Māori Mental Health: Past Trends, Current Issues, and Māori Responsiveness

Te Kani Kingi

Te Pūmanawa Hauora/Te Mata o te Tau

Research School of Public Health

Massey University

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Introduction

The currents problems in Māori mental health are well documented. Māori rates of admissions continue to exceed non-Māori and are similarly matched by concerns over service utilisation, how they are accessed and the patterns of Māori admissions. For many Māori, initial contact with a mental health service is through the justice system, via the police or welfare services, and under compulsion. Due in part to this, the problems tend to be more acute, often more difficult to treat, and accordingly result in outcomes that less positive and more difficult to manage.[1] Studies reveal that Māori are over-represented in acute disorders, and are almost twice as likely to be readmitted when compared to non-Māori.[2]

Heavy drug use amongst young Māori, particularly cannabis, has also led to a dramatic increase in drug-related disorders.[3] Psychosis and alcohol and drug abuse account for almost a third of first admission. Māori readmission rates for affective disorders and psychotic illness are 36 percent for women and 75 percent for men higher than corresponding non-Māori rates.[4] Schizophrenic psychosis is currently the second most common cause of admission for Māori males and are almost twice the rate of non-Māori.

Suicide, a problem that was almost unheard of in traditional times, increased by an alarming 162% during the 1980s and continues to have a dramatic effect on Māori communities.[5] More recently, problems associated with the use of meta-amphetamine have received considerable media attention, and, while information on its use is not

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1 Durie, M. H., (1998), 'Puahou: A Five Part Plan for Māori Mental Health', in *He Pūkenga Kōrero,* vol. 3, no. 2, Department of Māori Studies*, Massey University, Palmerston North.*

2 Deloitte and Touche Consulting Group, (1997), *National Acuity Review: Final Report on New Zealand's Mental Health Acute Inpatient Services,* Ministry of Health, Wellington.

3 Te Roopu Rangahau Hauora a Eru Pomare**,** (1995), *Hauora, Māori Standards of Health,* GP Print Ltd, Wellington .p. 156.

4 Other than schizophrenia or drug or alcohol psychosis.

5 Te Puni Kōkiri, (1996), *Ngä Ia o te Oranga Hinengaro Māori – Trends in Māori Mental Health*, 1984-1993, Ministry of Māori Development, Wellington.

extensive there is evidence to suggest it is becoming increasingly problematic for Māori in particular.[6]

Due to the extent of these problems and the publicity that often surrounds mental illness one could reasonably assume that these issues have always been a feature of Māori society, that in fact Māori are somehow genetically pre-disposed to mental illness, or that perhaps cultural factors are to blame. The mere fact that mental health problems disproportionately affect Māori provides a reasonable basis for this assumption and that perhaps solutions should focus on correcting genetic flaws or negative cultural behaviours.

However, there is little evidence to support either of these hypothesise, and in fact there is a considerable pool of research linking Māori culture (a secure identity) to positive mental health. Moreover, that mental health (or mental ill-ness) is a relatively recent phenomena and that historically Māori were viewed as a people of some considerable mental stability. Further, and while familial factors are sometimes used to explain the development of mental health problems (at an individual level) there is little to support an ethnic or racial bias.

When considering the structure and content of the presentation, I was very much tempted by the need to describe how bad things are, what problems exist, and what future concerns could be anticipated. Certainly, there is considerable evidence to assist with this and to shows the extent to which mental health problems now affect Māori. In this regard, there is little doubt that mental health remains the single most significant threat to contemporary Māori health development.[7]

However, and while appreciating the fact that major problems remain, I've decided to focus on Māori mental health (as opposed to illness), Māori development, and what achievements have occurred. While this is perhaps a more difficult path to follow it is

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6   Massey University, (2005), *Massey University: The Magazine for Alumni and Friends: Issues 18,* Massey University, Palmerston North.p11.

7 Durie, M. H., (1998), 'Puahou: A Five Part Plan for Māori Mental Health', in *He Pukenga Kōrero,* vol. 3, no. 2, Department of Māori Studies*,* Massey University, Palmerston North.

nevertheless important that we reflect on our achievements, what gains have been made, and how Māori have responded to these problems. In this way it becomes possible to reveal the extent to which developments have occurred, to likewise recognise the achievements of those in the past, and why it is important that we continue to develop innovative approaches to mental health promotion, treatment and care.

An Historical Overview

To begin with, and in order to provide an appropriate foundation for this presentation, I've decided to look into the past, and to describe historical patterns of Māori mental health. The available information is not great; however, there is sufficient data through which a broad appreciation of major trends and issues can be established.

As already noted, the issue of Māori mental illness is somewhat of a contemporary phenomena. Historical accounts of Māori health were typically focused on physical health problems. Indeed, and toward the end of the 19th Century, Māori health was an issue of Māori survival and there were real concerns that perhaps the race would become extinct, and within a generation or two. These ideas were based on sound advice and in particular statistics which showed that the population had decreased by more than two thirds – from an estimated 150,000 in 1800 to a mere 42,000 in 1896.[8]

Introduced diseases, warfare, land loss, and social change were largely responsible for this decline. Goitre, malnutrition, diphtheria, tebuculosis, and measles, were the main threats to Māori health and often had fatal consequences.[9] By 1900, and if mental health problems were evident, certainly they were not the focus official reports, research, or documentation. This is not to say that mental health problems did not exists, though is perhaps a reflection of the fact that other concerns, more lethal and life-threatening, were afforded greater attention and were thus of more associated interest. In any event, and while Māori health problems were significant, it appears that mental health issues were not.

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8 Durie, M. H., (1994), *Whaiora: Māori Health Development,* Oxford University Press, Auckland.
9 Ibid.

We can only speculate as to why mental health problems were less visible. As already noted, it may have simply been a lack interest or a focus elsewhere. Similarly, problems may have gone undetected and due to the fact that Māori were less likely to access health facilities, were typically cared for within the whānau, and therefore not counted within official statistics. Another, and perhaps more likely explanation, is the idea that the prevalence of mental disorder within Māori communities, and around the turn of last century, was extremely low.

Again, there is insufficient data to say with any certainly what the actual prevalence of disorder was – though I should also point out here that while a major prevalence study is currently underway, we still do not have accurate information on the actual numbers of people with mental health problems. In any regard, and based on official reports, admissions data, anecdotal accounts, and independent research reports, it would appear that mental illness was not of any great concern to Māori.

In further support of this it is worth noting that one of the first investigations into Māori mental health only took place in the early 1940s and was largely concerned with understanding the apparent lack of mental ill-ness within Māori communities.[10] That is, why Māori seemed less susceptible to mental disorder. Putting aside the obvious difficulties of assigning diagnosis, and the ability of non-Māori researchers to interpret cultural norms, the results of this study reveal a number of interesting findings. The first is based on observations of Māori communities and an analysis of admissions data. In this regard the study showed that the overall incidence of mental disorder, amongst Māori, was about a third that of Pākehā. In terms of major functional psychotic disorders the study also showed that the Māori incidence was about half that of Pākehā. Problems connected to war neurosis showed similar patterns.

When attempting to interpret this information, its significance and implications, a number of theories were put forward by the authors. Of interest was the idea that mental health problems were somehow impeded by cultural structures, particularly the whānau, and that somehow Māori culture offered a protective mechanism, a basic structure

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10 Beaglehole, E., Beaglehole, P., (1947), *Some Modern Māori ,* New Zealand Council for Educational Research, Whitcombe and Tombs Ltd, Auckland.

through which mental health problems were unable to develop or at the very least unable to take hold.[11]

In addition, and of associated interest, was the inclusion of a rather prophetic quote, a warning of future possible trends that was unfortunately to ring true in the coming years. The authors note:

> Judging from experience in other parts of the world, we may hazard a guess that the increasing adjustment of the Māori to the Pākehā way of life with its standards and values, morality and behaviour, will bring a tendency for the Māori mental disease figures to approximate more and more to those of the Pākehā population.[12]

This quote is of interest not only due to the fact that it was made by a non-Māori psychologist, or that it was based on research conducted during the 1940s. But, that it illustrates a clear relationship between culture and positive mental health. Moreover, that cultural decay would have a predictable and negative impact on Māori mental health. Remember, this was at time when Māori mental health problems were almost unknown and decades before terms like colonisation were used to explain contemporary patterns of illness and disease. In 2000 Tariana Turia was widely criticised for a speech which linked Māori mental illness to 'post-colonial stress disorders'. The mainstream media were quick to act, describing it as racist and ill-informed. Yet it appears that such notions were not based on the ideas of Māori radicals, but could just as likely be traced to the views of non-Māori some 60 years before. [13]

Moving into the 1950s and beyond more reliable and routine information on Māori mental health was being collected. And while this was again based on admissions data it revealed a similar pattern of relatively low incidence.

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11 Ibid p. 243.

12 Ibid p. 243.

13 http://pl.net/~keithr/thursday2000.html (21 January 2002).

In 1951 for example, Blake-Palmer reported that the incidence of Māori admissions to psychiatric hospitals was less than half that of the non-Māori population.[14] In 1960, 60 in every 100,000 Māori were admitted for the first time to a psychiatric hospital compared with a non-Māori rate of 119 per 100,000.[15] In 1962, Foster[16] further noted that for both males and females' lower admission rates for Māori (in all age groups and for most disease categories) could be expected. Psychoneurosis, for example, accounted for only 7 percent of all Māori first admissions compared with the corresponding non-Māori rate of 21 percent. In addition, the rate of psychosis related to old age was much higher for non-Māori. Alcoholism and manic-depression were also lower. Durie states:

> ...during the nineteen fifties, non-Māori admission rates to psychiatric hospitals were relatively high, mental hospitals were comparatively large and general hospital psychiatric units were few and small. It was the era of institutional care; interestingly, Māori did not feature as significant consumers.[17]

Other anecdotal accounts were also gathered and as part of the 1996 Mason inquiry into mental health services and likewise revealed similar trends.

> I worked at Oakley Hospital in the years shortly after the Second World War…There were more than one thousand patients in the hospital…of whom six were Māori.[18]

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14 That is, 20.61 per 10,000, compared to 47.73 per 10,000 for the non-Māori population.

15 Cited in M. H. Durie, (1994), 'Māori Psychiatric Admissions Patterns and Policies', in J. Spicer, A. Trlin, and J. A. Walton (eds.), (1994), *Social Dimensions of Health and Disease New Zealand Perspectives,* Dunmore Press, Palmerston North.

16 Ibid.

17 Ibid.

18 K. Mason, J. Johnston, and J. Crowe, (1996), *Inquiry Under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services,* Ministry of Health, Wellington, p. 137.

The Changing Pattern of Disease

It is difficult to say with any precision when the current problems in Māori mental health first began. The contrast between what was reported in the 1960s (and before) compared to the 1980s is rather stark and leaves one wondering what must have occurred during this brief period and in order to bring about such a dramatic change in Māori admission patterns. In short, we simply do not know – although there are a number of possible though likely explanations.

The first has already been touched on and concerns the issue of cultural decay or alienation. During the 1950s the second great Māori migration occurred, though this time was not from Hawaiki to Aotearoa, but from small rural communities to major urban centres. In search of employment, excitement, and opportunities, many Māori were enticed into the cities and quite often did fairly well as jobs were plentiful and excitement abundant. However, and as first noted in 1940s, this urban shift and social integration, also lead to cultural isolation and alienation from many of the traditional structures that in past had protected Māori. While many would have maintained cultural ties, networks, practices, and language, distance from traditional lands, marae, cultural institutions, whānau and hapū, would have made things difficult. For many cultural decay was inevitable as was an increased susceptibility to mental health problems.

A second potential explanation is linked to the first and the search for employment during the 1950s. In times of economic growth and prosperity jobs are relatively easy to come by, reasonably well-paying, and fairly secure. However, and during the 1970s, New Zealand experienced a significant economic decline. Two major issues were largely to blame. The first was the duel oil crises during the 1970s and their contribution to a long and sustained period of declining trade. The second occurred in 1973 and when Britain entered the EEC.[19] In the decades prior to this, and up until 1973, New Zealand produced and exported a relatively small range of primary products - lamb, beef, butter, and milk. The country was well suited to this type of economy, the geography and climate was near perfect and resulted in high quality produce.

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19 http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=20574 (25 May 2005)

Importantly however, was the fact that these limited range of goods had a ready market. To the extent that no matter how much we were able to produce, Britain would always be there to purchase what we had and more. This apparently insatiable market ended however, and as Britain entered the EEC during the 1970s. New markets and new products had to be found, and in the short term at least this proved to be a somewhat fruitless exercise. This coupled with the oil crisis had one major consequence – unemployment.

While the rising rates of unemployment had a detrimental effect on society as a whole, it was particularly devastating for the Māori community. Perhaps not because of ethnic bias (though this is also debatable) but due to the fact that Māori tended to be employed in primary industries – freezing workers, production hands, and associated sectors. Others were employed elsewhere, though typically worked in low skilled and volatile areas – once layed-off the chances of finding alternative employment was limited. This leading some to describe Māori as the "shock-absorbers for the rest of the economy".[20]

The obvious consequence was particularly high unemployment within the Māori community and the usual problems of low income, poor and overcrowded housing, reduced access to services, compromised educational outcomes, and the beginnings of a cycle of disadvantage and deprivation. While viruses and pathogens require certain conditions to flourish, the consequences of high unemployment (and all that is associated with it) created a perfect environment of mental health problems develop. And indeed, there is a significant amount of research to support this.[21] Accordingly, the impact of the economic downturn of the 1970s must be considered as significant when attempting to understand changing patterns of Māori mental ill-ness.

A third potential explanation relies more on anecdotal accounts and the idea that many Māori were in fact misdiagnosed with mental health problems. In speaking with those who worked in the sector during the 1970s, certain themes emerge and in particular how cultural norms were sometimes interpreted as clinical abnormalities. The issue is tricky

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20 http://www.listener.co.nz/default,1651,1627,2.sm (25 May 2005)

21   Te Puni Kōkiri, (1999), *He Pou Tarawaho mo te Hauora Hinengaro Māori – A Framework for Māori Mental Health: Working Document,* Ministry of Māori Development, Wellington.

in that not all so-called unusual behaviours are linked to cultural nuances – even though the behaviour itself may in fact show strong cultural tendencies or relationships. That is, just because the behaviour is strange or different, and includes cultural references; one should not assume it is typical or related to a particular cultural norm. On the other hand, it is equally important to consider that many behaviours are culturally specific and that what may seem strange or bizarre in one culture may in fact be normal or accepted within another.

A fourth possible reason for increased admissions is again culturally aligned but concerns the way in which mental health services or hospitals were perceived and an historical preference by Māori to care for their own within the whānau. Up until very recently most mental health facilities were located in remote or isolated settings, the buildings were large and often unwelcoming. Many were self-contained communities (complete with farms and shops) and meant that contact with outside world was infrequent. A strategy also designed to placate public fears of the mentally ill and to reduce the apparent risk of contamination.

As a consequence, this mode of care did not appeal to Māori. Barker notes:

> The Western psychiatric tradition of confining people with a mental health disability was foreign to Māoris, who had always cared for these people in their communities. The Mental Health system was originally established to cater for people to be taken out of society. Society had this fear of contamination from mental disease and also a massive denial that it even existed. These concepts were alien to Māori people whose whānau members suffering from trauma were always included within the whānau, hapū, iwi boundaries and given special status.[22]

However, and as the process of urbanisation took hold, traditional ties and cultural expectations were weakened. No longer could the whānau be relied upon to care for those in need, some had in fact lost contact with whānau, while for others the distance was too great. If low admissions were a partial consequence of Māori not seeking care then it appeared that by the mid-1970s Māori whānau were more willing to relinquish this responsibility – further contributing to increasing admissions.

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22 R. Baker, (1988), 'Kia Koutou', in C. Walsh and S. Johnson (eds.), *Psych Nurses, 88,* Wellington, p.40.

A final contributor I would like to touch on concerns all of the issues previously discussed, but focuses on the particular role of behavioural factors. As described alcohol and drug related disorders disproportionately affect Māori and reflect an overall pattern of unsafe and unhealthy consumption. As far as we can tell psychoactive or perception altering substances were unknown in traditional times and while beverages made from the kava root were consumed in many of the pacific islands, kava (nor any other type of hallucinogenic) made it as far as Aotearoa. Yet, today, alcohol has almost become a cultural norm for Māori and appears to be entrenched within many whānau. And, although this can be said for many families, both Māori and non-Māori, it is the pattern of consumption and the manner in which this is done that causes concern. In this regard, the culture of binge drinking, the associated link to other types of substance abuse, and the elevated risk of related social problems, has also done much to create a fertile environment for Māori mental ill-ness.

In the end, and like much of what has been discussed, it is impossible to say with any certainty what caused the transformation from the historical patterns of Māori mental health to the contemporary issue of Māori mental illness. The change was dramatic, though not entirely unexpected given the immense social, cultural, and demographic changes that took place. The one thing that is certain however, is that a combination of factors are responsible. The relative role each and the extent to which they contribute is not important, what is however is the fact that these dynamic and complex problems require equally as diverse and integrated solutions. Solutions which not only respond to the treatment needs of patients, but consider the socio-cultural context within which mental health and mental illness takes place.

A Māori Response to the Problem

Looking back to a previous point in this presentation it was noted that physical health problems were initially of greater concern to Māori and that by the end of the 19th century extinction of the Māori race was a very real possibility. The fact that we as a people still survive, live longer, and are more populous than at any other time in our history is an incredible feat and one which deserves some celebration. However, it is important to appreciate that this survival story was based neither good luck nor active government intervention. In many ways it was the result of desperate action by a desperate people, a desire to ensure continued existence and a refusal to accept what many believed was an inevitable outcome.

In considering these issues, and early Māori responses to these problems, Durie describes three periods of Māori health development, characterised by the individuals and groups involved as well as the particular health issues they faced.[23] The first is set in the early 1900s and reflects on the work of two Māori physicians – Dr Maui Pomare and Dr Peter Buck. While Pomare was the older of the two, they shared many similarities – both were from the Taranaki region and both educated at Te Aute College. Pomare was the first Māori doctor, while Buck was the first Māori doctor to graduate from a New Zealand university. Their similar views on Māori health development is a point of added interest. To this end, both knew that in order to arrest the rapid population decline, an integrated approached was required. One that utilised Māori networks and approaches - public health and health promotion initiatives, as well as political lobbying.

One can only imagine the types of problems they faced and the task in front of them. Certainly the situation must have seemed insurmountable if not entirely desperate – especially given the knowledge that the population was at an all time low, health problems, death and disease were commonplace, and basic drugs not yet developed. Yet, despite this, and not withstanding political ambivalence, their strategies did work, the population did increase, and a platform for Māori health development had been laid. In describing their work McLean notes that:

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23 Durie, M. H., (1994), *Whaiora: Māori Health Development,* Oxford University Press, Auckland.

In the six years between 1904 and 1909 they saw to it that some 1,256 unsatisfactory Māori dwellings had been demolished. Further, that 2,103 new houses and over 1,000 privies built. A number of villages had also been moved to higher ground. He notes that all this had been done at the cost of the Māori themselves without a penny of Government assistance or compensation. What had been achieved was due to the personal efforts of Pomare and Buck and a small bank of inspectors.[24]

Later, the Māori health and Māori Women's Welfare League were to make similar contributions as did individuals like Te Puia and Ratana. Eventually, the population was no longer under threat, and while new health problems developed, in a similar way Māori have continued to respond to these.[25]

Although there are any number of messages which arise from this discussion, of interest to this presentation is the notion of Māori responsiveness, a desire to take responsibility, and a refusal to accept that health disparities are more or less inevitable. While it should be stressed that contemporary Māori health issues are not as desperate as they were 100 years ago, there is at least an overall similarity in terms of attitude and how Māori have approached these concerns. In this regard the current problems within Māori mental health show similar patterns in terms of Māori responsiveness and likewise a comparable desire to confront them, to identify solutions, and to ensure that cultural factors are appropriately considered and utilised.

Māori Mental Health Services

As described, the dramatic increase in Māori mental health admissions during the 1970s (and subsequently) was cause for concern. Not merely due to the fact that the causes were uncertain, but a suspicion that conventional forms of treatment may prove less effective. Or at the very least out of sync with the expectations of Māori mental health consumers.

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24 MacLean, F.S, (1964), *Challenge for Health: A History of Public Health in New Zealand*, Government Printer, Wellington.

25 Ibid

As an initial response to these problems cultural therapy units (located within mainstream institutions) were developed. Whaiora, at Tokanui Hospital, and Te Whare Paia at Carrington, were amongst the first. Established in the mid-1980s the units did much to highlight the relationship between culture and mental health. And, while individual practitioners had previously explored the idea of culturally aligned interventions – for the first time two entire services, based on Māori philosophies of care, were established. While both were a departure from the more conventional approaches to treatment, these units were in fact consistent with developments elsewhere and in other sectors, particularly education and welfare. A Māori cultural renaissance was well underway and was often underpinned by the notion that a by-Māori for-Māori approach was best.

Despite this, these early Māori mental health services were not always greeted with enthusiasm and were often viewed as being separatist, divisive, and even unsafe. While Te Whare Paia was to eventually succumb to many of these misunderstandings, the outcome for Whaiora was much different – though the challenges for staff no less difficult. And, although Whaiora continued to develop as a consequence of the outcomes produced and the quality of care provided other factors were to also play a role.

First, a favourable relationship with both the Waikato Area Health Board and Tokanui Hospital had formed, and although the association was not always harmonious, for the most part serious differences were avoided. The second concerned the support received from the medical staff. The superintendent at Tokonui, Dr Henry Bennett, and psychiatric registrar, Dr Jennifer Rankin, were both Māori and were keen to support the establishment of the unit and so presented a rationale more acceptable to non-Māori clinicians and management. [26]

Coinciding with the Decade of Māori Development and spurred on by the success of these cultural therapy units the late 1980s provided further opportunities for the development of Māori mental health services. The importance of culture as it applied to

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26 J. F. A. Rankin, (1986), 'Whaiora: A Māori Cultural Therapy Unit', in *Community Mental Health New Zealand,* vol. 3, no. 2, pp. 38-47.

health was gaining momentum, and mainstream institutions and clinicians were beginning to appreciate the outcome-related benefits.[27] At a national and international level, an indigenous revival was occurring[28] which helped create an environment that no longer viewed ethnic perspectives with quite the same degree of antagonism and scepticism. Demands by Māori for more direct input into health-related activities was becoming more pronounced, various national hui confirming Māori intentions to play a more active role in matters of Māori health and development.[29] The relevance of the Treaty of Waitangi to health had also been recognised.[30]

When the health reforms of the 1990s arrived Māori were therefore well positioned to take advantage of the opportunities presented, to build on previous successes and to become more actively involved in mental health service provision. As a result the 1990s were characterised by considerable growth in the number and range of Māori specific mental health services. As with most developments of this kind, and as demonstrated in other sectors, this growth spirt was not without problems. For one, it was often difficult to determine exactly what was a Māori mental health service or to identify the criteria upon which they should be funded. In addition, and while opportunities for service development were presented, many were frustrated by the apparent attitude of funders – the short-term nature of contracts, the narrow range of tendered services, and inadequate resourcing.[31]

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27 Durie, M. H., (1994), *Whaiora: Māori Health Development,* Oxford University Press, Auckland.p. 115.

28 M. H. Durie, *et al.* (1993), '*Traditional Māori Healing',* a paper prepared for the National Advisory Committee on Care, Health, and Disability Services (The Core Services Committee)*,* Department of Māori Studies, Massey University, Palmerston North.

29 In particular Te Hui Whakapumau and Te Ara Ahu Whakamua. See Ministry of Health, (1995), *Ngä Matatini: Strategic Directions for Māori Health,* Ministry of Health, Wellington, p. 8.

30 New Zealand Board of Health, (1987), *Annual Report of the New Zealand Board of Health 1986–1987,* New Zealand Board of Health, Wellington.

31 Kingi Te K.R., (2002), *Hua Oranga: Best Health Outcomes for Māori,* Unpublished Ph.D. Thesis, School of Māori Studies, Massey University, Wellington.

As well, staffing shortages were to develop and similarly impacted on what services were provided and how they were structured. It was thought that Māori mental health services should ideally have a degree of autonomy, exist outside of mainstream settings, and be staffed entirely by Māori. However, the reality was somewhat different in that services attached to or located within the mainstream provided a vital interface for many Māori consumers, as well, access to clinical expertise was more available. A lack of appropriately qualified Māori staff also meant that many non-Māori were employed within Māori services.[32]

To some degree these problems continue, even today, however – they are not issues which have sat un-actioned or without strategies attached to them. In recent years greater numbers of clinically qualified Māori have emerged. As well, and during the 1990s, the nation's medical schools also began to incorporate cultural dimensions into their curriculum. Programmes such as Te Rau Puawai and more recently Te Rau Matatini have likewise contributed to the Māori mental health workforce by actively encouraging more Māori to consider a career in mental health. Rather than to focus on a narrow range of core disciplines these programme have recognised the need for active and broad Māori involvement within the sector – more psychiatrist and psychologists, but also health managers, support staff, midwives, social workers and nurses.

Te Rau Puawai provides scholarships and assistance to Māori interested in pursuing a career in mental health - through Massey University.[33] The success of Te Rau Puawai may be reflected in the fact that since its establishment in 1999 (and up until 2003) the programme had successfully increased the Māori mental health workforce by more the 100. However, an external evaluation of the scheme identified further critical success factors. In particular the rather unique approach taken by the programme – that is, providing scholarship recipients with access to Māori academic mentors, support structures that are aligned to Māori realities, and an environment based on whānau

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32 Te Pūmanawa Hauora, (1995), *Guidelines for Purchasing Personal Mental Health Services for Māori,* Te Pūmanawa Hauora, Department of Māori Studies, Massey University, Palmerston North.

33 http://te-rau-puawai.massey.ac.nz/ (25 May 2005)

principles. Of added interest was the fact that the review made particular comment on the enthusiasm of staff and the dedication of the Māori governing board.[34]

While funded by the Ministry of Health, Te Rau Puawai is in many ways an active response to a problem that was identified some years earlier. And, although workforce issues continue, it is unlikely that these types of gains would have been made if not for Māori insistence (within the Ministry of Health and elsewhere) and through the application of a Māori designed and implemented developmental framework. The recently released Raranga Tupuake document will also allow the Ministry of Health to identify ways in which more Māori can consider a career health.[35]

New Modes of Care

It is without doubt that workforce issues remain a significant impediment to the development of Māori specific mental health services. However, it is encouraging note that at least problem identification has led to a range of potential solutions and programmes – and that Māori have played a key role in this. The whole issue of workforce development is an unfortunate consequence of an increase in the number of Māori affected by mental-illness. A further appreciation of the fact that the ethnic and cultural composition of the health workforce should at least match that of the client base.

However, workforce needs are also a reflection of an increase in the number of Māori mental health services. In this regard it has often been difficult to define exactly what constitutes a Māori mental health service – accordingly, it is sometimes difficult to precisely count the total number of services available. Despite this, and not withstanding some problems, the number and range of Māori mental health services has increased considerably since the days of Te Whare Paia and Whaiora. And, in the space of just 20years, Māori mental health services have moved from a position of being novel or

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34 http://wfass-trinity.fass.waikato.ac.nz/docushare/dsweb/GetRendition/Document-966/html (18 May 2005)

35 http://stuff.co.nz/stuff/0,2106,3296239a8153,00.html (08 June 2005)

alternative to that of an accepted and integral part of the New Zealand Mental Health Strategy.[36]

As noted, there is sometimes confusion as to the purpose or intent of these services. Initially, they were viewed as racist or separatist and more recently their fundamental purpose has been linked to cultural enhancement. And while many, if not most, include cultural activities or programmes, the rationale behind these interventions has very little to do with culture per se and everything to do with health. In this regard, cultural activities, processes, or interventions are ultimately designed to improve treatment responsiveness and health outcomes. Culture therefore has little place within a Māori mental health service unless it satisfies the more fundamental requirement of improving the lives are well-being of Tangata Whaiora or Māori mental health consumers.

This requirement has in many ways shaped the manner in which cultural activities have been introduced within mental health services – both mainstream and Māori specific. Viewed through a narrow lens, activities such as powhiri, which often take place within Māori services, are seen as a simple process of encounter or welcome. However, a deeper analysis reveals that the whole process can also be quite settling, putting the Tangata Whaiora and their whānau at ease, providing reassurance, and creating an environment which supports recovery and rehabilitation. Tangata Whaiora are often encouraged to play a formal role in this process, either as speakers or kaitautoko. This is of course consistent with Māori custom, however it also recognises the range of skills that Tangata Whaiora possess and affirms the desire to ensure that they are not just idle participants within the process – but rather the focus.

Cultural assessments also feature within Māori mental health services and are used to complement the more usual clinical assessments. In this way a more comprehensive assessment of the problem is possible and the relationship between cultural and health

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36 Ministry of Health, (1994), *Moving Forward: The National Mental Health Plan for More and Better Services,* Ministry of Health, Wellington.

better understood. As a consequence broader options for treatment and care can be explored.[37]

Kaumātua are now employed within many mental health services and provide valuable support on issues of tikanga and protocol. However, and more than this, kaumātua are a vital link to the local community and can often identify solutions where previously none existed. In some instances they are also better able to engage with Tangata Whaiora, to create dialogue that is more open and which allows for a better understanding of the problem. In the assessment of issues such as mate Māori their advice is also critical.

Te Reo Māori has also been used within mental health services (for a number of years) and as means of engaging Tangata Whaiora. And, while it is accepted that most Māori are sufficiently capable of understanding Te Reo Pākehā, many are more comfortable conversing in Māori and may reveal a broader and deeper range of issues. Again, assisting with assessment and ensuring that all possible concerns are considered.

Whānau participation is likewise a characteristic of many Māori services. It is in many ways a feature of Māori culture and society and therefore appears within Māori health models. Whānau and the relationships that exist within them provide a base for cultural interaction and likewise a mechanism through which cultural knowledge is transferred from one generation to the next. Within a health service however, whānau participation has a range of additional benefits. Māori are likely to appreciate the advice and support of whānau members, and whānau will often expect to contribute to the treatment and healing process by actively participating in therapeutic activities.

Whānau participation can be particularly useful within mental health services and at the assessment phase. Here they are able to distinguish between cultural norms and mental disorder and in furnishing a more accurate picture of the stresses and strains that impact on Tangata Whaiora. These are often issues that clinicians are particularly interested in but are unable to completely appreciate without whānau input.[38] Although access to

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37 Te Pūmanawa Hauora, (1995), *Guidelines for Purchasing Personal Mental Health Services for Māori,* Department of Māori Studies, Massey University, Palmerston Nth.

38 Ibid.

whānau is sometimes difficult and participation not always recommended – of significance is the potential of whānau involvement and the manner in which this is used to enhance both treatment and outcomes.

For many, these types of processes or interventions are not new and could additionally include activities like waiata, Māori arts and crafts, rongoa and karakia. However, 20 years ago their application to a mental health setting would have scarcely been contemplated. Moreover, their role in promoting health gains would not have been completely understood – if at all.

To this end, Māori mental health services, and in particular the staff within them, have done much to advance the relationship between culture and health. All this despite workforce deficits, inadequate funding, short-term contracting, increasing demand, and recent political comment to suggest preferential treatment to Māori and likewise question the need for alternative approaches. While more services is an imperfect proxy for better services (and certainly significant problems remain) the point is that these providers have continued to evolve and develop, to find problems and identify appropriate solutions. The level of innovation within some services is also worth celebrating and is of interest both nationally and internationally.

Other Developments

Elsewhere within the sector other positive developments have occurred. As far back as 1994 RHA purchasing guidelines identified both Māori health and mental health as two of the four health priorities.[39] And while this did not always translate into increased funding for Māori it at least provided some policy recognition of the problem. Following on from this the 1996 Mason Report [40] also raised concerns and further assisted with placing mental health on the political agenda. More recently, and within the Ministry of Health itself, a Māori mental health team has been established within the Mental Health

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39 Ministry of Health, (1994), *Policy Guidelines for Regional Health Authorities 1995/96*, Ministry of Health, Wellington

40 K. Mason (1996), *Inquiry Under Section 47 of the Health and Disability Services Act 1993 In Respect of Certain Mental Health Services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley*, Ministry of Health, Wellington

Directorate. This was the first Directorate (outside of the Māori Directorate) to contain a specific Māori team.

The work of Māori within the Ministry of Health is difficult to quantify and they are often unfairly challenged for being crown agents – which of course they are. However, we sometimes fail to appreciate the difficult frameworks they are required to operate within – meaning that often their considerable work goes unnoticed or fails to receive the recognition it deserves. To this end it is unlikely that many of the current and past policy changes would have occurred if not for the increasing number of Māori employed within the Ministry. Many of you would be aware that the State Services Commission is currently conducting a review of policies and programmes within the Public Service and to ensure they are based on need, not race.

One suspects that Ministry staff would have bared the brunt of much of this inquiry and required to provide research, rationale and data as to why Māori approaches are needed. It is not too long ago that the Māori mental health portfolio (within the Ministry of Health) was the responsibility of a single individual. And while greater numbers of Māori involved in service provision is an encouraging sign – so is the increasing number of Māori at the policy level.

The establishment of a Mental Health Commission in 1996 can also be seen in a positive light. As an independent entity, part of the Commission's role is to monitor the implementation of the national mental health plan. Their *Blueprint*[41] document assists with this and describes how the strategy should be operationalised. Of interest is the fact that both *Blueprint* documents describe clear benchmarks for Māori services and have done much to further rationalise development of Māori specific mental health services. Also encouraging are routine progress reports which describe the extent to which these obligations to Māori are being met – or otherwise.[42]

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41 Mental Health Commission, (1998), *Blueprint for Mental Health Services in New Zealand: How Things Need to Be,* Mental Health Commission, Wellington. Note: this was followed up by a sequel *Blueprint* document the following year.

42 Mental Health Commission, (2001), *Report on Progress, 1998-2000: Toward Implementing the Blueprint for Mental Health Services in New Zealand*, Mental Health Commission, Wellington.

Within the research area, the number and range of Māori initiated and designed studies has also dramatically increased. While a number of factors have contributed to this, the establishment of two Māori health research units in 1993 provided considerable thrust and direction.[43] With regard to Māori mental health research, developments have likewise been encouraging.[44] Of particular interest has been the establishment of a Māori research team as part of the national mental health prevalence study. In the past, and with the exception of a few notable studies, "Māori research" was likely to describe "research on Māori". Typically, these studies were illness orientated, initiated and conducted by non-Māori, and almost always reflected non-Māori priorities and interests. As far as Māori involvement was concerned, participation was largely confined to the role of consumer or respondent with little expectation that information would be shared or used to inform Māori development.[45]

However, active involvement by Māori within this prevalence study is another example of Māori responsiveness to an issue. To this end the Māori research team has incorporated Māori research methods and practices into what is a highly technical and complex research initiative. In a world first, a range of cultural indicators are included within the data set and will assist in shaping the research findings. Of interest to this paper is the fact that Māori involvement (and the collection of cultural indicators) further strengthens the relationship between culture and mental health and will do much to advance Māori mental health at service and policy level.

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43 T.R.Kingi, (2005), *Māori Health and Māori Mental Health Research: Issues and Opportunities,* School of Māori Studies, Massey University, Wellington.

44 M. Levy, (2004), M*ental H*ealth R*esearch and Development S*trategy (*MHRDS): R*eview of O*utcomes for Māori 2000-2004*, Mental Health Research and Development Strategy, Unpublished Draft.

45 M.H.Durie, (1996), *Characteristics of Māori Health Research,* A Paper Presented at the Hui Whakapiripiri: Hongoeka, 1 February 1996, Department of Māori Studies, Massey University, Palmerston North.

Conclusion

In detailing some of the positive developments which have occurred over the past few years I have not concealed the fact that significant problems remain. However, this presentation isn't about what's going wrong, there is ample discussion on that, but it is about what's going right. And, to further recognise the efforts and advances made by those that for many years have worked and struggled within the sector. When attempting to describe the extent to which progress has been made a number of mechanisms can be used – quantitative and qualitative measures, data, statistics, and evaluations. However, a simpler approach would reflect on more pragmatic comparisons, that is, are Māori more likely to receive better care now than in the past. Quite simply, the answer is yes.

In this regard, and when speaking with many who worked within the old institutions one gets some idea as to how far things have advanced. I have already touched on the fact that during 1950s (and prior) admission to a psychiatric hospital would have bared some resemblance to incarceration within a correctional facility. Large, bleak, impersonal, and gloomy the old style psychiatric hospitals did not always provide an environment conducive to health and well-being. Many were situated in isolated rural areas, that, while deemed more therapeutic – further isolated patients from their whānau, friends, and support networks. For a range of reasons (not least of which concerned a lack of psychoactive drugs) admission to a mental hospital often resulted in a life-time sentence. Removed from society, patients were sometimes also relieved of their dignity, hope and for many their fundamental rights.

While the process of deinstitutionalisation has not been without its problems two important measures of progress are worth considering. The first is about recovery and an increased awareness and focus on this. Recovery, of course, has many different meanings and is often something that is quite individual. According to the Mental Health Commission, recovery is an ability to live well in the presence, or absence of ones mental illness.[46] To live well is of course a personal if not abstract concept though recognises personal goals and ambitions, the dignity of people and their right to live as valued members of society. Although there is still much to be done, the emphasis placed

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46 Mental Health Commission, (2001), *Recovery Competencies for New Zealand Mental Health Workers,* Mental Health Commission, Wellington.

on recovery demonstrates a maturing approach to mental health treatment and the fact that health outcomes should coincide the expectations of service users.

The second point is related to the first and concerns the role of consumers within the mental health sector. In the past, and while being the focus of treatment, mental health consumers were more often idle participants within this process. They often lacked information and more critically - control. While there is more to do in terms of consumer involvement, greater participation, at all levels, speaks volumes in terms of our approach to mental health treatment and care, and ultimately what objectives are sought.

These, rather blunt measures of progress are of course not solely attributable to Māori influence. However, it is my belief that Māori have played no small part in shaping these developments. To this end the recovery approach is not inconsistent with Māori beliefs and holistic Māori models of care. Furthermore, the drive toward greater consumer participation likewise has cultural dimensions and reflects notions of awhi, tautoko, and manaakitanga.[47] These concepts are often imbedded within Māori modes of service delivery and have certainly assisted with shifting attitudes, approaches, and basic philosophies.

This paper has attempted to describe some of the positive outcomes of increased Māori participation within the mental health sector. To highlight what challenges exist, but also to describe how Māori have responded to these issues – as we have done in the past, and will continue to do in the future. As noted, any number of measures can be used to illustrate this point – and I have selected but a few. Regardless it is clear that more Māori are involved in mental health research, service provision, clinical and non-clinical roles, policy design, and various leadership positions within the sector. As well, and more than this, Māori have contributed in no small part to the way in which care is delivered - the relationship between culture and health has been strengthened and have spawned innovative approaches to treatment and care. These innovations are of national and international significance and have further implications for other sectors. Is more required - definitely, will the problems get worse - probably, have Māori made a positive difference - absolutely.

47 Mental Health Services Hui: Maraeroa Marae, Porirua, 26 May 1998.

One hundred years ago the main threats to Māori health must have seemed insurmountable. Yet, these challenges were met and overcome and it is perhaps with some nostalgia that we reflect on these problems, the manner in which they were addressed, and how Māori actively responded to these challenges. Perhaps in a hundred years from now we may likewise reflect on present days issues and similarly consider Māori responsiveness and how too the problems in Māori mental health were identified, challenged and overcome.

As a final conclusion to this presentation I would like to consider this ancient tauparapara. It was first shown to me by my supervisor and appropriately describes many of the issues considered in this paper – or at least the notion of Māori responsiveness and action.

Whakataka te hau ki te uru	*Cease now the wind from the West*
Whakataka te hau ki te tonga	*Cease also the wind from the South*
Kia makinakina ki uta	*Let the murmuring breeze sigh over the land*
Kia mataratara ki tai	*Let the stormy seas subside*
	And let the red dawn come with a sharpened air,
KIA HI AKE ANA	*A touch of frost*
he ata-kura	*And the promise of a glorious day.*
He tio, he huka, he hau-hunga.	

The tauparapara is part of a very old karakia, a chant often rehearsed when Māori gather, and before commencing the business of the day. Essentially, it expresses a hope for better things to come. It may seem un-usual therefore to introduce it at the end of the paper and not at the beginning. However, the main reason for doing so is to illustrate the fact that we have not yet reached an end-point and that the overall journey is likely to continue.

The tauparapara has other implications as well and illustrates that growth and development does not come without effort. Just as a 'glorious day' compensates for the wind, stormy seas, and a 'touch of frost', so development is just recompense for our personal and collective efforts, a desire to move onward and upward. The tauparapara can be seen to add its own optimism to the area of mental health with the hope that we may one day look back on the issues of today, the efforts made, and the subsequent gains that were achieved. To this end I hope we respond the way we always have in times of adversity – with dignity, enthusiasm, and a fundamental belief that no task is ever too big nor too challenging. I am certain that wind, rain, and stormy seas will be encountered along the way, but am equally confident that through the efforts of many, and at the end of the day, the outcome will be positive and the promise of a glorious day realised.

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