Rangahaua Te Kūwatawata!

The Te Kūwatawata Evaluation

Final Report

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February, 2019

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TE AHO A MĀUI

He kupu aumihi: Acknowledgements

Rangahaua Te Kūwatawata!

Always be seeking knowledge

E tika ana, me mihi atu ki ngā tāngata nā rātau tēnei kaupapa i kōkiri. Ko te tūmanako ake, kia tū ai Te Kūwatawata hei puna hauora mō rātau e awhero ana kia kore katoa ai ngā taumahatanga e pēhi nei ki runga ki tō te Māori wairua. Ēkene, mā ēnei tuhinga e whai ake nei, hai tuku i tētahi kōrero whakamahuki ki ngā rangatira o te Ao Hauora.

Our sincere thanks go to all the stakeholders we interviewed, who fitted us into their very busy schedules to share their feedback on this service. Special thanks also go to the whānau who generously described for us their journey through the Te Kūwatawata service. Thank you for your heartfelt stories.

We are also grateful to the staff at Te Kūwatawata who good naturedly fielded our many questions and enquiries. We thank David Stevenson and Eraihia Ingle who provided us with the quantitative and audit data for this report and Heather Robertson who assisted with the clinical audit. Sincere thanks is also due to Mark Kopua for the use of his art work throughout this report.

We would also like to thank Professor Bob Marshall, for providing advice and feedback on the survey tools and quantitative data; Janine Perkinson, adminstrator for the EIT Research and Innovation Centre, for management of the contract; and Jillian Johnstone for proof-reading the final document.

Declaration of Potential Conflict of Interest:

Our evaluation lead, Professor David Tipene-Leach, had prior knowledge of this Māori mental health initiative, having first encountered Mahi a Atua when attending and presenting at a Hauora Tairāwhiti mental health *wānanga* in May 2017. He subsequently co-authored two papers describing the Mahi a Atua approach with psychiatrist, Dr Diana Rangihuna-Kopua, and Tairāwhiti tohunga, Mark Kopua - both of whom were in roles integral to the establishment of the Te Kūwatawata service. This pre-existing relationship was fully declared in our tender proposals. We argued that, although there was some potential for perceived conflict of interest, Professor Tipene-Leach was well experienced in separating research pursuits from intervention development and the relationship could be seen as being good for the evaluation in that, as *kanohi kitea*, (one who has been seen) he was already known to and accepted by both Mataora and the mental health service management team. We were awarded the contract with this Potential Conflict of Interest fully declared.

He kuputaka: Glossary

Ātea – marae courtyard
Atua – deity or god
CAMHS - Child & Adolescent Mental Health Services
CTO – Compulsory Treatment Order
DHB – District Health Board
DNA – Did Not Attend
EIT – Eastern Institute of Technology
FIT – Feedback-Informed Treatment
Hinekauorohia – 'She of the reflecting waters'/ reflection time in the wānanga
ICAMHS – Infant, Child & Adolescent Mental Health Services
Indici – a Patient Management System
Kaimahi - worker
Kaitono – person who makes a referral to Te Kūwatawata
Kaituruki – person who supports discussion leader
Kanohi ki te kanohi – face to face
Karakia – prayer/incantation
Kaupapa – topic, issue
Kura Kaupapa – Māori language school
Mahi a Atua – a Te Ao Māori methodology/therapeutic approach using traditional creation stories
Marae – traditional meeting place
Mataora - worker trained in Mahi a Atua
Mātauranga – knowledge, wisdom
Matataki - worker who receives referral, pre-assesses whānau and arranges first contact
MHS – Mental Health Services
MHSOP – Mental Health Services for Older People
MOH – Ministry of Health
MOU – Memorandum of Understanding
NGO – Non-Governmental Organisation
ORS – Outcome Rating Scale
Paepae – orators' bench
Pepeha - tribal saying
PHO – Primary Health Organisation
PMHS – Primary Mental Health Service
PMS – Patient Management System
PRIMHD - Programme for the Integration of Mental Health Data
PSA – Public Service Association
Pūrākau – creation narrative
Rangatahi – young person
Red Phone – a phone dedicated to calls from kaitono to make an appointment
RFP – Request for Proposal
RNFW – Registered, No first wānanga
ROI – Registration of Interest

SPoE – Single Point of Entry
SRS – Session Rating Scale
Taonga – treasure, precious item
Te Ao Māori – Māori worldview
Te Ara Maioha – Hauora Tairāwhiti secondary mental health services
Te reo Māori – Māori language
Tikanga - customary practice
TK – Te Kūwatawata
Tohunga – cultural expert
Tono – a referral to Te Kūwatawata
Ue - therapeutic group of mental health workers assigned to work together with whānau
Uekura – front desk, reception, administration team
Waka – canoe, vehicle
Wānanga – a learning opportunity session
Whakawhanaungatanga – the process of becoming acquainted with one another
Whānau – the people who the referred person presents with or, sometimes, just the referred person
Whanaungatanga – relationship, kinship
Whare wānanga – traditional learning environment

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Introduction and Background

New Zealand's mental health services have experienced increasing capacity problems with demand and access issues, gaps and roadblocks in care systems, stressed mental health workers and a call for wider attention to the cultural and social context of distress. Māori have persistently poorer mental health status and outcomes than non-Māori. Apart from the impacts of the social determinants of health, these disparities appear to be due, in part at least, to a systematic 'cultural competence' gap in the mental health worker skill set and institutional racism. The Tairāwhiti District Health Board (Hauora Tairāwhiti) has one of the highest levels of mental health distress in the country and in 2016-2017 the proportion of Māori in Te Tairāwhiti who accessed mental health services continued to be much higher than the proportion of non-Māori.[1,2] Hauora Tairāwhiti designed an ambitious new mental health care service in Gisborne with a Te Ao Māori framework that was to span the primary, secondary and non-government organisation (NGO) mental health sectors. Te Kūwatawata was framed to meet the particular needs of the Gisborne community, where Māori make up half the total population and two thirds of those using mental health services, and promote equitable mental health outcomes for Māori.

Commencing on 1 September, 2017, Te Kūwatawata was intended as a 'single point of entry' (SPoE) service for all whānau in the region experiencing mental distress. Funding for the contract period, which ran from June 2017 to September 2018, was obtained from the Ministry of Health's *Fit for the Future – a Systems Approach* Project and then subsequently extended till June 2019. This new service was to be a partnership of the Hauora Tairāwhiti secondary service, Pinnacle Midlands Health Network PHO (Pinnacle) and the community-based NGO, Te Kupenga Net Peer Support and Advocacy Trust (Te Kupenga). The partners had committed to working with Te Kurahuna (the hidden gem), an (unincorporated) local mātauranga Māori wānanga (storehouse of Māori knowledge) that had been training mental health (and other) workers in cultural competency over the previous two years.

[1] Williment R, Codyre D, Katene K. Report and recommendations for Tairawhiti adult mental health and addiction services: A pathway to better mental health 2008. 2008. Available from: https://www.parliament.nz/resource/mi-NZ/50SCHE_EVI_00DBSCH_EST_12167_1_A341281/a07ff3d83a5aed093a3a2bcc7b28b415b77fb3f3

[2] Ministry of Health. Mental health, alcohol and drug addiction sector performance monitoring and improvement. 2018. Available from: https://nsfl.health.govt.nz/accountability/performance-and-monitoring/baseline-data-quarterly-reports-and-reporting/mental

Te Kūwatawata deployed a Te Ao Māori methodological approach to care within a mainstream mental health service - something not done in any other service in Aotearoa New Zealand. It aimed to develop, in the manner of a single point of entry, an efficient and competent portal into the raft of services that were available to the mentally distressed. It also aimed to develop a Māori-resonant point of entry and holding space that had a therapeutic treatment pathway to offer. This used multi-disciplinary and culturally competent teams, most of whom entered training with Te Kurahuna and became experienced in pūrākau (ancestor and creation stories), a practice called Mahi a Atua (footsteps of the ancestor-gods). These workers, called Mataora, were a range of diversely qualified people with recognised expertise as tohunga, cultural experts, artists, administrators and clinicians, and were organised into work teams called Ue (a party that turns the tide). Central to the Te Kūwatawata service were the following principles:[3] immediate response; whanaungatanga (i.e. meaningful relationships); flexibility and mobility; tolerance of uncertainty; wānanga; and transparency. The vision for the new way of working did not privilege the primacy of diagnosis, Western therapy, medication or coercion. In addition, a 'culture of feedback' was to be introduced to the care teams with a therapist performance and whānau outcomes measurement system called Feedback-Informed Treatment (FIT). Finally, there was to be a clinical record (Indici) shared with primary care.

Our 12 month contract to evaluate the 13 month implementation phase of the Te Kūwatawata pilot (September 2017 to September 2018), commenced in February 2018, five months into implementation. We produced an Interim Report in June 2018. This Final Report covers the 13 months of the pilot plus includes some observations through to December, 2018.

Methods

Our evaluation approach was based on Kaupapa Māori principles and comprised formative, process and outcome components. Our aims were: to work alongside Te Kūwatawata Steering Group as a 'critical friend' during service implementation (formative evaluation); to describe the service and assess successes and challenges of the implementation process (process evaluation); and to assess the impact of the intervention on service efficiency and responsiveness, service and mental health worker cohesion and collaboration, service and mental health worker cultural competency, and mental health outcomes for whānau (process and summative evaluations).

Both qualitative and quantitative methods were used. Qualitative data sources included: relevant service and other documents; participant observation; interviews/focus groups with purposefully selected key persons/stakeholders across the full range of services; meetings or informal phone calls (not audio-recorded) with stakeholders to clarify details; and interviews with a small number of whānau who had accessed the service for themselves or with a whānau member. In total we interviewed and/or consulted with 97 stakeholders, 21 of them twice (or more) and heard the stories of 13 whānau (6 young people and 7 adults).

[3] Hauora Tairāwhiti Request For Proposals: For provision of an Evaluation Service for Fit for the Future Initiative – Te Kūwatawata. Hauora Tairāwhiti, 22.09.17

In our stakeholder interviews, data saturation was met early on but we continued to interview people to keep up to date with issues as they changed within an evolving environment. The whānau interviews provided us with personal narratives to embellish the general findings, in particular the perceptions of stakeholders regarding whānau experiences. We endeavoured to ensure a range of whānau were approached using a number of different referral approaches.

Quantitative data sources included: the Hauora Tairāwhiti Te Kūwatawata and other mental health services monitoring data; Te Kūwatawata whānau data collected during the months of February, May and August 2018; Te Kūwatawata My Outcomes Feedback-Informed Treatment data; Pinnacle PHO Primary Mental Health service data; and SurveyMonkey© questionnaire data from general practitioners (GP).

Qualitative data were analysed by thematic analysis and the quantitative data were descriptively analysed.

Findings

Formative evaluation

Our formative evaluation processes enabled us to observe the Te Kūwatawata Steering Group, to provide an informed 'listening ear' to individuals in the leadership team and, particularly in the earlier months, to give useful feedback pointing out the issues we had identified to date and any improvements that might be made. Much of this centred around the partnership with Pinnacle PHO finding itself unable to sign the Memorandum of Understanding (MOU). Pinnacle's critique was centred around a) the change management process in developing a partner relationship with primary care; b) policies and processes inside Te Kūwatawata (including referrals, notes, communication to referrers about whānau outcomes or changes in prescriptions and the complaints process); and c) and the perception of that Mahi a Atua was the only therapeutic process utilised by Te Kūwatawata.

Our 'critical friend' feedback concentrated on the need to progress the PHO relationship and the importance of engaging more fully with the general practice sector, the main referrer to the service. Although we observed important changes in the Te Kūwatawata processes, occurring in response to our and other's critical feedback, at the end of the pilot period the relationship remained problematic.

Service responsiveness and efficiency

As part of the process evaluation the Te Kūwatawata philosophy, components and wānanga pathway were described. We considered this useful for any scaling of the intervention to other regions.

In terms of service responsiveness and efficency, the aspects that stakeholders liked and felt worked well were: the service's easy access and quick response (no entry criteria, the ability to walk-in off the street and the relatively fast response time); a friendly, culturally resonant and non-clinical environment; working with the broader whānau; the breadth of skills provided by the multidisciplinary Ue teams; the use of Mahi a Atua as a therapeutic approach; the transparency of

the Hinekauorohia process (reflections of and open discussion of the case in front of the whānau); and the use of Feedback-Informed Treatment as a quality improvement tool.

Several challenges pertaining to responsiveness and efficiency of the service were reported on in our Interim Report and we followed these up. Many of the issues around policies and processes, including referrals, notes, and communication of outcomes, had been or were in the process of being addressed although some were not yet fully embedded. We observed ongoing changes in processes in response to critical feedback from both within and outside the service. Concerns identified earlier were: not enough clinical input into the first encounter; the dominance of the Mahi a Atua therapeutic approach; lack of choice around a different pathway; and a hesitance to refer on to secondary services. In later 2018, we observed new processes implemented. These included: all referrals were triaged for urgency by a senior clinician; people were given choices around approach, practitioner and venue and these were modified if they were seen to not be working.

The workload within Te Kūwatawata increased steadily over the year not only because of its open access policy but also because, workers informed us, they were now supporting whānau for longer until secondary service appointments became available. Over time Te Kūwatawata had addressed its reticence to refer on, but secondary services had become stretched through having lost staff in the change process and through deploying significant numbers of other staff to provide clinical expertise in the Te Kūwatawata first wānanga/assessment process.

Service and mental health worker cohesion and collaboration

Amongst the staff inside Te Kūwatawata there was a strong sense of whanaungatanga, despite the stress of ongoing changes and the increase in workload. This was enhanced by shared training through Te Kurahuna, regular hui, and working in multidisciplinary Ue teams. However, the relationship between Te Kūwatawata and secondary services was problematic, especially in the early months, largely because of the pace and manner of the change process. We observed an improvement in this relationship over the months, but by the end of the pilot there were still outstanding issues that had not been completely resolved.

Although there were some very robust relationships with some GPs, with a few training as Mataora and taking part in wānanga, for a range of reasons (see above) a formal relationship with the intended primary care partner, Pinnacle PHO, had not been finalised by the end of the pilot. Consequently there were questions over the viability of the intended SPoE to Te Tairāwhiti mental health services. By the end of the Te Kūwatawata pilot, Pinnacle PHO had still not signed a Memorandum of Understanding (MOU) and was not encouraging its general practice members to refer all people to Te Kūwatawata as the single point of entry. Thus Pinnacle's Primary Mental Health Service (PMHS) team continued to receive referrals directly from the primary care sector as well as from some external sources, such as schools. Many GPs also stressed that they wanted the continued option of referring people to the PMHS.

Facilitating intersectoral collaboration as a new service trying to establish itself is a huge endeavour. Nevertheless we saw some good examples of it, with workers from a number of other agencies

(such as Corrections, NZ Police, Oranga Tamariki, Tauawhi, schools and others) referring whānau to Te Kūwatawata and at times attending wānanga with them.

Service and mental health worker cultural competency

We observed positive changes in Te Kūwatawata workers' confidence in working with Māori as a result of the Te Kurahuna training they had undertaken and their ability to apply this daily in a conducive environment. In general, it appeared that Māori workers felt liberated by being able to work in ways that felt quite normal for them, while Pākehā workers felt empowered by gaining confidence in this new way of working, which they observed worked well for many of their whānau. Workers in other health services and agencies who had attended Te Kurahuna reported making changes in their environment and practice and also found this empowering. More systemic change was unrealistic at this point. Of note, however, was the keen interest of health personnel from other regions who visited Te Kurahuna and Te Kūwatawata and were intending to implement similar services in their regions.

Outcomes for whānau

Amongst the 13 whānau experiences there were many very grateful reports of their experience of the service and the benefit they derived. It was clear that central to these were the relationships developed with the Mataora; the respect they felt from all those involved, including the Uekura on the front desk; the inclusive approach taken; the flexibility around venue and approach; and, for some, the experience of Mahi a Atua. Several whānau gave very glowing accounts of their or their child's experiences and a few reported quite remarkable transformations. One mother spoke for others when she said,

> *I think about 90 percent of our whānau's healing was done in that one [first] wānanga. It was amazing.... I liked that they didn't work one-on-one. There were always two workers there. And I love the storytelling. I love the whakawhanaungatanga; that was beautiful. Just everything that our whānau had been going through from day one had been validated and heard and that just felt really empowering to us as a whānau. (Whānau, April 2018)*.

Not unexpectedly, there were a few whānau reports of negative experiences with the service. However, most of these whānau still supported the existence of the service. We also heard that where the Mahi a Atua experience was viewed as not so appropriate, such as with non-Māori clients, whānau were grateful for the opportunity to be held and supported in the service until they secured an appointment with secondary services . That is, the wānanga process was imbued with respect, inclusiveness, sacredness, caring and the invitation to provide honest feedback - aspects that were valued by clients from a range of cultures.

Quantitative data

Referrals to Te Kūwatawata

Approximately one third of all referrals came from GPs and another 30% from self-referrals. GPs referred increasing numbers of Māori to Te Kūwatawata and increasing numbers of non-Māori to the PHO PMHS over time. However, for self-referrals, although Māori made up two-thirds of the numbers, the rate of increase in numbers of referrals was the same for both Māori and non-Maori.

Whilst the total numbers of referrals increased only slightly over the pilot period, the workload, measured by 'unique clients' (whānau) seen by Te Kūwatawata (both Māori and non-Māori) and 'face to face contacts' per month, increased considerably. With a steady workload in PHO PMHS and other (non-SPoE) secondary services, this represents a considerable boost in mental health capacity in Gisborne. In addition, wait times were short with 20% seen on the day of referral, one third within two days and over half within a week. Compared to secondary services , Te Kūwatawata saw twice the number of clients with whānau members present.

Other areas of interest were reported on. A significant proportion (one third) of total referrals to Te Kūwatawata were made up of of Youth (aged <18 years). Youth referrals to the PHO PHMS and the Hauora Tairāwhiti ICAMHS, and admissions to the in-patient ward, decreased during the pilot period. Secondly, the use of compulsory treatment orders (CTOs) for Māori clients fell by 30% over the year. Thirdly, suicides doubled over the 2018/19 period from the previous year.

In addition, it was observed that approximately a quarter of referred whānau did not seem to get a first appointment. A subsequent clinical audit however, found that there had been intensive follow up of these whānau and that one third had already been transitioned to more appropriate service, one third did 'not want to engage' and the remainder were either uncontactable or were still being pursued by phone at the time of audit.

Finally, our SurveyMonkey© questionnaire to GPs (41% reponse rate) found that although all had referred patients to Te Kūwatawata, 63% had sent less than half of their referrals there, indicating strong continued use of the Pinnacle PHO PMHS pathway. GPs said this was because they had made a clinical judgement that it was more appropriate for their patient and nearly half responded in the affirmative to "I have some reservations about Te Kūwatawata". The survey confirmed that although GPs were sending a significant portion of their referrals to Te Kūwatawata, many were not supportive of Te Kūwatawata as the SPoE, that is, as the only point of entry to mental health services.

Discussion

Te Kūwatawata was the Hauora Tairāwhiti attempt to reconfigure mental health services in its region, in order to address high unmet need amongst distressed whānau in Gisborne with its large Māori population. The service was also to begin a process of tackling institutional racism in the mental health services. Deploying what was essentially a 'by Māori for everyone' approach was a mostly un-tested pathway in the mainstream, but all participants began the Te Kūwatawata project with partnership in mind. Previous workforce changes in Gisborne, however, had induced a sense of change exhaustion in secondary mental health services and resulted in resistance to this new change. In addition, despite initial willingness, by the end of the pilot period, the PHO had not joined the Te Kūwatawata partnership and had not activated primary care entry into the wider SPoE project. While many GPs were very supportive of Te Kūwatawata, most were keen to maintain a direct referral pathway to the PHO's PNHS.

Te Kūwatawata introduced a new way of working with distressed whānau that, differing from the orthodoxy, relied on prioritising whānau, their access to care and their voice in the conduct of the pathway. Ensuring the centrality of the whānau voice was a strong focus of Te Kupenga, the partner organisation that prioritised peer support and advocacy. The Te Kūwatawata service was also able to provide a Māori resonant pathway that was acceptable to many, providing social and pastoral as well as therapeutic support. We have demonstrated an increase in the capacity of mental health services in Gisborne since the advent of Te Kūwatawata, as both Māori and non-Māori took advantage of the walk-in facility. The number of both Māori and non-Māori self-referrals increased over time.

GP referrals of Māori to Te Kūwatawata also increased over time. But referrals of non-Māori did not; non-Maori were being increasingly referred to the PHO PMHS. Furthermore, with regard to pathways being increasingly defined by ethnicity, we note that GPs sent progressively fewer youth referrals to the PHO PMHS over time and that this was particularly so for Māori youth. We presume these youth were either referred to, or self-referred to, Te Kūwatawata. Finally, although we accept the notion that some whānau 'do not want a Māori service', this may suggest gate-keeping by some GPs who tended to see Te Kūwatawata as a Māori service rather than one for all-comers.

With respect to workforce development, both the Mahi a Atua therapeutic approach and the Feedback-Informed Treatment (FIT) aspect were critical to the Te Kūwatawata team. Our observation of 'liberated' Māori workers and 'empowered' non-Māori workers was important. It spoke to the training provided by Te Kurahuna who found a way to undertake cultural competence training in an inclusive fashion that resulted in the Mataora status that was valued by workers. The close relationship and regular meetings of Te Kurahuna (training) in the Te Kūwatawata workspace kept the pursuit of excellence to the fore. Significantly Te Kūwatawata introduced outcome measures to the clinical encounter through its use of FIT. This well established quality performance tool is innovative in Aotearoa New Zealand and Te Kūwatawata used it to introduce the whānau voice alongside cultural competence. The Te Kūwatawata FIT 'effect size' measurement of 1.8 was considered comparable with other good therapeutic services internationally.[4]

The primary critiques of Te Kūwatawata were to do with difficulties in the management of change process; the perception that the Mahi a Atua approach was dominating the SPoE service to the detriment of clinical input; and concerns about lack of policy development, constantly changing processes and poor paper work. While we saw changes over time within the service that remedied or mitigated many of these concerns, the relationship with the PHO and some GPs remained fraught, resulting in a partnership relationship with Te Kūwatawata not being formalised. This prevented implementation of the primary/secondary service SPoE. This dissonance may be explained in part by the different business models of the public-funded, population-oriented Te Kūwatawata and the private-business, patient-oriented PHO. In addition, the question of institutional racism arises. Was the 'resistance to change' a fear of having a Māori focussed

[4] personal communication Dr Scott D Miller, Director Interrnational Centre for Clinical Excellence

approach in the lead position, a Māori voice exposing the inequities and an 'unproven' Māori therapeutic modality entering into a fraternity of (sometimes unproven) Western practices? Clearly, more communication and relationship work with full participation by all sides is required if a primary/secondary services SPoE is still envisaged by Hauora Tairāwhiti.

There are two critical issues that need discussion in order that they are not left unnoticed or inappropriately attributed – the approximately one third decrease in Māori CTOs and the doubling of the number of suicides over the period of Te Kūwatawata development. Since 2013, there has been a nationwide Ministry of Health directive for DHBs to collect data on Māori subject to CTOs and, since 2017, to decrease the number of Māori detained in this fashion. The observed decrease from October 2016 to June 2018 in CTO use in Tairāwhiti was in progress before Te Kūwatawata was established and, given that most of these clients were cared for in secondary service, we are unable to say how much, if any, of the ongoing decline represents a sucessful outcome of the 'early care' provision predicted by the Hauora Tairāwhiti Te Kūwatawata proposal. In a similar fashion, we have no way of assessing the causation or attribution of the spike in suicide numbers. Firstly, the 2017/18 figures are provisional and may yet change and in addition, these are relatively small numbers which have fluctuated over the years with similar spikes in 2007/8 and 2014/15. Neither do we know how many of these deaths had involvement with mental health services and were therefore potentially preventable with better services but the role of a possible gap in service created by the change process or any primary failure in the Te Kūwatawata model needs to be examined as part of the pathway forward. Finally, it should be noted that this increase in Tairāwhiti suicides has occurred alongside a four years long national trend of a increase in suicides of which the 2017/18 year was the highest.[5]

Which pathway Hauora Tairāwhiti proceeds down now is critical. We see that some would have a Te Kūwatawata-like service simply 'bolted on' to a mainstream SPoE because, without the Te Ao Māori approach at the SPoE level, the coming together of primary and secondary care might be much simplified. We counsel against that. Pinnacle PHO and general practitioners will take their own approach and likely upgrade the present 'brief interventions located in the PHO' to the Procare PHO Stepped Care Model of 'brief interventions located in the general practice office'. This being the case, the public sector should continue to invest in the Te Ao Māori SPoE agenda that makes a positive contribution to Māori mental health while also being welcoming and providing benefit to all comers.

Te Kūwatawata is part of the Hauora Tairāwhiti answer to the equity provisions of Article 3 of the Treaty of Waitangi and we should celebrate their courage. Many of the provisions of the recent *He Ara Ōranga: Report of the Government Inquiry into Mental Health and Addiction* can be seen in Te Kūwatawata and Hauora Tairāwhiti could be seen to be front-footing this issue. Te Kūwatawata has laid out a pathway for the achievement of many of the outcomes recommended by this report, with increased access, short waiting times, greater whānau involvement, increased teamwork, a culturally

[5] Annual provisional suicide statistics for deaths reported to the Coroner between 1 July 2007 and 30 June 2018. Retrieved from: https://www.mentalhealth.org.nz/assets/Suicide/2017-2018-Annual-Provisional-Suicide-Statistics-Final.pdf

competent mental health workforce and the measuring of whānau outcomes. In addition, it is a current example of the He Ara Oranga directive to work toward eliminating “discrimination, institutional racism and unconscious bias" in the quest for equitable outcomes.[6]

Interest from other regions is high, with many watching Te Kūwatawata processes and outcomes with great interest. The service is scalable. Representatives from three major regions with significant Māori populations have visited Te Kūwatawata and two are keen to implement their own mana whenua version of Te Kūwatawata into their regions. This being the case, there are salutary lessons to be learned from the Te Kūwatawata experience, particularly around change management and communication. The risk in undertaking mainstream projects using a Te Ao Māori methodology is that the latter gets blamed for problems that are more systemic in nature. For this reason any new significant change process based on Te Kūwatawata would need to ensure the ground work is put in place, perhaps in line with the key fundamentals outlined in the Collective Impact theory, so that sound processes and strong cooperative relationships support the move forward. The Collective Impact (CI) model has influenced changes in approach within health, education, social service and business sectors internationally since 2011,[7] and we have used it here as a framework for our recommendations.

The impetus for change must not be lost. Both the move towards ‘prioritizing the voice of the consumer’ and the ‘mātauranga Māori’ approach are required to transform New Zealand’s reactive and transactional system of mental health treatment to a holistic and responsive, relational, person-centred, system of care and support for those in distress. Although there is still much work to be done and many difficulties to negotiate, Hauora Tairāwhiti has implemented a service for distressed people based on an indigenous approach that is showing great promise and is an example for other local and international communities.

[6] He Ara Oranga: Report of the government inquiry into mental health and addiction. 2018 November. Available from: www.mentalhealth.inquiry.govt.nz/inquiry-report/:p 88.
[7] Kania, J., & Kramer, M. (2011). Collective Impact. Stanford Social Innovation Review. Retrieved from: https://ssir.org/articles/entry/collective_impact

Ngā tohutohu: Recommendations

Rūaumoko

To ensure the success of the Te Kūwatawata project in Te Tairāwhiti

- **Create a 'Shared Agenda'**
  Continue the co-design process around the SPoE - maintaining the aim of bringing all partners increasingly together around the future of a SPoE that includes primary care services

- **Develop a 'Common Measurement'**
  Institute a database that enables efficient data collection of aggregated data feeding into a comprehensive set of measurable outcomes

- **Agree on 'Mutually Reinforcing Activities'**
  Introduce the opportunity of Te Kurahuna and Feedback Informed Treatment training across the Tairāwhiti mental health sector

- **Facilitate 'Continuous Communication'**
  Introduce a comprehensive communication plan that includes the primary care and secondary mental health sectors, Māori health networks and the wider community.

- **Strengthen the 'Backbone Support'**
  Clearly define the range of leadership roles in Te Kūwatawata - management, clinical and workforce development. Clarify and strengthen the governance oversight of this leadership.

  Complete the development of Te Kūwatawata documentation. Many of the Te Kūwatawata policy and procedures documents have been either inherited from Te Kupenga Net Trust or have become outmoded as processes have changed across the implementation.

  Develop a formal quality improvement process for Te Kūwatawata.

  Create dedicated 'office space' for Te Kūwatawata staff. While inviting, comfortable, and interesting for whānau, the present space is not the ideal working environment for staff.

Ensure structured human resources support and clinical supervision of Te Kūwatawata staff to prevent workers from becoming overloaded and stressed under pressures of high service demand.

To further develop the lessons of Te Kūwatawata

- **Further develop workforce development training opportunities**
  Develop the cultural competency of mental health staff across Te Tairāwhiti. Te Kurahuna working alongside Te Kūwatawata has been formative and similar opportunities across Hauora Tairāwhiti and the wider mental health sector need to be created.

  Develop wider cultural competency workforce training opportunities with Te Kurahuna among collaborating organizations in the social sector.

- **Formalize the Mataora role**
  Formalize an "accredited, integrated mental health practitioner able to meet the needs of the full spectrum of clients and able to be adapted to build effective therapeutic relationships when working with Māori" as per the Network 4 Platform Trust model.[8]

- **Formalize documentation of Mahi a Atua**
  Mahi a Atua requires robust documentation and a description of how it performs clinically, that is, a desription of Best Practice so people have assurance around clinical risk.

- **Implement Feedback Informed Treatment across the mental health sector**

- **Establish a shared Patient Management System**
  This would be across the primary and secondary mental health sectors to assist smooth transitions of whānau and their information.

To scale Te Kūwatawata

- **Assist other regions who wish to develop programmes similar to Te Kūwatawata**.
  They will differ slightly according to the needs of local people and mana whenua but should be availed of all the experience and lessons that the Te Kūwatawata experience has afforded us.

- **Insist on expert specialist change management person/team in the implementation.**

[8] Developing a service model for primary mental health support for moderate need: An evidence review developed by Network 4 in partnership with Platform Trust. 2016 November. Available from: https://static1.squarespace.com/static/57a93203d482e9bbf1760336/t/59127673d2b857d64b9f9435/1494382207821/Primary+Mental+Health+Evidence+Review+-+Network+4+and+Platform+Trust.pdf

There is no reason to think that change management will be any easier in other areas if the project includes a Māori approach.

- **Preserve the experience of Te Kurahuna**.
  The content of Te Kurahuna as a cultural competence teaching programme needs to be carefully documented.

- **Consider the 'location and structure' of any new mental health initiatives in the NGO sector.**
  This includes the possibility of a separate NGO structure with its own governance board that includes clinical and cultural expertise and local iwi representation.

- **Form a coalition of Māori mental health initiatives.**
  This will allow for a overview of policy development and strategy around funding at a national level, the coalescing of power and influence to advance that policy, the advancement of the new mental health worker (Mataora) model and leadership in Māori mental health

He whakawhanaungatanga: Our team

Paia-te-rangi

Māori & Indigenous Research is based at the Research and Innovation Centre, Eastern Institute of Technology, Napier. It is committed to research and evaluation that has a foundation assumption that poor Māori health outcomes result from inequitable social determinants of health, a culturally incompetent workforce, and institutional racism in the distribution of health resources. Our team for this evaluation comprises senior researchers who come with a mix of skills and considerable experience in research, evaluation and Te Ao Māori methodologies. We are all Hawke's Bay based.

Professor David Tipene-Leach (Ngāti Kere, Ngāti Kahungunu) is our lead evaluator. He is fluent in *te reo Māori me ōna tikanga* and has a background in general practice, public health and research. He is known for his volume of work on Māori health and disparities; in particular, the wahakura and the prevention of SUDI. He also has a history of general practice and research in the Tairāwhiti rohe. As part of his lead evaluator role, he is acting as the 'critical friend,' giving feedback to the Te Kūwatawata Steering Group. He is involved in all phases of the evaluation.

Dr Sally Abel (Pākehā, Ngā Ruahinerangi) has undertaken qualitative health research and evaluation for many years in both academic and community settings in Auckland, Te Tairāwhiti and Hawke's Bay. Since 2007 she has undertaken a range of health service evaluations, mainly of services aimed at reducing inequities for Māori. She is an independent researcher subcontracted to EIT for this evaluation. Together with Anne Hiha, she is undertaking the interviews/focus groups for this evaluation, conducting thematic analysis of interview data, and is involved in reporting and publication.

Dr Anne Hiha (Ngāti Kahungunu, Ngāi Tahu, Ngāti Rangitihi) has a particular interest in Kaupapa Māori frameworks and Māori pedagogy. Anne has published Kaupapa Maori Methodology: Trusting the Methodology through Thick and Thin (2016) and written on an approach that she calls the 'Whatu metaphor'. She has worked on a number of Hawke's Bay evaluations. She is an independent researcher subcontracted to EIT for this evaluation. Together with Sally Abel, she is undertaking the interviews/focus groups for this evaluation, conducting thematic analysis of interview data, and is involved in reporting and publication.

Professor Kay Morris Matthews has many years of academic research experience and has led a number of evaluations locally. She is currently the evaluation team co-leader of the *Ngātahi: Working with vulnerable children* project, working with 500 practitioners as they undergo a competency based training programme. *Ngātahi* implements a similar Action Research 'critical friend' approach to evaluation. Kay also has experience in the Tairāwhiti Arts and Museum sector through EIT and the Gisborne Museum. For this evaluation, she is the quality assurance lead, providing academic oversight and a peer review role.

He kupu arataki: Introduction

Tāwhirimātea

The Te Kūwatawata service was established as a 'single point of entry' (SPoE) to both primary and secondary mental health care in Gisborne. It was developed by a group of Te Tairāwhiti mental health providers as an innovative mental health and addictions initiative, in response to the Ministry of Health's (the Ministry) "Fit for the Future - A Systems Approach" tender. Te Kūwatawata utilizes a Te Ao Māori approach, multi-disciplinary therapy teams and a worker performance and client outcomes measurement system intended to produce improved mental health outcomes for priority populations.

The Ministry's tender asked applicants for the following:[9] to explore outcomes for people with mental health distress who 'are not easily managed in primary care and who do not meet the threshold for specialist services'; to invest money into 'existing initiatives in the sector' in order to build an 'evidence base about integrated models that work well and that were capable of being scaled up'; and to 'provide evidence that would inform the Ministry's longer term strategic plan to reshape our system to focus on outcomes'.

Hauora Tairāwhiti and Pinnacle Midlands Health Network PHO submitted a response in September 2016, to the Ministry's Registration of Interest (ROI) process. Having been shortlisted, in February 2017, the Gisborne providers responded to the Request for Proposal (RFP) with a third partner, Te Kupenga Net Trust, a non government organisation (NGO) with a mental health and addictions support and advocacy role. Together they proposed that the existing single point of entry (SPoE) to secondary services mental health care pathway be developed in order: to 'involve both primary and secondary providers'; to 'receive all comers, irrespective of the degree of distress'; and to 'adopt a Te Ao Māori framework, a shared clinical record and a client outcomes measurement system'.

Having been notified that they were successful in April 2017, with a 16 month contract from 1 June, 2017 to 31 September, 2018, the doors of the Te Kūwatawata service opened on 1 September, 2017 in a central Gisborne location. In October 2018, the service was notified of funding to extend the contract through to June 2019.

[9] Ministry of Health. Registration of interest (ROI): Existing initiatives for investment in building an evidence base (people with moderate mental health issues). Wellington: Ministry of Health, 2016 September.

The Māori and Indigenous Research team at the Eastern Institute of Technology (EIT) in Hawke's Bay responded to the Hauora Tairāwhiti August, 2017 ROI[10] and to the October, 2017 RFP[11] for the evaluation of Te Kūwatawata pilot phase (until 30 September 2018). In November 2017 we entered negotiations with Hauora Tairāwhiti to determine a contract for an evaluation that was to commence on 1 December 2017 but delays in the contracting process meant it did not commence until 1 February 2018. Our 12 month contract (that finishes on 31st January 2019) evaluated the Te Kūwatawata service over the 13 month period 1 September 2017 to 30 September 2018, although we have included some observations and qualitative feedback through to December 2018.

Our Rangahaua Te Kūwatawata Interim Report,[12] (see Appendix 1 for Executive Summary) covered the nine month period, from the opening of the service in September 2017 until May 2018 (inclusive). The evaluation commenced five months after the Te Kūwatawata service had opened and in the midst of significant change to the mental health sector in Te Tairāwhiti. Firstly, we observed and recorded some remarkable outcomes for whānau. This 'new way of doing things' had appeal for many and we noted increased capacity, easier access and short waiting times. We also observed and recorded considerable distress amongst some mental health workers and primary care referrers and heard reports that some whānau were not finding the new approach conducive to their needs. In the Interim Report we endeavoured to balance the concerns we observed relating to the management of change process and the appropriateness of the Te Ao Māori service model. This was alongside clear evidence of increased access to mental health services, and good outcomes for many Māori and non-Māori whānau.

This Final Evaluation report builds on the Interim Report. It begins with a **Background** that sets out the context of the Ministry's RFP. We discuss changing mental health pedagogy, international and local mental health service developments and the recent state of mental health services in New Zealand. All are connected to what the Ministry sought in their 'Fit for the Future' mental health tender documents, and to some extent, the ways in which the Te Kūwatawata service endeavoured to meet Ministry criteria. We next outline the evaluation **Methods** and how we sought and analysed our evaluative data. In our **Findings** we include a detailed description of the Te Kūwatawata service which is vital to the possible scaling of this intervention in other regions. We then present the qualitative thematic findings. Here we focus on factors influencing effective service implementation and service impact on four key domains, tracking the key strengths and challenges identified in the Interim Report. We also describe in depth themes and stories from whānau we interviewed about their experiences of the service. Next, we present a range of quantitative data to further assess service impact and to augment the qualitative themes. The **Discussion** scopes and discusses the qualitative and quantitative findings, drawing conclusions about project feasibility and potential scalability.

[10] Hauora Tairāwhiti, Registration of Interest (ROI): For provision of an evaluation service for Fit for the Future initiative - Te Kūwatawata. Gisborne: Hauora Tairāwhiti. 2017 August.

[11] Hauora Tairāwhiti, Request for Proposals(RFP): For provision of an evaluation service for Fit for the Future initiative - Te Kūwatawata. Gisborne: Hauora Tairāwhiti. 2017 October.

[12] Tipene-Leach D, Abel S, Hiha A Morris Mathews K. Rangahaua Te Kūwatawata. The Te Kūwatawata evaluation interim report. Eastern Institute of Technology. 2019 June.

He kupu tuarongo: Background

Rongomātāne

The intention of this section is to provide some background and context to the Ministry's issuance of, and the Hauora Tairāwhiti response, to a tender for what was an extremely complex project. This major 'management of change project' attempted to have three quite different mental health organisations working together to create a single point of entry for secondary to primary mental health services in Te Tairāwhiti. The aims included changing mental health referral pathways, introducing to the sector a completely new form of practitioner performance and patient outcomes measurement system, all within the context of a Te Ao Māori methodological approach to care. This was an ambitious endeavour, arising out of the dire state of mental health services, particularly for Māori, in Aotearoa New Zealand and some changing in thinking over time about what was needed to address this.

An evolving mental health service in Aotearoa New Zealand

Psychiatry and psychology are approaches to mental health distress that have come, over the years, to be the most influential in Western world health systems. However, the diminishing faith in the ability of science and technology to resolve complex human and social problems shifted the Critical Psychiatry Collective in Great Britain and the Radical Psychiatry movement in America in the early 2000s beyond their usual medical paradigms to engage with mental health service users within the social context and values of how they lived their lives.[13,14] A decade later, and in a similar vein, the British Psychological Society published a Position Statement[15] from which eventually developed the 2018, *Power, Threat and Meaning Framework*.[16] This proposes a conceptual change to psychiatric classification around emotional distress and troubled or troubling behaviour, to frame them, not as illnesses, but as reasonable responses to adverse social and cultural states of being.

> *"This Framework is intended to support the construction of non-diagnostic, non-blaming, de-mystifying stories about strength and survival, which re-integrate many behaviours and*

[13] Bracken P, Thomas P. Postpsychiatry: A new direction for mental health. *BMJ.* 2001: 322;7288, pg724–727.

[14] Roy, B. Radical psychiatry: An approach to personal and political change. In E. Aldarondo (ed.), Advancing social justice through clinical practice pp65-90. Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers, 2007.

[15] Awenat, F., B. Berger, S. Coles, C. Dooley, S. Foster, J. Hanna, et al. Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift. Leicester: British Psychological Society; 2013.

[16] Johnstone L. Boyle M. with Cromby J, Dillon J, Harper D, Kinderman P, Longden E, Pilgrim D & Read J. The power threat meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society; 2018.

> *reactions currently diagnosed as symptoms of mental disorder back into the range of universal human experience"* (p5).

Mental health services in Aotearoa New Zealand have been involved in ongoing change, reflecting development of practice around the world. The 1970s saw the closure of big psychiatric hospitals and gave rise to community placement of patients and outpatient treatment. The 1980s heralded the rise of mental health promotion and early intervention services, the incorporation of addiction into mental health services and the early stages of Māori focussed services. The 1990s saw the privileging of 'talk' therapies over drugs and the 2000s the introduction of mental health care initiatives, especially 'brief interventions', into primary care.[17]

The 2010s has seen a scrutiny of mental health services and, arguably, a move towards some of the positions of the British Psychological Society with *Blueprint II* (2012, p10),[18] the final report of the (New Zealand) Mental Health Commission, stating:

> *"We have a choice. We could continue as we are: delivering specialist support to those who access services and working on areas that still require improvement. Or we can be bold and commit to a vision and a road map for change that will create a 'new wave' of development for the mental health and addiction sector. This 'new wave' is built on an understanding of the interaction between mental health and addiction, physical health and a person's social context".*

Blueprint II demanded:

- earlier and more effective responses to mental health issues,
- an improvement in equity of outcomes for different populations,
- increased access to services,
- an increase in system performance and
- effective use of resources with partnerships across the whole of government.

… all of which can be seen in the Ministry's *Fit for the Future* Request for Proposal.

In 2016, the Ministry of Health commissioned a review of integrated models of mental health care in Aotearoa New Zealand to support the Ministry's *Fit for the Future* work programme. The Review[19] was intended to build an evidence base about improving outcomes for adults with moderate mental health and addiction problems and provide advice on emerging models of practice. In noting the lack of a single 'best practice' model, it recommended:

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[17] Dowell, AC., Garrett, S., Collings, S., McBain, L., McKinlay, E., Stanley, J. Evaluation of the primary mental health initiatives: Summary report 2008. Wellington: Wellington School of Medicine and Health Sciences, University of Otago and Ministry of Health; 2009.

[18] Mental Health Commission. Blueprint II: Improving mental health and wellbeing for all New Zealanders: How things need to be. Wellington: Mental Health Commission; 2012 June.

[19] Developing a service model for primary mental health support for moderate need: An evidence review developed by Network 4 in partnership with Platform Trust. 2016 November. Available from: https://static1.squarespace.com/static/57a93203d482e9bbf1760336/t/59127673d2b857d64b9f9435/1494382207821/Primary+Mental+Health+Evidence+Review+-+Network+4+and+Platform+Trust.pdf

- shared care between primary and secondary services;
- collaboration between the PHO and Non-Governmental Organisation (NGO) sectors; and
- the development of an accredited, integrated mental health practitioner able to meet the needs of the full spectrum of clients and able to be adapted to build effective therapeutic relationships when working with Māori.

… recommendations which are reflected in the subsequent *Fit for the Future* Request for Proposal.

The Director of Mental Health stated in his 2016 Annual Report that Aotearoa New Zealand mental health services "are on a transformational journey" and that their work was directed at "interagency relationships and early intervention" and were "focused on targeting identified vulnerable groups with high risk of poor outcomes".[20] There was acknowledgement of the need to address:

- increasing service demand
- disparities in outcomes for Māori
- and the challenge of those with moderate need who are not easily managed in primary care
- coercive parts of mental health care like Compulsory Treatment Orders (CTO) and seclusion.

Mental health services 'on the ground'

Despite this journey of transformation, the capacity of Aotearoa New Zealand's mental health services has been under increasing strain. The Health Promotion Agency reported a high prevalence of mental distress in the 2015 year, with 80% of the population having 'experience of mental health distress' personally or among people they knew.[21] The Ministry reported that people accessing mental health services had increased by 7% in the two years to 2016,[22] and in 2017 it stated that 20% of the population had a diagnosable mental health illness.[23]

There was little to indicate how well our services were coping. For comment in this regard, high profile New Zealanders have expressed disquiet in the newspapers,[24,25] and the New Zealand Herald series on mental health, *Break the Silence*[26], called for a 'national conversation' on suicide. In more systematic documentation, ActionStation's *People's Mental Health Report,* [27] a crowd-funded survey of 500 New Zealanders, noted that mental health and wellbeing in Aotearoa New Zealand was undermined by poverty, discrimination, the effects of colonisation, and high levels of domestic and

[20] Ministry of Health. Office of the Director of Mental Health annual report 2016. Wellington: Ministry of Health; 2017.
[21] Hudson S, Russell L, Holland K. Indicators of mental health and wellbeing in adults: Findings from the 2015 New Zealand mental health monitor. Wellington: Health Promotion Agency; 2017 June.
[22] Ministry of Health. Office of the Director of Mental Health annual report 2016 Infographic; 2017 December. Available from: https://www.health.govt.nz/system/files/documents/publications/odmh_annual_report_2016_infographic_dec2017-web.pdf
[23] Ministry of Health. Mental health and addiction workforce actionpPlan 2017–2021. Wellington: Ministry of Health; 2018.
[24] Garner, D. Duncan Garner: A piece of my mind: The mental health system is failing. 2017. Available from: https://www.stuff.co.nz/national/health/91772430/Duncan-Garner-A-piece-of-my-mind-The-mental-health-system-is-failing
[25] Shadwell, T. Mike King: New Zealand's mental health was not ready for the John Kirwan effect. 2017. Available from: http://www.stuff.co.nz/national/health/92412388/Mike-King-New-Zealands-mental-health-was-not-ready-for-the-John-Kirwan-effect
[26] Carville O. Break the Silence: New Herald Series. 2017 July 1.
Available from: http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11885369
[27] Elliot M. People's mental health report: A crowdfunded, crowdsourced story-based report. Wellington: ActionStation Aotearoa; n.d.
Available from: https://www.peoplesmentalhealthreport.com/

sexual violence. It noted: poor access to services and long wait times; limited treatment options in primary and community health services; high use of compulsory treatment and seclusion practices; ineffective responses to crisis situations; underfunding of services in the face of rising demand; and mental health workers who felt overworked, under-resourced and stressed. This was echoed a month later when the formal publication of the Office of the Auditor-General's *Mental Health: Effectiveness of the planning to discharge people from hospital* Report[28] commented on increasing pressure on services, inappropriate discharging of patients, and ignoring of "broader needs, such as getting help with housing, finances, or support from their employer or family" (p4).

In late 2017, the new Labour Coalition Minister of Health called for a wide-ranging Government Inquiry into Mental Health and Addiction that included in its scope kaupapa Māori approaches to mental health and the consideration of cultural factors, in particular the historical and contemporary differences in outcomes for Māori.[29] Its recent November 2018 Report, *He Ara Ōranga*[30] contained a set of recommendations for this "once in a generation opportunity"(p4) to "build a new mental health and addiction system on the existing foundations" (p11). They stated the need for increased access and choice with a people-centred, wellbeing approach; structural change around transformation of primary care and strengthening of the NGO sector; the reformation of alcohol and drug legislation and the Mental Health Act; and a comprehensive approach with targets around suicide. They suggested that it could all be overseen by a new Mental Health Commission.

Historically Māori have not fared well in the mental health system in Aotearoa New Zealand. Although internationally the prevalence of mental health disorders is generally not too dissimilar across ethnic groups,[31] and that this seems to be the case in Aotearoa New Zealand,[32] a much larger proportion of Māori present as mentally unwell to general practice.[33] Anxiety, substance abuse and depression are the main issues. Māori women, for example, have twice the consultation rate of non-Māori women[34] and general practitioners admit to under-diagnosing mental health problems, particularly depression, among Māori.[35] In secondary care, Māori have more acute admissions than

[28] Schollum G. Office of the Auditor General's report on Mental health: Effectiveness of the planning to discharge people from hospital. May, 2017. Retrieved from https://www.oag.govt.nz/2017/mental-health/docs/mental-health.

[29] Hon Dr David Clarke, Minister of Health. Establishment of the Government Inquiry into Mental Health and Addiction, Terms of Reference. Jan, 2018. Retrieved from https://gazette.govt.nz/notice/id/2018-go318

[30] He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction. Nov, 2018 Retrieved from www.mentalhealth.inquiry.govt.nz/inquiry-report/

[31] Breslau J, Kendler K, Su M, Gaxiola-Aguilar S. Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. Psychological Medicine. 2005; 35(3): 317- 327

[32] Baxter J, Kokaua J, Wells JE, et al. Ethnic comparisons of the 12-month prevalence of mental disorders and treatment contact in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry*. 2006; 40(10): 905–13.

[33] Bushnell J. Mental Disorders Among Maori Attending Their General Practitioner. *Australian & New Zealand Journal of Psychiatry*. 2005; 39(5): 401–6.

[34] Baxter J, Kingi TK, Tapsell R, et al. Prevalence of mental disorders among Māori in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry*. 2006: 40;10, p914–23.

[35] Thomas D, Arlidge B, Arroll B, Elder H. General practitioners' views about diagnosing and treating depression in Maori and non-Maori patients. *Journal of Primary Health Care*. 2010:2;3; 208–16.

others,[36] are readmitted more often after discharge,[37] are more likely to be secluded in hospital[38] and those with psychotic illness are overly incarcerated in prison forensic units.[39] In the *New Zealand Mental Health Survey, Te Rau Hinengaro,* Māori are noted to have the highest 12 month prevalence of 'any mental health disorder', 'serious disorder' or 'mental health visit' even after adjusting for age, sex, educational qualifications and household income.[40] Worryingly, Māori have two to four times higher rates of suicide ideation, suicide attempts and completed suicide than non-Māori.[41]

In 2016 a remarkable apology to Aboriginal Australians was made by the Australian Psychological Society that acknowledged, amongst other things, "assessment, diagnostic and treatment systems that do not honour cultural beliefs", "self-serving professional research" and a lack of advocacy on important policy issues like forced removal of indigenous children and subsequent placement by the State.[42] In Aotearoa New Zealand, there has been no such statement. Despite acknowledgement of the lack of culturally appropriate mental health services,[43] the ongoing promotion of appropriate Māori services,[44,45,46] and the questioning of inequitable mental health outcomes for Māori,[47] it seems there has been little evidence of change in the mental health system, apart from one paradigm challenging example of a traditional healer-psychiatrist collaboration[48] and some innovative local Māori primary mental health care initiatives.[49]

In July 2007, Hauora Tairāwhiti commissioned a review of their mental health services wishing to explore mental health promotion, illness prevention, early intervention, resourcing for 'specialist' services and collaboration between agencies.[50] Using mental ill-health prevalence figures established

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[36] Wheeler A, Robinson E, Robinson G. Admissions to acute psychiatric inpatient services in Auckland, New Zealand: a demographic and diagnostic review. *The New Zealand Medical Journal.* 2005: 118; 1226.

[37] Wheeler A, Moyle S, Jansen C, et al. Five-year follow-up of an acute psychiatric admission cohort in Auckland, New Zealand. *The New Zealand Medical Journal.* 2011: 124; 1336.

[38] Mental Health Commission. Seclusion in the New Zealand mental health services. Mental Health Commission, Wellington; 2004 .

[39] Easden MH, Sakdalan JA. Clinical diagnostic features and dynamic risk factors in a New Zealand inpatient forensic mental health setting. *Psychiatry, Psychology and Law*. 2015: 22;4; 483–99.

[40] Oakley Browne MA, Wells JE, Scott KM (eds). Te Rau Hinengaro: The New Zealand mental health survey. Wellington: Ministry of Health, 2006; p35.

[41] Oakley Browne MA, Wells JE, Scott KM (eds). Te Rau Hinengaro: The New Zealand mental health survey. Wellington: Ministry of Health, 2006; p35

[42] Apology to Aboriginal and Torres Strait Islander People from the Australian Psychological Society. *Australian Psychological Society Annual Congress*, 2016.

[43] Johnstone K, Read J. Psychiatrists' recommendations for improving bicultural training and Maori mental health services: a New Zealand survey. Australian and New Zealand Journal of Psychiatry. 2000; 34(1); 135–45.

[44] Durie M. Mental Health and Maori Development. *Australian & New Zealand Journal of Psychiatry.* 1999; 33(1); 5–12.

[45] Durie M. Indigenizing mental health services: New Zealand experience. Transcultural Psychiatry. 2011; 48(1–2); 24–36.

[46] Durie M. Indigenous mental health 2035: future takers, future makers and transformational potential. Australasian Psychiatry. 2011; 19(supp1): S8–S11.

[47] Elder H, Tapsell R. Māori and the Mental Health Act. In J Dawson and K Gledhill (eds). New Zealand's Mental Health Act in practice. Wellington: Victoria University Press; 2013.

[48] Niania W, Bush A, Epsten D. Collaborative and indigenous mental health therapy: Tataihono - Stories of Māori healing and psychiatry. New York: Routledge; 2017.

[49] Abel S, Marshall R, Riki D, Luscombe T. Evaluation of Tu Meke PHO's Wairua Tangata programme: A primary mental health initiative for underserved communities. *Journal of Primary Health Care*. 2012; 4(3); 242–8.

[50] Williment R, Codyre D, Katene K. Report and recommendations for Tairawhiti adult mental health and addiction services: A pathway to better mental health; 2008.

by *Te Rau Hinengaro*, they reported that the high Māori population and level of deprivation gave rise to Gisborne having the highest rate of 'serious mental health problems' in the country (p38). They posited a "clearly established relationship between socio-economic adversity and poor mental health and also between poor health and risk-laden lifestyles, including substance abuse and reckless spending" (p5). Against a background in which any reasonable recommendation would augment services to Māori, they stated that "the DHB is an example of excellent practice in relation to the integration of clinical and cultural responses" (p37) and recommended no change in relation to the structure or funding arrangements. Furthermore, they urged the maintenance of a "responsive, 24 hours a day, seven days a week coverage with excellent service delivery to non-Māori and integration with other core health and disability services" (p37). Not surprisingly, mental health remained unchanged in Te Tairāwhiti and in 2016-2017 the proportion of Māori in Te Tairāwhiti who accessed mental health services (6.31%) continued to be much higher than the proportion of non-Māori (3.59%).[51] Tairāwhiti DHB, along with Northland and Lakes, also had the highest number of people subject to CTO.

The emergence of Te Kūwatawata

Prior to Te Kūwatawata, mental health services in Gisborne consisted of the Hauora Tairāwhiti secondary care mental health service, *Te Ara Maioha*[52], the primary care sector's Pinnacle PHO primary mental health services, a number of community NGO providers of support, advocacy and other social services, and psychologists and counsellors available through private care pathways and through the Accident Compensation Corporation system.

Te Ara Maioha comprised three strands: *Te Whare Awhiora,*[53] (the 8-bed inpatient Ward 11); *Te Whare Oranga,*[54] (the Community Mental Health & Addictions services); and *Te Whare o Te Rito,*[55] (the Infant, Child and Adolescent Mental Health Services also known as ICAMHS). Pinnacle PHO's team had a number of employed Brief Intervention Specialists and various independent contractors who provided packages of care for those referred to them by general practitioners. Of the community-based NGO providers, one was Te Kupenga Net Trust which provided mental health and addictions peer support and advocacy to whānau and had a specialty focus on suicide prevention, and postvention activity.

Referrals to the above secondary, primary and NGO services came from a number of places. General practitioners, who did the bulk of mental health assessments, had multiple options including treating patients themselves, using the Pinnacle PHO's Primary Mental Health Service or referring to the secondary or NGO services. Other providers, such as the Emergency Department (ED), local schools, the Department of Corrections, Oranga Tamariki and the NZ Police also referred to

[51] Ministry of Health. PP6 Report: Access to mental health services, Oct 2016-Sept 2017
[52] Translation: 'the welcoming pathway'
[53] Translation: 'The life giving house'
[54] Translation: 'The house where health is built'
[55] Translation: 'The house of the new shoot'

secondary services. There was also some limited opportunity for clients to present directly to a service that they had been previously engaged with.

The objectives of 'single point of entry/access' projects are to reduce this fragmentation, increase integration among services and develop a smoother and more continuous transition between services.[56] The key driver of these outcomes is to reduce the multiple points of entry in order to allow for: a rapid and consistent response to calls/referrals; a tailored response to individual needs, including an assessment of urgency; and support between referral being received and assessment, with suggestions of alternative services if appropriate.

In 2015, Hauora Tairāwhiti developed a SPoE project for its adult secondary care mental health services. This SPoE brought all the acute adult mental health services (the inpatient ward, the crisis and the cultural assessment teams, and the hospital psychiatric liaison worker) and the non-urgent (triage and home-based treatment) teams together into a single service. The Infant, Child and Adolescent Mental Health Service (ICAMHS), which had a separate model of care and its own crisis team under Paediatrics, was later brought into the Mental Health service at this time. This big change management process took at least 18 months and, coming off the back of some service challenges at the time, was not without problems including staffing difficulties, high turnover and subsequent recruitment issues.[57]

In late 2016, the secondary mental health services and their SPoE were 'refreshed' and it was suggested that the SPoE should also include primary mental health care services.[58] Subsequently Pinnacle, who were very keen to participate in the SPoE, put forward their patient management system, *Indici*, to be utilised across all services engaged in the SPoE. By the time the Ministry had put out their *Fit for the Future* tender and Hauora Tairāwhiti was developing a proposal to submit for it, the new Head of Department in Mental Health had been using a Māori therapeutic approach to care called *Mahi a Atua*[59] for at least two years. The Head of Department was also an advocate, with years of experience, of a clinical performance and outcomes rating system called *Feedback-Informed Treatment* (FIT),[60] a pan-theoretical, evidence-based feedback tool that can measure both how well the client is progressing and how the client feels the therapist is performing. The primary-secondary partnership, the patient management system (Indici), the Te Ao Māori methodology (Mahi a Atua) and the Feedback-Informed Treatment system (FIT) were all incorporated into a new Hauora Tairāwhiti SPoE plan called Te Kūwatawata.[61]

[56] Cumming, J. Integrated care in New Zealand. International Journal Integrated CARE 2011;11 E138; Published online 18 November 2011
[57] Prince A, Stevenson D, Craft M. The single point of entry evaluation report, SPOE Evaluation working group. March 2016
[58] Personal Communication Dr J Crawshaw, Director Mental Health, Ministry of Health (08.04.19)
[59] Translation: 'the way of the ancestor-gods'
[60] Miller, SD. Feedback-Informed Treatment. International Centre for Clinical Excellence. Available from: http://www.scottdmiller.com/fit-software-tools/
[61] Hauora Tairāwhiti proposal to Ministry of Health Request for Proposal (RFP): Existing initiatives for investment in building an evidence *b*ase (People with moderate mental health issues). 2017 September.

What exactly did Te Kūwatawata propose?

As described earlier, the background to the promotion of a kaupapa Māori primary and secondary care SPoE partnership by Hauora Tairāwhiti was a national mental health system with increasingly severe capacity problems and persistent inequitable outcomes for Māori. Stressed mental health workers were operating in a professional world that was demanding wider attention to the cultural and social context of distress and it seemed clear that inequitable outcomes were, at least in part, due to a systematic (cultural) capability gap in services and a 'cultural competence' gap for individual mental health workers. Te Tairāwhiti had at the time one of the highest levels of mental health distress in the country[62,63] and Hauora Tairāwhiti developed the Te Kūwatawata proposal in response to the Ministry's Fit for the Future opportunity.

The Ministry of Health's September 2016 ROI[64] and January 2017 RFP[65] asked for proposals that, in summary, demonstrated:

- the development of an existing service into a DHB and primary care partnership
- the support of priority populations (Māori, Pacific and low socio-economic) to address inequitable outcomes
- improved outcomes for those not easily managed in primary care but do not meet the threshold for specialist care
- client-centred outcomes and results based measurement framework
- an ability to articulate what is required to scale an initiative up

The Hauora Tairāwhiti - Pinnacle Midland Health Network partnership response to the ROI documents said that they would develop a single point of entry into mental health and addiction services spanning the continuum of care and life course and that it would require:

- strengthening implementation of Mahi a Atua, an interagency approach that prioritised Māori psychology
- increasing access to community-based strategies including tohunga and traditional healing
- developing the use of Pinnacle PHO's patient management system (PMS) called Indici as a shared clinical record
- implementing Feedback-Informed Treatment (FIT) as a performance indicator within a Results Based Accountability framework

They added that the pursuit of strengthened mental health services would be achieved by:

- creating teams of workers with mixed disciplines, focus and experience

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[62] Williment R, Codyre D, Katene K. (2008) Report and recommendations for Tairawhiti adult mental health and addiction services: A pathway to better mental health. 2008

[63] Ministry of Health. PP6 Report: Access to mental health services, Oct 2016-Sept 2017

[64] Ministry of Health. Registration of Interest (ROI): Existing initiatives for investment in building an evidence base (People with moderate mental health issues). Wellington: Ministry of Health; 2016.

[65] Ministry of Health. Request for proposal (RFP): Existing initiatives for investment in building an evidence base (People with moderate mental health issues). Wellington: Ministry of Health; 2017 January.

- responding to referrals in a consistent and timely manner,
- eliminating barriers to referral and referrals between providers that delay access to treatment
- utilizing appropriate therapy and support without the mild, moderate or severe distress labels
- supporting workforce development by sharing skills, knowledge and experience across disciplines
- building expertise and infrastructure within general practice
- reducing demand for acute admissions, seclusion and CTO by providing early care
- offering an effective means for practitioners to engage with Māori individuals and whānau

The subsequent February 2017 RFP Proposal by the Hauora Tairāwhiti partnership included a third formal partner - the NGO, Te Kupenga Net Trust Mental Health and Addictions Peer Support and Advocacy Service, thus further refining the Te Kūwatawata SPoE project, extending it across both clinical and non-clinical mental health services. The Partners also declared that they would be creating a partnership with the community-based kaupapa Māori mental health workforce training initiative, Te Kurahuna,[66] whose speciality practice was Mahi a Atua. The proposal also indicated the need for community premises labelled 'a healing marae', and it indicated how the staffing of Te Kūwatawata would be accomplished. Most of the staff were expected to be drawn from secondary service teams, with some coming from general practice and the NGO advocacy service, and some from the creation of new positions for a tohunga and three 'not necessarily clinical' *Mataora* (workers trained in Te Kurahuna). There was also a major recognition that *whanaungatanga* (connectedness) should drive this collective of workers in the improvement of mental health outcomes and in the effort to "consolidate whānau potential and increase community capacity"[67] (p11). Finally, a shared governance vision was proposed involving the Partners and Te Kurahuna consolidated, as it were, under a Memorandum of Understanding.

Our approach to reviewing outcomes

The Ministry sought to have the Evaluation measure the 'outcomes' of Te Kūwatawata. Although health services, like other government agencies, tend to measure outputs rather than outcomes, more defined outcomes are vital in the measurement of intervention effectiveness and the demonstration of 'good value' for funders[68] and is consistent with an ongoing commitment to a market-led approach to service provision.[69] Outcomes that reflect positive changes that occur as a

[66] Translation:'the hidden gems of knowledge'. Te Kurahuna, at the time of the proposal, was a collective of ever-increasing numbers of mental health workers - clinicians, carers and managers - who had been pursuing, over a number of years, professional and cultural knowledge transfer and training in the Mahi a Atua approach to mental health care.

[67] Ministry of Health. Request for proposal (RFP): Existing initiatives for investment in building an evidence base (People with moderate mental health issues). Wellington: Ministry of Health; 2017 January.

[68] O'Brien M, Sanders J, Tennant M. The New Zealand non-profit sector and government policy. Wellington: Office for the Commnunity and Voluntary Sector; 2009.

[69] Moore C, Moore C. Community organisations, contracts for service and the government: An unholy trinity? Whanake: the Pacific Journal of Community Development, 2015: 1(2), 1–1.

result of an intervention are about knowledge and skill acquisition; shifts in attitude, behaviour or thinking; and change in client circumstance. In this evaluation, we were unable to assess such things quantitatively, primarily because of budget and time constraints, especially given the sensitivities and logistics of obtaining feedback from the large number of whānau that would be required. Neither were we able to use the Whānau Ora Outcomes Framework,[70] which requires a much wider view of whānau capability and capacity development around the intervention concerned.

What we have done here is examine various 'areas of concern' raised in the history of recent change in mental health service provision. This includes the philosophy of Fit for the Future planning, the Ministry of Health's mental health ROI and RFP, and the Te Kūwatawata proposal. From this we have drawn a set of what we propose to be 'outcomes' that, in the short term, will have relevance for a Minister of Health and a Ministry deliberating on longer term policy directions and funding decisions. These 'outcomes' include both narrow quantitative descriptors of service provision and the rich detail of qualitative testimony of stakeholders and whānau around the experiences and outcomes of Te Kūwatawata. We have presented these under the following headings: service efficiency and responsiveness; service and mental health worker cohesion and collaboration; service and mental health worker cultural competency, and mental health outcomes for whānau.

[70] The Whānau Ora Outcomes Framework. Empowering whānau into the future. Available from: https://www.tpk.govt.nz/docs/tpk-wo-outcomesframework-aug2016.pdf Nov, 2019

Te hanganga: Design and method

Haumietiketike

Establishing the evaluation

The Māori and Indigenous Research team declared in the contracting process at both ROI and RFP steps that evaluation lead, Professor David Tipene-Leach, had prior knowledge of Mahi a Atua. He first encountered the approach in May 2017 when attending and presenting at a Hauora Tairāwhiti mental health *wānanga* (learning opportunity). He subsequently co-authored two papers describing the Mahi a Atua approach with psychiatrist, Dr Diana Rangihuna-Kopua, and Tairāwhiti tohunga, Mark Kopua - both of whom were in roles integral to the establishment of the Te Kūwatawata service. This pre-existing relationship was declared in our tender proposals. We argued that although there was potential for a conflict of interest, Professor Tipene-Leach was well experienced in separating research pursuits from intervention development and the relationship could be seen as good for the evaluation project in that, as *kanohi kitea*, (one who has been seen) he was already known to and accepted by Mataora and the mental health service management team. With this relationship declared and considered, we were awarded the evaluation contract. On the 18th January 2018, we agreed to a 12 month contract that would run from 1st February 2018 to 31st January 2019.

The national Health & Disability Ethics Committee indicated that this evaluation did not need to be approved by them. Ethics approval was obtained from the EIT Research Ethics and Approvals Committee on 22 January 2018 (Ref: 17/67). An amendment was approved on 6 March 2018 to include interviews with whānau, and a further amendment was approved on 1 May 2018 to access anonymised patient data.

Being Napier based, our team made frequent trips to Gisborne for this evaluation. We spent the first month (February 2018) engaging in *whakawhanaungatanga* (making connections), with the Te Kūwatawata team; attending Te Kurahuna wānanga, talking with groups and individuals about how we were intending to undertake the evaluation and inviting questions and feedback.

Evaluation purpose and aims

The fundamental purpose of our evaluation was to answer the following question:

> *Will the building of a community-based mental health care service around a framework based on Māori cultural values and knowledge successfully serve the Tairāwhiti community, both Māori and non- Māori, who are experiencing mental distress?*

Our overall aims were:

- To work alongside the Te Kūwatawata team and Steering Group in a formative fashion, acting as a 'critical friend'[71] to ensure its implementation process runs as smoothly and successfully as possible
- To describe the service and assess the successes and challenges of the service and its implementation process
- To assess the impact of the intervention on
    - service efficiency and responsiveness
    - service and mental health worker cohesion and collaboration
    - service and mental health worker cultural competency
    - mental health outcomes for whānau

Evaluation design - Kaupapa Māori evaluation

As Te Kūwatawata sought to "reinstate Māori Psychology and Mātauranga Māori into health services and the community", our evaluation approach was based on kaupapa Māori principles and was multi-layered. Kaupapa Māori principles were considered essential given the Māori ideology underpinning the Te Kūwatawata initiative itself and the disproportionate need for mental health services in the Māori community. Indeed, the Ranga Framework describes Kaupapa Māori theory as the "buffer" between Te Ao Māori and the Western context.[72] It was important to have the evaluation model reflect this 'Kaupapa Māori' ideology - the philosophical doctrine incorporating the knowledge, skills, attitudes and values of Māori society.[73] Evaluation team member Dr Anne Hiha reminds us of the guidelines used by Māori that guide appropriate behaviour, that is, the four principles of: *Whanaungatanga*, recognising and respecting the connections between whānau, hapū and iwi through whakapapa; *Manaakitanga*, nurturing connections and relationships through action; *Tino Rangatiratanga*, relative autonomy; and *Taonga Tuku Iho*, cultural continuance.[74]

Within this context we applied a systematic enquiry over the various aspects of the Te Kūwatawata service in order to examine the strengths and weaknesses of the service and its implementation process and assess the effectiveness of service outputs and outcomes. Our design included formative, process and summative evaluation components and used mixed data collection methods.

In brief, our **formative evaluation** is a reflective process in which one evaluation team member is assigned the 'critical friend' role, providing ongoing feedback and, at times, problem solving, to the individuals and collective groups working with the process of service change and implementation. The aim is to optimise implementation effectiveness and enable ongoing quality improvements. The critical friend has been around for over two decades in educational research and remains a key

[71] Costa AL, Kallick B. Through the lens of a critical friend. Educational Leadership. 1993; 51(2).
[72] Doherty W. Ranga framework - He Raranga Kaupapa. In: N. Kaitūhono, editor. Conversations on Mātauranga Māori Wellington, NZ: New Zealand Qualifications Authority; 2012:15-36.
[73] Moorfield JC. Te Aka Maori-English, English-Maori dictionary. Auckland, NZ: Pearson Education; 2011:65.
[74] Hiha A. Whatu: Weaving Māori women educators' pedagogy. Kairaranga. 2015;16(2):24-34.

element of the New Zealand educational scene.[75] A **process evaluation** describes the service and the experiences of those implementing and participating in it. It also identifies service strengths and challenges during the implementation process. The **summative evaluation** ascertains the initiative's short term outcomes and impacts and likely longer term impacts.

Data collection methods

Both qualitative and quantitative data were collected. Qualitative methods are particularly well suited to assessing the feasibility of intervention implementation and its effectiveness from the perspective of those implementing or engaging with it.[76] Qualitative methods do not aim to generalise findings but rather to gather and make sense of the experiences and perceptions of a broad range of people knowledgeable about the field of enquiry. Qualitative data were collected from the following sources:

- Relevant service documents
- Participant observation
- Interviews/focus groups with purposefully selected key persons/stakeholders (see below). Data from these sources comprised the large majority of our database.
- Meetings or informal phone calls (not audio-recorded) with key persons to clarify details.
- Interviews with whānau who had accessed the service for themselves or with a whānau member.

Quantitative methods are well suited to measuring outputs and outcomes. Data were collected from the following sources:

- the Hauora Tairāwhiti Te Kūwatawata and other mental health services monitoring data
- Te Kūwatawata whānau data collected during the months of February, May and August 2018
- Te Kūwatawata My Outcomes Feedback-Informed Treatment data
- Pinnacle PHO's Primary Mental Health service data
- A SurveyMonkey© questionnaire to GPs

***Document review*:**
To understand the background and context to the Te Kūwatawata service we reviewed a range of relevant documents, contracts and academic literature.

***Participant Observation*:**
This involved participation and observation by one or more of the research team in: a number of Te Kurahuna training and professional development wānanga; a Te Kūwatawata information evening, a Te Kūwatawata weekend strategic planning hui; several Te Kūwatawata kaimahi (worker) morning hui; three wānanga with whānau, and observation of daily administrative processes. An important

[75] Baskerville D, Goldblatt H. Learning to be a critical friend: From professional indifference through challenge to unguarded conversations. Cambridge Journal of Education. 2009;39(2):205-21.

[76] Pope C, Mays N, editors. Qualitative research in health care. 3rd ed. Oxford, England: Blackwell/BMJ; 2006.

aspect of participant observation was the 'critical friend' participation in Steering Group meetings and other meetings for the formative evaluation component.

Interviews/ focus groups with key persons/ stakeholders:

As is appropriate in qualitative research, key persons/stakeholders were purposefully selected because of their in-depth knowledge about the issues of importance to the evaluation.[77] We aimed to ensure a broad scope of such people from both inside and outside the Te Kūwatawata service. The original intention was to interview up to 30 people from a range of organisations and roles, some of these at two time points. However, in the early stages of the evaluation, we decided a more comprehensive coverage of people and roles was required and we were also approached by people wanting to be interviewed. We therefore conducted a much larger number of interviews than originally planned.

Between March to May 2018, we undertook 17 focus groups and 17 one-on-one interviews, involving a total of 85 people. This was followed up throughout September to December 2018 by a further two focus groups and eight one-on-one interviews involving a further six new people and 16 for a second time. **Over the course of the year we interviewed 91 people, 16 of them twice**. In addition, we had meetings or phone calls that were not audio recorded with 11 key persons, 5 of whom had not previously been interviewed. **We therefore interviewed and/or consulted with 97 people, 21 of them twice (or more).**

Those interviewed or consulted with were from the following groups:

- Te Kūwatawata project leaders
- Te Kūwatawata partnership organisations' managers and governance personnel
- Te Kūwatawata kaimahi (mainly Mataora trained in Te Kurahuna), including *Tohunga* (experts), psychiatrists, nurses, social workers, artists, *Uekura* (reception, data and other personnel), general practitioners
- Hauora Tairāwhiti secondary mental health service, management and liaison personnel
- General practitioners and other primary care personnel, including PHO Primary Mental Health Service personnel
- External agencies/organisations engaging with Te Kūwatawata (e.g.: Te Kurahuna; Corrections, Oranga Tamariki, NZ Police, Tauawhi Men's Centre, Ngāti Porou Hauora, Pharmacist)
- Ministry of Health personnel
- Health service personnel outside Te Tairāwhiti interested in implementing the service elsewhere

Interviews and focus groups were undertaken primarily by AAH and SA, with DTL leading or co-facilitating five. Meetings/phone calls were undertaken primarily by DTL, occasionally with SA. Questions asked during the first phase varied according to the role of the person/people, but in

[77] Patton MQ. Qualitative evaluation and research methods. 3rd ed. Newbury Park, CA: Sage; 2002.

general sought feedback on their impressions of changes in their roles and the strengths and challenges of the new service and its implementation process (see Appendix 2 for question schedules). During the second phase similar questions were asked of new people while those approached for the second time were asked to update us on what they saw as the key issues of interest since the previous interview. Written consent was obtained prior to the first interview or focus group. They were assured confidentiality and strict security processes around their data.

Māori *tikanga* (traditional practice) was observed throughout the research, but particularly during the conduct of interviews/focus groups. Many interviews and groups followed a process similar to the Te Kūwatawata wānanga, commencing and completing with a *karakia* and engaging in whakawhanaungatanga. As anticipated, a number of participants used te reo Māori terms throughout their interview (for which both AAH and SA were well equipped). One person who had taken part in a focus group also wanted to be interviewed in te reo Māori. This was conducted by DTL, a fluent Māori speaker.

With the consent of participants, interviews/focus groups were audio recorded and the interviewer also took written notes. One person's recording did not work and one group did not want to be recorded so comprehensive notes were written up. The audio recordings were transcribed by a professional transcriber competent in basic te reo Māori who provided a confidential service. Transcripts were edited slightly for ease of reading and sent back to participants for approval. A small number made minor additions or clarifications.

Data saturation, where no new findings were being presented, was easily met with stakeholder interviews but we continued to interview people to keep up to date with issues as they changed within an evolving environment.

Whānau interviews:

Our intention at the outset was to conduct only stakeholder interviews and to not interview whānau. Firstly, we feared that it was too sensitive a time for whānau and interviews might be too intrusive. Secondly, we intended to ask all stakeholders who worked with whānau who had accessed the service about their impressions of whānau experiences of the service. We have found in other similar projects that stakeholders' impressions of their clients' experiences closely reflected those described by these clients. However, we were convinced by Hauora Tairāwhiti that whānau interviews would be a valuable addition to the evaluation, providing personal narratives to embellish what we found through stakeholders' perspectives and other data sources. Working within our existing resources we decided to interview 10 to 12 whānau who have engaged with Te Kūwatawata. At least half were to be whānau of children or adolescents using the service, and at least half were to be those who had accessed mainstream mental health services in the past so a comparison could be drawn between the two service experiences.

The number of whānau chosen were not intended to form a representative sample of those accessing the service. As mentioned above, this is not the purpose of qualitative research. However, we did endeavour to ensure a range of people were approached and to this end several stakeholders outside Te Kūwatawata were asked to identify one or more whānau they knew who

had engaged with the service. We went to some effort (by selection of some stakeholders known to not necessarily be supportive of Te Kūwatawata) to maximise likelihood of both favourable and non-favourable experiences. In addition, the Hauora Tairāwhiti Data Information Analyst provided us with a list of whānau who had exited the Te Kūwatawata service from which we selected people based on their demographic profile and whether they had accessed other services to ensure a mix of ethnicity, gender, age and service experience. The former group were approached by the referring stakeholder to obtain permission for us to approach them. Those on the Te Kūwatawata list were approached by one member of the Uekura team who kept names confidential. Two people who originally agreed later declined without giving a reason. Obtaining whānau referrals was considerably more difficult than we anticipated as stakeholders were all very busy.

In total we heard the stories of **13 whānau (6 young people and 7 adults)** who had used the service. We did not know anything about the experience of these whānau in the Te Kūwatawata service prior to our engagement with them. Because the number of whānau is relatively small we have decided to describe them in very general terms to ensure they are not identifiable. We spoke to whānau of both children and adolescents but to ensure confidentiality we refer to both as 'young people'. The ethnicity and gender breakdown of the 13 whānau are as follows:

Māori:	n=8 (4 young people, 4 adults)
Other:	n=5 (2 young people, 3 adults)
Females:	n=6 (3 young people, 3 adults)
Males:	n=7 (3 young people, 4 adults)

Overall, six had used other mental health services prior to or after engagement with Te Kūwatawata.

Because we did not have Ethics Committee approval to interview children and adolescents, we talked with their whānau instead. In addition, we interviewed the whānau of two adults who had used the services but were no longer in town. These whānau members were intimately involved in the wānanga sessions, providing valuable insights on their loved ones' experiences as well as a useful perspective on the impact of the service on they themselves as support people.

Whānau were asked to describe their journey to and through Te Kūwatawata, comment on how this differed from previous service engagement if relevant, describe what they liked and did not like about the service and offer any suggestions for change. Whānau interviews/ groups followed a similar process to the stakeholder ones in terms of tikanga Māori, confidentiality assurances, consent and interview process. We also returned their interview transcript for approval. We view the data provided by whānau as pivotal commentary on the Te Kūwatawata service experience and have privleged their perspectives and experiences in in the Findings section.

Hauora Tairāwhiti service monitoring data

The Indici Patient Management System that Pinnacle PHO had hoped would become an across-services patient record, was not ready for use at the Te Kūwatawata launch so the service turned to Exess[∝] which was being used by Te Kupenga Net Trust, as a database.

We worked with the Hauora Tairāwhiti Data Information Analyst to collect data that could give an insight into the outputs and outcomes of the Te Kūwatawata service. We were able to obtain for the months **September 2017 to September 2018 (13 months),** information about Te Kūwatawata referrals, wait times to first appointment, numbers seen and average wānanga per month, and the extent of wider whānau involvement. We were also able to compare some pre and post Te Kūwatawata elements of access and wait times from other services. We had intended to look at the number of appointments, treatment pathway, treatment activities and treatment outcomes but could not source these data through the Te Kūwatawata Exess database or the DHB's PRIMHD[78] database.

We also wanted to capture a picture of the ways in which the service dealt with whānau who were registered but had no first wānanga appointment and how many were transitioned to other services. As this information was not available in aggregated form, we arranged for an audit of all Registrations for February, May and August 2018. As we were not permitted to view identifiable service user data, this was undertaken by the Te Kūwatawata Kaituhituhi Mataora (in administration) who received and booked these Registrations. In addition we arranged for an analyst from the Hauora Tairāwhiti Funding and Planning team to review the notes of all those who had attended only one wānanga during two of these same months. The aim was to ascertain, if possible, to what extent these were successful brief interventions or whānau who simply did not return.

Te Kūwatawata Feedback-Informed Treatment data

We also obtained some Te Kūwatawata Feedback-Informed Treatment data. This was a single score known as an 'Effect Size', which is an aggregation of the Outcome Rating Scale scores pre and post engagement in the service, that is compared to a web-based database containing large samples of international psychotherapy results using the same system.

Pinnacle Midlands Health PHO's Primary Mental Health service data

Data on the PHO Primary Mental Health Service was obtained from Pinnacle PHO's website. Although we obtained other data from the service, we found in the end that the web based data better suited our needs. These data pertained to numbers seen by the service, wait times and total sessions before and during the Te Kūwatawata pilot period.

[∝] Exess is a New Zealand internet based Case/Client Management software programme

[78] Acronym: Programme for the Integration of Mental Health Data

SurveyMonkey© Questionnaire

Finally we developed a SurveyMonkey© questionnaire to obtain GP feedback on the service. The questionnaire asked about their referrals into mental health services, their knowledge about recent changes made in the Te Kūwatawata service, whether they had seen improvements since the changes, and whether the changes made them more likely to support a primary /secondary service SPoE. They were also invited to make any further comments on the service.

The questionnaire was disseminated by the Hauora Tairāwhiti GP Liaison to all Gisborne and Te Karaka GPs on her email list in early November 2018 and GPs were given five weeks to respond.

Data analysis

Data analysis was informed by kaupapa Māori principles. As evaluation team member Dr Anne Hiha points out, "Kaupapa Māori weaves in both cultural practice and critical analysis".[79] The database included the following:

- Relevant documents and academic articles
- Evaluation team notes from participant observation sessions
- 'Critical friend' notes on feedback to the Te Kūwatawata Steering Group
- Transcribed interview/focus group transcripts, written feedback, and interviewers' written notes
- Interviewers' notes from meetings with individuals
- Te Kūwatawata, Hauora Tairāwhiti Mental Health Service and Pinnacle Primary Mental Health Service data, as described.

Preliminary qualitative data analysis was undertaken prior to in-depth analysis in order to provide the ongoing 'critical friend' feedback to the Te Kūwatawata Steering Group. This involved team discussions of key issues gleaned from participant observation sessions, completed interviews and focus groups and relevant documents. Discussion points were formulated into notes, and fed back and power point presentations were also undertaken with the Te Kūwatawata Steering Group and staff.

A more thorough analysis of qualitative data was then undertaken. The transcripts and participants' written notes were carefully reviewed and, in combination with the interviewers' field notes and other written documentation, analysed using thematic analysis.[80] This involved close reading and examination of the data followed by the identification and description of key themes. The themes were developed by SA and AAH as the primary interviewers in the first instance, then discussed with and augmented by DTL from his own observations and discussions. These were then reviewed by our peer reviewer, KMM. Close attention was paid to ensuring culturally appropriate interpretations of the data.

[79] Hiha A. Whatu: Weaving Māori women educators' pedagogy. Kairaranga. 2015: 16(2):24-34.

[80] Pope C, Mays N. editors. Qualitative methods in health research (3rd ed). Massachusetts: Blackwell; 2006.

Apart from the SurveyMonkey© data, the quantitative data were supplied and prepared by Hauora Tairāwhiti, Te Kūwatawata and Pinnacle PHO. A descriptive analysis of the data was undertaken. Much of this analysis was undertaken by the Hauora Tairāwhiti Data Information Analyst and some was undertaken by DTL and SA, with oversight by EIT's Professor Bob Marshall. The SurveyMonkey© data were descriptively analysed by the software and interpreted by DTL and SA. These findings and their interpretation were then reviewed by the team.

Team roles in data collection and analysis

DTL took on the role of 'critical friend' receiving input from and providing feedback individually and collectively to Steering Group members. The feedback was informed by research evidence, participant observation and preliminary analysis of data from the interviews/ focus groups undertaken. Interviews and focus groups were undertaken primarily by AAH and SA. All three researchers, along with KMM, engaged in participant observation of some or all aspects described. DTL and SA took responsibility for the quantitative data. The Interim Report and this Final Report were written by DTL and SA with input from AAH. KMM provided a peer review role which included being a sounding board to discuss research related issues along the way and reviewing a number of drafts.

Ngā kitenga: Findings

Tangaroa

The findings presented here build on what we presented in the Interim Report, with relevant parts of that report repeated, edited or summarised. Our evaluation design comprised three components; formative, process and summative. We begin with a description of the formative 'critical friend' process. Almost the entire formative evaluation process was undertaken in the period covered in the Interim Report (up till May 2018) and an updated version is presented here. Next, we document process and outcome evaluation themes from the qualitative data together as there was considerable overlap here. We begin that section with a description of the Te Kūwatawata service as we have come to understand it. Following this we cover participants' perceptions of both the implementation process and service outcomes. Included here is a section on the whānau voice where their experiences of the service are described thematically with many verbatim quotes. Finally, we present the outcomes using the quantitative data we have been able to collect, much of which pertains to access and responsiveness.

The formative evaluation

The formative evaluation' critical friend', our Lead Evaluator DTL, provided an informed 'listening ear' to the Te Kūwatawata Steering Group and allowed our team to give useful feedback from the sectors interviewed (Te Kūwatawata staff, primary mental health care, secondary mental health care, general practice and external social services and other agencies). As a result, we were able to identify the big issues and signal those parts of the service where improvements could be made. As this evaluation did not commence until February 2018, five months after Te Kūwatawata opened on 1 September 2017, we were not involved at the project planning or early implementation phases so entered the field when implementation was well underway and early issues were already evident. As part of the formative evaluation DTL attended Te Kurahuna meetings, Te Kūwatawata meetings (including Steering Group meetings and a strategic planning weekend), various Te Kūwatawata meetings, staff training sessions, staff clinical evaluation sessions and a Feedback-Informed Treatment training workshop. Other team members also attended a number of Te Kurahuna wānanga and various Te Kūwatawata hui.

The 'critical friend' role was central to the formative evaluation process and was undertaken primarily in the evaluation's first few months (February to May 2018 - months six to nine of Te Kūwatawata service implementation). It included both being 'at the end of the phone' for any of the project partners in the Steering Group when they needed a listening ear and providing formal feedback. Feedback was informed by our team's observations/informal interviews and formal stakeholder focus groups/interviews undertaken in those first few months. Formal feedback sessions were given at two Steering Group meetings and to staff during this early period.

Feedback focussed primarily on issues in the relationship between Te Kūwatawata and Pinnacle Midlands Health PHO. Because of a lack of agreement on the Te Kūwatawata structure and its functions, particularly around clinical input into the initial assessment of the client/whānau and the ongoing options around clinical pathways, Pinnacle PHO had not signed the final Memorandum of Understanding by May 2018. Our feedback in the Interim Report stressed the importance of the general practice sector as a primary user of the service and the need to progress the formal inclusion of Pinnacle PHO into Te Kūwatawata and to also liaise directly with GPs. In addition we passed on feedback to the Steering Group from both secondary and primary service mental health workers. This feedback was around the impact of the 'management of change process' for the development of the primary and secondary services SPoE, against a background of 'change exhaustion' from the implementation of the 2015 secondary services SPoE. The critical friend role continued but in a considerably diminished capacity after the production of the Interim Report in June 2018 as we focussed more on outcomes. Nevertheless, with an ongoing stalemate between Te Kūwatawata and Pinnacle PHO, attempts to encourage the relationship continued up to the end of the period covered in this report, unsuccessfully as it turned out.

The process and outcome evaluation - Qualitative findings

In this section we present findings from the qualitative data, bringing together process and outcome findings. We begin with a description of the Te Kūwatawata service which includes comment on structure and staffing, the physical environment and the Te Kūwatawata whānau pathway. This is rather detailed but we believe this is necessary to better understand the commentary and critique that follows and later discussions about potential scalability. Next, we report stakeholder perceptions of both the implementation process and the service outcomes, in particular perceived successes and challenges of the service. In line with our evaluation aims these are described under the following headings: service responsiveness and efficiency; service and mental health worker cohesion and collaboration; and service and mental health worker cultural competency. In the final section, outcomes for whānau, we present both stakeholder perceptions as well as whānau descriptions of their own experiences of the service, commenting on the aspects they liked and did not like and their perceived outcomes. This is a fuller section than the others and contains many verbatim quotes. Whereas the Interim Report findings focussed in detail on stakeholder perceptions of the successes and challenges of the service in those earlier months, in this Final Report we focus more strongly on the whānau voice.

What is Te Kūwatawata?

In this section, we describe components and aspects of the Te Kūwatawata service hoping that it becomes clear to the reader how Te Kūwatawata worked to achieve the objectives that it set out for itself in the proposal to the Ministry. Te Kūwatawata the service was named after Te Kūwatawata the *atua* (ancestor-god) who admits those between life and death to the great underworld, Rarohenga,[*] or denies them entry and sends them back to the upper world of the living. Te

[*] Rarohenga the underworld is not analgous to the Christian idea of Hades. It is simply the realm of the dead.

Kūwatawata aimed to develop, in the manner of a single point of entry, an efficient and competent portal into the raft of services that were available to the mentally distressed. It also aimed to develop a Māori-resonance around this point of entry and holding space that also had a therapeutic treatment pathway to offer. This used multi-disciplinary and culturally competent teams, most of whom entered training with Te Kurahuna (the hidden gem), a mātauranga Māori wānanga (storehouse of Māori knowledge), and became experienced in pūrākau (ancestor and creation stories), a practice called Mahi a Atua (footsteps of the ancestor-gods). These workers were called Mataora and this range of diversely qualified people with recognised expertise as tohunga, cultural experts, artists, administrators and clinicians were organised into work teams called Ue (a party that turns the tide).

Hauora Tairāwhiti had the following (outcome) expectations of the Te Kūwatawata service:

- Improve service response to whānau experiencing mental health distress.
- Increase whanaungatanga within services, with other services, and with whānau.
- Build the cultural competencies of the workforce working at the interface with whānau.
- Enable whānau to achieve whole of health and wellbeing from within a Te Ao Māori paradigm.

Te Kūwatawata principles

The Te Kūwatawata service was guided by the following principles:[81]

- Immediate response to whānau in distress and working with the whānau as the smallest unit.
- Whanaungatanga (i.e. meaningful relationships) where whānau, friends, colleagues and care provider networks are considered as resources not objects of the treatment
- Flexibility and mobility so that response is adapted to fit every whānau and their social network and contact is arranged as often as needed and at a place jointly selected
- Responsibility for arranging the response is with whoever is first contacted. Every team member is responsible for all important concerns being discussed. It is the team's job to care and not to leave the whānau alone and, if people miss an appointment, to follow up.
- Continuity with the same team (or an individual) in charge of the whole process. Meeting for as long as is needed. Co-working to ensure optimal coordination and continuity of care for whānau, and a model which supports a workforce strong in critical reflection and active learning.
- Tolerance of uncertainty which means sharing the uncertainty, learning how to be together differently, avoiding premature decisions and treatment plans and knowing that some networks are more likely to find their own resources
- Wānanga, the basis of the therapeutic contact, emphasises open responsive relationships generating korero and co-creativity and reflective communication where everyone is heard and responded to. Transparency and decision making processes are discussed with everyone.

[81] Hauora Tairāwhiti. Request for proposals: For provision of an evaluation service for Fit for the Future initiative – Te Kūwatawata. Hauora Tairāwhiti, 22.09.17

Mahi a Atua practice and training

Mahi a Atua is an engagement with a whānau that is based on Māori principles of whanaungatanga (creation of relationships) and pūrākau (the telling of Maori creation and custom narratives). It can be utilized as an engagement tool, an assessment framework or as an intervention process depending on where the whānau wish to go with this approach. The mostly well-known stories provide an external focus for discussions of distress and trauma and help individuals and whānau to talk about the context in which they find themselves and possible pathways forward. These narratives are snapshots of 'mental states of being' and 'responses to distress and dis-ease', which are illustrated by the archetypal characters of the atua (ancestor-gods) who personify the spectrums of family and social dysfunction alongside resilience, resolution and well-being.[82]

> *"Mātauranga enables us to move away from only using western ideology to categorise distress while staying critical in our thinking as health professionals. We are not abandoning western psychiatric approaches; we are just putting other principles - such as relationships and community voice - forward as an immediate response. This helps us to respond quicker, closer to where people live and most importantly this makes people and community feel connected, rather than disempowered."*[83]

Mahi a Atua is not a 'brand new' concept. The re-telling of such narratives has also been used in South America where research into 'culturally sensitive psychotherapy' was done using Puerto Rican folklore.[84] Dr Diana Kopua developed a way of incorporating pūrākau in therapy in the mid 1990s,[85] particularly as an intervention for Māori children and youth. It was introduced into the clinical practice of a number of practitioners at the Te Whare Maire, the Māori Mental Health Unit in Porirua and its use has subsequently been explored.[86]

Since arriving at Hauora Tairāwhiti in 2014, Dr Kopua has practised Mahi a Atua alongside other therapeutic approaches. Collegial interest was high and in order to support its wider utilization, Mahi a Atua training was facilitated in *wānanga* (pursuing knowledge) sessions. It is presently convened in a Gisborne based *whare wānanga* (traditional learning environment) called Te Kurahuna, a forum developed in 2014 by Diana Kopua and tohunga Mark Kopua, as a way of bringing Mahi a Atua to an even wider range of interested mental health and social work professionals who work with distressed whānau in Te Tairāwhiti region.

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[82] Rangihuna D, Kopua M, Tipene-Leach D. Mahi a Atua: a pathway forward for Maori mental health? *NZMJ.* 2018; 131(1471):79-83.

[83] Kopua D. *Ground breaking response to distress*. Hauora Tairāwhiti media release, 13 September, 2017.

[84] Malgady, R. C., Rogler, L. H., & Costantino, G. (1990). Culturally sensitive psychotherapy for Puerto Rican children and adolescents: A program of treatment outcome research, Journal of Consulting and Clinical Psychology, 58, 704-712.

[85] Cherrington, L., & Rangihuna, D. (2000). Māori Mythology in the assessment and treatment of Māori tamariki (children) and rangatahi (youth). Unpublished paper presented at 'Joint RANZCP of Child and Adolescent Psychiatry Conference and Child and Adolescent Mental Health Conference, Auckland, New Zealand. June, 2000.

[86] Kopua, D. M. (2018). Factors that facilitate and constrain the utilization of a Kaupapa Māori therapeutic approach with Mahi-a-Atua. *Australasian Psychiatry*. https://doi.org/10.1177/1039856218810158

The Te Kurahuna wānanga teaching Mahi a Atua abides by three 'learning principles':

- Tēnei te pō, nau mai te ao (coming in from the dark, welcoming the light) is taken from a karakia of Te Kurahuna. It encourages the transfer of mātauranga Māori learning into everyday professional and personal life and its conceptual translation is 'Indigenize your space'. This principle drives the objective of introducing a Māori perspective into daily and professional life and thereby mitigating the effects of institutional racism – privileging the 'mātauranga Maori' rather than the more deficit-based 'culturally appropriate' services model.
- Ka mā te ariki, ka mā te tauira (as the teacher is enlightened, so is the student) is taken from another Te Kurahuna karakia. This 'Active learning' principle encourages practitioners to be responsive to whānau and the community by understanding and emulating how Maori ancestors-gods made sense of their realities. The pūrākau help to provide a scaffolding for the understanding of self, the world, and one's place in that world to help the worker and the whānau develop a meaningful response to distress and dis-ease.
- Hongihongi te wheiwheiā (inhale the unusual) is the Te Kurahuna principle around 'Embracing a culture of feedback'. It speaks to continually striving to do better. Specifically, practitioners are urged to constantly seek feedback from the whānau and colleagues on their performance in the journey of providing care and support and to be especially open and responsive to negative feedback.

The Te Kūwatawata environment

The Te Kūwatawata service has a remarkable main office space, as offices go. Its centre is a large 8m x 13m carpeted room with a high ceiling, white painted walls covered in vibrant paintings, comfortable furniture to seat 60 and artful displays of taonga Māori. In this space people, including, whānau, staff and members of the public, sit around talking, sometimes singing, drinking tea or simply being quiet. This room's name is Poutererangi (the entrance to the underworld).

Unlike most health service reception desks, the Te Kūwatawata reception area is an open plan. It is very welcoming and the welcome always includes a warm greeting, guidance through registration, a tour of the artwork, a cup of tea or water and an opportunity to 'just sit' without any overdone push to engage in discussing the distress or otherwise that may have brought one into this space.

Off Poutererangi are four other rooms of varying sizes. These rooms, Rarohenga (the abode of Hinenui-i-te-po, the female atua who looks after the deceased), Te Ao Tūroa (the world of the living), Puna (the wellspring) and Pito (the umbilicus) are wānanga rooms where whānau are seen by the Ue – the therapeutic teams. In a similar fashion these rooms have artwork and taonga pieces on the walls, freestanding or in display cabinets. They also have 'whiteboard' walls and ample writing implements for notes and drawings. They range from the seminar sized Rarohenga to the intimate Mum, Dad and baby sized, Pito.

Feedback-Informed Treatment

Feedback-Informed Treatment (FIT) is a pan-theoretical approach for evaluating and improving the quality and effectiveness of behavioural health services by the consistent monitoring of clients' progress and of the therapeutic alliance. "Clinicians gather real time input from clients through structured yet flexible measures that identify what is and is not working in therapy and how to better meet client needs".[87] FIT involves routinely and formally soliciting feedback from clients regarding the outcome of care (ORS - Outcome rating Scale) and the therapeutic alliance (SRS - Session Rating Scale) and then using the resulting information to inform and tailor service delivery. This system was being used by Dr Kopua prior to Te Kūwatawata and the routine use of FIT was proposed from the beginning of the Hauora Tairāwhiti planning around Fit for the Future, as a necessary component of a good clinical system.

Te Kūwatawata used formal online FIT workshops to upskill Mataora in how to use the ORS and SRS components of FIT and more recently had one of its designers, psychologist Dr Scott Miller, provide a New Zealand FIT training workshop in Te Tairāwhiti. Explanations for whānau around its use were well practised in the effort to maximise the likelihood they would be frank and truthful in assessing their own wellness and providing feedback on the workers' performance. We also observed that Mataora were taught that FIT data should not be used in isolation to make clinical decisions, but that the trajectories of whānau outcomes based on the large FIT database can be useful for monitoring progress and discussing that progress with whānau. We observed that the ORS and SRS were very open discussion items, the use and implications of which were shared freely with whānau.

The Te Kūwatawata pathway

In this section, we clarify the processes used in Te Kūwatawata, the vocabulary associated with those processes and cultural associations, and why and how they satisfy the 'Te Ao Māori' methodology proffered by Hauora Tairāwhiti and Pinnacle PHO in their proposal to the Ministry of Health. In many ways, these elements can be likened to Māori 'rituals of encounter,' engaging with the whānau and solidifying relationships, as if it were taking place in the Māori context of the marae.

The matataki

The *matataki* is the person at the head of the defiant *wero* (challenge) party on the marae, the person who interacts with visitor(s) at the gate and then places the *taki* (a twig of leaves) to be picked up – a sign that the visitor(s) wishes to proceed. In Te Kūwatawata, the matataki is both a process and the person performing that process. The matataki (process) collects essential information, registers the *tono* (referral) and ensures that the whānau receives an appointment for a first wānanga/assessment. The matataki (person) receives the tono, locates the whānau, registers the whānau into the Exess database, explains how the Te Kūwatawata service works and invites the *kaitono* (referrer) or whānau to outline the presenting distress, collects data that will inform the clinician of the nature of the presenting distress and the urgency of that distress, considers (most

[87] Prescott, D. S., Maeschalck, C. L., & Miller, S. D. (Eds.). (2017). Feedback-informed treatment in clinical practice: Reaching for excellence. Washington, DC, US: American Psychological Association. http://dx.doi.org/10.1037/0000039-000ΦΦ

often with the lead clinician) which Ue might provide the best clinical and cultural 'fit' (including determining if clinicians might need to be brought in from secondary services), and schedules the first wānanga/assessment appointment. Matataki are well trained in this engagement conversation. Responsibility then passes to the assigned Ue for making sure that engagement takes place.

The tono may come in by:

- the 'Red Phone' where a kaitono rings directly into a known 'Red Phone' number and arrangements are made immediately via the above matataki process
- or through the Uekura 'front desk', in cases where the whānau has walked in off the street.
- as a written referral (most commonly from a GP via the online BPAC^{nz} referral$^{\Phi}$ process)

As a result of ongoing feedback about clinical input, at the time of writing this report all BPAC^{nz} referrals were being initially screened by the Team Leader, an experienced mental health clinician, before being passed to the matataki (person) to complete the matataki process.

Matataki have a list of seven questions to ask, always asked in order, to complete the Registration Form. They are:

1. What are you worried about?
2. Who knows about these concerns?
3. Has there been any contact with our services before?
4. Is there any danger of hurting self or others?
5. What is happening to sleep?
6. How urgent is the situation?
7. Who should be invited to the first wānanga and where should that occur? What is the appropriate phone number(s) for us to get back to you/to the whānau?

In addition, an Outcome Rating Scale is explained and done by the matataki.

From these questions and the ensuing conversation, registration is completed, a first wānanga appointment is made and decisions are made with the whānau around how soon they need to be seen and the appropriate meeting place. There is also conversation about the expertise the whānau may want in the Ue they will be working with and that is noted when making the final decision about which Ue to assign. If the call has come via the Red Phone and the whānau are with the kaitono at the time, appointments are confirmed immediately. If the matataki is speaking to the kaitono only, they will attempt to engage with the whānau immediately. If this is a walk-in, then an appointment is confirmed, very often, for later that day or the next.

$^{\Phi}$ Acronym: Best Practice Advocacy Centre. A service provides various services to New Zealand general practice and other Providers of health care.

As evaluators, we observed the successful engagement of the whānau immediately after the kaitono calling them. We also observed the sometimes protracted process the matataki undertakes when whānau are not readily available. This process was most often by phone call/multiple phone calls but could include home visits. We observed on one particular occasion a thirty minute round of seven different phone calls, one directly after the other, involving three different whānau members in an effort to make sure that the appointment was secured. The matataki was admirably polite but steadfastly determined to make the appropriate contact. The seven questions were asked of all different whānau members in the quest to adequately triage the situation for the whānau.

When the tono comes by written referral, it arrives at Te Kūwatawata via the Hauora Tairāwhiti BPAC^{nz} system, usually the day after the kaitono writes it. It did take some months to enable immediate electronic receipt of BPAC^{nz} referrals in the Te Kūwatawata office and this was the source of some complaints after delays and loss of paper-based referrals. The tono is received by the *kaituhituhi* (the 'central team' data manager), who begins the registration and enters it into the patient management system, My Outcomes®.[τ] It is then conveyed to the matataki (some days they are the same person) who will add this to the 'list of people to be contacted today' so that the Registration can be completed and the appointments made. Tono that arrive through the Uekura at the front desk are 'registered' by the Uekura staff, who take written details. The whānau are passed on to the Ue which is assigned to take urgent calls that day, who perform the matataki function themselves, fill in details online and arrange the first wānanga (possibly at that very time).

The thoroughness of the Matataki process made an immediate impression on us. From the outset, the patient and engaging nature of the matataki, the quiet determined perseverance to make contact and secure the appointment was a stand-out feature.

The wānanga

Wānanga is the name attached to any engagement between the whānau and the Ue – the therapeutic team. The Ue teams are structured to ensure a range of skills in the team. Team members now comprise two (occasionally three) Mataora who may be clinical or non-clinical. The range of mental health workers amongst the Mataora includes clinical specialists, social workers, advocacy-support workers, cultural advisors and tohunga. Other Mataora with no formal mental health background are mostly, but not all, trained art graduates from Toihoukura, the EIT School of Māori Visual Arts who have particularly well developed tikanga Māori skills and who have subsequently trained in the Kurahuna. In the first assessment wānanga, clinicians (some of who are not Mataora) can be called in from either 'off the floor' or from secondary services to complete the team's complement of skills.

In each wānanga Ue members have pre-decided roles to play. Someone will be the facilitator (the *kaitātaki*), someone the observer/notetaker/supplementary member (*kaituruki*) and often someone is illustrating the kōrero on a white board, an iPad or on paper. These roles are explained to the

[τ] The Feedback-Informed Treatment interface See https://www.myoutcomes.com/

whānau. Whilst consistency of team members is valued, team membership can be changed if it becomes clear there is either a skill gap or any form of dissonance between whānau and Ue membership. Such changes are discussed with the whānau.

The Ue structure changed somewhat after the first few months, when whānau demand outstripped Ue capacity, and Ue were made smaller. One of the outcomes of this was that not all Ue had clinical expertise and this was recognized as a clinical risk. The effort to ensure appropriate clinical input into the first wānanga/assessment included mitigation strategies such as pre-assessment of clinical need and inclusion of secondary service clinicians, opportunistic clinician involvement of a nurse team leader and the psychiatrist, and careful attention and training around appropriate escalation procedures.

In May 2018, another change to Ue structure occurred, this time in response to exhaustion reported by Ue members presented with a continual flow of new whānau in need of first wānanga and assessment and the continuity of care required to follow-up other whānau. The number of Ue was decreased so that Ue membership could be boosted, clinical membership of every Ue was ensured, and the requirement for performance of first wānanga/assessment was put upon one individual in the Ue (based on whānau feedback about identifying primarily with one member of the team) during their one week in three turn on the acute 'on take' roster. Continuity of care then rested with that Ue member and they called upon the 'floating' senior clinician(s) and/or Tohunga for that first wānanga/assessment. In their week 'on take', the other two Ue members were doing follow-up wānanga with whānau – one of them was the primary 'continuity' team member for that whānau who had been on the first wānanga/assessment. In September 2018, at the end of the pilot, this new process appeared to be working better.

Feedback-Informed Treatment (FIT) is incorporated into each wānanga. The Outcome Rating Scale (ORS) at the beginning of the session, is where the client (and their whānau) rate their wellbeing and this is then compared to that of previous sessions and discussed. It is often used as a pointer as to what to focus on in that session. The Session Rating Scale (SRS) is done at the end of the session, to ascertain the client and the whānau assessments of the practitioners' effectiveness in working with them in that session. It becomes a subject for serious discussion, with the practitioner asking for the necessary negative feedback to ensure improved performance, and it also informs Te Kūwatawata whether the particular Ue is the best fit or not.

Initially the wānanga had a fluid structure with guidelines that were not strictly adhered to. This structure became a formal protocol after feedback was received that sometimes parts of the process were being missed and that there was a lack of structure. The components of the wānanga structure are based on Māori 'rituals of encounter' making it user friendly and culturally appropriate. Those components are:

- Karakia tīmatanga (Opening ritual)
- Whakawhanaungatanga (Introductions)
- ORS (Outcome Rating Scale)
- Kōrero (Talk)
- Pūrākau (Story telling)

- Kōrero (Discussion)
- Hinekauorohia (Review)
- SRS (Session Rating Scale)
- Karakia whakamutunga (Closing ritual)

The shape of the Te Kūwatawata wānanga is explained to the whānau and they are asked if they would like a karakia performed. Most often, whānau agree readily and an Ue member can do this. Not infrequently, a member of the whānau will do this. Occasionally whānau request a ritual from their own culture, or decline.

Whakawhanaungatanga then occurs, with the Ue and the whānau introducing themselves, emphasising 'who they are' rather than 'what they do'. The effort is to both clarify relationships that already exist (family and other relationships, noting that this is a small town) and to appreciate the therapeutic potential of those relationships that are not dependent on the presenting distress.

The ORS is then explained and done to ascertain how both the whānau and the distressed person is feeling at the beginning of this session. The kōrero then centres around the ORS, reflecting on how different members of the whānau feel about the situation at hand.

The Mahi a Atua approach is explained and other choices may be outlined, particularly where there is an indication that other therapies are appropriate. If the whānau agree, the pūrākau is begun, with the kaitātaki telling the story and the kaituruki making observations and comments about the characters in the pūrākau. There is then *kōrero* around how the story might relate to the situation of the whānau. Reactions are noted and discussed, and possible pathways and strategies entertained.

Then ensues a period called *Hinekauorohia* (She of the reflecting waters) whereby the Ue members, in front of the whānau, discuss the case and all the possible outcomes and appropriate pathways for the whānau to pursue. This is said to increase transparency of the process, to allow whānau to see if the Ue 'have got it right' or not and to allow the whānau another chance to reflect upon their situation and the pathway ahead.

That completed, the SRS *(Session Rating Scale)* is done. The whānau are asked to comment on how well they thought the Ue performed and to enumerate that performance. The aim here is to provide an Ue with feedback about how to lift its performance. It also offers a chance for further engagement with the whānau if they gave an assessment clearly at variance with the way in which the wānanga appeared to proceed. The session finishes, with agreement, with a karakia.

The governance, management and staffing of Te Kūwatawata

Te Kūwatawata was constructed as a partnership between Hauora Tairāwhiti, Pinnacle PHO and Te Kupenga Net Trust. In the Proposal it committed to partnering with the unincorporated Te Kurahuna to develop the service. As a service, Te Kūwatawata is funded by Hauora Tairāwhiti through its Funding and Planning division with monies from its successful winning of a $2.4m Ministry of Health 'Fit for the Future' contract. The decision was made to have Te Kūwatawata sit as a project under the community based NGO, Te Kupenga Net Trust. Being based in a community organisation whose

primary focus was on prioritising the consumer/whānau voice and their 'lived experience' was considered important. In addition, we were informed that this location was to mitigate the management and budgetary constraints inherent in a bureaucratic DHB system.

Originally, the Te Kūwatawata governance group was to include 'governors' from all partners brought together in a Memorandum of Understanding (MOU). The Board of Te Kupenga Net Trust, now the 'parent structure' of Te Kūwatawata, felt itself somewhat responsible for developing the Memorandum but in many ways was always the 'younger sibling' of the troika and its least influential. The Te Kupenga Board nevertheless was the pathway for budgetary approvals with the DHB, variations when they became necessary, procedure manuals etc and to some extent, became its governance Board. But the governance function, whereby a Board oversees the policy settings and the activity of a Chief Executive, did not exist. The 'younger sibling' was not entrusted with or did not take up this oversight of management function.

With no MOU group progressing a governance structure, and given the need of the DHB and Pinnacle PHO to have 'representation at the table', the Te Kūwatawata partners set up a Steering Group to act as a quasi-governance group and as a management group. The Steering group included both 'primarily governance' members - two from the Board of Te Kupenga Net Trust (including its Chair) and two from Hauora Tairāwhiti management (Clinical Care Manager for Medicine and Mental Health and the Quality Improvement Lead); and 'primarily management' members - the Project Manager, the Project Psychiatrist and the General Manager of Community Services at Pinnacle PHO. The final member was the Tohunga/Cultural Lead of Te Kurahuna. This structure ended up having a number of issues which are discussed in the Findings.

Staffing of Te Kūwatawata came from two sources: those who were already in the DHB performing SPoE duties and were then assigned to Te Kūwatawata and those who were newly hired for their particular Te Ao Māori skills. The former comprised child health, addiction and support workers, the entire acute psychiatric assessment and triage team (PATT) and cultural assessment and triage team (CATT), as well as some administration staff and a psychiatrist. The new hire roles included a Project Manager, a Project Co-ordinator, a Team Leader, a Te Kurahuna organiser, three non-clinical Mataora, two youth peer support workers, three administration staff and three 0.1 FTE GPs. Although there were clear managerial and clinical leadership roles in Te Kūwatawata, the workers were ascribed reasonably equal status independent of their professional background. The intended outcome was that this flat organisational structure might break down hierarchies between staff – and perhaps between staff and whānau

Staff came from various professions including psychiatric nurses, counsellors/therapists, support workers, social workers, tohunga and managers and administration staff. One specialist staffing area developed by Te Kūwatawata was employing art graduates from Toihoukura, the local School of Māori Arts, as Mataora. They brought with them a wide experience of mātauranga Māori, their local connections in the community, and added an 'artistic depiction of the wānanga' to the mix – a device that would often stimulate further conversation and exchange and was a source of wonder in itself, inside as it were, a clinical encounter.

Overall, the totality of Te Kūwatawata was more than the sum of the parts described above. There was staunch adherence to the principles expounded in Te Kurahuna that kept Te Kūwatawata firmly fixed on the vision of creating a nurturing, healing space for all comers in Te Tairāwhiti. On the other hand, there was a fluid flexibility that ensured that Te Kūwatawata could achieve their vision. Te Kūwatawata was the embodiment of the wānanga process they practised with whānau on a daily basis. They began the day together with karakia and whakawhanaungatanga, checked in on where they were at, they shared their stories, discussed them and wondered what was possible going forward and they were open to give and receive feedback so they could improve.

Service responsiveness and efficiency

The Te Kūwatawata service set out to provide an innovative approach that was responsive to the needs of those presenting with mental distress in Te Tairāwhiti, particularly those who had been falling through the cracks in the rather fractured previous system or who found mainstream services not conducive to their needs. A strengths-based service, it employed a Te Ao Māori approach, involving the deployment of multi-disciplinary teams and the prioritising of Te Ao Māori in terms of the environment, structure and therapeutic approach. Service responsiveness and efficiency are important aspects of Te Kūwatawata, given critiques that mainstream services have been neither. In this report we have assessed service responsiveness using the quantitative data presented later and by qualitative means, as presented here.

What worked well?

We found that stakeholders saw the service as meeting an important need and there was a lot of good will across all groups interviewed for it to work. A number of features were identified as being real strengths of its ability to reach and respond well to need:

- Easy access and quick response (no entry criteria, the ability to walk-in off the street and the relatively fast response time)
- A friendly, culturally resonant and non-clinical environment
- Working with the broader whānau
- The breadth of skills provided by the multidisciplinary Ue team
- The use of Mahi a Atua as a therapeutic approach
- The transparency of the Hinekauorohia process (reflections of and open discussion of the case in front of the whānau)
- The use of Feedback-Informed Treatment as a quality improvement tool.

With Te Kūwatawata having no restrictive criteria for access, GPs could refer anyone with distress immediately. GPs appreciated that they did not have to spend time, often unsuccessfully, wording their referrals to increase the chance that their patients would meet the threshold to qualify for assessment. They also liked the prompt response and the good outcomes they had seen for some people. Whānau were also able to walk in off the street, thus receiving relatively prompt care at a time they were reaching out for help and willing to engage, rather than be lost to the service through being unwilling to go to primary care or another referral agency or through long wait times. Although the service became busier over time, wait times remained relatively steady and in the

period up to 30 September 2018, almost a third were seen within one day and over half within a week (see Wait times in Quantitative section below).

> *And they (whānau) will be seen when the issue is acute and they're more likely to agree to be seen because of their distress. People have been seen who I think would have been very difficult to have got to. They would quite likely not have turned up to Community Mental Health.* (GP, April 2018)

> *It is excellent the "walk-ins" they are receiving. Anything that is reducing barriers to access care is excellent. As a therapy provider, they seem to be providing an alternative/more holistic/more traditional Maori way to care for people/whānau. This is excellent and will meet the needs of some that did not 'gel' with the traditional western approach.* (GP, November 2018)

The Te Kūwatawata environment was a feature of its responsiveness and was described as friendly, open, calm and non-clinical making it inviting for those who might feel uncomfortable or intimidated in a more clinical setting. Importantly, it was a culturally conducive space for Māori, who comprised a large proportion of those using the service. The importance of this welcoming relaxed environment cannot be underestimated as it had a large impact on the whānau level of comfort and ease (see whānau voice section below). One kaitono likened it to being on a marae.

> *Māori arts all around; there's almost like a marae type feeling in there, so that's one biggie for me.* (Outside Te Kūwatawata, September 2018)

The service took a strengths-based approach putting whānau at the centre and involving wider whānau in the wānanga process. This was seen as strengthening the person's support network enabling some responsibility to shift there. In addition, it enabled the team to identify and respond to the very real distress of those in this support network. This was another feature of the service's responsiveness to those suffering distress. One Mataora compared this inclusive approach with the more constrained way of working in mainstream services.

> *When the whānau comes in and they're both in distress; one is referred, the tono, but actually the other member is in distress, like husband and wife. And so we support both, not just one and not the other… They (mainstream services) go to a 15-year-old who's cutting and if she doesn't consent then the [professional] can't do anything. I said, "Well, Te Kūwatawata will sit there and say, well actually the mum's in distress about her daughter and how about we wānanga with her as well and put her back in the environment so the girl can be a part of it, when and as she pleases or not pleases, and let her decide for herself."* (Within Te Kūwatawata, March 2018*)*

The multi-disciplinary Ue enabled a mix of expertise that provided a broad skill base to call upon and the use of Mahi a Atua as a therapeutic approach was considered an innovative and powerful means to gently engage and ground whānau with their difficult issues.

> *Yeah, I think they have seen that pūrākau are a great engagement tool for whānau; it's less invasive into their personal story. When you hear some of the information and then you formulate which of the pūrākau you're going to use to reflect that information, then you go into wānanga about that pūrākau and they become engaged with it. In a funny, quirky way we're not talking about them, we're talking about these atua; so they don't feel as if their lives are being invaded by our clinicians.* (Within Te Kūwatawata, November 2018)

We heard from stakeholders and also observed that the approach was suited to not only Māori whānau but also many Pākehā. Important to this acceptability was that it was embedded in a wider holistic approach that prioritised the whānau.

The reflective Hinekauorohia process within the wānanga was considered an important feature of the service, ensuring transparency, openness and inclusivity with whānau. This process of *"not saying anything about you without you"* ensured whānau were privy to and involved in Mataora interpretations of their experience and in recommendations for their ongoing care. In addition, the use of Feedback-Informed Treatment was seen as an effective way of tracking whānau progress using their own assessment. This enabled immediate feedback on practitioner performance thus ensuring continued quality improvement. In October 2018, most Mataora attended a workshop with Scott Miller, who developed the programme, and reported getting considerable benefit from the new insights it enabled. Two Mataora in a focus group made these comments.

> *-It's pretty consistent that people will score in a certain pattern that allows you to have a greater chance of being able to actually focus on where the problems are sitting at the time.*
> *-It's a great system and a great tool because notes and all that can tell you so much, but a graph where you can actually see the ups and downs, that tells you a whole lot more.* (Within Te Kūwatawata, November 2018)

Another aspect of Kūwatawata responsiveness was that they continued to see and support whānau who were waiting for an appointment with specialist secondary services. This important bridging role contrasted with previous services where whānau needed to wait often unsupported for long periods until their appointment came up, increasing the chances of 'falling through the cracks'. Te Kūwatawata staff prioritised working with the whānau to determine their service needs, which were sometimes at odds with what was being requested by the referrer. Sometimes social or housing supports were needed more urgently than psychological services, and these were arranged, or the nature of psychological support differed from what was requested by the referrer.

> *For example, we had a GP send in a tono requesting a psychiatrist or psychologist for someone. [A Mataora] just rang this lady and she's got major grief issues, and she just needs someone to talk to. Why would you put a psychiatrist in that space? You might need a psychologist down the line and you might not; but in the first instance shouldn't she be given an opportunity to offload and to talk?* (Inside Te Kūwatawata, October 2018)

What were the challenges?

Several challenges pertaining to responsiveness and efficiency were raised by participants early in the evaluation and reported on in the Interim Report. They were a) issues around the difficult SPoE change management process; b) policies and processes inside Te Kūwatawata (including referrals, notes, communication to referrers about whānau outcomes or changes in prescriptions); and c) the perception that Mahi a Atua was the only therapeutic process utilised by Te Kūwatawata. Pinnacle expressed particular concern about a lack of clinical input into the first encounter and the lack of a formal complaints process. By the end of September 2018, some of these were remedied (clinical input into first wānanga/assessment), some were in the process of being so (protocols and paperwork) and some were considered by Te Kūwatawata to be mis-perceptions that were difficult to correct (whānau not being offered pathway choices).

The lack of clinical input into the first encounter, the Matataki triaging process, was fed back to the service and changes made. Initially clinicians from secondary services were brought in at times, but more recently a system was put in place whereby all BPAC^{nz} tono/referrals were assessed and prioritised by the Te Kūwatawata Clinical Team Leader or the Psychiatrist before being contacted by the Matataki team. However, this was not widely known about amongst GPs in November 2018 when we conducted our SurveyMonkey© questionnaire. In response to a question asking whether they were aware of this change, 60% of the 18 GPs who answered the question indicated that they were not, suggesting a need for more communication with general practice about such details.

Processes were also implemented to address the lack of feedback to referrers/kaitono about their whānau. This was of particular concern to GPs. An electronic Clinical Care Pathway Form was instituted to notify the kaitono 1) after the referral was received 2) if any change in medication was made and 3) on exit from service. In November 2018 the use of this form was still being embedded. For example, a third of the 19 GPs we surveyed that month were not aware of it and eight of the 13 who had referred people in the previous eight weeks had not received the form.

Early feedback identified concern both within and outside Te Kūwatawata about the cultural /clinical balance within the wānanga; namely that some Ue members had inadequate clinical skills or that they were reluctant to use them fully in an environment where the cultural approach was dominant. Some reported a lack of confidence in Te Kūwatawata staff's ability to know when to refer on to other services, especially to specialist services, and there were concerns about clinical safety. Whilst it was true that initially in some first wānanga Ue did not have clinicians, the purposeful selection of appropriate clinicians from inside Te Kūwatawata or from secondary services into that first wānanga quickly developed in response to feedback. In addition, new Ue configurations ensured more clinical input and, as Mataora confidence grew, clinical skills were more readily offered and used. More recently, the clinical team leader or the psychiatrist began to routinely vet all referrals, checking them for clinical urgency before going through the 'Matataki' process.

Reasons why whānau might not be referred promptly to secondary services as expected by GPs included: lack of capacity in secondary services requiring long waiting periods, clients subsequently being satisfied with the service provided by Te Kūwatawata which had its own clinicians, and some electing happily for Mahi a Atua. GPs reported via the SurveyMonkey© questionnaire that if an

earlier appointment could be found inside Te Kūwatawata for their client, they were happy for that to proceed. We noted that often these clients still proceeded on to secondary care and had simply received some attention in the meantime, fulfilling a primary purpose of a SPoE.

For some external stakeholders the issue of clinical risk remained, particularly since Te Kūwatawata had become a victim of its own success with an increasing workload and a limited number of clinicians. This was remedied to some extent by having a sizeable number of clinicians from the CMHAS service come in for two hours each per week and take part in wānanga. However, this then put a burden on the secondary service who itself was very busy. Some stakeholders acknowledged that process and clinical safety issues were and continued to be present in mainstream systems and that Te Kūwatawata continued to actively respond to critique. Nevertheless, some GPs and secondary service personnel continued to perceive this as an issue and one stakeholder was concerned that changes in response to feedback were often reactive, piecemeal and without consideration of the wider picture. The need for a considered and planned approach to change was recommended. Concern about the rapidity of change was also felt by some inside Te Kūwatawata. One Mataora commented that they wanted,

> *.. things to be done slower, with a bit more notice. Communication parts were a little bit better but it still happens pretty quickly and that's what adds to your stress levels. And it's quite unnecessary, to me it seems reactive. "This is an idea, this is how we're going to fix it, we're doing it Monday." Well, can you just slow down a bit? Because it affects us in our day-to-day work, and the relationships that we already have established with each other and with our whānau. So that can be improved and I think it is better than it was.* (Inside Te Kūwatawata, November 2018)

Although almost everyone we interviewed wanted Te Kūwatawata to succeed and believed Mahi a Atua worked well for a sector of the community, a common response was that "one size doesn't fit all". Early feedback found there were concerns about Mahi a Atua as the primary therapeutic approach and about the perceived lack of options for people who actively did not want this approach, such as those with a strong Christian faith or some Pākehā, or who simply wanted other approaches. This was still an issue for some at the end of 2018, with many GPs continuing to refer their patients directly to Pinnacle's Primary Mental Health Service, especially if they deemed the Mahi a Atua approach not to be suitable for them or if, after offering them a choice, their patients chose the mainstream service. Implicit here is that Te Kūwatawata was considered synonymous with Mahi a Atua. One GP wrote,

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> *Many patients have expressed they don't feel the service is culturally appropriate for them (in the same way we have heard Maori clients in the past state the previous service was not meeting their cultural needs).* (GP, November 2018)

In the later phase of our evaluation we found no evidence of Mahi a Atua being the only therapy being used. Although it was almost always offered as a first choice, Mataora said they did not use it when its introduction was rejected.

From the Te Kūwatawata perspective, the pathway forward needed to be determined by the whānau rather than by GP directive and this was best done through engaging whānau in a wānanga process where choices were then offered. However, GPs saw this as disrespectful of their long standing relationship with the person and their clinical expertise. One GP surveyed wrote,

> *Using TK as a SPOE (and being reassessed via the Wananga process) following a patient already having been seen by the GP and a management plan being made, also belittles the work that has already been done by a long period of time by the GP. What makes me uncomfortable referring people to TK is the unpredictable nature of what they will experience once they are there. When I am making a shared management plan with the patient I need to accurately describe for them what their experience will likely be like in each of the various options-but the experience people have had of TK is so variable that I find it difficult to do this.* (GP, November 2018)

Some GPs still queried the lack of choice offered and, if referring to Te Kūwatawata for secondary services, stated that the whānau did not want a wānanga. While in the beginning, clinically qualified Mataora were sometimes reticent to bring their clinical skills forward in a system that privileged the Māori way of doing things, this changed over time. As a result of more direct supervision they became more forward with their clinical skills and opinions. But Mataora, including those clinically qualified, were still insistent that whānau were given choices around practitioner, approach and venue and that they worked with the whānau to determine the appropriate pathway.

> ***So if you do get a whānau who the GP has written don't want to engage with Te Kūwatawata what do you offer them?***
> *So, [we ask] is it that you don't want to come into this space? Is it that you don't want a Māori approach? Is it that you want to go directly to Community Mental Health, in which case we'll invite someone from that team in, in the first instance. Is it that you want just the psychiatrist, or counsellor? We invite them in. We still will attend just so that they will have a waitlist, so that there's someone that you can ring up and say, "I'm feeling this way today." Just to support them until the whānau has been picked up by the service that they want to go to. If they don't want to come here, we'll do it at home. If they go do it by the beach, we'll do it by the beach. If they want to have their appointment at Community Mental Health then we'll do it that way. If they want to have it at CAMHS we'll do it that way. So we basically ask, what is it you want and what approach would you like?* (Within Te Kūwatawata, October 2018)

This statement picks up the important point made earlier that Te Kūwatawata filled an important need by holding people who were waiting for an appointment with secondary services. However, holding on to people waiting for an appointment also put an added strain on the already busy service. Some Mataora and whānau talked of long waits to get into secondary services and a service 'bottle neck'. Having to hold on to people until they were able to be seen by these services not only increased their workload but was not ideal for the whānau. With reference to holding on to clients when waiting for a secondary appointment, one Mataora stated,

> *We're doing as much as we can as in holding whānau wānanga three times a week, or five times a week if we have to do it, just making sure how the whānau are feeling. But we can't continue that if we don't have the supports from other services around us; we can only do so much in a clinical space for so long before we're just holding a whānau because we're holding a whānau. And we're not actually making plans for the whānau or improvements for the whānau.* (Within Te Kūwatawata, November 2018)

Another challenge faced by Mataora was the lack of space in the Te Kūwatawata venue. This included both a lack of work space to plan, make notes etc, but also getting access to appropriately sized wānanga rooms, particularly when more whānau turned up to the wānanga than was expected. In one focus group two Mataora commented,

> *We're getting big, like the demand is outgrowing what we can offer, as far as numbers... We've got this small living room basically out the back where you've got people at a dining table on the phones, really busy. Then you've got a dining table where you've got Mataora clinicians scrambling for seats and trying to do their work; yeah, we've outgrown our space I think....*
> *Yeah, definitely more space because we're scrambling as it is with all our whānau and first wānanga and all the rest. Space-wise, we're swapping and chopping and changing as soon as a whānau walks in and they've been booked in for two so they're booked in the little room and then they walk in with three and you need the bigger room.* (Within Te Kūwatawata, November 2018)

An area important to service effectiveness is good governance. We found that the Te Kūwatawata governance structure was not clear and therefore governance was not strong. The role was supposed to sit with a Board that was comprised of the partners coming together under the MOU. However, because the MOU did not get signed, the governance function bounced between Te Kupenga Net Trust Board, who oversaw and accounted for the budget derived from the Hauora Tairāwhiti Fit for the Future contract, and the Steering Group, who continued to pursue the development of the MOU. With the Steering Group absorbed in solving the partnership issues, the governance function of management oversight did not occur effectively. The Steering Group also had inherent conflicts. Because the size of Gisborne's workforce is small, a number of Steering Group members had potentially conflicting personal roles. The Chair of Te Kupenga Net Trust Board was also a Mataora working for Te Kūwatawata; the DHB manager had oversight of the wider service change process; the Project Manager was also the General Manager of Te Kupenga Net Trust; the Project Psychiatrist was both the inspiration for the project and the DHB Head of the Department; and the Tohunga/Cultural Lead of Te Kurahuna was also employed as a Tohunga at Te Kūwatawata. The Steering Group did not have a Terms of Reference, did not meet regularly and was thwarted with progressing good governance in part because a formal MOU had not been signed.

Service and mental health worker cohesion and collaboration.

Priorities for Te Kūwatawata were: promoting worker cohesion, particularly in light of reportings of an overstressed mental health workforce, working collaboratively across the mental health sector, and fostering collaborative relationships with other sectors. A central objective was to create a

primary and secondary mental health service partnership that would enable a Single Point of Entry (SpoE) to mental health services in Te Tairāwhiti. This was to involve working closely with general practice, ideally using a shared clinical record. In addition, there was an intention to improve intersectoral collaboration with health and social sectors. These were ambitious endeavours given the long history of these services working in silos with little or no real collaboration. In this section we report on how these intentions have fared over the 13 month contract.

Regarding worker cohesion, we found evidence of strong team work within Te Kūwatawata kaimahi which was enhanced by shared training through Te Kurahuna, regular hui, and working in multidisciplinary Ue. Whakawhanaungatanga was central to this cohesion. Mataora valued the collegial support and increased accountability to one's colleagues and to the whānau they worked with provided by this way of working.

> *I love the concept of whakawhanaungatanga and whanaungatanga. And I don't think this service could actually survive without it. When we come in tikanga is not bypassed, it's very much a part of who we are and the kawa of this place. An example, our morning meetings are probably not like other service morning meetings… It's about being together, and it almost cleanses us and sets us up for the day; okay, yeah, sweet, we've got each other's backs, on with it we go.* (Within Te Kūwatawata, March 2018)

Cohesion and collaboration between Te Kūwatawata and other secondary service workers was mixed, with some cooperating well with the new approach and others not. A particularly positive collaboration, which commenced in the latter half of the year, involved secondary service staff being invited into wānanga with whānau who were likely to be transferred to their service. This was considered a very elegant and sensitive way of introducing the whānau to their next team and of workers seeing their counterparts in action. The collaboration was popular with secondary service personnel, albeit rather time consuming.

Particularly in the early implementation phase, many secondary service staff were, however, very critical of the service and the manner in which it was implemented. Implementation within the time constraints of the Ministry of Health contract meant restructuring existing mental health services at a relatively fast pace. The nature and speed of change had resulted in some fall out in terms of relationships and confidence in the service. The unsettledness, described by secondary service staff earlier in the year, appeared to have settled somewhat over the course of the year. However, there were still detractors. For example, a formal complaint to the Hauora Tairāwhiti Chief Executive Officer by the Public Service Association on behalf of many of the Gisborne secondary mental health services occurred earlier in 2018. It was about the change process and the perceived limitations of Te Kūwatawata. By December 2018 this complaint had been reported on but still not completely resolved.

Collaboration between Te Kūwatawata and general practitioners was also mixed. Hauora Tairāwhiti had a part time GP Liaison whose role was to enhance communication and improve the interface between primary and secondary services, including primary care and Te Kūwatawata. This person had had some success with communicating issues and changes between Te Kūwatawata and GPs but

there continued to be a need for a much larger, more focussed communication strategy on the part of Te Kūwatawata. This was only in its developmental stage by the end of the pilot phase.

Although there were some very robust relationships with individual GPs, of particular concern was the lack of a formal relationship with the intended primary care partner, Pinnacle PHO, and consequently questions over the viability of the intended Single point of Entry (SPoE) to Te Tairāwhiti mental health services. By December 2018 Pinnacle PHO had still not signed the Memorandum of Understanding (MOU) and was not encouraging their general practice members to refer all people requiring mental health support to Te Kūwatawata as the SPoE. Thus Pinnacle's Primary Mental Health Service team continued to receive referrals directly from the primary care sector as well as from external agencies, such as schools. The primary ongoing concern for Pinnacle PHO continued to be that the first wānanga did not seem to involve a consistent clinical assessment with clear processes to offer a choice of pathway and referral out to other primary or secondary services. Without an assurance that these were in place and functioning as intended, the PHO was unwilling to enter a formal partnership with Te Kūwatawata. Despite some optimism on our part in June that these issues were being resolved, by December 2018 they remained a stumbling block and it appeared that the partnership relationship was unlikely to be formalised and that the full primary and secondary service SPoE was unlikely to eventuate.

Some GPs were very happy with the Te Kūwatawata service and continued to refer a sizable proportion of their patients with mental distress. However, they also wanted the option to refer their patients to a mainstream counselling service if they felt that person would not feel comfortable with Te Kūwatawata. These GPs identified the Te Ao Māori approach, the encouragement of wider whānau involvement and the use of several in the therapeutic team as inhibiting factors. Interestingly, these same aspects of the service were also considered its strengths by many others. One stakeholder summarised feedback we had received from the general practice sector in the following comment:

> *It's an amazing service to have available, but the strong cultural flavour and focus maybe isn't right for everyone, and for that reason should that be the single point of entry? I guess people with mental health needs are often in a fragile space and you put them in an environment that's not right for them, and if they're put off from the start it's hard to move forward. I know that there's been many mental health environments in the past that are off-putting and not right and it's really good to have a change, but I think the feeling from GPs seems to be great service, really good for patients, great response times, good wraparound and all those things; but - I don't know if it's that the wānanga process isn't right for everyone or that it's the Mahi a Atua process isn't right for everyone - but, because a lot of that has all been involved in the first assessment, they don't want that to be the only option for people.* (Outside Te Kūwatawata October 2018)

The negative response from GPs about the idea of a SPoE with Te Kūwatawata as the only point of entry was also evident in results from our November 2018 SurveyMonkey© Questionnaire to GPs. When asked whether they found it acceptable that, because of wait times for secondary services, some whānau may be asked if they would like an earlier Te Kūwatawata appointment, 94% of the 18

GPs who responded to the question found this acceptable. However, when asked whether this made them more comfortable about Te Kūwatawata becoming the SPoE, 55% stated 'No'. One commented:

> *The service is a great addition to existing MH services, I am grateful for it. Unfortunately several of my patients have either had very poor experiences there or heard negative things through the grapevine which put them off wanting to go there, so a choice of where to refer to is crucial. If you allow a choice, people will vote with their feet and thereby you will get honest feedback, which I think would be a lot better than having Te Kūwatawata as single point of entry*. (GP November 2018)

The proposed use of a single data system, Indici, between primary care and Te Kūwatawata had the potential to improve communication and collaboration between these services. However, because Indici was not available in time, Te Kūwatawata used the Te Kupenga Net system, Exess. It took some time to satisfactorily get Exess to work smoothly with primary care systems and these difficulties did not, unfortunately, foster an environment of ease and cohesion.

Te Kūwatawata specifically aimed to engage referring community and other services to broaden the base of support for whānau. The service established good working relationships with some GPs, other health sector NGOs (such as Tauawhi), a number of social service agencies (such as Corrections, NZ Police, Oranga Tamariki) and some schools (particularly Kura Kaupapa). Indeed across all groups we interviewed there was considerable good will for a Te Ao Māori service that could engage and work effectively with whānau who previously 1) did not engage with health services until in crisis, 2) waited so long to be seen that their condition escalated and 3) found the mental health service did not meet their needs. Even those who had strong criticisms of many aspects of the service wanted it to work.

Intersectoral collaboration, however, tended to occur at the individual practitioner level rather than at the service level. Many participants were pragmatic about this, seeing it as a constant challenge because everyone was so busy working in their own patch that it was difficult to find the time or incentive to see the wider picture or to make broad connections. There was also some element of patch protection involved. It was likened to a marriage which needed ongoing work to keep the relationship active and functional.

Service and mental health worker cultural competency

An integral part of the new way of working was making improvements for the mental health workforce. This included improving the way practitioners engaged with Māori (cultural competency). Many kaimahi within Te Kūwatawata talked of transformations in the way they now practised and in their own sense of identity as a result of undertaking training through Te Kurahuna. In general it appeared that Māori kaimahi felt liberated by being able to work in ways that felt quite normal for them, while Pākehā kaimahi felt empowered by gaining confidence in this new way of working, which they observed worked well for many of their whānau. One Mataora pointed out the importance of having a strong cultural presence in the wānanga for whānau to feel safe.

> *Somebody who is like a cultural rock, there's a certain ihi in that wānanga, that flows a confidence out to the whānau. It makes the room feel safe. So, the cultural competence is what makes for Māori families especially, the room safe, the wānanga safe? It's like. "I need to feel wairua safe", that sort of thing. I think that's the value of the whanaungatanga in wānanga, too, is to start layering that.* (Within Te Kūwatawata, November 2018)

Managers from both DHB services and Corrections reported seeing big changes in the confidence and cultural competence of their staff as a result of their attending Te Kurahuna wānanga and applying their knowledge and skills in Te Kūwatawata wānanga.

> *The change that you see in people as they go through wānanga is just amazing. Some of the narratives that we've had from staff that have maybe worked in secondary services and then moved over to working Te Kūwatawata, in terms of how they have developed cultural competency; but also how they've managed to weave maybe a westernised model alongside a Māori model...I think the principles of active learning, receiving negative feedback, and indigenising your space, those three, when they're adopted by people, they're simple statements, aren't they, but they can be quite challenging to do. And I've seen the growth in people as they've pushed into different spaces.* (Manager, March 2018)

Whether cultural competency had extended beyond the individuals who had been involved in Te Kurahuna to external workplaces was a moot point. Workplace changes were reported at Te Whare Oranga, where a wānanga space had been set up, at NZ Police Whāngaia Ngā Pā Harakeke (Family harm reduction service) and at Corrections where a number of staff had started to change their practice. A kaitono from one of these agencies conceded movement in indigenising the workplace was rather slow but felt Te Kūwatawata set a good example and had the potential to positively influence this.

> *I must admit we were all a bit slack in some of those areas and we could all be better, but we're very much mindful of wanting to improve in those areas. We've got karakia on the board and individual members are trying to do their own little bits and pieces, homework. I'll have to say that with Te Kūwatawata coming on board and being very Māori based that we'll have no choice but for that influence to filter up for the best, everybody else to play their part too.* (Outside Te Kūwatawata, September 2018)

Some small changes were reported in a couple of primary care environments where management had taken a lead. However, workplace change elsewhere was reported to be limited. Addressing cultural competence in other workplaces is a major endeavour and it would be unrealistic to expect any substantial institutional change in such a short time frame from a programme that is working to establish itself amidst a significant change process.

Albeit slow in development in places, important improvements in cultural competency amongst individual mental health workers and within services have occurred. Te Kurahuna, and the opportunities offered by Te Kūwatawata, have primarily been responsible for this. Te Kurahuna is at the heart of cultural competence development in services across Gisborne and has immense

potential to spread its teachings further afield as social and mental health services from outside the area search for an appropriate vehicle for their own regions. Indeed, personnel from Lakes and Hawke's Bay DHBs and from Taitokerau, other areas with high Māori populations, have made visits to observe the service to ascertain how a similar service might be implemented in their region and have been very positive in their feedback.

Those from Lakes DHB were impressed with the Te Kūwatawata environment, the Māori aspirations that drove Te Kūwatawata, the 'distress' rather than illness approach and the training of the Mataora. The Mataora role was considered not unlike a role being developed in Lakes called the Manawa Ora who are presently working in the 'distressed children's sector and they saw the Te Kūwatawata model applying to the 'wider picture of distress'. Impressed at the angle that Te Kūwatawata had taken as a mainstream provider of service, they were keen to replicate the Te Ao Māori model of care with 'alliance' models of governance that included DHB, primary care and community representation and remain in the 'mainstream' environment.
A long term Taitokerau mental health advocate, Moe Milne (Ngāti Hine, Psychiatric nurse, teacher), one of the many Māori health personnel who have visited from out of region considered the strength of Te Kūwatawata was Te Kurahuna, the constancy of training going hand in hand in an ongoing fashion with work activities. She was impressed with the addition of artists (experts in te mahi toi) and how 'drawing a clinical conversation' gave opportunity for the whānau to contribute easily. Mahi a Atua inside the Te Kūwatawata framework was "a culturally sound and clinically enhanced practice". It was the first time she had seen such a Māori focussed approach put into mainstream action. She stated:

> *"Kia mohio mai ai koe ko taku tino tautoko nei, katahi anō au i roto i a tātau mahi katoa, ka kite i te tino pūmau o te whakaaro o te tangata kia Māori mai tōna mahi mō te Māori, kia tautokohia a ratou mahi e a rātau clinical, Pākehā clinical; competencies"*
> ("I want you to know that this is the first time I have seen in all of our collective work, the steadfast and faithful adherence of Māori thinking to the work of constructing a pathway for Māori that is solidly supported by their Pākehā clinical practices")

Her recommendation was for robust documentation around a clinical description of what Mahi a Atua actually does and how it performs clinically. In other words, documenting Best Practice so people have assurance around clinical risk.

Whānau experiences and outcomes

In this section we start by describing stakeholders' perceptions of how the whānau they referred or worked with had fared after engaging with Te Kūwatawata. This is followed by a larger section where the experiences of the whānau themselves is described. Both sets of participants reported very positive experiences and outcomes alongside some less positive ones.

Stakeholder perceptions

There were a variety of reports from stakeholder participants about their perception of whānau experiences of the service. Many believed the service was reaching and responding very well to a

range of people, particularly those who previously had either not engaged with Mental Health services or had not been well served by them. One secondary services participant said:

> *In that mild-to-moderate category - I hate to use those terms, but it's terms we all know - I think that it's working really, really well with the people that are at that stage in their distress. I think it's a great early intervention thing, I think it's a great way to keep whānau engaged, or to get them engaged - and that's about supporting that person in their whānau that is in distress.* (Secondary services, March 2018)

A kaitono from an external agency who had attended wānanga with about ten whānau believed that the service filled an important gap and had worked very successfully with the whānau he had referred who had very specific needs. None of these whānau had had a negative experience and although the changes he observed were not transformative he believed he saw consistent positive outcomes.

> *I'm not talking in big, big changes where their whole life has suddenly made a big turnaround. The biggest change that I can see with the whānau that I have accompanied or escorted to a Te Kūwatawata session would be coming out of it feeling a bit more relieved, calmed, up-spirited and generally feeling a lot more at ease than when they walked in. That's the main biggie that I can see in terms of the good they've got out of going to Te Kūwatawata.* (Outside Te Kūwatawata, September 2018)

A GP, who had had positive feedback from a number of those referred, had referred a few Pākehā to the service who had also reported back positively about their experience.

> *Another Pākehā young woman who I sent and was initially seen by the Crisis Team, so not Te Kūwatawata - that was an evening - she ended up being seen by Te Kūwatawata teams and was very positive as well, felt she'd had good follow up.* (GP, April 2018)

Our whānau interviews and observations of wānanga with Pākehā whānau also showed that Te Kūwatawata was highly acceptable for some Pākehā. One adult Pākehā whānau said he felt very comfortable in the service and was "*very appreciative of what they've been doing*", while another expressed strong appreciation of the respect given.

Many of the Mataora working within Te Kūwatawata had received a lot of positive feedback from whānau they worked with and had also heard feedback from within the community that inspired them in their work. One stated,

> *The whānau I see come through the doors and getting help, and the help that obviously* [is] *needed, yeah, they appreciate the service. There are a lot of great stories that have come out of people that have ... come out the other end and are doing great now. I think one thing too, is that there are other iwi chomping at the bit to come and have a look at this. They've heard of the greatness of it and what it's doing for not only our people but for the community and they want to* [be] *part of it and want to structure their own type of Te Kūwatawata in their*

own iwi and rohe. So, that in itself tells you that it's a good place and it's doing marvels and wonders for the community. (Within Te Kūwatawata, November 2018)

On the other hand, a number of external stakeholders reported that some people they had referred or knew had not found the wānanga approach helpful. A few reported that the Mahi a Atua methodology did not suit certain Christian Māori and some Pākehā. The main issues reported were: not relating to karakia and the Mahi a Atua approach; wanting one-on-one therapy but not being offered it and not feeling able to ask for it; and feeling that the approach did not deal with the issues presented. A GP who had referred a Māori man said:

When I said that it was an indigenised service, he said "I want to be on the Pākehā waka." That's what he said, and I forwarded that on. But, it was just that kind of feedback that you needn't assume the cultural approach automatically matches the person's ethnicity. (GP, March 2018)

Interestingly we found that a few particular stakeholder stories about negative whānau experiences were repeated several times by other stakeholders, even long after the event had occurred. This might suggest that the experience had had a marked impression on the kaitono but it might also suggest it was used to validate others' negative perceptions of the service even after the issues had been addressed.

The whānau voice

As mentioned, we heard the stories of 13 whānau who had used the Te Kūwatawata service (7 adults and 6 young people). In selecting the whānau we aimed to ensure a mix of ethnicity, gender and age. Whānau were all referred by stakeholders inside and outside of Te Kūwatawata and we had no indication of what their experience of the service had been prior to the interview. Here we present key themes from these stories.

Negative feedback

As was expected, the whānau whose stories we were privileged to hear reported a mixture of experience with Te Kūwatawata. For the most part, these experiences were very positive but there was also some negative feedback. One whānau who accessed the service in the early stages felt they would have liked more in depth counselling but were not offered the choice and did not feel in a position to ask. Although they could not fault the manner in which care was provided and were very impressed with the respect they were given, they felt the therapeutic approach did not go "*deep enough*."

Very nice people, very pleasant times with them and, I suppose what I'm saying, not deep enough for me. I wouldn't like to have been mentally unwell and had the experience I had with them. But had I been presenting as mentally unwell they may have taken a different response from what they did. (Whānau, May 2018)

An aunt, who was the main support person of a young person attending Te Kūwatawata wānanga, was unhappy with the care he received. She felt the three person team was daunting and that they did not listen to her nephew properly even when it was clear he was not engaging. She said:

> *They weren't listening to him; he just needed that someone to speak to about his feelings and the changes and what was going on. Yeah, he didn't feel comfortable with the three staff members that were in there... [They were] drawing pictures on the board and explaining everything but he's not understanding what they're doing, but they just continue on with their pictures and I'm trying to explain he's not understanding what you're talking about. So then the whole session was drawing pictures; so they weren't listening to what [he] needed at the time. Then he lost interest and just stopped talking. ... He just shut down; didn't want anything to do with it, just wanted to leave... It wasn't a good experience for [him].* (Whānau, November 2018)

The aunt ended up arranging for him to be seen at CAHMS and was very happy with the service there, saying he was *"in a good place at the moment and doing really well".* Later in the interview she insisted, however, that she supported the Te Kūwatawata service, felt it was going through teething problems and was set to do good work once more established.

> *I've had a lot of people in my life that needed help. But I absolutely believe that Te Kūwatawata is the place to go - with the right training and the right people in those positions; it's going to help a lot of people, I think it's going to work. It's only just started. They can only improve, I believe, and I look forward to hopefully one day going back, and seeking those services. They're doing alright for, just starting out and learning what's going on within the organisation. It's gonna do really, really good things.* (Whānau, November 2018)

The mother of an young person who had used both CAMHS and Te Kūwatawata was not particularly impressed with either service, saying both services wanted to put her child on medication which she and her ex-husband both objected to. She also felt neither service explored the wider context of her child's situation thoroughly enough. The parents were separated and the child lived with the father in an environment the mother was not happy with and she felt this limited the effectiveness of the service.

> *Yeah, that's how these services don't really help. It's okay there, when you go there, and you talk or whatever with them, but when you go home it's back to the same old shit. So nothing will ever change.* (Whānau, November 2018)

Nevertheless her assessment was that her child did get better over time. She felt this improvement was largely due to the child's own will and support networks but conceded that Te Kūwatawata offered some benefit and that the service's Māori ethos was more conducive to her child's needs than mainstream services.

Another mother reported that her child did not respond well within the Te Kūwatawata service and she became concerned enough to consider booking an appointment at Family Works. However, after three or four sessions, which occurred over a three week period, the Ue team recognised that the young person was not improving and arranged for them to be seen by the in-house psychiatrist. A referral was made to CAMHS and a first appointment was made shortly afterwards (within 5 weeks of first attending Te Kūwatawata). The young person did very well under CAMHS care, improving almost immediately they engaged there. At the time of the interview the young person had just exited the CAMHS service and the mother was very happy with the care received and the outcome. In retrospect she was very grateful that her child was 'in the system' and being seen while waiting for the first CAMHS appointment.

> ***What are the things that you feel worked well within that system (Te Kūwatawata) for your child?***
> *Having a contact; so it wasn't a huge wait until we got to CAMHS and we weren't left hanging with no support. If we hadn't had that Te Kūwatawata support we would have waited from the GP to CAHMS. And they always said, "If there's a problem, ring," you know, they were very available.*
> ***So you're seeing them as sort of a good 'holding place'.***
> *Yeah, a good 'catch net', I said to someone...I don't think they were the best fit for [our child], but they tried, and we weren't left with nothing; but you don't know until you try.* (Whānau, November 2018)

She felt that Te Kūwatawata "*was a very adult environment*" that was not so conducive to teen and pre-teen young people. She acknowledged that this was a difficult age group to tailor services to and that CAMHS, whose environment appeared to be more geared to very young children, was also not ideal for this age group.

Positive feedback

The majority of what whānau shared, however, was very positive. This included feeling very at ease in the environment; feeling listened to and heard, being fully understood for the first time, and feeling totally supported. Some described transformative experiences (see blue box p. 73).

Having choices

Whānau reported that they were fully consulted on options and involved in decision making, whether this was around venue, the mix of practitioners in their Ue or the approach taken. One said,

> *Nothing was ever off the table. We were always consulted about 'was this working, did we want something else, was there another way we wanted to do it, were there other people we wanted to bring in, did we want to meet at my house instead of down there?' It was, anything was an option. That was amazing, because there were no limits on what healing looked like. It was always going to be on our terms, in our way and the way we thought best suited us. It was incredible.... It was definitely an option to look at different methods, but that pūrākau worked, so we didn't ever explore anything else.* (Whānau, October 2018)

One adult male who had had an intense and protracted experience of mental health services with a daughter some years before did not want to engage with the service, despite GP referral and several calls from Te Kūwatawata to set up a first wānanga. Eventually his wife became aware that he was not responding to calls, contacted the service, explained the situation and arranged for all appointments to be carried out at home. This was totally acceptable to the husband and he and his wife had a very positive experience of the four or five sessions involved, with a successful outcome. Having this choice was a crucial factor in this success. His wife who was at the interview said:

> *When he said to them, "I don't want to come to the hospital, I'm not going to go there," they said, "That's fine we'll come out here." So, everything was here, absolutely fantastic... And just the privacy. Like, we could come here, sit down, have a cup of tea. It didn't matter how long they were here for. It was just comfortable, super comfortable. Whereas, we've spent a lot of time in the psychiatric part of the hospital with our daughter, with mental illness; so he had no intention of ever going back there again. It was not a great time of our life. But they (TK) were just so comfortable, so welcoming, so easy to ring up and ask a question if we needed to;" here's our phone if you want". We didn't, but that's knowing that.* (Whānau, December 2018)

Another adult male who was reluctant to use mental health services for his depression was happy about the way he was introduced to the services, the choices given and the speed of access.

> *He (GP) referred me, and he must have got in contact with them, then they rang me and introduced themselves over the phone and said, of course, if I'd like to go in, or they could come over wherever to meet, to introduce ourselves. It was a pretty smooth introduction... it was pretty sharp, pretty fast. I didn't have to wait too long.* (Whānau, December 2018)

The Wānanga Process

Several whānau specifically mentioned the healing power of the wānanga process and the pūrākau. It was seen to destigmatise and create a fresh perspective on painful experiences. When asked what worked well, the mother of a Māori young person said:

> *The specifics, I guess, were definitely the pūrākau; because it created this third person - almost that you are not talking about how you feel, you're talking about this third person. It makes it a lot easier to have those conversations and to explore quite deeply. I think that's a really powerful technique. Most of us have grown up here in the region and have some sort of understanding of it, and when you can relate it to the story that sort of explains how you feel, it also I think reminds you that you're not the only one, and that there are people, millenniums before you, that have felt exactly the same way.* (Whānau, October 2018)

She also reported that her daughter found this 'third person' aspect of the pūrākau was useful in making sense of her friends' negative responses to her. The approach meant she could contextualise their behaviour without making them bad or wrong.

> *When [the Mataora] were talking about these different atua and their personalities and the traits they displayed, she could relate specific friends to those specific atua. She was saying,*

> *"Okay, yes, that person does display those traits and Ok I can see how that brings me down, or boosts me up." Again, it was a way for her to come to that conclusion without actually feeling like she's judging her friends.* (Whānau, October 2018)

A woman who came home to Aotearoa to heal and was recommended Te Kūwatawata at *"a time in my life that I was struggling... I didn't want to be here anymore"* found the wānanga process and the pūrākau very helpful. She had lived overseas for some time and felt frustrated that she did not know more about her Māori side. She said:

> *When I went to Te Kūwatawata they helped me more understand the Māori side and that kind of service helped me a lot. With things like the pūrākau, and all that stuff, that made me feel more connected; because the stories that they were telling related to me. I thought that was good; I really like that, the pūrākau and stuff. They didn't rush me or try and steer me in one way or another, they just let me talk and then put things in place, like things I could do to help me.* (Whānau, December 2018)

Whānau of a highly distressed young adult man who was fluent in *te reo Māori* described the relief they observed in him when he could talk in *te reo* to a Mataora and be fully understood. They also appreciated the many forms of communication they were offered and able to share. The mother said,

> *You know, it's true when they say, you're Māori, you're Māori, and when you're mamae (in pain) your heart will always talk. And that's how they are. They speak the reo but they also speak in pictures, English, however it is that makes you feel better. They're not disrespectful, they're loving, they're really understanding, and they hear. I think that was the main thing, that they heard us. There was no blaming or anything, they heard us, they heard him, they could hear him. Because, you know, I was so, so worried for him. You know, worried for him, eh.* (Whānau, May 2018)

When asked if they felt overall that engagement with Te Kūwatawata had been worthwhile for their son they replied:

- *Absolutely, I really do. I don't think my son would be here... That's what I'm saying but when he's been asked that he's said, "No way," you know, he's got his kids to live for. But his heart was broken, I heard it... [The wānanga process was] soothing. It gave him a bit of togetherness, that togetherness, to get his mind out of chaos, to breathe.*

- *Yeah, it was just relatable, all those stories... He [the Mataora] would turn around and bring it all out to suit him. And I thought, "Wow," you know he's talking about this boy, he's talking about this boy, but from a story point. And he could understand it, you know, he could understand it.* (Whānau, May 2018)

A mother, who was very grateful for the transformation she saw in her child after attending Te Kūwatawata, stated.

The only bad thing was the [Mataora] were always looking for ways to improve and I could never give them anything. (Laughter) It was just such a beautiful healing experience. There was nothing that I could name that shouldn't have happened; and nothing that I can think of that could have, that didn't. (Whānau, October 2018)

Some whānau commented specifically on the Hinekauorohia process, saying they liked its transparency.

And that was a commitment right from the get-go, that there were never going to be any corridor conversations before they came and spoke with us, and what they said about us was always said to us. That was huge, especially for [our daughter], to know that there was never any judgment, there was never any consultation that she wasn't a part of. None of her treatment was done without her involvement and that was huge. That was so valuable. (Whānau, October 2018)

One couple likened it to being on the marae.

- Yeah, it was consistent with being in the ātea, being on the marae. You know, we're still on the paepae, we've had our kōrero, now they're wrapping up. But they didn't go behind my back, sat right there in front of us to tell us what they thought of the session; we're still on the pae.
- Yeah, I just thought, "Woah, this is awesome." So, they did that in front of us.
- Yeah, kanohi ki te kanohi. They were fabulous. (Whānau, May 2018)

Stories of appreciation and benefit from the wānanga process were not confined to Māori whānau. We observed three Pākehā whānau fully engaging with this process and whānau of a Pākehā young person reported that the Mataora were culturally very respectful and careful to provide options.

If they were going to do an opening and closing prayer they always asked; they were very respectful on the cultural side of things. And if the cultural side of things, if it started a conversation with [name] they went with it, and if it didn't, that's fine. There was very good balance. (Whānau, November 2018)

A few people talked about how they found Feedback-Informed Treatment. In response to a question asking how she felt doing the Outcome Rating Scale at the beginning and the Session Rating Scale at the end of a session one woman said:

Yeah, that's a pretty good idea because it keeps track of where you're at. I'd go in sometimes, and I couldn't even remember the last session, or my behaviour or what I was thinking in that [session], and they'd bring it up and say, "Oh, you remember thinking this?" "Oh, true?" "Yeah, yeah, yeah." So, recording how they did, I thought it was cool because they just didn't sit there and listen; they took in what you were saying. There were a lot of things they did that I didn't even know they were doing at the time, and I thought it was quite cool. I'd go in there in the

morning and I'd feel really cold, really flat [and] most of the time I could come out of that with (my Mataora) and feel quite pleased and ready to face the day. Once again, it was just about having people to talk to. When you first go in and how you're feeling, what are your thoughts and all that. Then again after, you're like, "Oh, yeah." As opposed to, "Oh, I feel like shit." I feel better now. I thought that was bang on. For me, everything they did was bang on; well, it certainly helped me. (Whānau, December 2018)

The whānau approach

The wānanga process takes into account that the whānau members attending with the person in distress can themselves be distressed and the process works very actively with everyone. The mother of a young person described the profound healing, validation and empowerment the whānau themselves experienced as a result of their wānanga.

There was a lot of disconnection [in our whānau]. In hindsight, when I look at it, it's so simple, the answers are so simple. But for a family who are so disconnected, if they don't have opportunities to come together and talk about it, it's so hard; almost impossible. I think about 90 percent of our whānau's healing was done in that one [first] wānanga. It was amazing, just amazing.... I liked that they didn't work one-on-one. There were always two workers there. And I love the storytelling. I love the whakawhanaungatanga; that was beautiful. Just everything that our whānau had been going through from day one had been validated and heard and that just felt really empowering to us as a whānau. Accessing any [mainstream] service, usually we go and sit down and get told what to do and then go out and get the tablets and give them. It just felt a very empowering process. (Whānau, April 2018)

Another aspect of the whānau approach described was that the environment felt like home and the Mataora felt like whānau. This made it easier to be with the pain and distress. A Pākehā mother of a Māori young person said:

Definitely the whānau approach; especially in a community like Gisborne where the whānau approach isn't necessarily restricted to only Māori. But, because it's so intrinsic to who we are, 99 percent of the population here respond to that approach. It creates this environment where it's okay to be in pain, where it's okay to need help, and you don't feel like there's something wrong with you because of it. (Whānau, October 2018)

General experiences:

The sister of a Pākehā woman, who had addiction issues, supported her closely throughout her time at Te Kūwatawata. Her sister had since left town but she was happy to talk about her sister's experience:

With my sister, obviously a self-referral, we went in. I think that she got the help that she needed, and at that time she was ready for a change. We had an older lady come out and take her into an interview. My sister actually built a good relationship with a guy [and] he was always checking on her, and she did so well for two months. He was really, really good. Obviously, she fell off and relapsed, but he was still there to support her; and he did his job as

best as he could. But then she decided that, nah, she didn't want to stop doing what she was doing. I think that just came to an end there. But the experience with her was good. When we were welcomed, everything was private; the older lady, she felt confidence in her. Well this is her first time trying to go clean, so she needed that support and she got it. (Whānau, November 2018)

Several whānau praised the efforts made by the Mataora to support them and to communicate with them, even when they themselves weren't necessarily willing. One adult male who freely admitted that he was "*not the sort of fella who opens up too much"* and *"thought it might have been a bit strange talking to strangers",* was very grateful for how easy the Mataora made it to relate to them and with their persistence in following him up. When asked what part of the whole process he particularly appreciated, he said:

Their time and effort that they put in, even though at times I wouldn't go to the meetings because, like I said, I find it hard talking; but they would always follow-up, they'd always give me phone calls and a, "Hey, we're only a phone call away." They were always there and I appreciated that, the amount of effort they put in even when I didn't show any interest. It was pretty impressive. It didn't feel like I was in counselling, it just felt like I was sitting around with friends; it was pretty cool. (Whānau, December 2018)

This man, who had suffered enormous loss and grief in his life, was extremely grateful for the service.

Honestly, if it wasn't for [my Mataora] and the guys at the Te Kūwatawata I wouldn't be laughing now; I truly believe I'd still be back where I started... I am grateful to have them [Te Kūwatawata] here, as I am sure a lot of other people are. Grateful that they are here doing what they are doing. Because if they weren't I don't know where we would turn to; apart from my doctors and that. But, yeah, glad they are doing what they are doing. And it's good to know that we've got that safety net there should we need it again. That's all I've got to say. (Whānau December 2018)

The woman who had lived overseas who had come home to heal also praised the follow up by Te Kūwatawata, particularly when she first engaged with them.

I had my family here from (overseas) and then when they left - it was the long weekend - so, Te Kūwatawata were a bit hesitant to leave me by myself for that weekend but they were there to make sure I was okay for the weekend, and have the support and had their contacts if I had to; that was another good thing that they did... [And] the communication was really good; they always texted me to remind that an appointment was coming up, or just to check up on me. It was good. (Whānau, December 2018)

This woman has since gone on to be the kaitono and support person for a friend of hers and was keen to continue to encourage and assist others to access the service through her work.

Yep, and I've changed a lot since last year and I think this helped me, the cultural side of it, and building the confidence and everything I needed to get started again. So it put me on the right path again. It was that little boost I needed and so hopefully it will help my friend who's going through stuff at the moment too...I'll keep referring people there because it helped me when I needed that boost and that connection and everything too. I'll be referring people through my services; and whānau if they need it and all that; it helped me and it worked for me. (Whānau, December 2018)

The mother of a teenage girl felt getting her daughter seen promptly at Te Kūwatawata was crucial to her positive response. She described their journey as follows:

She didn't want to go to school. She didn't want to talk about it, she just cried a lot. I booked her in to see the GP... She did a referral to Te Kūwatawata. My daughter actually made a disclosure to her that she was suicidal; so that was news to my ears... We went I think a couple of days after that. They got back to us straight away, Te Kūwatawata, and made the appointment with her. We went in - her sister and I... but she was just really low, didn't want to talk to them, didn't want to engage with them at all. I said to them, "Oh, I might go out of the room 'cause maybe it's me." .. [I] didn't go anywhere but just sat outside in the big room. She just had a humungous wail cry. Think about an hour later they called me back in. They had had a talk to her about what had happened and they let me know, but not what she told them. We just asked what we needed to do after that. They set another appointment for her and we went to that appointment... It was the following week... When we had the second appointment with Te Kūwatawata, she was just such a different girl. She was talking how she usually talked. So, she's quite like, "You know," and, "Like," and that's how she talks, and she was that person again. (Whānau, April 2018)

Comparisons with other services

In order to compare experiences of Te Kūwatawata with mainstream services we set out to recruit at least six whānau who had used both services. Although we ended up interviewing only six whānau with experiences of both, others we interviewed drew comparisons based on their experiences of mainstream services with other whānau members or their general impressions of these services. As mentioned above, one of the whānau who had used both CAMHS and Te Kūwatawata felt that neither service was entirely satisfactory. Another two felt they did not see benefit in the young person they supported until they engaged with CAMHS, although one was appreciative of the 'catch net' role played by Te Kūwatawata. The other three whānau compared Te Kūwatawata very favourably to other services. For example, the mother of a young person (see box, p 73) described the rapid improvement in her child after engaging with Te Kūwatawata and her belief that, had the service been available three years before when her child became unwell, his recovery may have happened sooner. A couple whose adult son had previously engaged with mainstream services in another location and who chose Te Kūwatawata when he returned to Gisborne in great distress stated:

- *And to be honest I don't know whether he would have engaged as well, say, if he'd gone through the other service; I don't think he would have engaged as well. He may have done, but I don't think so.*
- *I don't think so. It was just instant with Te Kūwatawata, it was instant, so we're lucky... They were there when we needed them, they got us.* (Whānau, May 2018)

The woman who had come home from overseas had accessed mental health services elsewhere and compared the Te Kūwatawata Te Ao Māori approach favourably with these services.

> *Other services that I've been to don't have that, they're just very sterile and to the point kind of thing. Whereas if you connect a person to their culture then it makes them feel a part of something; especially with people that are really down. They feel alone and they feel disconnected from everything, so when you connect someone to something, even if it's just their culture, then they feel a part of something. I think that's a really good component that the service has.* (Whānau, December 2018)

A mother, whose child had not engaged previously with other services, nevertheless had strong views about the comparative benefits of Te Kūwatawata. She said:

> *Other than the environment and the language used and the scene that was set, I think the biggest difference with the mainstream counsellors and the psychiatrists, in my experience, (is that in mainstream) there's been a very definite structure to, "Okay, we will discuss this, and next session we will discuss that, and by this you should be all better." Or, "This is what's wrong with you and here's how we'll fix it." Which is a very confrontational and judgemental way to address something that's so fickle as emotion. Whereas, Te Kūwatawata didn't put any labels on it; there was no stigma to it; there was no timeframe, or pressure. It was just this soft place to land.* (Whānau, October 2018)

The warm, non-clinical nature of the environment and the approach taken were contrasted with mainstream services.

> *So, the association people have with going to psychologists or counsellors is typically a clinical environment, very cold and sterile, a hospital or psychologist's rooms where clearly you're going there because you've got something wrong with you. It creates its own internal label. When you go to a place like Te Kūwatawata you're going there to meet with whānau; you're going there to talk to people who care. It removes the stigma.... Even now seeing them in the supermarket it's a hug and kiss and "How are you doing?" and carry on. And, again, I think that helps take that stigma away, because you're just whānau and it's not a doctor environment, it's not a clinical environment, it's not a cold impersonal don't make eye contact when I see them out in the public environment. It's just helping.* (Whānau, October 2018)

The mother of an adolescent boy told this story, which is an exemplar of how Te Kūwatawata and clinicians in secondary services worked effectively to ensure the best experience and outcomes for the boy and his whānau.

So, three years ago he got into some trouble at school and his friends actually started to isolate him. He didn't want to go to school or participate in anything. He was just really in a low mood. So, we engaged with CAMHS. We kind of tried to push him through that. They said.... it was just social anxiety. It's like, okay, so just kind of pushed through with that.... He just got worse and worse. He was becoming quite resentful and cut us all off. Our house was really stressed, just going home to him. It was very stressful, caused a lot of fights... [Then one of the CAMHS workers] referred us to Te Kūwatawata...

How did your boy react within that [Te Kūwatawata] setting?

He loved it. He doesn't come out of his room. It was hard for us to get him there. There were lots of tears and lots of fighting. In the end I said to him, "We're not going home. We're all going to be here. We're all waiting for you," and he angrily got out of the car and went in and then just kind of fell. He fell into, oh my gosh, "everyone is here, everyone's here for me". [Afterwards] he came out and had tea with us. He doesn't do that. He doesn't come out. So, it was just like a whoa, I cannot believe this is happening.

Did he participate in the actual wānanga?

Yeah, he did. He got to talk about the things that he likes, the things that he doesn't like. He talked about the things that he could change and/or improve, so getting to sleep early which he said, "Stop gaming"; taking his tablets at the right time; sitting outside in the sun even. And they gave him a lot of time. Another good thing was they checked things out with him. They said, "It kind of sounds that you're feeling this way; is that right?" You know, they'd check it out with him and he'd be able to say, "Yes." "No." "Yes." "No." And that was really good.

Not once did they mention anything clinical. So, they kind of explained his depression as that long sadness and then shared a story of our Atua being in a time of that sadness. They spoke about one of Rangi and Papa's children, Uru.... He related to that god really well and they actually said to him, "You know, when that god was in its most heartbroken time it was able to make the best decision. So, even though he was feeling that way he could still make really good decisions." And he kind of picked up and put his shoulders back and looked at us. It was just amazing...

Most of our stories have been about Uru and his strengths. But he doesn't feel alone any more. That's the biggest shift that he's made. And also, the important stuff, like going outside and sitting on the ground, the real holistic things like sitting in the sun and putting his hands on Papatūānuku. So, those have been really huge changes. Before we went to Te Kūwatawata I tried to get him to do that, but I didn't know why I was trying to do that. "Come to the beach." Even I didn't understand why I was trying to make him do that. But now that we have this story to support why, it's just a lot more meaningful.

He just loves it there. They let him be who he is in that space and they don't try and change that...

I think one of the things my son's sickness or illness taught us is how important it is to get the proper first response right at the very get go. And I honestly 100 percent believe this; if Te Kūwatawata had been there three years ago we wouldn't be here where we are with him now. I doubt very much that we would be on this medication. (Whānau, April 2018)

Quantitative results

The primary purpose of the quantitative data was to comment on activity in Te Kūwatawata, changing referral patterns and the issue of access to mental health care across Te Tairāwhiti. It is important to note that the version of the Indici PMS that Pinnacle PHO had hoped would become an across-services patient record was not ready for use at the Te Kūwatawata launch and so the service turned to Exess, which was being used by Te Kupenga Net Trust. For this report we drew data from the Hauora Tairāwhiti Exess IPM system, Pinnacle PHO online data, an audit of Te Kūwatawata whānau notes and a SurveyMonkey© questionnaire.

The data give indications of patterns of referrals to Te Kūwatawata, including referral source and the age and ethnicity of whānau referred. In particular, we examined GP referrals and self-referrals for any obvious trends over time. We also examined wait times before first wānanga to ascertain whether the 'shorter wait times' objective had been met. Direct comparison across the services however, was not possible because of different wait time criteria employed. Within the limitations of the data we also tried to assess any 'change of workload' over the period of study. Other outcomes of interest we were able to source data for were; youth admissions to the psychiatric services, the use of compulsory treatment orders in Te Tairāwhiti, suicides, and whānau involved in appointments.

We also examined Pinnacle PHO data which was obtained from their website, with some clarification from PHO personnel. We attempted to assess how their workload had fared over the time period around Te Kūwatawata. The various services used different measures (eg new referrals vs discrete individuals) and time frames (eg months vs quarters) and were not directly comparable but nevertheless reveal some trends in service utilisation and referral patterns.

When confronted with questions around why a significant proportion of referred whānau had not got a first appointment, a possible gap in Te Kūwatawata service provision, we facilitated a clinical audit of three separate months (February, May and August 2018) of Te Kūwatawata notes. In the Interim Report we also assessed how many wānanga whānau had had, but we have since learned that these numbers did not reflect the total number of wānanga – only those wānanga up to and including the month audited. Those, for instance, who had only one wānanga recorded may well have just begun their package of care and on the basis of this we decided not to use these data here. We were unable to obtain data on the number of wānanga for those who had exited the service.

Unless otherwise stated the time period for data in the following tables and figures is the duration of the Te Kūwatawata pilot, September 2017 to September 2018 (inclusive).

Referrals

Referrals to Te Kūwatawata (TK) were derived from a number of sources. One of the ways in which Te Kūwatawata expanded access was to allow whānau to walk in off the street and register for care. These self-referrals and referrals from GPs comprised the majority of referrals. As shown in Table 1, approximately 30% of all referrals in the 13 month pilot period were self-referrals, and GPs, with a third (34%) of all referrals, were the single biggest referral source.

Table 1: TK referral source and percentage Māori

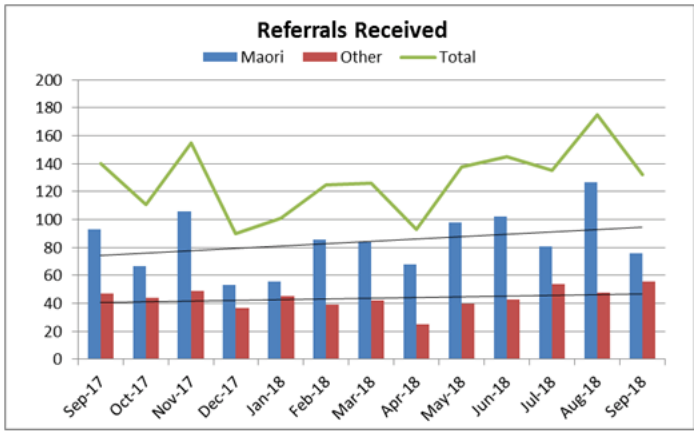
Referral Source	Sep -17	Oct-17	Nov -17	Dec -17	Jan-18	Feb -18	Mar -18	Apr -18	May-18	Jun-18	Jul-18	Aug -18	Sep -18	Total
Self-referral	22 16%	30 27%	39 25%	28 31%	26 26%	22 18%	37 29%	26 28%	51 37%	35 24%	50 37%	53 30%	41 31%	460 28%
General practitioner	26 19%	33 30%	39 25%	29 32%	50 50%	55 44)	52 41%	40 43%	54 39%	46 32%	38 28%	65 37%	41 31%	568 34%
Hospital Services	29 21%	16 14%	14 9%	14 16%	8 8%	15 12%	14 11%	9 10%	9 7%	18 12%	12 9%	15 9%	21 16%	194 12%
Other secondary	24 17%	10 9%	31 20%	3 3%	3 3%	3 2%	3 2%	3 3%	6 4%	1 1%	1 1%	3 2%	4 3%	95 6%
External Providers	21 15%	13 12%	25 16%	13 14%	13 13%	29 23%	15 12%	11 12%	13 9%	32 22%	21 16%	28 16%	18 14%	252 15%
Unknown or Other	18 3%	9 8%	7 5%	3 3%	1 1%	1 1%	5 4%	4 4%	5 4%	13 9%	13 10%	11 6%	7 5%	97 6%
Grand Total	140	111	155	90	101	125	126	93	138	145	135	175	132	1,666
% Maori Referrals	66%	60%	68%	59%	55%	69%	67%	73%	71%	70%	60%	73%	58%	66%

Source Exess IPM system Te Kūwatawata data

Also shown in Table 1 was that, of the 1666 'new referrals' over this 13 month period, two thirds (66%) were Māori.

For further elucidation around ethnicity, Figure 1 plots Te Kūwatawata referrals by ethnicity over the 13 month pilot period. As we know, a significantly larger proportion of referrals were Māori whānau but this figure also shows that there was a greater increase in referrals over time for Māori than for Other (non-Māori).

Figure 1: No. referrals by ethnicity to TK



Source Exess IPM system Te Kūwatawata data

Also examined was the age of those referred, by ethnicity (Table 2). This showed that those 0-17 years old comprised around 31% of all those referred and this proportion did not vary by ethnicity. The few referrals for older people were not unexpected. The Mental Health for Older People (MHSOP) service was not included in the Te Kūwatawata SPoE and GPs referred there directly.

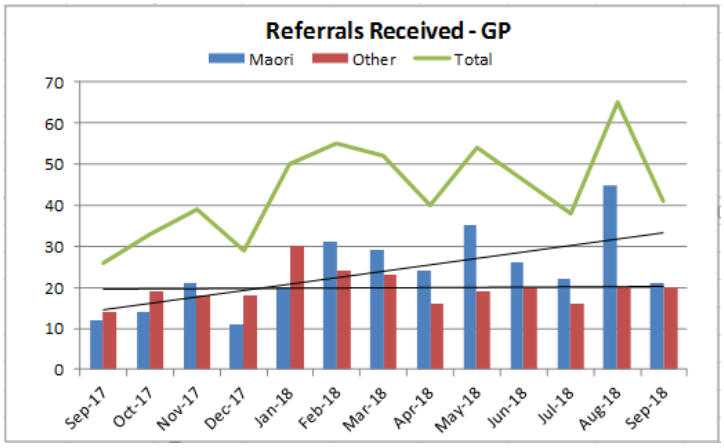
Table 2: No. referrals to TK by ethnicity and age

Māori				Other				Total			
0-17	18-64	65+	**Total**	0-17	18-64	65+	**Total**	0-17	18-64	65+	**Total**
345	735	17	**1097**	165	385	19	**569**	**510**	**112**	**36**	**1666**

Source Exess IPM system Te Kūwatawata data

We also plotted patterns in GP and self-referrals by ethnicity over the course of the pilot. There was a pattern of increasing GP referrals of Māori whānau (Figure 2), while referrals of non-Māori did not increase.

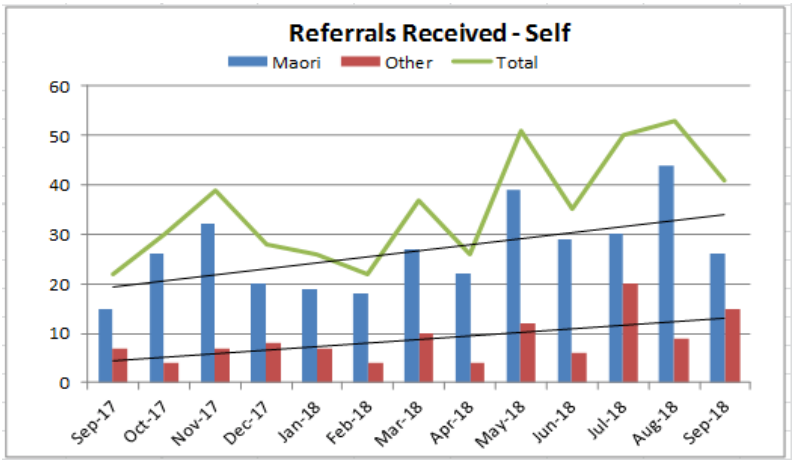
Figure 2: No. GP referrals to TK by ethnicity



Source Exess IPM system Te Kūwatawata data

Numbers of self-referrals, on the other hand, increased at a similar rate for both Māori and Others. Approximately two thirds of all self-referrals were Māori whānau (see Figure 3).

Figure 3: No. self-referrals to TK by ethnicity

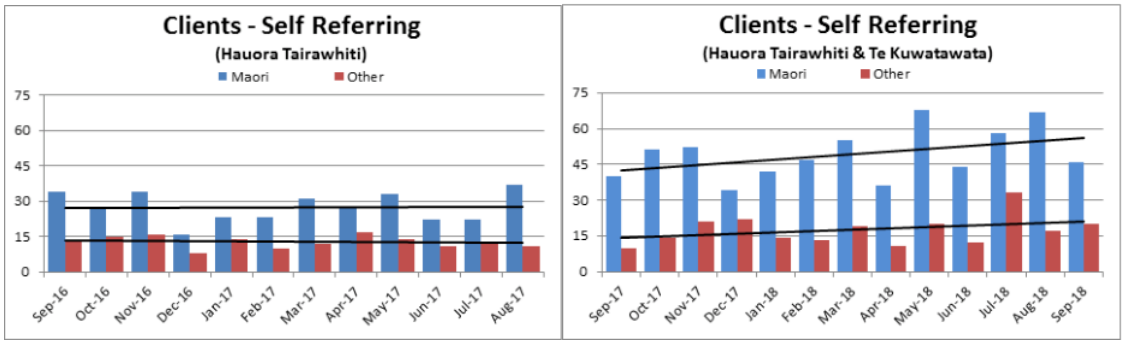


Source Exess IPM system Te Kūwatawata data

Prior to Te Kūwatawata, those who had already been engaged with Hauora Tairāwhiti services were able to self-refer back to that service. With the commencement of the Te Kūwatawata open access

policy, the number of self-referrals to mental health services in Gisborne increased. Figure 4 demonstrates this increased capacity. As expected, the number of Hauora Tairāwhiti self-referrals before the Te Kūwatawata pilot (left) were considerably fewer than those of Hauora Tairāwhiti plus Te Kūwatawata referrals during the pilot (right).

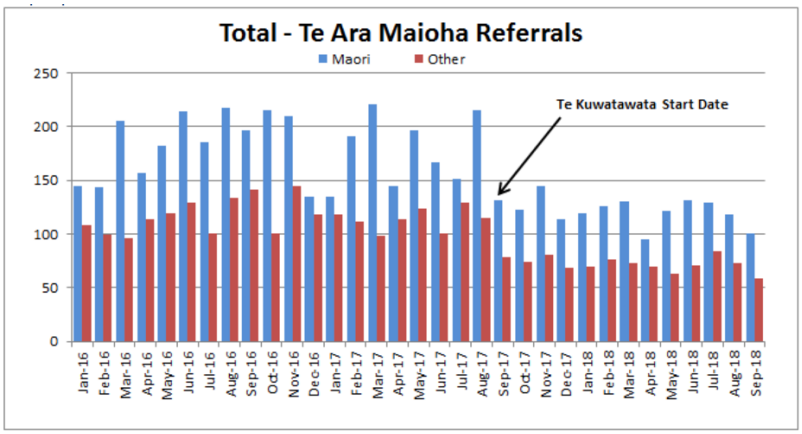
Figure 4: No. self-referrals to TDH MHS before and during TK pilot, by ethnicity



Source Exess IPM system TDH data

Total referrals to secondary services decreased after the commencement of Te Kūwatawata, as one would expect with the beginning of a SPoE (see Figure 5). This decrease occurred for both Māori and Others. Secondary service referrals after the commencement of Te Kūwatawata (September, 2017) were likely to be self-referrals to Addictions and the Older People's service as well as referrals from Te Kūwatawata to the services for which it ran the SPoE.

Figure 5: All referrals to TDH secondary services before and during TK pilot

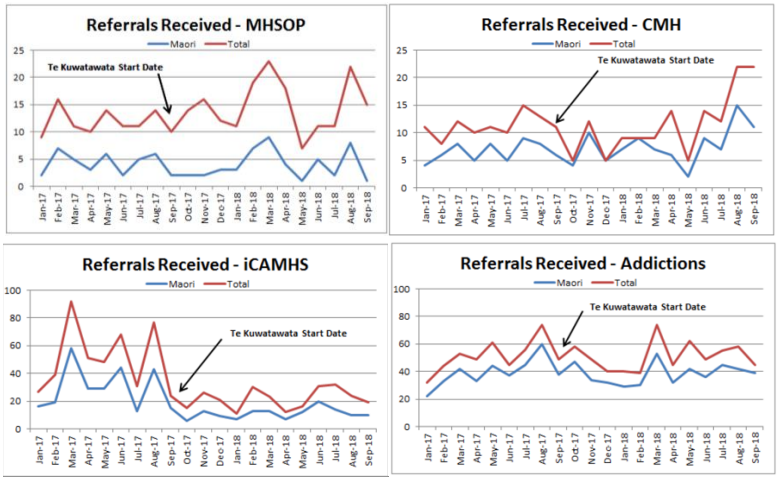


Source Exess IPM system TDH data

Figure 6 breaks down the above total referrals to Hauora Tairāwhiti services into the various service areas. It shows changes in referrals to four Hauora Tairāwhiti mental health secondary services from January 2017 to Sept 2018, eight months prior to and the 13 months of the Te Kūwatawata pilot. Referrals to Mental Health Services for Older People (MHSOP) and Addictions did not need to be transitioned through Te Kūwatawata but could occur directly so there was little change in referrals to these services once Te Kūwatawata commenced. On the other hand, ICAHMS clients needed to first register with Te Kūwatawata and referrals there showed a decrease once Te Kūwatawata commenced, suggesting that many young people were seen within Te Kūwatawata and did not need to be referred on. Referrals to Adult Community Mental Health Services were steady but increased

in August 2018, which matches the marked increase in Te Kūwatawata referrals for the same month, suggesting that many adults that month were referred on to this secondary service.

Figure 6: Changes in TDH's MHSOP, CMH, ICAMHS and Addictions services referrals, before & during TK pilot



Source: Exess IPM system TDH data

Wait times till first wānanga

Te Kūwatawata was committed to seeing whānau as soon as possible after referral and this was reflected in the relatively short wait times. Table 3 shows the number of people who waited for different time periods for their first wānanga during the 13 month pilot. Approximately 20% of whānau were seen on the day of referral and another 10% by the next day. A further quarter were seen within the first week. These wait times remained essentially unchanged over the course of the 13 month pilot.

Table 3: Wait times for 1st appointment in TK

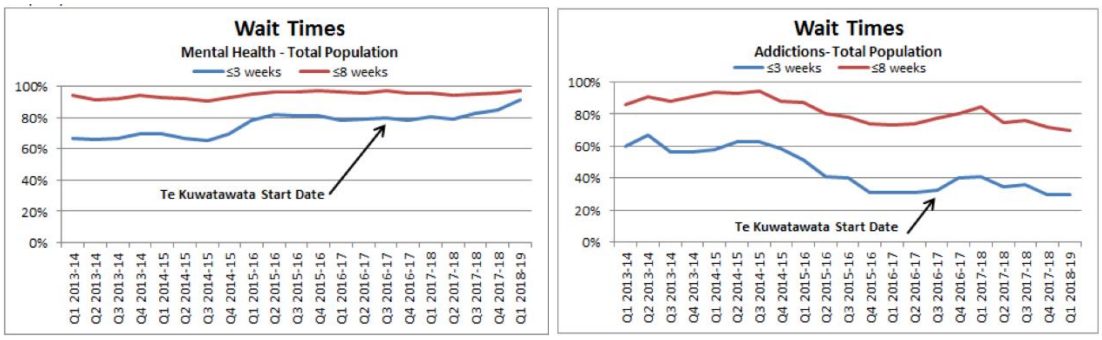
Ref Month	Same day	1 day	2 days	< 1 week	1-3 weeks	3-8 weeks	> 8 weeks	Grand Total
Sep-17	22	14	4	27	16	12	8	103
Oct-17	16	10	2	19	12	12	9	80
Nov-17	41	8	3	23	23	19	5	122
Dec-17	12	6	3	14	11	11	3	60
Jan-18	12	10	6	16	26	10		80
Feb-18	11	8	4	24	37	6	3	93
Mar-18	19	10	5	23	36	3	3	99
Apr-18	7	5	2	19	22	13	3	71
May-18	14	7	5	21	39	15	7	108
Jun-18	30	14	7	35	21	13	1	121
Jul-18	20	11	3	15	28	12	2	91
Aug-18	12	12	4	20	40	24	2	114
Sep-18	16	7	3	17	31	15	1	90
Grand Total	**232 (19%)**	**122 (10%)**	**51 (4%)**	**273 (22%)**	**342 (28%)**	**165 (13%)**	**47 (4%)**	**1232**

Source: Exess IPM system TDH data

Wait times for Hauora Tairāwhiti Community Mental Health and Addiction Services were reported in 'less than 3 weeks' and 'less than 8 weeks' measures. Using these measures, Te Kūwatawata wait times for the year of the pilot were somewhat shorter than Hauora Tairāwhiti, with 83% seen in less than 3 weeks and 96% seen in less than 8 weeks. Figure 7 shows the percentage of those seen by Hauora Tairāwhiti CMHAS within these wait times per quarter from July 2013 to August 2018. Of

interest, was the noticeable improvement in percentages seen within 3 weeks by Adult Mental Health services from the commencement of the Te Kūwatawata pilot in Q2 2017 - comparable with those for TK for the same period. This was probably because Te Kūwatawata provided service to many who otherwise would have attended the Adult Mental Health services. On the other hand, the percentages of those seen within these two time periods by the Addictions service, which were not affected by the advent of Te Kūwatawata, were much lower and declined for the period of the Te Kūwatawata pilot.

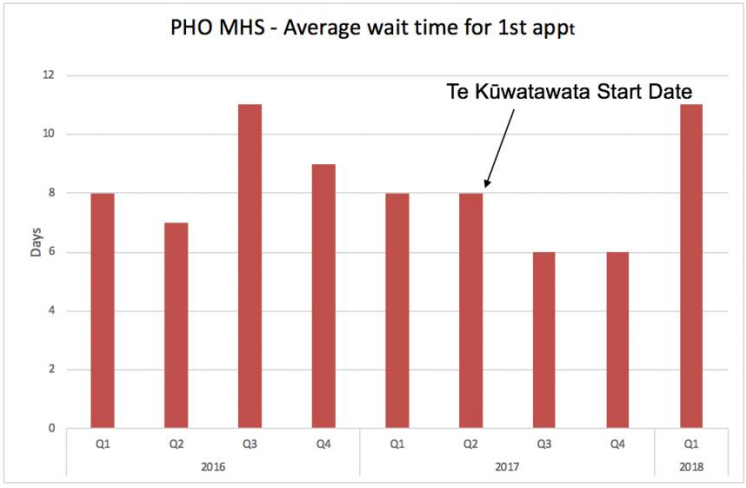
Figure 7: Wait times in DHB Mental Health & Addiction services before & during TK pilot



Source Exess IPM system TDH data

The PHO Primary Mental Health Service wait times were only given as averages each quarter. For the year prior to (before arrow) and the year of the Te Kūwatawata pilot, these averages varied but were between 6-11 days and averaged around 8 days (see Figure 8).

Figure 8: Average wait times (days) for 1st appt, Pinnacle PHO



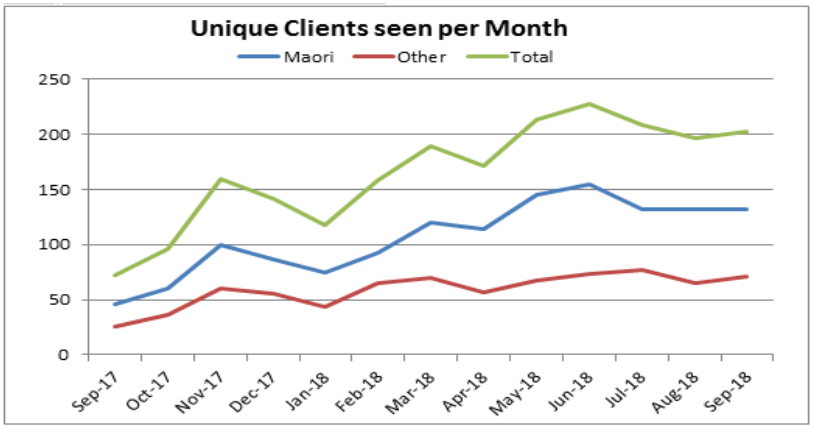
Source: Pinnacle PHO web page

Workload

Although we observed a consistent number of (new) referrals occurring over the Te Kūwatawata pilot period (Table 1), we were interested in 'total workload' and whether this was changing over time. Using available data in the Exess IPM system, we attempted to assess workload for Te Kūwatawata by using the following datasets: '*unique clients*', '*average activity per month/per client*' and a measure called *'face to face contacts.'*

Figure 9 shows the number of *unique clients (whānau) seen per month* during the 13 month pilot. It shows an increase over time for both Māori and Other.

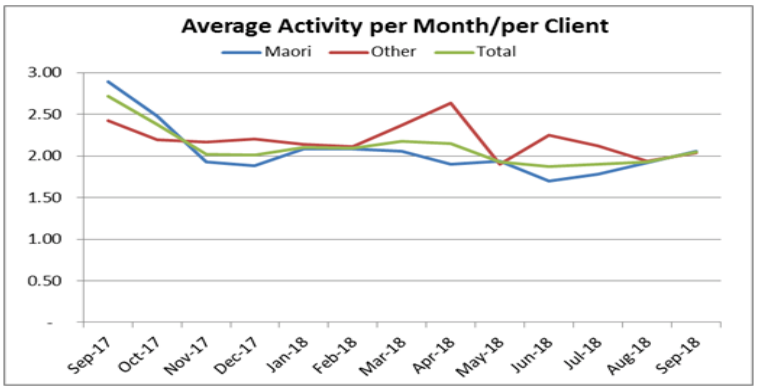
Figure 9: No. unique clients (whānau) seen per month in TK



Source: Exess IPM system Te Kūwatawata data

Figure 10 shows that, within Te Kūwatawata, the *average number of times a client (whānau) was seen* in any month was on average twice. This remained consistent over the last 10 months.

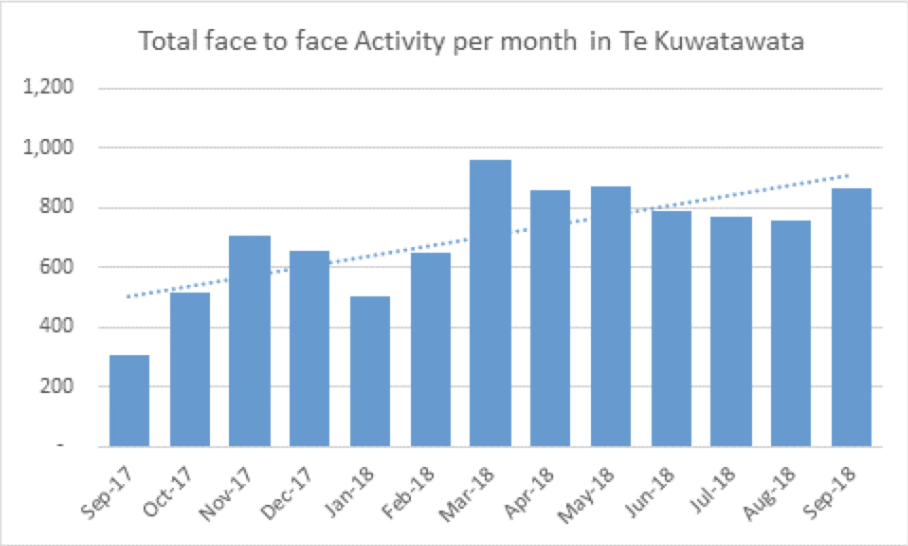
Figure 10: Average activity per month/per client (whānau) in TK



Source: Exess IPM system Te Kūwatawata data

We also obtained data on *face to face contacts* for Te Kūwatawata as a measure of workload. These included sessions that were labelled in the Exess IPM database as 'crisis', 'whānau involved' or 'client only' appointments. They included weekends and after-hours contacts - the crisis team being located in Te Kūwatawata. Figure 11 shows a steady increase in such contacts over the Sept 2017-Sept 2018 pilot period.

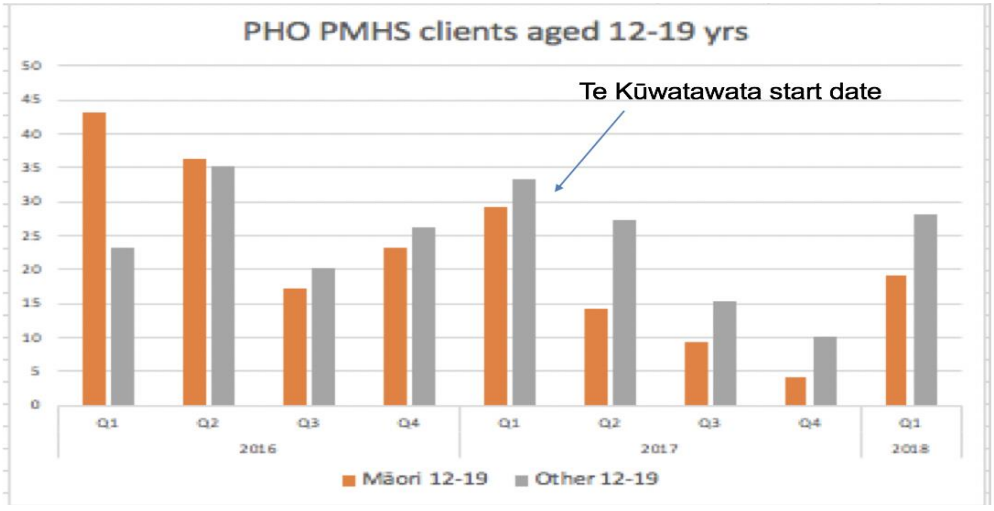
Figure 11: Total 'face to face' activity per month in TK



Source: Exess IPM system Te Kūwatawata data

Activity data for the PHO PMHS were not directly comparable because they are collated in quarters not months. We obtained data on the number of sessions delivered by PMHS per quarter where, as for TK, the same person could be counted in different quarters. The PHO data were divided into youth aged 12-19 years and those 20+ years. Figure 12 shows some seasonal variation in youth referrals with July, August and September (Q1) being peak months but overall reductions in the numbers of those seen after Te Kūwatawata commenced, particularly for Māori youth. The Māori to non-Māori referrals ratios were fairly similar before Te Kūwatawata opened but changed considerably after it opened, with a much bigger decrease in Māori referrals than in non-Māori referrals. It is likely that GPs referred significantly more of their Māori youth clients to Te Kūwatawata.

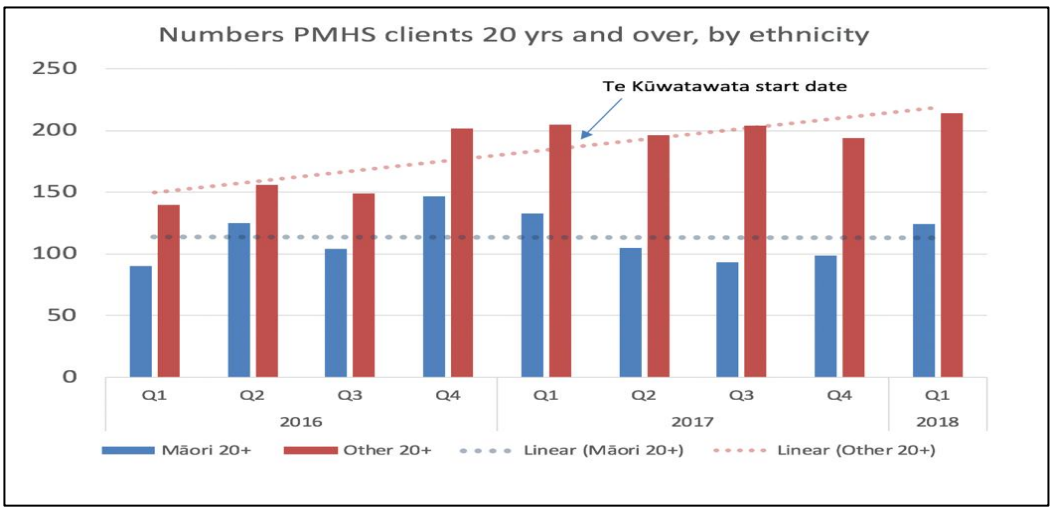
Figure 12: No. youth seen per quarter by PHO PMHS, by ethnicity, before & during TK pilot



Source Pinnacle PHO

Figure 13 shows that the number of adult clients seen by the PHO service increased overall but there was an ethnicity differential. Whilst Māori adult referrals were steady, non-Māori referrals increased significantly. This probably means that GPs referred some Māori but fewer non-Māori with mild to moderate distress to Te Kūwatawata.

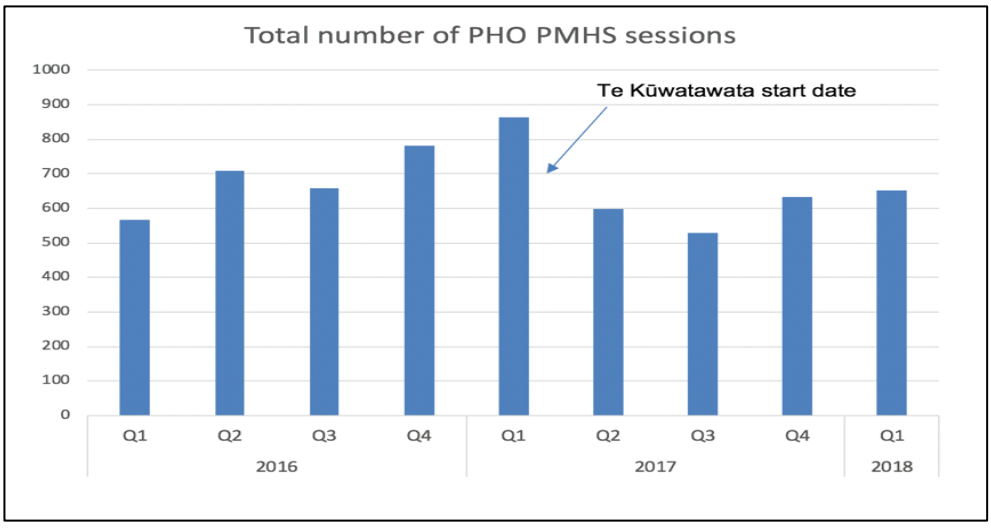
Figure 13: No. 20+ yrs seen per quarter by PHO PMHS, by ethnicity, before & during TK pilot



Source Pinnacle PHO

The PHO PMHS workload patterns before and after Te Kūwatawata commenced differed, with the previously sharp increase flattening considerably. Figure 14 shows the total number of sessions within the PHO service before and after Te Kūwatawata.

Figure 14: Total sessions per quarter by PHO PMHS before & during TK pilot



Source: Pinnacle PHO website

Other outcomes

Youth admissions to psychiatric services

Data on youth mental health admissions to the Hauora Tairāwhiti psychiatric and paediatric wards and referrals out of area to Wellington before and after the commencement of Te Kūwatawata, (Figure 15) show Māori youth were 5-6 times more likely to be admitted to a psychiatric ward before Te Kūwatawata commenced. Over the year of the pilot the Māori youth admission rate halved while the non-Māori rate was essentially steady, reducing the ethnic disparity to Māori being twice as likely to be admitted.

Figure 15: Youth admissions to TDH psychiatric ward 2 yrs before & during TK pilot

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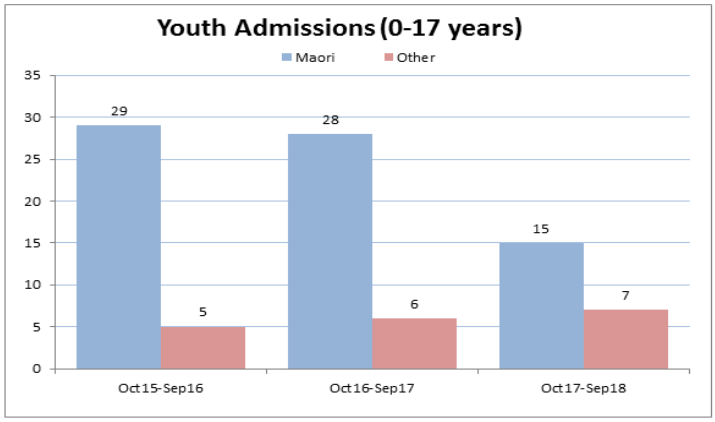


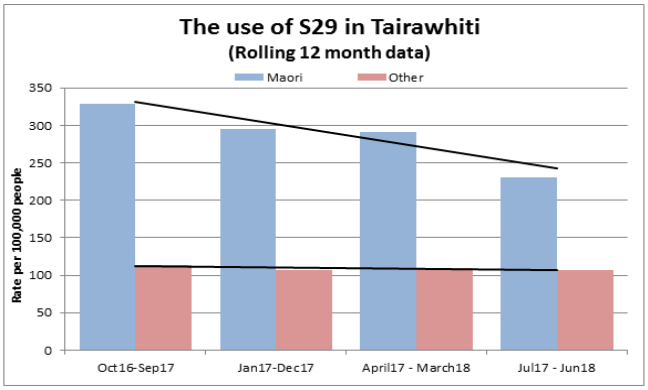
Source: TDH Data

Compulsory Treatment Orders

The number of Māori on compulsory treatment orders (CTO) under Section 28 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 continued its well established trend of decline following the commencement of Te Kūwatawata. Using rolling 12 month data from October 2016 to June 2018, Figure 16 shows CTOs for Māori reduced substantially over that period and are now significantly below the national average 292/100,000.[88] CTOs for non-Māori, did not change and remain lower. We report this here as it was suggested in the Hauora Tairāwhiti Fit for the Future contract that CTOs might decline as an outcome of Te Kūwatawata providing early care (see page 30). But there had been a pre-existing national project to reduce CTOs and, noting that most clients on CTOs are cared for by secondary care, we cannot say how much of this continued decline, if any, was attributable to the Te Kūwatawata service.

[88] Source: PRIMHD, QD extracted 15/01/2018, QA Extracted 04/04/2018, QB Extracted 18/06/2018, QC extracted 21/09/2018.

Figure 16: CTOs in Te Tairāwhiti before & during TK pilot

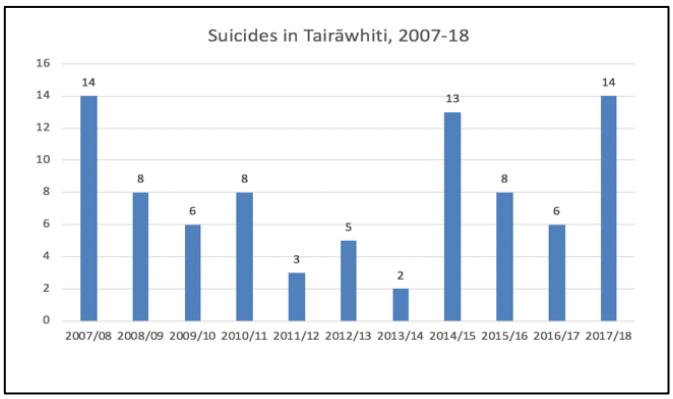


Source: Ministry of Health PRIMHD data

Suicides in Te Tairāwhiti

There was an apparent marked increase in suicides in Te Tairāwhiti during the July 2017 to June 2018 period, 10 months of which Te Kūwatawata was operational (see Figure 17). There were similar large spikes in suicide numbers in the 2014/15 and the 2007/08 years. We have no way of assessing causation or attribution of the 2017/8 spike in numbers. However, as in the 2014/15 year, this spike in suicides requires attention beyond the usual serious incident review to ascertain whether there have been gaps in service provision.

Figure 17: No. suicides in Te Tairāwhiti, 2007-2018



Source: Chief Coroners Report[89] Media release August 24, 2018

Whānau involvement

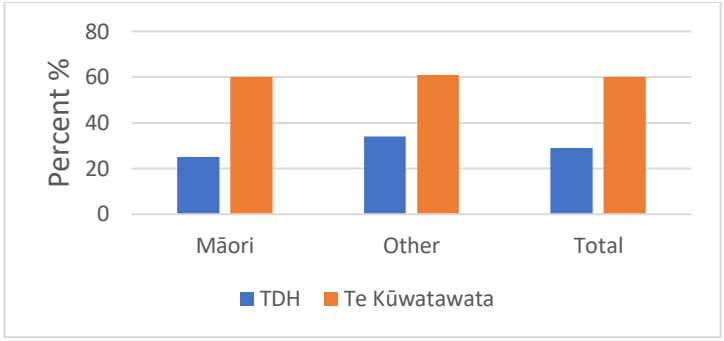
A further finding related to the involvement of other whānau members in the therapeutic sessions. The involvement of family is recommended in psychiatric care assessment and treatment.[90] Figure 18 shows that for the 13 month pilot period, Te Kūwatawata was able to involve both Māori and

[89] Retrieved from: https://coronialservices.justice.govt.nz/suicide/annual-suicide-statistics-since-2011/

[90] Ministry of Health (2000) Involving Families Guidance Notes: Guidance for involving families and whānau of mental health consumers/tangata whaiora in care, assessment and treatment processes. Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists.

non-Māori other whānau much more consistently in wānanga (60% for both) than Hauora Tairāwhiti, who had one third of non-Māori whānau involved and one quarter of Māori.

Figure 18: Percentage other whānau involved in TDH & TK sessions, by ethnicity



Source: Exess TDH & Te Kūwatawata data

Audit of Te Kūwatawata whānau data : February, May and August, 2018.

We decided to embark on an audit of clinical records for the three months February, May and August 2018 when we realised, soon after starting the Evaluation, that a sizeable number of whānau had 'registered' with the service but had 'no first wānanga' (RNFW) appointment. We wanted to know whether this occurred consistently, if these whānau came from a common referral source, what follow-up was undertaken and, most importantly, why they had not received their appointment.

'Registered but No First Wānanga' (RNFW)

Table 4 shows the numbers and proportions of RNFW whānau over the 3 audit months. The proportion remained steady at a quarter, despite the large difference in numbers of referral/tono over these three months. It is worth noting that the apparent increase in total referral numbers in Table 4 is not in fact confirmed by the wider picture shown in Table 1.

Table 4: RNFW/Total referrals (%): Feb, May & Aug 2018

	Feb 2018	May 2018	Aug 2018
RNFW /total referrals (%)	29/119 (24%)	32/131 (24%)	41/170 (24%)

Source: My Outcomes Audit Feb, May & Aug 2018

We examined whether the lack of a first wānanga appointment was related to the source of referral. Table 5 shows that these whānau were referred from a range of sources and while in February and May there was a slightly higher proportion from general practice than for total referrals, this had dropped in August. Self-referral RNFW proportions meanwhile began at a significantly lower proportion than for total referrals but in August were similar to the latter.

Table 5: Origin of referral for RNFW whānau, Feb, May & Aug 2018

Origin of referrals/tono	February Number (%)	May Number (%)	August Number (%)
General Practice	12 (41%)	13 (41%)	10 (24%)
Self-referral	3 (10%)	8 (25%)	13 (32%)
TDH Crisis team	3 (10%)	3 (9%)	2 (5%)
TDH Secondary care	4 (14%)	2 (6%)	7 (17%)
Primary sector	2 (7%)	1 (3%)	1 (2%)
Welfare sector	4 (14%)	3 (9%)	6 (15%)
Schools	1 (7%)	1 (3%)	2 (5%)
Not specified		1 (3%)	
TOTAL	29	32	41

Source: My Outcomes Audit Feb, May & Aug 2018

Our audit then assessed to what extent these whānau were followed up. We found that concerted efforts were made to follow up and these were recorded. Table 6 indicates that one quarter of RNFW whānau over the 3 audited months were contacted after a single call and the majority (70%) after 4 calls. Most of the remainder required 5-9 calls, with 5% requiring 10 or more calls. The number of calls made revealed the persistence of the Te Kūwatawata team to make contact.

Table 6: No. RNFW whānau by no. follow up calls, Feb, May & Aug 2018

No of calls	Feb 2018 Number	May 2018 Number	Aug 2018 Number	Total No. (%)of whānau
1	4	6	15	25 (25%)
2-4	16	11	19	46 (45%)
5-9	7	7	5	19 (19%)
10+	1	2	2	5 (5%)
Unknown	1	6		7 (7%)
Total	29	32	41	102

Source: My Outcomes Audit Feb, May & Aug 2018

Our audit also attempted to determine the reasons for no first wānanga appointment. Table 7 shows that just over a third (36%) of RNFW whānau had been transitioned to another service or transferred to a service they were already engaged with. One third (34%) indicated that they wanted no further contact and we have no indication of why. The majority of the final one third were not contactable or had moved away, and a small group were still being located at the time of the audit. This dispels the apparent impression that one quarter of whānau referred to Te Kūwatawata were 'lost' to follow-up, as many had either been allocated to another service provider or were not contactable. Only one third of them, that is 8% of all those referred, decided not to proceed with their original referral.

Table 7: Reasons for no 1st wānanga appt, Feb, May & Aug 2018

Reasons for RNFW appointment	Feb	May	Aug	Total
Immediate transition/already engaged with secondary care	11	11	17	37 (36%)
Not wanting to engage further	6	11	18	35 (34%)
Moved away	4	-	2	6 (6%)
Uncontactable	5	7	2	14 (14%)
Re-engaged with TK after phone contact	3	-	-	3 (3%)
Still being contacted at time of audit	-	3	1	4 (4%)
Not specified	-	-	1	1 (1%)
Total	**29**	**32**	**41**	102

Source: My Outcomes Audit Feb, May & Aug 2018

We were also interested in those who are traditionally labelled, 'did not arrive' (DNA) or, at Hauora Tairāwhiti 'missed appointments'. However, we found that Te Kūwatawata records were not reliably kept over time and that aggregated missed appointment data in the Exess database at Hauora Tairāwhiti was unreliable.

Feedback-Informed Treatment

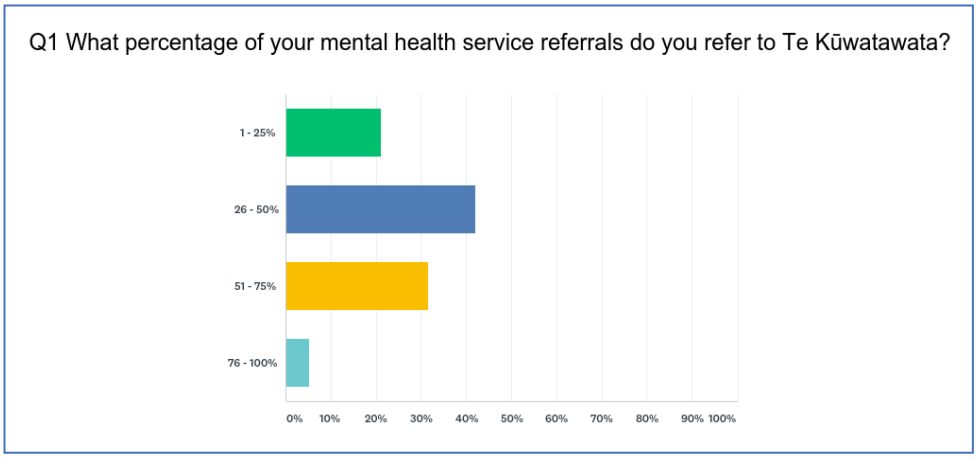
The pre-post 'effect size' for Te Kūwatawata as at 2 September, 2018 was 1.8. This was taken from the accumulated ORS data over the preceding 12 month period and is automatically calculated by the web-based database *My Outcomes*. When compared to the large sample of results contained in *My Outcomes*, an 'effect size' of 1.8 is indicative of a service who provide good outcomes for their clients.

SurveyMonkey© questionnaire with GPs

The SurveyMonkey© Questionnaire was disseminated to 46 GPs and, of these, 19 (41%) responded. This was considered a very good response rate by Hauora Tairāwhiti GP Liaison who typically received responses from about 14 of these GPs when she requested feedback or information from them.

All 19 responded to the first two questions which enquired about referrals to mental health services. Although GP referrals are a significant portion of all referrals to Te Kūwatawata, Figure 19 shows that 63% of those responding to our survey estimated that fewer than half their referrals to mental health services were to Te Kūwatawata, indicating strong continued use of the Pinnacle PHO Primary Mental Health Service.

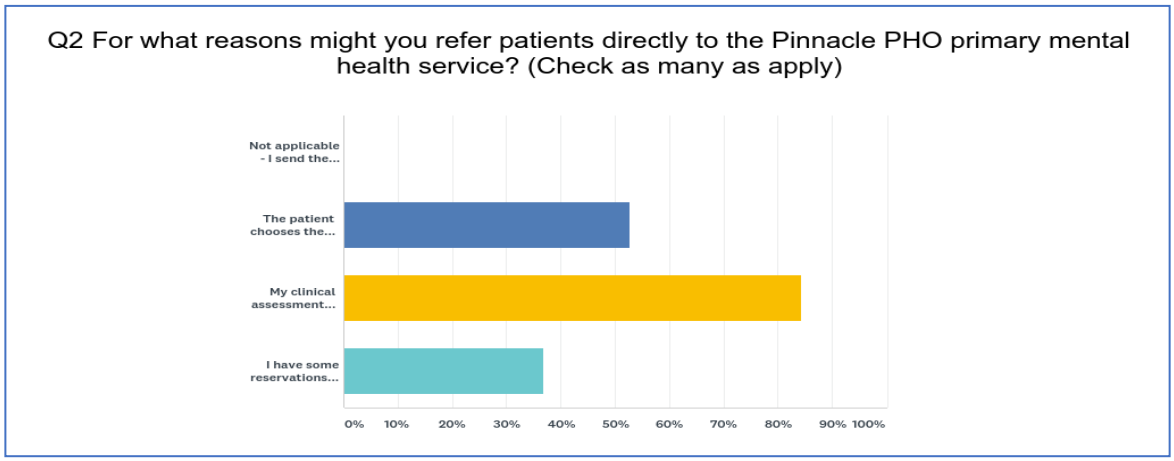
Figure 19: Percentage of GP mental health referrals to TK



Source: SurveyMonkey© Questionnaire

For the large majority of GPs the decision to refer to the PHO service was based on their own clinical judgement, with half reporting that it was (also) their patients' choice. Just over a third indicated that they had reservations about the service (see Figure 20). Clearly GPs' clinical assessment was the primary determinant of where their patients were sent and presumably for many, their reservations about Te Kūwatawata service had a strong influence on their decision. The few comments linked to this question included the reservations mentioned earlier. One indicated that they saw the two services as "*completely separate services for different indications*".

Figure 200: GP reasons for referral to PHO



Source: SurveyMonkey© Questionnaire

For the remainder of the questions 18 GPs responded. In response to the questions asked to gauge whether information about the service was reaching GPs we found that:

- 61% were aware that a quarter of referrals were self-referrals
- 28% were aware that one third of referrals were made by GPs
- 33% were aware of short wait times
- 39% were aware that at all BPACnz referrals were immediately reviewed by the Clinical Team Leader or a psychiatrist.

A further question to ask whether, in finding out this information, they were more comfortable about the possibility of Te Kūwatawata becoming the SPoE for primary and secondary care yielded a mostly negative response, with 67% indicating 'No' and narrative comments reiterating the range of reservations GPs had about the service already mentioned in the Findings section.

Two-thirds (67%) of GPs reported 'Yes' to a question asking if they were aware that Te Kūwatawata had responded to their earlier feedback and introduced an electronic Clinical Care Pathways Form to send them information about their referred patients: 1) after the referral had been received 2) if any change in medication had been made, and 3) on exit from service. However, of the 13 GPs who had referred patients in the previous eight weeks, only five reported that they had received this form, suggesting this process is still being embedded. These five, however, did indicate that they were happy with the form.

Finally, GPs were asked if they found it acceptable, if there was a long wait time for a Hauora Tairāwhiti secondary service appointment, that patients be asked if they would like an earlier Te Kūwatawata appointment. All but one (94%) found this acceptable. When asked again if this made them more comfortable about Te Kūwatawata possibly becoming the SPoE, 56% reported 'No'.

These results suggest that information about positive aspects of the service and about changes made in response to feedback had not filtered through to many GPs. In addition, at least amongst the GPs surveyed here, there was clearly not a strong appetite for a primary and secondary service SPoE.

Te Kūwatawata achievement framework

To gain an overview of the Te Kūwatawata performance in meeting its intended objectives we developed the following framework (Table 8).

Table 8: Te Kūwatawata achievement framework

Main outcomes	
Development of a primary and secondary SPoE	
Equitable outcomes for priority populations	✓
Mitigate social determinants of health	
Te Ao Māori approach	✓
An ability to scale an initiative up	✓
Address institutional racism	
Te Kūwatawata: 'new ways of working	
Deploying multi-disciplinary teams	✓
Cultural competence workforce development	✓
A client-centred outcomes framework	✓
Worker performance feedback system	✓
Shared client record	
To increase whānau involvement	✓
SPoE and 'access' measures	
Increasing access to primary mental health care	✓
Serving those who fall between 1^0 and 2^0	✓
Reducing roadblocks in appointments	✓
Eliminating strict access criteria	✓
Seeing people early in distress	✓
Careful follow-up around appointments	✓
Pastoral care whilst waiting for specialists	✓
Responding in a timely manner	✓
In a place determined as safe / 'closer to home'	✓
Link up with social services	✓
To reduce acute admissions, seclusion and CTOs	✓
Workforce issues	
Practitioners to engage with Māori	✓
Workforce development across disciplines	✓
Improving conditions for overstressed workers	✓
Improving collaboration with primary care GPs	

Great progress with this	✓
Needs some more work	
Difficult to assess	
Didn't happen at all	

He kōrerorero: Discussion

Tāne Mahuta

Te Kūwatawata is the ambitious new mental health care service in Gisborne, that was to span the primary, secondary and NGO sectors. Commencing in September 2017, it was designed to grapple with the problematic issues widely observed in New Zealand and other Western mental health systems. These issues have been well documented[91] and put into planning policy,[92] and they subsequently appeared in Fit for the Future thinking[93] and the 2016/17 ROI/RFP documents of the Ministry. The issues are also well recognized by communities and include: gaps in primary mental care, roadblocks in secondary care systems with multiple entry points, strict criteria for being seen, long wait times, burgeoning community demand in primary care, and overworked stressed workers in both sectors.[94] A simple theoretical outline for change called the *Wellbeing Manifesto – from 'big psychiatry' to 'big community'*[95] recently submitted to the 2018 Government Inquiry into Mental Health and Addiction contains a summary of relevance to these issues. (See Appendix 3)

Sir Edward Taihākurei Durie, in a submission to the Waitangi Tribunal 2575 Kaupapa Māori Health Claim in 2018, stated, "*health policy will work best if it sits within a mana motuhake framework that is community focused, that puts Māori in charge of the programme, and that is negotiated directly with the Crown*".[96] Te Kūwatawata is exactly that. What follows outlines how the service has attempted to reconfigure services to more appropriately address high unmet need amongst distressed whānau in a largely Māori community and begin a process to address institutional racism in the mental health services .

Te Kūwatawata was framed to meet the particular needs of the Gisborne community, where Māori make up half the total population and two thirds of those using mental health services, and promote equitable mental health outcomes for Māori. To do this, Hauora Tairāwhiti and Pinnacle PHO courageously elected to partner in the deployment of a Te Ao Māori methodological approach to

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[91] Mental Health Commission. Blueprint II: Improving mental health and wellbeing for all New Zealanders, How things need to be. Wellington: Mental Health Commission, 2012 https://www.hdc.org.nz/media/1075/blueprint-ii-how-things-need-to-be.pdf

[92] Ministry of Health. 2012. Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017. Wellington: Ministry of Health. www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-developmentplan-2012-2017.

[93] Developing a service model for primary mental health support for moderate need, An evidence review developed by Network 4 in partnership with Platform Trust. Nov, 2016 Retrieved from https://static1.squarespace.com/static/57a93203d482e9bbf1760336/t/59127673d2b857d64b9f9435/1494382207821/Primary+Mental+Health+Evidence+Review+-+Network+4+and+Platform+Trust.pdf

[94] Elliot M. The Peoples Mental Health Report: a crowdfunded and crowd-sourced story-based inquiry into the public mental health system in Aotearoa New Zealand. April, 2017. Retrieved from https://www.peoplesmentalhealthreport.com/

[95] M O'Hagan. 2018. *Wellbeing Manifesto for Aotearoa New Zealand: A submission to the Government Inquiry into Mental Health and Addiction* (prepared for PeerZone and ActionStation). www.wellbeingmanifesto.nz/.

[96] Extract from evidence of Sir Edward Taihākurei Durie to Waitangi Tribunal Hearing for WAI 2575, 2018

care in a mainstream mental health service - something not done in any other service in Aotearoa New Zealand. They developed a vision of a new way of working that did not privilege the primacy of diagnosis, Western therapy, medication or coercion. The vision was based on the deployment of a clinical workforce of culturally competent, multi-disciplinary teams based in the community. In addition, a 'culture of feedback' was to be introduced to the care teams with a therapist performance and whānau outcomes measurement system called Feedback-Informed Treatment (FIT). Finally, although it did not eventuate, there was also to be a clinical record (Indici) that was sourced from primary care – and was shared between the mental health services.

The proposal was to extend the existing secondary mental health services 'Single Point of Entry' (SPoE) to include the primary care services provided by Pinnacle PHO. The Te Kūwatawata partners committed to working closely with general practice, developing collaborative networks across health and social welfare services in an effort to offer better service to more people, earlier in their distress, in a place that the whānau determined as safe. This pursuance of the Ministry's vision of 'Better, Sooner, More Convenient'[97] care was aimed at increasing access to mental health care and thus going at least some way towards mitigating the social determinants of poor health in this community and at reducing acute mental health admissions.

Implementing Te Kūwatawata was never going to be easy. Wrapping the service transformation in a Te Ao Māori methodological approach was ambitious. But Hauora Tairāwhiti, with one of the highest Māori populations in the country, was certainly the right District Health Board to have attempted to do so. The subsequent funding of this by the Ministry of Health was perhaps testament to the value they placed on the opportunity to pilot an innovative 'by Māori for everyone' exploration of a 'wicked' health problem'.[98] Furthermore, the extension of the SPoE and further work-related changes for secondary care workers was never going to be simple occurring, as it did, on the back of a difficult and protracted process two years earlier. As for the primary care sector, although thoroughly supportive of any movement of resource to the primary/community sector, it was always likely to carefully protect its hard-won, existing primary mental health care team and referral pathway. Finally, the introduction of a client voice to the clinical process was also a challenging move. Clients enumerating both their own progress and scoring the clinician's performance were novel in New Zealand mental health services and, at the very least, challenging of established professional practice.

What Te Kūwatawata did well

Increasing access to service

Over the 13-month pilot period evaluated here, we observed increased access to mental health care, documenting significant numbers of referrals being processed by Te Kūwatawata with increasing numbers of clients being seen over time. The walk-in and no barrier for referral facilities certainly appeared to reduce 'un-met mental health need' across the board. We have shown this increasing

[97] Ministry of Health. 2011. Better, Sooner, More Convenient Health Care in the Community. Wellington: Ministry of Health.

[98] Ferlie E, Fitzgerald L, McGirven G, Dopson S, Bennett C. Public policy networks and 'wicked problems': a nascent solution? Public Administration 2011; 89 (2) 307-324 2011 https://doi.org/10.1111/j.1467-9299.2010.01896.x

utilization of services was via self-referrals and referrals from GPs. That the increase in GP referrals to Te Kūwatawata was mostly of Māori whānau, and that there was a similar increase of non-Māori referrals to the PHO, suggest that in many cases the whānau or the GP were choosing pathways based on perceived cultural aspects of the services. It might also suggest that GPs were to some extent 'gatekeeping' the entry of their non-Māori clients to Te Kūwatawata because, when able to self-refer, non-Māori presented themselves to Te Kūwatawata in ever increasing numbers.

With further regard to pathways being increasingly defined by ethnicity, we note that GPs sent progressively fewer youth referrals to PHO PMHS over time and that this was particularly so for Māori youth, who we presume were either referred, or self-referred, to Te Kūwatawata. Interestingly, Mahi a Atua was originally developed as an intervention for youth,[99] and we also note that, perhaps driven somewhat by the Te Kūwatawata Clinical Lead, this team 'kept' many of the one third of their clients who were below 18 years of age within the Te Kūwatawata precinct. This was reflected in lowered transitions to ICAMHS and admissions to the ward.

The increase in overall Māori referrals to mental health care services can be framed as a step toward more equitable outcomes and the mitigation of the effects of the poor social determinants of health in this community. We anticipate that as the Te Kūwatawata service becomes more embedded in the community, external providers like schools and the Police will increase their referrals. Visitors to Te Kūwatawata from outside the region have mentioned that in their own developments they are considering Mataora-like workers with a brief much wider than mental health services.

'Single point of entry' projects aim to reduce fragmentation, increase integration among services and promote the development of a more smooth and continuous transition between services.[100] Te Kūwatawata more or less did this. We saw evidence that some whānau referred for clinical support rather needed social supports, such as housing, and community and family resources were mobilized to help problem solve. Supportive 'therapy' was provided for others whilst waiting for secondary service appointments and this was greatly appreciated by whānau and considered acceptable to referring GPs. Another successful feature relating to access was the relatively short wait times, with one third of whānau being seen within twenty-four hours of referral, and over half within a week. We were not able to obtain wait times for these periods for other services, although we noted increasing percentages of Hauora Tairāwhiti Adult Mental Health service clients were seen within 3 weeks over the course of the Te Kūwatawata pilot.

We also noted in our clinical audit that great effort was made to follow up those who had registered but who appeared to have had no appointment made for their first wānanga RNFW. Persistent follow up by phone calls or house visits revealed that one third had been transitioned to a more appropriate service, one third 'no longer wanted contact' and one third were 'not otherwise

[99] Cherrington, L., & Rangihuna, D. (2000). Māori Mythology in the assessment and treatment of Māori tamariki (children) and rangatahi (youth). Unpublished paper presented at 'Joint RANZCP of Child and Adolescent Psychiatry Conference and Child and Adolescent Mental Health Conference, Auckland, New Zealand. June, 2000

[100] Cumming, J. Integrated care in New Zealand International Journal Integrated CARE 2011;11 E138 Published online 18 November 2011

contactable'. We consider these persistent efforts an exemplar of promoting access – a quality predicated upon the Māori notion of whanaungatanga. In efforts to make contact, the purposeful 'involvement of whānau' made it much more acceptable to so persistently pursue the client via a range of whānau members. In addition, and also 'promoting access', whanaungatanga enabled the service to dispense with the clinical formality of typical Western mental health service provision and offer whānau comfortable and culturally resonant off-site clinical engagements, a reasonable number of which were at the whānau home.

Whānau experience

Amongst the 13 whānau we interviewed we heard many very grateful reports of their experience of the service and the benefit they derived. It was clear that central to these were the relationships developed with the Mataora; the respect they felt from all those involved, including the Uekura on the front desk; the inclusive approach taken; the flexibility around venue and approach; and, for some, the experience of Mahi a Atua. We were not surprised about, and indeed expected, a few whānau reports of negative experiences. There will always be people who are unhappy with a service and there were certainly some hiccups in this service as it has become embedded. We found that the few whānau we interviewed who reported negative experiences also commented on positive aspects and supported what the service was doing. We also heard that where the Mahi a Atua experience was not so appropriate, whānau were grateful for the opportunity to be held and supported in the service until an appointment with secondary services came up. Several whānau gave very glowing accounts of their or their child's experiences and a few reported quite remarkable transformations.

Through interviews and observation in wānanga we also found that this Te Ao Māori service was not inappropriate for non-Māori clients. The wānanga process was imbued with respect, inclusiveness, sacredness, caring and the invitation to provide honest feedback - aspects that are valued by all cultures. This contributes in no small way to the argument held up by some advocates of Te Ao Māori services that 'getting it right for Māori, gets it right for everyone'.

The workforce

Te Kūwatawata created therapy teams confident in their cultural competence with high levels of work satisfaction. They perceived that improvements in their cultural competency brought about by Te Kurahuna training and the subsequent improvement in service for whānau was responsible for much of this satisfaction. We observed Māori workers feeling liberated and non-Māori workers feeling empowered and we attributed this largely to the close relationship between the Te Kurahuna training programme and the Te Kūwatawata workplace. Māori workers welcomed the escape from a strictly Western ideological clinical paradigm and non-Maori workers found an entry point to engage with a Māori ethos and with Māori whānau in the manner promoted by Durie.[101] Mahi a Atua as a therapy broadened the therapeutic scope for some, and created an accessible therapeutic approach for those Mataora untrained in the Western psychological paradigm. It could be said that the

[101] Durie M. Understanding health and illness: research at the interface between science and indigenous knowledge**. International Journal of Epidemiology.** 2004: 33, Issue 5, Pages 1138–1143, https://doi.org/10.1093/ije/dyh250

workforce have had their practice enhanced by the application of Māori thinking to existing knowledge. Importantly, Te Kūwatawata workers had a sense of satisfaction in their daily work despite being very busy and at times very stressed. The training around the ability to 'take negative feedback' appeared to have built resilient workers with ever improving skills and a whanaungatanga-based cultural approach. In addition, the development of multi-disciplinary teams able to provide significant capacity and the provision of Māori resonant therapeutic care flexible enough to cater for all comers, was an evident source of pride for Te Kūwatawata workers. Finally, the relatively flat managerial infrastructure and frequent meetings made the team a 'tight group', supportive of each other and their way of working – bound together, as it were, by whanaungatanga and the common cause.

It cannot be over emphasised that the key to maintaining a high level of integrity and enthusiasm in a high performing workplace is workforce development and clinical supervision. We saw that Te Kurahuna was the source of this for Te Kūwatawata. Important was its independence from the mainstream health institution, the medical tradition and psychiatric orthodoxy. It was a wānanga Māori, where the learning of pūrākau was the prime activity and the sharing of how to therapeutically apply these narratives was the real outcome. Alongside this ran the wānanga Pākehā, where the technical and professional development aspects of case management were crafted. Te Kurahuna was the vessel that contained and determined the Māori elements of the service. It remained at the heart of the service and survived the vagaries of the management change process.

Feedback-Informed Treatment

Another area that showed signs of early success was the implementation of Feedback-Informed Treatment (FIT), which was designed to track whānau functioning and the quality of the therapeutic alliance over the course of engagement. One of a number of feedback systems developed over the last two decades in association with psychological treatments,[102] FIT had become an integral part of the 'culture of feedback' of Te Kūwatawata and the wānanga process. The use of the Session Rating Scale to increase the effectiveness of worker performance is a demonstration of the Te Kūwatawata commitment to continuous quality improvement because such client feedback improves therapist performance,[103] therapeutic alliance,[104] and outcomes for clients.[105] Similarly, the use of a feedback score around whānau progress (the Outcome Rating Scale) defined by the whānau themselves was another marker of a commitment to effective whānau-centred service delivery.[106] Te Kūwatawata recognised that feedback, and the conversation around that feedback, were powerful interventions in themselves.

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[102]Overington, L, & Ionita, G. (2012). Progress monitoring: A brief guide. Canadian Psychology, 53, 82–92.

[103] Oanes, C. J., Anderssen, N., Borg, M., & Karlsson, B. How do therapists respond to client feedback? A critical review of the research literature. Scandinavian Psychologist, 2015 (2), e17. https://doi.org/10.15714/scandpsychol.2.e17

[104] Duncan BL, Miller SD, PhD Sparks JA, Claud DA, Reynolds LR, Brown J, Johnson LD. The Session Rating Scale: Preliminary Psychometric Properties of a "Working" Alliance Measure. Journal of Brief Therapy. 2003 (3)1

[105] Miller SD, Bargmann S. Chow D, Seidel J, Maeschalck C. Chapter 16, Feedback-Informed Treatment (FIT) : Improving the One Person at Outcome of a Time In: Psychotherapy Quality Improvement in Behavioural; Health. 2016 (Eds) O'Donohue W, Maragakis A. Springer

[106] Pinsof WM, Goldsmith JZ, Latta TA. Information technology and feedback research can bridge the scientist practitioner gap: A couple therapy example. Couple and Family Psychology: Research and Practice. 2012; 1(4), 253-273

A common critique of using FIT in the therapeutic encounter, particularly the Session Rating Scale, is that the power imbalance between therapists and clients mitigates against clients being able to easily critique the performance of their therapist. Mataora described the difficulties they observed for whānau when completing an SRS and in the Formative section of this report we described the systematic FIT training that Mataora (and other mental health workers) went through to minimise those difficulties. They were also trained to not see every SRS response as an accurate indicator of the efficacy (or otherwise) of the therapeutic alliance established within that particular wānanga. Likewise, ORS responses were not automatically 'taken as fact' but systematically examined to provide additional clues as to the well-being of the whānau at that time.

Nevertheless, the measurement of a change in wellness via 'effect size' has become increasingly common in psychotherapy settings that collect practice-based evidence utilizing any form of feedback-informed treatment.[107] The pre-post engagement 'effect size' over the 12 month period up to the 2nd September 2018 was 1.8. When compared to a web-based database containing a large sample of results from psychotherapists in a variety of international treatment settings, all of whom administered a web-based version of the ORS to their clients, an aggregated service score of 1.8 is considered a good rating and indicative of an overall group of clients who get considerable benefit from the service.[108]

Outside comment around the Te Kūwatawata use of FIT was at times severely critical. Much of this could well be because of a lack of experience in and understanding around the system. However, by implementing a process to consistently measure outcomes, the service has worked in accordance with a direction specifically encouraged by the Ministry of Health. The ongoing training in My Outcomes, and the user-friendly, web-based tool for administering, scoring, and interpreting the FIT Rating Scales, are likely to embed this practice well over time. The skill, intensity and feedback exchange between the Lead Psychiatrist and Mataora in sessions discussing 'outcome measures' for whānau was instructive for both Mataora and us, as participant observers.

Issues in the implementation of Te Kūwatawata

Differences in philosophical approach

The Te Kūwatawata partners committed to a SPoE that was to "receive all comers, irrespective of the degree of distress". This approach did not therefore differentiate between those with a milder form of 'mental distress' and those with more severe 'mental illness' where an established evidence-based treatment might be pursued. This lack of differentiation formed the basis on ongoing criticism from those who thought that clinical risk was not appropriately acknowledged or dealt with by the SPoE. On the other hand, the 'post-psychiatry' movement, with which Te Kūwatawata is arguably aligned, would claim that we have over-medicalised mental health, that we protect the interests of

[107]. Seidel JA, Miller SD, Chow DL. Effect size calculations for the clinician: Methods and comparability. Psychotherapy Research, 2013 August http://dx.doi.org/10.1080/10503307.2013.840812

[108] Personal communication, Dr Scott D. Miller, 3 October, 2018.

professionals and, as Bastion et al. argue,[109] that evidence based treatment relies on an uncontrolled and expanding industry of randomised trials, systematic reviews and meta-analyses which take place within a context of evolving evidence claims. This difference in philosophical approach is the likely basis of the ongoing, and potentially unsolvable, conflict between Te Kūwatawata proponents and its critics.

Collaboration

One key to the development of Te Kūwatawata was to have been its collaborative approach where all three levels of care in Gisborne (secondary, primary and NGO services) were involved and supportive of the SPoE, the Te Ao Māori framework and Te Kūwatawata as the vehicle for change. It was clear by the time of the Interim Report in June 2018 that this collaboration was not working well. Although firmly committed to change at the outset, at the time of writing (December 2018), Pinnacle PHO had still not signed the Te Kūwatawata Memorandum of Understanding with Hauora Tairāwhiti and Te Kupenga Net Trust. The general practice referral pathway to their Primary Mental Health Service had therefore not closed and the SPoE was functioning only around access to secondary care. It was as if Te Kūwatawata had taken their particular position in a 'kaupapa Māori versus medical model' tussle and the PHO was simply pushing back. We teased out the nature of the critique separating the partners in Te Kūwatawata as follows: (1) the management of change process had alienated many workers in both secondary and primary sectors (2) the perception that the Mahi a Atua approach was dominating the SPoE service to the detriment of clinical input with unsatisfactory client outcomes (3) concerns about policies and processes, including poor paper work, inconvenient changes in procedures and lack of feedback to referrers.

Change management

Change management processes are known to be difficult and management of change processes require significant support. Theories and approaches to change management are contradictory and lack empirical evidence,[110] but the consistent factor is that change threatens job security, personal standing and professional assumptions about 'how things should function. Strong support structures, robust change management strategies with skilled personnel, and a good communication strategy should have been firmly in place for the implementation of Te Kūwatawata. This was particularly necessary with the change coming so quickly after a tumultuous mental health service change in 2015, which included moving child and adolescent mental health into the wider mental health service. Short time-frames around contracts and, in retrospect, inadequate management resourcing seemed to work against good processes. Changing the 'old way of doing things', fell to those managers and clinicians whose primary investment was in the new approach. These were passionate, visionary but busy individuals who did not all possess specialist change management skills and clearly the time and resource needed for effective change management was underestimated.

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[109] Bastian H, Glasziou P, Chalmers I. Seventy-Five Trials and Eleven Systematic Reviews a Day: How Will We Ever Keep Up? PLoS Med 2010 7(9): e1000326. doi:10.1371/journal.pmed.1000326

[110] Brends E, Janssen B, Wouter TH. Effects of change interventions. What kind of evidence do we really have? Journal of Applied Behavioural Science 2013: Jan 28 https://doi.org/10.1177/0021886312473152

The Collective Impact framework,[111] stipulates that five elements are required to deal with our increasingly complex health and social problems. They include: *a common agenda* - where all participants have a common vision and a joint approach to change; *a shared measurement system* – where partners are to hold themselves and each other to account; *mutually reinforcing activities* - where pursuit of such activities is on the basis of an agreed agenda; *open and continuous communication* – where decisions do not favour the priorities of either organization(s); and *a viable 'backbone organization'* – where a jointly controlled organization does the work. Arguably, with Te Kūwatawata there was once a common agenda. PHO workers and managers, like all others we interviewed, said they wanted Te Kūwatawata to work. But as the common vision and joint approach fell away, and with no development of a shared measurement system, there were eventually no mutually reinforcing activities and communication, a vital activity of change management, was poor between the partners. Finally, Te Kūwatawata although nominally a community based NGO project, was funded via Hauora Tairāwhiti , managed by Hauora Tairāwhiti employees and staffed by Hauora Tairāwhiti clinicians. Although supposedly governed by the three partners, there was little chance of the PHO seeing Te Kūwatawata as 'their organization'. The difficulty of this management of change process was under-estimated. It was also under-powered and perhaps under-funded, with human resource issues and communications being primary failures.

One commentator, Todnem, argues for the importance of *change readiness* – a proactive and positive attitude to change with a shared interest and responsibility for the outcome.[112] In retrospect, the resistance of secondary care clinical workers to Te Kūwatawata might simply have been 'change fatigue' and stress. Pinnacle PHO, on the other hand, was a prime mover for primary care involvement in the SPoE and was likely greatly invested at the outset in such a 'shared interest and responsibility for the outcome.' However, for a number of reasons, this did not translate into the intended partnership. The failure of the PHO-Te Kūwatawata relationship requires us to look further than just the vagaries of change management and perhaps to the markedly differing business models of these players. The PHO, which is responsible primarily to its patient-centred, independent business-owning membership, was trying hard to create a smooth referral pathway for its busy GPs. Te Kūwatawata, on the other hand, are population focused, public service employees whose primary aims are pursuit of outcomes for large population groups. These two agendas do not sit easily side by side.

Mahi a Atua

Regarding the use of pūrākau, Mahi a Atua shares the same attributes that are said to be among the handful of curative factors shared by all therapies, chief among them being the extra-therapeutic phenomena (like support), the therapeutic relationship (empathy and warmth), and the engendering of hope and expectancy.[113] Given that there is no good evidence for the differential effectiveness of

[111] Kania J, Kramer M. Collective Impact Standford Socail Innovation Review, 2011 Winter

[112] Todnem, R. Organizational change management: A Critical Review. Journal of Change Management 2005; 5, 4

[113] Asay TP, Lambert MJ. The empirical case for the common factors in therapy: Quantitative findings. In *The Heart & Soul of Change: What Works in Therapy* (Eds). Hubble M,. Duncan BL,. Miller SD, 1999. American Psychological Association

different psychological treatments nor for outcomes improving with therapist experience,[114] the possibility that, for young Māori (and others) a new practice (Mahi a Atua) might actually be an efficacious therapeutic pathway, should not be lightly dismissed. Regarding concerns about clinical safety and reported in our Findings, a number of procedural changes particularly around clinical input, were made to the service in response to negative feedback and to some poor outcomes. We are not of the view at the present time that the service is inherently clinically unsafe, or that Mahi a Atua per se is where the risk lies. We do, however, understand that risk mitigation requires meticulous documentation of procedure in scenarios of change, that perceptions around clinical risk are pivotal, and that these perceptions are relationship dependent.

General practitioners

Although Te Kūwatawata remained committed to making the right connections with general practice, relationships with GPs were mixed. GPs were the biggest single source of referrals to Te Kūwatawata and many were supportive of the service, being particularly pleased that a kaupapa Māori service existed. They also appreciated the walk-in service and the short waiting times. Some GPs had trained as Mataora and found great personal and professional benefit from working in this way. A few referred the majority of their patients with distress there. Some referred freely to Te Kūwatawata unless they thought that the Primary Mental Health Service pathway was more appropriate for particular patients. Others were reluctant to engage because of negative perceptions of the service.

There appeared to be some gaps in basic information about the service. In the early months of Te Kūwatawata, only a few GPs came to the information evenings and we were later informed that GP participation was difficult to procure. This communication difficulty was not unrelated to change management issues and the later appointment of a Hauora Tairāwhiti GP Liaison was intended to improve this. However, communication issues persisted and the inherent disconnect seemed to be between general practitioners - who wanted to take advantage of pathways that would benefit their patients but did not want to give up control of the process, and Te Kūwatawata - who wanted to empower whānau to be able to participate fully in decisions around their health.

The PHO eventually came to a position in a December 2018, Hauora Tairāwhiti facilitated co-design meeting of the SPoE that general practitioners, wishing to exercise their clinical influence, needed their own (alternative) pathway to specialty services as well as continued access to their own primary mental health care services. In other words, they were not supportive of the wider SPoE at all. Our own feedback from GPs confirmed this. Although many GPs were extremely supportive of the Te Kūwatawata service, they wanted to maintain control over their own alternative pathway (PMHS) for their patients. Other SPoE projects have similarly demonstrated this desire for an easier referral processes without any loss of clinical control.[115]

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[114] Goldberg S, Tony Rousmaniere T, Miller SD, Whipple J, Nielson SL, Hoyt WQT Wampold BE. Do Psychotherapists Improve With Time and Experience? A Longitudinal Analysis of Outcomes in a Clinical Setting Journal of Counseling Psychology. 2016, (63) 1, 1–11)

[115] Raine R, Carter S, Senky T, Black N. 'Referral into a Void': Opinions of General Practitioners and Others on Single Point of Access to Mental Health Care. Journal of the Royal Society of Medicine 2005: 98, 4 https://doi.org/10.1177/014107680509800404)

GPs routinely refer freely to other specialty areas without having to dictate treatment pathways and one might ask why this is not the case here. It might be that with primary care having been asked to take on more responsibility for mental health care in recent years, they are now reticent to 'give power back' to the secondary sector. Alternatively, it might fall to the unclear primary/secondary service divide around ultimate responsibility for dealing with people with mental distress. It is also possible however, that this reticence reflects the institutional racism within primary health services, that is, the reluctance to trust a Māori-led initiative. Clearly, more communication and relationship work with full participation by all sides is required if a primary/secondary services SPoE is still envisaged by Hauora Tairāwhiti. In that case one might take heart from an account of the SPoE for children's services in Bristol[116] which found that, with facilitation, support, communication and some patience, the value of the SPoE was increasingly appreciated and the framework spread across services.

Issues of attribution

There are two critical issues that need discussion in order that they are not left unnoticed or inappropriately attributed – the approximately one third decrease in Māori CTOs and the doubling of the number of suicides over the period of Te Kūwatawata development. Since 2013, there has been a nationwide Ministry of Health directive for DHBs to collect data on Māori subject to CTOs and, since 2017, to decrease the number of Māori detained in this fashion. The observed decrease from October 2016 to June 2018 in CTO use in Tairāwhiti was in progress before Te Kūwatawata was established and, given that most of these clients were cared for in secondary service, we are unable to say how much, if any, of the ongoing decline represents a sucessful outcome of the 'early care' provision predicted by the Hauora Tairāwhiti Te Kūwatawata proposal. In a similar fashion, we have no way of assessing the causation or attribution of the spike in suicide numbers. Firstly, the 2017/18 figures are provisional and may yet change and in addition, these are relatively small numbers which have fluctuated over the years with similar spikes in 2007/8 and 2014/15. Neither do we know how many of these deaths had involvement with mental health services and were therefore potentially preventable with better services but the role of a possible gap in service created by the change process or any primary failure in the Te Kūwatawata model needs to be examined as part of the pathway forward. Finally, it should be noted that this increase in Tairāwhiti suicides has occurred alongside a four years long national trend of a increase in suicides of which the 2017/18 year was the highest.[117]

[116] Simpson N, Stallard P. Referral and access to children's health services. Arch Dis Child 2004 January http://dx.doi.org/10.1136/adc.2002.019794

[117] Annual provisional suicide statistics for deaths reported to the Coroner between 1 July 2007 and 30 June 2018. Retrieved from: https://www.mentalhealth.org.nz/assets/Suicide/2017-2018-Annual-Provisional-Suicide-Statistics-Final.pdf

Institutional Racism

Institutional racism, despite its widely debated definition in different settings,[118] is where an institution provides consistently inequitable outcomes for an already disadvantaged community - or more simply - 'inaction in the face of need'. Hauora Tairāwhiti was certainly not inactive. Te Kūwatawata was purposefully developed to promote more equitable outcomes and we have previously referred to this as a courageous undertaking. Has Hauora Tairāwhiti then, as the largest and most influential of the Partners, made a reasonable attempt at addressing the 'institutional racism in the mental health services' that they discussed in their mental health Quality Service Plan[119] and the *Fit for the Future* RFP? Although Hauora Tairāwhiti did not draw away from supporting Te Kūwatawata in the face of considerable local disquiet, founded or unfounded, there were still gaps in its performance. The change management programme was not well executed and, with the Hauora Tairāwhiti history of troublesome change in the mental health services, this should have been better resourced and supported.

And as for the local disquiet, one must ask how much of this was due to the management of change and how much was simply institutional racism. Was the 'resistance to change' a fear of having a Māori focused approach in the lead position, a Māori voice exposing the inequities and an 'unproven' Māori therapeutic modality entering into a fraternity of (sometimes unproven) Western practices. Although the PHO were a publicly funded body committed to supporting its "enrolled population and other eligible persons to stay well",[120] they were in reality a private enterprise with obligations to busy business owners whose interests were not well serviced by the change process. And what about the general practitioners? We found them to be busy, often not well informed and not invested in change. However, although many were not overjoyed with the new system, they participated in the service where they could see benefit for their patients. The third partner – Te Kupenga Net Trust – within which Te Kūwatawata sat, were always in an invidious position. They were the 'governors' who had little or no say over management, they accounted for the money but did not control the budget, they carried considerable risk but got little credit for their actions. They were in many respects the local heroes of the story. Despite their invidious position they stayed true to their organisation's kaupapa, working hard to advocate for consumers and whānau, ensuring their perspectives remained at the forefront throughout, particularly when process and system decisions were being made.

Scalability

Despite the many issues described, we propose that the Te Kūwatawata service is scalable. There is unmet service need for distressed people in all regions and Māori populations are demanding a new approach to distress, dispossession, disenchantment, disenfranchisement and disease. The Crown, represented by the Ministry of Health and the District Health Boards, is obliged by its Treaty partnership to reduce inequitable outcomes for Māori. Indeed, the Confidence and Supply Agreement between the Labour and the Green Party, committed both parties to the honouring of *Te*

[118] Phillips,C. Institutional Racism and Ethnic Inequalities: An Expanded Multilevel Fraomework. Journal of Social Policy, 2011: 40(1), 173-192. doi:10.1017/S0047279410000565

[119] Te Ara Maioha Service Patient safety, Quality and Risk Plan Service & Quality Plan 2016 -2017

[120] PHO Services Agreement. Section A6, PHO Outcomes 1 (a) pg 3

Tiriti o Waitangi [121]and not simply the 'principles' of the Treaty. So a strident demand for the equity provisions of Article 3 makes a radical approach to inequity necessary and Hauora Tairāwhiti has started this process. It will take a considerable period for the effect of Te Ara Ōranga: Report of the Government Inquiry into Mental Health and Addiction[122] and its funding suggestions around Māori health to be felt, but the impetus for change cannot be lost. Te Kūwatawata can comfortably fit into the pathway of 'proportionate universalism' where there is a universal level of service that everyone can count on but "with a scale or intensity that is proportionate to the level of disadvantage"(p9).[123]

Programming of this nature is in demand. Both the move towards 'big community' and the move towards a 'mātauranga Māori' approach are required to transform New Zealand's reactive and transactional system of mental health treatment to a holistic and responsive, relational, person-centred, system of care and support for those in distress. Whether other areas will 'import' Te Kūwatawata as a 'fit for purpose' programme, we do not wish to speculate on. Tribal autonomy is such that mana whenua will lead such processes with their local health authorities and with their own 'mātauranga Māori', so slightly different takes on a new mental health framework will emerge in different areas.

Te Kūwatawata and te Kurahuna had many visitors from other regions interested in this new way of doing mental health care in the community, with a particular interest in developing systems to care for Māori. Two visitors of particular note were from other very high Māori population areas. Both already have similar programmes in development and were committed to them being mainstream initiatives - neither believing that a 'kaupapa Maori only' service was sustainable in the longer term. Both said that 'by Maori for all' is the appropriate strategy for the underprivileged and distressed sector, independent of the ethnicity of that distressed whānau. One had a 'much wider than mental health' approach with Mataora-like workers called *Manawa Ora* working across Oranga Tamariki and Paediatric services. Another was working to transform a very large mainstream community-based mental heath, addiction and social housing enterprise to the needs of the deprived community. Like Hauora Tairāwhiti, they recognized the need for a Te Ao Māori approach and this Report will inform their scoping of the same questions Tairāwhiti asked that led to Te Kūwatawata.

There are salutary lessons to be learned from the Te Kūwatawata experience, particularly around change management and communication. The risk in undertaking mainstream projects using a Te Ao Māori methodology is that the latter gets blamed for problems that are more systemic in nature. For this reason any new significant change process based on Te Kūwatawata would need to ensure the ground work is put in place, perhaps in line with the key fundamentals outlined in the Collective Impact theory, so that sound processes and strong cooperative relationships support the move forward.

[121] Confidence and Supply Agreement between the New Zealand Labour Party and the Green Party of Aotearoa New Zealand. (Aug 2017) Policy 17, pg 5

[122] He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction. Nov, 2018 Retrieved from www.mentalhealth.inquiry.govt.nz/inquiry-report/

[123] Fair Society, Healthy Lives The Marmot Review A strategic review of health inequalities in England post-2010.

The Future

A key issue for the future is whether the original aim of bringing primary care fully into the SpoE is viable. This is a particularly pertinent consideration given new mental health endeavours in primary care elsewhere in Aotearoa New Zealand promoting in-house mental health practitioners[124] and increased extended GP consultation capacity. Should such initiatives be instituted in Gisborne, we would probably see reductions in primary care referrals out of the general practice setting and referrals to Te Kūwatawata would primarily be, as it is now, for secondary services and for those needing a specifically Māori approach.

A possible future option might be continuing with a secondary services SPoE with no criteria for access, the potential for walk-ins and GPs able to refer those requesting Te Kūwatawata. This would acknowledge GPs' demand for other options. It would also give time for the service to continue to consolidate while also working to nurture constructive working relationships with primary care to provide opportunities for them to better understand the service and its Māori methodologies.

An alternatively would be to separate out the SpoE and make Te Kūwatawata a stand alone Te Ao Māori service. This, however, runs the risk of ghettoising the service and losing the important advantages of a 'big community' approach. In addition, it would not encourage mainstream primary and secondary services, which would still see a large proportion of Māori, to critically examine their staff's cultural competency or their institutional racism.

Whatever shape the SPoE finally takes, the burgeoning pressure for psychology and psychiatry to become more community-driven, long advocated by indigenous peoples[125] and by Māori,[126,127] along with the development of indigenous psychologies must become a part of the future. These psychologies, more relational than the individual and deficit-focused Western approaches, have been described as "*sitting at the nexus between scientific foundations of the professions and the spiritual and metaphorical values upheld by Māori society*"[128] and are key in the re-shaping of mainstream mental health services in Aotearoa New Zealand.

Conclusion

There is no doubt that there are gems in the Te Kūwatawata model for those who wish to address burgeoning demand on mental health services, particularly where those demands emanate from the Māori community. Te Kūwatawata fits directly into the mould of the new approach to distress and mental health care labelled, earlier this year, as the "well-being and recovery-oriented system

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[124] Closing the loop: A person-centred approach to primary mental health and addictions. www.closingtheloop.org.nz

[125] Kim U., Yang KS., Hwang KK. (2006) Contributions to Indigenous and Cultural Psychology. In: Kim U., Yang KS., Hwang KK. (eds) Indigenous and Cultural Psychology. International and Cultural Psychology. Springer, Boston, MA.

[126] Durie, M. (2003). Keynote address: Is there a distinctive Māori psychology? In Nikora, L.W., Levy, M., Masters, B., Waitoki, W., Te Awekotuku, N., & Etheredge, R.J.M. (Eds). (2003). The Proceedings of the National Māori Graduates of Psychology Symposium 2002: Making a difference. Retrieved from https://researchcommons.waikato.ac.nz/bitstream/handle/10289/918/?sequence=1

[127] Nikora, LW. (2007). Maori and psychology: Indigenous psychology in New Zealand. In A. Weatherall, M. Wilson, D. Harper & J. McDowall (Eds), Psychology in Aotearoa/ New Zealand (pp. 80-85). Auckland, New Zealand: Pearson Education New Zealand.

[128] Bennet S. Ngā Rākau a te Pākehā: Matiu's story. In Waitoki W, Levy MP (Eds) Te manu kai i te matauranga: indigenous psychology in Aotearoa/New Zealand, New Zealand Psychological Society, 2016 (pg 126)

response" by the Mental Health Commissioner.[129] That there has been resistance to the implementation of this new approach from some quarters is not unexpected and the risk raised previously, that 'the Māori service' gets the blame for the difficult change management issues and is 'closed down', should be now behind us. Te Kūwatawata has laid a pathway to the achievement of many of the outcomes recommended by the *He Ara Oranga: Report of the Government Inquiry into mental health and addiction,* with increased access, short waiting times, greater whānau involvement, increased teamwork, a culturally competent mental health workforce and the routine monitoring of outcomes. In addition, Te Kūwatawata is a current working example of the *He Ara Oranga* directive to eliminate 'discrimination, institutional racism and unconscious bias' in the quest for equitable outcomes[130] for the 'most at risk' (Māori) population – the experience of whom was detailed in the recently leaked *Whakamanawa: Honouring the voices and stories of Māori* document.[131] After observing and interacting with the Te Kūwatawata service for over a year, we are of the opinion that the foundation it has established is the appropriate pathway to meet the needs of a Ministry of Health keen to develop a mental health system for New Zealand that is '*Fit for the Future'.*

[129] Kevin Allan, Mental Health Commissioner. New Zealand mental health and addiction services – The monitoring and advocacy reporrt of the Mental Health Commissioner. The Office of the Health and Disability Commissioner, 2018

[130] He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction. Nov, 2018 Retrieved from www.mentalhealth.inquiry.govt.nz/inquiry-report/ (pg 88)

[131] Russell L, Levy M, Cherrington L. Whakamanawa: Honouring the voices and stories of Māori who submitted to the 2018 Government Inquiry into Mental Health and Addiction in Aotearoa Dec, 2018

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Ngā kōrero tāpiri: Appendices

Appendix 1: INTERIM REPORT (June 2018) Executive Summary

Background

New Zealand's mental health services have been experiencing increasingly severe capacity problems, with stressed mental health workers and a call for wider attention to the cultural and social context of distress. Tairāwhiti has one of the highest levels of mental health distress in the country[132,133] and Māori have persistently had inequitable outcomes, which appear to be at least in part due to a systematic 'cultural competence' gap in services.

Te Kūwatawata is a 'single point of entry' (SPoE) service for all whānau in the Tairāwhiti District Health Board (DHB, Hauora Tairāwhiti) region experiencing mental distress. It involves both primary and secondary mental health services and uses a Te Ao Māori framework. Te Kūwatawata is funded for sixteen months (1 June 2017 – 30 September 2018) via the Ministry of Health's Mental Health and Addictions Project, "Fit for the Future – a Systems Approach". The service is a collaboration of four quite different mental health care providers in Gisborne; Hauora Tairāwhiti DHB's Mental Health and Addiction services; Pinnacle Midlands Health Network Primary Health Organisation (PHO); the community based non Governmental organisation Te Kupenga Net Peer Support and Advocacy Trust; and Te Kurahuna, a Māori whare wānanga whose training of mental health (and other) workers in cultural competency skills produces 'graduates' called Mataora. Te Kūwatawata opened on 1 September 2017.

This interim report documents the first nine months of service implementation, September 2017 to May 2018 (inclusive). A final evaluation report, due 31st January 2019, will cover the entire funded period up to 30 September 2018.

Methods

Our evaluation approach is based on Kaupapa Māori principles and comprises formative, process and outcome components. Our aims were: to work alongside Te Kūwatawata Steering Group as a 'critical friend' during service implementation (formative evaluation); to describe the service and assess successes and challenges of the implementation process (process evaluation); and to assess the impact of the intervention on service efficiency and responsiveness, service and mental health worker cohesion and collaboration, service and mental health worker cultural competency, and

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[132] Williment R, Codyre D, Katene K. Report and recommendations for Tairawhiti adult mental health and addiction services: A pathway to better mental health. 2008

[133] Ministry of Health. PP6 Report: Improving the health status of people with severe mental health illness through improved access. Oct 2016-Sept 2017. Retrieved from https://nsfl.health.govt.nz/accountability/performance-and-monitoring/baseline-data-quarterly-reports-and-reporting/mental

mental health outcomes for whānau (process and summative evaluations). The primary evaluation question was:

> *Will the building of a primary mental health care service around a framework based on Māori cultural values and knowledge successfully serve the Tairāwhiti community, both Māori and non- Māori, who are experiencing mental distress?*

Data collection included document review, participant observation and informal interviews, interviews/focus groups with 85 purposefully selected key persons/stakeholders, interviews with four whānau who had accessed the service for themselves or with a family member, service monitoring data, and audited whānau data collected during the month of February. Stakeholder participants were: staff and managers from Te Kūwatawata, primary mental health care, secondary mental health care, general practice and external social services and other agencies.

Findings

Formative evaluation processes enabled us to provide an informed 'listening ear' role to the Steering Group and to give useful feedback pointing out clearly the issues we identified and improvements that could be made. In particular, this centred around the partner relationship with Pinnacle PHO, which had not yet signed a Memorandum of Understanding (MOU). Our 'critical friend' feedback stressed the need to progress this relationship and the importance of engaging more fully with the general practice sector, the main referrer to the service. We observed some constructive change occurring in response to our own and external critical feedback towards the end of the period covered in this report.

As part of the process evaluation, Te Kūwatawata's philosophy, components and wānanga pathway were described as these will be useful for any up-scaling of the intervention to other regions. Also described are the Te Kūwatawata staff impressions of the changes in their professional roles.

Most stakeholder participants expressed that they wanted a Kaupapa Māori mental health service to succeed but there was also strong criticism of the service. These were centred around: a) the change management process as the DHB worked to develop the SPoE which included some restructuring of its secondary services and developing a partner relationship with primary care; b) policies and processes inside Te Kūwatawata (including referrals, notes, communication to referrers about whānau outcomes or changes in prescriptions); and c) and the perception of that Mahi a Atua was the only therapeutic process utilised by Te Kūwatawata.

The change management process was difficult for many participants. Many primary and secondary service staff found it unsettling, feeling they had had no input into the restructuring and that their services were being eroded. The Public Service Association union became involved, as it had with a previous restructuring of secondary mental health services in 2015. Issues to do with policies and processes were largely teething problems as the service became embedded and most of these are being addressed. Regarding the perception that the Mahi a Atua narrative approach was the only or primary approach, a common catch phrase was that "one size doesn't fit all". The PHO took issue with a range of factors, the most significant of which was the lack of clinical input into the first appointment and assessment with the client. They eventually complained to the Director of Area

Mental Health Services. GPs continued to refer directly to Pinnacle's Primary Mental Health Service when they felt the Mahi a Atua approach might not be suitable for their patient. While we saw clinical options being available within Te Kūwatawata, these were not as available as some outside the service expected. Some progress was being made in addressing this issue at the time of writing.

Regarding worker cohesion and collaboration, there was strong team cohesion amongst the multidisciplinary teams within Te Kūwatawata and good collaboration with external agencies whose staff attended Te Kurahuna and Te Kūwatawata wānanga with their clients. Collaboration with secondary services did occur, despite the dissension mentioned above, and secondary services workers regularly attended Te Kurahuna and some had become Mataora. With primary care providers this is a work in progress. Regarding the perceived impact on the cultural competency of the workforce, we found that workers who engaged with Te Kurahuna and Te Kūwatawata wānanga, whether they came from inside or outside the Te Kūwatawata service, experienced a considerable boost in confidence in their ability to work with Māori. For workers outside of Te Kūwatawata and Te Kurahuna, we did not see much impact, nor did we expect to.

Whānau experience of the Te Kūwatawata service was derived from interviews with workers who engaged with whānau and from the four whānau interviewed. Many stakeholders felt the service reached and responded very well to a range of people, particularly those who previously had either not engaged with mental health services or had not been well served by them. There were also reports that some whānau had found that the Mahi a Atua wānanga approach was not suited to their needs. This was despite the fact that Ue did not stick rigidly to the mahi a Atua approach, although the principles of whakawhanaungatanga, transparency and engaging feedback were always maintained. The whānau interviewed were largely very positive about their journey through the service. Although one felt the process did not go 'deep enough', the rest described transformative experiences and expressed great gratitude. For the final report we intend to interverview more whānau to provide a fuller picture of the whānau journey and experience.

Other key strengths identified by stakeholders in the process evaluation included: the responsiveness of the service to whānau (no entry criteria, the ability to walk-in off the street and the fast response time); being able to work with the broader whānau; the friendly, culturally resonant and non-clinical environment; the benefits of the multidisciplinary team; and the transparency of the Hinekauorohia process (reflections of and open discussion of the case in front of the whānau). Details about service responsiveness are outlined below in quantitative terms.

The quantitative data, provisional at this point, comprised the DHB's monitoring datasets over the eight month period from September 2017 to April 2018 and a Te Kūwatawata audit of whānau notes for the month of February 2018. We intend to include similar audits for the months of May and September 2018 in the Final Report. We were not able to obtain Pinnacle PHO's primary mental health data but will do so for the Final Report.

DHB data showed that on average 114 referrals were made to Te Kūwatawata each month. Māori comprised 66% of these. One-third of referrals came from GPs, the biggest referral source, and a quarter were self-referring 'walk-ins'. Another fifth came from other HBDHB services. As an

indication of increased access, there were two-thirds more Māori, and a quarter more non-Māori self-referrals to Te Kūwatawata over the first eight months than to Hauora Tairāwhiti mental health services in the eight months previous.

Regarding wait times to be seen after referral to Te Kūwatawata, on average 20% were seen the same day, 30% within 24 hrs and 60% were seen within a week. Data for Ministry of Health reporting timeframes of three and eight weeks were 85% and 96% respectively and these compared favourably with national (amalgamated) DHB mental health and addiction services, 2013/14 to 2017/18. Almost two-thirds of those seen at Te Kūwatawata had other whānau members involved. This compared with approximately 40% for those in HBDHB secondary services. There was a steady decline in the number of people with Compulsory Treatment Orders across Te Tairāwhiti between January 2017 and April 2018.

Te Kūwatawata February 2018 audit data of whānau records was generally consistent with the DHB data above. There were 119 whānau referred that month; 44% by GPs and 19% by self-referring 'walk-ins'. Of the 119 whānau who were Registered, 29% (n=34) had No First Wānanga (RNFW) appointment arranged and we looked at the way in which they were followed up as a 'quality issue'. Concerted efforts were made to follow up those 34 RNFW; most (65%) required between 2 - 5 phone calls. Thirty percent of the RNFW group were seen by another service - either they had been transitioned to another service on referral or had found another service themselves. Forty-one percent had moved away or were not contactable. Seven whānau, that is six percent of total referrals for the month, did not want to engage at all.

With regard the group usually labelled DNA (did not attend), only four of the eighty-five registered whānau who received a first wānanga appointment did not attend it. All these were contacted – one was transitioned immediately and three re-engaged in wānanga.

Of those who engaged in wānanga, 33% had one wānanga, and half had between two to four. The maximum number of wānanga was 10, with only one whānau needing that many. In total 11% (n=13) people were transferred to other services; five immediately and the rest after between 1-3 wānanga.

Discussion and conclusion

Te Kūwatawata's use of wānanga and the Mahi a Atua approach to engagement and retention of whānau in the therapeutic process appears to be effective for many, as evidenced by stakeholder feedback about whānau experience and our few richly described whānau stories.

There was clear evidence that Te Kūwatawata had been able to improve service response to distressed whānau through ease of access, quick reponse time, and persistent follow up of those registered without a first wānanga appointment and those not attending appointment. The number of wānanga required was not high and this may suggest that this fast service response mitigates exacerbation of the distress.

There was, however, considerable criticism of the service and a central role of the evaluation was to tease out the nature of this criticism into the three groups mentioned: the change management process, issues to do with protocols and processes and the use of Mahi a Atua as the primary therapettic approach. We found some of the strong negative responses to the manner of change were valid, and consistent with what is recognised as common in such change processes. Most of this required addressing and we believe that to be underway at the time of writing. We also found that some of the external critique arose because of misunderstanding or lack of information about the service, or an outdated understanding because the service was changing rapidly. For example, we observed a series of improvements in operational procedures and processes in response to both internal and external critique. This suggests there is further and ongoing work to do to inform stakeholders of the ways the service works and the changes that are made along the way in response to critique. Most of the resistance to Mahi a Atua was found to be based on the perception that clinical issues were not appropriately valued. We found this to be not entirely true, but there is work to do in systematically ensuring appropriate clinical input – alongside valuing Mahi a Atua as a genuinely valuable approach in its own right.

Improving collaboration with primary care, including the PHO Mental Health Services team and general practice, remains an extremely important area. General practice generated between one third and half of all referrals each month to Te Kūwatawata, however, they provided variable feedback about the service and continued to refer their patients directly to the Pinnacle Primary Mental Health Team effectively bypassing what is supposed to be a SPoE to mental health services.

We found for the most part, a very strong sense of whanaungatanga amongst Te Kūwatawata kaimahi and within their own Ue teams. Whanaungatanga with other mental health workers within secondary and primary services was more equivocal with both those who were excited to collaborate with the new sercvice and those disgruntled by it. A primary ingedient in improving whanaungatanga within and between services was participation in Te Kurahuna, which brought workers from across services, cultural experiences and ethnic groups together in a team approach to the pursuit of good outcomes for whānau. Te Kurahuna, and the opportunities offered by Te Kūwatawata, have been responsible for perceived improvements in cultural competency by individual mental health workers and by some in other services.

The impact and outcome for whānau are indicative only this stage of our evaluation but feedback from those interviewed was largely very positive and they compared the service favourably with other services. There were mixed reports from stakeholders about whānau experiences of the service and how well it catered for non-Maori, although there is no systematic evidence that Te Kūwatawata is only appropriate for Māori whānau.

A few issues have not been covered at this stage in the evaluation process. Firstly, there is more to be said about the potential to scale up this service. Te Kurahuna is probably the most difficult part of the Te Kūwatawata story to scale up in other regions and this deserves further attention. We have not yet documented a part of the wānanga process called the ‘discharge conversation’. As mentioned, we intend to examine outcomes for whānau more closely by adding further whānau interviews. We have noted the need for a better data collection system for Te Kūwatawata and the

development of secure electronic notes system that keeps general practice well informed about the progress of the whānau that they refer. We will follow this up. Finally, we have mentioned that Te Kūwatawata is actively working with the makers of the Feedback-Informed Treatment tool on both training for individuals and aggregation of service data to look at population outcomes. We will also be following this up.

In conclusion, perhaps not unexpectedly, there has been resistance from some quarters and teething problems putting new Te Kūwatawata structures in place. On the other hand, there has been near universal support for the development of a Te Ao mental health framework and service. The risk at this point is that 'the Māori service' gets the blame for the significant change management issues involved in implementing this rather complicated single point of entry service and that this might be used as an excuse to close down an innovative Māori service.

Despite its present partnership problems with the PHO, the performance story of this new service is one of decreased waiting times, low first wānanga DNA rates, excellent telephone follow-up of hard to find registered clients, shortened packages of care, greater whānau involvement, increased teamwork, a more culturally competent mental health workforce and the beginning of a growing collaboration with other social agencies. At this point in time we suggest that with attention paid to the issues that we and others have identified and with more time for embedding, Te Kūwatawata has a high chance of meeting the needs of a Ministry of Health keen to explore a mental health system '*Fit for the Future'*.

Appendix 2: Interview Schedules

Interview Schedule 1

Ngā Pātai: Project Leaders

Thank you for agreeing to be interviewed for this evaluation. Below are some general questions as a guide to what we will talk about in the interview.

1. Can you tell us about your vision for Te Kūwatawata and your role in the project?

2. In what ways has its implementation changed the Te Tairāwhiti mental health service?

3. What are the key components of Mahi a Atua that enable kaimahi to work with distressed whānau? In your experience, how are whānau responding to this?

4. In your view how usefulness has the FIT monitoring been in the clinical encounter?

5. At this point in the project, can you share your thoughts on the following questions:
    a. What do we know?
    b. What have we learnt so far?
    c. What's working well?
    d. What's not working so well?
    e. What can you identify as emerging issues?

6. How is the Te Kūwatawata partnership arrangement progressing?

7. The service also aims to improve inter-sectoral collaboration between primary and secondary mental health services. What are your thoughts on this?
    a. What helps and what hinders collaboration?
    b. Have the changes to primary mental health care had an impact on secondary services?

8. Can we talk now about the enablers of and barriers to change within the mental health service:
    a. What has made making change easier? How can we strengthen these?
    b. What has made making changes difficult? How might we address these barriers?

9. Anything else?

Interview Schedule 2

Ngā Pātai: Managers & Governance

Thank you very much for agreeing to be interviewed for this evaluation. Below are some general questions as a guide to what we will talk about in the interview.

1. What is your current role within Te Kūwatawata? How has that role changed from prior to the intervention?

2. What is your general impression of Te Kūwatawata's new way of working with distressed whānau?
   a. What's working well? What's not working so well?
   b. What could be done differently?

3. What is your understanding of the impact of the new service on the experiences and outcomes for whānau? What about non-Māori whānau?

4. What are your thoughts about the usefulness of FIT monitoring in the clinical encounter?

5. The service aims to improve cultural competence amongst the mental health workforce. What thoughts do you have about this? What helps and hinders change in this area?

6. How is the Te Kūwatawata partnership arrangement progressing?

7. The service also aims to improve inter-sectoral collaboration between primary and secondary mental health services. What are your thoughts on this?
   a. What helps and what hinders collaboration?
   b. Have the changes to primary mental health care had an impact on secondary services?

8. Can we talk now about the enablers of and barriers to change within your organisation:
   a. What made making change easier? How can we strengthen these?
   b. What made making changes difficult? How might we address these barriers?

9. Anything else?

Interview Schedule 3

Ngā Pātai: Inside Te Kūwatawata

Thank you very much for agreeing to be interviewed for this evaluation our study. Below are some general questions as a guide to what we will talk about in the interview.

Own practice:

1. What is your current role within Te Kūwatawata? How has that role changed from prior to the commencement of the new service? (If relevant)

2. How has Te Kura Huna training and the Te Kūwatawata service influenced or impacted on your personal practice with whānau? Can you give an example?

3. .How has Te Kūwatawata helped improve your whanaungatanga with whānau? How has it helped improve your whanaungatanga with other workers?

4. What are your thoughts about the usefulness of the FIT assessment tool to enhance your practice and your relationships with whānau?

Perceptions of whānau experience:

5. What is your impression of how whānau are experiencing the service? Can you give an example? How have non-Māori whānau reponded?

6. Thinking about whānau who have engaged with the mental health system both before Te Kūwatawata and since, what differences have you observed in their experiences and responses?

7. Do you have any comments around how whānau safety is maintained?

Perceptions of system changes/impacts

8. As a person working in Te Kūwatawata, what are your general observations of this new model of working with whānau?
    a. What's working well? What's not working so well?
    b. What could be done differently?

9. Can we talk now about the enablers of and barriers to change within your organisation**:**
    a. What made making change easier? How can we strengthen these?
    b. What made making change difficult? How might we address these barriers?

10. Te Kūwatawata aims to improve the cultural competence of its workers. What are your thoughts on this? What helps and what hinders this change?

11. The service also aims to improve inter-sectoral collaboration. What are your thoughts on this? What helps and what hinders this change?

12. Anything else?

Interview Schedule 4

Ngā Pātai: Participants outside Te Kūwatawata

Thank you very much for agreeing to be interviewed for this evaluation. Below are some general questions as a guide to what we will talk about in the interview.

1. What is your current role? How does your role engage with Te Kūwatawata? How has it changed since the commencement of the service?

2. What are your general observations of this new model of working with distressed whānau?
    c. What's working well and why? What's not working so well and why?
    d. What could be done differently?

3. What is your impression of the impact of the service on the experiences of whānau? Can you give an example? How have non-Māori whānau reponded?

4. Can we talk now about the enablers of and barriers to change within your organisation**:**
    8. What made making change easier? How can we strengthen these?
    9. What made making change difficult? How might we address these barriers?

5. Te Kūwatawata aims to improve the cultural competence of mental health service workers. What are your thoughts on this? What helps and what hinders this change?

6. The service also aims to improve inter-sectoral collaboration. What are your thoughts on this? What helps and what hinders this change?

7. Anything else?

Interview Schedule 5

Ngā Pātai: Whānau

Thank you very much for agreeing to be interviewed for this evaluation our study. Below are some general questions as a guide to what we will talk about in the interview.

1. Can you please tell me about what brought you to the Te Kūwatawata service?

2. Can you tell me about your experience of the service?

   What worked well?
   What didn't work so well?
   How could things have been done differently?

3. What are your thoughts on the cultural competency of the service?

   What worked well?
   What didn't work so well?
   How could things have been done differently?

4. (If they have accessed a mental health service prior to TK) How does your experience with Te Kūwatawata compare with your experience of other services you have accessed?

5. Do you have anything else you want to say about the service?

Appendix 3: The Wellbeing Manifesto – From big psychiatry to big community

The *Wellbeing Manifesto* [134]

Big psychiatry	Big community
Mental disorder is viewed primarily as a health deficit.	Mental distress is viewed as a recoverable social, psychological, spiritual or health disruption.
A mental health system with a health entry point led by medicine.	A wellbeing system with multiple entry points led by multiple sectors and communities.
Most resources are used for psychiatric treatments, clinics and hospitals.	Resources are used for a broad menu of comprehensive community-based responses.
Employs predominantly medical and allied professionals.	Employs a mix of peer, cultural and traditional professional workforces.
Has a legacy of paternalism and human rights breaches.	Has a commitment to partnerships at all levels and to human rights.
Focused on compliance, symptom reduction and short-term risk management.	Focused on equity of access, building strengths and improving long term life and health outcomes.
Responds to people at risk with coercion and locked environments.	Responds to people at risk with compassion and intensive support.
A colonizing medical system that excludes other world views.	A bicultural system that embraces many world views.

[134] M O'Hagan. 2018. *Wellbeing Manifesto for Aotearoa New Zealand: A submission to the Government Inquiry into Mental Health and Addiction* (prepared for PeerZone and ActionStation). www.wellbeingmanifesto.nz/.