Treaty of Waitangi—Foundation for Maori Rights—"What Place in the Development of Mental Health Services in New Zealand?"

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The Treaty of Waitangi is now regarded as the founding document of New Zealand as a nation and defines the indigenous status of Maori, and accords rights and responsibilities to both Maori and the Crown. The mental health and wellbeing of Maori is now a major health issue. Research involving 40 Maori mental health consumers, 10 family members and 10 Maori mental health staff all identify that recognition of the Treaty of Waitangi is a key to the provision of appropriate mental health services and support for Maori. Lack of Maori control, the need for appropriate cultural therapeutic activities and full Maori participation in all aspects of mental health service delivery in New Zealand are now policy and service development issues which require to be addressed for improved mental health outcomes for Maori.

Le traité de Waitangi est considéré maintenant comme le document de fondation de la Nouvelle-Zélande comme nation et il définit le statut indigène des Maori et les droits et les responsabilités des Maori et de la Couronne. La santé mentale et le bien-être des Maori est désormais un problème de santé important. Des recherches auprès de quarante patients en santé mentale maori, de dix membres de leurs familles et de dix employés en santé mentale maori identifient toutes que la reconnaissance du traité de Waitangi est essentielle pour fournir des services de santé mentale et un soutien appropriés aux Maori. Le manque de contrôle des Maori, le besoin d'avoir des activités culturelles thérapeutiques et la pleine participation des Maori dans

tous les aspects de la prestation des services de santé mentale en Nouvelle-Zélande sont désormais des questions de développement de politiques et de services qu'il faut aborder pour améliorer les résultats en santé mentale chez les Maori.

Introduction

The purpose of this paper is to discuss the importance of the Treaty of Waitangi, the place it occupies in New Zealand and how mental health services have been slow to respond to growing Maori requests for the development of culturally appropriate mental health services.

This paper will also share research from a Maori perspective the outcomes Maori consumers, *whanau*, and health workers expect from mental health services. The paper is written to acknowledge thc work of many Maori mental health workers who have united together at different hui (meetings) and forums to advocate for the development of culturally appropriate mental health services for Maori.

A number of Maori mental health services, some of which have been established for over a decade ago, are now described as *kaupapa* Maori mental health services. These are mental health services that operate from a Maori paradigm. Although Maori consumers and their *whanau* request services that acknowledge their cultural identity, Maori mental health services are still considered fringe mental health services, and their contracts generally only allow for the provision of rehabilitation and recovery support, accommodation and early intervention.

In contrast, mainstream mental health services in New Zealand, through Crown-owned hospitals, hold the majority of contracts, receive the bulk of mental health funding and have the responsibility to provide acute inpatient and community care, forensic care and general psychiatric assessment.

This paper will suggest both *kaupapa* or mainstream mental health services in New Zealand have a long way to go to meet the expectations of Maori mental health consumers and their *whanau* and Maori involved in service provision. All together Maori interested in mental health requesr greater recognition of the Treaty of Waitangi in the development of mental health services.

Treaty of Waitangi

Aotearoa, or the "land of the long white cloud," has been settled by Maori for many generations, and according to tribal stories of migration Maori came from Hawakii-nui and was discovered by Kupe around 750 A.D. As a group of people, Maori have links to different canoes, and these form the ties that unite different tribes.

When most Maori introduce themselves they will acknowledge their *iwi* (tribe), their tribal area, their *whakapapa* (ancestry), their *marae* (place to speak and ancestral home) and their links to their *waka* (canoe).

Tribal and cultural identity are important for Maori, and in the 1995 census almost two-thirds of the Maori population could identify at least one *iwi* group to which they affiliated through ancestral connections (Te Puni Kokiri, 1999).

Aotearoa or New Zealand is centred in the Pacific and its closest neighbour is Australia. Although people often think New Zealand is similar to Australia, it is an independent nation. New Zealand has close economic ties to Australia, but since first contact with *Tauiwi* (new settlers) in the early 1820s New Zealand has developed its own approach to the recognition, integration and assimilation of Maori into New Zealand society.

Maori take the view in New Zealand that tribal groups are *tangata whenua* (people of the land). Despite many battles over land with the British, the Maori believe they have never been totally defeated nor have they ceded total sovereignty.

In 1835, due to the initiative of some tribal leaders to be able to trade internationally, they formed an alliance and signed the Declaration of Independence (1835). This document was the forerunner and the basis on which over 500 Maori chiefs entered into an ongoing living social contract, called the Treaty of Waitangi.

The Treaty of Waitangi has international legal standing; it was initiated by Queen Victoria of England in 1840, creating an ongoing constitutional tie between England and New Zealand, and is now regarded as the founding constitutional document of New Zealand.

The treaty was initially signed on 6 February 1840 at Waitangi and then taken around the country for other tribes' support. There are

two versions of the treaty, one in Maori and the other in English. The Maori version takes precedence in New Zealand and this is defined in legislation through the Treaty of Waitangi Act, 1975.

The treaty's preamble clearly states that its overall purpose is to protect the interests of the Natives; this is followed by three main articles. A fourth article regarding religious freedom and customary law was discussed but not recorded.

In brief, the Treaty of Waitangi creates the following framework and relationships between Maori and the Crown, and between Maori and other citizens.

Article One allows for a government to be established on the proviso that the following two articles are recognized. Article Two gives Maori the right through tribal chiefs to maintain ownership and control over their tribes' lands, forests, fisheries, waterways and any other properties that they consider important; and secondly, if tribes want to sell land, the Crown has pre-emptive rights.

Maori take the view that people, health, culture, language and the environment are properties that should be protected by the Crown, and that Maori have the right to develop and run their own health, education, child welfare and justice services, and so forth. These views are no different than other Indigenous peoples (Te Puni Kokiri, 1994).

Article Three accords Maori the same benefits as other citizens. The current government considers this article to be the one that gives Maori the right to equal access to government services, and equitable outcomes from them (Te Puni Kokiri, 1998).

When the Treaty of Waitangi was signed in 1840, the estimated Maori population was over 200,000, compared to a non-Maori population of approximately 2,000 people. Maori owned collectively all of the resources, land forests, fish and water, and in all activities maintained a close relationship with both their physical environment and spiritual worlds.[1] Maori consider all objects to have their own spirituality and life force, which must be respected and acknowledged through appropriate protocol. Maori also never ceded total sovereignty to the Crown, only limited governorship.

Since 1840, the Treaty of Waitangi has played an important role in the mindset of Maori in that it has given Maori a place and plat-

form to continue to negotiate on a day-to-day basis their position in New Zealand. For over 150 years, Maori have kept the Treaty of Waitangi alive, even though it has gone through different periods of official recognition influenced by past governments and the judicial system.

At present, New Zealand is perhaps in a phase where the current government would like to deny the legality of the treaty, but legislative and judicial decisions in the 1980s cannot be easily forgotten or overturned. Maori have now learnt how to use the legal system, and to seek injunctions against government decisions both within the country and through the Privy Council in England.

Different tribes and Maori leaders are now involved in discussions over such matters as the ownership and guardianship of rivers and coastal land, the dangers associated with genetic engineering, and the settlement of past treaty grievances. There is a naïve view in New Zealand among some politicians that if we can settle past treaty grievances there will be no more to address in the future, and the treaty can then be put to one side.

Increasingly, there are also growing calls by different Maori organizations and leaders to restructure our current system of government and to establish new models of shared governance in which Maori and the Crown operate as equal treaty partners. Winiata (1998), for example, has proposed that the New Zealand government adopt a style of governance similar to the Anglican Church, where Maori and non-Maori work in equal partnership and have the authority to make decisions about matters that are important to each group in their own way. He also proposed that New Zealand consider constitutional change and have both a lower and upper house of parliament, the latter appointed to represent the interests of Maori and non-Maori in recognition that Maori are marginalized people in their own country.

In 1997, New Zealand elected its first government based on mixed proportional representation. Despite having four specific Maori seats in government for almost a century, this was the first time Maori had had a significant presence in government through "New Zealand First" and through Maori individuals being elected or nominated as list

members of different political parties.

Through New Zealand First, the first coalition government was established with the National Party. For the first time, Maori politicians were appointed to key portfolio positions other than minister of Maori affairs—treasurer, associate minister of health and associate minister of immigration. The role of Maori members of parliament role has been to influence the development and implementation of new government policies, such as support for the development of Maori health providers, free health care for children under six years of age, and the creation of education, employment and business opportunities for Maori.

These developments have occurred in different ways, such as through agreed coalition policies and by the establishment of specific task forces to address particular issues that are important for Maori. The state of Maori mental health, for example, has been identified by the Maori Health Commission as an important area to address, with a growing number of Maori needing help in this area (Te Puni Kokiri, 1996).

The coalition arrangement did not last the full three-year election term, but elected members of Parliament and the government have now recognized the presence of Maori. There is now a growing interest by politicians and members of the public to change the current system by reducing the number of members who can be elected or appointed. There is a growing preference in some sectors in New Zealand to return to the previous system of one party being the major power holder.

Mental Health Developments in New Zealand

Since the 1980s, mental health services in New Zealand have been changing radically, influenced by changes occurring overseas. Unfortunately, in overseas developments it is never stated clearly whether changes have included their Indigenous peoples and what outcomes have been achieved for them.

Often, as in Australia, mental health research studies have little involvement of Aboriginal peoples, yet policy makers in New Zealand are keen to follow similar developments there and in other parts

of the world (Andrew, 1994). This means that whatever current mental health model is fashionable, Maori have to negotiate to be involved in these developments in New Zealand and to reorient them to recognize Maori cultural values and structures.

For example, in New Zealand there has been the progressive closure or downsizing of large psychiatric facilities, and the development of new community care services and new forensic services. In the implementation of all of these major changes, Maori participation has been limited. Maori involvement often has only been accepted only at the later stages of planning, when considering who will take responsibility for the care of Maori mental health consumers when a facility is to be closed, or who owns the land on which the facility stands and has been gifted for a specific purpose, and which may now have to be returned to its original owners or used to help settle a treaty grievance.

The above developments have also taken place against a background where Maori are increasingly being admitted to in-patient mental health facilities. It is now recognized that Maori have quite a different pattern of admission and discharge than non-Maori (Te Puni Kokiri, 1993 and 1997). For example, Maori males:

- have a higher rate of first admissions
- are two times more likely to be admitted on a non-voluntary basis
- have a 40% to 60% higher chance of readmission
- are more likely to be given a psychotic or schizophrenia diagnosis on readmission
- are more likely to be cared for in a forensic service or in the justice system.

Similar mental health patterns are also beginning to emerge for Maori women, with in-patient admissions rising and admission increasing for Maori women in their middle years (40 or more), despite falling admissions for non-Maori women.

Since the 1980s, Maori have made it clear through many *hui* (meetings) and ministerial inquiries (Mason, 1988 and 1996) that they wish to see the development of culturally appropriate services. Maori also request recognition of a Maori view of health, the Maori

language, Maori social structures and the place of Maori as *tangata whenua* in New Zealand.

Since early 1994, past and current governments have given the following policy directions for the development of mental health services:

- the requirement to purchase *kaupapa* Maori mental health services
- the requirement for all mainstream mental health services to offer a cultural assessment to Maori clients if they wish
- the right of clients in health and disability services to have their culture recognized in all health services
- the requirement for all health services to recognize the Treaty of Waitangi in planning and implementation.

These developments are significant, and research suggests that, though these policy statements are in place to guide purchasing and provision of mental health service developments in New Zealand, there is still a long way to meet Maori expectations of mental health services.

Maori Outcomes Research: Methodology

Almost no research has been undertaken in New Zealand in mental health from either a bicultural perspective or by Maori for Maori (Health Research Council of New Zealand, 1997). To identify Maori expectations of mental health services from both a bicultural and Maori perspective, a research project was designed that enabled Maori clients to speak freely of their experiences and outline the outcomes they would like from mental health services. Separately, but alongside, another series of focus groups were held that enabled non-Maori to discuss their expectations of mental health services.[2]

The Maori component of the research was undertaken in Rotorua, a small provincial city and a major centre for Maori and general tourism due to its geothermal location. Maori account for over a third of the total population in this town and surrounding area and are a significant client group for local community and in-patient mental health services.

With the support of local *iwi* and local Crown mental health serv-

ices, forty Maori mental health consumers who had been admitted to Lakeland Health in the two years 1996-98, and who were still receiving some form of care, were randomly selected and invited to participate in the study.

Participants were stratified to match the national profile of Maori in patient mental health clients in terms of age, gender and diagnosis, and only those considered too ill at the time of the study by their case worker were excluded from the invitation to participate.

Local Maori researchers were employed to help with the recruitment and the implementation of the research and to assist participation, such as help with transport and giving consumers confidence to contribute.

Participants contributed to the study through an informed consent process. The study received ethical approval, and participants were invited to participate in two focus groups: the first to discuss mental health consumers' expectations of mental health services, and the second to critique a number of outcome instruments developed overseas and one locally, to identify important questions for Maori who were missing.

All participants received a *koha* (a small sum of money) for their contribution to each focus group they were invited to attend. All focus groups were held on a *marae* (meeting place), and due regard was given to respecting Maori protocol and the expertise each consumer had through experience of mental health services.

Each focus group included between eight to twelve people, with a number being observers who had come to provide support.

Focus Groups

The following focus consumer groups were established:

- *Rangatahi* (young people): under 23 years of age (This group was predominantly male, reflecting the pattern of in-patient admission for *Rangatahi*.)
- *Wahine* (women): aged 23 to 37
- *Tane* (men): aged 23 to 37
- *Pakeke* (older people): 37 years and over

With the approval of mental health consumers, the researchers then approached nominated *whanau* (family) members to invite them to participate in a *whanau* focus group. A *koha* was also provided to this group to assist with costs associated with participation. An additional focus group was established for local Maori mental health workers

All focus groups were given the same questions to discuss questions covering the following broad themes:

- the meaning of wellness and unwellness
- the meaning of recovery
- the meaning of culture and its importance in service delivery
- the role and contribution of *whanau*, family and friends
- the role of the community
- the measurement of mental health outcomes
- the relationship between outcome measures and mental health policy
- the evaluation of specific mental health outcome measures.

The main views expressed through each of the focus groups will now be briefly discussed. This is to illustrate, first, how important it is for Maori to have the Treaty of Waitangi at the heart of mental health service planning and delivery, and second, to show how far New Zealand is from achieving this ideal, despite policy makers' best intentions.

Rangatahi

Maori youth or *Rangatahi* are increasingly being admitted to mental health services in New Zealand, often for alcohol and drug abuse, or for psychosis, which is considered influenced by heavy cannabis use. This group is also often considered difficult to treat by mental health workers because they are considered difficult to engage with in terms of communication and compliance with care.

As a group it was found that *Rangatahi*, despite their anger with their life and choices they had available, overall had high expectations of the quality of life they wanted. They desire "the opportunity to work, to have their own place, to be in control of their life, to be on the ball, to have peace of mind and, overall, to be happy."

In being mentally unwell, *Rangatahi* acknowledged that sometimes their illness limited their ability to function, such as "not being able to focus," "the need for medication" and, as a result of their mental state, they experienced "astral travelling." This last was described as "where the mind travels but the body is grounded." The issue of spirituality and the relationship it has to being Maori was seen often by this group as the underlying cause of their illness or pathway to wellness.

Rangatahi were also critical of the quality of care and the environment in which mental health care was provided for them. To achieve positive mental health for *Rangatahi*, they requested more:

- Maori doctors and health workers
- involvement of *kaumatua*
- Maori faces for Maori cases at Maori places
- Maori culture to be part of their treatment and recovery process
- sports to keep the body and mind fit and healthy
- Maori advocates to go between *tangata whaiora*, the *whanau* and the health system
- involvement of *whanau* in care
- Maori icons to be visible
- music
- research into Maori medicines that could be used in mental health.

They also asked for the establishment of a "buddy system," "Maori activities to be available" and "staff who could be mother figures," rather than young women who raised their sexual interest. They explained that many of the nurses who provided care for them were of a similar age to them and were often visible at pubs and clubs where they socialized. As a consequence they felt "*whakama*" (shy) in front of them, particularly in relation to personal matters.

Rangatahi demand change. They want "urgently the development of a Maori mental health service" that has the "full involvement of *Te Arawa*" and that could use the many local *marae* available.

They also want Maori to take responsibility for "our care and

well-being," for often they felt excluded and "isolated from their own people." This was visible to them in the availability of educational scholarships for talented young *Te Arawa* people, while no financial support was available for *Rangatahi* who had a mental illness.

Recovery was seen as a lonely process for *Rangatahi*, with little support available. This feeling of isolation was reinforced by the mental health service constantly changing, such as changing doctors who have "little heart" and who "treat us as just another statistic." *Rangatahi* also commented on how difficult it was to communicate and establish rapport with psychiatrists from overseas "who were not fluent with New Zealand's English or culture." As a consequence, they did not share their real thoughts, and their *whanau* encouraged them "not to speak to get out of hospital."

Culture was identified as central to the recovery of *Rangatahi*. It was suggested that "there is a need to totally overhaul Ward 4" (the acute admissions ward), and to "recognize the *whanau* as central to our well being whilst in in-patient care and in the community."

Wahine

Participants in the *Wahine* focus group were aged 23 to 37. This group is typical of many Maori women who have to juggle each day different roles and responsibilities, such as caring for children, maintaining links with *whanau*, managing social welfare to access health care and income, and managing their own health.

Being well for this group meant "not being stuck at home," "able to do everyday chores" and "having a sense of security that their children were not going to be taken away from them due to your illness." As well, their aim was to be independent and to live their lives without the "constant surveillance" and "intrusion" of mental health services.

Being unwell often meant for *Wahine* "having to ask for help from *whanau* members," having "your thoughts and actions reinterpreted," "having to accept medication" and having to "heal rifts your illness created amongst *whanau* members."

Recovery for *Wahine* meant "getting well and able to get on with

your life," "being independent," being "able to do things within your limits," being able to undertake education and training, and "having a job."

Wahine, like *Rangatahi*, clearly know the outcomes they expect from mental health services. Some examples are:

- knowledge of what services are available locally
- the involvement of *whanau*
- access to a greater number of Maori key workers
- having a national Maori consumer network in place throughout the country that can be accessed anywhere.

Wahine also requested:

- specific Maori activities for occupational therapy
- the police to be more educated and skilled to be able to treat *tangata whaiora* with respect
- greater economic and educational support for *whanau* so they can see and be involved in stages of recovery
- greater support from health and social services so they do not have to constantly fear losing their children.

Overall, it was considered that the needs of Maori women were different from men, so they needed different support systems in place. Examples cited were "Maori women need assurance that our kids are not going to be taken off us," and the new Maori women's support group was considered "a great idea."

Tane

Members of this group were male and similar in age to the *Wahine* focus group. Both focus groups were run at the same time and there was no criticism of these arrangements.[3] Instead, the specific *Tane* focus group gave participants the opportunity to discuss issues of importance to them.

Te taha wairua (spiritual matters) were at the forefront of the minds of *Tane*, and this was an integral part of their well being. *Tane* have a clear view of the difference between spirituality and Christianity. *Wairuatanga*, or spirituality, related to their identity of being Maori, and belonging to a *hapu* or tribal group.

Being well for *Tane* meant 'keeping out of the in-patient mental

health ward," "having peace of mind," "having balance between being Maori and *Pakeha*," being able to "cope with daily life" and "having *wairuatanga*."

To achieve positive outcomes, *Tane* requested:

- more Maori staff
- involvement of *kaumatua* and *kuia* (elders)
- more respect and ability to control one's own life
- more cultural understanding by the mental health system
- a more informed public that is more tolerant of mental illness
- greater recognition of the Treaty of Waitangi in action, not just in rhetoric
- greater involvement of *whanau* as valued members of the mental health team.

With the process of colonization in New Zealand and changes in the status of both Maori and non-Maori women in society today, many Maori men have been stripped of their traditional roles and responsibilities. Since Maori men have a higher rate of unemployment than non-Maori, are more likely to be imprisoned and their children to be cared for by their partners on their own, they have fewer opportunities to acquire symbols that give males status in mainstream society.

The current position of *Tane* in New Zealand society also affects their relationship with *Wahine* and with others. For example, men in this group did not talk about the importance of their relationships with women or children, but rather of their search for their identity.

Tane consider recognition of the Treaty of Waitangi and the explicit partnership between Maori and the Crown as important, and this 'needed to be reflected in the health care" they received. They concluded that the lack of recognition of the Treaty of Waitangi marginalized them, and that it was time for Maori to develop their own mental health system.

Achievement and maintenance of *wairuatanga* was important for Maori men because it gave them self-esteem and respect. The majority of participants in this group living in Rotorua saw no real hope for the future but a continued dependence on government welfare and health services for support and accommodation.

A number of *Tane* did not want to live with others in supportive accommodation. They desired their own place, such as their own flat, where they could choose with whom they lived. It is often assumed that since Maori value the collective in terms of relationship with *whanau*, *hapu* and *iwi* they do not have same aspirations as *Tauiwi* (non-Maori). However, for this group this was not true: they wanted to have the same choices as other citizens in the community (Te Puni Kokiri, 1998). Article three of the Treaty of Waitangi is fundamental to the well-being of this group.

Pakeke: Over 37

Pakeke included both males and females over the age of 37 years. In general, participants had had a long history of contact with the mental health services, and some had experienced long periods of institutionalized care—for example, at Tokanui Hospital. Together they had traveled many different painful paths, which they hoped many young people could avoid in the future.

This group expected and requested Maori *tikanga* to apply throughout the focus group process. Being well for this group meant "learning how to conform to live in the community," with their focus on "good hygiene," "taking my medication," "following instructions from health professionals" and "being able to cope and able to manage your illness," such as "not responding to hearing voices."

As a number of participants of this group had been institutionalized, being unwell meant "not in control." Their expectations of mental health service were:

- to be treated with respect
- to have access to health services when needed
- to have the opportunity to attend *hui* and social events which were important to them
- to have improved communication
- to have access to *kaumatua* and *knia*
- to have more Maori activities such as *kapa haka* (Maori action songs) and *te reo*
- to have opportunities for exercise.

From the collective experience of this group, *Pakeke* want to see

the development of Maori mental health services by Maori for Maori, so that *Rangatahi* did not have to walk the same path that they had traveled. They could rely on their memory and experiences of being both Maori and a mental health consumer.

Participants in this group were the most experienced in the process and effects of custodial care on their health. They were also clear that radical changes needed to be made in the mental health area. As a group, they were willing to assist, for they saw themselves as playing a key role in mental health service development.

Whanau

Whanau participants were linked to *tangata whaiora* from all four *tangata whaiora* groups. A number of consumers also attended the *whanau* sessions to *awhi* (support) their *whanau* members and reciprocate the support they had received. The *whanau* appreciated being invited to participate, for they often felt excluded from mental health services. They felt empowered when they could give something back to the mental health services for the care their kin and *whanau* had received.

Reciprocity is important for Maori, and the giving and receiving of *koha* (a gift) is symbolic: it gives both the giver and receiver *mana* (power). *Whanau* viewed health and well-being holistically. They were interested in broad health outcomes to be achieved for their kin. Like *tangata whaiora*, they considered being well meant "being in control of one's actions and thoughts," and for them their health was directly related to their kin. "If they were unwell they were unwell!" Life is "like a roller coaster, up and down."

Although they were expected to be there for their kin who had contact with the mental health system, *whanau* felt that they were not treated with respect. "Minimal information is shared....there is no real information or training given on how to give or supervise medication." For example, they wanted to know "what are the short and long-term effects of different types of medication," "*rongoa Maori* [Maori herbal medicines], it seems, is not an option."

No resources are available for kin to be involved in the recovery process, such as assistance with travel, accommodation and so forth.

Similar to *tangata whaiora*, the majority of Maori *whanau* have little discretionary income to provide support to sick kin.

Most Maori *whanau* depend on income support, and this level of funding does not allow for any extras. Their expectations of positive outcomes from mental health services were as follows:

- access to health care when needed
- more Maori staff
- education and information
- a support network for *whanau*
- financial assistance for *whanau* to be involved in treatment and the recovery process
- *whanau* involvement in assessment and development of care plans for kin.

Concern was raised about the close interface between mental health and prison services, and the difficulty of accessing kin in either system, particularly those who were in forensic services. The comment was made that if "*whanau* members do not know how to use and access the system, many Maori youth that are mentally unwell end up in the prison system rather than the mental health system." *Whanau* suggested that Maori should continually monitor the interface between the two systems. Maori should also develop outcome measures that are appropriate for Maori for application to the justice system.

Caring for kin was seen by *whanau* as a *kaitiaki* (guardian) responsibility, even though at times it can be a challenge. In carrying out a *kaitiaki* role, *whanau* members expected "that the mental health services should have resources and support structures in place for them so that they could be equal partners with the clinical team."

Maori Staff and Maori Providers

Maori staff employed by Lakeland Health and representatives of selected Maori health providers was invited to participate in a focus group. For Maori staff and providers being well meant "feeling good," "having good health that you know is going to continue," "a sense of security," "having a job, a home and being independent, being able to set goals and achieve them," and "being able to move physically

and able to have a quality of life."

Being unwell meant "not being in control," having to "rely on others" and being "not able to enjoy life." To meet the needs of *tangata whaiora* and *whanau*, they considered that "we need to step outside of the service to provide a service," "to have care plans in place," to recognize that "discharge is only the beginning" and "more kaupapa Maori services."

Maori mental health workers consider for successful mental health outcomes to be achieved for Maori there is a need for:

- safety
- Maori health to be recognized as a separate identity
- Maori staff to be visible
- Maori mental health consumers (patients) to be able to return to *whanau*
- Maori mental health consumers to be able to stay out of hospital
- Maori mental health consumers to be resourced to able to help care for each other (for example, through support groups) as they have the solutions to address many of their own problems
- Maori mental health consumers to have choices, such as being able to choose the nurse they want
- *kaumatua* and *kuia* to be involved in care
- the *whanau* room to be available for use by *whanau* at any time.

Discussion

This research highlights the diversity of outcomes Maori consumers, *whanau* members and staff expect from mental health services. It also highlights the differences in expectations across different age groups and between males and females (Durie, 1998).

Despite the different groups experiences with mental health services, they all share similar views of the outcomes they would like mental health services to achieve on their behalf or contribute which relate directly to recognition of the Treaty of Waitangi

Overall, the research shows that:

- All groups feel disenfranchised, and this is directly related to the lack of recognition of the Treaty of Waitangi at all levels of public policy.
- Mental health services do not include sufficient recognition of Maori cultural values and activities.
- There is a need to employ a greater number of Maori staff to meet the expectations of *tangata whaiora* and *whanau* members.
- There is a need for greater recognition and support for the involvement of kaumatua and kuia in all aspects of mental health care.
- There is a need for greater support for the involvement of the *whanau* in the whole process of assessment, treatment and recovery.
- Financial resources should be available to establish and support health-related services that are appropriate for *tangata whaiora* and *whanau*, and allow them to access health care in relation to need, be involved in the recovery process and maintain wellness.
- There is a need to support the development of Maori mental health and related health services to provide wider choices for *tangata whaiora* and *whanau*. Such services will also provide additional options for non-Maori.
- There is a need to support the development of appropriate outcome instruments that recognize and support Maori views of health and ill health.

As well as the issues outlined above, a number of themes emerged consistently across all of the focus groups that are important for Maori achieving or maintaining mental wellness and overall good health.

Control

This research shows that, although Maori may have rights equal to other citizens, in general Maori mental health consumers, *whanau* and Maori staff feel that they have little control over their lives.

The issue of control and the ability to determine one's own des-

tiny is a fundamental issue for all Indigenous marginalized populations. For Maori, the ability to be well and to maintain wellness is directly related to recognition of the Treaty of Waitangi.

Key decisions that govern the quality of life many Maori live are now determined by Crown agencies or their representatives. Maori are increasingly seeing this as intrusive, a breach of both privacy and a lack of recognition of the Treaty of Waitangi.

Recovery

The research has also identified that, for Maori, recovery from a mental illness is not a passive but an active process. It involves the consumer and the *whanau* in activities, which are meaningful to them, such as being active and physically fit, playing sport and having the opportunity to be involved in meaningful Maori activities. Learning Maori, knowledge of one's own tribal history and involvement of *kaumatua* and *kuia* are crucial components of good mental health care for Maori.

The lack of Maori content in Maori care means that in general most mental health services in New Zealand are not achieving the outcomes Maori want nor meeting their responsibilities under articles one and three of the Treaty of Waitangi. The results also suggest that tribal groups are also not meeting their responsibilities under article two in protecting and nurturing the development of Maori properties or *taonga* (treasures) such as people and Maori culture.

Overall, the results of this study reinforce the view that health and culture cannot be separated, but one; and similarly mental health and illness cannot be defined in isolation from the culture and society in which mental health care is practiced and provided.

Maori Participation

Maori involvement and participation in all stages of the planning, implementation and monitoring of service delivery is a fundamental right for Maori in terms of all three articles and the overall purpose of the Treaty of Waitangi. There is a strong and growing view now in Rotorua and in New Zealand generally for "Maori faces for Maori

cases at Maori places."

In New Zealand, there is a need to support Maori to develop the full continuum of comprehensive Maori mental health care, from health promotion to full acute in-patient and community-based mental health care. This will require new mental health workforce development strategies to be developed in New Zealand where education and training resources are invested in Maori workforce development rather than looking to overseas for the recruitment of trained mental health personnel.

The development of competent and culturally appropriate health personnel is an important issue for Indigenous peoples. It will increasingly become an issue as globalization is promoted and Indigenous cultures are devalued. The provision of health care, which has its own underlying cultural values and beliefs, has been a powerful tool that has contributed to the colonization of Indigenous peoples.

Conclusion

The simple results of this research clearly show that Maori are no different than other Indigenous peoples. Maori clearly know the outcomes they expect from good quality health care, but like other Indigenous peoples, Maori have to speak out loudly before their voices are heard and policy becomes a reality rather than words with little meaning or substance.

The Treaty of Waitangi is New Zealand's founding document, and provides now and in the future the platform for ongoing Maori and tribal development and Maori people's relationship with the Crown, and Maori relationships with other Indigenous peoples in an international setting.

Notes

1 This view is similar to the views of other Indigenous peoples, and it is this connection to the physical and spiritual world that generally links and differentiates Indigenous peoples from other population groups, and that and underlies the values and principles in the Draft Declaration of Indigenous Peoples (Te Puni Kokiri, 1994).

2 This research has been funded by the Health Research Council of New Zealand

3 Generally, most *hui* held on *marae* involve all present, and participants would not be separated into different groups on the basis of gender, age or tribal affiliation.

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