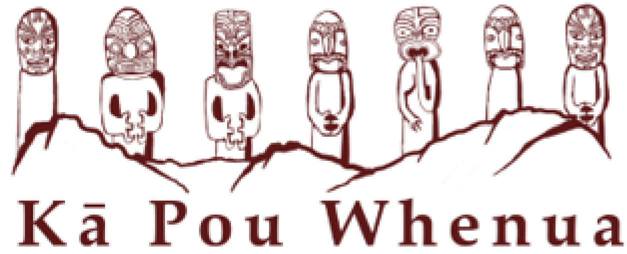
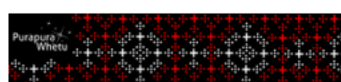


Mental Health & Addiction Collaborative System Design - Māori Workstream

Waitaha and Te Tai Poutini

Kā Pou Whenua Report



Report produced by:

Kā Pou Whenua project

Purapura Whetū Trust (2023)

To comment on the report please click here: https://www.surveymonkey.com/r/Kapouwhenua

Table of Contents

Executive Summary 3

Introduction 3

Engagement Process 8

Chapter 1. The Kōrero from Waitaha.. 11

Recommendations for Waitaha 26

Chapter 2. The Kōrero from Te Tai Poutini..…………………………………………………. 27

Recommendations for Te Tai Poutini…………………………………………………………. 34

Chapter 3. Summary of findings across Waitaha and Te Tai Poutini………………… 36

Appendix 1. Whakatauakī…………………………………………………………………...... 38

References………………………………………………………………………………………. 40

EXECUTIVE SUMMARY

Mehemea ka moemoea au, ko au anake. **Mehemea ka moemoea tatou, ka taea e tatou.** ***If I dream, I dream alone. If we all dream together, we can succeed.***

Introduction

Evidence from He Ara Oranga – Report of the Government Inquiry into Mental Health and Addiction services told us:

- Our mental health system is set up to respond to people with a diagnosed mental illness. It does not respond well to other people who are seriously distressed
- Few options are available to people who do not meet the threshold to access specialist or secondary mental health and addiction services
- More intensive community support options and pathways are required to support people, so they don’t need an inpatient admission

He Ara Oranga report also recommended that focus be given to expanding access and choice of mental health and addiction services for whānau seeking support in the community.

- Significantly increase access to publicly funded mental health and addiction services for people with mild to moderate and moderate to severe mental health and addiction needs
- Access to all services is broad-based and prioritized according to need, as occurs with other core health services
- Commit to increased choice by broadening the types of mental health and addiction services available
- Work to support expanded access and choice will include reviewing and establishing workforce development and worker wellbeing priorities

Whānau living across the two rohe have consistently told us that crowded and busy emergency department waiting rooms coupled with long wait times, elevated the level of distress already experienced by whānau. Whānau have also told us that accessing specialist or secondary services is fraught with multiple barriers of which entry criteria, historical negative or traumatic experiences of the system stood out as predominant features.

During the engagement phase of the Kā Pou Whenua project, whānau described a startling contrast in their experiences of accessing secondary services, kaupapa Māori and non-kaupapa Māori services. Listening to their stories was both humbling and moving, leaving many of the interviewers asking the question: Why are we still doing what we do when there is copious evidence informing us that what we are doing is not working? Why is it when we hear what is working well for whānau, what is working well is the least resourced? Why is there a shortage of qualified and experienced kaimahi working across the system, including tuakana-teina peer and lived experience workforce? How do build equity within the Māori workforce so we can increase workforce capacity?

Though these questions have yet to be explored in relation to service provision within Waitaha and Te Tai Poutini. We hope that the stories told to us by whānau and kaimahi, and recommendations made to improve the system and services are reflected in the implementation phase of the Kā Pou Whenua project.

The Kā Pou Whenua Project

Kā Pou Whenua is a kaupapa Māori centered rangahau that is leading several Māori workstreams within the Waitaha and Te Tai Poutini rōhe. Kā Pou Whenua and associated projects operate under the korowai of Purapura Whetū Trust and is led by their lived experience programme coordinator, Waiatamai Tamehana – Kairuruku Whaea.

Kā Pou Whenua is governed by a kaitiaki rōpū whose membership is made is made up of 18 subject matter experts from Mana Whenua, Tāngata Whenua and affiliated hāpu, tāngata whaiora and whānau. The kaitiaki rōpū and project team are experts in matters relating to Māori mental health & addictions systems, services and lived experience. The establishment of Kā Pou Whenua Kaitiaki rōpū and the project team is solidly built on the premise that system transformation can only be achieved if people with lived experience of mental health distress and/or addiction issues are at the center of and leading out system planning, design, implementation, education, and evaluation. Therefore, it is of no surprise that the kaitiaki rōpū and project team's membership is predominantly made up of lived experience subject matter experts.

Mental Health & Addiction collaborative System Design – Manatū Hauora / Te Whātu Ora, Waitaha

In 2021, Manatū Hauora (Ministry of Health) stood-up the mental health and addiction collaborative system design national programme. The programme is part of the expanding access and choice funding stream in response to He Ara Oranga government inquiry recommendations (2019). The purpose of the national programme was to ensure that there is local collaboration with tāngata whaiora & whānau, MH&A community stakeholders to identify areas for improvement within the system at a local level. Within this context Te Whatū Ora, Waitaha stood up several community-led initiatives that would enable Te Whātu ora to assess system and service performance across the two regions and to identify opportunity to improve current systems and services or opportunity to implement and test new or additional components to existing systems and services. Since February 2022, Kā Pou Whenua has been leading out the Māori workstream accross the two rohe of Waitaha and Te Tai Poutini.

Purpose of the project

The purpose of this project is to

- To hear the voices of hāpori and whānau with lived experience of mental health and addiction distress who access kaupapa Māori or non – kaupapa Māori mental health, addiction, and social services. Whānau members who support their whānau to access services and kaimahi Māori who work within a kaupapa or non-kaupapa mental health, addiction, and/or social service.
- Recommend specific system changes to improve Te Whatū Ora's approach to mental health and addiction, with a particular focus on Māori health equity, ease of access or increased access to kaupapa services, Māori workforce development, systemic and service wide cultural competency.
- To share report findings with Te Aka Whaiora – Māori Health Authority, to enable continuity of care through kaupapa service provision and the sharing of Māori aspiration, information, and data.

Kā Pou Whenua kaitiaki subject matter experts

Lived Experience

Waiatamai Tamehana (Kairuruku Whaea, Kā Pou Whenua Program Coordinator/Lived Experience)

Ngaire Button (Whānau Advisor)

Renee Barclay (Te Kete Pounamu, Peer Advisor)

Darryn Williamson (Te Kete Pounamu, Peer Advisor)

Ihorangi Reweti-Peters (Te Oranga Tamariki, Lived Experience Advisor)

Daryl Beattie (Pukenga Atahwai, Specialist kaupapa Services/Whānau Advisor)

Davida Simpson (Te Hono o Ngā Waka, Kaiwhakahaere/Lived Experience)

Mana Whenua and Tāngata Whenua

Lisa Tumahai (Ngāi Tahu Iwi, Kaiwhakahaere)

Michelle Turrall (Manawhenua ki Waitaha – Chair)

Te Whatu Ora – Te Tai Poutini

Kylie Parkins (Māori Health Unit, Portfolio Manager)

Moira Geer (Manaakitanga Specialist Services – Registered Nurse)

Kaupapa Māori NGO Sector

Karaitiana Tickell (Purapura Whetū, Kaiwhakahaere Matua)

Shelly Mills (Poutini Waiora – Te Kaihautu)

Tanith Petersen (He Waka Tapu, Operations Manager)

Wendy Dallas-Katoa (Te Kāhui o Papaki Kā Tai, Pegasus PHO - Advisor)

Secondary Services

Aroha Dibie (Specialist Services, Registered Nurse)

Dr Erihana Ryan (Specialist Services, Psychiatrist)

Māori health researchers

Dr Cameron Lacey (Department of Māori Indigenous Research Innovation – University of Otago, Associate Professor)

Dr Bronwyn Dunnachie (Whāraurau-Werry Workforce, Senior Advisor)

Project partners

Ngai Tahu Iwi, Waitaha, Te Tai Poutini

Mental Health Education and Resource Centre, Canterbury

Poutini Waiora, Te Tai Poutini - West Coast

Te Hono o Ngā Waka, Te Tai Poutini – West Coast

West Coast PHO – West Coast

Māori & Indigenous Health – University of Canterbury

Māori & Indigenous Research Innovation – University of Otago

External advisory panel

Dr Annabel Ahuriri-Driscoll

Senior Lecturer Above the Bar

Māori and Indigenous Health

University of Canterbury

Dr Kaaren Mathias

Senior Lecturer Above the Bar

School of Health Sciences

University of Canterbury

Interview panel members & support team

Waiatamai Tamehana

Renee Barclay

Ihorangi Reweti-Peters

Dean Rangihuna (Lived experience)

Shania Dudson (Māori student intern)

Davida Simpson

Daryl Beattie

Rosa Hibbert-Schooner (Māori student intern)

Dr Kaaren Mathias

Abbie Siataga & Sian Iti (Admin support)

Engagement process

The project targeted specific groups who through their experiences could provide us with information relevant to the kaupapa. Those groups were as follows:

- Māori accessing kaupapa or non-kaupapa mental health and addiction services
- Non-Māori accessing kaupapa Māori mental health and addiction services
- Whānau supporting their whānau to access kaupapa or non-kaupapa mental health and addiction services
- Kaimahi who work in kaupapa or non-kaupapa mental health and addiction services

Recognition was given to the context and unique features of both the Waitaha and Te Tai Poutini Māori communities. Our approach to engagement with Māori on the West Coast was based on the notion that many whānau have had minimal experience accessing kaupapa Māori services. Primarily this is due to having an insufficent number of kaupapa services available to meet the needs of whānau who live across a widely spread geographical area. With this in mind, our initial approach to engaging with whānau living on the Coast was to recognise the assumed experience of accessing non kaupapa Māori mental health and addiction services and to draw on that experience to imagine their ideal service within a kaupapa Māori context. However, once interviews commenced in Te Tai Poutini there were a number of tāngata whaiora and whānau who shared their experiences of accessing kaupapa Māori services on the coast. Their contribution to this review has provided invalueable insight into the experiences of whānau accessing kaupapa and non-kaupapa Māori services in Te Tai Poutini.

We would like to thank all tāngata whaiora, whānau and kaimahi who participated with us in the review of the mental health and addiction systems and services across the two rohe.

Methodology

The engagement methods used throughout this process enabled participants choice in how they wished to engage with the project, dependent on their individual or collective circumstances. Opportunities to participate were communicated using multiple forms of social media forums, poster distribution and formal hui presentations. Mechanisms that participants could use to engage included the following:

- On-line surveys
- Group and individual recorded interviews
- Marae-based noho wananga workshops

Interview Questions

Interviews began in the Waitaha and Te Tai Poutini rohe, firstly in December 2021 then over a 12-week period between June - August 2022. The interview phase of the project included the hosting of two noho wānanga workshops in both rohe.

Questions asked of tāngata whaiora and whānau remained the same across the two rohe with slight variations to the questions for the West Coast[i]. Likewise, questions asked of kaimahi remained the same across the two rohe[ii]. Further to the inquiry with kaimahi was the need to identify mechanisms that would support the capability and capacity of the Māori workforce within the sector. The following were some of the questions asked:

Tāngata Whaiora and Whānau

- How did you find out about the services you are using?
- Have you ever used a kaupapa Māori mental health and addiction service?
- Prior to accessing a kaupapa Māori mental health and addiction service, were you aware that it was a kaupapa Māori service?
- When you entered a kaupapa Māori mental health & addiction service, what kind of service or treatment supports were you expecting to receive?
- When you entered a kaupapa Māori mental health & addiction service, what expectations if any, did you have of the kaimahi/staff working in the service?
- Is there anything about your experience of receiving treatment & support that worked well?
- Is there anything about your experience of receiving treatment & support you would change?

Kaimahi

- Can you describe your process for referring tāngata whaiora to your service?[iii]
- Can you describe your process for receiving referrals from other services?

- How are whānau members included in your referral process?
- In your opinion, what does it mean to be a qualified and experienced kaimahi worker?
- In your opinion, why do you think there is a shortage of qualified and experienced kaimahi?
- What solutions could you propose to increase the capacity of kaimahi within the mental health and addictions workforce?
- How would you expect an organization to incorporate Te Ao Māori into health practice? Has this expectation been meet in the past? If so, how? If not, why not?
- Can you describe a time within your mahi where being a Māori practitioner was validated or compromised?
- What could be improved to make your workplace a better place to practice?
- As a practitioner, how are you supported to build your skill set and knowledge base?
- What specific skills and knowledge do you consider to be essential when working with tāngata whaiora and their whānau?
- Which of these, if any, would you consider to be compulsory learning for all practitioners?

Chapter 1: The Kōrero from Waitaha

> *"They understood our daughter and treated her like a person, valued her voice and supported her to connect with her environment and who she is in such a respectful way"*

Many participants who had accessed kaupapa Māori services spoke of the enactment of pōwhiri and mihi whakatau that facilitated a space where they felt safe to speak and within which would also be heard. This was a practice they considered to be essential to connecting with any service for the first time. They also described the enactment of manaakitanga that made them feel welcomed no matter which part of the service they entered through and no matter which ethnic group they identified with or described themselves as being.

Accessing Kaupapa Māori Mental Health and Addiction services

Knowledge of community-based kaupapa Māori mental health and addiction services is mostly unknown to government departments and community organizations within the Waitaha region. The majority of tāngata whaiora and whānau who were interviewed had attested to having no previous knowledge of Māori community services within the Waitaha rohe. They also spoke of non-referral to Māori services from their general practitioners, social workers, or counsellors. When asked why they thought such referral options were not available to them, they thought it was also due to lack a of knowledge of services.

Advertising of services through social media forums such as websites were difficult to navigate for many. Though reo Māori was appreciated within those forums, reo Māori language posed a barrier to most in understanding what the services were and how to access them. However, reo language did not pose a barrier for all. One whānau member equated their ease of access to services through social media advertising which also included the ability to self-refer to any one of the services being provided by the rōpū. They described being contacted by kaimahi within days, who made an immediate appointment to meet with them and their whānau to induct them into the service being requested.

Another whānau member who described an immediate access to services said the following:

"I walked in off the street needing help and help was there straight away. It can't get much easier… there was no stress, no drama".

Kaimahi made mention that most services have their own referral process, indicating that how each service makes or receives and processes a referral may differ quite drastically between services. It was suggested that kaimahi and pūkenga atawhai be part of the referral in/out process so that whanaungatanga occurs immediately and is maintained throughout the entry and exit process.

There were mixed preconceptions or opinions regarding who could access kaupapa Māori services. Some non-Māori participants felt that anyone can and should be able to access services regardless of ethnicity. Others reported that being non-Māori would preclude them from services. One Māori participant said they didn't mind if a service was Māori or not and had flexibility either way. Other Māori participants preferred to be in the care of Māori or Pasifika services only.

Confusion about eligibility to services was based on the premise that Māori services were for Māori whānau only, a premise that may be shared by general practitioners, government departments and other community-based services. Despite the mixed preconceptions or opinions about who could access kaupapa Māori services, once in the service participants felt welcomed and supported irrespective of their ethnicity.

Kaimahi spoke of service demand in the community and the inability of ropu to meet that demand due to kaimahi shortage, leading to delays and waitlists. A small number of tāngata whaiora and whānau also identified delays or waitlists as a barrier to accessing kaupapa Māori services. One tangata whaiora shared this experience:

"I have tried for years to access services; I was put on medication years before I was referred to kaupapa Māori support. It should be the other way around as my addiction developed after I started taking medication".

Another whanau member who was deeply impacted by their difficult experience accessing kaupapa Māori mental health services shared the following:

"Why did we have to wait over a year to get help from a kaimahi? Why did my grieving and unstable () get tossed to the side? Are we not Māori enough?"[iv]

It is important for systems and services to understand that although we know that demand on under resourced services can generate delays and waitlists, putting pressure on the system. Tāngata whaiora and whānau are not privy to this knowledge. Whānau expect to be seen by a service soon after a referral has been made. Lack of communication and referral follow-up have led some whānau to feel frustrated and devalued. It is the responsibility of the system to enable services to meet their demand so whānau have ease of access into services in a timely manner. It is also the responsibility of the service to communicate regularly with whānau who are being referred too or are waiting to access a service.

Barriers to accessing secondary kaupapa Māori acute services.

Secondary kaupapa Māori mental health services within the Waitaha rohe are part of a wider secondary service within Te Whatu Ora. Entry into services is triaged through a single point of entry within a non-Māori process and then assessed against a medical criterion which whānau described as dehumanizing. All tāngata whaiora and whānau interviewed described their experience of accessing secondary inpatient or community-based services as being extremely difficult, traumatic, discriminative, and sometimes racist.

Entry criteria were further described as being austere and inflexible leaving many whānau unable to access the secondary support they needed. One tangata whaiora described their experience of trying to access secondary services in this way: "***unless you are suicidal, they won't help you".*** However, another tangata whaiora mentioned that despite multiple suicide attempts, they continued to have difficulty accessing secondary services, adding: ***"more fuel"*** to an already acute downward spiral.

Kaimahi believed that that a major barrier for whānau trying to access secondary inpatient or community-based services was the service criteria: ***"In predominantly clinical services there is more of an interest that people meet the systems criteria first… and then there are the multiple layers of assessments that follows and that's before we can see whānau".*** Given the contrast in experiences of whānau trying to access secondary services, it could be assumed that the level of accepted acuity within entry criteria may differ between secondary services, or it could be assumed that accepted entry criteria may vary dependent on the attending clinician at the time.

In contrast, many kaimahi believed that access barriers came down to the issue of kaimahi

capacity and demand for services across the entire system: “***there is a real shortage of qualified and experienced kaimahi and pūkenga atawhai out there…it is difficult to meet the high demand on services, so whānau get put on long waiting list. Kaimahi end up working long hours…we then end up with a tired workforce”.***

Whānau members who had difficulty accessing secondary services for their whānau described how alone and overwhelmed they felt having to provide in-home supportive care to their whānau for an acute illness they had no expertise or knowledge of: ***“we felt abandoned by services who left us to look after ( ) who was so unwell. We started to become unwell too, in the end we all needed help”.***

Another whanau member described their experience this way: ***“It took a lot of time and we had to fight for this when the western system wasn’t providing for our () with what she needed. Even once we had support it felt rushed and wasn’t given the time and respect needed”.***

Therefore, kaimahi shortages, high service demand, an overworked workforce, coupled with an inconsistent entry criterion is impacting negatively on the service experience for tāngata whaiora and their whānau. This has left devastating consequences for some whānau who had described being traumatized, disappointed, let-down, abused and worse still, angry for losing whānau members to suicide because they could not get the help they needed, when they needed it.

Of note, it was unclear in the interviews how whānau were allocated to the kaupapa Māori secondary inpatient unit, *Te Korowai Atawhai* nor was it clear if tāngata whaiora and whānau were informed of the unit during the entry pathway. However, whatever the pathway whānau took to arrive there, the experience along the way was unanimously described as being traumatic.

Access to secondary community-based mental health services (non-kaupapa Māori) is triaged through the same single point of entry process as the inpatient units. Allocation to services is pre-determined, based on the residential locality of whānau. Tāngata whaiora and whānau reported negative experiences when accessing or trying to access community-based services. Some of the community-based teams were described as racist or discriminative in their approach to Māori and delivery of equitable care, treating them and their whānau poorly.

Some whānau felt that the employment of pukenga atawhai working within community-based secondary services was a tokenistic gesture made by services that did not enable kaimahi to deliver holistic approaches to hauora. Whānau believed that some kaimahi working within a western system may unconsciously project the same negative attitudes of the system towards Māori whānau. One whanau member described their experience as follows: ***"The pākeha service threw in a Māori worker, so that was an easy part of the service to access. But the kaimahi themselves disengaged and didn't follow through with mine or my () duty of care. It left us feeling helpless and unworthy of receiving help."***

Though many secondary community-based services were described negatively in their delivery of service. There were some secondary community-based teams described as providing adequate care.

Participants who reported on the variability of care across the service teams believed that the cause in variation was because the individuals within the teams or the team itself were biased in their attitudes and approaches towards Māori and mental illness. When whānau become dissatisfied with the level of care received within their locality, the challenge they face is their inability to be referred on to an alternative team of their choice due to the current locality-based service model. Participants felt that locality-based services limited choice and was unacceptable, arguing that appropriate treatments and support should not come down to ***'the luck-of-the draw'*** of where you happen to live at the time of crisis.

Conclusion:

Many tāngata whaiora and whānau had described their experience of accessing community based kaupapa Māori services as being relatively easy, once they became aware that such services were available to them. Prior to accessing services, they had little to no previous knowledge of services. This was also said of non-kaupapa community and government services, and general practices whom tāngata whaiora or whānau were already engaged with. Therefore, it is reasonable to assume that communication and information sharing of kaupapa Māori services to other community groups and government departments including GP services needs to be improved across the entire system. Information needs to include who can access services, how to access services and what each service provides, particularly if a kaupapa Māori rōpū delivers multiple services. This information needs to be easily

transmitted using multiple forms of communication in both Māori and English languages.

Though most tāngata whaiora and whānau interviewed had a positive experience accessing services, some whānau members experienced long delays, leaving them feeling frustrated and angry.

Accessing Kaupapa Māori secondary inpatient and community-based services is fraught with multiple barriers. Entry criteria and traumatic system processes stood out as being primary barriers for tāngata whaiora and whānau. In contrast, kaimahi believed that kaimahi shortage and high service demand alongside entry criteria were the primary barriers to accessing kaupapa Māori secondary services.

Tāngata Whaiora and Whānau Expectations of Kaupapa Māori Services

> *"I felt really welcome from the first day. I never felt like there was a difference. I never felt like I don't belong here. I feel like it's really open to everybody. It's not like, oh, it's just for Māori, we are not going to help anybody else… I feel like they realized that I needed help, and they gave it to me."*

Expectations of kaupapa Māori services were reportedly low prior to entry. One non-Māori participant reported having reservations about engaging in kaupapa Māori services, stating they had ***"very stereotypical views of Māori"*** people. These views coupled with having previous negative experiences of general mental health and addiction services led some to expect that kaupapa Māori services were even less likely to provide the right support to meet their needs ***"…We've got nothing in common and besides I'm too broken, if the white people can't fix me what are these guys going to do?"***

While there were mixed opinions about whether a kaupapa Māori service was appropriate for non-Māori, once in the service, participants felt welcomed irrespective of their ethnicity. Overall, there were overwhelming reports of positive experiences and raised expectations by tāngata whaiora and whānau once they had accessed kaupapa Māori services. They described services as exemplifying whānau-centrism and being holistic in their approach to support and care, a contrast to individualized medical approaches within non-Māori services.

Many participants also stated that kaupapa Māori services aligned with their own cultural and recovery values of whānau, connection, respect, genuine care, and self-determination. Alongside these reports were the expressed feelings of being seen, heard, respected, and treated as a whole person. The practice of specific health models such as Te Whare Tapa Whā was mentioned by whānau as one of the many reasons why kaupapa Māori services were able to achieve such an outcome in comparison to many non-kaupapa Māori services they had previously accessed.

Tāngata Whaiora and Whānau Expectations of Kaimahi

Many Māori tāngata whaiora and whānau accessing kaupapa Māori services had an expectation that kaimahi would predominantly be of Māori descent and have knowledge of tikanga Māori. However, some whānau noted that they found it difficult to be assigned to kaimahi of Māori descent within a kaupapa Māori service. This had left some whānau feeling that that the delivery of services for Māori by Māori was disingenuous.

Whilst many Māori tāngata whaiora and whānau spoke of accessing traditional Māori healing practices such as rongoā, mirimiri, taonga puroro and tohunga as being important, such traditional healing practices were not rated as high an expectation in comparison to their expectations of having 'qualified' and 'experienced' kaimahi working alongside them.

When asked what they meant by the words "***Qualified and Experienced"*** in the context of kaimahi expectations, the following were the definitions provided:

- Qualified – 'Trained in mental health and addictions, professional'
- Experienced – 'Lived a life like mine', 'walked in my shoes', 'someone just like me'
- Kaimahi – 'are of Māori descent and have knowledge of tikanga Māori'

In most instances, those expectations had been met by kaimahi providing an environment of familiarity and safety for tāngata whaiora and whānau. Of note, was the emergence of unanimous kōrero by whānau and kaimahi which shone the light on the importance of kaimahi having lived experience of mental health or addiction distress in addition to being trained, professional practitioners. This topic will be discussed further in the chapter 'Improvements to kaupapa Māori mental health and addiction services'

Conclusion

Overall, expectations of kaupapa Māori mental health and addiction services and kaimahi who worked within those services were reported as going beyond expectations. Kaupapa Māori services were whānau-centered and holistic in their approach with reference to the application of 'Te Whare Tapa Whā' model of health in practice. Knowledge of tikanga Māori and being of Māori descent was not only expected but was also considered important. This, alongside being professionally trained and having lived experience of mental health distress and/or addictions was also expected of kaimahi working with whānau across services.

These expectations of kaimahi shine a light on the workforce capacity and capability of kaimahi working within the sector across Waitaha. The primary interviewer wanted to seek clarity from kaimahi as to their own professional and cultural capacity to meet whānau expectations. Therefore, all kaimahi interviewed were asked how they were being supported to build their skill set and knowledge base of Te Ao Māori and how providers across all services were supporting them as Māori practitioners? Those questions and responses will be explored in following sections.

What worked well within Kaupapa Māori services.

> *"It feels like home. I feel I'm somewhere where I am comfortable and safe and all my values and my personal kaupapa are all aligned".*

Kaupapa Māori services were singled out for their friendliness and exceptional delivery of care to tāngata whaiora and whānau: ***"Like the vibe here is just amazing and unlike any other mental health service I've been in."***

Strengths noted included persistent communication and follow up, as well as staff going above and beyond to meet their needs. There were several examples shared of this, including the delivery of kai during the COVID-19 pandemic: ***"out of the kindness of their heart they brought food to our door"***. Another participant who did not know his birth origins due to closed adoption, was supported by kaimahi to have their DNA tested and therefore find their whakapapa and personal identity, which had a life-changing impact: ***"so they did that for me, no one's ever done anything like that for me. No one. Not even my own adopted mother.***

So, it's very special…now it totally flipped my life, totally up the other way. Now I've got a life, I know who I am".

Kaupapa Māori whānau-centered practice was appreciated, a contrast to being treated as an individual in general care. In this regard, the inclusion of tamariki or rangatahi in services that provided support to parents was distinguished as being different from other parenting programmes recommended by the Ministry of Education. Several noted that they valued being able to talk about their own mental health or addiction concerns as well as being provided advice and practical parenting support for their tamariki.

"They work a totally different way to general parenting groups… Most parenting groups are just giving you tips. This is totally hands-on and yeah, bring your child and we'll go over (support) the whole whānau, the whole village, so it was a lot different."

The delivery and governance of services according to tikanga and Māori values was also noted as a strength to kaupapa Māori services. Māori tāngata whaiora spoke of kaupapa Māori services as providing invaluable support in terms of connection to Te Ao Māori. Participants reported learning a lot about Māori ways of caring and sharing, te reo, rāranga, karakia and tikanga, simply by being part of the service. Further to this, participants spoke of the offering of multiple services within a rōpū as being like ***"a Māori cloak, wrapping itself around us"*** within the one organization.

However, some tāngata whaiora thought that the service they were using was the entirety of services. They were unaware that the organization delivered a suite of services and would have appreciated knowing there was more on offer. The provision of talking therapy support such as counsellors was noted as particularly beneficial for many. Some of those benefits included providing understanding and being there in times of need, as well as support to build independence and resilience:

- ***"Someone to support me to work through traumatic events."***
- ***"Helping me find ways to cope somehow."***
- ***"Giving me the tools to help me with panic attacks."***

However, it was noted that not all kaupapa Māori mental health services provided

counselling or psychological talking therapy support, whereas counsellors were easily accessible within addiction services. Lack of availability of counsellors and psychologists within kaupapa Māori mental health services meant that whānau had to seek support outside of services. Free or low-cost counselling or psychological services within the Waitaha rohe are minimal. The few that provide services are in high demand with extremely long waitlists, this includes services funded by ACC sensitive claims unit.

Additional comments highlighting the positive aspects of services include the following:

- Ease of access through an on-line self-referral process
- Flexibility – Services were flexible in terms of transport options to/from appointments and cancellations of appointments
- Range – A wide range of services within the organization, including group-based activities.
- Long-term support (longer than expected) was particularly beneficial for whānau navigating complex situations.
- Communications between kaimahi and whānau to arrange hui, coupled with regular phone/text check-ins.
- Transparency – The ability to read their own clinical and support plan notes
- Whānau inclusion – The acceptance and inclusion of whānau as a whole unit within services, including tamariki, rangatahi and other support people as identified by tāngata whaiora.

Negative experiences, though few, must be mentioned to enable opportunity for on-going improvements within kaupapa Māori services. In the previous sub-title, tāngata whaiora and whānau mentioned they have an expectation that kaimahi would have had similar lived experiences as themselves and equated such experience and knowledge as being an essential component to the workforce capability. However, some tāngata whaiora shared privacy concerns, due to having historical lived experience or whānau relationships with kaimahi. They spoke of situations they had encountered within services where kaimahi were also whānau members or were once social associates. Such familiarity into the personal or social

lives of tāngata whaiora was perceived as potentially undermining recovery progress and autonomy: ***“they know too much about me”, “I worry I will be judged if I don’t get it right”, “I don’t want everyone knowing my business”.***

Some tāngata whaiora reported dissatisfaction with community-based social housing or supported accommodation of which tenancy agreements were completed between the whānau and services. Tāngata whaiora reported long delays in completing rōpū agreements alongside having a lack of clarity about their rights as tenants under the Residential Tenancies Act 1986. Others spoke of the lack of cleanliness, hygiene, and workable chattels they encountered when they began their tenancy. The complaints process or the process to report concerns about the quality of accommodation whare was unclear to tāngata whaiora. There were also concerns about the potential of losing accommodation if complaints were reported, giving rise to feelings of apathy and even gratitude: ***“a messy house is better than no house”.***

Some tāngata whaiora felt that programmes were too long, requiring more than 10 hours per week in participation. Others felt that some programmes needed more structure, routine, and variety in their content. One tangata whaiora stated ***”Wouldn’t it be great if some of the programmes included speakers who had lived the experience I had, recovered, and made a life for themselves. That would be inspiring to see what I could one day be”.*** The Tuakana - Teina Māori peer rōpū is no longer active in the Waitaha region, leaving an unmet gap in service provision for whānau to access Māori peer workers, advocates, and Māori peer educators. Though there are a few non-Māori peer services operating within Waitaha, some peer workers have reported that most of their services do not have the cultural capacity or capability to provide Te Ao Māori value-based peer services.

Additional comments highlighting the negative aspects of services include the following:

- Not enough kaimahi Māori in kaupapa Māori services
- Difficulty accessing kaupapa Māori services through GP practice
- The social work team only contacted us twice. We never got to meet kanohi ki te kanohi

Conclusion

In summary, tāngata whaiora and whānau spoke of kaupapa Māori services as being exceptionable in providing whānau-centered care that was embedded with Te Ao Māori values, values that personally resonated with themselves as Māori and non-Māori alike. Examples were given of kaimahi going above and beyond in their delivery of services, including connecting whaiora with their whakapapa identity and whānau of origins. Reconnecting tāngata whaiora displaced from iwi, hāpu and whānau to their whakapapa was once a primary delivery feature of many kaupapa Māori mental health services, particularly during the late 90's - 2000. However, whakapapa reconnection was not overly reported on as a service feature by tāngata whaiora nor kaimahi. Reasons for the possible absence or macro requests for this service was not explored in this review but could be explored if validated as an essential component to service provision in the future.

Talking therapies provided by counsellors or psychologist were beneficial for whānau working through trauma. Though, talking therapy support such as counsellors was provided within addiction services, they were not so easily accessible within mental health services. External access to low-cost or affordable talking therapy options was limited in the community, due to minimal supply of affordable services, long waitlists, and high demand. Exploration into the demand and supply issues of talking therapy services within the Waitaha rohe was not covered in this review. However, potential for such exploration could provide information for rōpū who are considering expanding their services to include talking therapy options.

Rōpū provision for social housing or supported accommodation, though appreciated, was not given the same commendation as other aspects of service provision. Exploration into the application of the Residential Tenancies Act 1986 with rōpū tenancy agreements was not undertaken in this review. However, continual consideration must be given to the 'Code of Health and Disability Services Consumers' Rights and Regulations 1996' and the 'Health and Disability Services (Safety) Act 2001, when providing social or supported accommodation to tāngata whaiora and whānau using services. Tuakana/Teina peer advocates who are versed in the health and disability code, tenancy law and who have had lived experience navigating through those systems could provide independent confidential support to whānau requesting tenancy information or reporting concerns or complaints with their provider rōpū. Additional

support such as this coupled with lived experience of navigating systems would enable whānau to feel confident to self-advocate these or similar system issues or service concerns as part of their recovery and wellbeing journey.

Improvements to Kaupapa Māori mental health and addiction services

Tū pakari tonu mai e te Whare Tapawhā!

Let the house of health and well-being stand strong!

Reported improvements to kaupapa Māori mental health and addiction services were not directly attributed to any perceived or validated failures of kaupapa Māori services. On the contrary, improvements were reported as possible additions or add-ons to services that would enable greater choice and ease of access to services for tāngata whaiora and their whānau.

For example, tāngata whaiora imagined an inpatient service that was proficient in the practice of pōwhiri, whanaungatanga, whaikōrero and the enactment of manaakitanga. This imagination was not limited to specialist inpatient services but to the entire inpatient system which tāngata whaiora and whānau will have direct contact with. Access to an inpatient service and system which demonstrates cultural competence when triaging, assessing, diagnosing, and treating acute illness could minimize experiences of racism, discrimination, and dehumanization towards Māori whānau. Kaimahi recommended that mandatory cultural competency be required as a pre-requisite to all employment and professional development programmes across the entire mental health and addiction workforce. This included the delivery of competency based kaupapa Māori training programmes, specific key performance indicators (KPI) related to cultural competency and the enabling of culturally specific professional development opportunities including access to cultural supervision.

As mentioned in previous chapters, tāngata whaiora, whānau and kaimahi spoke of the need to have qualified and experienced kaimahi working in services. When asked to describe what was meant by the words 'qualified and experienced,' the general theme coming through was that of a person who had lived experience of mental health and/or addiction challenges and understood kaupapa values and philosophies when supporting Māori. They considered this a more desirable attribute than just having qualification-based training and registration and as mentioned above, qualification-based training had to include the demonstration of cultural competency.

Tāngata whaiora and whānau imagined secondary services providing access to Māori traditional healing practices such as rongoā rākau, mirimiri, taonga pūroro and tohunga. Tāngata whaiora who had previously accessed Māori traditional healing clinics whilst in secondary care spoke to the validity of various rongoā rākau prescribed by tohunga and its calming affects to the tinana and hinengaro. Some of the rongoā rākau mentioned by tangata whaiora included kumarahou to co-manage symptoms of depression and anxiety.

Of interest was feedback received by some kaimahi who recommended adding mental health and addiction services to existing marae-based community hubs. However, some believed that tāngata whaiora were not ready for marae-based services because of the tikanga protocols practiced on marae. In contrast to this assumption, tāngata whaiora made mention of many marae-based tikanga practices and philosophies they believed were pivotal to their wellbeing and reclamation of identity. These included tikanga practices such as, pōwhiri, whanaungatanga, karakia, waiata, kōrero and the sharing of kai. Tāngata whaiora went further to even recommend that such tikanga practices become normalized throughout the mental health and addictions services.

Peer support services for Māori were recommended as an additional add-on to existing kaupapa Māori services. Several Māori peers mentioned the closure of the kaupapa Māori peer services in Waitaha which has left a gap in service provision for tāngata whaiora requesting peer advocacy support or other peer-led provisions. It is important to note that the peer workforce has grown substantially across Aotearoa and is recognized as a specialized practice whose primary function is to build mutually respectful relationships and connections with tāngata whaiora and their whānau as they co-navigate the complexities of services, systems, personal recovery, and growth. It is also important to note that the role and function of the peer worker differs from that of a support worker or clinician who has had lived experience of mental health and/or addiction challenges. Peer workers are intentional in their support functions, guided by a set of recognized values, and practices both here in Aotearoa and across Australasia.

However, many Māori peer workers stated that the current NZQA peer curriculum or other peer support training modules such as Intentional Peer Support (IPS), does not consider the cultural context of Aotearoa nor the conversations had by Māori that recognizes the impact colonization, urbanization, loss of land and language has had on the wellbeing of Māori.

Therefore, complex conversations such as decolonization, reclamation of Māori indigeneity and the training required to enable safe conversation between the peer worker and tāngata whaiora is absent within the current training modules being delivered in Waitaha. Note: This review did not include examining service access data of Māori who have utilized peer support services in Waitaha.

Other potential areas for improvement recommended by tāngata whaiora, whānau and kaimahi include the following:

- Improved advertising and promotion of services across the health system, government departments including general practices
- Improved social media communications that includes service options that are available
- Implement a service on-line booking system that enables whānau to plan and manage their own appointments
- Resource packages of care with an allocated budget for each whānau, so whānau can access other supports that may not be included in service provision e.g., counselling, rongōa
- Include in kaupapa Māori mental health and addiction services access to the tuakana-teina peer workers who can provide specialized kaupapa Māori peer support
- More staff and higher levels of remuneration for kaimahi.

Conclusion

Tāngata whaiora, whānau and kaimahi imagined services across the entire system as being culturally vibrant, enacting Māori traditional tikanga and healing practices. To enable such vibrancy, access to and choice of the workforce and support systems must be culturally appropriate and competent. To enable this, it has been recommended that mechanisms are put in place across the system to develop the cultural responsiveness of services. Proposed mechanisms and enablers included the delivery of competency based kaupapa Māori training programmes, specific cultural key performance indicators (KPI) and measurement and the enabling of culturally specific professional development opportunities including access to cultural supervision.

Further to this, kaimahi who have had lived experience of mental health or addiction challenges, alongside having appropriate clinical or non-clinical qualifications were also considered essential to the workforce. Tuakana-teina Peer support services for Māori were recommended as an additional add-on to kaupapa Māori services. Peer services are specific in their values and practice which builds on mutual connections and relationships with whānau as they navigate services and personal lived experiences.

Recommendations for Waitaha

Following is a list of recommendations for service and system improvements or add-on features to existing kaupapa Māori mental health and addiction services within the Waitaha region, made by tāngata whaiora, whānau and kaimahi.

1. **Stand-up and test alternative options to accessing specialist services for tāngata whaiora who do not meet crisis entry criteria**
2. **Increase awareness of kaupapa Māori services and service components to other health providers, government agencies and general practices**
3. **Develop a comprehensive cultural competency recruitment plan, training and professional development framework and action plan that supports the on-going cultural development of kaimahi working across the entire system**
4. **Increase the kaimahi capacity to include kaimahi who have had lived experience of mental health and addiction challenges**
5. **Increase the kaimahi capacity to include tuakana-teina Māori peer workforce or add-on to existing services a tuakana-teina Māori peer service**
6. **Invest in the development of kaupapa Māori tuakana-teina peer training and workforce development**
7. **Resource packages of care with an allocated budget for each whānau, so whānau can access other supports that may not be included in service provision e.g., counselling, rongōa**
8. **Consider the option of basing new or existing kaupapa Māori mental health and addiction services at marae-based community hubs.**

Since the interviews were undertaken in June and July 2022, a new kaupapa Māori community-based crisis support service, Whakahohoro Te Hau is being piloted in Otautahi, Waitaha. Funding is being sought to continue service provision post pilot evaluation.

Chapter 2: The Kōrero from Te Tai Poutini

He āwhina, he aroha ngā miro tuitui i ngā haehaetanga a te mate.

Love and support knit together the lacerations of anguish.

Te Tai Poutini covers a wide geographical area and is made up of small to medium and sometimes isolated communities. During the community engagement process of the Kā Pou Whenua project it was not possible to cover all the communities within the timeframe provided. Focus was given to travelling to and meeting hāpori, tāngata whaiora, whānau and kaimahi in Hokitika, Greymouth and Westport.

In this review consideration has been given to the challenges facing organizations including Te Whatū Ora in providing services across a wide geographical region. Consideration has also been given to the impact limited access to services has on tāngata whaiora and whānau who live in communities where mental health and addiction services are not available. Several communities have a few social services available such as: Salvation Army, Whare Manaaki o te Waipounamu, Te Hono ō Ngāa Waka and Poutini Waiora. In most instances, whānau interviewed were more likely to access these services instead of mental health services because they were accessible within their locality.

Accessing Kaupapa Māori Mental Health and Addiction Services

"They helped guide and prepare me for what was to come, they understood the process and the extent of the trauma my () had gone through and what supports we all needed to survive this against all odds."

Many Māori tāngata whaiora are accessing help through non-Māori mental health services first. This could be due to the limited availability of kaupapa Māori mental health across the rohe or a lack of knowledge of what kaupapa Māori services were available within the community. Tāngata whaiora agreed that while services were limited, they were often not offered the choice to access kaupapa Māori services in the areas where they were available. Many stated that if they had been offered the choice, they would have chosen kaupapa

Māori health services first and foremost. Knowledge of kaupapa Māori health and social services was often transmitted to whānau by others who had accessed services or whānau members who worked within mental health, addiction, or social services.

For those who had accessed kaupapa Māori mental health or social services, a key theme for why they chose kaupapa Māori was that the service provided a place where Māori values and holistic practices were relatable and meaningful to them, and where they felt they belonged. Tāngata whaiora and whānau stated that kaupapa Māori services provided a social network, enabling a space to feel supported by the people they had contact with when things were not going well. Whānau spoke consistently of feeling that they were being treated and seen as a whole person, felt a sense of belonging as well as connection to their whakapapa and culture. They spoke of enjoying the manaaki, genuine care and guidance given from kaimahi.

Whānau also described being able to access tohunga and traditional Māori healing practices such as rongoā Māori and mirimiri. Alongside providing traditional Māori health practices to whānau, other activities such as self-help groups, maara kai gardens and pop-up pantries were often additional components of kaupapa Māori health and social services.

When asked what went well when using kaupapa Māori health or social services, tāngata whaiora responded by saying: ***"I felt like I was part of a whānau service. I felt connected to my whānau / family. I felt connected to my identity and culture."*** Tāngata whaiora attributed kaupapa Māori services to instrumental changes in their lives and the lives of their whānau. Many tangata whaiora described that once leaving services they returned as volunteers to work in the service, whilst others described entering a study programme so they could enter paid employment as either a kaimahi, kaiāwhina or as a peer advocate.

Accessing secondary mental health services and other government agencies

> *"I was only able to access kaupapa services because I'm good at advocating for myself, but many other people I know who would benefit from such services have never heard of them"?*

Tāngata whaiora and whānau interviewed expressed concern and disappointment when accessing secondary mental health and addiction services. They also expressed

disappointment when engaging with other government agencies, such as Accident Compensation Corporation (ACC). Counselling to work through trauma is not predominantly provided for within secondary or community-based services. Whānau requiring counselling services spoke of their inability to access needed support through ACC:

"I rang ACC a few times and it was basically my job to find an ACC counselor, which with no resources is really hard to do":

" I had spent months doing all this work to find a counselor and still nothing while I'm dealing with my mental health as it deteriorates. I felt I was just being passed back and forth between agencies and still got no help."

They described feelings of being: ***"mistreated, misunderstood, and not listened to"*** when accessing secondary services. Some whānau members felt that the system itself was traumatizing and the process used to gather information during an assessment was mana diminishing. Further, when whānau expressed concerns about themselves or whānau members experiencing acute distress, their concerns were not taken seriously:

"My mental health was worsening, and I can't really remember where I went or what happened. But there was no help. After approximately 5 suicide attempts there was still no help."

Pūkenga Atawhai[v] were mentioned as being extremely helpful for tāngata whaiora who required advocacy support when navigating the mental health system for the first time.

As previously mentioned, tāngata whaiora, whānau and kaimahi spoke of an inherent mistrust of the mental health system that prevented some whānau from accessing mental health secondary services. This mistrust was based on historical experiences of non-Māori systems and services described as traumatic, mana diminishing, racist, discriminative, and lacking genuine care for Māori and Te Ao Māori worldview:

"What it felt like was that these supportive people put me in a lower grade, they didn't really treat me as a person, they just treated me differently. Like I was just on the benefit, but I felt that someone in a suit and tie would have been treated completely differently, I think that needs to change."

"He had no trust in people or services because of his childhood experience of the system, so now we have two traumatized young people and family members trying to heal and needing support, but they don't trust anyone."

"Trust was nonexistent. There was no trust. Going back to when I was first homeless, the government, the people that worked for the government agencies didn't even care or want to hear my side of the story."

Barriers to accessing Mental Health and Addiction Services in Te Tai Poutini

Tāngata whaiora and kaimahi identified several barriers to accessing not just kaupapa Māori mental health and addiction services, but mental health and addiction services in general. Barriers identified are as follows:

- Limited kaupapa Māori mental health and addiction services
- Geographical location
- Shortage of kaimahi and pukenga atawhai
- Long wait-times
- Secondary service entry criteria
- Transportation
- Cost of living
- Service resourcing
- Racism and colonial systems
- Lack of knowledge of what services are available
- Lack of knowledge of whakapapa and cultural identity

Tāngata whaiora, whānau and kaimahi believed that the long wait-times for accessing secondary support or kaupapa Māori services was due to the high demand on services and the shortage of kaimahi and pukenga atawhai across Te Tai Poutini rohe. Limited early intervention support services along with kaimahi shortages means whānau do not get the help they need until they reach a crisis point, putting pressure on an already overwhelmed secondary service.

Tāngata whaiora and whānau spoke of not being given sufficient information about services, particularly kaupapa Māori services. Whānau described being sent from service to service

without having a full understanding of who the service was or why they were being referred there. Other whānau described experiencing acute distress where they required immediate help and oftentimes were either turned away, dropped by counselors, general practitioners and in most instances left to manage their circumstances alone.

Whānau also noted the lack of services available to respond to the needs of the entire whānau., particularly in relation to supporting tamariki and rangatahi. Whānau spoke of a huge gap in secondary or specialized support for rangatahi aged between 17-25 years within Te Tai Poutini. Rangatahi requiring specialized support are often referred to services outside of the rohe leaving many whānau displaced or disconnected from each other.

"I thought there would have been more services that could help me and the children."

"I expected to get help for the children and that just wasn't there."

"I got help for me but there was nothing available for my children."

Improvements to Mental Health and Addiction Services in Te Tai Poutini

> *Tū pakari tonu mai e te Whare Tapawhā!*
>
> *Let the house of health and well-being stand strong!*

Whānau and kaimahi said that there is limited availability of community-based mental health services in Te Tai Poutini, this included kaupapa Māori services. With limited options available in the community, whānau wait until they have reached crisis requiring secondary intervention. Those who had accessed secondary support spoke of the service as being dehumanizing and traumatic and did not want to return. Other whānau experiencing crisis told us that due to historical experiences of the system they did not seek help at all. In contrast to these experiences, tāngata whaiora and whānau spoke of the respect and trust they had for and from kaupapa Māori services and how those services supported them and their whānau to receive the help they needed. There is opportunity for mental health and addiction services to lean into kaupapa Māori providers and to adopt principles and values enacted by Māori that have meet the mental health, psychosocial and cultural needs of whānau across the rohe.

Further to this, whānau imagined a mental health and addictions workforce that was qualified and experienced. When asked what they meant by this, they described a workforce that was professional, clinically qualified when the role required it and with lived experience accessing systems, experience of mental health distress or historical experience of addictions and recovery. An opportunity presents itself to develop the tuakana/teina peer and lived experience workforce within Te Tai Poutini. The tuakana/teina peer role is non-clinical in its function and can provide intentional and relational support to whānau navigating systems or understanding the effects of medications and many other such experiences that both the tuakana and teina have or have had in common. The lived experience workforce can be both clinical or non-clinical and integrated through-out organizations. Increasing the tuakana/teina peer and lived experience workforce across the system will bring people with lived experiences to the heart of the system and can support the development of people-centered models of care and service.

Conclusion

There is limited availability of kaupapa Māori mental health and addiction services in Te Tai Poutini. Where kaupapa Māori services are not available it is likely that whānau would seek support from their local health providers, social services, including GP services[vi]. Kaupapa Māori services, when accessed were described as holistic and welcoming, and enabling of cultural and community connectedness. Social networks and connection with others were considered essential to the wellbeing of individuals, whānau and hāpori who live in isolated communities located many miles from each other. Knowledge of kaupapa Māori mental health and social services and how to access them was not often communicated to whānau by specialist services or other government organizations, but rather people who had already used services or worked within them.

Tāngata whaiora and whānau expressed disappointment in secondary services and described interactions as traumatic and mana diminishing amplifying historical mistrust of non-Māori systems. It is critical to the wellbeing of whānau and hāpori to have access to kind, caring and responsive mental health and addiction services. Kaimahi and whānau believe that the whānau experience of accessing secondary services could greatly improve if the services adopted kaupapa Māori principles such as whanaungatanga and manaakitanga into their

practice and service models. In addition, increasing the Māori workforce capacity will enable kaupapa Māori services to reach across Te Tai Poutini. This could be achieved by collaborating with other health or social service providers to provide a mobile service that could travel to other main centers or isolated areas.

An opopportunity presents itself to develop the tuakana/teina peer and lived experience workforce within Te Tai Poutini and to incorporate these roles across the system including funding and planning. The tuakana/teina peer and lived experience workforce will add a people-centered dynamic to the system as well as individual organizations and rōpū.

Since July and August 2022 when the interviews were being conducted two new kaupapa Māori services have opened in Te Tai Poutini. The government recently allocated funding to Te Tai Poutini to provide the Mana Ake school-based wellbeing programme. This programme is being delivered to more than three thousand primary and intermediate school-aged children living on the West Coast.

In the latter part of 2022, Poutini Waiora kaupapa Māori community-based mental health and social service opened a new service called He Hīkoi Manaaki. The service provides mobile and marae-based early intervention support to whānau that is both clinical and non-clinical. The workforce is a mix of cultural, clinical, and tuakana/teina peer kaimahi.

Recommendations for Te Tai Poutini

The following are recommendations to service improvements made by tāngata whaiora, whānau and kaimahi.

1. **Expand the reach of both kaupapa Māori and non-Māori services to cover geographical areas where access to services is limited or non-existent.**

Many communities located across Te Tai Poutini do not have the resources to establish new or existing mental health and addiction services, including kaupapa Māori services. However, during the time when interviews were being undertaken across the rohe, it was noticed that many local communities have existing small to medium scale community centers, hubs, churches, or whare. An opportunity presents itself for services to think differently about how they can reach people who are spread over a wide geographical area. Rather than delivering services where whānau are required to travel long distances to get help, could this be an opportunity to provide a mobile community response service that travels across the region and deliver services from the local hubs already established in the community?

Standing up a mobile community response service could be considered in collaboration with other mental health service providers including the West Coast PHO. This would enable the community to have access to kaupapa Māori and non-Māori services within a locality they are already familiar with.

2. **Increase the Māori workforce capacity and roles in the community.**

There is a genuine need to increase the Māori workforce within mental health and addictions services to meet the demand on services. This includes increasing the roles within the Māori workforce to include clinical psychologists, whānau ora kaimahi and tuakana/teina peer and advocacy kaimahi. Increasing the Māori workforce will enable existing kaupapa Māori services to meet the needs of whānau and tamariki requiring early intervention support in the community and schools, thus reducing demand on specialist services.

3. **Build a culturally competent and responsive workforce across the entire mental health and addiction system.**

One major improvement to services as identified by whānau and kaimahi was the need to

implement cultural training as part of the professional development of the mental health and addiction workforce. Tāngata whaiora and kaimahi believed that the entire system would improve considerably if services adopted and enacted kaupapa Māori principles of whanaungatanga and manaakitanga into their practice and service models. Connecting with tāngata whaiora and whānau prior to undertaking a service or treatment assessment is essential to establishing trusting relationships. Relationships built on trust, safety and acceptance will enable whānau to access any service when needed without the fear of being treated unfairly. Therefore, it is essential that all staff and kaimahi who have direct contact with tāngata whaiora and whānau can demonstrate professional and cultural competency in their practice. Cultural competencies should be measured against staff and kaimahi key performance indicators (KPI) and annual performance reviews. Engaging with workforce development agencies such as Te Rau Ora Māori workforce development agency and other similar agencies could assist services within Te Tai Poutini to identify and deliver on relevant cultural training programmes.

Further to this, whānau and kaimahi spoke of the workforce needing to be both qualified and experienced practitioners. Clinical and support work qualifications was considered appropriate to meet ethical practice and related requirements. However, they spoke of the workforce that had lived experience of mental health or addiction concerns as being beneficial to the relationship and connection between kaimahi and whānau. Investment into building the tuakana-teina peer and lived experience workforce and advisory boards across the system will enable a people-centered responsive system to whānau accessing services in Te Tai Poutini.

Chapter 3. Summary of findings across Waitaha and Te Tai Poutini

This chapter will review similarities and differences reported by whānau across the two rohe. Identifying similarities or differences help identify common themes within the system that have either a positive or negative impact on the provision of services and the experience of services by Māori whānau.

Similarities across the two rohe

The following summary will highlight similar barriers experienced by tāngata whaiora and whānau accessing both kaupapa and non-kaupapa mental health and addiction services.

- **Lack of awareness of kaupapa Māori mental health and addiction services by other health providers, government agencies and general practices**
- **Lack of alternative options to crisis services for whānau who do not meet secondary service entry criterion**
- **Historical traumatic or negative experiences of systems and services by Māori whānau**
- **Inconsistent and complex entry criterion and pathways to secondary services**
- **High demand on Māori and non-Māori services resulting in long wait times and wait lists**
- **Shortage of experienced and qualified kaimahi across the entire mental health and addiction system including the peer and lived experience workforce**
- **Cultural competency within the mental health and addiction workforce**

The following are similar experiences shared by whānau who have accessed kaupapa Māori services across the two rohe.

- **Services exemplified whānau-centrism and holistic approaches to support and care**
- **Services enacted whanaungatanga and manaakitanga and created an environment that made whānau feel welcome**
- **Whānau utilizing community-based kaupapa Māori services were able to access traditional Māori healing practices such as miri miri, rongoa rākau, taonga puroro.**
- **Whānau described services that enabled them to connect with their cultural identity**
- **Shortage of Māori kaimahi delivering kaupapa Māori mental health and addiction services**

Differences between the two rohe

- **Large geographical distances between services across Te Tai Poutini rohe making access difficult for whānau living in isolated parts of the rohe**
- **Limited to no availability of kaupapa Māori mental health and addiction services within Te Tai Poutini rohe**

Appendix 1. Whakatauki

Tino Rangatiratanga

Kia whai mai tēnei tumu, nā te take, he tino whakahirahira e maumahara ana au ki te Tino rangatiratanga o ētahi tangata.

The importance of understanding the autonomy and agency of individuals to access what they need.

Kei te awhi mātou i roto i tēnei rangahau, ngā tangata Māori i runga i tōna rangatiratanga, i tōna mana, i tōna moemoea hoki.

Within this research participants' mana, autonomy and aspirations were considered.

Taonga Tuku Iho

Ko tōnā Reo, rātou ko tōnā Mātauranga Māori, ko tōnā Ahurea, ko tōnā whakapapa Māori, Ko te mea nui o tēnei rangahau. Hei orite ki te whakatauāki matua, mēnā kāore e pumau tonu ki tōku taonga, e rite ana au ki te pūkaki awa kāore ōna hikuawa.

The importance of peoples' language, cultural wisdom, culture, values, and genealogy is at the centre of this mahi. Like the main whakataukī that talks to individual wellbeing, when you don't hold onto the teachings of your ancestors, you can lose sight of your path forward.

Ako Māori

Kei te kōrero mātou ki ngā tangata i roto i tēnei kaupapa i te ara tika mō tēnā tangata. He reo Māori, reo pākehā rānei. Mai i te pūrākau, mai te whakautu pātai rānei.

Within this research participants were able to deliver their experiences in English or in Te Reo Māori. Strategies used to deliver their kōrero was self-determined; be it stories or direct answers to questions.

Whānau

Ko te whanau te mea nui o te ao o ena tangata, o ena tangata. Noo reira, kia mau au ki te ara tika o whakawhanaungatanga me te hononga ki etahi tangata.

Whānau is one of the most important parts of an individual's lives. Therefore, part of the research methodologies is forming relationships and connections to each interviewee.

Te Tiriti o Waitangi

E ai ki Pihama(2001), kei te ata whakaaro o te Tiriti i roto i te mahi rangahau hei whakahirahira.

According to Pihama (2001), Te Tiriti o Waitangi is a very important grounding principle for research.

Te Ara tika, Te Whare Tapa Whā, Te Pae Mahutonga.

Ko ēnei nga pou tarāwaho i roto i tēnei kaupapa.

These are the strategies used and mentioned within this research.

I roto i ngā pou taraawaho e pa ana hauora nā Mason Durie, ko ngā mea whakahirahira, Ko ngā taha o hauora ki te tangata (taha hinengaro, taha wairua, taha tinana, taha whanau). I roto i te pae mahutonga he mea anō o Mauirora, waiora, toiora, Te oranga. Ko ēnei pou taraawaho he mea nui i te taha o hauora kia āta-haere au.

Kia whai mai au ki Te Ara Tika mai tēnei pou taraawaho. Ko te ara o Tapu ki te noa he mea hirahira i te rangahau. Tapu - kia tūpato - kia āta-korero - kia āta-whiriwhiri - kia āta-haere - Noa. He tino whakahirahira hoki kia maumahara tēnei patai. He aha whakapapa o tēnei kaupapa?, Me pehea e tika ai tēnei kaupapa?, Ma wai e manaaki tēnei kaupapa?, kei a wai te mana mo tēnei kaupapa?

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[i] The West Coast has limited kaupapa Māori services. The majority of Māori tāngata whaiora and whānau interviewed had not accessed kaupapa Māori services. Therefore, questions were shaped to inquire about their experiences being Māori accessing general mental health and addiction services.
[ii] Kaimahi were asked questions based on their experience working in the system which would assist the project team to identify the causation of barriers to accessing services for tāngata whaiora and whānau.
[iii] Services included specialist or secondary, community based and kaupapa Māori mental health and/or addiction services
[iv] () symbol replaces whānau member names or other personal identifiers
[v] Pukenga Atawhai refers to kaimahi who work within specialist services
[vi] Whānau may seek referral support to specialist services, from their GP or practice nurse