alienated from their cultural identity (Durie's compromised identity). These groupings and descriptions have not been derived from a formal study but more from how the people have described themselves and my own observations whilst I have been involved in working with them over the years. A knowledge of cultural disposition is necessary, to be able to work effectively with Maori. This means an awareness and sensitivity to the various groupings of Maori identity, and therefore a knowledge of the different approaches that are needed to work in a culturally sensitive manner.

Working with whanau who are strong in their identity as Maori, the secure identity allows for the inclusion of kaupapa Maori and tikanga Maori. This may include karakia at the beginning of the interaction followed by exchanges of whakapapa or tribal or historical recollections. Often food or a cup of tea is part of the hui. That is a custom of whakanoa and it reduces distance. Maori who are secure in their identity often have great pleasure in sharing their experiences of knowledge and events, particularly when a connection is able to be made through either whakapapa or historical knowledge. It is not usually until these formalities have taken place, albeit in an informal manner, that the whanau will disclose or be open to the need for the service. This is supported by Buck's (1949:411) own experiences as a Maori health practitioner in that:

> *The value of Medical Officers with Maori blood to the Department of Health and to the Maori people lay largely in their knowledge of the Maori language, customs, and etiquette, and in the fact that they had a blood tie with the people by virtue of their birth. However, some of the older people were suspicious at first that our intermixture with white blood might influence us in adopting the European procedure of enforcing new ideas without due consideration of native custom and feeling... we conformed at all times to Maori custom and etiquette.*

In working with whanau who are reclaiming their identity there is a 'give and take' approach of both exchanges of cultural information and identity. People in this whanau grouping can be both positive and self-assured, readily sharing what knowledge they do have, or whakamaa and shy about their little or lack of, knowledge. Sensitivity and care are needed to ensure the build-up of a sense of whanaungatanga in the working relationship.

By contrast, the approach for working with whanau who are alienated from their cultural identity necessitates first, the assurance of normality. This is often a major and important part in working with this group, as usually there is ignorance of, and in many cases, fear toward things Maori. Assurance of normality includes showing similarities as much as possible to things with which they are familiar. The assurance of safety is another important factor with this whanau group. "I am Maori and I am safe to be with". The 'ordinariness' of Maori needs to be firmly established before appropriate cultural practices, if any, may be incorporated into any helping programme with this whanau group. Social self-determination of tino rangatiratanga can, and will, be received only at a pace which is comfortable for the individual. Durie (1998:59) suggests that:

> *...it is now evident that there is no single Maori cultural stereotype, and being Maori may have quite different connotations for various groups... what is suggestive, however, is that a secure identity may have advantages beyond cultural affirmation. It may, for example, afford some protection against poor health; it is more likely to be associated with active educational participation and with positive employment profiles. The corollary is that reduced access to the Maori resources, and the wider Maori world, may be associated with cultural, social, and economic disadvantage.*

With the deinstitutionalisation process moving patients back to their communities, and in many cases to their whanau, a knowledge of the whanau and its cultural identity would provide some helpful information for the necessary follow-up cultural treatment and support. Another important factor is that workers without an awareness of the varying cultural needs of Maori patients may compromise the patient's identity unwittingly. This could result in a failure to recognise needs. As has been identified by Durie (1998) those with less access to Maori resources may be more disadvantaged culturally, socially and economically. It would be fair to assume that those patients belonging to whanau who are alienated from their culture and identity may have fewer resources to access when rehabilitating their whanau member back amongst themselves and into their communities.

Maori health status

First Contact

The 18th century European commentators were unanimous in their praise of the level of Maori health that was witnessed at the time of first contact with them. An example is Joseph Banks's reference to his belief that the source of the good state of Maori health was due to "a sound health philosophy and system... and not due to good luck" (Te Puni Kokiri, 1993:30*)*.

This is reiterated by Buck (1949:409 who notes that that there were no endemic or epidemic diseases in pre-European New Zealand days, and that diseases such as typhoid, tuberculosis, measles, and venereal diseases were all introduced after European contact. However, Buck (1949:405, 406) also discusses examples of pre-European mental health for Maori, where mental depression was often the result of an act that the patient had committed, but of which s/he was unaware. Treatment consisted of tohunga bringing the hidden case to the surface for the patient, thereby paving the way for recovery. Treatment also included spiritual cleansing rituals and purification rites, often where the patient was dipped in a stream while the tohunga recited karakia. These Maori cultural practices were about releasing the patient from a state of tapu to a place of noa, as mentioned at the start of this chapter. For some, these practices are still relevant today.

From the examples given, pre-European Maori did not have endemic diseases. States of depressive illness always related to a transgression or violation of tapu that was lifted during ceremonial rites by a tohunga. Today, both Durie (1994:125) and the Ministry of Health (1997:92) declare that there are no standardised measures that capture Maori health from a Maori perspective, however statistical data from census and other Government health research do provide indications of Maori health status (National Health Committee,1998).

Maori mental health today

In the area of mental health, Maori rates of first admission to psychiatric services have increased dramatically over the last 30 years, while Pakeha rates have remained stable (Te Puni Kokiri, 1993). Some of the main factors that have been identified as leading to Maori psychiatric admission are: drug abuse and drug psychosis; the lack of culturally appropriate early detection of drug and alcohol in schools: the lack of kaupapa Maori workers in the mental health field: the fact that Maori are more likely to be seriously ill before help is sought, and the lack of appropriate mental health services for Maori (Te Puni Kokiri, 1993).

As stated in *Kia Tu Kia Puawai* (1999:3) "there is compelling evidence that mental illness is the major health problem facing the tangata whenua of Aotearoa".

It has also been noted that for Maori, mental well-health is not just the absence of illness. Pomare and de Boer (1988) found that more effective work needed to be undertaken to address issues such as housing, unemployment and cultural isolation. Almost a decade after Pomare and de Boer's findings, the Ministry of Health (1997:50) are stating that mental health needs are still similar:

> *Mental health problems can be important either before or after homelessness or problems with housing occur. The disproportionately large numbers of mentally ill among the homeless are attributable not to mental illness per se, but to the fact that many of the mentally ill are multiply deprived in other ways, such as being unemployed, isolated, and unaware of their rights, and it is these factors that lead to their homelessness.*

It is important, therefore, that health and social agencies provide services that reflect the broader perspectives of social and environmental care, and extending that further, include culturally-competent workers. The principles which are promoted in the 1986 report, *Puao-te-ata-tu,* are as relevant at the end of the twentieth century as they were at the time the report was written to the then Minister of Social Welfare. They promote the concept of partnership between the Treaty partners and identify the needs and aspirations of Maori as tangata whenua. The recommendations acknowledged whanau, hapu and iwi and the need to promote the health and wellbeing of Maori. The report acknowledged:

> *Maori is strong, it is dynamic, it is culturally and spiritually rich and it has the ability/potential to look well to the needs of its people.* (Puao-te-ata-tu, 1986).

These statements, however, cannot be made in isolation from the provision of adequate resourcing, and the promoting of policy which assist Maori to reach their potential. There is a need for a comprehensive approach. John Rangihau, who chaired the committee which wrote *Puao-te-ata-tu*, in his last formal speech to the First New Zealand Conference on Social Work Education in Christchurch, stated that:

> *It may not be too long though before it is realised by professional groups that intervention vis-a-vis social problems may not be limited solely to social strategies but will need to depend on an amalgam of cultural and economic remedies. Maori people have long held the view that " people development" is synonymous with "economic development". If you align that viewpoint with people inseparable from their culture, you then have a recipe that takes out of welfare and into development and the new negotiated order of empowered communities.*
>
> (Department of Applied Sciences, 1996).

The previous chapter has outlined the effects of deinstitutionalisation and the need for the community to be amply resourced for successful rehabilitation of the mentally ill into the community (The Mason Report, 1988; and Torrey, 1987). In researching the effectiveness of discharge planning for the group of patients in this study, it will be worth noting how well-resourced the community of Tauranga is in coping with the rehabilitation needs of Maori mental health patients discharged from the hospital. The capacity to care, to a large extent is dependent on economic status, which in most cases is linked to Government resources.

The Treaty of Waitangi and mental health

In discussing any area of social or community work practice in New Zealand, including discharge planning in Aotearoa/N.Z., it is fundamental to begin with the Treaty of Waitangi, which has both in recognising the unique status of Maori as tangata whenua of Aotearoa ,and in the ongoing relationship between Maori and the Crown. In 1992, the Government issued its response to Maori issues in the health sector in a document that stated:

> *The Government regards The Treaty of Waitangi as the founding document of New Zealand, and acknowledges that it must meet the health needs of Maori and help address the improvement of their health status.*
>
> (Department of Health, 1992).

The Treaty, signed in 1840, was designed to protect the traditional possessions of Maori (Spoonley, 1988). The Articles of the Treaty provide for governance, specifically in the first article, the responsibility to govern; in the second, the responsibility to protect Maori interests and where necessary to redress grievances; and in the third, the responsibility to ensure that Maori people enjoy all the rights and privileges of citizenship (Durie, 1989). Grievances from the past continue to include issues of: land, language, authority, ownership, values and self-determination. Much of the 1980s-1990s tensions within Maori and Tauiwi relations were underpinned by unresolved Treaty grievances. The Royal Commission on Social Policy (1987) stated that:

> *In essence the Treaty was a partnership between Maori and the British Government. While it had potential for a fair and even agreement, inequalities between the parties quickly developed. Control, power and decision-making passed from one partner to the other and even by 1852, with the passing of the Constitution Act, the effective administration of New Zealand had become the province of the European settlers. The Anglo-Saxon traditions of individual effort and industry and the promise of full citizenship to male settlers, left little room for those whose traditions and values had other origins.*

Government policy and the reforms of the 4th Labour Government led to much unemployment for Maori (Kelsey, 1991). Unemployment, inflation and disparities in standards of living gave rise to further complications. Inequalities in all major economic and social areas of New Zealand society have led to a move to include Maori cultural perspectives as an integral part of our social policies (The Royal Commission on Social Policy, 1987). In the more recent policy guidelines for Maori mental health, the Ministry of Health has identified and proposed a strategic direction that is aimed at improving the mental health of Maori, so that it is at least as good as that of New Zealanders as a whole (Ministry of Health, 1994).

Mental health institutions in the past have not provided for the holistic healing needs of Maori, as mental health services are still mainly monocultural with emphasis toward clinical treatment. *Te Kawenata o Waitangi* (1984) states that:

> *by 1992, over 150 years after its signing, the Treaty of Waitangi had been accepted by the Minister of Health as the 'founding document' of New Zealand. Though the acceptance did not go as far as Maori would have liked and did not include any mention of the Treaty in the new health legislation, nonetheless it represented a significant move towards a more logical appreciation of health as a combination of social, cultural, economic and political factors. Maori health now stood some chance of being considered within a context that was meaningful both in terms of New Zealand's historical development and the contemporary aspirations of Maori people.*

Although a large gap still exists between acceptance of the Treaty and the translation of its aims into actual health gains for Maori, significant ideological movements that have helped to shape the pathway have been: firstly, the realignment of New Zealand's approach to health through bi-culturalism (Department of Social Welfare, 1994); secondly, the health reforms of 1991, which called for a greater accountability for the expenditure of health funds and a refocussing of health priorities that incorporated earlier forms of intervention, quality care and reduction of unacceptable disparities (Manatu Maori Te Tari Ora and Te Ohu Whakatupu, 1991 and Upton, 1991); and thirdly, the ideology of Tino Rangatiratanga which is 'by Maori for Maori'. The Crown has directed that the strategic planning for mental health:

> *ensures Maori involvement in the planning of mental health services for Maori, and in designing services appropriate to Maori, and improves the cultural safety of services and ensures that services accommodate cultural differences, especially for Maori.*
>
> (Ministry of Health, 1994).

The report " *Ka Awatea* " released in March 1991 stressed the need for Maori to fully participate and contribute to the development of New Zealand as a nation. This document advocated that Maori should be empowered to take a greater responsibility for their own social, economic and cultural well-being. Four areas of high priority identified were education, health, training and economic development. *Manatu Maori* (1991) suggested that the good health of Maori should be recognised as important for the development of this country, particularly as a significant proportion of the workforce in the next decade will be Maori, as the non-Maori population ages.

The Ministry of Health (1995) explain that the Waitangi Tribunal, the Court of Appeal, the Royal Commission on Social Policy and the Crown itself have defined particular principles arising from the Treaty. Three primary principles promoted by the Royal Commission on Social Policy are those of *partnership, participation* and *active protection*. *Partnership* refers to an ongoing relationship between the Crown or its agencies and the iwi and/ or its constituted authority; *participation* emphasises positive Maori involvement in all aspects of New Zealand society including decision-making and service delivery; and *active protection* in health terms is generally about health promotion and preventative strategies for the enhancement of Maori health.

The Tauranga Hospital, where the research on "the effectiveness of discharge planning for Maori mental health patients" was carried out, states a committment to the Treaty of Waitangi. This means that there is an awareness of the needs for both cultural safety, and Treaty of Waitangi training for staff, also the need for Maori patients to be cared for and treated in a culturally safe manner. It is a fair comment however, that it has been kaupapa Maori staff who have initiated and insisted upon the inclusion of their rights and Maori people's rights to these policies in health. Te Puni Kokiri has gone one step further and provided examples for health agencies specifically in relation to mental health. As further amplified by Te Puni Kokiri (1993) in accordance with mental health:

> *Article 1 This places responsibility on Government to put in place legislation and public policies which enable people to have access to health services and to make health choices easy choices. The Government has the responsibility in the area of mental health to ensure legislation to protect both individuals and the community and for mental health services to be available through appropriate administrative and funding agreements.*
>
> *Article 2 This gives Maori rights and responsibilities as members of whanau, hapu and iwi to hold onto properties or taonga such as land,*

> *rivers, forests and language that they hold as important. It gives Maori the right to pursue Tino rangatiratanga or self-determination on matters affecting well-being. It is vital that Maori are given the opportunity to be involved in shaping Mental Health legislation, the development of mental health policies, and to have resources to develop their own mental health services. Only by creating this environment will Maori be able to share with the Crown the responsibility of care and health development of their own people.*
>
> *Article 3 This accords Maori, as individuals the same rights and privileges as other citizens. This article complements Article 2, requiring the Crown to ensure that Maori have the right not only to equal access to health services, but also to equal health outcomes.*
>
> (Te Puni Kokiri, 1993).

Te Puni Kokiri's clarification provides specific guidelines for health providers, linking to each article of the Treaty of Waitangi. In particular the responsibilities of health providers, Government and Maori are emphasised.

Kelsey (1991:44) argues that while there has been some positive moves in some departments and agencies, most have been minor or cosmetic and reversible. She suggests that:

> *The spawning of isolated ministries risks greater fragmentation of marginalised sectors, reducing rather than increasing their power. It is true also that these initiatives have fed a rising tide of expectations, creating tensions within government agencies and disillusionment when those who seek to put the rhetoric into action find a lack of political commitment.*

Conclusion

In conclusion, this chapter traces the foundations of Maori health which have their roots in Te Ao Tawhito where systems of social control were governed by a lore of tapu. Ignorance or violation of a tapu could be appeased only by propitiation that returned the person to a state of noa. Some early examples of lifting of tapu by tohunga are considered as being equivalent to the diagnosing of disease (Buck, 1949:405). A model of assessment included examining the person's case history, including movements and actions prior to illness or attack, which thus provided knowledge for intervention in the form of appropriate tapu-lifting rituals.

One of the foundational elements of well-being for Maori was the land. This was not only a place to live. Land or whenua, signified a physical, spiritual, geographical, historical, ancestral and ecological relationship which united identities of the past and the present. Land was, and still is today, a means of identity for Maori. Loss of land has resulted in loss of identity for many Maori, and therefore loss of well-being and health also. Other Maori concepts that are integral to traditional and modern well-being are whanaungatanga links whereby "whanau ties and responsibilities are strengthened" (Durie, 1994:1). Learning of tikanga teaches values related to tribal customs, protocols and other important aspects of living and is a lifelong experience, resulting in practice-wisdom. Sadly for many Maori, land losses and urbanisation have separated them from their rights to the traditional models of nurturing and support and for some, identity.

In the deinstitutionalisation process, these are all factors that need to be considered in the discharging of Maori mental health patients back to their communities. Firstly, the turoro are Maori and secondly, if they are discharged to their homes, their caregivers are more than likely to be Maori. For the practitioners involved in discharge planning, ensuring that an already disadvantaged situation is not going to be further disadvantaged must be a key consideration.

Chapter Three – Measures for Discharge Planning

Introduction

This chapter begins by examining the background to discharge planning and the reasons why it came to be seen as necessary. This is followed by a description of the key principles governing discharge planning. It then looks at the national guidelines that have been formulated by the Ministry of Health. These guidelines are only a recent initiative by the Ministry, having been developed, formulated and distributed in the early 1990s. The purpose of the guidelines is to help mental health wards and psychiatric hospitals to achieve and maintain a consistency and standardisation of discharge planning services throughout Aotearoa. Although the national guidelines provided a framework for discharge planning care, each local mental health hospital service was then required to submit their own discharge planning policies. The chapter then, therefore, discusses the discharge planning policies in one locality. Tauranga Hospital, where this research has taken place, has adopted the national procedures and formulated their policies to suit the local area. A section of this chapter will make reference to the Tauranga Hospital guidelines as well as outlining the cultural, social, geographic and demographic environment within which these policies sit. In the analysis of the research, the discharge planning guidelines will be used as a measure against the actual findings.

Background to discharge planning

Discharge planning became an issue from the 1960s, following the move to deinstitutionalisation of mental health patients, accompanying the introduction of psychotropic drugs. As deinstitutionalisation increased, problems – some involving the safety of both the public, and former patients – manifested themselves.

Safety of the public and safety of the patient have been two major issues which have been a focus of the deinstitutionalisation process. The Mason Report (1988) was the result of an enquiry into procedures used in some psychiatric hospitals in relation to the way certain classes of patients were either admitted, discharged or released on leave. A case mentioned in the Report as being a catalyst for the enquiry was based on events surrounding the release of John Papalii, a mental health patient who had previously been in long-term psychiatric hospital care from the early 1960s and then for the following twenty years, was a person who had special patient status. His non-compliance with treatment and rules of the establishment, as well as aggression and violence toward both staff and patients, kept him in the special patient category.

In July 1986 a decision was made by the clinical team of Oakley Hospital that Papalii would be placed in the community, under the care of the Oakley District Nursing Service. Ten months later, he presented himself at the Carrington Hospital in a psychotic state, but could not be detained as he was not covered by the provisions of the Mental Health Act. A few days later, Papalii stabbed a man at a bus stop with a carving knife, and early the next morning stabbed another person, as well as wounding others (Mason Report, 1988).

Prior to the killings, concern had been expressed by clinicians, at the state of Papalii's mental health, and the fact that he refused to take medication. This case was one of many. They illustrated that discharge planning and follow-up support need to be put in place for patients being rehabilitated into the community. Even before the 1992 Act, which made it more difficult to detain people in mental hospitals, the public had started to become apprehensive and concerned and "many people expressed grave concern at the inadequate follow-up of psychiatric patients who had been discharged from hospital into the community" (Mason Report, 1988:3). There were some mental health patients for whom discharge planning would be difficult, if not impossible. However, avoiding discharge planning by keeping mentally ill people in prison did not necessarily guarantee their safety either, as was shown by the number of suicides of mental patients occurring in prisons (Mason Report, 1988:47).

Since 1987, there have been 67 inquiries which have been held into aspects of mental health services. As stated in the Mason Report (1996: 12):

> *Formal Inquiries contribute to the process of policy development but they also play a very effective role in shaping and monitoring standards of care. Inquiries are thus a very old method of facilitating quality assurance. This is apparent from the extent to which Inquiries... have led to operational change or improvement.*

Discharge planning is therefore undoubtedly essential, though at times extremely challenging, and it raises other issues. For example, although the Tauranga Hospital does not have a forensic unit or, at this stage a forensic contract, many of the patients who have been in forensic units in other towns are either transferred to Tauranga residential houses for mental health patients or they return home to live. Staff from other forensic units meet in Tauranga on a regular basis about such patients from, and in, the area. It is often the case then, for Maori, that the specialised services required to ensure the safety of these patients involves not only kaupapa Maori and mainstream secondary services but also their communities. In Cheyne, O'Brien, and Belgrave, 1997, the community is largely seen as often under-researched and under paid and:

> *Feminist analyses have highlighted the ways in which the change from state provision to "community care" often means care by the family, and therefore by women. (*Cheyne et al., 1997:102*).*

Among the need for specialised care after discharge is that of monitoring people who are suicidal. The suicide numbers for Maori are already high and therefore a significant part of the discharge and follow-up care begins with the assessment and on-going services and treatment. It has been found that:

> *In the course of a psychiatric episode, the most dangerous periods are at the beginning of the acute phase and after discharge (Applebee 1992 in Ministry of Health 1997). Goodlier and colleagues (1993) found the risk of suicide in the first four weeks after discharge is 213 times that of the general population for men and 130 times for women.*
>
> (Ministry of Health, 1997:430).

Key principles of discharge planning

The principal aims of discharge planning as guided by the Ministry of Health (1993) are to achieve continuity of care; co-ordination of care and treatment; provision of a level of support that meets the assessed need of the patient; a system that provides early intervention during crises or relapse of illness; and optimal health and well-being for the patient. A significant emphasis is placed on the patient's involvement in their discharge plans from the time of entry into the hospital ward. This is in line with recommendations in the literature, for example Hochberger (1995) argued that discharge planning 'is an integral part of the psychiatric nursing care and should begin as soon as possible after a client has been admitted to an inpatient unit'.

Other relevant features of the key principles of discharge planning relate to the family or caregivers having involvement, subject to cultural, ethical and legal constraints. This, for Maori, is more inclusive of the whanau concept of health and well-being and allows for the possibilities of a more holistic approach if that is the wish of either the turoro or the whanau. Dr. Quick's comments in the preface of the Mason Report (1996) expressed the fact that mental health differed invariably from physical health, and often, because it was not able to be seen, was misunderstood by others as well as by the patients themselves. He also suggested that personal care, time and attention were just as important to the patient as medication (Ministry of Health, 1996).

However, implementing these principles can be difficult. Mental health is different from physical health, and hence often misunderstood by both patients and the community. Cardiovascular disease, for example, is a more understood illness which will more than likely receive acceptance in the community, whilst a person with mental illness is more than likely to be either treated with suspicion, or avoided, because of misunderstanding. This creates issues for discharge planning.

Further, discharge planning needs to ensure that, in conjunction with the importance of medication for mental health ,here will be support for attention and time given to the patient's personal care (Ministry of Health, 1996). Where this comes mainly from whanau, then a large sector of carers for Maori are primarily women and predominantly Maori. A large majority of both women and Maori are already poor, so it is important not to add to their burdens by giving them extra unpaid responsibilities. Maori patient care must be properly resourced.

National guidelines for discharge planning for mental health patients

In 1993, the Minister of Health in New Zealand established that processes needed to be put in place to ensure that when mental health patients are discharged from hospitals they will receive adequate care and treatment in the community. A formalised system of discharge planning was one of the identified prerequisites to achieving this outcome. To help hospitals to achieve this, national guidelines were created. The Ministry (1993) maintained that an important and integral part of any decisions concerning the discharge of patients from hospital was the considerations of community treatment and care. It was also stated by the Minister, the Rt.Honourable Birch in 1993 (Ministry of Health, 1993:3) that:

> *with greater attention to discharge planning and with better information and monitoring systems the situation can be improved for people with psychiatric disorders who leave hospital in the future.*

In the same year, a request from the Ministry of Health required all Area Health Boards to submit discharge planning policies and protocols for mental health services. It was found that there was a considerable lack of uniformity throughout the regions due to the different patient groups in the areas. Some boards were confronted with the deinstitutionalisation of large hospital populations. Others used overseas protocols without necessarily adapting them to meet priorities in New Zealand. The Ministry then formulated guidelines as a more uniform basis for the development of comprehensive protocols for each mental health service (Ministry of Health, 1993).

The Ministry's 1993 conceptualisation of discharge planning is similar to Kemp's (1990) model, which provides prescriptive framework that guides the progress of an individualised programme of care and support based on assessed needs for the patient being discharged and rehabilitated to the community. This includes a coordinated approach to ongoing care and services that assist in early intervention during crises and/ or relapse of illness. The main aims of discharge planning are to accomplish optimal health and well-being for the discharged patient (Ministry of Health, 1993:6).

As stated earlier, Maori mental health consumers have a right to treatment and discharge plans which are culturally safe and appropriate. However, from the national guidelines, the principles that emphasise a specific cultural component are that:

> *Family, whanau and caregivers should be jointly involved with the patient and the treatment team in developing a discharge plan. This process as well as the discharge options will however be subject to cultural, ethical and legal constraints...Discharge planning must incorporate mental health services that are culturally safe for all the people that use them. The patients, when using a service provided by people of another culture should be able to do so without risk to their own cultural needs.*
>
> (Ministry of Health, 1993: 6).

In other words, these policies cover a broad generic cultural component that does not distinguish the roles and rights of Maori as tangata whenua from any other culture in Aotearoa. This is despite the fact that the Treaty of Waitangi, including Article Three, is an agreement between the Crown and tangata whenua which gives Maori their rights to distinctive cultural inclusions. However, a more recent policy document by the Ministry does acknowledge Maori as the tangata whenua and recommends appropriate treatment for Maori tuRoro in that "for Maori, the idea of partnership may be redundant if the mental health service is inappropriate to Maori, or does not recognise Maori values and processes (Ministry of Health, 1999:3). This indicates that, in principle at least, some progress is occurring.

Tauranga hospital discharge planning guidelines

As previously stated, the Ministry of Health formulated discharge planning guidelines as a basis for the development of comprehensive protocols for discharging mental health patients from each hospital. This section discusses the discharge planning guidelines of the Tauranga hospital, which are based on the national guidelines and are not unique to Tauranga. The key principles of discharge planning as documented by the Tauranga hospital are aimed at achieving the following four objectives: continuity and co-ordination of treatment and care; provision of a level of support that corresponds with the assessed needs of the patient post-discharge; early intervention during crises/ or relapse of illness, and optimal health and well-being for the client or patient. (See Appendix 1).

To achieve these objectives, the involvement of the patient is seen as one of the fundamental principles to the success of the operation of the plans. It is intended that the patient will set their own goals and aspirations for better mental health when they are participating in plans made with, or about, them. Family, whanau and caregivers too, with the consent of the patient, will be encouraged to assist in the discharge planning when they can. The purpose of whanau involvement is to support, if possible, and to perhaps share information that is relevant to the needs of the patient. Where there is whanau or other involvement, a fundamental principle is that the patient must have given consent first, otherwise there is the likelihood of violation of the Privacy Act. The guidelines also endorse services that are culturally safe. The objective of a culturally safe service is that "when using a service provided by people of another culture, patients should be able to do so without risk to their own cultural needs" (Western Bay Health, 1997).

An administrative requirement within Tauranga hospital discharge planning is that a Needs Assessment will be a preliminary step in the development of the plan. It had previously been identified that there was no uniformity among hospitals for discharge planning, including documentation. The national guidelines have designed a framework for assessments which can be summarised into four different components. Client details cover the patient's personal information of name, address, legal status, names of clinical case manager and clinician and a section that records incident reports with dates and references.

A comprehensive psychiatric assessment assists the patient to identify their own realistic goals and formulate plans towards successful rehabilitation. Within the assessment, particular needs for appropriate treatment are dependent on the nature of the patient's condition or illness.

The Tauranga Hospital guidelines for discharge planning begin with a statement which identifies that the hospital has "an active commitment to the Treaty of Waitangi and the improvement of Maori health" (Western Bay Health, 1997:1). Although government departments such as Health and Social Welfare have the Treaty of Waitangi as a foundation document for services, it is questionable whether this statement is merely one of rhetoric or whether it has practical application for the Maori mental health patients discharged from hospital. It appears that one of the main reasons why it is not seen to be more effective is that staff are often at various stages in their knowledge of the Treaty of Waitangi, and therefore of its practical applications. For consistency in cultural service delivery, education and training about the Treaty of Waitangi and cultural safety for all staff are basic requirements to ensure culturally safe education and training practices are maintained.

Another of the points highlighted within the document is that a high quality, as well as adequacy, of services within the community to meet the needs of the patients is necessary to attempt to address the re-admission rate for mental health clients. The Blueprint (Mental Health Commission, 1997:12) affirms that "Maori have substantially higher rates of re-admission than non-Maori" and that the rates have steadily increased over the years and are continuing to rise.

Other measures used as discharge planning guidelines at Tauranga Hospital ward for mental health patients are that the client and their whanau will be involved; an appropriate discharge plan will be developed and documented by the multi-disciplinary team; and for those people needing continuing care and support after discharge, a designated key worker or case manager will be responsible for co-ordinating and monitoring the implementation of the plan.

All the national discharge planning guidelines are covered by the Tauranga Hospital, including the aspect of a "system that provides early intervention during crises or relapse of illness". In a summary of the discharge planning guidelines the Tauranga hospital acknowledges the importance of the initial and comprehensive plans that are part of the inpatient treatment. They also continue the planning and monitoring as the patient moves into community treatment. However, the policies state that the responsibility for ongoing planning after discharge rests with those providing treatment in co-operation with the patients and their caregivers. It is argued that that monitoring of a mental health patient, particularly at the onset of illness after discharge, would surely assist in a more rapid response to mental health treatment and possibly, eliminate re-admission to hospital. Therefore good communication between hospital mental health staff involved in discharge planning and community caregiving organisations is essential.

Resources for effective discharge planning

An important part of care in health and social service treatment is the availability of services for follow up and ongoing support after a patient is discharged from hospital. For the purposes of discharging mental health patients, and in this case Maori mental health patients, into their communities, the health or social services that are accessible for patients is an important part of the discharge plans. As noted by Hochberger (1994:37):

> *Continuity of care and medication monitoring are necessary for all discharged psychiatric patients. After care options include appointments with a private therapist or psychiatrist, a mental health centre, psychiatric nurse specialist, psychiatric social worker or partial care programme...referrals to community support groups... with special emphasis placed on the patient's most prominent needs following discharge.*

As described in chapter two, there are cultural differences between Maori and non-Maori, and in that respect there is a need for the option of availability of specialised culturally safe care. This now exists to some extent in the Tauranga Moana area Maori delivery of health and social service care. These Maori provider groups, as well as mainstream hospital staff, have access to Treaty of Waitangi training and supervision set up to educate staff in cultural safety practices. It is therefore fitting that a brief presentation and overview of existing health and social services for Maori in the Tauranga Moana area is included later in this chapter.

In order for discharge planning for Maori mental health patients to be effective, there must be adequate care provided in hospital, plus there must be suitable support systems in the community. In addition, the social and economic factors which contribute to the high admission rates of Maori to mental hospitals also need to be addressed. The Mental Health Commission (1998) has maintained a commitment to the improvement of Maori mental health so that disparities in mental health status between Maori and non-Maori are eliminated. One of the fundamental factors for Maori as identified in the Blueprint (1998) is that "Maori must be able to access mental health services which are aligned to Maori cultural expectations". It has been only in the more recent years, particularly the past decade that a national emphasis by government has given credence to the importance of culturally appropriate health services for Maori. As mentioned in the previous chapter, Maori leaders such as Peter Buck Te Rangi Hiroa, Maui Pomare and Princess Te Puea, in their time made significant and leading contributions to the improvement of Maori health.

However, as Maori mental health statistics remain distinctively high in comparison with non-Maori, efforts to improve health call for a combined effort from a range of sources including government and local whanau, hapu and iwi. In my own experiences over the past ten years first as a Maori community health worker for six years and then as a mental health worker in secondary services for the last four years, I have seen an increase in developments of critical health services for Maori in the Tauranga Moana area. These particular services are both primary and secondary kaupapa Maori services. The primary services are based predominantly at hapu or iwi and marae settings whilst the secondary services are within the local public hospital. A more detailed illustration of these services is provided in following sections.

Community care, kaupapa Maori in Tauranga

The Tauranga hospital where this study has taken place, is located in the Tauranga Moana rohe. The geographical boundary of the Tauranga Hospital ,or Maori, is determined by the iwi boundaries of Mai Nga Kuri a Wharei in the Northern reach to Tekaokaoroa at the South-Eastern end. Within this area, five separate iwi are the tangata whenua of the land.

It is important to highlight the kaupapa Maori services which indicate options and choices for Maori mental health patients in this area. An illustration of both mainstream, included in the next section, and kaupapa Maori services within the Tauranga area gives an indication of what is available for Maori mental health patients overall. Kaupapa Maori services enable Maori patients firstly to have the option of Maori staff working with them and secondly, to link them to other culturally appropriate care if needed. One example of care would be the referral to a tohunga - and support- if/when required. The guiding principle for kaupapa Maori, as defined in the Blueprint (1997) assumes that services have a largely cultural component.

Tauranga hospital has a kaupapa Maori unit, Te Puna Hauora, consisting of a team of 34 staff providing a broad range of secondary health services. The kaupapa Maori specialist mental health services include whanau counselling, a consult-liaison service which assists children and their whanau needing either the mental health, social welfare or education services; dual diagnosis covering addictions and mental illnesses; early intervention in psychosis; a weekly mirimiri service for patients in the ward; a team of three nurses providing inpatient care; and a registered nurse who provides follow-up community care. Kaumatua and tohunga are also accessible to assist when patients are requiring such services. Te Puna Hauora is able to meet a wide range of patient and whanau needs, giving Maori an opportunity to exercise choice.

Over the past five years Te Puna Hauora Management staff have also been instrumental in recruiting Maori medical officers to the hospital. In 1999, two former Maori medical officers became Psychiatric Registrars. This will further enhance the mental health secondary service delivery and add to the expertise and care for Maori.

In generic health care, Te Puna Hauora staff provide community follow-up care for patients discharged from medical or surgical hospital treatment; diabetes education and marae community treatment clinics; kai awhina social work services; and outpatient clinics for gynaecology, paediatrics, hepatitis and diabetes. The wide range of kaupapa Maori services within the hospital then depicts the scope of health care or support that is available also for Maori mental health patients.

Inside of the geographic and iwi boundaries, there are eleven marae clinics providing primary health care, maintaining a range of services including mirimiri, rongoa, kaumatua care, diabetes services, whanau support, counselling, mental health follow-up and support, rangatahi programmes, tamariki ora as well as an iwi-driven G.P. service. Mental health patients are able to attend any of those services if it is the appropriate one for them. An example of a service criterion for access is that an assistant needs to accompany them. In addition to that, there are two groups providing residential care for the mentally unwell, and another iwi group running day programme, including a market garden scheme, for the same grouping.

A number of marae and Maori initiatives in primary health care have a whanaungatanga relationship with the Maori workers at Te Puna Hauora, in secondary health care. This makes for a continuity of service provision between primary and secondary health care for Maori wanting to use those services. There are demonstrable links between the Kaupapa Maori staff at the hospital and those in the community which is borne out by a model of care described as whanaungatanga and based on the principles of a type of whanau relatedness incorporating safe entry, safe care and safe exit between primary and secondary mental health services. This is where the community or hapu and iwi groups, knowing their people are becoming unwell or needing hospitalisation, will inform the Te Puna Hauora workers who are then aware of the patient's entry into the hospital, and will be part of the care or treatment plan if that is appropriate whilst they are in hospital, and will link in with the iwi workers for the patient's discharge into the community. This model of work has focussed on generic Maori health services as this has been the brief of most of the support workers, who are the link between primary and secondary care. The model of work described is based upon the principles of whanaungatanga and is a transferable concept which is able to be used across service delivery where Maori link together. The Maori mental health primary and secondary workers are now using this model in Tauranga. Up until 1999, there were relatively few Maori and iwi groups providing mental health care. However, a recent increase of four staff has boosted the local iwi mental health services. Maori staff at both primary and secondary health care levels , from time to time - and where appropriate for the patient - work in with mainstream in a multi-disciplinary environment.

A whakawhanaungatanga hui for Maori health workers in this rohe to strengthen and reaffirm ties, form new links and build relationships particularly for new workers, was held at the Hairini Marae Tauranga, in August 1999. An attendance of more than fifty kaimahi brought a wealth of Maori resources together in the one place. Information was shared by representatives of each roopu on the types of services they provided and the criteria for entry into their services. The researcher attended the hui where there was much excitement and passion amongst the attendants, especially at seeing the large numbers of local Maori workers together and the varied range of services that Maori could access. Some comments from the floor were "ten years ago we all knew the five or six Maori working in health in the whole of Tauranga Moana, even five years ago we knew everyone. Not now. We need to have these whakawhanaungatanga hui more often so we all know who's who out there and what we're all doing " (Hairini Marae, 1999). These comments markedly depict the changes that have taken place in Maori health development over the past decade and a little beyond.

It would be fair to say that Maori health services in Tauranga and other parts of Aotearoa have not just happened. To appreciate the changes that have taken place resulting in more Maori services and an increase in Maori health staff, it is necessary to revisit the Maori health journey, especially over the past decade. Without the drive and passion for tino rangatiratanga made by Maori with vision for kaupapa Maori development in the last decade, and the years beyond that, it is highly likely that Maori mental health patients would not have access to such services today. This history is significant for its effects on discharge planning for Maori mental health patients in that a foundation for Maori health services has been laid, and is now able to be built upon and expanded. A broad account of that history, including two major conferences which contributed to this development, can be found in Appendix 2.

Community care, mainstream services

Maori currently have choices in the services that they want to access. One option for Maori mental health patients is mainstream services, whilst another choice is kaupapa Maori. However, where Maori patients are not able to access kaupapa Maori services, they do not have a choice. In some cases this could be due to lack of either fiscal or human resources. In Tauranga there are both mainstream services and some kaupapa Maori services.

The Tauranga Hospital mainstream services in community mental health comprised four multidisciplinary teams covering four geographical areas. The teams include psychologists, social workers, occupational therapists, clinicians and nursing staff. A team of nurses is also available on twenty-four hour rostered shifts to provide rapid response services to mentally unwell people in crises. Additionally, another two teams of nurses provide intensive home-based care in acute situation, and they have a budget available to provide crisis respite.

Furthermore, post-discharge patients have access to clinicians at out-patient clinics and have regular follow-up appointments with their responsible clinicians. Tauranga Hospital also provides men's and women's life skills and social programmes for those who have been diagnosed with a mental illness, as well as educational groups for mental health patients with dual diagnosis, the description given to people with both a drug or alcohol related illness as well as mental illness. Plans for therapeutic group work are being considered within some of the multi-disciplinary teams. At present a lack of resources has seen such programmes that were formerly in existence, come to a halt.

Within the community in Tauranga, an independent and autonomous mainstream service provides a range of day activities and programmes for mental health patients. Attendants are able to socialise there, and a daily cooked meal is a part of the services. A number of the staff are Maori who assist with programmes centred around cultural activities such as bone and traditional wood carving. In the community, some of the other therapeutic resources are life skills programmes, budgeting advice groups, women against violence groups, thrive and survive groups as well as self-esteem building classes. These programmes are not specifically for mental health patients but are available to any who wish to attend.

Ten private residential housing services accommodate mental health patients in the Tauranga and Te Puke areas with facilities for those needing supervised care to those who are semi-independent. These homes are available to both Maori and non-Maori. There are four houses, accommodating 15 patients run by Maori specifically for Maori mental health patients. Altogether there is a total of fourteen residential homes in the area. Despite these residential houses, there is still a large gap in accommodation for mental health patients. (See chapter six).

Services, although important, are but one aspect of a person's wellbeing. As Durie emphasises when he writes that it is essential that:

> *the institutions of society are nurturing, that families, whanau and communities are strong and supportive and that the policies and laws of the nation are consistent with the dignity of the individuals (cited in Te Mana Putea Hauora O Aotearoa, 1999:9).*

The Mental Health Commission (1998) also maintained that the improvement of mental health services needs to be accompanied by a contribution and commitment from all sectors such as health, housing, welfare, education, employment, justice, police, local governments and community agencies, to name a few. Although the various sectors are starting to work more collaboratively, this is a relatively new approach, and more time is needed to evaluate how effective this model is.

The paradox still remains that for many whanau and communities, the impact of receiving the unwell into their care, places strain on already burdened situations.

Conclusion

One of the objectives of the discharge planning guidelines put out by the government in 1993, is to ensure that patients receive adequate care and treatment in the community after they have been discharged. To achieve this, the guidelines suggested that a formalised system aimed at greater attention to discharge planning, better information and monitoring systems, co-ordination and continuity of care as well as early intervention services, could help improve the situation for people with psychiatric disorders who are discharged from hospital. The purpose of the guidelines was to assist mental health services throughout Aotearoa, with a framework of uniformity in discharge planning. This means that when services were using the guidelines, mental health patients could expect similar types of service and treatment throughout Aotearoa. As previously mentioned, this had not been the case in the past.

Discharge planning would be a futile task without mental health services in the community. This chapter includes a section on both kaupapa Maori and mainstream mental health services in Tauranga, at primary and secondary levels of mental health and generic health care. This broad range of Maori health services has developed alongside other Maori national development strategies, significantly, Hui Taumata in 1984, Hui Whakaoranga in 1984 and Te Ara Ahu Whakamua in 1994. (See Appendix 2). This is the foundation for local initiatives which saw kaupapa Maori established.

This chapter has been woven as a kete using the threads of the key principles of discharge planning against the background of the Mason Report. It is important to remember that the range of culturally safe services provided by and for Maori form the base for the kete, while the local mental health services of both kaupapa Maori primary and secondary services form the sides. The kete in its completed state will hold the stories of the turoro and mental health staff, the participants in this research.

Chapter Four - Methodology

Introduction

This chapter begins by defining the research framework and describes the methodology used in this research which comes from a kaupapa Maori theoretical base. This is followed by a description of the preparation for the research and the processes used to collect the data. An increasing number of Maori are presently involved in research. This is borne out by the published proceedings of the Te Oru Rangahau Conference held at Massey University in 1998. The Proceedings include92 papers from the Conference, most of which were presented by Maori researchers. The final sections of this chapter describe selecting and meeting the research participants.

Defining the research framework

Kaupapa Maori research in its simplest form can be described as "by Maori for Maori". However, in the late 1990s researchers promoted various frameworks to describe the characteristics of Maori research. One such framework, promoted by Chris Cunningham at the Te Oru Rangahau Conference (1998:398) identifies four types of research. At one end is "Research not involving Maori" and has no impact on Maori. "Research involving Maori" is where Maori are involved as subjects. Both of these are controlled by mainstream organisations and analysis is in mainstream. At the next stage is "Maori-centred research", still controlled by mainstream, but with major participation by Maori. At the fourth stage, Cunningham describes "Kaupapa Maori research" which is controlled by Maori, produces Maori knowledge, where standards are set by Maori, the analysis is Maori and the control is by Maori.

This research is undertaken by a Maori research student under the supervision of Maori and non-Maori staff at a mainstream education institution - a university. The researcher works in a provincial hospital funded by mainstream, but within a kaupapa Maori unit, which provides Maori patients with services.

The patient participants in this research, all Maori, were former patients of the hospital. The staff participants were both Maori and Pakeha. Therefore if one "uses the framework to establish location" (ibid:400) of one's research, the questions which need to be asked are about "control" of the research, participation by Maori, the methods used in the research, and the analysis.

Using Cunningham's framework of Maori research descriptions, this research therefore is "Maori-centred research". The "control" for the research was with both mainstream and Maori, whilst participation was mostly by Maori. Both Maori methods, such as hui, and contemporary methods, such as the discharge planning guidelines - which were the assessment tools – were used in this research. This research has collected Maori data, and has applied a Maori analysis and results in the provision of Maori knowledge. Both as the researcher, and as a worker in Maori mental health, the present author uses a methodology that is conducive to researching the needs of other Maori in a culturally sensitive manner. This includes obligations to respect, and work within, a Maori cultural framework.

Inside of the framework of "Maori-centred research" my own values of who I am as a Maori, are the guiding principles of the research. One of those principles is "by Maori for Maori". In this case, the term describes the Maori researcher, doing research for Maori. However, I would change that around and put the emphasis on "**for** Maori by Maori" which shifts the focus of the recipient to a more empowering position and is the term that underpins my theoretical beliefs and base. Another guiding principle I have used in this research is "whanaungatanga". According to Bishop (1998:130) the concept of whanaungatanga as a research strategy has three major overlapping implications. Basically, the first is that the researcher is involved in maintaining and establishing relationships with 'whanau of interest' which is often an ongoing part of the research process. The second implication is that the researcher is involved in the process from a physical, ethical, moral and spiritual position and is not concerned just with the methodology. Lastly, by establishing relationships "in a Maori context addresses the power and control issues fundamental to research, because it involves participatory research practices". I agree with Stokes that research for Maori " simply for the sake of knowing is pointless "(1985: 125). It has been my intention from the beginnings of the seed that was sown in my mind for this research that turoro and their families will benefit in some way from their own stories, input and time. It is from this perspective that I have used the same principles as previously described by Bishop, as the guiding principles for this research.

Consequently, the responsibility on Maori researchers particularly "for Maori by Maori" carry obligations of both academic requirements as well as the exigency for the Maori participants, in that the research is not only about them but for them. The focus of this research, mental health, also presents its own needs as for too long it has been seen as the "poor second cousin" in health, and treated as such. Williams (1987), in writing about mental health patients, suggests that historically, they were locked in asylums where they predominantly were out of mind and therefore out of sight. A shift towards deinstitutionalisation over the more recent years and where mental health patients are supposedly permitted to have a say in their treatment and discharge, now theoretically allows for them to have the same opportunities for a fulfilling life following discharge as other hospitalised patients with either medical or surgical health needs. This research will give some indication of the effectiveness of discharge planning for Maori mental health patients in a local area.

Although I have not been a mental health patient myself and cannot interact from that experiential level, I am Maori and so understand some of the historical injustices that Maori have suffered in Aotearoa, namely losses of land, language and identity. It is from this perspective, too, that I can understand some of the injustices that have been meted out to mental health patients, an example being stigmatisation. I have recollections of the stigmatisation of being Maori in a predominantly non-Maori school and have experienced the effects of stigmatisation. My koha that I contribute to this research is that from a kaupapa Maori base and framework I bring my knowledge and experience as a Maori mental health worker. I have been involved in setting up secondary services for Maori using mental health services, and also have whanaungatanga relationships with turoro and their caregivers at the secondary/primary interface in the communities in which they live. A part of the research was also with mental health workers, and their stories and experiences have contributed towards this research.

Some perspectives and justification for Maori research

A significant event in the area of Maori research was Te Oru Rangahau Maori Research and Development Conference mentioned earlier. The conference presented opportunities for Maori to discuss issues relevant to Maori development as well as providing Maori researchers with a collective venue for sharing and pooling information. Attendance at the conference shows that more Maori are becoming involved in research, possibly realising the level of importance and involvement needed to make gains in a range of Maori development areas including hapu and iwi developments, health and social science issues, law, education and Treaty issues and claims. In Durie's (1998, 408) concluding comments at the hui, he stated that:

> *Had a Conference on Maori research been held ten or fifteen years ago it might well have attracted scorn rather than enthusiasm. Maori people and researchers have not always enjoyed each others company. Indeed for many years Maori participation in research was confined to filling out questionnaires and donating blood samples – and then hearing how bad it all was. The obvious truth, that research about Maori made little sense without active Maori involvement, had not yet arrived...Research relating to Maori development will do more harm than good if it fails to recognise the determination of Maori people to advance into the next century with improved standards of health, higher educational achievement, greater mobility to navigate the world, and to do all of those things while retaining a secure Maori identity, a distinctive* world view, and a sense of control over our own destiny.

From a paper submitted at the hui, Mutu (1998:51) states that "Research is all about the pursuit of knowledge which, in turn, is the key to the world and everything in it. Knowledge is also the key to power and everything in it". This is based on a whakatauaki or Maori proverb:

> *Ko te manu e kai i te miro, nona te ngahere,*
> *Ko te manu e kai i te matauranga, nona te ao.*

Stokes (1985) in discussing research states that a great deal has been written about Maori, mainly by Pakeha researchers and within the constraints and methodologies based on Western theories. She goes on to comment that:

> *There is an increasing awareness in the Maori world that Maori have been guinea pigs for academic research; that some academics have made successful careers out of being Pakeha experts on Maori; but that Maori have not gained a great deal by the process.*
>
> (Stokes, 1985: 125).

Research then, has often in the past been treated with suspicion by Maori, particularly as the information is about them and yet the recognition for either their stories or data has not seemingly returned to them (MacDonald, 1993). Another past criticism of research on Maori is that it tends only to highlight and reinforce negative statistics whilst very little has been done to provide guidelines for change (Stokes, 1985; Roa, Ropiha & Wilkinson 1993).

I would have to argue, however, that there has been a significant shift by Government Departments such as the Ministry of Health and Te Puni Kokiri over the more recent years that have seemingly consulted with Maori and sought to provide guidelines for improvement in Maori health and social services. This is evidenced particularly in mental health by two examples of recent documents, 'Looking Forward' and the 'Blueprint for Mental Health Services in New Zealand'. Both of these publications contain specific sections providing guidelines for improvement to Maori mental health care. One example from the Blueprint is that identification and support towards kaupapa Maori services with the need to provide their own cultural treatments for patients including:

> *whanaungatanga, whakapapa, cultural assessment, empowerment of tangata whaiora and their whanau, te reo Maori, tikanga Maori, kaumatua guidance, access to traditional healing, access to mainstream services, and use of quality performance measures which are relevant to Maori"* (Mental Health Commission,1998:62).

Although there appears to be more emphasis on a specific focus for Maori as a result of research, the statistics continue to confirm that Maori still have the poorest health and social status. Maori health, education and income levels have not benefited from research carried out on them. A suggestion offered by Stokes (1985:126) is that in research "perhaps the wrong questions have been asked". She comments in 1985 that presumably the policies of "assimilation" or "integration" have failed for Maori, while in 1996, Bishop noted that "efforts at producing positive effective policy towards change" had failed. Ropiha et al. (1993) also maintain that the insensitivity of research groups working in Maori communities should be reduced, resulting in a further reduction of a negative view of research for Maori. That is not to say that there is not a place for non-Maori in Maori research. Both Stokes (1985) and Bishop (1996) extol the virtues of non-Maori research. Bishop (1996:17) suggests that among some non-Maori researchers "there is a cohort of highly skilled, professionally trained non-Maori who are becoming bicultural and who are willing to work within Maori-controlled contexts". He maintains also that non-Maori leaving all Maori research to Maori "abrogates their responsibilities as Treaty partners" (17).

With the numbers of Maori now involved in Maori research as identified at Te Oru Rangahau Maori Research and Development Conference, it would appear that more research by Maori will continue in the various areas of Maori development, an will impact on policy change. Dr Ngatata Love (1998:11) states that:

> *Research will help us understand what is needed. Sound research will also provide us with solutions. Maori control of research will provide the confidence we have in data collection and analysis that the nation as a whole needs.*

This section discusses the importance of Maori research. Although there is not one definition of kaupapa Maori research, since the late 1990s, more Maori researchers are defining and describing cultural research practices and frameworks. Cunningham (1998) describes an analysis of Maori research from a four-part gradient of "not involving Maori" at one end, to "kaupapa Maori research", involving Maori researchers, Maori analysis, standards and knowledge, at the other end. As more Maori are involving themselves in research, results and findings should impact on policy change.

My journey leading up to the research

I will now use an analogy of the growth of a seed to describe the journey leading up to the research as I have traced it. The seed for this research was sown a decade ago in 1990. The seed was the concern about discharge planning and how patients and their families were going to cope in the deinstitutionalisation process. The fruit from that seed is this research. However, the fruits that were to come from the seed were not known at that time. On reflection, the journey from the seed to the fruit has been for me, more an integral part of a natural evolving course cultivated by, and based on, my experiences of working first in a marae-based community health initiative, and then a kaupapa Maori mental health service.

In 1990, the time that the seed was embedded in my mind, I was not working in mental health, and neither were there any Maori mental health services either in the local hospital or in the community in which this study took place. Nonetheless, the projected thoughts of how Maori were going to manage as more of the whanau were going to be rehabilitated in their communities was always something I thought about. Possibly this was driven, too, by the lack of resources both monetary and of personnel of which I was aware for Maori health at that time. I worked at Whaioranga Trust, Te Whetu Marae Tauranga, which was among the first marae-based Maori health initiatives in Aotearoa. In my role of providing whanau health and social support including education - within the community, I had started to witness the stresses and anxieties of Maori families in Tauranga who were being pressured by staff in the larger psychiatric institutions to take their whanau members who were in those hospitals, and who were ready to be discharged. Some families with whom I was working h in the area were contacted, mostly by telephone, and asked to take whanau members, some of whom they hardly knew because the family members had been brought up in other towns, or they had not had contact with them for a number of years.

One particular kuia in her seventies, who had a multitude of her own health problems, was contacted by psychiatric services about a mokopuna who needed to be discharged. The kuia was whakamaa in asking me to help. She had confided in me that she was unable to have her mokopuna as she knew that she was barely coping as it was. At the same time she felt guilty because her mokopuna needed to be discharged from the hospital he was in. I assisted her through a process of decision-making taking into account all the health and social factors. To have to refuse to have her mokopuna was not an easy decision for her to make, but in her case, that was the one that was best for her.

Another experience I share along this journey is that in 1990, one of my tasks was to help host a national Maori health hui at Te Whetu o Te Rangi Marae in Tauranga Moana. The focus of the hui was ' Prevention of Premature Deaths for Maori'. Through witnessing the beginnings of the deinstitutionalisation process within our Maori community and with these thoughts uppermost in my mind, I voiced my concerns about the effects of pending discharges from the psychiatric institutions to our local area, and the effects on families - particularly those who, for their own health or social reasons, were not able to cope.

My passion and interest in mental health and discharge planning concerns for Maori seemed to diverge from the other more common medical health concerns of cardiovascular diseases, diabetes, respiratory diseases, cancer and reduction of smoking and alcohol issues. At that time, few of the workers present at the hui were experiencing effects of deinstitutionalisation and the discharging of their whanau into the communities. However, patients were moving back into their communities. Almost ten years on it is a different matter as health and social workers, communities, and families themselves have been, and continue to be, involved directly or indirectly in the ongoing deinstitutionalisation process of the mentally ill. I would argue then, that it is timely to research discharge planning for Maori mental health patients in our rohe to find out how they are faring, in their transition from the hospital to their place of residence or rehabilitation.

In 1995 I took up a position with Te Puna Hauora, the kaupapa Maori health unit at Tauranga Hospital. It was here that a specific focus on mental health took place for me as I set up the whanau counselling services which were the start to the Maori mental health services. Since that time, I have been involved in guiding and leading the Maori mental health services and developments within our mental health team. This has been with the support of our management team and structure.

Often the developments have been slower than the identified needs would indicate, as our management team have had to struggle for resources and positions. There has been an increase in both staffing and developments over the past eighteen months as outlined in detail in the previous chapter. However, as in many examples of government health and social services, the morbidity statistics for Maori remain high, whilst equitable resourcing for culturally appropriate services has not yet been achieved.

On reflection, my journey in the mental health field has gathered momentum as my own roles have increased and expanded along with services for Maori. So, too, has the idea of studying "the effectiveness of discharge planning for Maori". If the korero from this study is able to reflect the voices of the people towards policy and practice changes for improvements as they see and experience it, then this journey is not in vain.

Preparing the ground

One of the first tasks in establishing the process for this research was to korero, at either a whanau, consumer or a professional level, with other Maori who were in some way connected with Maori mental health. The reason was to gauge responses to my thoughts and ideas of examining the effectiveness of discharge planning for Maori mental health patients. This happened in an informal way almost a year before the proposal was forwarded to the university. There were two main reasons that protocols of approval needed to be sought. The first was that this research was going to be about Maori who were sick and vulnerable, and the second reason was that I needed to talk with kaumatua and kuia about the protocols of researching potential participants from different iwi. I also discussed the idea with my Maori work colleagues as well as my mainstream colleagues in mental health. If I had not gained approval or support from those groupings of people at the start, it would not have been possible to continue with the idea.

Firstly, I needed the sanction from tangata whenua in Tauranga, as although my whakapapa links are to Ngati Pukenga, one of the iwi in Tauranga, this linkage has been a recent discovery for me. Regardless, one needs to consult with kuia and koroua and appropriate others, as a matter of protocol, especially in community issues concerning other people. In Maoridom, this may be carried out in both a formal and informal hui process. For this research the process used for gaining support from the tangata whenua was an informal one. Nevertheless, the obligations to respect the mana of all participants is an expectation. Secondly, both Maori and mainstream management groups were informed of my intention to undertake this research.

Ethical issues and dilemmas

The next stage was to submit an application to the Ethics Committees of both Massey University and the hospital. The hospital Committee approved the proposal at the first meeting after having received it, whilst the proposal from the university ethics committee took almost a year. The problems arose in relation to conflicts of interest, approaching mental health patients, a research method that was to be problematic and difficult. Another potential problem was that I was also a staff member of the hospital working in mental health which could have caused a conflict of roles.

My initial plan was to approach potential participants on the ward myself to inform them about the research. As an employee of the hospital I was quite aware of the ethical issues. However I was not based on the ward and I had proposed that I would not invite anyone to participate if they had been, or were, recipients of my services. Under the guidance of the Ethics Committee I was instructed to inform staff on the ward about the research and the need for participants. It then became the task of staff to inform patients and gain consent. This method, I believe, stagnated the process for acquiring participants. One example was that a nurse on the ward had informed some patients about the study and six people signed their consent forms. When I contacted these people, some withdrew because they had thought erroneously that participation would assist an early discharge, and others withdrew because they had signed up on account of knowing the nurse but declined because they did not know me. Other reasons why I believe that this process held up the study was that I had to keep reminding staff to inform patients, and as staff were often very busy my request was frequently not among the top priorities in their schedules.

It was during this period that, in supervision, a suggestion was made of asking Maori and mainstream mental health workers to be part of this research. Another idea was to talk with Maori who had been discharged from the ward to find out if they would be interested in being on the programme. I used the process set out by the ethics committee in that I informed staff who were running mental health day programmes about the proposal, who then in turn asked attendees if they were interested in knowing about my research and from there a hui was set up. This fits the cultural concepts of whakawhanaungatanga and the hui process. I maintain that the process I was instructed to use where I was not able to form whanaungatanga links with prospective participants at the beginning, from a cultural perspective, cut across the essence of "No hea koe? "Ko wai koe? (Where are you from and from whose waters do you come?) which is the fundamental and necessary starting place in any Maori relationship and meeting. This sets the course and opens the way for whanaungatanga, korero and ongoing hui. Walsh-Tapiata (1997:175) believes that an awareness of Maori ethics and approaches needs to be considered by ethics committees particularly as more research applications are coming from a hapu or iwi based perspective. She further suggests that unless more Maori are on these committees the lack of knowledge for alternative theories has the tendency to "continue the process of colonisation which validates western models and creates constraints whenever alternative models are offered" (1997:176).

The participants finally were made up of one patient who consented prior to being discharged from the ward, five patients already discharged into the community and six mental health staff. The staff participants were easy to recruit. Each person approached volunteered immediately, these were the first six asked from both primary and secondary interfaces of mental health care working both in mainstream and kaupapa Maori services.

Establishing the process

After more than six months with only one research participant, and with the guidance of my supervisors as previously mentioned, I started to interview staff who were involved with discharge planning of Maori mental health patients. I chose to ask both kaupapa Maori and mainstream mental health workers providing secondary services from the hospital who were involved at various stages of discharge planning for Maori mental health patients. I also selected staff participants from among some iwi mental health workers who were involved in caring for patients upon discharge from the ward. None of the staff participants had any hesitation about participating in the research. I contacted some by telephone first, and then met with them to inform them of the study. Others, I met with first to hui about the research.

Collecting the data

Choosing to interview the mental health workers turned out to have been an excellent move, as they had a huge amount and variety of experience of the issues facing discharged patients, and were more than willing to share their knowledge with me. Nonetheless, I had not given up on the original plan of seeking the korero of the turoro. It was now a matter of how best to do that. The strong belief that it was best to hear from the patients or people who had experienced mental illnesses themselves was borne out of a personal conviction that, because this was about them, then somewhere in the study we needed to hear their voices. Maori mental health patients need to be able to tell their own stories. I agree with Petersen (1998:5) that:

> *There is no substitute for a consumer's perspective on their own experiences. Others' interpretation of consumers' experiences may be important, but this can be sought alongside of, not instead of consumer perspectives. The voices of people with experience of mental illness are no less valid than the voices of family or mental health professionals, and need to be given equal weight.*

Perkins (1996:40), in discussing research which listens to the viewpoints of people with disabilities, also reiterates that "By sharing stories, individuals can gain an understanding of their situation and, therefore, transform their situation".

I therefore set about obtaining interviews with Maori who had experienced mental illness, been discharged from hospital and who were now living in the community. Through informing staff providing ongoing care for people who had been discharged from the hospital, hui were set up where I informed them about the project and from that point, ex-patients contacted me themselves if they wanted to be part of the research. This method was highly successful and, within a few weeks, I was able to set up hui with all those intending to be in the study. Maori patients had either whanau members with them at the hui or their whanau support workers, and sometimes both. Interestingly enough, although the patients were at various levels of cultural identity, out of the six, four chose the hui as a means for their korero, whilst two people selected the individual approach. For those who had their korero on their own, it appeared that an interview on their own was the most convenient way for them at that time due to other commitments, rather than lack of cultural identity. In a summary of the information seeking and gathering process, the two groups of participants - being the six patients and the six mental health workers - used both the hui process as well as individual interviews as a means of sharing their korero.

Another part of the information gathering process was to examine the patient files concerning their discharge plans. Wealleans (1998:5) describes triangulation, that is the process whereby information is gathered from different sources, such as the example in this research which used both patient and staff interviews as well as the discharge planning documentation obtained from the patient files.

Consent for me to access and peruse patient files for the discharge planning purposes of the research was first obtained from the patient participants. In gaining their consent I had to ensure that they understood that I would be looking at the files for the research. Because accessing the files was not for treatment purposes, the signed consent forms then went forward to the Clinical Director of the hospital who is in charge of all the patient files. Three of the six patient participants agreed for me to access their files, signed consent forms and each form was then added to their files. The other three patient participants were not able to be contacted at that time.

The sample of participants - the turoro.

Using purposive sampling can increase the breadth of information obtained. This entails the purposeful selection of information sources to acquire as broad and in-depth knowledge as possible (Patton, 1990). Rather than attempting to apply criteria (for determining the adequacy of sample size) derived from quantitative methods, the adequacy of purposeful sampling should be determined by considering the objectives of the study and the sampling strategy used to achieve the study's purpose. As Patton (1990: 185) states:

> *The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information richness of the cases selected and the observational and/or analytical capabilities of the researcher than with the sample size.*

As with any research, bias may cause distortion of the findings. Recall bias and observer biases are potential problems in purposive sampling and interview based qualitative research (Robson, 1993:30). The effects of these biases were minimised by ensuring that the number of interviews undertaken to the point of redundancy where no new information was collected (Denzin & Lincoln, 1994: 230; Yin 1994). The researcher needs to explicitly describe the reasons for their choice of sample size and participants, and to explicitly describe both the collection and analysis of data. This will allow the reader to make an assessment of the credibility and objectivity of the observer (the researcher) who is subject to peer review, consensual validation and judgement (Patton, 1990:186).

The final sample selection is six mental health staff both Maori and non-Maori, and six Maori people who have experienced mental illness. The gender mix of the patients is three men and three women, whilst among the staff interviewed for the study are four women and two men. A gender mix as well as both Maori and non-Maori staff, provided the opportunity for a range of opinions and experiences.

The ex-patient participants have been given pseudonyms. All, except one, gave permission to be identified by their iwi. Iwi identification where the patient participants claimed linkages to more than one iwi were Ngati Ranginui, Tainui, Ngati Pikiao, Te Arawa, Te Rarawa, Ngapuhi, Te Aopouri, and Tuhoe. The patient participants had been diagnosed with: bipolar affective disorder, schizophrenia, personality disorders and chronic drug and alcohol related illnesses including dual diagnoses.

Johnny

Johnny is a young Maori male in his mid-twenties, who has been in psychiatric care for the past two years. He lives in a small rural area among his hapu. Johnny is the only person in the study who gave consent and agreed to be a participant for this research whilst he was still a patient in the ward. After receiving Johnny's consent form I contacted him at the telephone number he had given. He had since been discharged, and was living at home with his grandmother. I explained a little about the study and asked if he was still interested in being involved. We then set up a time and place for a meeting which was to be at his grandmother's house. Johnny was attending a Polytechnic course, and therefore the appointment had to fit in with his course commitments. We agreed to meet on a Friday two weeks away.

On the day of the appointment, I was set to travel out into the country where Johnny lives, when I was called to the psychiatric ward. During my ward visit, I found that Johnny was attending a day treatment therapy programme there. After his therapy group had finished I asked one of the staff to inform him that I was there. I thought that, by asking a staff member to inform Johnny that I was there, but I was giving him the option to withdraw if he had changed his mind. He had not changed his mind and we met in the whanau room. This room is always kept locked unless individuals, families or staff are using it for hui. The room offers privacy, situated in a corridor away from the main service areas. When we met, we first shared basic whakapapa and whanaungatanga. Chapter two discusses the importance of making the whakapapa or whanaungatanga links that are essential for Maori in building relationships and connecting,. After that, I explained the information sheet concerning the research. Johnny was only too willing to have an input. Johnny said that he had been busy with his courses and had forgotten about our meeting. I asked him if he preferred to make another interview time but he said he would rather we talked at that time than set up another meeting. Johnny had his korero there in the whanau room which was locked from the inside so there was no possibility of interruption or intrusion and the control for that lay with us.

Haare.

Haare is a Maori male in his early thirties. He has been in psychiatric care and rehabilitation for the past ten years. Haare had been approached by one of the iwi mental health workers who had explained the study to him. He came to see me at my place of work without prior notification or any form of meeting. He lived in a residential house near to my office, and said that it had been convenient for him to "drop by" that morning. Haare was keen to be involved in the study, and said that he did have ideas about mental health. He submitted some written material which offered his ideas and thoughts on community services for Maori mental health patients. We arranged a time to meet and korero. At the time, Haare was a resident under an Inpatient Treatment Order and he felt that he would remain under that order for a lengthy term due to the nature of his illness.

I found it interesting that he had taken the initiative to make contact with me before I had had the opportunity to contact him. He did appear to be a busy person, as he informed me that he was also attending a day programme. However, he was able to maintain a sense of confidentiality particularly from his place of residence by coming to see me at work. His confidentiality was assured at my work because we have a wide range of people calling in for a myriad of reasons, so no-one else around at that time would have known what he was there for, only that he was seeing me. Haare had held a professional position before he became mentally ill. His mental illness, stemming from misuse of drugs ten years ago, resulted in psychosis. Over the years, Haare's mental state has deteriorated. Haare is now typical of a "revolving door" syndrome person, which describes the group of patients who repeatedly return to hospital. As stated in the Mason Report (1988:137) "Often, hospital staff become dispirited by this pattern of simply placing band-aids on those who need more intensive care, but for whom they can provide little more than a brief respite".

In the past Haare has been discharged back to his whanau, and at times discharged from hospitals to compulsory residential care. At the time of Haare's latest discharge, he was living in a residential home under an Inpatient Treatment Order which requires "the patient to be detained in a specified hospital and to accept treatment" (Ministry of Health, 1992:26). In Haare's case, the reason he was under the Act was that his mental illness had deteriorated, often through non-compliance with instructions concerning medication or treatment, and he was not able to take care of himself.

Hine

Hine is a Maori woman in her early forties. She has been in and out of institutions and psychiatric wards over the past twenty years, following the birth of her first child. She, too, is a "revolving door" syndrome patient. Both Hine and her whanau believe that, prior to hospitalisation and treatment, she had been suffering from a long term of post-natal depression which went undetected and untreated because of lack of knowledge by the family of such a condition.

Hine chose the hui process where she had her whanau support workers present, one of whom was related to her. Through asking mental health workers if they would inform and ask those of their turoro about the study, I was then contacted by the workers when turoro indicated that they wanted to be involved. Hine and two mental health workers decided that they wanted to be part of the programme, and it was agreed that they would hui with me. Hine wanted them to be with her as she is quite a shy woman and felt more comfortable that they were going to be with her when she spoke with me. The hui was held at the home of one of the whanau support workers. Hine was quite shy and spoke very softly. When she had finished what she wanted to say, it was clear that she "had had enough" and she stated that she felt tired. I was sensitive to her wishes, and ended the hui when she wanted to.

Charlotte

Charlotte is a young Maori woman in her early twenties. She has only once been admitted to the psychiatric ward for a three day period, and therefore has been discharged only once. Although her stay was short, she had been using mental health services in the community from time to time over the previous two years. Charlotte entered the mental health system in a state of crisis, having attempted to commit suicide as a means of escape from extended whanau who were physically beating and controlling her.

Charlotte chose to be involved in this study using the hui process at her place of work where she is employed as a clerical assistant at a mainstream day programme for mental health rehabilitation. Charlotte informed friends and staff that she was going to be a participant, so she elected to disregard her own anonymity. She seemed proud to be "helping out" on the study. The hui took place in the administration part of the building where staff frequently came and went, as this was also the space where they gathered for morning and afternoon teas. Charlotte was very bright and bubbly and excited about life itself. She lives in a flat with her partner. She has a job, and stated that she is able to look after herself.

Bernadette

Bernadette is an elderly Maori woman. She had been approached by her community nurse about the study. Bernadette has been a long-term patient who has experienced the transition from institutionalisation to community living. Bernadette began her treatment almost thirty years before, when psychiatric patients were largely seen as long-term and incurable (Williams, 1987:12). Perhaps that same attitude continues to influence and permeate Bernadette's ongoing long-term deinstitutionalised care plans is indicated by her constant readmission rate and lack of personal involvement in her own discharge plan.

I met with Bernadette in her own home, where she lives with her husband who is also her main caregiver. She appeared to be very abrupt and was making derogatory remarks towards her husband. She also seemed to be quite suspicious. She made some remarks that bordered on being inappropriate and I gauged that it was possibly better to bring the hui to a close with minimum attention. Bernadette invited me to speak with her husband about her care but the invitation seemed to be more in the form of a challenge. I decided not to talk with him, although his views on discharge planning could have been of great value particularly as he had nursed his wife over the thirty three years. It was more important to reassure Bernadette that my purpose there was to see and korero with her. Our meeting was quite short, and soon after she was readmitted to the Henry Bennett Centre.

Matt

Matt is a Maori man in his early forties. He is a newcomer to the mental health system, having entered as a result of a suicide attempt two years ago after a relationship breakup. Since that time he has been admitted to the ward in Tauranga twice. Matt also has drug-induced psychosis. At the time I interviewed Matt, he was well on the way to recovery, and was holding down a full-time job.

Matt lives with a brother. Because he does shift work he arranged to come and talk with me after one of his regular follow-up treatment sessions at the hospital. For him, that was a more convenient time and place, and was easier for him to manage. I ensured that we had access to a room that was private, and assured Matt of confidentiality. It was a room with which he was already familiar and comfortable. Matt chose to come on his own as he had just come from work, and his previous appointment coincided with that. He was familiar with the hospital and appeared to be relaxed, although he said he was tired after having just completed his shift. The venue was in a building that was private and peaceful.

Staff participants - the kaimahi

The six staff participants are people who are working with mental health patients at both the primary and secondary interface of mental health care. Some participants are employed at the hospital and were willing to be a part of the research as long as anonymity was assured. With the hospital carrying a staffing of approximately fourteen hundred, and the mental health staff numbering about one hundred and thirty, there is a high chance of recognition if we were not careful. Hospital participants have not been identified by nationality so as to help retain anonymity. There have been changes of systems, structures and leadership in the hospital over the past two years that some staff have found problematic at times, and some have found that being outspoken has not appeared to be welcomed. Some of the staff participants are working with the patients at the primary interface, and those who are iwi workers felt no threats from identifying themselves by their iwi, however did not wish to be personally identified. All of the staff participants invited to be involved in the study were more than willing to contribute their opinions and experiences of issues around discharge planning of Maori mental health patients.

Of the six, two are psychiatric nurses, and the remaining four are a mix of social workers and whanau support workers. One of the six is a supervisor of a residential home. All of the participants are in their middle years, and between them have seventy-five years of mental health work experience. Iwi identifications where the Maori participants claimed linkages to more than one iwi, were to the Ngati Ranginui, Ngaiterangi, Te Arawa, Ngati Pikiao, Te Aitanga a Mahaki, Kai Tahu, Kati Mamoe and Ngati Raukawa tribes.

The mental health whanau support workers seemed to be very involved in their community which included their services as well as their marae commitments. They also appeared to have in-depth knowledge about the people and the activities that went on in their community. This was reflected by their korero on how they had fostered their whanaungatanga relationships within their community which then enabled people to call them, often at the early intervention stages of mental health or social support issues.

Conclusion

In conclusion, this chapter has described, and presented justification for, the Maori-centred research methodology used. My own journey leading up to the research provides the reader with some insight into my reasons, passion and interest in the area of Maori health, and more specifically, mental health. I have described the participants, ensuring anonymity.

The participants included both patients and staff. All the patients were Maori. However, there was a mix of Maori and non-Maori among the staff who took part in the study. Because the study is about Maori, it was necessary that all patients in the study were Maori. The mix of Maori/non-Maori staff, though, was a deliberate choice for two reasons. Firstly, not all Maori mental health patients are cared for by the kaupapa Maori team in the ward. Secondly, once discharged the patients use a further range of services provided by both Maori and non-Maori. Therefore it seemed important to try to get a cross-section of participants providing services for Maori patients discharged from the hospital, and who were now living in the community.

Chapter Five - Telling Their Stories

Introduction

This chapter examines the success of discharge planning from the perspectives of the participants. Because the study is about the effectiveness of discharge planning from a hospital ward, I will be referring to the ex-patients as patients, because the research is about discharge planning processes that they had experienced, whilst they had been inpatients at the hospital. There are three themes of discussion in this chapter. The first theme centres on whether the patient had felt included in the process. The second is whether whanau had been involved. The third theme concerns whether the patients felt they had control in what was to happen with their care and treatment after discharge.

Of the six patient participants in this study, two were discharged from the hospital into supervised residential care and the remaining four were discharged to their whanau. One of the patients in supervised residential care was under an Inpatient Treatment Order issued under Section 30 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. The two key objectives of the Act are firstly, to establish whether treatment for mental disorder is required, facilitating the provision of treatment in the least restrictive environment and secondly, to ensure the enhancement of rights of the patient (Department of Health,1992:2). Chapter one of this thesis refers to the prerequisite for compulsory assessment and treatment under the Act which is "an abnormal state of mind characterised by delusions or disorders of mood, volition, cognition or perception." The abnormal state of mind described within the Act has to be of such a degree that a person poses serious threat either to themselves or to others; or where the capacity of a person to take care of themselves is seriously diminished.

In my reports of discussions, the patients are named by pseudonyms whilst the staff are referred to by numbers. This has a dual purpose. Firstly this reporting system maintains confidentiality for all participants and yet distinguishes the responses and comments between those of patients and those of staff. The quotes from the research participants and me are in italics and my questions or statements are prefaced by the letter C.

Of the participants, all patients are Maori whilst the staff in this study are a mix of Maori and non-Maori mental health workers. The staff representatives come from three distinct work backgrounds. These are the Tauranga Hospital kaupapa Maori services - whose philosophies are to provide the choice of a service that is by Maori for Maori - with practice based in tikanga; the Tauranga hospital mainstream services whom the majority of the work-force are largely non-Maori - who work with high numbers of Maori patients; and lastly, some participants from hapu and iwi groups who work in collaboration with - but independently of - the hospital.

Discharge planning process - patient involvement

The first theme discussed is discharge planning and patient involvement. One of the key principles of the discharge planning process is that the patient's strengths, aspirations and goals for achieving a sense of well-being will be identified through as much participation and involvement as possible in their own discharge planning (Western Bay Health, 1997). It is thought that maximum involvement by patients could assist towards achieving a sense of well-being, by personal identification of strengths, goals and aspirations (Ministry of Health, 1993:6).

I have included some discussion and comments from each of the patient participants because individual patient involvement is a key principle. From the accounts of the six patients, who have previously been introduced in chapter four, their own personal involvement in their discharge planning ranged from rather vague or insignificant input to passive acceptance of plans made for them. I discuss further in this chapter some of the implications for both patient and the whanau when patients are discharged to their "communities".

Johnny

Johnny, who was the first patient I met with and interviewed, was the only one in the patient-group who was quite definite about his inclusion and involvement in discharge planning. Johnny stated that he had been a patient in the ward for about a month before he involved himself in his discharge plans. Prior to that, ward staff had tried to involve him, but because of his state of unwellness he avoided personal contact with staff, and distanced himself from people. His awareness of his actions and reasons - which is endorsed by his comment that:

> *Nah, I was quite unstable. I didn't really want to talk with anyone that time when I first came in. I was, like, distancing myself from people. I was sick and I didn't want to talk to anyone just then.*

According to Christ, Clarkin and Hull (1994), and Hochberger (1995), discharge planning needs to begin at, or shortly following, admission. From Johnny's account, the time of admittance was not an appropriate time for him to be involved in his discharge plans. A key point I would pick up here is that Johnny, although sick at the start of this term in hospital, was in a decision-making state which enabled him to make a personal choice about the timing of involvement in his discharge plans. Although he did not convey the message in a verbal way to staff, the avoidance, distancing, and his need to be left alone, were considered in his treatment and care. Johnny said that when he began to feel better, which was a month after admittance, he started talking and mixing with others including staff. It was at that stage that he readily became involved with discussions on his discharge plan.

In discussing patient involvement with Haare, he seemed resigned to the fact that he had no real say in his discharge planning, but alluded to being aware of plans made for him. Haare is on an Inpatient Treatment Order where clinicians make decisions about treatment, including residency, after discharge.

Haare

> *I'm on an Inpatient Treatment Order so it's the doctors who decide where I go. I'm in a rehabilitation unit but I was aware of where I was going to and the plans made.*

When I asked Hine about her involvement in discharge planning, she did not have a lot to say about whether her discharge planning involved her except that:

Hine

> *Yes I knew a nurse was going to visit me at home.*

Charlotte

When we talked about her discharge plans and personal involvement, Charlotte started off by saying that she had been included at the admittance stage of hospitalisation and that she had understood the plans.

> *I was included straight away in my discharge plans. I understood what was happening, where I was going to.*

On reflection however, she did not feel so sure about whether she was fully involved, especially in actually having an opinion and input. She later thought that she may have just complied and given consent to plans, mainly because she was not really aware of what was happening.

> *I think I just gave consent. I wasn't at first satisfied with the plans because I didn't really know much about it...I didn't have any questions about my discharge plans but I didn't fully understand because I didn't really know what it involved, because I'd never been in mental health before or any of those homes.*

Charlotte had been an adolescent in crisis at the time of her admittance, and this, coupled with her age and the fact that it was a first admittance, made it evident that a residential home was the more appropriate place for her. The psychiatric ward at Tauranga Hospital does not have separate facilities, at this stage, to accommodate a young client-group. The danger is that, when young people are admitted, their options are either to be totally isolated in their bedrooms, or to mix with older mental health patients in the ward - who sometimes influence the young with bad habits. This may be as simple as the language that is used, or extend to the influences of knowledge and direction towards drugs, both legal and illegal. The environment in mental hospitals is often not conducive to recovery for young mental health patients. Although decisions around her discharge plans were probably the best that could be made, I would argue that Charlotte did not have personal involvement and decision-making within the discharge process.

For patients like Hine - who is a very shy and a quiet person, and Charlotte - who was young and in a state of crisis and trauma at the time of admission and of discharge, more emphasis needs to be placed by staff on ensuring that such patients are involved in their discharge plans, rather than merely informed. Often the commodities required for such cases are time and patience. Another factor is that the patient may need an advocate present, who ensures the voice of the patient is heard.

Bernadette

When asked if she had been involved in discharge planning, she said that she did not know. From the korero that took place that day, Bernadette said that she had been in hospitals for many years and had spent more time in than out. She was also resigned to the expectation of not having questions answered as she had constantly asked questions in the past, but had not received answers. It was from that perspective that Bernadette felt if anyone was going to be involved in her discharge planning, it would more than likely have been the caregiver, her husband, rather than herself. That was not to say that she did not want to be involved, as she stated that she had asked many times.

> *I don't know if I was involved. I've been in and out so much, I've been more in than out. Nobody told me anything. I asked plenty of times. They might have told (...), he's my caregiver.*

Matt

When I asked Matt whether he was involved in his discharge planning, he asked me to explain what that meant. He asked me if that was "letting him go" and proceeded to say:

> *I was in there about a month and then they told me on the last week about letting me go. And then they let me go home. They asked me if I was alright to go home. I said yeah.*

The concept of "letting one go", has for me, the connotations that one has been detained and then freed, and that there is a huge power imbalance. Matt's comments endorse the fact that he was not involved in, nor did he have knowledge of, his discharge plans. One of the mental health workers believed that some staff informed patients about their discharge plans, but did not necessarily check out to see if the patients had understood. It is a common occurrence among Maori to feel whakamaa in certain situations, often expressed by silence, particularly when feeling a sense of powerlessness. This can be misinterpreted by non-Maori as acquiescence or acceptance. The comments from number 5 of the staff participants, reinforce this opinion.

> *Information is given but not in the way that they (patients) wanted it and not always understood. And they (patients) don't say anything. Maori won't always ask, so the assumption is made that they understand, or the worker has done their part- they've told the patient anyway, they've carried out their duty.*

A significant step towards improvement of discharge planning in the Ministry guidelines (1993) is the requirement that the "patients are to be involved as much as possible in identification of discharge needs and goals" as set out in Chapter Three. It appears from the examples provided by these patients that there is a way to go towards ensuring that Maori patients are more fully involved and included, ensuring complete understanding of their own discharge plans.

Discharge planning - whanau involvement

Since the advent of deinstitutionalisation and a consequently greater rate of discharge, there has been an emphasis on not only patient, but also whanau involvement wherever possible. One of the fundamental requirements of both national and local mental health policies for discharge planning in Aotearoa, is that the "family, whanau and caregivers should be jointly involved with the patient and the treatment team in developing a discharge plan (Ministry of

Health, 1993:6; Western Bay Health, 1997:2).

In Maori culture and society the concept of "whanau" refers to the extended rather than the nuclear family. Durie (1990:112) describes some of the arrangements and obligations of the relationships within whanau where a younger cousin could be introduced as a "tuakana", an older brother, because the cousin's father is the older brother. In that example the obligation of respect is given to the younger cousin. Maori do have obligations to their extended whanau, as well as to their immediate whanau. Examples are given by Durie (1994:73). The Whare Tapa Wha model signifies the relationship and relevance of the extended family to health. The family is seen as the "prime support system for Maori, providing care and nurturance, not only in physical terms but culturally and emotionally". An example provided as to the lengths to which the obligations of the extended family may reach in some cases, for example, in dealing with abuse or neglect, is to remove a child and take over the parental custody. It is stated by Durie (1994:73) that:

> *Parental rights often tend to be seen as secondary to the interest of the whanau or even the tribe to ensure the future generations are protected.*

These same whanau obligations that are inherent within Maori customs, and have been a protection for some, may well cause pressure and anxieties for others. In Chapter Four I have remarked on my own personal experiences as a Maori community health worker during the time of the deinstitutionalisation process in the early 1990s. Some Maori families in Tauranga with whom I was working were being pressured into caring, or taking responsibility, for their relatives who had been long-term psychiatric patients within institutions and who were being discharged. In some cases, the appropriateness or adequacy of discharge care was not thoroughly considered, the emphasis resting more on the obligations of the extended whanau relationship to take the patient in, and the need for the patient to have somewhere to be discharged to than on concerns for the whanau caregivers. This, for some, placed added strain on already stressed or sick whanau, many of whom were either on unemployment or sickness benefits.

The inclusion of family, whanau and/or caregiver involvement with the patient and the treatment team in discharge planning as suggested by the Ministry, however, is more than likely to assist in gauging the adequacy of community treatment or care for the patient, once discharged. Most of the patients in the study had whanau involvement during their discharge. This ranged from attendance at discharge planning meetings by whanau members to their providing accomodation and, for some, included regular support for the patients whilst in hospital and also after discharge. Two patients had both immediate and extended whanau, two had immediate whanau only, and two patients did not include their whanau, the decisions being based on personal choice rather than on lack or unwillingness of whanau.

One of the participants, Johnny, lives with his grandmother amongst his hapu which is a very close-knit community. Members of the hapu share in his care and support, which helps to alleviate some of the responsibility of his grandmother. In that same community, Johnny was surrounded by friends and relatives with whom he had grown up. Resources in the hapu area included a Maori health centre which both Johnny and his grandmother are able to access. When I discussed with Johnny whether his whanau had been involved with his discharge planning, he stated:

> *Yes, yeah my grandmother, 'cause that's who I stay with, and I wanted her there too so she can get a bit more knowledge of how I was, you know when I was sick and that, so I was glad that my grandmother was there.*

Johnny is fortunate in the sense that he has his grandmother with him and he lives with her. Many Maori today do not have the same support structures of the past which included care and guidance from the wider whanau. Durie (1994) commented that whanaungatanga is not a passive process, and that for a whanau to continue to have a significant role in the future there needed to be planning and development between them.

Hine is another patient who has had long-term support from both her immediate and extended whanau, and who continues to be supported by, and live among them. Hine's responses indicated that the valuable contribution of her whanau instilled within her a sense of belonging. As well as immediate whanau support, a commitment to her care came also from her extended whanau, the hapu and iwi caregivers. It was quite clear from Hine's interview that she was cognisant not only of the importance of the support from her whanau and extended whanau, but also of the place that she held within them. This was reflected by her apparent ease with her own illness and lack of concern for any impending health needs. This reinforces the Maori concept of whanau, hapu and iwi which undergirds the structure and values of whanaungatanga linking and strengthening identity (Te Puni Kokiri, 1994: 40).

When I talked with Hine about whanau involvement in her discharge plan she stated that her brother and sister, as well as her hapu caregivers, had been involved. Hine has a strong supportive immediate whanau, and also extended whanau who are part of her mental health whanau support workers. Although Hine did not have much to say verbally, I noticed more what she did not say. Durie (1990:111) gives examples of this where in Maori terms "there is no need to have people verbalise what is there", using the analogy of "tears" speaking at a tangi - instead of words. In much the same way, Hine portrayed a sense of security and trust in her health care and treatment which was depicted by a warmth and bond of whanaungatanga between herself and her caregivers, which I noticed in the way that Hine looked at her caregivers. There were reciprocal exchanges of looks by the caregivers. In her case, Hine's whanau support workers are involved with her in her discharge planning, and she is willing to let them lead and guide her, rather than take the lead herself. It is in that sense that she spoke about plans being made for her.

> *Yes they (the staff) told my sister. They (the whanau, hapu and iwi workers) arranged everything. My sister picked me up from the hospital when I was ready to leave, and she brought me back to my brother.*

Two other participants in this study, Bernadette and Matt, were supported by immediate whanau only in their discharge planning. Bernadette, a kuia, appears to have resigned herself to the fact that her discharge planning involved her husband more than herself. Although she commented that she was happy for it to be that way, one would wonder if this was a result of institutionalisation.

> *Well, I knew my caregiver, it's my husband. I'm happy with that.*

Matt's brother, sister in law and sister were his main support at discharge planning time. This included hospital visits and meetings with staff. Matt was discharged to live with his brother, sister in law and their family. Neither Bernadette nor Matt is from the Tauranga Moana area, which is a possible reason for less whanau involvement.

The remaining two patient participants, Haare and Charlotte, chose not to have whanau involvement in their discharge planning. Haare, a single man who has been discharged from psychiatric care many times, decided against contacting his whanau during the latest discharge. He indicated that he was starting to feel, with his many readmissions and discharges, that he may have become a "hoha" to his whanau, although this had not been expressed to him. His whanau had been present and supportive during previous discharges, which is expressed by Haare.

> *No, not this time. Only because I didn't get in contact with them. They have been there for me at other times.*

Charlotte said that she was quite stressed and distressed still, at the time prior to discharge, and would have agreed to anything to escape the "clutches" of her whanau, of whom she was very fearful. Charlotte's choice, too, at the time of discharge was to exclude her whanau. This was for different reasons from those given by Haare, and was because she felt a need for freedom. It appears that she was able to cope without whanau input, and seemed to be exercising her rights as an individual and claiming some independence.

> *No I didn't want my whanau involved. I wanted to get away from them. When I was by myself, I didn't want anything else. I didn't want anything to do with my whanau. I wanted to be free. I feel that now, but I get on better with them now, too. I look after myself now.*

During the years of long-term institutionalisation clients' basic human needs such as "self-respect, quest for independence, and self-esteem were often ignored" (Butterworth, 1995: 353). By contrast, Charlotte's example indicates that, within her discharge plan, allowance was made for the development of her human basic needs as well as for the development of personal independence of choice of whanau exclusion.

A common feature of Maori is the need to belong to a whanau group. In many urban settings, Maori link with groupings of interest such as kohanga reo, who then become as a whanau group. The same concept is often adopted by people living together in residential, rehabilitative environments. Charlotte was discharged to a kaupapa Maori residential home, and even though her whanau were not involved, the caregivers who looked after the residential home were there to support. Between the caregivers and the other residents a whanau-like environment, with its support and restraints, was available.

Durie (1990: 111) describes a difference between Maori and non-Maori in that, in the western world, success is measured by individual self-sufficiency, autonomy and independence "but a Maori with those qualities is extremely unhealthy". This statement reinforces the cultural principles of whanaungatanga and the need for Maori to be part of either their own, or an extended, whanau.

It is evident here that all patients interviewed were more fully aware of whanau involvement than they were of personal involvement in their discharge plans. It is also evident that where whanau were involved in discharge planning the patients had better access to resources that supported their community care. Seemingly, discharge planning involving whanau was carried out with all patients who chose it, and therefore the discharge planning guidelines were fulfilled in this respect.

Patient control after discharge

One of the features of institutionalisation was that patients were not included in either their treatment or discharge plans, if any. In other words they had no control. It seemed important then, to find out from patients if, within the discharge planning, they felt they had any sense of control over what would happen to them following their discharge.

Responses from the patient participants reflected degrees of their control in the discharge planning process. This was affected by firstly, whether they returned to whanau after discharge or went to a residential home; secondly, by the level of their wellness and thirdly, by the level of institutionalisation that a patient had experienced. More importantly, a major aspect of degrees of control that a patient had was dependent on staff attitude and practice. At times an imbalance of decision making power between them and staff resulted in some limits on their control over the discharge plans.

> *We need to acknowledge that the predominant mode of relationship between staff and the users of services is one of control and the exercise of power.*
>
> (Mc Gill and Emerson in Perkins, 1996: 63).

Haare, who was discharged from the hospital to residential care, had an attitude that seemed to be similar to that of institutionalised patients where things "happened" to them rather than they had a say, or any control (Williams,1987: 95). Much of Haare's korero was flat and without enthusiasm or emotion. He, both verbally and non-verbally, gave the impression of not having much control over what happened or where he went. I would describe it as compliance with a system and situation with which he was very familiar and appeared powerless to change. It would be fair to add that Haare's flat state could also have been as a result of his medication.

> *No I don't have much control because I'm on an Inpatient Order. I can go out during the day though and I can go to groups. I can also go on programmes and go for walks but I don't have much control really.*

At the time of Charlotte's discharge from the hospital she was still quite unwell. It was interesting to note that, although Charlotte said she had been suicidal and was aware of the fact that she had needed close monitoring, she was also aware of how little control she had in her residential placement. The lack of control at the time only reminded her of her dominating whanau which made her angry. She expressed this as "seeing red a lot".

> *At the beginning I didn't feel I had much control cause I was quite suicidal so they (staff) watched me all the time and I had a lot of people who were visiting me. Even after I had got a bit better I wasn't allowed to do a lot by myself. In the place I was staying at they told me where I could go and who I was allowed to visit. They were quite strict and they*

> *had rules. I suppose at the time I was quite sick and I used to see red a lot, you know get real angry.*

Hine made the distinction between her hospitalisation in the early 1980s where she had no control or say, and contrasted her hospitalisation with her recent example where she feels more in control now. It would be fair to say that Hine's earlier experiences of hospitalisation were of isolation and lack of support. It has been only within the past five years that Hine has had access to community whanau support workers before and after discharge. The combination of a change in staff practices, where Hine feels more in control feels better for her. One example is - when she now asks questions about her medication, she is given answers - which is different from Hine's former experiences of the 1980s. Another factor that has helped Hine to feel more in control, is that she now has whanau support workers whom she can always ask - about anything she does not understand.

> *When I first went into hospital in 1980-81 I wasn't told much, what my medication was or anything. Now they do, so in that sense I feel more in control now. And when I don't understand anything I have whanau support workers who can help me now.*

Despite deinstitutionalisation, where, in between on-going residential psychiatric treatment, Bernadette is often at home and looked after by her husband, her attitudes towards control about her own care remain institutionalised. She tends to believe that she cannot take care of herself. Institutionalisation generates and fosters this concept particularly within the model of long-term care and treatment (Brunton, 1996; Somerville, 1996; Williams, 1987).

> *No I don't have control, my caregiver does and that's alright by me because that's my husband and he looks after me. I've been sick a long time.*

Cooper (1997) reflects on the fact that not all families want or are willing to accept responsibility for the patient, and in Matt's case, he said he would not tell his whanau if he was unwell anyway. Matt's comments indicate that he appeared to have control, however he did not want that control to exclude him from receiving services after discharge.

> *Yeah I think I had control. But I think that sometimes I wanted someone to check up on me to see if I was doing things right. Just because I went back to whanau doesn't mean that I'm in full control all the time. And if I'm not feeling good, I just want to carry on and not bother the whanau.*

Matt felt that his whanau were doing more than enough for him as he was living with them, and he did not want to burden them further. However, Matt was aware that he needed someone to check up on him. Hochberger (1994) places high importance on the necessity of continuity of care and monitoring after discharge of patients. With monitoring and support, particularly in the areas of medication and assessing of mental health state, the patient is able to be linked in to appropriate services at a faster rate than when left with no support. This practice has the potential either to be preventive and keep a person from being hospitalised, or to have a shorter and less acute state of mental ill-health.

Johnny felt he had control of his discharge. His further comments that staff had anxieties or apprehensions towards his ability to survive within his own whanau environment due to the influences of his friends and drugs, indicate that there were possible concerns for Johnny. However, the doctor involved supported the idea of Johnny going home to his whanau, which is what Johnny wanted and which also left him in control.

> *Yeah I felt I had a say. They (nurses) were still talking to me right up until the day I went home. All the things they said they were going to do were put in place, like Polytech. I wanted to go back to my grandmother. Some of them (staff) wanted me to live away from my home 'cause they were scared that I might start mixing with all my old mates and start smoking dope again but my doctor (...) he didn't want me to go and live somewhere else. I didn't want to, either. I still mix with my mates you know, 'cause they were still my mates before I started smoking dope. They all sorta look at me and they're pleased that I have stopped smoking.*

Deinstitutionalisation for people with mental illness allows for the opportunity to learn new skills, form networks to assist support, and to maintain as normalised lifestyle as possible (Mason, Johnston, & Crowe, 1996). However, this can happen only if there are good discharge plans which work, and with which the patient is happy.

A staff member participant gives two examples of control of the discharge plans being taken from patients, in the following comments. In both cases the patients wanted to go back to their homes where whanau were able to support them. It appears that there are still cases where the staff attitudes and ways of working have not changed since the days of long term incarceration of patients. At times, paid professionals make decisions without involving patients and/or whanau.

Staff participant 5

> *In one case the turoro was placed in a residential home. This was a decision made in a team meeting. The family didn't want her in a home but the team wanted her in a home. Because I wasn't on the team decision-making process, I couldn't help there.*
>
> *In another one, the family wanted him home, he wanted to be home but he was sent to a residential place and I mean, that took quite a while, a few team meetings before we were able to move him home. His illness isn't cured but the anxieties and stresses that he experiences are much less.*

This particular staff member often played an advocacy role on behalf of patients. The staff member also had felt frustrated when decisions were made more by the professional teams than by the patient or the whanau. However, this staff member said there were also lots of examples where patients did have a say in their discharge plans.

Conclusion

In conclusion, these examples imply that there are changes that need to happen within certain staff attitudes and practice, allowing more control and involvement for the patient and/or their whanau. One of the fundamental goals of deinstitutionalisation is that mental health patients are discharged to their own families and communities. A statement in Chapter One (8), clearly identifies that successful integration for the patient into the home or the community includes co-operation and consultation between the health professionals, the mentally ill and their families. In saying that, the key concepts are "co-operation" and "consultation" which then allow control in all aspects of discharge planning for patients. Participation by patients in discharge planning makes it more likely that optimal care and a sense of well being can be achieved.

Chapter Six - Information and services during and after discharge: Perspectives of turoro and kaimahi

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Introduction

This chapter continues the exploration of themes drawn from interviews and hui with mental health workers and ex-patients. The themes in Chapter Six are information, resources and cultural safety in discharge planning. There seemed to be a considerable amount of korero and dialogue in the section on information which I have compiled into the four following sections. The first centres on whether enough information is given to both the patient and the staff who are going to be caring for, or monitoring, the health of the patient discharged. Another section focuses specifically on the monitoring of patient medication after discharge. I have separated monitoring of medication as being different from general mental health support. Often patients are re-admitted to hospitals when they become unwell as a result of not taking their medication. The third area looks at services and whether patients feel they receive enough information on services available to them, and the fourth section is about whether patients are given the information of who their caseworker or keyworker is, and how to contact them if they start to become unwell. All these aspects, as mentioned in previous chapters, are important components of good discharge planning.

The Ministry of Health (1993) suggests that discharge planning should not be a rushed activity that takes place one or two days before discharge, as this does not allow for adequate gathering and imparting of important information and consultation towards a proper needs assessment. Part of the aim of this research is to see how far the local hospital system is managing to incorporate the Government's discharge planning objectives into practice, and whether patients understand the information which they are given.

The former patients in the study had concerns about the lack of information concerning ranges of services, social support groups and activities that were available for them in the community. Information is an essential tool as it enables and empowers one with the knowledge to make choices and decisions for oneself. If the patients are limited in their knowledge of services and activities available in the communities in which they live, then they are not in a position to even consider a choice, or attempt to access those services.

One of the remaining two themes is about resources, and the other is cultural safety. The issue of resources has a high impact on all people and services and in particular Maori, who are in the lowest socio-economic bracket in Aotearoa. Discharge planning which includes the patient going to the whanau, often therefore, has implications of burdening an already under-resourced situation. Lack of resources, particularly in the area of inadequate numbers of Maori staffing, was a problem perceived by some of the worker participants in the study.

Including cultural needs in discharge planning for mental health patients is a recent initiative, implemented by the 1992 Mental Health Act, and previously mentioned in Chapter One. Chapter Two also discusses the different cultural needs that Maori have in health. The participants in the study identified their cultural needs, which ranged from the need for Maori nurses and staff who understood them, to having access to tohunga and other healers. Another section on cultural needs led to patients identifying projects, programmes and services that they believed helped in their recovery.

Information

I asked participants whether patients were given sufficient information prior to discharge. Responses came mainly from the worker participants in the study. Some of the patients seemed vague about pre-discharge information and others were satisfied with whanau, rather than themselves, receiving the information, which is highlighted also in some of the responses in Chapter Five. The majority of mental health workers interviewed argued that there were deficiencies in the information given to patients and their caregivers, as well as inadequacies within the information systems. A goal of Regional Health Authorities towards improvement of mental health services, "is to ensure the development of appropriate information systems by psychiatric services with whom they contract in their region" (Ministry of Health, 1993: 15). Tauranga Hospital has started developing policies and guidelines in line with the Ministry's directive. However, it appears that some staff are still finding inadequacies within the existing system.

The amount of information given to patients and caregivers about their discharge

One of the mental health worker participants spoke about an information system that is seen to be lacking in a standardised format within the hospital. From a caregiving and monitoring perspective, this participant felt that a more comprehensive assessment form would assist a focussed approach in their role with the discharged person right from the start. An example given was that sometimes psychiatric nurses found themselves doing social work or tasks that belonged more with other health professionals. This was because the participant felt there was insufficient information on the discharge plan forms. The disadvantages were that time was unnecessarily wasted or lost by the caregivers in the community trying to determine the patient's needs, which with the often heavy caseloads, this mental health worker found frustrating. Staff participant 1 commented:

> *I think that assessments are inadequate prior to discharge, That is, assessments are not detailed enough. Assessments should be fuller to include social, physical and family issues. The discharge summary sheet is lacking in standardised format and therefore lacking in information... We need more in-depth standardised forms that let us know more about the patient and exactly what and who they will be returning to. We need to know what the social needs are so that nurses are not ending up doing social work. We need better documentation.*

A further comment implied that, with vague or insufficient documentation, roles of staff became blurred or mixed. The participant stated that some forms from other hospitals supplied detailed information which made it easier for hospital staff to follow the discharge plans. The comprehensive range of information helped staff to make quick identification of professional roles needed to support the patient's discharge plan. Staff participant 1 added:

> *The discharge planning and treatment is only as good as the skills and knowledge of the health care assistants or professionals. I have some other examples of other hospitals where they have referred people to us and their forms and information has (sic) been much more comprehensive...we need improvements on the documentation of*

> *discharge plans. At present they are not precise so the information is vague and unclear...*

As earlier identified, prior to 1993, there was a lack of uniformity in discharge planning policies and protocols throughout the different regions of Aotearoa (Ministry of Health, 1993). The framework of discharge planning guidelines as discussed in Chapter Three, was then put in place to assist hospitals for the mentally ill, toward consistency and uniformity in this very important stage of a patient's release. The discharge planning forms from the Tauranga Hospital are included in the appendices.

The following comments based on the experiences of staff participants 2 and 3, were similar to those of participant 1, in that they both felt that not enough information was given to them as caregivers in a whanau and hapu community when turoro were discharged back to their communities. In the hui that was held to hear their views, both whanau support workers felt extremely disadvantaged by lack of information from, and between, staff who were discharging patients into their geographical area.

These participants were aware of clients' rights and the Privacy Act. However, they were often working with them and providing whanau support, so most hospitalised Maori mental health patients in the small community where they lived were already in the iwi services. The breakdown for them was the lack of information prior to, and post-discharge, by hospital staff unless they, the iwi workers pursued the information themselves. For hapu and iwi workers, having the information prepared them with the knowledge that was needed to form good rehabilitation plans with the turoro and their whanau.

The Ministry of Health's (1995) report focussed on coordinated care as a way of providing access to appropriate health, disability support and associated services for Maori and also looked at the systems that manage those services. Collaborative and coordinated care seems to be the way of the future, with more communication needing to happen between groups. As mental health worker participant 2 commented:

> *I think that not enough information is given to us (community workers).*

> *There's a lack of information. The only time we know if someone is being discharged back into our community is if we go to (...) meetings. That's with the team that works in our area...there's not much communication from the (...) team to me - only when they want something. Mind you, it has changed though, and it is much better now.*

It seemed to be the case that there was insufficient liaison with the relevant community groups in the areas where discharged patients were going. Although coordinated care is happening to a degree in Tauranga, it appears that perhaps the alacrity with which mental health discharge is occurring has overtaken or burdened the rate of collaborative development between services at this stage. The iwi workers referred to the fact that a better system of information is needed between themselves and the mainstream secondary mental health support services designated to their geographical area. The present system includes mainstream teams which are made up of psychiatric nurses, psychiatrists, psychologists, social workers and occupational therapists as previously mentioned in Chapter Three. Although there was acknowledgment of improvement, the procedure for informing hapu and iwi workers about patients discharged to their communities can be enhanced. Staff participant 3 stated:

> *They (staff) should get in touch with services in the area that the turoro are going back to. There needs to be more co-ordination. Who is going to follow up? When are they going to come? All that sort of information. There needs to be better communication between the staff and the community...that they'll let us know when patients are discharged.*

For this study I gained permission from three of the six patient participants to look at their mental health records and discharge plans. It was documented in the records that each of those patients had received information concerning their illnesses. However, out of the three only one person was clear and had knowledge about their illness. These examples confirm my own findings and experiences of some Maori patients and information given to them, which for some reason they do not understand. Further to that, sometimes they do not ask, for the reasons outlined in Chapter Five. Staff participant 5 commented that "I think knowledge about people's illness could be improved".

One of the worker participants commented that not only do Maori need to be given more information on the Mental Health Act, but also that a flow chart would probably be useful. I would agree with the participant's comments on information about the Mental Health Act being made clearer to the patient, and their whanau, if that is the patient's wish. The Act, the components of which are described in more detail in Chapter One, is legislation of safety that is enforced upon patients if they are in danger of serious harm either to themselves or to others. Often at the time of admittance the patient is in a state of crisis and the whanau is in a state of ambivalence due to the fact that sometimes a whanau member is the one who has signed the admittance for their whanau member, and who are feeling guilt at the same time. At such times it is not unusual for both the patient and the whanau to be in states of trauma. The mandatory requirement of the provisions of the Act being quoted to the patient is often lost in even the hearing by the patient, let alone comprehension and understanding, due to the often volatile or extremely unwell situation of the patient.

Those with a mental illness admitted into the Tauranga acute inpatient ward in 1999 numbered 516. Of these 31.9% were Maori. The number of people with a mental illness admitted under the Mental Health Act was 208,and of those 26.4% were Maori. Staff participant 5 believes that more information should be given to patients, and states:

> *Also knowledge about the Mental Health Act itself... But Maori need to be given more information on these things, verbally, and something they can look at to help them understand, like flow charts.*

It would appear, from the comment of a staff participant, that inconsistencies can arise if systems are open to the discretion of individual professionals. Where that is the case - as has been the experience of one of the participants - then there is the need for firmer, fuller guidelines. A fair comment is that some psychiatrists appear to be better than others in informing and including patients and their whanau. Staff participant 5 adds:

> *I think that depends on the psychiatrist involved or the psychiatrist in charge of the person. Some inform. Some invite family to have input. Others convey the message that has been made by the team.*

With all the references (Ministry of Health 1993, Hochberger 1994, Kemp

1990, Mason Report 1988) to the patient being informed and having involvement in their own discharge planning, it was found in this study that most participants suggested that there is still a major gap in the delivery o information to patients and their whanau.

C. So are you saying that some turoro haven't been informed?

Staff participant 5 responded:

> *No not actively. They definitely need to be involved in the discharge planning. Well, personally, I think the discharge planning process could be made a lot easier for families, especially if the family meetings were held where they (families) are comfortable and they were able to speak what they want to decide.*

One of the workers talked about what should happen, and what does happen, in the best cases of information gathering and information sharing in a turoro discharge plan. Comments from participant 4, unlike those of participants 2 and 3, show more involvement and inclusion with the health professionals, the turoro and their whanau. This participant has been working in mental health for a number of years and has been part of the setting set up of systems and approaches for an integration between the primary and secondary levels of Maori mental health care and rehabilitation. Chapter Three discusses the whanaungatanga model of work that has been put in place by kaupapa Maori staff in the Tauranga Moana area. Participant 4 belongs to one of the iwi primary mental health providers, and suggests an example of the model in practice which includes the turoro, their whanau, and secondary as well as primary health care workers.

The idea of the whanau involvement where they are able to have input and give their opinions on perceptions of the turoro's health, provides another view in the overall discharge planning. Ideally, it seems that this model is working well for some groups and their turoro, but it is not yet practised fully by others. The following comments by participant 4 give an example of information exchanged and shared during discharge planning with the patient on the ward prior to discharge. Staff participant 4 states:

> *The most important part is the whanau meeting before and when preparing for discharge...there is much talking that needs to happen, about medications and injections et cetera. Yes we have a meeting with the patient, how we're going to work out the planning. The client has the floor. How they see themselves, opportunities that are available in the community. It is a long process so it's good when the whanau are there. They also know when the turoro is not telling the truth. That is the first part of the meeting. Then the turoro goes out, then we listen to the whanau to see how they perceive the client to be and what their views are of a plan for their whanau member. This is because sometimes the turoro might want to go home but, for whatever reason, the whanau aren't able to take them. Then we make a plan of all things considered and sometimes a whanau rehabilitation house is an option. We include things like daily activities based on what the client has said. We always look at how we can help them (patient) to help themselves, then the whanau. Then the client comes back in . We explain the plan to the client and then change what's not suitable. Once the doctor has the meds sorted out they like to discharge. I like to ask the whanau, it's important that the turoro is not hurried or rushed out from the ward. The best way is that they start with weekend leave, then staggered leave, then they learn to cope...I'm always involved in the discharge plans for the ones (patients) in our iwi area. The ones in our whanau hapu or iwi that want my help.*

For this participant who is involved only in the discharge planning of Maori mental health patients from the same hapu and iwi, the procedure described is normal. It is a process that the worker had helped initiate. However, not all iwi mental health workers are involved at that level. In most cases they do not have the resources, and other iwi groups are further away from the hospital.

Information about medication

Hochberger (1994) noted that two important factors of good discharge planning were continuity of care and medication monitoring. Often patients will agree to continue with their medication in the discharge plans and then decide not to take their prescription after discharge. In some cases the patient does not know the importance of taking, and the consequences of stopping, their medication. Whanau also are not fully informed of the significance for some patients in not continuing with their medication. In turn, patients have been known to relax the dosages or take medication only when they remember, without proper monitoring.

Some Maori patients elect to take rongoa and that is their choice. However, where patients have been prescribed medication, then there needs to be discussions between the appropriate health and cultural professionals as to the best interests of the patient in accommodating their needs. Sometimes this may cause conflict particularly in cases where Maori are opposed to chemical medications and are wanting to take rongoa only, or where health professionals do not see the value in any alternative source of medication such as rongoa. Professionals need to work together for the best outcome for the patient.

The Mason Report (1988) identifies that lack of knowledge of services is one aspect missing from discharge care that exacerbates the undermining of patient confidence in health services, leading to entrapment in the revolving door cycle. In my opinion, premature discontinuation, and the lack of monitoring, of medication are also factors in the revolving door syndrome for mental health patients.

C. Is enough information given about medication?

In the following section on information about medication the comments of worker participants 2, 3 and 4, are similar. They argue that they should be given information about the turoro's medication - especially as they are, in most cases, the ones who have to monitor the health and well-being of the patient discharged. At the time of discharge, the patient is most likely to be at a point of good mental health. It is meaningful for patients at that stage to agree to the dispensing of their own medication. Whilst in hospital, the patient in most cases has no option but to take their medication. They often dislike the side effects, and will try and manage without medication once they are freed from hospital routines and restrictions. As has been noted by participant 2 though, sometimes when patients start to become unwell they may not continue with medication - and it has been at that late stage that caregivers were called in. From these interviews, it is evident that participants 2 and 3 were not always informed of the patient's medication upon discharge. In cases where they had prior knowledge of patient discharge, the worker participants sought out the information themselves.

Staff Participant 2

> *Caregivers and community workers should have knowledge and awareness of the turoro's medication prior to discharge, rather that the turoro being the only one who has the information, especially when we are not informed or involved by hospital staff. At the time of the discharge the turoro are seen as being well enough to receive the information, but what about when they become unwell? It is us, then, who need to have that information too...*

This participant also felt the need to be informed about patient medication - especially when the patient was discharged to their care. If the caregivers or the whanau are informed about the use and abuse of medicines, then they are able to monitor their turoro with knowledge and purpose, surely assisting the patient in optimum well-being.

Staff Participant 3

> *Just recently one of my turoro was discharged. The medication had to be checked daily and I do that so I need the information.*

Again, here is reiteration of the importance of caregivers having the information about the medication for patients discharged to their care.

Staff Participant 4

> *When they're (patients) discharged I follow up... I'm involved in meds and follow-up psychiatrists' visits... we need to know what they're supposed to be taking and we can help to see that they're taking what they need to, and when.*

Not only has it been found in this study that information on medication would assist a more informed service delivery to patients, but also it has been seen that a regular medication review is a positive option. Along with medication, a support worker felt that education about both the illness and medication was essential for better understanding by the patient and their whanau - which is illustrated by participant 2 in the discussion stating:

> *Patients need to be re-assessed every six months, their medication and their treatment reviewed. I had a client who was 55 years old. He had been referred by his wife and I visited the whole whanau. His*

> *medication had not been changed for about five years. I asked who his doctor was and I told the whanau to ask the doctor to review his medication. The client was rocking himself, shuffling, piling on the weight and was very unmotivated. The doctor went through the patient's files and the medication had not been reviewed for a long time. The medication was changed. That man's health has improved. The change in the medication has changed him. I originally only went in to mirimiri (massage) his feet. He is a different man now. I see him walking down the beach...We provide constant follow-ups which have helped a lot of the whanau attitudes, especially about noticing turoro illness. We educate turoro and whanau about illness and medication.*

If a person has been mentally unwell for a number of years, it is highly likely that long-term medication has also been part of the history. It has been found in the United States of America, in the American experience of deinstitutionalisation, that anti-psychotic drugs did not solve all problems of mental health patients (Torrey, 1987).

The following comments from the patient participant Matt, reiterate the notion that loose discharge care does not assist mental health patients in knowing when they are becoming unwell and some are not seen until they have become ill.

C. Were you informed about your medication?

Matt.

Yeah I was on Aropax and Respirodol. I just got it from the chemist.

C. And was there any follow-up organised for you?

Matt.

> *No, no. there was supposed to be. They didn't have that this time. But three to four weeks later they (hospital) sent someone out but by then things were happening. I went down. I was ignoring them then they signed me off.*

C. Ignoring them. What do you mean?

Matt

> *At that time (...) had cancer. I was more worried about that than talking to them(nurses). I was never home.*

C. So they could have visited you and you may not have been home?

Matt

> *Could be.*

It seems, from Matt's account of knowledge about his medication that he was aware of the names of the medication - but nothing else. He states, too, that by the time a support person visited him he had already started to become unwell. He was also unsure whether he had been taking his medication at the right times.

Although Matt alluded to the fact that he was often not at home after discharge due to the illness of a friend, it seems imperative that, at times like these - when patients are stressed about other matters - the monitoring of medication by a caregiver or follow-up support worker is a priority for patients in maintaining a reasonable level of mental health.

Patients should be encouraged towards independence and decision-making, but I would argue that for some, the responsibility and monitoring of their own medication is not appropriate.

Johnny

> *Yes I was on medication. I just make sure I take it myself. I know I need it now, 'cause the last time I came into hospital, I had stopped taking it. Maybe two or three weeks and then I got sick again and I wasn't smoking or nothing so I was quite surprised that I got sick again.*

Both Matt and Johnny were responsible for their own medication. Johnny seemed to have learned from a previous experience the importance of taking his medication and the impact it had on his mental health when he did not take it. Matt, on the other hand, would have appreciated someone's coming to check on his medication, even simply to reassure him that he was doing the right thing.

Information on Services

Part of the hospital's discharge planning policies are that:

> *Discharge Planning is a process through which a client's identifiable needs can be safely delivered. This ensures optimal care as a client moves through the system from entry to exit. It is essential that care systems are acknowledged and factored into the care planning process with the client's assistance.*
>
> (Western Bay Health, 1997:1).

In the deinstitutionalisation process, there are several references to the importance of community services being available for mental health patients (Hochberger, 1994; Ministry of Health, 1993; Kemp, 1990; The Mason Report, 1988; and Mental Health Commission, 1998;) which therefore acknowledges the importance, and place within the process, of community care for the patient. It is in this section of the study that the patients are more vocal with their thoughts and opinions. I would argue that this aspect of their after-care evoked a passion because the patients were very clear about what it was that they wanted for themselves, and what they experienced to be lacking.

C. Is enough information given to turoro, their whanau, or caregivers about services available for Maori mental health patients?

Haare

> *Information is lacking about what is available in the community. Like classes, work-based programmes, courses on cleanliness. Sometimes I don't have a wash and I'm in care, what about others not in care? Life skills like cooking and cleaning and that... there's not enough information available. We need to know what's available out there in the community...clubs like Tai Chi and table tennis.*

Haare stated that he thought information was lacking on services available within the community. He referred to not only health and social service courses, but to interest groups as well. The Mason Report (1988) expressed concerns that, in post-discharge treatment, the broader range of activities was often left up to the patient to initiate. This, in many cases, led to deterioration in health due to lack of knowledge of services or awareness of community supports. Most people feel better about themselves when they are participating in productive interest activities or making a contribution to society. Mental health patients are no exception, and need awareness of activities available, so they can at least have the opportunity to participate and mix with other people in stretching their learning abilities or enjoying hobbies.

Another two participants, Johnny and Charlotte, both seemed busy and occupied with involvement in courses and groups. Both participants had been informed of post-discharge groups and activities. This was displayed by their enthusiasm and the manner in which they spoke. Johnny had also received assistance in securing funding to attend the local Polytechnic. He talked with pride about his course and also his attendance in ongoing support groups.

Johnny

> *Yeah I think so. Oh (...) and (...) were my nurses and they gave me some plans to keep my mind occupied with work. I'm now at Polytech and I'm doing a Maori course... they want me to get back into my sports. They know how much I used to like playing rugby. And aah, I go in to dual diagnosis group. I've been attending a lot of NA meetings as well, narcotics anonymous. I go to NA 'cause it's helpful, you know, listening to other people.*

Charlotte, too, had experienced participation in a range of interest, social support and therapeutic groups along with other patients in a residential house she had been living in at the time. Charlotte is now in part-time employment and has a place on a support group committee, keeping herself busy and involved in meaningful activity.

Charlotte

> *I used a lot of services while I was in the home, psychiatrist, respite and counsellor. We also went out to other mental health activities in the community, also some in the house. The services were compulsory to attend... but I'm not sure...I don't know. Might be because we stay*

> *together and all went together. The activities were alright. We had day programmes...sort of self-esteem work...teamwork and team building. I tried a part-time job, too, for a little while.*

When discussing this same issue with one of the worker participants, they chose to look at their own organisation in relation to the question. It is in the interest of the community for patients to be fully integrated into services or care.

Staff Participant 2

> *I'm not sure about when they're in hospital but we do (inform) them (patients) when they come home. We provide constant follow-ups which have helped a lot of the whanau attitudes especially about noticing turoro illness. We educate turoro and whanau about illness and medication. Living in our community is important, building trusting relationships in the community. They (people in the community) know who and where we are, and we know the links and networks into the hospital and also where to refer out.*

Participant 2 referred to their organisation informing discharged patients and their whanau about the services they provided, which included ongoing care, education and support. Reference was made also to a knowledge of networks that the group could access or inform patients about, linking them to secondary care. Continuity of care is a prominent feature in good discharge planning. The discussion and korero by participant 2 outlines a framework of a co-ordinated approach to working with turoro and their whanau, and in particular informing patients of services.

The participant in this case has chosen to speak about their own responsibilities of information-giving towards the patients whom they service. In my opinion, a pro-active stance was taken where the service provider has elected to look at their own organisational practice in relation to the query of whether enough information is given to patients and their whanau about available services. Having information about services gives patients the rights and power to make choices for themselves. In discussing services for people with disabilities, Perkins (1996:82) states:

> *The current experience of community opportunities is enjoyable, but also unpredictable, and outside of their control. People do not move*

> *forward in a planned direction by choice, they are dependent on the decisions of the service providers and unaware of the underlying policy changes.*

Information about follow-up care

One of the hospital discharge planning guidelines is that a key worker or clinical case manager will be responsible for co-ordinating the implementation of the discharge plan using case-management methods. For this to be effective the person needs to have an extensive knowledge of community services. (Western Bay Health, 1997:2).

> *The recently launched Government strategy for Health and Disability support services (1999) reiterates the government's goal to reduce the prevalence and impact of mental illness. Of significant relevance are the goals that give greater emphasis to population health approaches, intersectoral collaboration between agencies and providers, the Crown's acknowledgment of a special relationship with Maori under the Treaty of Waitangi, and its commitment to improving health outcomes.*
>
> (Te Mana Putea Hauora O Aotearoa, 1999*).*

According to the Discharge Planning Guidelines (1993) one of the prominent features of good discharge care is "a system that provides early intervention during crisis or relapse of illness". An effective way of ensuring that this safety net of early intervention is in place for the patient is that a caseworker or keyworker is appointed to a patient before discharge.

In the collaborative approach to mental health services and continuity of care in the community, a caseworker has a pivotal role in that they are the person appointed who is responsible for the co-ordination of all services involved with a patient. It is also the caseworker's role to ensure that information concerning the patient or other carers and service providers is communicated between parties. The caseworker, has also the overall task of maintaining an ongoing supportive relationship with the patient, particularly monitoring needs and linking with the other service providers.

The collaborative model of work has similar concepts to the whanaungatanga principles of relationship structures. Bishop (in *Te Pu Manawa Hauora* 1998:131) describes the whanaungatanga theme as focussing on "connectedness, engagement, and involvement with others in order to promote self-determination/agency/voice". Although Bishop was referring to whanaungatanga as a research process in this instance, the principles of whanaungatanga remain the same and are transferable. Maori mental health patients are more likely to respond favourably to this model of work. Over the history of health and social service delivery in Aotearoa, it has been common practice for a number of services to be working exclusively and independently of each other with the same patient or whanau, and without knowledge of how many or what other services are involved. The caseworker position helps to break down barriers and keep people informed. It is a vital role for the ongoing care of discharged patients.

Of the five patients who spoke on this aspect of their care, two people knew who their caseworker was and how to contact them, two had vague knowledge of what to do, whilst one was unaware. Both Johnny and Charlotte, the first two research participants, had good knowledge and experience of who their main caseworker was, and how to make contact. The contact system seemed to be an "open" one, in that contact could be made directly to any staff member on duty at the ward for Johnny, whilst Charlotte too, had access to a number of health professionals, as the following comments indicate:

C. What would happen if you started to feel unwell after you have been discharged? Do you know whom to contact?

Johnny

> *Yes, I'd get in touch with the ward, cause I'm sorta like a outpatient. They've told me if I'm not feeling right to just give them a call.*

Charlotte

> *I had quite a few people. The house manager. Still do, even though I'm out flatting. I still contact them all the time. It makes me feel good inside. They're still there if I need them even though I'm not under them. That's important for me. When I was sick the staff kept a close eye on me. They noticed, or I told them, and the respite team came in and the*

> *house nurse. I saw them every day.*

C. How did they help you and what did they do?

Charlotte

> *The respite team would come out. They had rules. I wasn't to harm myself, but I did. I was going through changes, but now, I feel much better now because I haven't got my family smothering me.*

The discussions and korero held with Hine and Matt showed that in a vague way, they had some knowledge of how to contact people if they became unwell. However, the mode of contact appeared to be thin. Both participants referred to the fact that they had been given cards with contact numbers. On the days that I talked with them, neither participant had the cards on them, or could locate them. Hine was more dependent on her caregivers monitoring her health as she stated:

> *Yes, I've got a card. But I don't know when I get sick. The health workers take me to the doctors when they or the whanau notice that I am sick.*

This is further endorsed by one of the worker participants in the following comment:

Staff Participant 4

> *I make sure that I'm contacted about patient appointments at the hospital. The turoro are not always aware if they're sick.*

Matt, too, appeared to be reliant on the knowledge that his brother knew how to contact people if he became unwell. For these two participants, it would seem that as long as they were in communication with their caregivers or whanau, they would more than likely receive the assistance needed to contact their caseworker. There is still scope for the ex-patients' knowledge of how to access their caseworker to be strengthened.

Matt

> *Yeah there was, they've got it on a piece of paper, where you can ring, where I can talk to them, doesn't matter what time, if I start to get sick.*

C. What if you lost that piece of paper?

Matt

> *My brother knows the number. I live with him.*

Bernadette seemed indifferent and not to have any awareness of her own state of mental health.

Bernadette

> *Ask the caregiver. I have a caregiver. The caregiver knows when I am sick.*

Bernadette continues to display ingrained patterns of institutionalisation, where although she spends much more time at home in her community now, she appears to be entrenched in the old mental health system of not having a say in her own care and treatment. I would argue that the effects of colonisation could well be a major factor. I qualify this by stating that in Maori terms, Bernadette is a kuia. The combination of her age and the years from when she was first institutionalised thirty-three years ago, places her in the era of, for Maori, a strongly colonial New Zealand society. Pool (1991) states "from 1945 to 1966, Maori mortality, their level of urbanisation and the labour-force distribution - all changed rapidly, and converged towards Pakeha patterns".

For Maori, this was in many cases a period of alienation from cultural identity, cultural knowledge and participation in Maori society. As an institutionalised Maori, Bernadette was further alienated and possibly lost sight of personal rights such as the least of these, which is to have, and voice, an opinion. According to the Mason Report (1988:168) " psychiatric hospitals were seen by them (Maori) as hostile places...psychiatric services as monocultural and resistant to change". Green (1993) previously quoted in Chapter Two, by contrast, referred to the combination and inclusions of family, connections to tribal lands, the environment and Maori language being important and essential to good Maori mental health.

Resources

The main argument in favour of the deinstitutionalisation process was that mental health patients would be discharged from institutions and hospitals and rehabilitated within their communities. However, concerns had been expressed as to whether sufficient resources would accompany the patient, post-discharge (Torrey 1987, Mason 1988). In Aotearoa, as mentioned in Chapter Two, the Government has made a commitment to The Treaty of Waitangi specifically relating to Maori mental health. The low socio-economic group in Aotearoa are largely Maori, and for Maori who are under-resourced to begin with, it would seem that the Government's responsibility in meeting their obligations under Article Two of the Treaty in regard to Maori mental health is imperative in order for Maori whanau to sustain the increasingly high numbers of Maori mental health patients moving back to their communities.

Article 2 of the Treaty of Waitangi as interpreted for Maori mental health states that it:

> *Gives Maori rights and responsibilities as members of whanau, hapu and iwi to hold onto properties or taonga such as land, rivers, forests and language that they hold as important. It gives Maori the right to pursue Tinorangatiratanga or self-determination on matters affecting well-being. It is vital that Maori are given the opportunity to be involved in shaping Mental Health legislation, the development of mental health policies, and to have resources to develop their own mental health services. Only by creating this environment will Maori be able to share with the Crown the responsibility of care and health development of their own people.*
>
> (Te Puni Kokiri, 1993).

In discussions and hui around resources, the main issues were that participants in this study largely related the korero to inefficiencies and under-resourcing of Maori mental health staffing.

> *Prior to the health reforms in 1993, the presence of Maori in the health sector was largely confined to Maori personnel working within mainstream.*
>
> (Te Mana Putea Hauora O Aotearoa, 1999).

Tauranga hospital was no exception in the 1980s and up until the mid-1990s. Of a staffing of between eight and nine hundred, only about 40 - including cleaners and other maintenance staff – were Maori. The Maori professional staff were a very small percentage of the forty. The decade of Maori development between 1984 and 1994 (Te Puni Kokiri, 1994), which harnessed a drive to improve the position of Maori, witnessed "an explosion of activity".

It was during the late 1980s and mid-1990s that a few pro-active Maori staff within the Tauranga hospital started to hold hui with both staff, community and iwi organisations. From their dedication, hard work and drive, we have seen the emergence of a kaupapa Maori Unit Te Puna Hauora, in 1992 - which services Maori within the hospital and in community follow-up care. Within the Te Puna Hauora Kaupapa Maori services in mental health there are ten staff. They are made up of three psychiatric nurses who work in the inpatient ward services, one psychiatric community nurse, two specialist counsellors, a child and adolescent consult/liaison co-ordinator, a dual diagnosis counsellor, an early intervention for first time psychosis worker and a social worker who has dual roles in both generic and mental health.

Although the kaupapa Maori unit, which has an equal share of nurses who work in medical, child and community health, is established and flourishing, the disparities between kaupapa Maori services and mainstream within the hospital continue to exist. One of the examples is the ratio of mental health staffing which, for Maori, is about 10% of the total mental health staffing number - although in the wards at least one third of admissions to the psychiatric ward are Maori.

The kaupapa nursing staff on the ward started in 1996, with one psychiatric nursing position argued for by Maori, and handed over by mainstream to start the development of a kaupapa Maori service for mental health patients. The nurse employed remained in the position for just four months. The vacancy was later filled, but only for a few months. It was not until three positions were targeted for by the kaupapa Maori team that there came some stabilisation and permanency of staff, which has been consolidated only within the past six months. For a Maori to work in isolation from other Maori is very difficult. Maori working together are able to support each other professionally, physically, mentally, spiritually and within a sense of whanau and belonging. It is therefore easier to retain staff when there is a group.

Maori have almost always had to prise positions from tightly clenched fists, it seems. Securing every single portfolio of the Maori mental health positions has not been without a struggle for the Te Puna Hauora management team. Despite the increase of the Maori mental health staff however, one participant observed that the small kaupapa nursing team were stretched to the point of not being able to get away from the ward to participate in the wider fields of networking, which for Maori, is a fundamental principle to good service delivery based on the concept of whanaungatanga. This is further exemplified by the comments of staff participant 6, who said:

> *There needs to be more support for kaupapa Maori nurses on the ward. They're kind of on their own. It's hard for them to get out to things or network. Another issue is when they are off the ward, training or sick, there's no other service for the patients. When something like that happens, it (...) up the whole system.*

When a kaupapa Maori staff member at the hospital is either in training or off sick, patients then have to be nursed by the mainstream services. The participant who made this comment had much to say about the fact that a lot of energy and time went into the kaupapa staff forming relationships with, and caring for, their turoro. The care involved the whanau wherever and whenever possible, and in some cases became as whanau to the patients. Patients are seemingly disadvantaged when there has been a break in the continuum of kaupapa Maori care offered to them because of a shortage of Maori staff. These comments are about a service, and not individuals, as the kaupapa Maori nursing team receive a lot of support from the mainstream team.

All Maori patients are given the option on admittance to the ward on the choice of services between mainstream and kaupapa Maori. For those patients who choose the Kaupapa services, and who start bonding and forming relationships with Maori staff first, and suddenly have those broken, this must surely add to their often already confused state. This was borne out by three of the patients in the study whose comments were similar in that they looked forward to their own Maori nurses being on the ward and missed them when they were away. An obvious conclusion could be drawn that there needs to be more Maori staff as identified by participant 6, who suggests:

> *Trained relief Maori staff to fill in. Even when they do the "specialling" monitored surveillance of at risk patients) on the ward for Maori patients. Often the resources aren't there for Maori.*

Whilst I agree with the need for more trained Maori staffing, there has not been an equitable match nationally between the increase of Maori mental health professionals needed to cope with the deinstitutionalisation process, and the rate with which Maori have returned from the institutions to the local psychiatric wards and communities. One of the strategies identified in Durie's *Puahou* plan for improving Maori mental health is that we need "a strengthened Maori workforce, including professionals and community workers working at all levels" (cited in *Te Mana Putea Hauora O Aotearoa* 1999:9).

As identified in Chapter Three, most of the Maori health organisations in the Tauranga Moana rohe are working in the areas of generic and health promotion. However there are two Maori organisations catering specifically for mental health patients in the community, three groups who provide day programmes, and two groups providing residential care. Although the whanaungatanga model of practice is used, providing the link between primary and secondary mental health services for Maori, there is still some way to go in ensuring a consistency of service delivery that has a seamless kaupapa Maori contingency plan as reiterated by another participant who in referring to resources, suggests:

Staff participant 5

> *Ah well no not enough, not specifically for Maori. We need more follow-up workers more community workers and more services toward employment... Maori patients need something that's going to lead to*

> *something. Support to something that's going to lead to employment.*

Another major gap in resourcing for Maori mental health patients - also identified mainly by staff, appeared to be in accomodation. Residential housing in Tauranga for discharged patients at times is stretched to the limit. One staff participant said that it was quite a common occurrence to have a distressed patient arrive unexpectedly, with the urgent need for accommodation. In some cases they have fallen out with whanau or people they are living with, or abused privileges and/or broken rules of supervised care. It is difficult at times for effective discharge planning to occur when there are insufficient resources for ex-patients in the community. Such is the experience of staff participant 5, who states:

> *It is hard sometimes to find somewhere for a patient to live. Especially if they arrive on your door at 5 at night. That has happened a few times... one had to pitch a tent on a lawn, another I remember, I had to work hard at getting somewhere for her for the night. I managed, and then helped her the next day to get a permanent place.*

Reasons for urgent housing, however, are not always negative. Some clients are people discharged from Treatment Orders and who have become well enough to either live on their own, or go flatting, and are at times restricted by the lack of suitable accommodation. It is common in Tauranga and the neighbouring town of Te Puke to find clusters of people with mental illness, in community care and treatment, living in caravan and holiday parks.

Cultural safety

> *Discharge planning will incorporate mental health services that are culturally safe for all people that use them. The clients, when using a service provided by people of another culture should be able to do so without risk to their own cultural needs.*
>
> (Western Bay Health, 1997:2).

The National Mental Health Standards for mental health care require that "the mental health service delivers treatment and support which is appropriate and sensitive to the cultural, spiritual, physical, environmental and social values of the consumer and the consumer's family and community" (Mental Health

Commission, 1998:96). In 1985, three levels of cultural safety were recommended by the Board of Health Standing Committee on Maori health. Level one was to provide educational opportunity to help New Zealand health professionals to realise the significance of culture to health. Level two was to introduce Maori language and culture to health students, and level three was training for people likely to work in the Maori communities and who would, therefore, need a greater knowledge of culture and language (Durie, 1994:116). As Durie states:

> *Although cultural safety was never defined, in the context of Aotearoa it was taken to mean that in order to give safe services to Maori, nurses needed to understand the impact of their own culture upon the reality of Maori, Cultural safety was to ensure non-violation of attitudes, values, and actions which had an effect on obligations of the Treaty of Waitangi and the practice of tino rangatiratanga.*
>
> (Durie, 1994:116).

From the Hui Whakaoranga 1984, mentioned in Chapter Two, Maori have enforced their rights to their own distinctions and interpretations of cultural perspectives of health, incorporating spirituality. Inclusive of the holistic model are the dimensions of *te taha wairua, te taha hinengaro, te taha tinana,* and *te taha whanau*, widely known now as the *Whare Tapa Wha* model which interprets an imbalance to the whole structure, if one of the dimensions is affected. This model is now held up as a framework and guide to mental health services and treatment, including discharge for Maori.

There is no specific reference to how this model is built into discharge planning. However, the range of essential components including clinical, are the cultural factors. These include whanaungatanga, whakapapa, te reo Maori, tikanga, kaumatua guidance and support, empowerment of the turoro and their whanau and access to traditional healing. The requirement is that mainstream work also takes place in a culturally safe manner. As discharge planning begins as soon as possible after a patient's admittance to a ward or hospital, then cultural safety for discharge starts at that point too.

Of the six patient participants, Johnny, Hine and Matt were very sure of their cultural identity and expected cultural input into their care including discharge planning. Two of the three were tangata whenua to the rohe of Tauranga Moana and participated at tangi and hui on their marae, whilst the third had also been brought up with a strong marae and whanau background. These were their main reasons for cultural safety input. Johnny had said that it was important for him to have Maori staff to contact his grandmother, and preferably someone who spoke te reo Maori, or had an understanding of this so they could communicate with his grandmother. He also felt a rapport would be built more quickly with a staff member who could converse in the native language with his grandmother. Hine expected her whanau and caregivers to be involved, and therefore felt culturally safe in, and with, her discharge planning. Matt was a fluent speaker of te reo Maori, and to hear staff using Maori greetings and the occasional Maori phrase helped him to feel a little like being at home. For both Hine and Matt, their cultural expectations were met.

In the experiences which I have shared in this thesis as a community health worker in the past, I described from personal experiences that where Maori were strong in their culture including identity, there was an expectation of culture in the practice. The three participants ,Johnny, Hine and Matt - who also fall into the same category - present a similar expectation. Matt added also that:

> *It would be good if we had our own marae to live on. You know for us when we get sick, and then we could be looked after there. We could learn about everything on the marae and have carving courses and kapa haka and all that.*

Charlotte did not care whether or not cultural safety was a component of her care, and that probably related to the fact of her need for personal safety and care. It was important for her to feel safe with whoever was helping. Charlotte said that a Maori staff member had assessed her initial suicidal state and then assisted her with a further referral to an on-call psychiatrist. She found both the Maori and non-Maori staff were helpful to her at that stressful time.

To Bernadette, cultural safety did not seem to matter either. However I would argue that for Bernadette, it was more likely to be that she had not felt consulted or included in her care, as stated in previous examples. Haare's cultural safety concerns were that his needs insofar as cultural programmes and activities were concerned would be met in the discharge planning. programmes and activities. He also added that:

> *It would be good to know about all the Maori programmes around so that we could go to them. Like kapa haka and learning how to speak it and that. I used to know but now I've forgotten so I want to learn again.*

Haare also felt that he had been misdiagnosed due to the fact that the staff who attended at his first admission ten years earlier did not have any knowledge of the cultural issues that he had been talking about. He was not able to elaborate on that point except to say "I feel I was misdiagnosed at the start".

One of the worker participants was of the same opinion in discussing the cultural safety issues, stating:

> *My opinion is that some patients are misdiagnosed. They are not asked the right questions at the start and therefore they are categorised only within the psychiatric diagnoses. I feel that all assessments and diagnosis for Maori should have a Maori consultant there, like a tohunga or someone who knows what the patient is describing especially if it includes spiritual things.*

The patient participants in this study showed a range of cultural expectations - from one who did not seem care whether or not there was cultural safety input, to others for whom there were high expectations. There are strong links between cultural expectations and cultural identity. Chapter Two discusses issues of identity for Maori, highlighting the fact that Maori are in various stages of cultural identity. This is dependent on a range of factors such as up-bringing, whether they have been isolated from their own turangawaewae, urbanisation in some instances, and colonisation. Durie (1994:167) suggests, that from post-World War Two, many third and fourth generation Maori became urban migrants and "were effectively cut off from any tribal links". He adds that "while tribal organisation has flourished since 1984, and a range of cultural activities has emerged to enhance a Maori identity, not all Maori have shared in those developments and assumptions cannot be made about Maori aspirations or preferences".

The Blueprint (1997 :33), which is the national mental health development plan for all mental health services in Aotearoa, has within the framework for Maori a guideline stating that there needs to be assessment of cultural status and cultural needs to enable Maori values and healing practices to be offered as an addition to treatment. The Blueprint also supports the view that an environment in which Maori protocols and processes are acknowledged, and which allows for both physical and spiritual healing to take place, must be incorporated into all mental health services to meet the needs of Maori. If services are not culturally safe, it is difficult to keep patients safe and prevent relapse.

Conclusion

In conclusion, this Chapter continued with the discussions of discharge planning based on participants' comments, centering around information, resources and cultural safety. In the section concerning the receiving of adequate information the varied responses of the patient participants concerning their experiences make it obvious that, from their perspectives, there are still many gaps. These were related to the lack of information about ongoing support services and social activities. It is the identification of such needs that can work towards improvement in services for Maori mental health patients and their whanau, and which will be part of the focus of the next chapter.

Resource gaps were seen mainly in the form of the need for more Maori mental health workers - which is also an acknowledgment of the Ministry of Health as earlier suggested. Cultural safety presented a number of ideas of patient needs for cultural sensitivity in care, to assistance into cultural programmes and activities including rongoa and the findings in both Chapters Five and Six, provides the foundation for the analysis and recommendations detailed in the next chapter.

Chapter Seven - The findings and recommendations around the effectiveness of discharge planning

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Introduction

I started this research with the question of evaluating the effectiveness of discharge planning for Maori mental health patients. This was from the perspectives of patients discharged from the ward of a provincial hospital, and staff involved at various stages of care in patients' discharges. I began with the objective of the research which is to improve discharge planning for Maori mental health patients.

Patient involvement

This research identified that the majority of patient participants perceived that they were not involved in their discharge planning. There are some key principles in the discharge planning guidelines that refer to patient involvement (Western Bay Health, 1994). One principle is that the client's strengths, aspirations and goals for achieving well-being are identified by personal participation. From the interviews and hui it was clear that only one participant identified their strengths, aspirations and goals during their discharge planning. The same person's assertiveness appeared to guide their timing of personal involvement in their discharge plans. The remaining five patient participants seemed unclear about personal involvement.

If we are to make improvements to discharge planning for Maori patients then mental health workers need to involve patients. Involvement is more than being informed about the plans. One of the staff participants suggested that when Maori patients do not comment or question things told to them by staff, assumptions of understanding may mistakenly be made. Contrary to this, the Maori person may be experiencing a sense of powerlessness or embarrassment resulting in a state of whakama. This is true at times for Maori who are well, and is, therefore, more likely to be so for Maori who are not well. I would agree that patients need to identify their own personal strengths, aspirations and goals toward well-being for a discharge plan to be effective.

The research identified that most of the patient participants were vague or unclear about personal involvement in their discharge planning. From their perspectives it is obvious that a more inclusive process is required. The question then for Maori is "How can we improve personal patient involvement in discharge planning for Maori patients?". Maori are a collective people and, as stated earlier, "a Maori on his (sic) own is unwell" (Durie, 1990:111).

Suggested developments for patient involvement

A recommendation is that the patient has someone of their choice with whom they have a trusting relationship, who can advocate and clarify issues in discussions or meetings concerning their discharge planning. This may be a whanau member, friend or particular staff member. More than likely the person would be Maori. The role of the advocate in this instance is to ensure that the voice of the patient is prevalent in the planning and decision-making. One way to assist this process would be to add a section to the guidelines to make provision for an advocate to be chosen by the patient.

Another key principle is that "discharge planning will be individualised for each client". An individualised programme cannot or should not, be drawn up without the input of the individual. In addition, staff need to ensure that the patient has full understanding of matters discussed at discharge planning meetings. To ensure that this always happened, the discharge form that the patient is given upon discharge should include a section referring to the individualised plan for/with the patient. A tick box for the patient to sign if they were involved with an individualised plan would then ensure that the patient had some control in the situation. If they were not involved, they would not sign the form. A copy of the discharge form would be placed in the patient file, which could then be used as a measuring and audit tool for effective discharge planning.

Whanau involvement

The key principle endorsing whanau involvement in the hospital discharge planning guidelines states that:

> *Family, whanau and care-givers will be jointly involved with the patient and the treatment team in developing a discharge plan. This process as well as the discharge options, will however, be subject to cultural, ethical and legal constraints with informed consent from the client.*
>
> (Western Bay Health, 1997:2)

The whanau concept is integral to Maori societal structure as the basic social unit is the whanau (see Chapter Two). Durie's (1994:1) example reiterates that the process of whanaungatanga is fostered through the strengthening of active involvement regarding whanau ties and responsibilities. These same principles are evident in the stories of whanau involvement for the patient participants in this study.

Two patients had both immediate and extended whanau support, two had immediate whanau only, one patient had the extended whanau support of the Maori staff and residents of a supervised home, whilst one patient chose not to have whanau support. The support given to the participants ranged from attendance, input and information-sharing at discharge planning meetings, regular pre-discharge hospital visits, pre-and post-discharge transportation, accomodation for the discharged person, post-discharge monitoring of patient well-being and on-going support. Examination of the three patients' discharge planning documentation provides evidence of whanau involvement in two of the three cases.

Suggested developments for whanau involvement

It is clear from the examples presented that, there was whanau support and involvement for the participants in this study, who chose to have it. Community care is often the family and in many cases, provided by women (Cheyne, O'Brien, & Belgrave, 1997:102). What we do not know is the health effects of caring upon whanau members, whose rates of poorer health compared to non-Maori are high to begin with (Department of Statistics, 1992). Are we making them more unwell by the deinstitutionalising of mental health patients? A valuable area of research for Maori would be to measure the spiritual, health and social impacts on whanau who are caring for their turoro discharged from psychiatric wards or hospitals. A recommendation for further research around the discharging of Maori mental health patients back to the community is to measure the physical, emotional, spiritual, family and monetary cost and impacts on the whanau. This could be a means of obtaining more support for caregivers.

Patient control after discharge

We have moved, in Aotearoa, from institutionalised care for mental health patients which was mainly long-term and where patients did not have control in either treatment or discharge. Deinstitutionalisation, by contrast, emphasises shorter stays in psychiatric wards or hospitals, discharging of patients to their communities, and patient and whanau involvement in care and treatment. This section examines whether or not patients felt that they had any control in post-discharge care plans.

The research revealed that only one of the patient participants felt they had full control. This was evidenced by comments that suggested regular staff/ patient interaction where the patient was part of the discharge planning decision-making. Two participants felt they had some control, two participants perceived that they did not have any control and one participant was unclear. Of the staff participants, one felt powerless and without control at times among other mental health colleagues in some of the decision-making processes concerning patients' discharge. This participant felt also that, often decisions for patients were made in meetings that were just for staff. As stated by participant 5:

> *Decisions about patients are made in meetings and then the patient is told. They don't really have any control in those cases.*

A key area identified where lack of control was experienced was in residential arrangements. The patient participant who was on an Inpatient Treatment Order felt he had no control over where he was to live as these decisions are made for him under the Order. The discharge planning documentation reported that the patient was to be discharged to a Level 4 accomodation. In Tauranga there is only one such residential place that fits the category. For this patient, not only was there no control, but there was also no choice.

Another participant who felt she had no control in the choice of her living arrangements after discharge experienced discharge planning that was rushed, and completed at short notice. Because she had never been into mental health services prior to the admission, she was not fully aware, or in control, of what was happening. Another participant, who has spent 33 years in institutionalised care, did not think she could make decisions for herself and therefore did not have control. The two participants who felt they had some control relied heavily on whanau input to assist in decision-making. Of the two, one felt disadvantaged by his own control. He felt that, because he was in control of his situation, he did not receive the follow-up care that he believed he needed. The staff participant who felt powerless during some of the discharge planning meetings gives some indication that plans are being made **for** patients rather than patients having control and decision-making power. If a presumably healthy staff member feels powerless among colleagues at times, a probability is that a patient would tend to feel even more powerless and have less control.

Another area in which the patients felt they had no control concerned activities and programmes. For some, the activities were part of residential care programmes which participants felt obliged to attend. If we are to make discharge planning more effective for Maori mental health patients in the deinstitutionalisation system, then we need to ensure that we do not impose institutionalisation practices in any area.

Suggested development for patient control

Patient control seemed largely dependent on staff attitude and practice at both primary and secondary levels of mental health care. As mentioned in Chapter Five, successful integration for the patient into the community is dependent on consultation and co-operation between health professionals, the patient and the whanau. Key concepts for successful integration of patients to the community are "consultation" and "co-operation" (see Chapter One) between patients, health professionals and caregivers. Consultation, and not imposition, should be the rule between all discharge planning parties. When mental health staff are able to consult from a platform of equality, this will eliminate any hierarchical power structure that may arise between professions and provide a collaborative approach between colleagues. Likewise, when patients and their whanau are consulted in discharge planning they are more likely to feel a sense of personal power and therefore will be more able to make a contribution towards their own plans for well-being.

However, unless systems are in place, practices, when left to individuals, changes according to the individual practitioner. Within discharge planning, a system to safeguard patient control would be to add a list of "patient satisfaction" items to the discharge plans. The areas where patients in this research felt lack of control were: where they were to live, and programmes and activities planned for them. A check-list for patient satisfaction and control of plans on the discharge planning forms would assist in ensuring the patient was more involved and in control of their situation. The Tauranga hospital have employed some consumers to ensure that there is a consumer advisory voice in the decision-making of mental health and mental health services. A suggested development of this is to approach the consumer group with these findings and to involve them in devising appropriate forms that meet the needs of patients in discharge planning.

Information - Discharge planning forms and documentation

The research identified that staff and patient participants found information lacking. One participant emphasised the deficiencies in the discharge planning documentation. This is evidenced also in the examination of the patients' files concerning their discharge. The three patient files examined produced three different styles of recording. One file contained basic information only, whilst the remaining two furnished more intensive reports. However, the more intensive reports were not consistent in either style or form.

The same participant also believed that the discharge planning forms could be improved to provide more information about the patient, including their physical health and social conditions. The research found also that at present on the ward there is not a standardised discharge planning form but that a basic discharge information sheet is given to each patient. However, this is a process that is to be examined. In Kemp's (1990) deinstitutionalisation plan, emphasis is placed on the use of standardised assessment and discharge planning instruments, including documentation forms.

Suggested development for discharge planning forms and documentation

Although the hospital guidelines for discharge planning are now in place it is evident from the staff participant interviews and the patient files that improvements in information gathering, documentation and recording of discharge planning are needed. This research found that there was not a standardised discharge planning form. This study recommends that a comprehensive standardised discharge planning form is devised and used for all discharges of mental health patients from the ward. One of the staff participants had stated that there were examples of better and more detailed discharge planning forms used at other hospitals. A project team, including the consumer group, could be involved in researching and producing forms that will make discharge planning effective not only for Maori, but also for all patients discharged from the mental health ward of Tauranga hospital.

Information – To patients and caregivers about the discharge

Another key area where a lack of information was identified was when discharges were made back to communities and Maori mental health staff in the community were not informed about discharges of patients returning to their iwi community. Often these workers had supported the person prior to admission, and were also there to provide the post-discharge care. These staff participants had experienced some improvement in communication with hospital staff discharging patients back to their area. However, there were still times when there was no communication, and staff participants were often unaware that the patient had been discharged until either they contacted the whanau or the turoro contacted them. It is by examples such as these that turoro are highly likely to fall through the gaps when there is no formal integrated service arrangement that ensures continuity of care or support. This also led on to lack of knowledge concerning patient medication.

An important part of post-discharge care is the patient's medication and the monitoring of this (Hochberger, 1994). The research found that the participants who were iwi support workers were, in general, often not informed about the discharged turoro's medication. In some cases the iwi workers were not called in until the turoro became unwell. From their perspectives they believe that informed and purposeful monitoring of medication assists the patient in optimum well-being. This was also supported by the evidence of some patient participants who were unable to take charge of their medication when they became unwell. One patient participant stated that he would have welcomed medication monitoring even to see if what he was doing was right. The research shows that review of medication needs to happen as well.

One staff participant discovered that a patient she had been visiting to provide mirimiri had not had his medication reviewed for a number of years. Through the participant's advocacy the medication was reviewed and changed and, in her opinion, the patient's health and well-being improved. I have argued that it is highly likely that re-admissions occur because of a lack of monitoring of medication, and/or premature discontinuation of medication. Monitoring of medication can assist the patient to maintain well-being in the community and perhaps lessen the revolving door syndrome for some Maori mental health patients.

Suggested development for information to patients and caregivers about discharge

Part of the information-gathering which should take place nearer the admission stage of the discharge planning with the patient would be to ascertain whether the patient has been using support services in the community. If the patient is satisfied with those services and intends to continue with their support after discharge, then the service providers, and in this case iwi, could be contacted during the discharge planning and informed about the care plan prior to patient discharge. This would provide a seamless service and ensure continuity of care particularly immediately after discharge, which can be a vulnerable time for many turoro leaving hospital. A formal link between primary and secondary mental health services in discharge planning for the turoro would also lessen the likelihood of gaps occurring between services - including abuse and misuse of, or failure to take, prescribed medication.

It is evident from the patient participants' discharge planning files, two of whom are regular readmissions to secondary mental health services, that review of medication happens often for those currently using services. However, for patients who have been discharged and whose mental health is managed and maintained in the community without regular readmissions to hospital, it is highly likely that – as the research found – over a period of years reviews of medication can be missed. A recommendation is that either six-monthly or annual "reviews of patient medication" are carried out by primary health care workers. This means community care plan forms would include documentation for medication review. This would ensure that medication is reviewed regularly particularly over long periods of time.

Information - On services

One patient participant found that information on services in the community was lacking. The Mason Report (1988) expressed concerns that broader post-discharge activities left solely to patients to initiate could lead to deterioration in health if they had no knowledge of groups and activities within the community. Two patient participants received adequate information about community activities and groups and were therefore able to participate. The staff participants in the study informed patients about services and groups and assisted patients to attend. From the research it is obvious that on the whole, information is given to patients. This seems to be dependent on the practice of the individual.

Suggested development for information on services

For a consistent and equitable sharing of information concerning services, information such as pamphlets and newsletters about community services should be accessible to patients. A community bulletin board within the ward would inform patients of the range of services so that they can make informed choices about groups or activities in which they would like to participate. Community organisations could be informed about the bulletin board and encouraged to leave pamphlets on the ward and update their information as/if it changes. A community diary which is published annually, advertising health and social services as well as interest groups, would add to the contribution and information of services on a bulletin board. Having information such as in pamphlets or newsletters available enables patients to make enquiries for themselves and has the potential to foster personal empowerment for the patient. Information supplied by staff about community services was helpful according to patient participants. This needs to continue. Between the two methods mentioned, of pamphlets and newsletters about services, and staff informing patients about services - all mental health patients should have some knowledge of the services to make informed choices for discharge planning. In addition, the discharge planning forms could have flyers attached about events and support groups. Some Maori community services produce monthly newsletters. Each current one, added to a patient's discharge form, would keep them up-to-date not only about events in that area, but also about services.

Information - Follow-up care

A key worker/clinical case manager has a major functional role as a case co-ordinator in the discharge of mental health patients from the ward (Western Bay Health, 1997). This role may emerge from any of the mental health professions such as nursing, medical, cultural, community work, social work, occupational therapy or psychology. The key worker has a pivotal position amongst all stakeholders involved in the patient's care. The outcomes of this role are to improve clinical management of discharged people and to ensure a seamless service (Western Bay Health, 1997). Both national and local guidelines suggest that the post-discharge key worker needs to be identified and that there is clear communication of the completed plan to the key worker.

This research identified that only two of the patient participants knew how to contact their caseworker. In both these cases there was a service to contact rather than a key worker. In reality, therefore, the patient participants were not aware of a specific person who was allocated as their caseworker. Two others had their caseworkers' contact telephone numbers on cards or written on paper. However, on the days that I spoke with the participants neither had the cards with their caseworker's contact numbers. They stated that they relied on either whanau or iwi workers to link them with their caseworker when they became unwell. Examination of the patient participants files in this section revealed that they lacked information on who the caseworker was in two out of three cases.

Suggested developments for follow up care

As the key caseworker has such a vital role in the on-going care and support role for patients' discharge to the community (Ministry of Health, 1993; Durgahee, 1996) identification of the caseworker for each patient needs to be assured. There is evidence that the hospital policies for a caseworker system are in place. However, the research found gaps in that not one patient participant knew the name of their caseworker. This research did not ascertain whether the system appointed a caseworker whilst the patient was in hospital and/or whether another caseworker was appointed after discharge, or in fact whether all discharged patients had a caseworker.

Managers need to establish clear roles for the management of patients in the community to encourage monitoring and support of the turoro and to prevent workers from avoiding their roles in the support network. The discharge planning forms need to include the name/s of the caseworker/s who then identify themselves to the patient, preferably before the patient is discharged, to discuss on-going treatment and care. Where the caseworker is an identified iwi community worker, a detailed risk assessment and discharge planning form needs to be part of the transfer.

Resources

The research identified two major areas concerning lack of resources as perceived by the participants in the study. Kaupapa Maori staffing was one issue and patient accomodation was another. Both staff and patient participants had concerns for the break in continuity of kaupapa Maori services for patients when a kaupapa Maori staff member was away from the ward. For some patients, these staff members were as whanau and both they and their services, were missed, when staff were off sick or at training. The research found that some staff participants, both primary and secondary, who were not part of the kaupapa Maori mental health services, felt that more support for Maori staff was needed. This was in the form of Maori relief staff to fill in when any member of the kaupapa team was away. Maori relief staff would also give the permanent staff opportunities to attend hui for networking and whanaungatanga. Currently, when kaupapa Maori staff are absent, the gaps are filled by mainstream staff. The argument is not about mainstream workers filling in, it is about providing Maori mental health patients with a seamless kaupapa Maori service when it is offered.

Research found also that there is a shortage of residential accomodation for mental health patients discharged from the ward. Residential housing is often stretched to the limit and many turoro are living in caravan parks and boarding houses. The Mason Report (1985) comments that deinstitutionalisation needed to be adequately resourced. A useful area of research today would be the effects of discharge planning and accomodation needs of the Maori mental health patients in Tauranga.

A secondary effect of the shortage of suitable accomodation is the added burden and stress for mental health staff at the coal-face. They are pressured by the turoro into finding somewhere for them to live, when sometimes there is nowhere for them. In one case a turoro had to pitch a tent on a lawn for the night. Sometimes turoro will not leave a mental health worker's office or place of work until a place has been found for them.

Suggested developments for resources

Durie's *Puahou* plan for improving Maori mental health is to strengthen the Maori mental health workforce at all levels (see Chapter Six). It was evident in the research that kaupapa Maori services in secondary care were under-resourced in Maori staffing. Responsibility lies with the organisational managements to fill the identified need. A recommendation is that Maori are resourced to provide, including a contingency of on-call relief staff. Staffing was also inadequate in both primary and secondary community care.

A further research need in Maori mental health is for a more in-depth study on the adequacy of resources, including staffing, for meeting the need of discharging turoro back to the communities. In-depth research on Maori mental health patients' accomodation needs, to assist policy development and practice towards providing adequate accomodation must also be instigated.

From a practice level, staff having to cope with extra stress and pressures need the support of the colleagial whanau as well as clinical and professional supervision. This is the responsibility of the organisation, in this case the Tauranga hospital mental health services.

Cultural safety

The research found that most of the patient participants were satisfied with the level of cultural safety they experienced whilst they were in care. However, one patient felt he had been misdiagnosed at the beginning of his mental illness as he did not have anyone present who had knowledge of the cultural spiritual issues he had attempted to convey. The point of the likelihood of Maori patients being misdiagnosed was supported by the comments of one of the staff participants who also suggested that a Maori consultant, such as a tohunga, should be present at all assessments and diagnoses. Patient participants expressed their desire for a marae environment where they could learn about their culture and participate in cultural programmes as part of their treatment. The Blueprint (1998:61) expounds the importance of culture in treatment for Maori, supporting an environment which acknowledges protocols and processes and allows for physical and spiritual healing to take place.

Suggested developments for cultural safety

The present assessment strategies for Maori are culturally limited. Maori mental health patients deserve greater emphasis on cultural assessment including the personal, interpersonal, whanau and their social systems using a model such as *Te Whare Tapa Wha*. A cultural assessment would need to be carried out by a Maori consultant or practitioner. Policy development of a research- based tool which is sensitive to cultural needs is recommended. A further recommendation is that cultural environments for Maori patients are made available by primary and secondary providers of mental health services for treatment and care.

Conclusion.

This chapter presents recommendations and suggested developments for discharge planning for Maori mental health patients. An analysis of the findings and suggested recommendations for improvement of discharge planning from the ward are: that patients are involved in their discharge planning and not just informed; that care be taken to ensure that patients have full awareness and understanding of their discharge plans; that an advocate for the patient is available ,if needed, during discharge planning; that research should be carried out to evaluate the physical, emotional, spiritual, family and monetary impacts for whanau in caring for their turoro in the community; that both primary and secondary practitioners ensure consultative processes rather than controlling ones; that formal links are made between secondary and primary mental health services before the transfer of patients between services; that regular reviews of patient medication for long-term community patients occurs; that patients are informed of various services and interest groups; that each patient's case worker forms a working relationship with the patient before discharge and ensures that the patient knows how to contact them; that resources are made available for adequate kaupapa Maori staffing for Maori mental health patients at all levels of care, including both primary and secondary; that research towards policy development in accomodation needs for turoro in the community is carried out; that cultural assessments with Maori consultants form part of treatment and care; and that turoro have access to cultural environments as part of their treatment and care, including discharge planning.

The growth of the seed - Final comments

A move in the mental health system towards patients being rehabilitated into their communities has seen major changes, not only in treatment but also in the need to initiate more and better services to meet the demands. It is within this environment that discharge planning has become a vital and important part of the care plans for any mental health patient discharged from a psychiatric ward or hospital today.

In researching the effectiveness of discharge planning for Maori mental health patients, this study sat within the framework of Maori-centred research as described by Cunningham (1998). However, because I am Maori and hold strongly to kaupapa Maori values and beliefs, the guiding principles are from a kaupapa Maori theoretical framework. These were the whanaungatanga relationships with the participants, involvement from physical, spiritual, ethical and moral positions, and Maori contextual relationships that address power and control issues (Bishop, 1998:130).

I traced the beginnings of the research journey which, for me, began ten years ago. The sowing of the seed was my aroha and concern for Maori whanau, including a kuia who was being pressured into caring for a mokopuna ready to be discharged from a psychiatric institution. The kuia was not in a position to care for her mokopuna due to her own health and social disabilities. The perceived pressure placed upon her caused her guilt and a state of whakama. As deinstitutionalisation was happening at a rapid rate, I wondered how Maori were going to cope with whanau members returning home, or to their communities. My own involvement in mental health as a counsellor and currently, team-leader of a kaupapa Maori mental health unit within a hospital, has heightened the awareness of the need for good discharge planning for Maori mental health patients. For the research I used method triangulation of patient participants, staff participants and patient files. The study identified that whanau, hapu and iwi workers have a vital role among Maori in their community. Long after the turoro have left the wards or hospitals, they are back to the long-term mental health support, in many cases, of their iwi workers.

My role in researching the effectiveness of discharge planning for Maori mental health patients does not finish with the completion of this thesis. Analysis of the findings of the research has identified a number of areas for suggested developments for discharge planning for Maori mental health patients. If we want to be a part of the change toward more effective discharge planning for Maori mental health patients then I believe that we must not only listen, but also assist further discharge planning policy development that will help to achieve those results.

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GLOSSARY

Aroha	Love
Awhinatanga	Help, assistance, support Embracement
Hara	Error
Hinengaro	Mind; heart; conscience
Hoa	Friend, mate
Hoha	Nuisance
Hui	Gather; meeting
Iwi	Tribe
Karakia	Prayers; incantations
Kaumatua	Male elder
Kaupapa Maori	Maori concepts and ideas; foundation
Kawa	To carry out ceremony; protocol
Kuia	Female elder
Manaakitanga	Befriendment; care and support
Mauri	Life-force
Mokopuna	Grandchild, grandchildren
Noa	Free from sacredness
Papakainga	Original home
Ritenga	Custom; meaning
Rohe	Border of land, boundary
Rongoa	Medicine
Roopu	Group
Tangata whenua	Native inhabitants
Taonga	Treasures; property; artefacts
Tapu	Sacred; unclean
Taunaha	Bespeak
Tauiwi	Foreigner
Te Ao Maori	The Maori world
Te AoTawhito	The old world
Te Reo	Language
Tiaki	To guard; look after
Tikanga	Custom; rule; principles
Tinana	Body
Tino rangatiratanga	Sovereignty; self-empowerment
Tohunga	Expert
Tupuna	Ancestors
Ture	Law; institution
Turoro	Patient
Wairua	Spirituality
Whakama	Shy; embarrassed;
Whakanoa	Remove tapu, render common
Whakapapa	Genealogy
Whakatauki	Proverb

Whanau	Family; extended families
Whanaungatanga	Relationships; connectedness
Whenua	Land

APPENDIX 1

Western Bay Health

• QUALITY CARE BY QUALITY PEOPLE •

Quality Care by Quality People

Nga Mahi mo te Hunga Wairangi

MENTAL HEALTH SERVICES

DISCHARGE PLANNING
FOR PEOPLE
WITH MENTAL ILLNESS

June 1997

These Guidelines are developed from, and consistent with, the National Guidelines developed by the Mental Health Services Section of the Ministry of Health, July 1993.

FOREWORD

Discharge Planning is a process through which a client's identifiable needs can be safely delivered. This ensures optimal care as a client moves through the system from entry to exit. It is essential that care systems are acknowledged and factored into the care planning process with the client's assistance.

There must be a high quality as well as sufficient quantity of community based care frameworks to meet the client's needs otherwise the re-admission rate for mental health clients will never be addressed.

When Discharge Planning is evident, and better information and monitoring systems are in place, then the service offered to those with a psychiatric illness and disorder can be truly patient focused and achieve clinical excellence.

Sue Lewer, B. Soc. Science
MENTAL HEALTH MANAGER

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We also acknowledge the work developed by the Mental Health Section of the Ministry of Health on 'Guidelines for Discharge Planning for People with Mental Illness', July 1993.

This project gives us the chance to take our Mental Health Services to the leading edge.

To be the best in the Bay

To be the best in the country

Thank you for your contribution

and

Welcome to a new era in Mental Health

CONTENTS

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INTRODUCTION

Western Bay Health has an active commitment to the Treaty of Waitangi and the improvement of Maori health.

Discharge Planning is a culturally safe formal process that leads to the development of an on-going, individualised programme of care and support which meets the objectively assessed needs of a client/consumer on leaving hospital. It addresses the social, cultural, therapeutic and education interventions necessary to safeguard and enhance that person's health and well being in the community.

Discharge planning involves the client, family, whanau, the treatment team, and it is particularly important in the case of patient with mental disorders (including substance abuse) who have been in mental health services with psychological problems or mental illness.

The multi-disciplinary team has the responsibility for developing and documenting an appropriate discharge plan. In the case of clients who are assessed as ensuring continuing care and/or support there should be a designated key worker/clinical case manager who is responsible for co-ordinating the implementation of the plan.

These Guidelines are intended to assist the development of discharge protocols for all clients. It is recognised, however, that for clients who are treated voluntarily and who choose not to comply with a discharge plan, it is only the nature and quality of the clinical relationship which can influence this.

These Guidelines are provided for staff of Western Bay Health to assist in the management of the discharge process for clients from the Mental Health Service.

This project takes us another step forward in our drive to be the best provider in Mental Health Services.

KEY PRINCIPLES OF CULTURALLY SAFE DISCHARGE PLANNING

1. The principal aims of discharge planning will achieve:

    continuity

and co-ordination of care and treatment

    provision and mobilisation of a level of support that will correspond to the assessed needs of the patient for community living

    early intervention during crises and relapse of illness

    optimal health and well being for the client/consumer

2. The strengths and aspirations of the client and his/her goals for achieving a sense of well-being will be identified through maximum possible client participation in the discharge planning process

3. Family, whanau and care-givers will be jointly involved with the patient and the treatment team in developing a discharge plan. This process as well as the discharge options, will however, be subject to cultural, ethical and legal constraints with informed consent from the client.

4. Discharge planning will incorporate mental health services that are culturally safe for all the people that use them. The clients, when using a service provided by people of another culture should be able to do so without risk to their own cultural needs.

5. A Needs Assessment of the client will be a preliminary step in the development of a discharge plan.

6. Relevant clinical issues will be addressed in discharge planning

7. Discharge planning will be individualised for each client.

8. A Key Worker/Clinical Case Manager will be responsible for co-ordinating the implementation of the discharge plan using 'Case

Management' methods. This will mean involving persons with extensive knowledge of community services.

9. The service to be responsible for the care of the client after discharge should be involved in the planning

10. Unit Mangers of Mental Health Services will be responsible for co-ordinating:

    i) regular audits of discharge planning to ensure that there is continuing improvement of its format and implementation

    ii) providing or linking with an effective 24 hour "acute response system" for dealing with psychiatric emergencies

    iii) where appropriate, ensuring that clients with chronic mental illness are given assistance to re-enter community residential care without delay if this becomes necessary on clinical grounds

    v) working to ensure that contracts entered into with Trusts and private organisations providing residential accommodation must have either approval or registration as set out in the HOMES process

THE PROCESS OF DISCHARGE PLANNING

Discharge Planning is formulated as part of the care plan from the time of the client's admission so that the transition from acute services to community is part of a seamless process.

Discharge planning for Western Bay Health clients should commence when a client is admitted to hospital or to the Mental Health Unit. There will be evidence of discharge planning throughout the treatment planning process.

The aim of discharge planning will address the following areas:

Adequacy of the services to meet the post discharge needs, including highest level of independent function and quality of life possible

> Individual level of functioning and response to treatment
>
> Compliance with the discharge treatment planning
>
> Appropriate modification in treatment programmes to reflect changes in the individual's condition with careful monitoring of medication side effects
>
> Appropriate support for family or other care providers following discharge from the acute services

PROCEDURE

A Key Worker/Clinical Case Manager will be appointed and from the assessment completed using the Assessment Tools available, will formulate a plan with the client for discharge needs and goals. The discharge plan will involve clients family, significant others, General Practitioners and community treatment groups.

KEY WORKER/CLINICAL CASE MANAGER

STANDARD

A key worker/Clinical Case Manager will be identified within the Mental Health Services for each client

SERVICE INDICATORS

Key workers /Clinical Case Managers are available and can be identified to support clients

A procedure for Key Worker/Clinical Case Manager allocation to client exists

Personnel understand, or can access information
about the Key Worker/Clinical Case Manager role.

OUTCOME

Improvement in the clinical management of clients

Seamless case provision if service to client is evident

Client expresses satisfaction with the service

POLICY AND PROCEDURE

GENERAL

1. Key Workers/Clinical Case Managers main function is a case co-ordinator
2. Key Worker/Clinical Case Manager may emerge from any mental health profession, i.e. psychological, nursing, medical, cultural, occupational therapy, community worker, social worker
3. Key Worker(s)/Clinical Case Manager may be appointed "The Responsible Clinician" when caring for clients under Compulsory Assessment and Treatment

KEY WORKER/CLINICAL CASE MANAGER ROLE

1. Is identified for the client at the time of admission
2. Advocates and co-ordinates the provision of health services to the client
3. Consults with whanau, significant others and peers from the time of assessment, through treatment and rehabilitation
4. Ensures that the procedure for informed consent is adhered to during all health transactions with the client
5. Incorporates other specialist activity as necessary or requested by the client (e.g. cultural consultancy)
6. Oversees and co-ordinates the clients' clinical resources, to ensure that communications are clear, legible and followed by each person involved in the case.
7. Maintains a regular updated report/record/information base indicating individual client progress, health activities planned, implemented and evaluations.

ASSESSMENT

STANDARD

A comprehensive assessment process is completed in partnership with clients and documented on entry into the Unit

SERVICE INDICATORS

Assessment procedures exist

Personnel are able to complete an assessment to the required standard

Assessment guidelines and procedures will be in place and adhered to

OUTCOME

The client's strengths, needs and issues are identified to the client and service

Clients are satisfied with the assessment

POLICY AND PROCEDURE
SERVICE GUIDELINES

General

1. Comprehensive assessment is completed and documented within 2 hours of presentation for admission

2. Initial or crisis assessment - basic information face-sheet is completed within half hour of first contact

3. As a result of the assessment, a treatment plan is formulated and implemented by the responsible clinician and/or key worker/clinical case manager

4. The assessment documentation reflects the information in the referral letters, assessment profiles and significant people involved with the client on admission

5. Documentation of individual assessment responds to the needs and wishes of the client

6. There is evidence of collaboration with other health and justice agencies as required

7 There is evidence that the assessment documents are discussed openly, honestly and sensitively with the client, and the client is able to add written comments if they so wish

8. Family and significant others are involved in the assessment as requested by the client

9. Issues and limits of confidentiality are discussed at first contact and documented

10. Documentation will be accurate, relevant and concise

11. There is evidence that the standard for Informed Consent is adhered to

12. Client and family satisfied

TREATMENT AND PLANNING

STANDARD

Treatment is planned and implemented in partnership with the client and will be based on the assessments

SERVICE INDICATORS

A treatment plan exists for each client

Personnel are able to complete a treatment plan to the required standard

Treatment and planning guidelines and procedures will be in place and adhered to

Discharge Planning activities will be reflected in the plan

OUTCOME

The client is satisfied with the planning and treatment options.
The client is satisfied with the discharge plan.

INITIAL DISCHARGE TREATMENT PLANNING

The following Discharge Planning activities will be reflected in the initial treatment plan which starts on admission:

Key Worker/Clinical Case Manager is appointed and documented

Client is involved as much as possible in identification of discharge needs and goals

Discharge plan is developed in association with assessment and treatment

Discharge plan reflects changing needs of client and involves family and significant others

COMPREHENSIVE PLANNING

The following discharge planning activities will be reflected in the comprehensive treatment plan:

Use the initial treatment plan and expand on it

Continue the maximum possible participation by the client and others significant to him/her in the development of the plan

Perform individual needs assessment.

Devise plans based on needs assessment

Initiate on-going contact with community based follow-up services

Initiate wellness management information/education including the presenting problems, use of medication

Include whanau/family/care-giver in education about the disorder and how it affects the client and his/her family

Implement initial steps of discharge plans including client and key worker visits to possible community accommodation, client attending community based services etc

POLICY AND PROCEDURE
SERVICE GUIDELINES

GENERAL

1. There is evidence of a documented treatment plan that is adhered to

2. Treatment plans included discharge needs and goals.

3 There is evidence of inter-disciplinary evaluation of planning and treatment where required and achievable and acceptance treatment goals are set with the client

4. All significant client contact is documented progressively and accurately by the allocated Key Worker/Clinical Case Manager

5. Treatment plans are legible and understandable

6. Interim treatment may need to be documented prior to the completion of assessment

7. Family, whanau and carers are involved in the treatment and planning as requested by the client

8. There is evidence that consultants from Iwi have participated in the treatment and planning as requested by the client

9. There is evidence that consultants were made available from other ethnic and relevant groups as requested by the client

10. The planning and treatment is regularly reviewed and evaluated for effectiveness involving all concerned parties, and where discharge of client is an option, the discharge procedure is adhered to

11. Treatment plans are available for the client to inspect, copy and add comment if they wish, where clinically appropriate

12. Treatment plan is kept in the client's file.

13. There is evidence that the standard for Informed Consent is adhered to

14. Client and whanau express satisfaction

DISCHARGE

STANDARD

To maximise the highest standard of independent living through a comprehensively planned standard of care

SERVICE INDICATORS

Key Worker/Clinical Case Managers maintain communication with all people presently involved or to be involved in the care of the client

OUTCOME

A comprehensive mental health service

will be available to the client dependent on needs

Quality of life for the client will be enhanced

Reduction in re-admission rates to the Psychiatric Unit, Western Bay Health

THE CONTENT OF DISCHARGE PLANS

The content of the "discharge plan" can be summarised into four different components. These are:

client details

a comprehensive psychiatric assessment

service arrangements

checklist of necessary client-related and administrative actions to be taken to ensure a well managed discharge

CLIENT DETAILS

This information can be taken from the mental health information system and includes:

name Maori non-Maori
date of birth
client number
legal status
current residential address
name of Key Worker/Clinical Case Manager
name of clinician (if different from Key Worker)
record of incident reports (date and reference)

COMPREHENSIVE PSYCHIATRIC ASSESSMENT

1. Strengths and Aspirations

This assessment will also identify the strengths and aspirations of the client and assist him/her to formulate realistic goals and is critical to the success of rehabilitation

2. Clinical Needs

An individual client has particular needs for appropriate treatment which depend on the nature of the condition(s) from which he/she suffers. These will be identified and procedures for meeting them specified

The clinical needs can be compiled from case notes or a case summary and from the initial and comprehensive treatment plans. These needs include:

diagnosis and clinical problem first

precipitants to illness

pre-illness level of functioning

treatment history and response to treatment

capacity and willingness of the client to co-operate in the safe administration of treatment

willingness of the client to be involved in discharge planning

identification of factors that may predispose to relapse of illness

family understanding of illness and treatment

family needs related to illness

specification of recommended further treatment and monitoring procedures

identification of the procedural requirements where compulsory treatment is undertaken pursuant to the Mental Health (Compulsory Assessment and Treatment Act) 1992

education of the client and caregivers with regard to treatment, including side effects of treatment

identification of risk factors which predispose the client to distress, relapse of illness or behaviour which may endanger him/her or the public

specification of procedures to deal with risk factors and adverse incidents

specification of dates for clinical reviews

GENERIC NEEDS

All clients who move into the community living situations have basic needs that will be identified using needs assessment and they will be considered in developing discharge plans:

a) Living Arrangements

living situation prior to hospitalisation

adequacy and the availability for return to living situation

needs for strengthening that situation

type of accommodation

capacity to mange daily living activities

supervision, support (family, health, professional, other)

encouragement and skill development for achieving an adequate level of independence functioning

b) Economic Needs

education or employment opportunities

work skills development

accessing & maximising appropriate income support

budgeting assistance

c) Personal Health Care

timely and affordable access to primary health care services and specialist health professionals as required

access to dental examinations and treatment

d) Social, Cultural and Spiritual or Religious Needs

opportunities for meaningful social, cultural, spiritual or religious activities

social skills and leisure skills development programmes

opportunities to participate in self help groups, survivor networks

DISCHARGE PLANNING

At discharge the following planning activities have been undertaken

Key Worker/Case Manager for post discharge has been identified

discharge preparation as in the comprehensive plan will have been completed

the various needs of the client's care in the community have been addressed (see initial treatment plan)

an integrated team approach is taken in planning service to meet the client's needs

there is clear communication of the completed plan to all health care workers involved

client expresses satisfaction

SELF DISCHARGE

1. Any client who wishes to discharge him/herself and who is legally entitled to do so, should sign a "discharge against medical advice" form
2. This form includes a statement that the client is discharging 'Against Medical Advice' and thus absolves the Unit of its responsibility to the client
3. The clinician responsible for the client should be notified that the client is about to, or has, discharged him/herself
4. A copy of the signed discharge form is to be placed on file
5. Where a client refuses to sign the 'Against Medical Advice', it should be signed by two clinicians witnessing the discharge

CLIENT ABSENT WITHOUT PERMISSION

1. Notify Supervisor and Armourguard to check hospital grounds
2. Notify family
3. Notify Police if client is dangerous, suicidal or a committed client who is at risk

POST DISCHARGE PLANNING

Responsibility for planning after discharge depends on the organisation of the follow-up programme. If on-going treatment is provided by an agency or individual not associated with Western Bay Health, that agency may assume the responsibility for continued planning.

SUMMARY

Specific discharge planning activities are important at each stage of treatment planning including the initial and comprehensive plans that are a part of inpatient treatment.

Continued monitoring and planning is required as the patient moves into the community based treatment.

Responsibility for the on-going planning, after discharge, rests with those providing the treatment in co-operation with clients, care-givers and family.

SERVICE ARRANGEMENTS

For each area of identified need there will be a statement about:

the service to be provided

or

the action to be taken

The complexity of discharge planning in the case of persons with multiple or complex disabilities makes the co-ordination of necessary services a critical issue. This may be managed by a suitable skilled key worker/clinical case manager properly matched with client need.

Good case management will include such factors as:

ability to form meaningful care relationship with client/family

treatment of co-morbid conditions such as alcohol and drug abuse, which may lead to the client being at risk

active follow-up when scheduled appointments are issued or when even minor adverse incidents are reported

efficient information systems that can identify clients currently at risk. e.g. clients of concern, client alert. Records should be readily available

CHECKLIST

There will be discharge checklists to monitor that all necessary actions are taken to make arrangements for the client's discharge, notify all concerned parties and to ensure that client information systems and hospital administrative procedures are updated.

INFORMATION SYSTEMS AND MONITORING CLIENTS

A significant difficulty in the discharge and community treatment and support, is monitoring the whereabouts of clients to ensure that they continue to have access to the necessary services. Information systems are being developed and/or improved to enable this.

Mental health Services information systems should:

ensure that details are kept of each client who is to be discharged and requires ongoing community treatment and support

The system must be kept current by mental health providers to record personal details such as:

name Maori non-Maori
date of birth and client identifier
date of discharge plan and file reference
legal status
current residential address
name of key worker
a record of incident reports (date and reference)

The information system will facilitate access to each client's file/case notes for follow-up purposes

All attendances/follow-up activities will be recorded and actively follow-up used if the client has not attended

At least six monthly, the client's clinical care state and aspects of care outlined in their individualised plans should be reviewed and a record made as to whether the client remains on the information system

Removal of the client from the information system should only occur in response to the client clinical review or if the client formally transfers to another psychiatric treatment service. The date and reason for removal must be recorded

Clients who are not subject to compulsory treatment orders are free at any time to discharge themselves from treatment. However, due to the nature of mental illness and some client's limited understanding of the consequences of ceasing treatment, it is important that every effort be made to continue to maintain contact and offer the necessary treatment services.

Regional Health Authorities will be ensuring the development of appropriate information systems by psychiatric services with whom they contact, in their region. They should also ensure that the information systems, where appropriate, can relate to each other and access care information for a central file. This will enable integration of services and continuity of care for clients.

APPENDIX 2

Kaupapa Maori Health Development, A Decade and Beyond.

The decade from the early 1980s was a time of great change and turbulence for all people in Aotearoa. New Zealanders were either a part of, or witnessed, radical restructuring of the state sector and dramatic social and economic reforms. These were driven by the beginnings of "Rogernomics" and a distinct shift towards market-driven policies of Libertarianism.

A pivotal point in the arena of Maori development was Hui Taumata, the Maori Economic Development Summit Conference convened in 1984 by Koro Wetere, the Minister of Maori Affairs. The conference emphasis on self sufficiency, strengthening of the tribal base and new environments for shaping social and economic initiatives for Maori was a turning point and added to the impetus to move forward (Te Puni Kokiri, 1994:58). Wira Gardiner (1994:58) declared that the hui "harnessed a drive and determination to improve the position of Maori and the following years witnessed an explosion of activity". Although both Maori and non-Maori were in times of political, social and economic turbulence it appears that, in many ways there were also times of opportunities.

Hui Whakaoranga, the Maori Health Planning Workshop held at Hoani Waititi Marae Auckland in 1984, was a leading national hui for Maori health. A commitment was made by a wide range of both Maori and non-Maori who attended the conference, and who agreed with – and were supportive of – the concepts that health is integral to Maori development, and that Maori culture is a key component to understanding health (Durie, 1994:1). It was there that Maori made the distinction for their own definitions of health clear, and affirmed that these were based on cultural perspectives. Other important focuses for health were the inclusive links of Maori language, marae and tribal developments and the aspirations for greater autonomy (Durie, 1994). According to Durie:

> *For Maori, the policy context needed to take into account not only socio-economic realities but also concepts such as wairuatanga (spirituality), whanaungatanga (family cohesion), mauri (the life principle) and mana (authority and control).*

He further expounded " that significant gains in Maori health could only be made if Maori were active participants in shaping priorities for health development and delivering health services (Durie,1994:2)

Some of those who had taken initiatives in tribal and community Maori health were present at the hui, and gave accounts of their success in delivery of acute health care and promotion of health within their communities (Hui Whakaoranga, 1984). This example exhibits that, although Maori were starting to take some autonomy in their own health care, there was also a need for further resourcing as reported by Mantell (1984) that "Maoris want to determine their own destiny and expect a greater voice in the allocation and distribution of health resources". Within the published documentation of the hui Dr. Mason Durie's views on some theories on the differences between Western and Maori concepts of mental health were included. He stated that a major contrast was that Western theories of good mental health were "equated with independence, directness and severance of generational ties" whereas for Maori " to be totally independent and a separate person is, in Maori terms, to be unhealthy"(Durie, 1984:8).

The single reference to discharge planning made at the hui was that made by the Minister of Health, the Honourable A.G. Malcolm. He commented that in the four psychiatric hospitals in Auckland a list of names of traditional Maori healers was available for patients wanting to use those services. He added that the traditional services were a valuable contribution " and will continue to be so in helping Maori people to be more quickly discharged from psychiatric hospitals" (1984:2). It has been only during the past four years that Maori traditional healers or tohunga have been accessible to Maori patients whilst they have been in treatment at the Tauranga Hospital. This is due to input by Kaupapa Maori staff at both primary and secondary levels of care, most of whom commenced employment within the past four years. In comparison, the Auckland hospitals appeared to be rather progressive in their cultural component of treatment for Maori mental health patients.

Te Ara Ahu Whakamua Hui held a decade later, in March 1994, was the next major national Maori health hui. It reflected on health developments from the Hui Whakaoranga as well as setting some foundational direction for Maori health of the future. A noticeable change commented on by the Minister of Maori Affairs, the Honourable John Luxton (1994:10), was that Maori were more prominent in driving the delivery of their own primary health services which addressed " the total health of the person and their family within the overall framework of whanau and iwi development". I attended the hui, and from the many Maori health groups that were represented and in my own networking amongst health workers I would agree that the comment was well substantiated. Another strong and common thread woven throughout the hui by various speakers during the workshops was the continued commitment to tino rangatiratanga, Maori taking control and Maori management of things Maori. The Associate Minister of Health the Honourable Katherine O'Regan (1994:32), affirmed that " the recognition of the achievement of many existing Maori health programmes indicated that Maori were more than competitive in the new health environment" but there was also a need for the mainstream health sector to take their share in commitment towards Maori service provision particularly "if substantial progress was to be made in Maori health".

In the Hui Whakaoranga which had been held ten years previously, the voice of Maoridom expressed their right to tino rangatiratanga (self-determination) and integral to that was the need for equitable resourcing, allocation and distribution of funds.

The strategic directions for the future of Maori health set at Te Ara Ahu Whakamua was that purchasers of services were to encourage and assist the development of Maori providers, and that there were to be options for Maori involvement including partnership and joint ventures in budget holding and service delivery (Te Puni Kokiri, 1994:32). Seemingly, there has been an increase in the realisation of the Maori aspirations that were set in the hui of 1984, which are only now showing some fruition ten years on, particularly in the form of Government Maori health objectives and policy.

A saying that is often referred to in Maoridom is that " we need to look back to go forward". In discussing services which Maori mental health patients are able to access in Tauranga Moana upon discharge, it should be noted that there are more Kaupapa services available now than was in existence ten tears ago. The emphasis and drive for changes for Maori towards their own self-determination in health and social matters have been borne by Maori themselves, mainly at a national level. From the Hui Taumata in 1984, where the conference emphasis was on self sufficiency, strengthening of the tribal base and new environments for shaping social and economic initiatives, there was for Maori a turning point and impetus to move forward. National drives for change by Maori then paved the way for local initiatives to forge ahead in their own communities. Not forgetting that, even at a larger national level, Maori have come together as in the Hui Taumata and Hui Whakaoranga from the whanau, hapu and iwi of their smaller localities. Maori from the Tauranga Moana rohe were involved in those significant hui, and continue to work towards change for Maori both locally and nationally. The services that turoro are able to access in health and mental health in Tauranga in 1999 are, 1 believe, rooted in those early struggles for change and equity.

APPENDIX 3

MASSEY UNIVERSITY

Application To Human Ethics Committee

Name of applicant	CINDY MOKOMOKO
Status of applicant	Masterate student
Department	Department of Social Policy
Employment	Te Puna Hauora, Western Bay Health
Project Status	Master Social Work
Funding Source	Massey University
Supervisors	Rachel Selby M.Phil. Dr Celia Briar
Title of The Research Project:	Kia Whai Te Whakatekainga o Nga Turoro Wairangi. The Effectiveness of Discharge Planning For Maori Mental Health Patients.
Attachments	Information Sheet Consent Form Questionnaire

Signature(s) Researcher ______________________

Supervisor ______________________

Supervisor ______________________

* The Supervisor's signature implies satisfaction with the content of this application.

Date: _____/_____/_____

Kia Whai Te Whakatekainga o Nga Turoro Wairangi

The Effectiveness of Discharge Planning For Maori Mental Patients

INFORMATION SHEET

1. **Researcher:** Cindy Mokomoko

Ko Whangatautia te maunga
Ko Karirikura te moana
Ko Te Ohaaki te Marae
Ko Te Rarawa te iwi o t6ku mama.

Ko Te Arawa te waka
Ko Ngati Whakaue me Pikiao nga iwi o toku papa. He wahine Maori ahau.

I am presently employed at Te Puna Hauora Tauranga Hospital as a whanau counsellor/therapist as well as the Maori mental health team leader. I have been involved in Maori mental health and well-being over the past 13 years. The first 4 years were spent in voluntary work at Arohata women's prison, the next 6 years as a community health worker at Whaioranga Trust, a marae-based health and social services clinic; and the past 3 years in my present employment.

The supervisors for this piece of research are Rachel Selby MSW and Dr Celia Briar. Ph D.

2. The researcher and supervisors can be contacted through Massey University, Department of Policy and Social Work. Ph; (06) 356-9099

3. The nature and purpose of the study is to measure the effectiveness of discharge planning for Maori mental health patients from Tauranga Hospital psychiatric ward; to monitor the responsiveness of Western Bay Health in relation to the national guidelines for discharge planning; to

provide data and information toward the improvement of Maori mental health; to highlight the needs of Maori mental health patients and their whanau and to satisfy the requirements of a dissertation for a masterate.

4. Participants will be invited to answer a questionnaire prior to discharge as well as to participate in a follow up visit 4-6 weeks post discharge. The first questionnaire will be to find out if turoro (patients) were involved in, or aware of, their discharge plan and follow up care, treatment and support; and the second visit would be to find out what had eventuated in relation to the discharge plans. Time of each participant's involvement would be no longer than I hour at each visit. There may be shorter visits to give draft reports. These will always be carried out with prior notice and prior consent.
5. Anonymity and confidentiality will be assured by the researcher. Participants may choose to identify themselves if they wish.
3. Participants have the right to decline to take part at any time throughout the research and may withdraw at any time even after giving consent. Participants have the right to decline to answer any questions they do not wish to answer.

1. Description of Project

1.1 Justification

There has been a dramatic rise in Maori rates of first admission to psychiatric care over the last thirty years, while Pakeha rates have remained stable. When Maori enter a psychiatric ward for the first time 40% of Maori are more likely than Pakeha to be re-admitted. Some possible reasons why re-admissions occur include; the illness was more serious at the time of first admission; the treatment at first admission was not culturally appropriate or effective; the discharge was too early. or there was insufficient or culturally inappropriate community support on discharge.

This piece of research aims to contribute towards the literature of discharge planning for Maori mental health patients, and patient and whanau needs.

1.2 Objectives

The objectives of the research are:

1. To measure the effectiveness of discharge planning **in** the deinstitutionalisation process from the client's perspective.
2. To monitor the responsiveness of Western Bay Health in relation to the national guidelines for discharge planning.
3. To provide data toward the improvement of Maori mental health.
4. To highlight the needs of Maori mental health patients and their families.
5. To satisfy the requirements of the thesis in order to graduate with a masterate.

1.3 Procedures for recruiting participants and obtaining Informed Consent.

Two approaches will be used:

1. Individuals will be invited to participate in the study and subject to agreement, will be interviewed in order to obtain their views on the effectiveness of their discharge plans.

2. Hui relevant to the study will be attended, and I envisage attending some of these with Kuia and Kaumatua; Te Puna Hauora Maori health team and services in Western Bay Health; turoro (patients) and their families; and Maori and non-Maori Mainstream staff in mental health services.

   All peoples consulted will be provided with an information sheet that sets out the title of the project with the objectives and justification for the study. Oral informed consent will also be obtained.

1.4 Procedure in which research participants will be involved.

Participants will be involved in the study both prior to discharge and post-discharge. For a more informed study on the effectiveness of the discharge plans, a post-discharge follow up is necessary to explore outcomes of health care plans made at time of discharge. Individual and collective informants will be approached for hui as and when required.

1.5 Procedures for handling information and material produced in the course of the research including raw data and Final research report(s).

All information will be kept in a locked cabinet. Notes taken during hui or group consultation will be collated and written up as soon after hui as possible. Copies of notes will be given to participants for validation. If tapes are used, consent will be sought prior to usage, and transcripts of tapes made available to all participants for validation.

Participants will be clearly informed on each part of the research process. Participants will also be prior-informed that final copies of the report will be going to Western Bay Health Kaupapa Maori and Mainstream mental health services.

2. Ethical Concerns.

2.1 Access to participants.

For participants to be involved in this study clarification of the aims and purposes of this piece of work will be ensured to gain their consent and participation. This will be done both verbally and in writing. Access to the report will be made available to all participants through Western Bay Health. The report will be available also to whanau, hapu and iwi through Te Puna Hauora as well as to the wider academic/research fraternity and the public at large.

2.2 Informed consent.

Significant Maori will be approached, as well as significant others. Informed consent will be obtained before any procedure for the study begins. It will be necessary to ensure that the mental health patients are fully aware of what they are consenting to. In some cases this may include whanau (family) discussions with the patient's consent prior to engaging in any part of the research. Consultation with medical staff may also be necessary. This also will be with the patient's consent.

2.3 Anonymity and Confidentiality.

No individual will be identified without prior consent. For the purpose of this piece of research 1 do not envisage that it will be necessary to identify individuals. Part of the process of ensuring anonymity and confidentiality is in the reading of transcripts and proofreading by all participants. Participants are able to withdraw or delete information given if they feel it may jeopardise either anonymity or confidentiality.

2.4 Potential harm to participants.

The information obtained in this research could be used in ways detrimental to the interest of those being researched and/or the researcher. Every effort will be made to inform participants of the potential for harm when procuring informed consent. The potential for harm is possible with every project where results and data could be skewed for self serving purposes not intended by the researcher.

2.5 Potential harm to researcher(s)

Potential harm to the researcher is possible if the research is used in ways detrimental to the use of the researcher. Supervision, consultation and the involvement of significant others, such as Kaumatua and Kuia, and regular feedback with turoro and their whanau are the measures which will be taken to ensure the research considers and meets all ethical issues.

2.6 Potential harm to the university

The piece of work will be carried out with integrity to ensure that all ethical considerations and commitments are upheld. It is not my intention to work in such a manner as to cause harm to the university.

2.7 Participants' right to decline to take part.

Participants will have opportunities throughout out all stages of the research to decline to take part.

1. During the process of seeking informed consent;
2. During the validation process; and
3. At the point of writing up the research, participants will be issued with a copy of the report and given the opportunity to decline.

2.8 Uses of the information

The information will be used for my masterate dissertation. It will also be used as an internal audit for Western Bay Health Maori mental health discharge service. The piece of work will be available for other whanau, hapu and iwi workers interested in the findings of this research. The information will be available to Maori mental health patients and their families.

2.9 Conflict of interest/conflict of roles

I am a whanau counsellor and mental health team leader for Maori mental health at Western Bay Health. 1 have purposed not to interview patients who attend counselling sessions with me. The team leader role is also one of assisting management in the development of Maori mental health services.

Data obtained from this study may provide keys to improvement of Maori mental health which will result in a reduction in the present high rate of Maori psychiatric re-admissions. Gathering the data needs to be supported and approved by Western Bay Health and the Tauranga hospital's Ethics Committee, to which 1 have made application.

2.10 Other ethical concerns

Kaupapa Maori staff and mainstream staff of the psychiatric ward will be notified of this piece of research.

3 Legal Concerns

3.1 Legislation

3.1.1 Intellectual Property legislation

e.g. Copyright Act 1994

Not applicable

3.1.2 Human Rights Act 1993

All participants will be treated fairly, equally and justly.

3.1.3 Privacy Act 1993

All participants will have access to all information about themselves procured during the research.

3.1.4 Health and Safety in Employment Act 1992

All aspects of research will be carried out in a responsible manner to ensure health and safety of researchers and all participants at all times.

3.1.5 Accident Rehabilitation Compensation Insurance Act 1992

Any accident to either the researcher or participants during the course of actual research will be documented and forwarded to the appropriate persons as soon as possible following the accident.

3.1.6 Employment Contracts Act 1991

Approval for study leave to interview turoro at the time of their discharge and again one month later needs to be accessed to enable me to carry out the piece of work. This will be either paid or unpaid leave at the discretion of the Kaupapa Maori Te Puna Hauora management team.

3.2 Other Legal Issues

I do not envisage that any other legal issues will arise.

4. Cultural Concerns

I am Maori and have the ability to work in a safe cultural way appropriate to Maori. As I am not a fluent speaker in te reo Maori, if either turoro (patients) or their whanau (families) converse in te reo Maori, 1 have access to people who can interpret Maori.

Kia Whai Te Whakatekainga o Nga Turoro Wairangi

The Effectiveness of Discharge Planning For Maori Mental Health Patients

CONSENT FORM

I have read the information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researchers on the understanding that my name will not be used without my permission. *(The information will be used only for this research and publications arising from this research project.)*

I agree/do not agree to the interview being audio/video taped.

I also understand that I have the right to ask for the audio/video tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed: ______________________________

Name: ______________________________

Date: ______________________________