Piki Kotuku Te Awhi Hinengaro: A Tikanga Mori Community

Deanna Hollis

INTRODUCTION

Western culture has dominated New Zealand history for the last century and a half, threatening Maori culture to a point where it became extremely difficult for forms of knowledge and learning used by Maori to be considered legitimate. The political activism of Maori has reasserted the validity and legitimacy of Maori epistemology (Smith, 1999). This in turn has highlighted the importance of services that meet the needs of Maori, in a manner conducive to Maori ways of understanding, particularly in the health arena. Maori ideologies and philosophies are not new, having developed over centuries, through cultural experimentation and consolidation (Salmond, cited in Ruwhiu, 1999). The need for kaupapa Maori health care services arrived not only out of political pressure, but also out of a need for social responsibility, moral accountability, and social relevance. In doing so it contributes towards overcoming the growing disparities between Maori and non-Maori within our communities, although statistically Maori still represent a disproportionate percentage in many areas of dysfunction. Poor health is only one area from a list of issues such as lack of education, high representational figures in prisons, lower socio- economic status, youth-suicide and unemployment, to name but a few.

Piki Kotuku Te Awhi Hinengaro is one example of efforts made to overcome the inadequacies in services provided for Maori, and contributes to the demand for social change made by Maori as a political group. As a Tikanga Maori community health based service, it provides specialised alcohol and drug rehabilitation services incorporating Maori culture and epistemology. The philosophy of learning back to well-being provides a kaupapa for clinical and cultural assessment and treatment, early intervention strategies, whanau support, education and learning, as well as consultation/liaison services to tangata whaiora, rangatahi and whanau. As a community, Piki Kotuku represents, not only the geographical base of the Rangitaane iwi, but is also defined as a relational community, of those with substance abuse issues. Prevention and intervention are relatively new concepts for the mental health field, having been borrowed from the public health system.

The logic of prevention is easy to understand, having been referred to as far back as 1963 by John F. Kennedy in one presidential message as cited by Heller (1984): "Our attack must be focused on three major objectives: First we must seek out the causes of mental illness and mental retardation and eradicate them. Here, more than in any other area, 'an ounce of prevention is worth more than a pound of cure', for prevention is far more desirable for all concerned. It is far more economical and it is far more likely to be successful. Prevention will require both selected specific programs directed especially at known causes, and the general strengthening of our fundamental community, social welfare and educational programs which can do so much to eliminate or correct the harsh environmental conditions which often are associated with mental retardation and mental illness".

Prevention has many definitions, but has evolved into a concept containing three levels, of primary, secondary and tertiary prevention. Put in simple terms, primary prevention is designed to prevent the disorder from occurring or reoccurring at all. Secondary prevention attempts to intervene at the earliest possible stage, in order to reduce the severity of the disorder. Tertiary prevention attempts to reduce to a minimum, the degree of impairment resulting from an existing disorder (Bolman, 1969, cited in Heller, 1984). Piki Kotuku promotes strategies at all of these levels by providing education programs for youth, to deter or prevent alcohol and drug abuse, as well as programs for early intervention and long-term suffering of substance abuse. This involves applying prevention strategies, not only on a community wide basis, but also at the level of the environment, by having identified the population at risk. Risk groups exist, not only because of individual characteristics, but also as a result of being faced with situations that place high demands on adaptive capacity. By strengthening the coping capacity of

individuals, they are much more likely to adjust to the change-orientated focus of prevention strategies, maximizing the success of programs (Price, 1979, 1980, cited in Heller 1984).

George Albee (1980) developed a formula for devising models of primary prevention: Incidence equals organic causes and stress divided by competence, coping skills, self-esteem, and social support systems.

He highlights an interesting, if not disturbing point that if emotional stress can be prevented through the reduction of stress and the development of competence, there seems little point in directing all our clinical efforts at the treatment of symptoms. Albee also believed the model of prevention chosen directly affects the kind of people we help, and the kind of institutions we develop for intervention and prevention, which in turn dictates the kind of people suitable for delivering the service. Piki Kotuku is an illustration of this theory in action, with the development of intervention strategies for Maori, using Maori philosophy and implemented by Maori. This is a perfect example.

McFarlane-Nathan (1997) uses a quote by Marsden (1988, p.23) that sums up the situation for Maori:

"The Maori approach to life is holistic. There are no sharp divisions between culture, society and their institutions. Because of their holistic approach, Maori avoids the disjunction between the secular and spiritual, the compartmentalisation and isolation of one institution from another, and the piecemeal approach to problem and conflict resolution. The piecemeal approach has one major weakness. It prescribes for the symptoms, rather than the causes. The solutions are temporary or partial because the real problems are either not understood or are simply ignored. Eventually the problem flares up in a more virulent form. A holistic approach aims at the harmonisation, integration, and reconciliation of the various elements of the situation."

This holistic view of health is gradually being recognised as a valid model for health for Maori, as opposed to westernised medical models. Te Whare Tapa Wha model (Appendix 1, Durie, 1994) acknowledges the Maori world view of health, illustrating the necessary balance between physical, cultural, spiritual and mental dimensions which impact on day-to-day living, and which cannot be segregated. Along with these concepts, other Maori health models include turangawaewae, whenua, whakapapa, which are all associated with tribal links and land, giving individual Maori a sense of identity and belonging within their culture. Durie (1996. p190) makes these concepts better understood with this statement: "Depopulation was greatest where land alienation had been most extensive. Loss of land had more than economic implications. Personal and tribal identity were inextricably linked to turangawaewae and Papatuanuku (mother earth), and alienation from land carried with it a severe psychological toll, quite apart from loss of income and livelihood."

At the 1997 Maori Health Summit, Mason Durie summed up the determinants of mental health with these words: "Good mental health is not compatible with unemployment, demeaning and unrewarding work, negative experiences in school, and powerlessness. Marginalisation within society leads in turn to trapped life-styles where alcohol, drugs, abuse, violence, rejection, parental abandonment and self-fulfilling prophecies of failure are the rule." This is further emphasised when recognising the high disparities between Maori and non-Maori, as a consequence of major demographic, cultural and social changes. Put simply, colonisation and its dominant culture gave birth to the cultural alienation of Maori people, due to forced assimilation into dominant cultural practices, originally foreign to them (Lawson-Te Aho, 1998).

How Did This Happen?

Historical decisions, such as the signing of Te Tiriti 0 Waitangi and subsequent land confiscation, have had a significant impact on present health patterns (Howden-Chapman and Cram, 1998). The last three decades, in particular, have seen the advent of the 'urban Maori', who has not only departed from their land, but also from their cultural institutions, values and ways. When considering social participation and relationships it is important to consider what type of relationship Maori have with their whanau. The mental health of the individual is as much influenced by the whanau as it is by their own actions. It is a recognised fact that whanau well-being can not be sustained unless members maintained strong connections with

each other, with their cultural heritage (tikanga and te reo), to their environment and land (turangawaewae), and have control over their destiny and economic security (rangitiratanga). Whanau remains an important link to the mental health of its members. Homen-Chapman and Cram (1998) highlight the importance and diversity of Maori whanau with a quote from the Public Health Group (1997, p11): "Whanau structures are as dynamic as Maori society itself is dynamic. Whanau must remain the building block of that society. That is why whanau must remain central to any strategy to improve Maori health." Urbanization has led to the demise of traditional whanau links in many cases, which in turn has contributed deculturation, as this has always been the main source of knowledge and learning of things Maori. Weak and dysfunctional links to whanau have meant that different approaches need to be developed to overcome this issue.

Even for those who nurtured their whanau and its ties, deculturation became rampant as Maori were expected to assimilate into Pakeha society and ways. No longer able to converse in te reo outside of the home or marae, and estranged from tikanga Maori, a cultural void was created filled with those who had departed from Maoridom, but could not fit into the monocultural society of Pakeha. Along with the cultural void came a loss of identity, a lack of self-esteem and a sense of isolation. This was reflected in the fact that by the mid 1970's ethnic differences in educational achievement, income levels, occupational groupings, offending and standards of housing had reached significant proportions (Spoonley, 1982).

The definition of whanau has evolved over time to adapt to the environment in which it exists. The contemporary whanau unit has become more diversified, so that it not only includes more traditional integration of generations, but also extends to a wider inclusion of members, with older generations still playing an important and integral role in overall functioning of the whanau. Rachael Selby (1994) encapsulates what it is to be a member of a whanau, describing it not only as an historical family unit, but also a vibrant, demanding, supportive, active unit, which plays an important and necessary part in the lives of tangata whenua. This makes those who are active members of whanau richer for the experience, and those who choose to be ignorant, all the more poorer.

Durie (2001) describes supportive and reliable whanau as being a fundamental gateway to Te Ao Maori, which has the greatest influence on children and adolescents, and where the adoption of positive lifestyles and a strong sense of identity are shaped. It is believed that more than any other single institution, whanau have the potential to convert risk and threat into safety, security, and the realisation of human potential. It is these beliefs and the values of the whanau that make it unique from other family units. An analogy used to best describe the whanau is based on the writings of Emile Durkheim (1858-1917). He likened modern society to an organism, with everyone performing individual tasks, interdependent on each other, no one individual being able to function independently. The whanau is the body, and the values are the organs that allow it to function. It is interdependence, which is the key difference between Maori, and Pakeha cultures.

By looking at the community from an ecological perspective, some further insight can be gained into the types of interventions required to successfully overcome the issues at hand. Kelly (1966) is cited in Levine and Perkins (1997) as an early proponent of this analogy in community psychology, looking at the community from the level of the population, the ecosystem and biosphere, as well as the defined area of the community itself. Kelly articulated four principles for approaching problems in community intervention, including the concept of interdependence, which dominates Maori culture, as well as cycling of resources, adaptation and succession. The implication of interdependence, from a theoretical perspective, not only highlights the complexity of change, but also indicates the necessity of using the community as a unit of analysis, rather than at the person-centered level. Another implication is that health professionals working within communities can be found working in environments outside of the norm, such as on the marae in the case of Piki Kotuku. Cycling of resources can also be identified within Piki Kotuku, with the clinic being contracted to the DHB, using a reallocation of resources to fund the service. Kelly's third principle of adaptation describes the process by which we vary habits or characteristics to cope with

available or changing resources. Without adaptation, changes in resources or the presence of toxins threaten survival, with significant loss of resources being a common trigger for adaptive responding. This can be seen in the case of the loss of much tribal land for Maori, leading to the necessity of moving from rural to urban areas, as a means of survival. The advent of the urban Maori is an adaptation to available resources. The concept of adaptation is useful, as it highlights the need for resources, necessary to provide alternatives. It also helps to accept individual differences, and consider political solutions to the problem of poor person-environment fit. A change in the environment may create conditions more favorable to one population and less to another, as has been the case of colonisation in New Zealand. While interdependence teaches us to understand the community before trying to change it, the fourth ecological principal of succession implies that change, both natural and human, can contribute to the overall understanding of the situation.

As much as there is strength in independence, there is also strength in interdependence, through realising the importance of ones family, culture and roots. There is honor in putting other's needs ahead of personal gain, and there is wisdom in using traditional values to overcome the demands of modem society. The individual Maori who have lost their way, are often those who have chosen to function outside of the whanau. Maori society has changed significantly over the past three generations from rural to urban society, which has had an impact on Maori and Pakeha alike (Bradley, 1995). The contemporary whanau may not have the strength of ancestral ties that traditional whanau did, but the values that make it unique still live on. It is this realisation that will ensure the future of Maori culture, and the future of families in all forms.

Identifying Key Issues

Determinants of health are inextricably linked. For Maori, social disadvantage leading to less income appears to be the cause of many mental health issues, such as depressive reactions, stress, drug and alcohol misuse, behavioural problems and offending. Mental health in these forms is now a major risk to Maori, even though, as recently as the 1970's this was one area that was not an issue (Durie, 1994). It is a sad fact that those who are socially disadvantaged are more likely to be the victims of poverty, poor living conditions, school failure, unemployment and low income. In addition they are more likely to suffer the ill effects of poor life-style choices such as smoking, drug and alcohol abuse and poor nutrition. Anyone of these equates to less than optimal health in one form or another, and the fact that they often travel hand-in-hand makes the impact even harsher, particularly when added to a lack of, or suppressed cultural identity.

Health will always be influenced by more than one factor at any one given time. No single factor can be accused of being the sole determinant of ill health, poor well-being, or even death. While individuals make choices about their lives and how they are lived, those choices made that affect health accumulate over a lifetime, and are partially determined within economic, historic, political and cultural contexts (Lynch et al., 1997, cited in Howden-Chapman and Cram, 1998). Determinants of health are further emphasised by the recognition that as indigenous peoples, there are commonalties in health issues, as a result of colonisation. Disparities in self-destructive behaviours such as alcohol and drug abuse and suicide can be directly or indirectly linked to disparities in other areas such as socio-economic status. Lawson-Te Aho (1998) talks of the existence of a 'cultural depression', which is characterised by these self-destructive behaviours, as well as low self-esteem, loss of confidence, feelings of hopelessness and inadequacy and depression. Kelly (1990) supports these statements with the acknowledgement that social issues such as substance abuse require interdependent and long-lasting multiple interventions, rather than the single discipline based intervention that dominate at present.

To improve the status of health and reduce health disparities it is necessary to identify the main factors that determine health, specifically those that protect and promote good health, and those that influence poor health. While Maori have gained significant improvements in many services, statistically Maori still represent a disproportionate percentage in many areas of ill health. When poor mental health becomes the expected consequence of unacceptably high disparities between Maori and non-Maori, due to a lack of positive participation in society and the economy, it is time to review our sociological

constructs, and assess the situation, so that processes can be implemented to overcome these issues.

Bringing About Social Change

Rappaport (1977) presents several strategies for social change, using intervention strategies designed for this purpose. He highlights the importance of decreasing discomfort for individuals living with differences in a non-destructive way. Social problems are viewed as created by difficulties between primary groups, with emphasis on the group, rather than individual members, so analysing this from a social system and ecological perspective will be useful for understand and adjusting the functioning of that system. He also recognises that the values and goals underlying groups within a community may fail to be acknowledged and/or implemented by our social institutions

Health services must include a level of cultural awareness and cultural safety, which gives the power to the consumer to define the quality of service on subjective as well as clinical levels. There is an obligation on services providers to understand the deeper dimensions of the subjective and emotional responses of their clients as the power structure of our society remains largely mono-cultural, with Maori being the minority, whose main tool of negotiation is Te Tiriti O Waitangi. Health, including mental health, is more than just the absence of illness for Maori. It should therefore be recognised that improved health care services alone will not overcome the issues that generate such a high number of Maori consumers in mental health care. Political, social, cultural and clinical strategies need to be integrated into any plans to improve the mental health of Maori (Durie, 1994).

Durie developed a five-part strategy, derived from Te Tiriti O Waitangi, as a realistic approach to solutions that would lead to change, thereby eliminating disparities between Maori and non-Maori. From principles such as recognition, partnership, options, active protection, and autonomy, he proposed that factors such as access to a secure identity, active participation in society and the economy, aligned services, accelerated workforce development, as well as autonomy and control were the solution to this burdening issue. While the Mental Health Commission has acknowledged its obligations under the Treaty of Waitangi, and is totally supportive of the Government's objectives to eliminate disparities in mental health status between Maori and non-Maori, a constructive and coordinated approach is essential to achieve this. These principles are also in line with Rappaport's theory of empowerment (cited in Tolan et al., 1990) as a goal of social and community intervention. He defines this as being concerned with the many who are excluded by the majority of society on the basis of demo-graphic, physical or emotional difficulties, experienced either in the past or the present, as is certainly the case for Maori. The values behind empowerment theory suggest that the work should benefit society's outsiders in the context of people and issues concerned, by giving voice to them. Rappaport (1987) defines empowerment further with this statement:

"Empowerment is not only an individual psychological construct, it is also organisational, political, sociological, economic and spiritual. Our interests in racial and economic justice, in legal rights as well as human needs, in health care and educational justice, in competence as well as in a sense of community, are all captured in the idea of empowerment. The reason that we foster a society whose social policies appreciate cultural diversity (The Community Psychologist, 1986) is that we recognise that is only in such a society that empowerment can be widespread" (p.130).

Two areas that have been identified as crucial for the development of bicultural psychological services are Maori people trained in these areas, and the willingness of health and educational institutions to implement changes that will make bicultural services available and effective (Thomas, 1993). Durie (1999) acknowledged when presenting a paper to an international counselling conference, that accurate assessment is a critical function of mental health workers. It demands knowledge and experience in a broad range of mental health settings, as well as particular skills in assessing cultural identity, whanau relationships and socio-environmental links. While differing world-views that form the basis of Maori and Pakeha philosophy have led many to assume that only Maori can work with Maori, this is not realistic, mainly due to the lack of Maori working within the system. Therefore it is essential that mental

health workers are open to learning the philosophies of kaupapa Maori psychology, and that Maori are open to receiving help from those who have taken the time and empathy to learn and understand Maori culture (McFarlane-Nathan, 1997). A further initiative that is relatively new to the mental health arena is supporting the establishment of parallel Maori organisations and services to provide for Maori, by Maori.

CONCLUSION

Failure to respond to the demands of Te Tiriti O Waitangi has resulted in an imbalance of power, leaving westernised philosophies as the basis of the dominant Pakeha culture, including the healthcare system. This is reflected in the differences that exist between western psychology and kaupapa Maori psychology, and has led to a lack of cultural sensitivity in counselling and health care provision for Maori. Proposed solutions that could lead to change are the empowerment of Maori to control the provision of health services for Maori, as well as the bicultural education of Pakeha to overcome the differences in service delivery. This can only be achieved through major changes within the health care system, using a multi-tiered approach to resourcing so self-determination can occur with dignity and autonomy.

Psychology, the most recognised solution to poor mental health, is not just a science, but is also the study of human behaviour. Within that study there must be accountability, not only for scientific knowledge, but for cultural knowledge also. At present this knowledge remains largely ethnocentric, with the basis of psychology remaining in westernised methods, which in terms of good mental health are contradictory when compared to Maori worldviews. Our world is in a continual state of flux as cultures evolve and adapt to new environments, and this is as true for Maori as for anyone. While it is important to be flexible it is just as important to hold alive past traditions and customs for future generations. In assessing the changes necessary to eliminate the disparities between Maori and non-Maori, it is essential to keep alive the language and culture, and traditions associated with them. Without them the meaning of what it is to be Maori is lost. The contributions that Maori have made, and have yet still to make to New Zealand society will lead new generations towards a truly bicultural society and a multicultural future (Spoonley, 1988).

Piki Kotuku Te Awhi Hinengaro was established to meet the demand for social change, and the delivery of services that met the needs of Maori. This required the implementation of new programs and the modification of existing services to meet these requirements. It is perhaps too early to evaluate the success of Piki Kotuku at a statistical level, but indications are, judging from the increase in demand for their service, that it fills a gap in our health system. In the process of establishing this service, it became apparent that the program existed, not only in the context of the community for which it was established, but in a broader context also, in relation to the program. The broader context is that of the successful implementation of an intervention strategy, designed to overcome an alarming social issue for New Zealand - that of the rising statistics for Maori in the area of substance abuse, as well as providing a stepping stone for further Tikanga Maori programs to be established (Levine and Perkins, 1997).

"As the wave of new awareness lifts our people in the land
And the call for mana Maori's made by the voices of demand.
It's the voice of the staunch and the voice of the bold.
A voice of today, but so many years old. . ."
(From the song "Positive", by the group Aotearoa).

KEY WORDS Maori Values. Prevention. Interdependence. Health

ABSTRACT Being marginalized in society, stuck with less opportunity for education, frequently facing unemployment or underemployment, and living poverty-stricken does not enable Maori to achieve, to enjoy life, and to contribute to the larger community. The historical past has led to a situation where political, social and economic change is essential. Maori approaches to health and to ways of living depend upon holistic concepts and practices that are culturally appropriate. Treating symptoms, unfortunately, does not offer long-term solutions. The author identifies and describes a program, as an example of a way to offer alcohol and drug rehabilitation services that fit both philosophically and practically the contemporary needs evident in the Palmerston North community.

REFERENCES

Albee, G.: A competency model must replace the defect model, pp. 75-104 (1980). In: L. A. Bond and S.J. Rosen (Eds.): *Competence and Coping During Adulthood*. University Press of New England, Hanover, NH (1980).

Bradley, J.: Before you tango with our whanau you better know what makes us tick. *NZASW Social Work Review "Te Komako"*, **7(1):** 27-29 (1995).

Durie, M.: *Whaiora: Maori Health Development*. Oxford University Press, Auckland (1994).

Durie, M. *Paiheretia: An Integrated Approach to Counselling*. New Zealand Association of Counsellors International Conference, June 1999, Hamilton, New Zealand (1999).

Durie, M.: *Hauora Tangata: Maori Health Foundations*. 150.202 Study Guide. Massey University, Palmerston North (2001).

Heller, K.: Prevention and health promotion, pp. 172-210. In: *Psychology and Community Change,* Chapter 7, 2nd Ed. K. Heller, R.H. Price, S. Reinharz, S. Riger and A. Wandersman. Dorsey, Homewood, IL (1984).

Howden-Chapman, P. and Cram, F.: *Social, Economic and Cultural Determinants of Health*. Paper prepared for the National Health Committee (1998).

Kelly, J.G.: Changing contexts and the field of community psychology. *American Journal of Community Psychology*. **18(6):** 769-792 (1990).

Lawson-Te Aho, K.: *Kia Piki Te Ora O Te Taitamariki – A Maori Youth Suicide Prevention Strategy for Aotearoa.* A paper delivered to Te Oru Rangahau Maori Research and Development Conference, July 1998, Massey University (1998).

Levine, M. and Perkins, D.V.: *Principles of Community Psychology: Perceptions and Applications*. 2nd Ed. Oxford University Press, NY (1997).

McFarlane-Nathan, F.: The Bi-cultural Therapy Project. In: *Te Komako, New Zealand Association of Social Workers and Social Work Review*, IX (1997).

Thomas, D.R.: What are bicultural psychological services? *New Zealand Psychological Society Bulletin,* **76**: 5-14 and 33-39 (1993).

Rappaport, J.: *Community Psychology: Values, Research and Action.* Holt, Rinehart, and Winston, NY (1977).

Rappaport, J.: Terms of empowerment/Exemplars of Prevention: Toward a Theory for Community Psychology. *American Journal of Community Psychology*. **15(2):** 121-144 (1987).

Ruwhiu, L.: *The Politics of Maori Social Policy Development*. Massey University, Palmerston North (1999).

Selby, R.: My whanau. In: R. Munford and M. Nash (Eds.): *Social Work In Action.* Dunmore Press, Palmerston North (1994).

Spoonley, P.: *Ethnicity.* Oxford University Press, Auckland (1988).

Tolan, P., Keys, C. Chertok, F. and Jason, L.: *Researching Community Psychology – Issues of Theory and Methods.* American Psychological Association, Washington, D.C. (1990).

Author's Address: Deanna Hollis, 14D Monrad Street, Palmerston North, NEW ZEALAND
E-mail: hollisdee@hotmail.com