ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
TULOU – OUR PACIFIC VOICES: TATALA E PULONGA

Under	The Inquiries Act 2013
In the matter of	The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions
Royal Commission:	Judge Coral Shaw (Chair) Ali'imuamua Sandra Alofivae Mr Paul Gibson Dr Anaru Erueti Ms Julia Steenson
Counsel:	Mr Simon Mount QC, Ms Kerryn Beaton QC, Ms Tania Sharkey, Mr Semisi Pohiva, Ms Reina Va'ai, Ms Nicole Copeland, Ms Sonja Cooper, Ms Amanda Hill for the Royal Commission Ms Rachael Schmidt-McCleave, Ms Julia White and Ms Alana Ruakere for the Crown
Venue:	Fale o Samoa 141 Bader Drive Māngere AUCKLAND
Date:	26 July 2021

TRANSCRIPT OF PROCEEDINGS

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useful for us, very particular and hit the mark every time.

I recognise your concern about the -- I think back when you were young, when you were first placed in care and the lack of full appreciation of what was happening in your life at that time, the emotional distress and the domestic abuse and the impact that that had on you, and the lack of understanding by the professionals but also your whānau I think about what was going on.

So I take your point too about the need to raise awareness amongst Pasifika communities about mental health issues, to raise understanding of what's going on. And your -- I know there's a strong call now for the Mental Health Act to be radically -- let's repeal it, as you put it, and replace it with a well-being act, I think that's a lovely idea.

There have been lot of strong calls by Māori mental health practitioners and survivors for more cultural models, and that's exactly what you're talking to about Samoan fofo and Māori massage, had a real impact for you, right, had a real effect. I think the strong message I got was just the like Sir Pieter, Dr Pieter, for example, was one of the few psychiatrists that you show your respect, and a big theme for me was your human dignity and respect for your autonomy and decision-making processes and that seems to be fundamental, is a need to respect you and to listen, just to listen to you and to meet your needs.

So we have listened very carefully, we have taken many notes and we have learned so much and so on behalf of this Inquiry I'd like to extend our aroha and thanks to you and your whānau, thank you so much, kia ora.

A. Thank you, kia ora.

[Samoan song]

COMMISSIONER ALOFIVAE: Fa'afetai lava, fa'afetai manuia.

Lunch adjournment from 1.24 pm to 2.25 pm

CHAIR: Good afternoon, Ms Va'ai.

MS VA'AI: Malo le soifua Madam Chair. Our last witness for the day is Leota Dr Lisi Kalisi Petaia. I will be referring to her as Leota Dr Petaia, just to honour both the titles that she holds as a high chief as well as a psychiatrist. Leota Dr Petaia is an expert witness and she has been recognised as the first and only Pacific forensic psychiatrist in the world. She is of Samoan and Tongan descent. Thank you, Madam Chair.

LEOTA DR LISI KALISI PETAIA

CHAIR: Leota Dr Petaia, you are most welcome. You are indeed the rarest bird in the room and we're very glad that you're here. Can I ask you please to take the affirmation.

A. Yes.

Q. Do you solemnly, sincerely and truly declare and affirm that the evidence you will give today will be the truth, the whole truth and nothing but the truth?

A. I do.

Q. Thank you very much. I'll leave you with Ms Va'ai.

QUESTIONING BY MS VA'AI: Thank you, Madam Chair. I'm going to invite Leota Dr Petaia to open our session. I understand she has some acknowledgments she would like to make.

A. Kia ora, mālō e lelei, talofa and warm Pacific greetings to you all this afternoon. It is an honour and privilege to be here in this fale to share some thoughts in the hope to assist the Commission and its important work. Before I proceed any further, I would like to firstly acknowledge and honour the survivors who shared their stories with us. Thank you for your courage, thank you for helping us understand what had happened to you so that appropriate measures are put in place to prevent their repetition in the future.

I also wish to pay tribute to the many survivors who for various reasons are not able to tell their stories. I've had the privilege to meet and talk to many of these survivors in prison as part of my work. I also have met many of them in community mental health clinics and in psychiatric hospitals in my capacity as a psychiatrist.

We've heard survivors' stories of abuse, racism and mistreatment in hospitals and State care. Stories of removal and dislocation from their families and loved ones, their multiple and unstable placements, lack of education opportunities and unemployment, which have all been part of their almost inevitable trajectory to prison.

Removal from families perpetuates a huge sense of loss, including mainly loss of connection and relationships with families and loss of cultural identity. The stories are complex, they are heart-breaking and what is clear is that the survivors suffer high rates of psychological distress and some have suffered serious mental health problems.

Amongst these sad stories are remarkable stories of success by survivors. Stories of unconditional love and support of families, friends, communities, including churches and relevant services. Survivors have frequently demonstrated to us significant levels of resilience, strength and recovery in rebuilding their own lives. I have noticed with admiration that these successful stories have often achieved -- have often been achieved by the survivors' efforts themselves. This human capacity to bounce back despite significant adversity and trauma gives us all hope and courage to do this work.

We owe it to the survivors and our communities to do the right thing. Do what's right and prevent repetition of the same mistakes in the future.

I respectfully acknowledge the Commissioners, Judge Coral Shaw, Dr Andrew Erueti, Ms Julia Steenson, Mr Paul Gibson and Ali'imuamua Leva'a Sandra Alofivae and all the teams involved in this Inquiry on your hard work. Oute faafetai faapitoa i lau afioga Aliimuamua Lealiivaa Sandra Alofivae. Lau susuga le tamatai loia sinia, ua fai lava oe ma sui o tagata Pasifka i lenei galuega taua ma le fita ma o se mitamitaga tele lea i tagata Pasifika ma au nei. Malo le galue, malo fai o le faiva. Ko e Ha'amoa au mo e Tonga. Ko 'eku kui ko Limoni Uesi (West), tamai 'eku fa'e mei fo'ui, meia Nōpele Vaha'i. Na'a ne ako mai, 'a e ngaahi anga fakatonga lahi kia kimautolu pea 'oku ou 'i he Komisoni ko 'eni mo e laumalie lelei ma'ae kakai ko ia 'o e pasifiki. 'Ofa ke tokoni mai 'a e 'Otua ki he fononga 'oku tau fai. 'Ofa lahi 'aupito atu. Mālo. Besides being Samoan I'm also Tongan, descended from my grandfather who taught me a lot on culture. I bring with me to this Commission the spirits of that background for the benefit and best interest of the Pacific people and may God help us all in this endeavour. Malo.

Q. Malo 'aupito and fa'afetai tele lava Lau Afioga Leota Dr Petaia. I'll just be mindful that we have sign language interpreters and stenographers who are trying their best to keep up with us, so we'll just keep our pace nice and slow and you're doing great.

A. Thank you.

Q. As the only Pacific forensic psychiatrist in the world, you are in a very unique position, because of both your clinical and cultural expertise and I know that talking about your many achievements, your successes and your background is something that you'd prefer not to highlight, but for the benefit of this Inquiry and our community listening in, can you please share a bit about your professional background and explain what brings you here to the Fale o Samoa today as an expert witness?

A. My full name is Leota Lisi Kalisi Petaia. Leota is my customary high-chief title matai tamali'i from my mother Melenaite Aiafi's family in Samoa. My grandfather, as I've mentioned, is Tongan from the village of Foui and I'm called after his Aunt Kalisi. I'm a medical doctor registered with the New Zealand Medical Council currently employed as a consultant forensic psychiatrist by the Waitemata District Health Board. I'm a fellow of the Royal Australian and New Zealand College of Psychiatrists. In my own time I work with Pacific communities on mental health education.

I'm an honorary senior lecturer for the Department of Psychological Medicine at the University of Auckland and also a guest lecturer at the University of Otago, teaching psychiatry and Pacific mental health to medical students.

I've mentored and supervised medical students and junior doctors of different races, including

Māori and Pākehā. I have presented locally and internationally on psychiatry and have authored and co-authored papers and articles in the area of Pacific mental health.

I was the founding president of the Pacific Island Mental Health Professional Association in Aotearoa, New Zealand. And I am the director for Petaia Medical Services and Le Toloa Limited, respectively two private companies involved in mental health services for Pacific people.

Q. Fa'afetai lava. Just reflecting on survivor stories, particularly from the story that we heard from a survivor today, a common question has been what does culturally appropriate care look like. And of course for health professionals providing care, their introduction to formal training is through tertiary institutions like medical school. So I'm going to take you right back to your experiences as a student, just so that we can have a better understanding of the actual foundations and structures of how health professionals are actually trained. So Leota Dr Petaia, when you were studying, was there any encouragement or emphasis on the importance of cultural awareness?

A. Education institutions in general are monocultural based on robust European university systems of learning and assessment. The study of medicine in particular is based on a strictly western scientific and biological framework and from my experience, the development of cultural awareness amongst graduates was an issue left to the individual student's discretion. This was often dependent on their exposure to the norms and nuances of their own ethnic backgrounds and/or awareness of the cultural, philosophical and psychological sensitivities of other people. Perhaps it might be easier to understand this by sharing my own experiences in training in the hope that it will bring home some of the key issues that would lead to some positive changes.

So I grew up in Samoa in the 70s and this was not long after Samoa gained its independence from the New Zealand administration back in 1962 and I attended the Government schools based on the New Zealand curriculum. We sat the New Zealand School Certificate and university entrance exams and I was fortunate to win a New Zealand Government scholarship to study at New Zealand -- at a New Zealand university with the intention to study medicine in New Zealand. But at the completion of my undergraduate degree there was a major change in New Zealand policy, so that all Samoan medical students were to be sent to the Fiji School of Medicine.

The Fiji School of Medicine has a very good reputation, and has trained the majority of doctors working in the South Pacific region. It was established by the British in 1885 during colonial times, we were trained by British doctors and Pacific specialists from -- who

graduated from New Zealand medical schools, so the basic medical training was mainly based on western perspectives and it took us six years to complete that medical training. At medical school I was asked this question most of the time as to why I'm interested in psychiatry, but at medical school I was very intrigued with psychiatry because I found it very challenging, and I excelled in it and decided to take it up as a specialist area. I returned to Samoa and worked as a junior doctor for a couple of years, and this is normal for all doctors who complete their training to do a couple of years of house surgeon and then moving on to specialist training.

In Samoa, within a short space of time I was able to work in our small mental health unit and I was working with very dedicated nurses, just three of them, and we contributed to major reforms in our mental health services in Samoa. It was through that work in Samoa that I became exposed to the big world of psychiatry, and I suppose I felt very ill-equipped to treat patients and manage mental health problems because I did not have the training at the time, so I was very fortunate to have had the opportunity to do specialist training in Christchurch on a private basis. And specialist training took another seven years, so overall it takes up to 15 years of formal training to become a fully qualified psychiatrist.

I suppose I'm talking about this because it's important. The duration of training is a critical point when it comes to workforce development in mental health, because it means that it's not easy to produce psychiatrists, and Pacific people are going to be mostly seen by non-Pacific doctors who are not familiar with Pacific cultural values.

So going back to your question about cultural awareness from my experience, there's minimal focus on cultural training in both basic medical training and specialist psychiatric training, and in my professional view as a Pacific psychiatrist, this lack of cultural emphasis in training is a major contributing factor to poor engagement, poor health outcomes, and significant health disparities for Pacific people in New Zealand.

The medical schools therefore have a moral responsibility to focus on cultural competency training, and I mean training doctors to understand Pacific cultural values and apply them appropriately to improve outcome for Pacific people. Cultural training must be included as part of their formal curriculum. No medical student will focus on Pacific cultural training, any relevance of Pacific culture in health and take it seriously if it is not going to be examinable.

There's good evidence that increasing cultural knowledge will improve the performance of doctors and clinicians. And I'm not just talking about doctors; I'm talking about nurses, social workers, occupational therapists, right across the different disciplines working in mental

health.

New Zealand is a country of many cultures, and cultural training is needed and necessary so we can have an open and honest discussion about other ideas to address health inequities. We should be willing to appreciate the benefit of diverse perspectives to improve care for people. And I'll be talking more about that later on. I'm just giving some examples to highlight what I mean.

Q. Thank you. I just would like to focus a bit more on your clinical training. Thank you for outlining the cultural side of your learning. Now turning to your clinical training, in paragraph 26 of your statement which you provided to the Inquiry you said, "There was no other Pacific or Māori psychiatric registrar in our cohort of registrar trainees in Christchurch" which is where you trained. Are you able to expand a little bit on more that, please?

A. Yes. I've talked about my clinical training, just also to highlight the importance of that aspect of training, and I value my western training and I have a lot of faith in my western training. I think it's important for us to remember that we are not just dealing with culture here, we're dealing with people who suffer from serious mental illness that require treatment. So I'm just going to talk about that a little bit.

Because there is significant studies that shows that major categories of severe mental disorders exist in all cultures and share similar signs and symptoms, or core psychopathological features. So Pacific people suffer from serious mental illness, they're not immune to serious or severe pathology like schizophrenia, depression, bipolar affective disorder that you may have heard of.

The point is that when these illnesses are identified and treated appropriately in a timely manner, Pacific people can make good recovery, and Pacific people should not be deprived of good treatment and overall mental health care. So during my clinical training I appreciated the complexity and the biopsychosocial nature of mental illness and the depth of the clinical treatments and various types of medications including treatment like ECT and other treatment for physical comorbidities that's very common in Pacific patients. And I also saw how a multi-disciplinary team of mental health professionals, not just psychiatrists, but psychologists, psychiatric nurses, social workers, occupational therapists and cultural workers included, and how they manage patients very well together as a team when it works well. So I have a lot of respect for these other disciplines.

I mentioned the complexity of mental health problems, they can't be resolved with simple solutions. We need different disciplines who can understand patients from different

perspectives and together as a team we can identify the needs and respond appropriately. So for Pacific people, they also need that kind of multi-disciplinary team management.

I also want to mention a few things that I noticed during my training in Christchurch, because I came straight from Samoa in the middle of winter and landed in Christchurch and you can imagine that was a shock for me to start off with. But during training and working in Christchurch there was a -- I experienced quite a lot of culture shock on many levels and I had to learn very quickly and adjust to be able to function well in that context.

I want to mention the difference between Pacific patients and I suppose Pākehā patients. For Pacific people, they're usually accompanied by their families mostly, most of the time, their families accompany them to hospital and to assessments, and they want to be involved in their care. They want to know what's happening and they want to know how they can be of help for their family member. And I think this can be traced back to the core values of being collective, communal and being inclusive. I think Luamanuvao spoke about all of this on Monday.

For Pākehā patients, they tend to prefer their privacy as they are more individualistic in their own views, so I'm not saying this in a negative way, it's just what I've observed during my training, and it's important for doctors and clinicians to understand this difference so that doctors, clinicians especially, should consider involving Pacific families in care plans, unless absolutely contra-indicated and not in the patient's best interests. But I've hardly come across that. I've had to deal with many Pacific families that want to be involved and want to know what's happening, and that's very helpful a lot of the time.

The New Zealand Medical Council has clearly stated that cultural misunderstanding and unconscious bias have contributed to the poor state of Pacific health. In psychiatry, I was aware of transcultural psychiatry. It was a discipline that was developed in the late 1990s and it examined the role of culture in the development and treatment of mental illness, and a design of mental health services responsive to a diversity of needs. So this discipline has come about from the recognition that mental illness is experienced, expressed and treated within particular culture and social contexts and if this context is ignored, the patients and their families and their needs will not be adequately addressed.

So overall I think --

CHAIR: Sorry, can I just interrupt you, we're getting little green pieces of paper coming up saying could we please ask you to slow down. I'm very sorry.

A. I'm very sorry, please feel free just to slow me down.

Q. That's all right.

A. Sorry about that.

Yeah. So I think just to give an example, in Christchurch, as you know, I was the only Pacific Māori person there, I was always very keen, because I just came from Samoa to Christchurch and I wanted to learn about Māori culture as well, but because there was so minimal, there was little focus on it during the training, I used to go to their -- they had a Māori Mental Health Service in Canterbury District Health Board and the Māori cultural workers there were called Pukenga Atawhai and I used to work alongside them in my interest to learn as much as I can about Māori culture, Māori history, their world views, how they deal with patients and families.

So I attached myself to the Māori service so that I can learn, so that I'm a better doctor to deal with the patients and their families. Sorry.

MS VA'AI: Thank you. I have to say, Madam Chair, this is normally how our conversations go anyway, us rapidly talking, but definitely we'll be mindful of that.

CHAIR: I know. I appreciate it's really hard when you have a racing brain, it's hard to stop your mouth from racing at the same time.

A. It's totally understandable. It is absolutely true because if I talk -- I don't normally talk like this to my patients, just to other professionals, but when I've got 100 other things waiting for me I tend to race a bit.

Q. Pretend that we are your patients.

A. Okay.

Q. And also we've got the danger of RSI over here for our stenographer if we don't -- if we go too fast as well.

A. Okay, sure.

QUESTIONING BY MS VA'AI CONTINUED: Thank you. So you mentioned something quite unique about Pacific patients is that they include their families and their families come along to appointments. There was a Pacific model that you mentioned in your statement that actually refers to the importance of family and it's the Fonofale model. I'm wondering, Leota Dr Petaia, whether you could share a bit more about how you incorporate the Fonofale model into your practice.

A. Sure. I'm not sure if you've got a diagram there that would make it easier for people to follow.

Q. We do, thank you.

A. Okay. So the Fonofale model was developed in 1995 by Fuimaono Karl Pulotu-Endemann. Fuimaono was the first Pacific psychiatric nurse in charge in Oakley Hospital back in the

late '70s. Fuimaono is well respected by the Pacific community for his work and dedication to improving Pacific mental health over the years in this country. Fonofale is the name of Fuimaono's grandmother that raised him before he came to New Zealand in the 60s and Fuimaono utilised the image of the Samoan fale to emphasise specific core values which are important to Pacific people's well-being. These are values that are not really emphasised in the mainstream western medical paradigm that is predominant in New Zealand. So if you look at the fale, and it's great that we're in this fale at this time whilst I'm talking about this, because I use this model to teach medical students about Pacific values.

We start off by looking at the foundation of the fale which is the family. It represents the foundation of life for Pacific people. We heard Luamanuvao Dame Winnie Laban last Monday in her opening statement articulated very well the importance of our Pacific values, our families, histories and genealogies. A strong family foundation contributes to stable mental well-being. In Samoan o lou aiga, o lou faleaoga muamua, your home is your first classroom. It's the place where you first learn how to speak and behave in good manners. You learn respect, reciprocity, love, boundaries within relationships. You're also quick to learn how to behave appropriately around your parents, elders, siblings, uncles, aunts and so forth. All these values and more form one's cultural identity, (Samoan), who am I, what kind of family do I belong to, where am I going in life?

So here we can see how things can go wrong if this family foundation is weak and the family is dysfunctional. We can also understand from this model what happens to children's identity when they are removed from their families at such a vulnerable early age, early stage of their development.

Looking at the posts of the fale, if we start from the physical post, that represents the importance of physical health and I'm talking about, for an example, what affects our body. So if we have diabetes, heart problems for instance, stroke, that can clearly impact our mind and mental health. So they're not separate entities, they are not -- they are -- our physical health and our mental health is inseparable, because whatever affects us mentally as well, the stress, the anxiety, the depression, can also make our bodies vulnerable to diabetes and all other physical illnesses.

So looking at the person as a whole, in a holistic way, addressing both the physical and mental health together makes sense, and I think that's been a mistake in medicine in the past, where we manage mental health over there and physical health over there, and we look at the services, the fragmentation and the silos, it's because of the way we conceptualise those

issues.

Spirituality is a core value. That's the other post. It's a core value in the lives of Pacific people, and you can't ignore that. It's important when you are assessing Pacific people to ask them about their religious beliefs and spirituality, it's a source of healing for people. But it can also be a source of distress if your ideas do not agree with the church's ideas and views. So that's all part of a good assessment to do that.

We've talked about mental health problems and "other" that's represented by the last post is about including issues and social factors like education, social class, age, employment, gender and sexual orientation. These are all important when you are assessing a Pacific person in terms of the kind of distress that they could be experiencing from some of these issues. All these factors are encapsulated in the circle, the roof of the fale to promote the philosophy of holism and continuity.

So the -- from a Pacific perspective, the distress in one realm or one domain leads to the loss of balance in the others. Healing and recovery from mental health problems succeeds only if all the domains or pillars or realms of this fale are addressed. The context, time and environment are all important elements. We saw this during the opening here last Monday, where we started off with a prayer followed by a kava ceremony welcoming everyone and Pacific people (Samoan) in an inclusive manner, we felt the warmth of relating to others that day. I observed people looking relaxed and connected with each other and everybody felt more culturally safe in this space to express themselves. So that environment is crucial in terms of assessment, because it also provides therapeutic opportunities to intervene if need be.

The Fonofale model articulates well the cultural values shared by Pacific people. And this is very important when you are trying to engage people in mental health services, because access to care is a huge problem. So there is a parallel process between our cultural values in this formal process of engagement and Pacific people in mental health services if we want to improve access and compliance with treatment, engagement and relationship with patients and their families is key in this process.

Q. Thank you. So together with the Fonofale model, your cultural and clinical experience, what are some of the unique considerations that you take into account when working with Pacific patients?

A. Pacific families are no different from any other family. They too need access to better, efficient, more convenient health services and accountability for results, as promoted by the New Zealand Ministry of Health.

If you look at the Medical Council position statement there's a statement about the New Zealand healthcare system that doesn't always meet the needs of Pacific patients and their families. Even when Pacific patients actively seek care, Pacific people often do not receive the high quality and timely services that they need.

There are socio-cultural values that are shared by Pacific people. We've talked about that. But I think another important point to remember when we are dealing with Pacific people is that we are quite a heterogeneous group of people, we are from 20 different cultures and -- sorry, nations and with different languages, but of course we share some of the values that I've already talked about. So we need to be cautious about using perceived membership of an ethnic or cultural group as a shortcut to acquiring knowledge about individual beliefs, values and needs.

Pacific people's mental health problems are very complex. When they come to hospital they bring a lot of social challenges with them, there's lot of social issues with regards to poverty, unemployment, poor education and especially insecure housing. And these are all contributors to poor mental health outcomes.

There's a lot of structural barriers that Pacific people face when seeing primary care or even hospitals, due to high costs, barriers with language, lack of transport. So these people won't be able to attend appointments. So it's not because they don't understand about mental health, it's just that they don't have transport or they are not able to afford it. So these are significant barriers to recovery and improving well-being.

Sometimes in my experience Pacific people with severe mental illness often prefer to remain under the cloak of the Mental Health Act so that they can access free medication and transport to a doctor's appointments, and that's important in terms of maintaining their well-being.

We've talked about the high rates of physical comorbidities in our Pacific population. It's in general most -- it's not just Pacific people, all people with mental health problems, serious mental illness have problems with physical comorbidities or physical problems like diabetes, cardiovascular, heart problems, high blood pressure, high cholesterol, obesity, complications of alcohol and substance abuse. And this usually leads to poor prognosis of mental illness and low life expectancy compared to other New Zealanders.

I've talked about the language barriers as a common problem. Communication is crucial. It's a major component of the clinical encounter and it's the platform on which patients and clinicians make informed treatment decisions.

One of the studies here in New Zealand showed that over 60% of Pacific people are functioning below the level of literacy required to effectively meet the demands of everyday life.

So that's a really important point to remember when you're dealing with Pacific people, because you've got to simplify things in a way that people can understand, so it's not just translating English pamphlets to patient and their families, you've got to have the language to actually explain things properly to patients and their families.

COMMISSIONER ERUETI: Doctor, can I -- it's Anaru here -- just quickly ask, you said something about patients preferring to remain under the cloak of the Mental Health Act to access medication, I didn't understand that by "under the cloak", is that --

A. So I suppose I've had some concerns with regards to the Mental Health Act, because there's been a lot of talk about repealing the Mental Health Act. But when you're under the Mental Health Act we are obligated to see patients every three months, and if people can't attend their appointments our community support workers will have to go out and bring them to the appointments, and their medications are also free if they're under the Mental Health Act.

So they get worried when they are off the Act because it means they will have to spend money on getting medications and when they do that, there's a high likelihood of them not getting their medication if they're expensive.

Q. Okay. Is this like a community supervision order that you're talking about?

A. It's the Community Treatment Order, that's right, Section 29.

Q. Thank you.

A. Yeah, sorry.

QUESTIONING BY MS VA'AI CONTINUED: I guess just to use your words, Pacific patient being under a cloak, there was a service called Faleola, which I believe you referred to in your statement. What kind of services -- would you be able to explain what kind of services Faleola provided for Pacific patients in need of mental health services?

A. Yes, I suppose I used Faleola as an example, because it's the only Pacific service that I worked in in South Auckland and I thought it would be good for us to understand some of these issues using this case scenario. So Faleola was a Pacific community mental health service that used to be part of Counties Manukau District Health Board in South Auckland and I had the privilege of working at Faleola as a psychiatric registrar in 2012. The service was established to provide care for Pacific people with serious and severe mental health problems. They usually have very complex needs, including history of being in State care, they're usually young men, immigrants from the Pacific Islands with very poor English. They are often unemployed and have very limited education. And as a result of their illness they're usually alienated from their families and friends, they're very isolated, sometimes

homeless. And illicit substance use is rife amongst these patients, to cope with pain and trauma, exclusion and deprivation, often leading towards repeated escalation of criminal offending and incarceration. So that's the population of patients that was under the service. So I was working with them in 2012 and I observed how they work. I'd just come from Christchurch for instance, I'd just finished part of my training, this was my last six months and I worked there, and I observed how they were working, and they were working with -- from this holistic model as stipulated by the Fonofale model. The staff consisted of mostly Pacific mental health clinicians, though there was a Fijian Indian doctor, Dr Andrew Sumaru as a doctor, and senior psychiatric nurses were there, they were Samoans, Cook Islands, Niueans, very experienced, very dedicated nurses.

We also had lots of social workers, occupational therapists and a psychologist, and there were senior cultural workers in this team and the service was -- the assessments of patients was usually delivered in patient's respective ethnic languages and that was quite important. And the team worked very well in terms of looking after this vulnerable group of patients. Their main strength was in engagement of Pacific patients and their families in a Pacific way. So for example, they use -- their use of language as we've talked about, they always start off with a prayer, so that spiritual aspect of care was important in their whole assessment and management of patients. They carry out their work mostly at home, so they do a lot of home visits and that was my opportunity as well to go out to the families and meet patients and it was really important because we all tend to see where people live and their lives out in the community.

This type of work though was quite hard because it requires a lot of collaboration with families and community workers and it required a lot of time and effort, and commitment from staff and management. But when it works very well, you can save a whole lot of time in the long term.

In the community when you care for patients or people with very complex issues, continuity of care is so crucial because you have to have time to develop rapport and build genuine relationships, so it's about quality relationship with patients and their families. That's what you call good therapeutic relationships. And they are key components in recovery and rehabilitation.

So these, the staff at Faleola, because they were working in a critical mass, they were able to support each other very well. They share the same philosophy of thinking and understand the concepts when they discuss patients and families in team meetings. And it's about empowerment, empowerment of staff to actually be in control of that work and take

the lead, and also empowerment of families in terms of educating families about the nature of mental health problems and the rationale behind treatment. That requires time. You can't rush that process through. You've got to build the relationship and be able to do this work properly. Only then patients will be able to access and want to access services. It's about trust. It's about people delivering the service, whether you can trust them or believe what they're saying, and also bringing it in the context of Pacific ways of thinking that we've been talking about.

CHAIR: Can I just ask you before you go on, what was the case load there? You had -- did you have a single team or did you have multiple teams and how many patients, how people were you caring for roughly?

A. So that was one team. It was a clinical team with cultural input, that was basically the philosophy behind this team, and the workload was huge, and I think that went towards the outcome that happened in the end when they closed it down, because the workload clinically was too much for everyone, because the staff, there was very few staff, but the number of patients at that time was about 150, 200 patients for one doctor, and it was just -- I guess that's why I had to leave quickly because I needed to gain more experience as well, and I was just feeling overwhelmed and needed help to support the team, I suppose, if I do more training and get more -- recruit more staff was my thinking at the time.

I think the cultural, then, the cultural aspect of the service was overwhelmed by the clinical demand of the service, because of the amount of the number of people that required care.

So if you think about schizophrenia for instance, if we have 1,000 -- 100,000 people in South Auckland for instance, the prevalence for schizophrenia is about 1% in a community. So you're looking at 1,000 people. There's no way a community Pacific service will be able to cater for that. So we ended up taking the most extreme cases.

Q. Which undermines what you said earlier about early and effective intervention?

A. Absolutely. I think that helped -- that's helpful to put it into context, I think the worsening of mental health for Pacific people.

Q. It must get harder to cure the longer it is, it just makes sense, doesn't it?

A. That's right, yes.

Q. We'll probably come back to this because I think we'd be interested to know later what you think would work, but we'll come on to that later.

A. Sure.

COMMISSIONER STEENSON: Sorry, can I just follow that with a question?

A. Yeah.
Q. So was it due to, or was it a combination of the lack of resourcing or people with the skill, when you were saying you were overloaded?
A. It's the lack of resources and lack of workforce, it's both.
Q. So a combination?
A. A combination of both, yeah. So we were fortunate, because I think we'd come a long way, the fact that we had doctors and nurses who are Pacific -- Pacific doctors and nurses and social workers in one place was great to start off with, but the numbers was very small, they weren't able to cater for the need, yeah. And of course the resources is a major thing. Especially when you're working with systems that don't really get the idea that this is how this cultural service should work. So there's a huge conflict.
Q. And the time and effort that it takes?
A. That's right, yeah. So it really required management services to understand the type of work that they were doing. That didn't go very well because of the difference in values and perspectives in the kind of services produced and what's expected, and you can imagine the conflicts that arises in that kind of context.
Q. Because developing relationships take a lot of --
A. Time and energy.
Q. Which isn't always valued in different cultural...
A. No, because in most health services, not just mental health, health services is about bottom lines, money, numbers.
Q. Transactional?
A. Yes, yeah. So there's a huge conflict there that needs to be bridged.
Q. Thank you.
A. Yeah. Thank you, I'm going slow, right?
QUESTIONING BY MS VA'AI CONTINUED: You're doing great.
A. Thank you.
Q. I'm wondering if you could please share about what was the impact of Faleola closing on Pacific people needing mental health services?
A. I also brought this example up for that very reason in terms of talking about the transitions. There's a lot of transitional points from one reform to another, and the risk is that families and patients always fall through the cracks and more so Pacific people. They're vulnerable, they're mostly disadvantaged. So when there's -- when there's always a change, Pacific people are the ones that always get the brunt of it. So for instance, we are still struggling

from the reforms in the 1960s in mental health services in terms of de- institutionalisation. And we're still struggling with that and a lot of these people in the community now have been managed under these kind of services. So Faleola was overloaded by these difficult and complex patients, and the staff were -- I mean, they were trained but ill-equipped to deal with this kind of complexity on their own. They did the best they can but they just couldn't manage with the demand of the complexity.

And this establishment of Faleola also highlighted the differences, as I've explained, of the expectations of services and the way the services should be working to manage the needs of Pacific patients that were under this care -- under their care. So I think, to answer your question in terms of the impact, the impact was huge, because the closure of Faleola and the dispersing of Pacific mental health clinicians into the mainstream meant that the cultural philosophy was then diluted hugely. So I'm not sure what's actually happening at the moment but I understand, because I do catch up with a lot of these staff members from time to time, most of them have left and that's the risk of change as well, you lose a lot of experienced Pacific workers.

So there's also the issue about institutional racism as well, because if it's resource issue and you're looking for cost cutting, possibly that's the way to probably save more money was to close Faleola because it was probably more costly from their perspective. So institutional racism played out in the health sphere is something that we commonly see in mental health and it's the collective norms and behaviours within organisations that systematically and unwittingly discriminate against those from minority ethnic group leading to inappropriate care and insensitive practice resulting in dissatisfaction and disengagement.

Q. Just building on from the systemic issues that you've just outlined, when we're looking at how to communicate effectively in allowing information to be clearly understood for Pacific patients, in your clinical experience what are some of the challenges that you've identified when working with Pacific patients?

A. There's a lot of challenges, but I'll just highlight a few key issues that are important. Pacific people often present in a very delayed stage. Because of the stigma, they don't access services in a timely manner. So they usually come with complications, and it's due to many factors. We've talked about the issue with cost, transport, the barriers with language, but a lot of these people also have very bad experiences with mental health services in the past.

Some of the challenges is the whole engagement process that we talked about. If people attend services and see doctors and they feel rushed and not engaged in a process that makes people feel welcomed then of course people are not going to be able to engage very well,

they're not going to be able to open up about their mental health problems. These are sensitive issues, they've got to have time to discuss things with patients.

So because they present very late with complications, their prognoses are very poor and they used to stay longer in hospital and that's a huge cost to the system as well. Like for instance, in forensic services, we experience identifying a lot of these Pacific people with mental health problems or illness after they've been convicted and sentenced. So they are not recognised earlier on in the process, a lot of them end up in prison.

So there's a lot of systemic issues in terms of poor engagement with clinicians. If you imagine primary care, there's always a lot of time pressure and we have this concept that we call "Don't ask, don't tell", so it's quite common in these circumstances where people feel pressured with time. So this can result in misdiagnosis, and increase in medications to manage distress that probably would have not needed medications to deal with it. So if only you have a lot more time to discuss things with people.

So the other major issue I wanted to raise was the complication with alcohol and substance use, but I'll probably talk about that a bit later. But I think, if I can just take this moment just to use a real case scenario to illustrate some of these key things that I've just talked about. So I've already asked my patient if I could talk about this and he's very happy to, but I'm going to use a different name for his own -- for confidentiality reasons.

So I was looking -- I was asked to see a young Tongan man. He was living in South Auckland with his aunty. He had a severe bipolar affective disorder for many years. But at this time he had a serious episode and he was required to be admitted to hospital. And he was in hospital for about six months, in and out of hospital, they discharged him to residential care because he just couldn't be managed by his family at home. He was getting worse, he was on a whole host of medications he was refusing to take, and I understand because it's probably he was experiencing a lot of side-effects and we heard a lot of that from Rachael's evidence.

So I was asked to go and see her -- him by his Pākehā nurse, because she was very worried that he was getting worse. So she asked me in the morning to go and see him. And I studied the notes, I read through them and I could see the complications and the difficulties for the last six months, doctors were struggling to cope with him and the staff were not able to manage him in acute inpatient at all.

So I understood from my cultural background being Tongan that the aunty has a very special and significant position in a Tongan family structure. So a fahu as they are known in Tonga, is the father's eldest sister and she's accorded the highest level of respect within a Tongan

family. So I decided to go and see her. So we went early in the morning and the Pākehā nurse was saying to me, "Are you sure we can go directly there at home?" I said, "Yes, I think we should", because I was worried that if I ring up or somebody makes contact with the family with all their bad experiences in the past there is a likelihood they will decline us coming. So we arrived at home, knocked on the door and the aunty -- we were lucky, good timing -- opened the door. It wasn't just one aunty but two aunties and a whole lot of relatives around the house that they were all -- they were all curious to know who this doctor was visiting their home. But they were having breakfast at that time, they welcomed us, so already it's a welcoming, inviting environment, so I'm referring back to the Fonofale model as I'm talking about this case. So the environment was just right, good timing, the family were there, and I was there, I spoke Tongan to them, so already fofola the fala before any medical engagement took place.

So we had time to talk about what has been happening and I had to listen first to their story of the last six months and how it happened, what happened, how it impacted on the family, and they were very concerned about him, they were talking about how they really wanted to have him home but just couldn't cope because his mood was all over the place.

So I had time to talk to them about the importance of treatment. I also had time to explain to them why he was refusing treatment. If you were on five, six medications at the same time, clearly you would be feeling so sedated and not able to concentrate. He was talking about really nasty side-effects that made him not want to take these medications. So because of the time, the environment, the language, and the fact that they were in their environment, they were in control, they weren't in my office where I can talk professionally most of the time and I always fear that that wasn't the right environment for most Pacific families. But in this particular environment at home we were able to discuss a lot of things that we would not have been able to discuss in the hospital.

So I asked him if they could come with me to the hospital to see Sione with me and they all came and Sione came willingly to see them because he thought that he's coming to see his family. Most of the time doctors go to see him he would refuse, wouldn't want to see anybody. So when he came in, he saw his family and I've never seen him like that before where he respected her and talked to her in a very respectful way. And the aunty turned to him and said, "Look, we've got this doctor here with us and I want you to listen very carefully to her."

So the rest was history because I was able to then describe the need for treatment and the need for follow-up in the community. I was able to explain the side-effects and why he was feeling

like that. But at the end of the day, what he wanted was to go home. So if he gets the treatment right, he would be able to go home and live with his family. So he got the right treatment, the right medication, there's no such thing as safe medications, only safe clinicians who can prescribe what's needed, the minimum dose that is required to keep people well clinically but it was delivered in a cultural way so that the family can accept it and Sione can accept it.

He went to work full-time and living with his family. So he could understand, "If I get this medication, it's treatable, I can be well and be back with my family." And then he was followed up by the mental health team regularly, and that's really important so he doesn't relapse and re-admit back again and again and again. We can prevent a lot of that, by involving the family. Because if I want to know something, I'll ring his aunty, I won't ring Sione because he won't tell me, he would probably not tell me about the side-effects and things because he might be worried I'll be increasing more medication and give him more treatment, but through the aunty who he respects really well, he would listen to her.

So those are just some of the examples that we can talk about in terms of illustrating cultural values and clinical values in improving outcome for Pacific people.

Perhaps if that had been done much earlier on in the piece that would have saved a lot of cost to the hospital, but more so trauma to the patient and the family, they don't need to necessarily have to go through a whole lot of 10, 11 admissions as we've heard Rachael talk about today. So I'm not critical of any of my colleagues or anything, I'm just trying my best to illustrate some very complex issues in a way that we could understand to improve care for Pacific people.

Q. Thank you. Your patient got the right treatment, the right medication, sounds like also the right doctor. Another significant issue that you highlighted earlier in your statement, and also just earlier today, you've wanted to highlight the importance or significance of alcohol. Can you expand on how this issue affects Pacific people in need of mental health services?

A. I'm just looking for my notes, just give me one sec.

Q. Take your time.

A. I think I wanted to make special reference to alcohol use as an example in terms of complicating factors with mental health problems. It's really, really hard to treat mental health problems when it's complicated by the use of alcohol and other substances, and I'm talking about elicit substances.

So in the He Ara Oranga most Pacific people perceived alcohol use to be the main driver of poor mental health outcomes for their community. This is them reporting about alcohol, it's not

what I'm saying.

So the Pacific people in the He Ara Oranga report, that inquiry, expressed concern about the ease of access and harmful effects of alcohol, in particular noting the potential for social harm if not tightly controlled. The report specifically mentioned how alcohol use fueled people's depression, anxiety and suicide; how they triggered violence and neglect in children. Family violence they talk about. And the Pacific people called for decisive action limiting the sale and promotion of alcohol, particularly -- sorry, limiting the sale and promotion of alcohol, particularly around children and young people including sports sponsorship.

So Professor Doug Sellman, he is a professor of Psychiatry and Addiction Medicine in the University of Otago, he was one of my teachers in Christchurch, I was curious to know what he was saying because he has been actively involved in dealing with people with alcohol and addiction problems. And this is what he said, I want to quote it because I think he said it perfectly well. And I quote, "The Government appears to be completely ignoring the following recommendation of the Mental Health and Addiction Inquiry to take a stricter regulatory approach to the sale and supply of alcohol informed by the recommendations from the 2010 Law Commission Review, the 2014 Ministerial Forum on Alcohol Advertising and Sponsorship, and the 2014 Ministry of Justice Report on Alcohol Pricing. Raising the excise tax on alcohol is the easiest and most effective evidence-based measure the Government can undertake to reduce alcohol-related problems and has been shown to be supported by a majority of New Zealanders. To not act at this time with robust alcohol law reform, in particular substantially raising the excise tax on alcohol, risks reducing this Wellbeing Budget to a set of platitudes. But even more concerning is that national, international evidence, formal recommendations and majority of public support is being ignored. The power of the alcohol industry lobbying of our Government becomes apparent, and this power to subvert alcohol law reform risks making a mockery of democracy and continues to undermine the reduction of alcohol-related misery and suffering in favour of the greed of powerful vested interests."

As a mental health clinician we encounter harm caused by alcohol and other drugs every day. It is a contributing factor to poor physical health and mental health and alcohol law reform is therefore one of the most effective way to improving well-being for Pacific people, and all New Zealanders for that matter.

So if the Government's desire and political direction is one of improving well-being and reducing high suicide rates in New Zealand, then considering reducing harm caused by alcohol must be considered as one of the top priorities, especially for a vulnerable population like Pacific

people.

Q. Thank you.

MS VA'AI: Madam Chair, I'm wondering whether this might be an appropriate time to take a break.

CHAIR: I think so. Time for a cup of tea, everybody. We'll take 15 minutes.

MS VA'AI: Yes, thank you.

Adjournment from 3.31 pm to 3.49 pm

CHAIR: Thank you, Ms Va'ai.

QUESTIONING BY MS VA'AI CONTINUED: Thank you Madam Chair. Just before the break, Leota Dr Petaia shared some of the challenges of working as a Pacific psychiatrist working with Pacific patients. Now we're going to turn to addressing some of these challenges.

Leota Dr Petaia one of our survivors spoke about the stigma around mental health just this morning. Can you share your views in response to Pacific families that may not be aware of the help or support available to them?

A. So we probably think about addressing some of these challenges that Rachael, of course, mentioned but many of our survivors have been experiencing. So I think thinking about the Fonofale model in terms of providing care in a holistic manner is crucial for mental health, for Pacific mental health. Thinking about the values incorporated in the Fonofale model in terms of assessing people's mental health, physical health, the family dynamics and the relationships that's going on in the family, spirituality, the social context of these people is so crucial in understanding the totality of what people are struggling with. You can't treat a lot of these things with medications, got to ask them, talk to them and usually some of the times they come up with their own solutions and you are there to facilitate the process and assist them or point them into the right direction in getting the actual help that they need. So the Fonofale model is crucial.

Family education is crucial. Because knowledge is empowering for people. If they know that illnesses can be treated, if they understand the side-effects of medications, they are more likely to engage with services. Community understanding of mental health and illness is key in changing attitudes towards mental illness. The focus of mental health education should be on early identification of disorders and disease and knowing where to seek help sooner rather than later. So we've all been unwell and sick, and when you are feeling unwell and sick you don't want people talking about other things that are not of interest to you, you just want to know who do I call, where do I go, and who are these

people that are going to help me.

So people have the right to access treatment in a timely manner, and when they do access services, they have the right to be treated by somebody that's clinically competent and culturally aware of the values of this person. It's a human right. New Zealand has also a code of health and disability services, consumers rights, right to be treated with respect, right to freedom from discrimination, coercion, harassment and exploitation, and the right to dignity and independence.

I think it's a really important point to not get stuck with models. It's not about the model, it's about how you understand the model and how you can apply it in an appropriate way to improve outcome. So it comes down to proper training, both clinically and culturally. Because you don't want one or the other, it's both, and you need to be competent in both of those aspects. Because you don't want to be focused on cultural values so much at the expense of the clinical treatment that people need. And the same goes with clinical treatment, you can't just blindly give people medications in the hope that they will become well and stay well. You've got to make sure that you engage people in a longer process to explain symptoms and explain treatment and monitor for any side-effects. There's a whole raft of medications that's available and you can always switch from one to the other or adjust the dose if people are not feeling good or having a good experience with their treatment. That requires time and genuine effort in engaging patients and their families.

So mandatory cultural training is important. I have been clinically trained well so I'm sure people should be engaged in good cultural training in the medical profession, not just doctors but nurses, social workers and cultural workers as well. We don't want Pacific people in mental health services just because they're Pacific and can speak the language, they need technical and good knowledge of what they're dealing with. And I've seen lots of people who are so good in managing distress. So if we look at Rachael's case today, she was talking about a lot of social stresses, about relationships, about family fa'alavelave's I'm sure that our own Pacific people are very familiar with.

And a lot of our Pacific mothers, and I see a lot of them who work in the community who are doing a fantastic job with our Pacific people. That kind of work does not require a psychiatrist. I can provide support where I can, but it's that kind of support, love and nurturing that's important for our people, and we've got the resource in the community amongst our Pacific community if we can just give them a bit more training to understand the risks and what's required and I'm sure they will be able to offer proper support. But we need a good system to make sure that the risks are contained.

Yes, I think that's -- has that answered your question Reina?

Q. Perfectly. Just thinking about systems as you've just mentioned, and the training required, both clinical and cultural competency, if you were to build a clinic with culturally competent and clinically competent people, what would this clinic look like?

A. I think before I speak about what it looks like and the workforce that's required, it's really important that we understand the problem and the needs before we address them. So in terms of mental health, the most, I suppose the most credible study or the most important New Zealand mental health survey that was done in New Zealand was the Te Rau Hinengaro. It was the First National community-based epidemiological study to investigate the rates of mental disorder and consider the severity comorbidity of mental disorders and help-seeking behaviours reported by ethnicity. So it's the only study that has any specific reference to Pacific people. And what that study highlighted was the high prevalence of serious mental disorders comorbidities in Pacific population.

So for instance, 24% of Pacific people experience mental distress compared to 19% of the general New Zealand population. Yet only 25% of Pacific people with mental illness received treatment from addiction and mental health services compared to 58% of those with mental illness in the general New Zealand population. So that's just to highlight the poor access despite severity and comorbidity in people with mental health problems.

The other important point that they found in this study is if you were born in New Zealand you have a two-fold increased prevalence rate or risk of developing a mental disorder compared with only 15% of Pacific people who migrated to New Zealand after the age of 18. So there appears to be a higher risk of developing a mental disorder if one was born in New Zealand. So migration is great for many things, but probably not for your mental health in general.

There's a lot of speculations about that, but I think it just requires more studies to work out the issues with regards to that. I guess the point there is the services must ensure that their approach takes into account the diversity of Pacific groups and provides services that are appropriate for all Pacific people.

The other important point that we need to remember also at this stage, we are all aware of the He Ara Oranga report and the inquiry into mental health because Māori and Pacific mental health is getting worse despite the funds that have been poured into mental health services over the years.

I think one of the things that I notice also in Pacific mental health services as well as Māori mental health services, is that inverse care law always prevails so that those who are most in need

gets the least access to services. Sir Michael Marmot, Chair of the World Health Organisation Commission on the social determinants of health summarised it very well, I quote:

"The toxic combination of bad policies, economics and politics is in a large measure responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible. Social injustice is killing people on a grand scale. The Government needs to understand the needs of our Pacific communities and allocate the appropriate resources to improve mental health literacy, prevent poor health at the community level and these programmes should largely be led by Pacific mental health clinicians using their respective languages to engage people better."

Pacific people are over-represented in acute mental health services and forensic services. We are very vulnerable and can develop serious mental illness with a lot of stress that people experience, and I've noticed in prison when Pacific people are -- there's quite a lot of them with severe mental illness that ends up in prison. The problem is that we can't treat them in prison and they're left untreated for a long time in prison and that's unethical and a violation of these people's human rights. We don't have enough acute beds in hospital for these people, so they wait in prison for quite a long time.

There are inadequate rehabilitation in communities as well. And this results in a vicious cycle of people not treated properly, they become non-compliant, they use drugs to cope most of the time, leading to re-admission to hospital and potential re-offending leading to imprisonment.

So I suppose in terms of developing mental health services I've been trying to highlight the complexity and the need to have multi-disciplinary professionals who are well-trained clinically and culturally. So it's a true integration of these concepts in terms of managing people, it's a broad understanding of people rather than just a medical western kind of monocultural system. They're complex problems that requires a good understanding of people's lives, not just an illness or a disease. We are talking about a whole lot of other social factors that are impacting on people and they find it very hard to recover when they don't get that help.

So we need doctors, of course, nurses, social workers the, all the social issues that we've been dealing with, housing is a huge one for people with mental health problems. We need occupational therapists, because of functioning, people can't function very well when they are mentally disturbed and they require good skills to retrain them to go back to work. So occupational therapists are very important people and also psychologists. I have a lot of

respect for psychologists and it's great to see some of our own Pacific psychologists now coming through that are addressing some of these difficulties. So having a quality team like that and the right resources to provide the services that's required by people I think will go a long way.

Q. Thank you. Do you have any ideas about how we can ensure that health professionals looking after our Pacific patients are trained effectively, both clinically and culturally?

A. The New Zealand Medical Council has recognised for years now that the cultural misunderstanding and unconscious bias, so we've been talking a lot about this bias which is really about racism and discrimination of patients in the system, and this have contributed to poor state of health for Pacific people. So the New Zealand Medical Council has this Health Practitioners Competence Assurance Act 2003 which reinforces the importance of cultural competence by stating that health professionals are to set standards of clinical competence, cultural competence, including competencies of course that will enable effective and respectful interaction with Māori, and ethical conduct to be observed by health practitioners of the profession.

Our college as well, the Royal Australian and New Zealand College of Psychiatrists when I was looking up what they were saying about the Commission of inquiry outlined a whole lot of important key messages which I'm just going to mention five of them because I think it's really important for this Commission.

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

Psychiatrists need to commit to developing strategies to reach out to communities which may still feel the impact of past harmful practises and continually improve them by establishing close relations, dialogue and partnership. They need to commit to equipping psychiatrists to be sensitive when dealing with patients affected by harmful practises in the past and to understand the consequences of traumatic memories in the present.

Psychiatrists are expected to show leadership, empathy and understanding regarding past harmful practises and to support any healing initiatives. They need to encourage people to openly discuss and acknowledge the past without any thought of retribution or litigation. A whole lot of these information and more can be found online. The regulations on upholding cultural competence as you can see has already existed in the health profession. Ensuring

commitment and consistency to cultural competence training requires collaboration with Pacific and Māori Health professionals, and mandatory completion of relevant training.

So in a way a lot of these things look very nice on paper, we've heard a lot about these kind of important ideas about how to improve health. But the key lies within implementation and how we actually put it into action. I don't see much of that, so there's a lot of good ideas, but what does it look like and how are we going to implement that.

As I've said about the medical students, no-one will take cultural training seriously if it's not mandatory and becomes part of any formal curriculum training that starts earlier in medical schools and maintained right throughout continuing professional development. So all doctors in this country get funds for continuing medical education and we travel around the world for conferences and things like that. I think that some of this fund should go into cultural training for doctors, I think, if we are true to what we're trying to achieve today.

I think I also need to just acknowledge that there has been some effort going into it, and this is the kind of discussion that we are now having with the universities of Auckland and Otago. So I'm meeting with Auckland this -- in the next two weeks and Otago at the end of the month and this is the message I'm delivering to them that I will continue to do it if they're going -- if it's going to be part of the formal training curriculum. Because I just feel that every year they ring me to come and do some lectures, but I didn't really feel it was going anywhere, you are wasting people's time, wasting my time and it has to be formally done in a way that is consistent. And I am aware of a lot of Pacific people that can actually help do this training. Thank you.

COMMISSIONER ERUETI: Doctor, can I ask, that statement is from the New Zealand Royal College of -- who was that statement from? Psychiatrists?

A. Yes, that's right, it's the Royal Australian and New Zealand College of Psychiatrists. I was very pleased that they had the statement for the Commission of Inquiry.

Q. I did notice that there's lot of emphasis on past poor practises. It's something that happened historically rather than there being contemporary issues, for example?

A. **[Nods]**.

Q. Or even unpacking what those past practises may have been. It's stated at a very broad level of generality without any particulars in the statement, did you sense that as well? Did you have any concerns about the generality of the statement and acceptance of prior poor practice, or whether they were ongoing?

A. I'm sorry, I didn't quite get the question, can you repeat that for me please.

CHAIR: Can I frame it, I've got a similar question, tell me if I get it wrong. It seemed from your

evidence, but I'm not sure if I've got it right or any of us understand this yet, did the Royal Society of --

A. The Royal College.

Q. Royal College come up with this list that you've referred to as a consequence of a response to the Royal Commission?

A. That's right, they actually outlined it specifically for the Royal Commission of Inquiry, because I was quite --

Q. So they were framing it in terms of the historical -- of us looking into the historical things?

A. That's right.

Q. That's the reference to past harmful practises?

A. Absolutely right, yeah, that's correct. So yes, it's in relation to the work of the Royal Commission of Inquiry, so it's encouraging its members, which is a good thing and that's why I wanted to list it down there that if anyone looks at my statement I'm not saying these things, this is what you said, now you need to --

COMMISSIONER ALOFIVAE: Do it.

A. Do it, yeah.

COMMISSIONER ERUETI: Also just for me to be more explicit about what those harmful practises were in the past and own them.

A. Whether they own the --

Q. Let me give you an example. You've done a great job of emphasising the need to balance the clinical and the cultural approach, so I think one of the core concerns for a lot of submissions made to the mental health and addiction inquiry was that there was too much of an emphasis on the clinical approach to treating patients including Māori and Pasifika. So perhaps that's what they mean by prior practises about placing undue emphasis on medication?

A. Absolutely.

Q. Yeah, okay.

A. Absolutely. I think we've come a long way, and even them listing down these important things that psychiatrists should consider when they see patients who have been in State care, for instance, that they are obligated to do good assessments in terms of acknowledging the harm and trauma in the past, and make sure that they do what's right for patients now. So it's acknowledging what has been happening and looking forward in terms of integrating good care to ensure that these people are not only treated properly, but have good rehabilitation so that they can recover, and live a normal life. And they can in a proper

service where you care for people properly with good treatment and using their families and the support services around them in their own local environment. People thrive in that.

Psychiatrists need to understand that that's equally important when you're managing people. It's not just giving them medication, then leaving them to just take their medication and not want to see them sort of thing. The idea is continuity of care where you're right there beside them with the whole team, I don't need to see people all the time because of the amount of work that we need to do. If we have a good team that I spend like an hour on a weekly basis to talk about their work and support them, they are empowered and confident to go out to the families and talk with them on an ongoing basis, and by doing that you're developing quality relationships with people so that they can engage better. And so when they relapse, for instance, they've got this the person, not a telephone conversation from somewhere, very impersonal kind of message from somewhere over there. We want people that we can -- it's face-to-face, "I know you, I can call you when I'm in trouble."

And if people understand those warning signs that they're starting to become unwell, that's the whole education you give to the patient and the family, this is what needs to happen when you're feeling like this, this is who you need to call, you can prevent a lot of those re-admissions, unnecessary re-admissions under the Mental Health Act because people have been unwell for quite a while and nobody really knows what to do.

The difficulty with mental health problems that I really need to emphasise is that physical problems, for instance if you have acute abdomen, acute pain you won't hesitate to pick up your son or daughter, whoever in the family put them in the car and go to the Emergency Department, you won't hesitate. But when somebody is not sleeping well, not behaving well in a manner that they normally do, it's like they put it down to maybe he's just tired or not happy with things. You need to get an assessment to make sure that you're not overlooking things that are going on now, you don't wait. The key is early identification and early treatment in a timely manner so that it doesn't get prolonged and get complicated to the point that when they come to mental health services, they end up in seclusion because they've left it for far too long and they had no choice but to put them under the Act and admit them to hospital.

My concern without the Act, the Pacific and Māori people will have the unintended -- we will have the unintended consequence of delaying further treatment. The Act is -- if we use the Act appropriately to ensure timely treatment now, then we will be able to get that acute care immediately. Otherwise people will miss out on acute treatment,

because they will not come to us quickly for help.

Q. Yeah, no you've presented an informed by wealth of experience, articulate case for the need to -- for this new approach. It's interesting with that statement by the Royal College of Australasian psychiatry, or whatever they're called, that it seems to be a historical problem of the past, when in fact of course which is clear today, it's an ongoing issue about how you care, and it's getting the appropriate mix of clinical and cultural methods to support the person and their whānau.

A. Yeah.

Q. Yeah.

A. I think there's very good recognition of the fact that we can't go just with the clinical aspect of things, we have to recognise the importance of our culture, our values and our families in this whole process.

Q. Thank you.

CHAIR: I'm going to interrupt, we've taken over I'm sorry.

MS VA'AI: Feel free.

CHAIR: It's so engaging. My question hits right on this point. You will be aware, Doctor, that our terms of reference require to us look at incidents of abuse in care.

A. Mmm-hmm.

Q. And that means that people who are in care and that's children, young people, vulnerable adults and it includes people who are held either voluntarily or compulsory in mental health units, institutions. The question is, what is abuse and I'm going to put the question bluntly to you now. Do you think that the failure to provide any form of cultural recognition, appropriate treatment, appropriate engagement with Pacific people is a form of abuse?

A. Absolutely, yes. I've tried to highlight the key issues in Pacific people's well-being. We started with looking at the Fonofale model, the importance of family, relationships that forms their identity, and language. So when these people are taken into care, they have no connection to their families anymore, to their identity, to their language, and if you go into a service of people that speak a foreign language, how are you going to engage with them? How do you get help from them if you were supposed to produce help or give them help? Obviously you need to have the means of communication to be able to engage with them and make sure that they get better or get the help that they were there for in the first place. But not having those cultural values there with the clinical care is meaningless, because people don't exist in a vacuum, they belong to some family or village or community where they've come from. And that's crucial to their well-being, they belong -- they have a spiritual

health as well that needs to be acknowledged when they are away from their families in those -- in hospital, for instance. So when you go into hospital, it's really important to engage with people by starting off with a prayer, it makes sense, people do that all the time at home. So why is it that they go to hospital, they detach from that? Because if that forms up your mental well-being which does affect your physical well-being, then the cultural aspects of care is fundamental to Pacific people.

Q. Thank you, you've answered my question.

A. Thank you.

Q. Back to you.

QUESTIONING BY MS VA'AI CONTINUED: Thank you Madam Chair.

Just finally, in light of your comments about effective and genuine implementation, what are some of the key things that you would like to see happen for Pacific survivors and communities in mental health, keeping in mind obviously that mental health is a very complex concept as you've laid out.

A. Yes, there's a lot of things but I just want to highlight maybe five key points, and we've stressed the importance of cultural care, understanding of Pacific cultural values in order to provide good service together with the clinical care. And to be able to produce such a service is about having the right people there, the workforce is critical to any service. You can't have a workforce with untrained, unskilled, incompetent people to carry out complex work. We are dealing with complexity, and you need people that are well-trained and skilled to be able to do that.

I want a service that my own family and my own people, my own loved ones would use, I would like to encourage them to use because I have confidence that when they go there they will be cared for appropriately. So workforce is important, staff training is important and the concepts that I used, cultural and clinical both are really important. You can't just manage people with culture as well without having the right treatment to be able to treat their underlying illness.

A lot of people have thanked me about the medications that they have. I hear people saying "Look I've got my mother back, I've got my son back, because he's been well-treated." And a lot of my -- I have a lot of good colleagues, they're not -- I mean I'm the only Pacific doctor in that service, but any well-trained professional has an obligation to treat people properly, and treatment is not just about medication, it's about understanding people from a broad perspective that we've been talking about, it's an obligation.

So it's a real shift, a shift from a monocultural, western-based illness approach to a

values-based approach stipulated by the Fonofale model, and incorporates broader understanding of people. It's not just about getting a diagnosis, it's important to have a diagnosis but it's about understanding why and how people were unwell at this point in time and what it is that we need to do now, because if you have a good assessment it will inform good management.

So that's one thing. The other thing is the complexities that we've been talking about. So we've talked about physical problems, social determinants, alcohol and drug use. You can't just treat mental health without addressing those issues. So we need to address social disadvantage, for instance, because that's also addressing health inequity and health disparity that Pacific and Māori equally suffer from.

The other most important thing as well is education. Of course we all know the key to preparing young people for the future in terms of careers is to have a strong education. We need to ensure the health and safety of our children as they grow up within our homes, and that requires responsibility of our families as well. It's not just the Government and services and other people. Children grow up in their home environment, so we need to focus on that in terms of teaching respect, language and all these other values that we've been talking about. So we do have a responsibility as well.

Mental health is very complex, but if we all work together starting from healthy environments where children are nurtured, safety is priority, like we don't abuse our children, that will automatically reduce mental health problems in a way, if people are -- children are safe.

There has been a lot of funding as we know that has gone into mental health. We have heard about millions of dollars that's going into Pacific mental health and that's a great thing. And I also want to acknowledge a lot of Pacific people that have already done or are doing a lot of good work for Pacific health. But I think it's really important that we have effective monitoring system to track these funds, where is this money going, who's been spending them and what have they spent it on? And it's about accountability.

And it's also good because the Government then would be confident to give us more money for Pacific services if we are showing good outcomes from our services. And these outcomes are actually improving the system, because if we continue to do the same thing in the last 20 years, we are not going anywhere. So we need to evaluate and clearly see for ourselves what's working, what's not working, and build -- we need to communicate through data, proper collection of evidence to show what's working well for Pacific people.

It sounds quite demanding in a way, everything that I've been trying to say, but it's

only then, it's only having systematic systems that can be reviewed and evaluated properly and documented properly that provides good evidence. So we need a good platform to work from. And then we can then only improve our services, I suppose. That's my vision actually, but yeah, I think that's basically some of the key issues that I've been thinking about.

But to finish off, I think it's about having courage and leadership in these Pacific services that we have to ensure that our people are well taken care of, and some of these abuse and challenges that we've been facing for years is actually being addressed properly.

Q. Malo le saunoa malo aupito fa'afetai tele lava i lau afioga Leota Dr Petaia mo le faaavanoaina o lou taimi. O se mitamitaga foi ia i matou lou afio mai aemaise lau saunoga matagofie. Faafetai lava.

A. Thank you.

Q. I will now hand you over to the Commissioners, I'm sure they might have more comments or questions.

A. Oh, I thought we were finished.

CHAIR: We're only just getting started. No, I'm going to ask my colleagues if there are anymore questions that they'd like to ask.

COMMISSIONER GIBSON: Thank you Leota Dr Petaia, really appreciate the courage and leadership you've brought to this issue and the thinking around, in particular, the cultural component. Going back to our contextual hearing, one of the witnesses, former mental health commissioner Mary O'Hagan talked about the need for both cultural education but to really transform the workforce that actually her vision, the mix needed to be something like about one-third traditional clinical workforce, about one-third cultural workforce and about one-third the consumer lived experience, lived mental health, psycho-social, disability experience workforce, but of course recognising there's big overlaps between all of those.

I suppose maybe it takes -- just wondering your thoughts on that, maybe it takes a big transformation of the make-up of the workforce to really get the mental health workforce in New Zealand, the transformation of a mix of workforce to make the difference. Also reinforcing you talked about critical mass in a service making a difference and losing that. Just thinking, do you have a vision yourself of what would be the mix of the workforce, mental health workforce in New Zealand if we were to succeed?

A. You've mentioned the consumers with lived experience and they are a critical part of mental health services, because they are the ones who experienced a lot of these things, so they should be part of the workforce. I've also talked about the Pacific communities. We

have a lot of good people that have already been doing a lot of informal work to support people with mental health problems. We perhaps need to engage them in those processes as well and Pacific in general are very quick to mobilise support and help and they know their communities. So if we maybe go to those most vulnerable, we need to target those most vulnerable communities and find out who are the Pacific leaders within this community, ask them, they normally know what's going on in their community and ask them how they can support whatever initiatives that we are hoping to implement in regards to mental health. So there is resource out there, I think we just need to look hard enough to engage more people to do the work.

So absolutely, I agree with you that we need to look at the workforce, but look in the way that is meaningful to Pacific people so that we can -- other cultures as well, but I'm talking mostly about Pacific so that we have services that address the needs of people and is meaningful for them, not just any service, we need to make sure we have the right mix like you're talking about, yeah, and the right cultural people with the cultural knowledge to train other people to make sure that we continue to have that workforce. So it's the resource, it's the human resources that's critical, yeah.

Q. Thank you for that. Also I suppose my experience, what I've learned, is that it is the consumer, the lived experience workforce who are the most attuned to abuse and neglect of what goes on in services. Is there a way of better utilising the wisdom from within there to educate, I suppose, both the workforce as a whole but also families, communities about avoiding and preventing abuse and neglect in care in services?

A. Absolutely. The consumer should be involved, they should be the voice in most of those decision-making, they should be part of the solution. We need to actively listen to the consumers and engage them and learn from them.

Q. Do you think there's enough of that happening at present?

A. No, no, it's not, because sometimes I wish there were consumers in meetings when I am at because we forget about that aspect, if there's no voice right there at the decision-making table to ensure that the consumer voice is there all the time, and be respected. It's not happening as much as I would like it to be, but I do think it's an important part if we want to improve outcome for mental health in this country. Does that answer your question?

Q. Yes, thank you.

COMMISSIONER STEENSON: Tēnā koe Leota Dr Petaia, e mihi ana ki a koe mō ō mōhio mahi ki te Kōmihana i tēnei rā. Thank you so much for sharing your immense knowledge with us today. I just have a couple of questions around this implementation and your

views. So you've talked about it being key and given us some really important points. I'm just wondering your view on, given that the system is set up to a particular lens, European lens.

A. Mmm-hmm.

Q. Do you see the requirement for a separate Pacific care structure, or do you see that one could work within the existing structures? So that's my first question, so I'll let you answer that, then I've got a follow-up to that.

A. So I work in a system, I mean in forensic services where I am the only Pacific psychiatrist there and there has been a lot of advocacy around having a separate Pacific service. Like anything, there's pros and cons about it. But from my perspective, we don't have the capacity right now to have a separate service. And if we have a separate service, that will marginalise Pacific people more, because they will not access specialists in the mainstream service as much as possible.

So a good example is having -- I guess I'm in a unique position because I am a clinician, I treat people from a clinical, western perspective, but I'm very culturally aware so that we do it together in that context, where cultural is a priority for our team, so we work in a multi-disciplinary team. So because of my position I'm in a lead position for a whole team, and that's unique in that sense because there's not many of us, there's no-one other than myself.

So, but I have observed how it works really well, if we deliver clinical services from cultural lenses, whether Pacific or Māori, we have to respect those cultures and it can work very well together, working alongside each other. So there are things that are already existing are working well now, and we don't need to re-invent things. But I think it's the respect of one to the other. So even if there's no psychiatric doctors, there will be cultural workers there of Māori and Pacific ethnicity, because that's one good thing, we're talking about mental health services, but this is happening right across other areas of medicine. And I think that cultural workers in the hospital, in the community, together with their psychiatrists, whether they're from Russia or wherever, Africa, it's about respecting each other and listening to each other.

So when I see Māori patients, for instance, I'm not Māori, I have a lot of respect for the Pukenga Atawhai, so I will take my meetings to the marae, for instance. I had a very complex patient that I had to deal with, no-one can manage any family meeting in the hospital, so I took them to the marae and I asked the cultural -- the kaumatua in the hospital, can you please lead this for me, I don't know what is important to Māori, but this

is the issue, this is the complexity, there's a lot of underlying issues with this family that needs to be resolved first so we can then discuss the clinical issues.

The staff observed that in the marae there was no arguments, no fights, the kaumatua led the whole discussion, I only came in just to talk about medications and the family accepted it very well. But it was the kaumatua that was chairing the meeting that was leading the whole discussion. So it's about having respect for those cultural processes and protocols, and utilising that to deliver whatever service that you need to do.

So no-one can dispute it if it works and I've shown it by doing -- I've done lots of things that people don't normally do and I've asked people to just do it because that's how I think it would work and if it doesn't work then it doesn't work, but let's try. But every time we try that, it works very well and it makes sense because people feel safe in the marae, people feel safe because they're speaking Māori first, before I even talk about medications. And it's a very warm and therapeutic way of delivering clinical services.

So I guess that's my view in terms of making sure that it's not one or the other, because we don't want also just the cultural services to be focused on everything culture and missing the point that these people need medications, because if you have cultural workers that are very culturally oriented and have no understanding of medications then they won't encourage people to continue to take the treatment that they need, that's the risk, and that's why working together in that context where we have very -- it's about relationships with the people in your team, and exchanging ideas, and ways to improve care for people. No-one will dispute that, people don't wake up in the morning and come to services and think let's do this because you're Māori or let's do this because you're Pacific, we don't do that, but it's about whether you're doing it the right way.

Q. So expanding the current system to be more holistic which requires some more resourcing and some training --

A. That's right.

Q. -- is essentially, if I could put it in a nutshell, which is not perfect, but close. So from a transitional point of view, let's say tomorrow the powers that be decided that that was going to work, and they would put it in place. Replicating that would require, what are the sort of things that you think immediately, if everyone had the right attitude, would it be super difficult or...

A. Which is the most difficult thing about it.

Q. Yeah.

A. It's never the people with mental health problems, always the staff around and their

personalities that you have to deal with. So if people agree, fantastic.

Q. So I guess what I'm trying to get to is how do we get from the here to there, what's that transitional?

A. I think we need to apply what we apply to clinical scenarios. I think the most important thing is about clear communication, effective communication in a very respectful way. So for instance, talking about Pacific, having Pacific discussions, talanoa, it doesn't have to take lots of thinking.

I'll give you an example. I have been working in Samoa since the tsunami, I led the team of mental health clinicians from here and psychologists to Samoa. And over the years since the tsunami I work very well with my friend and colleague Fuimaono Karl Pulotu-Endemann, he's well-respected, he created the Fonofale model. So we go to Samoa, for instance, we take professionals from here. And the thing about New Zealand is it takes a lot of time to think about things, you think, you think, you think, you plan, you plan, you plan, you plan and then maybe act. In Samoa you think, maybe, and then act and then you learn from it and then you keep going.

And I quite like that, because people are dying, you know, the suicide rates in this country is very high, it's shocking, we don't have time to muck around. So for a Pacific person advocating for Pacific we are in crisis, we are saying that mental health is worse in this country. So we've got so much knowledge already, we've got so much research that's been happening in this country, it's about the translation of that knowledge into action that needs to happen, it's not about more research and more research, we already know, I mean we've got knowledge; but we need leadership to encourage to actually start doing things that we think will work for Pacific. And I'm very young, we've got some very senior Pacific people here like our church minister and Bernie I think is here, he's been doing a lot of good work in the Pacific. We should ask them to help us and then we can plan together, because if you make people own that process, they will do it.

Q. Okay, so if I hear you right it's lead and act?

A. That's right.

Q. Kia ora.

A. A bit more action.

Q. Kia ora.

CHAIR: Yes, one of our witnesses who you might have heard of, Tigilau Ness, said to us the other day, "just do it". I'm going to leave you in the very capable hands of my colleague Ali'imuamua Alofivae.

COMMISSIONER ALOFIVAE: Lau Afioga Leota. Ma le agaga faaaloalo lava fa'apea ma le loto maualalo, e avea lou leo fa'atauvaa e fai ma fofoga taumolimoli a le afioga i le Komesina Taitaifono ia Judge Coral Shaw ae tainane le mamalu o le au nofo Komesina fa'apea ma le laulau o lenei matagaluega. E molimoli atu se matou fa'afetai ma le fa'amalo lava i lau susuga mo lau saunoga matagofie aemaise lava lau tapenapena lelei. O le sauniga maea o lau mataupu ma le fa'afofoga o le mamalu o le aofia. Ese le manaia i le fia fa'alogolgo o lo matou taliga i lau vagana fetalai ma lau saunoa atamamai aua o galuega fita ma tiute faigata ua tofia e lau susuga o le tamaitai foma'i. Ma ou te talitonu ia te a'u lava e leai lava se poto poo se atamai o se tagata e mafai ona fuli lenei mataupu silisili ona o le faigata fa'apea ma le ma'aleale ma le loloto ae pei o le matagofie o tofitofi iai i lau susuga. Malo lava le galue ma le fa'amaoni malo le onosai fa'amalo foi le sailimalo ma le tauivi. Ma ua ou fia Falealili fua ma ua mitamita le agaga ona ua iai se tasi o le alo o le atunuu ua tautuana ma ua fai ma auauna lelei ma le feasoasoani tele mai i lo matou taumafaiga aua galuega o le mamalu o lenei ofisa o le Komesina Faatupu o le Malo e ala lenei Faalapotopotoga a le Tatalo Pologa. Can I thank you on behalf of our Chair, our Royal Commission, the Inquiry, on your significant contribution to our talanoa. Fa'afetai mo lou alofa mo le tatou atunuu pele o Niu Sila faatasi ma atunuu o le Pasifika. Thank you for your heart, for our nation here of Aotearoa New Zealand, but particularly for our survivors and our different island nations, ia fa'amanuia le Atua ia te oe ma mea uma mo lau galuega fa'afetai lava.

A. Fa'afetai.

[Samoan song]

REVEREND HOPE: [Opening comments in Tokelauan] As we started in the beginning, I thank our mother for introducing us to this evening in prayer and one of our elders, as we had one this morning, to greet you in love and to thank you in love, one of our elders now will do the same, then I will lead our final prayer.

MALE SPEAKER: [Greeting and thanks in Tokelauan].

REVEREND HOPE: We ended with the hymn earlier, we will start with the hymn, that will be screened. I will say a prayer in Tokelauan and when I end my prayer I will end in a blessing in Māori and English. Thank you. **[Tokelauan song and prayer; blessing in Māori and English]**.

CHAIR: Thank you Tokelau, thank you.

Hearing adjourned at 4.53 pm to Tuesday, 27 July 2021 at 10 am