TE WHARE WĀNANGA O
AWANUIĀRANGI

A REVIEW OF FAMILY WHĀNAU INCLUSION IN MENTAL HEALTH AND ADDICTIONS

HORI AHOMIRO
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Te Whare Wānanga o Awanuiārangi, Whakatāne

By HORI AHOMIRO

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Henare Hori Ahomiro

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Ngawari now lives on in all our hearts and memories including the faces and traits of her two children, Te Rehutaimoana and Te Mahi. The year 2016 was memorable for two significant reasons, the latter and the other resulted in a momentous celebration of our revered Rangataua Sports and Cultural Club of Tauranga Moana, claiming our first ever BOPRFU Baywide Premier Championship.

I want to also acknowledge my supervisor Professor Paul Kayes, for his constant support and persistent encouragement, rugby banter and critique of my and other fellow students work over the last few years.

` Ngā mihi nui ki a koutou katoa e te whānau.

RANGATAUA
RSCC
TAURANGA
Est. 1907

ABSTRACT

This research will explore the notion of family/whānau inclusion and participation in a Mental Health and Addiction Service setting in Aotearoa, New Zealand. It will involve a process of examination, investigation, analysis, theories, language, data collection and literature. More importantly this research will identify and examine the importance of family/whānau inclusion. Question what changes need to occur from a systemic perspective. Then consider a more integrated and collaborative model of care utilising Mātauranga and kaupapa Māori theories and interventions as methods to support transformative change within a mainstream system and provide support to improve better outcomes for consumers, tangata whaiora and all family/whānau.

Family/whānau are the building blocks of any society and they provide information, support, love and comfort to those they love amidst overseeing that the basic human rights, freedoms and ‘voice’ is actively heard from the far corridors of home. But with the knowledge and ability also to source help from organisational staff, families, friends and agencies to investigate, interpret and challenge any inequity or a lack of consultation during the care and treatment process of their loved one’s journey of recovery and personal wellness.

Tōku Pepeha

Ko Rangiuru tōku Maunga
Ko Kaituna tōku Awa
Ko Ngāti Moko tōku Hapū
Ko Mokotangatakōtahi te Tangata
Ko Tapuika, Ngāti Awa me Ngai Tūhoe ōku Iwi
Ko Te Arawa me Mataatua ōku Waka.

Whilst growing up as a child in our small Māori communal village of Waitangi, just three kilometres east of Te Puke, in the Tapuika rohe, of Te Arawa. I and many other cousins of my age were fortunate enough to experience and be exposed to Te Reo Māori me ōna tikanga, including various karakia and rituals which supported whatever gathering or function we attended at that time and place. These ranged from whānau or manuhiri arriving on our doorstep and inviting us to community gatherings such as huritau, hura kōhatu, hākinakina, church services and tangihanga.

Whatever the occasion, as children we were unconsciously learning and being subjected to whānaungatanga, Kōtahitanga, Te Reo me ōna Tikanga and more importantly Mātauranga Māori in its natural form. Inadvertently knowledge was being transmitted to us without us even being aware of its importance in learning or relevance of it and its application at that point in time.

It was a natural occurrence and protocols were discussed and practiced daily by our Mātua and Tīpuna, associated to tikanga of course where the all-important aspects of tapu (restrictions) and noa (unrestricted) knowledge which formed the basis, of the right and wrong ways of doing things Māori. Subsequently our koroua and kuia were the holders and transmitters of this realm of knowledge which included pakiwaitara, waiata, karanga, mōteatea, oriori, whaikōrero and whakapapa.

The learning process for us as young children took many forms and included both practical type exercises as mentioned above and much more, eventually with an aim to equip us with a certain expected knowledge base to use later in life in our respective whānau. This form of education of Māori children may therefore be expressed within a philosophy that seeks to prepare the child for all aspects of living and to ensure that each child will have the opportunity and expectation to take an active, participatory role within Māori society.

Teaching and learning were not a "bits and pieces" process but was an "integrated developmental type of philosophy" (Pere, 1986:2), which always sought to acknowledge and validate the `absolute uniqueness' of the child and their position in their whanau, hapū and iwi (ibid). As people became more competent the form of pedagogy would change, with one means by which knowledge was transmitted being through the varied forms of Whare Wānanga and in the informal everyday teachings of life (Kaa, 1987).

Our elders' views and beliefs of not adhering to or following tikanga and kawa for certain kaupapa would not only be detrimental to the person but more so to their whānau, hapū and iwi, therefore these practices were always enforced by our elders in a subtle, but ceremonial manner which was underpinned by facets of tapu.

Later in life all this information became sort after and precious, as academics wanted to write about and understand how and why Māori acted and behaved in a certain manner. Consequently, questions were then posed as to, were these linked to and a form of resistance by Māori, due to the impact and effects of colonisation and hegemonic practices? Today Māori continue to reclaim our identity, mana and rangatiratanga and hold onto our precious taonga tuku iho including our language, whakapapa, customs, whenua, awa and moana to the best of our ability.

A number of authors indicate that the early education of Maori children was couched within the structure of `whānaungatanga' (relationships and connections between whānau) (Te Rangi Hiroa 1949, Makareti 1986, Hohepa 1990, Ka'ai 1990, Pere 1991, Royal-Tangaere, 1992). Members of the whānau were selected as kaitiaki (guardians) of some forms of knowledge. For the child, the earliest "personal instruction" was received from their Tīpuna (grandparents), this was made possible due to the whānau living arrangements (Te Rangi Hiroa, 1949).

Māori continue to transform ourselves by seeking higher education, critiquing and questioning issues that we believe are unjust and potentially negative to us as a people, environment and culture. Simultaneously positioning we strategically amidst the political, economic, social and educational structures of mainstream society, to challenge and regain some semblance of equity to eventually emancipate ourselves from the arms of subdued colonisation and hegemony within society.

Mātauranga Māori is a body of knowledge that seeks to explain phenomena by drawing on concepts handed from one generation of Māori to another. Accordingly, Mātauranga Māori has no beginning and is without end. It is constantly being enhanced and refined. Each passing generation of Māori make their own contributions to Mātauranga Māori. The theory or collection of theories, with associated values and practices, has accumulated mai i Te Ao Māori from the Māori beginnings and will continue to accumulate provided the whakapapa of Mātauranga Māori is unbroken. (Winiata as cited in Mead, 2003).

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CHAPTER ONE

INTRODUCTION

1.0 Chapter Introduction

The intention of this dissertation is to examine and explore how inherent and inclusive or not family/whānau participation, inclusion and experiences are in a Mental Health and Addiction Service setting within Aotearoa, New Zealand. This research defines the words family and whānau from a European and traditional Māori context and contrast experiences, issues and interpretations from a non-Māori and Māori or indigenous perspective and worldview. Simultaneously analysing what an integrated model of care may look like and what barriers may be encountered during this research and explore a framework for consideration that underpins my overall research.

We must also acknowledge the differential space for unity, power-sharing, discrimination, racism and prejudice which are still prominent in institutions, care and treatment facilities, practices and modern society in Aotearoa New Zealand today.

Family/Whānau would have a more equitable say in the care and treatment of their loved one’s care and would benefit more from an integrated and collaborative approach, instead of experiencing the continuous ‘fight for space’ critique and cultural discourse in recognition of a Kaupapa Māori or indigenous intervention being considered alongside a typical biomedical approach and paradigm which currently exists today.

Kaupapa Māori may also be viewed as a proactive ‘driver’ for change, transformative action and decolonisation of the more dominant western biomedical model of care.

Māori academics argue that research is very much concerned with power and politics (Bishop, 1996; Te Ariki, Spoonley & Tomoana, 1992) and seeks to maintain an uneven societal 'playing field' where there can only be one winning 'team'. It acts to perpetuate certain 'playing conditions' that heavily favours one side so that the 'match' remains unfair, making the result a foregone conclusion.

1.1 Background to the Study

From a Māori and family/whānau perspective in Aotearoa New Zealand, there is an expectation that a culturally appropriate 'space' and 'system" will be provided to uphold aspects of cultural safety, awareness and Māori worldviews or ways of knowing. Consequently, providing for a more meaningful and respectful experience and a collaborative approach to care and treatment. As opposed to that of an existing 'western biomedical model' of care that remains dominant and impenetrable in ideology and current practice.

Whānau 'voices and personal experiences good and bad will be at the centre of this research, but more importantly how can the service staff and clinicians better respond, empower and be more inclusive and understanding of the consumer and whānau needs which are interrelated on all levels of one's care and treatment.

By incorporating the use of Kaupapa Māori cultural practices, principles and indigenous worldviews to be part of an integrated model of care, this can only support better care and treatment for all concerned.

This research is for all family/whānau 'voices' to be heard, respected and valued for the purpose of acknowledging their whakapono (faith), tūmanako (hope) me te aroha (love) for their loved ones amidst the struggle, hurt and pain that family/whānau have and continue to endure during their loved one’s recovery to wellness. Subsequently for the service, clinicians and all advisors, a major task is to inform, educate, and support consumers and families to build resilience and ensure that the experience is positive and beneficial to them whilst providing appropriate care to the consumer or tangata whaiora in their own recovery process, whatever that may look like for them.

Family/Whānau need and consistently report feedback that they must be constantly informed and involved in the initial and continual care planning of a loved one’s care, from service admission to discharge to implementation and review of the mental health act and status of their loved one’s care. From such actions, the service can only benefit, learn and value the feedback and experiences to feed forward for future learning and service improvement opportunities.

Consequently, a more meaningful and collaborative process may be implemented with an aim to improve a whole of system approach for excellence in care and treatment. A consideration must then be made to address an organisation and systemic wide approach to support appropriate and future policies, procedures and meaningful objectives that acknowledge and are beneficial for all whānau of tangata Whaiora and all service users.

1.2 Research Aim

The overall aim of this research is to explore the meaning of family/whānau from a Kaupapa Māori and health context, and to identify and suggest an integrated model of care and space for transformative action. The transformative elements of this research will aim to provide a more competent bicultural workforce who can perform with confidence and the knowledge that they have attained a certain level of cultural competency from a Kaupapa Māori or indigenous perspective and model of practice with pride, commitment and personal growth and development through further education, informed 'cultural efficacy' and competent practice.

1.3 Research Questions

To achieve the aim as described above, the research seeks to first pose and answer the following questions.

- How important is family/whānau inclusion in the care and treatment planning process?
- Does our current model of care need to be reviewed and be more inclusive of Mātauranga and Kaupapa Māori interventions?
- What is an integrated model of care?

1.4 Significance

What is significant for me is locating myself within this research and first acknowledging both my Māori and Scottish ancestry including both whakapapa and genealogical links that form me as a person and deploy certain characteristics, therefore. This research is from an insider and lived family/whānau perspective of mental health and addictions services with an outsider opportunity to critique and suggest a more inclusive and bicultural approach of practice. With an ability to perform, create and respond more collaboratively to all Tangata Whaiora and their family/whānau needs in a mental health and addictions service or setting.

The involvement of family/whānau social networks and those who are important in the life of the Tangata whaiora presenting with difficulties is core in early interventions. When intervening early, it is much more likely that the Tangata Whaiora will be functioning at a level where they are still engaged with families and friends.

This research explores and analyses a series of discussions and interviews, whilst listening and recording stories from a selective and cross-sectional number of participants of family/whānau members and undoubtedly consumers or Tangata whaiora themselves. Who have either been part of or experienced the journey of their loved one's care and treatment from admission to discharge in a mental health and addictions service?

1.5 Inside Researcher

As mentioned earlier my positioning within this research is as an insider employee Family/Whānau Advisor, Registered Social Worker and outsider researcher of a mental health and addictions service with lived experience and engagement in and with services from a family/whānau perspective.

Therefore, I am supportive of the implementation of a more integrated and collaborative model of care, because of the high percentage of Māori Tangata whaiora or service users represented in the mental health and addiction services locally and nationwide. Who feel the 'system' is not meeting the needs of Māori and are overrepresented in national mental health statistics in comparison to other ethnic groups and the public?

Consequently, this has led to a national inquiry of our mental health services and delivery in 2018. Another factor is that such services would benefit by having a more bicultural approach to engaging with Māori and other ethnicities to improve cultural efficacy, support services and improve new policies and procedures that better reflect the affected target group in a more meaningful and collaborative manner. Family/whānau ‘voices and personal experiences good and bad will be at the centre of this research, but more importantly how can the service and clinicians better respond, empower and be more inclusive and understanding of whānau needs and expectations during the whole recovery, care and treatment process.

1.6 Overview of Dissertation

Chapter one, introduces my research topic and provides some back ground to the intention of this research topic will be to examine and explore how inherent and inclusive or not of family/whānau participation and experiences in a Mental Health and Addiction Service settings within Aotearoa, New Zealand.

Chapter two starts with an overview of Māori mental health in New Zealand. The literature review examines what models of care there are for Tangata Whaiora (persons in pursuit of his/her wellness) within a Māori health context. It then examines and critiques the major themes from the literature relevant to ‘transformative action, kaupapa Māori mental health services and indigenous examples of care within a mental health context.

Chapter three, describes and justifies the research methodology, research design and the data collection methods. The methods used will be based around Kaupapa Māori theory. The process for data analysis is clearly explained and participant selection process is described. The chapter also addresses validity and reliability, and any ethical issues relevant to the research.

Chapter four is where I present information gathered from the study and suggests areas for further research interviews and provide a summary of each of the participant’s thoughts and opinions. This contextualises the findings and connects the reader to the participants and their experiences.

Chapter five discusses the findings and links the earlier literature to the experiences highlighted by the participants.

Chapter six outlines the limitations for the study and suggests pathways forward. This is the concluding chapter which draws the threads together.

1.7 Chapter Summary

The previous chapter has given the reader a quick insight into where this study will be planning to take the reader. The following chapter reviews the literature on Kaupapa Māori in a health context and transformative models of practice. The literature has provided the background for the research and informed the development of the research questions.

CHAPTER TWO

LITERATURE REVIEW

2.0 Chapter Introduction

The aim of this section is to explore the meaning of family and whānau in a Mental Health context, then to identify and consider a more inclusive integrated model of care that can support ‘bicultural competency’ that can only add to and benefit better care and treatment for all service users, Tangata whaiora and family/whānau moving forward. Bicultural competency is not just about Māori and culture or linked solely to ethnicity and cultural efficacy but seeks one’s ability to understand themselves within a Māori context and applying this to their chosen work or discipline within Aotearoa, New Zealand. To have a better understanding of Māori mental health this literature review examines what models of care there are for Tangata whaiora, transformative action, Kaupapa Māori mental health services and indigenous examples of care within a mental health context.

Research suggests that Māori make fewer visits to mental health services despite their higher needs (Baxter et al., 2006a). Low utilisation rates have been proposed to stem from a combination of two things: reduced access to services and a lack of services that are appropriate for and effective in treating Māori patients. This indicates the possibility that mental health services currently fail to provide treatment that is relevant to or effective for Māori (Baxter, Kingi, Tapsell, & Durie, 2006b).

2.1 Family

In New Zealand and society in general there are a myriad of definitions of family which encompasses parents, siblings, uncles, aunts, cousins, friends, neighbours or any other relationship the consumer or Tangata Whaiora chooses as and defines for them as family. Members of family with biological links are also linked through shared experiences, emotional, spiritual and economic bonds. The complexities of defining family should be recognised and acknowledged by everyone involved in providing care or services.

However, a narrow definition of family does apply when legal issues or consent and confidentiality are under consideration pertaining to legislative requirements under relevant acts such as the New Zealand Mental Health Act 1992. The strength of the family lies in its social role, which is to provide wellbeing for its members, nurture and protect children, provide care for family who need it and provide material and emotional support and to pass on culture, knowledge, values and attitudes from one generation to the next. (J. Fitzgerald, K. Galyer, 2007).

2.2 Whānau

Whānau traditionally means to give birth or to bring forward (Williams 1988. p.487), but it also refers to a group of individuals connected by a common ancestor (Buck, 1970, p.333). Whānau links the human element to Papatūānuku (earth mother) and sets in place the stewardship qualities that exist between the whenua and the people. “People come out of the land and therefore are the living representatives of the land” (Ruwhiu, 1994, p.106). Traditionally, whānau included a very comprehensive extension of family.

Not only did it extend to include siblings, aunts, uncles, cousins, first and second, but it also included Mātua and cousins of the same or other generations. Traditionally, as a whānau expands over the generations, it acquires the status of hapū (subtribe) which includes the emergence of a leader. He or she is selected through their mana derived from their founding ancestors, their whakapapa; skill in diplomacy and the ability to strengthen the identity of the hapū by political marriages and fighting prowess.

The hapū was once the main political unit that controlled a defined stretch of tribal territory, as well as undertaking the major tasks necessary for the group's survival. When a hapū got too large it would split off under the leadership of a teina (younger sibling), who would then establish a separate whānau and eventually hapū (Walker, 1990).

"Both whānau and tino rangatiratanga (sovereignty) are inextricably tied to the notion of whakapapa and whenua. It becomes a crucial part of Māori development because it is an interpretation of the living universe and highlights the whanaungatanga (relationships) where the human element, although powerful is symbolically portrayed as a child, grandchild (tamariki, mokopuna), like an entity in relation to its founding parents, grandparents (mātua, kaumātua) the natural and esoteric dimensions" (Ruwhiu, 1994, p.2).

Whakapapa is to lay one thing upon another, to lie one generation upon another that is genealogical charts and family trees. "Through whakapapa all kin ship ties are linked and cemented" (Barlow, 1991, p.173)

Whānau will in fact be faced with a range of contingencies (e.g., income, housing, composition of members, support networks etc.) that will be particular to their situation and which will inevitably impact on their potential to provide a healthy environment.

In terms of mental health services, family/whānau participation is likely to be particularly useful at the assessment phase and when determining cultural assessment. Input into other levels of treatment may also be beneficial. This will need to be determined on a case-by-case basis and balanced against all other relevant factors such as client or whānau preference.

It is suggested that regardless of individual perspectives, the whānau are likely to have an important role to play in the overall health outcome of the client and should be considered when designing or reviewing models or aspects of health that reflect outcomes for Māori. Factors such as, living conditions, economic status and access to support networks have the potential to either hinder or assist treatment.

In summary, an outcomes measurement tool for Māori will need to incorporate the perspectives of family/whānau to:

(a) Ensure consistency with Māori concepts of health,

(b) Account for some of the factors which impact on the outcome of the client, outside formal treatment processes; and

(c) Balance the sometimes-conflicting views of client and clinician.

However, from a Māori and Indigenous perspective, it would be beneficial to have consistent representation or leadership on such organisations, boards or committees to give cultural efficacy and an indigenous worldview to enhance and support the best possible outcomes for Māori and others utilising the method already established as Kaupapa Māori theory in practice.

As Graham Smith (1997) has articulated, Kaupapa Māori initiatives develop intervention and transformation at the level of both ‘institution’ and ‘mode’. The mode can be understood in terms of the pedagogy, the curriculum and evaluation.

The institutional level is the physical component; economics; power; ideology and constructed notions of democracy. Kaupapa Māori challenges the political context of unequal power relations and associated structural impediments.

The arrival of the European and their western culture affected traditional Māori communities who moved from their rural tribal communal living to individual urban living and unstable work conditions. With little or no education Māori fitted into poor low socio-economic groups with little hope of employment opportunities. They could not afford the necessities of what society deemed a good healthy lifestyle and iwi structures. For those whānau who were able to adapt to western culture and worked hard to make ends meet, found they were classed as too rich for government assistance and yet too poor to be able to afford even health insurance.

Imperialism and colonisation were a way in which the European colonisers proclaimed intellectual dominance over the many indigenous peoples they came into contact with. According to Smith (1999) Imperialism is the system of control which secured the markets and capital investment.

2.3 Mental Health Family/Whānau Advisor Role

Family/Whānau Advisors as paid employees represent the perspectives and needs of family/whānau of consumers receiving services. They provide input into the development and delivery of services and advise on issues affecting family/whānau. Some of the tasks in the role description vary from District Health Board service to service but are as follows:

- Ensure the family/whānau perspective is represented within a mental health service at all levels.
- Promote an understanding of the need to involve family/whānau in the assessment, treatment and discharge of their loved one's care regardless of age or gender.
- Attend meetings at a clinical and management level, consult on planning, policies and documents that concern family/whānau.
- Gather information and feedback from family/whānau of present and past service consumers and ensure that this feedback is used for service improvement purposes.
- Provide information to family/whānau through education sessions and resources on their respective service and issues relating to a loved one's care.
- Promote family/whānau working in partnership with clinicians.
- Liaise and network with other advisors in other mental health services and attend national annual general meetings.
- Take part in staff orientation and promote the family/whānau information packs and perspective to clinicians and staff through in-service education sessions.
- Undertake projects including audits and promote family/whānau led initiatives within mental health services.
- Promote the development of voluntary advisory positions within mental health services where appropriate and support these.

2.4 An Integrated Model of Care

The case for an integrated model of care is reinforced by the need to develop whole systems working to address the demands arising from an ageing population and increases in the number of people with multiple long-term conditions either physical or mental. Developing integrated care means overcoming barriers to the experience of service users and their families, seen when organisations and services work together, make a compelling case for care to be coordinated around the needs of people and populations.

Developing integrated care means overcoming barriers between primary and secondary care, physical and mental health and social care to provide the right care at the right time at the right place. This requires a commitment to whole systems working involving not only health and social care but also other services that influence the health and well-being of communities.

The answers will of course depend on the context of public service solutions or approaches that will work everywhere and there is no ‘best way’ of integrating care and to acknowledge that changes to national policies and to the regulatory and financial frameworks are needed for local leadership to fully realise a vision for integration. (Fitzgerald, J. & Galyer, K., 2007).

Consumer engagement and family/whānau participation is more than just a set of activities. It involves a cultural shift in organisations to welcome partnerships with consumers at all levels from the waiting room to the board room (Coulter, 2012). At the direct care level this means working towards shared decision-making.

At the service planning level, it means ensuring the results of patient experience surveys directly influence quality improvement initiatives, and that consumers are represented in expert advisory groups. At the policy and governance level it means skilled, well networked consumer councils working in parity with clinical governance and reporting to boards.

It is important to recognise that consumer engagement is not just the responsibility of the consumer participation coordinator, the family/whānau participation coordinator, the front-line clinician. It is also a core governance responsibility. The attitudes of Boards to consumer engagement and person-centred care are an important driver of change. A recent study in Victoria, Australia, shows that positively engaged boards with clear plans of activities to promote consumer engagement are critical to success in their organisations, and positive patient experience feedback (Bismark et al, 2014).

The aim of this literature review is to identify the wider socio-cultural and organisational contexts in which consumer and family participation is based and draws a coherent and integrated picture linking the integration of healthcare and patient and family centred care with consumer and family participation.

The Treaty of Waitangi, New Zealand’s founding document defines the relationship between Māori and Crown in health care provision identifying 3 essential principles.

- Participation at all levels
- Partnership in service delivery
- Protection and improvement of Māori health status.

It will be argued that consumer and family/whānau participation, patient safety, cultural safety and a healthy and safe workplace for health care providers are related and inextricably linked concepts that have at their base, remarkably similar key values, such as the Treaty of Waitangi principles, along with best practice organisational process and “ways of being’ in the relationships between health care providers, other providers and consumers of healthcare services.

‘High activity, positive attitude… Boards discussed a range of benefits that flowed from consumer engagement and patient-centred care including mitigating risks, improving patient outcomes, and increasing responsiveness of services to patient needs.’
(Bismark et al, 2014, p.147).

2.5 The Bay of Plenty District Health Board

The Bay of Plenty District Health Board’s vision is that by 2020 Bay of Plenty health services will be centred on the needs of people, their families and whānau. People will be able to easily access services when required and healthcare workers will be able to seamlessly transfer care between settings when needed. People will be empowered to manage their own health and to share in decision making (BOP DHB, 2013).

Turning this vision into reality in Bay of Plenty District Health Board clinical services is being implemented through projects aimed to bring about a greater integration of healthcare and this involves a closer collaboration and partnership in health care delivery between health care providers and patients and families.

2.6 What is integrated healthcare?

There is no single, accepted definition of integrated healthcare (et al 2013). However, most definitions include references to seamlessness, co-ordination, patient centeredness, and whole-of-system working together. The approach to integrated healthcare is encompassed in seven themes depicted in Figure 1.

Figure One: BOP Integrated Healthcare Strategy 2020 themes[1]

Figure 1.

Health and disability services are delivered by a complex network of organisations and people. Integrated healthcare is seen as essential to transform the way that care is provided for people with long term chronic health conditions. It will enable people with complex

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[1] https://www.bopdhb.govt.nz/media/57307/cphac-dsac-agenda-open-040614.pdf

psychiatric, medical and psycho-social needs to live healthy, fulfilling, independent lives (Goodwin et al, 2012). People living with multiple health and social care needs often experience highly fragmented services which are complex to navigate, leading to less-than-optimal experiences of care and outcomes.

The challenge of integrated healthcare that is patient and family centred is twofold:

- Transforming service structure and process to enable safe and seamless transition between providers, and.
- Transforming the relationship and roles between patients and their family and the services that they utilize.

2.7 Integration through Patient and Family Centred Care

Patient and Family Centred Care (PFCC) redefine relationships in health care. It places an emphasis on collaborating with patients and families of all ages, at all levels of care, and in all health care settings. Further, it acknowledges that families, however they are defined, are essential to patients' health and well-being and are crucial allies for quality and safety within the health care system.

The Healthcare Excellence through Patient and Family Centred Care project aims to identify best practices and bring about system changes that enable the Bay of Plenty Health Board's (BOPDHB) clinical services, which includes Mental Health & Addiction Services, to become and remain patient and family centred by bringing the perspectives of patients and families directly into the planning, delivery and evaluation of health care and by building on our existing Health Excellence framework to improve quality and patient safety.

2.8 What is patient and family centred care

The following excerpt from the paper, Partnering with Patients and Families (2006), explains the concept of patient and family centred care:

“Patient- and family-centred care redefines relationships in health care. It places an emphasis on collaborating with patients and families of all ages, at all levels of care, and in all health care settings. Further, it acknowledges that families, however they are defined, are essential to patients’ health and well-being and are crucial allies for quality and safety within the health care system.”

The Institute for Family Centred Care defines Patient and family centred care as an approach to planning, delivery and evaluation of healthcare that is grounded in mutually beneficial partnerships among patients, families and healthcare providers (Conway 2006).

There are several definitions of patient and family centred care and although they all vary slightly, there is a high consensus of agreement regarding the key attributes and the definitions offered by the Picker Institute, the Institute for Patient- and Family-Centred Care, and Plane tree share common elements (Balik et al, 2011).

2.9 Patient and Family Centred Care Concepts

The Bay of Plenty District health Board has adopted the mission statement; Patient and family centred care is the participatory involvement of patients and families in care planning, delivery and decision making

The core elements of patient and family centred care identified most frequently in the documents reviewed are:

- Dignity and Respect. Health care practitioners listen to and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.

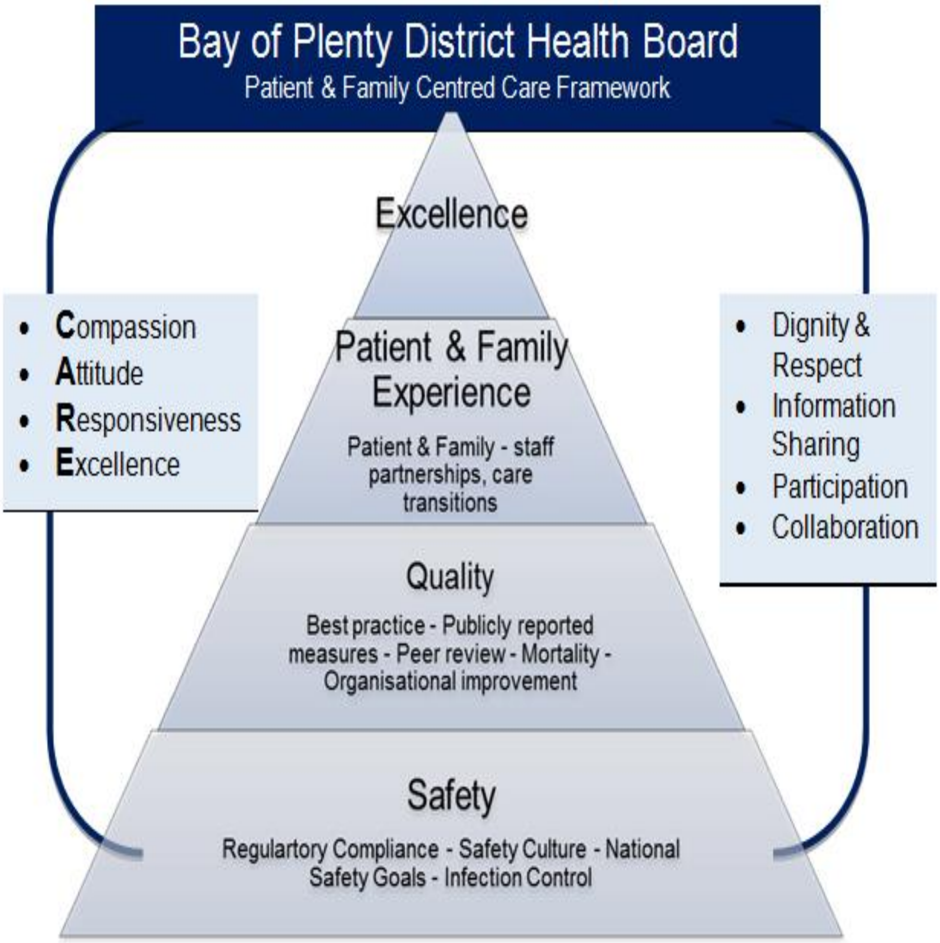
- Information Sharing. Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful.

Patients and families receive timely, complete, and accurate information to effectively participate in care and decision-making.

- Participation. Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

- Collaboration. Patients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

[2]Figure Two: Patient and Family Centred Care Framework



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[2] https://www.bopdhb.govt.nz/media/57307/cphac-dsac-agenda-open-040614.pdf

2.10 Drivers for patient and family centred care

Consumer engagement in health care is a global movement. A world health summit in 2013 focused on the critical role consumer engagement will play in shaping future health services.

‘The solutions to the health challenges of today and tomorrow won’t come from doing business as usual; they will come from building effective partnerships and harnessing the untapped global power of ordinary people who care about improving their health. There are powerful benefits from partnering with patients, families, communities, and healthcare workers at all levels.’
(World Innovation Summit for Health, 2013)

Consumer engagement is an essential component of quality and safety in health service design and delivery. Engaging consumers and providing patient-centred care has huge benefits in treatment outcomes, prognosis, morbidity and cost savings for organisations.

Consumers are increasingly demanding opportunities to be actively engaged, not only in their own health care through shared decision-making, but also in service design and policy formation to collaboratively develop programmes for sustainable improved health outcomes, and in governance to influence strategic direction of health care. Public value is more than “value for money” returned for the taxes that people pay.

Consumers expect to be able to trust those delivering the service, the service itself and the way they are included in the process and decision making (ASCQH, 2011). The New Zealand Code of Health and Disability Services Consumer Rights extends to any person or organisation providing, or holding themselves out as providing, a health service to the public or to a section of the public, whether that service is paid for or not (www.hdc.org) and the need for improved efficiency in service delivery is also driving the engagement of consumers and their families. Recent research indicates that a patient centred approach can make health service delivery more efficient (Charmel & Frampton, 2008).

Consumers bring unique and valuable perspectives from outside the health system ‘looking in’. The health system is there for all of us as consumers; however, the consumer’s experience and viewpoint can be lost in place of efficiency. Systems naturally focus on what is being measured. If time and efficiency and clinical outcomes are being measured, that is what clinicians will naturally focus on as targets. Engaging consumers helps ensure that person-centred care is valued.

Beyond seeking out a comfortable, satisfying healthcare experience, foremost on the minds of consumers is their safety and the safety of their loved ones. The public is increasingly concerned about medical errors and other adverse events. Failure to meet consumer expectations for clinical quality has serious implications outside of harm to the reputation of a hospital.

There are clear differences between the processes that empower individuals to contribute to improving the quality and safety of health care and the processes that allow the public to hold the health system to account. Involving the patients in making decisions about their own care and not treating them merely as passive recipients of health care is the basic building block for consumer engagement (ACSQHC, 2011).

Leadership, at the level of Service Executive and Governance, a demonstrated commitment to focus the culture of the organisation on patient and family care and be engaged to unify and sustain the organisation in a common strategic vision that is clearly and constantly communicated to every member of the organisation.

2.11 Involvement of patients and families

At multiple levels, not only in the care process but as full participants and/or advisors in key committees throughout the organisation. Care for the caregivers through a supportive work environment that engages employees in all aspects of process design and treats them with the same dignity and respect that they are expected to show patients and families.

Systematic measurement and feedback continuously monitor the impact of interventions and change strategies. Methods that engage patients and families directly in the process of care by facilitating information access and improved communication with their caregivers. Quality of the built environment that provides a supportive and nurturing physical space and design for patients, families and employees alike.

2.12 Cultural safety and consumer family participation

The New Zealand Health Strategy (2000) is based on seven underlying principles that the Government sees as fundamental. Two principles with a particular focus on Consumer engagement are:

- Acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi. This principle recognises that the Treaty of Waitangi is New Zealand’s founding document, and the Government is committed to fulfilling its obligations as a Treaty partner.

- To date, the relationship between Maori and the Crown in the health and disability sector has been based on three key

> principles: Participation at all levels, partnership in service delivery and protection and improvement of Maori health status. Not only is it important to improve Maori health status, but other goals based on concepts of equity, partnership, and economic and cultural security must also be achieved.

Active involvement of consumers and communities at all levels.
This principle identifies the need to have consumers and communities involved in decisions that affect them. This process should also ensure services at all levels of the health sector fully reflect the needs of individuals and communities.

2.13 Involvement of patients and families

For care to be patient centred, it must involve the patient and for patients to be truly involved, so must their families who provide vital support and information throughout the care process. Family has many meanings and includes not only bonds created by marriage and common ancestry, but also bonds created by close friendships, commitments, shared households, shared child rearing responsibilities and romantic attachments and the most important “family member” must be determined by the patient.

According to Bev Johnson (2008) president of the Institute for Patient and Family Centred Care, patients and families should be involved in multiple levels of care, consistent with the Institute of Medicine’s recommendations in the Crossing the Quality Chasm report.

- The first level is at the point of care delivery, where patients and families can contribute to the process of gathering information about perceptions of care and assist in analysing and responding to treatment strategies.

- The second level is at the clinical micro system, where patients and family advisors should participate as full members of quality improvement and redesign teams, participating from the beginning in planning, implementing and evaluating change.

- The third level is within the organisation leadership, where the perspectives and voices of patients and families are vital to quality improvement, planning and policy and development. Patients and families should participate on key committees such as patient safety, facility design, quality improvement, patient/family education, ethics and research.

One example of patient and family involvement at this level would be the patient and family advisory council. Such a council creates an opportunity for patients and families who represent the consumers served by the organisation to become members of a permanent group that meets regularly with senior leaders. While they do not function as boards, patient and family advisory councils can play a vital role in problem-solving, since they often identify opportunities or solutions that professional managers may overlook.

- Finally, at the fourth level, the perspectives of patients and families are critical in the development of local and national policies affecting the finance and delivery of care, such as accreditation and certification bodies and education needs (Shaller, 2007).

Consumers can be engaged as individuals, or collectively, with increasing power to influence quality and safety, from being given choices to having a real voice in partnership and giving feedback about their direct care experiences.

Consumer engagement varies from person to person. Not all consumers will want to be always involved. For a person being told a new and frightening diagnosis, being informed about different treatment options, and actively involving the family may be enough. The person may be happy to be offered an opportunity for feedback about their care. Some people may want to get more involved in improving the experience of care for others through being a representative involved in service delivery strategy and design. Some people, with motivation and skill, may want to extend their representation of other consumers in governance.

Features of organisations engaging well with consumers
Providers who are well engaged with consumers take the following actions (HQSC 2015).

2.14 Organisational preparedness and readiness

Leadership facilitating consumer engagement from the Boardroom to the waiting room.

Identifying staff champions at all levels of the organisation to lead the shift in values required for consumer engagement.

Resourcing and supporting all staff to make the cultural shift to value consumer engagement, through training in values and understanding the benefits of consumer engagement and its crucial role in building staff satisfaction and retention.

Making a culture or values shift in the organisation –when the values of the organisation are person-centred, then consumer engagement is valued.

2.15 Policy and governance

Senior leaders in your organisation champion consumer engagement.

Developing a vision of consumer engagement for the whole organisation.

Consumer representation at senior leadership level.

Establish a consumer council alongside clinical governance.

Use patient stories in every board meeting.

Bring senior leaders to ward rounds and make opportunities to talk to patients about their experiences.

2.16 Integrated care principles

Involving consumers or Tangata Whaiora and families in their own care planning.

Ensuring good mechanisms are created to support communication between hospital and community services and avoiding duplication and repetition.

Supporting the use of shared electronic records wherever possible and permitted by the consumer.

Bedside handovers become the norm.

Consumer and family centred discharge planning, listening to their values, preferences and goals of care.

2.17 Service design and evaluation

- Co-design of services- working in partnership with consumers.
- Quality improvement initiatives all involving consumers.
- Mapping patient journeys through an episode of care from GP through to hospital admission, stay and discharge.
- Patient experience survey data and other consumer feedback being used in real-time feedback to health clinicians and consumers, such as through quality boards in hospitals, on DHB websites, and visible to staff and consumers.
- Publicise ‘you said, we did’, showing how feedback from consumers is influencing change.

2.18 Cultural competency

Uphold the three key principles in health that align with the Treaty of Waitangi and Whānau Ora, and are also at the heart of consumer engagement:

- participation at all levels
- partnership in service delivery
- Protection and improvement of Māori health status.
- Collaborate closely with whānau, hapū and iwi, to create the best mix of services for each local community
- Education to ensure that clinicians respect the diversity of different communities, and understand and respect that their own culture may have an impact on the relationship
- Respect differences and ask questions to clarify what is important to the consumer
- Connect Māori consumer representative is together and supporting professional development.

2.19 Engaged staff

Support and encourage staff to review the culture and values of the organisation – this is re-invigorating and connects them with the core meaning of their work, which can otherwise get lost in the stressful demands of a busy workplace.

Provide values training involving consumers, such as ‘in your shoes, in our shoes’ – this will help to ensuring organisational values and structure reflect being patient-centred.

Promote the skills required to actively partner with consumers and elicit feedback – consider investing in staff training in skills such as active listening, giving room and respect for consumers’ concerns and opinions, and checking back for understanding (such as the ‘teach-back’ method).

In 1996 Te Pūmanawa Hauora developed a framework that aimed to conceptualise whānaungatanga. The Whakapiripiri Whānau Framework although specifically targeting whakapapa-based definitions of whānau, also examines concepts that may be applied to wider/contemporary definitions. The key characteristics of the framework are described in Table One.

TABLE ONE: Whakapiripiri Whānau Framework [3]

Principles and Health Implications of Whānau PRINCIPLES	HEALTH IMPLICATIONS
Tātau Tātau (collective responsibility)	• Healthy Development. • Access to informal health support. • Reduction in levels of stress. • Access to resources to promote a healthy lifestyle. • Safe environment.
Mana Tiaki (guardianship)	• Health Development. • Improved mental well-being. • Access to resources to promote a healthy lifestyle. • Enhanced quality of life. • Enhanced spiritual well-being.
Manaakitanga (caring)	• Enhanced quality of life. • Healthy Lifestyles. • Healthy policy development. • Healthy practices. • Models for health promotion.
Whakamana (enablement)	• Healthy development. • Improved mental health. • Access to health services. • Access to resources to promote good health. • Health promotion.
Whakatakoto Tūtoro (planning)	• Opportunities for early intervention. • Healthy policy development. • Access to resources to promote good health. • Improved access to health services. • Planning for health needs.

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[3] Source: Te Pūmanawa Hauora, 1996: 32

Whai Wāhitanga (participation)	• Improved access to health services. • Healthy lifestyles. • Health promotion. • Access to resources to promote good health. • Informal health support.

Although the above table gives some indication as to the capacity of the whānau to promote good health and well-being, it needs to be recognised however that not all whānau will be able to function in a positive way. Further, their ability to effectively promote a healthy environment will not always be the same.

In terms of mental health services, whānau participation is likely to be particularly useful at the assessment phase and when determining cultural assessment. Input into other levels of treatment may also be beneficial. This will need to be determined on a case-by-case basis and balanced against all other relevant factors such as client or whānau preference.

Whānau will in fact be faced with a range of contingencies (e.g., income, housing, composition of members, support networks etc.) that will be particular to their situation and which will inevitably impact on their potential to provide a healthy environment.

2.20 Health Outcomes and Whānau

Maori concepts of health and the role of whānau were discussed. It is suggested that regardless of individual perspectives, the whānau are likely to have an important role to play in the overall health outcome of the client and should be considered when designing models of health that are appropriate for Māori.

Factors such as, living conditions, economic status and access to support network have the potential to either hinder or assist treatment. Some environmental factors may never be accurately accounted for or able to be fully considered. However, as Table 4 illustrates, many aspects of client social interactions will be known to whānau. Te Pūmanawa Hauora (1995), op cit.

In summary, an outcomes measurement tool for Māori will need to incorporate the perspectives of whānau to:
(a) Ensure consistency with Māori concepts of health,
(b) Account for some of the factors which impact on the outcome of the client, outside formal treatment processes; and
(c) Balance the sometimes-conflicting views of client and clinician.

2.21 Current situation and progress

In the New Zealand context, the Ministry of Health and the Health Quality and Safety Commission expect DHBs to improve the consumer experience through increased consumer involvement in decision-making.10

Health & Disability Service Standards: NZS 8134: 2008 articulate and define the standards of consumer and family participation for Mental Health & Addiction Services.

Standard 2.5:
Consumers are involved in the planning implementation and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

Standard 2.6:
Whānau of choice are involved in the planning implementation and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

There are some effective and innovative initiatives supporting consumer engagement in our primary and secondary health services. Roles such as consumer advisors and consumer engagement managers and facilitators have been resourced in Mental Health & Addiction Services for sometimes are starting to be resourced in general hospital services as well.

Although New Zealand district health boards attain compliance with the standard in a variety of ways, the standard and its specific provisions mean that common elements most often implemented are:

- The MH&AS organizational chart and policy structure includes identification of and terms of reference for consumer and whānau participation.
- Employing a consumer and a whānau advisor (a person with lived or family member experience of mental illness and/or addiction issues; and/or
- Contracting with consumer and/or family advocacy groups including MOUs to provide contracted consumer and a family/whanau advice - as per the standards above.
- Consumer and whānau advisor(s) positions are structurally built into the MH&AS governance and management system.
- Consumer and whānau advisor(s) are consulted and involved in annual plans, projects, new service initiatives, service reviews, audits, protocols, serious incident reviews.
- Policies and practice support involving consumers and families in their own care planning and family centred discharge planning.

- Formal processes covering complaints, requests for information and change of clinician are in place for consumers and whānau.
- Health information Privacy, consent and information sharing policies and practices are well established.
- Work force development and training is provided to staff to make the cultural shift to value consumer engagement, through training in values and understanding the benefits of consumer engagement.

2.22 The New Zealand Mental Health Survey

"Te Rau Hinengaro: The New Zealand Mental Health Survey" (Oakley Browne, Wells & Scott, 2006) was the most frequently referenced data source used by works published in the last 10 years and thus it can be inferencing that authors found this to be the most relevant epidemiological reference. The published results of the survey contained a full chapter on Māori mental health statistics, written by Baxter et al. (2006b).

Prior to Te Rau Hinengaro, health data lacked information regarding Māori in a community setting, as most research was conducted on hospitalised patients. This survey reflected lifetime, 12-month and 1-month prevalence of mental disorders including anxiety, mood and substance abuse disorders, as well as service utilisation and satisfaction of care.

2.23 The New Zealand Ministry of Health

The Ministry of Health defines Kaupapa Māori mental health and addiction services as, services that have been specifically developed and delivered by providers who identify as Māori. Providers of those services may be within a District Health Board Provider, a community, or iwi organisation, and may be accountable to local, whānau, Hapū, iwi, Māori communities and the District Health Board (Ministry of Health, 2009, p2).

2.24 Models of Health Care

There are a considerable number of models proposed by the literature. The most frequently mentioned was Durie's (1994) model "Te Whare Tapa Whā". This model compares wellness to the four walls of a house, the significance here being that all four components are necessary for total functioning. These components are taha tinana (physical health), taha wairua (spiritual health), taha hinengaro (thoughts and feelings/mental health) and taha whānau (family health and wellbeing).

A second model that was regularly referenced was Pere's (1991) model "Te Wheke", which uses an analogy of an octopus to represent total wellness. In Pere's model, the body and head represent the individual or whānau, with each of the eight tentacles representing Māori concepts that are required for wellbeing and the suckers on the tentacles representing the many unique facets to each dimension (Ihimaera, 2004).

The eight main principles of Te Wheke are wairuatanga (spirituality), mauri, mana ake (individualism/uniqueness), tinana (the physical self), whānaungatanga (working together), whatumanawa (emotional development), hinengaro (the mind) and hā a koro mā a kui mā (heritage).

Themes expressed by both Te Whare Tapa Wha and Te Wheke and other less common models of Māori health such as Ngā Pou Mana o IO, include the concept of holistic wellbeing and an understanding of the impact of spirituality and collective identity are important facets of health when engaging with or assessing Māori.

The value placed on these concepts by Māori is proposed to be larger than the value given to them by Pākehā (Durie, 1994; Ihimaera, 2004), leading to a dissonance between Māori expectations of illness treatment and actual clinical practice - something that may be impacting on health outcomes.

2.25 Kaupapa Māori Mental Health Services

According to The Ministry of Health (2009) Kaupapa Māori mental health service providers will use Māori frameworks and models of care that encompass a holistic approach to health. Underpinned by the concepts of mana, tapu, and mauri, common elements of Māori models include:

- Taha tinana
- Taha whānau
- Taha hinengaro
- Taha wairua
- Turangawaewae
- Te Reo Māori
- Tikanga Māori

2.26 Transformative Action

Health disparities continue to exist between Māori and others in Aotearoa, despite increased resourcing of the health sector. This suggests that the promoted evidence-based practices and financial resources on their own are not sufficient to improve the health and wellbeing of Māori (Pipi, Cassidy & Huriwai, 2014).

2.27 Indigenous examples of health care

In the United States, the mental health of minority populations is due to barriers in organisational structure, diagnostic tools, cultural congruity and financing (Snowden & Cheung, 1990).

Minority populations (such as Māori) are often over-represented in the most financially disadvantaged sections of society, which prevents the utilisation of health services based on cost. If cost barriers are overcome, further issues appear to arise once minority populations find themselves in the health system. Some sources argue that symptoms reflecting poor mental health are underreported due to a mismatch between professional understanding of mental illness and the understanding held by indigenous groups, otherwise known as a lack of cultural congruity (Cheung, 1987).

2.28 Family/Whānau involvement with Tangata Whaiora

“People with serious mental illness are not ill in isolation. Their
families, extended whānau, and significant others, whatever they
think about the illness, cannot escape being affected by it”
Health and Disability Sector Standards
(Mental Health Commission, 1998, p.9).

In New Zealand in 2004 Bridgman and Tollestrup (2004) interviewed a small number of people who used Supporting Families support groups. Participants raised several issues that they experienced when working with mental health services.

The most common issues raised were:

- A lack of respect and difficulty in obtaining information about their loved one.
- Poor communication by services to the family/whānau.
- Problems with diagnosis, medications or treatments.
- The family/whānau voice and perspective was being ignored

Benefits of family/whānau Inclusion include.

- Use family/whānau as allies rather than burdens i.e., ‘many hands make light work’ responsibility and risk can then be shared.

- Family/Whānau can provide information that is undisclosed, specific, strengths and developmental history. They can also identify client daily functions eg. Sleep and eating patterns, activities, interests, work relationships, moods and personal skills.

- Family/Whānau understand their own social constructs, values, behaviours, beliefs through the lens of their culture, personal history, training and bias. Do not have tunnel vision.

- Family/Whānau provides resources such as love, security, housing, food, transportation, whānau, fun, activities and relationships. Clinicians are only visible for a brief period the family is there for the long haul in a variety of contexts.

- Family/Whānau provide valuable links for clients to the outside world and can support medication compliance, changes both positive and negative and respond according to care or treatment plans.

Partnership between the consumer/Tangata Whaiora, Family/Whānau and mental health staff are likely to produce the best and most efficient results in recovery and is supported by available research. (World Schizophrenia, 1998)

2. 29 Ngā Pou Mana o Io- A Traditional Framework

Te Whānau o Irākewa: Māori Health Services Framework

This model was developed pre-colonisation and its foundation links back to the spiritual and traditional belief system of Tangata whenua before the arrival of the Church Missionary Society in 1814.

The four sacred pillars of the traditional Māori world focus on a time when Tangata whenua (Māori) had complete tino rangatiratanga over their tribal estates, forests, fisheries, land resources and traditional spiritual beliefs.

Most of the models of care that are implemented today are focussed more on the clinical aspects of wellbeing, many of which can be attributed to the effects of colonisation and include, but are not limited to; abuse (sexual, mental, physical, emotional, drug and alcohol, raupatu, (forced alienation of Māori from their lands) and through the assimilation of Tangata whenua into another culture's spiritual values, beliefs, and practices.

The 'Nga Pou Mana o Io' model focuses on a holistic methodology for the achievement of Hauora (wellness), with the philosophy of whakatau ki (proverb) as its moral stance and guide. Within Māori society, whakatau ki are used at many levels to raise the social and moral perspective on issues raised within the community. Whakatau ki were and are used at an individual and organizational level to guide, teach, and build and maintain working relationships within the whole.

"As with most oral cultures, whakataukī fulfilled an important function in traditional Māori communities. They also served as a generalised code for establishing standards in ethical and moral behaviour. This was particularly so in traditional Māori community's, where many whakatau ki emerged widespread application and became an integral part of a moral code” (Moon, 1997).

There is little doubt that today, and within the ‘Ngā Pou Mana o Io’ philosophy, whakatau ki continue to fulfil an important function in Māori Society and indeed in establishing standards in health care. The validity of whakatau ki is not, however restricted to Māori people or Māori contexts only, but exists also in contexts of clinical application and cross-cultural achievement of common goals. In all cases, translated whakatau ki reveal common sense and even critical thinking transportable between cultures and appreciated by all. It is not difficult at all to find whakatau ki with powerful messages highly relevant in health environments and therefore usable in the transition of urihaumate (patients) from unwellness to wellness.

The whakatau ki (proverbs) presented in the following section are examples of the practicality required when in a state of ‘haumate’ (unwellness) but also provide an indication of the importance of the spiritual dimension during this time, an aspect certainly not exclusive to Māori culture, and with at least equal importance in the recovery process, despite the unfamiliarity to non-Māori of the practices and language used.

Mana Tangata: Patient Access

Kī mai koe ki ahau, “He aha te mea nui i tēnei ao?”
Māku e kī atu “he tangata, he tangata, he tangata”

The admission process is an integral part of the care plan for Urihaumate accessing our services. Te Pou Kokiri provides support by way of:

- Meet and greet.
- Introduction to clinical staff.
- Advocacy for urihaumate.
- Walking urihaumate and whānau, hapū and Iwi through the admission process.
- Ensuring the maintenance of te reo Māori me ōna tikanga when requested.

Mana Whenua: Patients Environment

‘Hoki ki tō Maunga kia pūrea koe e ngāhau o Tāwhirimātea”

When accessing our services, it is important that the patient’s physical environment is consistent to his or her cultural values. This is ensured by:

- Orientation around the unit/ward.
- Ensuring wellness in the ward.
- Culturally safe and friendly environment.
- Ensuring urihaumate have access to their turangawaewae recourses.
- Ensuring the maintenance of te reo Māori me ōna tikanga when requested.

Mana Tūpuna: Whānau Support

“Ka mate kaingatahi, ka ora kaingarua”

“It is in numbers that we are strong”

Whānau support is a key element to successful recovery of urihaumate when accessing Pou Kokiri services and is demonstrated by:

- Contacting whānau at request.
- Ensuring whānau support for urihaumate.
- Support for whānau members.
- Arranging the Rangimarie room (whānau accommodation).
- Effective communication between whānau and clinical staff.
- Ensuring the maintenance of te reo Māori me ōna tikanga when requested.

Mana Atua: Spiritual Support

“Ko te ahorangi ki mua, ko Te Ao tūroa ki muri”

“Gods worship first, worldly things later”

- Ensuring the maintenance of the spiritual values of urihaumate as an integral plan.
- Spiritual guidance is another key element that Pou Kokiri provide, when requested by the urihaumate or the whānau, hapū and iwi.

The Māori reality in the Ngā Pou Mana o Io Model acknowledges all spiritual beliefs and that this is one of the four key elements to ensure the successful holistic recovery and continued well-being of the urihaumate. Spiritual support is demonstrated by:

- Performing karakia on request.
- Spiritual guidance.
- Blessing of rooms and equipment.
- Ensuring the maintenance of te reo Māori me ōna tikanga when requested.

2.30 Te Whānau o Irākewa: Māori Health Services Framework

This model was developed pre-colonisation and its foundation links back to the spiritual and traditional belief system of tangata whenua before the arrival of the Church Missionary Society in 1814.

The four sacred pillars of the traditional Māori world focus on a time when tangata whenua (Māori) had complete tino rangatiratanga over their tribal estates, forests, fisheries, land resources and traditional spiritual beliefs.

Most of the models of care that are implemented today are focussed more on the clinical aspects of wellbeing, many of which can be attributed to the effects of colonisation and include, but are not limited to; abuse (sexual, mental, physical, emotional, drug and alcohol, raupatu, (forced alienation of Māori from their lands) and through the assimilation of tangata whenua into another culture’s spiritual values, beliefs and practices. The ‘Nga Pou Mana o Io’ model focuses on a holistic methodology for the achievement of hauora (wellness).

Mana Atua

Mana Atua refers to Māori cultural connections to the spiritual world. It is the recognition of the creator of all things – Io Matua Nui, known to other iwi and cultures by other names, and referring to many Atua (gods) who have authority over the various domains of the universe and the elements within. Mana Atua acknowledges the elements that are intrinsically linked to all that lives.

Mana Whenua

'Mana whenua' recognizes the time from one is conceived till the physical birth. The whenua ('placenta' and the Māori word for' land'), feeds and nourishes us whilst in te whare tangata (the womb). On entering the physical world, Papatūānuku (the Earth Mother) awaits offering her nurturing love. We survive in the whare tangata by means of the whenua (placenta) and once born, it is deposited into the whenua (earth, land) as the physical connection to the place of birth and cultural identity of where one comes from, the ancestral homelands of the ancestors.

Mana Tūpuna

'Mana Tūpuna' is an acknowledgement and recognition that we are the products of those who have gone before us. We are connected by blood and kinship ties. Our whakapapa (genealogy) ties us together and provides the backbone for everything we do for our children, mokopuna and for generations to come.

Mana Tangata

'Mana Tangata' is recognition of one's own authority, qualities and attributes. It is acknowledgement of another's expertise, with heed being taken as to ensuring one does not trample over the mana of another. It is also acknowledgement of the mana of a male and that of a female. This is our connection to our whānau, hapū, iwi and waka.

2.31 Standards of Practice

The following Standards of Practice provide the founding principles upon which the day-to-day delivery of Māori Health Services core business are established- Ngā Pou Mana o Io, and te reo me ōna tikanga.

Mana Atua: The Spiritual dimension

- Ensure that whānau, hapū, iwi have access to Te Ao o Ngā Atua – Mauriora.
- Ensure that content and delivery of services has spiritual relevance to whānau, hapū, iwi and Māori communities.
- Provide services that recognise the spiritual values, beliefs and practises of whānau, hapū, iwi, waka and Māori communities.
- Support services in recognising whānau, hapū, iwi, waka and Māori communities' spiritual aspirations.
- Ensure Māori traditional spiritual beliefs are incorporated into servicing cultural norms.
- Enable Māori to feel safe to express themselves spiritually within their own environment.
- Ensure staff recognises the importance of the role of the Tohunga, Kaumātua and or any spiritual leaders in te ao Māori.
- Ensure staff recognises that all Māori have a spiritual origin that contributes to their holistic wellness.

Mana Tūpuna: The ancestral connection to one's identity

- Ensure whānau, hapū iwi have access to te reo Māori and are supported with tikanga Māori issues.

- Ensure that content and delivery of services demonstrates the tangata whenua reality of whānau, hapū iwi and Māori communities.
- Ensure that whānau, hapū, and iwi have access to services, which acknowledge their cultural identity through their connection to their tūpuna.
- Ensure service has a cultural relevance to the whānau, hapū, iwi and Māori communities.
- Ensure that services recognise that each whānau, hapū, iwi and waka have their own unique identity.
- Contribute to staff's understanding of Māori and their ancestral links.
- Ensure that when staff engage whānau, hapū, iwi and Māori communities that it is acknowledged that they are the mokopuna of their ancestors.
- Facilitate an understanding that recognises cases of Māori disconnectedness from knowledge of their ancestry.
- Ensure staff promote, support and recognise the Mana tūpuna of Tangata whenua.

Mana Whenua: Recognition of one's connection to one's place of origin.

- Ensure whānau hapū iwi have access to natural resources.
- Ensure that content and delivery of services acknowledges whānau, hapū, iwi and Māori communities' rituals of encounter.
- Ensure that there are opportunities to engage with whānau hapū iwi and Māori communities in an environment that is conducive to their natural experience.
- Ensure that services reflect whānau hapū iwi and Māori communities' access to economic resources such as land, forests, waterways and fisheries.
- Assist with the understanding that whānau, hapū, iwi, waka and Māori communities are the kaitiaki of their whenua and tūrangawaewae.

Mana Tangata: The connection to one’s extended whānau

- Ensure that tangata whenua link to their whānau, hapū, iwi and waka structures.
- Ensure that content and delivery of services recognises tangata whenua aspirations.
- Ensure that the resources provided enable for the capacity of self-maintenance and continuity (Tino Rangatiratanga).
- Identify Community leadership to ensure effective delivery of programmes.
- Maintain close links with whānau, hapū, iwi to ensure tribal leaders are identified and acknowledged.
- Ensure effective communication between staff and whānau, hapū, iwi and Māori communities.
- Strengthen alliances between whānau, hapū, iwi and waka and Māori communities.
- Facilitate access to information to ensure good health leadership within whānau, hapū, iwi, and Māori communities.
- Attend training as required to ensure positive development of self and other staff and whānau, hapū, iwi, and Māori communities.
- Maintain a high standard of professional practice to ensure excellent role modelling.
- Participate in the forums of economic, educational, employment, decision making that reflects te ao tūroa (society).
- Recognising that every tangata whenua is a living descendant of his / her ancestors and that they have been born with qualities, skills and gifts through their ancestry and whānau, hapū, iwi and waka structures.

2.32 Chapter Summary

This chapter looked at the meaning of family/whānau in a Mental health context and then identified an integrated model of care that supports bicultural competency that can only add to and benefit better care and treatment for all service users, Tangata Whaiora and family/whanau moving forward.

The next chapter describes and justifies the research methodology, research design and the data collection methods. It outlines a mixed mode Māori centred research methodology based on Māori philosophical understanding of the research process that recognises appropriate principles and guidelines for conducting research into the lives of Tangata whaiora and their families. I present the research framework which comprises of a Kaupapa Māori (Māori philosophy and principles) epistemology and Mātauranga Māori (Māori knowledge) qualitative methodologies. The limitations of this framework are noted.

CHAPTER THREE

METHODS

3.0 Chapter Introduction

I will be using a mixed mode method approach to help describe and explain how each process categorically supports my research. The following methods have been used previously in one context or another and have consequently extracted the necessary information to inform and improve service delivery and support for Kaupapa Māori theory, groups and communities. A mixed mode approach adds value from a variety of contexts and perspectives and is appropriate and conducive to the overall research proposal and from a Kaupapa Māori context.

Therefore, the findings from my research will be disseminated back to my participants in the form of acknowledgements and recommendations for policy changes that cement a foundation for more meaningful participation and inclusion of family/whānau in a mental health and addictions service setting at a local and national level.

“...we need to acknowledge our participatory connectedness with the other research participants and promote a means of knowing in a way that denies distance and separation and promotes commitment and engagement” (Bishop, 1996, p. 23).

3.1 Qualitative Research

There are two types of methods of research which are normally the most used in the collection of data; these are identified as following: quantitative and qualitative methods (Ghauri et al., 1995). The quantitative methods consist in the systematic empirical studies which involve quantifying through the assistance of mathematics and statistics (Bryman and Bell, 2007). Data is collected and transformed into numbers which are empirically tested to see if a relationship can be found to be able to draw conclusions from the results gained.

In other words, quantitative methods are related to numerical interpretations. On the other hand, qualitative research does not rely on statistics or numbers. Qualitative methods often refer to case studies where the collection of information can be received from a few studying objects (Bryman and Bell, 2007). Furthermore, qualitative methods emphasize on understanding, interpretation, observations in natural settings and closeness to data with a sort of insider view (Ghauri et al., 1995). According to Bryman and Bell (2007) qualitative research is an appropriate approach for research in business and management administration. The type of research approach to select depends on the kind of studies that will be conducted.

However, Gunnarson (2002) argues that the benefit of applying a qualitative method in a research is that the method takes into consideration the overall picture in a way that the quantified method cannot. A qualitative approach will be more suitable to fulfil the purpose of this research, since this thesis is researching what factors are hampering firm growth, since perceptions, beliefs, ideas and opinions are difficult to measure in a quantitative way.

By thoroughly studying each firm, its internal behaviour and its external elements, using qualitative methods, it will be possible to understand perceptions and opinions regarding hampering factors of firm growth. However, quantitative methods are also used in this research to measure if the firms have been growing or not. Data are collected from each firm regarding their added value production and number of employees which are the two growth indicators chosen for this thesis. This data is collected by means of a questionnaire which is sent out to the companies and then returned to the authors through e-mail.

This research is for all family/whānau ‘voices’ to be heard, respected and valued for the purpose of acknowledging their whakapono (faith), tumanako (hope) me te aroha (love) for their loved ones amidst the struggle, hurt and pain the family/whānau have had to endure during the recovery process. Subsequently for the service, clinicians and advisors, a major task is to support, build resilience and ensure that the experience is positive and beneficial to the consumer or Tangata Whaiora and family/whānau in their own recovery.

Family/Whānau need to be informed and involved in any future planning, implementation and review of the mental health and addiction services. Once the service has learnt from these experiences and analysed feedback to feed forward for future learning and initiate the appropriate service improvements. A consideration must then be made to address an organisation partnership approach to set and support policy standards and procedures that reflect family/whānau wants and needs.

The transformative elements of this research will aim to have a more competent bicultural workforce who can perform with confidence and the knowledge that they have attained at a certain level of cultural competency from a Kaupapa Māori or indigenous perspective with pride, commitment and personal growth through education and awareness. Yet maintain their own professionalism, ethical and personal values, and beliefs without deconstructing their own to learn without prejudice or discrimination.

The main purpose of western research was to silence the voices of indigenous resistance by colonising the indigenous thought (Smith, 1999).

3.2 Data Collection

The collection of data will be ascertained by utilising collaborative Hui and interviews as a form of inquiry, listening and recording of stories, kōrero in both English and Te Reo Māori if applicable, about the journey and experiences of family/whānau and other participants from a physical and mental health perspective. There will also be dialogue between departments and different sections of the service from ward staff to clinical governance, community leaders and stakeholders.

Sources of information will include:

- Personal and community group interviews.
- Kaupapa Māori/indigenous models of care.
- A review of national and global integrated models of care.
- NZ Mental Health Commission, Family/Whānau policies.
- NZ Health and Disabilities Service Standards
- NZ National Health Statistics
- A review of patient and family centred care.
- BOPDHB Mental Health & Addictions & Family/Whānau policies
- Regional Māori Health Services input from a cultural perspective

3.3 Limitations

Some limitations that have been identified and need to be considered are:

- That the research process will be limited to the Bay of Plenty District Health Board which includes the Tauranga hospital site only.
- The number of family/whānau interviews will have to be negotiated and reliant on participant’s time and availability.
- To be aware of personal bias, subject knowledge and insider/outsider research dilemmas.
- Willingness of Regional Māori Health Services to participate fully in this research.
- Ethical considerations, reliability and validity of information need to be at the fore front of this research.
- Unwillingness of some subjects/participants to engage and be interviewed.

3.4 Collaborative Hui Approach

A collaborative hui approach will be used to communicate either in an individual or group context to extend any information for service improvement opportunities or to hear the ‘voice’ or ‘experiences’ of family/whānau. The interviewee/s will be asked if they would like to start the process with a prayer or karakia and the opportunity will extend to having the conversation in Te Reo Māori or in English with due respect and consideration given to the participants.

Hui is the Māori word for gathering or meeting. It involves meeting as a group (of any size, larger than focus groups) to discuss issues and has a set protocol that is used to guide the hui process. It is unstructured in its nature, although there is usually a ‘kaupapa’ or purpose for the hui that will guide the direction of the conversation. This method requires acute cultural awareness by the researcher as there are often culturally coded means of communicating that take place.

A Hui approach was conducted through a two-hour Hui with each of the family/whānau. Recording of Hui required the use of multiple methods including audio, written and verbal accounts.

Russell Bishop (1996) refers the Hui as providing a ‘spiral discourse’ (p.121) whereby a consensual collaboratively constructed story is paramount.

3.5 Ethical Considerations

Linda Smith (1999, pg.120) identifies seven behaviours that support a set of principles to provide a basis for accountability and ethical considerations for Tangata whenua research. These principles are not new to Tangata whenua and are used regularly to provide a safe space and direction for researchers.

These principles are: -

1. Aroha ki te tangata (respect for person/s).
2. Kanohi kitea Kanohi (face to face, present yourself as).
3. Titiro, Whakarongo, kōrero (look, listen, speak)

4. Manaaki ki te tangata (share and host, be generous).
5. Kia tūpato (be cautious).
6. Kaua e takahia te mana o te tangata (do not trample over the mana of people).
7. Kaua e māhaki (do not flaunt your knowledge).

3.6 Kaupapa Māori theory

Kaupapa Māori research seeks to address the issues of injustice, oppression, social justice and social change (Bishop, 1996; Pere 1994). Kaupapa Māori research is about challenging the 'ordinary' or notion of normal that has been constructed by the dominant culture, and seeks to identify and uphold Māori views, solutions and ways of knowing.

Kaupapa Māori may challenge and resist, but that is incidental to the primary focus which is to develop and advance as Māori using our own knowledge, values, and processes. Those of us who are involved in Kaupapa Māori do not do it because we are ‘rebels who have finally found a cause’, but because it is inherently right and normal for us to do so. Māori development and advancement are about practice and research that supports us as Māori to develop, not in relation to others, but to be where we want to be and to do what we want to do. It is about empowering Māori people, voice, processes and knowledge’. (Smith, 1999, pg.15).

3.7 Native theory

Russell is one author who appears to get around this paradox with her explanation of ‘Native Theory’. She defines Native Theory as “the right of indigenous people to make sense of their time and place in this world” (Russell, 2000, p.10). This may sound like stating the obvious because people have always had no difficulty in existing in their time and place, but it also infers that indigenous people do not need the West to acknowledge, research, record and affirm their knowledge for it to be valid and useful in research, in practice and in life. Neither do indigenous experiences need Western civilisation for them to exist or to define themselves.

Russell's approach agrees with the constructivist strand of Kaupapa Māori Theory where it operates without a need to reference itself to non-Māori and as such may seem more challenging to Western approaches but does not need to be. Native theory acknowledges that what many Māori seek is to move forward culturally as Māori in Māori contexts. Native Theory is a context that, for example, allows Māori research for Māori people using Māori processes and terms that may not yet be acceptable to the Western academy.

In comparison to Native Theory, the strength of a Critical Theory approach is that it identifies and challenges structural and systemic power differences and seeks to create social justice though re-distributive models. One of its weaknesses is that it is a modernist approach: where there is one answer to the problems we face, where if we can get everyone to be conscientized just like us then we can create social change and bring about a more equal society.

From a Native Theory perspective, Kaupapa Māori is about the right of Māori and iwi to make sense of their time and place in this world, to define them using their own reference points as to what is of value and what processes are important. It is about Māori constructing their own theory, explanations and outcomes.

However, the attacks on Kaupapa Māori as a theory and as a practice from outside our community continue, therefore we need to have a greater understanding and insight into what it is we are using to justify our processes and thus support the increasing desire to have Kaupapa Māori services and approaches that meet our needs in ways that are appropriate to us.

3.8 Chapter Summary

This chapter has argued about practice of Kaupapa Māori theories in the community, and our work, while using some of the useful elements of Critical Theory is more closely explained by a constructivist theoretical approach, particularly Native Theory. Critical Theory is attractive because it delivers, it emancipates and strengthens those involved in struggle, and it also provides a justification and channel for the frustrations over the marginalisation of Māori people and Māori knowledge. The answer may be to acknowledge that Kaupapa Māori has use of Critical Theory but is not necessarily defined by it.

The information and data collected for this research will be returned to the Tangata Whaiora and their families. I believe the design of my research process for participants has been met. The research framework presented within this chapter is culturally appropriate and is an effective way to maintain the integrity of information given.

CHAPTER FOUR

THE PARTICIPANTS

4.0 Chapter Introduction

At the core of this thesis are four families who have their stories experiences and learnings to convey to other family/whānau in similar or alternative circumstances. With the intention that they may have better awareness and information to best navigate the mental health system and processes. Three of these families are of Māori descent. Over a three-and-a-half-month period I spent about 4-6 hours talking with each of them about their experiences. This chapter gives details about each of the families and their journey to support their beloved family/Whānau member in this study which was unique and told from their worldview and respective lens and experiences.

Appendix E provides a platform and tool to better understand family/whānau expectations and experiences when engaging in mental health acute inpatient services. It also provides a level of learning for staff that endorses how important supporting family/whānau is in maintaining and improving overall service engagement and delivery.

Note that pseudonyms have been used for all family/whānau who participated in the study to ensure confidentiality.

4.1 Participant one: Te Rina K[4]

Te Rina is a daughter and whānau member of her mum who is a well-respected professional woman, who was admitted into service following a recent relationship break up with her husband and consequently diagnosed with depression, expressing delusional and

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[4] (Te Rina K., Personal Communication, June 16, 2018)

paranoid themes. Her daughter was initially acting as her support at the time of her unwellness and explained the following.

> *I initially took mum to our GP and we were very fortunate to get an appointment. The GP did a mental state examination, and an urgent referral was made to mental health services. Mum had been unwell for a few days prior, not eating, and not sleeping well at all. The day of her appointment and after a full comprehensive assessment was completed by a Doctor; she was admitted to the inpatient ward. One of the main questions was whether mum wanted any of her family/whānau involved in this consultation...she replied yes, my daughter by my side so that was enough for me and plus she did not really want any other whānau to know.*

What was also apparent for Te Rina was the presence of a cultural support worker which they engaged and made her, and mum feel comfortable in their meetings with Doctors during whānau hui or updates. They also participated in morning karakia and waiata on the ward. 'Which uplifted everyone's Wairua in the Hui'.

Te Rina sought professional help for her mum, who stayed in the inpatient ward for a week and was prescribed with antidepressants to help her depression. She did have her daughter and husband there alternately by her side as visits were regular, which led to her speedy recovery and ongoing antidepressant medication and community support for her.

4.2 Participant Two: Piripi M.[5]

Piripi is father to his son who recently suffered a drug induced psychosis after being on a drug and alcohol bender for five days straight. Son is a 19-year-old Māori male just returned to live with dad from overseas after six years and falling out with his mum over drug use and criminal activities. Piripi is getting to know his son's

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[5] (Piripi M., Personal Communication, June 30, 2018)

behaviours and symptoms as time and their relationship progresses.

While speaking with Piripi he shared that.

From his perspective one of the main factors of his son’s behaviours and eventual psychosis was the loss and grief he suffered as a child at the separation of his parents and not having a permanent male role model in his life. Therefore, Piripi felt whakamā or ashamed and wanted to make amends for his son, but admittedly said they were not off to a good start. His son had not been communicating that well since arriving home and had isolated himself from normal social gatherings. One of his cousins went to visit him and he was asleep in his bed and this cousin worked in mental health and said to him ‘you appear to be depressed…I think you should get some help or ask your father’. Since his son’s admission to the mental health inpatient ward, Piripi felt alone and isolated because the system and environment appeared ‘very clinical’. Consequently, he asked a nurse for support and she referred him to the ward Te Pou Kōkiri, cultural worker and Family/whānau Advisor for support. What transpired for Piripi were more insight, knowledge and information about mental health diagnosis and internal processes and ongoing support at whanau Hui from admission to discharge for his him and his son.

In this situation Piripi was in a foreign environment and unsure where to seek appropriate help or support whilst his son was receiving care and treatment in an inpatient facility. He too was ashamed and wanted to maintain his own privacy during the whole process but was ecstatic to have kaupapa Māori support in the service and clarify how things worked in acute mental health services.

4.3 Participant Three: Maria. U.[6]

Maria is mum to her daughter a 22-year-old single Māori mother of two tamariki. Her family rang the crisis team because she was talking about harming herself and speaking in tongues from the bible. The crisis team came out and assessed her, but because she was unwell and abusive, they had to get the police to come to restrain her. It was lucky that the crisis team explained the process to

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[6] (Maria. u., Personal Communication, July 14, 2018)

family/whānau, and they would have to take her to the inpatient ward and assess her in a safe space.

Marias’s daughter calmed down enough to be distracted and transported where she was assessed and given medication to sleep for the evening. Later she expressed the following.

Without the help of my family/whānau who have always been there when I get like this, I know I would not have my kids at all. They would be in Child, youth and families’ care. My whānau are my everything so when I do not take my regular medication that helps me with my well-being, I know I just lose the plot and I cannot afford to do that. When I feel myself feeling a little out of the ordinary, I quickly ring my mother to come over and help me so that my kids are always safe.

Family/whānau has an important role to play in the overall health outcome of any patient and they should be considered an ally when designing or reviewing models or aspects of health that reflect outcomes for all Tangata Whaiora and service users.

4.4 Participant Four: Sabastian. S[7]

Sabastian is a Manager of a Backpackers and provided important support to a 28-year-old male of English descent, when he became unwell while backpacking around New Zealand. He has a history of mental illness and had run out of medication but after a lengthy wait in Accident and Emergency he was able to see a doctor and was prescribed medication to help him. Sabastian shares his story.

He knew that he was unwell when he became increasingly frustrated while in the backpackers. He was agitated and knew he was in serious trouble of either hurting himself or others, so he requested my support out of the blue and I took him straight to the hospital for help. Fortunately, it was not too busy after a six hour wait in Accident and Emergency and the doctors were able to assess him and confirm his details. I will always be truly thankful for that. What was missing throughout his ordeal though was his immediate family whom he stated are always there supporting him through such issues. However later I did phone his sister to update them all and proudly

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[7] (Sabastian S., Personal Communication, July 21, 2018)

mentioned the awesome communication and help we received in A and E.

Sabastian was able to get medical help reasonable fast for his tenant, however it was unfortunate for him that he had no immediate family to help or support him in a foreign country apart from himself as Manager.

4.5 Chapter Summary

Throughout the interviews it was evident that the family/whānau were all quite pro-active in trying to get help with their illnesses. All participants shared their stories which were impressionable, and each displayed a sense of ownership around what was happening to each of them whilst conversing about their life experiences. It was a privilege to have listened to their stories and a quick insight into their lives.

Each of their stories were unique and has enriched this research.

The next chapter brings together the gathered information from the interviews and the key ideas from the literature review presented in Chapter three to answer the research questions from Chapter one.

CHAPTER FIVE

DISCUSS THE FINDINGS

5.0 Chapter Introduction

The previous chapter looked closely at the real stories of Family/Whānau. The study found that there were several barriers Family/Whānau faced in terms of general practice, processes and meeting their primary or secondary healthcare needs. Being able to acknowledge what was happening and being able to speak with someone about their needs and experiences helped to understand how to move forward in their own lives and navigate a mental health system better.

There were three main themes that surfaced during the interviews that the Family/Whānau elaborated on and saw as critical and pertinent in their lived experience. Each Family/Whānau signed a research consent form[8] which ensured that their information and comments were used appropriately and that they were represented accurately. During the interviews, the participants became emotional at times as they re-visited their past experiences and memories. The key themes that emerged from this chapter portray the way they surfaced in the interviews. The collective information recorded by audio was transcribed, collated and analysed. The dissection of information from all sources, were 'cross collated' and identified by their repetitive and recurrent themes, trends, patterns, connections and relationships.

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[8] Attached as Appendix A.

5.1 The interview themes

There were three main themes that appeared throughout the interviews, therefore, to show a connection and flow it was appropriate that I interweave the material and group it together rather than individually as a narrative approach inserting parallel sub-themes. This is valuable where there were comparing opinions and ideas of the same theme. The main themes are as follows:

5.2 Family/Whānau

All Family/Whānau participants bar one discussed the importance of family/whānau support in what they were going through. The degree of support available and used by each participant was varied and different in accordance with their aspirations, needs and culture.

5.3 Integrated healthcare

Two of the participants acknowledged that an integrated healthcare system is necessary in meeting Family/Whānau and Tangata Whenua needs and expressed more Māori cultural support workers was required to cater for Māori.

5.4 Patient and Family Centred care

Two participants shared their thoughts on Patient and family centred care being an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.

5.5 Colonisation

Three of the participants shared their thoughts around colonisation and the negative impact it has had historically and even today it continues to be perpetuated in our current healthcare system. Hence the need for a whole of system change incorporating Kaupapa and Mātauranga Māori bodies of knowledge.

5.6 Family/Whānau

When analysing the results of this research I found that Family Whānau support was a huge beneficial factor when Tangata Whaiora become unwell. This could include being by their side when they visited their local GP through to transportation, and emotionally supporting them through encouragement, listening and caring about their future wellbeing.

A related idea was that the participants felt responsible to their families. They saw themselves as part of a larger entity, and with this there were perceived responsibilities and duties to fulfil. The participants did not say that these responsibilities had been forced onto them: they saw these responsibilities as a way of contributing to their families.

Te Rina reflected on her mother’s case and commented that without the constant support for her mum, undoubtedly her wellbeing would have been compromised and recovery enduring, but it is amazing what love and compassion can achieve in adversity. Availing ourselves by her side through all life’s ups and downs has been huge for all of us. We are her constant family/whānau support both me my dad and siblings; I will do anything for my whānau in times of need.

Maria spoke positively about her immediate family saying that,
My children who are still very young, my cousins, brothers and sisters have all been such supportive people in our lives. Because my daughter had a psychotic episode, and I did not really know what was happening. I felt like I was in a dream but it just all felt so real. Luckily for me our town is small, so my family were able to come over

immediately and provide such support and ring the police and get help. I am so thankful they knew what they had to do.

Sabastian's situation was quite different where he had run out of medication while backpacking around New Zealand. He kindly recalls that day.

It was a nice warm summer's day, and I was in my bed waking up and just felt angry. I was angry because I had not brought enough medication to last me over my two-month backpacking holiday. Next thing I knew I was wanting to hurt myself and thinking bad thoughts. I picked up the phone to call my sister and she encouraged me to ask the manager that was on duty to get me to the hospital as soon as possible.

In support of this concept of whānau, Gibson (1999) when discussing Māori identity states, "Being Maori, for some, is not viewed as something external or separate from themselves. There is a responsibility to one's whānau which means that you do certain things for them" (p.66). The way the Tangata Whaiora involved their whānau in their experience showed the importance they had for their whānau and that the concept of whānau means everything to them.

5.7 Integrated healthcare

The primary focus of integrated health systems is to provide seamless care or coordinated care for patients and their families.

The theory is that it will lead to a higher quality of care as well as Better health outcomes for patients, by making sure patients transition appropriately through the healthcare system.

Te Rina as a whānau member spoke at length about the need of having an integrated healthcare system. She recounted, there really needs to be a lot of Māori kaupapa that needs to be in the admission and exit processes. The integration of karakia, mihimihi, whakatau and whānaungatanga would have been good.

Piripi also commented that, it felt white and ‘sterile’ as in no Māori kaupapa or face was to greet you when I first came into the mental health ward to support my son. Thank goodness I had some contact with the Maori cultural worker and Advisor throughout my sons stay it was culturally appropriate for me. We live in Aotearoa so you would think the easy thing like greetings in Te Reo Māori would be something the nurses and doctors would have said to me and others on arrival.

5.8 Patient and family centred care

Establishing a culture of patient and family centered care requires long term commitment and is a journey not a destination. The Excellence through Patient and Family Centered Care project will enable the Mental Health & Addiction Services to establish the resources, needs and priorities of their health consumers and begin the journey of implementation across their services. Overcoming a well-ingrained resistance to open disclosure and sharing power in all we do is a gradual process.

Patient and family centred care is not a “thing” that can be implemented within a short time but is about changing the mind set of healthcare providers and staff from the traditional medical centric model to an approach that focuses on providing compassionate, respectful care that is responsive to the needs, values, beliefs, and cultural backgrounds of patients and families through creating collaborative partnerships. Achieving this cultural transformation within the BOPDHB will take time and will require a system wide buy-in and commitment.

Piripi shared his thoughts again relating to patient and family centred care, “Following my son’s episode, while still in hospital, the nurses and doctors who worked with me became conscious of my whereabouts and needs and invited my whānau to attend Hui. While always talking to me directly, they shared their professional knowledge with my whānau as well”.

In sharp contrast Maria said, “The centre of conversations during my stay in hospital was about how my behaviour was. The doctor didn’t offer advice or guidance but more like instructions on what I and my family should be doing to help me get better”.

There are many potential barriers to individuals and whānau receiving optimal care. Barriers may or may not include the attitudes of healthcare providers and/or funders, the attitudes of individuals and/or whānau members, adherence to a biomedical paradigm, and expectations of those involved. There are other barriers that may exist which may include, the space available in consultation room for whānau members, the models of service delivery implemented, access to the healthcare services required, and the healthcare system itself. Planning is required to enable the management or removal of these barriers.

5.9 Colonisation

Colonisation is the extension of political and economic controls over an area by the state whose nationals have occupied the area and usually possesses organisational or technological superiority over the native population. It may consist simply in a migration of nationals to the territory, or it may be the formal assumption of control over the territory by military or civil representatives of the dominant power.

Colonialism is described as ‘The acquisition and colonisation by a nation of other territories and their peoples’. Colonies and Colonialism, territories, inhabited or not, acquired by conquest or settlement by a people or government previously alien to that territory; and, imposed foreign rule upon such territory.

Colonialism added a new burden on modern science: it was compelled to claim a monopoly in knowledge to retain its claimed superiority. This monopoly is based on the premise that all other forms of acquisition or accumulation of knowledge, all other epistemologies, are worthless, antiquated, magical, and must be eliminated. (Alvarez, 1991, p. 91)

As Linda Smith states, colonisation along with “the globalisation of knowledge and western culture constantly reaffirms the ‘west’ has done that with many indigenous knowledge’s, what is important about such a perspective is not the content of those knowledge’s but that they have been systematically oppressed. Prior to colonisation Māori did in fact have well-developed mechanisms for health protection and health promotion, and a comparatively advanced knowledge and understanding of how diseases were transmitted. Consequently, and despite the often-harsh environment, Māori were able to flourish within Aotearoa, and by 1800, the population had reached an estimated 150,000 (Te Kani, 2005).

Fast forward to the Mental health system today Māori first and foremost is no longer under threat of extinctions, but there are new emerging challenges. Smoking related conditions, obesity, cancer, asthma and the list goes on (Māori health foundations, 2003). According to Te Kani (2005) there is one problem which is of particular concern to Māori, and which accordingly is similarly problematic across most indigenous populations. This is mental health, or more correctly, mental ill-ness.

5.10 Chapter Summary

It was very insightful and humbling that all four participants shared their thoughts on the interview themes. The patient and family/whānau centred care model endorses the regulated requirements to which mental health professional practices must adhere in Aotearoa New Zealand, and the component behaviours are integral to many of these requirements.

CHAPTER SIX

CONCLUSION

6.0 Chapter Introduction

Studies show that results improve through coordinated effort and correspondence when patients and families are engaged and make informed decisions and participate in their own care. With the longing to enhance and change the patient care experience and provide quality healthcare, numerous healthcare organisations are executing marvellous activities utilizing techniques, for example, data gathering and performance enhancement or improvement tools.

Patients can converse with the specialist and make inquiries to become familiar with their health issues to make informed decisions regarding care. Discharge plans are also discussed as well as a care plan for when the patient is home.

Patient and family initiated rapid response teams encourage patients and their family to be actively involved by providing information upon admission and a mechanism for alerting the care team about a noticeable change in the patient's condition. Program brochures are available in public areas and signs are posted in patient rooms. Additionally, discharge phone calls are designed to alleviate the overwhelming feelings often associated with returning home after being discharged as they strive to schedule medication, doctors' appointments, and other changes into their daily routines. A discharge phone call can effectively bridge the gap between hospital and home (Saskatchewan Ministry of Health, 2011).

PFCC systems are intended to agree with the logic and centre ideas of PFCC and are proposed to make patients and their families individuals from the human services group and include them in the conveyance of consideration by enabling them to deal with their condition and involve them in the delivery of care by empowering them to manage their condition, actively participate in treatment, and collaborate with their providers.

6.1 Limitations of the study

The limitations of this study were that there were only four Tangata Whaiora that were interviewed. With a low number of participants, I was not able to delve deeper than what has been provided. It was important to understand that all the three of the four Tangata Whaiora live in one area of New Zealand and therefore location was another limitation. Another limitation of this study is that it involves only the experiences of Tangata Whaiora that I met. Further research could usefully include many other Tangata Whaiora who were from many other ethnicities and backgrounds.

I acknowledge that my own subjective biases were apparent in this study, especially in the earlier stages. The questions that were formulated at the beginning of this study had end results in mind and my need to find answers to my own disappointments. This was noted early in the process and my subjective interviewing strategies became less. After transcribing and listening to my first interview I became more aware of my own prejudices. I refined my questioning style after the first interview. The use of body language and tone of voice became indicators of my own narrow mindedness and the need to refrain from influencing the flow of information. I became more attentive to allowing the women to speak more and remain unbiased. Whilst it is not easy to take out all personal prejudices, striving to be neutral was a goal.

6.2 Future research

The experiences of the Tangata Whaiora in this study showed that there is still room to improve healthcare for Māori in the mental health sector. The comfort, support of family/whānau has proved to be invaluable for each of the Tangata Whaiora.

There is a need further studies to help increase our understanding of the internal processes of admission and exit within the mental health sector. There needs to be further research in the wairua (wellness) and mental health promotion, prevention and education of mental, acknowledgement of the role of Tohunga, kaumātua and rongoā Māori, minimise institutionalisation for Tangata Whaiora and their whānau and support mainstream enhancement in areas of priority (e.g., acute services).

6.3 Closing thoughts

Inequalities in wellbeing among Māori and non-Māori have been obvious for most of the colonial history of New Zealand. Although there have been improvements in the past 140 years, recent evidence demonstrates that the general gap in future between these gatherings is augmenting as opposed to narrowing. Clarifications for these distinctions include a complex blend of components related with financial and way of life attributes, lifestyle characteristics, discrimination, and access to health care.

Māori-driven and led programs proposed and intended to enhance health care services are adopting a 2-fold strategy approach that underpins both the improvement of Māori supplier administrations and the upgrade of standard administrations through arrangement of socially safe consideration. The main idea and influence behind the new initiatives portrayed here has been the proof of the poor status of the indigenous of New Zealand and their interest for enhanced wellbeing administrations.

Māori organisations including Māori mental health provider’s social are enterprises that have developed not in seclusion be that as it may, rather, inside a setting of full-scale level government arrangements that have been appeared to either advance or extraordinarily upset the wellbeing status of indigenous people groups.

The need to enhance the nature and quality of care provided by healthcare organisations keeps on being apparent all through the New Zealand healthcare system. Despite the usage of various across the country quality enhancement activities during recent hundreds of years to enhance the quality of care delivered, signs exist that propose extra measures are required.

The PFCC or Patient and family care approach, intended to enhance quality and safety performance by supporting the commitment of patients and family in healthcare while at the same time joining responsibility measures through transparency and empowering advancements in the workforce, has introduced itself as the most well-known inspiration of progress and change. Rebuilding the framework to join PFCC models throughout every healthcare organisation can enhance the quality of the whole entire system without increasing healthcare costs.

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GLOSSARY OF TERMS: NGA KUPU MĀORI – MĀORI WORDS AND PHRASES[9]

Aotearoa: North Island or now used to describe New Zealand
Hauora: health
Hapū: a cluster of families descended from a common ancestor
He rangahau Māori: Māori research
Hui: a gathering of people (meeting)
Hui-a-Iwi: a gathering (meeting) of a tribe
Iwi: tribes
Kai: food
Kaitiaki: guardian
Kaitiakitanga: guardianship/stewardship
Kanohi kitea: a face seen (to be physically present)
Kanohi ki te kanohi: face to face
Karakia: prayer
Karanga: ceremonial call for visitors onto a marae performed by female
Kaumātua: an elder
Kaupapa Māori: Māori philosophy, principles and practices
Kawa: marae protocol
Kāwanatanga: government
Kete: flax kit or basket
Kōrero: talk
Kuia: a female elder
Kōhanga reo: early childhood learning next
Kura: school
Mana: prestige, status
Mana whenua: The people of a place who have always held the occupation rights to that place.
Manaakitanga; to offer hospitality, to be courteous and respectful
Mātauranga Māori: Māori knowledge
Māori: a branch of the Polynesian people; pre-European settlers of New Zealand
Māoritanga: those values and symbols which have meaning for people who identify as Māori
Marae: a gathering place; the physical dimension of a group's identity, beliefs, mana, mauri, etc
Manuhiri: visitor/s
Mātauranga: knowledge
Mātauranga Māori: Māori knowledge base
Maunga: Mountain
Mauri: life force

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[9] Sourced by Moorfield, J. (2011) Te aka: Māori-English, English-Māori dictionary and index. Auckland: Pearson Longman

Moana: ocean/sea
Mokopuna: grandchild, grandchildren
Ngā uri whakaheke: succeeding generations of a family
Oriori: to chant a lullaby
Pā: Māori village
Pākehā: A New Zealander of European descent
Pakiwaira: story
Papakainga: the original area of settlement
Papatūānuku: Mother Earth
Pātere: chant
Pēpēha: tribal saying
Poroporoaki: farewell message
Pōwhiri/Pōhiri: ceremonial welcome
Puhi: virgin
Rangatira: chief/chieftainess
Ranginui: Sky Father
Ringawera: Caterers/cooks
Rūnanga: Tribal council
Taiaha: a long weapon of hard wood
Tamariki: children
Tane: god of the forests and birds
Tangata: Progenitor
Tangata Whaiora: persons in pursuit of his/her wellness
Tangata whenua: indigenous people of the land
Taurekareka: slaves
Taonga: property, anything highly prized
Te Āo Mārama: the world of light
Te reo Māori: Māori language
Tikanga: rule, plan, method
Tikanga Māori: Māori law
Tino Rangatiratanga: absolute authority/power/self-determination
Tūpuna: ancestors
Tūrangawaewae: the rights of a tribal group in land and the consequential rights of individual members of the group; the land so defined (lit. standing place for the feet)
Tohunga: skilled person
Waka: canoe
Waiata: song
Wairua: spirit
Whaikōrero: a formal speech
Whakapapa: genealogy
Whakatauaki: proverbial saying
Whaiora: a person seeking health
Whānaunga: relatives
Whānaungatanga: relationship; kinship ties

Appendix A: Consent form

TE WHARE WĀNANGA O
AWANUIĀRANGI
indigenous-university

School of Indigenous Graduate Studies
Rongo-o-Awa
Domain Rd
Whakatane

CONSENT FORM

A REVIEW OF FAMILY/WHĀNAU INCLUSION IN MENTAL HEALTH AND ADDICTIONS

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS

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

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

I agree to participate in this study under conditions set out in the Information Sheet but may withdraw my consent at any given time.

Signature: .... **Date:** ....

Full name – (Please Print): ....

Appendix B: Confidentiality agreement

TE WHARE WĀNANGA O
AWANUIĀRANGI
indigenous-university

CONFIDENTIALITY AGREEMENT

A REVIEW OF FAMILY/WHĀNAU INCLUSION IN MENTAL HEALTH AND ADDICTIONS

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS

I ....(Full Name – printed) agree to keep confidential all information concerning the project as outlined in the Information sheet/s.

Signature: .... **Date:** ....

Full name – printed: ....

Appendix C: Information Sheets

TE WHARE WĀNANGA O
AWANUIĀRANGI
indigenous-university

INFORMATION SHEETS

School of Indigenous Graduate Studies
Rongo-o-Awa
Domain Rd
Whakatane

A REVIEW OF FAMILY/WHĀNAU INCLUSION IN MENTAL HEALTH AND ADDICTIONS

Researchers Information

Ko Rangiuru tōku Maunga
Ko Kaituna tōku Awa
Ko Ngāti Moko tōku Hapū
Ko Mokotangatakōtahi te Tangata
Ko Tapuika, Ngāti Awa me Ngai Tūhoe ōku Iwi
Ko Te Arawa me Mataatua ōku Waka.

Hori Ahomiro, Bachelor of Social Work, Dip Adult Ed,
Student Researcher, Te Whare wānanga o Awanuiarangi 2019
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Supervisor
Professor Paul Kayes
Waea/Telephone (07) 307-1467
Waea Whakaahua/Facsimile (07) 307-1475

Thesis Title:

A REVIEW OF FAMILY/WHĀNAU INCLUSION IN MENTAL HEALTH AND ADDICTIONS

The thesis is a requirement for the completion of the Masters of Māori Studies at Te Whare Wānanga o Awanuiārangi.

Participant Recruitment

The research population will be four family/whānau participants that supported their loved whānau member in our services.

Data collection

This thesis will involve oral history research and 'hui' process for all the interviews. The data collection will be around genealogy, land ownership, influences, education experiences, and personal stories.

Confidentiality

Confidentiality of the information provided by the participants will be acknowledged. I am able to ensure anonymity of the information provided by the participants if they so wish, knowing that it must be treated with reverence. Preference will also be given to the participants who prefer to have their names on the document.

Semi structure interviews

An interview schedule with a set of questions is Appendix D. The questions will not necessarily be put in any structured or orderly way, because of the nature of the subject, but will allows for a more natural flow of information.

Reliability and validity

Research participant will receive a draft copy of the collated research submission prior to its submission to Te Whare Wānanga of Awanuiarangi. The research will be certified by kuia, kaumātua and whānau and vouch for its reliability and validity. Support and supervision have been indicated by family/whānau, the Maungatapu Marae committee, cooperatively with a supervisor from Te Whare Wānanga o Awanuiārangi.

Data analysis

The collective information recorded by audio and will be transcribed, collated and indexed and stored for analysing. The dissection of information from all sources, will be 'cross' collated and identified by their repetitive and recurrent themes, trends, patterns, connections and relationships. All information even if it is conflictual, is valid and should be accepted as such.

Thesis Procedures

The data obtained will be analysed in order to help the student researcher build up a picture of knowledge that will assist in the writing up of the chosen topic. All data received will be held in a locked filing cabinet when not in use. As recommended by the Te Whare Wānanga o Awanuiārangi Ethics Research Committee once the thesis is completed the data will be held in secure storage for five years and then it will be disposed of by the Faculty of Post Graduate Studies and Research.

Participants who wish to access a Summary Sheet of the data collected will have space on the interview sheet where they can indicate this requirement.

This Summary Sheet will then be posted out to the interested participants on completion of the thesis.

Participants Rights

The initial Consent Form protects your rights, and the completion of the interview implies consent. You have the right to decline to participate or to answer any particular question during the interview process. You also have the right to withdraw from the study at any time and ask any questions about the study at any time during participation. Participants who wish to access a Summary Sheet of the data collected will have space on the interview sheet where they can indicate this requirement. It must be acknowledged that as a participant your name will not be used unless you give permission to the researcher. This Summary Sheet will then be given out to the interested participants on completion of the thesis.

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

Support processes and project contacts

If you are unhappy about any of this research thesis or if you have any questions, you are welcome to contact the student researcher, or the supervisor as named on the first page of the information sheets.

Ethics Research Committee Approval Statement

This project has been reviewed and approved by Te Whare Wānanga o Awanuiārangi Ethics Research Committee, ERCA # eg. 09/001. If you have any concerns about the conduct of this research, please contact the Chairperson of the Ethics Research Committee.....etc.

Contact Details for Ethics Research Committee:
The Secretary
Ethics Research Committee
Te Whare Wānanga o Awanuiārangi
Ethics@wananga.ac.nz
Postal address:
Private Bag 1006
Whakatane
Courier address:
Cnr of Domain Rd and Francis St
Whakatane

Appendix D: Interview guide

Leading questions: Tell us about your experiences in a Mental Health Inpatient Unit, Te Whare Maiangiangi?

1. Did you seek help when you loved one became unwell? Where did you go to get help first?
2. Tell us about how your whānau member was admitted? What happened? What was it like? (Admission processes and support)
3. How did you get to the inpatient ward? Did someone drive you there? Where were you before you were admitted? (Seeking information on geographical challenges/GP/Home)
4. How many times have you been admitted to the ward?
5. How long were you in the ward? (Length of stay)
6. Were you ever in the seclusion unit? What was that like? (Seclusion rates)
7. Did you ever have to be restrained? What was that like? (Restraint practices)
8. Tell us about your experiences while in the ward. What really helped you get better? (Staff, respect, kaumātua, Māori health provider support, flexible visiting, medication, ongoing therapy, visiting hours etc).
9. What did not go so well while you were in the ward. What might need improvement? (Staff, lack of respect, cultural interventions, being listened too etc).
10. Did you have any physical health problems that also impacted on your overall well-being?
11. Tell us about your experiences around the discharge process?

Appendix E: Family/Whānau Inpatient Self Audit Tool

Staff Member: ……………………………………………

Service: ……………………………………………

Date: ……………………………………………

Signed:
(Clinical Coordinator/Team Leader) ……………………………………………

Competency		NHI #			Total
1.	Evidence that family/whānau provided with an information pack and code of rights given and discussed				
2.	Evidence that the family/whanau advisor has been contacted or available to support family/whānau				
3.	Evidence that referral purpose and any immediate concerns are discussed with the family/whānau				
4.	Family/whānau involvement in the risk assessment/ treatment plan are documented				
5.	Documentation is evident regarding family/whānau involvement in planning, goal setting and possible discharge				
6.	Evidence that family/whānau provided with a copy of the plan, initial assessment correspondence to the referrer and GP. Follow up or any ongoing case management				
7.	Evidence that treatment plan is developed collaboratively including family/whānau, filed appropriately, includes a diagnosis or provisional diagnosis and signed by the case manager/team leader or responsible clinician.				

Comments: (ie. level of competence, areas for improvement, etc.),

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……………………………………………………………………………