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Haurite - Balance

**Haurite:
Balancing Generic and Indigenous Approaches to
Mental Health Care:
Māori Experience**

Mason Durie
Massey University

Christchurch

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Beginnings

2004 represents the 150th anniversary of the establishment of the Wellington Mount View Asylum in 1854, the first dedicated psychiatric facility in the country. Although a pauper lunatic asylum had been attached to the Wellington Gaol as early as 1844, and the 1846 Lunatics Ordinance envisaged a public asylum system for all social classes, it was not until 1854 that a purpose built facility was opened. Nine years later the Sunnyside Asylum in Christchurch and the Dunedin Asylum were opened and in 1867 there was another in Auckland. Institutional care quickly became a characteristic of New Zealand's mental health system and because the rates of admission were higher than in England, the Inspector General of lunatic asylums, Inspector Skae, concluded in 1879 that the increased levels of insanity could be attributed at least in part to the excessive consumption of alcohol in the colony.¹ Needless to say the Inspector was dismissed later that year, not for his views about alcohol but because of alleged brutality at Mt. View.

The Tasks of Psychiatry

Although by the mid-1970s asylums had earned reputations as outmoded and oversized institutions that prepared inmates for long periods of confinement but not for life beyond the hospital walls, it is worth recalling that when they were first established, the early asylums were at the forefront of social reform. Imprisonment and death sentences had been a frequent mediaeval fate, insanity being attributed to witches or demons. Even in Europe well into the eighteenth century, persons who developed a psychosis were subjected to the same fate as prisoners. However, moral considerations and humanitarian ideals as well as scientific principles gradually led to a re-conceptualisation of insanity as a type of illness.

At the same time admission criteria to asylums erred on the side of social responsibility, catering for the poor and indigent as much as the sick or disturbed. But the generous admission policies led to some confusion about priorities between the asylum's three competing objectives: the treatment of so called medical conditions

such as insanity, the care of the socially rejected, and custody of those who posed threats to community safety.

Psychiatric practice, at least within mental hospitals, hinged on harmonising those three broad goals. Treatment was largely derived from medical science, though the evidence was not always robust and there was a little too much room for dubious innovation. Hydrotherapy for example, especially when conducted in ice-cold baths was of doubtful value; and much of the evidence for the wide-spread use of electro-convulsive therapy was anecdotal. Care on the other hand had its origins not so much in the discipline of medicine as in religious orders where humanitarian ideals flourished, at least until hospital populations expanded and human dignity was sacrificed for cost-saving management. Safe custody, the third goal had two dimensions. Patients needed protection from a wider social environment that was uncaring and exploitive. But communities also needed to be safe from disturbed people who might offend society's mores, standards, and conventions.

Balancing the three goals was challenging. In 1854 custody and possibly humane care were the major considerations but by the mid 1970s, as mental hospitals began to be replaced by community facilities and general hospitals, psychiatrists placed much greater importance on their skills as doctors (rather than custodians) and treatment was elevated as the prime objective. Custody and care were increasingly seen as marginally related to the core medical goal and a burden that psychiatrists should not be reasonably expected to shoulder. The public, however, saw it differently; they were increasingly worried about (their own) safety and sometimes about the standards of care that many itinerant mental patients were experiencing as they moved from one shelter to another.

Indigenous Pathways

The theme of the 39th RANZCP Congress – *Haurite: Balanace* - provides an opportunity to examine the balance within psychiatry and mental health services from several perspectives, not the least of which is the balance between treatment, care and custody. But by 1980 a further balancing point had been added to the mix: the balance between science and scientifically derived practice, and indigenous knowledge and culturally based approaches to treatment and care.

The Congress takes place at a time when technological advances have transformed mental health services from a set of compassionate and idealistic activities to scientific innovations in diagnostics, treatment, analysis, management and policy-making. At the same time, science and technology are not guarantees of uniformly high standards of care. There is a human factor that cannot be simply reduced to pharmacological opportunities or the mass application of scientific breakthroughs. While technology and science have critical places in modern mental health care and offer fresh hope for the future, human aspirations and beliefs are equally important to the healing process and need to be factored into the health care equation.

In that respect, indigenous health care in modern times is largely about the search for balance between scientific advancement, human spirituality, and world views shaped by long standing associations with the natural environment.

Although transcultural psychiatry had long ago demonstrated that diverse ethnic groups express psychiatric disorders differently and experience specific culture-bound syndromes, the study of culture and its application to psychiatry was essentially euro-centric, viewing ethnicities from the perspective of western philosophies, nomenclature and practices. Over the past two or three decades, however, the significance of culture to mental health and to the delivery of mental health services has been considered from ethno-centric perspectives.² Indigenous peoples have emphasised the importance of their own explanations of behaviour based on distinctive world-views, and have drawn attention to the different understandings that they bring to mental health and to mental health services.

It is now reasonably well accepted that psychiatry cannot be practiced outside the values and attitudes of society, nor can it be adequately understood beyond the cultural norms of a particular group or population. The Draft Declaration of the Rights of Indigenous Peoples also indicates that indigenous peoples should be able to participate fully in society without abandoning their own culture or identity. In the 45 articles covering cultural, spiritual, economic, political and constitutional rights the Declaration has major implications for the terms under which indigenous people will live within states and the way states will recognise indigeneity in modern times.

Indigenous rights, however, are not accepted by all states. Although the Draft Declaration was presented to the United Nations in 1993, it has not yet been ratified and some states maintain that it is inconsistent with the democratic rights that guarantee equal rights to all individuals. Meanwhile, although states may take exception to the Declaration and resist its passage through the United Nations process, it will serve to endorse indigenous aspirations, providing a basis for the internationalisation of indigeneity and a platform for shared debate between indigenous peoples if not between states.³

A second document about indigenous rights had its origins in 1999 when the World Health Organisation arranged an International Consultation on the Health of Indigenous Peoples in Geneva. Arising from the Consultation a *Declaration on the Health and Survival of Indigenous Peoples* was subsequently prepared and presented to the U. N. Permanent Forum on Indigenous Issues in 2002.⁴ Written in five parts the Declaration affirms the basic tenets of the parent *Draft Declaration of the Rights of Indigenous Peoples* but applies them to health. The links between culture, the wider natural environment, human rights, and health are discussed and a definition of health is proposed.

‘Indigenous Peoples’ concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously.’

The Declaration of Health and Survival also recommends strategies to improve health including capacity building, research, cultural education for health professionals, increased funding and resources for indigenous health, a reduction in the inequities accompanying globalisation, and constitutional and legislative changes by states. Broad determinants of health are identified: loss of identity, environmental degradation, community development, culturally appropriate care and ‘war, conflicts and vigilantism.’

In effect the two declarations propose that indigenous peoples should have access to the indigenous world with its values and resources, access to the wider society within which they live, access to a healthy environment, and a degree of autonomy over their own lives and properties. Whether or not the United Nations General Assembly ratifies the declarations, states will nonetheless need to consider how best to recognise indigeneity and the rights of indigenous peoples in a way that is consistent with the rights of all citizens. There is a potential for conflict between the democratic rights of all citizens and the rights of indigenous people. But the rights proposed in the *Draft Declaration* are more correctly parallel rights that enhance the concept of citizenship and extend the notion of human rights by enabling full participation in society, including indigenous society.⁵

Māori Health Development

The indigenous mood over the past two decades has arisen in various parts of the world and has shown remarkably similar themes with calls for cultural revitalisation, reclamation of properties, political autonomy and the inclusion of indigenous values and world-views in key public institutions. Māori have been part of that movement.

In the early 1980s a new approach to Māori policy shifted the focus away from an assimilatory pathway with high levels of state dependency, towards greater autonomy, the development of a positive economy, social equity and cultural affirmation. It was followed by an upsurge in Māori delivery systems across the education, justice, social services, and health sectors and the modification of existing practices to reflect Māori values, networks, and processes. Part of the impetus for change came from alarming social statistics that revealed excessively high Māori rates of incarceration, unemployment, educational failure and hospitalisation.

The evolution of active Māori participation in mental health services therefore coincided not only with the transfer of mental health services from institutional care to community centres, but also with increasing recognition of the significance of culture to mental health, the indigenous rights movement, positive Māori development and Māori over-representation in mental health services. It is possible to identify six phases of Māori mental health development.

In the first phase Māori perspectives of health provided a philosophical basis for health service development. It was followed by a phase during which a number of demonstration projects pioneered the introduction of Māori concepts into mental health services. The amendment of policies and legislation to incorporate Māori-specific objectives was a third phase and in the fourth, there was extensive Māori provider development, across a range of workforce categories. Phase five saw changes to mental health services at strategic and operational levels to accommodate Māori approaches to treatment and care. Still in progress, the sixth phase has seen the development of quality assurance measures.

Māori Health Perspectives

Conceptual foundations for Māori mental health have been provided by several Māori health perspectives. A frequently discussed Māori health perspective is known as Te Whare Tapa Wha, a construct that compares good health to the four sides of a house and prescribes a balance between spirituality (taha wairua), intellect and emotions (taha hinengaro), the human body (taha tinana) and human relationships (taha whānau). The perspective has been used as the basis for policy and planning and has been incorporated into assessment tools, treatment packages, and outcome measures.

Demonstration Projects

By 1984 pioneering Māori health initiatives had been established. Whaiora for example was a mental health facility within the Tokanui psychiatric hospital. It was based on Māori values and philosophies though also incorporated conventional methods of treatment. Similar initiatives occurred outside hospitals in the community, and tribal authorities also developed a range of health programmes in health promotion, disability support (including mental disability), alcohol and drug management, and primary health care. Although the initiatives were tolerated by conventional health services they were not necessarily endorsed by health authorities or professional bodies and were often limited by short term, uncertain funding.

Policy and Legislation

However, when major reforms to the health system occurred in 1993, Māori participation found a more secure future. Māori providers and services would be able to tender for services, and conventional services would be expected to endorse Māori values, beliefs and approaches. Health legislation in 1993 (New Zealand Health and Disability Services Act) and 2000 (New Zealand Public Health and Disability Act) as well as the Mental Health Act 1992 also endorsed the significance of Māori world views to service delivery and required health providers to demonstrate how Māori views would be taken into account. Both the New Zealand Health Strategy and the Mental Health Strategy have also recommended the inclusion of Māori-specific measures to improve Māori health and reduce inequalities in health.

Māori Providers

In the deregulated environment, the number of Māori providers of mental health services rapidly expanded. Hauora Waikato for example, a Māori community mental health service that had evolved from Whaiora, was able to offer a wide range of clinical and support services for inpatients, outpatients, forensic, and long-term clients. Māori workforce development also became a major focus. Te Rau Matatini, an independent body funded by the Ministry of Health spearheads a drive for increasing Māori mental health workforce capacity through increased recruitment, retention and the migration of mental health knowledge and skills to the primary health care sector. Other programmes facilitate Māori entry into the professional workforce. The Henry Rongomau Bennett Memorial Scholarships, named after the first Māori psychiatrist, are intended to foster Māori leadership within the sector, and Te Rau Puawai, a programme at Massey University, also funded by the Ministry of Health provides bursaries to assist Māori undergraduates and postgraduates who are either already working or intend to work in mental health services. All three workforce programmes recognise that Māori mental health workers need to be skilled in order to work effectively at the interface between medical science and indigenous knowledge.

Service Realignment

District Health Boards have taken two broad approaches to addressing Māori mental health needs. Contracts have been awarded to Māori providers for community-based

services – by Māori for Māori - and conventional services have developed protocols that reflect Māori values and communication processes as well as linking more directly to Māori networks. Elders, kaumātua are sometimes employed to oversee cultural interventions and there have been deliberate efforts to employ qualified Māori staff as well as Māori support staff.

Quality Assurance

Having greatly expanded Māori participation in the delivery of mental health services, there has been a more recent focus on quality and the development of quality assurance measures. While global and national measures have a place there has also been interest in developing measures that can reflect Māori values and world-views, as well as clinical progress. For example, an outcome measure, Hua Oranga assesses the results of mental health interventions by measuring impacts on spirituality, emotions and intellect, physical health, and the quality and quantity of social relationships. It adopts a triangulated approach and collates responses from patients, clinicians and family.

Impacts

The emergence of an indigenous mental health pathway has exposed a number of tensions between the two approaches with concerns about the way mental health services are construed and delivered. Some providers and consumers are questioning the use of a diagnostic manual such as DSM IV as an appropriate basis for addressing mental health problems. Once outside the categories of psychosis, depression and anxiety, the relevance of the clinical diagnostic system is less obvious, and often conflicts with cultural understandings. Nor is it totally accepted that mental health problems can be best understood as a series of illnesses or disorders, rather than, for example, micro- and macro- breakdowns in human and environmental relationships.

Tension between cultural approaches and clinical approaches has sometimes led to divergent pathways even within the same service. Although the two dimensions can jointly contribute to a more comprehensive understanding, and a management plan that makes more sense to patients, they are not infrequently introduced independently of each other, a practice that allows for fragmentation and confusion.

The introduction of indigenous perspectives and practices into services has also brought extra demands on mental health services. Aligning perspectives, priorities, and cultural as well as clinical inputs, has often been challenging since it has required balancing generic service delivery against targeted approaches to specific populations. On this point there is ongoing political debate. Champions of neo-liberalism argue that mental health is colour blind and individuals should be considered entirely on the basis of need without recourse to consideration of ethnicity or race. However, that view overlooks evidence from medicine and psychiatry suggesting a strong link between illness and ethnicity. In order to understand, assess and respond to need, an understanding of the ways in which need is expressed requires an appreciation of cultural nuance and cultural styles of communication, especially in the practice of psychiatry where physical evidence (such as blood tests) is not always very helpful. Admission and discharge data, as well as epidemiological data show that mental disorders are not evenly or randomly distributed within the population but are experienced disproportionately by some groups. In many developed countries, indigenous populations are over-represented in psychiatric facilities.

While there has been some call for health policies that are race and colour-free, the reality is that ethnicity, race and colour are very much part of the New Zealand epidemiological pattern. Māori patients for example are more likely to be admitted to an inpatient unit (63% for Māori, 33% for European). Pacific inpatient episodes have an average weight that is 35% above the national average while Māori have a weight that is 22% above average.⁶ Contrary to ideologies of services based entirely on individual need, socio-economic factors by themselves do not explain health disparities between indigenous peoples and non-indigenous populations. For example when Māori and non-Māori at the same levels of deprivation are compared, Māori health status remains lower than non-Māori. Justification for a Māori mental health policy is therefore supported by case mix, population characteristics (including socio-economic factors), and epidemiological evidence. There is also a persuasive case for recognition of indigenous peoples as distinct populations simply on the basis of indigenous right.

A Framework for Considering Quality Health Care for Māori

In the sixth phase of Māori health development, quality is a major focus and a quality care framework has been developed based largely on the Māori experience.⁷ It is a useful way of conceptualising the components of quality care and provides a basis for assessing progress. The framework encompasses three goals, a set of principles, three pathways and performance criteria.

Goals

Three goals for quality mental health care have been identified. The first concerns equitable access. Quality health care depends on services that are accessible. Financial, geographic, cultural, and information barriers can present formidable obstacles to care, especially if they are cumulative. In addition, Māori access is sometimes also blocked by exclusion criteria especially if they are based solely on likelihood to benefit from an intervention, or previous non-compliance with treatment. Inadequate access to primary health care or late entry into primary health care is a further significant barrier to effective mental health interventions.

A second goal, the promotion of human dignity, is concerned with the process of care. Interventions that do not afford due respect for human values, cultural world views and differing health perspectives, will undermine dignity and diminish self respect. In an outcome-driven environment, health care must also be concerned with the processes that lead to desirable outcomes and the ways in which best practice guidelines can be used to bolster human dignity.

Third, however, a goal of quality health care is to produce the best possible health gains measured against reliable benchmarks that accommodate differing health perspectives. Quality mental health care is not the same as patient satisfaction. Treatment might be appreciated and well received but unless it also produces health gains, it will be of limited value.

Principles

Three key principles for quality mental health care have been acknowledged by Māori over the past two decades: indigeneity, clinical expertise, and cultural competence.

The principle of indigeneity takes into account the determination of indigenous peoples to retain their own distinctive cultural identity, avoid assimilation and exercise a degree of autonomy. This principle goes beyond cultural recognition to assert a special place for indigenous peoples in the life of the nation. The principle of indigeneity does not mean other cultures should not also be duly recognised in health care, but it does acknowledge a unique position for indigenous peoples.

Clinical expertise is a second principle. Māori as much as other New Zealanders expect the best possible treatment using methods that have been adequately tested. They also expect that they will not be subjected to unnecessary interventions and will have access to new technologies and developments benchmarked against the best in the world.

Cultural competence, the third principle, suggests that health care workers should be competent at the interface between their own culture and the culture of others. Language barriers, differing codes for social interaction, variable community expectations and a willingness to involve friends or families in assessment, treatment and rehabilitation make important differences to the way care is experienced and the results it generates.

Pathways to Health

There is no single route that will satisfy the wide range of Māori health needs and three health pathways have been identified: Māori centred pathways, Māori added pathways and collaborative pathways.

Of three possible pathways a Māori centred pathway is one that is largely under Māori direction and has an obvious focus on increasing access and human dignity. In these pathways Māori cultural revitalisation is a parallel goal and Māori centred pathways are also closely linked to Māori communities tending to be aligned with the broader goals of Māori development as much as the goals of the health sector.

Most Māori are not cared for in Māori centred services. Instead they attend generic community hospitals, clinics and health centres. However, they might reasonably expect that a Māori dimension will be added to the treatment package, wherever it is

offered. The added Māori dimension may be symbolic (Māori signage for example) or an integral part of the treatment process. Some argue that it is too little, a token, while others complain that it is too much and forced on the wider population for little purpose. But, compared to 1984, there has been a major attitudinal shift and a demonstration that a Māori agenda can be accommodated and even encouraged within conventional health services.

A third pathway is concerned more with collaborative rather than solo effort. The collaboration might be between a Māori health service and a primary health care centre, or between a hospital and a Māori disability support service, or between a conventional mental health unit and a Māori community health team.

Institutional loyalty is a value worth promoting; but institutional solitude may not be in the longer term interests of clients or whānau. The collaborative pathway seeks to create a total picture out of several parts. It may well count against the ideological aims of absolute Māori independence or the conservative insistence on professional leadership, and it could be costly. But if excellent outcomes benchmarked against the best in the world are the aim, then increasingly collaboration of effort will become an integral pathway to quality health care.

Performance

In order to support high quality health performance for Māori, it has become apparent that three preconditions are necessary. First the legislative and policy framework must endorse best practice by recognising aspirations and involving Māori in decision-making, priority setting and service planning.

Second, without a skilled workforce, quality care will never be possible. Māori workforce development has three main objectives: the promotion of cultural competence in the wider workforce, the expansion of the indigenous health workforce across professional disciplines, and the training of mental health workers who have no formal qualifications. In all cases, the goal is a workforce that has both clinical and cultural skills.

Third, there must be measures that can reflect Māori world-views and realities. It is not sufficient to observe cultural practices and perspectives in the workplace without also ensuring that they can be measured in key result areas, using relevant targets and indicators - outcome measures, service performance measures and criteria for entry into treatment or care.

The Twelve-Point Framework

Twelve points relating to a framework for Māori mental health have been discussed:

- three goals: equitable access, human dignity, best health outcomes;
- three principles: indigeneity, clinical expertise, cultural competence;
- three pathways: Māori centred, Māori added, collaborative;
- three progress indicators: legislative and policy framework, workforce capacity, indicators and measures.

The framework can also be represented as a matrix (see Table 1): the horizontal axis contains the broad goals – equitable access, human dignity, best outcomes - and the vertical axis contains the principles, pathways and performance indicators.

The Māori mental health quality framework has been constructed on the basis of Māori experience over the past two decades in order to facilitate the search for balance between generic mental health services and health services that are specifically targeted towards Māori and other indigenous populations.

Whether the new approaches to mental health care for Māori can be translated into health gains is of major importance. While definitive studies have yet to be undertaken, anecdotal evidence suggests that there have been improvements in early intervention, better follow-up, and reduced inpatient bed stays. Of equal importance, however, is the degree to which Māori health awareness has been raised. Active participation within the mental health sector by Māori providers, consumers, and advisors has been accompanied by a level of enthusiasm that augers well for positive change.

The Māori experience has been one of innovation and enthusiasm though has also endured a fair share of trial and tribulation. It has, nonetheless, led to a sense of reclamation of responsibility for health and to a large extent, has retrieved some of the leadership from professionals. At the same time apart from gains to Māori health, indigenous participation in mental health and mental health services has contributed much wider benefits, including benefits to the science of mental health, benefits to the way in which services are delivered, and greater balance in the practice of psychiatry.

Table 1

Goals →	Equitable access	Human dignity	Best outcomes
Principles indigeneity clinical expertise cultural competence			
Pathways Māori-centred Māori-added collaborative			
Performance policy frameworks workforce capacity indicators & measures			

¹ E. Cunningham Dax, (1975), 'Australia and New Zealand', in Howells (ed.), *World History of Psychiatry*, Bailliere Tindall, London, pp. 723-5.

² Durie, M. (2001), *Mauri Ora The dynamics of Maori Health*, Oxford University Press, Auckland, pp. 48-60.

³ K. S. Coates, (1998), 'International Perspectives on Relations with Indigenous Peoples', in Coates, K. S., McHugh P. G., *Living Relationships Kokiri Ngātahi The Treaty of Waitangi in the New Millennium*, Victoria University Press, Wellington pp. 34-40.

⁴ Committee on Indigenous Health (2002), *The Geneva Declaration on the Health and Survival of Indigenous Peoples*, United Nations Permanent Forum on Indigenous Issues, New York.

⁵ Mason Durie, (2002), 'Universal Provision, Indigeneity and the Treaty of Waitangi', Carter D. Palmer M. (eds), *Roles and Perspectives in the Law Essays in Honour of Sir Ivor Richardson*, Victoria University Press, Wellington, pp. 167-96.

⁶ P. Gaines, A. Bower, B. Buckingham. K. Eagar, P. Burgess. J. Green, G. Mellsop, (2004), *Mental Health Classification Outcomes Study: Brief Report*, Health Research Council, Auckland.

⁷ Mason Durie, (2003), *Quality Health Care for Indigenous Peoples: the Māori Experience*, paper presented at the 3rd Asia Pacific Forum for Quality Improvement in Health Care, Auckland.