'Three Key Elements’ Mental Health Delivery Toward Maori

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‘Three Key Elements’

Mental Health Delivery Toward Maori

By

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Ngapuhi Ngati Porou

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Abstract

This project titled ‘Three Key Elements’ Mental Health Delivery Toward Maori explores literature on mental health service delivery in Aotearoa/New Zealand for Maori over the last thirty years. The evolution of changes in mental health delivery is traced and how this has affected Maori mental health status, Maori socioeconomic realities and the delivery of mental health services to Maori. This paper traces the changes to three modes of mental health delivery from a psychiatric institution in the 1970s through to community-focused care in the 1980s, and telenursing in the 1990s. In this project I position myself using a metaphor which encompasses my cultural, personal and professional area of expertise in mental health nursing. Interwoven are reflective accounts of my brother Sidney’s journey as a tangata whaiora in mental health services. I explore those factors which our whanau had to challenge in response to poor access, information and support in mental health at this time. I also trace Maori realities and Maori health status in the 1950s and the transition of Maori to urban society through to the 1960s. Urbanisation provided opportunities and also pressures for Maori and it was these pressures that led to Sidney becoming unwell in the 1970s. A renaissance in the 1980s of Maori activism explores Maori expression to improve Maori health status and better socioeconomic conditions. The Treaty of Waitangi as the foundation of health policy and service delivery is discussed. Cultural safety was developed to educate nurses about cultural awareness and difference in providing nursing care. In the 1990s kaupapa Maori services were established demonstrating improved service delivery, with Maori health professionals and Maori mental health frameworks which endorse Maori by Maori services. The paper concludes by exploring mental health telenursing and recommendations for healthcare delivery to improve the health of Maori. My vision for futuristic health and wellbeing for Maori is to provide a nationwide kaupapa Maori healthline.
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I would like to acknowledge and thank Sidney Neilson for the opportunity of allowing me to incorporate your journey of courage. I am honoured and proud of your remarkable achievements you have made to this present day.

To my whanau and extended whanau who continually provide encouragement and guidance to me. A special thanks to Linda Wain my sister for your endless support and aroha.

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A special thanks to my friend QaQanilawa (Jimmy) Matanatbu for your insight on life’s meaning. Life is not just about survival it is about spirituality.

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Last but not least my husband and friend John Edward Hornblow, thank you for believing in me. I acknowledge your strength of character and unconditional love. I have appreciated your patience throughout this journey.
Dedication

‘E kore e taka te parapara a oku tupuna, ka taka iho ki ahau’
‘I cannot fail to inherit the talents of my ancestors, they will descend to me’

This project is dedicated to my parents Nevel and Pirihira Neilson for their commitment to whanau and iwi which is forever treasured. In dedication I carved this oamaru stone planter as a taonga in memory to my parents and tupuna.

A pounamu encompasses John Firth Hornblow whose loyalty to family and community will be forever remembered. This is also in memory of kaumatua and kuia of Te Whare Marie and Forensic Services for their endless devotion to Maori whanau, hapu and iwi.

Each koru design depicts a shape which is representative of various aspects of my connection of whakawhanaungatanga. There are two unfolding koru which symbolize the links within a whanau. The koru shaped as a manawa represents leaving the protective circle of parent and whanau. This reflects reaching new growth and the continuation of one’s life cycle.

The hei matua represents the strength and determination of my affiliation to Ngapuhi and Ngati Porou iwi and connection by whakapapa. The double koru represents the pathway of life, people and the diversity of these experiences which continues to shape my life.

Figure 1: Oamaru stone planter
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**Preface**

This preface explains the project in a metaphorical context. The metaphor is represented as toru paua piringa toka o te ora (three paua on the rock of life). These three paua represent three key elements which have positioned this research project. These elements represent Sidney’s journey and our whanau (family) experiences in mental health services and also positions my beliefs of the old and new world. The following is an encounter which describes this metaphor as three paua, seaweed and a ray which parallels with three key elements throughout this project.

**Metaphor**

The inspiration for my approach to this project emerged through a summer holiday spent in Kairakau, Hawkes Bay. Kairakau is a place which has special significance for my husband John and I, it is a place which allows us to have a break where we can rejuvenate ourselves.

![Figure 2: Kairakau cliffs and beach](image)

In early February 2004 we travelled to Kairakau for a break and on arrival at the beach I was eager to put behind me the woes of commencing study. Although I was at the beginning stages of planning an approach to this research project, I thought that going for a dive for kaimoana (seafood) may distract me and give me some relief from the study that lay ahead.
As I walked around the rocks of Kairakau observing for signs of where best to dive I came across a pool which was crystal clear. The current of the water swirled, and I could see the bottom of the reef and surrounding rocks gleaming in the sun. To my amazement it was not long before I came across some kaimoana (seafood).

Within minutes I uncovered a rock face of paua of various sizes and shapes. This colourful paua is extracted from the rock as it clasps on for all its life. Hidden from within the black foot of the paua is all its beauty, the inner shell with vibrant shades of pink, blue, green, grey and purple, colours that shine like a rainbow.
A carpet of seaweed canvas sweeps around the floor of the reef and beyond the rocks, sea
creatures feed from the rich nutrient of the seaweed and protect the smaller creatures
from the break of the water’s current. The seaweed unravels and sways back and forth,
side to side, revealing all shapes sizes and colours of various kelp origins.

This dive provided three paua, I decided to call it an afternoon. As I swam ashore, a long
antenna appeared which looked like a crayfish. I swam in close to take a swipe with the
knife and discovered it was the tail of a ray. The ray hovered at sand level, appearing
majestic and unscathed. Startled, by the ray I exited the rocky pool.
Later during the day, I reflected on this diving encounter and those things which I encountered provided me with a plan of approach to this project. Inspired by this day of diving I liken this metaphor to the three elements which encompass my cultural, personal and professional perspectives which have shaped my life and which have positioned this research project.

**Three key elements**

As a Maori woman working in the speciality area of mental health nursing, I liken these three key elements to represent the fundamental foundations that have shaped my life. These foundations I have identified as my own cultural background, personal experiences and current profession.

The first paua (element) represents my cultural perspective and how I view this world by my own cultural identity through whakapapa (genealogy). The key concepts included whanau (family), hapu (sub tribe), and iwi (tribe), these are integrated further to wairua (spiritual), tinana (physical) and hinengaro (mental). Durie (1994) recapitulates these key concepts in te whare tapa wha (the four cornerstones of health), as a Maori mental health framework. Kaupapa Maori health delivery is discussed, that is by Maori for Maori.

The second paua enables me to trace those experiences and reflect on events where my brother Sidney’s story commences with his admission to Porirua Hospital. It adds how our whanau became involved with mental health services and the importance of
supportive whanau involvement in the treatment and care of a whanau member. This also covers the changes in mental health delivery and the effects this had on my whanau, and leads to the eventual recovery journey of Sidney in the community.

The third paua symbolises my current profession working in the speciality area of mental health telenursing, tracing the history of call centres and how the Mental Healthline was established in Aotearoa. It explores whether this latest mode of mental health service delivery could provide improved mental health service delivery to Maori. Included are my recommendations and vision for future health service delivery to Maori.

The significance of the seaweed in the metaphor literally appear in various colours, shapes and sizes, which dance with the tidal currents sweeping from side to side. This changes the flow of the seabed life. This represented the factors which have shaped me as a person both in the old and new world.

Lastly, the ray represents a beautiful creature. The creation of Tangaroa (god of the ocean), Papa-tu-a-nuku (earth mother) and Ranginui (sky father) are bigger than humankind. All that is of this earth, sky and sea should be valued, as these components provide humankind with the essential tools to survive. I view myself as insignificant, exposed to the elements of this lifetime and like those paua on the rock of life, I too hold onto the rock of this lifetime. Life’s insights are not just about survival, they are about spiritual evolution, wairua (spirituality), sacred sights, believing in our intuitions and overcoming the fear.
Section One: Introduction to the research project

Why this project?
Within this project I position myself using a metaphor which encompasses my cultural, personal and professional area of expertise in mental health nursing. This project explores those factors which impacted on our whanau (family) through my brother Sidney's experiences of mental health services. The three key areas explored are access, information and support in mental health.

This paper traces the political, legislative, social and economic trends which reflect the changes in mental health delivery over a period of thirty years to this present day. Reducing the high rates of poor Maori mental health status remains a priority today. The changes to three modes of mental health delivery are followed from a psychiatric institution in the 1970s through to community-focused care in the 1980s, to telenursing in 1990s and mental health telenursing today.

Incorporated in this project is telenursing. In 2002 a new mode of mental health delivery the Mental Healthline, was launched. Literature suggests telenursing crosses the social, cultural and geographical barriers to people disadvantaged (Erdman, 2001; Sharpe, 2001). In concluding this paper I offer a vision of developing healthcare delivery to improve the health and wellbeing of Maori.

The ethical aspects that I considered in writing Sidney’s story and whanau experiences in this project, included the process of informed consent. I discussed with Sidney and whanau that this report would be published in the public domain. I provided a consent form and information sheet to Sidney and whanau which I discussed with them and consent was agreed. Sidney understood that his consent was voluntary and that he or any whanau member could withdraw from this project at any time. I was aware of the issue of coercion and obligation that a whanau member may feel in this situation. Throughout this project I checked with whanau if the information was correct. Whanau requested that the final draft be checked before submission. Whanau checked the final draft and minor amendments were completed.

I acknowledge and recognise the burdens experienced by whanau and describe the strengths and determination of whanau who have a loved member in mental healthcare. I
acknowledge those tangata whaiora and whanau for whom I have had the pleasure to advocate and care for in the speciality area of mental health nursing. The project exploring mental health delivery to Maori over the past thirty years began with a simple question. The answer proved to be much more complex.

**My questions**

How has mental health delivery changed over the period of Sidney’s journey of thirty years in mental health?

How might mental healthcare delivery in nursing be improved for Maori?

**Aims**

To promote a better understanding and awareness by mental health nurses of Maori tangata whaiora and whanau experiences with mental health delivery.

To explore whether new modes of mental health service delivery such as mental health telenursing will be effective for Maori.

This research project is guided by course requirements which have limited the depth of each section. A brief exploration on each section has provided a minimum of the information researched. This project has raised numerous issues which require congruent discussion and rigorous academic research.

**Search strategy**

The literature search for this project is formulated as follows: Maori and indigenous people’s health status, Maori political and socioeconomic, Maori mental health frameworks or family support and involvement in client care, mental health policy and mental health telenursing.

The literature relevant to this project was obtained from the following databases: Te Puna, National Bibliographic Database/ Voyager, Medline/Pubmed, Internet, National Library of Medicine, PsychINFO, Greater Murray Accessline, Embase, Cinahl, Plunketline, Healthline, Cochrane, Ministry of Health, Mental Health Commission, ProQuest, Human Rights Commission, Mckesson New Zealand Limited and Victoria University of Wellington Library, Te Puni Kokiri and Ministry of Womens Affairs.

There is significant international literature relating to family support and involvement of family in client care. These include literature by Bradshaw and Everitt, (1995); Chapman, (1997); Collins, (2000); Doornbos, (2001); Potasznik and Nelson, (1984); and, Wright and Leahy, (1990).

The literature search on telenursing found an extensive range of international literature by Coleman, (1997); Darkins and Cary (2000); and, Sharpe, (2001). A literature search on healthline telenursing in Aotearoa, revealed one paper by St George, Cullen, Branney, Gregory-Horo and Duncan, (2003). I found no literature on mental health telenursing in Aotearoa/New Zealand. As mental health telenursing is a relatively new concept in Aotearoa/New Zealand so this finding is not unexpected. An extensive range of international literature on mental health telenursing is sourced from Australia, United States of America (USA) and United Kingdom (UK).

**Overview of sections**

In this project I position myself using a metaphor which encompasses my cultural, personal and professional area of expertise in mental health nursing. Interwoven are reflective accounts of my brother Sidney’s journey in mental health. This explores those factors which our whanau challenged in response to access, information and support in mental health.

The first section introduces the literature search and why I chose these questions, and how mental health delivery changed over the period of Sidney’s journey of thirty years in mental health. My second question is how mental health delivery in nursing could be improved for Maori. This explores tangata whaiora and whanau experiences in mental health which highlight the need to improve mental health delivery for Maori. This further explores new modes of mental health service delivery such as mental health telenursing and future recommendations to improve health delivery to Maori.
The second section interweaves my whanau background which includes a brief overview of my grandparent’s and parent’s connection with Ngapuhi (Northland) and Ngati Porou (East Coast) iwi. Within this section there is a reflective narrative which describes the colonising effect of Northland missionaries on Maori, and lived experiences of suppression of te reo Maori (Maori language) in schools. I reflect on the socioeconomic hardships of Maori, and discuss the effect of the rural-urban drift on Maori in the 1950s relating to poor Maori health status.

The third section traces Sidney’s story of adolescence and his admission for treatment to Porirua Psychiatric Hospital in the 1970s. Later Sidney was to experience a move from institution to community-focused care. Sidney’s journey reveals the barriers, stigma and discrimination associated with mental illness. My whanau faced the challenges of access, information and support of mental health professionals and service delivery. This also reflects how these effected Sidney’s treatment and care.

The fourth section reviews the Treaty of Waitangi as the foundation of health policy and discusses cultural safety developed from the principles of the treaty and implemented as criteria in nursing education and professional development. Nurses are educated in Maori historical and contemporary views. Legislation changes in the Mental Health Act (1992) and policy, endorse participation of client and family in mental healthcare.

The fifth section discusses the political and social activism of Maori in the 1980s, which led to a raised awareness of Maori socioeconomic issues which link with poor Maori health status. Following in the 1990s is a review of significant events such as the development of kaupapa Maori service delivery, Maori professionalism and Maori mental health frameworks. This section provides an overview of indigenous people’s health status and shows the similarities and differences of Maori and indigenous cultural perspectives and colonial histories which link to poor health status.

The sixth section explores the latest mode of mental health delivery in mental health telenursing, titled Mental Healthline. Exploration of telenursing reveals the break down of social, cultural and geographical barriers experienced by disadvantaged people. Further research is needed about mental health delivery, information and support to Maori. The project concludes with recommendations and a vision of healthcare delivery to improve the health and wellbeing of Maori.
Section Two: Interweaving my family background

Neilson whanau
This section positions Sidney and myself through a brief overview of my grandparents and parents, Nevel and Pirihira Neilson’s background. It was through their experiences and influence that Sidney developed his identity as a young Maori male growing up in an urban area. It is during these years as an adolescent that Sidney was to become involved in mental health services.

My grandfather Robert Ferguson Neilson of Norwegian descent owned a saddler and harness maker business in a rural town Ngawha, Kaikohe. Known to locals as Fergie, he was to marry Peti Rameka the daughter of Hone Rameka and Te Kahuwhero Pirika my great grandparents, of Te Uri Taniwha mea Te Whiu ngä hapu. Fergie and Peti had six children, three boys and three girls. The eldest son Uncle Sidney died on Christmas Eve in 1943 whilst serving in the 28th Maori battalion. My brother Sidney was named after his uncle. Nevel Frank Neilson my father was born in 1932, the youngest of his whanau.

![Figure 8: Tauwhara Marae, Waimate North](image)

Nevel Frank Neilson of Ngapuhi descent, a whangai (adopted) baby grew up around Tauwhara marae in a rural community in Waimate North. It is known that Maori hapu and iwi lived around Kerikeri inlet and Maori hapu later dwelled inland at Tauwhara (Sissons, Wiremu and Hohepa, 1987).
With the arrival of missionaries to Northland, Maori people’s lives and their environment were consequently affected. Easdale (1991) states “Christian beliefs and purposes within an utterly strange and strong Maori culture was an exhausting emotional struggle for the mainly youthful brethren” (p. 11). History relating to post-colonisation has shown detrimental effects on Maori, in that Maori sustained poor health, poor socioeconomic status, high unemployment, lower income levels, low rates of home ownership and low educational qualification (Durie, 2003a; Pomare et al, 1995; Te Puni Kokiri, 1998).

My memory of visiting whanau in Northland was to reunite our family kinship by whakawhanaungatanga (extended family). The hardships in Northland were evident by the unemployment and poor living conditions of Maori. My father rarely discussed his personal experiences as a child growing up in Waimate North and my visits to Northland as a teenager gave me insight into the poverty of Waimate North. As children we would gather around the open fire and listen to stories told to us by kaumatua (elder). Their stories were to reveal a different message from those I was to be taught at school. Both Sidney and I were to experience the first of many conflicts between our culture and that of the colonial viewpoints. These stories of the effects of colonisation were the motivation to write this project. It has been these conflicts that have shaped us to be the people we are today.

The elders would talk of the missionaries destroying carvings within marae by demonising the figures. They would reveal suppression of Maori language and Maori children at school. Akona te reo Maori language in state education 1840-1990 (n.d.) states “Maori concerns for the survival of language increased, by 1950 there was strong evidence pointing to the fact that the education system was failing Maori children” (p. 4).
My father Nevel spoke fluently in te reo Maori yet from the age of 8 years was to speak only English. He attended missionary school in Northland which predominately imposed English and missionary teachings. Stories were conveyed from my parent’s generation of punishment for speaking Maori in the classroom instead of English, and then on return home were punished further for speaking English instead of te reo Maori. The effects of colonisation on te reo Maori (Maori language) later became evident with the next generation such as Sidney being discouraged to learn te reo Maori to enable an easier transition of assimilation.

Rural migration of Maori in 1950s

As Nevel grew to a young man he ventured outside of Waimate North to seek better opportunities for employment. My father arrived in Wellington in the early 1950s with the clothes he wore and a couple of shillings. His brother and sisters had earlier migrated to Wellington and Nevel was soon reunited with his whanau. During the 1950s, Maori were increasingly migrating to urban areas. As King (n.d, para 5) New Zealand states

In the 1950s New Zealanders began to migrate in large numbers from the rural areas to cities in search of better opportunities. It is estimated that about 57% of the Maori population lives in main urban centres. Maori had difficulties adjusting to urban life and pakeha ways, and began to lose their culture and tradition. Recognizing these problems, the government and Maori themselves introduced programs to ease the situation.

Statistics New Zealand (2004, para 3) states “the Maori population underwent rapid urbanisation after (World War II), 38% Maori lived in urban areas in 1950s in comparison to 25% in 1945” (see Table. 1). Maori urbanisation and the accompanying massive demographic changes have had huge consequences for the social, cultural and economic structures and communities of Maori. Many rural iwi (tribe) now have a minority of members living within their rohe (district). These consequences are explored later in this section with my family background.
While living in the Maori Anglican hostel Pendennis in Wellington, Nevel was to meet Pirihira whom he later married. Wellington was to provide opportunities for employment, home ownership and financial security even though their employment was unskilled.

After a number of years my parents were to move into a new state housing suburb in Porirua which was to be their home for forty years. My memories of my parents are of their commitment to their iwi, the dedication to supporting Maori groups and community in Wellington, and the endless hours working to better our whanau.

**Porirua Hospital in the late 1960s**
Nevel and Pirihira commenced work for the Wellington Hospital Board in 1969. Both my parents combined work span at Porirua Hospital was for 40 years. My father eventually worked his way to be a food supervisor and Pirihira as the laundry supervisor. They both worked hard and were to become well known and respected by colleagues and the patients of Porirua Hospital.

In early 1980, my parents become involved in development of a support group for Maori at Porirua Hospital. The meetings provided Maori staff and tangata whaiora with a place in which they could express their perspectives and identity in a supportive environment.
This development coincided with the renaissance of Maori advocating for cultural identity in Aotearoa.

These support groups eventually led to Maori staff requesting a service which applied Maori tikanga that could be incorporated into addressing the needs of tangata whaiora in mental health. Williams (1987) writes from a Maori perspective, “Over the past two years we have tried to incorporate the Maori perspective into this hospital. We don’t see our perspective as taking anything away from what is already here, but we do see it as adding to it” (p. 334).

As a result Te Whare Marie was established in 1989 at Porirua Hospital. This was the commencement of a kaupapa Maori mental health service designed to address the needs of Maori, tangata whaiora (person seeking wellness) and whanau (family). This unit was the beginning of Maori health services working in partnership with tangata whenua (people of local area, tribe) and tangata whaiora to address the increasing demands of Maori in mental health services. Nowadays, Te Whare Marie is referred to as a kaupapa Maori mental health service, a place which provides Maori practices of tikanga (custom), kawa (protocol) and te reo Maori (language).

My parents yearned to take their knowledge and skills back to their turangawaewae (land of origin), my father would often say how he would one day return home to share his skills with his whanau in Northland. Sadly this did not eventuate, forever in our hearts, Nevel Frank Neilson died 30th January 1989 and Pirihira Neilson (nee Nukunuku) died 29th December 1998. Never forgotten and forever in memory. Ma te atua koutou katoa e manaaki.

**Nukunuku whanau**

This section interweaves my mother Pirihira’s background and experiences. My maternal grandfather Hakopa Nukunuku married Putiputi Houia of Ngati Porou and Spanish descent. They had a whanau of fifteen children, my mother Pirihira Nukunuku was born in 1935. Pirihira whanau lived in Whakawhitira which has a view over Mount Hikurangi. Maori express their identity through a strong spiritual connection to land. For Pirihira her cultural identity was symbolised by Mt Hikurangi maunga (mountain).
The memories I have of my mother are of her strength in personality and her beautiful singing. My mother had a natural melodic ability associated with song and music. This included singing, composing original songs and playing the ukulele.

Pirihira and her sisters shared a love of singing original songs which reflected stories of their parent’s and childhood experiences. One such story would be how she and her whanau were delivered by birth, my mother would proudly say, “I was born under a peach tree”. It was not till I returned to my mother’s whenua (land) at Whakawhitira that I realized that the river, land, mountain and trees are the objects that identify her whanau to the east coast. The visits home developed my appreciation of how my mother lived in her environment.

At the age of 11 Pirihira was whangai (adopted) and she spent those years living with relatives around the east coast. Later her sister, Auntie Kahu, settled at Pendennis hostel and sent for my mother to join her in Wellington. Later their youngest sister, Aunty Jane, was to follow them in the migration to the city. All three sisters worked long hours in unskilled jobs.
Maori women’s life experiences have changed dramatically over the last half of the 20th century. In the 1950s the Maori female population was predominately young and largely rural. Throughout the 1960s many Maori families moved from rural to urban areas. During this time Maori women were more likely than non-Maori women to participate in the labour force.

Pirihiira was to work in a number of jobs, each an equally unskilled role such as cleaner or as a factory hand. These roles offered little opportunity for her to gain new skills that would improve her career prospects.

**Urban migration and the influence on Maori**

With the migration to urban areas, Maori experienced many changes such as dispossession and dislocation from their whenua (land). As Maori strongly identified to their links to land and family there was a great feeling of loss of identity. Maori responded by setting up clubs and organisations which provided support though Maori cultural expression and whakawhanaungatanga (extended family).

My parents were to find security through their affiliation with Ngati Poneke Young Maori Club. They became club members in the late 1960s and were to remain members for over forty years. This provided my parents with kinship and manaakitanga (respect, togetherness) which enabled my parents to develop an identity and supportive networks while adjusting to urban life.

Dennis, Grace and Ramsden (2001) describe Ngati Poneke Young Maori Club as having commenced earlier but it is from the year 1937 onwards that the history of club can be traced for Maori who migrated to urban life. The adjustments enabled Maori to facilitate an easier transition to city life. The Evening Post (1971) states

Ngati Poneke signifies the best in Maori social and cultural expression. It has been a vital part of the capital scene for some 35 years, a focal point for activity in so many useful and pleasing forms. Its presence has given immense comfort and confidence to young Maori adjusting to city life for the first time.
Nevel and Pirihira now married, had their first child Sidney. They later moved to a new suburb in Titahi Bay where they were to live for forty years and eventually have four children.

In 1970, Sidney aged 19 years, began to display bizarre behaviour which emerged as the beginning stages of Sidney becoming unwell. My mother sought the assistance of a tohunga (healer) and rongoa wai rakau (Maori medicine). Sidney’s mental state continued to deteriorate over a period of time to where he became acutely ill and was admitted to Porirua Psychiatric Hospital, where he was later diagnosed with schizophrenia.

As our whanau struggled with Sidney’s illness I believe each of us were to experience the stages of Dr Kübler-Ross (1969) grief cycle. This cycle is defined as the stages of denial, anger, guilt, and bargaining then acceptance. Through Sidney’s journey our whanau would experience each stage of the grief cycle, each member dealing with the grief in there own way. My father was to move from the stage of grief to acceptance of Sidney’s condition while my mother was to remain in the stage of guilt and bargaining for many years. I too have memories of passing through the stages from denial when first been told of Sidney’s admission to Porirua Hospital to today where I accept Sidney for himself.

To summarise this section, as I reflect on my parent’s earlier years and I become aware of their determination and strength that had developed through their hardships and life experiences. The three key elements are the colonisation of Maori, the dislocation of
culture and dispossession of environment which is evidenced by the poor Maori socioeconomic realities described. Later when my parent’s migrated to the city they established an urban identity and become involved with organisations such as Ngati Poneke Young Maori Club, with its emphasis on culture and extended whanau. Opportunities arose for my parents in employment and housing in Wellington. Nevel and Pirihira were to settle and begin a family in Titahi Bay.

Sidney’s journey in mental health was to commence with challenges in his treatment and care. It has been these challenges that have inspired me to write of the difficulties Sidney, I and our whanau were to face in this journey. The following section traces the influences that shaped my brother’s journey in mental health service delivery and the barriers and discrimination my whanau were to challenge.

Section Three: Tracing those influences of my brother’s journey

Sidney’s story
Sidney was born 22\textsuperscript{nd} November 1954 and was one of the first generation of Maori to experience city life from birth. Sidney’s story starts at adolescence. Sidney remembers this time with fondest memories as a teenager growing up in the vibrant community of Titahi Bay. He enjoyed a life of surfing, sports and the social life of a small active community. Sidney recalls his achievements at school, as a leader in kapahaka (performance dance), a successful rugby player and as a popular teen amongst his peers. Life for Sidney appeared to being going well.

There were a number of pressures on Sidney during this time that I believe led to him becoming unwell. These factors include the responsibility of being the eldest son in a Maori whanau. Tradition places various responsibilities on the eldest son such as being expected to represent the mana of our whanau. There was also the pressure to achieve outside of the home, to be a high achiever at school, to be a prominent leader in kapahaka and excel in the sport of rugby. This pressure was from my parents and society who were keen to be seen as successful members of urban life.

According to Erickson the psychosocial crisis of adolescence is identity versus role confusion. Erickson (cited by Berger, 1988) states “ideally adolescents resolve this crisis by developing a sense of their own uniqueness and their relationship to society,
establishing a sexual, political, moral and vocational identity in the process” (p. 386). It was during this period of adolescence that Sidney was being subjected to frequent pressures to achieve while experiencing the conflicts of cultural identity versus the confusion of his responsibilities as an urban Maori. Erickson also describes the next phase of transition to a young adult.

Sidney appeared to be coping well on the outside. But in hindsight Sidney’s mental health status was deteriorating under the demands of cultural, environmental and developmental stages of adolescence.

Sidney at 19 years old began to regress and withdraw from his whanau and friends. Sidney’s behaviour became increasingly bizarre, for example he would shave his eyebrows and hair. He often isolated himself and his demeanour changed from a sociable person to one of a sullen introverted teenager. As a child I would observe Sidney’s abnormal behaviour such as when he would be outside punching the air as if fighting with an invisible person. While Sidney was not aware of his behaviours, my whanau were to watch Sidney as he battled his turmoil within, leaving us with a sense of helplessness.

**Admission to hospital in the 1970s**

In 1972 Sidney was admitted to an acute ward at Porirua Psychiatric Hospital. He was often heavily medicated and restricted in a secluded area. It often shocked our whanau to find that Sidney had been confined for long periods of time wearing little more than his pyjamas. It was to be seventeen years before Sidney was again living in the community.
The treatment was intensive and Sidney appeared to us as a completely different person. He was detached from himself, disconnected from his whanau and environment. When whanau would visit he would be in a world of his own and this would greatly distress my parents. They would often enquire into his treatment and received inconsistent responses from the mental health nurses.

Treatment in those times in psychiatric hospitals consisted of a biomedical model in comparison to today’s approach to treatment which incorporates models of health for Maori. A document published of four tangata whaiora experiences of mental illness, services and staff states “they too had experienced similar treatment during this period in psychiatric institutions in New Zealand” (p. 11), further add

Mainstream mental health services and discrimination were the biggest culprits, mainstream services were seen to be dominated by the western medical model that is pessimistic about recovery and assumes people will need medication and services for the rest of their lives. No efforts were made to treat tangata whaiora in a holistic way. Staff in these services was often unhelpful and did not address the cultural needs of participants. (Mental Health Commission, 2000, p. 11)

During the seventeen years of Sidney’s hospitalisation there was an identified need by health professions and Maori community to meet the increasing needs of Maori presenting to mental health services. Clients and families were not considered as participating in the management of client care.

Pomare et al (1995) researched Maori health status by providing statistics which gave a representation of Maori health in relationship to non-Maori. The over representation of Maori indicated a growing need to make available culturally appropriate services and frameworks. Durie (1994) and the Mental Health Funding Authority (1999) reiterate the need of Maori to access kaupapa Maori services, Maori staff and Maori mental health frameworks.

In the 1990s kaupapa Maori mental health services, Maori mental health professionals and Maori mental health frameworks for treatment and care, assisted Maori tangata whaiora with an approach that addresses Maori mental health and wellbeing and provides quality mental health delivery to Maori (Mental Health Commission, 2001).
Durie (2001) explains that Maori health frameworks support each aspect of tangata whaiora and can be applied to any health issue affecting Maori spiritual, physical and psychological wellbeing. Te whare tapa wha (the four cornerstones of health), incorporates four components representative of Maori philosophy towards health, these are wairua (spiritual), hinengaro (emotional) tinana (physical) and whanau (family).

In response to this need, Te Whare Marie, a kaupapa Maori service was established. Sidney was to attend this service for the remainder of his time in hospital. Sidney’s confidence excelled as he was in a milieu that was conducive to his wellbeing. Sidney had an excellent relationship with kaumatua (elder) and kaimahi (staff). He also enjoyed the Maori tikanga programmes. Sidney has a sociable personality and the opportunity to be with other tangata whaiora, whanau, kaimahi and manuhiri (visitors) was an ideal forum. Cunningham, Reading and Eades (2003) add that the implementation of kaupapa Maori services, recruitment of Maori health professionals, and the development of cultural frameworks relevant to Maori perspectives are essential, as this incorporates a holistic approach to the health of tangata whaiora and whanau. There remains a need to improve Maori mental health status and reduce the disparities of health between Maori and non-Maori (Te Puni Kokiri, 1998).

International trends and patterns of mental health services had led to New Zealand psychiatric hospitals closing and the deinstitutionalisation of Porirua Hospital began in the 1970s. An approach which included client and family in mental health services was to be developed. Sidney’s journey through this period was a movement from institutionalisation to community-focused care in the late 1980s.

Deinstitutionalisation in 1980s
International trends toward the closure of psychiatric hospitals in Aotearoa began in 1970s. During this movement there was a significant change in mental health service delivery that reflected global trends. Davis and Ashton (2000) state “deinstitutionalisation has been shaped by international and national trends, cultural legacies, social attitudes, management and fiscal pressures, and by the decision, actions and interactions of various interest groups” (p. 183). Williams (1987) add “the principal influences and changes required an emphasis on the rehabilitation of patients into the community and reduction of numbers of patients resident in the hospital” (p. 289). Porirua Hospital commenced deinstitutionalisation of wards from early 1980s through to
mid 1990s. Sidney was to move from an open ward for males in 1989 to a half way house run by a community trust.

During the 1980s, clients were expressing their rights including autonomy and dignity in treatment (Human Rights Commission, 1996). Family were also seeking participation in the management and care of family members in mental health services (Walker & Dewar, 2001). This movement required mental health staff to focus on better support and involvement of family in the treatment and care of clients (Bradshaw & Everitt 1995; Doornbos, 2001).

Wright and Leahey (1990) add that the focus on family involvement and participation encourages family to attend family management meetings relating to client care. Mental health policy and procedures endorse the participation and partnership of family in the support and care of a client (Evans, 2000; Gall, Elliott, Atkinson and Johansen, 2001).

Sidney’s movement from Porirua Hospital to the community was to provide a new set of challenges. Essentially Sidney had lost all living skills while in hospital and was unable to cook and clean, and struggled with budgeting. His mother and whanau were pleased to have Sidney out of the hospital environment as there were fewer restrictions. Sidney’s personality and skills showed considerable improvement.

**Barriers for Sidney and whanau**

During Sidney’s hospitalisation my parents had expressed feeling guilt over Sidney’s committal into hospital. Potaszniak and Nelson (1984) state “the psychological manifestation of this stress includes guilt such as, am I to blame for the situation?” (p. 602). There is a need to assist in the family’s manifestation of guilt and to enable effective coping strategies which are supportive (Collins, 2000; Isenalamhe, 2000). I believe that support, information and service delivery tailored toward Maori philosophies would have reduced my parents and whanau anxieties and feelings of helplessness.

Several barriers were encountered by our whanau. The first of which was the discrimination toward people with mental illness. This manifested itself in the attitude and behaviour of society’s lack of understanding around mental illness. There was a presumption by family and the community in which we lived that Sidney condition was genetic and there was fear of the possibility of other members who may incur the same
illness. There was also the belief in the extended whanau that Sidney would never become well. The barriers extended further from our whanau to the community where Maori mental health issues increased in urban areas, and the poor response to provide appropriate mental health delivery toward Maori was evident.

Today, anti discrimination campaigns are helping to dispel the myths and stereotypes of mental illness. A media campaign by the Mental Health Commission (2000) led to the development of the ‘Like minds, Like mine’ promotion to provide awareness in the community on recovery from mental illness and to provide consistent approaches toward reducing stigma associated with mental illness.

Another barrier encountered by our whanau has been the continued outdated attitudes of mental health professionals, who blame Maori for their poor state of health and wellbeing. I have worked with these attitudes of mental health nurses, doctors and health professionals. It is my belief that everyone employed in the health industry could benefit from an induction course into learning colonial histories of tangata whenua and indigenous people of the land and the power imbalances imposed on Maori and indigenous persons who identify as different. While Sidney was in Porirua Hospital there was a culture to not encourage family participation in treatment decisions. Sidney’s progress and health outcomes were hindered as his whanau challenged the conditions of service delivery and attitudes of mental health nurses and professionals.

Challenging mental health services and mental health nurses can be a daunting experience for family, especially if family are unfamiliar with the processes and procedures of mental health service delivery and the legal, ethical standards involved. In an ideal world mental health nurses should be required to learn knowledge of people’s plights and realities and be accountable to those for whom they care. Chapman (1997) states

Mental health nurses are now providing complex and diverse services in contexts that are often far removed from the traditional realms of health care provision. If they are to meet the challenge of contemporary and future mental health care needs, it is essential that mental health nurses be aware and understand the changing mental health environment. (p.1)
It was toward the end of the 1980s when our whanau noticed movement by mental health services and professionals to involve family in hui (meeting), management plans, treatment and care for Sidney. The establishment of kaupapa Maori mental health service delivery, Maori representation, professional, philosophy and frameworks, provided mainstream mental health services and professionals with a perspective outside of the traditional care to a contemporary approach of care for Maori. Sidney’s recovery journey was to commence with a movement into community-focused care.

**Sidney’s recovery journey**

Sidney’s description of recovery is living life “at one hundred percent and having the freedom to do what I like, when I like”. He believes he lives a full life and is able to make his own choices. Sidney states “I can sleep when I want, eat when I feel like it and enjoy my independence”. Sidney initially had to learn every day living skills and adjust to life in the community. The Mental Health Commission (MHC) (2000) states

> Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them. (p.33)

The Collins English Dictionary, (1996) defines recovery as to become healthy again, regain a former condition and get back a loss or expense. The MHC (1998) describes recovery as “to live well in the presence or absence of mental illness this definition is intentionally broad because the experience of recovery is different for everyone, each person defines for themselves what living well means to them” (p. 4).

The recovery approach provided the principles for service delivery which Sidney was to experience towards the end of his journey. These guidelines are provided through the Ministry of Health policy documents *Looking Forward*, (1994) and *Moving Forward* (1997a). These guidelines provide strategic direction and an integrated approach for mental health. Later the MHC was established to facilitate the implementation of the blueprint for mental health strategy.
The *Blueprint for Mental Health Services* is a benchmark to provide a high quality recovery approach throughout mental health services. The MHC (1998) explains the blueprint as “a plan for a mental health system to ensure good treatment and support for those affected by mental illness” (p. 1). The recovery approach empowers the clients to achieve their goals of maximum recovery.

In the recovery approach emphasis is placed on the importance of respect for human rights and the recognition of equality in recovery from mental illness. Equally important is the person’s life such as family, friends, work and home life. The recovery approach is aimed at eliminating discrimination and creating an environment where people with mental illness live with dignity. Today Sidney experiences a different approach to his delivery of care. Sidney is empowered to express his rights and autonomy by taking control of his own wellbeing.

Another aspect of Sidney’s recovery was his involvement with the kaupapa Maori mental health service, Te Whare Marie. My mother encouraged Sidney to attend Te Whare Marie. Sidney shared a partnership with the kaumatua (elder) and kaimahi (staff) and he also participated in taking a role on the paepae. Sidney developed and achieved well whilst under the guidance of Te Whare Marie. The Ministry of Health (2002) have developed a Maori mental health framework, *Te Puawaitanga*, which builds on improving services, delivery and to facilitate Maori tangata whaiora and whanau through the mental illness recovery. Possible options for improving service delivery to Maori in mental illness recovery would be the inclusion of a kaupapa Maori service, Maori health professionals and Maori frameworks which focus on healthcare tailored for Maori in telenursing. This vision is discussed and explored further in section six.

This summary traces the journey of Sidney being admitted to hospital through to recovery and living a full life in the community. Sidney’s story commences as being a popular adolescent who achieved well in all aspects of his life. It is at this time in which pressures led to Sidney’s deterioration in mental wellbeing. At times these pressures were to create conflict for Sidney.

Sidney was admitted to hospital in the 1970s where he was to receive treatment from a biomedical perspective. At this time my whanau were discouraged from having any participation in Sidney’s management of care. We were to experience three key
elements of barriers including; a service delivery which did not meet Sidney’s needs to care, the discrimination of community and stigma of mental illness, and the prevailing attitudes of mental health nurses and health professionals.

With the commencement of community-focused care Sidney’s recovery journey was about to begin. A strong influence in Sidney’s recovery journey has been his involvement with a kaupapa Maori service. Kaupapa Maori mental health services, Maori mental health professionals and the use of Maori frameworks are seen as necessary to improving Maori mental health status. A partnership relationship between services and Maori will determine an approach of mental health delivery which is beneficial to Maori health status and the wellbeing of tangata whaiora and whanau.

The following section explores the changes in Aotearoa legislation and political situation in the speciality area of mental health. Interwoven in this section are reflective accounts of the impact this had on Sidney and his whanau along with Maori mental health status and mental health service delivery for Maori.

Section Four: Tracing the changes in the speciality area of mental health

The Treaty of Waitangi

As discussed in the previous section Sidney experienced a poor response to his rights, partnership in treatment and the exclusion of family participation in decision making. In this section I explore the Treaty of Waitangi as it pertains to mental health delivery to Maori.

The foundation of government health policy in Aotearoa is the Treaty of Waitangi, a partnership between tangata whenua (people of the local area) and non-Maori. Signed in 1840 the treaty testifies as a living document to both Maori and non-Maori. Relating this in today’s terms the treaty is a founding document which provides a relationship between the mental health service provider, tangata whaiora and whanau.

The principles of the treaty provide a framework for developing practical responses to Maori health, cultural and property rights. The treaty provides Maori with protection to socioeconomic, cultural rights and tino rangatiratanga (self determination). Te Puni Kokiri (1993) states “the treaty places rights and responsibilities on both Maori and the
crown in the area of health” (p. 2). The New Zealand government recognises the treaty as the foundation of our nation and the basis of constitutional law. Under the context of the treaty Maori need to be provided protection in the delivery of services in mental health. The following two articles of the treaty outline briefly the interpretation of each article as it pertains to Maori health.

Article one requires active consultation by the crown with tangata whenua on issues of public policy and service provision. Article two establishes the principle of tino rangatiratanga (self determination) and jurisdiction for Maori communities and organisations so that Maori can manage their own property, assets and resources. (Mental Health Funding Authority, 1999, p. 8)

Translated to the provision of mental health delivery for Maori, article one requires the participation of Maori. Article Two requires partnership in the delivery of services and health policy. Today, this would translate to Sidney and my whanau having an equal relationship with service providers by whanau sharing a partnership and participatory role in Sidney’s management of care, thus providing the best outcomes for Sidney care.

The following section discusses cultural safety which was developed in response to the principles of the treaty to provide nurses with a foundation to work safely with people who differed from the nurse’s own perspective. Cultural safety is necessary to improve Maori health and wellbeing.

**Cultural safety in nursing**

Cultural safety was developed in Aotearoa in the 1990s to educate nurses about cultural awareness and recognition of difference in providing nursing care for Maori. The definition has been broadened to encapsulate any persons who are of difference. Ramsden (2002) states

Cultural safety has been developed from within Maori cultural reality. Maori people no longer accept that our world is a perspective on the reality of anyone else. We have our own whole viable legitimate reality. It operates in different ways for different Maori but it is one of the realities in this country, not a perspective. (p. 110)
Cultural safety is about nurses reviewing their own identity by requiring nurses to acknowledge their own social, cultural, sex, religious, belief systems and by not imposing their own beliefs on others. This enables nurses to examine their own colonial histories and look at the disadvantages of Maori and people’s of other difference health status. Ramsden (2002) states

> Cultural safety begins with the Maori response to difficulties experienced in interaction with western based nursing services. It does not accept that the culture of nursing is normal to patients. Cultural safety gives the power to the patient or families to define the quality of service on subjective as well as clinical levels. (p. 110)

In response to cultural safety needs Maori nurses implemented and continue to develop their own cultural beliefs, values and philosophy of practice in a style and manner which is more conducive to the needs of tangata whaiora and whanau. Later, cultural safety becomes internationally recognised in the disciplines of nursing and midwifery. I believe if Sidney was treated and cared for from his cultural experiences, his outcomes in mental health would have been more effective. It was over ten years of hospitalisation before Sidney was to see any reflection of his culture in his treatment by mental health nurses.

During the 1990s there were also changes in treatment approaches and greater recognition of client rights. This is reflected in changes in the mental health law as it pertains to the Mental Health Acts of 1969 and 1992 in Aotearoa/New Zealand. This change of direction for mental health delivery from paternalistic care to community-focused care restored and established tangata whaiora rights and dignity.

**Mental health and law**

Sidney was admitted to hospital under the Mental Health Act (MHA) 1969. This act was drafted from a paternalistic perspective whereby patient and family rights were essentially removed. The MHA (1969) and the idea that people with a mental illness were best treated by incarcerating them into psychiatric institutions for lengthy periods has since been replaced with the new Mental Health Act (Compulsory assessment and treatment) 1992 (Mackenzie & Shirlaw, 2002).
The 1992 act differs from its predecessor in that the act is based on the concept of dignity, respect and freedom which transpose as patient rights, autonomy and community care. The Human Rights Commission (1996, para 8) states

The principles provide a benchmark for the protection and treatment of people with illness and reiterate a number of fundamental freedoms and basic rights, as well as outlining the standards of treatment which can be expected from a mental health system.

The MHA (1992) sets out to protect patient rights to assessment and treatment. It emphasises community-focused care with hospitalisation only when necessary and in the least restrictive environment possible. Further principles of the act include respecting different cultural values and beliefs as an important part of assessment and treatment.

When Sidney was first admitted there was no discussion with whanau of Sidney’s rights to treatment and there appeared to be no consistency in his care. Any attempt by my parents to seek information of Sidney’s condition or treatment was unsuccessful. Today Sidney and whanau have the ability to be involved in his care and are encouraged to participate in his management. Sidney also now has access to literature and support groups which provide information into mental illness. Mental health nurses today are educated to incorporate the physical, spiritual, mental and family perspectives into treatment and care.

**Mental health standards**

The National Mental Health Standard (Ministry of Health, 1997b) is a guideline for mental health service delivery. The standard recommends the approach needed for the delivery of a quality mental health service including consistency of care by mental health service providers and the highest delivery of care for people with mental illness.

The movement of clients into the community created problems through lack of resources and wide public apprehension. Following a number of high profile incidents a national inquiry was launched into the deaths of two young men alleged to be suffering from mental illness (Ministry of Health, 1996). This report known as the Mason inquiry into mental health concerns lead to the establishment of the Mental Health Commission. The
The key role of the commission is to ensure the implementation of the national mental health strategy by monitoring and reporting on the performance of mental health services.

The Ministry of Health (1997b) states “mental health service will provide appropriate services to meet the needs of whanau, hapu and iwi” (p. 1). This would in time ensure tangata whaiora experiences in mental health would be consistent by creating supportive communities and a safe approach in recovery. Earlier, an example of services such as the kaupapa Maori service at Porirua Hospital was established to address the needs of Maori mental health needs.

As I reflect on Sidney’s journey and my whanau experience I have observed considerable change in mental health delivery. This includes the involvement of whanau in care and Sidney’s ability to have input into treatment decisions. These days Sidney is aware of the services available to him and is relaxed about accessing information. Walker and Dewar (2001) state “government health care policy urges service providers to involve service users in the decision making process” (p. 329).

There has also been a marked change of attitude of mental health professionals toward client and family involvement. Sidney’s journey reflects these changes and international trends. Gibson (1999) indicates international trends are to promote awareness and family participation in the treatment and care. The mental health setting and delivery has changed from the traditional realms of health that were narrow, to a much broader contemporary future in mental health.

To summarise, the three key legislative documents in health policy such as the Treaty of Waitangi, Cultural Safety, Mental Health Act (1992) and standards are critical factors for the improvement of Maori mental health status. Maori continue to aspire toward tino rangatiratanga (self determination) and the treaty is the foundation document which promotes the rights of Maori. The Mental Health Act (1992) has changed to provide improved rights and protection for clients.

Cultural safety has been developed from within a Maori cultural reality. Mental health nurses require ongoing education and understanding in regard to the historical and contemporary needs of Maori. Cultural safety is about the nurse owning their own
identity and not imposing their own beliefs on others. Cultural safety has become internationally recognised in the disciplines of nursing and midwifery.

Sidney’s journey from institutionalised care to the community has been one of considerable change. This has been observed by the change of Sidney and whanau having minimal involvement in his care through to today where Sidney and whanau are encouraged to be involved in his management of care.

As I reflect on Sidney’s journey and my whanau experiences with mental health service delivery I am aware that our story is similar to that of other indigenous peoples’ experiences. The following section will look at three key elements which link Maori political activism with socioeconomic strategy and how this links to the improvement of health status for Maori. Included is a comparison of Maori mental health status with those of other indigenous people.

Section Five: Maori concepts and indigenous people’s health status worldwide

Maori political activism
Maori activism arose in response to the poor economic and social circumstances of Maori. It is noted that Maori disparity in health status with non-Maori has resulted from a complex mix of social, cultural and economic factors which continue to affect Maori health and social development. Pomare et al (1995) state

Maori ill-health being to a great extent as a result of socioeconomic and socio-cultural factors which have their roots in colonialism and the struggle to adapt to rapid change arising from post World War Two urbanisation. (p. 14)

Maori economic and social circumstances remain a priority as Maori continue to experience poor health and poor socioeconomic status in comparison to non-Maori. Cunningham and Stanley (2003) and Te Puni Kokiri (1998) both discuss the progress needed to close the socioeconomic gaps between Maori and non-Maori.

Maori activism is a mechanism used to drive the improvement in Maori social and economic status. Maori political activism has developed from a failure to see progress in
the areas of land grievances, language and overall health status. These essentially have been from the determination of Maori people to maintain our intrinsic cultural beliefs. In the changing pattern of ill health for indigenous people, Foliaki and Pearce (2003, para. 2) state

European colonisation of the Pacific and the Americas after 1492 saw indigenous populations decimated by imported communicable diseases. In the Pacific indigenous people experienced high mortality from imported infectious disease mainly when their land was taken and their economic base, food supply and social networks were disrupted.

Maori development in the evolution of political activism has traditionally seen a number of strategies in response to issues. The following examples include the responses in the form of protest campaigns and the involvement of participants in marches. Maori insist on political and economic justice through tino rangatiratanga (self-determination) or transposed as Maori independence.

There has been a long tradition of struggle and resistance against the effects of colonisation. This is embedded in the conflicts over the Treaty of Waitangi and Maori leadership and resistance in land wars. In a modern context, Maori activism and leadership was recently demonstrated in response to the Labour government’s seabed and foreshore policy of 2004, where a protest march preceded and later saw the formation of a Maori Political Party.

Figure 14: Maori seabed and foreshore march
Source: Web gallery, 2004

Significant events have contributed to Maori socially throughout the history of post colonisation. It was during the 1970s in which a group called Nga Tamatoa raised public awareness of grievances experienced by Maori. The group Nga Tamatoa gathered to promote Maori cultural identity and to address the loss of Maori rights to land. My
whanau were involved in both land and foreshore marches of 1975 and 2004. Lee (2004, para 2) notes “in 1975 a Maori land march led by Dame Whina Cooper saw a gathering of Maori who wanted to gain back their rights to Maori land.” This event expressed Maori taking back control of Maori.

In the early 1980s a renaissance of te kohanga reo (language nest) began which developed further into kura kaupapa Maori (immersion classes). I believe Maori view language as an important taonga (possession) to preserve as Maori heritage. Maori iwi radio also commenced which provided information and local knowledge of news relevant to Maori. Recently the commencement of Maori television has provided Maori with a media of networks designed to revitalise language and culture. Today, Sidney is learning to speak te reo Maori through Maori television. Maori initiatives such as those described above require further development to ensure that Maori culture is fostered as unique to Aotearoa.

**Maori mental health**

Literature by (Durie, 1994; Mental Health Commission, 1998) note, mainstream services indicate a poor response in delivery to Maori. The disparities of health for Maori in comparison to non-Maori have been as a result of the socioeconomic factors which have their roots in colonialism (Pomare et al, 1995). It is therefore no surprise that Maori health and wellbeing are inextricably linked to the social and economic dimensions in which Maori are disproportionately represented in psychiatry, unemployment, crime, morbidity and mortality (Cunningham, Reading & Eades, 2003).

Maori mental health problems are a priority health concern for Maori. There has been an increase in psychiatric admissions, Maori men rate amongst the highest for alcohol and drug dependence, and Maori access to health services is at a later stage of illness, therefore Maori are more at risk of becoming seriously ill. Durie (1997) suggests five strategies to address the increasing Maori rates of mental illness. These include: access to Maori services, participation of Maori in education and employment, recruitment and retention of a Maori workforce, whanau and community supportive policies, and laws which will provide consistent dignity to individuals.
The Ministry of Health in partnership with tangata whenua developed a strategic plan, *Te Puawaitanga*, to ensure that Maori mental health services maintain a key identity within the government national health strategy. The Ministry of Health (2002) states

> The purpose of a Maori mental health national strategic framework is to provide district health boards with a nationally consistent framework for planning and delivery of services for tangata whaiora and whanau, so they can meet the government mental health policy objectives for Maori over the next five years. (p. 2)

Maori mental health requires strategic direction and the incorporation of Maori mental health frameworks to meet the changing needs of Maori in this 21st century. An example of a framework is Durie’s (1999, 2001) *Te Whare Tapa Wha* model. This model describes Maori health as a four-sided concept representing four basic beliefs of life. These are te taha hinengaro (psychological), te taha wairua (spiritual), te taha tinana (physical) and te taha whanau (family). These four concepts when balanced equally encompass a framework of understanding to Maori wellbeing.

Another important aspect to Maori is an awareness of a person’s identity and this is often stated in a pepeha (introducing a person’s identity) by asking, ‘where are you from’ rather than ‘what is your name.’ Maori identity is based upon an ancestral waka (canoe) a physical landmark or maunga (mountain), a body of water awa (river), moana (sea) and a significant tupuna (ancestor). Once this is known people can share a commonality of whakapapa (geneology) and whakawhanaungatanga. Bishop (1996) states

> Whakawhanaungatanga literally means relationship by whakapapa that is blood linked relationships. Whakawhanaungatanga is the process of establishing relationships which literally is by means of identifying through culturally appropriate means, your bodily linkage, your engagement and your connectedness and therefore an unspoken commitment to other people. (p. 215)

As a Maori nurse I have experienced in practice those tangata whaiora who connect with their nurse by identifying cohesive links by whakapapa. This process has positive results on the tangata whaiora when building a rapport and entrusting the care and management of the tangata whaiora and practitioner as working together to achieve the best outcomes.
Webby (2001) states “developing safe nursing practice for Maori requires ways of knowing, Maori mental health nurses must be given the ability to create their own practice to best meet the needs of tangata whaiora” (p. 16). It was later in Sidney’s journey that he would experience a kaupapa Maori mental health service and the ability to have choices with his multidisciplinary team of Maori mental health professionals.

While indigenous people have their own unique individual cultural identity, they share similarities in spiritual connection to Papatuanuku (earth mother) and Ranginui (sky father). Folklore defines one’s cultural identity through story. These stories may be in the experiences of struggles, resistance and disadvantages of indigenous people.

International literature indicates indigenous peoples share a commonality of disparities in healthcare, unemployment, inadequate housing and education (Foliaki & Pearce, 2003; Ring & Brown, 2003). Sidney’s story reflects similarities to that of other indigenous people.

**Indigenous people’s health**

In 2000 a group of indigenous people worldwide attended a ‘Like minds, Like mine’ mental health conference in Wellington. Throughout the conference there were themes of poor mental health status, poor social and economical situation, and the dispossession of people from their land. Holland (1992) notes

> The past 200 years of history leaves memories of tragic outcomes for Aboriginal people, which are major contributions to compound grief. These issues need to be dealt with in the context of a grief framework to examine the effects of loss and sorrow. (p. 14)

The impact on the mental health of indigenous peoples has led to experiences of disadvantage and unequal position in society. Wallen (1992) also notes that the standards of health of indigenous peoples show both differences and similarities.

In Australia, in regard to aboriginal experiences of mental health status, Brown (2001) states “aboriginal peoples life journey has been fraught with many crises, which are evidenced by crises such a loss of identity, of culture, of land, of social structure, of hunting grounds, of citizenship and of language” (p 35).
For the First Nation people of Indian descent in North America, health surveys show high rates of suicide, mortality, depression and substance abuse. Johnson and Cameron (2001) also state “barriers to provide effective mental health service to American Indians has been the culture of the clinician and understanding of person, socio cultural factors, resources, diagnosis, treatment, symptoms and appropriate frameworks and services to work with first nation people” (p. 215). The American Indian movement (AIM) is a political organisation which started in 1968. A Mohawk elder, Hall (1973, para. 1) comments

AIM is one voice of American Indians that have pledged to fight white mans injustice to Indians, his oppression, persecution, discrimination and malfeasance in the handling of Indian affairs. AIM shall be there to help the native people regain human rights and achieve restitution and restoration.

Maori are distinguished by the Treaty of Waitangi as a means of providing protection to Maori. However differences remain with other indigenous peoples who may not be protected by treaties. The similarity for Maori to the movement of AIM has been formed from the injustices, discrimination and oppression experiences of indigenous people. Johnson and Cameron (2001) note that like most indigenous populations throughout the world who have undergone innumerable cultural changes, the mental health care needs of First Nation people have experienced disproportionate similarities with indigenous peoples’ health status worldwide.

Literature by Ring and Brown (2003), and Young (2003), note indigenous peoples need to be actively supported on a global level. The socioeconomic factors that have been imposed on indigenous people remain in higher disproportion to non indigenous people hence Maori and indigenous health status remains a priority.

The three key elements that summarise this section are the political activism by both Maori and indigenous people worldwide, a raised awareness of the issues of similarities in health, and socioeconomic effects faced by Maori and other indigenous people and the need to improve health, education and delivery to Maori and indigenous peoples which still rate poorly in health statistics.
The similarities between Maori and other indigenous people’s colonial histories and power structures are evident in literature. The need to change in the United States, Canadian, Australia and Aotearoa to improve indigenous health status remains a priority.

In the next section is a discussion of a new innovative approach to mental health delivery, the Mental Healthline. This service has shown to be an effective tool in delivery of healthcare to Maori. Telemedicine and telenursing may also be of benefit to other indigenous peoples.

**Section Six: The speciality area of mental health telenursing**

**Background to telemedicine**

It is through discussing Sidney’s story and poor access to services that I look at the technology of telenursing. This technology is accessible to Maori and lacks any of the historical barriers related to other forms of service. Now that my brother Sidney is living in the community his primary tool for communication is the telephone.

The history of telemedicine and the idea of performing medical examinations and evaluations through the telecommunication networks developed in Norway. In the article, *Help for Ships*, (n.d., para.1) states “telemedicine dates back to the 1920s, during this time radios were used to link physicians standing watch at shore stations to assist ships at sea that had medical emergencies.” This contact is the first known use of telephone and medicine providing assistance of health care to people.

Further the article *History and Recent Developments* (n.d., para.2) notes “it wasn’t until the 1950s, under the pioneering efforts of Dr. Cecil Wittson and staff at the Nebraska psychiatric institute, that telemedicine was used in the field of mental health.” Wilson and Cullen (2001) add “the telephone has a long and honourable history in the provision of health services, particularly telepsychiatry which has been used for over 40 years in the United States of America and Australia, offered as a response to the remoteness of some communities and the difficulties in providing face-to-face services to these areas” (p. 351).

During the 1960s further expansion in both telepsychiatry and telemedicine was to be made in America. Darkins and Cary (2000) state “telecommunication technologies are
changing ways of thinking, acting and communication throughout the world, the new age is dawning” (p. 1). Technology has made it possible for psychiatrists to observe both the physical and emotional states of a person without invading the individual’s personal space. For example, in History and Recent Developments (n.d., para.8) doctors “reported that communication with adolescents, children and certain patients with schizophrenia, was easier than the conventional face-to-face interview process. For the first time, the technology was said to be more effective with these groups than the established best practice model.” What makes telenursing unique is the amalgamation of technology with medicine.

Coleman (1997) states “telephone triage is a new developing and controversial field of care, it involves prioritising clients health problems according to their urgency, educating and advising clients and making safe, effective and appropriate decisions” (p. 227).

**Telenursing in Aotearoa/New Zealand**

The Ministry of Health (2004) reports that all of New Zealand will have free access nationwide to health information by phone line by June 2005. International research indicates healthcare advice through telephone triage technology and clinical expertise is an effective way to access information about health services and delivery (Morrison, Hull and Shephard, 2000; Williams, Crouch, & Dale, 1995; Wilson and Cullen, 2001).

The history of telenursing for Aotearoa commenced with Plunketline in 1994, this operated as a 24 hour toll free telephone advice service. In 2000 Healthline was established followed by the Mental Healthline in 2002. Recently in 2004 the Meningococcal Line become operational and Plunketline have since amalgamated. Currently a telenursing service in Auckland is under development providing national healthcare coverage throughout New Zealand. The Mental Healthline which commenced as a pilot has since remained operational.

**Mental Healthline**

In 2001 a group of health professionals, providers and clients were involved in a study to set up a mental health telenursing service, in conjunction with the Ministry of Health and a private provider, Mckesson New Zealand Limited. The Mental Healthline provides three District Health Boards with mental health telenursing delivery.
The Mental Healthline was launched in 2002 and Coombes (2002) states the objective is “to provide a safe, effective and flexible service that improves the ease and timeliness with which clients can access mental health services and information” (p. 4). This service has the potential to provide an innovative approach through the application of software telephony and mental health expertise. This software programme Healthcare Management System (HMS) collates client records and provides a clinical database for management of calls. The software package has been customised to mental health terminology in New Zealand. Sharpe (2001) describes telenursing as “nursing practice in cyberspace” (p. 2) and this image portrays nurses in the health industry of the future.

The Mental Healthline has clinical care coordinators to provide triage, referral and general mental health information to callers. The clinical documentation is a compilation of the following; callers presenting concerns, risk status and establishing suicidal intention or ideation. A mental status examination is included by establishing behaviour, orientation, thoughts, affect, mood and insight. Another process such as triage is utilised to perform a non-diagnostic systematic assessment of client symptoms in order to determine the appropriate level of priority care to either emergency service, urgent care, speaking to the service provider or at the lesser level, recommendations of self care. Coombes (2002) adds “this improves the percentage of mental health callers who are directed to the correct service, thereby reducing the incidence of inappropriate calls to mental health services” (p. 4).

**Maori callers to telenursing**

The Mental Healthline provides services to three district health board. Of the three District Health Boards, Coombes (2002) states “Waikato represented the highest Maori per total population” (p. 5). This finding could provide a basis for possible research of the need of access to service delivery for Maori in this area. As discussed in previous sections poor Maori mental health status remains a health sector priority, this includes Maori access to mental health delivery (Pomare et al, 1995; Durie, 2001).

It is through interweaving Sidney’s story and the experiences of my whanau of mental health service delivery that I highlight the situation of Maori health status, Maori socioeconomic realities and poor delivery of mental health to Maori. Earlier, Sidney’s story discussed the cultural, environmental, attitudes and barriers that family have encountered in mental health.
Literature suggests that the use of technology and clinical expertise in telenursing effectively bridges the gap of poor health status between people by providing access to services, breaking the social barriers and encouraging the utilisation of support and availability of mental health information (St George et al, 2003; Williams, Crouch and Dale, 1995). Sharpe (2001) states

Currently, the focus is on the use of such information technology to deliver a wide array of health care services, supportive resources, and education to patients, their caregivers and health care practitioners in remote areas, or in areas with low ratios of practitioners in various clinical settings, hospitals or other health care facilities. It is an application of technology that is intended to provide the best possible nursing and medical care to those who are now the most underserved and the most disadvantaged, by distance, accessibility, socioeconomic status, age or education. (p. 2)

Sidney’s story is an exemplar of the social, cultural, attitudinal and environmental barriers that need to be overcome. Literature by (Darkins & Cary, 2000; Wilson & Cullen, 2001) suggest telenursing overcomes such barriers as the clinician’s decision making which does not rely upon visual cues in deciding on the client’s behaviour or culture and this reduces the clinician’s ability to misrepresent information based on client’s presentation and culture. Erdman (2001) adds

Cultural differences in emotional expression and social behaviour can be misinterpreted as impairment if clinicians are not sensitive to the cultural context and meaning of exhibited symptoms. Moreover among adults evidence suggest that persons from minority backgrounds are less likely than Caucasians to seek outpatient treatment in the mental health sector. (p. 562)

These further highlight the clinicians need to articulate information and decision making on triage without the use of body expression. This encourages the clinician to take responsibility in clinical decision making and not judge a client’s culture, ethnic origin, difference or social circumstance.

Literature by St George et al (2003) reports “Healthline is being used for health advice by Maori and appears to be accessible as it is for non-Maori” (p. 261). This indicates telenursing has the opportunity to further encourage Maori to access services. However
further research into Maori accessing Mental Healthline would provide evidence of Maori access to mental health services. Mental Healthline translates well toward delivery for Maori by overcoming the geographical barriers of service delivery and providing positive outcomes which defy social and cultural barriers.

However, there are also areas which necessitate improvement to enable Mental Healthline to be fully effective for Maori. These are discussed and recommendations are provided to highlight Mental Healthline as a factor toward positive outcomes in health delivery to Maori.

To summarise this report highlights further research is needed on Maori access, information and support in mental health service delivery to reduce the high rates of poor Maori mental health status which remains a priority today.

Telemedicine has developed from its initial service for shipping to today’s advanced services offering callers access to health professionals and health services. Telenursing uses software technology and clinical expertise to allow the triage of all calls and referral to appropriate services. The Mental Healthline commenced to provide easier, faster, responses to callers accessing mental health services and professionals.

As discussed in previous sections and shown in the literature Maori mental health status, Maori socioeconomic realities and mental health delivery for Maori remain health sector priorities. Statistical data reveals the highest usage area per total population of Maori mental health delivery is the Waikato district, therefore indicating further research is required to establish evidence of the access rate of Maori to Mental Healthline (Coombes, 2002).

Healthline has shown that Maori are accessing telenursing. Telenursing relates well toward overcoming the social, cultural and geographical barriers of people who are disadvantaged. Mental Healthline is pivotal to improving Maori health. However, improvements are required for Mental Healthline to effectively provide mental health delivery to Maori. The final section of this report concludes with a discussion, followed by recommendations to consider improved health delivery to Maori.
Section Seven

Discussion

At the beginning of this project my questions were how has mental health delivery changed over the period of Sidney’s journey of thirty years in mental health, and how mental health delivery in nursing could be improved to Maori. In answering these questions I hope to promote a better understanding of the issues faced by Maori tangata whaiora and whanau experiences with mental health delivery for mental health nurses. My second question is how mental health delivery in nursing could be improved to Maori. I have found from this project that it doesn’t matter what service, delivery or technology is envisioned, the three core elements required to provide optimum solutions for improvement in Maori health and wellbeing is kaupapa Maori health service delivery represented by iwi, secondly Maori health professionals and recruitment and lastly Maori health frameworks.

This project shows that Maori mental health status, Maori socioeconomic realities and delivery of mental health to Maori remain key health priority areas. Interweaved throughout this project are reflective accounts of Sidney’s journey in mental health over thirty years and the barriers which my whanau experienced. The background of Nevel and Pirihira influences reveals the colonisation of Maori and the effects of socioeconomic realities of rural Maori in the 1950s. It also reveals the pressures they faced on transition to urban society and also the opportunities to improve their lifestyle. This transition meant new demands on Nevel and Pirihira’s cultural and environmental circumstances and this is reflected in Sidney’s story.

Sidney appeared to be achieving well as a young adolescent. However the pressure and demands of culture, environment and developmental stages soon become a catalyst for Sidney becoming unwell. Sidney’s hospital experiences of treatment and care based on the biomedical model, conflicts and discrimination are discussed. After seventeen years of institutionalisation Sidney experienced a kaupapa Maori approach, and regained his confidence in his cultural perspective and environment. He was enabled to refocus on his wellbeing. Sidney faced many new challenges as he moved to community-focused care. It is here where Sidney learnt to adjust to a new sense of freedom and a lifestyle. Sidney’s journey in mental health also reveals my whanau experiences of the challenges and barriers in the stigmatisation of mental illness. These encounters show the poor
response to access, information, treatment and care for Maori. This situation combined with poor support networks and outdated attitudes of mental health nurses to Maori became significant barriers for whanau. These barriers in the 1970s that client and family experienced have since progressed today to now incorporate participation of the client and family into management of care.

This story reflects my cultural, personal and professional perspectives. I reflect on those challenges and conflicts in regard to the poor response to service delivery to Maori. This journey also highlights the pivotal factors to providing positive response to service delivery to Maori, by utilizing a kaupapa Maori approach. A renaissance in the 1980s of Maori activism originates from the disparities of Maori both socially and economically due to colonisation. This expression of activism enables Maori people to regain their dignity and to provide improvement in the socioeconomic needs of Maori. Other indigenous people also share similar experiences both in cultural perspectives and colonial histories. A change in the 1990s with the introduction of Mental Health Act (1992) highlights patient rights to care and autonomy. Augmented into mental health policy is the Treaty of Waitangi and cultural safety. Cultural safety is internationally recognized and is implemented as a competency in nursing standards of practice.

Service delivery from a kaupapa Maori approach, the recruitment of Maori mental health professionals and Maori health frameworks tailored toward cultural perspectives of Maori, demonstrate this to be effective health delivery for Maori.

In answer to the second question how mental health delivery in nursing could be improved to Maori I discussed new modes of health service delivery such as mental health telenursing. In 2002, the Mental Healthline was launched which combines software, telephony with mental health expertise. Telenursing crosses the social, cultural and geographical barriers often experienced by people who are disadvantaged, indicating this service could improve health delivery to Maori. Research in Healthline supports that Maori are accessing telenursing. Also identified is the need for research to be undertaken by Mental Healthline of the access and support required for Maori to mental health services.

At the beginning of this project I explained a metaphor as three paua on the rock of life. This has represented three core elements required to improve Maori health and wellbeing these are access, information, and support. In concluding this project I have proposed a
vision to be considered as recommendations for the future improvement of health delivery to Maori.

**Recommendations**

In tracing Sidney’s story and my whanau experiences in mental health services over the past thirty years it has become obvious to me that there are core elements required to provide optimum solution for improving Maori health. Review of the literature and my own experience as a Maori mental health nurse, indicate telenursing is a means of crossing the social, cultural and geographical barriers. However, mental healthline research could provide further evidence of mental health telenursing access, information and support for Maori. Sidney’s story and whanau experiences of mainstream mental health and kaupapa Maori service delivery to Maori, indicates kaupapa services as the core effective factor of delivery to Maori. Therefore, my vision for the future wellbeing and health to Maori could possibly be a nationwide Maori Healthline.

I envisage the Maori Healthline as titled Whanau Healthline, ‘Waea Whaiora Whanau’ which could encompass whanau, hapu and iwi health. This service could provide healthcare to Maori from tamariki (children), rangatahi (adolescent) and kaumatua (elder) this could address the health priorities of child, adolescence, adulthood and elderly health. Maori healthline possibly could be amalgamated with all disciplines of health expertise such as plunket, mental and medical healthcare.

Maori healthline could encompass three core elements essential to improving health outcomes such as a kaupapa healthline service with iwi representation, recruitment of Maori staff including cultural training, Maori software tools, and Maori research. This is how I envision it:

**Maori healthline service and iwi representation**
A kaupapa healthline service will ensure tikanga approach and establish appropriate healthcare delivery to Maori whanau, hapu and iwi.

**Maori staff recruitment and cultural training**
This service would recruit Maori and non-Maori staff that will provide cultural and professional expertise of Maori. Telenursing training would include cultural safety, cultural competencies and cultural linguistics.
Maori software and Maori research

Existing healthcare management software to operate effectively could be modified to reflect the needs of Maori by designing a triage in Maori terminology and linguistics including data of hapu and iwi to establish tribal affiliations. Maori health frameworks would define the healthcare database.

Further Maori research is required as this will provide factual evidence to the health status and health delivery to Maori. A Maori database would establish evidence of access, information and satisfaction of health delivery to Maori.

Conclusion

In concluding, the problems of this world are global, be it political, social, economical, pollution, illness, crime, war, wealth or poverty. Mental illness affects the wealthy and those in poverty, illness is in every society, race, colour and creed. Mental illness affects all cultures and status. Mental illness affects anyone at any place or at any time.

It is how we cope with this that matters. Some may say the difference is wealthy people survive by money and power. Some say the poor in society become rich by surviving on spirituality. No matter what eventuates, each individual is responsible to remember to reconnect to their own source of being. Be it religious, spiritual or not at all. It is about each person reconnecting to your own whakapono (faith) and (tumanako) hope. Ko te mea nui, ko te aroha (but the greatest gift of all is love).

It is my hope that this story will remind mental health nurses and health professionals of the political, social, economical context of Maori both from historical and contemporary views. This story is for mental health nurses to identify their power relations, be proactive in cultural safety competencies, and to be aware of attitudes in practice. Nurses can create positive change in healthcare for Maori or those of difference, ethnic origin, same sex orientation, religious belief and aged. This story is about nurses empowering tangata whaiora and whanau into an equal partnership relationship of care.

Finally, Sidney recently celebrated his 50th birthday and he now lives independently in the community with support from a mental health team. Sidney lives a full life and he works part time. He manages his daily living routines well and regularly attends a gym. Sidney has a sociable demeanour and contributes to whanau occasions. Sidney participates in kapahaka events and is currently learning te reo Maori by watching Maori
television. Sidney is a valuable asset to our whanau and an inspiration to those in the recovery journey. I asked Sidney how he saw his life today to which he replied, “I still feel young.”

Figure 15: Sidney Neilson (Bro)
Source: Neilson-Hornblow, 2004
Appendix
Appendix one
Kia ora koutou whanau

I am completing a Master of Arts (Applied) in Nursing at Victoria University of Wellington, and I am writing to ask you to consider participation in a reflective narrative research project as partial fulfilment of the requirements to complete the above degree.

The purpose of this project is to describe my journey and that of my whanau background through the changes and the experience of a whanau member involved in mental health service delivery from the 1970s through to this present day.

For the purposes of this paper several criteria are required. Firstly, your name or a pseudo-name is allowed to be published in this project. Secondly any reflective information and personal communication relating to the above project may be required could be collected and published. At any stage of this project you can withdraw any of your information at any time and no questions will be asked.

The information you provide will not be used for any other purposes or released to others without your written consent. If you are willing to participate, please read the whanau information sheet and then sign the attached consent form. If you have any further enquiries about this project, please contact,

Cherene Neilson-Hornblow
Web: www.myplace.co.nz
Email: Cherene@myplace.co.nz

or

Thelma Puckey
Victoria University Lecturer and Supervisor
Graduate School of Nursing & Midwifery
Victoria University, Wellington, New Zealand
Email: Thelma.Puckey@vuw.ac.nz

Naku na
Cherene Neilson-Hornblow
Consent Form

1. We/I have read and understand the information and I have had the opportunity to discuss this project with the researcher.
2. We/I am satisfied with the answers I have been given and have understood an explanation of this project.
3. We/I understand that my name well be written into this project or the option of a pseudo name would be available if required. We/I will circle which option you prefer ie: name or pseudo
4. We/I understand that this project should not be harmful to my dignity and maintained by the researcher and supervisor.
5. We/I understand that I can withdraw any information at anytime and no questions will be asked.
6. We/I understand that the verbal communication I will provide will not be used for any other purposes or released to others unless written consent has been obtained from me.
7. We/I have had time to consider whether to take part. We/I know whom to contact if I have any concerns or have any questions about this project.
8. We/ I understand that this present project is for educational purposes only and is part of a research paper submitted to the Victoria University of Wellington in partial fulfilment of the requirements for the degree of Master of Arts (Applied) In Nursing. This course is endorsed and has been approved by the Graduate School of Nursing & Midwifery at Victoria University, Wellington.
We/I ______________________________ (full name) hereby consent for my name or pseudo name to be in this research project/ I consent also for any verbal communication to be used in this project

We/I, ______________________________ (full name) hereby consent for my name or pseudo name as a whanau representative to take part in this project.

Signature ________________   Signature ________________
Date ________________   Date ________________

Researcher:
Cherene Neilson-Hornblow
Clinical Care Coordinator
Mckesson New Zealand Limited
125 The Terrace, Wellington

Research project was explained by:

Name: ______________________________
Signature: ___________________________
Date: ______________________________
References


