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A Report for the

COMMITTEE OF INQUIRY INTO THE DEATH AT CARRINGTON HOSPITAL OF A PATIENT MANIHERA MANSEL WATENE AND OTHER RELATED MATTERS

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My name is MASON HAROLD DURIE. I have the qualifications: Bachelor of Medicine and Bachelor of Surgery (University of Otago 1963), Diploma in Psychiatry (McGill University, 1970), Fellow of the Royal Australian and New Zealand College of Psychiatrists (1979). My current position is Professor, Department of Maori Studies, Massey University. I am also an Advisor in Mental Health to the Manawatu-Wanganui Area Health Board and am Chairman of the Ministerial Advisory Committee on Maori Health.

I have read evidence heard by the Committee from Bonar, Neal, Casley, Perez, Amos, Codlin, Wood O'Donnell, Newey, Hickey, Smith, Crengle, Plunkett, Benseman, McGeorge, Crozier, Baker, Hippolite, Vuletic, Wright, Roffe, Watene, Manu. I have also read a copy of Mr Watene's clinical file and the Extended Hours Team file.

This report is intended to assist the Committee regarding:

1. psychiatric illness and cultural factors;

2. Maori values and the therapeutic environment;

3. the relevance of cultural factors to the management of Watene.

1 PSYCHIATRIC ILLNESS AND CULTURAL FACTORS

The Committee has already heard extensive evidence from other witnesses on this matter and the following comments are made to further emphasise certain points and to introduce additional material.

1.1 There is considerable scientific literature outlining the significance of culture to the diagnostic process. What is abonormal in one culture may be entirely acceptable and normal within another. Visual and auditory

hallucinations, for example, do not by themselves constitute signs of psychosis in many world cultures; nor does suicide necessarily suggest mental ill health. A psychiatric diagnosis which has not taken into account the culture of the patient may be misleading, alienating and offensive to the patient, the family and indeed the whole of a particular culture. That is not to say schizophrenia or other illnesses do not occur in most cultures; rather it is to underline the importance of carefully considering cultural values and attitudes before reaching a diagnosis and embarking on a course of treatment that may shape the patient's life for many years ahead.

1.2 In the assessment process Western psychiatry places great emphasis on patterns of speech, modes of thinking and the establishment of rapport between patient and examiner. Those speech and thought patterns which are not typical of rational western adults are likely to be seen as abnormal. Proverb interpretation is an example of a culture-biased assessment tool. Tangential thinking is another symptom more appropriate to western than to Polynesian thought processes. Indeed in some Polynesian cultures, oblique references and indirect speech are considered desirable though in another context may be taken as signs of abnormal thought processes. Commnents on the establishment of rapport between patient and examiner may also be misleading. There are cultures which frown on an overly friendly approach, at least in the initial stages, and genuine efforts to make the patient feel at ease, may in fact create suspicion, distance and lack of ease.

Psychiatric illness is universal but the tools employed to confirm an illness and the signs and symptoms upon which that confirmation is based do not have universal validity. In short, patients from cultures other than that of the examiner, may be disadvantaged unless a specific effort is made to assess the relevance of cultural factors before diagnostic conclusions are reached.

1.3 Abnormal mental states were recgonised in traditional Maori socieities and *wairangi* and *porangi* are both words used to convey the notion of insanity. They do, however, have wider meanings and there does not appear to be a particular body of knowledge that separated out abnormal mental states from other behavioural abnormalities.

Instead, mental aberrations were regarded in much the same way as any physical abnormality and management followed similar lines of investigation and treatment. More attention was paid to understanding the cause of the condition with relatively little emphasis on the actual signs and symptoms. More often than not the patient's affliction was regarded as symptomatic of a family problem in which a law of tapu had been broken.

1.4 In a Maori framework, the distinction between physical and mental illness is not stressed. Emotional symptoms were described according to physical impact (eg the word for anxiety was *manawapa* - pounding of the heart; anger was *pukuriri* - a knotted stomach) while states of physical distress were often attributed to psychological causes such as *makutu*. The body itself was imbued with psychological and emotional characteristics, the head and genitalia being particularly special. Their violation, wittingly or unwittingly, could lead to a loss of status and a demeaning of the individual and his family.

1.5 States of abnormality, physical or mental, were managed along conventional lines. There were physical and psychological approaches. Psychological therapies depended heavily on the spiritual powers of healers but were augmented by *rongoa,* remedies selected from a range of native plants that possessed pharmacological properties. There does not appear to have been any conflict between spiritual and physical treatment methods. Indeed they were complementary.

These Maori views of illness are not necessarily incompatible with Western views but the balance is quite different. In summary, compared to Western approaches, the Maori emphasis:

- is on causation (aetiology) rather than form (signs, symptoms, natural history)
- is not dependent on a differentiation between physical and mental states
- is a spiritual one, augmented by physical treatments

- is on revitalising the *mauri* of the patient and family

- is on protecting the specialness of the patient.

1.5 While it is difficult to transpose these views to contemporary situations, the two points to be made are firstly that cultural attitudes to illness vary and secondly, cultural attitudes persist even when they do not form part of conscious thinking or are beyond individual articulation.

2 MAORI VALUES AND THE THERAPEUTIC ENVIRONMENT

2.1 Over the past decade, Maori dissatisfaction with psychiatric treatment and psychiatric hospital care has led to the development of therapeutic units where Maori values and attitudes prevail. Some of those units are located in psychiatric hospitals (Tokanui, Kingseat, Carrington). Others are not connected to any hospital and operate in an entirely Maori context.

2.2 For the most part the hospital Maori units have a number of characteristics in common and a marae philosophy can be detected in the overall milieu.

2.3 Relevant characteristics of the marae model include:

- a search for *whanaungatanga* and the fostering of kinship links that will cement bonds and mutual obligations

- after the initial challenge, a deliberate effort to avoid confrontation

- co-operation

- a structured approach which emphasises complementary roles rather than authoritarianism

- encouragement to be part of the group

- discouragement of individual isolation

- full acceptance of visitors, regardless of their views or abilities provided that the traditional beliefs of the marae are not offended

- a spiritual context into which is woven respect for ancestors, unity, and a belief in God.

2.4 These same characteristics operate in units such as the Whare Hui. Management of patients is based on a set of values and beliefs relating to the concepts of unity and co-operation that are to be found on a marae. Responses to patients are determined more by notions of *whanaungatanga* and *wairuatanga* than by individual diagnoses.

2.5 While diagnosis is not irrelevant, it is not the predominant factor that governs the patients management. What does matter is the cultural affinity that binds members of the unit to each other, regardless of disability. In that respect, a schizophrenic patient is recognised as having other personal qualities which can be nurtured so that interaction with the wider group can occur at a satisfying and meaningful level. Schizophrenia itself is not seen as the sum total of a patient's personality nor as a barrier to acceptance and inclusion.

2.6 On a typical psychiatric ward, however, expectations and interactions are closely linked to diagnosis. Indeed the stated diagnosis is often the basis for a management plan and responses are not infrequently determined as much if not more, by the diagnosis rather than the other characteristics of the patient.

2.7 Diagnostic categories are useful and have added to an understanding of mental illness as well as its treatment. But they also impose restraints on understanding the motives, attitudes, and feelings of patients and sometimes offer overly simplistic explanations of the wide range of human emotions.

2.8 It is possible that Maori therapeutic units might also impose restraints on human interaction, not because of preconceived ideas about diagnostic groupings, but because of preconceived ideas about what

should motivate Maori patients. To be a Maori does not necessarily mean to think or to feel Maori. It would be unhelpful to treat a Maori whose cultural identity was divorced from "a Maori background" as if he were totally in sympathy with that background. Equally, it would be unhelpful to expect all patients with schizophrenia to act, think and feel as if they were one homogenous group.

2.9 Nonetheless, patients who do identify as Maori, in attitude as well as in descent, are likely to find a level of acceptance and understanding in a Maori therapeutic unit that would be difficult to replicate in the ward of a psychiatric hospital.

In summary, a Maori therapeutic unit for Maori patients can bring benefits not readily found in other treatment settings:

- a spiritual dimension
- an acceptance based on shared ancestry and cultural affinity
- a recognition of positive aspects of the personality
- an opportunity to develop co-operative skills
- cultural affirmation with the opportunity to communicate in Maori

3 RELEVANCE OF CULTURAL FACTORS TO THE MANAGEMENT OF WATENE

3.1 Was WATENE Maori? Although Watene was assessed in 1976, 1978, 1980, 1982, 1984, 1986 and 1989, there was no evidence that his cultural affinity had been tested except in a very precursory manner in 1976. At that time his mother raised the possibility that Mansel had "broken a tapu" while in another tribal area. The initial psychiatric report stated that "he had no real knowledge of Maoridom" and no credence was given to the mother's explanation. At no other time in his lengthy psychiatric contact was there any reference at all to the significance of his cultural background.

3.2 At various times he was described in the clinical notes as "a 29 year old Maori", "a young Maori man", "a soft-spoken Maori man", "a tattooed young Maori male", a "pleasant Maori man", "a Maori youth", a "large fit-looking Polynesian", a "cheerful pleasant Maori". These notes, however, do not explore his level of cultural awareness or his degree of cultural affiliation. The term Maori, as used in the notes, appears to be limited to a description of an obvious physical characteristic. Consequently it is not possible to determine from the notes:

- whether he spoke Maori
- his tribe
- his marae
- his genealogy (beyond his parents)
- his knowledge of Maori custom
- his involvement in the Ratana church (listed as his religion)
- his land interests
- his own explanations of his behaviour

3.3 There are some entries in the clinical notes which would have warranted greater attention to a cultural assessment. His mother's explanation of his early abnormal behaviour in 1976 showed concern that a breach of tapu had occurred. The examining psychiatrist dismissed the possibility, perhaps hastily, certainly without any evidence of serious investigation. His report favoured, instead, a diagnosis of schizophrenia. Such "either/or" approaches are unhelpful.

Because Maori and western explanations are based on vastly different philosophical and cultural premises, there is little to be gained from attempting to incorporate a Maori view on aetiology into a classification system based essentially on a mental state examination. In other words a disagnosis of schizophrenia does not rule out the possibility of a breach of tapu nor does such a breach mean that schizophrenia cannot co-exist.

3.4 If one of the objectives of a psychiatric assessment is to gain better understanding of the ways in which patients think, and the problems which confront them rather than simply to make a diagnosis, then opportunities to understand Watene were missed. He was, for example a member of the Ratana church, an association which had it been pursued, might have uncovered a wider support group and some insight into the spiritual and cultural lives of Watene and his family.

Similarly, Watene himself, in 1980 referred to a fear of retaliation from other tribes. Perhaps because he later changed his mind, was a culturally important line of investigation was left unchecked. It may have amounted to little. But equally, it could have provided useful additional background information that might have alerted staff to the state of Watene's mind shortly before his death.

3.5 According to the nursing notes, 4.8.89, the day before his death, Watene was "engaged in very animated conversation about Maori and other things" with another patient. What was the significance of this fresh interest in things Maori? Did it reflect mental unrest, an indication that, in cultural terms, he felt vulnerable? Or was it simply part of a casual conversation?

3.6 It is accepted in Maori society that when a person feels vulnerable, nightfall brings its own heightened sense of risk. The avoidance of sleep, under those circumstances, is a deliberate effort to remain vigilant and to maintain self control. Did Watene experience such fears on the nights of 3.8.89 and 4.8.89?

3.7 In December 1976, similar mounting restlessness occurred in the evenings and nights resulting in an attack on a staff member (30.11.76) and fights with another patient (1.12.76). For reasons that are not

entirely clear a course of ECT was then administered and his mental state improved.

3.8 Watene's sleeplessness and aggression is noted in the clinical files but not explained. Despite his 13 year intermittant contact with the hospital, no real understanding of Watene's reasoning or his fears are recorded. It is not known whether cultural factors were relevant or not. The fact that they were not explored is a matter of concern.

3.9 Referral to the Whare Hui was made on 25.7.89 to improve contact/support from the family. There is no mention on the referral form that cultural factors needed further exploration in order to establish an accurate diagnosis.

3.10 Without some understanding of a patient's culture a comprehensive and reliable management plan is incomplete. In Watene's case, was there any cultural reason which would have made seclusion desirable? Did an animated conversation about Maori things have any prognostic significance? Was the avoidance of sleep based on a fear of the night and the possibility of retaliation? Was the violent struggle that preceded his death aggravated by an underlying sense of personal violation.

3.11 There are no answers to those questions. They are raised at this stage to underline the importance of culture to an understanding of illness and to highlight the fact that Mansell Watene's cultural background had never been assessed; or if it had, its significance had never been recorded for the benefit of successive treatment teams.

3.12 These comments are not intended as a criticism of overworked and committed staff. They do, however, pose questions about the limited perspectives of any psychiatric system which pays scant attention to family and cultural perspectives and which fails to document information basic to the development of a sound management plan.

3.13 In New Zealand, a basic assessment of the significance of Maori ancestry to a patient should not be beyond a specialist in Psychiatry. It is, in my opinion, an integral part of the initial assessment.

In this case referral to the Whare Hui may have been felt to remove an obligation on the part of medical and nursing staff to investigate the matter further. If that is correct, then a much greater effort towards team assessment will be necessary so that plans for treatment can be made with confidence at an early stage and with the full knowledge of the significance of culture.

3.14 The use of seclusion may not have been considered appropriate if more was known about the patient's cultural attitudes. In general terms, seclusion, especially at night, will be likely to raise anxiety levels in Maori patients if there already exists a suspicious, frightened state, and particularly if possible retribution relating to the laws of tapu underlines the fear. No such conclusion can be made about Watene on the night of 4.8.89. But neither is there, in the notes, any other hypothesis about his unsettled attitude and his change in sleep pattern.

4 CONCLUSIONS

4.1 In the management of patients with psychiatric illness, Maori methods and approaches have much to commend them. There is an emphasis on spirituality, acceptance, inclusion (rather than seclusion), and an avoidance of confrontation.

4.2 A psychiatric examination is incomplete without some assessment of the patient's cultural background. Such an assessment can lead to valuable insights that will assist in understanding the patient and the ways in which he might be managed.

4.3 In the case of Mansell Watene, a cultural assessment had not been recorded.

4.4 There is a strong possibility that some of Watene's disturbed behaviour related his own interpretations of Maori concepts and values.

4.5 The management plan, such as it was, did not consider that possibility.

4.6 Where a specialist unit exists to advise clinical staff on the relevance of cultural matters, clarification is needed as to whether regular psychiatric staff should conduct their own preliminary investigations.

4.7 If not, then at the outset the initial assessment should include an opinion about cultural matters, regardless of any intention to refer the patient to the special unit for future treatment.

4.8 More attention needs to be given to the therapeutic milieu. In New Zealand modern psychiatric practice can be usefully modified by the introduction of concepts and values found in Maori therapeutic settings. That is especially so when there are Maori patients but the qualities of acceptance, inclusion and co-operation have wider implications for all patients.

4.9 The use of seclusion for Maori patients needs further investigation both in general terms and in each particular case.

4.10 The avoidance of situations likely to lead to confrontation also merits further investigation. For some Maori patients, reduced levels of arousal can be achieved through *karakia* and other approaches. The same could well be true for other patients.

4.11 The presence or absence of cultural factors need not be incompatible with a western system of classification. Nor is there any reason why two approaches should not operate concurrently. Maori patients should not be expected to choose between Western or Maori approaches. Instead they should be given every opportunity to accept the best that each has to offer.

That afterall was the promise of the Treaty of Waitangi.