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“Ahakoa te momo mate, whakanuia tāngata”
Mental Health Inpatient Services:
Māori needs when extremely distressed

Julie Wharewera-Mika
(Ngāti Awa, Tūhoe, Te Whānau a Apanui)

A thesis
submitted in partial fulfillment
of the requirements for the degree of
Doctor of Clinical Psychology

The University of Auckland, Te Whare Wānanga o Tāmaki Makaurau
Aotearoa New Zealand

2012
PEPEHA

I boea mai o oku tupuna ma runga ki te waka o Mataatua
Ko Putauaki te maunga
Ko Ohinemataroa te awa
Ko Ngāti Hokopu te hapū
Ko Te Hokowhitu a Tu te marae
Ko Ngāti Awa te iwi
Ko Julie Wharewera-Mika tooku ingoa, ā,

be uri au no nga kawai rangātira o nga iwi o Ngāti Awa, Te Whānau a Apanui.
ABSTRACT

There are many possible explanations for the pattern of Māori over-representation in mental health inpatient services. High Māori admission rates, and readmission rates raise questions about Māori mental health in general, and about Māori access to services early enough to prevent the need for admission to inpatient services.

This research project was concerned with understanding what the needs of tāngata whaiora and whānau are from mental health inpatient services. Two studies were conducted. Study One reviewed the nature and extent of tāngata whaiora admission patterns utilising quantitative methods. More specifically, admission rates; ward admitted to upon admission (open ward versus intensive care unit); readmission rates; length of stay; and primary diagnoses were analysed. In Study Two, mixed methods were employed to investigate the needs of tāngata whaiora admitted to the Te Whetu Tawera inpatient service and the needs of their whānau; and to identify the factors that support and inhibit whakaoranga (recovery) and whānau ora (family wellbeing). Preferences for alternative care were also investigated along with the key aspects of inpatient service delivery that improved outcomes for Māori.

Study One found high admission rates of tāngata whaiora to inpatient services; high rates of Māori admitted directly to the Intensive Care Unit; high rates of Māori being diagnosed with schizophrenia and other psychosis type disorders; and low rates of Māori diagnosed with depression. Multiple explanations have been proposed for such admission patterns including: the influence of ongoing historical oppression; contemporary realities (such as marginalisation and poverty); and service access barriers and restrictive care practices.

The experiences of tāngata whaiora and whānau reported in Study Two described a number of critical factors contributing to, and inhibiting whakaoranga and whānau ora. Five thematic categories were discovered in the interviews: ‘Admission Process’; ‘Admission Experience’; ‘Therapeutic Environment and Interventions’; ‘Discharge Phase’; and ‘Future Admissions’. The majority of participants identified one or more aspects of the service where they felt valued and supported. Service satisfaction was associated with the kaupapa Māori service Kai Atawhai; positive staff attitudes and
behaviours; service experiences; and specific interventions contributing to whakaoranga. However, the majority of feedback identified the need for a number of significant improvements to service delivery. These related to: restrictive care practices that inhibit whakaoranga and result in further trauma for those already distressed; safety concerns; the need for accessibility of support for tāngata whaiora and whānau; therapeutic interventions to meet the needs of tāngata whaiora and whānau; negative staff attitudes and behaviours; and the need to investigate alternative care options, specifically kaupapa Māori services.

The implications for primary prevention and enhanced inpatient service delivery include: the implementation of six key principles supporting therapeutic engagement with Māori; and recommendations to enhance and develop staff practice (such as cultural competency; Māori workforce development; and enhancing the scope of practice). Recommendations include: improving access to kaupapa Māori services; and enhancing practices that support whakaoranga and whānau ora, such as balancing safety and restriction; reducing the negative impact of police involvement; reducing and eventually eliminating the use of force, seclusion and restraint; accessible supports for tāngata whaiora and whānau; increased implementation of kaupapa Māori therapeutic interventions; development and implementation of debriefing and reflective practices following critical incidents; and ensuring collaborative discharge meetings for all tāngata whaiora.

Future research should focus on outcome evaluations of inpatient services assessing whether the needs of Māori are being met; the efficacy of seclusion and restraint, with a focus on reducing and eventually eliminating these restrictive care practices; and the investigation of kaupapa Māori alternative service options.
ACKNOWLEDGEMENTS

“Ahakoa te momo mate, whakanuiatanga”

This whakatauki is an expression of hope; regardless of illness or distress, people deserve dignity and respect and the opportunity to become well again (MOH, 2006).

Firstly, I would like to acknowledge the tāngata whaiora and whānau participants of this research project. I feel humbled and honoured to have received your taonga, your experiences, views, opinions and knowledge. Your experiences and stories are the heart of this research project. He mihi aroha tenei ki a koutou!

During the development phase of this project I valued the positive assistance and encouragement from Te Whetu Tawera staff and management including Eileen Swan, John Thorburn and Dr. Thom Rudegeair; and the ADHB research committee. I would like to make a special acknowledgement to the Kai Atawhai team for your ongoing commitment, tautoko and aroha. Especially Veronica Karora Moates and the late Kataraina Ku Tuoro. who have both committed their lives to supporting the journey of recovery for hundreds of Māori. He mihi nui ki a korua he wahine toa!

I would like to acknowledge the amazing assistance I received from specialist data experts including: Patrick Firkin (Clinical Data Analyst, ADHB) for providing assistance with data collection; and Dr. Ian Wells (Statistics Advisor) for providing ‘hours and hours’ of support and guidance with quantitative data analysis and reporting. Thank you both!

I am truly grateful for the support of my supervisors for the duration of this project, which took a bit longer than originally planned. I would like to acknowledge my primary supervisor Professor John Read. Your commitment to improving the assessment, treatment and care of mental health service users is truly inspiring. Thank you so much for sharing your expertise and contagious passion. I truly valued both the critical feedback and encouragement you offered, as well as your support in keeping me on track. Tēnā rāwā atu koe! Dr. Lorna Dyall, my secondary supervisor, your contribution to research supporting whānau ora has also been motivating. Thank you for your
valuable guidance, especially during the early development phase of setting up this project. Kia ora koe mo to awhi!

I was extremely fortunate to receive expert advice and guidance from my rangahau whānau. I would like to make a special acknowledgement to Dr. Erana Cooper (Clinical advisor and close friend) who not only provided a much needed 'sounding board', but also travelled this journey alongside me completing her own PhD. Ki a koe te tuakana, nga mihi aroha. I am also grateful for the invaluable knowledge and tautoko from Tamati Kruger (Te Ao Māori advisor), tēnā rāwā atu koe; Robyn Wiki (consumer advisor); colleagues and friends from the National Standing Committee for Bi-cultural Issues, New Zealand Psychology Society (NSCBI) and the ‘Tight 5’ Māori science researchers groups; my clinical psychology class mates; and the Māori and Pacific postgraduate psychology research group.

This project was completed with financial support from a number of scholarships including: the Henry Rongomau Bennett- Clinical Psychology; Hauora Māori ; Māori Education Trust; and the Karahipi Tumuaki Presidents NZ Psychology Society. Additional financial grants were also gratefully received from: the Omataroa Trust; and Ngāti Awa.

Finally, I would like to acknowledge the contribution of my whānau and friends in completing this project, for without them it would have been extremely difficult to see light at the end of the tunnel. I am truly appreciative of the wonderful support and encouragement from my parents, Marion Nieuwland and Koona Timoti Wharewera, in nurturing and feeding my seed of potential. Dad you were the instigator of this all when you commented during my graduation “get rid of the fluff girl” (that is the fluff around the edge of my graduation gown hood) indicating your approval and support for my ongoing post-graduate studies. He mihi aroha ki a korua!

The completion of this project would never have come to fruition if it wasn’t for the support of my multi talented friends and whānau who were able to help with some of my mahi along the way. I am ever so appreciative for the support of Mary Kingi, Dean Wharewera and Sera Mika, and those that took fantastic care of my precious babies during the hectic research stages of my work, especially the Mika aiga, uncle Deano,
aunty Chonny, aunty Missy and the amazing Aoga Fa’aSamoa. Positive words of encouragement and affirmation, sometimes hidden within the phrases ‘what you’re still going?’ and ‘so are you finished yet?’ that kept me motivated, thanks Brett and Karl Wharewera.

To my special boys, I thank you for you ongoing love, patience and understanding. My eldest son JJ, thank you so much for stepping up and being such a wonderful tuakana for your baby brothers, I’m extremely proud of you! And to my thesis babies (born during my thesis journey), Jovahn and Josiah, welcome to post-thesis life! He mihi aroha ki a koutou!

None of this work would have been possible without the constant love and support of my husband Jerome. Thank you so much for being super patient (as my deadline continued to drag on), for providing ongoing encouragement and support, and constantly keeping me on track!! I am truly blessed to have such a wonderful whānau!

No reira ki a koutou te whānau he mihi aroha no ou manaaki ki a au I nga wa katoa.
TABLE OF CONTENTS

PEPEHA i
ABSTRACT ii
ACKNOWLEDGEMENTS iv
TABLE OF CONTENTS vii
LIST OF TABLES xii
LIST OF FIGURES xiii
LIST OF APPENDICES xiv

LIST OF ABBREVIATIONS xv
GLOSSARY OF KEY TERMS AND CONCEPTS xvi
PREFACE xx

Chapter One: LITERATURE REVIEW

BEHIND THE SCENES 1
  Personal research interests
  Literature review method

MĀORI HEALTH IN AOTEAROA 3
  Contextualising
  Māori and non-Māori disparities
  Māori mental health statistics
  Inpatient service admissions
  Inpatient service readmissions

INEQUALITIES AND DISADVANTAGES IMPACTING ON WELLBEING 8
  Understanding disparities
  Historical influences
  Contemporary realities
  Barriers and restrictive care practices
  Addressing disparities and inequality

MODELS OF HEALTH 17
  Western health models
  Māori understandings
  Māori health models
Conflict and collaboration

MĀORI HEALTH POLICY DEVELOPMENTS 29

Te Tiriti o Waitangi and the relationship with health policy
Te Tiriti o Waitangi guiding psychological practice
The path of Māori mental health policy developments

MENTAL HEALTH SERVICES 35

Inpatient services
Service evaluations
Innovative service improvements
Alternative inpatient care

MĀORI MENTAL HEALTH CHALLENGES AND DEVELOPMENTS 43

Restrictive care practices
Kaupapa Māori mental health services
Māori workforce development
Cultural assessment
Cultural competency
Protective factors

THE VISION: FUTURE MENTAL HEALTH DEVELOPMENTS 57

Chapter Two: METHODS

RESEARCH METHODOLOGY 59

The beginning phase of this study
Reasons for carrying out this study
The research context
Research framework and methodology
Kaupapa Māori theory
Qualitative research
Quantitative research
Conflict of interest
Aims of the research project

Study One: Tāngata whaiora admission patterns
Study Two: Tāngata whaiora and whānau inpatient experiences

RESEARCH DESIGN 66

Study One: Tāngata whaiora admission patterns
Ethical approval
Data collection procedures
Participants
Data storage
Sample size
Data decisions
Data analysis

Study Two: Tāngata whaiora and whānau inpatient experiences 69

Ethical approval
Research procedures
Participant recruitment
Participant characteristics
Interview process
Data storage
Qualitative analysis
Quantitative analysis

Chapter Three: STUDY ONE RESULTS

STUDY ONE: TĀNGATA WHAIORA ADMISSION PATTERNS 77
Māori population characteristics
Admission rates
Ward admitted
Readmission rates
Length of stay
Diagnosis

Chapter Four: STUDY TWO RESULTS

STUDY TWO: TĀNGATA WHAIORA AND WHĀNAU INPATIENT EXPERIENCES 89
Category 1: Admission Process’ 90
Police involvement
Mental Health Act and Deceived
Willing
Being unwell and distressed
Chapter Five: DISCUSSION

STUDY LIMITATIONS

Study One: Tāngata whaiora admission patterns
Study Two: Tāngata whaiora and whānau inpatient experiences

STUDY ONE: TĀNGATA WHAIORA ADMISSION PATTERNS

Admission rates
Ward admitted
Diagnosis

STUDY TWO: TĀNGATA WHAIORA AND WHĀNAU INPATIENT EXPERIENCES

Satisfaction with the service
Satisfaction with the kaupapa Māori service
Satisfaction with support
Satisfaction with positive staff attitudes and behaviours
Satisfaction with service experiences
Satisfaction with interventions contributing to whakaoranga

Participants identified significant improvements

Restrictive care practices
Safety issues
Support for tāngata whaiora and whanau needs to be accessible
Therapeutic interventions need to meet the needs of tāngata whaiora
Negative staff attitudes and behaviours inhibit recovery and whānau ora
Alternative care options need to be investigated

IMPLICATIONS AND RECOMMENDATIONS

Primary prevention issues
Commitment to addressing inequalities
Policy development and implementation

Implications for inpatient mental health service delivery
Principles supporting therapeutic engagement
Staff development
Kaupapa Māori services – improved access
Enhanced interventions and practices that support whakaoranga and whānau ora

FUTURE RESEARCH

CONCLUSIONS

Personal research reflections

REFERENCES

APPENDICES
### LIST OF TABLES

| Table 1. | Participant characteristics | 72 |
| Table 2. | Participants attendance at therapy sessions and whānau hui | 73 |
| Table 3. | Participants attendance at whānau hui | 74 |
| Table 4. | Māori population proportions | 77 |
| Table 5. | Gender proportions at admission | 79 |
| Table 6. | Average number of readmissions | 81 |
| Table 7. | Average length of stay (LoS) | 82 |
| Table 8. | Diagnosis by ethnicity | 83 |
| Table 9. | Diagnosis by ethnicity: Females | 85 |
| Table 10. | Diagnosis by ethnicity: Males | 87 |
| Table 11. | Summary of five categories and themes: derived from tāngata whaiora and whānau interviews | 89 |
| Table 12. | Themes and subthemes for category 1 ‘Admission Process’ | 90 |
| Table 13. | Themes and subthemes for category 2 ‘Admission Experience’ | 98 |
| Table 14. | Themes and subthemes for category 3 ‘Therapeutic Environment and Interventions’ | 104 |
| Table 15. | Themes and subthemes for category 4 ‘Discharge Phase’ | 148 |
| Table 16. | Themes and subthemes for category 5 ‘Future Admissions’ | 151 |
| Table 17. | Needs Questionnaire results: Needs | 155 |
| Table 18. | Needs Questionnaire results: Usefulness of therapeutic interventions | 159 |
| Table 19. | Needs Questionnaire results: Overall needs met | 162 |
| Table 20. | Positive experiences with kaupapa Māori services | 174 |
| Table 21. | Positive experiences with general staff | 177 |
| Table 22. | Negative experiences with staff | 184 |
| Table 23. | Recommendations to improve inpatient service delivery | 191 |
| Table 24. | Principles guiding therapeutic engagement with Māori | 192 |
LIST OF FIGURES

Figure 1. Māori and non-Māori proportions within the ADHB catchment Area (Māori Health, 2006) and Māori and non-Māori admissions To Te Whetu Tawera (2005 to 2008) 78

Figure 2. Ward admitted by ethnicity (2005 to 2008) 80
LIST OF APPENDICES

A. Ethics approval

B. Participant information sheets (PIS)
   Tāngata whaiora
   Whānau

C. Consent form

D. Interview schedule
   Tāngata whaiora
   Whānau

E. Needs Questionnaire
   Tāngata whaiora
   Whānau
# LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Phrase/service</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>Auckland District Health Board</td>
</tr>
<tr>
<td>AHBS</td>
<td>Acute home based services</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive behavioural therapy</td>
</tr>
<tr>
<td>CMHC</td>
<td>Community mental health centre</td>
</tr>
<tr>
<td>CSW</td>
<td>Community support worker</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical behavioural therapy</td>
</tr>
<tr>
<td>DHB</td>
<td>District health board</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>The diagnostic and statistical manual of mental disorders (4th Ed.)</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive care unit</td>
</tr>
<tr>
<td>LoS</td>
<td>Length of stay</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>MHC</td>
<td>Mental health commission</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>PRN</td>
<td>Pro re nata, as needed</td>
</tr>
<tr>
<td>RCS</td>
<td>Residential crisis service</td>
</tr>
<tr>
<td>TW</td>
<td>Tāngata whaiora</td>
</tr>
<tr>
<td>TWT</td>
<td>Te Whetu Tawera</td>
</tr>
<tr>
<td>WH</td>
<td>Whānau</td>
</tr>
</tbody>
</table>
# GLOSSARY OF KEY TERMS AND CONCEPTS

<table>
<thead>
<tr>
<th>Māori</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aotearoa</td>
<td>Long white cloud; New Zealand</td>
</tr>
<tr>
<td>Aroha</td>
<td>Love; caring; respect; compassion</td>
</tr>
<tr>
<td>Arohaina</td>
<td>Unconditional love and compassion</td>
</tr>
<tr>
<td>Awhi</td>
<td>Embrace; care</td>
</tr>
<tr>
<td>Kapa haka</td>
<td>Traditional warrior challenge</td>
</tr>
<tr>
<td>Hapū</td>
<td>Kinship group/tribe, sub-tribe; pregnant</td>
</tr>
<tr>
<td>Hinengaro</td>
<td>Mind, thought, consciousness</td>
</tr>
<tr>
<td>Hui</td>
<td>Meeting, gathering</td>
</tr>
<tr>
<td>Iwi</td>
<td>Extended kinship group/tribe; bones</td>
</tr>
<tr>
<td>Kai</td>
<td>Food</td>
</tr>
<tr>
<td>Kai Atawhai</td>
<td>Kaupapa Māori worker; caring person</td>
</tr>
<tr>
<td>Kaimahi</td>
<td>Worker</td>
</tr>
<tr>
<td>Kaimoana</td>
<td>Seafood</td>
</tr>
<tr>
<td>Kaitiaki</td>
<td>Guardian, carer</td>
</tr>
<tr>
<td>Kanohi kitea</td>
<td>The seen face</td>
</tr>
<tr>
<td>Karakia</td>
<td>Spiritual stimulation, prayer</td>
</tr>
<tr>
<td>Kaumātua</td>
<td>Elder (male or female)</td>
</tr>
<tr>
<td>Kaupapa Māori</td>
<td>Māori principle or theme</td>
</tr>
<tr>
<td>Kia tupato</td>
<td>Be careful, be cautious</td>
</tr>
<tr>
<td>Koha</td>
<td>Gift of appreciation</td>
</tr>
<tr>
<td>Kohanga Reo</td>
<td>Māori preschool language nests</td>
</tr>
<tr>
<td>Kōrero</td>
<td>Talk, speak, speech</td>
</tr>
<tr>
<td>Koroua</td>
<td>Elder</td>
</tr>
<tr>
<td>Ko wai? Nā whea? Nā wai?</td>
<td>Who are you? Where do you come from?</td>
</tr>
<tr>
<td></td>
<td>Who are your parents?</td>
</tr>
<tr>
<td>Kuia</td>
<td>Elder (female)</td>
</tr>
<tr>
<td>Kura</td>
<td>School</td>
</tr>
<tr>
<td>Makutu</td>
<td>Māori curse or witchcraft</td>
</tr>
<tr>
<td>Mana</td>
<td>Prestige, authority, dignity</td>
</tr>
<tr>
<td><strong>Mana Atua</strong></td>
<td>Powerful sense of the Gods/Power from above</td>
</tr>
<tr>
<td><strong>Mana Whenua</strong></td>
<td>Power/authority related to land</td>
</tr>
<tr>
<td><strong>Manaaki</strong></td>
<td>To take care of, support, protect, look out for</td>
</tr>
<tr>
<td><strong>Manaakitanga</strong></td>
<td>Hospitality, kindness</td>
</tr>
<tr>
<td><strong>Marae</strong></td>
<td>Courtyard, meeting place; complex of buildings</td>
</tr>
<tr>
<td><strong>Mate Māori</strong></td>
<td>Māori illness</td>
</tr>
<tr>
<td><strong>Mau rakau</strong></td>
<td>Traditional weapon training</td>
</tr>
<tr>
<td><strong>Mauri</strong></td>
<td>Life force, life essence, vitality</td>
</tr>
<tr>
<td><strong>Mauri ora</strong></td>
<td>Be full of wellness</td>
</tr>
<tr>
<td><strong>Mauri tau</strong></td>
<td>Inner peace</td>
</tr>
<tr>
<td><strong>Mihimihī</strong></td>
<td>Greeting, acknowledgement</td>
</tr>
<tr>
<td><strong>Mirrorī</strong></td>
<td>Massage</td>
</tr>
<tr>
<td><strong>Ngakau rorotu</strong></td>
<td>Optimism</td>
</tr>
<tr>
<td><strong>Nga Pou Mana o Io</strong></td>
<td>The prestigious posts of the supreme being</td>
</tr>
<tr>
<td><strong>Noa</strong></td>
<td>Common, safe, unrestricted</td>
</tr>
<tr>
<td><strong>Ora</strong></td>
<td>Be alive; well, healthy</td>
</tr>
<tr>
<td><strong>Pākehā</strong></td>
<td>Non-Māori New Zealander descended from settlers</td>
</tr>
<tr>
<td><strong>Pono</strong></td>
<td>True, genuine</td>
</tr>
<tr>
<td><strong>Poroporoaki</strong></td>
<td>Formal farewell</td>
</tr>
<tr>
<td><strong>Rahui</strong></td>
<td>Ritual prohibition either placed on a place, or on certain resources</td>
</tr>
<tr>
<td><strong>Rangatahi</strong></td>
<td>Youth; adolescent</td>
</tr>
<tr>
<td><strong>Rangātiratanga</strong></td>
<td>Self determination</td>
</tr>
<tr>
<td><strong>Rangahau whānau</strong></td>
<td>Research Advisory Group</td>
</tr>
<tr>
<td><strong>Reo</strong></td>
<td>Language</td>
</tr>
<tr>
<td><strong>Rohe</strong></td>
<td>Area, region</td>
</tr>
<tr>
<td><strong>Rongoa</strong></td>
<td>Traditional medicine and healing</td>
</tr>
<tr>
<td><strong>Taha Hinengaro</strong></td>
<td>Related to mental and emotional wellbeing</td>
</tr>
<tr>
<td><strong>Taha Tinana</strong></td>
<td>Related to physical wellbeing</td>
</tr>
<tr>
<td>English</td>
<td>Maori</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>Taha Wairua</td>
<td>Related to spirituality</td>
</tr>
<tr>
<td>Taha Whānau</td>
<td>Related to family connections and belonging</td>
</tr>
<tr>
<td>Tāngata</td>
<td>People</td>
</tr>
<tr>
<td>Tāngata whaiora; Tāngata whai I te ora</td>
<td>Person seeking wellness</td>
</tr>
<tr>
<td>Tāngata whenua</td>
<td>Person of the land</td>
</tr>
<tr>
<td>Taonga</td>
<td>Treasure</td>
</tr>
<tr>
<td>Tapu</td>
<td>Sanctity; sacred, special, restricted</td>
</tr>
<tr>
<td>Tautoko</td>
<td>Support, endorse</td>
</tr>
<tr>
<td>Te</td>
<td>The</td>
</tr>
<tr>
<td>Te ao Māori</td>
<td>Māori world view</td>
</tr>
<tr>
<td>Te ao turoa</td>
<td>The light of day; nature; physical environment</td>
</tr>
<tr>
<td>Te reo Māori</td>
<td>The Māori language</td>
</tr>
<tr>
<td>Te reo Māori me ona tikanga</td>
<td>The Māori language and its customs</td>
</tr>
<tr>
<td>Te Tiriti o Waitangi</td>
<td>The Treaty of Waitangi</td>
</tr>
<tr>
<td>Te Whare Tapa Wha</td>
<td>Four cornerstones of a house or of health</td>
</tr>
<tr>
<td>Te Whēke</td>
<td>The octopus</td>
</tr>
<tr>
<td>Te Whetu Tawera</td>
<td>The evening star</td>
</tr>
<tr>
<td>Tiaki</td>
<td>Guard, keep, look after</td>
</tr>
<tr>
<td>Tika</td>
<td>Right, correct</td>
</tr>
<tr>
<td>Tikanga</td>
<td>Cultural principles; practices and customs</td>
</tr>
<tr>
<td>Tinana</td>
<td>Body</td>
</tr>
<tr>
<td>Tino rangatiratanga</td>
<td>Self determination</td>
</tr>
<tr>
<td>Titiro</td>
<td>Look</td>
</tr>
<tr>
<td>Tohunga</td>
<td>Māori spiritual healer</td>
</tr>
<tr>
<td>Tupuna</td>
<td>Ancestor</td>
</tr>
<tr>
<td>Turangawaewae</td>
<td>Place of standing; safe place</td>
</tr>
<tr>
<td>Wai</td>
<td>Water</td>
</tr>
<tr>
<td>Waiata</td>
<td>Song</td>
</tr>
<tr>
<td>Wairua</td>
<td>Spirit; spirituality</td>
</tr>
<tr>
<td>Wairuatanga</td>
<td>Soul; spirit</td>
</tr>
<tr>
<td>Waka</td>
<td>Canoe</td>
</tr>
<tr>
<td>Whākahuru</td>
<td>Providing reassurance</td>
</tr>
<tr>
<td>Whakapapa</td>
<td>Geneology; descent</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Whakataukī</td>
<td>Proverb</td>
</tr>
<tr>
<td>Whakawhānaungatanga</td>
<td>The acts of establishing relationships; connecting</td>
</tr>
<tr>
<td>Whakamana</td>
<td>Enhance mana within; bestow mana; uplift; empower</td>
</tr>
<tr>
<td>Whakanoa</td>
<td>To remove tapu; make ordinary</td>
</tr>
<tr>
<td>Whakaoranga</td>
<td>Recovery</td>
</tr>
<tr>
<td>Whakarongo</td>
<td>Listen</td>
</tr>
<tr>
<td>Whānau</td>
<td>Family; extended family</td>
</tr>
<tr>
<td>Whānau ora</td>
<td>Family wellbeing</td>
</tr>
<tr>
<td>Whānaunga</td>
<td>Relative; relation; kin</td>
</tr>
<tr>
<td>Whānaungatanga</td>
<td>Kinship; relationships; social cohesion</td>
</tr>
<tr>
<td>Whare</td>
<td>House</td>
</tr>
<tr>
<td>Wharekai</td>
<td>Dining room; eating place</td>
</tr>
<tr>
<td>Whare nui; Whare hui</td>
<td>Tribal meeting house</td>
</tr>
<tr>
<td>Wharepaku</td>
<td>Toilet; bathroom facilities</td>
</tr>
</tbody>
</table>
This research project refers to the mental health inpatient admission patterns and experiences of Māori. For the purpose of this project, Māori service users have been referred to as ‘tāngata whaiora’ (also referred to as ‘tāngata whai te ora’); and general consumers (such as those of Pākehā descent) have been reported as ‘service users’. Some research participants have also referred to tāngata whaiora and services users as ‘patients’ which was a term commonly utilised by the medical profession.

The research location was Te Whetu Tawera (TWT), the Auckland City Inpatient Mental Health Service located within the central Auckland District Health Board (ADHB) region. This acute mental health unit provides a 24 hour hospital service for adults consisting of 58 service beds, which includes 12 intensive care unit (ICU) beds.

In addition, the TWT kaupapa Māori inpatient team is referred to as Kai Atawhāi which is consistent with kaupapa Māori services across the general ADHB hospital sites. The inpatient service TWT has also been referred to as ‘hospital’ by participants given it’s locality on the DHB hospital grounds.

The concept of recovery, discussed throughout this project, has been inter-changed with the Māori translation whakaoranga when referring to Māori specific experiences of recovery.

Abbreviations for common mental health terms and services have been used during this project with full service descriptions used in the first instance. Similarly, some Māori terms have been translated in the first instance, however a glossary of the Māori terms used and translations; as well as a list of abbreviations (p. xv) used have been provided for your convenience.
Chapter One
LITERATURE REVIEW

[A glossary of Māori terms and concepts is provided on pp. xvi - xix]

BEHIND THE SCENES

Prior to discussing the literature that portrays Māori mental health in Aotearoa, it is essential to present the process behind the development of this research project. This includes the researcher’s personal account of the project’s beginning and the method of literature collection.

Personal Research Interests

Many facets of my personal, cultural and professional life experiences have contributed to the development of this research project focused on contributing to the improvement of Māori mental health wellbeing. My personal beliefs and values related to my cultural background, and identity, connections and experiences as an indigenous person of Aotearoa of Māori decent (Ngāti Awa, Tūhoe, Te Whānau ā Apanui) have been major contributing factors. The strong connectedness of being raised on my turangawaewae (home ground), with whānau has created an increased sense of responsibility for the wellbeing of my community, tāngata whaiora (literal translation ‘people seeking wellness’; service user; consumer of mental health services), whānau (extended family), hapū (sub tribe) and iwi (tribe).

My personal familial life experiences, such as growing up with whānau including many koroua (elders), kuia (female elders), aunties, uncles and cousins at our marae; attending a rural kura (school) in Ruatoki immersed in te reo Māori me ona tikanga (Māori language and customs); hunting and diving with my dad (it has sometimes just been the simple things in life) have been significant in molding who I am, building my values and beliefs. These life experiences and my more recent personal role developments as a wife, mother and aunty, have all contributed to a strong collective sense of being which is portrayed in this whakatauaki: “Ehara taki toa taki tahi, engari he toa takitini” (my strength is...
not from me alone, but the strength of the people), namely from my whānau and those who came before me.

In addition to these nurturing and rewarding experiences, those of illness, distress and loss (many common natural life stages) have occurred. However, too often access to much needed support and resources has been difficult for my whānau and wider community further promoting my passion to consider a career in the helping profession of psychology. It wasn’t far into my Māori and psychology (community and social) studies that I was able to see the potential benefits for my people.

My professional work experience and training in community, social and clinical psychology, have also contributed to my research pathway. I was employed in the mental health area for several years prior to the commencement of this project, initially as a residential support worker in the community (highlighting service issues relating to lack of resources and community supports), then the inpatient service where I was employed as a therapy assistant and later Kai Atawhai, a Māori kaimahi cultural worker, with a dual role of supporting tāngata whaiora with cultural and social stressors, and advocacy; as well as providing cultural consultation to clinicians.

My journey through life has led to my interest and commitment to contribute to the growing body of knowledge in Māori mental health, to present a Māori perspective promoting whānau ora, highlighting the issues Māori face when admitted to an inpatient service, and providing recommendations for service delivery improvements. Although my professional experience has contributed to this area of research interest, it has also posed some potential research biases, as I am processes implemented to reduce the impact of such biases [which are discussed further in Chapter 6 Discussion in the Limitations section].

**Literature Review Method**

This review is based on the findings of a literature search for information covering the broad range of factors associated with, and contributing to, Māori mental health in Aotearoa. It includes information regarding traditional health services, and disparities including the impact of inequalities and disadvantages for Māori, and Māori models of health and health policies. Information pertaining to inpatient care services is also a focus of this literature review, with particular emphasis on the effectiveness of services in meeting the needs of Māori.
A broad range of sources were used to gather information pertaining to mental health in Aotearoa, and more specifically Māori mental health. Primarily articles were gathered from databases ‘PsychInfo’ and ‘Medline’. New Zealand health websites were also used, including the ‘Ministry of Health’ (MoH); the ‘Mental Health Commission’ (MHC); ‘Mental Health Foundation’ (MHF); ‘Te Pou o te Whakaaro Nai (Te Pou)’; the Māori and Psychology Research Unit (Waikato University); and many others. The ‘Google’ search engine was used to expand the literature search, using key terms ‘Māori mental health’; ‘mental health services in Aotearoa’; ‘indigenous mental health’; ‘inpatient mental health services’; ‘crisis mental health services’; ‘Māori and inpatient services’ combined with ‘admissions’; ‘readmission’; ‘inequalities’; ‘deinstitutionalisation’; and ‘Māori health policy’. Other key references were found in other bibliographies of key articles and papers reviewed from early stages of the search process.

**MĀORI HEALTH IN AOTEAROA**

The following section discusses the health disparities between Māori and non-Māori; and Māori mental health statistics including inpatient service admission and readmission rates. The importance of contextualising these statistics is also discussed.

**Contextualising**

Examining inequalities and making comparisons between populations based on ethnicity presents a number of challenges. This is primarily due to the multiple factors that can contribute to the differences, ranging from historical influences and contemporary realities (Walters, Simoni & Evans-Campbell, 2002), to differences in the way data is gathered, classified and reported. For instance, statistics can appear very convincing simply because most people interpret numbers as facts. However, the story behind the numbers may be more obscure than the figures suggest (Nazroo & King, 2002).

For these reasons it is critical to contextualise comparisons by providing information regarding those factors which can contribute to differences or inequalities between ethnic groups (Cooper & Wharewera-Mika, 2011; Kumar & Oakley Browne, 2008). It is important to view comparisons between ethnic groups with caution, taking into account the context in which the varying contributing factors occur and the influence they have on Māori mental
health rates, rather than interpreting differences as being influenced by ethnicity per se (Cooper & Wharewera-Mika, 2011). [The Inequalities and Disadvantages Impacting on Wellbeing section of this literature review will provide further discussion of these issues].

Māori and Non-Māori Disparities

In 2008, more than four million people resided in Aotearoa, of whom 15% identified as Māori (Statistics New Zealand, 2008) with females making up 51% of the total Māori population. In comparison with non-Māori, Māori display both a youthful population, with 35% of Māori aged younger than 15 years (non-Māori 19%), and have a higher growth rate. It has been predicted that for the period 2011 to 2021 the Māori population will rise by 21% compared to non-Māori 11% (Ministry of Health, 2006).

Despite some educational, social and economic gains in recent times, Māori remain disproportionately represented in the lower socio-economic groups, and the health inequalities between them and non-Māori remain marked (Ajwani et al., 2003). In 2004, 40% of Māori whānau lived with hardship, as compared to 19% of Pākehā families (Jansen, Bacal & Crengle, 2009). In exploring these inequalities more closely, certain persistent disparities between Māori and Pākehā on social and economic indicators can be described, such as: 25.5% of Māori having an annual income of $10 000 or less. In 2009, almost one third (31%) of working-age (aged 18 – 64 years) Māori were beneficiaries (Ministry of Social Development, 2010); 5.5% of Māori have no access to a telephone; 9.1% have no access to a motor vehicle; 69.9% do not own their own home, with a high proportion of Māori living in areas of deprivation (Ministry of Health, 2010).

In addition, aside from the more obvious negative effects of economic disparities, a range of social and health inequalities are present for Māori. Inequalities in health between ethnic groups in Aotearoa are most pronounced between Māori and Pākehā, who make up 67% of the population (Ajwani et al., 2003; Bramley et al., 2005). While gains in the health status of Māori have been made since the 1980s Māori still have a life expectancy at least 8 years less than non-Māori (Statistics New Zealand, 2004), with differences noted across most morbidity indicators (including most major chronic diseases, infectious diseases, and injuries). Also, Māori females’ cancer rates were three times higher; Māori female breast cancer 1.3 times higher; Māori female cervical cancer twice that of non-Māori; and Māori female lung cancer four times that of non-Māori (Ministry of Health, 2010).
Furthermore, disparities are portrayed through the over-representation of Māori in the justice system, as both offenders and victims. Māori represented almost half of all criminal justice offenders, significantly higher than the 14% of the population they currently make up (Department of Corrections, 2007). In 2006 Māori were more likely to be victims of crime than European, with younger Māori (aged 15 – 24 years) and Māori men particularly more likely to be victims (Statistics New Zealand, 2008).

Māori Mental Health Statistics
Despite some improvements in Māori mental health over the past four decades, disparities continue between Māori and non-Māori. The New Zealand Mental Health Survey, Te Rau Hinengaro (2006), contributed to an international mental health survey involving more than 28 countries, and was the first of its kind in Aotearoa. The study identified the prevalence of mental disorders. The impact of mental health difficulties and the barriers to health service use were also investigated, recorded at one-month, 12-month, and lifetime periods, to describe the patterns and barriers to health service use and the level of disability. A total of 12,992 people participated in the survey, with 2,595 (approximately 20% of the total sample) self-identified as Māori (Ministry of Health, 2006).

Researchers found that mental disorder is common in Aotearoa with 46.6% of participants meeting the criteria for a disorder at some time in their lives; and 20.7% having a disorder in the past 12 months (Ministry of Health, 2006). Mental disorders were more common amongst Māori and Pacific peoples. The prevalence of mental disorders in Māori was only slightly higher than average, with 50.7% of Māori experiencing a mental disorder over their lifetime, 29.5% in the past 12-months, and 18.3% in the previous month. The most common lifetime disorders among Māori were anxiety, substance use, and mood disorders, with lifetime prevalence of any disorder highest in Māori aged 25-44 and lowest in those aged 65 and over. Of Māori with any mental disorder, 29.6% had serious disorders, 42.6% moderate disorders and 27.8% mild disorders (Baxter et al., 2006).

Inpatient Service Admissions
Māori have had an increased number of first admissions to inpatient services since the 1950s, with rapid increases in the early 60s to 80s (Sachdev, 1989). Māori continue to enter inpatient services at a rate that is disproportionately higher than other population groups.
(Abas et al., 2003; Fitzgerald, 2004; Edmonds, Williams & Walsh, 2000; Ministry of Health, 2004; 2006), at least twice that of non-Māori (Te Puni Kokiri, 1998). Service pathways for Māori are also of concern with Māori admissions being primarily via the legal system (Durie, 1994; Edmonds et al., 2000), and rates of Māori admissions to secure or forensic services also high (Tapsell & Mellisop, 2007).

The high inpatient admission rates of Māori reflect the seriousness of Māori mental health difficulties. Of all 12,376 Māori admissions between 2003-2005, Māori aged 25-44 years had the highest rates, making up 52.9% of all Māori admissions; followed by 16-24 year olds (24.7%) (Baxter, 2006a). Elevated rates of Māori admissions for schizophrenia (47.9%), and manic episodes and bipolar (16.1%) indicate areas of high needs for Māori (Baxter, 2008). Inpatient service admission rates for Māori diagnosed with schizophrenia were 3.5 times higher than non-Māori; and for bipolar 2.4 times higher than non-Māori. However, Māori rates of admission due to a depressive or eating disorder diagnoses were lower than for non-Māori (Baxter, 2008). Overall, Māori males had the highest rates of admissions, 2.2 times that of non-Māori males, with Māori females 1.5 times higher than non-Māori females (Baxter, 2008).

Later reports from the MoH (2010) have identified similar trends for Māori inpatient admissions. Of the 7,476 service users admitted to inpatient services nationally between 2007 to 2008 Māori represented more than twenty five percent of all admissions (despite representing 14% of the total population). In comparison to other ethnic groups Māori, on average, received less inpatient admission days per episode Māori (16.3 days) compared with Pacific (21.2 days) and Asian (22.5 days); and less inpatient days per service user: Māori (25.2 days), Pacific (29.5 days) and Asian (27.3 days) (Ministry of Health, 2010). Subsequent investigation is required to interpret and understand these ethnic pattern variations in ‘length of stay’ within inpatient services. One possible explanation may be rooted in restrictive care practices. For instance Māori may be being discharged too early (Kumar et al., 2008). Furthermore, of all service user admissions to forensic services in 2007 - 2008 tāngata whaiora made up 39 percent. Therefore Māori were seen by forensic services at almost twice the rate that they accessed mental health services generally (Ministry of Health, 2010).

Wheeler and colleagues (2005) examined the admission rates of tāngata whaiora to three inpatient services in the Auckland region for the year 2000. There were 932 participants in the study, which included a total of 1,232 admissions. Māori were admitted
more frequently under the Mental Health Act (MHA), as previously reported by Durie (1994), with the most common diagnosis being schizophrenia (38%). Similarly to other studies, Māori admissions were significantly higher, and along with Pacific and Asian ethnic groups, were more likely to be diagnosed with a psychotic disorder (Wheeler et al., 2005).

International studies have also reported similar findings amongst ethnic minority groups such as men from Black Caribbean, Black African, and other Black groups in Canada. This study found that the minority group was more likely than other groups to have been detained under the MHA 1983 (Care Quality Commission, 2010). Similarly, other indigenous populations and minority groups have reportedly been over-diagnosed with schizophrenia and psychotic related disorders including Black Americans in United States of America (USA) (Strakowski et al., 1993); and Afro-Carribbeans in the United Kingdom (UK) (Sproston & Nazroo, 2002). A high rate of African Caribbean people being diagnosed with schizophrenia in the UK is well documented, with some studies reporting between two to eight times higher rates of diagnosis compared to the European population (Eaton & Harrison, 2000).

**Inpatient Service Readmissions**

Despite the development of community services, and the shift of primary service care from inpatient mental health services to the community, inpatient readmission rates have been a significant challenge for mental health services (Appleby et al., 1993; Gibson, 1999). Between 1980 and 1990, Māori were 40% more likely to be readmitted to inpatient mental health services than Pākehā, particularly Māori males. Between 1984 and 1993 the rate for Māori inpatient readmissions increased by 65%. Over the same period the readmission rate for Pākehā dropped by 25% (Bridgman & Dyall, 1993; 1996; Te Puni Kokiri, 1998).

Readmission rates might be linked to an inability of services to effectively meet the needs of those it serves, and high Māori readmission rates to mental health services may indicate unequal quality care for Māori. In a more recent study of readmission rates in the Counties Manukau DHB (CMDHB) catchment area (an area of relative social deprivation and higher numbers of Māori and Pacific peoples), Fitzgerald (2004) analysed first time admissions from 1997 to 2000. Each of the 443 Māori participants were followed for the next two years from their first admission. Similarly to other studies, Māori were significantly over-represented in the proportion of first admissions, making up 32% of the first admission
inpatients compared to 17% of the South Auckland population (Jackson et al., 2001). However, the readmission rate was not significantly different to that of non-Mäori, which might be related to the potential impact of the expansion and developments of kaupapa Mäori services including onsite kaupapa Mäori services, specifically the marae complex at the inpatient service; and compulsory tikanga training for staff contributing to cultural competence (Fitzgerald, 2004).

INEQUALITIES AND DISADVANTAGES IMPACTING ON WELLBEING

This section examines the literature pertaining to the inequalities and disadvantages faced by Mäori that impact on wellbeing. Included are historical influences; contemporary realities; and the influence of barriers and restrictive care practices.

Understanding Disparities
In exploring what may contribute to Mäori mental health issues, it is helpful to consider the broader factors which contribute to inequalities between Mäori and non-Mäori. It is well documented that social, political, cultural and economic factors cause substantial inequalities and disadvantages for indigenous peoples (Jansen, Bacal & Crengle, 2009; Leitner, 2008). Health inequalities for indigenous peoples can be related not only to socioeconomic deficits, but also to more specific factors such as colonisation, the loss of language and culture, and disconnection from the land (King, Smith & Grace, 2009).

Historical Influences
Explanations for ethnic disparities, specifically the over-representation of Mäori accessing inpatient services in both admission (Baxter, 2007; Fitzgerald, 2004; Edmonds et al., 2000) and readmission rates (Bridgman & Dyall, 1996), has been related to many factors both historical and contemporary. The ongoing impact of historical processes include the Mäori experience of past oppression through colonisation (McCaneor & Nairn, 2002; Smith, 1998; Walker, 2004), through warfare, land confiscation, legal injustices, assimilation polices (such as policies inhibiting the use of te reo in schools; Tohunga Suppression Act 1907); and social discrimination and racism (Dorie, 1998). The ongoing processes of institutional racism (Harris et al., 2006) and prejudice (Johnstone & Read, 2000); and acculturation stress
through rapid urbanisation (Abas et al., 2003; Duric, 1994; Keiha & Moon, 2008; Mocke-Pickering, 1996; Walker, 2004) are also contributing factors.

Inequalities between Māori and Pākehā are influenced significantly by Māori exposure to over 165 years of colonisation, resulting in significant land confiscation and loss of te reo Māori (Māori language). The breakdown of the traditional Māori way of life, beliefs, values and philosophy, social structures and systems of discipline and justice, as well as loss of identity, have all profoundly impacted negatively on social, cultural, economic and health facets for Māori (Durie, 1998; 2004; Pihama, Jenkins & Middleton, 2003; Te Puni Kokiri, 1997). For many Māori whānau, exposure to the ongoing processes of colonisation has resulted in greater social and economic disadvantage, resulting in higher rates of mental health difficulties (Durie, 1999). Consistent with indigenous populations elsewhere, Māori have lower standards of health which are associated with poverty and inadequate health care services that aggravate this situation (Gracey & King, 2009).

Internationally, similar patterns of inequality can be seen among indigenous peoples (Gracey & King, 2009; King, Smith & Gracey, 2009; Kirmayer et al., 2000) and it has recently been reported that colonisation of indigenous peoples and its manifestations “has been increasingly recognised as a fundamental underlying determinant of health” (McShane, Smylie & Adomako, 2009: p.19). Factors that may contribute to mental health difficulties for indigenous peoples also include colonisation and its manifestations such as: the destruction of social infrastructure; change in life style; rapid urbanisation; poverty; cultural alienation and loss of identity; family dislocation; and traumatisation (Bodley, 1990; Kirmayer et al., 2000; Tseng, 2003; Walters, Johnston-Goodstar & Palmanteer, 2005).

Traditionally Māori attributed mental health difficulties to spiritual causes (Durie, 1998) and relied upon tohunga (Māori spiritual healers) and traditional rongoa (Māori herbal medicine) for treatment. Policies focused on assimilating Māori into western society resulted in detrimental consequences for the wellbeing of Māori. In 1907 the Tohunga Suppression Act restraining all Tohunga from practice was forced upon the iwi (Stephens, 2001; Durie, 1998; Walker, 2004; Voyce, 1989) resulting in limited treatment options for Māori, and consequently having a devastating impact on Māori wellbeing.

The marginalisation of Māori has also been impacted by the process of urbanisation, which has been associated with isolation and dislocation from vital support networks. Many Māori whānau were distanced from their whakapapa (geneology) resulting in the decline of
traditional roles and reduced mutual support (Durie, 1994; Savdev, 1989a; Walker, 2004). Also significant in the processes of colonisation is the imposition of western ideology and practices in the social, educational and legal realms (Durie, 1994; Jackson, 1987; Smith, 1999; Walker, 2004). The move from traditional to contemporary modern lifestyles for many indigenous peoples has seen the rapid increase of ‘lifestyle diseases’, such as obesity, cardiovascular disease, type-two diabetes, and physical, social, and mental health difficulties (Gracey & King, 2009).

**Contemporary Realities**

In addition to the impact of historical factors, contemporary factors have also been associated with the increased risk of mental health difficulties for Māori. Such factors include: multiple disadvantages (Baxter, 2008; Tapsell & Mellsop, 2007); service pathway barriers (Durie, 1999; Dyall, 1999; Edmonds et al., 2000; Ministry of Health, 2010; Tapsell & Mellsop, 2007); a lack of culturally competent services and clinicians (Johnstone & Read, 2000; O’Hagan, 2001; Simpson et al., 2003); reduced levels of whānau understanding, acceptance and support (Abas et al., 2003; Kumar & Oakley Browne, 2008); and limited community capacity to support people when unwell (Wheeler, Robinson & Robinson, 2005). [Some of these factors are discussed further in the Māori Mental Health Challenges and Developments section of this literature review].

A recent surge in literature on the impact of inequality, particularly poverty, and mental health wellbeing has emerged (Wilkinson & Pickett, 2009).

“Being poor, a member of an ‘ethnic minority’ or a colonised people…can have psychological consequences. Denying these simple facts is unscientific and unhelpful” (Read & Johnstone, in press: p. 1).

Furthermore, researchers have concluded that poverty is predictive of psychological distress (Read & Johnstone, in press); suicide; depression; severe mental illness (Albee, 2006); and other negative health and social outcomes (Albee, 2006; Read, 2010; Wilkinson & Pickett 2009). Consistent with such reports, a relationship has been found between inpatient admissions and socioeconomic deprivation within Aotearoa (Abas et al., 2003) and internationally (Shepherd et al., 1997). Furthermore, deprivation has also been associated
with extended length of stay within inpatient services (Abas et al., 2008). Although the relationship between poverty and psychological distress is well evidenced, the influence of other social variables should not be excluded, which are themselves related to poverty. These include: child abuse and neglect; unemployment; gender; ethnicity; maladaptive coping strategies; and reduced access to economic and social resources (Barker-Collo & Read, 2003; Read & Johnstone, in press).

Read (2004b) described the relationship between poverty and extreme distress as a ‘circle of oppression’.

“Of course the poor in any society are subjected to more sources of stress than the wealthy…Even those with enough to eat and somewhere to live are more likely to experience powerlessness, isolation, lack of self-respect, physical ill-health etc…Having entered the system they are more likely, regardless of their behaviour, to be hospitalised and labelled ‘schizophrenic’. This is likely to further lower their self-esteem and motivation, and to frighten and distance loved ones” (Read, 2004b: p. 168).

From this perspective, those of indigenous backgrounds, specifically Māori, are therefore at higher risk of ongoing psychological distress, given the economic position many live in and the ongoing historical and contemporary outcomes of colonisation they are faced with.

**Barriers and Restrictive Care Practices**

Restrictive care practices are “psychiatric practices that reduce the autonomy and choice of the individual” (Kumar et al., 2008: p.1) which may, in turn, hinder recovery (Jacobson & Greenly, 2001). For instance, barriers to health service access, institutional and interpersonal racism, misdiagnosis, and lack of culturally competent care and services are all restrictive care practices that contribute to the ongoing health disparities of Māori.

The rates of Māori access to, and use of health services in general is of concern. Reports conducted by the MoH have found that Māori access mainstream primary health services less; present to secondary health services with often advanced conditions; and have less access to life-saving tertiary interventions (Ministry of Health, 2010). Access issues to health services are reflected, in part, in negative health statistics. Recent statistics compiled
by the MoH (2010) emphasised access issues when they found Māori to have an avoidable mortality rate that is “deaths occurring to those less than 75 years old that could potentially have been avoided through population-based interventions or through preventive and curative interventions” (Ministry of Health, 2010) two and a half times higher than non-Māori. Furthermore, despite similar statistics between Māori and non-Māori diabetes rates, Māori were eight and a half times (population rate) more likely to experience concurrent renal failure (Ministry of Health, 2010).

A number of studies have investigated the issue of Māori health service access and use, and accentuate a number of common barriers. The three main areas associated with Māori lack of timely access to adequate services included: economic barriers (such as medical costs relating to GP visits and the cost of medication) (Jatrana, Crampton & Norris, 2011); cultural expectation of the benefits, or lack of healthcare services (Crampton et al., 2000); and geographic factors and the lack of transport (Ellison-Loschmann & Pearce, 2006; Ministry of Health, 2002; 2010).

The low service access rates for Māori is of concern in the broader health domain and more specifically within mental health services. Given the high number of Māori struggling with mental health difficulties, the proportion of those accessing mental health services is relatively low (Ellison-Loschmann & Pearce, 2006). Te Rau Hinengaro survey (2006) reported that no marked inequality of access to healthcare treatment exists, but people with lower educational attainment and those living in rural areas had lower rates of visits to the services (Ministry of Health, 2006).

More specifically, of all Māori with any 12-month mental health disorder only 33% accessed mental health services compared to 41% of Others (Baxter et al., 2006; Ministry of Health, 2006). Difficulties accessing services for Māori often resulted in presentation to mental health services later, when conditions are more severe, therefore often requiring involuntary admission (Bridgman & Dyall, 1996; Edmonds et al., 2000). Potentially this may result in more aggression during inpatient admissions, and consequently higher rates of restrictive practices, specifically seclusion (Tapsell & Mellsop, 2009).

Disparity in mental health indices can also be understood through the marginalised position of Māori. A number of studies have identified Māori to be more likely to experience discrimination through institutional and interpersonal racism (Howden-Chapman & Tobias, 2000; Reid, Robson & Jones, 2000). Harris et al. (2006) identified racism, both
interpersonal and institutional, as an ongoing significant contributor to both Māori health losses and inequalities in health between Māori and Pākehā in Aotearoa. This study emphasised the importance of interventions and policies to improve Māori health and recommended that any attempts to address these inequalities should take into account the health effects of racism (Harris et al., 2006; Nairn et al., 2006). [Restrictive care practices specifically related to mental health services are discussed later in the Māori Mental Health Challenges and Developments section of this literature review].

Many Māori health researchers have asserted the need for action to address disparities for Māori and to:

“Address those societal factors, especially racism, that drive not only ethnic disparities but also non-Māori complacency and inaction in the face of inhumanity, represented by disparities” Reid, Robson and Jones (2000: p.46).

In addition to access issues, institutional and interpersonal racism, the lack of adequate cultural services and a culturally competent workforce is a factor influencing ongoing disparities for Māori. Outcome studies indicate that the health and rehabilitation needs of indigenous peoples are currently not being met (Harwood, 2010). Māori experience a lower standard of health care than non-Māori in the mental health system, with the consequences of poorer health outcomes (Simpson et al, 2003; Tapsell & Mellsop, 2007). Professor Sir Mason Durie (1997) reflected on the past 25 years (1972 - 1997) of mental health service reform:

“There is no guarantee that a Māori client will receive quality and timely treatment. Nor is there discernible Māori confidence in the system. The hospital record is essentially one of failure” (1997: p. 8).

The limitations and lack of cultural competency of the medical profession in working with tāngata whaiora have been an area of investigation. Johnstone and Read (2000) investigated psychiatrists' recommendations for improving bicultural training and Māori mental health services. Of the 247 psychiatrists surveyed only 40% believed that their training had prepared them to work effectively with Māori. Some of the suggested recommendations for
improving how they worked with Māori included: needing to understand Māori perspectives of well-being; and increasing the number of Māori professionals and kaupapa Māori services ‘by Māori for Māori’ (Dyall, 1999). Of psychiatrists who responded to the survey, 70% believed that there was a need to consult with Māori when working with Māori. Furthermore, the majority of participants identified historical influences (such as the impact of colonisation) and contemporary realities (such as poverty) as a reason for high Māori rates in mental health services. However, 28 psychiatrists (11.3%), all male, New Zealand born, and with 10 or more years clinical experience, believed that Māori were biologically or genetically more predisposed than others to mental illness. The researchers also noted that “several respondents offered other racist comments” (p. 135). For example:

“I am sick of questionnaires regarding Māori stuff, there is far more important issues than those regarding Māori mental health. Do you really think that psychiatrists need to have an understanding of such concepts like spirituality – come on give me a break”

“As a European I take offence to your study, why should I learn about taha Māori and not other cultures – New Zealand is no longer bicultural it is now multicultural. Given all the cultures within New Zealand, I would find this very time consuming and tedious”

“There is no need for taha Māori in training programs, as psychiatrists we are taught skills and we apply them in a cookbook manner. My effectiveness as a psychiatrist is not dependent on the colour of my skin, my culture, nor my understanding of bloody Māori culture”

“This questionnaire is worthless! I mean the Māoris are always going on about the importance of land etc. etc. so why did they bloody well give it away. . . . I feel that they are getting the appropriate services they need, just not using them, medication is the answer – but they just don’t take their pills – if cannabis was prescribed, I’d bet they’d bloody take that” (p. 141).
Such attitudes highlighted the need for cultural competency training (Johnstone & Read, 2000). Cultural competency is discussed further within the Māori Mental Health Challenges and Developments section of the literature review.

Addressing Disparities and Inequality

Tackling the issues pertaining to disparities and inequalities needs to be made a priority to improve Māori mental health wellbeing. This includes further research into inequalities and interventions that reduce these factors. In addition, the influence of existing and future social policy needs to be evaluated carefully.

“Correction of these inequities needs increased awareness, political commitment, and recognition rather than governmental denial and neglect of these serious and complex problems” (Gracey & King, 2009: p.65).

Inequalities are avoidable as they can be significantly reduced through government policy choices (Woodward & Kawachi, 2000). The development of broader policies to decrease societal inequalities for Māori in social, economic and education outcomes will lead to a reduction in physical health inequalities between Māori and non-Māori (Baxter, 2008). It has also been suggested that indigenous people need to be supported, via training and other educational modes, to become more involved in overcoming these challenges (Gracey & King, 2009). Furthermore, it has been asserted that:

“Inequity of health and rehabilitation outcomes speaks to the (under) valuing of peoples lives within their nation; such undervaluing of indigenous people will require a comprehensive and multi-faceted response that will address, rather than tolerate, disparities. A rehabilitation strategy that achieves the aspirations of indigenous peoples ultimately delivers the promise of a healthy nation” Harwood (2010, p.976).

In a recent study conducted by Cox and Black (2011) the narratives of the Waikato community locals were explored identifying poverty as a major issue. The report highlighted the significant levels of deprivation people were faced with, in particular Māori. In addition, principles focused on addressing inequalities were presented describing a move towards
‘economies of hope’. The reciprocal foundations of ‘economies of hope’ are: “…based on systems and values where people trade and exchange goods and services for mutual benefit of the society and all its members” Cox and Black (2011: p. 44).

The principles along with national strategies to address inequalities were identified, which are: enabling tino rangatiratanga (self-determination) such as strengthening cultural identities; strategies to address institutional racism; adequate funding for te reo Māori and tikanga in schools; and prioritising children and youth was of importance (such as introducing a child benefit; extended parental leave; and free health and dental care for children). Improving economic equality via the development of government policies that reduce income inequality (such as a comprehensive capital gains tax, and fair and just tax rates) was also discussed. Furthermore, creating a responsive state that works for all people (such as responsive and engaged parliamentary ministers) was seen as essential to the process of change; social security (for example ensuring adequate benefits that increase with the cost of living, and introducing a tax free threshold); equal access to health and social services; and full employment via the development of work and participation opportunities (such as creating jobs; community work) were also a high priority. Furthermore, the importance of additional aspects were described, which included: protection and wellbeing of the environment to ensure resources for future generations; outcomes of wellbeing; and government regulated markets through regulation of the finance industry (such as the reduced availability of credit cards and income related rental policy for Housing New Zealand tenants) (Cox & Black, 2011).

Supporting those faced with major disparities and inequalities, specifically indigenous peoples, has been an area of focus for social justice researchers internationally. A broad indigenous health framework for clinicians has been devised to improve understandings to promote more culturally appropriate ways to interact with, to assess, and to treat indigenous peoples. The areas discussed are: understanding indigenous notions of health and identity; mental health and addictions; urbanisation and environmental stresses; whole health and healing; and reconciliation (King et al., 2009). The development of recent research regarding cultural competency within Aotearoa has produced and various training initiatives, many within specific health professions, with varying levels or stages of competent practice identified (Levy, 2007; Ministry of Health, 2005). Cultural competency is discussed further
In summary, when examining inequalities caution is advised when making comparisons between population groups based upon ethnicity. As discussed, such disparities are influenced by a range of contributing factors that must be considered when analysing the disturbing health disparities for Māori when compared to their non–Māori counterparts, especially in relation to the mental health statistics (such as the inpatient service admission rates). Such statistics must not be viewed in isolation, however contextualised, but require consideration of the historical influences and contemporary factors (incorporating the influence of barriers and restrictive care practices) investigated in order to gain a full interpretation of the causative influences. Nevertheless, tackling the issues pertaining to disparities and inequalities is possible (significantly influenced by government policy choices) and must be made a priority to improve whakaoranga and whānau ora for Māori.

MODELS OF HEALTH

This section discusses both western health models and Māori understandings of health including a brief description of a number of Māori health models. Conflict between the two paradigms, as well as a collaborative pathway forward are also areas of focus within this section.

Western Health Models

Many western health frameworks have been reported, with some more frequently referred to and implemented than others. The following section will briefly discuss some of these models, including: the ‘medical model’ or ‘bio-medical approach’; psychosocial framework; and family systems perspectives. Since its development in the mid nineteenth century, biomedicine, also referred to as the medical model, has dominated understandings of health which forms the basis of western health services today. This model views health as predominantly an ‘absence of disease’ and explains disease and sickness within a biologically reductionist framework with an emphasis on the physical nature of disease. Furthermore, a high value is put on using scientific methods of research and on scientific knowledge (Jones, 2010).
A number of strengths and limitations of the bio-medical approach in supporting service users have been investigated. Some of the advantages relate directly to the curing of illness such as: diagnostic categories and ways of dealing with symptoms that may help in the treatment or prevention of life-threatening illnesses, for instance the diagnosis of particular heart conditions and surgery to prevent ongoing illness and death (Quinn, 2005); a prescribed process in which people can follow to get their health needs addressed (Beirman & Engel, 2009) sometimes involving examination and administered testing (such as blood tests and swabs); effective treatment for many serious illnesses such as life threatening asthma and allergies (Plottel, 2005); and highly trained specialised practitioners with many years of specialist training with mental health difficulties (Blouch & Singh, 2007).

Nonetheless, multiple limitations have been highlighted specifically related to: the reductionist, curative, individualistic focus, with little attention to social determinants of health (Bouch, 2011; Engel, 1977). In addition, biomedical practitioners are often criticised for being impersonal, as service user perceptions and understandings of their difficulties are not always prioritised, and clinicians have been reportedly more interested in symptoms rather than in people (Greenhalgh & Hurwitz, 1999). Also, because of the diagnostic categories and ways of dealing with pathologies’ focus, it has been argued that the dominance of the biomedical model within inpatient mental health services has resulted in the ‘medicate and wait’ approach. This refers to a ‘quick fix’ temporary solution that does not solve longer term associated difficulties such as social, spiritual and other broader factors, resulting in limited treatment options (Breggin, 1991). Furthermore, some medical interventions can have serious side effects (Rose, 2007) such as brain damage resulting from surgery mishap; and specialisation can result in a narrow scope of practice for practitioners (Rose, 2007). For instance a surgeon will not have specialist psychiatry skills and vice versa.

The medical profession is not isolated in its perspective on treating health difficulties. The history of psychology has also been strongly influenced by a western European context, consequently, adopting the philosophies, theory and practice of western models into the discipline (Fernando, 1988). Consequently the psychology profession has been criticised by many Aotearoa based psychology researchers for the lack of a Māori knowledge base (Herbert, 1997; Levy, 2007; Love, 2003; Milne, 2005; Nikora, 1989). Contemporary psychology is primarily focused upon reducing difficulties associated with mental health difficulties (Durie, 1984). These priorities are consistent with the popular
medical model used widely in western health settings which focuses on biological or inherited causes of mental health disorders (Kent & Read, 1998).

As the psychology profession has evolved so have the models and theories of practice. Contrary to the biomedical theory that is dominated by disease, the biopsychosocial model is based in part on the social cognitive theory (Halligan & Aylward, 2006). This model incorporates social, psychological and emotional factors in both diagnosis and treatment. The practice within a biopsychosocial framework contrasts with the biomedical model in that it acknowledges the links between socioeconomic deprivation and health difficulties (Engel, 1980).

One of the oldest and most distinguished theories in relation to working with whānau collectively in the psychological profession is the family systems theory (Corey, 2001). This theory of human behaviour views the family as an emotional unit and uses ‘systems thinking’ to describe the complex interactions within this unit (Carr, 2006).

Theorists suggest the connectedness and reactivity found among family members makes the functioning of family members interdependent (Corey, 2001) and founded the theory upon these principles (Bowen, 1978; Bowen & Kerr, 1988). For instance, family members have been shown to profoundly affect each other’s thoughts, feeling and actions (Rosenblatt, 1994). The development of this theory was based upon three main assumptions. Firstly, that service user difficulties may serve a function or purpose for the family; secondly, that service user difficulties may be a function of the family’s inability to operate productively; and thirdly, the maladaptive behaviour may be a symptom of dysfunctional patterns handed down from generations (Corey, 2001).

Māori Understandings

Many indigenous populations are known for their unique paradigms of health (King et al., 2009; Wilson, 2003) and this is certainly the case for Māori in Aotearoa (Durie, 2001; 1998; 1984; Taitimu, 2008; Walker, 2004). Although Māori paradigms of health have been in practice within the Māori culture itself, it has only been since the 1980s that these have been documented and shared with health professionals and services. This section will focus on traditional Māori society and concepts including tikanga Māori (Māori customs). The more common Māori health frameworks currently in use within Aotearoa will also be discussed, providing insight into the usefulness of traditional frameworks, further highlighting the
limitations of the western model when working with Māori and other indigenous populations.

Traditional Māori society was based upon collectiveness which encompassed different social units which included whānau (‘offspring, family group’ or ‘family’), hapū, and iwi incorporating at least three generations led by elders, kaumātua and kuia (Walker, 2004). The hapū, or ‘sub-tribe’ (Mead, 2003: p. 360) is a larger grouping of whānau. And on the larger scale, iwi are a ‘nation of people’ (Walker, 2004), which includes a grouping of hapū who shared a common ancestor or whakapapa (genealogy) (Walker, 2004). Many Māori, who have survived or overcome the impact of urbanisation and dislocation processes, continue to view their society through this collective traditional Māori world view.

The importance of cultural knowledge described as tikanga, when expanded to tikanga Māori refers to ‘the Māori way’ or done ‘according to Māori custom’ (Mead, 2003: p. 11). Tikanga Māori involves specific cultural practices (such as karakia; powhiri; and karanga) that provide protection for sacred elements such as tapu and mana (Durie, 1999). This section is by no means an exhaustive account of tikanga Māori but rather a brief description of Māori principles, values and ways of being relevant to understanding Māori mental health.

A number of practical aspects of tikanga have been described, relating to principles of tika (right or correct) and pono (true or genuine). Tika refers to the practice of a particular tikanga in that it needs to be implemented and delivered correctly (Mead, 2003). The principle of pono occurs where things are ‘permanent’ or ‘enduring’ in terms of the principles to Māoritanga (Māori culture) (Mead, 2003). The significance and depth of the Māoritanga concept is described further in this quote from Eruera Stirling (1980):

“Māoritanga is not action songs or haka, it is holding fast to the treasures of your ancestors, lands, marae, pa, the mountains, and returning in spirit to the minds of your forbearers. It is not a light and easy thing, but a difficult treasure, and heavy to carry” (cited in Stirling and Salmond, 1980: p. 247).

Tikanga Māori is interwoven between different dimensions. Such tikanga Māori principles include: whānaungatanga and manaakitanga. Firstly, whānaungatanga refers to ‘embracing whakapapa and focuses upon relationships’ (Mead, 2003: p. 28) and supporting each other as a collective group (such as during special ceremonies like tangihanga (funeral)). The concept
of whānaungatanga can also occur in non-relative relationships. Manaakitanga, an equally important concept, relating to ‘hospitality’ or the way in which one cares for another, has been linked with whānaungatanga. These concepts combined, manaakitanga whānaungatanga refers to ‘nuturing relationships, looking after people, and being very careful about how others are treated’ (Mead, 2003: p. 29). The concept of mana (authority; control; influence; prestige; power; effectual, binding, authoritative) has to do with the place of the individual in the social grouping. For instance, a person’s mana can be interpreted based upon ones leadership roles, from strong whakapapa with rāNgātira (chief) connections and on previous works or skills (Mead, 2003: p. 29).

Before discussing specific Māori health models it is important to understand the context in which they occur. Māori and other indigenous peoples are well known for their strong connection to the spiritual realm (Durie, 1994; Gracey & King, 2009; Walker, 2004) often referring to wairuatanga the ‘soul’ or ‘spirit’ (Mead, 2003: p. 54). The concept of mauri is derived from this traditional Māori creation story and has been defined as the ‘life principle’. This significance of mauri in the broader sense can be explained further in the following citation: “Ki te Māori he mauri kai roto in nga mea katoa, I nga tāngata, I nga whare, I nga rakau, I nga taonga whakairo”. Translated as: “To the Māori, the life principle is within everything, people, houses, trees, carved things” (cited in Ngata, web reference). That is, within Māori understandings, it is believed that the concept of mauri is present within all living things and provides a connection with the mana atua dimension (Ihimaera, 2004).

The inter-related concepts of mana, tapu and noa provide mechanisms of social organisation and law within traditional Māori society and are of relevance today (Sachdev, 1989a). The concept of tapu is an important element of tikanga Māori referring to something under ‘religious or superstitious restriction’ or being ‘sacred’. The power of tapu comes from spiritual beliefs and powers (Mead, 2003; Walker, 2004) consisting of two main categories. Firstly, inherent tapu has been refered to objects which are themselves tapu, such as a person’s head. Secondly, extensions of tapu are restrictions not because of their own intrinsic tapu but because of their relationship to some primary tapu and are imposed to protect in some way (Shirres, 1997: p. 34). For instance, a rahui ‘ritual prohibition either placed on a place, or part of a river, part of a foreshore or on certain resources’ (Mead, 2003: p. 365) following pollution has been detected to ward people off from gathering kai from the area. Intrinsic with tapu is the concept of mana referring to ‘control’, ‘dominance’ and
“prestige” (Ngata, 1993). It has been reported that a person who possesses mana is one of spiritual power and authority (Shirres, 1997).

The concept of noa is the concept to be ‘free from tapu’ or any other restriction with the term whakanoa (to cleanse) often referred to when lifting tapu. Such things responsible for this cleansing or whakanoa process include karakia (prayer), wai (water) and kai (food). For instance, the use of wai to lift tapu after leaving the sacred sanctions of a cemetery, and the use of kai following a powhiri to lift the tapu nature of connecting with the spiritual world (such as the karanga calling the spiritual realm) during the process (Mead, 2003).

These Māori concepts form the traditional belief system of Māori which provides alternative explanations for symptoms often misunderstood and misdiagnosed within western paradigms. Māori explanations of mental health experiences, that the biomedical model would often diagnose as symptoms of mental illness (Taitimu, 2008) include: ‘mate Māori’ (Māori illness) or makutu (Māori curse); and matakite (visionary, ‘seeing things’). Māori understood, and many continue to understand these extraordinary experiences today, from a spiritual foundation (Milne, 2005; Taitimu, 2008). Such abilities were often seen as strengths and talents of the individual gained via an ancestral pathway. For instance, a person with matakite abilities was often identified at childhood with the skill passed down from generation to generation (Walker, 2004).

Through the lens of te ao Māori (Māori world view), specific understandings and explanations for such experiences have been related to:

1. Porangi - feelings of total restrictions such as the feeling of being lost, in despair and being unable to rise above this state;
2. Wairangi - the feeling of sinking and having no solid base or safety;
3. Pohauhau - the feeling of being lost and total disempowerment, winds coming from different directions and unable to make a stand;
4. Rangirua - feeling hopeless and confused;
5. Pohehe - a wondering mind;
6. Puhaehae - intense serrated feelings; and
7. Whakama - in the state of shame (in the general sense), described as a sense of disadvantage or loss of standing (Durie, 2001). The impact of whakama
Traditionally Māori attributed mental health difficulties to spiritual causes and relied upon tohunga (Māori spiritual healers) and traditional healing methods including karakia (spiritual stimulation, prayer) and the use of rongoa Māori (Māori herbal medicine) for treatment (Durie, 1998). In 1907 the Tohunga Suppression Act, restraining all tohunga from practice was forced upon iwi including all Māori nationwide (Durie, 1998; Stephens, 2001; Voyce, 1989; Walker, 1990). This left Māori with limited trusted traditional treatment options resulting in devastating consequences for health outcomes. Although the Crown described the function of the Act was to improve Māori health at the time, there is also evidence to suggest it was implemented as a political weapon against Rua Kenana (a Tūhoe activist and prophet) in an attempt to gain certainty and political dominance (Stephens, 2001). Despite the suppressing Act the traditional practices of tohunga and modes of healing continue in Aotearoa today (BPAC, 2008).

Traditional Māori healing approaches may include rongoa Māori (traditional Māori medicine and healing), karakia, mirimiri (massage), whānau participation or not, and occur within tikanga Māori processes. Rongoa Māori refers to native plant extracts and preparations used for traditional healing practices (Durie, 2010; Riley, 1997). There have been many reports, both historic and current, of the usefulness of rongoa Māori in alleviating distress (spiritual, emotional, physical, and social) and improved overall wellbeing (Jone, 2006b; Moon, 2000; Robinson, 2005). The effectiveness of rongoa however is an area requiring further investigation which should be conducted by healers themselves (Durie, 2010).

Recent years have seen a reawakening of Māori interest in traditional approaches to health prompted by calls for rongoa Māori services to assume a greater presence in the health sector of Aotearoa. Jones (2000b) examined the place of traditional Māori healing in the early 21st century and found a high demand for traditional healing with many Māori health services incorporating elements of traditional healing into their agencies.

A qualitative study described one aspect of a group of traditional Māori healers' practice, namely diagnosis, and compared this with western medical practice (Jones, 2000a).
The overall diagnostic approach used by these healers was similar to that used in western medicine, with some important practical differences. One distinctive feature of traditional Māori healers was the emphasis on the spiritual dimension, consistent with their beliefs about health and causation of illness. A similar approach of the health practitioners was the function of diagnosis as an integral part of the healing process used to guide treatment (Jones, 2000a) highlighting the potential complimentary of the two approaches (Ngata, 1949).

Māori Health Models

In Aotearoa an important feature of the healthcare system today is the unique holistic perspective of health incorporating traditional Māori views acknowledging an interconnectedness between physical, spiritual, environmental and mental health (Bridgman & Dyall, 1996; Durie, 1994; Ministry of Health, 2002). Wairua (spirituality) is an intrinsic part of being Māori and is critical for Māori health development (Department of Health, 1984) and supporting whakaoranga and whānau ora (Goldsbury, 2004; Tse et al., 2005). The significance of wairua as an aspect of overall wellbeing for Māori has been evidenced widely (such as in the models that follow). Māori health researcher Ihimaera (2004) investigated the pathway to understanding the facilitation of taha wairua (spiritual dimension) in mental health services. Her findings highlighted the effectiveness of a wairuatanga (spirituality) through tikanga Māori in supporting healing and whakaoranga for tāngata whaiora.

During the early 1980s a number of models of Māori health were developed in an attempt to provide a framework for a Māori perspective of health. The four main models presented are Te Whare Tapa Wha (The Four Sided House), Te Wheke ("The Octopus"), Nga Pou (The Posts) and Nga Pou Mana o Io (The Prestigious Posts of the Supreme Being), all sharing similar themes. In 1984 Te Whare Tapa Wha framework, also known as the four cornerstones of health (Durie 1994), emerged and was readily accepted and utilised within Aotearoa health settings (Amor, 2002; Rankin, 1986). It portrays a traditional Māori approach of health along with mental health or emotional wellbeing as just one of the cornerstones of health (Durie, 1994). This holistic model of good health comprises four dimensions: te taha wairua relates to the capacity for faith and wider communion and suggests that health is related to unseen and unspoken energies; te taha hinengaro (mental or emotional dimension) is the capacity to communicate, to think and to feel, and suggests that
the mind and body are inseparable; te taha tinana (physical dimension) advocates that good health is necessary for physical growth and development; and te taha whānau (family dimension) which requires individuals to belong and to share, and the recognition that individuals are part of a wider society (Durie, 1994; Reid, 1999). In a symbolic sense, good health is represented as a strong house where each of the four dimensions represent a wall. Each dimension is equally important in determining well-being and each element is as important as the next, therefore to address one element, it is essential to look at the wider picture which includes all four aspects of the holistic approach.

Another model, Te Wheke (Pere, 1984) describes eight domains that collectively contribute to wellbeing. Similar to the previous model, Te Wheke includes: tinana (physical); wairuatanga (spiritual); hinengaro (mental); and whānaungatanga (extended family). Te Wheke also includes four other dimensions: mana ake (unique identity) recognising the importance of the individual; mauri (life principles) related to the 'life principle' or 'thymos of man’ and the breath of life of the living (Mead, 2003) discussed earlier. In addition are the dimensions ha a Koro ma a Kui ma (inherited strength) literally meaning the breath of life that comes from ancestors; and the whatamanawa (emotional) dimension (Reid, 1999). The Te Wheke model of health gained acceptance in the early 80s and is represented by an octopus, each of the eight tentacles representing the dimensions of health, while the body and head represent the whole whānau unit (Reid, 1999).

In the late 1980’s the Royal Commission on Social Policy described a set of areas for health focusing on factors that were primarily external to the individual (Durie, 1994; Reid, 1999). The Nga Pou model includes four supports believed to be necessary for health, such as: whānaungatanga (extended family); taonga tuku iho (cultural heritage); te ao turoa (the physical environment); and turangawaewae (source of identity) (Durie, 1994). This model, resembling supporting structures, recognised the need for health strategies to improve the overall health status of iwi and hapū (Ngata & Dyall, 1984).

In addition to the three models discussed earlier, similar frameworks incorporating broader tikanga Māori principles and philosophies have been presented, such as Nga Pou Mana o Io philosophy (Ngaropo, 2005). This philosophy was based upon the traditional Māori view described earlier, which displays how a tikanga Māori health framework, from a traditional belief system, can be integrated into mental health services. Four dimensions have been identified, mana Atua, mana tupuna, mana whenua, and mana tāngata. Firstly, the
mana Atua (authority and God or supreme being) dimension is related to ones connection with Io (supreme being, master of all gods), from where the spiritual beginnings of Māori are derived (Mead, 2003). The mana tupuna (authority and ancestor) dimension refers to ancestral relationships, to stand with pride, confidence, self-esteem and dignity and a secure cultural identity (Durie, 1994). The area relates to the whakatauki:

“A person who knows their identity is a true person who stands with confidence, pride and dignity. A person who doesn’t know who they are, are considered a lost soul” (Ngaropo, 2005: p. 6).

The concept of mana whenua (authority and land) refers to ones connection to the land and their place of origin such as forests, fisheries, places’ of cultural, spiritual, and ancestral landmarks of historical importance. For instance, the place where ones whenua (placenta) is buried has great significance representing the spiritual and physical connection to Papātuanuku. The mana tāngata (authority and person) dimension refers to one’s talents inherited through whakapapa, and represents ones connection and belonging (such as waka, iwi, hapū, and whānau) (Ngaropo, 2005; Ngata, 1993). The significant of this connection can be observed when Māori often beginning their kōrero (talk, speech) by discussing their origins (such as hapū; iwi; tāngata) and the places they connect to (such as maunga; awa; marae).

Conflict and Collaboration
The decline in psychoanalytical thinking in the 50s and 60s, and the introduction of pharmaceutical treatment saw the increased dominance of a medical model focused on biological causation based upon brain abnormalities and gene research. Historically criticism of the medical model has been limited possibly due to potential backlash from the prevailing medical profession (Engel, 1977) however the recent resurgence of research focusing on the narrow scope of practice has developed (Bouch, 2011; Read, Mosher & Bentall, 2004; Rose, 2007). Despite this, there continues to be some resistance to view broader explanations of understanding wellness, evident today by the public uproar of some medical professionals with the release of the ‘Models of Madness’ book (Read et al., 2004). The well evidenced content of this volume negates traditional theories of the medical model specifically related
to the diagnoses of ‘schizophrenia’, and in contrast places importance on the widely supported psychological and social approaches.

Recent research conducted by Taitimu (2008) investigated Māori ways of understanding extra-ordinary experiences (such as hearing voices and seeing visions) and schizophrenia. A number of explanations for the high rates of Māori being diagnosed with schizophrenia (Baxter, 2008; Dyall, 1997; Tapsell & Mellsop, 2007) were offered. Sound arguments were also presented regarding the implications of applying western phenomena to indigenous populations who have their own unique paradigms of health and interpretations for such experiences. These include Māori explanations of extraordinary experiences in a spiritual context therefore having different healing pathways, as opposed to the focus of medication in the biomedical stance. One recommendation from this study, which utilised kaupapa Māori methodology, was the need for culturally appropriate assessments and treatments (Taitimu, 2008).

This perspective has been echoed by other Māori health researchers, including Tapsell & Mellsop (2009): “Understanding the way in which Māori present and the significance of that for clinical assessment, management and research is of critical importance” (p. 322). The importance of understanding the context in which Māori mental health difficulties exist has been expressed in addition to the importance of incorporating both cultural variables and western approaches (Jones, 2000b). However, given the dominance of the western approach it may be more fitting, at this time, to have the focus on specific cultural variables and examine what these maybe.

Well before it’s time, the advanced whakaaro (thoughts) of Sir Apirana Ngata (1949) was shared with Māori psychiatrist Dr Henry Rongomau Bennett, highlighting the challenges and benefits of the two separate world views:

“E tipu, e rea,
Mō ngā ra o tōu ao;
Ko tō ringa ki ngā rākau a te Pāhekā
Hei ara mō tō tinana,
Ko tō ngākau ki ngā taonga a ā tīpuna Māori
Hei tikitiki mō tō māhuna,
Ā, ko tō wairua ki tō Atua,
Nāna nei ngā mea katoa”.

“Grow up and thrive
For the days destined to you,
Your hands to the tools of the Pākehā
To provide physical sustenance,
Your heart to the treasures of your Māori ancestors
As a diadem for your brow,
Your soul to your God
To whom all things belong”
(cited in Walker, 2005).

Through his whakatauki Ngata (1949) reflects on the challenges of living in both traditional Māori and Pākehā western worlds, each with their own philosophies and belief systems. His words encapsulate a vision of Māori development. A collaborative approach is portrayed encouraging one to learn and take hold of all the tools that would help them to prosper, encouraging Māori to seek out knowledge derived from science and technology and to blend it with Māori customary knowledge, urging movement in two directions simultaneously (Walker, 2005).

In summary, conflict between the two paradigms is obvious when comparing the western biologically reductionist framework to Māori understandings of health and wellbeing articulating physical, mental, emotional and spiritual elements from both individual and collective points of view. The vision shared by Ngata (1949) foresaw a collaborative pathway which continues to progress, somewhat, within Aotearoa today despite ongoing tension. In order to move forward mainstream health services must develop to become truly intercultural in order to improve whānau ora and take into account Māori understandings of health and preserve and strengthen the indigenous health systems, recognising and protecting Māori health definitions and norms and the collective traditional knowledge.
MĀORI HEALTH POLICY DEVELOPMENTS

This section discusses the progress in Māori health through policy development and implementation in Aotearoa. Firstly, the significance of Te Tiriti o Waitangi (Treaty of Waitangi) and its relationship with health policy development will be featured; along with the influence on health professions cultural competency progress. The journey of Māori mental health policy development will also be a theme of this section.

Te Tiriti o Waitangi and its Relationship with Health Policy in Aotearoa

Te Tiriti o Waitangi (the Treaty of Waitangi) (1840) is a foundation document, an agreement signed between Māori and the Crown ensuring specific rights to Māori, as tāngata whenua (people of the land; indigenous) for sharing the resources of Aotearoa (Ministry of Culture and Heritage, 2011; Walker, 2004). This document is the basis for respect and partnership between Māori and all peoples who live in Aotearoa. Reference to Te Tiriti has been reported frequently in research literature pertaining to Māori and government policies however for the purpose of this section the specific focus is on literature relating to Māori health.

It was not until the mid 1970s, with the introduction of The Treaty of Waitangi Act (1975) acknowledging Te Tiriti as “a constitutionally significant document” (Morgan, Coombes, & Campbell, 2006) that references observing Te Tiriti began appearing in various health policies, despite having been signed over a century earlier (Cooper, Rickhard & Waitoki, 2011). The Act was introduced to:

“...provide for the observance, and confirmation, of the principles of the Treaty of Waitangi by establishing a tribunal to make recommendations on claims relating to the practical application of the Treaty and to determine whether certain matters are inconsistent with the principles of the Treaty” (Morgan et al., 2006: p. 52).

To understand the significance of this constitutional embrace, it is essential to explore Te Tiriti further, with specific emphasis on its relationship with health policy. Te Tiriti is comprised of three main articles (Ministry of Culture and Heritage, 2011), with three key principles extracted from each guiding the Crown as a Te Tiriti partner, in respect of mental
health service development and delivery which include: participation; partnership; and protection (Ministry of Health, 2007).

The essence of Article One is to establish the Crown as the governing body, relating to the principle of partnership. The obligation to provide a balanced governance acting in the both the interest of Māori and non-Māori is outlined (Walker, 2004). The second, Article Two, guarantees to Māori the preservation of the ownership of their resources and taonga (asset; treasured possession) (Walker, 2004). This refers to tino rangatiratanga (sovereignty; self-determination) provisioned under Te Tiriti as a commitment of the Crown (Department of Social Welfare, 1989). And Article Three constitutes an assurance of equity for Māori in all benefits, with the same rights and privileges of citizenship within Aotearoa. This relates to the principle of protection and provides the basis for health policy in Aotearoa to improve outcomes for Māori. Responsibility is placed on the crown to ensure that Māori not only have equal access to health services but also experience equal outcomes (Department of Social Welfare, 1989).

Te Tiriti o Waitangi Guiding Psychological Practice
A report commissioned by the New Zealand Psychologists Board revealed a number of serious issues in regards to Māori perceptions and experiences of the psychology profession (Milne, 2005). The paradigms of the psychology profession were seen as marginalising Māori health models and the western based psychology training principles described “psychology as a dangerous profession for Māori” (Milne, 2005, p.14). Of the 69 participants, many described distrust and disapproval in regards to psychology training, theory and practice. It was evident from the findings in this study that Māori understandings of health varied significantly from non-Māori as did their understandings of psychology. A kaupapa Māori psychology; and the possibility of kaupapa Māori psychology training and scope of practice were also investigated in this report. Many confirmed that a broader more relevant kaupapa Māori psychology existed and asserted the need for Māori content in mainstream psychology training, which should include training aimed at increasing cultural awareness and competency of psychology professionals (Levy, 2007; Milne, 2005; Nikora, 1989).

Following the imperative findings highlighted in the Milne (2005) report, and in line with many other health professional disciplines (Medical Council of New Zealand, 2006; Nursing Council of New Zealand, 2002; Occupational Therapy Board of New Zealand,
2010; Social Workers Registration Board, 2005; New Zealand Society of Physiotherapists, 2008) within Aotearoa, the psychology profession moved towards a commitment to working in partnership with Māori under Te Tiriti obligations. The role of psychologists is to function as a discipline to promote the wellbeing of society, acknowledging the “position of power and influence they hold in relation to the individuals, whānau, groups and communities with whom they are involved” (New Zealand Psychological Society, web reference). In addition, the commitment of the psychology profession in relation to principles of Te Tiriti and Māori has been clearly stated in the Code of Ethics for Psychologists Working in New Zealand document (2002) which refers to:

“1.3 Relations between Māori and non-Māori: Psychologists practising in NZ recognise that Te Tiriti sets out the basis of respect between Māori and non-Māori in this country

1.3.1 Psychologists individually and collectively seek to be informed about the meaning and implication of the Te Tiriti for their work. This includes an understanding of the principles of protection, participation and partnership with Māori

1.3.2 Both Māori and non-Māori psychologists who work with Māori seek advice and undertake training in the appropriate way to show respect for the dignity and needs of Māori in their practice”

(New Zealand Psychologists Board, 2002: p. 5).

Furthermore, the NZ Psychologists Board has reinforced the commitment to the indigenous people of Aotearoa with the development of the Cultural Competencies document for psychologists registered under the Health Practitioners Assurance Act (2003) (New Zealand Psychologists Board, 2011). This document reaffirms the cultural competent practices outlined in the Code of Ethics (2002) discussing a commitment to Te Tiriti, and defining cultural competence and cultural safety.

The Path of Māori Mental Health Policy Developments

The past decade has seen the significant development of general health policies prioritising Māori wellbeing and contributing to more specific mental health policy developments and
consequently service progress. Firstly, He Korowai Oranga (‘Cloak of Wellness’): Māori Health Strategy document (Ministry of Health, 2002) emphasised the importance of whānau health and wellbeing as opposed to an individual focus. The introduction of the “whānau ora - Māori families supported to achieve their maximum health and wellbeing” concept emerged (Ministry of Health, 2002, p.1) with a focus on working collaboratively with whānau, iwi, Māori services and communities and to improve health outcomes and reduce disparities with non- Māori and improving Māori mental health outcomes and reducing Māori health inequalities (Ministry of Health, 2002).

Over the decade, whānau ora has emerged as a unifying concept, bringing together Māori aspirations around mental health and broader Māori development goals, specifically seeing mental health as rooted bicultural identity (Mental Health Commission, 2006). The recognition of whānau ora as critical to Māori health care delivery is woven into several key MoH strategies including: He Korowai Oranga (Ministry of Health, 2002); and the second Māori health action plan (Whakataataka Tuarua: Māori Health Action Plan 2006-2011 (Ministry of Health, 2006) setting objectives for the next five years. The journey of recovery or whakaoranga for tāngata whaiora has been has been described as the recovery of tino rangatiratanga or empowerment inclusive of whānau, hapū and iwi (Milne, 2001).

Whakaoranga has also been related to one’s cultural identity, for instance:

“The recovery process is more a journey of rediscovery. Ko wai? Nā whea? Nā wai? (Who are you? Where do you come from? Who are your parents?) Knowing the connection that make them who they are is a foundation of recovery” (Mental Health Commission, 2000: p. 10).

Whakaoranga has become aligned with the whānau ora concept, based upon “thriving relationships based on common values and beliefs” (Mental Health Commission, 2007: p.154). Although uniquely focused on collectiveness as opposed to the individual western perspective of recovery the two philosophies remain closely linked. The similarities include: shared values; a strengths focus; as well as inclusiveness and interdependence (Barnett & Barnes, 2010; Mental Health Commission, 2006; 2011).

The Whakatātaka: Māori Health Action Plan 2002 – 2005 (Ministry of Health, 2002) was the first Māori health action plan which identified a number of pathways to ensure the
implementation of He Korowai Oranga strategy (Ministry of Health, 2002). The plan described an overarching 'pathway ahead' relating to a collaborative relationship between mainstream and kaupapa Māori services along with health professionals working cooperatively. In order to achieve this approach, four pathways have been derived, which include: firstly, the development of whānau, hapū, iwi and Māori communities utilising models of whānau ora and support for kaupapa Māori initiatives; secondly, ensuring and supporting active Māori participation; thirdly, ensuring safe and effective health services for Māori; and finally working and accessing resources from broader health sectors (Ministry of Health, 2002).

The second Māori health action plan was Whakatātaka Tuarua: Māori Health Action Plan 2006-2011 (Ministry of Health, 2006) developed with the intention of building upon the previous action plan. This strategy was also aimed at reducing health inequalities between Māori and non-Māori. For that reason, the Whakatātaka Tuarua plan presented a framework for the MoH and District Health Boards (DHBs) to take a leadership role in improving Māori health outcomes.

Te Tiriti o Waitangi (1840) is the founding document on which much of the recent Māori health and Māori mental health policy reform has been established from. In addition, the huge body of knowledge relating to Māori over-representation in mental health services has also seen the development of policy-led reforms (Mason, Johnston & Crowe, 1996). Following the publication of the recovery focused document The Blueprint (1998) which incorporated an expanded area on the importance of meeting the needs of Māori (Mental Health Commission, 1998), a number of Māori health and specific Māori mental health policies and strategies have been developed with the intention of building upon this original report. These include: Te Puawaitanga and Te Puāwaiwhero. In addition, general mental health policies have been developed along with specific Māori focus sections, these include: Te Tahuhu, Te Kokiri and Tauawhitia te Wero policies (which can be divided into strategy focused and implementation policies).

Te Puawaitanga Māori Mental Health National Strategic Framework (2002) aimed at improving existing mainstream services (2002), from a Māori perspective, so that they are more effective for Māori (Ministry of Health 2002). The strategic Māori mental health development document highlighted five main objectives of future focus, these included: comprehensive clinical and cultural support for tāngata whaiora in most need (top 3%
identified); ensuring active participation of Māori in all levels of planning and service
delivery, with an emphasis on the incorporation of Māori health models; providing treatment
choice, mainstream or kaupapa Māori, for at least 50% of tāngata whaiora; Māori workforce
development; and improving liaison between the different sectors (such as primary health;
menthal health; education; community) involved in supporting tāngata whaiora (Ministry of
Health, 2002).

The objectives of He Korowai Oranga; whānau ora; and Te Tāhuhu were developed
further in Te Puāwaiwhero: The Second Māori Mental Health and Addiction National
Strategic Framework 2008-2015 (Ministry of Health, 2006). The focus of Te Puāwaiwhero
was on prioritising actions from Te Kōkiri to address Māori mental health needs based upon
the recent findings from Te Rau Hinengaro report (Ministry of Health, 2006).

The progress of mental health policy development was reviewed by the MHC who
initiated a process to review the Blueprint document (1998) through a discussion paper
entitled: Applying the Blueprint (Mental Health Commission, 2004c). This then led onto
further policy development and review with Te Tahuhu: Improving Mental Health and
addiction plans 2005-15 (Ministry of Health, 2005) the strategic direction and government
priorities for investment in mental health and addiction. This policy broadens the focus of
the existing mental health strategy to include prevention, promotion and primary care and
highlights the importance of recovery, where a secure, sustainable and effective mental
health system is developed. In addition, the importance of enabling people to lead their own
recovery, high quality service delivery provided in the least restrictive environment;
encompassing a holistic approach; responsive to all cultures and age groups; and being
delivered in recognition of whānau ora are also aspects emphasised (Ministry of Health,
2005).

on implementing Te Tahuhu. It concentrates on providing earlier access to mental health
and addiction services and calls for stronger links between primary and specialist health
services. Te Kokiri identifies specific measures to improve mental health and prevent
addiction, as well as identifying key stakeholders and organisations to meet these challenges
and timeframes for achieving progress between 2006 and 2015 (Ministry of Health, 2006).

Following the broader mental health service delivery policies were policies focused
on more specific issues. Tauawhitia te Wero: Embracing the challenge: National mental
health and addiction workforce development plan 2006-2009 (Ministry of Health, 2005) focused on mental health and addiction workforce development. The emphasis of this plan is on a systemic approach focused upon five key strategy areas, including: specialist workforce development; organisational development improving existing services; addressing staff recruitment and retention issues; professional development through additional training and education; and ongoing research and evaluation of services (Ministry of Health, 2005).

In summary, general health policies have emphasised the importance of whānau ora in reducing health inequalities for Māori. Service access to health services for Māori has also been a feature, with the goal of multiple service access pathways being offered involving collaborative working relationships between mainstream and kaupapa Māori services. In addition, specific mental health policy developments have emphasised the importance of improving the effectiveness of mainstream services to address Māori needs; and prioritising the development of mental health decline and specialist addiction services and workforce. To this date, the effective implementation of such policy developments remains an area of review.

MENTAL HEALTH SERVICES

The influence of deinstitutionalisation and closure of psychiatric institutions has seen the new era of services delivered in the community, which has been well underway for almost two decades now. This transformation has seen the development of community mental health services and other forms of community support, such as community housing, supported by inpatient services to cater for service users (Wilson, 2000). This section will discuss inpatient mental health services in Aotearoa including service evaluations; innovative service improvements; and alternative inpatient care.

Te Haerenga mo te Whakaoranga 1996 – 2006: The Journey of Recovery for the New Zealand Mental Health Sector (Mental Health Commission, 2007) described the voyage of mental health services in Aotearoa, incorporating the narratives of tāngata whaiora. The focus of this reflective report was during the 10 year period from the Looking Forward: National Mental Health Strategy (1994) through to the launch of Te Tāhuhu – Improving Mental Health 2005-15: The Second Mental Health and Addiction Plan (Ministry of Health, 2006). Significant achievements in the mental health sector over the past decade were
highlighted, including: services progressively more responsive to service user needs; improved service quality overall; progress towards achieving recovery (Clayton & Tse, 2003) and whānau ora; and reduced stigma and discrimination through community education initiatives (such as through social media advertising). Despite the positive feedback, attention was also drawn to the ongoing challenges associated with inequalities, specifically poverty and racism that contribute to mental health difficulties (Mental Health Commission, 2007). The need for a holistic approach shift beyond the biomedical approach (Read et al., 2004); whānau inclusion, and ongoing improvements for genuine recovery focused services were highlighted as areas in need of service delivery improvements (Barnett & Barnes, 2010).

**Inpatient Services**

While mental health services are now largely delivered in community settings, there remains a need to effectively treat some service users, with acute care needs, in a highly specialised environment (Ministry of Health, 2002). Every year thousands of tāngata whaiora become extremely distressed and are admitted to inpatient mental health services, from all communities, age groups and ethnic backgrounds (Ministry of Health, 2006). The period or state of extreme psychological distress has been described as ‘temporary states’ that overwhelm the person to the point where they cannot function with their usual personal resources or natural supports, and need external or expert assistance (Hoff, 2001).

Inpatient mental health services are for people with severe and acute symptoms who need 24 hour care in a safe environment. With the introduction of recovery focused policies, services have been directed to improve the therapeutic environment, however within Aotearoa inpatient services are typically 15 to 60 bed wards on general hospital sites, with communal dining rooms, seclusion rooms and secure areas for people in intensive care units (ICU). The main interventions reportedly are medication and containment, with many people there under the MHA and on medication, sometimes against their will (Mental Health Commission, 2006).

**Service Evaluations**

A review of current literature revealed very few Aotearoa based evaluations of inpatient services other than studies conducted by the Mental Health Commission (MHC); and through standard DHB audits. In 2001, the MHC explored service user views of inpatient services in
Aotearoa through service user forums in twenty DHB’s. There were some positive comments on the improving attitudes of staff and on new or renovated buildings, but most were negative. It was common for service users to experience a restrictive institutional experience, overcrowding, physical, verbal, or sexual violence, or the fear of it, traumatic experiences in seclusion, lack of empathetic attention from staff, over-reliance on medication, lack of psychological assistance, and boredom (Mental Health Commission, 2001).

In a later study conducted by the MHC (2005) investigating service user views of mental health service quality in general, almost all respondents reported that services had improved from 10 years ago, especially in regards to staff attitudes. However in this study the strongest levels of dissatisfaction were focused on inpatient services. Many issues were raised about the standard of care provided, poor continuity of care; poor quality treatment; being treated badly; being overly medicated; not being able to access newer medications; and a failure to treat service users with dignity and respect. In addition, language barriers; a lack of information; and being discharged too soon or not quickly enough were identified as negative areas of inpatient service delivery (Mental Health Commission, 2005).

The MHC (2006) was very critical of inpatient mental health services in a discussion paper reporting Aotearoa inpatient services often fail to respond well to people in inpatient crises with "many of these services are themselves in a state of crisis" (Ministry of Health, 2006). It was reported that service users who are extremely distressed are often turned away by crisis and inpatient mental health services, and service users admitted to hospital-based inpatient services often find them frightening, impersonal and untherapeutic. The discussion paper suggested inpatient services need to be accessible, acceptable and effective in order to promote healing. The development of alternative crisis care was welcomed, aimed at providing recovery-focused inpatient services in peoples own homes or in a community setting (as opposed to hospital based locations) (Agar-Jacomb & Read, 2009; Mental Health Commission, 2006). There is a strong need for inpatient services to be formally evaluated and service user outcomes measured to reveal whether services are responsive to service user and specifically tāngata whaiora needs. More vigorous inquiry is required into the service factors inhibiting recovery and areas making a positive difference in people’s lives.
Innovative Service Improvements

Following the inclusion of the recovery approach in mental health services a number of key areas focused on improving services have emerged including: service user involvement in service delivery; service evaluations; and mental health policy developments. The main areas focused on the improvement of inpatient services specifically included: improving the therapeutic environment of inpatient services; peer support development; and strategies focused on reducing restrictive care practices (such as seclusion and restraint).

Creating a therapeutic environment with central principles of wellness and recovery has been the focus of many inpatient services in Aotearoa (Te Pou o te Whakaaro Nui, 2009; 2011). Although few studies have presented these results, some research has contributed the changing face of inpatient service therapeutic environments through increased awareness of cultural, familial, spiritual and social aspects of recovery. For instance, embracing a more holistic approach of practice (Durie, 1994). Te Whare Ahuru inpatient service (Northland DHB) has reportedly developed strategies to enhance the inpatient environment. Some of the key strategies implemented have included: a treatment focus shift towards a recovery-based, non-discriminatory and holistic approach; staff cultural safety and psychodynamic training with a reflective practice approach; a smokefree environment; flexible therapeutic program to address boredom issues; increased staff levels to improve quality of care; the creation of low stimulus areas (such as relaxation rooms); and debriefing following critical incidents (such as assaults, restraint, seclusion) (Te Pou o te Whakaaro Nui, 2009).

The growing body of knowledge focused on mental health treatment interventions supporting recovery has also resulted in a number of innovative inpatient service delivery improvements. One such support based initiative is peer support, referred to as:

“…more than a change of mental health personnel. It is a rich philosophy of practice…which brings the abstract concept of ‘recovery’ to life” (Scott, Doughty & Kahi, 2011: p. 128).

Peer support specialists’, similar to mentors, role model recovery practices by sharing personal stories, personal tools and skills supporting recovery, hence displaying that Recovery is achievable (Davidson et al., 2006). The establishment of peer support within
Aotearoa is well under way, with every DHB nationwide currently offering some form of peer support (Scott et al., 2011).

*Te Mana* mental health service is a tāngata whaiora-led kauapa Māori service that provides peer support for community and inpatient tāngata whaiora living within the *Lakes DHB* catchment area. Informal feedback has been positive indicating that tāngata whaiora using the peer support service feel very supported to set and achieve personal whakaoranga goals (Te Pou o te Whakaaro Nui, 2009). There have however been some challenges for practitioners with peer support training being made accessible and affordable for services. Attempts to address the problems of risk; boundaries; integration; and information gathering within a peer support values base may stimulate innovative ways of working in the mental health sector as a whole (Scott et al., 2011). Although initial findings are promising, further exploration into this innovative support service is required to reveal its full potential.

In addition to improvements being made in the therapeutic environment, strategies supporting the reduction of restrictive care practices have also been a focus of inpatient services. Alternative strategies to minimise the use of restraint and seclusion have been developed by providing a low stimulus environment and a staff emphasis on development and training (such as de-escalation, non-violent crisis intervention) with seclusion and restraint used as a last resort and only for brief periods.

“The reduction of seclusion is really quite a simple concept about what good practice is, what is good treatment and what is about being able to provide a good therapeutic environment for people. Obviously we need to make sure people are safe when they need to be safe, but seclusion is predominantly, in my opinion, an archaic, one-dimensional practice. As health professionals in 2009, we should be able to be a bit more creative about how we deal with challenging people and challenging behaviours” Steve Allsop, Clinical Nurse Manager, *Hutt Valley DHB* (cited in Te Pou o te Whakaaro Nui website).

Although formal evaluation is yet to be completed, feedback from *Te Whare Ahuru* inpatient service (*Northland DHB*) suggests that seclusion reduction has been beneficial in improving the culture of service delivery. The rate of use of both seclusion and restraint has reduced significantly from 2710 seclusion hours and 101 restraints in 2006, to 1071 seclusion
hours and 40 restraints in 2008, and in 2009 to 232 hours of seclusion and six recorded restraints (Te Pou o te Whakaaro Nui, 2009).

One approach to reducing the use of seclusion and restraint at Te Whare Ahuru (Northland DHB) has been with the development of a sensory modulation room. Based upon international literature (Champagne, 2003) and a first in Aotearoa, the goal of the sensory room is to provide practical means to reduce distress among service users.

"The impact that inpatient psychiatry has on service users in their journey towards recovery cannot be overstated. It is therefore vitally important to use positive interventions which give our service users an opportunity to learn and experience alternative ways to help themselves in a caring supportive environment" Nancy King, Clinical Nurse Manager, Northland Acute Inpatient DHB (Te Pou o te Whakaaro Nui, 2009).

The function of sensory modulation rooms is to support service users to relax, self-regulate and self-soothe with the overall outcome of tolerating and coping with distress, and regaining self-control (Champagne, 2003). Te Ahuru inpatient service sensory modulation room contained:

“A recliner rocker, a massage chair, weighted blankets, ambient lighting, neutral heating, aromatherapy, stress balls and soft toys, music and relaxation CD’s, a range of hand creams and a foot spa” (Te Pou o te Whakaaro Nui, 2009).

Utilising the room involves service users having an individual safety plan identifying early warning signs and triggers of distress; as well as a personalised sensory plan detailing how they choose to make the most of the room; and a risk assessment (assessing “the likelihood of an event happening with potentially harmful or beneficial outcomes for self or others” (Morgan, 2000)). The room is used collaboratively with staff supporting the process as required. Positive results to this therapeutic intervention have been reported, with the use of seclusion and restraint from 2006 to 2008 reduced by 50 per cent (Te Pou o te Whakaaro Nui, 2009). Highlighted as essential to ensuring a positive outcome of innovative strategies
such as the sensory modulation rooms include: education, crucial to developing staff confidence; as well as strong leadership and staff support (Te Pou o te Whakaaro Nui, 2010).

**Alternative Inpatient Care**

A number of alternative care services have been devised and implemented as a result of numerous negative reports of inpatient service delivery; and the demand for mental health services that support service user recovery. Researchers have found that community based alternatives are just as effective, or even more helpful, than inpatient admissions (Fenton & Mosher, 2000). Such alternative care services include: *Residential Crisis Services (RCS)*; and *Inpatient (Acute) Home Based Services (AHBS)*.

*RCS* are alternative crisis services developed to support service users when distressed. The concept of this service is that extremely distressed service users are supported in a homelike environment, in an ordinary house in the community (Mosher et al., 1975) in a less restrictive and more normative environment, compared to inpatient services, and, as a result have the potential to be less disruptive, isolating and stigmatising for service users (Stroul, 1988).

The efficacy of residential crisis services has been reported in a number of studies. The first, *Soteria House*, was established by Mosher and colleagues (Mosher et al., 1975; Mosher & Menn, 1978) in the 70’s has been shown to have similar outcomes to inpatient services for symptom reduction and readmission rates; and improved outcomes in terms of quality of life measures (occupational levels and ability to live independently).

Likewise, Keisler (1982) reviewed 10 studies in which service users in distress were randomly assigned to either inpatient care or some form of alternative crisis care in the community. He found that the outcomes were the same for inpatient and alternative treatment and that community care was more effective regarding the probability of future employment; maintenance of long term relationships; independent living arrangements; and staying in school; as well as being a lot less expensive (Keisler, 1982).

A recent adaptation of the original Soteria model was *McAuliffe House*. Symptom reduction and service user satisfaction again was the same as for those treated in inpatient services. Service users that resided at *McAuliffe* reported significantly better contact with community supports (including community keyworkers); had more visits home; and were more likely to start a day program before discharge (Fenton & Mosher, 2000).
Given the evidence supporting community based crisis care internationally, Agar-Jacomb and Read (2009) explored the crisis needs of service users in Aotearoa, and the level of support for an alternative to an inpatient admission. Service users and tāngata whaiora recently discharged from an inpatient service were participants of the study and were asked what they needed; what they found helpful and unhelpful about inpatient admissions; and what alternatives they recommend for crisis support. Thematic analysis revealed five main themes relating to service user needs, what they found helpful and unhelpful, these included: “being there”, “being with”, “how treated”, “staff/systems”, “holistic approach”, and “medication”. And ninety-three percent of service users and mental health service providers supported the idea of residential crisis services in Aotearoa (Agar-Jacomb & Read, 2009).

Similarly, Gilburt and colleagues (2010) explored service user experiences of inpatient services and residential alternatives to inpatient services. Participants reported an overall preference for residential alternative care. Positive therapeutic environments were identified as: being safer; having more freedom and decreased coercion; and having more caring staff compared with traditional in-patient services. Despite these reports, service users identified no significant difference between their relationships with staff overall and the care provided between the two types of services. Therefore, for service users who have significant mental health difficulties but lower levels of disturbance, residential alternatives offer a preferable environment to inpatient services as they reduce coercion and increase freedom, safety and opportunities for peer support (Gilburt et al., 2010).

A number of studies have evaluated the effectiveness of alternative care services internationally however the efficacy of such services within Aotearoa requires further investigation. In addition to the residential crisis services discussed above, are Inpatient (Acute) Home-Based Services (AHBS) a recovery oriented service that provides a short-term alternative to inpatient treatment by using mobile teams to ensure speedy response and practical support to service users in their own home, or respite environment (Te Pou o te Whakaaro Nui, 2011).

“The idea was we offer another choice to them (service users) so they don't just have hospitalisation as the only option for overcoming a mental health problem…the AHBS is a really excellent alternative to hospitalisation... it offers a client and their family members intensive support service in order to keep them out of hospital and...
support them on the road to recovery” Pam Jezard-Clarke, Clinical Coordinator, AHBS (Te Pou o te Whakaaro Nui, 2011: website reference).

The AHBS provide a broad range of therapeutic supports incorporating both clinical and practical activities which includes: solution focused therapy and other psychotherapeutic interventions incorporates: dialectical behaviour therapy (DBT); and cognitive behaviour therapy (CBT); supportive counseling and mental health education; regular medical reviews; skill development (such as anxiety management); and practical support (including financial assistance and other community services) (Te Pou o te Whakaaro Nui, 2011).

Although no formal evaluations have been conducted into the effectiveness of AHBS, preliminary findings have indicated improved clinical outcomes for service users; less frequent use of inpatient services; and reduced rates of readmission and length of stay (Te Pou o te Whakaaro Nui, 2011). Preliminary qualitative service user feedback has reported the staff approach positively, with specific staff characteristics related to being: non-judgmental; practical; open-minded; listening; and offering good advice (Te Pou o te Whakaaro Nui, 2011). Current research suggests that alternative care services present many positive aspects in supporting recovery for service users when distressed and appear to be a well supported care option.

In summary, significant developments in health policy have occurred, directed by the relationship of Te Tiriti o Waitangi, and the guiding principles of participation; partnership; and protection. Māori health policy developments, however face the ongoing challenge of implementation, with such difficulties reflected through the negative experiences expressed within inpatient service evaluations. Despite this, the implementation of innovative service improvements, including alternative inpatient care services, is promising. In order for policy developments to be fully implemented within mental health services, the need remains for genuine ongoing commitment from those that make funding decisions, so that such initiatives can be well resourced and put into practice.

MĀORI MENTAL HEALTH CHALLENGES AND DEVELOPMENTS

This section focuses on the developments and challenges of Māori mental health progress in Aotearoa. The main areas covered include the challenges associated with restrictive care
practices for Māori such as involuntary admission, force, racism and misdiagnosis; kaupapa Māori mental health developments including cultural competence and cultural safety; and protective factors that may aid in improving Māori wellbeing.

**Restrictive Care Practices**

In addition to the restrictive care practices that Māori face in general health services (discussed earlier in the Inequalities and Disadvantages section of this literature review) an extension of such issues are also present within mental health services. Many studies have shown that Māori receive poorer care and more restrictive care practices than non-Māori, with mental health services perceived as punitive rather than assisting in recovery (Durie, 1994; Gaines et al., 2003; Krawitz & Watson, 1997; Simpon et al., 2003; Te Puni Kokiri, 1994; 1998). Specific restrictive care practices experienced by Māori have included: involuntary admissions (Dein & Lipsedge, 1998; Lloyd & Moodley, 1992); high levels of seclusion and restraint (El Badri & Mellsop, 2002; Tapsell & Mellsop, 2007), racism (Johnstone & Read, 2000); and misdiagnosis (Tapsell & Mellsop; 2007) which has been associated with an increased use of certain types of medication at higher doses (Humberstone, Wheeler & Lambert, 2003). Māori are given higher doses of anti-psychotic medication and are more likely to be given two or more medications at the same time (Wheeler et al., 2008). Furthermore, Māori are more likely to be injected rather than prescribed oral medication (Wheeler et al., 2008) as reported amongst African – Americans (Arnold et al., 2004).

The high number of Māori involuntary admissions to inpatient services involving compulsory treatment, associated with elevated levels of coercion and force compared with voluntary admissions (Kjellin et al., 2006) is of concern. The numbers of involuntary admissions for Māori, through the use of compulsory treatment orders, under the Mental Health (Compulsory Assessment and Treatment) Act 1992 of Aotearoa, to inpatient services are high. This example of discrimination against an indigenous ethnic minority group is consistent with studies internationally in Australia, Belgium, the UK and the USA (Read, 2004b). For instance, in the UK ethnic minority men from Black Caribbean, Black African and other Black groups were more likely than other groups to be detained under the MHA 1983 (Care Quality Commission, 2009).
The impact of force and coercion for tāngata whaiora can be further understood through a qualitative study conducted in the Otago region investigated Māori and whānau experiences of community treatment orders (Sections 27 - 30) (Gibbs et al., 2004). Findings highlighted negative experiences which included: “the sense of external control imposed on both ‘tāngata whaiora’ and staff, particularly concerning medication and restrictions on choices” (Gibbs et al., 2004: p. 1). Once discharged from the order tāngata whaiora reported a “greater sense of control and independence” (Gibbs et al., 2004: p. 834). Despite these reports some positive factors were associated with community treatment orders related to tāngata whaiora safety and whānau security through shared responsibility with services (Gibbs et al., 2004).

An additional process involving force for indigenous service users and other minority groups, such as tāngata whaiora, is that of seclusion. Excessive use of seclusion and restraint involving tāngata whaiora has been reported (Carpenter et al., 1988; Donovan et al., 2003; Spector, 2001) with 20% of tāngata whaiora admitted to inpatient services experiencing at least one period of seclusion during an admission compared to only 11% of Pākehā service users (El Badri & Mellsop, 2002). Furthermore, the use of seclusion was seen by tāngata whaiora and clinicians as having a primary function of safety, however conversely was associated with negative emotional consequences, with tāngata whaiora reportedly experiencing fear, anxiety and terror, and feeling punished, lonely and powerless (El Badri & Mellsop, 2002).

Internationally, research also indicates higher rates of seclusion for indigenous peoples in comparison to their European counterparts. An Australian based study found Aboriginal and Torres Strait indigenous service users between the ages of 25 - 34 were more likely to experience seclusion than non-indigenous people of the same age (Happel & Koehn, 2010). This disparity in seclusion rates is consistent with other research in the UK (Bennnewith et al., 2010) including research findings from the UK and USA indicating that service users involved in a violent episode were more likely to be secluded if they were Black (Spector, 2001).
Similar to reports of racism in general health settings, there have been reports of racist attitudes of clinicians towards Māori in mental health services. One study (Johnstone & Read, 2000) investigated psychiatrists’ recommendations for improving bicultural training and Māori mental health services. Twenty-eight (11.3%), all male, born in Aotearoa (with at least ten years of clinical experience) believed that Māori were biologically or genetically more predisposed than others to mental illness. Several respondents offered other racist comments. These findings are of significant concern especially given that within the western biomedical framework that dominates mental health services, psychiatrists often have the primary clinical responsibility for the care of tāngata whaiora.

In comparison, international studies involving indigenous and minority groups found some mental health staff in inpatient services display racist attitudes (Fernando, 2003). For instance, in the UK, inpatient staff reportedly perceived African Caribbean people as more likely to be aggressive and dangerous than European groups even though there was no evidence supporting this perception (Nazroo & King, 2002). Furthermore, inpatient services in the USA and the UK found that there was a general overestimation of potential violence for Black service users when compared with service users of European descent. The author noted that there was a higher tolerance level for ‘difficult’ behaviour with European service users and concluded that the results may reflect a possible ‘stereotyping effect’ towards Black service users (Spector, 2001).

Another study used data from 22 hospitals in the UK and found that Black service users were more likely to self-report coercive behaviour at admission than were European people. In fact, European service users reported the lowest proportions of self-report coercive behaviour at admission (Bennewith et al., 2010).

Research highlighting the high proportion of Māori over-diagnosed with psychosis related difficulties (El Badri & Mellsop, 2002; Tapsell & Mellsop, 2007) has resulted in a growing body of literature focused on explaining these prevalence rates. Māori clinical psychologist and health researcher Cherrington (1994) investigated the relationship between culture and symptoms related to a diagnosis of schizophrenia. Interviews involving comparisons from 14 Māori and 16 Pākehā found that Māori experienced higher levels of ‘hallucinations and delusions’ than Pākehā. The study identified Māori cultural knowledge as an influence in the content and frequency of delusions (Cherrington, 1994).
Further to the findings of Cherrington (1994), Māori health clinician and researcher Taitimu (2008) investigated the unique way in which Māori made sense of experiences often diagnosed as positive symptoms of schizophrenia (such as hallucinations and delusions). Within a kaupapa Māori framework this qualitative study interviewed 57 participants including: tāngata whaiora; tohunga; kaumātua and kuia; Pākehā clinicians; Māori clinicians; cultural support workers; and students. The results identified four thematic categories, which included: ‘making sense of experiences’, with participants often referring to a wairua or spiritual connection (such as mate Māori and matakite); ‘pathways of healing’ including mainstream and Māori cultural pathways; ‘making sense of the statistics’, with most participants referring to historical and contemporary oppression relating to the impacts of colonization, urbanization, racism and misdiagnosis; and ‘what can we do about the statistics’, with responses divided into three categories. This category identified primary (such as education regarding cultural explanations of such experiences); secondary (such as early intervention); and tertiary (such as education relating to the mental health system regarding medication, the MHA and diagnosis) levels. Sound arguments were presented into the implications of applying western phenomena to indigenous populations who have their own paradigms of health and interpretations for such experiences (Tapsell & Mellsop, 2007). Furthermore, the need for culturally appropriate assessments and treatments were recommended (Tapsell & Mellsop, 2007) to overcome restrictive care practices (or barriers to effective treatment) such as misdiagnosis (Taitimu, 2008).

International researchers have suggested that racism, discrimination and prejudice towards indigenous and minority groups can contribute to the over diagnosis of psychosis related diagnoses such as schizophrenia. This has been reported with African Caribbean people (Nazroo & King, 2002; Thomas et al., 1993) and indigenous people in the USA (Bresanhan et al., 2007; US Department of Health & Human Service, 2001), Aotearoa, Australia, Belgium, Denmark, Germany, Greenland, Israel, the Netherlands, Sweden, and the UK (Fernando, 2003; Read, 2004b).

Conversely, in a study conducted by Thomas and colleagues (2010) investigating general practitioners’ (GPs’) views about diagnosis and treatment of depression among Māori, tāngata whaiora were less likely to be diagnosed with depression compared to non-Māori. Qualitative feedback identified a number of potential reasons for the ethnic differences in diagnosis, which included: stigma related to Māori negative perceptions of
depression (such as the reluctance of tāngata whaiora to discuss symptoms and emotions associated with depression); and the lack of a positive therapeutic relationship between tāngata whaiora and clinicians (Goldsbury, 2004) resulted in communication barriers such as an unwillingness to ‘open up’. Similarly, it was found that GPs who are able to establish effective communication with patients, gain their trust and take account of the reluctance of some tāngata whaiora to talk about personal feelings, are more likely to diagnose and treat depression effectively (Thomas et al., 2010).

Further to the discussion of restrictive care practice of misdiagnosis, indepth investigation into the experience of ‘being given a diagnosis’ was investigated by Moeke-Maxwell and colleagues (2008). Tāngata whaiora perceptions of the function of diagnoses supporting recovery were explored involving a total of 70 tāngata whaiora participants in seven focus groups. Findings revealed that for many, given a mental health diagnosis was a significant event.

“While for clinicians diagnosing someone might be a discrete event and easily forgotten as a moment in a busy schedule, most people in this study remembered the occasion and aftermath very clearly” (Moeke-Maxwell et al., 2008: p. 5).

The findings of this study identified the actual process of being given the diagnosis as the most significant factor relating to recovery. For instance, the process of being diagnosed and the consequence of being ‘labelled’ with a mental illness were of great significance in the person’s life. Positive experiences were related to diagnostic assessment providing relief and hope such as when difficulties were validated and experiences normalised. Negative diagnostic experiences were related to feelings of confusion, disappointment and disillusionment. For instance, this occurred when a diagnosis did not lead to a cure, and, when service users have mixed feelings about medication. The impact of receiving multiple diagnoses and the transient mental health workforce were also unhelpful. Additional factors impacting on recovery following diagnosis were the level of support, the level of information provided, the use of medical jargon, and the ethnicity of the clinician. Overall, participants recommended that in order to achieve recovery with the support of diagnostic tools, it is essential to focus on how they are implemented, the meaning it gives to tāngata whaiora in
understanding their difficulties, and the variety of supports available as a result (not just medication) (Moeke-Maxwell et al., 2008).

In a similar study involving the diagnostic experience of Māori and non-Māori whānau and other support people that play a central part supporting tāngata whaiora, Laird and colleagues (2010) identified a number of key themes. The single most significant factor impacting on the experience was how the diagnosis was communicated and implemented in care planning. From a Māori perspective, the inclusion of Māori cultural concepts was seen to be important, and overall whānau in general had positive views of the contributions of diagnosis to tāngata whaiora care (Laird et al., 2010).

Kumar and colleagues (2008) investigated the pattern and extent of restrictive care practices at a Rotorua inpatient service. Quantitative methodology was used to analyse demographic and diagnostic characteristics, which found reportedly limited evidence of widespread restrictive care practices against Māori with diagnosis; seclusion rates; involuntary status on admission and readmission rates similar to non-Māori. However this study did find: Māori were more likely to be prescribed antipsychotic medication consistent with previous findings (Humberstone, Wheeler & Lambert, 2003) and at higher doses than non-Māori; were less likely to be referred to psychotherapy services; and had shorter lengths of stay which does suggest some restrictive care practices. The limitations of the study's quantitative design provide little insight into what contributed to the reportedly limited restrictive care practices. However, one may hypothesise this outcome to be related to the kaupapa Māori service supports available, incorporating a bi-cultural holistic approach into care (such as the use of mihimihi, karakia) with access to tohunga; staff with te reo and cultural staff ensuring tikanga Māori and cultural rights for tāngata whaiora were respected. The increased number of Māori clinical staff, and the other staff experience of working with Māori, given the high Māori population in the Rotorua area (35%) may also have contributed to the findings of this study (Kumar et al., 2008). Further investigation is required into the factors the contributed to the reduction in restrictive care practices of some factors and not others.

**Kaupapa Māori Mental Health Services**

The process of colonisation and its impact on Māori society saw the rapid shift in Māori health from traditional views to western practices (Durie, 1985). The popular western
mainstream perspective of health is not holistic and disregards certain dimensions that are essential to overall Māori health (Abbott & Durie, 1987). Unlike the socially based Māori approach emphasising spiritual and whānau components of living, health consequently became the responsibility of the individual rather than a community concern following colonising processes (Durie, 1984; Street & Walsh, 1996). Kaupapa Māori services were also developed, in part, to support whakaoranga and whānau ora for the high numbers of Māori diagnosed with mental health difficulties as a result of the limitations of the western paradigm in incorporating Māori health values and models. Therefore, the

“…dominant medical model of treatment prevented a holistic approach…the medical model (and has) still predominated in tāngata whaiora care, alienating Māori workers and whaiora” (Gibbs et al., 2004: p. 833).

Consequently, the past two decades have seen a complete rotation with many mental health services incorporating Māori models and frameworks (Durie, 2011).

Mental health services in Aotearoa have been significantly transformed by Māori cultural values and understandings of health. Since 1980 the inclusion of te reo Māori (Māori language); Māori health perspectives; and Māori psychological frameworks in the assessment and treatment of tāngata whaiora care have contributed to the changing face of mental health services (Durie, 1994). The development of kaupapa Māori services; an expanded Māori health workforce; and Māori leadership have been crucial in this process (Durie, 2011). The key elements highlighted for the effective delivery of kaupapa Māori mental health services include: services governed by tikanga Māori practices; implementation of hauora practices; offer a holistic approach; and have a commitment to whānau ora (Boulton, 2005).

Furthermore, the developments of the whānau ora philosophy have been implemented to guide service delivery practices. In relation to mental health settings five concepts have been highlighted based upon principles of Te Tiriti o Waitangi. The concepts guiding service delivery include: tino rangātiratanga (self-determination); turangawaewae (home, place of standing, restoration of mana); ngakau mahaki (empathy); tikanga (right behaviour, safe and ethical practice); and whānaungatanga (respectful, harmonious relationships) (Mental Health Commission, 2007: p. 154). Included in this model of service
delivery are whānau ora principles of collectiveness, inclusiveness and interdependence (Barnett & Barnes, 2010).

Durie (2000) recommended that the lead role in strengthening Māori society or enhancing Māori culture and knowledge should be assumed by Māori. One example of such as service in operation is Te Kakano. This kaupapa Māori service provides a culturally responsive service delivered by kaupapa Māori kaimahi (workers). The involvement of Māori amongst therapy staff and management is a step towards ensuring that Māori values and perspectives are represented within the service. In addition, autonomy to adapt treatment approaches to respond to the needs of tāngata whaiora is of importance. This is a progressive shift towards tino rangātiratanga whereby adequate control of resources for Māori and self-determination in the area of service development and delivery is enhanced (Durie, 2000).

The history of kaupapa Māori mental health services within the ADHB catchment area, portrays the developments of such services nationally. The initial ADHB kaupapa Māori service, Whare Paia, was established in the early 1990s, operating parallel to western mental health services (Durie, 1994). As expected with any new service, major challenges were experienced, specifically in relation to the differing notions of implementing bicultural practice without compromising tikanga Māori when working in liaison with mainstream services. For instance, the act of balancing tikanga Māori and clinical care was a major difficulty. As a result the service was transformed into Manawannui, a Kaupapa Māori inpatient residential service. Despite a major reorganisation, Manawannui was closed in 2003 as a result of funding issues and questions regarding the efficacy of the service despite no formal evaluations of the service being conducted. The next phase of kaupapa Māori service delivery within the ADHB area involved the shift in focus from acute care to community focused care Kapua Awatea (a place of new dawning) currently provides support within the community. Interventions of this service include: kaupapa Māori therapies and aromatawai (assessments); and community support and kanohi kitea (literal translation ‘the seen face’; face to face) interaction. A second service is also in operation, Maioha Tupuranga (welcoming of new growth) which consists of a multi-disciplinary clinical team which provides clinical support including intensive individualised package of care for tāngata whaiora with acute care needs (Auckland District Health Board, 2010).
The most recent reports from the MoH (2010) regarding mental health service access rates indicated that kaupapa Māori services (including alcohol and drug kaupapa Māori services) were accessed by 15 percent of all tāngata whaiora between 2007 and 2008. Referrals to kaupapa Māori services were more commonly made via GP; self or whānau referral; justice services; and inpatient services. Specific kaupapa Māori services within inpatient services were accessed on 526 occasions with gender access split almost evenly between 261 male and 265 female tāngata whaiora (Ministry of Health, 2010).

Despite the gains in services offering kaupapa Māori supports and therapeutic interventions, little formal research investigating the effectiveness of kaupapa Māori service delivery has been reported. There has however been some criticism of the position of kaupapa Māori support services based within mainstream services such as DHB’s. The focus of critique has described such kaupapa Māori services as “mainstream, western-based services, albeit with a Māori veneer” (Milne, 2005: p. 16). The limitations and effectiveness of stand alone kaupapa services and mainstream located kaupapa Māori services remains an area investigation. In addition, despite the many policies and guidelines which identify the importance of health services meeting the needs of Māori (Ministry of Health, 1998; 2002; 2005) little research has provided information into what tāngata whaiora identify their needs to be to improve service delivery. There appears to be a gap in research informing the efficacy of kaupapa Māori services and tāngata whaiora and whānau needs.

Research focused on service user journeys of recovery has provided valuable insight into the aspects of service delivery that support recovery. Lapsley, Nikora and Black (2002) conducted a study that explored the recovery process of service users, with specific influences of whakaoranga for tāngata whaiora relating to whānau care; understanding a Māori framework of mental health; Māori healing; cultural aspects within general mental health services (such as karakia, waiata) (Ihimaera, 2004); and kaupapa Māori mental health services. In addition, some tāngata whaiora found an appropriate cultural setting beneficial, and some were helped by just seeing a Māori face (Dyall et al., 1999). The dimension of spirituality was also found significant in relation to both illness and whakaoranga (Ihimaera, 2004) along with strengthening their Māori identity (Durie, 1998).

Services that support the journey of whakaoranga for Māori resulting in improved outcomes have been investigated. Dyall and colleagues (1999) identified a common expectation from tāngata whaiora to receive services in a Māori environment from Māori
people, in their study of Māori expectations of inpatient mental health services. This included: the importance of having control over their lives to support “tino rangātiratanga” for Māori at both an individual and a collective level; the need for kaupapa Māori services within inpatient settings; for ‘Māori faces for Māori cases at Māori places’, more specifically, access to Māori kaimahi and kaupapa Māori services for tāngata whaiora. With this development it was seen that kaumātua and kuia would be involved; tāngata whaiora and whānau members would be less isolated from the Māori community; and there would be greater respect to Māori as a Te Tiriti o Waitangi partner. In addition the study concluded that the lack of Māori content (such as Māori health frameworks; kaupapa Māori services; and Māori workforce) in tāngata whaiora care would result in mental health services unable to achieve positive outcomes for Māori wellbeing (Milne, 2005). Māori participation in all aspects of mental health such as planning; delivering; and monitoring was also highlighted. This was related to the need for Māori to be actively involved in defining and prioritising their health needs, recognising that overtime this will aid in reducing the high admission and readmission rates of tāngata whaiora into inpatient mental health services (Dyall et al., 1999).

The development and expansion of a Māori mental health workforce has been the focus of Te Rau Matatini (established 2001). The overarching service focus is to address Māori mental health disparities. The key features of this organisation are to: implement Māori mental health workforce development policies to enhance whānau ora, Māori health and wellbeing; conduct research; and promote careers in health, resources and educational training and opportunities (such as scholarships) for potential Māori mental health professionals. Recent service developments have included: te Umanga Whakaora; the accelerated Māori occupational therapy development strategy; te Whakauruora, restoration of health, specifically Māori suicide prevention resource; rangatahi bilingual mental health self help care website; inaugural tāngata whaiora led training fair; and dual cultural and clinical competency developments (Te Rau Matatini, 2009).

**Cultural Assessment**

The importance of cultural assessment in facilitating the identification of the cultural needs of tāngata whaiora, and guiding therapy and supports has been documented (Mental Health Commission, 2004; Milne, 2005) and responsiveness to Māori is now widely accepted as a key element of mainstream mental health service delivery and (BPAC New Zealand, 2008).
The practice of cultural assessment has been defined as “the process through which the relevance of culture to mental health is ascertained” (Durie et al., 1995) (cited in Mental Health Commission, 2004). Cultural assessors have been described as experts in te ao Māori (Māori world view) hosting a range of skills and knowledge including: te reo me ona tikanga; knowledge of the Te Tiriti o Waitangi; kaupapa Māori mental health; mate Māori; oranga hinengaro (emotional wellbeing) and oranga wairua (spiritual wellbeing) (Milne, 2003).

In a study conducted by the MHC (2004) investigating the delivery of cultural assessments for Māori, a number of barriers to accessing cultural assessments were highlighted. Such barriers were related to: issues with the ethnic identification of Māori (such as incidents where clinicians make assumptions about ethnicity based upon physical appearance (such as with lighter skinned tāngata whaiora misidentified as European or Pākeha); engagement difficulties with cultural assessors not informed of Māori admissions promptly or too late; and the reliance on the personal intervention of kaupapa Māori staff to initiate cultural assessment. Consequently, several areas of improvement were highlighted to ensure cultural assessments were better incorporated into mainstream services, these included: the integration of cultural assessment in policy and assessment processes and documentation; the inclusion of cultural assessment to treatment planning; and early and accurate identification of tāngata whaiora. Recommendations for kaupapa Māori cultural assessors included: regular cultural and clinical supervision for Māori teams; along with greater attention to powhiri or whakatau processes; an improved Māori continuum of care, including engagement with whānau through the treatment phase; engagement of Māori working with tāngata whaiora in discharge planning; communicating the cultural assessment to non – government organisations (NGOs), especially in discharge planning and transfer of care; and the consistent provision of poroporoaki (formal farewell) as part of planned discharge or transfer of care (Mental Health Commission, 2004).

**Cultural Competency**

One aspect improving the service delivery for tāngata whaiora has seen the emphasis on a mental health workforce possessing dual competency and culturally safe practice (Ministry of Health, 2005). That is dual competencies in both clinical and cultural spheres of practice (Ihimaera, 2004). Cultural competency can be defined as:
“A set of academic, experiential and interpersonal skills that allow individuals and systems to increase their understanding and appreciation of cultural differences and similarities within, among and between groups” (Jansen & Sorrensen 2002: p.306).

Therefore, becoming culturally competent in Aotearoa involves a fundamental shift in the way one views the world; and requires a willingness to learn and understand the values, traditions and customs of Māori and to work with cultural advisors (such as kaumātua, kuia) (Betancourt et al 2002).

There is a relationship, in part, between cultural competency and the concept of cultural safety. The latter arose via the Māori nursing profession in response to the health disparities of Māori; and the demands for service delivery improvements (Papps & Ramsden 1996). Cultural safety has been described as:

“Interactions that recognise, respect and nurture the unique cultural identity of each person to safely meet their needs, expectations and rights, and involves showing respect and sensitivity to people, and taking into account their spiritual, emotional, social and physical needs” (Paediatric Special Interest Group, 1998).

The basic foundation of such practice when working with Māori would include an understanding of Māori identity and Māoritanga (Milne, 2005). Furthermore, cultural competence training would involve: “…training that affirms indigenous practices and provides opportunities to learn culturally relevant knowledge and strengthen cultural identity for Māori (Levy, 2007: p. 231). This practice requires health professionals and clinicians to have undertaken a process of contemplation of their own cultural identity, and to adapt their practice in a way that affirms the culture of tāngata whaiora (Papps & Ramsden, 1996). Furthermore, mental health staff engagement that fosters manaaki tāngata (to support and take care of people) enhancing ones mana (Durie, 2001); and encourages whānaungatanga which can enhance the therapeutic alliance with tāngata whaiora, are also aspects of cultural competence (Drury & Munro, 2008).

Cultural competency training involves the transition of mono-cultural training into a bicultural context. Such training has been piloted and evaluated for clinical psychology students in Aotearoa (Waitoki, 2009). The development of appropriate methods of assessing
cultural appropriate standards of practice for clinicians working with Māori and other diverse cultural populations remains a focus for ongoing research. A Māori health researcher and clinical psychologist leading the development of cultural competency within the psychology profession, Waikaremoana Waitoki, highlighted the importance of cultural competency training when she stated: “In the future, I hope to see cultural competencies, cultural safety, and indigenous psychology as the basis for all tertiary institutions offering courses in psychology” (Te Kupenga o Mai, 2011: web reference).

Professor Mason Durie, a well-known and respected Māori psychiatrist who has paved the way of Māori health research development, summed up the progress in mental health to date, “the gains made over the past decade represent major transformations for the mental health sector and have positioned the country well to move into the next phase of development” (Mental Health Commission, 2007).

**Protective Factors**
The rejuvenation of Māori wellness has been a topic of discussion over many decades. More than a century ago, Māori leaders, including Ngata, Pomare and Buck (1897) identified five broad strategies for improving Māori mental health (cited in Durie, 2005), which have been developed further by Durie (1997). Specific areas identified include: firstly, supporting a secure Māori identity, as this is considered to have been disrupted or eroded by the process of colonisation for many Māori. Having a secure cultural identity is considered to be an important protective factor against negative health and life experiences for Māori (Durie, 1998; 2001; Moeke-Pickering, 1996; Tapsell, 2007). Secondly, active participation of Māori in society, decision making at policy and service levels is of importance (as discussed in earlier sections of this literature review). Thirdly, improving the quality and quantity of mental health services to address access issues for Māori is of importance. Improving engagement with Māori offers far greater chances of successful outcomes and can improve future service access (Drury & Munro, 2008). Fourthly, Māori workforce development should also be a focus. This has been underway for some time now with the assistance of Te Rau Matatini, who provide training, career advancement, scholarships and regularly updated information and resources for Māori health students and practitioners; And finally, autonomy and control for Māori development referring to both service delivery and policy formulation, planning and decision making. Māori should be actively involved in defining
and prioritising their health needs and supported to develop the capacity to deliver services to their own communities (Dyall et al, 1999).

**THE VISION: FUTURE MENTAL HEALTH DEVELOPMENTS**

More recently, the *MHC* has built upon the developments of Te Koriri and Te Tahuhu policies and published ‘Te Hononga: Connecting for greater well-being 2015’ (2007). This report provides a vision for mental health services and delivery in 2015, following the implementation of action plans and overcoming associated challenges highlighted in the strategies (Mental Health Commission, 2007). The *MHC* identified ten broad values, focuses and principles that need to be implemented to ensure this vision for mental health services is achieved. These include:

1. Putting people first, for instance striving to understand and meet peoples individual needs;
2. Wellbeing for everyone with a focus on incorporating essential holistic health values such as wairua (spirituality);
3. Recovery with the fundamental belief that everyone can live meaningful lives;
4. Affirming rights and autonomy;
5. Building strengths and resilience to develop skills to overcome challenges, cope with stress and maintain wellbeing;
6. Responding early to mental health difficulties through education and wellbeing promotion;
7. Support to maintain and develop connections and networks such as whānau ora;
8. Right responses, multiple support options aimed at meeting individual needs;
9. Collaboration between services and individuals; and
10. Services focused with the least amount of restriction, mostly in communities (Mental Health Commission, 2007).

Furthermore, the report discussed ‘responsive services’ with one main area being positive inpatient encounters that would involve short term intensive care services, in small and highly specialised inpatient services. They would be safe, violence-free environments...
focused on minimising restrictive care practices (such as the use of force and restraint) and the removal of seclusion. The services would also include specialised peer support workers as members of staff (Mental Health Commission, 2007).

In addition to the inpatient focus, services responsive to meeting the needs of Māori were also discussed. The choice of culturally appropriate services, both kaupapa Māori and mainstream services would continue to be offered (Taitimu, 2008); and active Māori participation in policy, planning, delivery and evaluation of services (Dyall et al., 1999). Ongoing Māori mental health workforce development and a culturally competent workforce were also part of the vision (Mental Health Commission, 2007).

This research project was designed to contribute to the MHC vision, and specifically, to the improvement of mental health services for Māori, by portraying the pattern of Māori admissions to inpatient services. Of importance was the voicing the experiences of tāngata whaiora and whānau accessing inpatient mental health services to address the gap in knowledge about the aspects supporting and inhibiting recovery. The two main aims were to review the extent and nature of the mental health needs of tāngata whaiora and whānau from an inpatient mental health service; and improve the understanding of Māori needs, identifying the factors that support and inhibit whakaoranga and whānau ora. This project utilised mixed methods and aimed to contribute to improved outcomes for Māori by gaining a better understanding of the factors that contribute to whakaoranga and whānau ora, offering recommendations from a Māori perspective, to improve the effectiveness of existing inpatient service delivery.
Chapter 2
METHODS

RESEARCH METHODOLOGY

The Beginning Phase of this Study
The first part of the two sections in this chapter discusses the development of this research project including the general intention behind carrying out the project; and a summary of the research context. The methodological choices are then examined, specifically: kaupapa Māori theory; psychological theories; and qualitative research; along with the measures taken to ensure the project’s responsiveness to Māori. This section concludes with the aims of the two studies described in this thesis.

Reasons for Carrying Out the Study
A main intention of this research project was to encourage better health outcomes for tāngata whaiora that experience extreme distress requiring inpatient mental health service admission. The importance of such research can be related to the current deficits in literature pertaining to inpatient service and kaupapa Māori service evaluations, specifically the service practices that support whakaoranga and whānau ora. It was anticipated that this research would contribute to the growing body of knowledge in Māori mental health and whakamana (empower) tāngata whaiora by (i) identifying the current patterns of Māori admissions to inpatient services; and (ii) providing a vehicle for tāngata whaiora and whānau to voice their experiences and needs. Through the process of examining literature regarding inpatient services in Aotearoa; and voicing the rich experiences of the participants this project may perhaps: contribute to the growing body of literature by providing suggestions to address the over-representation of Māori within mental health inpatient services; and highlight the implications associated with inpatient service delivery improvements.

The Research Context
The Auckland City Inpatient Mental Health Service, Te Whetu Tawera (TWT), was selected as the location for this study. TWT is an agency of the Auckland District Health Board (ADHB), which serves a catchment area of 404 892 people and provides health services to the people
of the central Auckland City area. In 2006, there were 29,826 Māori living in the Auckland City region, comprising 7.4% of the ADHB catchment population (Māori Health, 2006). The ADHB adult mental health services offered at the time of this project, for those aged 18 to 65 years, included: four community mental health centres (CMHC) which are all geographically based; and an inpatient service TWT (previously located in the Connolly Unit). Within these services there are service user/consumer advisory; crisis; Acute Home Based services (AHBS); and First Episode Psychosis (FEP) teams. ADHB also offers a Community Support Work service (CSW) and Māori mental health services (Maioha Tupuranga) (Auckland District Health Board, 2010).

The name gifted from mana whenua, Ngāti Whatua, to the new purpose built Auckland city inpatient mental health service was TWT (Auckland District Health Board, 2003). Translated by Ngāti Whatua as the ‘evening star’, TWT is seen as a guiding light in the journey of recovery, providing a beacon for service users, tāngata whaiora and whānau in times of darkness. The names gifted to the inpatient service wards within TWT reflect the recovery philosophy. The open wards Te Kakenga (to ‘ascend’) portrays ‘mountains to climb’; and Te Whitinga (to ‘cross’) ‘rivers to cross’; in addition, Te Tumanako (‘hope’) (ICU) providing a space where hope is sustained through TWT. The seclusion ward is Arohaina (unconditional ‘love’) referring to the unconditional and non-judgmental care needed for those that are extremely distressed (Auckland District Health Board, 2003). With the focus on recovery, the evolution of the ‘TWT Service User Journey’ draft document (Auckland District Health Board, 2005) was intended to represent a shift beyond the traditional biomedical focus of traditional inpatient service care, to incorporate a broader perspective embracing the bio-psychosocial model focused on individual service user recovery (Auckland District Health Board, 2003).

Working within TWT is a kaupapa Māori service, Kai Atawhai, which was developed following its establishment at the general hospital. Originally known as Te Whānau Atawhai, the service was established in a small office at the Connolly Unit in 1996, before moving into the new TWT facility. The purpose built facility of TWT encompasses the Kai Atawhai service which includes full onsite marae facilities such as: whare hui (‘meeting house’) named ‘Te Rama Ora’ (the ‘light’ of ‘health’); whare kai (‘eating house’) referred to as ‘Te Taro Ora’ (the ‘food’ of ‘health’); office space for kaimahi (‘worker’, ‘staff’); and wharepaku facilities (Auckland District Health Board, 2003).
Research Framework and Methodology

The following section presents the kaupapa Māori framework employed to conduct this research project, and the methodological theories utilised in the process of the research project. This project utilised a mixed-methods approach, with both quantitative and qualitative methods utilised.

Kaupapa Māori theory: Indigenous methodologies are often a mix of the methodological approaches of the colonisers and indigenous practices. The mix reflects the training of indigenous researchers, which is often both within the academia framework, and the boundaries and understandings of research that governs how indigenous peoples and researchers define their research processes (Smith, 2003).

Within the Aotearoa context, the emergence of indigenous kaupapa Māori methodologies and theories of understanding have emerged, united by the validation and inclusion of “te reo me ona tikanga” (the Māori language and it’s customs) (Smith, 1997). The core principles of kaupapa Māori theory include: the legitimacy and validity of being Māori; the importance of ensuring the survival of te reo me ona tikanga; and the importance of tino rangātiratanga to Māori cultural wellbeing (Smith, 1997). This kaupapa Māori approach, also referred to as tino rangātiratanga, Māori sovereignty, and Māori perspectives, relates to the process of privileging Māori values and knowledge in order to develop a research framework that is “culturally safe” and contributes to useful outcomes for Māori (Smith, 1999). The importance of the kaupapa Māori framework is essential to conducting research with Māori as it provides a framework in which to view the world theoretically, in turn facilitating understanding, explanations, descriptions and analysis (Pihama, 2001). Kaupapa Māori theory also ensures that fundamental research principles are upheld including the retention of Māori knowledge, Māori control and autonomy, and critical analysis (Levy, 2007).

In addition, kaupapa Māori theory also provides a framework for engagement. For instance discussion regarding priorities for Māori such as mental health, policy and practice developments, and future research directions based upon Māori values and knowledge can be facilitated (Smith, 1999). The analysis of existing power structures and social inequalities are also areas well suited within this framework (Pihama, 1993). Smith (1999) has identified specific practices to guide Māori researchers within a kaupapa Māori framework, which have been utilised in this research project. The seven guidelines are:
1. Aroha ki te tāngata (a respect for people) whereby researchers take on a mediator of both the space and power between the participants (Cram, 2001). The inclusion of kaumātua with local knowledge of the research area and mātauranga Māori is advised (Pipi et al., 2004);

2. Kanohi kitea (present yourself to people face to face) facilitates engagement and builds trust through contact (Cram, 2001);

3. Titiro, whakarongo…kōrero (look, listen…speak) displaying respect and developing trust;

4. Manaaki ki te tāngata (share and host people, be generous) working collaboratively through a reciprocal process;

5. Kia tupato (be cautious) be aware of personal processes and maintain a ‘political astuteness’ (Cram, 2001). For instance maintain as awareness of particular kawa and tikanga processes (Pipi et al., 2004);

6. Kaua e takahia te mana o te tāngata (do not trample over the mana of people) keep participants informed about the research process. For instance, disseminate findings and provide community feedback (Cram, 2001); and

7. Kaua e mahaki (do not flaunt your knowledge) be humble and share mutual celebrations of research achievements (Cram, 2001).

(Adapted from Smith, 1999: p.120).

Responsiveness to the needs and rights of Māori is crucial in research involving Māori directly or indirectly (Smith, 1999). In this research project, responsiveness to Māori was ensured in accordance with Te Tiriti o Waitangi and kaupapa Māori principles. Firstly, active participation from tāngata whaiora, whānau and tāngata whenua was ensured in the research process. This involved obtaining and incorporating feedback on the study aims and methodology. Secondly, working in partnership with tāngata whaiora and whānau involved close liaison for the duration (and following completion) of the study with Māori services, including: Kai Atawhai (the Kaupapa Māori service, TWT); the Māori consumer advisor, Mind and Body Consultants. And thirdly, the protection of Māori is this project was ensured by utilising appropriate kaupapa Māori methodology; and maintaining ongoing consultation and accountability for the duration of the project with a rangahau whānau (research family or
group). This included close liaison and consultation with: Māori health researchers; Māori mental health practitioners; and Māori cultural advisors.

Consultation, with twenty two individuals representing varying facets of the mental health field, was the beginning phase of the research design. The process began with discussion with tāngata whaiora and whānau who had had recent admission experiences to TWT. Discussion included their experiences in an inpatient service which highlighted incidents indicating that their needs within the existing services could be better met. Initial discussion was then held with the kaupapa Māori team Kai Atawhai, Ku Tuoro and Veronica Moates regarding different areas of interest that may potentially be useful for tāngata whaiora and whānau. Consultation was then held with: Māori health workers; Māori advocacy staff Robyn Wiki (Mind and Body Consultants) and Supporting Families services; and TWT management Eileen Swan (Clinical Psychologist, Manager) and John Thorburn (Clinical Psychologist, Psychology Advisor, ADHB). Discussions were then held with research supervisors Professor John Read (Department of Psychology, University of Auckland) and Dr Lorna Dyall (Population Health, University of Auckland); Māori cultural advisor Tamati Kruger (Te Ao Māori Mentor, Tūhoe Iwi Spokesperson); Māori health researchers and clinicians Dr Erana Cooper (Māori Clinical Psychologist and Kaupapa Māori Lecturer, University of Auckland), and Dr Melissa Taitimu (Clinical Psychologist); and inpatient mental health researcher Dr Kirsty Agar-Jacomb (Clinical Psychologist).

**Mixed methods - quantitative and qualitative research:** For most of the twentieth century, social science research was dominated by the positivist paradigm focused on quantitative analysis methods (Denzin & Lincoln, 2000). Despite popular opinion identifying qualitative methods as the preferred approach within a kaupapa Māori research framework, it has also been argued that quantitative methods have a place and purpose within this positioning (Barnes, 2000). The quantitative approach gathers and analyses statistics which are utilised for the purpose of meaning and to provide an understanding of a particular phenomena (Breakwell & Rose, 2006).

Traditionally, quantitative methods and statistics have sometimes been unhelpful for Māori, portraying Māori negatively without contextualising the data. This limitation fails to identify and provide an understanding into why the phenomena occurred, often resulting in misinterpretations (Cooper & Wharewera-Mika, 2011). Kaupapa Māori quantitative researchers, however, have worked towards remedying these misconceptions about
quantitative methods. One way in which quantitative methods have been adapted to suit Māori research, is by ensuring appropriate engagement with participants (such as through greater consultation with whānau, hapū and iwi).

Quantitative methods continue to be criticised for undervaluing meaning, purpose, agency and context, ignoring narratives and their central importance in creating meaning and conveying experience (Lapsley et al., 2002). More recently, alternative qualitative methods, for instance structured interviews, have frequently been used to explore how people think and feel (Seale, 1999). This is considered a more appropriate fit with kaupapa Māori research, and viewed as more empowering for participants (Barnes, 2000). A main focus for the current research was gaining a rich, in-depth understanding of tāngata whaiora and whānau experiences within inpatient mental health services (Barnett & Lapsley, 2006). Interviews were used to provide a description of the experiences which is then analysed to interpret how people gave their experiences meaning (Braun & Clarke, 2006). The use of semi-structured interviews has been suggested as an appropriate technique for research among different cultural groups. One advantage of this approach is that more complex issues can be probed and answers clarified (Bowling, 1997).

Thematic analysis fits under this category (Braun & Clarke, 2006). This is the qualitative analytic method that has been adopted for the data analysis in this research project:

“...identifying, analysing and reporting patterns (themes) within data. It minimally organises and described your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic” (Braun & Clarke, 2006: p. 79).

The main focus of analysis is to search for consistently reported themes utilising an inductive approach rather than the deductive approach.

“A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006: p. 82).
This process is different from content analysis in that the researcher does not set out with a pre-conceived list of categories and, instead, constructs the list from reading and thinking about the data. The advantages of thematic analysis are related to theoretical freedom as it is not tied to any specific theoretical position. It is a flexible tool for research providing a rich, detailed and complex account of data (Joffe & Yardley, 2004).

The combination of quantitative and qualitative data gathering is often referred to as ‘mixed methods’ as it involves combining both methods. For instance, qualitative methods might be used to understand the meaning of the conclusions produced by quantitative methods, which are often more readily accepted within the field of pure science and amongst health clinicians (Kral, Links & Bergmans, 2012; Morgan, 2007). The mixed methods approach is therefore useful in broadening the research questions and providing a more substantive understanding of the research area.

Conflict of Interest
Highlighted prior to the commencement of the research project was the potential conflict of interest of the researcher, as both a previous employee of TWT and as the principle investigator conducting research investigating participants’ perceptions (both positive and negative) of the service. An awareness and commitment to maintaining neutrality, as far as possible, during the process of conducting the research interviews and analysing the data were areas of focus. In consultation with rangahau whānau a number of measures were developed to reduce the impact of potential biases. These included: participants being reassured that their treatment would in no way be affected by participating in the study; reassurance around confidentiality and how the information would be used and reported; and my role as a researcher independent from TWT utilising interview data for research purposes only and not reporting back to TWT staff. During the data collection and analysis phases of the project supervision was used to maintain an awareness of the influence of my own values and preconceptions. An inter-rater reliability check was also used during the data analysis phase.

Aims of the Research Project
The main areas of interest for this research project came about from the question: ‘What are the needs of tāngata whaiora and whānau from mental health inpatient service?’ This project
aimed to identify factors that contribute to better outcomes for Māori when admitted to TWiT. The two main aims were (i) to review the nature and extent of tāngata whaiora using the TWiT inpatient mental health service, and (ii) to investigate the experiences and needs of tāngata whaiora using the TWiT mental health inpatient service and their whānau, and identify the factors that support and inhibit whakaoranga and whānau ora. Also investigated were preferences for options of alternative care. To address these aims, two studies were conducted:

**Study One: Tāngata whaiora admission patterns:** Data relating to all service users’ admission and readmission rates were gathered for the period January 1st 2005 to December 31st 2008, via computerised clinical documentation files. Also included was information relating to the Ward (open ward or ICU) admitted; the length of stay (LoS) at TWiT; and primary diagnosis.

**Study Two: Tāngata whaiora and whānau inpatient experiences:** To improve our understanding of the experiences and needs of tāngata whaiora and their whānau from inpatient mental health services, interviews explored: tāngata whaiora and whānau experiences whilst admitted to TWiT; and the therapeutic interventions offered from TWiT that tāngata whaiora and whānau found helpful or unhelpful in their journey of whakaoranga. The interviews were focused on a better understanding of ‘what works’ for Māori as well as identifying ‘areas in need of improvement’.

**RESEARCH DESIGN**

**Study One: Tāngata Whaiora Admission Patterns**

**Ethical approval:** Ethical approval was sought to collect the relevant quantitative data. As this was an audit of DHB records it was not considered necessary to gain informed consent from tāngata whaiora. The Auckland Ethics Committee approved the study (application number NYT/05/12/100).

**Data collection procedures:** This study was a retrospective cohort study of admissions; ward admitted to (open versus intensive care, ICU); readmissions; length of stay (LoS); and primary diagnoses. Data obtained from the routine collection of computerised clinical documentation were utilised to investigate potential associations with ethnicity (Māori, Pacific, Asian, European and Other). This data was collected retrospectively from the
ADHB Community Health Information Processing System (CHIPS) database. The data obtained included service user: gender; date of birth; ethnicity (selected from 24 different ethnicity categories); date of admission and discharge; ward admitted to (open wards: Te Whitinga or Te Kakenga; or ICU: Arohaina); and primary diagnosis (selected from 104 different DSM-IV categories).

**Participants:** The data included all tāngata whaiora admitted to TWT during the four year period from 1 January 2005 to 31 December 2008.

**Data storage:** The data was stored on a USB stored in a locked filing cabinet and on the researcher’s personal computer with a secure lock needing a password.

**Sample size:** The data included a total of 2 609 admissions and 1 550 tāngata whaiora participants, including all ethnic groups.

**Data decisions:** The CHIPS data set was gathered by the Information Technology (IT) specialist, Mental Health Management, ADHB. A total of 2 609 admissions were calculated, of which 1059 were repeat admissions. Analysis was firstly conducted using both repeat admissions and individual admissions with all results providing similar outputs. It was decided to conduct all analyses and report results for the individual admissions data set only (except for analyses specifically addressing readmissions).

In order to conduct analyses for ethnicity the data was re-grouped. Originally the CHIPS data produced 24 ethnic groups which were then placed into five categories:

1. Māori (Māori);
2. Pacific (Cook Island Māori, Samoan, Tongan, Niuean, Fijian, Tokelauan, Pacific Island NFD, Other Pacific Peoples);
3. Asian (Iranian, Malay, Indian, Middle Eastern, South East Asian, Chinese, Asian NFD, Other Asian);
4. European (European, Other European, NZ European); and
5. Other (Latin American, Not stated, Other, African).

There were 140 original diagnoses produced from the CHIPS data. These were re-grouped into seven discrete categories of diagnosis:
1. Schizophrenia (which includes any of the diagnoses with the word ‘schizophrenia’);
2. Other psychotic disorders (any reference to psychosis, delusions, hallucinations);
3. Mood disorders (depression, mania, bipolar as the primary feature such as depression with psychotic symptoms);
4. Anxiety (anything with the word 'anxiety' as the primary feature and post traumatic stress disorder);
5. Drug related disorder (any mention of drugs, cannabis, alcohol, opioid as a primary feature such as mental, behavioural disorder associated with multiple drug use);
6. Personality disorders (any mention of borderline, personality, dissociative as a primary feature); and
7. Other (dysthymia, delirium, acute stress, adjustment, aspergers, huntingtons and others)

Data analysis: Analysis for this study was carried out using SPSS version 15. Means and standard deviations were calculated for continuous variables, and percentages for categorical variables. Appropriate analyses (such as analyses of variance (ANOVA); chi square) were conducted to ascertain the following associations between ethnicity and the following five variables:

1. Admission rates;
2. Ward admitted (open ward or ICU);
3. Readmission rates;
4. Length of Stay (LoS); and
5. Diagnosis (primary diagnosis).

Study Two: Tāngata Whaiora and Whānau Inpatient Experiences

Ethical approval: Ethical approval was applied for to conduct and administer questionnaires to, and interviews with, tāngata whaiora and whānau. The Auckland Ethics Committee approved the study (application number NYT/05/12/100) after minor
amendments (Appendix A) and reassurance that tāngata whaiora were able to access alternative advocate support given my dual role as primary investigator and Kai Atawhai staff member. Research approval was also granted by the ADHB Research Unit (application number A+3379) and the Department of Psychology Research Committee, University of Auckland. Cultural ethical approval was obtained from the Māori Research Committee who operates as part of the ADHB research review process.

**Research procedures:** This study included semi-structured interviews with one form for tāngata whaiora and one form for whānau (Appendix D); and a 25-item likert scale Needs Questionnaire (Appendix E) developed from Māori mental health literature. The scale was used to measure what supports participants needed when admitted to TWT, how useful they found particular therapeutic interventions and the service in general. Participants were also provided with an area at the end of the questionnaire for any other comments. A Māori cultural identity scale (adapted from Cherrington, 1994) (see Appendix D) was also included in the interview. With the participants’ consent, the interview was audio-taped, and subsequently transcribed to ensure accuracy.

This study explored the needs of 20 tāngata whaiora who had had a least one recent admission to TWT the ADHB inpatient mental health service; and 10 of their whānau who had provided support during an admission. The perceived effectiveness of the inpatient service in meeting the needs of tāngata whaiora and whānau was investigated, and areas for improvement and options of alternative care identified.

**Participant recruitment:** The Kai Atawhai staff approached potential participants from tāngata whaiora who were currently using the service and were in the discharge phase. Excluded from the study were individuals who were unable to provide informed consent or who were extremely distressed at the time of assessment, as assessed by the relevant responsible clinicians. All potential participants were approached to avoid selection biases. A Kai Atawhai staff member was the first point of contact. Upon initial contact the Kai Atawhai staff member provided potential tāngata whaiora participants with information about the study. They then chose whether or not they would like to meet the primary researcher to find out more about participating in the study (PIS; Appendix B). Kai Atawhai staff provided tāngata whaiora with information relating to researcher contact details if interested in participating, either by dropping in to the Kai Atawhai office or asking the
potential participants how they would feel about the researcher approaching them with more information about the study.

The recruitment of participants was conducted during four assessment periods which included:

- 2006 December;
- 2007 June; July; October; November; December;
- 2008 February; April; August; and
- 2009 April; May

Once a person agreed to take part in the study, the interview process and options (such as location; support people) were discussed with them. All participants were interviewed by the primary investigator. At the beginning of the interviews, the interviewer went through the information participant sheet and consent form, and checked whether the person had any questions or issues around confidentiality, data storage or reporting. The majority of the interviews were transcribed by the researcher, with 10 transcribed by a Māori contractor who had signed a confidentiality agreement. Once the consent form (see Appendix C) was signed the interview would begin.

A total of 31 āngata whaiora were approached to participate in the study. Of these seven chose not to participate and four missed scheduled appointment times as they were either discharged from the inpatient service or I was unable to contact them to reschedule appointments. The remaining 20 represents a response rate of 64.50%. All āngata whaiora interviews were carried out at TWT, while they still resided there, either in the whare kai or whare hui onsite facilities.

All participants were given the opportunity to invite whānau members or other support people, to attend their interview with them to provide support during the interview process. One whānau participant was also a support person during one āngata whaiora interview. Eighteen whānau participants were identified by āngata whaiora. Seven participants could not be contacted via the contact details provided. Of the 11 whānau who were contacted and invited to attend the interview ten chose to participate. The ‘participant information sheet’ (see Appendix B) and ‘whānau consent forms’ (see Appendix C) were given and supporting whānau members were asked to sign a consent form. Whānau
interviews were carried out in a number of different Auckland settings, including people’s homes, workplaces or cafes, whichever the participant preferred.

**Participant characteristics:** The final number of interviews was 30, which included 20 tāngata whaiora and ten whānau participants. Data on characteristics of the participants is presented in Tables 1 - 3.
Table 1: Participant Characteristics (N = 30)

<table>
<thead>
<tr>
<th>Tāngata whaiora participants (n = 20)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
</tr>
<tr>
<td>Age range</td>
<td></td>
</tr>
<tr>
<td>18 – 23</td>
<td>3</td>
</tr>
<tr>
<td>24 – 29</td>
<td>3</td>
</tr>
<tr>
<td>30 – 34</td>
<td>3</td>
</tr>
<tr>
<td>35 – 40</td>
<td>2</td>
</tr>
<tr>
<td>40 +</td>
<td>9</td>
</tr>
<tr>
<td>Admissions to inpatient services</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3 – 4</td>
<td>8</td>
</tr>
<tr>
<td>5 – 9</td>
<td>4</td>
</tr>
<tr>
<td>10 +</td>
<td>2</td>
</tr>
<tr>
<td>Hapū / Iwi</td>
<td>Te Rarawa; Ngai Tahu; Ngāti Whātua; Nga Puhi; Tūhoe; Taranaki; Ngāti Raukawa; Ngāti Porou; Ngāti Kahungunu; Ngāti Tuwharetoa; Tainui; Taitokerau; Te Aopouri</td>
</tr>
<tr>
<td>Māori identity (0 = very uncomfortable; 10 = very comfortable)</td>
<td></td>
</tr>
<tr>
<td>With Māori in Māori situations</td>
<td>Mean = 8.45  Median = 10</td>
</tr>
<tr>
<td>With Pākeha in Pākeha situations</td>
<td>Mean = 7.15  Median = 8</td>
</tr>
<tr>
<td>How strongly do you identify as Māori</td>
<td>Mean = 9.30  Median = 10</td>
</tr>
<tr>
<td>Meaning of ‘being Māori’</td>
<td>A sense of pride; A sense of belonging, connected to tupuna and identity; Sharing a Māori worldview (te reo me ona tikanga)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Whānau participants (n = 10)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
</tr>
<tr>
<td>Age range</td>
<td></td>
</tr>
<tr>
<td>18 – 23</td>
<td>1</td>
</tr>
<tr>
<td>24 – 29</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 1: Participant Characteristics (N =30) cont.

<table>
<thead>
<tr>
<th>Whānau participants</th>
<th>(n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 – 34</td>
<td>0</td>
</tr>
<tr>
<td>35 – 40</td>
<td>1</td>
</tr>
<tr>
<td>40 +</td>
<td>7</td>
</tr>
<tr>
<td>Hapū / Iwi / Ethnicity</td>
<td>Tūhoe; Te Arawa; Ngāti Porou; European; Iranian</td>
</tr>
<tr>
<td>Relationship to tāngata whaiora</td>
<td>Mother (n= 2); father (n= 1); partner (n= 2); sibling (n= 2); aunty (n= 1); friend (n= 1); caregiver (n= 1)</td>
</tr>
</tbody>
</table>

Table 2: Participants’ Attendance at Therapy Sessions

<table>
<thead>
<tr>
<th>Participants (n = 8)</th>
<th>Participants attendance at therapy sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3  4  5  6  7  8</td>
</tr>
<tr>
<td>Number of sessions attended</td>
<td></td>
</tr>
<tr>
<td>Cognitive behavioural therapy</td>
<td>2  3  1  2  2  1  2  2</td>
</tr>
<tr>
<td>Distress tolerance skills group</td>
<td>2  2  3  0  0  0  0  0</td>
</tr>
</tbody>
</table>

Of the 20 tāngata whaiora who participated in Study Two, eight attended at least one cognitive behavioural therapy (CBT) group; and three attended at least two distress tolerance skills groups. The maximum number of group therapy sessions attended was three for both CBT and distress tolerance skills.
Table 3: Participants’ Attendance at Whānau Hui

<table>
<thead>
<tr>
<th>Participants (n = 10)</th>
<th>Whānau Hui Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Number of whānau hui attended

| Whānau hui | 1 | 1 | 3 | 1 | 1 | 1 | 1 | 3 | 1 | 1 |

Of the 30 tāngata whaiora and whānau participants, ten attended a whānau hui during their admission experience (or during the admission of their whānau member) to Te Whetu Tawera. A maximum of three whānau hui were attended by two of the participants.

**Interview and Needs Questionnaire process:** The interviews followed tikanga Māori processes. That is, they began with karakia (prayer) and mihiimihi (an appropriate cultural greeting process) with the interviewer introducing herself by discussing whakapapa (geneology). All participants chose to proceed with this process, often requesting that the researcher conduct the karakia. At the beginning of the interview participants were given a clear explanation of the interview process, and the opportunity to ask questions and to withdraw the consent form for the interview (which did not happen with any participants). Tāngata whaiora and whānau participants were encouraged to be honest, open and critical, and it was reaffirmed that there would be no negative consequences to anything they said. Participants were given the opportunity to share their needs from TWT, followed by some specific enquires regarding the admission. (See Appendix D for the full interview schedule). The interview concluded with questions pertaining to a Māori identity scale (adapted from Cherrington, 1994) to assertain the level of participants’ cultural identity, and a Needs Questionnaire (see Appendix E) with both tāngata whaiora and whānau versions. The Needs Questionnaire contained: demographic questions; background questions enquiring about the types of care received (such as medication, therapy), rating their effectiveness; and questions requiring participants to rate the effectiveness of the TWT service in meeting their needs (cultural; wairua; hinengaro; tinana; and whānau). Upon completion of the
questionnaire, the participants were thanked for their contribution; given a koha (donation); and the interview was closed with karakia and kai.

Of the 30 interviews, 21 were audiotaped. The further nine interviews were transcribed verbatim during the interview process due to difficulties in certain interview locations (such as cafes) where there were distracting noises (such as vehicles, others talking). Also, one participant did not want the recorder used as it increased her anxiety. Support (via clinical staff and the research supervisor) was available for participants, should they find the interviews distressing. However, no one reported any negative impact of the interview when asked following the interview and no one requested this support. Distress during the interviews was sometimes apparent (and monitored by the researcher) when participants recalled the initial admission experience and the level of their distress at the time, but everyone who became distressed wanted to continue when the researcher 'checked in' with them. The concluding process was quite emotional for many of the participants who often thanked the interviewer for providing an opportunity to reflect on experiences which many had never voiced before.

Data storage: The researcher assigned each participant with ID markers which were used to preserve confidentiality, and their names were not used in analysis or reporting of the data. The sheet containing the names and ID numbers were stored securely in a separate location to the data. Audio tapes and hard copies of interview data were stored in a locked filing cabinet, along with signed consent forms. Transcripts were posted to participants, unless they stated they did not want to see a transcript, and they were given 3 weeks to return them with any changes they may want made. Of the 30 participants 10 stated that they would not need their transcript posted. A total of five transcripts were returned with minor changes made. No participants withdrew after completion of the interview.

Qualitative analysis: Firstly, tapes were transcribed and checked for accuracy, then prepared for importation into NVivo 8, a qualitative data analysis software package. Next, each transcript was printed out and the initial process of analysis conducted. The interviews were initially organised around a simple sequence of three stages or categories: admission, intervention, and discharge. However, data analysis revealed five narratively sequenced categories: Admission Process; Admission Experience; Therapeutic Environment and Interventions; Discharge Phase; and Future admissions (alternative care suggestions). These formed the basis of our initial coding of all interview content in the software programme.
Thematic analysis was used to analyse the data, following the guidelines recommended by Braun and Clarke (2006). The guidelines identify six phases of conducting thematic analysis:

1. Becoming familiar with the data;
2. Generating initial codes;
3. Searching for themes;
4. Reviewing themes;
5. Defining and naming themes;
6. Producing the report.

Initial coding of the data involved coding interesting features of the entire data set and then collating the data relevant to each code. Once the initial coding had been done, work proceeded on thematic analysis for each category with potential themes identified and all data pertaining to each potential theme collated. A 'thematic map' was then developed and potential themes were reviewed. Ongoing analysis of the data was conducted to refine the themes and the overall narrative discovered during the analysis. Clear definitions and names for each main theme and subthemes were then developed. Independent checks of the categories and themes were conducted by other researchers (including the researcher’s supervisor, and a Māori health researcher) to reduce analysis biases. The independent checks conducted by the Māori health researcher involved twenty quotes being selected randomly (four were randomly selected from each of the five categories). The researcher then categorised the quotes into themes based upon these definitions of the themes. No discrepancies were found. The research supervisor randomly re-checked categories and themes in a more informal process.

**Quantitative analysis:** The quantitative data from the Needs Questionnaire was used to elaborate further upon some of the participants perceptions of inpatient care. For the purpose of this study, descriptive statistical analyses (including frequency, percentages and median ratings) were calculated and reported.
Chapter 3

STUDY ONE RESULTS

STUDY ONE: TĀNGATA WHAIORA ADMISSION PATTERNS

A total of 2609 service users had admissions to Te Whetu Tawera (TWT) over the four year period from January 1st 2005 to December 31st 2008. Of these, 524 went on to have at least one readmission within four years of discharge. The analyses therefore involved 1550 individual service user admissions. The pattern of tāngata whaiora admissions and readmissions to TWT were examined and compared to other ethnic groups (Pacific, Asian, European and Other). Additional admission data, including information relating to the ward of admission (Open ward or ICU); the length of stay (LoS) at the service; and primary diagnoses were analysed.

Māori Population Characteristics

In 2006 there were 404 619 people living in the Auckland District Health Board (ADHB) catchment area, of whom 29 847 were Māori (Table 4). Approximately 6.8% of the population aged between 15 and 64 years were Māori (Statistics New Zealand, 2006).

Table 4: Māori Population Proportions

<table>
<thead>
<tr>
<th>Year</th>
<th>NZ Māori population</th>
<th>ADHB population</th>
<th>ADHB Māori population</th>
<th>ADHB Māori population 15-64 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>565 329 (14.6%)</td>
<td>404 619</td>
<td>29 847 (7.4%)</td>
<td>19 944 (6.8%)</td>
</tr>
</tbody>
</table>

(Statistics New Zealand, 2006)
Admission Rates

Māori were over represented in their admissions to *TWT* during this period, making up 17.1% of the total admissions but only 6.8% of the *ADHB* Māori population aged 15 to 65 years (Figure 1). Thus the rate of admission for Māori was more than two and a half times greater than that which would be predicted from their proportion of the population in the catchment area.

*Figure 1: Above* Māori and non-Māori proportions within the *ADHB* catchment area (Māori Health, 2006); and *below* Māori and non-Māori admissions to *TWT* (2005 to 2008)
A chi-square test was performed to determine whether the five ethnic groups were equally admitted to TWT at an equal rate. Analyses revealed a significant difference (p= .005) in admission rates between the ethnic groupings Māori (17.1%), Pacific (11.4%), Asian (11.8%), European (55.2%), and Other (4.4%). Binomial tests were conducted to investigate the probability of getting the observed number of admissions (or greater) per ethnicity given the expected number of admissions (proportions). A significant difference $\chi^2 = (4, N = 1550) = 687.20, p = .000$ between the admission rates of the five ethnic groupings was found. Māori were admitted at a rate two and a half times (2.52) the expected rate, and Asian were under-represented at half (0.48) the expected rate.

Females made up 44.3% and males 55.7% of admissions, with the pattern of higher male admissions consistent across all ethnic groupings (see Table 5). The average age of admission for males (36.5 years) was lower than females (39.3 years). An analysis of variance (ANOVA) found a significant difference between average age across the five different ethnic groups in $F(4, 1550) = 20.22, p = .000$. Further analysis of multiple comparisons using a Bonferroni identified significant differences ($p = .000$) between European who were older in age upon admission (40.1 years) when compared with Māori (35.9 years), Pacific (32.4 years) and Asian (35.6 years) ethnic groups.

Table 5: Gender Proportions at Admission

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>European</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>53.21</td>
<td>54.80</td>
<td>52.72</td>
<td>57.20</td>
<td>57.35</td>
</tr>
<tr>
<td>Female</td>
<td>46.79</td>
<td>45.20</td>
<td>47.30</td>
<td>42.81</td>
<td>42.65</td>
</tr>
</tbody>
</table>
Ward Admitted

A comparison of the ward admitted to on arrival to TWT, either the open ward or ICU, indicated a significant difference between ethnicities $\chi^2 = (4, 1550) = 14.109, p = .007$. 55.8% of Māori were admitted directly into ICU, but only 44.6% of Europeans, 46.7% of Asians and 49.7% of Pacific (see Figure 2). Further analysis revealed a significant difference between the Māori and European groups $\chi^2 = (4, 1117) = 3.626, p = .001$ with Māori more likely admitted to ICU, and European more likely admitted to the open ward.

![Figure 2: Ward Admitted by Ethnicity (2005 to 2008)]
Readmission Rates
An ANOVA found no significant differences between ethnic groups in the average number of readmissions $F(4, 524) = 1.30, p = .27$ (see Table 6).

Table 6: Average Number of Readmissions

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>108</td>
<td>3.14</td>
<td>1.85</td>
</tr>
<tr>
<td>Pacific</td>
<td>65</td>
<td>3.34</td>
<td>1.77</td>
</tr>
<tr>
<td>Asian</td>
<td>51</td>
<td>2.67</td>
<td>1.24</td>
</tr>
<tr>
<td>European</td>
<td>284</td>
<td>2.98</td>
<td>1.82</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>2.75</td>
<td>1.18</td>
</tr>
<tr>
<td>Total</td>
<td>524</td>
<td>3.02</td>
<td>1.76</td>
</tr>
</tbody>
</table>

Length of Stay
An ANOVA conducted to investigate the average Length of Stay (LoS) by ethnicity groupings found no significant differences between groups $F(4, 1550) = 1.14, p = .67$ (see Table 7).
Table 7: Average Length of Stay (LoS)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>266</td>
<td>28.16</td>
<td>34.28</td>
</tr>
<tr>
<td>Pacific</td>
<td>178</td>
<td>34.55</td>
<td>31.59</td>
</tr>
<tr>
<td>Asian</td>
<td>186</td>
<td>30.15</td>
<td>29.01</td>
</tr>
<tr>
<td>European</td>
<td>851</td>
<td>28.91</td>
<td>37.63</td>
</tr>
<tr>
<td>Other</td>
<td>69</td>
<td>27.69</td>
<td>23.74</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1550</strong></td>
<td><strong>29.52</strong></td>
<td><strong>34.96</strong></td>
</tr>
</tbody>
</table>

Diagnosis

There were 140 original diagnoses which were grouped into seven categories: 1=schizophrenia; 2=other psychotic disorder; 3=mood disorders; 4=anxiety; 5=drug related disorder; 6= personality disorders; and 7= Other. Analysis investigated the diagnoses by ethnicity and found a significant difference between ethnic groups $F(24, N = 1550) = 94.10, p = .000$ (see Table 8).

Furthermore, proportions of diagnoses across Māori and European ethnic groups indicated a significant difference between groups ($p = 0.000$). Māori were significantly more likely than European to be diagnosed with schizophrenia (37% vs 26%) and psychotic disorders (24.9% vs 20.6), $F(4, N = 464) = 11.02, p = 0.026$. Māori were less likely than European to be diagnosed with a mood disorder (20.4% vs 32%), $F(4, N = 430) = 12.12, p = .017$. 

82
Table 8: Diagnosis by Ethnicity

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Māori (n=266)</th>
<th>Pacific (n=178)</th>
<th>Asian (n=186)</th>
<th>European (n=851)</th>
<th>Other (n=69)</th>
<th>Total (N=1550)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% within ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>99</td>
<td>76</td>
<td>50</td>
<td>222</td>
<td>18</td>
<td>464</td>
</tr>
<tr>
<td></td>
<td>37.2%</td>
<td>42.7%</td>
<td>26.9%</td>
<td>26.1%</td>
<td>26.1%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Other</td>
<td>66</td>
<td>55</td>
<td>63</td>
<td>175</td>
<td>14</td>
<td>372</td>
</tr>
<tr>
<td>Psychotic</td>
<td>24.8%</td>
<td>30.9%</td>
<td>33.9%</td>
<td>21.0%</td>
<td>20.3%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Mood</td>
<td>54</td>
<td>28</td>
<td>45</td>
<td>270</td>
<td>30</td>
<td>430</td>
</tr>
<tr>
<td></td>
<td>20.3%</td>
<td>15.7%</td>
<td>24.2%</td>
<td>32.0%</td>
<td>43.5%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>1.1%</td>
<td>0%</td>
<td>1.1%</td>
<td>1.2%</td>
<td>0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Drug</td>
<td>21</td>
<td>2</td>
<td>10</td>
<td>52</td>
<td>1</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>7.9%</td>
<td>1.1%</td>
<td>5.4%</td>
<td>6.1%</td>
<td>1.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Personality</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>56</td>
<td>1</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>2.3%</td>
<td>2.2%</td>
<td>1.6%</td>
<td>6.6%</td>
<td>1.4%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>13</td>
<td>13</td>
<td>66</td>
<td>5</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>6.4%</td>
<td>7.3%</td>
<td>7.0%</td>
<td>7.8%</td>
<td>7.2%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Analysis by gender found a significant difference $F(6, N = 1550) = 46.73, p = .000$. Furthermore, proportions of diagnoses across Māori and European ethnic groups indicated a significant difference between groups ($p = .000$). Māori were significantly more likely than European to be diagnosed with schizophrenia (37% vs 26%) and psychotic disorders (25% vs 21%). Māori were less likely than European to be diagnosed with a mood disorder (20% vs 32%).

A significant difference was found between ethnicities when investigating the difference between diagnosis and female gender $F(24, N = 689) = 42.37, p = .012$ (see Table 9). However, no significant difference was found between Māori and European ethnic groups ($p = .221$).
Table 9: Diagnosis by Ethnicity: Females

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Māori (n=124)</th>
<th>Pacific (n=80)</th>
<th>Asian (n=87)</th>
<th>European (n=366)</th>
<th>Other (n=29)</th>
<th>Total (N=689)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% within ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>27</td>
<td>30</td>
<td>26</td>
<td>71</td>
<td>6</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td>21.8%</td>
<td>37.5%</td>
<td>29.9%</td>
<td>19.4%</td>
<td>20.7%</td>
<td></td>
</tr>
<tr>
<td>Psychotic</td>
<td>37</td>
<td>24</td>
<td>27</td>
<td>91</td>
<td>8</td>
<td>187</td>
</tr>
<tr>
<td></td>
<td>29.8%</td>
<td>30.0%</td>
<td>31.0%</td>
<td>24.9%</td>
<td>27.6%</td>
<td></td>
</tr>
<tr>
<td>Mood</td>
<td>36</td>
<td>18</td>
<td>26</td>
<td>124</td>
<td>13</td>
<td>217</td>
</tr>
<tr>
<td></td>
<td>29.0%</td>
<td>22.5%</td>
<td>29.9%</td>
<td>33.9%</td>
<td>44.8%</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>2.4%</td>
<td>0%</td>
<td>1.1%</td>
<td>3.3%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>6.5%</td>
<td>1.3%</td>
<td>2.3%</td>
<td>3.3%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Personality</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>33</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>2.4%</td>
<td>3.8%</td>
<td>1.1%</td>
<td>9.0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>4</td>
<td>4</td>
<td>30</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>8.1%</td>
<td>5.0%</td>
<td>4.6%</td>
<td>8.2%</td>
<td>6.9%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Analysis investigating the diagnosis by ethnicity and gender found a significant difference between males $F(24, N = 689) = 85.46, p = .000$ (see Table 10).
Table 10: Diagnosis by Ethnicity: Males

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Māori (n=141)</th>
<th>Pacific (n=97)</th>
<th>Asian (n=97)</th>
<th>European (n=487)</th>
<th>Other (n=39)</th>
<th>Total (N=861)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>% within ethnicity</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>71</td>
<td>46</td>
<td>23</td>
<td>150</td>
<td>12</td>
<td>303</td>
</tr>
<tr>
<td></td>
<td>50.4%</td>
<td>47.4%</td>
<td>23.7%</td>
<td>30.9%</td>
<td>30.8%</td>
<td></td>
</tr>
<tr>
<td>Psychotic</td>
<td>29</td>
<td>31</td>
<td>35</td>
<td>84</td>
<td>6</td>
<td>185</td>
</tr>
<tr>
<td></td>
<td>20.6%</td>
<td>32%</td>
<td>36.1%</td>
<td>17.2%</td>
<td>15.4%</td>
<td></td>
</tr>
<tr>
<td>Mood</td>
<td>18</td>
<td>10</td>
<td>19</td>
<td>149</td>
<td>16</td>
<td>213</td>
</tr>
<tr>
<td></td>
<td>12.8%</td>
<td>10.3%</td>
<td>19.6%</td>
<td>30.7%</td>
<td>41.0%</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>13</td>
<td>1</td>
<td>8</td>
<td>40</td>
<td>1</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>9.2%</td>
<td>1.0%</td>
<td>8.2%</td>
<td>8.2%</td>
<td>2.6%</td>
<td></td>
</tr>
<tr>
<td>Personality</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>23</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>2.1%</td>
<td>1.0%</td>
<td>2.1%</td>
<td>4.7%</td>
<td>2.6%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>36</td>
<td>3</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>5.0%</td>
<td>8.2%</td>
<td>9.3%</td>
<td>7.4%</td>
<td>7.7%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Furthermore, analysis of gender differences between Māori and European diagnoses found a significant difference between males $F(24, 861) = 63.40, p = .000$. Māori men were more likely than European men to be diagnosed with schizophrenia (50% vs 31%) and psychotic disorders (21% vs 17%). Māori men were less likely than European men to be diagnosed with a mood disorder (13% vs 31%).
Chapter 4

STUDY TWO RESULTS

STUDY TWO: TĀNGATA WHAIORA AND WHĀNAU INPATIENT EXPERIENCES

This chapter reports the results of both the interviews and the Needs Questionnaire. It begins by presenting the five thematic (narratively sequenced) categories that have been discovered from the tāngata whaiora and whānau interviews: Admission Process; Admission Experience; Therapeutic Environment and Interventions; Discharge Process; and Future Admissions (see Table 11). Each category consists of themes and, in some cases, sub-themes. Some themes have been divided into positive and negative groupings when the content has reflected both viewpoints. When reporting direct quotes of participants pseudo-names have been used to ensure privacy. Participants have either been identified as tāngata whaiora (TW) or whānau (WH) participants. The number of participants from each group who commented on each theme, and the total number of comments, are presented in the tables summarising each category.

Table 11: Summary of Five Categories and Themes Derived from Tāngata Whaiora and Whānau Interviews

<table>
<thead>
<tr>
<th>Categories</th>
<th>(1) Admission Process</th>
<th>(2) Admission Experience</th>
<th>(3) Therapeutic Environment and Interventions</th>
<th>(4) Discharge Phase</th>
<th>(5) Future Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Themes</td>
<td>Police involvement</td>
<td>Support</td>
<td>Physical facilities</td>
<td>Wellness</td>
<td>Te Whetu Tawera</td>
</tr>
<tr>
<td></td>
<td>MHA and deceived</td>
<td>Anger, fear and confusion</td>
<td>Kaupapa Māori services</td>
<td>Discharge process</td>
<td>Alternative care</td>
</tr>
<tr>
<td></td>
<td>Willing</td>
<td>Memories of the past</td>
<td>People</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being unwell and distressed</td>
<td>CMHC</td>
<td>Experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interventions</td>
<td></td>
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</tbody>
</table>
Category 1: Admission Process

Five themes were derived from the category of ‘Admission Process’ which refers to the process of tāngata whaiora accessing the service and any associated barriers. The themes in this category include: Police involvement; Mental Health Act and deceived; Willing; Being unwell and distressed; and Admission via mental health services (see Table 12). Each will be discussed, along with sub-themes below.

Table 12: Themes and Sub-themes for Category 1 ‘Admission Process’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Number of participants coded (N = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police involvement</td>
<td>Restraint, assault and abuse</td>
<td>10 tāngata whaiora</td>
</tr>
<tr>
<td></td>
<td>Trauma and Fear</td>
<td>2 whānau</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20 references</td>
</tr>
<tr>
<td>Mental Health Act and deceived</td>
<td>Mistrust and Anger</td>
<td>6 tāngata whaiora</td>
</tr>
<tr>
<td></td>
<td>Resistance and Force</td>
<td>11 references</td>
</tr>
<tr>
<td>Willing</td>
<td>Safety</td>
<td>8 tāngata whaiora</td>
</tr>
<tr>
<td></td>
<td>Familiar</td>
<td>11 references</td>
</tr>
<tr>
<td>Being unwell and distressed</td>
<td>Precipitating stressors</td>
<td>13 tāngata whaiora</td>
</tr>
<tr>
<td></td>
<td>Symptoms</td>
<td>3 whānau</td>
</tr>
<tr>
<td></td>
<td>Can’t remember</td>
<td>27 references</td>
</tr>
<tr>
<td>Admission via mental health services</td>
<td>Supportive</td>
<td>6 tāngata whaiora</td>
</tr>
<tr>
<td></td>
<td>Non-adherence</td>
<td>4 whānau</td>
</tr>
<tr>
<td></td>
<td>Frustration</td>
<td>13 references</td>
</tr>
</tbody>
</table>

**Police involvement:** This theme refers to an admission following involvement with police services. Admission Process to inpatient services often involved restraint, assault and abuse of tāngata whaiora.

**Restraint, assault and abuse:** Over one-third of participants referred to an admission experience involving police where they, or their whānau member, had been restrained. This type of encounter resulted in traumatic memories of assault, harsh treatment and abuse. Verbal abuse including racial discrimination portrayed through prejudiced remarks made by police staff were a feature of such experiences.
Yes they to the Auckland police station… they told me to shut my mouth and get my black arse in there and they pushed me back in the cell (Hori, TW)

The cops arrested me, took me away, treated me like shit the whole time. I had one English cop going “oh you fucken little bastard, you fucken little bastard” (Mani, TW)

**Trauma and fear:** The negative experiences of tāngata whaiora directly related to police involvement during Admission Process resulted in considerable trauma and fear for all. All participants reported frightening experiences associated with perceived life threatening encounters and a fear for their safety.

The police had to bring me across on a little inflatable boat… I said “oh hey it looks pretty rough out there” … He said “nah you’ll be alright, you’ll be alright”… it was rough as it must have been about 3 to 4 metre swell …the trip it was really bad it was so traumatic, because when they put me on the boat they put me up the front of the cab in the plastic cuffs, the tie around ones, and then strapped me to the seat…the cop be said to me “you’ll be right mate, someone will come and get you” and I said “well, that’s very reassuring considering we got out on this rough water”. There was two of them there but none of them sat near me, I just sat there by myself … the boat was going boom, boom, sometimes he had to stop because it was so deep and I was spewing everywhere…I handled it for about 10-15 minutes…and in the end I started yelling out, “wow, wow” because it was starting to cut into my hands and the lady came down and said “are you alright?” And I said “does it sound like I’m fucken alright?” I said “no I’m not alright!” and I said “can you please cut these off? These are really hurting.” And my hands were red as, my wrist red as and so she cut one off, she tried cutting the next off but she couldn’t get that off … I said “do you know what would happen if this boat tipped over?” “You would never get me out of here, ever (Hori, TW)

…we were under ground down in the cells and that was traumatic, I took four days in ICU to get over that. That was traumatising…that was probably the darkest period of my life so far, locked up in that cell there (Mani, TW)

**Mental Health Act (MHA) and deceived:** Participants admitted under the MHA with a compulsory treatment order described feelings of being deceived and betrayed by those responsible for their care and safety. Frequent reports regarding negative emotions were
made, specifically related to anger and a loss of trust in caregivers and mental health clinicians.

**Mistrust and anger:** Emotions of mistrust and anger were described by most participants admitted to TWT via involuntary processes reportedly involving coercion.

I trusted them…I thought they were bringing me to the hospital to look at my arm…they tricked me, they really did…I felt angry once realising where I was in the mental health side, so many people around…I felt angry…they said my daughter signed it but she did not…I was thinking I’m not stupid, what on earth are they doing? Somebody get me out of here, these people have got it all wrong, mentally I’m ok (Hinehou, TW)

My key-workers came out and I said to them “I don’t trust yous, you bought me here on false pretenses, you said that I’ll be going home with you”. Yes so basically they lied to me. They knew I was coming here, and they knew I was going to be sectioned, they knew I wasn’t going back, they didn’t explain the processes. I felt betrayed and lied to and it felt horrible (Hori, TW)

**Resistance and force:** One tāngata whaiora participant reported force by way of restraint during his admission under the MHA and compared his experience to that a prison confinement.

When I got here four guys jumped on me and gave me an injection…I spent 2 weeks in ICU…it was hard aye Julie, it’s like a jail with the doors locked…I was under the MHA so couldn’t do anything…it had been 10 years since I had been in Mt Eden (prison), it reminded me of that…being under the MHA is like doing a life sentence…might as well be aye…section 16 the judge always believes the doctor before me though (Dave, TW)

**Willing:** Despite the admission resistance of some tāngata whaiora to the inpatient service, some participants reported a willingness and described an internal sense of acceptance driven by the goal of achieving wellness.

I said I want to go to Te Whetu Tawera because I knew I was sick and needed to get support to stay safe (Ashley, TW)
**Safety:** Four participants described the environment as a safe place which was associated with an acceptance of an inpatient service admission.

I was admitted to TWT by my key-worker and my psychiatrist at my CMHC. They had been called around to our house because I had talked about harming myself, surprisingly they were there really fast, they put me under a section and told me they were going to put me into TWT to monitor me…I didn’t know anything about the MHA but thought okay if it’s for my own benefit then that’s okay cause I was feeling quite edgy and frightened and things, so yeah, the way she put it sounded as though it was for my own benefit and my own wellbeing which was good (Materoa, TW)

**Familiar:** Some participants were accepting of the admission as they had previous involvement with the service and found the familiar environment positive in supporting whakaoranga.

I was relived in a way coming here (TWT). I knew that I was going to get help and they would be administering my medication like last time I was here (Josh, TW)

**Being unwell and distressed:** Participants of this study often became quite emotional and tearful when discussing their level of distress and despair prior to their inpatient admission. Some of the participants reflected upon the experience of being unwell and distressed during the admission phase to TWT, recalling stressors and symptoms.

**Precipitating stressors:** Many of the participants displayed insight into their difficulties and were able to identify the stressors precipitating their distress and subsequent admission into TWT. Common factors were associated with grief, exposure to violence, whānau stressors, financial difficulties and drug use.

Well it all started with my cat passing away, I watched her get put down, I saw her last breath and my the girlfriend she wasn’t really understanding me, how I felt, I tried to tell her how I felt but she was too young so yeah we were on and off. I don’t like violence at all and two weeks before my admission I witnessed an axing, someone getting axed, and that really blew my mind away…Yeah, that really freaked me out and I started using lots of drugs to get rid of that image in my mind so I
started smoking methamphetamine and I was up for about two days, it didn’t help, it didn’t help me at all, I just felt more depressed and when I came off it I just felt more depressed (Josh, TW)

There were lots of whānau stressors and pressure...our car was stolen, I had issues with employment grievances, financial stressors...she never liked the medication she was on...when she got sick we didn’t even know what it was...her workload had intensified, she started thinking strange thoughts, seeing images of cut up bodies, crying a lot and she just got progressively worse...I found it so frustrating cause I didn’t know what to do or what it was. We tried taking time-out and went away up north but nothing seemed to help (Junior, WH)

Symptoms: Some of the participants discussed their experience of extreme distress and were able to identify specific symptoms they had experienced. A number of participants related their distress to spiritual cause whereby their wairua had been negatively impacted.

I started hearing people’s thoughts, what they were thinking about, so I knew there was something up with my wairua (Jamie, TW)

Other participants noticed a change in their mood consequently impacting upon their behaviour.

It was then I realised that I wasn’t normal, that I was manic or whatever you call it, and then I thought oh yeah I’m going through another breakdown...I thought oh yeah, I’m here cause I’ve lost the plot again, I’ve gone unwell (Rahui, TW)

I was suicidal and I tried to commit suicide twice (Luke, TW)

Command auditory hallucinations were reportedly experienced by a few participants.

I actually was in mental health because they prescribed...(sobbing)...they prescribed medication that I hadn’t been taking, how do I explain it? There were thoughts in my mind there and voices yelling at me telling me to kill (Ashely, TW)
And one incident involving violent behaviour as a result of extreme distress was reported.

I assaulted someone, a close friend of mine, and I broke his jaw, I just flipped, I just … I pinned him down and broke a couple of his teeth off, when I realised what happened I just left and ran home, I left it for a couple of days… we were close, he didn’t expect to see that side of me…I felt a bit sad and depressed cause I did that to my mate, I was pretty down (Issach, TW)

**Can’t remember:** It was also common for participants to have difficulty recalling the experience of being unwell and distressed.

My daughter, um I had a break down and got her to ring the doctor and then... I can’t remember, I’m getting better now and, and I have forgotten what I was like. You know what I mean? I wasn’t very well…I don’t really remember coming into hospital, I was too far gone (Edith, TW)

**Admission via mental health services:** Some tāngata whaiora were admitted via a CMHC, or crisis team, or with input from a key-worker. Some described positive experiences, finding the community services supportive.

**Supportive:** Reportedly, CMHCs were supportive during the inpatient Admission Process phase of admission to TWT for some tāngata whaiora and whānau participants.

My therapist contacted the CMHC on my behalf, and between the two it came to me going to A&E… I waited there with two people from the crisis team and there they spoke to me about what was happening, that whole process from A&E to TWT was about three and a half hours…I felt like quite a long time to wait, I was pretty anxious, not too sure about what was going to happen, and if I didn’t go into TWT what would happen to me then. I was feeling really unsafe, wanted to harm myself, so that’s why I was anxious while I waited… I did have nursing staff coming and making sure I was okay, that was reassuring with the man from the CMHC (Hoani, TW)

My key-worker told me about TWT. They just said they’d look after you and it’s gonna be a different atmosphere but you know the doctors and the nurses from the CMHC were totally supportive and optimistic (Luke, TW)
**Non-adherence:** Some participants were admitted to TW as a result of non-adherence with treatment plans.

I missed an appointment and they were looking for me, with my community key-worker, then they told me I had to go into hospital cause of what had happened, I didn’t really feel like coming in cause I had just come out of Mason clinic, they just told me straight up that I’m going into Auckland hospital, I just said okay, they sectioned me, my doctor. It sort of bit me hard, after that meeting, probably an hour and a half I was in hospital, it was fast, the crisis team brought me here cause dad had rung them I think (Issach, TW)

**Frustration:** In addition to the positive experiences with community services, some tāngata whaiora and whānau described frustration associated with a lack of urgency from clinicians and not ‘being listened to’ and consequently feeling ‘unheard’.

Well I actually tried to ring the doctor at the CMHC and I got the new location but when I tried to go there I was just going round and round in circles, it was so difficult to find... when I finally found it I was like, mate, I want to see someone and he said well mate you got to sit over there and wait...I was thinking, well what are we waiting for, why are you making me wait for when I’m sick aye! (Hamiora, TW)

I hit the nurse because I’m so protective of my mum, mum was trying to tell the nurse what was happening and she sort of laughed and thought it was a big joke saying “there’s nothing wrong”. It felt like the nurse wasn’t listening to mum, that made me get angry, I sort of kept quiet for a while and when she didn’t listen to mum I lashed out, it was tough, I punched her in the head I think it was, pretty bad stuff...maybe if she listened to mum, just talked to her and sorted it out it would have been okay...the nurse went back to the CMHC and they filed for me to go to court, they called the cops and they came here and arrested me and brought me here (Jasmine, TW)

A number of participants reported difficulty getting community support when they needed it.
I was pissed off. I rang the CMHC and they said “we have to see him before we get medication” which is bull shit you know… I was pissed because all someone had to do here was look up his medication, see what worked, and double it, say here’s your emergency pack… you know, and like I firmly believe that the quicker you bring him back down to earth the better it is for everybody right (Brian, WH)

His mental state deteriorated, I noticed so starting liaising with the CMHC, but he was considered well by them, he was under GP care at the time. I kept in touch by visiting, his neighbours who became more concerned, he had no food and they hadn’t seen him for 2 days a nosy friend said. He was left in the community quite unwell for a while with no extra clinical care from the CMHC (Macie, WH)

Category 2: Admission Experience

The category of ‘Admission Experience’ refers to tāngata whaiora and whānau experiences of the inpatient admission process, including related thoughts and feelings. The three themes in this category were: Support; Memories of the past; and Anger, fear, and confusion (see Table 13). Each will be discussed, along with sub-themes below.
Table 13: Themes and Sub-themes for Category 2 ‘Admission Experience’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Number of participants coded (N = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>Positive Whānau support</td>
<td>7 tāngata whaiora; 2 whānau 11 references</td>
</tr>
<tr>
<td></td>
<td>Negative Whānau not informed of admission Lack of support</td>
<td>6 tāngata whaiora; 3 whānau 9 references</td>
</tr>
<tr>
<td>Anger, Fear and Confusion</td>
<td>Force</td>
<td>9 tāngata whaiora; 5 whānau 27 references</td>
</tr>
<tr>
<td></td>
<td>Deceived</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fear of the unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uncomfortable</td>
<td></td>
</tr>
<tr>
<td>Memories of the past</td>
<td>Positive A familiar environment is comforting</td>
<td>3 tāngata whaiora; 3 references</td>
</tr>
<tr>
<td></td>
<td>Negative Painful</td>
<td>3 tāngata whaiora; 1 whānau 5 references</td>
</tr>
</tbody>
</table>

**Support:** Participants reported both positive and negative experiences of support during their admission phase to TWT.

**Positive:** Almost one-third of participants reported positive experiences of support.

**Whānau support:** The involvement of whānau during admission to TWT was seen as supportive by many participants in providing a sense of security and comfort.

*It was securing with my mum there cause I didn’t want to be separated from my mum cause they might do something to me if I’m in that sort of state, quite fragile… when mum went home it felt strange cause you don’t know who they are and what they want from you but I felt safe cause I knew that Ibowa was with me and he gave me the mana and the wairua to deal with these issues and if anything, out of this, I’ve become a lot stronger to God, to Ibowa I have a connection to him (Jamie, TW)*

*I went with her to the hospital, it was a little bit better than what I thought it would be, people were randomly screaming and having fags outside…I grabbed a blanket, cuddled her and sung some praise and worships songs (Junior, WH)*
Negative: Almost one-third of participants reported negative experiences of support during the inpatient admission phase.

Whānau not informed of admission: Some participants described negative experiences associated with the lack of whānau involvement and support as whānau were unaware of the admission to TWT.

None of our whānau were at her admission to hospital because she had come in straight from her supported accommodation, we hadn’t been contacted…there was only the staff member there from her home…this was very traumatic for our poor whānaunga (Barb, WH)

Lack of support: Negative experiences were also recalled when there was a lack of support for participants during the admission to TWT. A lack of whānau support caused further distress, trauma and sadness for tāngata whaiora and whānau participants.

I was sad, I didn’t even know he was in hospital at first or what he had done to himself; I felt horrible when I found out (Queenie, WH)

Mum didn’t come with me, she just came later on in the night…it was the cops and two of the nurses that brought me here to TWT, I had calmed down and was crying in the back of the car, crying for mum and my family (Jasmine, TW)

Some participants offered suggestions of how issues related to a lack of support could be better managed and improved by ensuring the inclusion of supportive people in the process. A familiar person such as a key-worker was recommended as an area where support could be accessed.

I was already anxious about all the uncertainty and not sure whether I could trust them I was very suspicious of everybody, I guess I was just being polite and saying hello when they spoke to me but I didn’t want to give any other information, a big element of mistrust…I had put up a big wall and not wanting to share any personal information. To feel less anxious and suspicious…if I had of actually gone with my key-worker it would have made a big difference…I didn’t want whānau to
take time off work and for things to go around their work about their whānau, the big thing of having to ask his boss for time off would have been hard (Materoa, TW)

Access to support from a kaupapa Māori service and / or Māori staff were also identified as areas of support for tāngata whaiora and whānau during the admission phase of admission.

I knew they were taking me to hospital, my whānau worked there (Kai Atawhai in the medical hospital)...so I asked can you get me Kai Atawhai please...“no they’re not on duty” is what a psychiatrist said... If they would have got somebody from Kai Atawhai who would have understood the situation, yes I think it would have been entirely different, they just didn’t want to know (Hinehou, TW)

In the admission room they could have had a Māori person, maybe a beautiful wahine person to sit down and talk because, I know it sounds strange but when your in that sort of state you wouldn’t hit anybody especially somebody as beautiful as yourself, then the Māori can trust the Māori as well as the Pākehā (Jamie, TW)

**Anger, fear and confusion:** Almost half of the participants interviewed reported experiences of anger and frustration about their admission to TWT related to the physical force applied; and deception during the process.

**Force:** A number of participants reported negative emotions such as fear and anger following interventions involving physical force.

I got into ICU...they were trying to get me into one of those rooms like a cell,a seclusion room and I refused cause that brings back memories... I felt angry...I was thinking I’m not stupid, what on earth are they doing? Then they tried to get me to take some tablets and if I didn’t they were going to give me an injection...I said I’d get my lawyer...they kept saying oh no...That was making me really angry (Hinehou, TW)

**Deceived:** The sense of deception also contributed to negative admission experiences for tāngata whaiora and whānau.
Not a good feeling at all going to TWT. I was feeling angry because that lady didn’t even know who I was and she sectioned me for whatever reason it was she sectioned me for. And the reason being, she said was because people had been ringing her up, instead of actually coming and seeing me, talking to me. There was my key-workers and the doctor and me in the assessment, it was very unsettling, the way they were. She was asking the questions, all the time (Hori, TW)

**Fear of the unknown:** Tāngata whaiora and whānau reported experiences of fear and discomfort during their admission to TWT in addition to the extreme distress they were already experiencing, further compounding their difficulties.

I was already anxious about all the uncertainty and not sure whether I could trust them. I was very suspicious of everybody. I guess I was just being polite and saying hello when they spoke to me but I didn’t want to give any other information. A big element of mistrust. I had put up a big wall and wasn’t wanting to share any personal information (Materoa, TW)

**Uncomfortable:** It was a common experience for tāngata whaiora and whānau to feel discomfort during the western admission assessment process.

We went in and there were heaps of them, heaps of Pākehā doctors, cause at that time they did not introduce me to the Māori side here, it was all Pākehā’s. It was uncomfortable cause they were all firing questions at me. Doctors Pākehā woman and a Pākehā man, I was answering their questions but in a high buzzing state (Rahui, TW)

**Memories of the past:** Many participants reported memories of previous involvement with mental health services, during their initial contact with TWT, which resulted in both positive and negative feelings towards the service.

*Positive:* Positive experiences were related to:

*A familiar environment is comforting:* Some participants described the familiar environment as comforting following a previous positive experience with mental health services
The last time I was here it was really supportive so I felt positive being back…my history of TWT, and my experiences here have always been good ones (Hoani, TW)

Coming to TWT it felt okay…it’s cause last time it was quite caring, even though you might not think they care they do actually care you know, like my nurses checking on me every so often, even when I’m napping (Maui, TW)

Negative: However, memories of past involvement with mental health services also resulted in negative experiences for many participants

Painful: For some participants painful memories associated with mental health services were recalled.

I was nervous, I was stuttering…it was kind of scary, cause of memories of last time when I had been here and I was really unwell (Dominic, TW)

For a number of participants, painful mental health service memories were related to those shared with whānau members.

It brings back memories, my mother was in a place like that for five years and I just cannot stand those doors…I always remember mum shutting those doors and looking at me and saying I love you daughter, it’s painful (Hinehou, TW)

I have been in mental hospitals before but only visiting my brother and that was 15 years ago…he was psychotic and he had a bit of an episode and he was very sick so I was the one who went to see him nearly every day…it just brought back memories and I thought “what am I doing here?” (Hori, TW)

Category 3: Therapeutic Environment and Interventions
The category of ‘Therapeutic Environment and Interventions’ refers to the experiences of tāngata whaiora and whānau regarding the effectiveness of the TWT environment and interventions in supporting their recovery and whānau ora. This category has been divided into five broad themes including: Physical environment; Kaupapa Māori services (Kai Atawhai te ao turoa; Kai Atawhai staff; Kai Atawhai support); People (staff; whānau; other
service users); Experiences (open ward; ICU; relaxation and time out; boredom; beliefs; safety); and Interventions (positive and negative) (see Table 14). Each will be discussed, along with sub-themes below.
**Table 14:** Themes and Sub-themes for Category 3 ‘Therapeutic Environment and Interventions’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Number of participants coded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical facilities</strong></td>
<td><strong>Positive</strong></td>
<td></td>
</tr>
<tr>
<td>unexpected physical facilities</td>
<td>Location</td>
<td>3 tāngata whaiora; 3 whānau</td>
</tr>
<tr>
<td>unexpected physical facilities</td>
<td>Unexpected</td>
<td>10 references</td>
</tr>
<tr>
<td>unexpected physical facilities</td>
<td>Comforting</td>
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</tr>
<tr>
<td>unexpected physical facilities</td>
<td>Kai</td>
<td></td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td>Kai</td>
<td>7 tāngata whaiora; 3 whānau</td>
</tr>
<tr>
<td>unexpected physical facilities</td>
<td>Cleanliness</td>
<td>12 references</td>
</tr>
<tr>
<td>Kaupapa Māori services</td>
<td><strong>Positive</strong></td>
<td></td>
</tr>
<tr>
<td>- Kai Atawhai te aotearoa</td>
<td>Mauri tau/relaxed/Ha a koro ma e kui ma/cultural heritage</td>
<td>5 tāngata whaiora; 4 whānau</td>
</tr>
<tr>
<td>- Kai Atawhai staff</td>
<td>Whakawhānaungatanga (relationships/connectedness)</td>
<td>15 tāngata whaiora; 8 whānau</td>
</tr>
<tr>
<td>- Kai Atawhai staff</td>
<td>He tāngata manaaki, atawhai (caring, helpful to others)</td>
<td>34 references</td>
</tr>
<tr>
<td>- Kai Atawhai support</td>
<td>Admission</td>
<td>14 tāngata whaiora; 2 whānau</td>
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<tr>
<td>- Kai Atawhai support</td>
<td>Therapeutic intervention</td>
<td>28 references</td>
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<tr>
<td>People</td>
<td><strong>Positive</strong></td>
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</tr>
<tr>
<td>- Staff</td>
<td>Helpful</td>
<td>10 tāngata whaiora; 3 whānau</td>
</tr>
<tr>
<td>- Staff</td>
<td>Manaakitanga</td>
<td>30 references</td>
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<tr>
<td>- Staff</td>
<td>Supported</td>
<td></td>
</tr>
<tr>
<td><strong>Negative</strong></td>
<td>Busy</td>
<td>3 tāngata whaiora; 3 references</td>
</tr>
<tr>
<td>- Whānau</td>
<td>Recommendations</td>
<td></td>
</tr>
<tr>
<td>- Whānau</td>
<td><strong>Positive</strong></td>
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<td>- Whānau</td>
<td>Whānau hui</td>
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<td>- Whānau</td>
<td>Recommendations</td>
<td>8 references</td>
</tr>
<tr>
<td>Negative</td>
<td>Confused</td>
<td>Informed or not Recommendations</td>
</tr>
<tr>
<td>- Other tāngata whaiora</td>
<td>Friendship</td>
<td>Understanding others distress</td>
</tr>
<tr>
<td>Positive</td>
<td>Extreme distress</td>
<td>Difficulties Theft Noise</td>
</tr>
<tr>
<td>Experiences</td>
<td>Freedom Transition</td>
<td></td>
</tr>
<tr>
<td>- Open Ward</td>
<td>Restrictions</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>Secure</td>
<td></td>
</tr>
<tr>
<td>- ICU</td>
<td>Unsafe Mistrust Restricted</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>Mauri tau/Peace and quiet</td>
<td></td>
</tr>
<tr>
<td>- Relaxation and time out</td>
<td>Nothing to do Recommendations</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>Tapu Resistance to Pākehā system</td>
<td></td>
</tr>
<tr>
<td>- Boredom</td>
<td>Reassurance</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>Harassment Drugs Assault Recommendations</td>
<td></td>
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<tr>
<td>Interventions</td>
<td>OT recovery programme Psychological therapy Medication</td>
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<td>Positive</td>
<td>Medication Restraint Diagnosis OT recovery programme recommendations</td>
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**Physical facilities:** Tāngata whaiora and whānau discussed the therapeutic nature of the *TWT* environment in supporting or inhibiting recovery. Both positive and negative aspects were reported.

*Positive:* Some participants reported positive aspects of the physical facilities of *TWT* which were related to a number of key areas.

**Location:** Some participants associated positive aspects of the physical environment with the location of the service, conveniently situated near a large domain with access to nature such as large fields; manicured gardens; walking tracks; and a duck pond.

> Being close to the domain is nice, we could go for long walks and go to nice cafes, it felt as though she was still a part of the real world (Junior, WH)

> It was convenient being next to the domain, we went out walking with her, her physical health was benefited, it gave her a sense of freedom, she became more content with herself (Pete, WH)

*Unexpected:* For some participants the positive aspects of the physical environment of the inpatient service were unexpected in comparison to the traditional mental health institutions they had visualised.

> It's a wonderful environment, modern, clean, there was nice artwork, it didn’t seem like an institution. The staff were really good, we would come in so often that they knew us…it’s not what I expected, I thought it would be like “one flew over the cookoo’s nest” but it’s not! (Leah, WH)

**Comforting:** A number of participants found the regular routine of the service to be comforting with scheduled meal times and recovery programme activities.

> The good things were the regularity of the timing of everything, breakfast, lunch, dinner (Materoa, TW)

> Our daily routine has been helpful (Issach, TW)
The OT room was great for him, he enjoyed yoga, relaxation, thai chi, it was the first time he had ever tried it at the hospital, he loved it...it was really good to hear him being positive about something...it has now sparked an interest for him in martial arts (Leah, TW)

**Kai:** A few participants commented on the positive aspects of the meals provided.

*The food was really nice, it tastes good, the meals are real nice (Jamie, TW)*

And identified the importance of ensuring physical health for overall wellbeing.

*The kai, the kai was great, because on the outside all I usually have is peanut butter, jam and bread that’s all I have, and coffee, and the rest of my money goes on rubbish, smokes etc… I’ve put on 5kg since I’ve been here. Good kai keeps you well mentally, good kai actually helped keep my mind well (Pita, TW)*

**Negative:** In addition to the reported positive aspects of the physical environment, one-third of participants described negative aspects. General comments were made in related to:

*The beds are really uncomfortable, they are heavy and stiff, which makes it difficult to sleep and relax (Materoa, TW)*

And,

*The phone booth thing, this was a real privacy issue (Junior, WH)*

**Kai:** Although some participants made positive comments about the kai within the inpatient service, an equal amount of participants provided negative reports of the kai and made suggestions for improvements to the service menu. A number of tāngata whaiora and whānau felt that more substantial meals would be beneficial with specific feedback calling for the inclusion of ‘Māori kai’.
...the lunch is always sandwiches, they suck, they have a soup but it's watery, nothing solid, you know what Māori's are like, love their kai (Rahnui, TW)

The worst food I've had was here in hospital, all I wanted was rewana, fried bread and boil up (Dave, TW)

I would have liked boil ups, maybe even a hangi, it would have felt more like home for me (Dave, TW)

Cleanliness: The issue of cleanliness was reported by many tāngata whaiora and whānau participants as a negative area of the inpatient environment in urgent need of attention.

I got a little bit of a fright because of the mess…everybody smoking and chucking butts on the ground …I don’t like paru-ness (dirtiness), it makes me sick (Hamiora, TW)

We thought the hospital was paru (dirty), smokes butts lying around and quite dirty and smelly (Barb, TW)

Kai Atawhai te ao turoa: The majority of tāngata whaiora and whānau participants shared positive views of the therapeutic nature of the Kai Atawhai physical facilities such as the whare kai and whare hui.

Positive: All participants described these facilities in a positive light. Such experiences reportedly had a positive relationship on one’s recovery and whānau ora being, viewed as a cultural environment well suited with the cultural identity of the participants that they could relate to and feel comfortable in. Encounters of feeling connected to their Māoritanga, and the soothing of one’s wairua were reported.

Mauri tau (relaxed), turangawaewae (safe), ha a koro ma e kui ma (cultural heritage): The sense of safety and cultural connectedness provided within the Kai Atawhai te ao turea reportedly provided participants with an environment to relax and was often described as a sanctuary.

Once I came through to the open ward I came to Kai Atawhai, I come here all the time, …this is
like being at home, for me this is home, as soon as I go through the doors I feel safe, I home, and I only go to the wards when I have to… I feel I can’t stay out there on the ward cause there’s too much depression you’ve got people out there with all different problems where as I can come in here I can make a cup of tea, I can use the microwave, I can do all those things I can’t do out there…for me personally I find it soothing with my whānau around or here (Kai Atawhai), it’s a sanctuary (Edith, TW)

…coming from a world where its Pākehā and into a world where its Māori was the best part…I’d say the marae and wharehui were the best parts of the hospita...the pictures in the marae of Maui, Maui’s wahine and just the pictures they have inside the marae…all I wanted was little bit of peace and quiet and that’s what I got there (Jamie, TW)

Visiting Luke was fine, Kai Atawhai would meet us in the wharekai and tell us to make a cup of tea which made us feel relaxed (Leah, WH)

Kai Atawhai (facilities) it’s a sanction, I wait for the door to open, this is my sanctuary…it’s a haven for everyone…the little time we have in here is really really important (Hinehou, TW)

Kai Atawhai staff: Many participants expressed their views of the Kai Atawhai staff in TWT.

Positive: Over two-thirds of participants described the Kai Atawhai service positively reflecting upon specific characteristics of the roopu (team) members. Participants felt more comfortable to engage with Kai Atawhai staff.

Oh yeah, without Kai Atawhai here I don’t think I would have been the same to me, I think I would have just shut myself away and I have a tendency to do that, so it’s like if there’s any problems around I’ll run away…Ido like people but I do find that some of the people here are hard to get on with in the mental health ward. I’ll miss Kai Atawhai, Matua and W’haea very much (Hinehou, TW)

Engagement with Kai Atawhai staff was facilitated, at times, through cultural activities and processes.
When she was in ICU a lovely nurse would bring her out for visits to the wharehui which she really liked, we think it was quite therapeutic…she would do karakia, kapa haka, string games, poi and waiata with the Māori staff (Kai Atawhai) down there, sitting and listening to the kaumātua, having conversations with him, she loved it…I think it was a really important part in helping her get better (Barb, WH)

For one participant, just seeing a familiar face resulted in positive engagement.

I remember meeting Whaea from Kai Atawhai when I was in the whare kai, I had met her before, so it was good to see a familiar face (Edith, TW)

**Whakawhānaungatanga (relationships and connectedness):** Specific Kai Atawhai staff characteristics tāngata whaiora and whānau participants reportedly found helpful in supporting recovery were related to a number of areas. Firstly, the process of whakawhānaungatanga and the ability to work with whānau.

Some of the staff were nice, especially the Kai Atawhai staff, it was very important to have them working with my sister, the Māori staff, she felt more at home with them, it felt like having whānau there, they could connect with her (Moana, WH)

It was really important for her to feel connected with her whānau because they all live so far away but do come and visit when they can…the Māori staff helped by keeping in touch with the whānau and she felt really comfortable with them (Pete, WH)

And secondly, participants reported a sense of connectedness with Kai Atawhai staff.

Oh everything here at Kai Atawhai has supported my recovery, they’re my family, they have been while I’ve been here with no body else (Ashley, TW)

Having someone Māori she can talk to made Materoa feel safe, in a sense it was like having an aunty there (Junior, WH)
The sense of connectedness with Kai Atawhai staff was reportedly related to both iwi connections and the sense of a shared world view based firmly in te ao Māori (the Māori world).

...the best thing that I know that they’re from the same iwi which helped, I felt really comfortable being around my whānau but even though I had never met them but it was good to be around someone that knows where I’m from and thinks the same as me, Māoritanga, tikanga Māori, it was so cool to have that service of aroha around for me (Jamie, TW)

He tāngata manaaki, atawhai (caring, helpful to others): Specific Kai Atawhai staff qualities related to a caring and nurturing trust were associated with kanohi kitea (face to face) contact, such as visiting tāngata whaiora on the wards; having a positive attitude reflected in a smile; and a gentle caring approach towards participants displaying arohaina. Furthermore, participants reported that support during the admission to TWT for both tāngata whaiora and whānau was portrayed through comforting experiences with Kai Atawhai staff such as being welcomed; seeing a Māori face; and showing aroha. Contact and interaction such as kanohi kitea was viewed as a caring staff approach.

...it just feels like someone cares, I've never felt intimidated by Matua, I've always felt a gentleness about him, I think it’s because he’s Māori and that’s the type of person he is (Hoani, TW)

Participants experienced connectedness and trust through engagement with Kai Atawhai staff.

Some of the people there were cool like Whaea, having someone Māori she can talk to made Materoa feel safe, in a sense it was like having an aunty there, someone that trusts in that systems and makes her feel safe (Junior, WH)

Whaea she was so cool to me, such a lovely person. When I was in ICU she was there, she was happy, she just made me pick myself up...She was just a beautiful person, she was full of love and she wanted to help and I could see and she was always there for me, you know when I was being a
bit mischief but I’d tell her any way cause I trust her and she’s just cool aye, I really like her aye, and Matua (Jamie, TW)

*He tāngata aroha ki te tāngata* (concerned for others): A genuine empathy and understanding was an attribute to *Kai Atawhai* staff perceived as positive. More specifically, tāngata whaiora and whānau experiences related to kanohi-ki-te-kanohi (face to face) contact, open and respectful communication (simply being asked how one is feeling), and staff presenting a positive attitude provided participants with an approachable face.

Whaea from *Kai Atawhai* is good she’s very caring, talking to me…a very caring person, it makes me feel good! Yeah she always asked how I was getting on…. we would sit down and have a chat (Edith, TW)

*Kai Atawhai* staff reportedly displayed positive attitudes and were approachable.

*Kai Atawhai* they know her. We got good support from Whaea…I think it’s her personality, it make you feel better, it’s really good for families…she is always happy, smiley, always smiling, always got encouraging words…even though you have a problem, when you see Whaea and see her smiley face it makes you feel better…she is really approachable (Aroha, WH)

Participants found *Kai Atawhai* staff supportive.

They’re (*Kai Atawhai*) always here, they’ve always been here on my side. When I met with the doctor and the team I was here and then *Kai Atawhai* came in and the thing is, the doctors and nurses were all sitting on the other side (of the room) and I was sitting here (on the other) and when *Kai Atawhai* came up and sat right next to me you know, tautoko hard…it made me feel like a Māori aye you know like I’m a Māori hard-out, it’s just primo, like they’ve always got your back (Luke, TW)

*He tāngata pukuaroha* (sympathetic, understanding): The qualities of effective communication including listening; being understanding; and non-judgemental in style were seen as important for participants.
Kai Atawhai, he could understand where I was coming from just by listening...they helped get furniture for my new place (Dave, TW)

Having the Māori team onsite was excellent, excellent, it's really good to have...they've helped me so much, most of my help has been from them, they've always been there for me, they provide a unique service, they really care and are understanding, listening and all of that (Hori, TW)

The understanding nature of Kai Atawhai staff was valued by participants.

Looking back now we think that the hospital was really good in meeting our whānau needs, keeping in touch with us about what was going on for her, and giving us updates all the time...the staff were all supportive, especially the Māori team, they really understood what we were going through and supported us (Barb, WH)

A non-judgemental approach along with providing reassurance towards participants was also valued by participants.

At time's I wondered where I had gone wrong in parenting him for him to end up like this...Kai Atawhai provided me with reassurance which is what I needed at the time, and let us know that this type of mental illness can be temporary which was so good because we thought he would be like this forever. The Māori unit, Kai Atawhai, they were absolutely fantastic (Leah, WH)

*He tāngata pumahara, pukenga (thoughtful, wise, skilled):* Such characteristics in this sub-theme relate not only to kanohi ki te kanohi interaction, but also the way in which situations are dealt with. Kai Atawhai response to participants needs, such as being quick to action and address needs (such as accommodation and housing difficulties) and other broader social issues were important for tāngata whaiora and whānau participants.

It was major, I'm not sure about the meds he got there, but the care he got, having access to professionals, liaising with Māori mental health service like Kai Atawhai, they were really easy to approach, quick response, they attended meetings and then supported the process of investigating alternative accommodation options (Macie, WH)
Well Kai Atawhai staff always greet me in the right way, that’s what I like about them, they always acknowledge me…Kai Atawhai have been helping sort out stuff with my accommodation and organising someone to look after my cat so I don’t have to worry, that has been really good for me, no stress now (Hamiora, TW)

Possessing the appropriate skills and expertise, both clinical and cultural knowledge encompassing a holistic approach, was also seen as a beneficial attribute of Kai Atawhai staff.

She (Kai Atawhai staff member) knows where I’m from, she thinks the same as me, you know, our Māoritanga, tikanga Māori (Jamie, TW)

They (Kai Atawhai) understood the importance in healing my wairua (Hori, TW)

**Whakamana (empowering):** Participants were supported to engage in activities and with services that support their cultural identity development. Kai Atawhai provided positive affirmation, kindness, and advocacy which were seen as crucial in nurturing this process. Supportive interventions included cultural therapeutic specific interventions such as karakia, string games, poi, and waiata. Engaging in cultural interventions enhanced the sense of cultural identity and spiritual healing for many providing a distraction from their distress as well as an opportunity to learn new skills.

The Māori team Kai Atawhai were Hamiora’s voice in front of the clinical team, he felt very comfortable with them, it was very empowering having Kai Atawhai support…he was always looking to discover his identity, I’m positive that this admission and his closeness with Kai Atawhai had an impact on him…it was a wake up call. He got into discussions with Māori mental health services in the community and Kai Atawhai were able to explain to him that the service offered a lot more than just playing rugby. He even got to meet them while he was in hospital, it was really good. He then went to the Māori community service and had a powhiri there, it was wonderful! (Macie, WH)
Whaea from Kai Atawhai she was just talking to me about how life is, just to believe in myself and it sort of gave me confidence, you know what I mean. Kai Atawhai is cool as, always friendly and they always say hi when they visit the wards. They’re just nice, not mean (Madison, TW)

**Kai Atawhai support:** Many participants valued the specific support offered by Kai Atawhai during the admission process.

First time I got into the admission room…it was good having Kai Atawhai here, a Māori person, I feel comfortable with it, yeah I feel comfortable about myself more (Issach, TW)

During the admission Kai Atawhai were fantastic, supporting all of us, Luke and the family. They were non-judgemental and just talked about anything really, we found them very supportive (Leah, WH)

**Kai Atawhai therapeutic interventions:** Some participants discussed the usefulness of a holistic approach and specific cultural therapeutic interventions (such as karakia and weaving) offered by Kai Atawhai. The intervention of karakia was reported by many tāngata whaiora participants as useful in supporting recovery.

…church in here, karakia every day, church on Sundays in the spiritual room, I found this was a big help for me (Hinehou, TW)

Specific Māori cultural activities with Kai Atawhai reportedly provided a useful distraction from distress and assisted with concentration difficulties.

Yes I’m a Māori but can’t even speak the reo but I love coming to morning prayer, karakia, I love coming to karakia, I sometimes forget for some reason but when I do come its awesome…yes karakia, but I would always forget…hopefully I will remember in the morning…I need reminding in the morning… Kai Atawhai it has helped me more than the Pākehā side, everytime I see a Māori I think yes a Māori, yes aroha, spiritual healing, tendercare, loving, care, aroha, aroha, aroha…and when I’m on the Pākehā side it’s “here’s your medication” “you can’t do that” but
when I come in here aroha, aroha aye, the Māori side of this mental institution has helped me more than the Pākehā side (Rahui, TW)

I like doing weaving and stuff, I’ve been going into Kai Atawhai for that kind of stuff, it helps me to use my concentration on doing something, making me focused on doing something different, that helps me, I learn things like that from different people…since I’ve been in the open ward I’ve been able to get Kai Atawhai to get me some harakeke (flax), I’ve been making little lighter bags… since I’ve been in hospital I’ve used those skills to distract myself and refocus my attention…it’s helped a little bit, it’s given me a bit of space and time to heal, to think about things (Issach, TW)

Negative: Despite many positive participant reports of the Kai Atawhai service, some participants reported negative experiences with the Kai Atawhai service and suggestions were made on how to address these issues

Busy: It was common for participants to describe the Kai Atawhai service and staff as ‘busy’, and at times this limited tāngata whaiora and whānau access to kaupapa Māori supports and services.

I haven’t spent much time with Kai Atawhai, there is always meetings or something, I seem to come at the wrong time (Brad, TW)

They are very, very busy, I know they can’t do and be everywhere at once, and I understand that …I didn’t get my bloody McDonalds last night and I was a bit angry but I just thought oh, don’t worry about it, you can get McDonalds any day, don’t be an egg, I don’t hold anything against them and I never would, they’ve helped me so much (Hori, TW)

Recommendations: Possibly related to the demand and ‘busy’ nature of the Kai Atawhai service, a recommendation was made (by one tāngata whaiora participant) to address inconsistencies within the Kai Atawhai cultural recovery programme.

There was a sign saying karakia every mornings, I made the decision to go regularly, I went there and there wasn’t anyone there, so I enquired to staff, I went twice and it wasn’t regular so I didn’t go back…consistency would have been good (Materoa, TW)
People

Staff: All of the study participants described positive inpatient staff characteristics and behaviour supporting recovery, along with negative attributes inhibiting recovery.

I’ve had a lot to do with the hospital staff so I don’t have any problem with them. You have good and bad in everything, it’s just like the staff there (Aroha, WH)

Positive: Almost half of the participants recalled positive aspects of TWT staff behaviour.

Helpful: Many participants found the staff within TWT to be helpful

The staff are good, pretty helpful, I got on with mostly everyone…I could joke with the doctor, he asked if I had any other questions and I said “to be or not to be” and they all laughed, it showed me that they are real people, it made me laugh seeing him laugh (Issah, TW)

I listened to sound advice from my nurses and Kai Atawhai, they explained to me how and what I needed to do to get well, like I’m the car and they’re the mechanics and they’re going to get me working again…they were clear at giving me directions too, like telling me not to do things that could put me at risk and not going into the ladies rooms (Brad, TW)

Specific mention was made regarding the helpful support of the social worker within the inpatient service.

I’ll tell you who is good, the social worker, she is excellent, she’s onto it babe…she is direct, she says it straight “you do this and then we can do that” and that’s how she works, it works well for me. We went to Kiwibank so I could get some shoes (Pita, TW)

Manaakitanga: Many participants made positive comments about the manaakitanga of the general TWT staff that supported whakaoranga. The caring actions of some staff (such as words of encouragement; support with daily activities like getting up in the morning) provided a sense of hope and feelings of being taken care of and genuine concern
from staff for tāngata whaiora wellbeing. Manaakitanga was displayed through non-judgemental actions and avoidance of labelling.

*Both doctors have been really good, I didn’t feel judged by them, they weren’t comparing me to another patient, they weren’t comparing me, the reasons how I got here, my history of addiction, history of having been in jail, history of being really transient yeah I didn’t feel that they put me into any slot or gave me any labels other than a diagnosis so I could access the CMHC. I didn’t feel as though I was being put down or given any labels, that was really important to me, it made me feel that I had as much value as the next person here, you know as a human being, that I wasn’t a criminal or some kind of addict that things hadn’t gone wrong again, I just believed yeah that* [interruption] *I feel that I had a right to be here, just as much right as the next person* (Hoani, TW)

Manaakitanga was also portrayed through encouragement, support and caring actions of staff members.

*I was drugged to the hilt, this nice lady came and asked if I was alright and if I’d like a cigarette cause she knew I smoked… she was a nurse, a very motherly person, I think I felt as though I had gone through so much stuff, I felt ashamed and all that kind of stuff, my god what’s happening to me, these people think I’m mad, I just felt so ashamed… I was lucky that nurse was there, I think I would have just given up, that’s just how I felt… she was really lovely, she said "come on darling, life’s not that bad"* (Edith, TW)

*Just being looked after… my nurses looking after me, they were concerned about me and made sure I took my meds so I didn’t slip back, even in the morning when I was sleeping they’d get me up and remind me to have my medication… yip well I’m better now, and hopefully I’ll stay out of hospital now, there were people here that helped me to get well and get me to where I am today… like the nurses* (Dominic, TW)

The respectful greeting of a hongi (traditional Māori greeting where two individuals press noses) created an instant connection between one tāngata whaiora and a staff member that continued throughout the admission journey.
I know a lot of them come under a lot of stress because of the work they do but I was able to go into the unit and be sweet with one (Pacific) staff member straight away cause be came and gave me a hongi, he made me his friend straight away …we’re like that now, we’re close, we’re very close (Hori, TW)

**Supported:** Many participants also felt supported by the TWT general staff. Interventions and behaviours of staff that made participants feel supported included a staff member cooking a boil up meal resulting in the tāngata whaiora feeling valued it makes me feel worth it (Madison, TW). The inpatient social workers supported tāngata whaiora and whānau with stressors resulting in tāngata whaiora feeling respected, being treated normally, I really appreciated that (Materoa, TW) and valued I deserve to be taken care of (Hoani, TW)

The last time I was here it was really supportive so I felt positive being back, the staff were really good, they were great, the social worker yeah he was great, they helped me find accommodation. My history of TWT and my experiences here have always been good ones (Hoani, TW)

Participants felt supported by staff that were ‘lovely’, ‘polite’, and treated them as ‘normal’.

There were a lot of staff coming and going, my nurse was lovely, oh they were all lovely…I felt it was just nice that (staff member) was very strong in her work when dealing with me, you could just feel her presence, her wairua, she was just lovely, the nurses were very, I don’t know, I guess some of them weren’t very but some were really lovely…I remember one nurse, on one particular day, in hospital I was always polite, and one nurse when I was feeling particularly stroppy one day, I threw water cup and it fell on the floor and made a mess, a nurse saw me and told me off, ‘Materoa clean that up what are you doing” and I actually appreciated just being treated normally, so I really appreciated that (Materoa, TW)

**Negative:** Despite the many positive experiences, at least half of the participants in this study recalled negative experiences with TWT general staff members.

**Shortage and inconsistency:** Many participants commented on the lack of staff and inconsistency of staff members involved in their care. Difficulties were raised in relation
to the inconsistency of nursing staff (such as the primary nurse responsible for tāngata whaiora care) which reportedly caused confusion and frustration for participants.

The nurses do work crazy hours cause there doesn’t seem to be enough of them…maybe they could even bring in like a structured roster. I see at the moment the staff don’t actually know what team they’re working on and when they arrive they have this stupid hand over time and all this sort of stuff. With the roster, it would be good to have more consistency, yeah so you know who your nurse is going to be, I keep a diary of the nurses that I’ve had and I’ve had four different nurses in two days and that really throws you (Maui, TW)

Some participants related the inconsistency of staffing with issues developing rapport with staff.

It gets a bit frustrating when the nurses are short staffed and um changing nurses all the time, id just stick to two or three nurses not having five different nurses…yeah it’s hard to try and build up a rapport with that nurse and as soon as he’s gone then there’s another nurse in there and oh no you got to start all over again (Josh, TW)

Issues regarding safety and limited contact with staff were also areas concerning participants.

The hospital seems to be short staffed, there are a lot of patients in there, it can be quite dangerous, some of the patients used to get scared…staff need to spend more one on one time with each patient (Moana, WH)

Staff need to be connected to patients, less rotation of staff, so they know them personally and what their requirements are…more attention to individual needs of patients (Pete, WH)

**Attitudes:** Many participants described negative attitudes of some general staff members and the inhibiting impact on recovery. For some tāngata whaiora avoidance was used to cope with negative staff attitudes.
…there were some that were quite cold actually, they weren’t very, oh you’d get your needs met but they weren’t all that friendly, maybe the stress or the pressure of the job, one in particular I’d try and avoid and detour to someone else a bit nicer (Materoa, TW)

One participant found it helpful to raise the issues with staff during the weekly inpatient forum meetings.

There have only been a couple of issues with the staff but then at the community forums on Tuesday everyone complained...she (the nurse) really is quite lovely but she has a stuck up attitude, but everyone was complaining about them, the same people, so it was sorted, well both the nurses are really good now, well you can’t afford to be patronising (Edith, TW)

**Poor communication:** Some tāngata whaiora and whānau participants described situations where a lack of communication had been an issue inhibiting recovery and whānau ora. A number of participants reported frustration and confusion regarding a lack of information pertaining to their treatment plan and misinformation from various staff members.

I got all frustrated not knowing what’s happening, lack of communication when the doctor says your going to the open ward today and the nurses are like no your not, that was the confusing part (Jamie, TW)

Sometimes they (staff) take too long mucking around, mucking around and I start getting angry and angrier, why should I wait? That’s what happened this morning, I was waiting for my meeting with the doctor, my nurse said “he wants to see you”. Ages later he still hadn’t come I said “you told me you were gonna bring me a doctor, that’s why I stayed up there waiting” and I was getting angry and I went bang! (Hamiora, TW)

The sense of not being ‘heard’ by staff was equally frustrating for participants.

I’ve had a few bad experiences with the staff because they don’t listen ...I’ve asked for things and they go ‘wait a minute because I’m busy at the moment,’ but a minute turns into two hours or even
four hours … It makes me feel that they’re not listening to me, I feel unheard, like someone else is more important … Like this morning, I got up and I asked one of the nurses for my shaver cause I wanted a shower. He said “give me an hour” and he wasn’t listening and he wasn’t gonna listen … And then when I went back, I went back over an hour later I said “can you get my shaver please, I need to have a shave please” and he says “oh you have to wait until the (shift) change over” then I got aggressive after that because that’s the only way I know. I think the staff here need to be a bit more honest the patient too, when they say they’re going to do something for the patient then do it, don’t make them wait (Hori, TW)

Some participants reported difficulty being open during assessment interviews with clinicians given the number of health professionals in attendance.

I’m not reluctant to open up entirely to doctors but when there’s ten people…like you’re bought into this concrete secure facility and here’s the doctor, here’s the transcriber, here’s the student cause there’s a lot of student nurses, then there’s the registrar…I don’t know, you’re sort of instinctively submissive cause you’re in here, this is their profession you know you’ve been in mental health for ten fifteen years…it made me feel inferior with them all there…I have no problem telling people stuff it’s just that I’d rather see one persons reaction rather than seven of them, I’m quite a paranoid person (Luke, TW)

**Disrespected:** A few participants described situations with general staff members where they had felt disrespected.

Oh certain staff that don’t know me and talk with disrespect as if they’re in charge of me, like the way they ask me to do stuff “come over here”, it’s not that hard to use manners and say ‘please’ and ‘thank you’… in order get respect you give respect… I feel respected when people are just sitting there, listening and not judging or taking sides (Ashley, TW)

One participant commented on how general staff could better care for and respect tāngata whaiora.
Keep an eye on the patient, making sure they’re safe and secure, making sure they’re getting better cooperating, reporting back to services to keep a look out on the patient, being aware of their individual needs, understanding what they need, what the consumer is entitled to, being respected, understood, understanding the consumer and that they are entitled to good support and help (Dominic, TW)

**Mistrust:** One participant described a lack of trust towards general staff and suggested how a specific situation may have been better dealt with.

I remember when I was in high psychosis on the first night, in was pitch black, I was asleep and heard rattling at the door, I hid my head under the blanket, and then the door opened I popped up to see and this huge light shone in my face and I thought shit they’re coming to get me, they were there for five seconds and then the door just closed, so I think it was the night watch coming to check, it was my first night there so I found that quite scary. They don’t say anything to you about it, they should just say look we’re coming to do a check at around 2am or whatever, and make sure you’re okay in the middle of the night, so if you hear us don’t be alarmed it’s just us doing our check…that would have been helpful (Materno, TW)

**Distracted and absent:** Some participants described the general staff as distracted from the job and often absent from the ward. Participants reported common situations of staff in the nurse station using the computers rather than interacting with tāngata whaiora. Such staff behaviour reflected an uncaring approach to tāngata whaiora care.

Some of staff can sit down for hours in that office, especially the night shift... they’ve got a sweet job here. Some of them are hoba...yeah well, it’s up to them aye? Whether they want to sit there all night...I mean they get up to walk around and next minute they’re back again...it makes me think that it doesn’t matter, they don’t care about us lot...all of them sitting there joking (Hinehou, TW)

I swear to God if you go to the nurses station there will be at least half a dozen nurses sitting behind a glass shield...They’re not helping the staff and they’re certainly not helping the patients (Brian, WH)
TWT staff members that appeared distracted and absent were reportedly perceived as unapproachable by tāngata whaiora and whānau.

*Some staff are cold, bossy, sour face, and don’t talk very much, they seem to be there just for the money, no interaction, you can tell they’re not really listening to you and are distracted…it’s only about one staff member on every shift, they are not approachable at all, I would never go to those ones. Communication is really important, being listened to (Aroha, WH)*

**Recommendations:** Many participants provided suggestions to address the negative experiences of tāngata whaiora and whānau with general staff. Staff behaviour that was gentle, caring, trusting and honest was suggested as positive staff attributes that would result in successful engagement with tāngata whaiora.

*Well I think you’ve just for to be gentle, got to be gentle, if you can explain it to them in a much, how would I handle it, no I don’t know if I would…I’d be really gentle and loving…very very gentle, get their trust, they need someone to love them, when your family goes it’s like who have I got…don’t ever let them think, don’t say something you don’t mean…be honest at all times, don ‘t ever say you agree to something then go …be there for them, let them, make sure they have your confidence, it’s really important (Hinehou, TW)*

A focus on the needs of individuals was also suggested by a number of tāngata whaiora and whānau participants as positive staff behaviour. Specifically ensuring safety and behaving in a respectful and understanding manner were recommended behaviours and attributes for positive engagement.

*They’re not doing enough to look at the whaiora as individuals… they need to look at the person more and see what his needs are, such as you know working by command, for example I’m not used to could you please, I’m just used to do this do that… I’m not saying be psychic but read the person. They could have done something like an assessment to find out my needs, I think they asked me when I wasn’t well, if they asked me right now I’d give them different information than when I first came in (Pita, TW)*
Keep an eye on the patient, making sure they’re safe and secure, making sure they’re getting better cooperating, reporting back to services to keep a look out on the patient, being aware of their individual needs, understanding what they need, what the consumer is entitled to, being respected, understood, understanding the consumer and that they are entitled to good support and help (Dominic, TW)

An emphasis on kanohi kitea contact was also seen as essential practice supporting recovery.

...just get out of that office and have more contact with the patients and hands on, go and sit in there and do your reports and then hands on, you got to get out there, the office ... you got to have that rapport with people, meet their needs because if you’re not meeting their needs by sitting in there and by looking out ... it would make a big difference because people will feel cared for (Hori, TW)

Some participants felt that staff recruitment was necessary to increase the availability of kanohi kitea engagement... more staff would be good too cause our whānaunga needed lot's of one on one support (Barb, WH). Furthermore, one participant suggested that staff who had experienced extreme distress themselves may be more understanding of tāngata whaiora difficulties and needs.

Have a break-down and see how it is, try experiencing some of the treatment yourself (Materoa, TW)

Whānau: Tāngata whaiora and whānau participants expressed both positive and negative views of whānau experiences at TWT.

Positive: Some participants (6) described positive whānau experiences related to open, honest communication and support from staff, the hospital have been honest with my wife about my recovery, the needs of my whānau were met 100% (Brad, TW). Close liaison with whānau who were kept informed during the inpatient admission were also associated with positive whānau experiences.
Yes they have taken care of my whānau needs, my daughter is very caring, she cares for me and from here I was supposed to go back to her whare with her tamariki, we were all for that...they kept my daughter up to date with what was happening (Rahui, TW)

Looking back now we think that the hospital was really good in meeting our whānau needs, keeping in touch with us about what was going on for her, and giving us updates all the time...the staff were all supportive, especially the Māori team, they really understood what we were going through and supported us (Barb, WH)

TWT staff that were approachable and accessible provided positive experiences for whānau.

If mum has any questions she goes straight to my nurses, the hospital has been good keeping in contact with mum, especially Veronica from Kai Atawhai, that’s who mum usually goes to see...maybe not that doctor, it happens a lot in hospital with the doctors, not listening to mum and me as a patient (Jasmine, TW)

Participants also reported experiences of manaaki tāngata and feeling well supported by TWT staff.

It was pretty good coming in to visit, the staff were very good to whānau coming in, there wasn’t high security on visitors, and then they got to know you, they looked after me, offered a cup of tea and even something to eat, they were very good in that manner, we felt welcomed (Moana, WH)

Whānau hui: Two participants commented on the usefulness of whānau hui in maintaining close liaison with staff and whānau regarding tāngata whaiora recovery progress.

We had meetings with the clinical team (green team), liaison was really good...the communication was really good, very professional frame, everything done in time, meetings were organised well (Macie, WH)

Negative: More than one-third of participants described negative whānau experiences related to confusion around the hospital stay and lack of communication
**Confused:** Some whānau reportedly required additional information regarding the recovery progress of their whānaunga, and when not informed of treatment plans felt confused and frustrated.

I don’t think anyone knew from my whānau that medication was being forced on me. Should I need help in the future, I’m not going to get that help where my husband’s concerned cause he’s lost... my husband thought he was doing the best thing for me, by getting me in here and treatment, he didn’t realise it was for my mental status, he thought it was for my heart, he was worried about me not sleeping, and that could upset my heart, I wasn’t eating...my whānau needed someone that knew the health system, by that time my whānau were all upset...my husband needed a bit more explanation so matua from Kai Atawhai was able to do (Hinehou, TW)

Supportive advice for whānau is needed, we didn’t get that (Macie, WH)

**Informed or not:** Some whānau were reportedly not informed of their whānaunga admission to the inpatient service.

None of my whānau have come in to see me, I don’t think they know that I’m here (Pita, TW)
I can’t remember having any whānau hui...I don’t think they did keep in touch with my husband, but I remember that he would come in every day so kept informed, it was really tough for him (Materoa, TW)

**Recommendations:** Some participants offered suggestions to address the issues relating to negative whānau experiences of TWT. These included: whānau being informed of recovery progress and involved in collaborative treatment planning through whānau hui.

I think that with my mum I think that they should tell her straight away what’s going on which is good so that she knows my progress so she’s not worried. I think they remember my mum she comes in and she sees the progress as well but she gets worried about me but I don’t want her to worry about me cause I can look after myself you know (Jamie, TW)
More communication with whānau is needed, and proper meetings that are not rushed (Moana, WH)

It was important for us to be told if she was out or too unwell to visit...we used to visit her every Sunday, sometimes we would go all the way there and we found that she had gone out somewhere, there was no communication with us. I blew them up, we went all the way for nothing, it was inconvenient, it happened about three times, I was so annoyed (Pete, WH)

In addition, whānau needed more information regarding the extreme distress their whānaunga was experiencing and information pertaining to additional support services.

I did a lot of research online to find out more about what was going on for her and about the services available, this was helpful, I think if I would have understood a bit more from the start of her admission I wouldn’t have been so stressed...our whānau support for Materoa was a big part of her getting well again, I was trying to be there as much as I could, when she sees me there she just relaxes (Junior, WH)

What could have been done to support him? Maybe Supporting Families would have been good if we would have known, having someone to bounce ideas...Whānau needs met? I guess so, when he came in KA would be around and she would talk to him and he would ask questions...he wanted more answers he would initiate conversation with them to find out (Materoa, TW)

Other tāngata whaiora: Tāngata whaiora and whānau participants described both positive and negative experiences of being with other service users when unwell and the influence on recovery.

Positive: Some participants described positive experiences of being around others when distressed related to social connection and friendship, as well as liaison with others sharing a similar experience.

Friendship: Social interaction and friendship of the communal inpatient services were reported as positive experiences.
Being around others in TWT is good, I’m not isolating myself, the social interaction is good, I even made a few friends (Josh, TW)

There were lot’s of advantages and disadvantages of her being there…she made lot’s of nice friends there that took care of her…I remember one lady another Whaiora that would always make her a cup of tea of ask her if she was okay (Moana, WH)

Understanding others distress: Some participants were understanding of the extreme distress faced extreme faced by other service users.

Well you have to remember that people are sick (Hinehou, TW)

Oh I don’t mind being around other that are unwell, it doesn’t get on my nerves, I know that they will get there one day, I mean it might take two or three months, it might take six months it might take more than a year but those people in ICU they’ll get through. I only wish the best for them to get better (Maui, TW)

Being in a group of people and together we’re strong and we bring each other right (Josh, TW)

Negative: More than one - third of participants described negative experiences of being around others when extremely distressed related to others level of unwellness and associated difficulties.

Extreme distress: Some participants reported frustration related to being around others when extremely distressed when at a different stage of recovery.

The transition from ICU to the open ward was cool but coming down into a level where you see everyone else is not well and when you start getting well it sort of makes you think like, what am I doing here? Then at the same time you gotta acknowledge that there is some sort of balance between un wellness and wellness you know, it’s like when you become well you start seeing other people when there not well and that was a little bit frustrating…how that could be improved is to either separate, like if someone’s getting nutty and starts swearing I reckon they should go straight back to ICU cause it’s just a struggle for everyone else, they leave it too late. There could be a good fight going on
like, say if one persons unwell and the other ones becoming well, well that one person can make them more unwell so if you can isolate the cause before it gets to a point where its gonna bubble up it would be better to remove that person or take that person to the side with a couple of nurses and doctors to talk to that person and see what the problem is (Jamie, TW)

**Difficulties:** A number of participants reported the common difficulties experienced when living in communal situations.

Other mental health patients were scabbing off me which was a downer, um my CSW was bringing me money but I had to fork out for the other patients wanting cigarettes (Dominic, TW)

**Theft:** A few participants reported issues with theft by other tāngata whaora and the implications associated with a lack of support from staff.

Yeah I had problems with a guy, he was stealing stuff and taking peoples clothes...it would have been helpful if the nurses could have come in and pull him to the side instead of letting me try to do it my own way instead of isolating him first before he was out of balance...yeah, would be nice but then again you got to remember that the staff are pretty busy any way, I mean, if they could just have the time to see a problem and then deal with it straight away instead of letting people swear at each other and then both of them end up in ICU then that’s pointless (Jamie, TW)

**Noise:** Some participants also described the negative impact of noise within the communal service.

Noise from the patients, day and night, they’re yelling and stuff. It’s no good for me, I just go in my room cause I like the quiet which makes me feel sad (Edith, TW)

**Experiences**

**Open ward:** Participants described specific experiences on the ‘open ward’ of the service

Positive: Some participants (six) recalled positive experiences supporting recovery on the open ward relating to having less restriction and transitioning from the ICU ward.
**Freedom:** One of the main positive experiences reported by participants as contributing to recovery was the sense of freedom within the confined inpatient service. This was experienced when the doors of the service were open (on the open ward), with the flexibility to receive treatment but also able to continue being part of the community (with the use of leave), having the open ward, being able to come and go to the park was good (Materoa, TW).

**Transition:** The significance of the transition phase from relative confinement to the less restricted level of care portrayed progress and hope in the journey of recovery for participants.

*In the open ward it was good, I had moved onto the next stage, the place was good, the whole place was just great, nice showers…I’ve been here about 3 weeks, it’s been good cause each day I’m getting better and better, I’m not angry or anything and I can sleep (Brad, TW)*

*I was progressing in my recovery and going somewhere, not just getting moved around and getting kept in there, it made me see that I actually have a direction to move in, in terms of wellness and that I’m actually improving, it gave me hope (Materoa, TW)*

**Negative:** Some participants (4) recalled negative experiences while admitted to the open ward related to imposed restriction.

*I just don’t like it when they lock the doors in the open ward…our freedoms been taken away, were not free to take walks or go anywhere, it’s a bit of a worry when the doors are locked constantly…it feels like a prison (when the doors are locked) but it’s not a prison (Josh, TW)*

Whānau participants expressed concern regarding the increased freedom for some whānaunga.

*I thought that he had too much freedom and leave on the open ward though…his friends were coming and going using drugs, it made access to drugs easy for him, inhibiting his recovery. His ex-girlfriend was coming in too and having a negative impact on his mental state, playing a lot of mind games with him…Sometimes he was out on leave which made me feel a bit concerned at times, I felt*
strongly that he should be kept in a safe environment for a longer time, he was on leave after being in hospital only a few days (Leah, WH)

**Recommendation:** One participant felt that it would have been useful to discuss the process of transition from one ward of the service to the next in relation to recovery.

I stayed in ICU for a while…transitioning to the open ward I didn’t even understand what it meant going from ICU to the open ward, I didn’t know I was going from serious to moderate that’s how I was being treated, it was never explained, getting more freedom to go outside to the gardens and stuff…it would have been helpful if someone would have told me, someone could have just said “look we can see you’re progressing really well, we still need to keep an eye on you, so we see that you’ve progressed from serious to a bit more moderate so we’re going to move you to a room with a bit more freedom to come and go and do your thing” (Materoa, TW)

**Intensive care unit (ICU):** Participants described positive and negative experiences in the ICU ward that supported and inhibited recovery

*Positive:* A few participants recalled positive experiences while on the ICU ward relating to staff interventions and a sense of security.

*Secure:* One of the main positive aspects of the ICU included the secure nature of the ward and how this was balanced with supervised visits/outings with staff. For instance, a sense of safety (and relief) was felt by whānau, knowing that their whānaunga was being observed closely and that their responsibility for caring for their unwell whānau member could now be shared with staff. Positive aspects associated with safety included: tāngata whaiora being away from stressors (safe from bad influences); and time out for whānau, friends and care givers through shared responsibility (especially when serious risk issues to the self or others was a concern).
ICU was an experience, I was enlightened...I was locked up but still had freedom to walk around and that...I liked that, actually I’d rather be in ICU that the open ward, because it’s locked up, I like being locked up perhaps because it takes away my responsibility from things...in ICU what I saw was that the people outside were safe and I was safe (inside)...that was really good that’s why I like being locked up, because the people outside are safe from me, and I’m safe from them (Pita, TW)

I was in ICU for one night then I came out here (open ward), ICU was alright, staff were good, kindness, nothing was too much for the nurses, I’d like to say thank you for all they did for me (Brad, TW)

**Negative:** Just over one - third of participants described negative experiences while admitted to ICU relating to a sense of feeling unsafe, having a lack of trust towards staff and restrictions that were imposed upon them. Specifically a number of participants referred to inappropriate cultural practice.

*In seclusion the pee pans in the room is disgusting! It’s worse than prison, at least in prison you’ve got your own toilet, in there you’ve got a pee pan, that sucks...the toilet would definitely be better in another room, if they can do that in prison, where bad buggers go, why can’t they just do it here? (Rabui, TW)*

*Having kai next to a pan that you’re supposed to urinate in isn’t right aye, it’s a breech of tikanga, a breech in the way we do things (Jamie, TW)*

**Unsafe:** Both male and female participants expressed concerns regarding the safety of tāngata whaiora while admitted to a mixed gender ICU ward where tāngata whaiora are often extremely distressed and vulnerable.

*I remember in ICU, there was a younger girl and a couple of guys were in there too, and I did actually feel a bit funny being in a mixed (gender) area. Her and I talked and she was saying the guy across from you is blah blah blah, so we made a pact that we would put the heads of our beds to*
the same wall so we would hit on the wall to each other if something happened, so there were a few
issues around safety for us…it would be good not to have men and women on the same wing, that’s
just my preference (Materoa, TW)

ICU that’s not safe, people are pretty unwell there, pretty soon people are going to react, for men to
do that to a woman that are mentally disturbed that sucks. ICU for men, not woman, woman that
need it that’s okay but not with the men, I’m dead against it. I complained about that to staff
(Rahui, TW)

Some whānau participants expressed concern regarding the safety of a tāngata whaiora when
discharged too early from ICU, still experiencing extreme distress, because of a bed shortage.

We (the whānau) thought she needed a bit more time in ICU to recover, cause it was smaller with
less people, but she had to move into the open ward quickly to accommodate for others coming into
hospital…maybe they should get more beds in ICU so people don’t have to be forced out before
they’re ready…they need more beds for people really unwell in ICU (Barb, WH)

**Mistrust:** One participant expressed mistrust following an encounter with an
unknown staff member while in ICU.

ICU care was um, it’s really hard to remember, I remember there was one lady OT that came in
and she was doing foot spas and with lovely herbal cream, that was really nice, she was rubbing
down our feet, but then the whole mistrust thing, not knowing who she was…when we saw her she
was just like come and have a foot spa and I didn’t really know who she was, it would have been
good for her to briefly introduce herself, like I’m so and so the OT here and I come down every couple
of days, I do foot massages and whatever else, so would you like a nice little foot massage? (Materoa,
TW)

**Restricted:** Most of the participants admitted to ICU described the negative impact
of the restricted nature of the ward. Some of the participants felt that the restrictions inhibit
recovery and may have been imposed as a result of racial discrimination
When I was put in ICU...when I got here 4 guys jumped on me and gave me an injection...I spent two weeks in ICU...it was hard aye Julie, it's like a jail with the doors locked...I was under the MHA so couldn't do anything...it had been 10 years since I had been in Mt Eden (prison), it reminded me of that...fuck it was a cunt, I thought my life was fucked...was never that sick in the first place. ICU was closed in like jail...the staff, I don't know, I think they were a bit scared of me, cause of my tattoos, and cause I'm Māori and stuff aye...I could see the board in the nursing station with my name on it, it had 'caution- dangerous' next to my name (Dave, TW)

The confined restricted ICU experience was compared to a prison experience by a number of participants.

It feels like a prison when the doors are locked, but it's not a prison (Josh, TW)

I really wanted to go home...they wouldn't let me go on un-escorted leave and stuff and it just made me feel like, not exactly claustrophobic but like a prison and I just really wanted to get out and it was just so hard being in here...I went AWOL about four or three times (Madison, TW)

For some tāngata whaiaora, the confined environment inhibited recovery reportedly creating further distress spiritually.

Like the ward it inflicted decline, it makes you worse, in ICU cause you know you're with other people who are really crazy or are just hostile and depressed. I was really scared and I just got angry, I felt like my wairua was trapped...If I don't get any exercise in here I just get anxious (Luke, TW)

At first he was locked up which is really bad for him as he's what you call a 'free-spirit', he just hated it! It wasn't really therapeutic for him, the drugs he had taken didn't help either making him irritable, he's very strong willed. Fortunately the doctors noticed and moved him to the open ward within a few days (Leah, WH)
Relaxation and time out: Some participants described TWT as relaxing and a place to have ‘time out’.

Positive: The TWT environment was perceived positively by some participants who found it relaxing.

Mauri tau/peace and quiet: The opportunity for tāngata whaiora to relax during the admission and have time out/relaxation from the stressors of everyday life was seen by some as very useful for recovery. This provided time to think and develop strategies to promote and maintain wellness; time out to reflect and deal with old issues; and escape from bad habits (such as drugs and bad influences).

It gave me time to relax, time to look at what I’ve done, focus on getting myself better and what can be done to keep myself well, strategies Dominic, TW)

I’ve had a good stay and a good rest, I haven’t rested like this in 30 years, it’s been a long time, not since my mum died (Pita, TW)

I’ve been able to chill out and take some time out from the dak because I was smoking quite a bit which usually I just keep going everyday so that’s been a big factor in my chill out process. When I do go back to Waibke i know I’d be able to manage that a lot better you know (Hori, TW)

Negative: Although the opportunity for time-out was viewed as beneficial by some participants, others found this experience to hinder recovery.

Boredom: For many participants the TWT was 'boring' and provided little accessible activity.

Nothing to do: It was common for participants to associate boredom with having ‘nothing to do’ within the restricted inpatient service. Some whānau members expressed concern regarding the minimal activities available and the potential for their whānaunga to engage in other harmful behaviour (such as smoking).

There wasn’t enough activity, all they do is sit around and wait for the next smoke, there was a horrible smoking area on the deck, health-wise it’s not good at all. I would have like to have seen
some exercise and craft, there was an art room but I only saw one painting of hers the whole time she was there (Moana, WH)

Oh yeah, I remember, cause I was in there so long things did become a bit mundane, there were no activities happening so yeah I remember it being long and mundane (Materoa, TW)

As a result of boredom some tāngata whaiora report walking and pacing throughout the inpatient service to pass time.

It’s so boring here, I have been doing a lot of walking inside the hospital to pass time…yes it needs something, it needs something of authority. It needs somebody big to turn it…make a change to some of the staff that just sit around and aren’t caring…they could have a pool table over there, ab a bit of gardening (Edith, TW)

One whānau participant observed such pacing behaviour and made this comment.

You know I know they’re mentally ill, but what’s the best thing when you’re in here or your mentally ill, what’s the best thing to stimulate your recovery. To stimulate your recovery is an act of mind, right, so what do they do all day here? They really really really need kilometre recorders on their heels because you ill be surprised how many k’s these people walk all day every day, you know, they just walking, what are they walking for? Because there’s nothing to do, you know (Brian, WH)

Recommendations: Some participants offered suggestions, both mainstream and Māori specific activities, to address the issue of boredom. These included: increased physical activities such as sport and outings;

I would have liked sports, art class, touch, I played touch once. I played cricket in the corridor at night and that was cool, van trips driving around the beach and hills sight seeing (Madison, TW)
More outings, a game of cricket at the beach, entertainment cause it can get pretty boring in hospital, maybe a band (Dominic, TW)
Cultural specific activities:

There needs to be more activities, maybe te reo, a class on te reo or everyone, cause I hear a lot of things, that’s one suggestion, and getting in an artist or someone that knows ta moko, yeah cause I’ve got uncles that do it and stuff but I don’t want to learn there ways, I want to learn from someone else (Issach, TW)

More sessions with Kai Atawhai would have been good, speaking te reo, doing kapa haka...this would have helped me cause I really get into that kind of stuff, it makes me feel more like myself and not sick (Dominic, TW)

And more accessible activities:

Are there playing cards? Are there board games? Do you know what I mean? Go back to school and see what they have o occupy little kids you know I mean, they do nothing and that’s just crazy, they incarcerate them here to do nothing, to pump the medication in to them and that’s it end of story. I mean ask the longest serving patient in here how many times they’ve seen a psychologist during their stay, can we guess what the answers gonna be, yeah zilch and that’s just crazy, that’s crazy shit. So what we do is we medicate, the system medicates them up here and then when someone thinks they’re well enough (Brian, WH)

Beliefs: The influence of personal beliefs about TWT and mainstream mental health systems on recovery were discussed by a few participants.

Tapu: One participant’s belief about the service being tapu made her experience at TWT unsettling.

A long time ago, these hospitals are built on graves. Carrington and Auckland hospital... you may as well say the whole worlds a grave yard and we are the walking dead. Yes find it around this hospital... there’s a lot of evil around it. That’s how I find it. So I think this place is tapu (Edith, TW)
**Resistance to Pākehā system:** Another participant felt resistance towards the mainstream system, and believed it did not understand the influence of Māori beliefs and a holistic view of health

I find that the Pākehā system can help but can also bring you down as well...they don't understand cause the Pākehā they don't understand the Māori side of things, our wairua, cause they don't understand that before the Pākehā got here we didn't have any diseases at all and when the Pākehā came they bought the diseases with and labels like mental illness, I don't want anything to do with them and their labels (Jamie, TW)

**Safety:** The sense of feeling safe and secure while admitted to TWT was discussed by a number of tāngata whaiora and whānau participants.

**Positive:** Some participants recalled positive experiences of safety within the inpatient service.

**Reassurance:** The admission to TWT gave some whānau participants reassurance that their whānau member was safe and supported in their journey of recovery.

I did notice differences that he was starting to get better, it helped that he was removed a bit from his old environment, removed from his ex-girlfriend, stresses, and friends that are bad influences. In hospital there were lot's of people talking to him giving him more options about his future. He needed to be there, he was a danger to himself, he needed no contact with friends for at least the first few days (Macie, WH)

I was happy that he had been in hospital where he was safer...it meant that mum could be more relaxed and less stressed out about Luke, it gave both her and Luke the support she needed (Queenie, WH)

I was always incredibly grateful that she was safe, she couldn’t kill herself in there...it is a matter of having to trust the process though which is tough when you don’t know what to expect (Junior, WH)

**Negative:** Almost one-third of participants recalled negative experiences relating to safety, specifically related to harassment, drugs and assault.
**Harassment:** One youthful female participant expressed concern regarding harassment during her admission experience.

I also found it quite stressful here... sexual harassment, people, other patients calling me a slut cause I wouldn’t kiss him, asking me for sex in the toilets, dodgy... it made me feeling really uncomfortable, I didn’t feel safe and was having scary dreams (Madison, TW)

**Drugs:** The increased accessibility of drugs within the inpatient service was a major concern for some participants, resulting in significant fear for safety.

The only problem was with security, but they sorted it. Drugs was the main issue, a guy bringing it into the unit and offering to take whāiora out (of the service), get them drugs and bring them back into the open ward. This scared my daughter and so she ran away. We were really concerned and worried about my daughter and everyone else in the hospital... if her mind isn’t right I’m really concerned about her running away as she would be really unsafe out there (outside of the service). I spoke with the staff at TWT immediately when she discussed this issue with me. They called the police straight away, closed the doors to monitor who was going into the ward. I was happy with how they dealt with it, reducing my concerns about safety in TWT (Aroha, WH)

**Assault:** A number of incidents involving assaults were reported by tāngata whaiora and whānau participants. Such events resulted in fear and further trauma for tāngata whaiora already experiencing extreme distress.

Another thing that happened was my daughter being assaulted by another whaiora. A girl came into her room and kicked her in the head; I think she was jealous; it was about a boy on the unit that liked my daughter I think, while she was on the open ward. She had bruises, we took pictures but she decided not to press charges, because she can get like that herself sometimes when she’s unwell. The staff there informed me of the assault and we had a couple of discussions about it and did a plan for safety. The other girl was transferred to ICU which helped her because she was really scared (Aroha, WH)
Recommenda**tions:** One participant offered a suggestion on how the issue of safety could be addressed

The more violent people should be separated, some people seemed to be in higher security, it was quite scary, I was concerned about what they might do to her, she’s old and vulnerable, this made me really worried and anxious (Moana, WH)

Interventions supporting recovery: Tāngata whaiora and whānau participants described treatment, therapy and other interventions provided by TWT they found helpful in supporting the journey of recovery.

Positive: Just over two-thirds of participants described positive interventions supporting recovery which included the OT recovery programme, psychological therapy and medication.

**OT recovery programme:** The main therapeutic interventions seen to positively contributing to recovery were activities in the OT recovery programme. Some activities were seen as a useful distraction, such as swimming, cooking, dancing, music concerts, art, gym, drumming session, table tennis, self soothing techniques useful, breathing, relaxation groups, yoga, thai chi and the walking group.

The medications been helpful in helping me get off to sleep but I’ve also been doing the breathing exercise, slowing down my breathing, relaxation, slowing down my breathing part which the staff have been helping with, yeah so I’m getting use to it now…I’ve been doing therapy stuff in the OT room, playing table tennis, painting pictures, going for walks in the mornings, being a part of the walking group it was a great help, being in a group of people and together we’re strong and we bring each other right (Josh, TW)

The OT room was great for Luke, he enjoyed yoga, relaxation, thai chi…it was the first time he had ever tried it at the hospital, he loved it. It was really good to hear him being positive about something…it has now sparked an interest for him in martial arts (Macie, WH)
**Psychological therapy:** A number of participants discussed additional therapeutic interventions including 1:1 psychological therapy and the DBT skills groups were seen as useful in aiding the process of understanding unwellness and distress, with a focus on precipitating factors and coping skills. Some participants found sharing and verbalising their experiences as useful in supporting recovery.

I've had a psychologist for about three weeks, I went to see her once a week, it was pretty good, useful just to talk, to get things out and off my chest that was pretty good (Jasmine, TW)

The psychologist therapy here I think has been pretty good, I think because I seem to have a cluster of issues sometimes I get a bit confused in therapy (with previous therapy) which I experienced here a bit sometimes, but I think the staff were genuinely trying to undo all the knots so they and I can see a bit more clearly what it is that brings me into this kind of situation (Hoani, TW)

Therapy was seen as supporting recovery longer-term, perceived potentially as a mechanism for avoiding further distress and inpatient admissions.

I was involved in DBT distress tolerance… I applied what I learnt to an activity, and a situation, it was related to what I needed…I also saw a psychologist but I only saw them about twice then I was getting discharged…I think they are going to get me another psychologist out in the community which will be good…help me stay out of hospital (Dominic, TW)

**Medication:** Some participants commented on the positive effects of medication in supporting recovery. Specifically useful was the opportunity for medication to be altered in a safe environment (involving close observation).

Oh they (staff) have helped me a lot. Yeah they gave my meds properly, you know put me on the right track (Edith, TW)

I got help with my medication, they were like changing and administering my medication and I think they got it bang on now…the medications been helpful in helping me get off to sleep (Josh, TW)
**Interventions inhibiting recovery:** Participants described treatment, therapy and other interventions provided in *TWT* that were unhelpful and actually inhibited recovery for some tāngata whaiora.

*Negative:* More than two-thirds of participants described interventions that inhibited recovery including medication, restraint and diagnosis

*Medication:* Experiences of being over-medicated resulting in functional difficulties, and a lack of information regarding the side-effects of medications were negative factors for some participants.

*The medication wasn’t good, at one stage she couldn’t even talk to me, she was weak, not herself, it was like she was a drongo, I was worried. I said to one of the nurses I would like to speak to the doctor, next time I was there she made an appointment which was good, I was worried sick. The meeting with the doctor was very brief because she was very busy apparently. The doctor gave me a list of all the medication she was on, I did my own check on all of them, ingredients and side-effects cause they hadn’t told me about those…the doctor didn’t really say much* (Moana, WH)

An additional issue raised by participants, related to staff reliance of prescribed medication rather than utilizing other strategies to manage and tolerate distress.

*When my anger would come onto me, that’s the first time I tried PRN, I found that was helping, so I’d just tell my nurse for PRN, after 15-10 minutes I’d just be calm…no others skills were suggested, they would have been helpful too* (Issach, TW)

Participants that experienced multiple medication trials reported a loss of faith in medication as a useful therapeutic intervention.

*…the meds in hospital never worked, we were always cautious, we didn’t like her being treated as a guinea pig, trialling different medication combinations on her…trying to get her meds right was always a battle and so she just didn’t want to take them* (Junior, WH)
**Restraint: Trauma and force:** All of the participants that experienced restraint reported fear and the consequent negative impact of their journey of recovery. Some compared the restraint process to prison experiences.

*When I got here 4 guys jumped on me and gave me an injection...I spent 2-weeks in ICU...it was hard aye Julie, it's like a jail with the doors locked...I was under the MHA so couldn't do anything...it had been 10 years since I had been in Mt Eden (prison), it reminded me of that...when I was put in ICU, fuck it was a cunt, I thought my life was f**ked...was never that sick in the first place...I even had a mental illness in the first place, ICU was closed in like jail...the staff, I don't know, I think they were a bit scared of me, cause of my tattoos and stuff aye...I could see the board in the nursing station with my name on it, it had caution- dangerous next to my name (Dave, TW)*

Many of the participants reported extreme distress during the restraint process and described feeling ‘mad’ as a result.

*The second day I was there they threatened me with the injection because I refused the oral...I fought, it wasn't forced on me until, oh I can't remember the date...no they held me down cause I fought...I didn't get the medication till 3 days later...I don't think anyone knew from my whānau that I was going to have the medication...they offered me that oral medicine and I said know...be actually showed me the injection...I have a very very low tolerance to medication...it's just me cause I get asthma and anything like that would trigger it off...they pulled me through to the room, the door was left open, the mattress was on the floor and they just put me on the mattress and I felt the injection and I screamed, that's the only time I felt I was a mad woman cause it was frustration and I remember yelling out...I was so angry and I remember crying and really crying and they just left me (Hinehou, TW)*

I felt totally mad, cause I was back in a mental institution, this is for the mentally disturbed...just being in a mental health place cause I go back to Oakley electric shock treatment days...once they put me into ICU (seclusion) there was no freedom, I thought here we go again...it is scary, it was and it is, and every time I go in there yeah this place is for the ones that are mentally disturbed, it sets me off when I go in there, I go in there a raving lunatic, I just let loose, I struggle all the way, I
just pound scream and hammer, I keep it up...the confined space reminds me of being mad, I've lost it again, I'm mad again, it reminds me of the Oakley days, I'm kicking and I don't stop...once they do let me out into open space it's like being in here (Kai Atawhai) the tension and everything is just gone, it's choice, yeah all the tension and whatever you want to call it goes (Rabni, TW)

The use of force and restraint was also extremely distressing for whānau participants who described a sense of hopelessness when their whānau were restrained. Restraint was viewed by a number of participants as a means of punishment rather than a ‘therapeutic’ intervention ensuring safety.

When I came in to visit I was like a nurse there, I helped her have a shower, it seemed as though she was frightened of them (the nurses), she was scared...she would get locked up if she was bad, put into ICU/seclusion I think, with just a mattress on the floor, that's not how you should treat an old kuia...she seemed to be blamed for lot's of things, with her being locked up I felt horrible, she isn't like that, I really wanted to blast them (the staff), I didn't find this at all helpful in her recovery, she was being treated like a child, they could have just talked to her, had a chat (Moana, WH)

**Recommendation:** Many of the participants felt that restraint could be avoided if communication was improved, more specifically listening to the needs of tāngata whaiora.

I got an injection...I was swearing and going off saying that I don't want to be here, and pushing staff, I was trying to tell them that I didn't want to be here anymore, cause at home I can be myself and be with my sister who is my best friend, and my brother would visit sometimes...being restrained and taken into seclusion, the restraining was sort of scary, they put my hands behind my back and put me onto the ground face down which was scary, they would have got my arms and put me in my room rather than putting me on the floor, getting your head put down is the worst, it pulls on your neck and has left me with a sore back...I've been restrained three times which scares me about hospital...they don't need to restrain, just listen more (Jessica, TW)

...they don't need to hold people down when they try and restrain people, I remember this old lady that got restrained...I don't know why but I laughed, but after that I thought that's not right, there should be something different for that lady or other tāngata whaiora when they get treated badly, I
thought that they shouldn’t have done that, they should have just talked to her first, calmed her down, and then suggested something else after that to cool her down to see what she was going on for her (Dominic, TW)

**Diagnosis:** The negative impact of being given a diagnosis was discussed by a few of the tāngata whaiora and whānau participants. Some participants felt misunderstood by the clinicians who were supposed to be taking care of her.

*When I first came in here I was shy as it was my first time and I didn’t know anyone…in my meetings with the doctors I didn’t know what to talk about, it felt as though they couldn’t understand me, they were just throwing labels at me, schizo and stuff like that* (Madison, TW)

Concerns regarding misdiagnosis were also as issue expressed by participants.

*While she was in there she also got misdiagnosed with diabetes, since she’s been at the supported accommodation two years down the track they’ve realised she doesn’t have it at all. Nothing changed for her after I spoke to the doctor, I walked to staff, a nurse and she was quite helpful, reassuring me that it would take time to see change* (Moana, WH)

**OT recovery programme recommendations:** Some of the participants were unfamiliar with specific mental health terminology (such as the term ‘recovery’) *Recovery? I can’t honestly say I knew about the programme, I just thought what is recovery?* (Rahui, TW); and unaware of therapeutic interventions and activities offered through the OT recovery programme. A number of participants offered suggestions to improve the interventions offered to support recovery, specifically involving more active participation of service users in the choice of therapeutic activities.

*Like sometimes places like this can hold you back from what I want to do, I think they should have a day when the tāngata whaiora ask what they want to do today or nurses even just one day a week they go fishing or swimming or diving or something, they should have an activity one day a week where they can ask the tāngata whaiora what they want to do* (Jamie, TW)
A fixed plan is really boring; I want to do something spontaneous that we choose to do (Madison, TW)

Increasing the number of activities, creating more options and choices for service users was also recommended by many participants.

…they should up the routine, like more stuff during the day, like weaving, cooking and stuff (Issach, TW)

More and new activities would be good so they don’t get as bored and start smoking (Barb, WH)

There wasn’t enough activity, all they do is sit around and wait for the next smoke, there was a horrible smoking area on the deck, health-wise it’s not good at all. I would have like to have seen some exercise and craft, there was an art room but I only saw one painting of hers the whole time she was there (Moana, WH)

Excursions into the community, potentially facilitating community reintegration, were also a common recommendation by participants.

I think it would be good to go out on rides in a big huge van to the beach and stuff, it would be good to get out of hospital and see the scenery and stuff (Jasmine, TW)

One whānau participant felt that tāngata whaiora did not have enough access to therapy and believed it to be a critical aspect of recovery.

There’s not enough psychologists, I mean he’s been here for nearly two weeks and they’ve given him medication to bring him down, but that’s it for treatment…a lot of those people out there, who do they talk to? Some of those people out there they need psychologist’s, they need counselors to talk to because why are they here? No one’s listening to them… I don’t believe they need psychiatrists I think they need psychologists, because all the psychiatrists job is to mask the problem, a psychologists is to unravel the problem. Who do they talk to because no one’s listening to them? I said to the doctor, these people, they need psychologist’s they need counselors to talk to otherwise why are they here? (Brian, WH)
**Category 4: Discharge Phase**

The category of ‘Discharge Phase’ refers to tāngata whaiora and whānau experiences during the discharge phase of the admission, including thoughts and feelings. The two themes in this category are: Wellness, and Discharge process (see Table 15). Each will be discussed in further detail, along with sub-themes below.

*Table 15: Themes and Sub-themes from Category 4 ‘Discharge Phase’*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Number of participants coded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness</strong></td>
<td>Happiness</td>
<td>5 tāngata whaiora; 1 whānau 6 references</td>
</tr>
<tr>
<td></td>
<td>Eager to leave</td>
<td></td>
</tr>
<tr>
<td><strong>Discharge process</strong></td>
<td>Discharge planning and supports</td>
<td>6 tāngata whaiora; 4 whānau 13 references</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recommendations</td>
<td></td>
</tr>
</tbody>
</table>

**Wellness:** Tāngata whaiora and whānau described their whakaoranga during the discharge phase of admission, with a specific emphasis on ‘oranga’ (wellness).

**Happiness:** As stages of progress and goals of recovery were met participants reported a great sense of happiness and accomplishment.

> My wife wanted me back as the husband I was five years ago, loving and thoughtful so that’s what we’re been working towards, and I’m getting there (Brad, TW)

Many participants acknowledged the contribution and support of recovery provided by TWT staff.

> During her admission the whānau were not that happy with the service at the hospital, I guess we were still in shock about her being in there… but towards the end of her admission when we saw her getting better we started to appreciate what the hospital was doing for her…we’re really thankful to them for taking care of her! (Barb, WH)
**Eager to leave:** It was common for participants to report difficulties associating with other service users who are unwell once their own level of distress subsides.

It was horrible when she was getting better and having to take her back to the hospital with lot’s of sick people (Junior, WH)

(Tāngata whaiora) had to stay in hospital because they couldn’t get the community to follow her up. She was declined for Māori mental health community services so is with a CMHC now. It was hard because everyone else is sick but xxxx is better, she got really frustrated. Our doctor from TWT was really good at trying to help (Aroha, WH)

**Discharge process:** Tāngata whaiora and whānau participants discussed experiences of the discharge phase of their admission from TWT.

**Discharge planning and supports:** Of the participants who experienced discharge meetings (8 out of 20 tāngata whaiora participants), involving planning and establishing community supports, all reported positive experiences. Working collaboratively in the planning process was an important aspect for participants.

I had the meeting in the whare kai, opened in karakia, we kind of worked things out with the psychiatrist, my key-worker, my partner, Kai Atawhai, it felt really good having everyone around the table working out a plan to keep me well (Materoa, TW)

The importance of connecting with community support prior to discharge was emphasized.

Because she had been in hospital so long she was very adverse to change so they organised a long discharge process which worked well for her. She didn’t want to move if she could help it. Fortunately she was discharged to just the right place, I wish they had more places like that around to reduce the population in hospital. There is less pressure on staff there and more resources, I’m so grateful for her place (Pete, WH)
A planned discharge process, specifically devised around the individuals needs, was essential. This allowed time for specific community issues to be sorted (such as finding appropriate accommodation).

The discharge process was very collaborative, he went for quite a few leaves while he was in hospital, visiting his new flat for a day, then two, then nights, it was progressive. This was very important and done well, it was a new place and home for him so it was very important to allow time for him to adjust. From hospital they also took him to different places in the area to get him used to it, like the supermarket and library. Liaison with the CMHC in the area also occurred while he was in hospital, he was able to meet his new key-worker. Because the transition was done so smoothly he wasn’t frightened, everything was made like something to look forward to, ‘a new beginning’. All the community supports were setup before he was discharged, which made things really easy for him (Macie, WH)

Unknown: A few participants were unfamiliar with the discharge process and were unable to recall attending a discharge meeting with clinical staff.

The discharge process? Well I didn’t really know what discharge was, I thought it was the other kind of discharge (laugh), I didn’t know the lingo, the second time that discharge process took a little bit, all I remember is sitting in Kai Atawhai and waiting for the doctor to finish cause of some other crisis (Materoa, TW)

Recommendations: Tāngata whaiora and whānau participants provided suggestions to ensure positive discharge experiences for all tāngata whaiora, with a focus on establishing community supports prior to discharge

I suppose, just let the patient be heard I guess which I feel like they’ve done with me…try and, I know it’s a difficult one but to try and ensure that community support is all in place before the patient leaves, which I know is difficult to do sometimes with beds and everything, that’s why the vision of a respite home as an in-between could be a really good place (Hoani, TW)
Discharge with the ‘safety net’ in place, like community supports CMHC, keyworker, CSW etc… don’t hurry the process, you need to think- what is in place for this person to survive? (Macie, WH)

Category 5: Future Admissions

The category of ‘Future Admissions’ refers to the place or places tāngata whaiora and whānau would like to go if unwell in future, also identifying possible alternative accommodation options. The themes in this category include: TWT (familiar and needs met; cultural support), and Alternative care (respite; turangawaewae; and Mind Matters) (see Table 16). Each will be discussed in further detail, along with sub-themes below.

Table 16: Themes and Sub-themes from Category 5 ‘Future Admissions’

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Number of participants coded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Te Whetu Tawera</td>
<td>Familiar and needs met</td>
<td>11 tāngata whaiora; 5 whānau</td>
</tr>
<tr>
<td></td>
<td>Cultural support</td>
<td>17 references</td>
</tr>
<tr>
<td>Alternative care</td>
<td>Respite</td>
<td>13 tāngata whaiora; 5 whānau</td>
</tr>
<tr>
<td></td>
<td>Turangawaewae</td>
<td>19 references</td>
</tr>
<tr>
<td></td>
<td>Mind Matters</td>
<td></td>
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</tbody>
</table>

Te Whetu Tawera (TWT): Just over half of the participants discussed a preference to return to TWT if ever unwell in future.

Familiar and needs met: Previous positive admission experiences, where tāngata whaiora needs had been met, were factors associated with a willingness to return to TWT if extremely distressed in future.

Definitely, TWT, honestly, when he first went into hospital everything went to crumble, his accommodation, his mental state, relationships went unbelievably low. The old guy was discharged even better than before, he had a new house, a new key-worker, CMHC, CSW, everything helped and still helps, it’s like a safety net, he didn’t have that before (Macie, WH)

No I’d like to come back here, I wouldn’t want to go anywhere else, cause I know this system and the people here, no I’d hate to go anywhere else (Hinehon, TW)
Cultural support: The kaupapa Māori cultural support service provided onsite was also factor contributing to the decision for participants to return to TWT if unwell in future.

I’d wanna come back here to TWT on the fact that Kai Atawhai is here, yeah because the Māori service is here and I know they can take care of me (Rahui, TW)

Alternative Care: Almost two-thirds of participants discussed alternative care preferences if ever unwell in future.

Respite: For some participants respite provided a better option for care because of the smaller more intimate environment it offered.

Respite, it was good there, a lot nicer, she can go for walks around the cafes and park, it’s like a nice motel, way better than TWT (Jamie, TW)

Some participants felt that an environment with less people would be positive

No not TWT unless things improve or if it was only for a short time, less than a week. She would be better off going to respite, less people around would be better for her (Pete, WH)

I’d want to go to respite, it’s more relaxed only a few people there, not so crowded (Dominic, TW)

Turangawaewae: Some participants described alternative care options with an emphasis on having a connection to turangawaewae. This included being close to whānau; and service located in a natural environment. A marae environment was perceived as a safe alternative care option.

My marae, yeah that’s my, where my tipuna are…going to my marae…at least it would be safe (Edith, TW)

Close proximity to whānau was an important factor when discussing alternative care options.
I would prefer to go to Aitataki, I’d get really well there (laugh)... I’d rather go and stay with whānau, somewhere natural nature and therapeutic environment where I could hang out and do interesting stuff, somewhere with a nicer environment (Materoa, TW)

I’d prefer to be at home with mum, I’d be able to talk to my sister, she understands me and keeps me well (Jessica, TW)

An environment where one can connect with Papatuanuku, Tanemahuta and Tangaroa, was viewed as a healing therapeutic option.

I’d like to go to the bush and sit down in Tanemahuta and karakia...being in the bush, like at a camp...maybe some Māori people and some staff; I reckon if you took some of these people out into the bush where they’re allowed to camp that’s therapy, I’d say they’d really enjoy it ...getting some connection with Papatuanuku and Tangaroa and I bet there’s a lot of people in here that would like to go fishing and probably just go for a swim in the ocean (Jamie, TW)

Other therapeutic alternatives to inpatient services were also described, such as residential based services.

An alternative place might be good, an old house, ten rooms, veranda front and back, nice big garden, lots of lawn area, maybe some fruit trees, nice big communal kitchen and lounge or a couple, always having the privacy of your own room, I suppose at least one live-in person who would be managing the place, ongoing support with mental health services coming in and saying hi, the opportunity to get on with doing things like work, education, similar to A&D residential places how they’re set up, like a community house...this would be a preference for me, being ‘high functioning’, not for acute care but as an alternative more a thing of a situation like I am now, a transition from hospital to the community, like in the discharge phase where I am now (Hoani, TW)

**Mind Matters:** A few of the participants had also experienced a community inpatient service called ‘Mind Matters’ and preferred to go back there rather than TW if ever unwell or extremely distressed in future.
From TWT he was transferred to ‘Mind Matters’... he seemed to fit in there better as there were higher functioning people there... in TWT there were so many unwell people, much worse than him. We would definitely want him to go back to Mind Matters if he became unwell again, not TWT unless he really needed to be there (Leah, WH)

No somewhere else with more therapy with psychologists is what he needs, not staying here at TWT getting pumped with medication, something like Mind Matters (Brian, WH)

**Tāngata Whaiora and Whānau Needs Questionnaire Results**

Frequency ($f$), percentage (%) and median (M) ratings of tāngata whaiora and whānau responses to items on the needs questionnaire are presented in Table 17.
Table 17: Needs Questionnaire Results: Needs

<table>
<thead>
<tr>
<th>Needs</th>
<th>Participant response (N = 30)</th>
<th>Tāngata Whaiora (n = 20)</th>
<th>Whānau (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>Median</td>
</tr>
<tr>
<td>Access to kaumatua</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>2=not very often</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>3=some of the time</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>4=most of the time</td>
<td>4</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>13</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>5</td>
</tr>
<tr>
<td>Access to tohunga</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>2=not very often</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>3=some of the time</td>
<td>6</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>4=most of the time</td>
<td>1</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>10</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4.5</td>
</tr>
<tr>
<td>Access to rongoa Māori</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>2=not very often</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>3=some of the time</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>4=most of the time</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>10</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Access to karakia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>1</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>2=not very often</td>
<td>1</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>3=some of the time</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>4=most of the time</td>
<td>4</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>11</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>5</td>
</tr>
</tbody>
</table>
Table 17: Needs Questionnaire Results: Needs cont.

<table>
<thead>
<tr>
<th>Needs</th>
<th>Participant response (N = 30)</th>
<th>Tāngata Whaiora (n = 20)</th>
<th>Whānau (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>Median</td>
</tr>
<tr>
<td>Access to mirimiri</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>4</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>2=not very often</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>3=some of the time</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>4=most of the time</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>5=all of the time</td>
<td>11</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>5.0</td>
</tr>
<tr>
<td>Support with finances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>2=not very often</td>
<td>1</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>3=some of the time</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>4=most of the time</td>
<td>4</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>5=all of the time</td>
<td>10</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4.5</td>
</tr>
<tr>
<td>Support finding accommodation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>8</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>2=not very often</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>3=some of the time</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>4=most of the time</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>5=all of the time</td>
<td>5</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>2.0</td>
</tr>
<tr>
<td>Access to kapa haka</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>2=not very often</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>3=some of the time</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>4=most of the time</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>5=all of the time</td>
<td>10</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4.0</td>
</tr>
</tbody>
</table>
Table 17: Needs Questionnaire Results: Needs cont.

<table>
<thead>
<tr>
<th>Needs</th>
<th>Participant response (N = 30)</th>
<th>Tāngata Whaiora (n = 20)</th>
<th>Whānau (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>Median</td>
</tr>
<tr>
<td>Reconnecting with whānau</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>4</td>
<td>20%</td>
<td>3</td>
</tr>
<tr>
<td>2=not very often</td>
<td>2</td>
<td>10%</td>
<td>1</td>
</tr>
<tr>
<td>3=some of the time</td>
<td>2</td>
<td>10%</td>
<td>2</td>
</tr>
<tr>
<td>4=most of the time</td>
<td>3</td>
<td>15%</td>
<td>2</td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>9</td>
<td>45%</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Reconnecting with hapū / iwi</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>7</td>
<td>35%</td>
<td>3</td>
</tr>
<tr>
<td>2=not very often</td>
<td>3</td>
<td>15%</td>
<td>1</td>
</tr>
<tr>
<td>3=some of the time</td>
<td>2</td>
<td>10%</td>
<td>2</td>
</tr>
<tr>
<td>4=most of the time</td>
<td>2</td>
<td>10%</td>
<td>2</td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>6</td>
<td>30%</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>2.5</td>
</tr>
<tr>
<td>Support with learning te reo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>7</td>
<td>35%</td>
<td>5</td>
</tr>
<tr>
<td>2=not very often</td>
<td>3</td>
<td>15%</td>
<td>2</td>
</tr>
<tr>
<td>3=some of the time</td>
<td>1</td>
<td>5%</td>
<td>2</td>
</tr>
<tr>
<td>4=most of the time</td>
<td>3</td>
<td>15%</td>
<td>0</td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>6</td>
<td>30%</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>2.5</td>
</tr>
<tr>
<td>Support in dealing with difficult situations and stressors (e.g. violence, abuse)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>6</td>
<td>30%</td>
<td>5</td>
</tr>
<tr>
<td>2=not very often</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>3=some of the time</td>
<td>3</td>
<td>15%</td>
<td>4</td>
</tr>
<tr>
<td>4=most of the time</td>
<td>2</td>
<td>10%</td>
<td>0</td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>9</td>
<td>45%</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4</td>
</tr>
</tbody>
</table>
Responses to the Needs Questionnaire in relation to specific ‘needs’ when admitted to Te Whetu Tawera (TWT) highlighted a number of significant aspects essential to support whakaoranga. Of interest were the contrasting responses from tāngata whaiora in comparison to the whānau responses. More than half of the tāngata whaiora rated traditional Māori healing practices including access to kaumatua; tohunga; rongoa Māori; karakia; mirimiri and kapa haka as therapeutic interventions needed ‘all the time’ to support recovery. In addition, support with managing finances; and dealing with difficult situations and stressors were also needed ‘most of the time’ for over 50% of tāngata whaiora.

In comparison, over half of the whānau participants reported support with finances; and finding suitable accommodation as needed ‘most of the time’. Traditional healing practices, including access to tohunga; rongoa Māori; kapa kaha; along with support dealing with difficult situations and stressors, were rated as required ‘not very often’ by more than 50% of whānau.
Table 18: Needs Questionnaire Results: Usefulness of therapeutic interventions

<table>
<thead>
<tr>
<th>Usefulness of therapeutic intervention</th>
<th>Participant response (N = 30)</th>
<th>Tāngata Whaiora (n = 20)</th>
<th>Whānau (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>Median</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all helpful</td>
<td>3</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>2=not very helpful</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>3=neutral</td>
<td>4</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>4=very helpful</td>
<td>4</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>5 = extremely helpful</td>
<td>9</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Recovery programme</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all helpful</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>2=not very helpful</td>
<td>2</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>3=neutral</td>
<td>6</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>4=very helpful</td>
<td>5</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>5 = extremely helpful</td>
<td>7</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Cognitive behavioral therapy (CBT) group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all helpful</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>2=not very helpful</td>
<td>2</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>3=neutral</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>4=very helpful</td>
<td>4</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>5 = extremely helpful</td>
<td>1</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Distress tolerance skills group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all helpful</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>2=not very helpful</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>3=neutral</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>4=very helpful</td>
<td>2</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>5 = extremely helpful</td>
<td>1</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>100%</td>
<td>4</td>
</tr>
</tbody>
</table>
Participants rated the ‘usefulness of therapeutic interventions’ they received whilst admitted to TWT (see Table 18). The use of medication in supporting recovery was seen as ‘very’ to ‘extremely helpful’ by 65% of tāngata whaiora and 70% of whānau participants. There were however 15% of tāngata whaiora who found this form of treatment ‘not at all helpful’. In addition, the recovery programme was rated as ‘very’ to ‘extremely helpful’ by more than 70% of tāngata whaiora. More specific psychological therapies ratings were poorly attended (or offered) to tāngata whaiora, with only seven of the 20 tāngata whaiora who participated in the study having attended at least one cognitive behavioural therapy (CBT) group session, and three out the 20 had attended a distress tolerance skills group. Ratings of the CBT varied significantly, with 70% of tāngata whaiora rating its therapeutic effectiveness as ‘very’ to ‘extremely useful’, and 29% (2 of 20) rating the CBT group as ‘not very helpful’. Of the three participants who attended the distress tolerance skills group, all found it ‘very’ to ‘extremely useful’. Of the whānau participants who rated these therapeutic group interventions all
reported limited knowledge of the specific nature of the groups or therapy models. More than 85% of tāngata whaiora and whānau rated one on one interaction with staff as ‘very’ to ‘extremely helpful’.
Table 19: Needs Questionnaire Results: Overall needs met

<table>
<thead>
<tr>
<th>Overall needs met</th>
<th>Participant response (N = 30)</th>
<th>Tāngata Whaiora (n = 20)</th>
<th>Whānau (n = 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>%</td>
<td>Median</td>
</tr>
<tr>
<td>Overall needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>1</td>
<td>5%</td>
<td>0</td>
</tr>
<tr>
<td>2=not very often</td>
<td>1</td>
<td>5%</td>
<td>0</td>
</tr>
<tr>
<td>3=some of the time</td>
<td>5</td>
<td>25%</td>
<td>3</td>
</tr>
<tr>
<td>4=often</td>
<td>4</td>
<td>20%</td>
<td>5</td>
</tr>
<tr>
<td>5=all of the time</td>
<td>9</td>
<td>45%</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Cultural needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>1</td>
<td>5%</td>
<td>0</td>
</tr>
<tr>
<td>2=not very often</td>
<td>2</td>
<td>10%</td>
<td>0</td>
</tr>
<tr>
<td>3=some of the time</td>
<td>5</td>
<td>25%</td>
<td>2</td>
</tr>
<tr>
<td>4=often</td>
<td>1</td>
<td>5%</td>
<td>4</td>
</tr>
<tr>
<td>5=all of the time</td>
<td>10</td>
<td>50%</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4.5</td>
</tr>
<tr>
<td>Spiritual needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>2</td>
<td>10%</td>
<td>1</td>
</tr>
<tr>
<td>2=not very often</td>
<td>2</td>
<td>10%</td>
<td>2</td>
</tr>
<tr>
<td>3=some of the time</td>
<td>4</td>
<td>20%</td>
<td>1</td>
</tr>
<tr>
<td>4=often</td>
<td>4</td>
<td>20%</td>
<td>2</td>
</tr>
<tr>
<td>5=all of the time</td>
<td>8</td>
<td>40%</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4</td>
</tr>
<tr>
<td>Emotional needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1=not at all</td>
<td>1</td>
<td>5%</td>
<td>0</td>
</tr>
<tr>
<td>2=not very often</td>
<td>3</td>
<td>15%</td>
<td>0</td>
</tr>
<tr>
<td>3=some of the time</td>
<td>4</td>
<td>20%</td>
<td>1</td>
</tr>
<tr>
<td>4=often</td>
<td>7</td>
<td>35%</td>
<td>7</td>
</tr>
<tr>
<td>5=all of the time</td>
<td>5</td>
<td>25%</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>100%</td>
<td>4</td>
</tr>
</tbody>
</table>
Table 19: Needs Questionnaire Results: Overall needs met cont.

<table>
<thead>
<tr>
<th>Overall needs met</th>
<th>Participant response (N = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tāngata Whaiora (n = 20)</td>
</tr>
<tr>
<td></td>
<td>F</td>
</tr>
<tr>
<td>Physical needs</td>
<td></td>
</tr>
<tr>
<td>1 = not at all</td>
<td>1</td>
</tr>
<tr>
<td>2 = not very often</td>
<td>1</td>
</tr>
<tr>
<td>3 = some of the time</td>
<td>5</td>
</tr>
<tr>
<td>4 = often</td>
<td>5</td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
<tr>
<td>Whānau needs</td>
<td></td>
</tr>
<tr>
<td>1 = not at all</td>
<td>0</td>
</tr>
<tr>
<td>2 = not very often</td>
<td>2</td>
</tr>
<tr>
<td>3 = some of the time</td>
<td>6</td>
</tr>
<tr>
<td>4 = often</td>
<td>3</td>
</tr>
<tr>
<td>5 = all of the time</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

The majority of participants, both tāngata whaiora (65%) and whānau (70%), indicated that their overall needs were met ‘often’ or ‘all of the time’ (see Table 19). However, more than a quarter of tāngata whaiora (25%) and whānau (30%) reported some inconsistency, with their overall needs met only ‘some of the time’, and two tāngata whaiora rated their overall needs as ‘not at all’ and ‘not often’ met by the Te Whetu Tawera service.

In relation to the holistic measures used to indicate the needs of participants, more than half of the tāngata whaiora and whānau rated that the cultural, spiritual, emotions, physical and whānau needs were met ‘often’ or ‘all of the time’. Despite this, there were also some indications of an inconsistency in care, with needs being met only ‘some of the time’, specifically in the domains of spiritual needs (20% of tāngata whaiora); emotional needs (20% of tāngata whaiora); physical needs (25% of tāngata whaiora); cultural needs (25% of tāngata whaiora) needs; and whānau needs (30% of tāngata whaiora; 40% of whānau). In addition, the spiritual needs of some participants were reported as ‘not at all’ and ‘not very
often’ met (20% of tāngata whaiora; 30% of whānau).
Chapter Five

DISCUSSION

This chapter begins with the limitations of the study before the key findings are discussed in light of the literature. Implications for primary prevention and service delivery in Māori mental health are then outlined. The chapter concludes with recommendations for further research.

STUDY LIMITATIONS

Study One: Tāngata whaiora admission patterns

The quantitative data collection process for this study was conducted utilising the computerised programmes within ADHB, which are utilised by district health boards nationally. One limitation of the data set related to the ethnic identification of tāngata whaiora (Mental Health Commission, 2004). At times tāngata whaiora may be too unwell to respond to questioning during the admission assessment. Clinical staff may therefore have been forced to make assumptions about tāngata whaiora ethnicity. This may have resulted in some minor differences in the actual number of service users identified as Māori, such as the case for some lighter skinned tāngata whaiora assumed to be of Pākehā descent. An additional limitation with the quantitative data collection potentially related to human error with data entry input. Potentially the reliability of the data may have been affected although given the experienced staff involved in this process this was probably minimal.

Study Two: Tāngata whaiora and whānau inpatient experiences

The first limitations of the qualitative study relate to participant recruitment and sample characteristics. All of the participants for the study were recruited via the kaupapa Māori service at TWT. To avoid selection bias, such as recruiting only the participants that had been positively involved with the Māori services, a number of methodological techniques were utilised. These included selecting participants at random times (refer to Chapter Two Methods) and approaching all those in the ‘discharge phase’ of admission.

In regards to a possible sample bias, the sample was not representative of the entire Māori population accessing TWT services. The majority of participants interviewed
identified as being highly secure in their Māori identity, and had had multiple admissions to inpatient services. However, it was also notable that a higher number of Māori males who were of older age were recruited, but this is consistent with the Māori admission rates to TWT from 2005 to 2008 (see Results). Of the 31 tāngata whaiora participants invited to participate, the 20 who were actually interviewed were representative of this group of 31. An obvious limitation of this study (which has been discussed in Chapter One: Personal research interests; and Chapter Two: Overall research design sections), was my role as a previous employee within the TWT service. The influence of my personal and professional values and beliefs on the research process may potentially have impacted on my ability to be objective. For instance, it is possible that I was more attentive to, or inviting of, more positive views of the service. Consequently, a number of steps were taken to address these biases, included: reassuring participants that their treatment would in no way be affected by participating in the study; reassurance around confidentiality and how the information would be used and reported; and my role as a researcher independent from TWT. The majority of interviews (22 of the 30) were conducted once I had left the service. During the data collection and analysis phases I also maintained an awareness of my own values and preconceptions (using supervision). An inter-rater reliability check was used during the data analysis phase with a 100% agreement obtained for the categories and themes. I also attempted to gain evidence of both positive and negative feedback by asking participants for both helpful and unhelpful experiences. During the interview process it was obvious that the majority of tāngata whaiora and whānau had little difficulty in reporting a range of experiences, positive and negative of their time at TWT.

In relation to the second component of Study Two, the Needs Questionnaire, the limitations associated with general self-report measures were identified. More specifically, the most obvious limitation most identified as potential misinterpretation or the difficulty for participants to fully understand the questions being asked. In order to reduce the impact of this, participants were offered support, from the interviewer, regarding any interpretation difficulties. During the questionnaire completion process approximately 15% of participants requested clarification regarding some of the questions posed or support with language definitions. The questionnaire was purposely completed at the end of the interview to reduce any potential bias or influence on the qualitative interview process.
In addition, an obvious limitation of the Needs Questionnaire was the small sample size (N = 30). However for the purpose of this study, the questionniare data was viewed in collaboration with the larger qualitative component of the study and was not meant as a stand-alone measure. Therefore the quality of data obtained from the Needs Questionnaire provided a richer indepth analysis of the participant’s inpatient experiences and further understanding of the needs when distressed, as intended.

**STUDY ONE: TĀNGATA WHAIORA ADMISSION PATTERNS**

The following section relates the key findings of tāngata whaiora admission patterns. These findings are then related to previous research.

**Admission Rates**

In this study Māori were significantly over represented (p= 0.005) in their admissions to the inpatient mental health service TWT, making up 17.1% of the total admissions and yet only 6.8% of the ADHB Māori population aged 15 to 65 years. Māori were admitted at a rate two and a half times the expected.

This finding confirms multiple previous studies. Since the significant increase of Māori first time admissions to mental health inpatient services in the 1970’s major mental health disparities between Māori and non-Māori have continued (with Māori admission rates significantly higher) (Abas et al., 2003; Edmonds et al., 2000; Fitzgerald, 2004; Ministry of Health, 2004a; 2004b; 2006; Te Puni Kokiri, 1998; Wheeler et al., 2005). This finding is also consistent with the admission patterns of the world’s indigenous populations and ethnic minority groups (Care Quality Commission, 2009). Researchers have found indigenous populations in Australia (Aboriginal and Torres Strait); Canada (Commission for Healthcare Audit and Inspection, 2005); America; and the UK (Read, 2004) to all have high admission rates to inpatient services when compared to non-indigenous populations.

Interpreting and understanding these statistics is complex as multiple causative influences are involved. A number of issues contributing to high Māori admissions to inpatient services have been highlighted in Chapter One including: inequalities; ongoing historical oppression; and contemporary realities (such as barriers and restrictive care practices). Many of these contributing factors relate directly to the substantial inequalities
Māori are confronted with (Crengle, 2009; Leitner, 2008; Woodward & Kawachi, 2000) which are closely linked to severe mental illness (Wilkinson & Pickett, 2009). The ongoing historical oppression Māori face through colonisation (such as land confiscation, legal injustices) (McCreanor & Nairn, 2002; Smith, 1998; Walker, 1990) including social discrimination, racism (Durie, 1998; Harris et al., 2006), prejudice (Johnstone & Read, 2000; Kumar & Tapsell, 2001; Read & Johnstone, in press), acculturation stress and isolation through rapid urbanisation (Abas et al., 2003; Durie, 1994; Keiha & Moon, 2008; Moeke-Pickering, 1996; Savdev, 1989; Walker, 2004) continue to impact on the wellbeing of Māori. The marginalisation of Māori and multiple disadvantages they are exposed to (Baxter, 2008; Tapsell & Mellsop, 2007) impact upon ones cultural connection and identity (Durie, 1994), emotional and psychological wellbeing (Albee, 2006) creating further challenges in maintaining ones wellbeing. Of major concern is the significant number of Māori living in poverty in Aotearoa (Jansen et al., 2009; Ministry of Health, 2010) and the impact this has on whānau ora. Poverty is predictive of mental unwellness, suicide, depression, severe mental illness (Albee, 2006) and other negative health and social outcomes (Albee, 2006; Read, 2010; Wilkinson and Pickett 2009) therefore positioning some Māori at further risk of experiencing extreme distress and consequent inpatient admissions.

In addition to the risk factors outlined above, maintaining whakaoranga and whānau ora remains an ongoing challenge for Māori. Difficulties associated with accessing services early enough to prevent admission (Durie, 1999; Dyall, 1999; Edmonds et al., 2000; Ministry of Health, 2010; Tapsell & Mellsop, 2007); a lack of culturally competent mental health services and clinicians (Abas et al., 2003; Dyall et al., 1999; Johnstone & Read, 2000; Simpson et al., 2003) and limited support for tāngata whaiora (Abas et al., 2003; Kumar & Oakley Browne, 2008) remain ongoing influences in maintaining wellness.

**Ward Admitted**

55.8% of Māori were admitted directly into ICU, compared to 44.6% of Europeans, 46.7% of Asians and 49.7% of Pacific. There was a significant difference (p=0.001) between the Māori and European groups. An admission directly to ICU requires the compulsory admission of tāngata whaiora under the MHA (1992). This finding is consistent with previous studies that found significantly higher rates of Māori admitted to inpatient services under the MHA (Durie, 1994; Wheeler et al., 2005), this is also the case for indigenous
peoples’ and minority groups internationally (Fernando, 2003; Care Quality Commission, 2009; Read, 2004b).

In an attempt to explain the high number of involuntary Māori admissions to inpatient services a number of key factors have been identified including: poverty; late presentation to mental health services; and racial discrimination. Some researchers strongly insist that poverty remains the ‘strongest and most consistent predictor’ of compulsory admission (Bindman et al. 2002).

In addition, previous studies have highlighted the late presentation of Māori accessing mental health services (Dyall, 1997). It has been reported that Māori often access support only when the level of unwellness is severe, (Baxter et al., 2006; Ministry of Health, 2006) therefore requiring more intensive support such as that provided in ICU. Reported Māori inpatient admissions primarily via the legal system (Edmonds et al., 2000) requiring force (Durie, 1994), with rates of Māori admissions to secure or forensic services also high, (Tapsell & Mellsop, 2007) reflect this pattern of late presentation. Similar findings are been reported amongst the international literature (Read, 2004) such as for African Caribbean and other ‘Black’ people in the UK (Nazroo, 2001).

Evidently, racial discrimination from some staff within mental health services is an additional factor identified as impacting on the care received by Māori (Durie, 1994a; Johnstone & Read, 2000). International researchers found that although there is no evidence indicating that African Caribbean people are more likely to be aggressive than Europeans, staff in inpatient services were more likely to perceive them as potentially dangerous (Nazroo & King 2002).

Participants in this research project reported racial discrimination from police officers during the Admission Process phase of their admission. Some TWT staff may have been more fearful of tāngata whaiora as a result of a number of factors such as: admission via police escort; negative stereotypes, perpetuated in the media (Nairn et al. 2006); and an unfamiliarity with cultural bound symptoms. For instance, one participant in this study was reportedly admitted to ICU and deemed more dangerous as a result of staff fear of him based upon his appearances (Māori male with tattoos). It is therefore possible that Māori were admitted directly to ICU (rather than the open ward) partly because they were considered more high risk and in need of a safe contained environment such as ICU.
Readmission

No significant differences between ethnic groups in terms of the average number of readmissions were found. Despite previous reports of high Māori readmission rates to inpatient services (Appleby et al., 1993; Gibson, 1999; Bridgman & Dyall, 1993; 1996; Te Puni Kokiri, 1998) recent research has not replicated this pattern (Fitzgerald, 2004; Kumar et al., 2008). There are a number of explanations for the recent findings, which include: enhanced community supports (such as kauapapa Māori services) better supporting tāngata whaiora post inpatient discharge (Fitzgerald, 2004; Kumar et al., 2008); and tāngata whaiora relocating to other DHB areas following discharge therefore being admitted to inpatient services other that TWT when distressed.

Length of Stay (LoS)

Analysis investigating the LoS found no significant differences between ethnic groups, consistent with findings from a recent study in Aotearoa (Kumar et al., 2008).

Diagnosis

This study found a significant difference (p=0.000) ($\chi^2= 94.101^*$) between ethnic groups and diagnosis. Māori were significantly more likely than European to be diagnosed with schizophrenia (37% vs 26%) and psychotic disorders (24.9% vs 20.6%). Conversely, Māori were less likely than European to be diagnosed with a mood disorder (20.4% vs 32%).

Previous studies have found similar results (Wheeler et al., 2005) with admission rates to inpatient services, with Māori diagnosed with schizophrenia 3.5 times more often and bipolar 2.4 times more often than non-Māori (Baxter, 2008). This pattern of Māori being over-diagnosed with schizophrenia has been found in both inpatient (Wheeler et al., 2005) and outpatient services (Wheeler, 2007) in Aotearoa. And as in this study, Māori rates of admission due to a depressive illness have been found to be lower than for non-Māori (Baxter, 2008; Bridgman & Dyall, 1996; Thomas et al., 2010). International studies have found that indigenous peoples are also more likely to be diagnosed with schizophrenia (Fernando, 2003; Read, 2004) and psychosis (Harrison, 2002; Nazroo & King 2002; U.S Department of Health and Human Services, 2001).

Multiple causative factors are associated with Māori presentation and symptoms interpreted and labelled as psychosis or ‘schizophrenia’ (Read, 2010). The traditional bio-
medical genetic theories used to explain such extraordinary experiences have recently been rejected by some researchers and health professionals, with a focus more on the associated psycho-social factors (Bentall, 2009; Geekie & Read, 2003; Read, 2010; Read et al., 2004; Johnstone & Read, 2000; Taitimu, 2008). Some of the major factors for Māori over-diagnosis are associated with marginalisation, such as poverty, racism, discrimination and isolation, and misdiagnosis.

The marginalised position of Māori within society provides a vehicle for understanding the ongoing mental health disparities with non-Māori, such as the over-representation of Māori diagnosed with psychotic related disorders. Colonisation and its manifestations (Abas, 2003; Durie, 1994; Keiha & Moon, 2008; Kowai & Paridies, 2005; Moeke-Pickering, 1996; Walker, 2004); the high levels of poverty amongst Māori (Bodley, 1990; Savdev, 1989; Tseng, 2003); and the fact that Māori are more likely to experience discrimination through institutional and interpersonal racism (Howden-Chapman & Tobias, 2000; Reid, Robson & Jones, 2000) are all contributing factors.

The impact of poverty continues to play a key role in negatively impacting upon Māori psychological wellbeing. The ‘circle of oppression’ has been presented by Read (2004), this describes a cyclic process of powerlessness, further compounded by the mental health system itself. This perspective may aid one in further understanding the complexity of factors and processes that contribute to Māori over diagnosis of psychotic disorders (Read, 2004).

“Of course the poor in any society are subjected to more sources of stress than wealthy…Even those with enough to eat and somewhere to live are more likely to experience powerlessness, isolation, lack of self-respect, physical ill-health etc…Having entered the system they are more likely, regardless of their behaviour, to be hospitalised and labelled ‘schizophrenic’. This is likely to further lower their self-esteem and motivation, and to frighten and distance loved ones” (Read, 2004: p. 168).

The over-diagnosis of Māori with schizophrenia and other psychotic disorders has been related to misdiagnosis (Dyall, 1997; Tapsell & Mellsop; 2007). Some researchers have been critical of applying western phenomena to indigenous populations who have their own
paradigms of health and interpretations for such experiences otherwise defined as hallucinations and delusions (Taitimu, 2008; Tapsell & Mellsop, 2007). Consequently the need for culturally appropriate assessments and treatments for psychological difficulties has been recommended (Dyall, 1997; Taitimu, 2008; Tapsell & Mellsop, 2007) to overcome misdiagnosis. This is essential given the influence of Māori knowledge on the content and frequency of delusions (Cherrington, 1994) and the relationship between Māori understandings of symptoms such as delusions and hallucinations otherwise labeled as symptoms of schizophrenia (Taitimu, 2008). Research has also found that clinicians who are able to establish sound therapeutic relationships, such as effective communication with tāngata whaiora, gain their trust and take account of the reluctance of some Māori to talk about personal feelings, are more likely to diagnose and treat effectively (Thomas et al., 2010).

In summary, the key findings from Study One, the over-representation of tāngata whaiora admitted to inpatient services; the high rates of Māori admitted directly to ICU; and the high rates of Māori being diagnosed with schizophrenia and other psychosis type disorders are consistent with previous research in Aotearoa, and with the international literature. An explanation of these negative statistics can be rooted in the ongoing inequalities and marginalisation Māori face, mental health service accessibility issues, and potential misdiagnosis related to limited access to culturally competent clinicians and assessment tools. Of major concern is the potential ‘circle of oppression’ (Read, 2004) of a psychotic diagnosis and the impact this has on Māori who are already marginalised in mainstream society, a toxic combination to deal with, especially when already extremely distressed.

STUDY TWO: TĀNGATA WHAIORA AND WHĀNAU INPATIENT EXPERIENCES

This section presents the key findings of Study Two which are discussed in two sections. The first focuses on some reports of satisfaction from participants related to the TWTT service. The second discusses the significant improvements suggested by participants.
Satisfaction with the Service

Feedback from the Needs Questionnaire indicated a general sense of satisfaction with TWT in meeting the overall needs of participants ‘often’ or ‘all of the time’, with more than half of the tāngata whaiora and whānau indicating that their cultural, spiritual, emotional, physical and whānau needs were met ‘often’ or ‘all of the time’ (see pp. 152 - 161). The majority of positive experiences was related to engagement with the TWT kaupapa Māori service. Other reports of satisfaction related to feeling supported during the admission; general staff positive attitudes and behaviour; and specific therapeutic interventions supporting recovery.

Satisfaction with support: All participants who had whānau or other familiar support people present (such as a CMHC key-worker) during the admission process reported a positive experience. The significance of support during the admission experience was highlighted by participants, and is of importance given that low levels of whānau understanding, acceptance and support can contribute to increased risk of psychological distress (Abas et al., 2003; Kumar & Oakley Browne, 2008).

The collective nature of both traditional and contemporary Māori society has been described through understandings of whānaungatanga, with a focus on relationships (Mead, 2003: p. 28) with the significance of whānau resembling supporting structures for complete wellbeing (Durie, 1994; Perc, 1984). The importance of feeling supported collectively maybe understood through these cultural underpinnings such as whānau ora. The related concept of manaakitanga, ‘nuturing relationships, looking after people, and being very careful about how others are treated’ (Mead, 2003: p. 29) may also be an influence.

Of interest in this study was the changing face of the traditional whānau and hapū extended family support systems of Māori. The innovative adaption of Māori was portrayed in this study via the support people identified by tāngata whaiora to participate in this study. Several were non-Māori (European; Samoan; Iranian); one whānau participant was a caregiver; and another a friend (rather than blood relative or partner). Consistent with findings in previous studies, it appears that Māori are progressively overcoming the issues of dislocation by creating broader more modern whānau and community support networks (Mental Health Commission, 2011).

Satisfaction with the Kaupapa Māori service: The majority of participants described positive experiences with the kaupapa Māori service Kai Atawhai, and many reported cultural needs to be met ‘all of the time’ (50% of tangata whaiora; 40% whanau) (see p. 159).
summary of the specific aspects supporting recovery and the response from participants is presented in Table 20.

Table 20: Positive Experiences with Kaupapa Māori Services

<table>
<thead>
<tr>
<th>Positive experiences with Kai Atawhai</th>
<th>Participant responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Te ao turea (Physical environment)</td>
<td>Safe, sanctuary, peaceful, Māori world, relaxing, comfortable, connected, supported, 'like whānau', aroha</td>
</tr>
<tr>
<td>Ha a koro ma e kui ma (incorporating aspects of Māori cultural heritage)</td>
<td>Lifted spirit, trusting, safe, supported, nurtured, Listened to, understood, cared for, supported, reassured, acknowledged, important, empowered, supported, belief in myself, confidence, comfortable</td>
</tr>
<tr>
<td>He tāngata (Staff)</td>
<td></td>
</tr>
<tr>
<td>Manaaki, atawhai (caring, helpful to others)</td>
<td></td>
</tr>
<tr>
<td>Pumahara (thoughtful, understanding)</td>
<td></td>
</tr>
</tbody>
</table>

The two key sub-themes for the Kaupapa Māori service Kai Atawhai, supporting recovery and whānau ora included: te ao turea (the physical environment), specifically ha a koro ma e kui ma (cultural heritage); and he tāngata (the people/staff), including characteristics associated with: he tāngata manaaki, atawhai (caring, helpful people); and he tāngata pumahara (thoughtful and understanding people).

The Kai Atawhai te ao turea (physical environment) was commented upon positively by all participants. This innovative kaupapa Māori environment emphasises ha a koro ma e kui ma and has been established similar to a traditional marae including a whare hui, whare kai, with the addition of the Kai Atawhai staff office adjacent to ensure accessibility. The Māori cultural space had significant meaning for tāngata whaiora and whānau who described a sense of mauri tau (inner peace), turangawaewae (safety) with a calming affect that facilitated healing (Taitimu, 2008). In particular, the whare hui was seen as a familiar place for many; providing an escape from unwellness and an opportunity and safe space for whakawhānaungatanga (relationships and connections) to occur; being a cultural environment that many Māori can relate to and feel comfortable in. Encounters of feeling connected to their Māoritanga, and the soothing of one’s wairua were also reported. This sense of a ‘safe’ cultural environment has been emphasised as therapeutic for Māori (Durie, 1994; Lapsley et al., 2002). By creating a sense of turangawaewae (home, place of standing, restoration of mana) where whānaungatanga (respectful harmonious relationships) can occur further contributes, in part, to the strengthening of ones Māori identity (Barnett &
Barnes, 2010). This relates to the assumption that a secure identity is necessary for one’s recovery and can contribute to recovery and whānau ora (Durie, 2003). This can also be explained via Nga Pou Mana o Io philosophy, and the dimension of mana tupuna (Ngaropo, 2005). The significance of knowing and having a connection with one’s ancestral relationships provide confidence, self-esteem and dignity and a secure cultural identity (Durie, 1994).

“A person who knows their identity is a true person who stands with confidence, pride and dignity. A person who doesn’t know who they are, are considered a lost soul” (Ngaropo, 2005: p. 6).

The second area highlighted as significant in supporting recovery and whānau ora for Māori were specific Kai Atawhāi staff qualities. Specific attributes related to the sub-themes of he tāngata manaaki, atawhāi (caring, helpful to others); and he tāngata pumahara (thoughtful and understanding people). The sense of connectedness participants felt with Kai Atawhāi which was helped, in part, by just seeing a Māori face (Dyall et al., 1999) and kanohi kitea contact, were major aspects that contributed positively to engagement and Māori recovery experiences. Feeling a natural connectedness with the Kai Atawhāi was common, and appeared also to be facilitated by shared iwi (ancestral history) and a shared worldview based within te ao Māori. This can be better understood via Nga Pou Mana o Io philosophy, whereby the dimension of mana tāngata portrays the significance of one’s connection through iwi, hapū, and Whānau (extended family) (Ngaropo, 2005; Ngata, 1993).

The ability of Kai Atawhāi to impart a genuine empathy, arohaina and understanding towards tāngata whaiora and whānau was an additional attribute participants reported as significant in supporting whānau ora.

(Kai Atawhāi staff member) was full of love and she wanted to help and I could see she was always there for me…I trust her (Jamie, TWM)

In addition, the main Kai Atawhāi attributes identified as supporting recovery included effective communication and engagement. In particular giving participants the opportunity to be heard; being respectful and displaying an understanding of distress, without making
judgment were important. Kai Atawhai reportedly exhibited attributes related to he tāngata pumahara, pukenga (thoughtful, wise, skilled) identified and responded to participants social and cultural needs and strengths promptly, utilising a holistic approach involving both clinical and cultural knowledge. Similar to previous research, understanding both the western and Māori indigenous health paradigms is of importance to achieving wellness (Betancourt et al., 2002; Ngata, 1949; Taitimu, 2008).

A crucial aspect supporting recovery, facilitated by Kai Atawhai, was their ability to whakamana (empower) the participants (Barnett & Barnes, 2010; Dyall et al., 1999), further supporting a secure cultural identity (Durie, 2003). Providing positive affirmation, advocacy and access to therapeutic cultural activities (such as karakia, string games, poi, waiata) nurtured this process (Ihimaera, 2004). Engaging in cultural interventions enhanced the sense of cultural identity and spiritual healing (Durie, 2003) for many providing a distraction from distress as well as an opportunity to learn new skills (Taitimu, 2008).

Kai Atawhai it has helped me more than the Pākehā side, everytime I see a Māori I think yes a Māori, yes aroha, spiritual healing, tendercare, loving, care, aroha, aroha, aroha…

The findings of this study support the recommendations of Dyall and colleagues (1999) that mental health services offer “Māori faces for Māori cases at Māori places” (Dyall et al., 1999: p. 7). That is, effective treatment for Māori encompassing a Māori workforce, such as Kai Atawhai, within an appropriate Māori cultural environment, such as Kai Atawhai te ao turanga. Of interest in this study, is the ability for a kaupapa Māori service to be situated within a mainstream service TWT, and to still be seen as therapeutic for tāngata whaiora, contrary to previous reports (Milne, 2005).

**Satisfaction with positive staff attitudes and behaviours:** Most participants described positive experiences with the TWT general staff. (However many also reported negative experiences). A summary of the factors supporting recovery and the responses from participants are presented in Table 21.
Table 21: Positive Experiences with General Staff

<table>
<thead>
<tr>
<th>Positive experiences with staff</th>
<th>Participant responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Valued, makes the staff feel like real people</td>
</tr>
<tr>
<td>Helpful communication, direct, offering sound advice, humour</td>
<td>Not feeling judged, valued, sense of hope, connection, taken care of, respected, staff have a genuine concern for their wellbeing</td>
</tr>
<tr>
<td>Manaakitanga (greeted with a hongi)</td>
<td>Worthiness, deserve to be taken care of, respected, appreciation being treated normally</td>
</tr>
<tr>
<td>Supported (aid from social worker with accommodation and finances)</td>
<td></td>
</tr>
</tbody>
</table>

During the past decade it has been reported that mental health staff attitudes towards tāngata whaiora have improved (Mental Health Commission, 2005). Three key areas of staff attitudes and behaviours were highlighted from this study as factors supporting recovery, communication; manaakitanga; and support.

Firstly, communication was perceived as effective when involving clear direction, honest, open (*telling it like it is*) yet respectful style, offering sound advice and being treated like a ‘normal’ person. Staff that used humour with Participants were perceived as ‘real people’ and this was also received positively.

The second key staff attitude related to manaakitanga. The genuine actions of kindness and support offered by some staff consequently resulted in tāngata whaiora and whānau feeling valued, providing a sense of hope for participants further supporting their journey of recovery.

Participants highlighted the supportive role of many staff, especially social workers, which were potentially related to the high level of social needs (such as financial and housing needs) amongst tāngata whaiora. Interventions and behaviours of staff that made participants feel supported included a staff member cooking a boil up meal resulting in the tāngata whaiora feeling valued *it makes me feel worth it*, social workers sorting stressors resulting in tāngata whaiora feeling respected, *being treated normally, I really appreciated that*, and valued *I deserve to be taken care of*.
The interviews were consistent with the data from the Needs Questionnaire. ‘One to one’ interactions with staff were rated as the most helpful of the six ‘therapeutic interventions’ by both the tāngata whaiora and whānau.

**Satisfaction with service experiences:** More than half of the participants in this study reported a willingness to return to TWT if unwell in the future, based upon positive service experiences. The main factors associated with participants’ positive experiences related to feeling secure while maintaining a sense of freedom. For instance, a sense of security (and relief) was felt by whānau, knowing that their distressed whānau member was being observed closely in a secure environment. The opportunity for whānau, friends and care givers to take time-out from caring for their distressed whānau member, through shared responsibility (especially when serious risk issues to the self or others was a concern) was a valued experience (Gibbs et al, 2004). In addition, the opportunity for tāngata whaiora to relax during the initial phase of the admission, provided distance from everyday life stresses (such as financial and relational stresses) which was seen by some as very useful in supporting recovery. An admission experience for some participants provided time-out to think and develop strategies to promote and maintain wellness; time out to reflect and deal with old issues; and escape (temporarily) from bad habits (such as drugs and other bad influences).

As one’s journey of whakaoranga progressed, the sense of freedom within the confined environment of the inpatient service was valued by participants. This was experienced when tāngata whaiora were transitioned from ICU to the less restricted open ward, and when leave provisions were increased. For instance, it was common practice for leave from the service to be extended as tāngata whaiora distress subsided. This provided flexibility for participants to receive treatment within TWT and also continue to be active within the community and essential progression for ongoing recovery (Mental Health Commission, 2006).

**Satisfaction with interventions contributing to whakaoranga:** The main therapeutic interventions seen as positively contributing to whakaoranga for participants included the investigation of other medication options and alternative therapeutic interventions and discharge meetings.
Firstly, for a number of participants, the inpatient admission provided an opportunity for their current medication regime to be reviewed and other medication options trialled safely under close staff supervision.

Secondly, alternative therapeutic interventions offered by TWT were valued. Activities offered by the OT recovery programme reportedly provided a useful distraction from distress and an opportunity to rehearse self-soothing strategies. Specific activities participants valued included swimming, cooking, dancing, music concerts, art, gym, drumming session, table tennis, relaxation groups, yoga, thai chi and the walking group. Additional therapeutic interventions included one to one psychological therapy, CBT and DBT skills groups. The main therapeutic aspects supporting recovery were related to the supported process of understanding unwellness and distress with a focus on sharing experiences and identifying precipitating factors. Learning new coping skills and the supported process of rehearsing skills was also valued.

Thirdly, discharge meetings were perceived by all who attended one (ten out of 30 participants) as an extremely valuable intervention. These involved planning and setting up community supports prior to tāngata whaiora being discharged to avoid potential relapse. The positive aspects of the discharge phase for participants included the process of working collaboratively (tāngata whaiora, whānau, inpatient staff, and community services) in planning community reintegration (such as progressive leave, extended leave, to overnight leave). The focus on individual progress was also seen as beneficial. For instance, a longer discharge process (when needed) could be negotiated. This may involve extended leave from TWT allowing time for tāngata whaiora to readjust from the hospital environment to independent living, consequently reducing potential fear and anxiety.

The Need for Significant Improvements
Despite the reports of participant satisfaction with the TWT service, there was a significant amount of negative feedback highlighting the need for major improvements to inpatient service delivery for Māori. More than two thirds of participants identified flaws in the service describing experiences and interventions that inhibited whakaoranga. Over a quarter of tāngata whaiora (25%) and whānau (30%) reported their overall needs to be met only 'some of the time'; and two tāngata whaiora rated their overall needs as ‘not at all’ and ‘not often’
met by TWT. Furthermore, an inconsistency in care and service delivery was described, with needs being met only ‘some of the time’, specifically in the domains of spiritual needs (20% of tāngata whaiora); emotional needs (20% of tāngata whaiora); physical needs (25% of tāngata whaiora); cultural needs (25% of tāngata whaiora); and whānau needs (30% of tāngata whaiora; and 40% of whānau). In addition, the spiritual needs of some participants were reported as ‘not at all’ and ‘not often’ met (20% of tāngata whaiora; and 30% of whānau) (see pp. 152 – 161).

These findings are comparable with reports of poor quality treatment in untherapeutic inpatient service environments in Aotearoa (Mental Health Commission, 2005; 2006). Many of these factors were associated with admission to the service and experiences involving restrictions such as involuntary admissions, restraint and seclusion. In addition, safety issues; the accessibility of support; and therapeutic interventions meeting the needs of tāngata whaiora were also identified as major areas for improvement. Furthermore, specific staff attitudes and behaviours inhibiting recovery and alternative care options were areas identified for development.

**Restrictive care practices inhibit recovery and result in further trauma for those already distressed:** The main imposed restrictions reported by participants included: involuntary admissions via the MHA; physical force and restraint; and experiences of seclusion.

Admission to TWT was generally a negative experience for many participants. This was related to factors associated with involuntary admissions via the MHA which was forced upon tāngata whaiora and involved intervention by police officers. Over one-third of participants had police involvement in their admission, involving physical restraint (including reports of assault and abuse). Consequently, tāngata whaiora and whānau participants reported traumatic experiences during this process, associated with negative feelings of trauma and fear.

…”we were underground down in the cells and that was traumatic, I took four days in ICU to get over that. That was traumatising…that was probably the darest period of my life so far, locked up in that cell
The negative experiences for Māori in the process of being admitted to inpatient services is a major concern especially given the high numbers of Māori accessing these services via involuntary admissions under the MHA (Durie, 1994; Wheeler et al., 2005). In part, this can be related to the reported ‘late’ presentation of Māori to mental health services, when their distress is more extreme (Bridgman & Dyall, 1996; Edmonds et al., 2000).

Secondly, the use of force and physical restraint was traumatic for tāngata whaiora and whānau participants in this project. They found this extremely disempowering. Some evidence for racial discrimination (as discussed earlier in the section ‘ward admitted’) was reported. One participant felt they were restrained because of the staff perceptions of them and associated fear (specifically towards a Māori man with tattoos; however it is also possible that his level of unwellness and distress was also a factor). Participants described a fear of staff, whānau felt helpless, and extreme distress and fear was associated with restraint. In this study, negative experiences for Māori while being admitted to inpatient services were related to key areas including inadequate communication and information, and ethnic and cultural miscommunication. Māori were very aware of the quickness of police officers, and to some extent, health professionals’ to stereotype and make assumptions about them based on their ethnicity, and expressed concerns around the lack of awareness and understanding of their culture. Restraint has been described as an “archaic, one dimensional practice” (Allsop, 2009) that is counter therapeutic and contrary to recovery principles. However as a last resort, restraint (in some rare situations) can be an effective practice in ensuring safety.

Thirdly, the restrictive environment of ICU, and more specifically seclusion, was described as a negative experience for many. The seclusion experiences of participants were often compared to a confined prison encounter. ICU was perceived as inhibiting recovery I felt like my wairua was trapped, reportedly an untherapeutic environment being contained to that level. Previous findings from inpatient service evaluation studies have also reported a ‘restrictive institutional experience’ (Mental Health Commission, 2001) and traumatic experiences for tāngata whaiora in seclusion (Mental Health Commission, 2005).

Many studies have highlighted specific restrictive care practices experienced by Māori, often associated with the later presentations to mental health services (with mental health services perceived as punitive rather than assisting in recovery) (Durie, 1994; Gaines et al., 2003; Krawitz & Watson, 1997; Simpson et al., 2003; Te Puni Kokiri, 1994; Te Puni Kokiri, 1998). Māori are subjected to high levels of involuntary admissions (Bridgman &
Dyall, 1996; Dein & Lipsedge, 1998; Edmonds et al., 2000; Lloyd & Moodley, 1992), admitted under a compulsory MHA (1992), with high levels of force (Durie, 1994; Wheeler, Robinson and Robinson, 2005) involving seclusion and restraint (Carpenter et al., 1988; Donovan et al., 2003; El Badri & Mellsop, 2002; Spector, 2001) and admitted to secure wards (Tapsell & Mellsop, 2007).

Safety issues need to be addressed (potential risks, cultural safety and harassment):
Concerns regarding safety issues focused on a number of key aspects of care which included general safety issues (and harassment) and cultural safety. Firstly, concerns regarding safety were related to tāngata whaiora being discharged too early from ICU and the open wards of TWT. Although a concern reported in previous research involving service users (Mental Health Commission, 2005) this study found no significant difference in the LoS between ethnicities. Some participants reported this as a result of bed shortage. Participants felt strongly that premature discharges could result in relapse and readmission to the inpatient service. Despite the positive reports of discharge meetings it should be noted that most tāngata whaiora did receive a formal discharge meeting.

Also of concern was the safety of participants’ within the service when confronted with harassment such as verbal, physical and sexual threats and assaults from other service users when unwell. This was also compounded by the reported increased access to drugs from other service users and visitors. In addition, concerns regarding tāngata whaiora safety were raised in relation to the mixed gender ward, specifically in ICU. A number of participants expressed concern in an environment where tāngata whaiora tend to be more unwell and at times more vulnerable. Common issues including pressure for cigarettes and money, theft and noise which have been reported in previous research (Mental Health Commission, 2001). Participants have recommended that services users assessed as high risk are closely monitored with adequate supports in place to contain any challenging behaviours.

Furthermore, cultural safety issues were also raised. Of concern for some participants were issues relating to serious breeches of tikanga Māori. For example, infringements of tapu were described in seclusion rooms when urine pans and kai are placed near one another.

Support for tāngata whaiora and whānau needs to be accessible: Accessing supports during the inpatient admission was problematic for some participants. One - third of tāngata whaiora and whānau participants reported negative experiences when admitted to TWT.
related to the absence of support during the admission process. Admission to an inpatient service is often daunting for tāngata whaiora who are extremely distressed. A lack of support during this process can further heighten the distress experienced, especially if the environment is unfamiliar, as is the case for a first admission. Of concern for some participants was the lack of communication between mental health services and whānau. Too often whānau members were unaware of their whānaunga pending admission to TWT, as they had not been informed by either the community or inpatient mental health staff. Although the majority of discussion regarding the Kai Atawhāi service was positive, there were a few areas of concern for a few participants. These related to accessibility, with the demanding schedule of staff resulting in one participant finding it difficult to spend time with the Kai Atawhāi staff as they were often busy with meetings. Another issue raised by one participant was regarding inconsistency, specifically related to the scheduled karakia time not happening regularly. This feedback may, to some extent, be understood by the teams staffing levels. During the duration of this research and data collection period (of 3 years), the staffing capacity of the Kai Atawhāi team varied significantly from 1.5 FTE to 4FTE, related to staff absences, employment vacancies and recruitment issues. Given the importance of the Kai Atawhāi service, kaupapa Māori staff recruitment and retention must be a priority to ensure adequate access to cultural supports. For instance, access to on-call 24 hour kaupapa Māori services would be beneficial (given the acute nature of the service many tāngata whaiora will be admitted after hours).

Secondly, access other mental health service supports, such as CMHC and crisis assistance, when tāngata whaiora displayed early warning signs of relapse, was less than optimal. Some participants reported not getting support when they needed it resulting in frustration. A number of participants described experiences where the admission could have been avoided if intervention had been available from community mental health services earlier. For instance, one participant reportedly approached community services requesting support (including a prescription) but was not able to access the support needed. A previous study has reported service users often being turned away by community crisis and inpatient mental health services when extremely distressed (Mental Health Commission, 2006).

**Therapeutic interventions need to meet the needs of tāngata whaiora:** A negative experience for the majority of tāngata whaiora participants admitted to TWT was boredom,
as reported in other studies (Ministry of Health, 2001), and limited activity to stimulate recovery once tāngata whaiora start to improve.

This study found medication, although helpful for some tāngata whaiora, to be the main intervention inhibiting recovery (in both interview and questionnaire results) (Taitimu, 2008). Many participants reported being over-prescribed with medication, similarly to previous studies (Mental Health Commission, 2001; 2005) and being prescribed too many different types of medication, being treated like a guinea pig (Wheeler et al., 2008). Medication was the only intervention assessed as being on the ‘not helpful’ side of the mid-point in the Needs Questionnaire – by both tāngata whaiora and whānau.

Despite the positive reports of therapeutic interventions (such as psychological therapy), access to such therapeutic interventions for Māori participating in this study was minimal (as reported in the study questionnaires). The DBT and CBT groups were reportedly held infrequently and therefore under-utilised by Māori participants. Tāngata whaiora referrals to psychological services were also low despite feedback from tāngata whaiora and whānau valuing such interventions. Reported difficulties accessing psychological assistance in inpatient services has been a focus of previous service evaluations (Mental Health Commission, 2001).

**Negative staff attitudes and behaviours inhibit recovery and whānau ora:** Despite all of the positive feedback relating to staff behaviour and interventions, there was an equal amount of discussion involving negative experiences. A summary of the factors relating to negative experiences are presented in Table 22.

*Table 22: Negative Experiences with Staff*

<table>
<thead>
<tr>
<th>Negative experiences with staff</th>
<th>Participant responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortage and inconsistency</td>
<td>Difficult to develop rapport and trust, concerns about risk, frustration</td>
</tr>
<tr>
<td>Attitudes, cold and distant, distracted and absent</td>
<td>Avoidance, concern with staff stress, uncaring, unhelpful, unheard</td>
</tr>
<tr>
<td>Poor communication</td>
<td>Confusion, unsettling, unheard, not important, anger sometime spiralling into aggression, mistrust, inferior, ‘instinctively submissive’, disrespected</td>
</tr>
</tbody>
</table>
There were three key areas of staff attitudes and behaviours associated with inhibiting recovery and whānau ora, including shortage and inconsistency of staff; cold and distant, distracted and absent attitudes; and poor communication.

Firstly, some staff were perceived as being under intense pressure and stressed from working long hours due to staff shortage and a high number of casual staff. The inconsistency of staff resulted in difficulties developing rapport and an inability to develop positive trusting relationships with staff. Some participants highlighted potential risk issues given the low staff levels and unfamiliarity of staff with those they work with. Such reports can be related to inpatient service evaluations reports of workforce issues, more specifically difficulties retaining staff with crisis services, described as being ‘in crisis’ themselves (Ministry of Health, 2006).

The second key aspect was the attitudes of some staff members. The described cold and distant attitudes resulted in some participants avoiding particular staff members. Potentially related to the issue with staffing, some staff were also described as distracted and absent, and reportedly spent a lot of time in the nursing station areas with a focus on report writing rather than face to face contact with service users. This behaviour was perceived as uncaring and unhelpful. Difficulties managing both administrative tasks and clinical care have been highlighted in previous studies (Jackson & Stevenson, 2000) as well as the lack of empathetic attention from staff (Ministry of Health, 2001) and a failure to treat tāngata whaiora with dignity and respect (Mental Health Commission, 2005). The focus on a crisis orientated model of care (Cleary, 2004) with an emphasis on symptom stabilisation have been suggested as an effective model of practice (Fortinash & Holoday-Worret, 2004). However, research has also reported the importance of the therapeutic relationship as fundamental in inpatient care (Fourie et al., 2009)

The third key area of concern relating to negative experiences of staff was poor communication. Conflicting information from different staff members (doctors and nurses) has resulted in tāngata whaiora and whānau feeling extremely confused about what is happening with their care. Associated experiences of being unheard and feeling not important, at times resulting in anger and sometimes aggressive responses were also unsettling for participants. The result of such communication difficulties related to a lack of information can also result in mistrust (Mental Health Commission, 2005) further impacting upon the therapeutic relationship. In addition, assessment/interview meetings have
reportedly, at times, involved too many clinicians (doctors, nursing staff and students) out numbering tāngata whaiora. The outcome for some participants was a feeling of inferiority, consequently resulting in participants becoming instinctively.

**Alternative care options need to be investigated:** More than half of the participants would be happy to return to TWT if unwell or extremely distressed in future, based upon positive experiences of the service. Crucial to that decision was the inclusion of the cultural support offered by the onsite kaupapa Māori service Kai Atawhai. Another factor influencing participants’ decisions to return to TWT is the sample of tāngata whaiora interviewed. Most of the participants had had multiple admissions to TWT and consequently may feel more comfortable returning to a familiar environment; or struggle to imagine alternative care options other than what they have already received.

Despite participants’ reports of satisfaction with the service offered by TWT, almost two-thirds of participants discussed alternative care preferences if ever unwell in future. Alternatives to inpatient services has been previously endorsed by service users in Aotearoa (Agar-Jacomb & Read, 2009; Gilburt et al., 2010), and found effective in supporting recovery internationally (Fenton & Mosher, 2000; Keisler, 1982; Stroul, 1988).

The main alternative care options discussed in this study fall into two categories: existing services; and the development of kaupapa Māori te ao turea. Firstly, the preference of some participants was to receive care within low stimulus environments based in the community, such as in smaller respite services and other community services. Mind Matters a charitable trust located in the native bush suburb of Titirangi, Auckland, was discussed. The service offers a community-based alternative to inpatient admissions for young people (aged 16 to 30) with severe mental health difficulties. Most tāngata whaiora reside at the service from one to three weeks, either attending the day and/or residential programme. Specific therapeutic interventions focus on brief focused interventions such as the development and rehearsal of coping skills, and an activity-oriented programme of social and living skills (O’Brien, 2007).

Mental health services that remain integrated within the community have been the focus of the MHC for some time now (Mental Health Commission, 2007). Some alternative inpatient services are now being offered by the Inpatient (Acute) Home-Based Services (AHBS) provided by some DHB’s in Aotearoa. The focus is to provide short-term practical support for tāngata whaiora in distress in their own home, or a respite environment (Te Pou o te
Whakaaro Nui, 2011). However, as a newer service this option was not discussed by any of the participants in this study.

In addition to existing alternative care services, the development of specific therapeutic kaupapa Māori te ao turea was discussed by a number of participants. Tāngata whaiora and whānau participants described services that were turangawaewae based (such as marae) providing a safe environment where whānau could be actively involved at all stages of recovery. A natural native setting, near Tanemahuta and Tangaroa, was seen as an integral aspect of such a service, providing tāngata whaiora with the opportunity to connect and draw upon the healing power of Papatuanuku and other significant cultural figures (Durie, 1994; Dyall et al., 1999; Lapsley et al., 2002). This relates directly to Nga Pou Mana o Io dimension of mana whenua and one’s connection with the land and ancestral landmarks (Ngaropo, 2005).

**IMPLICATIONS AND RECOMMENDATIONS**

The following section discusses the implications for primary prevention and service delivery improvements of mental health inpatient services. These aim to address the over-representation of Māori suffering extreme psychological distress and consequent admissions to inpatient services, and also improve inpatient mental health services for tāngata whaiora and whānau that best support the journey of recovery and whānau Ora.

**Primary Prevention Issues**

This section discusses the significance of a government commitment to addressing inequalities; and policy development and implementation in improving mental health wellbeing for Māori.

**Commitment to addressing inequalities:** Achieving ‘whānau ora’ for Māori needs to begin with addressing the factors contributing to the ongoing disparities and inequalities which they are faced with. A number of strategies, visions and policies based upon the pursuit of social justice have been described as a premise for such work. It has been widely accepted amongst researchers in pursuit of social justice that primary prevention to address disparities and inequalities involves political commitment and
recognition (Cox & Black, 2011; Read, 2010; Wilkinson & Pickett, 2009). Leading indigenous health researchers have asserted that:

“Correction of these inequities needs increased awareness, political commitment, and recognition rather than governmental denial and neglect of these serious and complex problems” (Gracey & King, 2009: p. 65).

Inequalities are avoidable to some extent as they can be significantly reduced through government policy choices (Woodward & Kawachi, 2000). Moreover, researchers in Aotearoa have concluded that the development of broader policies to decrease societal inequalities for Māori in social, economic and education outcomes will consequently lead to a reduction in physical and mental health inequalities between Māori and non-Māori (Baxter, 2008). This is also recognised internationally:

“The best way of responding to the harm done by high levels of inequality would be to reduce inequality itself…reducing inequality would increase the wellbeing and quality of life for all of us” (Wilkinson & Picket, 2009: p. 33).

Many researchers assert that poverty is the ‘first step’ in primary prevention (Albee, 2006: p.451). The impact of poverty on one’s mental wellbeing is highly significant (Mental Health Commission, 2007) especially for Māori, who are often faced with a complexity of additional impeding factors (Durie, 1994). Health inequalities for indigenous peoples are related not only to socioeconomic deficits but also indigenous specific factors. These factors can include the ongoing impacts of colonisation, the loss of language and culture, and disconnection from the land (King et al., 2009).

**Policy development and implementation:** The broad role of mental health policy makers is to create and implement policies that support Māori wellbeing explicitly whānau ora. Their role in this sense is to implement policies that reduce disparities and inequalities; ensure existing policies supporting Māori wellness are implemented and the outcomes measured; and support recovery. The latter aimed at addressing access issues and barriers; and ongoing policy developments supporting kaupapa Māori services that support whānau ora. Furthermore, the development of clinical and cultural competency frameworks and
guidelines for health professionals and professions working in the mental health field (including culturally appropriate assessment tools, and therapeutic interventions) are also of importance.

Evidently, the He Korowai Oranga health (Ministry of Health, 2002) policy in conjunction with the Whakataatā Tuarua: Māori Health Action Plan 2006-2011 (Ministry of Health, 2006) affirms the support need for Māori to achieve whānau ora (Ministry of Health, 2002; Mental Health Commission, 2006). A main aim of the policy is to improve Māori mental health outcomes and reduce Māori health inequalities. Over the decade, such policy implementation has seen the emergence of whānau ora bringing together Māori aspirations around mental health and broader Māori development goals (Mental Health Commission, 2006); however ongoing progress is required to see the full effect of these policies.

Given the the relationships of inequality, poverty, racism, prejudice and discrimination to mental health difficulties it is critical for those with access to this knowledge (such as mental health professionals, health researchers, tāngata whaiora and whānau) to take action (Read, 2010). Such active responsibility may be in the form of lobbying government to prioritise objectives that eradicate inequalities and enhance a fairer just society (Cox & Black, 2011). Strategies and policies aimed to address institutional racism (Harris et al., 2006); reduce alienation within mainstream mental health services; and improve access of adequate funding for te reo Māori and tikanga in schools are factors that can promote such advancements (Cox & Black, 2011). In addition, improving economic equality; building resiliency and prioritising children and youth (such as through primary prevention programmes that focus on reducing child abuse and child poverty) (Read, 2010); and equal access to health and social services and supporting full employment should also be the focus of future strategic policies (Cox & Black, 2011).

The complexity and the implications related to the mental health wellbeing of Māori are summed up by Harwood (2010), who proclaims that:

“Inequity of health and rehabilitation outcomes speaks to the (under) valuing of peoples lives within their nation; such undervaluing of Indigenous people will require a comprehensive and multi-faceted response that will address, rather than tolerate,
disparities. A rehabilitation strategy that achieves the aspirations of indigenous peoples ultimately delivers the promise of a healthy nation” (p. 976).

Moreover, as a psychology profession focused on supporting recovery a wero (challenge) to bring change has been asserted by Albee (1996):

“Psychologists must join with persons who reject racism, sexism, colonialism, and exploitation and must find ways to redistribute social power and to increase social justice. Primary prevention research inevitably will make clear the relationship between social pathology and psychopathology and then will work to change social and political structures in the interests of social justice. It is as simple and as difficult as that!” (Albee, 1996: p. 1131)

Implications and Recommendations for Inpatient Mental Health Service Delivery

The majority of participants in this study identified satisfaction with experiences and therapeutic interventions that supported the journey of recovery and whānau ora. The successful progress of the TwT service from previous inpatient service delivery evaluations (Mental Health Commission, 2001; 2005; 2006) deserves to be celebrated. Specific achievements include: the development and implementation of successful kaupapa Māori supports; enhanced staff attitudes and behaviour supporting recovery; and recovery focused therapeutic interventions. Consistent with reports from Te Haerenga mo te Whakaoranga 1996-2006 (Mental Health Commission, 2007) significant progress has been made in inpatient mental health service delivery, such as: improved quality of services; and progress towards achieving recovery and whānau ora. However it is evident that despite the improvements made there remain ongoing challenges. The following section provides recommendations to address these issues for Māori.

Although the recommendations made here are contextually specific to the TwT service, suggestions to improve mental health inpatient services in the broader Aotearoa context have been offered with a focus on fundamental service delivery factors. The following are suggestions for inpatient clinicians and service managers intended to improve service delivery, by supporting a positive recovery experience for tāngata whaiora and whānau. The key areas discussed are: principles supporting therapeutic engagement; staff
development (such as cultural competency; workforce development; enhancing the scope of practice); improved access to kaupapa Māori services; and enhanced practices and interventions that support whakaoranga and whānau ora (see Table 23).

Table 23: Recommendations to Improve Inpatient Service Delivery

<table>
<thead>
<tr>
<th>Inpatient service focus</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Engagement with tāngata whaiora and whānau</td>
<td>Principles supporting therapeutic engagement</td>
</tr>
<tr>
<td>Staff development</td>
<td>Cultural competency</td>
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<tr>
<td></td>
<td>Workforce development</td>
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<tr>
<td></td>
<td>Enhancing the scope of practice</td>
</tr>
<tr>
<td>Kaupapa Māori services</td>
<td>Improved access</td>
</tr>
<tr>
<td>Practices and interventions - Develop and enhance practices</td>
<td>Safety - balancing safety and restrictions</td>
</tr>
<tr>
<td></td>
<td>Reduce the negative impact of police involvement</td>
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<tr>
<td></td>
<td>Reduce the use of force, restraint and seclusion</td>
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<tr>
<td></td>
<td>Accessible supports for tanagata whaiora and whānau</td>
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<td></td>
<td>Enhance therapeutic interventions</td>
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<td></td>
<td>Develop and implement debriefing and reflective practices following</td>
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<tr>
<td></td>
<td>critical incidents</td>
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<td></td>
<td>Ensure collaborative discharge meeting for all tāngata whaiora</td>
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**Principles supporting therapeutic engagement:** Although this study did not involve a formal evaluation of the effectiveness of the TWT inpatient service, many positive statements were made regarding the service’s role in supporting recovery and whānau ora, highlighting the therapeutic relationship as fundamental in inpatient care. However many negative participant experiences were also highlighted as recovery inhibiting factors primarily related to specific staff attitudes and characteristics. In light of these findings, what follows is an attempt to summarise the themes of positive staff attitudes and behaviours that were most valued by the participants. Six principles that enhanced positive experiences for participants have been identified as a guide for therapeutic engagement practices with Māori, see Table 24. (Not all principles were named during the interviews but all have been drawn from the comments made regarding positive staff experiences).
Table 24: Principles Guiding Therapeutic Engagement with Māori

<table>
<thead>
<tr>
<th>Principles</th>
<th>In Practice/Implementation</th>
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</table>
| Whakaute – Respect               | Whakawhiti kōrero – communication, respectfully direct, honest, listens, more 1:1 contact, kanohi-ki-te-kanohi interaction  
                             | Pumahara – thoughtful, listens, understanding, respectful  
                             |                                                                                              |
| Mana motuhake – Self determination| Whakamana – empowering, positive affirmation, advocate  
                             | Mana ake – unique identity  
                             |                                                                                              |
| Whakaoranga / Whānau Ora – Recovery / Wellbeing | Whakahuru – Reassuring  
                             | Ngakau rorotu - Optimistic  
                             |                                                                                              |
| Whānaungatanga – Connectedness   | Manaaki whānaungatanga – Nurturing relationships, whānau, hapū, iwi  
                             | Engagement with Tāngata Whaiora Māori and  
                             | Whānau through positive open, trusting and transparent relationships; effective liaison and communication  
                             |                                                                                              |
| Manaakitanga – Hospitality       | Atawhai – helpful, nurturing  
                             | Pono – genuine, honest, integrity  
                             | Arohaina – unconditional love  
                             | Manaaki – caring, non judgemental, warm  
                             | Puku aroha – sympathetic, listens  
                             | Hangai – focused  
                             |                                                                                              |
| Wairuatanga - Spirituality       | Pukenga – skilled and knowledgeable in both cultural and clinical expertise; cultural competence; holistic approach  
                             |                                                                                              |
Firstly, the principle Whakaute relates to interactions involving respectful engagement (Drury & Munro, 2008) and whakawhitikōrero (communication) (Bridgman et al., 1999). Communication that is direct, honest and thoughtful are crucial for respectful engagement. The significance of kanohi kītea (face to face) interaction and the importance of just listening are also of high importance.

They (staff) just need to get out of that office and have more contact with the patients and hands on, go and sit in there and do your reports and then hands on, you got to get out there, the office … you got to have that rapport with people, meet their needs because if you’re not meeting their needs by sitting in there and by looking out ….it would make a big difference because people will feel cared for

The second principle emphasises the importance of maintaining and ensuring Mana motuhake (self determination) (Dyall et al., 1999). Practices pertaining to whakamana – empowerment (Drury & Munro, 2008) include positive affirmation and advocacy. Upholding and supporting the mana ake (unique identity) of Māori is also of importance (Bridgman et al., 1999; Durie, 1998).

Thirdly, belief and commitment to Whakaoranga and whānau ora (recovery and wellbeing) is identified as a key principle. The implementation of this principle can be provided via whakaahurū (providing reassurance) and ngakau rorotu (optimism) for tāngata whaiora during the recovery journey.

The fourth principle, Whānaungatanga (connectedness, respectful and harmonious relationships) (Barnett & Barnes, 2010) relates to practices focused upon manaaki whānaungatanga (nurturing relationships) (Drury & Munro, 2008; Mead, 2003). The importance of working collaboratively with whānau, hapū, and iwi is crucial to the implementation of this principle. In addition, engagement involving positive, open, trusting and transparent relationships can contribute to effective liaison and communication (Eley et al., 2006).

The fifth principle of Manaakitanga (hospitality) is also identified as important (Drury & Munro, 2008). The implementation of this core value is centred within the traditional beliefs and practices of tikanga Māori. Such principles focus on attributes of atawhai (helpful, nurturing); pono (genuine, honest, integrity); arohaina (unconditional love);
manaaki (caring, non judgemental, warm); puku aroha (sympathetic, listens); and hangai (focused and attentive).

The final principle refers to Wairuatanga (spirituality), related to the importance of spirituality in the overall wellbeing of Māori. An understanding of Māori cultural knowledge, specifically the impact on one’s wairua during times of both distress and recovery, is seen as essential (Durie, 1998; Mental Health Commission, 2007). The significance of the wairua dimension in Māori models of health was represented in the findings of this research project with an emphasis on the level of clinicians’ pukenga (skill and knowledge) (see pp. 111-112). Supporting the wellbeing of one’s wairuatanga is crucial to achieving overall whakaoranga (Durie, 1994; Goldsberry, 2004; Tse et al., 2005). Consequently, a high level of cultural or dual competency was seen as essential for a clinician’s understanding, engagement, assessment and treatment of Māori (Goldsbury, 2004; Ihimaera, 2004; New Zealand Psychology Board, 2002; Papps & Ramsden 1996; Thomas et al., 2010). For instance, accessing appropriate cultural expertise, assessment and therapeutic interventions is of importance to implementing this value.

**Staff development:** In addition to the principles discussed, aimed at guiding engagement with Māori, a number of additional areas relating to inpatient staff development have been identified.

**Cultural competency:** The development of cultural competency training focused on understanding te ao Māori including tikanga Māori, te reo Māori, and wairuatanga (Ihimaera, 2004; Tse et al., 2005). In addition, comprehensive clinical and cultural assessments of tāngata whaiora presentations which incorporate Māori understandings and frameworks of health (Durie, 1994; Durie, 1997; Ngaropo, 2005; Pere, 1984) are necessary for the needs of tāngata whaiora and whānau to be met. Accurate assessments that include input from both clinical and cultural experts will guide the therapy pathway that best supports recovery and whānau ora for Māori.

**Workforce development:** In addition to the implementation of the principles already discussed, improved service delivery is dependent on a number of additional variables. These variables include staff recruitment, retention and scope of practice within this specialist environment. A focus on staff workforce development, specifically an increase in Māori clinicians is crucial to supporting whakaoranga (Durie, 1999; Ministry of Health, 2006; Te Rau Matatini, 2009).
Enhancing the scope of practice: This study highlighted the need for services and health education institutions to establish what is fundamental to inpatient care, and, identify the minimal practice standards in relation to nursing practice in this specialty context (Fourie et al., 2009). The traditional focus has been that of a crisis orientated model of care (Cleary, 2004) with the primary aim to address tāngata whaiora needs in the ‘present’ and symptom stabilisation. The attention of such a framework is based on triage, assessment, stabilization and containment of risk (Fortinash & Holoday-Worret, 2000). Despite evidence supporting this structure, a key aspect to tāngata whaiora care appears neglected, that is, therapeutic engagement encompassing quality relationships with staff. Facilitated via micro-counseling skills and supportive ‘talking therapy’ interventions (Te Pou o te Whakaaro Nui, 2010) positive therapeutic engagement is essential in supporting whakaoranga as this can contribute to service user recovery and a valued experience (Breeze & Repper, 1998).

Kaupapa Māori services - Improved access: The need for consistent and accessible kaupapa Māori services needs to be a priority given the services reported usefulness and difficulties with the inpatient Admission Process. A focus on adequate staffing levels to ensure optimum service delivery at all times is critical for service consistency. For instance, this would ensure that specific culturally focused activities (such as karakia, harakeke, te reo) can be provided on a regularly basis. An ‘open door policy’ where tāngata whaiora and whānau are able to access Kai Atawhai support when needed (with the support of full staffing levels) may also improve accessibility to the services offered. In addition, given the reported positive engagement kaupapa Māori services had with most participants it would be beneficial to have this service support available at all stages of the admission process especially during the initial contact phase. This may serve to improve this critical engagement time and ensure any trauma for tāngata whaiora and whānau is reduced.

Practice and intervention: Develop and enhance practices that support whakaoranga and whānau ora: A focus on improving inpatient service delivery is recommended with specific attention to a number of key service delivery areas:

Safety- Balancing safety and restriction: The difficulty of providing a safe environment for tāngata whaiora during an admission to an inpatient service within the least restrictive environment has long been an issue of contention (Agar-Jacomb & Read, 2009; Davidson et al., 2006; Mental Health Commission, 2001; Te Pou o te Whakaaro Nui, 2009). Inevitably some level of risk taking is necessary in order to empower service users taking
decisions about their own lives (Department of Health, 2007; Shepherd et al., 2008; Stickley & Felton, 2006). The principles of recovery provide a guiding framework for the assessment of risk and management strategies (Sainsbury Centre for Mental Health, 2008). For instance, one may ask “will the service users sense of control be increased or decreased by this risk practice? Was their ability to access opportunities outside mental health services increased or decreased? Did the risk practice impair their level of hope for the future?”. Central to the success of this recovery orientated approach is collaboration involving tāngata whaiora and their whānau in an open and transparent manner (Shepherd et al., 2008).

In addition, a number of suggestions were made by participants in this research project related specifically to additional safety issues. For instance, increasing the number of female staff within ICU was seen as a potentially positive move as male tāngata whaiora reportedly respond well with females rather than male staff (perceived as threatening); and the need for an increased number of ICU beds to avoid early transitions from ICU into the open. A review of such safety practices is therefore required.

**Reducing the negative impact of police involvement:** At times, given critical situations and safety issues, the police-force are required during the initial contact and admission to inpatient services. To reduce further trauma for tāngata whaiora and whānau a number of strategies may be implemented with a focus on liaison, engagement and education. It is recommended that improved service liaison (Ministry of Health, 2006) between CMHC crisis teams and police departments be developed. The feasibility of specialised kaupapa Māori admission crisis teams should also be the focus of future developments. Close liaison with specialised mental health services and Māori cultural mental health expertise is essential, especially given the high number of tāngata whaiora admitted via police services (Tapsell & Mellsop, 2007). It is also recommended that, where possible, support from whānau and specialist mental health service support (such as crisis team and kaupapa Māori services) during police engagement be prioritised.

The inclusion of mental health education and alternative strategies to minimise the use of restraint and force in order to respond to crisis calls more effectively is recommended for frontline police force staff. Such as the use of de-escalation, to better engage with and understand tāngata whaiora extreme emotional distress. Literature presenting effective communication patterns by the police during negotiation crisis situations has identified a number of key aspects influencing the development of a positive alliance. A collaborative
approach, moving towards and with each other (psychologically or physically) during a respectful liaison (Fisher & Shapiro, 2005) enhanced positive outcomes (Donohue & Roberto, 1993). The use of humour can also contribute positively (Misino; 2004).

Reducing the use of force, restraint and seclusion, with a focus on eliminating these restrictive care practices: A focus on creating therapeutic inpatient environments, along with alternative strategies to support service users faced with extreme distress are potential strategies to reduce the use of force, restraint and seclusion. Therapeutic environments providing low stimulus areas where tāngata whaiora are able to self-soothe and tolerate distress, such as an adapted sensory modulation room (incorporating kaupapa Māori interventions) may provide alternative distress tolerance strategies. In addition, given the calming nature of the marae space (Durie, 1994; Lapsely et al., 2002; Taitimu, 2008) it is envisioned that this area could also be utilised in such a way. This would require the development and investigation of appropriate safety plans.

In addition to the creation of a safe therapeutic environments, enhanced staff training aimed at reducing force has been developed and operating within existing inpatient services nationwide (Te Pou o te Whakaaro Nui, 2009). An ongoing emphasis on staff cultural and clinical development and training, incorporating skills related to de-escalation and other non violent crisis interventions is encouraged.

Accessible supports for tāngata whaiora and whānau: Accessible supports, particularly during the Admission Process are essential. Multiple options of support can be provided (or offered) including whānau (Bridgman et al., 2000); kaupapa Māori support workers (Lapsley et al, 2002) and kaumatua; another familiar person (such as a key-worker or community support worker); via Supporting Families (SF); and/or peer support specialists (Scott et al., 2011). Further exploration into the introduction and development of peer support specialist services is also recommended with a focus on tāngata whaiora kaupapa Māori services (Scott et al., 2011) such as Te Mana services (Te Pou o te Whakaaro Nui, 2009). The choice of which supports to access is of course the right of tāngata whaiora (Taitimu, 2008).

Increased implementation of kaupapa Māori therapeutic interventions: Enhanced therapeutic activities and supports within inpatient services (Te Pou o te Whakaaro Nui, 2009; 2011) specifically related to the recovery programme; access to therapy, and debriefing/reflective approach are recommended. More than half of the tangata
whaiora participants rated traditional healing practices such as access to: kaumatua; tohunga; rongoa Māori; karakia; mirimiri; and kappa haka as therapeutic interventions needed ‘all of the time’ to support whakaoranga (see p. 156).

The extension of the existing recovery programme to address boredom issues (Te Pou o te Whakaaro Nui, 2009) focused on both mainstream and Māori specific cultural activities and tāngata whaiora directed activities is recommended. For instance, extended physical activities such as sports (such as touch rugby, cricket, volley ball); opportunities to learn new skills (such as art classes and gardening); outdoor expeditions (such as van trips and sightseeing); and cultural related activities (such as karakia, te reo Māori, education regarding the significance of ta moko, weaving, mirimiri and kapa haka) (Wirihana, 2008) could be areas of future development.

In addition, there is a significant need to improve access to psychological therapy for Māori which participants perceived as a critical aspect of recovery (Kumar et al., 2008). More specifically, access to therapy groups including DBT skills and CBT, and 1:1 assessment and brief therapy with psychologists. This would require the therapy groups to be help regularly, consistently and possible the employment of more therapy professionals (clinical psychologists).

Access to additional therapeutic interventions may in turn reduce reliance on PRN (pro re nata; as needed) medication with tāngata whaiora adopting alternative skills and strategies to tolerate distress (Mental Health Commission, 2007).

Develop and implement debriefing and reflective practices following critical incidents: Following critical incidents (such as admission; restraint; seclusion; assault) the
process of debriefing (Te Pou o te Whakaaro Nui, 2009) has been recommended to support the continued journey of recovery for tāngata whaiora and whānau. Such practice within inpatient services would also contribute to the ongoing enhancement of the services therapeutic environment (Te Pou o te Whakaaro Nui, 2009). In particular, it is recommended that a model similar to the critical incident stress debriefing (CISD) strategy (Everly & Mitchell, 1997; Mitchell, 1983), encompassed within a kaupapa Māori framework, utilising holistic Māori health models and processes (Durie, 1994; Ngaropo, 2005; Pere, 1984) be implemented.

Providing an opportunity for tāngata whaiora and whānau to reflect upon their inpatient experience is also recommended. Many tāngata whaiora provided positive responses in relation to the reflection experience during this research which commonly provided insight into the factors precipitating the admission and the process of healing, such as:

Talking with you (researcher) has been really good, it was good cause I guess it made me reflect back through my whole experience, on what made me well, what stressors have contributed to my break-down, cause work has been a big part, and a lot of Māori concepts I knew I have gone back to, aroha, awhi, manaakitanga, the softer values, I would always try to apply that to myself, I remember trying to make myself more independent, install discipline so that (admission) wouldn’t happen again, so I guess this would kind of help with my discharge

Ensure collaborative discharge meetings for all tāngata whaiora: There is a need for consistency in discharge meeting processes, especially given the participants reported need for such meetings. It is recommended that discharge meetings are made accessible for every tāngata whaiora and their whānau, within a culturally safe appropriate environment. Effective discharge meetings would ensure that tāngata whaiora and whānau participate in the process and are collaboratively involved in planning the discharge process (such as progressive leave from the service to the home environment); and work in partnership with services, therefore offered a range of choices of community support services (such as Māori mental health services, CMHC, key-worker, community support worker, social services) have engaged prior to discharge from the inpatient service.
FUTURE RESEARCH

An obvious direction for future research would be to replicate the smaller two studies within this research project involving a larger scale study including multiple inpatient services from other DHB’s. Of particular interest in Study One were the rates of Māori admitted directly into the ICU restricted ward and diagnosed with psychosis related disorders. A national study may, if the findings were consistent, result in more urgent policy developments. A larger scale version of Study Two could include a broader range of tāngata whaiora and whānau participants (for instance, participants with no previous admissions; varying levels of cultural identity) to make the conclusions of this study more generalisable across inpatient services nationally. It would be essential to maintain the kaupapa Māori methodology framework when conducting any future research with Māori participants.

In addition, this research project explored inpatient service experiences, as well as reflecting on interventions. Although the reported usefulness of the inpatient service provided an in-depth understanding into the factors that contribute to and inhibit recovery this was not specifically an ‘outcomes’ study. Exploring outcomes for tāngata whaiora and whānau in more detail, such as measuring the effectiveness of services, is required. It is recommended that future research examining outcomes of TWT and other inpatient services nationally utilises culturally specific outcome tools such as the Hua Oranga (Kingi & Durie, 2002) as well as other clinical outcome measures that may be of benefit (such as the HoNOS which is currently utilised by inpatient services). An outcome evaluation would formally assess the contribution of inpatient services in supporting whakaoranga and whānau ora for Māori.

Furthermore, following the key findings of this research project, future research directions would focus on:

• The principles and factors that support therapeutic engagement with tāngata whaiora and whānau. A longer term focus would be on developing guidelines and training for mental health professionals
• The effectiveness of kaupapa Māori services located within mainstream mental health services.

200
• The efficacy of seclusion and restraint, with a focus on reducing and eventually eliminating these restrictive care practices. Further investigation regarding debriefing and reflection following an inpatient admission and traumatic experience (such as restraint) is also needed. This could include the development and piloting of a kaupapa Māori debrief and reflection process for tāngata whaiora and whānau.

• Alternatives to inpatient treatment for tāngata whaiora, specifically kaupapa Māori services.

CONCLUSIONS

Despite the limitations of this project (discussed earlier), there are a number of strengths. Firstly, the kaupapa Māori methodological process was guided by the research principles of te Tiriti o Waitangi (1840) and literature provided by esteemed Māori researchers (Cram, 2001; Pihama, 1993; Smith, 1999; 2006) which provided the overarching framework for conducting the research. This was complemented by the qualitative approach which provided a sound fit with the recovery philosophy, whakaoranga and whānau ora. Active participation of, and collaboration with, participants and the wider Māori health community (consultation, liaison), working in partnership and ensuring the protection of knowledge, were all strengths of this research project.

Secondly, the role of the researcher (previously discussed as a limitation of the study related to potential bias) was also a major strength. The two key aspects of strength were related to the cultural identity and clinical knowledge of the researcher. The cultural identity of the researcher is consistent with the principle that research be conducted ‘for Māori by Māori’ (Cram et al., 2003; Jones et al., 2010) sharing common understandings, experiences and worldviews. A focus on a collaborative relationship between the researcher and participants was important, as was the need to be sensitive to the issues of misinterpretation to avoid potential further marginalisation (Ormond, Cram & Carter, 2006). The researcher’s genuine concern for the wellbeing of Māori and willingness to contribute to the growing body of literature supporting Māori development was also a major strength. In addition to the researcher’s cultural identity, my clinical experience and knowledge was also beneficial. Experience working with tāngata whaiora and whānau; an understanding of the system; openness to hearing about the usefulness and limitations of service delivery; skills of
engagement and effective communication (listening); and a commitment to the philosophies of recovery, whakaoranga and whānau ora were also positive researcher attributes.

Thirdly, an obvious strong point of this project was related to the recovery research focus of Study Two (Barnett & Lapsley, 2006). The emphasis on sharing the experiences of those who have used the TWT service, specifically tāngata whaiora and whānau, was important. Through this approach we were able to explore these unique recovery perspectives, provide insight into practices that support recovery, and thereby produce recommendations for improvements, such as staff development (for instance enhancing the scope of practice); and the development and enhancement of practices that support whakaoranga and whānau ora (such as balancing safety and restriction).

Personal Research Reflections
The thesis journey has been a lengthy one, which, combined with the complexity of simultaneously undertaking clinical psychology training, was extended further with the blessings of two additions to our whānau. The arrival of our precious taonga provided much fulfilment along the way, which was welcomed when facing research challenges, obstacles and delays.

The research area of interest was always going to be tricky to manage, especially the challenge of staying focused on only a narrow part of the broader area of improving Māori wellbeing. There were times when I felt confronted by a passion and sense of responsibility of wanting to ‘save the world’, to contribute more, cover a broader area of inpatient care and the multiple complexities of acute unwellness, as well as understanding the underlying factors associated with the ‘golden question’ of ‘why are Māori being admitted to inpatient services at such high rates in the first place?’ The research project seemed to cover only a ‘slither of the pie’, just a small segment of the overall issues, which at times created some unease. A focus on contributing towards a project that was achievable and that would provide useful, practical outcomes for Māori provided some satisfaction, along with the belief that this thesis would contribute in part to the ‘larger picture’ of supporting whakaoranga and whānau ora.

An additional ongoing area of tension was related to a sense of ‘pressure’, to complete the research project timely, especially so I could begin clinical practice within a mental health workforce desperate for Māori clinicians; contribute to my whānau, hapū and
iwi; as well as manage my role within my whānau (as a mother, wife, sister, aunty, daughter, mokopuna). Subsequently, there were times when my thesis would drop down my priority list as more urgent pressures would surface. This was difficult, as I had a genuine desire to honour these amazing people (my research participants) and provide the vehicle to share their experiences and stories to bring about change.

During the writing phase of my thesis, particularly in relation to the discussion section, I became more aware of the effect of my personal values and beliefs influencing the process, specifically, the impact of my dual role (as a previous employee of TWT and a researcher) on reporting a critique of the service. Mindful that this may be a service of future employment, finding a balance between honouring the voice of my participants (and not filtering their kōrero) whilst maintaining professional boundaries was important (and sometimes a struggle). This issue didn’t suddenly arise during the research process, it was something I was fully aware of from the commencement of the project, so utilising clinical and cultural support to problem-solve these process challenges was extremely helpful.

Some Final Words
To conclude this journey, I would like to share this inspirational quote summarising the essential beliefs described by one Māori health professional, Moe Milne (2001), in supporting tāngata whaiora and whānau during the recovery journey:

“To do this work you must have a belief in recovery in which hope and respect are absolutely crucial but also a belief in oranga. You must have an acceptance of people, patience, be non-judgemental, have responsibility, aroha, unconditional love for people (that’s hard sometimes), humour, strength, skills, persuasion, commitment, convictions, passion, manaakitanga, tautoko. Just being a good person” (Milne, 2001: p. 8).

These sentiments were matched by the participants in this research:

Well I think you’ve just got to be gentle…I’d be really gentle and loving… get their trust, they need someone to love them, when your family goes it’s like who have I got… don’t say something you
don’t mean...be honest at all times...be there for them, make sure they have your confidence, it’s really important

Keep an eye on the patient, making sure they're safe and secure, making sure they’re getting better...being aware of their individual needs, understanding what they need, what the consumer is entitled to, being respected, understood...good support and help

...aroha, spiritual healing, tender care, loving, care, aroha, aroha, aroha...
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APPENDIX B. Participant information sheets (PIS)

Mental Health Inpatient Services:
Improving our understanding of the needs of Māori when acutely unwell

Information Sheet for Participants

Tena koe
My name is Julie Wharewera-Mika. I am of Ngāti Awa, Tūhoe, Te Whānau a Apanui descent. I am from Whakatane. I am studying towards a Doctorate in Clinical Psychology at the University of Auckland. I am conducting this research for the purpose of my thesis. You are invited to take part in a study investigating the needs of tāngata whaiora Māori and whānau when acutely unwell. The aim is to find out what areas of the inpatient service were effective for you, and how the services offered might be improved. Taking part in this study is your choice, and you have the right to not participate.

Who will benefit from this study?
It is hoped that tāngata whaiora and whānau will benefit from this research by having their opinions and experiences heard. It is also hoped that the inpatient services will benefit, by learning what was effective and what was not effective from those interviewed.

What does the study involve?
Kai Atawhai has been asked to contact current or past tāngata whaiora Māori that may be interested in participating in this study. Tāngata whaiora Māori will then be asked to identify whānau who may also be interested. I hope to interview about 30 people altogether. During the interview I will ask you to talk about your thoughts and feelings on the service you received. This will include your admission experience, and things that you found helpful and unhelpful. You will also be asked about your thoughts and feelings on the outcomes of your time at Te Whetu Tawera. Your thoughts and feelings may relate to general clinical practice, specific cultural factors, or a combination of both. The interview should take about one hour, but this will depend on how much information you wish to share with me. You do not have to answer all the questions and can stop the interview at any time, either for a break or to finish completely. I need to take a few notes and audio-tape the interview, so that I can be sure that I have a correct record of what you tell me. There will also be a short questionnaire I will ask you to complete at the end of the interview.
Where will it be done?

We will hold the interview in a place where you feel comfortable and where we can talk with privacy. I will pay for any costs involved in getting there, such as petrol money or a bus ticket. You are more than welcome to bring along whānau or friends for support.

What will happen at the end of the study?

After our interview I will write-up the main themes from the audio-tape. You will have a chance to check the record of your interview. This will be a few weeks after the interview. You can take out, change or add to anything that you said in the interview. I would like to report the final results back to you and if you are interested, discuss them with you. No material that could personally identify you will be used in the write-up of the study. The university requires that the information you give me is kept in secure storage after the completion of the study. No one except me and my two research supervisors will have access to this information.

What are your rights as a participant?

If you do agree to take part, you can choose to withdraw from the study from 3-weeks after the transcripts are sent to you. This also includes the right to withdraw the information you have given me. You would not have to give a reason for your withdrawal and it will not affect any treatment you may receive in the future from Te Whetu Tawera or any other mental health service. You can contact either me, or one of my supervisors, with any questions, or concerns that you have at any stage of the study. My supervisors are John Read (Psychology Department) and Lorna Dyall (Department of Māori and Pacific Health), both from the University of Auckland. Their contact details are given below. If you have any questions or concerns about your rights as a participant in this study and you do not want to ask me or my supervisors, you can contact the Health and Disability Consumer Advocate on 0800 423 638. If you want to make a complaint, you can address it to me, my supervisors, or the Administrator of the National Ethics Committee, at the address given below.

Are there any risks involved?

There is a risk of bringing back the thoughts and feelings that you were experiencing when you admitted to the unit. If you think it may be a problem for you, it may be better that you do not take part in this study. Alternatively, we can begin and then stop if you feel uncomfortable. You can have a break and then continue, or stop altogether. If necessary, I can help you to access support you may require. You are also welcome to discuss these issues with me. If any issues arise that suggest your safety or someone else’s safety may be at risk, I will need to talk about this with someone that I think can help reduce this risk.
Where can I get more information about the study?

You can contact me either via Kai Atawhai staff at Te Whetu Tawera, or by the phone number supplied below, leave a message for me and I will call you back as soon as I can. By replying, you are not committing yourself to the research. What you are agreeing to is giving me your contact details and allowing me to contact you to discuss whether you may like to participate. I would be very grateful if you could take the time to reply to me as soon as you have had enough time to think about this. This study has received ethical approval from the National Auckland Ethics Committee.

Thank you for taking the time to read this information sheet and considering sharing your valuable knowledge with me. I hope I will hear from you soon.

Tēnā anō hoki koe,

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For any queries regarding ethical concern please contact the Administrator of the National Ethics Committee:
Administrator
National Ethics Committee
Private Bag 92-522
Wellesley Street
Auckland
(09) 580-9105
Tena koe,
My name is Julie Wharewera-Mika. I am of Ngāti Awa, Tūhoe, Te Whānau a Apanui descent. I am from Whakatane. I am studying towards a Doctorate in Clinical Psychology at the University of Auckland. I am conducting this research for the purpose of my thesis. You are invited to take part in a study investigating the needs of tāngata whaiora Māori and whānau when acutely unwell. The aim is to find out what areas of the inpatient service were effective for you, and how the services offered might be improved. Taking part in this study is your choice, and you have the right to not participate.

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What does the study involve?

Kai Atawhai has been asked to contact current or past tāngata whaiora Māori that may be interested in participating in this study. Tāngata whaiora Māori have been asked to identify whānau who may also be interested, which is why we have approached you. I hope to interview about 30 people altogether. During the interview I will ask you to talk about your thoughts and feelings on the service your whānau member received while in Te Whetu Tawera, and your needs as a whānau member. This will include the admission experience, and things that you and your whānau member found helpful and unhelpful. You will also be asked about your thoughts and feelings on the outcomes of your whānau members time at Te Whetu Tawera. Your thoughts and feelings may relate to general clinical practice, specific cultural factors, or a combination of both. The interview should take about one hour, but this will depend on how much information you wish to share with me. You do not have to answer all the questions and can stop the interview at any time, either for a break or to finish completely. I need to take a few notes and audio-tape the interview, so that I can be sure that I have a correct record of what you tell me. There will also be a short questionnaire I will ask you to complete at the end of the interview.
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We will hold the interview in a place where you feel comfortable and where we can talk with privacy. I will pay for any costs involved in getting there, such as petrol money or a bus ticket. You are more than welcome to bring along whānau or friends for support.

What will happen at the end of the study?

After our interview I will write-up the main themes from the audio-tape. You will have a chance to check the record of your interview. This will be a few weeks after the interview. You can take out, change or add to anything that you said in the interview. I would like to report the final results back to you and if you are interested, discuss them with you. No material that could personally identify you will be used in the write-up of the study. The university requires that the information you give me is kept in secure storage after the completion of the study. No one except me and my two research supervisors will have access to this information.

What are your rights as a participant?

If you do agree to take part, you can choose to withdraw from the study from 3-weeks after the transcripts are sent to you. This also includes the right to withdraw the information you have given me. You would not have to give a reason for your withdrawal and it will not affect any treatment you may receive in the future from Te Whetu Tawera or any other mental health service. You can contact either me, or one of my supervisors, with any questions, or concerns that you have at any stage of the study. My supervisors are John Read (Psychology Department) and Lorna Dyall (Department of Māori and Pacific Health), both from the University of Auckland. Their contact details are given below. If you have any questions or concerns about your rights as a participant in this study and you do not want to ask me or my supervisors, you can contact the Health and Disability Consumer Advocate on 0800 423 638. If you want to make a complaint, you can address it to me, my supervisors, or the Administrator of the National Ethics Committee, at the address given below.

Are there any risks involved?

There is a risk of bringing back the thoughts and feelings that you were experiencing when your whānau member was admitted to the unit. If you think it may be a problem for you, it may be better that you do not take part in this study. Alternatively, we can begin and then stop if you feel uncomfortable. You can have a break and then continue, or stop altogether. If necessary, I can help you to access support you may require. You are also welcome to discuss these issues with me. If any issues arise that suggest your safety or someone else’s safety may be at risk, I will need to talk about this with someone that I think can help reduce this risk.
Where can I get more information about the study?

You can contact me either via Kai Atawhai staff at Te Whetu Tawera, or by the phone number supplied below, leave a message for me and I will call you back as soon as I can. By replying, you are not committing yourself to the research. What you are agreeing to is giving me your contact details and allowing me to contact you to discuss whether you may like to participate. I would be very grateful if you could take the time to reply to me as soon as you have had enough time to think about this. This study has received ethical approval from the National Auckland Ethics Committee.

Thank you for taking the time to read this information sheet and considering sharing your valuable knowledge with me. I hope I will hear from you soon.

Tēnā anō hoki koe,

Julie Wharewera-Mika
(09) 373-7999, extn. 87198
j.wharewera-mika@auckland.ac.nz
Psychology Department
University of Auckland
Private Bag 92019
Auckland

Supervisors:
Dr. John Read
(09) 373-7999, extn. 85011
j.read@auckland.ac.nz
Psychology Department
University of Auckland
Private Bag 92109
Auckland

Dr. Lorna Dyall (Ngāti Maniapoto)
(09) 373-7999, extn. 84915
l.dyall@auckland.ac.nz
Māori and Pacific Health Department
University of Auckland
Private Bag 92019
Auckland

Other contact details:
Professor Fred Seymour
Head of Department
Psychology Department
University of Auckland
Private Bag 92019
Auckland
(09) 373-7999, extn. 88414

For any queries regarding ethical concern please contact the Administrator of the National Ethics Committee:
Administrator (09) 580-9105
National Ethics Committee
Private Bag 92-522
Wellesley Street
Auckland
I have read and I understand the information sheet dated --/--/----- for participants taking part in this study designed to investigate the needs of tāngata whaiora Māori and whānau from an acute inpatient mental health unit. I have had the opportunity to discuss the study with the researcher and ask questions, and am satisfied with the answers that have been given.

I understand that taking part in this study is my choice, that I may withdraw myself or any information I have provided 3-weeks after the transcript of the interview has been sent to you. Neither deciding not to participate nor withdrawing during the study, will in no way affect my future treatment at any mental health service. I understand that my participation in this study is confidential and that no material that could identify me will be used in the final report.

I have had time to consider whether to take part in this study. I know whom to contact if I have any problems arising as a result of this study, and I know whom to contact if I have any questions or would like to make any complaints about the study. I consent to the researcher taking notes and to my interview being audio-taped. I have discussed with the researcher how she can report/discuss the outcomes of this study with me.

I _____________________________________________________________________ hereby consent to take part in this study.

Signature:   Date:

Full name of researcher: Julie Wharewera-Mika
Contact phone number for researcher: (09) 373-7999, extn.87198
Project explained by: Julie Wharewera-Mika
Project role: Researcher

Signature:                                Date:

**Principle Investigator:** Julie Wharewera-Mika
Doctorate of Clinical Psychology Student
(09) 373-7999, extn. 87198
Psychology Department, University of Auckland,
Private Bag 92019, Auckland
REQUEST FOR INTERPRETER

<table>
<thead>
<tr>
<th>Language</th>
<th>Interpreter Request</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>I wish to have an interpreter</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Māori</td>
<td>E hiahia ana ahau ki tetahi kaiwhakaMāori/kaiwhakaPākeha kōrero</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

I have read and I understand the information sheet dated --/--/---- for participants taking part in this study designed to investigate the needs of tāngata whaiora Māori and whānau from an acute inpatient mental health unit. I have had the opportunity to discuss the study with the researcher and ask questions, and am satisfied with the answers that have been given.

I understand that taking part in this study is my choice, that I may withdraw myself or any information I have provided 3-weeks after the transcript of the interview has been sent to you. Neither deciding not to participate nor withdrawing during the study, will in no way affect the future treatment of my whānau or myself at any mental health service. I understand that my participation in this study is confidential and that no material that could identify me will be used in the final report.

I have had time to consider whether to take part in this study. I know whom to contact if I have any problems arising as a result of this study, and I know whom to contact if I have any questions or would like to make any complaints about the study. I consent to the researcher taking notes and to my interview being audio-taped. I have discussed with the researcher how she can report/discuss the outcomes of this study with me.

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Signature:   Date:

Full name of researcher: Julie Wharewera-Mika
Contact phone number for researcher: (09) 373-7999, extn.87198
Project explained by: Julie Wharewera-Mika
Project role: Researcher

Signature:   Date:
**Principle Investigator:** Julie Wharewera-Mika  
Doctorate of Clinical Psychology Student  
(09) 373-7999, extn. 87198  
Psychology Department, University of Auckland,  
Private Bag 92019, Auckland
APPENDIX D: Interview schedules

Tāngata whaiora

1. Background
   Is it alright if we start by talking about your admission to TWT?

2. Discussion
   - Is it alright if we start by talking about your admission to hospital?
     (thoughts and feelings)
   - Can you tell me of your first memories of what happened when you first came into hospital (Te Whetu Tawera)? Take as long as you need
   - After you were admitted to hospital how was it for you in TWT?
   - When you started to feel better and were getting ready for discharge how was it for you in TWT?
   - Now looking back in retrospect, can you tell me about what you found helpful (what did you like) about coming to Te Whetu Tawera? If anything?
   - What was not helpful (what didn’t you like)
   - Looking back now, when you were unwell, do you think that Te Whetu Tawera met your needs? Why? Why not? What could we be providing?
   - If you were ever unwell in future, where would you like to go? Te Whetu Tawera? Why? Why not?
   - If there were somewhere else would that be good? Suggestions?
   - Do you think Te Whetu Tawera met the needs of your whānau? Why? Why not?
   - What advice would you give to staff, manager, ADHB of what they could do for people admitted here?

3. Anything else
   - Is there anything else that you would like to add?

4. Feedback
   - How was this talk for you?
5. **Iwi and hapū connections** (visual analogue)

- Firstly, on a scale of 0 to 10, where 0 is very uncomfortable, and 10 is very comfortable, how comfortable do you feel with Māori and in Māori situations?
- Secondly, on the same scale, how comfortable do you feel with Pākehā and in Pākehā situations?
- Now, on a scale of 0 to 10, with 0 as not at all, and 10 as very strongly? How strongly do you identify as Māori?

And the last question in this area is, what does being Māori mean to you?
1. Background
   - Is it alright if we start by talking about the first admission of your whānau to an inpatient unit?

2. Discussion
   - Can you tell me of your first memories of when your whānau was admitted to hospital (Te Whetu Tawera)? Take as long as you need
   - After your whānau was admitted to hospital how was it for you (and whānau)?
   - When your whānau member in hospital started to feel better and was getting ready for discharge how was it for you (the whānau)?
   - Now looking back in retrospect, can you tell me about what you found helpful (what did you like) when your whānau member came to Te Whetu Tawera? If anything?
   - What was not helpful (what didn’t you like)
   - If there were somewhere else to take your whānau member would that be good? Suggestions?
   - Looking back now, when your whānau was unwell, do you think that Te Whetu Tawera met your needs as whānau? Why? Why not? What could we be providing?
   - Do you think that Te Whetu Tawera met the needs of your tāngata whaiora? Why? Why not?
   - If you had family ever unwell in future, where would you like them to go? Te Whetu Tawera? Why? Why not?
   - What advice would you give to staff, manager, ADHB of what they could do for people admitted here?

3. Anything else
   - Is there anything else that you would like to add?

4. Feedback
   - How was today for you?

5. Iwi and hapū connections (visual analogue)
   - Firstly, on a scale of 0 to 10, where 0 is very uncomfortable, and 10 is very comfortable, How comfortable do you feel with Māori and in Māori situations?
▪ Secondly, on the same scale, how comfortable do you feel with Pākehā and in Pākehā situations?
▪ Now, on a scale of 0 to 10, with 0 as not at all, and 10 as very strongly? How strongly do you identify as Māori? And the last question in this area is, what does being Māori mean to you?
APPENDIX E. Questionnaires

Tāngata Whaiora Māori

Tena koe
Nga mihi nui ki a koe

Any information you provide in this questionnaire will be completely anonymous and confidential. Please fill in whatever you can.

If it is difficult for you to fill in the questionnaire on your own please ask ---------- ---------- (independent assistant) to help you.

SECTION ONE

<table>
<thead>
<tr>
<th>Age (please circle)</th>
<th>18-23</th>
<th>24-29</th>
<th>30-35</th>
<th>35-40</th>
<th>Over 40</th>
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<tr>
<th>Gender (please circle)</th>
<th>Male</th>
<th>Female</th>
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<tr>
<th>Hapū, Iwi</th>
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<tr>
<th>Psychiatric Hospital Admissions (please circle)</th>
<th>1</th>
<th>2</th>
<th>3-5</th>
<th>5-10</th>
<th>10 or more</th>
</tr>
</thead>
</table>

SECTION TWO

Please indicate how much you needed each of the following factors when you were recently admitted to Te Whetu Tawera (from 1 = “Not at all”, 2 = “Not very often”, 3 = “Some of the time”, 4 = “Most of the time”, 5 = “All of the time”).

<table>
<thead>
<tr>
<th>What I needed</th>
<th>1-5</th>
<th>What I needed</th>
<th>1-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Kaumatua</td>
<td>Support with finding accommodation</td>
<td></td>
<td></td>
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<tr>
<td>Access to Tohunga</td>
<td>Support in participating in kapa haka</td>
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<tr>
<td>Access to rongoa Māori</td>
<td>Support in reconnecting with whānau</td>
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<tr>
<td>Access to karakia</td>
<td>Support in reconnecting with hapū / iwi</td>
<td></td>
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<tr>
<td>Access to mirimiri</td>
<td>Support in learning te reo Māori</td>
<td></td>
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<tr>
<td>Support with my finances (liaising with WINZ, arranging benefits)</td>
<td>Support in dealing with difficult situations (e.g. violence, abuse)</td>
<td></td>
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</tr>
</tbody>
</table>
Please indicate below how helpful you found the following therapy interventions (from 1 = “Not at all helpful”, 2 = “Not very helpful”, 3 = “Neutral”, 4 = “Very helpful”, 5 = “Extremely helpful”).

<table>
<thead>
<tr>
<th>How helpful was therapy?</th>
<th>Need 1-5</th>
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</thead>
<tbody>
<tr>
<td>Medication</td>
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<tr>
<td>The Recovery Programme (specify groups you attending):</td>
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<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<tr>
<td>Cognitive Behavioural Therapy group (specify the number of sessions attended): --------</td>
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<td>Dip</td>
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<tr>
<td>Distress Tolerance group (specify the number of sessions attended): ---------------------</td>
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<tr>
<td>One-on-one talks with staff (specify staff details):</td>
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<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>Whānau Hui (family meetings)</td>
<td></td>
</tr>
<tr>
<td>Any other therapy (please specify):</td>
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<td></td>
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</tbody>
</table>
Please indicate below how much you thought the following factors were met, (from 1 = “Not at all”, 2 = “Not very often”, 3 = “Some of the time”, 4 = “Most of the time”, 5 = “All of the time”).

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Not very often</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
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<tbody>
<tr>
<td><strong>Your overall needs while in Te Whetu Tawera</strong></td>
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<td>3</td>
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<td>5</td>
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<tr>
<td><strong>Your cultural needs (Te Taha Māori)</strong></td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Your spiritual needs (Te Taha Wairua)</strong></td>
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<td>1</td>
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<td>5</td>
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<tr>
<td><strong>Your emotional needs (Te Taha Hinengaro)</strong></td>
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<td>5</td>
</tr>
<tr>
<td><strong>Your physical needs (Te Taha Tinana)</strong></td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Your family needs (Te Taha Whānau)</strong></td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
KIA ORA

Thank you for your time and your effort in completing this questionnaire

Noho ora mai,

Na Julie Wharewera-Mika

Kia ora
Māori.org.nz
mo nga kowhaiwhai ataahua
Whānau

Tena koe
Nga mihi nui ki a koe

Any information you provide in this questionnaire will be completely **anonymous** and **confidential**. Please fill in whatever you can.

If it is difficult for you to fill in the questionnaire on your own please ask ------------ --------------- (independent assistant) to help you.

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<tr>
<th>Age (please circle)</th>
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<td>1</td>
<td>2</td>
<td>3-5</td>
<td>5-10</td>
<td>10 or more</td>
</tr>
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</table>

### SECTION TWO

Please indicate how much you and your whānau (tāngata whaiora) needed each of the following factors when they were recently involved with Te Whetu Tawera (from 1 = “Not at all”, 2 = “Not very often”, 3 = “Some of the time”, 4 = “Most of the time” 5 = “All of the time”).

<table>
<thead>
<tr>
<th>What our whānau needed</th>
<th>1-5</th>
<th>What our whānau needed</th>
<th>1-5</th>
</tr>
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<tbody>
<tr>
<td>Access to Kaumatua</td>
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<td>Support in dealing with difficult situations (e.g. violence, abuse)</td>
<td></td>
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</tr>
</tbody>
</table>
SECTION THREE

Please indicate below how helpful you found the following therapy interventions for your tāngata whaiora when they were recently admitted to Te Whetu Tawera (from 1 = “Not at all helpful”, 2 = “Not very helpful”, 3 = “Neutral”, 4 = “Very helpful”, 5 = “Extremely helpful”).

<table>
<thead>
<tr>
<th>How helpful was therapy?</th>
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<tbody>
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<td>Medication</td>
<td></td>
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<td>1.</td>
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<td></td>
</tr>
<tr>
<td>Any other therapy (please specify):</td>
<td></td>
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</tbody>
</table>

SECTION FOUR
Please indicate below how much you thought the following factors were met for you and your whānau, (from 1 = “Not at all”, 2 = “Not very often”, 3 = “Some of the time”, 4 = “Most of the time”, 5 = “All of the time”).

<table>
<thead>
<tr>
<th>Your overall needs while in Te Whetu Tawera</th>
<th>Not at all</th>
<th>Not very often</th>
<th>Some of the time</th>
<th>Most of the time</th>
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</table>

<table>
<thead>
<tr>
<th>Your cultural needs (Te Taha Māori)</th>
<th>Not at all</th>
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<table>
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<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Your emotional needs (Te Taha Hinengaro)</th>
<th>Not at all</th>
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<th>Most of the time</th>
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<table>
<thead>
<tr>
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<td>5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Your family needs (Te Taha Whānau)</th>
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<th>Not very often</th>
<th>Some of the time</th>
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<tbody>
<tr>
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<td>1</td>
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</table>

Any other comments
Thank you for your time and your effort in completing this questionnaire

Noho ora mai,

Na Julie Wharewera-Mika