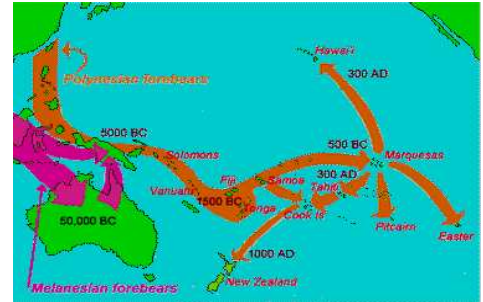


Extracts from the Te Iho Website (interim information until website reconstructed)

History and the Treaty of Waitangi **Exploration and Discovery**

The Polynesian people who were to become New Zealand Māori discovered and settled New Zealand between 950 and 1130 AD. Māori oral history tells that they sailed to Aotearoa in groups of great seagoing outrigger canoes or waka - these waka giving rise to the various iwi or tribes. The mythical Māori homeland is said to be Hawaiiki and Māori tradition tells of Kupe, one of the great Polynesian navigators, who set sail from Hawaiiki in his waka Mata-hou-rua. He is said to have sailed first into the Wellington area, perhaps around the year 925 AD. After spending some time in New Zealand, Kupe is said to have returned to Hawaiiki, describing Aotearoa as "a distant land, cloud-capped, with plenty of moisture, and a sweet-scented soil". The first Polynesian arrivals later settled in the far north of New Zealand, at Hokianga.



DNA analysis has shown that New Zealand Māori migrated from Asia through the Philippines, Indonesia, West Polynesia, East Polynesia and finally to New Zealand. Linguistic analysis shows that the languages of indigenous peoples from Madagascar, Easter Island, Taiwan, Vietnam, Northern Australia, New Zealand and most of the Melanesian and Polynesian Islands have many words in common.



Māori initially lived in kainga (small unfortified settlements), then in the last 500 years before colonisation in larger fortified settlements, or pas. The staple food was kumara (sweet potatoes) augmented by other vegetables and fish and by shellfish, birds and eels, and in the south, moa and seal meat. The move to larger fortified settlements partly occurred as tensions arose over rights to land and areas rich in

food resources, with raids and reprisals between tribes. Tribal boundaries were defined by major landmarks such as sacred mountains and rivers, hence the importance of these in whanaungatanga today.

In 1642 Dutch explorer Abel Tasman sailed into New Zealand waters. The first landing party met violence on encountering local Māori near Golden Bay in Marlborough. After partially charting the coast from near Hokitika to the tip of the eastern North Island, Tasman left New Zealand without ever himself having set foot ashore. The name Nieuw Zeeland or Zealandia Nova became established by 1648 and is of Dutch origin, linked to the Dutch East India Company's name for Australia of Nieuw Nederland or Hollandia Nova. At first there was no Māori name which referred to the whole of New Zealand. The name Aotearoa came into use after the arrival of Europeans, and may initially have applied largely to the North Island, while the South Island was known as Te Wai Pounamu ("the greenstone waters").



100 years passed before James Cook - a British explorer, and Jean François Marie de Surville - commander of a French trading ship - both arrived in New Zealand in 1769. The two ships passed nearby but unseen, during a storm. De Surville's crew were in poor condition from scurvy and landed in the Hokianga to refresh supplies, eventually leaving hurriedly after an altercation with local Māori when they captured a local chief, Ranginui. De Surville later drowned near Peru and Ranginui died from scurvy. Cook's was a more organised expedition, with Tupaia, a Tahitian priest and chief, as cultural advisor, and included Joseph Banks as botanist, Daniel Solander as naturalist, and Charles Green from Greenwich Observatory. Cook arrived at Poverty Bay then circumnavigated New Zealand in a figure-eight from North to South Islands, charting most of the coastline in under six months.

Annexation and the Treaty of Waitangi

From the late 1790s on, whalers, traders and missionaries arrived, establishing settlements along the coast. With the arrival of their ships in the Bay of Islands, northern tribes were able to trade flax, kumara, fruit and wild pig meat for muskets. Soon other tribes followed suit and all the northern tribes were armed. Between 1820 and 1835 the inter-tribal "musket wars" led to a large scale redistribution of the Māori population, and unscrupulous captains aided warlike Chiefs such as Te Rauparahau in long-range raids decimating South Island Māori as well.



Early European New Zealand was largely a series of lawless whaling and trading towns filled with drunkenness, prostitution and violence, with chaotic and illegal land deals abounding. Baron de Thierry persuaded local chiefs to sell him 40,000 acres of Hokianga land for 36 axes and later talked of setting up an independent state there. Māori population around the first capital Kororareka in Northland dropped sharply due to disease and violence. Concern about the deteriorating situation in 1831 led to thirteen Northland chiefs backed by the Church Missionary Society asking Britain to intervene. The British decision was influenced by rumours of French colonial intent and pressure from the New Zealand Company. James Busby, the initial Official British Resident from 1833 was replaced in 1838 by Captain William Hobson whose mission was to organise a treaty and persuade Māori chiefs to accept British sovereignty over the country. The intent was in theory to protect Māori from unscrupulous land sharks taking advantage of the chaos, and to ensure the safety of 2000 settlers.



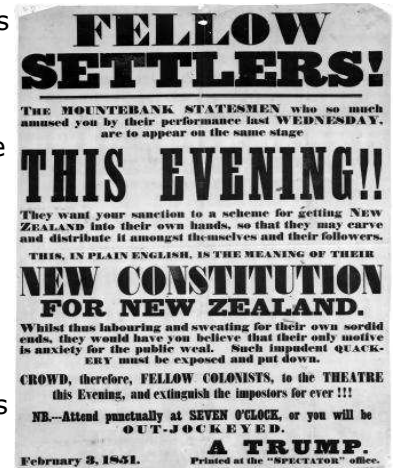
The Treaty of Waitangi was finally signed on 6th February 1840, after a two-day hui at Waitangi. Some chiefs in favour of the Treaty were Rawiri Taiwhanga, Hone Heke and Tamati Waka Nene. In the end Tamati Waaka Nene of Hokianga spoke out in favour of the Treaty. He reminded Māori of the destructive intertribal warfare and spoke of the benefits of living in harmony with Pākehā with peace and order for European and Māori. He asked Hobson to preserve Māori customs and to stop Māori land from being stolen. The chiefs signed the Treaty, and New Zealand became a British colony.

Not all chiefs were present at Waitangi and Hobson travelled until 3rd September to gather more signatures. In all, over 500 chiefs signed, although a number of important Chiefs refused to sign the Treaty, including Te Wherowhero of Waikato, Taraia of Thames, Tupaea of Tauranga, the Te Arawa of Rotorua and the Ngati Tuwharetoa of Taupo. Despite the good intentions inherent in the Treaty, it was largely ignored for many years and only from 1989 have greater powers been given to the Waitangi Tribunal, which can now pronounce sentences on Treaty claims to redress injustices breaching the articles of the Treaty. As a result, the national holiday Waitangi Day stirs mixed feelings and has been a focus of activism.

From the beginning, Hobson experienced difficulties with many settlers who disliked the Treaty. They objected to Hobson's plan to make Auckland the capital instead of Port Nicholson at Wellington, the base of initial New Zealand Company settlement. Land owners objected to Hobson's offer of higher wages to labourers for work on government buildings in the north. The settlers felt Hobson was too pro-Māori in adhering to the conditions of the Treaty of Waitangi. They balked at British rule and wanted self government. Hobson died in office in September 1842.

Captain Robert FitzRoy succeeded Hobson and difficulties with the settlers continued. They complained that FitzRoy continued Hobson's 'pro-Māori' policies. In addition to this, the Governor's Office Fitzroy inherited was bankrupt and the New Zealand Company in London also experienced severe financial problems leading to discontent among the settlers. Those who had bought land from the Company found they were unable to have it properly surveyed. Labourers who had emigrated on the promise of employment and pay found themselves jobless.

FitzRoy's relations with the settlers came to a head with accusations concerning his 'pro-Māori' policies. The settlers demanded that Britain recall FitzRoy and were supported by New Zealand Company allies. Māori were also beginning to regret the annexation of their land, and to express discontent. Relations between Māori and the settlers deteriorated further and the administration began to force Māori to sell land at low prices, reselling to settlers at much higher prices.



Governor George Grey, an army officer, was nominated as FitzRoy's successor in 1845. The British Government granted subsidies and stabilised the Colony's finances. Grey began to purchase land from Māori on a large-scale basis. Edward Gibbon Wakefield was the founder of the New Zealand Company. The British Government had bailed out the New Zealand Company financially and the Company purchased the Canterbury Plains, with 3,500 immigrants settling some of the finest pastoral land in New Zealand. In 1875 the settler-run provincial system of government gave way to a centralised national bureaucracy based in Wellington.



Edward Gibbon Wakefield

Apart from gold miners from Australia and America during the Otago gold rush era of 1861, the majority of European settlers were from Great Britain: England, Scotland and Ireland. This group made up approximately 40% of the Europeans in New Zealand in 1886. They were principally from lower and middle-class labouring backgrounds. After this group came Germans and Scandinavians with Asian and southern European immigrants. Several hundred Dalmatians from today's ex-Yugoslavia settled in North Auckland during the 1890s. Later arrivals have included Pacific Island peoples, Asian, South African and Yugoslavian immigrants.

The New Zealand Wars

From 1843 the first confrontations of The New Zealand Wars erupted. These were a series of hostilities fought by Māori, the British Army and European settlers and militia, between about 1843 and 1881, in various places across New Zealand. They started in 1843 when violence followed a confrontation over disputed land in the Wairau Valley, Nelson, then in 1845 Hone Heke attacked Kororareka.



Hone Heke falls the flagstaff at Kororareka

In the 1850s, growing discontent with the continuing sale of land led to a group of tribes in the Waikato area forming a federation and then electing a King in 1858. In 1860 the Taranaki Wars began, the British hoping to break the King movement. A massive invasion of the Waikato by British troops from 1863 was the defining engagement. Other areas in conflict included the Hutt Valley, Wanganui and Tauranga, with major battles fought at Gate Pa and Te Ranga.

War spread throughout Taranaki in the 1860s.

In the mid 1860s Pai Maarire followers believed that their mission was to evict all Pākehā.



Charismatic leader Te Kooti from Poverty Bay was imprisoned in 1866 on the Chathams, where he established the Ringatu faith. He escaped in 1868 in a captured schooner and was hunted by Government forces, finally finding sanctuary at Te Kuiti with the Māori King. In 1891 he was finally given an area of land at Wainui, where a marae for the Ringatu church was established after his death.



Pa Maarire ceremony at Tataroa, 1865

The prophets Te Whiti and Tohu were based at Parihaka and this settlement passively resisted land sales and settlers for many years, until 1881 when Parihaka was invaded by the British and half destroyed. Te Whiti and Tohu were exiled for some time to the South Island.

For more information on injustices leading to the New Zealand Wars, see the [Identity](#) pages. This has been an inadequate and cursory overview of the complex campaigns of the New Zealand wars. The overall outcome, as was doubtless inevitable for an indigenous people facing a better armed and equipped major world power, was that the European forces prevailed. However, Māori became renowned as fierce and intelligent fighters, often successfully adopting guerilla tactics, and their innovations in pa-based and trench defenses and warfare were revolutionary. For a detailed and fascinating account, see *The New Zealand Wars* video series by Professor James Belich, from the University of Auckland's History Department. It appeared on New Zealand's TV1 in 1998.

Social and Cultural History

Te Reo Māori:

After 1847 schools were required to teach in English in order to receive state subsidies. The use of the Māori language in schools was actively discouraged in order to encourage assimilation of Māori into European culture as rapidly as possible. By 1896 the Māori population had declined sharply and it was confidently assumed by Europeans that the Māori race would be assimilated and simply disappear. This did not occur, but by 1960 only 26% of Māori spoke Māori as their first language. Thanks to the campaigning efforts of Sir Apirana Ngata, Māori language became a university subject in 1951. Later, the third Labour government established teacher-training schemes for native Māori speakers and from 1976, courses in Māori were included in the curriculum of 5 universities and 8 teacher training colleges. In 1981 the first kohanga reo ("language nest") pre-school Māori language immersion programme was established, led by Māori women. The aim was to make every Māori child bilingual by the age of 5. By



Sir Apirana Ngata on the \$50 note

1994 there were 809 kohanga reo established. In 1985 the Waitangi Tribunal declared the Māori language to be a taonga, to be protected under the Treaty of Waitangi. In 1987 the Māori Language Act declared Māori as an official language of New Zealand. The Māori Language Commission was also established to promote Māori as a living language. The Broadcasting Act 1989 reinforced the promotion of Māori language and culture and radio and television stations have been established, by Māori and for Māori, and in the Māori language. Each year, a National Māori Language Week is held.

Health, Welfare and Education:

In the early days of colonisation Māori were killed by disease, poverty, muskets and the New Zealand wars. Tuberculosis was



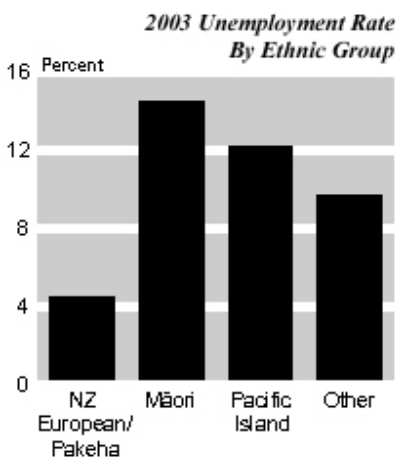
Maori hut: conditions felt to contribute to tuberculosis

common and by 1896 the population had dropped to about 42,000. In 1900 The Māori Councils Act created public health programs. Three Māori leaders were prominent in bringing about improvements in Māori health: Apirana Ngata (a lawyer and the organising secretary of the Māori Councils), Maui Pomare, a doctor who became the first Māori Health Officer in 1900, and Peter Buck, also a doctor, assistant to Maui Pomare. These three leaders brought about significant improvements in Māori health and quality of life. They were educated at Te Aute College and all three were later knighted. The Reverend Samuel Williams, a missionary's son, established Te Aute College in 1854, a church boarding school for Māori. Later, students from Te Aute College formed the Young Māori Party in 1902. The aims of the Young Māori Party were to seek co-operation and partnership with Pākehā so as to bring better healthcare and education to Māori.

In 1920 Peter Buck was nominated first Director of Māori Hygiene. Many reforms in the area of Māori health were achieved. The national school syllabus became the same for both Māori and non-Māori children in 1928. From 1935 The Labour Government increased spending on education, and secondary education became free, with the school leaving age raised to 15. Apirana Ngata became Native Minister and helped pass legislation to assist Māori farmers. In 1933 legislation was passed for relief of unemployment and The Social Security Act of 1938 introduced the 'Welfare State' proper. In 1946 a Family benefit of £1 per week was made universal. Health Services improved. The construction of State houses for Māori increased, until by 1951 3,051 homes had been constructed, representing 16% of Māori houses. Rent was scaled according to income, and the Fair Rent act was passed. The Factories Amendment Act of 1936 reduced the manufacturing week to 40 hours.



political poster about the Labour Government's Housing policy



The importance of Māori identity and culture has gradually been enhanced in a number of institutions such as creation of a Minister of Māori Affairs and Māori Deputies, The New Zealand Māori Council, The Māori Women's Welfare League and the Māori Education Foundation. Nearly all cities have Māori cultural festivals and kapa haka societies are common in schools. In 1996, there were fifteen Māori MPs out of 120, the highest number of Māori MPs on record. The process of developing specifically Māori institutions and departments has not been easy or free from controversy. There have been high-profile scandals regarding alleged misuse of funds or inefficiencies in the development of Māori structures and Government-funded services. As with all media, New Zealand news services tend to focus on any bad news and ignore quiet achievements, and perhaps also tend to highlight mistakes or misuse of funds more where these are linked with Māori services, rather than with non-Māori institutions.

There remains much to address. In the early 20th Century, most Māori were a source of cheap, replaceable rural labour. In the Great Depression many agricultural workers were laid off and 40% of the unemployed were Māori, with 75% of Māori men unemployed by 1933. Even by the 1950s the majority of the Māori workforce were unskilled and economic hardship was acute. Only 6% of Māori held qualified positions, and not until the latter part of the 1960s were training programs and hostel accommodation established in the cities. Many Māori moved from rural areas where work was scarce and poverty common, to find work in the cities. This led to loss of connectedness with iwi, marae and whānau, increasing alienation and problems with alcoholism, drug abuse, intra-familial abuse, imprisonment and psychological disorders especially from the 1970s onwards.



See the [Reparation and Renaissance](#) pages for more details on the positive changes which have

occurred. Many iwi now run their own health programmes and there is a mixture of separate development and of Māori services integrated into the public health system. There are however still serious inequalities in Māori health and Māori mental health status, compared with the non-Māori population.

See the [Epidemiology](#) sections for more detail on this.

The legacy of Colonial injustice has affected several generations, and is not likely to be rectified in a single generation.



Progressive Loss of Maori Identity

Loss of Land: the ancestral heritage

The New Zealand Wars occurred ~1843-1881. They were precipitated by a number of factors, not least of which was unjust legislation designed to wrest land from Māori. In 1863 two Acts of Parliament the New Zealand Settlement Act and the Suppression of Rebellion Act were passed. Under these the government gave itself powers to confiscate traditional lands. Tribes who actively or passively resisted surveyors or sales were called rebels and their lands confiscated. Over 3 million acres of land were taken in this way. Other laws were passed specifically to speed up sales and transfer ownership from tribal collectives to individuals. The Native Land Acts of 1862 and 1865 largely removed customary land titles, freeing up land for sale and undermining the social links between families and in tribes. Traditional lands also meant ancestral links so maintained spiritual well-being. Māori society had depended on common interests in traditional lands for cohesion and purpose. As land was transferred through one means or another, so Māori identity and well-being were progressively damaged. Out of nearly 66.5 million acres, by 1890 only 11,000 acres remained in Māori ownership

Loss of Tino Rangatiratanga: Political Autonomy

The 1852 NZ Constitution Act gave the right to vote to European men who owned property. Communally owned land did not qualify thus Māori men were denied the right to vote. The 1867 Māori Representation Act then set up 4 Māori parliamentary seats as a means of removing the threat of Māori having a majority vote in electorates where some individual land titles had been purchased. In 1875 the provincial system of government was abolished. Māori were disenfranchised politically by the development of a centralised national bureaucracy. Rural isolation led to the majority of Māori being excluded from the government's political processes. As the pace of land alienation increased, so did Māori reliance on seasonal labour so as to supplement a declining resource base. Most Māori were relegated to a working underclass. Many were a source of cheap replaceable labour, primarily in rural areas. In the 1930s Great Depression, agricultural labourers were among the first to be laid off and it is estimated that 40% of unemployed were Māori, with 75% of Māori men unemployed by 1933.

Loss of Taha Tinana: Physical Health and Well-being

By 1900 the Māori population had dropped to around 40,000 and Europeans in power are quoted as seeing their task being not to address this but to "smooth the pillow of a dying race". Over 100 years, travellers and settlers had brought measles, influenza and tuberculosis, decimating the population. The Land Wars hastened this trend and caused demoralisation. The influenza pandemic of 1918 took a further great toll, with newspapers of the time reporting Māori lying dying in the streets. Māori generally lived in poor housing conditions conducive to infection, with little access to or trust in European medical care. Their native healers (tohungas) had been suppressed by law. Matters have improved but the relative health status of Māori remains poor. Hospitalization rates for cervical cancer among Maori women are 3-4 times more than in non-Māori. Life expectancy is 67.2 years for Maori men and 71.6 for Maori women, compared to 75.3 and 80.6 for non-Maori men and women. Factors that contribute are relative poverty, poor diet and high smoking rates, higher in Māori women than in men.

Loss of Taha Hinengaro: Mental and Emotional Health and Well-being

For complex reasons (see the Health & Mental Health pages) mental disorder rates have markedly increased since 1975. This despite Māori rates of some health problems (heart disease & infant mortality) declining. Late presentation for treatment is a significant reason for higher acuity levels. 38% of Māori referrals come from law enforcement or welfare services. In 1999, Māori youth suicide rates were 42/100,000 (male) & 19/100,000 (female), with non-Māori rates of 28/100,000 (male) & 13/100,000 (female). Deliberate self-harm rates are especially elevated in young Māori women. The multiple stressors on Māori identity and self-esteem described elsewhere have resulted in higher rates of substance abuse and gambling. There are higher psychiatric admission rates, more commonly for drug and alcohol use and psychosis, and more use of compulsory treatment and intramuscular antipsychotic medication in Māori patients. The diagnosis rate of schizophrenia in Māori is 2-3 times greater than non-Māori. In addition, prisons contain high rates of Māori inmates suffering from mental disorders.

Loss of Te Reo: the near destruction of the Māori Language

From the signing of the Treaty of Waitangi in 1840, the British colonial office and the settler government were determined to "civilise" Māori by assimilation into European culture. Schooling was seen as an effective means to achieve this agenda. From 1880 official attitudes to any use of Māori hardened and schools were instructed to "actively discourage Māori beliefs and practices and replace them with European beliefs and values". It became policy to prevent children from speaking Māori in school grounds and to punish any who did. This led to the inevitable decline of Māori as a commonly spoken language. In his book *Mauri Ora*, Mason Durie notes: "In the 1995 National Māori Language Survey only 8% of the surveyed population were highly fluent speakers and a number of concerns were raised about the viability of the Māori language. Relatively few domains of usage were reported, mainly *kōhanga reo* and the *marae*, and there was a distinct threat that Māori would become a language of ritual and symbol only."

Loss of Tikanga Māori: Traditional Beliefs and Customary Practices

These were eroded on many fronts. Mason Durie notes: 'Māori adoption practices, based on a collective approach to childcare, were all but prohibited. ...the greatest blow to the organisation of Māori knowledge and understanding occurred in 1907 when the *Tohūnga Suppression Act* was passed. By outlawing traditional healers, the Act also opposed Māori methodologies and the legitimacy of Māori knowledge in respect of healing, the environment, the arts, and the links between the spiritual and the secular.' 'In a current longitudinal study...about one-third of all Māori have little or no contact with a *marae*. Nor do more than one-quarter possess...even minimal knowledge about *whakapapa* or tribal history...the level of alienation of Māori from their own resources is severe.' 'In response to colonisation .., Māori identities were often ..reconfigured in a fatalistic light....Urbanisation decided the issue for many post-World War II city migrants. No longer exposed to tribal homes, a loss of culture, traditions and language gave way to 'alcohol drugs and crime'....negative identities accompanied by deculturation have been recognised as causes of mental ill health..'

Loss of Taha Wairua: Spiritual Well-being

In 1907 the *Tohūnga Suppression Act* was passed. "By outlawing traditional healers, the Act also opposed Māori methodologies and the legitimacy of Māori knowledge in respect of healing, the environment, the arts, and the links between the spiritual and the secular" (Mason Durie). As these traditional healers went underground considerable knowledge was lost. Changes in socioeconomic circumstances, population, family structure and modern living have markedly affected traditional spiritual practices. Urban Māori find it more difficult to return their dead to an ancestral *marae*. Urban funeral homes often do not meet Māori needs but private homes are too cramped for all attending so inhibit open expression of grief. Rigidity or inefficiency of health services has caused great distress to traditional Māori for whom early retrieval of a relative's body is critical to spiritual practices. At a more fundamental level, close ties with traditional lands created a harmony with nature and *tūpuna*(ancestors) that maintained spiritual health, and these have been lost for many disenfranchised, alienated Māori.

Loss of Whānau ties: Family and Social Relationships

Extended *whānau* ties in traditional Māori society were alien to the European settlers. In the 1860s there was talk of eradicating "the beastly communism of the Māori race". Traditional structures were over-ridden and ignored, e.g. Māori adoption practices, based on a collective approach to childcare, were all but prohibited and welfare agencies routinely removed children to foster care. Traditional *whānau* and *hapū* had a modifying effect, intervening if abuse occurred in a particular family. Urbanisation and colonisation led to alienation from *marae*, *whānau* and *hapū* supports, nor did urban Māori know their genealogies. Māori families moved to nuclear units where small houses made it hard to maintain the extended family. Worrying rates of divorce, separation and abuse, especially of women and children, are reported - allegedly the legacy of colonisation from loss of extended family supports. One view is that the breakdown of any community will be reflected in abuse of the aged, women and the young. When a community and its culture feels isolated, irrelevant and powerless, anger and frustration are taken out on the most vulnerable members of that community.

Reparation And Renaissance

Activism, Reparation and Reform

Despite policies encouraging assimilation, indeed passive extinction, in the late 19th century, Māori did not die out. Following World War II there was considerable Māori rural-urban drift, but also a gradual decline of assimilationist views - however New Zealand remained essentially monocultural, with Māori largely marginalised. The Māori Renaissance movement from the 1970s (see below) was associated with greater political activism - Land Hikois (protests) in 1975 and 1979, the occupation, eviction and settlement of Bastion Point, Donna Awatere's drive for Māori sovereignty and the protests and riots of the 1981 Springbok tour being examples.

Urban Māori, previously alienated and isolated, are increasingly socially and politically organised and have begun to be recognised as effectively forming and having the rights of traditional tribal groups. Parties representing Māori such as Mana Motuhake have arisen, and although not successful overall, have perhaps strengthened the ties between government and Māori, with greater powers (as below) to the Waitangi Tribunal, and the Devolution programme, aimed at restoration of land where possible, or adequate compensation.

In an important gesture, Queen Elizabeth II publicly apologised in 1995 for the actions of previous governments against Māori. In 1995, and after protracted litigation and negotiation a Tainui tribe, Waikato, concluded a Raupatu (confiscation) Settlement with the Government and gained a measure of economic power. The agreement resulted in a monetary settlement and the return of land (only a small amount of that taken via the New Zealand Settlements Act). The total value of the settlement was \$170,000,000. The Tainui people had long had a distinctive political movement known as Kingitanga (the Māori King Movement) which has Te Arikinui Dame Te Atairangikaahu as the Māori Queen.

The Treaty of Waitangi Act was passed in 1975, establishing the Waitangi Tribunal, so as "...to make recommendations on claims relating to the practical application of the Treaty and to determine whether certain matters are inconsistent with the principles of the Treaty." Hopeful as this was, the Tribunal seemed largely powerless until the mid 1980s. In 1984 however, the Tribunal decided against the interests of Industry and made a recommendation for the iwi in the Waitara case, where traditional Maori fishing grounds were being polluted by industrial waste: an infraction of the Treaty. While the government initially rejected the recommendation, after public pressure it was forced to uphold the Tribunal's recommendations.

The Tribunal was granted further powers in 1985, being allowed to investigate claims (but only against the Crown) back to 1840. Hopes that this would lead to a return of alienated resources were disappointed however, as the Tribunal was only permitted to make recommendations to the government, not legally binding decisions. This attitude is shifting gradually however, with the Treaty itself accepted as an integral part of legislation since 1989, when the Prime Minister stated "...the Treaty of Waitangi has a potential to be our nation's most powerful unifying symbol." In line with this, greater powers have been given to the Waitangi Tribunal, which can now pronounce sentences.

Gradually, some laws have taken account of Māori cultural values. The Resource Management Act of 1991 requires that Māori environmental and cultural values are recognised regarding building permits, land or water use or resource utilisation consent.

As recently as 1967, Land Laws were largely aimed at the alienation of Māori land, but the 1993 Te Ture Whenua Māori Act now makes it extremely difficult for Māori land to pass from Māori ownership. Multiple ownership is now actively encouraged. Greater power now rests in collective decision making, so Māori individuals are no longer as free to dispose of Māori land as they might wish.

The Tu Tangata programme was introduced by the National government in 1980. It appeared to be an important step as its goals were to "...assist Maori communities, groups, and individuals to achieve...self-sufficiency" and to reduce their dependence on welfare services. Resources from welfare institutions were shifted directly to iwi, in theory allowing them to build up decentralised local projects. The programme was not however particularly successful as financial savings were emphasized rather than the return of traditional lands.

Social policy legislation has also begun to reflect tikanga Māori. The Children, Young Persons and Their Families Act 1989 requires social workers to fit in with tribal arrangements and Māori family relationships, especially those of whānau. The Social Welfare department commonly took custody of Māori children up to the mid-1980s, but their philosophy now affirms that children are best raised within their own cultural context and with their own people. There are of course difficulties with resourcing and uncertainties about the rights and welfare of the child as opposed to the rights of the family, but the Act in general supports a positive Māori identity, allowing proper whānau hui to be held regarding the care of children, with kaumātua and kuia taking leadership roles.

The Health and Disability Services Act of 1993 is less clear about Māori culture or identity, but Government health policy does recognise strengthening Māori culture and society so as to improve Māori health. Government policy identifies Māori health as one of four priority areas, thus tribal and community health programmes organised by Māori are rapidly increasing. Health Boards and hospitals are required to demonstrate how their services provide for and relate to Māori.

The 1992 Mental Health Act now recognises the significance of cultural identity. Section 5, together with Section 65, require that any Court or Tribunal exercising power under the Act must respect a person's cultural and ethnic identity, language, and religious or ethical beliefs. There must also be recognition of the importance of family ties, including whānau, hapū and iwi.

Renaissance

In the 2001 census, 1 in 7 people in New Zealand were Māori, and a quarter of these spoke the Māori language. This change has occurred due to the Kōhanga Reo movement (Māori language kindergartens), and as Māori is now widely taught in secondary and tertiary educational institutions. Many adults study Māori and courses in Te Reo are freely available, and at times free of charge to employees in the public sector. In 1987, after demands by Māori, the government declared both Māori and English to be the official languages in NZ.

The change to an MMP electoral system in 1996 has meant greater influence for groups previously marginalised under the old "first past the post" system. This has included a more meaningful political voice for Māori, but real political power continues to be a contentious issue.

In the 1970s a cultural movement known as The Māori Renaissance began, with a reintroduction of Māori culture within New Zealand arts, language and media. Maori arts and crafts were recognised as taonga (treasures) and this revived a self-confidence in creative expression. This came to fruition in Te Māori, a world acclaimed touring exhibition of Māori artefacts, in 1984-1987.

Aspects of this cultural change have been the works of writers such as Patricia Grace and Witi Ihimaera. Māori language programming is a regular feature on National radio and greater air-time is given for Māori musicians on many radio stations. Musicians such as Bic Runga are known well beyond New Zealand, and artists such as Che Fu have adapted American hip-hop with a melodic Pacific flavour, communicating local issues to young Māori.

Television has also screened many more programmes with Māori content and history, notably the much-praised "New Zealand Wars" historical series which presented a more accurate view of a history which had been distorted by the colonial victors. The Māori cultural and political renaissance claimed the right to self determination in art and art practices, and many Maori artists have used art as a vehicle of protest. Increasingly, Maori arts and their kaitiakitanga (cultural custodianship) are a matter

of tino rangatiratanga (self-determination).

Official recognition of the status and rights of Māori as New Zealand's indigenous people (see the section discussing the concept of biculturalism) is mandated in law and in public sector policy. Health service employees are required to integrate these principles into clinical work and into staff and community relations, and to attend workshops and courses so as to understand the Treaty, Māori history and culture and so as to learn appropriate attitudes respecting cultural values, when working with Māori and their whānau.

These are positive changes and show a promising trend, but a considerable negative legacy of colonisation remains, as other areas of this website describe (see Epidemiology). Considerable anger between Māori and non-Māori continues and the struggle to reach a better accommodation and balance will remain an important task for all New Zealanders, especially with many new immigrants adding their cultural needs and issues to the debate.

Identity, Conflict and the Search for Nationhood

Mason H. Durie

RANZCP Congress College Address 1996



He Mihi

E nga reo; e nga waka, e nga karangatanga maha i huihui mai nei, e nga iwi e rua, tēnā koutou katoa. Ngati Toarangatira tēnā koutou i whakatau mai i a tatou i roto i na ahuatanga e pa ana ki a tatou. Ko nga mate huhua, i hinga atu i hinga mai i runga i nga marae maha o te motu, kia ratou te tini te mano, kua mene atu na ki te po. Haere, haere, haere, whakaoti atu.

Engari ko tatou nei o te hunga ora, tēnā tatou katoa i runga i te tino miharo o tenei huihuinga. Tēnā hoki koutou, i whakanuitia mai ki tenei whakaritenga. Anei nga takuta hinengaro o te motu, whiti atu ki Poi Hakena, ki Ahitereiria whanui, me etahi o nga moutere o te Moana-Nui-a-Kiwa. Ko te kaupapa e mauria mai e ratou ko te hauora hinengaro, a ko te tino take, ko te oranga tangata. Heoi ano tēnā koutou i tae mai i tenei po ki te tautoko, ki te tutaki tatou ki a tatou. Kia ora ano tatou.¹

Introduction

Mr President, distinguished guests, Fellows, ladies and gentlemen.

It is indeed a privilege to be invited to deliver the College Address for this Congress, which occurs in the fiftieth anniversary of the founding of the College and its antecedent, the Australasian Association of Psychiatrists. I have accepted the invitation with some hesitation; there are others more able to capture the significance of the occasion. But equally I have accepted with a sense of pride because the invitation recognises the increasing contribution being made by Māori people to health, to human understanding and to the continuing evolution of psychiatry as a profession grounded in the lives, culture and ever-changing circumstances of communities and their people.

Essentially there are only three points I wish to make. All are linked to identity and more specifically to the conditions which promote security of identity. The first point recognises that the alienation of people from their land and their culture subjects them to a fragmentation of identity and, along with loss of possessions, a loss of spirit. The second point is that although the law does not create an

identity, laws have the capacity to enhance identity or at the very least not to destroy a sense of positive identity. And the third point is simply that identity can be secured more firmly if people are able to feel a sense of participation in the affairs of the nation and can relate to the symbols of nationhood.

Although in making these points I will draw heavily on experiences in , I expect that the meanings will extend well beyond these shores to encompass similar journeys in and indeed the many nations of the Pacific.

Dr Henry Bennett

But before going any further; I wish to draw attention to an event of particular significance to psychiatry and to Māori people. Fifty years ago this College of Psychiatrists was born. In the same year, a young Māori doctor began a period of service to psychiatry which ended fifty years later with his retirement in March of 1996. In many ways his remarkable career personifies the struggles and accomplishments which will form the substance of my address. It is an honour to be able to acknowledge Dr Henry Bennett tonight and to do so, briefly, in our own language.

No reira e te Rangatira, te tohūnga, he mihi kau atu tenei ki a koe, mo tou mahi ataahua i waenganui i a tatou i nga tau kua pahure ake. I piki ake koe ki nga tihi maunga; hei haeata whakahirahira mo te hunga turoro, he kaiwhakaora, he pononga. E Pa, nau i whakawatea te ara ma matou i whai muri i a koe, kia tu tahi i nga Pakeha i roto i tenei whakaminenga o nga takuta hinengaro. Kei konei tonu koe ki te awhina, te manaaki, te tohutohu mai. No reira, ko tenei matou, te tu ngatahi, kei te mihi atu ano ki a koe; te rnihi atu hoki ki Te Arawa, i roto i te ngakau whakawhetai. E te rangatira, te takuta, ae, te rata, kei te whakamoemiti. Tēnā koe.²

Legislation and the Erosion of Identity

Fellows and delegates, 1996 is an exciting year to visit . Later in the year there will be a general election based on MMP - mixed-member proportional representation. It will herald a significant move away from our first-past-the-post system and represents a major departure from the parliamentary arrangements which have dominated political representation since 1854. That was the year when a Settler Government was established. I will not attempt to forecast the outcome of this year's general election, or the alliances which will subsequently be formed. But I raise the first MMP election as one sign that is developing its own style of governance and representation. There are also other signs that we are walking a more independent pathway. Recourse to the Privy Council, a feature of the judicial appeal system since 1840, will be abandoned this year. It will be replaced by a specially convened court presided over by three Court of Appeal judges. Moreover, on a related matter it has been decided this Year that the honours system will move towards a peculiarly New Zealand model, though retaining some elements of the Imperial system such as knighthoods. If there were doubts that the old order was changing, events this year will go quite a long way to dispelling them but they may not alleviate qualms about the process being adopted for change.

This year, 1996, is also census year. It will likely reveal a growth in total population to over 3.6 million and a rise in the Māori population by around 10% to more than 480,000. One hundred years ago, in 1896, there was also a rise in the total population - then to some 701,101. But there was a corresponding and devastating decline in the Māori population to a mere 42,650, a reduction from around 175,000 in 1800. 1996 is therefore not only the fiftieth anniversary of the College but the hundredth anniversary of the lowest ever recorded Māori population.

I will not enlarge on the reasons for the threatened extinction except to say that a combination of disease, musket warfare, and starvation contributed disproportionately to the near disappearance of the Māori race. And the depopulation was greatest where land alienation had been most extensive. Loss of land had more than economic implications. Personal and tribal identity were inextricably linked to Papatuanuku - the mother earth - and alienation from land carried with it a severe psychological toll, quite apart from loss of income and livelihood.

Two methods were used to separate Māori from their land. The most unjust was confiscation, through two Acts of Parliament, the New Zealand Settlement Act and the Suppression of Rebellion Act, both Passed in 1863. Under them the government gave it self wide ranging powers to confiscate traditional lands. Tribes who actively or passively resisted surveyors or sales were regarded as rebels and their lands were confiscated. Even if there were little more than a suspicion of "rebellion", land could be taken - and over 3 million acres were alienated in that way.

Other laws were passed with the express purpose of speeding up sales and transferring ownership from tribal collectives to individuals. The Native Land Act 1862 and the Native Land Act 1865 largely did away with customary land titles, freeing up land for sale and in the process undermining the social links between families and within tribes. Māori society had depended on common interests in traditional lands for cohesion and purpose. As land was transferred, through one means or another, so Māori identity and well-being were rendered vulnerable until eventually even survival appeared unlikely. Out of nearly 66 and a half million acres, by 1890 only 11,000 acres remained in Māori ownership. And as I have mentioned, by then, in parallel fashion, the Māori population had declined to less than 43,000. A widespread sense of resignation was typified by a Government conviction that its plain duty was to 'smooth the pillow of a dying race'.

This demographic saga is a story in its own right but tonight I would like to draw attention to two Māori strategies each of which helped turn the tide and transform an expected genocide into an unexpected recovery. One approach to the problem of Māori dispossession advocated adaptation to Western society but with the retention of a strong Māori cultural identity. The key was to be professional Māori leadership and government accommodation of Māori interests. The other approach also supported the acquisition of Western knowledge and skills but placed greater emphasis on Māori control and autonomy with less dependance on government goodwill.

The call for acceptance of a predominantly Western world was first made by a small group of Māori students from Te Aute College a little over a hundred years ago. During the summer vacation they began travelling to rural and often remote communities bringing new messages - education, ventilated housing, agriculture, economic development and, important to this meeting, health and hygiene. Two of the Te Aute group, Maui Pomare and Peter Buck, were to become medical graduates before they entered politics.

Both were subsequently knighted. A third, Apirana Ngata, also became a knight and achieved distinction in law, politics, literature and land reform.

Māori social, economic and cultural revival is often credited to this trio, Ngata, Pomare and Buck, and their select band, the Young Māori Party. Their philosophy was simple enough: create pride in a Māori identity and Māori culture and use that as a platform for accessing the best of Western technology and education. Because they were able to address their audiences in Māori and employ Māori metaphors to make key points, their task was so much easier; and more importantly, they had a level of credibility which non-Māori could never possess.

In contrast to the Young Māori Party and their confidence in Western democracy, other Māori leaders considered that a dual identity was not only impossible, but had contributed to the dramatic population decline in the nineteenth century. For them, the answer to dispossession and disease was Māori sovereignty. Ngata, Pomare and Buck were in no doubt that the answer to Māori survival lay in the need to adapt to Western society and to do so within the overall framework imposed by the law. Though strongly and emphatically in support of Māori language and culture, they were equally passionate advocates of Western democracy, education and modern health practices. They believed it was possible to retain a secure Māori identity while embracing Pakeha values and beliefs. What they had not foreseen was Government rejection of Māori language and culture as relevant to the twentieth century.

While sharing the belief of the Young Māori Party that reformative measures were needed if Māori were to survive, the approach of the Māori sovereigntists was to use the new tools of education and technology but to focus Māori energies on building an identity which not only lauded Māori language

and culture but also included a sense of ownership and control. The emphasis was on Māori autonomy and authority, even if it meant defying the law. This group was less convinced about the need to adapt to colonial frameworks. They considered that it ought to be the settlers who made the adaptations. After all Māori were the ones who were at home. Some Māori sovereigntists, including Rua Kenana, went further, advocating the expulsion of all Europeans from the country.

Not surprisingly, Government sympathies were with Ngata's approach and legislation was introduced to bring Māori within the orbit of what was then mainstream. The 1900 Māori Councils Act, for example, established local Māori committees but gave them little real power. The second part of Ngata's prescription - a strong Māori identity - was not only sidelined in legislation but in one way or another was actively discouraged. It became policy, for example, not to allow Māori children to speak Māori in the school grounds. Those who did were punished. And Māori adoption practices, based on a collective approach to childcare, were all but prohibited. So too was the practice of traditional Māori religion. Even the new Māori Christian churches such as Ratana attracted scorn and were promptly labelled by other churches as heretic.

But the greatest blow to the organisation of Māori knowledge and understanding occurred in 1907 when the Tohūnga Suppression Act was passed. By outlawing traditional healers, the Act also opposed Māori methodologies and the legitimacy of Māori knowledge in respect of healing, the environment, the arts, and the links between the spiritual and the secular - te kauae runga and te kauae raro. The Tohūnga Suppression Act had dual but contradictory purposes: on the one hand it sought to promote Māori health, while on the other it actively discouraged Māori autonomy. The Ottawa Charter would recognise the two as incompatible. By associating poor Māori health with tohūnga (traditional healers) the Act was rationalised as an instrument to improve Māori health. Special concern had been expressed about the way healers treated patients with tuberculosis, and the Act would prohibit them from further healing activity. In fact the methods adopted by the tohūnga to treat tuberculosis were not too different in practice or in theory from the standard medical treatment of the time. Tohūnga immersed their patients in the cold running water of a mountain stream, while wealthy patients who could afford it travelled to sanatoria in where icy temperatures and an abundance of alpine breezes achieved a similar goal.

But a more sinister motive behind the Act was to bring certain Māori leaders into disrepute, in particular Rua Kenana. Though not opposed to Western technologies and amenities, Rua Kenana was opposed to Māori subservience to the Crown and had gained support from a large following who shared his discontent. His prophecy that one day all Europeans would leave sent chills down Government spines and attracted scorn and hostility in Parliament. The Tohūnga Suppression Act provided an opportunity to silence him and largely to justify his arrest; a clause was added to the Act which made it an offence to foretell Māori futures:

"Every person who gathers Maoris around him by practising on their superstition or credulity, or who misleads or attempts to mislead any Maori by professing or pretending to possess supernatural powers in the treatment or cure of any disease, or in the foretelling of future events, or otherwise, is liable on summary conviction before a Magistrate to a fine not exceeding twenty-five pounds or to imprisonment for a period not exceeding twelve months ..."

In 1916 Rua Kenana was sentenced to twelve months' imprisonment, having been found guilty, not of foretelling the future but of using moral resistance against the police. When released he appeared to have softened his position and well before his death in 1937 his mission for Māori autonomy and sovereignty had been effectively silenced.

Legislation and the Enhancement of Identity

So far tonight I have outlined some of the reasons why Māori survival and a Māori cultural identity were threatened, and the laws which were responsible. Although those times may be distant, the grievances still linger, so that even in 1996 any sense of a meaningful cultural identity remains elusive for many Māori. Last year, however, a significant step was taken to resolve at least one injustice and to provide comfort if not full compensation for the pain inflicted. After protracted litigation and negotiation a Tainui tribe, Waikato, concluded an agreement with the Crown for the return of some

land - as it happens, only a fraction of that which was confiscated under the New Zealand Settlements Act - as well as cash payments. The total value of the settlement was \$170,000,000. Not all tribal members thought it was a fair arrangement but there was sufficient support for the Crown to agree to the deal and to include it in new legislation. As well, in an unprecedented move, Queen Elizabeth II publicly apologised for the actions of previous governments.

This success and those that are expected to follow reflect a new phase in 's history. Since 1975, when the Treaty of Waitangi Act was passed, successive governments have grappled with the Treaty and the status of Māori as tangata whenua (indigenous people). While much remains to be done, and Māori patience is often tested to the limit, the paternalism and assimilative policies of last century are dwindling. In their place, there has been a greater recognition that Māori not only have legitimate claims based on the Treaty of Waitangi, but also have rights by virtue of being indigenous to , including the right to be Māori. Change has not come easily: litigation, confrontation and the mutual exchange of accusations and bitterness have characterised progress. But there has also been the demonstration of goodwill, abundant patience and, overall, a desire to move beyond the injustices of the past and on to more positive developments.

Slowly, some of the laws of the land have come to reflect Māori perspectives and values. The Resource Management Act 1991, for example, requires that Māori environmental values be taken into account along with the recognition of cultural values pertaining to any building permit, land or water usage or resource utilisation. The Te Ture Whenua Māori Act 1993, an act about Māori Land , is based on traditional Māori attitudes to land and its importance for future generations. Whereas land laws even as recently as 1967 were largely written to speed up the alienation of Māori land, the 1993 Act now makes it extremely difficult for Māori land to pass out of Māori ownership. Multiple ownership, once decried as inconsistent with economic development, is now actively encouraged through provisions for a variety of trusts and incorporations. The new Act also provides for improved management structures to enable better commercial returns on tribal land. In the process, trade-offs have been made between individual rights and collective rights, so that greater power is now vested in collective decision making, as it was before the imposition of British law. At the same time, Māori individuals are no longer free to dispose of Māori land as they might wish. Their task, according to the legislation, is to practise wise stewardship for the benefit of future generations.

Social policy legislation has also incorporated Māori values, beliefs and practices. The Children, Young Persons and Their Families Act 1989 requires social workers to fit in with tribal arrangements and with Māori family relationships, especially those of whānau (extended family). Far from encouraging Social Welfare custody over Māori children, a common approach up to the mid-1980s, the philosophy now rests on the assumption that children are best raised within their own cultural context and with their own people. Leaving aside difficulties with resourcing and not-infrequent uncertainties about the rights (and welfare) of the child as against the rights of the family, the Act appears to support a positive Māori identity. It allows for tribal elders to take active leadership roles in family group discussions and requires professional workers to observe - or at least not to ignore - cultural preferences and customs.

In the health sector, the Health and Disability Services Act 1993 is less explicit about Māori culture or identity, but Government health policy, even without legislative backing, recognises Māori culture and society as strategies for improving Māori health. In identifying Māori health as one of four health gain priority areas, there is active encouragement for more Māori health providers, and tribal and Māori community health programmes are rapidly increasing. In addition, mainstream providers in hospitals are asked to indicate how their services will contribute towards health outcomes which are relevant to Māori . Few know the answers but at least the question is being asked without assuming that all New Zealanders subscribe to the same notions of good health.

The Mental Health Act 1992 similarly recognises the significance of a Māori cultural identity. Section 5, reinforced by section 65, requires that any court or Tribunal that exercises power under the Act must have respect for a person's cultural and ethnic identity, language, and religious or ethical beliefs. They must also show proper recognition of the importance to the patient's well-being of family ties, as well as whānau (extended family), hapū (subtribe) and iwi (tribe).

A National Identity

These examples of laws which endorse Māori world-views are not necessarily an indication that Māori identities are now secure or that there is consensus about the place of a Māori dimension in the life of New Zealand. Far from it. Māori often regard the state's efforts as piecemeal and minimal, without any real impact, either in day-to-day matters or in the allocation of power. In contrast, non-Māori often complain that a focus on Māori, no matter how minimal, is out of place in a multicultural society and does little more than divide an otherwise united nation. Both views may seem plausible, at least to their own followers, but neither fully recognises the significance to of the growth of a jurisprudence which draws on both British law and Māori customary law.

If the law is any indication, there is potential for constitutional changes in at quite fundamental levels. And, apart from legal reform, there are other signs as well. On more than one occasion the Prime Minister has raised the possibility of becoming a republic and although serious debate on the subject is yet to be heard, events elsewhere in the world may hurry that prospect. Māori interest in fundamental constitutional reform is also high, though for different reasons. At a series of meetings over the past 12 months (the most recent being in April this year) Māori tribal leaders and urban Māori have discussed options for major constitutional changes. One option would see the emergence of a Māori chamber in the House of Representatives; another recommends a separate Māori parliament to make its own laws and raise taxes. Radical though those suggestions may sound however, they are considerably less extreme than the view espoused by younger Māori who seek a constitution based entirely on tikanga Māori - Māori custom law.

Perhaps the unifying strand is that has outgrown its identity as a nation knitted exclusively from the cultural and philosophical threads of the well-worn fabric of Imperial Britain. Thus, in raising the possibility of a republic, and in searching for a more consistent and essential Māori voice, the prime Minister and the so-called radical Māori groups may have more in common than is generally appreciated, or even than they themselves would be inclined to admit. What is needed is a planned constitutional debate that amounts to more than front-page headlines and from which a rational basis for reform might emanate. Crucial to such an inquiry will be a more explicit recognition of the heritage of Māori and other New Zealanders, and a realistic appreciation of each other's position on the globe.

Meanwhile, there are certain lessons from history which can inform the future. And having at last embarked on a voyage towards reconciliation and fairness, it would be foolhardy indeed to ignore the past or to continue the myth that we are not in the South Pacific. To dismiss Māori from the national identity equation again would be a signal for outrage. Second time around, and given the youthful nature of its population, I doubt that Māori would stand for it. Nor I suspect would other indigenous peoples in other countries.

Identity and Mental Health

It may not be very clear how these matters of land alienation, the law and constitutional arrangements relate to psychiatry or to psychiatrists. In my opinion, however, there are several implications.

First and perhaps most obviously, the disproportionate number of Māori patients admitted to psychiatric hospitals for treatment means that most psychiatrists in , and perhaps in , will be called on to treat Māori patients. How that responsibility is discharged is currently of great concern to Māori, to purchasers of health services and of course to the profession itself. If the mistakes of the past are to be avoided, then psychiatric treatment should not carry with it any risks to cultural identity. This does not necessarily mean abandoning usual clinical standards or opting to withhold psychotropic medication, but it does mean that the significance of a Māori identity to assessment and treatment will need to be given careful and deliberate thought.

Identity has been a key theme in this address. I regard it as an important concept for psychiatry even though it is now some decades since Erikson reminded us of its psychosocial implications. In a current longitudinal study of Māori households known as Te Hoe Nuku Roa,³ the preliminary analysis of data

suggests that a secure Māori identity will act to protect against poor health, even in the presence of adverse socio-economic conditions. A secure identity appears to be least often associated with problematic or threatened health status. In this study a secure identity includes not only a sense of being Māori but also access to various cultural markers such as whānau (family), Māori land, a marae (communal meeting place where Māori is the cultural priority), knowledge of ancestors, Māori language, and opportunities for associating with other Māori people. Māori health workers, particularly those involved in mental health, have also recognised the importance of identity. Frequently they now include a formal evaluation of identity as one part of the assessment process. The Mental Health Act could be interpreted to mean that psychiatrists should do likewise.

In any event it is clear that since the health reforms have favoured the engagement of Māori providers of mental health services, psychiatrists will have much greater contact with other health workers. Co-operation with these community-based providers, even when they adopt different frameworks, will challenge psychiatrists to look beyond the usual boundaries of professional practice. The challenge will be to share in case management without assuming that there is a single philosophical or theoretical thread, or only one explanation for behaviour.

Related to this point, psychiatry will be particularly challenged by the emergence of traditional healing as a legitimate health practice. When the Tohūnga Suppression Act was passed in 1907, healers disappeared from public view but went underground, operating under adverse conditions away from the gaze of the law. There they remained even after the repeal of the Act in 1964. It was not until 1993, with the formation of a national organisation of Māori healers, Nga Ringa Whakahaere o te Iwi Māori, that the place of traditional healing within 's health services was raised again. Submissions to the Core Services Committee (now the National Health Committee) and the Ministry of Health argued for the inclusion of traditional healing within the publicly funded health services. As a consequence, in 1995 the Committee recommended that traditional healing services could be purchased alongside other primary healthcare services. The recommendation was passed on to Regional Health Authorities some of which have already signed contracts with traditional healers for health services. Psychiatry will not be able to ignore this development or to dismiss it because it is outside established parameters or College guidelines. Nor should we try. There is every chance that a collaborative approach could see the development of a type of psychiatry which is firmly grounded in a Māori identity and, more to the point, is able to respond positively to clients whose perspectives and reasoning are shaped by a Māori identity.

Conclusion

As I mentioned at the beginning of this address, I had intended to make only three points. The first was that the erosion of identity through the law or through sheer power of numbers has had devastating effects on Māori well-being. The second point was that some redress of that situation, however tentative, can be found in a range of laws introduced over the past decade or so. And the third point is that the next step in reconciling the past with the present and with the future will require fundamental constitutional changes for the country and a shift in the national identity. In the New Zealand context that shift will need to give greater recognition to the many cultures and ethnicities now living within the country, and particular recognition to Māori.

These points may not sound immediately applicable to the more urgent problems besetting patients. Nor will they help psychiatrists find universal truths which can be used in all situations. Quite the reverse. Psychiatrists, like jurists, and no matter how objective, are not free from contradictions and blind spots. All too often any real understanding or meaningful communication has been prevented by the imposition of strong Eurocentric values. Those values have made little sense to men and women from different origins and cultural backgrounds. Rather than being empowered by medical science, or psychiatry, or the law, or even by democracy itself, so-called benefits to generations of Māori frequently carried a price - the relinquishment of cultural identity. It is a price which no people should be required to pay, nor is it necessary. And I expect that Pakeha groups, unable to accept that there is more than one approach to justice or social equality, are equally bent on removing any reference to a Māori identity in the laws of the land or the practices of the professional workforce.

In conclusion, the gradual reshaping of government policies, the law, and institutional practices has shown that diversity can be accommodated within fair frameworks and that uniformity need not be the overriding objective. It would of course be naive to suggest that the changes have been comprehensive, adequate or always well received. Even as we meet tonight, Māori in other arenas are exploring options for disentangling themselves from the residual bonds of colonial arrogance. They are planning quite separate systems for governance, health care, education and economic gain.

But in common with similar moves in other countries, including , has nonetheless embarked on a journey to construct a new national identity. It has the potential to be more than a display of outward symbols (the fern, the koru) instead, a genuine reflection of the heritage and the aspirations of all its people. This time it will it be unacceptable for a future national identity to be built on notions of sameness or a single world view, or to pretend that the law is necessarily neutral as to culture, or that professional practice can be constructed on bland protocols which fail to acknowledge culture and identity as vital ingredients for good health. There is a unique opportunity for psychiatry and the Royal Australian and New Zealand College of Psychiatrists to travel on that same journey and to examine the implications of diverse cultures to its own identity and its practices.

Mr President, I am deeply grateful for the opportunity to deliver this address and mindful of the significance of occasion.

Before concluding, I would like to add my own good wishes to those who have been honoured tonight and to who have achieved special recognition by the College. Congratulations. And to aspiring Fellows of the College: I wish you well in the years ahead. *Ko nga takuta Māori i waenganui i a tatou i tenei po; koutou e hiahia ana kia tomo mai ki te karete nei, hei rata mo nga turoro Māori , kia kaha, kia maia, kia manawanui.*⁴

*Heoi ano tena koutou i tae mae i tenei po k; te tautoko, hei kanohi ora mo ngai tatou, kia mohio ai te katoa, kei konei tonu te ao Māori . Ngati Toarangatira tena koutou i whakatau mai i a tatou i roto i na tikanga a koro ma a kui ma.*⁵

Finally, may I join others in applauding the College on its fiftieth birthday and wish it well for the future. The past fifty years have witnessed the emergence of psychiatry as a rigorous medical discipline built on sound evidence-based methodologies, the application of scientific principles and best clinical practices. The achievements are nothing if not spectacular. Perhaps, however, it is for the next fifty years to find common ground with the views and beliefs of peoples and cultures who start from quite different philosophies. It may sound unfashionably grandiose to suggest that psychiatry could play some role in speeding the emergence of a society which is both fair and enriched by cultural diversity. We have the capacity and the potential not only to learn from other approaches but also, through our work and influence, to create a climate which will actually advance autonomy and cultural identity as two prerequisites for health and for the development of a national identity.

If the science of psychiatry is about the subjection of hypotheses and observations to scientific scrutiny, and if the art of psychiatry is about rapport and creating therapeutic relationships, and if psychiatry is to be more than the mechanical application of DSM-IV, then the soul of psychiatry - and I am inclined to believe that psychiatry does have a soul - then the soul of psychiatry must be anchored with the identities of those who share our domain. Human identity is at the heart, the soul, of our endeavours. Our task is not to negate cultural identity, or to squeeze others into the straitjackets of cultural neutrality. The challenge is to understand cultural identity as a keystone for healing, for living, and eventually for dying.

Others, well before my time, have reached similar conclusions. A proverb from the people of Northland, for example, asks "What is the most important thing in the world: the answer without any doubt is that it is people. They above all else are at the heart of existence."

In Māori it says:

*Hutia te rito o te harakeke,
kei hea to komako e ko;
ki mai koia ki ahau, he aha te mea nui i te ao,*

*maku e ki atu
he tangata, he tangata, he tangata.*⁶

Thank you. *Tēnā tatou katoa.*

Footnotes

1. An acknowledgement of the welcome by the host tribe, Ngati Toarangatira and a lament for those, now deceased, who have contributed to the advancement of health. Literal translation: "An acknowledgement: greetings to the many tribal representatives assembled, and to the peoples from diverse cultures and nations. A particular word of acknowledgement to Ngati Toarangatira, the local tribe who welcomed us here tonight. And in greeting each other it is sad, but appropriate, that we should also think of those who have passed on to other realms. Farewell.
Nonetheless, for those of us who are here in person tonight the occasion is one of significance and importance. Gathered here are psychiatrists from and other countries in the Pacific. Their purpose is to share views and issues for the improvement of health. Thank you for coming to show your interest and support, and to provide us with an opportunity to meet each other. Stay well."
2. A tribute to Dr Henry Bennett of the Te Arawa tribe for his service to psychiatry, Māori health and Māori doctors. Literal translation: "My eminent colleague, in view of your untiring efforts among us over these years past, it is a pleasure to greet you on this occasion. As a healer, but also a servant of the people, you have been like a beacon shining forth from the highest summit. Thereby you have cleared the way for those of us who follow by standing tall alongside Pakeha colleagues and as an equal within this psychiatric fraternity. Moreover you are still here to provide support, help and advice. We speak with one voice in thanking you. and your people from Te Arawa. Distinguished colleague, doctor, healer, we salute you."
3. Te Hoe Nuku Roa is a longitudinal study of Māori households being undertaken by the Department of Māori Studies at Massey University .
4. Special recognition and best wishes to Māori psychiatrists In training. May you be attended by every success.
5. Thanks to Māori people who have attended, and, by their presence, added significance to the occasion. We have all been honoured by the gracious welcome from Ngati Toarangatira, of the Wellington area.
6. A proverb: Peel back the leaves of the flax bush so that the centre may be revealed; ask of me what is the most important thing in the world and I will reply, it is people, it is people, it is people.

Cultural Competence

Transcript of an address by Mason Durie at the launch of Te Iho - Auckland, July 2003

First of all congratulations to all of those of you who have been involved in what is a hugely significant milestone for training. To be able to have a website such as this that can inform people in such an easy way is I think a huge advantage so to Janssen Cilag and the psychiatrists and others who have been involved in this, congratulations and thank you for creating it. I am sure it will be a wonderful asset.

It makes me think of my own training in psychiatry and the notion of where culture fits in psychiatry. I had the very great fortune to be in contact with two transcultural psychiatrists, Professor Wittkower and Raymond Prince. They were eminent in North America in the field of transcultural psychiatry and every winter when it got too cold in Canada they would go to these exotic places all around the world and look for strange and wonderful syndromes and they would come back and describe to the rest of North America what they had seen. Of course what they did was to look at another culture, identify the strangeness of it and then interpret it using the tools that they had at their own disposal. So in fact you would get a re-interpretation of a culture through someone else's eyes.

Well we have moved quite a long way from that I think - I know the Canadians have moved a long way from that and I think they have south of the border although you can't be one hundred per cent sure, there's still a slight tendency to interpret other cultures according to their own beliefs... But generally psychiatry has moved a huge way to recognise that the relationship of culture to the practice of psychiatry is hugely important if we are going to make gains in health.

One of the reasons I wanted to talk about this was to acknowledge a very important lady who passed away earlier this year: Irihapeti Ramsden. She for a time single-handedly and with a huge amount of both public and professional effort began to talk about cultural safety. She was talking largely to the Nursing Council and nursing tutors and the point she made was that in addition to all of the other knowledge bases that are important to nursing and to healing, culture is extremely important. Her view was that you needed to understand your own culture so as to understand your patient. Irihapeti was really saying: look around you, try and identify what your own culture is. If you can identify that rather than taking it for granted, then you might be in a better position to understand other people who don't share that culture.

It was to a large extent misinterpreted and there were court cases where a nurse trainee in Christchurch argued in court that the cultural safety approach was a gross infringement and quite unnecessary to her becoming a nurse. The Nursing Council to its very great credit stuck with this and despite public opposition insisted that cultural safety be a core component of the nursing curriculum, which it is to this day. So Irihapeti really was a pioneer in this work and her loss to New Zealand was great. It was premature and a huge loss, and what I am talking about reflects to a large extent many of the insights that she was able to make in a much more eloquent way.

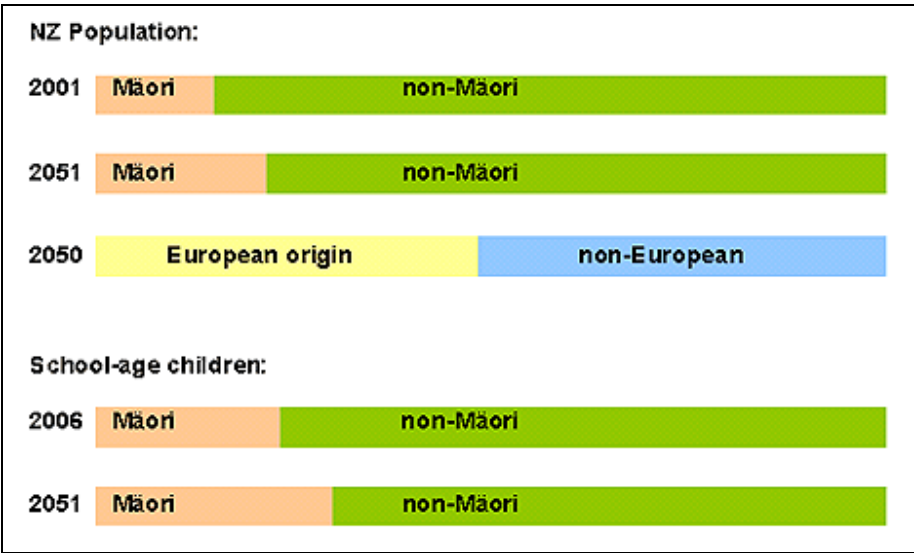
There have developed in New Zealand two approaches. Irihapeti was talking about one and I am talking about the other. She talked largely about cultural safety and the perspective from cultural safety was to put the client in the centre and to argue that any healing process, no matter who is doing the healing, ought to be able to take into account the client's perspective. For a time, it was given a political slant and people described it as entirely concerned with political correctness, so there were big debates about that. What wasn't stressed, at least not in the public arena, was that this was essentially about best health outcomes and not about being politically correct.

Culture is a convenient way of describing the ways members of a group understand each other and communicate that understanding

Cultural competence is the acquisition of skills to better understand members of other cultures in order to achieve best health outcomes

Cultural competence focuses less on the client and more on the practitioner and of course concerns all health professionals, although what I am going to talk about tonight may have more relevance to psychiatrists. The point that I am stressing with cultural competence is that the only justification for embarking on this is that health outcomes should be better. So this focuses on improving health gains rather than on being politically correct or simply doing something because the Treaty of Waitangi says you have to.

Why is cultural competence important? It is important for a number of reasons but the reality is that New Zealand's demography is changing rapidly. In 2006 - that's not too far away - a quarter of all the children attending school will be Maori and in 50 years time a third of all children attending school will be Maori.



Associated with the demographic change is the importance of being able to understand the people who we are going to deal with as practitioners, and it's not only Māori who will increase in numbers. The face of New Zealand is changing rapidly, with large immigrations from the Pacific, migrants from India and Asia and in 50 years' time about half of New Zealand's population won't say that their background is that of a European. For many people, in 25 to 50 years, English may not be the preferred language of communication. It certainly may not be the language you would use when you want to describe what's in your heart. It might be the language you use when writing an assignment.

The point is that if we are talking about the culture of New Zealand a generation from now, certainly in two generations, then New Zealand may not be best described as a Western country. It may equally well be described as an Eastern country or a Polynesian country. So the cultural climate in New Zealand is changing rapidly. All the professions, and the healing professions in particular, need to be ready for that change - that's why being competent from a cultural point of view is important. Put all that together of course with the fact that the world is constantly shrinking and that the launch of this website tonight also reminds us that with websites around the world, people can change very quickly. So New Zealand is no longer an isolated little country at the bottom of the globe, if it ever were.

Now I just wanted to take a look at some aspects of cultural competence as they might apply to psychiatry by talking about health from the perspective of the values that we express through professional practice. An example of clinical acumen and how culture is related to that. What do you do about language barriers? How to interpret - or what are the mistakes we make in trying to interpret styles of communication if we only use one method of doing that? What are the realities in the communities around us and some implications for the workforce?

The first point - When it comes to understanding health there are of course many approaches and many bodies of knowledge, and science is one body of knowledge, indigenous knowledge is another and religious faith is another - and they are all different. It is a huge mistake to try to understand one by using the tools of the other. You will never understand faith through science and you will never understand science through faith and you will never understand indigenous knowledge by relying entirely on science. One of the particular mistakes people make for example with traditional healing is to try and work out through scientific eyes why traditional healing is important or how it might operate - when it is based on quite a different body of knowledge. So there are some dangers in presuming that one body of knowledge can explain the other.

Four hundred years ago this year an academy was formed in Rome, the Accademia dei Lincei - one of the very early academies. One of the first people to publish work in that academy was a man called Galileo who added to the theory and observations already made by Copernicus and wrote that the centre of our solar system wasn't the earth, it was our sun. Galileo invented the telescope and used this plus mathematical calculations to confirm that the earth was not at the centre of the solar system and that the earth travelled around the sun. He published his work in the academy and got into huge trouble with the religious leaders of the day who argued that it was the earth which was at the centre of the solar system not the sun, their point being that human beings are essentially what creation is about and that if you put the sun at the centre you demean God. So this big debate went on, Galileo was put under house arrest and not allowed to publish any more work, and he was labelled a heretic. He was tried and it was not until the 1990s that he was finally pardoned by the Pope. That is a very long time to wait.

The reason I am telling this story is they were both right of course. The religious people were trying to use the tools of faith to understand science and Pope John Paul eventually realised that this was not the right approach. His final pardon of Galileo makes very good reading because he basically says we are all winners; Galileo's ideas in fact add to the majesty of the universe and our understanding of God. So when Galileo first published his work people tried to understand science through religion and here we are 400 years later trying to understand genetic engineering through science and not realising there are other bodies of knowledge that are relevant, including indigenous knowledge and including faith.

So we need to be careful we don't assume that the only body of knowledge comes through science such as medical science and that it is the only way of understanding the world. Remember my great mentors Professor Wittcower and Raymond Prince when they went to the darkest places in Africa looking for strange and exotic syndromes then interpreted them all according to the psychiatric wisdom of the day - there is some danger in that. The other thing to remember of course is that many scientists go to church on Sunday. It is possible to hold more than one body of knowledge concurrently and not to feel any conflict - so many of us who are scientists also subscribe to indigenous knowledge and don't necessarily see a conflict. The conflict comes only when you try and explain one through the tools of the other.

Now culture is a source of value in professional practice, but most of the time you never think about the culture that you have and you don't go around thinking whether you have been culturally cognitive or not. When you're dealing with clients you mostly take culture for granted. I am told that for visiting doctors to New Zealand, the most difficult person to understand is the average Kiwi bloke, because average Kiwi blokes - if you don't understand the culture - have a great way of understating what they feel. They turn up for an opinion and say they are feeling 'a bit crook' or 'a bit off' and if you don't understand what that means you might take it at face value and say 'well you're not too bad' and you

might triage them out of the system. Whereas in fact if the average Kiwi bloke comes to the doctor at all and says they are feeling a bit crook, things are really bad - but you wouldn't know that unless you knew the culture.

Men are changing of course - they've become New Age and are quite good now at complaining. However two decades ago that wasn't how men behaved - I don't think it was that they were being macho, it was just that they didn't want to be a nuisance to anybody. Most cultural things are felt intuitively and if you are of the same culture as your patient the intuition is helpful because you sort of know what the other person is thinking or feeling. If you're dealing with someone from another culture, say if you're a psychiatrist dealing with an Asian patient, you may not have any sense of what is significant to that other person.

I want to talk now about some aspects of Māori culture - how we use time and space - as examples of how culture impacts on professional practice. I don't know if any of you have ever been to a marae other than this virtual one that's on the website, but if you go to real ones you would know that in order to enjoy the experience the wise thing to do is leave your watch in the car, then you're not constantly looking at it to see what the hold-up is. It really is a different attitude to time and the difference is that on a marae what is valued is making sure that you allocate enough time to do what has to be done. When you're not on the marae what is of crucial importance is being on time, and that is why you look at your watch to see if you're on time or not. There is quite a different approach on a marae where you do what has to be done, and then after it has been done you do the next thing. Every so often if you're on the marae you'll see a very angry woman come out of the dining room and shake her fist at the speakers which means the meal's getting cold and you're keeping these people waiting, but shake the fist or not it doesn't make any difference because the speaker knows that what has to be done has to be done. If it takes time it takes time and being on time is much less important than making sure that sufficient time is allocated to what needs to be done.

Now if you think how that impacts on practice there's a problem, because you have 40-45 minutes then on to the next one, a waiting room full of people and you cannot allocate time so easily. But all I'm saying is that time is a value which will impact on the professional relationship in a very big way particularly in some cultures, and there are many Māori people who won't talk the first time you see them to any extent other than to admire your office (or not) because they have not had time to get to know you - they have not had time for first things first. The first thing may be to go through with you some type of negotiation about the terms of your relationship and I don't think that would be done in an explicit way, but if you use the marae as an example, what happens on the marae when people are talking forever is that they are really negotiating the terms of the relationship that they will have with each other and you also need a chance to do that in a clinical situation. Getting straight down to the DSM-IV criteria before you have had a chance to negotiate the terms of the relationship is not making good use of time and is likely to get a fairly negative response, and rightly so.

The other thing where your office comes into it is how we use space, because what is obvious on a marae is that the negotiation of the relationship between one group and another takes place in quite a big space of 20 yards or more. This is called the marae 'atea' and you need space for these negotiations, you can't do it in crammed quarters if you want to get away in a hurry. Say the negotiations go badly and you suddenly realise that the people you are talking to are the wrong group or that you're not as welcome as you thought you were going to be. Then you need a little bit of distance so you can make your retreat very quickly - you can't do that in a crammed situation. Space is necessary to negotiate the relationship. It is very difficult to do that in an office which has a desk in the middle and to get to your chair you have to stamp over someone's foot to get behind the desk to talk to them.

So space and time are values we don't often think about as cultural values, but different groups interpret space and time quite differently and both of these are fairly critical to establishing a professional relationship with positive outcomes. The other issue that comes with the space issue is giving people distance. In the community psychiatry era in the late 1960s and 1970s some doctors threw off their white coats and rushed out into the community and said 'don't call me doctor call me

Bill', and were very friendly with people in an effort to establish good rapport. This sort of contact can be easily misconstrued and despite the smile and the offer of the cheek and the hongi, there are many Māori who are very reserved and will not appreciate a casual and close encounter before the negotiation of the relationship has taken place. So just a word of caution - not everyone likes a very friendly approach straight away because it can be misleading; friendly approach one minute, next minute haloperidol in you.

Another thing is that in different cultures of course not everyone presents symptoms in the way that we would like them to according to the text books. It'd be much easier if they did, but they don't. There are some presentations which are universal but there are many that are not universal. Depression is an example of a syndrome where different cultural groups have different ways of expressing the syndrome. There are emotional, mental and physical symptoms attached to depression and why we classify depression as a mental illness absolutely escapes me when most of the symptoms are physical and the treatments used are physical yet we call it a mental illness - it's a strange approach peculiar to Western psychiatry and Western practice. If you look around the world, in the United States the studies done show that in people who are depressed, mood disturbance is the most common thing they report - unhappiness and sadness. If you have been to the States you will understand that they have an absolute intolerance of being unhappy. They will say 'have a wonderful day' and really mean it, they're very friendly, very warm and not very good at tolerating unhappiness and they notice it very quickly when someone is unhappy so mood tends to be reported. (cartoon of Texan shootg depressn)

In the United Kingdom, unhappiness is a way of life. People don't notice terribly much being a bit sadder than they were yesterday. The symptoms that are most frequently reported in the United Kingdom are cognitive symptoms, particularly guilt and sometimes the delusional thinking that goes with that. So cognitive symptoms seem to be much more prominent in the UK. In Asian populations what is most distressing are the biological symptoms, so gastric discomfort is a hugely reported complaint, far more frequently reported than mood change or feelings of guilt. With Māori, what stands out more with depression is a loss of energy. Not that there is no capacity for guilt but it's not such a huge problem, and it's the shift in energy that is reported more frequently as being the most disturbing and causing irritability and other problems. So you can ask as a result of that, whether depression is actually a culture-bound construct as a mental disorder. Is 'depression' a peculiarly Western bound phenomenon, because in some parts of Asia it does not exist as 'depression'. What exists is what we regard as the physical symptoms associated with 'depression'.

Now just a few things on language - it is one of the huge barriers to understanding people. I once worked at the Montreal Children's Hospital and just about all the clients spoke French and I didn't speak any French. Every six months the residents were surveyed by a patient sample for a report and I came out ahead of my French-Canadian colleagues. The patients said 'the reason he is a good doctor is that he doesn't say anything'. So language itself can be a problem.

One issue that it brings up (and I think this will happen more and more in New Zealand) is the technique of using a translator. For example how much should you rely on the family to translate or how much should you use a professional translator. One of the problems relying on the family to translate is that you may get the wrong answer. Say you ask the relative to translate 'have you been hearing voices?' and the translator, the relative, says 'this silly doctor wants to know if you have been hearing voices but you haven't have you?' So you get the answer 'no, she doesn't hear voices' and the other thing you get is a family argument. A simple question you might ask is 'Is there anyone in the family that might be adding to your distress?' and then it's all on and five minutes later the translator says to you 'No'. ...so there are some problems using relatives as translators.

But I think increasingly psychiatrists and others who work in the mental health field will be called on to use translators and I think this will be an increasingly important psychiatric tool. I will highlight a couple of words here - anxiety and anger - which show the complexities of translating a mental or physical symptom, and demonstrate that literal translation is less important than conceptual translation. Usually we say anxiety is a mental symptom but the Māori word for it is 'manawa-pa' or

'something affecting the heart', not a mental thing at all and I think probably a reflection of palpitations. Anger is 'pukuriri' - the stomach that is knotted up and tight. So this throws into some question why we call something a mental symptom or a physical symptom, and shows that a literal translation would not convey the full meaning.

If you go to a marae people think in different ways especially on formal occasions. The flow of energy goes outwards so that you start at a small point which gets bigger and your understanding comes not from knowing the small details but from knowing the big picture and the relationship between things which is even wider. Most of the time in psychiatry we are taught to go the other way. We get this mass of symptoms and we try to narrow it down, to get it into the DSM-IV criteria as quickly as we can so we can feel more relaxed about what we are dealing with. So our understanding comes from narrowing down this huge range of information to get to detailed points. That's centripetal thinking, where you get smaller and smaller and it goes inward to a point, a detail.

Whereas with centrifugal thinking you understand things by the relationship they have to something else, not by the details. So if your thinking is centrifugal it may start with a detail, but it moves out to the relationships between details and on outward to bigger things. That can lead to some problems because some people say you spend all your time up in the clouds and never get to the nitty-gritty of the matter.

It can also lead to opportunities for misdiagnosis - an example of different ways of knowing is the following three responses to a statement:

WAYS of THINKING

The weather this spring has been terrible

1. **'That's why grass growth has been slow'**
(centripetal, causal, linear)
2. **'A spring in my step?'**
(tangential)
3. **'The heavens must be crying'**
(centrifugal, metaphoric)

If you look at these three responses you can see that if you are not used to centrifugal or metaphoric thinking you could draw the wrong conclusion and mistake it for the second one, which is tangential or thought-disordered.

WAYS of UNDERSTANDING

Bill and John often arrive late for meetings

1. **'They must both have busy jobs'**
(centripetal, similarity based on a component detail)
2. **'Bill must be John'**
(idiosyncratic, delusional)
3. **'They must be destined to share the same destiny'**
(centrifugal, similarity based on larger context)

Here again it might be possible to confuse two with three - the idiosyncratic or delusional response with the larger-context way of understanding. I raise these points because there is every opportunity to confuse tangential or delusional thinking with metaphoric thinking if one is not aware of different cultural ways of thinking.

The other aspect of cultural competence has to do with what communities expect from us. As psychiatrists we are sure that when we treat someone the outcome is good, as they have lost the delusion, lost the hallucination - a pity they can't walk because they are so full of medication, but that is a minor issue as at least they are not deluded. Communities of course expect that if you send someone for treatment when they come back not only will they be mentally more relaxed but they just might be able to walk as well, and it would be a great advantage if they were also able to interact with people. So communities expect different things and judge an outcome differently. The other thing is that psychiatrists perhaps more than other medical specialists find that they are not the only ones who are experts in mental health in some communities - there are traditional healers as well. Increasingly, psychiatrists will need to work in co-operation and collaboration with traditional healers - not trying to explain the traditional healer's role according to their own viewpoint but accepting that there is another body of knowledge and a way of understanding through other eyes. Working with healers who have quite a different way of looking at the world is I think going to be an increasing demand on psychiatrists and the issue is trying to understand the viewpoint and where they are coming from and not necessarily trying to interpret it to fit in the DSM-IV.

Just a final note here on workforce composition, and this is why the website is going to be so useful. Next year will be the centennial year of the graduation of Te Rangi Hiroa (Peter Buck) who was the first Māori doctor to graduate in New Zealand, as Maui Pomare graduated overseas. His entry into medical school in 1900 came about largely because of the University of Otago's affirmative action programme. One hundred years ago they started this programme so that there would be two Māori medical students taken in for medical training - the other one was Tutere Wirepa. It was an attempt to try to get the medical workforce in New Zealand to approximate the composition of New Zealand's population. It was very enlightened thinking 100 years ago, so enlightened that in the United States I understand they are now getting rid of affirmative action programmes because they think they have run their course. However New Zealand's workforce is changing and New Zealand graduates are moving overseas very quickly, so a lot of overseas doctors are coming in and we are getting quite a different cultural mix. The Henry Rongomau Bennett Programme is one attempt to try to get more Māori doctors into psychiatry. Last year there were five scholarships awarded to Māori registrars and the idea is again that we should get a psychiatric workforce that begins to approximate community reality.

There are a lot of implications for cultural competence and not necessarily by the way just for doctors who come from overseas, because most doctors who come from overseas to New Zealand are much more use to working in multicultural situations than New Zealand doctors. Our environment here is a very narrow environment really whereas doctors from other parts of the world have by and large been much more exposed to a range of cultures than have New Zealanders. So it's not necessarily a question of New Zealand doctors and overseas doctors, it's a question of all doctors being able to have some sense of cultural competence. The question comes up should that be regularly examined? In other words should getting your Practising Certificate depend on being able to show competence culturally as well as clinically.

That really is all I wanted to say - just to raise the question of cultural competence and to say how important I think this website is going to be because that is essentially what it is doing, it is explaining to psychiatric registrars in an easy to handle way the significance of culture in psychiatric training. So again congratulations to those who have been involved in launching this and I am sure it will be a great asset to trainees.

Kia ora, Mason Durie

Tirohanga Māori by Mason Durie
Extracts from Chapter Five of Mason Durie's book 'Whaiora'
(reproduced with the author's permission)

Tirohanga Māori - Māori Health Perspectives

At the opening of the Hui Whakaoranga, a national Māori health conference held on the Hoani Waititi Marae, Auckland, in 1984, the Hon. Ben Couch, Minister of Māori Affairs in the National Government, declared,

'...there is no such thing as Māori health or Pakeha health; there is only people health'.

He went on to ascribe differences in health standards to self-inflicted lifestyle choices,

'...most people who enjoy good health have earned it. The rules are the same for people of all races; good eating, plenty of sleep and exercise, and moderation in all things'.¹

His views were not atypical of the era but they were out of step with Māori thinking in two respects. First, they ignored Māori experience and the growing body of evidence which linked culture and health; and, second, they disregarded socio-economic status as a significant determinant of good health, quite apart from individual motivation.

Over the succeeding two days the Hui Whakaoranga rejected the notion that cultural factors were irrelevant to health and concluded on quite a different note, recommending that 'health and educational institutions recognise culture as a positive resource' and that 'the feasibility of including Māori spirituality in health education programmes in schools and in tertiary educational institutions be investigated'.²

Illness And Treatment

Prior to 1976, professional and academic interest in Māori perspectives on health and sickness tended to confine discussion to particular clinical syndromes which were unique to Maori and of anthropological as much as medical interest. Makutu and mate Māori, for example, attracted considerable comment from Western-trained psychiatrists, though tended to be reinterpreted as superstitious phenomena and of doubtful diagnostic significance^{3,4}. Māori concepts of illness were increasingly reinterpreted by the medical anthropologists in mental and psychic realms, scarcely relevant to the vast majority of human illnesses and hardly applicable to contemporary times. It was left to Māori writers to point out the continuing relevance of culture to illness and treatment, and to provide some balance for the more esoteric ideas which had appeared in the earlier medical and scientific literature. The process started with an examination of medical practice and hospital procedures to determine the significance of culture to Māori patients in everyday situations. Durie concluded that, although Māori were more often than not Westernized, or at least appeared to be, cultural heritage continued to shape ideas, attitudes, and reactions, particularly at times of illness. 'The concepts of tapu and the perception of illness as an infringement against tapu are central to much of the anxiety and depression which surround the Māori patient while in hospital. Family involvement at times of illness is likewise a very traditional and culturally necessary attitude which must be recognised in the management of the whole patient and not just his impaired organ.'⁵

The relationship between tapu and noa, and explanations of illness based on a postulated breach of tapu, continued to have meaning for Māori and therefore had implications for doctors in the management of Māori patients as well as the care of the deceased as long as they were still in hospital custody. Because early retrieval of a relative's body was critical to uphold the mana of the family and the individual, mourning Māori families were grossly offended if the body were not released within twenty-four hours of death. Post-mortem delays, or simple administrative inefficiencies, could add immeasurably to the grief of an already distressed family.⁶

Tipene-Leach, writing about aspects of the doctor-patient relationship, described a number of sensitivities and behaviours relevant to communication during a clinical examination.⁷ For instance, immediately asking patients to reveal their names, without any preliminary remarks, could lead some Māori to feel threatened even before the examination had commenced. Similarly, expecting a Māori patient to engage in direct eye-to-eye contact could be interpreted as an invitation to demonstrate bad manners since looking an older person in the eye was a sign of haughtiness or disrespect. Various parts of the body were also described as having special significance, though not necessarily at a conscious level. Medical or nursing interventions involving the head, sexual organs, hair, and nail clippings, required a measure of caution and a greater degree of circumspection than was customary in busy hospital wards.

The gradual introduction of Māori concepts into medical routines was not entirely welcomed, but nor was it dismissed outright. By the mid-1970s there was some tentative recognition that ethnicity and culture had implications for health. Māori views, though not always understood, were often taken on board at face value, even though they could not be rationalized in medical terms. Moreover, discussions of similarities between *tohunga* and doctor in the *New Zealand Medical Journal* had generated sympathetic interest.⁸ Both, it seemed, were experts in history-taking as a prelude to making a diagnosis; both took extensive family histories (*tohunga* more than doctor); both employed specific treatment methods; and both recommended periods of rehabilitation. By removing Māori concepts from the realms of the supernatural, and emphasizing their continuing importance even when a patient did not profess to subscribe to them, Western trained health professionals were more able to appreciate their significance and respect them.

Health And Well-Being

Having shown the relevance of culture to health and sickness, Māori interest then turned to the wider contexts of health and community. For some years it had been acknowledged that there were many dimensions to health. In its 1947 definition, the World Health Organization concluded that health was greatly influenced by social and cultural factors: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.⁹ The definition was a reminder to the world that there was more to health than biological dysfunction and that it went well beyond the province of the health sector. Neither was it the exclusive province of the medically trained doctor or nurse, although they had a particular interest in some aspects of it having made spectacular advances in the treatment of physical illnesses, especially infections, from the 1940s onwards. The problem was, or at least was perceived as being, that medical interest in physical disease greatly outweighed an interest in the person as a whole within a sociological and ecological environment. A cellular focus no longer seemed adequate for understanding the complexities of health even though it had been a useful step in the past.

During the 1970s Māori were beginning to insist that a narrow focus on micro-organisms or even on physical illness created a distorted framework within which to consider health and to plan for the future. Interest moved towards a view of health that made sense to Māori in Māori terms, and outside hospital. As Māori participation in the health debate escalated, a number of Māori perspectives were advanced. All emphasized the value of traditional belief systems to health, though not necessarily at the expense of Western medical practice. Indeed, seldom did debate move towards an exclusively Māori system. Greater balance was the goal.

Several views emerged, but one which subsequently gained wide acceptance as 'the Māori health perspective' was a four-sided health construct, later known as *whare tapa wha* (a four-sided house).¹⁰ Though often described as a traditional Maori approach to health, more correctly it was a view of health which accorded with contemporary Māori thinking. Its ready acceptance by Māori was to some extent proof of that. The characteristics of *whare tapa wha* are shown in Table 12.

The Whare Tapa Wha Four-Sided House

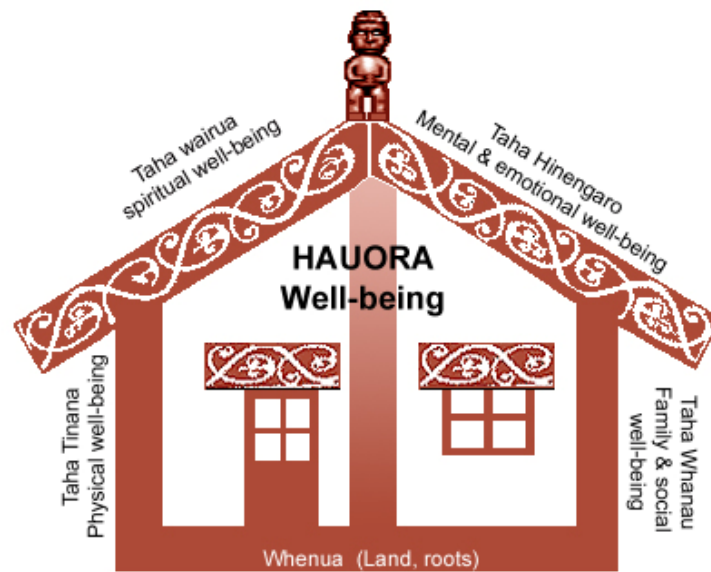


Table 12: The Whare Tapa Wha Model

	Taha Wairua	Taha Hinengaro	Taha Tinana	Taha Whānau
Focus	spiritual	mental	physical	extended family
Key Aspects	the capacity for faith and wider communion	The capacity to communicate, to think and to feel	The capacity for physical growth and development	The capacity to belong, to care and to share
Themes	Health is related to unseen and unspoken energies	Mind and body are inseparable	Good physical health is necessary for optimal development	Individuals are part of wider social systems

Whare Tapa Wha

Briefly, the whare tapa wha model compared health to the four walls of a house, all four being necessary to ensure strength and symmetry, though each representing a different dimension: taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side), taha whānau (family). The concept of health as an interaction of wairua, hinengaro, tinana, and whānau was first presented at the Rahui Tane Hostel in Hamilton in August 1982 during a training session for fieldworkers in the Māori Women's Welfare League research project, Rapuora.¹¹ During the welcome, kaumātua Tupana te Hira had emphasized in Māori the importance of wairua as a starting-point for health. It was a view that many kaumātua shared and which was frequently heard on marae throughout the country. Later that evening, psychiatrist Henry Bennett spoke about mental illness and mental health, while Dr Jim Hedge of the Medical Research Council described some of the common disorders such as kidney failure which affected Māori disproportionately. Dr Mason Durie, also a psychiatrist, drew these themes together, calling them taha wairua, taha hinengaro, taha tinana, and

taha whānau and leaving League members with a broadly based view of health which seemed to combine the four basic ingredients for good health. Importantly, a notion of balance between them was also introduced. The model later appeared in the Rapuora report: 'To say that a person is a psychosomatic unity, a personality formed jointly by physical and mental processes, only partly embraces the Māori concept. A study of Māori health must follow more than two strands. Tinana is the physical element of the individual and hinengaro the mental state, but those do not make up the whole. Wairua, the spirit and whānau the wider family complete the shimmering depths of the health pounamu, the precious touchstone of Māoridom'.¹²

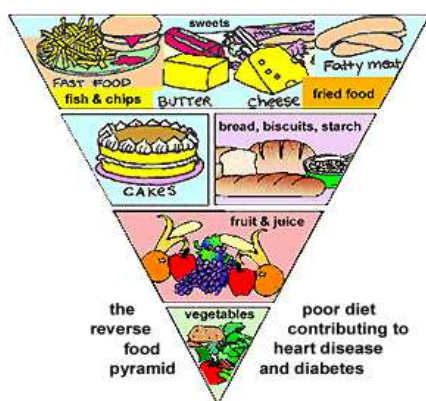
The four-part framework was again presented by Durie at a health hui held at the Palmerston North Hospital in December 1982¹³ and further developed for the 10th Young People's Hui held at the Raukawa marae in May 1983.¹⁴ The four dimensions of health were originally portrayed as a set of interacting variables, not dissimilar from a holistic view, nor for that matter from the World Health Organisation 1947 definition but, unlike them, firmly anchored on a spiritual rather than a somatic base.

Taha wairua is generally felt by Māori to be the most essential requirement for health. It implies a capacity to have faith and to be able to understand the links between the human situation and the environment. Without a spiritual awareness and a mauri (spirit or vitality, sometimes called the life-force) an individual cannot be healthy and is more prone to illness or misfortune. A spiritual dimension encompasses religious beliefs and practices but is not synonymous with regular churchgoing or strong adherence to a particular denomination. Belief in God is one reflection of wairua, but it is also evident in relationships with the environment. Land, lakes, mountains, rivers have a spiritual significance, quite apart from economic or agricultural considerations, and all are regularly commemorated in song, tribal history, and formal oratory.¹⁵ lack of access to tribal lands or territories is regarded by tribal elders as a sure sign of poor health since the natural environment is considered integral to identity and fundamental to a sense of well-being.¹⁶



Spiritually, the hours immediately following death are particularly significant. As the deceased person's spirit hovers tentatively between the visible world and the world of spirits, mourners themselves are able to feel a spiritual presence and to experience a renewed sense of continuity with their own ancestors, their history, and their future. For that reason a rapid retrieval of a deceased relative from hospital becomes a matter of urgency.

Taha hinengaro is about the expression of thoughts and feelings. In Māori nomenclature, thoughts and feelings derive from the same source, located within the individual. The notion that they are vital to health is a well-recognized concept among Māori. Western authorities have reached similar conclusions though through circuitous routes that have traversed psychological and psychiatric observations, a



path that other cultures have not needed in order to finish up at the same point. Māori thinking can be described as holistic. Understanding occurs less by division into smaller and smaller parts, the analytical approach, than by synthesis into wider contextual systems so that any recognition of similarities is based on comparisons at a higher level of organization. Consistent with this style of thinking, health is viewed as an interrelated phenomenon rather than an intra-personal one. Healthy thinking from a Māori perspective is integrative not analytical; explanations are sought from searching outwards rather than inwards: and poor health is typically regarded as a manifestation of a breakdown in harmony between the individual and the wider environment. There are several words and expressions which bind the individual to the outside world. Whenua, for example, can mean both placenta and the land, rae is either the forehead or a land promontory,

iwi refers equally to a bone (ko-iwi) or to a nation of people, while hapu can denote pregnancy and a section of a large tribe. The word for birth is whānau, the same term used to describe a family and wairua, spirituality, can also be used to refer to an insect, just as kapo can mean blind or a species of

eel. Whakapo is to darken (as in approaching night) and, as well, to grieve, waimate is a hereditary disease but also polluted water, kauae can be the jawbone or a major supporting beam in a building, and tahuu refers both to the vertebral column and the ridge pole of a meeting-house.

A further distinctive feature of taha hinengaro is its relevance to both thoughts and feelings. While Western thinking distinguishes between the spoken word and emotions (and generally encourages the word more than the feeling), Māori do not draw such a sharp distinction. Communication, especially face-to-face, depends on more than overt messages. Māori may be more impressed by the unspoken signals conveyed through subtle gesture, eye movement, or bland expression, and in some situations regard words as superfluous, even demeaning. Emotional communication can assume an importance which is as meaningful as an exchange of words and valued just as much. Condolences, for example, are frequently conveyed with tears; infrequently with words. So, when Māori children are chided by their teachers for showing what they feel, instead of talking about their feelings, they are not only made to feel unworthy (of their feelings) but must also contend with a sense of frustrated expression.

Taha tinana (bodily health) is a more familiar health dimension though the Māori emphasis is different in that there is the clear separation of tapu and noa. Certain parts of the body and the head in particular, are regarded as special (tapu), and bodily functions such as sleeping, eating, drinking, and defecating are imbued with their own significance, reflecting various levels of importance and requiring quite different rituals. Food, for example, is a leveller which removes any vestige of sacredness or distance (as between people). Because cleaning the body and eating are polar opposites, separation of food from toileting functions is regarded as necessary to maintain good health, a condition severely tested in hospital wards where all functions are frequently conducted in the same confined space. Body image may be regarded differently by Māori. Slender body forms are not necessarily prized more than well-rounded shapes, nor does obesity provoke the same sense of disapproval encountered in society generally. Perhaps because of this, anorexia nervosa remains relatively infrequent among Māori girls. By the same token, however, health workers report difficulties in trying to convince Māori patients that they should lose weight. Their efforts might be better spent in appealing to health risks, especially for future generations, rather than to personal vanity.

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The fourth dimension of health, taha whānau, acknowledges the relevance of the extended family to health. There are at least two important considerations. The first is that the family is the prime support system for Māori, providing care and nurturance, not only in physical terms but culturally and emotionally. Reported rises in the prevalence of family dysfunction including signs of abuse, do not lessen the point but underline its significance.¹⁷ Māori still maintain that ill health in an individual is a reflection on the family and may well blame a family for allowing a person to become ill or to die, even when there is no direct causal link. The practice of muru is still observed in some areas. When there is evidence that a lack of quality care by the family has contributed to death, neighbours and more distant relatives may seek retribution by removing family property or personal belongings, especially when the deceased is a community leader. Similarly, in cases of child abuse or neglect the extended family may take it upon themselves to remove the boy or girl from parental custody and take over the

caring role. Parental rights often tend to be seen as secondary to the interests of the whānau or even the tribe to ensure that future generations are protected.

A second consideration of taha whānau relates to identity and sense of purpose. The much-lauded state of self-sufficiency or self-realisation does not convey a sense of health to Māori. Quite the reverse, since an insistence on being overly independent suggests a defensive attitude, while a failure to turn to the family when the occasion demands is regarded as immaturity, not strength. Inter-dependence rather than independence is the healthier goal. Sometimes this goal clashes with the European regard for independence in teenagers as 'one of critical developmental tasks of adolescence, ...a fundamental building block of health'.¹⁸

Even in modern times a sense of personal identity derives as much if not more from family characteristics than from occupation or place of residence. Interest in family and tribal background rivals personal qualifications or achievements so that credibility, certainly in Māori settings, depends on an individual being able to make the links and demonstrate that there is active whānau and tribal support. On that basis, it has become a common occurrence for family members to accompany job-seeking applicants to an interview. Their role is a dual one: to convince the interview panel that their relative is the best person for the job, but also to ensure that the job itself is suitable and not likely to lead to exploitation, unfulfilled expectations, or disrespect. There have been instances when an applicant has been successful but the family, unhappy about the interview, has counselled against accepting the position. Similarly, there are numerous anecdotal accounts of candidates being passed over because of the family's confronting attitude during the interview.

Underlying the whare tapa wha model is the consistent theme of integration. Individual health is built into a wider system, the boundary between personal and family identity being frequently blurred. Similarly the divisions between temporal and spiritual, thoughts and feelings, mental and physical are not as clear-cut as they have been in Western thinking since the advent of Cartesian dualism.¹⁹ Māori interest in redefining health in their own terms and reclaiming a positive role in shaping health services was accelerated when the whare tapa wha model was introduced. It was simple, even simplistic, but that was also its appeal. In addition, it appeared at a time when Māori were debating the general direction which health services were taking. Widespread concern had focused on three issues.

First, Māori were not impressed by the overemphasis on physical aspects of health with its biological constructs and increasing preoccupation with cellular phenomena. Nor for that matter were a number of other New Zealanders. At a national conference to consider the role of the doctor, holistic care was emphasized to balance a perception that many doctors had acquired too narrow a focus, their work often lacking ecological and caring dimensions. 'Because the scientific and technical aspects of practice cannot be separated from human concerns and social skills, particular attitudes are required: the readiness to treat people as equals; empathy; willingness to share information two ways; and a recognition that patients have a responsibility for their own health.'²⁰

Second, many Māori felt that their relationship with health professionals, and with the health system generally, had become strained. Rightly or wrongly a feeling of alienation had arisen, not necessarily because of poor access or even inadequate care, but mainly because there was a lack of shared decision-making and limited recognition of Māori views. The more professionals acted as if they knew best, the less tolerant Māori became. Surely, they argued, Māori health belonged to Māori people. Māori health perspectives such as whare tapa wha were welcomed because they provided the necessary framework within which a semblance of ownership over health could be entertained. Third, despite a century and a half of colonization, Māori remained convinced that good health could not be gauged by simple measures such as weight, blood pressure, or visual acuity. Spiritual and emotional factors, though more difficult to measure, were equally important.

Te Wheke

There were other Māori health perspectives which gained acceptance in the 1980s. One of these, te wheke (the octopus), was discussed by Pere at the Hui Whakaoranga in 1984. In order to illustrate the

main features of health from a Māori family perspective, she compared health to an octopus.²¹ Each of the eight tentacles of the octopus symbolized a particular dimension of health while the body and head represented the whole family unit. The intertwining of the tentacles indicated the close relationships between each dimension.

Like te whare tapa wha, the model included wairuatanga (spirituality), taha tinana (the physical side), hinengaro (the mind), and whānaungatanga (the extended family, similar to taha whānau). The other dimensions were: mana ake, the uniqueness of the individual and each family and the positive identity based on those unique qualities; mauri, the life-sustaining principle resident in people and objects, including language; ha a Koro ma a Kui ma, literally the breath of life that comes from forebears and an acknowledgment that good health is closely linked to a positive awareness of ancestors and their role in shaping the family; whatumanawa, the open and healthy expression of emotion, necessary for healthy human development; and waiora, total well-being for the individual and the family, represented in the model by the eyes of the octopus.

Nga Pou Mana

In 1988 the Royal Commission on Social Policy described another set of values and beliefs - four supports, nga pou mana - as pre-requisites for health and wellbeing.²² As with the other models a set of interacting variables was proposed, the combination leading to individual and group well-being manifest by the retention of mana, cultural integrity a sound economic base, and a sense of confidence and continuity. This model, unlike the other two, placed greater stress on the external environment and the significance of oral tradition as a stabilizing influence. Though prepared primarily to examine foundations for social policies and social well-being, nonetheless it has relevance for health and has similarities with Durie's three 'institutions of health' - land, language, and family.²³

The four supports - family (whānaungatanga), cultural heritage (taonga tuku iho), the physical environment (te ao turoa), and an indisputable land base (turangawaewae) - brought together social, cultural, and economic dimensions in a way which could be readily appreciated by Māori and which demonstrated the links between the three. Particular reference to the environment (te ao turoa) was perhaps influenced by the Waitangi Tribunal's landmark decisions in respect of claims made by tribes against the Crown and on the basis of pollution of tribal waterways.²⁴ These claims had all recognized the significance of a clean environment for good health and drew attention to the overlap between physical and cultural pollution. Quite apart from the effects of effluent on seafood and the consequent risks of hepatitis or other alimentary diseases, Māori claimants also described a type of pollution which debased spiritual and cultural values. Disposal of human waste, treated or not, onto potential food sites or into wahi tapu (historical sites declared tapu) offended Māori just as the depletion of traditional foods through pollution created embarrassment when families were unable to meet customary hospitality obligations when visitors arrived.

Turangawaewae is a pou mana with cultural, social and economic significance. Not only does it refer to land rights and access to an economic base, it also includes the marae, an institution, perhaps like no other, where Māori custom and tradition, including language, have priority. A measure of Māori identity, and indirectly a health measure, is the level of access, as of right, which an individual has to a marae. Since the marae is the epitome of a collective identity and one of the few remaining opportunities for social relationships to be strengthened in a manner which is mutually supportive, it enables Māori to redress some of the imbalance between individual and group pursuits inevitably created by life in suburbia.

Taonga tuku iho, cultural heritages upon which intellectual and philosophical traditions are based, are also valued by Māori because they suggest a continuity with past wisdom and consolidate a Māori identity. Increasing recognition of language as a taonga (treasure), important for cultural and health reasons, has resulted in extensive revitalization strategies locally and nationally. After considering a claim brought by Nga Kaiwhakapumau i Te Reo (the Wellington Māori Language Board), the Waitangi Tribunal described language as a taonga, categorizing it along with physical resources such as land.²⁵ The Tribunal report made it very clear that there was a Treaty of Waitangi obligation on the Crown to ensure that Māori language was strengthened before it was lost altogether, and the point was made on several occasions that without language any sense of pride or cultural integrity is seriously undermined.

Cultural heritage, as a basis for well-being if not health, also concerns the ownership of intellectual and cultural property. Cultural erosion has come about not only because of assimilation but also because history, traditions, art forms, healing methods, and poetry have often been appropriated by others and in the process Māori have been denied a guardian or custodial role, or have lost access to their own material altogether.

The Draft Declaration on the Rights of Indigenous Peoples recognizes that the significance of intellectual property to indigenous peoples as well as indigenous forms of health care, based on traditions passed down over the generations.²⁶ Article 22 of the Draft Declaration states that 'Indigenous peoples have the right to their traditional medicines and health practices, including the right to the protection of vital medicinal plants, animals and materials'. Article 27 is more specific: 'Indigenous peoples have the right to special measures to protect, as intellectual property, their sciences, technologies and cultural manifestations, including genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs and visual performing arts'. Table 13 summarizes the main features of the three perspectives:

Table 13: Māori Health Perspectives - Three Models

	Whare Tapa Wha	Te Wheke	Nga Pou Mana
Components	Wairua Hinengaro Tinana Whānau	Wairuatanga Hinengaro Tinana Whānaungatanga Mana ake Mauri Ha a koro ma a kui ma Whatumanawa	Whānaungatanga Taonga tuku iho Te ao turoa Turangawaewae
Features	Spirituality Mental health Physical Family	Spirituality Mental health Physical Family Uniqueness Vitality Cultural heritage Emotions	Family Cultural Heritage Environment Land base
Symbolism	A Strong House	The Octopus	Supporting Structures

Other Māori health perspectives were advocated on various occasions. Te Roopu Awhina o Tokanui, a group of Māori health professionals at a psychiatric hospital, became active in promoting Māori health, particularly mental health, and were instrumental in establishing a Māori unit, Whaiora, within Tokanui Hospital. At the Australian Congress of Mental Health Nurses held at Adelaide in 1986, they presented a nine-part framework to guide psychiatric nursing: taha wairua (spirituality), taha whānau (family), taha hinengaro (well-being), taha tinana (physiology), taha whenua (environment), taha tikanga (compliance), Māoritanga (old world), Pakehatanga (new world), taha tangata (self).²⁷

All Māori health perspectives had similar themes. Essentially they sought to widen understandings of health, to translate health into terms which were culturally significant, and to balance physical and biological approaches with cultural and sociological views. The Department of Health agreed that, 'Māori people in general believe that their current health status is ultimately linked to their historical, social, cultural, economic, political and environmental circumstances. In order to achieve any improvement in health status, health initiatives must incorporate a holistic definition and approach;

and be part of a developmental strategy to improve the overall status and well-being of a Māori community, tribal or family group. In doing so Māori people would like to define health for themselves; identify their own specific health concerns; ...take responsibility for their own health; be involved in their own health care.'²⁸

The appearance of the Māori health perspectives in the early part of the 1980s was not altogether surprising, given the strong moves towards positive Māori development and a rejection of assimilationist ideals. In education, housing, social welfare, and political representation Māori were intent on injecting a genuine Māori point of view as a prelude to reclaiming some degree of ownership and autonomy over social as well as economic arenas. Health was no exception.

But the perspectives also reflected a more general re-examination of New Zealand's health goals and its health services. Māori often articulated issues which had worried a wide cross-section of New Zealanders but which had not otherwise been able to find expression. The S-Factor for example was a concept used to encompass spirit, spirituality, or even 'something which represents that which defies being placed into the categories of ethics, psychology, religion, and sociology'.²⁹ It was seen to be similar to taha wairua, but more relevant to Western than Māori culture, and it was introduced to balance a preoccupation with measurable and quantifiable health outcomes. Once Māori began to talk about spirituality, thoughts, feelings, and family in connection with health, others followed.

However, not everyone was impressed by the Māori health perspectives. To sceptics, they were based on romantic visions of the past, devoid of practical application and likely to discourage Māori patients from seeking appropriate health care, in a time when science and technological advances were enabling organ transplants and new hopes for the disabled, Māori, it seemed, were longing for the quiet life and a return to a world now recognizable only in the history books. Further, because whare tapa whā extended the focus for health well beyond the individual, a sense of futility often developed among health workers. How could a diabetic regain health if the land injustices of the past century were ignored? By taking the debate to the widest possible levels, health programmes ran the risk of being so general and indistinguishable from welfare programmes that they would have no significant impact. Worse, if cultural factors were so important, sometimes it seemed pointless to treat a diabetic unless steps were also taken to provide parallel cultural enrichment; and health workers sometimes felt that they should take the initiative.

Far from improving treatment opportunities, it was argued that the new perspectives would displace clinical priorities and resources with sociological, economic, or political agendas. A further issue concerned the difficulty in measuring concepts as diffuse as taha wairua. While measurements of physical illness and subsequent medical interventions lacked accuracy, they were improving and at least there was some agreement about the desirable indicators. Not so in mental health (taha hinengaro) and even less so in spiritual matters. Was taha wairua of any practical value if it could not be measured? The critics felt not.

Generally, however, Māori health perspectives were consistent with new orientations and global trends: general systems theory, family psychotherapy, the community health movement, health promotion, primary health care, and calls for de-medicalization of the human life cycle. New Zealand was moving in the same direction and, in recommending a national health policy in 1988, the New Zealand Board of Health advocated five principles: holism, empowerment, social and cultural determination, equity of access and devolution, and equitable and effective resource use.³⁰ The Board had borrowed extensively from Māori views and writings.

By 1990, Māori views on health had made a significant impact on New Zealand health services generally, but more importantly they had given Māori people the necessary confidence, based on their own understandings of health, to challenge the system and reclaim a more active participatory role in society and within the health sector.

Specific Cultural Syndromes

Mate Māori and other Specific Māori Concepts relating to Mental Health

Note that while it is useful for psychiatrists and registrars working with Māori patients and whānau to have some idea that mate Māori and other specific conditions exist and to have heard the terms, it is very important that non-Māori mental health clinicians do not assume that they in fact understand these conditions or have any expertise in them. This is the area of expertise of local tohunga and kaumātua assisted by Maori cultural workers, and if such concepts arise in work with Māori patients and whānau, it is vital to seek expert cultural assistance.

In Mauri Ora, (Published Oxford University Press 2001), Mason Durie writes:

"While many disorders are recognised the world over, even if they do present in different ways, there are some mental and behavioural states that cannot be accommodated in Western classifications... Although culture-bound syndromes are not frequently recognised among Māori, explanations for poor health can be quite different from Western beliefs... Mate Māori, for example, leads to an affliction said to be related to spiritual causes, and requires the intervention of a traditional healer, a tohunga. In Rapuora, the 1984 study of the health of Māori women, one in every five women respondents said they would go to a Māori traditional healer if they had a mate Māori though not all knew who might be an appropriate healer, nor could one in five women say what was meant by mate Māori.¹ The term refers essentially to a cause of ill health or uncharacteristic behaviour which stems from an infringement of tapu (a tribal law) or the infliction of an indirect punishment by an outsider (a mākutu).² The prevalence of mate Māori has never been recorded although there are published accounts of isolated cases of the condition and its management.³ It may take several forms, physical and mental, and various illnesses not necessarily atypical in presentation may be ascribed to it.

While mate Māori applies to physical as well as mental illnesses, increasingly it has become a focus to explain emotional, behavioural and psychiatric disorders, presumably because many physical illnesses are now seen as having a more specific cause. Thus there is no single clinical presentation and clinicians need to be alert to the possibility that relatives may have considered the possibility of mate Māori. Most families will be reluctant to discuss mate Māori in a hospital or clinic setting, fearing ridicule or pressure to choose between psychiatric and Māori approaches. In fact, one approach need not exclude the other; cooperation between traditional Māori healers and health professionals is now becoming acceptable to both groups. Mate Māori does not mean there cannot be a coexisting mental disorder. At best, the term is a comment on perceived causes of abnormality rather than on the symptoms or behaviour which might emerge. Yet it remains a serious concept within modern Māori society, and to many people, mate Māori sounds more convincing than explanations that hinge on a biochemical imbalance or a defect in cerebral neurotransmission.

Other situational responses may present as if they were mental disorders. Whakamaa for example, a mental and behavioural response that arises when there is a sense of disadvantage or a loss of standing, can be manifest as a marked slowness of movement and a lack of responsiveness to questioning, as well as avoidance of any engagement with the questioner.⁴ A pained, worried look can add to a picture that is suggestive of depression or even a catatonic state. But the history is different and the onset is usually rapid - unlike those other conditions where a more gradual development occurs. Sometimes, because Māori will often report seeing deceased relatives or hearing them speak, a diagnosis of schizophrenia or some other psychosis may be made. However, if visions or hearing voices are the only symptoms there is never a firm basis for diagnosing a serious mental disorder."

Footnotes:

1. E. Murchie, Raupora: Health and Maori Women, Maori Womens Welfare league, Wellington (1984)
2. Elsdon Best, Māori Religion and Mythology, Dominion Museum Bulletin No. 11, Wellington, p.108 (1982)
3. G. Blake Palmer, Tohungaism and Mākutu, Journal of the Polynesian Society, vol 63, no. 2, pp 147-163 (1954)
4. Joan Metge, Whakamaa, Mana and Māori Self-Image, in Philip Culbertson (ed.), Counselling Issues and South Pacific Communities, Accent Publications, Auckland, pp 46-47 (1997)

Epidemiology: Māori General Health

(Written by Dr Felicity Plunkett, 2003)

Introduction:

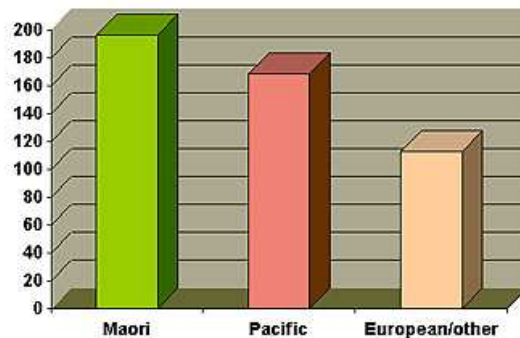
W.H.O. has recognised the social and cultural components of health since 1947, defining health as "a state of physical, mental and social well-being and not merely the absence of disease or infirmity". Māori view health holistically, with several dimensions as described by Durie in Whaiora (1994). To Māori, self-sufficiency and self-realisation do not convey a sense of health because inter-dependence is considered a healthier goal than independence. Health is seen primarily as a collective responsibility, although individuals have some responsibility for their own health. Individual health is seen as part of a wider system, and the divisions between temporal and spiritual, thoughts and feelings, and mental and physical, are not as clear-cut as in Western thinking. See [Maori Health Perspectives](#) for more details.

Māori health has become a priority area for New Zealand public health initiatives and for the Ministry of Health, due to serious discrepancies in the health of Māori compared with non-Māori. Several sources have demonstrated these differences, as follows.

DALYs:

The epidemiological study *Our Health Our Future: the Health of New Zealanders* used disability adjusted life years (DALYs) to assess the burden of disease. DALYs were calculated by adding years of life lost as a result of fatal diseases and injuries to years lost to disability as a result of non-fatal diseases and injuries.

Disability Adjusted Life Years (DALYs) per 1000 population, in New Zealand for 1996 (a DALY represents one year of life lost to either death or disability)



One DALY represents a year of healthy life lost. DALYs were calculated for about 85 diseases and injuries, and for eight major risk factors where solid evidence exists for a causal link to fatal illnesses or non-fatal but significant disability. Data for Māori and non-Māori (apart from Pacific peoples) came from 1996. Pacific data came from 1996 and 1997 due to smaller numbers.

Cardiovascular diseases were the largest cause of health loss in Māori, followed by cancer. Ischaemic heart disease was the leading disease cause of DALYs lost among Māori men and women. Smoking was the leading risk factor cause of DALYs lost among Māori men and women. DALYs were then adjusted for potential modifiability. On a scale combining individual diseases and risk factors, smoking was the leading cause of modifiable DALYs lost by Māori men and women.



Mortality Statistics:

Government mortality statistics show that the Māori mortality rate (764 per 100,000 population) was 85.0 percent higher than the non-Māori rate (413 per 100,000 population) in 1999. Mortality from all cardiovascular diseases is higher among Māori than the general population. Coronary heart disease is the leading single cause of death for Māori. Māori males had an ischaemic heart disease mortality rate that was 92% higher than the non-Māori rate, while the Māori female rate was 127% percent higher than the non-Māori female rate. The coronary heart disease mortality rate for Māori aged under 65 years is almost three times higher than that of non-Māori in this age group. Death rates from hypertensive disease are five times higher in Māori than non-Māori. Māori males had a cerebrovascular disease mortality rate that was 26.4% higher than the non-Māori rate, while the Māori female rate was 34.6% higher than the non-Māori female rate. Māori males had a cancer death rate that was 53.2% higher than the non-Māori male rate, while the Māori female rate was 70% higher than the non-Māori female rate.

Lung cancer was the leading cause of cancer death for Māori in 1999.



Tamariki Māori:

There are also serious concerns about the health status of Māori children. Children in Māori society ensure the future survival of whānau, hapū and iwi, and the continuation of Māori culture, language and traditional beliefs and practices. The strong social structures of whānau, hapū and iwi provided support mechanisms that protected and nurtured tamariki and reinforced their sense of belonging. Children are the responsibility of the entire whānau. Since colonisation there has been a marked deterioration of traditional Māori structures which has adversely affected the health and wellbeing of whānau, including children. Māori whānau, communities and individuals have very different lifestyles. Some Māori have strong ties to their iwi, hapū, and marae while others have lost these connections. Māori live in urban and rural communities and socio-economic factors such as lower income, reduced employment, poorer housing and poorer educational outcomes are big contributors to disparities between Māori and non-Māori child health.

Tamariki aged 0-14 years make up 38% of the Māori population, and this percentage is likely to continue. Tamariki Māori have poorer health than non-Māori children across a wide range of indicators, even though in the past decade some gains in the health of Māori children have been achieved. In part, this is due to Māori involvement in health planning and service delivery and also improvements in the responsiveness of health professionals towards Māori. There has been a substantial reduction from 1970 to 1991 in the mortality rate in the first year of life for Māori infants. Perinatal causes of death in Māori from 1987 to 1991 decreased by a third and respiratory diseases by more than half between 1980 and 1984, with substantial reductions in death rates from unintentional injuries as well.

However there are continuing disparities which indicate that, to date, measures taken to improve general child health have not been as effective or appropriate as had been hoped, for Māori children. Māori children are at greater risk than non-Māori of dying before the age of 15 years. In 1994, Māori recorded a death rate 63 percent higher than non-Māori in this age group. There are higher death rates for tamariki Māori for most of the major causes of death in children. Sudden Infant Death Syndrome (SIDS) is still a major cause of Māori infant death. Although the Public Health Commission purchased a national Māori-focused health programme, in 1991 Māori still had a SIDS rate just over three and a half times that of non-Māori. The death rate for respiratory conditions was 2.7 times that for non-Māori children. For road traffic injuries and other injuries and poisonings, tamariki Māori had death rates 1.5 times higher than non-Māori children. The largest disparities between Māori and non-Māori rates of hospitalisation are in respiratory conditions, nervous system conditions, injuries and poisonings. For each of these conditions, tamariki Māori are hospitalised at rates around twice the non-Māori rates.

Māori children's health will have a substantial effect on the health and productivity of New Zealand as a nation. Important public health goals are to increase the Māori rate of immunisation to 95% by the year 2000, and to reduce hearing loss in Māori children to under 5% of those who fail their first hearing test at school. Access to and cost of health services and medications are major issues for

Māori families, determining whether children are seen and treated within the health system. The Central Regional Health Authority found that, despite identified need and improved purchasing arrangements, Māori children in areas such as in Wairoa and Porirua still missed the opportunity for grommet insertion. The reasons for barriers to care need to be clarified and addressed. The Ministry of Health released a policy paper in 1996 on Child Abuse Prevention. There is a need to review the relevance, cultural appropriateness and effectiveness of child and family policies for Māori, particularly programmes aiming to prevent and respond to child abuse. This is a complex area which requires a wide range of research across agencies and with Māori.

Māori women generally have a lower rate of delivery complications than non-Māori women. Māori women's fertility rate is slightly above non-Māori women so the number of births recorded as Māori are likely to significantly increase. It is estimated that by 2050 approximately one third of the New Zealand population will be Māori. The lower rate of complications of Māori births highlights that at birth Māori babies are likely to be healthier than non-Māori. But from the first day of life their health is influenced by their social, economic and physical environment.

Health of Māori Women:

The Māori Women's Welfare League's 1984 study Rapuora - Health and Māori Women was an important community-based research project. The survey found that women who were most involved in marae or Māori activities were more likely to enjoy better health than other Māori women. Stress was identified as a major health problem, due to the many roles and responsibilities Māori women had in caring for others, and the pressures of living within a severely limited income. In 1992, the life expectancy of Māori females at birth was five years longer than Māori males, although Māori women's life expectancy is still six years less than non-Māori women.

Cancer and coronary heart disease are the two major causes of death for Māori women aged 25-64 years. The major sites for cancer are lung, breast and cervix. Hospital admissions for Māori women for these diseases also do not accurately reflect need. Half the adult Māori female population still smokes, despite their significant awareness of the dangers of tobacco and the introduction of different smokefree and quit programmes. The government released a national policy on tobacco and alcohol in 1996, but despite awareness of the harm these drugs do to Māori health, no national goals have been set specifically for Māori. The effectiveness of screening programmes for Māori women have also needed to be reviewed from a Māori perspective. Examples are the national cervical cancer screening programme and the proposed national mammography programme for women aged 50 to 64 years. Since the introduction of the cervical screening programme in 1990, Māori women have challenged the boundaries of health service delivery. For example, they advocated that the programme should involve their partners, recognise Māori values and beliefs, and enable Māori women to be health educators and smear takers.

Violence, homicide and injuries are growing health problems for Māori women, often leading to deaths and hospital admissions. Research is needed to investigate the outcomes for Māori women and whānau in relation to legislation to combat domestic violence, national crime prevention programmes, changes in the sale and consumption of alcohol and wider introduction of new modes of gambling, which tend to target those already caught in the poverty trap.



The Māori population is beginning to age. Over the next two decades the number of Māori aged 60 years or over is expected to increase from just over two percent to 12% of the Māori population. Since Māori women live longer than Māori men, kuia will make up a growing proportion of Māori elders, yet their needs have not yet been adequately addressed in health planning. Healthcare for older people is not yet a government priority area for targeted funding.

Health of Māori Men:

Māori men's growing interest in their health is part of the general movement of men interested in their own health and personal development, similar to the early stages of the women's health movement in the 1970s. When the Māori Women's Welfare League released Rapuora in 1984, the New Zealand

Māori Council was challenged to initiate a similar study by and for Māori men. This challenge has yet to be taken up by any organisation. It is known that Māori men have a lower life expectancy than Māori women and generally die three or four years earlier. Death rates for Māori men are higher than for Māori women in all age groups. They are most marked from ages 15 to 24, when the rate is two and a half times greater.

Motor vehicle crashes, other accidents and suicides are major causes of death for Māori men aged 15-24 years. Injuries are increasingly the cause of Māori admissions to hospitals. Falls and motor vehicle crashes comprise the largest categories of hospitalisation causes. Those aged from 20 to 24 were the most likely to be admitted for injuries relating to motor vehicle crashes, assault and injury. In the North Health area in 1992, unintentional injuries alone accounted for a third of Māori male hospital admissions. There is also an increase in homicide, especially among 15 to 24 year olds.

Coronary heart disease is a major killer of Māori, with the rate for men higher than that for women. This is particularly so in the 25 to 44 age group, when Māori men should be in good health and contributing to their whānau, hapū, iwi and the wider community. Despite the high rate of Māori death from coronary heart disease, Māori men have a low admission rate for treatment, so there are significant barriers to care.



Cancer is a leading cause of death and illness for Māori, occurring earlier and in different sites in men compared to women. The leading sites for men are the lung, stomach, and prostate. As the Māori male population begins to live longer, prostate and colon cancer are on the increase.

Whānau Health:

In two important hui about Māori Health in 1994 a major emerging theme was the need to rebuild and strengthen Māori whānau and to support Māori women who often act as the kaitiaki of their whānau. Research into whānau health is difficult due to the definition of the concept. Interpretations range from tribal descent groups known as hapū and iwi, all of the descendants of a relatively recent ancestor and their spouses and adoptive or foster children, single person or nuclear whānau, or groups which may not have blood ties but who live as a cohesive unit (a household). However, for Māori the concept of whānau generally implies some linkage by whakapapa, irrespective of how many generations or kin are included. One of the problems of determining the health and socio-economic profile of Māori whānau is that there is little statistical information available on traditional Māori whānau groupings. Instead, information is collected on Māori households, which is not at all the same.

It is being recognised increasingly that the whānau is the cornerstone of Māori society. If Māori are to have a secure future, social and economic policies, legislation, health and social services must strengthen whānau, and help reintegrate members who have become estranged from kin. One issue which has been mentioned is the incidence of abuse in Māori families. Looking at international comparisons, Morris (1998) found that 3% of Canadian or Australian women had experienced physical or sexual violence by a spouse or ex-spouse within the last 12 months, compared to 25% of Māori women in New Zealand. 15% of Canadian women and 8% of Australian women experienced at least one violent incident during their relationship, compared to 44% of Māori women and 15% of non-Māori New Zealand women. Māori children are much more likely than non-Māori children to be assessed by C.Y.F.S. as abused or neglected. In 2001, the rate per 1,000 was 7.2 for Māori and 4.9 for non-Māori. Aroha Terry at the 1995 Public Health Conference proposed that Māori should be supported in developing their own processes for healing and dealing with abuse. These processes support the care and rehabilitation needs of the victim, as well as working with the perpetrator of violence who is often kin. She suggested that the marae was the most appropriate place for healing to take place for victim and perpetrator. The Children, Young Persons and Their Families Act 1989 incorporates family conferences, recognition of Māori values and kinship, and development of iwi social services.

Information available on Māori households and individuals suggests that the health of Māori whānau is at a crossroads, and that this worsened significantly in the late 1980s and 1990s. Economic restructuring increased the incomes of those in higher income groups to the disadvantage of those in lower socio-economic groups. Almost one-third of Māori households are headed by a sole parent -

usually women with little support and dependent on state benefits. The proportion of Māori households in the bottom quartile increased significantly (from 26% to 43%) between March 1988 and March 1992. All this impacts directly on health status.

Te Puni Kokiri's analysis of the labour market also identified increasing disparities between Māori and non-Māori. TPK concluded that even if the economy significantly improved, the marginal position of Māori in the labour force might not change. Future employment opportunities will need educational qualifications. In 1991, approximately two-thirds of Māori men and women over 15 years had no educational qualification. Poverty is increasing in New Zealand with many families, particularly Māori, now living below an unacceptable income level. Children in these families live in situations where housing and employment are insecure. They have few choices, limited access to health care or to an education which nurtures who they are, their cultural identity or their aspirations.

Decision makers and health workers need reminding of the interrelationship between health and socio-economic status, Māori rights under the Treaty of Waitangi, and health promotion strategies listed in the Ottawa Charter. The World Health Organisation also reminds us through the Alma Ata Declaration of 1978, to which New Zealand is a signatory, that socio-economic differences must be addressed for health disparities to be eliminated. Another issue is that Māori processes include the individual and the whānau. If these were fully recognised in law, Māori could challenge the Code of Consumer Rights, the Code of Health Information and the Health and Disability Services Act 1993. These processes provide defined rights for individuals but not for the collective. Consistent with the Alma Ata Declaration, Māori at the 1994 Te Ara Whakamua hui defined good health as a strong sense of identity, self esteem, confidence and pride; control over your own destiny; knowledge of te reo and tikanga; economic security; positive leadership and respect for others; and intellectually, spiritually and physically alert individuals and whānau.

Summary:

In the light of all these issues, the Ministry of Health continues to focus on reducing inequalities in health, via the Māori Health Strategy. The Health Research Council is making research to clarify these issues a priority, and Māori iwi and other organisations continue to work to bring services to their people in a form which reduces the barriers to healthcare entrenched in older, European-model health systems. The overall thrust is for partnerships between 'By Māori for Māori' providers and mainstream providers, at all levels within the health sector and between government agencies. Closer consultation with Māori is improving the effectiveness of healthcare delivery and of public health campaigns to reduce risk factors. The complex interwoven causes of poorer health in Māori are however likely to alter only slowly, being bound up with urban isolation from whānau, hapū and iwi, loss of ties to the land, socio-economic status, employment, diet, addictions and psychological health.

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Epidemiology: Māori Mental Health

(Written by Dr Felicity Plunkett - 2003)

Introduction:

Increasingly, mental illness is a serious health problem facing Māori. Mental Health Foundation Research Director Geoff Bridgeman and Lorna Dyll who carried out a report on Māori mental health for the Ministry of Health (1998) said the rate of psychotic illness among Māori indicated a "culture under siege". Approximately 25% more Māori were first admitted to psychiatric institutions than Pakeha, with readmission rates increasing by 65% between 1984 to 1993, such that they are now twice the rate of European New Zealanders. Alcohol related admissions represented the greatest area of increase with drug psychosis admissions making up 21% of all Māori admissions related to drugs and alcohol. Readmission rates were also particularly high for schizophrenia and mood-related psychoses, with 38% of Māori admitted to psychiatric hospitals in 1993 being diagnosed as having schizophrenia compared with 22% of Pakeha. This may not reflect increased true rates of schizophrenia in Māori however as many of these patients recovered rapidly and their conditions did not follow the longer-term course of schizophrenia. Lack of understanding about the adverse life experiences of many Māori patients may lead non-Māori clinicians to misdiagnose major psychoses when a condition is in fact caused by stress, substance abuse, or both. In addition, the possibility of misdiagnosis of a Māori state called *mate Māori* has been raised. *Mate Māori* can include similar symptoms of bizarre thoughts, voices, disconnected speech and behavioural changes, but has different causes and is felt to respond better to cultural and spiritual interventions. (See [Specific Cultural Syndromes in Māori](#))

Mental Health Service Utilisation:

Hospitalisation patterns for Māori also indicate that proportionally more Māori are committed to hospital under the Mental Health Assessment and Treatment Act. This increases the likelihood that by the time Māori do come into contact with specialist services they will experience them as punitive rather than as aiding the process of healing. Barriers clearly exist for Māori in accessing mental health services at an earlier stage, but better service utilisation studies are needed to clarify these. Mental Health Services need to assess how well all population groups are served and with which disorders Māori present, compared to non-Māori. In order to answer these and other questions it is critical that clinical staff collect ethnicity and diagnostic data accurately. However the Public Health Consultancy of the Wellington School of Medicine and Health Sciences in developing a Population Needs Assessment for twelve of the provincial DHBs noted considerable difficulties in needs assessment for Māori due to ethnicity data not being accurately and consistently collected, such that current service utilisation figures could not be assumed to accurately reflect the true number of Māori accessing services. In addition, diagnosis was frequently not reported.

Mental Health Priorities:

Māori women now have a greater risk of alcohol and drug abuse and of being admitted to a psychiatric facility than non-Māori women. This is linked to the increased stress on many Māori women from economic hardship, dislocation from *whānau*, *hapu* and *iwi*, unemployment, histories of abuse and dysfunctional relationships, and child rearing - often on their own and with little support. Mental health is increasingly being recognised as a major issue for Māori men as their initial and re-admission rates continue to rise. In the 20-29 year age group, Māori men are at greatest risk of mental illness. Their first admission rates to a psychiatric inpatient unit are now more than three times the overall rate. Alcohol and drug abuse is a major factor. Despite deinstitutionalisation and the development of community-based mental health services over the last decade, Māori men still have poor access to mental health care services. A third of Māori male admissions to mental health services from 1984 to 1993 were non-voluntary, often directed by the justice system. Māori men were also more likely to be in a forensic care setting, to be diagnosed with schizophrenia, and to spend less than half the time in hospital for this diagnosis than non-Māori. The issue of improving access to and effectiveness of mental health services is growing in importance as it becomes accepted that poverty, unemployment, *whānau* dysfunction, low educational achievement, alcohol and drug abuse and marginalisation increase the incidence of psychological distress and mental disorder. Motor vehicle crashes, accidents and suicides are major causes of death for Māori men aged 15-24 years. The

frequent lack of culturally appropriate early detection and support systems for young Māori men has been blamed for the current high admission rates. Schools have a particular responsibility to increase general awareness of Māori mental health needs and to be aware of mental health issues for young Māori.

Despite some attempts by public services to take the needs of Māori into consideration, many remain essentially monocultural. The development of kaupapa Māori services based on tikanga Māori principles is thus a focus of Ministry of Health planning. To aid planning, more accurate information is needed. At present, due to patchy health service data-gathering and confounding factors such as barriers to presentation, it is not known whether the true prevalence of mental illness in Māori is in fact higher or lower than that of the rest of the population. To investigate this, the Ministry of Health in conjunction with the New Zealand Health Information Service and the Health Research Council commissioned an epidemiological survey for mental health in 2002. The results should provide clearer information on the prevalence rates of certain mental illnesses in the general population by age group and ethnicity. A Māori outcome tool was also developed, and was to be trialled during 2002.

Mental Health of Prison Inmates:

A further indicator of lack of access to timely and appropriate mental health care is the number of Māori prison inmates suffering from mental disorders. In a study carried out throughout New Zealand prisons via the Department of Corrections to investigate the prevalence of mental illness among prison inmates, approximately half the inmates identified themselves as Māori, highest amongst women inmates where 55.6% identified as Māori. In the general population Māori make up one in seven (2001 census). The results of this study indicated a significantly higher rate of mental disorder in inmates than that in the community, particularly for schizophrenia, bipolar disorder, major depression, obsessive compulsive disorder and post traumatic stress disorder (PTSD). This study also showed that nearly 60% of all inmates had at least one major personality disorder. The study found that lifetime prevalence of PTSD for women inmates was 37% and one-month prevalence was 16%. This incidence of PTSD was grossly elevated relative to the community at large and was more in keeping with findings for high risk populations such as victims of criminal offences and combat veterans. Rates for depression were twice as high as those in the community. The study also revealed that 90% of those with major mental disorders also had a substance abuse disorder. This was comparable with the total prison population, where 89.4% had a current substance abuse or dependence diagnosis.

Suicide and Intentional Self-Harm Rates:

The reported rate of Māori suicide has increased considerably over the past few years and in Māori males it exceeds that of non-Māori. Suicide is also a significant cause of death for Māori youth. Several recent hui have discussed the rising rate of Māori suicides, particularly the high rates in young men.

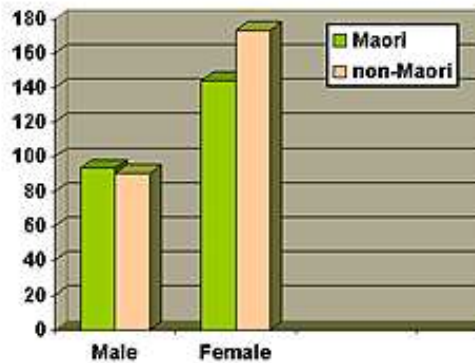
Mortality statistics are always somewhat delayed due to coroners' processes. In 1994 the official definition for recording Māori ethnicity altered, and in 1995 the method of recording ethnicity for death statistics changed. Prior to this ethnicity data was recorded by funeral directors, subsequently by the doctor certifying death. It is as yet unclear what differences this may make to accuracy. Front-line data collectors in the past often recorded ethnicity merely from the physical characteristics of the deceased person. On the basis of current data collection processes, there is thus no way of determining the true rates of Māori suicide across many years. In some studies of discrepancies between reported death statistics and actual numbers of Māori deaths, the percentage of under-counting has ranged from 28% to 82%. The following graphs, despite being based on the official figures, may thus be an under-representation.

Intentional Self-Harm:

Statistical problems with accuracy are most marked for intentional self-harm. It is also important to note that intentional self-harm, although closely linked to attempted suicide, is not the same thing. Official figures for intentional self-harm are derived only from hospitalisations and miss all those patients treated at emergency departments who are never admitted - a fair proportion. The graph below is thus a gross underestimate of the real rates of intentional self-harm.

Several papers are pending from the Māori Attempted Suicide Case Control Study, which will provide a more accurate picture.

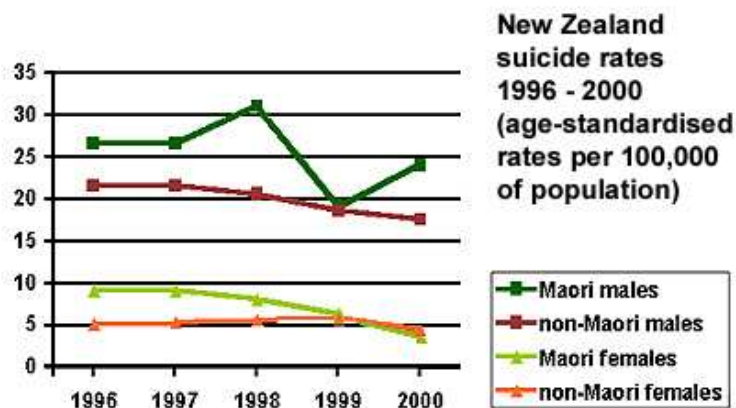
New Zealand rate per 100,000 of people hospitalised for intentional self-harm in 2000-2001:



In 1995, Māori females aged 15-19 years had the highest official rate of intentional self-harm of all population groups. This may have implied a higher attempted suicide rate. More recent data however indicate that the trend is reversing. Overall, there are still more females hospitalised for intentional self-harm than males. Females more commonly choose methods such as self-poisoning that are generally not fatal but are still serious enough to require hospitalisation. The official female-to-male ratio for intentional self-harm in New Zealand in 2000/2001 was 1.8 female hospitalisations to every male hospitalisation (i.e. 64% were female). Māori presentations with intentional self-harm are common - the Case Control Study mentioned above found that these occurred every other day to Emergency Departments in the greater Auckland region. The median age of Māori presenting in this way was 27, half were not in paid employment and 61% were women.

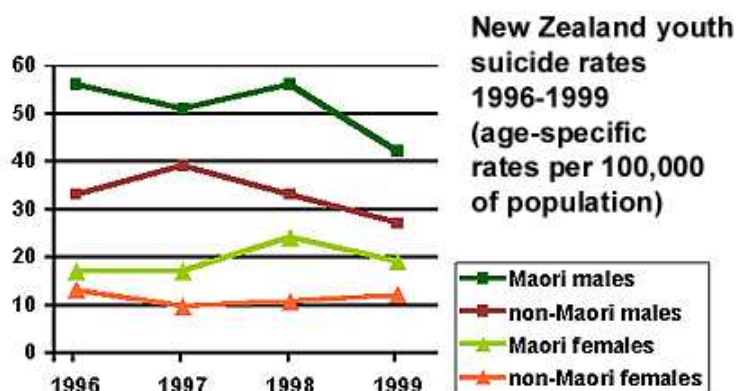
Completed Suicide:

The Māori male rate of suicide in 1998 was almost 50 percent higher than the non-Māori male rate, and the Māori female suicide rate was 41 percent higher than the non-Māori female rate. While non-Māori account for the majority of suicides, the rate is significantly higher in Māori than in non-Māori. The suicide rate in young Māori in 1998 was 4-5 times the overall rate for young adolescents aged 10-14 years, in youth aged 15-24 years it was over twice as high, and for adults aged 25-44 years it was slightly higher.



Suicide deaths have reduced in non-Māori and in Māori females overall, but have remained elevated in Māori males. In 2000, the overall rate of suicide in Māori was 13.1 per 100,000 compared with 10.7 per 100,000 in non-Māori, but the Māori female rate recently fell to just below that of non-Māori. It is thus the Māori male rate that causes most concern, together with the rates for young people, as below.

Youth Suicide:



New Zealand has one of the highest rates of youth suicide (15-24 year olds) in a comparison of OECD countries. Māori youth suicide has risen significantly since 1984. The overall trend is downward, but the rates remain elevated.

Cultural Factors and Mental Health Status:

Cultural alienation is frequently given as an explanation for indigenous populations having higher rates of drug and alcohol abuse and mental health problems including depression and suicide. Durie has noted that a secure Māori identity acts to protect against poor health even in the presence of adverse socio-economic conditions. This finding was derived from preliminary results of the Hoe Nuku Roa: Māori Profiles research project where Māori in the study associated a secure identity with "a sense of being Māori and access to cultural markers such as whānau, Māori land, knowledge of ancestors, Māori language and opportunities to associate with other Māori people." Studies in North America have confirmed a relationship between the loss of cultural identity, ties and values and alcoholism in Native American women. Research on indigenous youth suicide in the USA found that high suicide rates were associated with drug and alcohol abuse, high unemployment, child abuse and neglect, and that less traditional tribes had higher rates of suicide than traditional tribes. The reason was thought to be due to a greater sense of belonging and greater support of adolescents within more traditional tribes.

The underpinnings of suicide are complex where indigenous peoples are concerned. Risk factors such as drug and alcohol abuse, unemployment, low educational achievement, poverty, domestic violence and family dysfunction take a greater toll in the context of colonisation and loss of cultural identity. Psychotic illnesses are present in every culture but they seem closely linked for Māori with drug and alcohol disorders, which have no equivalent in traditional Māori society. Some argue that increasing mental health service use by Māori alongside increasing suicide rates indicates that mental health services are failing Māori. Adequate resources to counteract economic hardship should lead to better service access but many see cultural poverty rather than economic poverty as the crucial factor in addressing higher rates of mental health problems and suicide in Māori, especially Māori youth.

In traditional Māori society the act of suicide was not frequent and may have been practiced occasionally by bereaved women or as a reaction to shame due to having caused harm. This is entirely different from current Māori suicide rates where suicide mainly occurs in young Māori males alienated from their culture. Durie states that suicide is a culturally alien behaviour for Māori and this means

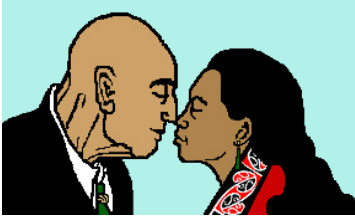
that the act has greater impact for contemporary Māori.

A new concept of "cultural depression" has arisen (also called cultural grief, collective post-traumatic stress disorder or acculturative stress). This psychopathology is felt to include self-destructive behaviour such as substance abuse, and feelings of low self-esteem, worthlessness, inadequacy, hopelessness and depression. This is an explanatory model of the rates of mental illness and substance abuse within colonised indigenous populations. When looked at across a marginalised culture, individual behaviour becomes a deficient explanation for widespread indigenous mental disorders. Underlying factors such as cultural genocide, loss of control of a people's destiny, and tensions developing from attempts to live in both cultures at once may in part explain this.

The cultural traditions of pre-colonised Māori cannot be restored in entirety as a means to address Māori rates of mental illness, psychological distress and substance abuse, nor would this necessarily be welcomed by those affected. However many aspects of cultural practice, identity and belonging for communities and whānau can be strengthened in the modern world and may prove protective for later generations. Improvements in the training of clinicians working in mental health services with Māori patients and whānau, and in the cultural appropriateness of mental health services are also needed.

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Māori Rituals of Encounter by Dr Rees Tapsell

In essence the powhiri is the traditional process of engagement between two or more groups. It involves a series of highly ritualised processes which, traditionally, occur in a marae setting. It is a process of determining the relatedness and connectedness of each group with respect to the other and with respect to the spiritual, physical and metaphorical domains. It involves a process by which the tangatawhenua or home people invite visitors to declare their intentions (whether friendly or not) and involves a series of contextualised rules governing the process of the coming together of the groups. This formalises the process of establishing the ancestral identity of each group relative to the other, as well as to the physical and natural world and to the spiritual world.

In the process of the formal speeches, Gods and the ancestral origins of all those attending are acknowledged as are important ancestral connections. Characteristically, there is recognition of all of those who have gone before (tūpuna or ancestors) and who now reside in the spirit world watching over the living. There is a ritualised process of the separation of the deceased from the living before the speaker is free to concentrate on the issues at hand for those attending. Recognition is made of local groups or significant local figures of prestige (for example the Māori Queen) and visitors are again formally welcomed and warmly greeted. Dependent on the reason for the powhiri there is often opportunity to voice significant issues, concerns or challenges to those attending prior to the formal closing of the speech. Traditionally, a speaker is supported by those of their sub-tribe with the incantation of a waiata, traditionally significant to the area of the speaker. It is important to recognise that there is variation between specific tribes but that the essential tenets of the powhiri are similar.

Following the formal process of the powhiri, visitors are welcomed as one of the tangatawhenua (home people), sealed with the traditional touching of noses, the hongi. Following this it is traditional for all attendees at the powhiri to be fed and entertained by the home people at a hākari or feast, to celebrate the coming together of friends.

Dr Rees Tapsell on the importance of Rituals in Clinical Practice

"Māori patients and their whānau see the doctor as having a position of power and influence within the mainstream hierarchy. Consequently, if that doctor is seen to be a positive, supportive, even active part of a whānau meeting involving the processes of mihimihi, whakawhanaungatanga, karakia and kōrero, then that can be very powerful in terms of engaging that patient and their family, and encouraging them to listen to what the doctor has to say, and to trust that it is said by someone who has approached the patient considering them from a total and holistic perspective, including their culture and spirituality. Alternatively, if the doctor is absent from such processes or clearly not supportive of them, then exactly the opposite is achieved."

Often, in the clinical context, a more informal process of welcome is undertaken yet some of essential elements of the powhiri and some of the more informal aspects of the mihimihi are utilised. These rituals will be important in whānau meetings, or in case conferences involving whānau or members of the local Māori community. Other less directly clinical contexts where you may encounter these rituals might be meetings with local Māori representatives about mental health services, or meetings with your own local Māori cultural service providers.

Most often, a kaumātua (a wise elder) from the home people (the clinical team or hosts) will stand, recite special prayers for the purposes of blessing the proceedings and will welcome attendees (for example visiting whānau) and pose some questions and challenges for the purposes of the meeting. Traditionally, this will be followed by a waiata sung by members of the clinical team, so as to support their speaker.

Following this, a similar process is usually undertaken by one or more speakers from the visiting group (perhaps by a kaumātua from the whānau), again followed by a waiata. In the context of a whānau hui, the cultural worker or kaumātua leading the host clinical team may suggest further introductions, or may at this point indicate to the doctor that they can begin the clinical part of the meeting. It pays to remember that at such rituals of encounter the main speakers are expected to provide considerable information in a formal introduction. Such a formal speech is not expected of a non-Māori doctor, but it is best to say more than just your name. Many families are not quite sure what a "registrar" is, so an explanation of your qualifications and role on the team, and some personal background, is appropriate. For example, you might say where you were born and raised, where you trained as a doctor and how long you have been practising, and how long you have been working for your current clinical team.

During the meeting, it pays to remember that while you have a special role and mana (prestige and power) as the responsible doctor, you are not "running" the meeting. Be alert for cues from your cultural adviser or local kaumātua as to the process. Whatever the purpose of the whānau hui, once all are agreed that the main goals have been achieved the host service's cultural worker or kaumātua will generally begin the ritual of closure. This may involve a short speech and/or a prayer or karakia.

Following the speeches, it would be usual at a powhiri for the group to seal friendship with the touching of noses (the hongī) followed by a traditional hākari (feast). In the clinical context, if non-Māori seem uncertain about the hongī a kiss on the cheek is often substituted, and the final feast is more often represented by available refreshments such as tea and biscuits. Registrars and psychiatrists work under considerable time pressures, but it is extremely impolite to rush off at this point before participating in the final aspect of the ritual. To remain and socialise briefly will cement trust and rapport gained during the meeting. A whānau hui involving proper rituals of engagement and closure cannot be crammed into a short space of time, and can be invaluable in developing rapport and partnership with patients and their families.

It is sufficient for the non-Māori psychiatrist or psychiatric registrar to have some sense of this process and how it might unfold. It is also important to remember that as the responsible doctor, the visitors will look to you as a person who holds mana and to whom they must listen and show respect. Accordingly, the success of a whānau hui using some variation on the processes of powhiri, mihimihi and whakawhanaungatanga depends on the responsible doctor being clearly seen to be an active and supportive part of the proceedings, if not directly involved in them. As with all rituals of encounter, the quality and sustainability of the relationship which one is able to establish with the patient and their whānau can be greatly enhanced if the doctor is seen to acknowledge the importance of the process and is seen to be a positive and supportive participant. It is my experience that this is one of the ways in which a sense of trust can develop between the psychiatrist and their Māori patient and family. It also provides a culturally safe and appropriate context for the airing of concerns and the sharing of information.

Participation in such processes can also serve to communicate to Māori patients and their whānau the importance that the clinical team place upon culture, heritage and spirituality in the overall assessment and management of those presenting to psychiatric services. Given the perception of some in the community that doctors are "pill pushers" with a rigidly biological outlook, participation in these processes offers the opportunity to communicate a commitment to a truly holistic approach.

I recommend that psychiatrists or psychiatric registrars wanting to know more about how to participate in such processes consult kaumātua, kuia or cultural workers assigned to their services. A large whānau meeting (and they are often large gatherings) can be daunting at first, but learning how to take part in these rituals so as to work with Māori patients and their whānau is vital if the best outcome is to be achieved, and is an important skill for a psychiatrist practising in New Zealand.