



Mental Health Inquiry Pacific Report



New Visions: Collective solutions

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Executive Summary

E fōfō e le alamea le alamea” means the stingy fish heals the injury from the stingy fish – The Pasifika people heal their own Pasifika people’s issues. [Samoa, Submission by Pacific Matua]

We work within a broken system that has lost its common sense. It is Western-based, academically-based, pharmaceutically-based... A lot needs to change. [Pacific Community Fono]

Transformation. Transformation. Transformation. If you were to sum up the strongest sentiment of the Pacific submissions in three words, these would be the words.

Transformation of a broken system that has lost its common sense. Transformation of a system that isn’t working well – let alone able to create wellness. A system that was not even trusted by those entrusted with making it work.

The Pacific Report summarises and synthesises Pacific online submissions, emails, oral contributions in fono/meetings and written submissions. Confidence was low. Energy was low. Trust was low. For those on the receiving end of the system, it was clear. People who were suffering were seeking help but were struggling to receive help that was actually helpful. Submissions expressed how the most vulnerable people, along with their families, experienced more suffering after being exposed to the mental health system, despite this being the place that was supposed to offer pathways to wellness.

For Pacific peoples at the delivery-end of the system, there was an acute sense of being under-resourced, under-valued and pushing against a very strong tide where a particular way of doing things has all the power, all the mana, all the money and all the authority. The message was clear. Things need to change. Not just a little bit. Not just for Pacific peoples. But for everyone. In the words of a gang member now dedicated to helping people with methamphetamine addiction - “Something extraordinary needs to happen”.

A complete systemic overhaul was called for by those on every side of the system. The Pacific professionals delivering services as well as the people receiving services. The submissions called for changes from top to bottom - from the leadership at the helm, to what is contracted, all the way to front-line delivery and every kind of crisis response.

Across the entire ecosystem, there were consistencies in messaging: strong criticism of the mental health system in its current configuration and a desire for significant change. Pacific peoples repeatedly said:

- Listen
- Meet us where we are
- Empower us and our communities to help ourselves and our whānau

There was absolute clarity that the current system is not working for Pacific peoples. Pacific participants in the inquiry were consistent in their critical assessment of the current system itself, the ethos of the services within it, and the dominant modes of practice. As Pacific peoples brought their voices, thoughts, reflections, observations, passionate pleas and carefully considered written submissions to the inquiry process, it became clear that the answer to many of the problems was seen to lie in another way of thinking. Another approach to caring for those in distress. Another way of engaging with people in crisis. Another way of supporting people and their families to survive.

The point of difference provided by Pacific professionals, Pacific practice and Pacific services was genuinely considered advantageous by service-users, families and the Pacific workforce. Pacific peoples and providers did things differently compared to the rest of the system. This way of doing things could be described as an 'indigenous ethic of care' sourced to the cultures, islands and homelands of the Pacific region. This mode of practice is not Western, academic or pharmaceutical. While Pacific submissions did not want to deny access to any of these options for Pacific peoples, what was preferred was an ethic of care culturally aligned to the indigenous people of the Pacific region.

For this reason, this kind of practice was much more attuned to what Māori providers deliver and Whānau Ora practice. The source inspiration, ideas, values and principles of this ethic of care traces back to traditional healing practices and ways of caring for those people in distress, that have been practiced for centuries in the islands of Moana Nui-a-Kiwa.

Two proverbs speak to the two core conclusions of this report. The first proverb is: "O le e lave i tiga, ole ivi, le toto, ma le aano." This translates as: "They who rally in my hour of need become my kin." This is a Samoan proverb that encapsulates the magic that can happen when Pacific services align with and uphold Pacific cultures in ways that really count for Pacific communities.

To summarise, ideal practice with Pacific peoples:

- works with heart
- upholds dignity and respect
- help us, our whānau and our communities to help ourselves
- transforms our lives through and beyond times of distress and illness
- accesses therapeutic activities sourced to Pacific worldviews and wisdom which are often beyond the scope of standard clinical practice and beyond mainstream appreciation of what is healing
- without reducing choice or denying access to any other therapeutic options
- however long that takes
- even when considerable depth is required
- supports whānau and individuals to address the root causes of distress, disorder and mental anguish - as well as alleviate symptoms,
- facilitates processes of genuine return to wholeness and wellbeing;
- in ways that empower and respect Pacific peoples and their loved ones, upholding their dignity in times of extreme crisis and despair
- focusing on their return to full participation in, and contribution to, their collectives [family, work, communities, village, islands etc.] with both self-determined autonomy and a connected sense of belonging
- with a spirit of 'ofa, alofa, aro'a, aroha, aloha (love) – compassion, empathy and relational mindfulness
- rather than racism, blame, shame, lack of care, lack of empathy, and professional risk management
- avoiding unwanted, unwelcome and intrusive interventions, police involvement, criminalisation, over-medication, using the Mental Health Act, seclusion, forced treatment,

restraint and restriction of freedoms - as well as avoiding referrals to services that are well known to operate in these ways

- and empowers people, their whānau and their communities to co-operatively and knowledgeably manage and maintain wellness and resilience and live free lives.

Paramount to making this vision work, requires having Pacific peoples who understand and grasp all of this cultural, clinical and community complexity at the commissioning and contracting level. Without Pacific presence within the procurement process, there was frustration that there would be “more of the same”. What one matua described as: “throwing the chicken to let go, but holding tight to its string”.

To realise this vision, requires systemic change that:

- Has Pacific peoples participating with influence and relative autonomy at all levels of power within the system, especially at commissioning, contracting and decision-making levels and ensures Pacific cultural integrity is enabled and upheld in the best interests of Pacific communities
- Shares power with, and listens to, the needs of those served by the system (Pacific peoples, consumers, community, youth, rainbow etc.) in ways that are more meaningful than co-design (often experienced as tokenistic), with ongoing active involvement and accountability
- Is not characterised by competition for scarce resources, a lack of co-operation, tightly held intellectual property, job insecurity due to short-term contracts and patch protection – rather a co-operative, complementary, co-ordinated environment encouraged to cross-refer, collaborate and flow
- adapts and adopts Whānau Ora for a mental health context recognising that this is one of the few initiatives working well
- prioritises public health activities, education, policy changes, and environmental interventions, research, promotion, prevention, early intervention - as well as treatment - and has multiple entry points
- grasps the impact of determinants of health, particularly the severe financial deprivation in Pacific communities, as well as other well evidenced barriers and meets this with effective funded tactics
- harnesses novel and new technologies
- values research, evaluation and constant learning and improvement and which establishes clearly ‘what works’
- Is timely, responsive, co-ordinated, seamless, able to respond to crisis, culturally competent and able to give people a wide range of options and choices

The emergent vision, born out of the collective aspirations of many voices who participated in this inquiry process, is an integrated extended whānau of Pacific services working co-operatively and collaboratively with each other. No longer posited in competition with each other, but incentivised to collaborate and cross refer. This would be a co-operative of like-minded Pacific services able to reach across the length and width of the country.

Collectively, they would be able to operate across the entire spectrum of care – from positive mental health promotion and public health campaigns reducing stigma at one end – to acute beds and respite services for the most critically unwell at the severe end. This highly skilled “team” would move well beyond DHB boundaries, with capacity to reach all the way out to the regions and draw

within and across a wide spectrum of expertise. Every moving part would be governed with the same ethic and ethos of care shared by Pacific peoples.

From a powerful place of purposeful procurement, these co-operating services could meet the needs of Pacific peoples and their families holistically and 'where they are' – in culturally appropriate ways as the overarching and underpinning driver, no matter how acute or mild to moderate the problem. No one gets lost.

This shared ethic of care would stretch to reach and encompass ethnic specific models, rainbow models, youth approaches, addiction expertise, gang realities, church contexts: all of this diversity carried with skill and understanding within a broader framework of collectively agreed principles and culturally connected practice. These services would be able to:

- understand their context well and meet this with an appropriate paradigm of care
- work in unfettered alignment with cultural values and models of care, and operate with absolute cultural integrity - enabled rather than hindered by contracting
- respond effectively to the whole matrix of what it means to be Pacific, including youth and rainbow, and be able to meet ethnic-specific and language needs
- engage and fully involve families (and/or significant networks and relationships of support) in meaningful ways
- include a far less-hierarchical mix of clinical, cultural, community and peer support skills characterised by respect, equality, partnership and synergy
- able to provide cultural as well as clinical assessments
- be available in – or be able to deliver in - local, easily accessible settings, including mobile options; and should be available to all peoples regardless of their own location
- offer same day access, respond effectively to crisis and provide high quality timely referrals to other services with a similar passion and purpose without losing people in the system.

This whānau of services would be governed and managed in a way that demonstrates Pacific authority and autonomy to make the right decisions that are in the best interests of Pacific peoples accessing services, staff and Pacific ways of being and doing. This reflects absolute cultural and ethical integrity, incredibly high quality and a vision of inclusion, recovery, healing and safety.

The strength of this potential whānau of services and experts is epitomized in the Samoan proverb: *Ua sau le va'a na tiu, 'ae tali le va'a na tau, o lo'o mamaulago i le va'a na faaafolau. One boat returns from the catch; the other is tied to the strand; the third one is propped up in the boat-shed.* That is, at every vantage point in the ecosystem, at every significant point in the continuum of care, a Pacific option is present and viable. And all of those Pacific options are connected to one another in ways that move with people. All of these 'boats' as referenced in the metaphor, will co-ordinate swiftly with each other, connecting the dots and gaps across the system, responsive and responsible for the safety of people in their sphere of influence and care.

It is envisaged that this whānau of Pacific services - vessels fit-for-purpose - would be a choice among many other items on the menu available to all New Zealanders seeking kind, high quality mental health and addiction support and recovery. This is not just a re-brand of what is, and forcing existing services to work with one another, it is a chance to do things completely differently, with integrity and intention.

On reading this document, filled with voices from across the Pacific mental health and addiction landscape – from different positions and perspectives - there may emerge other visions. Within these pages lie many ideas, reflections, observations, learnings and perspectives. May they be a source of wisdom and guide reflection and decision-making.

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account of this experience. Next to these voices from the water, are the families who have been in the waters with their loved ones. Another Tongan proverb guides this analogy, “Fe’ofa’aki a kakau”. This translates as “the love of swimmers”, recognising that when people are up to their necks in water, you may want to show love for those around you, help them or rescue them, but when you are all swimming in that water together, it can be very difficult to show or realise that love. This particular proverb provides dignity and compassion to families that are struggling out there. Those who are not necessarily short of love for each other, but are doing their best to keep their heads afloat. These voices in the water are vital to the inquiry process. They are worthy of being heard and it is imperative that they are not drowned out by other interests in the inquiry process.

The next section of the report turns to those in the vaka / waka. It provides space for those who are captaining and crewing the boats, life-rafts and large vessels that provide aid every day to those in the water. They are the fishermen and the navigators, the providers and ‘helping’ services and organisations that assist people in distress. They are the ‘tufuga / tufunga’ or specialists who are there at the frontlines. Their perspectives contain firsthand experiences of what is happening at the coal-face. They hold important information that needs to be understood at the top of the mountain.

Alongside the voices from the vaka, are the voices from our matua. These are the elders, the most experienced in the boats. They are the ones with the long track record of service who have authority to speak about issues. Giving the matua their own space is also consistent with Pacific cultural norms that value the wisdom of age and experience. These are our leaders who are often sought as subject experts for their opinions. What is often missed via this process are the voices of the outliers on the margins. The youth voices. The voices of rainbow communities. Those who float a bit beyond the safe central waters and whose voices we cannot afford to miss. The mountain needs to hear these voices. Given that this work tends to include the most vulnerable, these voices of advocacy are given a separate space to be heard.

Finally, we move to the perspective captured in the metaphor of the trees. The view from the trees stands back from the water and has greater oversight and distance. But it sees things those who are up-close and personal miss. Patterns, weather changes, overall conditions can be seen relatively objectively from this position. Their value is in seeing the sector as a whole. The trees includes researchers, universities, interest groups, policy think tanks, workforce development centres, charitable institutions, collectives and conglomerates. They often bring a public or population health approach. They have a very good grasp of the evidence and operate with considerable influence and authority. They are often considered experts and sought for their ability to integrate and explain the trends and patterns of considerable complexity. However, they are not at the frontlines of service provision and are far from using services themselves.

With the perspective of those voices in the water, on the water, and from the trees, it is hoped that a comprehensive and complementary range of voices and interests reach the maunga. This report concludes with a summary of common themes that can be found across all of the perspectives. It ends with a synthesis of this collective feedback; despite the diversity of feedback there is a coherency that can be found across the many submissions. The synthesis pieces together aspirations out of many different ideas.

All submissions were read and analysed for Pacific voice, self-identification or experiences relating to Pacific ethnicity. These were analysed for content. Twenty-nine (29) written submissions (online, email, hardcopy,) self-identified, or were identified by analysts, as Pacific service providers, service users or families. There were also additional submissions that raised issues relating to Pacific peoples and included Pacific content. These were also analysed for this report.

More Pacific peoples participated in the inquiry orally. For consultation fono attended by the Inquiry panel, thirty-nine (39) are identified as having Pacific voice. “Voice” indicates those who *spoke* at these meetings. This does not indicate total numbers of Pacific attending these or other fono. However, a number of meetings and fono were targeted specifically at the Pacific community or Pacific providers. These meetings captured a wide range of Pacific voices.

Ultimately, the aim of this document is to provide an accurate account of the voices of Pacific peoples who participated. It is hoped that the truth and potency of insights to be found at all the multi-layers and many-levels of this dynamic and interconnected eco-system will be realised. And that these hard-won thoughts, experiences and learnings will reach the hearts and minds of those on the maunga.

VOICES FROM THE WATER

Anu tahi. Soaked deep in the waters and tides of problems. [Tongan proverb]

I want to be sure this is not a tick box exercise. I want to be sure that something is going to happen. [Pacific Service User, Community Fono]

Very few Pacific peoples who openly self-identified as having lived experiences of mental distress and addiction, or using services, participated in the inquiry process. During the inquiry process a unique gathering was attended by 75 people, many of these consumer leaders and consumer service users.

It was argued that,

Government do not understand mental health clients – what it's like being a mental health client. [Pacific Service User, Community Fono]

The divide between those on the mountain and those in the water was seen to be almost insurmountable. The importance of being compassionate, non-judgmental and being able to listen and understand the support, needs, and life experiences of consumers was considered fundamental.

The direct quote from one written submission by a Pacific service-user below touches on many themes that are raised across the submissions. What makes it different from other submissions is that it is personalised by one individual with lived experience.

The injection worked well for me after all the medication had only suppressed the chaos but not rid of them like the injection. However, it's only been four days on the injection but already it kicked in immediately unlike almost two weeks on certain medication. Exercise, healthy eating, lots of sleep balancing all this helps a lot for me

Feeding my mind with positives ie. Reading my spiritual devotions, shopping, only connecting with positive friends/family. Eliminating all the negative things and giving space to people who may be problematic. Educational reads, documentary helped for me.

For the voices it helps to acknowledge it and make peace with it on your own in the park in your home but also indirectly addressing the persons voice with the person without seeming you are accusing them with something that was all manifested in your own mind. Just also being open about certain things yet still keeping your integrity.

I think there are messages we are supposed to learn through this storm and medications is only a temporary fix, but most importantly is exercise, healthy eating, sleeping.

It's working well for me I'm Samoan born in NZ but I believe it will work for everyone. However, the spiritual side, I'm unaware for the Pakehas as some are not spiritual?

This vignette from a Pacific service-user identifies and validates common themes that consistently emerged in Pacific submissions:

- A genuinely holistic approach includes: spirituality, nutrition, physical activity, healthy thoughts and cognitive processes and healthy relationships.
- Human relationships – negative and positive - are vital to wellbeing outcomes.
- Education is power. There is genuine concern about loved ones struggling to understand what is going on. They need to be part of the journey too.

- Having drug education, medication choices, and being able to access the most effective medication with the most optimal outcomes is important. However, this is inadequate on its own and medication may be considered a temporary fix to simply suppress disruptive symptoms.
- Many influential and effective therapeutic activities occur well beyond the scope of clinical services and activities.
- There was genuine gratitude expressed for Pacific services.
- Many life experiences that are constructed as secular mental health issues in Western culture, are made sense of spiritually and are perceived through a spiritual lens in Pacific cultures. This is another significant departure, signalling very different philosophies and ways of knowing, interpreting and potentially treating exactly the same symptoms and problems.
- There are many culturally distinctive ways of interpreting, addressing and treating phenomenon such as ‘hearing voices’. In Pacific cultures, when people are ‘hearing voices’, rather than dismissing these as delusions, the treatment pathway involves: accepting and validating these voices; identifying who they belong to and listening carefully to what they are communicating. This is considered a valid pathway to resolution and recovery. These are significant departures from mainstream thinking.
- A ‘storm’ suggests a temporary and threatening challenge to learn from. This temporality and the construct of a ‘life learning experience’ contrasts with a life-long medicalised diagnosis and disease or biological condition.
- Pacific approaches to restoring wellbeing could be optimal for anyone, regardless of their background or culture.

Knowledge is Power

Another self-identified Pacific service-user who made a written submission to the inquiry wrote:

What I would like to see is health system focusing more on educating those with mental health issues, rather than providing a service.

According to this service-user, this meant knowing what to do to stay safe, choices associated with being well and the challenges that must be confronted. He said that accepting the condition you have and finding the skills to cope is crucial. He writes:

Understanding depression and the suicidal thought process is knowledge, and that is what I see will be the most important aspect of what the Mental Health system should focus on.

Services Beyond the Clinical

Other service users spoke about the need for services that do more than just the bare minimum of clinical delivery. This feedback is consistent with Pacific providers who argued that activities ‘beyond the scope’ of standard mental health services were crucial.

People are treated poorly. There is a lack of resources for places for people to go. The residential homes and activity programmes have been closed down... For the last three years we’ve running service-user groups with no funding—selling raffles... Our people will recover if we fill the gaps in concrete ways. [Pacific Peer Support Provider]

One participant was part of a voluntary peer group who had noticed that the most useful thing in people's recovery journeys were:

Their own remedies. Talking to peers helps more than the Pākehā world that uses a lot of medication. We need more mindfulness skills. We need to look at traditional remedies; traditional healing. [Pacific Service User, Community Fono]

Whānau Included

At one Pasifika Community meeting of service-users, there was some consensus that recovery options needed to be "client-centred, family and whānau-centred". Throughout the mental health service-user journey 'voices needed to be heard'. In addition, 'follow up with family after a situation has occurred' was considered important.

Drugs, Side Effects, Weight Gain

The need for drug education, a better understanding of side effects and their negative impact on physical health was repeatedly raised as an issue.

People need to be understanding what they're taking, their symptoms and 15 mins is not enough time to explain. They need a place to go to inform them, have group sessions regarding the medication and drugs they take. [Pacific Service User, Community Fono]

Alongside drug education: "Courses are needed for people diagnosed with mental illness e.g., on gaining weight, learning how to cook. All we do is stay home... possibly 2-3 days a week. E.g., Activities with WINZ – walking groups." As well as activities, the importance of, "Supporting individuals to help each other, having a support network," was identified.

The need for a focus on nutrition and physical health was also echoed by providers. One explained that people find that the drugs affect their size and the ways that they make informed decisions. Most people want help with losing weight without compromising their wellbeing. [Pacific Provider, Pacific Community Meeting]. The role of nutrition and its impact on wellbeing was felt to be neglected. In contrast, the over-use of medication was seen to be widespread.

Medication is the quick fix, when they really need someone to talk to. There is not enough listening and lots of assumptions. [Pacific contributor, Community Fono]

Practical [Socio-Economic] Assistance

"Affordability" was raised repeatedly. It was acknowledged that many: "consumers were homeless or in poor housing conditions". This needed to be addressed, as "benefits not enough". The issue of some services offering food parcels was raised and healthy food parcels were seen to be a much-needed initiative. For the homeless participants, practical assistance included a one-stop shop to get I.D's and extra documentation necessities.

The challenges of finding accommodation, eating well, getting criminal records while unwell, and the challenges of getting a job were raised by this group. One of the ideas raised by the homeless participants was the need for apprenticeships for young people who are homeless.

Stigma plays a big part in the lives of people. It affected everything from seeking housing to gaining employment. Notably this group were happy that: "Pasifika services do exist, grateful for that support".

Genuine Choice

During the inquiry process, a range of prominent peer-led organisations advocated that all people want choices, and a menu of health options. Pacific services and models were positioned as a culturally distinctive exemplar from a suite of service options appropriate for the New Zealand population. People might want to try this, regardless of their participation in the medical paradigm. [Peer Support Provider Submission]

These peer services advocated that Pacific services informed by Pacific values pertinent to the function of these organisations creates choice for all New Zealanders, not just Pacific peoples. The cultural integrity of Pacific services was an issue that many submissions passionately raised. So was the sentiment that that Pacific people have something special about the way they approach recovery and healing and that this could be of value for all people in distress. Despite very few submissions from Pacific peoples with lived experiences, there were multiple submissions from Pacific providers and sector stakeholders who spoke to the same issues. It is important, however, that the voices from the water are not spoken for by the providers and people in the safety of the boats.

FAMILIES IN THE TIDES

Fe'ofa'aki a kakau. The love of swimmers. [Tongan proverb]

The proverb encourages us to imagine a group of people swimming, perhaps a family, all up to their necks in water. If one person starts to experience serious difficulties, the others are limited in their capacity to help them. This is because they are all up to their necks in the same water. No matter how much they love one another, they are not in a strong position to help each other. In many ways, this proverb gives dignity to the family in crisis, the family that is struggling.

A few Pacific families – very few – wrote down their stories to share with the Inquiry panel.

I write this on behalf of my family but more specifically, for our loved one... what follows is a story that he has always wanted to tell, but the chance for anyone to listen and address it never came.

We do not write to lay blame with any one person, community organisation, or agency. The hope is that when you read this, you will discover the challenges, inadequacies, prejudices and discrimination (conscious or unconscious), and culture/cultural attitudes in this snapshot in the life of our loved one, and our family.

This particular story of the family above cannot be told word-for-word because of length, but it does need to be heard. It speaks to an experience of a young Pacific man who ended up being admitted to the psychiatric ward by police during an extremely drunken incident. He was cuffed, drunk and disoriented. He was very angry that he was being hospitalised. During this experience, he was only allowed his handcuffs removed if he agreed to take sedating medication.

It was asserted by this young man that he'd never heard voices, but he was not believed. He continued to be medicated. His drugs were increased. He talks about getting angry, feeling pissed off and frustrated with the system. More and more medication was the answer. His experience was of not being believed, of having his motivations questioned, and staff making him out to be something that he wasn't – something he described as 'not good'. Something damaged.

He speaks of the shame of the experience. How embarrassed he was to let his family know. He describes the way staff interacted with his family.

The way he came into the house and how he was sitting in front of dad like disrespecting dad in his own house. He was arrogant. I saw Dad's look on his face, like he couldn't believe this was happening in front of him.

The family goes on to describe:

When he was released from hospital, he lived with our parents. Our mother was responsible for ensuring he took his medication. This was a responsibility that our mother should not have been given. As it were, he did not receive his medication. Our mother... did not believe (or want) him to take medication. This was over a period of two years. He became isolated, a recluse, and turned to drugs...

Understandably, my parents did not know what they were dealing with; they had no understanding of what he was going through or strategies in how to respond to his behaviour. To them, he should get off the drugs because this is what they associated his erratic and irrational behaviour with. Finally, he was committed.

There has not been a good outcome for this young man. His family explains:

Today, our loved one lives a transient lifestyle, at times he sleeps rough, or couch surfs at various dwellings. Every month he gets his medication.

He himself writes about how incredibly fit he was before his first interaction with the mental health system. He was working full time when he was first admitted in a drunken state. "It was the fittest I ever been...all gone after that." As a family, they explain:

Our family's support for him might have been stronger and more 'together' if we were a closer unit. We were a fragmented lot, not knowing what, where, or when. I think it's important to recognise that some families are not the 'normalised' version of what a family should be in times of crisis.

In this submission the parents speak to completely broken relationships with their son. Relationships of shame, anger and frustration.

The other day he came here and he was saying he's sick of things – what he's doing and where he is living... He went outside and screamed, called me names; told me to come out here or he'll come down to my work. I called the police, I don't know what else to do.

Even for Pacific peoples who worked within the mental health and addiction system, they spoke of how hard it was to participate in, or navigate, that system on behalf of family members or themselves. One submitter said:

I have a clearer understanding now as to how mental health services are structured and operate. For a 'newbie' in this area, it is not an easy system to get one's head around or to navigate. It is, in my view, complex. However, with this newfound knowledge, I am better able to support my loved one...

Another submitter (a mother of a service user) shared that she felt she'd failed to some extent - she herself works in the industry, but her own family weren't equipped with knowledge and education to be able to cope.

These challenges speak to how hard it is for Pacific families to navigate the system, and in fact to even participate in this inquiry process. Very few families made submissions or spoke out at public meetings. The ones who did participate talked about experiences with professionals who did not really seem to care.

This struggle continues daily. Services will lose clientele if the frontline person treats them like a number... You want people who want to make a difference to the lives of many, not the ones who go for a pay cheque and that's it... [Bereaved Pacific Family member]

To sum up, Pacific families shared their experiences of:

- A genuine lack of compassion, care and lack of dignity for people in crisis
- A complicated system to navigate that is not user-friendly
- Police involvement and unwanted, unwelcome interventions at the most intrusive end of the spectrum
- Hostile environments with the hallmarks of institutional racism
- Over-medication, poor follow-up and few supports
- Lack of meaningful engagement with families
- Little building of knowledge that would be empowering to help with self-managing and improve whānau support
- No cultural competency or evidence of effective engagement or building relationships
- A high level of shame and stigma accompanied the experience which was never mitigated

- Disempowered, disillusioned, angry and eventually destructive service-users
- Detrimental and damaging outcomes, including worse physical health and sometimes bereavement by suicide
- Pain

Those at the helm of Pacific services advocated strongly for the inclusion of Pacific families.

Working with the family ensures that the journey towards recovery is one that is not taken alone. The service user can grow and recover along with their family. The reality is, families are impacted by having a member of their family who experiences mental disorder including alcohol and/or drug addiction. [Pacific Provider]

Pain... With the lack of ability to deal with the bureaucracy... People with no money to put in the car told they have to come back for another appointment... Let people know that referrals don't cost—finances are a massive barrier. [Clinician, Pacific Provider]

Understanding the context Pacific families operate in was seen to be fundamental to effective care, particularly the reality of socio-economic deprivation. Drawing on Pacific cultural ways of being and values was seen to be the antidote to unkind and hostile bureaucratic institutions, where respect for others and a desire for their health and wellbeing was not evident. Research identifies that in most Pacific cultural therapeutic approaches, respect and humility are guiding philosophies, alongside kindly treating people 'as if they were family'². This was in direct contrast with impersonal, often bewildering, unwanted, unkind encounters with possibly racist professionals and institutions. This section ends with the final words of one of the few family submissions made in the inquiry process:

A refreshed system would involve de-colonised policies and thinking, and a more compassionate and empathetic society.

² Mafile'o, T. (2006) Matakainga (behaving like family): The social worker – client relationship in Pasifika social work. *Tu Mau 2, Social Work Review*. XVIII(1):31-36

VOICES OF THE OUTLIERS

We need a mandate to work across the system and rebuild the system that is oppressing our people... if you don't start from a place of understanding this can't happen. [Pacific Navigator]

Pacific youth and Pacific rainbow voices of lived experience are often absent, marginalised or misunderstood. Gang voices are barely present. And the homeless are also under-served when it comes to having a strong voice in public policy and government-led forums. They are often considered too hard-to-reach, vulnerable, at-risk and in crisis by professionals, experts, policy makers and those on frontline services. Below is a typical sentiment expressed about these groups by other submitters:

We are in crisis mode with the youth suicide rates for our Māori and Pasifika youth, who are often in survival mode from the impact of social determinants of health, poverty, unemployment, family violence, alcohol and drug addiction. [Individual submission, no ethnicity identified]

Listen: Fa'alogo mai

The strong message from the submissions of these groups was to 1) listen and 2) involve them in anything affecting them. During the mental health inquiry process a collective of Pacific young people put their voices to paper to explain their reality. They were very clear that although it could be challenging to involve youth perspectives, it was an important thing to do.

If we are planning to move forward regarding these serious issues, please provide the space for us to voice our thoughts... One key thing we note and continuously note after every media release or statement, is that we don't have any platform to feedback to the top... We understand in some ways it may seem hard/challenging to engage with young people but there are those of us who are willing to speak for our peers given the platform. [Pacific youth contributors]

Similarly, voices from Pacific rainbow communities said:

The mental health status of the Pacific rainbow community is undervalued and have often been 'left out' of the frame. The Inquiry is an opportunity for their voices to be heard and takes affirmative action against those who traditionally have spoken on their behalf.

The inquiry was seen to be a starting point. There were strong signals that anything further that might be developed must create processes and spaces for youth and rainbow voices to speak and be heard, rather than be spoken for.

Meet us where we are

There also were repeated messages from these groups that the needs and aspirations of the communities should drive the shape of services and interventions targeted to them.

What I've learnt though is we need to start where the community priority is...the community wants safety and youth opportunities, so start there... What is being done by services to build trust with communities at a broader scope? To collaborate with the community on what they care about as a vehicle to begin working in other areas? [Pacific Navigator]

Why don't we go to a place where people connect to? We need to connect to local churches and youth groups. People are there. [Pacific youth contributor]

One suggestion from a Pacific student organisation was to:

Target church gatherings

Homeless participants in a Pacific Community Meeting said that they:

Need support/social workers to walk around the community at night to help with queries

This sentiment – to start with communities and to meet communities in their own localities was very strongly echoed by Pacific services:

Locally planned services that examine the key social and mental health and addictions issues that affect people in that area and then allows people including community reps, providers and sectors to come together to take responsibility to plan, agree and achieve a set of positive outcomes. This will require these parties to decide and prioritise what are the key outcomes that is required and then jointly plan who and how each party will take responsibility for its achievement. [Pacific Provider]

There needs to be a new paradigm of care that is reflective of the context in which Pacific people live their lives. [Pacific Provider]

Provide services and programmes in the communities where the communities gather. E.g.: Churches, maraes, youth groups etc [Pacific Provider]

One Pacific provider gave an example of how this community-led approach worked for them:

Have to be intentional about relationships; started one with ministers' wife of Samoan church in ...; she was open and willing to do anything to help her flock. Building that relationship and doing what she wanted to prioritised health-wise with the church and the ECE—resourced what she wanted to do to support families and children. From that other Pacific learning nests saw this and began to request the same support—the resources were needed from other services, not just DHB—public health nurses, Sports groups, health providers re: vision/hearing checks/B4 school checks. A working group made up of different services; main focus is to improve response of services and also to improve face-to-face engagement between services and families.

Similarly, the following success story was also shared:

The financial wellbeing of our community was very low. We talked to all the people about their deprivation. We gathered different groups and listened to their stories. We found out that so many people had high-interest debts. So we designed a financial wellbeing course in response, which has been going now for seven years. The mission is to bring out the best in our community. This is an example of community having solutions themselves. The course grows the capacity in our communities so we train past participants to become facilitators as well. [Pacific provider]

Immediate Environments Matter: Locality Justice

It is well known that the majority of Pacific peoples are clustered in areas that are socio-economically deprived. A number of suggestions for improvements in mental health and wellbeing were about modifying the 'unhealthy' environments around them. This included from the homeless participants:

- Building more public toilets
- Shutting down the synthetic shops in the community

Other submissions requested environmental and council level modifications to prevent neighbourhoods being saturated with liquor stores, pubs and mobile truck stores. The modification of tangible and immediate environments was seen to be something that could make a difference to wellbeing. One positive story came from an NGO:

We've wanted a supermarket in this area for the 18K people who live here. We have been asking for one for years. When a recent new development came into being they got one. This is social injustice. We created a regional fruit and veggie co-op to bulk buy fruit and veg for the area. \$1 from every parcel sold goes back to pay for their regional coordinator. [Pacific practitioner]

Shame: Hurting the hurting

There is a lot of pressure and stigma. Stigma is major cause of distress in Pacific communities. [Pacific student]

It was consistently clear from the submissions that discrimination and stigma is high. There is: "Stigma wherever you go. Pacific people feel shame and are reluctant to use services." [Pacific provider]

A range of providers lamented the fact that the Like Minds, Like Mine contracts were stopped. Many services who had lost a 'Like Minds, Like Mine' contract believed that they were doing an excellent job. The loss of the "Like Minds, Like Mine" contracts was a sour point raised in a number of Pacific submissions. All argued that reducing stigma programmes are much needed in the Pacific community.

It was raised that no Pacific and Māori organisations hold any 'Like Minds, Like Mine' contracts. This meant that mainstream organisations are speaking to Pacific and Māori about issues that are culturally informed. This was considered inappropriate.

Decriminalisation: A Tale of Two Countries

Feedback from homeless participants who attended a Pacific community meeting focused on the need for decriminalisation and opportunities for life-skills and work. They wanted accessible support and environmental changes that make neighbourhoods safer. In addition, they asked for fair sentencing for low level crimes.

There was genuine concern by those working within the system about how readily and disproportionately criminalised the behaviour of Pacific peoples were – men in particular. The criminalisation of addiction in particular, was seen to be majorly problematic, leaving people stuck, without support, in stigma and shame.

The mental health system is an old cloth [we are] patching it with new cloths. There are new ideas introduced in the system but the foundation is still the same. Yesterday we had a mother come to us recommended by police, disclosed fears and issues about son's use of synthetics. We would love to have supportive accommodation for Pacific, where contained and appropriate support and services provided for them – addressing his mental health issues. When discussed with him, people still see him as a criminal. Addiction as a crime not health issue. [Pacific contributor]

AOD is poor brother [sic] of mental health. There's an importance of keeping addictions as a focus of the Inquiry. Addiction has been overshadowed by mental health for long time; it's seen as a criminal issue rather than health issue.

Unemployed addicts can't get work because can't pass drug test but they are addicted without help, which is a criminal issue – how does this help kids? [Pacific Provider]

My people (gangs) can't go to marae or funerals. We are judged before we even arrive, told 'you're a disgrace to us'. But the marae are funded to help... Why don't we look for help? Why don't we stop selling? It's because its employment, it puts food on the table. What is meth to society – it's employment. It's everything the rich want without knowing what addiction is. Because it has been 30 years, we've (gangs) learnt from the mistake – it's our employment now. Without other employment and education, nothing will stop. [Pacific contributor]

From the submissions it appeared that the divide between the highly functioning, well-paid working world – that “solid land-based place” which is epitomised by the perspective of the ‘trees’ and the ‘maunga’- felt worlds away from the dark, underwater realm of the poverty, addiction, illegality, mental health strife and despair of the unemployable and homeless. In many ways this illuminated a tale of two countries, that co-exist simultaneously but are not really connected. The huge divide between funded health promotion efforts and the hard realities that people were experiencing was pointed to.

[Organisation] - what a joke with their cartoon pictures. Real society don't understand that. They want to see what it does to people – all the negative health things to do with addiction... Why haven't we got negative addiction education on TV, why don't we have crack babies on TV and in Plunket or dentist posters, rather than bad teeth on cigarette packets? Next part of movement is posters to stop people. Professionals get cut up when I tell the truth, then they start blaming us. If you want to be professional, you need to understand both sides of the fence. We are wasting a lot of money. [Pacific contributor]

On some level – with varying levels of ability - the people on the boats - or voices from the vaka - were ferrying across and mediating the divide between these fundamentally different realms (but not always). Some of them were able to move skillfully between these two co-existing realities. They saw that too many people were out there alone, without support, struggling.

The increasing numbers of Pasifika peoples entering the criminal justice system and our work in prisons and with corrections gives us particular insight. A significant gap in the provision of transition support services, and specific Pasifika rehabilitation programmes needs Government attention. We consider that funding of ‘therapeutic communities’ for example is a better way forward than ‘building bigger prisons’ based on well-established and evaluated models of delivery models... [Pacific Addictions Provider]

Decriminalisation was repeatedly mentioned by the voices from the vaka, the outliers and some of the voices in the trees. It was seen to be a way of reducing and mitigating the huge and growing divide between the two worlds mentioned above. Other countries which have decriminalised/legalised drugs, such as Portugal, were pointed to. The Drug Courts model in Auckland was seen to have a good recovery focus. Restorative justice was an avenue where there could be a much stronger emphasis on mental health.

Those who worked in the sector, ferrying between the worlds, had many ideas about what opportunities could be realized if something meaningful could be done instead of chronic underfunding, shame and criminalisation. It was agreed that “something extraordinary needs to happen”.

Everyone knows how to make drugs today. Education is everything, but I'm scared about what the education looks like. I present my education vs professionals and see which one scared them. Something extraordinary needs to happen: we need prevention and education and who gets money to do that and what does it look like? DARE comes to mind from 80s. Not scare mongering but something real, through schools, Plunket and antenatal classes. We know baby in the womb can hear what's going on. I understand law and order has 80% of funding and health 20%. Mental health situation, going to blame education and education going to blame health. Why don't education want to know about it? Why no education programme for last 30 years? Netherlands and Portugal are working because 90% of funding goes to health and 10% to law enforcement, they are closing down jails, and growing education programmes. In New Zealand we have \$53m going into preventing meth import when everyone knows how to make it. Put some of that money into mental health and education. All walk-ins with one big workshop on what education looks like and would make a big difference. You get results... [Pacific contributor]

Stretch and Reach: The wide wake of what is considered Pacific

The outlier voices ushered in a concern that definitions of what 'Pacific' is and means, must have both stretch and reach. How we construct Pacific must be inclusive and reach the diversity of what currently sits under the Pacific umbrella.

We top the stats for all the wrong reasons but there's nothing specifically for us—our cultures are all different—we're Pacific and then underneath that are all these different cultures. We need an ethnic specific approach for Pacific students—community and values are different. Our form of respect is different and institutions don't understand that. [Pacific Tertiary Student]

The importance of intersectionality was spoken to by a consumer leader organisation:

Trans-Pasifika youth who doesn't fit into rainbow NGOs or with Pasifika service—no support for the overlaps. You can be a Pasifika young person but there isn't much room for other overlaps. [Peer Support Provider]

The issue of what constitutes Pacific and what a truly Pacific service might look like is talked about at great length by service providers and can be found in the cultural integrity section. Certainly, when one definition of Pacific culture is privileged over others, and is practiced in an exclusive way, then cultural politics will determine that those with least power in Pacific communities are marginalised³. Given who mental health services target, the idea of leaving those most vulnerable under-served is unthinkable. Evidence shows that for Pacific youth, relationships of acceptance are vital to positive mental health outcomes⁴. Generally, it is argued that respect, humility, compassion and service are integral to Pacific values that services aim to align with.

One service user talked about Cook Islands ethnic-specific approaches being vital for making sense of their situation and pursuing recovery. Ethnic-specific versus Pan-Pacific is a very real tension that consistently plays out when trying to design and deliver effective interventions with Pacific peoples. At the same time as there was a strong demand for meaningful alignment with core Pacific values, there was an acknowledgement of a changing demographic from many Pacific submissions. Being

³ Mila-Schaaf, K. (2010). Polycultural capital and the Pasifika Second Generation: Negotiating Identities in Diasporic Spaces. Unpublished PhD Thesis. Massey University. Albany, Auckland.

⁴ Ibid

able to reach this generation was seen to be important by many participants in the submission process.

The cohort of young people is changing, we have a “fruit salad generation” (mixed races). [Pacific Community Fono]

Cultural clash is common element—kids live two lifestyles between friends and home. This is a real challenge. There is a lot of anxiety. [Pacific Provider]

In addition, the growing number of people with mixed Māori and Pacific heritage were mentioned by families with lived experiences.

My son died by suicide. He is a Cook Island Māori. How would he be classed as he is not just Māori nor is he just Pasifika. How does this work for the many others who have mixed ethnicities? [Bereaved Pacific Parent]

It was also mentioned by community leaders and clinicians.

Two thirds of Pasifika kids now have mixed ancestry – often with Māori – with two cultural cohesion sets of values and duties of care. When different values systems are at play, the sense of duty children feel to either is diluted. For example, when there are two Tongan parents, there are Tongan kids. But when there is one Tongan parent and one something else, there becomes a change (in the sets of values and duties of care). We find that as a community we are struggling as an older generation to address this impact on social cohesion. [Pacific Clinician, Pacific Provider]

One matua with a lot of experience in the sector was interviewed about what might work better. She explained that it was vital that Pacific peoples themselves – who deeply understand this cultural complexity – are in a position to commission and have the power to shape services right from their conception, and execute them in the right ways so that they reach the right people. This very real complexity could not be met with ‘dumbed down’ understandings of who Pacific peoples are from professionals whose personal, socio-economic and cultural circumstances were very distant from these realities and who had little vested personal interest in their success. There is much more detail about these issues in the Matua section.

A complicated, slow moving system

The issue of a fragmented, complicated, unresponsive and unfriendly bureaucratic system was raised consistently. This was identified by youth stakeholders and Pacific staff in those services.

Access is already limited and there needs to be more support via a reduction in bureaucracy to make services more available. It makes a barrier for minority groups [Pacific Tertiary Student]

Access to something is more important than waiting 5-6 weeks for something more longitudinal. Shouldn't have to be waiting a long time. [Pacific Provider]

Concerns about timeliness were echoed by Pacific providers.

Only Police or crisis team will see someone on the same day as problem and you can't get help on Friday evenings/weekends. [Pacific Provider]

The situation was described well by a Provider, who called it:

An over-complicated, under-resourced system at a time when they are extremely vulnerable. Service gate-keeping (for example, a mental health crisis team being unable to support a person who is not already registered with mental health services) result in significant missed opportunities to support people when they reach out for

help. The growing use of Police to respond to individuals in crisis which can result in use of force and non-therapeutic detention practices [Service Provider]

Help us, help ourselves and our loved ones

Akin to the message from the service-user at the beginning, empowering people to help themselves and their loved ones with the right knowledge and education was raised. The young Pacific peoples who participated in this inquiry, described it like this:

Mental health and addiction concerns are common and take place long before us young people get in contact with a professional. In fact, many do not get to professionals at all, or ever. We turn to our peers, who often are struggling themselves and find it hard to give the specific support that we need. When we do however, get in contact with a professional (if we do), we are impacted by, met with inaccessibility (often unaffordability), having services that are accessible, (being able to practically afford going to a GP), stigma and discrimination around who we are, lack of being listened to or trusted by professionals and then entered into a system that is so under resourced that sometimes they don't even follow-up or take us seriously. [Pacific Youth contributors]

It is well known among Pacific youth that there is a heavy reliance on vulnerable peers for support, who don't necessarily have adequate knowledge, resources, supports, health literacy, and social capital to help as much as they would like to. Young people went on to say:

There is a big Pacific population between 18-25. As a country we need a preventative approach that is included in health and safety for work, and also other places. We need professionals from outside of schools to connect, build trust and remove access barriers to support, so they don't have to travel. Mental health and addictions support should not come from teachers, rather someone unrelated...

It needs to focus more on children, those in high deprivation, more on women. Focus on schools and communities. This new system must be acceptable to our values. Up and downstream approach. [Pacific Student contributors]

There needs to a bigger investment in evidence-based public education. Practically there needs to be more engagement activities, campaigns and awareness strategies. For this to be truly effective – efforts need to be done in our educational institutions, faith communities and workplaces to create the platforms where the understanding of mental illnesses and disorders are treated equally as any other health condition. [Pacific Youth contributors]

Help us find the right words

There was feedback that having conversations about mental health needs to be normalised. It was also clear that this should be done when people are still young. There was support for finding ways to do this in schools.

Start mental health education younger than 12—creating safe spaces in schools like mat time where you talk about feelings, the build-up to being 11 or 12 and learning why we do it; it eliminates stigma around saying 'I'm not okay and don't feel good'. [Pacific youth contributors]

We need less formal ways to talk about it - mental health challenges. [Pacific Youth contributors]

Teaching resilience, and how to pull through... Appreciate in different ages we need different messages. We are gonna use the teachers in the communities people are in. [Pacific Student contributors]

This was echoed by others:

At high school level and as university student when people look at you as a supporter...if you feel stress or pressure, who do you go to? If you don't go to church or have a community where do you go? [Pacific Student contributors]

There were also some innovative solutions emerging from young Pacific peoples:

You have the birds and the bees. When are parents encouraged to do this for mental health and addictions? Maybe it's called the "U's & the me's."

Consider a wellbeing rating like the health tick. Based from the idea that there is energy rating of appliances. If you were having a drinking session every day you would get a low rating. [Pacific Youth Advocate]

Calls for public health information campaigns were made at all levels. Particularly by the organisations represented in this report as "the trees". One Pacific submission states:

We believe that game changers for Pasifika wellbeing are: • Mental health literacy in schools led by mental health and culturally competent experts (not school teachers) would be an effective upstream intervention (including antibullying, alcohol and other drugs harm reduction). • Use technology to reach youth and care for their wellbeing. • Access to parenting and healthy relationship education focussed on behaviour change • Education programmes incorporating cultural identity to strengthen self-worth. • Invest in growing Pasifika leadership and clinical workforce to influence outcomes in mental health, addiction and preventing suicide. [Pacific Provider]

Technology

Use of technology was raised by Pacific young people.

We currently live in an information technology age. There needs to be further research into utilising information technology to expand the engagement and outreach of people into mental health and addiction treatment. [Pacific Youth contributors]

Everyone is saying nanotech, cloud & AI. How are we future preparing wellbeing for this? [Pacific Youth contributors]

I'm sick and tired of hearing that social media is causing a problem. We can't believe that it's the cars fault, for the accident. We need to take responsibility. We need to stop blaming, call it what it is and do something. [Pacific Student contributors]

The Importance of Creativity

Multiple submissions pointed to the importance of creativity. This is another activity often considered outside the scope of legitimate medicine. However, both service users and service providers argued that creativity was a potent contributor to the recovery of wellbeing. Notably, the energy, ease, beauty, order and flow of creativity is the polar opposite of depression, compression, illness, stasis, inaction, disorder and disease. The words below from a submission from Pacific young people, cannot be said any better:

Sometimes school destroys things like poetry, music and dance. We must empower creativity it is a solution.

To be creative,

It's about expression not perfection

You need to be courageous and put yourself out there.

Imagination makes things incredible - seeing someone's imagination moves from inside of them to outside of them. [Pacific Youth contributors]

The Crew Matters: A Pacific workforce please

Finally, the outliers spoke to the importance of seeing themselves reflected in the 'helping professions' that aimed to serve them.

One main suggestion we have, is building and investing in our workforce. [Pacific Youth contributors]

Having a Pacific workforce was considered to be a really important way of overcoming a lot of the access and service barriers. There was, however, a caveat about concerns of confidentiality.

Are they going to maintain that confidentiality? Re: Pacific programmes you feel that they may know someone who knows your mum or uncle.

Our aiga love us but you don't want to share certain pressures with them—confidentiality at every single level. At different leadership levels—same confidentiality we see with health services with volunteers, etc. One provider was talking about issues and she told them that some Pacific students wouldn't ever go to certain leaders because of confidentiality. [Pacific Tertiary Student]

In our experiences it shouldn't also be people who are associated with the same ethnic groups, they might tell our parents at the next community meetings. [Pacific Student contributors]

There were genuine fears expressed about confidentiality from an ethnic-specific 'old guard' that already had a role in regulating and monitoring community members. However, still a strong desire for the community to serve the community.

Pasifika clinicians and trained community leaders should lead it. It should be connecting with people the young people are comfortable with. It should be led from community not the medical model leaders. [Pacific Student contributors]

It is clear that many of the positives of cultural compatibility, being personally approachable, understanding the context and being able to relate is undone when high professional standards are not adhered to. Repeatedly among submissions emerged the desire for the best of the balance between cultural, clinical, personal and professional. Finding this 'sweet spot' resulted in positive outcomes for all.

This is discussed in more detail in the next section. Similarly, it is clear that Pacific youth also desire to choose from a wide menu of options, that may or may not include Pacific services depending on their issues, their levels of trust, their needs and experiences.

TUFUGA: VOICES FROM THE VAKA

Fetuiaki a kupenga tutui. The mixing of fishermen who can cut straight through entanglements. [Tonga]

It defies logic that you can service people without knowing who we are – and do not consider the context... It's not a one size fit approach – instead it might be a matrix. Mainstream is not serving us well, we could do it better. We are happy to fix ourselves, we just need the opportunity. [Pacific Provider Leader]

The voices from the vaka are the navigators and the fishing boats, the providers and 'helping' services and organisations that assist people in distress. They are the 'tufuga / tufunga' or specialists who are there at the frontlines. In this section you will find the issues that Pacific service providers felt were important to them, organised according to a thematic analysis. Their observations, reflections and analysis describes the current context and challenges associated with delivering Pacific services or serving Pacific clients. For those sitting at the maunga, what they share here also signals and shapes future viable solutions.

On the sharp edge: Unwanted, Involuntary, Over-Medicated Experiences

Akin to the family story shared earlier in this report, submissions raised concerns that Pacific peoples often experience the sharp edge of the 'involuntary' end of the mental health spectrum.

There are disproportionately high numbers of Pacific who end up at Mason clinic, often entering through the Criminal Justice Act, which results from late presentation often arising from factors such as stigma and discrimination surrounding mental illness. [Pacific Provider]

The high rate of seclusion of Pacific people tells us current model doesn't work. e.g. highest rates of seclusion are Tongan men. It could be different if someone speaks to them in Tongan and respectful manner... A Pacific P addict needed addiction-centric services. Instead, he hurt six staff members as Māori response didn't work as not his Pacific culture. [Pacific Health Providers]

One practitioner explained at a Pacific meeting, that as a Pacific person working in an acute unit, the high rates of seclusion were preventable if someone was there from their own culture, able to soothe and comfort them.

Yes, we have the highest seclusion rates... it's not rocket science - that for that person, that scary moment – having someone there who may resonate – can just help with the anxiousness, nervousness, will end up with a better outcome. [Pacific Contributor]

Another person working within an acute ward spoke of how Pacific staff sometimes worked double-shifts and co-ordinated with one another, to ensure someone Pacific on staff was there to care - otherwise Pacific peoples on the ward would be vulnerable without them.

Can you imagine what that it is like? They are in cells! They are caged and hearing voices! [Pacific Contributor]

Pacific practitioners working on the front lines of acute units spoke with concern about the genuine lack of compassion shown to Pacific peoples experiencing mental anguish. They talked about the lack of safety for these vulnerable peoples in a mainstream system if Pacific staff weren't present. They expressed concern about the way the Mental Health Act was wielded.

The Mental Health Act is as a blunt tool/instrument which drives a dominant Pakeha worldview. Specific Pacific worldviews are not considered within the Mental Health Act. Cultural significance and meaning held by patient's/service users and their families are not given credence. [Pacific Provider]

They noted that: Current efforts for using a service-user outcomes tool (self-rating from the service user) has 'fallen over' [Pacific Health Providers]. Participants identified that the ways Pacific peoples were treated were in direct contradiction to Pacific values of respect, humility and dignity. They raised very real concerns about how the existing system further traumatises Pacific peoples and their families who are in pain. There was much anguish and upset expressed about the lack of care and compassion for Pacific people by the current system in its existing configuration.

Mainstream missing the boat

E vaka putaputa. A boat full of holes. [Cook Islands]

Submissions consistently communicated concerns about the inadequacy of mainstream approaches and services and the treatment of Pacific peoples in their care.

People are getting very well paid for making it difficult for people to get help... [Service Provider]

There is a lack of compassion in the coordination of delivery and a "not my/our job" mentality that too quickly results in whai ora being referred elsewhere, with no follow-up, nor explanation. [Individual submission, ethnicity unidentified]

Mainstream services have no cultural capability. To have a psychiatrist and someone interpreting is not okay. We need strongly contextual services... Mainstream have let us down. Currently 'you get what you get, if you don't like it bugger off'. [Pacific Providers]

They are medicating to the max. [Pacific contributor].

Over-use of medication – yet most mental health related sicknesses appear to be culturally addressed. [Pacific Clinician]

We see non-Pacific assessing our people. They don't understand the cultural factors. [Pacific Provider].

At all levels people have stopped listening [Pacific Providers].

The inadequacies of mainstream were echoed by users of services and their families.

We suffer in silence. Let our parents know what's happening for us –get in an interpreter. [Pacific Students contributors]

As a 'space' it was unwelcoming, inhospitable and depressing to be there. [Pacific family submission]

The R-word

Racism is a word that is often avoided in New Zealand policy making documents, strategy or health reports. However, many Pacific participants spoke about feelings caused by being on the receiving end of racism. There was reference to what was not done, made accessible or helped with because of racism. There was reference to unkind behaviour and ill-treatment. Over-representation of seclusion, over-medication, a lack of care, a lack of resourcing, a lack of referrals, and poorer outcomes across a range of markers could be traced back to a genuine disconnection by non-Pacific peoples from the authentic humanity of Pacific peoples and their needs. This was witnessed by other

non-Pacific peoples who saw first-hand the discrimination that Pacific families and service-users faced and the discrepancies in quality of care.

Anecdotally I have seen very little support and a racially driven lack of empathy towards Māori and Pacific cultures... Victim blaming is very prevalent in the mental health institutions. Empowering should be the focus. [Individual submission, ethnicity unidentified]

With Māori and Pasifika whānau I come to support. Very cold and clinical. I'm working hard to engage with the process but there has to be a better way. And if unsuccessful they won't go again. [Service Provider]

Racism permeated the Pacific experience of the mental health system. Many of the Pacific providers were willing to call out racism, rather than leaving it as an unspoken elephant in the room. They were impatient with the ways it had not been addressed in any meaningful or evidence-based way. This lack of response leaves it with the people who are hindered by it and does not confront in any way those who perpetuate racism openly or covertly within the system.

We are still not addressing the barriers caused by discrimination, racism (including institutional racism), culture and language. [Pacific Clinician]

Look at institutional racism. The moment institutional racism is dropped, people freak. You've got to open it to address it. Need more research data so more than anecdotal evidence. [Pacific Provider]

When FTEs aren't filled in with Māori and Pasifika, the money is clawed back – so if we don't have filled FTEs when the review occurs regularly, they claw back the money off us. But for non-Māori and non-Pacific, it is not – if they don't have FTEs filled, nothing happens. The way the system treats community providers is like chalk and cheese. The current system still does not deal with us in a way that is fair. It's called institutional racism – there's a lot of racism in the system. [Pacific Clinician, Pacific Provider]

Obvious Gaps: Unmet Need

Associated with a level of institutional racism were certain areas where there was glaringly obvious need that has been unmet by successive governments. These are areas of inadequate attention and lack of care largely because the communities affected so negatively are poor, vulnerable, high needs and not politically powerful. An example was the danger of synthetics:

We have had 90 deaths now from synthetics. If they had been from a rich area, would this still be a problem? If they died from cookies, would the factory still be going?

...There are drugs hitting the scene now that we still haven't even seen. I'm worried about Māori and Pacific people after 20 years going to do what's been done to New Zealand. Addiction will destroy cultures. [Pacific contributor]

Pain was expressed about the unmet need and obvious neglect in the system. The lack of Pacific youth mental health services was one raw point. Providers were genuinely worried about that generation, the high proportion of suicides, the wide prevalence of drugs such as methamphetamine and synthetics, the binge drinking, lack of cultural confidence and a poor sense of belonging.

The obvious unmet need was hard to stomach by those on the frontlines.

We need more residential Rehab centres like Red Door to meet demand. Why don't we have a retreat centre where ex-addicts work with addicts? [Pacific contributor]

The homeless participants saw the need for:

A night shelter with social workers, programmes, spiritual guidance, 24hr support and care to learn life skills. [Pacific Community Fono]

Another area where there were obvious gaps was in dual diagnosis. This was not seen to be effectively addressed by the present system. Beyond the dyad of addiction and mental health, there were other dual diagnosis areas identified, such as with disability.

The lack of support and services, when the need was so obviously high, was felt as systemic violence. It contributed to the hopelessness, burnout, exhaustion and lack of sustainability experienced by those within the system.

There was also concern about how there was very little incentive for existing providers to meet this need or demonstrate that they were trying, when their reporting structures were more about “bums on seats”.

From PHO point of view, those that really need the service and have complex needs and intense poverty aren't coming to service. How do we solve the problem of unmet need—that's what's interesting about reporting. How do we provide access? Many communities have their own cultures re: how they access service and to whom—there should be the flexibility in contracting to be collaborative so there's no full stop in someone's service. [Pacific Provider]

There was also a lot of concern about the regions beyond the major cities and the unavailability of Pacific services in those areas. There were worries about the unmet need in geographical regions where Pacific services did not reach.

Direct questions to the Inquiry panel about unmet Pacific mental health and addiction need in the South Island and regions outside of Auckland were raised. These were considered urgent, as were regionally based addiction services. Submissions from these regions include the following statements:

- Pasifika are less visible – policy and service delivery (no longer mentioned in strategic plans like Māori people) [Pacific Community Fono]
- We are often overlooked or bundled into Māori or mainstream providers. [Pacific Provider]
- We need a dedicated Pasifika funding stream and Pacific-specific strategy with accountabilities from DHBs. No Pacific on governance level, no Pacific liaison at this DHB. [Pacific Provider]

There were also some positive exemplars of communities in the region rallying and building critical mass when there was none and weaving community webs of care and expertise where none existed.

The development manager has an education background at one High school and at another school with large percentage of Pacific students. He has been at DHB for a while. He got a call from the principal about the suicide of a young Pacific man. The initial reaction was to ring the PHO and asked about the process: there was no process. We called and there was no Pacific person.

He knew some old boys from the school who were social workers, went to school to lay out plan to go forward. At funeral a Pacific elder said they needed to have a community meeting and highlighted the importance of doing something with youth.

We called together another meeting for those concerned for suicide in the community—health was the most important thing but what about our culture, our traditions, etc.: language, family, etc.

When asked to rate priorities, health was 9 or 10 on the list. Everything is important and it's only when something happened that we realise we need to do something—there is a willingness to do something.

A few years later the school had another suicide—there was then a Pacific navigator in community and they followed up with the community leaders to talk to family. The family meeting was terrible because services had all been there and family had no idea what was happening and they wouldn't let anyone else come in. They eventually calmed the waters but the issue was that when the services came back one of the workers was wearing a miniskirt and that was inappropriate. This highlights the need for cultural awareness for Pacific community. [Pacific Provider]

This short vignette illustrates some of the issues faced by the region, where the critical mass of Pacific professionals is low and cultural competency among mainstream providers is not high. It is an example that making something out of nothing can give birth to what is needed. The importance of engaging community is commonsense and best process. Letting the community set the agenda may mean that mental health isn't top of the agenda but meaningful change is.

Cultural Models and Modalities of Care: Integrity Matters

Submissions from Pacific providers asserted strongly – somewhat unsurprisingly - that Pacific services were very important and were more successful in delivering to Pacific peoples.

The establishment of cultural specific services in the mid 1990s onwards was the right strategy that allowed for culturally appropriate and relevant support and care packages for patients in the community where they belong and reduce burden on secondary and tertiary services... [Pacific Clinician]

Below are some of the consistent messages and themes emerging about Pacific models and modalities of care and the importance of cultural integrity. Many of the sentiments expressed about Pacific culture as part of the solution to existing problems are summed up in the following quote:

Pasifika culture can be characterised by strengths such as kindness, spirituality, compassion and love. More needs to be done to strengthen and amplify these qualities so all people can be better connected and supported to thrive in Aotearoa NZ. We need to change from a deficit model that focuses on mental illnesses and clinical settings, to a strengths-based approach that promotes and celebrates wellbeing in families and communities, and equips our Pasifika community with the skills to make things better. [Pacific Provider]

Default shared cultural understandings

One of the strengths raised by Pacific services was that they are starting from a base of shared cultural understandings.

We know our communities have unique needs that we have the capacity to understand and then look at a solution and be prepared to take the risks [Pacific Provider]

We need more culturally appropriate therapy; everyone's different and it's hard to reach out to organisations that can offer that. [Pacific Provider]

Communication styles become even more sensitive and significant.

How Pasifika see things is from a completely different perspective so we need for Pacific people to have a conversation and different approach. It's not culturally safe otherwise. [Pacific Provider]

Learn to ask questions in an effective manner appropriate to Pasifika people. [Pacific Community Fono]

Although communications must be respectful, it was also acknowledged that laughter is regularly a way that people connect, especially in stressful circumstances.

We connect through laughter. When we have family time we laugh, even at funerals - we grieve then we laugh. We need to connect positivity as a country, and do it culturally. [Pacific Youth contributors]

Assess distress in culturally aware ways

Submissions also made it clear that, at its most fundamental level, Pacific service delivery needed to be able to culturally contextualise mental health and addiction behaviour and understand how service-users perceive their distress and illness. There must be:

Awareness of cultural beliefs that may be affecting a person's mental wellbeing and to ensure holistic wellbeing it is important to understand the fears and beliefs the client has. [Pacific Provider]

We work in a more holistic way; cultural and clinical assessment. We do the treatment plan together with the family. Educate the families on types of illness and treatment. We speak our language and our culture [Pacific Provider]

Distress is linked to a person's circumstances, world view, family, identity, values, beliefs and environment. The solution to distress should also be framed with in a person's culture and worldview in order for it to be relevant and effective. [Pacific Clinician]

What was considered valuable was the ability to contextualise and understand the cultural framing of experiencing trauma, intergenerational problems, spirituality, breaching tapu and the consequences of broken relationships and other pressures. They recognised that the dominant models of mental health care conflict with, compete with, and uneasily co-exist with Pacific interpretations of the same symptoms.

Is it schizophrenia – hearing voices – or is it avanga? (Tongan construction of a spiritually derived illness) [Pacific Community Fono]

If we were back at home (Fiji) the way we would interpret that, is that the woman was possessed. [Pacific Community Fono]

Pacific models of care

Multiple submissions spoke to the importance of Pacific models of care.

By Pacific for Pacific services are more than just having Pacific peoples at the frontline to work with their own. By Pacific for Pacific services mean that the model of care reflects the values and philosophies of Pacific. There is an incorporation of Pacific theories and beliefs about good mental health. There is an acknowledgement of Pacific treatment modalities and care [Pacific Provider].

To improve mental health care for our Pacific community through a holistic perspective as determined and promoted by our various Pacific models of health care such as Fonofale, Te Vaka, Tivaevae, Fonua and others; and distinct models that all

recognize the importance of clinical care, culture, family and spirituality, as well as physical, sexuality, age, gender and socio-economics, time, environmental and context dimensions. [Pacific Mental Health contributors]

Ethnic Specific Capacity

Some submitters argued specifically for the value of ethnic-specific approaches, tools and models.

Ethnic specific initiatives – e.g. Paolo Suicide Prevention resource for Samoans. When the resource was released in 2007 it was well received by the community, they found it useful and effective. The demand was so great that the MHF had to reprint it twice. It needs a refresh but it's still applicable. The "one size fits all" and "pan pacific" approach is too blunt to be effective. [Pacific Contributor]

We went to training workshop last week with no reference to culture. If there is, it's about one Pacific rather than 7 different Pacific Island Nations with own needs, values and belief they are brought up with [Clinician, Pacific Provider].

Cultural Integrity

There were a number of criticisms about existing Pacific services and therapeutic approaches not able to truly operate in alignment with cultural ways of knowing.

These are just a brown version of mainstream services - not truly Pacific models. [Pacific Provider Leader]

Current Pacific services/organisations are mostly just brown services operating on a Palagi medical tikanga. [Pacific Clinician]

This was seen to be unacceptable. Pacific practitioners were frustrated that holistic Pacific modalities of healing and care were exceptionally hard to practice within the confines of a system set up to practice in a bio-psycho-social way.

We need natural medicine like what our ancestors did: healing foods, spiritual people. We are trying to help our people understand that there's nothing wrong with hearing voices. We are teaching our people who don't believe in spirits or voices, that they are actually real. They exist in our loved ones minds. All our loved ones need is love, and acceptance and support. [Pacific Community Fonofono]

Massage is a traditional way of soothing the feelings of a patient. Traditional healing, understanding about supernatural beings, the very positive way of our aitu (spirits), our taula aitu (those who can anchor in the world of the spirits and make meaning of it), those stories can inform your knowledge about your illness is all about according to a cultural perspective. [Pacific Community Fonofono]

We need fōfō, to walk, to play the guitar, take off your shoes and put grass under your feet, sand between your toes... we need exercise and talking therapy... That's what I want to offer, but how do we pay the overheads? We need a Pasifika environment where people are understood. [Pacific Community Fonofono]

It was also argued that cultural factors are the first ones that underpin a Pacific point of difference. Sometimes, however, Pacific services were not good at articulating and identifying what their special points of difference are.

What we need to be focusing on is what makes us unique and how do we show it? Each organisation needs to review that and then ensure they practice and embrace their point of difference so their target client who wants that difference will also appreciate and value it. [Pacific Provider]

Further research into Pacific approaches to healing was recommended.

Research into traditional methods – not all westernised methods consider Pasifika healing. [Pacific Community Fono]

Finally, also mentioned was the establishment of Pacific outcomes frameworks. This recognised that many current frameworks do not fit for Pacific. It was considered that there were unique opportunities to build on lessons of what has worked and how Pacific services can measure effectiveness.

Not Just Clinicians Driving

La fili i le tai se agava'a. Choose on the high seas who ought to pilot the boat. [Samoan proverb]

The marginalisation of Pacific approaches to therapeutic outcomes seemed to co-exist with clinical disregard for cultural and community workers and their practice. Professional gatekeeping, power struggles and poor outcomes for Pacific peoples were witnessed and spoken about by Pacific staff and organisations.

Clinical staff do not respect the insight and knowledge that our CSW/PSW have in terms of clients, despite them being the ones who mainly support the individuals. This lack of respect can lead to clinical staff over ruling our staff in terms of decisions around care and treatment which can, and does result to repetitive cycles that affects/impacts the client negatively. [Pacific Provider]

There is an overwhelming narrow focus on medical treatment and academic solutions to “fix” mental illness. An “Expert mentality” - the philosophy that a few people (trained professionals, academic and clinicians) are the ones who hold the solutions and “fix”. It is expensive, unsustainable and hasn't worked. Community are seen as unqualified and useless while on the other hand the “experts” are painted as the clinicians and academics. [Pacific Clinician]

The clinical safety response is to get security, while the Pacific safety response is to get Aunty. [Pacific Provider]

The ideal was seen to be integration and mutual respect for both clinical and cultural knowledge.

Sometimes as a society we give great emphasis to the expert mentality disregarding the fact that seeking solutions and positive outcomes should value and support the understanding that everyone can help, everyone can make a difference at every level of society. Supporting someone who has attempted to commit suicide requires not only the psychologist, it may also require the understanding and well positioned voice of a Faifeau (church minister) who may be held in high esteem by the family or individual, it may require the support of a friend or rugby coach that's voice is still able to be heard within the void of hope of someone who is contemplating taking their own life. [Pacific Provider]

We need cultural support to go side by side with crisis team to facilitate the engagement. They organise meetings, family meeting, translate and explain and demystify the mental health services. [Pacific Provider]

Deep Divers Onboard

He ringa miti tai heke. Hands that lick the ebbing tide. Said of those experienced handling waka in difficult waters. [Māori proverb]

It was consistently asserted that best practice values the experience and expertise of the service user. It was argued that people with lived experiences should be involved through service design, research, education, advocacy and support.

Inclusive of those staff with lived experience and fully recovered is the best practice. Involve users with lived experience of mental illness to develop and run programmes, as they can provide support and education and share their experiences. [Pacific Clinician]

The politics of a system that privileges the clinical were also addressed.

Peer support workers are not valued. They have on-going and strong relationships with their clients but their narratives and knowledge about their clients are not considered, particularly by clinical personnel. [Pacific Provider]

Strengthen the entire crew

Developing the Pacific mental health and addictions workforce was seen to be a priority by many. It was agreed there needed to be investment into areas that build the Pacific workforce.

This includes funding for the Pacific community support work certificate programme which only ran for one year under the Pacific Provider Development fund (PPDF) through [named] programme but due to limited resources, this was discontinued. Further support for this training should be examined. This training is critical given the fact that there has been a noticeable increase in Pacific people entering the mental health and addictions workforce. The non-regulated workforce entry points have been through this critical training. This avenue is critical for encouraging people without tertiary qualifications into the mental health and addictions field. [Pacific Provider]

There were serious concerns expressed that existing training programmes did not have the capacity to prepare culturally competent workers. The priority was seen to be developing a competent Pacific Mental Health Workforce:

There are also institutional barriers from academic institutions which does not address the needs of Pacific students. The Pacific worldviews around education and ways of learning and knowing are either superficially covered or otherwise ignored. There is a need to include Pacific frameworks, models and tools into our current nursing curriculum to attract and retain Pacific nurses and increase the need of the health system. This needs to be reflected at all levels, up to postgraduate level. We need to build our Pacific nurses at every level, nurse practitioners, nurse specialists, leadership, education, research, policies and positions of influence. [Pacific Provider]

Professional staff who have come to our organisation need to be “untrained” as their education and/or mainstream experiences have taught them to be remove the emotional aspect for their role. Connecting and engaging with our clients and families through a shared understanding and mutual respect is what makes us different to mainstream. How do people expect to engage and make a real impact with at risk families and individuals if they cannot show that they genuinely wanting to help and make a difference. [Pacific Provider]

As well as including Pacific world views in existing primary, secondary and tertiary (medical and nursing) curriculums, one of the ideas put forward was to establish a Cultural and Clinical Training Centre.

Generally, Pacific workers talked about how important it was to be in a supportive Pacific environment, with Pacific colleagues, doing their best to work in alignment with Pacific values and ways of doing things. The recent termination of a Pacific service, and merging with a mainstream team would counteract this. Concerns were expressed that new Pacific graduates will miss opportunities to learn from Pacific practitioners and being immersed in Pacific-specific services.

Concerns point to the importance of environments that are collectively oriented around meeting Pacific needs specifically and the value and power of this expertise, collegiality, critical mass and spirit. It was made clear that it is not the same as one or two Pacific roles within mainstream services.

Whānau on board

Motu e va'a 'e taha, 'oku ongo katoa ia ki he fu'u 'akau. If one branch breaks the rest of the tree is affected. [Tongan]

We MUST work as aiga/ magafaoa/ 'anau/ matavuvale/ families in the Pasifika way and the cornerstone of our cultures for long-lasting wellbeing and recovery for service users. [Pacific Community Fono]

The frustration expressed about the lack of respect by powerful clinicians and 'experts' for cultural knowledge was also extended to a frustration about the lack of respect for Pacific families and whānau. It was argued that it is very often the family that looks after a person when they are discharged or not in an inpatient unit. There was strong support for personalised family solutions over individual solutions. There was criticism of individual based models and approaches:

Treating someone as a single entity doesn't work in anyway whatsoever without... the meaningful people in your life. Privacy concerns are a different concern – this needs to be better understood. We must mobilise all resource to help people keep well. [Pacific Provider]

Services are more effective when they understand and respect individuals' support circles and identities, and how they are supported by and support others. A person's connection with their family, culture and identity can be a significant source of strength and recovery... It is not uncommon for many of these carers to burn out because they are so busy helping their family member remain well, that they neglect themselves. What would be great to see is more circles of support in place for carers. [Pacific Provider]

We need support there with the whānau—we support the individual but the families don't get the support they need and the family itself becomes unwell. Where does that leave the family? [Pacific participant, Provider]

Pacific providers also drew attention to the very desperate socio-economic conditions and challenging realities faced by many Pacific families.

Income distribution is bad. The mean income is \$12,000. The reality is not well understood or recognised. We need to truly understand the context – the barriers to care - instead of thinking they are not turning up to the clinic, noncompliant, bad, naughty people! There are 80,000 people in overcrowding housing. 43% tell us they are often cold in their homes. How can they heal or be well when they are worrying about core things to survive? [Pacific Provider Leader]

An effective way of working:

Recognises personal need but is also cognizant of the need to work with the system that surrounds service users, the most important system being, family.

Many of the people we work with, have a strong desire for family acceptance and belonging. Many of the young people that we have worked with in our youth service recognize the importance of their peers yet still find their identity and sense of belonging within the structures of families. Middle-aged to older service users are more than often concerned about their family's welfare and especially the welfare of their children. Although our service works with the service user who has been referred to us, this often cannot ignore the system that they belong to and to which they seek identity, that is, the family. [Pacific Provider]

The unanimous support for whānau involvement had this caveat:

Family includes meaningful people in your life. Mainstream and clinical have trouble with this broad definition. Mainstream is about autonomy of the individual, the rights and informed consent of the individual with no family approach in medicine. DHB operate a biomedical model while Māori and Pacific is village and tribe model. [Pacific Provider]

The idea that a service could work with the family of someone in distress and support them, without ever seeing that person themselves, was the pinnacle of understanding that crisis is not an individual experience.

We are able to work with fono even if the person with gambling problems never presents. [Pacific Provider]

Working in ways that harness whānau and mobilise them as recovery resources was strongly advocated for. Finally, there was considerable support and enthusiasm from the sector about Whānau Ora. Praise of Whānau Ora was so consistent that it is worthy of its own section.

Whānau Ora

Whānau Ora was repeatedly referred to as one of the few things within the existing system that was working. A whānau ora approach was considered a "godsend" and could be extended to, adapted and tailored to a mental health context. However, Whānau Ora was not seen to be embedded enough in the mental health and addiction sector, as some of the quotes below indicate.

The Whanau Ora concept could be extended to include Mental Health and Wellbeing because it is more holistic (good fit). [Pacific Clinician]

Focus on patient centered care MHS adopting the Whanau Ora approach to support patients and their families. [Pacific Contributors]

Whanau ora is great in the general population but current experience notes lack of prioritization and commitment to mental health and addictions. Mental health and addictions need to lead a mental health Whanau Ora approach. [Pacific Provider]

Whānau Ora has been a Godsend: we pay for school fees, school books, uniforms. We used to pay for these things out of our pockets; we can't just let the kids not go to school. No one knows what we struggle with. [Pacific Provider]

The provider who described Whānau Ora as a godsend because it enables them to practice in a way that was consistent with their Pacific values, outlined the comparative difficulties that they have with their mental health contract.

Our mental health contract is for ages 0-19. This contract has been a struggle for us to link up secondary and primary care. We look at Pacific as family, not as individual. But the criteria only looks at the individual. You can't leave family out with Pasifika. The child is taken away and no services are provided to the family at all. They'll look at severity but not at prevention of mental health problems. It's a struggle to be assisted by psychiatrists. The entry criteria are very high. It doesn't fit within our family or the way we do things. The age group ends at 19. Where do they go after 19? [Pacific Provider]

Whānau Ora is strengths-based and it's the only model that takes our culture into consideration. It's a model that unifies our strengths. It might be small but it's an important vehicle for inspiration because the strengths that I have are actually based on my culture. [Pacific Provider Leader]

Catch our people at the shoreline, not the deep ocean

He au kei uta, e taea te kape; he au kei te moana, e kore e taea. Knowing that, the rapids on shore can be bypassed, the whirlpool at sea, cannot. [Māori proverb]

The importance of prevention and early intervention was raised repeatedly.

We receive clients at the 'crisis level' and is often onerous. Much needs to be done around early intervention and improving mental health literacy throughout the education system and for families. [Pacific Provider]

Current support and treatment is reactive rather than proactive. This is reflected in the lack of funding commitment to health and mental health promotion [Pacific Provider]

Secondary mental health package is the focus but primary care picks up children much earlier re: mental health service use. Care packages should be focused on primary care level, so that parents or teachers can refer to counselling earlier on without waiting to escalate. [Pacific Provider]

The unwillingness to fund community-based activities as valuable mental health recovery options, extended to an unwillingness to fund health promotion. As one person commented below, the whole system operates on a:

Deficit/illness model and approach. [That] you have to be really sick to qualify for treatment is crazy idea [Pacific Clinician]

Services need to have a larger community focus so they engage more with our people (80% out and 20% in the office). [Pacific Community Fono]

Focusing on protective factors is one way of doing this.

A focus on protective factors would include providing community-based social and health support, peer support and services that build protective factors across the lifespan. It would include:

Strengthening connection with culture and cultural identity

Building social connection and positive and meaningful relationships, and addressing isolation and loneliness

Growing family cohesion, supporting positive parenting and nurturing whānau connections

Developing skills for wellbeing, problem solving and distress tolerance

Services and supports (including peer support) that focus on recovery and hope, and provide care and follow-up after a mental health crisis, suicide attempt or experience of suicidality. [Pacific Provider]

The importance of early intervention also extended to strengthening resiliency and valuing the mental health of mother, infants, children and supporting parents.

Value the mental health of our children now; examples: by reducing adverse childhood experiences i.e. prevent child sexual abuse and neglect; Identify and treat postnatal depression other mental health concerns; Address parental substance use; gambling and domestic violence. [Pacific Contributors]

Prevention needs to be prioritised. We need to be building our families and communities up in terms of health literacy and awareness, but also in terms of how to communicate and teach kids to be resilient. We need to have more Pacific specific parenting programmes utilised to help our families be stronger. [Pacific provider] has helped develop and pilot two Pacific specific parenting programmes targeting Samoan and Tongan parents with children under the age of 5. These programmes were a success and we have evaluation from [research company] that shows this as well. We need to look at how we can get families to be a safe space for children to disclose their feelings and emotions and prepare our parents to talk about tough and culturally taboo topics such as suicide. [Pacific Provider]

Finally, the importance of education programmes was raised repeatedly.

Needs to happen earlier for our young people (in schools) – plant the seed early so that they in turn are better equipped to understand mental health and addiction. They can also assist their own family, matua (elders) to understand also. [Pacific Community Fono]

Stuck on the surface

Many practitioners spoke of the difficulty of trying to address complex and deep rooted problems in the current system. There were comments about the challenges of having fifteen minutes to solve challenging and sometimes intergenerational issues. There was frustration expressed about always working with the symptoms, rather than the cause.

A talking therapist explained that all she was allowed to do was three block sessions or six block sessions and then had to refer them on.

That person doesn't get them. They can't afford it. [Pacific Community Fono]

So many people were talking about sexual abuse, needed to be there to talk to people. Pressured like every doctor is to see as many people as possible—people have cobbled together 18 dollars and tell their story. They've been everywhere but not directed to the right area. It gets her into trouble with her workmates because she will not let them leave. Bureaucracy gone mad—when we've got our specialty we're supposed to put the patients first but that doesn't happen. So broken that it's impossible to fix it. [Clinician who works with Māori and Pacific]

The practitioners wanted to be able to work effectively with the deep roots of the serious challenges and issues people opened up about. This required:

Depth: long term solutions to complex problems [Pacific Clinician].

This was echoed in sentiments about the way that contracts were awarded.

The sustainability of the current commissioning model is very time limited. This does not work for Pasifika and Māori. We have a lifetime of problems to resolve, it won't happen overnight. So if we're looking at a commissioning model, then the contracting needs to be for a longer period. [Service Provider]

Beyond the scope is often where healing happens

A consistent theme of submissions from practitioners was the therapeutic value of activities beyond the scope of clinical expertise and contracting expectations.

Cultural related activities including language groups and events do matter. The activities can help re-work the physical bodies of people with mental illness and also occupying the time of those with addictions. Activities are therapies to people and enhancement of their creativities help them think positively. For example artworks, mosaic, canvas paintings can turn into a fulltime work for money. Inclusive of community is another long term recovery to people with experience of mental illness and addictions. [Pacific Clinician]

We have a strong commitment to an activities based programme. This is not funded by health but is possible through small community grants. These programmes enable us to deliver programmes that encourage recovery beyond just mental health specific programmes, these include: Employment preparations including, job interview training, dress for success, developing cv's, finding employment; Financial management including budgeting, examining cultural barriers to effective financial management; Overcoming stigma and discrimination including self-stigma; securing long-term housing; drivers Licensing training; developing self-reliance through education. [Pacific Provider]

It was also noted by a provider who delivered these programmes that the therapeutic or behaviour change outcome may happen inadvertently. Even though you are targeting one area, it can end up having a significant impact on another. The beauty of 'beyond the scope' activities is this kind of magic; the coming together of people, and a holistic approach to multiple life problems that manifest clinically in a fairly narrow way. We need:

Community Informal Support Groups for Pacific people e.g. Church; Sports; Youth; Women Groups that focuses on general well-being and resilience of Pacific people [Pacific Contributors]

Successful family-based model: MOH Smoking programme was not working as families still smoking. But a financial literacy programme (more innovative approach) on cost of smoking and buying takeaways (evidence) changed their behaviours. They stopped smoking. [Pacific Provider]

The importance of these cultural and community activities – often in the forms of physical activity - was echoed by Pacific workers at the DHB during the Pacific meeting in Auckland. They said that because their services were considered clinical in contrast to NGOs, these kinds of activities had been curtailed, cut or restricted. They argued that, in fact, collective and communal events were vital to recovery and improvement for Pacific service-users. However, the value was not seen at a higher level and it was very hard for it to be funded and supported.

Poorer Pay for Poorer Cousins

There was repeated feedback from those working in Pacific roles and in Pacific NGOs that their expertise and effort was not reflected back in their pay packets. The lack of regard for Pacific cultural and community knowledge, and the unwillingness to reimburse it in a way that

demonstrated its true value was experienced as a form of institutional racism. In addition, it was felt the “extra mile” and additional hours required to truly care for Pacific clients and engage meaningfully with their whānau often fell within a culture of expecting that they would “do it for love”. It was “well known” that many Pacific clients required a lot more time, energy and skill in order to achieve good outcomes. Many Pacific clients who fell into the “too hard basket” were referred on by mainstream providers. And yet, there was no measure of increased resource, often there was much less. This meant that Pacific providers experienced significant disparities on multiple levels. The belief was that this was, on some level, known by funders, but ignored and abused because it would likely be done anyway.

Increase salaries of Pasifika staff to match the mainstream equivalent and the extra duties they inherit (cultural support for colleagues). [Pacific Community Fono]

We need pay parity; you can't lump us in with equality due to disparities. [Pacific Provider]

The current funding system is inequitable. [Service Provider]

Be paid what you're worth – pay Pasifika staff according to skill levels [Pacific Community Fono]

We need to relook at resourcing and workforce and family and whanau involvement. [Pacific Provider]

Mainstream funders view to us – take what you can get and work with it. DHB answer is always no. Workforce is stretched to the max. There are barriers for us to link into mainstream services. The system is not working for us. [Pacific Provider]

This lack of parity with regard to professional pay and organisational resource was experienced in a sector that was described as being in a state of drought with regard to resourcing.

Static and shrinking budgets make our jobs harder. Unacceptable that no funding increase for many NGOs in past 8 years faced with known increase in demand and complexity. Increase stress at the frontline and organisation level because of funding. We are trying to provide holistic services. Contracts limit what can provide when more prevention is needed. [Pacific Provider]

We only have 1.5 FTE covering [named cities] from [DHB] (as the biggest provider). The funding is nowhere near enough to cover the need. The waitlist is huge (around 6-8 weeks). The danger is that people get worse by the time we get to them. [Pacific Provider]

We need funding for more staff and to be able to retain staff. We need funding for more beds [Pacific Community Fono]

Better Flow in the System

If we believe that mental health is impacted by the burden and complexity of increasing factors such as low socio-economic positioning, lack of availability of safe, warm and affordable housing and an effective education system, what is required is a macro-level agreement for effective collaboration at all levels of the system. Those responsible for the management of the system need to understand the nature of its own complexity. The system needs to address its barriers and the inherent discrimination of the system and the effects these have, on the attainment of positive individual, family and societal outcomes. [Pacific Provider]

We want to provide an integrated family service: nurse-led work, a doctor, behavioural and mental health - all working from one space. Best practice shows that

this is what works for communities like Pasifika. This is how we already work except we're confined by our national contracts which don't allow for it. Re: funding: all Ministries should be working together instead of being siloed as mental health touches on everything; health, education, vulnerable children, etc. [Pacific Provider]

Submissions from providers and practitioners raised concerns about people getting lost in the system's referral process. They desired seamless transition of care. Examples of concerns raised included:

Services are not always notified of clients being discharged despite already being involved in client care; Transition from secondary care to primary care not always managed well; Links between DHB and community providers could be improved; Hospital staff not always familiar with services available in the community which impacts on discharge; Information on referrals can be lacking and assessments etc are not shared with the community providers. [Pacific Provider]

The referral system is not working. [Pacific Community Fono]

The current system creates a silo approach to working with communities. Collaboration is often prevented by patch-protection. This is not only amongst Pacific but often from mainstream. Sometimes however, when integration and collaboration becomes a focus, the perception is that to make things easier to integrate, assimilation is the preferred option. This has been seen not only in the history of New Zealand but also within the system that supports this society. Historically, assimilation creates alienation and often Pacific, like Māori, become exposed to having to justify their models of care, to validate their experiences and as such validation is often pitched against Western measures and interpretations. [Pacific Provider]

Our staff would appreciate the ability/authority to refer to specialists such as CBT practitioners and psychiatric services etc. Our staff see the need for these services for their clients, however the only way the client is able to receive these services is by going through the system again which is often due to a relapse or they have attempted to take their own life. If we are able help prevent these situations occurring through referring on, then our families and communities will be spared a lot of heart ache. If our staff could be granted the respect and authority to refer to more advanced mental health services that would be extremely helpful. [Pacific Provider]

There needs to be a "Step down" from hospital before patients are going home so that all involved (including aiga/whanau) are well supported to assist recovery. [Pacific Community Fono]

There needs to be a programme for residents to help them integrate back into the community after supported accommodation. [Pacific Community Fono]

The following wish-list by Pacific contributors, generally articulated that they wanted Pacific peoples to be:

- identified early by clinically and culturally competent mental health professionals;
- to receive the right assessments & interventions in an appropriate setting and timely manner, utilising integrated and holistic cultural models of care e.g. (physical, mental, spiritual, others);

- if in custody comprehensively assessed with a culturally informed approach to their assessment and management, equivalent to that which is available in the community;
- able to access secure hospital level of care if indicated;
- followed up in the community in a co-ordinated way involving the full range of social, mental and physical health support agencies.

There was preference for a set-up:

where services follow people rather [than] people be stuck with the services in their area, like it or lump it. [Pacific Provider]

And:

Engaging with the Pacific community using a public health approach designed with a clinical intervention outcome. [Pacific Provider]

Finally, it was acknowledged that the Pacific mental health and addiction sector were relatively good at keeping in touch, networking and knowing one another. Even though there is patch protection and competition, there is a lot of collaboration and intersectoral connection happening. This was considered to be one of the Pacific sector strengths.

THE MATUA

Alongside the voices from the vaka, are the voices from our matua. These are the elders, the most experienced in the boats. They have considerable influence and authority. The matua raised many of the same issues as the providers and practitioners. Their perspectives lend weight to some of the issues in the previous section – as people who are legitimately involved in current services and have a long track record of working in them. They raised the same issues about cultural integrity, the clinical and cultural power dynamics, the importance of whānau, the importance of relationships and their dismay with mainstream. However, the issue that the most experienced sector matua all spoke to was the issue of power. That is, power associated with decision-making, procurement, contracting and ensuring that services were aligned with integrity to Pacific values. For this reason and because it was only the most experienced and senior Pacific sector members that spoke to this issue, it is the focus of the matua section.

Power

Ko te tumu herenga waka. The stump to which the boat is tied. [Māori]

Pacific people have never really held the locus of control [Pacific Provider]

To cut straight to the heart of the issues, the decision-making and funding power was seen to be in the wrong hands. This was summarised by the submission from one matua who explained allegorically, “the government has its ongoing attitude of throwing the chicken to let go, but holds tight to its string”. This is translated as meaning that while the government purports to support ‘By Pacific, for Pacific’ and culturally resonant services, they retain “the authority to create policies and procedures” without truly relinquishing that control, and “the outcomes are always a mess”. [Pacific Matua].

The “lack of control by Pacific services” at a decision-making, management and contracting level, means that Pacific services are “forced to operate under a western model, then get blamed for inefficiency of services to produce good outcomes”. [Pacific Contributors]

We need to make sure we have Pacific leadership... to have a voice. The absence of our voice up there means we will never be heard. No non-Pacific can understand what we are going through. It feels like talking to a brick wall. The mainstream already has their model of care in place, so we have to go with what they say.

Pacific matua and tufuga spoke with some despair about the decision-making being in the hands of people who do not have community mental health or addiction experience, or an understanding of cultural experiences. Shifting power to get better outcomes required more than having one person on a taskforce, committee – as one person mentioned: “co-design is more than one person”. They were also clear that the DHB’s own needs as a provider overrode their commissioning capacity. They were not set up to be an independent funder.

Current funding of Pacific mental health and addiction services within DHBs are stagnant and old fashioned. It creates competition and isolation rather than collaboration and trust amongst the service providers. [Pacific Provider]

Mainstream is not serving us well, we could do it better. We are happy to fix ourselves, just need opportunity. We need to get commissioning power out of 20 DHBs and MOH with different mechanisms. Separate provider and funder (although this is not the biggest issue, it’s about outcomes). We do not want our stuff with Mental Health Commission. But mental health commissioning agencies without

fragmentation and with a consistent planning approach. Two models; one model that partners with particular populations with clear agreement over outcomes, parameters and gaps... Don't have a system run for exceptions. Turning funding on its head. Purchasing power with flexibility for specific services for our people; more power to get what you need for your people. [Pacific Provider Leader]

Experienced matua were quite staunch that given that it is: "Māori and Pacific who are poorly served; we need to specifically grow Māori and Pacific leadership". [Pacific Provider Leader]. They recommended establishing a Pacific funding group.

Planning mental health services for Pacific needs a different approach with Pacific leading. Not a one fit approach – instead might be a matrix. Pacific sector to learn strengths and how we can bring those to bear collectively. It's not a job others can do for us. [Pacific Provider Leader]

Pacific families of those with lived experience could also see that services were constrained by their contracts.

I am also aware that Services have a strict policy and procedure set up where deep down, they wish to help more but their contracts will not allow them to do so. [Bereaved Pacific Family Member]

The negative impact of contracts being designed by those who don't understand what is required to provide good service to Pacific communities was discussed.

There is a need to break-down the boxes of current contracts which stifle people's ability to be innovative and to do what it takes to achieve outcomes that matter to those who are being supported. These boxes also include geographical boundaries. Pacific people move in and across boundaries. Locally based integrated services are important but so is the ability to provide follow-up for our people on a district wide level. This ability recognizes the traditional transiency of our population. [Pacific Provider]

Contracts need to be revised - Staff are contracted for a certain number of hours per client, but some clients need more additional support to ensure their own safety. Our staff do not feel comfortable sticking to the set number of hours dictated by the contract if they know that it will result in adverse outcomes for the client. [Pacific Provider]

System is not going to meet people's complexity with simplicity (tick box contracts) [Pacific Provider]

It was repeatedly pointed out that the funding received was not commensurate with what Pacific services actually do.

Generational challenges will take a while to see results so we need to stretch out the duration so that sustainable outcomes can be achieved. The current funding structures inherently disadvantage us in very subtle ways. [Pacific Provider Leader]

Pacific-led decision-making that is cognisant of the cultural community and Pacific service delivery context at procurement and contracting level was seen to be vital for services to be able to work the way that is required to deliver the best outcomes. Having the power to shape services at this level would mean that, for example: "specific investment (funding) into Pacific services reflecting deprivation and population needs" would occur [Pacific Contributors].

Pacific peoples having decision-making power at governance level, management level and service delivery level was also seen as vital. This is well articulated by the submission from a Pacific Provider. A lengthy excerpt is provided below:

This means robust boards who maintain a strong Pacific presence and control. Who are not only concerned with the strategic direction of the organization but who also maintain a respect and concern for how this strategic direction is achieved and whether this direction keeps the interest of its Pacific service users and community within their line of focus at all times.

By Pacific for Pacific services ensure management who respect, own and understand Pacific values and philosophy and are committed to ensuring positive outcomes for Pacific. By Pacific for Pacific services ensure staff who are not only professional, effective and efficient but who practice from a strong Pacific cultural lens that recognises and are sensitive to Pacific aspirations of those they serve... Many wonderful and effective initiatives for Pacific make an impact amongst Pacific...positive initiatives which fall by the way as Pacific have no control over how far they can take these initiatives, because ultimately, they do not hold any real control. The resultant effect is a start/stop approach which does not invest in long term effectiveness, does not yield any real return on investment.

Similarly, at one of the Pacific Community Fono, community members queried where the evidence was that showed that services were not effective when they were shut down. The inability to prevent programmes that were evaluated as successful from being discontinued was another tangible example and outcome of the lack of Pacific power and presence around decision-making tables.

There was a lot of discussion around a separate Pacific commissioning agency.

A Pacific Funding Commission for mental health similar to the existing Pacific Whanau Ora initiative. This commission would develop a strategy for the achievement of agreed outcomes which turn the curve for Pacific families especially in the area of mental health and addictions and its related areas including housing, employment, etc. They would be accountable to demonstrate its health and social gains on an annual basis. Constituent members would be all the national 'By Pacific for Pacific services'. [Pacific Provider]

Establish a Pacific Mental Health Commission to ensure Pacific models of care and worldviews are respected and incorporated into all aspects of health care [Pacific Contributors]

At a Pacific Community Fono, one of the Inquiry panel asked the group if there was consensus that a Pacific commissioning agency was a priority. There was unanimous support in the room for this. "Funding that is ring-fenced to enable us to deliver services to our people". [Pacific Providers].

An influential matua made the following comment:

If our name's on it there will be an expectation we will deliver. Bring in current leaders and youth. There needs to be alignment with bigger body to be strategic and part of decision making and links to providers and different layers in the system. [Pacific leader]

In the quote below, the ideas about an independent commissioning agency are further elaborated upon. On balance, there were also cautionary and concerned comments from other matua and providers that there was a danger in concentrating power in the hands of a small group of powerful players. Concerns about "empire building" were also raised. Indeed, whatever is done, will require

a very careful and ethical process that is inclusive and involves a range of views around decision-making tables so that these concerns – and perceived self-interest – is fully mitigated.

It is clear that there was huge support from the sector for something like this. The alarm that delivering within current contracting constraints was unsustainable was powerfully raised. There was absolute consensus that current contracting processes are a considerable barrier to delivering good outcomes. The following were recommendations from a Pacific written submission:

Pacific Mental Health and Addiction independent commissioning agency so solutions being empowered in the hands of Pacific peoples. There is a commissioning body for Pacific (Whanau ora) but not mental health... Needs to be separate for mental health focus and worried is that it would be subsumed. It would need network right down to community. Functions:

Monitoring and accountability

Service development: provider capacity and capability development; workforce development; cultural training; workforce pool

Strategic: Linkages to other agencies all across the system specifically hospital, Pacific providers and mainstream providers also other sectors e.g. disability. Also policy and research. Willingness to work across so everyone responsible for Pacific not just us.

Funder for self-determination: Pacific Island providers; develop new services (youth and elderly services). Flexible contracting so everyone able to work across.

If couldn't get money for a Pacific independent agency... a subsidiary of proposed Mental Health Commission with accountability, monitoring and training.

A senior Pacific clinician in the sector made the following observations about a commissioning model.

The advantage of a Commissioning Agency is it allows providers to work collaboratively: working collectively around how to co-design, gather data and bring evidence to be able to tell rich descriptive stories for potential investment. If there is going to be a streamline of work working collaboratively with mental health, how are we going to co-design that?

Sometimes whānau need a service that is from a competitor. I would like to see a Commissioning Agency that allows providers to work together rather than worry about who gets the money for the services. There is no gain in getting someone to a different service if you going to lose funding. If community can put all they have to offer on the table then whānau get access to all the skills and providers. Then the whānau get to choose from the menu of providers. If a Commissioning Agency could do that we would advance the quality of care exponentially.

We might have to create something new so we don't carry all the institutional behaviours that stop change from happening. If we had a Pacific agency – philosophical pillars would allow us to do it. There is no evidence we can do better than we are if we've never had the chance – but there is high probability. But we need a paradigm shift. [Clinician, Provider]

Even though this section focuses on the matua, it is worth acknowledging that the lack of power and the inability to work in a "Pacific way" and in alignment with those values, given that staff can see that these are the pathways for recovery and positive outcomes, impacts also on the staff. The submission from a Pacific Provider articulates these issues well:

We have... difficulty providing holistic responses to families; the time limits imposed by contracts creating tensions when interventions are still needed. Within our Trust and in our interagency relationships, we end up mirroring the dynamics and survival tactics of the individuals, families, communities and groups we are purporting to support. We end up behaving badly as professionals – the core source of stress. As frontline staff, we make difficult choices where ever we are in the organisation. For example, people allow contractual obligation to define their role – this is what the contract says. This is what I deliver. Very similarly, people are starting to survive on a day by day basis. At an individual level, people start to not attract attention to themselves by being seen as difficult or stropky. But also at agency level, we do not step out of line in case it jeopardises our contracts. We lose our identity... [Pacific Provider]

The cumulative effects of not being able to deliver services in a culturally responsive way that leads to health, recovery and quality of life for Pacific peoples in need is a source of real pain among Pacific workers and organisations. It is directly linked to contracting, funding and power.

THE TREES

Kare o te vaka to'ie'ie rangatira. A drifting canoe has no navigator. [Cook Islands]

The perspective of the trees comes from those who are generally not at the front lines of services, nor people with lived experiences in some cases. These are influential and well-informed sector stakeholders such as researchers, universities, workforce development centres, interest groups, policy think tanks, charitable institutions, collectives and conglomerates. Notably, compelling and evidence-based submissions from the “trees” is rarely Pacific-led or Pacific-focused (with the exception of only a few). Instead Pacific organisations are named to enhance the sense of collective mandate, but are essentially written by non-Pacific collaborative consortiums. It was consistently argued that strategic shifts at the macro-level of law making and policy would create more healthy environments.

Leadership

Multiple calls were made by these stakeholders for greater and more accountable leadership. What was suggested is a named Minister responsible or an independent Ministry of Mental Health and Wellbeing. Alongside more specialised, well-connected leadership, were calls for cross-Ministerial and cross-agency efforts. This included flexible funding so that people get what they need.

Within this vision of a more focused, coherent leadership approach were calls for valuing the importance of Pacific leadership. Relating to power issues associated with funding and Pacific peoples. It was argued that on all levels the approach should be: “Integrate top-down with bottom up perspectives”. [Pacific Provider]

A Public Health Framework

A public health framework is strongly recommended that focuses on determinants of health. This shifts away from the focus on personal responsibility and health service efforts, and moves towards creating a more accepting and equal community. This recommends a path of tackling wider social economic relationships and in particular, the relationship between poverty, unhealthy housing and inadequate healthcare and education and poor health and life outcomes.

Responding effectively to widespread socio-economic deprivation in the Pacific population

New Zealand society experiences significant inequalities. The lifelong impact of socio-economic deprivation, experiencing child poverty and adversity and its relationship to disproportionate mental health, addiction, suicide and gambling problems is evidenced. The disproportionate burden of these challenges for Pacific and Māori is consistently identified.

The prevalence of child poverty and mental health issues is likely to be higher for Māori and Pasifika than for other children and young people.

While many Māori and Pasifika children are subject to inequities in material and socio-economic circumstances as well as institutional racism, they also experience the benefits of a rich cultural life and sense of belonging that is seldom accounted for in research reports that focus on deprivation. [Advocacy Group]

What is recommended was doable strategies that stem and address growing inequities between children in poverty and others. This was echoed by Pacific service provider submissions and was part of the rationale for “beyond the scope” activities.

If we believe that mental health is impacted by the burden and complexity of increasing factors such as low socio-economic positioning, lack of availability of safe, warm and affordable housing and an effective education system, what is required is a macro-level agreement for effective collaboration at all levels of the system. [Pacific Provider]

Environmental interventions

Environmental interventions were recommended that can improve the health of communities and help create conditions where the people thrive and reduce stress. This requires taking seriously what makes life harder for people to stay afloat and tackling these issues.

Recommendations were not limited to, but included:

Eliminate poverty, effectively address issues of inequitable access to services including housing, education and employment and recognises mental health in the context of all aspects that causes mental distress for people.

Levers of change at an environmental / macro-policy level included:

Reduce high density of pokie machines [Pacific Provider]

Recognising that housing is a human right. [Provider]

Reduce alcogenic environments by raising alcohol prices (minimum unit price and excise taxes), raising the purchase age, reducing alcohol accessibility, and reducing marketing and advertising [Pacific Church contributors]

Recognise that lack of regulation place many vulnerable communities at considerable risk legally and financially (e.g. bearing the costs of trying to limit the number of alcohol licenses in the community, through local action plans that are challenged in court).

Urban planning that facilitates community connectedness and reduces isolation. addressing loneliness by increasing the connectedness of people⁶ [Addictions Contributors]

Early Intervention, Education and Health Promotion

Most of the submissions from these stakeholders called for an investment into early interventions and health promotion. It was argued that more needed to be invested in upstream causes, protective and risk factors. In particular, the youth demographic and large number of children in the Pacific population was pointed out. The mental health of mothers, small children and wellbeing of families is vital given the Pacific demographic.

We believe that a focus on the early years is a pivotal primary prevention approach. Almost half of the Pasifika population is under the age of 20 and knowing that many of these young people will soon become parents points to the importance of a life-course approach... The Growing Up in New Zealand Study identified a higher rate of depression symptoms among Pacific pregnant women when compared with other ethnicities. Waldie et.al. (2015) estimated a prevalence of antenatal depression in 23.5% of Pacific women. However when held up against their responses to the question of whether they had been previously diagnosed with depression by a

⁶ Kelley J-F, Breadon P, Davis C, Hunter A, Mares P, Mullerworth D, Weidmann B. 2012, Social Cities, Grattan Institute, Melbourne.

doctor, only 7% responded “Yes”. This finding indicates that a significant number of Pacific women may be falling through the system and therefore are not receiving adequate support for themselves and their child(ren).

We want to advocate on behalf of Pasifika families, mothers, fathers, caregivers and children who are often suffering in silence or relying heavily on their families and/or communities for support. [Pacific Provider]

When it came to Pacific, it was argued that risk factors are not necessarily the same as for mainstream, and Pacific research affirms this. The following are evidenced-informed strategies for Pacific peoples.

- 1) **Connect** – relationships based on love make us feel valued and develop our self-worth.
- 2) **Strong Families** – families can give us a sense of self and support during tough times.
- 3) **Talk** – talking helps us process thoughts and feelings and reach out for help when we need it.
- 4) **Cultural identity** – evidence shows for Pasifika young people that the stronger the cultural identity the stronger their mental wellbeing.
- 5) **Spirituality** – connecting with God or something bigger than ourselves supports purpose and meaning in life.

Public health education campaigns were recommended. This included an education “campaign that gave the public, communities, friends and relatives the ‘right words to help’.” [Addictions Contributors]. Improving mental health literacy was seen to be an important goal. School-based programmes delivered by experts were recommended, alongside parenting programmes and programmes that incorporate cultural identity and strengthen self-worth. [Provider]. Using new and evolving technologies effectively for all of this activity was raised repeatedly, especially for youth.

Understanding barriers to access for Pacific peoples

It was identified that any effective approach for Pacific peoples must contend with the evidence-based identified barriers to access.

Cost and transport, a lack of awareness of, or discomfort with, primary care services; cultural norms, language and communication differences; and stigma and health beliefs, and a preference for traditional medicines and healers. [Pacific Contributors]

Ideas about future directions for services

It was proposed that there ought to be dedicated centrally funded services inclusive of a spectrum of delivery approaches including not only ‘secondary type’ treatment, but community, prevention, early intervention, respite options and peer-run crisis respite services. Notably, “more beds” were also asked for by Pacific peoples in the Auckland Pacific meeting. The kinds of services identified resonated with many things the Pacific providers also advocated for. All the quotes below can be attributed to the lengthy submission of an influential provider. What is required is:

A timely, multi-disciplinary crisis response that has a clear therapeutic focus.

A range of options for support that are recovery-focused, trauma-informed, non-compulsory, engaged with whānau and support networks, informed or led by peers who have been through similar experiences, and culturally responsive...⁷

This also includes a call for more talk therapies.

Services should provide holistic social and clinical support, including factors such as cultural connection, strengthening whānau relationships, housing, employment and education, to support individuals to lead lives where they have choices and dignity.

In addition: greater access to prevention and comprehensive early intervention services...

Any door is the right door approach.

Health and social sector and community working together in responsive way to support mental health and wellbeing at an individual, whānau and community level

Individualised services to better meet the needs of people. What happened to you? What do you need right now? Yes, we can help you get that support

We care, we listen, and we act. [Provider]

With regard to what is targeted towards the individual, the following was recommended:

Prevention of distress, promoting wellbeing (understood as including mental, emotional, social, physical and spiritual wellbeing) and growing individuals' capacity to respond well to life's problems. This includes promoting individual wellbeing skills (such as mindfulness, distress tolerance, sleep hygiene, physical activity, stress management and nutrition), whānau cohesion and supportive environments within schools, workplaces and communities across New Zealand.⁸

In addition, location and targeting to places where the community already gathers was raised.

Increase the number of primary and secondary schools with school-based health services, including mental health services [Advocacy Group]

Cultural Integrity

In support of previous submissions about mainstream missing the boat and concerns about cultural integrity, it was argued that:

Cultural views, language, and history significantly influence the way in which Pacific peoples perceive, access, and use health services in New Zealand.

In order to understand the beliefs, ideas, and values that influence and inform the behavior and mental well-being, we need to understand the Pacific indigenous knowledge system these derive from. Traditionally Pacific cultures are inherently collective and relational with a holistic perspective of well-being where cognitive, emotional, spiritual, physical, environmental, and relational dimensions of the self are required to be in harmony for holistic well-being. [Pacific Provider]

⁷ Note: footnotes in the original quote containing references have been deleted

⁸ Note: footnotes in the original quote containing references have been deleted

Addictions

Addictions were raised as a specific and separate issue that needed its own space. Pacific statistics were shared that demonstrated a range of evidence-based inequalities. In brief, what was highlighted included:

The impact of criminalising drugs on Māori and Pacific peoples and better understanding of the drivers of crime;

Māori and Pacific AOD needs continue to be unmet:

There is no residential treatment centre for Pacific peoples;

The NZ Drug Harm Index 2016⁹ highlighted that “the cost to the community of harms associated with drug abuse was \$892.7 million in 2014, which exceeds the collective harms to the drug users themselves (\$601.0 million).

A better sense of cost of harm to family and friends associated with drug use, including the high cost to children exposed prenatally to drugs, and/or who are living in environments where there is on-going illicit drug use;

Co-occurrence of mental health and addiction. [Addiction Contributors]

Addiction was described as “the poor brother” of mental health. Poor rehabilitation associated with imprisonment and addictions was seen as a huge service gap by a national addictions provider. Young people and ‘outliers’ spoke of how off-putting current ways of addressing addictions are and how new ways of framing and talking about addictions are needed. Coming up with new ways and approaches must involve them in order to truly have reach.

Non-Pacific providers admitted that too much unhelpful, judgemental, shame and blame was put on Māori and Pacific addiction clients. This lack of empathy was considered racially motivated and demonstrated a basic lack of tolerance and kindness that Māori and Pacific service-users appeared to experience at the hands of services.

Suicide

Suicide was raised as a separate issue demanding its own attention, effort, and focus by these stakeholders. Pacific statistics were shared, which indicated areas of significant risk - particularly high rates of attempts. The strong association between socio-economic deprivation and suicide was identified, recognising how prevalent poverty is in the Pacific community.

A number of reputable organisations raised the following five priorities:

Support strong well connected leadership

Build a co-ordinated public health approach

Focus on protective factors and build wellbeing

Address inequalities and target response to where needs are greatest

Include mechanisms to continually learn [Suicide Contributors]

Similar to mental health and addiction, it was argued that a community response to discrimination, drug and alcohol misuse, poverty, unemployment, childhood adversity, violence and dysfunction needed to be in place.

⁹ McFadden Consultancy. Research Report: NZ Drug Harm Index 2016. (2nd Ed). Wellington: Ministry of Health

Systemic Change

Echoing the concerns by the Pacific providers, the need for systemic change was identified. Notably, that too much power:

Is controlled by DHB and Ministries. • NGOs in the main are unable to directly promote services and help people. • Difficult referral processes. • Long waits for services. • Exclusion and rules to keep people out. Non-attendance results in discharge, requiring a crisis to occur or police intervention when a crime is committed. • Thresholds to access secondary mental health services are very high, therefore people must be in crisis before they receive services.

One way – not 21 ways. Dedicated centrally funded services with a focus on community, prevention and early intervention. [Provider]

Pacific Workforce

Growing the size and skills of the Pacific workforce was repeatedly referred to as a priority.

Skilled Pasifika workers bring connections with Pasifika communities, personal understanding of Pasifika issues, and cultural and language skills into the workplace. A robust Pasifika health workforce can positively influence Pasifika equity in health outcomes by integrating cultural practices, concepts, and diverse worldviews into high-quality, evidence informed health services. [Pacific Provider]

The current cultural competency training available was well received and positively evaluated. Notably, Pacific services agreed with this but argued that this was not enough on its own to effectively enhance mainstream's capability with Pacific clients. Going further than what is currently on offer was recommended.

Further Research

Further research was persuasively argued for in every priority area. It is fair to sum up that, for Pacific peoples, that meant ethnicity data and measures in all mental health, addictions and suicide data gathering and analysis.

In addition, further research on Pacific cultural approaches based on an exploration of indigenous knowledge and how this can translate to meaningful practice in services was clearly a priority. Some of this research has been done but not necessarily disseminated or extended to where it needs to go. Mana Moana is one of these examples.

Generally, there was a paucity of research in almost every relevant Pacific mental health area. The effective use of evaluation to inform decision-making and ensure the sector is constantly learning was not considered a strength.

CONCLUSION

Hange ha lingi lolo ki ha tahi peau. Like pouring oil onto rough seas. [Tongan proverb]

We need to be human again and relearn what love is. [Whānau Ora Provider]

The Pacific community consistently and collectively expressed a deep desire for transformational change to the current mental health system. They raised serious concerns about the way the current system is unable to respond in humane and generous ways to extreme crisis and pain. Families spoke of disrespect and damage that they have never recovered from. Individuals spoke about feeling disempowered: unwanted intrusions, over-medicated responses, hostile environments and professionals with very little empathy and understanding. Pacific mental health providers spoke of witnessing the bewilderment of families navigating incredibly complicated systems and experiencing institutional racism.

It is clear from the length of the report and the multitude of issues raised, that there were a lot of ideas, perspectives and opinions about what can improve. Three overarching core issues emerged through the submissions. The first is widespread criticism of the current system and a strong demand for transformational change.

The mental health and addiction system in New Zealand is not considered to be working well. It is not working fairly or equitably. There were many criticisms, especially of 'mainstream' which was seen to be missing the boat. The poor flow, gaping holes in the system, lack of care, dehumanisation, over-medication, racism, significant unmet need, and incredibly disappointing outcomes were evidenced.

The second major theme that emerged was the value of Pacific services. The solution to many of the existing problems – on many levels - was seen to lie in another way of thinking; another approach to caring for those in distress; another way of engaging with people in crisis. This was – for lack of a better term – 'the Pacific way' of supporting people and their families - to assist them with dignity - through some of their most difficult and dark times. This ethic of care is an indigenous ethic of care sourced to the cultures of the Pacific Ocean. It aligns with the ways that people of the Islands of the Pacific have approached healing and restoring wellbeing for centuries.

In concluding this report, it would be a missed opportunity for the Pacific sector if there was not an attempt to synthesise one of the strongest messages, which is that Pacific services – against many odds – are working for Pacific peoples. Some submissions struggled to articulate individually what their point of difference was – glossing this as "Pacific" – whereas others were effortlessly able to articulate their mode of practice. By reviewing all of the submissions collectively, clear patterns emerged. These are detailed below.

The last area of focus is an attempt to take on board and transform all that has been said into coherent aspirations that are consistent with, and cognisant of, the advice and learning submitted by and for Pacific peoples. This brings us to what might be possible if procurement, contracting and funding was done differently, led by and decided upon by Pacific peoples themselves. These aspirations are brought about by listening to the echoes of the entire eco-system and shaping the flow of consistent messages into the language of action.

Transformational Change

Pacific Services - Understanding their Point of Difference

O le e lave i tiga, ole ivi, le toto, ma le aano. They who rally in my hour of need are my kin.
[Samoan Proverb]

Pacific submissions deem that Pacific services matter because when people are in crisis, having shared cultural understandings as the default means that all kinds of implicit understandings are in place that create safety for Pacific service users. This in itself, however, is not enough. Pacific services matter because Pacific cultures recognise the power of relationships and understand that all relationships are either medicine, or not. Simply the act of caring and connecting is considered to be healing. The choice to not care or connect is damaging and willfully unkind. Especially when people are in crisis.

Pacific practices not only prioritise relationships, but they acutely understand that all healing happens in the contexts of relationships. Therapeutic practice activates relatedness. One of the current trends in the mental health sector is mindfulness. Mindfulness is usually seen to be an individual internal cognitive practice. However, when it comes to activating relatedness a deep mindfulness can be found in the act of relating in Pacific cultures. This relational mindfulness pays close attention to the qualities of the relational spaces between people (the va). This mindfulness transcends far beyond the words that are actually spoken in the va, but it also listens to silence. It pays attention to body language, to tone, and gauges stress levels. It 'reads' the 'va' – the space between self and others – and respectfully tends to that space until the other person is ready to speak into it. This is a practice of priming space which is captured in the 'talanoa' literature about preferred communication styles. It is considered indirect, because it treads carefully. Direct questions may in fact be asked, but not until it is appropriate. Connection trumps all. Establishing a meaningful connection takes priority over the transaction at hand. All is guided by a respectful kindness with the aim of creating a sense of relatedness. Purposively creating these relationships reach necessarily beyond the 'here and now' of the health-related transaction. They activate authenticity, enable truth to emerge and open up the potential to heal.

This is an indigenous ethic of care that is sourced to the Islands of the Pacific. Encounters with services special enough to offer this indigenous ethic of care, make people feel warm (mafana) and trusting. They can trust that the people who work there will care for them with the kindness that they would want for their own loved ones. Staff within these services work - with heart - to uphold the dignity and respect of Pacific peoples and help them transform their lives through and beyond times of distress and illness.

As is reflected in Pacific submissions, this way of doing things - in a system permeated with power differential, control and risk management - brings soothing and relief to Pacific service users. Instead of an impersonal quest for information or rehearsing and reinforcing status and power differentials in a deeply personal context of shame, crisis and pain, this way of doing things first seeks connection. It builds on, and harnesses, shared understandings. It brings a level of equation – a dynamic described by one submission as “collegiality” – between tangata whaiora and practitioner. Clinical and professional power hierarchies between service user and service provider are disregarded in favour of human and cultural connection. This kind of practice is premised on an intrinsically deep level of interpersonal respect. There is enough of a sense of relatedness and empathy for practitioners to be able to put themselves into their clients' shoes and uphold their dignity at a time of great testing and turmoil.

Notably this is the counter-opposite of 'unconscious bias' which are the words New Zealand has officially chosen to acknowledge institutional and interpersonal racism experienced by minority

groups in New Zealand. Pacific submissions lamented the lack of this quality within hostile expert-driven environments that were often coercive, controlling, cold and clinical. Pacific families in distress encountered unkind and uncaring transactional exchanges with professionals who were described as doing “more harm than good to a grieving person”. [Pacific bereaved family member]

The ethos and ethic of care described by Pacific submissions had no similar genealogy— characterised predominantly by restoring relationships and bringing people back into balance with their social, natural and spiritual environments. This was via identifying breaches of relationships – holistically encompassing spiritual, intergenerational and environmental – as well as interpersonal. Restoring and rebalancing these relationships, via processes of atonement, restoring justice, forgiving, reconnecting, and returning to states of ‘ofa, alofa, aroha, aro’a, underpins Pacific beliefs about what heals.

In the current mental health system, this paradigm of care jostles, wrestles and vies for attention and application alongside other, far more dominant, much more acceptable and deeply institutionalised ways of understanding symptoms, causes and treatment. While there were concerns about the safety of Pacific service users – especially when Pacific staff weren’t there to protect and buffer the harshness of the most hostile, frightening, punitive and risk-averse environments – no Pacific submissions wished to restrict access to medicalised options. Rather they wanted to increase the range of therapeutic choices and to have the space and support to create a well-resourced and high-quality alternative with enough authority to operate in alignment with its own ethic and ethos of care.

Pacific submissions allude to the reality that this requires the time, effort and energy needed to establish truly authentic relationships that lead to a genuine engagement with people's pain and true circumstances. The time, energy and effort to connect with families so that they are also on this journey. To empower them with information and assist them to be part of the solution. The time, energy and effort required to take the deep dives necessary to address the root causes of distress and disorder. The time, effort and energy required to identify other pressing needs that are obstructions to full health and wellbeing. The skill to assist with navigating a complicated bureaucratic system so people can understand and access the additional support and specialist care they are entitled to. The energy, effort and creativity required to set up and run activities - creative, sporting, cultural – all of them therapeutic - that socialise isolated people back into society and help them restore their confidence to connect to community. The activities and upskilling, training, resourcing and confidence-building required to tackle the very real-life challenges of finding housing, accommodation, paid employment and achieving financial security.

This activity is beyond the parameters of existing contracts. The time and energy required to do this was not allowed for, compensated or reimbursed within the context of mental health and addiction contracts. This has left the Pacific sector exhausted, despairing, also operating on the brink of financial hardship, maintaining unsustainable practice in the face of a bureaucratic machine that does not value, recognise, or appreciate the true value, scope or sophistication of its efforts.

As reflected in submissions, the typical Pacific spirit of being resourceful, creative, colourful, operating on a shoestring, happy, doing ‘something for nothing’ and above all, ‘doing it for love’ was endemic, exhausting, unsustainable and unfair. There was constant scrambling to pull in funding from other sources, so as to do the bare minimum of what needs to be done. Those who worked in the DHBs described having their hands tied, because what they needed and wanted to do, was considered ‘NGO work’.

Pacific services who practiced in this way found Whānau Ora contracting a ‘godsend’. As one provider described:

Families can enter services in multitude of ways. When people walk in, will have matua whose only job is to greet people 'cuppa teas'. No one leaves until needs met on the day. Focused on the family and what they need. Families go through process with navigators to identify what's important and together we work out how to get there; families do the plans. [Pacific Provider]

The ethos and ethic of these services and the magic that happens there can be captured in the proverb: "O le e lave i tiga, ole ivi, le toto, ma le aano: They who rally in my hour of need are my kin." This is something that Pacific people deeply understand and is reflected at the heart of their practice.

An Extended Whānau of Pacific Services

Ua sau le va'a na tiu, 'ae tali le va'a na tau, o lo'o mamaulago i le va'a na faoafolau - One boat returns from the catch; the other is tied to the strand; the third one is propped up in the boat-shed.

Traditionally, this proverb is translated in the following way: The boat returning from fishing is compared with the travellers; the anchored boat refers to the chiefs, orators and young men; the third boat is likened to the old people staying at home. However, in this context and in light of Pacific submissions, the boats are used metaphorically to refer to an interconnected co-operative or a Pacific whānau of services that are all committed to the same agenda and work seamlessly with another at all ends of the service spectrum: from acute beds and respite, to secondary-type services, to primary-care type mental health services, all the way to health promotion. At every step of the system is a strong Pacific presence, an interconnected network of Pacific providers – or one large service – that seamlessly flows, serving the needs of Pacific peoples.

As has been evident in some Pacific submissions, the strength of this extended whānau of services would be their reach and ease of referral relationships with one another – providing a culturally aligned smooth continuity of care. The skills of this crew - representing the wide matrix of Pacific community identities - would extend from health promotion and prevention, to delivery of therapeutic services, to Pacific respite and acute beds. With multiple points of entry, and not diagnosis driven nor geographically driven, it would be able to refer within its own network.

Everyone who is a part of this crew would be known to each other, so that it is genuinely a work whānau whereby referrals to unknown practitioners happen as the exception, not the rule. To a large degree, it would have the capacity to refer within its own system and not need to go beyond it in most cases, enabling flow and ease of referral. Specialists are a part of this whānau but also may be pulled in as required.

Pacific submitters believe there should be well-connected and seamlessly flowing extended multidisciplinary whānau of services; capable of delivering addiction and gambling treatment and suicide prevention programmes, provide talk therapies, dispense medicine, and engage in public health prevention and promotion.

On the basis of Pacific submissions, there would be a strong health promotion component, so that the messaging going out in multiple ways (Pacific languages on radio, youth messaging via technology etc.) casts a wide net and educates the community and ensures broad name recognition and reach. It would share health promotion messages and run programmes in multiple areas including: gambling harm, resiliency, health literacy, reducing stigma, physical activity, nutrition, seeking support for addictions, cultural identity, recognising depression, finding the right words, parenting programmes, economic and budgeting skills.

As was shared by some Pacific submitters, these whānau services would leverage off the many benefits of a collective endeavour. For example, the health promotion campaigns that increase mental health literacy would have the added benefit of promoting access to services run by the same people. There would be a high level of visibility and trust in this whānau of organisations. The health promoters would also deliver programmes and groups so that people who become aware of these issues or services are able to go to this service and not simply be referred along. Many of these programmes would be considered beyond the scope of existing mental health services.

Pacific submissions consider that services within this integrated, independent and interdependent Pacific System would represent a connected matrix that collectively is able to provide what is needed, whether it be mild to moderate, severe, or merely working with the whānau of people who are affected by distress and illness. It comes through strongly in submissions, that as a collective, Pacific services should be able to dispense medication and have their own respite care unit and acute beds. These would be Pacific run. Pacific-run acute beds and respite would be widely used accessible options.

Pacific submissions were clear that a person should be able to enter these services in a multitude of ways including self-referral. Accessed by 0800 number if necessary, however, face to face was repeatedly referred to as preferable. These services would not be diagnosis driven, but based on needs. It would encompass promotion, prevention, community, primary, specialist and acute services in a seamless flow. There would be same day access. Urgent cases would be dealt with urgently. The service would be timely in all ways. The service would not be geographically determined. It would be open to non-Pacific clients should they wish to access it. It should meet people where they are, in community places and be mobile, as well as having identifiable hubs.

Necessarily, this would mean public sector funds would be provided to Pacific peoples/providers, who would determine that the procurement process and scope of the contracts actually fund what needs to happen in order to get good outcomes for Pacific peoples. In this context, submitters maintain that how we fund, what we fund, where it is allowed to go – must undergo transformational change – learning from the only example that Pacific submissions held up as working for the people: Whānau Ora. Some Pacific submissions have been strong in their stance in that to see real change, contracting and funding must help - not hinder - the ability to deliver what will truly deliver recovery and resiliency for Pacific people and their families.

As expressed in Pacific submissions, while you can establish Pacific-specific services, if they are funded assuming that practitioners only work with individuals, and only work within an extremely time-limited, narrow clinical scope, then possibilities to create good outcomes are constrained from the outset. Pacific procurement processes would start with community needs and those around the table would have deep expertise in understanding complex Pacific realities in order to fund a fleet of vessels fit for purpose. Not just one or two boats, but a co-operative, complementary fleet.

Pacific submitters firmly believe that people around the funding or commissioning table should share power with those served by the services, i.e., youth, rainbow, the relevant population with relevant lived experiences. This would enable the truly conscious and intentional design of authentically responsive services. The way that they would design co-operative services would reward collaboration and co-operation and encourage it. The funding would ensure that this whānau of services would be able to work holistically. Practitioners would be able to take the time to build relationships, to enhance community cohesiveness and recovery via participation in group activities, to work with the families and to take the time required to go beyond symptoms and beyond the surface to where true healing and recovery lies. This includes activities beyond the scope of clinical operations and beyond the scope of usual hours per client.

In addition, Pacific submitters express that all services for Pacific peoples should be designed to meet with understanding, compassion and practical assistance, the widespread socio-economic hardship in Pacific communities. Clear information would be made available to people so that they know what they are entitled to, and that costs are not a barrier. The design would also mitigate other well-established barriers of finances, transport, distance, lack of flexibility, delays, and so on. Submitters have been strong in the view that by partnering clinical, cultural, peer support and community skills, these vessels would be able to respond effectively and collectively to acute crisis, assessment and diagnosis of the serious cases, with ease of access to its own Pacific-run respite care and acute beds. Pacific submitters believed that Pacific peoples should be able to assess clinically and culturally and offer treatment plans based on preference and choice. The clinical path and options, would transparently sit side by side with the culturally-based pathways and plans. This ensures that the onus of integrating conflicting diagnostic and treatment information would not rest solely with service-users and their families, but these intercultural complexities would be grasped and understood by the services themselves. They would understand the stress of trying to resolve conflicting treatment paradigms, and work with cognisance of these realities. They would be committed to enabling the cultural and clinical integrity of the whānau of services and the importance of choice for service-users and their families within those services. Choice of the client and their whānau would be the dictum.

Submitters firmly maintained that this approach necessarily understands that crisis is rarely an individual experience and that supporting the supporters is vital. Whānau, however this is meaningful to the people in need, are on the vaka / waka.

Submitters clearly believe that the configuration of Pacific services should be governed and managed in a way that demonstrates Pacific authority and autonomy to make the right decisions that are in the best interests of Pacific clients, staff and Pacific ways of being and doing. This should reflect and enable absolute cultural integrity of inclusion, recovery, healing and safety. The leadership must not be compromised in their execution of such a vision. While this may be inclusive with regard to who sits in these decision-making roles, they should not be led, overly influenced or dominated by people with monocultural understandings or limited mainstream skillsets.

As has been voiced by Pacific submitters, the Pacific crew of the extended whānau of Pacific services available would be multi-lingual, multi-generational, of diverse sexualities, genders and represent many ethnic-specific interests, holding clinical, community and cultural skills. Pacific culture in all of its diversity would not be compromised. The staff would reflect the wide and changing matrix of Pacific diversity, including youth and older adults.

Pacific views are strong in that clinicians would not drive these services, but be part of a respectful team of health workers. All kinds of expertise would be valued equally – not just clinical. The teams would hold a blend of cultural, community, peer-support and clinical knowledge where the usual hierarchies are not deployed in ways that do not serve co-operation or the client. This would be a respectful, multi-disciplinary collective endeavour.

Pacific submitter input is steadfast in that positive Pacific indigenous values would inform practices of care and would be evident in all of the practice, from the receptionists through to the psychiatrist, through to HR and governance level. A heart for Pacific peoples, compassion and a passion for health and wellbeing of others – alofa, 'ofa, aro'a, aroha, aloha – would be the driver. The voices of Pacific convey that services should not only be able to articulate their own point of difference, but they should be able to articulate a cultural rationale for aetiology and treatment with clarity and understand cause, effect and therapeutic logic interventions according to cultural knowledge. There should be obvious evidence of these ideas and values demonstrated in its operations.

Submitters uphold that ideally services should have the capacity to work in ethnic-specific ways and use ethnic-specific models and practices, should this be desirable and advantageous. They should also be able to operate in a way that is shared among Pacific cultures and consistently valued across ethnic-specific diversity. This should bring a level of cohesiveness across the service even if a variety of models and metaphors are used to suit individual clients and their families. There are many connections as well as differences.

It has been signalled that one five-year Pacific-led research project shows promise and has undertaken in-depth detailed work into Pacific indigenous approaches to healing in a mental health context. This is Mana Moana. Its intervention rationale is in alignment with traditional healing logic and practices across the Pacific. It is based on a shared language canon of seventy Pacific indigenous words found in most Pacific languages, that include concepts, values, metaphors, and archetypes and reference hundreds of proverbs and significant shared narratives relevant to wellbeing. Mana Moana shows promise in its depth and has been widely consulted on for validity and cultural credibility.

To finally conclude, you can fund one or two Pacific boats that float in an otherwise mainstream world, doing their best to throw out lifelines to those up to their necks in the water or to the families struggling in the tides. It matters that they are there. They will be battling against the flow of the way things are usually done, going against the cold, clinical tides that prevail in the current mental health system and doing their best to leave no one behind. They will be working in isolation and there will be a lot of limits to their influence and impact. However, to fund a fit-for-purpose fleet that is collectively responsible - on the shore, in the water, in the boathouse – that work together co-operatively and take full responsibility - is another matter entirely.

In sum, Pacific submitters have laid down the challenge whereby, to give Pacific peoples and services true autonomy to work in synchrony with one another, to work in alignment with core values and offer a seamless indigenous ethic of care that is shared by all of the vessels – working co-operatively with one another - this creates safety for Pacific service-users in ways never before dreamed of. When all of these services are funded to work co-operatively, rather than in a competitive system, this empowers and resources a large group of Pacific services and professionals to collectively take full responsibility for the community they are completely committed to. To deliver all they can, to be supported to give their all, to offer the best that we have to those who most need it, in ways that work for us. There is no doubt: “Something extraordinary needs to happen.”