Te Mata o te Tau: Academy for Māori Research and Scholarship
Te Pūmanawa Hauora: Māori Health Research Unit

Indigeneity and Māori Mental Health

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TABLE OF CONTENTS

INTRODUCTION

Thank you for the opportunity to speak today and to finally visit this wonderful part of the country. It is perhaps appropriate that an indigenous symposium on health is held here, in Waitangi, as it is a place that not only has particular significance for New Zealand and for Māori, but in broader sense illustrates how indigenous people have attempted to secure their own rights and identity, what historical challenges were faced, and more so what contemporary issues remain unresolved.

While much of my presentation considers the dual issues of Māori and mental health, given the theme of this symposium a broader range of topics are also introduced, in order to provide a platform for discussion, but also to show how the Māori experiences (while somewhat unique to this country) shares many similarities with other indigenous groups throughout the world and in particular those within Polynesia and the pacific.[1]

WHAT IT IS TO BE INDIGENOUS?

While many indigenous people now find themselves as minorities within their own traditional homelands, the indigenous population, as a whole, is not so insignificant. Worldwide, there are in fact more than 5000 indigenous and tribal groups, a population of about 200 million, and making up about 4% of the total global population.[2] Certainly the experiences, cultures, and beliefs of these groups vary considerably and have likewise been shaped by both internal and external factors. These internal factors include the natural environment and access to physical resources. Connections with other tribes or groups is another internal structure and which has likewise influenced the unique way in which these indigenous cultures have developed. However, external and less controllable influences have also impacted on indigenous populations and to the extent that contact with other (non-indigenous groups) has also affected the way in which indigenous people now view the world and their place within it.

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1 M.H.Durie, (2005), *Ngā Tai Matatū: Tides of Māori Endurance,* Oxford University Press, Melbourne, Australia

2 M.H. Durie, (2005), *Psychiatry and Indigeneity: The Interface Between Science and Indigenous Knowledge,* Indigenous Stream Presentation, Cairo, Egypt

Despite the obvious cultural and physical differences which exist, there are a number of key criteria which help define what it is to be indigenous and which serve to link all indigenous groups throughout the world. Last year, our Co-ordinating Minister for Race relations suggested that living in Wainuiomata may serve as a reasonable proxy for being indigenous,[3] however, this view is not entirely consistent with my own and therefore I would like to introduce a set of alternative criteria.

In this regard, and according to Mason Durie,[4] there is at least one primary characteristic of being indigenous, that is, the relationship that indigenous people have with the land and their natural resources. It is therefore not uncommon for indigenous groups to hold significant views on the land which extend to more than just its capital or economic value and which are more often than not considered from a spiritual and even maternal perspective. Indeed, to many indigenous people, land is not simply a means through physical life is sustained but likewise a mechanism for spiritual, emotional, and cultural enhancement. It is not surprising therefore, that land loss has impacted on indigenous groups and in such a profound way. And, that compensation which is calculated in fiscal terms only can tend to miss the point or at least how the value of indigenous land is determined.

A secondary characteristic of being indigenous is the dimension of time. While obtaining a passport, the ability to vote, or the right to call yourself a Kiwi, Ozzy, Yankee or Pom may come with time, it does not necessarily give you the right to call yourself indigenous. Indeed, and for many indigenous groups the notion of time and occupancy is measured in hundreds or even 10s of thousands of years and not just by mere residency. This is not to say that non-indigenous residents do not have rights or to claim an association with a particular country or region, though it does suggest that mere occupancy is an imperfect proxy for being indigenous.

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3 Parliamentary Questions for Oral Answers, Tuesday 3 August, 2004

4 M.H. Durie, (2005), *Psychiatry and Indigeneity: The Interface Between Science and Indigenous Knowledge,* Indigenous Stream Presentation, Cairo, Egypt

A culture which celebrates the human/environmental union is a further characteristic of being indigenous. To some extent this notion has been touched on already and when exploring the relationship indigenous people have with the land. However, this union between people and the environment warrants further consideration in that it also illustrates the symbiotic way in which life and even death is viewed. That is, a sense of harmony or one-ness with the natural environment is typically a feature of indigenous groups – an intangible connection, if you like, with the land, the water, the birds, the forests and all creatures within indigenous territories.

An indigenous knowledge system is also part of what defines being indigenous. It requires a unique way of viewing and explaining the world and is often illustrated through traditional stories, songs, the unique mechanisms for the transmission of knowledge, for protecting and promoting health, and for engaging others. Balanced development and sustainability for future generations is another feature or belief that indigenous people have in common. While early anthropological examinations of indigenous groups often focused on so-called alternative beliefs as mere curiosities, they failed to completely consider the fundamentals of indigenous practice and culture and the fact that life was often based around a single purpose - survival and on ensuring the growth and development of future generations.

A final feature which helps define being indigenous is the existence of a distinctive language.[5] Language is important in that it often underpins the uniqueness of an indigenous culture and to the extent that a culture may find it difficult to survive unless the language also is nurtured and maintained. Unfortunately, we know that more than 2500 indigenous languages will be lost this century, that is 25 this year, and about one every two weeks – gone forever and along with it a unique and critical part of an indigenous culture.[6] Some have suggested that this is perhaps not as bad as it appears and that in fact English is the modern language of commerce. However, and like land, these types of statements again miss the point in that the desire for indigenous people to maintain their language is seldom linked to it's commercial appeal or potential profit and more clearly aligned with maintaining ones culture, identity, and unique place within the world.

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5 Ibid

6 A.Dalby, (2002), *Language in Danger: How Language Loss Threatens our Culture*, Penguin Press,

THE INDIGENOUS EXPERIENCE

There are of course other features of being indigenous and which serve to characterise the indigenous experience.[7] For many (if not most) contact with other cultures has led to adversity, a lack of control and self-determination, as well as the erosion of cultural practices and beliefs. Colonisation of course has largely been responsible for this, though in many cases rapid urbanisation was similarly at fault and has played a particular role in the decline of traditional cultural practices. The policy of "pepper-potting" was introduced into New Zealand during the 1950s and 60s and was designed to better integrate Māori families into non-Māori communities.[8] It was hoped that by deliberately placing urban Māori migrants within predominantly non-Māori communities (pepper-potting) it would assist the process of assimilation by allowing Māori to adopt western lifestyles.

In one sense the policy was successful in that isolating Māori from each other (particularly within urban areas) did much to break-down the more traditional behaviours and lifestyles. However, the policy had a fundamental flaw in that it was assumed that assimilation (though isolation) would have a positive affect on Māori and aid Māori development. However, the opposite occurred, in that the abandonment of traditions and cultural practices did little to enhance urban Māori life and in particular in times of economic adversity. To this end, urbanisation and deliberate attempts at deculturation is another feature of the worldwide indigenous experience.

Despite recent talk of Māori privilege, as a researcher it is somewhat difficult to reconcile what is reported in the media and promoted within political debate to what we actually know. And, as with most other indigenous populations the socio-economic position of Māori is another unfortunate characteristic we all share. Typically, indigenous groups are more likely to have poorer paying jobs and when compared to the general population, un-employment statistics are likely to be higher, educational outcomes poor, home ownership lower, and access to key social services is also likely to be compromised.

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7 Ibid

8 Ministry of Māori Development, (2004), *Māori Language in the Community,* Ministry of Māori Development, Wellington.

As a consequence, indigenous people are more likely to have overall poorer health when compared to the general population. We know for example, and when comparing the health of indigenous people from New Zealand, Australia, the United States, and Canada that these groups are significantly more likely to smoke, to have diabetes, and to have overall reduced access to health services.[9] And, while there is no single measure of health status, of major concern is the fact that all these indigenous groups have lower life expectancy than the general population. For Māori, we can expect to live about seven years less than the general population, for native Americans and First Nations in Canada, the difference is about six years. If you are indigenous to Australia, then you can expect to die some 20 years before others within the general population. These statistics are disturbing and for a number of reasons, but are of interest due to the fact that collectively, these countries are amongst the wealthiest in the world. It appears, therefore, that the only real privilege we have is to die sooner than what others within our society have come to expect. Some have suggested (and with particular reference to Māori) that these differences are primarily a consequence of socio-economic circumstance, and, that by correcting the overall socio-economic position of Māori these differences in life-expectancy, and other health concerns, will be eliminated. However, we know that this in not entirely true, and that wealthy Māori (for example) will still die sooner than their wealthy non-Māori counterparts.[10] A recent report commissioned by the Waikato DHB also revealed that Māori living within affluent suburbs had worse health than non-Māori living in deprived areas.[11] Other explanations for the differences in health status and life-expectancy therefore need to be considered including of course behavioural and socio-economic factors, but like-wise systemic issues, discriminatory attitudes, and structures which impede Māori access to health services and which ensure that our health outcomes are less positive.

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9 D. Bramley, (2005), *Indigenous Health Inequalities, A Comparative Analysis: New Zealand, Australia, Canada, The United States,* Harkness Fellowship Presentation, 2005.

10 Ministry of Health, (2004), *Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980 – 1999,* Ministry of Health, Wellington.

11 http://www.stuff.co.nz/stuff/0,2106,3440322a8153,00.html (12/10/05)

MĀORI HEALTH: PAST AND PRESENT ISSUES

Given the range of health problems currently faced by Māori it would be reasonable to assume that we are somehow destined to be unhealthy and that the factors which contribute to poor Māori health have always been a feature of Māori society. However, quite the opposite is true, and in fact early accounts of Māori typically described a people of some considerable physical presence, a vibrant and complex culture, an intelligent and sophisticated race. Prior to colonization Māori did in fact have well-developed mechanisms for health protection and health promotion, and a comparatively advanced knowledge and understanding of how diseases were transmitted. As a consequence, and despite the often harsh environment, Māori were able to flourish within Aotearoa, and by 1800, the population had reached an estimated 150,000.

Unfortunately, the 1800s were not a particularly positive century for Māori and in fact a census conducted in 1896 revealed that the Māori population had declined by more than 2/3rds to just 42,000 - and in a little over two generations. Putting this in perspective, it would mean that those people sitting to both your left and right would be gone. One can only imagine the impact this would have had on the Māori population. And, if there were three words to describe Māori during the 1800s - despondency, despair, and de-population would seem appropriate.

The reasons for this decline and change in health profile are complex, though are not difficult to identify. The land and tribal wars during the 1800s had a particular and negative impact on the Māori population as did of course the introduction of diseases that Māori had little biological protection from. Isolation from other parts of the world, allowed a unique culture to develop and flourish, but it also made Māori susceptible to many of the diseases which had ravaged other parts of the world. The population was unprepared, biologically and socially, the effects therefore were often quite devastating.[12]

Cultural decay had a similar, though perhaps less obvious impact. As colonization took effect, cultural decay resulted and with it the abandonment of many of the social

12 M.H.Durie, (1994), *Whaiora: Māori Health Development,* Oxford University Press, Auckland.p29

structures and practices which for hundreds of years had been used to promote and protect Māori health.[13]

Concerns over Māori health, and in particular the population decline, were documented as early as 1837 and eventually led to New Zealand's first Māori health strategy – a treaty, which was signed right here in Waitangi, on the 6th of February 1840. While much of the discourse surrounding the Treaty of Waitangi has focused on issues of sovereignty, land acquisition, or textual differences – concerns over Māori health provided much of the backdrop, and were not insignificant in terms of both shaping and selling the Treaty. In this regard, an 1837 report from James Busby (the then New Zealand Resident) reflected on the plight of the Māori and in particular their rapidly decline health. In his dispatch to his superiors in England he noted the "miserable condition" of the Māori which promised to "leave the country destitute of a single aboriginal inhabitant". He suggested some form of intervention, to manage the colonial process, and to hopefully arrest the rapid population decline.[14] Even then, experience from other parts of the world had revealed how colonization typically had a profound and negative affect on the indigenous population. Keen to avoid this, a Treaty was recommended, though was not the only option put forward. Busby in fact, favored a "protectorate" where by the Crown would administer the affairs of the country in the interest of all inhabitants – Māori and European.[15] William Hobson, New Zealand's first Governor, promoted an alternative "factory" plan. This would have led to the establishment of European type settlements within certain geographical locations and within which English laws put in place. Māori settlements would similarly be established within which Māori custom and law would apply.

Despite this, the Colonial Office in England determined that the only way to protect Māori sovereignty and interests (including health) was to annex the country – transferring sovereignty (absolute control) to the Crown. For this to occur a Treaty of

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

14 Te K.R.Kingi, (2005), *The Treaty of Waitangi 1800 – 2005,* Presentation to Te Hui Tauira, Waikawa Marae, Picton.

15 http://www.dnzb.govt.nz/dnzb/default.asp?Find_Quick.asp?PersonEssay=1B54 (07/11/05)

cessation (the Treaty of Waitangi) was required. The actual intent behind the Treaty remains an issue of considerable debate and certainly the Crown was not purely concerned with Māori well-being. However, contained within the Treaty is an explicit desire by Her Majesty "to avert the evil consequences that must result from the absence of necessary laws and institutions". References to "Royal Protection" are also referenced within the Treaty and likewise suggest that health problems (as a result of unmanaged colonization) were anticipated.[16]

The potential of the Treaty as a mechanism for Māori health development was certainly evident, though a reluctance to fully implement it restricted its overall effectiveness. By the close of the 19th century, and when reflecting on the population decline the situation for Māori seemed hopeless prompting many to believe extinction was inevitable. In a notable quote Dr Isaac Featherston summed up what was at the time the prevailing attitude and noted that:

> "The Māoris are dying out, and nothing can save them. Our plain duty, as good compassionate colonists, is to smooth down their dying pillow. Then history will have nothing to reproach us with."[17]

Others were more circumspect, suggesting that the population decline was merely a consequence of *natural selection*. Buller suggesting in 1884 that:

> "Just as the Norwegian rat has displaced the Māori rat, as introduced plants have replaced native plants, so the white man will replace the Māori"[18]

Māori entry into the 20th Century was therefore both un-spectacular and somewhat un-expected. The population had reached an all-time low and there was little confidence that in fact this trend could be reversed. Specific Government polices for Māori health were also non-existent, though at the time there seemed little need for them as it appeared inevitable that the race would forever be confined to the pages of history.

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16 C.Orange, (1987), *The Treaty of Waitangi,* Port Nicholson Press, Wellington, NZ.

17 http://www.teara.govt.nz/1966/F/FeatherstonDrIsaacEarl/FeatherstonDrIsaacEarl/en (07/11/05)

18 http://culturalsafety.massey.ac.nz/ChapterFive.htm (07/11/05)

Fortunately, we know that the expected extinction did not eventuate, though this was due neither to good luck nor active Government intervention. More correctly, it was the consequence of an approach and response designed by and targeted at – Māori. In considering these issues, and the 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.[19] 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 of course was the first Māori doctor, while Buck was actually 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 new 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 presented to 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 some 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:

> 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.[20]

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

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

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 in time, new health problems have developed, in a similar way Māori have continued to respond to these.[21] 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. In another sense it also serves as a testament to those that worked so tirelessly in the past, with little support or recognition, but with a fundamental belief the Māori health was inextricably linked to Māori development, Māori culture, and Māori ways of working.

Despite the fact that Māori are no longer under threat of extinction, new health challenges have emerged. As already noted, Māori are significantly affected by diabetes and smoking related conditions, as well, heart disease, obesity, cancer, asthma, and motor vehicle accidents also disproportionately affect Māori – the list in fact is almost endless.[22] However, there is one problem which is of particular concern to Māori and which accordingly appears to be similarly problematic across most indigenous populations. I am of course referring to mental health, or more correctly, mental ill-ness.

MĀORI MENTAL HEALTH

A World Health Organisation report on indigenous mental health states that . For Māori, the situation is similarly concerning leading some to describe mental ill-ness and the single most significant threat to contemporary Māori health development. Māori rates of admissions continue to exceed the non-Māori rates, many Māori also access mental health services under compulsion, via the police or justice system. As result the problems tend to be more acute, more costly, more difficult to treat, and with a greater

21 Ibid

22 School of Māori Studies, (2003), *Māori Health Foundations: Study Guide,* School of Māori Studies, Massey University, Wellington.

chance that the outcomes will be less positive.[23] Māori are over-represented in acute disorders, and are almost twice as likely to be readmitted when compared to non-Māori.[24]

Heavy drug use amongst young Māori, particularly cannabis, has also led to a dramatic increase in drug-related disorders.[25] While there is a dearth of information of meta-amphetamine use, there is evidence to suggest it is of particular concern to Māori.[26] Suicide was almost unheard of in traditional times, but increased by an alarming 162% during the 1980s.[27]

Due to the extent of these problems and the publicity that often surrounds mental illness one could reasonably assume (as with our physical health problems) that these issues have always been a feature of Māori society, that 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 to the problem of Māori mental illness should focus on correcting generic flaws or negative cultural behaviors.

However, there is little evidence to support either of these hypothesizes, 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

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23 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.

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

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

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

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

development of mental health problems (at an individual level) there is little to support an ethnic or racial bias.[28]

MĀORI MENTAL HEALTH RESEARCH

As already described, and despite the contemporary focus on Māori mental ill-ness, problems of this nature are relatively new. We know that historical accounts of Māori health (particularly during the 1800s and throughout most of the 1900s) were focused on physical health problems. One hundred years ago for example, the main threats to Māori health were typhoid, influenza, measles, scarlet fever, diphtheria, tuberculosis, pneumonia, malnutrition, and goiter. A review of the various health reports reveals the magnitude of these problems, though are of additional interest due to the conspicuous absence of any mental health reporting. That is, historical descriptions of Māori health were almost entirely focused on physical health concerns. This of course does not suggest that mental health problems did not affect Māori, however, it does imply that mental health concerns were at least not as significant as physical health problems or were so low that they didn't warrant inclusion or comment.[29]

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.[30] That is, why Māori seemed less susceptible to mental disorder. In this regard the study showed that the overall incidence of mental disorder, amongst Māori, was about a third that of Pākehā and were significantly less in terms of major functional psychotic disorders and war neurosis.

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,

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28 M.H.Durie, (2001), *Mauriora: The Dynamics of Māori Health,* Oxford University Press, Melbourne.

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

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

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.[31]

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."[32]

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 academics some 60 years before. [33]

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

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31 Ibid p. 243.

32 Ibid p. 243.

33 http://pl.net/~keithr/thursday2000.html (21/01/02).

> "...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."[34]

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."[35]

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.[36]

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 centers. 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

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34 Ibid.

35 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.

36 Te K.R.Kingi, (2005), *Māori Mental Health: Past Trends, Current Issues, and Māori Responsiveness,* Te Mata o te Tau Academy for Māori Research and Scholarship, Massey University

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.[37] 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 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 laid-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".[38]

37 http://www.beehive.govt.nz/ViewDocument.aspx?DocumentID=20574 (25/05/05)

38 http://www.listener.co.nz/default,1651,1627,2.sm (25/05/05)

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.[39] 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 behaviors are linked to cultural nuances – even though the behavior itself may in fact show strong cultural tendencies or relationships. That is, just because the behavior 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 behaviors 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.

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39 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.

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, hapü, iwi boundaries and given special status.[40]

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 behavioral factors. As described alcohol and drug related disorders disproportionately affect Māori and reflect an overall pattern of unsafe and unhealthy consumption. Although alcohol was unknown in pre-colonial times, today it has almost become a cultural norm for Māori and appears to be entrenched within many whānau. This can be said for many families, both Māori and non-Māori, but it is the pattern of Māori consumption that is of 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

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

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.

A MĀORI RESPONSE TO THESE PROBLEMS

At this point in the presentation it would be easy to dwell on these problems and to further reflect on what additional issues remain - and indeed there is ample opportunity for this. However, the theme of this symposium is a timely reminder and that while numerous problems in Māori health exist, the Māori response has in many ways been positive, optimistic, and at times inspirational.

A look into the past reveals that despite the challenges faced by Māori and the real threat of extinction, our people refused to accept what many believed to be an inevitable outcome. At the turn of last century, strategies for Māori health were developed and in the face of what must have seemed to be insurmountable odds. The population was at an all-time low - we lacked a health workforce, health resources, health funding, and health technology. Yet, and despite this, Māori leaders in health emerged and displayed a tenacity which eventually saw the population recover, develop, and grow. Certainly, and if it is indigenous inspiration that we are looking for, then we need look no further than to our past.

As I mentioned, and although our population is no longer under threat, new health challenges have emerged. This presentation has focused on the particular issue of Māori mental health, and certainly this remains an issue of particular concern to Māori. Yet, and despite the problems which exist – and the future issue anticipated - Māori continue to respond to these and in a manner which underscores the belief that health and culture are inextricably linked. Further that Māori methods, approaches, systems, and ways of working must underpin strategies for Māori mental health development. A generic approach to mental health is therefore unlikely to meet the needs of Māori and especially if cultural, ethnic, and indigenous perspectives are absent.

This approach is in many ways at odds with what many political commentators would want, and indeed it raises the seminal issue of why culture should be introduced and why Māori should be treated any different to rest of the population. The response to this however is quite simple and that typically when the principle of "treating everyone the same" is applied – then Māori (and indeed our Pacific cousins) are usually the one's that fail to benefit.

It is therefore with some enthusiasm that I look toward the future. This is not because I expect the problems to get any better or because greater support for Māori specific approaches are anticipated. This enthusiasm is derived from an examination of our history and the fact that despite the adversity we face, we have always responded to our health problems in a proactive and positive way. I have no doubt that in the years to come, future generations will likewise be inspired by the work of the present generation and the manner in which we have responded to the issue of Māori mental health.

As a final conclusion to this presentation I would like to consider this ancient tauparapara. It was first shown to me by my supervisor a number of years ago, and while it offers a unique Māori perspective, it has broader implications as well and likewise reflects an indigenous way of viewing the world.

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*
Kia hi ake ana !!	*And let the red dawn come with a sharpened air,*
he ata-kura	*A touch of frost*
He tio, he huka, he hau-hunga.	*And the promise of a glorious day.*

The tauparapara is actually 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 in terms of health development 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 Māori health, mental health, and indigenous development. 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. The theme of Indigenous Inspiration in Health is consistent with this and I have not doubt that we will 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 equality 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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