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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Adjournment from 11.10 am to 11.33 am

CHAIR: Good morning Mr Pohiva.

MR POHIVA: Good morning Commissioners and a special mālō e lelei to Commissioner Gibson. Our second witness for today, Commissioners, is Rachael Umaga who is of Samoan descent. She will be giving evidence about her experiences as a patient in psychiatric units in Wellington. She will also be describing the lack of care she received and the ongoing practice of over-medicating patients, her concerns about the current model as well. Before we begin, Madam Chair, I wonder if this is the appropriate time for the affirmation.

RACHAEL LEMALIE UMAGA

CHAIR: Yes. Rachael, if I can just ask you to take the affirmation please. Do you solemnly, sincerely and truly declare and affirm that the evidence you give today will be the truth, the whole truth and nothing but the truth?

A. I do.

Q. Thank you.

MR POHIVA: And before we get into her evidence, ma'am, I anticipate that 12.30 will be a short break and I also anticipate that lunch will be slightly later at approximately 1.30, which still allows us to get the full one hour lunch.

CHAIR: That's fine. As long as we have a full hour of lunch, that's the most important thing.

QUESTIONING BY MR POHIVA: Yes. Malo le soifua oute fa'atalofa atu ia te oe Rachael ma lou aiga ua afio mai i lenei aso. Rachael, thank you for your courage in being here today and I also acknowledge your family members who are here in support. For the benefit of our Commissioners and everyone here, you have your daughter here in support and your good friend Lorraine. To begin with, Rachael, can I please ask you to introduce yourself to the Commissioners and all of us here.

A. Talofa, my name is Rachael Lemalie Umaga. I was born in 1964. I am 57 years old.

Q. Thank you Rachael. I'm just going to ask if you could please put the mic, speak closer to the mic if you can. Apologies. And I'll just get you to ask if you can take us through your statement, starting at paragraph 2.

A. My parents are Samoan and they are both deceased. I have four siblings and we were all born in Wellington. I am the middle child. My parents migrated to New Zealand from Samoa separately in the 1950s. My dad settled in Newtown in Wellington, and my mum initially worked in Auckland but then moved to Wellington. My parents then met in Wellington, returned to Samoa to get married and then returned to Wellington to settle.

This is where we grew up. At the time, there was a big Polynesian population in Wellington and there were jobs available and that is what brought my parents to Wellington.

I was the victim of significant physical and emotional abuse during my relationship with my ex-partner GRO-C The abuse I suffered was the catalyst for my very first admission to ward 5 of Hutt Hospital in 1992. Ward 5 was the psychiatric unit for the Hutt Valley.

I was first taken into psychiatric care by my family. To this day I do not think that that was right. I was a victim of domestic violence, I was struggling to cope and needed support, not to be thrown into hospital.

Q. Thank you Rachael. And just for the benefit of us all, I understand that your time in psychiatric facilities began in 1992?

A. That's correct.

Q. And ran all the way through to 2013, is that right?

A. That's correct.

Q. And the reason you are coming forward to the Inquiry?

A. It's to share my experience of the abuse I suffered in psychiatric care and to highlight areas of concern. In 2020, I requested and received my medical file from the Hutt Valley District Health Board. I will refer to one of the documents in my file in my statement.

Q. So we'll see that a little later on during your evidence, thank you very much Rachael. To begin with, I understand that you had an earlier experience when you were 22 years old with the mental health services. Can you share with us or tell us about that?

A. My first experience with mental health services was in 1986. I was 22 years of age at the time. My parents thought my behaviour was concerning and that I was mentally unwell. I had dyed my hair bright orange and was partying a lot. I was flatting with my friends at the time and I believed I was just enjoying life. They thought this was behaviour that was not befitting of a young Samoan girl at the time.

My mum worked as a nurse in the Hutt and Porirua and I thought she was well versed in picking up behavioural issues from her nursing experience. My dad was primarily concerned about what the church people thought. He was stern but was also looking for answers about why I was behaving the way I did. In my mind, I was just being a normal 22 year old.

My dad took me to see two mental health professionals at ward 27 in Wellington

Hospital for the behavioural issues. The professionals concluded that I did not have a mental health issue. I was not put on any medication, nor was I admitted to a psychiatric unit on this occasion.

Q. Thank you Rachael. I'm now going to ask you to tell us about your very first admission to ward 5, the Hutt Hospital and whilst you're doing that please feel free to slow down and take your time, we can take breaks as we go on.

A. Thank you. In August 1992 I left that violent relationship, I sought a protection order against him. I moved in with my friend and her husband. My ex-partner was trying to visit me at my friend's house. I remember I wasn't able to sleep. I had to take time off work and left my daughter with her dad because I couldn't cope anymore. That is when I believe the mania started. My friends were annoyed with me re-arranging furniture. I had become fixated with having everything in balance. I was physically and emotionally exhausted and struggled to sleep.

My friend and my family decided to take me to ward 5 on 1 September 1992. This was a traumatic experience for me. They literally picked me up and threw me into the back of the car. I was seated, one was seated at my head, another holding me at my feet and I was not sure which one, but one of them was sitting on me until we got to the hospital.

My friend then took me inside ward 5 to do the admission interview with the psychiatric registrar. I remember the psychiatric registrar asking me "Why do you think you're here?" I said "Because you guys don't see the real problem." I was referring to the fact that I was a victim of abuse, I needed help, but I was the one being admitted to the ward instead of my abusive ex-partner who remained in the community.

Medical professionals described my behaviour as hypomania, but for me my behaviour was a culmination of the physical, mental and emotional abuse I received and a lack of sleep. This admission was done informally. I discharged myself from the ward 15 days later but was then readmitted three days after that on a formal basis.

Q. Rachael, I'm just going to ask you to describe the difference between informal and formal admissions, it's just carrying on with paragraph 18?

A. At the time I did not know the difference between the informal and formal admissions. No-one ever explained this to me. From what I understand, an informal process meant admission on a voluntary basis as opposed to a formal process which required being sectioned under the Mental Health Act under a compulsory treatment order.

Under an informal admission, patients could leave the facility or discharge themselves after five days. However, this was subject to the facility's conditions. For

example, if staff did not feel that a patient was ready to leave, they could formally section them under the Act. Patients could also be sectioned under the Act during their time at the unit if this was necessary.

Q. Thank you Rachael. I understand that when you first got taken in by family members, you did not know that that that admission was voluntary, is that right?

A. That's correct.

Q. And you certainly didn't volunteer to be there, is that also correct?

A. That is correct.

Q. On a different point you mentioned earlier that you received your file or your medical file and you'd gone through that. In terms of your ethnicity, I understand that that was recorded incorrectly throughout your file?

A. That is correct.

Q. Can you tell us what other -- what you found when you were going through your file, and that's at paragraph 21?

A. For this first admission my file is noted as, and my descent, my ethnicity is noted as Tongan. My name was always miss-spelt, my address details were always wrong. I also noticed that someone else's nursing notes were recorded in my file. This to me indicated they were ignorant and careless towards me.

Q. Thank you Rachael. Just take a moment. I'm now going to ask you when you are ready to tell us about ward 5.

A. Ward 5 was not a stand-alone unit, it was part of the main hospital. In those days the unit was the only place at the hospital with smoking rooms. We were not allowed to roam around the hospital but others came to the ward to smoke.

There were two seclusion rooms. There was a women's side and a men's side of the unit. There were about six patients in one room, so we didn't get much privacy. Single rooms were available for patients depending on their mental state.

I was put in a room with five other unwell women. There were no curtains to give us privacy. There was a person next to you and then another person next to that person. My storage space was what I could fit under my bed. It was crammed.

The sleeping quarters were not therapeutic for me. The most therapy I ever got from that place was when the Māori healers came to the ward and they massaged us. These healers only came in because there was a nurses' strike and there were no overnight nursing staff. We had the most amazing night with them because they massaged us and they didn't tell us to go back to our rooms. I remember we couldn't sleep at night because we had slept

all day.

The fact that there was a shortage of medical nurses on the unit made it an unsafe place at this time because people who came in to cover for the nurses did not know what to do. For example, we had managers coming in to give breakfast and one of them gave a patient a non-diabetic meal which was the wrong meal as she needed a special diet. I also found the male nurses quite creepy. I fell twice in the toilet and it was the same male nurse who responded to my call. I would have preferred a female to respond.

I recall one registrar who attended to me who was a young guy. He was a New Zealander. Back then that was unusual. The psych unit was full of foreign nurses and foreign doctors who I felt did not have any idea of New Zealand culture, let alone my Samoan culture.

During this admission I was given a lot of medication and I was never told exactly what the medication was. I had never been on any type of psychotropic medication prior to 1992. I was heavily drugged against my will and it was a continuous pattern of over-medication. I felt like a human guinea pig. It was like "What colour would you like this week Rachael? Did that yellow pill help? Well, maybe we'll try a green pill."

I consider the experimenting that they did with the pills so abusive. After experiments my behaviour was then measured against the DSM4 psychiatric manual. The manual contained a checklist, framed in questions, of symptoms being presented. They were generally closed questions requiring a yes or no response. Depending on the number of boxes ticked yes, they would then diagnose us. The behaviour I presented to them allowed them to label me in a certain way.

Q. So essentially, Rachael, you're saying that they were going off a checklist or another manual to determine what you would be diagnosed, is that right?

A. That's correct.

Q. Just take a breather and then when you're ready continue on paragraph 30.

A. My medication included a drug called Haloperidol which gave me what patients called restless legs. It made my legs want to move all the time. It was such an awful feeling I could not control. All I wanted to do was sit and relax. Haloperidol also gave my legs a burning sensation. Because of the burning sensation, I put my legs in the toilet and flushed it with the water to help them cool down. The effect of this was that it gave my legs nerve damage. My legs were always in pain when I walked. The nurses knew this was happening, so they gave me another drug to relieve that pain. I was also prescribed Lithium which made me really sedated so I couldn't stay awake and I had to do fortnightly blood

tests to monitor the level of Lithium in my blood. Then it was another drug on top of another.

There was nothing to do at the unit. We just sat there all day and smoked. I felt neglected because there was nothing to do except wait for 10 o'clock, 12 o'clock, 3 o'clock, 5 o'clock for our pills or for a cup of tea. We were bound to get on each other's nerves. You could not get well in a place like this.

I got really frustrated with how the nurses operated the unit. They would give us tasks to do, like greeting people, making cups of tea for patients and people who came to visit, and looking after the plants. When people came to the unit, I would welcome them and say "Hi, who did you come to see?" Then I would take them into the day room or to their bedrooms. The day room was always full of more people than were actually admitted on the ward because people came from other wards would come in to smoke. I felt like I was doing their job for them, but I learned a lot about how to run the unit during my time there. I felt that I was quite high functioning despite the drugs I was given.

I remember on one occasion an occupational therapist took me and other patients to play soccer on the asphalt. As you would expect, people who were really drugged up would not be able to kick a ball. I was, however, able to kick the ball from one length to the other. I would just kick the ball and walk to the other end and kick the ball back. I would think to myself God I'm going to kill myself with this, it's so boring. That's why I believe patients get so frustrated. Another activity which they made us do was throw the basketball to each other saying our names as we did it. None of the patients caught the ball but we had to do this repeatedly.

After a couple of weeks at the unit, I discharged myself on 15 September 1992. I left because I was having many arguments with the psychiatric registrar about not being able to go on leave from the unit. He did not think I could go on leave. When I decided to leave, the registrar threatened "If you leave I'd make sure you never leave again if you come back." I also remember one of the psychiatrists on the ward telling me that he could guarantee I would be back at the unit in a few days. I believe his comment meant that I would already be hooked to the medication after spending 15 days at the unit. I learned later that it takes about 15 days for the medication to go through your system and for someone to get addicted to it.

Q. Thank you Rachael. So on that occasion you discharged yourself, that was what you refer to as a voluntary discharge?

A. Correct.

Q. And when you were talking about that comment from the doctors at the time, your understanding was that once you -- you realised that once you were in psychiatric unit it was so hard to get out of it once you're addicted, is that right?

A. That's correct.

Q. I'm just going to ask you to take us through your second admission and that's at paragraph 35, bearing in mind that you can take your time and take a breather when you need it.

A. A few days after I discharged myself, I was readmitted to ward 5 following an incident where my legs gave way and I couldn't walk. On admission, I was made to sign a contract. This meant that I was sectioned under the Mental Health Act and was only permitted to go on escorted leave with a family member or a nurse.

I was put into a seclusion room. I think this was because I was a flight risk to them. I remember the nurses sedating me to bring my energy levels down and them having to restrain me to the bed.

Q. Take your time Rachael.

A. The seclusion rooms were like a cell, only big enough to fit a single hospital bed. The door had a little shutter window on which staff could move to see if I was okay. There was also a little square window in the room that you couldn't open. The room smelt sterile and like urine and smoke. I put colourful soaps on the windowsill to get rid of the smell. The seclusion lasted for a long time. I don't know exactly how long it was for, but it was around two weeks.

While in seclusion there was no water given and no toilet. The room was locked and staff had to let you out to go to the toilet when you needed. Staff were often late to open the door and patients often urinated and soiled themselves. This contributed to the smell in the unit. Later in 1998 they gave you three glasses of water and a disposable bed pan overnight.

One time, one time I drew a forest scene on my door with chalk and wrote "No doctors allowed zone unless you're my friend." I did this because it was my private space. A doctor walked right in and I had to tell him that he wasn't my friend so he couldn't come into my room.

I remember seclusion made me feel isolated because I had no contact with anyone else apart from the staff. I thought about nothing else but why I was there which added to my frustration of being there in the first place. I was stuck in the room, restricted from doing anything else on the ward, they let me out to have my meal, but they restricted the number of visitors I could see. It was a dehumanising experience and a power play by the

nurses and doctors in that they made all the decisions for me.

I also remember one time when I nearly got ECT treatment because the staff got me mixed up with another patient. I was taken to the ECT room and the person there asked me who I was and then realised I wasn't the correct patient. I was then taken back to ward 5. This incident wasn't recorded in my medical file as I didn't end up getting the treatment. ECT was done in another room outside of the main ward and was usually done on a Friday. I remember the lights used to flicker when it was happening.

Q. So with this Rachael, you could see the lights flickering often?

A. Yeah, every Friday.

Q. And this was a close one, or near miss for you?

A. Could you repeat the question?

Q. And this was a near miss?

A. That's correct.

Q. When you are ready, Rachael, can I ask you to -- you wrote a letter to the Ministry of Health expressing your concerns about the mental health system and I'm at paragraph 42. And you were concerned about the treatment you have been receiving. Can you tell us a bit more about that?

A. Yes, I remember writing to the Minister of Health expressing my concerns about the mental health system and service. I was concerned about the treatment I received. And the place was a pigsty, it stunk. You couldn't get rid of the smell of body waste in the unit because patients didn't always wash and lost control of themselves because of the medication.

I stayed at the unit for a couple of months until I was discharged on 19 November 1992. During this time, I was in seclusion for a long period of time.

Following discharge, I was put under the care of Dr Joanna MacDonald through Community Mental Health Services. Dr Joanna MacDonald was the wife of my psychiatrist, Dr Alex MacDonald at ward 5. She was the total opposite of her husband. She was easy to talk to and I liked her. I had to catch a bus from home or leave work early every fortnight to visit her at her office in the Hutt. At this time, I was working for the Insolvency and Trustee Service as their Senior Insolvency Officer. I really enjoyed that job because it involved training others.

Q. So you had at the time a professional role in employment?

A. Correct.

Q. And just carrying on at paragraph 45 you talk about your memories of this experience. Can you take us through that?

A. Today my experience at ward 5 are still quite vivid in my memory. Ward is now used for plastic surgery but if I were to walk into it today, I would be able to remember where everything used to be, from the seclusion rooms to our bedrooms. One of those vivid memories is the smell of the unit and the window in the seclusion room.

Q. Thank you very much Rachael. I'm now going to ask you questions about your third admission. Can you take us through, I understand it's Te Whare Ahuru now and it was in 1998.

A. My third admission to Te Whare Ahuru was on 3 February 1998. I was 33 years old. There was a long period of being very well without medication since my second admission.

My relationship with my ex-partner was on and off and during this time I was back with my ex-partner and the problems continued. I ended up seeing my doctor as I was sleep deprived. Our relationship was very tense during this time and continued to deteriorate. I took my children and moved to my parents' home nearby.

In January 1998 my parents took me and the children to Auckland for my cousin's wedding. While we were in Auckland, I took my 8 year old daughter to a concert at Auckland Domain. We had a really good time but at the end of the concert I became separated from her. I was very anxious and confused and headed towards the concert exit area to look for her. I then heard my name over the loud speaker, but the security guard would not allow me to go back into the park. I didn't know why they wouldn't let me in. All I wanted to do was to try and find my daughter.

Q. Thank you Rachael. That's fine, carry on at paragraph 50.

A. Despite what the doctors thought, I believed that there was nothing psychiatrically wrong with me. There was a lot going on with me. I was separated from my ex-partner, I was sleep deprived, I was dealing with four kids and I was still recovering from the birth of my sons. There was also a lot of people at the Domain and my 8 year old daughter was exploring and then went to the toilet. She took a long time and that is when I started to look for her. The situation at the Auckland Domain was therefore unfortunate.

Q. Thank you Rachael. And I understand that on this occasion in 1998 your ethnicity was recorded differently again. Could you tell us about that?

A. In my 1998 medical notes, my ethnicity was recorded as Tokelauan which again indicated ignorance and carelessness to me. The staff just assumed my Pacific Island ethnicity and they had that typical perception that all Islanders looked the same. They didn't ask me to clarify or confirm my ethnicity, they just wrote it down.

Te Whare Ahuru was meant to be a place of calm. This to me was anything but

calm. Te Whare Ahuru was a stand-alone unit across from the main entrance of the Hutt Hospital. There were approximately 22 beds at the unit which were all in single rooms. Patients got their own room which were bigger than normal, so there was more privacy this time round. There was a side called Te Rangimarie which was the intensive care unit which was where they put the most unwell and those in seclusion. Then there was an open side for patients who were more likely to be informally or voluntarily admitted.

There was a dining room, craft room, music room and a room you could cook or bake under the supervision of a nurse. None of them were fully resourced so activities were not able to be done properly. There were other things available for our recreation, but again, nothing worked properly. The piano wasn't tuned and had missing keys, the puzzles were all mixed together with other puzzles which was really frustrating. It really felt like the staff provided us all these things to show they cared but it was all just surface level and for show.

There was a courtyard, it had fake grass on it and all you could do was walk around it because it was worn and split so it was a tripping hazard. So this was hardly used. There were unusual things happening at the place that were not conducive to our well-being. For example, the craft room was called the purple room but it was in fact yellow. It was things like this that really played with my mind. I'm not sure whether it was intentional or unintentional, but it certainly played with my mind.

I felt as if the occupational therapists, who were present during the day, came but never stayed long enough during the shift. Patients were aware of the schedule or programmes they had planned in advance and we looked forward to these programmes. However, the programmes never consistently ran because they were always cancelling it. The staff didn't seem to care about implementing these programmes that we were looking forward to because we had nothing else to do. It felt like staff were only concerned about having a programme plan for us on paper but not so concerned about doing it. This was frustrating for me.

Unfortunately the mental health practice never changed. The over-medication was the same. The doctors or nurses were not responsive to patients needs and we were just left waiting. Many of the nurses were what I refer to as bin nurses, because they worked in the mental health services for a long time. They were set in their ways, they liked to run things their own way and they lacked compassion or kindness. They were not open to conversation or talking about my daily experiences of being at the unit. This was the same sort of practice that occurred at ward 5, they just had a nicer venue.

Q. Thank you, Rachael, we don't have to go into paragraph 58 and we'll -- we can take a break now if you would like or finish off the few paragraphs before we have a break.

A. Finish off a couple more.

Q. Thank you. Could I just ask you to jump to 59 and do take your time and when you're ready, take us through that.

A. I was discharged from Te Whare Ahuru on 18 March 1998. I moved into my own flat with my children. I got assistance from the Richmond Fellowship who provided me with care to assist with the care of my sons. The discharge was followed by weekly visits from my community psych nurse, Fae Logovae from Community Mentality Health Services. Fae's job involved checking to see whether I was okay and that I was getting sufficient sleep and eating and getting out with the kids. She visited weekly and then fortunately and then monthly until I was settled at home. Thereafter I had a 6-monthly visits with my community psychiatrist.

I went back to work after parental leave. In 2000 I moved into my parents' home following a big argument with my ex-partner. I got my ex-partner removed from our home and rented it out. I continued to care for my children. I wasn't on any medication over this period and I found my work to be quite rewarding.

Q. So there was a long period since that time?

A. Yes.

MR POHIVA: And I'm wondering whether that's a good time to take a break for now and perhaps we'll take 10 minutes?

CHAIR: Is that all right for you Rachael?

A. Yes, that's fine.

Q. Good, okay, we'll take 10 minutes, thank you.

Adjournment from 12.16 pm to 12.28 pm

CHAIR: Thank you. Rachael, are you ready to carry on now?

A. I am.

Q. Thank you.

MR POHIVA: Thank you, Commissioners. Just in terms of housekeeping, I suspect that we will go through to the lunch on time that we initially said and when she finishes her evidence there are a couple of points that she wishes to raise further.

CHAIR: Very well.

QUESTIONING BY MR POHIVA CONTINUED: Thank you, Rachael. We are at paragraph 61 of your statement and I understand that that's your fourth admission in 2003. If you

could please take us through at your pace what happened there.

A. In 2003 my ex-partner was stalking me, followed me, and at one time he spat on me in public. He was often leaving threatening and abusive telephone messages. This triggered a lot of anxiety in me and I was traumatised again by him. When this happens, I am not able to sleep as I am constantly in fear of my ex-partner. It got worse and my friends took me to see the CATT team at Hutt Hospital.

Following the CATT assessment I was readmitted to Te Whare Ahuru. I was admitted informally to Te Whare Ahuru on 28 April 2003 and placed under the care of Dr Pieter van der Westhuizen who was a South African psychiatrist. He was a caring and a kind man. He was one of the few psychiatrists that spoke with me not at me. When we discussed my case, I always felt like he was listening. Other psychiatrists would just ignore me and then write down notes about me.

During this admission, medical staff recorded on my file that I was Māori. I considered this to be ignorant and it showed that they didn't care because I was constantly telling them that I was Samoan.

The practice was still the same. When it was time for our routine psychotropic medication, we had to line up in front of the medication room. They lined us up at about 9.30 so that we were all in bed by 10 pm and asleep by 10.30 pm. The nurses carried a medicine folder and it had all our names in alphabetical order, but we were never called in that order. It was a long and dumb process. We would get our pills in a little pottle and our water came in another pottle. That was all the water we got for the medication.

I felt like the small amount of water we were given was not adequate and not honouring a fundamental human right. I wrote to Te Whare Ahuru about the lack of water given with our medication and expressed my views about this.

Q. Thank you, Rachael. I'll just get you to pause there and I'll ask that the exhibit be brought up on screen. Can you tell us what this is?

A. This is a memo I wrote to Te Whare Ahuru staff raising my concerns about the amount of water we were being given with our medication.

Q. I'll just get you to read excerpts from that. Just starting at the top there, could you take us through that? You can move it closer if it's...

A. That's better. Yeah. "I write this memo in anger at how I see medication delivered on the ward. One fluid ounce disposable cup will hold all tablets or fluid depending on how it is preferred, and then another cup of the same size will be filled with water. This is the usual method. I question the validity and the ethics behind, because in most cases what is printed

on the package would say that medicine should be taken with a full cup of water, most commonly 250 mls. If the nurses administering these medications are reading from the packets, why then is a full cup not given for every tablet? Some boxes will have warnings that include "To be taken with food" or to "Avoid milk". What then is the purpose of administering medicines in the manner so practised? Simple, it's to sedate clients sufficiently nowadays so that nurses can...

Q. And we'll just bring up the second page.

A. ...so that nurses can get on with writing their notes as was told to one patient this evening. However, that is the general response. If sedation is the purpose, where is the care? What is the likely outcome on patient? A continued need for hospital services? A vicious cycle from where I'm sitting and as a current patient in Te Whare Ahuru."

Q. And just a bit further down that exhibit, another excerpt.

A. "As I understand it, there is a high percentage of mental health patients that end up in some other part of the system due to complications that can be attributed to the supposed medical care received in mental health institutions. Little comfort or pleasure in that."

Q. And finally you shared some views of your own.

A. "I dream of the day that I no longer have to take such medication and can do my healing holistically without the aid of pharmaceutical companies ever increasing products, not only cost but variety as well, and nurses get back to caring for patients rather than turning into word processors."

Q. Thank you, Rachael. After your memo you wrote to staff at Te Whare Ahuru you talk about how they changed their policy?

A. That's correct.

Q. And referring you to paragraph 67, what happened there?

A. Te Whare Ahuru then changed its policy so that we got at least 250 mls of water in a polystyrene cup and we were able to ask for more. I used to just take up a jug of water because the medication not only made me thirsty, but it dehydrated my whole body. My vision was affected at times and it also caused the skin on my feet to crack.

I also experienced a number of falls during this admission. As referred to in this statement, it was due to the medication and having restless legs. I also felt dizzy and high and would fall on the floor. The nurses noted these incidents on my file as "attention seeking behaviour", but I believe that the falls were a side effect of the psychotropic medication I was taking, not me being attention seeking.

During this admission my parents were concerned about my lack of progress so

they decided to fly a Samoan fofo, healer, to New Zealand to treat me. I wrote a letter addressed to the staff at Te Whare Ahuru advising them that I no longer wished to take further psychotropic medications.

With the permission of Dr van der Westhuizen I was allowed to undertake the Samoan fofo for seven days on the proviso I returned to Te Whare Ahuru for a further week's observation without medication. I returned, did not relapse, and was discharged without medication.

I remained well which I believe was attributed to the Samoan fofo. The fofo was not only healing, but the process was spiritual and natural. I was wrapped in leaves, plants and a sheet to help get rid of any toxins in my body by sweating it out. I was then showered with natural scents and leaves from rose bushes and was blessed at the end of the fofo. I was eventually discharged from Te Whare Ahuru on 16 June 2003.

Q. So during that admission that was the first time you experienced something of your own culture?

A. That is correct.

Q. And you found that quite beneficial?

A. Very much so.

Q. Moving on to your fifth admission in 2005.

A. My fifth admission to Te Whare Ahuru was on 20 May 2005. The day before my admission I visited my community psychiatrist who diagnosed me with epilepsy. I questioned him on the diagnosis as I did not think this was accurate. He was the type of psychiatrist that lent back on his chair and put his legs on the table when you were in the room. We never got on well.

He asked me during the visit what I was thinking, and I said, "I'm thinking you're an arsehole." He didn't like that at all. He said, "You can't talk to me like that". So he told me to leave.

As I was leaving, I kicked his door then kicked open the glass on the main entrance door while I was talking to my community mental health advisor and her colleague Lupe.

Later that afternoon Fae came back to my home and took me to see another psychiatrist, Dr Mathews, who arranged my 2005 admissions to Te Whare Ahuru the following day.

This admission was a weird one for me because it was the staff that determined that I needed to be admitted. My family were not aware of this admission and were not

involved. This was different to my other admissions because I was not unwell and I had not been on any medication for two years prior to the admission. I remained well after the Samoan fofo in 2003. Despite what the doctor said, I believed I was not becoming mentally unwell and I did not want to take any further medication. To this day, I'm not sure why the staff admitted me on this occasion.

Q. So just to clarify, Rachael, you did have circumstances that made you unwell and you believe, however, it was your belief that you didn't have a mental illness; is that right?

A. No.

Q. And carry on at paragraph 79.

A. I was put on a drug called Topiramax for suspected epilepsy. I was also taking other psychotropic medications but I made little progress or improvement.

I had to take so many pills, possibly as many as 13 pills at a time. I also took other medication for different side-effects. For example, nurses or doctors would give me medication for a sore tummy. It was easy for them to chart medication for side-effects.

As a result, my kidneys started to fail. I knew this because my kidney function levels were normal when I was admitted but it started to decline. This was picked up by the medical registrar at Te Whare Ahuru.

In addition to the psychotropic medication, I was put on anti-inflammatories. This was because I was experiencing very bad joint pain from the psychotropic medication. The anti-inflammatories were meant to ease my joint pain but they instead made things worse and must have contributed to my renal failure.

The nurses never gave me any food with the medication, only water. I believe that whatever medication I was on and had over the years caused my renal failure. Prior to my admission into psychiatric ward, I was not on any medication at all. I didn't even like to take Panadol.

Because of the issues I had with my kidney, I wasn't able to walk properly. I had a number of falls. My feet were always in pain and I felt dizzy and often fell to the ground. Like previous admissions, I believe the falls were a side effect of the medication I was taking, and my kidney issues exacerbated it.

I was sectioned under the Mental Health Act and transferred to the Te Rangimarie side of the unit. I wanted to seek legal advice of being put under the Mental Health Act and the duration of it, so I was able to access a lawyer, Kerri Preston, from the duty list roster through Te Whare Ahuru. I used this duty list roster a couple of times.

I think the worst thing for me was that these lawyers were rostered on. Because

they were on duty, they didn't really have any vested interest in whether I did well or not. They might see me for five minutes and go through my case. That was the nature of what was going on during my encounters with the lawyers.

I was also placed in seclusion during this admission. I felt like I was in seclusion for a long time. I just want to be clear that I don't ever want anyone in the future to experience seclusion. It is lonely and boring and makes you feel like an animal in a cage. We have no freedom. The staff just leave you in there and there is nothing for you to do in seclusion.

Around the time of my discharge, the psychiatrist advised my family members that I was an unfit mother. This was a difficult time for me. I remained in the unit until 28 July 2005.

In relation to the epilepsy diagnosis, I had an EEG done at Wellington Hospital. Following this test, it was confirmed that I didn't have epilepsy. This confirmed my own belief about that diagnosis because I never believed I had epilepsy. Nevertheless, I was still forbidden to drive for a year after this admission because my records showed a diagnosis of epilepsy.

Q. Thank you, Rachael. And I'll now ask you to take us through your sixth admission and again, at your own pace, taking it as slow as you want to at paragraph 91.

A. My sixth admission to Te Whare Ahuru was on 29 September 2007 under the care of Dr Garcia. Prior to this admission my dad was very unwell for months and he passed away immediately prior to my admission. His funeral lasted eight days and at the time I felt like people were coming to me for advice to make sure everything ran smoothly. I ended up being stressed, had no sleep and this led to my family contacting the Community Mental Health team.

Two Pacific members of the Community Mental Health Services visited me during the funeral and there was no indication that my thought -- that they thought I was unwell. I assumed they visited to support me.

I was taken to Te Whare Ahuru by my family. I met with a psychiatrist Dr Roy. He decided that I needed to be admitted. I was immediately taken to seclusion in the Te Rangimarie side of the unit. I was angry because I felt let down and I had spoken to my family and expressed my thoughts, but they instead decided to take me in to be admitted. This is what hurt me most. I then went back to the unit to my own room.

I was formally sectioned around 14 October 2007 and placed in seclusion again. This time it was for setting off an alarm. I never wanted to be in that place and felt it was

not helping me at all. I often acted out because I never wanted to be there.

During this admission, I again experienced restless legs and was constantly falling over due to the medication. I remember on this occasion I rejected taking Epilim because it was foul tasting and was not good for my teeth.

A week before discharge I had had enough and decided not to take any further psychotropic medication because of the effect it was having on me. I was subsequently discharged from Te Whare Ahuru on 7 November 2007.

Q. And now we are jumping to your seventh admission in 2008. When you're ready Rachael.

A. My seventh admission to Te Whare Ahuru was on 4 July 2008. This was a short informal admission for depression under the care of Dr Garcia. I was still grieving over the death of my father. The treatment I was getting was much the same as previous admissions as described above.

I was discharged on 21 July 2008 and I went and stayed with my friend in Hamilton for about two weeks. My friend worked in mental health services in Hamilton and I wanted time away from my family to recover. My children were looked after by my family during this time. However, I took them back after two weeks when I returned to Wellington.

In 2009 I had to undergo dialysis treatment for my renal failure. My renal function continued to deteriorate. This impacted my relationship with my children and my family generally. I couldn't work anymore or attend any functions. This had a wider impact on my family.

In February 2011 I had a live donor kidney transplant given by my sister. At this time I was caring full-time for my mother as I was not working due to my health issues. For my family this meant that I was available to look after our mother. I cared for our mother despite my health issues and I also had my children in my care at the time.

Q. If I can just jump to your eighth admission in 2012. Again, Rachael, please take your time.

A. My eighth admission to Te Whare Ahuru was on 2 May 2012. This admission was most unusual for me as I went to Te Whare Ahuru with a friend to advocate for her. I told the staff that what they were proposing for my friend was unfair. The matter escalated and I ended up being physically restrained and admitted to the unit. I was formally sectioned under the Mental Health Act so I was not able to leave.

I was taken into several -- into seclusion several times during this admission. On admission I was taken to seclusion on the Te Rangimarie side of the unit. I started experiencing the falls and the restless legs again, which I hadn't experienced since my last

admission up until that point as I had not taken any psychotropic medication for approximately a year prior to this admission.

My frustration with the staff grew. Every time I wanted to talk to nurses or doctors about something, they would tell me to wait. I was sick of them telling me to wait 5 minutes. I felt like no-one was listening to me. I only got responses when I raised issues about a personal relationship between two staff members. For example, I spoke to a senior staff member about an unprofessional relationship between a psychiatrist and a staffing member and that psychiatrist then actually gave me a response about something. It was an interesting situation.

I really wanted to take a drug holiday. The medication was making me drowsy and I had had enough. I wrote to my doctor at the time to express how I was feeling. I did not want to take more medication because it was literally making me worse. I wanted to be healed by way of natural methods such as Samoan fofo. This did not happen.

I was also taken into seclusion again after being accused of assaulting a staff member. I remember this incident well because I did not actually hit the staff member. I remember I waved my arm like that and he fell over. Nevertheless I was secluded for this incident and on several other occasions during this admission. I was eventually discharged on 4 July 2012 to my home.

Q. And Rachael, I understand that your ninth and tenth admissions happened next and you'll be talking about them both. If I can refer you to paragraph 110.

A. I was readmitted informally on 21 September 2012 for depression and discharged on 5 November 2012 under the care of Dr Kure. I was readmitted on 10 December 2012 for low mood and non-compliance with my medication under the care of Dr Kure.

Q. Just to clarify, these admissions were pretty much the same as your previous admissions?

A. Yes, except with the non-compliance that means I refused to take medication, medication is forcibly given to you by injection in your buttock, you're restrained.

Q. And then that takes us to your 11th admission, paragraph 113.

A. My 11th admission to Te Whare Ahuru was on March 2013 under the care of Dr Kure. This admission was done informally. Medical staff described my condition as major depressive episode and suicidal ideation.

On this occasion I had asked professionals for help as I wasn't coping at home. I was still looking after my mum full-time. I was struggling as a solo mother while caring for my elderly daughter (sic). I was struggling to cope.

During this admission I was experiencing much of the same treatment I received

as previously explained in my statement. A lot of the time I did not feel safe at Te Whare Ahuru and did not feel staff listened to my concerns. There was negativity from medical professionals and other patients. Staff were falling asleep on night shifts. Patients were also intrusive and abusive. I had limited contact with my family. There were always restrictions on my leave conditions. For example, I had to be back to the unit by a certain time which I understood was for my safety. Nevertheless, it was not a healthy environment for me.

The reason I say they did not respond to our concerns because I would raise my concerns if I was in pain. They would tell me to go and sit in front of the glass office and wait for a nurse. When a nurse came and told them -- I told them my issue, they would send me to another chair around the corner. Then another nurse came and acknowledged that I was there and wrote some notes and that was it. I felt as if they were playing games with us rather than doing anything to help us.

The medical registrars had some unusual practises. For example, I would complain about having a sore tummy and foot at 7 pm at night and the doctors would arrive to check me at 2 am in the morning. This scared me when they came at such an early hour. I often did not get any responses to when I raised concerns about how I was feeling. I tried to follow-up on this and I was told that the doctors came to see me, but I was asleep. I suspected these visits were during the night again. Sometimes nurses would respond by saying "They've got busy schedules." To me, the medical practice did not work in the best interests of the patient.

By this time, the District Inspector service was available. This was not available in my earlier admissions. The District Inspector was a lawyer whose role was to visit all inpatient clients weekly and talk to them about any particular issue that they might have been having at the unit. They would interview you and tell you whether you had a good case or not. Then they would take you through the complaint process. The unit would amend, adjust or assess anything as a result of the complaints.

I did not feel as though I could make complaints about my treatment through the District Inspector service. I did speak to one lawyer through this service about the anti-inflammatories I was taking which caused my kidney failure. He said I had a good case but at the time I felt I could not raise this concern in fear of being kept longer at Te Whare Ahuru. I was getting close to being discharged so I did not take this any further. I was eventually discharged in May 2013.

Q. So that was shortly after you had spoken to the District Inspector, is that correct?

A. Correct.

Q. Thank you, Rachael, that takes us through your experience of psychiatric units. I understand that you have some views about your diagnosis. Could you talk to us about that and I'm referring to paragraph 122 of your statement.

A. Throughout my admissions I was diagnosed with various conditions. To me these were labels they put on me to justify my admissions. However, the diagnosis did not make sense to me. For example, during my first admission in 1992 I was diagnosed with postnatal depression. This did not make sense to me because my daughter was two and a half years old. Then I was diagnosed with bipolar affective disorder after my 1992 admission. Later I was diagnosed with epilepsy which tests confirmed was wrong. To me I felt like I was labelled with a particular medical condition that gave medical professionals a licence to pump me with more drugs. I believe they were just experimenting with their drugs on me.

When I was reviewing my medical file, I noticed other labels being used by staff throughout my admissions. These labels included mania, hypomania, psychosis, bipolar disease, depressive phase of my illness, suicidal ideation, schizo-affective disorder, elevated mood, depression and sedated.

These labels were hurtful and degrading and I could not help but wonder why they did not inform me about what they were writing at the time of writing this. I was never told of these conditions and neither were they explained to me.

Q. Thank you, Rachael, you speak also of the lack of care given. That's at paragraph 125. Can you talk to us about this?

A. Throughout my admissions, I raised issues about the lack of response from medical staff and care from them. The facilities improved from when Te Whare Ahuru was used but the medical practice was the same. The main focus was on medicating patients which caused side-effects and so patient then received more medication to relieve the side-effects.

The environment was not conducive to my well-being. There were programmes and activities available but not consistently implemented or fully resourced to allow these activities to be done properly. These factors added to my frustration which made the experience worse.

Medical staff often got my ethnicity wrong despite me telling them constantly that I am Samoan. To me, this showed that they were ignorant and careless and it did not help the situation if they were not getting the basic things accurate. The staff assumed what ethnicity I belonged to and that did not sit well with me. It caused an unfortunate, unfavourable reaction from me because they often did not get the simple stuff right.

Q. Thank you Rachael. Just pause there for a moment. Before we get into, when you're ready, just take us through the impacts or the -- of the overall abuse on you. That's at paragraph 128.

A. Due to the over-medication, I experienced terrible side-effects and reactions to the various drugs I was taking. I went from having no drugs at all to having a lot of drugs. Haloperidol was a drug I got and was deeply affected by. I also couldn't tolerate Lithium which I called the battery drug. There was just a whole range of drugs I was put on and they caused significant side-effects. I am still impacted by my experience and suffering the consequences of this drug taking. I was put on dialysis for my renal function problems.

There were no thought or talk about therapy or alternative ways of healing apart from the one instance. There was only drug therapy. It was robotic. You were given medication on a regular basis and that was expected to make you well. There was no creative outlet, just some walks around the hospital grounds. I believe that options such as Samoan fofo or Māori massage should be readily available because they worked well for me.

Today I still experience what some people would call white coat fever which is basically experiencing high blood pressure every time I walk into a hospital because simply being there gave me anxiety.

For me, medication should only be a last resort. I feel like mental health hospitals are not well places or conducive to healing. I don't have any faith in these hospitals, whether they are inpatient or community based. My biggest issue with any mental health service is that they are unwilling to consider other alternative treatments. Whenever I have friends who are feeling mentally unwell, I dis-courage them from calling the CATT team because I believe the mental health culture and practises haven't changed.

The smell of the unit is still vivid in my memory. The first thing that hits you is the clinical smells and the smells of bodily waste.

My time in psychiatric care has also impacted my lifestyle. I went from being a very active mum to be an isolated, shy and quite introverted person, fearful of being in social settings. Even doing the shopping became a problem for me. I had this fear that everyone knew I was on a psychiatric ward so they judged me or labelled me before they got to know me. I used to play rugby and netball, but I could not do that after my renal failure.

Also, back then there wasn't any education around mental health and unfortunately our Pacific families have this idea that the medical model is the only model of care. With

the medical model being the dominant one, many Pacific families believed that this was the answer to certain behaviours. They believe everything the doctors tell them and diligently take their pills.

The feeling of shame is very real. For people that have been in these units, they carry the stigma of shame. We feel shame. Shame stops us from making friends. The stigma makes us untrustworthy of people, always insecure and cautious of people all the time. I am often questioning people whether what they are proposing is in my best interests because of my experience. I used to be outgoing and quite extroverted. I have been forced by the shame to behave differently and to be more introverted.

The use of the word "mental" carries negative connotations. I feel that it doesn't take into account the fact that there are many issues that make someone unwell and behave the way I behaved. These are issues like social issues, housing issues and socio-economic issues. Being a victim of domestic violence is a huge contributor to my behaviour, but that was often looked at in isolation or as a separate issue. Many Pacific people still do not fully understand mental health and respond negatively to people such as myself who have been in psychiatric wards.

Q. Thank you Rachael. I understand that you also have thoughts about looking forward. Can you share those with us? And I'm referring to paragraph 138 of your statement.

A. I have not gone through any redress process. In the '90s a staff member asked me if I was in charge of ward 5 what would I change. I told them that I would not have it attached to a hospital. I told her that it would be like a retreat. It would have to have a sea view or be in the country where it would be therapeutic, where you could walk in nature, really walk in nature as opposed to fake grass. You would have massage therapists, you would have art and you would have music. You would have all things that people could be passionate about to help them become well. It would all be about well-being.

I also told them that there should be psychotherapists and other mental health therapists, not just psychiatrists, so there are different options available for people. The Samoan fofo I had would be available to people as well as alternative methods of treatment. There would be diversity in people's skill sets, ethnicity and practise. There would be some medication but not everyone needed to be so medicated.

I would also change the clinical services in terms of what's on offer and how it's run. They should be more patient-focused and consistent. For example, the occupational therapist would be consistent and actually implement the plans they had in place.

The word "mental" has a stigma. The legislation should be called something that

reflects what they want to achieve. They should call it the being Wellbeing Act or the Wellness Act. I think they need to stop the drugs and give hugs. But then if I gave a hug they consider it inappropriate.

I guess the question for me, who are going to be the reformers and who are going to make sure that there are big changes for the future of care? I believe that survivors are a good start to consult with.

Q. Thank you Rachael. I also understand that you have further thoughts to finish off with today. If you could share those with us when you are ready.

A. When I was first diagnosed with bipolar I was told that it was a chemical imbalance and I asked what are the chemicals and what is the imbalance? And that could not be answered. So when they created -- when they use drug therapy they're trying to balance that imbalance and what they tend to do is give you medication from the maximum dose going back and it's a trial and error process. That creates issues for people and that creates over-medication. And I believe that's a practise that should not be used.

I believe that the Mental Health Act should be repealed and a new one replacing it. I believe there is room for an independent advocacy service for all inpatients in mental health units who can advocate for the needs of every patient. I believe there needs to be a focus on addressing the workforce and developing care practises and policies that address the needs of patients, not only the medical model, but alternative ones as well. I also believe in introducing an agreed note-taking process, because the current one is totally subjective, it is only the notes taken by doctors and nurses that are recorded on medical files.

That's all I have to say.

Q. Thank you very much Rachael. I'll hand it over to the Commissioners now, but before I do so, I say fa'afetai tele lava, Rachael, malo le faamalosi, malo le lototele, malo le loto finau. Thank you Commissioners.

CHAIR: Rachael, we don't have any questions for you, but my colleague Dr Erueti's going to thank you.

COMMISSIONER ERUETI: Fa'afetai Rachael. Ngā mihi ki a koe me tō whānau. Ka puta mai ki te tuku kōrero ki mua i te aroraro o te Kōmihana. Tēnei te mihi mahana ki a koe. I want to thank you on behalf of the Inquiry, Rachael. I know it wasn't easy to come and speak with us today, but you stuck to your guns and I know that you were determined to share your experience with us. And it was so comprehensive in many ways, I was just thinking your recommendations at the end and they were so very useful and insightful and very

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.