WHANAUNGATANGA EMBODIED IN MENTAL HEALTH PRACTICE

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Heta Hakaraia was born in Warkworth of Ngāti Kuri, Te Aupouri and Ngā Puhi iwi.

He was raised and schooled in Te Atatū South and received a scholarship to attend St Stephen's College. He married Anita Lord at Hoani Waititi Marae in 1985 and has five sons and a daughter with three mokopuna and two more on the way. He started working at Te Whānau o Waipareira Trust in December 2013.

Abstract

This article considers the scope of *whanaungatanga* within the mental health practice of a Community Support Worker (CSW) working to further a *Te Ao Māori* framework in social and health services. The article examines how whanaungatanga works in practice and how can it be described to validate the approach to clients and their *whānau*. A case study of a 30-year-old Māori male diagnosed with Post Traumatic Stress Disorder (PTSD) and Schizophrenia is outlined. The history, services, problems and the changes introduced for the client are reviewed according to the degree of whanaungatanga and how this approach has potentially benefitted outcomes for the whānau member. The changes observed through the documenting of this process substantiate whanaungatanga as a quantifiable outcome. It is concluded that the implementation of whanaungatanga and gathering of evidence is only limited by time, but as the author concludes "is a beginning to an end unseen."

Key words: mental health, whānau, whanaungatanga

Introduction

Whanaungatanga is an appropriate subject to comment on being a foundation principle upon which the vision of Te Whānau o Waipareira Trust is realised. The extent of the role of whanaungatanga in the formation of the Trust by those who pioneered its establishment was depicted in every theatre of discussion from homes, *marae*, public forums, courts and to the seat of Government.

Whanaungatanga reinforces the guiding values of *Te Kauhau Ora* o Te Whānau o Waipareira Trust, along with *wairuatanga, te reo Māori, pōhiri, aroha, tiakitanga, manaakitanga* it serves to acknowledge and extend the philosophies of *Te Ao Māori* within a framework of social and health services that are available to the community. To this end I will endeavour to identify and explain the scope of whanaungatanga within my practice.

I am presently employed as a mental health support worker within the service. I have four years' experience in this role after 30 years in industrial engineering as a boilermaker/welder. I have gained a Level 4 certificate in mental health and addictions, the Whānau Ora Diploma and the Applied Suicide Intervention Skills Training (ASIST) certificate in suicide intervention. I also undertake *kaumātua* duties when required.

I must admit that at the beginning of my role as a Community Support Worker (CSW) in mental health, I had a resolute opinion of whanaungatanga as a kinship-based entity connected by blood ties to eponymous ancestors with the aim of strengthening familial ties and facilitating the perpetuity of *papa whenua.* These views still remain valid for the context to which they belong, however, the role of whanaungatanga has evolved to suit the purpose of strengthening a wider population base. Urban Māori have attained iwi authority, spreading kinship ties. The hope is to confirm the edicts of *Te Kauhou Ora* as a sustainable vehicle to promote the Māori wellness model to the wider community.

Whanaungatanga, at its core, is *whānau* connection. In my experience of working with whānau impacted by mental health I have found that the acknowledgment, retention and reinforcement of whanaungatanga within the whānau is one of the greatest non-clinical interventions available to whānau. This is a way of attaining and cementing a strategy toward a pathway of personal and social wellness for the client. So, what does this look like in practice? How is the need to strengthen whanaungatanga recognised? How do I describe the implementation of whanaungatanga in my work to validate its worth to the client and their whānau?

Case Study

Ake is Māori in his early 30's, he lives with his older brother who along with his partner and five children all share the same Housing New Zealand home. The two brothers are the only living relatives from their immediate whānau of

seven. Ake has suffered from epilepsy since early childhood and was diagnosed with co-existing mental health conditions of Post Traumatic Stress Disorder (PTSD) and Schizophrenia as an adult. The clinical notes give a brief but stark description of Ake's psychological condition at the time of his assessment: "subject is illiterate and socially challenged, has suicidal tendencies".

I met Ake two plus years ago in a *Kaupapa Māori* programme that I was assisting with. I would meet his whānau later when my role as a CSW was introduced. Meeting Ake for the first time was part of my own introduction to the clinical treatment administered to mental health clients. Ake initially presented himself in a way that was not too different from his clinical brief, at times appearing lethargic and displaying signs similar to an intoxicated or substance induced state. Conversations with Ake were a struggle as it appeared that his thought processing was a painful affair for him and his verbal responses took minutes to take shape.

Medication is the pre-eminent approach to the treatment of a mental health diagnosis—this is statutory law, there is little or no consultation with clients or their whānau regarding this process and the range of drugs available to treat Ake's conditions are many. So, too, are the side-effects. From the description of the medication approach it is fair to assume that the auspices of whanaungatanga are but a frayed tether. Most of my clients, including Ake, agree that treatment is necessary. Very often though, the procedure of finding just the right dose of a particular medication suitable to a particular person can take many years.

Whanaungatanga between us began with the most fundamental method of meeting and greeting in the Māori way. Ake was welcomed to the programme with a *mihi whakatau* preceded by *karakia* and supported by *waiata.* He struggled to find words in his reply yet he evoked a cheekiness that was genuinely Māori and the few words he uttered would confirm his deep desire to attend the programme regularly. Indeed, there were moments during Ake's induction period when a more coherent and insightful persona would be presented—relapse, however, was persistent.

When I first met Ake's whānau at home, as with many Māori, we found that we shared *tūpuna* connections. This was important as Ake and his brother had sought information on their ancestral roots as a physical and spiritual point of origin. This subject would endorse the concept of whanaungatanga between service user and service provider in that I was already in a position to assist in strengthening whānau connections.

More importantly, however, the information that Ake's whānau shared about his history would lead me to think far more objectively about his clinical brief and to the effectiveness of the overall care he had received. Whanaungatanga on a wider scale would be attempted to effect a better outcome.

Whanaungatanga intends to bind the relationships between whānau and community services to deliver appropriate care. A bullet point overview of Ake's wider whanaungatanga is as follows:

Service providers:

- DHBs mental health (MH) services, Acute MH units, Māori MH services
- Te Whānau o Waipareira Trust MH services
- Housing New Zealand (HNZ)
- Work and Income New Zealand (WINZ)
- Greenwood Park care co-ordinators

Others:

- Police and Corrections

Ake's history:

- despite seizures enjoyed a happy childhood
- pre-onset was living independently, working, driving cars since age 11
- onset of PTSD from severe trauma events in late teens, placed under the Mental Health Act
- co-existing schizophrenia
- exhibits violent episodes, referred to secure MH facility for extended period
- moves with whānau to Waitakere city

The problems:

- Ake is self-medicating but inconsistent, whānau tries to help but Ake hides some meds, seizures and relapses are regular
- whānau want to voice concerns about Ake's medication as he is often too doped out to get out of bed
- medication is delivered to the home but gets left lying around
- high alcohol consumption and some synthetic drug use impact on medication
- the actions of service providers are of a more internalised nature

Positives:

- an authentic *aroha* is shared between the siblings and extends to all the whānau in the modest home, they also enjoy close ties to the partner's whānau
- Ake encouraged and supported to attend Māori mental health whanaungatanga activities and programmes
- Ake's care plan is elevated to risk level management across the services

Change:

More often occurring in mental health treatment through a progressive analysis of evidence-based outcomes. Sometimes prompted by a need to address a pressing issue at hand. Both reasons apply here:

- Two severe seizure events occur within months of each other, both of which highlight some concerns regarding medication. Meetings with whānau and especially service providers concentrate more on working in unison to address the immediate needs of the whānau.
- The second incident puts Ake into a coma and a dire prognosis was relayed to the whānau. Spiritual assistance was sourced by Ake's brother and a healer, an aunty, visited them.
- Ake regains consciousness the next day and claims he felt his aunty near him.
- Revised medication including an ongoing care plan is constructed and implemented. Improvements in Ake's physical and mental health accelerate. Buoyed by Ake's recovery his whānau put in place clear boundaries on alcohol use.
- The whānau are resurgent in their desire to explore *taha Māori* (Māori identity), *te reo me ona tikanga, ngā taonga tuku iho* (the Māori language and customs, the treasures handed down to us).

Evidence:

- Notes entered into the Whānau Tahi database documents all health target plans and engagements between service user (SU) and service provider (SP). Included are all records of contact and correspondence with other SP's and professionals connected to the SU. The process substantiates the efforts of my own work as a quantifiable outcome.
- Above all else the evidence stands with Ake, regular monthly seizures have not occurred for over four months now. The hint of cheekiness replaced by humorous wit. Sluggish responses make way for articulate banter with an added desire on his part to do more for those less fortunate. All details noted in WTN.

Conclusion

Each and every level of involvement concerning this case was an exercise in correlating the degree of whanaungatanga, i.e. in service to the benefit of whānau, inviting strength and vibrancy through connections.

I had intended to provide another view of whanaungatanga within my role as a CSW, but I must admit that explaining the way I implement whanaungatanga in my work is limited only by the time I make available to the task. The groundwork involved in providing the evidence of whanaungatanga eats away at time so I constantly bemoan the lack of it. If I may describe my opinion of whanaungatanga in its briefest format, it is a beginning to an end unseen.