MAORI HEALTH INSTITUTIONS

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The effects of deinstitutionalisation have been recognised as a priority for action in the mental health field (1). Having concluded that many large institutions for the treatment of the mentally ill were not conducive to good health, treatment within the community was advocated in most Western countries from 1960 onwards. Alternative community structures however, were often not available, nor always appropriate, and the plight of the mentally ill as an alienated group within society has become a major source of concern within New Zealand (2). To some extent, the theme of deinstitutionalisation is familiar to Maori leaders, albeit from a different perspective, and in an historical context.

Disparities in Maori - non-Maori health standards have been documented by several authors (3, 4), but there has also been recognition of the rapid advances made in Maori health over the past one hundred years (5). The Maori population has risen to 12% of the total, with 63% of its members being under the age of 24. The general trend has been towards a narrowing of the gap in most areas of health. A striking exception however, is the area of mental health.

MAORI MENTAL HEALTH

Data about mental health is far from adequate, and a complete picture is difficult to obtain. Most health statistics

focus on admissions to psychiatric hospitals, a narrow indicator of mental health. Even so, Maori rates of admission are increasing for most age groups, and overall have trebled in less than two decades (6). The suicide rate of Maori youth has increased six fold over the same period. The Department of Social Welfare reports that offending by Maori juveniles is six times greater than for non-Maori (7) and nearly half of all prisoners are Maori (8). Over 60% of Maori children leave school without a higher qualification, and unemployment is a distinct possibility for many of them. The street kid cult is thought to be a largely Maori phenomenon, closely associated with widespread solvent abuse. In those urban New Zealand neighbourhoods which have special health needs ("pockets of misery"), there are many Maori people (9), and in a recent survey of Maori women, symptoms of poor mental health were the most frequent health problems (10).

CULTURAL CHANGE

Urbanisation is sometimes held responsible for this alarming situation, with unemployment, low incomes, lack of parental supervision and excessive alcohol use being contributing factors. But Maori leaders have long identified more basic and critical factors. It is as well to remember that the institutions of health as they are now known, are relatively recent in New Zealand. For centuries, health was inseparable from social encounter, agriculture, warfare and the environment.

Health care was a function of the community, and health leadership came from the political and spiritual leaders of the tribe.

The European colonisation of New Zealand led to the rapid submergence of Maori health values in favour of Western thinking and practices. The spiritual basis for health was replaced by scientific method; the authority of the tribal elder was challenged by the health professional; and the role of the family in community health care was undermined by institutional care for the sick, the homeless and the law breakers. By the end of the 19th century a process of "deinstitutionalisation" was well advanced, with Maori people becoming separated from the traditional institutions that had nurtured them and maintained standards of health, including mental health. Maori leaders relate current health concerns to this separation and they focus on three principal institutions traditionally regarded as critical determinants of good mental health : land (whenua), family (whanau) and language (reo).

LAND AS A BASIS FOR MENTAL HEALTH

Few text books emphasise land as a foundation for mental health, but Maori people have always regarded it as crucial, referring to the earth as Papa-tuanuku, the earth mother, whose functions might be compared to motherhood. Bonding a child to its biological mother has been a Western preoccupation for decades, but bonding

the child to the land has been regarded as a more useful practice by Maori people. The ritual burying of the placenta symbolises the formation of a unique relationship between the land and the infant, and it is not a coincidence that the word for land (whenua) is also the word for placenta. Both provide nourishment, security, anchorage and shelter. Land becomes part of the internalised identity and provides a secure footing (turangawaewae) from which one can emerge with a past and with confidence. The spiritual significance of land is afforded little attention in the materialistic and scientific world. Pollution of earth, lakes, rivers and the sea front is from a Maori point of view, as much an assault on the mind as it is on the land; it is a deterrent to good mental health, even a cause of mental ill health.

Failure to establish an affiliation with tribal land places an individual in an "at risk" situation with poor health a likely consequence. It is the plight of many Maori families throughout the New Zealand. Alienation from the land remains an unresolved source of tension between Maori and Pakeha. Loss of land (11) by legislation, confiscation, and to a lesser extent by legitimate sale, resulted in loss of "mana" (self esteem, dignity, self determination) with resultant despondency and demoralisation. Maori efforts to reclaim some of that land and to re-establish tribal management over it are positive mental health measures, with hopeful implications, even for urbanised and deculturised Maori youth. The extension of the Waitangi Tribunal's powers

to consider land grievances dating back to 1840 has been welcomed by Maori leaders as an important step which may strengthen land as an institute of health.

Land ownership provides a formula for social hierarchy which is still considered basic in Maori circles. The concept of "tangata whenua" is based on the notion that there are certain people who have responsibilities and privileges associated with particular land rights. Health authorities have not always been aware of the concept, and have been surprised when health programmes not involving the tangata whenua have floundered. The Treaty of Waitangi implied recognition of tangata whenua, and much Maori discontent today relates to the failure of most Westernised institutions in New Zealand to acknowledge that principle. In Maori terms, bypassing the rights of the tangata whenua is to be "trodden on" (takahi), a source of shame and discouragement.

FAMILY INTEGRITY AND MENTAL HEALTH

The separation of Maori people from their land and the manner in which it was done, had a serious effect on social structure and led to major disruptions of the second major health institution, the family. Traditional land was owned on a collective basis, ensuring family cohesion and co-operation (whanaungatanga). The Native Land Act (1865) encouraged the individualisation of land titles and did much to break up family networks. A further threat to family cohesion came from the Western emphasis on individualism and individual competition.

Mental health theorists and practitioners have advocated independence, equating health with self-determination and maturity with self sufficiency. The "person in her own right", a popular mental health concept is an unhealthy concept in Maori ears, since it elevates the individual above the family. Family characteristics and strengths find greater favour than individual attributes, a difficult lesson for aspiring Maori individuals. Maori family organisation provided a comprehensive system of child care, with reliance on tribal parents as much as on biological parents. It was a system that compared favourably with the limitations of one or two parent families, or a variety of foster homes. Maori experience with the nuclear family has been costly, and the Matua Whangai scheme has been introduced to restore extended family support to some of the casualties. Intact Maori networks offer a three-tier support system : the tribe (iwi), sub-tribe (hapu), family (whanau) and developments at a tribal level are likely to influence the individual.

Despite some lack of understanding of the positive forces of tribalism (12), tribal councils have survived into the 1980's and remain the basis for Maori social and family organisation. Mental health programmes for Maori families need to acknowledge these structures, and to work within their frameworks, rather than focussing on small, isolated units without reference to the tribal council.

LANGUAGE AND MENTAL HEALTH

Health workers attempting to develop positive aspects of whanaungatanga will soon discover that family life and child care hinge on Maori concepts that cannot easily be translated into English (manaakitanga, aroha, whangai). Mental health professionals have long known that communication is a basic requirement for health, but have been slow to appreciate the Maori language, or to advocate it as a necessary skill for Maori people. The limitations of English as an adequate medium for expression have been increasingly recognised over the past decade, and Kohanga Reo (Maori kindergartens) for preschool children have been enthusiastically received by Maori children, parents and grandparents. Sixty years ago, however, Maori was discouraged in schools with consquent frustration in two languages.

The Maori language is a spoken one, with auditory rather than visual reception. Emphasis on the written word is an aspect of Western culture which has placed Maori students at a disadvantage. It has also limited the participation of Maori elders at seminars and meetings where written submissions have been required.

Many Maori leaders have seen language as the centre of culture, and certainly equate its absence with incomplete personal development. It is not only the familiar sounds that are appreciated, but more importantly, the style of expression. For Maori speakers, language and emotion

are closely related, and the division between affect and cognition is effectively bridged. Directness is valued less than allusion, and detailed analyses are less frequent than global, integrating statements. Maturity, in Maori terms, is reflected to a large extent on the ability to use language as a vehicle for holistic expression.

THE MARAE

Most sub-tribes (hapu) and a number of families have central, communal meeting places known as Marae. The marae brings together the three institutions, land, family and language (13), and has come to symbolise the essence of Maori health aspirations as the 21st century approaches. The land on which a marae is established is inalienable, and collectively owned, the owners have a common ancestry and shared responsibilities, and Maori is the language of choice. Indeed on formal occasions, it is the only adequate language. The possibility that some Maori people might never have direct links with these basic rights, or with a tribal marae, could only have been predicted by those who understood the forces of Westernisation.

To most mental health professionals, deinstitutionalisation refers to the re-integration of discharged patients back into society. Maori concern is not only for those discharged or released from institutions, but also for thousands of Maori children who have been born into a state of deinstitutionalisation, alienated from

tribal lands, apart from an extended family, and deprived of a natural language.

MENTAL HEALTH PROFESSIONALS AND MAORI HEALTH

As mental health professionals prepare to cope with the effects of deinstitutionalisation, the question needs to be asked whether they are adequately trained to assist, in a meaningful manner, the disproportionately high number of Maori clients. Are they able to relate to the Maori institutes of health? Almost certainly the answer would be a disappointing "No". Courses in mental health are essentially monocultural, with occasional excursions into Maoridom. Relatively little formal teaching or experience in Maori aspects of health is required, and that are no examinations which test a student's knowledge of the Maori world. Competence in the Maori language is never a pre-requisite. This is not surprising when the composition of staff at Universities and Polytechnics is considered. A Maori presence is scarcely visible. In some mental health specialties there are no Maori graduates at all (occupational therapy, child psychotherapy) and in clinical psychology, psychiatry, guidance counselling and medical social work the total Maori work force is less than twenty. It is a matter of extreme regret and embarrassment, that health professionals, particularly those qualified as experts in community development, lack any real appreciation of Maori values in mental health. All too often their work is passed over to untrained, voluntary Maori groups.

The situation must change if mental health problems facing Maori people are to be seriously addressed. If University faculties or other training institutes are unable to introduce biculturalism into mental health courses, then Maori centres of learning must be funded to train professionals who will be able to work in the reality of New Zealand society.

Over the past decade, the effectiveness of many large health institutions has been called into question. As New Zealand struggles to find suitable alternatives, Maori leaders have re-affirmed their confidence in New Zealand's oldest health institutes: land, family and language.

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