Witness Name: Leota Dr. Lisi Kalisi Petaia

Statement No.: WITN0659001

Dated: 12.07.2021

ROYAL COMMISSION OF INQUIRY INTO ABUSE IN CARE

EXPERT WITNESS STATEMENT FOR LEOTA DR. LISI KALISI PETAIA

I, Leota Dr. Lisi Kalisi Petaia, will say as follows: -

ACKNOWLEDGEMENTS

1. I would like to firstly acknowledge and honour the survivors who provided their consent to disclose their statements to me, as an expert witness. I have had the privilege of reading their stories. I thank them for their courage to tell their stories, which has helped shape our understanding of the past, so that appropriate measures are put in place to prevent their repetition in future.

2. I also wish to pay tribute to the many silent people who, for various reasons, are not able to tell their stories. I have met many of these survivors in prison, in my capacity as a psychiatrist. Their mistreatment and abuse in State Care was part of their almost inevitable trajectory to prison.

3. It is an honour and privilege for me to share my opinion, through this statement, in the hope that this may assist the Commission's important work.

4. Ou te mua'i fa'atalofa atu i le agaga faáaloalo i a outou Afioga (Panel of Commissioners) aemaise lau Afioga, Aliimuamua LeVa'a Sandra Alofivae; lau

susuga a le tamaitaí loia sinia, ua fai oe ma sui o Tagata Pasefika i lenei galuega taua, ma o se mitamitaga tele lea i tagata Pasefika, ma a'u nei.[1]

INTRODUCTION

5. My full name is Leota Dr. Lisi Kalisi Petaia. Leota is my customary high chief title (matai tamali'i) from Samoa.

6. I am of Samoan and Tongan descent. I was born and raised in Samoa. My maternal grandfather is from Tonga.

7. I left Samoa at the age of 18 to study in New Zealand for a Bachelor of Science: (BSc) majoring in Biology and Chemistry at the University of Waikato. I then attended The University of the South Pacific in Fiji for a Bachelor of Medicine and Bachelor of Surgery (MBBS).

8. At Medical School, I was intrigued by psychiatry because it was challenging with aspects that were different from the pure sciences I was accustomed to. My teacher, Professor Jude Ohare from Nigeria influenced me to take a deeper interest in the subject. I developed a deeper passion for the subject and excelled.

9. After graduating as a doctor, I returned to Samoa to work and in a short space of time, I became Head of Unit for the small, neglected, and poorly resourced Mental Health Unit at the main national hospital. I was faced with the challenge of how to raise awareness and elevate the profile of mental health in the country. I first led an actual facelift for our physical office; got a computer through a foreign donor (JICA) plus internet connection, and built up the morale of our small staff of four (myself and three psychiatric nurses) to have pride in our work.

10. After a few trips abroad to represent Samoa at various forums on mental health, I organised and convened Samoa's Inaugural National Symposium on Mental Health ("the Samoa National Symposium 2003") which brought together country leaders and representatives of a cross section of the community. The

[1] To the commissioners, I greet you with respect and humility. I especially wish to acknowledge Ali'imuamua Le Va'a Commissioner Sandra Alofivae, a leading Samoan lawyer, representing Pacific people in this incredibly meaningful and important line of work. As a matai (chief), as a lawyer and as a woman from our community, Ali'imuamua, I acknowledge your leadership and take pride in your commitment to our people.

symposium led to major reforms such as the National Policy in Mental Health 2005 and the Mental Health Act 2006 (repealing the old law since Independence from NZ Administration, 1962). I left for New Zealand before the completion of these developments due to a rare opportunity to pursue a Fellow in psychiatry. The full report on the Samoa National Symposium 2003 of which I was one of the two co-authors is available online; it is a source of energy and motivation for all my work in mental health, as it is proof I had instigated something from virtually nothing in Samoa, therefore with better resources and expertise available in New Zealand, I truly believe there is so much more good we could do and achieve collectively with all other stakeholders including Government if we have the will for things to happen.

11. I returned to New Zealand and Australia respectively, for specialist training qualifications in Psychiatry through the Royal Australian New Zealand College of Psychiatrists (RANZCP) as affiliated with the University of Otago's Medical School in Christchurch. I subsequently obtained a Certificate in Forensic Psychiatry from the RANZP, and a Post Graduate degree Forensic Science from the Swinburne University of Technology, Melbourne, Australia.

12. I am a medical practitioner and I have been registered with the New Zealand Medical Council since 2004. I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP). I am currently employed as a Consultant Forensic Psychiatrist by Waitemata District Health Board based at the Regional Forensic Psychiatry Services at the Mason Clinic in Auckland.

13. I also work with Pasifika communities in my own time, I provide mental health support for teachers and parents at low decile schools. I am an Honorary Senior Lecturer for The Department of Psychological Medicine at the University of Auckland. I have been and continuing to be a guest lecturer at the University of Otago and the National University of Samoa respectively, teaching Pacific Mental Health to medical students. I have mentored and supervised medical students and junior doctors of many different races including Maori and Pasifika. I have presented locally and internationally on psychiatry and I have authored and co-authored papers and articles in the area of Pacific mental health.

14. I belong to large extended families, both Samoan and Tongan and am involved with various cultural affiliations and family activities throughout each year.

15. I serve my church and the community through various leadership roles;

    a) Inaugural President of the Pacific Islands Mental Health Professional Association (PIMHPA) in Aotearoa New Zealand;

    b) Director for Petaia Medical Services Ltd; and the Le Toloa Ltd, respectively - private companies involved with Mental Health services;

    c) Convener of Social Committee & Fundraisings for the Manurewa Methodist Church.

16. I have also received awards throughout my studies and career;

    a) Gold Medallist in Psychiatry in my undergraduate medical degree.

    b) The inaugural recipient of the Les Ding Award in Recognition of Clinical Excellence & Professionalism in Psychiatry 2012; Department of Psychological Medicine, University of Otago;

    c) Recipient of the Best Teacher Award for the Auckland Psychiatric Registrar Training Program 2016;

    d) Winner of the Dawn Short Trust Prize for Best Paper presented at the RANZCP New Zealand National Office Conference by a consultant within 5 years of achieving Fellowship.

TRAINING TO BECOME A PSYCHIATRIST

17. My training was broadly mono-cultural, based on robust European university systems of learning and assessment. The learning was based on a strictly western scientific framework. The development of cultural awareness amongst graduates was an issue left to the individual students' discretion. This was often dependant on their exposure to the norms and nuances of their own ethnic backgrounds and/or awareness of the cultural, philosophical and psychological sensitivities of other people.

18. Prior to the 1970s, it was very difficult for women in general to become doctors, let alone to specialise in any specific field of medicine. I was fortunate to have been able to enter medicine in the early 1990s with several other women, but like in most areas of medicine, the consultants in psychiatry were mostly men.

19. Psychiatry was not a popular career choice among medical students for several reasons. The stigma traditionally associated with mental illness has played a large role in the shortage of psychiatrists in New Zealand over many years.

20. To become a psychiatrist, one must first complete six years of medical training to become a doctor, and then two years as a house surgeon (a supervised junior doctor). You can then decide to start a specialist training program such as the psychiatric training as a psychiatric registrar. Young doctors must be eligible to apply to be accepted into a specialist training program because there are limited opportunities. It was a difficult screening process that I went through to be accepted. However, my entry into the training program meant the start of a difficult and strenuous journey requiring one to pass, what seemed to me at the time, to be impossible exams. I managed in the end with a lot of hard work and invaluable support from my supervisors, mentor psychiatrists, senior colleagues and specialists.

21. Psychiatric registrar specialist training takes another five years or more (post basic medical qualification) and not every candidate completes it. This is followed by two years of subspecialty training, for instance in forensic psychiatry it takes roughly 13 to 15 years or more of training to become a fully qualified psychiatrist.

22. I did my basic psychiatric training in Christchurch and my subspecialty training in Forensics in Auckland. I was very fortunate to have been trained and supervised by some of the best minds in psychiatry in New Zealand. I received a lot of support and supervision throughout my professional training.

23. The training institutions therefore have a moral responsibility to focus on cultural competency training of mental health professionals and this must be included as part of their formal curriculum. There is good evidence that increasing cultural knowledge will improve the performance of practitioners. Cultural training is needed and necessary given our diversity of society in New Zealand. We need to be open minded about others' ideas and be willing to appreciate the benefit of diverse perspectives.

24. There has been a recent increase in the number of medical students entering into psychiatry training. There are several reasons for this surge including the awareness of the interesting nature of the field, growing interest in science like

genetic biomarkers involved in psychiatric diagnoses, newer medication, and improved training with more evidence-based interventions over time.

25. I am aware that there is currently some effort being put into Maori and Pacific cultural perspectives in mental health training, however I consider that this is far from adequate considering the significant health inequities and the high prevalence of mental disorders in Maori and Pacific populations. Research shows that socio-economic, political, and cultural factors influence the epidemiology of illness and the availability of services. If this context is continually ignored, then treatment and care will continue to be compromised.

TRAINING AS A PACIFIC WOMAN IN PSYCHIATRY

26. There was no other Pacific or Maori psychiatric registrar in our cohort of registrar trainees in Christchurch.

27. The Christchurch psychiatric training program is one of the best in Australasia, and I consider myself very lucky to have been trained there. Being the only Pacific psychiatric registrar, I am forever grateful for the support I received from my palagi supervisors and colleagues within that training program.

28. I appreciated the complexity and the biopsychosocial nature of mental illness and the depth of the clinical treatments, various types of medications, ECT, and treatment of physical co-morbidity, provided by the multidisciplinary team of mental health professionals including psychiatrists, psychologists, psychiatric nurses, social workers, occupational therapists, and cultural workers.

29. Major categories of severe mental disorders exist in all cultures and share similar core psychopathological features. Pacific people suffer from serious mental illnesses including but not limited to schizophrenia, depression, bipolar affective disorder and anxiety. When these illnesses are identified and treated appropriately in a timely manner, Pacific people can make good recovery. Pacific people should not be deprived of good treatment and overall mental health care.

30. I had to unlearn a lot of my own Samoan cultural ways to fit in and to survive the pressure of training in the mono-cultural western way. I learnt a lot about the palagi culture by immersing myself in the palagi way of life; whilst at the same time maintaining my own cultural identity through active involvement with the church, my extended family, and the Pacific community in Christchurch.

31. During clinical work, I experienced culture shock on many levels. This was particularly evident when working with patients and families in New Zealand There was an obvious difference in perspectives and the values that people uphold. For instance, Pacific patients are usually accompanied by their families to hospital and normally want their families to be involved in their care. Pacific families also want to know about what is happening and how they can be involved in the care of their family member. This can be traced back to core Pacific values and the collective, communal and inclusive nature of many Pacific communities.

32. In my experience, palagi patients tend to prefer their privacy as they are more individualistic in their views. This is an important difference that clinicians need to understand when dealing with Pacific people in health. Clinicians should consider involving Pacific families in care plans unless absolutely contraindicated and not in the patient's best interest.

33. According to the New Zealand Medical Council, cultural misunderstanding and unconscious bias have contributed to the poor state of Pacific health.

34. Transcultural psychiatry was developed in the late 1990s and examined the role of culture in the development and treatment of mental illness, and the design of mental health services, responsive to a diversity of needs. This discipline has come from the recognition that mental illness is experienced, expressed and treated within a particular cultural and social context.

35. In my experience, there is minimal focus on cultural training in both basic medical and specialist psychiatric training. There is a huge gap in cultural training and the application of cultural concepts in clinical practice. In my professional view as a Pacific psychiatrist, this lack of cultural emphasis in training is a major contributing factor to poor engagement of patients and their families, contributing to poor health outcomes.

36. Possessing knowledge is not enough, because a person can be very knowledgeable but remain racist and dogmatic. Having open discussions and looking at different perspectives and models of care is a good start so that we can examine what we can do together to improve outcomes in vulnerable population groups. A genuinely collaborative working relationship with a Pacific

or Maori cultural service is an authentic way of learning about the perspectives of these communities.

37. For example, I voluntarily attached myself to the Maori mental health service within the Canterbury DHB as I wanted to learn more about the Maori culture to enhance my cultural awareness and ability to work successfully and respectfully with Maori patients. This was an excellent learning experience which I undertook at Pukenga Atawhai specialist mental health services in Christchurch. I learnt about Maori history, worldviews and models of health. This experience helped me understand how to relate to Maori patients and their families.

WORKING WITH PACIFIC FAMILIES IN A MENTAL HEALTH SERVICE

38. I would like to preface this part of my statement by acknowledging that much of what I will touch on regarding Pacific demographics, health outcomes and other indicators of deprivation have been well researched and are commonly acknowledged both within and outside our communities. However, I understand that arguably I am the only Samoan Forensic Psychiatrist in the world, and it is in this unique capacity that I add my voice, based on my personal and clinical experience, to the growing body of knowledge around the needs of Pacific people in the mental health sphere.

39. Pacific families are no different from any other family. They, too, need access to better, efficient, more convenient health services, and accountability for results, as promoted by the New Zealand Ministry of Health. According to the New Zealand Medical Council, the New Zealand healthcare system does not always meet the needs of Pacific patients and their families. Even when they actively seek care, Pacific people often do not receive the high quality and timely services that they need. [5]

40. A starting point to providing quality care is understanding what the term 'Pacific' encompasses. In the New Zealand context, 'Pacific' relates to descendants from over twenty different Pacific nations with their own unique languages, cultural values, customs, belief systems, and traditional ways of living. This demonstrates significant diversities between and within Pacific groups. We need to exercise caution in grouping all Pacific people together and making assumptions about 'Pacific' preference. We should be very cautious about using

perceived membership of an ethnic or cultural group as a short cut to acquire knowledge about individual's beliefs, values and needs.

41. However, there are socio-cultural values that are shared by Pacific people including strong extended family relationships, religious beliefs, social inclusion and connection with each other. These factors are real strengths for most Pacific people, arguably because they still have a holistic and communal approach to life, compared to western societies and their individualistic way of living.

42. Pacific peoples' mental health problems are complex as they are often socially disadvantaged through poverty, unemployment, poor education and insecure housing. These are all major contributors to poor health outcomes. When unwell, Pacific people may have difficulties seeing their GPs due to high costs, barriers with language and a lack of transport to attend appointments. These are significant barriers to recovery and improving well-being. In my experience, Pacific people with severe mental illness often prefer to remain under the cloak of the Mental Health Act so that they can access free medication and transport to doctors' appointments.

43. Pacific people have much higher rates of physical co-morbidities such as respiratory problems from chronic smoking, cardiovascular problems from diabetes, high blood pressure, high cholesterol, obesity, complications of alcohol and substance use. This usually leads to poor prognosis of mental illness and low life expectancy compared to other New Zealanders.

44. Language barriers are a common problem. Communicating effectively is a major component of the clinical encounter and is the platform on which patients and clinicians make informed treatment decisions.

45. Pacific people in New Zealand experience limited English proficiency and levels of health literacy. Over 60% of Pacific people are functioning below the level of literacy required to effectively meet the demands of everyday life. The degree of English-language proficiency and acculturation often determines socioeconomic status. Those with limited English proficiency are less likely to receive mental health services if in need than English speaking non-citizens.[2]

46. The stress that Pacific people experience in addition to the acculturation leads to many social, psychological and physical problems. Studies have shown that Pacific people are overrepresented in mental health and criminal systems; they

are predominantly from socially disadvantaged backgrounds with poor education and unemployment. [13] There is robust evidence to show that the under-privileged in society are overrepresented in mental health, courts and criminal services and that environmental adversity is instrumental in the occurrence of several types of psychopathology. Pacific people are more likely to have mental disorders that are underdiagnosed and untreated. [13]

47. Ethnic minority status has been correlated with low socioeconomic status, dysfunctional families, unemployment, and poor educational achievement; each of these factors has been highly correlated with increased rates of offending, mental illness, smoking mortality, alcohol abuse, increased morbidity, lower life expectancy and higher risks of physical health problems. [5] It is little wonder, therefore, that people of minority ethnicity, such as Pacific people, are over-represented in hospital and prison settings. Overall care for Pacific patients clearly requires attention to the social determinants of disadvantage.

48. Despite all these difficulties, the strong communal values that many Pacific people hold are evident in the way families wish to care for their loved ones suffering from mental illness. Pacific patients usually attend appointments with their families. Pacific families are willing to be involved in the care plans and often wish to look after their loved ones at home.

49. Engaging Pacific people using the Pacific cultural values stipulated in the Fonofale Model of care may improve access and compliance with treatment. Pacific peoples' experiences of the health system are influenced by their own perspectives, values, and cultural belief systems. [6] This can be illustrated by the Fonofale Model of Mental Health Care which reflects Pacific cultural values and world views. The Fonofale model was developed in 1995 by Fuimaono Karl Pulotu Endemann and utilises the image of the Samoan fale (house) to include the important domains of family, culture, and spirituality in mental health care. These features are quite different from the mainstream Western paradigm that is predominant in New Zealand.

50. The Fonofale model emphasises Pacific core values in its culture and extended family concept. The main elements consist of family, physical, spiritual, mental, and 'other', which refers to factors that can affect health directly or indirectly (including education, social class, age, employment, gender, and sexual orientation). Pacific cultural values and these domains of health are all important

in maintaining stability and wellbeing of Pacific people. All this is encapsulated in a circle to promote the philosophy of holism and continuity. Distress in one realm leads to the loss of balance in the others. Healing and recovery from mental illness succeeds only if all are addressed. [6]

51. The Fonofale model, for example, would recommend that a cultural worker from the same ethnic group as the patient who can speak the same language should be present during the consultation. Asking about spirituality and encouraging family involvement are important components for Pacific peoples' mental health.

52. Research has shown that health professionals who are familiar with their patient's cultural heritage are likely to offer improved patient care, making cultural competency essential for high quality healthcare. [5]

53. Faleola was a Pacific Community Mental Health Service that used to be part of Counties Manukau DHB in South Auckland. I had the privilege of working at Faleola as a psychiatric registrar in 2012. The service was established to provide care for Pacific people with serious mental illness and complex needs, including young men with a history of being in state care, immigrants from the Pacific Islands with poor English; the unemployed; and those who have a limited education. As a result of their illness they become alienated from their families and often become homeless and socially isolated. Illicit substance use is rife amongst these patients to cope with pain, trauma, exclusion and deprivation, often leading towards repeated escalating criminal offending and incarceration.

54. Faleola used the holistic model of health care stipulated by the Fonofale Model. The staff consisted of Pacific mental health clinicians, a psychiatrist, senior psychiatric nurses, social workers, occupational therapist, a psychologist, and senior cultural workers who were able to deliver services in patient's respective ethnic languages. This multidisciplinary team worked well in terms of looking after this vulnerable group of Pacific people. Their main strength was in engagement of Pacific patients and families in a Pacific way, for example, through use of the patient's native language, acknowledging the spiritual dimension by saying prayers and carrying out their work at peoples' homes. This type of proactive and genuinely collaborative community work however required more time, effort, and commitment from staff and management.

55. In community mental health, continuity of care by building a good therapeutic relationship with families is a key component in the recovery process. Faleola had the advantage of a critical mass of trained Pacific mental health and cultural workers sharing the same philosophy to support and empower them to carry out their work effectively. Psych-education of families about the nature of mental disorders and the need for treatment are important to prevent relapses and frequent hospitalisation.

56. Faleola was dismantled in 2018 as the result of a new re-configuration of mental health services within Counties Manukau DHB. Some of the patients who had been cared for by Faleola for years have since ended up in acute inpatients services, forensic services and prison.

57. Faleola's case in my professional view was a classic example of how patients and their families fall through the cracks during health reforms similar to the Deinstitutionalisation Reform of the 1960s and 1970s. [3] The disestablishment of Faleola also highlighted the differences between goals, expectations and desired outcomes from different perspectives for example, management vs clinicians, with management's focus being on numbers and bottom-lines whilst clinicians' focus is on the quality of patient care. These differences can result in significant conflicts between management and clinicians at the expense of patients.

58. Effective mental health services need to be responsive to the needs of their communities. The closure of Faleola and the dispersing of Pacific mental health clinicians into the mainstream service meant that the cultural philosophy of care that was so carefully cultivated at Faleola was dismantled. In my professional view, this was a classic example of institutional racism playing out in the mental health sphere; "the collective norms and behaviours within organisations that systematically and unwittingly discriminate against those from minority ethnic group, leading to inappropriate care and insensitive practice resulting in dissatisfaction and disengagement". [3]

59. Effective mental health services require leadership, competent clinicians, effective management, adequate policies, and political commitment to ensure the provision of a culturally and clinically appropriate service. In my view, the differences in management and professional goals have contributed to the poor mental health response for Pacific people. This is in addition to chronic

inadequate funding and scarcity of skilled workforce. All these factors have contributed to poor mental health for Pacific people as outlined in the recent *He Ara Oranga* report. [11]

CHALLENGES OF REACHING PACIFIC PEOPLE WITH MENTAL HEALTH ISSUES

60. Pacific people have delayed presentations and poor access to community mental health services. This is due to multiple factors such as, lack of knowledge about mental health, stigma associated with mental illness, bad experience with health services, rushed assessments leading to poor engagement, families not involved, costs, a lack of transport and language barriers. Yet, Pacific people have more admissions to acute inpatient services and utilise forensic services more. Pacific people tend to stay longer in both general mental health psychiatric units and forensic hospitals. [12]

61. In forensic services, Pacific people experiencing severe mental illness are often recognised after they have been convicted and sentenced, rather than being recognised earlier in the court process. This late recognition of Pacific people with serious mental illness can prolong inpatient admission and can be fatal as the Pacific population has a high rate of suicide attempts. [13]

62. Systemic issues include poor engagement with doctors and other clinicians due to time pressures. The "Don't ask, Don't tell" scenario is quite common in these circumstances, resulting in misdiagnosis and an increase in pharmaceutical interventions to manage distress.

63. Community mental health services often have difficulty providing for Pacific people with serious mental illness as these patients' circumstances are often complicated by alcohol and substance abuse, frequent admissions to inpatient units, alienation from family and homelessness. They are often caught up in the criminal justice system.

64. Within service providers, management who are unaware or uninterested in the complex needs of Pacific people may be inflexible around the time and effort required for comprehensive assessment of Pacific patients and their families. Failure to involve Pacific families or significant support people like the church minister, fahu or matai of the family; and seeing Pacific people in inappropriate settings instead of at home or in a familiar environment, can lead to poor engagement, assessments, and management.

ADDRESSING CHALLENGES

65. Mental health education at the community level can increase knowledge and awareness leading to increased access to services. Community understanding of mental health and illness is key in changing attitudes towards mental illness. Understanding that mental illness is treatable can increase positive views towards seeking help early. The focus of mental health education should be on early identification of disorders or disease and knowing where to seek help sooner rather than later.

66. When Pacific people do seek help with mental health services, assistance should be provided by skilled staff competent in both cultural and clinical mental health assessment and treatment. Pacific people have the right to engage with a professional who can understand their cultural and clinical needs. They have the right to receive an appropriate intervention for their diagnosis and at a minimum be cared for in a decent, humane, and non-abusive setting.

67. New Zealand's Code of Health and Disability Services Consumers' Rights states that everyone has the "Right to be treated with respect; Right to freedom from discrimination, coercion, harassment and exploitation and the Right to dignity and independence".

68. Utilising holistic Pacific models of care that incorporate Pacific values such as the Fonofale model is crucial to Pacific mental health and well-being. Assessment under such models includes focus on family, spirituality, physical, mental, socioeconomic and cultural context in terms of time and the environment. For example, interviewing Pacific people in their home environment with their families can increase rapport and establish good therapeutic relationships which lead to increased compliance and engagement with services.

69. Family education about the nature of the illness and rationale of treatment increases knowledge, reduces fear, and empowers people to seek help early.

70. Mental health professionals should have mandatory cultural training modules as part of their formal training and Continuing Medical Education (CME).

71. To increase understanding of Pacific people's behaviours, clinicians must learn about Pacific people's history of migration to New Zealand, their values, belief

systems, impact of 'the dawn raids', and why Pacific people are overrepresented in mental health and forensic services.

72. Mental health issues are complex and require a skilled multi-disciplinary team of professionals for example, cultural workers guided by Pacific cultural values and practises who can connect Pacific patients with culturally competent health workers; psychiatrists, psychologists, psychiatric nurses, social workers, occupational therapists, physiotherapists, traditional healers and spiritual leaders. It is important that this team can be easily accessed by patients and their families. The team needs adequate clinical expertise as well as a deep understanding of the cultural context and social environment in which their patients live.

73. Clinician attachment to Pacific Services would be a good opportunity for clinicians to genuinely engage and learn about Pacific cultures and their ways of life.

74. Clinicians must genuinely invest time to actively listen to Pacific patients and their families' stories. Family and group work are ideal for Pacific people. Engagement requires time and genuine effort to develop therapeutic relationships with patients and their families.

75. Service provider management must understand what constitutes quality mental health care for Pacific people and allocate adequate and appropriate training and resources to improve patient outcome. Only paying lip service to improving Pacific mental health will continue to worsen outcomes over the coming decades.

DEVELOPING MENTAL HEALTH SERVICES FOR PACIFIC COMMUNITIES

76. In New Zealand, little is known about Pacific people's mental health. *Te Rau Hinengaro: The New Zealand Mental Health Survey*, was the first national community-based epidemiological study to investigate the rates of mental disorder and consider the severity and co-morbidity of mental disorders and help-seeking behaviours reported by ethnicity. [7]

77. The study showed a high prevalence of serious mental disorders and comorbidities in the Pacific population. For instance, 24% of Pacific people experienced mental distress compared to only 19% of the general New Zealand population. Yet only 25% of Pacific people with mental illness received

treatment from addiction and mental health services, compared to 58% of those with mental illness in the general New Zealand population. [7]

78. *Te Rau Hinengaro* also found that Pacific people who were born in New Zealand had a two-fold increased prevalence rate (31%) of any mental health disorder, compared with only 15% of Pacific people who migrated to New Zealand after the age of 18. [7] There appears to be a higher risk of developing a mental disorder if one was born in New Zealand. Pacific people who are born and raised in New Zealand experience a different environment to their counterparts from the Pacific Islands. New Zealand born Pacific people may not necessarily share the same cultural views and belief systems with those from Pacific nations, including their own parents. Services must ensure that their approach takes into account the diversity between and within Pacific groups and provides services that are appropriate for all Pacific peoples.

79. The mental health of New Zealand people, in particular Maori and Pacific, is getting worse despite the funds that have been poured into mental health services, and the fact that mental health services have largely been community based over the last two decades. [14]

80. In my professional view, the most appropriate place to start is at the government level, so that people in authority can allocate the resources responsibly where they are most needed to improve outcomes for Pacific mental health. Inverse care law usually prevails, where the availability of good medical or social care tends to vary inversely with the need of the population served.

81. Sir Michael Marmot, Chair of the WHO Commission on the Social Determinants of Health, stated:

> *"The toxic combination of bad policies, economics, and politics is, in large measure responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible. Social injustice is killing people on a grand scale".*

82. The Government via the Ministry of Health for instance, must continue to improve their understanding of the needs of Pacific communities and allocate further resources to improve mental health literacy and prevent poor health at the community level. Programs should be led by Pacific mental health clinicians using their respective Pacific languages.

83. Pacific people are overrepresented in acute mental health and forensic services. Vulnerable Pacific people with serious mental illness are often left untreated in prison in severely distressed states due to the lack of acute beds. This is unethical and a violation of human rights. This is often linked to poor follow up in the community by under-resourced community mental health services. [13]

84. Developing Pacific community mental health services like Faleola in Counties Manukau is vital because any effective mental health service should be responsive to the needs of our most vulnerable populations. Some of these needs are set out in the paragraphs below.

85. There are not enough appropriate rehabilitation beds and housing for people with serious mental illness. This hinders recovery and functioning, resulting in a vicious cycle of partial treatment, non-compliance and readmission to hospital, relapse and potential re-offending leading to imprisonment.

86. Additionally, there is currently a shortage of appropriate alcohol and drug services in the community. Harm minimisation from alcohol and substance use is clearly needed to address mental distress and family violence. Strict government regulations have been recommended by the *He Ara Oranga* report 2019 but are yet to be actioned. [11]

87. Non-governmental organisations involved with Pacific people must be properly evaluated and reviewed for transparency and accountability.

88. Educating families and communities about what constitutes good mental health and what happens when children are exposed to adversity is important. For example, early trauma, alcohol, abuse, neglect and violence cause chronic anxiety and fear leading to inability to concentrate and learn.

89. Families should have easy access to support services; parent groups, social agencies, health, welfare and police when they need them. They should have the contacts and the resources available to them in a timely manner to assist with any social or health issue to avoid unnecessary delay in getting the help they need.

90. Collaboration and partnerships between families and schools/teachers should be encouraged. Programs need to be developed to engage parents and teachers together so that they can discuss and talanoa about their mental health

concerns and work out how to address them with the resources they have available in their community.

91. Community programs in churches, focused on prevention should also be fostered. Effective church programs could play an integral part in looking after the mental health of the adults that children rely on.

DEVELOPING A PACIFIC MENTAL HEALTH SERVICE

92. Pacific cultural values include strong extended family ties, social inclusion, and connection with each other. Of significance to mental health, care for family members suffering from mental illness is often informally provided from within the family and families usually want to be involved in decision making when it comes to care plans. Most Pacific cultures value respect and uphold spiritual faith.

93. Interestingly, the literature shows that individuals with psychotic disorders in developing countries have better outcomes when compared to those from developed countries. [15]

94. Pacific people in New Zealand appear to suffer more mental distress compared to the general population. [7] There are no studies on the prevalence of mental disorders in the Pacific Island nations but from anecdotal experience in the Pacific Island countries, there appear to be strengths within traditional Pacific societies that contribute to improved well-being and better outcomes in individuals with mental illness. [4] Pacific societal, cultural values and strengths should therefore be considered when designing mental health services for these communities.

95. Pacific people should not be deprived of medical treatment for mental illness. For example, antipsychotic medication is the mainstay of treatment for psychosis. Adequate treatment will mitigate risks to the individual (deliberate self-harm or suicide) and to others (hostility, aggression and violence). These symptoms are common sequelae of untreated mental illness.

CARING FOR PACIFIC PATIENTS

96. When it comes to illness, care for the sick is paramount regardless of ethnicity. The reality for Pacific patients is that they may very rarely be seen by Pacific clinicians. The key to developing and appropriate and effective treatment plan

is performing a good holistic assessment using the Fonofale Model or an equivalent and evaluating cultural identity and language proficiency as a starting point.

97. Treatment should involve utilising multidisciplinary team assessment and interventions where necessary. This should include discussing family support and involvement with the patient. The physical and mental components of effective treatment are inseparable.

98. Adequate time is needed to obtain collateral information after consent is obtained from the patient or an authorised surrogate. You need time to explicitly inquire about the views of members of the patient's family and social network to develop an appropriate treatment plan. Placing the patient in the context of a community will help the patient and their family engage more fully in the treatment process, help the clinician understand their priorities and enhance their care. Psychoeducation of patient and family re: nature of disorder and rationale for long term treatment is crucial in preventing relapses. Assertive medical treatment of common co-morbidities is fundamental, for example, alcohol and substance use must also be taken into account and addressed as part of the holistic treatment. In addition to this, GP and mental health services should work collaboratively to arrange for regular follow up in the community.

TRAINING AND RESOURCES REQUIRED TO ENSURE THAT CULTURALLY APPROPRIATE CARE IS PROVIDED TO PACIFIC PATIENTS

99. To ensure that culturally appropriate care is provided for Pacific patients, there needs to be formal, mandatory, in-depth cultural competency training programs during medical school, registrar training and for consultant continuing medical education (CME). The focus should be on the history of Pacific people in New Zealand, their values and perspectives in relation to health. It would also be helpful to enforce a mandatory placement during training in a Pacific cultural service for at least three to six months.

100. Additionally, clinicians must be encouraged to actively engage with the Pacific community by performing community service in South Auckland, for example, participating in educational programmes on mental health in a church or a school. Furthermore, there must also be a commitment and genuinely collaborative efforts from health professionals to join peer groups with Pacific

mental health clinicians, nurses, and social workers on cases relating to Pacific patients.

REGULATING HEALTH PROFESSIONALS AND ENSURING COMMITMENT TO CULTURAL COMPETENCY

101. The Health Practitioners Competence Assurance Act 2003 reinforces the importance of cultural competence by stating that health professionals are to "set standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct to be observed by health practitioners of the profession".

102. Furthermore, the Royal Australian and New Zealand College of Psychiatrists in relation to the work of the Royal Commission of Inquiry encourages its members to, I quote:

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

b) Commit to developing strategies to reach out to communities which may still feel the impact of past harmful practices, and continually improve them by establishing close relations, dialogue, and partnership.

c) Commit to equipping psychiatrists to be sensitive when dealing with patients affected by harmful practices in the past, and to understand the consequences of traumatic memories in the present.

d) Expect psychiatrists to show leadership, empathy, and understanding regarding past harmful practices, and to support any healing initiatives.

e) Encourage people to openly discuss and acknowledge the past, without any thought of retribution or litigation.

103. This information and more can be found online at www.ranzcp.org. The regulations on upholding cultural competence already exist in the health profession. Ensuring consistent commitment to cultural competence requires collaboration with Pacific and Maori health professionals and mandatory completion of relevant training.

104. The key lies within implementation. No one will take cultural training seriously if it is not mandatory and becomes part of the curriculum and formal training that starts earlier on in medical schools and maintained right through to Continuing Professional Development (CPD).

OTHER SYSTEMIC ISSUES THAT ARE RELEVANT TO PACIFIC PATIENTS

105. Pacific people are overrepresented in acute mental health hospitals, courts, prisons and forensic services. Vulnerable Pacific people in mental health services usually have a history of being abused in state institutions such as prisons, where there is a risk that they are left untreated and therefore left in neglected, degrading, demoralising and severely acute states due to the lack of acute inpatient beds. [10] This is unethical and a violation of human rights. This is often linked to under resourced and underfunded community mental health services. This lack of resourcing leads to poor patient follow up, non-compliance with treatment, frequent relapses, multiple hospital admissions and frequently, to criminal offending. Improving treatment and rehabilitation for those with serious mental illness are critical components of good mental health care. [12]

106. *The Mason Report: A Commission of Inquiry 1988* followed an incident involving a Samoan man, who migrated to New Zealand in the 1960s. He was diagnosed with schizophrenia associated with serious violence. He was refused hospital admission and on the same night, killed two fellow residents at his boarding house and seriously injured two other members of the public.[10] The recommendations of the *Mason Report* focused on establishing forensic mental health services for offenders with serious mental health problems. The *Mason Report* recommended the following:

a) prisoners with mental illness have the same right to access mental health care as anyone else in the population;

b) the health system, rather than corrections, is primarily responsible for the care of mentally ill offenders and

c) cultural understanding and the provision of services in a manner respectful of the person's cultural, spiritual and ethics beliefs, is an essential clinical requirement. [10]

107. Unfortunately, services to meet the demand for acute treatment and rehabilitation of those with serious mental illness have become unsafely stretched largely due to lack of resources.

108. At this juncture, I wish to make a special reference to alcohol use. Alcohol is a common factor identified by many Pacific survivors in their statements to the Abuse In Care Inquiry as being a major trigger for family conflict and violence leading to abuse and neglect. It is a critical barrier to recovery and a contributing factor for poor prognosis.

109. Many Pacific people perceive alcohol use to be the main driver of poor mental health outcomes for their communities. *He Ara Oranga* reported that many Pacific people expressed concern about the ease of access and harmful effects of alcohol, in particular noting the potential for social harm if not tightly controlled. The report specifically mentioned:

> "They talked of our national 'love affair' with alcohol, how alcohol use fuelled their depression and suicidal thoughts or triggered violence and neglect of children. They called for decisive action limiting the sale and promotion of alcohol, particularly around children and young people (including sports sponsorship". [11]

110. Professor Doug Sellman, (Professor of Psychiatry & Addiction Medicine, University of Otago), responded to *He Ara Oranga* stating:

"The Government appears to be completely ignoring the following recommendation of the Mental Health and Addiction Inquiry [to] 'Take a stricter regulatory approach to the sale and supply of alcohol [as] informed by the recommendations from the 2010 Law Commission review, the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship and the 2014 Ministry of Justice report on alcohol pricing.' […] Raising the excise tax on alcohol is the easiest and most effective evidence-based measure a government can undertake to reduce alcohol-related problems; and has been shown to be supported by a majority of New Zealanders. […] To not act at this time with robust alcohol law reform, in particular substantially raising the excise tax on alcohol, risks reducing this Wellbeing Budget to a set of platitudes. […] But even more concerning is that because rationality, international evidence, formal recommendations and majority public support is being ignored, the power of alcohol industry lobbying of our government becomes apparent. This power to subvert alcohol law reform risks making

a mockery of democracy and continues to undermine the reduction of alcohol-related misery and suffering in favour of the greed of powerful vested interests."

111. As mental health clinicians, we encounter harm caused by alcohol and other drugs every day. Alcohol is a significant contributing factor to poor physical and mental health. Alcohol law reform is therefore one of the most effective ways of improving the well-being of all New Zealanders.

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

CONCLUSION & RECCOMENDATIONS

113. It is imperative to reiterate the fact that Pacific people are overrepresented as users of mental health, physical health, and in the criminal justice system. Their poor socio-economic status likely contributes to poor mental well-being and peoples' inability to thrive under social determinants of health such as poor educational achievement, unemployment, homelessness, and poverty.

114. The causes of serious crime include poverty, inequality, alcohol and substance use, exposure to family violence and trauma, and destabilising peer influences. Removing these risk factors removed on a short-term basis, at a population level is no easy feat. However, providing support for the health and wellbeing of parents, vulnerable children and their families might help address the common underlying risk factors as outlined above. This will require strong leadership and political will and a genuinely collaborative approach across successive governments working with Pacific communities.

115. It is crucial that appropriate and adequate mental health interventions are accessible in a timely manner and this requires raising awareness with Pacific families and communities about what services are available. Pacific communities and families also must be made aware about the potential consequences of mental illness remaining unrecognised and untreated, such as serious violent offending.

116. Early identification and assertive treatment of severe mental illness is crucial in reducing fatal outcomes such as violent offending and completed suicide. A holistic approach, including treatment of mental illness, addressing substance use and management of physical health problems, should be integrated into care plans for Pacific people.

117. Culture is fundamental to the causes, course and care of individuals with mental illness. Furthermore, the alignment of services from GP to secondary to tertiary services provided by a skilled workforce competent in both cultural and clinical aspects of management is fundamental to mental health care.

118. Healing from a Pacific perspective requires restoring the balance between all domains of mental well-being including mental health, physical health, spiritual, social and family relationships. All these domains are incorporated into the Fonofale Model, referred to earlier in this brief.

119. My vision for the future is that Pacific people will receive timely, caring, safe, professional clinical and culturally competent mental health services that I could encourage my own loved ones to use, should they need to. These services will be based on an integrated model of Pacific cultural values and clinical care provided by a skilled and competent workforce.

120. Care for those suffering from serious mental illness is a priority. This requires a professional workforce guided by evidence-based medicine that includes patient values, clinical expertise and available empirical evidence. My vision is aspirational, but it is also a work in progress, furthered by important investigative work such as that of the Commission, and opportunities such as this to critically analyse and evaluate current and past services from a Pacific perspective and to bring about change.

121. A list of references is **annexed** to this statement at **"Annexure A"**.

122. A copy of my written consent to use my statement is **annexed** to this statement at "**Annexure B"**.

Statement of Truth

This statement is true to the best of my knowledge and belief and was made by me knowing that it may be used as evidence by the Royal Commission of Inquiry into Abuse in Care.

Signed: GRO-C

Dated: 12.07.2021

Annexure A

1. Statistics New Zealand: Pacific Progress: A Report on the Economic Status of Pacific Peoples in New Zealand. Wellington: Statistics New Zealand, 2014. Available at: http://archive.stats.govt.nz/browse_for_stats/people_and_communities/pacific_peoples/pacific-progress.aspx. Accessed February 10, 2020

2. Ministry of Health: Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018. Wellington: Ministry of Health, 2014. Available at: https://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-andwellbeing-2014-2018. Accessed January 22, 2021

3. Te Ara, the Encyclopedia of New Zealand: Pacific Islands and New Zealand. Available at: http://www.TeAra.govt.nz/en/pacific-islands-and-new-zealand. Accessed January 22, 2021

4. Mulder RT, Petaia L, Pulotu-Endemann FK, et al: Building on the strengths of Pacific mental health: experience from Samoa. Aust New Zealand J Psychiatry 50:397–398, 2016

5. Medical Council of New Zealand: Best Health Outcomes for Pacific Peoples: Practice Implications. Available at: https://members.mauriora.co.nz/best-healthoutcomes-for-pacific-people/. Accessed January 22, 2021

6. Pulotu-Endemann K: Fonofale Model of Health, 2001. Available at: https://d3n8a8pro7vhmx.cloudfront.net/actionpoint/pages/437/attachments/original/1534408956/Fonofalemodelexplanation.pdf?1534408956. Accessed December 6, 2019

7. Te Rau Hinengaro: The New Zealand Mental Health Survey. Edited by Oakley Browne MA, Wells JE, Scott KM. Wellington: Ministry of Health, 2006 Available at: https://www.health.govt.nz/publication/te-rau-hinengaro-new-zealand-mental-healthsurvey.

8. Barwick H: Improving Access to Primary Care for Maori and Pacific Peoples. Literature review commissioned by the Health Funding Authority, 2000 Available at:

https://pdfs.semanticscholar.org/0a35/d28712d33b2598c7e0dc1ee840d997a7d8b9.pdf.

9.Tamasese K, Peteru C, Waldegrave C, Bush A: Ole Taeao Afua, The New Morning: A Qualitative Investigation into Samoan Perspectives on Mental Health and Culturally Appropriate Services. Aust NZ J Psychiatry 39:300-309, 2005

10. Mason K, Bennett H, Ryan E: Report of the Committee of Inquiry into Procedures used in Psychiatric Hospitals in Relation to Admission Discharge or Release on Leave of Certain Classes of Patient (Mason Report). Wellington: Department of Health, 1988. Available at: https://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/2DC94A246D93272C4C2565D7000DDA26/%24file/Mason%20Report.pdf. Accessed March 21 2020

11. New Zealand Government (2018) *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington, New Zealand: New Zealand Government.

12. Mental Health Commission: Pacific Mental Health Services and Workforce: Moving on the Blueprint. Wellington: Mental Health Commission, 2001

13. Simpson AI, Brinded PM, Fairley N, et al: Does ethnicity affect need for mental health service among New Zealand prisoners? Australian and New Zealand Journal of Psychiatry 37:728-734, 2003

14. Jorm AF, Patten SB, Brugha TS, et al. (2017) Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry* 16: 90–99.

15. Jablensky A, Sartorius N, Ernberg G, *et al:* Schizophrenia: Manifestations, incidence and course of different cultures. A World Health Organization ten-country study. Psychological Medicine 20:1-97, 1992

Annexure B

Consent to use my statement

I, Leota Dr. Lisi Kalisi Petaia confirm that by submitting my signed witness statement to the Royal Commission of Inquiry into Abuse in Care, I consent to its use in the following ways:

- reference and/or inclusion in any interim and/or final report;
- disclosure to those granted leave to appear, designated as core participants and where instructed, their legal representatives via the Inquiry's database or by any other means as directed by the Inquiry;
- presentation as evidence before the Inquiry, including at a public hearing;
- informing further investigation by the Inquiry;
- publication on the Inquiry website.

I also confirm that I have been advised of the option to seek anonymity and that if granted my identity may nevertheless be disclosed to a person or organisation, including any instructed legal representatives, who is the subject of criticism in my witness statement in order that they are afforded a fair opportunity to respond to the criticism.

Please tick one of the two following boxes:

if you are seeking anonymity

or

(tick) if you are happy for your identity to be known

Signed: GRO-C

Date: 12.07.2021