



TAKING ACCOUNT OF CULTURE

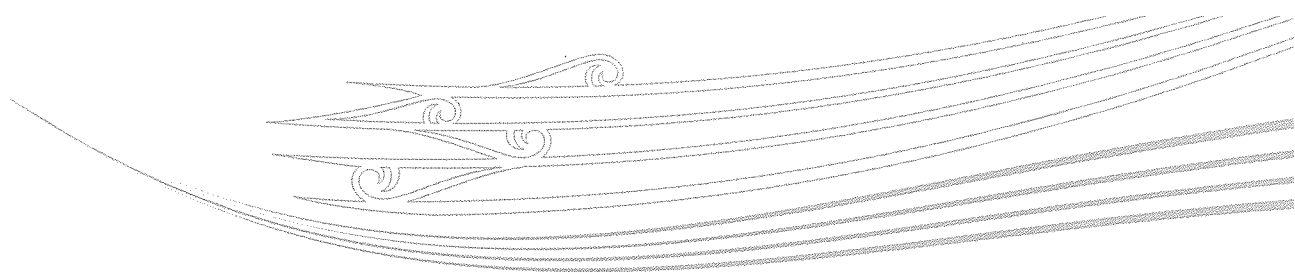
The contracting experience of Māori mental health providers

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Abstract

The major reforms in the New Zealand health sector during the 1990s resulted in a burgeoning in the numbers of Māori health providers, many of who worked in the area of mental health. Occurring alongside these health reforms was an increased concern with public accountability and interest in measuring the performance of Crown agencies. During 2001–2004, research was undertaken that sought to understand the mental health contracting experience from the point of view of Māori health providers. The research examined the experience of Māori mental health providers as they contract to deliver Māori mental health services in a health sector dominated by “Western” or mainstream approaches to accountability, contracting, and performance measurement. This article presents one of the key findings from this research: that Māori mental health providers regularly and routinely work outside the scope of their contracts to deliver mental health services which are aligned with those values and norms enshrined in Māori culture¹. The types of additional burdens and responsibilities Māori face in contracting for mental health services within a mainstream health system, as well as the reasons for these “extra-contractual” activities, are discussed. The article concludes that in the New Zealand health sector a contracting framework—one which takes account of the unique role *tikanga* (customs, practices) and *kawa* (protocols) play in Māori mental health service delivery—is required.


Setting the scene: An overview of Māori mental health service delivery in New Zealand

Māori

Māori are the indigenous people of New Zealand. The term indigenous has many definitions and many usages and can be politically charged. Key features which unite indigenous peoples throughout the world include an ancient relationship with a defined territory, ethnic distinctiveness and a shared worldview that places significance upon the idea that humans are intrinsically linked to the natural world. Indigenous peoples also share the common bond of experiencing “unacceptably large” differences between their own health status and that of the non-indigenous populations within developed nations.

In 1840, Māori and the British Crown signed the Treaty of Waitangi, an agreement that has come to be known as the founding document of New Zealand. Differences in the Māori and English versions have resulted in discrepancies between Māori and non-Māori

1. The research also found a range of additional responsibilities and tasks in mental health contracting that impact upon Māori and non-Māori providers alike; however, these findings will be reported in a separate paper.



interpretations of the intent of the document. According to the English version, Māori exchanged sovereignty for Crown protection, whereas in the Māori text tribal chiefs of the day may have understood they were being offered an arrangement similar to administrative authority or a protectorate. However, in the years since its signing, the Treaty has become an integral part of the New Zealand constitutional framework with attempts by recent governments to implement Treaty principles in order to redress past breaches of the Treaty. These principles of partnership, participation and protection have been established by New Zealand Courts, by the Waitangi Tribunal and by the Royal Commission on Social Policy. They have guided much of the Crown's public policy in relation to Māori and underpin the most recent Māori health policy documents .

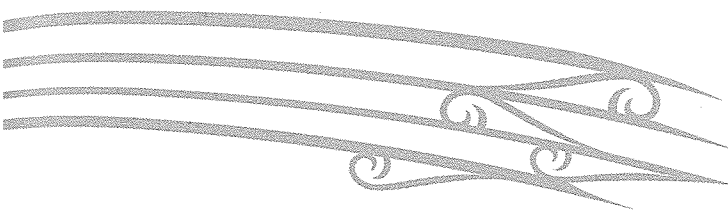
At the time the Treaty was signed, Māori were predominantly a tribal people, living on ancestral lands, with close spiritual ties to that land and to their rivers, lakes, seas and forests. By comparison, Māori of the 21st century are as diverse a group of people as any other, with mixed views on religion, politics, culture, education, health or any other institution of modern life. In coining the term “diverse Māori realities”, Durie stated that far from being homogeneous, Māori are a complex population living in a range of cultural worlds where there is no single reality nor any one definition that will encompass the range of lifestyles Māori lead. The diverse nature of the Māori population complicates the issue of how best to meet the health needs of Māori in terms of service delivery within the community as no single mode will accommodate all lifestyles and/or all realities. Nowhere is the need for diverse approaches to service delivery more necessary than in the area of mental health.

The evolution of Māori mental health service delivery

In New Zealand, mental health service delivery for Māori has moved through three distinct phases of care since the middle of the 19th century: institutionalisation; deinstitutionalisation; and the current period of “cultural affirmation”. From the mid 19th century, New Zealand followed the European trend of housing the mentally ill in large asylums or psychiatric hospitals. By the 1960s, however, the practice of providing long-term, secure care and support for the mentally ill was gradually being phased out. Psychiatric hospitals declined in size as mental health consumers were discharged to live and be treated within the community.

By the late 1990s, the third phase of Māori mental health service delivery—that termed “cultural affirmation”—was well under way. This period continues to the present and has

2. For a fuller explanation of the Treaty of Waitangi and its application to health policy refer to Durie M., & H. Whaiaora (1994). *Māori Health Development*. Auckland: Oxford.



been characterised by the growth of a diverse range of mental health service providers², including 'Mental Health Services for Māori' (services, which while catering for Māori do not necessarily operate from within a Māori cultural context) and 'Māori Mental Health Services' (those which start from and are based upon a Māori philosophical premise). This period has been one during which practitioners have begun to acknowledge the role culture has to play in the recovery of Māori mental consumers. Now, the empowerment of consumers and their families is regarded as critical to the successful delivery, evaluation and governance of mental health services and systems. "Culturally appropriate" services, particularly kaupapa Māori mental health services, began to appear. Kaupapa Māori services were able to provide a treatment environment based on Māori cultural values, processes and beliefs; it accommodated views and philosophies that were not based solely on Western concepts of "good health", but rather embraced more holistic approaches to Well-being³.

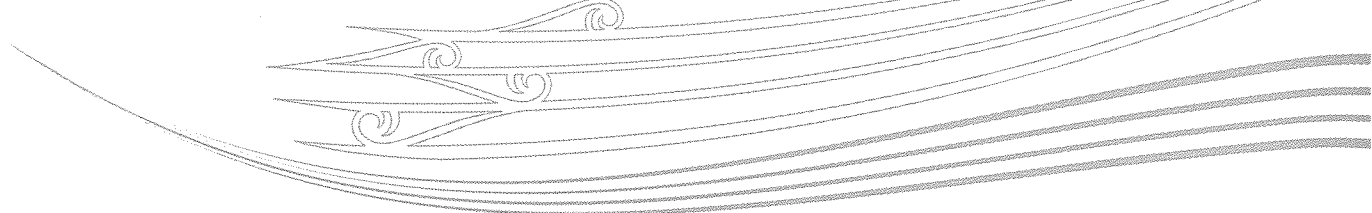
The growth in the number of kaupapa Māori mental health service providers—from around 20 in 1993 to 240 in 2005⁴—coincides with a period of major economic and state sector reform which began in the late 1980s and continued on through the 1990s. These reforms, with their initial focus on increased competitiveness and greater accountability, created the conditions under which community-based health service provision, such as that undertaken by Māori mental health providers, could emerge.

A series of health sector reforms

In the course of the last twenty years the New Zealand health sector has undergone four separate restructurings. The reform process began in the mid to late 1980s and was primarily concerned with the machinery of government and the restructuring of financial management systems. However, by the early 1990s the need to control expenditure in health care created the conditions for the restructuring of the health sector.

The National Government announced its intention to reform the health sector with the release of *Your Health* and the *Public Health* in 1991⁵. Prompted by the need to improve efficiency in the use of public health resources, the reforms rolled out in 1993 included a number of features, including: the separation of the roles of purchasing and provision of secondary health care services; the establishment of four Regional Health Authorities whose role was to purchase all personal health services for the people of their geographically

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3. A Kaupapa Māori service is a clinical service (but may also include non-clinical services) that has an underlying Māori kaupapa or culturally derived philosophy that is woven into all aspects of the service and this distinguishes it from other mental health services.
 4. <<http://www.Māorihealth.govt.nz/2004/providers.php>> accessed 13 May 2005.
 5. Also referred to as the Green and White Paper after its negotiable and non-negotiable aspects Laugesen, M., & G. Salmond (1994). "New Zealand Health Care: A Background." *Health Policy* 29(1–2): 11–23.



defined region; and the reconfiguration of public hospitals into Crown Health Enterprises that were to be run like businesses.

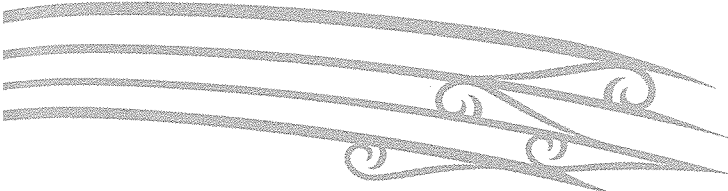
The separation of functions of purchase and provision afforded community-based providers the opportunity to contract directly with Regional Health Authorities to provide health services. With the introduction of competitive tendering and contracts for service, these voluntary agencies and community-based services—many of which were Māori health, welfare and social service organisations—became a key means for the government to deliver its services in the community. However, these “third sector” agencies were expected to reconcile their own priorities and needs, as well as their accountabilities to their clientèle, management teams and boards, with those of the Crown as outlined in their service contracts.

Further, albeit relatively minor, changes to the health sector were implemented in 1997 by a National–New Zealand First Coalition government. While some elements of the 1993 reforms were modified, the purchaser/provider split was maintained, arguably retaining some of the efficiencies gained through the use of contracts for service.

In 2001 the most recent round of health restructuring began. The New Zealand Public Health and Disability Act 2000 (NZPHDA) was enacted by a Labour–Alliance Coalition Government and this signalled a return to greater public participation in identifying and making decisions about the health needs of local communities. Several features of the new model differentiate it from the previous structure including: a new set of organisational arrangements with the establishment of 21 majority-elected District Health Boards (DHBs); a “Health Funding Package” where the size of the health budget is clearly signalled three years at a time; and a number of high profile, sector-wide strategies driven from central government.

Aside from the fact that this is the first time the Treaty of Waitangi has been included in social policy legislation, this legislation is also significant for its explicit policies of minimum Māori representation on Health Boards, and the inclusion of Māori input into decision-making on health and disability services.

Three national level strategies now guide Māori health service funding, purchasing and provision: The New Zealand Health Strategy; The New Zealand Disability Strategy and The Māori Health Strategy—He Korowai Oranga. The central tenet of He Korowai Oranga is “whānau ora”, or “families supported to achieve their maximum health and Well-being”. The inclusion of whānau ora as the key principle in national Māori health policy represents a clear shift in the focus from an individualistic approach to health and Well-being to one which is more inclusive of a Māori worldview.



Contracting and mental health

A range of frameworks, regulations, guidelines and acts of Parliament control and prescribe how mental health services are to be delivered in New Zealand⁶. In community mental health, contracts for service between the funder (usually the DHB) establish the parameters of the funders' relationship with providers and are the main mechanism for ensuring the timely and appropriate delivery of high quality mental health services. Contracts or "Agreements" are generated and managed by the Agreement Administration Team of HealthPAC Dunedin, a national processing centre and information repository. Agreements are standard legal documents and include information on the term of the agreement, services purchased, price, volume, payment information (such as schedules and invoice amounts) and monitoring information. Agreements are prepared using generic or master agreements, which contain standard sections and clauses and tend to be volume based (payment based on a maximum number of interventions and funding capped at that level), or paid on a fee-for-service basis.


The research project: Investigating the experience of Māori mental health providers

Research methods

Research undertaken throughout 2001–2004 investigated the mental health contracting experience from the point of view of Māori engaged in, or knowledgeable about, this activity. This qualitative research project used two main methods of data collection. The first method comprised face-to-face, in-depth, semi-structured interviews with two sets of respondents: key informants and Māori mental health service providers. The second method was a detailed document analysis of providers' performance monitoring and contractual documentation.

The first set of interviews was undertaken with key informants from various backgrounds and disciplines. Key informants comprised Ministry of Health and other policy officials (n=4), District Health Board Managers responsible for Māori and/or Mental Health (n=5), Māori mental health provider managers (n=3), mental health workers (n=5), and academics (n=3). All the key informants were Māori. The second group of informants comprised community-based Māori mental health providers who held one or more mental health contracts with the Ministry of Health, DHB or other funder such as a Māori Development Organisation. In this second group of interviews a total of seven, self-identified Māori

6. These include the Mental Health Commission, the Commission's Blueprint for Mental Health Services in New Zealand, yearly progress reports on the Blueprint and the National Mental Health Sector Standard.



mental health providers, comprising a mix of some 15 staff and board members, were interviewed in three sites throughout New Zealand. The entire project elicited data from a total of 35 key informants and staff and management of Māori mental health providers.

Content analysis was the primary analytical process used to analyse interview transcripts. Initial analysis was accomplished by defining broad categories derived from the interview schedule, reflections on the literature and, in the case of provider interviews, the interviews with key informants. Interview notes were reviewed and coded according to these categories and new themes were sought. Previously coded interviews were re-coded as new themes emerged. Coding and analysis of data was done both manually and using NVivo, a specialist software package for qualitative data analysis.

Documentary material was accessed from six of the seven providers who participated in the research. Of the seven providers, one declined to release any documentary material, citing commercial sensitivity, while a further service provided performance monitoring material, but declined to release contractual material, again citing commercial sensitivity issues. Providers were asked to provide one example of a current mental health contract for the purpose of analysis. Thematic content analysis was used to analyse the contract and performance measurement documentation.

The coding frame for the documents was derived from interviews with providers as well as by a preliminary analysis of the contracts themselves. Contracts were analysed by type of contract, type of language used (including jargon), complexity and ease of use. Performance monitoring documentation was reviewed primarily for examples of monitoring information collected and the types of information reported in the narrative section. Finally, in a process of triangulation the data collected from the interviews was compared with the thematic analysis undertaken of the contract and performance monitoring documentation and with the journal and field notes.

Research findings

Introduction

The research sought to examine the experience of Māori mental health providers as they contract to deliver Māori mental health services in a health sector dominated by mainstream approaches to accountability. Key informants and providers were asked about their perceptions and experiences of a series of key mental health accountability instruments: performance measures, performance monitoring reports, and service contracts. The findings reported here relate specifically to the adequacy, appropriateness and usefulness to Māori mental health providers of the latter instrument, the service contracts.



Adequacy of contracts for service

There was a general consensus among key informants and providers alike that the contracts for service were not adequate nor sophisticated enough to capture the extent of the work done by Māori mental health providers. Contracts were regarded as inflexible, difficult to interpret and use, and unable to take account of the nature of the work required to treat tangata whaiora, as evidenced by the following comments:

... if a Māori goes out, from the community mental health team, out to a home to deal with a person has a mental illness, that person, clinician is dealing with a broken arm, a snotty nose, a cold, the whole... works. In other words the treatment of the whole family. And that is not allowed for in the contract, but they've got to do it... because it's part of being Māori.

(Key Informant 5)

I think many providers just do what they want to do irrespective of what the contract says and they've tried to mould their whānau ora development thing based on what they believe it should be and then... they try and satisfy the contracting requirements. (Key Informant 7)


For many providers, the regular and repeated provision of services that are outside the scope of the contract appears to be a normal part of contracting in Māori mental health. The types of “extra-contractual” work or services provided can be grouped into the following broad categories:

1. Work undertaken to deliver a culturally appropriate and tika (authentic or realistic) Māori mental health service (according to a provider's own understanding of what constitutes a culturally appropriate service);
2. Work done for the benefit of, or out of a sense of obligation to, tangata whaiora (Māori mental health consumers); and
3. Work done to improve the service, improve service resources or improve staff capabilities.

Categories of extra contractual work

Delivering a culturally appropriate service

Māori mental health providers noted that most of the additional work was associated with delivering a culturally appropriate service. All the providers who participated in the research described themselves as kaupapa Māori services. From their perspective, being a kaupapa



Māori service placed additional obligations, responsibilities and expectations upon them. Examples of additional work required of them as kaupapa Māori providers included taking tangata whaiora to whānau tangi (family funerals) or even attending the tangi (funeral) of tangata whaiora, helping to trace whakapapa (genealogy) links, arranging activities such as kina (sea-urchin) expeditions or fishing to encourage whanaungatanga (relationship, kinship), and “cultural learning” such as waiata (songs, chants), reo (language) and kapahaka (form of modern Māori cultural group performance):

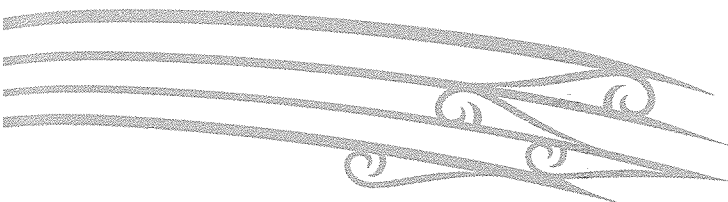
We go out and we pick them up. We have to, we actually went out and sought funding to buy us a van to go pick them up. And it's not about making them dependent on us, it's actually 1) a lot of them don't have transport; 2) give a break to whānau; 3) get the tangata whaiora out to actually socialise. Some are quite happy to stay home sometimes. So that's where transport comes in.... transport is actually the whole (point) of the thing... you're actually looking after their wairua (spirit, attitude). You're actually looking after their physical tinana (body), by physically going to get them. You're actually looking after their hinengaro (mind, heart) and you're actually looking after their whānau. And that's where tapa whā .
(Māori Provider 3A)

Delivering a culturally appropriate service often required a greater time commitment from the provider as a whole and individual staff.

I mean, we can spend two or three days on end with a client and we're talking just, the person's not here for an hour. We're talking they are here eight, ten, twelve, fourteen hours in this building.
(Māori Provider 4B)

I mean, you know one of the things that we have difficulty with is that mainstream and kaupapa Māori are very different. Now.... I asked one of the adolescent staff, Community Health Worker, I said 'how's your work going, how's your workload?' And she said to me 'at the moment I'm dealing with three intense', and I said '... what do you mean intense?' And she more or less explained that she's been referred person A, she goes out to see person A and the whole whānau is involved, then she spends quality time with them and... has to go back at night because the father is at work and, you know do it all again. Those sorts of things? It's never taken into account by the DHB or the Ministry you know?
(Māori Provider 7A)

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7. The Whare Tapa Wha model of health, first coined by Durie in 1984, compared health to the four walls of house, with all four being necessary to ensure strength and symmetry. The four walls or dimensions of health include taha wairua (spirituality), taha hinengaro (thoughts and feelings), taha tinana (the physical side and taha whānau (family).



In addition to requiring more time to deliver a culturally appropriate service, participants also noted that delivering a culturally appropriate service may require additional protocols to be observed or more people are involved in a therapy or intervention. For example, instead of one face-to-face meeting with one tangata whaiora that lasted for half an hour, delivering a culturally appropriate service might require an all day hui (meeting, gathering) at a marae (meeting area of a village or settlement or community) for that tangata whaiora and their whānau, an official pāwhiri (welcome, opening ceremony), hākari (feast) before the business at hand could be attended to, then poroporoakā (farewell, closing ceremony). This activity might include all the staff at the service as well as members of the marae committee, from ringawera (cook, kitchenhand) to kaumātua (elder, elderly men).


If you think of how Māori process... there's no time limit. I mean, try going to a pāwhiri, they can take anything from five minutes to twenty hours you know? I mean if you've been through that Māori process and what's happening within that process, you can't put a time limit on what should be happening.
(Key Informant 7)

Methods of service delivery or “therapy” may also be different in a kaupapa Māori service compared to a mainstream service, requiring greater planning, greater time commitment and a greater emphasis on volunteers and community support.

The thing is that we use our environment. We go up to the ngahere (forest, bush) which is just up the road and then we go to the beach you know?... We have people, other tangata whaiora coming out and teaching how to make taiahas (weapon, spear) and all of those types of things. I think what's additional too is that they don't ask where we hold these things. I always say marae based and they are held on the marae, so therefore the hapā (sub-tribe) is involved automatically. So that's additional to our service. Actually I see it all as bonuses and I don't think the Ministry of Health is really interested.
(Māori Provider 3A)

Additional services

Transporting tangata whaiora was the most commonly cited “additional” service that providers offered their clients but were not specifically contracted to do. Examples of transporting clients include taking them to the dentist, taking them to the food bank and getting them to and from the service itself.



And then you know we might have to run them in somewhere or, so, run them in to the hospital or whatever or different things like that. That sort of extra work you know? That sort of stuff.

(Māori Health Provider 6A)

However, another commonly cited example was where the provider acted as a “lead carer” and organised services to support a tangata whaiora, or worked directly with agencies in a brokerage capacity to access services.

We take part in the process of strengthening family, which we’re not contracted to do, but... for our tangata whaiora, take on the role of lead provider. So we coordinate their care for them and that might be working across a wide network of people, bringing them all together. And we’ve had some very successful outcomes from that.

(Māori Health Provider 2C)

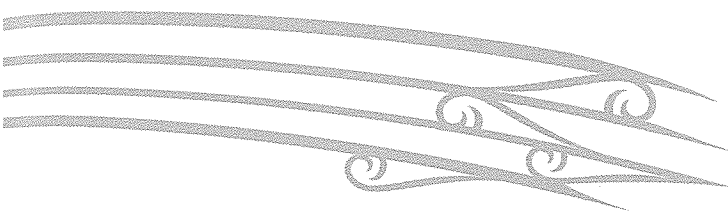
Housing is obviously a big issue... we had one tangata whaiora and for three days back to back we couldn’t find anywhere for him to live. He was going to get kicked out of [the] Mission... so there was three staff sort of tied up for three days... cos that’s what you try and do. You can’t have a guy living on the street. Well you can, but we chose not to.

(Māori Health Provider 4B)

Assisting tangata whaiora to trace their whakapapa, to gain access to Māori institutions such as marae and Rānanga (assembly) or to negotiate access to their hapā or iwi (tribe) were also considered additional to their contract. For many Māori mental health providers this sense of obligation is a key driver in compelling them to “go the extra mile”.

Additional responsibilities and tasks

The third type of additional work or activity that was identified in the research was related to improving the skills set of the organisation or of individual staff so that they could deal with tangata whaiora more appropriately. Often training or study in aspects of te ao Māori were cited as an example of the additional responsibilities or tasks staff engaged in. That staff were involved in te reo Māori (Māori language) courses or hapā-run hui on tikanga (protocols, practices, customs), kawa (protocol). Whakapapa and hapā history was not only important as a means of keeping in touch with the local community, it was also a means of maintaining the cultural integrity of services.



Examples of additional work done in order to improve the service, improve service resources or train staff included the development of Māori resources to use with tangata whaiora, taking te reo Māori classes outside work hours so that staff are able to kārero (speak) Māori during their work, and working outside one's job description to ensure a planned activity goes ahead. For example, one respondent noted that although her job description stated that she was employed to network and liaise with the DHB, if there was no one to run the afternoon's cooking class, she would do so rather than let tangata whaiora down (Māori Health Provider 1A).


Reasons for extra-contractual activity

When asked why Māori mental health providers would undertake work or activities outside the scope of the contract, by far the most common response given by participants appeared to be associated with the unique worldview or philosophy Māori mental health providers bring to service provision:

We just go that extra mile. It's the kaupapa that drives you, it's not actually the business. Certainly we have a business which is mental health, but the kaupapa is the thing that will drive you 'til you drop to your grave. And its about the kaumātua (elders), it's about the history that's attached to the Rānaka (an assembly or organisation representing tribes or sub-tribes), it's about the kaupapa (in this sense the job, duty or mission), it's about whakapapa, it's about who we are. It's that what makes us unique.

(Māori Health Provider 4B)

In the interviews the reason "it's because we're Māori" or "we do it because we are Māori" was queried further. It became apparent that the reason "its because we're Māori" disguises a range of cultural imperatives that compel the provider to deliver their service in a particular manner, summing up unique ways of practising for each provider. Each provider was attempting to deliver a contracted mental health service from within their own unique understanding of Māori health and Well-being and from a philosophical view grounded in Māori culture. It is the particular worldview of the Māori mental health provider that differentiates their service provision from that of any other provider of mental health services, both mainstream and Māori. While Māori providers may share a common worldview or a commonality of view at a philosophical level, it is unlikely that any two Māori mental health providers will have exactly the same set of core beliefs and guiding principles at a working level. These working beliefs may be referred to as the "kawa" of the organisation.



The research identified four specific characteristics of Māori mental health service delivery which occur as a direct result of practising from within a Māori worldview:

1. being governed by tikanga;
2. the use of hauora (health) practices;
3. the adoption of a holistic approach; and
4. a focus on whānau ora.

Being governed by tikanga

Iwi- and hapā-based Māori mental health providers are governed by the tikanga of the iwi or hapā which gives them the mandate to operate in a particular area. Tikanga determines the boundaries, obligations, rights, duties and responsibilities to which a Māori mental health provider must adhere.

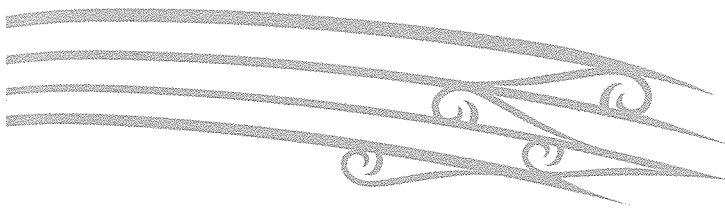
You know why do we do it?... let me answer it this way..., what is the tikanga of our service and our whānau here? That's how I answer it. What is the tikanga? Because tikanga is based on manaaki (care for, show respect), it's based on aroha (love), its based on wairuatanga (spirituality). Now I can't see any of that sort of terminology in DHB/Ministry documentation. And those other things that our tāpuna (ancestor[s]) got brought up on.

(Key Informant 8)

It's about... having a dual agenda really... one of them is to the Crown and to the contract and the other one is a completely 'nother set of objectives which is around whānau, hapā, iwi development if you like... or for some other people its around tikanga, you know around being responsive or responsible about your principles and around your tikanga.

(Key Informant 11)

Usually these obligations and responsibilities are endowed with an element of reciprocity: should the provider need the skills, expertise or support of the iwi or hapā, they will be there. Evidence of this reciprocity was provided by the examples given of kaumātua support for the providers in their work with tangata whaiora (for example, the men's fishing course [Māori Health Provider 2B]), and by broader hapā support (for example, the use of the marae and surrounds for running workshops with tangata whaiora [Māori Health Provider 3A]).



The use of hauora practices

For the purposes of this research, the term “hauora” is used to describe a range of practices and therapies that, in a Western sense, would not usually be associated with the care of mental health consumers, but in traditional Māori culture are entirely appropriate. Providers who took part in this research indicated that the therapies they used included mirimiri (massage), rongoā (traditional medicine) and karakia (prayer), as well as “group therapy” sessions which involved participating in a traditional art forms (taiaha or kapahaka) or in learning about the ngahere and wider environment.

The [name of intervention] was something I designed for tane (men) 'cos what I discovered was that a lot of our tangata whaiora, especially our tane, don't even go out fishing. So this way was about... bringing them back onto the marae, so it's a marae based programme and it's about getting them kind of feeling comfortable within the marae, learning about waiatas and karakias and also learning about how to make a hānaki (eel pot, eel traps), a traditional one, and also a contemporary one.

(Māori Provider 2B)

Delivering mental health services using hauora practices might also mean that more innovative and alternative methods of therapy are employed, such as the use of cooking and shared meals as a method of treatment.

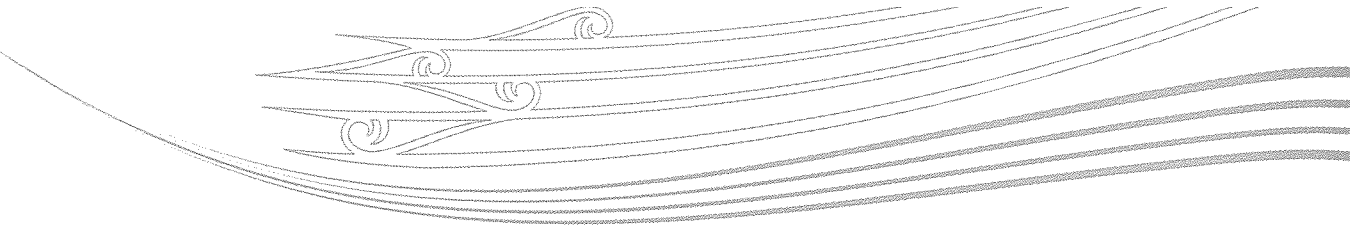
A holistic approach

A holistic approach in terms of this research meant that Māori mental health providers would deal not only with the mental health needs of tangata whaiora, but also with their other health needs if they had any, or with other aspects of their broader social Well-being.

We don't work like the segment of a pie... A psychiatrist will look at mental illness and a diagnosis. He will prescribe medication. We look at the whole person and... look at well, 'what's happening within your circle that's making you go like this', you know? So we... don't deal with just one. You can't, otherwise you're missing a link, you know?

(Key Informant 1)

If you say that Māori providers do more than is expected of them then you're absolutely right... because Māori working in that field work in the whole person. The non-Māori view of mental health is some block in the brain and they don't



take into account in terms of that brain not functioning properly being associated with any other part of the body... Māori cannot isolate the biological body from its spiritual dimensions.

(Key Informant 12)

In a holistic approach, mental health is not viewed in isolation from other areas of health, nor in isolation from broader socio-economic determinants of health. Dealing with these other wider determinants (e.g. other health needs, housing needs, education and employment concerns) will naturally incur an investment of time that other, mainstream mental health providers are neither expected to nor asked to make.

A whānau ora focus

The Māori mental health providers who participated in this research indicated that caring for the tangata whaiora naturally meant caring for the whānau. While it might be an individual who initially presents to a service, these providers noted that to deal effectively with the tangata whaiora, the whānau of that tangata whaiora had to be involved in any therapy or intervention.

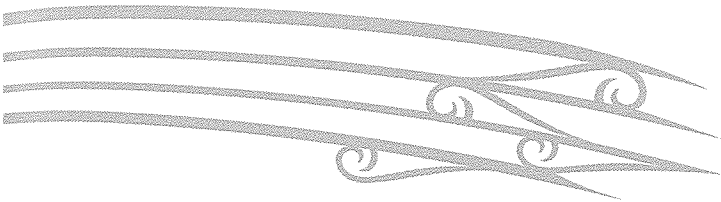
We don't just deal with the individual, we deal with their whānaus [sic] which is quite different. For example, with mental health quite often they're affected, the whole family and I've gone in and talked to the whole family. So... the rest of the family become very important, if not more important, because they are the ones that are carrying that member throughout the whole family. And that's the difference. We work with the rest of the family as well... and that's not added in the contracts.

(Key Informant 4)

Several Māori mental health providers noted that dealing with the whānau as well as with the tangata whaiora required them to step outside the scope of their contract to deliver a service to an entire family or arrange their contracts in such a way as to give themselves the freedom to work across age groups and family members.

Discussion


There are a number of implications for the health sector arising from this research. Contracting represents one component of an overall performance measurement framework which the Crown employs to ensure that any funds it makes available for service provision are spent wisely and appropriately. Almost without exception, the respondents who participated in this research reported that the current contracting system does not inadequately capture the extent of work done by Māori mental health providers, nor does



it adequately acknowledge or validate that work. The research shows that Māori mental health providers working from within a Māori worldview will often feel compelled to operate outside the scope of their narrowly defined contracts in order to deliver a service in a way more in keeping with the ideal of “whānau ora”; in other words, to work not just with the individuals that present to a service, but with their wider family and personal networks. The research indicates that contracts may actually be constricting providers’ ability to deliver “whānau ora” or to deliver mental health services in a culturally appropriate way to a distinct population group within the community. It may also indicate that the contracts themselves are not keeping up with innovations occurring at the community level.

At a local level, however, much can be done to improve the contracts, to incorporate local or regional differences or even cultural differences. Understanding the local context in which a provider works is the responsibility of the Funding and Planning Unit of the DHB. The NZPHDA outlines the relationship DHBs are to have with central government and with the community and places a large emphasis on local input into decisions about health care, health needs and health services. The Act clearly states that DHBs have obligations to improve the health of people and communities, particularly Māori, while having regard to, and by taking cognisance of, the interests of the local people. It is well within the spirit of the Act for DHBs to use contracts with providers to pick up on local variation, to include more meaningful measures and to reflect back to Māori an understanding of the context in which they work. To do so in a formal document would acknowledge the unique aspects of Māori service delivery that differentiates it from mainstream services, as well as the unique aspects of service delivery particular to that service, which differentiate it from other Māori mental health providers in the community.

Māori health and social service providers often play an intermediary role between the government and their communities, being very aware of the particular needs of the community in which they work. This research shows that Māori mental health providers similarly enjoy a very close link with their communities. Often this link is one of whakapapa, particularly with iwi- and hapā-based providers. In such cases, neither Māori mental health providers, nor the workers that are employed by them, are distinct from their communities. As a result providers find it difficult to distance themselves from requests for assistance, or to turn away those who present with real needs, despite the fact that these needs might not necessarily fall within the scope of their mental health contracts. The obligations towards, and responsibility to, the wider community that Māori mental health providers feel is not necessarily an obligation or responsibility shared by other health providers. Failure to manage these obligations can pose a number of risks to the provider and to their staff in terms of staff burnout, failure to perform and loss of the service contract, as well as failure to deliver to an expected level by the community. Māori mental health providers may need to consider “managing down” the expectations placed upon them by, in many cases, their own people.



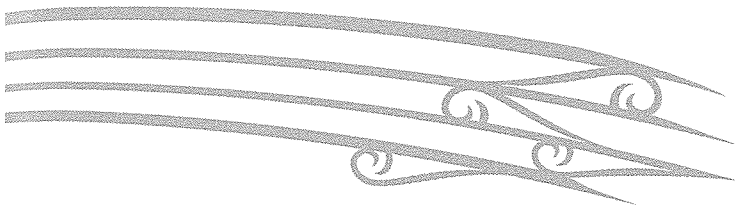
At the same time however, contracts for service must be flexible enough to recognise that Māori mental health providers are bound by another set of “rules” beyond those which apply universally to all health services. DHBs will need to be mindful and respectful of local kawa and tikanga if they are to understand aspects of Māori service delivery. The “rules” of tikanga may compel Māori mental health providers to take extra time when dealing with a client, to observe specific protocols or to involve other people expert in things Māori in particular therapy or intervention. Contracts and the contracting process as a whole needs to be flexible enough to support practices based on tikanga Māori.

This research indicates that many of the extra-contractual activities undertaken by Māori mental health service providers are in fact desirable and beneficial to the community as a whole. While the extra-contractual activities may not fall under the rubric of mental health in a strict sense, this is not to say that the wider community does not benefit from this work being undertaken. Much of this activity contributes to Māori development goals and objectives such as building capacity and capability in the community or strengthening whānau and hapā. Halting such activity would be injurious to greater Māori development. The question then remains of how best to fund activity which contributes to health in its broadest sense, to Māori development, and to the public good.

Conclusion

New Zealand’s mental health performance measurement and contracting framework is a complex and evolving one. Its initial development occurred at a time when it was taken for granted that mainstream understandings of health and mainstream systems of service delivery would not only be appropriate for all New Zealanders, but would also service the needs of all New Zealanders. Latterly, however, there has been an acknowledgement that a wholly different understanding of health and health care has existed in this country, namely the worldview understood and shared by tāngata whenua (indigenous people, ie: Māori).

The New Zealand Government has recognised and reaffirmed in its Māori health policy document, He Korowai Oranga, that health services which practise Māori views of health are not only desirable but should be actively encouraged. However, it is not enough to simply develop and promulgate a policy of service provision “by Māori for Māori”. Nor is it enough to expect Māori providers to achieve the goal of “whānau ora” without supporting these policies with appropriate funding, purchasing, contracting and performance measurement systems. The achievement of policy goals will not occur if isolated from the wider structural frameworks that support health service delivery.



This research indicates that the time is ripe for consideration to be given as to how funding might be better realigned to take advantage of the work of Māori mental health providers and how contracts for service might be improved to allow for greater flexibility of delivery. At the very least, and as a starting point, a performance measurement and contracting framework, which integrates both worldviews and which takes account of the unique role tikanga and kawa play in Māori mental health service delivery, is required. Only then will the extra-contractual provision, which regularly and routinely occurs in Māori mental health service provision, be adequately acknowledged and validated.