# Oranga Tāngata, Oranga Whānau

A Kaupapa Māori Analysis of Consultation with Māori for the Government Inquiry into Mental Health and Addiction

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# Executive Summary

*"Moemoeātia te moemoeā, engari whakatinanahia.*
*Dream the dream, but achieve it also."*
(Collective including lived experience, whanaunga of someone with lived experience, and kaimahi)

*"Mō tātou, ā, mō ngā uri ā muri ake nei.*
*For us and our descendants after us."*
(Māori organisation)

This report makes visible and audible the voices of whānau, kaimahi and iwi who made submissions to the 2018 Government Inquiry into Mental Health and Addiction. Collectively, they called for transformational change in the health system in order for Māori to achieve optimal wellbeing. Their view is that a paradigm shift is needed towards a system grounded in tikanga Māori values; one that is holistic, whānau-centred and decolonising, and which takes a life-course approach to wellness.

The dream articulated by submitters is for a flourishing Pae Ora society where whānau have ready access to all the determinants of good health: quality housing; education; employment; and to the practises handed down from tūpuna. It is a society where a kaupapa Māori approach is normalised, and reo, tikanga and interactions with the natural environment play a part in daily life. It is one where Māori are able to participate in practices and pursuits in order to maintain hauora; it is where there are strong connections between whānau, marae and whenua, and where society is grounded in the kaupapa of tino rangatiratanga, manaakitanga, mana, whanaungatanga and whānau ora; it is where whānau have hope and are empowered to determine their own futures. Such a society is centred on whānau wellbeing where time with whānau is valued and intergenerational connections are strong.

Submitters were clear that Te Tīriti o Waitangi must be at the heart of all solutions relating to mental health and addiction. Te Tiriti o Waitangi anticipates mutual benefits for Māori and the Crown and requires genuine partnership between the Crown and Māori to share decision-making that impacts on whānau, hapū and iwi – and for the Crown to transfer decision-making power and resources to Māori to support self-determination which is critical to Māori health and wellbeing. Strong Māori leadership is required with effective

collaboration across all sectors, including close relationships with Māori communities, to ensure appropriate service delivery and ongoing evaluation and improvement. Wellbeing needs to be positioned at the heart of all policy, practice and service development, and equity between tāngata whenua and tāngata Tīriti needs to be prioritised and well monitored.

Whānau Ora positions whānau as the experts in their own lives, and is a key mechanism through which to achieve systemic and structural change. *He Korowai Oranga, the Ministry of Health Māori Health Strategy* is a strong platform for guiding development, where the aspirational concept of Pae Ora encompasses the dimensions of mauri ora, whānau ora and wai ora, ensuring a holistic view of health and wellbeing. Kaupapa Māori and Whānau Ora services and strategies need to be prioritised, valued and appropriately resourced.

Cultural recovery – regaining language, heritage, custom, community - is important and whānau need access to their traditional practices for healing and daily life such as rongoā, mirimiri and tōhunga. A continuum of care is required that is collaborative and integrated, provided via a health system which is caring, flexible, trusted and non-judgemental.

What is also required is an equitable, diverse, multi-skilled workforce that is both clinically and culturally competent and able to work in a kaupapa Māori framework. The mana of Māori workers with tikanga, experience and community connections needs to be recognised, and the development of the peer workforce prioritised.

The lived experiences of Māori speak of a health system that is fundamentally racist and which serves to recolonise or marginalise them. It separates Māori from their whānau and identity as Māori, and fails to listen to or hear their concerns. This has resulted in distrust of a system that has ill served whānau over the years and has failed to respond to their needs as tāngata whenua, in many cases causing further harm. The criminalisation of mental health sees whānau enter the justice system at times when health care is needed, causing further harm. There are few services for those with mild to moderate distress and this unmet need means whānau distress can escalate before help is received.

Governmental contracting and funding criteria underserves kaupapa Māori services and community initiatives, encourages unproductive competition between services, and forces decisions to be made based on fiscal reasons rather than the needs of whānau. Access to health services is difficult, the system hard to navigate, and whānau are kept waiting or turned away. Communication is poor and accessing appropriate information on services and care is difficult. Whānau feel they are not listened to in a system that excludes them, and

there is considerable unmet need. Whānau are overmedicated in a system that fails to recognise their spiritual, physical and social healing processes.

The mental health and addictions workforce across all sectors does not reflect the communities they serve, there is an urgent need for more Māori in all disciplines. Staff shortages and high demand mean that workers have high caseloads, and are forced to deal with situations beyond their training. There is a disconnect between many health professionals and the reality of whānau lives, with limited awareness of the challenges they face.

Māori continue to feel the impacts of colonisation, with a disproportionate number of whānau living in poverty. The marginalisations experienced are many and complex; particularly for those who are homeless, live with a disability, or identify as takatāpui or LGBTIQ+. Māori are all too often denied the right to their language and culture, and whānau fragmentation and dispersal as a result of poverty, trauma, violence, suicide and addictions is now intergenerational. These experiences mean that many whānau experience fear, distrust, shame, stigma and feel they are a burden on the system therefore many don't access services when needed.

Healing requires sustainable long-term solutions, necessitating courageous commitment, innovation and determination. Kaupapa Māori models work for Māori. Through their experiences with the current system, Māori submitters collectively put forward a number of practical, achievable solutions to improve the system and service delivery, strengthen suicide prevention and response, further develop the workforce, and support whānau to be agents of their own wellbeing.

In brief, there needs to be a paradigm shift from the current biomedical and pharmaceutical focussed model of health to one that centralises holistic family wellbeing – oranga tāngata, oranga whānau.

# Contents

# Introduction

This report draws together Māori aspirations for the Government Inquiry into Mental Health and Addiction in Aotearoa (the Inquiry). Between February and September 2018, consultation hui were held around the country, and submissions to the Inquiry were received verbally, in writing, online, or via the 0800 freephone number.

The importance of this kaupapa for whānau, hapū and iwi cannot be overemphasised. Māori are disproportionately affected by mental health conditions, addictions, and by the system itself. These inequities are influenced by a number of drivers including colonisation, racism and socioeconomic factors. In recognition of these inequities, and of the relationship Māori have with the Crown under Te Tīriti o Waitangi, the Inquiry Terms of Reference determined there be specific consultation with Māori communities, whānau, hapū and iwi.

The opportunity to effect meaningful change in mental health and addiction policy and services, as well as in wider society, mobilised many individuals, whānau and groups to put forward submissions to the Inquiry. This report honours the voices of Māori present in the consultation process and is intended as a public record that makes those voices visible. Every submission that was identified as coming from Māori, or as containing a Māori voice, was read, analysed and contributes to this report.

*Oranga Tāngata, Oranga Whānau* sits alongside the formal Inquiry report *He Ara Oranga* which was presented to the Minister of Health in November 2018,[1] and also the *Submissions Summary Report* which was released in December 2018.[2]

*Oranga Tāngata, Oranga Whānau* draws out the numerous challenges and solutions for mental distress and addiction policy and services in Aotearoa, as voiced by whānau, hapū and iwi, and Māori working in health and other social service sectors.

*'Oranga Tāngata, Oranga Whānau'* was the name given to the Inquiry. It is used as the title of this report to privilege both the collective approach to wellbeing endorsed by Māori, and a collective voice. To appropriately honour Māori voices in the consultation process and give centre-stage to the insights and experiences of Māori submitters, most of the report is presented in the first person i.e. in their voices as submitted and recorded. Where words such as 'our' or 'us' are used, they represent the voices, views and opinions of Māori submitters; the authors of this report have taken care to faithfully capture themes from submissions and to not incorporate their own personal perspectives.

[1] https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf
[2] https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/Submissions-Summary-Report.pdf

The report comprises four parts:

Part A: Pae ora – a society in which we will flourish;
Part B: What works for us and what is needed;
Part C: Our solutions; and
Part D: Our lived realities.

Taking a strengths-based approach, this report places the aspirations of Maori submitters at the forefront, beginning with a description of 'Pae Ora - a society in which we will flourish' as Part A.

A key theme of the Inquiry was the need invest more in what is working and to change what is not. Part B gives an overview of the factors which Māori submitters determined are either currently working for them or which are needed. While it is not the purpose of this report to make recommendations, given those are set out in *He Ara Oranga*, Part C lists those values articulated by Māori submitters which must underpin any current and future change strategies for Māori. This is coupled with a list of practical, achievable solutions that were put forward by submitters, including whānau and kaimahi, during the Inquiry process. The transformational change and paradigm shift that they see is required is also described in this part.

Another key theme of the Inquiry was the importance of being listened to. Part D describes the current lived realities experienced by tāngata whai ora, whānau and kaimahi, as voiced by them throughout the inquiry process. Expressed in this section are the experiences of whānau with the system, the challenges faced by kaupapa Māori services and kaimahi, the pressure on the workforce, and most importantly, the impact on the mauriora of those most affected.

*"When we participate in hui like this we give a piece of our soul,*
*and we ask that you take care of it."*
(Hui participant)

*"The Panel has the opportunity to effect systemic change and to be here is exciting;*
*to nurture and reinstate Māori methodology and practices*
*for tāngata whenua o Aotearoa."*
(Hui participant)

## Data and analysis

The dataset for this report includes the meeting notes from 118 consultation hui, 96 written submissions, 74 online submissions, and three phone calls made to the Inquiry 0800 number – all of which were identified as coming from Māori respondents, or from hui where the voices of Māori were present.

There was some difficulty in identifying which of the over 5,200 submissions were from Māori. The paramount purpose of the consultation document was to hear the voices and obtain the views of submitters. Therefore, while the consultation document contained a number of questions about demographics to help determine ethnicity, these were voluntary. As a result, only partial demographic and ethnicity information on submitters and contributors was received. This necessitated the development of inclusion criteria to identify which submissions were from Māori. These were: referring to selves as Maōri; referring to whānau; using te reo; or referring to a Māori worldview. This process resulted in the identification of 74 online submissions and three phonecalls to the 0800 number as coming from Māori. Māori were also often included in group submissions (oral and written) though did not always articulate a distinctive Māori perpsective.

Written submissions were sent via email, postal delivery or were handed in in person at consultation hui. Of the total 96 written submission, 54 were identified as coming from Māori organisations, service providers and groups, 23 from Māori individuals with lived experience, 14 from kaimahi Māori and five from Māori whānau members of those with lived experience.

Māori voice in the consultation hui was identified by note-takers in attendance. Identification was based on whether speakers self-identified as Māori, or were personally known by the note-takers. While some hui contained a significant number of Māori, in many of the hui there was a sole or marginalised Māori voice present. In either case, hui notes were read in their entirety.

A kaupapa Māori analysis of the dataset was undertaken, which privileged the use of Māori principles (kaupapa) to build a strengths-based, thematic framework for analysis and develop the structure of the report. All submissions were assigned a unique identifier so that themes and quotes could be traced back to the source if required. Quotes have been used where possible to illustrate pertinent points – although the quotes from consultation hui may in some instances be less direct quotes and more paraphrased ones given the

written record of the hui was made by note-takers. All quotes have been anonymised to uphold the confidentiality of hui participants and submitters and be in accordance with the legal and ethical principles which guided the Inquiry.

## The Inquiry Process

Some participants expressed a level of doubt and dissatisfaction with the inquiry process. Participants questioned whether publicity around the Inquiry and submissions process had reached the intended populations, raised issues about the short time frames given for making submissions[3] and short notice periods for attending hui, and did not trust that positive change would result from the Inquiry. Barriers to online and written methods of submission were highlighted and a number of specific issues were raised about the consultation hui. Some participants said they felt unsafe in some hui locations (such as hospitals) and that these locations deterred greater participation by Māori, they raised issues about the lack of a tikanga approach at many of the hui and the marginalisation of Māori voices and some said they felt rushed and not adequately listened to.

On the other hand, participants also expressed gratitude at having the opportunity to speak and acknowledged the burden of responsibility for the Panel. They appreciated the passion and interest of the Panel, were hopeful for change and felt that the process of the Inquiry itself was healing. Pounamu were presented to each Inquiry Panel member by one Māori stakeholder in a gesture of acknowledgement, gratitude and trust, and with a wero to ensure they understood the significance of what the pounamu represented.

> *"Thank you for the privilege of speaking, sharing and making a stand for change."*
> (Whanaunga of someone with lived experience)

[3] Submissions were received during 7 of the Inquiry's extended 10 month timeframe in 2018

## PART A: Pae Ora – a society in which we will flourish

> *"Success looks like Pae Ora for our Whānau."*
> (Māori health senior management collective)

Submitters were clear that the aim should be for an equitable, decolonised society where Māori can live well and thrive. It is one in which a kaupapa Māori approach is normalised as a way of life, where tikanga and reo provide the pathways not only for Māori, but for all in Aotearoa. It is one where connections to marae and whenua are strong and to which there is regular access, and where resilient communities that maintain wellbeing and therapeutic environments for healing are promoted. We need a society and system that cares; that is based on manaakitanga, where we feel secure and are supported in raising our families, where we feel safe in sharing our stories and where we are confident in the system to seek help when it is needed. It is a society based on mutual trust and respect, where the acknowledgement of mana provides the foundation for all relationships.

> *"… a poverty-free country [where] everybody matters, [where] valuing people in employment [is important], [where] education in schools on drug prevention [is important], [where] mindfulness, self-confidence, empathy, caring, managing money, appreciation for what we have, [and] being a kaitiaki is important. [Where] everybody matters. A country that values all people and the best medical, health and educational services are there for all."*
> (Whanaunga of someone with lived experience)

Transformational change is required to create a health and social services sector that is well-informed, aware, non-judgemental, caring, nurturing, open-minded, discrimination-free, culturally aware, and with a united service provider approach under one roof.

In their vision for Aotearoa, kaimahi Māori describe a socially-responsive society that is informed by Māori health principles that are therapeutic, mana-enhancing, and do not create dependence. Kaimahi Māori speak of mental health and addiction services that genuinely reflect a Tiriti o Waitangi partnership, with equitable leadership and decision-making capabilities.

For many who made submissions to the Inquiry, a flourishing society was seen as one with connection to the natural environment, opportunities to participate in exercise and creative pursuits as part of daily lives and the maintenance of hauora. It is one which is centred on whānau, where we spend more time with our tamariki and mokopuna and intergenerational connections are supported. A flourishing society ensures us ready access to the determinants of good health and the maintenance of wellness.

In such a society, we have hope, we can make plans for the future of our whānau, we have shared aspirations and we are empowered as tāngata whenua to make our own decisions to realise these aspirations. In such a society, tāngata whai ora are treated equally with respect and dignity and are supported by a shared sense of collective responsibility.

In this society, mental health was seen as something that was no longer spoken about as distinct from overall wellbeing; it is no longer something that carries stigma, shame or punishment, and it is inseparable from the concept of individual and whānau health and wellbeing.

In essence, the submissions pointed to a transformative paradigm shift in our society: from mental health to oranga hinengaro, oranga whānau. To facilitate this shift, a commitment to listen to the voices of those most often disregarded is required. Courage and imagination are needed to enable local communities to lead the way. Transformation requires substantial determination and energy.

*"People in our communities want to flourish, be enabled and supported to thrive. We want to raise our children in a warm whare, connected to their marae, whānau and hapū, [where they] have access to their reo and culture, [and] access to education and employment."*
(Whanaunga of someone with lived experience)

*"We must embrace He Korowai Oranga and Pae Ora and bring it to life, with a holistic view and approach to how we care for and love and support our whānau."*
(Māori health senior management collective)

# PART B: What works for us and what is needed

## 1. System-level

### 1.1. Te Mana o te Tīriti o Waitangi

Māori submitters placed considerable emphasis on Te Tīriti o Waitangi as the founding document of Aotearoa/New Zealand.

A key part of Te Tiriti o Waitangi is the commitment made by Māori and the Crown to work together in partnership to realise mtual benefits and to ensure equitable outcomes for Māori, including in health and wellbeing. The Crown needs to take this commitment much more seriously and ensure both partners to the Treaty are included and engaged in strategy and policy making and funding decisions. There was recognition that a genuine commitment to Treaty partnership by the Crown requires strategic collaborations between Māori and all levels of the system, including with Ministers, Ministries, DHBs and other Crown entities. The need for a dedicated Māori Health portfolio within government was also suggested. The explicit targeting of policies and resources to address the inequities faced by whānau, coupled with equitable access to the determinants of health and wellbeing (such as housing and employment), are essential for Māori to thrive.

> *"We need a Pae Ora system that partners with tāngata whenua leaders as Tīriti partners."*
> (Māori leader)
>
> *"We are not interested in being told what it's going to look like. We want to be part of the group that says, 'Here's how we're going to do this. Here's how to design it: procurement, funding and contracting'. But we cannot do any of this without having any control at the top end."*
> (Māori health, education and social service provider)

Submitters also agreed that another key part of Te Tiriti o Waitangi is that it affirms the right of Māori to be self-determining and exercise their tino rangatiratanga – a right also affirmed in the United Nation's Declaration on the Rights of Indigenous Peoples. As such, Māori have developed their own successful health and wellbeing models, strategies and programmes of action, policies, priorities, resourcing and systems of service delivery. Key examples raised by submitters were the development of Māori health and social service provider organisations and the Whānau Ora model. They also asserted that the Crown needs to do much more to affirm Maori rights to be self-determining, including transferring decision-making power to Māori in relation to the health and wellbeing of their people and ensuring they have much more equitable access to resources.

Māori voices were adamant that the exercise of their rangatiratanga also means the inclusive representation of all those affected, and particularly those voices that are often marginalised by Crown processes such as rangatahi, the takatāpui and LGBTIQ+ community, wāhine Māori and kuia and koroua.

> *"Inclusion is a healing tool."*
> (Whanaunga of someone with lived experience)

### 1.2. Monitoring and accountability

A further concern raised in the submissions from Māori related to the inequity between the two Treaty partner populations, Māori and non-Māori. It is evident in almost all health outcomes. These inequities are significant, long-lasting, and in some cases, are widening over time. Government agencies, DHBs and service providers need to do more to improve service delivery for Māori and monitor their progress towards equity.

What will work for Māori is ensuring all legislation, policy and service provision is consistent with Te Tīriti o Waitangi, enabling a more concerted focus on equitable outcomes. To achieve this, high quality data by ethnicity is required. Wellbeing targets determined by Māori are also needed to measure progress. A national mental health and addictions performance management framework was suggested, that would include feedback mechanisms to inform continuous improvement, best practice evidence to achieve performance excellence, incentives, Indigenous service specifications and transparent reporting and publishing by ethnicity of system and service performance.

### 1.3. Intersectoral collaboration

Of the many concerns raised by Māori submitters, a repeated one was about the ways different parts of the system might work better with each other. Collaboration across all sectors is critically important. Mental health and addictions doesn't sit in the domain of health alone and instead spans all sectors, especially the justice system, social services and education. Intersectoral collaboration would help ensure that the ongoing improvement of mental health is a shared responsibility. Policy needs to actively promote collaboration.

> *"… so how do these services work alongside each other? There's nothing in the structure or policy to make true collaboration available—racist policy keeps us there."*
> (Kaupapa Māori service provider)

### 1.4. Leadership

The question of Māori leadership within the health sector was often highlighted in submissions. Māori leadership within Ministries, DHBs and other Crown entities is critical to ensuring we have decision-making power at a national level.

Leadership is also needed to focus more definitively on wellness – as well as sickness – such as through the establishment of a Māori Health and Wellbeing Commission, a Ministry of Mental Health and Wellbeing, the re-establishment of the Mental Health Commission with a clear brief to adopt a wellbeing framework relevant to Māori or the formation of an entirely new institution more broadly focused on wellbeing and more specifically concerned with Māori health.

> *"We as leaders need to change ourselves to see ourselves as agents of tāngata whenua who work for the Crown in order to ensure it honours the Treaty of Waitangi."*
> (Māori health senior management collective)

### 1.5. Having a strategic, community-informed direction

Submitters argued for the generation of deliberate policy with clear alignment between words, intent and implementation within their communities. The wellbeing approach in a culturally-grounded strategy such as *He Korowai Oranga: Māori Health Strategy* is seen as a strong platform for guiding consistent Māori health development across Aotearoa.[4] The concept of Pae Ora, incorporated into the revised strategy in 2014 builds on the government's vision for healthy Māori futures, encompassing the holistic concepts of Mauri Ora, Whānau Ora and Wai Ora – terms defined, determined and decided by tāngata whenua during the extensive consultation undertaken to develop this strategy. Developed in 2002, and refreshed in 2014, *He Korowai Oranga* needs to be further developed to more effectively guide actions and monitor accountability.

> *"He Korowai Oranga needs to be re-prioritised, and more coherent, with [the] United Nations Declaration on the Rights of Indigenous Peoples and Te Tīriti o Waitangi (Māori text), to ensure the improvement at organisational and local community levels, and across the whole health system."*
> (Organisation/service provider/group)

The Ministry of Health's 'Fit for the Future' focus in the 2016 updating of the *New Zealand Health Strategy* placed a stronger emphasis on equitable health outcomes for Māori and in future-proofing strategies.[5] The Mental Health Advocacy Coalition 2008 document *Destination: Recovery. Te Unga ki Uta: Te Oranga* articulated many of the ideas needed to inform the new systems and ways of thinking the Inquiry was seeking.

Māori submissions to the Inquiry also considered that policies must be responsive to the communities they serve, taking into account localised demographic differences including population structure, socioeconomic position, geographical features and the history, kawa and tikanga of each rohe. Responses must be timely, culturally-nuanced, participatory and

[4] Ministry of Health. (2002). *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.
[5] https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf

co-designed. Optimal solutions require iwi-specific responses across the spectrum, from research and knowledge generation to service and programme provision. Strong community engagement is the foundation of robust partnership, and is able to unlock community leadership, which in turn strengthens community repsonse for whānau, hapū and iwi.

> *"DHBs working for local solutions in partnership with Iwi is [the] way to go. We know our communities, [we] understand the nuances and issues."*
> (Organisation/service provider/group)

> *"We don't need to be 'engaged with' or 'consulted with'. We want to be at the table, we want to be part of the solution."*
> (Māori health, education and social service provider)

## 2. Service delivery

### 2.1. Whānau Ora

Whānau Ora is seen as a Māori wellbeing paradigm in action and in many submissions was widely noted as being particularly effective.

> *"Wai Ora/wellbeing is achieved using a Whānau Ora, whole-of-system and cross-sectoral approach across all services and activities which have the potential to contribute to flourishing individuals, whānau/family, communities and environments."*
> (Organisation/service provider/group)

Whānau Ora locates whānau as the experts in our own lives; as agents of change primed for success; as carriers of identity, culture and belonging. Whānau Ora is aspirational, culturally grounded, empowering, emancipatory, strengths-based, mana-enhancing and whānau-determined, rather than system or service-driven. Whānau Ora is tailored to specific whānau contexts and needs, offers holistic solutions and opportunities which invest in intergenerational development leading to sustainable outcomes, and engages with whānau at the earliest time, as determined by whānau.

Whānau Ora encompasses the collective impact of mental distress with whānau empowered to be informed and involved in long-term wellbeing. It provides opportunities to move beyond situations where whānau are overwhelmed, diminished and rendered powerless. Whānau own their wellbeing while Whānau Ora service providers facilitate the process for them.

> *"Whānau Ora as an aspirational framework of service provision supports whānau to actively pursue and determine their own sense of success and what this means for them."*
> (Organisation/service provider/group)

Whānau Ora is also a mechanism by which to achieve the systemic and structural change required as part of the movement towards a wellbeing paradigm. The recognition of Māori interconnectedness exists in contrast to the individualistic, interventionist approaches that currently dominate the system and service provision. The Whānau Ora approach can also be of benefit to diverse communities across Aotearoa, including immigrants and refugees.

> *"The kaupapa tuku iho of whānau relate to birthrights which are mana-enhancing and, therefore, conducive to best health. While this is an Indigenous solution, its application is not exclusive to Māori: every person is born into a family."*
> (Organisation/service provider/group)

Māori submitters identified the *Whānau Ora Outcomes Framework*, developed by Te Puni Kōkiri, as a useful tool to guide aspirational planning within whānau and to consistently measure progress and enable organisational learning about service effectiveness.[6]

The Whānau Ora concept could be expanded to Mauri Ora to cover a wider spectrum of services. A Whānau Ora Interagency Panel was proposed as a useful mechanism to faciliate its further development, with active representation from all sectors. Similarly, the establishment of a Ministry of Whānau Ora with an associated, increased Vote is also supported. Collective Impact methodology, which focuses on systems transformation and a structured approach to bringing together separate organisations to resolve complex issues within local contexts, is already used within Whānau Ora models and there is support for its further refinement and development.

Two key barriers to Whānau Ora were identified by submitters. Low governmental commitment to resourcing Whānau Ora and whānau-centred models of practice severely impacts the capacity of providers to meet whānau needs. Institutional racism was believed to underpin this apathy towards Whānau Ora. Renewed commitment within the context of a Tiriti o Waitangi relationship is critical.

The second barrier is the existing systems, structures and policies which limit opportunities and constrain the ongoing development of Whānau Ora. Whānau-directed outcomes are entirely achievable with adequate structural support. A 'decolonising-practice' approach is needed to assist institutions to genuinely move towards improving outcomes for Māori. This requires government agencies to relinquish their desire for overall control.

### 2.2. Kaupapa Māori service provision

> *"Our models actually work. Te Whare Tapa Whā actually works."*
> (Kaupapa Māori health provider)

It was clear from submissions that kaupapa Māori approaches were considered to be effective and accessible. The programmes that work for Māori are kaupapa and tikanga driven. They are culturally safe for both Māori and Pākehā. We need Indigenous responses for tāngata whenua. Kaupapa Māori services need to be self-determining and not be forced into a mainstream model of operating.

[6] https://www.tpk.govt.nz/docs/tpk-wo-outcomesframework-aug2016.pdf

Kaupapa Māori services are creative, innovative, revolutionary and resilient. Whānau need culturally safe, unhindered access to kaupapa and tikanga driven mental health and addiction responses that are underpinned by a commitment to address Māori health through a Māori world view or lens. The importance of whanaungatanga is recognised, and supporting whānau to reconnect to their whānau, hapū, iwi, maunga, awa and waka and to develop and strengthen connections within the community is an integral part of the healing journey. Some Kaupapa Māori services have mechanisms in place to facilitate this reconnection for individuals and whānau.

Kaupapa Māori recognises that positive cultural identity, whakapapa, traditional practices and wairuatanga are integral in the journey towards wellness.

*"They have given me the right to be me."*
(Representative of a collective)

*Whakapapa is theorised as the pathway by which profound healing of the wounded spirit can be achieved.*
(Whanaunga of someone with lived experience)

*"The actual act of performing your mōteatea is to get your grief out and be heard so that healing can result ... there are more opportunities to get [it] out through kapa haka, song, karakia."*
(Iwi leader)

We aspire for Kaupapa Māori service provision to become the norm.

Many services and programmes were endorsed in the consultation hui, such as:

- The Taiwhenua initiative;
- Ngāti Kahu programmes;
- Wāhine Tū;
- Youthspace;
- Like Minds, Like Mine;
- He Waka Eke Noa;
- Te Kūwatawata integrated model of care;
- CAFS (Child, Adolescent and Family Services);
- Te Pou Matakana framework;

- Waves programme;
- P-Pull;
- Wesley Community Action;
- Rangatahi units;
- We CAN;
- Oranga Tonutanga;
- Pā Harakeke model; and
- Te Ara Whiriwhiri.

### 2.3. Shared experiences

For Māori submitters, people with lived experience and peer relationships were seen as key players in services for Māori. Shared experiences make a difference to success. Ex-addicts present a great opportunity to develop the peer workforce, with the opportunity, for example, for past drug users from all areas of addiction to support the wellbeing aspirations of current users. The greatest opportunity for response is our tāngata whai ora; programmes that are designed and often led by tāngata whai ora are effective, however, the imprisonment of so many tāngata whai ora limits this opportunity. People who have been bereaved by suicide need help from others bereaved by suicide.

### 1.1. By the community, for the community

*"What's working in the community?*
*Community is working in the community."*
(Hui participant)

*"We don't work in the community, we ARE the community."*
(Social worker)

A community focus was a recurring theme in the Māori submissions. What works are community-led initiatives designed from the ground up by clients. They recognise that the majority of support happens within the community. Such initiatives take a strengths-based

approach, build on what's working and shift leadership to the community. There is automated feedback within this structure that constantly assesses what whānau need and what works best.

Successful initiatives are those that use Whānau Ora and iwi opportunities, are driven by the needs of our people and have workers from local areas working with their own communities. Frameworks and models with whānau at the centre are most successful. This necessitates flexible, unrestricted funding structures that allow community organisations to provide what they know is needed, facilitated by a framework or model that is kaupapa Māori.

> *"It's not even a model, it's a family."*
> (Hui participant)

### 1.2. Holistic responses and finding healing outside the biomedical model

> *"No one wants anything from me here, except to see me well."*
> (Graduate of Kaupapa Māori programme)

For a wide range of Māori submitters, holistic responses and collective impact models were seen to work best. We are better placed to consider overall wellness by removing the barrier between mental health and physical health. Effective healing is found outside the biomedical model of care and through activities such as art, craft, music therapy, rongoā clinics, community gardens, diving, sharing of kai, gathering kaimoana, digital storytelling and activism. Rangatahi have responded well to programmes that include mindfulness, sleep, hygiene, sensory boxes, outings, cooking, nutrition, life skills and positive journaling. We need to teach our tamariki and rangatahi how to recognise and express emotion, and healthy strategies to cope with emotional challenges.

Improved information sharing about these wellbeing and healing pathways is important. Participating in cultural wellness pursuits such as Te Matatini, Patu Aotearoa, waka ama and Iron Māori maintain wellbeing. We need a de-medicalised approach: clinical narratives

undermine and oppress Māori. Cultural recovery is important, re-learning that it's special and unique to be Māori; learning pepehā, waiata, reo, karanga, kapa haka, maara kai, and having tuakana-teina models and kaumatua support. The power of recovery is in connection, identity, belonging, unconditional acceptance, working together and wairuatanga.

Homelessness and poverty are also considerable drivers of stress. Finding homes for whānau and securing financial support, including via improved access to paid employment, is a priority in order to be able to deal with mental illness and addiction. The spectrum of wellbeing services must reflect the realities and diversity of our whānau.

> *"Addressing the cultural, environmental, socio-economic and historical factors that have impacted the mental wellbeing of Māori, through cultural paradigms such as whakawhanaungatanga, has been the domain of Kaupapa Māori mental health services for decades."*
> (Organisation/service provider/group)

### 1.3. A continuum of care that is collaborative and integrated

> *"We don't want to go shopping around.*
> *We don't want to go from service to service.*
> *We don't want to tell bits of our story here and there."*
> (Kaupapa Māori service provider relating clients' comments)

Submissions from Māori identified the need for joined up services. What works is excellent, timely referral flow between and across services. This requires collaboration, integration, co-designed solutions and co-location of health and social services for ease of access so the best-fit service for whānau can be identified. Communication is important, where the 'kumara vine' is effective for information sharing.

What also works are funding models based on collaboration, which are whānau-centred and which go directly to the community services, allowing for flexibility and reflexivity.

A collaborated integrated approached aided the survival of Christchurch services following the earthquake.

### 1.4. Appropriate, flexible, reflexive, sensitive, caring services

> *"They give me a kiss and a hug and ask me how I am."*
> (Kaupapa Māori service user)
>
> *"It's lifted me and loved me back to life."*
> (Kaupapa Māori service user)

Some submitters saw effective services as those that see gaps and take risks, incorporate what whānau want and allow growth and development to be whānau-led. They are fluid and adaptable, create healing spaces and do away with the idea they are here 'to fix you'. A service must be able to feel the pain and challenges but be able to sit with you and build a programme to suit. It's about aroha.

> *"She would do things not in her job description, she helped with housing and went the extra mile."*
> (Hui participant)

To do good work for whānau, there is a need to go above and beyond what the institution supports and recognises as mahi. What's useful is flexible funding to meet whānau need. High trust, sustainable contracts make a difference to how kaupapa Māori services are able to function and recruit and retain able staff.

Examples of good funding models included Te Taiwhenua o Heretaunga and Te Kūwatawata in Tairāwhiti where the DHB provides the funding and the Iwi prioritises where it goes. Te Pou Matakana (North Island Whānau Ora Commissioning agency) was also mentioned as a successful funding model.

## 1.5. Responding to trauma

Trauma and adversity were specifically raised as the root causes of much mental distress, addiction and suicide. A considerable amount of trauma experienced by our whānau is related to colonisation and includes racial discrimination and the lack of recognition of mātauranga, tikanga and te reo Māori. Racist behaviours and subtle insinuations about Māori are an ongoing source of adversity. Trauma is both individual and transferable from generation to generation. Left unresolved, this contributes to mental health and addiction issues. Whānau are traumatised when they lose a loved one to suicide. Many whānau experience trauma as a result of adverse experiences within the health system itself.

Particular groups within our population are particularly vulnerable to the impacts of trauma, such as those who have a history of institutionalisation – for example, those who are or have been imprisoned, those who are or have been held in youth facilities and those who are or have been wards of the state – and also those who have experienced historical trauma from other colonising actions.

*"...often mental health is [the] outcome of addiction.*
*And they got to the addiction place because of trauma that's happened."*
(Whanaunga of someone with lived experience)

*"Our kids look to 'P' for relief from trauma."*
(Social worker)

*"Addictions can only be understood by looking at*
*historical trauma of land loss … widespread uplifting of children*
*by the state and language loss."*
(Kaupapa Māori research institute)

Trauma in all its forms needs to be recognised as a contributor to mental distress. Identifying and eliminating systemic racism within mental health and addiction services is key to healing. The impact of different kinds of trauma on mental health requires different approaches. We need culturally appropriate, relationship-based responses to trauma support.

The Tūramarama Declaration acknowledges the trauma of suicide and provides an Indigenous response. The taha Māori programme once run at Hanmer Springs' Queen Mary Hospital, although no longer running, was identified as particularly effective for whānau and a desire for its reinstatement was expressed.

## 2. Workforce

> *"Having Māori working in the services, seeing a Māori face and hearing te reo, there is healing in there that is not currently valued."*
> (Hui participant)

### 3.1 A culturally competent workforce

In their submissions, Māori providers were particularly concerned with the need for cultural competency in the workforce. What works is an equitable, diverse, multi-skilled, clinically and culturally competent workforce that is able to work holistically within a wellbeing framework for whānau. Meaningful staff engagement with whānau is best supported when mental health and addiction workers – both Māori and non-Māori – have access to ongoing, high quality, Māori-led professional development opportunities.

Areas identified as having a particular need for an increased dually-competent (clinical and cultural) workforce include: psychologists; psychiatrists; medical officers; occupational therapists; maternal mental health; perinatal, child and adolescent mental health; and early psychosis intervention workers and service areas.

The need for a more culturally competent workforce is not just limited to the health sector but is needed in the social services and justice sectors also, including, for example, in social work, nursing, counselling and the Police. There needs to be an explicit whole-of-system commitment to improving equity for Māori, including by the non-Māori workforce in these sectors. Reliance on an international workforce is a consideration with regards to cultural competency.

Key elements of a cultural competency plan for the workforce were suggested in many Māori submissions:

- a reorienting of professional practice towards a system of holistic and collective wellbeing which builds cultural capacity and capability across services, systems and communities;
- understanding the importance of whānau defining and determining their own wellbeing pathways;
- development of a comprehensive cultural competency training model, designed by Māori, for use across the entire health system workforce pipeline to ensure holistic models of practice are embedded in the practice and monitoring of all health professionals;
- having access to ongoing professional development opportunities that include kaupapa Māori approaches, tools and strategies for health and wellbeing – including knowing how and when such approaches, skills and expertise are best used; and
- development of the capacity to support prevention and long-term healing (not just acute incidents).

Submitters also stressed the need for all workforce groupings and services to be able to actively demonstrate cultural responsiveness, assessed against standards determined by Māori. The establishment of a national Māori regulatory and/or Health Accreditation body to facilitate and regulate cultural competency has been suggested. Specific functions would include:

- to govern and oversee the provision of high-quality service delivery to Māori;
- to support the development of consistent models of support which integrate Māori models of practice;
- to explore new models of Māori mental health and addictions care; and
- to set and monitor cultural competency standards.

### 3.2 Māori workforce development

Recognition of the unique expertise within the Māori workforce was also raised in the submissions from Māori. The mana of Māori workers with tikanga, experience and community connections needs to be recognised in a system that currently over-values educational qualifications. We need more Māori advocates and navigators. Māori cultural workers play a pivotal role within the sector, and more positions are needed across the range of services.

We need a continuation of programmes aimed at supporting Māori into health careers and building the Māori workforce. Programmes raised as important included:

- Kia Ora Hauora;
- the Puhoro initiative;
- WhyOra;
- Te Rau Puawai; and
- Te Ao Māramatanga- a Treaty-based nursing programme with a bicultural lens.

### 3.3 Workforce retention and building a 'community of practice'

> *"Our workers move seamlessly between clinical and cultural practices in line with whānau expectations. Our services purposefully take time to build trust and connection with whānau over time."*
> (Organisation/service provider/group)

Māori submitters stressed the importance of a stable and valued Māori workforce. Continuity of care for whānau is diminished by a high turnover of staff, particularly psychiatrists. Building long-term relationships is important for sustaining effective care.

The non-regulated occupations comprise the largest proportion of the Māori health workforce. The significance of this sector requires recognition, targeted investment, innovation and co-ordination. Mental health nursing staff, particularly those placed in communities, are important, and can provide essential lifelines for whānau.

Relationships are important, both across services in order to facilitate integration, as well as across the range of organisations who have as their focus Māori health, such as Te Rau Matatini, Te Puni Kōkiri, academics and researchers. Such relationships are crucial to building a 'community of practice' across the wellbeing workforce.

### 3.4 Leadership and planning

Submitters were also clear that a key feature of obtaining best outcomes was strong and connected Māori leadership. Leadership is important in addressing systemic workforce

issues and for transformative change that is strategic, co-ordinated, visionary and innovative.

A national Māori workforce plan is needed. Comprehensive collection of workforce data, by ethnicity and particularly including the unregulated workforce is needed in order to identify needs and monitor progress. National Māori accreditation and regulatory agencies are required to ensure the competency of all practitioners working with whānau Māori.

# PART C: Our solutions

## 3. Ngā mātāpono Māori – our values and philosophies

### 3.1. Tino rantagiratanga, kaupapa Māori

> *"We want access to employment, a warm whare, to our reo and our tikanga."*
> (Hui participant)

A recurring theme in the submissions from Māori was the need for a dedicated 'by Māori, for Māori' approach. Better still a 'by Māori, for *all*' system is required, with services that have kaupapa Māori values at their core and which can address intergenerational trauma by revitalising our mātauranga Māori. These services provide an environment where our whānau can have autonomy over their own lives. A long-term government commitment to kaupapa Māori services that goes beyond short term contracts is needed, with dedicated funding going to kaupapa and tikanga-based programmes. Contracting should be co-designed and led by both providers and whānau based on what families want and to achieve community-driven outcomes.

Relevant frameworks already established were identified including: He Korowai Oranga; Te Pae Mahutonga; the Takarangi Framework; the Manawanui Principles; and the Tūramarama Declaration.[7] A kaupapa Māori framework will also allow for localised differences and the role of mana whenua. We need strong Māori leadership at all levels, and a shift of responsibility and decision-making to Iwi and Māori community leadership – Iwi me hapori kei mua. A Māori health or wellness commission, and a funding structure that is cross-sector and systematically able to address Te Whare Tapa Whā, needs to be considered.

Te Tiriti o Waitangi must be a foundation to all programmes and services, enabling us as tāngata whenua to give expression to our rangatiratanga, which is essential to Māori wellbeing.

[7] Provided in Appendix 1.

### 3.2. Whānau ora, whānau at the centre, te korowai aroha o te whānau

There was wide agreement among Māori submitters that the Whānau ora concept was a successful one and could be expanded to Mauri Ora to cover a wider spectrum of services. Wider still is the need for structural transformation, where whānau are at the centre of a system based on the principles of whānau ora, free from frameworks dictated by a western bio-medical model. Such a system would enable whānau to access what they need and address the social determinants of wellbeing, rather than constantly operating at the acute end. Such a system would also work with whānau to build the necessary skills for maintaining wellness, with success and wellbeing pathways measured according to whānau outcomes.

Whānau need to be at the centre of decision-making and empowered to maintain rangatiratanga. All aspects of whānau need to be considered across our natural life course, from pēpi, rangatahi, pākeke to kaumātua, and also whāngai, mātua whāngai and kaitiaki. Having access to kuia and kaumātua can also be healing.

### 3.3. Whanaungatanga, hononga

Māori submitters stressed the importance of healthy relationships as critical for wellbeing – relationships with self, whānau, community, services and the wider natural environment. Developing connections and maintaining positive relationships should be included in care programmes. We need to connect in a mana-enhancing way. Opportunities to talk, share and connect need to be a part of healing programmes. Fostering tuakana-teina relationships can provide support and guidance.

We need to have an open door for urgent and acute care if whānau deteriorate. An informal 'hub' for rangatahi is needed, where rangatahi can engage with different service providers and build relationships so that when services are needed, they can more readily reach out to a familiar face and trusted adult.

Relationships, effective communication and information sharing between providers is critical for ensuring individualised, comprehensive care. When these relationships are present services are utilised to their best potential, and referrals are more frequent. Services need to be able to trust the next service they refer whānau to as the responsibility for referred individuals remains with the initial service until that person is successfully picked up by the next service.

*"We are people that need to gather together, which is why tangi are so important and remembered. It's where you gather with your aunties and get to be all the things that have been taken away from you."*
(Kaupapa Māori Health Provider)

*"Whanaungatanga or building a therapeutic relationship(s) with people who come in[to] mental health services is a very natural, non-stigmatising way of addressing power differentials/imbalances between professionals and service users."*
(Kaimahi)

### 3.4. Mahitahi, kotahitanga, whakapiripiri tāngata

Submitters placed significant emphasis on relationships at a number of levels. Commitment to and development of Treaty-based partnership opportunities between Māori and the Crown ensures that Māori are part of the group that designs services, and part of the solution.

Unity and collaboration across services is essential for providing the most appropriate care for whānau, and for providing seamless transitions to other services. Intersectoral, multidisciplinary collaboration is important; spanning all health, education, justice and social services and including WINZ, ACC and councils. Integration requires time and planning. To promote working together, a shared vision is necessary. We need collective efforts and collective solutions.

*"We all want the same thing, why are we sitting in our silos?"*
(Kaupapa Māori service provider)

### 3.5. Tikanga Māori

In the submissions, there was a strong call to include cultural assessments in psychiatric and other health assessments, and to include tikanga as a healing method. Culturally-grounded

activities such as pōwhiri, whanaungatanga and the sharing of kai are important to us as Māori, and are therapeutic processes.

> *"Welcoming people into services using the pōwhiri has a multitude of therapeutic benefits; engagement is done through a lens of mana and tapu, and the person, their whānau, hapū, Iwi and all that they carry with them is respected, acknowledged and validated through this process."*
> (Kaimahi)

Cultural competency needs to be improved across health, justice, social service and educational workforces, with cultural accountability included in staff contracts. We would also like to see tōhunga practitioners integrated with clinical practitioners. Tikanga, reo and wairuatanga need to be normalised in services and communities.

### 3.6. Manaakitanga, aroha, tautoko, awhinatanga

> *"[We] don't want someone cold and clinical, we want someone with aroha."*
> (Hui participant)
>
> *"How do you bring a person into a pathway of wellness and walk alongside them?"*
> (Mother of tangata whai ora)
>
> *"Ko te ngākau te mata me te kuaha o te wairua."*
> (Kaumatua)

The importance of warmth and compassion in the healing process was highlighted across the range of Māori submissions. There is a need for a paradigm shift from the biomedical model of care to a system and society based on aroha, delivered by a workforce that truly cares. Compassion needs to be at the fore during the initial stages of encountering a service and whānau that are bereaved by suicide need ongoing, effective grief support. We need funding to support aroha; contracts must enable rather than restrict our ability to manaaki our people and whānau.

We need to actively eliminate the attitude to 'harden up', which inhibits help-seeking behaviour and discourages talking about mental distress, further adding to the negative stigma around mental health. We need to change the staunch attitude particularly for our men. Manaakitanga starts with care of self; our people need to feel safe in knowing that their voices will be heard and to feel safe to access the health system when needed.

### 3.7. Mana tāngata – mana wāhine, mana tāne, mana tamariki, mana Māori

*"If you look for the best in people, you'll find it."*
(Hui participant)

*"We don't see the behaviour, we see the potential, the whakapapa. That's Kaupapa Māori."*
(Māori service provider)

Respect for human dignity was an oft-repeated theme in the submissions. We need to create a non-judgemental system that allows people to be themselves, and which acknowledges the mana of the individual, the whānau and of mana Māori katoa. This allows us our autonomy as individuals and whānau, and rangatiratanga as Māori. Tāngata whai ora want to participate in the health system as healers and in providing guidance to others – and need to be empowered and resourced to carry out this role by the system itself, with more funding directed towards community-led programmes.

There is a need to promote mental wellbeing at school, to keep abreast of the changing world, and to facilitate those with real experiences to be the educators of such programmes. Rangatahi need to be listened to, and health-seeking behaviour supported in schools and society.

Racism and privilege within the system needs to be addressed for a more equitable society. Changing the way we talk about oranga hinengaro and tāngata whai ora is an important part of restoring and enhancing the mana of our whānau.

## 3.8. Whakapapa

> *"When you give bad service, you give bad service to my whakapapa and my future."*
> (Hui participant)

Māori submitters were cognisant of the lifecycle changes that are part and parcel of whānau realities. For positive transformation, we need to focus on long term, sustainable change across the whole whānau. Whakapapa is about the past but also the future. Intergenerational trauma needs to be addressed by revitalising our mātauranga and tikanga. We need to plan for the changing demographics in our country – for example, an ageing population means higher imminent needs for our kaumatua, and funding needs to be configured to support this.

Learning about whakapapa and looking to the gifts of our tūpuna for relevant solutions can strengthen our sense of identity and belonging and promote healing.

We need to calm our whānau as they come through the doors of a service, through pōwhiri and whakatau, and acknowledge this is someone's child; that through their whakapapa they belong to an iwi, a hapū.

## 3.9. Tūmanako pai

It was clear from Māori submitters that hope and aspiration are vital to maintaining oranga hinengaro. We need to have intent, vision and strategy and to see the potential in our people; we need to reclaim our belief in ourselves, and in our mauri. This means moving away from the deficit model where shame dominates. Changing the way we talk about mental health will also help inspire hope and positivity – through using preferred terms such as tāngata whai ora and oranga hinengaro.

We often hear more about what is not working than what is working. Celebrating success and survival, and promoting positive role models are important factors for inspiring hope.

*"He wants to give up cannabis. He succeeds, passes drug test, gets a job. Now he has a sense of hope."*
(Service provider)

### 3.10. Wairuatanga, ūkaipō, tūrangawaewae, marae, taiao, kaitiakitanga

A repeated plea from Māori submitters was the need to replace clinical interventions with the wairua interventions found in our tikanga, reo, mātauranga and marae – including haka, waiata, mau rakau, tā moko, māramataka, karanga, rāranga, whakairo, mirimiri, rongoā and growing and gathering kai. We need a focus on learning peace, mindfulness, positivity and appreciation, and to start this in schools with our tamariki. We need access to exercise as part of our daily life, and to incorporate the things that sustain our mauri.

Our urbanised, digital environment distances us from the natural world. We need to connect more with our physical environment, our marae, our awa, our moana and our maunga. Healing is found in nature and the health of the whenua impacts the health of our people. Our role as kaitiaki is important, and can also facilitate healing. Marae-based services, and the construction of urban marae help maintain connectedness and provide a place where whānau can come to whakatau their wairua. Using multiple environments to connect, including the natural environment, and paying attention to the physical design of service spaces is important for us as Māori.

*"The marae won't have padded cells."*
(Hui participant)

*"Develop a model of healthcare that has spirituality at its base."*
(Whanaunga of someone with lived experience)[8]

*"[I] cannot express strongly enough the importance of our whānau reconnecting to their tūrangawaewae."*
(Organisation/service provider/group)

*"We need a better belief system in ourselves: to believe in our mauri, the energy of light that resides within. This will guide us to better days."*
(Hui participant)

## 3.11. Pūrākau

Stories are incredibly powerful for mental health intelligence. Some submissions drew attention to desire of children and rangatahi to tell their stories and be listened to, and similarly of people's pain and background – they need to be heard. We need to honour their voices and reflect them back. The opportunity to share stories should be incorporated into wellness activities, and be part of the process of grief management.

We have our own stories from our tūpuna, which are part of our whakapapa. These can be used to provide understanding, healing and a reconnection with who we are as Māori.

*"It's not structured or systematic, it's a space that's just there.*
*I just rock up and talk about some shit I need to talk about."*
(Rangatahi)

*"We hear your stories from our knowing.*
*We know about discrimination and stigma and the end of the queue."*
(Service provider)

### 3.12. Mahi auaha

Among the many submissions were accounts from whānau who shared stories of resilience, innovation and creativeness; from finding ways to provide the basic necessities for their children despite extreme poverty, to working within system constraints.

Creative pursuits were also promoted as methods for healing and maintaining wellness. Those mentioned (in addition to tikanga Māori activities) included: day centres; art; craft; music; gardening; physical exercise; martial arts; dance; and outdoor pursuits. Investing time in positive and constructive pursuits is therapeutic and important for maintaining wellbeing.

Services are often required to be creative in order to meet the varied and changing needs of our whānau rather than conforming to contractual obligations which are often restricting. We need innovation in intervention.

## 4. Paradigm shift and transformation

*"Unless we shift our thinking, we won't change our practice."*
(Māori mental health Professional)

*"What if 'mental health' services were repositioned as 'wellbeing' services?*
*How would the way in which services were delivered, perceived,*
*and the workforce trained [be], if we came from a place of wellbeing*
*and not pathology?"*
(Organisation/service provider/group)

*"Something as simple as promoting kindness and acceptance … "*
(Tangata whai ora)

Arising from the major themes in the Māori submissions, was the need for a major paradigm shift across Aotearoa that would position mental health and wellbeing in a culturally-grounded, holistic, strengths-based and decolonising context. A holistic, lifecourse-focussed, wellbeing paradigm is required, placing wellness at the heart of all policy, practice and service development. This would help ensure collective responsibility for the health and wellbeing of all. It requires a recognition of the interconnection between health and the wider social determinants, taking a public health perspective to addressing the upstream causes of unwellness, and implementing a whole-of-system approach to mental health. There needs to be a focus on hope and opportunities.

Such a shift would mean a centralisation of whānau, iwi, hapū and community aspirations and a move away from individualistic, economic gain. All governance structures, strategies and policies would be strongly underpinned by Te Tīriti o Waitangi.

The value of manaakitanga would be normalised, with a focus on kindness, compassion and caring for self, others and the environment. In a strengths-based approach, the questions would move from 'what is wrong' to 'what is strong', and from 'what is the matter with you' to 'what matters to you'. Practice and solutions would be tranformative, innovative and sustainable.

*"I would start by re-organising the mental health system*
*to orient to Te Tiriti o Waitangi, [so] that [it] holds people*
*in their diversity, and works to heal people, their whānau and communities*
*rather than simply manage their symptoms."*
(Whanaunga of someone with lived experience)

*"Uphold the mana and mauri of whānau, empowering them*
*to lead and be active agents of Pae Ora pathways that they co-design*
*to engineer their own sustainable solutions,*
*shifting from states of kahupō to Wairua Ora ..."*
(Organisation/service provider/group)

## 5. Practical, achievable solutions

Solutions suggested by Māori submitters to the Inquiry fell under five key themes, largely consistent with the themes in this report: system, services, workforce, suicide and supporting whānau.

| 1. Improving the system |
|---|
| *a. Consider projected demographic changes when allocating funding*<br>Health system funding needs to take into account projected demographic changes. For example, considerable growth is expected in the elderly Māori population and so far there has been little change in the distribution of resources to support this growth. |
| *b. Separate provider and funding arms* |
| *c. Integrate support across sectors and agencies* |
| *d. Report and publish performance of the system by ethnicity* |
| *e. Leadership*<br>Greater leadership to support mental health and wellbeing in general. |
| *f. Undertake quality research*<br>The application of international research for the context in Aotearoa needs to be considered. Examples mentioned include, Johann Hari research (depression), Kaiser Permanente (adverse childhood experiences), passive supporter approach for police, trauma informed care, and Open Dialogue model (Finland). Research needs to inform the action needed on the ground. |
| *g. Control alcohol pricing and availability*<br>Pricing and availability controls can reduce access to alcohol. Implement alcohol intervention in schools. |
| *h. Use contracting structures as a mechanism for services to work collaboratively* |
| *i. Implement the recommendations of Te Rau Matatini* |
| *j. Provide mental health education in schools* |

| 2. Service Delivery |
|---|
| *a. Further develop and extend Whānau Ora* |
| *b. Ensure culturally responsive service delivery*<br>Services need to respond to cultural and spiritual needs before the clinical. Kaitakawaenga and kaumatua need to be involved in Māori deaths. Cultural assessment needs to be included in managerial and CEO key performance indicators. |

| |
|---|
| *c. Increase and further develop service provision and facilities*<br>Face-to-face services and home visits need to be increased, services for mild to moderate mental distress need to be developed, and dedicated facilities for transition from hospital to the community also need to be developed. |
| *d. Listen to rangatahi*<br>Rangatahi give the most amazing viewpoints on how basic solutions can be. Rangatahi need to be supported to find their own voice and this voice needs to be included in service design. The United Nations World Youth Report is instructive here.[9] |
| *e. Develop and fund infant mental health, including parent and infant relationship services* |
| *f. Facilitate ongoing organisational change*<br>Use complaints processes better to promote change, including incorporating feedback from focus groups and other mechanisms, to ensure the ongoing improvement of services. |
| *g. Use technology*<br>The creative use of technology offers opportunities to promote our culture and reo, to maintain connections and as a platform to access health and health services. However, this must be balanced with the realisation that not everybody has access to technology. |
| *h. Increase GP visit times* |
| *i. Focus on zero seclusion* |
| *j. Use contracting structures as a mechanism for services to work collaboratively* |
| *k. Create a WINZ triage system for clients with mental health conditions* |

| 3. Suicide prevention and response |
|---|
| *a. Change the building code*<br>Many Māori and Pacific deaths are by hanging. The building code should be changed to no longer permit exposed rafters in houses or garages. |
| *b. Implement media reporting guidelines around suicide*<br>There are national media reporting guidelines in place that are not adhered to. The guidelines need be updated and implemented. |
| *c. Create a multi-agency response to suicide*<br>Toxicology investigations should be conducted in every case of suspected suicide. We need to make the coronial processes more robust and increase information from coroners around data and levers of suicide. Bereaved families need greater support in the months after a suicide. A culture change is required in services regarding suicide: from a blame culture to a just culture. We need to establish a suicide prevention centre of excellence and stop government agencies from coming in and constraining community suicide prevention work. |
| *d. Improve security at inpatient units so whānau don't get out and suicide* |
| *e. Provide culturally appropriate post-suicide support for whānau* |
| *f. Provide post-suicide support for health workers* |

[9] https://www.un.org/development/desa/youth/world-youth-report.html

| 4. Workforce |
| --- |
| *a. Develop the peer workforce*<br>Peer workforce development needs to be strengthened by training whānau, past addicts and those who have experience with suicide and other mental health conditions, and pairing this with clinical expertise. |
| *b. Diversify the workforce*<br>Diversify to reflect the community. In particular, more male nurses are needed in mental health. |
| *c. Use the role of pharmacists more effectively*<br>Pharmacists are often better informed than GPs regarding medications. They need to have a greater information-sharing role regarding medications. |
| *d. Introduce mental health competency assessments for GPs (update two-yearly) and for all mental health workers including kaupapa Māori practitioners* |
| *e. Ensure succession planning for key Māori workforce roles* |
| *f. Develop whānau advocacy roles* |
| *g. Train police in mental health intervention* |
| *h. Whole of system commitment to and national monitoring of ongoing cultural competency training* |
| *i. Develop a national Māori workforce plan to consider and implement solutions* |

| 5. Supporting Whānau |
| --- |
| *a. Develop an A&E checklist*<br>Whānau need to be provided with useful information following a mental health and/or addiction event - similar to that provided for heart attack patients. |
| *b. Develop a register of all mental health services*<br>Whānau need to be provided with easy access to information on all of the mental health services available in their local area. |
| *c. Use language we can all understand* |
| *d. Provide respite care for whānau* |
| *e. Provide cost-free courses to help supporters in whānau* |
| *f. Mentor prisoners when they leave* |
| *g. Expand bereavement leave* |
| *h. Enable Lifeline, What's Up and Kidsline to be 24/7 services* |
| *i. See whānau in their own homes, rather than an institution* |

## PART D: Our lived realities – what is not working and its impacts

*"What hurt me … when you told me I was sick and unwell;*
*when you put me in that place, because you thought you knew best;*
*when you didn't take the time to listen to me;*
*when you labelled me with an illness, that wasn't mine;*
*when you held me down and injected me, because I refused to take your pills;*
*when you didn't come and visit me; when you made decisions, without asking me*
*what I wanted or needed; when you refused to listen to me;*
*when you trusted the doctors more than you trusted me;*
*when I asked you to stay … and you left;*
*when you stopped me from spending time with my family, because I raised my voice;*
*when you judged me; when you told me I couldn't come to church, because I was sick;*
*when you made me doubt myself;*
*when you replayed my past, while I was trying to step into my future;*
*when you didn't take the time to listen; when you took my children away from me;*
*when you punished me for having emotions; when you stopped believing in me;.*
*when you valued your beliefs … more than you valued mine;*
*when you told me to be quiet, when I wanted to sing;*
*when you thought you always knew what was best … for me; when you didn't listen …*
*What mattered to me …*
*the cup of coffee that you brought me when I was thirsty;*
*when you came to visit me in that place, even though you were afraid;*
*when you listened to me and didn't judge the words I spoke;*
*when you treated me the same; when you made me laugh at myself;*
*when you spent the night with me, because I was afraid;*
*when you saw my strengths … and not my weaknesses;*
*when you told me I wasn't crazy;*
*when you listened to me and helped me make sense of it all;*
*when you took care of me when I needed you most; when you visited me;*
*when you pressed your hand to mine through the glass door when I was locked away;*
*and you stayed there … while I cried;*
*when you never lost sight of who I really was;*
*when you defended me and gave me back my voice; when you loved me;*
*when you came to see me after work and took me for a drive;*
*when you listened to me and valued the words I spoke; when you didn't label me;*
*when you said sorry for not coming to see me in that place; when you showed me how to find a way through it all; when you believed in me again;*
*when you finally allowed me to learn what was best … for me;*
*when you listened ..."*
(whanaunga of someone with lived experience)

## 6. The system

*"I feel like I'm on fire in a room and there are people surrounding me and no-one's helping."*
(Whānau member)

### 6.1. Racism: systemic, interpersonal, internalised

Many Māori submitters were adamant that the mental health system is fundamentally racist as it has been developed on Western models. There are discrepancies between Māori and non-Māori services; larger, non-Māori services receive more funding because they have a more robust infrastructure, and Māori services are often disestablished without any input from Māori. Providing an authentic Māori service is constrained by the Pākehā platform on which it operates. We experience discriminatory care in non-Māori services, for example, where we are forced to take medications when non-Māori aren't for the same condition.

*"There is an unconscious bias in the system that's discriminating against us."*
(Hui participant)

*Why is it that when something works for Māori, they cut the funding and call it a pilot?"*
(Hui participant)

Prejudice is evident at the referral level. We are often not referred to kaupapa Māori services and are sent to mainstream services instead. There is less respect for the staff in kaupapa Māori services, and the services themselves are viewed as inferior.

We are often sent to health services in other locations, removing us from whānau support systems and severing our ties to whānau which is damaging. We feel we are not listened to and therefore don't return, losing faith and trust in the system. Many of our whānau live

with the feeling of being second class citizens - which is perpetuated, internalised and maintained by the colonial context.

> *"The first thing staff did there was change her name from her tūpuna because her name was too hard to pronounce."*
> (Hui participant)
>
> *"All they can do is stand by and watch this happen to their child. Absolutely no respect for their culture and identity as a whānau unit, and no empathy."*
> (Mental health nurse)

## 6.2. Impact of the legal system

A further concern raised in submissions was discrimination in the administration of Compulsory Treatment Orders and seclusion. A disproportionately higher number of Māori are subject to Treatment Orders. Our whānau endure instances where the enforcement of these orders transgresses tikanga, such as mental health service workers being sent to tangi to ensure a whānau member takes medications, and where enforcement impacts on the mana of those with terminal illnesses. There is no accountability for psychiatrists in forensic mental health, who hold all the power in the courtroom with no allowance for the expertise of the whānau. This power is experienced as being misused.

## 6.3. Criminalisation of mental health

Māori voices were loud in the condemnation of the criminalisation of mental health and addiction. The lack of services for mild to moderate mental distress means that symptoms often escalate to high levels of severity before intervention. Services are often only available after police become involved – crisis services advise whānau to call the police at times of urgency; the police say they require a crime to occur in order for them to act, and sometimes crimes are fabricated in order to gain access to much needed services. Our whānau experience direct harm when an enforcement approach to mental health and addiction is taken. The damaging attitudes of police are an area of concern, police are not

trained in dealing with mental health situations, but are often called upon due to a lack of resources elsewhere in the system. Whānau report experiences of rough handling by police. Our whānau have limited trust and faith in the police and justice system.

Often 'care and protection', youth justice and prisons function as holding places for those unable to get help when needed. This can include whānau with Foetal Alcohol Syndrome Disorder (FASD), Traumatic Brain Injury, Attention Deficit Hyperactivity Disorder (ADHD) and high rates of trauma exposure. We need pathways other than the criminal justice system for whānau with mental health and addiction issues.

> *"Prison is an outcome when all the previous fail, such as diagnosis, and adequate supports have not been put into place."*
> (Organisation/service provider/group)
>
> *"... [there is a] pressing need for significant shifts in the justice system from a model of criminalisation and discrimination, to a Pae Ora paradigm that focuses on intervention, healing and recovery."*
> (Organisation/service provider/group)

Some submissions noted that recent positive initiatives to involve mental health staff in criminal assessments . However, there are still difficulties in 'compulsory care' legal processes which include psychiatric advice that is usually uncontested. There is sometimes the need for 'defence psychiatrists' to support whānau needs. Many whānau have identified the lack of facilities and adequate clinical knowledge amongst forensic psychiatrists in relation to specific disorders such as Pervasive Development Disorder, Autism and Asperger's.

Compulsory treatment orders are often placed on whānau by staff within the justice system who have limited or no expertise in mental health and addiction. This practice is questioned in terms of human rights and ethics. Many whānau feel they have not been listened to within the justice system. Our concerns regarding side effects of medications are often not heard, many are prescribed medications without the knowledge of what they are and what their purpose is, and the long term effects or administration of medications have led to some of our whānau being unable to fully participate in society.

Recognition of how the system itself contributes to mental distress and criminal actions is required. As an example, when a case manager decides not to grant someone a benefit,

then that person goes without and if they are disconnected from other supports such as whānau, hapū, iwi or community, then they are forced to commit crimes as a means of survival, sometimes even against their own whānau. For many of our whānau in prison, their offending is directly related to survival. A recognition of the interplay between unaddressed mental health needs, homelessness, alcohol, drug use and addiction and subsequent offending is needed. The acknowledgement of mental health and addictions as a determinant of crime would enable prioritisation of the treatment of poor mental health, rather than incarceration being seen as the sole solution. This approach would require the full involvement of the Justice system and the review of sentencing practices within the context of mental health and addiction.

We experience inequitable treatment within the justice system. Māori inmates have less time with healthcare staff, and young non-Māori offenders are placed in less volatile prison units compared to Māori. The prison environment impacts negatively on those who have mental health and addiction issues. Addiction issues in particular are not being treated as a legitimate health need. There is a lack of culturally appropriate strategies to provide for the health and wellbeing of our whānau who are in prison.

> *"There is no stimulation and they are left alone with their thoughts to manage their torment of poor mental health. They receive no spiritual input or even any understanding of their beliefs."*
> (Organisation/service provider/group)

The link between health and offending was seen to be an area of high need. Mental health and addiction services within prisons are limited, overstretched and impacted on by workforce issues. Treatment and support for offenders is not consistent. Staff shortages in correctional facilities impact on time inmates spend out of their cells, which impacts on overall wellbeing. There is a lack of support for Māori staff working with whānau who are incarcerated with mental health and addiction needs. The effective management and support of whānau members on bail is also a challenge. Māori feel that prison and police staff are not adequately equipped with the cultural knowledge required to work effectively with our whānau who have mental health and addiction needs.

## 6.4. Contracting, funding and prioritisation

*"[I'm] sick of the Crown saying you don't satisfy criteria so can't get funding."*
(Hui participant)

*"[I've] heard 'my contract doesn't do that' too many times – whānau don't see that, instead [they] feel alienated and rejected."*
(Hui participant)

Māori submitters were also adamant that there is inadequate allocation of government funding towards mental health and addiction. Funding is often misdirected, such as the $53million spent on the prevention of methamphetamine importation when in reality it is predominantly being made in this country, or the resources directed to acute and chronic conditions rather than towards the treatment of mild to moderate mental health and maintaining wellness. There is underinvestment in community resources, with the bulk of funding going to secondary and tertiary services. In Christchurch, the earthquake fund was understood to be directed to GPs rather than the community services who were providing the mental health services.

The severe limits placed on funding leads to increased demand for free services such as churches.

Contract configurations and funding restrictions create a strong competitive environment between Māori providers which makes collaboration difficult. Competition for scarce resources can set Māori providers against each other. Current contract structures treat people like products to meet contract outcomes and DHB funding does not allow flexibility to meet the needs of whānau. Decisions are based on fiscal reasons not people's needs. Kaupapa Māori services are inappropriately assessed by mainstream frameworks that use deprivation as a measure of success. When contracts expire and funding is allocated to another provider, services are required to 'hand over' their clients, with whānau then having the sense they are abdicating their responsibilities. This impacts on the continuity of care for whānau.

There is severe inequity in funding allocation – such as mainstream services receiving extra funding for forensic beds while funding for cultural activities is ceased. Whānau don't want to access the services that are currently being funded, so kaupapa Māori services are having to provide that support without financial resource.

### 6.5. Data

Concerns about data were also raised by Māori submitters. It has become apparent that statistical data on suicide and self-harm is undercounted and inadequate; there is no data on hospitalisations following suicide attempts. The things we need to know about are not being measured, and not all data is provided by ethnicity. The PHO and DHB information systems are not compatible, making it arduous to extract statistical information.

Privacy laws don't allow information sharing across services which limits the capacity for our whānau to be provided with a comprehensive and tailored service.

### 6.6. System distrust

The question of trust was raised in a number of submissions. Our whānau do not always trust DHB services. Many whānau bereaved by suicide report poor interactions with DHB services, resulting in distrust. Many whānau also describe a fear of becoming caught up within a punitive mental health system, having their children taken from them or benefits cut, and therefore do not access services. Whānau would rather suffer in silence, on the streets or in violent relationships, than be subjected to the damaging effects of the system. Past experiences of whānau not being heard or treated well become a barrier to seeking help in the system.

Many seek support from whānau, hapū and iwi, however this level of support is not resourced and relies on aroha of those already overstretched. The mental health system is seen as a last resort.

## 7. Services

### 7.1. Access and availability

#### *7.1.1. A hard to reach system: barriers, delays, waiting lists, costs, referrals*

*"Who are the hardest to reach? Our government."*
(Hui participant)

*"To have people not bother to get back to you - it's trust-destroying.*
*Why would I go back to them if they let me down?*
*They've already destroyed this trust."*
(Māori disability support person on how the clients feel)

*"We are running on air and it's not enough."*
(Parent of tangata whai ora)

Unsatisfactory access to essential services was heard in a large number of submissions. We get answerphones when reaching out for help and there are long, unacceptable waits for urgent care. We are still waiting for psychological assessment three months after a suicide attempt, we are still waiting for a service to ring back 18 months later. Waitlist times are unacceptable, particularly for whānau who are in crisis. Whānau seeking help are turned away from service after service, and suffer shame, regret, guilt and fear as a result.

To have security guards at the door, untrained in mental health, is a barrier. Waiting in queues is too much for someone hearing voices. Entry point to mental health services is primary care, particularly GPs, and that's a barrier especially for rangatahi. Counselling and private therapists cost money and most of us cannot afford it. Considerable stress occurs as the end of allocated counselling sessions draws near. Costs are significantly greater for whānau living rurally. Health insurance is affected by mental health declarations.

Many of our whānau are lost to follow-up or referral, and trust in the system is diminished. Strong advocacy skills, energy and persistence are required in order to navigate the system. Whānau are exhausted from constant attempts to access the health services they need. Not being able to engage and access support and services in a timely way has serious consequences for whānau; delay can cause an escalation of symptom severity. Mental health facilities are too full, and whānau have to wait till they become a danger to themselves or others before they are admitted.

Some whānau recounted how that were able to secure help because of their own strong advocacy skills, but others had received help only after they had made formal complaints and the situation was publicised on social media. There is concern for those who are not able to advocate for themselves in these ways.

### *7.1.2. Thresholds and criteria*

> *"I went and spilled my beans and I was told I wasn't serious enough."*
> (Rangatahi)

Several submissions focussed on thresholds and criteria for accessing services which often meant that many whānau go underserved, those with mild to moderate needs can't access help until their needs escalate, and there are limited or no services to serve this level of moderate need. Unrealistic criteria prevent whānau getting help. Sometimes conditions need to be over-emphasised in order to gain access. Access to rehabilitation programmes is difficult; an individual needs to have committed a crime, have suicidal ideation or to have hit rock bottom.

There is a cut-off age of 18 for youth mental health facilities, yet maturity is not taken into account during admission to adult mental health services, leading to inappropriate treatment which can have negative effects.

There are instances where suicidal whānau members are turned away from services, sent home, and have suicided. Different services have different criteria, leading to confusion for whānau. Whānau report experiences of children as young as 12 years old not being given urgent priority despite the presence of issues such as self-harming, suicidal thoughts and hearing voices.

> *"… because she didn't tick 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."*
> (Hui participant speaks of police attending to a suicidal girl)

Some whānau suggest that better support such as effective follow-up and free medication can be more easily accessed under 'compulsory care' – and which are sometimes accessed by coercive means. Whānau therefore receive a diagnosis of a more serious mental illness.

### *7.1.3. Responsivity of crisis services*

Submitters maintained that many whānau received an inadequate response from crisis services. Access is difficult through the need to be registered and strict eligibility criteria. The lack of comprehensive assessment or follow-up after a crisis presentation are issues of serious concern. Whānau have traumatic experiences of having to plead for crisis intervention, calling a helpline to be told that no one is available to take the call, pushing hard to receive services that should be readily available, and feeling pressured by mental health crisis teams to take the responsibility for keeping their whānau member safe.

> *"... suicide waits for no doctor to register them.*
> *Give them the help they need right there on the spot. If family call on behalf, take action. Don't give them the runaround."*
> (Whānau member with lived experience)

### *7.1.4. Information, education, health promotion and communication*

A frequent complaint by submitters was that information to promote health and wellbeing to whānau is inadequate and inappropriate. Medication can be confusing, and whānau don't know what they're taking. We are inadequately informed to make decisions and fully informed consent is not being sought for some procedures and treatments. Communication on complaints processes is inefficient, and there is limited information on the range of services available. Lack of knowledge causes stress. The right of whānau to full and appropriate information is not being met, and whānau are expected to navigate the system with low health literacy.

Communication is often poor, delayed or non-existent. There is a lack of contact and support from agencies before and after suicide events. We are deliberately denied information, and whānau are prevented from having access to their family members in mental health units.

There is difficulty accessing information such as private Facebook accounts following suicide, yet ease of access to lurid websites which can be harmful.

#### *7.1.5. Whānau experiences: exclusion, not being listened to*

Māori submitters repeatedly pointed out they were not listened to by the system, and were often 'talked to' rather than 'spoken with'. Listening to the voices of whānau with lived experiences is critical. Too often whānau are excluded from assessment, treatment and discharge processes, denied information and prevented from having access to their whanaunga in mental health units. Often whānau have valuable information which can assist in treatment and management.

There is a lack of knowledge of how to work effectively with whānau. Many clinicians are not supportive of whānau involvement, and whānau members are often judged, assumed they will not understand diagnoses and explanations, or considered problematic.

> *"When we questioned their assumptions or diagnosis we were made to feel stupid and silly and the psychiatrist would report that the family were aggressive and adhering to ignorance."*
> (Whanaunga of someone with lived experience)

### 7.2. Acceptability of services for Māori

#### *7.2.1. System neglect, inappropriate and inadequate care, misdiagnosis, undiagnosed conditions*

> *"[the] primary [school] kids saw him hanging, they needed counselling but there was nothing."*
> (Mother, whānau member bereaved by suicide)

The non-availability of urgent services was an all too frequent grievance raised in the submissions from Māori. We are deprived of essential services, particularly suicide postvention. The sector is overworked, under-resourced, and services are inadequate or

wrongly configured. Appointment times are too short to meet our complex needs; in 15 minutes with the GP we barely get through the list of medication side-effects. We need longevity of treatment plans – a life won't be turned around in 12 weeks. Crisis services operate between 8am-4pm but need to be available 24 hours a day, seven days a week.

The sanctioning of benefits for missed appointments is harmful. Whānau have to fight to access services, and treatment centre shortages see prisons used instead. Whānau are not properly prepared when leaving prison to re-enter the community.

There are many reports of Foetal Alcohol Syndrome Disorder (FASD) not being diagnosed. There is only one FASD assessor in Northland, with children not being assessed. Warning signs for mental distress and suicide are ignored. We are concerned at the number of primary school children with anxiety, the limited training for teachers and the lack of support for parents. Diagnosis can be confused with impact; no one gets all the symptoms of a health condition – it's more useful to consider the impact it has on their lives rather than the diagnosis itself. Many services are unable to cope with dual diagnosis. Grief isn't depression, stress isn't a disorder, and pathologising these (and other) emotional states can increase stigma and lead to misdirected care programmes.

There isn't enough appropriate service provision or information about how to access it. Our whānau struggle to know where to get help from, and rural areas are particularly underserved. There are whānau living in hiding with HIV as they have no place to go. Often whānau can't access a service unless they have strong advocacy skills and perseverance. The system is configured for the individual, with no platform of engagement for whānau.

Our needs are not being met; we receive inadequate care, and we're being sent back to living environments where our ongoing wellness is not supported, leading to a cycle of re-admissions. Formal referrals to services are not being provided by some GPs, and whānau are expected to contact services themselves. Information is not passed on between services and whānau often need to tell their story again and again, and sometimes to the wrong services. General health care is overlooked with the focus on mental health only. Services disagree on diagnoses, some conditions are undetected, and mental health conditions are not given the same level of importance as other medical conditions.

*"Why are mental health survivors never celebrated or revered for our survival?"*
(Hui participant)

*"When someone is presenting as suicidal or self-harming [to A&E], let's take it as seriously as we do a tight chest."*
(Mother of a son who died by suicide)

To many submitters there appeared to be an assumption that when whānau are discharged, they are well – and there is limited community mental health follow-up. Our whānau face situations where suicide attempts are not assessed by the Crisis Assessment and Treatment Team (CATT) or a counsellor, and are then discharged without a plan. Services that are aimed at alcoholism don't necessarily understand drug addiction; our whānau are being sent to the wrong places and receive inappropriate care.

> *"We weren't aware of his depth of mamae from the interventions caused by the system."*
> (Sister of tangata whai ora)

### *7.2.2. Unmet need*

Submisssion after submission spoke of an over-worked and overloaded system. Our system is strained. Service demand is high across all primary, secondary and tertiary services, and they do not have the capacity to meet this demand. Whānau are turned away and have nowhere to go. The inconsistency in services also impacts the quality of relationships with whānau, and can impact the likelihood of whānau to seek help when needed.

Services and support for takatāpui and LGBTIQ populations is particularly limited, not only in relation to mental health and addiction but across health services in general. There is a lack of service choice for tamariki and rangatahi, and a high need for addiction services. There is an overall lack of rehabilitation, residential treatment and community detox facilities for addiction issues, along with a more specific lack of culturally appropriate kaupapa Māori services. Huge unmet also exists in relation to synthetic cannabis, and very few services are equipped to support methamphetamine addicts which are often only accessible via court-mandated processes.

There is heavy tobacco use amongst whānau with mental health needs, but it is felt that the majority of these whānau would be likely to stop if they could access the appropriate support and assistance.

There is unmet need for maternal mental health, particularly in rural areas. Whānau experience waitlists of ongoing counselling, transport costs. Many midwives lack knowledge around mental health issues.

Many whānau have high and complex needs, and comorbidities, and the specialist support required is unavailable in most communities, placing further pressure on services unequipped to manage these needs. Providers can be reluctant to take on such cases resulting in whānau being turned away in times of need.

> *"...It also places these services and staff at imminent personal and organisational risk as they do not have the resources (or the training) to manage high, complex mental health need in the NGO sector. Moreover, when they are expected to do so the impact of vicarious trauma on their staff is immense and is wholly unnecessary as collaborative approaches to working with whānau will mediate this issue."*
> (Organisation/service provider/group)

### *7.2.3. Lack of service integration and collaboration*

A disconnected and confusing system had been the experience of many Māori who made submissions to the Inquiry. There is a lack of service collaboration, cohesion and consistency which is seen as a consequence of a risk-averse and service-focused system. Mental health and addiciton is described as a 'sector of closed doors'. Links between services are missing, affecting referral flow and information sharing. This results in whānau requiring multiple appointments, developing relationships with multiple service professionals, and having to repeatedly tell their stories at each point of engagement. This risks whānau being overwhelmed with multiple interventions from multiple agencies, resulting in withdrawal from services altogether.

### *7.2.4. System-focused service delivery*

Having whānau at the centre of service delivery was seen as critical by Māori submitters. Support is described as being system-focused as opposed to being focused on individuals or whānau. Dictating appointment dates and times is one example. A re-think of how to reach

whānau who have missed appointments is required, rather than dismissing individuals who do not attend appointments three times. Services need to find ways to better secure these engagements with whānau.

Effective methods of engagement with whānau to facilitate easy access needs to be recognised and implemented, particularly in relation to prevention and early intervention. Recognition needs to be given to the impact of low income and rurality on accessing services and support.

> *"People don't have the resources to travel to multiple appointments or collect multiple versions of the same information for different services."*
> (Organisation/service provider/group)

### *7.2.5. Overmedicalisation and normalisation of the biomedical model of care*

> *"Stop prescribing drugs. Prescribe care."*
> (Māori warden)
>
> *"We assess our people with tools that aren't ours, follow models that aren't ours."*
> (Hui participant)

Submitters also raised critical concerns over the fact of medicine often being the only treatment offered; with drug companies having a monopoly over the mental health system as a result. Reducing one's medication is not supported, even when the desire is there and we are actively trying to do that. Medicines have side effects, such as heavy sedation, robotic movements, suicidal thoughts, low energy and motivation, spasms, twitches, flutters, heart palpitations, impacts on speech, weight gain and low confidence – all of which can impact on quality of life. Some side-effects are irreversible. To counter the side effects, further medication is administered with another set of side effects. Whānau are not fully informed about the debilitating impact of the multiple side-effects of medication. Some describe feeling like 'lab-rats'. Clinicians can be reluctant to be open with information and explanations, which contributes to anxiety and diminished trust by tāngata whai ora

and whānau. Polypharmacy seems to be the trend, and high caseloads lead to an overreliance on medications. Medication often treats only the surface issues, neglecting underlying factors including physical health and social and cultural needs.

Medication is seen as particularly inappropriate for rangatahi Māori, for those whose issues are spiritual in origin or as a response to cultural needs being explored or addressed. The use of medications in the management of FASD was also questioned by submitters.

The biomedical model was seen to be prioritised and normalised in a system dominated by medical professionals. This model conflicts with Māori frameworks and philosophies. The current system is a 'one-size fits all' model, deficit-oriented, individualised, siloed, illness-focussed and Western-based. This does not result in good outcomes for our whānau, and provides a considerable barrier to accessing services.

> *"It's almost like mental health services are a way of colonising people again. You come in, you're disconnected from your land, your culture, and your language. You can't articulate values that are part of your ancestry."*
> (Organisation/service provider/group)

Current services are unable to address symptoms of 'spiritual unease' and symptoms which are routinely ignored or misdiagnosed within Western mental health systems. Research on the importance of mental health professionals acquiring deeper knowledge and training around such experiences is needed. Without an effective interface between psychiatry and Māori worldviews, the system will continue to struggle to provide effective responses. We require a transformational shift from the medical model of care to a psychosocial model, incorporating cultural aspects of wellbeing, and particularly wairuatanga.

> *"Transformation means that you have to leave some things behind that you have confidence in and know. When you know better, you do better."*
> (Hui participant)

### *7.2.6. Inpatient service experiences*

Whānau who are admitted to acute mental health services, spoke in their submissions about being further traumatised and adversely affected by the system itself. We experience treatments contrary to recovery, are provided inadequate support and our needs are not met.

Whānau referred to the ongoing practice of forced electroconvulsive therapy (ECT) in mental health service and its detrimental impacts, and reported that this practice has increased in recent years.

## 7.3. Kaupapa Māori service realities

> *"We want to be able to deliver culturally appropriate services and not have to spend significant amounts of time convincing non-Māori of the value and merits of them."*
> (Organisation/service provider/group)
>
> *"Mainstream services are not working for Māori.*
> *Māori teams inside mainstream services try to buffer and protect Māori but they are often doing twice the work."*
> (Organisation/service provider/group)

Many Māori submitters considered that the fundamental challenge for kaupapa Māori services was the failure of the mainstream Western system and society in general to recognise kaupapa Māori service provision as legitimate and valid, both within mental health and addictions and across wider health and social service delivery. The value and capacity of kaupapa Māori services is continually doubted and questioned. Comparisons are made with mainstream services rather than against our own standards. Kaupapa Māori services are under constant pressure due to working within a system in which Māori knowledge, learning and experience is disregarded, and where the Māori workforce is not regarded as having credible and respectable leadership. The core contributions made by kaupapa Māori services are not recognised, and this is evident in inequitable resourcing decisions and subsequent limited service delivery to whānau. Our services are often 'sidelined' in favour of mainstream services.

The devaluing of kaupapa Māori services is intensified with the wider lack of value placed on mental health and addiction service provision in general.

Despite increasing service demand and overall increases in health and mental health funding, significant funding decreases for kaupapa Māori services have continued, particularly over the last decade. Investment remains minimal and inadequate, and the inequity in funding has widened as mainstream providers have expanded and increased their service provision.

> *"Mainstream healthcare services distributed 98 per cent of all funding, with only two per cent apportioned to kaupapa Māori services, even though 60 per cent of the population accessing mental health and addiction services are Māori."*
> (Organisation/service provider/group)

Many of our whānau are uneasy about accessing mainstream services which means that kaupapa Māori services are having to provide the support needed without the funding to do so. Funding restrictions mean that there are limited opportunities for growth and development of kaupapa Māori services. Resources are often inappropriately targeted, maintaining a focus on acute and chronic conditions, rather than early intervention and maintaining wellness.

There is underinvestment in community resources, reflecting poor funder and planner knowledge of Māori community needs. This impacts on service access for whānau, particularly for addictions.

There is a dominance of individualised, deficit and illness-focussed models in the health system, and these impact on the ability of kaupapa Māori service providers to operate from a whānau centred approach. Funding models remain compartmentalised, bed-based, individually-focussed and siloed. Geographical location and deprivation are often not accounted for in funding structures for kaupapa Māori services. Rigid, single focus contracts encourage competition instead of collaboration.

*"[we are] tired of competing with others for scraps and hand me downs from ungenerous funders and Treaty partners. Funders are pitting us against one another - who will do more for less money."*
(Organisation/service provider/group)

Whānau experience significant barriers to accessing kaupapa Māori services. Access is often only available via a single point of entry from mainstream secondary services, and the lack of referrals made to kaupapa Māori services following release from inpatient services is a concern.

*"As Māori providers, we are frustrated that we are often bypassed within the referral system. This means that our rangatahi primarily end up enduring negative first contact experiences with the system."*
(Organisation/service provider/group)

## 8. Workforce

It was asserted in many submissions that the mental health and addictions workforce did not reflect the community it served. There was an urgent need for more Māori in health, legal, education and social services roles. Non-Māori are filling roles intended for Māori. Mental health workers are undervalued, under-resourced and overworked, and the profession doesn't hold appeal to students. Cultural training is not viewed as a priority, and kaupapa Māori is seen as the responsibility of Māori alone. Support workers need greater levels of support.

Staff shortages in mental health services often led to providers in NGOs picking up more acute cases and have huge caseloads, preventing individualised time and care. There is tension amongst health workers, and often infighting between staff members. Providers are conscious of being overloaded, and rather than set a precedent that they won't be able to follow up, are forced to decline referrals. Workers in kaupapa Māori services report

dealing with situations beyond the training of their kaimahi, and needing to urgently train staff in mental health first aid and family violence in order to meet the needs of the community they serve. Appropriate clinical supervision is identified as a specific need for the Māori workforce.

> *"Our workforce is burnt out – they're traumatised by what we make them do."*
> (Kaupapa Māori service provider)

Staff need to work as a team, and this requires time to incorporate it into overloaded schedules. Cultural competency and supervision needs to be a requirement for all workers in the health system, with key performance indicators for accountability. Politicians and health professionals are disconnected from our reality; they have limited awareness of the lives our whānau lead or the challenges we face.

Those with lived experience are a valuable contribution to the workforce; this includes experience in mental health and addictions, but also across the range of sectors, such as WINZ and the Police. More peer support workers are needed, and appropriate training provided.

> *"[We need] more peer workers; unwell people are desperate to have people that understand what they are thinking and feeling."*
> (Organisation/service provider/group)

## 9. Our whānau

### 9.1. We continue to feel the impacts of colonisation

Detailed within many of the submissions from Māori was a sense of alienation and annexation. We continue to feel the ongoing, deeply entrenched, intergenerational impacts of colonisation. These damaging effects are evident in our persistently higher rates of

suicide, incarceration, homelessness, unemployment, alcoholism, substance abuse, gambling, violence, addictions, transiency, gang living, diagnosed mental health conditions, and in low levels of formal education and health and financial literacy. Many whānau don't have fundamental life skills such as planning, budgeting and household management. There is a direct correlation between those who were taken into state care as youth and those who have been in or are currently in prison.

### 9.2. Our whānau are living in poverty

Also detailed within many of the submissions were experiences of material hardship. The realities of whānau lives are inconsistent with good health. Many of our whānau are homeless or living in inadequate, cold, damp housing. Our tamariki are growing up knowing hunger on a daily basis. Poverty means limited access to health services and educational or employment opportunities. People in survival mode don't have the luxury of thinking beyond the day.

Prisons are holding cells for our people – including tāngata whai ora – who have no appropriate housing to go to. Our communities lack fundamental resources such as supermarkets. Reduced employment opportunities and low rates of pay for those who are employed mean the illicit drug industry provides income or supplementary income to many whānau and communities.

> *"These kids have to learn that it's normal to have food every day."*
> (Hui participant)

### 9.3. We experience multiple marginalisations

Submitters drew attention to the triangle of crime, mental health and addiction and the ways in which whānau experience multiple marginalisations because of this. Further marginalisations are experienced by those who live with disability, or identify as takatāpui or LGBTQI+. The roles of wāhine Māori have been negatively impacted by colonisation.

We have instances of four meth-using generations. The layered effects of poverty, trauma, violence, transiency, suicide and addictions are passed through generations and have

become chronic conditions for many of our whānau. We need sustainable intergenerational healing which requires time and courageous commitment, starting with the next generation who are being raised within and are dealing with these conditions. Many whānau have been affected by suicide several times over, and the age at which whānau members are self-harming or taking their own lives is increasingly younger.

> *"[I'm] sick of burying people and carrying them to the urupā."*
> (Hui participant)

### 9.4. We are denied our own language and culture

A recurring theme in submissions was the significance of te reo Māori as a foundation for wellbeing but which is denied by a monocultural and monolingual system. We are unable to live freely in a society that values our language, culture and philosophies. This ongoing suppression is blatantly evident in all aspects of our society, and our traditional way of life is subsumed and assimilated into the dominant culture in this country. Our tamariki need a sense of knowing who they are; without a clear identity and sense of belonging, mental health deteriorates. This identity as Māori and a sense of belonging is denied to our tamariki and whānau in present society.

The impact of the Tōhunga Suppression Act is still felt today and more tōhunga are needed. There is a lack of commitment to cultural competency in the system. Biculturalism is often left aside for multiculturalism, which fails to acknowledge that the Treaty is between the Crown and Māori.

> *"We know what happens to people when culture has been taken away from them; gangs exist because culture is taken away from young brown men ... how do we let people grow into their own culture and how does the government do that as well? We need to grow mana."*
> (Hui participant)

### 9.5. Our whānau are fragmented and dispersed

The separation of whānau from each other and from te ao Māori was seen in submissions as a serious risk to health and wellbeing. Social isolation and severed connections to whānau and whenua contribute greatly to compromised mental health for our people. Those who live rurally have limited access to services. Others are forced into urban environments which often means disconnection from whānau support. Drugs, alcohol and violence also fragments family units. Kuia and koroua are caring for mokopuna when parents are affected by drugs, ill health or incarcerated.

Most of our whānau live away from their ancestral marae, and maintaining that connection is often difficult due to limited finances. Many of our whānau live overseas, particularly Australia, which means less support networks for those living here at home in Aotearoa.

There is research that evidences social isolation among Māori. A better understanding of the correlation between disconnection and issues such as suicide, family harm, mental distress and addiction is required.

> *"Māori experience trauma in distinct ways that are linked to the experience of colonisation, racism and discrimination, negative stereotyping and subsequent unequal rates of violence, poverty and ill health."*
> (Organisation/service provider/group)

### 9.6. Suicide, suicidality and self-harm

Concerns about the high Māori rates of suicide were raised in a number of submissions. The rate of suicide for Māori is alarmingly high, and increasing. This is an issue that must be addressed without delay. There is currently no national strategy or direction for suicide prevention in Aotearoa, despite a fundamental need for change in suicide, suicidality and suicide ideation rates in our country.

The pathways to suicide and suicidality were seen to be complex, and linked to diverse experiences of trauma, enduring adversity, cultural alienation and significant adverse life events. These are often associated with drug and alcohol challenges. There is an increased risk of suicide 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.

The assessment process for whānau considered at risk of suicide was considered inadequate; risk indicators are not being adequately considered, there is a lack of psychiatric input into initial assessments and approaches to suicide risk are inappropriate. There is a need for improved crisis response, prioritisation of cases requiring urgent attention and adequate follow up and resource allocation. Effective wrap-around support must be provided for those who are at risk.

While clinical support is identified as important, there was also a strong emphasis on growing the capacity of whānau and communities to respond themselves, within their own cultural context. This is further highlighted by a lack of faith in the mental health system to provide adequate support for whānau. Whānau and communities, including rangatahi, require tools able to help them identify distress and provide support until appropriate help is able to be accessed. Programmes such as free community Gatekeeper trainings (e.g., ASIST and SAFETALK by Lifeworks) were referred to as useful.

Cost was identified as a barrier to services for many whānau.

Submitters also noted that Aotearoa already has a solid foundation for addressing Indigenous suicide in, for example, the Tūramarama Declaration.[10] We need Māori worldviews, cultural practices and self-determination as platforms for hope-building within Indigenous suicide prevention. Suicide prevention needs to be integrated within an everyday focus on how to build, create and sustain wellbeing, and to promote resilience and emotional agility.

The voices of whānau with lived experience should be prioritised when seeking solutions and responses to suicide. Rangatahi have described reservations around talking to adults about concerns they might have for the safety for another rangatahi, also noting that at times their immediate whānau are not always the best people to approach, and there is often the need for another trusted adult in their lives.

The effect of suicide on whānau and friends is profound. Whānau bereaved by suicide are a vulnerable, priority population requiring meaningful support. For some, this experience contributes to their own suicidal thoughts, and they are affected by issues such as self-blame, guilt and self-destructive coping mechanisms such as substance abuse.

[10] https://journalindigenouswellbeing.com/media/2018/07/73.69.Indigenous-suicide-The-Turamarama-Declaration.pdf. See Appendix 1.

Ensuring whānau are effectively supported after a suicide, and upholding the right of whānau to determine their own processes for healing is critical. Some whānau disengage with mainstream services such as Victim Support, as they often don't meet the needs of whānau Māori, don't always make timely contact and whānau often don't perceive of themselves as 'victims'. Brochures provided for whānau affected by suicide are outdated. Connection to the range of support available is critical. Agencies that implement whānau-centred approaches are particularly relevant. WAVES, an eight-week programme for those bereaved by suicide, is referred to as being useful.

The need for culturally appropriate, whānau-centred, rangatahi-specific responses for rangatahi Māori affected by suicide is also specifically advocated for. Adequate postvention support for the workforce is also identified. The use of local and international suicide research in developing services and initiatives is recommended.

Ensuring coronial processes are more robust, with toxicology investigations conducted in every suspected suicide, is also recommended.

A suicide prevention centre of excellence has been suggested to drive community suicide preventon work, including a focus on measuring the effectiveness of suicide prevention initiatives.

### 9.7. Alcohol, other drugs and addiction

> *"Minimising the spread of methamphetamine abuse is one of [the] biggest challenges our communities currently face, we expect this urgency to be reflected at a national level."*
> (Organisation/service provider/group)

Māori submitters also raised serious concerns about the impact of alcohol and drugs on whānau. Our whānau are heavily impacted upon by alcohol, drugs and addiction, particularly methamphetamine, which has devastating impacts on whānau and communities. Those who work in education are particularly aware of the negative impact of addiction on children.

Alcohol and addiction needs to be reframed from being a criminal and justice issue to a health issue, with the focus placed on regaining wellness. This requires a review of the

Misuse of Drugs Act 1975. Drug laws disproportionately impact our whānau and Māori are over-represented in convictions and imprisonment for drug-related offences. Decriminalisation of certain drugs, harsher penalties for those manufacturing and selling illegal drugs, increased drug rehabilitation facilities and court-ordered treatments are seen as important. There is some shift in this direction with the existence of Therapeutic Courts, although these are still driven from within the justice system.

Drug enforcement funding should be more effectively redirected to drug treatment, education and prevention, better positioning primary healthcare to more effectively respond to addiction issues for Māori.

> *"Prison beds could be swapped for drug rehab beds."*
> (Kaimahi)
>
> *"Decriminalisation has the potential to remove this stigma and fear of incrimination that drug users experience when considering support or treatment and, therefore, the potential to improve mental health and addiction outcomes."*
> *(*Organisation/service provider/group*)*

There is a high level of need for effective addiction services, detox and alcohol and other drug (AoD) counselling for our whānau, particularly rangatahi. Whānau need ready access to kaupapa Māori AoD services, long-term support and appropriate information on services and achieving wellness. A dedicated addiction workforce is required to support this. Education on addiction prevention is needed in both schools and workplaces.

## 10. Impact on mauriora

> *"When our whānau go through domestic violence, they tend to refuge each other rather than reach out for help, 'cause once you call the cops, there goes your kids, there goes your whānau, there goes your everything."*
> (Social worker)

### 10.1. Fear and distrust

It was clear from the submissions that there is a disturbing lack of trust in services. There is a deep distrust of a system that is judgemental and provides inappropriate, inadequate care for our people. Many whānau live with the real fear of imprisonment, being placed on medications or fear of their children being taken from them. This stymies access to necessary services. Whānau experience daily anxiety from fear of Oranga Tamariki cold calls. Despair and hopelessness escalate when whānau are informed children won't be returned, promoting a return to drugs and unwellness. Whānau carry the stigma of poor mental health, suicide and poverty.

We experience whakamā at our limits in knowledge of our own culture and reo and this impacts deeply on our sense of identity and security. Suicide carries a weight of whakamā for the bereaved whānau.

We are ashamed at the inability to provide basic necessities for our children, with an associated loss of self-belief in being able to fulfil this role. There is immense stress from living in material poverty and without essentials such as a secure place to live and enough food. Most whānau live in rented accommodation, which can lead to transiency. Migration impacts our whānau and we are particularly vulnerable when we move towns.

We are made to feel we are a burden on the system. Often our physical symptoms are not believed because of 'mental illness', or our mental symptoms not believed because 'it's just cannabis'. There is no industry to prepare us for the death of a loved one - either in a practical sense or emotionally - as there is to prepare us for the birth of a child (such as antenatal classes and Lead Maternity Carer support). Unresolved grief impacts on our wellbeing. Whānau have to fight for services and we experience further stress when our involvement in the care of loved ones is rejected. Many whānau are in distress, and many communities feel helpless.

> *"The biggest problem for us was being ignored right at the front desk of the mental health service because they don't want to speak to family. They want to talk to him, not us. But he can't. He's too traumatised to speak for himself."*
> (Mother of tangata whai ora)

## 10.2. Stigma

> *"Many people don't engage with mental health and addiction services because of the stigma associated with mental illness and addictions. We need to do more to reduce this stigma through positive marketing and promotion in order to see a true improvement in engagement from those who are distressed and need support."*
> (Organisation/service provider/group)

The stigma attached to mental health was identified in submissions as a major deterrent to seeking help. There is a persistent stigma attached to mental health. For our whānau, this stigma is intertwined with racism. Stereotypes and negative connotations attached to mental health are major barriers to accessing support services.

The language used in mental health needs to change. Jargon needs to be avoided, along with language that implies blame or fault. Jargonistic language distances us; whānau report officials using alien terms such as 'cohorts' and 'contagions' to talk about our babies. The use of military-style instructions given to our whānau needs to stop. There is a tendency to patronise rangatahi and make their decisions for them. The way mental health is discussed publicly and societally has a huge impact on people's value and self-worth.

# Conclusion

This report presents an overwhelming call to action for the government to effect positive and sustainable change in the health system in relation to mental health and addictions for tāngata whenua to thrive in Aotearoa. Kaupapa Māori solutions are required for Māori to live in a society that is founded on the principles handed down from the ancestors, and one in which there will be ready access to all the determinants for good health and wellbeing.

It is clear from submissions that the current system cannot continue. Whānau have expressed considerable concerns about a system that is overly focussed on pharmaceutical solutions, is difficult to navigate, is colonising, racist, and does not respond to needs in a timely or effective manner. We are made to feel disempowered in a system that doesn't acknowledge mana Māori and in fact, has in many cases caused further harm. Our workforce is overburdened. Kaupapa Māori services are stretched, underacknowledged, underresourced and constrained in a system founded on principles that conflict with our inherent values.

Those who made submissions to the Inquiry not only brought out the shortcomings of a dysfunctional system but also pointed towards the solutions. In these pages there is the strong message that Māori solutions will work for our whānau, and will offer approaches that is inclusive of all.

The voices of whānau Māori have been heard, and heartfelt acknowledgement is made to all those who came forth during the consultation, either in writing or in person, and shared stories, pain, hopes and aspirations for our future.

Ngā mihi aroha ki a koutou katoa.

# Appendix 1: The Manawanui Principles and the Tūramarama Declaration

## The Manawanui Principles

These principles were developed at a hui on methamphetamine and drug usage on 9 March 2018 at Manawanui (DHB Māori mental health service), Point Chevalier.

The 'P' phenomenon was seen as a response to wider environmental adversity and led to advocacy for an approach where cultural enrichment, whānau integrity, iwi leadership and other preventative measures were supported. The nine key principles are as follows:

- Manawanui: a determination to address all facets of the problem;
- Te Ao Wairua: recognition of a spiritual dimension and spiritual voids as part of the addiction reality;
- Te Ngangara: a concerted effort to erase the drug scourge;
- Te Korowai Aroha o te whānau: the role of whānau as both a protector and solution;
- Whakapiripiri tāngata: collective efforts and collective solutions;
- Aukati: prevention by focusing on homes, schools, streets, outlets;
- Ngā Ara Tuturu: pathways to wellness that are aligned to tikanga Māori; kimihia he huarahi i te ao Māori;
- Ūkaipō: spiritual, physical and cultural nurturance; and
- Iwi kei mua: leadership, influence and initiative from iwi.

## The Tūramarama Declaration

- We, participants in Turamarama ki te Ora World Indigenous Suicide Prevention Conference, held in Rotorua, New Zealand on 1-3 June 2016, are deeply concerned about the high rates of suicide among indigenous peoples.
- We weep for the increasing number of our people whose lives have been cut short by suicide.
- We respect the courage and fortitude of families and friends who have endured unexpected and often inexplicable losses of dear ones.
- We commit ourselves to healing our own wounds and the wounds of our lineage, and in doing so to exemplify the ways in which light can be brought into the world inhabited by our elders, our peers and our young people.
- We declare that all our people should be able to 'live well, into old age'.
- We believe that the will to 'live well' is strong when the human mauri is strong; 'living well' means being able to live as Māori, as Indigenous Peoples, and as citizens of the world.
- We will strive to build safe and nurturing communities that generate confidence, integrity, inclusion, equity and goodwill.
- We recognise the key roles that whānau and families play in strengthening the mauri by transferring knowledge, culture, language, values, and love to their children and grandchildren.
- We endorse the benefits of tikanga, kawa, healing, and other cultural protocols to lift the spirit and strengthen our people in schools, health centres, sporting clubs, social media, the workplace, and the streets.
- We expect health, education and all social service providers to offer services that are accessible, timely and effective for indigenous peoples.
- We urge our own indigenous leaders, tribal authorities and community champions to create opportunities for our children,youth, women, men and our older people so they can be part of te ao Māori and the indigenous world, and can be active participants in the communities where they live and work.
- We challenge national and local authorities and city councils to adopt and enforce regulations to reduce the availability of alcohol and other harmful substances, to ensure that homes are warm, comfortable, and affordable, to insist that streets, workplaces, schools, and the internet are all safe places for our peoples, and to combat practices that diminish self-worth and hope.
- We call on our elected leaders in parliament, especially those who have responsibilities for education, social services, health, housing, employment, indigenous development, and the environment, to work together in order to create a

society where equity of access, equitable outcomes, and extended opportunities can prevail.

- We recommend that our people in the United Nations Permanent Forum on Indigenous Issues make all nation states aware of the extent of Indigenous suicide and ensure that suicide prevention is highlighted in the UN Millenium Goals. We pledge ourselves to work collectively so that our combined energies can create a world where the mauri can flourish and all our peoples can live well, into old age.

Declared at Rotorua, New Zealand, 2-3 June 2016.