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“Hua Oranga”

Best Health Outcomes for Māori

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DOCTOR OF PHILOSOPHY  
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## POROPOROAKI

*Ko koutou ra Rongomau mā, kua riro i te ripo ki whakaterere ki  
whakanunumi ki whakangaro, hāere hāere hāere atu ra, okioki mai i roto i  
te manaakitanga o te Runga Rawa.*

## ABSTRACT

Poor mental health is recognised as a major threat to Māori well-being. Over the past three decades Māori admissions to psychiatric facilities have increased dramatically and have coincided with increasing socio-economic disadvantage – gaps which exist between Māori and non-Māori, as well as progressive alienation from te ao Māori (the Māori world).

*Hua Oranga* (translated literally as the fruits of health) is both the title of this thesis and the name given to the tool which it describes. The tool is a measure of Māori mental health outcome and is based on Māori perspectives of health, Māori philosophies, aspirations, and world views. It is a tool designed for clinical and care settings, and measures the efficacy of treatment, or health interventions. The tool employs a triangulated method of outcome assessment and considers the views of tangata whaiora (Māori mental health consumers), clinicians, and whānau (family members). A series of five clinical-endpoints have been identified to allow the tool to be applied with greater precision.

By itself the tool will not address all of the complex problems associated with Māori mental health – nor is it designed to do so, indeed that is well beyond the brief of this investigation. What it does however, is to illustrate the utility of seeking outcomes of cultural significance, the employment of Māori perspectives to shape outcome measurement, and the implications for treatment and care. At a broader level, the tool has the potential to contribute to the development of more effective strategies, policies, and service design. To this end, *Hua Oranga* will contribute to improved health outcomes for Māori.

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## PREFACE

This thesis has a dual focus. It is about Māori health, and in particular the measurement of Māori health; but it is also about Māori people and the retention of Māori values in modern times.

The first aim is aligned with academically derived objectives and seeks to explore a central research question: ‘How can mental health outcomes for Māori be measured?’ Underlying the question is the hypothesis that good outcomes for Māori consumers of mental health services (tangata whaiora) should reflect not only improved mental state but enhanced spiritual, physical and social well-being. Further, Māori mental health services need to be measured against outcomes that are culturally relevant. The rationale is explored more fully in the following chapters but is essentially based on the idea that Māori concepts of health, effectiveness, and outcome, require measures that reflect Māori worldviews.

The second aim is to explore Māori values as they apply to health, and as they continue to mould Māori understandings of health within a health system that has, in the past, struggled to recognise the implications of culture for health and well-being. While the relevance of Māori health perspectives has been more or less accepted for at least two decades, the primary measuring tools have not kept pace with Māori aspirations for a health system that not only allows Māori to be Māori but challenges professionals to endorse that aim.

There are many reasons for conducting research at a doctoral level. For some it is a vehicle for the attainment of a higher qualification, in order to pursue a career or profession. Others may have more academic goals, wishing to contribute to the existing knowledge base in some significant way, and to produce a scientifically sound document that will be welcomed in the scientific community.

For Māori researchers and doctoral candidates these objectives may be broadened by a range of additional imperatives, often directed at the broad field of Māori development and consistent with ensuring that 'research' is not merely conducted for 'research's sake' but becomes an avenue through which Māori aspirations and objectives are considered, developed and progressed.<sup>1</sup>

Internationally, many hundreds of instruments are used to measure health and the efficacy of treatment and care. Most are used at a service level and provide insight into what outcomes are preferred by service users and clinicians alike. However, no instrument has ever been constructed to measure the outcome of treatment for Māori users of mental health services. And while many so-called 'generic' measures have been employed for the purpose, serious concerns remain as to their validity and their capacity to measure outcomes important to Māori.<sup>2</sup>

The aims of thesis are therefore centred around the measurement of outcomes for Māori mental health: to construct a tool, to identify fundamental requisites, to examine key theoretical underpinnings, to consider the implications and applications, and ultimately to make a difference to the quality of care and treatment.

This last point has been a major consideration. While the creation of new knowledge has been the overarching motivation for this thesis, the underlying purpose of the thesis has been to make a significant contribution to Māori health, Māori development, and Māori advancement. Indeed, such a requirement is important to research activity in Māori health, at least when the researcher is Māori.<sup>3</sup> In any event, the two strands of the thesis – the theoretical and the applied – are neither contradictory nor inconsistent – and if both are met then the study will have satisfied a double agenda.

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<sup>1</sup> E. Stokes, (1985), *Māori Research and Development: A Discussion Paper*, University of Waikato, Hamilton.

<sup>2</sup> Mental Health Commission, (1999), *New Zealand's National Mental Health Strategy: Review of Progress 1994–1999*, Mental Health Commission, Wellington, p. 22.

<sup>3</sup> M. H. Durie, (1996), 'Characteristics of Māori Health Research', a paper presented at the *Hui Whakapiripiri*, Hongoeka Marae, Plimmerton.

## THESIS STRUCTURE

The thesis has eight chapters. Each is made up of several sections, beginning with an introduction or opening and ending with a conclusion, summary or review. Each chapter focuses on a particular aspect, and in the case of Chapters 3, 4, and 5 also includes methodological issues.

Chapter 1 provides an overall context for the study. It explores the rationale for the thesis, drawing from historical and contemporary data, and examines Māori patterns of mental health, what is known, and also what is implied. Chapter 2 outlines relevant methodological considerations, the assumptions that have been made, the approaches selected, and the process through which the objectives of this thesis will be met. Chapter 3 is an examination of Māori mental health services. It draws from a broad base and is used to describe the context within which outcome measures are used as well as the imperative for measures that reflect cultural perspectives. It considers the historical foundations of the current health service infrastructure, the impact these have had on the contemporary environment and implications for mental health service delivery. It describes policy issues, present strategies, as well as current issues and opportunities.

Chapter 4 is the first of three chapters that describe the development of *Hua Oranga*. It outlines a framework for measuring Māori mental health outcomes. Chapter 5 describes the transformation of the framework into a more practical measure, and highlights the features of the tool, its design and operation. Chapter 6 is comparatively brief, and

considers the implications of the measure, the limitations and potential applications. Chapter 7 contextualises the *Hua Oranga* measure within a broader landscape. It draws from the previous chapters to highlight the insights revealed, the new knowledge created, and locates the importance of the work to health, to Māori development, to indigenous people and new approaches to mental health treatment and care.

Chapter 8 is a conclusion. It simply identifies the five key contributions that the thesis makes to understandings of Māori health and the advancement of the Māori people.

## Chapter One

# MĀORI MENTAL HEALTH: PARAMETERS AND PATTERNS

### INTRODUCTION

This chapter provides an overall context for the thesis and is divided into four main sections. Section one examines Māori mental health, as a concept, an end-point, an indicator of well-being (or more correctly a lack of well-being), and a reflection of Māori health status alongside that of other New Zealanders. The relationship of mental health to wider historical and contemporary experiences is discussed, as well as the utility of measures currently used to gauge progress and change.

Section two explores the broader contributors to Māori mental ill-health. It draws from an existing socio-economic baseline (the 'Closing the Gaps' report) and examines the implications that this report has for Māori mental health.

Section three considers why these problems are so persistent and reviews current theories and discourse on Māori mental ill-health.

The fourth and final section is comparatively brief but is significant in that it describes the overall direction of the thesis, its parameters and its focus.

## **MENTAL HEALTH AND MENTAL ILLNESS: CONCEPTUAL CLARIFICATION AND EPIDEMIOLOGICAL TRENDS**

The concept of Māori mental health is something of a misnomer, since it is usually more closely linked to illness rather than health. Nonetheless the prevalence and incidence of disorders is an indicator, however crude, of trends within Māori society and bears some relationship to the wider issue of well-being. Mental disorders are, by default, a type of proxy measure of the absence of mental health. The accessible data on Māori mental health are at best vague. While some information is available, the limitations, reliability and validity have often reduced the extent to which accurate trends and patterns can be revealed.<sup>1</sup> Despite these issues, an exploration of data, however qualified, is useful, and at least provides an impression through which broader trends and concerns can be established.

### **Historical Trends, Assumptions and Impressions**

An historical analysis provides an appropriate point at which to begin this discussion. Indeed, a preferred Māori approach to planning is to predict the future by looking back (as much as ahead) in order to create a foundation through which more contemporary issues and concerns can be explored.<sup>2</sup>

It is difficult to determine, however, the extent to which mental health problems might have affected Māori in distant times, or if in fact issues of this nature would have been perceived in terms of illness or disability.<sup>3</sup> Historical data and anthropological manuscripts have provided some insights, but are likely to be culturally biased as many of the early documented descriptions of Māori mental health were formulated

by non-Māori, few of whom had any appreciation of Māori perspectives of health and well-ness, and were therefore unlikely to fully appreciate what was observed:

Although mental health is often delineated as a separate area of inquiry based to a large extent on the state of the mind, its thoughts and feelings, the notion of the mind itself has only developed in response to the evolution of Western scientific thinking....While Western medicine tended to emphasise bodily health at the expense of those which could be explained by the laws of physics, Māori theories of health minimised mechanistic forces in favour of the strong influences of mental attitudes and supernatural powers.<sup>4</sup>

At its most basic level, mental health problems may be defined according to a set of parameters, that govern the extent to which behaviour is accepted or otherwise classified as being abnormal. Often these parameters are founded on notions of normality that are in turn, more often than not, grounded in cultural bias. As a consequence, what is rational and clear in one system of knowledge or cultural belief, may become distorted and misread if it is analysed within the constructs of another body of knowledge.<sup>5</sup> Normal and/or acceptable behaviour in one culture may be viewed as alternative, different, or even psychotic within another.

From an historical perspective such issues have a range of implications and bring into question the ability of non-Māori historians, academics or anthropologists to assess the perceived abnormal behaviours of individuals within Māori communities.

Consequently, the extent to which more subtle cultural nuances have been interpreted by non-Māori, casts some doubt on the reliability of Western texts and documents to reflect accurately Māori behaviour, thinking and understanding. Yet they have been predominantly used to describe historical trends in Māori mental health. While

significantly flawed in this regard, it is possible to draw two broad assumptions about the presence of mental health problems within early Māori communities.

The first assumption is that mental illness (as defined according to Western criteria) is likely to have existed within Māori communities before European contact. This assumption is based on the observation that mental disorders have been known to exist within all cultures, and that it is most unlikely that Māori alone could have developed the means, biological or otherwise, by which such conditions (now termed 'mental disorders') could have been entirely avoided.<sup>6, 7</sup> Moreover, linguistic and literary evidence also suggests the existence of problems specifically related to the mind. For example, terms like pōrangi and wairangi are used to describe individuals considered to be mad or out of their mind.<sup>8</sup> Leaving aside the difficulties in equating pōrangi or wairangi with psychosis or other serious disorders, the words themselves suggest a departure from the norms of the community. While not necessarily being perceived by Māori as an illness in pre-colonial times, such terms can be seen as 'evidence' of the recognition of abnormal states of mind.

Sachdev and Beaglehole attempt to describe a pre-colonial Māori perspective of mental abnormality. Sachdev<sup>9</sup> states that before European settlement, the notion of 'mental illness' was unfamiliar to Māori and that issues associated with insanity or psychological disability would have been explained through transgression of sanctity. In essence these transgressions resulted in a 'state of mind' rather than an 'illness of the mind'. Therefore according to Sachdev, the transgressions were the ultimate cause of the abnormal state of mind and needed to be addressed if the behaviour was to cease.<sup>10</sup> Beaglehole held a similar opinion:

...the phenomenon of mental disease brings a catch of anxiety and fright to the Māori (as it has to the Pākehā in the past and still does to many Pākehā today) which he tries to understand in terms of a world of obscure spirits interfering for good, but often unknown reasons, with the normal workings of the body and mind. It is natural that the Māori should seek aid from the one person, the curing Tohunga, who claims to understand the workings of these spirits and therefore believes that he can control them.<sup>11</sup>

While, both Beaglehole and Sachdev appear to support the assumption that mental illness was unfamiliar to Māori, they do not rule out the presence of abnormal states and the use of cultural paradigms to explain them. However, in the end they favour a Western explanation and appear to regard the Māori explanation as a proxy for more informed opinion.<sup>12, 13</sup>

Although inadequate cross-cultural interpretations have seriously impacted on Māori mental health, in particular through the mis-assignment of diagnosis,<sup>14</sup> transcultural investigations are nonetheless useful when exploring the ‘second assumption’ (i.e. that the comparatively high rates of Māori mental illness are a recent phenomenon, and historically Māori showed considerable mental stability). Again, the available data are scarce and difficult to interpret,<sup>15</sup> yet it is sufficiently consistent to suggest that mental health problems, if they existed at all, were not of major concern to Māori, until more recently.

Historical examples of Māori mental health, as opposed to illness, can be illustrated in a number of ways and through patterns of morbidity. Suicide, for example, is now an issue of considerable concern for Māori, yet was traditionally unknown, except by widows during bereavement. Gluckman,<sup>16</sup> when drawing comparisons between

Māori and non-Māori, also observed that the insanity rate for non-Māori was about three times that of Māori.<sup>17</sup> Beaglehole's investigations in mid-1940s further highlighted the apparent lack of mental disorder within the Māori community and how Māori appeared to be less susceptible to emotional and mental problems:

In 1943....the incidence of all types of mental disorder among Māoris was about one third that of the Pākehā incidence. An earlier investigation into the relative incidence of the major functional psychotic disorder among the inmates of New Zealand mental health hospitals shows that these disorders occur about half as frequently for Māori as among Pākehā inmates. A similar difference exists in the incidence of war neurosis among Māori and Pākehā soldiers. According to the report of the New Zealand rehabilitation board 14 per cent of the demobilized Pākehā returned soldiers are classified as psychiatric cases whereas only 7 per cent of the Māori returned soldiers are so classified.<sup>18</sup>

Later investigations produced similar results. In 1951, Blake-Palmer reported that the incidence of Māori admissions to psychiatric hospitals was less than half that of the non-Māori population.<sup>19</sup> In 1960, 60 in every 100,000 Māori were admitted for the first time to a psychiatric hospital compared with a non-Māori rate of 119 per 100,000.<sup>20</sup> In 1962, Foster<sup>21</sup> further noted that for both males and females lower admission rates for Māori, in all age groups and for most disease categories, could be expected. Psychoneurosis, for example, accounted for only 7 percent of all Māori first admission compared with the corresponding non-Māori rate of 21 percent. In addition, the rate of psychosis related to old age was much higher for non-Māori. Alcoholism and manic-depression were also lower. Durie states:

...during the nineteen fifties, non-Māori admission rates to psychiatric hospitals were relatively high, mental hospitals were comparatively large and general hospital psychiatric

units were few and small. It was the era of institutional care; interestingly, Māori did not feature as significant consumers.<sup>22</sup>

Anecdotal accounts support this contention:

I worked at Oakley Hospital in the years shortly after the Second World War...There were more than one thousand patients in the hospital...of whom six were Māori.<sup>23</sup>

The reliance on hospital admission and anecdotal accounts has reduced the extent to which robust and more extensive conclusions can be drawn, especially when accounting for inconsistencies in ethnic determination and the lack of a clear association between hospital admissions and community prevalence. Nevertheless, examination of the changes in admissions (the only comparable data available) seems to confirm that if mental disorders were prevalent to any great extent in Māori communities, they were tolerated, regarded as a natural phenomenon, or were simply not afforded any special significance.

However, in the mid-1970s, the apparent low prevalence of mental disorders among Māori was to change somewhat dramatically.

In contrast to historical patterns, the past 30 years has seen a significant increase in the number of Māori accessing mental health facilities. The implications have been considerable and have led, in part, to the development of Māori-specific treatment facilities, and an increased emphasis on special mental health policies for Māori. However, the availability of mental health data, upon which sound policies can be built, remains problematic.

## **Admissions-based Data**

As described, much of what is known about Māori mental health (in terms of patterns and trends at least) is based on hospital admissions. Although this approach utilises available data, it is flawed in a number of key respects. For example, admissions data only consider those who access treatment and therefore are unable to reflect community prevalence. As non-psychotic conditions are often treated in outpatients services it is also unlikely they will be consistently included in such data sets.<sup>24</sup> Admission data likewise fail to consider why people use particular services, when they use them, and why they choose to use them.<sup>25</sup> In the absence of routine data collection it is also difficult to establish contemporary trends, issues, and gains beyond the hospital. Of similar concern is the contention that many Māori who require treatment do not receive it, or do so at a late stage. In this respect, concerns about the high numbers of Māori hospital admissions might need to be balanced by the high numbers who warrant hospitalisation but never gain admission.<sup>26</sup>

Problems and inconsistencies associated with defining ethnicity have further compounded efforts to establish accurate profiles. Several definitions have been used to classify, consider and determine Māori ethnicity, the characteristics of which have changed over time, along with the methods of collection.<sup>27</sup> As a consequence, it has been difficult to compare or to cross-tabulate the data sets from various sources and to reliably map links or patterns.

In 1988, Thomas devised a scale to gauge cultural capital. It comprised a 40-item questionnaire that required understanding of a variety of everyday words together

with an awareness of Māori institutions.<sup>28</sup> Using the scale he was able to conclude that Māori children who had knowledge of Māori language and culture gained higher scores on achievement tests than Māori children who had little or no knowledge of their culture. His main point was that culture and ethnicity are not identical and because not all Māori have the same cultural capital, outcomes for Māori cannot be assumed to reflect cultural differences totally.<sup>29</sup> Thomas further notes that:

It is likely that much of the New Zealand research comparing Māori and non-Māori samples has methodological shortcomings that cast doubt on accuracy of the resulting data. Most of the articles surveyed [as part of this study] did not meet the minimum expected standards for reporting procedures used to categorise ethnicity. Especially notable was the lack of information provided by authors about the categorisation of participants of dual or multiple ethnicity. There seemed to be little awareness of the major changes that have taken place in the New Zealand census questions relating to ethnicity.<sup>30</sup>

In 1974, the Māori Affairs Amendment Act brought about a new method of recoding ethnicity, an approach that moved away from blood quantum or biological characteristics, toward Māori ancestry and self-identification. Within the health sector assessment of ethnicity was often made on the basis of appearance and physical characteristics, rather than any actual inquiry. However, the redefinition of ethnicity from blood quantum to ancestry and self-identification has often been used to explain, in part, the growth in Māori admissions. This due to the fact that a greater number of patients would now fit the 'Māori' criteria.<sup>31</sup>

Alternatively, changes in ethnic determination may have simply endorsed a practice that had been evolving. For example, before the enactment of the Māori Affairs Amendment Act 1974, many Māori were already self-identifying as Māori, regardless

of the degree of Māori blood. This in itself may have inflated rates of Māori admissions, supposedly restricted to those with half or more Māori blood quantum.<sup>32</sup> On the other hand, it is also entirely possible that the trend toward increased Māori admissions may have reflected a greater utilisation of psychiatric facilities by Māori or even a greater prevalence of mental illness. As such, it is difficult to determine precisely the impact that changes in ethnic definition have had on Māori prevalence rates. What is certain, however, is that Māori admissions to psychiatric facilities, however regarded, rapidly increased in the 1970s.

Given the data limitations, efforts to improve the accuracy of prevalence measures and mental health data collection and examination have recently become a key focus. For example, the Health Research Council is currently involved in funding a major epidemiological study to determine the prevalence of mental disorders.<sup>33</sup> This will be the first of its kind in New Zealand and should contribute significantly to the existing pool of data by providing better estimates beyond hospital data.

Additionally, the New Zealand Health Information Service has almost completed the Mental Health Information Project (MHIP),<sup>34</sup> in an attempt to address the limitations of previous data and to provide a more current and precise interpretation of hospital admission statistics.<sup>35</sup>

Existing national collections of information from mental health service providers are incomplete, inflexible and – in some instances – up to three years out of date. The objective of the MHIP [Mental Health Information Project] is to provide complete, accurate and timely information on secondary mental health services. This will allow adequate

monitoring of the implementation of the national mental health strategy and provide a database for research into the provision of mental health services.<sup>36</sup>

Although the MHIP will likely improve the existing data set, a number of issues will first need to be addressed. For example, concerns have been raised about the potential for double counting, especially patients with multiple diagnoses or those who have accessed several different services.<sup>37</sup> Likewise, concerns about the collection and definition of ethnicity have also been raised, in particular the willingness or capacity of some services to collect accurate data.<sup>38</sup> In an attempt to address ethnicity concerns and to provide some consistency with other data sets, a standardised ethnicity collection schedule has been adapted from Statistics New Zealand, so that the MHIP data would at least be comparable with census data. However, historical variations in the manner in which Statistics New Zealand has gathered ethnicity data will reduce the extent to which reliable comparisons, trends and patterns can be established, over time. In this regard, profiles derived from either ethnicity, or ancestry, can significantly impact on how data are presented and interpreted:

... if we compare the first admission rates for Māori and non-Māori women with psychiatric disorders between the years 1991-1993, we find that there is a significant disparity using sole Māori as the denominator. By using the Māori ethnic group as the population denominator, this disparity is sizably reduced and may result in different policy advice being proposed.<sup>39</sup>

Apart from these problems, the most significant limitation of the MHIP study is that it remains admission-based and presents a picture that, while useful, is far from complete. However, and until the results of the current epidemiology study are

known, it is likely that this information will inform the shape of policy and service development.

Although these data [admission based statistics] are the only universally collected information on mental illness in New Zealand, they are severely limited as a reflection of mental illness in the population. Indeed, they are little more than a reflection of the policies that guide admission policies in different areas, reflecting the availability of beds, the availability and effectiveness of community-based mental health services of all types and the level of tolerance of illness in the community rather than reflecting the severity or type of illness being experienced by the ill individual.<sup>40</sup>

### **Contemporary Trends and Available Analysis**

In spite of the apparent lack of quality data, numerous investigations,<sup>41</sup> research reports<sup>42</sup> and policy documents<sup>43</sup> have attested to the poor state of Māori mental health. Many of these have relied on admission data, though some have utilised anecdotal accounts as a supplement. Notwithstanding some obvious problems with data analysis and integrity, a qualified examination of what has been revealed is useful, not only as a means through which more general assumptions can be made, but also to identify what information gaps exist.

As described, one of the more well-considered and documented trends concerns the growth in Māori mental health admissions during the mid-1970s. Before the 1970s Māori had been low users of psychiatric facilities, and were perceived as people of considerable mental stability. However, from approximately 1975 onward, it became increasingly clear that the whole pattern of Māori hospitalisation – for reasons of mental health – was changing. By the mid-1980s the rates of Māori psychiatric admissions were two, and in some categories, three times that of non-Māori.

Problems related to alcohol and drug misuse were particularly evident over this period, though additional concerns were linked to the manner in which Māori were accessing psychiatric facilities. Increasingly, large numbers were being admitted under compulsion, through the justice system, rather than through conventional medical referral systems.<sup>44 , 45</sup>

Between 1960 and 1990, non-Māori first-time admissions to psychiatric facilities, had only slightly increased.<sup>46</sup> However, the corresponding Māori rate (over the same period) was more than 200 percent.<sup>47</sup> Between 1980 and 1991, suicide rates for Māori males had also increased by 162 percent.<sup>48</sup> Although suicide rates for young Māori and non-Māori were relatively similar, there was some evidence to suggest that the ‘true rates’ for Māori were likely to have been much higher.<sup>49</sup>

Māori readmissions were cause for further concern. Readmission rates for Māori males increased by 65 percent between 1984 and 1994, nearly two times higher than non-Māori male rates and three times higher than corresponding Pacific Island rates. While showing an overall decrease, admissions for drug and alcohol disorders have also remained a major concern for young people and especially Māori, both male and female.<sup>50</sup> Heavy drug use amongst young Māori, particularly cannabis, has also led to a dramatic increase in drug-related disorders.<sup>51</sup> Psychosis and alcohol and drug abuse account for almost a third of first admission. Māori readmission rates for affective disorders and psychotic illness, other than schizophrenia or drug or alcohol psychosis, were 36 percent for women and 75 percent for men higher than corresponding non-Māori rates. Schizophrenic psychosis is currently the second most common cause of admission for Māori males, with a rate of 2.7 per 10,000, twice the rate of non-Māori. Disproportionate numbers of Māori mental health referrals are from law enforcement

or welfare services. This suggests that early access to mental health facilities is often problematic,<sup>52</sup> with outcomes likely to be less favourable.

Studies have also shown that Māori are over-represented in terms of acute psychiatric admissions, accounting for 23 percent.<sup>53</sup> Other investigations have also suggested that Māori spend on average 40 percent less time in hospital (due to mental health problems) compared with non-Māori, in spite of being admitted for more serious diagnoses.<sup>54</sup>

Collectively these data add weight to the contention that mental illness is now a major health threat to Māori.<sup>55</sup> Although these types of statistics have helped the development of Māori specific mental health services and the design of more tailored and strategic policies or plans, the extent of the problem is still unknown.

In light of this, the following section takes a more exploratory look at Māori mental health, to examine issues known to affect mental health, but which are less likely to feature as part of a 'mental health' profile.

## **SOCIO-CULTURAL DETERMINANTS AND INDICATORS**

Factors outside the influence of health policies, though within other macro- and micro-policy areas, must be recognised as contributing, either positively or negatively to the state of Māori health.<sup>56</sup>

The key underpinning of this section is that the current mental health problems faced by Māori have less to do with biological or genetic predisposition and are more closely linked to environmental stressors. The supporting evidence is both qualitative

and quantitative in that no theories have evolved around biological predictors nor has a gene been discovered that predisposes Māori to mental ill-health.<sup>57</sup> Almost entirely, the hypotheses concerning Māori mental ill-health have been formed around a socio-economic base, indicators, predictors, or triggers that are linked to the wider environment.

Arguably, healthy lifestyles are sustained not only by controlling the symptoms and direct causes of individual illness but also by creating conditions in which Māori can pursue healthy lifestyles. In this context, the decline of Māori mental health has sadly occurred against the backdrop of increasing unemployment rates, low income, underachievement in education and a breakdown in the family unit. Many Māori without a strong sense of self, suffer a crisis of confidence which seems to lead to ill-health.<sup>58</sup>

In light of this, a more dynamic approach to measuring Māori mental health is required, a method that appreciates the need to examine broader issues and is consistent with more contemporary notions of how Māori mental health should be expressed.<sup>59</sup> , <sup>60</sup> The socio-economic indicators of the 'Closing the Gaps' reports, produced by the Ministry of Māori Development in 1998 and 2000, have been used to construct a framework through which the contributors to Māori mental ill-health can be considered. These reports were a prelude to the short-lived 'Closing the Gaps' policy of the 1999 Labour/Alliance Government, and provided an overview of Māori performance in health, economics, education, and employment.<sup>61</sup> Although the statistics merely presented existing information, at the time of their release both the media and politicians were quick to express their concern at the relatively poor Māori socio-economic status compared with non-Māori. In addition, the reports also increased public and political interest in the growing disparities between Māori and non-Māori, and provided the impetus for a range of strategies aimed at the reduction of gaps:

Alongside economic transformation it is our determination to close the gaps that have opened up throughout New Zealand society. There are gaps between skilled and unskilled New Zealanders and between employment rich and employment poor regions. But the most profound and most urgent are those between Māori and Pacific peoples and others.<sup>62</sup>

Viewed collectively, the issues disclosed in the 'Closing the Gaps' reports give some indication of the overall socio-economic position of Māori within New Zealand society. The second of the two reports, raised additional concerns and provided further evidence that within many indices, minimal or even negative progress was being made.<sup>63</sup> Although some improvements in socio-economic status had occurred from 1998 (when the first of the two reports were released), these were often offset by even greater gains within the non-Māori sector. So considerable disparities still remained. Although neither of the two reports represented an exhaustive account of the issues, they nevertheless provided an important baseline against which Government policy objectives for Māori development could be measured.

The socio-economic indicators (i.e. education, income, employment, housing, criminal justice and health)<sup>64</sup> are used as a framework from which to gauge an appreciation of the association between broader indicators and Māori mental health.

Each indicator is examined and explores:

- the links between the specific indicator and mental health;
- the current status of Māori vis-à-vis the indicator; and
- the implications for Māori mental health.

## Māori Educational Attainment

Along with income and employment status, education is critical to determining peoples social and economic position and thus their health.<sup>65</sup>

Education has long been considered an indicator of health and forms a protective function against mental ill-health. Access to high quality pre-school education provides a barrier to mental illness, as does literacy and the capacity to effectively communicate and receive information.<sup>66</sup> Low educational uptake is associated with an increased perpetration of partner abuse, homicide and assault on strangers by young males. This is further linked to suicidal ideation, antisocial activity and substance abuse behaviours.<sup>67 , 68 , 69</sup> In a broader sense, poor achievement at school can negatively impact on an individual's employment prospects, income, housing, and relationship with the criminal justice system.<sup>70</sup>

Māori unfortunately have a long history of poor educational attainment. Although in recent years some improvement have occurred, for the most part these gains have been inconsistent,<sup>71</sup> and a mixed picture of Māori participation within the education sector has emerged. Improvements in the number of Māori enrolling in early childhood education programmes have occurred, but Māori participation remains well below that of non-Māori.<sup>72</sup> Even within Kohanga Reo, enrolments have shown a steady decline.<sup>73</sup>

At secondary school, Māori of all ages are less likely to sit exams than non-Māori. Fewer Māori remain in school for their senior years and as a result fewer still are able to obtain higher level secondary school qualifications. In addition, there is a greater likelihood of Māori repeating classes in earlier years. Although there has been some

notable gains in the number of Māori leaving school with qualifications, the majority still leave with a qualification no higher than 6<sup>th</sup> Form Certificate.<sup>74</sup>

Māori are only half as likely as non-Māori to participate in tertiary education, despite the greater range of options now available. Māori also tend to enrol in a limited range of study areas and are over-represented in foundations courses, trade training, fisheries and forestry. Participation in science and engineering is low, and Māori are disproportionately represented in the Humanities. Between 1994 and 1997, greater numbers of Māori completed programmes at the tertiary level; however, most of these were concentrated within lower-level qualifications.

Continued educational underachievement will almost certainly have a negative effect on Māori mental health. Educational failure reduces employment opportunities, the ability to obtain higher levels of income, appropriate housing and living conditions, and further increases the risk of engaging in anti-social behaviours, such as violence. Such conditions are not conducive to good health outcomes. As such, the current levels of educational underachievement can be said to predispose Māori to mental ill-health.

### **Income, Poverty, and Māori Mental Health**

Relative poverty excludes people socially and materially from the normal life of society and this appears to be a significant factor. Such effects on behaviour may be mediated by stress, low self-esteem and poor social relations, all important risk factors for mental health.<sup>75</sup>

Income is often described as the single most important determinant of health.<sup>76</sup> These connections have been established across a wide range of indices and conditions,

including mental health, and further serve to highlight the importance of measuring health within a broad context. Notwithstanding issues on the relative nature of income or the precise meaning of poverty,<sup>77</sup> the link between psychological distress and poverty has been recognised for at least 140 years.<sup>78</sup>

Studies into the effects of poverty on mental health have focused predominantly on women and children, given their over-representation amongst deprived groups. These have shown that for single mothers in particular, depressive conditions are more likely to be linked to unemployment, housing problems and inadequate income. Children (five-to six-year cohort) whose parents are socio-economically disadvantaged are also at an increased risk for early developmental delay.<sup>79</sup> Low income has also been shown to predispose children to psychiatric disorder, poor scholastic performance and social impairment, irrespective of other variables such as family dysfunction or low levels of maternal education.<sup>80</sup> Children (six to eleven years) living in poverty are 3.3 times more likely to have at least one psychiatric disorder, compared with children of affluent parents.<sup>81</sup>

Community psychiatric studies have revealed that the spatial distribution of mental disorders in large urban areas was more a function of the concentration of poverty within the city centres, than a consequence of any specific location.<sup>82</sup> An Epidemiological Catchment Area (ECA) study further illustrated that the six-month prevalence of any *DSM-III*<sup>83</sup> disorder was 2.86 times higher in the lower socio-economic status (SES) group than in the highest SES group, after controlling for both age and sex.<sup>84</sup>

Within New Zealand, statistics on income have also been used to classify the population, to cross tabulate data, to form relationships and draw conclusions. Of interest is the long-standing disparity between the income levels of Māori and non-Māori, and recent evidence suggests this disparity is widening. For example, in 1987, Māori households received 22 percent less income than non-Māori households. Ten years later this gap had increased to 26 percent.<sup>85</sup> Only 11 percent of Māori are located in the highest income band, compared with 20.9 percent of non-Māori. Although for both Māori and non-Māori the most common source of income was wages and salaries, 36.3 percent of Māori were reliant on Government benefits, compared with only 14.3 percent of non-Māori. Māori were twice as likely as non-Māori, to receive the Domestic Purposes Benefit or Unemployment Benefit, though less likely to have National Superannuation.<sup>86</sup> For almost all occupations, Māori receive lower incomes than their non-Māori counterparts.

The implications of these issues for Māori mental health are more likely to impact on women and children, contributing to depressive conditions or developmental delays that may lead to psychiatric disorder. Problems linked to alcohol dependence and abuse are also more likely,<sup>87</sup> as is the increased risk of men becoming abusive toward their partners. Such abuse creates a family environment that is detrimental to health, mental and physical.<sup>88</sup> At another level, financial insecurity prevents Māori from participating within their own cultural circles and from developing many of the cultural mechanisms that protect against mental ill-health.<sup>89</sup> Durie has further defined poverty to include inadequate access to culture, and has postulated that the effects of cultural disadvantage may be as devastating as the effects of financial disadvantage.<sup>90</sup>

Income has the potential to influence significantly an array of socio-economic determinants and to create environments that either sustain or impede mental health. If it is assumed that income is the major determinant of health, the position of Māori appears to be most under threat.

## **Employment and Māori Mental Health**

The main factor determining adequate income is participation in paid employment.<sup>91</sup>

The mental health implications of employment are not dissimilar to those of income and poverty. However, unemployment can have a more direct influence on mental health. For example, the Mental Health Commission has highlighted the positive relationship between employment and mental health recovery, the potential to reduce mental health prevalence, and improved consumer outcomes.<sup>92</sup> Employment may further aid recovery through giving structure to the lives of consumers and through providing an environment where real life choices and decisions can be made. In 1994, the Prime Ministerial Taskforce on Employment also noted the negative effect of unemployment on mental health and psychological well-being.<sup>93</sup> The unemployed tended to have higher levels of clinical depression and anxiety and were more likely to attempt suicide.<sup>94</sup> Other studies have also revealed that health tends to deteriorate when employment ceases and improves once employment is re-established. Job insecurity further creates an environment that is uncertain and volatile, producing a situation that is adverse to mental health or that inhibits the recovery process.<sup>95</sup>

Although access to social support could lessen the negative impacts of unemployment, public perception and stigma are just as likely to offset whatever protective mechanisms are in place. In addition, while employment may serve as a

buffer to mental illness, unsatisfactory or unrewarding work may still contribute to psychological and emotional distress.<sup>96</sup>

Not surprisingly, disparities in income and education are further reflected within Māori employment profiles. Contemporary demands for an educated workforce have had a dramatic impact on Māori who, as shown, are less likely to engage in post-secondary education or to be qualified in areas where stable work can be anticipated.<sup>97</sup>

The recession of the mid-1980s led to significant disparities between Māori and non-Māori labour forces. A youthful Māori population, combined with lower levels of educational attainment, ensured that Māori were most likely to feel the adverse effects of economic decline. Concentrations of Māori within lower skilled occupations further contributed to these problems and exacerbated the un-likelihood of successfully negotiating alternative forms of employment.<sup>98</sup>

More recently, three phases of contemporary Māori employment have been established:<sup>99</sup> First, a large drop in employment between 1986 and 1991; second, a rapid increase between 1992 and 1995; and third, minimal growth since 1995. These fluctuations have tended to be more acute and dramatic for Māori, as opposed to the general population, and further highlights the volatile nature of Māori employment trends.

Other estimates indicate that although there have been improvements in the overall rates of Māori unemployment, Māori continue to be more likely than non-Māori to be unemployed, with Māori rates two and a half times that of non-Māori. Since December 1999, the unemployment rates of all ethnic groups declined. However, statistics for the December 2000 quarter show that Māori continue to lead the

unemployment statistics (13.0 percent), followed by Pacific peoples (11.4 percent), other ethnic groups (8.1 percent), and European/Pākehā (4.0 percent).<sup>100</sup> More recent figures (September 2001) have shown little change, with Māori unemployment running at 12.3 percent, 8.2 percent for Pacific peoples, 7.5 percent for the other ethnic groups, and 3.8 percent for European/Pākehā.<sup>101</sup>

Given the link between employment and income, many of the mental health consequences associated with poverty are also linked to unemployment. The effects of economic restructuring and rising unemployment are likely to be felt first and most significantly by Māori. Lower educational qualifications can reduce the prospects of finding alternative employment, and even if work is found the jobs are likely to be unrewarding, low paying and insecure.

Of added concern is the volatile nature of the current situation and the consequences of both national and international market forces on Māori employment. In this regard it has been suggested that in times of economic down-turn, Māori will usually serve as shock absorbers for the entire economy.<sup>102</sup> They are most likely to lose their jobs, have reduced hours or rates of pay, or face poorer working conditions. Such situations are likely to lead to higher levels of clinical depression and anxiety, as well as an increased prevalence of suicide. If alternative employment is secured there is a high probability that it will be short-term, further inhibiting sustained recovery. While supportive social networks may lessen the effects of such adversity, accessing the networks may be problematic if employment and income are compromised.

## Housing and Māori Mental Health

The evidence that links poor-quality housing to mental disorder is considerable.<sup>103</sup> Damp, overcrowded and/or excessively noisy domiciles are likely to precipitate both physical and mental health problems.<sup>104</sup> Further, those who are economically deprived are more likely to live in substandard accommodation.<sup>105</sup> Access to adequate and affordable housing can contribute to mental health recovery and maintenance, or exacerbate existing problems where housing is poor. Stresses related to inadequate housing, such as discomfort, poor state of repair, dampness, dilapidation and pest infestation, have also been shown to adversely affect mental health. Housing costs can add to stress, both directly and indirectly, by encouraging overcrowding, reducing the ability to heat a house or undertake repairs, and preventing a move to better accommodation.<sup>106</sup>

For Māori, housing patterns have changed considerably over the past 60 years. Before 1940, Māori were more likely than non-Māori to own their homes. However, by the 1950s this trend had reversed. Research suggests that the migration of Māori from rural to urban areas, particularly after 1945, was a significant turning point, especially as rental accommodation became an alternative and was far more practical, available, and affordable.<sup>107</sup> More recent statistics have further reflected these trends and show that Māori continue to be less likely than non-Māori to own their homes and more likely to live in rental accommodation or in overcrowded situations. Māori are also more likely to pay a higher proportion of their income on rent.<sup>108</sup> From 1993 to 1994, Māori housing loans and rental accommodation provided by the Ministry of Māori Development were transferred to mainstream agencies.<sup>109</sup> The new agencies however,

failed to effectively continue the Department of Māori Affairs's housing programme, and as a consequence the housing needs of Māori were further compromised.

These trends paint a dismal picture of Māori housing. Māori are, for example, less likely to be in a position where a reasonable standard of housing can be secured, and for many, the prospect of owning a house remains distant, if not unattainable. A greater number will be forced to live in substandard rental accommodation, or to reside in overcrowded environments where the stresses of everyday life are enhanced. Poorer educational attainment, reduced employment opportunities, and lower expected incomes can lead to a greater proportion of income being spent on housing and therefore fewer resources for other necessities. Options, including more affordable accommodation, may provide little respite, as alternative accommodation is likely to be damp, overcrowded and/or noisy. Such housing conditions have significant implications for mental health and can increase stress levels, as well as heighten feelings of deprivation and hopelessness.

### **Criminal Justice and Māori Mental Health**

The Department of Corrections recently undertook a major psychiatric morbidity study of the New Zealand prison population.<sup>110</sup> The results of this study revealed that a large number of inmates suffered significant morbidity from a range of psychiatric disorders. Key findings included:

- eighty-nine percent of inmates had, at some time in their lives, suffered from a substance abuse disorder (usually alcohol or cannabis) and about a third from a range of other disorders;

- approximately one-quarter had experienced some type of major depressive disorder, with nearly ten percent suffering from a current episode of major depression; and
- up to 121 inmates had either schizophrenia or another related disorder, while another 54 were estimated as possibly suffering from a manic episode of bipolar affective disorder.<sup>111</sup>

In addition, a further study indicates that there could be as many as one in ten offenders serving community-based sentences of supervision, parole or community programmes who may have special mental health needs.<sup>112</sup>

Levels of homicide, child abuse and neglect, violence and crime further provide a broad indication as to the mental health and well-being of a community.<sup>113</sup> A history of sexual abuse, for example, increases the risk of suicide, anxiety, depression, bulimia and sexual dysfunction. Victims of partner abuse also appear to have a higher incidence of depression, stress, anxiety, somatic complaints and suicide attempts. Rape and sexual assault victims have a higher incidence of anxiety, post-traumatic stress disorders, depression, sexual dysfunction and impaired social functioning. Victims of elder abuse and neglect are also at increased risk of depression. The perpetrators of violent crime are predominantly male, and victims are predominantly female.<sup>114</sup> In addition, Māori are significantly over-represented both as victims and perpetrators of violence in families/whānau.<sup>115</sup>

Social and economic disadvantage is closely linked to rates of offending. Te Puni Kōkiri (Ministry of Māori Development) reported that in 1998 Māori represented 40 percent of all apprehensions (including arrests and cautions), 41 percent of prosecuted

cases, and 44 percent of all those committed for an offence. Māori are more likely to be victims of assaults and threats, or to experience threats and assaults against them. Overall, since 1991, disparities throughout the various stages of the criminal justice system have continued to widen. By 1998, Māori were 3.3 times more likely to be apprehended, 3.6 times more likely to be prosecuted and 4.1 times more likely to be convicted than non-Māori.<sup>116</sup>

Māori make-up almost half (49 percent) of the prison population, yet only about 14 percent of the general population.<sup>117</sup> Māori males account for 41 percent of community-based sentences and orders,<sup>118</sup> while Māori females account for approximately 47 percent of community-based sentences and parole.<sup>119</sup> Almost 91 percent of Māori are likely to be reconvicted after serving a term of imprisonment.<sup>120</sup>

Māori over-representation in the criminal justice sector is both disturbing and portentous. Whether or not those with mental health problems are more likely to commit crime, more likely to be caught, or more likely to develop problems as a consequence of imprisonment is another matter. Of significance is the fact that negative relationships with the criminal justice sector, in whatever form, do not bode well for mental health. Of added concern are the covert and pervasive effects on women, children, the whānau and future generations.

## **Physical Health and the Implications for Mental Health**

Mental health indicators are not included in the set of 'Closing the Gaps 2000' indicators due to the poor quality of current mental health information, which focuses exclusively on inpatient mental health care.<sup>121</sup>

The 'Closing the Gaps' reports cover a range of indicators though not many are directly related to mental health. However, statistics on physical health and youth suicide are included and are worth considering from a mental health perspective.<sup>122</sup>

Numerous studies have linked low mood to low levels of physical activity.<sup>123</sup> Investigations into the level of fitness of anxious or depressed patients have also found that most were relatively unfit when physiologically tested. Some community-based investigations have further found a fourfold increase in the rate of depression and a two-and-a-half fold increase in the rate of anxiety disorders, with a trend for the more seriously disabled to be more severely depressed or anxious. Older persons who are fit are more likely to maintain better cognitive function, even after controlling for factors such as education, perceived health status, medical condition and medication.

When describing the health status of Māori, Te Puni Kōkiri examined 16 different indicators.<sup>124</sup> Their analysis revealed that overall, the health status of Māori was considerably lower than that of non-Māori. For example, death rates for coronary heart disease were two-and-a-half times higher for Māori than non-Māori. In 1997 lung cancer rates for Māori were four times that of non-Māori and within the same year Māori were well over-represented in terms of motor vehicle-related deaths.

While the evidence linking poor physical health to poor mental well-being has been relayed through a number of scientific studies, the significance of this for Māori is more than systematic or technical, and extends further to reflect the more fundamental concepts upon which Māori ideas of health are premised. In the absence of good physical health, an individual's mental well-being cannot be sustained, and will likewise impact on other dimensions such as wairua, and relationships with whānau

and the wider Māori community. The status of physical health should not be considered in isolation from mental health, and broader analysis – at a more conceptual level – is also pertinent.

### **Socio-economic Summary**

While not exhaustive, the issues described in this section highlight significant concerns about the contemporary position of Māori within New Zealand society. By considering the implications of socio-economic indicators on mental health, a more comprehensive understanding of Māori mental health can be formulated, adding a wider dimension, that complements the narrowly focused information such as hospital admission data sets. The table below provides a summary of the key issues and implications of the socio-economic indicators for Māori mental health.

Table 1.1 Social Determinants of Māori Mental Health

SECTOR	MĀORI POSITION	MENTAL HEALTH LINKAGE	MENTAL HEALTH CONSEQUENCES
<b>EDUCATION</b>	<ul style="list-style-type: none"> <li>Some improvements over the past 15 years; Though gains by non-Māori have also been made</li> <li>Low Māori participation in early childhood education</li> <li>Fewer Māori obtain higher level secondary school qualifications</li> <li>Lower Māori participation at the tertiary levels</li> </ul>	<ul style="list-style-type: none"> <li>Education can protect against poor mental health</li> <li>Lower educational achievement linked to partner abuse, homicide, assault, suicide, antisocial and substance abuse behaviours</li> <li>Implications for other indicators of mental health such as employment, income, and housing</li> </ul>	<ul style="list-style-type: none"> <li>Failure to develop mental health protection mechanisms</li> <li>Disadvantage in terms of employment, income, housing, and therefore mental health</li> <li>Can cause cycles of disadvantage, which add to perpetuation of mental ill-health within Māori communities</li> </ul>
<b>INCOME</b>	<ul style="list-style-type: none"> <li>Widening income gap between Māori and non-Māori</li> <li>Higher rates of Māori reliant on Government benefits</li> <li>More people per household, compounded by lower household incomes</li> <li>Higher numbers with fewer assets</li> </ul>	<ul style="list-style-type: none"> <li>Income the single most important determinant of health</li> <li>Children at particular risk if parents are disadvantaged socio-economically</li> <li>Can impact at a number of levels (education/housing)</li> </ul>	<ul style="list-style-type: none"> <li>Relative poverty more likely to effect Māori</li> <li>Socio-economic disadvantage connected to poor mental health</li> <li>Reduce access to te ao Māori</li> <li>Lack of control and helplessness</li> </ul>
<b>EMPLOYMENT</b>	<ul style="list-style-type: none"> <li>Most affected by the recession of the 1980s</li> <li>Lower skilled, less likely to secure sound employment</li> <li>Fluctuating levels of employment, but overall poor</li> <li>Māori more likely to be unemployed and to remain so for longer periods of time</li> <li>Unemployment levels around 15 percent</li> </ul>	<ul style="list-style-type: none"> <li>Employment a major contributor to mental health.</li> <li>Employment can aid the recovery process</li> <li>A lack of employment may precipitate mental health problems (such as depression) and further impede recovery</li> <li>Job insecurity also problematic</li> </ul>	<ul style="list-style-type: none"> <li>The mental health problems of low income are similarly linked to unemployment</li> <li>Negative effects of economic downturn felt first by Māori. Fewer qualifications impede re-entry into workforce (poorer conditions, lack of security). Low self-esteem a risk factor</li> <li>Inability to access traditional or established supportive networks if employment compromised</li> </ul>
<b>HOUSING</b>	<ul style="list-style-type: none"> <li>Pre-1940 Māori more likely to own home. Position now reversed</li> <li>More likely to rent or live in overcrowded environments</li> <li>Quality of housing generally poorer. Linked to education and employment issues</li> </ul>	<ul style="list-style-type: none"> <li>Poor quality housing linked to mental disorder</li> <li>Dampness overcrowding and noise linked to mental health problems</li> <li>Housing important for recovery; homelessness likely to exacerbate mental health problems</li> <li>Housing cost can add to stress</li> </ul>	<ul style="list-style-type: none"> <li>Prospects of owning a house more remote for Māori. A lack of security may precipitate mental health problems</li> <li>Substandard accommodation (overcrowded, dilapidated, disrepair) imposes interpersonal risks, security problems, lack of personal space</li> </ul>
<b>CRIMINAL JUSTICE</b>	<ul style="list-style-type: none"> <li>In 1998, Māori were 3.3 times more likely to be apprehended; 3.6 times more likely to be prosecuted and 4.1 times more likely to be convicted when compared with non-Māori</li> <li>More likely to be victims of assaults and threats</li> </ul>	<ul style="list-style-type: none"> <li>High rates of prison inmates shown to suffer from mental health problems</li> <li>Levels of homicide, child abuse and neglect, violence and crime provide broad indication of mental health and well-being of community</li> <li>Alcohol and drug problems also related</li> </ul>	<ul style="list-style-type: none"> <li>Levels of offending, abuse, violence, drug and alcohol use paint poor picture of Māori mental health. The implications for individuals likely to be significant and possibly lead to imprisonment. However, problems felt by family and wider community should also be considered from mental health perspective</li> </ul>
<b>HEALTH</b>	<ul style="list-style-type: none"> <li>Significant gaps in almost all measures of health status</li> <li>Heart disease, lung cancer, smoking, suicide, and motor vehicle crashes of particular concern</li> <li>The reasons for these problems are diverse and include culturally related factors</li> </ul>	<ul style="list-style-type: none"> <li>Various studies have linked physical health with mental well-being</li> <li>Poor physical health also linked to poor mental health</li> <li>Some disagreement about the physical/mental relationship, but sufficient evidence to affirm a positive connection</li> </ul>	<ul style="list-style-type: none"> <li>Concepts of Māori mental health include physical dimensions</li> <li>A range of physical ailments are likely to inhibit programmes aimed at Māori mental health</li> <li>Strategies for Māori mental health need to be broad and appreciate range of factors (including physical health) that can impact in positive or negative manner</li> </ul>

## **DISLOCATION, SOCIAL, CULTURAL, AND POLITICAL CHANGE**

The problems described in the previous section, while disturbing, have contributed to an increased awareness of the state of Māori mental health, and a growing interest in why these trends and patterns have developed. As yet, no biological or genetic drivers (linked specifically to Māori) have been identified and for the most part have not been regarded as significant.<sup>125 , 126</sup> The ecological approach does not mean that genetic factors can be excluded as irrelevant, but places greater weight on the external conditions – and triggers – that lead to changes in health and in particular coping mechanisms. It should also be noted that mental disorders, the subject of much genetic inquiry, do not account for the total mental health burden and do not arise outside a social-cultural context.<sup>127</sup>

The following section explores a number of socio-cultural theories that have attempted to explain the poor state of Māori mental health. The effects of colonisation are considered, as well as political factors, cultural breakdown, socio-economic influences, and contemporary lifestyles and behaviours.

### **Two Worlds in Conflict**

Judging from experience in other parts of the world, we may hazard a guess that the increasing adjustment of the Māori to the Pākehā way of life with its standards and values, morality and behaviour, will bring a tendency for the Māori mental disease figures to approximate more and more to those of the Pākehā population.<sup>128</sup>

Comments by the Associate Minister of Māori Affairs (Tariana Turia) in 2000, – linking mental illness to ‘post-colonial stress disorders’, led to considerable debate about the role of colonisation and the impact it might have had on Māori development. Many, particularly those within the mainstream media, described her comments as racist, or ill-informed.<sup>129</sup> However, the shallow analyses of the media failed to take seriously the link between the experiences of a people over generations, and their health status.

Beyond what was played out in the media, the connection between colonisation and Māori mental health has been known, or at least suspected, for some time. The process of urbanisation in particular, has had a profound effect on Māori mental health by creating considerable social disruption and diminishing traditional Māori support structures and mechanisms.

The link between colonisation and mental health derived in part, from an interest in Māori mental health admissions and, in particular, the patterns that occurred before, and leading up to, the 1970s. In this regard, it is postulated that the process of urbanisation, which was linked to more fundamental economic objectives, had a dramatic effect on Māori society, diminishing those cultural activities and support structures that provided resilience to mental ill-health.<sup>130</sup> In search of employment, many Māori were enticed into the cities, with the vision of a more attractive lifestyle and access to a full range of other amenities. However, an unfortunate consequence of urban migration was the inevitable removal from whānau, ancestral lands, the marae and the Māori community. In this

regard, a sense of purpose, a network of support, and access to a secure identity were also reduced.

In 1961, a report to Parliament, by the then Secretary of Māori Affairs, Jack Hunn, raised concerns about Māori socio-economic performance, and was probably the first attempt to analyse Māori and non-Māori standards of living on a large scale. Hunn drew attention to serious disparities and blatant inadequacies in health, housing, and education, and prescribed new structures that emphasised a move away from the tribal system. The report, while not entirely ignorant of urban realities, was perhaps too quick to advocate the establishment of new structures, a policy of 'pepper potting' whereby Māori households would be scattered within communities in order to integrate.<sup>131</sup> In hindsight, the process of urbanisation was poorly managed, and undervalued the significance of being Māori.

While the immediate effects of the urban migration were often mitigated in times of economic prosperity, the negative consequences were more likely to be felt during periods of recession or high unemployment. Mental health problems were more likely to be evident at those times:

The deliberate policy of moving families away from their traditional lands ignored the spiritual and cultural bonds that made up a vital mental health force. Within a generation, uprooted families, advised to seek the tools of the Pākehā, lost self-esteem, confidence, status and became alienated from their own past.<sup>132</sup>

Several commentators<sup>133</sup> have similarly argued that on the whole, rural Māori society offered more reliable mechanisms for overcoming psycho-social crisis than urban centres. Furthermore, the community as a whole was not unaccustomed to calamity<sup>134</sup> and was able to absorb many of the emotional and behavioural impacts of stress, whether financial, interpersonal, or life-style based. Urbanisation created another type of community. While some Māori may have attempted to maintain or re-establish these types of traditional coping mechanisms, the urban environment had its own characteristics that meant any reconstruction of former support networks was at best a poor replica and at worst a contributing factor to further alienation.

In times of economic down-turn, such issues would have become more pronounced. Unemployment, for example, would have added to the tensions associated with urbanisation, creating higher levels of anxiety on top of already stressed whānau. In addition, the cultural costs were high and contributed to the new health dilemma. Where cultural structures were absent, a key protective mechanism was lost, or at the very least compromised:

The fact that there are fewer neurotic and psychotic illness among Māori than among Pākehās in New Zealand emphasises among other things the tremendous value to the Māori of possessing a psychological security that comes from tribal and family security.<sup>135</sup>

According to Te Aho-Lawson, the process of urbanisation also created environments where Māori perspectives were devalued and made redundant, often viewed as being unnecessary, inappropriate, or primitive. Further, cultural alienation, identity and role

confusion, combined with a loss of cultural systems, can be linked to higher rates of youth suicide.<sup>136</sup> Others have also questioned the extent to which urbanisation impacted on traditional gender roles and functions and how far these issues are responsible for differences in Māori male and female health concerns.<sup>137</sup> Of particular concern to the emerging patterns of mental ill-health, is the position of Māori men.<sup>138</sup>

Overall, the impact of urbanisation on Māori mental health is unknown. What is known, however, is that social disruption did occur and was consistent with a Māori migration from rural to urban settings. It would be inaccurate to suggest that this in itself led to mental ill-health, though it is likely that many cultural institutions and mechanisms were at odds with what this new environment offered. Further, in times of economic or psychological hardship, access to cultural support mechanisms were compromised by geography, finance, the expectations of non-Māori, and an atmosphere built on Western views of health, support, treatment and care.

## **Land Loss**

The theme of urbanisation captures a particular aspect of Māori mental health and explores issues that are not necessarily inconsistent with, or mutually exclusive from, other themes, concepts, and theories, all of which seek to rationalise Māori mental health. Consequently, the notion of political ambivalence also fits, and is a theme with a number of associated implications. An important issue here is the impact of land alienation on Māori and the subsequent loss of spirituality, group support, mana and identity. It is further presumed that any consideration of Māori mental health today must appreciate

interactions with the cultural heritage of Māori and the contemporary reality within which Māori now reside.<sup>139</sup> These issues have been described in a more global context and again reflect on the broad implications of colonisation:

Given the trauma and dislocations that indigenous peoples have experienced, and to which they continue to be subjected, we can assume that they suffer from high rates of various neuropsychiatric and behavioural problems, yet relatively few data exist concerning the mental health status and treatment needs of indigenous peoples. What we do know points to great unmet needs. Throughout the Western Hemisphere, indigenous peoples suffer from high rates of alcoholism and suicide. The same can be said of the peoples in Oceania and in northern Russia, as well as the aboriginal groups of Taiwan. Furthermore we can safely conjecture that dislocation, epidemics, depopulation, and subjugation have put indigenous people everywhere at high risks of depression and anxiety.<sup>140</sup>

The process of colonisation led to significant land alienation, which removed a key economic and cultural resource from Māori. The loss of land contributed to impoverished lifestyles, and precipitated a range of other social problems, in housing, education, and health. Cycles of disadvantage continue to be reflected in Māori socio-economic indicators, and are inconsistent with mental well-ness.<sup>141</sup>

In other ways, the loss of land also rendered Māori unable to maintain effectively cultural practices that had traditionally been based on the identification of ancestral land and *turangawaewae*.<sup>142</sup> For example, Huriwai<sup>143</sup> notes that cultural decay and land alienation led to a loss of spirituality, dignity, identity and respect amongst Māori, that ultimately impacted negatively on mental health. Recent developments in treatment have supported

this explanation and have further emphasised the cultural significance of land in promoting mental health.<sup>144 , 145</sup>

## **Political Indifference**

Government actions were largely responsible for creating the means and methods through which Māori were ultimately relieved of their customary lands. In addition, Government policies tended to undermine Māori traditions, values and beliefs, the notion of spirituality, mana and identity. For example, the Tohunga Suppression Act 1907, although officially designed to encourage Māori acceptance of conventional (medically based) treatments, effectively reduced the perceived validity of traditional Māori approaches to health, and heralded a trend away from traditional practices and methodologies in favour of Western/scientific modes.<sup>146</sup> While Māori have gained much from Western medical practice and science, the cost of outlawing traditional practices has been significant, contributing to deculturation, and to a collective undervaluing of cultural values, practices and beliefs:

Loss of land led to loss of cultural base, loss of turangawaewae, loss of base of whānau, loss of economic base, loss of strength of future. Introduction of an industrialised technology and development of urban New Zealand led to urban drift as Māori sought economic stability for their whānau, but were further separated from the basis of their identity. Government's policy of malign paternalism and assimilation was essentially Eurocentric, having little awareness and less heed to the impact on Māori. From a robust and vibrant society, over less than two hundred years Māori have become disadvantaged, disabled by inequity in all areas of contemporary life.<sup>147</sup>

## PARAMETERS AND BOUNDARIES

Although a range of issues have been discussed, this chapter is used to highlight two important points. First, mental health problems are a significant health risk for Māori and reflect on the position of Māori in modern society. They are related to an array of socio-economic, cultural, political, and historical stressors. The second point is that the solutions are complex. In light of the various factors that affect mental health, strategies aimed at arresting the current trends will need to be diverse and comprehensive, and focused on both societal (public health approaches) and personal levels (care and treatment).

This thesis does not purport to provide high-level answers to mental health nor to prescribe pathways for prevention or treatment. However, by examining and understanding the wider context within which mental health problems emerge, it has been possible to formulate a view of mental health that embraces social, cultural, historical, and economic factors.

Having arrived at a broad understanding, it then becomes possible to ensure that further explorations of Māori mental health are similarly positioned along a highway that reflects values, realities, adversities, and both Western and Māori practices and perspectives. Out of this landscape, the possibility of a tool to measure outcomes has emerged.

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- <sup>1</sup> R. Lange, (1999), *May the People Live: A History of Māori Health Development, 1900–1920*, University of Auckland Press, Auckland.
- <sup>2</sup> He hokinga mahara he kitenga huarahi - A memory from the past , a pathway to the future.
- <sup>3</sup> V. Keefe-Ormsby, N. Watene-Hayden, W. Maniapoto, G. Taumata-Bishara, and H. Potaka, (1993), *Tino Rangatiratanga and Māori Mental Health*, Department of Health, Wellington.
- <sup>4</sup> M. H. Durie, (1986), 'Te Taha Hinengaro: An Integrated Approach to Mental Health', in *Community Mental Health in New Zealand*, vol. 1, no. 1, pp. 4-11.
- <sup>5</sup> See for example M. Jackson, (1988), 'The Mentally Ill Offender: A Māori Perspective', in *Community Mental Health in New Zealand*, vol. 4, no.1, pp. 45-51.
- <sup>6</sup> Te Puni Kōkiri, (1996), *Ngā Ia o te Oranga Hinengaro Māori - Trends in Māori Mental Health, 1984-1993*, Ministry of Māori Development, Wellington, p. 19.
- <sup>7</sup> K. Te Aho-Lawson, (1999), *A Review of Evidence: A Background Document To Support Kia Piki Te Ora o Te Taitamariki*, Te Puni Kōkiri, Wellington, p. 12.
- <sup>8</sup> See for example H. W. Williams, (1992), *Dictionary of the Māori Language*, GP Publications Ltd, Wellington.
- <sup>9</sup> P. S. Sachdev, (1989), 'Mana, Tapu, Noa: Māori Cultural Constructs with Medical and Psycho-social Relevance', in *Psychological Medicine*, vol. 19, pp. 29-39.
- <sup>10</sup> D. Chaplow, (1993), 'Addressing Cultural Differences in Institutions: Changing Health Practices in New Zealand', in *Criminal Behaviour and Mental Health*, vol. 3, pp. 307-321.
- <sup>11</sup> E. & P. Beaglehole, (1947), *Some Modern Māori*, New Zealand Council for Educational Research, Whitcombe and Tombs Ltd, Auckland, p. 241.
- <sup>12</sup> G. Bridgman, (1997), 'Mental Health Awareness in 1997: Mental Illness and Pacific People in New Zealand', in *Te Māori: Ngā Hui Hui ngā Kōrero o Aotearoa*, vol. 2, no. 32, pp. 10-11.
- <sup>13</sup> Cherrington also explores the relationship between culture and the expression of psychopathology. See L. Cherrington, (1994), *A Comparison Study of the Presenting Symptoms Between Māori and Pākehā Patients Diagnosed with Schizophrenia*, MA Thesis, Massey University, Palmerston North.
- <sup>14</sup> Personal Communication, Interview Database Entry – Record 18 (see Chapter 2: Ethical Issues, for detail)
- <sup>15</sup> Lange, (1999), *op cit.*
- <sup>16</sup> L. K. Gluckman, (1976), *Tangiwai: A Medical History of 19th Century New Zealand*, Gluckman and Whitcoulls, Christchurch.
- <sup>17</sup> These estimates were established around the turn of last century.
- <sup>18</sup> Beaglehole, (1947), *op cit.*, p. 243.
- <sup>19</sup> That is, 20.61 per 10,000, compared to 47.73 per 10,000 for the non-Māori population.
- <sup>20</sup> Cited in M. H. Durie, (1994), 'Māori Psychiatric Admissions Patterns and Policies', in J. Spicer, A. Trlin, and J. A. Walton (eds.), (1994), *Social Dimensions of Health and Disease New Zealand Perspectives*, Dunmore Press, Palmerston North.

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- <sup>21</sup> Ibid.
- <sup>22</sup> Ibid.
- <sup>23</sup> K. Mason, J. Johnston, and J. Crowe, (1996), *Inquiry Under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services*, Ministry of Health, Wellington, p. 137.
- <sup>24</sup> Te Roopu Rangahau Hauora a Eru Pomare, (1995), *Hauora, Māori Standards of Health*, GP Print Ltd, Wellington, p. 116.
- <sup>25</sup> Ibid., p. 121.
- <sup>26</sup> Ibid., p. 116.
- <sup>27</sup> P. Reid and B. Robson, (1998), 'Dying to be Counted', in Te Pūmanawa Hauora (ed.), *Te Oru Rangahau Māori Research and Development Conference, 7-9 July 1998 Proceedings*, School of Māori Studies, Massey University, Palmerston North, p. 267.
- <sup>28</sup> D.R. Thomas, (1988), 'Culture and Ethnicity: Maintaining the Distinction', in *Australian Journal of Psychology*, 38, 3, pp. 371-380.
- <sup>29</sup> D.R. Thomas, (1988), 'Development of a Test of Māori Knowledge', in *New Zealand Journal of Psychology*, 17, pp. 59-67.
- <sup>30</sup> D. R. Thomas, (2001), 'Assessing Ethnicity in New Zealand Health Research', in *New Zealand Medical Journal*, vol. 114, no. 1127, p.88.
- <sup>31</sup> M. H. Durie, (2001), *Mauriora: The Dynamics of Māori Health*, Oxford University Press, Auckland.
- <sup>32</sup> Durie, (1994), *op cit*.
- <sup>33</sup> This study examines the epidemiology of mental disorders in the New Zealand community for adults 16 years and over, and will provide: One-month, 12-month and lifetime prevalence rates for mental disorders among the non-institutionalised population of New Zealand, and information about their socio-demographic and ethnic group patterning; Information on the level of disability associated with mental disorders; Information on patterns of health service use and barriers to service use among those with disorders; Baseline data and calibration of a short instrument measuring the common mental disorders that can be used in future generic health surveys.
- <sup>34</sup> The project was first authorised by the Minister of Health in September 1997.
- <sup>35</sup> A number of service providers are not yet 'compliant' with the project.
- <sup>36</sup> New Zealand Health Information Service, (1999), *Mental Health Information Project: Background Pilot; National Rollout Benefits*, New Zealand Health Information Service, Wellington, p. 12.
- <sup>37</sup> New Zealand Health Information Service, (1997), *Mental Health Information National Collection: Layout Specifications*, New Zealand Health Information Service, Wellington.
- <sup>38</sup> Minutes: Mental Health Information Project, Māori Advisory Board - 4 February 2000.
- <sup>39</sup> Reid and Robson, (1998), *op cit*, p. 266.

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- <sup>40</sup> B. Disley, (1997), 'An Overview of Mental Health in New Zealand', in P. M. Ellis and S. C. D. Collings (eds.), *Mental Health in New Zealand from a Public Health Perspective, Public Health Report*, no. 3, Ministry of Health, Wellington, p. 17.
- <sup>41</sup> See for example K. Mason, *et al.* (1996), *Inquiry Under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services*, Ministry of Health, Wellington. See also L. Dyall, (1997), *Hauora o Te Hinengaro - Pathway to Māori Mental Health and Wellness: Report of the 1997 Hui Rangahau Hauora Hinengaro*, Health Research Council of New Zealand, Auckland.
- <sup>42</sup> See for example Te Puni Kōkiri, (1999), *He Pou Tarawahomo te Hauora Hinengaro Māori - A Framework for Māori Mental Health: Working Document*, Ministry of Māori Development, Wellington. See also Te Roopu Rangahau Hauora a Eru Pomare, (1995), *Hauora, Māori Standards of Health*, GP Print Ltd, Wellington.
- <sup>43</sup> See for example Mental Health Commission, (1998), *Blueprint for Mental Health Services in New Zealand: How Things Need to Be*, Mental Health Commission, Wellington. See also M. H. Durie, (1998), 'Puahou: A Five Part Plan for Māori Mental Health', in *He Pukenga Kōrero*, vol. 3, no. 2, Department of Māori Studies, Massey University, Palmerston North; Ministry of Health, (1995), *Whakapainga Hauora o Ngā Tangata Tokomaha o Te Ao*, Ministry of Health, Wellington.
- <sup>44</sup> Committee of Inquiry, (1988), '*Psychiatric Report*', a report to the Minister of Health, Wellington.
- <sup>45</sup> P. S. Sachdev, (1989), 'Psychiatric Illness in the New Zealand Māori', in *Australian and New Zealand Journal of Psychiatry*, vol. 23, no. 4, pp. 529-541.
- <sup>46</sup> From 119 per 100,000 to 127 per 100,000.
- <sup>47</sup> From 60 per 100,000 to 200 per 100,000.
- <sup>48</sup> See Te Puni Kōkiri, (1996), *op cit.*
- <sup>49</sup> K. Skegg, (1997), 'Suicide and Parasuicide', in P. M. Ellis and S. C. D. Collings (eds.), *Mental Health in New Zealand from a Public Health Perspective, Public Health Report*, no. 3, Ministry of Health, Wellington, p. 428.
- <sup>50</sup> Disley, (1997), *op cit.*, p. 21.
- <sup>51</sup> Te Roopu Rangahau Hauora a Eru Pomare, (1995), *op cit.*, p. 156.
- <sup>52</sup> Durie, (1994), *op cit.*
- <sup>53</sup> Deloitte and Touche Consulting Group, (1997), *National Acuity Review: Final Report on New Zealand's Mental Health Acute Inpatient Services*, Ministry of Health, Wellington.
- <sup>54</sup> Durie, (1998), *op cit.*
- <sup>55</sup> *Ibid.*, p. 61.
- <sup>56</sup> M. H. Durie, (1993), 'Māori Development and Purchasing Plans for Māori Health', *Proceedings of the Contracting Quality Health Care Conference, 15 March 1993*, Auckland.
- <sup>57</sup> However, the major enzymes involved in alcohol metabolism, alcohol dehydrogenase (ADH) and acetaldehyde dehydrogenase (ALDH), are not present in all racial groups to the same extent – Māori have lower levels than some groups. This can impact on alcohol tolerance and consumption capacity.

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- <sup>58</sup> Te Puni Kōkiri, (1999), *op cit.*
- <sup>59</sup> Disley, (1997), *op cit.*, p. 9.
- <sup>60</sup> Durie states that neither hospital admission rates nor estimates of mental disorder give a comprehensive picture of either the prevalence of poor mental health or mental health status generally. Other indicators should be taken into account, such as the rates of Māori within prisons, forensic services, child health camps, supervisory care, women's refuge, alcohol and drug services, and injury services. Cited in M. H. Durie, (2000), '*Te Pae Mahutonga: A Model for Māori Health Promotion*', Department of Māori Studies, Massey University, Palmerston North. See also B. English, (1997), *Te Oranga Hinengaro Māori - Māori Mental Health Conference, 28 August 1997*, Wellington; Ministry of Health, (1997), *Mental Health Promotion for Younger and Older Adults: The Public Health Issues*, Ministry of Health, Wellington.
- <sup>61</sup> Te Puni Kōkiri, (1998), *Progress Towards Closing Social and Economic Gaps Between Māori and Non-Māori: A Report to the Minister of Māori Affairs*, Ministry of Māori Development, Wellington.
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## Chapter Two

# METHODOLOGICAL CONSIDERATIONS

### INTRODUCTION

Identifying aims and objectives brings with it an implicit understanding, an appreciation that a process will be undertaken, a method through which goals can be met. The last section of the previous chapter described the broad parameters of the study, providing direction and focus. To ensure that these objectives could be successfully achieved a considered research approach was developed. This chapter discusses the theoretical underpinnings, general approaches, and methods used in the research.

### RESEARCH PARADIGMS

Paradigms provide the framework within which research is carried out. They reflect fundamental beliefs or metaphysics and are concerned with the essential and underlying principles that shape and define perceptions of the world, its nature, and the place of people within it. These beliefs provide the foundation through which impressions of reality are formed. They are most often based on faith, not science, and are consequently impossible to assess in terms of truthfulness or validity.<sup>1</sup> A paradigm is a particular 'world view' or perspective, often used to break down the complexity of the real world and to provide a manageable means through which worldly matters can be understood. Paradigms determine what is important, reasonable, relevant and legitimate. For the researcher, these assumptions allow fundamental decisions to be made, without the

requirement to engage in lengthy existential or epistemological considerations.<sup>2</sup> A paradigm determines what can be considered legitimate priorities, how problems are considered, as well as which methodologies and methods are acceptable.<sup>3</sup>

In reflecting on the relationship between paradigms and research, Guba and Lincoln state:

Inquiry paradigms define for the inquirer what it is that they are about and what falls within and outside the limits of legitimate inquiry. The basic beliefs that define inquiry paradigms can be summarized by the responses given by proponents of any given paradigm to three fundamental questions, which are interconnected in such a way that the answer given to any one question, taken in any order, constrains how the others may be answered.<sup>4</sup>

In reference to the quote above, the three fundamental questions are: What is the form and nature of reality, and therefore what can be known about it? – the ontological question. What is the nature of the relationship between the knower or would-be knower and what can be known? – the epistemological question. How can the enquirer (would be knower) go about finding out what he or she believes can be known? – the methodological question.

In reflecting on the range of paradigms, Guba and Lincoln describe four that are of particular relevance to the social sciences - positivism, post-positivism, critical theory, and constructivism. The suitability of these paradigms (in terms of research activity) can be assessed by exploring their ontological, epistemological, and methodological positions.

Positivism, is an inquiry paradigm that has dominated the Western social and physical science discourse over the past 400 years. A positivist assumes (or rather asserts) that the goal of knowledge is simply to describe the phenomenon that is experienced. Inquiry is therefore confined to what can be observed and measured. What cannot be measured or observed is consequently impossible:

When I think of positivism (and the related philosophy of logical positivism) I think of the behaviourists in mid-20th Century psychology. These were the mythical 'rat runners' who believed that psychology could only study what could be directly observed and measured. Since we can't directly observe emotions, thoughts, etc. (although we may be able to measure some of the physical and physiological accompaniments), these were not legitimate topics for a scientific psychology. B.F. Skinner argued that psychology needed to concentrate only on the positive and negative reinforcers of behaviour in order to predict how people will behave – everything else in between (like what the person is thinking) is irrelevant because it can't be measured.<sup>5</sup>

The ontological perspective of positivism (commonly called 'naive realism') is that there is one reality that is assumed to exist and that is driven by rigid natural laws and mechanisms. Knowledge is typically defined in terms of time and context-free generalisations that often take the form of cause and effect laws. Reality is how we sense it to be and our senses provide a direct impression of reality. Through consideration and exploration, reality is therefore determined.<sup>6</sup>

Naive realism, in philosophy, is the view that when we perceive objects we perceive them immediately. Our perception of objects is not mediated by our immediate perception of sensory experience. I do not perceive the chair by perceiving my sensory experience as of it. The chair is the immediate object of my perception.<sup>7</sup>

The epistemological perspective of positivism is described as 'dualist and objectivist'. Both the researcher and the subject are viewed as being independent of each other. It is assumed that the researcher is able to conduct investigative inquiry autonomously, without influencing the subject or being influenced themselves. Processes and procedures are followed to negate threats to validity and bias, and truths can be determined from a positivist perspective.

Methodology is 'experimental and manipulative'. Various questions or hypotheses are posed in propositional form and further examined through empirical analysis. Confounding conditions may be reduced through careful research planning and manipulation of certain conditions or factors. This process is often specifically engineered, ensuring that the research and any outcomes are not unduly influenced by factors that are beyond the interest of the research, yet may still be capable of affecting the result.

Post-positivism reflects more recent efforts to respond to some of the criticisms of positivism, while still conforming to essentially the same set of basic beliefs. The ontological perspective is 'critical realism'. It is assumed that reality exists but is not perfectly understood due to human intellectual shortcomings and the fundamentally fluid and unpredictable nature of the phenomenon under investigation. The term 'critical realism' derives from the perceived need to critique the notion of reality and to examine it in the broadest and most critical manner. This allows one to explore reality as closely as possible and with a dynamic appreciation. However, it also assumes that reality cannot be understood perfectly or in its entirety.

The epistemological question is described as 'modified dualist/objectivist'. In this sense dualism is mostly abandoned and regarded as being impossible to maintain. However, objectivity is still considered a regulatory ideal. Emphasis is placed on external regulators responsible for critical objectivity, review and critique. Findings are most likely true, but may be subject to falsification. Methodology is 'modified experimental/manipulative'. In this sense critical multiplism (a form of triangulation) is engaged as a direct means of falsifying a hypothesis. The methodology is designed to capture and perform research within its natural setting. Information is collected within its normal environment and discovery is introduced as a particular part of the overall inquiry. Often, especially within the social sciences, perspectives are solicited in order to assist with the interpretation of individual viewpoints and actions as well as contributing to grounded theory. This type of input is typically gathered through qualitative research techniques:

A post-positivist might begin by recognizing that the way scientists think and work and the way we think in our everyday life are not distinctly different. Scientific reasoning and common sense reasoning are essentially the same process. There is no difference in kind between the two, only a difference in degree. Scientists, for example, follow specific procedures to assure that observations are verifiable, accurate and consistent. In everyday reasoning, we don't always proceed so carefully (although, if you think about it, when the stakes are high, even in everyday life we become much more cautious about measurement. Think of the way most responsible parents keep continuous watch over their infants, noticing details that non-parents would never detect).<sup>8</sup>

Concerns related to both positivism and post-positivism have been raised, in particular because they tend to remove the context from the phenomenon being studied. The implication is that the opportunity by which findings from the research can be generalised and applied is often reduced. The approach further excludes the meaning and purpose people attach to activities and can impose alien theories, notions or hypotheses that are of little meaning to this group. It assumes that facts are value free when instead they may be a reflection of a broader value system.

Critical theory is used to describe a set of alternative paradigms, including neo-marxism, feminism, materialism, and participatory inquiry. These are linked by the assumption that inquiry is value determined. Its ontological perspective is termed 'historical realism', with reality being shaped by:

...the congeries of social, political, cultural, economic, ethnic, and gender factors, and then crystallized (reified) into a series of structures that are now (inappropriately) taken as 'real,' that is, natural and immutable. For all practical purposes the structures are 'real,' by virtual or historical reality.<sup>9</sup>

Epistemology is termed 'transitional and subjectivist'. The researcher and subject are assumed to be linked, with the values and beliefs of the investigator influencing the inquiry and how it is conducted. This position challenges the more fundamental distinctions between ontology and epistemology. What can be known is inextricably linked with the interaction between an investigator and the particular issue or group under investigation. Methodology is 'dialogic and dialectical'. Because inquiry requires dialogue between the investigator and subject, this interaction must be dialectical in

nature. This enables the transformation of what is unknown into more informed notions or concepts.

Constructivism is an alternative paradigm characterised by the move from ontological realism to ontological relativism. Constructivists argue that both knowledge and reality lack an objective or absolute value, therefore there is no way of knowing this reality. Researchers interpret and construct a reality based on their experiences and interactions with their environment as opposed to thinking of truth in terms of a match to reality. Ontology is termed 'ontologically relativist', with realities viewed as intangible mental constructions. These are socially and experientially based and are both local and specific in nature. In this regard their content and form is dependent on the perceptions of individuals or groups holding or perceiving these constructions:

Constructions are not more or less 'true', in any absolute sense, but simply more or less informed and/or sophisticated. Constructions are alterable, as are their associated realities.<sup>10</sup>

Epistemology is termed 'transactional and subjectivist'. The researcher and the subject are assumed to be linked so that the results are developed as the research progresses. As part of this the distinction between ontology and epistemology becomes non-existent, thus linking it to critical theory. Methodology is 'hermeneutical and dialectical'. Research therefore, can only be conducted through interaction between and among the researcher and the respondent. Table 2.1 summarises these four inquiry paradigms.

Table 2.1 Basic Beliefs (metaphysics) of Alternative Inquiry Paradigms

Item	Positivism	Post - positivism	Critical Theory	Constructivism
Ontology	Naïve realism 'real' reality but apprehendable	Critical realism, 'real' reality but only imperfectly and probabilistically apprehendable	Historical realism, virtual reality shaped by social, political, economic, ethnic and gender values; crystallised over time	Relativism, local and specific constructed realities
Epistemology	Dualist/objectivist findings true	Modified dualist/objectivist; critical traditional/community; findings probably true	Transactional/subjectivist; value mediated findings	Transactional/subjectivist; created findings
Methodology	Experimental/manipulative; verification of hypothesis; chiefly quantitative methods	Modified experimental/manipulative; critical multiplism; falsification of hypothesis; may include qualitative methods	Dialogic/dialectical	Hermeneutical/dialectical

*Source:* Denzin and Lincoln, 1994: 109

## ADAPTATION OF A WESTERN PARADIGM

Māori academics have raised concerns about the legitimacy of Western paradigms as the broader framework for research among indigenous peoples.

Smith contends that:

...the Western cultural archive contained within it several traditions of knowledge and rules of practice for engaging in debates over knowledge....The notion of research as an objective, value free and scientific process for observing and making sense of human realities is often taken for granted by many social scientists....Social science fields of inquiry are dependent on the way the society is viewed, and the body of knowledge which legitimates this viewpoint...<sup>11</sup>

She further asserts that Western research has essentially developed from within a positivist tradition. The implications for research with indigenous peoples can be significant as it brings with it a different set of cultural values, alternative concepts of space and time, theories of knowledge, and language that may be highly specialised. She adds:

... to a large extent theories about research are underpinned by a cultural system of classification and representation, by views about human nature, human mortality and virtue, by conceptions of space and time, by conceptions of gender and race. Ideas about these things help determine what counts as real. Systems of classification and representation enable different traditions or fragments of traditions to be retrieved and reformulated in different contexts as discourses, and then to be played out in systems of power and domination, with real material consequences for colonized peoples.<sup>12</sup>

Generally, Māori have questioned whether Māori research can be conducted from within a Western paradigm. Although Māori lack an 'articulated' inquiry paradigm, Māori perspectives, behaviours, and cultural constructs, serve to shape a unique Māori world view. The implications for this investigation are significant, given that this research programme is intended to provide a measurable contribution to mātauranga Māori, and thereby to Māori development.

### **A Māori Research Paradigm**

Historical Western research activity has been heavily criticised by Māori.<sup>13</sup> Often impressions of Māori society and culture were misinterpreted through Western views of normality and morality. Further, many research processes have served to alienate Māori by placing them under an observer's metaphorical microscope with little opportunity for dialogue and interaction.<sup>14</sup> Consequently, Māori have advocated for a more appropriate approach to research involving Māori. 'Kaupapa Māori' is a term often used to describe a Māori inquiry paradigm. Although there is no single understanding of 'kaupapa Māori', it is the centre for discussion of an emerging Māori inquiry paradigm.

Nepe suggests that kaupapa Māori is based on an epistemology which may, and should, be distinguished from those articulated in Western discourse, and that these differences will impact on the way in which the world is viewed, how it is organised, how questions are designed and solutions formulated.<sup>15</sup> Irwin suggests that kaupapa Māori meets many of the requirements of a paradigm and should therefore be considered as such.<sup>16</sup> Bishop

states that kaupapa Māori counters the prevailing ideologies of cultural superiority that pervade our social, political and economic institutions, and that kaupapa Māori research is located within an alternative perspective of the world from which solutions and cultural aspirations can be generated.<sup>17</sup>

In drawing together the discussions on kaupapa Māori, and its emergence as a distinct paradigm, Smith states that it is both more and less than a paradigm:

It does set out a field of study which enables a process of selection to occur, and which defines what needs to be studied and what questions ought to be asked. It also has a set of assumptions and taken for granted values and knowledge, upon which it builds. In this sense it can be fitted into some of the ways in which a paradigm is defined. It is also, however, more than a sum of those parts. Kaupapa Māori research is a social project; it weaves in and out of Māori cultural beliefs and values, Western ways of knowing, Māori histories and experiences under colonialism, Western forms of education, Māori aspirations and socio-economic needs, and Western economics and politics.<sup>18</sup>

The overall position, therefore, is that while consensus on the exact nature of kaupapa Māori has yet to be reached, there is some agreement that it is an emerging paradigm that may provide parameters for Māori focused research, including the present investigation. The following sections further explore the notion of kaupapa Māori in terms of ontology, epistemology, and methodology.

## **A Kaupapa Māori Ontology**

According to a kaupapa Māori paradigm, reality is shaped or determined by the cultural values through which one perceives the world. Therefore research carried out within a kaupapa Māori paradigm will be consistent with Māori values, traditions and cultural practices.

In reflecting on a 'Māori world view', Henare refers to the notion of 'Māoritanga'<sup>19</sup> and its connection to whenua (Te Ika a Maui and Te Wai Pounamu),<sup>20</sup> to Polynesia, to Oceania and to the Indo-Malaysian world. He notes that many of the practices that have come to characterise Māori culture are linked to the relationship between Māori and the natural environment, and in particular the land. He points out that these practices have evolved, over many thousands of years, and according to a range of values, social systems and social organisations. The Māori world view incorporates a belief system that is founded on the inter-relatedness of people and nature, and therefore holism.<sup>21</sup>

According to Cunningham:

The traditional Māori world view is acknowledged to centre on the concept of holism. The concept centres on notions of connectedness and interdependence, on the personal and collective, and on the relationship between man and the environment, both physical and spiritual.<sup>22</sup>

The notion of holism and how this is central to a Māori world view is further discussed by both Durie<sup>23</sup> and Pomare.<sup>24</sup> While colonisation has undermined many Māori cultural values and practices, it is also true that a Māori worldview is dynamic, adapting to contemporary challenges. Durie notes the diversity of Māori realities:

Far from being homogeneous Māori individuals have a variety of cultural characteristics and live in a number of cultural and socio-economic realities. The relevance of so-called traditional values is not the same for all Māori, nor can it be assumed that all Māori will wish to define their ethnic identity according to classical constructs. They may or may not enjoy active links with hapū or iwi, or other Māori institutions yet they will describe themselves as Māori and reject any notion that they are less Māori than their peers.<sup>25</sup>

Undoubtedly the assimilatory function of colonisation has served to disrupt many of the institutions and practices that supported the integrity of a unique and singular Māori world view. However, despite the forces of colonisation, Māori cultural values have retained their relevance in contemporary times and are important in understanding and interpreting modern Māori experience. That said, it should also be acknowledged that the experience of colonisation, alongside other factors, has influenced a contemporary Māori world view.<sup>26</sup>

To this end the notion of holism, Māori values and tradition, and the concept of integration, remain consistent with how Māori perspectives and world views are articulated. These ideas shape a contemporary Māori reality and world view and are illustrated through contemporary models of Māori health, such as te whare tapa whā and

te wheke.<sup>27</sup> Holism has also featured within contemporary developmental frameworks and more broadly in discussions on Māori advancement.<sup>28</sup>

### **A Kaupapa Māori Epistemology**

Salmond<sup>29</sup> and Te Awēkotuku<sup>30</sup> state that before colonisation Māori had a comprehensive knowledge base and well-developed mechanisms for sharing and protecting information. These were undermined, however, by the impacts of colonisation, with emphasis placed on Western philosophies and ideas, and rejection of so-called 'primitive' knowledge systems.<sup>31</sup>

According to Ratima,<sup>32</sup> 'Māori consider knowledge to be culturally bound and hence values-based, the epistemological position of a Māori inquiry paradigm is values mediated'. The nature of the relationship between the researcher and research participants is interactive, and the values of the researcher influence the research. It is therefore assumed that the researcher is not objective, and that the researcher's values influence the way in which ideas and concepts are interpreted. This position requires an inclusive outlook, emphasising interactivity and the fundamental relationship between the researcher and participant, as well as the responsibility of the researcher as a repository of material and a guardian (kaitiaki) of information.

Knowledge is viewed from a variety of perspectives, depending on the perceived value or worth. Access to specialist knowledge, for example, brings differences between Māori and Western methodologies into sharp relief – at least on the surface.<sup>33</sup>

According to Stokes:

There are some inherent conflicts in attitudes to knowledge between Māori and Pākehā. There is an attitude among many Pākehā academics that in the social sciences the individual researcher has some sort of divine right to investigate whatever topic he or she chooses, provided that the usual methodological and ethical restraints of the particular discipline are adhered to...However, too many Pākehā researchers fail to see or understand that there are other dimensions to the value of knowledge; that the perceived purpose of the research may be irrelevant in Māori terms; that the Māori “guinea pigs” provide answers (if they co-operate at all), which they think the researchers want, out of politeness and hospitality; or may even occasionally deliberately distort responses according to Māori logic not be perceived or understood by the researcher.<sup>34</sup>

The Māori tendency is to safeguard some forms of knowledge and reduce accessibility; the Western practice is to disseminate knowledge. However, such practices may be more apparent than real. Much scientific knowledge is restricted to the relationships of specialist journals and access to higher levels is often blocked by a range of prerequisites and preliminary requirements.<sup>35</sup>

### **A Kaupapa Māori Methodological Perspective**

Research carried out within a kaupapa Māori paradigm typically utilises a range of Western and Māori methodologies. The fundamental criterion is that these methodologies must be consistent with Māori beliefs and values.

Distinct Māori methodologies are only now being articulated.<sup>36 , 37 , 38</sup> Bevin-Brown,<sup>39</sup> for example, identifies ten 'ingredients' that are stressed or deemed as highly desirable for Māori research, and that are relevant in terms of developing distinctly Māori methodologies. Each 'ingredient' is deliberately generic and allows the model to be applied to a wide range of research initiatives:

1. Māori research must be conducted within a Māori cultural framework and therefore would incorporate Māori concepts of knowledge, skills, experiences, attitudes, processes, practices, customs, reo, values and beliefs.
2. Māori research must be conducted by people who have the necessary cultural, language, and research expertise. They must also possess a commitment to things Māori, the trust of the Māori community being researched, and an understanding of and commitment to the obligations, liabilities and responsibilities that are an integral part of Māori research.
3. Māori research should be focused on areas of importance and concern to Māori. It should arise out of their self-identified needs and aspirations.
4. Māori research should result in some positive outcome for Māori. This may be manifest in many different ways, e.g., improved services, increased knowledge, health gains, or more effective use of resources.
5. As much as possible, Māori research should involve the people being researched as active participants at all stages of the research process.

6. Māori research should empower those being researched. This empowerment should stem from both the research process and product.
7. Māori research should be controlled by Māori, particularly in relationship to ethical requirements, assessment, funding, intellectual property rights, and ownership and dissemination of knowledge.
8. People involved in conducting Māori research should be accountable to the research participants and to the Māori community in general.
9. Māori research should be of a high quality. It should be assessed by culturally appropriate methods and measured against Māori-relevant standards.
10. The methods, measures and procedures used in Māori research must take cognisance of Māori culture and preferences. They must take into account the previous nine requirements of Māori research.

Smith<sup>40</sup> also refers to these types of requirements, and notes in addition the need to consider a more fundamental range of questions: ‘Who defined the research question?’, ‘for whom is the study worthy or relevant – who says so?’, ‘what knowledge will the community gain from the study?’, ‘what knowledge will the researcher gain from this study?’, ‘what are some of the likely positive outcomes from this study?’, ‘what are some of the possible negative outcomes?’, ‘how can the negative outcomes be eliminated?’, ‘to whom is the researcher accountable?’, ‘what processes are in place to support the research, the researched and researcher?’.

Royal<sup>41</sup> also reflects on the term rangahau, a literal translation of the word research that is frequently used by Māori to describe research activity. He notes that no real attempt has been made to define rangahau precisely, but that it should fundamentally be applied only to research conducted from within te ao Māori – a Māori world view. Bishop<sup>42</sup> describes the use of whakawhanaungatanga (establishing relationships in a Māori context) as a research process, and considers three important implications of this:

- that establishing and maintaining relationships is a fundamental, extensive, and often an ongoing part of the research process.
- that researchers must understand themselves to be involved somatically in the research process. This includes moral, physical, spiritual, and ethical obligations and not just those associated with the methodology.
- that there is an implicit need to establish a relationship (from within a Māori context) that addresses the power and control issues which are fundamental to the research.

These types of issues reflect the ongoing development of Māori methodologies, from within a distinctly Māori paradigm. The framework below is used to summarise the key aspects of kaupapa Māori research, as it has been operationalised in this research programme.

Table 2.2 A Kaupapa Māori Summary Framework

Position	Components	Implications for Research
Ontological	<ul style="list-style-type: none"> <li>● Māori values, beliefs, traditions and cultural practices are central</li> <li>● The notion of Māoritanga and the inter-relatedness between people, nature and the development of social system and social organisations</li> <li>● The concept of holism is fundamental</li> </ul>	<ul style="list-style-type: none"> <li>● Emphasis is placed on gaining knowledge through investigation of inter-relationships</li> <li>● Connections between health and broader social, economic, cultural, and historical factors is emphasised</li> <li>● Māori health research should be carried out in a way that appreciates Māori heritage, beliefs, values, and practices, and thereby affirms Māori identity</li> </ul>
Epistemological	<ul style="list-style-type: none"> <li>● Assumes that the values of the researcher influences the research</li> <li>● The relationship between the researcher and participants is interactive</li> <li>● Is linked to the accumulation/acquisition of knowledge and it's transmission</li> </ul>	<ul style="list-style-type: none"> <li>● Importance of a culturally competent research team</li> <li>● Methodologies and methods will be selected that are cognisant of the interactive relationship between researchers and participants</li> <li>● Data interpretation is influenced by the researchers values</li> <li>● Need to be explicit as to the researcher's value-base</li> </ul>
Methodological	<ul style="list-style-type: none"> <li>● Methodologies must be consistent with Māori beliefs and values</li> <li>● Appropriate frameworks will need to be developed</li> <li>● A wide range of components or considerations are relevant, including Māori language, Māori participation and input, Māori aspirations, control, accountability, and quality</li> </ul>	<ul style="list-style-type: none"> <li>● The need to further develop distinctly Māori methodologies</li> <li>● Western and other non-Māori methodologies that are consistent with a kaupapa Māori paradigm will be utilised</li> </ul>

## Alignment with a Māori Health Research Framework

Durie has developed a Māori-centred approach to health research located in, and therefore consistent with a kaupapa Māori paradigm.<sup>43</sup> This approach considers many of the issues described in the previous section (e.g., the relevance of Māori cultural values, integration and interconnectedness, active Māori participation, multiple methods) and is of added interest due to its focus on Māori health research.

The components of the framework, described below, are connected and designed to illustrate how Māori people, culture, knowledge and processes can be placed at the centre of health research activity.

Table 2.3 A Māori-centred Health Research Framework

		Principles		
		Whakapiki tangata enable	Whakaurunga integrate	Mana Māori Māori control
Purpose of Research	(i) Health gains for Māori, (ii) to strengthen Māori identity as Māori (iii) to advance positive Māori development and the acquisition of new knowledge			
Practice of Research	(i) Active Māori participation (ii) multiple methodologies (iii) measures relevant to Māori			
The Practitioners of Research	(i) Māori researchers (ii) interim solutions (iii) competencies - Māori knowledge - Health research - Māori society			
The Politics of Research	(i) Treaty of Waitangi (ii) Māori and Iwi (iii) Funding			

Source: Durie, 1996: 13

The three principles provide the central tenets that are intended to foster Māori health advancement. The *Whakapiki Tangata* principle highlights the need to conduct research with the ultimate aim of enhancing the lives of people. This may mean an improvement in health status, a capacity to take greater control of their own health, or both. The *Whakaurunga* principle emphasises the holistic view of Māori health, and provides for a link between health, culture, economic factors, social standing, as well as historical events. The third principle, *Mana Māori*, reflects the need for Māori control, particularly in relation to Māori society, culture and knowledge.

The *Purpose of Research* refers to those global aims that can be applied generally to Māori health research. It includes the requirement for research to contribute to Māori health gains and to provide Māori with the opportunity to maximise their health, recognising that health gains should enhance (not undermine) a Māori cultural identity. It also recognises, that Māori health activities have not occurred entirely within the traditional health sector and that the broad field of Māori development is the appropriate context for locating Māori health research.

*The Practice* of Māori health research includes the ways in which Māori participate in research, and includes issues of participation, ownership, accountability, definition and methodology, intellectual property rights, and the incorporation of Māori world views.

*The Practitioners* of Māori health research is an issue already touched on, and relates to a ‘by Māori for Māori’ approach. It ensures that researchers are adequately equipped to undertake the study and that they have the relevant technical and cultural skills.

*The Politics* of Māori health research considers the broader issues of research activity, the Treaty of Waitangi, self determination, access to, and arrangements for, research funding. Political issues are fundamental in determining research priorities, what relationships should be fostered to promote the goals of research, how resources are accessed, and the limitations that may be imposed.

Essentially the framework provides an explicit approach to Māori health research within a kaupapa Māori paradigm.

## **A Theoretical Research Framework**

This research programme is located within a kaupapa Māori paradigm and takes a Māori-centred approach. Drawing on the work of Durie, Smith and other Māori academics, six principles were identified that provided the theoretical structure for this research programme. These principles and their implications for this study are outlined below:

- The investigation should reflect a Māori world view and be conducted in a manner consistent with those views. Māori values, traditions and cultural practices should underpin the process.

- The investigation, while meeting rigorous academic standards, should encourage gains in Māori mental health. Indeed there is an expectation that any research involving Māori should provide some measurable benefit to Māori. There is little Māori tolerance for research conducted for the sake of research.
- Māori research methodologies should be used as appropriate. The use of Māori research methodologies does not mean that other methodologies cannot be used in parallel, provided they are not inconsistent with the values and methods of kaupapa Māori research.
- Māori must be actively involved in the research process. A spirit of partnership should colour the relationship between the researcher and the research participants.
- The manner in which information is stored and protected is important. Apart from the usual ethical standards, there is a need to investigate additional strategies to safeguard information of cultural significance.
- To be of value, it is important that research information is made available to Māori. To this end, mechanisms to ensure Māori access to the research findings will need to be developed. Such processes will further ensure that the investigation is adequately critiqued, reviewed, and ultimately applied so that its potential benefits can be realised.

## QUALITATIVE VS QUANTITATIVE APPROACHES TO INQUIRY

The following section examines two distinct approaches to research inquiry – qualitative and quantitative, and discusses the approach most suited to this investigation.

### Definitions and Concepts

According to Denzin and Lincoln, qualitative research is:

... multi-method in focus, involving an interpretive, naturalistic approach to subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomenon in terms of the meaning people bring to them. Qualitative research involves the studied use and collection of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual texts – that describe routine and problematic moments and meanings in individual's lives.<sup>44</sup>

Patton<sup>45</sup> further describes qualitative research in terms of data forms and the types of information collected. It may include detailed descriptions of some particular situation, event, people, interactions and observed behaviours. It may comprise direct quotations from people and their experiences, attitudes, beliefs and thoughts. Excerpts or entire pages from documentation may be included, likewise correspondence, records and case histories. Qualitative data provides both depth and detail through direct quotation and careful description. Measurement relies on the use of instruments to provide standardised frameworks by which data collection can take place, to established criteria, or to analyse

categories. The data are open-ended in order to discover what people's lives, experiences and interactions mean to them, in their own terms, and in their natural settings.

This mode of inquiry typically strives to understand the phenomenon or situation as a whole. The researcher is able to develop inductive strategies whereby the setting can be entered with no preconceived ideas or expectation as to results. Observations are made, patterns identified and eventually conclusions formulated. The strategy of the qualitative researcher is therefore based on the premise that important dimensions will emerge from the analysis. There is no presumption as to what important issues, ideas or concepts may be expected. The naturalistic nature of a qualitative research design demands a focus on the research setting; understanding this without external modification and within its natural context.<sup>46</sup>

In contrast to qualitative investigations, quantitative studies stress the measurement and analysis of casual relationships between variables, rather than processes. Quantitative measurement relies on the use of instruments that provide a standardised framework and that control the collection of data to pre-identified response or analysis categories.<sup>47</sup> McCracken<sup>48</sup> states that the essential difference between qualitative and quantitative research is the manner in which each tradition treats analytic categories. The objective of quantitative study is to isolate and define categories as concisely as possible, before research begins, and then to determine the relationship between them. Conversely, the goal of qualitative study is to isolate and define categories as the study proceeds. For

quantitative research, concise, well-defined categories, are the means of the research; from a qualitative perspective, research categories are the object of the research.

While qualitative research usually explores patterns and relationships between numerous categories; quantitative research focuses on sharply delineated relationships between limited categories, and as a consequence the methods of data reporting will often be different. Quantitative studies are conducted when it is expected that the respondent will be able to answer questions quickly, concisely and unambiguously. Qualitative inquiries are required when the interpretation and precision of response is in question. Therefore, broader, more flexible information-gathering techniques are required.

A further difference between qualitative and quantitative approaches is the number and kind of respondents who will typically be recruited as part of the research process. Quantitative research requires the identification of a sample, carefully selected and large enough to generalise to a wider population. Conversely, for qualitative research, the issue is not that of generalisability, but access. That is, the purpose of the qualitative interview is not to discover how many or what type of people conform to a certain characteristic, but to gain access to certain cultural categories and to determine how they view the world.

The table below illustrates the main differences between the quantitative and qualitative approaches.<sup>49</sup>

**Table 2.4** Quantitative and Qualitative Styles

QUANTITATIVE STYLE	QUALITATIVE STYLE
Measure objective facts	Construct social reality, cultural meaning
Focus on variables	Focus on interactive processes, events
Reliability is key	Authenticity is key
Value free	Values are present and explicit
Independent of context	Situationally constrained
Many cases, subjects	Few cases, subjects
Statistical analysis	Thematic analysis
Researcher is detached	Researcher is involved

*Source:* Neuman, 1991: 14

### **A Qualitative or Quantitative Approach?**

The purpose of research, its aims and objectives, dictates to a large extent the appropriate research approach. As already noted, kaupapa Māori is the paradigm within which this investigation is based. However, to consider and implement the research process fully it is also necessary to locate and rationalise the mechanism through which this can or should take place. In this sense it is necessary to consider the relative merits of adopting a qualitative or quantitative research approach within the kaupapa Māori paradigm.

The objectives of this thesis require the examination of new ideas and concepts, categories that cannot be precisely defined before the investigation. Presumptions as to what may be expected are not always appropriate and a prescriptive approach is best avoided. It is expected that various themes and categories will evolve as part of the inquiry process and that ideas and solutions will develop as a consequence. To accommodate the application of a kaupapa Māori research paradigm, the research approach will also need to be relatively flexible and dynamic. Diverse impressions and perspectives can be expected as the researcher grapples to establish clear relationships, patterns, or trends. It is anticipated that data and responses will be gathered, and that broad, flexible information-gathering techniques will be most appropriate. A naturalistic outlook is desirable as the investigation seeks to examine processes or activities as they occur within their natural setting. The views and perspectives of various groups and individuals will serve as a guide to the research and what conclusions can be established. For these reasons a qualitative research approach was considered to be most appropriate.

## **RESEARCH METHODS**

Locating this research programme within a kaupapa Māori paradigm, and the utilisation of Māori-centred and qualitative approaches, provides the parameters within which appropriate research methods can be selected to meet the objectives of the research programme. The methods selected for this study are document review, key informant interviews, direct and participant observation. Presentations also allowed for direct feedback on the study. Māori process issues were also incorporated as well as systems to

enhance data quality. A computerised software system was employed and used to assist with data management and analysis.

The application of these processes is described more fully within Chapters 3, 4, and 5 – where they are used to achieve identified objectives. This section examines more broadly their rationale, utility, and scope within the context of this thesis.

## **Document Review**

Literature reviews are a particularly valuable aspect of research activity. They allow the investigator to become more familiar with a particular area, to examine relevant theories and issues, to identify key individuals and discourse, and to provide a general guide through which the research can proceed. Literature reviews allow ideas to be compared and assessed, incorporated or discarded.

During the course of this research programme an extensive range of documents were reviewed and assessed for utility and relevance. A structured process of literature identification was undertaken before documents were reviewed, with searches being conducted through a range of bibliographic databases.<sup>50</sup> ‘Key Word’ searches were conducted, trying alternative word combinations to ensure a comprehensive assessment of material was made. To avoid repetition, each combination was logged and filed along with various successful ‘hits’. Key informants were also consulted and used to determine what information might be relevant, where it could be found, and what search parameters should be employed.

Much of the written material was sourced from the Massey University Library; however, the Ministries of Health, Māori Development, and Social Development provided supplemental as well as specialist information. After review, relevant excerpts were documented along with page numbers and bibliographical information. A computerised database (described later in this section) was then created and used to store this information. The system ensured that important material could be sourced when required, and that more focused searches of reviewed material could be made.<sup>51</sup>

## **Interviews**

A reliance on literature or written material can limit the extent to which relevant ideas and concerns can be assessed. Contemporary developments can often be missed and there is a risk that the views presented will reflect those of a particular group, or of academics, researchers, policy makers, or others who tend to publish. Interviews, therefore, provide the means through which alternative perspectives on a particular issue can be gathered. Direct feedback and input can also be obtained by this means, ideas can be tested, and alternatives considered.

Interviews provided a major data source for this study. Key person interviews were conducted using standardised open-ended questionnaires. In total, a sample of 15 experts were identified and subsequently interviewed. These individuals were selected due to their broad knowledge of Māori mental health, Māori culture and custom, as well as an ability to provide informed comment on Māori mental health outcomes. These

informants had a range of backgrounds and skills. Consultation allowed an initial list of experts/respondents to be compiled. Following this, additions were made to ensure access to a comprehensive range of opinion, for example, adequate representation from clinicians, support staff, researchers, management staff, policy personal and tangata whaiora.

Four of the key informants were clinicians, and although two were not currently practicing, each were able to provide comment on outcomes and in particular issues related to clinical practice, the need for robust tools, functional, reliable and valid. Four of the expert were involved in policy design or management and were particularly useful in providing advice on the application of outcomes data, past and current trends, as well as plans for the future. Non-clinical support staff (2) provided particular advice on logistical issues and confirmed the need for instruments that were simple and suited to clinical practice. Two tangata whaiora advisors provided guidance on consumer issues, needs, and expectations. The remainder of the expert respondents (3) were selected due to their cultural skills, their knowledge of applying cultural models of care, and general experience in Māori mental health.

Although all the interview questions and their sequence were determined before the interviews took place, the format was 'open-ended' in that interviewees were able to formulate their own responses. Consistent with accepted Māori research practice, all key person interviews were conducted 'kanohi ki te kanohi' [face-to-face] at times and locations that suited each respondent. Key person interviewees were given a small koha<sup>52</sup>

for their time (usually a book) and offered feedback on the study. Within Chapter 5, questionnaires were used to obtain a wider range of informed feedback. While this limited the extent to which a face-to-face method could be adopted, processes were included to ensure that Māori expectations were met. Detail outlining the respondent numbers and profiles is provided in Chapter 5.

### **Direct and Participant Observations**

‘Direct Observations’ often involve site visits, observations of meetings, activities, and other similar types of examinations. They provide the means through which the ‘reality’ of a situation or issue can be explored and assessed in order to form an appropriate context. ‘Participant Observations’ require a more hands-on approach. They allow the researcher to become actively involved in the study and to participate in the event or issue being studied. Participant observations offer insights that are similar to direct observations but may also reveal perspectives of interpersonal behaviour and motives.<sup>53</sup>

The researcher’s participation in a number of national and local health forums enabled specific issues in Māori mental health to be identified and viewed from a national policy perspective. Significant input was obtained from a range of committees, and in particular from the Public Health Association National Executive,<sup>54</sup> The Mental Health Commission’s Māori Advisory Board,<sup>55</sup> the advisory board to the National Mental Health Epidemiology Study,<sup>56</sup> the Māori advisory board of the Mental Health Research and Development Strategy – Case Mix,<sup>57</sup> the Board of Studies for The Diploma in Public Health (Otago University) and The Mental Health Information Project reference group.<sup>58</sup>

A number of Māori mental health hui complemented these types of forums. These hui were usually focused on a particular group or issue but incorporated a focus on Māori mental health. Hui of particular interest were the national Māori mental health summit in August of 1997 (Wellington), the Mental Health Commission's consultation hui in April 1998 (Lower Hutt), the New Zealand Association of Adolescent Health conference in December of 1999 (Auckland), the Royal Australian and New Zealand Association of Psychiatrists annual conference in July of 2000 (Rotorua), the 'Realising Recovery' conference in November 1999 (Wellington), the 'Māori Child and Adolescent Services' hui in July 1999 (Porirua), the 'Association of Māori Medical Practitioners' hui in April of 1999 (Plimmerton), and a Māori mental health training hui in November 1998 (Gisborne).

'Site visits' to a number of Māori mental health services were also arranged and provided further opportunity to gather data, test assumptions, and draw conclusions. Initial visits were conducted at five sites in Auckland (3) Waikato (1), Hawkes Bay (1), and Wellington (1), in August 1998. Follow-up visits were arranged in July 1999. As well, the researcher had the opportunity to spend a week (August 2000) with a service in Wellington. This provided the opportunity to gain a hands-on impression of service function and operation as well the chance to interview staff and to gain more informal guidance and feedback.

## **Māori Process Issues**

Locating the research programme within a kaupapa Māori paradigm and using a Māori-centred approach requires explicit consideration of Māori process issues.

To this end a number of mechanisms, designed to ensure the consideration of Māori issues, were incorporated into the study. A cultural advisory group was established and provided guidance on issues of protocol and other cultural matters. The researcher is culturally competent and has experience in undertaking research within Māori contexts. As described, key person and specialist interviews were conducted ‘kanohi ki te kanohi’ with respondents being offered a koha for their time. Additionally, these interviews were usually conducted in Māori settings where respondents felt most comfortable, usually their homes, sometimes on marae or at work, and frequently in less formal social environments. Although a structured questionnaire was used, the interviews typically took place in an intuitive fashion, allowing the respondent to guide the research process, how it proceeded and its duration. Formal greetings (in Māori) often took place before the interview. Where appropriate (and particularly in hui) karakia<sup>59</sup> and formal poroporoaki<sup>60</sup> were provided. Wider interviews (those that did not permit a face to face approach) were also conducted in a manner consistent with Māori values and perspectives.<sup>61</sup>

All respondents, and others who participated in the research, were offered feedback on the study. Presentations were also given and designed to obtain direct input and comment.

## Data Quality

Consideration of data quality issues is important in qualitative research, as the approach can rely on interpretation, description, generalisations and evaluative judgments.<sup>62</sup> A number of mechanisms (including redundancy of data gathering and procedural challenges to explanations) may be implemented to counter threats to data quality.<sup>63</sup> Triangulation is one such mechanism, whereby multiple perceptions are used to clarify meaning, or to verify the repeatability of an observation or interpretation. Further, as no observation or interpretation is perfectly repeatable, triangulation enables clarification by identifying multiple ways in which the phenomenon or issue can be understood.<sup>64</sup>

Stake<sup>65</sup> describes four basic triangulation protocols, that while framed within a case-study strategy, usefully illustrate the types of protocols that may be employed within qualitative studies. First, data source triangulation, which assesses whether or not the issues under investigation remain the same in other times, in other spaces, or in different situations. It involves a study of the activity, display or observation, to determine whether or not it is influenced by the situation or context within which it exists. The second protocol, investigator triangulation, is applied when an investigator has access to other researchers who have some detailed knowledge or expertise. This method allows other researchers to examine data and to compare their perceptions to your own.

Theory triangulation, the third protocol, though similar to investigator triangulation, is more focused in that reviewers are selected to provide an alternative theoretical viewpoint. It is uncommon for researchers to interpret information in an entirely homogeneous way, and, either intentionally or unintentionally, researchers will be influenced by their theoretical position, professional training or expertise. This diversity provides the means through which information can be examined, and considers alternative interpretations or perceptions.

The last protocol is methodological triangulation, which uses observations, interviews and document reviews, for example, to investigate a given phenomenon. While not identified as a triangulation protocol, Stake also alludes to the process of member checking, where the accuracy of data is confirmed or otherwise by source informants. This process will usually require the investigator to review statements, experiences or observations with the respondent.

By applying one or several protocols, qualitative researchers are able to make a more reliable assessment of data and to draw conclusions that are well informed and more likely to be truthful. Triangulation protocols were deliberately incorporated into this study and used to enhance the quality of data gathered. Methodological triangulation is most clearly evident and is illustrated within the various observations, hui, interviews, and literature review. However, investigator and theory triangulation protocols have also been included along with member checking. These were further used to enhance data quality.

## Data Management

Qualitative studies can pose particular issues in terms of data management and information quality. Large quantities of data can be gathered, and if managed inappropriately the very quantity of the data can lead to information being misplaced, mis-categorised, or misinterpreted.

Berg<sup>66</sup> describes qualitative data as the essence of people, objects and situations, raw experiences which are converted into words and typically compiled into extended text. The words may be based on observations, interviews or documents. The mode of collecting data may be largely open, unstructured and event driven, or more tightly defined, structured and researcher driven. However, the sheer quantity of qualitative data may serve to conceal important themes or issues and accordingly may reduce the quality of the research and its utility. For this reason it is important that raw material is effectively managed, systematically controlled, and presented in a manner that facilitates analysis and data management.

Hubberman and Miles<sup>67</sup> define data management as the operation needed for the systematic, coherent process of data collection, storage and retrieval. Three essential aims of this process may be identified:

- To ensure high-quality, accessible data.
- To ensure documentation of exactly what analyses have been carried out.
- To ensure the retention of data and associated analyses after the study is complete.

The first point (as described by Hubberman and Miles) is designed to confront some of the systematic problems associated with conducting research: the need to have a mechanism through which relevant (or irrelevant) source information can be stored and accessed. The second point states that once analysed, source information will need to be sorted and managed. The third point is more complex and is categorised into an additional set of three sub-processes, data reduction, data display, and conclusion drawing/verification.

Data reduction allows information to be reduced in an anticipatory way, permitting the researcher to develop a conceptual framework, research questions, cases and instruments. Once field data, including notes, interviews, tapes, or other data, are available, data summaries, coding, theme finding, clustering and story writing provide the opportunity for further data selection and condensation.

Data display is defined as an organised, compressed assembly of information that allows conclusion drawing and/or action taking, and may be a second, if not inevitable, part of the data analysis process. In this sense, the researcher will need to view a set of reduced data to consider its meaning. More focused displays may also include structured summaries, synopses, vignettes, network-like or other diagrams, and matrices with text rather than numbers in the cells.

Conclusion drawing and verification involves interpreting information and drawing meaning from displayed data. The means by which this is achieved can be diverse, noting comparisons and contrasts, patterns, themes and clusters. Triangulation is often used to verify results and determine significance and relevance. As a consequence, 'data transformation' takes place as information is condensed, clustered, sorted and linked.<sup>68</sup>

A range of computerised software packages have recently been developed and provide useful tools through which research data can be more effectively managed and analysed. The Microsoft Access software package has been used extensively throughout this study. It was selected in consultation with other researchers and experts from Massey University. It has proved to be robust and allows data to be transferred simply across platforms (from desktop to laptop). The package is relatively user-friendly, with easily manipulated fields and functions, it copes well with large quantities of data, does not use large amounts of computer memory, and is compatible with other Microsoft software (e.g., Microsoft Word).

As already mentioned, the system was used to sort and manage literature and was also employed throughout the interviews and when storing and analysing hui and committee data. Once programmed, it further assisted the triangulation of views and perspectives. Data analysis (particularly in interviews) was also enhanced by the package through data reduction, data display, conclusion drawing and verification.

## **Data Analysis**

In broad terms, the theoretical research framework described earlier in this chapter has been used to guide data analysis. The implications of the framework are that data are analysed from a Māori perspective, and therefore the value of Māori beliefs and perspectives is implicit. The analysis was carried out by a culturally competent Māori researcher, and preliminary results were presented for discussion to other Māori academics and at Māori community hui. Further, rigorous academic standards should be met in data analysis and with this in mind data were analysed using the well-tested method of content analysis.

Content analysis involves the identification, coding, and categorisation of primary patterns in the data. This process allows identification of key themes to emerge from the data.<sup>69</sup> For the purposes of this study, content analysis was carried out manually.

## **Ethical Issues**

The ethical issues associated with this research were largely linked to the interview process, the need to obtain informed consent, and to have in place mechanisms through which data were safeguarded. As an illustration, and to assist confidentiality, interview respondents are identified according to their database coding number. For example 'Personal Communication, Service Database Entry (clinical) – Record XX.'

## SUMMARY

This chapter has so far considered, the three following important foundations. First, the relevance of a kaupapa Māori research paradigm that is able to reflect a Māori world view, contribute to Māori health gains and development, incorporate Māori practices and approaches, facilitate Māori participation, develop appropriate information protection and storage mechanisms, and ensure relevant dissemination of information.

Second, the qualitative nature of the investigation has been highlighted. It is expected that the research will reveal a diverse range of impressions and perspectives and that numerous information-gathering techniques will be required. A naturalistic outlook is anticipated with a need to understand how certain issues behave within their natural environment. There are no prior expectation as to what results may be revealed.

Third, a research method has been described and is used to ensure that the objectives of this thesis can be met. These methods are appropriate to qualitative investigations, are flexible enough to incorporate a kaupapa Māori perspective, and are able to maintain data quality.

Each of these foundations is designed to provide an overarching framework through which the investigation can proceed.

## CONCLUDING COMMENTS

In researching this thesis, the juxtaposition of a Māori-centered approach alongside more conventional empirical approaches did not create obstacles, nor diminish the significance of any one method. Instead, the experience has reinforced the view that research into contemporary Māori life will be enriched by the adoption of multi-methodological strands. The application of these concepts are discussed more fully, where appropriate, and within the context of each relevant chapter.

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- <sup>6</sup> Denzin and Lincoln, (1994), *op cit.*
- <sup>7</sup> <http://www.xrefer.com/search.jsp> (10 August 2001).
- <sup>8</sup> <http://trochim.human.cornell.edu/kb/positvsm.htm> (10 August 2001).
- <sup>9</sup> Guba and Lincoln, (1984), *op cit.*, p. 110.
- <sup>10</sup> *Ibid.*, p. 111.
- <sup>11</sup> L. T. Smith, (1999), *Decolonizing Methodologies: Research and Indigenous Peoples*, University of Otago Press, Dunedin, p. 164.
- <sup>12</sup> *Ibid.*, p. 44.
- <sup>13</sup> M. G. Soutar, (2000), *Ngāti Porou Leadership – Rapata Wahawaha and the Politics of Conflict*, Ph.D. Thesis, Massey University, Palmerston North.
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- <sup>17</sup> R. Bishop, (1994), 'Initiating Empowering Research?', in *New Zealand Journal of Educational Studies*, vol. 29, no. 1, p. 175.
- <sup>18</sup> Smith, (1999), *op cit.*, p. 190.
- <sup>19</sup> Things 'Māori'. Associated with Māori culture, tradition and custom.
- <sup>20</sup> The North and South Islands of New Zealand.
- <sup>21</sup> M. Henare, (1988), 'Standards and Foundations of Māori Society', in *Ngā Tikanga Me Ngā Ritenga O Te Ao Māori*, vol. III, Part One, Royal Commission on Social Policy, Wellington, pp. 5-41.
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- <sup>24</sup> E. Pomare and G. de Boer, (1988), *Hauora Māori Standards of Health: A Study of the Years 1970-1984*, Department of Health, Wellington, p. 22.
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- <sup>27</sup> These models are described in Chapter 4.
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- <sup>40</sup> Smith, (1999), *op cit.*, pp. 172-173.
- <sup>41</sup> C. Royal, (1998), 'Te Ao Marama – A Research Paradigm', in Te Pūmanawa Hauora (ed.), *Te Oru Rangahau Māori Research and Development Conference, 7-9 July 1998 Proceedings*, School of Māori Studies, Massey University, Palmerston North.
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- <sup>46</sup> Ibid.
- <sup>47</sup> Ibid.
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- <sup>49</sup> W. L. Neuman, (1991), *Social Research Methods: Qualitative and Quantitative Approaches*, A Viacom Company, Needham Heights, MA, USA, p. 14.
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- <sup>51</sup> The literature database eventually contained more than 151 documents (most relevant sections were transcribed or photocopied). This information was then numbered and filed (1 to 152) within a central repository (physical database).
- <sup>52</sup> A gift.
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- <sup>54</sup> The researcher was a member of the Public Health Association national executive committee from 1996 to 1999. Meetings were held 3-4 times a year in Wellington.
- <sup>55</sup> The researcher has been a member of the Mental Health Commissions' advisory board since 1998. The board meets in Wellington, 5-6 times a year.
- <sup>56</sup> This project is currently underway. The research team corresponds fortnightly by way of teleconference and meet 2-3 times a year.
- <sup>57</sup> This project is currently underway and nearing completion. The researcher has been a member of this team since 2001 – meetings have taken place in Auckland and are scheduled 5-6 times a year.
- <sup>58</sup> The researcher is a former member of this board and was a nominated Public Health Association representative. Meetings were held 4-5 times a year in Dunedin or via teleconference.
- <sup>59</sup> A prayer – designed in this sense to open formally a meeting or discussion.

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- <sup>60</sup> A formal farewell.
- <sup>61</sup> These issues are discussed more fully in Chapter 5
- <sup>62</sup> J. Maxwell, (1992), 'Understanding and Validity in Qualitative Research', in *Harvard Educational Review*, vol. 63, pp. 279-300.
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- <sup>64</sup> U. Flick, (1992), 'Triangulation Revisited: Strategy of Validation or Alternative?', in *Journal for the Theory of the Alternative*, vol. 22, pp. 175-198.
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- <sup>68</sup> See C. Turner, (1987), *Organising Information: Principles and Practice*, Bingley Press, London.
- <sup>69</sup> See <http://writing.colostate.edu/references/research/content/pop2a.cfm> (1 February 2002)

## Chapter Three

### APPROACHES TO MĀORI MENTAL HEALTH PROBLEMS

#### INTRODUCTION

Chapter 1 examined Māori mental health patterns, and highlighted the need for effective broad based strategies, specific to Māori mental health. However, while it is clear that connections beyond health are required, for the most part health policy has been confined to the health sector and, in particular, to the development of health services.

The focus of this chapter is on Māori mental health policies and services, and is intended to consider their overall position within the health sector. It contains several parts. The first discusses research issues – the methods employed to obtain the necessary information to describe policies and services to address Māori mental health problems. It draws from Chapter 2 and places these ideas within a context specific to this chapter. The second part is an historical narrative and explores the broad foundation on which the infrastructure of the New Zealand health service has been built. Part three places a more direct focus on mental health service development and examines the environment within which mental health services for Māori have developed.

Part four has a more contemporary focus and describes the significance to Māori mental health of the health reforms of 1993. This section introduces contemporary issues, in particular the structures that have shaped the current environment. Policies for mental health services, and those specific to Māori, are examined in part five. Parts six and

seven consider the present state of Māori mental health services, policies, goals and objectives, opportunities and workforce implications.

The final part is a chapter summary. It ties together the various sections and places them within a context relevant to this thesis.

## **RESEARCH ISSUES**

This chapter evolved from a structured research process, drawing from a range of sources, and employing a number of methods to gain the necessary understanding of policies and services for Māori mental health. As an initial step, a review of relevant literature was conducted and used to examine current research, what gaps existed, and what issues required further investigation.

As a complement to the literature review, a number of hui were also attended. The hui provided a forum for identifying additional issues, those not examined within the written material or inadequately considered. Other observations were also made and largely facilitated through participation on various national health committees. Interaction with Māori mental health networks, at hui or through committee work, was a major methodological tool in this study.

To obtain more structured input, a series of service-based interviews were conducted. These took place in seven sites across the country,<sup>1</sup> and included representatives from NGOs<sup>2</sup> (including iwi based providers), Māori specific services, as well as those (Māori

designated services) based within mainstream/hospital settings. Comment was gathered through the application of a structured open-ended questionnaire with 52 respondents eventually taking part.

To ensure a kaupapa Māori approach, a number of mechanisms were included within the research design. These mechanisms varied according to context and situation, but were designed to introduce a cultural dimension. For interview respondents, a koha<sup>3</sup> was offered and a process based on cultural practice initiated.<sup>4</sup> Presentations designed to obtain feedback on the study included powhiri (where appropriate) or similar types of formal introductions. Karakia and poroporoaki were also typically included, as well as the opportunity to share a light meal.

To assist with data management and analysis, the Microsoft Access program was employed. It was used at all stages of the data gathering process and provided the means through which data could be stored, coded, categorised, and analysed. As part of the interview process, data fields (consistent with the questionnaire template) were created enabling raw interview data to be transcribed directly into the computer system. Through the creation of 'summary fields', displayed data could then be reviewed, reduced, and reliable conclusions formed.

The study did not raise significant ethical issues, aside from the interview process. In this regard, formal letters of introduction were sent to each of the participating services outlining the objectives of the study and requesting input from those staff able and

willing to participate.<sup>5</sup> Once willing respondents had been identified, suitable times and venues were arranged. Before each interview, respondents were again provided with an overview of the study, its purpose, their role, responsibilities, and the option to withdraw from the study at any time. A signed consent form was also provided and removed before data was inputted and source material stored. All information contained within the database was coded, making it impossible to link any information to particular participants. At the end of each interview, informants were offered feedback on the study, once completed.

The interview process allowed a range of views and perspectives to be triangulated. The review of literature, hui, and other presentations further assisted the triangulation process. As an additional quality control mechanism, interviews of a more specialised nature were conducted with a selected range of key informants. In a technique similar to the presentation and feedback process, these informants were used to provide an alternative interpretation of analysed data.

## **NEW ZEALAND HEALTH SERVICES: FOUNDATIONS AND IMPLICATIONS**

Historically, the New Zealand health system has been characterised by generations of staunch guardianship or gate-keeping of perceived health professional responsibility, and active suppression of indigenous healing practices.<sup>6</sup>

Issues of contemporary significance have often evolved from historical constructs, mechanisms or processes, providing the fundamental base through which modern systems are shaped to become part of what is deemed ‘normal’, ‘conventional’, ‘accepted’, or ‘established’. The following section is an abridged examination of the New Zealand health system, with a particular focus on service provision. Although not intended as a comprehensive historical discourse, a diverse and broad range of issues are considered to provide some background to understanding more recent developments in Māori mental health.

### **Genesis of the New Zealand Health System**

The New Zealand health system has undergone significant changes over the past decade. The health reforms of the early 1990s ushered in a system of health care that was in many ways at odds with what people had come to expect – a perception that health care and access to health services was a birth right of all New Zealanders and that the Government’s role was to ensure adequate access to services. These expectations were in

many ways founded on historical conventions, public ideals and demands, many of which had evolved half a world away, grounded on Western paradigms and constructs.

The post-colonial health system emerged out of 18<sup>th</sup>-century England and the desire to care more appropriately for those who, through financial incapacity, were unable to arrange their own care. Under this system, wealthy benefactors or philanthropic subscribers were able to nominate selected patients to facilities for the care of the poor. Medical services were typically offered gratis by medical staff, often as a way of seeking professional distinctions and social favour. It was a class discriminatory system, but had arisen out of a charitable desire to provide health care to those of limited financial means.

Social stratification had in many ways shaped colonial attitudes to health, especially the British, but also the Scottish and Irish immigrants, many of whom had negative experiences of their homelands as a consequence of the reorganisation of rural Scotland and Ireland during the 19<sup>th</sup> century. Many colonists had a heightened sense of social and moral justice, particularly as it applied to the care of the poor or those who had traditionally (within Britain at least) suffered through the class system. Other factors further served to reinforce this notion, including the concept of 'co-operative community', and the idea that sickness and poverty were burdens to be shared by the community rather than the individual. Although these ideals were not universally held, or consistently applied, they reflected a collective approach to health as well as the desire to initiate a system of health care provision so that even those badly off, could receive attention.<sup>7</sup>

As early as 1841 Colonial Surgeons or Health Officers were appointed to each major New Zealand settlement, and the establishment of four colonial hospitals quickly followed. Although the hospitals were largely financed through land endowments, a small fee was usually charged to the colonists, but Māori (initially at least) were admitted free. Without sufficient numbers of wealthy philanthropists, the system was significantly hamstrung and in this regard differed from the British model. Moreover, the scattered nature of settlement further impeded efforts to develop and maintain any kind of formal structure.<sup>8</sup>

Following the 1852 New Zealand Constitution Act,<sup>9</sup> the Colonial hospitals were transferred to provincial Governments and were administered by Provincial Executive Councils. As part of this arrangement, the provision of charitable aid became the function of the hospitals, with admissions controlled at the discretion of each provincial Government. Not surprisingly this approach led to fragmentation, not only in terms of the criteria for admission but also how the hospitals were managed and administered. By 1885, to encourage a more consistent approach, local hospital boards were established and the country was divided into 12 hospital districts. By 1908, due mainly to regional parochialism, these districts were further expanded to 28. Unfortunately, the management and funding of hospitals differed across the country and failed to provide the consistency anticipated or required. A sometimes confusing and often complicated hospital administration and admission system was the result and as a consequence the type and quality of care varied considerably across the country.<sup>10</sup>

In the two decades that followed, various reforms were introduced to ensure a more consistent approach to health provision, along with streamlining aimed at greater efficiencies. Although mostly successful, the reforms fell short of public expectations and by 1935 (under the first Labour administration) further changes were promised:

We believe that the medical scheme should develop along the lines of our education system – be freely available to all whatever their rank, station, or income ...From our knowledge of the trend in respect of social legislation it is beyond dispute that the citizens of this country have a fixed determination to provide as far as possible for those who are unable to provide for themselves.<sup>11</sup>

The result was the 1938 Social Security Act. Financed primarily through taxation, and co-ordinated through a central Department of Health, the Act pioneered New Zealand as the world's first fully socialised health service. From 1938 onwards, central Government took on complete responsibility for financing of public hospitals, despite much of the management activities and clinical responsibilities remaining with individual hospital boards:<sup>12 , 13</sup>

New Zealand will never respect or tolerate a [health] service which gives one type of service to the poor and another to the well to do...Any scheme which divides people into two groups, those able to pay private fees and those unable to do so...would be foreign to the ideals and aspirations of the Government and people of New Zealand.<sup>14</sup>

Cracks within this system were however inevitable, especially as New Zealand's economic position deteriorated. High public expectations were beginning to be

compromised, as costs grew and Government revenues declined. The size and diversity of local health authorities and hospital boards further contributed to inefficiencies. Although some amalgamations did occur, public resistance, historical parochialism, and an unwillingness by hospital boards to adopt the new regime, ensured that to a large extent the status quo remained.

By the 1970s it was evident that the health sector required a radical overhaul. Numerous reviews had confirmed inefficiencies within the system, poor lines of accountability, and inadequate mechanisms through which rising costs could be managed. It was clear that the well-meaning attitudes and expectations of the past could not be sustained and that urgent modifications to the system were required. However, it was not until 1989 that any major restructuring occurred, when, through the Area Health Boards Act 1983, 14 area health boards were created, allowing for the integration of both population and hospital health services. But the new 1990 National Government took the reforms further, using a business model and deregulating the whole industry.<sup>15</sup> In contrast to the public hospital system, private practice remained a significant part of the New Zealand health system, especially primary care. While the reforms of this first Labour administration provided for a fee-for-service Government subsidy, part charges were not eliminated. Indeed, primary care was essentially conducted as a private system. Those aspects totally subsidised, such as immunisation, represented a relatively small part of general medical practice.

Quite apart from clinical services in hospitals and general practice, a public health sector was developing. Its twin goals were health protection and health promotion, and the establishment of the Department of Public Health in 1900 marked the beginning of centralised public health activities. Medical officers of health, public health nurses, and health inspectors comprised the public health workforce and assumed control, among other things, for Māori health.<sup>16</sup>

But as treatment services developed, public health initiatives were less popular. Perhaps it was because infectious diseases – the major focus of public health services – had been brought largely under control. In any event it was not until the 1993 health reforms, discussed later in this chapter, that a dedicated Public Health Commission was established; and then it was short lived, being disestablished and brought back into the Ministry of Health in 1996. Distinctions between population approaches, championed by public health experts, and personal treatment and care, have been well recognised in mental health as well as health generally, though often without agreement about which approaches has the most to offer.

## **Māori Participation and Input**

The interaction between Māori and hospitals in the later decades of the nineteenth century presents a complex and varied picture. Some Pākehā actively discouraged Māori participation, for a variety of reasons. On the other hand, many Māori became disillusioned with Western medicine, or were discouraged by opposition from Europeans. Hospitals were often thought to

be exclusively for the treatment of Pākehā illnesses, and to be run by people who were disdainful of Māori beliefs.<sup>17</sup>

Apart from being consumers, Māori perspectives and approaches to health were largely subsumed within Western frameworks and methods derived from European standards, imported and modelled to suit the local environment. Despite being largely subjugated in this manner, the process was not entirely devoid of Māori input, and in fact Māori were to play a significant role in realising Māori aspirations for health.

Initially, the priority placed on Māori health was not great and indeed by the beginning of the last century serious questions had been raised about the ongoing survival of the Māori race. Before 1900, the Native Department had shown all but minimal interest in Māori health and, for the most part, was preoccupied with matters of a more political nature, especially land acquisitions and those other 'native' situations that inevitably arose out of this process.<sup>18</sup>

This guarded attitude to Māori health was somewhat surprising, as a number of reports had detailed the benefits of Māori-specific health strategies, noting in particular the benefits of improved nutrition, housing, and public health measures.<sup>19</sup> In 1884, the Native Minister commissioned a plan for Māori health reform that outlined health promotion and protection measures as well as community-based, early intervention initiatives. Yet despite the evidence, the Native Department often showed little interest in Māori social policy, except in education and in situations where assimilatory policies could be nurtured.

The Public Health Act of 1900 and the subsequent establishment of the Department of Public Health, however, provided direction for Māori health, in part because a means had been created for a co-ordinated health service infrastructure, but more importantly because Māori had been included within the Department's designated responsibilities. Although the Department placed little emphasis on Māori health, and was initially more concerned with a potential outbreak of bubonic plague the process did at least ensure that public health was included within the Government's social policy agenda.<sup>20</sup>

Other positive developments occurred when in 1901 Maui Pomare was appointed 'Health Commissioner for the Natives', and later in 1905, was joined by Te Rangihiroa (Peter Buck). Both were medical practitioners and well aware of the poor state of Māori health. Further, they identified the need to involve the Māori community in any developments, especially as no dedicated Māori health workforce existed. Adding to these problems was the issue of finance and the scant amount of funding set aside for Māori health. The Native Civil List allowance of £7,000 p.a. (from which Māori health funding was drawn) had not changed since 1852, moreover only about £3,000 was earmarked for expenditure on health.<sup>21</sup>

...he [Pomare] had achieved some improvement in sanitation of the Māori villages, and had stimulated the Māori to look forward to the future with greater hope. In the six years, 1904 to 1909, some 1,256 unsatisfactory Māori dwellings had been demolished, and 2,103 new houses and over 1,000 privies built. A number of villages had also been moved to higher ground. All this had been done at the cost of the Māoris themselves without a penny of Government

assistance or compensation...What had been achieved was due to the personal efforts of Pomare and Buck and a small bank of inspectors.<sup>22</sup>

Notwithstanding these impediments, both Pomare and Buck were instrumental in arresting what appeared to be an inevitable genocide. They actively engaged the Māori community and supported the provisions of the Māori Councils Act (1900). Under the Act, a range of public health functions was devolved into a network of regional Māori councils, and although some problems were noted,<sup>23</sup> the councils appeared to function well, and were especially useful in promoting sanitary and housing regulations. Ongoing political bickering as to the council responsibilities and effectiveness, as well as cuts in funding, eventually meant they were to become nothing more than tokens. But their effectiveness had been widely recognised. Although in 1920, Buck (as director of the Division of Māori Hygiene) revived the councils, funding inadequacies and Government indifference again placed limitations on the extent to which the councils could operate. In 1927, Buck left his position and was replaced by Dr Edward Ellison. Three years later Ellison resigned, after which the Division of Māori Hygiene was disestablished.

Despite political frustrations and bickering, the contribution of Pomare, Buck, and the Māori councils (as well as others) to Māori health, was significant. The introduction of Māori expertise had been accomplished and health gains were achieved as a consequence. In reviewing the contribution of Māori to Māori health development, Durie<sup>24</sup> highlights the efforts of Pomare and Buck, the Māori Councils, the Division of Māori Hygiene, as well as the work of Te Puia and Ratana. Later, between 1930 and 1975, the efforts of the Women's Health League and Māori Women's Welfare league

were further examined, as well as their approach that similarly built on Māori networks, traditional structures, and mechanisms based around whānau. Durie also explores the more contemporary efforts by Māori to engage the health system, the development of Māori specific health services, the thrust these services provided, and the difficulties posed through inadequate and often short-term contracting, a policy environment where the goal posts were frequently moved.

This historical overview, while not extensive, illustrates two important points. First, that the foundations on which the New Zealand health infrastructure is based has largely been drawn from Western paradigms and concepts, and that these ideas have continued to dominate the manner in which health services are perceived and structured. Second, that Māori input into this process has often been frustrated by political unwillingness and more covertly by systems and methods that failed to recognise alternative approaches or those that were culturally ground.

## **MENTAL HEALTH SERVICE DEVELOPMENT**

The New Zealand mental health system was similarly shaped by the social and moral concerns of 18<sup>th</sup> century England, and the desire to provide more adequately for those most in need. Confusion surrounding the exact nature of mental illness did, however, cause some early problems, and the mentally ill were initially catered for within local jails. Although a number of hospitals made special provisions for mental health patients, the practice was uncommon. In some instances 'Boarding Out' or community placement was also offered, but again this option was not extensively used.<sup>25</sup>

In contrast to the colonial hospitals, the Lunatics Ordinance of 1846 did not restrict patient entry according to status or financial position and reflected a somewhat progressive attitude toward mental health care. Further humanitarian concerns also meant that provisions within local jails were short lived, and by the 1850s alternative modes of care were being explored. Discussions were mostly confined to the perceived merits of a regional network or centrally administered single asylum, but by 1872 the decision to construct a network of provincial lunatic asylums had been made.<sup>26</sup>

The asylums were typically located on the outskirts of the settlements they served. Although the rationale behind this was partly due to public attitudes, fear, and discrimination, the locations also provided a more therapeutic environment, where various forms of milieu could also be applied. These settings also meant that many facilities became somewhat self-supporting, utilising these rural locations for horticulture, and the patients as a cheap and available source of labour, rationalised as motivational therapy. The treatment was generally administered by medical professionals, though uniquely lay keepers and superintendents were often used in a supporting role.

The asylums came under central Government control in 1876, a move designed to facilitate a more consistent approach to care and management. An inspector was also appointed, and in 1880 the role was expanded to include hospitals and charitable institutions.<sup>27</sup> The inspector's powers were wide ranging,<sup>28</sup> however, the monitoring

function was dictated by the extent to which the asylums were able to provide care. As the majority of patients were considered incurable, and unlikely to be released, the psychiatrist was often required to do little more than manage patient care or prescribe restraints where necessary.

A generous admission policy meant that overcrowding within the asylums became a problem and necessitated the construction of additional facilities. With improvements in communication, roading, and rail systems, it was also possible to situate these asylums in even more remote locations. This enabled large facilities to be constructed and beneficial therapies, associated with farming and physical activity, could also be designed. A disadvantage of establishing remote facilities, however, was that patients were further distanced from the wider community, their families and social networks. Moreover, many of facilities were far from purpose built and failed to address the problems of overcrowding or the need to create a therapeutic environment. Other problems also arose:

The asylums, which had been humane and effective alternatives for the care of the mentally ill, became large, physically isolated institutions which were little more than great crowded warehouses of despair.<sup>29</sup>

Treatment objectives were also compromised as patients with a wide range of conditions, abilities and behaviours, were managed within the same type of dormitory environment. As well as making it difficult to apply treatment, of more concern was the fact that the progress of some was being adversely affected by the behaviour of others. Later, as

improved opportunities for the sub-classification of patients was presented, more individualised settings were utilised, such as small cottages or villas. The limited availability of these units, however, inevitably diminished the extent to which they were utilised.<sup>30</sup>

The First World War had a dramatic effect on the way in which mental health was perceived. Many of the returning soldiers were being diagnosed with a relatively new condition known as 'shell shock'. The idea that those who had fought so bravely for their country should be cared for within existing institutions was abhorrent to many friends and relatives. The end result was a further reconsideration of the institutionally-based model of psychiatric care. Subsequently, a range of additional services (outside the large institutions) were constructed. Although initially designed to treat soldiers, the method was later expanded to include general patients and those diagnosed as having 'less acute' mental health disorders. More importantly, these were annexed from the larger institutions and in this regard they went some way to reducing the stigma attached to mental health:

By the end of the last century [19<sup>th</sup>] state mental hospital admissions showed a greater use by persons of the upper and middle class and, consequently, lunacy gradually became mental illness... 'Mental hospital' and 'inmate' therefore replaced 'lunatic' and 'asylum' in an attempt to restore the acute treatment function of institutions upon the hospital model... The recognition of 'shell shock' as a legitimate psychiatric condition during the First World War tended to confirm a growing awareness that mental illness was not a disease of the lower social classes alone. The area of the new madness was veiled behind reference to the 'borderlands', 'nerves' and 'neurasthenia'. Treatment for such cases required 'half-way houses'. From 1906 a variety of

peripheral services was tacked on to existing institutions so as to cater for the mentally ill of superior social classes.<sup>31</sup>

In 1925 further reforms to the mental health sector were made. A stocktake of psychiatric services found that initial moves toward deinstitutionalisation had provided many benefits including an improved standard of care. As a result, smaller services (linked to larger institutions) were developed within the community. Although the public impression of mental illness remained tolerable at best, these types of services did at least raise public awareness. For the first time, outpatient clinics were attached to general hospitals, and provided useful alternatives for patients requiring less intensive treatment. Although confined initially to Auckland and Wellington, the success of the approach led to the development of similar services throughout the country. Later, more intensive inpatient services were provided, and while activities were limited by the availability of psychiatric professionals, these services did provide a more accessible and often less distressful alternative to the larger institutions. Moreover, these hospitals provided a much needed buffer, particularly as the larger facilities were struggling because of overcrowding.<sup>32</sup>

Into the 1950s, and with the development of new psychoactive drugs, a new era in psychiatric treatment and care emerged. It was no longer assumed that the more severe psychotic conditions were untreatable or that a lifetime of supervised care was required in every instance. Clinicians began to explore the possibility of managing the care of long-term patients outside the established institutional settings. It was part of a world-wide trend. The development of specific hostels or community homes for the intellectually

disabled reinforced these moves,<sup>33</sup> as did the construction of old peoples homes and improved arrangements for the care of geriatric patients away from large hospital settings:

The recognition of the detrimental effects of hospitalisation and developments in psychopharmaceutical, psychotherapeutic and social treatments gave impetus to deinstitutionalisation and opened doors to new approaches now associated with community psychiatry and community care. Treating the patient in the least restrictive environment and consumer empowerment have made social functioning and social performance important concepts, not only for patients, practitioners and researchers, but certainly also for family members and close relatives of patients.<sup>34</sup>

By the 1970s and 80s various non-Government organisations were providing residential care facilities. Promoted through the use of Government subsidies, most maintained a direct relationship with their regional psychiatric hospitals and were used to provide an alternative form of rehabilitation and complemented the process of deinstitutionalisation. Unfortunately, these arrangements developed unevenly across the country, and consequently reflected the type of regional diversity that had historically characterised the larger mental health facilities. Despite this, deinstitutionalisation was well underway and became the preferred Government alternative to institutionally-based care.<sup>35</sup> Not everyone agreed with the trend. Community care had not been organised in a systematic way and concerns about inadequate supervision and care were often heard when readmission was declined or incidents of abuse arose. The deinstitutionalisation movement was overdue, and necessary, but it had been poorly managed. Hospital boards

were generally unprepared for the task and lacked both the expertise and planning capacity. Therefore, when the Department of Health formally disestablished the Division of Māori Hygiene in 1972 and responsibility for psychiatric hospitals passed from central Government to hospital board control, the gaps and unevenness in the system were all too apparent. Thirty years later, concerns about community care, and the inability to gain access to inpatient care were still being voiced.<sup>36</sup>

Changing attitudes and an improved understanding about the nature of mental illness, meant that the philosophies of the previous few decades were beginning to change. Many of the larger psychiatric facilities had been constructed in an era when policies were developed with the dual aims of treatment and asylum, with architectural designs often based on the need for security. Although these hospitals provided centralised locations for the treatment of all types of mental disorders, too often they were located in remote locations and isolated individuals from their families and social networks. As the relevance of social factors became more accepted, deinstitutionalisation presented the opportunity to adopt alternative forms of treatment and rehabilitation. For those patients accustomed to institutionalised care, this process was mostly a welcome alternative. However, issues of co-ordination and consistency of care were to be felt for many years:

Deinstitutionalisation was partly a response to the big, ugly, prison-like mental institutions in which people even with the mildest forms of mental illness were treated for the first fifty years of this century. Isolated from their communities, supervised and dis-empowered, people leaving psychiatric institutions frequently saw themselves as escaping. In a broader sense, deinstitutionalisation became a metaphor for escaping from closed attitudes and limited thinking.

But deinstitutionalised care was also decentralised care. With decentralisation came problems of integration, and co-ordination. The success of deinstitutionalisation often came to be measured by reduced rates of hospitalisation rather than improved rates of access to treatment or support.<sup>37</sup>

Though highly touted, deinstitutionalised care did not replace nor reduce the need for the more specialised mental health institutions, initially at least. The larger facilities were to maintain their profile and all but monopolised the available clinical and professional expertise. However, changes to the manner in which mental health care was administered appeared inevitable, and while masked by the notion that deinstitutionalisation was a much more effective/humane means of treatment, there was little doubt that the drive toward greater efficiencies within the health sector was a significant motivating factor.

By the 1990s, the mental health sector appeared willing to explore the opportunities offered by the health reforms and to further refine the deinstitutionalised approach to mental health care. A mental health strategy, *Looking Forward*, captured the new mood and set out two major goals: decreasing the prevalence of mental health problems within the community; and increasing the health status and reducing the impact of mental disorders on consumers, their families, caregivers, and the general community.<sup>38</sup> A sequel document, *Moving Forward*, identified a series of objectives and targets, including the introduction of cultural assessment procedures for Māori consumers and increased Māori involvement in the design and purchasing of services appropriate to Māori needs.<sup>39</sup>

## **Māori Participation in the Mental Health Sector**

The large psychiatric facilities had dominated the New Zealand mental health sector, and reflected the philosophy that those with mental health problems would best be cared for within isolated environments, removed from the general population, their families and others. Although officially designed to create the most suitable environments for care, such moves were equally motivated by the all too obvious discriminatory attitudes of the public, fear of the mentally ill, and ambivalent approaches to policy development.

In stark contrast, Māori philosophies of care, including that of the mentally ill, were based on integrated and inclusive models, emphasising holism, integration, whānau, iwi and hapū responsibilities. The notion that those requiring care should be removed from society, and their extended whānau, was contrary to perceived traditional notions of health. There initially seemed little need to consider the cultural needs of Māori, given low rates of admission, although it just as likely that low admissions were indicative of an approach to care that was, for the most part, monocultural, rather than needs based:<sup>40</sup>

The Western psychiatric tradition of confining people with a mental health disability was foreign to Māoris, who had always cared for these people in their communities. The Mental Health system was originally established to cater for people to be taken out of society. Society had this fear of contamination from mental disease and also a massive denial that it even existed. These concepts were alien to Māori people whose whānau members suffering from trauma were always included within the whānau, hapū, iwi boundaries and given special status.<sup>41</sup>

Initial moves toward cultural alignment occurred during the 1970s and 1980s and although not endorsed at an official level, anecdotal accounts tend to highlight Māori concerns about the appropriateness of psychiatric care:

In the early days, clinicians had a more custodial role and there was nothing really that you could call cultural input. Some of the Māori staff and family members were, however, keen to incorporate methods or approaches which were more appropriate to Māori, maybe offering something a little different or building on existing methods. I was always of the opinion that if it helped and if it caused no other problems then certainly it should be allowed. I guess being a Māori helped me to appreciate this.<sup>42</sup>

Aside from these anecdotal accounts, however, there is little to suggest that Māori had much control over the manner in which care was provided. From the 1970s onward, a re-examination of the role of culture within mental health was beginning to take place. These moves coincided with the changing patterns of Māori admissions, and a growing sense of unease with the provision of treatment and care. It also corresponded with greater Māori determination to break down cultural and power barriers in education, social welfare and the wider health sector. For Māori staff, it was clear that cultural factors were seldom considered, but could nevertheless influence diagnosis and treatment outcomes.

When we look at the increasing rates during the 1970s a lot of factors could be blamed for this. But for me, we can put much of it down to misdiagnosis...some of those clinicians were not able to recognise the things that some of our kids were presenting with. The fact was, well, I believe

anyway, was that many of them did not have a mental illness. In many respects the things that they were telling the clinician were normal and not the result of any psychotic condition, you know seeing a deceased relative at night for example. However, if you're unable to understand this then you're unable to assign a correct diagnosis, the wrong treatment is prescribed and that's when the problems begin. A lot of kids spent some time within institutions as a result of this.<sup>43</sup>

Clinicians – nurses, doctors – were generally oblivious to cultural dimensions. However, that conservative view was to change, and much of the change could be attributed to two significant developments. At one level, and as part of the wider Māori development movement, Māori philosophies and values were being recognised.<sup>44</sup>

At another level, Māori staff were actively instituting new approaches within the wider hospital setting, culminating in the 1980s with the development of two cultural therapy units: Whaiora (at Tokanui Hospital) and Whare Paia (at Carrington Hospital). In response to increasing rates of Māori admissions, there was some attempt to understand cultural values and perspectives. But generally, the possibility that the whole system was being driven by monocultural assumptions proved difficult to explore. Each unit developed autonomously, though both maintained a similar overall focus, with a broad philosophy centred on integration and holism, and a belief that culture and mental health were intimately related.<sup>45</sup>

The development of these services was based, to some extent, on a perceived need, a conviction that cultural identity would produce health benefits, as well as the drive and enthusiasm of Māori staff. However, in Whaiora, two further features were to ensure

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

Te Whare Paia was less successful. Probably the link between culture and health was insufficiently recognised by those in charge, and at times political objectives seemed to outweigh health objectives. In the end it closed in a blaze of publicity that did little to help public understanding of the issue.<sup>46</sup> The Auckland Hospital Board had been keen to advance Māori cultural perspectives but had not recognised the need for building a strong cultural-clinical interface. Te Whare Paia was succeeded by Manawanui, a post-acute inpatient rehabilitation service, but it too closed in December 2001.

The experiences encountered by these early Māori mental health services were influenced by their respective environments, the personnel involved, access to resources, and the formation of relationships with clinical and managerial staff. However, each service had much more in common than their overall philosophies and desires to meet the needs of Māori patients more adequately. For all the difficulties, inroads were made through carefully nurtured relationships and strategic moves at various levels throughout each organisation. Moreover, the dogged enthusiasm and determination of Māori staff ensured

that their demands for improved care arrangements could not be ignored. Little by little, secure foundations were laid through which other cultural therapy units could be developed. Just as importantly, however, were the valuable lessons learnt and the strategies used to overcome the obvious difficulties encountered:

We have made some significant changes over the past few years, but you know it was really hard in the beginning. We had our little meetings, in our own time, and sometimes the Pākehā didn't like this. I think they were worried as to what we were getting up to. We were lucky that we had a few staunch people to push the kaupapa along. I think that the biggest problem was that we did not, at that stage, have the right people in the right places, especially in the management side of things. The other problem, of course, was that there were very few Māori psychiatrists, but then again, that has always been a problem.<sup>47</sup>

Coinciding with the Decade of Māori Development, the late 1980s provided further opportunities for the development of Māori mental health services. The importance of culture as it applied to health was gaining momentum, and mainstream institutions and clinicians were beginning to appreciate the outcome-related benefits.<sup>48</sup> At a national and international level, an indigenous renaissance was occurring<sup>49</sup> that helped create an environment that no longer viewed ethnic perspectives with quite the same degree of antagonism and scepticism. Demands by Māori for more direct input into health-related activities was becoming more pronounced, various national hui confirming Māori intentions to play a more active role in matters of Māori health and development.<sup>50</sup> The relevance of the Treaty of Waitangi to health had also been recognised.<sup>51</sup>

Into the 1990s further opportunities for the development of Māori mental health services were presented, and although staffing shortages impeded progress, greater numbers of clinically qualified Māori began to emerge. The nation's medical schools were beginning to incorporate cultural dimensions into their curriculum, and while limited, there remained a quiet confidence that the initiatives of the past could be further developed and translated into health gains. In addition, many of those who had contributed to the developments of past two decades had remained within the sector. Significantly, many were now in positions of considerable influence, regionally, nationally and, for some, internationally. Armed with skills that had been honed over years of experience many were formidable in their attempts to promote change. Differing skills had led to a range of career paths, some became more actively involved in mental health policy formulation, consultation, teaching, academia and research, others remained more directly involved with service provision and clinical activities, and a notable few were able to utilise their skills at various levels, providing insight toward issues of a more global and strategic nature.

By the time the health reforms were introduced, Māori were keen to take advantage of the skills they had gained and the inroads they had made. Indeed, it was anticipated that the reforms would provide an ideal vehicle by which Māori aspirations in health could progress. However, despite some obvious gains and opportunities, the reforms were not without problems, and some of the early hope was frustrated by inconsistent policies and competitive practices that discouraged co-operative Māori endeavour.

## **HEALTH SYSTEM REFORMATION, 1993 AND BEYOND**

The health reforms of the early 1990s represented the most significant change to the New Zealand health sector for more than six decades. Not only were there structured changes, but major philosophical changes underpinned the reforms. Health was now identified as a commodity rather than a right or need. The following section focuses on the health reforms of 1993, the impact they had on the health sector, and the implications for Māori mental health service development.

### **The Structure for the Reformed Health Sector**

Throughout the 1980s and early 1990s, dissatisfaction with New Zealand's health system comprising 14 locally elected area health boards, which both 'funded' and provided hospital and some other services in their regions, was rife. Reports pointed to inefficiencies, poor management, budget overruns, and badly eroded assets in public hospitals. Waiting lists were increasing, and falling public confidence in the system was associated with a growth in private insurance. Area health boards were criticised for facing no clear incentives to be efficient or responsive to patients and for weak accountability.<sup>52</sup>

The Health and Disability Services Act came into effect on 1 July 1993 and established the structure and function of the reformed health sector. The Act itself was the result of an earlier Health Services Taskforce (1991), which identified numerous problems within the sector: lengthy waiting lists, poor administration, and an inefficient system of funding. The review noted that Area Health Boards effectively had the role of both purchaser and provider and were therefore unable to take advantage of contracting to the

most cost-effective supplier. The system of subsidies and part-charges was also seen as problematic.

As a result, major reforms to the health sector were recommended, and involved five key changes: separation of the purchaser and provider roles; integration of primary and secondary care; definition of core health services; establishing systems for public and personal health; and integration of funding. The overarching goal was to ensure fair and affordable access to health and disability support services and to maximise cost-effectiveness.

Under the reforms, the Ministry of Health remained the Government's prime adviser on health and continued to oversee the changes to the health sector. Area Health Boards were disestablished in favour of four regional health authorities – set up as Government purchasing agents. Twenty-three Crown Health Enterprises (CHE) were established to run the restructured hospitals. The enactment of new legislation enabled the CHEs to act as separate commercial companies, and were expected to return a profit.

Following a brief implementation phase, the Regional Health Authorities and CHEs embarked on what was to become a long-drawn-out process of contract negotiations for services. This process also allowed for direct negotiations to take place with other potential providers, including private hospitals, community agencies, and other non-Government entities interested in health service provision. The process was designed to create a competitive funding environment and increase efficiencies. Independent of

personal clinical services, a Public Health Commission was established to comment on public health issues, provide policy advice, and purchase public health services. A Core Services Committee was also established to determine the range of core services to be funded.<sup>53 , 54</sup>

To assist Regional Health Authority purchasing decisions, policy guidelines were produced and included special requirements 'to better meet the needs of Māori', and to reflect this within regional purchasing strategies. Other recommendations were also incorporated, including an emphasis on greater participation by Māori at all levels of the health sector, resource allocation priorities that took account of Māori health needs and perspectives, and the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of health services.<sup>55</sup>

Later versions of these regional guidelines were to maintain a similar theme in terms of Māori input and participation. In addition, the 1995/96 guidelines also listed four Government priority health gain areas, of which Māori health and mental health were two,<sup>56</sup> inferring that Māori mental health service development would be accelerated.

## **Consequences and Implications of the Reforms**

The outcomes seemed poor, compared with initial predictions. Competition between health care providers was never implemented. The establishment of contracts between purchasers and providers created costs and inefficiencies. The system was also criticised for emphasising throughput and volume of services rather than maintaining quality of care, and blamed for

reducing staff morale. Notably, during this period, activity rates rose whilst average length of stay and unit costs fell.<sup>57</sup>

The implementation of the reforms was anticipated to take up to three years. Although no formal review took place, a number of concerns were noted following the implementation phase. Many of the providers, including the CHEs, reported that while significant increases in terms of the volume of services had occurred, this growth might have resulted irrespective of the reforms and as a natural consequence of previous health sector objectives. Indications were that the reforms were relatively more effective in terms of funding services such as rest homes and less well suited to those more complex interventions such as mental health or surgical services. The goal of fair and affordable access to the health and disability support services was impeded by an escalation in General Practice consultation fees, and that created additional barriers to those most in need of primary health care. Hospital waiting lists for many procedures had increased by as much as 50% and necessitated further negotiations outside existing contracts in order to address the backlog. Anticipated savings of 20–30% failed to materialise and in fact losses (by a similar figure) were experienced. Regardless of Government directives, CHEs were also unable to operate at a profit and typically incurred substantial debts to meet funding shortfalls.<sup>58</sup>

Despite these problems, the health reforms were initially viewed positively by Māori. The new competitive funding regime created, in theory at least, a mechanism through which health service provision, by Māori and for Māori, could be enhanced. Durie states:

...iwi, were particularly interested in two aspects of the reforms. Firstly, they could tender to provide services under regional health authorities. The very considerable experience already gained in health delivery, in geriatric care, community health work and health counselling would place some Māori providers in an advantaged position to continue those services on contract and without area health board domination. But of particular significance to Māori was the possibility that, as an alternative to regional health authorities, iwi could establish their own health care plans, receiving bulk funding to provide a comprehensive range of health services.<sup>59</sup>

Although the reforms were not primarily intended as a vehicle through which Māori health services could be developed, the opportunity was nevertheless evident. Moreover, the skills that Māori had previously developed under the old Area Health Boards proved useful under the new funding arrangements:

... area health board domination had proved useful as an introduction for iwi into the health system and, more importantly into the ways in which they might advance Māori health. On the one hand inadequate funding, short term goals and limited roles, had been frustrating. Yet at the same time valuable experience had been gained in health policy formulation, the management of health services (no matter how limited), community health work and programmes of health promotion and disease prevention. Useful links had also been established with a variety of service providers and health administrators.<sup>60</sup>

The benefits inferred as part of the health reforms did at least suggest that Māori objectives in terms of health service provision would be met.<sup>61</sup> However, the changes again meant that fresh skills and strategic relationships had to be developed. New systems and processes were introduced, while administrative and management structures

were further enhanced due to a greater emphasis on efficiencies and competitive contracting for services. Moreover, and for all their good intent, the RHA guidelines were simply 'guidelines' and were to cause a degree of frustration (amongst Māori providers) due to the inconsistent manner in which they were interpreted and applied.

Often, objectives for Māori health were seen to be met by purchasing a range of targeted services that did little to enhance Māori autonomy or participation within the health system.<sup>62</sup> To many Māori, self-determination (in terms of health service provision) was a valid means through which health outcomes could be improved and sustained. However, the Health Authorities appeared less willing to accept this position and as a consequence did not provide the expected level of autonomy that Māori had been anticipating.<sup>63</sup> The reasons for this are complicated and not always clear, but it was likely that two factors were particularly important.

First was the perceived risk associated with purchasing 'Māori' services in favour of those based on more established/Western methods of operation. Some may have doubted Māori capacity and ability to take on the role of major service provider. However, and as previously noted, these concerns may have been unwarranted in that Māori had gained some experience in the preceding years and had developed skills in a wide range of health related initiatives. Nevertheless, the requirement to better meet the health needs of Māori was often interpreted in an unsatisfactory manner – to Māori at least – and accordingly frustrated ongoing efforts for greater autonomy and control.

Second, the perceived inaction of the Regional Health Authorities may have occurred due to a lack of certainty about how purchasing decisions for Māori services could be made. In many respects Māori providers reflected a diverse group of entities and organisations that had far more differences than similarities, though they maintained a common cultural base. Regardless, the purchasing guidelines did not provide the detail required through which definitive and consistent purchasing decisions could be made. As a result, various types of purchasing models, frameworks, and relationships developed, and while they may have reflected attempts to meet regional needs,<sup>64</sup> confusion and inconsistency often resulted.<sup>65</sup>

### **Growth within the Mental Health Sector**

Despite problems, indications were that the reforms aided the growth of health services, especially within the mental health sector. Two years after the reforms, community residential providers increased by 33% and community service providers had grown by 52%. In addition, there was a notable growth in community providers within the private sector.<sup>66</sup> However, there is uncertainty about the extent to which these gains could be solely attributed to the reforms. From 1994 onwards, the mental health sector was to benefit from significant funding increases. Monies from the 1996 Mason inquiry provided additional impetus, making available additional funding for 'new' services.<sup>67</sup>

For Māori mental health services, the reforms had a similarly dramatic effect. After initially focusing on primary health care initiatives, greater numbers of Māori began

contracting directly with Regional Health Authorities for mental health services. Additionally, mainstream providers began to show greater sensitivity toward Māori and were keen to improve services for Māori, often by employing Māori staff, recruiting cultural advisors, or establishing Māori units. The overall shift may have reflected a growing awareness amongst mainstream providers that 'alternative' philosophies and approaches to care had validity, though the incentives linked to the promise of greater funding may have equally assisted their enthusiasm.

Regardless, a 1995 stocktake indicated that there were 58 mental health service providers that incorporated a specific Māori component as part of their delivery, representing an 80% increase on 1993.<sup>68</sup> More recent estimates have also shown that growth has been sustained. Whereas in 1995, 13 HHS (Health and Hospital Services) were providing mental health services for Māori and 23 NGO providing 'for Māori by Māori' mental health services, by 1998 all 22 HHS were providing some mental health services for Māori and the number of NGO had increased by almost three-fold.<sup>69</sup>

Although encouraging, the figures lacked the required detail through which a legitimate assessment of growth could be made and provided little evidence of service effectiveness or the quality of care being provided. Inconsistencies and uncertainty associated with defining 'Māori mental health service' had also hindered attempts to gather timely and reliable data to the extent that the HFA admitted that the numbers taken from their own lists of Māori mental health contacts (on which the 1998 figures are based) were likely to be incomplete. Further concerns were raised about the ongoing gaps in service provision

across the country and about the Health Funding Authority's inconsistent approach to the development of mental health services for Māori.

### **Further Reforms, Restructures and Relationships**

In 1996 and following a protracted negotiation process, a new coalition Government was formed between the National Party and New Zealand First. A coalition policy on health was agreed and led to further adjustments to the health sector. These changes, although not as dramatic as 1993, were designed to provide a more consistent approach to funding health services and reducing the bureaucratic inefficiencies that had developed under the previous system. The four regional health authorities were replaced by a single health funder<sup>70</sup> and all crown health providers were given new directives, to move from a profit to a 'health outcomes' focus.<sup>71</sup> The Agreement placed more emphasis on funder accountability, and in recognition of the level of resources located within the sector, greater efficiencies were demanded in order to make 'the most effective use of every dollar spent':

...The Coalition Government's health policy has the overriding goal of ensuring principles of public service replace commercial profit objectives for all publicly provided health and disability services. The Coalition partners are committed to publicly funded health care that encourages co-operation and collaboration rather than competition between health and disability services. By July 1998 there will be one funding body...Public health providers (CHE Services) will be required to function in a business-like manner. The new focus will be on achieving health outcomes and improving the health status of the population they serve.<sup>72</sup>

Within the Agreement, and under the heading of Key Policy Initiatives, 'Point 6' referred specifically to Māori health. Two broad objectives for Māori health were identified. First, the development of 'competent' Māori health providers through:

- accelerated development of the professional Māori workforce,
- development of administrative and organisational expertise,
- Māori leadership within the Ministry of Health with dedicated provider approval, monitoring and evaluation functions, and,
- increased public health resources for Māori provider development both directly to Māori providers and with a service obligation to Regional Hospital and Community Services.

Second, preferred Māori providers<sup>73</sup> would be funded to supply a comprehensive range of primary healthcare, community-based health and disability services, and identified secondary health and disability services. Point 8 made specific reference to mental health, and stated that the recommendations of the 'Mason Report'<sup>74</sup> should be fully funded and implemented.

The overall impact of these changes is difficult to gauge. The Coalition Government lasted less than one term and the time taken to implement the agreement was longer than expected. New elections resulted in a change of Government, and with it new philosophies, strategies, and structures. While the available data tend to suggest that

Māori services continued to develop over this period, it is uncertain whether or not this growth would have occurred regardless and, more importantly, if health gains were made as a result. What is certain, however, is that the process caused further confusion within the sector, both for mainstream providers, and in particular for Māori providers who were less able to cope with frequent and ongoing changes.

### **More Elections and Further Changes**

In 1999, and as a consequence of another general election, the health sector was modified, yet again. As part of this, the Health Funding Authority was restructured and incorporated within the Ministry of Health. Twenty-one District Health Boards (DHBs) were established, each with an elected Board, supplemented by Ministerial appointments (of Māori members). In the new environment distinctions between funder and provider became even more blurred. DHBs were not only funders of health services, including primary care, but also providers of secondary and tertiary care. The desire to inject a stronger public health perspective into the health system was met by disestablishing the 'run away' HFA, and allocating some of its role to the Ministry of Health and some to the DHBs. It was a partial retreat to the philosophy of the welfare state, but did not entirely dispense contestability (between providers) and allowed some local initiative. But a stronger role for central Government had been prescribed and despite the rhetoric of local input at DHB level, in fact most of the funding allocations were more likely to be prescribed by the Ministry with relatively little discretion at the DHB level.

Importantly, Māori health and mental health remained a priority area.

## **The Treaty of Waitangi**

The reforms of 1993 and 2000 took into account policies for Māori development and, in turn, the implications of the Treaty of Waitangi. The Treaty had not been regarded as highly relevant until 1988 when the Royal Commission on Social Policy published the ‘April Report’.<sup>75</sup> The New Zealand Board of Health had emphasised the same point in 1987, and an article in the New Zealand Medical Journal in 1989 had introduced a medical relationship to the Treaty debate.<sup>76</sup> But Government was hesitant to legislate for Treaty recognition in social policy. Eventually, and after opposition within and without the House, a Treaty clause was inserted into the Public Health and Disability Act 2000. Under the Act, District Health Boards, were required to recognise the Crown’s Treaty obligations by involving Māori in planning and governance.

It was not until 2001 however, when the Waitangi Tribunal received a claim that the closure of the Napier Hospital was contrary to the Treaty of Waitangi, that a clear legal view of the relevance of the Treaty emerged. The Tribunal concluded that there were several health implications (at least as they related to the Napier Hospital closure) arising from the Treaty, based on the principles of partnership, equity, options, good faith conduct, and consultation.

The view of the Tribunal was that the relationship between Māori and the Crown was akin to the principle of partnership and that over time the balance between the two had clearly shifted in the direction of the Crown. The point was made ‘that it was now

sometimes difficult to distinguish partnership from protective or fiduciary obligations'. The principle of equity was centred around the premise that standards of health care for Māori should equal that of non-Māori. Moreover, that measures to ensure 'equality of access' were also required. While there was no Treaty requirement for equality of health outcomes (since healthcare alone could not determine health outcomes), integration between services and measures to ensure the reduction of disparities between Māori and non-Māori were required.

The principle of 'options' guaranteed the right of Māori to choose their own social and cultural path, and in terms of health services included making allowances for Māori medicine and arrangements for Māori customs within public hospitals. The 'duty of good faith conduct' was an issue within the claim because it was felt that the crown was not entirely truthful in their public communications over the future of the Napier hospital. 'Duty of consultation' reflected an earlier court ruling that the Crown must consult on 'truly major issues' and that the down-grading or closure of the hospital constituted this. Although health legislation placed an obligation on some health bodies to consult with the community, arrangements specific to Māori were also required.

More broadly the Tribunal had appeared to agree with the approach taken in the Public Health and Disability Act 2000 that described explicitly how the Treaty would be put into effect, rather than relying on a more interpretive set of 'Treaty principles'.<sup>77</sup>

## POLICIES AND PLANS FOR MĀORI MENTAL HEALTH

Following a damning report about the provision of mental health services,<sup>78</sup> the Government began to rethink the approach to mental health. A strategic plan, *Looking Forward*, had already been published to provide greater direction to the sector and the type of focus seen to be lacking. It identified key principles and a range of measurable targets and, although having a number of shortcomings,<sup>79</sup> was significant in that a baseline for future development had been established. But after the 1996 'Mason Report', it was clear that more focused action was necessary.

### *Looking Forward and Moving Forward*

*Looking Forward* was the first of two strategic policy documents aimed specifically at mental health. Released in 1994, it was designed to operate over a six-to ten-year period with a broad focus on service development.

As mentioned, the strategy contained two goals: to decrease the prevalence of mental illness and mental health problems within the community, and to increase the health status and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community. Seven strategic directions were also identified: more mental health services; more and better services for Māori; better mental health services; balancing personal rights with protection of the public; developing and implementing the national drug policy; developing the mental health service infrastructure; and strengthening promotion and prevention.

Aligned with these strategic directions was a set of national objectives and targets, steps through which the strategy could develop. A set of principles were also set out and designed overall to improve the responsiveness and quality of life for people with mental health disorders. A benchmark was established that required access to services by 3% of the general adult population as well as by children and youth.

While *Looking Forward* outlined the broad direction for mental health, it was clear that its objectives could not be met, at least through service development. Issues of prevalence were more likely influenced by a broader range of socio-economic determinants, beyond the immediate reach of the health sector. The 1996 'Mason Report' also noted a lack of leadership within the mental health sector and the absence of a national organisation through which the strategy could be implemented. Further, the Mental Health Strategy Advisory Group recommended that in order to be effective the goals of *Looking Forward* needed to be measurable.<sup>80</sup> Others noted similar concerns:

Looking Forward was merely descriptive – no plan was put in place to achieve these goals.

When a plan was put in place we did not really have any mechanism through which to achieve this.<sup>81</sup>

As a result of these concerns, a revised strategy, *Moving Forward*, was released in 1997. Within this, a set of national objectives and targets were established and intended to guide the work of the Ministry of Health, and the Health Funding Authority, and to assist the recently established Mental Health Commission with its monitoring functions.<sup>82</sup>

*Moving Forward's* stated aim was to build on the five strategic directions contained in *Looking Forward* and deal with the range of issues that had arisen.<sup>83</sup>

The National Mental Health Strategy is wide in its scope. It includes not just mental health services but also mental health promotion, prevention and primary healthcare activities. It is written at a national level and has measurable targets, most of which relate to policy development, funding and purchasing.<sup>84</sup>

However, *Moving Forward* failed to provide the detail through which the shape and structure of mental health services could be developed. In response, the newly established Mental Health Commission set about developing a 'Blueprint' to describe more fully what service developments were required. The first 'Blueprint' document was released in December of 1997<sup>85</sup> and was followed with a second release eleven months later.<sup>86</sup> The latter report emphasised the need for services to focus on recovery, consumer rights/empowerment, best outcomes, and increased consumer control and objectives that enabled consumers to fully participate within society. Additionally, it described service quality requirements, essential service components, and resource guidelines. All in all the 'Blueprint' was designed to complement the National Mental Health Plan and to assist with its prime objectives.

The Blueprint (2<sup>nd</sup> Ed.) noted that improvements toward the objectives of the National Mental Health Plan had been made and that growth within the sector had occurred. However, as part of its monitoring role the Commission also revealed a number of shortcomings. Of particular concern was the slow rate of service development and the

levels required to meet established timelines successfully. For example, too many people with mental illness still lacked access to appropriate mental health services,<sup>87</sup> issues of discrimination were still problematic, the national mental health standards were being implemented too slowly, and no framework for measuring outcomes had been developed. Service provision across the country also varied considerably, relationships and responsibilities between sectors was unclear, and consumer responsiveness required improvement.

With specific reference to Māori mental health the Commission noted that:

At all levels across the mental health sector, stronger participation by Māori is needed, to ensure implementation plans and service development recognise the Treaty and deliver improved mental health outcomes for Māori.<sup>88</sup>

Although there had been improvements since 1994,<sup>89</sup> a number of problems continued to impede progress. For example, significant workforce deficits existed and were compounded by inadequate recruitment and retention plans. More support for Māori provider organisations was needed and improved participation by Māori at all levels required. Gaps in service provision also existed, particularly in rural communities and especially for children and youth. Moreover, mainstream services were often unresponsive to the needs of Māori.

More recent examinations of the National Mental Health Plan have indicated a growth in the number and range of Māori mental health services, and an increase in Māori

community mental health workers employed within HHS and NGO organisations. However, questions remained about the objectives of the plan and whether or not they could be met within the established timeframe and through the mechanisms identified.<sup>90</sup>

## **Kia Tu Kia Puawai**

Aware of the limitations of the National Mental Health Plan, *Kia Tu Kia Puawai* was developed by the Health Funding Authority in 1998.<sup>91</sup> It promoted a broad approach to mental health, emphasising health prevention, promotion, early intervention, community and intersectoral development:

Currently the mental health sector focuses predominantly on the treatment of serious mental illness. *Kia Tu Kia Puawai* complements this approach through placing an emphasis on mental health promotion and illness prevention, using a community health development approach and local resources. It also looks beyond the formal mental health care system to examine and address other factors that affect our mental well-being such as housing, education, employment, and the impact of our environment.<sup>92</sup>

The strategy was initially centred on four demonstration programmes, designed to act as pilots, and to focus on Tamariki, Kaumātua, Mokopuna and Wahine, and Rangatahi. Within each of these, a service provider was selected and contracted to offer a range of services targeted to the needs of their particular client group. *Kia Tu Kia Puawai* aimed to place Māori concepts of health more securely within an established Government framework. Although the model appeared to facilitate this, the strategy was criticised for being too fragile, and susceptible to infrastructural change and Government ambivalence.

As a consequence, the strategy was not as widely accepted as anticipated. Many were concerned that it was not linked to the National Mental Health Plan and was therefore vulnerable. Others had also observed that it was not a strategy but a purchasing plan within which monies 'ring fenced' for service development were being applied to health promotion and prevention activities. Moreover, questions were raised as to the scope of the strategy, and considered that funding should not come out of a mental health budget, but from other sectors (for example, the Ministry of Social Development):

...it [*Kia Tu Kia Puawai*] is taking monies away from the specific treatment focused services. It appears that it has been presented as a strategy. However it is not a strategy it is a purchasing plan. It does not address issues associated with the acute side of treatment and it is not aligned with any policy documents. Therefore the plan may come at some expense. It has to have a strategy through which it can be contextualised, at present this does not happen. This type of thing has been tried before and it has failed. We should avoid providing to particular age groups as this goes against the holistic approach that we have always emphasised. Also what is the rationale for providing to the groups that have been identified. The clinical side of things still needs to be addressed. It is trying to say that the whole mental health model can be linked to this. It is targeting the soft end of the market. If this document is for Māori mental health it does not give the whole part of the picture and it does not appreciate the complexities of mental health provision. It may be exposing some of the providers to difficulties that they are unable to deal with, this is dangerous (mental health provision is particularly difficult...not just anyone can do it...even from a public health perspective). It is not aligned with other strategies of the HFA. It appears that they may select the best providers therefore it will be set up to succeed (this is not always a good thing as it may not present an accurate impression of how it will actually work in real situations).<sup>93</sup>

## **He Pou Tarawaho Mo te Hauora Hinengaro Māori**

*Kia Tu Kia Puawai* was significant in that it had, to some extent, gained Government approval and funding. However, other plans for Māori mental health had also been developed before *Ki Tu Kia Puawai*, though these were never implemented. *He Pou Tarawaho Mo te Hauora Hinengaro Māori*,<sup>94</sup> was a plan produced by Te Puni Kōkiri (the Ministry of Māori Development) in 1999 and aimed at addressing the identified weaknesses within the National Mental Health Plan; in particular, the need to have in place a secure funding stream through which the objectives for kaupapa Māori based services could be met.

The document provided a brief summary of Māori mental health status, noting data limitations, and the need to consider the broader indicators of Māori mental health such as housing and employment. In section two the policy environment was discussed and included an analysis of Māori concerns, the impact of the health reforms, the national mental health strategy, the role of the Health Funding Authority, and The Mental Health Commission. Most significantly, however, section three described a framework for translating principles into action, designed to describe critical success factors and identifiable steps through which the relevant objectives of the National Mental Health Plan could be met.

The success factors translated the current 'ideas based' service components<sup>95</sup> into annual, incremental, specific and therefore fundable approaches. A framework was conceived

and based on the premise that the mental health system could be viewed in terms of two key processes, resource allocation and service delivery. Resource allocation included both national and regional activities, those associated with the planning and funding of mental health service, the setting of policy guidelines, consultation, and decisions on what was funded and where. The service delivery component was based on critical success factors, such as those outlined in the Mental Health Commission's *Blueprint*.

The framework was ultimately intended as a guide through which to steer mental health professionals, including policy makers, so that gains in Māori mental health could be made in the short and medium term. Furthermore, it was also intended to identify current gaps in policy and services, and to link with the Health Funding Authorities, five-year planning and funding process. It usefully drew together literature on Māori mental health and its application within the context of resource allocation and service delivery. In addition, and unlike *Kia Tu Kia Puawai*, it linked well with the National Mental Health Plan and especially the objective for 'more and better mental health services'.

The framework was unfortunately never implemented. The reasons are unclear but can be linked to a range of issues, including the fact that the plan had intended to translate the ideas around service development into annual, incremental, and fundable approaches, yet did not include measurable targets, goals or objectives. Furthermore, the framework differed little from the Mental Health Commission's *Blueprint*, which in turn was partially based on *Guidelines for Purchasing Personal Mental Health Services for Māori*, a document originally developed in 1995.<sup>96</sup>

## **Puahou: A Five Part Plan for Improving Māori Mental Health**

Both *Kia Tu Kia Puawai* and *He Pou Tarawaho Mo te Hauora Hinengaro Māori* were Government designed and were primarily focused on service development. However, a seminal address first delivered at the Māori Mental Health Summit in 1997 outlined a broader approach to Māori mental health development, which, while not intended as a policy document has been used to inform a number of Māori mental health plans.<sup>97</sup>

The plan, *Puahou*,<sup>98</sup> described five requisites for Māori mental health and development.<sup>99</sup> The first, was access to a secure identity and emphasised the fact that good mental health would need to be consistent with the broader components of Māori development, such as Māori culture, whānau, language and land. The second component was active participation in society and the economy, and considered many of the contributors to Māori mental ill-health, unemployment, poor housing, educational underachievement, alcohol and drug misuse. The third part called for aligned services, designed to meet the diverse cultural expectations of Māori as well as being integrated and seamless. The fourth component reflected on current workforce deficits and the need for accelerated workforce development strategies. The last component called for greater Māori autonomy and control at all levels of the sector, so as to ensure strategies and objectives were consistent with the needs of Māori.

Although it lacked specific or measurable tasks, the plan was intended to be a guide, a mechanism through which improved policies for Māori mental health could be constructed.

## **The National Māori Mental Health Plan**

*Te Puāwaitanga: Māori Mental Health National Strategic Framework* was released in 2002. This plan was designed to link directly with the National Mental Health Plan (*Moving Forward*) and the Mental Health Commission's *Blueprint* – thus giving it a degree of stability. It ties together much of the existing work on Māori mental health (including those plans previously described) and applies these within a policy-supported framework.

The purpose of this framework is to provide District Health Boards with a nationally consistent method for planning and delivery of services to tangata whaiora and their whānau, in order that the Government is able to meet its mental health policy objectives for Māori over the next five years. Described are a set of seven 'Guiding Principles' that are used to provide the broad framework within which a set of goals and objectives are identified.

- Services covered by Te Puāwaitanga will actively acknowledge the special relationship between the Crown and Tangata Whenua under the Treaty of Waitangi.
- Te Puāwaitanga should reflect Māori realities and Māori priorities.
- Services covered by this strategy must protect and enhance the cultural and personal safety of tangata whaiora and their whānau.
- Improved effectiveness requires better specification of Māori mental health services and consistently applied standards.
- Māori models of well-being require mental health initiatives to occur in an inclusive and integrated manner.

- Capacity building of Māori service providers is a priority.
- Intersectoral and intra-sectoral collaboration is essential to implementing holistic models of care and well-being.

The five goals and objectives include:

- provide comprehensive clinical, cultural and support services to at least 3 percent of Māori with the greatest mental health needs, and to their whānau, within any six-month period.
- ensure that active participation in the planning and delivery of mental health services reflects Māori models and Māori measures of mental health outcome realities.
- ensure that 50 percent of Māori adult tangata whaiora accessing services will have a choice of a mainstream or a kaupapa Māori community mental health service.
- increase the number of Māori mental health workers (including clinicians) by 50 percent over 1998 baselines.
- maximise opportunities for intra-and intersectoral co-operation.

The framework, while primarily focused on service delivery, is significant in that it is supported at a strategic policy level. Regardless of whether or not its objectives will be met, the framework is consistent with the ongoing development of Māori mental health plans and strategies and will at least extend the existing boundaries of Māori mental health policy design.<sup>100</sup>

## **MĀORI MENTAL HEALTH SERVICE DEVELOPMENT**

Policies are often developed in response to a particular issue or need, and are designed with some kind of resolution in mind. In terms of Māori mental health, the problems previously described highlight the difficulty of developing effective mental health strategies. Although plans may be implemented, in themselves they do not guarantee a solution. For all the gains made, further problems inevitably arise and serve to challenge the manner in which policies are developed and devised.

The following section is a further examination of Māori mental health services, but focuses on the contemporary environment, and the features that characterise Māori services.

### **Mental Health Services for Māori**

Service components promoted for Māori mental health tend to be conceptual, and lack the level of measurable specificity as service components proposed for other mental health priority areas.<sup>101</sup>

In less than two decades the number and range of Māori mental health services has increased significantly and now feature as an integral part of the New Zealand mental health infrastructure. However, measuring the impact of this growth has been difficult, current information gathering systems are incomplete, confusion remains as to what constitutes a Māori mental health service, and the results have yet to be assessed.

The growth of Māori services was influenced by several factors. The desire to provide care to a culturally diverse population with differing needs and expectations encouraged diversity of operation. Deinstitutionalisation and the development of alternative health care delivery mechanisms further facilitated diversity, while the extent to which mental health services could be characterised took added meaning (i.e. inpatient/ outpatient/ residential/ respite/ community care/ counselling/ crisis intervention/ rehabilitation/ liaison and consultation/ Hospital/NGO based). Services were also distinguished by the contractual arrangements, the means through which funding was accessed,<sup>102</sup> and the consequences for service delivery:

...We are funded to provide a specific service...the contract is clear on this...so basically what we do is guided by the contract, and this can be frustrating...<sup>103</sup>

However, it soon became clear that a Māori mental health service could not easily be generalised. The importance of local custom to service delivery, inevitably shaped service design and structure.<sup>104</sup> Moreover, a rigid approach to service description was unlikely to appreciate fully the culturally diverse needs and multiple realities of Māori:

We have to be careful when designing care with a cultural component. Some will respond well to a powhiri and tikanga, others (not familiar with their culture) may feel out of place, ashamed, or embarrassed. Both will benefit from tikanga Māori, the question is how much, and at what level.<sup>105</sup>

Within urban environments other concerns about the distinguishing features of a Māori mental health service arose:

In Auckland we have a lot of problems trying to meet the needs of specific clients. Most of the people are from all over the place so it's hard to meet the needs of everyone. What we try to do anyway is make sure that if their from Ngā Puhi they are able to see someone from Ngā Puhi or from around their area, this seems to work, but depends on the staff available at the end of the day. For the most part we observe the kawa of the tangata whenua, as we should, however there are opportunities to do this type of thing. Another issue is the fact that some are not too in touch with cultural things so we need to be careful. At the end of the day we have to go by their [tangata whaiora] wishes.<sup>106</sup>

It difficult to provide a generic definition that captures the essential features of all Māori mental health services. The reality is that Māori mental health services have developed from within a dynamic framework, reflecting a range of care options, and reflect the need to meet the many expectations (both cultural and clinical) of tangata whaiora.

As a result, a more fluid approach to defining a 'Māori mental health service' has evolved, that endorses the need for diversity while at the same time recognising certain key elements. To this end, a number of service guidelines for Māori mental health services have been developed.

One of the first was constructed in 1995 and designed as a tool through which RHA purchasing decisions could be made. The report, *Guidelines for Purchasing Personal*

*Mental Health Services for Māori*,<sup>107</sup> listed eight components or activities that would normally feature as part of a Māori mental health service. Included were cultural assessments, whānau participation, use of Māori language, incorporation of Māori tikanga and cultural practices, the therapeutic application of Māori arts and crafts, karakia, the use of Māori medicinal herbs/therapies and rongoa, and the involvement of Tohunga and traditional healers.

The report outlined the manner in which activities could be applied, their significance and their purpose. Further, it was noted that cultural interventions would not constitute a mental health programme alone but that interventions related to clinical activity were also necessary. Before the construction of the guidelines, purchasing decisions for Māori mental health services often took place in an adhoc and inconsistent manner.<sup>108</sup> The diverse range of regional purchasing strategies tended to exaggerate these problems.<sup>109</sup> However, a far more significant issue was the fact that cultural approaches to mental health care were relatively new and to some extent untested. While cultural therapy units such as Whaiora, Te Whare Paea, and Te Whare Marie had provided valuable practical guidance, many of the approaches had yet to be formalised or placed within a generic framework suited to regional purchasing plans.

*Te Whaariki Manaaki*<sup>110</sup> was a similar report developed in 1998. It was based on three key principles: traditional Māori practice, te whare tapa whā/contemporary Māori health practice, and orthodox health practice. Each principle was designed to interact in a synergistic fashion and in a manner that promoted the best possible outcomes.

Traditional Māori practice included, tohunga, rongoa, and mirimiri, as well as karakia, and the concept of whanaungatanga. Te whare tapa whā/contemporary Māori practice, described the importance of cultural assessment, whānau support, assessment and care programmes. Orthodox health practice considered the value of clinical practice and intervention, ECT (Electroconvulsive therapy), pharmacology, and/or behavioural therapy.

While designed for a specific purpose<sup>111</sup> *Te Whare Manaaki* described concepts and features consistent with the purchasing guidelines document and, in particular, emphasised the need to align both cultural and clinical processes. It further recommended that traditional concepts and approaches had a place within contemporary structures and the mental health environment.

Aside from these two reports, a number of hui also explored the characteristics of a Māori health service. More recently, at the National Māori Alcohol and Drug Summit:

The extent of the debate around determining what is a kaupapa Māori service provides some insights into why it has been difficult to determine what they look like, how one might operate and what the special characteristics might be. 'Kaupapa Māori' therefore has as many meanings as service providers. The principal reason behind this diversity is that tikanga belongs to iwi, it is not a set of principles that can be universally applied.<sup>112</sup>

The hui offered some guidance in terms of service description. For example, the involvement of koroua and kuia was seen as an integral part, as was whānau support.

Services that were marae based and recognised mana whenua, karakia, and a holistic method of operation were also frequently seen in Māori services. However, it was agreed that these types of activities should be interpreted with some care, and that a rigid description of kaupapa Māori health service was best avoided.

These examples provide some insight into the debate surrounding the definition of a Māori mental health service. Other agencies, including the Health Funding Authority,<sup>113</sup> Mental Health Commission,<sup>114</sup> Māori Health Commission,<sup>115</sup> Ministry of Health,<sup>116</sup> as well as independent researchers<sup>117</sup> and academics<sup>118</sup> have also developed useful models, frameworks, structures, strategies, and statements. However, most have been drawn from the characteristics initially described in the purchasing guidelines document of 1995.

In order to explore these matters further, a sample of Māori mental health workers were interviewed (as part of this study) and asked to consider the unique components of their service, the philosophies on which they were based and the key characteristics. This process was designed to complement the literature, and to consider any gaps in information.

The first conclusion reached was that although Māori processes and activities, such as karakia, mirimiri, and whanaungatanga, were being actively applied – even if not necessarily in a standardised fashion – of greater importance was matching the activity according to client preferences. However, in some instances, confusion about the purpose of certain cultural activities was responsible for the variation. For example, in

services where cultural assessments were being performed, various inconsistencies had developed. In this regard, cultural assessment tools would often differ, sometimes considerably, in terms of their design, application, and even purpose.<sup>119</sup> Although the Mental Health Commission has attempted to provide assistance more recently with a cultural assessment booklet,<sup>120</sup> the Commission's approach has deliberately sought to offer guidance rather than strict criteria.

The application of holistic models and frameworks also appeared to be a consistent finding among those interviewed. Māori models, particularly te whare tapa whā, were used to guide service activity. Again, the interpretation tended to vary across services, and even by staff employed in the same service. To some extent the inconsistencies reflected service operation and design, and inadequacies in staff development and training programmes. Additionally, some considered it necessary to apply the models in a fluid manner, stating that they were intentionally designed to be flexible, modified in order to suit the particular needs of tangata whaiora. More important than the detail involved with the application of these models, was the intent to consider health from a holistic perspective.

The need to combine cultural and clinical activity was further highlighted. For most, it was accepted that Western medicines and approach were vital to promoting and maintaining health, and could be practised in an appropriate cultural context without compromise. The problem, however, was that many services were unable to provide clinical interventions directly, because well-trained clinical staff were not available. As a

result, most had forged close relationships with other (more clinically qualified) providers.

Respondents also referred to the intangibles that make up the services and to some extent the ideals on which Māori services were based. They were difficult to quantify. Many of the concepts were located at a more philosophical level and were shaped by notions such as manaakitanga and whanaungatanga, cultural process, and the need to create environments that were welcoming, safe, focused on wellness, and that empowered tangata whaiora. They were not always described in a consistent manner, or fully understood by the respondents. Nevertheless, they were considered critical to understanding Māori mental health service provision:

I've worked in the mainstream, and I can tell you that it's totally different. From my experience anyway most of the staff there treat it as just a job, the patients are just patients and nothing more. Here it's a lot different...OK, it's a job, but when you talk to the people here you'll know that they have a real passion for the work, and especially for the people that they treat and care for...it is important that this place has a good wairua...a healthy sense about it...<sup>121</sup>

Other criteria were also suggested: 'Tino Rangatiratanga',<sup>122</sup> or an approach that was 'by Māori for Māori'. However, there was less agreement as to what this actually meant, especially when considering the large number of Māori providers based within mainstream settings. The employment of Māori staff, was considered an essential requisite, but was again imperfect, at least in part, as many 'Māori services' had employed non-Māori staff.<sup>123</sup>

Durie<sup>124</sup> suggests that the essential characteristics of any Māori health service (mental health or otherwise) should be based on *health* rather than *political* objectives, an approach that reflects on the purpose of a service, rather than its components. In this regard, four characteristics are identified: clinical inputs consistent with the best possible outcomes; a cultural context that makes sense to clients and their whānau; outcome measures which are similarly client focused; and the integration of health services with other aspects of positive Māori development. The characteristics are relatively broad, and designed to suite a range of mental health settings. They reflect the difficulty of providing guidelines that can be useful in several settings and with a range of clients.

The overall impression presented, therefore, is that to understand Māori mental health services a broad framework is required. Cultural interventions or processes will feature as part of service delivery, but in addition an appreciation of clinical issues is required.

The philosophical foundations upon which Māori mental health services are built are also a significant distinguishing feature. These include an approach that is holistic, and the creation of environments that are nurturing, empowering or 'tika'<sup>125</sup> as one respondent stated. It may draw from traditional concepts such as tapu and noa,<sup>126</sup> or manaakitanga and include more contemporary models such as te whare tapa whā, te wheke, or ngā pou mana.<sup>127</sup> Outcomes based on Māori perspectives will also feature, and are reflected in service activities and specific service objectives.

The capacity of Māori health services to link with the broader aspects of Māori development is also a recurring theme.<sup>128</sup> Most services recognise the need to establish and maintain connections with the mana whenua,<sup>129</sup> to adopt practices consistent with local kawa,<sup>130</sup> and to utilise tribal experts and networks. However, these connections extend beyond a cultural context and are reflected within holistic models of care, consideration of the needs of tangata whaiora (outside a service setting) and the promotion of well-ness in the broader sense. To this end, health is viewed as more than just an absence of symptoms or maladaptive behaviour; health recognises the importance of being able to function as part of a whānau, to have a job, a home, the opportunity to access cultural networks and institutions to strengthen identity, and the capacity to participate in society in a meaningful way. For all these reasons, services for Māori often operate across and through sectors, Māori and mainstream, and in a manner ultimately designed to best meet the needs of tangata whaiora.

The most consistent theme however, is that Māori mental health services maintain a focus on Māori clients – tangata whaiora. Although features, characteristics, guidelines, and criteria have been developed, a fluid approach to service description has been preferred, focussed on achieving the best possible outcomes for tangata whaiora.

## A Māori Mental Health Workforce

The composition of the workforce in a mental health service is an important cultural factor. While it is possible to call on outside expertise and to rely on whānau for advice and assistance, day-to-day interactions with clients, and the development of a therapeutic milieu, is to a large extent a function of the regular workforce. As a general principle the ethnic and cultural composition of the workforce should approximate the composition of the client base.<sup>131</sup>

One of the most visible impediments to Māori mental health service development is the lack of an appropriately qualified and abundant workforce. The statement above highlights the importance of Māori within the sector, and their role in providing care within a cultural context. Yet for a variety of reasons, Māori participation is low, and despite efforts to increase participation and to promote workforce development, significant problems remain:<sup>132 , 133</sup>

Pleasing progress has been made in the last two years. Services have increased in almost all areas and important quality initiatives have been established. However, much still remains to be done. Considerable further growth and development will be required over several more years to successfully meet people's needs when they have a mental illness.<sup>134</sup>

Opportunities for Māori within the mental health sector have developed in parallel with the more recent changes to the health sector. The health reforms, for example, encouraged a less regulated approach to health care provision and likewise served to broaden the definition of a mental health worker or professional. A system of care, initially dominated by psychiatrists and nursing staff, began to embrace new categories of

workers – community support workers, and consumer advisors.<sup>135</sup> For Māori, an additional subset of professions has also emerged, to include Kuia and Koroua,<sup>136</sup> cultural advisors, and Māori healers. In addition, and especially since the health reforms, the roles of management and administrative staff have become more significant.

As a result, the overall picture of Māori within the mental health sector is one of growth and development, facilitated by innovative delivery modes, new approaches to treatment, and systemic change. However, the lack of a comprehensive Māori mental health workforce remains significant; although growth within many professions has occurred, deficits remain elsewhere. The extent of these problems is difficult to profile accurately, given the data limitations:<sup>137</sup>

...there is little reliable information, by job type and health profession group, about the numbers of Māori staff who work in mental health services.<sup>138</sup>

However, a number of studies have explored current workforce issues. For example, a 1999 telephone survey<sup>139 , 140</sup> indicated that out of a total of 1434 Māori mental health workers, 74.7% were full-time and 25.3% part-time. Almost 45% of the workforce were involved with support-related activities, and although most of these were employed full-time, almost 30% were part-time.<sup>141</sup>

Registered nurses (the second largest category) accounted for 17.3% of the total Māori mental health workforce, although a large number were employed as managers and team leaders and were not directly involved in treatment related activities. Forty-eight

kaumātua were identified (23 HHS and 25 NGO). Tangata whaiora made up 4% of the total workforce, with most (88%) part-time consumer advocates. Only two Māori consultant psychiatrists were identified, one child psychiatrist (one less than in 1996), one psychiatric registrar,<sup>142</sup> and seven clinical psychologists.<sup>143</sup>

Eighty-nine (6.2%) of the sample were employed as team leaders or managers. Ninety-eight (6.8%) were classified as counsellors (mostly working in the alcohol and drug area), many of these with no formal qualifications. One hundred and thirty were classified as 'other', as they did not fit within any of the identified categories. This group included project workers, clinical co-ordinators, psychotherapists, and co-ordinators.<sup>144</sup>

Consistent with national demographics, the Midland region was shown to have the largest proportion of workers, and the Southern region the least. Forty percent worked within a 'Māori' service, the remainder were employed within mainstream institutions. The majority of support workers, registered nurses, and social workers were employed within mainstream services.<sup>145</sup>

The survey, while not comprehensive, highlights two important issues. First, workforce growth has occurred, although it remains well short of approximating the needs of the Māori client base. Second, the vast majority of workers are employed in support-related activities and there are corresponding deficits in the clinical fields. A more recent study has further highlighted these issues, and in particular the deficits that exist within the clinical area.<sup>146</sup>

A number of factors have contributed to these problems and reflect an overall lack of forward planning:

Submissions to CAPE [Committee Advising on Professional Education] for organisations concerned with mental health and Māori health illustrate the serious problems caused by failing to plan and develop the workforce needed to implement Government policies in these priority areas.<sup>147</sup>

Plans for education and training also lacked precision and leadership:

...until recently, little attention has been paid to the importance of education in documents on health and disability strategy and in policy to improve the effectiveness and safety of health and disability services. We have found much confusion about who should be responsible for ensuring that adequate provision is made for the development and education of the workforce.  
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Moreover, educational facilities were slow to appreciate what training needs were required:

Workforce skills required in the mental health sector have changed and are continuing to change with new services development such as increasing community care. Training at pre-entry and post-entry level and continuing up-skilling have not kept pace with the competencies now required for modern mental health workers. The education sector, which largely controls education and training for health workers, has not proved responsive to the changing needs of the

sector. The health services are very dependent on the education sector for their supply of skilled health workers...<sup>149</sup>

The sector additionally suffered as a result of the past ambivalence of policy developers, an ill-appreciation of the role and function of the mental health worker, and a failure to anticipate adequately the requirements of the health reforms, in particular the full implications of community care:

Many of the workforce problems of the mental health services have resulted from the historical under-development of mental health services and the relatively recent change in emphasis from institutional-based to community-based care.<sup>150</sup>

More recently, the number and range of training opportunities available have improved.<sup>151</sup> Workforce funding has increased,<sup>152</sup> and a National Mental Health Workforce Coordinating Committee has been established.<sup>153</sup> However, the Committee has further alluded to the various and ongoing problems within the sector, in particular, a lack of co-ordination in workforce development, insufficient numbers of staff with certain skills, unsatisfactory skill mixes, inappropriate attitudes and skills, inappropriate training to deal with a changed delivery environment, and as recruitment and retention difficulties.

In response, the Health Funding Authority produced a five-year plan for mental health workforce development based on *Tutahitia te Wero*.<sup>154</sup> Specific arrangements for the development of the Māori mental health workforce were made and, along with the Te

Rau Puawai scholarship programme (discussed later in this chapter), will go some way to addressing many of the issues identified. However, these strategies are unlikely to impact immediately on existing deficits, and it may be some time before the fruits are realised. Further, both strategies are limited in the extent to which they are able to influence clinical skill deficits. Until a comprehensive workforce strategy is developed that is appropriately funded and implemented, Māori mental health workforce issues are likely to continue.

### **The Expectation of Cultural Competency**

As the use of Māori orientated processes has increased the need to identify the cultural limitations of care and treatment for individual Māori clients has arisen. Assuming that all Māori are the same and have an understanding and/or knowledge of 'customary' Māori beliefs, values and principles with little appreciation of contemporary Māori society may create new barriers to treatment. A further complicating factor is that not all Māori clinicians are able to understand and or deliver a range of 'customary Māori' services and the degree of understanding and integration of these values varies from practitioner to practitioner and service to service.<sup>155</sup>

Interviews used to inform the debate surrounding the definition of a Māori mental health service were also used to identify service issues. One of the more significant problems concerned the false expectation of cultural competency and the assertion that not all Māori were in a position to administer care within a cultural context.

The situation had arisen from the employment of Māori staff who had little or no cultural knowledge. In addition, cultural understanding or knowledge did not guarantee a

capacity to apply these skills within a mental health context. To some extent it was expected that service description and operation would influence how Māori models of health were interpreted and likewise how staff members would apply these. However, beyond this was the notion that many Māori staff were uncertain of their cultural abilities, and often lack confidence in the abilities of their peers:

He's very good at the cultural side of things e hoa...but he has no idea of mental health...unfortunately that doesn't stop him from getting involved or telling others what to do...it's dangerous, you know...<sup>156</sup>

Te Rau Puawai and Te Rau Matatini are strategies designed to address these types of concerns and will complement some of the existing 'service initiated' training programmes.<sup>157</sup> Te Rau Puawai is a joint initiative between Massey University and the Ministry of Health that aims to increase the professional Māori mental health workforce by 100, by 2003. It has been in operation since 1999 and provides bursaries to Māori students seeking university qualifications in a mental health-related discipline.<sup>158</sup> Te Rau Matatini is a current (2002) Māori mental health workforce development programme and is also a joint Massey University, Ministry of Health/Māori Mental Health Coalition initiative. The programme has the broad aim of assisting the acceleration and promotion of the professional Māori mental health workforce, those currently working in the field. Among other goals, Te Rau Matatini will produce a national strategic plan for Māori workforce development and assess training and professional development needs of Māori mental health professionals.<sup>159</sup>

However, and until the outcomes of these plans are realised, the expectation that all staff are culturally competent without being supported with appropriate training will continue to impede the effectiveness of Māori mental health services.

## **The Cultural-Clinical Interface**

Mental health programmes for Māori require appropriate clinical interventions, based on accepted practices and professional standards of care and treatment. While cultural inputs are necessary, by themselves they do not constitute a mental health programme even though they might guide programme delivery and content.<sup>160</sup>

Aligned with the expectation of cultural competency is the apparent inability of some staff to manage the cultural/clinical interface. Both skills sets are necessary components of a Māori mental health service, but the relationship is sometimes confused, unbalanced, or inadequately considered. To a degree the poor interpretation can be attributed to an over-zealous application of professional boundaries. However, all mental health staff require some degree of clinical understanding, an imperative that must be considered if the needs of tangata whaiora are to be met. Despite this, interviews suggested that some staff lacked key clinical knowledge, and that access to training was also limited. As a consequence it appeared that services with minimal contact with clinicians, held ambivalent – and often negative – views about mental health care and treatment. While this attitude was not wide-spread, certainly some were of the opinion that the mental health needs of Māori could be met entirely through the application of cultural interventions.

The implications were that an incomplete assessment of tangata whaiora needs would be made and that the care provided was unlikely to be sufficient in terms of the outcomes desired.

### **The Business of Health Service Provision**

For all their proposed benefits, the health reforms of 1993 were as much about finance as they were about health. Decades of rising costs, increasing demands and public expectations were placing pressure on a system that had evolved as part of the welfare state and the philosophy of free health care for all. By the 1970s it had become clear that the health budget could not sustain uncapped growth and that a more efficient structure and funding mechanisms were required. However, it was not until the reforms of 1993 that any significant modifications to the health sector were made and with them the promise of greater efficiencies, and improved and more equitable outcomes.

As described the overall success of the reforms has been difficult to gauge, since both positive and negative consequences have occurred. Regardless, an alignment between health and business had been established and continues to shape the manner in which the health sector is structured. At a service level the competitive environment meant that providers were to take a much more considered approach to issues of intellectual property, and as a consequence became less likely to share resources and knowledge. Monitoring requirements and issues of accountability were more explicit, as was the need for robust and efficient information technology systems. The all-too-frequent changes to

the health system often created confusion, and not only required providers to develop new relationships but also to ensure that they were well abreast of the changes and their implications.

For Māori health services, the negative consequences of these changes tended to be magnified as the organisations were often in developmental mode and lacked the range of skills through which adaptations to new environments could be made quickly, efficiently, and effectively. Nor did they have sufficient infrastructure to cushion unforeseen exigencies:

The competitive environment generated by the health reforms has encouraged a lack of transparency in business arrangements between the CHEs, the CHEs and the Divisional Offices, and between Divisional Offices themselves. There is duplication, no transfer of good practice, and over-commercial sensitivity.<sup>161</sup>

For many Māori mental health services, the interface between health and business was not always compatible and at times seemed inconsistent. To make matters worse, clinical skill deficits were equally matched by deficits in management and commercial skills. As a result, many Māori mental health services have been slow to adapt to the contemporary environment, the frequent and ongoing changes, and the implications these changes pose for service development.

## Workforce Perceptions and Implications

The skills, values, morale, and attitudes of the mental health workforce have an enormous impact on the cost, quality, and efficacy of mental health services. The significant and on-going restructuring of mental health services of the past decade has weakened the morale of the workforce.<sup>162</sup>

One of the more difficult issues to consider, at least from a strategic perspective, is the manner in which the mental health profession is perceived. Numerous documents suggest that morale within the sector is low and attracting new professionals is often difficult.<sup>163</sup> , <sup>164</sup> , <sup>165</sup> Anecdotal accounts provide further support and raise additional concerns about the viability of existing policies, the capacity to develop the workforce, and facilitate sustainable growth.

Part of the problem is again linked to changes in delivery mode. As previously described, a deinstitutionalised environment facilitated Māori entry into the mental health sector, the development of community-based services, and the provision of care in a less formal, socially orientated environment. Unfortunately, those employed at the community level often lacked formal or professional qualifications.

A sense of inferiority also developed because decisions on patients welfare were often assessed by those more formally qualified in technical and clinical areas. Such perceptions were further enhanced by frequent and ongoing changes to the sector, the drive toward greater efficiencies often being translated into cost cutting measures

affecting those who were least qualified. The short-term nature of health contracts tended to aggravate these concerns, along with the perception that other types of services or activities (deemed to be more critical) would receive greater priority.<sup>166</sup>

At a more global level, the well-documented workforce deficits have placed increasing pressure on existing staff, often exacerbated by increasing workloads. The low numbers of Māori with both clinical and cultural competencies has also meant the demands on time have become unrealistic. Complaints about the manner in which some staff had been 'poached', by other services, caused additional problems, especially as some providers were unable to offer much in the way of incentives.<sup>167</sup>

If you ask me what are some of the problems with Māori services I say it's only one and it's really got nothing to do with the services themselves. What I'm talking about are the poor conditions that we have to work under, our pay rates that are so uncompetitive, a lack of resources (we have one car for about 20 of us), unclear career paths, inadequate training, and the whole uncertainty as to what changes will happen next.<sup>168</sup>

Although many of these issues are generic, and not unique to Māori, a number of Māori-specific issues also exist. These revolve around the manner in which Māori approaches to care are implemented, and the long work hours,<sup>169</sup> which added to concerns over burnout. However, a more serious worry is the fact that Māori specific activities are not always regarded as part of formal treatment and little credit is given or recognised in the contract. The frustration associated contributes to a sense of an overall lack of

appreciation of the value of Māori approaches and methods. For some it has led to a desire to leave the mental health sector.<sup>170</sup>

### **Philosophical Frustrations**

The fundamental philosophies on which Māori approaches to care are based are often at odds with Western or contemporary styles of operation. The rationale stems from the fact that the current system, while now more than ever sympathetic to the needs of Māori, remains fundamentally monocultural, derived from European standards, philosophies and pedagogy.

A conflict therefore exists and is reflected in the type of frustrations mentioned previously (i.e. an ambivalent attitude toward Māori approaches, a sense that these views are often unscientific, or less valid than established theories, methods, or modes of treatment). In a broader sense, these attitudes have often inhibited opportunities for service development and indeed the experience of early Māori mental health services (such as Whaiora) suggests that development was impeded by a clash of cultures or philosophies.

To a significant extent dogmatic attitudes have remained and have continued to constrain Māori service development. For example, interview responses indicated that contracting is biased toward a particular approach, structures fail to appreciate the value of cultural workers, the significance of wairua, tinana, and whānau to mental health is not being realised, and monitoring frameworks typically measure only one dimension of health or

service operation. Interviews conducted with non-Māori<sup>171</sup> have tended to support these concerns, and confirmed other, less obvious suspicions, that clandestine attitudes and perspectives often inhibit service development and are in fact more detrimental than explicit unsympathetic attitudes:

...as a non-Māori clinician I have access to information that the Māori staff do not. The issues described in the hui are merely those which they are aware of. I can tell you that what I know or what I have heard of would shock you. The systems here are deliberately geared against them. Many [non-Māori staff] question the need for a Māori service, the resources required, and the way they operate. These people are those in high management positions, those who are in control, those who make the big decisions...<sup>172</sup>

These masked problems cannot easily be addressed and require a more fundamental shift in attitudes and ways of thinking. In recent years the relationship between culture and mental health has been strengthened through research, often in response to Māori demands, and more directly as a consequence of Māori mental health services. However, there remains a somewhat ambivalent attitude toward the place of culture within a mental health setting. Significant developments have occurred, yet do not extend far enough, or in a manner which fully facilitates Māori methods and approaches. Until this occurs, mental health services for Māori are unlikely to reach their full potential, and, importantly, the outcomes expected (by tangata whaiora) are unlikely to be achieved.

## CHAPTER SUMMARY

This chapter has contained a number of key themes and issues. The discussion initially focused on the development of New Zealand's health service infrastructure, the historical foundations on which it was built, the philosophies, objectives, and broad direction. Despite concerns over Māori health, the mechanisms for health service delivery did little to reflect Māori aspirations and ideals and were to a large degree based on Western concepts and paradigms.

Introduced diseases, land wars, inter-tribal conflicts, and social change, had, over a short period, decimated the Māori population, yet the health needs of Māori were often subsumed within a generic framework, despite indications of ongoing health problems. By 1900, and notwithstanding political indifference, Māori began to seek greater input into how policies were shaped and health services delivered. With pressure from key individuals, certain functions (particularly within the public health area) were devolved to Māori and there was a reversal of a trend that would have led to genocide. The approach was innovative, building on existing tribal structures and networks, recognising the role of community leaders, and the fact that health is not necessarily the sole responsibility of the health sector.

By the 1930s and through similar methods, the Māori Women's Welfare and Health Leagues encouraged health gains. By engaging Māori networks and utilising the traditional function of women (as nurturers and carers), mechanisms that centred on

whānau and community development were utilised and healthy lifestyles promoted. Over the past thirty years gains in Māori health have continued but the focus has shifted to direct Māori participation in health service delivery.

Within the mental health sector these new approaches were to have a positive impact. However, Māori were not high users of psychiatric facilities, initially at least, and there appeared little need to include cultural perspectives and approaches. As hospital admissions increased, conventional treatment methods and approaches came under increasing scrutiny. Questions were asked of the efficacy of institutionally based care, the impact this was having on Māori patients, and whether or not the right kind of environments were being created. Moves away from the strict, impersonal, isolated and highly clinical regimes were proposed and eventually dedicated facilities for the care and treatment of Māori patients were established.

The first Māori mental health services were located within larger hospitals, but provided treatment within a cultural context and from within a holistic base. The approaches were typically inclusive, designed to facilitate whānau connection and interaction, to consider the physical consequences of care, and to ensure that the deeper perspectives of wairua (spirituality) were not inadequately addressed, or misunderstood.

The experiences encountered by these early Māori mental health services provided the foundation through which similar units and dedicated services could be established. Aided by the health reforms of the early 1990s, the number and range of Māori mental health services increased and likewise strengthened the connections between culture and

mental health. Problems were, however, inevitable. Service growth occurred in an inconsistent and at times adhoc manner, and was far from even. The balance of services was also problematic, most Māori participants being involved with non-clinical, community-based or residential care activities. Funding constraints, a lack of sustained investment and short-term contracting, all led to limitations in service capacity. The frequent and ongoing changes within the sector added to the confusion, creating an environment of uncertainty and volatility. The overall impression of the sector in terms of career potential, consequently suffered, which further contributed to concerns about staff recruitment and retention.

Workforce deficits were also discussed. The lack of appropriately qualified clinical staff is of particular concern, likewise, the spread of management personnel is uneven, and many services find it difficult to negotiate contracts, meet monitoring requirements, or dealing with the all-too-frequent, and often complex, sectoral changes. These problems are matched by the belief that all Māori staff have some inherent cultural ability, and are fully able to apply cultural values to treatment contexts. Moreover, although relevant training may be available, geographical, financial, and practical restrictions may reduce the ability to up-skill.

Of greatest concern is the fact that Māori methods of operation appear to be hamstrung, but in ways that are not always obvious or easy to quantify. They reflect fundamental differences in the way in which health and health service delivery is viewed and evolved through historical constructs that failed to recognise Māori perspectives and world views

adequately. A health service infrastructure derived almost entirely from Western views resulted, and consequently restricted Māori service delivery. The impacts are felt in a number of ways, through, for example, rigid and inflexible contracting mechanisms that discouraged cross-sectoral interaction, and the undermining of the role of cultural advisors, *tohunga*, or *kaumātua*.

Until relatively recently, the mental health sector lacked a consistent national direction. *Looking Forward* provided some initial thrust, although the detail through which its objectives could be measured and driven was absent. *Moving Forward* offered greater specificity, and produced targets enabling the Mental Health Commission to fulfil its monitoring function. Although the Commission has subsequently provided critical advice on how the objectives of the national mental health plan can be met, a range of deficiencies have also been identified, many of which relate specifically to Māori, and most of which have been previously described.

A number of strategies and policies for Māori mental health have been developed. *Tutahitia te Wero* attempts to tackle some of the more outstanding workforce issues, and while having a number of limitations, is at least a move toward addressing workforce deficits. *The National Māori Mental Health Plan* builds on previous plans such as *Kia Tu Kia Puawai*, but has a more strategic intent, linking well to *Moving Forward* and providing a greater degree of overall stability.

These strategies are unlikely to address the mental health needs of Māori, nor will they satisfy the full range of service needs. They will, however, contribute to the ongoing development of Māori mental health services and the broader desire to improve mental health treatment and care. However, there exists a need for a more dynamic focus or emphasis. While the development of more Māori mental health services is important, a parallel thrust is required toward better mental health services, focused on positive outcomes, and designed to meet the expectations of tangata whaiora. A dual and integrated focus on clinical and cultural needs is required.

For this to occur, the issues described previously will need to be addressed. Those related to process or output (e.g., workforce development, funding, training) are more quantifiable and perhaps more manageable from a strategic perspective. Those that reflect philosophical conflicts are a different matter. A change in attitude or approach is required as well as a fundamental recognition of the value of Māori mental health services. In this regard, little real progress will be made until there is a clear shift toward outcomes, rather than a sole focus on inputs and process. Outcome measures capable of reflecting cultural and clinical dimensions will be vital and are an issue that is further discussed in the following chapter – *Māori Centred Frameworks for Health*.

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- <sup>1</sup> Auckland (3), Hamilton (1), Hawkes Bay (1), Wellington (1), Dunedin (1).
- <sup>2</sup> Non-Government Organisations
- <sup>3</sup> In most instances, a book.
- <sup>4</sup> All respondents were contacted indirectly either through their services or a third party. Interviews took place in locations and at times convenient to the respondents. The interview process was typically guided by the respondents, sometimes over a period of days. Respondents were also offered feedback on the study.
- <sup>5</sup> Each service had previously agreed to staff participating in the study if they so wished.
- <sup>6</sup> P. Hirini, (1997), 'Counselling Māori Clients: He Whakawhiti Ngā Whakaaro I te Tangata Whaiora Māori', in *New Zealand Journal of Psychology*, vol. 26, no. 2, pp. 13-18.
- <sup>7</sup> A. Shearer, (1974), *A Health Service for New Zealand*, Government Printer, Wellington.
- <sup>8</sup> Ibid.
- <sup>9</sup> Although preceded by the Treaty of Waitangi in 1840, this Act provided machinery for authority to be devolved to a 'Settler Government' for both Māori and European.
- <sup>10</sup> Shearer, (1974), *op cit.*
- <sup>11</sup> A. J. H. R., 1938, 1-6, pp. 7, 11.
- <sup>12</sup> For Primary Health Care, the medical profession retained the right to charge a fee in addition to a Government-financed subsidy, although during the 1950s and 60s the Government subsidy was usually sufficient to cover the cost of most consultations.
- <sup>13</sup> F. S. MacLean, (1964), *Challenge for Health: A History of Public Health in New Zealand*, Government Printer, Wellington.
- <sup>14</sup> K. S. Adam and R. M. Wintrob, (1977), *World Studies in Psychiatry New Zealand*, vol. 1, no. 3, Medical Communications Inc., IL., p. 11.
- <sup>15</sup> A. Hornblow, (1997), 'New Zealand Health Reforms: A Clash of Cultures', in *British Medical Journal*, vol. 314, no. 7098, pp. 1892-1894.
- <sup>16</sup> MacLean, (1964), *op cit.*
- <sup>17</sup> D. A. Dow, (1999), *Māori Health and Government Policy, 1840-1940*, Victoria University Press, Wellington, p. 71.
- <sup>18</sup> Ibid.
- <sup>19</sup> In the 1860s Florence Nightingale recommended that the Government should give more attention to the state of Māori housing and nutrition. The advice was not taken.
- <sup>20</sup> MacLean, (1964), *op cit.*, p. 197.
- <sup>21</sup> Dow, (1999), *op cit.*
- <sup>22</sup> MacLean, (1964), *op cit.*, p. 197.
- <sup>23</sup> Buck was particularly concerned about the inefficient processes adopted at some meetings.
- <sup>24</sup> M. H. Durie, (1994), *Whaiora: Māori Health Development*, Oxford University Press, Auckland.
- <sup>25</sup> Shearer, (1974), *op cit.*

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- <sup>26</sup> New Zealand's first asylum was established in 1844. This was attached to the Wellington jail and only provided care and treatment for settlers.
- <sup>27</sup> New Zealand Gazette, 1880, I, p. 264.
- <sup>28</sup> A. J. H. R., 1876, H-4c, p. 4.
- <sup>29</sup> K. Mason, (1988), *Psychiatric Report: Report of the Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients*, Department of Health, Wellington, p. 135.
- <sup>30</sup> These villas were first trialed at the Seaview asylum in 1879. However, the approach was not actively promoted as Government policy until 1903. From then on most new hospitals offered villas.
- <sup>31</sup> Shearer, (1974), *op cit.*, p. 43.
- <sup>32</sup> *Ibid.*, p. 43.
- <sup>33</sup> Before this, intellectually disabled patients were usually segregated within mental hospitals.
- <sup>34</sup> A. Schene, R. Tessler, and G. Gamache, (1996), 'Instruments Measuring Family or Caregiver Burden in Severe Mental Illness', in G. Thornicroft and M. Tansella (eds.), *Mental Health Outcome Measures*, Springer, New York, p. 53.
- <sup>35</sup> K. Mason, *et al.* (1996), *Inquiry Under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services*, Ministry of Health, Wellington.
- <sup>36</sup> 'Husband to Face Murder Charges', *The Dominion*, Thursday 13 December 2001.
- <sup>37</sup> D. Burns, D. Barret, V. Daley, P. Duigan, and K. Saville-Smith, (1994), *Towards a Post-Institutional Response to Mental Health*, Health Research Council of New Zealand, Auckland, p. 3.
- <sup>38</sup> Ministry of Health, (1994), *Looking Forward - Strategic Directions for Mental Health Service*, Ministry of Health, Wellington.
- <sup>39</sup> Ministry of Health, (1994), *Moving Forward - The National Mental Health Plan for More and Better Services*, Ministry of Health, Wellington.
- <sup>40</sup> W. A. Brunton, (1972), *Royal Commission to Inquire into and Report Upon Hospitals and Related Services: Stage II Psychiatric Services*, Department of Health, Wellington.
- <sup>41</sup> R. Baker, (1988), 'Kia Koutou', in C. Walsh and S. Johnson (eds.), *Psych Nurses*, 88, Wellington, p. 40.
- <sup>42</sup> Personal Communication, Interview Database Entry – Record 42.
- <sup>43</sup> Personal Communication, Interview Database Entry – Record 32.
- <sup>44</sup> M. H. Durie, (1977) 'Māori Attitudes to Sickness, Doctors, and Hospitals', in *New Zealand Medical Journal*, vol. 86, pp. 483-485.
- <sup>45</sup> J. F. A. Rankin, (1986), 'Whaiora: A Māori Health Cultural Therapy Unit', in *Community Mental Health New Zealand*, vol. 3, no. 2, pp. 38-47.
- <sup>46</sup> Mason, (1988), *op cit.*
- <sup>47</sup> Personal Communication, Interview Database Entry – Record 34.
- <sup>48</sup> Durie, (1994), *op cit.*, p. 115.

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- <sup>49</sup> M. H. Durie, *et al.* (1993), 'Traditional Māori Healing', a paper prepared for the National Advisory Committee on Care, Health, and Disability Services (The Core Services Committee), Department of Māori Studies, Massey University, Palmerston North.
- <sup>50</sup> In particular Te Hui Whakapumau and Te Ara Ahu Whakamua. See Ministry of Health, (1995), *Ngā Matatini: Strategic Directions for Māori Health*, Ministry of Health, Wellington, p. 8.
- <sup>51</sup> New Zealand Board of Health, (1987), *Annual Report of the New Zealand Board of Health 1986–1987*, New Zealand Board of Health, Wellington.
- <sup>52</sup> N. Devlin, A. Maynard, and N. Mays, (2001), 'New Zealand's New Health Sector Reforms: Back to the Future', in *British Medical Journal*, vol. 322, p. 1171.
- <sup>53</sup> The Public Health Commission was disestablished two years after the health reforms, and its role taken on by the Ministry of Health. Increasing difficulties associated with defining 'core' health services led to the restructuring of the Core Services Committee, now known as the National Health Committee.
- <sup>54</sup> Hornblow, (1997), *op cit.*, pp. 1892-1894.
- <sup>55</sup> M. H. Durie, (1993), 'Government Objectives for Māori Health', a paper presented at the conference for Successfully Implementing Māori Health Policy Objectives, Wellington.
- <sup>56</sup> Ministry of Health, (1994), *Policy Guidelines for Regional Health Authorities 1995/96*, Ministry of Health, Wellington.
- <sup>57</sup> Devlin, *et al.* (2001), *op cit.*, p. 1171.
- <sup>58</sup> Hornblow, (1997), *op cit.*, pp. 1892-1894.
- <sup>59</sup> M. H. Durie, (1992), *Māori Development, Māori Health, and the Health Reforms*, Department of Māori Studies, Massey University, Palmerston North, p. 15.
- <sup>60</sup> *Ibid.*, p. 7.
- <sup>61</sup> Section 8 of the Health and Disability Services Act (1993) stated that, amongst other things, a requirement for all Government health agencies to take account of the special needs of Māori. This is a reflection of the Government's 1992 commitment to ensure greater Māori participation at all levels of the health sector, resource allocations, that took into account Māori health needs and perspectives, and the development of appropriate, culturally aware, and sensitive practices and procedures in the purchase and provision of health services.
- <sup>62</sup> Personal Communication, Interview Database Entry – Record 3.
- <sup>63</sup> Personal Communication, Interview Database Entry – Record 12.
- <sup>64</sup> Ministry of Health, (1993), *Your Guide to the Crown's Objectives for Regional Health Authorities*, Ministry of Health, Wellington.
- <sup>65</sup> Personal Communication, Interview Database Entry – Record 49.
- <sup>66</sup> Ernst and Young, (1996), *1995 Stocktake of Mental Health Services*, Ministry of Health, Wellington.
- <sup>67</sup> \$24,000,000 in the 1996/97 Financial Year.
- <sup>68</sup> Ernst and Young, (1996), *op cit.*

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- <sup>69</sup> Mental Health Commission, (1999), *New Zealand's National Mental Health Strategy: Review of Progress 1994-1999*, Mental Health Commission, Wellington.
- <sup>70</sup> Initially the Transitional Health Funding Authority, and then The Health Funding Authority.
- <sup>71</sup> Steering Group to Oversee the Health and Disability Changes, (1996), *Implementation of the Coalition Agreement on Health*, Ministry of Health, Wellington.
- <sup>72</sup> Ibid., Appendix 2.
- <sup>73</sup> The minimum standards for these were set by the Ministry of Health.
- <sup>74</sup> Mason, *et al.* (1996), *op cit.*
- <sup>75</sup> Royal Commission on Social Policy, (1988), *The April Report*, Royal Commission on Social Policy, Wellington.
- <sup>76</sup> New Zealand Board of Health, (1988), *Priorities for New Zealand Health Services*, New Zealand Board of Health, Wellington, p. 6.
- <sup>77</sup> T. Bennion, (2001), *Māori Law Review: A Monthly Review of Law Affecting Māori*, September Issue, Tom Bennion, Wellington.
- <sup>78</sup> Mason, *et al.* (1996), *op cit.*
- <sup>79</sup> Development initially focused on service development only.
- <sup>80</sup> Mental Health Strategy Advisory Group, (1996), *Statement to the Minister of Health*, Ministry of Health, Wellington.
- <sup>81</sup> Personal Communication, Interview Database Entry – Record 19.
- <sup>82</sup> The Mental Health Commission was established in 1996, initially for a five year period, and to ensure the implementation of the National Mental Health Strategy.
- <sup>83</sup> For example the change in purchasing structures which occurred during this time.
- <sup>84</sup> Ministry of Health, (1997), *Moving Forward: The National Mental Health Plan for More and Better Services*, Ministry of Health, Wellington.
- <sup>85</sup> Mental Health Commission, (1997), *Blueprint for Mental Health Services in New Zealand: Working Document*, Mental Health Commission, Wellington.
- <sup>86</sup> Mental Health Commission, (1998), *Blueprint for Mental Health Services in New Zealand: How Things Need to Be*, Mental Health Commission, Wellington.
- <sup>87</sup> Access was set at 3% but was then estimated at only half of this.
- <sup>88</sup> Mental Health Commission, (1999), *op cit.*, p. 7.
- <sup>89</sup> For example, better co-ordination between central Government agencies on Māori mental health issues, improved Māori input into health funding, and substantial growth in the number of kaupapa Māori mental health service providers, as well as NGO organisations. All HHS also had Kaumatua input.
- <sup>90</sup> Mental Health Commission, (2001), *Report on Progress, 1998-2000: Toward Implementing the Blueprint for Mental Health Services in New Zealand*, Mental Health Commission, Wellington.
- <sup>91</sup> Health Funding Authority, (1999), *Kia Tu Kia Puawai*, Health Funding Authority, Christchurch, p. 4.
- <sup>92</sup> Ibid., p. 4.

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- <sup>93</sup> Personal Communication, Interview Database Entry – Record 22.
- <sup>94</sup> Te Puni Kōkiri, (1999), *He Pou Tarawaho mo te Hauora Hinengaro Māori - A Framework for Māori Mental Health: Working Document*, Ministry of Māori Development, Wellington.
- <sup>95</sup> For example the Mental Health Commission's Blueprint.
- <sup>96</sup> Te Pūmanawa Hauora, (1995), *Guidelines for Purchasing Personal Mental Health Services for Māori*, Te Pūmanawa Hauora, Department of Māori Studies, Massey University.
- <sup>97</sup> Health Funding Authority, (1999), *op cit.*, p. 9.
- <sup>98</sup> M. H. Durie, (1998), 'Puahou: A Five Part Plan for Improving Māori Mental Health', in *He Pukenga Kōrero*, vol. 3, no. 2, Department of Māori Studies, Massey University, Palmerston North.
- <sup>99</sup> The Puahou is a native tree, the leaves of which have five fingers.
- <sup>100</sup> Ministry of Health, (2002), *Te Puāwaitanga: Māori Mental Health National Strategic Framework*, , Ministry of Health, Wellington (advanced draft).
- <sup>101</sup> Te Puni Kōkiri, (1999), *op cit.*, p. 28.
- <sup>102</sup> For example, District Health Boards, Hospitals, Charitable Trusts, City Councils, Child Youth and Family Service.
- <sup>103</sup> Personal Communication, Interview Database Entry – Record 22.
- <sup>104</sup> Minutes: Mental Health Commission, Māori Advisory Panel – 17 March 2000.
- <sup>105</sup> Personal Communication, Interview Database Entry – Record 14.
- <sup>106</sup> Minutes: Mental Health Commission, Māori Advisory Panel –17 March 2000.
- <sup>107</sup> Te Pūmanawa Hauora, (1995), *op cit.*
- <sup>108</sup> T. Tutara (Health Funding Authority) – Presentation Speech (Mental Health Promotion for Young Māori, Conference of the RANZCP Faculty of Child & Adolescent Psychiatry and the Child & Adolescent Mental Health Services), 29 June 2000. Auckland.
- <sup>109</sup> The four regional health authorities developed a range of approaches to meeting the needs of Māori. In the Northern RHA, Māori purchasing organisations (MAPO) were developed, within the Midland region, joint venture boards were established, within the Central region, direct contract negotiations were favoured, and within the Southern region a less formalised approach was adopted.
- <sup>110</sup> E. Ryan, (1998), *Māori Mental Health Services: A Proposal for Change*, Māori Health Commission, Wellington.
- <sup>111</sup> The model was specifically designed to describe how clinical practice could be considered as part of a proposed Māori mental health service development.
- <sup>112</sup> Alcohol Advisory Council of New Zealand, (2000), *National Māori Alcohol and Drug Summit, 25-27 June 2000, Manu Ariki, Taumarunui Summit Report*, Alcohol Advisory Council of New Zealand, Wellington, p. 11.
- <sup>113</sup> Health Funding Authority, (1998), *Māori Mental Health Provider Hui – Christchurch*, Health Funding Authority, Wellington.

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- <sup>114</sup> Mental Health Commission, (1999), *Blueprint for Mental Health Services in New Zealand*, Mental Health Commission, Wellington.
- <sup>115</sup> Māori Health Commission, (1998), *Tihei Mauri Ora*, Māori Health Commission, Wellington.
- <sup>116</sup> Ministry of Health, (1995), *op cit*.
- <sup>117</sup> Health Services Research Centre, (1994), *Barriers to Mental Health Care in the Community: Towards an Economic Model*, Health Services Research Centre, Wellington.
- <sup>118</sup> M. H. Durie, (1994), *Māori Cultural Identity and its Implications for Mental Health Services*, Department of Māori Studies, Massey University, Palmerston North.
- <sup>119</sup> Minutes: Mental Health Classification and Outcomes Study, Māori Advisory Panel – 28 September 2001.
- <sup>120</sup> Mental Health Commission, (2001), *Cultural Assessment Processes for Māori: Guidelines for Mainstream Mental Health Services*, Mental Health Commission, Wellington.
- <sup>121</sup> Personal Communication, Interview Database Entry – Record 28.
- <sup>122</sup> In this sense used to describe full Māori control of Māori mental health services.
- <sup>123</sup> Preliminary results: Māori Mental Health Census Review Team Presentation – 17 October 2001.
- <sup>124</sup> M. H. Durie, (2001), *Mauriora: The Dynamics of Māori Health*, Oxford University Press, Auckland.
- <sup>125</sup> Right or correct.
- <sup>126</sup> In this instance tapu is used to denote caution, while noa describes safety.
- <sup>127</sup> These models are described more fully in the following chapter.
- <sup>128</sup> Mental Health Commission, (1998), *Report of the Key Messages to the Mental Health Commission from the Hui held February–April 1998*, Mental Health Commission, Wellington.
- <sup>129</sup> The people of the local tribe.
- <sup>130</sup> According to the particular customs of the local tribe.
- <sup>131</sup> Te Pūmanawa Hauora, (1995), *op cit.*, p. 24.
- <sup>132</sup> Mental Health Commission, (2001), *op cit*.
- <sup>133</sup> Mental Health Commission, (1997), *op cit*.
- <sup>134</sup> ‘Media Release’, *Mental Health Commission*, 23 February 2001.
- <sup>135</sup> Ministry of Health, (1996), *Towards Better Mental Health Services: The Report of the National Working Party on Mental Health Workforce Development*, Ministry of Health, Wellington.
- <sup>136</sup> Māori elders, Female (Kuia), Male (Koroua).
- <sup>137</sup> A 1999 telephone survey of mental health services confirmed that many mental health services did not consistently maintain ethnicity records.
- <sup>138</sup> Mental Health Commission, (1998), *op cit.*, p. 16.
- <sup>139</sup> Services that took part in this survey were identified through HFA contracts.
- <sup>140</sup> WDCC, (1999), *Developing the Mental Health Workforce: A Report of the National Mental Health Workforce Development Co-ordinating Committee*, National Mental Health Workforce Development Co-ordinating Committee, Wellington.

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- <sup>141</sup> Support workers tended to be involved in a range of activities including residential support accommodation, respite services, day care programmes, as well as cultural advisors.
- <sup>142</sup> Anecdotal accounts suggest that there was more than one psychiatric registrar.
- <sup>143</sup> All but one of the psychologists were working within a HHS.
- <sup>144</sup> National Mental Health Workforce Development Co-ordinating Committee, (1999), *Developing the Mental Health Workforce*, National Mental Health Workforce Development Co-ordinating Committee, Wellington.
- <sup>145</sup> That is, mental health services that did not have a specific Māori focus.
- <sup>146</sup> Preliminary results: Māori Mental Health Census Review Team Presentation – 17 October 2001.
- <sup>147</sup> CAPE, (1997), *Education and Development of the Health and Disability Workforce: Recommendations from CAPE's Consultation with Health, Disability, and Education Sectors*, Committee Advising on Professional Education, Wellington, p. 11.
- <sup>148</sup> *Ibid.*, p. 7.
- <sup>149</sup> Ministry of Health, (1996), *op cit.*, p. 9.
- <sup>150</sup> *Ibid.*, p. 49.
- <sup>151</sup> For example, in 1997 a national certificate in mental health support work was established and by 1998 had more than 100 enrolments. From 1996, The Clinical Training Agency purchased 160% more full-time equivalent mental health positions as well as five new training programmes.
- <sup>152</sup> Health Funding Authority, (1998), *National Mental Health Funding Plan 1998-2002*, Health Funding Authority, Wellington.
- <sup>153</sup> Minutes: Mental Health Commission, Māori Advisory Board - 15 October 1999.
- <sup>154</sup> Health Funding Authority, (1999), *Tuutahitia te Wero: Meeting the Challenges, Mental Health Workforce Development Plan 2000-2005*, Health Funding Authority, Wellington.
- <sup>155</sup> Alcohol Advisory Council of New Zealand, (2000), *op cit.*, p. 11.
- <sup>156</sup> Personal Communication, Interview Database Entry – Record 25.
- <sup>157</sup> For example, Te Whare Marie at Porirua hospital has regular tikanga training sessions.
- <sup>158</sup> <http://www.massey.ac.nz/~wwmaori/Te-Rau-Puawai/general/index.html> (14 January 2002).
- <sup>159</sup> Personal Communication, Paul Hirini (Trainer – Te Rau Matatini), Monday 14 January 2002.
- <sup>160</sup> Te Pūmanawa Hauora, (1995), *op cit.*, p. 27.
- <sup>161</sup> Mental Health Commission, (1997), *Financial Tracking Report: A Review of Funding and Expenditure in the Mental Health Sector*, Mental Health Commission, Wellington, p. 5.
- <sup>162</sup> Mental Health Commission, (1997), *op cit.*, p. 53.
- <sup>163</sup> Mason, *et al.* (1996), *op cit.*
- <sup>164</sup> Health Funding Authority, (1998), *op cit.*, p. 25.
- <sup>165</sup> Mental Health Commission, (1999), *op cit.*, p. 7.
- <sup>166</sup> Personal Communication, Interview Database Entry – Record 50.
- <sup>167</sup> Personal Communication, Interview Database Entry – Record 50.

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<sup>168</sup> Personal Communication, Interview Database Entry – Record 29.

<sup>169</sup> Preliminary results: Māori Mental Health Census Review Team Presentation – 17 October 2001.

<sup>170</sup> Mental Health Commission, (1998), *op cit*.

<sup>171</sup> Two non-Māori clinicians (working in the area of Māori mental health) also took part in the interview process.

<sup>172</sup> Personal Communication, Interview Database Entry – Record 44.

## Chapter Four

# MĀORI CENTRED FRAMEWORKS FOR HEALTH

### INTRODUCTION

Frameworks are useful bases for research inquiry. If applied correctly, they offer a guide through which the investigation can proceed, suggesting broad principles, concepts, methods and approaches, as well as critical success factors.

This chapter outlines a framework for measuring Māori mental health outcomes and likewise serves as the foundation for Chapter 5. The first part of this chapter considers several Māori health frameworks, their scope, utility, application, and context in terms of this study. The second part describes the research process. Part three explores the notion of outcome, definitions, characteristics, and issues of relevance, while part four reflects on the cultural components of health outcome, Māori perspectives and views. The final part describes the mental health outcomes framework, from which key conclusions are drawn.

### UNDERSTANDING MĀORI HEALTH

The frameworks upon which Māori concepts of health are formulated and implemented, are not identical to generic frameworks. While they move in similar directions, and may reflect similar high level goals, Māori frameworks centre on Māori values and perspectives. For more than a decade, a number of frameworks relevant to Māori health

have been advanced. They differ according to their purpose, context and origin, but have in common a broadly based view of health, a reliance on principles that are based on Māori values, and an integrated approach to policy, service delivery, and monitoring.

Many of the frameworks now used within the health sector were developed in Te Pūmanawa Hauora, a Māori Health Research unit in the School of Māori Studies at Massey University. Te Pūmanawa Hauora was established in 1993 as part of a Health Research Council initiative aimed at strengthening the Māori health research capacity. Three major research interests were identified: health services development, health promotion, and health policy. In each case there was a high demand for frameworks within which Māori perspectives and aspirations could be accommodated and Te Pūmanawa Hauora afforded priority to those needs.

As described, the health reforms of the early 1990s led to greater competition between providers and, as Māori health was a health gain priority area, Māori health providers were more actively sought by funders. At the same time, an increase in the number of Māori health providers identified a gap; new ways of conceptualising and measuring Māori health activities were needed so that the full potential of Māori approaches to health could be realised.

However, even before the reforms, there had been calls for Māori solutions to Māori health problems. In 1987 the Māori Health Committee of the New Zealand Board of Health outlined a strategic framework for the provision of health services by Māori. It

identified tribal authorities, not only as planners and tribal custodians but also as potential agents for social service (especially health service) delivery.<sup>1</sup> The Report promoted a shift of health care away from an exclusive reliance on conventional health agencies towards community-based organisations, and justified tribal authorities as health agents on the grounds that they were able to include health care with other aspects of tribal development such as land development and cultural and language development. While the framework was ahead of its time in so far as neither tribal authorities nor health agencies were completely ready for the challenge, it did lay the foundation for a direction in health care that was to become the 'norm' within a decade. Important was the recognition of Māori leadership and the utilisation of Māori social structures alongside the more conservative structures within the health sector.

Other frameworks soon followed. A framework for reporting on Māori clients in a disability service was published in 1994. This framework (The MDI or "Māori Disability Information" Framework)<sup>2</sup> identifies information useful to Māori communities, but not normally collected through other means. It includes three principles, four Māori specific data sets, and four considerations for the generation and transfer of data.

The three principles are the Treaty of Waitangi, confidentiality and guardianship, and purposeful and consistency. The Treaty of Waitangi, as the first principle, provides an overall guide for the framework and is consistent with Māori desires for greater control, equity, partnership, participation, and active protection. The principle of confidentiality and partnership reflects the need to ensure that information is obtained in a secure way

and in line with privacy provisions. The last principle (purposeful and consistency) highlights the requirement to collect information that is both useful and consistent, allowing for comparisons and projections to be made (e.g., service planning, monitoring of quality requirements and service delivery).

**Table 4.1** The MDI Framework - Principles

CATEGORY	COMPONENTS	GUIDELINES
PRINCIPLES	Treaty of Waitangi	The dual-focused framework: <ul style="list-style-type: none"> <li>• Kāwanatanga</li> <li>• Tino Rangatiratanga</li> <li>• Oritetanga</li> <li>• Partnership</li> <li>• Participation</li> <li>• Active Protection<sup>3</sup></li> </ul>
	Confidentiality and Guardianship	<ul style="list-style-type: none"> <li>• Privacy Act 1993<sup>4</sup></li> </ul>
	Purposeful and Consistency	<ul style="list-style-type: none"> <li>• Relevance and Use</li> <li>• Uniformity of Information</li> </ul>

*Source:* Te Pūmanawa Hauora, 1994: 25

The four Māori specific data sets include, ethnicity, cultural, circumstance, and disability data. The first component calls for a more consistent approach to which ethnicity data is collected and that contemporary definitions be used as a guide – for example those developed by Statistics New Zealand. The second component highlights the importance of collecting culturally specific data – such as iwi and hapū information, as well as an individual’s capacity to access Māori networks. The third component, circumstance, is

broadly linked to the requirement to collect information that considers an individual's socio-economic position and access to whānau support networks. By collecting this type of data a more comprehensive indication of individual needs can be formulated. The final component, disability data, states that the collection of Māori-specific data need not be inconsistent with the more usual data collection mechanisms – moreover that both data sets should ultimately complement each other.

Table 4.2 The MDI Framework – Specific Data

CATEGORY	COMPONENTS	GUIDELINES
MĀORI SPECIFIC DATA	Ethnicity	<ul style="list-style-type: none"> <li>• Māori Affairs Amendment Act 1974 definition</li> <li>• Descent and self-identification</li> <li>• Census Questions 1991</li> </ul>
	Cultural	<ul style="list-style-type: none"> <li>• Hapū and Iwi<sup>5</sup></li> <li>• Māori networks</li> <li>• Māori affirmation</li> </ul>
	Circumstance	<ul style="list-style-type: none"> <li>• Whānau support</li> <li>• Economic position</li> <li>• Other social indicators</li> </ul>
	Disability Data	<ul style="list-style-type: none"> <li>• Same as mainstream</li> <li>• Correlation of disability (multiple disabilities)</li> </ul>

Source: Te Pūmanawa Hauora, 1994: 26

The final category, ‘Generation and Transfer of Data’, is more technically focused and considers the practical issues associated with the collection of accurate and meaningful data. It highlights the need for systemic development – data and technology systems that are compatible and transferable; the need to ensure that issues of cultural safety are considered (e.g., how information is collected, stored, and applied); consideration of the methods of data collection (what information is collected and why); and lastly, data processing issues, to ensure that clear procedures are in place, that information is safe and secure, and that those gathering the data have some form of accountability to those from whom it is collected.

Table 4.3 The MDI Framework – Data Transfer

CATEGORY	COMPONENTS	GUIDELINES
GENERATION AND TRANSFER OF DATA	Data and Technology	<ul style="list-style-type: none"> <li>• Compatibility</li> <li>• Transferability</li> </ul>
	Cultural safety	<ul style="list-style-type: none"> <li>• Cultural safety issues<sup>6</sup></li> </ul>
	Methods of collection	<ul style="list-style-type: none"> <li>• Physical recording</li> <li>• Completed details</li> </ul>
	Data processing	<ul style="list-style-type: none"> <li>• Clear procedures</li> <li>• Accountabilities</li> <li>• Guardianship and security</li> </ul>

Source: Te Pūmanawa Hauora, 1994: 27

The MDI Framework represented a new approach to the collection, analysis, and retention of disability data. It was aimed at a national policy level and was broad enough to meet the diverse requirements of each provider organisation. Importantly, it highlighted the need to consider cultural factors within existing data collection mechanisms.

Another framework for use in the disability sector, *He Anga Whakamana*, has been used to help develop services for the disabled. Six key principles feature: whakapiki (enablement), whai wāhi (participation), whakaruruhau (safety), tōtika (effectiveness), putanga (accessibility), and whakawhanaungatanga (integration).<sup>7</sup> The principles reflect Māori values and emphasise the need for disability services to adopt a fundamental philosophy consistent with Māori views and perspectives.

The framework identifies specific service implications for each of these principles and further provides indicators through which these implications can be assessed. The indicators are not intended as rigid markers but are used as broad guidelines through which generic service plans could be developed.

Table 4.4 on the following page describes the key components of the framework.

**Table 4.4** He Anga Whakamana: A Framework for the Delivery of Disability Support Services to Māori

Principles	Service Implications	Indicators
Whakapiki Enablement	Client input and choice at all levels of decision making Observation of Māori cultural requirements Provision of Māori focused services by Māori Least intrusive service options	Quality information and collection  Client participation
Whai Wahi Participation	Active client participation Active whānau involvement Links forged with Māori institutions	Caregiver/case manager participation  Whānau participation
Whakaruruhau Safety	Cultural safety, including cultural enhancement of mainstream services Professionally qualified services with representative staff Raised community awareness of disability	Appropriate use of Māori language
Tōtika Effectiveness	Improved health status and health gains for Māori Representative workforce Community contribution	Links with Māori institutions  Consistency
Putanga Accessibility	Quality information Timelessness Availability of culturally and professionally safe services Environment	Workforce composition and sensitivity
Whaka – Whanaungatanga Integration	Links with Māori institutions Links with other service providers Networking with Māori	Assessment procedures Consultation Māori specific factors

*Source:* Ratima et al, 1995: 43

A third framework, *He Taura Tieke*, sets out parameters for health service effectiveness. Its key dimensions are technical (or clinical) competence, structural and systemic responsiveness, and consumer satisfaction.<sup>8</sup> The framework identifies those key health service attributes or components required to meet the needs and expectations of Māori consumers. In doing so, *He Taura Tieke* proves a simple ‘checklist’ through which service plans can be designed and operationalised.

**Table 4.5** He Taura Tieke

<b>Technical and Clinical Competence</b>	<ul style="list-style-type: none"> <li>• competence and safety</li> <li>• health framework</li> </ul>
<b>Structural and Systemic Responsiveness</b>	<ul style="list-style-type: none"> <li>• Māori development</li> <li>• Māori workforce development</li> <li>• preferred providers</li> </ul>
<b>Consumer Satisfaction</b>	<ul style="list-style-type: none"> <li>• access</li> <li>• information</li> <li>• informed choice</li> <li>• trust and respect</li> <li>• participation</li> <li>• seamlessness</li> </ul>

*Source:* Cunningham, 1996: 25

The components of the technical and clinical competence dimension (competence and safety and health frameworks) require safe, appropriate and timely services. This is based on the fundamental understanding that consumers need services that are technically/clinically competent, monitored, evaluated, and able to meet the legal and regulatory standards established by Government and other professional bodies.

Structural and technical responsiveness has three components (Māori development, Māori workforce development, and preferred providers). This dimension considers the expectations of Māori and that health services should contribute to broader Māori objectives, be aware of the particular needs of Māori, and employ relevant frameworks and philosophies (e.g., The Treaty of Waitangi, Whare Tapa Whā, and the Ottawa Charter). This dimension also calls for formal monitoring mechanisms through which the needs of Māori can be assessed.

The third dimension (consumer satisfaction) is based on the simple premise that consumer needs should be met. To improve access to, and use of health services, Māori preferences, choices and decisions must be fully considered. The components of this dimension (access, information, informed choice, trust and respect, and participation) are broadly designed to facilitate improved Māori access, participation, and outcomes. Like *He Anga Whakamana, He Taura Tieke* was designed to account for the diverse needs of service providers, including both cultural and clinical requirements.

After the Health Reforms, when contracting for health services became a regular aspect of service delivery, a guide for public health contracting with Māori providers was adopted by the Public Health Commission. The CHI <sup>9</sup> framework<sup>10</sup> provides a basis on which provider contracts can be audited for cultural appropriateness and health gains for Māori. The model adopts an holistic framework and seeks to be interactive.

Table 4.6 The CHI Audit Model

Principles	Implications
Cultural Integrity	<ul style="list-style-type: none"> <li>Care is culturally bound and reliant on cultural credibility (language, concepts and treatment)</li> </ul>
Medical Pluralism	<ul style="list-style-type: none"> <li>traditional approaches to care are not necessarily inconsistent with more contemporary methods – the objective is “health”</li> </ul>
Self-determination	<ul style="list-style-type: none"> <li>the capacity to exercise some control over how practices are implemented and applied</li> </ul>

*Source:* Durie, 1993:

The health contracting environment also took tentative steps toward recognising Māori traditional healing as a legitimate health service that qualified for funding. However, a framework within which traditional healing could be conceptualised was required. Important to that task was the link between healing and culture and the recognition that quite different bodies of knowledge could exist, side by side, without needing to be interpreted according to the standards and norms of the other. In other words, mātauranga Māori (Māori knowledge) was itself a legitimate body of knowledge that gave rise to distinct views on health and remedies for health problems. The challenge was to reconcile that approach with more conventional approaches without distorting the underlying rationale. The framework for purchasing traditional healing services attempted to address these challenges. It emphasised the adaptive nature of culturally

derived healing but also stressed the principle of cultural integrity. Traditional healing was distinguished from other ‘alternative’ therapies on the basis of its longstanding cultural significance and its foundation of Māori values and a Māori philosophical outlook. Importantly, the framework provided the basis for Ministry of Health policy.<sup>11</sup>

**Table 4.7** A Framework for Purchasing Traditional Health Services

Item	Characteristics
Traditional basis	<ul style="list-style-type: none"> <li>● evidence that the approach does have a traditional foundation</li> </ul>
Relevance to today	<ul style="list-style-type: none"> <li>● approaches are able to meet and deal with contemporary needs</li> </ul>
Accessibility	<ul style="list-style-type: none"> <li>● cost, geography, insufficient information, may impede access</li> </ul>
Demand	<ul style="list-style-type: none"> <li>● an awareness of how demand is measured</li> </ul>
Based on an integrated body of knowledge	<ul style="list-style-type: none"> <li>● traditional treatment and care may draw from a range of sources in order to make a diagnosis or assign treatment</li> </ul>
Training for practitioners	<ul style="list-style-type: none"> <li>● often difficult to determine individual level of skill (ability not determined by formal qualifications)</li> </ul>
Internal arrangements to ensure standards	<ul style="list-style-type: none"> <li>● the capacity to monitor and set standards</li> </ul>
An openness to other approaches	<ul style="list-style-type: none"> <li>● linked to the notion of medical pluralism but highlights the need for both approaches to accept the benefits the other may provide</li> </ul>
Not harmful	<ul style="list-style-type: none"> <li>● the objective is ‘health’</li> </ul>
Accountable	<ul style="list-style-type: none"> <li>● to patients, funders, and communities</li> </ul>
Liaison	<ul style="list-style-type: none"> <li>● the need to liaise with other sectors – a holistic, and integrated approach to health</li> </ul>

*Source:* Durie, 1996:

Strategic frameworks for Māori health have also been developed. *Te Pae Mahutonga* is a framework, adopted as a strategic guide to health promotion, including mental health promotion.<sup>12</sup> It uses the symbolism of the constellation of stars known as the Southern Cross (Te Pae Mahutonga); the four stars making up the cross represent mauri-ora (identity, access to te ao Māori), wai-ora (environmental integrity), toi-ora (healthy lifestyles) and te oranga (well-being). The two ‘pointers’ represent ngā manukura (leadership) and te mana whakahaere (autonomy). The framework has become widely used in New Zealand as a health promotional framework and has been especially welcomed by Māori health workers for whom the imagery has particular meaning and significance. Moreover, by adopting a celestial analogy, the subject is elevated to a broader level of conceptualisation, consistent with Māori preferences for looking at the ‘larger picture’ to give context and allow for relationships to be explored.

### **Measuring Outcome – A Challenge for Mental Health Services**

Well-constructed measures of outcome provide significant opportunities for the health and mental health sector alike. In terms of policy formulation, they are often used to assess the effectiveness of prevention programmes, to facilitate quality review, to develop local initiatives in health care, to inform and prioritise funding decisions, and to highlight areas for future research.<sup>13</sup> For consumers, outcomes data can also empower and provide for greater involvement in the treatment and rehabilitation process.<sup>14</sup> At a service level, outcome measures may similarly be used to design more effective treatments or therapies, and assist with staff development and deployment, monitoring, case mix,

recruitment, quality assurance, and the identification of particular service areas that require enhancement or modification.<sup>15</sup>

However, the extent to which these measures have been used has been limited, mainly because of theoretical and logistical concerns. As a consequence, many of the gains anticipated from the use of outcome data have yet to be realised.<sup>16</sup> The reliability<sup>17</sup> and validity<sup>18</sup> of outcome measures have remained a somewhat contentious issue, with numerous caveats limiting the extent to which such tools may be applied, in what situations, and with which patients. For users of outcome measures many of these problems have been associated with the application of the tools, the practicalities of conducting routine outcome assessments, and the systematic and integrated use of outcomes data.<sup>19</sup>

For Māori, these issues are compounded by the fact that no instrument capable of measuring Māori mental health outcomes had ever been constructed – moreover, little theoretical work has taken place to provide a robust platform. In order to address this situation, and to ensure that an appropriate foundation could be created, this chapter describes a framework for Māori mental health outcomes. Like the frameworks previously described, it allows for a Māori conceptual base and Māori health perspectives. Other, more fundamental issues can also be considered, including research parameters, definitions, applications, mental health issues, and cultural implications.

## **RESEARCH ISSUES**

The complexity of this chapter presented numerous technical and logistical challenges, in part due to the difficulty of outcomes study, but also because few investigations had considered the cultural dimensions of mental health outcome assessment. As a consequence, a detailed research method was developed and ensured that the objectives were successfully met.

### **The Policy Context**

A large number of studies have investigated the development and application of health outcome measures and were to form an important part of this research. Unfortunately, few of these studies have been conducted within New Zealand and as a consequence there remain significant gaps in local research activity.<sup>20</sup> However, efforts to improve the situation have occurred since 1996 as a result of the coalition agreement on health.<sup>21</sup> Since then the Health Research Council has also provided some thrust by emphasising and funding locally developed measures of outcome.<sup>22</sup> In 1997 the Mental Health Research and Development Project was established to actively promote the initiation, coordination and dissemination of mental health outcomes research.<sup>23</sup> It marked an official recognition of outcomes research as a necessary part of health service development.

## Interviews

A wide variety of obstacles stand in the way of obtaining useful information from the research literature (including many technology assessment reports), including: \* lack of relevant, well-conducted, outcome-based evidence for most services \* lack of agreed methods for assessing methodological quality of studies \* concerns about the generalisability of overseas work to New Zealand environments \* scarcity of definitive answers concerning outcomes even when good studies exist \* sheer volume of literature and difficulty sifting for relevant studies in timely manner \* lack of relevant cultural and/or indigenous specific material.<sup>24</sup>

In order to complement the literature review a number of local and international interviews took place.

The first group of interviews was conducted with locally based outcomes researchers, and although this pool was relatively small it did assist with the identification of relevant expertise in the field. These interviews were designed to consider some of the more logistical and practical issues associated with outcomes research and to guide the overall development of the study. Interviews were unstructured in that no formal questionnaire was used, rather respondents were encouraged to discuss broadly the issue of outcomes research and how this might be applied or considered from within a cultural context. Information gathered from the process was recorded and later transcribed.

Due to a lack of culturally aligned outcomes research it was important that the views of Māori mental health experts were incorporated into the research process. As a

consequence, a second range of interviews were initiated, this time with a sample of individuals identified as having both cultural and clinical mental health knowledge. Again, these interviews were broad in scope but structured to consider five basic issues:

- What type of mental health outcomes are unique to Māori?
- Why are these important?
- How are these outcomes achieved?
- How can they be measured?
- How can they be conceptualised within a framework?

The interviews were conducted with the aid of a simple structured open-ended questionnaire. This was administered by the researcher to a group that included Māori clinicians, tangata whaiora, health researchers, academics, service personnel, and whānau.

### **Committee Participation**

The researcher's participation on various health committees<sup>25</sup> provided the opportunity to consider the concept of health outcome from a national perspective. Within these forums assessments were made as to the utility of outcome measures, and in particular how they could be applied to the local health environment. Issues linked to outcomes were frequent agenda items and enabled issues to be identified and to some extent unravelled. By considering these concerns, it was possible to gain additional ideas on the construction of outcome tools, requirements, applications, and contentions.

## **Presentations**

The previous research activities provided sufficient data through which a reasonable range of assumptions could be made and a broad notion of Māori mental health outcome formulated. To consolidate these assumptions, a number of presentations on the study were initiated, initially to obtain direct feedback on the study, and further to facilitate an even wider range of comment and critical review. This process was especially useful as it allowed direct and timely feedback. In this regard participants were encouraged to voice their particular concerns, to highlight potential problems, and to suggest modifications or enhancements. The presentations had in fact provided an opportunity for extensive reviews.

## **Data Management**

The storage, management, and analysis of data were assisted by the use of the Microsoft Access Program. Reviewed literature, interview data and information gained through the committees and presentations were stored within the database.

## **Kaupapa Māori Measures**

Measures were included within the study design to ensure that Māori expectations were met. At each information gathering point an assessment was made of the extent to which cultural factors would be relevant and the manner in which they might be incorporated within the research process.

For example, Māori interview participants were typically accessed or introduced via a third person and made aware before being contacted (by the researcher) that their participation in the study might be required. Where appropriate, letters of introduction were sent, as well as details outlining the study, its purpose, application, and the role of the participants. If permission was granted, interview dates and times were set and, in accordance with the wishes of the participant's a suitable location arranged. The interviews took Māori protocol into account. Sometimes a formal exchange of greeting occurred; almost always the researcher and respondent engaged in a hongi,<sup>26</sup> often there was a preliminary discussion about relatives in common, recent bereavements and the broader topical issues related to Māori people. No effort was made to move to the specific purpose of the meeting until it was clear that the necessary preliminaries had been completed. In two instances the first meeting was devoted entirely to the preliminaries and return visits were necessary. By then there was a greater sense of mutuality – the way had been cleared to proceed to the next step.

At the completion of each interview further informal discussions often took place and were frequently unrelated to the purpose of the investigation. Although for the most part interviews were conducted in English, the preliminaries – as well as aspects of the main discussion – were generally held in Māori. Respondents and the researcher recognised a preference for Māori when engagement was occurring and switched to English only when the nature of their relationship had been clarified. Clarification included the mutual acknowledgement of tribal backgrounds and respect for those relatives or friends, known to both parties, who had passed on. On completion of the interviews, participants were

asked if they required feedback on the study and updates on its progress. Additionally, a small koha was presented.

Hui and various other types of presentations were also included as part of the study design and as a means of gather additional data. Although it was not always possible to influence the format of these, a number of procedures were developed to ensure Māori input and participation. These included formal powhiri (welcome), other introductions, hākari (sharing of food), and poroporoaki (formal farewell). Different types of information sheets were developed and distributed through a range of networks to provide the scope through which a range of opinions could be secured. With consent, a participant list was distributed following each presentation, allowing individuals or organisations to be contacted and to obtain ongoing feedback if they so wished. The hui and consultation schedule is attached in Appendix IV.

## OUTCOME DEFINITIONS, CONTENTIONS AND CHARACTERISTICS

The field of health outcomes research is often complicated, convoluted, and confusing. In order to highlight issues and controversies, the following section explores the concept of health outcome, provides definitions, examines characteristics, details requirements, and notes difficulties.

### Defining Health Outcome

The problem of defining 'health' and 'health outcome' has bedevilled attempts to set priorities based on effectiveness and outcomes, in New Zealand and elsewhere. They continue to do so today. A decades-long debate has surrounded the definition of 'health' and has failed to provide consensus on this issue.<sup>27</sup>

There is a lack of overall consensus as to what constitutes a health outcome, or the key features that characterise this particular field of study.<sup>28</sup> Simplistic definitions have tended to confuse the concept with more pragmatic ideas of 'output', 'consequence', and/or 'effects'.<sup>29</sup> While the context within which 'outcome' is used will help define its nature and characteristics, for most outcomes researchers a set of clearly identified parameters or considerations have been developed. While they add to the clarity, researchers have yet to agree on any one definition.

In exploring possible options, the so-called 'Sunshine Statement' is perhaps the most generic and widely accepted definition:<sup>30</sup>

A health outcome is a change in the health of an individual, or a group of people or population, which is wholly or partially attributable to a intervention or series of interventions.<sup>31</sup>

Other definitions have also been proposed, Armstrong for example notes that:

An outcome-related performance indicator in the health and welfare field is a static or other unit of information which reflects, directly or indirectly, the performance of a health and welfare intervention, facility, service or system in maintaining or increasing the well being of its target population.<sup>32</sup>

At another level broader explanations have been preferred to reflect the range of factors that can potentially influence outcome. Hall et al state:

... An improvement in 'health' may not be the outcome of health services. However, in this context it is measures of those aspects of health which are likely to be affected by changes in health services which are required as indicators of outcome. This concept of outcome implies both a measure of change in health status and an association with health service use/provision ...Evaluating health outcomes involves determining the effect of the utilisation and provision of health services on the health status of the population.<sup>33</sup>

Other statements have also emerged:

An outcome is a natural or artificially designed point in the care of an individual or population suitable for assessing the effect of an intervention, or lack of intervention, on the natural history of a condition.<sup>34</sup>

As demonstrated by these examples, the concept of health outcome remains the subject of some considerable debate and a consensus view or opinion has yet to be formulated. Despite this, it is important that a definition of health outcome is attempted, at least for the purposes of this thesis. Although it is quite possible to select or justify any of the many definitions as an appropriate base, such a decision is just as likely to raise further issues as to the selection of one over another. In light of this, another approach to the question of definition is warranted, and rather than selecting a rigid or established statement, it is far more useful to describe those generic features held in common.

One of the first issues to emerge from the definitions so far established is the relationship between an intervention and the outcome: an outcome is attributable to an identifiable intervention. The *Sunshine Statement* implicitly illustrates the point and makes it clear that an outcome is of little consequence unless the cause or intervention is also known. Within the health sector in particular, the identification of an intervention can be difficult, and since a multitude of factors/interventions contribute, the health intervention may be only one of many factors leading to the result. Regardless, and again as illustrated in the example given by Hall et al., there appears to be some agreement on the relationship between an outcome and an intervention, so that identifying the intervention becomes as important as determining the outcome.<sup>35</sup>

A second issue concerns the measurement of outcome and the fundamental need to determine what change (in terms of health) has occurred. In this sense, an outcome

measurement should enable comparative assessments of health status and interventions to be made. Measures of outcome are typically designed to do so and will most often include mechanisms through which nil or negative change can be considered. It should not be assumed that an intervention will automatically lead to a consequential improvement in health. Aligned with the need to measure change are the philosophical and positional debates on the exact meaning of 'change', how this is defined and the relevance of what is being measured to the individual or group of individuals under investigation.<sup>36</sup> Culturally defined notions of health are obviously relevant to the outcomes debate and will continue to influence the assessment of change (these issues are discussed more fully later in this chapter). For now, the requirement to measure 'change' is presented as fundamental to the concept of health outcome.

A third and final feature concerns the health outcome focus (i.e. the purpose of measuring outcome). Within each of the given examples is the assumption that an outcome must measure change as it affects either an individual, group of individuals or a defined population. A health outcome is not concerned with epidemiological illness patterns, prevalence rates, or what policies have been most effective. Neither should it be confused with measuring economic or fiscal performance. Rather, the focus is directed toward the examination of more fundamental health components, the consumer or a larger group at which an intervention is directly targeted.<sup>37</sup> Other definitions of outcome may not prescribe to this view. However, within the context of health outcomes research, a focus on people is a generally accepted principle.<sup>38</sup>

Based on these features or principles, a primary framework (Table 4.8 below) has been constructed. It is designed to be widely applicable and capable of reflecting the diverse environments, situations, and conditions, within which measures of health outcome are developed and applied.

**Table 4.8 Outcome Features**

FEATURE	INTERPRETATION
<b>The Relationship between Outcome and Intervention</b>	An outcome is a consequence of an identifiable intervention or series of interventions. The intervention must therefore bear a relationship to the outcome. Likewise the outcome should be attributable to the intervention
<b>Measurement and Relevance</b>	Health outcome is concerned with the measurement of change, both positive and negative, and in a manner relevant to the those under examination
<b>A Consumer Focus</b>	Health outcomes and outcome measures are consumer focused and are designed to measure outcome as it relates to the health status of an individual or group of individuals

## THE TASK OF MEASURING HEALTH

Health services are the key mechanism through which Government objectives for health are achieved. They have provided treatment-related services, health promotion, education and protection activities, as well as disability support services and care. These multiple services illustrate a three-pronged approach to health care; prevention of illness; treatment of illness; or reduction of the negative effects of any long-term morbidity or disability. The capacity of health services to meet these objectives effectively is determined by numerous factors, many of which are likely to fall beyond the immediate control and influence of the health sector – for example, socio-economic development.<sup>39</sup> As a consequence, it has often been difficult to measure the efficacy of health services or to determine whether or not the activity provided has led to a discernable improvement in health. With such a diverse range of requirements, environments, and situations, it has not been possible to construct a truly generic measure of outcome and, as yet, no tool has been appropriate in every situation or with every individual or group of individuals:<sup>40</sup>

The reason for assessing outcomes will influence the evaluation process and the types of measures used. Also the context in which measurement occurs is different depending on personal characteristics and the social setting of the consumer, and the nature of the illness and associated effects. There will for instance be differences in the concerns of a young person with a severe psychotic illness and a middle-aged woman with depression. The process for assessing outcomes needs to reflect these differences. Service provider and consumer and family perspectives are different and require different measures, but each is vital for a full evaluation. Each perspective can be assessed in a variety of ways, including the use of focus groups, or

individual stories, as well as scales. Group outcomes can also be assessed using demographic variables such as employment and housing types.<sup>41</sup>

Hence a variety of approaches to outcome measurement have been developed at a number of levels. For example, population-based measures of outcome have been used extensively at a policy level and are especially useful when attempting to determine epidemiological patterns, illness trends, or service utilisation patterns. For the most part, the data required are readily identifiable, though not always routinely collated or accessible. For instance, data may be used to determine the outcome of a particular strategy or policy directive, the success of which may be derived from a documented reduction in prevalence or incidence.

Although useful, measures at the population level have been criticised because of a range of primary limitations. For example, it is frequently impossible to establish a clear relationship between the policy and any outcomes that may have resulted. Indeed it may be just as likely that other factors, policies, or strategies, have all played an active role in whatever outcome is identified.<sup>42</sup> , <sup>43</sup> In addition, the information typically lacks the detail required to make a comprehensive and complete assessment of outcome. It can be difficult to determine the net effect of the intervention on the health of the individual or the target population.

Input-based data and measures have also been used as an alternative or complement, and have similarly been popular because of the relative ease with which this type of information can be obtained.<sup>44</sup> , <sup>45</sup> The approach assumes that various input-based

mechanisms or processes can be used as a proxy for determining outcome. Outcome is assumed according to what inputs are provided. At a service level this method infers optimum outcome can be satisfied if certain inputs or activities have taken place at a reasonable level of competency. For the most part health service funding and indeed health policy development has evolved on the assumption that health activity or service provision lead to a measurable improvement in health.<sup>46</sup> Unfortunately, inputs do not in themselves guarantee positive outcomes nor a level of health that can be predetermined. The inherent limitations of all interventions will ultimately influence what outcome can be expected, as will the particular situation/condition of each individual requiring treatment or care. For all these reasons input-based outcome measures have long been regarded as imperfect, though useful in terms of service description and current funding criteria.

Institution or process-based outcome measures, though similar to population-based indicators, refer specifically to the activity of personnel within a service environment, and have likewise been used as a proxy for outcome. Data are usually well recorded and may include information such as client/clinician ratio, frequency of contact, length of contact, or case-mix. As with input-based measures of outcome the assumption is that activity leads to an outcome and that the outcome will be determined by the type of intervention prescribed. While these types of indicators are both useful and necessary, they illustrate a fundamental flaw in that it cannot be assumed that any activity will have a desired result or even results that are consistent and universally applicable. The data may provide information related to a particular illness, for example, the symptoms being experienced

and whether or not an intervention has had an effect; however, symptom reduction should not be confused with outcome as it may not reflect a goal entirely acceptable or desirable from a patient's perspective, particularly if unwanted side effects have resulted. This frequently used aphorism 'The operation was a complete success...unfortunately the patient died',<sup>47</sup> reminds us that process and outcome can be quite different.

A final level at which outcome can be measured is an individual or group-based one. For the most part, measures of outcome have tended to operate at this level as it provides the most reliable means through which intervention and outcome may be linked. At the consumer level, the results of the intervention are directly assessed and usually aided through the application of an outcome schedule or questionnaire. While the problems of assessing outcome may be more effectively controlled at this level, consumer-focused outcome measures can pose significant challenges to both outcome researchers and designers. Importantly, contention abounds as to what aspects of outcome 'should' be measured and the most effective means of eliciting reliable responses.

The framework below provides a summary of the main features of each outcome level, the advantages and disadvantages.

**Table 4.9** Levels of Outcome

<b>Measurement Level</b>	<b>Features</b>	<b>Advantage</b>	<b>Disadvantage</b>
<b>Population-based</b>	Used to determine epidemiological patterns, illness trends, or service utilisation patterns	Data are identifiable, accessible, and routinely collected	Difficult to link the outcome to intervention effectively. Difficult to control for environmental factors. May be some years before outcome is determined
<b>Input-based</b>	Inputs used as a proxy measure of outcome. Various inputs will lead to an outcome	Data are relatively easy to collect, identifiable and routinely collected. Useful in terms of service description and funding	Inputs are an unreliable measure of outcome. Difficult to establish link between outcome and intervention
<b>Institution or Process-based</b>	Personal activity or operation within a service setting	Data are relatively easy to collect, identifiable and routinely collected	Wrongly assumes timely and appropriate activity will necessarily lead to positive outcome. Difficult to link outcome and intervention
<b>Consumer-based</b>	Consumer focused. Designed to measure outcome at consumer level	Intervention and outcome may be more easily linked and assessed. Problems such as environmental factors can be controlled. Tools are more focused and reliable	Difficult to design appropriate tools. Contention about what should be measured

## Consumer-Focused Measures of Outcome – A Preferred Approach

A consumer-based focus provides the most reliable means through which service-related treatment outcomes and effectiveness can be determined. Many of the problems that prevent accurate outcome assessment may be effectively controlled at this level because a more direct link between an outcome and an intervention can be established. Questionnaires, schedules, or surveys are typically associated with consumer measures of outcome and provide a simple and uncomplicated mechanism through which relevant issues can be explored and connections made.

Despite the relative suitability of the approach, one of the more fundamental problems when using consumer-focused measures of outcome, concerns the identification of what should be measured. As a general rule, most consumer-focused tools have been designed to assess a range of health-related concepts, for example, mobility, pain, disability, lifestyle limitations, psychological function/disability, or health perception. Broader multidimensional models have also been developed to assess factors affecting quality of life, and have included social and economic factors, well-being, satisfaction and, more recently, spirituality.<sup>48</sup> The relevance of each dimension will largely be determined by individuals, their perception of health, their particular needs, and the priority they place on what is measured. These issues, though not entirely preventing the development of generic measures of outcome,<sup>49</sup> have raised questions about the validity of consumer-focused measures and their capacity to account for the individual needs of all consumers. This is especially evident in tightly focused schedules and questionnaire-based tools.<sup>50</sup>

In response to these problems, disease-targeted or condition-specific measures of outcome have been developed (e.g., clinical and physiological indicators such as blood pressure or serum cholesterol) that are able to provide greater precision as to the dimensions of health being considered and assessed.<sup>51</sup> However, these types of measures do not easily permit cross-conditional comparisons and are unlikely to account for other, equally important factors, such as disability or pain. The usual response to these issues has been to combine various measures, to enhance existing ones, or to develop new methods or schedules. As a result, a large number of consumer-focused measures of outcome have been developed, each designed to address a particular need or situation, but limited in their application by the narrow range of inquiry.<sup>52</sup>

### **The Problem of Measuring Mental Health Outcome**

All consumer-focused measures of outcome have fundamental problems. These are compounded by a further set of concerns particular to mental health and that make outcome measurement especially difficult.

Most consumer-focused measures of outcome have a clear preference toward self-reporting inventories and a presumption that the consumer is best positioned to document an informed response. Respondents may be asked a range of outcome-related questions, and to rate them according to a scale or other marker. Based on this information, an outcome assessment can be made, health trends established, and/or data potentially combined with other sets or tools to produce a more comprehensive indicator.

The value of this approach is dependent on two key assumptions: First, the tool being used is valid; second, the respondent's answers will be reliable and accurate. The first point has to a large extent already been discussed; it requires that the measure is constructed to a reasonable standard and with adequate rigour and testing. The second point is far more difficult when applied within a mental health context. It cannot be assumed, for example, that all mental health consumers are able to provide a informed response or that they will have a complete understanding of what is being asked. Some mental health problems lead to a distortion of reality and impede judgment. While the ability to make informed judgments is unimpaired for most consumers, it is unreasonable to expect that entirely valid responses will be obtained from all individuals undergoing psychiatric treatment or care.

To address this problem, many 'proxy' measures of mental health outcome have been constructed, often designed as clinical aids and requiring the clinician to assess outcome 'on behalf' of the patient. A lack of confidence with consumer-focused (self-rating) tools provides a reasonable rationale for this. However, the reliability of this approach is dependant on the clinician's ability to interpret accurately the consequences of an intervention, and to do so in a manner relevant to the patient. While in many instances it may be possible, a reliable judgment or assessment is likely to depend on a number of factors, such as the clinician's experience, training, qualifications, level of professionalism, bias, cultural understanding or background. As a result, accuracy cannot

be guaranteed as the assessed outcome will depend on who makes the assessment. Reliability (in terms of repeatability) is therefore likely to be compromised:<sup>53</sup>

...as a psychiatric registrar all of my patients got better, and none of them became worse...officially at least...we'll... you don't expect any clinician to say that their care has been of no value...do you?...<sup>54</sup>

An additional problem concerns the point in time when the measurement of outcome is made. MacBeth notes:

...the identification of outcome requires the selection of a particular point in time at which to label and measure it – the outcome of a surgical operation might be defined either in terms of immediate success or the well-being of the patient six months later.<sup>55</sup>

While this problem is not unique to mental health there are a number of reasons why it is particularly relevant. The mental health system, and especially treatment-related activity, can be divided into a number of steps, grouped, for example, according to service type or client focus. Consumers of these services can also expect to receive a number of treatment and therapy options ideally designed to meet their individual needs. Given the range of options, it has become increasingly difficult to fix an ideal time to measure outcome.<sup>56</sup> Many mental health treatments do not expect immediate results, and it can be a number of weeks, months, or even years before a final outcome can be concluded. Moreover, numerous other factors can influence what outcome might be expected and when it should occur. For example, despite having similar diagnosis and treatment, an

outcome in mental health can be influenced by an individual's age, gender, cultural perception, sexual orientation, severity of condition, or availability of external support mechanisms.<sup>57</sup>

Contemporary approaches to mental health care have posed additional problems. Integrated care plans, for example, have been shown to provide considerable benefits to patients and are now an accepted means through which more comprehensive treatment can be provided in some countries.<sup>58</sup> , <sup>59</sup> Various interventions can also be used concurrently: psychoactive drug therapy may be combined with milieu therapy, psychotherapy and counselling, making it difficult to determine the most significant therapeutic determinant of outcome. While it may be possible to gain an overall impression of whether or not health status has improved, accepted definitions of health outcome require that a more detailed assessment is made and that an intervention, effectively linked to the outcome, is further identified.

As a variety of interventions or processes may have been used as part of the treatment or care plan, it is not always clear what actually caused the outcome, or how much should be attributed to each component. Of greater concern is the possibility that the negative consequences of a particular intervention may have been offset or masked by the gains made through another.

Related to this problem is the impact of other non-treatment-related variables. As noted throughout Chapter 1, mental health problems can be caused or exacerbated by a range of

non-biological contributors, such as abuse, violence, unemployment or inadequate housing. The ability of such factors to influence mental health has additional implications in terms of measuring outcome and determining the effects of an intervention. The previous example described the difficulties involved in attempting to determine outcome when a number of interventions have been applied in a concurrent and integrated manner. Additional problems can also result from the impact of environmental factors, often unforeseen, but potentially able to influence outcome. For example, an individual undergoing treatment for depression may show little sign of improvement despite receiving appropriate treatment. In this instance the outcome may have been 'off-set' by any number of factors that have little to do with the 'formally' administered intervention. It is just as likely that factors linked to the individual's employment status, peer or family support, personal relationships, alcohol or drug use, violence or abuse, would have adversely affected the eventual outcome, no matter how efficacious the treatment. Conversely, a weak intervention may be associated with a positive outcome if supportive environments are in place or if spontaneous remission of a condition occurs.<sup>60</sup>

A final problem associated with the measurement of mental health outcome concerns the clarity and validity of outcome related data. Unlike most physical ailments, a good mental health outcome is not always easy to determine and is less subject to more scientific methods of assessment, such as blood tests or x-rays. For most mental health problems evidence is more likely to rely on subjective impressions, nuances, and observed changes in behaviour. While clinicians are trained to recognise clinical and

behavioural changes, it is often difficult to make an objective judgment or to fully appreciate what changes have occurred.<sup>61</sup> Further problems may also develop as decisions are made about the ‘ideal’ outcome. ‘Cure’ may not always be an end-point. Instead a combination of clinical, behavioural, physical, and social variables may lead to levels of improvement that fall short of the expectations of others. Outcome scales must therefore avoid crude measures such as ‘total cure’ or ‘full recovery’. In short, diagnosis is not a sound starting point for outcome. The following table summarises the limitations of mental health outcome measurements.

**Table 4.10** Mental Health Outcome Measures – Limitations

<b>Limitation</b>	<b>Issue</b>
<b>Patient Perspectives</b>	A patient’s impression of outcome may be distorted as a result of mental health problems
<b>Clinical Perspectives</b>	Clinically applied measures of mental health outcome have been developed to obtain a more reliable impression of outcome. Such tools, however, assume the clinician has a complete understanding of the outcomes produced and is able to fully assess outcome in a manner relevant and acceptable to the patient
<b>Timing</b>	An immediate outcome from an intervention may be unrealistic and it is sometimes difficult to determine when an outcome should be measured
<b>Person Variables</b>	Despite having similar diagnosis and treatment, an outcome may be influenced by age, gender, cultural perception, sexual orientation, severity of condition, or the availability of external support mechanisms
<b>Identification of the Intervention</b>	Numerous interventions may have been applied as part of a comprehensive and integrated treatment plan. Attribution of outcome to intervention will be uncertain
<b>Environmental Contingencies</b>	Environmental factors may have contributed to the outcome, for example, employment, access to support, housing, access to goods and services
<b>Outcome Data</b>	Often difficult to agree on the appropriate level of outcome. Subjective estimates rather than objective determinants

## **CULTURE, HEALTH, AND HEALTH OUTCOME**

A range of factors serve to impede the measurement of health outcome and are enhanced within a mental health context. As a result no truly generic measure of mental health outcome has been constructed.<sup>62</sup> Although a number of different schedules and tools have been developed they have typically targeted particular areas, conditions, or population groups. Very few have attempted to consider health outcome from a cultural perspective, even though there is now a well-established relationship between culture and health and an awareness of culturally bound perspectives of health and well-ness.<sup>63</sup>

Culturally determined views of health and well-being have particular implications for the reliability of schedule-based, consumer-focused measures of health outcome. Two particular difficulties can arise. First, a schedule assumes that the questions posed are fully understood by the respondent and that they are unambiguous in their interpretation. Second, it is assumed that these questions in fact consider aspects of health and outcome that are relevant to the respondent. As measures of outcome are fundamentally designed to consider what is important or relevant, they can be biased toward the designers preconceived notions of relevance.

A number of authors have written about the nature of health perception and how both the physical and psychological signs of illness can be interpreted very differently according to ethnicity,<sup>64</sup> gender,<sup>65</sup> social networks, and religion.<sup>66</sup> In New Zealand, others have drawn the link between Māori culture and health perception, noting that health outcome

preferences will be influenced, if not determined, by an individual's concept of health and the cultural position:

An elderly Māori who is overweight, breathless on exertion and prone to gout, may be seen by himself and his community as healthy because his whānau (family) relationships are mutually rewarding and he maintains a sense of harmony with the wider environment.<sup>67</sup>

Given the importance of culture to health it is not difficult to understand how some schedules may be inappropriate, especially where the cultural background of the respondent does not match that of the tool's designer or their concepts of health, wellness, or outcome. For example, the following question may be used as part of a health outcome assessment to determine the result of a hip replacement:

...as a result of the procedure are you now able to walk round the block ?

A sequence of options – 'Much Better', 'Better', 'The Same', 'Worse', 'Much Worse' may also be offered, and used to produce a measurable response. At face value the question and response options appear simple enough. The outcome is related to the intervention, a range of responses are offered (including the option of a negative outcome), and it can be assumed that the respondent's judgment is not unduly impaired. However, this example illustrates the futility of making any assumptions without considering how measures may be perceived and especially where there is a cultural divide between the respondent and the tool's designer.

First, the question makes the assumption that its interpretation will be unambiguous, that it is clearly expressed, presented, and understood. It assumes that ‘everyone’ is able to appreciate that a ‘block’ is a standardised measure of distance. Unfortunately, in certain countries the distance applied to a ‘block’ can vary according to geographical location, local bylaws, or historical arrangements. Further, the example does not take into account variations in climate (hot and humid, cold and wet) or terrain (flat or hilly) both of which can impact on how the question is interpreted in a given situation. A recent study alluded to these types of problems and how language and concepts of health may be perceived or expressed. The study, *Oranga Kaumātua*<sup>68</sup> involved a comprehensive assessment of the socio-economic, cultural and health status of 400 kaumātua (elders) using a variety of measures, including a health outcome questionnaire, SF-36.<sup>69 , 70</sup> Particular attention was given to the research methodology and the requirement to conform with accepted Māori research practice. While various cultural protocols, practices, and procedures were observed, a dilemma arose over the appropriateness of the assessment tool and the manner in which SF-36 would be interpreted by the respondents. It was expected that while all could speak English, questions remained as to the interpretation of the tool, not only where the respondents first language was Māori but also where cultural norms were at odds with SF-36 norms.

As a consequence, a number of modifications were incorporated into the questionnaire. The original questionnaire was translated into Māori and was designed to ensure that none of the questions would be misunderstood if described only in English. Māori

speakers were recruited to administer the questionnaire, to explain difficult or confusing questions, and to assist with any other issues. Show Cards were also used to clarify the questionnaire.

*Oranga Kaumātua*, while successful in meeting its broad goals, highlighted concerns over how questionnaires and schedules are interpreted, particularly by Māori. The experience gained from the study suggested problems relating to interpretation, especially as many of the interviews took far longer than anticipated, some respondents finding it difficult to understand what was being asked. Moreover, differing perspectives of health became apparent when respondents rated their health high, despite multiple medical problems.<sup>71</sup>

A second issue is related to the relevance and significance of what is being measured. An outcome tool should ideally measure aspects of health important or necessary to the recovery of an individual. It has also been noted that while some generic outcome principles can be devised, cultural or philosophical bias will often limit the extent to which broader notions of outcome can be explored. The example used earlier attempts to measure outcome by assessing an individual's ability to 'walk around the block'. The question is obviously designed to measure mobility and whether or not this has improved as a result of the surgery. Although the utility of the question may be determined by the manner in which it is interpreted, the question also makes an assumption that this type of activity is of 'equal' importance to all respondents. That is, they will all view the activity with a similar degree of enthusiasm or priority.

As an illustration, and as part of this investigation, an elderly man was asked to consider the example and to hypothetically assume that he had recently undergone hip replacement surgery. Two questions were posed to him. First 'do you understand what is being asked?' His response, as expected, was 'Yes'. The second question required a slightly more detailed answer 'e koro...what do you think of this question?' His response was as follows:

OK... I suppose... but why would I want to walk around the block for?...I never do that...too long...anyway, seems a bit silly...I got my car outside for that.<sup>72</sup>

Assessing outcome by determining an individual's ability to walk around the block is somewhat less useful than may be expected. The koroua had no desire to walk around the block, nor was this activity important to him. Moreover, 'the block' in his rural area (Poroporo) was a distance of some 15 kilometres. Perhaps a better and more relevant question would have been to assess his ability to stand for a given length of time, something he is often required to do on his marae and when welcoming visitors.

## **A FRAMEWORK FOR MEASURING MĀORI MENTAL HEALTH OUTCOMES**

The discussion thus far has provided an introduction to the field of outcome measurement, and has described the key parameters and requirements through which measures of outcome can be constructed. Based on these findings, and as a result of the research process, a framework for measuring Māori mental health outcomes was constructed. The framework incorporates five principles, three key stakeholders, four domains of outcome (based on a Māori model of health), and the concept of clinical endpoints.

### **FIVE PRINCIPLES OF OUTCOME**

Measures of outcome are typically developed with a particular need or purpose in mind and are based on clearly defined goals or objectives, more often than not formulated through an analysis of specific requirements, applications, or any number of other obligations, restrictions or caveats. The broad parameters are important, since they also give some shape to the philosophy that underpins the measure. In this study, five guiding principles have been distilled as a basis for locating the measure within a particular context. For many of the Māori interviewed in connection with an outcomes framework it was important that the proposed instrument had an 'arahi',<sup>73</sup> a mechanism through which the broader intentions and objectives of the investigation could be considered. Aside from the technical requirements of the framework, a Māori measure of mental

health outcome would need to be underpinned by a set of more fundamental principles in order to give a sense of direction and at the same time a firm anchor.

### **Principle 1: The Principle of Well-ness**

The public perception of mental illness has never been entirely positive. For much of the last century, institutions for the care of the mentally ill were deliberately situated in isolated locations away from any major settlements or contact with the wider community. As a consequence many hospitals became self-supporting, and largely independent, showing little perceived need to engage with the outside world or its various communities.

The development of new and more effective psychotropic drugs in the 1950s corresponded with an increased awareness and understanding of the nature of mental illness. As a consequence, a greater range of treatment options could be used and there were increased opportunities for patients to be reintegrated back into mainstream society. Since then, the process of deinstitutionalisation has led to a policy of community care with an increasing de-emphasis on hospitalisation as the major therapeutic intervention. No longer is it accepted that mental health consumers should be locked away, that isolation is the best form of treatment and that recovery is the preserve of a select few:

...People with mental illness remain significantly disadvantaged by discrimination; prevention and early intervention services are still lacking in many places; and the recovery approach needs to be more widely understood and used.<sup>74</sup>

The principle of 'well-ness' is fundamentally associated with the new approach to care and treatment, an appreciation that more effective treatments are now available, and a realisation of the potential for consumers to lead full and rewarding lives. From a cultural perspective, the concept of 'well-ness' is also important and is linked to more traditional notions of health care and service provision. Discussions and interviews with selected experts in Māori mental health raised concerns about the structure of the mental health sector and the failure of present mental health facilities to meet the needs of tangata whaiora. Services often contributed to the access difficulties experienced by Māori, and to a reluctance to seek care soon enough. A key concern was linked to a Māori perception that mental health facilities were out of touch with Māori views of health, especially when they imposed distance between consumer and whānau.

By constructing a more positive philosophy and outlook toward mental health care, it was expected that the problems associated with access could be reduced and longer term gains achieved. Further, the Māori experts distinguished between recovery from an ill-ness and the attainment of well-ness. While psychiatric treatment seeks to remove symptoms, Māori interest centres on a more basic state of well-ness. In other words, according to the Māori respondents, the shift from institutionalised care to community care needed to be accompanied by a shift from symptoms and syndromes to a focus on well-ness. In this respect the principle of well-ness is more ambitious than the principles of recovery and care. Well-ness is less concerned with classification and diagnosis – which still tends to dominate modern psychiatric practice – but is more concerned with subjective well-being

and quality social functioning. The goals are different and the end-points are correspondingly premised on different criteria:

...the mental health system [needs to] ensure Māori priorities have equal consideration in the mental health sector [and to] develop and implement a process that measures the quality of service which tangata whaiora receive [and to] identify what contributes to the well-ness of tangata whaiora.<sup>75</sup>

## **Principle 2: The Principle of Cultural Integrity**

The second principle embodies the idea that a cultural measure of outcome must have an appropriate cultural foundation, derived from a relevant philosophical base. The principle of 'cultural integrity' affirms this idea and emphasises the role of culture within a mental health setting.

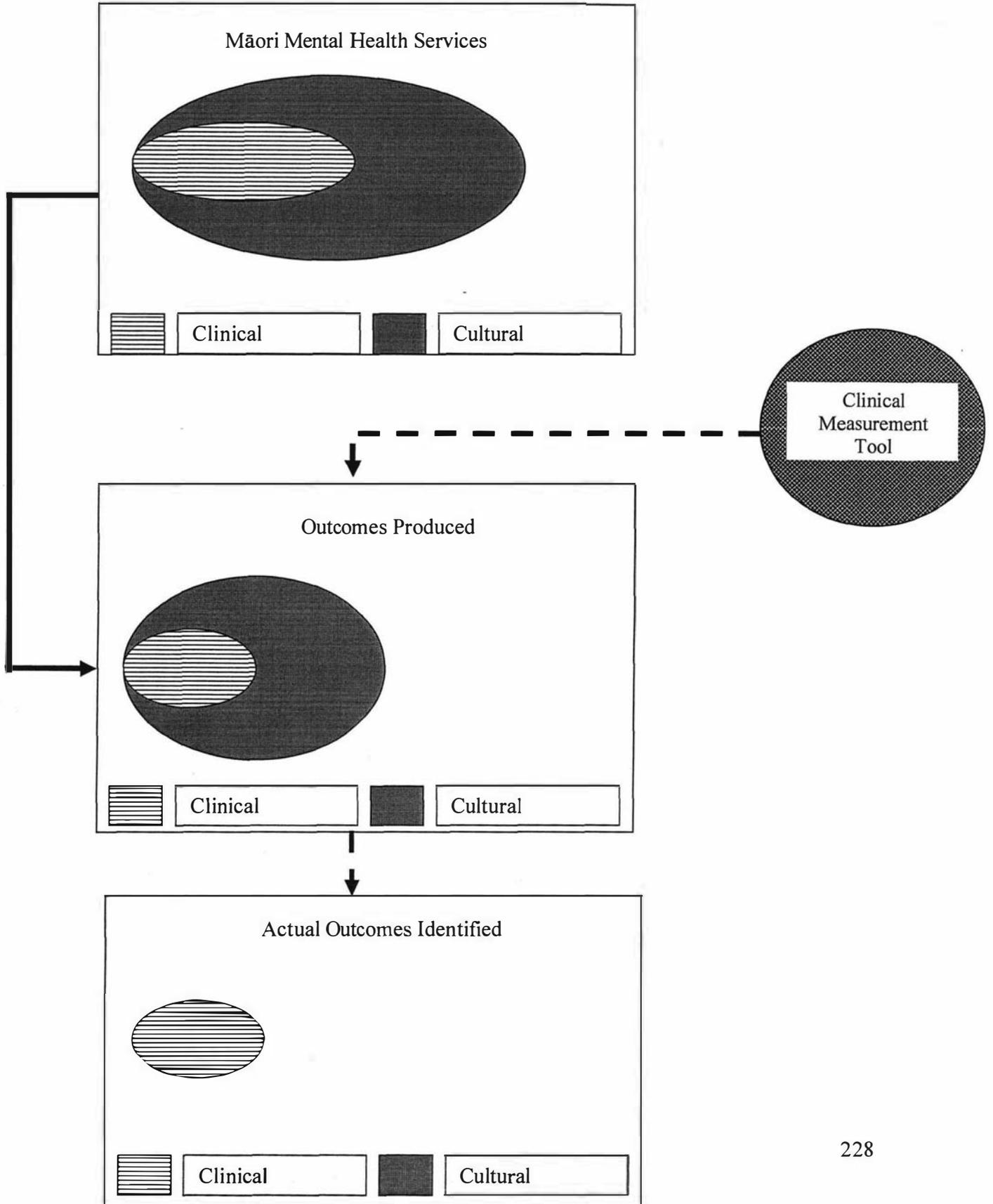
Many of those who took part in the interview process described outcome in terms of service activity and the uniqueness of Māori-designated mental health services. The participants maintained that Māori services often promoted outcomes that were fundamentally different from that which could be expected or identified from a mainstream provider. Such outcomes were seen to have a positive impact on tangata whaiora but were in many respects difficult to quantify, yet conservative outcome measures were not able to capture the added dimension that tended to characterise Māori mental health services:

Māori have not actively sought to apply outcome measures and have expressed some concern as to the validity of measures which do not reflect Māori concepts of health, well-ness, and outcome.<sup>76</sup>

Performance measures must have the capacity to include all the range of achievements and results produced by Māori mental health services. Performance measures developed on Western based paradigms are unlikely to fully appreciate many of the concepts and activities which are crucial to recovery for tangata whaiora; not taking these issues into account places Māori mental health services at a distinct disadvantage, particularly when seeking further funding and endorsement of their particular approach.<sup>77</sup>

The principle of ‘cultural integrity’ addresses these concerns. At a service level the application of the principle means that culturally aligned interventions can be assessed according to improvements in outcome so that the impacts of culture can be factored in to the result. The following schema highlights the issue. The top box broadly considers the types of interventions that may be provided by a Māori mental health service – where both cultural and clinical interventions are applied. The box below shows the types of outcome produced from this activity – and as illustrated, both culturally and clinically derived outcomes have been produced. However, the measurement tool lacks the capacity to measure those features of outcome that are culturally aligned. Therefore, the outcome identified is incomplete and does not reflect the full range of outcomes produced by the service – the assessment of service efficacy (in terms of outcome) is therefore imperfect.

Figure 4.1 Cultural and Clinical Outcomes



### **Principle 3: The Principle of Specificity**

Service components promoted for Māori mental health tend to be conceptual, and lack the level of measurable specificity as service components proposed for other mental health priority areas.<sup>78</sup>

The third principle, ‘specificity’, is linked to the particular emphasis necessary for an outcome measure. First, targeted or specific measures of outcome are required according to the type of intervention under consideration. The corollary is that no measure will be suitable in every situation. ‘Specificity’ also affirms the principle of ‘cultural integrity’ in so far as the clients being assessed have a particular cultural orientation. As a final point, ‘specificity’ highlights the need to locate a point in time at which to measure outcome. In terms of mental health outcome measurement, this requirement is particularly troublesome as treatment and care embrace a number of distinct and sometimes not so distinct phases that may collectively last for months or years. The precise time at which to measure the treatment outcome is therefore important.

### **Principle 4: The Principle of Relevancy**

The principle of ‘relevancy’ is linked to both the ‘cultural identity’ and ‘specificity’ principles, and has two important components. The first is relevance to those who choose to use the instrument. In recognition of the diversity of Māori cultural identity, assumptions about cultural understanding and perception should not be made, and may only serve to further alienate those Māori whose cultural experience is inconsistent with the philosophies on which the measure is based. Māori service staff and tangata whaiora were especially adamant in this regard, noting that while it was important that services

for Māori were based on Māori philosophies of care, it was just as imperative to consider the manner in which these processes were applied. A typical comment was:

Our service is based on a kaupapa Māori philosophy. Our staff are familiar with this and we organise our work around it. Many of our clients are, however, not as comfortable in Māori settings as you would expect, but on the other hand some are. As a result we have to be careful in how we express or apply these processes in a treatment setting. For some, they may benefit from a full on Powhiri, while for others this may just make them worse. I'm not saying that we should restrict these processes to only those Māori who speak [Māori language]...what I mean is that different levels of input will be needed so as to meet individual needs.<sup>79</sup>

In terms of outcome measurement, the tool will need to appreciate and consider adequately the diverse manner in which culture and outcome is linked, understanding that culturally derived outcomes will only be important if they are relevant. It cannot be assumed therefore that all Māori will have the same degree of cultural experience or that their understanding or interpretation of cultural issues will be the same.

The second aspect of the 'relevancy' principle highlights the need for a tool that is valuable in a range of different situation. Although mental health consumers will remain the prime focus, clinicians, service providers, funders, and policy makers are just as likely to appreciate the results. To be of most use, measures of outcome should be relevant to a range of sectors, organisations, and indeed health workers.

## **Principle 5: The Principle of Applicability**

The difficulties and limitations associated with health outcome measurement has led to the development of a large number of tools or instruments. The reasons for this are not always clear but are likely to be associated with the environments within which they operate and the limitations inherently part of any measure of outcome. To be useful, an outcome measure must be applicable to those who choose to use it, to the context within which mental health services operate, and to Māori cultural preferences. It must be easily administered, unobtrusive, and not overly complicated. It should not place any unreal demands on clinical time, or involve additional staff.

In discussions with clinical workers and past users of outcome measures it was frequently stated that the complexity and time associated with administering tools played a major role in the reluctance to use them on any regular basis. For many, administrative duties, meetings, training, and monitoring requirements, had been the cause of much frustration and reduced the amount of time they were able to commit to treatment and care-related activities. It was recommended that any measure of health outcome would need to be relatively easy to administer and interpret, and, most important, ‘quick’.<sup>80</sup>

## **THREE KEY STAKEHOLDERS**

Consumers have, to date, had little say in what measure are used to assess them, and for what purpose. Nor have they had adequate opportunity to contribute to what they believe to be dimensions or domains of significance.<sup>81</sup>

A lack of confidence with self-reporting outcome inventories has prevented their wide application within the mental health sector, and to a large extent proxy measures of outcome have been preferred. The proxy approach appears to stem from clinical concerns about the ability of mental health consumers to document an informed response and the potential for their impressions to be distorted because of their illness. However, the premise upon which these assumptions are made is too sweeping. It is unreasonable to assume that ‘all’ consumer impressions will be inaccurate or that this will remain so all the time and for the duration of their treatment. Indeed, throughout the sector there has been an increased awareness of the value of consumer input, especially in terms of service development and policy formulation.<sup>82</sup> Yet there remains some uncertainty as to the exact role and function of consumers within a treatment setting and their capacity to assist in guiding treatment activity. Regardless, it is generally assumed that consumers should contribute to their own care and that outcomes should be measured in terms that are relevant to them:

A recent review of mental health outcomes recognised the unfolding development of this complex field. There are no simplistic solutions. Key requirements must, however, include a conceptual framework recognizing the theoretical and real issues affecting those with mental health problems and disorders; the social-political contexts of mental health care and the need for attention of outcomes with these contexts and information systems infrastructures; but most importantly true partnership with consumers for their outcomes – not ours.<sup>83</sup>

Throughout this study concerns about consumer participation – or the lack thereof – were shown to be the cause of considerable frustration. On the one hand, a clinically focused ‘proxy’ approach to outcome measurement seemed valid and was in fact in line with established practice. On the other, was the need to appreciate changes within the sector, overall improvements in care, and a growing awareness of the important role of mental health consumers as key stakeholders in the treatment process. Linked to this was a cultural dimension and Māori approaches to care that have tended to emphasise the role of consumers.<sup>84</sup>

A consensus view failed to emerge and as such a universally accepted approach remained elusive. The reasons for this were essentially related to the reliability of the two identified approaches and to the fact that both the clinical and consumer-based methods had substantial and to some extent unacceptable shortcomings.<sup>85</sup> Proxy measures of outcome appeared to be the standard, and although it was generally agreed that consumers should have some input into the assessment process, the extent of input was uncertain. The central issue concerned the perceived difficulties associated with adopting a self-reporting schedule as a basis for a framework. For many, the anticipated complications far outweighed any perceived benefits, yet at the same time it was acknowledged that tangata whaiora provided the foundation upon which most Māori mental health services were based. A typical comment was:

...the thing that makes us [kaupapa Māori mental health services] unique is the manner in which we relate to tangata whaiora. I worked in a mainstream environment for many years and it was

totally different...they were just patients. Here they are people, they are whānau, we respect them, and they respect us.<sup>86</sup>

The net results of these discussions eventually led to the conclusion that reliance on only self-reporting or proxy measures of outcome would be inappropriate and that ideally some type of compromise should be attempted. From a clinical perspective it was difficult to see how a self-reporting inventory could be validated, yet there remained a fundamental requirement to incorporate consumer input within the process:

The involvement of consumers and carers in planning outcome assessment studies is vital...There was poor convergence between consumers' and service providers' assessments. This highlights that the assessment of mental health status is not straightforward, and any assessment process requires the contribution of the relevant stakeholders, wherever possible.<sup>87</sup>

As an initial step, a parallel approach was adopted, whereby a measurement framework would be constructed on the premise that a schedule or mechanism would somehow consider both perspectives. However, this compromise was again imperfect as initial reviews suggested difficulties with respect to an anticipated divergence of opinion and the unlikelihood that the views expressed would correlate with each other. To counter this, a weighting system (emphasising the position of the clinician) was suggested, but sat uncomfortably with cultural notions of consumer enhancement.

As a final compromise it was proposed to introduce a third key stakeholder into the equation. As noted, it is often difficult to measure outcome because factors external to

the formal treatment process are likely to influence whatever outcome is identified. For the most part it is impossible to take all potential contingencies into account because they are often too broad and frequently undetectable.<sup>88</sup> However, through a selected perspective the impact that environmental factors have on mental health outcome can be considered. For this reason it was decided to include a whānau perspective within the framework as an integral part of the measurement approach. The assumption was that whānau would be more aware (than clinicians) of environmental factors, and make allowances for these. They would also be able to straddle cultural and social concerns.

This approach was based on the idea that family members could contribute to the outcome assessment process and had the capacity to determine whether or not an intervention had contributed to the well-being of their relative. In line with deinstitutionalised care, whānau were more likely to provide care to relatives, albeit informally, and moreover were capable of monitoring health status as well as the impact of non-treatment-related variables such as alcohol or drug use. Formal interventions could therefore be considered alongside other non-treatment related contingencies.

The inclusion of a whānau perspective was also influenced by a cultural dimension and the importance of whānau to Māori concepts of health:

Whakawhanaungatanga was constantly emphasised as the basis for healing and the means of interconnectedness for Māori. Whānau participation can be particularly useful at the assessment stage and in furnishing a more accurate picture of the pressures that impact on the person.<sup>89</sup>

By providing such a perspective the cultural uniqueness of the framework could be expressed and aligned with the body of evidence that supported the inclusion of whānau within the treatment process.<sup>90</sup>

The inclusion of the whānau dimension was also justified on technical grounds. Each key stakeholder brought a unique and distinct perspective to the outcome assessment process. But each had some inherent limitation. By having three contributors to outcome assessment, a triangulation of sorts would be created, avoiding the need for a complicated system of weighting. This method, although not perfect, seemed appropriate, and offered a suitable mechanism through which alternate views of outcome could be considered.

## **MĀORI MODELS OF HEALTH**

The definition of outcome, in all its full dimensions noted in both the long and short document, misses the concepts essential to Māori health outcome. Māori can offer new words which better reflect Māori health outcome (such as wairua, mana motuhake, loss of tino rangatiratanga etc) but the problem is still one of Māori being asked to 'fit' their concepts into what is essentially either a medical or economic model...The hui offered many words and ideas which would encompass a Māori view of effectiveness or outcome. However there was a negative feeling about just 'fitting' their Māori world view of health into the principles as they existed at present. It was in this area that the belief that 'starting again' with definitions might be the only way. The proposed process as it is currently structured may not adequately include the Māori view of health, health outcome and need (including provider and workforce development).<sup>91</sup>

Measures of health outcome are often criticised for their failure to measure relevant or important aspects of health, especially when considered from consumer or cultural points of view. Complicating such concerns is the fact that 'health' is not easily or universally defined and will often mean different things to different people.<sup>92</sup> For some the notion of health is linked with illness, its absence, or whether or not disease has prevented or impeded normal functioning. Others may draw comparisons with ideas that are far more non-descript, linking health with the wider environment, spirituality or personal contentment.<sup>93</sup>

In order to grapple with the range of views, various models of health have been produced and, for Māori, have typically emphasised notions of holism and the idea that health cannot be considered without taking into account, for example, the environment, links with the past, or obligations to future generations. However, the purpose of such models is not to define health, but to describe how it may be viewed or the principles on which Māori concepts of health are based. Models provide the flexibility through which relevance can be applied or considered by a broader group of individuals or situations. To this end, many are 'purposefully non-descript', fluid and designed for dynamic interpretation. In this regard they provide a base from which to view Māori concepts of health from both a mental health and outcome perspective.

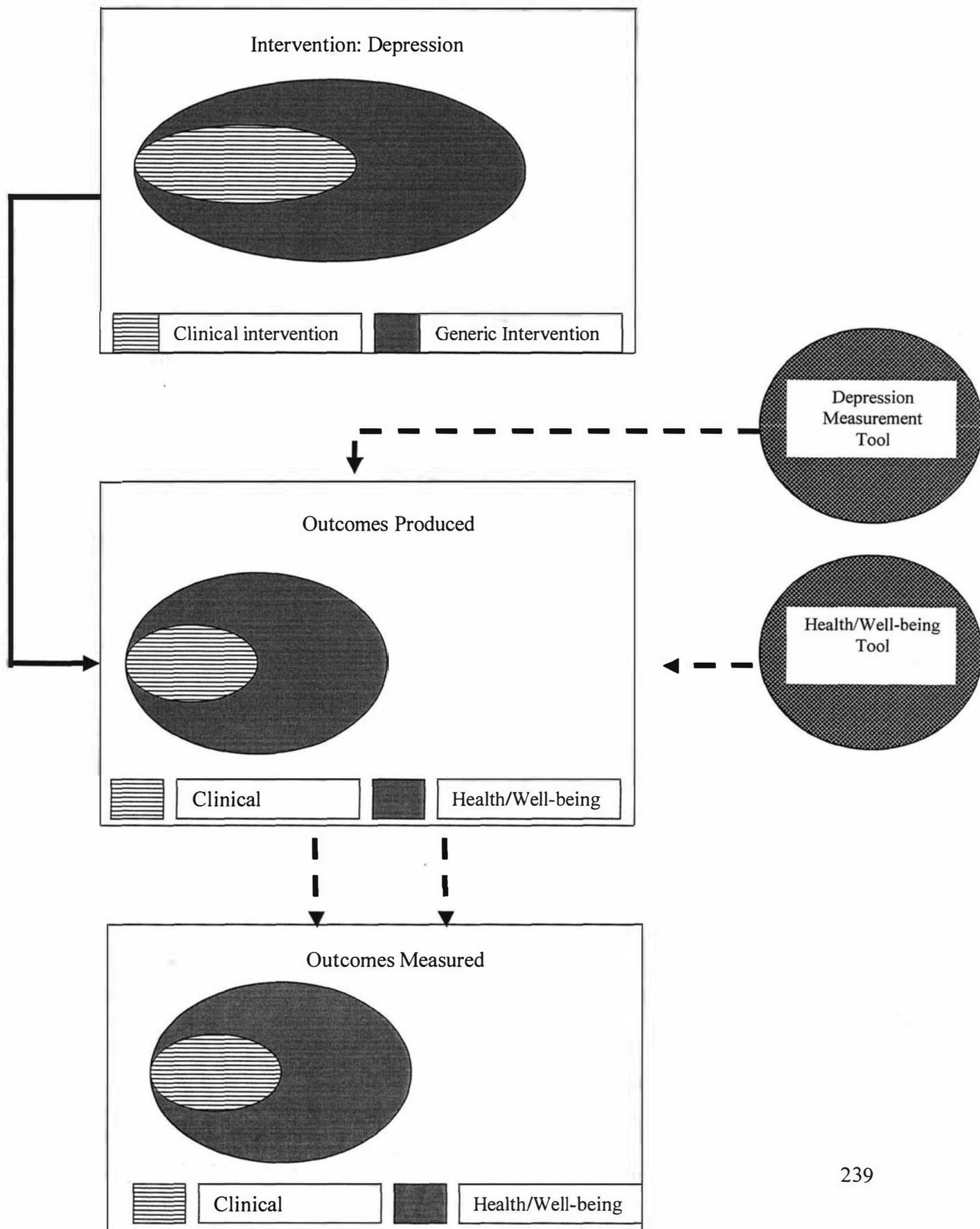
The central issue, concerning this study at least, is how to create a schedule or instrument capable of measuring mental health outcomes relevant to Māori. Though difficult in itself, such a problem is further complicated by the diverse nature of contemporary Māori

society, and the fact that individual perceptions of outcome are likely to vary anyway. Moreover, there is the problem of how to create an instrument that is suitable within a range of clinical environments, for example, an outcome measure just as suitable for Māori clients with schizophrenia as it is for those with a manic-depressive disorder, or for clients who are outpatients or inpatients.

While the application of a Māori model of health could potentially solve the problem of what to measure, suitability across a range of conditions was far more contentious. Certainly, a schedule could be constructed from a model designed to elicit outcome-related preferences that were both culturally aligned and relevant to a particular psychiatric condition. However, such an approach would require the construction of an endless array of instruments designed for specific clinical situations or service environments. To overcome this, a further series of expert consultations was undertaken, as well as a re-examination of literature. Eventually it was decided to construct a generic instrument, a broad-based tool that could be applied to any clinical situation. Further, and in recognition of the need for a more specific instrument, it should be able to complement existing, but more clinically focused measures. The schema that follows (figure 4.2) is used to illustrate this point:

Numerous clinical instruments already exist and a lot of them are very good. It seems pointless to construct a cultural measure which duplicates these...it seems far more reasonable to construct a single generic measure to complement these...if an individual is suffering from depression, use an established clinical measure, but complement it with a tool designed to consider culturally derived preference, if they have schizophrenia, same thing...<sup>94</sup>

Figure 4.2 Generic Outcome Assessment



Although controlling for the need to construct an array of measures there still remained the requirement to apply a model of Māori health in a manner that met the conditions of the outcome framework. Two main issues were of concern. First, the identification of an appropriate model, and second applying the model.

Addressing the first problem was made easier by the literature available and the fact that information pertaining to Māori models of health was readily available. Although a number have been promoted, four models in particular have gained a degree of popularity and wide acceptance.<sup>95</sup>

The first is *Te Whare Tapa Whā*, often described as the four cornerstones of well-being, and originally developed by Durie during the early 1980s.<sup>96</sup> The model is consistent with other holistic definitions of health<sup>97</sup> but is unique in that the notion of holism is placed within a Māori-specific context. Four components are compared to the four walls of a house, each playing an essential and complementary role and providing the necessary means by which a sense of total health and well-being can be maintained. Each component is therefore linked to the others and cannot be considered in isolation. In this model, a physical health problem would not be viewed from a biological perspective alone but the mental, spiritual, and family dimensions associated with the problem would also be considered. The framework that follows illustrates the main features and components of the model.

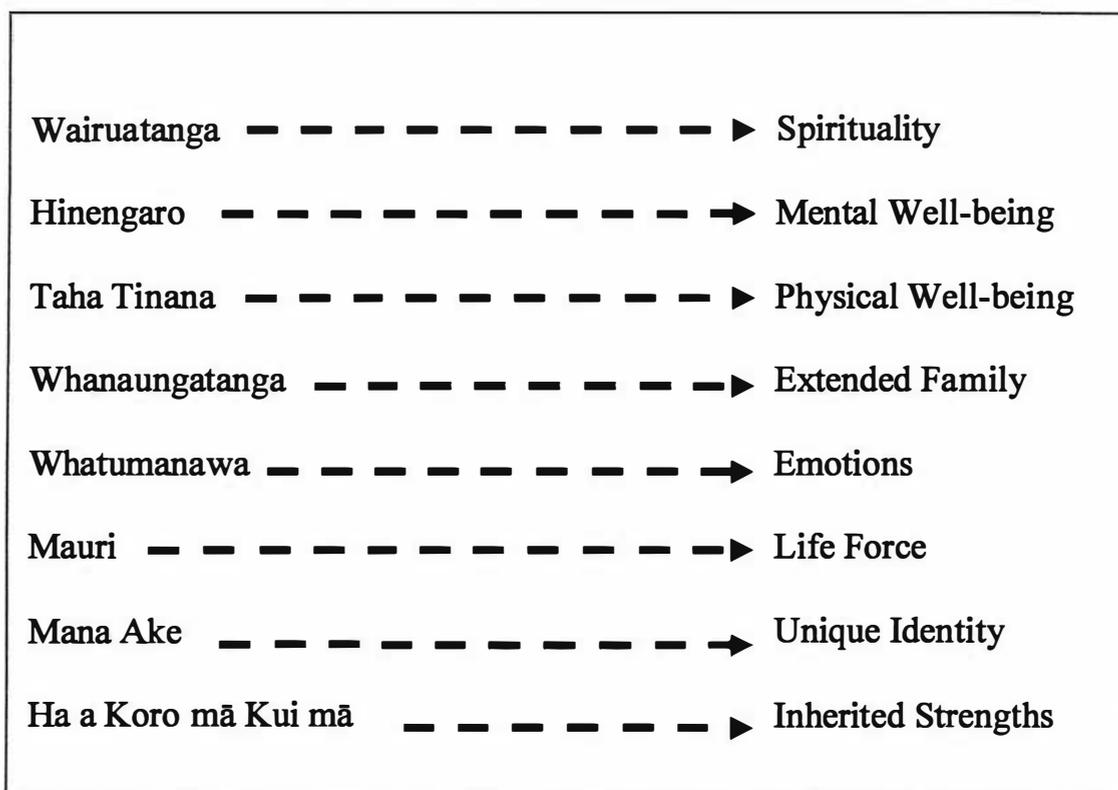
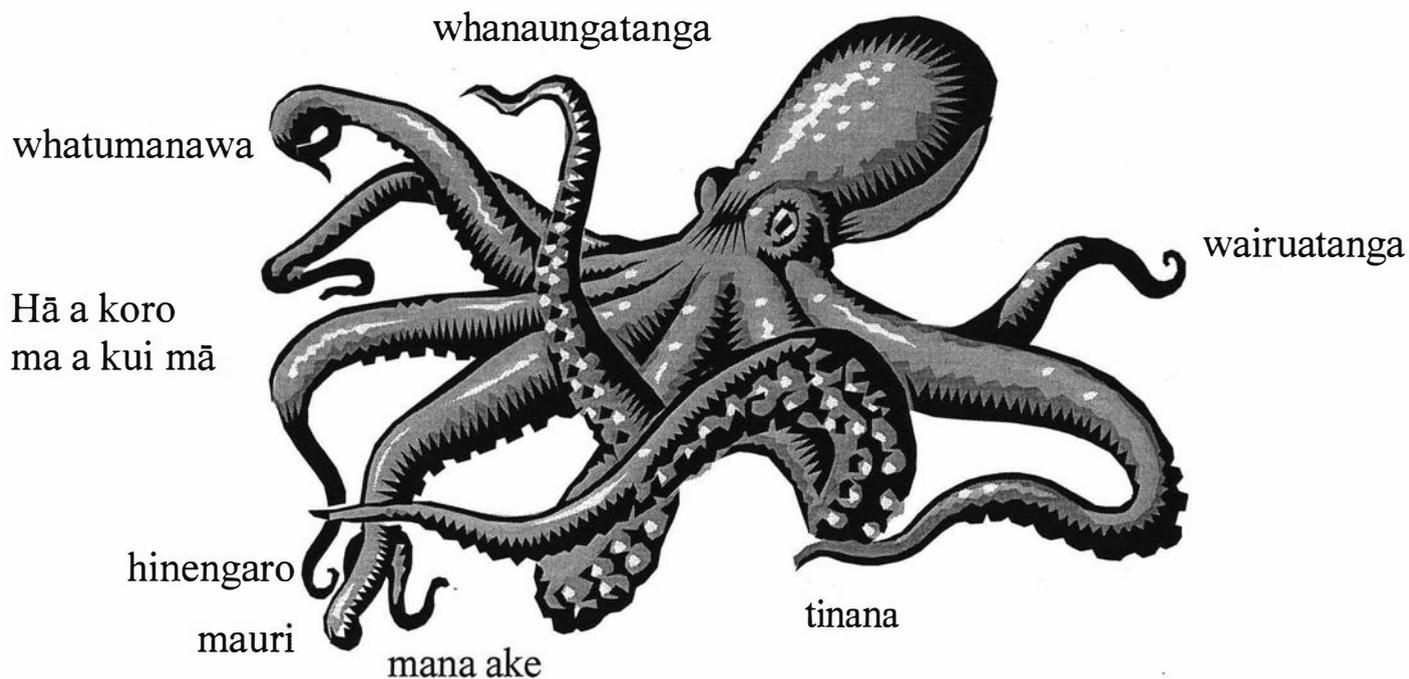
**Table 4.11** Te Whare Tapa Whā Model

	<b>Taha Wairua</b>	<b>Taha Hinengaro</b>	<b>Taha Tinana</b>	<b>Taha Whānau</b>
<b>Focus</b>	Spiritual	Mental	Physical	Extended Family
<b>Key Aspects</b>	The capacity for faith and wider communication	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
<b>Themes</b>	Health is related to the unseen and unspoken energies	Mind and body are inseparable	Good physical health is necessary for optimal development	Individuals are part of wider social systems

*Source: Durie, 1995: 71*

*Te Wheke* (The Octopus) was developed as a model for health by Pere in 1983 and was first presented at the Hui Whakaoranga.<sup>98</sup> Like te whare tapa whā it considers Māori health in holistic terms but has eight rather than four components, each also designed to work in a complementary and interdependent manner. These are illustrated below:

Figure 4.3 Te Wheke



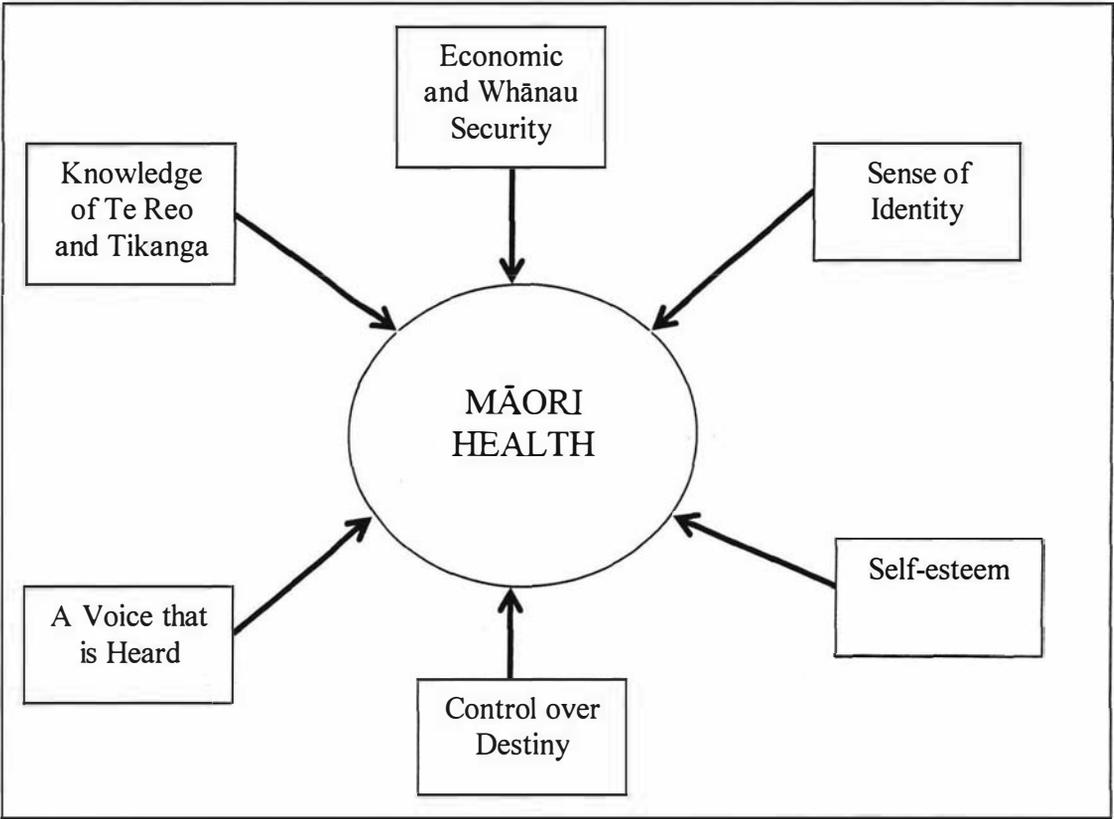
*Ngā Pou Mana*, was developed as part of the Royal Commission on Social Policy proceedings in 1988.<sup>99</sup> The model states that for an individual or group of people to be healthy the appropriate social and economic policies must be in place. These policies must also recognise the importance of whānaungatanga (extended family), taonga tuku iho (cultural heritage), te ao turoa (physical environment), and turangawaewae (source of identity). Like the two previous models, the concept of holism is promoted, but in this case from a more global position. The schema below describes the relationships:

Figure 4.4 Ngā Pou Mana



*The Fourth Model* was devised by Te Puni Kōkiri and first presented at the hui Te Ara Ahu Whakamua, in 1994.<sup>100</sup> The model is in many ways consistent with the previous three and is again targeted at the broader social and political environment. It highlights the importance of Māori identity, economic security, te reo and tikanga, control, self-esteem, and acknowledgement.<sup>101</sup>

Figure 4.5 Te Puni Kōkiri - Te Ara Ahu Whakamua



## **Selection of an Appropriate Model**

It was expected that any one of these models could be placed within an appropriate context and utilised for the purposes of this study. However, and on the advice of key informants, it was recommended that only one be selected, and that some formal selection criteria be established. From this, four requirements were subsequently identified.

First, the model would need to be widely accepted and viewed as a reliable model of Māori health. Second, it would need to have a place in the discourse on Māori mental health services and intervention processes. Third, it should, as much as possible, be consumer focused though designed to incorporate the perspectives of the three key stakeholders. Last, the model would need to be relatively simple, noting the principle of 'applicability' and the reality that many measures are not used because they are too complicated or impractical.<sup>102</sup> Based on these requirements, a checklist was developed along with a four-point rating scale - four being most suited, one being least suited. Through interviews and a review of literature (described in the following section), the researcher was able to make an informed assessment of each of the four models and to number them accordingly.

Table 4.12 Comparison of Māori Models of Health

	Te Whare Tapa Whā	Te Wheke	Ngā Pou Mana	Te Puni Kōkiri, Te Ara Ahu Whakamua
Wide Acceptance	4	3	2	1
Consumer focused	4 =	4 =	1 =	1 =
Suitable to Mental Health	4	3	2	1
Simple	4	3	2	1
Totals	16	13	7	4

### Te Whare Tapa Whā: A Suitable Model

It is important to note that any of the models described might have been suitable to reflect Māori health concepts, but, and based on the requirements of the investigation, te whare tapa whā was identified as being ‘most’ suitable. The ratings for this are shown in Table 4.12 above. However, the rationale is described below in greater detail.

The ranking of each model from 1 to 4 was designed to provide a clear set of selection criteria. As indicated, however, the numbers assigned to each model was largely interpretive and based on interviews with Māori mental health service providers<sup>103</sup> as well as a review of literature. The review of literature was a relatively simple process and involved gathering written material on Māori models of health and health care practice. The interview process was designed primarily as a complement and as a means of providing greater emphasis on mental health issues. This process allowed the researcher to gather a broad impression of the models and to assign a number in a more informed manner.

The analysis of the interview data revealed that of those who identified a particular model(s) more than 80% referred solely to te whare tapa whā. In addition, 100% mentioned it in some context, or in association with others, such as te wheke or ngā pou mana and, with one provider, a new model called 'te tuakiri'.<sup>104</sup> This evidence was important in two key respects. First, it certainly appeared that the model was widely accepted as a valid representation of Māori health. Second, the model was already being actively applied within mental health treatment settings.

The review of literature further supported the application of te whare tapa whā, many documents noting its utility in terms of mental health treatment. Indeed, Whaiora (one of the first Māori mental health services/units), based its entire philosophy of care on te whare tapa whā.<sup>105</sup> Numerous more contemporary examples were also uncovered, some making explicit link to outcome and performance applications:

While the whare tapa whā model of health has not been subjected to rigorous evaluation, its similarities with the SF-36 approach indicate that operationalisation is possible. The eight dimensions of SF-36 contain a range of health measures: general health, mental health, physical functioning, social functioning, physical role limitations, emotional role limitations, vitality, and bodily pain. Each of these has implications for the four aspects of whare tapa whā. Although there is no clear dimension which is immediately transferable to spiritual health, the vitality dimension does have some relevance to taha wairua; taha hinengaro is reflected in the mental health scale as well as in the social functioning and role disability scores; taha tinana is measured by the physical functioning and the bodily pain scales while taha whānau is closely aligned to both of the role limitation scales and social functioning.<sup>106</sup>

Subsequently the Mental Health Commission's consultations supported the choice:

The hui indicated that there was a need to develop effective outcome measures for how well a service had improved the health of Māori with a mental illness. It was recommended that these performance measures should be based on the *whare tapa whā* model of health... The outcome measures go beyond the immediate clinical parameters to encompass the wider measures of good health that Māori health services pursue. This model measures good outcomes for health and is not simply the removal of symptoms, which was a criticism of Mainstream Services.<sup>107</sup>

The requirement to construct a simple 'no fuss' measure also influenced the selection of the *whare tapa whā*. Complicated, confusing, or time-consuming measures of outcome are unlikely to be widely accepted or used, especially in treatment settings where demands on time are often excessive. In examining each of the models it was decided that both *ngā pou mana* and the framework developed by Te Puni Kōkiri were unsuitable when considered from a treatment/service perspective. While useful at a macro-level, they lacked the specificity necessary for a consumer focus. Te Wheke was likewise considered, and although well positioned to meet individual consumer needs, contained a larger number of individual dimensions.

## **CLINICAL END-POINTS: WHEN TO MEASURE OUTCOME**

An outcome measurement issue of particular concern to mental health, is the identification of a point in time when outcomes should be measured. Variations in treatment, expected outcome, and client-related variables aggravate the problems, as does the nature of contemporary psychiatric treatment methods.<sup>108</sup> As a means of contending

with these issues, the treatment process was divided into measurable end-points, or locations at which an outcome could be expected or measured. Five end-points were initially selected: assessment, inpatient treatment, outpatient treatment, community care, and community support.

It is unlikely that all clients will progress through these treatment phases, or that this range of options will be made available in every service. However, by targeting a specific clinical end-point a measurement tool can be applied with greater certainty and the outcome more securely linked to the intervention. Additionally, the focus on clinical end-points provides an appropriate structure relevant to contemporary service provision where different service components are supplied by quite different providers.

## **Assessment**

Some argue that an outcome should not be expected from an assessment, and that such a process could hardly be described as an intervention.<sup>109</sup> However, for Māori users of mental health services the assessment phase is a critical pathway that has major implications in terms of recovery and expected outcome. An appropriate mental health assessment will ensure that the needs of the client are understood and a treatment plan developed taking into account clinical, social and cultural parameters. By assessing the outcome of the assessment phase, an indication is obtained as to whether or not relevant procedures and processes have been followed and whether the consumer has benefited from the intervention. In short, a well-conducted assessment can bring positive outcomes

of its own: affirmation of cultural identity, better understanding of the problems, a sense of relief, and the development of a management plan.

### **Inpatient Treatment**

Inpatient treatment typically refers to a period in hospital and ends with discharge. It is at this point that most measures of outcomes are applied, and it is this phase of treatment that is most easily identifiable. However, the length of inpatient treatment can vary in duration and may cover, days, weeks or even months, complicating the outcome measurement process. Accordingly, it is important that outcomes are regularly assessed as there is often a lag period of inpatient care. Where inpatient care is usually brief – 24 hours or so – some assessment of the usefulness of the intervention is nonetheless important, not only because it could be a critical phase in a larger management care plan, but also because decisions to discharge are not always made on clinical grounds alone (sometimes the demands for beds or demands to leave override clinical decisions).

### **Outpatient Treatment Phase**

The process of de-institutionalisation saw that development of a number of ‘alternatives’ to institutional care and the evolution of community-based mental health services. There were several reasons for deinstitutionalisation linked to clinical, political, moral, and economic concerns. In addition, newer treatment methods no longer justified lengthy inpatient care, or if hospital admission was necessary it was generally brief and geared toward outpatient follow-up.

As a consequence, the option of outpatient treatment has become the norm, and termination of outpatient care provides a suitable point at which mental health outcome can be determined. Like inpatient treatment, the modes of outpatient treatment vary and can include hospital-based outpatient clinics, therapy at mental health centres, domiciliary visits, and community-based crisis intervention.

### **Community Care**

Like outpatient treatment, community care is now an established mode of management, and is often delivered by non-health professionals and even whānau. The components of community care are diverse and can include clinical as well as non-clinical activities, coordinated health care, home visits, attendances at day programmes/programmes in the community, or full-time residential care. For Māori whānau, community care can be especially attractive as it allows a more active role in the whole treatment process, assisting with activities, monitoring and referral. Community care can therefore be described as a clinical end-point and lends itself to outcome assessment.

### **Community Support**

The final clinical end-point was originally determined as discharge. However, and in recognition that some clients will require on-going care and treatment, final discharge was seen as an unattainable end-point, hence the notion of community support was introduced. This end-point provided sufficient scope for closure as well as the option for ongoing care. Table 4.13 below highlights the main features of the MMHO (Māori mental health outcome) framework and summarises the concepts previously described.

Table 4.13 The MMHO Framework

<i>Principles</i>	<i>Stakeholders</i>	<i>Domains of Outcome</i>	<i>Clinical End-points</i>
Well-ness	Consumer	Taha wairua	Assessment
Cultural integrity	Clinician/carer	Taha hinengaro	Inpatient Treatment
Specificity	Whānau	Taha tinana	Outpatient Treatment
Relevance		Taha whānau	Community Care
Applicability			Discharge

## **Māori Frameworks for Health**

This chapter has focussed on the development of a framework within which mental health outcomes for Māori might be measured. The MMHO framework is an example of a Māori health framework developed for a particular purpose and a particular target group (Māori clients of mental health services). It was noted at the beginning of the chapter that several frameworks have been created to provide guidance in the application of Māori values and perspectives to contemporary health services and structures. At a wider level, frameworks for understanding Māori participation in modern society generally, have also been developed. The *Te Hoe Nuku Roa Framework*, for example, has been useful in identifying the key elements that make up cultural identity and the relationship of identity to other determinants of well-being.<sup>110</sup> In the *Te Hoe Nuku Roa Framework*, identity is constructed as an interaction between an individual who identifies as Māori and te ao Māori (the Māori world). Measurable components are suggested including the use of Māori language, access to marae, access to traditional lands, associations with other Māori, access to Māori societal organisations, and access to Māori services (such as educational and health services).

Using specific Māori cultural institutions, a similar broad framework has been constructed as a basis for conceptualising a distinctive Māori psychology. The assumption is that the characteristics of Māori thinking, feeling and behaving are best exemplified on the marae during formal encounters. The framework explores the characteristics of nine domains – space, time, the circle, mind and earth, safety, the metaphorical domain, authority and generosity, interconnectedness and synchronicity.<sup>111</sup>

It is concluded that ‘mental energy flows’ for Māori tend to be centrifugal rather than centripetal; similarities and meaning derive not so much from the analysis of detail as the construction of bigger pictures. By implication, a conventional analysis of Māori thinking patterns runs the risk of painting fragments of a whole that lack meaning because the connections have not been drawn. Holism and connectedness characterises Māori understanding.

Māori health and well-being frameworks, such as *MMHO*, *Te Hoe Nuku Roa* and a *Māori Psychology*, as well as those discussed at the beginning of the chapter, have developed in parallel with the increasing Māori autonomy in social policy areas. Their emergence reflects not only a desire to incorporate Māori perspectives and promote a Māori-friendly context for services, but more importantly to compensate existing frameworks that all too often fail to make sense to Māori and do not spawn active engagement. The Māori frameworks emphasise an integrated approach to health and well-being. For example the two-fold distinctiveness of the *MMHO Framework* is its holistic view of health – mental health outcome assessment embraces spiritual, physical and social dimensions, as well as mental aspects – and the way that the views of individuals are balanced by the views of significant others. Tangata Whaiora are not regarded as isolated elements but as part of a wider social order requiring a broader model for assessment and understanding.

Despite the relatively large number of Māori health and well-being frameworks, they have in common a number of key themes. They all endorse Māori values, Māori imagery, and Māori philosophies, and attempt to apply cultural paradigms to modern times and modern services; they are not about perpetuating old practices. Generally, Māori health frameworks are compatible with other more conventional measures though emphasise different priorities, different starting points and explore parameters that other measures bypass. Importantly, they are usually developed with Māori users in mind (both providers and consumers) so that the use of Māori language is often a priority. Finally, Māori health frameworks have been developed by Māori health workers, researchers and academics. Their focus is on improving Māori health using Māori health and well-being paradigms while taking account of contemporary operating environments.

Māori health frameworks can be grouped according to their purpose. Table 4.14 shows the key frameworks for each of the four areas: conceptual, strategic, contractual, and service development.

Table 4.14 Māori Health Frameworks - Purpose and Use

Purpose	Examples of Frameworks	Potential use	Status
Conceptual frameworks	Māori Psychology	Psychotherapy, counselling, education	Published
	Te Hoe Nuku Roa	Integration of cultural identity and socio-economic variables	Used extensively in social policy areas
	Traditional Healing	Role of healing alongside modern care and treatment	Ministry of Health endorsement
Strategic frameworks	Tribal authorities	Health service delivery by tribes	Endorsed by Board of Health
	Te Pae Mahutonga	Health promotion	Published and recognised in Ministry of Health policy
Contractual frameworks	CHI	Public health contracts	Published; endorsed by Public Health Commission
	He Anga Whakamana	Disability support contracts	Endorsed by National Health Committee
Service development frameworks	He Taura Tieke	Health service monitoring	Ministry of Health approved
	MMHO	Mental health outcomes for Māori	Endorsed by Ministry of Health

Māori health frameworks have been discussed in this thesis to illustrate their utility and application; the manner in which they draw from traditional concepts and yet reflect contemporary concerns and aspirations. The *MMHO Framework* has been discussed in some detail, since outcome measurements are likely to be major challenges for the health sector in the future. The framework is based on a Māori model of health – te whare tapa whā - and moves toward an integrated approach to health by incorporating the views of consumer, clinician and whānau. The conclusion reached is that an outcome measure can successfully incorporate Māori values and perspectives and provide a rational substrate for the formulation of Māori health policies, programmes, service, strategies and clinical measurements.

The next chapter, *Hua Oranga*, explores the application of the MMHO framework – from which a measure of Māori mental health outcome is proposed.

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- <sup>1</sup> Māori Health Committee, (1987), *Tribal Authorities as Advocates for Māori Health*, New Zealand Board of Health, Wellington.
- <sup>2</sup> Te Pūmanawa Hauora, (1994), *The MDI Framework: A Report Prepared for the Ministry of Health*, Department of Māori Studies, Massey University, Palmerston North.
- <sup>3</sup> M. H. Durie, (1994), *The CHI Model: A Culturally Appropriate Auditing Model*, Public Health Commission, Wellington.
- <sup>4</sup> Including the Health Information Privacy Code 1994.
- <sup>5</sup> Department of Statistics Iwi Classification.
- <sup>6</sup> I. Ramsden, (1990), *Kawa Whakaruruhau: Cultural Safety in Nursing Education in Aotearoa*, Ministry of Education, Wellington.
- <sup>7</sup> M. M. Ratima, M. H. Durie, G. R. Allan, P. S. Morrison, A. Gillies, and J. A. Waldon, (1995), *He Anga Whakamana: A Framework for the Delivery of Disability Support Services for Māori*, Te Pūmanawa Hauora, Department of Māori Studies, Massey University, Palmerston North.
- <sup>8</sup> C. Cunningham, (1996), *He Taura Tieke: Measuring Effective Health Services for Māori*, Ministry of Health, Wellington.
- <sup>9</sup> The key feature of the model is that it *Consolidates* (C) previous work, adopts a *holistic* (H) framework and seeks to be *interactive* (I)
- <sup>10</sup> M. H. Durie, (1993), *A Culturally Appropriate Auditing Model: The C.H.I Audit Model*, Public Health Commission, Wellington.
- <sup>11</sup> M. H. Durie, (1996), 'A Framework for Purchasing Traditional Healing Services', a report prepared for the Ministry of Health, Department of Māori Studies, Massey University, Palmerston North.
- <sup>12</sup> M. H. Durie, (2000), *Te Pae Mahutonga: A Model for Māori Health Promotion*, Department of Māori Studies, Massey University, Palmerston North.
- <sup>13</sup> B. Borman and N. Wilson, (1999), *Outcomes, Indicators, and Community Health Status: A Discussion Paper for the Action for Health and Independence Conference*, Ministry of Health, Wellington (unpublished).
- <sup>14</sup> B. Raphael, G. Hugh, and G. Stewart, (1996), 'Mental Health Outcomes', a paper presented at the Integrating Health Outcomes Measurement in Routine Health Care Conference, Canberra, Australia.
- <sup>15</sup> A. Hutchinson, E. McColl, M. Christie, and C. Riccalton, (1996), 'Health Outcomes for Primary and Out-patient Care: An Editorial Overview', in A. Hutchinson, E. McColl, M. Christie, and C. Riccalton (eds.), *Health Outcomes for Primary and Out-patient Care*, Harwood Academic Publishers, United Kingdom.
- <sup>16</sup> Ministry of Health, (1996), *Towards Better Mental Health Services: The Report of the National Working Party on Mental Health Workforce Development*, Ministry of Health, Wellington, p. 10.
- <sup>17</sup> That is, the accuracy of the measurement, for example, consistency and test/re-test.
- <sup>18</sup> That is, does the tool measure what it claims to measure.

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- <sup>19</sup> J. Peters, (1994), '*Performance and Outcome Indicators in Mental Health Service: A Review of Literature*', a report prepared for the Ministry of Health, Ministry of Health, Wellington.
- <sup>20</sup> Ibid.
- <sup>21</sup> This policy directive indicated that health outcomes would form the basis of the new health structure.
- <sup>22</sup> L. Dyal, *et al.* (1999), 'Māori Outcomes: Expectations of Mental Health Services', in *Social Policy Journal of New Zealand*, Issue 12, Social Policy Agency, Wellington.
- <sup>23</sup> Health Funding Authority, (1998), 'June 1998 Report on the Mental Health Research and Development Project', in *Fostering Mental Health*, Health Funding Authority, Wellington.
- <sup>24</sup> Health Funding Authority, (1998), *How Shall We Prioritise Health and Disability Support Services? A Workshop Background Paper*, Health Funding Authority, Wellington, p. 7.
- <sup>25</sup> Mental Health Commission – Māori Advisory Board, Mental Health Research and Development Strategy – Māori Expert Panel, Public Health Association – National Executive, Mental Health Information Project – Advisory Team, National Mental Health Prevalence Study – Inquiry Team, Case Mix Classification Team – Māori Advisory Group, Māori Mental Health Workforce Census – Technical Group.
- <sup>26</sup> A customary Māori greeting where noses are pressed together.
- <sup>27</sup> Health Funding Authority, (1998), *op cit.*, p. 7.
- <sup>28</sup> Borman and Wilson, (1998), *op cit.*, p. 2.
- <sup>29</sup> J. Shanks, (1994), 'Outcomes in Mental Health', in T. Delamothe (ed.), *Outcomes into Clinical Practice*, British Medical Journal Publishing Group, United Kingdom.
- <sup>30</sup> K. Eagar, (2000), 'An Overview of Health Outcome Measurement in Australia', in Health Research Council of New Zealand (ed.), *Mental Health Outcomes Research in Aotearoa: Proceeding of the September 2000 Conference and other Developments in Mental Health Outcomes Research*, Mental Health Research and Development Strategy, Auckland, p. 142.
- <sup>31</sup> Australian Health Ministry's Advisory Council: *Health Outcomes Bulletin*, no. 1, February 1994, p. 5.
- <sup>32</sup> B. Armstrong, (1994), '*Getting Health Outcomes into State and National Health Policy: A National Perspective*', a paper presented to the NSW Health Outcomes Conference, 12-13 August 1994, Sydney, Australia.
- <sup>33</sup> J. Hall, G. Masters, K. Tarlo, and G. Andrews, (1984), *Measuring Outcomes of Health Services*, Department of Community Medicine, NSW, Australia, p. 8.
- <sup>34</sup> J. McCallum, (1993), 'What is an Outcome and Why Look at Them?', in *Critical Public Health*, vol. 4, no. 4, p. 4.
- <sup>35</sup> G. Andrews, L. Peters, and M. Teesson, (1994), *The Measurement of Consumer Outcomes in Mental Health*, Australian Government Printer, Australia.
- <sup>36</sup> H. Sheps, (1955), 'Approaches to the Quality of Hospital Care', in *Public Health Reports*, vol. 70, pp. 877-886.

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- <sup>37</sup> J. Sansoni, (1997), 'Health Outcomes - Made to Measure', in *Australian Private Hospitals Association Caring with Skill Conference, July 1999 Proceedings*, Sydney, Australia.
- <sup>38</sup> Eagar, (2000), *op cit.*, p. 142.
- <sup>39</sup> P. Crampton and P. Howden-Chapman, (1997), *Socio-economic Inequities and Health: Proceedings of the Socio-economic Inequities and Health Conference, 9–10 December 1996*, Institute of Policy Studies, Victoria University, Wellington.
- <sup>40</sup> B. Howard, *et al.* (1995), 'Use of Outcome Studies by a Managed Care Organisation: Valuing Measured Treatment Effects', in *Medical Care*, vol. 33, no. 4, J. B. Lippincott Company, California.
- <sup>41</sup> T. Stedman, P. Yellowlees, G. Mellsop, R. Clarke, and S. Drake, (1996), *Measuring Consumer Outcomes in Mental Health: Field Testing of Selected Measures of Consumer Outcomes in Mental Health*, Department of Health and Family Services, Canberra, Australia, p. 2.
- <sup>42</sup> Sansoni, (1997), *op cit.*
- <sup>43</sup> A. Donabedian, (1966), 'Evaluating the Quality of Medical Care', in *Milbank Memorial Fund Quarterly*, vol. 44, pp. 166-206.
- <sup>44</sup> *Ibid.*, pp. 166-206.
- <sup>45</sup> R. Jenkins, (1996), 'Measuring Outcomes in Mental Health: Implications for Policy', in *Mental Health Outcome Measures*, Springer, New York.
- <sup>46</sup> M. Goldacre, (1996), 'Health Outcomes from a Medical Perspective', in H. M. MacBeth (ed.), *Health Outcomes: Biological, Social, and Economic Perspectives*, Oxford University Press, New York, p. 70.
- <sup>47</sup> See for example <http://www.msiac.dmsi.mil/journal/sp0013/moe13.html>. (24 January 2002).
- <sup>48</sup> See M. Becker, R. Diamond, and F. Sainfort, (1993), 'A New Patient Focused Index for Measuring Quality in Persons with Severe and Persistent Mental Illness', in *Quality of Life Research*, vol. 2, pp. 239-251.
- <sup>49</sup> SF-36 is perhaps the most well-known multi-dimensional measure of health outcome. The reliability and validity of this tool has come under much scrutiny and has subsequently been modified to meet the needs of certain populations more adequately. Other similar measures include the Nottingham Health Profile, Sickness Impact Profile, Quality of Well-being Profile.
- <sup>50</sup> That is, if the schedules do not provide the scope through which issues of importance to particular individuals can be considered.
- <sup>51</sup> Howard, *et al.* (1995), *op cit.*
- <sup>52</sup> Panel Discussion: Mental Health Outcomes Research in Aotearoa Conference, Brentwood Airport Hotel, 8 September 2000. 15 October 1999.
- <sup>53</sup> This is based on the assumption that the tool will perform identically no matter who is undertaking the assessment.
- <sup>54</sup> Personal Communication, Interview Database Entry – Record 15.
- <sup>55</sup> H. M. MacBeth, (1996), *Health Outcomes: Biological, Social, and Economic Perspectives*, Oxford University Press, New York, p. 27.

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- <sup>56</sup> Donabedian, (1966), *op cit.*, pp. 166-206.
- <sup>57</sup> See for example <http://www.leeds.ac.uk/nuffield/infoservices/UKCH/home.html> (27 January 2001)
- <sup>58</sup> Mental Health Research Consortium, (1994), *Barriers to Mental Health Care in the Community: Towards an Economic Model*, Ministry of Health, Wellington.
- <sup>59</sup> I. Falloon and G. Fadden, (1995), *Integrated Mental Health Care*, Cambridge University Press, Cambridge, United Kingdom.
- <sup>60</sup> In this instance the individual would have shown improvement even if an intervention had not been administered.
- <sup>61</sup> Interviews conducted as part of this thesis suggested that clinical staff were sometimes unsure about the outcome of an intervention and whether or not the health of patients had improved.
- <sup>62</sup> That is, a single measure of outcome that is valid and reliable in every situation.
- <sup>63</sup> See for example *International Journal of Culture, Health, and Sexuality*, Institute of Education, London.
- <sup>64</sup> A. Henley, (1979), *Asian Patients in Hospital and at Home*, King Edward's Hospital Fund, London.
- <sup>65</sup> M. Baxter, (1983), 'The Causes of Disease: Women Talking', in *Social Science and Medicine*, vol. 17, no. 2, pp. 59-69.
- <sup>66</sup> I. Zola, (1973), 'Pathways to the Doctor: From Person to Patient', in *Social Sciences and Medicine*, vol. 7, no. 9, pp. 677-689.
- <sup>67</sup> M. H. Durie, (1995), *Characteristics of Māori Health Research*, Department of Māori Studies, Massey University, Palmerston North, p. 7.
- <sup>68</sup> Te Pūmanawa Hauora, (1996), *Oranga Kaumātua - The Health and Well-being of Older Māori: A Report Prepared for the Ministries of Health and Māori Development*, School of Māori Studies, Massey University, Palmerston North.
- <sup>69</sup> Short Form 36 is a 36 item questionnaire; Discussed more fully in Chapter 6.
- <sup>70</sup> SF-36 only made up part of the assessment process. Other factors related to demographic and cultural factors, whānau interaction, views on ageing, sickness and disability, health service utilisation, and lifestyle factors were also considered.
- <sup>71</sup> Personal Communication, Research Officer (Oranga Kaumātua Study), Friday 21 September 2001.
- <sup>72</sup> Personal Communication, Interview Database Entry – Record 33.
- <sup>73</sup> A guide.
- <sup>74</sup> Mental Health Commission, (1999), *New Zealand's National Mental Health Strategy: Review of Progress 1994-1999*, Mental Health Commission, Wellington, p. 7.
- <sup>75</sup> Mental Health Commission, (1998), *A Travel Guide for People on the Journey Towards Equality, Respect, and Rights for People who Experience Mental Illness*, Mental Health Commission, Wellington, p. 19.
- <sup>76</sup> Mental Health Commission, (1998), *Report of the Key Messages to the Mental Health Commission from the Hui held February-April 1998*, Mental Health Commission, Wellington, p. 11.

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- <sup>77</sup> Mental Health Commission, (1998), *Blueprint for Mental Health Services in New Zealand: How Things Need to Be*, Mental Health Commission, Wellington, p. 59.
- <sup>78</sup> Te Puni Kōkiri, (1998), *Towards Māori Mental Well-health: A Framework for Translating Principles into Action*, Ministry of Māori Development, Wellington, p. 1.
- <sup>79</sup> Personal Communication, Interview Database Entry – Record 41.
- <sup>80</sup> Bill Dahl, (2000), ‘Client Outcome and Research Management (CORM) Assessment’, in Health Research Council of New Zealand (ed.), *Mental Health Outcomes Research in Aotearoa: Proceeding of the September 2000 Conference and other Developments in Mental Health Outcomes Research*, Mental Health Research and Development Strategy, Auckland, p. 115.
- <sup>81</sup> Raphael, *et al.* (1996), *op cit.*
- <sup>82</sup> Mental Health Commission, (1998), *Consumer Opinion and Family Opinion about Mental Health Services*, Mental Health Commission, Wellington, p. 1.
- <sup>83</sup> Raphael, *et al.* (1996), *op cit.*, p. 19.
- <sup>84</sup> Mental Health Services Hui: Maraeroa Marae, Porirua, 26 May 1998.
- <sup>85</sup> During the interview process clinical staff raised significant concerns about the reliability of self-reporting inventories. Māori, likewise, considered it imperative that consumers had input into the outcome assessment process.
- <sup>86</sup> Personal Communication, Interview Database Entry – Record 21.
- <sup>87</sup> Stedman, *et al.* (1996), *op cit.*, p. 3.
- <sup>88</sup> W. W. Holland, R. Detels, and G. Knox (eds.), (1991), *Oxford Textbook of Public Health*, 2nd edn, vol. 1, Oxford University Press, New York.
- <sup>89</sup> Mental Health Commission, (1998), *op cit.*, p. 14.
- <sup>90</sup> Mental Health Services, (1993), *Guidelines on the Management of Suicidal Patients*, Ministry of Health, Wellington. See also S. Tawhai, (1997), ‘What are Psychiatric Survivors Seeking from Māori Mental Health Services and from Māori Mental Health Managers’, Aotearoa Network of Psychiatric Survivors, Wellington; T. Douglas, (1996), *Māori Health Workforce Development: A Discussion Document*, Ministry of Health, Wellington.
- <sup>91</sup> Health Funding Authority, (1998), *op cit.*, p. 7.
- <sup>92</sup> *Ibid.*, p. 7.
- <sup>93</sup> Vera Keefe-Ormsby, Naina Watene-Hayden, Winston Maniapoto, Gloria Taumata-Bishara, and Helen Potaka, (1993), *Tino Rangatiratanga and Māori Mental Health*, Department of Health, Wellington.
- <sup>94</sup> Panel Discussion: Mental Health Outcomes Research in Aotearoa Conference, Brentwood Airport Hotel, 8 September 2000. 15 October 1999.
- <sup>95</sup> Ministry of Health, (1997), *Mental Health in New Zealand from a Public Health Perspective*, Ministry of Health, Wellington, p. 92.
- <sup>96</sup> The model was first presented at the Rahui Tane Hostel in Hamilton in August 1982 during a training session of fieldworkers in the Māori Women’s Welfare League research project, ‘Rapuora’.

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- <sup>97</sup> For example the 1947 World Health Organisation definition: 'Health is a state of complete, physical, mental, and social well-being, not simply the absence of disease or infirmity'.
- <sup>98</sup> Hui Whakaoranga was convened by the Department of Health in 1983. At this hui a positive approach to Māori health was stressed and the relevance of Māori philosophies and health initiatives was affirmed.
- <sup>99</sup> School of Māori Studies, (2002), *Māori Health Foundations – Book of Readings*, School of Māori Studies, Massey University.
- <sup>100</sup> Te Ara Ahu Whakamua focused specifically on the strategic development of Māori health. The goals of the hui, which were to be reached by the year 2000, were: greater political power for Māori, Māori control of their own destinies, stronger and healthier whānau, full employment, and equality between Māori men and women.
- <sup>101</sup> Te Puni Kōkiri, (1994), *Te Ara Ahu Whakamua: Proceedings of the Māori Health Decade Hui 1994 March*, Ministry of Māori Development, Wellington.
- <sup>102</sup> See Hutchinson, *et al.* (1996), *op cit.*
- <sup>103</sup> Questions relating to these interviews were incorporated as part of the service questionnaire described in Chapter 3.
- <sup>104</sup> As described by the Māori mental health team at Porirua Hospital.
- <sup>105</sup> J. F. A. Rankin, (1986), 'Whaiora: A Māori Cultural Therapy Unit', in *Community Mental Health in New Zealand*, vol. 3, no. 2, pp. 38-47.
- <sup>106</sup> Te Pūmanawa Hauora, (1995), *Guidelines for Purchasing Personal Mental Health Services for Māori*, Te Pūmanawa Hauora, Department of Māori Studies, Massey University, Palmerston North, p. 33.
- <sup>107</sup> Mental Health Commission, (1998), *op cit.*, p. 11.
- <sup>108</sup> For example, the availability of a much wider range of psychoactive drugs.
- <sup>109</sup> Māori Mental Health Services Hui, 26 August 1998, School of Māori Studies, Massey University, Palmerston North.
- <sup>110</sup> M. H. Durie, (1995), 'Te Hoe Nuku Roa Framework: A Māori Identity Measure', in *Journal of the Polynesian Society*, vol. 104, no. 4, pp. 461-470.
- <sup>111</sup> M. H. Durie, (1999), 'Marae and Implications for a Modern Māori Psychology: Elsdon Best Memorial Medal Address', in *Journal of the Polynesian Society*, vol. 108, no. 4, pp. 351-366.

## Chapter Five

# HUA ORANGA: A MĀORI MEASURE OF MENTAL HEALTH OUTCOME

### INTRODUCTION

Frameworks often bring an expectation of application, where the utility is derived from, how they are interpreted, in what way, and to what end. The previous chapter described the development of a framework for understanding mental health outcomes for Māori. Along with other Māori health frameworks, it illustrated how cultural values and processes can be incorporated into modern health policies and practices. It also illustrated how Māori concepts of health and outcome are not inconsistent nor at odds with established outcomes theory or practice. This chapter builds on Chapter 4 by translating the framework into a tool that can be applied at the clinical interface and used to measure the outcomes of various interventions. It shows that instruments used to measure health need not be devoid of a cultural dimension and can be quantified to reflect Māori perspectives as well as clinical progress.

*Hua Oranga* is the measure produced and is designed to consider Māori perspectives of mental health outcome. Its construction strengthens the argument that Māori concepts of health and outcome, are somewhat different from that of non-Māori, and that measures of outcome need to reflect Māori perspectives and concepts. By combining Māori health perspectives with a Māori philosophy that stresses holism and integrated action, the tool goes some way to filling a gap and extending Māori health perspectives into measures of health outcome.

This Chapter, while containing several parts, has two main sections. The first is a discussion of research issues and is designed to clarify the mechanism through which Hua Oranga was eventually developed. The second part describes the outcomes of the research process, the rationale upon which the tool is based, its objectives, characteristics, and function.

## **RESEARCH ISSUES**

The objectives of this chapter were used to guide the research. A range of information-gathering techniques and quality assurance measures were utilised, along with arrangements specifically designed to maintain a kaupapa Māori approach to the study. For consistency, the research component of this chapter follows that of the previous. It is divided into three main parts. The first is a brief narrative or summary, outlining how the objectives of the chapter are to be met. The second, leads on from the first but is more descriptive in detailing the specifics of the research process. The third is a supplement and describes the additional arrangements deliberately designed to enhance the quality of the investigation.

## **PART 1: FRAMEWORK TRANSFORMATION AND APPLICATION**

While this chapter has a range of clearly identified objectives, they were all essentially reliant on the transformation of the MMHO framework into a reliable measure of Māori mental health outcome.

In considering the most reliable and effective means of transforming the framework into a workable measure, a comprehensive testing process was instituted.<sup>1</sup> Using the framework as a base, a draft instrument would need to be developed and then piloted within a range of clinical settings. This piloting process would allow the concepts outlined in the framework to be tested (through the draft instrument) and give service users, their whanau, and staff, the opportunity to comment on the drafts utility, accuracy and practicality. This informed comment would allow the draft instrument to be refined. By re-exposing the refined instrument to a further series of tests additional modifications could then be made and a final measure recommended. The rationale behind the piloting process stemmed from the need to apply the framework in practical situations as well as the requirement to gather qualitative data on Māori concepts of mental health outcome, characteristics, applications, and requirements.

As a consequence the framework proceeded through a logistical transformation so that an appropriate draft could be constructed. The draft itself would not necessarily constitute a near final tool but merely provide a means through which the concepts in the framework could be applied within a practical/service-type setting, providing, by extension, a suitable mechanism through which the cultural dimensions of mental health outcome could be identified and assessed.

In keeping with the requirements of the framework, the draft measure took the form of three separate questionnaires designed to assess outcome from the perspective of the client, clinician, and whānau. The measure would need to be consumer focused, capable

of measuring outcome from a cultural perspective (based on the whare tapa whā model), adaptable for use at a range of clinical end-points, and consistent with the principles of well-ness, cultural integrity, specificity, relevance, and applicability.

These three draft instruments are summarised in Tables 5.1, 5.2, and 5.3, below:

**Table 5.1** Consumer Baseline Questionnaire

<b>CONSUMER</b>	<b>Baseline Questions</b>
Q1, Taha Wairua	Has the intervention made you feel stronger in yourself as a Māori?
Q2, Taha Hinengaro	Has the intervention led to an improvement in the way you think, feel and act?
Q3, Taha Tinana	Has the intervention resulted in an improvement in your physical health?
Q4, Taha Whānau	Has the intervention led to an improvement in the way you get on with others, especially your whānau?

**Table 5.2** Whānau Baseline Questionnaire

<b>WHĀNAU</b>	<b>Baseline Questions</b>
Q1, Taha Wairua	Has the intervention made your relative stronger in his/herself as a Māori?
Q2, Taha Hinengaro	As a result of the intervention has your relative's patterns of thinking and behaviour improved?
Q3, Taha Tinana	Has the intervention resulted in an improved standard of physical health for your relative?
Q4, Taha Whānau	As a result of the intervention, do you feel that your relative is more appropriate socially, including with the whānau?

**Table 5.3** Clinical Baseline Questionnaire

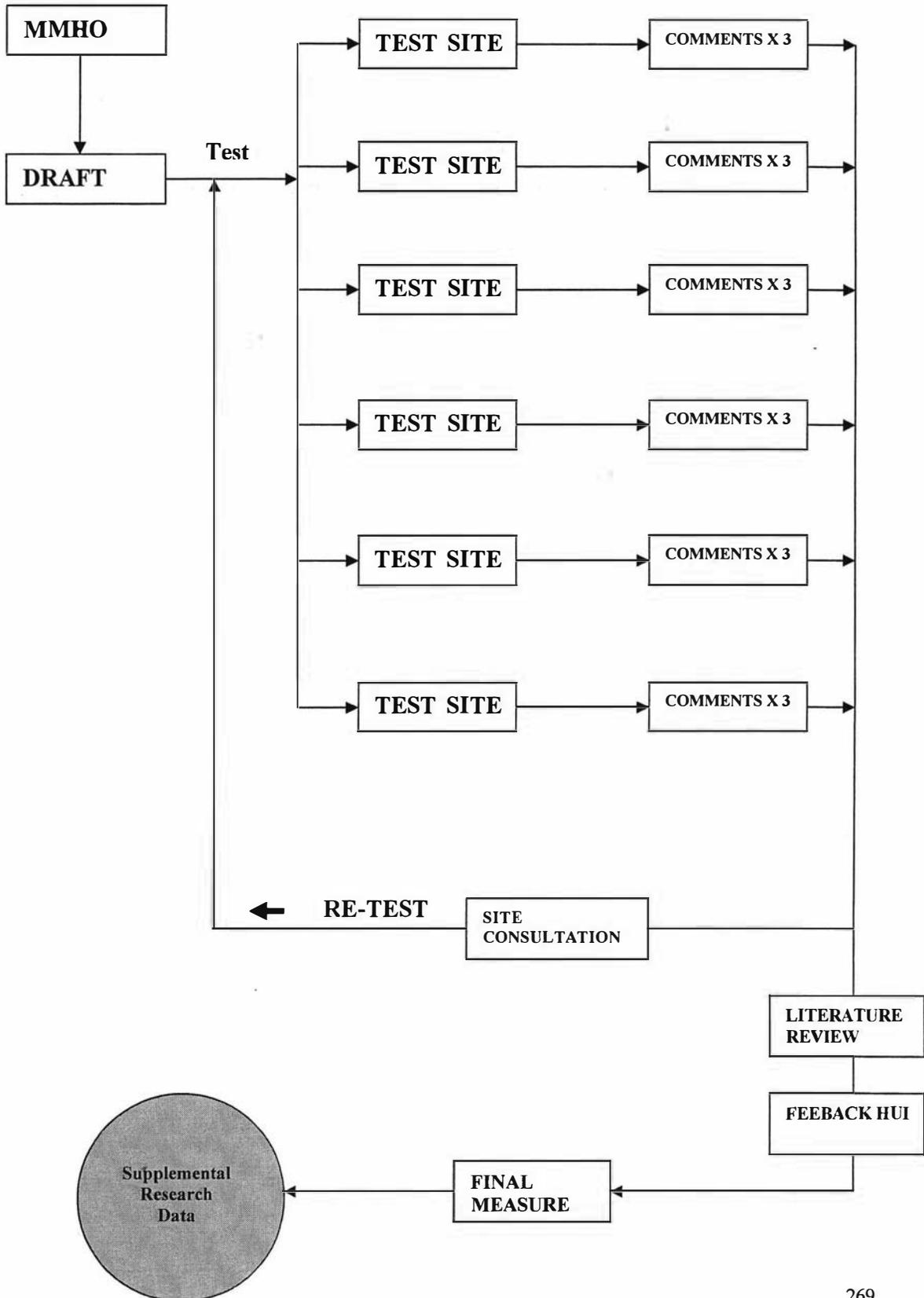
<b>CLINICAL</b>	<b>Baseline Questions</b>
Q1, Taha Wairua	Did your intervention result in the patient being stronger in him/herself as a Māori?
Q2, Taha Hinengaro	As a result of the intervention have the patient's overall thoughts, feelings and behaviour become more appropriate?
Q3, Taha Tinana	As a result of the intervention has the patient's physical health improved?
Q4, Taha Whānau	As a result of the intervention has the patient's social and whānau functioning improved?

## **PART 2: THE TESTING AND REFINEMENT PROCESS**

### **Summary**

As described it was decided to pilot the draft tool within in a range of clinical settings. As an initial step, six Māori mental health services were invited to participate in the study. Five were assigned one particular clinical end-point to test and a sixth provided an assessment across the full range of end-points. Each service was asked to recruit three types of respondents (clinical, tangata whaiora, and whānau) to test the respective questionnaires. Respondents were essentially required to comment on the questionnaire (with the aid of a “Data Schedule” – described later) and to suggest suitable refinements to increase relevance and practicality. To enhance the findings, the process was repeated. As well, a review of literature and feedback hui were used to further interpret and explore the findings from the two testing phases. The schema below (Figure 5.1 ) provides a brief summary of the testing and refinement process.

Figure 5.1 Hua Oranga – Testing and Refinement Process



The first round of tests were conducted with the draft instrument described in Tables 5.1, 5.2, and 5.3. Based on the comments gathered, and with the aid of presentations to participating sites, the second round of tests were conducted with a new/modified instrument. Following the second and final test round further modifications were made. Presentations and feedback hui were organised to discuss the phase two modifications and to explore alternative options and approaches. Here, participating sites were encouraged to comment, more openly, about the research process, the tool, and the modifications which had been recommended. As well, more informal discussions with individual staff members were undertaken and allowed for more direct 'one-on-one' feedback.

As a final prelude to the construction of the measure a review of literature was undertaken. This allowed the various views and research data to be consolidated, and unravelled, and to explore the broader context within which these issues were located.

While the prime purpose of the testing process was to create a final measure of mental health outcome, additional data, linked to the application, design, and implementation of outcome measures was also gathered. This information was supplemental to the testing and refinement process and was often reflected in comments about the tools potential, its utility, and limitations. This 'Supplemental Research Data' was used to consider the tools overall position (within the mental health sector) and to reflect on its strengths and weaknesses, future developments and impediments – these issues are discussed in Chapter 6.

## **Data Schedule**

To obtain the type of data required, and as a general aid to the research process, a specific information-gathering schedule was constructed and appended to each draft questionnaire. Respondents, after considering the relevant draft instrument, would then provide comment and feedback, using the schedule.<sup>2</sup>

## **Test-Site Selection**

Each test site was deliberately selected to obtain a range of perspectives. Although all sites catered for Māori clients, they varied significantly in the range of services provided and the particular clients treated. The groups were geographically and demographically disparate, reflecting an urban, rural and residential mix, as well as a wide range of clinical settings and varying degrees of acculturation and de-culturation.<sup>3</sup> As a consequence (and as a result of the two test runs), 245 respondents participated in the study, including 84 clinicians, 84 tangata whaiora, and 77 whānau members.

## **Test Preparations**

Before the formal testing process a series of hui were conducted with service representatives. They were primarily designed to outline the objectives of the study and the logistical issues associated with its management. However, the hui approach also enabled direct feedback on the study and the sharing of information between participants. Each of the sites could meet each other and discuss the applications and implications of the investigation. Following an initial meeting, a number of other hui and training sessions were conducted (five in total). They were similarly designed to obtain feedback

on the study but also served as training sessions through which issues associated with the application of the tool (at each site) could be discussed (See Appendix IV). Similar training sessions were conducted at each of the six test sites mainly for clinical staff who would be participating in the study.

### **The Information-gathering Process**

Each test site was given a number of 'Stakeholder Packs'. The 'Stakeholder Packs' contained the three draft questionnaires, one each for the clinician, tangata whaiora, and whānau member. As well, on the reverse side, an evaluation form was attached. Clinical staff at each site were asked to collect a 'Stakeholder Pack' from a designated staff member (responsible for the collection and distribution of packs within each institution). Clinical staff would then approach tangata whaiora and ask if they were willing to participate in the study and if it was possible to involve a relative or someone they considered whānau. If consent was given, the whānau member was also asked to participate in the study.

After the completion of a particular clinical end point (e.g., an 'Assessment'), all three respondents would then complete their respective questionnaires. They were then asked to evaluate the questionnaire using the evaluation form located on the reverse side of the questionnaire. Immediately after both tasks were completed, all three questionnaires were placed in an envelope, sealed, and returned to the designated staff member. Once all the packs had been completed (at each institution) they were mailed to the researcher for analysis.<sup>4</sup> After data from the first round of testing were analysed, modifications to

the draft tool were made. A further consultation hui was also held with test site representatives to discuss the modifications, suggest additional changes, and outline test round two.<sup>5</sup>

The second round of tests were conducted within the same institutions but with another group of clinicians, clients and whānau. Feedback was obtained in a similar manner.

### **Data Management and Analysis**

The questionnaire evaluation sheets were specifically designed to complement the software package<sup>6</sup> and to facilitate the transfer and encoding of written comments. As the stakeholder packs were returned, the evaluation sheets were removed and prepared for data input. Three separate databases were created, one for each of the three key stakeholders.

With the aid of the software package, 'summary data fields' were produced and analysed. Where key themes and issues were identified, a more detailed analysis was conducted to assess the relevance of issues such as age, gender, intervention type, condition and severity.

### **Ethical Issues**

Because of the geographical spread of the test sites, four separate ethical applications were submitted. In addition, a fifth application was prepared for the Manawatu/Wanganui ethics committee that acted as primary ethical co-ordinator. While at times arduous and time consuming, the process proved useful in terms of obtaining

further expert comment on the study and the logistics of carrying out the investigation. For example, the language used on the consumer information-gathering sheets was adjusted to cater for a range of abilities; the phone numbers of consumer advocacy groups were also provided, as well as their contact details. All sheets contained information identifying the researchers, the purpose of the investigation, their role, the outcomes, options for feedback, and a consent form.<sup>7</sup>

During the data input and analysis phase the anonymity of respondents was ensured by removing identifying information before data input and keeping the information in separate locations. A coding system also employed within the database meant that the names of respondents were not included. All questionnaires, evaluation sheets, and consent forms have been stored.

### **PART 3: SUPPLEMENTAL RESEARCH ACTIVITIES**

The testing process was the prime mechanism through which the information required for this chapter was obtained. However, a range of other research-related activities was also incorporated to aid the quality of information gathered, and to ensure that an appropriate focus was maintained.

#### **Literature Review**

As described, a review of relevant literature formed an important part of the inquiry process. The review was conducted to aid the transformation of the MMHO framework and to ensure that the testing process would provide the information required. As well,

the review provided the opportunity to further consider the comments and information gathered, to further explore the issues raised and to describe them within a broader landscape.

An analysis of similar outcome measures and schedules provided some guidance, particularly in terms of layout, typography, and function of the measure. Additional information was also gathered in order to explore the development of these tools, the rationale for adopting particular application approaches, and how certain theoretical issues were identified or overcome. Many of the more popular measures (e.g., SF-36 or MHI)<sup>8</sup> had also been the subject of numerous evaluations and assessments. The extensive literature review allowed for the development of an appropriate research guide, a reliable method for converting the MMHO framework into a useful clinical tool, and a means through which the tool modifications and recommendations could be linked to contemporary mental health discourse.

## **Interviews**

While the testing process generated a significant amount of data and formed the basis for completing the task, a series of key person interviews was also conducted and was useful in terms of the analysis and interpretation of raw information. Eleven experts in Māori health, mental health, and outcome measurement were again targeted and asked to provide informed comment on the initial findings. This process not only assisted with the analysis of information but also provided a pathway by which problematic issues were identified and often explained.

## **Presentations**

Throughout the testing process several presentations were made to professional audiences (those not directly involved in the research process). These presentations were designed to provide feedback on the study's progress and to test any assumptions made through the analysis. As a complement, formal presentations were also initiated to engage debate of a more specialist nature. These were typically targeted at academics, outcome researchers, or policy analysts to provide critical review and to test the key assumptions or conclusions that had been made.

## **Kaupapa Māori Measures**

Throughout the research process a range of kaupapa Māori mechanisms were incorporated. Many of the experts interviewed had previously contributed to the development of the MMHO framework and were already familiar with the project and the issues.

Hui and presentations were also conducted in a manner that facilitated cultural activity and protocol. Where possible, powhiri or similar types of introductions were included as well as karakia and poroporoaki. Pānui announcing the hui were distributed widely through a range of different networks. A participant list, distributed following each presentation, was used to contact participants and to obtain feedback.

As the main information-gathering mechanism it was important that the testing process included activities and protocols that maintained a kaupapa Māori focus. Hui to provide

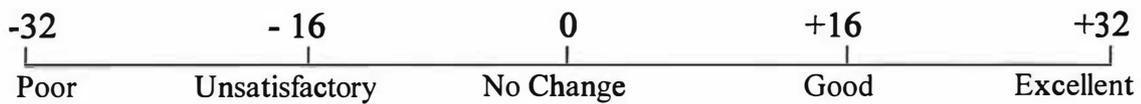
feedback on the study were held at frequent intervals throughout the investigation. While presenting the opportunity to outline the study, the hui also enabled staff from the various sites to meet 'kanohi ki te kanohi' to correspond and to discuss the implications of the study. Pamphlets outlining progress were periodically produced and delivered to each of the test sites, for distribution to interested respondents. A koha<sup>9</sup> was also given to each of the test sites for their time and associated costs but more importantly to strengthen an ongoing relationship with the project. Following the investigation, copies of the final report were distributed to the participating organisations. A follow-up letter of thanks was sent, along with an invitation to obtain further reports and to discuss issues that had arisen as a consequence of the study.

## **HUA ORANGA: FINAL BASE-LINE QUESTIONS**

The research process described above led to the identification of a final series of outcome related questions. The rationale behind their selection is outlined within the following sections – however, they are introduced here as a key outcome of the research process and in order to provide some context to the discussion which follows. While the research was used to inform the types of outcomes expected/preferred, the questions themselves were constructed in a more intuitive manner, through consultation and in discussions with supervisors. This process was designed to ensure that the questions identified adequately articulated the issues and concepts raised within the research process, through the various presentations, after the review of literature, and in line with the comments made by selected experts.

In line with the recommendations of the MMHO framework the three schedules/questionnaires which follow require input from tangata whaiora, whanau, and clinical staff. Each is required to complete their respective questionnaire and simply circle the most appropriate response. Each response is given a score - ranging from + 2 (*Much More*) to - 2(*Much Less*). By totalling these scores (across all three questionnaires) and calculating an average, a final outcomes score is generated. The 'outcomes continuum' below can then be used to obtain an overall impression of outcome.

### Outcome Continuum



Further guidelines for the tools application, interpretation, and analysis are detailed in Appendix I. However, pages 279 to 281 contain samples of the finalised Hua Oranga schedules for tangata whaiora (patient), whanau (family), and clinician. They represent the final versions as amended after the clinical trials, review of literature, and subsequent consultations. The main difference between these questionnaires and the original drafts are:

- A greater range of questions are used to measure each dimension
- some simplification of the wording of questions
- the accompanying scoring schedule was modified in order to capture concerns about an appropriate mechanism for collating responses

The remainder of the Chapter 5 describes the outcomes of the research process, the rationale upon which the measure is based as well as the key features and components of the measure.

# TANGATA WHAIORA SCHEDULE

Q1. As a result of the INTERVENTION do you feel: (Please Circle One)

- a) more valued as a person      =>>   =>>   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) stronger in yourself as a Māori   =>>   =>>   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more content within yourself      =>>   =>>   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) healthier from a spiritual point of view   =>>   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q2. As a result of the INTERVENTION are you: (Please Circle One)

- a) more able to set goals for yourself   =>>   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more able to think, feel and act in a positive manner   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more able to manage unwelcome thoughts and feelings   =>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) more able to understand how to deal with your health problem   =>>>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q3. As a result of the INTERVENTION are you: (Please Circle One)

- a) more able to move about without pain or distress   =>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more committed to having good physical health   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more able to understand how physical health improves mental well-being   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) physically healthier   =>>   =>>   =>>   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q4. As a result of the INTERVENTION are you: (Please Circle One)

- a) more able to communicate with your Whānau   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more confident in your relationships with other people   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) clearer about the relationship with your Whānau   =>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) more able to participate in your community   =>>>   

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
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# WHANAU SCHEDULE

Q1. As a result of the INTERVENTION does your relative feel: (Please Circle One)

- a) more valued as a person      ⇒⇒    ⇒⇒    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- b) stronger in his/herself as a Māori    ⇒⇒    ⇒⇒    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- c) more content within him/herself    ⇒⇒    ⇒⇒    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- d) healthier from a spiritual point of view    ⇒⇒    ⇒⇒    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------

Q2. As a result of the INTERVENTION is your relative: (Please Circle One)

- a) more are to set goals for him/herself    ⇒⇒    ⇒⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- b) more able to think, feel and act in a positive manner    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- c) more able to manage unwelcome thoughts and feelings    ⇒⇒⇒⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- d) more able to understand how to deal with their health problem.    ⇒⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------

Q3. As a result of the INTERVENTION is your relative: (Please Circle One)

- a) more able to move about without pain or distress    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- b) more committed to having good physical health    ⇒⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- c) more able to understand how physical health improves mental well-being    ⇒⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- d) physically healthier    ⇒⇒    ⇒⇒    ⇒⇒    ⇒⇒    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------

Q4. As a result of the INTERVENTION is your relative: (Please Circle One)

- a) more able to communicate with the Whānau    ⇒⇒    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- b) more confident in relationships with other people    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- c) clearer about the relationship with the whānau    ⇒⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- d) more able to participate in the community    ⇒⇒    ⇒    

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------

# CLINICAL SCHEDULE

Q1. As a result of the INTERVENTION does the patient feel: (Please Circle One)

- a) more valued as a person ⇒⇒ ⇒⇒ ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) stronger as a Māori ⇒⇒ ⇒⇒ ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more content within him/herself ⇒⇒ ⇒⇒ ⇒ ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) healthier from a spiritual point of view ⇒⇒ ⇒⇒ ⇒ ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q2. As a result of the INTERVENTION is the patient: (Please Circle One)

- a) more to set goals for him/herself ⇒⇒⇒⇒⇒⇒⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more able to think, feel and act in a positive manner 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more able to manage unwelcome thoughts and feelings ⇒ ⇒ ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) more able to understand how to deal with their health problem. ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q3. As a result of the INTERVENTION is the patient: (Please Circle One)

- a) more able to move about without pain or distress ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more committed to having good physical health ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more able to understand how physical health improves mental well-being ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) physically healthier ⇒⇒ ⇒⇒ ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q4. As a result of the INTERVENTION is the patient: (Please Circle One)

- a) more able to communicate with the Whānau ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more confident in relationships with other people ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) clearer about their relationship with the Whānau ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
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- d) more able to participate in the community ⇒⇒ ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
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## OUTCOME CONCEPTS AND MĀORI PERSPECTIVES

The extensive testing and research process provided the means through which a Māori mental health outcome measure was constructed. Key to this was the transformation of the MMHO framework from theory into practice. In conducting this process a critical alignment also took place and was based on the need to somehow consider te whare tapa whā from within a mental health and outcomes context. To some extent this had been achieved through the initial draft schedules. However, the testing process was to reveal several key shortcomings, in particular the need to reconsider how the selected model of Māori health could be applied to a mental health clinical setting. In this respect the initial draft instrument, while providing a suitable testing mechanism, was found to be somewhat limited and did not reflect the range of outcomes expected or required. In order to be valid, a broader range of outcome preferences (linked to each dimension of te whare tapa whā) would need to be identified and formulated.

The following section discusses the application of the whare tapa whā model of Māori health to mental health outcomes. As part of this, the outcome-related attributes of each dimension of te whare tapa whā have been identified. These attributes, while relying heavily on the testing process, have also been aided by a review of relevant literature, consultation with key informants, hui discussions and direct feedback. As described, these attributes provide the key substrate through which the three outcome schedules were constructed.

## WAIRUA, DEFINING THE SPIRITUAL DIMENSION OF MENTAL HEALTH OUTCOME

All things in nature cohere. It is the wairua that is the cohesive element. The wairua consists of many aspects and components; the identification of those components gives insight and offers explanations for behaviour not only mentally and psychologically but also physically. From a mental health perspective the wairua of an individual, their whānau, hapū, iwi and waka and all that these entail take precedence over all other considerations.<sup>10</sup>

Wairua is the first dimension in the whare tapa whā model, and reflects the need to consider and address outcomes which are spiritual in nature. Although wairua has featured as part of the established discourse on Māori health for many years it has been difficult to define the meaning of the concept, how it may be interpreted, and importantly how it can be measured, at least from a mental health perspective. Conservative explanations of wairua and wairuatanga were frequently considered (within the testing process) from a holistic perspective, highlighting the interconnectedness between an individual and other, often non-descript concepts, of the spiritual world.

The mental health sector, and especially Māori, have been quick to emphasise the relationship between spiritual health and mental health:

The traditional Māori health system was integrated in nature, mental and physical health not clearly being separated. Retaining traditional Māori concepts within the Christian faith. The old tendency for psychiatry to pathologise religious and spiritual attitudes is shown as not only culturally inappropriate but as clinically inadequate.<sup>11</sup>

In considering the implications of wairua to mental health outcome some analysis is required to determine accurately what is a 'healthy' as opposed to an 'unhealthy' spiritual experience. To a great extent, notions of spirituality stem from an individual's most basic and fundamental understanding of how their reality and world view are formed, how moral attitudes are shaped, how meaning is given to everyday situations, and how judgements and decisions are formulated. Moreover, these beliefs, interactions or connections, will ultimately underpin any outcome-related preference:

The religious and spiritual dimensions of culture are amongst the most important factors that structure human experience, beliefs, values, behaviour and illness patterns. Religion and spirituality have always had an influence on the form and especially the content of mental illness, yet in mainstream psychiatry the tendency has been for them to be pathologies, ignored or relegated to an uneasy borderland, with labels such as 'existential' or 'cultural'.<sup>12</sup>

A growing awareness and recognition of the relationship between health and spirituality has led to a proliferation of research activity, especially amongst Western researchers who had traditionally focused their attentions on so-called pure science, biological and chemical interactions or imbalances. Perhaps the most comprehensive investigation exploring the relationship between health and spirituality was conducted by the World Health Organisation as part of the development of its WHOQOL-100 measure. This multidimensional tool was constructed with the aid of more than 15 centres around the world, included input from more than 4500 respondents, and involved the testing of some 300 outcome-related questions, of which 100 were eventually selected.<sup>13</sup> Like te whare

tapa whā, spirituality was but one component of the overall schedule, and other domains such as physical health, psychological function, level of independence, social relationships, and the environment, were also included. Though not a pure measure of outcome, the schedule highlighted the need to consider health from a broad and inter-related perspective and how notions of spirituality would be considered through the application of a self-reporting assessment schedule.<sup>14</sup>

The instrument has proved its utility by exploring the diverse factors that contribute to a state of total well-being. The process through which the tool was constructed further illustrated that although spirituality was an important part of health and health outcome, the concept could not easily be defined. In fact, notions of spirituality would almost certainly vary according to a person's own religious beliefs, environment, peer attachments, upbringing, notions of personal contentment, or self-constructed views on how the non-physical domains of life were considered. Further, while cultural factors tended to dictate the overall manner in which spirituality was perceived, spirituality was often constructed on the basis of more diverse influences and personal impressions.

A paper developed by Te Roopu Awhina o Tokanui<sup>15</sup> provided some initial guidance on the notion of spirituality and how it relates to Māori mental health. It also demonstrated that although wairua was an important component of Māori mental health, it was often difficult to describe precisely what it actually meant or how it could be interpreted, because it was couched in poetic, metaphorical language.

WELCOME TO THE GALLERY OF TAHA WAIRUA OR THE DIMENSIONS OF  
SPIRITUALITY

*Taha Wairua is: the timeless twinkle of celestial lace in a crystal-crisp night sky,  
the warm and open smile of an innocent child,  
the calm caring touch of a faithful friend,  
the denial of pleasures given to each other, and the protection of the basic principles of  
nature and human kind.*

*Taha Wairua is also: the gleeful roar of the raging surf  
A half-halo rainbow on a clouded rainswept sky,  
The pristine gold of an untrodden beach,  
The hypnotic quality of natural masterpieces,  
The spiralling beauty of bird and people song,  
And the fractured reflections of a mosaic raindrop.*

*It is: the unforgettable cry of birth,  
The magical moment of natural death,  
And the sobering hallowed anguish from crucified humanity.*

*Taha wairua allows each person, in time, to see their true inner selves and to amend any  
deficits in a more enlightened and positive way.*

*Everyone has some Taha Wairua, but rarely is it used, all day and every day.  
Some people deny its existence and endure a lifetime of spiritual emptiness.  
Often misuse it and are denied further riches to their lives.  
Taha wairua is the god force that transcends all man-made boundaries.*

*It can be found behind a grotesque façade, in the wretchedly deformed container or  
tragically mirrored across a brutally shattered window.  
It is the most difficult gift to receive but is the easiest to use.  
It is the only gift which is indescribably beautiful with a magnificent purity that beautifies  
the environment.  
It also shows as a quiet incandescence in the eyes of those afflicted*

*Taha Wairua makes the intolerable, tolerable:  
The biased, objective:  
Despair, hopeful:  
And man-kind god-like*

*It is the seed of world peace,  
The power for brotherly and sisterly love,  
And the crucial element for the mature man-kind*

Other studies and papers have similarly explored the relationship between wairua/spirituality and mental health.<sup>16</sup> However, these have yet to provide any real consensus. While it is generally agreed that spirituality is important to mental health, other than stating this, few investigations have attempted to consider what it actually means in terms of inputs, outputs or outcomes.<sup>17</sup> Where some form of guidance is given, often the information is too broad to be useful or so specific that its utility is compromised.

This study, and more specifically the testing process, provided a unique opportunity to develop a more structured analysis of notions of wairua and the link to positive mental health outcome. The four features or functions that follow have been identified as part of the testing process, and represent a three-tiered interface between wairua, service activity/intervention, and positive health outcomes.

### **Wairua and the Notion of a Non-Physical Component of Health**

Linking wairua to mental health outcome is a task made no easier by the fact that individual impressions and constructs are likely to be widely diverse, with a range of idiosyncratic views about spirituality. The testing of the draft measure certainly affirmed this assumption. Of all the dimensions of te whare tapa whā, wairua was the most difficult to operationalise. In grappling with this issue, four key features were identified, and while each evolved equally, and on the basis of its relative merits, one feature of

wairua was especially prominent, i.e. the generic belief in a non-physical dimension or force.

At a service level, evidence supporting this view was most noticeably illustrated in discussions with staff, and although many could actively provide comment on wairua, these discussions were often inconclusive or overly influenced by personal observation. Yet, at the same time there was a degree of commonality. Links were made to a fundamental belief in some kind of spirit or entity. Similarly, the data obtained from tangata whaiora and whānau, although wide ranging, also confirmed the existence of a non-secular element that could promote positive mental health outcome.

Data supporting the importance of wairua were further provided within the findings of the WHOQOL project, which also concluded that the spiritual dimensions of health could not be defined according to a narrow set of parameters and its exploration would need to encompass a position on which few assumptions have been made. As an illustration, the following question is extracted from the WHOQOL-100 measure and is designed to consider the spiritual dimensions of health:

F24.1 (F29.1.1) Do your personal beliefs give meaning to your life? <sup>18</sup>

Though at face value simple enough, the question is cleverly constructed and bears three features important to outcome measurement. First, it is targeted at the individual (i.e. 'Do you...'); second, it is framed in a manner relevant to the respondent (i.e. '...give meaning to your life'); and third, it assesses personal beliefs with no obvious assumption as to

what these might be. Insofar as the belief in a non-physical being, force, or entity is concerned, the question further shows that a broad interpretation is required. Otherwise there is a risk of ‘fitting’ individuals within parameters that are too confining and therefore inappropriate. As the tool itself was designed to be used within a range of populations and cultures such considerations were particularly important and relevant.

### **Wairua and Cultural Identity**

The second feature of wairua relates to the notion of cultural identity and the idea that while spirituality may be a generic concept, ‘wairua’ is fundamentally unique to Māori and therefore reflects Māori ideals, paradigms and cultural constructs. Throughout this investigation into outcomes, international studies and literature were used to inform the research process, and provided essential guidance on a number of key theoretical fronts. However, defining the concept of wairua and wairuatanga (spirituality) proved elusive in that although material concerning spirituality and health was often available, it did not accurately equate with the concepts raised by key informants and the data obtained through the testing process. In this regard, discussions pertaining to wairua were frequently placed within a cultural context and linked to the notion that an individual’s wairua could be damaged if cultural identity was compromised or tarnished. Other research documents also provided evidence of a link between cultural identity and wairua.<sup>19</sup>

In discussions with staff working in Māori mental health services, the relationship between identity and wairua was again presented, but this time within a treatment-related

context. It was suggested that many of the so-called cultural interventions or processes were designed with clinical and cultural objectives in mind; a dual focus designed to bring complementarily. While many cultural activities were developed to enhance the relevance of the therapeutic milieu,<sup>20</sup> they were also designed to improve or sustain an individual's cultural identity and mental health. A significant number of providers also indicated that interventions designed to raise cultural identity were in essence a means through which wairua could be enhanced:<sup>21</sup>

For tangata whaiora the recovery process is more a journey of rediscovery. Ko wai? No whea? Na wai? (who are you? where do you come from? who are your parents?) Knowing the connections that make them who they are is the foundation of recovery. For many this foundation is missing because the traditional tribal nature of Māori culture has been gradually erode by the effects of colonisation and urbanisation...All four participants in this paper needed to reclaim their identity as Māori to begin the journey to well-ness.<sup>22</sup>

Durie provides further evidence of this relationship and notes:

Access to a secure identity is a right of all New Zealanders and there is no good reason why that should be any less true for those with a mental illness. In developing mental health services, Māori perspectives and Māori health aspirations should be taken into account...For Māori this means having access to te ao Māori and the confidence to participate as Māori. In the process, meaningful participation [within their communities] will be more likely if there is a security of identity. Finally there is an added onus on providers of services to Māori. Not only should the aim be to restore clients to optimal health, but every opportunity should be taken to reinforce the cultural identity of all clients, and, in the case of Māori, to recognise the values and beliefs of

those who wish to be Māori. The personal and family costs of mental illness are high enough; they should not be compounded by cultural alienation.<sup>23</sup>

Although the previous extract does not precisely draw the link between cultural identity and wairua it does illustrate how identity can be used to promote mental well-ness and how it underpins a sense of integrity and the capacity for sharing with other Māori.

### **Wairua: Dignity and Respect**

People's ability to take responsibility and control over their lives is central to their quality of life.

Empowerment is an important health goal for consumers.<sup>24</sup>

The third feature of wairua reflected the overall focus of the outcomes framework as well as the essential requirement that outcomes should be important and relevant to mental health consumers or tangata whaiora. Their desires and aspirations for the clinical setting should therefore be afforded high recognition. In the past, mental health institutions played a custodial role, patients having little active voice within the treatment process. However, in recent years, a greater emphasis has been placed on consumer participation, coinciding with an increased awareness of the role of consumers within the sector and the valuable contribution they can make to service and policy development.<sup>25</sup> More than simply providing opportunities for greater input, consumer can also aid their own treatment and recovery process. According to the Mental Health Commission, such considerations will be important to the mental well-being of all mental health consumers:

...People in the health sector [need to] understand how its systems, processes and personnel can discriminate against people with mental illness, and put into place measures which ensure: adequately resourced mental health services, equitable access to, all health services for people with mental illness, respect for people with mental illness, recognition and promotion of their rights, services users and tangata whaiora influence decision making.<sup>26</sup>

Despite such imperatives, there is some evidence to suggest that the rights of consumers are not always appropriately considered, and many consumers remain relatively ignorant of the obligations of service providers. For Māori consumers of mental health services, issues can be complicated in situations where cultural issues are relevant or where cultural practices or behaviours prevent them from participating as they might expect:

The services were inadequate and unhelpful and they made things worse. When I first went to hospital, there was definitely something happening but it wasn't dealt with. I had an experience of psychosis or mental illness or whatever, but on top of that I was re-traumatised through the hospitalisation process. Nothing was explained to me. I had side effects from the medication, I wasn't fully informed or part of the decision making. I didn't know about advocates. I didn't know what I was entitled to. Lack of support for myself and my whānau definitely hindered my recovery. It took two years for my healing and recovery to start.<sup>27</sup>

I didn't know that I had any rights. They just said that this is going to happen, you'll do this, we'll look after you, we'll make you better...there was not a lot of information. In fact, I wasn't told a damn thing. Looking back, I don't know how they got away with treating me the way that they did.<sup>28</sup>

In Chapter 3 the characteristics of Māori mental health services were explored, essentially to consider what makes them different and unique. Numerous interviews and perspectives were obtained to supplement much of the information gathered from the review of literature. However, an unexpected, and perhaps unrelated issue, evolved from discussions with service staff regarding the types of relationships they were able to develop and promote with Māori clients. Many commented that Māori staff tended to interact differently with Māori patients, perhaps a reflection of changes in contemporary attitudes to care, but for Māori staff, perhaps a reflection of a more fundamental observation of cultural concepts and behavioural norms. Others described how they were able to establish links with Māori clients, either through whakapapa or social networks, and how this added to the ability to treat them in an appropriate manner. Treating individuals with dignity and respect appears to be a common Māori understanding of wairua. It is an interaction occurring between people and the wider environment.

As an aspect of wairua, 'dignity and respect' implies that a positive mental health outcome will need to reflect and be consistent with notions of consumer world views and human equality. For Māori mental health consumers, such concepts are also aligned with more traditional ideas of manaakitanga, whanaungatanga, or whakamana, and provide the necessary cultural context through which an appropriate link to wairua can be established:

When people come into our service, they are acknowledged, we have a powhiri to do this, or if they prefer a small mihimihi...the important thing is that they are made aware that they are part

of the whānau, that they are important, and that they bring with them their own unique whakapapa and wairua.<sup>29</sup>

## **Wairua and Personal Contentment**

Just as a meeting house has wairua that is distinct from the wairua of a kitchen or dining room so has an institution or service. This wairua will depend on several factors or influences and can be made up of the staff and personnel, the buildings, the function of each building, its artwork, furniture and a host of other factors that impact on those who are not only employed in the service but who also provide a service to its clientele.<sup>30</sup>

The fourth and final feature of wairua is again linked to the notion of a non-physical or spiritual experience as well as the well-ness principle of the MMHO framework. It has been noted that wairua is intangible, personal, and cannot easily be defined according to a set of rigidly established criteria. However, this investigation suggests that wairua is also something that can be sensed (sometimes felt, sometimes touched, sometimes seen) and importantly something especially noticeable when absent:

Curiously enough the wairua seems to be partially material, inasmuch as it can be seen by human eyes, at least by those of persons who are matakite.<sup>31</sup>

Many of the comments about wairua were conveyed in terms of interactions with people and how, particularly within close whānau, one could feel or sense if someone was unwell or troubled:

The second I saw him I knew something was wrong, not by what he said, or the way he looked, I could sense it you know, something was not right...<sup>32</sup>

Mental health workers were especially certain about this type of relationship, and further linked it to the process of cultural assessment. Qualified cultural assessors would be capable of discerning a wairua that might not be assessed during a typical clinical assessment:

While clinical protocols for mental health status examinations are well developed, there is less agreement about the essential nature of a cultural assessment or its relationship to a mental disorder. It will at least provide a basis for a better understanding of the client and may lead to a cultural formulation of the problem, to complement a DSM IV diagnosis.<sup>33</sup>

The point is that wairua is closely linked to a sense of personal contentment – a dimension that may or may not accord with a mental state. A wairua may be ‘intact’ in the face of serious illness, or alternatively in considerable disarray in the absence of illness. A failure to show dignity and respect may undermine wairua.

**Table 5.4** Outcome Features: Wairua

Feature	Description
Spirituality (non-physical experience)	An intangible belief in the non-physical spiritual aspect of health
Cultural Identity	Māori cultural identity is a measure of wairua
Dignity and Respect	Reflects the alignment of the tool with the needs and aspirations of Māori clients and a sense of personal integrity
Personal Contentment	A personal sense of calmness or equilibrium. A settled and contented outlook

## **HINENGARO AND MĀORI MENTAL HEALTH OUTCOME**

Of the four domains of the whare tapa whā model, hinengaro is most closely aligned with the more usual measures of mental health outcome. It is a domain that considers an individual's thoughts, feelings and behaviours, and has received the most sustained focus from mental health researchers and clinicians. Despite this, and despite the fact that the model has been used extensively within kaupapa Māori mental health services, the appropriate measures of hinengaro have received little attention.

### **Hinengaro: Motivation**

The first aspect of hinengaro is linked to 'motivation'. In identifying this aspect, numerous outcome assessment schedules were examined and although many were too specific to provide any reasonable guidance, motivation was a theme presented consistently enough to highlight its importance. Within a clinical context, motivation provides a useful guide to an individual's capacity to effect positive change and willingness to contribute constructively to well-ness. Motivation is not a culturally neutral concept, nor is it always the best indicator of health. But it is a sufficiently valued quality in Māori thinking to include as a key component of hinengaro. Moreover, as an indicator of outcome, it lends support to Māori emphasis on action. Ideas often used to epitomise Māori thinking and behavioural patterns are essentially about high levels of motivation, the ability to set personal goals, and the initiative to chart a course of action.

Data obtained through the testing process revealed that notions of hinengaro were often constructed within the context of a specific condition. This was perhaps a reflection of the manner in which the testing process took place and the requirement to assess the instrument in a practical consumer-focused situation. Yet, comments frequently revealed the need to assess outcome in terms of how the intervention or treatment had contributed to an individual's drive or enthusiasm:

The patient has a range of problems and it is difficult to determine how the intervention has or should contribute to their well-being...there are so many variables and options to consider...however certainly if an improvement in motivation was noted, this would constitute some progress in this instance.<sup>34</sup>

### **Hinengaro: Cognition and Behaviour**

A second aspect of hinengaro is aligned to clarity in thought and purposeful action. A synergy between thoughts and behaviour underpins the concepts of hinengaro. Where thinking patterns are inconclusive or run only in circles, they do not accord with the notion of purposeful mental functioning, a state that is valued by Māori. Indeed purposefulness of thought is an important component of the concept of hinengaro, along with actions that are decisive and adaptive. Where thinking is not adaptive or behavioural patterns not compatible with achieving personal or group goals, then a deficit in thinking patterns is evident. Māori styles of thinking and behaving have their own characteristics that may differ from other cultural norms. Thus the concept of hinengaro carries with it not only the functions of cognition and behaviour but also the expectation that Māori-specific patterns may prevail. A good outcome is one where tangata whaiora

will be able to think and act in a positive manner, at least in terms of their own cultural frameworks.

### **Hinengaro: Management of Thoughts and Feelings**

The capacity to manage thoughts and emotions is the third aspect of hinengaro. Many people with mental disorders are bothered by unwelcome thoughts and feelings that may be so overwhelming that reality itself becomes distorted. As a concept, hinengaro includes a strong reality principle. Emotional excesses that lie outside a contextual norm are not regarded as healthy. Self-management therefore implies a degree of control over emotional excesses and cognitive distortions. Many treatments are aimed at improving control but often do so at the expense of motivation and clarity of thought. From a Māori perspective, and having regard for the parameters of hinengaro, self-control and management of thinking and feeling are fundamental qualities, necessary for healthy functioning. Within mental health services there is a general move towards self-control and self-management – a step away from the paternalism and institutionalisation that dominated psychiatric care for many years. The Māori emphasis is consistent with this trend:

Traditional mental health services have been based on a ‘benevolent paternalism’ which assumes ‘best interest’ decision making by clinicians on behalf of consumers...this model of services has been the most serious barrier to consumer participation in the past. The result has been that many consumers, particularly those who has spent periods of time in institutions, lack the faith in their ability to assert control over their own affairs...more recently many of these assumptions have been challenged.<sup>35</sup>

## **Hinengaro: Knowledge and Understanding**

At a mental health outcomes conference in 2000,<sup>36</sup> a consumer representative made comment that outcomes and outcome measures were often the domain of clinicians and overlooked a basic consumer expectation of being able to simply understand ‘what was going on’. These types of concerns were frequently raised as part of discussions on outcome objectives and in particular in comments made by consumers and whānau. In recognition of these concerns the last feature of hinengaro, ‘knowledge and understanding’, reflects the notion that positive outcomes should in part consider whether or not an individual has been made aware of the treatment process, the nature of their condition, and how they are able to contribute to their own well-being.

As previously discussed, mental health treatment facilities have not always adopted a recovery approach to care nor have they actively sought to respond in a manner that is empowering or dignifying. It is important therefore that mental health consumers are placed in a position of confidence and are likewise able to understand what problems they may have and the processes in place to deal with them. Though similar to the ‘management of emotions and thinking’ feature, this component goes further to encompass some of the more pragmatic realities of mental illness and the need for consumers to be informed of the various issues that can impact on their recovery. The ability to process knowledge and information in order to reach a sound understanding of illness or situation is an important function of hinengaro.

Many of the comments received by both tangata whaiora and whānau illustrated that the process of mental health care was often unclear, and some clinical staff were unable to describe the nature of the problem effectively or to do so in a manner that was entirely comprehensible. Of more concern, however, were comments that indicated that very little communication had taken place. In terms of outcome, such implications require that processes are in place through which improved ‘understanding’ is facilitated:

This conference has focused on outcomes and outcomes research...to me being simply able to understand what is going on is a positive outcome and I’m sure that this goes for most of us..<sup>37</sup>

**Table 5.5** Outcome Features: Hinengaro

Feature	Description
Motivation	The capacity of an individual to contribute to well-ness
Cognition and Behaviour	Clarity of thought and purposeful actions
Management of Thoughts and Feelings	Capacity to manage thoughts and feelings effectively and maintain a sense of reality
Knowledge and Understanding	Understanding the problem and the ways to gain better control/management

## TINANA: THE PHYSICAL DIMENSION OF MĀORI MENTAL HEALTH OUTCOME

The relationship between physical health and mental well-being is now well established and has been recognised as important in terms of designing appropriate treatment processes.<sup>38</sup> For Māori, dividing the mental and physical realms has often been seen as forced or contrived:

The traditional Māori health system was integrated in nature, mental and physical health not clearly being separated. The conceptual separation of mind and body has been described by contemporary Māori as an aberration of Western thinking.<sup>39</sup>

In more recent times, Western researchers and clinicians have also become aware of the mind-body relationship and have further emphasised the need to consider the interaction between physical health and mental well-ness. Many studies have described the negative effect physical disability can have on an individual's mental health and vice versa.<sup>40</sup> Depression and suicide are not infrequently linked to physical illness and by the same token heart disease and possibly cancer may sometimes be attributable to mental disorders.<sup>41</sup> Accordingly, many policy documents stress the need to consider physical health as part of a comprehensive approach to mental health treatment.<sup>42</sup>

Notwithstanding these connections, there is evidence (based on the testing and interview process) to suggest that the physical needs of mental health consumers are often not met,

and that even within Māori mental health services, which promote holistic modes of care, the mind-body relationship is undervalued.

### **Tinana: Mobility and Pain**

Physical symptoms provide audible signs of poor health. Although reflecting an endless range of specific disease categories, most physical complaints are fundamentally linked by the limitations they cause, the restrictions they can place on an individual's lifestyle and capacity for normal social functioning.

The identification of 'mobility and pain' as an outcome feature of tinana, came about as a result of discussions with consumers and concerns about the ability of some services to meet their physical health needs. For consumers, loss of mobility (for whatever reason) and the presence of pain, were the most frequent physical concerns.

Comments obtained from the testing process were less precise about the features of tinana but also raised issues relevant to the notion of 'mobility and pain'. The following extract gives an indication of the types of concerns raised:

Some medications are extremely good, especially the new anti-psychotics; however, if they reduce your functioning to a level that you can't even chew your food, swallow, or lead an active life, surely the outcome is not entirely positive...obviously it [ the outcome] could be better from a patient's perspective.<sup>43</sup>

This statement illustrates one of the more fundamental theories of outcome measurement: it cannot (or rather should not) be assumed that symptom reduction is the major goal of any intervention or that it will equate with a positive outcome. In many cases the reduction of 'mental symptoms' may well be seen as a good result, but if in the process there has been a deterioration in physical functioning, there may be less reason for celebration. An intervention needs to be assessed in terms of its impact on physical health, and the opportunity cost of symptom reduction has to be fully explored before concluding that the result is favourable.

### **Tinana: Opportunity for Enhanced Health**

Every health intervention, whether for mental health or other reasons, should be presented as an opportunity for health promotion. The 'opportunity' might consist of dietary advice, or advice about exercise, or sleep, or lifestyles. What is important is that treatment should not be divorced from the goal of well-being; and often that goal requires some attention to physical as well as psychological determinants:

When we were selecting a site for our service we deliberately went looking for something with a rural outlook, but at the same time close to town and other amenities... this site gives us that and provides an environment that is more therapeutic for our tangata whaiora...there's a pool, tennis courts, a sports field, and a bit of a nature walk out the back...this is exactly what we need...<sup>44</sup>

By providing the opportunity for enhanced physical health, the therapeutic benefits of more specific mental health interventions can be improved, goal setting encouraged, and a sense of accomplishment fostered. As mental health problems affect a range of

individuals, both young and old, and with varying degrees of physical capacity and function, priorities for enhanced physical health will not be the same. For younger, relatively fit, tangata whaiora, team sports such as touch or rugby or softball may produce optimal benefit. For the elderly, a simple game of chess or line dancing once a week, may provide similar results. Nutritional advice may be more relevant to others, or cessation of smoking. The important thing is that the issue is considered and appropriate assistance delivered.

### **Tinana: Mind and Body**

Māori views on health do not recognise a sharp line between mind and body. In contrast, Western approaches to mental health care have tended to overemphasise the division, and locating mental hospitals in remote areas was one expression of the division. Even though modern mental health care does not always encourage mind-body fusion, an important outcome for clients will be whether they can see the link and apply it in a useful way.

Unfortunately, many of the comments made by tangata whaiora revealed that to a large extent they were unaware of the benefits physical activity could provide and less than enthusiastic about exploring physical types of therapy. Discussion with clinicians underlined the point, a typical statement being:

...we now well know the benefits that physical activity can have on mental health. The full benefits of this, however, can only be realised if people participate, and are willing to do so...for

this to happen an awareness of the mind and body link must be established...when people are aware, they will participate...<sup>45</sup>

The notion of a 'mind-body link' as an outcome goal evolved out of these concerns. An understanding of mind-body relationships is critical and is in itself a positive outcome. Such ideas are consistent with notions of 'knowledge and understanding' and 'opportunities for enhanced health'. However, the 'mind-body' link is more clearly focused on knowledge about physical health, an appreciation of how this can improve mental well-ness and the activities that may encourage improvement. Similarly the impact of mental ill-health on physical health requires attention.

### **Tinana: Physical Health Status**

The final aspect of tinana was a more blanket and simpler requirement, reflecting the need for an overall assessment of health status. In brief, physical health should be better at the end of any health intervention than it was before hand. A mental health assessment is not complete without some assessment of physical health. Nor should mental health treatment proceed without attention to bodily health. Measuring the level of physical health is another matter, and both subjective and objective measures will be helpful. In time it would be expected that clinicians would rank changes in physical health on the basis of scored health status measures such as weight, respiratory reserve, blood pressure, blood chemistry, mobility. Whānau and tangata whaiora will use more subjective measures – which may be just as useful in terms of fashioning an overall impression of physical health status. The table below sets out the outcome components of 'tinana'.

Table 5.6 Outcome Features: Tinana

Component	Description
Mobility and Pain	Considers how/if physical problems have been addressed and what effect if any the intervention has had on physical health
Opportunity for Enhanced Health	Opportunities should be provided for improving physical health during mental health interventions
Mind and Body Links	Appreciation of the relationship between mental health and physical health is important
Physical Health Status	Gains in physical health should accompany gains in mental health. Maintaining of both is important

## WHĀNAU AND MĀORI MENTAL HEALTH OUTCOME

It has been long known that if one wishes to know anything about a client's developmental milestones, onset of the illness, social and family development and interaction, likes and dislikes, fears and phobias, levels of functioning, drug or alcohol dependencies, reliability, honesty, criminal behaviour, anger or violent tendencies, and a host of other information, then for Māori, we don't rely solely on the client - we ask the whānau.<sup>46</sup>

Like wairua, whānau is difficult to conceptualise within a mental health context, and while there is sufficient evidence to support the benefits of whānau/family involvement, particularly within the treatment process, there is less agreement as to the nature of this relationship and how whānau may be able to support positive outcomes. In most instances it can be assumed whānau will aid treatment and rehabilitation activity, and will

provide valuable information in terms of assessment and desired outcomes.<sup>47</sup> However, this assumption can fail to appreciate that not all whānau are capable or willing to offer support or that input from the whānau is actually desirable in every instance.<sup>48</sup> Some mental health consumers do not want whānau to be involved. Whānau in modern times are scattered, do not necessarily have good contact with each other, and may opt to affiliate only on an occasional basis. Simply put, and informed (rather than presumed) approach to whānau input is required, one which fully considers the wishes of tangata whaiora.

Other issues have concerned the definition of whānau within a contemporary context, how wider societal values and norms have changed, and how this severely impacts on traditional interpretations of whānau.<sup>49</sup> Metge notes:

Most of the changes currently in progress are changes in the structure of the parent-child family, which is the major building block of the whānau: a decrease in the number of children per mother, increases in the proportion of de facto compared to de jure marriages, in the frequency of marital break-up, in the proportion of children living with one parent, in blended families or moving between two parental homes.<sup>50</sup>

In an attempt to more effectively draw the relationship between whānau and health, Durie describes five key functions of whānau: manaakitanga (the capacity to care); tohatohatia (the capacity to share); pupuri taonga (the capacity for guardianship); whakamana (the capacity to empower); and whakatakoto tikanga (the capacity to plan ahead).<sup>51</sup> In a similar vein, other researchers have also developed specific frameworks through which

the principles of whānau are linked to health. An example of one is *Whakapiripiri Whānau*, developed by Te Pūmanawa Hauora in 1996 as a framework for understanding the relationship of whānau to health.<sup>52</sup>

**Table 5.7** Whakapiripiri Whānau Framework

PRINCIPLES	HEALTH IMPLICATIONS
<b>Tātau Tātau (collective responsibility)</b>	<ul style="list-style-type: none"> <li>● Healthy Development</li> <li>● Access to informal health support</li> <li>● Reduction in levels of stress</li> <li>● Access to resources to promote a healthy lifestyle</li> <li>● Safe environment</li> </ul>
<b>Mana Tiaki (guardianship)</b>	<ul style="list-style-type: none"> <li>● Health Development</li> <li>● Improved mental well-being</li> <li>● Access to resources to promote a healthy lifestyle</li> <li>● Enhanced quality of life</li> <li>● Enhanced spiritual well-being</li> </ul>
<b>Manaakitanga (caring)</b>	<ul style="list-style-type: none"> <li>● Enhanced quality of life</li> <li>● Healthy Lifestyles</li> <li>● Healthy policy development</li> <li>● Healthy practices</li> <li>● Models for health promotion</li> </ul>
<b>Whakamana (enablement)</b>	<ul style="list-style-type: none"> <li>● Healthy development</li> <li>● Improved mental health</li> <li>● Access to health services</li> <li>● Access to resources to promote good health</li> <li>● Health promotion</li> </ul>
<b>Whakatakoto Tūtoro (planning)</b>	<ul style="list-style-type: none"> <li>● Opportunities for early intervention</li> <li>● Healthy policy development</li> <li>● Access to resources to promote good health</li> <li>● Improved access to health services</li> <li>● Planning for health needs</li> </ul>
<b>Whai Wāhitanga (participation)</b>	<ul style="list-style-type: none"> <li>● Improved access to health services</li> <li>● Healthy lifestyles</li> <li>● Health promotion</li> <li>● Access to resources to promote good health</li> <li>● Informal health support</li> </ul>

*Source:* Te Pūmanawa Hauora, 1996: 32

These models are valuable in that they suitably consider the potential of whānau as a health promotion mechanism, and recognise the changing nature of Māori culture and society. In spite of this, there remains the need for greater consideration of how the whānau dimension of health can be placed within a relevant context, linked both to mental health and health outcome.

### **Whānau: Communication**

...whakawhanaungatanga was constantly emphasised as the basis for health and the means of interconnectedness for Māori. Whānau participation can be particularly useful at the assessment stage and in furnishing a more accurate picture of the pressures that impact on the person. Providing opportunities for participation at all stages of treatment and rehabilitation was considered beneficial as well.<sup>53</sup>

Although disagreements have arisen about the capacity of whānau to promote positive lifestyles Māori have confirmed the notion that whānau remain an essential mechanism through which positive health gains can be achieved and maintained.<sup>54</sup>

In exploring the link between whānau and mental health outcome the most consistent theme to emerge was communication between tangata whaiora and whānau and whether the periods of treatment had added anything positive to the relationships. Some individuals had lost contact with their whānau or chose to keep a distance. While this may be the preferred option it is nevertheless important that there is an opportunity so that at least the position can be communicated effectively. In a practical sense, this may

not necessarily mean a closer relationship, but rather a clearer statement about the relationship. Māori service providers have often endorsed whānau participation as a pre-requisite for any Māori focused service, yet are also aware that a degree of caution should be exercised and it should not automatically be assumed that whānau involvement will be beneficial.<sup>55</sup>

For a variety of reasons, consumers of mental health services may have lost contact with whānau and may not be in a position to re-establish links or to maintain links over a period of time.<sup>56</sup> An effective intervention process should be able to consider these issues within the overall context of the outcomes being sought.<sup>57</sup> While better communication may be an objective, the extent and nature of this should be defined by the tangata whaiora's own circumstances and the capacity of the whānau to respond in a positive way. Although communication with the whānau could provide and sustain positive outcomes, the need to consider potential risks is also evident. A comment made by a tangata whaiora respondent is used to highlight this point:

I know that there is a push to have more whānau involvement and all that...which is good most of the time...but, you know, for some of us that's not possible...we've just lost contact...still others say that the whānau are the biggest problem...they don't want anything to do with them.<sup>58</sup>

## **Whānau: Relationships**

If there is anything you wish to know about me don't ask me, ask my whānau. The whānau can take many forms and consist of people other than direct family members but the function and purpose of the whānau is such a potent force in the assessment process.<sup>59</sup>

The need to improve whānau/tangata whaiora communication as a mental health outcome objective is aligned with the broader need to form meaningful relationships as well as the desires of tangata whaiora to participate actively within society. The principles identified by Durie as well as those suggested in the *Whakapiripiri Whānau Framework*, consider some of the features of whānau, yet describe relationships or interactions that can be applied in a number of different social situations. To this end, although an individual may have lost contact with parents, brother or sisters, nonetheless meaningful relationships may have been forged with others who may not have actual blood ties. Moreover, these relationships may fit comfortably within traditional notions of manaakitanga, tohatohatia, pupuri taonga, whakamana, and whakatakoto tikanga. In this respect, a whānau may conceivably take the form of a supportive group such as a kōhanga reo, social group, or even a sports team.<sup>60</sup>

Using the whānau models, the capacity to form helpful relationships in a variety of social situations becomes an important consideration. A good outcome is one where the quality and quantity of the relationships are appropriate to the level of well-being. For some people, minimal relationships will be preferable to a plethora of relationships. Others will be best served by shallow, low-key relationships, in contrast to those who prefer highly charged, substantial relationships. Whether the relationships are with whānau or not, is less important than the being able to enjoy relationships that enhance mental well-being. From a holistic perspective, and in appreciation of the relationship between whānau and Māori concepts of health, an intervention should therefore be assessed on

how it has supported the individual's capacity to develop positive interpersonal relationships, in whatever shape or form these may take:

From a Māori perspective, positive health is equated with inter-dependence, whereas the move toward independence is generally seen by Europeans as being one of the critical development tasks of adolescence, and therefore is viewed as a fundamental building block of health.<sup>61</sup>

### **Whānau: Mutuality**

I will want to race off home to sort myself out with the help of my whānau. They have lived my illness with me and have lived my well-ness with me too. If I didn't have them to support me, where would I go? Home! Home to where there are people who know instinctively what my needs are and how to awhi me and who know how to fix me up without the medication! The same people can teach us about how to make our communities healthy, about how we can prevent mental illness, who grieve over the problems of our young people. Who don't have formal qualifications or the recognition for their skills or the recognition of their vast knowledge.<sup>62</sup>

Mutuality and the notion of shared responsibility is a concept which is also closely aligned with whānau and whānau activities. While not unique to Māori, it is significant in terms of how whānau (in what ever sense) is perceived. Like the function of communication, it is unlikely that every whānau will be able to express mutuality positively or that such interactions will have a beneficial effect on mental health. However, it is important that expressions of mutuality are considered and assessed in terms of how they can lead to improved mental health outcomes for Māori.

The *Whakapiripiri Whānau* framework highlights many concepts aligned with the notion of mutuality; not only through the ‘Tātau Tātau’ (collective responsibility) principle, but also in terms of ‘Mana Tiaki’ (guardianship), ‘Manaakitanga’ (caring) ‘Whakamana’ (enablement), and ‘Whai Wāhitanga’ (participation). Likewise, ‘Manaakitanga’, ‘Tohatohatia’, ‘Pupuri Taonga’, ‘Whakamana’, and ‘Whakatakoto Tikanga’ are all linked to mutuality or shared responsibility. Taiapa considers how the concept of tohatohatia (the capacity to share resources fairly and viably) may be examined within a practical context. In the following example of a family reunion she states:

Sharing was visible at all times, between and across the generations particularly of resources such as blankets, tents, kai, clothes, money. Kaumātua freely shared their knowledge and information about whakapapa and history. There was a sense of collective responsibility for the well-being of every person there. Special attention was paid to those who were unable to care for themselves, namely the very young and the disabled.<sup>63</sup>

It is important, however, not to assume that mutuality is always in the interest of a patient. Mutuality can be a euphemism for domination and control. By living lives that are too closely intertwined, there may be inadequate opportunity to develop a sense of individuality, or to cope alone, when support is simply not available. Mutuality is therefore both an asset and a risk. Either way, it is worthy of comment but without any foregone conclusions that it is always an indicator of a good outcome. It may be the reverse.

## Whānau: Social Participation

Lack of adequate access to clinical treatment options (including skilled counselling and psychotherapeutic types of support), and insufficient involvement in clinical treatment decisions (particularly those concerning medication) were frequently of concern to consumers. Families clearly expressed a need for more support, involvement, education, and information.<sup>64</sup>

The three previously identified aspects of whānau reflect specific needs, important in terms of outcome, relevant to Māori mental health, and aligned with the concept of whānau. The fourth and final feature considers the broader notion of whānau and how improved communication, meaningful relationships, and participation may be applied within a wider context to reflect interaction at a community level.

In a paper outlining strategies for Māori mental health, Durie concluded that the needs of mental health consumers should be met at fundamental levels and that mental health for Māori includes mechanisms that facilitate active participation within society and the networks within which they live.<sup>65</sup> Consumers themselves have endorsed the theme and affirmed that while support at a family level is important to encourage sustained, and positive outcomes, reintegration and wider participation within society is also necessary.<sup>66</sup> Barriers to community integration can have a significant effect on mental well-being, particularly when attempting to live normal and productive lives.<sup>67</sup> Public stigma can affect employment prospects, housing, access to services, and other social networks, further exacerbating existing problems and impeding the chances of recovery.

Deinstitutionalisation and the move toward community-based treatment facilities was partially based on the premise that mental health outcomes could be improved if patients

were given the opportunity to reintegrate back into society and to form positive relationships outside a treatment setting.<sup>68</sup> However, living in the community does not necessarily mean healthy integration and the parameters of social participation require further clarification. For now, the point is that an aspect of the whānau dimension is concerned with social participation in the community. Balance is again important since unwise participation may be more maladaptive than isolation. The framework below summarises these last four features and their characteristics.

**Table 5.8** The Whānau Dimension of Māori Mental Health Outcome

Feature	Description
Communication	An intervention should at the very least improve the communication networks between consumer and whānau
Relationships	Highlights the need to improve the quality of relationships with the whānau. May not necessarily mean a closer relationship is formed
Mutuality	Reflects the need to foster balanced relationships with whānau. This aim may not be to promote a good or even positive relationship, rather an improvement
Social Participation	Emphasises the need/desire of mental health consumers to play a full and active role within their communities and to contribute to the social environments within which they live

## DOMAINS OF OUTCOME

As a final summary, a Multi-Dimensional Framework has been constructed. It considers the four components of te whare tapa whā from a mental health perspective, and highlights those aspects that are important in the assessment of outcome.

Table 5.9 A Multi-dimensional, Outcome Framework

	<i>DOMAINS</i>			
	<b>Wairua</b>	<b>Hinengaro</b>	<b>Tinana</b>	<b>Whānau</b>
<b>Dimension 1</b>	dignity, respect	motivation	mobility/ pain	Communication
<b>Dimension 2</b>	cultural identity	cognition/ behaviour	opportunity for enhanced health	relationships
<b>Dimension 3</b>	personal contentment	management of emotions, thinking	mind and body links	mutuality
<b>Dimension 4</b>	spirituality (non- physical experience)	understanding	physical health status	social participation

## TRIANGULATION AND CLINICAL END-POINTS

Apart from the *whare tapa whā* foundation, the MMHO Framework was also unique because of the triangulated assessment protocol, involving three sets of assessors, and a set of clinical end-points to make the process more manageable and relevant. The rationale behind these additional components was linked to five major issues: the need to disaggregate the treatment process into more manageable components; the unreliability of self-reporting inventories; the inadequacy of proxy measures; the desire to incorporate consumer perspectives; the need to account for outcome contributors that may be external to formal treatment activity.

Testing the measure sought to confirm that while not without some difficulties,<sup>69</sup> the method of triangulation and clinical end-points suitably controlled some of the more fundamental problems associated with mental health outcome measurement and provided a sound mechanism through which mental health outcomes for Māori could be measured and considered. However, concerns were raised about the selection of an appropriate *whānau* member, someone who could offer an alternative perspective to the clinician and *tangata whaiora*. In this regard it was noted that not all *tangata whaiora* had contact with *whānau* and in some instances deliberately preferred to maintain a distance. As a consequence, accessing an appropriate *whānau* member – to provide input – was sometimes problematic.

As a counter it was suggested that a reasonably broad definition of whānau be adopted and that this definition need not exclude those who were not blood relatives. In reflecting on the triangulated assessment method, and the desire to include whānau, it was determined that a more fundamental requirement or intent was the need to offer a third (alternative) perspective and that familiarity with the tangata whaiora was more important than a blood connection. It was an approach consistent with popular understandings of whānau.<sup>70</sup> As a consequence, the term 'whānau' (in terms of outcome assessment) was used in a broad context, to describe someone capable of offering a third perspective, who was sufficiently familiar (with the tangata whaiora) to provide informed comment. The only caveat being that tangata whaiora should select this person, and, that the individual should be neither another tangata whaiora nor a staff member.<sup>71</sup>

Another issue concerned the manner in which the three perspectives would be triangulated and interpreted. The results from the testing process revealed that in many instances significant disparities between each of the three key stakeholders arose and that a system to manage and interpret these variances was required. It was initially suggested that a system of weighting be introduced and that clinical perspectives be given higher credence. However, this approach also sat somewhat uncomfortably and indeed appeared at odds with the need for consumer input and empowerment, the notion of holism, and the importance of whānau input. To this end it was agreed that a system of weighting would be unnecessary, particularly as the tool was designed to be used in a complementary fashion, with more targeted, clinically focused measures of outcome.

The idea being that any significant variances could be weighed against what a more specific measure would indicate.

For example, a tangata whaiora with depression may undergo an outcome assessment using the cultural measure. The results obtained may show a high degree of divergence between each of the three key stakeholders, so much so that a consensus view becomes unlikely. In order to obtain useful outcomes data, the cultural measure could be used in association with the Hamilton Rating Scale for depression,<sup>72</sup> thereby adding to the existing data set and providing a more objective perspective on what impressions are likely to be valid. Alternatively, the detection of significant discrepancies could prove useful in itself by identifying individual expectations and deficits, and which dimensions of outcome are being addressed or alternatively, neglected. The precise manner in which the data are triangulated and applied is described in Appendix I.

The identification of the clinical end-points raised similar concerns in that the theory behind them proved somewhat less ideal in practice. Of significant concern was the fact that not all tangata whaiora would progress through these distinct stages of treatment and care. In response, it was suggested that the clinical end-points be used as a guide only, and that the tool could be applied at any point where an outcome could be expected. Further, that an ongoing process of outcome assessment would provide the best means through which long-term outcome progress could be monitored. By gathering data regularly and consistently, the data could be used in a more informed manner. Details related to this are contained in Appendix I.

## GLOBAL IMPERATIVES

The guidelines produced in Appendix I, were designed in part to avoid misinterpretation and to ensure the measure was not used out of context. In consultation on the use of the measure, and how the various outcomes could be promoted, concerns were raised as to the overall context within which the measure was used and the need to consider more fully the intent of the measure and what it implied. From these discussions four points were raised and identified as ‘global imperatives’, issues that would need to be considered by users of the tool and those wishing to promote outcomes that were in sync with Māori perspectives and philosophies.

The first point is associated with the notion of holism and the idea that an integrated approach to health care, treatment and rehabilitation is required. The MMHO Framework was based on this concept – that positive mental health outcomes for Māori would require an assessment of results that went beyond the narrower modes of psychiatric treatment and care. Additional concerns were raised about the manner in which Māori models of care, while typically holistic, had become compartmentalised due to the current system of health care provision.<sup>73</sup> Of primary concern was that the individual components of the *whare tapa whā* model could be treated independently within a service setting and that services were ill-structured to deliver the types of interventions or activities that Māori concepts of mental health outcome demanded.

An historical overemphasis on symptom ablation, aggravated the trend; mental health services could potentially treat the symptoms of mental ill-health, without adequate regard for the implications on *wairua*, *tinana*, or *whānau*. In this regard it was suggested

that while the multi-dimensional outcomes framework had served to locate more precisely the actual components of whare tapa whā (from a mental health outcome perspective), the risk was that each component would be viewed independently rather than as a part of a whole:

...there is a hangover from the compartmentalised approach taken by many health professionals, in that the four taha have become compartmentalised. Instead of understanding the impact of change on all aspects of the individual and their whānau's functioning, many health workers still reduce down to the various component parts of the four taha. Until there is true integration of these matters, until people recognise that any change in the balance of an individual of their system requires restoration of that balance in order to return to full health, then the provision of holistic and appropriate, therefore effective health care for Māori people will be a dream.<sup>74</sup>

The second point concerned the relationship between culture and health. While many of the components described within the multi-dimensional framework were not unique to Māori they nevertheless needed to be conceptualised within a culturally derived framework. In a practical sense this would mean that all the dimensions described, even those associated with hinengaro, would need to be considered for cultural relevance. That although the intervention and objective may be entirely clinical, the role of culture in promoting these objectives was important.

The third point highlighted the importance of maintaining an appropriate focus on tangata whaiora well-ness. This idea was not new and formed one of the more fundamental concepts upon which the MMHO framework was constructed. However, as part of the frameworks transition, the concept had become blurred, due to the process of

triangulation, and as a consequence of the range of outcome features identified. Some respondents (especially whānau) had confused the process of triangulation with an attempt to consider how they felt, rather than how they perceived their relative felt. In this regard greater emphasis needed to be placed on the primary intention or focus of outcome assessment that was very much consumer orientated.

The fourth point highlighted the need for a broad approach to outcome promotion: that the mental health needs of Māori could not be met by the health sector alone, and that services would need to establish wider links with other sectors, and within the context of Māori development. Such connections emphasised the move away from illness and disease, toward well-ness, the capacity to function as part of a community, and, consequently, to grow.

**Table 5.10** Hua Oranga: Some Imperatives

IMPERATIVE	FUNCTION
Integration	The tool must function in an integrated manner. Each dimension is interdependent and a good outcome should reflect gains in each dimension
Culture and Health	The promotion of each dimension must take place in a cultural context – even in clinical situations or where no obvious cultural element is evident
Consumer Focus	The instrument and the outcomes are consumer focused. While others may provide insight, the outcomes should be fundamentally consistent with consumer goals and objectives
Māori and Social Development	Services will need to establish and maintain connections with other sectors

## CONCLUSION

This chapter had two main aims. First, to describe the process of testing and refining the MMHO framework. Second to show that it was possible to construct an outcome measure based on Māori health perspectives, suitable for mental health services. Both aims are linked and have led to the development of *Hua Oranga* – a Māori measure of mental health outcome.

Although *Hua Oranga* is presented as a Māori mental health measure, it does not replace other measures (e.g., HoNOS)<sup>75</sup> that give greater specificity for clinicians. Indeed the lack of detailed psychometric outcomes will be seen as a limitation – especially if the measure is used alone. At the same time, however, *Hua Oranga* is not intended to act as an inventory of psychopathology or to measure symptom reduction. Instead, in keeping with Māori health views, it draws attention to higher order outcomes that are of interest to clients and their whānau, and attempts to measure the usefulness of an intervention according to its broader impacts. In the end, tangata whaiora are more interested in the parameters of well-being than the presence or absence of psychopathology.

This type of imperative does not negate the importance of rating tools such as the Hamilton Depression scale, but it does introduce a different benchmark for determining whether a higher level of health has resulted. *Hua Oranga* adopts a baseline derived from notions of well-being rather than recovery from sickness. It deliberately downplays the sectorisation of health into a series of specialty areas that often have little connection, and works toward building up a picture of health where the component parts are synthesised into larger units. In this way a consumer-focused balance is achieved.

In the early 1980s, a renewed interest in Māori health resulted in the inclusion of Māori principles and values into policy and practice. However, performance measures were either lacking or were so crude they could neither incorporate cultural perspectives nor unravel cultural inputs from clinical wisdom. The current phase of Māori health development is now more concerned with measuring results from several perspectives and recognising that outcomes, like processes, have cultural determinants.

In constructing *Hua Oranga*, criteria for measuring Māori health have become clearer. Most important is the recognition that narrowly defined clinical measures are of limited value, and unless they reflect the views of clients, family, clinicians, and service providers, they run the risk of being misleading or even irrelevant. In other words, a measure that has high clinical specificity may miss the more significant point, at least in Māori eyes, because it fails to address questions of well-being. However, in addition to cultural, spiritual and social aspects, a Māori measure of health must also be able to comment on both physical and psychological functioning. In that sense it is more than simply a statement about cultural integrity.

*Hua Oranga*, like other Māori health measures, attempts to link clinical requirements with cultural values and philosophies so that they can be applied to modern settings and provide useful information without compromising Māori world views. In this particular study, cultural views, mental health policies, health practice, and the aspirations of tangata whaiora and their whānau all contributed to the measure's final shape.

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<sup>1</sup> Discussions with Māori health researchers suggested that a testing process would be the most effective and efficient means of achieving the objectives of the study.

<sup>2</sup> See Appendix II.

<sup>3</sup> The six test sites covered four regions: Greater Auckland, Waikato, Hawkes Bay, and Wellington.

<sup>4</sup> To help the analysis of each questionnaire, evaluation forms and stakeholder packs were numerically coded.

<sup>5</sup> See Appendix IV

<sup>6</sup> Microsoft Access.

<sup>7</sup> See Appendix III.

<sup>8</sup> (MHI) Mental Health Inventory – Discussed in the following chapter.

<sup>9</sup> A monetary donation was given to each participating service.

<sup>10</sup> Mental Health Section, (1995), 'Guidelines for Cultural Assessment', in *Mental Health Services, He Purongo e pa ana, Te Whakahianga o Ngā Arotakenga Tika kei roto I Te Ratonga o Te Oranga Hinengaro*, Ministry of Health, Wellington, p. 15.

<sup>11</sup> J. Turbott, (1996), 'Religion, Spirituality, and Psychiatry: Conceptual, Cultural, and Personal Challenges', in *Australian and New Zealand Journal of Psychiatry*, vol. 30, pp. 727-729.

<sup>12</sup> *Ibid.*, p. 721.

<sup>13</sup> The research was deliberately conducted to obtain comment from a range of different cultural perspectives. This was part of the rationale for developing the study across so many countries.

<sup>14</sup> See for detail <http://www.svhm.org.au/whoqol/Chapter%203.htm> (27 January 2002).

<sup>15</sup> Te Roopu Awhina o Tokanui, (1986), 'Cultural Perspectives in Psychiatric Nursing', a paper presented at the Australian Congress of Mental Health Nurses Twelfth National Convention, September 1986, Australia.

<sup>16</sup> See for example J. Turbott, (1996), 'Religion, Spirituality, and Psychiatry: Conceptual, Cultural, and Personal Challenges' in *Australian and New Zealand Journal of Psychiatry*, vol. 30, pp. 721-730. See also Mental Health Foundation, (1986), *The Future of Mental Health Services in New Zealand*, Mental Health Foundation, Wellington; M. H. Durie, (1996), 'A Framework for Purchasing Traditional Health Services', a report prepared for the Ministry of Health, Department of Māori Studies, Massey University, Palmerston North; D. Chaplow, (1993), 'Addressing Cultural Differences in Institutions: Changing Health Practices in New Zealand', in *Criminal Behaviour and Mental Health*, vol. 3, pp. 307-321.

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- <sup>17</sup> See for example Ministry of Health, (1994), *Looking Forward – Strategic Directions for Mental Health Services*, Ministry of Health, Wellington, p. 18. See also Mental Health Section, (1994), *Guidelines for the Management Of Patients with Co-existing Psychiatric and Substance use Disorders*, Ministry of Health, Wellington, p. 16.
- <sup>18</sup> <http://www.who.int/dsa/cat98/men8.htm> (12 December 2000).
- <sup>19</sup> See for example Ministry of Health, (1996), *Towards Better Mental Health Services: The Report of the National Working Party on Mental Health Workforce Development*, Ministry of Health, Wellington. See also Te Pūmanawa Hauora, (1995), *Guidelines for Purchasing Personal Mental Health Services for Māori: A Report Prepared for the Ministry of Health*, Department of Māori Studies, Massey University, Palmerston North; P. Kingi, (1994), 'Kōrero Mai: Māori Mental Health and the Treaty of Waitangi', in *Mental Health News*, Summer 1995, p. 11.
- <sup>20</sup> For example, cultural performances, carving, flax weaving.
- <sup>21</sup> An example of this is karakia. Durie states this may be done in a relatively low-key manner within services attempting to develop these types of processes. For example, Māori signage, an occasional Māori visitor, a Māori song or traditional Māori meal. See M. H. Durie, (1994), *Māori Cultural Identity and its Implications for Mental Health Services*, Department of Māori Studies, Massey University, Palmerston North.
- <sup>22</sup> Mental Health Commission, (2000), *Four Māori Kōrero about their Experiences of Mental Illness*, Mental Health Commission, Wellington.
- <sup>23</sup> Durie, (1994), *op cit.*, p. 12.
- <sup>24</sup> Ministry of Health, (1995), *A Guide to Effective Consumer Participation in Mental Health Services*, Ministry of Health, Wellington, p. 5.
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- <sup>27</sup> Mental Health Commission, (2000), *op cit.*, Tania's Story.
- <sup>28</sup> *Ibid.*, John's Story.
- <sup>29</sup> Personal Communication, Service Database Entry (clinical) – Record 63.
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- <sup>34</sup> Personal Communication, Service Database Entry (Clinical) – Record 60.

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- <sup>37</sup> Panel Discussion (Mary O’Hagan): Mental Health Outcomes Research in Aotearoa Conference, Brentwood Airport Hotel, Wellington, 8 September 2000.
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- <sup>44</sup> Personal Communication, Interview Database Entry – Record 31.
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- <sup>61</sup> C. Maskill, (1991), *A Health Profile of New Zealand Adolescents*, Discussion Paper 14, Health Research Services, Department of Health, Wellington, p. 34.
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- <sup>66</sup> Mental Health Commission, (1999), *op cit.*
- <sup>67</sup> L. Thompson, (1996), *Mental Health Research Project Report: A Report Prepared for Te Puni Kōkiri*, Ministry of Māori Development, Wellington.
- <sup>68</sup> H. Haines and M. Abbott, (1985), 'Deinstitutionalisation and Social Policy in New Zealand: Historical Trends', in *Community Mental Health in New Zealand*, vol. 1, no. 2, pp. 44-56.
- <sup>69</sup> The majority of concerns being linked to the method of triangulation and whether or not a system of weighting should be employed.
- <sup>70</sup> For example the *Whakapakari Whānau Framework*.

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- <sup>71</sup> Within many Māori mental health services, tangata whaiora and clinicians are considered whānau. However, the requirement to exclude staff members from the instruments definition of whānau is entirely based on the need to provide three alternative perspectives of outcome.
- <sup>72</sup> Clinician-rated semi-structured interview. 21 items, with 3 - 4 - and 5-point scales used. Symptoms covered include: feelings of guilt, suicide, insomnia (early, middle, late), agitation, genital symptoms, loss of weight.
- <sup>73</sup> See Keefe-Ormsby, *et al.* (1993), *op cit.*
- <sup>74</sup> E. Ryan, (1993), 'Tino Rangatiratanga in Forensic Psychiatry and the Development of the Forensic Services', in *Tino Rangatiratanga and Māori Mental Health Conference, 28-30 June 1993*, Wainuiomata, p. 38.
- <sup>75</sup> Health of the Nation Outcome Schedule. Described in the following chapter.

## Chapter Six

# HUA ORANGA: APPLICATIONS AND IMPLICATIONS

### INTRODUCTION

The previous chapter described the transformation of the MMHO framework into a more practical measure of Māori mental health outcome – *Hua Oranga*. The research process allowed for a more insightful examination of the framework, the schedules initially proposed, and the suitability of te whare tapa whā as a base for outcome measurement.

Aside from the data used to inform *Hua Oranga*, a range of other issues were further raised that, while not significant in terms of the tools design, are important in understanding the application of the tool and the overall context within which it can be applied.

### THE CONTEXT OF HUA ORANGA

Although designed for Māori, *Hua Oranga* is consistent with other measures of mental health outcome and illustrates features reflected in established discourse and theory. In a report investigating processes for the routine assessment of consumer outcome, Andrews et al,<sup>1</sup> reviewed almost 100 measures of health outcome (potentially suited to mental health) and identified five of possible use: Behavioural and Symptom Identification Scale (BASIS-32); the Mental Health Inventory (MHI); the Medical Outcomes Study 36-item

Short-Form Survey (SF-36); the Health of the Nation Outcome Scales (HoNOS); and the Role Functioning Scale (RFS).

Comparisons between these measures and *Hua Oranga* can be made at a number of levels. For example, like *Hua Oranga*, each of the measures are multi-dimensional in that they consider a number of distinct health categories. BASIS for example, contains 32 items categorised into five groupings: the patient relationship to self and others; daily living and role functioning; depression and anxiety; impulsive and addictive behaviour; and psychosis. HoNOS, contains a set of 12 scales that cover aggressive and disruptive behaviour, suicidal thoughts and self-injurious behaviour, health and social problems associated with alcohol and drug use, problems involving memory, orientation and understanding, problems associated with physical disorders, mood disturbance, problems associated with hallucinations and delusions, other mental and behavioural problems (e.g., panic, phobias, obsessive-compulsive disorder, eating and sleep disorders), problems with making supportive social relationships, social environment – housing and locality, social environment – employment, recreation, finance, overall severity of functional disability.<sup>2</sup> SF-36 contains eight dimensions covering physical functioning, physical role limitation, emotional role limitation, bodily pain, mental health, social functioning, vitality, and general health perceptions.<sup>3</sup> MHI has five dimensions: anxiety; depression; loss of behavioural or emotional control; general positive effect; and emotional ties.<sup>4</sup> RFS contains four domains: work; independent living and self-care; immediate social network; and extended social networks.<sup>5</sup>

Unlike these five measures, the dimensions of *Hua Oranga* are shaped by cultural as well as technical requirements, though is similarly designed for a specific task: for use in an identified range of situations. However, all these measures, including *Hua Oranga*, highlight the usefulness of considering more than one aspect of health outcome, and conclude that a broad-based approach to outcome assessment is warranted with tools that measure a range of interrelated dimensions.

Both HoNOS and RFS are clinician rating scales, BASIS and SF-36 can either be interviewer administered or self administered, while MHI is self/consumer administered. None of these tools provide a mechanism through which whānau/family perspectives can be considered, although most include an assessment of social functioning – concepts consistent with the whānau dimension of *Hua Oranga*. The most significant difference, however, is in the application of the triangulated outcome assessment protocol in *Hua Oranga* – three perspectives are used to form a single measure. This approach is designed to counter some of the more pragmatic concerns of health outcome measurement (especially in mental health) and the extent to which ‘proxy’ and ‘self-reporting’ measures provide legitimate insight. While some tools can be used by either client or clinician these perspectives are often tabulated independently of each other or to establish comparisons. Here also *Hua Oranga* differs in that the alternate perspectives are combined and considered equally, and also as part of a formal health outcome assessment.

As described in Chapter 4, an impediment to routine outcome use is linked to logistical barriers; in particular to the need for instruments able to function in a practical sense, in clinical settings, and in a manner that places no unreasonable demands on those who choose to use them.<sup>6</sup> The selection of BASIS, MHI, SF-36, HoNOS, and RFS by Andrews et al., was derived from a range of imperatives, not least of which was the need for a measure that had practical utility.<sup>7</sup> This concern was reflected in the design of *Hua Oranga*, its brevity, simplicity, and the design parameters placed on its application and length. The capacity to be used ‘alongside’ other measures of outcome was another design feature used to enhance *Hua Oranga’s* overall effectiveness. In the end, and like so many measures of outcome, the application of *Hua Oranga* will depend on its ‘usability’ as much as its ‘utility’. Certainly, the discussions concerning *Hua Oranga’s* application were frequently linked to its function in a clinical setting.

Measurement of change is another consistent feature demonstrated within *Hua Oranga* and each of the five measures described. Each measure also employs a simple scoring or rating system. Like *Hua Oranga*, BASIS has a five-point rating scale, while HoNOS has a four-point scale. SF-36 is somewhat more complicated, with a system of weighting, though for only two of the eight dimensions considered. The MHI is again similar to *Hua Oranga* in that the scores for each dimension are sub-totalled, then aggregated to give an overall MHI score. RFS has a seven-point scale that is also summed to give a global index.

These types of scoring mechanisms provide a simple means through which conclusions can be gathered and compared with other dimensions or between individuals. Further, by collecting the data over an extended period, progress can be monitored and assessed and mechanisms to address particular needs/deficits can also be considered. There is a trend that appears to favour the simpler methods of scoring – no doubt a reflection of administrative and logistical concerns.<sup>8</sup> These requisites influenced the scoring method adopted for *Hua Oranga*, although inevitably the triangulated system of measurement ensured that the tool was not as simple as some.

The most consistent parallel between *Hua Oranga* and all measures of outcome, however, – including the five described, is that they are all in some way limited. For all their usefulness, measures of outcome will inevitably be judged by what they cannot do or fail to measure. This shortcoming is indicative of the fact that no single measure of outcome is capable of measuring all that is important or the multiplicity of perspectives relevant to those who use them. These limitations do not nullify the use of outcome measures but suggest a degree of caution when using them or interpreting the data they produce.

While *Hua Oranga* is the first tool specifically designed to measure Māori mental health outcomes, another study has also attempted to consider the notion of well-ness and the implications for Māori mental health outcome measurement.<sup>9</sup> This other study had objectives that were different from *Hua Oranga*. However, it provided data that highlighted the dissimilar way in which Māori perspectives of health and well-ness were

conceived and shaped. Further, it also highlighted the fact that health outcome priorities in mental health were in part derived from cultural determinants – factors that would inevitably determine what instruments were used.

Within the context of health outcome measurement, *Hua Oranga* sits comfortably within the established discourse and has been guided by other, more established tools and instruments. *Hua Oranga* will likely add to the existing pool of knowledge and help create a more informed approach to the development of similar measures, especially those that require cultural consideration.

## **CAVEATS ON THE USE OF OUTCOME MEASURES**

Aside from the limitations that determine the context within which measures of outcome are used, an associated issue concerns the way in which outcomes data are interpreted to aid service development or policy design. Measures of outcome are often viewed (frequently by policy makers) as the ‘holy grail’.<sup>10</sup> They provide mechanisms that move beyond process or input, to reveal data based on ‘what worked’, as opposed to ‘what happened’ or ‘what was funded’. Frequently, however, the implications of outcome measures are overstated. While they provide useful information, they are unlikely to offer an ultimate solution, nor information that is perfectly reliable, or universally applicable. A risk, therefore, is that policies or services are shaped extensively or exclusively on measures of outcome, and fail to appreciate the broader context within which health service delivery takes place or the complexity of the issues.

Measures of outcome, including *Hua Oranga*, are not perfect and must be viewed within the context of their limitations, what they fail to consider, and the parameters within which they operate. Both inputs and outcomes have their relative strengths and weaknesses and in an imperfect world both need to be considered alongside each other, taking cognisance of what they reveal and what they do not. Contrary to some opinion measures of outcome will not provide a panacea, but if used correctly will enable more informed decisions to be made.

## THE CONTEMPORARY POLICY CONTEXT

Local interest in health outcome measures has increased since 1996, partially as a consequence of the National–New Zealand First coalition Government agreement on health and its emphasis ‘...on achieving health outcomes and improving the health status of the populations that they serve’.<sup>11</sup> The implementation of this objective was not only hampered by the ‘short-lived’ nature of the Coalition Government, but also due to the confusion surrounding the concept of ‘outcome’, a lack of conceptual development of outcome measures (within New Zealand at least), and some uncertainty as to how outcomes could be used nationally, in order to contribute to improved service delivery and design.<sup>12</sup> Nevertheless, interest in health outcomes, and health outcome measures has escalated and has influenced policy and practice.

During the latter half of the 1990s investigation into outcomes, at least for mental health, was centred around the Mental Health Research and Development Strategy (MHRDS), an

initiative administered by the Health Research Council, on behalf of the Ministry of Health. The strategy had three main areas of interest: epidemiology, case-mix, and outcomes. For outcomes the aims are ‘...to assess and assist the implementation of systems for measuring outcomes of mental health services which will improve the planning, purchasing and delivery of mental health services in New Zealand’.<sup>13</sup>

The extent to which these aims will be met is, for the time being, uncertain; many of the activities supported by the strategy had not been completed by 2002. Regardless, the potential for outcomes measures to assist policy development is significant, and is reflected in the broad aims that have been prescribed. They reflect a parallel thrust within the mental health sector to ensure that service growth is considered alongside service development (i.e. services that are more efficient, more capable, and more effective).

The mental health sector has experienced considerable expansion in the past decade, since the health reforms of the early 1990s. A greater number and range of services are available, designed to meet a range of needs and the expectations of consumers, their families, and the wider community. Quantifying service growth, and the precise reasons for this growth, is difficult, although possible when measured against data quality.<sup>14</sup> However, a more contentious issue concerns the notion of effectiveness, what this means, how it is measured, and how policy makers are able to take advantage of what data are available. It is in this regard that measures of outcome are of particular interest, allowing policy to be developed in a more informed way, so that ‘more’ services can lead to ‘better’ services.

*Hua Oranga* is a distinctive measure of mental health outcome but, as shown, is comparable with other tools such as, HoNOS, BASIS, SF-36, MHI or RFS. It differs, however, in that it measures outcome preferences that reflect a Māori perspective. It considers the cultural dimensions of mental health outcome, as well as the efficacy of cultural interventions, treatments or care.

These distinctive characteristics make the tool especially appealing to policy makers as it allows Māori mental health services to be considered in terms that are relevant to Māori, and that appreciate Māori approaches and the philosophical foundations upon which they are based. Policy development is best informed through accurate and relevant data<sup>15</sup> and will therefore be enhanced by the perspectives offered with *Hua Oranga*.

## FUNDING IMPLICATIONS

...health authorities have failed to address the central issue of whether the activity being paid for is worthwhile. The key question is not how many services are being provided or how long the people wait for them but whether these services lead to a significant improvement in health.<sup>16</sup>

Māori mental health services are typically funded on process, or input, derived in part from theory, and more often on faith, what is assumed to work, anecdotally, or according to tradition, Māori beliefs, and cultural practice. This pragmatic approach to service development is, in many ways, out of step with the more usual evidence-based methods of service design. *Hua Oranga* has attempted to merge these two paradigms by providing

an interface through which the value of Māori mental health services and interventions can be considered from an evidence-based, Māori-centred, perspective.

Many of the frustrations experienced by Māori mental health services have centred around the contractual process that, aside from demands for greater financial support and an ill appreciation (by funders) of Māori methods of operation, has caused additional problems. From a Western perspective, Māori modes of service delivery have often appeared too fluid, untested, and more conceptual than practical. This has, to some extent, influenced the manner in which Māori purchasing plans have been developed. Although frameworks and models (outlining the characteristics of a Māori mental health service) have guided service activity, and have usefully described funding criteria, the interpretation of these models has varied according to local needs and kawa. As a result, the funding of Māori mental health services has often taken place in an adhoc and inconsistent manner.<sup>17</sup>

With a lack of theoretical evidence-based development, Māori mental health services have often found it difficult to ratify their methods and to negotiate the level of funding required. *Hua Oranga* considers Māori methods of operation while at the same time providing evidence through which activities can be quantified or measured. The implications here in terms of funding are potentially significant and consistent with policy objectives in health, the move from input based-funding to outcomes. The challenge, however, is to determine to what extent funding derived from outcomes is

accepted, the manner in which the process is managed, and the capacity to include Māori perspectives.

## **MONITORING**

Outcome measures are often used as monitoring mechanisms. As described in Chapter 4, this approach depends on the accuracy of the tools used, the capacity to measure what is important or relevant, the range of outcomes produced, and the links connecting outcome to intervention. For Māori mental health services the issue is not so much about what is measured, but what is not; whether a tool is able to consider outcomes of significance to Māori or the objectives derived from treatment. *Hua Oranga* does not negate nor reduce the need for more clinically focused measures of outcome. What it does reveal, however, is that Māori mental health services often produce outcomes not always considered by the more conventional methods. Further, monitoring frameworks need to appreciate the full range of outcomes produced by Māori mental health services, as well as the mechanisms by which they are achieved. A failure to do so will mean that Māori services are assessed according to criteria that do not fit, or that lack relevance. While Māori services will need to be measured against administrative, technical, and clinical competencies, evaluation of efficacy must encompass a broader range of variables and outcomes.

## **TANGATA WHAIORA AND WHĀNAU RESPONSIVENESS**

Workforce development has already been discussed in Chapter 3. However, it has become increasingly apparent that consumers and families must be more actively engaged in treatment and care. Until recently, the role of consumers within the mental

health sector was largely passive, care was administered by clinicians with minimal opportunity for active or meaningful consumer input. For families, the situation was little better; the information given was often inadequate, frequently too technical, or presented in a manner that discouraged participation. More enlightened attitudes, coupled with improved modes of care, have led to a more positive relationship being formed between consumers, whānau, and clinicians.<sup>18</sup>

*Hua Oranga* has demonstrated the value of a triangulated outcome assessment protocol. The views of whānau, consumers, and clinicians can be considered together, without conflict or compromise. The application of the tool is described in Appendix I along with an explanation of how the three perspectives can be managed and interpreted. A concern, however, is the manner in which the often divergent perspectives of outcome are read, the implications they have, and deciding which perspective is 'most' correct.

In resolving these issues, the measure avoids rating one perspective over another and each is regarded as being of equal value. This may, from time to time, cause problems. However, the tool is designed to be used in association with other more specific measures, thereby offering greater objectivity and precision. Regardless of these issues, and whether or not a weighting system should be employed, divergent opinions present the opportunity to identify individual needs, perspectives and issues more clearly. For tangata whaiora and whānau the opportunity is significant, certainly welcomed, but not always facilitated. Ideally, clinicians will similarly appreciate the chance to obtain structured and confidential input from consumers and their families though not all will

receive the measure or the approach with enthusiasm. In the end, however, the opportunity to consider consumer and whānau perspectives is an important dimension of the tool and will provide information that has not always been generated.

## **HEALTH PROFESSIONALS**

Information capable of determining the efficacy of care has obvious benefits, especially in the mental health sector where assessments of treatment effectiveness are sometimes clouded or tentative. The pragmatic development of Māori mental health services, coupled with the variable manner in which cultural therapies are applied, has made it difficult to determine the way, or the extent to which these activities have contributed to health gains. Moreover, when tools have been used, they have often failed to capture the essence of what outcomes were sought.

As described, many of the so-called cultural interventions, such as powhiri, karakia, mirimiri, or whanaungatanga, have obtained their validity through the process of time, through cultural practice, experience, and understandings of health. Anecdotal evidence of the links between culture and treatment have provided further support, as have various developments within the area of transcultural psychiatry, and indigenous research that has focused on Māori mental health.

*Hua Oranga* allows for greater specificity in the application of Māori interventions and processes and for the assessment of their efficacy in ways that make sense to Māori. The measure does not seek to validate Māori approaches to care, but it does provide a

mechanism through which cultural therapies, treatments and interventions can be linked to outcomes. For clinicians, the implications are that care can be planned with more certainty and with a greater likelihood of improved consumer outcomes.

## **LOCAL MANAGEMENT**

Increasing costs, the drive toward greater efficiencies, and a more complex environment have meant that the role of the health manager has become increasingly significant. Managerial activities reflect the importance of non-clinical personnel to contract negotiation, staff development and deployment, lobbying, legal and ethical issues. The planning associated with health service delivery (at least from a managers perspective) is often built around financial, human, and logistical resourcing. These are more usually quantified in terms of inputs or process, a series of systems linked, assorted and assumed to contribute to the wider goals of the service.

As described, the link between process and outcome, though at times tenuous, is not entirely without substance – depending on what outcomes are desired or activities conducted. However, as the drive toward greater efficiencies is matched by an equal desire for improved outcomes, the interest in health outcomes, as opposed to health process, will become more apparent.

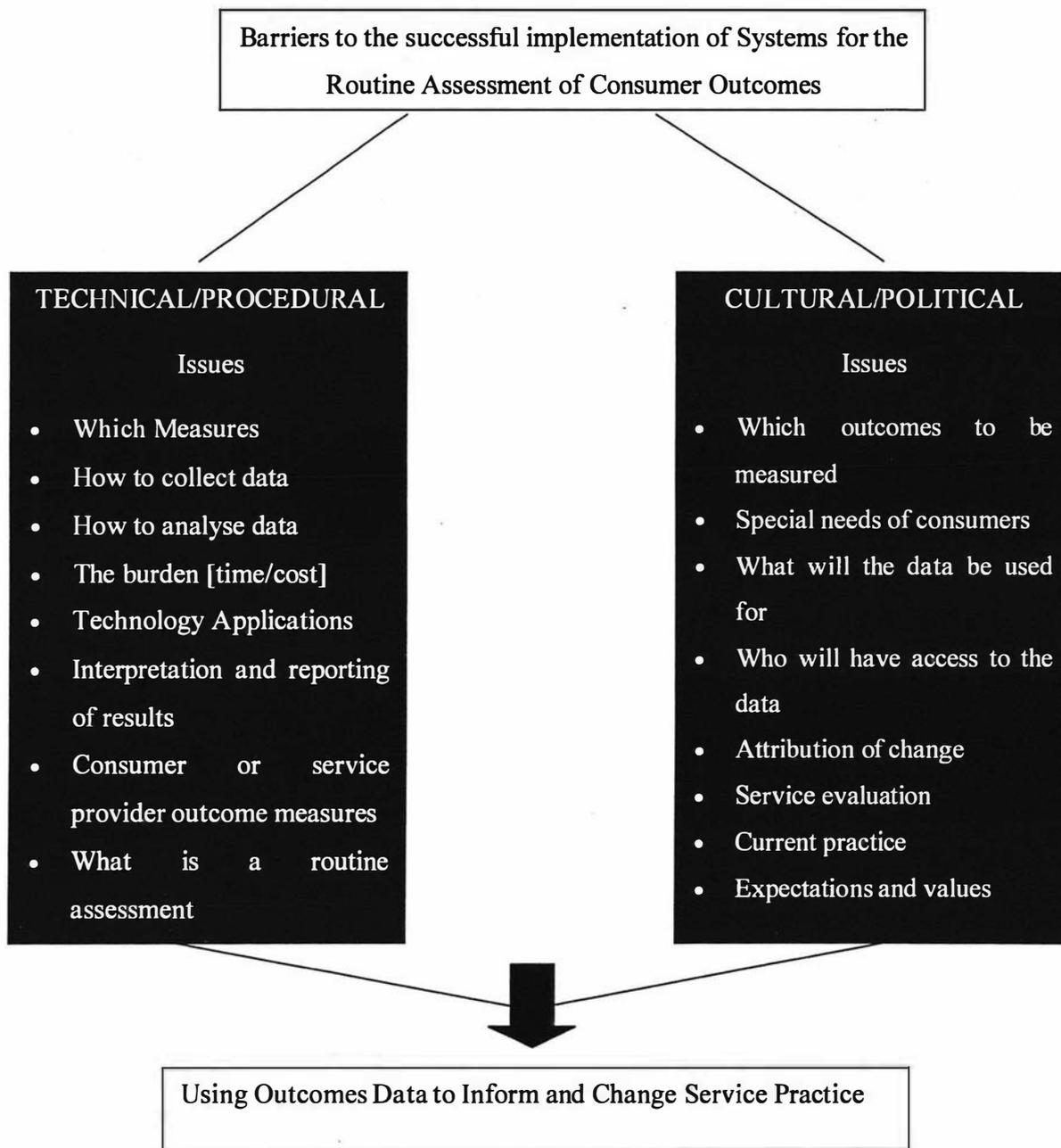
For managers of Māori mental health services the issue of process and outcome is a contentious one. Cultural activity related to treatment is difficult to quantify, and obtaining funding can be problematic. As noted in the previous section, the application

of *Hua Oranga* may more clearly link cultural activity to cultural outcome. However, the implications for Māori health managers extend further, especially where planning for health service delivery is required. Resources can, for example, be more effectively targeted into areas where outcome deficits exist. As well, a more structured approach to issues of workforce development can be taken, including employment needs, external relationships, and the application of new methods, or activities.

## **CONSIDERATIONS FOR APPLICATION**

Aside from issues of validity and reliability, the application of outcome measures has suffered due to systemic complications and logistical issues that have impeded deployment at a practical level.<sup>19</sup> In describing these types of impediments, Mellsoop and O'Brien have identified two broad categories of interest illustrated in the schema below.<sup>20</sup>

Figure 6.1 Outcome Implementation Barriers



Source: Mellso and O'Brien, 2000: 124

Part of the model reflects issues already considered within this thesis (e.g., what measures to use, and which outcomes, consumer or service provider, are to be measured). However, of interest are the components associated with how the data are collected and analysed (in a practical sense), the burden and time involved, the special needs of consumers and whānau, data access, interpretation and application of results, and opportunities for computerised implementation.

These types of concerns were revealed during discussions on the application of *Hua Oranga*, and further highlighted the need to consider carefully how the tool might be used. A number of other concerns were also raised, consistent with the model, but more specific to *Hua Oranga*. Six are of particular interest.

**Transparency:** One of the main themes to emerge. If measures of outcome are adopted (particularly as a funding mechanism) it was important that the processes used to gather outcomes data were transparent and that Māori services were aware of how the outcomes were to be measured and the data used to aid funding decisions. There is some evidence to suggest that Māori health services often fail to receive the type of information they require and as a result have not been able to develop in a consistent and robust way.<sup>21</sup> In order for Māori services to take advantage of the opportunities that outcome measures provide, adequate information and transparency of operation is imperative.

**Utility:** As mentioned earlier all measures of outcome, including *Hua Oranga*, are constrained by limitations. If outcome measures are to be used, the limitations must be clearly stated, to ensure the data produced are used in an informed way, and that inaccurate or misinterpreted conclusions are avoided. Comments concerning the application of *Hua Oranga* described the concern that the tool might be used out of context, applied too rigidly as a prescriptor of health outcome rather than as an indicator, and misused if applied to children.

**Systemic Reliability:** The application of outcome measures also require systemic integrity.<sup>22</sup> Processes must be in place to ensure data are collected, analysed, and reviewed in a consistent and reliable manner. This concern is connected to the issue of data quality and having in place adequate systems to capture consistent and reliable data. To assist systemic reliability and data quality, appropriate training in the use of the measure, in data collection, and in management will be required.

**Acceptability:** Along with the technical difficulties associated with the measurement of outcome, many tools have failed to gain wide acceptance due to the logistical problems that make their practical application difficult. Service staff have become increasingly frustrated by the amount of time dedicated to non-clinical activity, and while measures of outcome present the opportunity to aid the treatment process, the time required to do so is sometimes seen as an imposition. The construction of *Hua Oranga* led to a particular point in the process of outcome design and application. Of interest also will be the manner in which the logistics of the tool, at a service or policy level, are managed.

**Consultation:** As described in Chapter 3, changes to the health sector have often taken place with little or no Māori input, the consequences of which have meant that systems, structures or policies have not always reflected Māori aspirations or been entirely compatible with Māori philosophies and views on health. Frequently, Māori have failed to feel part of the process and as a result ‘buy in’ from the Māori community has been problematic. Although *Hua Oranga* is a Māori measure of health outcome, the process by which it is implemented will need to take place in discussion with the Māori community, and in light of Māori concerns and aspirations.

**Cost:** An issue associated with all five points. Measures of outcome are frequently used to enhance efficiencies and to cut costs. However, the extent to which these benefits are realised will depend, in part, on the resources invested. The costs associated with training, data collection, data analysis, data storage, and data dissemination are likely to be significant, but will be imperative to the successful application of the tool.

The framework below describes the six requirements and the implications for health services.

**Table 6.1** Outcome Application Requirements

REQUIREMENT	IMPLICATIONS
Transparency	Awareness by services as to how information would be used
Utility	Data limitations and extent to which information could be reliably interpreted and applied
Systemic Reliability	Guarantee of data quality
Acceptability	Ease of use and acceptability by users (clients, clinicians, and whānau)
Consultation	Adequate and active consultation in implementation process
Cost	Adequately resourced

## CONCLUSION

*Hua Oranga* sits within a broader context of health outcome measurement and contains characteristics consistent with other tools and measures. Its usefulness and potential to assist policy development, service design, and consumer outcomes are clearly evident, and a range of potential users of the tool can be identified. For this potential to be realised, however, a degree of caution is required and an understanding that the tool is not an end-point or by itself a means through which positive mental health outcomes for Māori can be promoted or sustained. The mental health sector is a complex interaction between various processes, individuals, sectors, and structures – placing undue emphasis on any one of these is unlikely to be beneficial.

If *Hua Oranga* is to be implemented further work is also required, to identify more clearly tool limitations, systemic issues, and administrative and financial implications. Most important will be the need to engage Māori and to seek ongoing input. Ultimately, if the tool is to be used it must be accepted and embraced by the Māori mental health community, it must be valued, and a sense of ownership by Māori must be felt.

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- <sup>2</sup> J. Wing, (1994), *Health of the Nation Outcome Scales: HONOS Field Trials*, Royal College of Psychiatrists Research Unit, London.
- <sup>3</sup> C. A. McHorney, J. E. Ware, and A. E. Raczek, (1993), 'The MOS 36-Item Short-Form Health Survey (SF-36): II. Psychometric and Clinical Tests of Validity in Measuring Physical and Mental Health Constructs', in *Medical Care*, vol. 31, pp. 247-263.
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- <sup>6</sup> B. Dahl, (2000), 'Client Outcome and Research Management (CORM) Assessment', in Health Research Council of New Zealand (ed.), *Mental Health Outcomes Research in Aotearoa: Proceeding of the September 2000 Conference and other Developments in Mental Health Outcomes Research*, Mental Health Research and Development Strategy, Auckland, pp. 115-118.
- <sup>7</sup> Andrews, *et al.* (1994), *op cit.*
- <sup>8</sup> Dahl, (2000), *op cit.*, p. 115.
- <sup>9</sup> L. Dyall, *et al.* (1999), 'Māori Outcomes: Expectations of Mental Health Services', in *Social Policy Journal of New Zealand*, Issue 12, Social Policy Agency, Wellington.
- <sup>10</sup> Minutes: Mental Health Epidemiology Study, Māori Advisory Group - 4 December 2000.
- <sup>11</sup> The New Zealand First, New Zealand National Party Agreement, *Policy Area Health*, December 1996.
- <sup>12</sup> Prioritisation Team, (1998), *How Shall We Prioritise Health and Disability Services: A Discussion Paper*, Health Funding Authority, Wellington.
- <sup>13</sup> <http://www.hrc.govt.nz/MHR&D-outcomes.htm> (21 January 2002).
- <sup>14</sup> For example, inconsistent definitions of 'Māori mental health service' has made it difficult to establish reliable trends. The extent to which the health reforms contributed to the growth of mental health services is also uncertain.
- <sup>15</sup> M. Hill and G. Bramley, (1988), *Analysing Social Policy*, Basil Blackwell Inc., New York, p. 2.
- <sup>16</sup> M. Goldacre, (1996), 'Health Outcomes from a Medical Perspective', in H. M. MacBeth (ed.), *Health Outcomes: Biological, Social, and Economic Perspectives*, Oxford University Press, New York, p. 70.
- <sup>17</sup> T. Tutara (Health Funding Authority) – Presentation Speech (Mental Health Promotion for Young Māori, Conference of the RANZCP Faculty of Child & Adolescent Psychiatry and the Child & Adolescent Mental Health Services), 29 June 2000. Auckland.
- <sup>18</sup> IRN Press Release, 'Greens Push For Mental Health Family Rights', 29 November 2001.

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- <sup>19</sup> R. Jenkins, (1996), 'Measuring Outcomes in Mental Health: Implications for Policy', in *Mental Health Outcome Measures*, Springer, New York.
- <sup>20</sup> G. Mellsop and G. O'Brien, (2000), 'Outcomes Summary Report', in Health Research Council of New Zealand (ed.), *Mental Health Outcomes Research in Aotearoa: Proceeding of the September 2000 Conference and other Developments in Mental Health Outcomes Research*, Mental Health Research and Development Strategy, Auckland, p. 118.
- <sup>21</sup> L. Dyal, (1997), *Hauora o Te Hinengaro - Pathway to Māori Mental Health and Wellness: Report of the 1997 Hui Rangahau Hauora Hinengaro*, Health Research Council of New Zealand, Auckland.
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## Chapter Seven

### A CONTEXTUAL MAP FOR HUA ORANGA

#### GROUNDING THE THESIS

Although this thesis is about mental health, and in particular about the construction of a mental health measure for Māori, it has grown from a broader landscape. Already that will have been evident from the earlier chapters where the determinants of mental health have been tracked and the consequences considered. It will be recalled that Chapter 1, *Māori Mental Health: Parameters and Patterns*, discussed mental health trends for Māori and concluded that epidemiological change, at least according to hospital admissions, has paralleled modern Māori experience and major reconfigurations of whānau, family and cultural identity. Chapter 2, *Methodological Considerations*, described the methods used to undertake the study, while Chapter 3, *Approaches to Māori Mental Health Problems*, scoped the development of Māori mental health services, both within conventional mental health facilities as well as in new services dedicated to Māori clients.

However, the effectiveness of the new services, with their distinctive approach to treatment and care through the incorporation of Māori values and practices, could not be adequately gauged by conservative measures, since the underlying premises were different and the expectations tended to be focussed on other priorities. To explore the utility of measures that captured Māori approaches to care and treatment and which could be used across the range of mental health services, the outcome study took shape. Chapter 4, *Māori Centred Frameworks for Health*, presented a framework for evaluating

outcomes, and in addition to incorporating a Māori health perspective as the basis for measurement, also emphasised the importance of a triangulated approach that involved tangata whaiora, clinician, and whānau. The conversion of the framework to a tool was discussed in Chapter 5, *Hua Oranga: A Māori Measure of Mental Health Outcome*, and in Chapter 6, *Hua Oranga: Applications and Implications*, other issues concerning its characteristics, use and design were considered.

Yet the wider context within which this thesis is embedded is not simply shaped by mental health trends, or indicators of well-being, or even Māori health perspectives, but by events and advances that reflect the position of Māori in New Zealand and the routes that have been taken to secure Māori advancement. This chapter, *A Contextual Map For Hua Oranga*, analyses those routes by identifying peaks, pathways, converging streams, intersections, and highways, and concludes by locating *Hua Oranga* in a setting that is as much a sign post for Māori social development as it is for care and treatment.

Table 7.1 Hua Oranga: A Contextual Map

Landmark	Features
Peaks of Knowledge	Dual bodies of knowledge – science and Mātauranga Māori
Parallel Pathways	Fairness and universalism Indigeneity and Māori autonomy
Converging Streams	Health and culture Cultural views and health
Intersections	Cultural values and beliefs and the implications for clinical practice
Māori Advancement Highway	Māori participation in the wider society and in te ao Māori Māori delivery systems
The Mental Health Landscape	Deinstitutionalisation; community care; sickness and well-being
Destinations	Measures that reflect Māori progress

## PEAKS OF KNOWLEDGE

Arguments advanced in this thesis depend on the accumulation of data that has been obtained from systematic inquiry. The process has been driven by the scientific method and any emerging new knowledge is largely indebted to empiricism and objective evaluation of the evidence. Rational and explicit approaches to the development of knowledge, according to tried and true methodologies, are characteristic of science and

scientific inquiry and make up the foundations of academic research not only in New Zealand but universally, transcending language, geography and the field of study. The product of research – new knowledge – has a validity conferred by the method through which it has been acquired. In the scientific method, knowledge itself is not contested so much as the way in which knowledge has been obtained. Proof depends on the manner in which data has been manipulated and its compatibility with the findings of others working in similar fields.<sup>1</sup> Ultimately, approval by the scientific community is granted if others can replicate the results using the same methods. Scientific criteria are exacting yet always open to scrutiny and scepticism; nothing is set in concrete.

However, although science, and the scientific method underpin the thesis, science is not the only body of knowledge that has contributed to the conceptual frameworks and the philosophy upon which the thesis rests. Mātauranga Māori is a knowledge system derived from customary beliefs about the position of humankind in relationship to the wider environment and to each other.<sup>2</sup> Rather than depending on empirical data for conclusions about cause and effect, it draws on established world views and applies them to contemporary situations. Mātauranga Māori provides a backdrop against which other pictures unfold. It is not a universal explanation about phenomena nor a system that encourages ongoing revision and modification. Instead, like indigenous knowledge world wide, it claims a validity that is based on time and consistency over time. Mātauranga Māori can be conceptualised as a system of absolutes, a set of fundamental truths that have been passed down from one generation to another until after a thousand years or so, they have the ring of conviction. At the same time, however, Mātauranga

Māori, and indigenous knowledge generally, can also be conceptualised as universal values and principles that are not distorted by time since they are primarily about survival, adaptation to the environment and human endeavours.

Between the two systems – science and Mātauranga Māori – there are bridges but essentially they are quite dissimilar bodies of knowledge. The tools that are useful to critique one system are inadequate to critique the other since the rules and the understandings are different. Knowledge derived from science constantly changes. Indeed if reliance is placed on the findings that came out of research conducted 50 (or even less) years ago, there is the risk that they will be out of date and therefore of doubtful consequence. Scientific knowledge has a youthfulness about it and the practitioners also tend to be young. Mātauranga Māori on the other hand improves with age. The test is withstanding the onslaught of time, not being modified by time; the practitioners are old and wise, and their knowledge is not contested.

*Hua Oranga* has drawn on both systems. Although the methodology reflects the scientific method, many of the underlying assumptions are drawn from Mātauranga Māori. There are perspectives and attitudes to health for example that stem from customary Māori values and world views and in the thesis they have been simply ‘assumed’. There has been no scientific rationale submitted for adopting whare tapa whā as the basis for *Hua Oranga*, rather than another model; instead, because it accords with customary Māori approaches, it has been incorporated more or less as a given. The question is whether the mixture of two systems of knowledge enhances the thesis or undermines them both by

creating an unintelligible hybridity. Can connections between knowledge peaks create yet a third form of knowledge, not so much a hybrid as a composite of two approaches, in order to understand people and their world?

Indigenous people are testing the bounds of possibility. Strong in their own systems of belief, the product of centuries of experience and conceptualisation, they have also discovered science and its unlimited implications for development.<sup>3</sup> *Hua Oranga* does not attempt to marry the two systems nor to exploit the differences between them. But it does acknowledge that there is more than one approach to understanding the truth.

Regardless, the prime purpose of the thesis has been to draw on wisdom from various sources and to climb many peaks in order to create new knowledge.

## **PARALLEL PATHWAYS: A NEW ZEALAND JOURNEY**

Māori calls for greater autonomy, the revitalisation of language and culture, the return of unjustly alienated resources, and the retention of customary social structures such as whānau and hapū, caught many New Zealanders by surprise in the 1970s and 1980s.<sup>4</sup> On the surface, Māori appeared to subscribe to the imposed view that urbanisation would see an end to tribalism, and passive resignation to the passing of te reo Māori and its associated culture. There was, therefore, widespread disbelief when being Māori appeared to matter, at least to Māori, and reclaiming a lost heritage was tinged with enmity. At the same time, an indigenous voice was emerging around the globe, often

with greater force than in New Zealand and with less restraint.<sup>5</sup> It had, perhaps, been naive to imagine that somehow Māori would take another route.

Part of the New Zealand astonishment at the fervour with which Māori pursued self determination can be attributed to the nation's proud record in social justice. Following the 1935 general election and the establishment of the welfare state, Māori perhaps more than other citizens stood to benefit since they had been disproportionately impoverished during the Great Depression.<sup>6</sup> Philosophically, there were also shifts: the country embraced the principle of universalism and the underlying premise that all men were equal. The Māori cause, if there was one, had become submerged in the war against poverty and class; political attention came to rest on guaranteeing basic standards of living, free education and health care, and security in old age.<sup>7</sup> Within a generation, universal provision had become synonymous with the state's version of a fair deal for Māori.

In many ways it was. Housing subsidies were generous, access to the family benefit was universal, as was the old age pension. Though hardly enough to maintain an extravagant life-style, they provided a modest income that did at least ensure a minimum standard of living. But there was a price. First, state dependency was a poor substitute for autonomy. Second, universalism implied monoculturalism – one approach for all. Māori language was not favoured in schools or in any other institutions of the state;<sup>8</sup> nor was there any perceived need for a Māori perspective to be applied to social policy areas. Demographically, Māori were more visible than ever, but visibility was confined to skin

colour, and there was an accompanying expectation that Māori social needs would be met in the same way as for other New Zealanders.

Consequently, when Māori demands for greater responsiveness from the health, education, justice, and social service sectors emerged, most agencies vigorously rejected any insinuation that they might be racist or less than sympathetic to Māori. Despite clear evidence that on almost all indicators Māori were experiencing lower standards of living,<sup>9</sup> there was a reluctance to move away from the established pattern of monocultural service provision. *Puao te Ata tu* changed that.<sup>10</sup> John Rangihau and a ministerial review team accused the Department of Social Welfare of institutionalised racism. It was a blow to the very department that had prided itself on being fair and sympathetic to Māori, even if fairness had been confused with paternalism and sympathy with lowered expectations.

Nonetheless the report was a catalyst for change. It was closely followed by a radically new approach by the fourth Labour Government to economic and social policies marked by a reduced role for the state in service provision, deregulation of labour markets, a greater confidence in the private sector, and reliance on the free market to create its own brand of fairness.<sup>11</sup> Māori policy followed a similar trend – away from state dependency towards greater autonomy and self sufficiency.<sup>12</sup> Meanwhile, Māori-centred pathways in education had been forged as early as 1983 with the early childhood kohanga reo system, and in 1987 the New Zealand Board of Health had argued that tribal authorities had a role to play in the delivery of health services.<sup>13</sup> The Waitangi Tribunal had also

recommended a raft of measures to recognise the Māori language as an official language of New Zealand and to promote its use in a variety of domains.<sup>14</sup>

Close on the heels of *Puao te Ata tu* and the burgeoning Māori interest in tino rangatiratanga (self-determination), and in parallel with rapidly escalating indigenous demands for rights based on indigeneity, rather than impoverishment, the *April Report* was published. The 1988 Report of the Royal Commission on Social Policy reinforced the message of devolution and direct Māori involvement in the delivery of services to Māori by drawing attention to the relevance of the Treaty of Waitangi to social policy.<sup>15</sup> Until then, the relevance of the Treaty was largely to be limited to physical resources such as land.

From 1975, legislative provisions were also changing, partly to recognise the constitutional significance of the Treaty of Waitangi and partly to protect Māori interests. While many laws in the past were used to restrict Māori interests, there has been an increasing recognition in statute of Māori rights, particularly since 1975 when the Waitangi Tribunal was established under the *Treaty of Waitangi Act*. But the Treaty of Waitangi is not the only mechanism through which indigeneity can be recognised in law. From Table 7.2 it is evident that the special position of Māori within statute is only sometimes linked to the Treaty of Waitangi when it appears to suggest a special relationship between Māori and the Crown (e.g., *Resource Management Act 1991*); sometimes it seems to stem from Māori as a disadvantaged minority (e.g., *Health and Disability Services Act 1993*), or a culturally different client group (e.g., *Children, Young Persons and their Families Act 1989*), or an indigenous people with a distinctive culture

(e.g., *Māori Language Act 1987*), or a group with a unique constitutional right (e.g., *Electoral Reform Act 1993*).<sup>16</sup>

**Table 7.2** Recognition of Māori Interests in Statute

Basis for Recognition of a Māori Interest	Effect of Statutory Provisions	Examples of Statutes
The Treaty of Waitangi	The Treaty is enforceable where it is incorporated into legislation	State Owned Enterprises Act 1986 Conservation Act 1986 Resource Management Act 1991 Public Health and Disability Act 2000
Protection of Customary Assets	Māori language and Māori land are afforded protection	Māori Language Act 1987 Ture Whenua Māori Act 1993
Fairness and Social Well-being	Requirement to consider Māori social networks, culture, and custom; and to reduce disparities	Health and Disability Services Act 1993 Children Young Persons and their Families Act 1989 Law Commission Act 1985
Māori Constitutional Position	Māori representation in Parliament is guaranteed	Electoral Reform Act 1993
Settlement of Treaty of Waitangi Claims	A process for investigating claims against the Crown is established; the terms of settlement cannot be varied except by repealing the law	Treaty of Waitangi Act 1975 Treaty of Waitangi (Fisheries Claim) Settlement Act 1992 Treaty of Waitangi (Tainui Waikato) Settlement Act 1995

*Source:* Durie, 2000

Despite the clear recommendations of the Royal Commission on Social Policy, the more usual pattern for recognising Māori rights in social policy legislation was to do so without reference to the Treaty of Waitangi. However, the basis for Māori recognition has not always been consistent or explicit. For example, in the *Health and Disability Services Act 1993* (now repealed), an objective was that Māori health should be at least as good as the health of non-Māori, implying a focus on disparities. On the other hand, the *Children Young Persons and Their Families Act 1989* acknowledges customary values and the balance between individual and group rights, while a requirement in the *Law Commission Act 1985* to ‘take into account te ao Māori’ (the Māori dimension), and also to give consideration to the multicultural character of New Zealand society seem to encourage the recognition of Māori custom in law.

In one sense these various provisions have suggested there is something special about the position of Māori in New Zealand, though what is special has largely been left undefined. Is the Māori dimension about disadvantage (but there are many disadvantaged groups in society), or about righting past wrongs, or about indigeneity?<sup>17</sup>

The question was partially clarified by the 1999 Labour Government when it included a Treaty of Waitangi clause in the *Public Health and Disability Bill 2000*. It was a contested action and in the event the wording in the final act was considerably weaker than originally proposed. Section 3(1)(b) of the Act states that the purpose of the Act is to provide public funding for health services in order to, inter alia, ‘reduce health

disparities by improving the health outcomes of Māori and other population groups'; the familiar disparities argument. Section 4, however, adds another dimension: 'In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services'.

But to make it clear that the Treaty clause will not conflict with the fundamental principle of universalism, there is a further qualification: 'To avoid any doubt, nothing in this Act (a) entitles a person to preferential access to services on the basis of race; or (b) limits section 73 of the Human Rights Act 1993 (which relates to measures to ensure equality)'.

Quite apart from questions of health status, or disparities between Māori and non-Māori standards of health, the *Public Health and Disability Act* appears to value indigeneity per se and moves some way towards clarifying the Government's attitude to Māori in social policy. That distinction is sometimes expressed as the difference between settling for a policy that accommodates Māori, instead of a policy that advances Māori.<sup>18</sup>

In any event, the pathway for Māori advancement has been constructed on clear Māori rejection of assimilation, varying recognition by the state of a distinctive Māori claim to self-determination, and agreement that social policy cannot be premised on notions of mono-cultural imperialism. Importantly, there is also statutory confirmation of the Māori position. Sometimes the stand is described as divisive, sometimes as separatist,

sometimes as unrealistic. Yet for all the controversy, New Zealand, it seems, has more or less agreed that a single pathway, grounded in monocultural perspectives and a single life-world view, is not the way forward. For now, parallel, if not multiple pathways offer a better prospect of national advancement and, ironically perhaps, national coherence.

## **CONVERGING STREAMS: HEALTH AND CULTURE**

In earlier chapters the relationship of culture to health was discussed. Māori health perspectives formed much of the discussion and their incorporation into health systems has been a focus for the thesis. However, medicine, and at a wider level the health system, have not always appreciated the implications of culture to health; nor indeed is it currently paid any more than scant attention in many health settings and health institutions. The disregard is not necessarily about the rejection of culture as important to groups and peoples, but about the universalism of professional practice, regardless of culture.

Bio-medical traditions do not usually look for cultural understandings to explain molecular functioning, physiological connections, and anatomical observations. In so far as the focus is on the physical substrate – the body and its component parts – other variables are largely a distraction from the main field of study. Histological analysis seldom considers culture, nor for the most part can culture be seen under the histological microscope. To all intents and purposes culture is to one side of the central concern of bio-medicine. Or at least that is how it is widely perceived both within and without the discipline. Because the bio-medical tradition dominates health sciences and health

practice, the same attitude has been carried over when the disciplines of anatomy, physiology, pathology, and biochemistry were applied to clinical practice.

However, the further away from the laboratory, the less tenable is the notion of a non-interacting body. In other words, once the focus changes from organs and organ systems to people as they go about their business, so too does the relevance of culture assume greater significance. The contributions from social medicine have established the connection so that there is now relatively little challenge about the links between culture and health and well-being or the implications for care and treatment.<sup>19</sup> What are not so clear, however, are the mediating influences played on health status by culture, as distinct from social class.

Culture is a means through which various groups within society communicate and understand each other. Often meaning is implied through behaviour as opposed to words, and interaction between members is governed by mutual values linked at an unconscious or instinctive level.<sup>20</sup>

Groups may have their own unique culture – gangs or youth, organisations or institutions. While this thesis has focused on culture as it relates to ethnicity, it is important to remember that in a treatment setting, ethnicity derived from culture is but one cultural dynamic alongside others. What matters for Māori university students, for example, may not be the fact that they are Māori, but rather that they are at university and are able to participate as part of the ‘student culture’.

Ethnicity therefore is not the only source of culture but it is the one of particular relevance to this thesis. While Māori health efforts since the 1980s have focussed on demonstrating the importance of culture to effective health care, the initial propositions were less about health care than health perspectives. The essential point was that health itself was not a culture-free concept and if there were to be gains in Māori health there needed to be some appreciation of the philosophical foundations that give meaning to health.

Health promotion is a health discipline where culture, however defined, is of critical importance. Because it concerns the way in which communities are empowered, and as a consequence is linked to political ambitions as well as cultural aspirations, health promotion cannot be separated from the overall standing of communities or peoples.<sup>21</sup> Patterns of communication, the language used, social organisation, preferred gathering places, styles of leadership, levels of deculturation and acculturation, are all essential to the promotion of health. If a television advertisement for smoking cessation for example, provides information but does so in a way that has no cultural appeal to Māori viewers, it is unlikely that the message will be received. Unlike bio-medicine, where culture is seen as peripheral to the prime focus, health promotion cannot advance beyond step one if the cultural dimension is ignored.

In the mental health field, cultural significance was for many years tied to the out-of-the-ordinary rather than the everyday experience. Transcultural psychiatrists recognised the

importance of culture to mental disorders but, following the tradition of anthropology, took a much keener interest in exotic conditions from 'foreign' cultures often without attempting to apply the insights from other cultures to their own practices. A fascination with the syndromes of Koro (a preoccupation that the penis will withdraw into the abdomen) and latah (possession and trance) for example, attracted the interest of many Western psychiatrists. Correspondingly, there was an element of blindness to culture within Western-dominated countries even where a number of ethnic groups lived side by side as minorities. Increasingly, however, transcultural interests have contested the accusation that transcultural psychiatry is little more than a preoccupation with exotica and have described instead both theoretical and practical implications. The comparative method offers an aid to understanding and conceptualising and distinguishing between 'the essential and universal from the peripheral and parochial'.<sup>22</sup> A concern about comparative analysis, however, is that most Western-trained doctors use the scientific method to explain observations derived from other systems of knowledge.

A medical practitioner's view of health is often underpinned by science and the scientific method. Treatment efficacy is derived from evidence and from criteria based on scientific rigour. Physicians are therefore likely to bring this perspective to their surgery with the understanding that the patient will hold similar views or perspectives. Although Māori, like other New Zealander's will tend to accept this position, they may not necessarily conform to the scientific view.

Carl Jung referred to synchronicity – the significance given to the simultaneous occurrence of events not obviously related in a scientific ‘cause and effect’ manner. This is one example of a ‘non-scientific’ belief system where patterns of meaning are connected to time and that events that occurred at similar times were therefore linked.

To many Māori the notion of synchronicity is highly regarded.<sup>23</sup> A series of unrelated events may take on increased relevance when they are linked together by time. A tangi may for example bring a particular whānau together but may also initiate a bond with other whānau or hapū, those who have experienced a similar loss, on the same day or week. The bond established is in part due to the mutual loss of a loved one, but is additionally linked to the sharing of a moment in time. While connecting the two events may lead to an examination of circumstance or setting, exposure to the same illness or agent, it is time that binds the events and the people, not the causality.

A conflict arises when the connection between the two events is considered from the perspective of ‘cause and effect’ and is either supported through quasi-scientific justification or contested because it does not meet with scientific approval. However, there is a unwillingness to be bound by science; other systems of knowledge are also valid. Religious doctrine, for example, is often explained through faith yet many professionals, who have absolute confidence in scientific rationality nonetheless hold dear their religious beliefs.

## **INTERSECTIONS: CULTURAL AND CLINICAL CROSSROADS**

In contrast to transcultural psychiatry, cross-cultural studies of mental disorders are aligned much more closely to regular clinical practice, being less concerned with the bizarre than with influence of culture on the experience and presentation of mental disorders.<sup>24</sup> There are a range of ambiguities in clinical practice where cultural interpretations can be markedly different from what was intended.

Probably most important is the assessment process. The Fourth Edition of the Diagnostic and Statistical Manual of Diseases notes the potential impact of (ethnic) culture on the formulation of a diagnosis and sounds some warnings so that opportunities for misdiagnosis are reduced.<sup>25</sup> The cross-cultural divide has given rise to two related concepts: cultural safety and cultural competence. Both refer to clinical situations where a member of one cultural group is being treated by a person from another culture. The patient will only be safe if the healer is culturally competent.

Cultural competence is concerned with the development of skills, skills used to achieve a better understanding of members of other cultures. Essentially it is another dimension to the relationship with the patient, and can provide health workers with additional information necessary for better clinical results.

Cultural competence also appreciates other belief systems without the need to defend science as the only valid way of viewing the world. The important thing to recognise is

that the patient may not entirely accept the medical explanation and is not always willing to engage in treatment that is scientifically based. The implications are that a medical approach may require a complement, where the opinion of a traditional healer or cultural advisor is also considered. Neither approach will necessarily negate the other. Indeed, as the shape of New Zealand society becomes increasingly culturally diverse, doctors will need to share the healing platform with others who do not base their interventions on scientific evidence. Rather than regarding the other healers with apprehension or scepticism, a culturally competent doctor will see opportunities for collaboration.

Language is perhaps the most reliable pathway to culture. Groups often speak a language of their own, punctuated by certain subtleties, idioms, often difficult to describe through the written word or within formal speech. New Zealand is, however, a nation of many cultures and languages and it seems unlikely that doctors or other health professionals will be conversant in them all. English may be a second language and fluency here will often take priority over the acquisition of other languages, including Māori. The challenge therefore is to understand and appreciate culture, perhaps not through language but by considering the central tenets or values upon which culture is based.

As described, the values which characterise most cultures are often 'taken for granted' by its members and are infrequently discussed openly. They are intuitive, they make sense, and require little justification or rationale. Values are not always overtly acknowledged even though they are intuitively recognised and understood by members of the same cultural group. They are applied as a matter of course. Problems develop when a doctor

with an alternate set of values is unable to interact at this intuitive level. More often than not subtleties of interaction are lost, dismissed or ill-regarded.

As an illustration, Māori patients frequently hold values linked to the use of space and time. These concepts are often displayed on the marae where, for example, the physical distance between visitors (manuhiri) and hosts (tangata whenua) is maintained. Certain rituals are exchanged until a pathway for a closer relationship is cleared. Disregarding protocol, engaging contact or space prematurely can cause offence and create unease. Space allows any risk from an encounter to be assessed before a commitment is made. In addition, and again in reference to a marae setting, the importance of time takes on a different meaning. Being 'on time' is of less importance than allowing sufficient time, even if it conflicts with prior plans, schedules, or arrangements. The important thing is that relevant tasks are completed – the time taken to do so may be of less importance.

Less widely considered is how the same values surrounding space and time continue to be applied beyond the marae, again in an intuitive rather than deliberate manner. In the surgery or clinic for example, Māori clients may feel at unease where there is inadequate physical space, at least until the rules of the encounter have been defined. When the physical distance between patient and doctor is restricted, the opportunity for the patient to assess any risk in the encounter is compromised. In some instances where space is confined the architecture may be at fault; but professional good intention may be equally blamed; a well-intended attempt to bridge distance quickly can be interpreted as a threat or takahi (to trample) – where one's mana is compromised.

The values associated with time can similarly be misinterpreted in a clinical setting. The apprehension associated with a full waiting room and the limited time available to see each patient can lead to the construction of an agenda based on the clock rather than patient priorities. The fact is that most medical schedules are time-based rather than problem-based. If it is obvious that time is severely rationed, many Māori patients, and in fact others, will be reluctant to embark on a discussion of their problem; if it seems they will be unable to complete their story, they may simply opt for a more superficial encounter that saves face, but excludes the more significant issue.

If professional practice does not allow for time and space to be valued, a working relationship between professional and patient will be difficult. An approach that is professional according to one set of values, may be seen as a disregard for other value systems, and will inevitably reduce the effectiveness of the consultation.

The classification of disorders, and diagnostic criteria has a generic dimension that allows physicians the world over to use similar standards. The signs and symptoms of an appendicitis, or otitis media transcend cultural and ethnic boundaries. However, the relative weighting attached to symptoms is less constant. Across cultures there are different symptom hierarchies and the interpretations of both severity and importance may be different. Depression for example, is a disorder thought to be widespread in New Zealand, with a life time prevalence in the range of ten to twenty percent.<sup>26</sup>

While it is regarded as a mental disorder, the symptoms of depression are as much physical as mental and for many patients it is the physical distress that will cause the greater suffering. There is also growing evidence that depression manifests itself differently and in accordance with cultural factors. Patients in Western eurocentric cultures are more likely to complain about the emotional and psychological aspects of the condition while many non-Westerners are much more worried about the physical dimensions: loss of energy, debilitation, weight loss, abdominal pains, poor appetite, sensitivity to cold.<sup>27 , 28</sup>

In non-Western cultures depression may not necessarily be considered a mental disorder but rather as a disorder of energy, or gastro-intestinal malfunction, or sleep disturbance. Although definitive studies have yet to be undertaken, anecdotal accounts<sup>29</sup> suggests that Māori patients who have a depressive disorder are not necessarily plagued by the emotional symptoms of depression such as sadness, or hopelessness, or guilt. Of far greater concern is the presence of physical symptoms – a loss of appetite, an inability to sleep, loss of weight, musculo-skeletal pains, reduced libido, and a feeling of coldness.<sup>30</sup>

## **THE HIGHWAY TO MĀORI ADVANCEMENT**

A thesis about mental health outcome measures may not immediately appear to relate directly to Māori advancement, and in so far as the progression of Māori people is often assessed in economic terms there might be some justification for that conclusion. Using the terminology that emerged from the 1984 Hui Taumata, the Māori Economic Summit,

mental health activities could even indicate 'negative' as opposed to 'positive' spending.<sup>31</sup> , <sup>32</sup> The distinction between the two poles hinges on making a difference to the economy through positive development, rather than draining the economy by funding programmes that support non-productive elements. However, the approach taken in this thesis, and the way in which *Hua Oranga* has been constructed, lead to another conclusion.

In 1984, and largely because New Zealand was living beyond its means, massive economic reforms were instituted. It was presumed that social benefits would follow. But it is now obvious that economic policies that allow for labour market deregulation, free trade, reduced inflation rates and single figure interest rates do not necessarily translate into higher standards of living, better health, or improved educational standards.<sup>33</sup> Unless there is a deliberate effort to follow economic and social goals together, without assuming that getting the economy right will then cascade down as social benefit, gains in health or employment will not be felt by all parts of the community; there will be some who do very well, and others who lose out. As already noted, disparities between Māori and non-Māori have not been reduced by the economic restructuring, and in some instances the Māori position now lags further than ever behind.<sup>34</sup>

Earlier approaches by the Government to Māori development stressed economic growth as the main developmental activity. But once the responsibilities had been devolved to *iwi*<sup>35</sup> or to urban Māori authorities, the pointlessness of pursuing economic gains without

concomitant attention to social and cultural goals, was glaringly obvious. Iwi found it difficult to separate the three and often did so only to be eligible for sectoral funding arrangements.

A characteristic of Māori advancement then is the integration of economic, social and cultural goals. As much as others, Māori wish to participate fully in the wider society. There is a high Māori expectation that their children should be able to succeed in the professions, in the commercial world, and in technological industries and be able to interact with others from different cultures and countries while making a contribution to a greater good, nationally and globally. But there is also a clear expectation that Māori should also be able to live as Māori.<sup>36</sup> That means being able to have access to te ao Māori, the Māori world – access to language, culture, philosophical foundations, values, marae, whānau, and resources such as land and fish.<sup>37</sup> If economic growth brings riches to the many, or even to the few, but there is no growth in cultural riches, or social cohesiveness, then Māori advancement will have been to little ultimate value. At least that is the view of many Māori leaders, both tribal and urban.<sup>38</sup>

In order to combine the two aspirations – to participate in society and the economy and at the same time ‘to live as Māori’ – the growth of Māori service delivery systems has been an important innovation.<sup>39</sup> The development of kaupapa Māori health services has been discussed extensively in this thesis but it needs to be remembered that the delivery of educational services, social services, recreation services, and employment services has also been part of the move to accelerate Māori advancement. Māori services, no matter

what the focus, emphasise Māori values, access to Māori networks, Māori staff, Māori clients and Māori control. There has been some debate about which group is best placed to deliver the service and whether the distinctions between Māori services and mainstream services are more rhetorical than real. Neither is it always appreciated that the aims of a Māori service may not match the aims of the funder. But there has been little Māori disagreement about the need for Māori delivery systems or, for that matter, about their overall efficacy in meeting objectives and raising awareness.

On the other hand, these views about participation in te ao Māori, as integral to Māori advancement are not shared by all New Zealanders. There is, for example, an opinion that Māori language is not worth maintaining, and efforts in that direction are simply a waste of effort and money.<sup>40</sup> Similarly, from time to time doubts are expressed about Māori services on the grounds that they are less efficient than general services or are based on criteria that do not conform to universal standards. The much publicised financial woes of one iwi swayed popular perception of Māori management, though after the near collapse of New Zealand's major airline, the concerns about tribal misjudgement became subdued.

Nonetheless there is a perception that, if Māori systems are compared with general systems, they perform badly. While there is no evidence to confirm that perception, the more serious concern is that Māori aspirations should be seen to be similar to non-Māori, therefore fully justifying comparisons about performance. What is seldom taken into account is the widespread Māori view that the goals of advancement and positive

development are not simply aimed at participation in society and the economy but at participation in te ao Māori as well. That in turn requires different measures of success. A good health outcome for a Māori child must reflect that child's aspiration to live in both worlds. For a non-Māori child a good result may not need to be quite so ambitious, since belonging to the Māori world will not usually be a consideration.

Part of the misunderstanding comes from a lack of clarity about Māori advancement itself. The preoccupation has been with either a reduction of socio-economic disparities between Māori and non-Māori or a commitment to settling Treaty of Waitangi grievances within a decade or so.<sup>41</sup> In a nation that has a strong tradition of universality, the elimination of gaps in society is a logical and well-deserved goal, strengthened by an intolerance of inequities. But by itself it is not a sound basis for defining Māori advancement. Nor for that matter is the settling of grievances. For one thing there are different time concerns. Settling Treaty claims is about the past; Māori advancement is about the future. Settlements have an end point. Once a settlement has been negotiated, the 'full and final' clause makes it clear that the end point is to be durable. Māori advancement, on the other hand, is about planning for the future, there is no endpoint. Settlements are about negotiating within a Crown framework; advancement is about a Māori agenda for development that is premised on Māori world views and aspirations.<sup>42</sup>

What is missing from the disparities approach and the settlement approach is the reality of being Māori and having the right to self-determine a course for the future. Planning that course, and communicating the plan to others, have required the development of

systems of information and methodologies capable of incorporating Māori values, processes and aspirations. In Chapter 2 the emergence of kaupapa Māori methods of research was discussed. Frequently, conventional research methods are also helpful to Māori advancement, and an exclusive reliance on one method or another is unlikely to address the multiple areas of development that underpin Māori advancement on economic, social and cultural fronts. But at the same time, Māori advancement cannot ignore Māori values and world views, otherwise the exercise is futile. Advancement needs methodologies that are capable of delivering empirical insights while retaining Māori understandings.

## **A CHANGING TOPOGRAPHY: THE MENTAL HEALTH LANDSCAPE**

Although the distinction between mental health and mental health services is clear enough, the boundaries around each are diffuse rather than discrete. The diffuseness leads not only to confused understandings, but also expectations that can seldom be adequately met. Mental health, in its broadest sense, approximates well-being. It is about having a strong sense of identity and role, an affinity with reality, and a capacity to communicate, emotionally and intellectually. But much of the popular debate about mental health is actually about the management of mental disorders. More than that, it is about the serious disorders that mental health services address rather than the full gamut of emotional and behavioural variations that most people are likely to experience. The focus on the serious end of the disorder spectrum has historical roots. Asylums were established to care for the insane who might otherwise have been incarcerated in prison,

or exposed to the vagaries of the streets. The mission was essentially a humane one and the major therapy was simply the administration of compassion.

Medicalisation of the asylums changed the focus from care to treatment, and by the twentieth century mental hospitals, as they became known, boasted a quasi-medical orientation as well as a continuing tradition of care. They expanded quickly to become by far the largest hospitals in New Zealand, and by the late 1950s had benefited considerably from medical advances. Some therapeutic innovations were spectacular. Electric shock treatment, when used appropriately, produced dramatic cures; even more startling recoveries followed the use of anti-psychotic medication, initially chlorpromazine and then a variety of even more potent (and effective) drugs.

By the mid-1970s New Zealand, like other comparable countries, was set to embark on a new direction for mental health care.<sup>43</sup> Intractable behaviour and bizarre preoccupations were now modifiable by the new treatments so that long periods in hospital were no longer required. Instead of institutional care, community care became the aim and the process of deinstitutionalisation saw the closure of most mental hospitals within a decade.<sup>44</sup> But whereas the earlier asylums sought only to provide compassionate care, the new community model was committed to delivering treatment with less responsibility for care.<sup>45</sup> Moreover, the shift away from a residential base, carried with it a narrower medical focus on 'the problem'. A new classificatory system, DSM IV,<sup>46</sup> introduced a preciseness into diagnosis, based on defined criteria and natural histories. Compared with former times where, for example, the highly subjective 'praecox feeling' was

sufficient to diagnose schizophrenia, the DSM model offered a platform for greater objectivity and a level of standardisation that far surpassed the efforts of earlier psychiatrists.

There were, of course, many other factors that led to the reform of the mental health system, including a world-wide move away from institutionalisation and its harmful effects, and a growing human rights concern about unnecessary involuntary incarceration. Despite the considerable advantages of the new approaches, however, there was a down side. A preoccupation with a precise diagnosis, so that the most effective medication could be prescribed, created the impression that a psychiatric condition was comparable to any other medical condition. It was probably a useful reconfiguration contributing to the destigmatisation of mental illness. Yet it also played a part in restricting the sense of responsibility, so that once the medical functions of diagnosis and prescription had been performed, what happened next was someone else's responsibility. In effect, psychiatry had regained its medical roots. In the process, psychiatrists returned to practicing a type of medicine for which they were well trained but which was to offer only a partial answer for most patients. To complement their efforts, the multi-disciplinary team was born, a range of professionals each offering a specialised aspect of treatment though often with little to create a sense of coherence or continuity. In some teams the fragmentation of effort was so severe there was a need for a primary therapist, someone who could weld together the efforts of psychiatrist, psychologist, social worker, nurse, occupational therapist and psychotherapist.

Not surprisingly there was a risk that the patient might become lost. Inadequate follow-up often meant an actual loss, especially as the population of people with mental disorders became highly mobile, and community care arrangements were notoriously likely to fall through. There were other types of loss as well: loss of dignity in a community that did not have great sympathy; loss of continuity of care as the team changed faces and even boundaries; loss of enthusiasm in response to soporific medication; and loss of spirit as an isolated life on the edge of society dampened motivation and sense of purpose. Mental health had become synonymous with the absence of overt mental illness.

While the objectives of deinstitutionalisation had been met, and the hospitals had been closed in favour of brief-stay units in general hospitals coupled with community care, communities themselves were increasingly unhappy about the new approaches. A series of public inquiries into patient mismanagement did little to add to public confidence, and eventually in 1998 a Mental Health Commission was established to address some of the concerns. Recognising the problem as one of gross under-resourcing, the Commission drew up a blueprint for radical redevelopment of services based on best practice and international trends. Generally they were supported by the Government with increased funds earmarked for mental health and Māori mental health. The public, meanwhile, previously unaware of the issues surrounding mental health because they were handled in distant and closed institutions, now wanted guarantees that the money would make a difference.

But much of the underlying philosophical tension about the fragmentation of care and the medicalisation of a problem that had large social and cultural components, remained unresolved. If anything, the Māori perspectives on health, which had first been applied in the mental health field, offered a chance to rebalance the conventional view that mental disorders could be conceptualised as if they were some type of organ failure, akin to heart disease. The Māori view advocated a broader, not narrower approach. Recognition of spiritual and cultural values, as well as physical health and family interaction, reaffirmed the need for mental health to be seen in a broad ‘well-being’ context, not simply as a state of relative recovery from a disorder. In other words the discharge of responsibility by health professionals could not be considered complete unless treatment and care were married in a meaningful way and other humane dimensions were factored into the professional obligation.

*Hua Oranga* emerged from that debate.

## **DESTINATIONS: HUA ORANGA**

It is unlikely that a Māori measure of mental health outcome would have been proposed a generation ago. First, the interest then was almost exclusively on processes and outputs rather than results. To some extent that remains the case. Second, while the importance of a Māori perspective in health had been acknowledged, it had not been incorporated into the core business of clinical practice. It was largely a rhetorical platform. Third, Māori advancement was itself in a defensive mode; the ‘right’ of the aim was sufficient to justify the cause, and measurements of success were not accorded high priority. Even now, the

measurement of results is problematic.<sup>47</sup> Fourth, Māori delivery systems were at the innovative stage and had not been bedded down as permanent fixtures across social policy areas. Fifth, while there were signs of change, mental health priorities were centred on the pragmatics of developing new systems and simply coping, rather than assessing the impacts of services on their clients. Sixth, though recognising the limitations of universal measures, Māori methodological approaches to measurement had not been advanced.

*Hua Oranga* is therefore a product of its time. In the metaphors of this chapter it is not itself a destination but a step on the way towards a destination – a vehicle. Fundamentally, *Hua Oranga* is a measure of Māori progress. It recognises the option of more than one pathway for national development. It bridges the streams of culture and health, crosses the cultural-clinical intersection, moves comfortably on the broad highway of Māori advancement, and nestles within the contemporary mental health landscape.

Hua Oranga is about health, mental health, Māori health, and Māori advancement within an evolving New Zealand.

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## Chapter Eight

### CONCLUSIONS

*Whakataka te hau ki te uru  
Whakataka te hau ki te tonga  
Kia makinakina ki uta  
Kia mataratara ki tai  
Kia hi ake ana  
he ata-kura  
He tio, he huka, he hau-hunga.*

*Cease now the wind from the West  
Cease also the wind from the South  
Let the murmuring breeze sigh over the land  
Let the stormy seas subside  
And let the red dawn come with a sharpened air,  
A touch of frost  
And the promise of a glorious day.*

The tauparapara above is part of an ancient karakia, a chant often rehearsed when Māori gather, and before commencing the business of the day. Essentially, it expresses a hope for better things to come. It may be seen as unusual therefore to introduce it at the end of this thesis, rather than at the beginning. But the main reason for doing so is because although Chapter 8 is the concluding chapter, in fact the thesis itself is a beginning, not an end. The significance of *Hua Oranga* will depend not only on whether it proves a point and contains a reasoned argument, but whether it can find a place within the business of mental health; the tauparapara expresses the hope that it might.

But the tauparapara has other implications as well. New knowledge does not come without effort. Just as a 'glorious day' compensates for the wind, stormy seas, and a

‘touch of frost’, so new knowledge is just recompense for conjecture, theory, hypotheses, and analysis. Further, the tauparapara can be seen to add its own optimism to the area of mental health care. In the dark years when treatment and care were modelled on bigotry and narrow-mindedness, the sun seldom shone on those who had been consigned to endless years of exile in hospital. It has not been until relatively recent times, the last 30 or 40 years or so, that approaches to mental health have been based on consideration of the person and the return of human dignity, as well as findings from science. While the current theory and practice leave room for further development, the ‘promise of a glorious day’ reflects the possibility that new knowledge and new approaches can introduce fresh perspectives in order that comfort and certainty, if not ‘cure,’ can be added to lives burdened by emotional and psychological problems.

There is also the significance of a fruitful outcome – the kernel of this thesis. Care and treatment, no matter how well intentioned, will be of limited value if they do not lead to better health. The aim of the exercise is not simply to guarantee good access to treatment even if it is delivered in a culturally appropriate manner, but to ensure that improved health is a likely outcome of treatment. For too long the focus in mental health has been on administering treatments that make more sense to professionals rather than to those being treated. This thesis emphasises the importance of focusing on the outcome of treatment, rather than solely the treatment itself. In the metaphor of the tauparapara, the wind, the rain, and the frost are part of the experience but should not be confused with the final goal. The ‘promise of a glorious day’ is the desired outcome.

The thesis has five broad conclusions:

- Mental health problems constitute a serious threat to Māori advancement
- Māori cultural values and perspectives are integral to understanding and improving Māori health
- Advances in Māori health are linked to the wider goals of Māori and indigenous development
- Māori world views and aspirations can be reflected in health outcome measures
- *Hua Oranga* is able to make a positive contribution to Māori health development at policy, service and personal levels.

There is little doubt that mental health issues remain a significant threat to Māori health and Māori advancement. Māori admissions to psychiatric facilities have increased dramatically over the past 30 years and continue to reflect patterns of illness far in excess of the general population. They occur within the wider contexts of socio-economic disadvantage, alienation from te ao Māori, and a degree of estrangement from the broader New Zealand society.

On the one hand, mental health interventions are unlikely to change the big picture, and some argue that energies should be targeted at national strategies and at macro policies. In that connection effective policy development requires working across sectors rather than expecting gains to be made through independent action by sectors or within sectors. But high-level interventions do not lessen the need for services that can respond to the needs of peoples and reduce the impacts of illness from whatever

cause. Against this backdrop, mental health services for Māori have developed, and since the mid-1980s have grown considerably, both in size and in scope.

Their development has reflected, in part, the new international trends in mental health care, but also the voice of indigenous experience, a degree of political willingness, structures and policies that are more accepting of a Māori approach, and as already noted a rise in the number of Māori consumers. Institutionally based models of care have given way to approaches that are more synchronised with Māori methods and philosophies, community-based delivery, a regard for consumer input, whānau involvement, and at least some consideration of the physical and spiritual dimensions of mental health.

While the new approaches have been consistent with international trends, and the growing awareness of the relationship between culture and mental health, the contribution of Māori to this process has not been insignificant. Cultural therapy units, such as Whaiora and Te Whare Paea, provided an initial thrust and have given rise to new and innovative approaches to mental health care. Māori models of health have also developed, offering new perspectives, building on the notion of holism, and the need to embrace well-ness alongside treatment. The trends have been consistent with positive Māori development on a broader front and the determination by Māori to achieve a higher level of self sufficiency, retention of language, culture and physical resources, and a greater degree of autonomy.

Māori approaches to care have continued to evolve to meet new challenges within the realities of the constantly changing health sector environment and Māori expectations. Ironically, as gains have been made, so shortcomings have been more readily

identified. Despite introducing Māori perspectives into care and treatment, seldom were those views reflected in the formal measurements of the service. As a result, there was an element of frustration about restrictive contracting policies that measured volume but little else, and an equal concern that a type of mental health service was developing where parallel cultural and clinical approaches were being instituted with little to connect them. Cultural programmes (delivered by Māori) and clinical programmes (delivered by professionals) seldom touched the same base. Nor were the two skill bases equally recognised.

Those concerns call into question the value being placed on Māori philosophies and paradigms in the core business of health care – assessment, treatment plans, workforce evaluation, measures of progress, the rationale for funding, effectiveness. Although Māori health perspectives have been accepted for more than two decades, attitudes based on Western views and concepts continued to shape perceptions of mental health service delivery, at a policy level, but also in a more covert way, at a personal level, through fixed mind-sets, and conservative views on mental health.

This thesis addresses some of those matters. It has described the need to examine the rationale upon which mental health services for Māori are premised, to move beyond notions of process to consider services in terms of health, and according to standards that are relevant to Māori. In that sense *Hua Oranga* makes a three-fold contribution to Māori mental health.

First, it redefines the broad aims of mental health services for Māori. There are three fundamental paradigm shifts: from inputs (such as treatment methods or cultural inputs) and outputs (such as the numbers of people treated) to outcomes; from

preoccupations with illness to considerations of well-ness; and from a split of mind and body to a holistic integration of mind, body, spirit, and relationships with others.

Second, *Hua Oranga* proposes a mechanism for implementing Māori health perspectives. The rhetoric of Māori values and cultural understandings of health is transformed into a method of quantification. Māori views become central to the measurement of good health.

Third, there are implications for the quality of mental health services. If the outcomes envisaged in *Hua Oranga* are to form the basis for determining effectiveness, then services will need to re-examine some basic assumptions: the removal of symptoms may be less important than functional criteria; clinical and cultural arenas will need to be integrated; physical health will be included with considerations of mental health; the views of clinicians will form only one part of an outcome agenda; and the significance of culture to health will be acknowledged in the centre of the service rather than at the periphery.

The recent drive toward more mental health policies and services has led to a parallel thrust toward better mental health services, more capable, more effective, and more able to meet the needs of consumers. It is in this regard that measures of health outcome are of particular value, and why they are often used as an indicator of service effectiveness. If Māori mental health services are to achieve their potential and to operate in ways that best meet the needs of tangata whaiora, then they must be measured against and designed around Māori concepts of health outcome.

*He tio, he huka, he hau-hunga.*

## GLOSSARY OF MAORI TERMS<sup>1</sup>

### A

Arahi A guide

### H

Hākari Sharing of food

Hapū Sub-tribe

Hinengaro The mind

Hongi A customary Māori greeting where noses are pressed together

Hua Oranga The fruits of health

Hui Meeting

### I

Iwi Tribe

### K

Kai Food

Kaitiaki Guardian

Kawa According to the customs of the local tribe

Kāwanatanga Government

Kanohi ki te kanohi Face to face

Karakia Prayer

Kaumātua Māori elder (both male and female)

Kohanga Reo Māori language nests (pre-school education)

Koha A gift

Koro Grandfather

Kuia and koroua Māori elder (kuia, female – koroua, male)

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<sup>1</sup> Definitions of Māori words are considered in a context relevant to this thesis and may not be generically applicable.

## M

Mana motuhake	Māori self-determination
Mana whenua	The local tribe
Mana tiaki	Guardianship
Manaakitanga	The capacity to care
Manuhiri	Guest
Māoritanga	Things 'Māori'. Associated with Māori culture, tradition and custom
Marae	Traditional Māori place of gathering
Matakite	To have visions
Mātauranga Māori	Māori knowledge
Mauri-ora	Identity, access to te ao Māori
Mirimiri	Massage
Mokopuna	Grandchild (pre-school)

## N

Ngā manukura	Leadership
Ngā Pou Mana	A Māori model of health (five components)

## O

Oritetanga	Measurement
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## P

Pākehā	Non-Māori
Pānui	Message
Pōrangi	Mentally unwell
Poroporoaki	A formal process of farewell
Pupuri taonga	The capacity for guardianship
Putanga	Accessibility

## R

Rangahau

Rangatahi

Rongoa

Reo

## T

Taha

Takahi

Tamariki

Tangata whaiora

Taonga tuku iho

Tapu and Noa

Tatau tatau

Tauparapara

Te ao Māori

Te ao turoa

Te Ika a Maui/Te Wai Pounamu

Te mana whakahaere

Te oranga

Te Puni Kōkiri (TPK)

Te Whare Tapa Whā

Te Wheke

Tika

Tikanga Māori

Tinana

Tino rangatiratanga

Tohatohatia

Tohunga

Toi-ora

Tōtika

Turangawaewae

Research

Māori youth

Traditional Māori medicines

Language

Side

Trample

Child

A Māori consumer of mental health services

Cultural heritage

Caution and safe

Collective responsibility

Chant or ritual incantation

The Māori world, a Māori dimension, a Māori world view

Physical environment

The North and South islands of New Zealand.

Autonomy

Well-being

Ministry of Māori Development

A Māori model of health (four dimensions)

A Māori model of health (eight dimensions)

Correct

Māori customary practices

The body

Māori self-determination

The capacity to share

Expert (healer)

Healthy life-styles

Effectiveness

Ancestral land

## W

Wahine	Woman
Wai-ora	Environmental integrity
Wairangi	Mentally unwell
Wairua	Spirit
Wairuatanga	Spirituality
Waka	Canoe/Affiliation derived from Māori migratory vessels
Whai wāhi	Participation
Whakamana	The capacity to empower
Whakapapa	Ancestry
Whakapiki	Enablement
Whakaruruhau	Safety
Whakatakoto tikanga	The capacity to plan ahead
Whakatakoto tūtoro	Planning
Whānau	Family
Whanaungatanga	Establishing contact within a Māori context/ integration

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# APPENDIX I

## Guidelines and Schedules for the Application and Interpretation of ‘Hua Oranga’

# INTRODUCTION

This document is designed to assist with the application of the *Hua Oranga* measure of Māori mental health outcome and to provide guidelines for its clinical use. It contains a full series of questionnaires and scoring schedules.

The tool is designed to be a quick, easily administered measure of outcome, appropriate for routine clinical use. It may be used as a specific cultural measure of outcome or combined with other, more targeted, clinical tools. Application of the tool should take no longer than 10–5 minutes.

# OVERVIEW

*Hua Oranga* is a cultural measure of mental health outcome, designed specifically for Māori consumers of mental health services.

The measure requires the application of three separate questionnaires, one designed for the client, one for the clinician, and one for a designated whānau member. Each respondent is required to complete their respective questionnaire. With the aid of a scoring schedule a numerical score is produced for each respondent. These scores are then compiled and divided by three. The resulting score is then used to provide an indication of overall outcome. An outcome continuum is provided in order to assist with this process.

## THREE PERSPECTIVES OF OUTCOME

As indicated, *Hua Oranga* requires the application of three separate questionnaires; one each for the client, clinician, and designated whānau member. The clinical schedule is designed to be used by any health professional involved with the treatment and care of Māori mental health consumers. The whānau schedule is to be completed by a relative of the client and must be an individual whom the client nominates. The designated whānau member may not necessarily be a blood relative and could be a close friend or some other associate. As three distinct perspectives of outcome are required for this measure the whānau respondent should neither be a service staff member nor another consumer.

## CLINICAL END-POINTS

Five clinical end-points are prescribed. These are guidelines designed to assist with the application of the tool by breaking the treatment process up into five, more manageable, components: 'Assessment', 'Inpatient Treatment', 'Outpatient Treatment', 'Community Care', and 'Community Support'. The tool may be applied at any of these points, either independently or concurrently and as part of a more extensive outcome assessment process. The tool may also be used at any point where an outcome from a particular intervention is expected. Clinical end-point definitions are also given.

# APPLYING "HUA ORANGA"

Each respondent should complete their respective questionnaire by simply answering each of the questions and circling the most appropriate response. With the aid of the 'Scoring Schedule' each response can be converted into a numerical score.

These numerical scores should be totaled for each of the three respondents. These three scores should then be added and then divided by three to produce an 'outcome score'. This 'outcome score' should then be compared to the 'Outcome Continuum' thus providing a final indication of outcome. *N.B. Both the 'Scoring Schedule' and 'Outcome Continuum' should not be viewed by either the client or whānau member during the assessment process. Rather, they should be kept as a separate appendix and produced only after all respondents have completed their schedules.<sup>1</sup>*

The outcome score provides an overall impression of outcome. However, a more detailed analysis of the individual scores, as they relate to particular questions or stakeholders, may provide more detailed information concerning to the effectiveness of a particular clinical end-point or intervention.

*Hua Oranga* is not recommended for children under the age of 15 years or with clients whose functioning is significantly impaired. When applying the tool, clinicians may be required to clarify certain words or concepts. Though this is permissible, clinicians should take care not to influence the response of either the client or whānau member.

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<sup>1</sup> There is some evidence to suggest that viewing these scoring schedules prior to the completion of the tool may potentially bias the responses given.

# **CLINICAL END-POINT DEFINITIONS**

**ASSESSMENT** – *New Case, Completion of Process. Endpoint is when assessment is completed.*

**INPATIENT TREATMENT** – *Period in Hospital. Endpoint is when the Patient is Discharged from Hospital.*

**OUTPATIENT TREATMENT** – *Includes Therapy, Medication, Outpatient Clinics and Hazard Intervention. Endpoint is after about six months of care. N.B This does not require waiting six months before applying the tool.*

**COMMUNITY CARE** – *Includes Clinical and non-Clinical, Day Programmes, Co-ordinated Health Care, Home Visits, Attendance at a day center/programme in the community, support for chronic, full time residential care.*

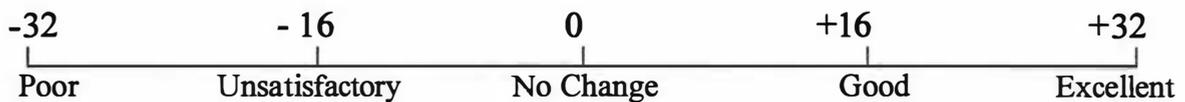
**COMMUNITY SUPPORT** – *Residential Care in the community. Endpoint is after a six month period of care. N.B This does not require waiting six months before applying the tool.*

# SCORING MECHANISMS

## Scoring Schedule<sup>2</sup>

<u>RESPONSE</u>		<u>SCORE</u>
" Much More "	→	+2
" More "	→	+1
" No Change "	→	0
" Less "	→	-1
" Much Less "	→	-2

## Outcome Continuum



<sup>2</sup> The schedules which follow are 'generic'. In an clinical situation the term 'intervention' would be replaced with 'Assessment' or 'Inpatient Treatment' or 'Outpatient Treatment' and so on.

# TANGATA WHAIORA SCHEDULE

Q1. As a result of the INTERVENTION do you feel: (Please Circle One)

- a) more valued as a person      ⇒⇒    ⇒⇒    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) stronger in yourself as a Māori    ⇒⇒    ⇒⇒    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more content within yourself    ⇒⇒    ⇒⇒    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) healthier from a spiritual point of view    ⇒⇒    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q2. As a result of the INTERVENTION are you: (Please Circle One)

- a) more able to set goals for yourself    ⇒⇒    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more able to think, feel and act in a positive manner    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more able to manage unwelcome thoughts and feelings    ⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) more able to understand how to deal with your health problem    ⇒⇒⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q3. As a result of the INTERVENTION are you: (Please Circle One)

- a) more able to move about without pain or distress    ⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more committed to having good physical health    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more able to understand how physical health improves mental well-being    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) physically healthier    ⇒⇒    ⇒⇒    ⇒⇒    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q4. As a result of the INTERVENTION are you: (Please Circle One)

- a) more able to communicate with your Whānau    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more confident in your relationships with other people    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) clearer about the relationship with your Whānau    ⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) more able to participate in your community    ⇒⇒⇒    

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

# WHANAU SCHEDULE

01. As a result of the INTERVENTION does your relative feel: (Please Circle One)

- more valued as a person      =>=> =>=> => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- stronger in his/herself as a Māori   =>=> =>=> => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- more content within him/herself   =>=> =>=> => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- healthier from a spiritual point of view =>=> =>=> => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------

02. As a result of the INTERVENTION is your relative: (Please Circle One)

- more are to set goals for him/herself   =>=> =>=> => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- more able to think, feel and act in a positive manner 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- more able to manage unwelcome thoughts =>=>=>=> => and feelings 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- more able to understand how to deal with their =>=> health problem. 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------

03. As a result of the INTERVENTION is your relative: (Please Circle One)

- more able to move about without pain or distress => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- more committed to having good physical health =>=> 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- more able to understand how physical health =>=> improves mental well-being 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- physically healthier =>=> =>=> =>=> => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------

04. As a result of the INTERVENTION is your relative: (Please Circle One)

- more able to communicate with the Whānau =>=> => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- more confident in relationships with other people   => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- clearer about the relationship with the whānau   =>=> 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------
- more able to participate in the community   =>=> => 

Much more	More	No Change	Less	Much less
-----------	------	-----------	------	-----------

# CLINICAL SCHEDULE

Q1. As a result of the INTERVENTION does the patient feel: (Please Circle One)

- a) more valued as a person ⇒⇒ ⇒⇒ ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) stronger as a Māori ⇒⇒ ⇒⇒ ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more content within him/herself ⇒⇒ ⇒⇒ ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) healthier from a spiritual point of view ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q2. As a result of the INTERVENTION is the patient: (Please Circle One)

- a) more to set goals for him/herself ⇒⇒⇒⇒⇒⇒⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more able to think, feel and act in a positive manner 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more able to manage unwelcome thoughts and feelings ⇒ ⇒ ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) more able to understand how to deal with their health problem. ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q3. As a result of the INTERVENTION is the patient: (Please Circle One)

- a) more able to move about without pain or distress ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more committed to having good physical health ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) more able to understand how physical health improves mental well-being ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) physically healthier ⇒⇒ ⇒⇒ ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

Q4. As a result of the INTERVENTION is the patient: (Please Circle One)

- a) more able to communicate with the Whānau ⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- b) more confident in relationships with other people ⇒ 

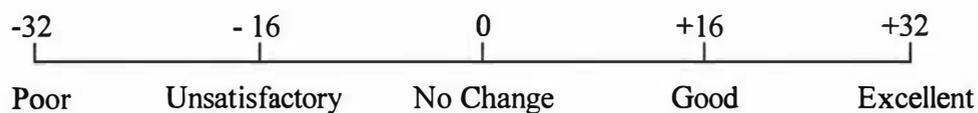
<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- c) clearer about their relationship with the Whānau ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------
- d) more able to participate in the community ⇒⇒ ⇒⇒ 

<i>Much more</i>	<i>More</i>	<i>No Change</i>	<i>Less</i>	<i>Much less</i>
------------------	-------------	------------------	-------------	------------------

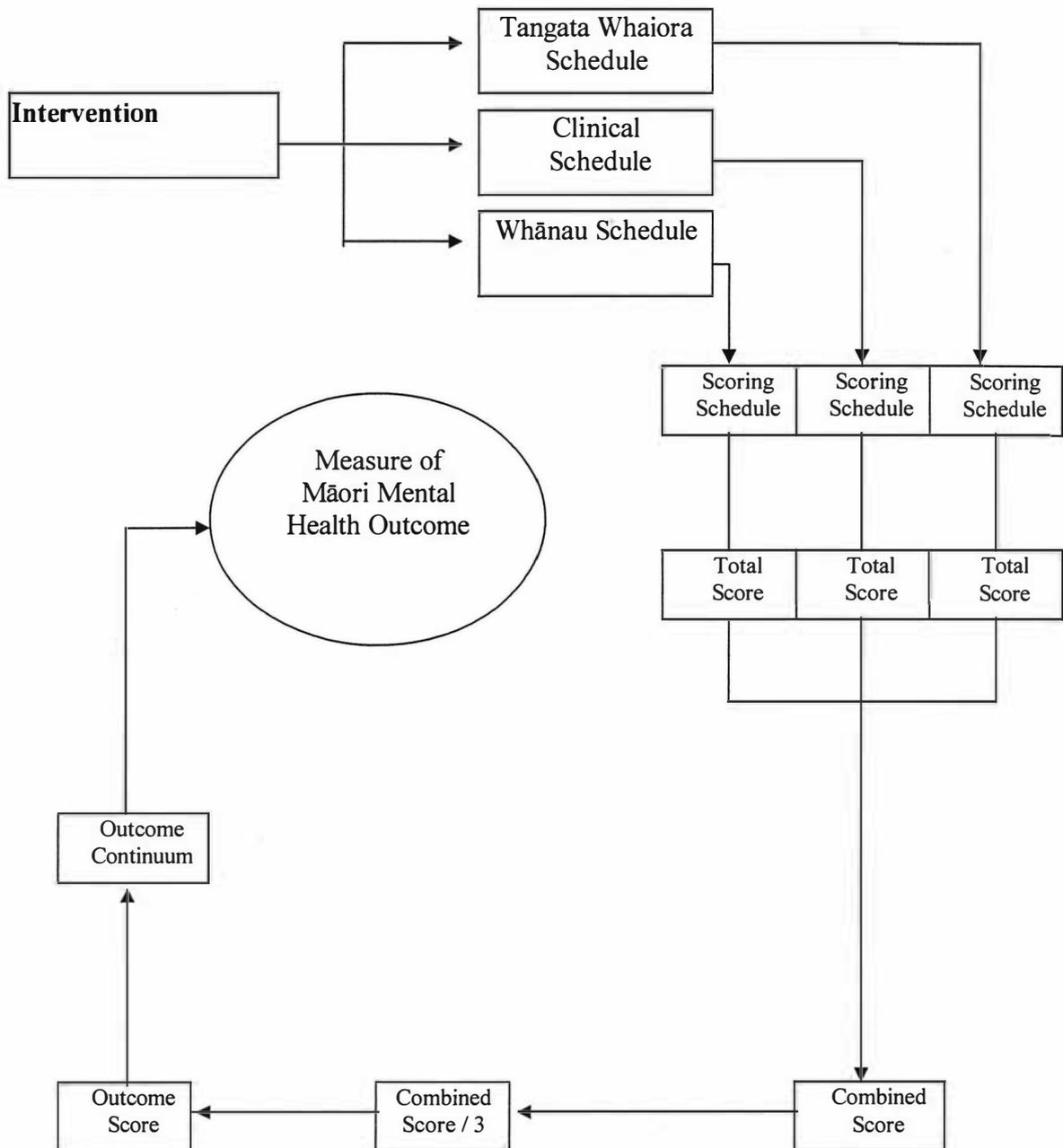
## ADDITIONAL DATA INTERPRETATION

As illustrated each schedule contains 16 questions, four for each of the dimensions of te whare tapa whā. Each question has a possible scoring range of – 2 (Much Less) to + 2 (Much More). By rating and adding each of the 16 questions, three total scores are produced, for each of the three respondents. By adding these total scores a combined score is produced, and, by averaging this combined score (i.e.  $\div 3$ ) and outcome score is produced. With the aid of the outcome continuum, below, the outcome score can be used as an indication of outcome. The continuum has been constructed to reflect the range of possible outcome scores.



## Diagrammatic Process Representation

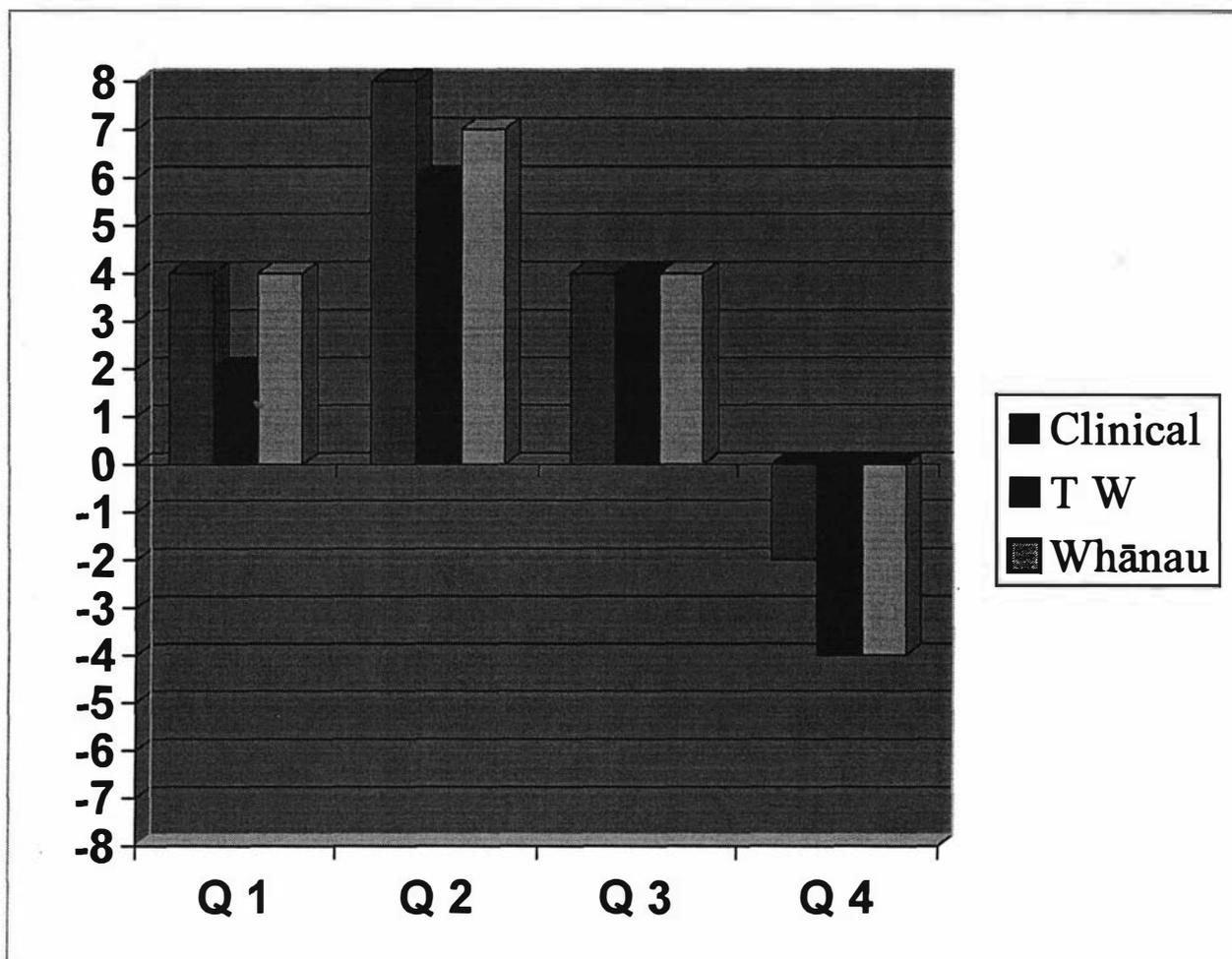
The following diagram has been constructed to further illustrate the application and interpretation process.



### Comparing the Outcome Scores

Although the outcome score is designed to provide an overall impression of outcome it has also been designed to facilitate a more precise examination of the relative scores, by identifying specific aspects of therapy which could be enhanced or further supported.

The table below is a hypothetical example of scores from the three key stakeholders.



Based on the example above, an outcome score of + 11 (i.e  $14 + 8 + 11 = 33$ ,  $33/3 = 11$ ) is produced, which based on the outcome continuum is a reasonably favorable result. However, a closer analysis of this data suggests that outcome, in terms of the ‘whānau’ dimension (question 4) is less desirable and therefore particular attention should be applied to enhancing this dimension. Likewise, the chart also illustrates that the ‘tinana’ dimension (question 3) of outcome was especially encouraging. This would suggest that the intervention was successful in terms of addressing the physical aspects of mental health outcome. This approach to data analysis may be used to supplement the outcome score and to provide a more detailed impression of the treatment process. It is a discretionary option that can be used when appropriate and in circumstances where a more comprehensive assessment is required.

### **Periodic Outcome Assessment and Interpretation**

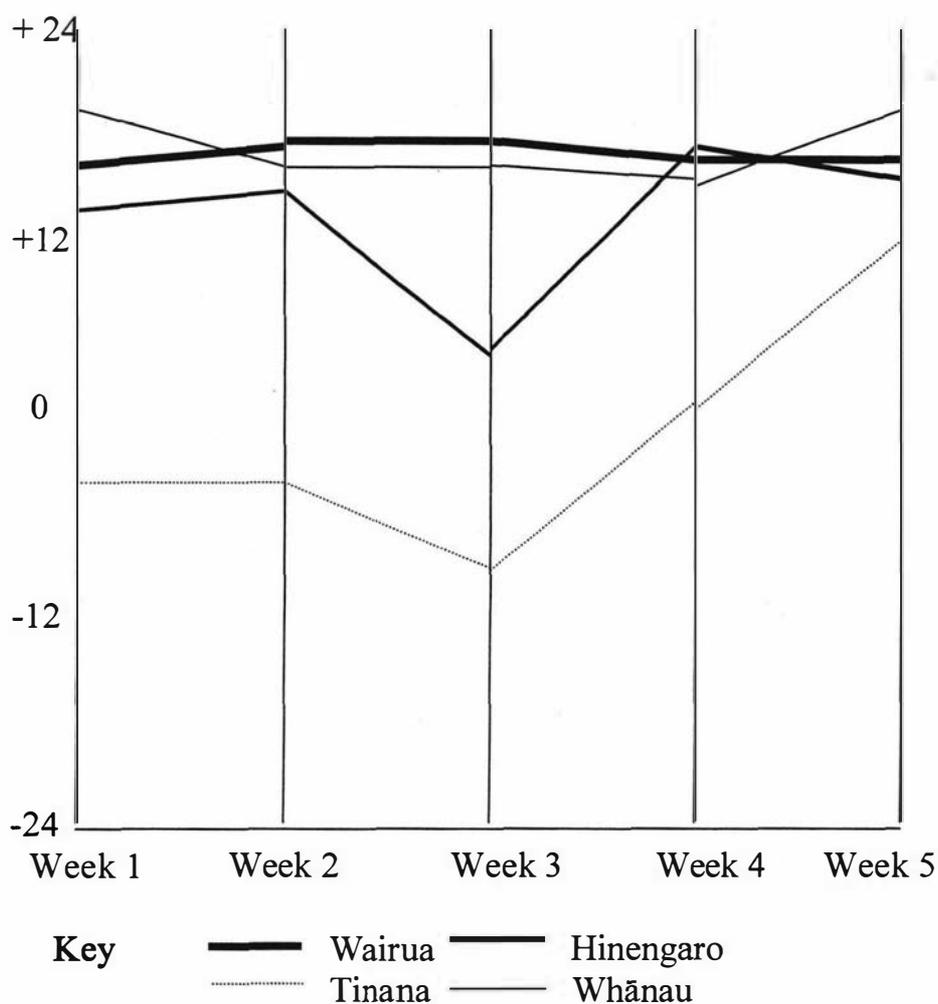
At another level, clinicians may wish to incorporate the tool as part of a longer term outcome assessment process, when for example attempting to assess the utility of a particular treatment plan or approach. The graph on the following page illustrates how the tool may be applied over a five week period.<sup>3</sup> Here the results from each of the four health dimensions are compiled and plotted on a graph.<sup>4</sup> By examining the results, a clinician is able to determine which particular health dimensions require attention. Accordingly, various treatment options may be trialed in order to determine if these needs are now being addressed.

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<sup>3</sup> This duration may vary according to the clients particular situation and needs.

<sup>4</sup> In this example dimension scores for each of the three key stakeholders should be added together. In this manner four scores are produced with a range of +/- 24. As with the other examples a positive score is an

As the following example illustrates, 'Week 1' shows a favorable outcome in all aspects of care, except 'Tinana'. By modifying care plans a clinician is able to incorporate mechanisms specifically designed to enhance physical health. The approach can therefore be monitored on a weekly basis. Similarly, any adverse consequences can be determined.



indication of a favourable outcome. A low or negative score would indicate that the outcome was poor.

## APPENDIX II

### Data Gathering Schedule<sup>5</sup>

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<sup>5</sup> The schedule which follows is a facsimile of the Clinical data-gathering sheet. The whānau and tangata whaiora schedules are consistent with this, save the requirement to detail diagnosis, age, and gender.

Did you fully understand the questions being asked in **question 1** ?

YES  COULD BE IMPROVED

If *COULD BE IMPROVED*, How ?

---

---

---

Did you feel the questions asked in **question 1** were relevant as a way of measuring the outcome of the treatment or care ?

YES  COULD BE IMPROVED

If *COULD BE IMPROVED*, How ?

---

---

---

---

Did you fully understand the questions being asked in **question 2** ?

YES  COULD BE IMPROVED

If *COULD BE IMPROVED*, How ?

---

---

---

Did you feel the questions asked in **question 2** were relevant as a way of measuring the outcome of the treatment or care ?

YES  COULD BE IMPROVED

If *COULD BE IMPROVED*, How ?

---

---

---

---

Did you fully understand the questions being asked in **question 4** ?

YES  COULD BE IMPROVED

If *COULD BE IMPROVED*, How ?

---

---

---

Did you feel the questions asked in **question 4** were relevant as a way of measuring the outcome of the treatment or care ?

YES  COULD BE IMPROVED

If *COULD BE IMPROVED*, How ?

---

---

---

---

Did you fully understand the questions being asked in **question 3** ?

YES  COULD BE IMPROVED

If *COULD BE IMPROVED*, How ?

---

---

---

Did you feel the questions asked in **question 3** were relevant as a way of measuring the outcome of the treatment or care ?

YES  COULD BE IMPROVED

If *COULD BE IMPROVED*, How ?

---

---

---

---

Please briefly describe the intervention

Are there any comments you wish to make about the QUESTIONS on this page ?

Patients DSM-IV Diagnosis (if known)

Patients age (if known)

Male/Female \_\_\_\_\_



# APPENDIX III

## Consent and Information Sheets

# MAORI MENTAL HEALTH OUTCOMES STUDY

## TANGATA WHAIORA INFORMATION SHEET

### Who are the researchers?

The main researchers are both from the School of Māori Studies, Massey University. Te Kani Kingi is a Research Fellow in Te Pūmanawa Hauora and Professor Mason Durie is a psychiatrist and Head of School.

### How can they be contacted?

Te Kani Kingi  
Research Fellow  
Te Pūtahi-a-Toi / School of Māori Studies  
Massey University  
Palmerston North  
Ph (06) 350 5350

## What is the study about?

You are invited to take part in this Māori Mental Health Outcomes study in which we are trying to find a way of measuring the effects of psychiatric treatment or care on health. To do this we have written a short questionnaire and now want to see how good it is.

## What will I be asked to do?

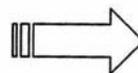
If you want to take part in this study you will be asked to fill in the questionnaire on “page 3” and then to tell us what you think of it using the “Evaluation Form” on “page 4”. This is on the back page.

A relative or close friend and your health worker will also be asked to fill out another questionnaire. All three questionnaires will then be put in an envelope which will then be sealed. The envelope will be sent straight to us. You will not need to write your name or address on the questionnaire. The consent forms will be removed from the questionnaires by the researchers. Filling out your part of the questionnaire will only take about 5 minutes.

## Who else will take part ?

Your relative and your health worker will also be asked to take part and to fill in similar questionnaires and evaluation forms. The health workers have already agreed to take part in the study. However, the study will only go ahead if you agree. Your view will be considered first.

This study is taking place in five other sites around the North Island. In total about 30 tangata whaiora, like yourself, will be asked to take part.



## What are the benefits of the research ?

This research will lead to a way of measuring the benefits of treatment for Māori. It is likely to lead to better care and will help ensure that services are focused on clients.

**Remember !** : You do not have to take part in this study- You can;

- refuse to answer any questions or stop at any time.
- ask any questions you want about the study.
- not be identified and your name will not be recorded anywhere.

Taking part in this study will not in any way effect your access to services.

Please feel free to contact the researchers at a latter to see how the study is going. Contact numbers of patient advocates are as follows.

Auckland (09) 623 5799  
Waikato (07) 834 3960  
Hawkes Bay (06) 8772010  
Wellington (04) 5700850

## TANGATA WHAIORA CONSENT FORM

I have read or have had read to me the information sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask more questions at any time. I may also request the assistance of an interpreter if needed.

I understand that I am free to pull out from the study at any time, or not to answer any particular question in the study, and that this will in no way affect my access to health services. I agree to give this information to the researchers on the understanding that it is completely confidential.

I agree to participate in this study under the conditions set out in the information sheet.

Name: \_\_\_\_\_ Signed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

# MAORI MENTAL HEALTH OUTCOMES STUDY

## CLINICAL INFORMATION SHEET

### **Who are the researchers?**

The main researchers are both from the School of Māori Studies, Massey University. Te Kani Kingi is a Research Fellow in Te Pūmanawa Hauora and Professor Mason Durie is a psychiatrist and Head of School.

### **How can they be contacted?**

Te Kani Kingi  
Research Fellow  
Te Pūtahi-a-Toi / School of Māori Studies  
Massey University  
Palmerston North  
Ph (06) 350 5350

### **What is the study about?**

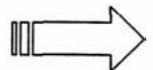
We are trying to find out a suitable way to measure the effects that psychiatric treatment or care has on the health of the patients/clients. To do this we have written a short questionnaire and now want to see how accurate the questions are.

### **What will I be asked to do?**

You may have been involved in the previous study and had the aims explained to you as well as your role. However here is a brief summary.

Three questionnaires will be used. The questionnaires are designed to consider the perspectives of three “key stakeholder” groups, “Clinical” “Whānau” and “Patient/Tangata Whaiora”. These perspectives will target a number of clinical endpoints. For ease of use each series of clinical endpoint questionnaires, such as these, have been colour coded. You will be asked to sign the consent form on “page 2” and to complete the questionnaire on “page 3” and then provide feedback using the “Evaluation Form” on “page 4” at the back. REMEMBER, Your comments on “page 3” are with respect to your observations of the client. “Page 4” is designed to evaluate the questions on “Page 3”.

In addition you will also be asked to approach selected clients and a relative/carer/Whānau member to participate in the study. You will be asked to supply them with a form similar to this. If they decide to participate in the study they will also be asked to complete a similar consent form and then proceed to fill in the questionnaire and evaluation form. REMEMBER, only after all three “key stakeholders” agree to participate can the study continue. The decision of the client is, however, paramount.



**What happens next ?**

You will need to be present with the Whānau and patient when outlining the project (this is to answer any queries they may have). Once completed, you will need to return the questionnaires to the envelope they were supplied in. The envelopes have been numbered and this number will correspond with the number on the questionnaires.

Please ensure that all **three** questionnaires are returned to the envelope. IMPORTANTLY, please ensure that you seal the envelope in their presence before forwarding the envelope to your SERVICE CONTACT PERSON.

**What are the benefits of the research?**

This research will lead to the development of a method for measuring the benefits of treatment for Māori. It is likely to lead to higher standards of treatment and care and will help ensure that services are focussed on clients. N:B This study is not designed to measure your performance or the performance of the service, rather the effectiveness of the tool described.

**REMEMBER:** You have no obligation to take part in this study - you have the right to decline. Those who agree to be participate;

- can refuse to answer any questions or stop at any time.
- may ask any questions they want about the study.
- will not be identified and responses will remain confidential.

You may have already been asked to complete this consent form. However we ask that you please take the time to complete this form for every case.

## CLINICAL CONSENT FORM

I have read the information sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask more questions at any time. I may also request the assistance of an interpreter if needed.

I understand that I am free to withdraw from the study at any time, or to decline to answer any particular question in the study. I agree to provide information to the researchers on the understanding that it is completely confidential.

I agree to participate in this study under the conditions set out in the information sheet.

Name: \_\_\_\_\_ Signed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

# MAORI MENTAL HEALTH OUTCOMES STUDY

## WHĀNAU INFORMATION SHEET

### **Who are the researchers**

The main researchers are both from the School of Māori Studies, Massey University. Te Kani Kingi is a Research Fellow in Te Pūmanawa Hauora (The Health Research Unit) and Professor Mason Durie is a psychiatrist and Head of School.

### **How can they be contacted?**

Te Kani Kingi  
Research Fellow  
Te Pūtahi-a-Toi / School of Māori Studies  
Massey University  
Palmerston North  
Ph (06) 350 5350

### **What is the study about?**

You are invited to take part in this Māori Mental Health Outcomes Study in which we are trying to find a way of measuring the effects of psychiatric treatment or care on health. To do this we have written a short questionnaire and now want to see how accurate it is.

### **What will I be asked to do?**

If you wish to take part in this study you will be asked to fill in the questionnaire on “page 3” and then give feedback using the “Evaluation Form” on “page 4” at the back. Your relative (who is here for treatment) and their health worker will also be asked to complete separate questionnaires. All three questionnaires will then be placed in an envelope which will be sealed in front of you. The envelope will be sent straight to us.

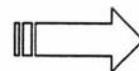
You will not need to write your name or address on the questionnaire. The consent forms will be removed from the questionnaires by the researchers. Filling out your part of the questionnaire will only take about 5 minutes. REMEMBER, Your comments on “page 3” are with respect to your observations of your relative. “Page 4” is designed to evaluate the questions on “Page 3”. This is the main purpose of this study.

### **Who else will be involved?**

As noted, your relative and their health worker will also be asked to take part and to fill in similar questionnaires and evaluation forms. The health workers have already agreed to take part in the study. The study will only continue when you and your relative agree to take part. The view of your relative, however, will be considered first.

This study is taking place in five other sites around the North Island. In total about 30 tangata whaiora, like your relative, will be asked to participate.

**Please Turn Over**



## FURTHER INFORMATION AND CONSENT FORMS

### What are the benefits of the research?

This research will lead to a way of measuring the benefits of treatment for Māori. It is likely to lead to better care and will help ensure that services are focused on clients.

### REMEMBER: You do not have to take part in this study- You can;

- refuse to answer any questions or stop at any time.
- ask any questions you want about the study.
- not be identified and your name will not be recorded anywhere.

Taking part in this study will not in any way effect your relatives access to services.

Please feel free to contact the researchers at a latter date as to the development of the questionnaire and this study.

## WHANAU CONSENT FORM

I have read the information sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask more questions at any time. I may also request the assistance of an interpreter if needed.

I understand that I am free to withdraw from the study at any time, or to decline to answer any particular question in the study, and that this will in no way affect my relatives access to health services. I agree to provide information to the researcher on the understanding that it is completely confidential.

I agree to participate in this study under the conditions set out in the information sheet.

Name: \_\_\_\_\_ Signed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

# APPENDIX IV

## Consultation Schedules

## Dedicated presentation/hui schedule – Chapter 4

<b>PARTICIPANTS</b>	<b>NO. ATTENDEES</b>	<b>LOCATION</b>
Mental Health Commission (Māori Expert Panel)	14	Wellington
Māori Mental Health Services	30	Wellington
Māori Mental Health Issues	80	Gisborne
Association of Māori Medical Practitioners Conference	80	Plimmerton
Dip. Addition Studies Students	30	Palmerston Nth
Māori Mental Health Services	30	Wellington
Māori Child, Adolescent and Family Services Conference	80	Porirua
Dip. Addition Studies Students	30	CIT Wellington
Dip. in Business Management and Māori Health Students	30	Palmerston Nth
The Treasury	30	Wellington
Realising Recovery Conference	50	Wellington
Ngā Oranga o te Rae	25	Wellington

Informal presentation/hui schedule – Chapter 4

<b>PARTICIPANTS</b>	<b>NO. ATTENDEES</b>	<b>LOCATION</b>
Te Tatau Pounamu – Health Service	12	Te Puke
Te Korowai Aroha – Health Service	11	Thames
Hauora Waikato – Māori Mental Health Service	5	Hamilton
Hauora o te Hinengaro – Māori Mental Health Service	7	Palmerston Nth
Ministry of Health – Māori Policy Group	20	Wellington
Mental Health Commission – Māori Expert Panel	12	Wellington
Māori Mental Health Workers	40	Wellington
Hauora o te Hinengaro	43	Auckland
Mental Health Purchasing Strategies	80	Rotorua
Mental Health Commission	12	Auckland
Māori Mental Health Workers	23	Hamilton

## Site Consultations – Chapter 5

Site Presentations	No. Attendees*	Location
<b>Manawanui</b> Māori Mental Health Services	<b>40</b>	<b>Pt. Chevelier, Auckland</b>
<b>MOKO Services</b> Waitemata Health	<b>20</b>	<b>Waitakere City, Auckland</b>
<b>Whai Ora</b> Māori Mental Health Services	<b>30</b>	<b>Te Awamutu, Waikato</b>
<b>Te Puawai o te Whānau</b> Healthcare Hawkes Bay	<b>25</b>	<b>Hastings, Bay</b> <b>Hawkes</b>
<b>Te Whare Marie</b> Capital Coast Health	<b>20</b>	<b>Porirua, Wellington</b>

\* Estimates

## Hui Participants ( x 2) – @ Massey University – Chapter 5

Prof. Mason Durie	Te Pūtahi-ā-Toi	Palmerston North
Te Kani Kingi	Te Pūmanawa Hauora	Palmerston North
Ani Sweet	Te Whare Marie	Porirua
Lisa Cherrington	Te Whare Marie	Porirua
Materoa Mar	Te Whare Marie	Porirua
Pikau Arthur	Te Whare Marie	Porirua
Wi Keelan	Auckland Central	Auckland
Bob Elliot	Hauora Waikato	Hamilton
Wayne Mulligan	MOKO-Waitemata Health	Waitakere City
Iona Edmonds	MOKO-Waitemata Health	Waitakere City
Rawinia Hape	Te Puawai o Te Whānau	Hastings
Wiremu Stirling	Te Wahanga Hauora Māori	Hastings
Mere Hammond	Te Puawai o Te Whānau	Hastings
Awhi Ropiha	Health Care Hawkes Bay	Hastings
Winston Maniapoto	Auckland Healthcare	Auckland
Diana Rangihuna	Te Whare Marie	Porirua
Rongo Larkin	Te Whare Marie	Porirua
Karen Steele	Te Pūmanawa Hauora	Palmerston North
Maureen Holdaway	Te Pūtahi-ā-Toi	Palmerston North
Tony O'Brien	Massey University	Palmerston North
Ani Wharekura	Whai Ora	Te Awamutu
Cindy Hewitt	Whai Ora	Te Awamutu
Pue Whakaruru	Whai Ora	Te Awamutu
Maise Whakaruru	Whai Ora	Te Awamutu
Tui Taurua	MOKO-Waitemata Health	Waitakere City
Louise Ihimaera	Te Puawai o Te Whānau	Hastings
Margaret Hiha	Healthcare Hawkes Bay	Hastings
Paddy Brooking	Te Puawai o Te Whānau	Hastings
Jim Whaanga	Te Puawai o Te Whānau	Hastings
Trevor Taurima	Healthcare Hawkes Bay	Hastings