Māori experiences of bipolar disorder: pathways to recovery. A summary document
This document summarises the key findings presented in the report, *Māori experiences of bipolar disorder: pathways to recovery* (Waitoki, Nikora, Harris, & Levy, 2014). The research drew together information about the experiences of Māori who were diagnosed with bipolar affective disorder and considered the systemic factors that influenced Māori wellbeing.

Bipolar disorder is a mood-related disorder that produces extreme contrasts in mood and functioning (Urosevic, Abramson, Harmon-Jones, & Alloy, 2008). People with bipolar disorder often experience high levels of stress even when they are not having symptoms. Additionally, people who live with significant negative life events relapse faster and take longer to recover from bipolar episodes than those without such events (Jones & Tarrier, 2005). While Māori are known to experience a higher incidence of mental health and addiction problems compared to non-Māori (Baxter, 2008), little exploratory research has been conducted into Māori experiences of bipolar affective disorder.

The aims of this research are:

1. To explore trends in the rates of Māori with bipolar affective disorder accessing primary and secondary mental health services.
2. To explore and gain a better understanding of the experiences of Māori living with bipolar affective disorder.
3. To identify the priorities, issues and information gaps in Māori experiences.
4. To make recommendations to improve support and service delivery for Māori with bipolar disorder.

### Findings from whānau stories

Twenty-two whānau1 diagnosed with bipolar affective disorder, 15 wāhine/women and seven tāne/men aged from early 20s to late 70s were interviewed and shared their stories with the researcher. The common themes from their collective experiences include:

- Whānau had multiple unmet needs early in life. Systemic failure to address these contributed to mental illness.
  - When some whānau engaged with the health sector after a suicide attempt, their immediate health issue was treated, but they were not referred to mental health services.
  - Whānau reported that despite frequent involvement of social and justice sectors, childhood or relationship abuse and other traumas were often not addressed.

- Family was often a protective factor, but children were at risk of being removed from their families due to inadequate support systems for parents.

- Culturally appropriate and trauma-informed approaches to service provision led to the best outcomes for whānau.

All whānau experienced multiple unmet need, including unresolved mental health issues, at some point in their lives—childhood, adolescence or early adulthood. Exposure to childhood adversity such as sexual and physical violence, parental mental illness and abandonment issues, led to acute and post-traumatic stress, substance abuse, poor relationship choices, depression, anxiety and safety issues for some whānau. These unmet needs and significant negative life events further led to cycles of health disparity, placing whānau at a significant disadvantage due to a loss of productivity and lost potential. Many whānau also reported they experienced unstable and inadequate living conditions, poverty, low education and difficulties in attaining and maintaining employment. Evidence from whānau’s stories indicated that if

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1 - The term whānau rather than participant has been used throughout the report and in this summary. Family is used to refer to their relatives.
these unmet needs had been addressed earlier in their lives, many pathways into mental unwellness may have been avoided.

Many whānau became unwell when their right to self-determination was compromised or when their support systems were fragmented. At times, due to the repeated and severe nature of multiple stressors, whānau reached breaking point, causing them to react. In many cases those reactions were used to confirm the presence of bipolar disorder, shifting the focus from external factors to biological causes.

Whānau’s stories highlighted serious gender issues: the women were often powerless in their intimate relationships, during pregnancy and childbirth. They lived in fear of losing their children, had their children taken from them, or were told not to have children. Each woman whose children were taken away described a deep sense of loss or trauma about not being able to raise them. Several of the men who were also fathers were equally concerned about losing their children or not being able to provide for their families. The consequences of losing a child or being the child who was removed were profound.

Whānau’s pathways to recovery showed the critical importance of maintaining connections with significant family members over their lifespan. Serious gaps in support systems for parents with mental health problems were identified. These support systems are critical, because as whānau aged, they often became primary caregivers to their grandchildren or disconnected from their children and grandchildren.

“When I had lost a limb I would have got more support. Would they have taken my babies if I couldn’t catch up with them when they crossed the road?”

When external and internal factors to achieving wellness were optimal, whānau were productive, connected, and enjoyed their family and personal relationships. They had opportunities to live balanced lives, engage in leisurely pursuits and enjoy social connections. Whānau emphasised the protective nature of these factors, noting how family and social supports played a pivotal role in their journey towards recovery. When they were in healthy relationships and connected to significant family members, whānau were better equipped to incorporate wellness strategies into their lives. Conversely, unhealthy relationships and/or being disconnected from family contributed to becoming unwell, exacerbated stress levels and prevented whānau from seeking wellness. While there were times when children and family were seen as stressors, they were also seen as protective factors as whānau tried to improve their personal wellbeing to benefit their family.

Treatment of co-existing mental illness and addiction problems, correct diagnoses, access to stable and appropriate medication, prevention and early intervention, and timely and detailed mental health information contributed to and helped whānau maintain their wellness. It was suggested that a trauma-focused approach to assessment and treatment could have made a positive difference for whānau and their families. Whānau achieved their best outcomes when they had access to Māori-led and culturally appropriate services and supports. This reinforces the need for recovery strategies to include access to talking therapies and kaupapa Māori services.

Conclusions

Supporting whānau to reconnect and stay connected to their family and friends was central to their recovery. Strong family connections provided stability, conveyed to whānau that they were valued and loved family members, facilitated faster recovery and extended the periods between relapses. This research supports the need for urgent development of cultural-specific supports to strengthen families,
in their various configurations and dynamics, throughout their developmental lifespan. In order to provide an environment where security, connection, support, belonging and identity can be nurtured, whānau’s collective wellbeing, a fundamental construct in Māori society, must be prioritised (Irwin et al., 2011).

The stories whānau shared highlight the need to coordinate primary and secondary health services for Māori across the lifespan. The fragmented approach to service provision seen throughout this study appeared to result in a shift away from broader issues such as family violence, childhood adversity, sexual abuse, drug and alcohol abuse and disconnected families. Across all whānau it was apparent they needed help earlier, some as young as three years old, if they were to live to their full potential.

These findings support Baxter’s (2008) argument that significant unmet mental health needs among Māori reflect differences in patterns of access to services at a primary care level, diagnostic practices, and/or referral practices to secondary care. Some whānau did not seek help until they were in serious need, or some sought help early and were treated for other conditions. This study also found that a range of government, social and education systems missed multiple early opportunities to help whānau identify and remedy their mental health issues. As a result many whānau’s situations escalated to acute levels before they received support. Improved early intervention in both primary and secondary care should be used as a mechanism to reduce the impact of mental health problems on the person and their family (Gluckman, Low & Franco, 2011; Ministry of Health, 2012).

The evidence reinforces the need for a systems approach to understand Māori mental health needs, comprehensively identifying and addressing barriers to timely and appropriate access to services that provide good outcomes for Māori (Baxter, 2008). A competent mental health and addiction workforce, that can identify and treat depression due to unresolved trauma separately from bipolar disorder, is critical to improving service access and effectiveness for Māori. The whole health sector, the broader social, education and justice sectors, and the mental health and addiction sector need to draw on the approach outlined in Whānau Ora and work in partnership with whānau and each other to develop recovery strategies (Taskforce on whānau-centred initiatives, 2010). Policy directives need to emphasise cross-sector responsibility and the importance of helping whānau receive timely, high quality, effective and culturally appropriate services.

References


