Māori Mental Health

A report commissioned by the Waitangi Tribunal for the Wai 2575 Health Services and Outcomes Kaupapa Inquiry

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About the author

Timothy Gassin is an historian based in Wellington, who has worked within the Waitangi Tribunal Unit since August 2017, initially as a Researcher/Analyst and later as a Senior Researcher/Analyst. He is a graduate of the University of Melbourne, from which he received the degrees of Bachelor of Arts (Honours) and Doctor of Philosophy. His doctoral thesis examined constitution-making and the processes of national federation in Canada and Australia. He has previously worked as a tutor for both the School of Social and Political Sciences and the School of Historical and Philosophical Studies at the University of Melbourne.

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Introduction

Background

In memorandum-directions issued on 28 June 2018, Judge Stephen Clark confirmed the priority issues for stage two of the Health Services and Outcomes Kaupapa Inquiry and that the Tribunal would 'commission three separate overview reports, one for each of the priority issues'.[1]

On 5 September 2018, the Tribunal commissioned Ross Webb to complete a report on Māori mental health, including suicide and self-harm.[2] From the beginning of the project, I worked with Mr Webb. On 8 February 2019, following Mr Webb's resignation from the staff of the Tribunal, Judge Clark issued further directions, cancelling the original commission and commissioning me to complete the report.[3]

The commission for the mental health report called for an outline of contemporary mental health services and significant historical developments. It also required the report to consider issues of 'disparity in mental health outcomes, accessibility of mental health services, responsiveness of mental health services and effectiveness of mental health services for Māori', in addressing, where possible, a range of questions:

> a. How does the contemporary mental health system, including legislation, policies and practices recognise and provide for Māori mental health needs? To what extent, if any, does implementation and outcomes [sic] diverge from policy objectives?
>
> b. To what extent does mental health policy and practice provide culturally appropriate mental health services and treatment for those Māori who require it, or provide for Māori led and developed systems and methods of mental health care/kaupapa Māori?
>
> c. To what extent have Crown acts or omissions, if any, contributed to disparities and how are these recognised and addressed?
>
> d. What barriers, if any, do Māori experience in accessing mental health services and what are existing Crown policies and practices for recognising such barriers?
>
> e. How effective is current mental health monitoring and data collection for identifying and addressing any disparities in mental health services and outcomes for Māori?
>
> f. How have shifts in national mental health policy during the last 20 years impacted on Māori and to what extent have Māori had opportunities to contribute to relevant policy and legislative developments?

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[1] Wai 2575 2.5.29, pp 2-3.

[2] Wai 2575 2.3.1.

[3] Wai 2575 2.3.5; Wai 2575 2.3.6.

g. What key historical developments have contributed to the current system of government mental health services for Māori and to Māori experiences and attitudes to mental health services?[4]

The structure and approach of this report

This report is not structured around the eight questions posed by the commission, but rather seeks to address the issues they raise through five chapters, providing both background and explanation of the mental health system and its history and detailed analysis of major pertinent issues. An overview of these chapters is provided directly below, while a guide to the report based around the commission questions is provided in a following section.

The first chapter provides an overview of the history of Māori and New Zealand's mental health system, tracing the system's development, including the shift from institutional to community-based care and the growing focus on providing services tailored to Māori, the rapid increase in the reported rates of mental illness among Māori in the second half of the twentieth century, and the proliferation of inquiries and policies that have shaped mental health services since the 1980s.

Chapter 2 examines the mental health system as it exists today. Given the absence of a standalone and distinct mental health system, it sets out the structure of the heath system as a whole and explains the range of mental health services available within it and the variety of bodies that have an involvement in delivering services or overseeing the system and the treatment of patients. While recognising that mental health services are embedded within a broader system, this chapter also examines particular features that set mental health services apart, including the use of compulsion under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the practices of seclusion and restraint, and the particular pathways into treatment for those entering via the criminal justice system. Attention is also given to the level of provision of kaupapa Māori services, the number of Māori in the mental health workforce, and measures of cultural competence of the mental health workforce as a whole.

Following on from these two chapters that provide an overview of how the system came to be the way it is and how it functions today, the report turns to look at some significant issues in greater depth. The first of these concerns the involvement of Māori in the system in decision-making capacities and as independent service providers. Chapter 3 summarises the objectives of a number of current and recent government policies that seek to promote Māori taking a role in decision-making and looks at the variety of capacities in which Māori can influence the mental health system, including through examining the representation of Māori within the Ministry of Health and in health governance roles, the inclusion of Māori on advisory boards and on inquiry and review panels, and the extent to which Māori have been able to take charge of and shape the

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[4] Wai 2575 2.3.6.

services they deliver as independent service providers. It also identifies structural barriers within the system that can minimise the extent to which Māori perspectives are translated into practice or frustrate the ability of Māori providers to determine the types of service they deliver.

In Chapter 4, the focus turns from Māori involvement in making decisions about the system to the experience of those Māori who seek treatment within the system, with an examination of the barriers that can prevent Māori from accessing the treatment they need. Barriers examined include inability to gain admission to under-resourced and disjointed services, cost, distance, transport and communications, cultural inappropriateness, stigma, and fear. While many of these barriers to access are by no means specific to Māori, they are assessed to determine the extent to which they may affect Māori disproportionately, with many closely linked to broader socio-economic disparities.

Chapter 5 addresses suicide and self-harm. It examines the dramatic growth in Māori suicide rates in recent decades, from being lower than those recorded for the general population to being significantly higher, and the explanations that have been advanced to explain this, considering historical, cultural, and socio-economic factors. It also provides an overview of government suicide prevention strategies and programmes, whether aimed at all of the New Zealand population or targeted specifically at Māori, and concerns about the limited support available for the relatives of those who have taken their own lives.

After a final conclusion, the report includes, as appendices, a copy of the directions commissioning research and a summary of issues raised in claims related to mental health.

As required by the commission and necessitated by limitations of time, this report provides an overview, rather than seeking to provide a comprehensive account of mental health-related issues for Māori. The approach is largely high-level and national in focus. As such, there is limited analysis of possible regional variations, for example, in regard to differences in approach adopted or services delivered by different District Health Boards or difficulties that people in particular parts of the country may face in accessing services. The report overwhelmingly draws on existing published materials, which have been supplemented, where necessary, by personal queries and some limited targeted searches of Ministry of Health files. It is hoped that this report brings together much of what is known in a format that is convenient to the Tribunal.

It should be noted that this report is focussed firmly on mental health policy and services. Such an approach, in effect, largely means focussing on the metaphorical ambulance at the bottom of the cliff, rather than examining in any great detail the original causes of mental ill health amongst Māori that have led to the substantial disparities in the prevalence of mental illness that are seen today. Any thorough examination of these matters would be a much larger project than is possible in the time available and would fall outside the core scope of the commission.

A guide to the report structured by the commission questions

The following notes are provided as a guide to the content of this report based around the questions posed in the directions commissioning research. To assist readers, indications are provided not only of which chapters are relevant to each question, but which aspects of the questions are addressed in each chapter.

a) *How does the contemporary mental health system, including legislation, policies and practices recognise and provide for Māori mental health needs? To what extent, if any, does implementation and outcomes* [sic] *diverge from policy objectives?*

An overview of recognition of, and provision for, Māori in terms of legislation, policies, and service provision in the contemporary mental health system is provided in Chapter 2. Chapter 3 provides further details concerning arrangements for the involvement of Māori in health system decision-making and service provision. Chapter 4 addresses barriers to accessing services for Māori and Crown actions that may contribute to or alleviate these barriers. Analysis of policies concerning suicide and how they provide for Māori can be found in Chapter 5.

b) *To what extent does mental health policy and practice provide culturally appropriate mental health services and treatment for those Māori who require it, or provide for Māori led and developed systems and methods of mental health care/kaupapa Māori?*

The extent to which mental health policy and practice provides for culturally-appropriate mental health care is examined in Section 2.4 of Chapter 2 and in Chapter 3. The provision of culturally-tailored suicide prevention programmes is addressed in Chapter 5. The historical policy developments that led to the establishment and growth of kaupapa Māori services can be found in Chapter 1.

c) *To what extent have Crown acts or omissions, if any, contributed to disparities and how are these recognised and addressed?*

Some suggestions by scholars concerning the causes of the elevated rates of mental illness and suicide among Māori, including the likely effects of broader Crown policies, are noted in Chapters 1 and 5. However, the ultimate causes of mental health disparities are not a major focus of this report for reasons discussed above.

d) *What barriers, if any, do Māori experience in accessing mental health services and what are existing Crown policies and practices for recognising such barriers?*

These matters are addressed in Chapter 4.

e) *How effective is current mental health monitoring and data collection for identifying and addressing any disparities in mental health services and outcomes for Māori?*

Current arrangements for monitoring and data collection for the prevalence of mental illness and service provision are examined in Section 2.5 of Chapter 2.

f) *How have shifts in national mental health policy during the last 20 years impacted on Māori and to what extent have Māori had opportunities to contribute to relevant policy and legislative developments?*

The development of mental health policy over the last 20 years is addressed in Chapter 1 from Section 1.5 onwards and the development of suicide-related policy is addressed in Chapter 5.

Chapter 2 summarises a range of broader health system developments and includes some sections concerning mental health workforce-related developments. Chapter 4 discusses a range of policies and programmes that affect accessibility of services and barriers to access.

Chapter 3 examines legislation and Crown policies that relate to the involvement of Māori in shaping policy-making, governance, and service-delivery. It also examines the extent to which Māori are represented in governance and policy-making positions and the extent to which Māori voices are heard through advisory groups, inquiries, and reviews.

g) *What key historical developments have contributed to the current system of government mental health services for Māori and to Māori experiences and attitudes to mental health services?*

These matters are addressed in Chapter 1.

Chapter 1 Māori and the mental health system: an historical overview

1.1 Introduction

While mental health is recognised as a key contemporary health concern for Māori, we know very little about the historical relationship between Māori and mental health policy and services. Very little has been written of the historical Māori experience of mental health services, especially for the years before 1940, making an historical overview of Māori experiences of mental illness and mental health services difficult. This chapter provides a brief historical overview of what we do know about the history of Māori and the mental health system in New Zealand, focusing on broad mental health trends that are supported by selected studies and examples. The chapter concentrates on the period between 1975 and the 2000s, which saw: a shift from an institutional model of mental health care to a focus on community care; the establishment of the foundations of the current mental health system; and major increases in disparities of mental illness between Māori and non-Māori.[5] The chapter is not a comprehensive historical overview, and the entire topic of Māori engagement with the mental health system is much larger than can be covered here.

Most of the claims relating to mental health in this Inquiry have a contemporary focus. However, claimants have also highlighted the relationship between the history of the mental health system and how the system operates today. In particular, claimants have highlighted the disparities in mental illness that emerged in the 1970s, and the reforms in the 1990s and 2000s that established the foundations for the contemporary system.[6] As this chapter illustrates, mental health policies and services have been shaped over time by broader historical shifts, including: colonisation; political and fiscal imperatives; ideology and broader trends in psychiatry; and increasing demands from Māori to play a greater role in mental health care and policy making.

In the pre-casebook discussion paper prepared for this Inquiry, Dr Therese Crocker suggested that due to the contemporary focus of the claims, any required historical overview could be brief. She stated that while there was 'sufficient historical background material for major developments with health generally', material specifically relating to Māori experiences of mental health is 'scattered and difficult to access'.[7] She therefore suggested that material be organised into a 'brief

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[5] Therese Crocker, 'Māori Health Services and Outcomes Inquiry (Wai 2575) Pre-casebook Discussion Paper: Part 1', (Waitangi Tribunal Unit, 2018), Wai 2575, 6.2.3, p 30.

[6] A summary of claim issues relating to mental health is provided in Appendix 2.

[7] Crocker, Wai 2575, 6.2.3, p 37; a Crown-commissioned research report on Māori involvement in the health system was filed on 20 August 2019.

overview of major developments specific to Māori mental health'.[8] This chapter primarily addresses commission question g: 'What key historical developments have contributed to the current system of government mental health services for Māori and to Māori experiences and attitudes to mental health services?'[9] It also provides historical context for the commission questions regarding: the reasons behind disparities in mental health between Māori and non-Māori (commission question c); barriers to accessing mental health services (commission question d); and Māori involvement in mental health policy (commission question f).[10]

The Crown imported an English system of mental health care that focused on building institutions for the mentally ill (known various over time as psychiatric hospitals, mental hospitals, or lunatic asylums). These institutions were administratively and professionally separate from other health and social services, and continued, until the latter part of the twentieth century, to be the dominant part of the mental health system, albeit with some adjustments.[11] For much of the period prior to the mid-twentieth century, Māori made up a small proportion of patients in asylums, although there were debates about the actual rates of Māori mental illness throughout the first half of the twentieth century.

Current disparities in Māori and non-Māori mental illness are a relatively recent phenomenon, beginning in the mid-1970s. By the end of the century Māori rates of mental illness were increasingly recognised as a significant concern and, by 1998, were being described as a crisis of 'unprecedented proportions'.[12] Disparities have been influenced by a host of factors, which are discussed in this chapter, and have coincided with an emerging emphasis on caring for the mentally ill outside of institutions. This culminated in full-scale 'deinstitutionalisation', which was characterised by the downsizing or closure of psychiatric hospitals and the transition to community-based services. This transition formed part of wider health sector reforms in the 1980s and 1990s. The emerging awareness of mental illness as an important health issue for Māori has, in turn, led to an increased emphasis on policies, practices, and treatment facilities that are specifically designed to provide for Māori mental health needs.[13]

The chapter illustrates that many of the issues and concerns raised in the Government's 2018 Mental Health and Addiction Inquiry have been longstanding and well-known. For example, Māori have long concluded that the western approach to mental health care has failed Māori mental health needs and have called for a 'by Māori for Māori' approach for much of the period covered. While there have been significant changes in mental health care (some of which have been positive changes), major limitations remain, especially around: the responsiveness of

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[8] Crocker, Wai 2575, 6.2.3, p 37.

[9] Judge S R Clark, Memorandum-directions of Judge S R Clark commission research, 8 February 2019, Wai 2575, 2.3.6, p 3.

[10] Wai 2575, 2.3.6, p 2.

[11] Warwick Brunton, 'The place of public inquiries in shaping New Zealand's national mental health policy 1858–1996', *Australia and New Zealand Health Policy*, vol 2, no 24 (2005), pp 1-2.

[12] Maori Health Commission, 'Maori Mental Health', *Tihei Mauri Ora! Report of the Maori Health Commission June 1998* (Wellington: The Maori Health Commission, 1998), p 14.

[13] B Robson and R Harris, *Hauora: Māori Standards of Health IV, A Study of the Years 2000-2005*, (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 2007), pp 121-122.

mainstream services; the resourcing for kaupapa Māori services; and Māori workforce development. By around 2000, these were the key issues in state policy concerning Māori mental illness and mental health services.

1.2 The institutional period, 1840-1970s

As discussed above, there is very little historical information regarding Māori mental health. Derek A. Dow, for example, omitted mental health in his study *Māori Health and Government Policy, 1840-1940*, because 'it appears that few Maori were treated by Western doctors prior to 1940' for mental health issues.[14] The collection of essays on mental health treatment entitled '*Unfortunate Folk': Essays on Mental Health Treatment 1863-1992,* edited by Barbara Brookes and Jane Thomson, focuses largely on the Otago region and makes no mention of Māori experiences.[15] Lorelle Barry and Catharine Coleborne wrote that there are few studies of mental health in New Zealand that deal with insanity among Māori.[16] Their study of Māori patients in the Auckland Mental Hospital between 1860 and 1900 (drawn from Lorelle Barry's thesis on the same topic) is the rare exception.[17]

This historical overview will detail what we do know about Māori engagement with mental health services. However, it will not go into great detail about the general system of mental health services in New Zealand before the 1980s.[18] This is partly a result of lack of source material and information. As Te Kani Kingi writes, 'it is difficult to describe with absolute certainty a definitive historical account of Māori mental health. The information to do so simply does not exist'.[19] Despite this, Kingi adds, there is sufficient evidence for two major conclusions. The first is that it is likely that mental illness occurred among Māori prior to European contact. Kingi writes: 'This conclusion is simply based on the notion that mental disorders have been known to occur within all cultures and that it is most unlikely that Māori alone could have developed the means, biological or otherwise, by which such conditions (now termed mental disorders) could have been avoided'.[20] Kingi's second conclusion is that the high rate of mental

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[14] Derek A Dow, *Maori Health and Government Policy 1840-1940* (Wellington: Victoria University Press, 1999), p 13.

[15] Barbara Brookes and Jane Thomson, eds., '*Unfortunate Folk': Essays on Mental Health Treatment 1863-1992,* (Otago: Otago University Press, 2001).

[16] Lorelle Barry and Catharine Coleborne, 'Insanity and ethnicity in New Zealand: Māori encounters with the Auckland Mental Hospital, 1860-1900', *History of Psychiatry*, vol 22, no 3 (2011), p 289.

[17] Barry and Coleborne, 'Insanity and ethnicity in New Zealand', p 289; Lorelle J Burke, '"The voices cause him to become porangi" Maori Patients in the Auckland Lunatic Asylum' (MA thesis, University of Waikato, 2006).

[18] This is covered in the existing literature and readers should consult this literature for an overview. For a short summary of New Zealand mental health policy since 1840 readers should consult Brunton and McGeorge, 'Grafting and Crafting New Zealand's Mental Health Policy'.

[19] Te Kani Kingi, 'Introduction', in Te Kani Kingi et al., Maea Te Toi Ora: Māori Health Transformations (Wellington: Huia, 2018), p 11.

[20] Kingi, 'Introduction', p 3.

illness among Māori is a recent phenomenon. In particular, Kingi notes that the number of Māori accessing mental health services has significantly increased in the last forty years.[21]

Other reports produced for Waitangi Tribunal inquiries provide some insight into the historical relationship between Māori and the mental health system. Dr Helen Robinson, for example, presented evidence for the Te Rohe Pōtae District Inquiry (Wai 898) on Māori health and the Crown in the inquiry district between 1840 and 1990.[22] Robinson confirms that there has been very little work on historical Māori mental health, stating that '[t]he state of Māori mental health before the mid-twentieth century is difficult to determine, and uncertain even after that'.[23] Nevertheless, her research suggests that psychiatric problems among Māori have shown a general increase since the early 1970s, particularly for men.[24]

1.2.1 Māori mental health in the nineteenth century

Māori mental illness only very rarely features in nineteenth century official records[25] but we know that Māori were a small minority in state asylums. Labrum suggests that in 1871 five per 10,000 Māori women and four per 10,000 Māori men were admitted into mental institutions. In 1877 there were only 14 Māori patients out of a total 872 patients nationwide and, in 1898, only 21 Māori patients out of a total 2,480.[26] According to Dr Helen Robinson, 'it is generally assumed' that Māori who experienced mental illness during this period would have been considered to be suffering from a spiritual affliction, such as possession or mākutu, and that their whānau and wider hapū would likely have cared for them.[27] Robinson outlines that 'Māori were generally reluctant to involve Pākehā in the care of mentally ill whānau members', while 'Pākehā authorities were equally reluctant' to treat Māori within the mental health system.[28] As an example, Dow discusses the Uriori hapū who, when meeting with Premier and Native Minister Richard Seddon in 1894, requested the release of one of their chiefs who was confined in an asylum.[29] Dow writes that they requested his release because his condition was not improving and his whānau wished to care for him instead.[30]

The rate of mental illness among Māori during the nineteenth century is similarly unable to be determined. According to Robinson, there were numerous factors that may have contributed to

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[21] Kingi, 'Introduction', p 11.

[22] Helen Robinson, 'Te Taha Tinana: Māori Health and the Crown in the Te Rohe Pōtae Inquiry District, 1940-1990', (Waitangi Tribunal, 2011), Wai 898 A31.

[23] Robinson, 'Te Taha Tinana', p 304.

[24] Robinson, 'Te Taha Tinana', p 304.

[25] Dow, 'Maori Heath and Government policy, 1940-2000', p 176.

[26] The Inspector of Asylums, 'Lunatic Asylums – Reports of Inspectors', Appendix to the Journals of the House of Representatives, 1878, H-10, p 18; The Inspector of Asylums, 'Lunatic Asylums of the Colony', Appendix to the Journals of the House of Representatives, 1899, H-7, p16.

[27] Robinson, 'Te Taha Tinana', p 24.

[28] Robinson, 'Te Taha Tinana', p 24.

[29] Dow, 'Maori Heath and Government policy, 1940-2000', p 176.

[30] Dow, 'Maori Heath and Government policy, 1940-2000', p 176.

Māori mental illness. These included 'loss of land and consequent loss of mana, cultural and spiritual disruption caused by the arrival and dominance of Pākehā, and cultural marginalisation in the late nineteenth century'.[31] Robinson believed such factors would likely be made worse by treatment within a Pākehā system such as a mental institution.[32] As Te Kani Kingi writes, while the institutional model was based on the idea that mental health issues were best addressed in isolated environments, away from the broader population, they were equally motivated by discriminatory attitudes of the public. Māori 'philosophies of care', on the other hand, encompass an integrated and inclusive model that emphasises 'holism, integration, and whānau, iwi and hapū connections'.[33]

While instances of institutional confinement of Māori suffering from mental illness was more of a twentieth century phenomenon (from the late 1920s onwards, in particular), historians do demonstrate some important nineteenth century developments. As discussed above, Lorelle Barry and Catharine Coleborne examined the case notes of Māori patients at the Auckland Mental Hospital between 1860 and 1900.[34] They suggest that looking specifically at Māori patients reveals more about the unequal power relations within colonial societies 'both inside and outside settler institutions', such as mental institutions.[35] Unequal power relations, they argue, have left New Zealand and other settler colonies with two legacies: evidence that the ongoing impacts of colonisation have caused indigenous peoples to suffer mental illness; and health services that continuously fail to deliver mental health services that are suitable and appropriate for indigenous peoples.[36] The authors also suggest that while Māori were not separated from Pākehā patients (unlike situations in Fiji, colonial India and parts of Southern Africa during the nineteenth century), 'a careful reading and interpretation of patient case notes reveals that Māori experienced forms of cultural alienation which were reinforced by the institutional regimes of bodily examination, description and reform or "civilizing"'.[37] According to Bronwyn Labrum, the Māori rates of committal 'shows how explanations of committal in terms of colonial rule only begin to have salience in the early twentieth century'.[38]

1.2.2 Māori mental health in the early to mid-twentieth century

Māori remained a small proportion of mental hospital patients into the early twentieth century. According to Labrum, by 1911 the number of Māori admitted to mental institutions had risen to

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[31] Robinson, 'Te Taha Tinana', pp 24-25.
[32] Robinson, 'Te Taha Tinana', p 25.
[33] Kingi, 'Mental Health Services for Maori', p 42.
[34] Barry and Coleborne, 'Insanity and ethnicity in New Zealand', pp 285-301.
[35] Barry and Coleborne, 'Insanity and ethnicity in New Zealand', p 286.
[36] Barry and Coleborne, 'Insanity and ethnicity in New Zealand', p 286.
[37] Barry and Coleborne, 'Insanity and ethnicity in New Zealand', p 286.
[38] Bronwym Labrum, 'Looking Beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910', *The New Zealand Journal of History,* vol 26, no 2 (1992), p 128.

14 per 10,000 Māori women and 23 per 10,000 Māori men.[39] In 1909, Māori made up just over one percent of the total of 3,549 psychiatric inpatients nationwide, rising to 1.8 per cent in 1938 of a total of 7,797.[40] Ten years later, in 1948, this had increased to 2.6 per cent nationwide (this figure represented 20.8 per 10,000 population, while for non-Māori the figure was 51 per 10,000).[41]

Despite these relatively low numbers, psychologists and anthropologists began to take a greater interest in Māori mental health by the mid-twentieth century.[42] Before outlining a few examples, it is important to note that Te Kani Kingi warns against taking these accounts too seriously. Kingi writes that historical and anthropological accounts provided some early insights, but states that they 'lacked robust analysis, were frequently based on anecdotal accounts and were often subject to cultural bias and misunderstanding'.[43] Kingi also warns that 'their perspective were too often derived from the impressions of non-Māori: those unfamiliar with Māori society, who were, ultimately, unable to divorce their own cultural bias from clinical assumptions'.[44]

One of the first studies of Māori mental health was undertaken by Ernest and Pearl Beaglehole in 1946.[45] The Beagleholes suggested that the lower rates of mental illness among Māori could, in part, be attributed to 'the tremendous value to the Maori of possessing a psychological security that comes from tribal and family membership'.[46] But they also predicted an increase in mental illness among Māori, as part of the 'debit' of 'becoming more like a Pakeha in his way of life'.[47] In a further study in 1958, Ernest Beaglehole stated that the rates of first admissions for Māori were 6.4 per 10,000 compared to 10.5 per 10,000 for Pākehā.[48]

In an important critique, Dr F McDonald of Porirua Hospital claimed that while Beaglehole's statistics 'certainly seem to bear out his contention that the Maori is less afflicted with mental disease than the Pakeha', the figures were, in fact, 'meaningless'.[49] McDonald's 1958 critique—which addresses Māori reluctance to enter mental hospitals, the inadequacies of research, and cultural differences—is worth quoting at length:

> Now it is dangerous and unjustifiable to assume that admissions to Mental Hospitals will give an adequate picture of Maori ill-health if we use the above classification. Dr Beaglehole has little or no contact with the patients in these institutions or he would realise that Maoris are very reluctant to enter them, so that the only Maoris seen there are those who are so floridly and severely psychotic that even their loving and tolerant

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[39] Labrum, 'Looking Beyond the Asylum', p 128.

[40] Inspector-General, 'Mental Hospitals of the Dominion, (Report on) For 1909', 1910, *Appendix to the Journals of the House of Representatives*, 1910 Session 1, vol 3, H-07, p 23; Director-General, 'Mental Hospitals of the Dominion, (Report on) For 1938', 1939, *Appendix to the Journals of the House of Representatives,* 1939 Session 1, vol 3, H-07, p 14.

[41] Robinson, 'Te Taha Tinana', p 198.

[42] For more information on the various studies on Maori psychiatry and mental illness in the mid-twentieth century, readers should consult Chapter 9 of Dow, 'Maori Heath and Government policy, 1940-2000'.

[43] Te Kani Kingi, 'Introduction', p 2.

[44] Te Kani Kingi, 'Introduction', p 2.

[45] Ernest Beaglehole and Pearl Beaglehole, *Some Modern Maoris* (Oxford: Oxford University Press, 1946), p 243.

[46] Beaglehole and Beaglehole, *Some Modern Maoris*, p 243.

[47] Beaglehole and Beaglehole, *Some Modern Maoris*, p 244.

[48] Ernest Beaglehole, *Mental Health in New Zealand*, 2nd ed (Wellington: Price Milburn & co, 1958), p i.

[49] McDonald, 'Books: The mental health of the Maori', p 57.

> families can no longer cope with them, i.e., the wildly manic, the acutely hallucinated, the acutely suicidal… A Maori voluntary boarder is a rarity, and these are the ones who will be suffering from any of his first four categories, not because these cases are rare in the Maori, but because they stay with their tolerant family and tribal groups rather than enter a Mental Hospital. Staying with their families, they manage to get along somehow, seen only perhaps by the tohunga who, it must be regretfully admitted, is liable to give them a vastly better type of supportive psychotherapy than a pakeha therapist can provide. So his figures are really meaningless. He would explain them by a subtle re-statement of the myth of the noble savage, happy and relaxed with his beer, cigarettes and making love in the sunshine, untroubled by the tensions which beset the superior pakeha. And of course, it is a myth which could be exploded by general practitioners working in such places as Rotorua and Auckland. [50]

McDonald then called for further research, preferably done by Māori.

> The whole problem needs to be re-assessed and by Maoris, preferably Maori psychiatrists and psychologists. It is difficult enough for a pakeha to diagnose other pakehas, let alone to plunge into the unfamiliar territory of Maori values, myths and symbols which are of much greater importance to Maori psychic life than the corresponding religious symbols are to pakehas. Anyhow, the pakeha is just not trusted, "he wouldn't under-stand," and this is unfortunately true. There are perhaps some gulfs which just cannot be bridged by kindness and the desire to help. Even if the Maori patient does talk, the most a pakeha can do is give mild supportive therapy even if he has "made a study of the Maori." … No treatment can be successful unless the therapist is prepared to accept the reality of these experiences and this is just the sort of thing that many Europeans cannot and will not swallow… There is a great need (and the possibility) to pursue the problems of Maori mental ill-health from different premises, premises more suited to the realities of Maori psychic life.[51]

McDonald's contention that admission rates did not reflect the broader levels of mental health remains a methodological issue for historians of Māori mental health. Citing a 1962 report on Māori patients in mental hospitals, Dr Robinson claims that the idea that Māori patients had more serious issues if they were in institutions is borne out by the fact that, on average, Māori stayed in hospital for longer periods.[52] McDonald was also the first to draw attention to the link between the criminal justice system and mental health, claiming that Māori with mental illness might also likely be in prison, as they might be considered criminals rather than mentally ill (the connection between criminal justice and mental health is discussed in subsequent chapters).[53] In a similar vein, Dr Geoffrey Blake-Palmer wrote an article for the *Medical Journal of Australia* in 1956 entitled 'Maori Attitudes to Sickness', in which he wrote that 'European hospital treatment must mean some separation from family, and offers no comforts comparable to a credible assurance that "Maori business" is countered effectively by Maori methods'.[54]

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[50] McDonald, 'Books: The mental health of the Maori', p 58.

[51] McDonald, 'Books: The mental health of the Maori', *Te Ao Hou*, pp 58-59.

[52] F H Foster, *Maori Patients in Mental Hospitals* (Wellington: Department of Health, 1962), pp 25-26; Robinson, 'Te Taha Tinana', pp 198-199.

[53] McDonald, 'Books: The mental health of the Maori', *Te Ao Hou*, p 58.

[54] Geoffrey Blake-Palmer, 'Maori Attitudes to Sickness', *Medical Journal of Australia*, vol 2, no 11 (1956), p 405.

1.2.3 Emerging disparities after 1960

In 1962, the Health Department's Medical Statistics Branch released a report entitled *Maori Patients in Mental Hospitals,* which detailed Māori rates of admission to mental hospitals, although some critiqued the methodology of the report at the time.[55] As outlined above, admission rates give us some clues, but do not reflect the actual rates of mental illness, regardless of how it may be defined. Dr Helen Robinson provides a brief analysis of Māori and non-Māori first admission rates from 1959 to the late 1980s, drawing on the Annual Reports of the Medical Statistician on the Medical Statistics of New Zealand (NZMS).[56] Robinson found that rates of admission for both Māori and non-Māori increased in the early 1960s, but that they increased more quickly for Māori. Following this increase, non-Māori rates remained stable before declining slightly from the mid-1970s and throughout the 1980s. Rates for Māori, by contrast, continued to rise throughout the late 1960s stabilised throughout the 1970s, and increased again during the 1980s (see Figure 1.1).[57]

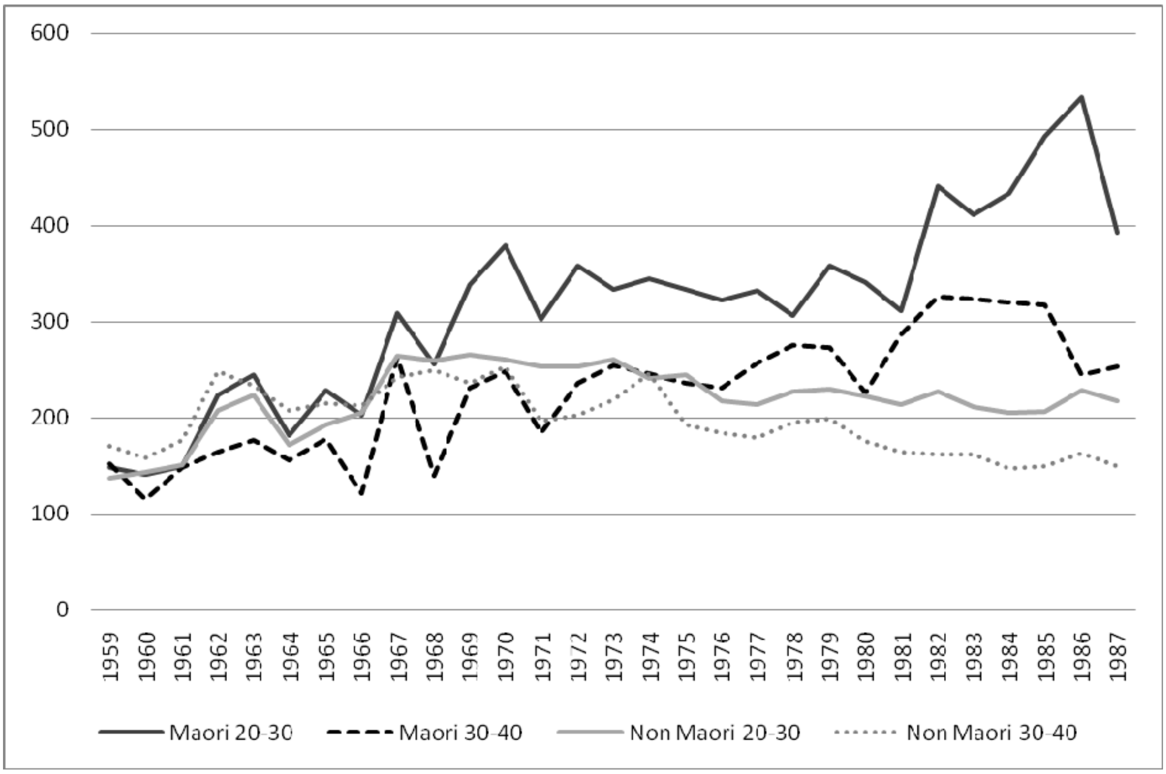

Figure 1.1 Psychiatric First Admissions by Age, per 100,000 population, 1959 to 1987[58]

Robinson cautions that these figures do not necessarily reflect actual rates of mental illness but may also reflect changes in admission practices. Regardless, Robinson argues that the different

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[55] F H Foster, *Maori Patients in Mental Hospitals*, (Wellington: Department of Health, 1962); A Howard, 'Review of *Maori Patients in Mental Hospitals*', *Journal of the Polynesian Society*, vol.72, no.1 (1963), pp 51-53.

[56] Robinson, 'Te Taha Tinana', pp 199-202.

[57] Robinson, 'Te Taha Tinana', pp 199-200.

[58] Source: NZMS: Mental Health, 1959-1987, reproduced from Robinson, 'Te Taha Tinana', p 199.

admission patterns for Māori and non-Māori illustrate that these changes cannot simply be described as the impacts of general mental health policy:

> It is not possible to know whether these patterns reflected changing levels of mental illness, an increasing likelihood that mentally ill Māori would be admitted to psychiatric care, or both, but the differing patterns for Māori and non-Māori show that it cannot simply be attributed to general mental health policy.[59]

While Mason Durie argued that these changes likely did reflect increasing rates of Māori mental illness, he also proposed that the increase may partially be explained by an increased utilisation of services by Māori and by increased levels of Māori ethnic self-identification.[60] Robinson concludes that there does appear 'to have been a significant decline in overall Māori mental health from the 1960s until at least 1990, particularly amongst those aged under 30', and that rates of Māori psychiatric hospitalisation, suicide, and self-harm all rose, with the sharpest increase in the 1980s (rates of non-Māori male suicide also rose in the 1980s).[61] In the 1970s, some psychiatrists had started to notice the change. In 1971, for example, the *Review of Maori Health* noted that Māori admissions for mental health treatment had doubled in the decade between 1959 and 1969. This decade saw a switch from a situation in which the age-standardised rate of European admissions was 'substantially higher' than that for Māori to one in which Māori had a slightly higher age-standardised admission rate than Europeans.[62] New Zealand's first Māori psychiatrist, Dr Henry Bennett, suggested in this report that the incidence of mental illness was approximately the same for Māori and non-Māori.[63] According to Dow, this was a 'marked change from the situation which had prevailed in the years before the urbanisation of Maori'.[64] The increase marked the beginning of a new period in which Māori would consistently suffer mental illness at elevated rates.

1.3 Changes in mental health care since the 1970s

The period after the 1970s was marked by several major developments that are relevant to this report: the deinstitutionalisation of mental health services; a series of structural reforms of the health sector more broadly; increasing disparities in Māori mental health compared to that of non-Māori; and an increased emphasis on policies and practices to provide specifically for Māori mental health needs, including the development of Māori-specific facilities. This section focuses on the growing disparities in mental illness between Māori and non-Māori, the explanations

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[59] Robinson, 'Te Taha Tinana', p 200.

[60] Mason Durie, 'Māori psychiatric admissions: Patterns and policies', in *Social Dimensions of Health: New Zealand Perspectives*, ed John Spicer, Andrew Trlin and Jo Ann Walton (Palmerston North: Dunmore Press, 1994), p 328.

[61] Robinson, 'Te Taha Tinana', p 205.

[62] Maori and Polynesian Health Committee, *Review of Maori Health: Report of the Maori and Polynesian Health Committee,* (Wellington: Board of Health, 1971), pp 17-18.

[63] Maori and Polynesian Health Committee, *Review of Maori Health*, p 8.

[64] Dow, 'Maori health and government policy, 1940-2000', p 179.

behind these disparities, and Crown responses. It also details what public inquiries into the mental health system in the 1980s and 1990s said about Māori mental health. Deinstitutionalisation and the health reforms of the period are covered elsewhere in the literature and are topics largely beyond the scope of this report. The focus the chapter will be on how these developments impacted Māori mental health and opportunities for involvement in mental health policy and service delivery, along with the major reasons cited by commentators and scholars on the causes behind the growing disparities between Māori and non-Māori. Another key issue during this period that is not discussed in this chapter was the development of what some scholars call a 'decade of Māori development' in Māori health, which emphasised tino rangatiratanga, the Treaty of Waitangi, iwi development, cultural advancement, economic self-reliance, and social equity.[65] This occurred both within the context of, and contributed to, a growing commitment of government and government agencies to biculturalism.

1.3.1 Deinstitutionalisation and community care: legacies for Māori

'Deinstitutionalisation' refers to the closure or downsizing of psychiatric hospitals across the country over the course of the later decades of the twentieth century 'under the twin pressures of laudable social objectives and fiscal imperatives'.[66] It began with the 'apparent decision' in 1963 to cease planning new institutions, which was followed by a 1973 decision to construct no further accommodation at institutions and culminated with the rundown and closure of institutions from the 1980s. Between 1984 and 1996, deinstitutionalisation saw the devolution of most institutional mental health services to 'sector-defined services' and community centres.[67] The resulting post-institutional policy framework drew on a broad policy community that included Māori organisations, voluntary service providers, advocacy groups, service users, and interest groups made up of professionals and providers.[68]

One of the most important developments arising from deinstitutionalisation was what Dr Mason Durie has called the 'indigenisation of the mental health system'.[69] Amohia Frances Boulton agrees that '[d]einstitutionalisation could be regarded as one of the catalysts of Māori mental health service provision' in later years.[70] Brunton and McGeorge provide an optimistic assessment of the late twentieth century developments as they relate to Māori mental health. They write:

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[65] Mason Durie, *Whaiora: Māori Health Development,* Second Addition, (Oxford: Auckland, 1999); Boulton, 'Provision at the Interface', p 18.

[66] Brunton, 'The origins of deinstitutionalisation in New Zealand', p 77. See also: Alun E Joseph and Robin A Kearns, 'Deinstitutionalization meets restructuring: the closure of a psychiatric hospital in New Zealand', *Health and Place*, vol 2, no 3 (1996), pp 179-189.

[67] Brunton and McGeorge, 'Grafting and Crafting New Zealand's Mental Health Policy', p 281.

[68] Brunton and McGeorge, 'Grafting and Crafting New Zealand's Mental Health Policy', p 273.

[69] Mason Durie, 'Transforming Mental Health Services in Aotearoa New Zealand', in Te Kani Kingi et al., Maea Te Toi Ora: Māori Health Transformations (Wellington: Huia, 2018), p 82.

[70] Boulton, 'Provision at the Interface', p 14.

> [T]he government transformed the Treaty of Waitangi (1840) between Maori and the Crown into an enduring bicultural partnership based on principles of protection, partnership and participation. This was important given the surge in Maori ethnic identity (now one New Zealander in seven). Maori health became a general health care priority. Maori aspirations and involvement in policy and services were recognised; culturally appropriate services were affirmed and strengthened, a Maori health workforce was nurtured and high Maori mental health admissions rates were addressed … Maori psychiatrist, Sir Mason Durie gained widespread acceptance for an understanding of *te hauora hinengaro* (mental health) as one of the four foundations of Maori health symbolised by *Te Whare Tapa Wha* (meeting house) … Such insights informed the increased cultural sensitivity of most psychiatric hospitals as they built relationships with *iwi* (tribes) and *whanau*, incorporated Maori values and beliefs into treatment programmes and supported Maori health professionals.[71]

Te Kani Kingi adds that the considerable 'increase in the number of Māori accessing mental health' services described above led to the establishment of Māori-targeted treatment facilities and more emphasis on Māori mental health policies.[72] Kingi also describes the sense of optimism that accompanied such developments:

> In the end, the significant developments that had occurred within the mental health sector during the 1970s and 1980s saw the formal introduction of cultural philosophies into service delivery. These were typically driven by Māori staff themselves and were often supported by broader changes within society and a greater recognition of Māori values, norms and rights. A quiet sense of enthusiasm and confidence was building within Māori mental health.[73]

However, Kingi adds that such optimism required a structure through which such ideas would be expressed as well as 'a more deliberate and organised mechanism for Māori mental health service development'.[74]

Scholars also recognise the negative impacts of deinstitutionalisation in general and its impact on Māori in particular. John C. Weaver writes that the transformation 'left victims in its wake, because accidental gaps, liberal practices, and government retrenchment contributed to suicides'. In his research Weaver asserts that 'files portray a system scrambling ceaselessly to adapt'.[75] Elsewhere, Weaver writes that there were 'a shocking number of instances where the hasty de-institutionalization of mental health care allowed young people with schizophrenia greater freedom but less protection'.[76] Moreover, the number of individuals with schizophrenia who committed suicide was low until the late 1970s, but rose substantially from the 1980s (suicide is discussed in more detail in Chapter 5).[77] According to Joseph and Kearns, Tokanui Hospital's

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[71] Brunton and McGeorge, 'Grafting and Crafting New Zealand's Mental Health Policy', p 280.

[72] Kingi, 'Introduction', p 11.

[73] Kingi, 'Mental Health Services for Māori', p 47.

[74] Kingi, 'Mental Health Services for Māori', p 47.

[75] John C. Weaver, *Sorrows of a Century: Interpreting Suicide in New Zealand, 1900-2000* (Wellington: Bridget Williams Books, 2014), pp 207, 213.

[76] John Weaver and Doug Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide: The Case of New Zealand, 1980–2000', *Journal of Social History*, vol. 46 no. 3 (2013), p 771.

[77] Weaver and Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide', p 771.

closure in 1998 may have added to the mental health concerns of Māori, as Māori made up a large portion of both patients and workers. As Joseph and Kearns point out, '[h]ospitalization rates at Tokanui … typified the over-representation of Maori in institutions nationally'.[78] The Māori nursing staff of Tokanui had established a treatment unit there that was based on Māori values, but the institution's closure meant the dismantling of such initiatives.[79] More broadly, the process developed unevenly across the country, and community care was organised in an unsystematic way and was poorly managed.[80] As one report from 1994 stated, '[t]he success of deinstitutionalisation often came to be measured by reduced rates of hospitalisation rather than improved rates of access to treatment and support'.[81]

1.3.2 Mental illness is recognised as 'the number one health concern for Māori'

Both deinstitutionalisation and the broader reforms of the health sector of the 1980s and 1990s coincided with a growing recognition and awareness of the significance of mental health as an issue for Māori. As discussed above, Māori psychiatric admissions increased dramatically in the 1980s. Kingi states that by the mid-1980s, Māori 'admissions were two, and in some categories, three times that of non-Māori'.[82] Between 1960 and 1990, while 'non-Māori first-time admissions to psychiatric facilities had only slightly increased', the corresponding Māori rate had increased by more than 200 per cent.[83] Kingi also states that '[r]eadmission rates for Māori males increased by 65 per cent between 1984 and 1994', a rate that was 'nearly two times higher than non-Māori male rates and three times higher than corresponding Pacific Island rates'.[84] The patterns of hospitalisation were changing as well and admissions relating to alcohol and drug abuse had become a particular concern. At the same time, 'increasingly large numbers [of Māori] were being admitted under compulsion, through the justice system, rather than through conventional medical referral systems'.[85] For first admissions for psychiatric treatment between 1972 and 1990, Māori referred by law enforcement stood at 20 per cent, compared with 8.2 per cent for non-Māori.[86]

In 1994, the Public Health Commission identified mental illness, among other things, as a threat to Māori health.[87] Four years later, the Māori Health Commission took this further by describing

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[78] Joseph and Kearns, 'Deinstitutionalization meets restructuring', p 185.
[79] Joseph and Kearns, 'Deinstitutionalization meets restructuring', pp 179-189.
[80] Kingi, 'Mental Health Services for Māori', p 39.
[81] D Burns et al., *Towards a post-institutional response to mental health* (Auckland: Health Research Council of New Zealand, 1994).
[82] Kingi, 'Mental Health Services for Māori', p 12.
[83] Kingi, 'Mental Health Services for Māori', p 13.
[84] Kingi, 'Mental Health Services for Māori', p 13.
[85] Kingi, 'Introduction', pp 13.
[86] Robinson, 'Te Taha Tinana', p 295.
[87] Public Health Commission, *Our Health, Our Future: Hauora Pakiri, Koiora Roa: the State of Public Health in New Zealand* (Wellington: Public Health Commission, 1994), p 67.

the state of Māori mental illness as a crisis of 'unprecedented proportions'.[88] Te Puni Kōkiri, too, described Māori as a 'culture under siege' in its discussion of mental health statistics of the last decade.[89] This growing concern was accompanied by a call for more information. The 1995 *Hauora: Māori Standards of Health III* report stated that a 'comprehensive review of Māori mental health is necessary'.[90] The Mental Health Commission's 1998 *Blueprint for Mental Health Services* also commented on the lack of data.[91] Even without detailed information, various investigations, inquiries, research reports, and policy documents all highlighted the poor state of Māori mental health.[92] Both health experts and the government recognised the issues and called for new approaches. Mason Durie became a vocal advocate for change and raised the issues in numerous ways, publishing on the issues and speaking in the media. In 1997, for example, Durie argued for a 'broad-based approach for real improvement', claiming that Māori mental health was 'as much a problem now as tuberculosis was 100 years ago'. Minister of Health, Bill English, said that 'paternalistic models of mental health care' have often not worked for Maori, that 'the story of past inadequacies is told in the statistics', and that some attempts to cater to Māori in the system were simply 'token grafting' of cultural elements on to mainstream services. [93]

1.3.3 Inquiries into the mental health system, 1987-1996

The prominence of Māori in mental illness statistics was made clear in inquiries into the mental health system. Two of the most prominent inquiries were The Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in relation to Admission, Discharge, or Release on Leave of Certain Classes of Patient, 1987-1988, and a Ministerial Inquiry into mental health in 1995-1996. These inquiries were both headed by Judge Ken Mason and are together known as 'the Mason Inquiries.' Both followed high-profile incidents involving people with mental illness, including a number of suicides and a violent attack.[94] These were just two of 67 such investigations into mental health service shortcomings between 1987 and 1996.[95] According to Amohia Frances Boulton, the two Mason inquiries 'demonstrated serious shortcomings in the mental health sector; shortcomings underlined by the publication of Māori mental health admission and readmission rates'.[96]

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[88] Maori Health Commission, 'Maori Mental Health', p 14.

[89] Cited in Dow, 'Maori health and government policy, 1940-2000', p 184.

[90] Robson and Harris, *Hauora: Māori Standards of Health IV*, pp 121-122

[91] See Chapter 6 of Mental Health Commission, *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Wellington 1998).

[92] Kingi, 'Introduction', p 12.

[93] Bill English, 'The Oranga Hinengaro Maori', speech at the Maori Mental Health Conference, 28 August 1997, https://www.beehive.govt.nz/speech/oranga-hinegaro-maori-maori-mental-health-conference, paras 41-44.

[94] Warwick Brunton, 'Mental health services - Community care, 1990s onwards', Te Ara - the Encyclopedia of New Zealand, http://www.TeAra.govt.nz/en/photograph/29424/mason-report-1988, accessed 15 October 2018.

[95] Brunton and McGeorge, 'Grafting and Crafting New Zealand's Mental Health Policy', p 281.

[96] Boulton, 'Provision at the Interface', p 21.

The Mason Inquiry 1987-1988

The Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in relation to Admission, Discharge, or Release on Leave of Certain Classes of Patient, 1987-1988 (commonly known as the 'Mason Inquiry'[97]), was primarily concerned with systemic failures of mental health services, particularly those provided in prisons for offenders. The prominence of Māori in mental health statistics was reflected by the appointment of an all-Māori panel, comprising District Court Judge Ken Mason, psychiatrists Dr Henry Bennett and Dr Erihana Ryan, and with John Turei serving as the panel's kaumātua member.[98] The panel made a 'special effort' to seek the views of the Māori and Pacific Island communities, inviting the New Zealand Maori Council, the New Zealand Māori Women's Welfare League, Māori trust boards and incorporations, and other identifiable Māori organisations to participate.[99]

The panel took a regional approach to assess the quality of services for Māori. In Auckland, the panel identified three Māori mental health groups: He Putea Atawhai in Swanson; the Whare Paia at Carrington; and a very active whānau of Māori workers attached to Kingseat Hospital. In Wellington, it found that there were no facilities that specifically addressed the needs of the Māori community. At that time, the Inner-City Mission was working in conjunction with Te Roopu Taha Māori o Porirua to establish a community-based facility for Māori people. The Christchurch Hospital Board employed a Maori Health Coordinator based at Sunnyside Hospital who had a liaison role within the Māori community, but the services available in the Christchurch region fell short of any 'bicultural dimension'.[100] At Rehua Marae, participants told the panel that 'mental health services had little to offer Maori people and that they had little impact on the planners and decision makers in that area'.[101] Similarly, in Otago, there were no community psychiatric services specifically aimed at the Māori community.[102]

Due to the disproportionately high numbers of Māori in prisons and in psychiatric hospitals, the report dedicated a chapter to the quality of psychiatric services for Māori, which provides a regional overview of submissions before outlining more general issues. In some areas, such as Wellington, the panel were told that there 'was no tangible evidence of a commitment to biculturalism and the Treaty of Waitangi', and that Māori saw psychiatric hospitals as 'hostile places' and psychiatric services as 'monocultural and resistant to change'.[103] The report also noted the massive increase in admissions of Māori patients.[104]

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[97] This name is also used for another inquiry into mental health services in 1995-1996 chaired by Ken Mason. This later inquiry is discussed in the following section.

[98] Dow, 'Maori health and government policy, 1940-2000', p 183; Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on leave of certain classes of Patients, "Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on leave of certain classes of Patients' (Wellington: The Committee, 1988), p 7.

[99] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', p 7.

[100] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', p 145.

[101] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', p 145.

[102] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', pp 142-146.

[103] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', pp 167-168.

[104] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', p 193.

In summing up the concerns expressed over the course of hearings, the panel reported that Māori saw little evidence of Health Department commitment to its policy of incorporating the principles of the Treaty of Waitangi, which Māori participants considered to be 'fundamental to the development of a bicultural service'.[105] Participants had also called for a reassessment of the kind of training required to enter the health profession, arguing that training programmes are monocultural and that admissions criteria did not recognise expertise in taha Māori. As one participant noted:

> There are … many aspects of care in which the training is in Taha Maori, and it is for us to determine the validity of the quality of that training. This training is a lifelong process, which is performed in context of the individual's whanau, hapu, iwi, and with their Kaumatua and Kuia. This qualification is equally as valid as any university degree you may set as a criterion, and people with these qualifications must be incorporated into multidisciplinary psychiatric teams. Only people with this training can provide this quality of care - taha Maori.[106]

Other concerns were raised about the ways in which patients were assessed from the viewpoint of Western psychiatry, with little consideration of culture, whānau, and wairua. The psychiatric assessment process was considered a fundamental time to involve professionals with knowledge of taha Māori. Lastly, participants argued that whānau and iwi must be involved in hospital care, in discharge decisions, and in post-discharge care, and that management teams must include people that are skilled in taha Māori. In summary, the report noted: the over-representation of Māori in psychiatric hospitals and in prisons; the fact that services were not culturally appropriate for Māori; and that Māori often sought medical advice much later and therefore were more likely to require hospitalisation.[107]

The Mason Inquiry 1995-1996

Brunton describes the era leading up to the 1995-1996 Mason Inquiry as one of cost cutting, well-advanced deinstitutionalisation, and public anxiety about inadequate co-ordination between service providers. Public anxieties were also heightened by two police shootings of people with histories of mental illness, leading to some calls to reinstate traditional institutions. In 1995, a police officer fatally shot an armed person who had suffered from mental illness. Following this, a private member's bill to set-up an inquiry was prepared by a Labour MP. The National Government of the day ruled out a large inquiry, instead giving consideration to the establishment of a national task force. Following the second shooting in similar circumstances, the Government decided to establish a ministerial inquiry 'rather than have one imposed by the Opposition'.[108] In the context of these events, Brunton argues there was 'an element of political damage control' to the Inquiry.[109]

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[105] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', p 178.
[106] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', p 178.
[107] Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals, 'Report', p 166.
[108] Brunton, 'The place of public inquiries in shaping New Zealand's national mental health policy 1858–1996', p 10.
[109] Brunton, 'The place of public inquiries in shaping New Zealand's national mental health policy 1858–1996', p 10.

The 1995-1996 Mason Inquiry focussed on the two key issues of improving public safety and service co-ordination. It included a small chapter on Māori, which highlighted a number of changes in Māori mental illness statistics, including: the fact that Māori now made up a disproportionate number of mental health services users and, once admitted, were more likely to have poor outcomes; that Māori were more likely to be admitted involuntarily; and that Māori readmission rates had increased by 40 percent over the previous decade.[110] The Inquiry also drew attention to: the Ministry of Health's failure to demonstrate leadership, influence, and capacity to address the crisis in mental health; the lack of culturally appropriate services designed to meet the needs of Māori; and the tough social and economic environment that many Māori were living in.[111]

The Mental Health Commission was established as a result. The Commission started its work as a Ministerial Committee in September 1996 and later became a Crown entity under the Mental Health Commission Act 1998.[112] In 1998, the Mental Health Commission published the *Blueprint for Mental Health Services in New Zealand.* This outlined everything the Commission believed needed to change in order for the government to reach the targets set in its 'national mental health strategy', *Looking Forward* and *Moving Forward*, both of which are discussed below.

1.3.4 Explanations for growing disparities in mental health

While the increasing disparities in mental health between Māori and non-Māori since the 1980s have been well documented, the reasons behind them are not so straightforward. According to Kingi, the focus has been on behavioural issues, environmental factors (including colonisation) and socio-economic stressors. More specifically, Durie identifies '[t]he adverse effects of urbanization, inadequate primary health care, and 'racial' discrimination in treatment regimes' as factors.[113] Kingi notes the difficulty of saying 'with any certainty' the reasons for the sudden and unexpected spike in Māori admissions, but that a combination of factors played a part.[114] Mason Durie agrees that:

> There no single cause of poor mental health, nor a single solution … For the most part mental health problems amongst young Māori reflect social, economic and cultural trends and any comprehensive solutions must be similarly broad.[115]

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[110] 'Inquiry Under Section 46 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services', Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley, May 1996, p 137.

[111] 'Inquiry Under Section 46 of the Health and Disability Services Act 1993', p 137.

[112] Mental Health Commission Act 1998.

[113] Joseph and Kearns, 'Deinstutionalization meets restructure', p 181, citing Durie, Kaupapa hauora Maori: policies for Maori health, Proceedings of the Hui Ara Ahu Whakamua, (Wellington: Te Puni Kokiri, 1994).

[114] Kingi, 'Introduction', p 18.

[115] Mason Durie, *Ngā Kāhui Pou: Launching Māori Futures* (Wellington: Huia, 2003), p 147.

A number of sources detail the explanations for growing disparities in mental health since the 1980s. Eru Pomare and Gail de Boer's examination of Māori health trends for the years 1970 to 1984 linked the increasing disparities in mental health to the 'distressing social and economic disadvantage and progressive acculturation experienced by Maori people', as well as the 'loss of self-esteem and mana from unemployment, racial discrimination and cultural denigration'.[116]

Māori urbanisation in the second half of the twentieth century has been linked to mental ill-health, according to some sources, in that it led 'to cultural isolation and alienation from … traditional structures that in the past had protected and nurtured Māori'.[117] As Kingi writes, '[w]hile many would have maintained cultural ties, networks, practices and language, distance from traditional lands, marae, cultural institutions, whānau and hapū would have made things difficult. For many, cultural decay was inevitable as was an increased susceptibility to mental health problems'.[118] Kingi draws on the work of anthropologists Ernst and Pearl Beaglehole, and their book, *Some Modern Maoris*, to suggest the potential impact of colonisation and what the Beagleholes saw as the 'tremendous value to the Maori of possessing a psychological security that comes from tribal and family security'.[119] Related to Māori urbanisation was the increasing contact between Māori and the mental health system as a result of closer proximity. As discussed above, some suggest that Māori were more likely to care for whānau members within the home. Thus, as urbanisation accelerated, 'traditional ties and cultural expectations were inevitably weakened'. It should be noted, however, that the recent work of Melissa Matutina Williams has challenged the notion that urbanisation was an entirely negative phenomenon and demonstrates that Māori maintained important links 'back-home'.[120]

As mentioned above, the Pomare and de Boer linked the social and economic burdens experienced by Māori (among other things) to the increasing disparities in mental health. Unemployment, low income, poor educational achievement and substandard housing—all areas in which Māori were increasingly and disproportionately impacted—were identified as 'known predisposing factors of mental ill-health'.[121] The economic downturns of the 1970s and the subsequent neoliberal economic reforms of the 1980s and 1990s have been identified as factors in the growing disparities in mental health. Māori were hit hard by factory closures and growing unemployment during these decades. In 1986, for example, the Māori unemployment rate stood at 24.2 per cent, more than double the non-Māori rate of 9 per cent. A University of Otago study has explored the connections between job losses following industrial closures and health, with a focus on the Whakatu freezing works in Hastings.[122] It found that the closure jeopardised the stability of the community and of individual health, identifying that 'older Māori men were

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[116] Eru W Pomare and Gail M de Boer, *Hauora: Maori Standards of Health: A Study of the Years, 1970-1984* (Wellington: Department of Health and Medical Research Council, 1988), p 119.

[117] Kingi, 'Introduction', p 15.

[118] Kingi, 'Introduction', p 15.

[119] Kingi, 'Introduction', p 16.

[120] Melissa Matutina Williams, Panguru and the City: Kāinga Tahi, Kāinga Rua, An Urban Migration History (Wellington: Bridget Williams Books, 2015).

[121] Kingi, 'Introduction', pp 14-15.

[122] Vera Keefe-Ormsby, *Tihei Mauri Ora: The Human Stories of Whakatu* (University of Otago: Wellington, 2008).

particularly vulnerable to suicide'.[123] During this time, alcohol and drug consumption also continued to play a role in the large numbers of admissions to psychiatric facilities.

Studies also point to examples of discrimination in terms of employment of Māori in mental health services and what this meant for culturally appropriate treatment.[124] The inability to access services, or the deliberate avoidance of them, have been identified as two potential reasons for the disparities in mental illness between Māori and non-Māori. Specifically, service inaccessibility and avoidance have been linked to the trend of Māori accessing mental health care at a later stage, which increased the likelihood that they were seriously ill by the time they accessed care, prolonging the recovery period and increasing the likelihood of involvement of the police and courts.[125] The reasons identified for low usage of service include the 'belief in conditions such as mate Māori and mākutu, which cannot be treated by western health care, and a lack of culturally appropriate mental health services'.[126] Other explanations include mis-diagnosis. Based on anecdotal evidence, this theory suggests that cultural behaviours and nuances were interpreted as mental disorders leading to the recommendations of admission to a psychiatric facility.[127]

1.4 Māori involvement in developing mental health policy, 1980s-1990s

The growing awareness of mental health as a significant concern for Māori since the 1980s has led, in turn, to the development of policies, practices, and treatment facilities that are specifically designed to provide for Māori mental health needs. It has also led to further calls by Māori for a greater role in mental health policy making and service delivery. Kingi attributes this to a number of reasons, some of which have already been discussed: structural and legislative changes; philosophical and clinical shifts; the increasing number of Māori within the mental health sector (both as staff and patients); and a greater acceptance that there is a relationship between culture and health.[128] Mason Durie writes that this 'indigenisation' of the mental health system was achieved by:

> Māori health perspectives, cultural protocols for assessment, treatment and rehabilitation and a Māori workforce comprising increased numbers of Māori health professionals as well as Māori community workers, kaumātua, and dedicated Māori services. All contributed to an approach to mental health treatment and care that recognised culture as an important component in both assessment and recovery.[129]

While these changes are largely associated with the post-institutional care system, there were some developments towards kaupapa Māori frameworks or attempts to introduce Māori culture

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[123] Vera Keefe-Ormsby, *Tihei Mauri Ora: The Human Stories of Whakatu* (University of Otago: Wellington, 2008), p iii.
[124] Dow, 'Maori health and government policy, 1940-2000', p 181.
[125] Robinson, 'Te Taha Tinana', p 295.
[126] Robinson, 'Te Taha Tinana', p 295.
[127] Kingi, 'Introduction', pp 14-15.
[128] Kingi, 'Mental health services for Māori', p 52.
[129] Durie, 'Transforming Mental Health Services in Aotearoa New Zealand', p 82.

within the institutional model.[130] Mason Durie suggested that there were three ways hospital health boards could develop culturally appropriate health services for Māori. These were: to fund Māori groups to develop their own programmes; to incorporate Māori perspectives into already established programmes; or to develop alternative programmes that run alongside already established programmes.[131] According to Joseph and Kearns, the third option was adopted with the establishment of Te Whai Ora in the mid-1980s. This was a state-funded psychiatric unit set up at Tokanui Hospital alongside existing psychiatric services.[132] Māori nurses were employed at Tokanui and they played a significant role in the nationwide shift towards 'cultural safety' in nursing practices, a trend that 'involved the relaxing of institutional orthodoxy and the opening of space for Māori ways within institutions and health care practices'.[133] Wi Huata, who later became a Mental Health Coordinator for Te Whare Hauora o Ngongotaha, recalled that after admissions to various mental health units, '[i]t wasn't until I got to Tokanui that I was able to be looked after by Māori. I didn't feel as though I could communicate with anyone unless they were Māori'.[134]

Another early Māori health unit at Carrington Hospital, Te Whare Paia, was less successful and closed in the wake of public controversy over its dysfunctional operation.[135] Its closure by the Hospital Board was recommended in the 1988 Mason Inquiry, and its operation was condemned in a report by Race Relations Commissioner Hiwi Tauroa, but this was interpreted by others as a racist and political act.[136] However, as mentioned above, the closure of hospitals meant the end of such initiatives, even if deinstitutionalisation paved the way for other opportunities for kaupapa Māori services. According to Kingi, despite being victims of the broader closures of hospitals, they highlighted how 'health and culture could be integrated without conflict or compromise'.[137] Moreover, those who contributed to the developments described above remained in the sector while the number of clinically qualified Māori also increased.[138]

1.5 Māori Mental Health Policy and Strategy since 1992

The structures of the current mental health system were established in the 1990s and early 2000s. The Mental Health (Compulsory Assessment and Treatment) Act 1992 and the New Zealand

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[130] Robinson, 'Te Taha Tinana', p 295.

[131] Mason Durie, *Whaiora: Maori Health Development* (Oxford, Oxford University Press, 1994) cited in Joseph and Kearns, 'Deinstitutionalization meets restructuring', p 181.

[132] J F Rankin, 'Whai Ora: A Maori cultural therapy unit', *Community Mental Health in New Zealand,* Volume 2, pp 38-47.

[133] Joseph and Kearns, 'Deinstitutionalization meets restructuring', p 182.

[134] Wi Huata, quoted in Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006: The Journey of Recovery for the New Zealand Mental Health Sector' (Wellington: Mental Health Commission, 2007), pp 152-153.

[135] Kingi, 'Mental Health Services for Maori', pp 44-45; Brunton and McGeorge, 'Grafting and Crafting New Zealand's Mental Health Policy', p 280.

[136] For more on this, see Dow, 'Maori health and government policy, 1940-2000' p 182.

[137] Kingi, 'Mental Health Services for Maori', p 44.

[138] Ibid., p 46.

Public Health and Disability Act 2000 are the two key pieces of legislation that continue to underpin the system of mental health. The details of each act as they relate to the contemporary system are discussed in more detail in the following chapter. The Public Health and Disability Act 2000 aimed, among other things, to provide a voice for community within the health sector and reduce health disparities and inequalities between Māori and non-Māori.[139]

In March 2000, the Mental Health Commission released a report outlining Māori experiences of mental illness, based on four case studies. The report followed a hui in 1998, which was organised by the Mental Health Commission and included Māori in both kaupapa Māori and mainstream mental health services. It provides some important insights into the issues faced by Māori within the system by the turn of the century. The Commission concluded that Mason Durie's Whare Tapa Wha model, which was 'a holistic approach to wellbeing' that incorporated taha hinengaro, taha whānau, taha wairua, and taha tinana, 'must be used to measure outcomes for Māori who chose to have kaupapa Māori treatment, whether they be in a kaupapa Māori service or a mainstream service'.[140] The Commission also concluded that there needed 'to be a strong Māori workforce, and more and better mental health services that are controlled by consumers, whanau, and their community'.[141]

During these same decades, the Ministry of Health issued numerous mental health strategies that aimed to 'explore the opportunities offered by the health reforms and further refine the deinstitutionalised approach to mental health care'.[142] This included how Māori-specific policies could be incorporated, and how Māori might play a role in policy-making and care provision. Such strategies were building on—and responding to—a groundswell of support for Māori-led health services and are discussed below. The strategy documents reveal the evolution of thinking on government action regarding mental health and the research that underpinned it. Yet, while many of the strategies set key targets, it is not always clear how such policies and strategies were implemented. Lisa Arleen Ferguson argues that, after 1983, successive governments have produced numerous Māori health policies, but that the 'cyclical nature of policy makings suggests that it is not always followed by policy implementation'.[143]

1.5.1 Looking Forward and Moving Forward

In 1994, the Government released *Looking Forward: Strategic Directions for the Mental Health Services,* which was intended to guide the transition from institutional-based services to community-based services. The strategy acknowledged that the system was not providing adequate services to the

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[139] Boulton, 'Provision at the Interface', p 8.

[140] M. H. Durie, 'A Maori Perspective of Health', *Journal of Social Sciences and Medicine*, vol 20, no 5 (1985); Mental Health Commission, 'Four Maori Korero about their Experience of Mental Health' (Mental Health Commission: Wellington, 2000), p 7.

[141] Mental Health Commission, 'Four Maori Korero about their Experience of Mental Health', p 7.

[142] Kingi, 'Mental Health Services for Maori', p 43.

[143] Ferguson, 'Health Reform and the Impact on Māori 1983-1997', p ii.

community and that the shift to community care brought with it 'significant resource implications'.[144] It also stated that 'mental health institutions were not well funded in the first place [and] not enough funds were redirected to community services to deal with the increasing numbers of patients who were being transferred to community care'.[145] Furthermore, it noted, among other things, that an area of major concern was the disproportionate demand for mental health services from Māori, youth, and people in the criminal justice system.[146] Nevertheless, the report stressed that community-based care was internationally recognised as 'the best and, ultimately, the most cost-effective way of providing mental health services'.[147] Thus, *Looking Forward* aimed to smooth out the transition and create a coherent framework for community care. Two major goals were:

- to decrease the prevalence of mental illness and mental health problems within the community
- to increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community. [148]

Greater Māori involvement was included as part of these goals. 'Māori will also be a priority for mainstream mental health services', the report stated, 'as well as being involved in developing their own specialist services'.[149] Strategic Direction 2, entitled 'Encouraging Māori involvement in planning, developing and delivering mental health services', pointed to: the considerably higher prevalence of mental health issues among Māori compared to the rest of the population; the fact that mental health services remained 'mainly monocultural'; and stated that future services – both mainstream as well as those services managed or delivered by Māori – needed to be 'culturally safe and be able to provide treatment at a spiritual, physical, emotional, and cultural level'.[150] The national objectives were:

- to reduce the level of mental illness for Māori so that it is no higher than that of the general community
- to increase Māori involvement in the delivery of mental health services
- to increase the responsiveness of mainstream mental health services to the special needs of Māori.[151]

The report also called for an increase in the number of Māori working in community mental health services.[152] Two years later, in 1996, there was further recognition of the need for more funding and specific policy to achieve the aims outlined in *Looking Forward.* This came on the

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[144] Ministry of Health, *Looking Forward: Strategic Directions for the Mental Health Services*, (Ministry of Health: Wellington, 1994, p 1.

[145] Ministry of Health, *Looking Forward*, p 1.

[146] Ministry of Health, *Looking Forward*, p 1.

[147] Ministry of Health, *Looking Forward*, p 3.

[148] Ministry of Health, *Looking Forward*, p 4.

[149] Ministry of Health, *Looking Forward*, p 6.

[150] Ministry of Health, *Looking Forward*, p 9.

[151] Ministry of Health, *Looking Forward*, p 9.

[152] Ministry of Health, *Looking Forward*, p 9.

back of the second Mason Inquiry, which recommended the establishment of the Mental Health Commission.

Looking Forward was followed in 1997 by *Moving Forward: The national mental health plan for more and better services*. The aim of the report was making sure that *Looking Forward* was implemented and its broad focus included mental health 'promotion, prevention and primary health care'.[153] While mental health services had become more responsive to Māori since 1994, the report claimed that there was much further to go to achieve the objectives outlined in *Looking Forward*. As the title suggested, it realised the need for 'more and better' services, including for Māori. Once again, the National Objectives included '[encouraging] Māori involvement in planning, developing and delivering mental health services' (National Objective 2.1) and '[increasing] the responsiveness of mainstream mental health services to the special needs of Māori' (National Objective 2.2).[154] The report again noted that mental health services had 'operated in a predominantly monocultural manner' and required 'the active involvement of Māori in the first stages of service development and at all stages of service delivery'.[155] The report set the following targets under its 'first steps':

> TARGET 2.1.1
>
> By July 1998, the planning process of the funding/purchasing body will involve Māori, and the plans themselves will include specific undertakings to increase **Māori involvement in the design and purchasing of services** appropriate to Māori needs.[156]

> TARGET 2.2.1
>
> By July 1999, all mental health services will be using **cultural assessment procedures** for Māori consumers.
>
> TARGET 2.2.2
>
> By July 2000, all mental health services will be operating under **cultural effectiveness protocols**.[157]

Under its longer term 'next steps', the report outlined the need to continue to increase the 'responsiveness to the special needs of Māori, by providing access to both kaupapa Māori and mainstream services', and included the following target:

> TARGET 2.3.1
>
> By July 2005, 50% of Māori adults will have a **choice of a mainstream or a kauapapa Māori community support mental health service**.[158]

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[153] Ministry of Health, *Moving Forward: The national mental health plan for more and better services* (Ministry of Health: Wellington, 1997).

[154] Ministry of Health, *Moving Forward*, pp 63-64.

[155] Ministry of Health, *Moving Forward*, p 19.

[156] Ministry of Health, *Moving Forward*, p 63.

[157] Ministry of Health, *Moving Forward*, p 64.

[158] Ministry of Health, *Moving Forward*, p 40.

Lastly, the report included objectives and targets relating to Māori mental health workforce development (National Objective 6.4.), and Māori mental health promotion and mental health prevention (National Objective 7.6). Again, it included the following target:

> TARGET 6.4.1
> By July 2005, the **Māori mental health workforce** (including clinicians) will have increased by 50% from the baseline in 1997/98.[159]

No targets were set for the reduction of mental illness for Māori to at least the rate of non-Māori, but, the report explained, by July 1999 'targets for improving the mental health of Māori will be set, using the proposed baseline epidemiological study of Māori mental health'.[160] The Mental Health Commission Act 1998 included *Looking Forward* and *Moving Forward* as 'national mental health strategy' and set out that one of the functions of the Mental Health Commission was to 'monitor, and to report to and advise the Minister on, any matter relating to the implementation of the national mental health strategy'.[161] The extent to which the targets in *Moving Forward* were met is difficult to assess and as far as research for this report has found, there are no reports that follow up on these targets.

1.5.2 Te Puawaitanga and Te Puāwaiwhero: Māori Mental Health National Strategies

In 2002, the Ministry of Health published *Te Puāwaitanga: Māori Mental Health National Strategy.* According to the Mental Health Commission, the report 'was significant because, for the first time, a dedicated focus on Māori mental health entered the policy arena'.[162] *Te Puāwaitanga* was born out of the 'ground-breaking work' of *Looking Forward* and *Moving Forward,* which stressed 'health promotion, prevention, and primary health care activities', and aimed to give District Health Boards across the country a consistent framework to meet government objectives.[163] *Te Puāwaitanga* also connected the mental health needs of Māori to broader issues, arguing that 'Māori mental health is ultimately about Māori development'.[164] It also supported the position of Mason Durie that Māori mental health 'is more than efficient health services'.[165] The report also stated that, '[f]or Māori, good mental health also requires access to the institutions of Māori society such as te reo Māori, land, marae, and ready access to primary health care, education, housing and employment opportunities'.[166] Many of the targets or goals in the report mirrored what was included in *Moving Forward*, the *Blueprint*, as well as reports produced by the Mental

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[159] Ministry of Health, *Moving Forward*, p 46.
[160] Ministry of Health, *Moving Forward*, p 71.
[161] Mental Health Commission Act 1998, s 6(d).
[162] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', p 155.
[163] Ministry of Health, *Te Puawaitanga: Maori Mental Health National Strategy* (Ministry of Health: Wellington, 2002), p 2.
[164] Ministry of Health, *Te Puawaitanga,* p iii.
[165] Ministry of Health, *Te Puawaitanga,* p 3.
[166] Ministry of Health, *Te Puawaitanga,* p 3.

Health Directorate.[167] This included the following goals (each with five and three year objectives, and one year deliverables):

> Goal 1: Provide comprehensive clinical, cultural and support services to at least 3 percent of Māori, focused on those who have the greatest mental health needs.
> Goal 2: Ensure that active participation by Māori in the planning and delivery of mental health services reflects Māori models of health and Māori measures of mental health outcomes.
> Goal 3: Ensure that 50 percent of Māori adult tāngata whaiora will have a choice of a mainstream or a kaupapa Māori community mental health service.
> Goal 4: Increase the number of Māori mental health workers (including clinicians) by 50 percent over 1998 baselines.
> Goal 5: Maximise opportunities for intra- and intersectoral co-operation.[168]

According to Derek Dow, the goal regarding Māori mental health workers remained a 'major stumbling block' for progress due to the low rates of Māori entering the mental health workforce.[169] The continuing issue of workforce development is discussed in later chapters.

Te Puawaitanga was followed in 2008 by an updated strategy: *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008−2015.* The second Māori mental health strategy also followed broader government strategies to address mental health and addiction, including *Te Tāhuhu – Improving Mental Health 2005-2015* and *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015.* At the same time, it sought to integrate mental health policy into broader Māori health policy and, in particular, the policy set out in *He Korowai Oranga: Māori Health Strategy.*[170] The overarching aim of *He Korowai Oranga* was achieving whānau ora, meaning that 'Māori families [are] supported to reach their maximum health and wellbeing'.[171] *Te Puāwaiwhero* acknowledged the 'unacceptable disparities' that persisted between Māori and non-Māori, recognising that Māori suffered from a greater prevalence and severity of mental illness.[172] *Te Puāwaiwhero* also acknowledged that the relative socioeconomic disadvantage and deprivation of Māori remained major risk factors for mental illness, arguing that Māori 'bear a disproportionate burden of risk for mental ill health due to socioeconomic disadvantage.'[173] Finally, the report also attributed the high prevalence of mental illness to the fact that Māori were a young population.[174] The report drew on *Te Rau Hinengaro: The New Zealand Mental Health*

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[167] These include: M. Milne, *Ngā tikanga tōtika mo te oranga hinengaro oranga wairua: Best practice guidelines for kaupapa Māori mental health services*, unpublished hui report prepared for the Ministry of Health (2001); and Massey University, *Hua Oranga: Māori Outcome Measurement Tool*, (Palmerston North: Massey University, 2000).

[168] For more detail on the five and three-year objectives and one-year deliverables, see Ministry of Health, *Te Puāwaitanga*, pp 11-19.

[169] Dow, 'Maori Health and Government Policy, 1940-2000', p 187.

[170] Minister of Health, *Te Tāhuhu – Improving Mental Health 2005-2015* (Wellington: Ministry of Health, 2005); Minister of Health, *Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015* (Wellington: Ministry of Health, 2006); Annette King and Tariana Turia, *He Korowai Oranga: Māori Health Strategy* (Wellington: Ministry of Health, 2002).

[171] King and Turia, *He Korowai Oranga*, p 1.

[172] Ministry of Health, *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008−2015* (Wellington: Ministry of Health, 2008), p iii.

[173] Ministry of Health, *Te Puāwaiwhero*, p 4.

[174] Ministry of Health, *Te Puāwaiwhero*, p 6.

Survey, in order to develop a framework to meet the requirements under the Public Health and Disability Act 2000.

1.6 Kaupapa Māori mental health services

By the end of the twentieth century, Dow notes, '[k]aupapa Maori services were well established'.[175] The Mental Health Commission defined kaupapa Māori in the context of mental health as 'the culturally derived philosophy that underlies and is woven into all aspects of service delivery, with wellness for Māori being the desired outcome'.[176] By 1995 there were 23 kaupapa Māori mental health services, and by March 1999 there were approximately 95.[177] The report noted, however, that the increase in the number of Māori service providers had not been accompanied by an increase in the size of the Māori mental health workforce, as discussed below.[178]

Looking back over the decade 1996-2006, the Mental Health Commission called the development of kaupapa Māori services 'a great achievement of the decade' and one that made New Zealand a 'world leader in indigenous mental health services'.[179] It noted that 'spending on kaupapa Māori services provided by DHBs and NGOs [non-governmental organisations] was $81.7 million (GST excl), amounting to 9.4% of mental health funding'.[180] It noted that Māori also access mainstream services (as discussed below), which varied 'in their cultural responsiveness'.[181] In terms of access, figures at the time indicated 'that 3,196 people accessed kaupapa Māori services in the first six months of 2005 and 79% of [those] identified as Māori'.[182] It should be noted, however, that these figures would 'be understated because many kaupapa Māori services [were] provided by NGOs that do not report to [the Mental Health Information National Collection]'.[183] During the same period, '11,132 Māori service users were reported as using services'.[184] In 2001, Te Rau Pani was launched in Taranaki with the aim of providing 'an iwi-based specialist kaupapa Maori mental health service to whanau, hapu and iwi in Taranaki with the aim of enabling and empowering Maori', and included a 22-strong team of tohunga, kaumatua, and kuia.[185] In 2006, a kaupapa Māori rehabilitation unit was opened by the Auckland-

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[175] Dow, 'Maori Health and Government Policy, 1940-2000', p 186.

[176] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', p 157.

[177] National Mental Health Workforce Development Co-ordinating Committee, 'Developing the Mental Health Workforce', (Wellington, 1999), p 106.

[178] National Mental Health Workforce Development Co-ordinating Committee, 'Developing the Mental Health Workforce', (Wellington: National Mental Health Workforce Development Co-ordinating Committee, 1999), p 106.

[179] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', pp 50, 79.

[180] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', p 20.

[181] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', p 20.

[182] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', p 79.

[183] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', p 254.

[184] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', p 79. This data was drawn from Mental Health Commission, 'Report on Progress 2004–2005' (Wellington: Mental Health Commission 2006). This report was not located in time during the research for this report.

[185] *Daily News*, 7 August 2001. Source: ProQuest Newspapers.

based Mason Clinic Regional Forensic Psychiatry Services.[186] According to the Mental Health Commission, Hauora Waikato, a kaupapa Māori unit based in Hamilton offered a unique kaupapa Māori early-intervention service that covered the entire population of its region and had 'a high uptake by Māori young adults'.[187]

During the years in which *Te Puāwaitanga: Māori Mental Health National Strategy* (2002) was being developed, the Ministry of Health also developed nationwide service specifications for kaupapa Māori mental health services. Some early reports highlighted important aspects of kaupapa Māori services. The first came in 1995, with the report from Te Pūmanawa Hauora entitled *Guidelines for Purchasing Personal Mental Health Services for Māori*, which provided eight characteristics of a typical Māori mental health service. This included 'cultural assessments, whanau participation, use of Māori language, incorporation of Māori tikanga and cultural practices, the therapeutic application of Māori arts and crafts, karakia, the use of Māori medicinal herbs/therapies and rongoa, and the involvement of tohunga and traditional healers'.[188] The Ministry of Health's service specifications similarly identify common characteristics of kaupapa Māori mental health services without prescribing their specific activities.[189] Such an approach is suitable, according to Te Kani Kingi:

> Given the variety of views, it is unlikely that any single approach to the delivery of mental health services to Māori is possible, and it is perhaps unwise. Mental health concerns are complex, and any approach to care must inevitably take into account personal experiences and expectations as well as factors that are often entirely unique to the individual. Also, cultural interventions cannot easily be described, especially as the cultural expectations of Māori will vary. The key, therefore, is that frames for care are developed that can be tailored to meet both the clinical and cultural expectations of tangata whaiora. Choice is required, and an entirely bespoke approach is needed that is ultimately designed to encourage the best possible outcome for those receiving treatment and care.[190]

But while the increase in Kaupapa Māori services signalled a positive step, there were remaining challenges. Following hui in 1998, the Mental Health Commission summarised the potentials but also the concerns raised regarding kaupapa mental health services:

> The kaupapa Maori services mentioned in these stories provided a whanau atmosphere for those who could access them. The people using the services felt 'at home' and were able to find their own path to better health … [but] providers reported that many

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[186] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', p 57.

[187] Mental Health Commission, 'Te Haererenga mo te Whakaōranga 1996-2006', pp 60-61.

[188] Te Pūmanawa Hauora, *Guidelines for Purchasing Personal Mental Health services for Māori* (Palmerston North: Te Pūmanawa Hauora, Māori Studies, 1995).

In 1995, the Crown also began purchasing traditional healing services for the first time. The inclusion of tohunga and rongoā in government-funded services marked a substantial shift in approach. The Tohunga Suppression Act 1907 had banned the activities of tohunga and this ban remained in place until 1962, although, in practice, it was rarely enforced. The Tohunga Suppression Act 1907 and the Crown's attitude towards rongoā Māori more generally were considered by the Tribunal in Chapter 7 of Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims Concerning New Zealand Law and Policy Affecting Māori Culture and Identity. Te Taumata Tuatahi* (Wellington: Legislation Direct, 2011).

[189] Ministry of Health, *Kaupapa Māori mental health and addiction services – Mental health and addiction services – Tier two service specification*, April 2017, https://nsfl.health.govt.nz/service-specifications/current-service-specifications/mental-health-services-specifications/kaupapa.

[190] Kingi, 'Mental Health Services for Māori', p 56.

> kaupapa Maori services were treating many more people than they were funded for, relying on the goodness of staff working extra unpaid hours and voluntary workers. They expressed concern that referrals to kaupapa Maori services were not accompanied by the necessary funding. It is also general knowledge that there is not the range of kaupapa Maori services to cope with various levels of support needed.[191]

It should also be noted that the rise in the numbers of kaupapa Māori health providers also occurred against the backdrop of increased interest in measuring Crown agency performance and wider concerns with public accountability.[192] In 2005, Amohia Frances Boulton assessed the 'experience of Māori mental health providers as they contract to provide mental health services for the Crown' within a 'health sector dominated by "western" approaches to contracting and performance measurement'.[193] Boulton concluded that 'Māori mental health providers deliver mental health services at the interface between two philosophical viewpoints or worldviews'.[194] First, is 'that of the Māori community in which they are located and to whom they provide services'.[195] Second, is 'that of the funder, from whom they obtain resources to enable them to deliver services.' [196] As a result, Boulton argues that 'Māori providers regularly and routinely work outside the scope of their contracts to deliver mental health services which are aligned with those values and norms enshrined in Māori culture' and that 'a more responsive contracting environment and a performance measurement framework, which integrates both worldviews and which takes account of multiple accountabilities that Māori providers manage, is required'.[197]

Kaupapa Māori services today are discussed in later chapters.

1.7 Mainstream services responsiveness to Māori by end of the century

While iwi and NGO providers often met the criteria that Māori themselves control and manage service delivery (a notion that aligns well with rangatiratanga within the health sector), according to Kingi, 'this does not adequately reflect the reality that most Māori still access and receive care from mainstream providers, many of which have dedicated Māori mental health units that employ Māori cultural and clinical staff and provide care that is derived from holistic Māori models of health'.[198] Indeed, scholars note that mainstream providers were eager to improve services and showing greater sensitivity towards Māori, 'often by employing Māori staff, recruiting cultural advisors or establishing Māori units'.[199] Until the 1990s, Māori health services were largely delivered through the mainstream system, which was 'expected to be "responsive

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[191] Mental Health Commission, 'Four Maori Korero about their Experience of Mental Health', p 7.
[192] Boulton, 'Provision at the Interface', p 1.
[193] Boulton, 'Provision at the Interface', p 1.
[194] Boulton, 'Provision at the Interface', p 7.
[195] Boulton, 'Provision at the Interface', p 7.
[196] Boulton, 'Provision at the Interface', p 7.
[197] Boulton, 'Provision at the Interface', p 7.
[198] Kingi, 'Mental Health Services for Māori', pp 52-53.
[199] Kingi, 'Mental Health Services for Māori', p 50.

to" Māori'.[200] This resulted in a number of developments, including: the appointment of Māori to health boards; the establishment of taha Māori programmes for nurses; and the 'expectation that non-Māori would become more "culturally aware"'. Between 1993 and 1995 there was an 80 per cent increase in the number of mental health service providers that had included a Māori component as part of their service.[201] While this increase was sustained and reflected in other areas, there was little evidence either of the effectiveness of services or of the quality of care being provided, and data collection remained an issue. Similarly, there were concerns raised about the inconsistent approach to Māori mental health service development across the country.[202]

According to those who experienced the system, mainstream mental health services were sometimes entirely unresponsive to Māori mental health needs and maintained aspects of coercion. The 1999 Mental Health Commission report, entitled 'Four Maori Korero about their Experience of Mental Health', demonstrated this point. Describing their admission to a mainstream service, one participant claimed:

> [when] I first went to hospital… [n]othing was explained to me. I had side effects from the medication, I wasn't fully informed or a part of decision making... It's 'Do what we say, comply with your pills, don't make a fuss and you'll be able to get out of here'. That's a kaupapa of total coercion.[203]

1.8 Māori workforce development

As discussed above, Dow argues that the development of a Māori mental health workforce has remained a 'major stumbling block' for progress in addressing major mental health disparities between Māori and non-Māori.[204] The 1999 report by the National Mental Health Workforce Development Co-ordinating Committee argued that issues concerning the Māori mental health workforce needed to be addressed in order for gains to be achieved in addressing disparities.[205] It called for a 'committed and co-ordinated approach' and noted the urgent need to develop the Māori mental health workforce.[206] This included increasing the Māori mental health workforce 'so that it proportionally represent[ed] the number of tangata whaiora using mental health services', as well as increasing training and capability.[207] The report outlined several key goals to increase the number of Māori mental health workers, to increase access to a range of services,

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[200] Boulton, 'Provision at the Interface', p 22.
[201] Kingi, 'Mental Health Services for Māori', p 50.
[202] Kingi, 'Mental Health Services for Māori', p 51.
[203] Mental Health Commission, 'Four Maori Korero about their Experience of Mental Health', p 15.
[204] Dow, 'Maori Health and Government Policy, 1940-2000', p 187.
[205] National Mental Health Workforce Development Co-ordinating Committee, 'Developing the Mental Health Workforce', pp 103, 175.
[206] National Mental Health Workforce Development Co-ordinating Committee, 'Developing the Mental Health Workforce', p 108.
[207] National Mental Health Workforce Development Co-ordinating Committee, 'Developing the Mental Health Workforce', p 103.

and to strengthen primary health services.[208] Later, in 2000, a Mental Health Commission report also suggested that Māori staff often felt restricted within mainstream services.[209]

By 2007, some scholars noted that 'substantial progress' had been made in Māori health and disability workforce development more broadly in the previous fifteen years and noted a number of workforce development activities that had contributed.[210] For example, a joint undertaking by the Ministry of Health and Massey University, Te Rau Puawai, had 'contributed 146 graduates to the Māori mental health workforce' and provided 'comprehensive support to Māori students seeking university qualifications in mental health fields'.[211] Similarly, a Ministry of Health-funded national Māori mental health workforce development organisation, Te Rau Matatini, contributed to policy development, increasing capacity and capability, and promoting career opportunities in the Māori mental health workforce.[212] Such examples, the authors concluded, provided 'a strong basis for ongoing action to address inequities in Māori health workforce participation'.[213]

The current situation around Māori mental health workforce is discussed in later chapters.

1.9 Conclusion

The comparatively high rate of Māori mental illness is a fairly recent phenomenon, emerging in the second half of the twentieth century and then accelerating due to the broader social and economic context of the period. Changes in the system itself came as a result of broader economic and policy changes, shifting approaches to mental health, increasing recognition of the crisis in Māori mental health, and growing demands by Māori to play a greater role in providing services. Dow writes that, by the year 2000, provisions for Māori suffering from mental ill health had clearly improved since the nineteenth century. However, the increased scale of the problem, and a continuing lack of resources to implement a 'by Māori for Māori' approach meant that the situation was 'far from satisfactory'.[214] Indeed, while the last quarter of the twentieth century has seen growing opportunities for Māori to play a role in mental health care and services, these have had their limitations. As the following chapters will detail, disparities remain between Māori and non-Māori, and the concerns about Māori mental health as a crisis have not dissipated. Indeed, the concerns that emerged in the 1990s have only intensified.

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[208] National Mental Health Workforce Development Co-ordinating Committee, 'Developing the Mental Health Workforce', pp 105-106.

[209] Mental Health Commission, 'Four Maori Korero about their Experience of Mental Health', p 7.

[210] Mihi M Ratima et al., 'Strengthening Māori participation in the New Zealand health and disability workforce', *MJA*, vol 186, no 10 (2007), pp 541-543.

[211] Ratima et al., 'Strengthening Māori participation in the New Zealand health and disability workforce', p 541. Also see Maori & Psychology Research Unit, University of Waikato, 'Te Rau Puawai, 2002-2004, An Evaluation' (Maori & Psychology Research Unit, Te Rau Puawai Massey University, and Ministry of Health, 2005).

[212] Ratima et al., 'Strengthening Māori participation in the New Zealand health and disability workforce', p 542.

[213] Ratima et al., 'Strengthening Māori participation in the New Zealand health and disability workforce', p 541.

[214] Dow, 'Maori Heath and Government policy, 1940-2000', p 187.

Chapter 2 The Contemporary Mental Health System

This chapter provides an overview of the New Zealand mental health system as it exists today. It begins by providing an overview of the key structures and funding arrangements of the health system as a whole, before summarising the types of mental health services that are available and how they are delivered. This is followed by overviews of a number of key matters related to the use of compulsory treatment, the extent to which Māori are involved in the system, and the extent to which the system is responsive to Māori needs. The chapter finishes with a number of brief summaries of the roles of a variety of bodies and individuals who have some responsibilities for dealing with mental health issues or for the oversight of the mental health system, but which generally fall outside the core mental health system. As a chapter that is intended to provide an introduction to the various aspects of how the system is structured and functions, it does not offer overall conclusions. However, some critiques by others are noted and some observations are made within individual sections.

2.1 The New Zealand Health System

The basic structure of the New Zealand health system as it exists today was established under the New Zealand Public Health and Disability Act 2000. The legislation followed the formation of a Labour-Alliance government in 1999, which believed that the work of health care professionals had been 'hampered by the commercial focus of health care' prevailing as a result of the market reforms of the 1990s.[215] Indeed, the 2000 Act swept away important aspects of the health reforms of 1993 and 1998, including abolishing the Health Funding Agency and replacing commercially-based Hospital and Health Services with District Health Boards (DHBs). The newly created DHBs were Crown entities with partially elected boards.[216] These changes to the overarching structure of the health system were followed shortly afterwards by the implementation of a new Primary Health Care Strategy that promoted the creation of non-profit Primary Health Organisations (PHOs). Funded by DHBs, PHOs would deliver primary services to enrolled populations.[217] Thus, these reforms in the early 2000s established the Ministry of Health, DHBs, and PHOs as the key bodies in the New Zealand health system, as they remain today. Outside of these bodies, the health system today encompasses a multitude of other

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[215] Annette King, 'The New Zealand Health Strategy' (Wellington: Ministry of Health, 2000), p 3. Available at: https://www.health.govt.nz/system/files/documents/publications/newzealandhealthstrategy.pdf, accessed 24 October 2018.

[216] Peter Quin, 'New Zealand Health System Reforms', Parliamentary Library Research Paper 09/03, pp 18-19.

[217] Annette King, 'The Primary Health Care Strategy' (Wellington: Ministry of Health, 2001) Available at: https://www.health.govt.nz/system/files/documents/publications/phcstrat.pdf, accessed 25 October 2018.

organisations, both government and non-government – some of these will be discussed later in this chapter to the extent that they are involved in matters of mental health.

This section outlines the key functions of the Ministry of Health, DHBs, and PHOs before outlining health funding, providing important context for understanding how mental health care (discussed in more detail in the following sections) fits in within the broader health system. The structure of the system is also presented in the form of a diagram in Figure 2.1.

2.1.1 Ministry of Health

The Ministry of Health has the primary leadership role within the New Zealand health system and the overall responsibility for its management. As part of this role, the Ministry fulfils a number of functions, including:

- Providing policy, clinical, and technical advice to ministers;
- Purchasing and regulating national health services (including such matters as immunisations, maternity services, and ambulance services);
- Funding and monitoring DHBs and other health-related Crown entities and leading performance improvement;
- Providing support to health-related Crown entities in matters of planning and accountability
- Ensuring compliance with legislation;
- Providing national information systems; and
- Providing payment services.

Although the Ministry is central to the running of the health system, it is only a small part of the system, accounting for approximately 1 per cent of operational and capital funding provided through Vote Health for 2018-19.[218]

2.1.2 District Health Boards

Twenty DHBs across New Zealand are tasked with providing health services for the people of distinct geographical areas. DHBs provide services to their populations both directly, for example through public hospitals that they own and operate, and through funding services delivered by private and other non-government providers. Each DHB is governed by a board of up to 11 members. Ordinarily this would include seven members elected by eligible voters at elections held in conjunction with the triennial local government elections and up to four

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[218] 'What we do', Ministry of Health, https://www.health.govt.nz/about-ministry/what-we-do, last modified 10 May 2018.

members appointed by the Minister of Health.[219] In making appointments, the Minister must 'endeavour to ensure that':

> (a) Maori membership of the board is proportional to the number of Maori in the DHB's resident population (as estimated by Statistics New Zealand); and
> (b) in any event, there are at least 2 Maori members of the board.[220]

In certain circumstances, it is possible for the Minister to intervene in the governance of a DHB, including by appointing Crown monitors, replacing the board with a commissioner, or giving directions.[221]

The New Zealand Public Health and Disability Act 2000 sets out a number of objectives for DHBs in matters including improving health, addressing disparities, maintaining standards, and remaining connected and responsive to the communities they serve. These objectives include:

> i. to reduce health disparities by improving health outcomes for Maori and other population groups:
> ii. to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:[222]

The Act also provides that the functions of DHBs include

> (d) to establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement:
> (e) to continue to foster the development of Maori capacity for participating in the health and disability sector and for providing for the needs of Maori:
> (f) to provide relevant information to Maori for the purposes of paragraphs (d) and (e):[223]

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[219] New Zealand Public Health and Disability Act 2000, s 29(1), Schedule 2 ss 3 and 9.

[220] New Zealand Public Health and Disability Act 2000, s 29(4). The Act also, in ss 34, 35, and 36, includes requirements that boards must provide for Maori representation on specified advisory committees and, in Schedule 3 s 38(2), requirements that boards 'must endeavour, where appropriate, ensure to representation of Maori' in any other committees they may establish. There are also requirements in Schedule 3 s 5 for boards to provide training for members who are not already familiar with a variety of matters, including 'Maori health issues, Treaty of Waitangi issues, or Maori groups or organisations in the district of the DHB'.

[221] New Zealand Public Health and Disability Act 2000, ss 30, 31, 32, 33, 33A, 33B.

[222] New Zealand Public Health and Disability Act 2000, s 22(1).

[223] New Zealand Public Health and Disability Act 2000, s 23(1).

2.1.3 Primary Health Organisations[224]

Primary Health Organisations are bodies funded by DHBs to provide primary health services to the communities that they serve. They must be established as not-for-profit bodies, involve their communities in governance, and involve practitioners and providers in decision-making.[225]

Although funded by individual DHBs, the manner in which PHOs are funded is determined by a national formula based on the size and characteristics of the population they serve, 'consistent with that used to calculate the DHB's population-based funding'. PHOs are thus required to keep a regularly updated register of their enrolled population.[226] An individual can only be enrolled with a single PHO at a time.[227] The PHO 'first contact' funding formula, nevertheless, differs from the population-based funding formula used for DHBs as it takes into account only age and gender, excluding consideration of ethnicity and socio-economic status.[228]

These matters, however, are considered in determining eligibility for some forms of additional funding. Services to Improve Access Funding is available to all PHOs for services and activities targeted at Māori, Pacific peoples, and those residing in decile 9-10 areas in the New Zealand Deprivation Index.[229] These factors are also used in assessing the eligibility of practices to join the Very Low Cost Access (VLCA) scheme, which provides increased capitation payments to practices that limit fees.[230] Since 2009, eligibility has been limited to practices with over 50 per cent of their enrolled patients being Māori, Pacific people, or those living in areas falling within deprivation quintile 5. VLCA is widely criticised due to its poor targeting of funding, which is aimed at practices rather than individuals. An analysis conducted in 2013/14 concluded both that 44 per cent of those enrolled in VLCA practices do not belong to these high-needs groups and that 44 per cent of those in the high-needs groups were not enrolled in a VLCA practice.[231]

Under these arrangements, PHOs, like DHBs, receive public funding on a capitation basis, rather than on a fee-for-service basis. It is not compulsory for medical practitioners to join a PHO or for patients to enrol with one. However, those who do not enrol do not receive the benefits of population-based public primary health funding.[232]

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[224] The Tribunal considered matters of primary health care in Stage 1 of this Inquiry. The discussion of matters related to primary health care here and elsewhere in this report was largely drafted independently prior to the release of the Stage 1 report and should be read separately to it.

[225] Ministry of Health, 'A Guide for Establishing Primary Health Organisations' (Wellington: Ministry of Health, 2002), pp 14-17, 27.

[226] Ministry of Health, 'A Guide for Establishing Primary Health Organisations', p 11.

[227] Ministry of Health, 'A Guide for Establishing Primary Health Organisations', p 12.

[228] Amy Downs, 'From Theory to Practice: The Promise of Primary Care in New Zealand' (Wellington: Fullbright New Zealand, 2017), p 15.

[229] 'Services to Improve Access', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/services-improve-access, last modified 9 July 2014.

[230] Downs, 'From Theory to Practice', p 15.

[231] Downs, 'From Theory to Practice', p 36.

[232] King, 'The Primary Health Care Strategy', pp 5, 7.

While PHOs must meet certain basic national requirements, they vary substantially in their form and how they fulfil their responsibilities. They can range from small iwi-run services operating a limited number of clinics and services through to bodies that encompass a multitude of practices with many hundreds of thousands of enrolled patients. They may be structured as charitable trusts, incorporated societies, or not-for-profit companies.[233] They may provide services through employing practitioners or through contracts with practices and providers.[234] The manner in which individual services are funded can be decided by PHOs, subject to requirements to satisfy DHBs that these meet not-for-profit requirements and are in line with the aims of the Primary Health Care Strategy – '[s]alaries, capitation payments, fees for service, target payments, allowances and blended payment methods are all possible arrangements that may be adopted by PHOs.'[235] There are a total of 32 PHOs operating around New Zealand, a number greatly reduced as a result of government-encouraged mergers from the 81 that existed in 2010.[236] It was originally intended that PHOs would normally deliver services within the boundaries of a single DHB except in particular circumstances and, to this day, it is common for a PHO to operate solely within a single DHB. However, in practice, a number of PHOs operate across DHB boundaries.[237] Amongst the requirements for PHOs set out in the Primary Health Care Strategy are that they 'identify and address those groups in their populations that have poor health or are missing out on services' and provide for the 'different needs and priorities' of ethnic communities.[238] The strategy also outlines an expectation that mainstream primary health providers will 'organise and deliver services that are culturally competent and effective' for Māori and Pacific people and that, 'where possible', PHOs with significant Māori and Pacific populations should establish 'specific services for these people'.[239]

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[233] Ministry of Health, 'A Guide for Establishing Primary Health Organisations', p 13.

[234] Ministry of Health, 'A Guide for Establishing Primary Health Organisations', p 12.

[235] Ministry of Health, 'A Guide for Establishing Primary Health Organisations', pp 12, 17.

[236] 'Push to merge Primary Health Organisations', *Stuff*, http://www.stuff.co.nz/national/health/3292054/Push-to-merge-Primary-Health-Organisations, last modified 4 February 2010.

[237] Ministry of Health, 'A Guide for Establishing Primary Health Organisations', p 13.

[238] King, 'The Primary Health Care Strategy', p 10.

[239] King, 'The Primary Health Care Strategy', p 15.

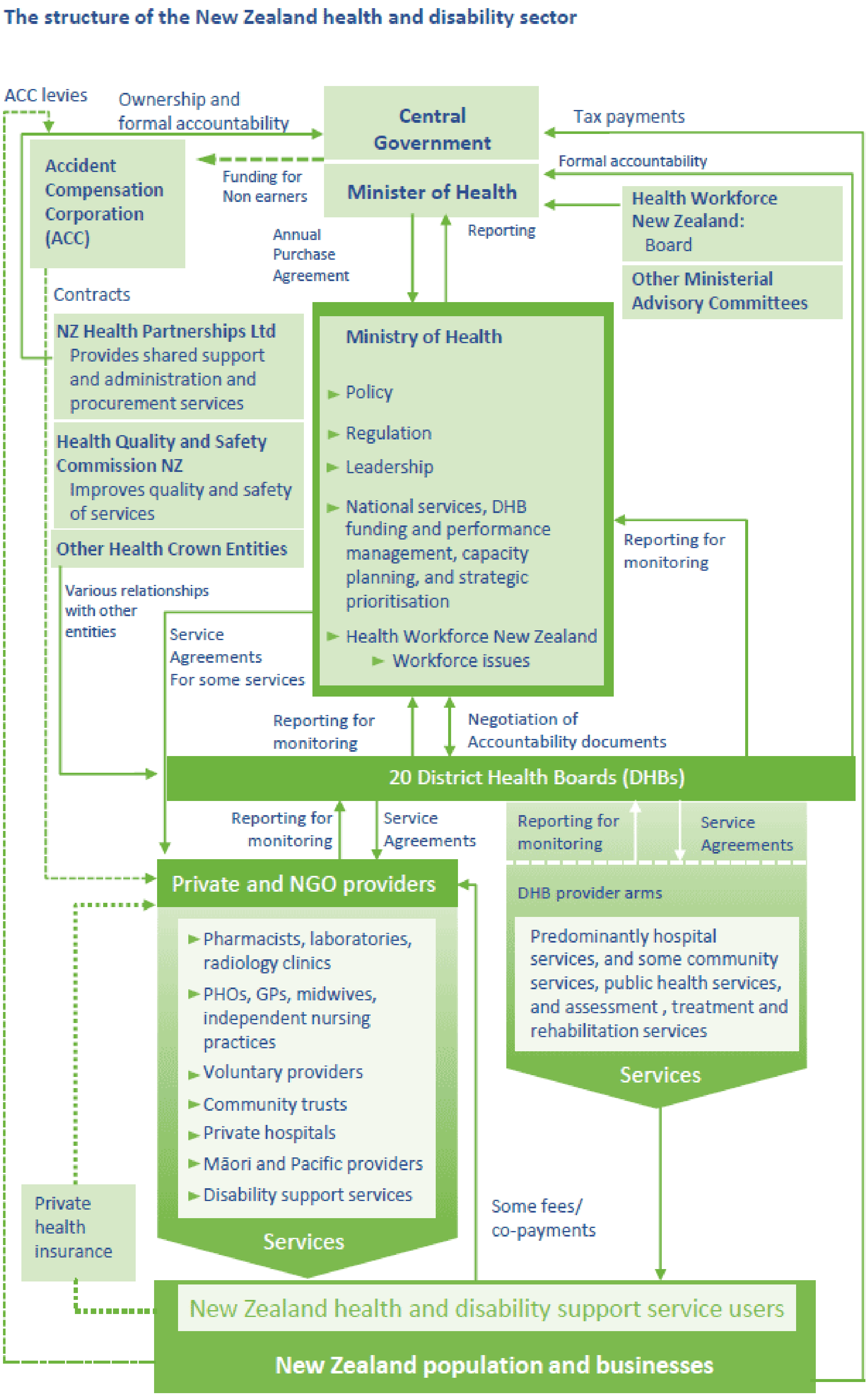

Figure 2.1 The structure of the New Zealand health and disability sector.[240]

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[240] Source: ‘Overview of the health system’, Ministry of Health, https://www.health.govt.nz/new-zealand-health-system/overview-health-system, last modified 30 March 2017.

2.1.4 Health funding

The largest component of funding for health services is delivered to DHBs through the population-based funding formula (PBFF), which was first introduced in 2003/04.[241] The formula includes both a core component and a number of adjusters. The core component is based primarily on the population of the DHB, including consideration of its demographic profile with regards to age, sex, ethnicity (Māori, Pacific, and other), and socio-economic status. These figures are used to estimate the share of funding required for the DHB to provide services to its community.[242] The three adjusters applied take into account other factors that may have varying impacts on DHBs or where the government has policy objectives for the delivery of additional services to population groups:

- The rural adjuster provides additional funding for DHBs serving rural communities to cover additional costs incurred in such matters as transferring patients and operating small hospitals. [243]
- The overseas eligible and refugee adjuster allocates additional funding to DHBs on the rates of use of publicly funded services by people who are not ordinarily resident in New Zealand and the number of refugees settled within the DHB's area.[244]
- The unmet needs adjuster provides additional funding based on the number of those within a DHB's area who are of Māori or Pacific ethnicity or live in areas of high socio-economic deprivation. These groups are recognised as experiencing health disparities, suggesting that their needs are not being met by current services and that a funding formula based on historical usage rates would see these disparities continue. This adjuster, therefore, 'is intended to be used to provide services over and above existing services and/or expenditure in order to work towards reducing the disparities for high-need groups.'[245]

The PBFF relies on census data, with the use of new data 'as soon as possible' being recognised as essential '[i]n order to maintain confidence in the system'.[246] The Ministry of Health, however, is still using figures based on the 2013 census, due to the delays in releasing data from the 2018 census, and, according to a March 2019 media report, stated that, at that time, it could not comment on whether it was confident in the data that would eventually be released from the

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[241] 'Review of the Population-Based Funding Formula 2015 – Cabinet Paper', p 1. Available at: https://www.health.govt.nz/system/files/documents/pages/pbff_review_-_final_cab_paper.docx, accessed 23 October 2018.

[242] 'Review of the Population-Based Funding Formula 2015 – Cabinet Paper', p 2.

[243] 'Population-Based Funding Formula: Five Yearly Review Summary, 2007-08', Ministry of Health, Pre-publication version, pp 18-19. Available at: https://www.health.govt.nz/system/files/documents/pages/pbff_review_version_pre_publication.docx, accessed 23 October 2018.

[244] 'Population-Based Funding Formula: Five Yearly Review Summary, 2007-08', pp 19-20.

[245] 'Population-Based Funding Formula: Five Yearly Review Summary, 2007-08', p 18.

[246] 'Review of the Population-Based Funding Formula 2015 – Cabinet Paper', p 3.

2018 census.[247] The 2018 census had a response rate that the Government Statistician has acknowledged was 'unacceptably low' and Stats NZ are currently working to use administrative data to supplement data gathered from census forms.[248] The national collection response rate was 83.3 per cent, (down from 92.2 per cent for the 2013 census), while the figure for Māori was 68.2 per cent (down from 88.5 per cent) and the figure for Pacific peoples was even lower at 65.1 per cent (down from 88.3 per cent).[249]

In 2016-17, the operating budget for the health system provided through Vote Health amounted to $15.351 billion. Approximately $1.425 billion of this was spent on mental health and addiction services, the bulk of it by DHBs with $70 million spent by the Ministry of Health. Out of this total amount, $991 million was spent on services delivered by DHBs and a further $434 million was spent on services contracted to NGOs. These figures are solely for specialist services and do not cover expenses related to the treatment of mental health conditions in general services, such as by general practitioners or nurses in PHOs or through primary mental health services.[250]

Funding for mental health services is provided as part of the funding delivered through the PBFF.[251] However, unlike funding for other services, funding provided to DHBs for specialist mental health and addiction services is ring-fenced. In other words, this funding must be spent on mental health and addiction services and cannot be diverted by DHBs for other purposes. If a DHB wishes to spend more on mental health services than the ring-fenced amount, it is free to do so.[252]

2.2 Mental Health Care in New Zealand

There is no single and distinct New Zealand mental health system. Rather, mental health services are delivered in a variety of ways throughout the broader health system. These services are designed to cater to the needs of those suffering from mental health problems of varying degrees of severity, including everything from inpatient specialist mental health services to primary treatment by a general practitioner through to online self-help services. This range of services is designed to form part of a stepped-care approach, covering self-help, primary, and specialist

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[247] Cate Broughton, 'Health boards, schools may lose funding as Ministries forced to use 2013 census data', Stuff, https://www.stuff.co.nz/national/health/111036613/health-boards-schools-may-lose-funding-as-ministries-forced-to-use-2013-census-data, last modified 5 March 2019.

[248] '2018 Census collection response rates unacceptably low', Stats NZ, https://www.stats.govt.nz/methods/2018-census-collection-response-rates-unacceptably-low, last modified 22 July 2019.

[249] '2018 Census collection response rates unacceptably low', Stats NZ.

[250] Ministry of Health, 'Appendix Five: Mental Health Funding and Expenditure', Submission to the Government Inquiry into Mental Health and Addiction, May 2018, p 1. Available at: https://www.health.govt.nz/system/files/documents/pages/submission-government-inquiry-into-mental-health-and-addiction-appendix5.pdf, accessed 23 October 2018; personal communication with Principal Advisor, Mental Health, Ministry of Health, 4 March 2019; Government Inquiry into Mental Health and Addiction, 'He Ara Oranga' (Wellington: Government Inquiry into Mental Health and Addiction, 2018), p 216.

[251] 'Review of the Population-Based Funding Formula 2015 – Cabinet Paper', p 2.

[252] Ministry of Health, 'Appendix Five: Mental Health Funding and Expenditure', p 1.

services, that 'involves intervening in the least intrusive way' and is intended 'to provide a seamless, integrated response whereby people receive support that is appropriate and timely'.[253]

2.2.1 Mental Health and Addiction Services

Specialist mental health and addiction services are designed for those with long-term or complex needs, a group that constitutes only a small fraction of the total number of New Zealanders who will suffer from mental health issues over the course of any year.

The Ministry of Health established a benchmark of 3 per cent in 1994 as a target for the proportion of the adult and youth population to whom mental health services should be delivered. This figure was established primarily on the basis of an estimate made in New South Wales of the proportion of the population requiring general mental health services and was adjusted upwards to take into account differences in demography, service-use patterns, and prevalence rates amongst Māori.[254] Analysis by the Health Funding Authority in 1998 suggested only 1.5 per cent of adults and 0.7 per cent of children were receiving mental health services.[255] In 2016, 3.6 per cent of the population accessed specialist mental health and addiction services.[256] While the provision of services has clearly improved, the Mental Health Commissioner has noted that the Ministry's target has not been revised in over 20 years and may no longer be appropriate.[257]

Specialist services are predominantly delivered in the community with 91 per cent of service users accessing only community services. A further 9 per cent received a mixture of inpatient and community services with fewer than 1 per cent receiving solely inpatient treatment.[258] The most common form of treatment is individual treatment sessions, with other services including 'peer support, kaupapa Māori services, therapeutic, physical exercises, and psychoeducational groups, and community support.'[259] DHBs are responsible for the delivery and funding of specialist mental health and addiction services for their populations, drawing on the ring-fenced mental

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[253] Ministry of Health, 'Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017' (Wellington: Ministry of Health, 2012), pp 47, 64.

[254] Ministry of Health, 'Looking Forward: Strategic Directions for the Mental Health Services' (Wellington: Ministry of Health, 1994), p 2.

[255] Health Funding Authority, 'National Mental Health Funding Plan 1998-2002' (Wellington: Health Funding Authority, 1998), p 5.

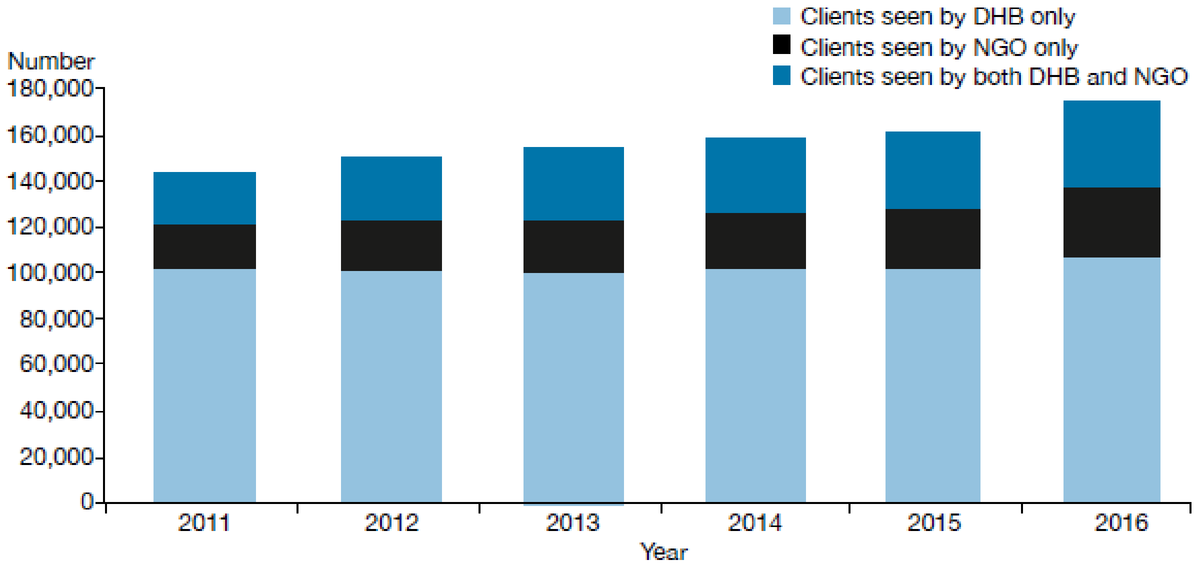
[256] Some caution must be exercised when comparing these figures. The original New South Wales estimate explicitly excluded forensic services, alcohol and drug treatment, and services for the elderly. The 3 per cent New Zealand target, as originally announced, related only to adults and youth, with benchmarks for children, older people, and those needing drug and alcohol treatment still to be considered. The 2016 figure of 3.6 per cent includes those who accessed addiction services without accessing other mental health services. Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016' (Wellington: Ministry of Health, 2017), p 4; Ministry of Health, 'Looking Forward', p 2.

[257] Kevin Allan, 'New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner, February 2018' (Auckland: Health and Disability Commissioner, 2018), p 25.

[258] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 5.

[259] Allan, 'New Zealand's mental health and addiction services', p 25.

health funding discussed earlier as well as any additional funding they may choose to commit. These services may be delivered directly by DHBs or through funding services delivered by non-government organisations (NGOs).



Source: Programme for the Integration of Mental Health Data (PRIMHD).

Figure 2.2 Number of people engaging with specialist services each year, 2011-2016[260]

The majority of those who access specialist mental health and addiction services across New Zealand each year access only DHB-run services, with smaller, but still significant, numbers accessing either only NGO-run services or a mix of DHB and NGO services.[261] (See Figure 2.2). Whilst there are some substantial variations between the respective roles and importance of DHB and NGO services across the country, there are some clear patterns that are apparent on a national scale. All inpatient services are run by DHBs and DHBs are also overwhelmingly responsible for the delivery of forensic services – just 1 per cent of those working in funded NGO adult mental health and addiction services in 2014 were involved in forensic positions, in comparison to 17 per cent of those employed by DHB services.[262] Conversely, residential services are firmly the domain of NGO providers with 36 per cent of the NGO mental health and addiction workforce in 2014 providing these services, as opposed to 0 per cent of staff in DHB services.[263] There are also substantial differences nationally between DHB and NGO services in terms of the proportion of their staff in clinical positions; 75 per cent of staff of DHB mental health services in 2014 were in clinical roles in comparison to just 11 per cent of those

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[260] Source: Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 4.
[261] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 4.
[262] Allan, 'New Zealand's mental health and addiction services', p 22; Te Pou o Te Whakaaro Nui, 'NGO adult mental health and addiction workforce: 2014 survey of Vote Health funded services (Auckland: Te Pou o Te Whakaaro Nui, 2015), pp 10-11.
[263] Te Pou o Te Whakaaro Nui, 'NGO adult mental health and addiction workforce', pp 10-11.

working in NGO mental health services.[264] Over half of all full time equivalent positions in NGO mental health services were for community support or residential support roles.[265]

2.2.2 Primary Mental Health Care

For most New Zealanders who are seeking professional help for mental health issues their general practitioner (GP) is their first port of call.[266] For those with more complex or enduring issues, consultation with a GP may lead to a referral to a specialist mental health service. For those with mild to moderate symptoms – estimated at 16 per cent of the population in 2006 – treatment can be provided by a GP and other primary health professionals, with some services and individuals receiving government support and others being available through private practice.[267] While, by their very nature, they are generalists rather than specialists, GPs play an important role in the treatment of mental health issues. Indeed, they are trained in the identification, treatment, and management of mental health issues and are able to provide some interventions and prescribe medication.[268]

General practitioners are likely to see a significant number of patients with mental health issues, although only a small proportion of consultations will be specifically in relation to them. A 2001 study of patients presenting at general practices in Taranaki and Wainuiomata indicated that, of those who completed a survey, 23.4 per cent had significant psychological symptoms. The general practitioners themselves identified 20.6 per cent of the patients as having psychological symptoms, but identified only 5.7 per cent of consultations as being for psychological issues.[269]

In addition to the funding provided by DHBs to PHOs for primary health care, further funding is provided specifically for particular primary mental health services. In 2016-17, for example, this amounted to $26 million or roughly 2 per cent of DHB spending on mental health and addiction services.[270] These primary mental health services are delivered primarily by PHOs, although in some cases they are delivered by NGOs or directly by a DHB, and include:

- extended general practitioner or practice nurse consultations
- brief interventions (for both mental health and AOD)

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[264] The differences between the proportion of clinical roles in NGO and DHB addiction services and combined mental health and addiction services are less marked, although still significant. Te Pou o Te Whakaaro Nui, 'NGO adult mental health and addiction workforce', p 14.

[265] Te Pou o Te Whakaaro Nui, 'NGO adult mental health and addiction workforce', p 15.

[266] Allan, 'New Zealand's mental health and addiction services', p 24.

[267] Allan, 'New Zealand's mental health and addiction services', pp 24-25; Mark A Oakley Browne, J Elisabeth Wells, and Kate M Scott (eds), 'Te Rau Hinengaro: The New Zealand Mental Health Survey' (Wellington: Ministry of Health, 2006), p 23.

[268] Allan, 'New Zealand's mental health and addiction services', p 24.

[269] John Bushnell et al, 'Psychological problems in New Zealand primary health care: A report on the pilot phase of the Mental Health and General Practice Investigation (MaGPIe)' https://www.otago.ac.nz/wellington/otago019166.pdf, accessed 24 June 2019. (Originally published in *New Zealand Medical Journal* vol 114 (2001), pp 11-13)

[270] Allan, 'New Zealand's mental health and addiction services', p 24.

- individually tailored packages of care (which cover a variety of services such as cognitive behavioural therapy, medication reviews, counselling and other psychosocial interventions)
- group therapy.[271]

Given the limited funding available, these primary mental health services are often only made available to certain groups, including Māori, Pacific people, young people, and Community Service Card holders.[272] In total, these services were provided to 2.8 per cent of the population in 2016-17, a figure significantly lower than the proportion of the population suffering mild to moderate mental health issues.[273] Other primary health services, including consultations with psychologists, are available to the general population through private practice on a fee-for-service basis.

2.2.3 Self-help, online, and telephone services

A number of services are available to assist those suffering from mental health problems that can be accessed remotely and do not involve face-to-face contact. Services funded by the government include:

- The National Telehealth Service, which is operated by Homecare Medical under a 10-year government contract. The service can be contacted by telephone, and in some cases by text or other means, 24 hours a day and provides specialised services for a number of conditions and circumstances. Services focussed on mental health issues include 1737 Need to talk?, Depression Helpline, and Gambling Helpline. In the year to 30 June 2018, the National Telehealth Service was contacted 634,000 times, with its mental health counselling team offering support to over 60,000 individuals.[274]
- Websites run by the Health Promotion Agency as part of the National Depression Initiative – depression.org.nz, which includes pages targeted at specific groups including Māori and the

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[271] 'Primary mental health', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/primary-mental-health, last modified 7 March 2017.

[272] Allan, 'New Zealand's mental health and addiction services', p 25.

[273] Allan, 'New Zealand's mental health and addiction services', p 24.

[274] Mental health and addiction services offered through the National Telehealth Service generally answer calls reasonably quickly, with 93 per cent of calls answered within a minute between July 2016 and June 2017. Nevertheless, a significant number abandon their calls before they are answered – 36 per cent of callers to the Gambling Helpline and 14 per cent of callers to other mental health and addiction services in the year to October 2016. By comparison, only 6 per cent of callers to Healthline and 8 per cent of callers to Quitline hung up before their calls are answered. 'Range of services provided', Ministry of Health, https://www.health.govt.nz/our-work/national-telehealth-service/range-services-provided, last modified 4 February 2019; 'About us', Homecare Medical, https://www.homecaremedical.co.nz/en/about-us, accessed 1 March 2019; Sapere Research Group and Litmus, 'Technical Appendices for the Post-Implementation Review of the National Telehealth Services', 18 December 2017, p 8, available at https://www.health.govt.nz/system/files/documents/pages/technical-appendices-post-implementation-review-national-telehealth-service.pdf.

self-help tool 'The Journal', and the youth-targeted 'The Lowdown'.[275] Both of these websites are linked to telephone and text counselling services provided as part of the National Telehealth Service.[276]

- Websites and apps supported as part of the Prime Minister's Youth Mental Health Project. Among these is the SPARX app, designed to deliver cognitive behavioural therapy in a form resembling a computer game to those between the ages of 12 and 19 suffering from anxiety or depression.[277]

There are also some significant services of this type freely available to the public that operate independently of government. Some, such as Barnardos' 0800 What's Up counselling service for children and teenagers rely on a mix of funding from government and other sources.[278] Others, such as Lifeline and its sister services Suicide Crisis Helpline and Kidsline, currently receive no government funding and instead rely entirely on donations.[279]

2.3 Compulsory treatment

Not all mental health services are entered voluntarily, and individuals can be compelled to undergo treatment. The Mental Health (Compulsory Assessment and Treatment) Act 1992 sets out the circumstances in which individuals may be ordered to undergo assessment and treatment for a mental disorder, where they pose a serious danger to the health and safety of themselves or others or have a diminished capacity to take care of themselves.

Over the course of 2016, 10,311 individuals – approximately 6.1 per cent of those using specialist mental health and addiction services – were subject to the Mental Health (Compulsory Assessment and Treatment) Act, with 5,163 under compulsory assessment or compulsory treatment orders on the final day of the year.[280] Approximately 88 per cent of those under compulsory treatment orders received treatment in the community, rather than as inpatients.[281]

While Māori have higher recorded rates of mental illness and higher rates of use of mental health services than the general population, the rates of compulsory treatment for Māori and non-Māori are even more disproportionate. In 2016, Māori were 3.6 times as likely to be under a community

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[275] 'National Depressions Initiative', Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/national-depression-initiative, last modified 30 May 2019. See https://depression.org.nz/ and https://thelowdown.co.nz/

[276] 'National Depressions Initiative', Ministry of Health.

[277] 'Frequently asked questions', SPARX, https://www.sparx.org.nz/faq, accessed 1 March 2019; 'Youth Mental Health Project', Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project, last modified 23 April 2018.

[278] 'About us', 0800 What's Up, https://www.whatsup.co.nz/about-us/, accessed 1 March 2019.

[279] 'About us', Lifeline Aotearoa, https://www.lifeline.org.nz/about-us, accessed 1 March 2019.

[280] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 19; Personal communication with Principal Advisor, Mental Health, Ministry of Health, 1 March 2019.

[281] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 20.

treatment order than non-Māori and 3.4 times as likely to be under an inpatient treatment order.[282]

2.3.1 Process of compulsory assessment and treatment

Having someone subjected to compulsory assessment and treatment involves a number of steps and incorporates a range of safeguards, requiring, at different stages, assessments by medical practitioners and determinations by judges. These steps are explained in detail below and are set out in a much more abbreviated form in Figure 2.3.

The process is started when a person completes an application form requesting the Director of Area Mental Health Services for an assessment of another individual.[283] The applicant must have seen the person for whom the request for assessment is being made within the last three days and must state the grounds on which they believe that the applicant is suffering from a mental disorder. The application must also be accompanied by a certificate issued by a health practitioner who had examined the person within the three days before the application is made and which must, amongst other things, set out the reasons why the practitioner believes the 'person's condition may come within the statutory definition of mental disorder'.[284] Upon receiving an application, the Director of Area Mental Health Services must make arrangements for the person to undergo an immediate assessment by a psychiatrist or, where one is not 'reasonably available', by an appropriately qualified medical practitioner or nurse practitioner.[285]

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[282] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 25.
[283] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 8.
[284] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 8A, 8B.
[285] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 9.

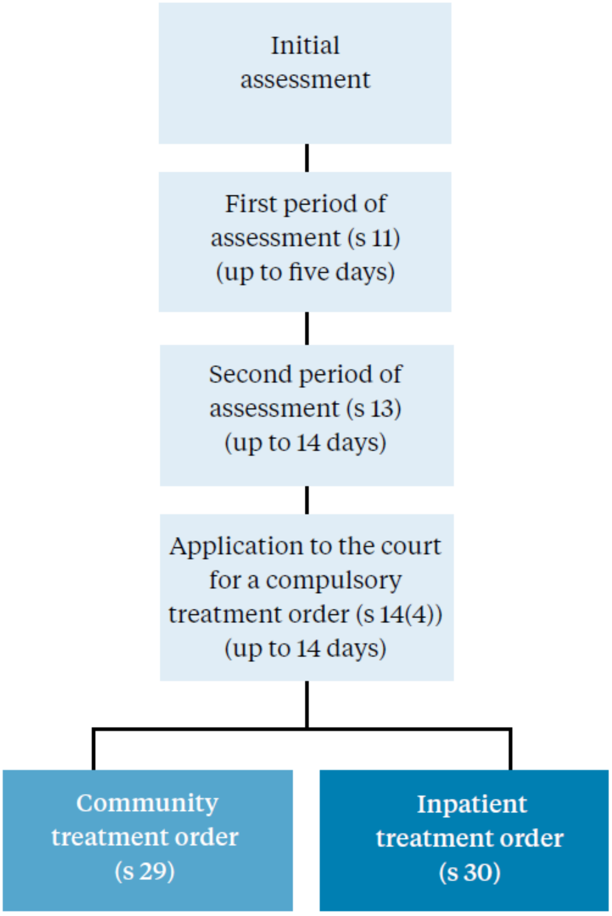

Figure 2.3 Steps in the process of compulsory assessment and treatment.[286]

If this health practitioner makes a finding that ‘there are reasonable grounds for believing that the proposed patient is mentally disordered’ and that further assessment and treatment is ‘desirable’, he or she must require the person to undergo further assessment and treatment over an initial period of five days.[287] This may occur in the community or through detention of the person at a hospital. During this period, the responsible clinician may change the patient’s inpatient or outpatient status or terminate compulsory status.[288]

If the responsible clinician records a finding that the patient is mentally disordered prior to the end of the initial assessment period, the patient must then receive assessment and treatment for a further period of 14 days. The responsible clinician may alter the terms of this second period or end it on the same terms as for the first period.[289] Prior to the end of this period, the responsible clinician must apply to a court for a compulsory treatment order if ‘of the opinion that the

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[286] Source: Ministry of Health, ‘Office of the Director of Mental Health Annual Report 2016’, p 20.
[287] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 10, 11.
[288] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 11.
[289] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 13.

patient is not fit to be released from compulsory status'.[290] Throughout the periods of compulsory assessment, patients may request a judicial review of their condition.[291]

Every application for a compulsory treatment order is to be heard and determined by a judge of the Family Court or, where this is not practicable, by a judge of the District Court.[292] The judge must examine the patient as soon as possible, and in no case more than 14 days after the application is made, and consult with the responsible clinician and at least one other medical professional involved in the case.[293] Where possible, the judge is to conduct any hearing in accordance with provisions set out in the Act, although the court may make a determination in relation to an application without a formal hearing if it is satisfied no one wishes to be heard regarding the application.[294] If a compulsory treatment order is made, it may be either for treatment in the community or as an inpatient.[295] However, an impatient order can only be granted if the court considers the patient cannot be adequately treated as an outpatient and if the patient has already been receiving assessment and treatment as an inpatient.[296] To place a current outpatient on an inpatient order requires a further period of assessment to be completed.[297]

A compulsory treatment order lasts for an initial period of six months.[298] For the first month, the patient must 'accept such treatment as the responsible clinician shall direct.'[299] After this time, the patient is not required to accept treatment unless he or she consents in writing or a psychiatrist appointed by the Mental Health Review Tribunal, in addition to the responsible clinician, considers that the treatment is in the patient's interest.[300] In the case of some treatments, there are additional requirements. The use of electro-convulsive treatment requires the patient's consent or the approval of a psychiatrist appointed by the Mental Health Review Tribunal even within the first month of compulsory treatment.[301] In the case of brain surgery, the patient must consent, the Mental Health Review Tribunal must be satisfied that consent was given freely and with an understanding of the likely effects of surgery, and the responsible clinician and an additional psychiatrist, who has been appointed by the Tribunal and has consulted with at least two other health professionals involved in the case, must consider it to be in the patient's interest.[302]

The responsible clinician may, within the 14 days preceding the expiry of the compulsory treatment order, conduct a review of the case and, if satisfied that the patient is not fit to be released from the order, apply to the court for an extension of the order for a further six

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[290] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 14.

[291] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 16

[292] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 17.

[293] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 18.

[294] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 18, 26.

[295] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 28, 29, 30.

[296] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 29 (2) and (3).

[297] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 29 (3).

[298] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 33.

[299] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 59(1).

[300] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 59(2).

[301] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 60.

[302] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 61.

months. At the end of that six-month period, another application may be made to extend the order, although, in this case, the extension is for an indefinite period.[303] An order may be ended at any time if the responsible clinician considers the patient fit to be released from it.[304] Patients, their friends and relatives, district inspectors, and official visitors are amongst those who are able to apply to the Mental Health Review Tribunal, which has the ability to release individuals from compulsory orders, if it considers them to be fit for this to occur.[305]

2.3.2 Special patients and restricted patients

Special patients are individuals who are detained in a mental health facility, having come there through the criminal justice system. These individuals become special patients through a variety of provisions in the Armed Forces Discipline Act 1971, Mental Health (Compulsory Assessment and Treatment) Act 1992, Criminal Procedure (Mentally Impaired Persons) Act 2003, Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, or the Criminal Procedure Act 2011 and include:

- people charged with, or convicted of, a criminal offence and remanded in hospital for a psychiatric report
- remanded or sentenced prisoners transferred from prison to hospital
- defendants found not guilty by reason of insanity
- defendants unfit to stand trial
- people who have been convicted of a criminal offence and both sentenced to a term of imprisonment and placed under a compulsory treatment order.[306]

Treatment for special patients is provided separately from other patients in five DHB-operated Regional Forensic Psychiatry Services located around the country.[307] Some of these incorporate kaupapa Māori services.[308] It is required that 'every special patient shall be given such care, treatment, training, and occupation as the patient would be given if he or she were subject to a compulsory treatment order.'[309] In some cases, special patients may not meet the definition of mentally disordered that would be required for the making of a compulsory treatment order. For example, section 46 of the Mental Health (Compulsory Assessment and Treatment) Act allows for the chief executive of the Department of Corrections to arrange for a prisoner, whether or

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[303] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 34.

[304] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 35 (1).

[305] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 35 (2), s 76 (7), s 79.

[306] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 41. The definition of 'special patient' in section 2(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 provides details of the specific legislative provisions under which orders are made for the assessment and treatment of these various classes of individuals.

[307] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 41.

[308] For example, the Mason Clinic and services delivered by Hauora Waikato.

[309] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 44

not mentally disordered, to be detained in a hospital for psychiatric care that is not available in the prisoner's usual place of detention, provided that the prisoner consents to this.

In 2016, a total of 378 individuals were special patients, with approximately 196 individuals having this status on any given day.[310] In the same year, 87 per cent of special patients were male. Māori were substantially overrepresented, accounting for 50 per cent of all special patients. There was, however, a distinction in the representation of Māori between different categories of patients detained in forensic services. They accounted for 36 per cent of those found not guilty due to insanity, unfit to stand trial, or admitted as restricted patients, but 58 per cent of those transferred from prisons or under a 'hybrid order' (that is, sentenced to imprisonment and ordered to be detained as a special patient).[311] The extent of Māori over-representation in these figures, whilst substantial, is, however, comparable to that seen throughout the criminal justice system. In 2016, 50.4 per cent of sentenced male prisoners were Māori.[312]

Restricted patients share significant similarities in their treatment with special patients, including management as inpatients by Regional Forensic Psychiatry Services and more stringent conditions for granting leave or being released from their status than are experienced by those under standard compulsory treatment orders.[313] Restricted patient status does not come about on account of a patient's connection with the criminal justice system, but rather by a court order on the application of the Director of Mental Health in relation to a patient who is under an inpatient order.[314] A restricted patient order can only be made where the court is satisfied 'that the patient presents difficulties because of the danger he or she poses to others'.[315] While restricted patient status is not directly connected with the criminal justice system, often those with restricted status 'will have a long history of contact with forensic services, and may have previously been detained as special patients.'[316] The use of restricted patient orders is very rare, with fewer than ten people being subject to one between 1992 and 2017.[317]

2.3.3 Administration of the Mental Health (Compulsory Assessment and Treatment) Act

The Mental Health (Compulsory Assessment and Treatment) Act 1992 provides for the appointment of individuals to a number of positions with responsibility for the administration of the Act and for the protection of the rights of patients. These include:

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[310] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 41.

[311] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', pp 41-43.

[312] Wai 2540 3.1.31(a) Agreed up-to-date statistics for Wai 2540 inquiry (Updated 21 June 2016)

[313] Ministry of Health, 'Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992' (Wellington: Ministry of Health, 2012), p 55.

[314] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 54, 55.

[315] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 55(3).

[316] Ministry of Health, 'Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992', p 55.

[317] Ministry of Health, 'Special Patients and Restricted Patients: Guidelines for Regional Forensic Mental Health Services (Wellington: Ministry of Health, 2017), p 29.

- The Director of Mental Health, who is appointed under the State Sector Act 1988 and is 'responsible for the general administration of the Act under the direction of the Minister and the Director-General of Health'.[318] A Deputy Director of Mental Health may also be appointed, who may assume the responsibilities of the Director in cases where he or she is absent or where the office is vacant.[319]
- Directors of Area Mental Health Services, who are appointed by the Director-General of Health and must report to the Director of Mental Health every three months on the exercise of their powers, duties, and functions under the Act.[320] They are senior mental health clinicians and assign a responsible clinician for each person receiving compulsory assessment or treatment. They are also responsible for appointing health practitioners as duly authorised officers to respond to those with mental illness and arrange for examination under the Act.[321]
- District Inspectors are lawyers appointed by the Minister of Health who have extensive powers to inspect mental health facilities, including being able to access all areas, all patients, and documentation required to be kept under the Act.[322] They must report to Directors of Area Mental Health Services after each visit to a hospital and service and to the Director of Mental Health monthly on the exercise of their powers, duties, and functions under the Act.[323] District inspectors can, of their own accord or on the direction of the Director of Mental Health, inquire into breaches of the Act or of the duties of officers or employees of health services and, more generally, into such matters as thought fit in relation to patients or the management of hospitals or health services. In carrying out inquiries, district inspectors have the same powers in relation to evidence as a commission of inquiry.[324]
- Official visitors share many of the functions of District Inspectors, but do not need to be lawyers and have more limited powers and responsibilities, for example they cannot conduct inquiries and do not need to make monthly reports of the Director of Mental Health.[325]

2.3.4 Rights of patients under the Mental Health (Compulsory Assessment and Treatment) Act

Part 6 of the Mental Health (Compulsory Assessment and Treatment) Act provides for a number of rights for those under compulsory assessment and treatment. These are, subject to certain limitations:

- the right to information (s 64);
- respect of cultural identity (s 65);[326]
- the right to treatment (s 66);

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[318] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 91(1).

[319] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 91(1)(b), s 91(2)

[320] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 92.

[321] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 6.

[322] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 94, 96, 97

[323] Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 98, 98A.

[324] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 95.

[325] The powers and responsibilities of official visitors are set out alongside those of district inspectors in ss 94, 94A, 96, 97, 98, and 99A of the Act.

[326] This relates specifically to the requirements in s 5 of the Act.

- the right to be informed about treatment (s 67);
- the right to be informed of and to refuse visual and audio recording (s 68);
- the right to independent psychiatric advice (s 69);
- the right to legal advice (s 70);
- the right to company (s 71);
- the right to receive visitors and make telephone calls (s 72); and
- the right to receive and send letters and postal articles (ss 73, 74).

The Act also provides a number of other rights and protections in relation to cultural beliefs, identity, and the use of language.

Section 4 prohibits the invocation of procedures for compulsory assessment and treatment on a range of grounds, including a 'person's political, religious, or cultural beliefs'. Section 5 provides that powers and proceedings under the Act must be carried out:

> (a) with proper recognition of the importance and significance to the person of the person's ties with his or her family, whanau, hapu, iwi, and family group; and
> (b) with proper recognition of the contribution those ties make to the person's wellbeing; and
> (c) with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.

Section 6 requires that, where practicable, in relation to the exercise of powers or conduct of proceedings under the Act, an interpreter must be provided if:

> (a) 1 of the following applies:
> i. the first or preferred language of the person is a language other than English, including Maori and New Zealand Sign Language; or
> ii. the person is unable, because of physical disability to understand English …[327]

Section 103 provides for a person of the same ethnic identity or gender as the patient to be co-opted to the Mental Health Review Tribunal, where no person on the Tribunal is of that ethnic identity or gender. The Tribunal must co-opt a suitable person under these provisions if the patient or applicant requests this.

2.3.5 Seclusion and restraint

While section 71(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 provides for patients to have a right to the company of others, this right is qualified by the

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[327] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 6(2).
The drafters of the Act appear do not appear to have considered that anyone exercising powers or conducting proceedings under the Act might be able to speak the same non-English language as the patient. A literal reading of this section would appear to require a translator to be present even where both a patient and a person exercising powers under the Act are native Maori-speakers, provided that it is practicable to provide one.

allowance of the use of seclusion in certain circumstances. Significantly, Māori have consistently been over-represented amongst those placed in seclusion. Section 71(2) of the Act reads:

> (2) A patient may be placed in seclusion in accordance with the following provisions:
> (a) seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients:
> (b) a patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services:
> (c) except as provided in paragraph (d), seclusion shall be used only with the authority of the responsible clinician:
> (d) in an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion, but shall forthwith bring the case to the attention of the responsible clinician:
> (e) the duration and circumstances of each episode of seclusion shall be recorded in the register kept in accordance with section 129(1)(b).

Guidelines published by the Ministry of Health set out a number of requirements when commencing the use of seclusion, including that careful deliberation be given to the physical and psychological effects on the patient, that all other preferred alternative interventions have been considered or tried, and that the cultural needs of the patient are recognised.[328] While the use of seclusion is intended to be a last resort, a number of situations are identified where it may be appropriate:

> (a) the control of harmful behaviour occurring during the course of a psychiatric illness that cannot be adequately controlled with psychological techniques and/or medication
> (b) disturbance of behaviour as a result of marked agitation, thought disorder, hyperactivity or grossly impaired judgement
> (c) to reduce the disruptive effects of external stimuli in a person who is highly aroused due to their illness
> (d) to prevent harmful or destructive behaviour, using specific indicators of impending disturbance which may be identified by the individual or the staff, and which should wherever possible be part of an agreed management plan.[329]

Throughout the period a patient is in seclusion, there are requirements for observation of the patient to be continuous or at intervals of no more than ten minutes, for assessments by a registered nurse or medical practitioner at least once every two hours, and for a psychiatric assessment to be made at least once every eight hours.[330]

The Health and Disability Services (Restraint Minimisation and Safe Practice) Standards, published in 2008, have as their main intent 'to reduce the use of restraint in all its forms and to

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[328] Ministry of Health, 'Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992' (Wellington: Ministry of Health, 2010), p 1.

[329] Ministry of Health, 'Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992', p 5.

[330] Ministry of Health, 'Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992', pp 2-3.

encourage the use of least restrictive practices.'[331] The reduction and elimination of the use of seclusion is also a goal in the Ministry's 2012-2017 mental health and addiction service development plan.[332] The Health Quality and Safety Commission (HQSC) is also collaborating with Te Pou o te Whakaaro Nui (Te Pou) on the 'Pathways to Eliminate Seclusion by 2020' project. The HQSC hopes to 'achieve as close as we can to zero seclusion' by 2020, recognising this as 'ambitious' and an 'aspirational goal'.[333] Strategies considered likely by the HQSC to contribute to reducing seclusion include ensuring effective staff communications, the use of structured risk assessments, and the implementation of cultural change driven by organisational leadership.[334]

In the period in which the Ministry's goals have been in place, there has been some significant progress in reducing seclusion rates. In 2016, the number of people being placed in seclusion in adult mental health inpatient services reduced 25 per cent since 2009 and the total number of hours patients spent in seclusion reduced by 62 per cent. In more recent years, there has been some steadying in these figures, with the number of people being secluded between 2015 and 2016 increasing by six per cent, whilst the total number of seclusion hours continued to decrease by 11 per cent.[335]

As mentioned, Māori have consistently been over-represented amongst those placed in seclusion. In 2016, for example, 44 per cent of those placed in seclusion in adult inpatient facilities were Māori and Māori were 4.8 times as likely as non-Māori to be secluded in an adult inpatient facility.[336] Whereas non-Māori were placed in seclusion at a rate of 19 individuals per 100,000 population, the equivalent figure for Māori was 91.7 per 100,000.[337] These disparities have only grown as Māori seclusion rates have remained stubbornly high, decreasing by only 9 percent between 2007 and 2016, while rates for non-Māori, starting from a lower base, have decreased by 30 per cent.[338]

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[331] Health and Disability Services (Restraint Minimisation and Safe Practice) Standards NZS 8134.2:2008 Standards New Zealand/Ministry of Health, p 5.

[332] Ministry of Health, 'Rising to the Challenge'.

[333] 'Mental health and addiction quality improvement programme: New projects announcement 1 December 2017 Q&A', Health Quality and Safety Commission, https://www.hqsc.govt.nz/assets/Mental-Health-Addiction/NEMR_files/QA_on_new_MHAQI_projects_announced_Dec_1_2017_v7_final.pdf, accessed 31 July 2019.

[334] 'Mental health and addiction quality improvement programme: New projects announcement 1 December 2017 Q&A'.

[335] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', pp 33-34.

[336] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 38.

[337] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 38.

[338] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 39.

2.4 Māori and mental health services

As discussed in the previous chapter, the disparities in mental health between Māori and non-Māori emerged from the 1970s onwards. Today, it is widely recognised that Māori suffer from mental illness and use mental health services at higher rates than the general population.

Te Rau Hinengaro, the national mental health survey published in 2006, found that Māori have higher rates of mental illness, including that:

- In the last 12 months, 29.5 per cent of Māori, 24.4 per cent of Pacific people, and 19.3 per cent of 'Other' had suffered from a mental disorder[339]
- 39.5 per cent of the sample had experienced a mental disorder over the course of their life prior to being interviewed.[340] For Māori, the figure was 50.7 per cent.[341]
- Lifetime risk of mental disorder for Māori was the highest of all ethnic categorisations at 1.7 times that of the 'Other' category. When adjusted for age and sex, the Māori risk was still 1.4 times that of the 'Other' category.[342]

The full report of the survey includes much more information, including prevalence rates of various conditions for Māori and some exploration of the extent to which sociodemographic factors may account for the high prevalence rates found amongst Māori.

Given these high rates of mental health problems, it is not surprising that Māori access specialist mental health services at a higher than average rate. In 2016, Māori, accounting for 16 per cent of the population, constituted 27 per cent of users of specialist mental health services. In total, 6.1 per cent of Māori used specialist mental health services, almost twice the rate of 3.1 per cent for non-Māori.[343] The extent to which Māori are significantly overrepresented amongst those subject to compulsory assessment and treatment has been discussed earlier in this chapter. Māori are also significantly overrepresented amongst deaths in mental health inpatient units, with 36.51 per cent of those who died in the period between 1 January 2009 and 6 August 2019 identified as Māori.[344]

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[339] Mark A Oakley Browne, J Elisabeth Wells, and Kate M Scott, 'Executive Summary', in *Te Rau Hinengaro: The New Zealand Mental Health Survey*, eds Mark A Oakley Browne, J Elisabeth Wells, and Kate M Scott (Wellington: Ministry of Health, 2006), p xx.

[340] Mark A Oakley Browne, 'Lifetime Prevalence and Lifetime Risk of DSM-IV Disorders', in *Te Rau Hinengaro*, eds Oakley Brown, Wells, and Scott, p 62.

[341] Joanne Baxter, Te Kani Kingi, Rees Tapsell, and Mason Durie, 'Maori', in *Te Rau Hinengaro*, eds Oakley Brown, Wells, and Scott, p 150.

[342] Oakley Browne 'Lifetime Prevalence and Lifetime Risk', p 69.

[343] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016', p 25.

[344] In this period, there were 63 recorded deaths in inpatient units, with 23 (36.51%) identified as Māori, 34 (53.97%) as non-Māori, and 6 (9.52%) of unknown ethnicity. These figures exclude deaths of inpatients who were AWOL (there was one such death in the period and this person was Māori) and include deaths in forensic services. The figures are approximate as, in some cases, locations of death were either not logged or not provided by the services, with such shortcomings in data tending to relate to less recent events. Personal correspondence from Principal Advisor, Mental Health, Ministry of Health, 7 August 2019.

Elevated rates of Māori accessing medical services for mental health issues do not, however, necessarily indicate that Māori needs for appropriate services are being met or even that they are being met to the same extent as for other population groups. Te Rau Hinengaro found that 32.5 per cent of Māori with a mental disorder in the last 12 months had accessed services in relation to it, a figure higher than the equivalent figure for Pacific people of 25.4 per cent, but still significantly lower than the figure of 41.1 per cent for those in the 'Other' category. These figures include access to a much wider variety of services than specialist mental health services, including, amongst other things, other health practitioners, social workers, religious or spiritual advisors, and complementary and alternative medicine providers.[345] It is unclear whether these lower rates of access to services for Māori and Pacific people with mental health needs have changed in the period of over a decade that has passed since the survey was conducted.

2.4.1 Kaupapa Māori mental health services

Kaupapa Māori mental health services are delivered both directly by DHBs, which operate them in addition to their mainstream services, and a multitude of Māori-led NGOs located around the country. Kaupapa Māori services are used by a substantial minority of Māori receiving treatment for mental illness. While issues of local accessibility may prevent some from accessing these services, it is also important to note that not all Māori desire to use kaupapa Māori services.

In 2017/18, Ministry of Health records indicate that over $107.54 million was spent on Māori mental health services delivered by both DHBs and NGOs – a figure that likely undercounts the total spend as some Maori services may be purchased as part of mainstream purchase units.[346] This figure fluctuated in the period since 2008/09, hitting a low of $80.45 million in 2011/12 and a high of $109.22 million in 2016/17.[347] (See Figure 2.4).

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[345] Mark A Oakley Browne and J Elisabeth Wells, 'Health Services', in *Te Rau Hinengaro*, eds Oakley Brown, Wells, and Scott, pp 119-120, 133.

[346] This figure includes DHBs and NGOs and exclude addiction and problem gambling services. 'Maori' is defined here as 'contracts with a Maori GL code, contract ID, purchase unit code, or contracted service'. Figure 2.4Personal correspondence from Principal Advisor, Mental Health, Ministry of Health, 9 August 2019.

[347] These figures include DHBs and NGOs and exclude addiction and problem gambling services. 'Maori' is defined here as 'contracts with a Maori GL code, contract ID, purchase unit code, or contracted service'. Personal correspondence from Principal Advisor, Mental Health, Ministry of Health, 9 August 2019.

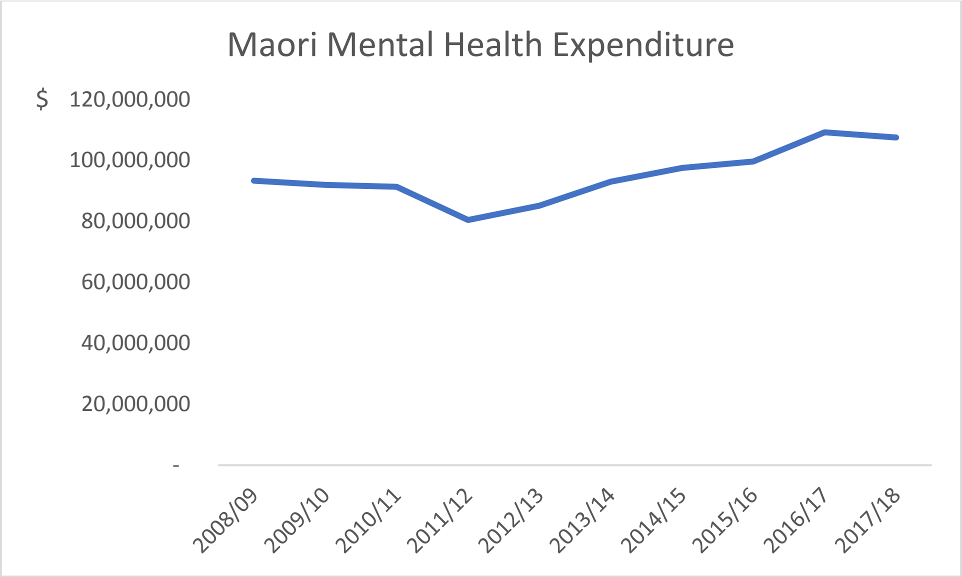

Figure 2.4 Expenditure on Māori mental health services by year.[348]

Besides expenditure, the proportion of mental health workers employed in kaupapa Māori services can also provide an indication of the extent of service provision. Te Pou's 2014 survey of the workforce in Vote Health-funded mental health and addiction services revealed that 11.2 per cent of full-time equivalent roles in mental health services were in ethnic-specific services. The vast majority of those roles were in kaupapa Māori services, equating to 85.8 per cent of roles in ethnic-specific services or 9.6 per cent of roles across all mental health services.[349] The proportion of the mental health workforce working in kaupapa Māori services is significantly lower than the proportion of Māori in the New Zealand population, let alone the proportion of Māori amongst users of specialist health services. However, as noted above, only a minority of Māori accessing mental health services are doing so through kaupapa Māori services. While provision of culturally-tailored services may lag behind the number of Māori accessing mental health services, the extent of provision of these services is much greater than that provided for other population groups who may have their own cultural needs. A comparison between Māori, Pacific peoples, and Asians in terms of proportion of the New Zealand population, proportion of mental health and addiction service users, and proportion of total mental health and addiction roles in mental health and addiction services specific to each ethnic group is provided in Figure 2.5.

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[348] These figures include DHBs and NGOs and exclude addiction and problem gambling services. 'Maori' is defined here as 'contracts with a Maori GL code, contract ID, purchase unit code, or contracted service'. Source: Personal correspondence from Principal Advisor, Mental Health, Ministry of Health, 9 August 2019.

[349] Te Pou o Te Whakaaro Nui, 'Adult mental health and addiction workforce: 2014 survey of Vote Health funded services' (Auckland: Te Pou o Te Whakaaro Nui, 2015), p 62.

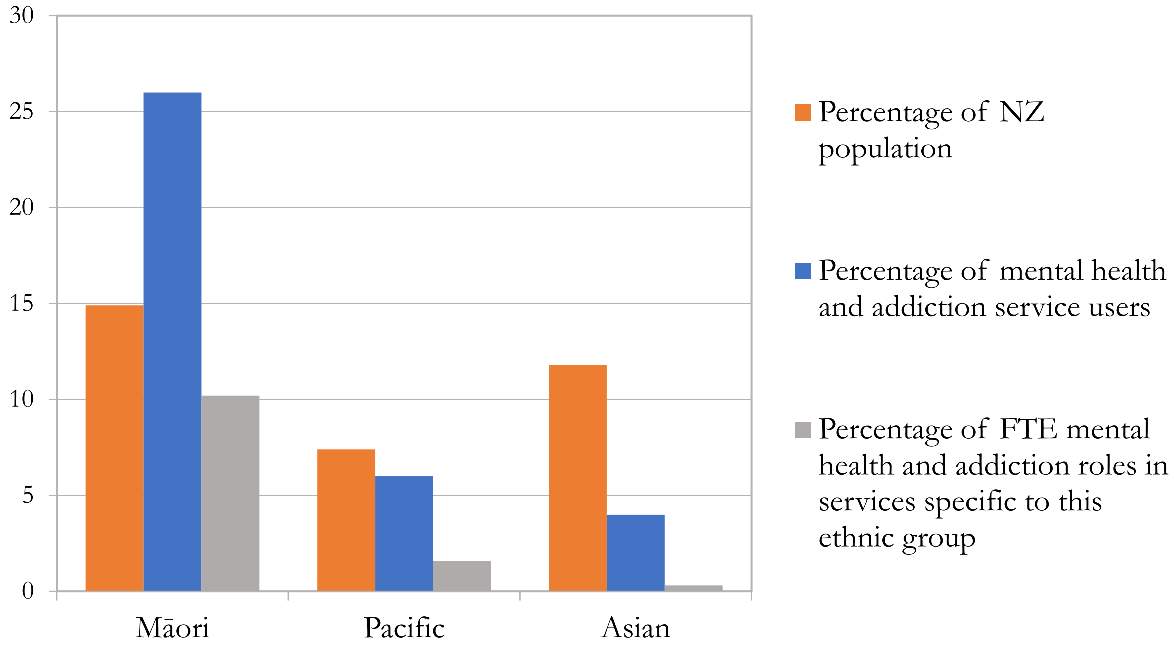

Figure 2.5 Population, mental health and addiction service use, and proportion of mental health and addiction roles in ethnic-specific services for Māori, Pacific, and Asian ethnicities.[350]

Across all ethnic-specific services, an average of 77.2 per cent of staff were reported as belonging to the ethnic group they were serving.[351]

The level of staffing of kaupapa Māori services around the country is not even, either geographically or in terms of matching service provision with the scale of the regional Māori population. Indeed, figures from Te Pou's 2014 survey indicate that half of all the workforce in kaupapa Māori mental health and addiction services is concentrated in a region stretching from Northland to Counties Manukau, with the staffing of these services decreasing both in real terms and in relation to the regional Māori population as one heads southward through the country.[352] (see Table 2.1).

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[350] Population figures from: '2013 Census Quickstats about national highlights', Stats NZ, http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-national-highlights/cultural-diversity.aspx, accessed 4 March 2019. Mental health service use and mental health workforce figures from: Te Pou o Te Whakaaro Nui, 'Adult mental health and addiction workforce: 2014 survey of Vote Health funded services', p 62.

[351] Te Pou o Te Whakaaro Nui, 'Adult mental health and addiction workforce: 2014 survey of Vote Health funded services', p 61.

[352] Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services' (Auckland: Te Pou o Te Whakaaro Nui, 2016), p 16.

Table 2.1 Distribution of kaupapa Māori mental health and addiction service workforce in comparison with adult Māori population.[353]

Region[354]	**Percentage of national adult Māori population**	**Percentage of reported FTE kaupapa Māori mental health and addiction service workforce**
Northern	32%	50%
Midland	32%	28%
Central	22%	17%
South Island	14%	5%

The kaupapa Māori mental health service workforce also differs from the overall mental health workforce in rates at which they are involved in providing certain types of services – Te Pou's 2014 survey indicated that the vast majority are involved in providing community services (46 per cent) or forensic services (39 per cent).[355]

Further discussion of the role of Māori providers in delivering kaupapa Māori services can be found in Chapter 3.

2.4.2 Māori in the mental health workforce

Māori have long been underrepresented in the health workforce in general and, for some time, the government has included addressing this issue in health strategies and plans.[356] A variety of measures have been adopted to increase the number of Māori health professionals, including scholarships, such as the Hauora Māori Scholarships and Te Rau Puawai Māori Mental Health Workforce Development programme run by Health Workforce New Zealand and Massey University.[357] Te Rau Matatini, the first Māori mental health workforce development

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[353] Due to a number of kaupapa Maori services not returning surveys, it is likely that the workforce for the Northern, Midland, and South Island regions is underreported. Source: Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', p 16.

[354] The regions identified correspond with the following DHBs – Northern: Auckland, Counties Manukau, Northland, Waitemata; Midland: Bay of Plenty, Lakes, Tairawhiti, Taranaki, Waikato; Central: Capital and Coast, Hawkes Bay, Hutt Valley, Midcentral, Wairarapa, Whanganui; South Island: Canterbury, Nelson Marlborough, South Canterbury, Southern, West Coast.

[355] Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', pp 27-28.

[356] See, for example: Annette King and Tariana Turia, 'He Korowai Oranga: Māori Health Strategy' (Wellington: Ministry of Health, 2002); Ministry of Health, 'Rising to the Challenge'; Ministry of Health, 'Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008-2015 (Wellington: Ministry of Health, 2008); Ministry of Health, 'Mental Health and Addiction Workforce Action Plan 2017-2021' (Second Edition) (Wellington: Ministry of Health 2018).

[357] 'Hauora Māori Scholarships 2019', Ministry of Health, https://www.health.govt.nz/our-work/populations/maori-health/hauora-maori-scholarships-2019, last modified 14 February 2019; 'Te Rau Puawai – Māori Mental Health Workforce Development', Massey University, http://www.massey.ac.nz/massey/maori/study/maori_research/te-rau-puawai/te-rau-puawai_home.cfm, last modified 4 May 2018.

organisation, was established in 2002 and originally based at Massey University.[358] It has since broadened its focus to Māori health generally and now operates as an independent organisation under the name Te Rau Ora.[359] There has been some success in increasing the numbers of Māori in the health workforce, even if Māori remain very much under-represented within many health professions and the rate at which their presence is increasing is quite variable. For example, the proportion of nurses who are Māori has increased from 3.6 per cent in 2009 to 6.5 per cent in 2015.[360] Between 2005 and 2010, the number of psychologists who responded to the annual workforce survey who identified as Māori increased from 38 to 60, representing an increase from 3.8 per cent of psychologists who responded to 4.5 per cent.[361]

The Mental Health and Addiction Action Plan 2017-2021 notes the continued underrepresentation of Māori in health professions and international evidence demonstrating that indigenous communities see better health outcomes when 'the workforce reflects the local community'.[362] It also places the need to increase the Māori workforce in the context of the Treaty relationship, stating that:

> Participation requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.[363]

The plan sets out three steps to be achieved over the following four years under the action item 'Grow and develop the Māori workforce':

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[358] Tariana Turia, 'Launch of Te Rau Matatini – the first Maori Mental Health Workforce Development Organisation', Beehive.govt.nz, https://www.beehive.govt.nz/speech/launch-te-rau-matatini-—-first-maori-mental-health-workforce-development-organisation, last modified 8 March 2002.

[359] 'Our whakapapa', Te Rau Ora, https://terauora.com/about/our-history/, accessed 24 June 2019.

[360] Ministry of Health, 'Health of the Health Workforce 2015' (Wellington: Ministry of Health), p 12.

[361] There was some fluctuation of figures in this period, with the lowest figures for Maori being recored in 2006 (33 individuals, 3 per cent of the respondents) and a high being recorded in 2009 (65 individuals, 5.3 per cent of the respondents). 'Māori health workforce occupations', Ministry of Health, https://www.health.govt.nz/system/files/documents/publications/maori-health-workforce-occupations-apr11.xls, accessed 24 June 2019.

[362] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan 2017-2021' (2nd edition) (Wellington: Ministry of Health, 2018), p 14.

[363] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan 2017-2021', p 5.

Action 4.2	**Grow and develop the Māori workforce.**
1–2 years	• Prioritise Māori recruitment to and retention in clinical and non-clinical roles and implement strategies to address this priority. • Contribute to achieving the Māori workforce objective 2.3 of He Korowai Oranga – 'to increase the number and improve the skills of the Māori health and disability workforce' – in relation to mental health and addiction.
3–4 years	• Contribute to the Māori workforce goals (Raranga Tupuake: Māori Workforce Plan 2006, Ministry of Health 2006) of investing in Māori students, expanding the skill base and providing equitable access for Māori to training opportunities in relation to mental health and addiction.[364]

A recent snapshot of the numbers of Māori in the adult mental health and addiction workforce is provided by Te Pou's 2014 survey. Responses to the survey that included ethnicity data indicated that 19 per cent of mental health and addiction workers were Māori, with Māori filling 15 per cent of clinical roles and 24 per cent of non-clinical roles.[365] However, given the pattern of services that did and did not provide ethnicity data, Te Pou considers that these figures may underestimate the numbers of Māori in the workforce. It has estimated that Māori constitute 21 per cent of the workforce, filling an estimated 16.9 per cent of clinical roles and 25 per cent of non-clinical roles.[366] While these figures indicate that Māori are overrepresented in the mental health and addiction workforce relative to their numbers in the population, particularly in relation to non-clinical roles, the proportion of Māori in the workforce remains lower than the proportion of Māori amongst service users.

There are sharp differences not only between the representation of Māori in clinical and non-clinical roles, but also between the representation of Māori in different service types. Figures from Te Pou's 2014 survey indicated that Māori constituted 27.3 per cent of staff in residential services, but only 9.4 per cent of those working in forensic units.[367] (See Figure 2.6 for further details.) The same survey also indicated substantial differences between the proportions of the DHB and NGO mental health workforces that are Māori, with Māori constituting 27 per cent of the reported NGO workforce, but only 12.5 per cent of the DHB workforce.[368]

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[364] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan 2017-2021', p 37.

[365] Te Pou o Te Whakaaro Nui, 'Adult mental health and addiction workforce: 2014 survey of Vote Health funded services' pp 62-63.

[366] Te Pou o Te Whakaaro Nui, 'Adult mental health and addiction workforce: 2014 survey of Vote Health funded services', pp 62, 143-144.

[367] Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', p 36.

[368] Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', p 37.

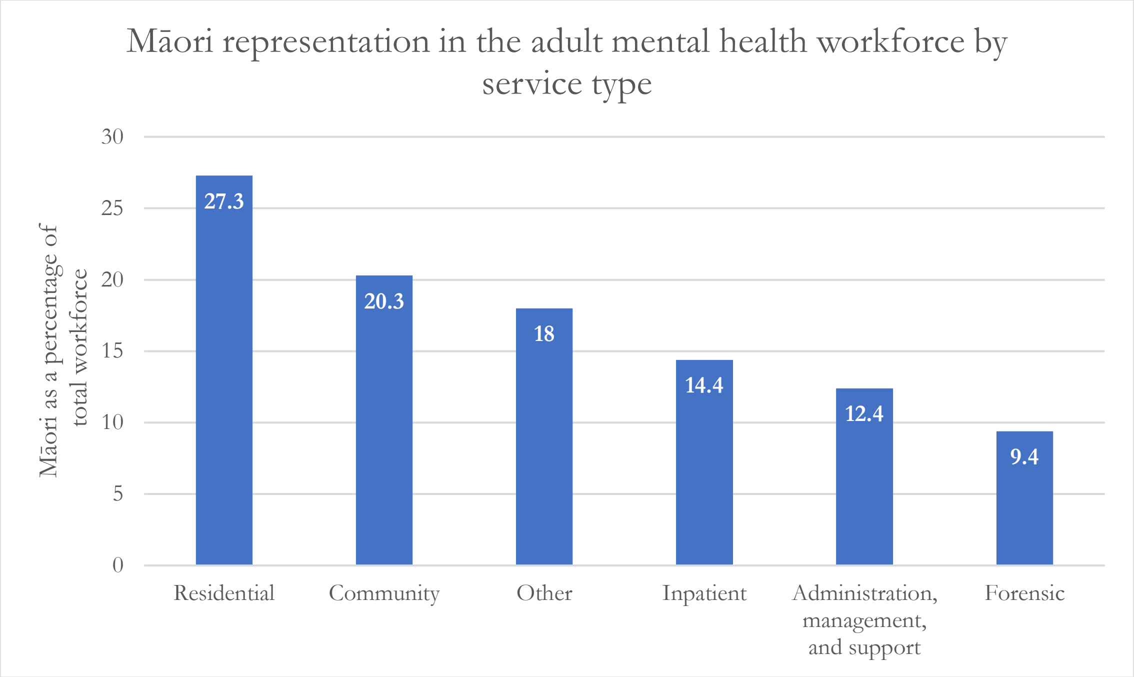

Figure 2.6 Māori representation in the adult mental health workforce by service type.[369]

The patterns of Māori representation in the mental health workforce appear to be broadly consistent with those in the health workforce generally. Figures published by Te Rau Matatini indicate that 66 per cent of Māori in the health workforce work in the NGO sector, as opposed to 54 per cent amongst all the health workforce.[370] Māori health workers are also much more likely to be in the unregulated health workforce, serving in roles that fall outside the scope of the Health Practitioners Competence Assurance Act 2003. Indeed, 71 per cent of the Māori health workforce are in unregulated roles, whereas over 60 per cent of all health workers are in regulated roles.[371]

2.4.3 Cultural competence of the mental health workforce

Te Pou's 2014 survey indicated that a majority of providers who responded believed their workforce needed to increase its cultural competency in dealing with Māori across a range of measures. On every measure, a higher proportion of DHB providers than NGO providers

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[369] Figures from Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', p 36.

[370] J Sewell, 'Profiling the Māori health workforce 2017' (Wellington: Te Rau Matatini, 2017), p 7.

[371] Sewell, 'Profiling the Māori health workforce', pp 5-6. The Health Practitioners Competence Assurance Act 2003 regulates a variety of health professions including, but not limited to, medicine, nursing, pharmacy, psychology, and psychotherapy. 'Responsible authorities under the Act', Ministry of Health, https://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/responsible-authorities-under-act, last modified 4 May 2015.

indicated that increases in their workforces' competencies were required. However, while NGO providers were less likely to indicate a need to improve competencies overall, a greater proportion of NGO providers indicated a need for large increases in competencies.[372] (see Figure 2.7 and Figure 2.8).

Responses from kaupapa Māori services indicated that the overall proportion stating a need to increase competencies was similar to that recorded among all services (see Figure 2.9). However, across all measures, a higher proportion of kaupapa Māori services indicated a need for a large increase in competencies than was recorded among all services, whether DHB or NGO.[373] Caution must be exercised in interpreting these figures, as it would seem unlikely that levels of cultural competence in kaupapa Māori services are lower than in other services. It may instead be the case that kaupapa Māori services set a higher bar in their expectations of cultural competence and are more acutely aware of the shortcomings of their workforces in this area than is ordinarily the case in mainstream services.

The need to build a culturally competent and responsive mental health workforce and services across the mental health sector has long been recognised by government and has been included in a variety of strategies and action plans.[374] The current Mental Health and Addiction Workforce Action Plan 2017-2021 states a desire to have, in five years, a workforce that is culturally competent and in which '[c]omptency frameworks form the basis for all recruitment, training and professional development.' [375] The Plan states that a culturally competent workforce is one that:

> can use knowledge of tikanga, whānau ora and Māori models of care and can apply their cultural competence in working with Māori. Crucially, it also does not see cultural and clinical practice as distinct from one another.[376]

Actions set out in the plan to achieve this include the provision of training on Māori cultural models and the development of culturally-appropriate mental health literacy programmes that would form part of the training for new health professionals and for those already in the workforce.[377]

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[372] Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', pp 44-45.

[373] Te Pou o Te Whakaaro Nui, 'Adult Mental Health and Addiction Workforce: 2014 survey of Vote Health funded services, pp 144-145; Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', pp 44-45.

[374] See, for example, Ministry of Health, 'Te Puāwaitanga: Māori Mental Health Strategic Framework (Wellington: Ministry of Health, 2002); Ministry of Health, Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008-2015 (Wellington: Ministry of Health, 2008); Minister of Health, Te Kōkiri: The Mental Health and Addiction Action Plan 2006-2015 (Wellington: Ministry of Health, 2006); Ministry of Health, 'Tauawhitia te Wero – Embracing the Challenge: National mental health and addiction workforce development plan 2006-2009 (Wellington: Ministry of Health, 2005).

[375] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan 2017-2021', p 33.

[376] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan 2017-2021', p 28.

[377] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan 2017-2021', p 33.

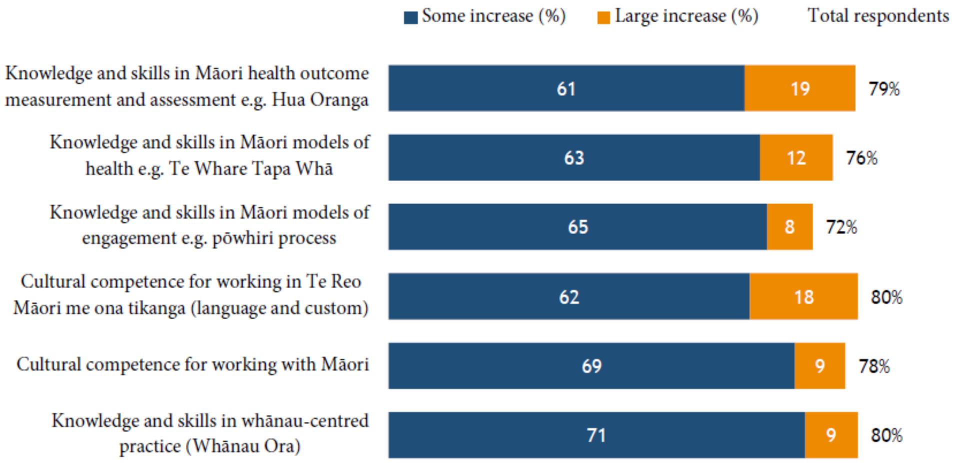

Figure 2.7 Proportion of DHB respondents identifying their workforce needs to increase knowledge or skills for working with Māori.[378]

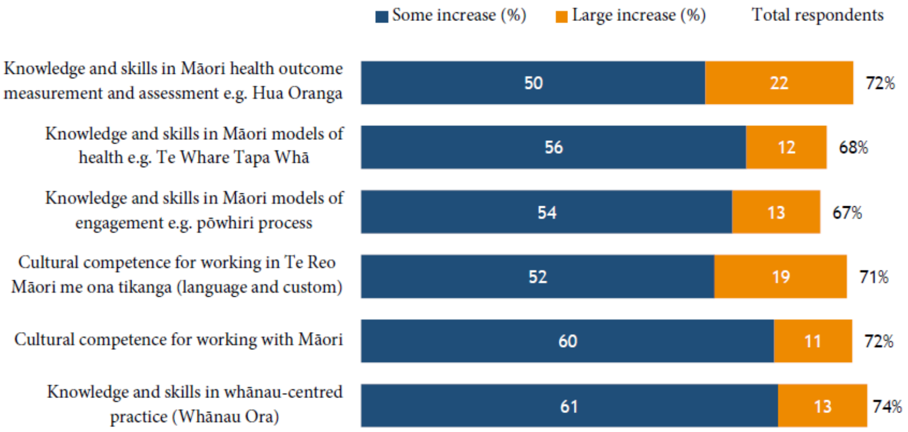

Figure 2.8 Proportion of NGO respondents identifying their workforce needs to increase knowledge or skills for working with Māori.[379]

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[378] Source: Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', p 45.

[379] Source: Te Pou o Te Whakaaro Nui, 'Māori adult mental health and addiction workforce: 2014 survey of Vote Health funded services', p 45.

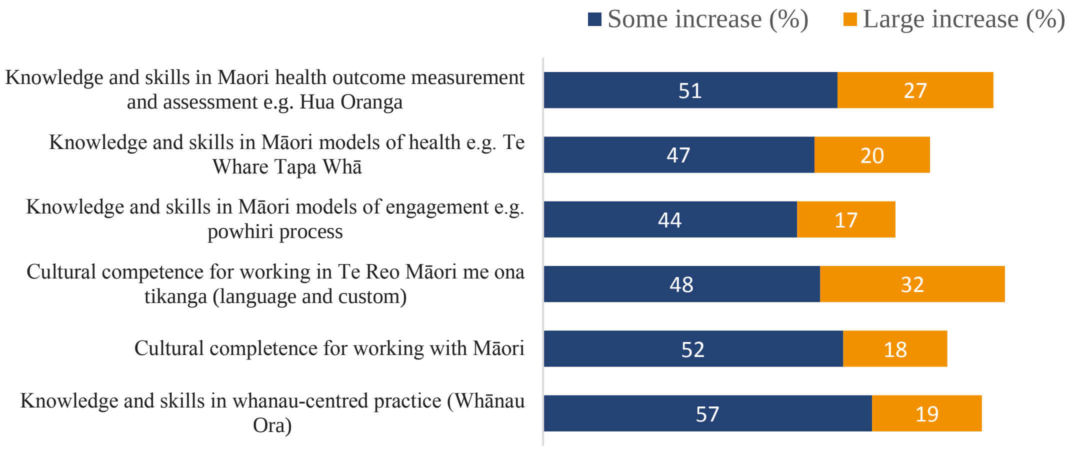

Figure 2.9 Proportion of kaupapa Māori service respondents identifying their workforce needs to increase knowledge or skills for working with Māori.[380]

2.5 Monitoring of prevalence of mental illness and service activity and outcomes

2.5.1 Surveys

The prevalence of mental health conditions in the New Zealand population is regularly monitored by a number of surveys.

The Ministry of Health's New Zealand Health Survey (NZHS), which was previously conducted at intervals of several years, has since 2006 been conducted continuously, publishing annual updates. Prior to 2011, the Ministry also conducted a series of surveys on particular topics, including mental health, at three to four-year intervals, which have subsequently been incorporated into the NZHS.[381]

In its current form, the NZHS is designed for an annual sample of roughly 5,000 children and 14,000 adults.[382] Questions concerning mental health form a part of the core content of the NZHS, which remains similar from year to year in order to allow comparisons.[383] Mental health and substance use also featured as one of the changing module components of the survey in

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[380] Figures from Te Pou o Te Whakaaro Nui, 'Adult Mental Health and Addiction Workforce: 2014 survey of Vote Health funded services, p 145.

[381] Ministry of Health, 'Methodology Report 2017/18: New Zealand Health Survey' (Wellington: Ministry of Health, 2019), p 1.

[382] Ministry of Health, 'Methodology Report 2017/18: New Zealand Health Survey', p 6.

[383] Ministry of Health, 'Methodology Report 2017/18: New Zealand Health Survey', pp 3-4.

2016/17. Modules on other topics that are often related to mental health, including various forms of substance use and problem gambling, have been included in other years.[384]

The Ministry of Health publishes a variety of data derived from the survey and in recent years has made some of this data available through online data explorer tools that allow for breakdowns by a range of factors, including ethnicity, and comparisons with data from previous years.[385]

Surveys with smaller sample sizes conducted by the Health Promotion Agency also provide data on mental health issues.[386] The biennial Health and Lifestyles Survey has included questions about mental health and wellbeing, knowledge of available mental health services, and mental health-related discrimination.[387] The more focussed New Zealand Mental Health Monitor (also known as the New Zealand Mental Health and Wellbeing Survey) has been conducted in 2015, 2016, and 2018.[388] The 2018 survey included questions relating to a variety of topics including wellbeing and connectedness, knowledge of mental health and available services, mental health stigma, and personal mental health both in the recent past and over the longer term.[389]

While these regular surveys provide a clear picture of important aspects of the state of mental health of the New Zealand population and other related matters, they do not match an earlier national survey in terms of its combination of depth and large sample size. Te Rau Hinengaro: The New Zealand Mental Health Survey was funded by the Ministry of Health, Health Research Council, Alcohol Advisory Council, and the Mental Health Research and Development Strategy and involved a total of 12,992 interviews, with Māori and Pacific people being oversampled 'to allow (for the first time) estimates of acceptable precision for those communities'.[390] The main objectives of the survey were to:

> - describe the one-month, 12-month and lifetime prevalence rates of major mental disorders among those aged 16 and over living in private households, overall and by sociodemographic correlates
> - describe patterns of and barriers to health service use for people with mental disorder
> - describe the level of disability associated with mental disorder

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[384] Ministry of Health, 'Content Guide 2017/18: New Zealand Health Survey' (Wellington: Ministry of Health, 2018), p 5.

[385] A variety of published data from the NZHS is available via: 'New Zealand Health Survey', Ministry of Health, https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey, last modified 25 March 2019.

[386] For the 2016 Health and Lifestyles Survey, the sample size was 3,854 of whom 930 were Māori. For the 2016 New Zealand Mental Health Monitor, the sample size was 1,646 of whom 341 were Māori. Lynne Russell, *Te Oranga Hinengaro – Māori Mental Wellbeing: Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey* (Wellington: Health Promotion Agency, 2018), p 15.

[387] See, for example, Health Promotion Agency, '2016 Health and Lifestyles Survey Questionnaire' (Wellington: Health Promotion Agency Research and Evaluation Unit, 2017); Health Promotion Agency, '2018 Health and Lifestyles Survey Questionnaire' (Wellington: Health Promotion Agency Research Unit, 2018).

[388] 'Our surveys', Health Promotion Agency, https://www.hpa.org.nz/our-work/research/our-surveys, accessed 12 August 2019.

[389] Health Promotion Agency, '2018 New Zealand Mental Health Monitor: Questionnaire' (Wellington: Health Promotion Agency, 2009).

[390] Out of all interviewees, 2,595 reported Māori ethnicity. Mark A Oakley Browne, J Elisabeth Wells, and Kate M Scott eds, *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Wellington: Ministry of Health, 2006), pp xix, xxiii, xxiv.

> - provide baseline data and calibrate brief instruments measuring mental disorders and psychological distress to inform the use of these instruments in future national health surveys.[391]

Figures from Te Rau Hinengaro are still regularly cited in discussion of mental health in New Zealand today. However, they can hardly be considered up-to-date – the results of the survey were published in 2006 and the survey itself was conducted in 2003 and 2004.[392] Indeed, the desirability of conducting a new survey on a similar scale to Te Rau Hinengaro appears to be broadly recognised. The Mental Health Commissioner, Kevin Allan, has recommended such a survey be commissioned, noting that 'it would provide essential information, needed to identify and respond to current levels of need'.[393] The panel of the Government Inquiry into Mental Health and Addiction similarly concluded that 'we should undertake a new and more comprehensive mental health and addiction survey', believing this was 'essential for health care planning' and observing that Te Rau Hinengaro was both 'out of date' and did not cover some groups (notably children).[394] The panel also noted that, in 2017, planning for a new survey had already been conducted.[395] In these circumstances, it is perhaps unsurprising that the government accepted the Inquiry's recommendation 'to undertake and regularly update a comprehensive mental health and addiction survey.'[396]

2.5.2 Service activity and outcomes data collection

Since 1 July 2008, the Ministry of Health has collected a range of data concerning service activity and outcomes through the Programme for the Integration of Mental Health Data (PRIMHD). Prior to this, data was gathered through the Mental Health Information National Collection (MHINC).[397]

DHBs have been required to report to PRIMHD since its commencement, while bringing NGO providers into the programme has been a more gradual process. In December 2017, there were 204 NGO providers participating.[398]

While the quantity of data collected from a multitude of sources by PRIMHD is significant, this brings its own complications. The Ministry of Health suggests that caution needs to be exercised

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[391] Oakley Brown, Wells, and Scott eds, *Te Rau Hinengaro*, p xvii.

[392] Oakley Brown, Wells, and Scott eds, *Te Rau Hinengaro*, p 231.

[393] Allan, 'New Zealand's mental health and addiction services', p 38.

[394] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 126.

[395] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 126.

[396] 'Government Inquiry into Mental Health and Addiction', Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction, last modified 6 June 2019.

[397] 'PRIMHD – mental health data', Ministry of Health, https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/collections/primhd-mental-health-data, last modified 3 October 2018.

[398] Ministry of Health, 'Office of the Director of Mental Health and Addiction Services: Annual Report 2017' (Wellington: Ministry of Health, 2019), p 88.

in analysing PRIMHD data due to a variety of factors, including that apparent differences in data over time or between services may simply reflect adaptation to the PRIMHD system or differences in data entry processes rather than actual differences in service use, outcomes, or populations being served. Data extracted at different times may also vary, due to processes of updating and revisions as additional data becomes available. For example, the combination of ethnicity data from PHO records with the National Health Index (NHI) in 2017 resulted in roughly 10,000 additional people being identified as Māori in the NHI, which is used as the basis for identifying ethnicity in PRIMHD.[399]

2.6 Other official bodies and individuals involved in the mental health system

There are a number of other government departments, agencies, commissions, and officers of Parliament that have responsibilities in relation to mental health including such matters as service funding and provision, the promotion of health and wellbeing, and the oversight of the mental health system and protection of the rights of those with mental illness. Brief summaries of the roles played by some of the most important of these bodies and individuals are provided below.

2.6.1 Bodies involved in delivering funding or services

Health Promotion Agency

The Health Promotion Agency (HPA) was established in 2012 by amendments to the New Zealand Public Health and Disability Act 2000, replacing the Alcohol Advisory Council and the Health Sponsorship Council.[400] In addition to fulfilling some alcohol-specific functions, it is required to:

> lead and support activities for the following purposes:
> (a) promoting health and wellbeing and encouraging healthy lifestyles:
> (b) preventing disease, illness, and injury:
> (c) enabling environments that support health and wellbeing and healthy lifestyles:
> (d) reducing personal, social, and economic harm.[401]

The HPA runs two programmes focussed on mental health:

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[399] Ministry of Health, 'Office of the Director of Mental Health and Addiction Services: Annual Report 2017', pp 88-89.

[400] New Zealand Public Health and Disability Amendment Act 2012, s 6; 'About Us', Alcohol.org.nz, https://www.alcohol.org.nz/about-us, accessed 28 May 2019.

[401] New Zealand Public Health and Disability Act 2000, s 58.

- Like Minds, Like Mine, which seeks 'to counter stigma and discrimination associated with mental illness and distress.'[402] (This programme is discussed in greater depth in Chapter 4.)
- National Depression Initiative, which seeks 'to reduce the impact of depression and anxiety … by helping early recognition, appropriate treatment, and recovery.'[403] The Initiative includes an advice and counselling service via telephone, support for research, two websites – depression.org.nz (which includes some pages targeted specifically at Māori) and the youth-focussed 'The Lowdown' – the creation of print resources, and the use of advertising on television and digital platforms.[404]

Besides these programmes, the HPA also researches and monitors mental health issues through the New Zealand Mental Health Monitor and the Health and Lifestyles Survey and in 2018 released a report on Māori mental wellbeing drawing on these surveys.[405]

Accident Compensation Corporation

The Accident Compensation Corporation (ACC) provides coverage for 'mental injury' in a limited number of circumstances. These are:

- Where a significant mental condition is caused by physical injuries that are covered by ACC. For example, in the case of a car accident that resulted in injuries, significance is placed on whether the mental injury resulted from the trauma of the accident itself or from the injuries sustained as a result of the accident. Where a combination of factors contributed to the mental injury, ACC can provide cover if 'the physical injury was a significant cause of the mental injury'.[406]
- Where a significant mental condition is work-related and results from a single sudden event. This event must be one 'that could reasonably be expected to cause mental injury to people generally'.[407] Examples provided for events that would meet this criterion include a hostage situation, drive-by shooting, or a bus driver running over someone who deliberately stepped in front of his bus. Work-related mental injuries resulting from a gradual process are not covered.[408]
- Where a significant mental condition is materially caused by a medical treatment injury.[409]
- Where a mental injury is 'significantly linked' to forms of sexual abuse specified in the Crimes Act 1961.[410]

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[402] 'Mental Health', Health Promotion Agency, https://hpa.org.nz/programme/mental-health, accessed 21 February 2019.

[403] 'Mental Health', Health Promotion Agency.

[404] 'Mental Health', Health Promotion Agency.

[405] 'Mental Health', Health Promotion Agency; Russell, *Te Oranga Hinengaro*.

[406] 'Mental Injury Assessments for ACC', Accident Compensation Corporation, https://www.acc.co.nz/assets/provider/mental-injury-assessment-guide.pdf, accessed 11 October 2018, p 4.

[407] 'Mental Injury Assessments for ACC', pp 4-5.

[408] 'Mental Injury Assessments for ACC', p 5.

[409] 'Mental Injury Assessments for ACC', p 6.

[410] 'Mental Injury Assessments for ACC', p 6.

Oranga Tamariki – Ministry for Children

Oranga Tamariki has the leading responsibility within government for the welfare of children. This responsibility, amongst other things, involves placing children in care, dealing with young offenders, and running youth justice and care and protection residences.

Māori are disproportionately represented amongst those being served by Oranga Tamariki – around half of those who come into contact with it are Māori and, at the end of June 2017, 69 per cent of children in state care identified as Māori.[411]

Estimated figures published by Oranga Tamariki's predecessor agency, the Department of Child, Youth and Family Services (CYFS), in 2000 suggested that one in five of the young people being served by CYFS had a diagnosed mental health issue recorded. It was also estimated that 40 per cent of those being dealt with by CYFS for care and protection or for youth justice issues suffered from an anxiety disorder and 30 per cent from depression.[412]

Department of Corrections

The Department of Corrections has the primary responsibility of the provision of healthcare to those detained in New Zealand prisons – a population in which Māori are significantly over-represented. In 2016, 50.4 per cent of sentenced male prisoners and 56.9 per cent of sentenced female prisoners were Māori.[413]

The Department's health services largely mirror those provided to the general population by primary health organisations, but with some significant differences, including the role assigned to nurses in dispensing medications and screening, their role in responding to emergencies, and the need to deal with significant numbers of minor health issues that would usually be addressed through consulting family and friends or taking over-the-counter medication outside a prison environment.[414] Section 75(2) of the Corrections Act 2004 requires that '[t]he standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.' Secondary and tertiary health care for prisoners is delivered by district health boards on referral from the Department's health service.[415]

Mental health problems are common amongst those who are imprisoned. A study published by the Department in 1999, co-sponsored by the Ministries of Health and Justice, found that rates of bipolar disorder, schizophrenia, major depressive disorder, personality disorder, obsessive

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[411] 'Briefing to the Incoming Minister', Ministry for Vulnerable Children, Oranga Tamariki, October 2017, pp 3, 11 https://www.beehive.govt.nz/sites/default/files/2017-12/Children.pdf, accessed 15 October 2018.

[412] *Towards well-being: Responding to the needs of young people* (Wellington: Department of Child, Youth and Family Services, 2000), p 7.

[413] Wai 2540 3.1.31(a) Agreed up-to-date statistics for Wai 2540 inquiry (Updated 21 June 2016).

[414] Chief Ombudsman Beverley Wakem and Ombudsman David McGee, 'Investigation of the Department of Corrections in relation to the Provision, Access and Availability of Prisoner Health Services' [Presented to the House of Representatives in accordance with section 29 of the Ombudsmen Act 1975], pp 15,26.

[415] 'Investigation of the Department of Corrections', p 16.

compulsive disorder, substance abuse, and post-traumatic stress disorder were all 'significantly elevated'.[416] A further report published by the Department in 2016 showed a similar pattern of elevated prevalence of mental health disorders in the prison population, although there were some significant changes from the 1999 study in the prevalence of certain conditions.[417] This later report also found that, in 2015, 62.2 per cent of prisoners had been diagnosed with a mental disorder in the last 12 months and that 90.9 per cent had been diagnosed with a mental disorder over their lifetime. These figures were substantially higher than the equivalent figures of 20.7 per cent and 39.5 per cent in the general population in 2006.[418]

As in other matters of health care, the Department is responsible for the provision of primary mental health care to prisoners. These primary mental health services are responsible for most mental health treatment in prisons. A 2012 report by Chief Ombudsman Beverley Wakem and Ombudsman David McGee noted the standard of mental health care in prisons was 'variable' and 'insufficiently responsive' with problems including limited psychiatric training of medical officers, a lack of clinical support for nurses dealing with difficult cases, a lack of mental health nurses on some teams, and medical officers reporting 'a shortage of counselling and therapeutic interventions'.[419]

Regional Forensic Psychiatric Services run by DHBs provide secondary mental health care to those in prison. This can be in the form of outpatient services provided within the prison environment or by transferring prisoners to secure hospital facilities. The ombudsmen noted that, whilst these forensic services deal with those who would qualify, outside prison, for specialist mental health services due to the severity of their condition,

> in practice, forensic teams deal with many prisoners with treatable primary level mental health problems because of a lack of alternative services and a lack of clarity about the role of secondary mental healthcare in prisons.[420]

The Department attempts to identify any mental health issues within a short period of a prisoner's arrival. Observations of mental state are made during the Reception Health Screen carried out within four hours of arrival and the more extensive health assessment conducted within 24 hours of arrival, with the latter also including questioning about mental health history.[421] In 2012, the Department introduced a mental health screening tool for male prisoners to assist in identifying mental health conditions and thus enable appropriate treatment.[422] This tool was approved for use with female prisoners by the New Zealand Forensic Psychiatric

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[416] A I F Simpson et al, 'The National Study of Psychiatric Morbidity in New Zealand Prisons' (Wellington: Department of Corrections, 1999), p 1.

[417] Devon Indig, Craig Gear, and Kay Wilhelm, 'Comorbid substance use disorders and mental health disorders among New Zealand prisoners' (Wellington: Department of Corrections, 2016), v-ix.

[418] Indig, Gear, and Wilhelm, 'Comorbid substance use disorders and mental health disorders', ix.

[419] 'Investigation of the Department of Corrections', p 94.

[420] 'Investigation of the Department of Corrections', p 95.

[421] 'Investigation of the Department of Corrections', p 96.

[422] 'Investigation of the Department of Corrections', pp 96-97; Department of Corrections, 'Department of Corrections Annual Report: 1 July 2011 – 30 June 2012' (Wellington: Department of Corrections), p 15.

Advisory Group in 2014. Currently, there is no approved screening tool for youth, who are referred to Regional Forensic Mental Health Services for assessment in cases where Corrections staff have concerns about their mental health.[423]

Department of Internal Affairs – responsibilities for problem gambling

The Department of Internal Affairs (DIA) has a role in the reduction of problem gambling – a problem that affects Māori at a higher rate than the general population – as it is responsible for the administration of gambling legislation, non-casino gambling licensing, and ensuring compliance.[424] Legislation and regulations administered by DIA are intended to reduce gambling harm through a variety of measures including banning ATMs in gaming areas, limiting prizes on gaming machines, advertising restrictions, self-exclusion and venue-initiated exclusion orders for problem gamblers, and requirements that venues train staff about problem gambling and provide problem gambling information for patrons.[425]

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[423] Personal communication with General Manager Health, Department of Corrections, 4 March 2019.

[424] The 2016 Health and Lifestyles Survey recorded higher prevalence of moderate-risk and problem gambling among Māori (6.7%), Asians (5.9%), and Pacific peoples (3.3%) than those of European/Other ethnicity (1.1%). T. Thimasarn-Anwar et al., 'Gambling report: Results of the 2016 Health and Lifestyles Survey' (Wellington: Health Promotion Agency Research and Evaluation Unit, 2018), pp 97-98; 'New Zealand Gambling Laws', Department of Internal Affairs, https://www.dia.govt.nz/Web/diawebsite_historical.nsf/wpg_URL/Services-Casino-and-Non-Casino-Gaming-New-Zealand-Gambling-Laws, accessed 15 October 2018.

[425] 'Problem Gambling', Department of Internal Affairs, https://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Services-Casino-and-Non-Casino-Gaming-Problem-Gambling, accessed 15 October 2018; 'Exclusion Order (Problem Gamblers) Guidelines', Department of Internal Affairs, https://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Services-Casino-and-Non-Casino-Gaming-Exclusion-Order-(Problem-Gamblers)-Guidelines

The Ministry of Health’s role in relation to problem gambling

Whilst the DIA has an important role in limiting harmful gambling and providing related education and information to the public, the Gambling Act 2003 also requires the Ministry of Health to develop a problem gambling strategy that includes public health measures, treatment and assistance services, scientific research, and evaluation. This is overseen by the Addictions team within the Ministry of Health’s Mental Health and Addiction group.

The Ministry’s latest problem gambling strategy, released in June 2019, includes two strategic objectives that refer specifically to Māori:

> **Objective 1:** There is a reduction in gambling-harm-related inequities between population groups (particularly Māori, Pacific and Asian peoples, as the populations that are most vulnerable to gambling harm).
> **Objective 2:** Māori have healthier futures, through the prevention and minimisation of gambling harm.

The priorities for action listed in relation to these objectives include the provision of ethnic-specific services, ensuring the cultural appropriateness of all services, support for Māori to provide advice to the Ministry of Health and DIA on issues of gambling harm, and the development of one or more initiatives targeted at the reduction of inequities experienced by Māori related to gambling harm.

Currently, the Ministry of Health has contracts with a mix of mainstream, Māori, Pacific, and Asian providers for the provision of problem gambling intervention services and problem gambling public health services. Over 5,400 people accessed Ministry of Health-funded services in 2017/18 for problems caused by gambling, whether their own or that of someone else. Of these, 31 per cent were Māori. The overall figure of those who sought help in the same year increases, if brief interventions outside a clinical environment are included, to over 11,600.

Sources: ‘Problem Gambling’, Department of Internal Affairs; ‘Gambling’, Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/gambling, last modified 8 April 2019; Ministry of Health, ‘Strategy to Prevent Gambling Harm 2019/20 to 2021/22’ (Wellington: Ministry of Health, 2019), pp 9, 19, 21-23, 45; ‘Problem gambling services’, Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/gambling/problem-gambling-services, last modified 18 July 2019.

2.6.2 Oversight of mental health-related issues and the protection of the rights of those with mental illness

Mental Health Commissioner

The Mental Health Commissioner currently operates under the Health and Disability Commissioner with delegated powers, duties, and functions.[426] Primary areas of responsibility include '[t]o make decisions on complaints, including complaints about mental health and addiction services' and '[t]o monitor and advocate improvements to mental health and addiction services'.[427]

From 1996 until 2012, there had been a separate Mental Health Commission, independent of the Health and Disability Commissioner, which had a broader range of responsibilities. The background to the establishment of this commission and its role in the development of mental health policy are discussed in Chapter 1. The current government committed in the Labour-New Zealand First coalition agreement to re-establish an independent Mental Health Commission.[428] The Government Inquiry into Mental Health and Addiction was subsequently tasked with making recommendations on the new commission's roles and responsibilities as part of its terms of reference.[429] In its report, the Inquiry endorsed the establishment of a 'Mental Health and Wellbeing Commission' with the following core functions:

> - Report on progress against implementation of the Government's response to the recommendations of the Government Inquiry into Mental Health and Addiction
> - Facilitate a national co-designed service transformation process and provide backbone support for national, regional and local implementation
> - Develop an investment and quality assurance strategy for mental health promotion and prevention
> - Ensure any national strategies relating to mental health and wellbeing are implemented by responsible agencies and publicly report on progress
> - Advocate for the collective interests of people with mental health and addiction challenges and their families and whānau
> - Provide advice to the Government, at the Commission's discretion, on any matters relevant to mental health and wellbeing (including funding)
> - Facilitate best practice, innovation and evaluation
> - Promote collaboration, communication and understanding about mental wellbeing and issues that contribute to mental distress[430]

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[426] Health and Disability Commissioner Act 1994, s 9(3)

[427] 'Our team', Health and Disability Commissioner, https://www.hdc.org.nz/about-us/our-team/, accessed 12 October 2018. 'Coalition agreement between the New Zealand Labour Party & New Zealand First Party', authorised by Jacinda Ardern MP and Winston Peters MP, https://d3n8a8pro7vhmx.cloudfront.net/nzfirst/pages/1911/attachments/original/1508875804/LabourandNewZealandFirstCoalitionAgreement2017.pdf?1508875804, accessed 15 October 2015

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[429] 'Terms of Reference', Government Inquiry into Mental Health and Addiction, https://www.mentalhealth.inquiry.govt.nz/about-the-inquiry/terms-of-reference/, last modified 9 October 2018.

[430] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', pp 201-202.

The Government, in its response to the Inquiry, gave a split response to the Inquiry's recommendation. It accepted establishing 'an independent commission to provide leadership and oversight of mental health and addiction in New Zealand' – a proposal that was already government policy.[431] However, it did not endorse the Inquiry's recommendations in relation to the commission's functions and powers, stating that further consideration was needed.[432] Further recommendations concerning the establishment of a ministerial advisory committee to act as an interim commission and the role of the commission to monitor progress on the Government's response to the inquiry were accepted in principle.[433]

Human Rights Commission

The Human Rights Act 1993 includes 'disability', which is defined to include 'psychiatric illness', as a prohibited ground of discrimination.[434] The Act also states that one of the primary functions of the Human Rights Commission is 'to promote and protect the full and equal enjoyment of human rights by persons with disabilities'.[435] In carrying out its primary functions, the Commission is empowered, amongst other things, to act as an advocate on human rights issues, to inquire into matters that may involve human rights infringements, and to bring civil proceedings before the Human Rights Review Tribunal.[436]

Ombudsman

The Ombudsman is an officer of Parliament and has a number of roles and responsibilities that can involve the oversight and review of government mental health policies and services. These include:

- The investigation of complaints concerning 'administrative acts and decisions of central and local government agencies.'[437]
- Alongside the Human Rights Commission and the non-government New Zealand Convention Coalition, serving as an independent mechanism under Article 33 of the United Nations Convention of the Rights of Persons with Disabilities tasked to 'promote, protect and monitor' the Convention's implementation.[438]

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[431] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 202; 'Government Inquiry into Mental Health and Addiction', Ministry of Health.

[432] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 202; 'Government Inquiry into Mental Health and Addiction', Ministry of Health.

[433] 'Government Inquiry into Mental Health and Addiction', Ministry of Health.

[434] Human Rights Act 1993, s 21(1)(h)

[435] Human Rights Act 1993, s 5(1)(e)

[436] Human Rights Act 1993, ss 5(2), 92B, 92E.

[437] 'Complaints about state sector agencies', Office of the Ombudsman, http://www.ombudsman.parliament.nz/what-we-do/investigations/complaints-about-state-sector-agencies, accessed 12 October 2018.

[438] 'Disability Convention', Office of the Ombudsman, http://www.ombudsman.parliament.nz/what-we-do/protecting-your-rights/disabilities-convention, accessed 12 October 2018.

- The monitoring of places of detention, in fulfilment of New Zealand's obligations under the Optional Protocol to the Convention against Torture (OPCAT). This monitoring covers not only prisons, but also a variety of other places where individuals are 'deprived of their liberty', including secure facilities within hospital and rest homes and child care and protection residences.[439]
- The ability to launch self-initiated investigations, which are 'usually prompted by serious or systemic issues, where the Ombudsman thinks their intervention [sic] has the potential to result in wider administrative improvement.'[440] A 'particular commitment' has been made to focus on improvement in matters involving disabilities and prisons.[441] Reflecting this focus, in 2012, the Ombudsman released the report of its investigation of prisoner health services, which included some examination of mental health services.[442]

Controller and Auditor-General

The Controller and Auditor-General is an officer of Parliament tasked with auditing all public entities in New Zealand. The office's functions include carrying out annual audits of entities' financial statements and other information, performance audits, and inquiries into entities' use of resources.[443]

In addition to regular audits of public-sector health entities, the Auditor-General has occasionally looked more specifically at matters relating to mental health. Since 2008, reports have been released which have examined discharge planning for mental health inpatients, the collection and use of information about suicide, and mental health services for prisoners.[444]

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[439] 'Monitoring places of detention', Office of the Ombudsman, http://www.ombudsman.parliament.nz/what-we-do/protecting-your-rights/monitoring-places-of-detention, accessed 12 October 2018.

[440] 'Self-initiated investigations', Office of the Ombudsman, http://www.ombudsman.parliament.nz/what-we-do/investigations/self-initiated-investigations, accessed 12 October 2018.

[441] 'Wider administrative improvement investigations', Office of the Ombudsman, http://www.ombudsman.parliament.nz/what-we-do/investigations/wider-administrative-improvement-investigations, accessed 12 October 2018.

[442] Chief Ombudsman Beverley Wakem and Ombudsman David McGee, 'Investigation of the Department of Corrections in relation to the Provision, Access and Availability of Prisoner Health Services', available at http://www.ombudsman.parliament.nz/system/paperclip/document_files/document_files/456/original/own_motion_prisoner_health.pdf?1349735789, accessed 12 October 2018.

[443] 'About the Controller and Auditor-General', Controller and Auditor-General, https://www.oag.govt.nz/about-us/about-cag, last modified 18 April 2017.

[444] Controller and Auditor-General, *Mental health services for prisoners* (Wellington: Office of the Auditor-General, 2008); Controller and Auditor-General, *Collecting and using information about suicide* (Wellington: Office of the Auditor-General, 2016); Controller and Auditor-General, *Mental health: Effectiveness of the planning to discharge people from hospital* (Wellington: Office of the Auditor-General, 2017).

Health Quality and Safety Commission

The Health Quality and Safety Commission (HQSC) was established in 2010 as a result of amendments to the New Zealand Public Health and Disability Act 2000.[445] The HQSC's objectives

> are to lead and co-ordinate work across the health and disability sector for the purposes of–
> (a) monitoring and improving the quality and safety of health and disability support services; and
> (b) helping providers across the health and disability sector to improve the quality and safety of health and disability support services.[446]

The HQSC's current Mental Health & Addiction Quality Improvement Programme involves it working with health providers and those who use mental health and addiction services and their families. The programme's priority areas of focus are:

- to learn from serious adverse events and the experience of service users;
- to improve the physical health of those with mental health and addiction issues;
- to improve transitions in and out of services;
- to minimise the use of restrictive practices, such as restraint and seclusion; and
- to improve processes and practices around prescribing and management of medications.[447]

The Commission is also able to establish mortality review committees

> to carry out any of the following functions that HQSC specifies by notice to the committee:
> (a) to review and report to HQSC on specified classes of deaths of persons, or deaths of persons of specified classes, with a view to reducing the numbers of deaths of those classes or persons, and to continuous quality improvement through the promotion of ongoing quality assurance programmes:
> (b) to advise on any other matters related to mortality that HQSC specifies in the notice.[448]

The Suicide Mortality Review Committee was initially established on a trial basis and was made permanent in 2017.[449] Of the four other review committees, issues of mental health and suicide

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[445] New Zealand Public Health and Disability Amendment Act 2010, s 17.

[446] New Zealand Public Health and Disability Act 2000, s 59B.

[447] 'Programme', Health Quality & Safety Commission New Zealand, https://www.hqsc.govt.nz/our-programmes/mental-health-and-addiction-quality-improvement/programme/, last modified 31 July 2017.

[448] New Zealand Public Health and Disability Act 2000, s 59E(1).

[449] Conflicting statements on the Committee's website state that it was established either in late 2013 or in 2014. 'About us', Health Quality & Safety Commission New Zealand, https://www.hqsc.govt.nz/our-programmes/mrc/sumrc/about-us/, last modified 10 October 2018; 'Terms of reference', Health Quality and Safety Commission New Zealand, https://www.hqsc.govt.nz/our-programmes/mrc/sumrc/about-us/terms-of-reference/, last modified 15 October 2018.

feature heavily in the reports of the Child and Youth Mortality Review Committee, the Perinatal and Maternal Mortality Review Committee, and the Family Violence Death Review Committee.[450]

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[450] The reports of all the mortality review committees are available from the HQSC website: https://www.hqsc.govt.nz/our-programmes/mrc/

Chapter 3 Māori involvement in decision-making and as service providers

One of the more significant developments in the New Zealand health system in recent decades has been the growing consideration of Māori perspectives and presence of Māori presence in decision-making and service provision. What was once a monocultural health system has increasingly sought to provide culturally-appropriate services to Māori, including, in some cases, the incorporation of traditional Māori health practices. Requirements to consult with Māori have become common throughout the health sector and Māori are present in greater numbers, not only in the health workforce, but also in positions that can provide opportunities to shape policies and services directly, whether in policy-making, governance, or as independent Māori health providers. The changes in the sphere of mental health have been particularly notable, with not only widespread provision of Māori-targeted services, but a greater use of Māori providers to deliver services than is common throughout much of the remainder of the health sector.

While it may be clear that progress has been made in bringing Māori perspectives into the system and that governments have introduced a range of measures to encourage this, that certainly does not mean that problems have disappeared or that Māori are universally satisfied. A multitude of claims to the Tribunal raise a range of relevant issues, including the provision of culturally-appropriate services and traditional healing, the involvement of Māori in decision-making and consultation processes, and the ability of Māori to develop and deliver services for themselves, both in relation to mental health and the health system generally.[451]

This chapter sets out some of the ways in which Māori perspectives are taken into consideration and Māori input into, or control over, decisions is provided for within the health system. It also explores some of the factors that may frustrate the translation of Māori perspectives into policy and practice. In doing so, it summarises key government policies and examines the provisions for, and extent of, Māori representation in decision-making and advisory structures and the extent to which Māori providers have been able to take a lead in developing services that fit the needs of their own people.

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[451] Claims that raise these issues, either individually or in various combinations, include Wai 58 1.1(j); Wai 88 1.1(e); Wai 89 1.1(d); Wai 179 1.1(c); Wai 558 1.1(b); Wai 619 1.1(f); Wai 662 1.1(f); Wai 874 1.1(d); Wai 884 1.1(d); Wai 966 1.1(c); Wai 1460 1.1.1(b); Wai 1536 1.1.1(c) and 1.1.1(e); Wai 1544 1.1.1(c); Wai 1666 1.1.1(c); Wai 1677 1.1.1(a); Wai 1732 1.1.1(b); Wai 1775 1.1.1(a); Wai 1835 1.1.1(d); Wai 1837 1.1.1(b); Wai 1957 1.1.1(e); Wai 2006 1.1.1(a); Wai 2060 1.1.1(c); Wai 1868 1.1.1(c); Wai 1941 1.1.1(a); Wai 2179 1.1.1(c); Wai 2257 1.1.1(e); Wai 2476 1.1.1(a); Wai 2494 1.1.1(c), Wai 2510 1.1.1(b); Wai 2623 1.1.1; Wai 2626 1.1.1; Wai 2632 1.1.1; Wai 2648 1.1.1; Wai 2761 1.1.1; Wai 2683 1.1.1; Wai 2685 1.1.1; Wai 2686 1.1.1; Wai 2695 1.1.1, Wai 2697 1.1.1, Wai 2723 1.1.1; Wai 2725 1.1.1; Wai 2728 1.1.1; Wai 2729 1.1.1; Wai 2734 1.1.1; Wai 2738 1.1.1. This list is not exhaustive.

3.1 Health strategies and plans

Health strategies adopted by the New Zealand Government have for some time included commitments to consultation with Māori, representation of Māori throughout the health system, and support for the development of Māori-led and culturally appropriate services. These commitments have been based on a mix of reasoning, referencing both Treaty obligations and a desire to address health disparities. In the latter case, this has sometimes involved commitments to the involvement of a number of priority groups rather than solely Māori. Some of the relevant sections of current and recently expired strategy documents are set out below. Policies and legislative provisions relating specifically to representation of, and consultation with, Māori in DHB and PHOs are addressed in later sections of this chapter.

3.1.1 New Zealand Health Strategy

The New Zealand Health Strategy, adopted in 2016, includes as the first of its eight principles 'Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi'.[452] It notes that this:

> should guide the design of training for health workers and board members to ensure they have appropriate knowledge about the Treaty, what it means for the participation of Māori in the health system, partnership approaches to services and the need to improve the health status of Māori.[453]

The actions set out as part of the Strategy include a number of elements that seek to increase the system's responsiveness to Māori and other population groups and increase their involvement in service design and delivery. This includes to:

- Make the health system more responsive
    - 'Enable Māori to contribute to decision-making on health and disability services and participate in the delivery of those services.'[454]
    - 'Build cultural competence in the system to reflect New Zealand's cultural diversity.'[455]
    - 'Increase engagement, especially by priority population groups and population groups that are hardest to reach.'[456]

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[452] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016' (Wellington: Ministry of Health, 2016), p 3.

[453] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016', p 2.

[454] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016', p 7.

[455] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016', p 7.

- 'Engage the consumer voice', including through increasing the participation of priority groups in the health system.[457]
- 'Promote people-led service design' with a particular focus on 'examples that effectively reach and understand high-need priority populations'.[458] This includes developing 'methods for involving priority groups in service design.'[459]
- Establish workforce development initiatives to enhance diversity, amongst other things, with progress toward diversity goals to be tracked and published in co-operation with a number of bodies, including iwi and Te Puni Kōkiri.[460]

3.1.2 He Korowai Oranga

He Korowai Oranga, the government's Māori Health Strategy, was first released in 2002 and was subsequently updated in 2014.[461] One of the key 'threads' of the strategy is rangatiratanga, recognising 'that Māori are both a legitimate and an essential part of decision-making in the health and disability sector', which can be brought about by formal means (such as requirements for Māori representation on DHB boards), less formal means (such as influencing service design), and the role played by Māori institutions, including Māori health providers.[462] Another key 'thread' of the strategy is '[b]uilding on the gains', recognising the 'significant gains in Māori health' in recent decades, including in relation to 'Māori participation at all levels of the health and disability sector'.[463]

The first of the strategy's pathways for action concerns the '[d]evelopment of whānau, hāpu, iwi and Māori communities' and includes supporting the building of Māori capacity and the development of Māori initiatives, including the development of 'programmes and interventions that incorporate Māori models of health and wellbeing, rongoā (traditional healing) and innovation'.[464] The second pathway concerns the participation of Māori in the health and disability sector, noting that Māori involvement in service delivery and decision-making 'will ensure services are appropriate and effective for Māori'.[465] The objectives in this pathway are supported by the Māori Provider Development Scheme and the establishment of Māori workforce development organisations, scholarships, and leadership programmes.[466]

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[456] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016', p 7.
[457] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016', p 8.
[458] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016', p 8.
[459] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016', p 8.
[460] Minister of Health, 'New Zealand Health Strategy: Roadmap of actions 2016', p 20.
[461] Annette King and Tariana Turia, 'He Korowai Oranga: Māori Health Strategy' (Wellington: Ministry of Health, 2002); Ministry of Health, 'The Guide to He Korowai Oranga: Māori Health Strategy 2014' (Wellington: Ministry of Health, 2014), p 2.
[462] Ministry of Health, 'The Guide to He Korowai Oranga', p 8.
[463] Ministry of Health, 'The Guide to He Korowai Oranga', p 8.
[464] Ministry of Health, 'The Guide to He Korowai Oranga', p 10.
[465] Ministry of Health, 'The Guide to He Korowai Oranga', p 10.
[466] Ministry of Health, 'The Guide to He Korowai Oranga', p 10.

The strategy's remaining pathways of action concern the health system and government services more broadly through improving effectiveness and working across sectors.[467]

3.1.3 Rising to the Challenge

Rising to the Challenge is the New Zealand Government's most recent mental health and addiction service development plan, released in 2012 and running through to 2017. The plan includes a number of actions specifically related to Māori and, amongst other things, requires:

- The involvement of tāngata whenua in service planning for mental health and addiction services, in order to increase the likelihood of services being used by Māori and being helpful and effective for them;
- Mental health services for children and infants to work with local Whānau Ora providers to identify and deliver agreed services that would make a positive contribution to whānau using Whānau Ora services; and
- Mental health and addiction services to work with tāngata whenua and social services to identify disparities and decide how to address them, measure the impact of actions taken, and, using this, refine future investment and services.[468]

The plan states that kaupapa Māori services are to be prioritised 'for making better use of public funds' in certain circumstances, but does not present them as something that should always be made available as an option to Māori:

> Where the number of Māori who need a service is sufficiently high and Māori are not achieving equitable outcomes relative to other populations from mainstream service use, DHBs will offer kaupapa Māori services. They will also evaluate whether these services are more effective than mainstream services in addressing disparities in outcomes.[469]

3.1.4 Mental Health and Addiction Workforce Action Plan

The Mental Health and Addiction Workforce Action Plan 2017-2021, developed in response to an action item in Rising to the Challenge, includes a number of measures relating specifically to Māori.

It notes that Māori leadership is 'critical' for building a foundation for improved Māori health outcomes and presents its fostering, through investment to grow capacity and capability, as a

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[467] Ministry of Health, 'The Guide to He Korowai Oranga', p 11.

[468] Ministry of Health, 'Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017' (Wellington: Ministry of Health, 2012), pp 34-35.

[469] Ministry of Health, 'Rising to the Challenge', p 35.

'vital step'.[470] To achieve this, it proposes 'providing culturally relevant upskilling and developing clear pathways into leadership positions'.[471]

The plan also recognises that Māori are under-represented in the health workforce and includes as one of its actions the growth and development of the Māori workforce.[472] Objectives set for the coming years were to:

- 'Prioritise Māori recruitment to and retention in clinical and non-clinical roles and implement strategies to address this priority';
- 'Contribute to achieving the Māori workforce objective 2.3 of *He Korowai Oranga* – "to increase the number and improve the skills of the Māori health and disability workforce" – in relation to mental health and addiction'; and
- 'Contribute to the Māori workforce goals (*Raranga Tupuake: Māori Workforce Plan 2006*, Ministry of Health 2006) of investing in Māori students, expanding the skill base and providing equitable access for Māori to training opportunities in relation to mental health and addiction.'[473]

Besides these measures to strengthen Māori leadership and participation in the health workforce, the plan also recognises the importance of having a culturally competent workforce that is able to respond to Māori and apply Māori health models.[474]

3.2 Representation of Māori in health governance and policy-making

3.2.1 Ministry of Health

For many years, the Ministry of Health had a dedicated Māori unit providing advice on Māori health matters. Through the 1980s and early 1990s, there was a series of bodies within or associated with the Department of Health or the Board of Health dedicated to Māori health that came and went, including a project team, a Board of Health standing committee, a ministerial advisory committee, and a Maori Health Unit.[475] Te Kete Hauora, the Māori Health Directorate, which succeeded these earlier arrangements, had a more lasting existence, continuing for over 20 years until it was abolished in March 2016 as part of a restructure first announced in December

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[470] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan 2017-2021' 2nd edition (Wellington: Ministry of Health, 2018), p 23.
[471] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan', p 24.
[472] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan', pp 36, 37.
[473] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan', p 37.
[474] Ministry of Health, 'Mental Health and Addiction Workforce Action Plan', pp 27-34.
[475] Hekia Parata and Mason Durie, 'Maori Health Review: A Report for the Department of Health on how it can meet the Government's Maori health objectives' (1993), pp 10-13 (Available at http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/44A4176CB3911D3D4C2565D700185E57/$file/Maori%20health%20review.pdf)

2015.[476] In its place was established a single 'Māori Leadership' position as part of the Executive Leadership Team, who was to be assisted by an executive assistant and chief advisor, with the functions of Te Kete Hauora dispersed around the wider Ministry.[477] The stated purpose of this change was to 'ensure that the goal of reducing Māori health inequalities is integrated and owned throughout all of the Ministry's activities and in our work with other agencies'.[478] However, the loss of a dedicated team focussed on Māori health prompted concern and criticism from some involved in researching Māori health and providing healthcare to Māori.[479]

This change was not long-lived. In October 2018, as part of another restructure, the Māori Leadership position was abolished and a new Māori Health Directorate was established with an ixpected staff of approximately 25 individuals.[480] As part of this new structure, the Deputy Director-General Māori Health is to have 'an explicit focus on the Crown's Treaty obligations to protect and improve Māori health outcomes'.[481] The re-establishment of a Māori Health Directorate did not absolve other Ministry staff of a responsibility to Māori, with the Director-General of Health emphasising that 'all Ministry staff members have a responsibility for improving Māori health and driving increased equity of health outcomes.'[482]

Māori are proportionally under-represented amongst Ministry of Health staff in comparison to both the general population and the wider public service. As at 30 June 2018, 16 per cent of all public servants were Māori, but Māori accounted for only 8.2 per cent of Ministry of Health staff.[483]

3.2.2 District Health Boards

The representation of Māori on District Health Boards is provided for under the New Zealand Public Health and Disability Act 2000, which, as discussed in a previous chapter, requires the

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[476] Heather Came and Keith Tudor, 'Unravelling the whāriki of Crown Māori health infrastructure', *New Zealand Medical Journal* vol 130, no 1458 (2017), p 43; 'Ministry on the Move: Building our capacity to lead – Executive Leadership Structure Decision, December 2015', Ministry of Health, https://www.health.govt.nz/system/files/documents/media/moh-elt-structure-decision-2016.pdf, accessed 6 May 2019.

[477] 'Ministry on the Move'; 'Māori health', Ministry of Health, https://www.health.govt.nz/our-work/populations/maori-health, last modified 5 December 2018; Heather Came and Keith Tudor, 'Unravelling the whāriki of Crown Māori health infrastructure', *New Zealand Medical Journal* vol 130, no 1458, p 44.

[478] 'Ministry on the Move'.

[479] Came and Tudor, Unravelling the whāriki of Crown Māori health infrastructure', pp 43-46; Gabrielle Baker, 'Summer health series: Treaty partnership and decision making', The Spinoff, https://thespinoff.co.nz/atea/23-01-2018/summer-health-series-treaty-partnership-and-decision-making/, last modified 23 January 2018.

[480] 'Delivering on the Ministry's Sector Leadership and Stewardship Roles: Final decision document on changes to the Ministry's second-tier structure, 1 October 2018', Ministry of Health, https://www.health.govt.nz/system/files/documents/pages/moh-structure-decision-document-1oct-2018.pdf, accessed 6 May 2019.

[481] 'Delivering on the Ministry's Sector Leadership and Stewardship Roles'.

[482] 'Delivering on the Ministry's Sector Leadership and Stewardship Roles'.

[483] State Services Commission, 'Our People: Public Service Workforce Data 2018' (Wellington: State Services Commission, 2018), p 35

Minister, when making appointments, to 'endeavour to ensure that' Māori representation on boards is proportional to the number of Māori in the DHB's population and that there are at least two Māori on each board.[484]

In effect, with DHBs having at most 11 board members, the second of these requirements would seem to provide for a slight over-representation of Māori among DHB board members on a national basis and a significant over-representation of Māori on DHB boards in some DHBs where Māori form a smaller than average proportion of the population. This is provided, of course, that the Minister makes every endeavour to ensure the appropriate level of Māori representation.[485] In reality, the representation of Māori on DHB boards has not always met the requirements in the legislation. In November 2018, while there were higher proportions of Māori on 11 of the 19 DHB boards than in the equivalent regional populations and in most other cases the numbers of Māori were close to proportional, the Northland DHB had only two Māori board members (equivalent to 18 per cent of all board members) while serving a population that was 34 per cent Māori.[486] Historically, there have also been regular failures to guarantee that there are at least two Māori on each DHB board. This problem was most common in figures for 2007 and 2013, at which times five DHB boards each had only a single Māori member.[487]

This proportional over-representation of Māori provided for in the legislation appears to have been recognised and endorsed by the Clark Government that was responsible for the establishment of DHBs. Indeed, in a memorandum to the Cabinet Social Policy and Health Committee, Annette King, the then Health Minister, made an explicit case for disproportionate representation of Māori for reasons including making 'it more likely that the Māori voice will be

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[484] New Zealand Public Health and Disability Act 2000, s 29(4)

[485] In a situation in which all DHBs had the maximum 11 board members, the requirement to have two Māori members (without accounting for additional Māori members that may be required in some DHBs under the preceding provision for proportional representation of Māori) would seem to ensure that Māori should occupy at least 18.2 per cent of all DHB board positions, a proportion higher than the 14.9 per cent of the population who identified as Maori in 2013. The proportional over-representation of Māori provided for by this provision is even greater in the following DHBs, with the proportion of their populations who identified as Māori in 2013 provided in brackets: Auckland (7%), South Canterbury (7%), Canterbury (8%), Southern (9%), Waitemata (9%), Nelson Marlborough (9%), West Coast (10%), Capital & Coast (10%). Laugesen and Gauld have suggested both that governments have appointed Māori in addition to those required and that the proportion of Māori on DHB boards has been lower than the proportion of Māori in the general population, a seemingly impossible combination if Ministers had appointed the required number of Māori. Came identified that the proportion of DHB board members who were Māori was in line the proportion of Māori in the general population. However, she determined whether board members were Māori on the basis of whether they were listed on the Māori electoral roll, suggesting a potentially significant number of Māori members of DHB boards who had chosen to be on the general roll would have been missed and thus that the proportion of DHB board members who are Māori may be significantly higher than she has claimed. '2013 Census QuickStats about culture and identity', Stats NZ, http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/ethnic-groups-NZ.aspx, accessed 7 May 2019; 'Population projections', Ministry of Health, https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/tatauranga-taupori-demographics/population-projections, last modified 28 August 2018; Miriam J Laugesen and Robin Gauld, *Democratic Governance & Health: Hospitals, Politics and Health Policy in New Zealand* (Dunedin: Otago University Press, 2012), p 146; Heather Anne Came, 'Institutional Racism and the Dynamics of Privilege in Public Health' (PhD thesis, University of Waikato, 2012), p 186.

[486] Wai 2575 3.2.19(a), p 2.

[487] Wai 2575 3.2.91(a), pp 1-5.

heard' and to demonstrate a commitment to addressing Māori health disparities.[488] The Regulatory Impact Statement included in the memorandum also tied the proposals to Treaty obligations:

> The policy objective is to give effect to the Treaty principle of partnership by ensuring that Maori are represented on Boards in a number and manner that will enable them to have an effective and informed voice in the conduct of the DHB Boards' business.[489]

While a proposal in King's memorandum to ensure that Māori would be over-represented on all DHB boards was not endorsed by cabinet, the requirement for at least two Māori on each DHB board remained and, as noted previously, was embodied in the Act as passed by Parliament.[490]

It was recognised by government that elections alone could not guarantee Māori representation, even though the Single Transferable Vote system that was adopted for DHB elections subsequent to the first election would be more likely to result in Māori representation than a First Past the Post system. Accordingly, it was believed representation would need to be boosted by appointments made by the Minister.[491] This has proven to be the case, with Māori proportionally under-represented amongst candidates for and those elected to DHB boards. (See Table 3.1 and Table 3.2). Māori have, in turn, been heavily over-represented amongst those appointed to DHB boards by ministers, with, at least in some appointment cycles, over 60 per cent of appointees identified as Māori.[492]

Table 3.1 Māori as a percentage of District Health Board candidates 2001-10[493]

2001	2004	2007	2010
12	13	11	n/a

Table 3.2 Māori as a percentage of District Health Board members elected 2001-10[494]

2001	2004	2007	2010
3	8	8	n/a

The King memorandum noted that officials recognised 'that Maori will want to be involved in the selection of candidates for appointment' and set out a number of possible appointment

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[488] Annette King, 'Equitable Representation of Maori on Dhb Boards 1/3', Beehive.govt.nz, https://www.beehive.govt.nz/feature/equitable-representation-maori-dhb-boards-13, accessed 7 May 2019.

[489] Annette King, 'Equitable Representation of Maori on Dhb Boards 3/3', Beehive.govt.nz, https://www.beehive.govt.nz/feature/equitable-representation-maori-dhb-boards-33, accessed 7 May 2019.

[490] King, 'Equitable Representation of Maori on Dhb Boards 1/3'; King, 'Equitable Representation of Maori on Dhb Boards 3/3'.

[491] King, 'Equitable Representation of Maori on Dhb Boards 1/3'; Laugesen and Gauld, *Democratic Governance & Health*, pp 143-144.

[492] Laugesen and Gauld, *Democratic Governance & Health*, p 149. Details of the numbers of elected and appointed Māori members for each DHB can be found in Wai 2575 3.2.19(a) and Wai 2575 3.2.91(a).

[493] Figures from Laugesen and Gauld, *Democratic Governance & Health*, p 145.

[494] Figures from Laugesen and Gauld, *Democratic Governance & Health*, p 147.

processes.[495] While the process currently being used of requiring individuals to make an expression of interest in order to be appointed is similar to one of the options set out in the King memorandum, it is notable that the Ministry website that explains the process makes no mention of consultation with Māori. Indeed, the closest it comes to saying anything about Māori representation is that 'people from groups not represented among the elected members' are among those whom 'the Minister may wish to appoint'.[496]

While Māori appear well-represented on DHB boards in terms of the proportion of board members who identify as Māori, this does not of itself indicate that the views and perspectives of local Māori are reflected in the governance of DHBs. Indeed, while the majority of those on DHB boards are elected by the residents of the DHB area, DHB boards are accountable to the Minister of Health, are required to implement government policy, and can be subjected to monitoring or dismissal if the Minister is not satisfied with their performance.[497] As Laugesen and Gauld observed:

> It is extremely difficult for a board and its elected members to challenge government policy or speak out about issues on behalf of their local communities that may pose risks for the Minister of Health. In sum, elected DHB members are in the rather unusual position of being local 'representatives' with little capacity to do much more than represent central government.[498]

The high proportion of Māori DHB board members who are appointed by the Minister rather than elected would seem to reduce further the ability of DHBs to reflect local Māori interests. Appointed members neither receive the authorisation of local Māori to act as representatives nor have any direct form of accountability to their local communities, depending instead on maintaining the support of the Minister for their reappointment. To the extent that appointed Māori members represent Māori, it is in a descriptive sense – the fact that they are of the same ethnicity.[499] While requirements to use appointments to guarantee a certain number of Māori are on each board might tend to presume a commonality of interest amongst Māori, there is nothing here that would guarantee that Māori who are appointed have life experiences, values, or opinions that are typical or 'representative' of local Māori communities or that they even live within the district. Thus, the extent to which such appointees can be considered even descriptive representatives of local Māori may, in some cases, be a very limited one.

It would be wrong, however, to assess the extent of Māori representation on DHB boards solely by looking at the number of DHB board members who are Māori. The fact that non-Māori elected members have been elected by a constituency that includes Māori means they also have a

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[495] Annette King, 'Equitable Representation of Maori on Dhb Boards /3', Beehive.govt.nz, https://www.beehive.govt.nz/feature/equitable-representation-maori-dhb-boards-3, accessed 7 May 2019.

[496] 'DHB board appointment process', Ministry of Health, https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/dhb-board-appointment-process, last modified 29 May 2019.

[497] Laugesen and Gauld, *Democratic Governance & Health*, p 141.

[498] Laugesen and Gauld, *Democratic Governance & Health*, p 141

[499] For a much more thorough discussion of the nature of descriptive representation, see Hanna Fenichel Pitkin, *The Concept of Representation* (Berkeley: University of California Press, 1967), pp 60-91.

role as representatives for Māori. The extent to which individual non-Māori members rely on Māori votes or see themselves as having a particular role in representing Māori interests undoubtedly varies. However, it seems entirely possible that a non-Māori member could function as an effective representative for local Māori by carrying their voices into decision-making and advancing their interests and could thus enjoy substantial Māori support in his or her representative role, even though, in terms of ethnicity, he or she did not give descriptive representation to Māori. Making any assessment of the extent to which non-Māori DHB board members have been able to be effective in representing their Māori voters would be a large and inevitably subjective task and is thus not attempted here.

The legislation does not focus solely on DHB board membership in its requirements for Māori to be included in decision-making. It requires Māori representation on DHB community and public health, disability support, and hospital advisory committees.[500] It also places obligations on DHBs, not only to address Māori health disparities, but also to enable Māori participation and contribution to strategies to improve Māori health and to foster Māori capacity to participate in the health sector and to provide for Māori needs.[501]

3.2.3 Primary Health Organisations

The Primary Health Care Strategy includes a number of minimum requirements that seek to ensure that PHOs are inclusive of, and responsive to, their communities and health providers, including Māori. Minimum requirements for PHOs include that they:

- 'demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community';
- 'demonstrate how all their providers and practitioners can influence the organisation's decision-making'; and
- 'work with those groups in their populations (for example, Maori, Pacific and lower income groups) that have poor health or are missing out on services to address their needs.'[502]

The Strategy requires that PHOs must be able to satisfy the DHBs from which they are receiving funding that they are meeting these requirements.[503]

One way in which Māori have been able to take an active role in primary health care is through the establishment of Māori PHOs. Out of a total of 32 PHOs, there are currently four generally considered to be Māori PHOs. Three of these – Ora Toa PHO, Ngati Porou Hauora, and Nga

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[500] New Zealand Public Health and Disability Act 2000, ss 34, 35, 36.
[501] New Zealand Public Health and Disability Act 2000, ss 22, 23.
[502] Annette King, 'Minimum Requirements for Primary Health Organisations' November 2001 Available at: http://www.moh.govt.nz/notebook/nbbooks.nsf/0/c7c0dcc14014f723cc257788000aaaec/$FILE/MinReqsPHO.pdf
[503] Annette King, 'Minimum Requirements for Primary Health Organisations'.

Mataapuna Oranga – are relatively small, servicing specific geographical areas. The National Hauora Coalition is considered also a Māori PHO, but takes a somewhat different form. It is a larger PHO, encompassing clinics spread across Auckland, Waikato, and Whanganui, many of which have no visibly Māori identity and could not be considered Māori providers in their own right. Indeed, both Europeans and Asians constitute higher proportions of those enrolled with the National Hauora Coalition than Māori.[504] The number of Māori PHOs has declined significantly over time due to mergers and closures.[505] For example, the National Hauora Coalition was formed into a single organisation from what were formerly eight separate Māori PHOs, while Te Kupenga a Kahu Trust PHO closed after it was unable to repay a debt to Lakes DHB and its contract was cancelled.[506]

However, it would be mistaken to look only at the relatively small number of current Māori-led PHOs in considering the extent to which Māori have input into governance of PHOs. Indeed, Māori involvement in governance and decision-making in PHOs can take a number of forms and such involvement is required by the Primary Health Care Strategy. For example, half of the members of the boards of Te Tai Tokerau PHO and Western Bay of Plenty PHO have been appointed appointed by iwi or Māori organisations.[507] Hauraki PHO's arrangements are similar with its seven-member board including three members appointed by Māori health organisations, three general practice representatives, and an additional Māori representative.[508] A more common arrangement is for PHOs to have one or more positions reserved for Māori representatives. While it was not possible in the time available to determine whether there was at least one Māori member serving on the board of each PHO or the exact proportions of Māori

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[504] In the final quarter of 2014-15, the percentages of National Hauora Coalition patients by ethnicity were Asian 28.6%, European 31.8%, Maori 21.5%, Pacific 13.4%, Other 4.5%, Non Stated 0.1%. National Hauora Coalition, 'The Sustainability of Very High-Needs Primary Care Practices in a Capitated Environment' (Auckland: National Hauora Coalition, 2016), p 15.

[505] The exact number of Maori PHOs that existed in the past is unclear. Opening submissions for the Wai 1315 claim state that '[a]t the peak, there were 14 Māori PHOs'. A report by Russell, Smiler, and Stace states that, at an unspecified date, 23 PHOs were classified by the Ministry of Health as 'Self-Identified Māori PHOs' or 'PHOs with a focus on Māori'. A 2009 New Zealand Herald article referred to 11 Maori-led PHOs, although it is not entirely clear whether this was the total number in existence at the time or merely a subset who had formed a coalition. In 2008, the Ministry of Health reported that there were 16 Maori-led PHOs. Wai 2575 3.3.3, p 10; Lynne Russell, Kirsten Smiler, and Hilary Stace, 'Improving Māori Health and Reducing Inequalities between Māori and Non-Māori: Has the Primary Health Care Strategy Worked for Māori? An Evaluation of the Period 2003-2010' (Wellington: Health Research Council of New Zealand and Ministry of Health, 2013), p 21; Simon Collins, 'Govt showing interest in Maori-style social services', New Zealand Herald, https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10609211, last modified 14 November 2009; Ministry of Health, 'Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008-2015' (Wellington: Ministry of Health, 2008), p 12.

[506] Wai 2687 1.1.1, p 1; Wai 2575 A30, p 3.

[507] 'Te Tai Tokerau PHO Board', Te Tai Tokerau PHO, https://www.tttpho.co.nz/your-pho/tttphoboard-members/, accessed 14 May 2019; 'The WBPO PHO', Western Bay of Plenty Primary Health Organisation, http://portal.wboppho.org.nz/about-us/what-is-primary-health-the-wbop-pho/, accessed 14 May 2019. Since research for this section was completed, Te Tai Tokerau PHO has merged Manaia Health PHO to from Mahitahi Hauora. Information on the Mahitahi Hauora website indicates that its board includes representatives of iwi and hapū and Māori health providers, although the exact number of these representatives is not made clear. 'About us', Mahitahi Hauora, https://www.mahitahihauora.co.nz/uploads/Mahitahi-Hauora-About-Us.pdf, accessed 23 August 2019.

[508] 'Board of Trustees', Hauraki PHO, https://www.haurakipho.org.nz/about-us/governance/board-of-trustees/, accessed 14 May 2019.

on PHO boards, a cursory look at the membership of PHO board membership reveals that Māori membership of PHO boards is widespread.

Russell, Smiler, and Stace, in their evaluation of the Primary Health Care Strategy, noted that it was common for mainstream PHOs to rely on Māori representatives on their boards to fulfil a role in providing advice and engaging with Māori communities, with some instead relying on Māori providers with which they worked to fulfil these roles.[509] Their research, however, indicated that the presence of Māori board members did not of itself indicate strong community engagement or a strong Māori voice in decision-making. In some cases, other PHO board members could be dismissive of the perspectives or expertise brought by Māori.[510] They also heard accusations that some PHOs, particularly those dominated by general practitioner interests, while 'functioning under the guise of a population approach' mandated by the Primary Health Care Strategy, were more interested in looking after what they had invested in their businesses and were reluctant to seek community input.[511]

3.3 Inclusion of Māori in inquiries, reviews, and advisory boards

Māori have also been able to play a role in informing decisions about services and the overall direction of mental health policy through involvement in a variety of bodies that provide advice to government and health providers. Advisory groups can be found at all levels of the health system and serve a variety of purposes, including providing clinical expertise, reflecting the views of service users, and representing the community. In some cases, specific Māori advisory groups are established, such as in the case of the iwi or Māori relationship boards established at each DHB and Te Rōpū Māori at the Health Quality and Safety Commission.[512] Although the sheer number and variety of advisory groups that exist throughout the health system would complicate any attempt to determine the exact proportion of members who are Māori, or how effectively these bodies represent Māori perspective, it appears that the inclusion of Māori on these bodies is widespread.

The following sections provide an overview of Māori involvement in what are the most important bodies providing recommendations to government on mental health and the health system more broadly in the current term of Parliament, namely the Government Inquiry into Mental Health and Addiction and the New Zealand Health and Disability System.

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[509] Russell, Smiler, and Stace, 'Improving Māori Health and Reducing Inequalities between Māori and Non-Māori', pp 46, 49.

[510] Russell, Smiler, and Stace, 'Improving Māori Health and Reducing Inequalities between Māori and Non-Māori', p 46.

[511] Russell, Smiler, and Stace, 'Improving Māori Health and Reducing Inequalities between Māori and Non-Māori', pp 44-45.

[512] Ministry of Health, 'The Guide to He Korowai Oranga', pp 2, 8; 'Te Rōpū Māori', Health Quality & Safety Commission, https://www.hqsc.govt.nz/about-us/te-ropu-maori/, last modified 16 May 2019.

3.3.1 Government Inquiry into Mental Health and Addiction

An inquiry to 'fix our mental health crisis' was included as part of the 100-day plan that the Labour Party took to the 2017 election.[513] With the formation of a Labour-led coalition government following the election, work soon began on establishing this inquiry with the terms of reference announced in draft form on 23 January 2018 and the establishment of the Inquiry officially signed off by the Minister of Health two days later.[514]

The panel of six that was appointed to the Inquiry by the Minister of Health included two Māori members – the psychiatrist and Māori Studies scholar Sir Mason Durie and Dean Rangihuna, a Māori consumer advisor from Canterbury DHB – and there was a strong focus on engaging with Māori over the course of the Inquiry. While the Terms of Reference called for an approach that respected a variety of population groups, the Inquiry stated that '[e]ngagement with Māori was especially important'.[515] In describing the ways it had engaged with the community, the Inquiry made a point of noting how it had sought to reach Māori via iwi radio, TVNZ's 'Marae' programme, and social media and had engaged with Māori in person at a multitude of meetings, including at events held at marae.[516]

The final report presented to the Minister of Health on 28 November 2018 reflected the focussed attention on Māori, who received more coverage than any other population group.[517] In addition to frequent references to Māori throughout the report, there were also specific sections devoted to what the panel had heard from Māori and what it believed to be the key changes required in relation to Māori health and wellbeing.

Even so, the Inquiry has attracted criticism for not adequately engaging with Māori. Māori mental health lecturer Dr Keri Lawson-Te Aho has claimed that the inquiry 'failed to faithfully

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[513] 'Taking action in our first 100 days', New Zealand Labour Party, https://www.labour.org.nz/100days, accessed 10 May 2019.

[514] Victoria Young, 'Labour sets terms of reference for mental health inquiry', National Business Review, https://www.nbr.co.nz/article/labour-sets-terms-reference-mental-health-inquiry-vy-211829, last modified 23 January 2018; 'Cabinet Paper: Inquiry into Mental Health and Addiction', Government Inquiry into Mental Health and Addiction, https://mentalhealth.inquiry.govt.nz/assets/Uploads/Establishing-the-Government-Inquiry-into-Mental-Health-and-Addiction.pdf; 'Establishment of the Government Inquiry into Mental Health and Addiction', *New Zealand Gazette*, 30 January 2018, no 2008-go318, pp 1-4.

[515] 'Establishment of the Government Inquiry into Mental Health and Addiction'; 'Inquiry engagement', Government Inquiry into Mental Health and Addiction, https://mentalhealth.inquiry.govt.nz/about-the-inquiry/regional-events/, last modified 3 December 2018.

[516] 'Inquiry engagement'.

[517] It is instructive to compare the level of focus on Māori with that devoted to other groups who may have particular mental health issues or cultural needs. A text search of the report revealed 246 instances of 'Māori', 186 of 'Pacific' and 8 of 'Pasifika', 11 of 'migrant(s)', 15 of 'refugee(s)', 28 of 'rainbow' and 3 of 'LGBTIQ'/'LGBTIQA+', 19 of 'rural', 7 of 'elderly', 57 of 'youth', and 10 of 'disabled' (there were also 105 references to 'disability' but these mostly referred to officials, organisations, or legislation, e.g. 'Health and Disability Commissioner' or 'Health and Disability Sector Review', rather than the experiences of individuals). Interestingly, no minority ethnic groups, besides Māori and Pacific, appear to have received any attention in the report, other than to the extent they may have been intended to be caught by general mentions of 'migrants' or 'refugees'. For example, there were no references at all to 'Asian(s)', 'Chinese', 'Indian(s)', 'Middle Eastern', or 'African(s)' in the report.

represent or to heed the Treaty partner.'[518] Michael Naera of Te Runanga o Ngati Pikiao Trust stated that 'the inquiry report was a complete shambles for Māori' and that it took 'a one size fits all approach', with its recommendations ignoring, amongst other things, a widely-endorsed National Māori Strategy for Addressing Suicide that was presented to the panel and 'strong consensus among Māori' in relation to the inclusion of te reo Māori, te ao Māori, matauranga Māori, and whānau.[519]

Much of this criticism of the Inquiry has related to the handling of the Māori submissions summary report that, after its release was delayed, was leaked in draft form in December 2018 and then officially released in a heavily reworked form at the beginning of February 2019. Among the changes between the two versions was a dramatic reduction in length and the removal of some pointed criticisms of government policy and the Inquiry process. Dr Lynne Russell, one of the authors of the original draft Māori submissions report, has stated in the media that the rewriting resulted from a process marred by 'methodological racism' in which oral submissions were not properly recorded, Māori submissions were not appropriately identified, and there was limited time for thorough analysis.[520]

Addressing a question concerning the reasons for the rewriting of the submissions report, a former member of the Inquiry secretariat explained that a review of an earlier version of the leaked draft version had raised concerns about 'substantial issues' of privacy and natural justice, length, the lack of an executive summary, and inappropriate author interpretation and commentary.[521] A letter from former Inquiry panel members published in *The Press* and *Dominion Post*, in which they stated that they 'firmly reject' claims that they sidelined Māori, explained that the original draft report 'was not a faithful representation of submitter's voices'.[522] This disagreement is significant as it goes to the heart of what Māori presented in evidence to the Mental Health and Addiction Inquiry and the extent to which the Inquiry's findings and subsequent government policy based on them reflect meaningful consultation with Māori.

Without assessing the full range of submissions made by Māori to the Inquiry, it is impossible to determine the extent to which either the draft or final versions of the submissions summary provide an accurate account of them. Such an assessment is in turn rendered impossible by the

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[518] Jessica McAllen, 'Māori NGO leaks supplementary mental health inquiry report', Radio New Zealand, https://www.rnz.co.nz/news/te-manu-korihi/378710/maori-ngo-leaks-supplementary-mental-health-inquiry-report, last modified 20 December 2018.

[519] McAllen, 'Māori NGO leaks supplementary mental health inquiry report'; Te Runanga o Ngati Pikiao Trust, 'Mental Health Report disheartens Maori Health Provider', Scoop, http://www.scoop.co.nz/stories/GE1812/S00030/mental-health-report-disheartens-maori-health-provider.htm, last modified 5 December 2018. The strategy to which Naera is referring is presumably M H Durie et al., 'Tūramarama ki te Ora: National Māori Strategy for Addressing Suicide, 2017-2022' (Rotorua: Te Rūnanga o Ngāti Pikiao Trust, 2017).

[520] Jessica McAllen, 'Māori voices "missing" from Mental Health and Addictions Inquiry', Stuff, https://www.stuff.co.nz/national/health/112309355/maori-voices-missing-from-mental-health-and-addictions-inquiry, last modified 30 April 2019.

[521] Personal communication from former Mental Health and Addiction Inquiry secretariat member to Ross Webb, 21 February 2019.

[522] 'Inquiry team: Māori not sidelined', *The Press*, 7 May 2019, p 12; 'Māori not sidelined', *Dominion Post*, 8 May 2019, p 17.

approach to submissions adopted by the Inquiry. Contrary to the practice ordinarily adopted by commissions of inquiry, the Mental Health and Addiction Inquiry did not publish the submissions presented to it. Section 32 of the Inquiries Act 2013 provides for the application of the Official Information Act 1982 (OIA), with certain exceptions, to 'all documents created by the inquiry or received in the course of the inquiry' once it has reported. The Inquiry, however, took advantage of one of these exceptions, making orders under s 15(1)(a) of the Inquiries Act that forbid the release of a wide range of documents, including individual submissions, notes taken during public and private meetings, and drafts of submission summary reports.[523] The approach adopted by the Inquiry in this regard is much more restrictive than was originally envisioned and went beyond the commitments made to submitters in relation to privacy.[524]

3.3.2 Health and Disability System Review

The New Zealand Health and Disability System Review, established in August 2018, is tasked with identifying

> opportunities to improve the performance, structure, and sustainability of the system with a goal of achieving equity of outcomes, and contributing to wellness for all, particularly Māori and Pacific peoples.[525]

The Review is being conducted by a seven-person expert review panel, chaired by Heather Simpson. From a cursory examination of their backgrounds, it would appear that only one of the seven panel members – Shelley Campbell – is Māori.[526] However, this proportion of Māori – 1 in 7 – closely aligns with the proportion of the overall population who identify as Māori.

Since December 2018, the Review has also been assisted by a six-member Māori Expert Advisory Group 'to ensure that Māori perspectives on key aspects of the Health and Disability

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[523] The restrictions on the release of group and organisation submissions are more limited, applying to those 'raising privacy, confidentiality or natural justice concerns which are unable to be appropriately redacted to ensure protection from possible harm within time and resources available to the Inquiry before reporting to the Minister'. By contrast, the only circumstance in which an individual submission can be released is when the OIA request is made by the original submitter. Government Inquiry into Mental Health and Addiction Minute No. 2, 27 November 2018, available at: https://mentalhealth.inquiry.govt.nz/assets/Uploads/Orders-Minute-No.-2.pdf

[524] Government Inquiry into Mental Health and Addiction Minute No. 1, 21 April 2018, available at: https://mentalhealth.inquiry.govt.nz/assets/Uploads/Minute-21-April-2019.pdf; 'Legal information about your submission', Government Inquiry into Mental Health and Addiction, https://mentalhealth.inquiry.govt.nz/about-the-inquiry/legal-information-about-your-submission/, last modified 4 December 2018.

[525] 'Terms of reference', New Zealand Health and Disability System Review, https://systemreview.health.govt.nz/about/terms-of-reference/, last modified 21 December 2018.

[526] The full list of panel members is available at 'Expert Review Panel', New Zealand Health and Disability System Review, https://systemreview.health.govt.nz/about/expert-review-panel/, last modified 5 April 2019.

System Review are well considered and understood'.[527] To date, this is the only advisory group established by the Review.

The Māori Expert Advisory Group hosted a series of wānanga in May and June 2019 to provide 'an opportunity for Māori to discuss and help shape what the future New Zealand health and disability system might look like.'[528] In holding these wānanga, the Advisory Group hoped to hear views on both issues that currently affect Māori and how the health system could 'prioritise Māori health equity, outcomes and aspirations' in the future.[529]

3.4 Critiques of Crown engagement with Māori and effectiveness of Crown policies

While it is clear that the Crown has taken some significant steps to ensure Māori representation in health governance, policy-making, and reviews and to include processes of consultation with Māori, there has been criticism of the extent to which Māori voices can truly influence health policy and an apparent disconnect between what policies say and what is happening in practice.

Heather Came has identified a number of ways in which Māori voices can be diminished or ignored in the health policy cycle, including through being a structural minority within both the population and decision-making bodies, the limited political will of governments to pursue policies for Māori, the privileging of Western knowledge and research over Māori evidence and the rejection of Māori analysis, the lack of cultural competence by managers and policy-makers, and flawed consultation processes.[530] These problems were identified through a series of interviews with individuals who had experience working in the health sector and were in many cases mirrored in a later study by Came and others examining the experiences of Māori and Pacific people serving on health advisory groups.[531] Given the small sample size for these studies and the sourcing of informants from the existing networks of the researchers and their close associates, caution needs to be exercised in considering the extent to which the experiences and perceptions recorded reflect those of Māori in the health sector more broadly.[532]

Just as Māori voices can be sidelined in policy-making processes, the translation of policy into practice on the ground does not always occur effectively. In an interview with Heather Came,

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[527] 'Māori Expert Advisory Group,' New Zealand Health and Disability System Review, https://systemreview.health.govt.nz/about/maori-expert-advisory-group-profiles/, last modified 18 February 2019.

[528] 'Upcoming wānanga', New Zealand Health and Disability System Review, https://systemreview.health.govt.nz/news/upcoming-wananga/, last modified 30 April 2019.

[529] 'Upcoming wānanga', New Zealand Health and Disability System Review.

[530] Came, 'Institutional Racism and the Dynamics of Privilege in Public Health', pp 183-200.

[531] Came, 'Institutional Racism and the Dynamics of Privilege in Public Health', pp 39-43, 183-200; Heather Came et al., 'Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand', *Kōtuitui: New Zealand Journal of Social Sciences Online* vol 14, no 1 (2019), pp 126-135.

[532] Details concerning the selection of participants can be found in: Came, 'Institutional Racism and the Dynamics of Privilege in Public Health', pp 39-43; Came et al., 'Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand', p 128.

Māori nurse and health manager Hayden Wano recounted how budgeting and resourcing decisions could stymie policy initiatives:

> I've had too many experiences where the planning process has been used as a way of getting a tick in the box for addressing inequalities but actions have not followed or been sustained for long enough to make a difference.[533]

Came noted that Wano argued Māori health plans, made separately from other planning processes, 'are often waved around and get quoted and referenced' but result in 'no significant change in terms of improved outcomes'.[534]

The disconnect between policies that say all the right things and the reality of service delivery is one that seems to be relatively widespread in the health sector, not least in mental health, and is not limited to only initiatives that are proposed by Māori. The Government Inquiry into Mental Health and Addiction lamented this problem:

> Areas for action are outlined in multiple reports and strategies. Widespread agreement exists about the need for change and, in many respects, what changes should look like. Yet, despite so much consensus, the system has not substantially shifted.[535]

In the same section, the panel noted that '[w]e cannot afford to have another report that repeats the same messages but does not result in real change.'[536] Elsewhere, they observed that little progress has been made on goals related to community-based support, prevention, and early intervention 'despite worthy policies and strategies'.[537]

Such a general failure to deliver the changes that are widely recognised as necessary and that have been included in government policies suggests that failures to transform Māori views into practice are unlikely to be solely a result of dismissive attitudes towards, or poor engagement with, Māori. Although these factors may play a part, the problem here is much wider. Putting aside the question of whether Māori voices are heard less strongly than others in the policy-making process, the fact remains that the general failure to transform services in line with the recommendations of both Māori and others has likely had a disproportionately negative effect on Māori, given the higher rates of mental illness amongst Māori and the higher than average proportion of Māori who use mental health services.

3.5 Kaupapa Māori mental health services

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[533] Hayden Wano quoted in Came, 'Institutional Racism and the Dynamics of Privilege in Public Health', p 200.

[534] Came, 'Institutional Racism and the Dynamics of Privilege in Public Health', p 200.

[535] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga' (Wellington: Government Inquiry into Mental Health and Addiction, 2018), p 96.

[536] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 96.

[537] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 8.

Kaupapa Māori mental health services are today delivered both directly by DHBs and by NGOs. As discussed in previous chapters, kaupapa Māori approaches to mental health care were pioneered in the 1980s and the health reforms of the 1990s led to the proliferation of Māori NGO service providers who were now able to tender for government contracts.

Defining what constitutes a kaupapa Māori mental health service is not straightforward and there can be much variation between the approaches adopted by different services. As Te Kani Kingi notes, while '[t]he application of cultural interventions and therapies is a constant', differences of opinion can exist on a variety of matters, including what these interventions and therapies are, the inclusion of clinical interventions, and the extent to which Māori must be in control of service delivery.[538] Kingi explains that it is 'unlikely' that a single approach could be adopted and 'perhaps even unwise' to do so, noting that differences of personal experience and cultural expectations amongst Māori mean that services must be tailored to individual needs.[539]

The Ministry of Health's service specifications require providers of kaupapa Māori services to identify as Māori (whether as part of DHB provider arm or an NGO provider) and to 'use a Māori framework and models of care that encompass a holistic approach to health'.[540] The specifications also identify a number of characteristics that form part of kaupapa Māori services:

> - linkage with Māori whānau, hapu, iwi community organisations
> - supported by manawhenua and/or the local Māori community
> - utilisation of Māori derived beliefs, values and practice
> - staff more likely to be of Māori descent
> - aims that are consistent with wider aims and aspirations of Māori development
> - facilitation of access to, and support of, kaumātua (male and female)
> - there is an emphasis on whakawhanaunatanga [sic].[541]

As noted in Chapter 2, 9.6 per cent of all full-time equivalent positions within the New Zealand mental health system were located within kaupapa Māori services in 2014, a number much lower than the 26 per cent of service users who were Māori.[542] It is apparent there is insufficient resourcing for kaupapa Māori services to see to the needs of all Māori using mental health services. However, a comparison of these figures cannot give a definitive answer on whether the level of kaupapa Māori service provision is appropriate, since not all Māori will wish to use them. Submissions to the Government Inquiry into Mental Health and Addiction, however, suggest that some Māori are unable to access kaupapa Māori services, that many believe that the mental

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[538] Te Kani Kingi, 'Mental Health Services for Māori', in *Maea Te Toi Ora: Māori Health Transformations* (Wellington: Huia, 2018), pp 52-53.

[539] Kingi, 'Mental Health Services for Māori', p 56.

[540] 'Kaupapa Māori Mental Health and Addiction Services – Mental Health and Addiction Services – Tier Two Service Specification', Ministry of Health, https://nsfl.health.govt.nz/system/files/documents/specifications/kaupapamaorimentalhealthandaddictionservicesmhakt2april2017.docx, accessed 26 June 2019.

[541] 'Kaupapa Māori Mental Health and Addiction Services – Mental Health and Addiction Services – Tier Two Service Specification'.

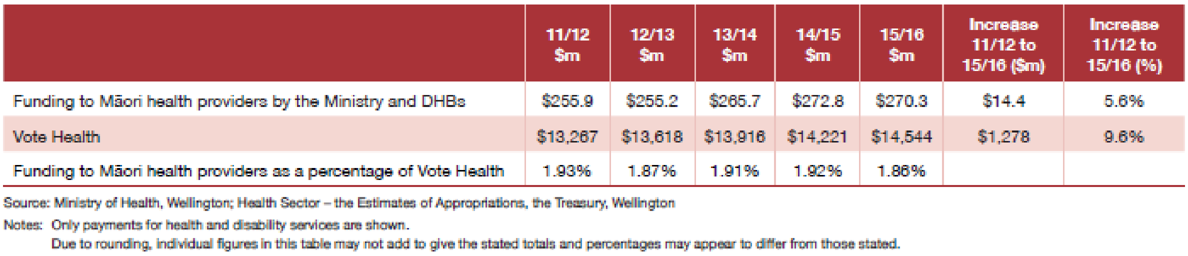
[542] Te Pou o Te Whakaaro Nui, 'Adult mental health and addiction workforce: 2014 survey of Vote Health funded services' (Auckland: Te Pou o Te Whakaaro Nui, 2015), p 62.

health system continues to be dominated by services and practices that are ill-fitted to Māori needs, and that there is insufficient funding to meet demand for kaupapa Māori services.[543]

3.6 Service delivery by Māori NGO providers

The growth of Māori providers may have been a significant development since the 1990s, but Māori providers remain only a small part of New Zealand's health system. Figures for 2015/16 indicate that $270.3 million, or only 1.86 per cent of Vote Health, was provided in funding to Māori health providers and that the amount of funding for Māori providers had grown at a slower rate than health funding overall over the previous four years. (see Table 3.3).

Table 3.3 Funding to Māori health providers by the Ministry and DHBs as a percentage of Vote Health, 2011/12 to 2015/16[544]



	11/12 $m	12/13 $m	13/14 $m	14/15 $m	15/16 $m	Increase 11/12 to 15/16 ($m)	Increase 11/12 to 15/16 (%)
Funding to Māori health providers by the Ministry and DHBs	$255.9	$255.2	$265.7	$272.8	$270.3	$14.4	5.6%
Vote Health	$13,267	$13,618	$13,916	$14,221	$14,544	$1,278	9.6%
Funding to Māori health providers as a percentage of Vote Health	1.93%	1.87%	1.91%	1.92%	1.86%		

Source: Ministry of Health, Wellington; Health Sector – the Estimates of Appropriations, the Treasury, Wellington

Notes: Only payments for health and disability services are shown.
Due to rounding, individual figures in this table may not add to give the stated totals and percentages may appear to differ from those stated.

Funding figures also indicate, however, that Māori providers have a much more substantial role in delivering mental health services than is the case for health services generally. In 2017/18, $80.7 million was spent on services provided by Māori NGO providers, equivalent to 6.26 per cent of all mental health expenditure or 22.27 per cent of all expenditure on mental health services provided by NGOs. (see Table 3.4). There would appear, however, to have been a substantial reduction in the number of Māori mental health providers over the past decade. Whereas the Ministry of Health identified 123 Māori mental health or addiction services in 2008/09, as at July 2019 only 106 Māori mental health or addiction services had active or draft contracts with the Ministry and/or a DHB.[545]

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[543] Government Inquiry into Mental Health and Addiction, 'Oranga Tāngata, Oranga Whānau: A Kaupapa Māori Analysis of Consultation with Māori for the Government Inquiry into Mental Health and Addiction (Wellington: Department of Internal Affairs, 2019), pp 58-62; Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report' (Wellington: Government Inquiry into Mental Health and Addiction, 2018), pp 133, 140, 153.

[544] Source: 'Funding to Māori Health Providers by the Ministry of Health and District Health Boards, 2012/12 to 2015/16', Ministry of Health, https://www.health.govt.nz/system/files/documents/publications/funding-to-maori-health-providersv2.pdf, last modified 14 July 2017.

[545] 'Maori' defined as contracts with 'a Maori GL code, contract ID, PU code, or contracted service'. Personal communication from Principal Advisor, Mental Health, Ministry of Health, 6 August 2019. A higher figure of approximately 144 providers in 2008 is identified in Ministry of Health, 'Te Puāwaiwhero', p 11.

Table 3.4: Mental health expenditure 2017/18: total, all NGO providers, and Māori NGO providers[546]

	$millions
Total mental health expenditure	1,290.0
Mental health expenditure for all NGO providers	362.3
Mental health expenditure for Māori NGO providers	80.7

In interpreting figures in relation to the number of Māori health providers and their funding, it is important to note that this category is somewhat narrowly defined:

> The Ministry of Health has defined a Māori health and disability provider as:
>
> a) a provider that is owned and governed by Māori and currently funded by the Ministry of Health, District Health Board and Primary Health Organisation for the provision of health services; and
>
> b) a provider that is delivering health and disability services primarily but not exclusively for Māori.[547]

As is the case with PHOs, such a definition may exclude a variety of providers in which Māori have substantial input, but which fail to meet one of the above criteria. Thus, Māori health provider figures alone cannot be used to make a reliable assessment of the overall extent of Māori control of and input into decision-making within the field of health service provision.

The Crown has provided some funding to support the growth of Māori service provision within the health sector. The Māori Provider Development Scheme provides funding to build capacity and capability in the eight areas that are measured under the Māori Provider Capacity Assessment Tool. For 2019/20, $8.889 million is being made available as part of the Scheme, with the bulk of this directed to Māori health and disability providers, $800,000 directed to national Māori health and disability organisations, and $1,237,500 directed to the Hauora scholarship programme.[548] There is also Te Ao Auahatanga Hauora Māori: the Māori Health Innovation Fund, which seeks to remedy service gaps and unmet Māori need by supporting 'innovative initiatives' by Māori health providers.[549] This fund provides support for a period of

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[546] Excludes problem gambling and addiction services. 'Maori' defined as contracts with 'a Maori GL code, contract ID, PU code, or contracted service'. Personal communication with Principal Advisor, Mental Health, Ministry of Health, 21 June 2019.

[547] Ministry of Health, 'Māori Provider Development Scheme (MPDS) 2019/20: Purchasing intentions' (Wellington: Ministry of Health, 2019), p 5.

[548] Ministry of Health, 'Māori Provider Development Scheme (MPDS) 2019/20: Purchasing intentions', pp 1-2.

[549] 'Te Ao Auahatanga Hauora Māori: the Māori Health Innovation Fund 2018-2022' Ministry of Health, https://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/te-ao-auahatanga-hauora-maori-maori-health-innovation-fund-2018-2022, accessed 28 June 2019; Brown Research Ltd, 'Te Ao

up to four years.[550] A variety of other programmes that are targeted at boosting the Māori health workforce, and thus have the potential to feed into the growth and success of Māori service providers, are discussed in Chapter 2.

3.7 Contracting of Māori NGO providers

A number of claimants argue that the Crown has treated Māori health providers prejudicially in comparison to other mainstream providers, to the extent that it has hindered their ability to properly deliver a Māori approach to healthcare. Specifically, claimants argue that Māori health providers are monitored more intensely, are audited more frequently, receive shorter contracts, and have more onerous reporting and other compliance requirements than mainstream providers.[551]

District Health Boards (and less commonly, the Ministry of Health) commission service providers to deliver a broad range of health services within specified contract conditions, such as those concerning contract duration, funding, and quality assurance (including auditing).[552] In 2013, in a statement to Radio New Zealand, the Director-General of Māori Health stated that ‘contract lengths vary and auditing is done more frequently when there is an issue of concern with the organisation’.[553] More recently, in 2016, the Ministry of Health stated that ‘Māori providers have the same standard contracts as other providers and the accountability and reporting requirements are the same’.[554] However, there is a small body of academic and anecdotal evidence that supports claims that Māori health providers are treated differently to mainstream health providers. While research is not available that looks specifically at Māori

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Auahatanga Hauora Māori: the Māori Health Innovation Fund – Analysis of Te Kākana: Seeding Innovation 2013-2017’, p 3 Available at: https://www.health.govt.nz/publication/te-ao-auahatanga-hauora-maori-maori-health-innovation-fund-analysis-te-kakano-seeding-innovation

[550] Brown Research Ltd, ‘Te Ao Auahatanga Hauora Māori: the Māori Health Innovation Fund – Analysis of Te Kākana’, p 3.

[551] See, for example, Wai 762, 1.1(d), p 19, 48-49; Wai 1837, 1.1.1(b), p 4-5; Wai 2206, 1.1.1(d), p 17; Wai 2626, 1.1.1, p 2; Wai 2629, 1.1.1, p 2; Wai 2630, 1.1.1, p 2; Wai 2631, 1.1.1, p 2; Wai 2632, 1.1.1, p 2; Wai 2636, 1.1.1, p 2; Wai 2637, 1.1.1, p 2; Wai 2639, 1.1.1, p 3; Wai 2640, 1.1.1, p 2; Wai 2644, 1.1.1, p 2; Wai 2646, 1.1.1, p 2; Wai 2648, 1.1.1, p 3; Wai 2649, 1.1.1, p 3; Wai 2651, 1.1.1, p 2; Feedback from Grant Hewison to Timothy Gassin on draft research report, *Māori Mental Health*, on behalf of Wai 2828, 19 July 2019. Tamaki Legal have provided an alternative view by suggesting that NGO providers (including kaupapa Māori providers) may need to be more heavily monitored due to some shortcomings, see feedback from Tamaki Legal to Timothy Gassin on draft research report, *Māori Mental Health*, on behalf of Wai 433, Wai 2005, Wai 1886, Wai 2890, Wai 2761, Wai 2671, Wai 2729, Wai 2206, and Wai 1196, 19 July 2019.

[552] Personal communication from Senior Contracts and Relationship Manager, Māori Health Service Improvement, Māori Health Directorate, Ministry of Health to Brittany Whiley, 9 May 2019; Heather Came et al., ‘Institutional racism in public health contracting: Findings of a nationwide survey from New Zealand’, *Social Science & Medicine,* vol 199 (2018), p 134; Ministry of Health, *Standard Contract v1: Agreement to Purchase and Provide Services,* provided by Senior Contracts and Relationship Manager, Māori Health Service Improvement, Māori Health Directorate, Ministry of Health to Brittany Whiley, 13 May 2019.

[553] Teresa Wall, Director-General of Māori Health, cited in Radio New Zealand, ‘Close watch on Maori health providers’, Radio New Zealand*,* https://www.rnz.co.nz/news/te-manu-korihi/222111/close-watch-on-maori-health-providers, last modified 19 September 2013.

[554] Ministry of Health quoted in Aaron Smale, ‘Maori Health Providers Scrutinised More Closely’, Radio New Zealand, https://www.radionz.co.nz/national/programmes/morningreport/audio/201815917/maori-health-providers-scrutinised-more-closely, at 00:47, last modified 13 September 2016.

mental health providers, the experiences of Māori health providers generally are likely to also apply.

3.7.1 Differences in the contracting and oversight of Māori and mainstream providers

Difficulties faced by all non-government providers

A 2009 report on the experiences of mental health and addiction NGOs that contract with DHBs identified a number of difficulties with the DHB-NGO contracting relationship, noting that '[f]or most NGOs, the contracting environment and their contracting relationship with DHBs present immense frustrations'.[555] Difficulties included: 'cumbersome reporting regimes'; a lack of transparency within the contracting environment; a lack of 'mutually respectful relationships between funding and planning managers and community organisations'; and a 'clumsy' system that diverts resources away from frontline service provision.[556]

The 2018 Government Inquiry into Mental Health and Addiction similarly noted the difficulties that non-government mental health providers (including Māori mental health providers) face when contracting with government, which the Inquiry described as widespread throughout the health and wider social sector.[557] This included: short-term contracts; insecure and competitive funding; onerous reporting and other contract compliance requirements; managing multiple funders and contracts; contracts that are 'too focused on inputs and outputs' rather than outcomes; and power-imbalances between providers and government.[558] The Government Inquiry outlined that these practices can undermine the sustainability of providers, restrict how they operate, and limit real partnership with government. It formally recommended 'a clear stewardship role within central government to support NGO development and sustainability and improve commissioning of health and social services with NGOs'.[559]

Difficulties faced by Māori non-government providers

It is possible that these problems fall more heavily on Māori providers. The Government Inquiry noted that kaupapa Māori service providers often spend time doing work that is outside of their contracts but is necessary for achieving their goals for whānau health and wellbeing, such as working with schools and other government agencies.[560] It also noted that many Māori expressed the desire to 'determine how services are commissioned, delivered and evaluated'.[561] The Inquiry suggested 'replacing short-term contracts shaped around DHB priorities with commissioning

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[555] Platform Trust, *NgOIT: 2008 NGO-DHB Contracting Environment* (Wellington: Platform Charitable Trust, 2009), p 4.
[556] Platform Trust, *NgOIT: 2008 NGO-DHB Contracting Environment*, pp 4-5.
[557] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 138.
[558] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 138.
[559] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 13.
[560] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 85.
[561] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 39.

arrangements built around Māori and Iwi priorities' as a means to address inequities and honour the Treaty of Waitangi.[562]

The Chief Executive of Te Whānau o Waipareira Trust, John Tamihere, argues that there are 'different rules' for Māori and mainstream providers.[563] Specifically, he argues that Māori providers are not trusted, are audited more, and are scrutinised more heavily.[564] Kaiwai and Allport's qualitative data from interviews with health providers in the disability sector also describes an 'over-auditing' of Māori health providers.[565] Frequent auditing was seen by interviewed providers as 'a barrier to effective service delivery' and 'something that was not necessarily compatible with delivering best outcomes for Māori'.[566] A report on rural health by the National Health Committee similarly noted that Māori rural providers report they 'have too many reporting requirements and are too frequently audited'.[567]

A survey by Heather Came et al. revealed statistically significant variation in contracts and the monitoring of contracts between Māori public health providers and mainstream public health providers.[568] Firstly, Māori public health providers were more likely to have contracts of short duration. Sixty-one percent of mainstream providers had a most recent contract length of more than two years compared to only 37 percent of Māori providers.[569] The authors reflect that having contracts of short duration 'make it difficult for providers to engage in adequate strategic planning and make it more challenging to recruit and retain senior staff, especially for Māori where workforce pools are constrained'.[570] Secondly, Māori providers were audited more frequently. Fifty-nine percent of mainstream providers were audited during the five-year period between 2009 and 2014 compared to 85 percent of Māori providers.[571]

The research showed no disparities between mainstream and Māori providers concerning the frequency of monitoring, however, Māori providers were more likely to report that the contracting process was 'burdensome'.[572] Māori providers were also more likely to report high compliance costs, although no quantitative data is provided to support this.[573] Qualitative data also described that some Māori and mainstream providers felt there was 'a significant power imbalance between themselves and their funders', but that 'Māori providers were clearer on this imbalance and described the funder-provider relationship as "one-sided"'.[574] Some Māori providers also reported being 'told off', patronised, or bullied, and expressed concerns about non-Māori DHB and Ministry of Health staff not understanding Māori worldviews.[575] Came et

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[562] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 86.

[563] Te Whānau o Waipareira Trust is a Māori community organisation that provides a range of services. John Tamihere quoted in Aaron Smale, 'Maori Health Providers Scrutinised More Closely', at 00:26.

[564] John Tamihere quoted in Aaron Smale, 'Maori Health Providers Scrutinised More Closely', at 00:26.

[565] Hector Kaiwai and Tanya Allport, 'Māori with Disabilities (Part Two): Report Commissioned by the Waitangi Tribunal for the Health Services and Outcomes Inquiry (Wai 2575)', p 64.

[566] Kaiwai and Allport, 'Māori with Disabilities (Part Two)', p 64.

[567] National Health Committee, 'Rural Health: Challenges of Distance, Opportunities for Innovation' (Wellington: National Health Committee, 2010), p 27.

[568] Came et al., 'Institutional racism in public health contracting', p 132.

[569] Came et al., 'Institutional racism in public health contracting', p 135.

[570] Came et al., 'Institutional racism in public health contracting', p 137.

[571] Came et al., 'Institutional racism in public health contracting', p 135.

[572] Came et al., 'Institutional racism in public health contracting', p 135.

[573] Came et al., 'Institutional racism in public health contracting', p 135.

[574] Came et al., 'Institutional racism in public health contracting', p 136.

[575] Came et al., 'Institutional racism in public health contracting', p 137.

al. attribute their findings to 'unconscious (or conscious) bias or a general lack of trust or confidence from government officials individually and/or collectively, in Māori providers'.[576]

The impact of contract terms on the operation of Māori mental health providers

The Crown's contracting processes for NGO providers can also act to stifle innovation and frustrate the ability of Māori providers to deliver services on their own terms. In her 2005 thesis, Amohia Boulton concluded that contracting processes for mental health services were insufficiently responsive, failing:

> to take account of the unique perspectives, processes and practices Māori mental health providers bring to mental health service delivery, nor the pressures put upon them in the course of that delivery.[577]

Boulton observed that there was a dissonance between the objectives and processes of government and funders on the one hand and the philosophy of Māori providers on the other, and that Māori providers sometimes needed to deliver services beyond those for which they were funded in order to meet the expectations of their communities and patients.[578]

It would appear that little has changed since 2005, with submitters to the Government Inquiry into Mental Health and Addiction raising a variety of concerns about contracting practices that they felt did not meet Māori expectations and left them under-resourced.[579]

3.7.2 Factors that may account for differences in contracting practices between Māori and mainstream providers

Multiple contracts

There are a number of other factors that may account for differences in contracting practices, and Came et al. caution that more research is needed to rule out 'a variety of confounding variables that may have impacted on [their] primary analyses'.[580] Came et al. report that Māori public health providers in their study were 'significantly more likely' to hold a contract with the Ministry of Health as well as a DHB, which doubles the reporting and other contract compliance workload.[581] In a statement to Radio New Zealand, Marion Blake, the Chief Executive of

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[576] Came et al., 'Institutional racism in public health contracting', p 137.

[577] Amohia Frances Boulton, 'Provision at the Interface: the Māori Mental Health Contracting Experience' (PhD thesis, Massey University, 2005), p 251.

[578] Boulton, 'Provision at the Interface: the Māori Mental Health Contracting Experience', pp 252-254.

[579] Government Inquiry into Mental Health and Addiction, Oranga Tāngata, Oranga Whānau', pp 61-62; Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', pp 64-65.

[580] Came et al., 'Institutional racism in public health contracting', p 137.

[581] Came et al., 'Institutional racism in public health contracting', p 135.

Platform – a network of community groups working in mental health, also commented that some community providers have '30 or 40 contracts with one DHB'.[582]

Depending on the scope of services they provide, Māori health providers may also have contracts with additional government agencies, which again increases the monitoring and compliance workload.[583] This is an issue that claimants have raised, although it is unclear whether it is unique to, or more onerous for, Māori health providers.[584] Claimants have also noted that rural Māori health providers particularly struggle due to a demand for them to provide a broad range of services.[585] The report by the National Health Committee sets out that rural health providers do generally tend to provide a broad range of services and that this means managing multiple contracts that come with their own auditing and reporting requirements.[586] It states that '[t]he transaction costs associated with this level of complexity divert resources from frontline services and place an extra burden on rural providers that, due to their size, have few back office staff.[587]

The National Health Committee report also discusses a local initiative in 2003 where a provider and the Ministry for Social Development developed an 'integrated contract', which combined 36 individual contracts into one concise contract, significantly cutting down the provider's reporting, monitoring, and other compliance costs.[588] The Committee included as one of its recommendations to: '[i]mprove funding arrangements and reduce contract transaction costs by having fewer funding streams and encouraging greater use of integrated contracts'.[589] A more recent review of health services on the East Coast similarly notes that reporting for multiple contracts is an issue and suggests 'streamlin[ing] contract reporting'.[590] More research would be required to determine whether Māori health providers are more likely than mainstream providers to have contracts with multiple agencies.

Size, age, and reputation

The size, age and reputation of the provider may also impact contracting practices. Claimants have argued that smaller providers are often Māori providers, that they are expected to fulfil the workload of larger providers, and that smaller Māori health providers have less 'negotiating power' with funders.[591] The Chairperson of the New Zealand Medical Association, Dr Stephen

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[582] Marion Blake quoted in Karen Brown, 'Mental health in line for major reform', *Radio New Zealand*, https://www.rnz.co.nz/national/programmes/morningreport/audio/2018697046/mental-health-in-line-for-major-reform, at 02:49, last modified 28 May 2019.

[583] Came et al., 'Institutional racism in public health contracting', p 135; Personal communication from Senior Contracts and Relationship Manager, Māori Health Service Improvement, Māori Health Directorate, Ministry of Health to Brittany Whiley, 9 May 2019.

[584] Wai 2206, 1.1.1(d), p 17.

[585] Wai 762, 1.1(d), pp 17-18; Wai 2206, 1.1.1(d), p 16.

[586] National Health Committee, 'Rural Health: Challenges of Distance, Opportunities for Innovation', p 23.

[587] National Health Committee, 'Rural Health: Challenges of Distance, Opportunities for Innovation', p 23.

[588] National Health Committee, 'Rural Health: Challenges of Distance, Opportunities for Innovation', p 25.

[589] National Health Committee, 'Rural Health: Challenges of Distance, Opportunities for Innovation', p xiv.

[590] David Moore, Tom Love, and Nieves Ehrenberg, *Review of health services on the East Coast – Public Report* (Wellington: Sapere Research Group, 2013), p 70.

[591] Feedback from Grant Hewison to Timothy Gassin on draft research report, *Māori Mental Health*, on behalf of Wai 2828, 19 July 2019; Wai 1837, 1.1.1(b), para 18.

Child, stated on Radio New Zealand that as 'a general contracting rule', there will be 'less due diligence' when contracting with larger, well-known providers with previously demonstrated good performance in comparison to smaller, newer providers.[592] Came et al. also note 'a trend by funders to exit relationships with smaller providers and to contract with larger entities'.[593] Māori health providers vary in size and more research is needed to determine whether contracting practices based on size, age, and reputation are more likely to negatively impact them.[594]

3.7.3 Steps taken by government

In 2002/2003, the Ministry of Health ran a series of workshops with Ministry and DHB staff on raising awareness about health inequalities, using racism and ethnic inequalities as a case study. According to an evaluation report, participants identified 'inflexible contracting systems' as a process issue, as well as 'the need to change contracting and monitoring processes' in order to address health inequalities.[595] The workshops resulted in recommendations to develop contracting and monitoring frameworks that prioritise reducing inequalities and to support contract and monitoring staff to do this.[596] The report notes that staff had progressed action plans, including action plans to improve contracting and monitoring, but that there was low attendance at follow-up sessions and that 'most did not achieve all they had planned'.[597] A more recent article reports that further training was undertaken with Māori health providers.[598] However, as Came et al. state in their joint brief of evidence, it is unclear whether the recommendations were fully implemented.[599]

As discussed above, the Government Inquiry into Mental Health and Addiction recommended that the Government '[i]dentify a lead agency to … take a lead role in improving commissioning of health and social services with NGOs'.[600] The Government has since accepted this recommendation 'in principle'.[601] Budget 2019 also allocated $213.1 million over four years to DHBs for funding mental health and addiction treatment services, part of which will involve

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[592] Dr Stephen Child quoted in Aaron Smale, 'Maori Health Providers Scrutinised More Closely', at 01:30.

[593] Came, et al., 'Institutional racism in public health contracting', p 137.

[594] Came, et al., 'Institutional racism in public health contracting', p 137; Wai 1837, 1.1.1(b), para 18. Came et al. also state that 'Māori and/or iwi providers tend to be more boutique organisations with a broad development and tino rangatiratanga (self-determination) focus' but it is unclear what they mean by this (see p 134).

[595] Christopher Carroll et al., 'Tackling Inequalities: Moving theory to action, A final report on Health Inequalities Awareness Workshops for the health sector' (Wellington: Ministry of Health, 2004), pp v, 10.

[596] Carroll et al., 'Tackling Inequalities', pp viii, 13.

[597] Carroll et al., 'Tackling Inequalities', pp v, 19.

[598] Louise Signal, et al., 'Tackling health inequalities: moving theory to action', *International Journal for Equity in Health*, vol 6, no 1 (2007), p 16.

[599] Carroll et al., 'Tackling Inequalities'; Wai 2575, A57, p 11.

[600] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 17.

[601] 'Government Inquiry into Mental Health and Addiction', Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction, last modified 6 June 2019.

‘scaling up some successful services’, including Māori mental health non-government and community providers.[602]

3.8 Conclusion

The involvement of Māori in making decisions about policy, governance, and service delivery is now widespread throughout the New Zealand mental health system, reflecting government policies and legislative requirements. This represents significant progress given the almost complete absence of Māori from much of the health system only a few decades ago. It should not, however, be taken as evidence that all is well or that further effort is not required. Indeed, Māori remain underrepresented in some key decision-making roles and, even where Māori appear to have a reasonable presence in decision-making structures, there are often serious reasons to doubt the extent to which they can speak for local Māori communities. Māori can also face barriers in translating their presence at the table into changes in practice, including having to confront dismissive attitudes and being constrained by restrictive contract terms.

While government programmes continue to support the growth of a Māori health workforce and the development of Māori health providers, it is clear that, to some extent, there has been a failure to achieve the sort of Māori involvement envisioned by the health reform of the early 2000s. In some respects, at least, development appears to have stalled or even gone backwards in recent years. This reflected in the diminished number of independent Māori PHOs and mental health providers and suggests that much further work is required if government is to translate oft-repeated policy aspirations into practice.

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[602] ‘Strengthening existing mental health and addiction services’, ‘The Wellbeing Budget: Taking mental health seriously’, The Treasury, https://www.budget.govt.nz/budget/2019/wellbeing/mental-health/strengthening-existing-services.htm, accessed 16 July 2019.

Chapter 4 Barriers to accessing mental health services

The barriers that can impede access to mental health services take a variety of forms. Some barriers are relatively obvious, such as when particular services are not available or when an individual cannot make use of services due to being unable to afford fees or unable to travel to services due to distance or lack of transportation. Others can be more subtle and can manifest even where services are available and accessible. In such circumstances of apparently adequate service provision, some may still find services to be culturally inappropriate and thus alienating or ineffective. Individuals may also avoid treatment due to the stigma associated with mental illness and fear of the potential negative consequences of seeking help for oneself and one's family.

For Māori, the types of barriers that exist are generally the same as for the population as a whole. However, as a population group, lower than average socio-economic position and higher prevalence of mental illness mean that Māori are likely to experience a range of barriers at elevated rates. There are also some barriers that are more specific to Māori. Cultural barriers related to the appropriateness of care in a system predominantly established around European cultural norms, for example, are not shared with the population as a whole, even if Māori are not the only ethnic minority to face challenges of this type. Wherever relevant figures are available, this chapter seeks to provide comparisons between Māori and other population groups on matters that are likely to have a significant bearing on the extent to which barriers to accessing services are likely to exist.

The attempts that governments have made to reduce barriers to accessing treatment for mental illness are also examined in this chapter. Initiatives have included targeting additional health funding and services at Māori and other 'high needs' groups, establishing and supporting services that fit Māori cultural needs, and running campaigns to reduce stigma and discrimination associated with mental illness. The focus here is necessarily narrow, with only those initiatives related directly to mental health examined and thus the picture painted is only a partial one. In reality, the fact that many barriers are intimately linked to socio-economic factors means that a much wider range of government policies have a significant bearing on the ability of individuals, including Māori, to access the help they need. While significant, these matters fall outside the scope of this report and are not explored here.

4.1 General shortcomings of the mental health system

Some of the most significant barriers to Māori accessing mental health service relate to shortcomings of the mental health system as a whole. These include a lack of services available for those with low and moderate level mental health issues, high thresholds and waiting periods for admittance to specialist mental health services, and the fragmented nature of the system with often poor interconnection between services. All of these problems feature prominently in recent reports on the mental health system.[603] These barriers are not Māori-specific, facing instead all who need to access public mental health services in New Zealand and this is reflected in the fact that these issues were raised by both Māori and non-Māori submitters to the Government Inquiry into Mental Health and Addiction.[604] However, the greater rates at which Māori are reported to have mental health problems suggest that these system failings likely affect Māori disproportionately.

This section addresses the range of services available, the ability of individuals to gain admission, and the manner in which services are linked together, looking at these matters from a largely national level and without consideration of particular regional variations. These are by no means the only areas in which there are shortcomings in the system – a variety of other issues relating to the design of the system, including the cost charged for services and the location of services, are addressed in separate sections in this chapter.

4.1.1 Limited availability of services for those with mild and moderate level mental health problems

The provision of funding for mental health services in New Zealand is overwhelmingly for those with severe mental illness, with specialist mental health services receiving $1.425 billion in funding in 2016-17.[605] In comparison, the amount spent on primary mental health services in the same period was only $26 million.[606] While these services are aimed at those with mild and moderate mental health issues, estimated at 17 per cent of the population, in 2016-17 they reached only 2.8 per cent of the population.[607] As noted elsewhere, the availability of these

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[603] See, for example, Government Inquiry into Mental Health and Addiction, 'He Ara Oranga'; Allan, 'New Zealand's mental health and addiction services'; Marianne Elliott, 'People's Mental Health Report: A Crowdfunded, Crowdsourced Story-Based Report' (Wellington: ActionStation Aotearoa, 2017).

[604] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 152.

[605] Ministry of Health, 'Appendix Five: Mental Health Funding and Expenditure', Submission to the Government Inquiry into Mental Health and Addiction, May 2018, p 1. Available at: https://www.health.govt.nz/system/files/documents/pages/submission-government-inquiry-into-mental-health-and-addiction-appendix5.pdf, accessed 23 October 2018.

[606] Allan, 'New Zealand's mental health and addiction services', p 24.

[607] Allan, 'New Zealand's mental health and addiction services', p 24; 'Primary mental health', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/primary-mental-health, last modified 7 March 2017.

funded primary mental health services is limited to young people, Māori, Pacific people, and community services card-holders and, even for these groups, the types of service provided and number of consultations are both limited and, in some cases, may be totally unavailable.

The Government Inquiry into Mental Health and Addiction was told that GPs faced limited options for services to which they could refer patients who had mental health needs and that equally DHB service staff found a lack of 'step down' services to which they could refer those who might need help, but whose needs were no longer acute.[608] It found that New Zealand's mental health system was 'underdeveloped' with key components 'missing' and a lack of a continuum of care.[609] It noted that problems included that, for some, the system could offer medication but not appropriate support, that it failed to address individual's wider social needs, and that there were few publicly-funded treatment options available for those with common issues including depression, anxiety, stress, and trauma.[610]

The Inquiry concluded that there was a 'fundamental disconnect … between stated strategic direction, funding and operational policy and ultimately service delivery', identifying failures to achieve the continuum of care promised by government mental health policies and achieve the transformation of primary care envisioned in the Primary Health Care Strategy that would have seen primary care providers taking a significant role in dealing with mental health issues.[611] Its recommendations included increasing access to services, setting a new target for mental health and addiction services, basing access on need, broadening the types of service available, and an explicit focus on mental health and addiction in future primary health care strategies.[612] In its response to the Inquiry, the Government either accepted these recommendations or accepted them in principle.[613] In the 2019 Budget, the Government announced plans to increase access to primary mental health and addiction supports over five years, with $48.138 million committed in 2019/20, rising to $176.089 million in 2022/23.[614]

4.1.2 Accessibility of specialist mental health services and support

While specialist mental health services receive much more funding than those available within primary health care, these services are not available to everyone and may not be able to be accessed immediately.

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[608] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 56.

[609] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 79.

[610] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', pp 79, 81.

[611] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', pp 108-109.

[612] The most immediately relevant recommendations are nos 1-6, 13, and 14. Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', pp 16-17.

[613] 'Government Inquiry into Mental Health and Addiction', Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction, last modified 6 June 2019.

[614] 'Summary of Initiatives in Budget 2019', The Treasury, https://treasury.govt.nz/publications/summary-initiatives-budget-2019-html#child-5, last modified 30 May 2019.

In considering issues around access to specialist services, it is important to remember the broader context of the matters discussed in the previous section, as the lack of other lower-level mental health services may exacerbate the effects of being unable to gain access to specialist services. Indeed, in many cases, acceptance by a specialist service may be the difference between receiving treatment and not receiving any meaningful treatment at all.

High thresholds for admittance

Recent inquiries and reports on the mental health system have noted that a regular theme in submissions is the difficulty in gaining access to mental health services due to high thresholds.[615] These reports recorded the frustration of individuals, including those who had summoned the courage to seek help, or who had been referred after a number of earlier attempts to gain help, and who were turned away on the grounds their condition was not serious enough.[616] As one Māori youth told the Government Inquiry into Mental Health and Addiction, 'I went and spilled my beans and I was told I wasn't serious enough'.[617]

These barriers are also experienced by those who are suicidal, with reports of individuals and families being denied help when it is requested, being told that crisis teams are too busy and thus unavailable, and suicidal patients being sent home without follow up. In some cases, those who were sent away committed suicide soon after.[618] One Māori participant in a hui organised by the Government Inquiry into Mental Health and Addiction spoke of the police attending to a suicidal girl:

> … because she didn't tick all the boxes though, they had to take her home and two hours later they had to go back and pick up her dead body. This has happened three times [in our community]. Our people are screaming for help and we need to help them.[619]

One factor undoubtedly contributing to difficulties gaining admittance to inpatient units is the fact that the occupancy levels for some are already running at, or above, capacity, with some having to adopt '1 in, 1 out' approaches to admissions at times.[620] In 2018, it was reported that

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[615] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', pp 54; Allan, 'New Zealand's mental health and addiction services', pp 40-41; Elliott, 'People's Mental Health Report', p 13.

[616] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 54; Allan, 'New Zealand's mental health and addiction services', pp 40-41; Elliott, 'People's Mental Health Report', p 13.

[617] Government Inquiry into Mental Health and Addiction, 'Oranga Tāngata, Oranga Whānau: A Kaupapa Māori Analysis of Consultation with Māori for the Government Inquiry into Mental Health and Addiction (Wellington: Department of Internal Affairs, 2019), p 52

[618] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', pp 54-55; Elliott, 'People's Mental Health Report', p 13.

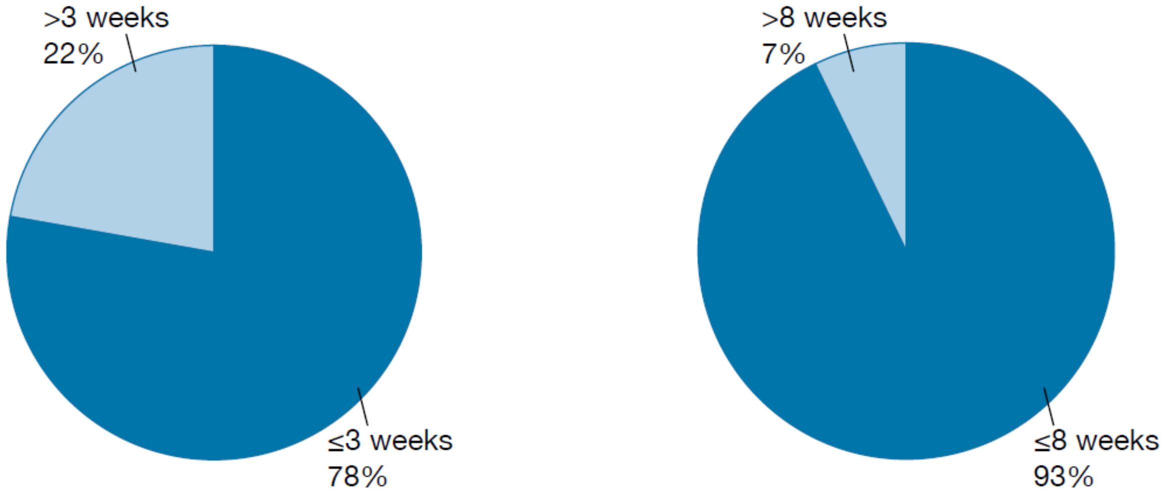
[619] Government Inquiry into Mental Health and Addiction, 'Oranga Tāngata, Oranga Whānau', p 52.

[620] Oliver Lewis, 'Occupancy at Hillmorton Hospital's acute inpatient service "unsustainable', Stuff, https://www.stuff.co.nz/national/health/105219406/occupancy-at-hillmorton-hospitals-acute-inpatient-service-unsustainable, last modified 6 July 2018; Sam Hurley, 'Innocent people are dying due to mental health pressures, says murder victim's daughter', New Zealand Herald, https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12137507, last modified 6 October 2018;

the Henry Rongomau Bennett Centre at Waikato Hospital had an average occupancy rate of 115 per cent, with its interim chief medical officer, Dr Rees Tapsell, stating that '[t]hat means we have got people sleeping in places where there are no beds. On mattresses, in offices, in TV rooms'.[621]

Waiting times

Many people referred to specialist mental health services are seen relatively quickly, with 45 per cent of new clients (those who had not accessed mental health and addiction services in the last year) being seen within 48 hours in 2016.[622] However, for some, the wait can be much longer, with 7 per cent waiting more than 8 weeks to be seen (see Figure 4.1).



Source: PRIMHD data

Figure 4.1 Percentage of people seen by mental health services within three weeks (left) and within eight weeks (right), 1 January to 31 December 2016[623]

Submissions to the 2018 Government Inquiry into Mental Health and Addiction raised problems related to the length of waiting times, with problem areas identified as including access to ongoing support after time in hospital and access to early intervention services in the community. One mental health professional wrote of 'unacceptably long waits of several weeks or longer especially in the cities, unless it is a [mental health] crisis and then admission is oft

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Libby Wilson, 'More patients than beds at Waikato mental health inpatient unit', Stuff, https://www.stuff.co.nz/national/health/105815220/more-patients-than-beds-at-waikato-mental-health-inpatient-unit, last modified 8 August 2018.

[621] Wilson, 'More patients than beds at Waikato mental health inpatient unit'.

[622] Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016' (Wellington: Ministry of Health, 2017), p 17.

[623] Source: Ministry of Health, 'Office of the Director of Mental Health Annual Report 2016' (Wellington: Ministry of Health, 2017), p 18. '>' represents 'greater than'. '≤' represents 'less than or equal to'.

represents 'less than or equal to'.en required.'[624] Problems related to waiting times also feature heavily in the submissions that formed the basis of ActionStation's 'People's Mental Health Report', featuring in 84 out of the 179 stories that raised access issues.[625]

It is important to note that problems of waiting times are not solely a matter of whether an individual is receiving treatment or not, but whether they are receiving appropriate treatment. For example, a claim before the Tribunal raises the issue of children being placed in an adult inpatient unit, while they wait for a bed to become available in a child unit located outside their district.[626]

4.1.3 A fragmented system

The fragmented nature of mental health services can result in difficulties for those seeking to access appropriate services and for those already receiving treatment who are transferred between services.

Submissions to the Government Inquiry into Mental Health and Addiction raised concerns about the difficulties faced in trying to navigate the system 'that is really multiple systems with complex boundaries' that separate:

- mental health services and addiction services
- primary health care and secondary services
- medical treatment and social support
- mental health services and physical health services
- mental health services and disability services[627]

For those seeking to gain access to treatment, problems can include a lack of information concerning available services and how to access them and unclear referral processes.[628] Gaining access to services, however, is not the only hurdle, even if it can be a difficult one to leap over. Individuals can encounter a variety of other hurdles in trying to continue to receive services and ensure that services work effectively for them. Submissions to the Government Inquiry into Mental Health and Addiction noted problems including poor continuity of care for those moving between services or being discharged, differences in eligibility criteria and care models experienced by those moving between DHBs, and inadequate record-keeping and sharing of

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[624] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report' (Wellington: Government Inquiry into Mental Health and Addiction, 2018), p 133.

[625] Elliott, 'People's Mental Health Report', pp 13.

[626] Wai 2695 1.1.1, p 3.

[627] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 57.

[628] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 57; Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 140.

information that resulted in individuals having to provide the same, sometimes sensitive, information multiple times to multiple providers.[629]

Some Māori submitters emphasised the importance of taking the approach that 'every door is the right door' and of services working together to support whānau.[630] Such an approach would appear to contrast with that described by a Māori NGO provider, which believed a convoluted referral process was hampering their work:

> The current entry process to Māori NGO services are directed via Secondary Services. This is a barrier to Whānau accessing [Māori NGO's] services earlier themselves. We believe that to actively support Whānau, at the earliest possible time, to access support when they need it could prevent them needing to access Secondary Services[631]

4.2 Cost

The issue of cost as a barrier to receiving healthcare is one that naturally arises wherever services are not fully government subsidised. It is raised as a problem in a number of claims to the Tribunal, both in relation to mental health treatment and healthcare more generally.[632]

In assessing the extent to which cost can be a barrier for Māori, both generally and in comparison to other population groups, it is necessary to consider a number of factors including the economic position of Māori, what fees are charged for mental health services and for other services that form part of the referral pathway, and the targeting of government subsidies to reduce health costs both for the entire population and for disadvantaged groups.

While the discussion of the economic status of Māori that follows is relevant to a number of potential barriers to accessing health treatment, the exploration of cost as a barrier in this section is limited to the direct costs of health services and prescriptions. Other barriers that are closely linked to socio-economic status and the incidental costs of seeking medical treatment (for example, in relation to transport) are addressed in later sections.

4.2.1 The economic status of Māori

The fact that Māori, as a population group, suffer from economic disadvantage has been widely recognised over a long period of time. At the last census, median gross personal income of

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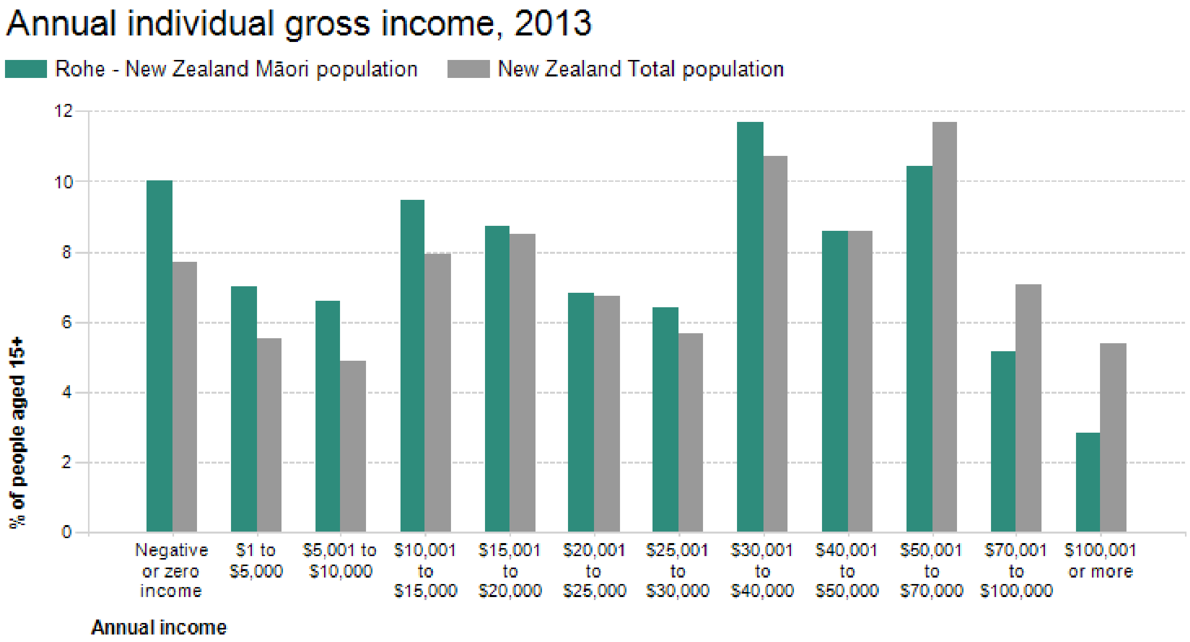
[629] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', pp 57-58; Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 179.

[630] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 184.

[631] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 140.

[632] See, for example, Wai 1775, 1.1.1(a); Wai 2632, 1.1.1; Wai 2683, 1.1.1; Wai 2723 1.1.1; Wai 2734 1.1.1.

Māori usually resident in New Zealand and aged 15 years or over was $22,500, which was substantially below the figure for the total population of $28,500 and those for European ($30,900) and 'Other ethnicity' ($37,100).[633] Māori median personal income was, however, greater than that for Asian, Middle Eastern/Latin American/African, and Pacific ethnic groups.[634] While Māori median income increased slightly between the 2006 and 2013 censuses, the gap between Māori and average national incomes increased – in 2006, the Māori median income was 84 per cent of the national median, whereas in 2013, it was only 69.1 per cent of the national median.[635] The range of Māori personal incomes – overrepresented in lower income brackets and underrepresented in higher income brackets – can be seen in Figure 4.2.



Source: Statistics New Zealand, Census of Population and Dwellings, 2013.

Figure 4.2 Annual individual gross income, Māori and New Zealand total population, 2013.[636]

Household income figures appear, on first glance, to tell a different story. Indeed, a smaller proportion of Māori in the 2013 Census were recorded living in a household with annual income

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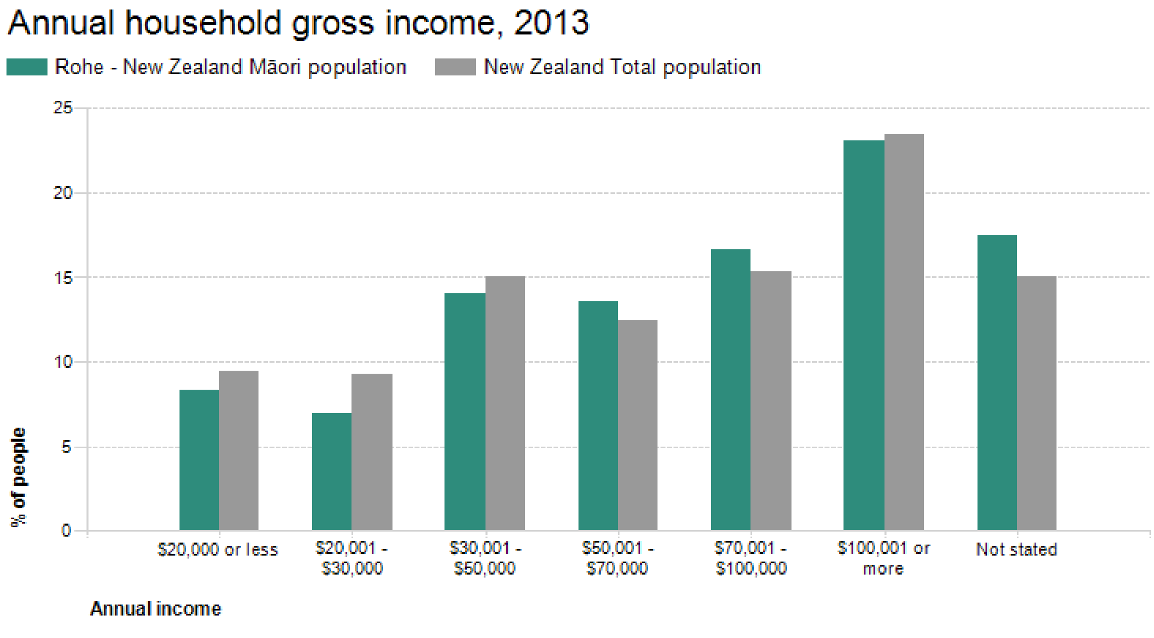
[633] 'Other ethnicity' includes those who identified their ethnicity as simply 'New Zealander'. Statistics New Zealand, '2013 Census Quick Stats about income' (Wellington: Statistics New Zealand, 2014), pp 12, 23.

[634] Statistics New Zealand, '2013 Census Quick Stats about income', 23.

[635] Statistics New Zealand, '2013 Census Quick Stats about income', 23.

[636] The use of 'rohe' in the legend of this and subsequent graphs from Te Puni Kōkiri (TPK) can be disregarded, as it appears solely as a result of the regional selections of Maori population available in the generation of these graphs. In each case the green columns simply represent figures for the New Zealand Maori population. Source: 'New Zealand: Individual income', Te Puni Kōkiri, https://tpk.idnz.co.nz/tpk/individual-income?GPBMID=0, accessed 24 January 2019.

of $50,000 or below than the total New Zealand population. Māori were more likely than the total population to reside in households with annual incomes of $50,001-$100,000 and only slightly less likely than the total population to reside in households with annual incomes over $100,000.[637] Figure 4.3 shows the distribution of Māori across a range of household income brackets.



Source: Statistics New Zealand, Census of Population and Dwellings, 2013.

Figure 4.3 Annual household gross income, Māori and New Zealand total population, 2013.[638]

In interpreting household income figures, it is important to consider differences in household composition. Māori are significantly more likely than the overall population to live in households with a larger number of inhabitants (see Figure 4.4). The 2013 census found over three-fold differences between the proportions of Māori and the total population living in households in both the smallest and largest categories – 5.3 per cent of Māori lived in households with one usual resident and 18.6 per cent lived in households with six or more usual residents. The equivalent figures for the total population were 22.9 per cent and 4.5 per cent respectively.[639] These figures indicate that, whilst Māori may be somewhat more likely to reside in households with higher incomes, those households tend on average to have a substantially higher number of usual residents and, thus, this household income is, in many cases, likely being more thinly spread to meet the needs of inhabitants.

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[637] 'New Zealand: Household income', Te Puni Kōkiri, https://tpk.idnz.co.nz/tpk/household-income?GPBMID=0, accessed 24 January 2019.

[638] Source: 'New Zealand: Household income', Te Puni Kōkiri, https://tpk.idnz.co.nz/tpk/household-income?GPBMID=0, accessed 24 January 2019.

[639] 'New Zealand: Household size', Te Puni Kōkiri, https://tpk.idnz.co.nz/tpk/household-size?GPBMID=0, accessed 24 January 2019.

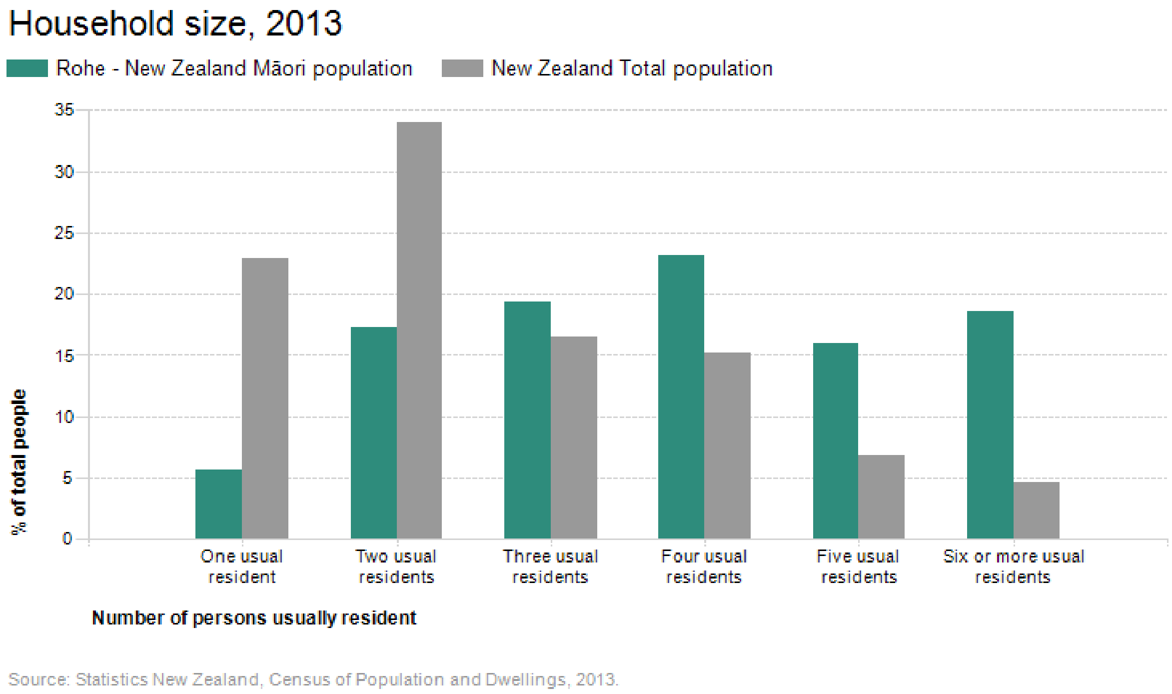

Figure 4.4 Household size, Māori and New Zealand total population, 2013.[640]

Māori are also disproportionately represented amongst those unable to find sufficient employment. In the December 2018 quarter, Māori had an unemployment rate of 8.2 per cent, significantly higher than that national rate of 4.3 per cent and higher than the rate for all other ethnicities except Pacific peoples.[641] The Māori underutilisation rate of 20.7 per cent was both higher than the national rate of 12.1 per cent and higher than those recorded for all other ethnicities.[642]

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[640] Source: 'New Zealand: Household size', Te Puni Kōkiri, https://tpk.idnz.co.nz/tpk/household-size?GPBMID=0, accessed 24 January 2019.

[641] 'Household labour force survey tables for December 2018 quarter', Statistics New Zealand, https://www.stats.govt.nz/assets/Uploads/Labour-market-statistics/Labour-market-statistics-December-2018-quarter/Download-data/household-labour-force-survey-december-2018-quarter.xlsx, published 7 February 2019.

[642] 'Household labour force survey tables for December 2018 quarter'. Underutilisation is a 'broader measure of untapped capacity in the labour market' that includes those who:
' - do not have a job, but are available to work and are actively seeking employment – unemployed
- are employed part time (fewer than 30 hours a week) and who both want and are available to increase the number of hours they work – underemployed
- want a job and are available to work, but are not currently looking for a job – available potential jobseeker
- are unavailable to start work but are looking for a job as they will be able to start work within the next month – unavailable jobseeker.'
'Underutilisation rate', Stats NZ, https://www.stats.govt.nz/indicators/underutilisation-rate, accessed 27 May 2019.

4.2.2 Direct cost barriers to accessing mental health treatment

Due to differences in funding arrangements and service availability, cost barriers experienced by service users vary significantly across the spectrum of mental health treatment, with some services being fully government-funded, some being partly subsidised, and others often being available when needed only through private practice with the payment of full fees. Accordingly, the potential cost barriers to accessing a number of different types of service and purchasing prescription medicines are discussed in separate sections below. The combination of lower average incomes and higher rates of mental illness increase the chances that Māori are likely to experience these cost barriers. However, additional funding targeted at Māori and other disadvantaged groups, may also reduce barriers to accessing certain services in comparison to those experienced by other population groups.

General primary health services

The starting point for most people seeking treatment for mental health issues is their general practitioner (GP), who can provide treatment, prescribe medications, and refer individuals to other services.[643] Indeed, GPs are the main referral pathway to specialist mental health services.[644]

For most of the population, GP and other primary health consultations require the payment of fees for service, presenting a potential cost barrier. The impact of fees is borne out by the New Zealand Health Survey which indicated that, in 2017/18, 14.9 per cent of those aged 15 or over had a medical problem in the last 12 months for which they had not visited a GP due to cost. The equivalent figure for Māori aged 15 or over was substantially higher at 22.6 per cent.[645]

The government provides capitation funding for primary health services provided by PHOs through DHBs, providing a subsidy for services that usually also requires the payment of additional consultation fees. A number of government initiatives, however, ensure that services for many individuals are subsidised at higher levels, providing for the reduction or total elimination of fees. These initiatives include:

- Free GP and nurse visits for children aged 13 and under.[646]

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[643] Kevin Allan, 'New Zealand's mental health and addiction services: The monitoring and advocacy report of the Mental Health Commissioner' (Wellington: Office of the Health and Disability Commissioner, 2018), p 24.

[644] 'Mental health services – where to get help', Ministry of Health, https://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services/mental-health-services-where-get-help, last modified 16 October 2017.

[645] 'New Zealand Health Survey Tier 1 Data Explorer, November 2018', Ministry of Health, https://minhealthnz.shinyapps.io/nz-health-survey-2017-18-annual-data-explorer/, accessed 7 March 2019.

[646] 'Lower cost general practice visits', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/lower-cost-general-practice-visits, last modified 17 January 2019.

- Reduced fees for Community Service Card (CSC) holders and their dependants, capped at $18.50 for adults and $12.50 for 14-17-year olds who have a parent or caregiver who has a CSC.[647] To receive a CSC, an individual must meet be 'on a low income, or living in public housing, or receiving an accommodation supplement.'[648]
- The Very Low Cost Access (VLCA) scheme. This provides increased funding to practices that keep fees below a specified level, currently $18.50 for those aged 18 years and over and $12.50 for 14-17 year olds. Since 2009, only those clinics that have at least 50 per cent of their enrolled population from 'high needs' groups (Māori, Pacific peoples, and those living in NZ Deprivation Index quintile 5 areas) are eligible to enter the scheme.[649] While this arrangement would appear to increase the likelihood of Māori receiving more highly subsidised care, as noted in Chapter 2, the scheme's inefficient targeting of practices rather than individuals has been widely criticised, with many in 'high needs' populations not receiving VLCA services and many outside the target groups receiving them.[650] (See Table 4.1 for 2017 average VLCA consultation fees).

Table 4.1 Average patient consultation fees at Very Low Cost Access (VLCA) and non-VLCA practices for patients 18 years and older in 2017.[651]

Age group	VLCA	Non-VLCA
18-24	$15.31	$39.75
25-44	$15.76	$42.60
45-64	$15.73	$42.68
65+	$14.46	$40.43

For those who do not qualify for the above schemes, fees can be substantially higher. In 2017, the average consultation fee for an adult charged by practices that were not part of the VLCA scheme was approximately $40.[652] Those who are not enrolled with a clinic or who require a consultation with a provider other than the one with which they are enrolled face substantially higher fees, as their treatment generally does not receive any government subsidy.

Primary mental health services

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[647] 'Lower cost general practice visits'.

[648] 'Community Services Card', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/community-services-card, last modified 28 November 2018.

[649] 'Very Low Cost Access scheme', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/very-low-cost-access-scheme, last modified 3 December 2018; Downs, 'From Theory to Practice', p 36.

[650] Downs, 'From Theory to Practice', p 36.

[651] Data from Amy Downs, 'From Theory to Practice: The Promise of Primary Care in New Zealand' (Wellington: Fullbright New Zealand

[652] A 2015 report noted the range of fees for GP consultations for adults in New Zealand ranged from $15 to $70. Royal Australian & New Zealand College of Psychiatrists, 'Minding the Gaps: Cost barriers to accessing health care for people with mental illness' (Wellington: Royal Australian & New Zealand College of Psychiatrists, 2015), p 12.

The cost of primary mental health services varies significantly depending on meeting eligibility for funded services. Eligibility for DHB-funded primary mental health services is generally limited to Māori, Pacific people, youth, and those with Community Services Cards.[653] While these services themselves are provided free of charge, gaining access involves having a consultation with a GP and thus a potential cost barrier.[654] Limitations of funding and availability of funded services may also mean that even individuals who meet eligibility criteria may have little option but to look to private practice for treatment. For example, the Capital and Coast DHB provides six funded sessions of cognitive behavioural therapy with a psychologist for those with mild mental health symptoms, but, once the budget for this programme is exhausted for a year, no further services are offered.[655]

In considering cost barriers for Māori in accessing primary mental health services, it should be noted that, on an individual level, the use of ethnicity in eligibility criteria likely places many Māori in a position of significant advantage compared to others, such as those of European or Asian ethnicity, who may have comparable mental health needs and financial resources. A submission by one DHB to the Government Inquiry into Mental Health and Addiction raised concerns about the use of ethnicity and income as determinants of eligibility for mental health services:

> These services should not be limited to ethnicity or if you have a "community services card", so many of our clients are waged but struggling to make ends meet, they cannot afford private services, but do not meet the criteria for funded services, yet these are the clients who need to keep well and working[656]

The Inquiry, in its report, came to much the same conclusion, noting that:

> Access to services should be broad-based and related to the level of mental health and addiction need, rather than targeted on the basis of age, ethnicity or income (as current primary mental health services are). This is consistent with the approach to funding other core health services. We see no reason why mental health and addiction services should be treated differently. It is imperative that access for people with the most severe needs is not reduced in any way.[657]

For those who need to seek treatment through private practice, the fees can be substantial. In 2015, the fee to see a psychiatrist was around $180 per hour, while an initial consultation with a private psychologist or counsellor was in the range of $200-250 and follow up visits in the range

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[653] Allan, 'New Zealand's mental health and addiction services', p 25.

[654] Allan, 'New Zealand's mental health and addiction services', p 80.

[655] The RANZCP report refers to this programme being delivered by the 'Capital and Coast PHO', which would appear to be an error. Royal Australian & New Zealand College of Psychiatrists, 'Minding the Gaps', p 13.

[656] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 143

[657] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga' (Wellington: Government Inquiry into Mental Health and Addiction, 2018), p 110.

of $100-150.[658] Counselling is provided by some religious organisations and charities at lower cost, but such services frequently have substantial waiting lists.[659]

Specialist mental health services

Specialist mental health service, as with other public secondary services in New Zealand, are provided free of charge.[660] This, however, does not mean that direct cost barriers are completely absent. Where such barriers exist is in some referral pathways, such as fees for GP consultations, rather than in relation to the specialist services themselves.

In cases where an individual is provided a direct referral by a GP with whom they are enrolled and is accepted into a specialist service, the cost barrier cannot be considered high (particularly when the clinic is a VLCA clinic or the individual has a Community Services Card). Such fees may, however, present a more serious barrier to gaining access to specialist services for those of very limited means or those who find they need to make multiple attempts to gain admission to a specialist service.

Prescription medicines

The cost of prescription medicines can also be a barrier for some. The New Zealand Health survey indicates that 13.2 per cent of Māori aged 15 years or over had not had a prescription filled due to cost within the preceding 12 months – twice the rate of 6.6 per cent recorded across the entire population.[661]

Most prescriptions medications in New Zealand are heavily subsidised for those eligible to receive public healthcare. The prescription charge for subsidised medicines is usually $5 and there is no fee for these medicines for those under the age of 14.[662] Subsidised medicines prescribed by a private specialist for an adult are generally charged at a higher rate of $15, although for CSC-holders this is reduced to $5.[663] The government also operates a prescription subsidy scheme that allows families that have paid for 20 prescription items within a 12-month period (running from 1 February to 31 January) to receive subsequent prescriptions for free.[664] Increasing competition in recent years has resulted in some pharmacies filling prescriptions for

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[658] Royal Australian & New Zealand College of Psychiatrists, 'Minding the Gaps', p 14.
[659] Royal Australian & New Zealand College of Psychiatrists, 'Minding the Gaps', p 14.
[660] Royal Australian & New Zealand College of Psychiatrists, 'Minding the Gaps', p 11.
[661] 'New Zealand Health Survey Tier 1 Data Explorer, November 2018'.
[662] 'Prescription charges', Ministry of Health, https://www.health.govt.nz/your-health/conditions-and-treatments/treatments-and-surgery/medications/prescription-charges, last modified 28 November 2018.
[663] 'Prescription charges', Health Navigator New Zealand, https://www.healthnavigator.org.nz/medicines/p/prescription-charges/, last modified 6 February 2019.
[664] 'Prescription subsidy scheme', Ministry of Health, https://www.health.govt.nz/your-health/conditions-and-treatments/treatments-and-surgery/medications/prescription-subsidy-scheme, last modified 25 February 2019.

subsidised medicines for less than $5 or even for free, absorbing some or all of the co-payment collected by the government.[665]

4.3 Residence in rural areas and distances from services as barriers

Residing in a rural area or simply outside a major centre can be a barrier to accessing treatment due to greater distance from any mental health services at all or the particular types of services required by an individual. Issues of distance as a barrier are raised in claims, with some noting that the concentration of Māori in rural areas is a particular source of disparities.[666]

In assessing the extent to which these issues have an effect on Māori access to services and health outcomes, it is necessary to consider the distribution of the contemporary Māori population and figures relating to differences between access to healthcare and health outcomes in rural and urban areas. While such figures provide a useful overview, they must be considered with some caution as they do not cover access to mental health services specifically and the barriers that exist are likely to differ substantially between different communities and between individuals depending on their conditions and personal circumstances.

4.3.1 Distribution of the Māori population

In considering matters of rural residence and distance from services, it is important to note that some ideas that may once have been true of Māori as a population group are no longer the case. Urbanisation over the course of the twentieth century has dramatically changed the distribution of the Māori population. In 1936, only 17 per cent of Māori lived in urban areas; by 2006 over 84 per cent of Māori did so. This was very close to the figure for the general New Zealand population, which was just shy of 86 per cent.[667] (See Figure 4.5).

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[665] Anuja Nadkarni, 'Free prescriptions, competition shakes up pharmacy industry', *Stuff*, https://www.stuff.co.nz/business/105706347/free-prescriptions-competition-shakes-up-pharmacy-industry, last modified 29 July 2018.

[666] See, for example, Wai 179, 1.1(c); Wai 884, 1.1(d); Wai 1460, 1.1.1(b); Wai 1544, 1.1.1(c); Wai 1677, 1.1.1(a); Wai 1941, 1.1.1(a); Wai 2060, 1.1.1(c); Wai 2179, 1.1.1(c); Wai 2257, 1.1.1(e); Wai 2670, 1.1.1; Wai 2683, 1.1.1; Wai 2695, 1.1.1; Wai 2697, 1.1.1; Wai 2723 1.1.1; Wai 2734 1.1.1.

[667] Paul Meredith, 'Urban Māori', Te Ara': The Encyclopedia of New Zealand, https://teara.govt.nz/en/graph/3571/maori-urbanisation-1926-86, last modified 17 February 2015; 'New Zealand: An Urban/Rural Profile Update' – 'Updated Data Tables: People' http://archive.stats.govt.nz/~/media/Statistics/browse-categories/maps-and-geography/geographic-areas/urban-rural-profile-update/people.xls, accessed 24 January 2019.

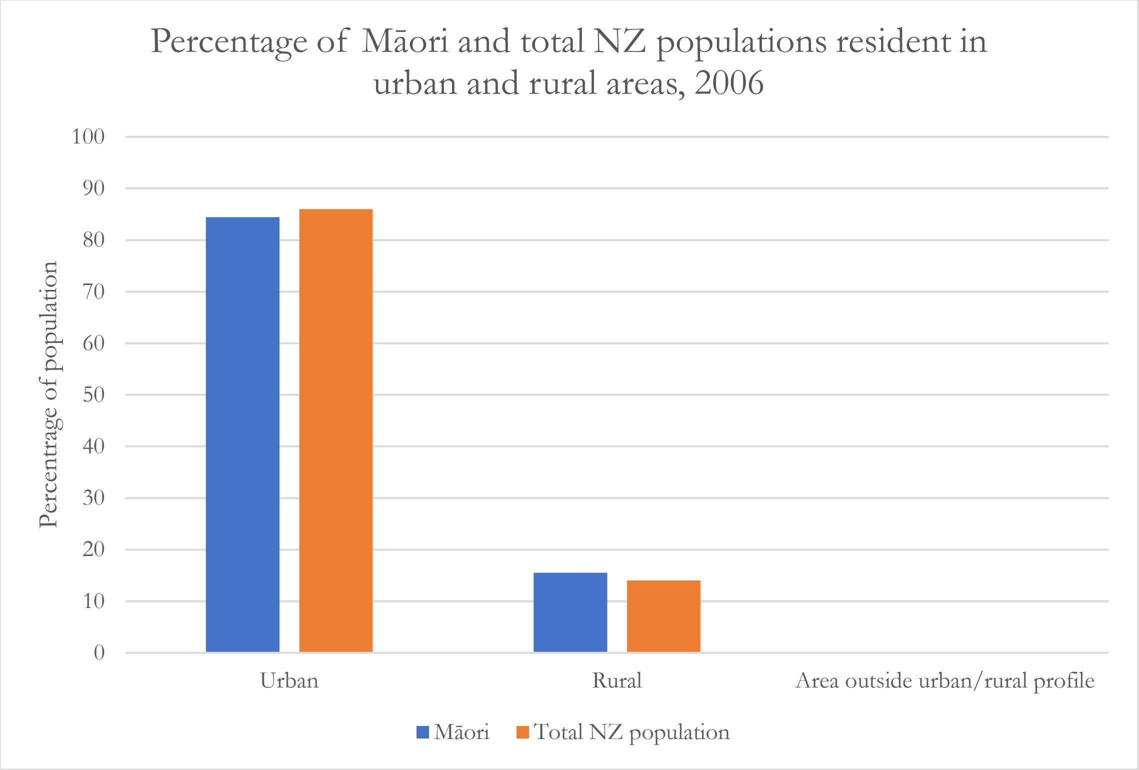

Figure 4.5 Percentage of Māori and total NZ populations resident in urban and rural areas, 2006.[668]

While the overall urban/rural split of Māori may not differ substantially from that of the total population, greater distinctions are apparent when individual statistical categorisations of urban and rural areas are examined. (See Figure 4.6). These show a tendency within the broader urban and rural categories for Māori to be more likely than average to live in areas categorised as more removed from major centres or urban areas more generally. Māori were less likely than average to live in a main urban area, but more likely than average to live in satellite and independent urban areas. Similarly, Māori were less likely than average to live in rural areas with high urban influence, but more likely than average to live in the other three rural categories – all with varying lower levels of connection with an urban area. That said, main urban areas still accounted for almost two-thirds of the Māori population, with 64.67 per cent of Māori living in these areas, compared to 71.82 per cent of the overall population.[669]

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[668] Figures from: 'New Zealand: An Urban/Rural Profile Update' – 'Updated Data Tables: People'. In this chart, 'Urban' combines the main urban, satellite urban, and independent urban categories, while 'Rural' combines the rural with high urban influence, rural with moderate urban influence, rural with low urban influence, and highly rural/remote categories.

[669] 'New Zealand: An Urban/Rural Profile Update' – 'Updated Data Tables: People'.

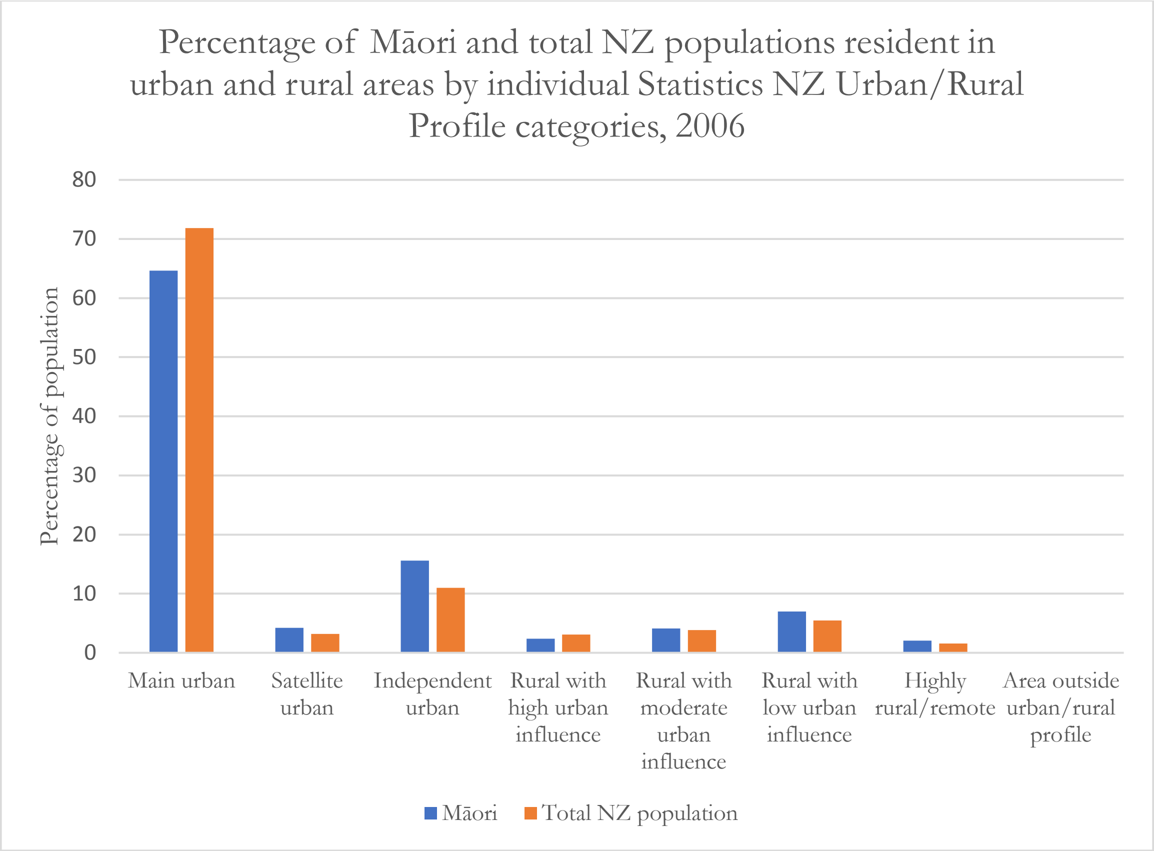

Figure 4.6 Percentage of Māori and total NZ populations resident in urban and rural areas by individual Statistics NZ Urban/Rural Profile categories, 2006.[670]

4.3.2 Differences in urban/rural healthcare access and mental health

Figures from the 2006/07 New Zealand Health Survey indicated that there were not substantial differences between Māori living in rural and urban areas in terms of access to basic medical services.[671] A smaller percentage of Māori aged 15 and over in rural areas (73.7 per cent) than those in urban areas (79 per cent) reported seeing a GP in the last 12 months, although this result was not considered statistically significant.[672] Rural Māori aged 15 and over were less likely than urban Māori aged 15 and over to report an unmet need for a GP in the last 12 months (10% compared to 12.8%) or, amongst those who had received a prescription, to have had an

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[670] Figures from: 'New Zealand: An Urban/Rural Profile Update' – 'Updated Data Tables: People'.

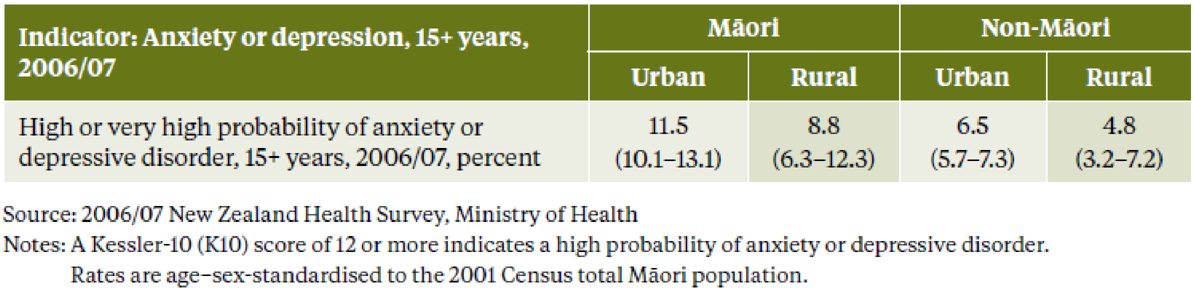
[671] The Ministry of Health has indicated that, while data broken down into urban and rural categories from the 2017/18 New Zealand Health Survey has not been published, this data could be requested. In response to queries about accessing this more up-to-date data, it was indicated that its extraction would require 'coding, testing and output' and that this could not be achieved within the timeframes required for the completion of this report. Feedback from the Ministry of Health to Timothy Gassin on draft research report, *Māori Mental Health*; personal communication from Senior Advisor, Mental Health, Ministry of Health, 7 August 2019.

[672] Ministry of Health, 'Mātātuhi Tuawhenua: Health of Rural Māori 2012' (Wellington: Ministry of Health, 2012), p 51.

uncollected prescription in the last 12 months (13.2% compared to 14.8%). Again, however, these differences were not considered statistically significant.[673]

In terms of mental health, a lower number of responses from rural Māori aged 15 and over to the survey indicated a high or very high probability of anxiety or depressive disorder than those from urban Māori aged 15 and over, but the difference was not considered statistically significant. Both the urban and rural Māori figures were higher than those for non-Māori.[674] (See Table 4.2).

Table 4.2 High probability of anxiety or depressive disorder, Māori and non-Māori aged 15 years and over, by urban/rural area, 2006/07[675]



Indicator: Anxiety or depression, 15+ years, 2006/07	**Māori**		**Non-Māori**	
	Urban	**Rural**	**Urban**	**Rural**
High or very high probability of anxiety or depressive disorder, 15+ years, 2006/07, percent	11.5 (10.1–13.1)	8.8 (6.3–12.3)	6.5 (5.7–7.3)	4.8 (3.2–7.2)

Source: 2006/07 New Zealand Health Survey, Ministry of Health

Notes: A Kessler-10 (K10) score of 12 or more indicates a high probability of anxiety or depressive disorder.
Rates are age-sex-standardised to the 2001 Census total Māori population.

Suicide rates from 2004-08 indicate a slightly lower rate of Māori suicides in rural areas than urban areas and this pattern is replicated across all age groups between 15 and 64 years, except for the 15-24-year group, although the differences were again not statistically significant. The differences in overall rates recorded between Māori and non-Māori in rural areas were also not statistically significant, unlike those recorded in main urban areas, where Māori suicide rates were double those of non-Māori.[676] (See Table 4.3).

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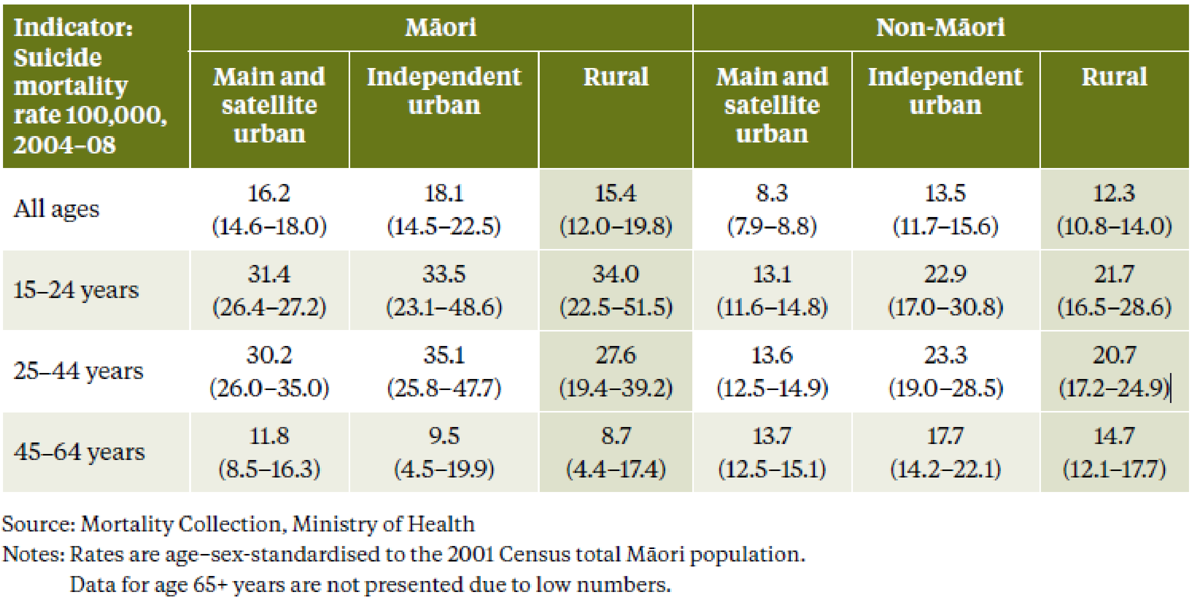
[673] Ministry of Health, 'Mātātuhi Tuawhenua', p 51.

[674] Ministry of Health, 'Mātātuhi Tuawhenua', p 43.

[675] Source: Ministry of Health, 'Mātātuhi Tuawhenua', p 43.

[676] Ministry of Health, 'Mātātuhi Tuawhenua', pp 42-43.
More details concerning regional variations in suicide can be found in statistics published online by the Ministry of Health. While these published figures present suicides in five-year blocks by DHB area, they do not include further breakdowns by ethnicity or by statistical urban/rural categories. 'Suicide Facts: Data tables 1996-2015', Ministry of Health, https://www.health.govt.nz/system/files/documents/publications/suicide-datattables-1996-2015-final-3oct18.xlsx, published October 2018.

Table 4.3 Suicide, Māori and non-Māori, by age group and urban/rural area, 2004-08[677]



Indicator: Suicide mortality rate 100,000, 2004–08	Māori			Non-Māori		
	Main and satellite urban	Independent urban	Rural	Main and satellite urban	Independent urban	Rural
All ages	16.2 (14.6–18.0)	18.1 (14.5–22.5)	15.4 (12.0–19.8)	8.3 (7.9–8.8)	13.5 (11.7–15.6)	12.3 (10.8–14.0)
15–24 years	31.4 (26.4–27.2)	33.5 (23.1–48.6)	34.0 (22.5–51.5)	13.1 (11.6–14.8)	22.9 (17.0–30.8)	21.7 (16.5–28.6)
25–44 years	30.2 (26.0–35.0)	35.1 (25.8–47.7)	27.6 (19.4–39.2)	13.6 (12.5–14.9)	23.3 (19.0–28.5)	20.7 (17.2–24.9)
45–64 years	11.8 (8.5–16.3)	9.5 (4.5–19.9)	8.7 (4.4–17.4)	13.7 (12.5–15.1)	17.7 (14.2–22.1)	14.7 (12.1–17.7)

Source: Mortality Collection, Ministry of Health
Notes: Rates are age-sex-standardised to the 2001 Census total Māori population.
Data for age 65+ years are not presented due to low numbers.

4.3.3 Difficulties in accessing suitable mental health services

Figures indicate that Māori residents of rural areas do not have greater unmet needs for basic medical services and do not show signs of greater risk for some common mental health problems than those in urban areas. However, this does not mean that those living in rural areas, or even those simply outside the major centres, do not face particular difficulties in accessing appropriate mental health services.

A claim before the Tribunal raises the issue of the lack of provision of child inpatient mental health services within the rohe of Ngāti Kahungunu.[678] This covers a large area of the country and includes the full range of statistical classifications from main urban to highly rural/remote. The claimant, a healthcare assistant in Nga Rau Rakau, the adult inpatient mental health unit for Hawke's Bay, noted that the absence of district youth inpatient facilities means that local youth could spend over a week at Nga Rau Rakau, while waiting for an available bed in the Rangatahi facility operated by Capital and Coast DHB in Wellington.[679]

> Ngāti Kahungunu children who require inpatient mental healthcare and treatment are transferred to a facility outside of their rohe away from their whanau support structures. If a bed is not immediately available children are placed in the adult Nga Rau Rakau facility while they await transfer to a child facility. The current system is failing to actively protect the mental health and wellbeing of Ngāti Kahungunu children, and is failing to

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[677] Source: Ministry of Health, 'Mātātuhi Tuawhenua', p 42.
[678] Wai 2695, 1.1.1.
[679] Wai 2695, 1.1.1, pp 1-3, 7-8.

> work in partnership with Ngāti Kahungunu children and whanau to address their mental healthcare needs.[680]

The claimant noted that the arrangements in place made the separation of children from whānau – a problem with any inpatient unit with limited visitation rights – worse by the combination of distance and financial restraints, which left many families unable to visit and offer support.[681]

The situation described in Hawke's Bay is not unusual, with specialist services often being shared by DHBs and requiring patients and their families to travel long distances. For example, the Child and Family Unit at Starship Hospital serves as the psychiatric inpatient unit for those aged 13-18 from a region stretching from Taranaki to Cape Reinga and for those aged under 13 from across the entire North Island.[682]

For those living in rural and remote areas, the challenge can be to access mental health services at all, not simply to access particular specialist forms of mental health service. For example, a claim before the Tribunal from a Māori alcohol and drugs forensic clinician notes that there are no mental health services available within the rohe of Ngāti Te Wehi and the fact that this results in a need 'to travel extended distances to seek sufficient healthcare and treatment'.[683] Kāwhia, with a population of approximately 300, is the main settlement in the rohe and has a single GP with the local health centre seeing around 13 patients each day.[684] For those based in Kāwhia, counselling services are available in Otorohanga, a 58 km drive away. A larger range of mental health services, including those provided by Waikato DHB, can be accessed in Hamilton, over 80 km away.[685] While such distances are not likely to be insurmountable for most, the extent to which they form a barrier to accessing services must be considered in combination with other factors. Those without access to a car or for whom the cost of petrol is prohibitive may find travelling such distances for treatment a very substantial barrier.

4.3.4 Policies and funding to improve services in rural areas

The additional costs involved in delivering health services to dispersed rural populations and the fact that rural populations may have particular mental health needs have both been recognised to

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[680] Wai 2695, #1.1.1, p 3.

[681] Wai 2695, #1.1.1, pp 7-8.

[682] 'Starship Paediatric Child & Family Unit', Starship Child Health, https://www.starship.org.nz/patients-parents-and-visitors/directory-of-services/Child-and-Family-Unit/, accessed 18 March 2019.

[683] Wai 2670, #1.1.1, pp 3-4.

[684] Keira Stephenson, 'Kāwhia calling', New Zealand Doctor, https://www.nzdoctor.co.nz/article/opinion/pictured/kawhia-calling, last modified 1 August 2018.

[685] See 'Services we offer', Citizens Advice Bureau, http://www.cab.org.nz/acabnearyou/otorohanga/Pages/services.aspx, last modified 16 September 2010; links to various services from 'Mental Health and Addictions', Waikato District Health Board, https://www.waikatodhb.health.nz/about-us/a-z-of-services/mental-health-and-addictions/, accessed 18 March 2019. Distances provided by Google Maps, https://www.google.co.nz/maps, accessed 18 March 2019.

some extent by the Crown in its policy-making. The Ministry of Health notes that '[e]nsuring comprehensive, quality services for people living in rural areas is a priority for the Government.'[686] The number of government initiatives in recent years that seek to address these matters would, however, appear to be quite limited.

As noted in Chapter 2, the funding that the Crown provides to DHBs under the population-based funding formula is adjusted to take into account the additional costs of serving rural areas, such as in operating small hospitals and transferring patients over long distances.[687]

A series of rural mental health initiatives were launched by the previous National-led government as part of an 'Emergency Response to Support Rural Mental Health'. The involved a series of Ministry of Health contracts, amounting to a total value of $875,000, which provided funding for the Rural Health Alliance Aotearoa New Zealand to deliver 'services relating to the mental wellbeing and resilience of the rural community'.[688] Additional funding was also provided to the Rural Health Alliance for 'psychosocial earthquake recovery support' in Kaikoura and for the development of a rural mental health and addiction outcome improvement framework.[689] Initiatives supported over the life of the 'Emergency Response' included suicide prevention workshops, the development of programmes for managing suicidal patients, and the completion of a needs analysis for rural youth.[690]

It is possible that there will be greater investment in future for rural mental health programmes as part of the additional mental health funding announced in the 2019 budget. The Ministry of Health is planning to include a variety of groups, including Māori and those living in rural areas, in co-designing primary mental health services to meet their needs. Those living in rural and isolated areas have also been identified as a particular target for additional funding for telehealth and digital services for mental health.[691]

4.4 Transport and communications

Access to transport and communications are important factors in allowing effective engagement with mental health services. They allow individuals to travel to attend consultations in person, to

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[686] 'Rural health', Ministry of Health, https://www.health.govt.nz/our-work/populations/rural-health, last modified 4 February 2019.

[687] 'Population-Based Funding Formula: Five Yearly Review Summary, 2007-08', Ministry of Health, Pre-publication version, 18-19. Available at: https://www.health.govt.nz/system/files/documents/pages/pbff_review_version_pre_publication.docx, accessed 23 October 2018.

[688] Personal correspondence from Senior Project Manager, Mental Health, Ministry of Health, 9 August 2019.

[689] Personal correspondence from Senior Project Manager, Mental Health, Ministry of Health, 9 August 2019.

[690] 'New funding to assist rural mental health'; 'Rural Mental Health Initiatives', Rural Health Alliance Aotearoa New Zealand, https://rhaanz.org.nz/rural-mental-health-initiatives-2/, accessed 14 June 2019.

[691] 'Budget 2019: Mental health, wellbeing and addiction initiatives', Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/budget-2019-mental-health-wellbeing-and-addiction-initiatives, last modified 30 May 2019.

contact crisis services in times of need, and to make use of the range of telephone and internet-based support and self-help services. Census figures show that Māori have lower levels of access to private transportation and communications than the general population. A number of claims raise issues of the extent to which these disparities act as barriers to Māori accessing mental health services or health services generally.[692]

4.4.1 Access to transport

Figures from the 2006 and 2013 censuses indicate that Māori are significantly more likely to live in households without access to a car than non-Māori.[693] In 2006, while the percentage of Māori without access to a car was lower in rural and other areas than in urban areas, it was in these areas that the differences between Māori and non-Māori were most marked. Whereas Māori were roughly twice as likely as non-Māori to live in a household without a car in urban areas, in rural areas they reported living in such a household at over four times the rate of non-Māori.[694] (See Table 4.4).

Table 4.4 Percentage living in household without motor vehicle access, all age groups, Māori and non-Māori, by urban/rural area, 2006[695]

Māori			Non-Māori		
Main and satellite urban	Independent urban	Rural and other areas	Main and satellite urban	Independent urban	Rural and other areas
9.5 (9.4-9.6)	10.7 (10.5-10.9)	5.1 (4.9-5.2)	5.1 (5.1-5.1)	5.3 (5.2-5.4)	1.2 (1.2-1.3)

There is a strong correlation between income and access to a car, with between a quarter and a third of households in each of the annual income brackets up to $20,000 not having a car, while less than 1 per cent of households with incomes of over $100,000 did not have a car. (See Figure 4.7). Additionally, mental disorder, in some cases, can be a basis on which an individual is found unfit to drive.[696] The Land Transport Act 1998 requires health practitioners to inform the Transport Agency of individuals who they believe are likely to drive against medical advice and

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[692] Wai 558 1.1(b); Wai 884, #1.1(d); Wai 1460, #1.1.1(b); Wai 1775, #1.1.1(a); Wai 1941, #1.1.1(a); Wai 2179, #1.1.1(c); Wai 2494 #1.1.1 (c); Wai 2510 #1.1.1(b); Wai 2632, #1.1.1; Wai 2645, #1.1.1; Wai 2697, #1.1.1; Wai 2723 #1.1.1; Wai 2734 #1.1.1

[693] Ministry of Health, 'Mātātuhi Tuawhenua', p 17; '2013 Census ethnic group profiles: Māori', Stats NZ, http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/ethnic-profiles.aspx?request_value=24705&tabname=Motorvehicles,andphones,fax,andInternet, accessed 13 March 2019.

[694] Ministry of Health, 'Mātātuhi Tuawhenua', p 17.

[695] Ministry of Health, 'Mātātuhi Tuawhenua', p 17.

[696] For details of the circumstances in which mental disorder would be considered to render an individual unfit to drive, see NZ Transport Agency, 'Medical aspects of fitness to drive: A guide for health practitioners' (Wellington: NZ Transport Agency, 2004), pp 98-105.

for the licences of those placed under inpatient orders or treated as special patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992 to be suspended.[697] Given these circumstances, it is likely that Māori with serious mental illness have lower rates of access to private transportation than the Māori population as a whole.

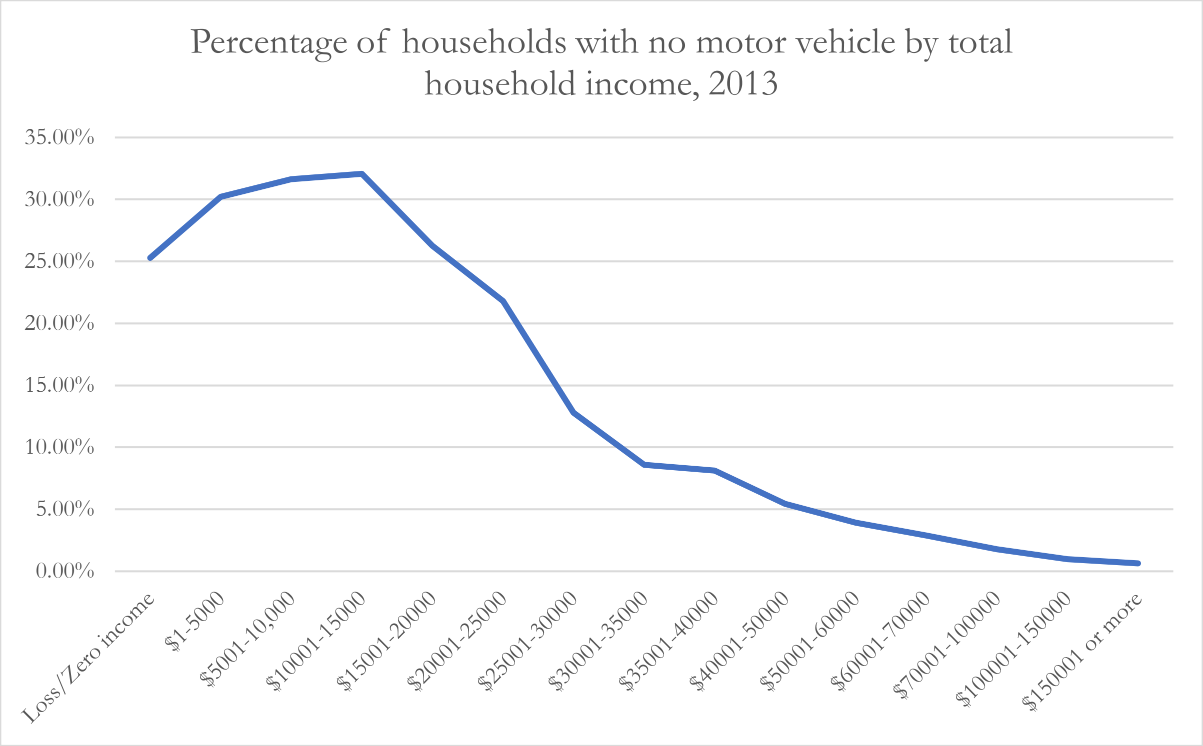

Figure 4.7 Percentage of households with no motor vehicle by total household income, 2013.[698]

4.4.2 Access to telecommunications

Māori are also more likely than the general population to have no access to any form of telecommunications, with the 2006 and 2013 censuses recording lower than average access rates across all but one form of telecommunications.[699] (See Table 4.5) Figures from the 2006 census indicate that there was little variation between urban and rural areas in terms of the rates at which individuals had no telecommunications access. However, the differences between Māori

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[697] Land Transport Act 1998, ss 18, 19.

[698] Data from '2013 Census QuickStats about transport and communications', Stats NZ, http://archive.stats.govt.nz/~/media/Statistics/Census/2013%20Census/profile-and-summary-reports/quickstats-transport-comms/quickstats-transport-comms-tables.xls, accessed 27 March 2019. Figures presented here are based on 'Total households stated' figures, which exclude those who did not respond and those whose response was unidentifiable.

[699] 'Telecommunications access', Te Puni Kōkiri, https://tpk.idnz.co.nz/tpk/telecommunications-access?GPBMID=0, accessed 24 January 2019.

and non-Māori were much more substantial, with Māori reporting not having telecommunications access at rates several times higher than non-Māori.[700] (See Table 4.6)

Table 4.5 Telecommunications access, Māori and New Zealand total population, 2006 and 2013.[701]

	2013		2006	
	Māori in NZ	NZ total population	Māori in NZ	NZ total population
Access to a mobile phone	85%	79.4%	77.9%	71.1%
Access to a telephone	72.7%	81.1%	78.5%	87.8%
Access to a fax machine	9.6%	13.8%	19.1%	24.9%
Access to the internet	68.8%	72.8%	50.3%	58%
No access to telecom systems	3%	1.6%	4.5%	2%
Not elsewhere included	2.1%	5.2%	2.1%	4.2%

Table 4.6 Percentage living in household without telecommunications access, all age groups, Māori and non-Māori, by urban/rural area, 2006.[702]

Māori			Non-Māori		
Main and satellite urban	Independent urban	Rural and other areas	Main and satellite urban	Independent urban	Rural and other areas
5.1 (5.0-5.1)	7.0 (6.8-7.2)	6.5 (6.3-6.6)	1.2 (1.2-1.2)	1.5 (1.5-1.5)	1.1 (1.1-1.2)

Significantly, the proportion of both Māori and the total New Zealand population who did not have telecommunications access dropped between 2006 and 2013 (see Table 4.5) and this appears to be part of a longer-term trend of improving communications access. The percentage of New Zealand households without telecommunications access decreased from 3.6 per cent in 2001 to 2 per cent in 2006 and then to 1.6 per cent in 2013.[703] These figures, however, show substantial regional variation. For example, Opotiki, where 60.6 per cent of the population stated

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[700] Ministry of Health, 'Mātātuhi Tuawhenua', p 17.

[701] 'New Zealand: Telecommunications access', Te Puni Kōkiri, https://tpk.idnz.co.nz/tpk/telecommunications-access?GPBMID=0, accessed 24 January 2019.

[702] Ministry of Health, 'Mātātuhi Tuawhenua', p 17.

[703] '2013 Census QuickStats about transport and communications', Stats NZ, http://archive.stats.govt.nz/~/media/Statistics/Census/2013%20Census/profile-and-summary-reports/quickstats-transport-comms/quickstats-transport-comms-tables.xls, accessed 19 March 2019.

they were of Māori ethnicity, had the highest rate of lack of telecommunications access in 2013 at 6.3 per cent, but this was a substantial decrease from the figure of 9.5 per cent in 2006.[704]

4.5 Cultural barriers

The New Zealand mental health system, as discussed in previous chapters, has historically been one dominated by Western medical approaches, largely excluding Māori perspectives and employing few Māori staff. While there have been significant changes in recent decades, with the introduction of kaupapa Māori services, a growing Māori workforce, greater Māori involvement in decision-making, and a greater focus on cultural competence of staff, most of the system is still firmly based on standard Western approaches to healthcare and operates in a world of European cultural norms.

While kaupapa Māori services are relatively widespread, Māori are not always able to access them and, in these circumstances, some may find they experience cultural barriers to engaging with mental health services. The Government Inquiry into Mental Health and Addiction concluded that:

> Māori participation in conventional services has too often been hindered by the exclusion of whānau, a failed engagement process, offensive practices such as stigmatisation, seclusion, committal, over-reliance on medication, overt racism, and an inability of clinicians to understand Māori world views or te reo Māori.[705]

The Inquiry panel contrasted these problems experienced by Māori in mainstream services with the practice adopted in kaupapa Māori services.[706] Similar comparisons were made by some submitters to that Inquiry, with one Māori leader stating that:

> Whānau talked of feeling further alienated by services – they also identified success where cultural [connections] occurred with clinicians or kaimahi as navigators, of the importance of wrap-around for the whole whānau and the strengths of alternative pathways to mauri ora[707]

Issues related to the provision of culturally-tailored services are also raised in many claims to the Tribunal, with some indicating that the lack of culturally appropriate services formed a barrier to receiving treatment. Indeed, it has been claimed that:

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[704] '2013 Census QuickStats about transport and communications', Stats NZ, http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-transport-comms/access-telecomms.aspx, accessed 19 March 2019; '2013 QuickStats about a place: Opotiki District', Stats NZ, http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-a-place.aspx, accessed 19 March 2019.

[705] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 84.

[706] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 84.

[707] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 61.

> The Crown's failure to ensure that Maori perspectives are considered and provided for has resulted in Maori being less likely to engage with medical professionals and as a result health services are not effective for Maori.[708]

In other cases, this barrier has been framed not in terms of willingness to engage with services, but of the effectiveness of engaging with mainstream health services, with one claim noting that '[t]he lack of protection of kaupapa Māori negatively impacted on the ability of the Claimants to access relevant and helpful health services.'[709]

Further discussion of the extent to which governments have supported kaupapa Māori service delivery and the development of a more culturally competent mental health system can be found in other chapters.

Cultural barriers, however, can also extend beyond the nature of the services that are delivered to Māori. Indeed, one claim to the Tribunal noted both that the nature of treatment historically offered by Whangarei Hospital had been 'entirely inappropriate' and that the situation of the hospital on a wāhi tapu 'alienated the Hapū from the community which would access health services in that place.'[710]

4.6 Stigma

The stigma associated with mental illness can form a significant barrier in seeking and accessing treatment. Stigma is a factor that influences the substantial treatment gap that exists worldwide in respect to mental illness and can manifest in institutional barriers (in matters such as funding for and availability of services), in community attitudes and behaviour, and at an individual level.[711] Stigma on an individual level can come from many sources – from relatives, friends, colleagues, and even from those working within the health system. Stigma in the health system itself has been identified as creating 'barriers through such pathways as delays in help-seeking, discontinuation of treatment, suboptimal therapeutic relationships, patient safety concerns, and poorer quality mental and physical care.'[712]

4.6.1 Stigma among Māori in the Health and Lifestyles Survey

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[708] Wai 1544 1.1.1(c), paragraph 2.7; Wai 1677 1.1.1(a), paragraph 2.7.

[709] Wai 2671 1.1.1.

[710] Wai 2060 1.1.1(c).

[711] Claire Henderson, Sara Evans-Lacko, and Graham Thornicroft, 'Mental Illness Stigma, Help Seeking, and Public Health Programs', *American Journal of Public Health* vol 103, no 5 (2013), p 777.

[712] Stephanie Knaak, Ed Mantler, and Andrew Szeto, 'Mental illness-related stigma in healthcare: Barriers to access and care in evidence-based solutions', *Healthcare Management Forum* vol 30, no 2 (2017), p 112.

The results of the 2014 Health and Lifestyles Survey conducted by the Health Promotion Agency indicate there may be some difference between levels of stigma when comparing Māori with those in the European/Other ethnic group. When respondents were asked whether they would be comfortable with a new community mental health centre opening in their suburb, 70 per cent of Māori responded 'Yes', whereas the equivalent figure for European/Other was 80 per cent.[713]Any differences in responses between European/Other and Māori to all other questions concerning mental health stigma in the survey, covering both location of a mental health centre at other levels of proximity and comfort with interacting with a person with a diagnosis of schizophrenia, were not of statistical significance.[714] This stands in contrast to Asian responses, which, in the case of almost all relevant questions, indicated, to a level of statistical significance, greater wariness towards the opening of a mental health centre or interaction with a person with schizophrenia than amongst those in the European/Other category.[715]

4.6.2 Like Minds, Like Mine: New Zealand's anti-stigma and discrimination campaign

The Like Minds, Like Mine programme was established in 1997 in line with a recommendation in the Mason Report of 1996 as one of the first national and comprehensive campaigns of its type.[716] This government-funded programme is designed to reduce mental health-related stigma and discrimination and has included policy initiatives, media campaigns involving both well-known figures and ordinary New Zealanders, and the use of community workers.[717] Since 2015, the Health Promotion Agency has been the lead agency responsible for the programme, with the Ministry of Health retaining a role in strategic development.[718]

A survey of mental health service users conducted in 2010-11 indicated that a substantial majority (69 per cent) believed that the programme had assisted to some extent in reducing discrimination, with only 8 per cent believing it had not assisted and the remainder not knowing

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[713] K Holland, 'Measuring stigma: Attitudes towards social inclusion of people with mental illness within the community' (Wellington: Health Promotion Agency Research and Evaluation Unit, 2015), p 1.

[714] Holland, 'Measuring stigma: Attitudes towards social inclusion of people with mental illness within the community', pp 1-2; K Holland, 'Measuring stigma: Attitudes towards social inclusion of people with mental illness within a sports club setting' (Wellington: Health Promotion Agency Research and Evaluation Unit, 2015), pp 1-2; personal communication from Data Analyst, Health Promotion Agency, 26 February 2019.

[715] Holland, 'Measuring stigma: Attitudes towards social inclusion of people with mental illness within the community', pp 1-2; K Holland, 'Measuring stigma: Attitudes towards social inclusion of people with mental illness within a sports club setting', pp 1-2.

[716] Ministry of Health and Health Promotion Agency, 'Like Minds, Like Mine National Plan 2014-2019: Programme to Increase Social Inclusion and Reduce Stigma and Discrimination for People with Experience of Mental Illness (Wellington: Ministry of Health, 2014), p 3; 'Inquiry under Section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon. Jenny Shipley' (Wellington: Ministry of Health, 1996), pp 163-164.

[717] Callum Thornicroft et al, 'Impact of the "Like Minds, Like Mine" anti-stigma and discrimination campaign in New Zealand on anticipated and experienced discrimination', *Australian & New Zealand Journal of Psychiatry* vol 4, no 4 (2014), p 361.

[718] Ministry of Health and Health Promotion Agency, 'Like Minds, Like Mine National Plan 2014-2019', p 5.

or not responding.[719] Indeed, a series of regular surveys indicate that the programme would appear to have been successful. Between the first and twelfth surveys, there was a general decrease in negative attitudes and a general increase in willingness to accept people with mental illness, both amongst the total sample and amongst Māori.[720] In terms of attitudes, the improvements seen on the measures that had been used from the beginning of campaign were greater for Māori than for the total sample.[721] The survey also revealed that the use of Māori and Pacific people in media campaigns was apparently effective, with both groups indicating higher than average recall of Like Minds, Like Mine advertisements.[722]

By early 2010, it was estimated that over $52 million had been spent on Like Minds, Like Mine, with one cost benefit analysis indicating that, up to that point, it had an economic benefit of approximately $720 million.[723]

4.7 Fear

Fear can be a significant barrier to individuals seeking support for mental health issues. This fear can be linked to the issues of stigma and discrimination discussed above. It can also relate to specific potential consequences that can flow directly from seeking help. These include fear of the use of coercion in various forms within the mental health system, of facing criminal charges, and of losing custody of one's children.

4.7.1 Fear of use of coercion

The use of coercion within mental health systems can be a source of fear that prevents individuals from seeking help with their mental health problems. A study in the United Kingdom of mental health service users identified concerns about being detained against one's will, of being compelled to undergo unwanted treatment (for example, being medicated when they simply wanted to talk to someone), and of patronising and infantilising staff who, even when not under compulsory treatment, they felt needed to be obeyed and not questioned lest they seek to

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[719] Thornicroft et al, 'Impact of the "Like Minds, Like Mine" anti-stigma and discrimination campaign in New Zealand on anticipated and experienced discrimination', pp 368-369.

[720] Allan Wylie and James Lauder, 'Impacts of National Media Campaign to Counter Stigma and Discrimination Associated with Mental Illness, Survey 12: Response to Fifth Phase of Campaign' (Auckland: Phoenix Research, 2012), pp 22-25, 27-29, 47-50, 54-55.

[721] Wylie and Lauder, 'Impacts of National Media Campaign to Counter Stigma and Discrimination Associated with Mental Illness, Survey 12', pp 51-52.

[722] Wylie and Lauder, 'Impacts of National Media Campaign to Counter Stigma and Discrimination Associated with Mental Illness, Survey 12', pp 6-9, 11.

[723] Rhema Vaithianathan and Kym Pram, 'Cost Benefit Analysis of the New Zealand National Mental Health Destigmatisation Programme ('Like-Minds Programme")' (Auckland: Uniservices, 2010), p 3.

impose compulsory treatment. Some involved in this study who had previous experience of compulsory treatment noted that they tried to avoid mental health services completely.[724]

Such fears are apparent in New Zealand too. One participant in a survey conducted for Pharmac of Māori service users recalled that:

> I was becoming unwell so I rang the crisis team, I was being proactive I thought, next thing there are 3 police cars outside to come and take me away. I guess because I have a history, but that was then and this is now, when this happens you get worried what's going to happen to you, so you try and do it yourself rather than getting the help[725]

The discouraging effect of the use of coercive practices in a system in which 'Māori ways of working are secondary to the dominant Western model' was also noted by an individual service provider in a submission to the Government Inquiry into Mental Health and Addiction:

> People who need the most support can be put off engaging with [mental health] services for fear of Mental Health Act and compulsory treatment and restraint and seclusion. I would not advocate/encourage a family member to receive support from [mental health and addiction] services for these reasons[726]

4.7.2 Fear of punishment

Fear of action by the police, including the laying of criminal charges, can affect how families deal with situations relating to the behaviour of an individual during a mental health crisis. Submissions to the Government Inquiry into Mental Health and Addiction noted that, where an individual has physically assaulted someone while significantly distressed, family members were 'less likely to seek help or to tell the truth', with some alluding 'to the fact that they hide some facts to protect the service user and family unit'.[727] Where submitters disclosed cases of assault to the police, it was noted that they 'may regret the consequences for the service user or tāngata whaiora'.[728]

4.7.3 Fear of loss of custody of children

The fear of losing custody of one's children as a result of seeking help for mental health and addiction issues was raised in submissions to the Government Inquiry into Mental Health and Addiction. One Māori service user submitted that:

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[724] Angela Sweeney et al, 'The role of fear in mental health service users' experiences: a qualitative exploration', *Social Psychiatry and Psychiatric Epidemiology* vol 50, no 7 (2015), pp 1080, 1082-1083, 1084, 1085.

[725] Yesterday Today & Tomorrow Ltd, 'A Qualitative Investigation of the Impact and Barriers to Use of Antipsychotic Medication by Māori Tangata Whaiora in Aotearoa' (Wellington: Pharmac, 2006), p 9.

[726] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 119.

[727] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', pp 124, 161.

[728] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 124.

> The biggest threat our whānau face is losing their children to the Ministry … Once a whānau loses a child to the Ministry, it's devastating. If there's no-one to intervene at that point they go down the path of drugs/meth – end up in addiction.[729]

This fear is not a problem only in New Zealand, with overseas studies confirming the role of fear of intervention by social services and the loss of child custody in discouraging mothers with mental health problems from seeking treatment.[730] Studies also suggest that these fears are well-founded. A study of mothers in Philadelphia found that those with severe mental illness were almost three times more likely to have had involvements with the child welfare system or have had a child put into an out-of-home placement.[731] The same study found that mothers with serious mental illness were over four times as likely to have suffered the loss of custody of a child than those without these conditions – a figure lower than that recorded in previous studies.[732] Similar patterns have been revealed in New Zealand, with one study finding that, out of the mothers of children who were put into state care in the 2005 financial year before the age of two, 43 per cent had mental health problems and 71 per cent had alcohol or drug problems.[733]

It would seem possible that fear of child removal may be higher among Māori given the high rates at which Māori children are removed from their parents. At the end of June 2017, 69 per cent of children in state care identified as Māori.[734] The disparity in the rates at which Māori are taken into state care has worsened over the years, with the number of Māori children in state care increasing by 20 per cent in the 12 years to 2013, a period in which the number of Pākehā children in care decreased by 20 per cent.[735]

4.8 Health literacy

Health literacy 'is the capacity to find, interpret and use information and health services to make effective decisions for health and wellbeing'.[736] Given the complexity of the mental health system

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[729] Government Inquiry into Mental Health and Addiction, 'Submissions Summary Report', p 58. Similar fears, in this case specifically in relation to disclosing addiction problems in a family, are noted in the 'Submissions Summary Report', p 161.

[730] Sweeney et al, 'The role of fear in mental health service users' experiences', p 1080; Phyllis Montgomery et al, 'Mothers with Serious Mental Illness: Their Experience of "Hitting Bottom"', *ISRN Nursing* (2011), pp 1-2; Jung Min Park, Phyllis Solomon, and David S Mandell, 'Involvement in the Child Welfare System Among Mothers With Serious Mental Illness', *Psychiatric Services* vol 57, no 4 (2006), pp 493, 497.

[731] Park, Solomon, and Mandell, 'Involvement in the Child Welfare System', pp 493, 496.

[732] Park, Solomon, and Mandell, 'Involvement in the Child Welfare System', p 496.

[733] David Rankin, 'Meeting the needs of New Zealand children and young people who have been abused and neglected', *Best Practice Journal* iss 37 (2011), p 6.

[734] 'Briefing to the Incoming Minister', Ministry for Vulnerable Children, Oranga Tamariki, October 2017, pp 3, 11 https://www.beehive.govt.nz/sites/default/files/2017-12/Children.pdf, accessed 15 October 2018.

[735] Amohia Boulton et al., 'E tipu E rea: the care and protection of indigenous (Māori) children', *New Zealand Law Journal* 2018 no 3, pp 3, 4.

[736] 'Health literacy', Ministry of Health, https://www.health.govt.nz/our-work/making-services-better-users/health-literacy, last modified 21 May 2015.

and the issues that individuals face in accessing the services they need, possessing a decent level of health literacy would seem necessary to navigate through the system successfully.

Research has shown that individuals with poor health literacy are affected in a variety of ways, including that they:

- -are less likely to use prevention services (such as screening)
- have less knowledge of their illness, treatment and medicines
- are less likely to manage their long-term/chronic condition
- are more likely to be hospitalised due to a chronic condition
- are more likely to use emergency services[737]

The 2006 Adult Literacy and Life Skills Survey revealed that New Zealanders score poorly in terms of health literacy with the average score received being below 275 (on a scale of 0 to 500) – the minimum considered necessary 'to meet the complex demands of everyday life and work in the emerging knowledge-based economy'.[738] Levels of health literacy for Māori were lower than for non-Māori and this does not appear to be solely a result of lower socio-economic status, lower levels of education, or other variations in population make-up. Indeed, even when broken down by sex, age, rural/urban residence, education level, labour force status, and household income, Māori consistently had lower health literacy levels than non-Māori.[739] In total, three quarters of Māori women and four fifths of Māori men were found to have poor health literacy.[740]

4.9 Conclusion

The barriers that Māori face in seeking to access mental health treatment can be substantial. The most significant barriers, however, are not unique to Māori, but are related to major failings of the mental health system as a whole that can affect all New Zealanders. As it exists today, those with mild to moderate symptoms have few, if any options, to receive meaningful treatment within the publicly-funded system. Even those with serious conditions may struggle to gain admittance to specialist mental health services. Many other barriers that effect some Māori are also not unique to them, such as facing lengthy travel to reach services or being deterred from seeking health care on account of stigma.

However, high prevalence rates of mental illness and lower socio-economic status mean that many barriers are likely to fall harder on Māori as a population group than on the New Zealand population as a whole. Māori can also, in some cases, face particular cultural barriers in engaging

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[737] Ministry of Health, 'Kōrero Mārama: Health Literacy and Māori, Results from the 2006 Adult Literacy and Life Skills Survey' (Wellington: Ministry of Health, 2010), p iii.
[738] Ministry of Health, 'Kōrero Mārama', p iv.
[739] Ministry of Health, 'Kōrero Mārama', pp 7-15.
[740] Ministry of Health, 'Kōrero Mārama', p iv.

with a system that reflects a dominant European worldview. They may also have particular fears of engaging with a system in which coercive practices are still common and in which engagement may lead to state actions that negatively affect their lives and families in other respects.

Chapter 5 Suicide and self-harm

5.1 Introduction

The rate of suicide amongst Māori today is widely recognised as having reached crisis levels. The high Māori suicide rate is a relatively recent phenomenon with many complex causes. It has been well documented since the 1980s and 1990s, and reflects a broader trend for indigenous peoples in Australia, the United States, and Canada.[741] The rate of suicide generally in New Zealand is high and in recent years has been trending upwards. Our high youth suicide rate is among the worst in the OECD and has been described as a 'national shame'.[742]

The high rate of suicide was one of the catalysts for a recent government inquiry into mental health and addiction. The resulting report, *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction,* noted that the country had recorded 'persistently high suicide rates' for decades.[743] Provisional figures released by the Office of the Chief Coroner show that the suspected suicide rate had increased over the four year period leading up to *He Ara Oranga* and was at its highest in 2017/18 since provisional statistics were first recorded in 2007/08.[744] [745]

The *He Ara Oranga* report noted that the government's approach to suicide prevention is 'patchy and under-resourced'.[746] Furthermore, the report found insufficient support available for those bereaved by a suicide, acknowledging 'every suicide creates significant, far-reaching impacts on the person's friends, family and whānau, and the wider community'.[747]

This chapter focuses on those Māori whānau members who have been lost to suicide and the current effectiveness of government's response to this devastating loss. Following a summary of the claims to the Waitangi Tribunal relating to suicide and self-harm, this chapter goes on to

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[741] Anton C Clifford, Christopher M Doran and Komla Tse, 'A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand', *BMC Public Health* (2013). Available at: https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/1471-2458-13-463, accessed 25 February 2019.

[742] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga' (Wellington: Government Inquiry into Mental Health and Addiction, 2018), pp 9, 50, 74.

[743] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 8.

[744] Office of the Chief Coroner, 'Chief Coroner releases provisional annual suicide figures', press release, 24 August 2018, https://coronialservices.justice.govt.nz/suicide/annual-suicide-statistics-since-2011; Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', pp 8.

[745] Provisional suicide figures released by the Office of the Chief Coroner will differ from Ministry of Health figures because '[t]hey include active cases before Coroners where intent has yet to be established [and] therefore may eventually be found not to be suicides'. Ministry of Health figures are also calculated by calendar year. See Office of the Chief Coroner, 'Chief Coroner releases provisional annual suicide figures', press release, 24 August 2018, https://coronialservices.justice.govt.nz/suicide/annual-suicide-statistics-since-2011.

[746] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 11.

[747] Government Inquiry into Mental Health and Addiction, 'He Ara Oranga', p 181.

provide a review of the relevant literature, a brief historical overview, a summary of Crown suicide prevention policies and strategies, and a description of the support available for bereaved whānau.

This chapter draws largely on published reports and articles. It also draws on a number of resources produced for the purposes of the government's 2018 inquiry into mental health and addiction which provide insights into the most recent developments around suicide prevention and Māori. An unfortunate gap in the korero around Māori suicide is a lack of literature and reports that might address potential prevention strategies and local exemplars of these. Much of the published literature focuses on rates of suicide among Māori, but with little analysis of policy, prevention, and Māori involvement in policy-making and suicide prevention initiatives. This is even more evident in the literature on self-harm. While Māori suicide has received some attention in the literature, we still know very little about intentional self-harm among Māori, rangatahi in particular. This dearth of information is reflected in the discussion in this chapter.[748]

5.2 Issues raised in Claims to the Waitangi Tribunal

The claims in this Inquiry relating to suicide and self-harm allege that the rate of Māori youth suicide is over three times higher than the rate for non-Māori. This disparity, they allege, is the result of the Crown's failure to acknowledge the role of self-determination, which would have utilised 'Māori knowledge, worldviews, Te Reo and Tikanga in the design of suicide prevention programmes'.[749] The claims also allege that the Crown has failed to address the disproportionate suicide and self-harming rates while Māori are incarcerated in prisons, psychiatric units, or held in police custody. The claims summarised in the table below reflect those that predominantly relate to suicide and self-harm. Numerous claims to the Waitangi Tribunal refer to these issues. Major claim issues in this Inquiry concerning suicide are set out below:

1176	Te Karaka Karaka on behalf of himself, his whānau the direct descendants of Te Karaka and on behalf of the hapū Te Paatu	• The Mental Health (Compulsory Assessment and Treatment) Act 1992 does not provide recognition of the principles of Te Tiriti o Waitangi. • In 2010 Northland had the second highest regional suicide rate, far above the national average.
2575	Tasilofa Huirama on behalf of Zipporah Grace Huirama (deceased), her whānau, who are members of Ngāti Ueoneone and Ngāti Tautahi of Ngāpuhi	• Māori are more likely than non-Māori to be subjected to the Mental Health (Compulsory Assessment and Treatment) Act order. • The Crown failed to protect Zipporah's mental health while she was under the care of mental health services, which led to her early death by suicide. • The claimants are bereaved by their loss.

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[748] Casey Alexandra Mendiola, 'He Koha Aroha Ki Te Whānau: Deliberate Self Harm and Māori Whānau' (PhD thesis, University of Auckland, 2011).

[749] Dr Keri Lawson-Te Aho, Statement of Claim, Wai 2626, 1.1.1, p 3

2599	Rawiri Jenkins (The Suicide and Self-Harm in Prison and Police Custody Claim)	• Failure to provide spiritual, cultural, and mental health care especially whilst in prison and police custody. • Suicide rate in NZ prisons eleven times higher than general population caused by high rates of mental health problems and lack of psychiatric care. • The higher incarceration rate of Māori men compared to that of non-Māori mean Māori men are at a greater risk of suicide and self-harm while imprisoned. • Suggestion that reduction of Māori suicides in custody is most likely to be achieved by tackling overrepresentation of Māori in custody.
2626	Dr Keri Lawson-Te Aho (The Māori Youth Suicide Claim)	• Poor delivery of services to mentally ill Māori. • Need for general incorporation of rongoā and Matauranga Māori. • Lack of mental healthcare. • Misguided and damaging practices of mental healthcare.
2643	Rosaria Hotere, Jane Hotere and Whānau (The Mental Health, Addiction and Suicide Claim)	• Failure to provide healthcare to those suffering from mental health issues including after attempting suicide. • Lack of acknowledgement of the high suicide rate for Māori. • Failure to support whānau following an attempted suicide of a whānau member.
2671	Jane Stevens, Nicky Taiaroa Macpherson Stevens (the Mental Health Services (Stevens) Claim)	• Suicide of son Nicky Stevens in acute inpatient care. • Lack of genuine Kaupapa Māori care. • Waikato DHB's policy for assessment and management of patients at risk of self-harm expired over 2 years prior to Nicky's death. • No relevant Waikato DHB policy regarding Māori mental health, risk harm to Māori or Māori youth suicide. • Institutional failures in the treatment and care of Nicky as well as the police handling of the search for Nicky. • Failure to protect Māori and Pākehā mental health and wellbeing to the same standard.
2686	Tuta Ngarimu (The Tairāwhiti DHB and Mental Health Claim)	• Lack of culturally appropriate services for Māori mental illness sufferers. • Failure to meet healthcare needs of Tairāwhiti Māori due to inadequate DHB funding tools (PBFF). • Failure to implement a suicide prevention strategy for Māori and specifically the lack of inclusion of kaupapa Māori in the programmes. • Failure to address youth suicide among Māori. • Under resourcing of suicide prevention programmes.

2688	Glennis Rawiri (The Māori Health (Rawiri) Claim)	• Failure to provide assistance to whānau members suffering from mental illness and depression. • Lack of acknowledgement of high incidence of suicide by Māori. • Failure to provide assistance of whānau members affected by suicide. • Lack of whānau-based initiatives in place to decrease suicide rates.
2729	Susan Taylor (Mental Health Services (Taylor) Claim)	• Traditional treatment for mental health abolished with Tohunga Suppression Act 1907. • Research showing Māori mental health linked to social and cultural cohesion. • Urbanisation detrimental to Māori mental health. • Lack of cultural awareness leading to misdiagnosis of mental health problems. • Māori significantly more likely to develop mental, anxiety, mood disorder than non-Māori or non-Pacific people. • Māori are at highest risk of mental disorder across sex and age, educational qualifications, and equivalised household income. • Failure to consult Māori over delivery of health services. • Daughter of claimant took own life whilst in care of mental health services. • Mana and wairua disregarded in treatment of Māori mental illness. • Tikanga of death disregarded when daughter died which impacted claimant's mental health.

5.3 Suicide rates over time

An historic analysis of Māori suicide is problematic. The manner in which ethnicity was recorded in New Zealand prior to 1995 means that Māori suicide rates were likely underestimated.[750]

John C. Weaver's aptly named *Sorrows of a Century: Interpreting Suicide in New Zealand, 1900-2000* is a sophisticated analysis of coroners' records over the twentieth century and provides a discussion on the difficulties of tracing rates of suicide among Māori in the past.[751] As Weaver notes, while numerous government-sponsored discussions of ethnicity and suicide in New Zealand 'dwell on current trends for Māori, and properly so', and in some cases provide figures for the period after the 1980s, historical analysis of Māori suicide rates remain difficult.[752] Weaver also warns against

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[750] A L Beautrais and D M Fergusson, 'Indigenous suicide in New Zealand', *Archives of Suicide Research*, vol 10, no 2 (2006), pp 159-160

[751] John C Weaver, *Sorrows of a Century: Interpreting Suicide in New Zealand, 1900-2000* (Wellington: Bridget Williams Books, 2014).

[752] Weaver, *Sorrows of a Century,* pp 41-47.

making strong conclusions about Māori suicide historically, writing that '[n]o Māori rates before 1950 are reliable on account of the under-reporting of Māori deaths generally'.[753] This was because Māori remained largely rural during the first half of the twentieth century, and because of the 'difficulty of determining from case files who was Maori in urban settings' since ethnicity cannot always be assumed by personal names.[754] Some Māori had either adopted European names or were given these at birth.[755] Additionally, there may have been less oversight by authorities of Māori registration of births and deaths. Nevertheless, as mentioned, it was generally acknowledged that prior to the mid-1980s, suicide rates for Māori were significantly lower than those for non-Māori.[756] Drawing on the Annual Reports of the Medical Statistician on the Medical Statistics of New Zealand, Robinson notes that 'between 1944 and 1968, the Māori death rate for suicide and self-inflicted injury fluctuated between 1.0 and 7.5, decreasing slightly, while the Pākehā rate varied between 8.0 and 11.0' per 100,000 of the population.[757]

A significant increase in Māori suicide rates occurred during the 1980s and 1990s.[758] With this increase, 'disparities between Māori and non-Māori rates emerged, particularly among the young'.[759] The suicide rate for Māori males increased by 162 per cent between 1980 and 1991, bringing the rate of suicides for Māori and non-Māori males to 'relatively similar' levels.[760] Evidence suggested, however, that the 'true rates' of Māori suicide were 'likely to have been much higher'.[761]

In 2001, a report entitled *Suicide Trends in New Zealand 1978-1998* was commissioned by the Ministry of Health. It found that in 1997, the 'Māori male suicide rate was 28 percent higher than the non-Māori rate, while the Māori female rate was almost 60 percent higher than the non-Māori female rate' (see Table 5.1).[762] The report also found that suicide was concentrated among the 25–44 year old age group, followed by youth aged 15–24 years.[763] Indeed, it found that '[y]outh accounted for one-quarter of suicide deaths in 1997'.[764] In 1996, Annette Beautrais observed the three-decade increase in New Zealand's youth suicide rate had raised it to 'among

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[753] Weaver, *Sorrows of a Century,* p 248.
[754] Weaver, *Sorrows of a Century*, pp 43, 248; John Weaver and Doug Munro, 'Country living, country dying: Rural suicides in New Zealand, 1900-1950'. *Journal of Social History*, vol 42, no 4 (2009), p 954.
[755] Weaver, *Sorrows of a Century*, pp 43, 248; Weaver and Munro, 'Country living, country dying', p 117.
[756] Robinson, 'Te Taha Tinana: Māori Health and the Crown in the Te Rohe Pōtae Inquiry District', Commissioned research report, Wellington: Waitangi Tribunal, 2011, Wai 898 #A31, p 203.
[757] Robinson, 'Te Taha Tinana', p 203.
[758] Joanne Baxter, 'Mental Health: Psychiatric Disorder and Suicide', in *Hauora: Māori Standards of Health IV: A study of the years 2000-2005*, ed B Robson and R Harris (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare 2007), p 126.
[759] Baxter, 'Mental Health: Psychiatric Disorder and Suicide', p 126
[760] Te Kani R Kingi, '"Hua Oranaga": Best Health Outcomes for Māori' (PhD thesis, Massey University, Wellington, 2002), p 13.
[761] Kingi, '"Hua Oranaga"', p 13
[762] New Zealand Health Information Service (NZHIS), *Suicide Trends in New Zealand 1978-1998* (Wellington: Ministry of Health, 2001), pp 27-28. Available at: http://www.moh.govt.nz/notebook/nbbooks.nsf/0/6A3A3EDA84465C03CC256DB6006E769B/$file/suicide78-98-2001.pdf.
[763] NZHIS, *Suicide Trends in New Zealand 1978-1998*, p 29.
[764] NZHIS, *Suicide Trends in New Zealand 1978-1998*, p 20.

the highest in the developed world'.[765] Between 1980 and 1991, suicide rates among Māori aged 15-24 years increased by a substantial 250 per cent.[766] Among males aged 25–44, 'Māori had a suicide rate that was 22% less than that of 'non-Māori non-Pacific people in 1981–84, but by 1996–99 the rate was 70% greater'.[767] While the overall death rate for Māori aged between 25-44 years fell by 24 per cent between 1980-1984 and 1987-1991, suicide was the only cause of death that rose, increasing by 10 per cent.[768] However, among people aged 45–74, non-Māori and non-Pacific people had the highest rates.[769] More generally, researchers noted the increase in youth suicide generally for both Māori and non-Māori.

Table 5.1 Suicide death rates, numbers, 1978–97 (rates per 100,000 population).[770]

Year	Male			Female			Total
	Total	Māori	Non-Māori	Total	Māori	Non-Māori	
1978	13.0	9.1	13.3	7.0	2.8	7.1	9.9
1979	13.3	11.9	13.5	5.2	1.3	5.5	9.2
1980	13.7	7.7	14.2	6.4	3.9	6.5	10.0
1981	14.6	7.1	15.1	4.4	0.7	4.7	9.4
1982	14.9	10.3	15.3	6.1	3.2	6.2	10.4
1983	14.3	6.1	14.9	5.8	2.6	6.0	10.0
1984	16.8	13.5	17.0	5.0	2.7	5.1	10.8
1985	14.3	9.1	14.6	4.6	1.0	4.9	9.3
1986	17.0	8.6	17.7	6.1	2.9	6.2	11.5
1987	20.1	11.2	20.8	5.4	1.5	5.7	12.6
1988	21.0	9.6	21.8	5.3	3.5	5.3	13.1
1989	20.6	16.4	20.8	5.1	1.5	5.4	12.7
1990	19.7	11.1	20.4	4.7	1.0	5.1	12.1
1991	20.4	20.3	20.9	4.9	1.9	5.3	12.5
1992	21.3	13.4	23.0	5.0	3.4	5.2	13.0
1993	18.2	9.9	19.4	4.7	3.4	4.9	11.3
1994	21.2	16.0	21.9	5.0	6.6	4.9	12.9
1995	22.0	n/a	n/a	5.7	n/a	n/a	13.7
1996	21.6	25.2	20.4	5.7	8.4	5.2	13.4
1997	22.3	26.8	21.0	6.0	8.6	5.4	14.0

From the late 1970s suicides by males generally increased and, by the 1990s, suicides by Māori males had exceeded the rates of non-Māori. For females, Māori rates increased in the 1990s,

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[765] Annette Beautrais, 'Youth Suicide', *New Zealand Annual Review of Education*, vol 5 (1996), p 3

[766] Eru Pōmare et al., *Hauora: Māori Standards of Health III: A study of the years 1970-1991* (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 1995), p 65.

[767] Ajwani *et al.*, 'Decades of Disparity: Ethnic mortality trends in New Zealand 1980-1999' (Wellington: Ministry of Health and University of Otago, 2003), p 38.

[768] Pōmare et al., *Hauora: Māori Standards of Health III*, p 68.

[769] Ajwani *et al.*, 'Decades of Disparity', p 38

[770] Source: NZHIS, *Suicide Trends in New Zealand 1978-1998*, p 27.

exceeding those of non-Māori in 1994. The authors of the report note that 'Māori and non-Māori data is not available for 1995 because of changes in the recording of ethnicity in death statistics' and that '[d]ata for 1996 onwards is not comparable to earlier years'.[771]

Figure 5.1 shows that suicide rates in 1996 and 1997 were higher for Māori than non-Māori. As discussed above, in 1997 the suicide rate for Māori males was 28 per cent higher than non-Māori males (reflected as 26.8 deaths per 100,000 population for Māori males compared to 21.0 deaths per 100,000 population for non-Māori males).[772] For this same year, the suicide rate for Māori females was nearly 60 per cent higher than non-Māori females (reflected as 8.6 per 100,000 population for Māori females compared to 5.4 per 100,000 population for non-Māori females).[773]

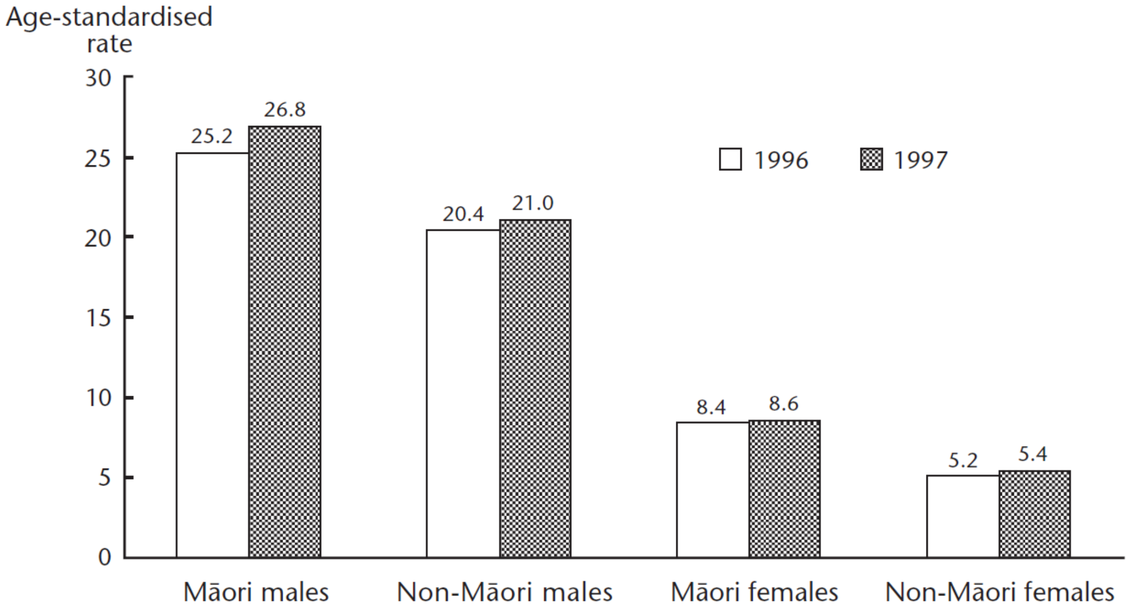

Figure 5.1 Suicide death rates, by ethnicity, 1996 and 1997.[774]

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[771] NZHIS, *Suicide Trends in New Zealand 1978-1998*, p 23, 27. For more information of on the difficulties of comparing ethnicity statistics across time, see 'APPENDIX 1: Significant Changes to Ethnicity coding in 1995', in NZHIS, *Suicide Trends in New Zealand 1978-1998,* pp 62-64.
[772] NZHIS, *Suicide Trends in New Zealand 1978-1998*, p 28.
[773] NZHIS, *Suicide Trends in New Zealand 1978-1998*, p 28.
[774] Source: NZHIS, *Suicide Trends in New Zealand 1978-1998*, p 28.

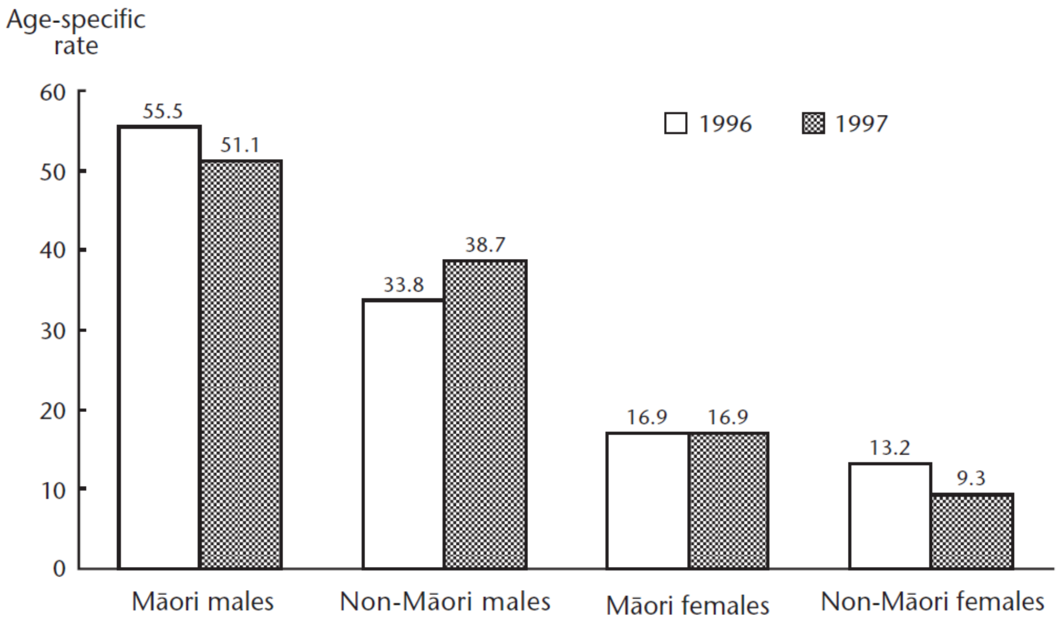

Figure 5.2 Youth suicide rates, by ethnicity, 1996 and 1997 (combined). Age-specific rates per 100,000 population.[775]

By the mid-1990s calls for action on suicide prevention increased. The authors of the 1995 *Hauora* report concluded there was an urgent need to address these tragic statistics with appropriate interventions, and to view suicide 'with the pattern of mental illness amongst Māori, and with the known risk factors, including stressful life events, sexual abuse and substance abuse'.[776] The report continued by noting that '[s]uicide, especially youth suicide, has been recognised by some communities as a priority issue, with hui and interventions beginning to be developed', and suggested that 'these deserve further support given the disturbing increases in Māori suicide rates'.[777]

5.4 Suicide among Māori prison inmates

Since the 1990s, there has been growing recognition of the high suicide rates affecting Māori in custody. Keren Skegg and Brian Cox, in their 1993 article 'Suicide in Custody: Occurrence in Maori and nonMaori New Zealanders', which analysed deaths in prison for the period 1973-1988 and suicides in police cells between 1980 and 1991, found that '[s]uicide in custody accounted for about a quarter of all suicides in Maori men aged 15-49, but only 1.7% of suicides in nonMaori

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[775] Source: NZHIS, *Suicide Trends in New Zealand 1978-1998*, p 47.
[776] Pōmare et al., *Hauora: Māori Standards of Health III*, pp 81-82.
[777] Pōmare et al., *Hauora: Māori Standards of Health III*, p 82.

men'.[778] They found that the proportion of the Māori population that died from suicide while in prison 'was eight times higher than that for the nonMaori population' and that '[t]he proportion of Maori men who died in police custody was nine times higher' than that for non-Māori.[779] The authors attributed these statistics to the fact that 'Maori men were… six times more likely… to be in prison', a statistic reflected in that fact that half of all sentenced prisoners at the time were Māori.[780] They found that the rates of suicide among all prisoners were similar for Māori and non-Māori men (reflected as 38.7 Māori and 40.4 non-Māori suicides per 100,000 male prisoners) and concluded that a reduction in Māori suicide rates would most effectively be addressed by 'tackling the overrepresentation of Maori people in custody'.[781]

In 1996, a joint review by the Department of Corrections and Te Puni Kōkiri was commissioned to address the high number of suicides by Māori inmates in New Zealand's prisons.[782] Between 1971 and 1995, a total of 47 Māori inmates died from suicide.[783] Although the characteristics of Māori and non-Māori inmates who died of suicide were similar, Māori were at higher risk of suicide.[784] Reasons suggested for this were 'high rates of imprisonment, increasing [rates of] mental illness, and [persistent] economic and social disadvantage'.[785] The review made 39 recommendations and highlighted 'two key elements to the effective assessment and management of Māori inmates at risk of suicide or self-harm'.[786] These were 'an acknowledgement of cultural factors in the assessment and management of Māori inmates', and 'the involvement of the whānau in the management of Māori inmates at risk of suicide or self-harm'.[787]

More generally, Julia Carr has claimed that '[e]ffective interventions at the interface between the criminal justice system and health systems have the potential to make a significant impact on hauora Māori'.[788] She noted that, under the Corrections Act 2004, 'the state has a "duty of care" and inmates have a right to health care "equivalent" to that available outside prison'.[789]

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[778] Skegg and B Cox, 'Suicide in Custody: Occurrence in Maori and nonMaori New Zealanders', *New Zealand Medical Journal*, vol 106, no 948 (1993), p 1.
[779] Skegg and Cox, 'Suicide in custody', p 1.
[780] Skegg and Cox, 'Suicide in custody', p 1.
[781] Skegg and Cox, 'Suicide in custody', p 1.
[782] Māori Suicide Review Group, 'Reducing Suicide by Māori Prison Inmates', (Wellington: Department of Corrections and Te Puni Kōkiri, 1996).
[783] Māori Suicide Review Group, 'Reducing Suicide by Māori Prison Inmates', pp 1, 11.
[784] According to the Māori Suicide Review Group report, the characteristics of those most at risk of suicide in prison were male remand inmates under the age of 34. If they had been sentenced, they were likely to be long sentences for violent offences, and to have a medium or maximum security classification. Suicide was more likely to occur within six months of arriving in prison, in the inmate's cell (by hanging), between 6.00pm and 6.00am on a Saturday. Māori Suicide Review Group, 'Reducing Suicide by Māori Prison Inmates', pp 11, 25-26.
[785] Māori Suicide Review Group, 'Reducing Suicide by Māori Prison Inmates', p 1.
[786] Māori Suicide Review Group, 'Reducing Suicide by Māori Prison Inmates', p 1.
[787] Māori Suicide Review Group, 'Reducing Suicide by Māori Prison Inmates', p 1.
[788] Julia Carr, 'Prison Health', in *Hauora: Māori Standards of Health IV: A study of the years 2000-2005*, ed B Robson and R Harris (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare 2007), p 221.
[789] Carr, 'Prison Health', p 222.

5.5 Māori suicide rates by late twentieth century and current trends

More recent studies and statistics confirm the high rate of suicides among Māori, especially among young Māori men. In 2006, the government suicide prevention strategy concluded that the suicide rate was significantly higher for Māori and was 'characterised by a significant pattern of suicide occurring in the under-35 year age group'.[790] Those aged over 45 years had a much lower rate of suicide.[791] According to the 2005 figures, the Māori suicide rate was about 1.5 times higher than the non-Māori rate.[792] By 2010, Māori suicide rates had risen to 'twice that of non-Māori', with the male rates significantly higher than female.[793] As already indicated, Māori and non-Māori between the ages of 15-44 years had the highest suicide rate.[794] The same report commented on intentional self-harm, explaining that overall Māori (and particularly Māori women) were 'significantly more likely than non-Māori to be hospitalised for intentional self-harm'.[795] Recently, in a report produced for the Mental Health and Addiction Inquiry, Sheree Gibb and Ruth Cunningham from the University of Otago provided an overview of recent trends in mental health service use, including sections on unmet needs, information gaps, and suicide.[796] The authors found that New Zealand had 'good quality data' on deaths by suicide and noted that summaries were published by the Ministry of Health annually.[797] Suicide rates for the overall population remained static between 2006 and 2015, but were 'higher for males, Māori, and individuals living in high deprivation areas'.[798] They also found that rates were slightly higher in rural areas, which could reflect the lower levels of mental health services available to people in rural areas.[799]

The Crown has recently filed data on Māori health trends between 1990 and 2015 which relate to suicide and self-harm. The Crown report concluded that 'Māori have a higher incidence of suicide mortality than non-Māori over time, except for older Māori (aged 45-64 years). In 2012-14, Māori were over one and a half times as likely as non-Māori to die by suicide'.[800] Furthermore:

> Māori males have the highest suicide mortality rates overall.
> The difference between Māori females and non-Māori females has increased over time (over twice as likely).

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[790] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', (Wellington: Ministry of Health, 2006), p 5.

[791] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', p 5.

[792] Baxter, 'Mental Health: Psychiatric Disorder and Suicide', p 133.

[793] Ministry of Health, *Tatau Kahukura: Māori Health Chart Book 2010*, 2nd Edition, (Wellington: Ministry of Health, 2010), p 45.

[794] Ministry of Health, *Tatau Kahukura*, p 45.

[795] Ministry of Health, *Tatau Kahukura*, p 44.

[796] Sheree Gibb and Ruth Cunningham, 'Mental Health and Addiction in Aotearoa New Zealand Recent trends in service use, unmet need, and information gaps', July 2018, report commissioned by the Mental Health and Addiction Inquiry.

[797] Gibb and Cunningham, 'Mental Health and Addiction in Aotearoa New Zealand', p 24.

[798] Gibb and Cunningham, 'Mental Health and Addiction in Aotearoa New Zealand', p 24.

[799] Gibb and Cunningham, 'Mental Health and Addiction in Aotearoa', 2018, p 24.

[800] Wai 2575, B2, 'Māori Health Trends 1990 – 2015 Project: Suicide and Self-Harm Module', 26 February 2019, p 1.

> Young people aged 15-24 years had the highest suicide mortality rates of all age groups with Māori males in particular having the highest rates of mortality. Suicide mortality rates have increased over time for young Māori females aged 15-24 years. The difference between Māori females and non-Māori females has increased over time.[801]

Further statistics provided by the Ministry of Health show similar trends for the years 1996-2015. Māori consistently have higher rates of suicide than non-Māori, except for the 45-64 age band (see Figure 5.3, Figure 5.4, Figure 5.5, and Figure 5.6).

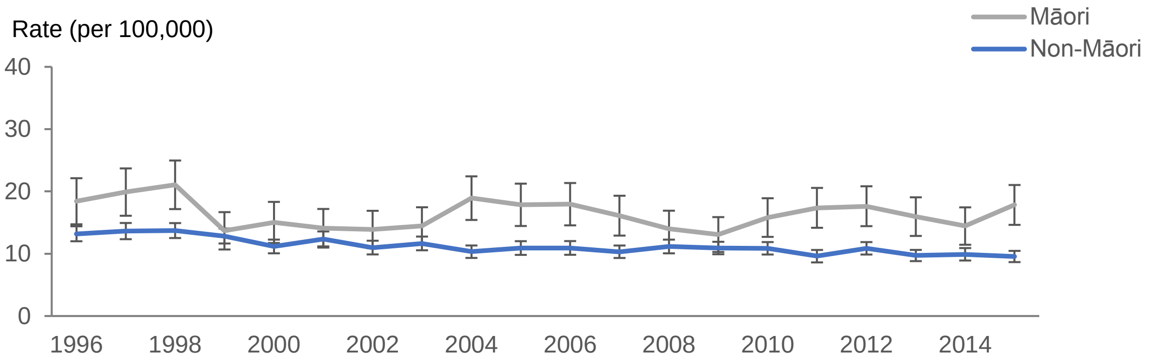

Figure 5.3 Age-standardised suicide rates for Māori and non-Māori, 1996-2015 (rates are expressed per 100,000 population and age standardised to the WHO World Standard Population) [802]

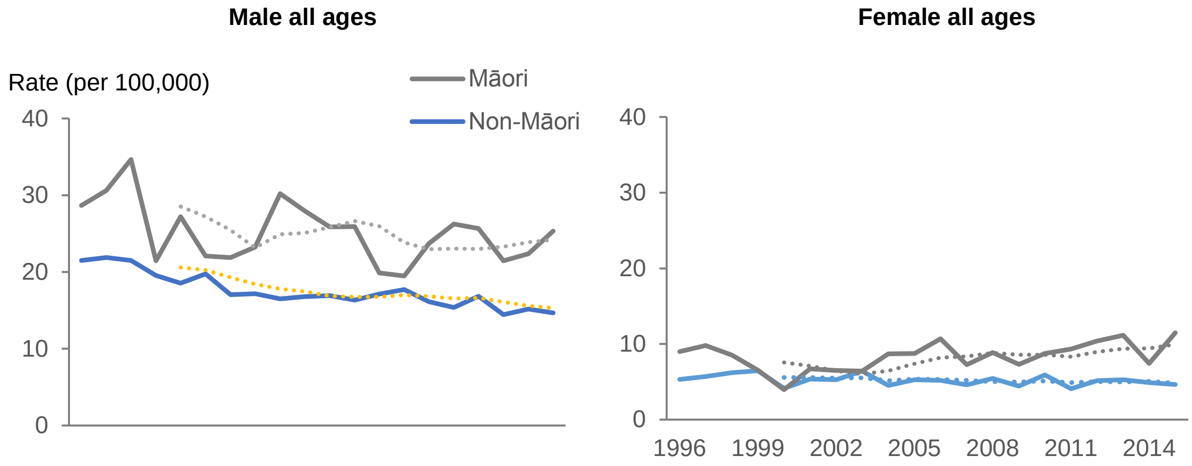

Figure 5.4 Age-standardised suicide rates for Māori and non-Māori, by sex, 1996-2015 (rates are expressed per 100,000 population and age standardised to the WHO World Standard Population, dotted line represents the five-year rolling average) [803]

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[801] Wai 2575, B2, 'Māori Health Trends 1990 – 2015 Project: Suicide and Self-Harm Module', 26 February 2019, p 1.
[802] Ministry of Health, 'Suicide rates by Māori/non-Māori', data provided to Timothy Gassin, 6 August 2019.

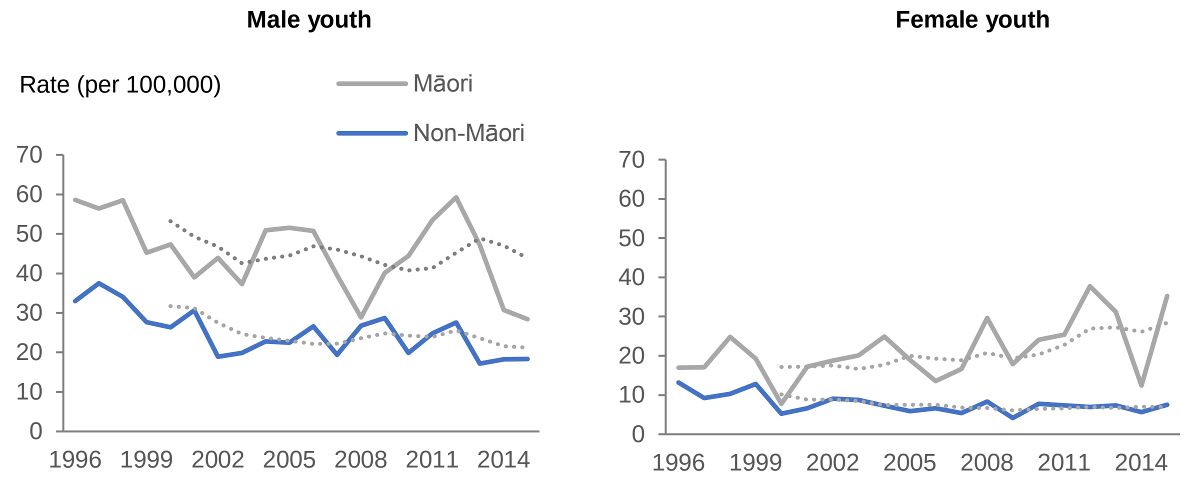

Figure 5.5 Age-specific rates for Māori and non-Māori youth (aged 15-24 years), by sex, 1996-2015 (rates are expressed per 100,000 population, dotted line represents the five-year rolling average) [804]

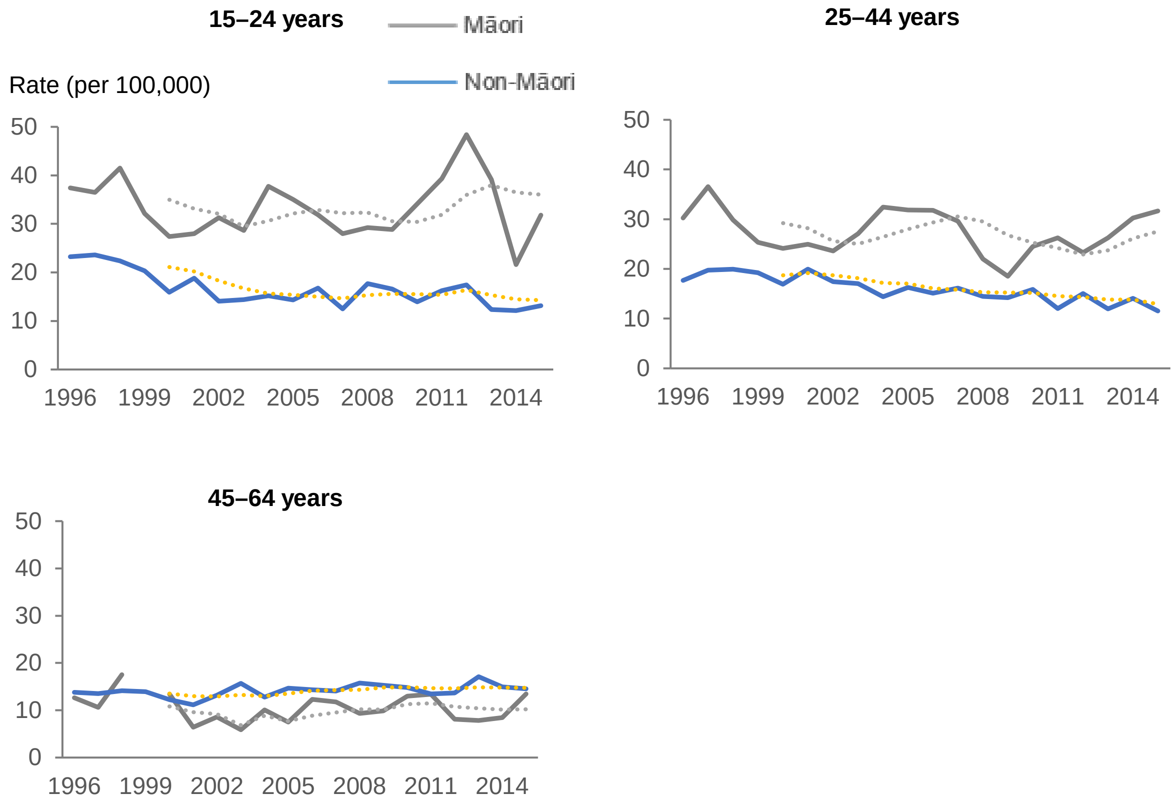

Figure 5.6 Age-specific suicide rates for Māori and non-Māori, by life-stage group (rates are expressed per 100,000 population, rates are not shown for Māori aged 65+ years or where a category has fewer than five suicide deaths, dotted line represents the five-year rolling average) [805]

‘Suicide rates by Māori/non-Māori’, data provided to Timothy Gassin, 6 August 2019.

[805] Ministry of Health, ‘Suicide rates by Māori/non-Māori’, data provided to Tim Gassin, 6 August 2019.

More recent provisional statistics published by the Ministry of Health show that in 2016 the suicide rate for Māori was twice the rate for non-Māori, for both females and males (see Figure 5.7). In particular, the suicide rate for Māori males increased significantly between 2013 and 2016 (from 2.12 per 10,000 to 3.17 per 10,000) and was the highest in 2016 for the 10-year period from 2007-2016.[806]

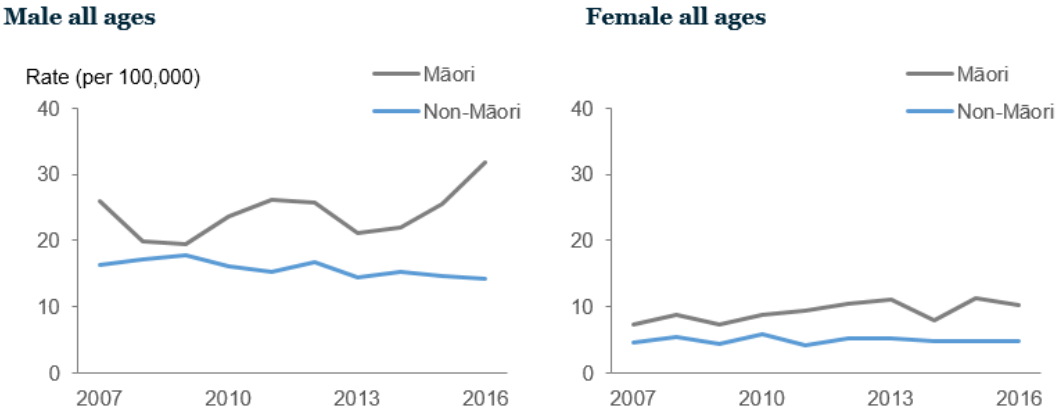

Figure 5.7 Age-standardised suicide rates for Māori and non-Māori, by sex, 2007-2016 (rates are expressed per 100,000 population) [807]

5.6 Self-harm

Intentional self-harm, as defined by the Mental Health Foundation of New Zealand, is 'the direct, deliberate act of hurting or injuring your body, but without necessarily wanting to die'.[808] This is an extreme way 'some people cope with intense or very difficult emotions, or overwhelming situations and life events' and it occurs at higher rates amongst young people.[809]

The reported incidence of self-harm occurring within New Zealand and internationally can vary dramatically depending on the definitions adopted and the methodology by which it is assessed. Garisch and Wilson noted that studies of self-reported non-suicidal self-injury (NSSI) amongst adolescents had indicated lifetime prevalence rates of between 7 per cent and 66 per cent.[810]

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[806] Ministry of Health, 'Suicide Facts: 2016 data (provisional)', Suicide data and stats, Ministry of Health, https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/suicide-data-and-stats?mega=Health%20statistics&title=Suicide, published 10 July 2019.

[807] Ministry of Health, 'Suicide Facts: 2016 data (provisional)', Suicide data and stats, Ministry of Health, https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/suicide-data-and-stats?mega=Health%20statistics&title=Suicide, published 10 July 2019.

[808] 'Self-harm' Mental Health Foundation of New Zealand, https://www.mentalhealth.org.nz/get-help/a-z/resource/49/self-harm, accessed 18 August 2019.

[809] 'Self-harm' Mental Health Foundation of New Zealand.

[810] The authors defined 'Non-Suicidal Self Injury' as 'the intentional, culturally unacceptable, self-performed, immediate and direct destruction of bodily tissue that is of low-lethality and absent of overdose, self-poisoning and suicidal intent. Suicidal self-injury is viewed as qualitatively different to NSSI'. Jessica Anne Garisch and Marc Stewart Wilson, 'Prevalence, correlates, and prospective predictors of non-suicidal self-injury among New Zealand

Their own survey of New Zealand adolescents revealed a lifetime prevalence of 48.7 per cent, with little difference found between males and females.[811] They noted that this rate was higher than that found in most other studies of NSSI, believing this was due to the use of a more comprehensive survey, but still concluded that 'NSSI is highly prevalence among New Zealand secondary school students'.[812]

Fitzgerald and Curtis, surveying New Zealand university students, recorded a lifetime prevalence rate of NSSI of 38 per cent, with a figure of 29.4 per cent for males and 41.7 per cent for females.[813] They found that Māori did not have a greater risk of NSSI than New Zealand Europeans, but rather that those in both of these groups were more likely to have a history of NSSI than those of other ethnicities.[814] The researchers thought the figures they found may have been elevated by the self-selection bias of participants.[815]

A survey of Wellington school students by Robinson et al. recorded a prevalence rate of NSSI of 19.1 per cent.[816] In this study, the researchers found that 'adolescents whose families are experiencing socioeconomic deprivations are a greater risk of poor mental health outcomes, including anxiety, depressions, and self-injury'.[817] However, they also found that, despite facing greater deprivation, 'Māori youth do not appear to be significantly more likely than non-Māori youth to report NSSI'.[818]

Results from the 2012 New Zealand Schools Survey, which posed a single question about self-harm, indicated that, amongst all respondents, 24 per cent had deliberately self-harmed within the preceding 12 months.[819] Amongst Māori respondents, the rate was 28.7 per cent, with a higher proportion of females (36.6 per cent) reporting self-harm than males (19.8 per cent).[820]

Besides surveys, self-harm prevalence is also measured through the number of hospitalisations, although naturally these figures capture only a small part of the overall problem. Hospitalisation rates for intentional self-harm in the early 1960s indicated that European and age-adjusted Māori rates were the same overall, at two per 10,000.[821] But between 1978 and 1990, Māori hospitalisation rates for self-harm were consistently higher than those of any other ethnic

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adolescents: cross-sectional and longitudinal survey data', *Child and Adolescent Psychiatry and Mental Health*, p 1, https://doi.org/10.1186/s13034-015-0055-6.

[811] Garisch and Wilson, 'Prevalence, correlates, and prospective predictors', p 5.

[812] Garisch and Wilson, 'Prevalence, correlates, and prospective predictors', pp 7, 9.

[813] John Fitzgerald and Cate Curtis, 'Non-suicidal self-injury in a New Zealand student population: Demographic and self-harm characteristics', *New Zealand Journal of Psychology* vol 46, no 3 (2017), pp 156, 158-159.

[814] Fitzgerald and Curtis, 'Non-suicidal self-injury in a New Zealand student population', pp 156, 159.

[815] Fitzgerald and Curtis, 'Non-suicidal self-injury in a New Zealand student population', p 161.

[816] Kealagh Robinson et al., 'Socioeconomic deprivation and non-suicidal self-injury in New Zealand adolescents: The mediating role of depressions and anxiety', *New Zealand Journal of Psychology* vol 46, no 3 (2017), p 130.

[817] Robinson et al., 'Socioeconomic deprivation and non-suicidal self-injury', p 133.

[818] Robinson et al., 'Socioeconomic deprivation and non-suicidal self-injury', p 133.

[819] Adolescent Health Research Group, 'The Health and Wellbeing of New Zealand Secondary School Students in 2012: Youth'12 Prevalence Tables (Auckland: Uniservices and Faculty of Medical and Health Sciences, The University of Auckland, 2013), p 97.

[820] S Crengle et al., *The health and wellbeing of Māori New Zealand secondary school students. Te Ara Whakapiki Taitamariki: Youth'12* (Auckland: The University of Auckland, 2013), p 22.

[821] F H Foster, *Maori Patients in Public Hospitals* (Wellington: Department of Health), p 24.

group.[822] As Robinson concludes, Māori rates 'were usually at least 50% higher than for Pākehā, and there was a rise in Māori rates from 1986, probably reflecting the increased youth suicide rate at the time'.[823] However, in contrast to suicide rates, rates of self-harm hospitalisation were higher for Māori women.[824]

Data filed by the Crown demonstrated that:

> Māori were more likely than non-Māori to be hospitalised for intentional self-harm, particularly since the early 2000's.
> There has been a steep increase in self-harm hospitalisation rates for females, particularly since the late 2000's.
> Over time, self-harm hospitalisation rates have increased for both males and females with a widening disparity particularly evident between Māori males and non-Māori males.[825]

In 1999, Cate Wilson showed 'deliberate self-injury is a significant social problem affecting youth in New Zealand'. [826] In her review of the evidence, Wilson found that rates of 'hospitalisation for youth (aged 15 to 19) from deliberate self-injury approximate 225 per 100,000'.[827] Wilson also noted the high rates for Māori women. 'From 1987 to 1993, an average of 488 Maori women per 100,000 population have been hospitalised each year'.[828]

Wilson concluded that while suicide and self-harm are often discussed together, deliberate self-injury should not simply be treated as an 'adjunct of youth suicide' and 'prevention strategies designed for youth suicide are problematic in terms of deliberate self-injury'. [829] Moreover, the government had 'no comprehensive plan' to reduce the problem and 'more attention' was needed to reduce 'deliberate self-injury, not only in the overall rate, but specifically in the Maori rate'.[830]

Research focussed specifically on self-harm amongst Māori has been limited, although within the last decade there has been some research on self-injury amongst rangatahi Māori and the effects of self-harm on Māori whānau.[831]

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[822] Ministry of Health, *New Zealand Suicide Trends: Mortality 1921-2003, hospitalisations for intentional self-harm 1978-2004: Monitoring report No. 10* (Wellington: Ministry of Health, 2006), p 24.

[823] Robinson, 'Te Taha Tinana', p 205.

[824] Ministry of Health, *New Zealand Suicide Trends: Mortality 1921-2003, hospitalisations for intentional self-harm 1978-2004: Monitoring report No. 10*, p 25.

[825] Wai 2575, B2, 'Māori Health Trends 1990 – 2015 Project: Suicide and Self-Harm Module', 26 February 2019, p 1.

[826] Cate Wilson, 'Ethnicity and deliberate self-injury: A review of the literature', in *Maori and psychology: research and practice - The proceedings of a symposium sponsored by the Maori and Psychology Research Unit*, ed N Robertson (Hamilton: Māori & Psychology Research Unit, 1999), p 1. Available at: https://researchcommons.waikato.ac.nz/bitstream/handle/10289/883/?sequence=1, accessed 25 February 2019.

[827] Wilson, 'Ethnicity and deliberate self-injury', p 1.

[828] Wilson, 'Ethnicity and deliberate self-injury', p 1.

[829] Wilson, 'Ethnicity and deliberate self-injury', p 1.

[830] Wilson, 'Ethnicity and deliberate self-injury', pp 7-8.

[831] See Casey Alexandra Mendiola, 'He Koha Aroha Ki Te Whānau: Deliberate Self-Harm and Māori Whānau' (Doctor of Clinical Psychology thesis, University of Auckland, 2011); Tahlia Erana Te Ao Mihi Kingi, 'Ko ngā pūtake o te mātānawe ki tā te rangatahi: An exploration of self-injury in rangatahi Māori (PhD thesis, Victoria University of Wellington, 2018); Tahlia Kingi et al., 'Mā te mātau, ka ora: The use of traditional Indigenous

5.7 Some possible explanations for the high Māori suicide rate

As stated earlier, the reasons for the high Māori suicide rate are complex and varied. Suicide rates are very much connected to rates of mental distress as well as a range of factors related to the impacts of social and economic events over time. There have been numerous studies carried out into the high rates of Māori suicide, but little analysis of the likely explanations and causes. The long term and ongoing effects of colonisation, cultural loss, and more recently, economic deprivation, have all been suggested as having close interrelationships with the increasing rates of Māori suicide.

In 1998, Dr Keri Lawson-Te Aho, who is also a claimant in this Inquiry, outlined a number of factors that, in her view, caused the high suicide rate among young Māori. She wrote that the 'idea that history affects the contemporary socio-cultural position and contemporary behaviour of youth is part of the analysis of suicide for indigenous peoples the world over'.[832] Lawson-Te Aho continued:

> One of the responses to enforced acculturation and colonisation for Māori was the establishment of negative behaviours as coping mechanisms for the trauma of colonisation. These have been transmitted inter-generationally through role modelling so that over time adverse behaviours have become normalised… Although it is hard to measure the exact impact of colonisation on contemporary Māori lives, the symptoms of Māori cultural crisis speak volumes about the impact of colonisation on Māori cultural institutions and Māori in contemporary Māori society… History is a living part of, and fundamental to, contemporary Māori realities.[833]

As discussed in relation to mental health in Chapter 1, unemployment and socioeconomic hardship are identified as key factors, especially in the 1980s and 1990s when Māori were disproportionally impacted by the recession and economic restructuring. In the 1995 *Hauora III* report, Eru Pōmare wrote that 'the trends of increasing suicide, homicide and mental ill health among Māori over the last decade indicate a classic picture of a population undergoing an upturn in unemployment and hardship'.[834]

More recent studies have reinforced this picture. The 2016 Suicide Mortality Review Committee report, which analysed data from deaths by suicide between 2007 and 2011, noted that half of rangatahi Māori lived in the lowest socio-economic areas around the country.[835] Many were unemployed, with 42 per cent of working age and 53 per cent mental health service users

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knowledge to support contemporary *rangatahi* Māori who self-injure', *New Zealand Journal of Psychology* vol 46, no 3 (2017).

[832] Keri Lawson-Te Aho, 'A Review of Evidence: A Background Document to Support Kia Piki Te Ora o Te Taitamariki' (Wellington: Te Puni Kōkiri, 1998), p 14.

[833] Lawson-Te Aho, 'A Review of Evidence', pp 14-15, 18.

[834] Pōmare et al., *Hauora: Māori Standards of Health III*, p 149.

[835] Suicide Mortality Review Committee, *Ngā Rāhui Hau Kura: Suicide Mortality Review Committee Feasibility Study 2014–15 Report to the Ministry of Health, 31 May 2016*. (Wellington: Suicide Mortality Review Committee, 2016) p 26.

(compared to the non-Māori rates of 30 per cent and 40 per cent respectively).[836] In her 2005 doctoral thesis on Māori suicide prevention, which involved interviews with 250 Māori who had attempted suicide (as well as 250 random, Māori community-based controls), Nicole M Coupe, found 'that poor general health status was the key risk factor associated with attempted suicide among Māori', suggesting that the broader inequalities in health outcomes played a role.[837] Coupe also identified that 'marijuana utilisation and interpersonal abuse are the next major risk factors'.[838] 'Having a notional identity', she suggested, 'and not being connected to Māoritanga … is associated with the risk of suicidal behaviour'.[839]

Mason Durie similarly argues that suicide does not have a single cause and cannot always be explained by mental illness. In his 2017 article, 'Indigenous suicide: The Turamarama Declaration', he sets out that suicide among indigenous peoples can be linked to both personal factors (such as mental illness, social and family adversities, and social disadvantage) and historically-embedded collective factors (such as colonisation, spiritual disconnection, loss of language and culture, and loss of land).[840]

Government strategy documents (which are discussed in more detail below) also provided possible explanations for the high Māori suicide rate. *Kia Piki Te Ora o Te Taitamariki* noted that the 'suicide rate of taitamariki Māori is probably linked to the historical erosion of those conditions which promote security of identity in taitamariki Māori, and in Māori in general'.[841] It continued, 'the alienation of people from their land and their culture subjects them to a fragmentation of identity and a loss of spirit'.[842]

In 2000, Annette Beautrais and David Fergusson found that socioeconomic advantage and colonisation were generally provided as explanation for the high rate of Māori suicide.[843] These explanations remained 'the subject of ongoing debate and speculation', lacking in conclusive evidence, though international studies linked the two when accounting for the high suicide rate among indigenous people in Australia, Canada, and the USA.[844] Beautrais and Fergusson added that explanations for the Māori youth suicide rate beyond these factors include the 'increased tendency for societies to become more individualistic' in the last two decades of the twentieth century, 'offering fewer opportunities for social identity and attachment'.[845] Another study suggested that there are potential dangers in an overemphasis of 'cultural risk', in that other 'potential protective factors may be overlooked'. In addition, it raised the issue of assuming

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[836] Suicide Mortality Review Committee, *Ngā Rāhui Hau Kura*, p 26.

[837] Nicole M Coupe, 'Whakamomori: Māori suicide prevention' (PhD thesis, Massey University, 2005), p iii.

[838] Coupe, 'Whakamomori', p iii.

[839] Coupe, 'Whakamomori', p iii.

[840] Mason Durie, 'Indigenous suicide: The Turamarama Declaration', *Journal of Indigenous Wellbeing – Te Mauri: Pimatisiwin*, vol 2, no 2 (2017), pp 60-61.

[841] Ministry of Youth Affairs, Ministry of Health, and Te Puni Kōkiri, *Kia Piki Te Ora o Te Taitamariki: Strengthening Youth Wellbeing* (Wellington: Ministry of Youth Affairs, Ministry of Health, and Te Puni Kōkiri, 1998), p 6.

[842] Ministry of Youth Affairs, Ministry of Health, and Te Puni Kōkiri, *Kia Piki Te Ora o Te Taitamariki*, p 6.

[843] Beautrais and Fergusson, 'Indigenous Suicide in New Zealand', p 165.

[844] Beautrais and Fergusson, 'Indigenous Suicide in New Zealand', p 165.

[845] Beautrais and Fergusson, 'Indigenous Suicide in New Zealand', p 165.

'cultural homogeneity among Māori', when 'Māori are a diverse group, both culturally and ethnically'.[846]

Writing about suicide among young people more generally, John C. Weaver and Doug Munroe explore the connections between neoliberal economic austerity and restructuring and youth suicide since the 1980s. They suggest a link between rising suicide rates in young men and economic restructuring, arguing that '"Rogernomics" affected young people materially and emotionally'.[847] In the public discussion of youth suicide, critics of the government pointed to economic retrenchment, while 'psychiatrists and psychologists alleged it was almost wholly a product of mental illness'.[848] 'Secondary literature, conventional documentary sources, and qualitative evidence' also pointed to 'retrenchment and restructuring' as key factors.[849] However, the authors add that such a connection was unachievable, and a variety of other factors contributed including that fact that 'retrenchment and restructuring coincided with a period when the sexual revolution and youth autonomy were working their way through the country's domestic culture'.[850] The use of 'hard drugs and cannabis were increasing' during this period, and numbers of 'young offenders … in remand centres and prisons' were increasing. Furthermore, as discussed in the first chapter, this was a time during which 'mental health services were in upheaval'.[851] These trends, Weaver and Munroe argued, 'converged in "a perfect storm" bearing down on young people'.[852]

The government's 2006 Suicide Strategy concluded that '[s]uicidal behaviour in Māori, as well as non-Māori, is closely linked to mental health status'. It also recognised broader issues, acknowledging:

> when set against the historical context, many other factors have been suggested as intensifying the risk factors for Māori. Suicidal behaviour among Māori today are extremely complex; however, ethnic and cultural differences and their effects on behaviour are important considerations in reducing Māori suicide.[853]

In a 2018 report commissioned for the Mental Health and Addiction Inquiry, Professor John D. Potter *et al.* explain that suicide is the 'outcome of a wide array of influences', which include:

- socio-demographic factors and restricted educational achievement;
- family discord and poor family relationships;
- the tendency to impulsiveness;
- what is termed externalising behaviour (anti-social behaviours and alcohol problems);
- what is termed internalising behaviour (e.g., depression);

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[846] S Collings and A Beautrais, 'Suicide Prevention in New Zealand, A Contemporary Perspective: Social Explanations for Suicide in New Zealand' (Wellington: Ministry of Health, 2015), p 9.

[847] John Weaver and Doug Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide: The Case of New Zealand, 1980–2000', *Journal of Social History*, vol. 46 no. 3 (2013), p 760.

[848] Weaver and Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide', p 761.

[849] Weaver and Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide', p 763.

[850] Weaver and Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide', p 758.

[851] Weaver and Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide', p 758.

[852] Weaver and Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide', p 761.

[853] Ministry of Health, New Zealand Suicide Prevention Strategy 2006–2016, p 21

- low self-esteem, hopelessness, loneliness;
- drug and alcohol misuse;
- a history of suicide attempts by friends and family members; and
- exposure to partner- or family-violence in adolescence.[854]

In submissions to the 2018 government inquiry, Māori pointed to 'diverse experiences of trauma, enduring adversity, cultural alienation and significant adverse life events', which were 'often associated with drug and alcohol challenges'.[855] Submitters also pointed to the increased risks for 'whānau with mental health needs who are in prison, those on bail awaiting sentencing, rainbow communities, those who are bereaved by suicide and those who have previously attempted suicide'.[856] The *He Ara Oranga* report added that '[n]early half of New Zealanders who die by suicide had recent contact with mental health services, and the Chief Coroner told us that many more are likely to have had contact with a general practitioner over the previous year. This suggests we are missing opportunities for preventative action and early intervention'.[857]

5.8 Government Strategies for Preventing Suicide by Māori

Over the past three decades, the government has produced a number of policy and strategy responses to the high Māori suicide rate, and especially for suicide among Māori youth.[858] As with mental health policy and strategy more generally, by the 1990s there was a growing awareness that Māori suicide prevention 'called for a different, more culturally relevant response'.[859] However, Lawson-Te Aho, who wrote a doctoral thesis on Māori suicide prevention in New Zealand, suggested 'the place of cultural values in suicide prevention such as the preservation and protection of whakapapa' and 'the potential of whakapapa healing and reconnection… appears to be problematic for government to believe in and act on'.[860]

Lawson-Te Aho theorises Māori suicide as 'an outcome of the wounding of the indigenous spirit as a result of complex trauma birthed during colonisation' and that this trauma has been 'transferred inter-generationally'.[861] She also details 'therapies for soul healing… in the context of

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[854] John D Potter *et al.*, 'Toward a Whole of Government/Whole of Nation Approach to Mental Health', Presentation to the Government Inquiry into Mental Health and Addiction by the Social Sector Science Advisors, May 10, 2018, p 8. Available at: https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/SSSA-report-Toward-a-Whole-of-Government-Approach.pdf, accessed 22 February 2019.

[855] Government Inquiry into Mental Health and Addiction, 'Oranga Tāngata, Oranga Whānau: A Kaupapa Māori Analysis of Consultation with Māori for the Government Inquiry into Mental Health and Addiction' (Wellington: Department of Internal Affairs, 2019), p 66.

[856] Government Inquiry into Mental Health and Addiction, 'Oranga Tāngata, Oranga Whānau', pp 66-67.

[857] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 183.

[858] See for example, *Kia Piki Te Ora o Te Taitamariki* and *In Our Hands: New Zealand Youth Suicide Prevention Strategy.*

[859] Keri Lawson-Te Aho, 'Whāia Te Mauriora, In Pursuit of Healing: Theorising Connections between Soul Healing, Tribal Self-Determination and Māori Suicide Prevention in Aotearoa/New Zealand' (PhD thesis, Victoria University of Wellington, 2013), p 96.

[860] Lawson-Te Aho, 'Whāia Te Mauriora', p 96.

[861] Lawson-Te Aho, 'Whāia Te Mauriora', p 8.

indigenous self-determination'.[862] Such therapies privilege Māori cultural worldviews, practices, and knowledge, and shift the 'focus from suicide prevention to healing of the wounds afflicting the spirit'.[863] In her thesis, Lawson-Te Aho interprets suicide as 'indicative of a loss of hope initiated from the historical legacy of colonisation into which Māori are born'.[864] Lawson-Te Aho's work provides a helpful overview of trends in Māori suicide, kaupapa Māori approaches, government strategies for Māori youth suicide prevention, and indigenous approaches to suicide prevention.

This chapter draws on Lawson-Te Aho's overview of government policy. In 1998, Lawson-Te Aho produced a review of evidence that supported the government's suicide prevention strategy for Māori, which is discussed below.[865]

5.8.1 Kia Piki Te Ora o Te Taitamariki and In Our Hands

In 1996, as the increase in Māori youth suicide was causing more concern, the Ministry of Youth Affairs, Te Puni Kōkiri, and the Ministry of Health began work on a youth suicide prevention strategy which, in 1998, was produced in two parts: *Kia Piki te Ora o te Taitamariki: The New Zealand Māori Youth Suicide Prevention* and *In Our Hands: New Zealand Youth Suicide Prevention Strategy.* While *In Our Hands* was described as 'inclusive of Māori', *Kia Piki te Ora o te Taitamariki* provided a 'suicide prevention strategy… specific to Māori'.[866] *Kia Piki te Ora o te Taitamariki* was developed after the three agencies – the Ministry of Youth Affairs, Ministry of Health, and Te Puni Korkiri – and 'the Mäori Reference Group agreed that a distinct strategy for Mäori youth suicide prevention should be developed'.[867] This was 'in line with the Crown's commitment to the Treaty of Waitangi', and designed to address the 'unacceptably high' Māori youth suicide rate.[868] Under *Kia Piki te Ora o te Taitamariki,* the Ministry of Health funded a programme in a number of Māori communities to address Māori youth suicides. As discussed below, 'this programme was re-focused to an "all age" suicide prevention programme' to reflect the broader change in strategy during the 2000s.[869]

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[862] Lawson-Te Aho, 'Whāia Te Mauriora', p 8.

[863] Lawson-Te Aho, 'Whāia Te Mauriora', p 20.

[864] Lawson-Te Aho, 'Whāia Te Mauriora', p 21.

[865] Keri Lawson-Te Aho, *A Review of the Evidence: A Background Document to Support Kia Piki Te Ora O Te Taitamariki* (Wellington: Te Puni Kōkiri, 1998).

[866] Ministry of Youth Affairs, Ministry of Health, and Te Puni Kōkiri, *Kia Piki te Ora o te Taitamariki,* p 5.

[867] Ministry of Social Development, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy' (Wellington: Ministry of Social Development, 2003), p 20; Ministry of Youth Affairs, Ministry of Health, and Te Puni Kōkiri, *Kia Piki te Ora o te Taitamariki: The New Zealand Māori Youth Suicide Prevention,* p 6.

[868] Ministry of Social Development (MSD), 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', (Wellington: Ministry of Social Development, 2003), p 20; *Kia Piki te Ora o te Taitamariki: The New Zealand Māori Youth Suicide Prevention,* (Ministry of Health, 1998), p 6.

[869] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', Report for the Ministry of Health (2014), p 3. Available at: https://www.health.govt.nz/system/files/documents/publications/kia-piki-te-ora-suicide-prevention-programme-evaluation-final-report-jun15.pdf, accessed 25 February 2019, p 3.

In 2000, the government approved funding for a programme as part of its 'Reducing Social Inequalities' budget programme, which was aligned with *Kia Piki te Ora o te Taitamariki*. It was entitled Community Development Programme for Taitamariki Suicide Prevention and consisted of six pilot programmes in six regions along with the development of informational resources. The programme was evaluated externally, and in 2003, Te Puni Kōkiri also undertook an audit at the request of Cabinet. This is discussed below in Section 1.6.[870]

The strategy did not come without its criticisms. In 2000, Coupe suggested that the national suicide prevention strategies *In Our Hands* and *Kia Piki te Ora o te Taitamariki* set 'broad goals and objectives, which together form a comprehensive but far too narrowly targeted approach to reducing suicide in Aotearoa/New Zealand'.[871] In her statement of claim, and also in her doctoral thesis, Lawson-Te Aho details some of the processes by which the strategy was created and implemented, and concluded that:

> What could have been a world leading social and cultural development programme grounded in history and identity, became essentially a service coordination programme that failed to reveal and capitalise on the identity construct of whakapapa in suicide prevention programming. The interpretation and application failed. Yet the vision and intent of Kia Piki te ora o te Taitamariki is still relevant today.[872]

5.9 Current Government Suicide Prevention Strategy

The Ministry of Health website includes an overview of what the government is focusing on to prevent suicide. The Ministry claims that 'New Zealand has had a long-term commitment to suicide prevention', which is currently informed by the New Zealand Suicide Prevention Strategy 2006–2016 and supported by the New Zealand Suicide Prevention Action Plan 2013–2016.[873] In the Ministry's words, these sit 'within the context of government-led mental health promotion and service development, and a wide range of initiatives that indirectly contribute to reducing risk factors for suicide at national and local levels'.[874]

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[870] Te Puni Kōkiri, 'Community Development Programme for Taitamariki Suicide Prevention Effectiveness Audit' (Wellington: Te Puni Kōkiri, 2003), featured in Wai 2575, A76(a), pp 310-353.

[871] Nicole M Coupe, 'Māori Suicide Prevention in New Zealand', *Pacific Health Dialog,* vol 7, no 1 (2000), p 25.

[872] Dr Keri Lawson-Te Aho, Statement of Claim, Wai 2626, 1.1.1, p 19; Lawson-Te Aho, 'Whāia Te Mauriora', p 108.

[873] 'What the Government is doing to prevent suicide', Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide/what-government-doing-prevent-suicide, accessed 25 February 2019.

[874] 'What the Government is doing to prevent suicide', Ministry of Health.

5.9.1 New Zealand Suicide Prevention Strategy 2006–2016

The 'New Zealand Suicide Prevention Strategy 2006–2016' built on *In Our Hands* and *Kia Piki te Ora o te Taitamariki*. The strategy had seven goals:

1. Promote mental health and wellbeing, and prevent mental health problems.
2. Improve the care of people who are experiencing mental disorders associated with suicidal behaviour.
3. Improve the care of people who make non-fatal suicide attempts.
4. Reduce access to the means of suicide.
5. Promote the safe reporting and portrayal of suicidal behaviour by the media.
6. Support families/whānau, friends and others affected by a suicide or suicide attempt.
7. Expand the evidence about the rates, causes and effective interventions.[875]

The Strategy acknowledged the key role of culture, stating that 'having a positive attitude about identity is important for Māori towards achieving cultural and spiritual wellbeing', and that 'culture influences expressions of health'.[876] It outlined the requirements of a suicide prevention strategy to address the high Māori suicide rate. Requirements included actions that worked to reduce 'the differences in suicide rates between Māori and non-Māori'.[877] Actions 'consistent with Māori needs and expectations', that utilised 'Māori concepts of hauora and whānau ora', and enabled 'the dual goals of Māori development and improvement of Māori health and well-being'.[878] The Strategy also acknowledged the need for responsiveness to Māori, for encouraging Māori participation 'in all levels of the health and disability sector', and 'effective partnerships with iwi and Māori communities'.[879]

The strategy also noted that suicide prevention required efforts wider than effective implementation of the strategy. It required broader policies and programmes in the areas of: mental health; alcohol and drug abuse and dependence; low income; unemployment; and a host of other social issues.[880] The introduction of the strategy outlined the need for a 'broader all ages response' rather than the previous focus on youth, which had garnered some criticism.[881] According to Lawson-Te Aho, author of the review of literature for the government strategy (and one that recommended a community approach), the 2006 'All Ages Strategy… departed from the Māori community development approach to suicide prevention contained in *Kia Piki te Ora o te Taitamariki'*.[882] A Māori Community Development approach refers to whānau, hapū, iwi, and Māori communities assessing their own needs and delivering initiatives to meet those needs with the goal of giving communities greater control over what happens in their community and increases their confidence to tackle problems. The move away from this approach has seen a

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[875] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', p 23.
[876] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', p 20.
[877] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', p 9.
[878] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', p 9.
[879] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', p 11.
[880] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', p 11.
[881] Ministry of Health, 'New Zealand Suicide Prevention Strategy 2006–2016', p 9.
[882] Lawson-Te Aho, 'Whāia Te Mairiora', p 95.

‘noticeable trend towards clinical interventions and the weakening of a strong focus on Māori community development, historical analyses of suicide and the value of cultural development for Māori suicide prevention’.[883] Similarly, the authors of the 2007 *Hauora* report noted that the ‘all age’ strategy needed to remain aware of the pattern in Māori suicide rates, where suicide among young people was a particular concern.[884]

As part of the shift, there was also a change in the nature of programmes at a local level. As mentioned above, under the 1998 New Zealand Youth Suicide Prevention Strategy, the Ministry of Health funded the programme ‘Kia Piki te Ora o te Taitamariki’ in a number of Māori communities, to address Māori youth suicides.[885] In 2005, the programme ‘re-focused’ to become an ‘all ages’ strategy, and it was renamed ‘Kia Piki te Ora’.[886] The programme funded nine regional providers to deliver the revised ‘all age’ Kia Piki te Ora suicide prevention programme, and employed seventeen coordinators in nine regions. The regions and the organisations involved included:

- Northland Far North: Te Rūnanga o te Rarawa
- Northland Mid North: Ngāti Hine Health Trust
- South Auckland: Raukura Hauora o Tainui Trust
- Bay of Plenty: Te Ao Hou Trust
- Lakes District: Te Rūnanga o Ngāti Pikiao Trust
- Hawke’s Bay: Te Kupenga Hauora – Ahuriri Charitable Trust
- Whanganui: Ngā Tai o te Awa Trust
- Christchurch: He Waka Tapu Ltd
- Invercargill/Southland: Ngā Kete Mātauranga Pounamu Charitable Trust[887]

Kia Piki te Ora was ‘intended to have a distinctive character and approach grounded in tikanga Māori’, a focus on services ‘by Māori and for Māori’, and programmes ‘focused on whānau ora and whānau wellbeing’.[888] Kia Piki te Ora providers had the ‘freedom to tailor their activities to their own region, incorporating the plans and needs of local iwi, hapū, marae and whānau’.[889] As discussed below, Kāhui Tautoko Consulting was contracted in 2014 by the Ministry of Health to produce an evaluation of the programme.[890]

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[883] Lawson-Te Aho, ‘Whāia Te Mairiora’, p 97.
[884] Baxter, ‘Mental Health: Psychiatric Disorder and Suicide’, p 136.
[885] Kāhui Tautoko Consulting, ‘Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report’, p 3.
[886] Kāhui Tautoko Consulting, ‘Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report’, p 3.
[887] Kāhui Tautoko Consulting, ‘Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report’, p 3.
[888] Kāhui Tautoko Consulting, ‘Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report’, p 3.
[889] Kāhui Tautoko Consulting, ‘Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report’, p 3.
[890] Kāhui Tautoko Consulting, ‘Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report’, p 4.

5.9.2 New Zealand Suicide Prevention Action Plan 2013–2016

The New Zealand Suicide Prevention Action Plan 2013–2016 was published in 2013 and set out to work towards the goals of the 2006-2016 strategy. One of the objectives was to 'support families, whānau, hapū, iwi, and communities to prevent suicide, and reduce the impact of suicide.[891] As action listed as part of this objective was to:

- Support Māori whānau, hapū, iwi, Pasifika families and communities to develop solutions to suicide through:
  - building the capacity and capability of Māori whānau, hapū, iwi and Pasifika families and communities, to prevent suicide
  - ensuring that culturally relevant education and training are available to Māori whānau, hapū and iwi and Pasifika families and communities that focuses on building resilience and leadership
  - build the evidence base of what works for Māori whānau, hapū and iwi and Pasifika families and communities to prevent suicide, through research carried out by, with and for these groups building the leadership for suicide prevention
  - build the leadership for suicide prevention.[892]

Other objectives include providing 'support for families, whānau, hapū, and iwi and communities after a suicide', and improving 'services and support for people at high risk of suicide who are receiving government services'.[893] The Ministry of Health and seven other government agencies are responsible for implementing the strategy (Education, Oranga Tamariki, Social Development, Youth Development, Justice, Corrections, and Police), while other agencies are also represented on an Inter-Agency Committee on Suicide Prevention (Te Puni Kōkiri, Ministry of Pacific Island Affairs, Ministry for Women, and Accident Compensation Corporation).[894] Cabinet received updates on progress with the New Zealand Suicide Prevention Action Plan 2013–2016 every six months. The government provided '$25 million over 4 years to implement the 30 actions in the New Zealand Suicide Prevention Action Plan 2013–2016'. [895] This included the establishment of the Te Au (previously Waka Hourua), the National Māori Suicide Prevention Centre, in 2014.[896]

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[891] Ministry of Health, 'New Zealand Suicide Prevention Action Plan 2013–2016', (Wellington: Ministry of Health, 2013), p 3.

[892] Ministry of Health, 'New Zealand Suicide Prevention Action Plan 2013–2016', p 4.

[893] Ministry of Health,'New Zealand Suicide Prevention Action Plan 2013–2016', p v.

[894] 'What the Government is doing to prevent suicide', Ministry of Health.

[895] 'What the Government is doing to prevent suicide', Ministry of Health.

[896] Feedback from Ministry of Health to Timothy Gassin on draft research report, *Māori Mental Health*, 31 July 2019; 'What the Government is doing to prevent suicide', Ministry of Health.

5.9.3 Replacing the expired Suicide Prevention Strategy

In April 2017, the Ministry of Health released a new draft strategy for public consultation. This process involved seeking submissions from the public and holding a variety of public and private meetings.[897] The completion of this strategy was, however, shelved in the lead-up to the 2017 election and no final version was ever adopted.[898] In its report released in late 2018, the Government Inquiry into Mental Health and Addiction recommended that the government '[u]rgently complete' the strategy and an implementation plan and this recommendation was accepted by the government in its response to the report in 2019.[899]

Subsequently, it has been reported that a new draft strategy and action plan, *Every Life Matters*, which aims for a 'future where there is no suicide', has been completed and circulated for feedback.[900] Unlike the 2017 draft, the 2019 draft strategy has not been released publicly, but rather was provided to a select group of stakeholders who were given only a week to provide comments. In comments to media, the Deputy Director General Mental Health and Addiction explained that this approach was adopted to avoid delay, noting that '[i]t is important we get a new strategy in place and don't relitigate the Inquiry'.[901]

5.9.4 Te Puni Kōkiri - Rangatahi Suicide Prevention Fund

In 2015, Te Puni Kōkiri established the Rangatahi Suicide Prevention Fund, which provides approximately $2 million per annum to reduce rangatahi Māori suicide and self-harm (a total of $10m funding for 38 organisations since 2015).[902] According to Te Puni Kōkiri, the programme focuses on a wide range of activities to increase 'visibility, kōrero, and understanding' around suicide.[903] It also works towards increasing confidence and participation in kapa haka and other cultural activities, leading to 'improvements in behaviour at school and increased communication around risk factors and suicide ideation'.[904] (Suicide ideation refers to thinking about or planning

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[897] 'A Strategy to Prevent Suicide in New Zealand: Draft for public consultation', Ministry of Health, https://www.health.govt.nz/publication/strategy-prevent-suicide-new-zealand-draft-public-consultation, last modified 26 June 2017.

[898] Jessica McAllen, 'Every Life Matters: Government's draft plan for a "no suicide" future', Stuff, https://www.stuff.co.nz/national/politics/113921721/every-life-matters-governments-draft-plan-for-a-no-suicide-future, last modified 2 July 2019

[899] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 187; 'Government Inquiry into Mental Health and Addiction', Ministry of Health, https://www.health.govt.nz/our-work/mental-health-and-addictions/government-inquiry-mental-health-and-addiction, last modified 6 June 2019.

[900] McAllen, 'Every Life Matters: Government's draft plan for a "no suicide" future', Stuff.

[901] McAllen, 'Every Life Matters: Government's draft plan for a "no suicide" future', Stuff.

[902] Feedback from Te Puni Kōkiri to Timothy Gassin on draft research report, *Māori Mental Health*, 31 July 2019; Te Puni Kōkiri, 'Rangatahi Suicide Prevention', https://www.tpk.govt.nz/en/whakamahia/rangatahi-suicide-prevention, accessed, 18 August 2019.

[903] Te Puni Kōkiri, *Pūrrongo ā-tu, Annual Report for year ended 30 June 2017* (Wellington: Te Puni Kōkiri, 2017), p 32.

[904] Te Puni Kōkiri, *Pūrrongo ā-tu, Annual Report for year ended 30 June 2017*, p 32.

the carrying out of a suicide, which may or may not actually result in a suicide attempt or death by suicide.) The programmes are 'delivered in a Te Ao Māori setting', incorporate tikanga, have a whānau-centered approach, promote cultural identity and pride, and emphasise Māori cultural frameworks to develop resilience and strength in rangatahi.[905]

5.10 Evaluations of government strategies for suicide prevention

Several evaluations and audits of government suicide prevention strategies and policies have been carried out:

- A Te Puni Kōkiri audit of the Community Development Programme for Taitamariki Suicide Prevention, 2003;
- Evaluations of the New Zealand Suicide Prevention Strategy, 2003 and 2005;
- Kia Piki te Ora local service delivery evaluation 2014.

Each of these are discussed in turn below. Also considered are the recommendations from the government's *He Ara Oranga* Mental Health and Addiction Inquiry report relating to suicide prevention strategies.

5.10.1 Te Puni Kōkiri audit of the Community Development Programme for Taitamariki Suicide Prevention, 2003

Te Puni Kōkiri audited the Community Development Programme for Taitamariki Suicide Prevention in 2003 at the request of Cabinet. The audit found that the programme was 'underpinned by a community development framework', that it had a 'robust contract monitoring mechanism', and that there was a 'high level of Māori involvement in both the implementation and evaluation of the programme'.[906] It also found evidence of 'consultation and ongoing communication between the Ministry and Māori stakeholders regarding the programme'.[907]

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[905] Feedback from Te Puni Kōkiri to Timothy Gassin on draft research report, *Māori Mental Health*, 31 July 2019; Te Puni Kōkiri, *Pūrrongo ā-tu, Annual Report for year ended 30 June 2017*, (Wellington: Te Puni Kōkiri, 2017), p 32; Te Puni Kōkiri, *Pūrrongo ā-tu, Annual Report for year ended 30 June 2018*, (Wellington: Te Puni Kōkiri, 2018), p 30.

[906] Te Puni Kōkiri, 'Community Development Programme for Taitamariki Suicide Prevention Effectiveness Audit' (Wellington: Te Puni Kōkiri, 2003), featured in Wai 2575, A76(a), pp 318-319.

[907] Te Puni Kōkiri, 'Community Development Programme for Taitamariki Suicide Prevention Effectiveness Audit', pp 318-319.

5.10.2 Evaluations of the New Zealand Suicide Prevention Strategy, 2003 and 2005

Five years after the 1998 *Kia Piki te Ora o te Taitamariki* and *In Our Hands* strategy documents, government decided to evaluate the effectiveness of the programmes. In 2003 and 2005, the Centre for Social Research and Evaluation/Te Pokapū Rangahau Arotake Hapori at the Ministry of Social Development provided an evaluation of the New Zealand Suicide Prevention Strategy in two parts.[908] The first part aimed to address the implementation of the strategy and what stakeholders' perceptions of the strategy were, while phase two would focus on in-depth studies and key findings that emerged out of stage one. Phase one found that it was 'widely commended as an excellent framework', and '[t]he inclusion of a separate framework for Māori was supported as illustrating a positive partnership approach and providing culturally specific information to improve the way that youth suicide prevention occurs for taitamariki Māori'.[909] It was noted that the strategy was an important 'reference tool' that guided local efforts, and that the understanding of youth suicide prevention had increased as a result. Stakeholders also identified the emergence of local initiatives, including the 'Kia Piki te Ora o te Taitamariki' (discussed below).[910] The report also noted that the youth suicide rate had 'declined significantly from a peak of 156 deaths in 1995 to 96 deaths in 2000', which saw the lowest number of suicides since 1986, but it did not directly connect this to the strategy and noted that other nations saw similar trends, including those without suicide prevention strategies.[911] Stakeholders believed that the strategy could be one factor in explaining the reduction in suicides, though the report concluded that the 'multi-causal nature of youth suicide and the need for improved Strategy implementation planning limited the extent to which improvements could be solely attributed to the Strategy'.[912]

However, the broad nature of the strategy was cited as a barrier to implementation in a practical way and the 'perceived inadequacy of planned implementation' was also cited.[913] The separation of the two strategies *Kia Piki te Ora o te Taitamariki* and *In Our Hands* meant that stakeholders often chose one which 'discouraged mainstream responsiveness to Māori, [and] mainstream use of the Kia Piki te Ora o te Taitamariki framework'.[914] Lastly, the evaluation dealt with the 'lack of clear information on intervention effectiveness', the nature of funding (funding came largely from the existing government agency baseline), and the main issues around 'barriers to effective

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[908] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy'; New Zealand Youth Suicide Prevention Strategy Phase Two Evaluation (Wellington: Ministry of Social Development, 2005); 'New Zealand Youth Suicide Prevention Strategy Evaluation Phase One and Phase Two', https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/planning-strategy/youth-suicide-prevention-strategy/index.html, accessed 25 February 2019.

[909] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', p 6.

[910] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', p 6.

[911] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', p 6.

[912] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', p 6.

[913] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', p 7.

[914] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', p 7.

implementation [that] mirror findings from other evaluative work within the state sector'.[915] It was this report that also suggested the focus be shifted to include all ages.[916]

5.10.3 *Kia Piki te Ora* local service delivery evaluation 2014

As mentioned above, in 2005, the government began focusing on an 'all ages' suicide prevention strategy. They renamed 'Kia Piki te Ora o te Taitamariki' as 'Kia Piki Te Ora', and continued to fund the programme in a number of Māori communities to address Māori suicide.[917] In 2014, Kāhui Tautoko Consulting Ltd carried out an evaluation of Kia Piki te Ora, which focused on service delivery across nine regions between July 2010 and December 2013.[918] The evaluation found, amongst other things, that:

- Kia Piki te Ora provided 'a way to coordinate locally developed and directed activities, giving effect to its intended role in coordinating change driven by or grounded in the community';
- Kia Piki te Ora providers were considered 'good at acting as a conduit between whānau, iwi, hapū and marae,… [as well as] other organisations such as the Police and District Health Boards';
- Kia Piki te Ora providers facilitated 'conversations in their communities to address suicide issues (whether preventatively or after suicides have occurred)';
- 'The focus on kaupapa Māori is seen as a strength of the programme, allowing providers to promote wellbeing in culturally appropriate ways';
- 'Stakeholders saw KPTO activities as successful because they were locally developed and adapted to local needs'.[919]

Drawing on interviews with stakeholders, the report found that while all stakeholders believed Kia Piki te Ora programmes provided valuable resources for suicide prevention in the local Māori community, the broad scope of the Kia Piki te Ora objectives made it difficult to assess the degree of impact.[920] Stakeholders also reported stronger relationships, improvements in communications, and the importance of Kia Piki te Ora in engaging with Māori in each region.[921] It also concluded that in some regions – such as Hawke's Bay, South Auckland, and Canterbury – the size of the area was too large for Kia Piki te Ora providers to cover with only a few coordinators.[922] The evaluations also 'highlighted a need for greater national coordination and leadership in several regions, including training for KPTO Coordinators,… [and] the development of resources for use at the local level'.[923] While the programme was delivered in a 'culturally competent way in all regions', some questions were raised about 'how well the

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[915] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', p 7.
[916] MSD, 'Phase One Evaluation of the New Zealand Youth Suicide Prevention Strategy', pp 7-8.
[917] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report'.
[918] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', p 4.
[919] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', p 4.
[920] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', p 5.
[921] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', p 5.
[922] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', p 5.
[923] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', p 6.

activities in the annual service plans reflected Māori models of health care or Māori views on suicide and suicide prevention'.[924]

Considering all the strengths and limitations of Kia Piki te Ora, the evaluation recommended the following:

> 1. Review KPTO objectives and the scope of services to ensure that they are realistic and consistent with Māori cultural values and views of suicide. If the KPTO programme is intended to primarily support suicide prevention, then it should be made clear that agency requests to support emergency responses is not the preferred focus.
> 2. Communicate expectations of the KPTO programme more clearly to a wide range of stakeholders, through a variety of means that include news media and common messages.
> 3. Review the distribution of KPTO providers in terms of both geographical distribution and the appropriate size of the region covered by each provider.
> 4. Consider establishing a structured national leadership mechanism for the KPTO programme. National leadership could provide training for Coordinators, develop consistent resources and guidelines, develop a consistent communication plan and brand, share information across different providers to improve learning about what works under different circumstances, and coordinate programme delivery.
> 5. Review funding levels for KPTO providers to ensure that they are able to meet their objectives.[925]

5.10.4 *He Ara Oranga* - suicide prevention recommendations

The Government Inquiry into Mental Health and Addiction made recommendations around suicide prevention, which included:

- **Urgently complete** the national suicide prevention strategy and implementation plan and ensure the strategy is supported by significantly increased resources for suicide prevention and postvention.

- **Set** a target of a 20% reduction in suicide rates by 2030.

- **Establish** a suicide prevention office to provide stronger and sustained leadership on action to prevent suicide

- **Direct** the Ministries of Justice and Health, with advice from the Health Quality and Safety Commission and in consultation with families and whānau, to review processes for investigating deaths by suicide, including the interface of the coronial process with DHB and Health and Disability Commissioner reviews.[926]

The report also suggested that 'raising awareness of suicide by itself was not enough', and 'prevention initiatives should be monitored and evaluated for effectiveness, and there must be

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[924] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', p 6.

[925] Kāhui Tautoko Consulting, 'Kia Piki Te Ora Suicide Prevention Programme Evaluation Final Report', p 7.

[926] Bold in original. Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 187.

avenues for people to access early support for their distress'.[927] Submitters to the inquiry questioned why the government did not have a national suicide prevention strategy.[928] The Inquiry panel suggested that suicide prevention lacked coordination and resourcing, and, as discussed below, families and whānau bereaved by suicide needed more support.[929]

The Government accepted the Inquiry's recommendations that related specifically to suicide, with the exception of the 20 per cent reduction target.[930] The Health Minister, Dr David Clark, stated that this recommendation was rejected because 'every life matters, and one death by suicide is one death too many.'[931]

5.11 Māori involvement in suicide prevention

Claimants in this Inquiry and Māori submitters to the 2018 Government Inquiry into Mental Health and Addiction have noted the lack of involvement of iwi, hapū, and whānau in the design and implementation of suicide prevention initiatives. As outlined in the summary of submissions to the government inquiry, submitters identified clinical support as important but also emphasised the importance of 'growing the capacity of whānau and communities to respond themselves, within their own cultural context'.[932] It outlined that '[w]hānau and communities, including rangatahi, require tools able to help them identify distress and provide support until appropriate help is able to be accessed'.[933] Submitters also advocated 'for culturally appropriate, whānau-centred, rangatahi-specific responses for rangatahi Māori affected by suicide'.[934]

5.12 Support for whānau following suicide in the postvention period

Claimants have raised concerns about the lack of support for whānau members after a suicide. This has been reinforced in submissions before the Mental Health and Addiction Inquiry. The Inquiry report claimed that 'hundreds of submissions from families and whānau affected by suicide highlighted serious deficiencies in how they were supported through an extremely traumatic process'.[935] The process following a suicide included 'lengthy police, coronial, DHB and Health and Disability Commissioner processes', during which time the bereaved were faced

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[927] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 80.

[928] The report noted that the draft national suicide prevention strategy prepared in 2017 has not been progressed. Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 62.

[929] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 14.

[930] 'Government Inquiry into Mental Health and Addiction', Ministry of Health.

[931] Jacinda Ardern and David Clark, 'Taking mental health and addiction seriously', Beehive.govt.nz, https://www.beehive.govt.nz/release/taking-mental-health-and-addiction-seriously, last modified 29 May 2019.

[932] Government Inquiry into Mental Health and Addiction, 'Oranga Tāngata, Oranga Whānau', p 67.

[933] Government Inquiry into Mental Health and Addiction, 'Oranga Tāngata, Oranga Whānau', p 67.

[934] Government Inquiry into Mental Health and Addiction, 'Oranga Tāngata, Oranga Whānau', p 68.

[935] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 48.

with 'inadequate communication from services and professionals, a sense of being disregarded and excluded, a lack of affordable professional services, services that were not culturally appropriate for their grieving, and processes that were traumatising rather than healing'.[936] In other words, submitters were calling for 'postvention', which the inquiry report defined as 'interventions in the aftermath of a suicide' which serves a 'dual focus on bereavement support and suicide prevention among those who have lost a loved one to suicide'.[937] One submitter stated: 'Those of us bereaved by suicide are the forgotten group, we're expected to get over it, get on with it and fall back into life as it used to be'.[938] The inquiry noted that the suicide of someone close was 'highly associated with increased suicide risk', and that 'support for people who are bereaved by suicide is extremely important'.[939] There was limited evidence, however, about 'the effectiveness of interventions to support people who have lost someone to suicide'.[940] For bereaved families, the coronial process is drawn out, sometimes taking years to complete with submitters to the Mental Health and Addiction Inquiry describing the process as 'adversarial and re-traumatising'.[941]

5.13 Conclusion

Suicide amongst Māori increased rapidly from the 1980s and 1990s, and today remains tragically high amongst whānau, rangatahi in particular. We still know very little about the exact causes of the high rates of suicide, but researchers and commentators agree that the causes are varied and complex and include ongoing historical trauma from colonisation, socio-economic deprivation, and cultural changes since the 1980s. Since the mid-1990s, when the increasing rates began to receive significant attention, the Crown developed several strategies designed to stem the high rate of Māori suicide. Research and independent evaluations of these interventions are mixed, with some suggesting that the programmes have been too broad and high level, while others suggest that the interventions work well in local communities and encourage sustained Māori involvement in suicide prevention. But despite these initiatives and prevention strategies, the rate of suicide for Māori sadly remains terribly high. It may be that turning around the high rate of suicide would require policies and programmes much broader than the health system alone can provide. It may need to include total systemic change – what Weaver and Munro call 'deep-prevention, consisting of measures that are long-term and pertain to health from cradle to grave, meaningful work, and far reaching education'.[942]

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[936] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 48.
[937] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 23.
[938] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 48.
[939] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 184.
[940] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 184.
[941] Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, p 183.
[942] Weaver and Munro, 'Austerity, Neo-Liberal Economics, and Youth Suicide', p 778.

The responsibilities of the Crown under the Treaty of Waitangi to address these disparities and to do so in consultation and partnership with Māori are also acknowledged by researchers, as well as by claimants in this Inquiry. In 2000, Coupe asserted that the government 'has a duty under the Treaty of Waitangi to ensure that policies and services are developed in consultation with Maori, that they are appropriate and effective for Maori, and that they reduce disparities in outcomes'.[943] Elsewhere Coupe noted that 'culturally appropriate strategies for Māori suicide prevention will enable policy makers, health purchasers and providers to address this important public health issue'.[944] Coupe added that the 'Treaty of Waitangi plays a pivotal role in the restoration of Māori self-determination', and the 'principles of protection, participation and partnership are all being violated while the number of Māori who are completing suicide remains at the extremes'.[945]

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[943] Coupe, 'Maori Suicide Prevention in New Zealand', *Pacific Health Dialog*, p 25.

[944] Nicole M Coupe, 'The epidemiology of Māori suicide in Aotearoa/New Zealand', in *Psychology in the South Pacific: Global, Local and Glocal Applications*, eds F H Bolitho, S C Carr, and B M Reilly (eBook published by the *South Pacific Journal of Psychology*), p 60. Available at: http://spjp.massey.ac.nz/books/bolitho/Chapter_4.pdf

[945] Coupe, 'The epidemiology of Māori suicide in Aotearoa/New Zealand', p 60.

Conclusion

New Zealand's mental health services and their interaction with Māori were transformed over the latter decades of the twentieth century. The number of Māori patients grew dramatically and this growth was, from the 1980s onwards, accompanied by a significant shift from the monocultural ethos that had dominated the mental health sector. Where once Māori perspectives were largely excluded and Māori staff rare, there were increasingly attempts to deliver culturally-tailored services to Māori and to increase their representation within the workforce. Simultaneously, the structure and nature of services was transformed by deinstitutionalisation and broader health reforms that encouraged the contracting out of many services, resulting in the dominance of community-based mental health treatment and the growth of Māori service providers. Given the starting point, the extent of transformation in these years must be considered significant.

However, neither the extent of change achieved nor the fact that the mental health system today recognises Māori needs, to a greater of lesser extent, in legislation, policies, and practices should be allowed to cloud the fact that there remain serious problems in New Zealand's delivery of mental health services. Too often, there have been yawning gaps between policy aspirations and practice in everything from governance arrangements to the ability of individuals to access basic services. It is also clear from claims to the Tribunal and the range of submissions to the recent Mental Health and Addiction Inquiry that many Māori believe that the system is not working for them.

Despite a widespread presence of Māori in health governance structures and advisory bodies, and requirements for engagement with Māori, it is not always clear how appointed Māori 'representatives' actually represent local Māori communities or how this Māori presence at the table translates into changes in practice. The story of Māori involvement in leading service provision is also very much a mixed one. While government efforts to increase the size of the Māori mental health workforce continue to bear fruit, the number of Māori mental health service providers has declined, some Māori service providers continue to feel they are constrained by restrictive contracting processes, and some Māori find they are unable to access the kaupapa Māori services they desire. It is clear that the aspirations of the health reforms of the early 2000s for greater Māori participation have not always been fulfilled.

Māori also continue to experience a range of barriers in accessing services. Many of these barriers are not unique to Māori. Indeed, a substantial proportion are the result of a system that is failing to deliver the services that people need, with major gaps in service delivery, high thresholds for admittance, and poor interconnection between services. Many of these problems have persisted despite having been recognised by the government for many years. A variety of other barriers will affect individuals differently depending on their financial means, place of residence, and access to transport and communications. Given high prevalence rates for mental illness and lower average socio-economic status, all of these barriers are likely to fall more heavily on Māori as a population group than on the New Zealand population as a whole. Māori may also face additional barriers on account of finding mainstream services culturally unacceptable and may have particular reasons to fear the use of coercive practices within mental health services and the potential negative consequences for themselves and their families that may result from engaging with services.

It is also impossible to ignore the fact that the prevalence of mental illness and suicide amongst Māori remains alarmingly and stubbornly high. Indeed, the disparities between Māori and non-Māori populations are readily apparent in regular surveys conducted by government bodies. Whether or not government should be collecting more thorough information, the problem is already plain to see. These long-standing disparities have played a substantial role in driving government mental health initiatives, yet the changes to policy and practice that have been made seem to have had little effect on them. As Mason Durie has noted, however, 'the incidence and prevalence of mental health disorders are not measures of the effectiveness of health services'.[946] Thus, the continuation of disparities cannot in themselves be regarded necessarily as a reflection of government policy failures regarding mental health services.

That does not mean that government policy has no effect on current mental health disparities, but rather that, in seeking to understand the ultimate causes of mental ill health amongst Māori, a much broader lens must be adopted. The full suite of government social and economic policy can have a profound effect on whether individuals and communities have a sense of security, purpose, and opportunity that allows them to lead happy and fulfilling lives. A thorough examination of the government policies that affect these broader determinants of mental health is well beyond the scope of what is possible in this report, but, without it, the picture that is painted here is inevitably only a partial one.

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[946] Mason Durie, 'Transforming Mental Health Services in Aotearoa New Zealand', in *Maea Te Toi Ora: Māori Health Transformations* (Wellington: Huia, 2018), p 72.

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Appendix 1

OFFICIAL **Wai 2575, #2.3.6**

IN THE WAITANGI TRIBUNAL

Wai 2575

CONCERNING	the Treaty of Waitangi Act 1975
AND	the Health Services and Outcomes Kaupapa Inquiry

MEMORANDUM-DIRECTIONS OF JUDGE S R CLARK COMMISSIONING RESEARCH

8 February 2019

Direction commissioning research

1. Pursuant to clause 5A of the second schedule of the Treaty of Waitangi Act 1975, the Tribunal commissions Dr Timothy Gassin, a member of the Tribunal's staff, to prepare a report on Māori mental health including suicide and self-harm, for the Health Services and Outcomes Kaupapa Inquiry.

2. This direction commissions the research originally commissioned from Ross Webb, which could not proceed and was previously cancelled.[1]

3. The researcher should focus on providing an outline of contemporary mental health services relevant to Māori, how these are implemented, the impacts and outcomes for Māori, and Māori responses. Māori participation in mental health legislation, governance and policy developments should also be examined, with a particular focus on the last two decades when the system changed from an institutional model to a model with greater emphasis on community and voluntary care.

4. The researcher will provide a brief outline of significant historical developments relevant to the development of the current health system including Māori historical experiences of government mental health services and how these may have contributed to any current barriers to service.

5. Utilising the four key topics identified in the pre-casebook discussion paper of disparity in mental health outcomes, accessibility of mental health services, responsiveness of mental health services and effectiveness of mental health services for Māori, where possible the overview will address:

    a. How does the contemporary mental health system, including legislation, policies and practices recognise and provide for Māori mental health needs? To what extent, if any, does implementation and outcomes diverge from policy objectives?

    b. To what extent does mental health policy and practice provide culturally appropriate mental health services and treatment for those Māori who require it, or provide for Māori led and developed systems and methods of mental health care/kaupapa Māori?

    c. To what extent have Crown acts or omissions, if any, contributed to disparities and how are these recognised and addressed?

    d. What barriers, if any, do Māori experience in accessing mental health services and what are existing Crown policies and practices for recognising any such barriers?

    e. How effective is current mental health monitoring and data collection for identifying and addressing any disparities in mental health services and outcome for Māori?

    f. How have shifts in national mental health policy during the last 20 years impacted on Māori and to what extent have Māori had opportunities to contribute to relevant policy and legislative developments?

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[1] Wai 2575, #2.3.5.

   g. What key historical developments have contributed to the current system of government mental health services for Māori and to Māori experiences and attitudes to mental health services?

6. As a new commissionee, Dr Gassin will require time to familiarise himself with the project and the materials gathered. The completed report draft will therefore now be made available to parties for feedback by 28 June 2019 to be followed by quality assurance and final revision with the final report filed by 30 August 2019. An electronic copy of the report and supporting documentation should be submitted to the Registrar in Word or PDF file format.

7. The report may be received as evidence and the author may be cross-examined on it.

8. The Registrar is to send copies of this direction to:
   - Dr Timothy Gassin
   - Claimant counsel, Crown counsel and unrepresented claimants in the Health Services and Outcomes Kaupapa Inquiry
   - Chief Historian, Waitangi Tribunal Unit
   - Principal Research Analysts, Waitangi Tribunal Unit
   - Manager Research Services, Waitangi Tribunal Unit
   - Manager Inquiry Facilitation, Waitangi Tribunal Unit
   - Inquiry Facilitator, Waitangi Tribunal Unit
   - Solicitor General, Crown Law Office
   - Director, Office of Treaty Settlements
   - Chief Executive, Te Puni Kōkiri

The Registrar is to send this direction to all those on the notification list for Wai 2575, the Health Services and Outcomes Kaupapa Inquiry.

DATED at Hamilton this 8th day of February 2019

Judge S R Clark
Presiding Officer
WAITANGI TRIBUNAL

Appendix 2

Summary of Claim Issues for the Māori Mental Health report

The following claims were identified as being relevant to this topic as at December 2018. The table is expanded from one prepared for the pre-casebook discussion paper.[947]

Wai	Named Claimants (Claim Name)	Issues
58	Nuki Aldridge & Patricia Jane Tauroa (Tribes of Whangaroa) Wai 58 1.1(j)	• Criticism of Māori culture and a failure to understand it led to significant mental health issues for Māori • Traditional knowledge should be better incorporated into the provision of health services
88/89	Ani Parata, Darrin Parata, Rawhiti Verdon Higgot and Lois Uruhina McNaught (88 Kapiti Island Claim, 89 Whitireia Block Claim) Wai 88 1.1 (e) & Wai 89 1.1 (d)	• Māori health issues consistently neglected • Mainstreaming of Māori health within health sector • Significant institutional barriers to Māori accessing healthcare • Neglect of inclusion of mental health within New Zealand historical record • Māori admission to psychiatric care more likely than non-Māori to have been based on referral from law enforcement • Lack of culturally appropriate mental health services
179	Colin Malcolm, Anne Davies & Huhana Seve (Māori Affairs Act & Burials and Cremations Act Claim)	• Forced abandonment of holistic lifestyle and healing methods • Inadequate delivery of service to mentally ill • Lack of accommodation of mātauranga Māori and rongoā in healthcare policy • Misguided and damaging practices of mental health care
421 593 869	Multiple Claim Names	• Failure to uphold health and wellbeing of generations • Need to interlink mental, physical & spiritual health • Overcrowding in houses experienced by Māori contributes to mental health issues

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[947] Crocker, pp. 57-59

1040 1247 1383 1890		• Lack of safe and securing housing had impact on Māori mental health
558	John Kameta, Te Rua Rakuraku & John Te Rehita Pio (Ngāti Ira O Waiōweka Rohe Claim) Wai 558 1.1 (b)	• Institutional discrimination towards Māori within health sector • Failure to improve poor health status of Māori • Failure to implement programmes and policy aimed at improving poor Māori health status • Lack of access to health facilities • Māori mental illness remains disproportionate • Need for Māori health providers which are hapū and community-specific • Need for wairua-driven treatment
605	Dr Terrence Lomax (Te Waimimiti Block claim) Wai 605 1.1 (c)	• Acts and omissions led to social, cultural, and emotional breakdown • Failure to provide for Māori with mental health issues and recognise the needs of the community • Forced urbanisation and an unfamiliar environment contributed to health-related issues • A failure to provide adequate services for transgender Māori contributed to mental health issues • Failure to recognise the causes of ‘Gender Identity Disorder’ (Gender Dysphoria) for Māori and continuing to ignore the causation of sexual abuse to mental health issues both have ongoing impacts for individuals • The invisibilisation of transgender Māori has had significant impacts particularly on mental health
619	Waimarie Bruce-Kingi (Ngāti Kahu o Torongare & Te Parawhau Hapū Claim) Wai 619 1.1 (f)	• Ngāti Kahu o Torongare me Te Parawhau not given same healthcare provision, services, and outcomes • Failure to consider Māori mental health within services • Lack of understanding of customary Māori practices • Suppression of Māori health practices and tikanga (wairua, mauri, te haa) • Undermining of traditional health practices

662 1575 1835 1838	Multiple Claim Names Wai 662 1.1 (f) Wai 1835 1.1.1 (d) Wai 1868 1.1.1 (c)	• Health and wellbeing of Māori is a taonga • Gap between Māori and non-Māori health statistics remained due to institutional discrimination • Closure of Taihape hospital and regionalisation of Hospital services • Inadequate representation of Māori on Whanganui Regional Health Board • Lack of input in decision making/provision of healthcare • Māori health disproportionately affected following economic downturns • Necessary inclusion of culturally appropriate treatment
864	John Hata, Russell Hollis & John Brown (Moutohora Quarry claim) (Amended statement of claim received, but not yet registered)	• Continued failure of Crown policy and initiatives for Māori • Widening of youth suicide statistics between Māori and Pākehā traced back to institutional discrimination towards Māori in the health sector while other statistics remain steady but wide. • Māori need to be included in decision-making especially regarding the provision of health services • Need for wairua-driven treatment • Necessary acknowledgement and use of traditional Māori medicines
874	Rawiri Brown (Mangatu Block Claim) 874 1.1 (d)	• Lack of consultation with Māori over provision of health services • Adoption of assimilationist policies to detriment of Māori health (and mental health) • Lack of provision for mental health disorders • Failure to include whānau in treatment • Lack of acknowledgement of traditional practices • Tikanga not acknowledged in health delivery models
884 1460 1941 2179	Multiple Claim Names Wai 884 1.1 (d)	• Created an environment of health service delivery which prejudices Māori • Māori disproportionately affected by suicide • Suppression of Māori medicines • Poorer access to medical services, particularly in rural areas • Lack of access to Māori health practitioners • No attempt to make available Māori medical practices

	Wai 1460 1.1.1 (b) Wai 1941 1.1.1 (a) Wai 2179 1.1.1 (c)	• Failure to address depression, self-harm and suicide • Failure to train and employ Māori health practitioners.
966	Gray Theodore, Pereme Porter & Rangimarie Maihi (Ngapuhi Ti Tiriti o Waitangi Claim) Wai 966 1.1 (c)	• Neglect of Māori health issues • Need for culturally appropriate treatment • Need to improve overall Māori health outcomes • Lack of prompt access for psychiatric patients in Te Tai Tokerau • Inadequate dementia services in Te Tai Tokerau • Need for mental health services for young people and those with maternal depression needed in Te Tai Tokerau • Māori mental health history has not been well researched • Lack of culturally appropriate mental health services
996	David Potter & Andre Paterson (Ngati Rangitihi Inland & Coastal Land Blocks) Wai 996 1.1 (j)	• Need for appropriate delivery of service to mentally ill • Lack of mental health care • Rapid urbanisation and substandard housing led to mental health issues for Māori • Need for acknowledgement of mental health of homeless
1536	Mary-Anne Tapu Baker (Descendents of Te Kemara uri o Maikuku raua ko Hua Claim) Wai 1536 1.1.1 (c) & (e)	• Lack of understanding of tikanga, hauora, rongoā and their significance • Lack of recognition of rongoā Māori as a taonga • Lack of knowledge regarding pathways for Māori care • A loss of tikanga and mātauranga relating to hauora has resulted from prejudices
1544 1677 2575	Multiple Claim Names	• Underrepresentation of Māori on decision-making boards • Failure to consult with Māori resulted in less effective service • Need for culturally appropriate services • Tohunga Suppression Act 1907 detrimental to Māori wellbeing • Strain of providing knowledge of traditional medicines on a volunteer basis

		• Disproportionately poor mental health outcomes for Māori
1666	Ani Taniwha (Ngati Hone Ngati Kawau, Ngati Kawhiti and Nga Uri o Te Pona (Taniwha) Claim) Wai 1666 1.1.1 (c)	• Failure to provide care for Māori with mental health disorders • Lack of recognition of mana and tikanga in health services • Cultural decay resulted from treatment of those suffering mental disorders
1732	Mate M Pihema, Cyril D Chapman & Oneroa M Pihema (Te Kohatutaka and Ngati Kiore (Pihema, Chapman and Pihema) Claim) Wai 1732 1.1.1 (b)	• Failed to address cultural and spiritual needs of Māori • Disconnection of Māori culture, language and customs denying hinengaro, tinana, wairua and whānau wellbeing.
1775	John Hata & Russell Hollis (Ngati Patumoana (Hata) Claim) Wai 1775 1.1.1 (a)	• Failure to improve health status of Māori compared with non-Māori • Regionalised health services decrease accessibility • Failure to deliver health outcomes when youth suicide statistics in Opotiki area so high • Māori self-harm, depression, and mental illness remain disproportionate • Need for methods to address the issues of mental health • Need for culturally appropriate treatment
1813	Tania Haerekitera Wolfgramm, Rachel Maunganui Wolfgramm, Wikuki Kingi, Te Uranga o Te Ra Kingi Tohunga, Puroku Fraser Tawhai Tohunga & Manuka Henare (Maori Health and Social Development (Wolfgramm) Claim)	• Māori more likely to access mental health services through criminal justice system • Māori have higher rates of mental illness • Higher rates of injury from intentional self-harm • Critically high injury rates from intentional self-harm among youth groups
1837	Deidre Nehua (Whanau and Hapu of Te Tai Tokerau Settlement Issues (Nehua)	• Māori healthcare providers face prejudice inhibiting their work • Mortality rate from suicide suggested to be higher in Te Tai Tokerau than nationally

	Claim) Wai 1837 1.1.1 (b)	• Mental health services not adequately provided in Northland • Little information on psychiatric treatment of Māori • Māori mental health neglected in historical record • Lack of resourcing to psychiatric hospitals post-war
1957	William Reihana & Wayne Petera (Maunga Kawakawa Block Claim) Wai 1957 1.1.1 (e)	• Historical Māori unfamiliarity with Western mental services • Urbanisation led to a rapid increase in Māori mental disorders and the breakdown of family systems to care for ‘porangi’ whānau • As Māori were not present in mental health facilities, the existing crisis was not acknowledged. • Overcrowding and type of housing led to mental health issues • ECT & lobotomy used experimentally • Mental health administrative practices culturally and spiritually inappropriate • Traditional Māori treatment options were not acknowledged • Loss of kaupapa Māori leading to hurt, humiliation, and damage to spiritual wellbeing • Active discouragement of kaupapa Māori inclusion in health policy
2006	Priscilla Sandys (Upokorehe and Whakatoia Hapu Claim)	• Suppression of indigenous medical and mental health knowledge
2051	Whetu Kenrick (Kenrick Whanau Mental Health Claim)	• Māori more likely to suffer from mental illness than non-Māori • Education, income factors in Māori suffering from mental illness • Māori have lesser access to health services and are less likely to use them
2060	Hinemoa Apetera (Apetera Whanau and Te Parawhau Whanau Claim) Wai 2060 1.1.1 (c)	• Health services built on whenua that was wāhi tapu excluding those who wished to uphold their tikanga • Alienation of hapū from wider community limited access to healthcare • Need to interlink mental, physical, and spiritual health
2217	Maringitearoha Kalva Emily Pia Broughton (Children of	• Diminishing mana causation of mental ill health

	Te Taitokerau (Broughton) Claim)	• Poorer health outcomes for Māori children which go on to affect mental health
2257	Maruhaeremuri Stirling for and on behalf of whanau, hapu and iwi of Te Whanau-a-Apanui (Te Whanau Apanui Mana Wahine (Stirling) Claim) Wai 2257 1.1.1 (e)	• Need for consultation over provision of health services • Treatment needs to be culturally appropriate • Key mental health services lacking • Youth and maternal mental health services needed • Poor housing contributor to poor mental health • Little research on Māori mental health
2476	Bryar Te Hira (The Tohunga Suppression Act (Te Hira) claim) Wai 2476 1.1.1 (a)	• Rongoā central to Māori identity • Māori have higher rates of schizophrenia, suicide than non-Māori • Failure to recognise te reo me ōnā tikanga in health services • Non-Māori prioritised over Māori for treatment • Failure to ensure adequate representation on health boards • Loss of mana and rangatiratanga within health sector
2494	Donna Awatere-Huata (Racism Against Māori Claim) Wai 2494 1.1.0001 (c)	• Māori youth suicide significantly higher than non-Māori youth suicide • Lack of input in decision making/provision of healthcare • Self-harm, depression and mental illness disproportionately affect Māori • Need for Māori-specific treatment centres
2510	Wiremu Te Kahika & Joe Kahika (The Land Confiscation (te Kahika) Claim)	• Health and wellbeing of Māori is a taonga • Gap between Māori and non-Māori health statistics remained due to institutional discrimination • Lack of input in decision making/provision of healthcare • Māori health disproportionately affected following economic downturns • Necessary inclusion of culturally appropriate treatment • Self-harm, depression, and mental illness disproportionately affect Māori
2599	Rawiri Jenkins (The Suicide and Self-Harm in Prison and	• Failure to provide spiritual, cultural, and mental health care, especially whilst in prison and police custody

	Police Custody Claim) Wai 2599 1.1.1	• Suicide rate in NZ prisons eleven times higher than general population caused by high rates of mental health problems and lack of psychiatric care • The higher incarceration rate of Māori men comparted to that of non-Māori means Māori men are at a greater risk of suicide and self-harm while imprisoned • Suggestion that reduction of Māori suicides in custody is most likely to be achieved by tackling overrepresentation of Māori in custody
2623	New Zealand Māori Council (The New Zealand Māori Council Health Claim)	• Poor delivery of services to mentally ill • Need for general incorporation of rongoā and matauranga Māori • Lack of mental healthcare • Misguided and damaging practices of mental healthcare
2626	Dr Keri Lawson-Te Aho (The Māori Youth Suicide Claim) Wai 2626 1.1.1	• The disparity in statistics of Māori and non-Māori suicide is widening • Current methods to address suicide are working for non-Māori, but not for Māori • The current system fails to address the disproportionate rates of suicide among Māori • Failure to include Māoritanga in the design of suicide prevention programmes • Māori are not able to determine the health policy and practices best suited to them • Māori public health has low visibility within core policy documents • Policy makers currently have no requirement to have cultural and political competency which has resulted in a failure to incorporate Māori culture into policy • The consultation process with Māori for health policy is arbitrary, inadequate, and tokenistic • Key recommendations made by Māori health hui remain unaddressed due to lack of accountability to communities
2632	Kereama Pene (The Māori Health (Orakei) Claim)	• Physiological, sociological, and spiritual states often disregarded • Failure of funding models of Māori health services • Continued failure to address spiritual wellbeing
2643	Rosaria Hotere, Jane Hotere and Whānau (The Mental	• Failure to provide healthcare to those suffering from mental health issues, including after

	Health, Addiction and Suicide Claim) Wai 2643 1.1.1	attempting suicide • Lack of acknowledgement of the high suicide rate for Māori • Failure to support whanau following an attempted suicide of a whānau member
2645	Susan Mary McKenna (The Canterbury Health Claim)	• Māori suffer significantly disproportionate ill-health compared to non-Māori
2648	Tina Latimer, James Eruera & Ricky Houghton (The Pamapuria Health Claim)	• Physiological, sociological, and spiritual states often disregarded • Failure of funding models of Māori health services resulting in lack of parity between Māori and Pākehā health providers • Continued failure to address spiritual wellbeing
2654	Marion Wilkie (The Meningitis & Coronial Policy Claim)	• Coronial laws/policy/practice breach tikanga and impact wairuatanga and mental health • Connection between racial discrimination and poor mental health • Clear link between over-crowding and poor mental health • Young child died and tikanga breached when it took 2.5 years for organ to be returned significantly affecting mental health
2670	Jack Rifle for and on behalf of Ngāti Te Wehi (The Treatment of Substance Abuse Issues Claim)	• High levels of substance abuse amongst Māori communities resulting in mental illness/psychiatric admission to hospital • No mental health facilities in rohe of Ngāti Te Wehi
2671	Jane Stevens, Nicky Taiaroa Macpherson Stevens (The Mental Health Services (Stevens) Claim) Wai 2671 1.1.1	• Suicide of son Nicky Stevens in acute inpatient care • Lack of genuine kaupapa Māori care • Waikato DHB's policy for assessment and management of patients at risk of self-harm expired over 2 years prior to Nicky's death • No relevant Waikato DHB policy regarding Māori mental health, risk harm to Māori, or Māori youth suicide • Institutional failures in the treatment and care of Nicky as well as the police handling of the search for Nicky • Failure to protect Māori and Pākehā mental health and wellbeing to the same standard
2673	Sheena Ross (The Sexual Abuse of Māori Wāhine and	• Negative mental health effects and psychotic disorders associated with child sexual abuse • Likelihood of sexual violence for Māori wāhine

	Tamariki Claim) Wai 2673 1.1.1	and tamariki almost twice as high as the general population which affects mental health statistics • Failure to incorporate tikanga into treatment for sexual abuse
2681	Stephen Henare (The Depression and Mental Illness (Henare) Claim) Wai 2681 1.1.1	• Interactions with the Serious Fraud Office, WINZ, and IRD have resulted in depression and mental illness suffered by claimants • Travel for attendance at meetings and interviews contributed to the strain on the claimant's mental health • Cultural safety was not guaranteed in meetings contributing to mental health issues • Depression suffered by the claimant described • Health and wellbeing as a taonga should be recognised and protected • Diminishing of mana by agencies led to mental health issues
2682	Richard Takuira (The Medical Practitioners Racial Prejudice Claim) Wai 2682 1.1.1	• Failure to remedy racial prejudice toward Māori patients • Racial prejudice and substandard treatment resulted in anxiety and emotional harm
2683	Hokimate Painting (The Bay of Islands Healthcare Claim)	• Failure to meet healthcare needs of Northland Māori due to inadequate DHB funding tools (PBFF) • Need for sufficient resources for mental health treatment • Failure to engage with Māori on planning and implementation of mental health treatment
2684	Lynne Russell (The Healthcare of Imprisoned Māori Claim)	• Overrepresentation of Māori in prisons affects all following points • Poorer mental health of those incarcerated • Sixty percent of inmates have diagnosed personality disorders • 52 percent of inmates experience anxiety and psychotic mood disorders • 20 percent experience suicidal ideation • 'At Risk Units' have limited access to appropriate mental healthcare • Risk of individuals hurting themselves minimised but not treated • Very few referrals for therapeutic interaction of mentally ill inmates • Higher rates of mental illness among inmates than public in general

		• Failure to provide equivalent care of inmates compared to the public • Lack of culturally appropriate treatment for claimant's brother after several suicide attempts
2685	Hemi Biddle (The Mate Māori and Mental Illness Claim) Wai 2685 1.1.1	• Electroconvulsive therapy/shock treatment used as treatment and management of mental illness despite being culturally controversial • Imposition of improper psychiatry practices has failed patients • Māori traditions and customs ignored pertaining to 'mate māori' • Lack of support of individuals with a mental illness and their whānau
2686	Tutu Ngarimu (The Tairāwhiti DHB and Mental Health Claim) Wai 2686 1.1.1	• Lack of culturally appropriate services for Māori mental illness sufferers • Failure to meet healthcare needs of Tairāwhiti Māori due to inadequate DHB funding tools (PBFF) • Failure to implement a suicide prevention strategy for Māori and specifically the lack of inclusion of kaupapa Māori in the programmes • Failure to address youth suicide among Māori • Under resourcing of suicide prevention programmes
2688	Glennis Rawiri (The Māori Health (Rawiri) Claim)	• Failure to provide assistance to whānau members suffering from mental illness and depression • Lack of acknowledgement of high incidence of suicide by Māori • Failure to provide assistance of whānau members affected by suicide • Lack of whānau-based initiatives in place to decrease suicide rates
2689	Rama Smith & Areta Koopu (The International Law Heath Obligations Claim)	• Māori adults have higher probability of having an anxiety or depressive disorder • Need for sufficient mental health resources
2695	Koreene Cracknell (The Ngāti Kuhungunu Children and Youth Mental Health claim)	• Lack of adequate care of mentally unwell children • 8-year-old child admitted as inpatient to adult mental health ward • Lack of mental health inpatient facility for youth • Failure to work in partnership with Ngāti Kahungunu to address mental healthcare needs

	Wai 2695 1.1.1	• Current inpatient mental healthcare and treatment fails to meet best interests of the child - United Nations Convention on the Rights of a Child not upheld in this instance • Lack of acknowledgement of tikanga Māori in treatment – taha whānau not acknowledged • Māori are less likely to request help for mental health than other ethnic groups • Prejudice faced due to lack of appropriate funding and services
2697	Anthony Brooking (The Holistic Māori Health Approach Claim)	• Failure to work with Māori represented in number of Māori suffering from mental illness • Physical and mental health need to be treated together rather than ignoring one • Significant overrepresentation of Māori with mental illness • Housing difficulties can be a factor in the deterioration of mental health • Importance of whānau not recognised by mainstream mental health services
2703	Georgina Beyer (The Takatāpui Healthcare Claim) Wai 2703 1.1.1	• Failure to recognise takatāpui as a gender grouping with specific healthcare needs • Takatāpui do not have equal or equitable access to healthcare • Lack of recognition of takatāpui in Human Rights Act and statistics collection • Failure to apply recommendations targeted at reducing takatāpui discrimination • Lack of gender identity recognition contributes to poor mental health
2719	Beverly Te Huia (Maternal Health Services Claim) Wai 2719 1.1.1	• Unfounded beliefs of maternal health practitioners that Māori are genetically more prone than Pākehā to psychosis • Desire to see further analysis of the Māori mental health disparities
2723	Maria Baker (Te Rau Matitini Claim)	• Mātauranga Māori should be central in mental health • Disproportionate number of Māori who suffer from mental health issues • Māori have ability to deal with mental health issues in appropriate ways and should be empowered to do so • Legislation leads to poorer mental health outcomes for Māori through lacking preventative and supportive measures • Māori suffer from mental illness at greater rates

		than non-Māori • Lack of culturally appropriate care and treatment for Māori • Socio-economic factors can lead to risk factors that trigger mental illness a swell as exacerbate symptoms • Needs of Māori population differ to those of non-Māori regarding mental health treatment • Younger Māori population more likely to suffer effects of social media use and impacts on mental health • Rural areas with large Māori populations have difficulty accessing care required • Whakamā has become a significant issue when considering mental health issues • Lesser access for Māori to primary care has a number of other impacts on wellbeing
2725	Michelle Levy (The Psychology in Aotearoa Claim)	• Māori overrepresented as consumers of psychological services • Systemic failures within psychology encountered by Māori • Failure to ensure registered psychologists are culturally competent • Low representation of Māori within Psychology profession having effects on treatment provided • Failure to support kaupapa initiatives related to mental health • Western psychology favoured over Māori psychology • No ability for Māori to specialise in kaupapa Māori psychology • Māori approx. 6% of total registered psychologists • Unavailability of Māori psychologists problematic in court, corrections, justice, mental health services, education and social development sectors
2728	Sharon Campbell (The Mental Health Services (Campbell) Claim)	• Ineffective support for individuals and whānau suffering from mental illness • Lack of culturally appropriate mental health services • Traditional healing practices have been attacked • Lack of consultation with whānau about preventative measures for mental health • Lack of support until mental illness is serious

		and psychiatric unit or medication is required • Māori affected by mental illness at rates higher than non-Māori • Failed to address intergenerational mental health issues and consequences • Mental health services not adequately resourced • Poor mental health care services in rural communities have huge effect on Māori • Assessment criteria results in misdiagnosis of mental illness for Māori • Rangatiratanga disregarded in the development of mental health care plans • Socio-economic outcomes for Māori affecting mental health • Current health system fails to account for Māori needs • Inadequate access to kaupapa Māori health services • Financial cost to assisting whānau with mental health where there was critical lack of support
2729	Susan Taylor (Mental Health Services (Taylor) Claim)	• Traditional treatment for mental health abolished with Tohunga Suppression Act 1907 • Research showing Māori mental health linked to social and cultural cohesion • Urbanisation detrimental to Māori mental health • Lack of cultural awareness leading to misdiagnosis of mental health problems • Māori significantly more likely to develop mental, anxiety, mood disorder than non-Māori or non-Pacific people • Maori are at highest risk of mental disorder across sex and age, educational qualifications, and equivalised household income • Failure to consult Māori over delivery of health services • Daughter of claimant took own life whilst in care of mental health services • Mana and wairua disregarded in treatment of Māori mental illness • Tikanga of death disregarded when daughter died which impacted claimant's mental health
2734	Tania Thomas (the Te Roopu Taurima (Thomas) Claim)	• Kaupapa Māori organisation which provides support services in mental health among other areas • Frameworks and policies have inhibited the

		organisation from further developing its kaupapa Māori approach
2737	Ada Ataimihia Lambert & Patricia Appleby-Lambert (Prison, Probation and Parole Healthcare (Lambert) Claim)	• Incorrect administration of medications whilst in remand • Mental stress and anguish caused by lack of adequate mental advice whilst remanded in prison • Inadequate care whilst in the care of the Crown
2738	Tētahi Kereme Nā Kahurangi Fergusson-Tibble (Mental Health and Addiction (Fergusson-Tibble) Claim)	• Claimant working in mental health and addictions field • Māori disproportionately affected by systemic failures and inequities in mental health and addiction services • Māori have higher overall rates of disorder than non-Māori • Māori experience lower contact with health services for mental health needs relative to need • Māori aged 15-24 years are two times more likely to die by suicide than non-Māori • Number of Māori employed in mental health and addiction sector does not reflect the number Māori who access the services (60% of total). • The number of Māori seeking mental health and addiction services also not reflected in funding allocations meaning levels are disproportionate to actual need • Culturally appropriate services not recognised or protected by the Crown • Māori working in mental health sector subjected to lower pay than Pākehā • Disregard for Māori tikanga, knowledge, and expertise in mental health sector • Less funding allocated for provision of mental health and addiction services for Māori • Very little support for Māori health kaupapa and initiatives • Need for more Māori to be working in the sector
2756	Arohanui Harris (Descendants of Ani Ngapera Claim)	• Māori have higher rates of suicide and self-harm than non-Māori • Burden of mental health treatment often falling on whānau