Te Mata o te Tau

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Cultural Interventions and the Treatment of Māori Mental Health Consumers

Te Kani Kingi

Te Pūmanawa Hauora

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 are less positive and more difficult to manage.[1] Past studies have shown 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 is a leading cause of first admissions for Māori. Māori readmission rates for affective disorders and psychotic illness were 36 percent for women and 75 percent for men higher than corresponding non-Māori rates.[4] Schizophrenic psychosis is the second most common cause of admission for Māori males and is 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), *Ngā Ia o te Oranga Hinengaro Māori – Trends in Māori Mental Health*, 1984-1993, Ministry of Māori Development, Wellington.

widely available there is evidence to suggest that 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 for this assumption and that perhaps solutions should focus on correcting generic 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 thing 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 what developments have occurred and in particular the role of Māori specific mental health services. While this is perhaps a more difficult path to follow, the

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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 Pūkenga Kōrero,* vol. 3, no. 2, Department of Māori Studies, Massey University, Palmerston North.

significant problems in Māori mental health need to be balanced against the increasing recognition of Māori approaches to treatment and care and how these problems have in effect lead to considerable amount of innovation.

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, tuberculosis, 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.

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

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

9 Ibid.

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.

In further support of this it is worth noting that one of the first investigations into Māori mental health (conducted in the early 1940s) 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 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

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

11 Ibid p. 243.

> 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 de-culturation were used to explain contemporary patterns of illness and disease.

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. 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.[13]

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.[14]

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

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12 Ibid p. 243.

13 Ibid.

14 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.

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.[15] 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.

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

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

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 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".[16]

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.[17] 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 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

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

17 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.

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.[18]

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.

A final contributor I would like to touch on concerns the all of the issues previously discussed, but focuses on the particular role of behavioural factors. As described alcohol

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

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 bindge 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 equality 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.

Māori Mental Health Services

While appreciating the complex nature of Māori mental health, and the integrated way in which solutions should be designed, the development of Māori specific mental services (during the mid-1980s) was a positive step toward considering, at the very least, the manner in which Māori patients could be treated. When first introduced, and for some of these services at least, there was a degree of misunderstanding with respect to their fundamental purpose or role. Some were labelled as racist or separatist and perhaps offering advantages to Māori patients that were not available to the wider population. However, and within this debate, the true objectives of these services were sometime lost – in that the arguments were often focused on issues of equality or fairness rather than

the more relevant issue of health. In any event, and even when questions of equity were raised, it appeared that Māori patients (in particular) were less likely to respond positively to treatment and to experience positive outcomes.

The issues which surround this are complex; however, Māori mental health services were initially established for one single reason, and in order to better improve the health outcomes of Māori mental health consumers. And to this end remains the fundamental principle which shapes their activity and focus.

The way in which this is achieved varies from service to service, and it is important to appreciate that while they are universally described as Māori mental health providers, the similarities often end there in that they function in ways that are not easily prescribed. Many are located within, or attached to, mainstream services, while others are more autonomous or have closer links to iwi. Access to clinical and cultural skills also varies - not all are staffed by Māori, and many treat and care for non-Māori consumers as well. Despite this, and the diversity which exists, they all share a common focus on the care of Māori consumers as well as an interest in providing treatment in a holistic and integrated manner.

These broad philosophies therefore influence the way in which care is provided and are fluid enough to appreciate the diverse settings and environments within which Māori mental health services operate. Māori models of health are often used to give practical expression to these philosophies and likewise guide what outcomes are sought. This does not mean that clinical interventions, activities, or outcomes are not valued, and on the contrary, it is important that clinical expertise is applied and in order to meet the diverse needs of Māori mental health consumers. Indeed no intervention is complete unless both clinical and cultural issues are considered. However, it is the cultural aspects of care that I wish to focus on and to perhaps discuss in greater detail.

Cultural Activities and Interventions

Given the diverse way in which Māori mental health services function, it is somewhat difficult to describe, with certainty, how cultural activities or interventions are used, or even what these are. However, there are some activities which (while not consistent across all services) provide some insight into Māori approaches to treatment and care.

Many of these were described in the Mental Health Commission's *Blueprint for Mental Health Services* which provided a broad template or description of what might feature within a Māori mental health service. Included within this is the notion of cultural assessment. And, while it was not described in any detail with the first *Blueprint* document, subsequent research by the Commission has bought some clarity to the issue. In this regard it appears that while there is a general acceptance of cultural assessments within both Māori and mainstream settings there is an inconsistent approach to their application – furthermore, there is some confusion as to what the actual purpose of a cultural assessment might be.[19]

While acknowledging these inconsistencies, Mason Durie describes cultural assessment as the process through which the relevance of culture to mental health is ascertained. It should provide a basis for a better understanding of the client and may lead to a cultural formulation of the problem, to complement a DSM IV diagnosis.[20]

While any assessment of mental health is likely to be more accurate if it is undertaken by a person of the same culture as the client. Short of that, all clinicians who have responsibility for assessment should be aware of the influence of culture, their own included, on the assessment process and should take steps to ensure that formal assessment includes an examination of cultural variables. Frequently, because relatively few professionals have any formal training in tikanga Māori,[21] assistance from others who have expertise will be needed; and more often than not, family and/or whānau will be able to make useful suggestions. The purpose of a cultural assessment is not only to assist in reaching a conclusion about mental state but also to plan treatment and rehabilitation programmes which are relevant and motivating.

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19 Mental Health Commission, (2005), *Delivery of Cultural Assessment for Māori,* Mental Health Commission, Wellington.

20 Ministry of Health (1995), *Draft Guidelines for Cultural Assessment*, Ministry of Health, Wellington

21 R. Sawrey (1990), A Survey of Psychologists' Opinions and Behaviour on Aspects of Māori Mental Health, MA thesis, Victoria University, Wellington

Pōwhiri (or a formal Māori welcome) is also a cultural process which has been used for therapeutic purposes – and not only in mental health. Recent media commentary on the use of pōwhiri (or poroporoaki), particularly within the public service, has resulted in much uninformed debate as to it's purpose or function, and in particular the relative gender roles which are prescribed. As a consequence some (mostly non-Māori) have openly condemned the process – though understand little of it's intent, substance, traditional or contemporary significance. In this regard a pōwhiri has little to do with suppressing the views of any one particular group (as some would have us believe) nor is it less significant now than it was 50, 100, or even 500 years ago. [22]

Viewed through a narrow lens, the activities and interactions involved in a pōwhiri can be seen as a simple process of encounter or welcome. However, and from a mental health perspective, a deeper analysis reveals that the whole process can also be quite settling, putting the tangata whaiora and their whānau at ease, providing comfort, and creating an environment which supports recovery and rehabilitation. The formalities which guide the pōwhiri are consistent with contemporary Māori expectations – a desire to establish a platform or springboard for ongoing care, to arrive at a common understanding, to establish parameters for engagement, and perhaps most importantly, to offer reassurance.

Kaumātua or cultural advisors are now also 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 and can likewise assist the process of cultural assessment.

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22 H. Tauroa and P. Tauroa, (1986), *Te Marae: A Guide to Customs and Protocol,* Reed Publishing, Auckland.

Te Reo Māori has also been used within Māori 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 and speaking Te Reo Pākehā, many are more comfortable conversing in Māori and may reveal a broader and deeper range of issues. Some are in fact uncomfortable with providing detail on their personal lives and activities, and although this might be problem regardless of language or culture, there is a tendency for Māori to reveal much more within Te Reo Māori. 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 distinguishing 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.[23] Although access to 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.

Māori leisure pursuits include painting, flax weaving, wood carving, taniko, kite making and flying, bone carving, singing and playing musical instruments have also been used to good effect. In this regard occupational therapy activities become more relevant when Māori crafts are introduced. Similarly when it is difficult to converse with words, non-verbal cultural activities may produce a greater sense of effective communication. A

23 Ibid.

teenager for example may say more with a guitar than with a string of words, a reminder that programmes which depend on an exchange of words do not always appeal to Māori.

More broadly, the adaptation of Tikanga Māori (or Māori culture) within a mental health setting has included a variety of practices such as the manner in which visitors are received, the way meetings are conducted, group decision making processes, opportunities for consensus development, reciprocity and sharing resources. The underlying themes reflect group (rather than individual) bias, formality (rather than a lack of structure) and process (rather than outputs). Often Māori language is the means of communication, at least for some events, and more often than not an older person (kaumātua, whaea) lends guidance to the proceedings. While there is debate about the appropriateness of introducing tikanga into situations remote from a marae, and the risks of cultural compromise which can threaten the integrity of tikanga, in practice, Māori clients and whānau are even more uncomfortable when some aspects of tikanga are not observed.[24]

Concluding Comments

The examples provided are not comprehensive, but are used to give some indication of the type and range of activities which may feature as part of a Māori mental health

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24 V. Keefe-Ormsby, N. Watene-Hayden, W. Maniapoto, G. Taumata-Bishara, H. Potaka, (1993), *Tino Rangatiratanga and Māori Mental Health 1st national Hui for Māori Mental Health Workers, Wainuiomata marae, Wainuiomata, 28-30 June 1993*

service. More than this however, they illustrate the role of cultural within a mental health and to highlight the fact that cultural activities are fundamentally designed to improve clinical outcomes, responsiveness to treatment, assessment, rehabilitation and recovery. There is some confusion that cultural activities are aimed at cultural enhancement, and, while this may be an initial objective – the more fundamental purpose is aligned with the single aim of improving health outcomes for tangata whaiora Māori.

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