

Culture and mental health care in New Zealand: indigenous and non-indigenous people

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INTRODUCTION

A distant land, cloud capped, with plenty of moisture and sweet scented soil.

Kupe (cited in Te Matorohanga, 1913)

This chapter sets out to provide an overview of mental health services in New Zealand, with specific attention to the cultural aspect of these services for both indigenous people (*Māori*) and migrants. We are ourselves both migrants to New Zealand and approach this chapter as insiders and outsiders to the system, giving us a unique perspective. There are a number of limitations we would like to highlight: We do not claim to speak for all New Zealanders and acknowledge that this chapter is a beginning reference point, not a comprehensive review of all mental health issues. This chapter focuses on adult mental health and excludes in-depth discussion of child and youth mental

health issues, problem gambling and alcohol and other drugs. We do not claim to be experts in issues related to *Māori*, since we are not ourselves *Māori*.

Throughout the chapter we use the term '*tangata whai ora*' rather than 'patient'. We do this to recognize and acknowledge the unique context of the New Zealand consumer's reality but in doing so also acknowledge that all terms have their politics and limitations. *Māori* words and terms used in this chapter are italicized for the benefit of the non-New Zealand reader and a glossary is provided at the end.

The chapter begins with an overview of the unique background and contextual issues that have shaped the New Zealand mental health system. It presents demographic information, discusses the significance of the Treaty of Waitangi and the structure of the health system, with particular reference to the health reforms of the 1980s and 1990s. It emphasizes the importance of the recovery model and the role of consumers in the

delivery and development of mental health services. The first section concludes with a summary of the role of the Mental Health Commission. The chapter then continues with a discussion of the unique bicultural nature of New Zealand, with particular reference to *Māori* and the role of the Treaty of Waitangi. There follows a discussion of key aspects of psychiatric practice in New Zealand and a separate section describing the mental health services that are provided for *Māori*. Issues of workforce development are discussed and the chapter concludes with a discussion on migrant and refugee communities and their mental health requirements and service provision.

BACKGROUND AND CONTEXT

New Zealand achieved independent dominion from Britain in 1907 and today has a population of four million people. Three-quarters of the population live in the North Island and 85 per cent live in urban areas. Like other Western countries, the population is ageing and the median age is 35. Twenty-nine per cent of New Zealanders live in its largest city, Auckland. Changes heralded in the Immigration Act 1987 have led to an increasingly diverse population. Whilst European New Zealander's make up 75 per cent of the population and *Māori* account for 14.7 per cent, Pacific people make up 6.5 per cent and Asians now account for 6.6 per cent. Asians are also the fastest growing ethnic group, increasing by around 140 per cent over the last ten years. The predominant language spoken in New Zealand is English (96.1 per cent) followed by *Māori* (4.5 per cent), which is an official language. Sixteen percent of people are bilingual or multilingual speakers. The median income for the population is US\$21 000 (Statistics New Zealand, 2005).

THE TREATY OF WAITANGI AND CULTURAL SAFETY

When Britain assumed governance of its new colony in 1840, it signed a treaty with *Māori*

tribes. *Te Tiriti O Waitangi*/The Treaty of Waitangi is today recognized as New Zealand's founding document and its importance is strongly evident in health care and social policy. As a historical accord between the Crown and *Māori*, the treaty defines the relationship between *Māori* and *Pakeha* (non-*Māori*) and forms the basis for biculturalism, which Sullivan (1994) defined as:

- Equal partnership between two groups.
- *Māori* are acknowledged as *tangata whenua* ('people of the land').
- The *Māori* translation of *Te Tiriti O Waitangi* is acknowledged as the founding document of *Aotearoa*/New Zealand.
- Biculturalism is concerned with addressing past injustices and re-empowering indigenous people.

Durie (1994) suggests that the contemporary application of the Treaty of Waitangi involves the concepts of biculturalism and cultural safety, which are at the forefront of delivery of mental health services. This means incorporating 'principles of partnership, participation, protection and equity' (Cooney, 1994, p. 9) into the care that is delivered. There is an expectation that mental health staff in New Zealand ensure care is culturally safe for *Māori* (Mental Health Commission, 2001). Simply put, 'unsafe practitioners diminish, demean or disempower those of other cultures, whilst safe practitioners recognize, respect and acknowledge the rights of others' (Cooney, 1994, p. 6). The support and strengthening of identity are seen as crucial for recovery for *Māori* along with ensuring services meet *Māori* needs and expectations (Mental Health Commission, 2001). Cultural safety goes beyond learning about such things as the dietary or religious needs of different ethnic groups; it also involves engaging with the socio-political context (McPherson *et al.*, 2003; DeSouza, 2004).

THE PUBLIC HEALTH SYSTEM

The health system is a predominantly a public-based system. The country is divided into 21 District Health Boards (DHBs), which provide

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services with the objective of improving, promoting and protecting the health of people and communities. There is a strong emphasis in psychiatric practice on community-based services. Recently, primary mental health care has been strengthened with the development of the Primary Health Care strategy and establishment of primary health organizations (PHOs) whose focus includes addressing the mental health needs of their populations who present with mild to moderately severe mental health problems or disorders as well as working in partnership with mental health services to provide care for moderate to severe disorders. Building up the capacity and responsiveness of PHOs in primary care is a priority as they are seen as having a pivotal role in the overall provision of mental health care.

New Zealand's first psychiatric hospital was opened in Dunedin 1863 (Bloomfield, 2001). It accommodated 21 *tangata whai ora*. By 1938, New Zealand had become the first country in the world to introduce universal health care, as part of a post-depression welfare state. The modern health system has been shaped by the shift to neo-liberal ideologies from the mid-1980s (Crowe *et al.*, 2001). No other country embraced the market-driven model and corporatization of public assets to the extent New Zealand did. Underpinned by free trade, market liberalization, limited government involvement and a deregulated labour market, New Zealand's public service underwent dramatic reforms between 1987 and 1999 (Crowe, 1997). Unsurprisingly, this has profoundly influenced the provision of mental health care. Since the election of a Labour-led coalition government in 1999, there has been a gradual winding back of neo-liberalism and a return to more socially oriented measures with greater state involvement in public service delivery (Saul, 2005).

The legacy of the reforms is seen in the transition from large mental hospitals to psychiatric inpatient units within general hospitals, which also began in the 1980s. Law and policy changes throughout the 1990s encouraged the process of deinstitutionalization and hospital beds were reduced from over 10 000 in 1973 to less than 2000 by 1996 (Currier, 1997). The Mental Health (Community Assessment

and Treatment) Act 1992 allows for the compulsory treatment of people with serious mental illness in the community while the Looking Forward strategy (Ministry of Health, 1994) advocated for more community-based mental health services to be provided by publicly funded non-governmental organizations (NGOs) as well as by DHBs and for the continued reduction of hospital admissions.

Dew and Kirkman (2002) suggest that the process of deinstitutionalization was flawed in that it was not government-led and occurred erratically. The result has been fragmentation and underfunding of community mental health services. They argue that the workforce was ill-prepared and the result has been a dearth of recovery/rehabilitation-orientated professionals and a paucity of services and resources, such as accommodation, which has seriously impeded service delivery. These issues are addressed by the national mental health strategy, 'the Blueprint' (Mental Health Commission, 1998), which promotes a recovery approach for mental health service providers and incorporates notions of consumer empowerment, self-determination, awareness, maintenance of rights and full participation in society (Ministry of Health, 2003). Hospital-based mental health services now provide short-term care for people while they are acutely unwell, but bed shortages remain a concern.

RECOVERY AND THE CONSUMER MOVEMENT

In parallel to the economic reforms, the consumer movement has influenced a movement in mental health service delivery from a medical to a psychosocial rehabilitation model. New opportunities have arisen for consumers to interact with policy-makers, professionals and others from a position of strength. Consumer-operated programmes and initiatives have emerged from dissatisfaction with clinical mental health services and consumers now report finding consumer-staffed organizations more empathetic, tolerant and understanding because of their own struggles with psychiatric disability (Worley, 1997). Guidelines have been developed as a result of increased consumer

participation in professionally run mental health agencies (Ministry of Health, 1995) and this led to changes in the relationship between consumers and professionals. There is a growing recognition on the part of professionals of the value of experiential knowledge and what consumers have to offer other consumers.

MENTAL HEALTH COMMISSION

Established in 1997 to ensure the implementation of the National Mental Health Strategy, the Mental Health Commission's role is to improve services and outcomes for people with mental illness and their families/*whānau*. It evolved from the Mason Committee, set up to inquire into mental health services and the findings of which revealed strengths and significant weaknesses in New Zealand mental health services (Mason *et al.*, 1996). Initially, the Commission was involved in reviewing the standards for mental health services and strategic planning for implementing better services over a five-year period. The Commission formulated a blueprint for mental health services and proposed that the recovery approach become standard practice in all services. This document is now government policy, setting out expectations around what levels of service need to be present to meet the needs of different groups. It defines guidelines for delivering services to *Māori*, so that they have a choice of accessing high-quality, culturally effective mainstream services. It has also responded to the growing populations of Pacific and Asian communities through the development of resources.

The Commission defines recovery as something that:

happens when people can live well in the presence or absence of their mental illness and the loss that may come in its wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of losses.

(Mental Health Commission, 1998, p. 1)

The concept of recovery originates in the USA and is derived from the self-help movement, users of mental health services and psychiatric rehabilitation principles.

It is noted that stigma and discrimination associated with mental illness are major barriers to recovery. In New Zealand, the 'Like Minds Like Mine' Project, a public health-funded project, began in 1997 to reduce stigma associated with mental illness and the discrimination that people with mental illness face in the community. Nationwide and community-based programmes are making significant progress through advertising campaigns, policy initiatives and so forth. A co-ordinated cross-sectoral approach with the Mental Health Commission, the Human Rights Commission and the Office for Disability Issues is also under development.

The Mental Health Commission (2001) suggests that understanding, supporting and strengthening identity are important components of recovery. Cultural assessment, or the process through which the relevance of culture to mental health is ascertained, in the treatment and support of *tangata whai ora* is strongly advocated. While undertaking a cultural assessment helps to identify a person's cultural needs, cultural supports or healing practices are also needed to strengthen identity and enhance wellness. Cultural assessment can be used to assess mental status and it is also important as a tool for planning treatment and rehabilitation (Mental Health Commission, 2001).

MĀORI/TANGATA WHENUA

Durie (1999) suggests that the greatest threat to good health for *Māori* is poor mental health. Prior to Western systems of health *Māori* followed indigenous practices where illnesses were generally attributed to the violation of *tapu* (supernatural influence or restriction) or the presence of *makutu* (curse). The *tohunga* acted as an intermediary between humans and *atua* (gods) and performed atonement or addressed imbalances of supernatural power (Sachdev, 1998). As Durie (1985) explains, *Māori* concepts of health are broader than Western concepts, encompassing spiritual and family

components in addition to the physical and psychological aspects. Furthermore, *whenua* (land), *whānau* (family) and *reo* (language) are crucial determinants of good mental health for *Māori*.

There remain significant disparities between *Māori* and non-*Māori* in mental health. Mental health services have a responsibility to respond to *Māori* health issues by improving care through understanding the socio-political issues and historical processes that impact on the status of *Māori*. Furthermore, *Māori* are underrepresented in the health workforce despite the proliferation of *Māori* mental health service providers (Mental Health Commission and Ministry of Health, 1999).

Whilst health status of *Māori* has improved significantly over the last four decades, their indices of health still lag behind non-*Māori*, with higher rates of common disorders. *Māori* are overrepresented in crisis, acute inpatient and forensic services and have substantially higher rates of readmission than non-*Māori* (Pomare, 1986; Pomare and deBoer, 1988). Hyslop *et al.* (1983) suggest that this is due to poor delivery of health care services to *Māori* or an ineffective use of these services by *Māori*.

The leading causes of first admission for *Māori* are alcohol dependence or abuse and, for readmission, schizophrenia (men) and affective psychosis (women). *Māori* are more likely to be admitted through involuntary and committal procedures (36 per cent versus 24 per cent). *Māori*, and in particular *Māori* youth, have higher than average rates of suicide. In 1997 the suicide rate for *Māori* was 33.9/100 000 and for non-*Māori* was only 24.2/100 000.

Māori communities have experienced considerable change since 1945, with a significant population drift from rural to urban areas, a related dislocation from tribal affiliations and inter-marriage with Europeans (Harre, 1968). Westernization and urbanization has altered the traditional fabric of society and the role of extended family and tribal structure (*whānau*, *hapu* and *iwi*) as a fundamental unit has been broken with no suitable substitute (McCreary, 1968). Traditional supports and controls on behaviour have consequently been lost (Sachdev, 1989) and other risk factors such as cultural alienation, the impact of history through

intergenerational modelling, behavioural transfer and confusion over identity remain for many.

PSYCHIATRIC PRACTICE IN NEW ZEALAND

In 2002, 1.7 per cent of the New Zealand population were users of mental health services. In the first six months of 2002, 0.14 per cent of the population received inpatient care and 0.3 per cent of the population was treated by alcohol and drug services (Gaudin, 2004). At this time, the total number of general adult inpatient beds was 1375. Forty-seven per cent of *tangata whai ora* were being assessed and treated under the Mental Health Act 1992.

More than 90 per cent of mental health services are provided free of charge to *tangata whai ora* through government subsidy and this funding is allocated through local DHBs. In 2001/2002, funding totalled NZ\$725 million, the equivalent of NZ\$184 per capita. Approximately 69 per cent of this funding went to community mental health services and 31 per cent to inpatient services. *Māori* services received 9.5 per cent of the total mental health budget and services for Pacific people received 1.4 per cent (Gaudin, 2004).

Benchmarking for various service components such as the number of inpatient beds is set by the National Mental Health Strategy. However, it does not discuss the gradient required in those benchmarks in order to effectively address deprivation. There is a strong association between areas of deprivation and psychiatric bed utilization (Abas *et al.*, 2003). People living in deprived areas, such as south of Auckland, have approximately three times the admission prevalence of those living in the least deprived areas. It is suggested that the higher admission rates in the most deprived areas is the result of poor access to primary care, poorer quality of primary care or poorer access to outpatient mental health care (Stuart *et al.*, 1996; Jacobson, 1999).

Public services

The New Zealand Government provides the vast majority of funding made available to mental

health services and 70 per cent of all funding is spent by public providers through DHBs and GPs, including PHOs. The government identifies five key outcome perspectives for service delivery (Kriebel, 2003): Consumer, Cultural, Family, Care, and Public.

Non-government organizations (NGOs)

NGOs have become an integral part of mental health service delivery. Services provided by NGOs include residential care, community support, employment services and consumer and family support services. NGOs receive one-third of the funding allocated to mental health and are coordinated through their own national network, Platform, the New Zealand Association of Support Services and Community Development in Mental Health.

Accident compensation scheme

New Zealand has a publicly funded model of no-fault accident insurance. Whilst this relates primarily to physical (and particularly sporting) injuries, the Accident Compensation Corporation (ACC), which administers the scheme and provides personal injury cover for all New Zealand citizens, residents and temporary visitors to New Zealand, also deals with the mental health effects of sexual abuse or sexual assault. These 'sensitive claims' include depression and post-traumatic stress disorder (PTSD). ACC provides cover for a mental injury resulting from a physical injury, such as PTSD or depression resulting from a motor vehicle accident.

Housing

According to the Mental Health Commission (1999), recovery from mental illness often requires specific housing arrangements combining support, a quality physical environment and suitable local environment. With the shift to community-based care, housing difficulties now affect 17 per cent of *tangata whai ora*, with a similar number living in circumstances that could involve a

heightened risk of future homelessness. About 4 per cent of *tangata whai ora* are homeless or living in temporary or emergency accommodation. One-third of *tangata whai ora* have problems affording housing and another third face a lack of choice (Peace and Kell, 2001). Peace and Kell note that discrimination, unsuitable locations, loss of accommodation during acute illness or hospitalization can affect between 10 and 20 per cent of *tangata whai ora*. Problems with accommodation can lead to deterioration in mental health, particularly during the transition from clinical care to independent housing. Peace and Kell contend that an additional factor affecting Pacific consumers is overcrowding and many mental health providers identify housing difficulties as being a serious issue for *Māori*.

Compulsory treatment

With the introduction of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) there occurred a major revision in the law regulating the involuntary admission of psychiatric *tangata whai ora*. The MHA defines the circumstances and conditions under which a person can be subjected to compulsory psychiatric assessment and treatment. The Act reformed and consolidated the law relating to the assessment and treatment of persons suffering from mental disorder. It defines the rights of such persons and provides protection for those rights. The MHA placed greater emphasis on the protection of civil rights through regular judicial review and, under this legislation the initiation of involuntary hospitalisation is carried out by a Duly Authorised Officer (DAO) appointed by the Director of Area Mental Health Services. The Act defines the rights of *tangata whai ora*, recognizes cultural safety and provides a multi-tiered system of advocacy. *Tangata whai ora* can challenge their compulsory status, including requesting a second opinion, a judicial review or making a request to the Mental Health Review Tribunal for a review of their compulsory status. Contrary to previous legislation but in line with current practice, the Act emphasizes community treatment over institutional treatment (Currier, 1997). Further refinements have been

made in the Amendments to the MHA, which came into force in 1999.

Tangata whai ora committed to community care have the right to refuse medication after the first month of treatment and a process of second opinion must be initiated to enforce medication compliance. The MHA defines grounds for involuntary hospitalization as the person must be suffering from an 'abnormal state of mind', including delusion or impairment of cognition, volition or perception and the mental disorder results in significant risk to danger to self or others or in a substantial impairment of ability to care for self. The MHA does not recognize cultural beliefs, sexual preferences, criminal or delinquent behaviour, substance abuse or an intellectual handicap as mental disorder.

Forensic psychiatry

Forensic psychiatric services provide care for prison inmates, mentally ill persons proceeding through the courts and those found to be not guilty through disability and insanity. Decisions regarding violent inmates with mental health concerns are made on a clinical basis and not through reference to legal status. A dilemma exists regarding the forensic status of personality-disordered or intellectually disabled prisoners, since there is no equivalent psychopathic disorder defined. Inpatient forensic services work almost exclusively with patients subject to compulsory inpatient treatment orders either through civil commitments or by the criminal justice legislation.

The Mason Report (Mason *et al.*, 1996) shaped the future of forensic psychiatry in New Zealand. Following this report, four new types of forensic service were established:

1. Medium and a minimum security psychiatric units
2. A prison liaison service
3. A court liaison service
4. A community forensic psychiatric services.

In addition, a consultation and liaison service for general psychiatric services was established. Regional forensic psychiatric services were created as a part of the regional mental health services and established to cater to for *tangata whai ora* for a period of up to three years in secure rehabilitation.

However, as some *tangata whai ora* have required significant longer rehabilitation periods, long-term rehabilitation units have also been built.

Clinical practice in this area is largely influenced by the Mental Health Act 1992, which provides for compulsory care of the mentally ill both within inpatient unit and also in the community. Criminal law deals with concerns of criminal responsibility, fitness to plead and the legal definition of mental disorder. The person found to be mentally disordered before the court in a criminal matter can be dealt with through provisions in MHA, the Summary Proceedings Act 1957 and the Criminal Justice Act 1985. Insanity provisions are contained in section 23 of the Crimes Act 1961 (see Chapter 7, section on New Zealand mental health law).

A psychiatric report can be requested by the Court for a person either charged (before or during their trial) or convicted of an offence under section 121 of the Criminal Justice Act 1985. This allows a person to be remanded to prison or psychiatric care pending such report or for the report to be prepared as a condition of bail. Such reports address fitness to plead, insanity or other pre-sentence issues that might assist the presiding Judge in arriving at an appropriate disposition. The assessment of 'fitness to plead' under New Zealand law is similar to that of other Commonwealth jurisdictions but New Zealand law lacks a provision for claiming of 'diminished capacity' through mental disorder at the time of offending (Brinded, 2000). The disposition available to the court for an individual found to be not guilty by virtue of insanity is similar to person unfit to plead under section 115 of the Criminal Justice Act 1985. The experienced member of the multidisciplinary team provides the court liaison service based in the court. Following a reference either from the judge, police, lawyers or the family of the accused person the health professionals perform the initial assessment. This service is available in almost all high courts of New Zealand.

Outpatient forensic psychiatry services work closely with inpatient services and also with community mental health centres. This facilitates the smooth transfer of the *Tangata whai ora* and tends to avoid the artificial barriers between inpatient

care and the community. The treatment for sex and violent offenders remains largely based in correctional facilities.

Suicide

Suicide is one of the indicators of mental health in the population. New Zealand has the highest reported male youth (15–24 years) suicide rate and the second highest female youth suicide rate amongst OECD (Organisation for Economic Co-operation and Development) countries. For all ages suicide rates for males in New Zealand ranks fifth amongst OECD countries and for females, sixth. Local research suggests that almost 90 per cent of people who die by suicide or make serious suicide attempts will have one or more mental disorders at the time of their attempt, with these disorders typically being accompanied by other sources of stress and difficulty (Beautrais *et al.*, 2005). The government's youth suicide prevention strategy provides a framework for understanding what suicide prevention is and signals the steps a range of government agencies, communities, service providers, *iwi* and *whānau* must take to reduce the incidence of suicide. Since 2001 the Ministry of Youth Development (2004) has led the promotion and co-ordination of this strategy. *Māori* have higher rates of suicide than non-*Māori* for both men and women. Additional risk factors appear to be related to cultural alienation and confusion over identity. Official statistics indicate that suicide among *Māori* aged over 45 years is virtually non-existent, suggesting that there may be culturally specific factors that may be protecting this group against suicide.

Rural services

New Zealand has significant rural populations and this provides challenges for the delivery of mental health services. These included staff retention, a shortage of skilled mental health staff, limited access to hospital-based services, lack of funding for psychiatric services, frequently being on call and effective management of risk is challenging in rural psychiatry. Risk exists in the limited opportunities to obtain a second opinion and the lack of collegiate

support. There are few opportunities for rural mental health staff to participate in continuing medical education (CME) and quality assurance issues can arise due to professional isolation. The lack of trainees is also a significant problem for those working in rural areas.

MĀORI MENTAL HEALTH SERVICES

Durie (1985) reported that communication problems between professionals and *Māori tangata whai ora* and the inflexibility of the health system to accommodate cultural differences presented by *Māori* caused under-utilization of mental health services by *Māori*. The health system has traditionally been dominated by the Western medical model and *Māori* have been an underrepresented minority as well as a socio-economically disadvantaged minority as well.

Since the early 1990s, mental health services have increasingly recognized the need to develop a *Māori* mental health workforce. New Zealand has developed parallel services that are 'for *Māori* by *Māori*' and 'For Pacific people by Pacific people'. One aim of the national strategic framework for *Māori* mental health, *Te Puawaitanga* (Ministry of Health, 2002a) is to increase the number of *Māori* mental health workers, resulting in new research, tertiary training and workforce development initiatives. *Te Rau Matatini* was established to ensure that *Māori tangata whai ora* have access to a well-prepared and well-qualified *Māori* mental health workforce. The goal was to increase recruitment and retention of *Māori* staff through increasing *Māori* participation, to increase the expertise of the broader *Māori* workforce and of *Māori* staff in related sectors. This model promotes excellence in the workforce through the development of clinical and cultural expertise (Te Rau Matatini, 2004).

Awareness of cultural differences is needed not only in culturally specific services but also in the mainstream services, since not all *Māori* or members of other ethnic or cultural groups have access to or choose to use culturally specific services. Fears regarding treatment can arise from concepts that are generally disregarded in the Western construction

of mental health. As Durie (1977) observes, *Māori tangata whai ora* can present with an 'unspoken and unconscious fear' (p. 484) of some infringement of *tapu* and families might seek the services of a traditional healer in *tohunga* in order to identify and 'treat' such an infringement. The traditional role of the *tohunga* does not replace the doctor, rather it may be complementary with some *Māori* leaders arguing for a greater degree of co-operation between the two systems. They suggest that the two roles could be seen as serving different but complementary functions for *tangata whai ora*. There is evidence of improved health outcomes within *Māori* communities when culturally appropriate responses emerge from the community itself and such that Western medical practices are re-conceptualized within a *Māori kaupapa* (Department of Health, 1984).

Localized attempts to provide culturally based care in the community include GP services based within *Marae*, specialist outreach clinics, culturally specific health education programmes and *Māori* mental health teams. However, research shows that health professionals can feel ill-prepared to deal with such services: Johnstone and Read (2000) found that whilst 70 per cent of psychiatrists responding to their survey believed there was a need to consult with *Māori* when working with *Māori tangata whai ora*, only 40 per cent felt that their training had prepared them to work effectively with *Māori*.

Kaupapa Māori services and strategies for managing overrepresentation

The establishment of *kaupapa Māori* mental health services appears to be an effective strategy in that they deliver a culturally safe, specific and responsive service to *Māori tangata whai ora*. In addition to educating health care professionals, training and employing more *Māori* in the health professions the use of bicultural intermediaries has been adopted as a strategy for increasing *Māori* utilization of mental health services. *Marae*-based health programmes have been developed and *kaumatua* have been used as cultural interpreters by health professionals. Psychiatric hospitals can

now be expected to have the services of a *kaumatua* available to act as a counsellor for *Māori tangata whai ora* and to assist and advise the staff with regard to providing culturally appropriate care.

Since the *marae* is central to many aspects of *Māori* culture and a place of both belonging and contact, *marae*-based services offers the potential for addressing poor access to mainstream services and for providing a culturally appropriate services in a safe and familiar setting. Their purpose is to complement community health services already in place, rather than to replace them, and many *marae*-based programmes are attempts to educate and enrich *tangata whai ora* and their *whānau*.

Durie (1997) suggests five strategies that can lead to improved mental health outcomes for *Māori*:

1. Development of a secure identity. Identity is a prerequisite for good mental health and *Māori* identity requires more than a superficial knowledge of tribal affiliation or ancestry, depending as it does on access to the cultural, social and economic resources of *te ao Māori* (the *Māori* world).
2. Active participation of *Māori* in society and in the economy. Unemployment, unrewarding work, negative experiences at school and powerlessness, marginalization within society is not compatible with good mental health and can lead to drug and alcohol abuse, violence and parental abandonment.
3. Improving the quality and quantity of mental health services so that *Māori* can access them and *Māori* outcomes are enhanced. This can be done through *kaupapa Māori* services focused on both cultural and clinical goals and when *kaumatua* guide and work along side clinicians to bring a more comprehensive approach to treatment than possible in usual services.
4. Accelerated *Māori* workforce development as *Māori* are underrepresented in the mental health discipline.
5. Autonomy and control for *Māori* for service delivery and for policy formulation, planning and key decision-making.

Transferability

Māori initiatives to address mental health disparities have been innovative and offer potential for others. Sachdev (1998) sees the *Māori* experience in New Zealand as being relevant for other minority ethnic communities. The major lesson, he suggests, is that primary initiatives must come from communities themselves and for this change to occur the appropriate socio-political conditions must be created. Disadvantaged communities must be empowered to bring about change and the mainstream health system must recognize such change as adaptive, rational and even cost-effective (see the approach in UK described in Chapter 5, in Australia in Chapter 18b and in Europe in Chapter 20).

WORKFORCE DEVELOPMENT

The quality and further development of New Zealand's mental health services have been constrained by a shortage of appropriately trained staff (Health Funding Authority, 2000). More precisely issues such as the poor co-ordination of

development, lack of skilled staff, problems with recruitment and retention and unsatisfactory and inappropriate skill mixes have been identified as important issues. It has been suggested by the Health Funding Authority that too little staff training has been available to assist with the transition into the changed health environment. The areas of most concern have been *Māori*, Pacific and child and youth mental health services. The mental health sector faces particular challenges in recruiting and retaining skilled and experienced staff which also reflect global factors, such as an international shortage of doctors and mental health nurses. New Zealand trained staff often move overseas and New Zealand must compete with other countries (most notably Australia, Canada and the UK) for new staff. In 2003 there were 5293 FTE mental health positions in the public mental health system and 523 vacancies (Mental Health Commission, 2004). Staff shortages directly impact on service delivery and negatively impact on the ability to achieve previously agreed strategic targets for mental health.

Reflecting a systemic approach, the Workforce Development Framework (Ministry of Health, 2002b) shown in Figure 17.1 identifies five areas that aim to broaden the focus from training to



Figure 17.1 Workforce development frame work (Ministry of Health, 2002, p. 21).

include a more comprehensive approach to the development of the mental health workforce.

MIGRANTS AND REFUGEES

Almost one in five New Zealanders was born overseas. This rises to one in three in Auckland, where half of the migrant population resides. The highest proportion of Pacific and Asian migrants live in Auckland. The great Tahitian Chief, Kupe, first discovered *Aotearoa* in AD 950. Europeans began arriving after 1769, with organized settlement occurring from 1840 (King, 2003). Visibly different migrants, such as Indians, Chinese and Samoans, became 'others' because of their different physical appearance, religion or culture. Though the first Indians and Chinese came to New Zealand in 1850s and 1860s, fear of the impact of foreigners led to restrictive Acts of Parliament being introduced between 1870 and 1899, such as the Asiatic Restriction Bill 1879 and the Chinese Immigrants Act 1881. These were repealed only labour market demands increased (DeSouza, 2004).

In the last three decades different trends have impacted on migration. The first was an initial increase in migration from the Pacific Islands during the late 1970s and again following the Fiji coup of 1987. Pacific Island migration decreased in the 1990s due to the shrinkage in manufacturing and the closure of factories as trade tariffs were removed. The second trend saw an increase in Asian migration through the encouragement of foreign investment. Refugees arrived from Cambodia and Vietnam and migration from Hong Kong increased as the colony was returned to China. The third trend saw an increase in migration from South Africa and the Middle East. These trends have led to an increase in the number of migrants from non-traditional source areas. Critics such as Thakur (1995) argue that the official rhetoric recognizes the legitimacy of *Māori* and *Pakeha* but excludes migrant cultures that are non-white and non-indigenous, excluding them from the debate on identity and the future of the country in which they live. As Mohanram (1998, p. 21) asks, 'what place does the visibly different

coloured immigrant occupy within the discourse of biculturalism?' This tension around inclusion and belonging exists for many other groups as well, for example Wittman (1998, p. 39) has commented 'on the exclusionary effect of any others by the ideology of biculturalism' for Jewish people in New Zealand.

The post-1945 notion of assimilation positioned the ideal migrant as 'invisible'. Migrants were expected to fit in, not change the society they had entered and so change was one-way. Whilst Canada and Australia embraced multiculturalism during the 1960s, transforming the notion of settlement into a two-way process whereby change was required by both migrants and the host society, New Zealand policy made this strategic move only as recently as 1986. The Immigration Act 1987 eased access into New Zealand from non-traditional source countries and replaced entry criteria based on nationality and culture with ones initially based on skills. This changed in 1991 to a points-based system that saw migrants with experience, skills, qualifications and money being selected for business investment in New Zealand.

Today Asians make up the fastest growing ethnic population, between 1991 and 2001 the number of people identifying as Asians more than doubled to almost 6.4 per cent of the population. Chinese are the largest ethnic group within the Asian population, followed by Indian and Korean.

Research has identified factors such as unemployment, communication and lack of English proficiency as significant in adjustment. Several studies have found unemployment or underemployment, having experienced discrimination in New Zealand, not having close friends, being unemployed and spending most of one's time with one's own ethnic group are predictors for poor adjustment among migrant groups (Pernice *et al.*, 2000).

Pacific people

People from the Pacific Islands began migrating to New Zealand in the 1950s and continued through to a peak in the late 1970s. According to the Mental Health Commission and Ministry of

Health (1999) unemployment, low income, poor housing, the breakdown in family networks, cultural fragmentation and rising alcohol and drug problems have led to increasing concerns about the mental health of Pacific people. An identified priority is to develop a skilled Pacific Island mental health workforce and this initiative has been successful in bringing mature, culturally knowledgeable and bilingual staff into the workforce. These services have facilitated improvements in the delivery of mental health services to Pacific *tangata whai ora*. Recently, 'Te Orau Ora: Pacific Mental Health Profile' was published, which is the first document targeted specifically at Pacific people's mental health to be published by the Ministry of Health (2005). It provides demographic and mental health-related information to assist in the planning of cultural specific services.

Refugees

Refugees who have resettled in New Zealand mostly originate from Africa, the Middle East, South-East Asia and Eastern Europe. A United Nations-mandated quota of 750 refugees per year is accepted, along with approximately the same number of asylum seekers. Increased numbers of immigrants and refugees have led to the formation of specialized mental health services, for example the Refugees as Survivors (RAS) centre. A study of Somali communities in Hamilton found that GPs played a significant role in terms of the mental health of the research sample and were key gatekeepers of health (Guerin *et al.*, 2003).

Asians

There are no official data available on the mental health of Asians (the use of the term in New Zealand is broader than in the UK and includes people from China and South-East Asia). However, an outcome of a report on the mental health of Asians in New Zealand has been an increase in responsiveness to the needs of those communities (Yee, 2003). Research activity, information provision, collaboration and Asian-focused operational activities and policy are

some of the strategies that are being used by government agencies (Yee, 2003).

A study among recent Chinese migrants using the General Health Questionnaire found that 19 per cent reported psychiatric morbidity (Abbott *et al.*, 1999). A study of older Chinese migrants aged 55 found that 26 per cent showed depressive symptoms (Abbott *et al.*, 2003). Lower emotional supports, greater number of visits to doctor, difficulties in accessing health services and low New Zealand cultural orientation increased the risk of developing depression. Research with Asian immigrants, refugees and student sojourners in New Zealand shows that social supports can assist newcomers to cope with the stresses of migration and reduce the risk of emotional disorder (Abbott *et al.*, 1999). Conversely, research shows that language and cultural barriers can limit access to health services (Abbott *et al.*, 1999; Ngai *et al.*, 2001).

CONCLUSION

Mental health services in New Zealand have many similarities with services elsewhere, however, New Zealand also offers a unique insight into the value of delivering culturally specific services alongside mainstream mental health services. The New Zealand experience also offers a useful case study into the dramatic effects of neo-liberalism, their failure and a subsequent attempt to refocus health care on a more socially constructed basis. Structural and systemic problems clearly exist in New Zealand, as elsewhere. Financial constraints and a shortage of appropriately trained staff continue to impinge on service delivery.

Mental health practice in New Zealand has been significantly influenced and enhanced by consumer participation, ranging from self-help groups and NGO-based service delivery to providing policy input. New Zealand today is a multicultural country with varied ethnic groups but one which is grounded in biculturalism, the relationship between *Māori* and *Pakeha* inherent in the principles of the Treaty of Waitangi. This results in a general acceptance that the incorporation of cultural perspectives in psychiatric services is crucial.

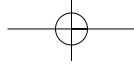
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GLOSSARY

<i>Aotearoa</i>	Lit. 'Land of the long white cloud'. The Māori term for New Zealand
<i>Hapu</i>	Subtribe
<i>Iwi</i>	Tribe
<i>Kaupapa [Māori]</i>	The philosophy of Māori knowledge and learning
<i>Māori</i>	The indigenous people of Aotearoa/New Zealand
<i>Marae</i>	Communal meeting house (for iwi or hapu)
<i>Pakeha</i>	Europeans and other non-Māori
<i>Tangata whenua</i>	Māori, literally, the people of the land
<i>Tapu</i>	Sacred, to be treated with respect, a restriction, being with potentiality for power, integrity
<i>Te reo [Māori]</i>	The Māori language
<i>Tohunga</i>	A spiritual advisor and traditional healer
<i>Whānau</i>	Extended family
<i>Whenua</i>	The land



AUTHOR QUERIES

- Q1 The Treaty Of Waitangi and cultural safety, para 2
McPherson, Harwood, & McNaughton, 2003 – please supply reference.

