ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
TULOU – OUR PACIFIC VOICES: TATALA E PULONGA

Under	The Inquiries Act 2013
In the matter of	The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions
Royal Commission:	Judge Coral Shaw (Chair) Ali'imuamua Sandra Alofivae Mr Paul Gibson Dr Anaru Erueti Ms Julia Steenson
Counsel:	Mr Simon Mount QC, Ms Kerryn Beaton QC, Ms Tania Sharkey, Mr Semisi Pohiva, Ms Reina Va'ai, Ms Nicole Copeland, Ms Sonja Cooper, Ms Amanda Hill for the Royal Commission Ms Rachael Schmidt-McCleave, Ms Julia White and Ms Alana Ruakere for the Crown
Venue:	Fale o Samoa 141 Bader Drive Māngere AUCKLAND
Date:	26 July 2021

TRANSCRIPT OF PROCEEDINGS

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ANTONY ROBERT DALTON-WILSON

RACHAEL LEMALIE UMAGA

LEOTA DR LISI KALISI PETAIA

[10.02 am]

REVEREND HOPE: To explain Tokelauan protocol, in order to begin our ceremony we begin with one of our elders who will do a greeting in Tokelauan, then he will pass over to the clergy, which is myself. My name is Reverend Linda-Teleo Hope. I'm reluctant to say my name because really I should introduce our elders who represent all of us in Aotearoa New Zealand. So please thank you so much for your graciousness in allowing us this small acknowledgment.

MALE SPEAKER: [Greeting in Tokelauan]

REVEREND HOPE: I will ask you to be seated. As those of you who are Pacific are aware, it is very difficult for someone to stand with their back in this way, which is why I've chosen to come here. Probably not very popular with the camera crew, but preferably popular with my God. Let us pray. **[Prayer in Tokelauan]**

Our hymn is going to be -- we're just going to sing for this morning verse 1 and the chorus, the second verse we'll sing at the end of the day if you're privileged to remain with us. For this hymn which is also our ending, I would just ask us to stand, thank you.

[Tokelauan song]

CHAIR: Thank you Reverend and thank you to the Tokelauan community who have graced us with their presence today. That was a very beautiful hymn and I look forward to the end of the day when we will hear the last part of it, so thank you.

Welcome, nau mai haere mai ki a koutou katoa to everybody who is attending today, whether you are in person in the room here in this wonderful fale or if you're watching on the livestream, you are most welcome. Can I particularly welcome, apart from our Tokelauan community, the survivors who are in the room and the survivors who are watching. This hearing, in fact this whole Royal Commission is about you and we acknowledge the bravery of those survivors who are able to come and speak to us and to the nation. So I just want to acknowledge those people. Some of them I know are in the room and getting excited about giving their evidence already. So here we start the day.

The last thing I want to say is that you will notice that we are no longer four, we are now five Commissioners, and we're very happy to finally welcome Commissioner Paul Gibson. If you weren't here on the first day I explained that Paul was always going to be part of our hearing panel, but unfortunately in the week before, weekend before the hearing he fell and broke a bone in his foot and was unable to travel. He has now travelled, he's still on crutches, he's still got a moon boot, but I don't think he could bare to stay away for another moment longer. He's been watching on livestream, so welcome Paul. Did you want to say anything at all before we -- everybody else got a chance to.

COMMISSIONER GIBSON: Fa'afetai, thank you, Coral, for your words and thank you everybody for the contribution which has been brought so far. It's the been amazing to listen from a distance, both gruelling in terms of the content but inspiring in terms of the courage that people have brought forward. It's a learning experience for many of us. I think because of what has been shared by survivors, by experts, we will be able to make a difference and it is a privilege to sit here and to whakamana the Pacific community, the people of all the places, ethnicities around Moana Nui a Kiwa. Thank you, thank you for having me here.

CHAIR: Wonderful, so now we are whole. So I'm now going to invite Ms Copeland, our counsel who is going to be leading our first and very special witness, Antony Dalton.

MS COPELAND: Talofa lava, mālō e lelei, fakaalofa atu, good morning Commissioners. The first witness this morning is Antony Dalton-Wilson who is with us today. I invite him now, together with his family, to come up to the front please.

ANTONY ROBERT DALTON-WILSON

CHAIR: Before we commence, I wonder, Ms Copeland, if you'd like to introduce the members of Antony's family, all of whom are a very important part of today's work.

MS COPELAND: I will, thank you Madam Chair. If we start with Antony and by way of introduction, Antony is half Samoan on his father's side, and he is English German, Jewish and Roma on his mother's side and Antony is supported in -- at the table this morning by his mother Christine, his sister GRO-B, and his brother GRO-B and he's also supported by other whānau and friends who are sitting in the first few rows of the public gallery this morning.

Antony has also asked me if I would acknowledge his wife, his other brother GRO-B and his fathers who are with him here today in spirit and to acknowledge his whānau and friends, many of who are watching on the livestream this morning.

I thought I would first start by just telling the people here today just a little bit about Antony. Antony loves travelling, he's travelled to more than 30 countries. He absolutely loves Lego and he is incredibly witty with an almost encyclopaedic knowledge of joke books, many of which he's shared with me and which I really appreciate.

Antony is going to give evidence this morning by way of a pre-recorded interview and he's going to talk about when he was crushed by a truck at aged 7 and how he learned to walk and talk again. And he then will go on to talk about various care settings that he was in as a child, including two residential schools.

Antony has completed a full statement and that statement will be available online later today. Antony's brother, GRO-B, and his sister, GRO-B, have indicated that at the conclusion of his evidence today that they would like to say a few words to the Commissioners.

CHAIR: They would be very welcome.

MS COPELAND: Thank you. And lastly, by way of formalities, and before getting into the video evidence is just the affirmation that needs to be given and I've talked about that with Antony and what that means, so I'll leave it to you, Madam Chair.

CHAIR: Hello Antony. Do you remember me?

A. No.

Q. I'm over here. Antony, all I want to ask you is do you agree to tell the truth today?

A. Hello Coral.

Q. Good thank you.

A. Yeah I am.

Q. Thank you very much Antony.

MS COPELAND: Thank you, I'll invite the video to now be played, thank you.

[Video played]

A. "Early life". My name is Antony. I was born in 1967, I was born in National Women's Greenlane hospital, where I'm half Samoan, half English.

"Siblings." I've got stepsisters and stepbrothers and real brothers and real sisters. And my bloodlines is on my mum's side is four children, me GRO-B and my stepsisters and stepbrothers are GRO-B.

"Biological dad." My dad was the first person to set up the basketball team in Ponsonby church. That's why I like him. But other cases I don't like him, like when we came home -- he was a Seventh Day Adventist. When we came back from church one day he said "Lie on the floor naked", so I did, well I had to because he's my father. And then he stood on my back and he got the belt with a buckle and he thrashed me one.

"Step dad." He was a good friend. He took us all around the world. We usually just called him dad. Because he was a good lawyer, so good at law and that. One day someone asked him if he'd like to be judge. He was -- he flown in the Royal Air Force. The plane that he flew was a Kitty Hawke, a tiger moth and Corsiar. You know what he did? He did acrobatics in the plane. He was one of the first pilots in Whakatane, as well as he was a Māori chief.

"Accident 7 years old." That was sad. I was at Westfield freezing works, that's where dad was, his work was, and I was on this really high ramp, but I wanted to -- because that was the day, for the next day's (inaudible). I went on this ramp and the men was parking this articulated truck on to the ramp, and that was when I got my brain crushed and the boy was saying "The boy dad, dad the boy!" And the driver wasn't listening to him, because he was trying to park his truck.

And that was the time when my brain got crushed and someone rang the ambulance. So here comes the ambulance from Middlemore Hospital. Now what they were doing is, they went to this field, jumping fences and skidding around the corners all for me. Now the ambulance came. Now they got their stethoscope, felt my heart, but in those cases they used to strip off your top half so they could listen to your heart. And dad finished work and he came down. He was nauseated. And now this ambulance took me to Middlemore Hospital, but Middlemore Hospital said they haven't got enough beds, so they referred me to Auckland Hospital critical care. Well, it's not there anymore and so I was there for about seven months and I put in another ward called head injury. And that was the day when mum took me for a walk and she had an ice cream in one hand and she said "Now Antony I'm just going to tie my hair back", but this hand was speeding and went for that ice cream and I ate it all, yeah. **[Laughs].** And then I went to Dr Dimson's clinic was in the ward then but it's not anymore and it's called Princess Mary Hospital.

"Rehabilitation." I had to learn to walk, talk and I had to learn to see. Now that comes into Zanadoo. Her real name was Mrs McDonald, she taught me how to walk and that. And I went into the old physiotherapist building and then Zanadoo taught me how to see and then Henry was just a physiotherapist, she taught me how to walk. And then it was at the Wilson Home which I met and I saw all these patients learning to walk with holding on bars and that. Well, I said no, I'm not going to do that, so I got off my wheelchair and I tried to stand up, plonked on the floor, four times and the fifth time I made it.

"What was Wilson Home like?" It was scary, I thought I'd never see my mum and dad again.

"Ward 12, Auckland Hospital." That was no good.

"Did you think about running away?" Yeah, but I couldn't. There are no windows, no doors only the one they locked. All the ladies used to always ask if he could put me in time-out. The ladies never did it in those days, only in Mt Wellington residential school the ladies did that.

"Mangere hospital - school holidays." It was a sad story, I went to Mangere Hospital, really that hospital was only for those who had disabilities, right. Now they locked me in this room where I didn't feel comfortable and they said we're going to have to go to GRO-B Home where it was just like a jail. Like they sent me out in their courtroom. Well, I don't know if it's a courtroom but it was an outside gathering where it was all fenced off, and I thought now, now is the time I can escape. So I climbed the fence and jumped down and I ran away and I think that was -- that was a good thing which I did. Can I tell you more about Mt Wellington?

"Mt Wellington residential school." When I reached Mt Wellington residential school, mum said to the staff "I want to know how you're going to treat my son" and they said "Oh everything's going to be all right, yeah, yeah." So when mum and dad drove away, they just put me in time-out. I was in Mt Wellington Residential School and I'll tell you, that was a bloody school, it was shopping day, Tuesday and we went to St Lukes and I met GRO-B which was one of the physiotherapists. Well, I went to shake her hand, who was it GRO-B he pulled me away and said "Now we're going to send you back to the van and put you in time-out", which was a room with no food, no bed, they just left me there all night and I wasn't happy with that.

"Waimokoia Residential School." At Mt Wellington school there was a fire. I went home for the weekend and next time I came back they had another boarding school which they put me in, named Waimokoia. That was at Pigeon Mountain, that's where Waimokoia was built. Now when there was a fire at the Mt Wellington school and the holidays had gone, I can remember them setting up Waimokoia and while they were doing that, the staff, do you know what they said? "You'll have to wander the streets."

"Treatment from staff and students." I didn't like it there, because all the children were copying off the staff, giving the fingers, saying rude names to me like bung eye or -- and I wasn't going to put up with it. So she's another bloody woman. She just sat there in the -- on the couch there laughing and then there was supposed to be a sergeant. Well, all of these people copied him and they -- and they sent me to school and GRO-B she was a good teacher, and she said to us when we got in the classroom, "Why are you late?" And I said, I actually wet the bed, which was not my fault, it was my medication. And GRO-B came and he said "Now, because you're late we will punish you." So again they put me in time-out and going back to Mt Wellington School, GRO-B she was a nice staff and there again it was activity night, that was Tuesday, and they all gathered together and said "What activities would you like to do?" Well, who was it, GRO-B he said he was going to take up boxing. Well, he said "Come down to the gym room." So I did, where they were practising boxing. I didn't like it.

And on the way down there I skinned my head because the stairs which I had to go to were made of wood, but they were filled with mud and I fell over. Well, who was on duty? GRO-B and he said "Right come on, up to the van", so I went and they took me to the doctors. But he didn't let me get in the van, he got me by my collar, threw me in the van, which I didn't deserve. So he said "We're going to take you to the doctors in Panmure." So we did.

Now what happened is when I got out of the van he wouldn't let me get out. He got me by the collar and threw me out. When we got to the doctor's surgery he said "Now, stand there", so I did. Now, he talked to the receptionist and the receptionist said he's busy with another client, and he said "Wait in the waiting room." Well, it was that GRO-B again. He went into the waiting room and "Now sit there". I was going to sit down but no, he got me by my collar and threw me on the seat and then I went to the doctors surgery. They fixed me up and then it was time to go back and he threw me in the van and then he said to the others when we got back, "Now what shall we do with him?" And he said -- they all said "Throw him in time-out." So they did.

"Discipline." One day I was having my shower when GRO-B asked for some paper, she was in the toilet. So I got myself dressed, went to the staff room and asked for some shit paper -- oh-oh, toilet paper, sorry. And I had to go and stand in line up by the classroom. It was letter writing day, and I was invited to -- into class and expected me to write down what was on the blackboard but it was too late, he had rubbed the writing off the blackboard. And so GRO-B well, I tell you he lived in GRO-B and so the teacher says I'm going to have to GRO-B to I waited and waited, and GRO-B have to put on these seats here and he went to talk to GRO-B the headmaster, and then GRO-B came and said now is the time you can go and see GRO-B. Now it was letter writing day and GRO-B said this is the day that I got the strap. "You've been naughty for" GRO-B and I wasn't, they could say that I was always learning, never lazy. So GRO-B said "Now I must punish you." So he said pull my pants down, he took his belt off with the buckle, thrashed me on the legs, which I'm not going to take, and that's why I think that school was not a good school.

"Being defended." GRO-B she was a lovely teacher.

"What happened to Mrs M when she stood up for you?" GRO-B I tell you he's a blimmen arsehole and, you know, he GRO-B by the collar and ran with them, threw her across the room and he said "Now, do you want us to put you in time-out?" And then GRO-B returned to her car and drove away.

"Seclusion/time-out." I was invited into his classroom and he probably had my hand down like this dancing on the stairs. And he wasn't going to put up with that, and so he got my chair, tipped it back and I fell down and then he said "Now what will we do with him?" What did they say? "Put him in time-out", which was a room with no bedding, no food, locked there all night. I was scared because I hopped in the time-out room, yes, but I was scared because GRO-B the way that they treated me there, I was scared GRO-B would just throw me in.

"Needing to go to the toilet." Pulled my pants down and I went to the toilet, because there was no toilet, was there, by the cell. Well, I thought good because that teaches them a lesson.

"Wetting the bed." They'd say "Go down to the laundry and wash yourself", and then I was late for school and I got in trouble.

"Cold water punishment." GRO-B did that. That was damn GRO-B she just sat in the corner of the room on the sofa and laughed.

"Other forms of punishment." "Cigarette burns." When the weekend was over and we stayed in the staff room and at that time I was feeling not all there and, yeah, that's what they did.

Q. What did they do?

A. Put their cigarette butts on me, like when they finished a smoke and then they used to get my leg and press it on the smoke.

"Setting the dining room." I was sent up to the dining room and I had to set the table for all the school. If I didn't do it how they wanted it, then they'd get very angry.

"Naps." I asked them but what did they say? No, no, no. If I don't I can go blind.

"Lego." Mum was doing a project with GRO-B Australia. She sent me some Lego and GRO-B he said "Look at this, we'll put it up in the staff room on the desk." Well, they did that, yes, but when it come the weekend time to go home, I asked "Can I have my present please off mum?" And they denied it and so I went home. The next morning when I came back they wouldn't let me have it. Very, very sad. That's my favourite thing, see all these Lego, I built them.

"Carrington Hospital." Then the Police station referred me to Carrington Hospital and they locked me in the room all night again and then one day my dad came along and he collected me.

"Time-out/seclusion." I yelled for help and I got on my back and was banging the door with my feet. No-one came, but I knew that I could hear them, they were discussing something and they wouldn't let me out, and the next morning I was free.

"Love and marriage." We were on the way to a meeting in Canada. We stopped off at Fiji and she had a brain injury and GRO-B her father rang up the hospital and said "My daughter needs a boyfriend." So here was my wife in an institution where she wasn't going to meet her mother and father again. And so nurse GRO-B unlocked the door and all the patients ran out. Some had their tongues split open and GRO-B was the last one out. She put her case on the stool and when she ran out of St Giles, that's the hospital, she ran with her arms open and she hugged me and she said "You're my husband."

So we went and had a little time with her GRO-B who lived in Fiji and she was good and then it was time for us to reach the airport, which was not in Suva, it was called Nadi International Airport. So we hopped on that airline with GRO-B and away we went to Auckland. And -- oh yeah, one of -- one of GRO-B brother-in-law he said "Would you like to have a wedding?" So we did.

Now the cake was cheesecake and that's what we had instead of a proper wedding cake. And it happened in our front yard. We had the marquees up there and GRO-B wedding, we saw her walk in the front door, in each hand she had a child and GRO-B said she must be the patron of children and so we had that and that was -- years later the GRO-B bad arthritis in her legs. And she was a Muslim who belonged to a Muslim family. And one day she felt it hard to reach her walker, so that was when she had trouble reaching her walker, her legs, the pain in her legs just made her flop down on the floor. And, you know, since she had -- she couldn't just be lifted up by one person, it took two Polynesians to lift her up, and, who was it, mum called the ambulance which took her to Auckland Hospital, and she -- this is magic, because when I walked in the room, you know what happened? Her body shone like an angel and she sat up and she said "Hello Antony", then she lay back and died, I tell you, when we went to Fiji, I tell you, bloody GRO-B he said that people who have brain injuries may never marry, and I think that's just a scam. I knew that it wasn't right and mum and dad GRO-C.

"Impact of abuse." "Why did you share your story." Because of the wicked things that the GRO-B of Mt Wellington school did to me. Lots of people in my case have had many other cases just like it.

"Nightmares." About Mt Wellington, but I didn't want to share them with mum because sometimes I think now is mum busy or not, but I think that just like mum, they all have pain in them. I don't see anything but I just hear the words.

Q. What words do you hear?

A. I hear of GRO-B saying "I'm sorry, please forgive me."

MS COPELAND: Thank you Commissioners. I have talked to Antony about the fact that the Commissioners may have a few questions for him, so I'll leave it with you.

CHAIR: So shall we ask our questions and leave it for the family to make their comment?

MS COPELAND: I think so.

CHAIR: Let's find out who would like to ask some questions.

COMMISSIONER ERUETI: Fa'afetai Antony, kia ora, tēnā koe, it's Anaru here, one of the Commissioners, we met earlier this morning upstairs. I just wanted to ask you a question about, I know -- I wanted to thank you first of all for being very brave in coming with your whānau to speak with us today. Nga mihi, ngā mihi nui ki a koe i te rangatira. I know that you are bringing a claim to the Ministry of Social Development and the Ministry of Education and I know it's tough for you, it's really hard for you, and I just wanted to ask you what do you think would make it better for you in bringing those claims against the Government for the abuse you had.

A. Money.

Q. Money makes a difference, yeah.

A. **[Laughs]**.

Q. Are people looking after you when you bring your claim, do you feel like you're being supported in making your claim?

A. Yes.

Q. Good, that's good to hear.

A. But I want more.

Q. Yes. Ka pai.

A. Anymore things you want to ask me?

Q. Yes. I'm thinking about what we should do with those time-out rooms, what would you like to do to those time-out rooms?

A. Well, I'd like to smash them down.

Q. And Antony, I know you had lots of good teachers but you also had a lot of bad teachers, particularly at Waimokoia and I wanted to ask you, how do we keep the bad teachers out of these schools?

A. By giving them a punch.

Q. Ka pai e hoa, ka pai.

A. **[Laughs]**. Anything else you'd like to ask me.

CHAIR: Yes, that was from Andrew, I'm how going to ask Julia if she'd like to ask you any questions.

COMMISSIONER STEENSON: Thank you. Tēnā koe Antony. Thank you so much for coming and telling, sharing your experiences, they're very, very important for us to hear. I have just one question. What do you think, what is something that could make a difference to the care that is needed?

A. Well, the person who set up those schools was a top psychiatrist Dr GRO-B, and one day when we were having a game of volleyball I could see all the teachers running away. Then I knew at that moment it must be Dr GRO-B. He ordered me to go to those schools.

Q. Okay, so better people in charge?

A. Yes.

Q. Thank you, thank you so much.

CHAIR: Now I'm going to ask Ali'imuamua Sandra.

COMMISSIONER ALOFIVAE: Talofa Antony, fa'afetai mo lou talanoa i lenei taeao. Thank you for your rich thoughts, for your sharing for us this morning. And how amazing that you found love in Fiji of all places. GRO-B was a very, very lucky woman to have you, Antony.

A. Why is that?

Q. Because you're incredibly amazing by the sounds of things. You were a good husband to her too? I think so.

A. Well, I don't know, I believe in ghosts.

Q. My question, Antony, for you is if you could say something directly to our Prime Minister, Jacinda Ardern --

A. Yes, where is she? Man I'd love to give her a hug.

Q. Yeah, if you could give her a direct message through your talanoa this morning, what would you like to say to her about what happened to you and what really needs to change?

A. Just as I say, I'd like more money. Yeah, and I wish her a happy birthday.

Q. Is it the Prime Minister's birthday?

A. That's right.

Q. We could all wish her a happy birthday then.

A. But we can't do that because she's not here right at this moment.

Q. We can make sure she gets this message from you, Antony.

A. Hope so.

Q. Thank you very much.

CHAIR: Antony --

A. What time is it?

Q. It's 5 to 11 and we're nearly finished.

A. And I thought we were getting into that island buffet.

Q. Yeah, that's coming very soon. Everybody's waiting for the island buffet. **[Laughter]**

A. I'm glad that you gave that a laugh.

Q. You make us laugh, Antony, and we love laughing with you, it's wonderful. Antony, I've got one question that I want --

A. That's good.

Q. Good. So you have told us about what happened to you, but you said something that I think is pretty important, and that is that it just didn't happen to you, that there were other people, other people with disabilities who also had a bad time in these schools, like Mt Wellington, like Waimokoia. Is that right?

A. Now can you tell me, I know but I'm afraid you don't, where is Waimokoia?

Q. That's the thing, that's what I'm asking you. You don't have to tell me the names, but do you think lots of children were treated badly and lots of people were treated badly in those schools as well as --

A. Not like me.

Q. Not like you. So do you think you got special bad treatment?

A. Yes.

Q. Do you have an idea why that was the case?

A. Because the teachers at Waimokoia, they didn't like the things that I was doing.

Q. So they punished you by putting you in time-out?

A. Yes.

Q. It seems that they were also very rough to you, they threw you into vans and threw you out, is that right?

A. Yes that's right.

Q. Do you think they did that to other people as well or just to you?

A. Well, when I went to Mt Wellington school, no, I didn't see any person being punished like I did.

Q. Okay. Thank you for answering my questions, we've got one more person to talk to you and that's Paul who you met before.

A. And why Jacinda?

Q. I'm sorry I'm not Jacinda, but we're going to -- as Sandra says, we're going to pass the message, your message on to her, is that all right? She can't be here today. I'm going to ask Paul now, he's going to say something to you, okay, before we have the buffet lunch.

COMMISSIONER GIBSON: I'm looking forward to the buffet lunch too, Antony.

A. I thought so.

Q. A couple of questions first. You've had some bad teachers, you've had some good teachers. What makes a good teacher?

A. One who believes in God.

Q. Anything else, that they believe in you?

A. They didn't believe in me, they were hell to me.

Q. And you've had some bad schools?

A. Yes.

Q. What would a good school be like, how would a good school treat somebody like you?

A. Well, I don't know, although Mr GRO-B the GRO-B of Mt Wellington, we gave my doctor's file, but do you know he just burned them.

Q. So schools shouldn't be run by doctors, it shouldn't be doctors sending people to -- choosing what school they do go to?

A. Yes.

Q. Another question, you said some people tried to stop you from getting married. There might still be some people who think that some people with disability shouldn't be allowed to get married. What do you want to say to them?

A. Say that again?

Q. Some people didn't want you to get married. I think you had to take them to court. I think there's still some people who believe that not all disabled people should be allowed to get married.

A. Yes, that is right.

Q. Do you think all disabled people should be allowed to get married?

A. No.

Q. Not all?

A. Say that again?

Q. You should be allowed to get married, shouldn't you?

A. Yeah.

Q. And should people like you be allowed to get married?

A. Yes, they should.

Q. And do you think people should understand more that you had a great time, a loving relationship with your wife who is now in the spirit world?

A. Yes.

Q. And wouldn't it be great if more people could understand that and not try and stop people, disabled people like yourself from getting married?

A. They can't. I'd give them a punch.

Q. I think you might be teaching people a lot as you talk Antony.

A. I talk, I'm talking now and nothing happened.

Q. I think what's going to happen is things will change because of what you've shared. I bet that Jacinda hears about what you've said today and it will make a difference. We hope so.

A. That's good.

Q. And now --

A. I'll say to Jacinda I want to marry her. **[Laughter]** I knew that would give all you'se a laugh.

COMMISSIONER ALOFIVAE: We'll make sure she gets that message too, Antony.

COMMISSIONER GIBSON: I don't think she could get a better birthday present than that.

A. **[Laughs]**.

Q. I think now it's time for me to thank --

A. My brother, he has something to say.

CHAIR: Yes, he's going to say something very soon.

COMMISSIONER GIBSON: Fa'afetai Antony. It's a privilege to hear you speak, to hear your courage, to hear the great range of experiences you've had in your life, some of them really hard. The range of abuse, all the time-out at so many different places. Some of us call that seclusion, solitary confinement, that shouldn't happen.

A. What do you call that? Do you call that child abuse?

Q. Yes, we do, we call it wrong and we think that needs to change. But also you've experienced so many great things, you've experienced the love of your family, the love of your wife, you've experienced marriage, and you've travelled the world, and you and I are about to experience this great buffet coming up I understand.

A. I'm waiting to get stuck into it.

Q. We might have to let your brother speak first, but thank you so much for the courage that you've shared with us today, your story and all the experiences you've had over your wife. We do believe it will make a difference, manuia.

A. Now, please pass that on to Nicole, she's got all the knowledge.

CHAIR: Yes, we have to thank Nicole for helping you come forward and helping us understand your whole story. Which of your family would like to speak?

A. GRO-B Brother, he's coming up, now he's gone I don't know why.

Q. I think your mother Christine wants to say something, is that right? Who's going to speak?

GRO-B Brother: Kia ora, talofa lava and greetings to you all on behalf of our older brother, Antony. We stand here this morning in solidarity with you all and as his younger siblings to acknowledge and give thanks. We wish to thank all those who were involved in the initial investigation of abuse in care by the Royal Commission of Inquiry, particularly those who are a part of this Pacific investigation, Tulou - Our Pacific Voices.

We extend our embrace of aroha to all the victims of abuse and thank them for sharing their painful and dramatic stories to assist others. Peace be with you. We are grateful and thankful for the experience and the skills that the Commissioners bring, all you fellas up there, thank you very much. We would like to thank Commissioner Sandra Alofivae who came to our home with her warm and friendly team. We also thank Helenā Kaho and Nicole Copeland and the team who have patiently, with deep understanding, listened to and felt Antony's deeply painful memories and helped them present them to you.

GRO-B Sister: We remember those in our family no longer with us physically, but who we know remain with us in spirit on this important day for Antony. We remember our youngest brother, GRO-B, also a victim of abuse in State care and as a result tragically lost his life in 2012 while on holiday in Samoa, our father's birth place and for whom we continue as a family to seek resolution, truth and justice from the Samoan Government.

We acknowledge and give thanks for our parents who came to this land, albeit by differing circumstances, but who made this land our home. We, as their children, realise that while we have been blessed and fortunate in many ways, life has not always been easy for them or at times for us. A life-changing event such as an accident or illness or impairment to a family member can change the dynamics of any family immensely, as it did ours.

While we experienced love and care, our parents ended up divorcing with domestic violence being one but not the only factor. And then the challenge of caring for a son, brother who had received such a significant head trauma and brain injury meant that sometimes Antony ended up in circumstances and situations that were beyond his control. As siblings, we were not fully aware of what Antony was experiencing and going through as we were only children ourselves and we also know our parents were trying to do their best for us too in what way they could at the time.

As a family we have grown to have a better understanding of how intricate, complex and fragile the human brain is and how any damage and trauma to a person's brain can have a huge affect on their personality and behaviour and well-being. This can mean people with head injuries like Antony become vulnerable and more likely to experience forms of abuse while in care.

While a person with a head injury can present with many challenging behaviours, families need to know our vulnerable loved ones will still be treated with the respect, care, dignity and protection they deserve wherever they may be.

GRO-B Brother**:** We are thankful to all those that have had and continue to have a positive, helpful supportive impact and role in Antony's life and his care, particularly our mum Christine, whose years of dedication and self-less service to this day are an immeasurable and important contribution to his and our life.

Most importantly we are thankful for our brother Antony, a son, an uncle, a nephew, a husband. We are thankful his life was saved and we thank him for his courage and bravery in telling his story and reliving these memories. We thank him for his energetic, loving soul and being someone who continues to teach and help us all. May we all learn from his experiences so that others do not have to go through the unnecessary trauma and pain that Antony did. We live in hope that as a nation we can all learn from Antony's experience so we can do better for Pacific people, for all people.

Solo i tua ni ao taulia. When the clouds pass, they will leave behind a sense of healing and well-being. Clouds that are spent are retreating. Thank you.

CHAIR: Thank you very much, I don't think we can say another word. But thank you for your support to Antony that brought him here today. And please, the last thing, enjoy your lunch.

[Samoan song].

CHAIR: We will adjourn.

Adjournment from 11.10 am to 11.33 am

CHAIR: Good morning Mr Pohiva.

MR POHIVA: Good morning Commissioners and a special mālō e lelei to Commissioner Gibson. Our second witness for today, Commissioners, is Rachael Umaga who is of Samoan descent. She will be giving evidence about her experiences as a patient in psychiatric units in Wellington. She will also be describing the lack of care she received and the ongoing practice of over-medicating patients, her concerns about the current model as well. Before we begin, Madam Chair, I wonder if this is the appropriate time for the affirmation.

RACHAEL LEMALIE UMAGA

CHAIR: Yes. Rachael, if I can just ask you to take the affirmation please. Do you solemnly, sincerely and truly declare and affirm that the evidence you give today will be the truth, the whole truth and nothing but the truth?

A. I do.

Q. Thank you.

MR POHIVA: And before we get into her evidence, ma'am, I anticipate that 12.30 will be a short break and I also anticipate that lunch will be slightly later at approximately 1.30, which still allows us to get the full one hour lunch.

CHAIR: That's fine. As long as we have a full hour of lunch, that's the most important thing.

QUESTIONING BY MR POHIVA: Yes. Malo le soifua oute fa'atalofa atu ia te oe Rachael ma lou aiga ua afio mai i lenei aso. Rachael, thank you for your courage in being here today and I also acknowledge your family members who are here in support. For the benefit of our Commissioners and everyone here, you have your daughter here in support and your good friend Lorraine. To begin with, Rachael, can I please ask you to introduce yourself to the Commissioners and all of us here.

A. Talofa, my name is Rachael Lemalie Umaga. I was born in 1964. I am 57 years old.

Q. Thank you Rachael. I'm just going to ask if you could please put the mic, speak closer to the mic if you can. Apologies. And I'll just get you to ask if you can take us through your statement, starting at paragraph 2.

A. My parents are Samoan and they are both deceased. I have four siblings and we were all born in Wellington. I am the middle child. My parents migrated to New Zealand from Samoa separately in the 1950s. My dad settled in Newtown in Wellington, and my mum initially worked in Auckland but then moved to Wellington. My parents then met in Wellington, returned to Samoa to get married and then returned to Wellington to settle.

This is where we grew up. At the time, there was a big Polynesian population in Wellington and there were jobs available and that is what brought my parents to Wellington.

I was the victim of significant physical and emotional abuse during my relationship with my ex-partner GRO-C The abuse I suffered was the catalyst for my very first admission to ward 5 of Hutt Hospital in 1992. Ward 5 was the psychiatric unit for the Hutt Valley.

I was first taken into psychiatric care by my family. To this day I do not think that that was right. I was a victim of domestic violence, I was struggling to cope and needed support, not to be thrown into hospital.

Q. Thank you Rachael. And just for the benefit of us all, I understand that your time in psychiatric facilities began in 1992?

A. That's correct.

Q. And ran all the way through to 2013, is that right?

A. That's correct.

Q. And the reason you are coming forward to the Inquiry?

A. It's to share my experience of the abuse I suffered in psychiatric care and to highlight areas of concern. In 2020, I requested and received my medical file from the Hutt Valley District Health Board. I will refer to one of the documents in my file in my statement.

Q. So we'll see that a little later on during your evidence, thank you very much Rachael. To begin with, I understand that you had an earlier experience when you were 22 years old with the mental health services. Can you share with us or tell us about that?

A. My first experience with mental health services was in 1986. I was 22 years of age at the time. My parents thought my behaviour was concerning and that I was mentally unwell. I had dyed my hair bright orange and was partying a lot. I was flatting with my friends at the time and I believed I was just enjoying life. They thought this was behaviour that was not befitting of a young Samoan girl at the time.

My mum worked as a nurse in the Hutt and Porirua and I thought she was well versed in picking up behavioural issues from her nursing experience. My dad was primarily concerned about what the church people thought. He was stern but was also looking for answers about why I was behaving the way I did. In my mind, I was just being a normal 22 year old.

My dad took me to see two mental health professionals at ward 27 in Wellington

Hospital for the behavioural issues. The professionals concluded that I did not have a mental health issue. I was not put on any medication, nor was I admitted to a psychiatric unit on this occasion.

Q. Thank you Rachael. I'm now going to ask you to tell us about your very first admission to ward 5, the Hutt Hospital and whilst you're doing that please feel free to slow down and take your time, we can take breaks as we go on.

A. Thank you. In August 1992 I left that violent relationship, I sought a protection order against him. I moved in with my friend and her husband. My ex-partner was trying to visit me at my friend's house. I remember I wasn't able to sleep. I had to take time off work and left my daughter with her dad because I couldn't cope anymore. That is when I believe the mania started. My friends were annoyed with me re-arranging furniture. I had become fixated with having everything in balance. I was physically and emotionally exhausted and struggled to sleep.

My friend and my family decided to take me to ward 5 on 1 September 1992. This was a traumatic experience for me. They literally picked me up and threw me into the back of the car. I was seated, one was seated at my head, another holding me at my feet and I was not sure which one, but one of them was sitting on me until we got to the hospital.

My friend then took me inside ward 5 to do the admission interview with the psychiatric registrar. I remember the psychiatric registrar asking me "Why do you think you're here?" I said "Because you guys don't see the real problem." I was referring to the fact that I was a victim of abuse, I needed help, but I was the one being admitted to the ward instead of my abusive ex-partner who remained in the community.

Medical professionals described my behaviour as hypomania, but for me my behaviour was a culmination of the physical, mental and emotional abuse I received and a lack of sleep. This admission was done informally. I discharged myself from the ward 15 days later but was then readmitted three days after that on a formal basis.

Q. Rachael, I'm just going to ask you to describe the difference between informal and formal admissions, it's just carrying on with paragraph 18?

A. At the time I did not know the difference between the informal and formal admissions. No-one ever explained this to me. From what I understand, an informal process meant admission on a voluntary basis as opposed to a formal process which required being sectioned under the Mental Health Act under a compulsory treatment order.

Under an informal admission, patients could leave the facility or discharge themselves after five days. However, this was subject to the facility's conditions. For example, if staff did not feel that a patient was ready to leave, they could formally section them under the Act. Patients could also be sectioned under the Act during their time at the unit if this was necessary.

Q. Thank you Rachael. I understand that when you first got taken in by family members, you did not know that that that admission was voluntary, is that right?

A. That's correct.

Q. And you certainly didn't volunteer to be there, is that also correct?

A. That is correct.

Q. On a different point you mentioned earlier that you received your file or your medical file and you'd gone through that. In terms of your ethnicity, I understand that that was recorded incorrectly throughout your file?

A. That is correct.

Q. Can you tell us what other -- what you found when you were going through your file, and that's at paragraph 21?

A. For this first admission my file is noted as, and my descent, my ethnicity is noted as Tongan. My name was always miss-spelt, my address details were always wrong. I also noticed that someone else's nursing notes were recorded in my file. This to me indicated they were ignorant and careless towards me.

Q. Thank you Rachael. Just take a moment. I'm now going to ask you when you are ready to tell us about ward 5.

A. Ward 5 was not a stand-alone unit, it was part of the main hospital. In those days the unit was the only place at the hospital with smoking rooms. We were not allowed to roam around the hospital but others came to the ward to smoke.

There were two seclusion rooms. There was a women's side and a men's side of the unit. There were about six patients in one room, so we didn't get much privacy. Single rooms were available for patients depending on their mental state.

I was put in a room with five other unwell women. There were no curtains to give us privacy. There was a person next to you and then another person next to that person. My storage space was what I could fit under my bed. It was crammed.

The sleeping quarters were not therapeutic for me. The most therapy I ever got from that place was when the Māori healers came to the ward and they massaged us. These healers only came in because there was a nurses' strike and there were no overnight nursing staff. We had the most amazing night with them because they massaged us and they didn't tell us to go back to our rooms. I remember we couldn't sleep at night because we had slept all day.

The fact that there was a shortage of medical nurses on the unit made it an unsafe place at this time because people who came in to cover for the nurses did not know what to do. For example, we had managers coming in to give breakfast and one of them gave a patient a non-diabetic meal which was the wrong meal as she needed a special diet. I also found the male nurses quite creepy. I fell twice in the toilet and it was the same male nurse who responded to my call. I would have preferred a female to respond.

I recall one registrar who attended to me who was a young guy. He was a New Zealander. Back then that was unusual. The psych unit was full of foreign nurses and foreign doctors who I felt did not have any idea of New Zealand culture, let alone my Samoan culture.

During this admission I was given a lot of medication and I was never told exactly what the medication was. I had never been on any type of psychotropic medication prior to 1992. I was heavily drugged against my will and it was a continuous pattern of over-medication. I felt like a human guinea pig. It was like "What colour would you like this week Rachael? Did that yellow pill help? Well, maybe we'll try a green pill."

I consider the experimenting that they did with the pills so abusive. After experiments my behaviour was then measured against the DSM4 psychiatric manual. The manual contained a checklist, framed in questions, of symptoms being presented. They were generally closed questions requiring a yes or no response. Depending on the number of boxes ticked yes, they would then diagnose us. The behaviour I presented to them allowed them to label me in a certain way.

Q. So essentially, Rachael, you're saying that they were going off a checklist or another manual to determine what you would be diagnosed, is that right?

A. That's correct.

Q. Just take a breather and then when you're ready continue on paragraph 30.

A. My medication included a drug called Haloperidol which gave me what patients called restless legs. It made my legs want to move all the time. It was such an awful feeling I could not control. All I wanted to do was sit and relax. Haloperidol also gave my legs a burning sensation. Because of the burning sensation, I put my legs in the toilet and flushed it with the water to help them cool down. The effect of this was that it gave my legs nerve damage. My legs were always in pain when I walked. The nurses knew this was happening, so they gave me another drug to relieve that pain. I was also prescribed Lithium which made me really sedated so I couldn't stay awake and I had to do fortnightly blood tests to monitor the level of Lithium in my blood. Then it was another drug on top of another.

There was nothing to do at the unit. We just sat there all day and smoked. I felt neglected because there was nothing to do except wait for 10 o'clock, 12 o'clock, 3 o'clock, 5 o'clock for our pills or for a cup of tea. We were bound to get on each other's nerves. You could not get well in a place like this.

I got really frustrated with how the nurses operated the unit. They would give us tasks to do, like greeting people, making cups of tea for patients and people who came to visit, and looking after the plants. When people came to the unit, I would welcome them and say "Hi, who did you come to see?" Then I would take them into the day room or to their bedrooms. The day room was always full of more people than were actually admitted on the ward because people came from other wards would come in to smoke. I felt like I was doing their job for them, but I learned a lot about how to run the unit during my time there. I felt that I was quite high functioning despite the drugs I was given.

I remember on one occasion an occupational therapist took me and other patients to play soccer on the asphalt. As you would expect, people who were really drugged up would not be able to kick a ball. I was, however, able to kick the ball from one length to the other. I would just kick the ball and walk to the other end and kick the ball back. I would think to myself God I'm going to kill myself with this, it's so boring. That's why I believe patients get so frustrated. Another activity which they made us do was throw the basketball to each other saying our names as we did it. None of the patients caught the ball but we had to do this repeatedly.

After a couple of weeks at the unit, I discharged myself on 15 September 1992. I left because I was having many arguments with the psychiatric registrar about not being able to go on leave from the unit. He did not think I could go on leave. When I decided to leave, the registrar threatened "If you leave I'd make sure you never leave again if you come back." I also remember one of the psychiatrists on the ward telling me that he could guarantee I would be back at the unit in a few days. I believe his comment meant that I would already be hooked to the medication after spending 15 days at the unit. I learned later that it takes about 15 days for the medication to go through your system and for someone to get addicted to it.

Q. Thank you Rachael. So on that occasion you discharged yourself, that was what you refer to as a voluntary discharge?

A. Correct.

Q. And when you were talking about that comment from the doctors at the time, your understanding was that once you -- you realised that once you were in psychiatric unit it was so hard to get out of it once you're addicted, is that right?

A. That's correct.

Q. I'm just going to ask you to take us through your second admission and that's at paragraph 35, bearing in mind that you can take your time and take a breather when you need it.

A. A few days after I discharged myself, I was readmitted to ward 5 following an incident where my legs gave way and I couldn't walk. On admission, I was made to sign a contract. This meant that I was sectioned under the Mental Health Act and was only permitted to go on escorted leave with a family member or a nurse.

I was put into a seclusion room. I think this was because I was a flight risk to them. I remember the nurses sedating me to bring my energy levels down and them having to restrain me to the bed.

Q. Take your time Rachael.

A. The seclusion rooms were like a cell, only big enough to fit a single hospital bed. The door had a little shutter window on which staff could move to see if I was okay. There was also a little square window in the room that you couldn't open. The room smelt sterile and like urine and smoke. I put colourful soaps on the windowsill to get rid of the smell. The seclusion lasted for a long time. I don't know exactly how long it was for, but it was around two weeks.

While in seclusion there was no water given and no toilet. The room was locked and staff had to let you out to go to the toilet when you needed. Staff were often late to open the door and patients often urinated and soiled themselves. This contributed to the smell in the unit. Later in 1998 they gave you three glasses of water and a disposable bed pan overnight.

One time, one time I drew a forest scene on my door with chalk and wrote "No doctors allowed zone unless you're my friend." I did this because it was my private space. A doctor walked right in and I had to tell him that he wasn't my friend so he couldn't come into my room.

I remember seclusion made me feel isolated because I had no contact with anyone else apart from the staff. I thought about nothing else but why I was there which added to my frustration of being there in the first place. I was stuck in the room, restricted from doing anything else on the ward, they let me out to have my meal, but they restricted the number of visitors I could see. It was a dehumanising experience and a power play by the nurses and doctors in that they made all the decisions for me.

I also remember one time when I nearly got ECT treatment because the staff got me mixed up with another patient. I was taken to the ECT room and the person there asked me who I was and then realised I wasn't the correct patient. I was then taken back to ward 5. This incident wasn't recorded in my medical file as I didn't end up getting the treatment. ECT was done in another room outside of the main ward and was usually done on a Friday. I remember the lights used to flicker when it was happening.

Q. So with this Rachael, you could see the lights flickering often?

A. Yeah, every Friday.

Q. And this was a close one, or near miss for you?

A. Could you repeat the question?

Q. And this was a near miss?

A. That's correct.

Q. When you are ready, Rachael, can I ask you to -- you wrote a letter to the Ministry of Health expressing your concerns about the mental health system and I'm at paragraph 42. And you were concerned about the treatment you have been receiving. Can you tell us a bit more about that?

A. Yes, I remember writing to the Minister of Health expressing my concerns about the mental health system and service. I was concerned about the treatment I received. And the place was a pigsty, it stunk. You couldn't get rid of the smell of body waste in the unit because patients didn't always wash and lost control of themselves because of the medication.

I stayed at the unit for a couple of months until I was discharged on 19 November 1992. During this time, I was in seclusion for a long period of time.

Following discharge, I was put under the care of Dr Joanna MacDonald through Community Mental Health Services. Dr Joanna MacDonald was the wife of my psychiatrist, Dr Alex MacDonald at ward 5. She was the total opposite of her husband. She was easy to talk to and I liked her. I had to catch a bus from home or leave work early every fortnight to visit her at her office in the Hutt. At this time, I was working for the Insolvency and Trustee Service as their Senior Insolvency Officer. I really enjoyed that job because it involved training others.

Q. So you had at the time a professional role in employment?

A. Correct.

Q. And just carrying on at paragraph 45 you talk about your memories of this experience. Can you take us through that?

A. Today my experience at ward 5 are still quite vivid in my memory. Ward is now used for plastic surgery but if I were to walk into it today, I would be able to remember where everything used to be, from the seclusion rooms to our bedrooms. One of those vivid memories is the smell of the unit and the window in the seclusion room.

Q. Thank you very much Rachael. I'm now going to ask you questions about your third admission. Can you take us through, I understand it's Te Whare Ahuru now and it was in 1998.

A. My third admission to Te Whare Ahuru was on 3 February 1998. I was 33 years old. There was a long period of being very well without medication since my second admission.

My relationship with my ex-partner was on and off and during this time I was back with my ex-partner and the problems continued. I ended up seeing my doctor as I was sleep deprived. Our relationship was very tense during this time and continued to deteriorate. I took my children and moved to my parents' home nearby.

In January 1998 my parents took me and the children to Auckland for my cousin's wedding. While we were in Auckland, I took my 8 year old daughter to a concert at Auckland Domain. We had a really good time but at the end of the concert I became separated from her. I was very anxious and confused and headed towards the concert exit area to look for her. I then heard my name over the loud speaker, but the security guard would not allow me to go back into the park. I didn't know why they wouldn't let me in. All I wanted to do was to try and find my daughter.

Q. Thank you Rachael. That's fine, carry on at paragraph 50.

A. Despite what the doctors thought, I believed that there was nothing psychiatrically wrong with me. There was a lot going on with me. I was separated from my ex-partner, I was sleep deprived, I was dealing with four kids and I was still recovering from the birth of my sons. There was also a lot of people at the Domain and my 8 year old daughter was exploring and then went to the toilet. She took a long time and that is when I started to look for her. The situation at the Auckland Domain was therefore unfortunate.

Q. Thank you Rachael. And I understand that on this occasion in 1998 your ethnicity was recorded differently again. Could you tell us about that?

A. In my 1998 medical notes, my ethnicity was recorded as Tokelauan which again indicated ignorance and carelessness to me. The staff just assumed my Pacific Island ethnicity and they had that typical perception that all Islanders looked the same. They didn't ask me to clarify or confirm my ethnicity, they just wrote it down.

Te Whare Ahuru was meant to be a place of calm. This to me was anything but calm. Te Whare Ahuru was a stand-alone unit across from the main entrance of the Hutt Hospital. There were approximately 22 beds at the unit which were all in single rooms. Patients got their own room which were bigger than normal, so there was more privacy this time round. There was a side called Te Rangimarie which was the intensive care unit which was where they put the most unwell and those in seclusion. Then there was an open side for patients who were more likely to be informally or voluntarily admitted.

There was a dining room, craft room, music room and a room you could cook or bake under the supervision of a nurse. None of them were fully resourced so activities were not able to be done properly. There were other things available for our recreation, but again, nothing worked properly. The piano wasn't tuned and had missing keys, the puzzles were all mixed together with other puzzles which was really frustrating. It really felt like the staff provided us all these things to show they cared but it was all just surface level and for show.

There was a courtyard, it had fake grass on it and all you could do was walk around it because it was worn and split so it was a tripping hazard. So this was hardly used. There were unusual things happening at the place that were not conducive to our well-being. For example, the craft room was called the purple room but it was in fact yellow. It was things like this that really played with my mind. I'm not sure whether it was intentional or unintentional, but it certainly played with my mind.

I felt as if the occupational therapists, who were present during the day, came but never stayed long enough during the shift. Patients were aware of the schedule or programmes they had planned in advance and we looked forward to these programmes. However, the programmes never consistently ran because they were always cancelling it. The staff didn't seem to care about implementing these programmes that we were looking forward to because we had nothing else to do. It felt like staff were only concerned about having a programme plan for us on paper but not so concerned about doing it. This was frustrating for me.

Unfortunately the mental health practice never changed. The over-medication was the same. The doctors or nurses were not responsive to patients needs and we were just left waiting. Many of the nurses were what I refer to as bin nurses, because they worked in the mental health services for a long time. They were set in their ways, they liked to run things their own way and they lacked compassion or kindness. They were not open to conversation or talking about my daily experiences of being at the unit. This was the same sort of practice that occurred at ward 5, they just had a nicer venue.

Q. Thank you, Rachael, we don't have to go into paragraph 58 and we'll -- we can take a break now if you would like or finish off the few paragraphs before we have a break.

A. Finish off a couple more.

Q. Thank you. Could I just ask you to jump to 59 and do take your time and when you're ready, take us through that.

A. I was discharged from Te Whare Ahuru on 18 March 1998. I moved into my own flat with my children. I got assistance from the Richmond Fellowship who provided me with care to assist with the care of my sons. The discharge was followed by weekly visits from my community psych nurse, Fae Logovae from Community Mentality Health Services. Fae's job involved checking to see whether I was okay and that I was getting sufficient sleep and eating and getting out with the kids. She visited weekly and then fortunately and then monthly until I was settled at home. Thereafter I had a 6-monthly visits with my community psychiatrist.

I went back to work after parental leave. In 2000 I moved into my parents' home following a big argument with my ex-partner. I got my ex-partner removed from our home and rented it out. I continued to care for my children. I wasn't on any medication over this period and I found my work to be quite rewarding.

Q. So there was a long period since that time?

A. Yes.

MR POHIVA: And I'm wondering whether that's a good time to take a break for now and perhaps we'll take 10 minutes?

CHAIR: Is that all right for you Rachael?

A. Yes, that's fine.

Q. Good, okay, we'll take 10 minutes, thank you.

Adjournment from 12.16 pm to 12.28 pm

CHAIR: Thank you. Rachael, are you ready to carry on now?

A. I am.

Q. Thank you.

MR POHIVA: Thank you, Commissioners. Just in terms of housekeeping, I suspect that we will go through to the lunch on time that we initially said and when she finishes her evidence there are a couple of points that she wishes to raise further.

CHAIR: Very well.

QUESTIONING BY MR POHIVA CONTINUED: Thank you, Rachael. We are at paragraph 61 of your statement and I understand that that's your fourth admission in 2003. If you could please take us through at your pace what happened there.

A. In 2003 my ex-partner was stalking me, followed me, and at one time he spat on me in public. He was often leaving threatening and abusive telephone messages. This triggered a lot of anxiety in me and I was traumatised again by him. When this happens, I am not able to sleep as I am constantly in fear of my ex-partner. It got worse and my friends took me to see the CATT team at Hutt Hospital.

Following the CATT assessment I was readmitted to Te Whare Ahuru. I was admitted informally to Te Whare Ahuru on 28 April 2003 and placed under the care of Dr Pieter van der Westhuizen who was a South African psychiatrist. He was a caring and a kind man. He was one of the few psychiatrists that spoke with me not at me. When we discussed my case, I always felt like he was listening. Other psychiatrists would just ignore me and then write down notes about me.

During this admission, medical staff recorded on my file that I was Māori. I considered this to be ignorant and it showed that they didn't care because I was constantly telling them that I was Samoan.

The practice was still the same. When it was time for our routine psychotropic medication, we had to line up in front of the medication room. They lined us up at about 9.30 so that we were all in bed by 10 pm and asleep by 10.30 pm. The nurses carried a medicine folder and it had all our names in alphabetical order, but we were never called in that order. It was a long and dumb process. We would get our pills in a little pottle and our water came in another pottle. That was all the water we got for the medication.

I felt like the small amount of water we were given was not adequate and not honouring a fundamental human right. I wrote to Te Whare Ahuru about the lack of water given with our medication and expressed my views about this.

Q. Thank you, Rachael. I'll just get you to pause there and I'll ask that the exhibit be brought up on screen. Can you tell us what this is?

A. This is a memo I wrote to Te Whare Ahuru staff raising my concerns about the amount of water we were being given with our medication.

Q. I'll just get you to read excerpts from that. Just starting at the top there, could you take us through that? You can move it closer if it's...

A. That's better. Yeah. "I write this memo in anger at how I see medication delivered on the ward. One fluid ounce disposable cup will hold all tablets or fluid depending on how it is preferred, and then another cup of the same size will be filled with water. This is the usual method. I question the validity and the ethics behind, because in most cases what is printed on the package would say that medicine should be taken with a full cup of water, most commonly 250 mls. If the nurses administering these medications are reading from the packets, why then is a full cup not given for every tablet? Some boxes will have warnings that include "To be taken with food" or to "Avoid milk". What then is the purpose of administering medicines in the manner so practised? Simple, it's to sedate clients sufficiently nowadays so that nurses can...

Q. And we'll just bring up the second page.

A. ...so that nurses can get on with writing their notes as was told to one patient this evening. However, that is the general response. If sedation is the purpose, where is the care? What is the likely outcome on patient? A continued need for hospital services? A vicious cycle from where I'm sitting and as a current patient in Te Whare Ahuru."

Q. And just a bit further down that exhibit, another excerpt.

A. "As I understand it, there is a high percentage of mental health patients that end up in some other part of the system due to complications that can be attributed to the supposed medical care received in mental health institutions. Little comfort or pleasure in that."

Q. And finally you shared some views of your own.

A. "I dream of the day that I no longer have to take such medication and can do my healing holistically without the aid of pharmaceutical companies ever increasing products, not only cost but variety as well, and nurses get back to caring for patients rather than turning into word processors."

Q. Thank you, Rachael. After your memo you wrote to staff at Te Whare Ahuru you talk about how they changed their policy?

A. That's correct.

Q. And referring you to paragraph 67, what happened there?

A. Te Whare Ahuru then changed its policy so that we got at least 250 mls of water in a polystyrene cup and we were able to ask for more. I used to just take up a jug of water because the medication not only made me thirsty, but it dehydrated my whole body. My vision was affected at times and it also caused the skin on my feet to crack.

I also experienced a number of falls during this admission. As referred to in this statement, it was due to the medication and having restless legs. I also felt dizzy and high and would fall on the floor. The nurses noted these incidents on my file as "attention seeking behaviour", but I believe that the falls were a side effect of the psychotropic medication I was taking, not me being attention seeking.

During this admission my parents were concerned about my lack of progress so they decided to fly a Samoan fofo, healer, to New Zealand to treat me. I wrote a letter addressed to the staff at Te Whare Ahuru advising them that I no longer wished to take further psychotropic medications.

With the permission of Dr van der Westhuizen I was allowed to undertake the Samoan fofo for seven days on the proviso I returned to Te Whare Ahuru for a further week's observation without medication. I returned, did not relapse, and was discharged without medication.

I remained well which I believe was attributed to the Samoan fofo. The fofo was not only healing, but the process was spiritual and natural. I was wrapped in leaves, plants and a sheet to help get rid of any toxins in my body by sweating it out. I was then showered with natural scents and leaves from rose bushes and was blessed at the end of the fofo. I was eventually discharged from Te Whare Ahuru on 16 June 2003.

Q. So during that admission that was the first time you experienced something of your own culture?

A. That is correct.

Q. And you found that quite beneficial?

A. Very much so.

Q. Moving on to your fifth admission in 2005.

A. My fifth admission to Te Whare Ahuru was on 20 May 2005. The day before my admission I visited my community psychiatrist who diagnosed me with epilepsy.
I questioned him on the diagnosis as I did not think this was accurate. He was the type of psychiatrist that lent back on his chair and put his legs on the table when you were in the room. We never got on well.

He asked me during the visit what I was thinking, and I said, "I'm thinking you're an arsehole." He didn't like that at all. He said, "You can't talk to me like that". So he told me to leave.

As I was leaving, I kicked his door then kicked open the glass on the main entrance door while I was talking to my community mental health advisor and her colleague Lupe.

Later that afternoon Fae came back to my home and took me to see another psychiatrist, Dr Mathews, who arranged my 2005 admissions to Te Whare Ahuru the following day.

This admission was a weird one for me because it was the staff that determined that I needed to be admitted. My family were not aware of this admission and were not involved. This was different to my other admissions because I was not unwell and I had not been on any medication for two years prior to the admission. I remained well after the Samoan fofo in 2003. Despite what the doctor said, I believed I was not becoming mentally unwell and I did not want to take any further medication. To this day, I'm not sure why the staff admitted me on this occasion.

Q. So just to clarify, Rachael, you did have circumstances that made you unwell and you believe, however, it was your belief that you didn't have a mental illness; is that right?

A. No.

Q. And carry on at paragraph 79.

A. I was put on a drug called Topiramax for suspected epilepsy. I was also taking other psychotropic medications but I made little progress or improvement.

I had to take so many pills, possibly as many as 13 pills at a time. I also took other medication for different side-effects. For example, nurses or doctors would give me medication for a sore tummy. It was easy for them to chart medication for side-effects.

As a result, my kidneys started to fail. I knew this because my kidney function levels were normal when I was admitted but it started to decline. This was picked up by the medical registrar at Te Whare Ahuru.

In addition to the psychotropic medication, I was put on anti-inflammatories. This was because I was experiencing very bad joint pain from the psychotropic medication. The anti-inflammatories were meant to ease my joint pain but they instead made things worse and must have contributed to my renal failure.

The nurses never gave me any food with the medication, only water. I believe that whatever medication I was on and had over the years caused my renal failure. Prior to my admission into psychiatric ward, I was not on any medication at all. I didn't even like to take Panadol.

Because of the issues I had with my kidney, I wasn't able to walk properly. I had a number of falls. My feet were always in pain and I felt dizzy and often fell to the ground. Like previous admissions, I believe the falls were a side effect of the medication I was taking, and my kidney issues exacerbated it.

I was sectioned under the Mental Health Act and transferred to the Te Rangimarie side of the unit. I wanted to seek legal advice of being put under the Mental Health Act and the duration of it, so I was able to access a lawyer, Kerri Preston, from the duty list roster through Te Whare Ahuru. I used this duty list roster a couple of times.

I think the worst thing for me was that these lawyers were rostered on. Because they were on duty, they didn't really have any vested interest in whether I did well or not. They might see me for five minutes and go through my case. That was the nature of what was going on during my encounters with the lawyers.

I was also placed in seclusion during this admission. I felt like I was in seclusion for a long time. I just want to be clear that I don't ever want anyone in the future to experience seclusion. It is lonely and boring and makes you feel like an animal in a cage. We have no freedom. The staff just leave you in there and there is nothing for you to do in seclusion.

Around the time of my discharge, the psychiatrist advised my family members that I was an unfit mother. This was a difficult time for me. I remained in the unit until 28 July 2005.

In relation to the epilepsy diagnosis, I had an EEG done at Wellington Hospital. Following this test, it was confirmed that I didn't have epilepsy. This confirmed my own belief about that diagnosis because I never believed I had epilepsy. Nevertheless, I was still forbidden to drive for a year after this admission because my records showed a diagnosis of epilepsy.

Q. Thank you, Rachael. And I'll now ask you to take us through your sixth admission and again, at your own pace, taking it as slow as you want to at paragraph 91.

A. My sixth admission to Te Whare Ahuru was on 29 September 2007 under the care of Dr Garcia. Prior to this admission my dad was very unwell for months and he passed away immediately prior to my admission. His funeral lasted eight days and at the time I felt like people were coming to me for advice to make sure everything ran smoothly. I ended up being stressed, had no sleep and this led to my family contacting the Community Mental Health team.

Two Pacific members of the Community Mental Health Services visited me during the funeral and there was no indication that my thought -- that they thought I was unwell. I assumed they visited to support me.

I was taken to Te Whare Ahuru by my family. I met with a psychiatrist Dr Roy. He decided that I needed to be admitted. I was immediately taken to seclusion in the Te Rangimarie side of the unit. I was angry because I felt let down and I had spoken to my family and expressed my thoughts, but they instead decided to take me in to be admitted. This is what hurt me most. I then went back to the unit to my own room.

I was formally sectioned around 14 October 2007 and placed in seclusion again. This time it was for setting off an alarm. I never wanted to be in that place and felt it was not helping me at all. I often acted out because I never wanted to be there.

During this admission, I again experienced restless legs and was constantly falling over due to the medication. I remember on this occasion I rejected taking Epilim because it was foul tasting and was not good for my teeth.

A week before discharge I had had enough and decided not to take any further psychotropic medication because of the effect it was having on me. I was subsequently discharged from Te Whare Ahuru on 7 November 2007.

Q. And now we are jumping to your seventh admission in 2008. When you're ready Rachael.

A. My seventh admission to Te Whare Ahuru was on 4 July 2008. This was a short informal admission for depression under the care of Dr Garcia. I was still grieving over the death of my father. The treatment I was getting was much the same as previous admissions as described above.

I was discharged on 21 July 2008 and I went and stayed with my friend in Hamilton for about two weeks. My friend worked in mental health services in Hamilton and I wanted time away from my family to recover. My children were looked after by my family during this time. However, I took them back after two weeks when I returned to Wellington.

In 2009 I had to undergo dialysis treatment for my renal failure. My renal function continued to deteriorate. This impacted my relationship with my children and my family generally. I couldn't work anymore or attend any functions. This had a wider impact on my family.

In February 2011 I had a live donor kidney transplant given by my sister. At this time I was caring full-time for my mother as I was not working due to my health issues. For my family this meant that I was available to look after our mother. I cared for our mother despite my health issues and I also had my children in my care at the time.

Q. If I can just jump to your eighth admission in 2012. Again, Rachael, please take your time.

A. My eighth admission to Te Whare Ahuru was on 2 May 2012. This admission was most unusual for me as I went to Te Whare Ahuru with a friend to advocate for her. I told the staff that what they were proposing for my friend was unfair. The matter escalated and I ended up being physically restrained and admitted to the unit. I was formally sectioned under the Mental Health Act so I was not able to leave.

I was taken into several -- into seclusion several times during this admission. On admission I was taken to seclusion on the Te Rangimarie side of the unit. I started experiencing the falls and the restless legs again, which I hadn't experienced since my last admission up until that point as I had not taken any psychotropic medication for approximately a year prior to this admission.

My frustration with the staff grew. Every time I wanted to talk to nurses or doctors about something, they would tell me to wait. I was sick of them telling me to wait 5 minutes. I felt like no-one was listening to me. I only got responses when I raised issues about a personal relationship between two staff members. For example, I spoke to a senior staff member about an unprofessional relationship between a psychiatrist and a staffing member and that psychiatrist then actually gave me a response about something. It was an interesting situation.

I really wanted to take a drug holiday. The medication was making me drowsy and I had had enough. I wrote to my doctor at the time to express how I was feeling. I did not want to take more medication because it was literally making me worse. I wanted to be healed by way of natural methods such as Samoan fofo. This did not happen.

I was also taken into seclusion again after being accused of assaulting a staff member. I remember this incident well because I did not actually hit the staff member. I remember I waved my arm like that and he fell over. Nevertheless I was secluded for this incident and on several other occasions during this admission. I was eventually discharged on 4 July 2012 to my home.

Q. And Rachael, I understand that your ninth and tenth admissions happened next and you'll be talking about them both. If I can refer you to paragraph 110.

A. I was readmitted informally on 21 September 2012 for depression and discharged on 5 November 2012 under the care of Dr Kure. I was readmitted on 10 December 2012 for low mood and non-compliance with my medication under the care of Dr Kure.

Q. Just to clarify, these admissions were pretty much the same as your previous admissions?

A. Yes, except with the non-compliance that means I refused to take medication, medication is forcibly given to you by injection in your buttock, you're restrained.

Q. And then that takes us to your 11th admission, paragraph 113.

A. My 11th admission to Te Whare Ahuru was on March 2013 under the care of Dr Kure. This admission was done informally. Medical staff described my condition as major depressive episode and suicidal ideation.

On this occasion I had asked professionals for help as I wasn't coping at home. I was still looking after my mum full-time. I was struggling as a solo mother while caring for my elderly daughter (sic). I was struggling to cope.

During this admission I was experiencing much of the same treatment I received as previously explained in my statement. A lot of the time I did not feel safe at Te Whare Ahuru and did not feel staff listened to my concerns. There was negativity from medical professionals and other patients. Staff were falling asleep on night shifts. Patients were also intrusive and abusive. I had limited contact with my family. There were always restrictions on my leave conditions. For example, I had to be back to the unit by a certain time which I understood was for my safety. Nevertheless, it was not a healthy environment for me.

The reason I say they did not respond to our concerns because I would raise my concerns if I was in pain. They would tell me to go and sit in front of the glass office and wait for a nurse. When a nurse came and told them -- I told them my issue, they would send me to another chair around the corner. Then another nurse came and acknowledged that I was there and wrote some notes and that was it. I felt as if they were playing games with us rather than doing anything to help us.

The medical registrars had some unusual practises. For example, I would complain about having a sore tummy and foot at 7 pm at night and the doctors would arrive to check me at 2 am in the morning. This scared me when they came at such an early hour. I often did not get any responses to when I raised concerns about how I was feeling. I tried to follow-up on this and I was told that the doctors came to see me, but I was asleep. I suspected these visits were during the night again. Sometimes nurses would respond by saying "They've got busy schedules." To me, the medical practice did not work in the best interests of the patient.

By this time, the District Inspector service was available. This was not available in my earlier admissions. The District Inspector was a lawyer whose role was to visit all inpatient clients weekly and talk to them about any particular issue that they might have been having at the unit. They would interview you and tell you whether you had a good case or not. Then they would take you through the complaint process. The unit would amend, adjust or assess anything as a result of the complaints.

I did not feel as though I could make complaints about my treatment through the District Inspector service. I did speak to one lawyer through this service about the anti-inflammatories I was taking which caused my kidney failure. He said I had a good case but at the time I felt I could not raise this concern in fear of being kept longer at Te Whare Ahuru. I was getting close to being discharged so I did not take this any further. I was eventually discharged in May 2013.

Q. So that was shortly after you had spoken to the District Inspector, is that correct?

A. Correct.

Q. Thank you, Rachael, that takes us through your experience of psychiatric units. I understand that you have some views about your diagnosis. Could you talk to us about that and I'm referring to paragraph 122 of your statement.

A. Throughout my admissions I was diagnosed with various conditions. To me these were labels they put on me to justify my admissions. However, the diagnosis did not make sense to me. For example, during my first admission in 1992 I was diagnosed with postnatal depression. This did not make sense to me because my daughter was two and a half years old. Then I was diagnosed with bipolar affective disorder after my 1992 admission. Later I was diagnosed with epilepsy which tests confirmed was wrong. To me I felt like I was labelled with a particular medical condition that gave medical professionals a licence to pump me with more drugs. I believe they were just experimenting with their drugs on me.

When I was reviewing my medical file, I noticed other labels being used by staff throughout my admissions. These labels included mania, hypomania, psychosis, bipolar disease, depressive phase of my illness, suicidal ideation, schizo-affective disorder, elevated mood, depression and sedated.

These labels were hurtful and degrading and I could not help but wonder why they did not inform me about what they were writing at the time of writing this. I was never told of these conditions and neither were they explained to me.

Q. Thank you, Rachael, you speak also of the lack of care given. That's at paragraph 125. Can you talk to us about this?

A. Throughout my admissions, I raised issues about the lack of response from medical staff and care from them. The facilities improved from when Te Whare Ahuru was used but the medical practice was the same. The main focus was on medicating patients which caused side-effects and so patient then received more medication to relieve the side-effects.

The environment was not conducive to my well-being. There were programmes and activities available but not consistently implemented or fully resourced to allow these activities to be done properly. These factors added to my frustration which made the experience worse.

Medical staff often got my ethnicity wrong despite me telling them constantly that I am Samoan. To me, this showed that they were ignorant and careless and it did not help the situation if they were not getting the basic things accurate. The staff assumed what ethnicity I belonged to and that did not sit well with me. It caused an unfortunate, unfavourable reaction from me because they often did not get the simple stuff right.

Q. Thank you Rachael. Just pause there for a moment. Before we get into, when you're ready, just take us through the impacts or the -- of the overall abuse on you. That's at paragraph 128.

A. Due to the over-medication, I experienced terrible side-effects and reactions to the various drugs I was taking. I went from having no drugs at all to having a lot of drugs. Haloperidol was a drug I got and was deeply affected by. I also couldn't tolerate Lithium which I called the battery drug. There was just a whole range of drugs I was put on and they caused significant side-effects. I am still impacted by my experience and suffering the consequences of this drug taking. I was put on dialysis for my renal function problems.

There were no thought or talk about therapy or alternative ways of healing apart from the one instance. There was only drug therapy. It was robotic. You were given medication on a regular basis and that was expected to make you well. There was no creative outlet, just some walks around the hospital grounds. I believe that options such as Samoan fofo or Māori massage should be readily available because they worked well for me.

Today I still experience what some people would call white coat fever which is basically experiencing high blood pressure every time I walk into a hospital because simply being there gave me anxiety.

For me, medication should only be a last resort. I feel like mental health hospitals are not well places or conducive to healing. I don't have any faith in these hospitals, whether they are inpatient or community based. My biggest issue with any mental health service is that they are unwilling to consider other alternative treatments. Whenever I have friends who are feeling mentally unwell, I dis-courage them from calling the CATT team because I believe the mental health culture and practises haven't changed.

The smell of the unit is still vivid in my memory. The first thing that hits you is the clinical smells and the smells of bodily waste.

My time in psychiatric care has also impacted my lifestyle. I went from being a very active mum to be an isolated, shy and quite introverted person, fearful of being in social settings. Even doing the shopping became a problem for me. I had this fear that everyone knew I was on a psychiatric ward so they judged me or labelled me before they got to know me. I used to play rugby and netball, but I could not do that after my renal failure.

Also, back then there wasn't any education around mental health and unfortunately our Pacific families have this idea that the medical model is the only model of care. With the medical model being the dominant one, many Pacific families believed that this was the answer to certain behaviours. They believe everything the doctors tell them and diligently take their pills.

The feeling of shame is very real. For people that have been in these units, they carry the stigma of shame. We feel shame. Shame stops us from making friends. The stigma makes us untrustworthy of people, always insecure and cautious of people all the time. I am often questioning people whether what they are proposing is in my best interests because of my experience. I used to be outgoing and quite extroverted. I have been forced by the shame to behave differently and to be more introverted.

The use of the word "mental" carries negative connotations. I feel that it doesn't take into account the fact that there are many issues that make someone unwell and behave the way I behaved. These are issues like social issues, housing issues and socio-economic issues. Being a victim of domestic violence is a huge contributor to my behaviour, but that was often looked at in isolation or as a separate issue. Many Pacific people still do not fully understand mental health and respond negatively to people such as myself who have been in psychiatric wards.

Q. Thank you Rachael. I understand that you also have thoughts about looking forward. Can you share those with us? And I'm referring to paragraph 138 of your statement.

A. I have not gone through any redress process. In the '90s a staff member asked me if I was in charge of ward 5 what would I change. I told them that I would not have it attached to a hospital. I told her that it would be like a retreat. It would have to have a sea view or be in the country where it would be therapeutic, where you could walk in nature, really walk in nature as opposed to fake grass. You would have massage therapists, you would have art and you would have music. You would have all things that people could be passionate about to help them become well. It would all be about well-being.

I also told them that there should be psychotherapists and other mental health therapists, not just psychiatrists, so there are different options available for people. The Samoan fofo I had would be available to people as well as alternative methods of treatment. There would be diversity in people's skill sets, ethnicity and practise. There would be some medication but not everyone needed to be so medicated.

I would also change the clinical services in terms of what's on offer and how it's run. They should be more patient-focused and consistent. For example, the occupational therapist would be consistent and actually implement the plans they had in place.

The word "mental" has a stigma. The legislation should be called something that reflects what they want to achieve. They should call it the being Wellbeing Act or the Wellness Act. I think they need to stop the drugs and give hugs. But then if I gave a hug they consider it inappropriate.

I guess the question for me, who are going to be the reformers and who are going to make sure that there are big changes for the future of care? I believe that survivors are a good start to consult with.

Q. Thank you Rachael. I also understand that you have further thoughts to finish off with today. If you could share those with us when you are ready.

A. When I was first diagnosed with bipolar I was told that it was a chemical imbalance and I asked what are the chemicals and what is the imbalance? And that could not be answered. So when they created -- when they use drug therapy they're trying to balance that imbalance and what they tend to do is give you medication from the maximum dose going back and it's a trial and error process. That creates issues for people and that creates over-medication. And I believe that's a practise that should not be used.

I believe that the Mental Health Act should be repealed and a new one replacing it. I believe there is room for an independent advocacy service for all inpatients in mental health units who can advocate for the needs of every patient. I believe there needs to be a focus on addressing the workforce and developing care practises and policies that address the needs of patients, not only the medical model, but alternative ones as well. I also believe in introducing an agreed note-taking process, because the current one is totally subjective, it is only the notes taken by doctors and nurses that are recorded on medical files.

That's all I have to say.

Q. Thank you very much Rachael. I'll hand it over to the Commissioners now, but before I do so, I say fa'afetai tele lava, Rachael, malo le faamalosi, malo le lototele, malo le loto finau. Thank you Commissioners.

CHAIR: Rachael, we don't have any questions for you, but my colleague Dr Erueti's going to thank you.

COMMISSIONER ERUETI: Fa'afetai Rachael. Ngā mihi ki a koe me tō whānau. Ka puta mai ki te tuku kōrero ki mua i te aroraro o te Kōmihana. Tēnei te mihi mahana ki a koe. I want to thank you on behalf of the Inquiry, Rachael. I know it wasn't easy to come and speak with us today, but you stuck to your guns and I know that you were determined to share your experience with us. And it was so comprehensive in many ways, I was just thinking your recommendations at the end and they were so very useful and insightful and very useful for us, very particular and hit the mark every time.

I recognise your concern about the -- I think back when you were young, when you were first placed in care and the lack of full appreciation of what was happening in your life at that time, the emotional distress and the domestic abuse and the impact that that had on you, and the lack of understanding by the professionals but also your whānau I think about what was going on.

So I take your point too about the need to raise awareness amongst Pasifika communities about mental health issues, to raise understanding of what's going on. And your -- I know there's a strong call now for the Mental Health Act to be radically -- let's repeal it, as you put it, and replace it with a well-being act, I think that's a lovely idea.

There have been lot of strong calls by Māori mental health practitioners and survivors for more cultural models, and that's exactly what you're talking to about Samoan fofo and Māori massage, had a real impact for you, right, had a real effect. I think the strong message I got was just the like Sir Pieter, Dr Pieter, for example, was one of the few psychiatrists that you show your respect, and a big theme for me was your human dignity and respect for your autonomy and decision-making processes and that seems to be fundamental, is a need to respect you and to listen, just to listen to you and to meet your needs.

So we have listened very carefully, we have taken many notes and we have learned so much and so on behalf of this Inquiry I'd like to extend our aroha and thanks to you and your whānau, thank you so much, kia ora.

A. Thank you, kia ora.

[Samoan song]

COMMISSIONER ALOFIVAE: Fa'afetai lava, fa'afetai manuia.

Lunch adjournment from 1.24 pm to 2.25 pm

CHAIR: Good afternoon, Ms Va'ai.

MS VA'AI: Malo le soifua Madam Chair. Our last witness for the day is Leota Dr Lisi Kalisi Petaia. I will be referring to her as Leota Dr Petaia, just to honour both the titles that she holds as a high chief as well as a psychiatrist. Leota Dr Petaia is an expert witness and she has been recognised as the first and only Pacific forensic psychiatrist in the world. She is of Samoan and Tongan descent. Thank you, Madam Chair.

LEOTA DR LISI KALISI PETAIA

CHAIR: Leota Dr Petaia, you are most welcome. You are indeed the rarest bird in the room and we're very glad that you're here. Can I ask you please to take the affirmation.

A. Yes.

Q. Do you solemnly, sincerely and truly declare and affirm that the evidence you will give today will be the truth, the whole truth and nothing but the truth?

A. I do.

Q. Thank you very much. I'll leave you with Ms Va'ai.

QUESTIONING BY MS VA'AI: Thank you, Madam Chair. I'm going to invite Leota Dr Petaia to open our session. I understand she has some acknowledgments she would like to make.

A. Kia ora, mālō e lelei, talofa and warm Pacific greetings to you all this afternoon. It is an honour and privilege to be here in this fale to share some thoughts in the hope to assist the Commission and its important work. Before I proceed any further, I would like to firstly acknowledge and honour the survivors who shared their stories with us. Thank you for your courage, thank you for helping us understand what had happened to you so that appropriate measures are put in place to prevent their repetition in the future.

I also wish to pay tribute to the many survivors who for various reasons are not able to tell their stories. I've had the privilege to meet and talk to many of these survivors in prison as part of my work. I also have met many of them in community mental health clinics and in psychiatric hospitals in my capacity as a psychiatrist.

We've heard survivors' stories of abuse, racism and mistreatment in hospitals and State care. Stories of removal and dislocation from their families and loved ones, their multiple and unstable placements, lack of education opportunities and unemployment, which have all been part of their almost inevitable trajectory to prison.

Removal from families perpetuates a huge sense of loss, including mainly loss of connection and relationships with families and loss of cultural identity. The stories are complex, they are heart-breaking and what is clear is that the survivors suffer high rates of psychological distress and some have suffered serious mental health problems.

Amongst these sad stories are remarkable stories of success by survivors. Stories of unconditional love and support of families, friends, communities, including churches and relevant services. Survivors have frequently demonstrated to us significant levels of resilience, strength and recovery in rebuilding their own lives. I have noticed with admiration that these successful stories have often achieved -- have often been achieved by the survivors' efforts themselves. This human capacity to bounce back despite significant adversity and trauma gives us all hope and courage to do this work.

We owe it to the survivors and our communities to do the right thing. Do what's right and prevent repetition of the same mistakes in the future.

I respectfully acknowledge the Commissioners, Judge Coral Shaw, Dr Andrew Erueti, Ms Julia Steenson, Mr Paul Gibson and Ali'imuamua Leva'a Sandra Alofivae and all the teams involved in this Inquiry on your hard work. Oute faafetai faapitoa i lau afioga Aliimuamua Lealiivaa Sandra Alofivae. Lau susuga le tamatai loia sinia, ua fai lava oe ma sui o tagata Pasifka i lenei galuega taua ma le fita ma o se mitamitaga tele lea i tagata Pasifika ma au nei. Malo le galue, malo fai o le faiva. Ko e Ha'amoa au mo e Tonga. Ko ʻeku kui ko Limoni Uesi (West), tamai ʻeku fa'e mei fo'ui, meia Nōpele Vaha'i. Na'a ne ako mai, ʻa e ngaahi anga fakatonga lahi kia kimautolu pea ʻoku ou ʻi he Komisoni ko ʻeni mo e laumalie lelei ma'ae kakai ko ia ʻo e pasifiki. ʻOfa ke tokoni mai ʻa e ʻOtua ki he fononga ʻoku tau fai. ʻOfa lahi ʻaupito atu. Mālo. Besides being Samoan I'm also Tongan, descended from my grandfather who taught me a lot on culture. I bring with me to this Commission the spirits of that background for the benefit and best interest of the Pacific people and may God help us all in this endeavour. Malo.

Q. Malo 'aupito and fa'afetai tele lava Lau Afioga Leota Dr Petaia. I'll just be mindful that we have sign language interpreters and stenographers who are trying their best to keep up with us, so we'll just keep our pace nice and slow and you're doing great.

A. Thank you.

Q. As the only Pacific forensic psychiatrist in the world, you are in a very unique position, because of both your clinical and cultural expertise and I know that talking about your many achievements, your successes and your background is something that you'd prefer not to highlight, but for the benefit of this Inquiry and our community listening in, can you please share a bit about your professional background and explain what brings you here to the Fale o Samoa today as an expert witness?

A. My full name is Leota Lisi Kalisi Petaia. Leota is my customary high-chief title matai tamali'i from my mother Melenaite Aiafi's family in Samoa. My grandfather, as I've mentioned, is Tongan from the village of Foui and I'm called after his Aunt Kalisi. I'm a medical doctor registered with the New Zealand Medical Council currently employed as a consultant forensic psychiatrist by the Waitemata District Health Board. I'm a fellow of the Royal Australian and New Zealand College of Psychiatrists. In my own time I work with Pacific communities on mental health education.

I'm an honorary senior lecturer for the Department of Psychological Medicine at the University of Auckland and also a guest lecturer at the University of Otago, teaching psychiatry and Pacific mental health to medical students.

I've mentored and supervised medical students and junior doctors of different races, including

Māori and Pākehā. I have presented locally and internationally on psychiatry and have authored and co-authored papers and articles in the area of Pacific mental health.

I was the founding president of the Pacific Island Mental Health Professional Association in Aotearoa, New Zealand. And I am the director for Petaia Medical Services and Le Toloa Limited, respectively two private companies involved in mental health services for Pacific people.

Q. Fa'afetai lava. Just reflecting on survivor stories, particularly from the story that we heard from a survivor today, a common question has been what does culturally appropriate care look like. And of course for health professionals providing care, their introduction to formal training is through tertiary institutions like medical school. So I'm going to take you right back to your experiences as a student, just so that we can have a better understanding of the actual foundations and structures of how health professionals are actually trained. So Leota Dr Petaia, when you were studying, was there any encouragement or emphasis on the importance of cultural awareness?

A. Education institutions in general are monocultural based on robust European university systems of learning and assessment. The study of medicine in particular is based on a strictly western scientific and biological framework and from my experience, the development of cultural awareness amongst graduates was an issue left to the individual student's discretion. This was often dependent on their exposure to the norms and nuances of their own ethnic backgrounds and/or awareness of the cultural, philosophical and psychological sensitivities of other people. Perhaps it might be easier to understand this by sharing my own experiences in training in the hope that it will bring home some of the key issues that would lead to some positive changes.

So I grew up in Samoa in the 70s and this was not long after Samoa gained its independence from the New Zealand administration back in 1962 and I attended the Government schools based on the New Zealand curriculum. We sat the New Zealand School Certificate and university entrance exams and I was fortunate to win a New Zealand Government scholarship to study at New Zealand -- at a New Zealand university with the intention to study medicine in New Zealand. But at the completion of my undergraduate degree there was a major change in New Zealand policy, so that all Samoan medical students were to be sent to the Fiji School of Medicine.

The Fiji School of Medicine has a very good reputation, and has trained the majority of doctors working in the South Pacific region. It was established by the British in 1885 during colonial times, we were trained by British doctors and Pacific specialists from -- who graduated from New Zealand medical schools, so the basic medical training was mainly based on western perspectives and it took us six years to complete that medical training.

At medical school I was asked this question most of the time as to why I'm interested in psychiatry, but at medical school I was very intrigued with psychiatry because I found it very challenging, and I excelled in it and decided to take it up as a specialist area. I returned to Samoa and worked as a junior doctor for a couple of years, and this is normal for all doctors who complete their training to do a couple of years of house surgeon and then moving on to specialist training.

In Samoa, within a short space of time I was able to work in our small mental health unit and I was working with very dedicated nurses, just three of them, and we contributed to major reforms in our mental health services in Samoa. It was through that work in Samoa that I became exposed to the big world of psychiatry, and I suppose I felt very ill-equipped to treat patients and manage mental health problems because I did not have the training at the time, so I was very fortunate to have had the opportunity to do specialist training in Christchurch on a private basis. And specialist training took another seven years, so overall it takes up to 15 years of formal training to become a fully qualified psychiatrist.

I suppose I'm talking about this because it's important. The duration of training is a critical point when it comes to workforce development in mental health, because it means that it's not easy to produce psychiatrists, and Pacific people are going to be mostly seen by non-Pacific doctors who are not familiar with Pacific cultural values.

So going back to your question about cultural awareness from my experience, there's minimal focus on cultural training in both basic medical training and specialist psychiatric training, and in my professional view as a Pacific psychiatrist, this lack of cultural emphasis in training is a major contributing factor to poor engagement, poor health outcomes, and significant health disparities for Pacific people in New Zealand.

The medical schools therefore have a moral responsibility to focus on cultural competency training, and I mean training doctors to understand Pacific cultural values and apply them appropriately to improve outcome for Pacific people. Cultural training must be included as part of their formal curriculum. No medical student will focus on Pacific cultural training, any relevance of Pacific culture in health and take it seriously if it is not going to be examinable.

There's good evidence that increasing cultural knowledge will improve the performance of doctors and clinicians. And I'm not just talking about doctors; I'm talking about nurses, social workers, occupational therapists, right across the different disciplines working in mental health.

New Zealand is a country of many cultures, and cultural training is needed and necessary so we can have an open and honest discussion about other ideas to address health inequities.

We should be willing to appreciate the benefit of diverse perspectives to improve care for people. And I'll be talking more about that later on. I'm just giving some examples to highlight what I mean.

Q. Thank you. I just would like to focus a bit more on your clinical training. Thank you for outlining the cultural side of your learning. Now turning to your clinical training, in paragraph 26 of your statement which you provided to the Inquiry you said, "There was no other Pacific or Māori psychiatric registrar in our cohort of registrar trainees in Christchurch" which is where you trained. Are you able to expand a little bit on more that, please?

A. Yes. I've talked about my clinical training, just also to highlight the importance of that aspect of training, and I value my western training and I have a lot of faith in my western training. I think it's important for us to remember that we are not just dealing with culture here, we're dealing with people who suffer from serious mental illness that require treatment. So I'm just going to talk about that a little bit.

Because there is significant studies that shows that major categories of severe mental disorders exist in all cultures and share similar signs and symptoms, or core psychopathological features. So Pacific people suffer from serious mental illness, they're not immune to serious or severe pathology like schizophrenia, depression, bipolar affective disorder that you may have heard of.

The point is that when these illnesses are identified and treated appropriately in a timely manner, Pacific people can make good recovery, and Pacific people should not be deprived of good treatment and overall mental health care. So during my clinical training I appreciated the complexity and the biopsychosocial nature of mental illness and the depth of the clinical treatments and various types of medications including treatment like ECT and other treatment for physical comorbidities that's very common in Pacific patients. And I also saw how a multi-disciplinary team of mental health professionals, not just psychiatrists, but psychologists, psychiatric nurses, social workers, occupational therapists and cultural workers included, and how they manage patients very well together as a team when it works well. So I have a lot of respect for these other disciplines.

I mentioned the complexity of mental health problems, they can't be resolved with simple solutions. We need different disciplines who can understand patients from different perspectives and together as a team we can identify the needs and respond appropriately. So for Pacific people, they also need that kind of multi-disciplinary team management.

I also want to mention a few things that I noticed during my training in Christchurch, because I came straight from Samoa in the middle of winter and landed in Christchurch and you can imagine that was a shock for me to start off with. But during training and working in Christchurch there was a -- I experienced quite a lot of culture shock on many levels and I had to learn very quickly and adjust to be able to function well in that context.

I want to mention the difference between Pacific patients and I suppose Pākehā patients. For Pacific people, they're usually accompanied by their families mostly, most of the time, their families accompany them to hospital and to assessments, and they want to be involved in their care. They want to know what's happening and they want to know how they can be of help for their family member. And I think this can be traced back to the core values of being collective, communal and being inclusive. I think Luamanuvao spoke about all of this on Monday.

For Pākehā patients, they tend to prefer their privacy as they are more individualistic in their own views, so I'm not saying this in a negative way, it's just what I've observed during my training, and it's important for doctors and clinicians to understand this difference so that doctors, clinicians especially, should consider involving Pacific families in care plans, unless absolutely contra-indicated and not in the patient's best interests. But I've hardly come across that. I've had to deal with many Pacific families that want to be involved and want to know what's happening, and that's very helpful a lot of the time.

The New Zealand Medical Council has clearly stated that cultural misunderstanding and unconscious bias have contributed to the poor state of Pacific health. In psychiatry, I was aware of transcultural psychiatry. It was a discipline that was developed in the late 1990s and it examined the role of culture in the development and treatment of mental illness, and a design of mental health services responsive to a diversity of needs. So this discipline has come about from the recognition that mental illness is experienced, expressed and treated within particular culture and social contexts and if this context is ignored, the patients and their families and their needs will not be adequately addressed.

So overall I think --

CHAIR: Sorry, can I just interrupt you, we're getting little green pieces of paper coming up saying could we please ask you to slow down. I'm very sorry.

A. I'm very sorry, please feel free just to slow me down.

Q. That's all right.

A. Sorry about that.

Yeah. So I think just to give an example, in Christchurch, as you know, I was the only Pacific Māori person there, I was always very keen, because I just came from Samoa to Christchurch and I wanted to learn about Māori culture as well, but because there was so minimal, there was little focus on it during the training, I used to go to their -- they had a Māori Mental Health Service in Canterbury District Health Board and the Māori cultural workers there were called Pukenga Atawhai and I used to work alongside them in my interest to learn as much as I can about Māori culture, Māori history, their world views, how they deal with patients and families.

So I attached myself to the Māori service so that I can learn, so that I'm a better doctor to deal with the patients and their families. Sorry.

MS VA'AI: Thank you. I have to say, Madam Chair, this is normally how our conversations go anyway, us rapidly talking, but definitely we'll be mindful of that.

CHAIR: I know. I appreciate it's really hard when you have a racing brain, it's hard to stop your mouth from racing at the same time.

A. It's totally understandable. It is absolutely true because if I talk -- I don't normally talk like this to my patients, just to other professionals, but when I've got 100 other things waiting for me I tend to race a bit.

Q. Pretend that we are your patients.

A. Okay.

Q. And also we've got the danger of RSI over here for our stenographer if we don't -- if we go too fast as well.

A. Okay, sure.

QUESTIONING BY MS VA'AI CONTINUED: Thank you. So you mentioned something quite unique about Pacific patients is that they include their families and their families come along to appointments. There was a Pacific model that you mentioned in your statement that actually refers to the importance of family and it's the Fonofale model. I'm wondering, Leota Dr Petaia, whether you could share a bit more about how you incorporate the Fonofale model into your practice.

A. Sure. I'm not sure if you've got a diagram there that would make it easier for people to follow.

Q. We do, thank you.

A. Okay. So the Fonofale model was developed in 1995 by Fuimaono Karl Pulotu-Endemann. Fuimaono was the first Pacific psychiatric nurse in charge in Oakley Hospital back in the late '70s. Fuimaono is well respected by the Pacific community for his work and dedication to improving Pacific mental health over the years in this country. Fonofale is the name of Fuimaono's grandmother that raised him before he came to New Zealand in the 60s and Fuimaono utilised the image of the Samoan fale to emphasise specific core values which are important to Pacific people's well-being. These are values that are not really emphasised in the mainstream western medical paradigm that is predominant in New Zealand. So if you look at the fale, and it's great that we're in this fale at this time whilst I'm talking about this, because I use this model to teach medical students about Pacific values.

We start off by looking at the foundation of the fale which is the family. It represents the foundation of life for Pacific people. We heard Luamanuvao Dame Winnie Laban last Monday in her opening statement articulated very well the importance of our Pacific values, our families, histories and genealogies. A strong family foundation contributes to stable mental well-being. In Samoan o lou aiga, o lou faleaoga muamua, your home is your first classroom. It's the place where you first learn how to speak and behave in good manners. You learn respect, reciprocity, love, boundaries within relationships. You're also quick to learn how to behave appropriately around your parents, elders, siblings, uncles, aunts and so forth. All these values and more form one's cultural identity, (Samoan), who am I, what kind of family do I belong to, where am I going in life?

So here we can see how things can go wrong if this family foundation is weak and the family is dysfunctional. We can also understand from this model what happens to children's identity when they are removed from their families at such a vulnerable early age, early stage of their development.

Looking at the posts of the fale, if we start from the physical post, that represents the importance of physical health and I'm talking about, for an example, what affects our body. So if we have diabetes, heart problems for instance, stroke, that can clearly impact our mind and mental health. So they're not separate entities, they are not -- they are -- our physical health and our mental health is inseparable, because whatever affects us mentally as well, the stress, the anxiety, the depression, can also make our bodies vulnerable to diabetes and all other physical illnesses.

So looking at the person as a whole, in a holistic way, addressing both the physical and mental health together makes sense, and I think that's been a mistake in medicine in the past, where we manage mental health over there and physical health over there, and we look at the services, the fragmentation and the silos, it's because of the way we conceptualise those issues.

Spirituality is a core value. That's the other post. It's a core value in the lives of Pacific people, and you can't ignore that. It's important when you are assessing Pacific people to ask them about their religious beliefs and spirituality, it's a source of healing for people. But it can also be a source of distress if your ideas do not agree with the church's ideas and views. So that's all part of a good assessment to do that.

We've talked about mental health problems and "other" that's represented by the last post is about including issues and social factors like education, social class, age, employment, gender and sexual orientation. These are all important when you are assessing a Pacific person in terms of the kind of distress that they could be experiencing from some of these issues. All these factors are encapsulated in the circle, the roof of the fale to promote the philosophy of holism and continuity.

So the -- from a Pacific perspective, the distress in one realm or one domain leads to the loss of balance in the others. Healing and recovery from mental health problems succeeds only if all the domains or pillars or realms of this fale are addressed. The context, time and environment are all important elements. We saw this during the opening here last Monday, where we started off with a prayer followed by a kava ceremony welcoming everyone and Pacific people (Samoan) in an inclusive manner, we felt the warmth of relating to others that day. I observed people looking relaxed and connected with each other and everybody felt more culturally safe in this space to express themselves. So that environment is crucial in terms of assessment, because it also provides therapeutic opportunities to intervene if need be.

The Fonofale model articulates well the cultural values shared by Pacific people. And this is very important when you are trying to engage people in mental health services, because access to care is a huge problem. So there is a parallel process between our cultural values in this formal process of engagement and Pacific people in mental health services if we want to improve access and compliance with treatment, engagement and relationship with patients and their families is key in this process.

Q. Thank you. So together with the Fonofale model, your cultural and clinical experience, what are some of the unique considerations that you take into account when working with Pacific patients?

A. Pacific families are no different from any other family. They too need access to better, efficient, more convenient health services and accountability for results, as promoted by the New Zealand Ministry of Health.

If you look at the Medical Council position statement there's a statement about the New Zealand healthcare system that doesn't always meet the needs of Pacific patients and their families. Even when Pacific patients actively seek care, Pacific people often do not receive the high quality and timely services that they need.

There are socio-cultural values that are shared by Pacific people. We've talked about that. But I think another important point to remember when we are dealing with Pacific people is that we are quite a heterogeneous group of people, we are from 20 different cultures and -- sorry, nations and with different languages, but of course we share some of the values that I've already talked about. So we need to be cautious about using perceived membership of an ethnic or cultural group as a shortcut to acquiring knowledge about individual beliefs, values and needs.

Pacific people's mental health problems are very complex. When they come to hospital they bring a lot of social challenges with them, there's lot of social issues with regards to poverty, unemployment, poor education and especially insecure housing. And these are all contributors to poor mental health outcomes.

There's a lot of structural barriers that Pacific people face when seeing primary care or even hospitals, due to high costs, barriers with language, lack of transport. So these people won't be able to attend appointments. So it's not because they don't understand about mental health, it's just that they don't have transport or they are not able to afford it. So these are significant barriers to recovery and improving well-being.

Sometimes in my experience Pacific people with severe mental illness often prefer to remain under the cloak of the Mental Health Act so that they can access free medication and transport to a doctor's appointments, and that's important in terms of maintaining their well-being.

We've talked about the high rates of physical comorbidities in our Pacific population. It's in general most -- it's not just Pacific people, all people with mental health problems, serious mental illness have problems with physical comorbidities or physical problems like diabetes, cardiovascular, heart problems, high blood pressure, high cholesterol, obesity, complications of alcohol and substance abuse. And this usually leads to poor prognosis of mental illness and low life expectancy compared to other New Zealanders.

I've talked about the language barriers as a common problem. Communication is crucial. It's a major component of the clinical encounter and it's the platform on which patients and clinicians make informed treatment decisions.

One of the studies here in New Zealand showed that over 60% of Pacific people are functioning below the level of literacy required to effectively meet the demands of everyday life.

So that's a really important point to remember when you're dealing with Pacific people, because you've got to simplify things in a way that people can understand, so it's not just translating English pamphlets to patient and their families, you've got to have the language to actually explain things properly to patients and their families.

COMMISSIONER ERUETI: Doctor, can I -- it's Anaru here -- just quickly ask, you said something about patients preferring to remain under the cloak of the Mental Health Act to access medication, I didn't understand that by "under the cloak", is that --

A. So I suppose I've had some concerns with regards to the Mental Health Act, because there's been a lot of talk about repealing the Mental Health Act. But when you're under the Mental Health Act we are obligated to see patients every three months, and if people can't attend their appointments our community support workers will have to go out and bring them to the appointments, and their medications are also free if they're under the Mental Health Act.

So they get worried when they are off the Act because it means they will have to spend money on getting medications and when they do that, there's a high likelihood of them not getting their medication if they're expensive.

Q. Okay. Is this like a community supervision order that you're talking about?

A. It's the Community Treatment Order, that's right, Section 29.

Q. Thank you.

A. Yeah, sorry.

QUESTIONING BY MS VA'AI CONTINUED: I guess just to use your words, Pacific patient being under a cloak, there was a service called Faleola, which I believe you referred to in your statement. What kind of services -- would you be able to explain what kind of services Faleola provided for Pacific patients in need of mental health services?

A. Yes, I suppose I used Faleola as an example, because it's the only Pacific service that I worked in in South Auckland and I thought it would be good for us to understand some of these issues using this case scenario. So Faleola was a Pacific community mental health service that used to be part of Counties Manukau District Health Board in South Auckland and I had the privilege of working at Faleola as a psychiatric registrar in 2012. The service was established to provide care for Pacific people with serious and severe mental health problems. They usually have very complex needs, including history of being in State care, they're usually young men, immigrants from the Pacific Islands with very poor English. They are often unemployed and have very limited education. And as a result of their illness they're usually alienated from their families and friends, they're very isolated, sometimes homeless. And illicit substance use is rife amongst these patients, to cope with pain and trauma, exclusion and deprivation, often leading towards repeated escalation of criminal offending and incarceration. So that's the population of patients that was under the service. So I was working with them in 2012 and I observed how they work. I'd just come from Christchurch for instance, I'd just finished part of my training, this was my last six months and I worked there, and I observed how they were working, and they were working with -- from this holistic model as stipulated by the Fonofale model. The staff consisted of mostly Pacific mental health clinicians, though there was a Fijian Indian doctor, Dr Andrew Sumaru as a doctor, and senior psychiatric nurses were there, they were Samoans, Cook Islands, Niueans, very experienced, very dedicated nurses.

We also had lots of social workers, occupational therapists and a psychologist, and there were senior cultural workers in this team and the service was -- the assessments of patients was usually delivered in patient's respective ethnic languages and that was quite important. And the team worked very well in terms of looking after this vulnerable group of patients. Their main strength was in engagement of Pacific patients and their families in a Pacific way. So for example, they use -- their use of language as we've talked about, they always start off with a prayer, so that spiritual aspect of care was important in their whole assessment and management of patients. They carry out their work mostly at home, so they do a lot of home visits and that was my opportunity as well to go out to the families and meet patients and it was really important because we all tend to see where people live and their lives out in the community.

This type of work though was quite hard because it requires a lot of collaboration with families and community workers and it required a lot of time and effort, and commitment from staff and management. But when it works very well, you can save a whole lot of time in the long term.

In the community when you care for patients or people with very complex issues, continuity of care is so crucial because you have to have time to develop rapport and build genuine relationships, so it's about quality relationship with patients and their families. That's what you call good therapeutic relationships. And they are key components in recovery and rehabilitation.

So these, the staff at Faleola, because they were working in a critical mass, they were able to support each other very well. They share the same philosophy of thinking and understand the concepts when they discuss patients and families in team meetings. And it's about empowerment, empowerment of staff to actually be in control of that work and take the lead, and also empowerment of families in terms of educating families about the nature of mental health problems and the rationale behind treatment. That requires time. You can't rush that process through. You've got to build the relationship and be able to do this work properly. Only then patients will be able to access and want to access services. It's about trust. It's about people delivering the service, whether you can trust them or believe what they're saying, and also bringing it in the context of Pacific ways of thinking that we've been talking about.

CHAIR: Can I just ask you before you go on, what was the case load there? You had -- did you have a single team or did you have multiple teams and how many patients, how people were you caring for roughly?

A. So that was one team. It was a clinical team with cultural input, that was basically the philosophy behind this team, and the workload was huge, and I think that went towards the outcome that happened in the end when they closed it down, because the workload clinically was too much for everyone, because the staff, there was very few staff, but the number of patients at that time was about 150, 200 patients for one doctor, and it was just -- I guess that's why I had to leave quickly because I needed to gain more experience as well, and I was just feeling overwhelmed and needed help to support the team, I suppose, if I do more training and get more -- recruit more staff was my thinking at the time.

I think the cultural, then, the cultural aspect of the service was overwhelmed by the clinical demand of the service, because of the amount of the number of people that required care.

So if you think about schizophrenia for instance, if we have 1,000 -- 100,000 people in South Auckland for instance, the prevalence for schizophrenia is about 1% in a community. So you're looking at 1,000 people. There's no way a community Pacific service will be able to cater for that. So we ended up taking the most extreme cases.

Q. Which undermines what you said earlier about early and effective intervention?

A. Absolutely. I think that helped -- that's helpful to put it into context, I think the worsening of mental health for Pacific people.

Q. It must get harder to cure the longer it is, it just makes sense, doesn't it?

A. That's right, yes.

Q. We'll probably come back to this because I think we'd be interested to know later what you think would work, but we'll come on to that later.

A. Sure.

COMMISSIONER STEENSON: Sorry, can I just follow that with a question?

A. Yeah.

Q. So was it due to, or was it a combination of the lack of resourcing or people with the skill, when you were saying you were overloaded?

A. It's the lack of resources and lack of workforce, it's both.

Q. So a combination?

A. A combination of both, yeah. So we were fortunate, because I think we'd come a long way, the fact that we had doctors and nurses who are Pacific -- Pacific doctors and nurses and social workers in one place was great to start off with, but the numbers was very small, they weren't able to cater for the need, yeah. And of course the resources is a major thing. Especially when you're working with systems that don't really get the idea that this is how this cultural service should work. So there's a huge conflict.

Q. And the time and effort that it takes?

A. That's right, yeah. So it really required management services to understand the type of work that they were doing. That didn't go very well because of the difference in values and perspectives in the kind of services produced and what's expected, and you can imagine the conflicts that arises in that kind of context.

Q. Because developing relationships take a lot of --

A. Time and energy.

Q. Which isn't always valued in different cultural...

A. No, because in most health services, not just mental health, health services is about bottom lines, money, numbers.

Q. Transactional?

A. Yes, yeah. So there's a huge conflict there that needs to be bridged.

Q. Thank you.

A. Yeah. Thank you, I'm going slow, right?

QUESTIONING BY MS VA'AI CONTINUED: You're doing great.

A. Thank you.

Q. I'm wondering if you could please share about what was the impact of Faleola closing on Pacific people needing mental health services?

A. I also brought this example up for that very reason in terms of talking about the transitions. There's a lot of transitional points from one reform to another, and the risk is that families and patients always fall through the cracks and more so Pacific people. They're vulnerable, they're mostly disadvantaged. So when there's -- when there's always a change, Pacific people are the ones that always get the brunt of it. So for instance, we are still struggling from the reforms in the 1960s in mental health services in terms of de- institutionalisation. And we're still struggling with that and a lot of these people in the community now have been managed under these kind of services. So Faleola was overloaded by these difficult and complex patients, and the staff were -- I mean, they were trained but ill-equipped to deal with this kind of complexity on their own. They did the best they can but they just couldn't manage with the demand of the complexity.

And this establishment of Faleola also highlighted the differences, as I've explained, of the expectations of services and the way the services should be working to manage the needs of Pacific patients that were under this care -- under their care. So I think, to answer your question in terms of the impact, the impact was huge, because the closure of Faleola and the dispersing of Pacific mental health clinicians into the mainstream meant that the cultural philosophy was then diluted hugely. So I'm not sure what's actually happening at the moment but I understand, because I do catch up with a lot of these staff members from time to time, most of them have left and that's the risk of change as well, you lose a lot of experienced Pacific workers.

So there's also the issue about institutional racism as well, because if it's resource issue and you're looking for cost cutting, possibly that's the way to probably save more money was to close Faleola because it was probably more costly from their perspective. So institutional racism played out in the health sphere is something that we commonly see in mental health and it's the collective norms and behaviours within organisations that systematically and unwittingly discriminate against those from minority ethnic group leading to inappropriate care and insensitive practice resulting in dissatisfaction and disengagement.

Q. Just building on from the systemic issues that you've just outlined, when we're looking at how to communicate effectively in allowing information to be clearly understood for Pacific patients, in your clinical experience what are some of the challenges that you've identified when working with Pacific patients?

A. There's a lot of challenges, but I'll just highlight a few key issues that are important. Pacific people often present in a very delayed stage. Because of the stigma, they don't access services in a timely manner. So they usually come with complications, and it's due to many factors. We've talked about the issue with cost, transport, the barriers with language, but a lot of these people also have very bad experiences with mental health services in the past.

Some of the challenges is the whole engagement process that we talked about. If people attend services and see doctors and they feel rushed and not engaged in a process that makes people feel welcomed then of course people are not going to be able to engage very well, they're not going to be able to open up about their mental health problems. These are sensitive issues, they've got to have time to discuss things with patients.

So because they present very late with complications, their prognoses are very poor and they used to stay longer in hospital and that's a huge cost to the system as well. Like for instance, in forensic services, we experience identifying a lot of these Pacific people with mental health problems or illness after they've been convicted and sentenced. So they are not recognised earlier on in the process, a lot of them end up in prison.

So there's a lot of systemic issues in terms of poor engagement with clinicians. If you imagine primary care, there's always a lot of time pressure and we have this concept that we call "Don't ask, don't tell", so it's quite common in these circumstances where people feel pressured with time. So this can result in misdiagnosis, and increase in medications to manage distress that probably would have not needed medications to deal with it. So if only you have a lot more time to discuss things with people.

So the other major issue I wanted to raise was the complication with alcohol and substance use, but I'll probably talk about that a bit later. But I think, if I can just take this moment just to use a real case scenario to illustrate some of these key things that I've just talked about. So I've already asked my patient if I could talk about this and he's very happy to, but I'm going to use a different name for his own -- for confidentiality reasons.

So I was looking -- I was asked to see a young Tongan man. He was living in South Auckland with his aunty. He had a severe bipolar affective disorder for many years. But at this time he had a serious episode and he was required to be admitted to hospital. And he was in hospital for about six months, in and out of hospital, they discharged him to residential care because he just couldn't be managed by his family at home. He was getting worse, he was on a whole host of medications he was refusing to take, and I understand because it's probably he was experiencing a lot of side-effects and we heard a lot of that from Rachael's evidence.

So I was asked to go and see her -- him by his Pākehā nurse, because she was very worried that he was getting worse. So she asked me in the morning to go and see him. And I studied the notes, I read through them and I could see the complications and the difficulties for the last six months, doctors were struggling to cope with him and the staff were not able to manage him in acute inpatient at all.

So I understood from my cultural background being Tongan that the aunty has a very special and significant position in a Tongan family structure. So a fahu as they are known in Tonga, is the father's eldest sister and she's accorded the highest level of respect within a Tongan family. So I decided to go and see her. So we went early in the morning and the Pākehā nurse was saying to me, "Are you sure we can go directly there at home?" I said, "Yes, I think we should", because I was worried that if I ring up or somebody makes contact with the family with all their bad experiences in the past there is a likelihood they will decline us coming. So we arrived at home, knocked on the door and the aunty -- we were lucky, good timing -- opened the door. It wasn't just one aunty but two aunties and a whole lot of relatives around the house that they were all -- they were all curious to know who this doctor was visiting their home. But they were having breakfast at that time, they welcomed us, so already it's a welcoming, inviting environment, so I'm referring back to the Fonofale model as I'm talking about this case. So the environment was just right, good timing, the family were there, and I was there, I spoke Tongan to them, so already fofola the fala before any medical engagement took place.

So we had time to talk about what has been happening and I had to listen first to their story of the last six months and how it happened, what happened, how it impacted on the family, and they were very concerned about him, they were talking about how they really wanted to have him home but just couldn't cope because his mood was all over the place.

So I had time to talk to them about the importance of treatment. I also had time to explain to them why he was refusing treatment. If you were on five, six medications at the same time, clearly you would be feeling so sedated and not able to concentrate. He was talking about really nasty side-effects that made him not want to take these medications. So because of the time, the environment, the language, and the fact that they were in their environment, they were in control, they weren't in my office where I can talk professionally most of the time and I always fear that that wasn't the right environment for most Pacific families. But in this particular environment at home we were able to discuss a lot of things that we would not have been able to discuss in the hospital.

So I asked him if they could come with me to the hospital to see Sione with me and they all came and Sione came willingly to see them because he thought that he's coming to see his family. Most of the time doctors go to see him he would refuse, wouldn't want to see anybody. So when he came in, he saw his family and I've never seen him like that before where he respected her and talked to her in a very respectful way. And the aunty turned to him and said, "Look, we've got this doctor here with us and I want you to listen very carefully to her."

So the rest was history because I was able to then describe the need for treatment and the need for follow-up in the community. I was able to explain the side-effects and why he was feeling like that. But at the end of the day, what he wanted was to go home. So if he gets the treatment right, he would be able to go home and live with his family. So he got the right treatment, the right medication, there's no such thing as safe medications, only safe clinicians who can prescribe what's needed, the minimum dose that is required to keep people well clinically but it was delivered in a cultural way so that the family can accept it and Sione can accept it.

He went to work full-time and living with his family. So he could understand, "If I get this medication, it's treatable, I can be well and be back with my family." And then he was followed up by the mental health team regularly, and that's really important so he doesn't relapse and re-admit back again and again and again. We can prevent a lot of that, by involving the family. Because if I want to know something, I'll ring his aunty, I won't ring Sione because he won't tell me, he would probably not tell me about the side-effects and things because he might be worried I'll be increasing more medication and give him more treatment, but through the aunty who he respects really well, he would listen to her.

So those are just some of the examples that we can talk about in terms of illustrating cultural values and clinical values in improving outcome for Pacific people.

Perhaps if that had been done much earlier on in the piece that would have saved a lot of cost to the hospital, but more so trauma to the patient and the family, they don't need to necessarily have to go through a whole lot of 10, 11 admissions as we've heard Rachael talk about today. So I'm not critical of any of my colleagues or anything, I'm just trying my best to illustrate some very complex issues in a way that we could understand to improve care for Pacific people.

Q. Thank you. Your patient got the right treatment, the right medication, sounds like also the right doctor. Another significant issue that you highlighted earlier in your statement, and also just earlier today, you've wanted to highlight the importance or significance of alcohol. Can you expand on how this issue affects Pacific people in need of mental health services?

A. I'm just looking for my notes, just give me one sec.

Q. Take your time.

A. I think I wanted to make special reference to alcohol use as an example in terms of complicating factors with mental health problems. It's really, really hard to treat mental health problems when it's complicated by the use of alcohol and other substances, and I'm talking about elicit substances.

So in the He Ara Oranga most Pacific people perceived alcohol use to be the main driver of poor mental health outcomes for their community. This is them reporting about alcohol, it's not what I'm saying.

So the Pacific people in the He Ara Oranga report, that inquiry, expressed concern about the ease of access and harmful effects of alcohol, in particular noting the potential for social harm if not tightly controlled. The report specifically mentioned how alcohol use fueled people's depression, anxiety and suicide; how they triggered violence and neglect in children. Family violence they talk about. And the Pacific people called for decisive action limiting the sale and promotion of alcohol, particularly -- sorry, limiting the sale and promotion of alcohol, particularly around children and young people including sports sponsorship.

So Professor Doug Sellman, he is a professor of Psychiatry and Addiction Medicine in the University of Otago, he was one of my teachers in Christchurch, I was curious to know what he was saying because he has been actively involved in dealing with people with alcohol and addiction problems. And this is what he said, I want to quote it because I think he said it perfectly well. And I quote, "The Government appears to be completely ignoring the following recommendation of the Mental Health and Addiction Inquiry to take a stricter regulatory approach to the sale and supply of alcohol informed by the recommendations from the 2010 Law Commission Review, the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship, and the 2014 Ministry of Justice Report on Alcohol Pricing. Raising the excise tax on alcohol is the easiest and most effective evidence-based measure the Government can undertake to reduce alcohol-related problems and has been shown to be supported by a majority of New Zealanders. To not act at this time with robust alcohol law reform, in particular substantially raising the excise tax on alcohol, risks reducing this Wellbeing Budget to a set of platitudes. But even more concerning is that national, international evidence, formal recommendations and majority of public support is being ignored. The power of the alcohol industry lobbying of our Government becomes apparent, and this power to subvert alcohol law reform risks making a mockery of democracy and continues to undermine the reduction of alcohol-related misery and suffering in favour of the greed of powerful vested interests."

As a mental health clinician we encounter harm caused by alcohol and other drugs every day. It is a contributing factor to poor physical health and mental health and alcohol law reform is therefore one of the most effective way to improving well-being for Pacific people, and all New Zealanders for that matter.

So if the Government's desire and political direction is one of improving well-being and reducing high suicide rates in New Zealand, then considering reducing harm caused by alcohol must be considered as one of the top priorities, especially for a vulnerable population like Pacific people.

Q. Thank you.

MS VA'AI: Madam Chair, I'm wondering whether this might be an appropriate time to take a break.

CHAIR: I think so. Time for a cup of tea, everybody. We'll take 15 minutes.

MS VA'AI: Yes, thank you.

Adjournment from 3.31 pm to 3.49 pm

CHAIR: Thank you, Ms Va'ai.

QUESTIONING BY MS VA'AI CONTINUED: Thank you Madam Chair. Just before the break, Leota Dr Petaia shared some of the challenges of working as a Pacific psychiatrist working with Pacific patients. Now we're going to turn to addressing some of these challenges.

Leota Dr Petaia one of our survivors spoke about the stigma around mental health just this morning. Can you share your views in response to Pacific families that may not be aware of the help or support available to them?

A. So we probably think about addressing some of these challenges that Rachael, of course, mentioned but many of our survivors have been experiencing. So I think thinking about the Fonofale model in terms of providing care in a holistic manner is crucial for mental health, for Pacific mental health. Thinking about the values incorporated in the Fonofale model in terms of assessing people's mental health, physical health, the family dynamics and the relationships that's going on in the family, spirituality, the social context of these people is so crucial in understanding the totality of what people are struggling with. You can't treat a lot of these things with medications, got to ask them, talk to them and usually some of the times they come up with their own solutions and you are there to facilitate the process and assist them or point them into the right direction in getting the actual help that they need. So the Fonofale model is crucial.

Family education is crucial. Because knowledge is empowering for people. If they know that illnesses can be treated, if they understand the side-effects of medications, they are more likely to engage with services. Community understanding of mental health and illness is key in changing attitudes towards mental illness. The focus of mental health education should be on early identification of disorders and disease and knowing where to seek help sooner rather than later. So we've all been unwell and sick, and when you are feeling unwell and sick you don't want people talking about other things that are not of interest to you, you just want to know who do I call, where do I go, and who are these people that are going to help me.

So people have the right to access treatment in a timely manner, and when they do access services, they have the right to be treated by somebody that's clinically competent and culturally aware of the values of this person. It's a human right. New Zealand has also a code of health and disability services, consumers rights, right to be treated with respect, right to freedom from discrimination, coercion, harassment and exploitation, and the right to dignity and independence.

I think it's a really important point to not get stuck with models. It's not about the model, it's about how you understand the model and how you can apply it in an appropriate way to improve outcome. So it comes down to proper training, both clinically and culturally. Because you don't want one or the other, it's both, and you need to be competent in both of those aspects. Because you don't want to be focused on cultural values so much at the expense of the clinical treatment that people need. And the same goes with clinical treatment, you can't just blindly give people medications in the hope that they will become well and stay well. You've got to make sure that you engage people in a longer process to explain symptoms and explain treatment and monitor for any side-effects. There's a whole raft of medications that's available and you can always switch from one to the other or adjust the dose if people are not feeling good or having a good experience with their treatment. That requires time and genuine effort in engaging patients and their families.

So mandatory cultural training is important. I have been clinically trained well so I'm sure people should be engaged in good cultural training in the medical profession, not just doctors but nurses, social workers and cultural workers as well. We don't want Pacific people in mental health services just because they're Pacific and can speak the language, they need technical and good knowledge of what they're dealing with. And I've seen lots of people who are so good in managing distress. So if we look at Rachael's case today, she was talking about a lot of social stresses, about relationships, about family fa'alavelave's I'm sure that our own Pacific people are very familiar with.

And a lot of our Pacific mothers, and I see a lot of them who work in the community who are doing a fantastic job with our Pacific people. That kind of work does not require a psychiatrist. I can provide support where I can, but it's that kind of support, love and nurturing that's important for our people, and we've got the resource in the community amongst our Pacific community if we can just give them a bit more training to understand the risks and what's required and I'm sure they will be able to offer proper support. But we need a good system to make sure that the risks are contained.

Yes, I think that's -- has that answered your question Reina?

Q. Perfectly. Just thinking about systems as you've just mentioned, and the training required, both clinical and cultural competency, if you were to build a clinic with culturally competent and clinically competent people, what would this clinic look like?

A. I think before I speak about what it looks like and the workforce that's required, it's really important that we understand the problem and the needs before we address them. So in terms of mental health, the most, I suppose the most credible study or the most important New Zealand mental health survey that was done in New Zealand was the Te Rau Hinengaro. It was the First National community-based epidemiological study to investigate the rates of mental disorder and consider the severity comorbidity of mental disorders and help-seeking behaviours reported by ethnicity. So it's the only study that has any specific reference to Pacific people. And what that study highlighted was the high prevalence of serious mental disorders comorbidities in Pacific population.

So for instance, 24% of Pacific people experience mental distress compared to 19% of the general New Zealand population. Yet only 25% of Pacific people with mental illness received treatment from addiction and mental health services compared to 58% of those with mental illness in the general New Zealand population. So that's just to highlight the poor access despite severity and comorbidity in people with mental health problems.

The other important point that they found in this study is if you were born in New Zealand you have a two-fold increased prevalence rate or risk of developing a mental disorder compared with only 15% of Pacific people who migrated to New Zealand after the age of 18. So there appears to be a higher risk of developing a mental disorder if one was born in New Zealand. So migration is great for many things, but probably not for your mental health in general.

There's a lot of speculations about that, but I think it just requires more studies to work out the issues with regards to that. I guess the point there is the services must ensure that their approach takes into account the diversity of Pacific groups and provides services that are appropriate for all Pacific people.

The other important point that we need to remember also at this stage, we are all aware of the He Ara Oranga report and the inquiry into mental health because Māori and Pacific mental health is getting worse despite the funds that have been poured into mental health services over the years.

I think one of the things that I notice also in Pacific mental health services as well as Māori mental health services, is that inverse care law always prevails so that those who are most in need gets the least access to services. Sir Michael Marmot, Chair of the World Health Organisation Commission on the social determinants of health summarised it very well, I quote:

"The toxic combination of bad policies, economics and politics is in a large measure responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible. Social injustice is killing people on a grand scale. The Government needs to understand the needs of our Pacific communities and allocate the appropriate resources to improve mental health literacy, prevent poor health at the community level and these programmes should largely be led by Pacific mental health clinicians using their respective languages to engage people better."

Pacific people are over-represented in acute mental health services and forensic services. We are very vulnerable and can develop serious mental illness with a lot of stress that people experience, and I've noticed in prison when Pacific people are -- there's quite a lot of them with severe mental illness that ends up in prison. The problem is that we can't treat them in prison and they're left untreated for a long time in prison and that's unethical and a violation of these people's human rights. We don't have enough acute beds in hospital for these people, so they wait in prison for quite a long time.

There are inadequate rehabilitation in communities as well. And this results in a vicious cycle of people not treated properly, they become non-compliant, they use drugs to cope most of the time, leading to re-admission to hospital and potential re-offending leading to imprisonment.

So I suppose in terms of developing mental health services I've been trying to highlight the complexity and the need to have multi-disciplinary professionals who are well-trained clinically and culturally. So it's a true integration of these concepts in terms of managing people, it's a broad understanding of people rather than just a medical western kind of monocultural system. They're complex problems that requires a good understanding of people's lives, not just an illness or a disease. We are talking about a whole lot of other social factors that are impacting on people and they find it very hard to recover when they don't get that help.

So we need doctors, of course, nurses, social workers the, all the social issues that we've been dealing with, housing is a huge one for people with mental health problems. We need occupational therapists, because of functioning, people can't function very well when they are mentally disturbed and they require good skills to retrain them to go back to work. So occupational therapists are very important people and also psychologists. I have a lot of respect for psychologists and it's great to see some of our own Pacific psychologists now coming through that are addressing some of these difficulties. So having a quality team like that and the right resources to provide the services that's required by people I think will go a long way.

Q. Thank you. Do you have any ideas about how we can ensure that health professionals looking after our Pacific patients are trained effectively, both clinically and culturally?

A. The New Zealand Medical Council has recognised for years now that the cultural misunderstanding and unconscious bias, so we've been talking a lot about this bias which is really about racism and discrimination of patients in the system, and this have contributed to poor state of health for Pacific people. So the New Zealand Medical Council has this Health Practitioners Competence Assurance Act 2003 which reinforces the importance of cultural competence by stating that health professionals are to set standards of clinical competence, cultural competence, including competencies of course that will enable effective and respectful interaction with Māori, and ethical conduct to be observed by health practitioners of the profession.

Our college as well, the Royal Australian and New Zealand College of Psychiatrists when I was looking up what they were saying about the Commission of inquiry outlined a whole lot of important key messages which I'm just going to mention five of them because I think it's really important for this Commission.

So the College acknowledge the ongoing impact of past mental health practises and commit to learning from them with continued vigilance of current practices to prevent harm to the people with a mental illness and commitment to including in the core psychiatry training programme or curriculum relevant facts about past harmful practises and evidence of their ongoing impact.

Psychiatrists need to commit to developing strategies to reach out to communities which may still feel the impact of past harmful practises and continually improve them by establishing close relations, dialogue and partnership. They need to commit to equipping psychiatrists to be sensitive when dealing with patients affected by harmful practises in the past and to understand the consequences of traumatic memories in the present.

Psychiatrists are expected to show leadership, empathy and understanding regarding past harmful practises and to support any healing initiatives. They need to encourage people to openly discuss and acknowledge the past without any thought of retribution or litigation. A whole lot of these information and more can be found online. The regulations on upholding cultural competence as you can see has already existed in the health profession. Ensuring commitment and consistency to cultural competence training requires collaboration with Pacific and Māori Health professionals, and mandatory completion of relevant training.

So in a way a lot of these things look very nice on paper, we've heard a lot about these kind of important ideas about how to improve health. But the key lies within implementation and how we actually put it into action. I don't see much of that, so there's a lot of good ideas, but what does it look like and how are we going to implement that.

As I've said about the medical students, no-one will take cultural training seriously if it's not mandatory and becomes part of any formal curriculum training that starts earlier in medical schools and maintained right throughout continuing professional development. So all doctors in this country get funds for continuing medical education and we travel around the world for conferences and things like that. I think that some of this fund should go into cultural training for doctors, I think, if we are true to what we're trying to achieve today.

I think I also need to just acknowledge that there has been some effort going into it, and this is the kind of discussion that we are now having with the universities of Auckland and Otago. So I'm meeting with Auckland this -- in the next two weeks and Otago at the end of the month and this is the message I'm delivering to them that I will continue to do it if they're going -- if it's going to be part of the formal training curriculum. Because I just feel that every year they ring me to come and do some lectures, but I didn't really feel it was going anywhere, you are wasting people's time, wasting my time and it has to be formally done in a way that is consistent. And I am aware of a lot of Pacific people that can actually help do this training. Thank you.

COMMISSIONER ERUETI: Doctor, can I ask, that statement is from the New Zealand Royal College of -- who was that statement from? Psychiatrists?

A. Yes, that's right, it's the Royal Australian and New Zealand College of Psychiatrists. I was very pleased that they had the statement for the Commission of Inquiry.

Q. I did notice that there's lot of emphasis on past poor practises. It's something that happened historically rather than there being contemporary issues, for example?

A. **[Nods]**.

Q. Or even unpacking what those past practises may have been. It's stated at a very broad level of generality without any particulars in the statement, did you sense that as well? Did you have any concerns about the generality of the statement and acceptance of prior poor practice, or whether they were ongoing?

A. I'm sorry, I didn't quite get the question, can you repeat that for me please.

CHAIR: Can I frame it, I've got a similar question, tell me if I get it wrong. It seemed from your evidence, but I'm not sure if I've got it right or any of us understand this yet, did the Royal Society of --

A. The Royal College.

Q. Royal College come up with this list that you've referred to as a consequence of a response to the Royal Commission?

A. That's right, they actually outlined it specifically for the Royal Commission of Inquiry, because I was quite --

Q. So they were framing it in terms of the historical -- of us looking into the historical things?

A. That's right.

Q. That's the reference to past harmful practises?

A. Absolutely right, yeah, that's correct. So yes, it's in relation to the work of the Royal Commission of Inquiry, so it's encouraging its members, which is a good thing and that's why I wanted to list it down there that if anyone looks at my statement I'm not saying these things, this is what you said, now you need to --

COMMISSIONER ALOFIVAE: Do it.

A. Do it, yeah.

COMMISSIONER ERUETI: Also just for me to be more explicit about what those harmful practises were in the past and own them.

A. Whether they own the --

Q. Let me give you an example. You've done a great job of emphasising the need to balance the clinical and the cultural approach, so I think one of the core concerns for a lot of submissions made to the mental health and addiction inquiry was that there was too much of an emphasis on the clinical approach to treating patients including Māori and Pasifika. So perhaps that's what they mean by prior practises about placing undue emphasis on medication?

A. Absolutely.

Q. Yeah, okay.

A. Absolutely. I think we've come a long way, and even them listing down these important things that psychiatrists should consider when they see patients who have been in State care, for instance, that they are obligated to do good assessments in terms of acknowledging the harm and trauma in the past, and make sure that they do what's right for patients now. So it's acknowledging what has been happening and looking forward in terms of integrating good care to ensure that these people are not only treated properly, but have good rehabilitation so that they can recover, and live a normal life. And they can in a proper service where you care for people properly with good treatment and using their families and the support services around them in their own local environment. People thrive in that.

Psychiatrists need to understand that that's equally important when you're managing people. It's not just giving them medication, then leaving them to just take their medication and not want to see them sort of thing. The idea is continuity of care where you're right there beside them with the whole team, I don't need to see people all the time because of the amount of work that we need to do. If we have a good team that I spend like an hour on a weekly basis to talk about their work and support them, they are empowered and confident to go out to the families and talk with them on an ongoing basis, and by doing that you're developing quality relationships with people so that they can engage better. And so when they relapse, for instance, they've got this the person, not a telephone conversation from somewhere, very impersonal kind of message from somewhere over there. We want people that we can -- it's face-to-face, "I know you, I can call you when I'm in trouble."

And if people understand those warning signs that they're starting to become unwell, that's the whole education you give to the patient and the family, this is what needs to happen when you're feeling like this, this is who you need to call, you can prevent a lot of those re-admissions, unnecessary re-admissions under the Mental Health Act because people have been unwell for quite a while and nobody really knows what to do.

The difficulty with mental health problems that I really need to emphasise is that physical problems, for instance if you have acute abdomen, acute pain you won't hesitate to pick up your son or daughter, whoever in the family put them in the car and go to the Emergency Department, you won't hesitate. But when somebody is not sleeping well, not behaving well in a manner that they normally do, it's like they put it down to maybe he's just tired or not happy with things. You need to get an assessment to make sure that you're not overlooking things that are going on now, you don't wait. The key is early identification and early treatment in a timely manner so that it doesn't get prolonged and get complicated to the point that when they come to mental health services, they end up in seclusion because they've left it for far too long and they had no choice but to put them under the Act and admit them to hospital.

My concern without the Act, the Pacific and Māori people will have the unintended -- we will have the unintended consequence of delaying further treatment. The Act is -- if we use the Act appropriately to ensure timely treatment now, then we will be able to get that acute care immediately. Otherwise people will miss out on acute treatment, because they will not come to us quickly for help.

Q. Yeah, no you've presented an informed by wealth of experience, articulate case for the need to -- for this new approach. It's interesting with that statement by the Royal College of Australasian psychiatry, or whatever they're called, that it seems to be a historical problem of the past, when in fact of course which is clear today, it's an ongoing issue about how you care, and it's getting the appropriate mix of clinical and cultural methods to support the person and their whānau.

A. Yeah.

Q. Yeah.

A. I think there's very good recognition of the fact that we can't go just with the clinical aspect of things, we have to recognise the importance of our culture, our values and our families in this whole process.

Q. Thank you.

CHAIR: I'm going to interrupt, we've taken over I'm sorry.

MS VA'AI: Feel free.

CHAIR: It's so engaging. My question hits right on this point. You will be aware, Doctor, that our terms of reference require to us look at incidents of abuse in care.

A. Mmm-hmm.

Q. And that means that people who are in care and that's children, young people, vulnerable adults and it includes people who are held either voluntarily or compulsory in mental health units, institutions. The question is, what is abuse and I'm going to put the question bluntly to you now. Do you think that the failure to provide any form of cultural recognition, appropriate treatment, appropriate engagement with Pacific people is a form of abuse?

A. Absolutely, yes. I've tried to highlight the key issues in Pacific people's well-being. We started with looking at the Fonofale model, the importance of family, relationships that forms their identity, and language. So when these people are taken into care, they have no connection to their families anymore, to their identity, to their language, and if you go into a service of people that speak a foreign language, how are you going to engage with them? How do you get help from them if you were supposed to produce help or give them help?

Obviously you need to have the means of communication to be able to engage with them and make sure that they get better or get the help that they were there for in the first place. But not having those cultural values there with the clinical care is meaningless, because people don't exist in a vacuum, they belong to some family or village or community where they've come from. And that's crucial to their well-being, they belong -- they have a spiritual health as well that needs to be acknowledged when they are away from their families in those -- in hospital, for instance. So when you go into hospital, it's really important to engage with people by starting off with a prayer, it makes sense, people do that all the time at home. So why is it that they go to hospital, they detach from that? Because if that forms up your mental well-being which does affect your physical well-being, then the cultural aspects of care is fundamental to Pacific people.

Q. Thank you, you've answered my question.

A. Thank you.

Q. Back to you.

QUESTIONING BY MS VA'AI CONTINUED: Thank you Madam Chair.

Just finally, in light of your comments about effective and genuine implementation, what are some of the key things that you would like to see happen for Pacific survivors and communities in mental health, keeping in mind obviously that mental health is a very complex concept as you've laid out.

A. Yes, there's a lot of things but I just want to highlight maybe five key points, and we've stressed the importance of cultural care, understanding of Pacific cultural values in order to provide good service together with the clinical care. And to be able to produce such a service is about having the right people there, the workforce is critical to any service. You can't have a workforce with untrained, unskilled, incompetent people to carry out complex work. We are dealing with complexity, and you need people that are well-trained and skilled to be able to do that.

I want a service that my own family and my own people, my own loved ones would use, I would like to encourage them to use because I have confidence that when they go there they will be cared for appropriately. So workforce is important, staff training is important and the concepts that I used, cultural and clinical both are really important. You can't just manage people with culture as well without having the right treatment to be able to treat their underlying illness.

A lot of people have thanked me about the medications that they have. I hear people saying "Look I've got my mother back, I've got my son back, because he's been well-treated." And a lot of my -- I have a lot of good colleagues, they're not -- I mean I'm the only Pacific doctor in that service, but any well-trained professional has an obligation to treat people properly, and treatment is not just about medication, it's about understanding people from a broad perspective that we've been talking about, it's an obligation.

So it's a real shift, a shift from a monocultural, western-based illness approach to a values-based approach stipulated by the Fonofale model, and incorporates broader understanding of people. It's not just about getting a diagnosis, it's important to have a diagnosis but it's about understanding why and how people were unwell at this point in time and what it is that we need to do now, because if you have a good assessment it will inform good management.

So that's one thing. The other thing is the complexities that we've been talking about. So we've talked about physical problems, social determinants, alcohol and drug use. You can't just treat mental health without addressing those issues. So we need to address social disadvantage, for instance, because that's also addressing health inequity and health disparity that Pacific and Māori equally suffer from.

The other most important thing as well is education. Of course we all know the key to preparing young people for the future in terms of careers is to have a strong education. We need to ensure the health and safety of our children as they grow up within our homes, and that requires responsibility of our families as well. It's not just the Government and services and other people. Children grow up in their home environment, so we need to focus on that in terms of teaching respect, language and all these other values that we've been talking about. So we do have a responsibility as well.

Mental health is very complex, but if we all work together starting from healthy environments where children are nurtured, safety is priority, like we don't abuse our children, that will automatically reduce mental health problems in a way, if people are -- children are safe.

There has been a lot of funding as we know that has gone into mental health. We have heard about millions of dollars that's going into Pacific mental health and that's a great thing. And I also want to acknowledge a lot of Pacific people that have already done or are doing a lot of good work for Pacific health. But I think it's really important that we have effective monitoring system to track these funds, where is this money going, who's been spending them and what have they spent it on? And it's about accountability.

And it's also good because the Government then would be confident to give us more money for Pacific services if we are showing good outcomes from our services. And these outcomes are actually improving the system, because if we continue to do the same thing in the last 20 years, we are not going anywhere. So we need to evaluate and clearly see for ourselves what's working, what's not working, and build -- we need to communicate through data, proper collection of evidence to show what's working well for Pacific people.

It sounds quite demanding in a way, everything that I've been trying to say, but it's only then, it's only having systematic systems that can be reviewed and evaluated properly and documented properly that provides good evidence. So we need a good platform to work from. And then we can then only improve our services, I suppose. That's my vision actually, but yeah, I think that's basically some of the key issues that I've been thinking about.

But to finish off, I think it's about having courage and leadership in these Pacific services that we have to ensure that our people are well taken care of, and some of these abuse and challenges that we've been facing for years is actually being addressed properly.

Q. Malo le saunoa malo aupito fa'afetai tele lava i lau afioga Leota Dr Petaia mo le faaavanoaina o lou taimi. O se mitamitaga foi ia i matou lou afio mai aemaise lau saunoga matagofie. Faafetai lava.

A. Thank you.

Q. I will now hand you over to the Commissioners, I'm sure they might have more comments or questions.

A. Oh, I thought we were finished.

CHAIR: We're only just getting started. No, I'm going to ask my colleagues if there are anymore questions that they'd like to ask.

COMMISSIONER GIBSON: Thank you Leota Dr Petaia, really appreciate the courage and leadership you've brought to this issue and the thinking around, in particular, the cultural component. Going back to our contextual hearing, one of the witnesses, former mental health commissioner Mary O'Hagan talked about the need for both cultural education but to really transform the workforce that actually her vision, the mix needed to be something like about one-third traditional clinical workforce, about one-third cultural workforce and about one-third the consumer lived experience, lived mental health, psycho-social, disability experience workforce, but of course recognising there's big overlaps between all of those.

I suppose maybe it takes -- just wondering your thoughts on that, maybe it takes a big transformation of the make-up of the workforce to really get the mental health workforce in New Zealand, the transformation of a mix of workforce to make the difference. Also reinforcing you talked about critical mass in a service making a difference and losing that. Just thinking, do you have a vision yourself of what would be the mix of the workforce, mental health workforce in New Zealand if we were to succeed?

A. You've mentioned the consumers with lived experience and they are a critical part of mental health services, because they are the ones who experienced a lot of these things, so they should be part of the workforce. I've also talked about the Pacific communities. We have a lot of good people that have already been doing a lot of informal work to support people with mental health problems. We perhaps need to engage them in those processes as well and Pacific in general are very quick to mobilise support and help and they know their communities. So if we maybe go to those most vulnerable, we need to target those most vulnerable communities and find out who are the Pacific leaders within this community, ask them, they normally know what's going on in their community and ask them how they can support whatever initiatives that we are hoping to implement in regards to mental health. So there is resource out there, I think we just need to look hard enough to engage more people to do the work.

So absolutely, I agree with you that we need to look at the workforce, but look in the way that is meaningful to Pacific people so that we can -- other cultures as well, but I'm talking mostly about Pacific so that we have services that address the needs of people and is meaningful for them, not just any service, we need to make sure we have the right mix like you're talking about, yeah, and the right cultural people with the cultural knowledge to train other people to make sure that we continue to have that workforce. So it's the resource, it's the human resources that's critical, yeah.

Q. Thank you for that. Also I suppose my experience, what I've learned, is that it is the consumer, the lived experience workforce who are the most attuned to abuse and neglect of what goes on in services. Is there a way of better utilising the wisdom from within there to educate, I suppose, both the workforce as a whole but also families, communities about avoiding and preventing abuse and neglect in care in services?

A. Absolutely. The consumer should be involved, they should be the voice in most of those decision-making, they should be part of the solution. We need to actively listen to the consumers and engage them and learn from them.

Q. Do you think there's enough of that happening at present?

A. No, no, it's not, because sometimes I wish there were consumers in meetings when I am at because we forget about that aspect, if there's no voice right there at the decision-making table to ensure that the consumer voice is there all the time, and be respected. It's not happening as much as I would like it to be, but I do think it's an important part if we want to improve outcome for mental health in this country. Does that answer your question?

Q. Yes, thank you.

COMMISSIONER STEENSON: Tēnā koe Leota Dr Petaia, e mihi ana ki a koe mō ō mōhio mahi ki te Kōmihana i tēnei rā. Thank you so much for sharing your immense knowledge with us today. I just have a couple of questions around this implementation and your views. So you've talked about it being key and given us some really important points. I'm just wondering your view on, given that the system is set up to a particular lens, European lens.

A. Mmm-hmm.

Q. Do you see the requirement for a separate Pacific care structure, or do you see that one could work within the existing structures? So that's my first question, so I'll let you answer that, then I've got a follow-up to that.

A. So I work in a system, I mean in forensic services where I am the only Pacific psychiatrist there and there has been a lot of advocacy around having a separate Pacific service. Like anything, there's pros and cons about it. But from my perspective, we don't have the capacity right now to have a separate service. And if we have a separate service, that will marginalise Pacific people more, because they will not access specialists in the mainstream service as much as possible.

So a good example is having -- I guess I'm in a unique position because I am a clinician, I treat people from a clinical, western perspective, but I'm very culturally aware so that we do it together in that context, where cultural is a priority for our team, so we work in a multi-disciplinary team. So because of my position I'm in a lead position for a whole team, and that's unique in that sense because there's not many of us, there's no-one other than myself.

So, but I have observed how it works really well, if we deliver clinical services from cultural lenses, whether Pacific or Māori, we have to respect those cultures and it can work very well together, working alongside each other. So there are things that are already existing are working well now, and we don't need to re-invent things. But I think it's the respect of one to the other. So even if there's no psychiatric doctors, there will be cultural workers there of Māori and Pacific ethnicity, because that's one good thing, we're talking about mental health services, but this is happening right across other areas of medicine. And I think that cultural workers in the hospital, in the community, together with their psychiatrists, whether they're from Russia or wherever, Africa, it's about respecting each other and listening to each other.

So when I see Māori patients, for instance, I'm not Māori, I have a lot of respect for the Pukenga Atawhai, so I will take my meetings to the marae, for instance. I had a very complex patient that I had to deal with, no-one can manage any family meeting in the hospital, so I took them to the marae and I asked the cultural -- the kaumatua in the hospital, can you please lead this for me, I don't know what is important to Māori, but this is the issue, this is the complexity, there's a lot of underlying issues with this family that needs to be resolved first so we can then discuss the clinical issues.

The staff observed that in the marae there was no arguments, no fights, the kaumatua led the whole discussion, I only came in just to talk about medications and the family accepted it very well. But it was the kaumatua that was chairing the meeting that was leading the whole discussion. So it's about having respect for those cultural processes and protocols, and utilising that to deliver whatever service that you need to do.

So no-one can dispute it if it works and I've shown it by doing -- I've done lots of things that people don't normally do and I've asked people to just do it because that's how I think it would work and if it doesn't work then it doesn't work, but let's try. But every time we try that, it works very well and it makes sense because people feel safe in the marae, people feel safe because they're speaking Māori first, before I even talk about medications. And it's a very warm and therapeutic way of delivering clinical services.

So I guess that's my view in terms of making sure that it's not one or the other, because we don't want also just the cultural services to be focused on everything culture and missing the point that these people need medications, because if you have cultural workers that are very culturally oriented and have no understanding of medications then they won't encourage people to continue to take the treatment that they need, that's the risk, and that's why working together in that context where we have very -- it's about relationships with the people in your team, and exchanging ideas, and ways to improve care for people. No-one will dispute that, people don't wake up in the morning and come to services and think let's do this because you're Māori or let's do this because you're Pacific, we don't do that, but it's about whether you're doing it the right way.

Q. So expanding the current system to be more holistic which requires some more resourcing and some training --

A. That's right.

Q. -- is essentially, if I could put it in a nutshell, which is not perfect, but close. So from a transitional point of view, let's say tomorrow the powers that be decided that that was going to work, and they would put it in place. Replicating that would require, what are the sort of things that you think immediately, if everyone had the right attitude, would it be super difficult or...

A. Which is the most difficult thing about it.

Q. Yeah.

A. It's never the people with mental health problems, always the staff around and their personalities that you have to deal with. So if people agree, fantastic.

Q. So I guess what I'm trying to get to is how do we get from the here to there, what's that transitional?

A. I think we need to apply what we apply to clinical scenarios. I think the most important thing is about clear communication, effective communication in a very respectful way. So for instance, talking about Pacific, having Pacific discussions, talanoa, it doesn't have to take lots of thinking.

I'll give you an example. I have been working in Samoa since the tsunami, I led the team of mental health clinicians from here and psychologists to Samoa. And over the years since the tsunami I work very well with my friend and colleague Fuimaono Karl Pulotu-Endemann, he's well-respected, he created the Fonofale model. So we go to Samoa, for instance, we take professionals from here. And the thing about New Zealand is it takes a lot of time to think about things, you think, you think, you think, you plan, you plan, you plan, you plan and then maybe act. In Samoa you think, maybe, and then act and then you learn from it and then you keep going.

And I quite like that, because people are dying, you know, the suicide rates in this country is very high, it's shocking, we don't have time to muck around. So for a Pacific person advocating for Pacific we are in crisis, we are saying that mental health is worse in this country. So we've got so much knowledge already, we've got so much research that's been happening in this country, it's about the translation of that knowledge into action that needs to happen, it's not about more research and more research, we already know, I mean we've got knowledge; but we need leadership to encourage to actually start doing things that we think will work for Pacific. And I'm very young, we've got some very senior Pacific people here like our church minister and Bernie I think is here, he's been doing a lot of good work in the Pacific. We should ask them to help us and then we can plan together, because if you make people own that process, they will do it.

Q. Okay, so if I hear you right it's lead and act?

A. That's right.

Q. Kia ora.

A. A bit more action.

Q. Kia ora.

CHAIR: Yes, one of our witnesses who you might have heard of, Tigilau Ness, said to us the other day, "just do it". I'm going to leave you in the very capable hands of my colleague Ali'imuamua Alofivae.

COMMISSIONER ALOFIVAE: Lau Afioga Leota. Ma le agaga faaaloalo lava fa'apea ma le loto maualalo, e avea lou leo fa'atauvaa e fai ma fofoga taumolimoli a le afioga i le Komesina Taitaifono ia Judge Coral Shaw ae tainane le mamalu o le au nofo Komesina fa'apea ma le laulau o lenei matagaluega. E molimoli atu se matou fa'afetai ma le fa'amalo lava i lau susuga mo lau saunoga matagofie aemaise lava lau tapenapena lelei. O le sauniga maea o lau mataupu ma le fa'afofoga o le mamalu o le aofia. Ese le manaia i le fia fa'alogolgo o lo matou taliga i lau vagana fetalai ma lau saunoa atamamai aua o galuega fita ma tiute faigata ua tofia e lau susuga o le tamaitai foma'i. Ma ou te talitonu ia te a'u lava e leai lava se poto poo se atamai o se tagata e mafai ona fuli lenei mataupu silisili ona o le faigata fa'apea ma le ma'aleale ma le loloto ae pei o le matagofie o tofitofi iai i lau susuga. Malo lava le galue ma le fa'amaoni malo le onosai fa'amalo foi le sailimalo ma le tauivi. Ma ua ou fia Falealili fua ma ua mitamita le agaga ona ua iai se tasi o le alo o le atunuu ua tautuana ma ua fai ma auauna lelei ma le feasoasoani tele mai i lo matou taumafaiga aua galuega o le mamalu o lenei ofisa o le Komesina Faatupu o le Malo e ala lenei Faalapotopotoga a le Tatalo Pologa. Can I thank you on behalf of our Chair, our Royal Commission, the Inquiry, on your significant contribution to our talanoa. Fa'afetai mo lou alofa mo le tatou atunuu pele o Niu Sila faatasi ma atunuu o le Pasifika. Thank you for your heart, for our nation here of Aotearoa New Zealand, but particularly for our survivors and our different island nations, ia fa'amanuia le Atua ia te oe ma mea uma mo lau galuega fa'afetai lava.

A. Fa'afetai.

[Samoan song]

REVEREND HOPE: [Opening comments in Tokelauan] As we started in the beginning, I thank our mother for introducing us to this evening in prayer and one of our elders, as we had one this morning, to greet you in love and to thank you in love, one of our elders now will do the same, then I will lead our final prayer.

MALE SPEAKER: [Greeting and thanks in Tokelauan].

REVEREND HOPE: We ended with the hymn earlier, we will start with the hymn, that will be screened. I will say a prayer in Tokelauan and when I end my prayer I will end in a blessing in Māori and English. Thank you. **[Tokelauan song and prayer; blessing in Māori and English]**.

CHAIR: Thank you Tokelau, thank you.

Hearing adjourned at 4.53 pm to Tuesday, 27 July 2021 at 10 am