Culture clash: A discussion of the provision of mental health services for Maori consumers in New Zealand

Helen Jeffery

Abstract

The technical rational approach to knowledge generation, the way knowledge is valued, and the use of knowledge, guide the medical model and subsequent provision of health services in New Zealand. This approach to information is western in its cultural roots. Traditional Maori beliefs and practices regarding health and ill health are at variance with many aspects of western models of health care. A greater understanding and acceptance of Maori ways and changes to service provision are necessary if the resultant dissonance is to be resolved and practitioners in mental health are to provide more appropriate services for Maori. Parallels are drawn between many aspects of the occupational therapy culture and Maori culture with regards to provision of services in the mental health field.

Key words

Technical rational, Maori, culture, mental health services, occupational therapy

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Introduction

Occupational therapists are often involved in the provision of treatment to Maori consumers of mental health services. The current drive for evidence based practice, the western paradigm that dominates current psychiatric practice, and Maori culture all provide challenges for the therapist working in mental health.

This article explores assessment and treatment planning for Maori consumers of mental health services. The dissonance between the western way of psychiatric assessment and treatment, reinforced by government legislation and guidelines around best practice, and the cultural inappropriateness of this for Maori is becoming apparent. Maori Ways of Knowing and the Technical-Rational approach have been chosen as models through which to explore this dissonance.

Maori, as with any culture, have a diverse array of world-views and of translating situations and environments into meaning. This diversity makes it just as difficult to define Maori ways of knowing as non-Maori, and generalisations are at times inevitable. Royal, cited by Cunningham and Stanley (2003) contrasts three world views: a Western view focusing on a relationship with God as external, an Eastern view which focuses internally and on reaching within, and an Indigenous view which focuses on a seamless relationship with nature. Maori culture is part of this indigenous world-view, which contributes to particular differences in ways of viewing health and ill-health from western perspectives. The technical rational approach utilises scientific approaches developed and researched in the western scientific paradigm. This has a very real impact on how mental health services are delivered in New Zealand throughout the assessment and treatment process.

Treaty of Waitangi obligations and the government's attempts to meet these obligations are increasingly encouraging health practitioners toward more culturally appropriate assessment and treatment, particularly with 'by Maori-for Maori' (kaupapa) services. Part of the Mental Health Workforce Development Plan for developing services for Maori is to fund and facilitate the training of more Maori 'professionals'. Although this will address many of the issues it can be argued that the training in traditional professions (medical, nursing, psychology, occupational therapy etc) is itself influenced by western culture.

This article aims to enhance occupational therapists' awareness of this dissonance and offer an understanding of some of the causes of the resultant cultural issues. The article also encourages occupational therapists to examine occupational therapy as a distinct culture. Parallels between Maori and occupational therapy cultures are drawn.

Mental health service provision in New Zealand

When people in our society become unwell, either with physical illness, injury or mental illness; they tend to seek help from western medical fields or professions. Primary health care in New Zealand revolves around general medical practitioners,

Helen Jeffery, PG Cert OT, Dip OT, Occupational Therapist with Southland Mental Health Services.
Email for correspondence: helenjeffery@xtra.co.nz

and secondary health care is generally initiated by referral from general practitioners. Three quarters of those with mental disorders now receive their treatment from general practitioners with specialist mental health staff in community settings treating the remainder (Andrews & Brown, 2000). Individuals involved in provision of this health care are generally well recognised and considered "professional" by the very nature of their training and qualification. Most mental health services use a case management approach, and most stipulate that the case manager must be a qualified health "professional".

Currently, Mental Health Services are generally provided within a medical model paradigm for people who have a moderate to severe mental illness, as defined by the Diagnostic and Statistical Manual Volume IV (American Psychiatric Association DSM IV, 1994). Funding guidelines (Service Specifications, General Adult Mental Health and Psychiatric Disability) require that the formally diagnosed illness be at a moderate to severe level before referral to mental health services. Treatment is provided via what is termed as mainstream (non-Maori) and Kaupapa (Maori) services. A medical doctor or a psychologist makes formal diagnosis. DSM IV is the diagnostic guideline most often used, and is based on western theory of health and ill health. Assessment procedures are usually by interview and observation of appearance and behaviour. Some assessment tools in the form of checklists and questionnaires may be used (Andrews & Brown, 2000). Collateral information is also sought and considered in assessment.

The concept of culture, its impact on relationship and service provision and the development of cultural safety principles has enjoyed a growing recognition over the last fifteen years. The term 'cultural safety' was coined at a nursing hui in Christchurch where the issue of limited numbers of Maori nurses completing their training was being discussed. This marked the beginning of a wave of discussion, debate, research and writing which has resulted in the concept and practice of cultural safety becoming integral to not only nursing but also most other health professions. Cultural safety is defined by Te Kaunihera Tapuhi o Aotearoa/The Nursing Council of New Zealand (1996) as: "The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognises the impact of the nurse's culture on his or her own nursing practice" (p. 1).

The impact of expectations of culturally safe practice in mental health service provision has informed changes in attitude. Recognition of the power within helping relationships has facilitated the development of more kaupapa Maori services and has challenged professionals working in the western paradigm to reflect on their practice and make changes. Culturally safe practice is now an expectation of New Zealand occupational therapists. The New Zealand Occupational Therapy Board has incorporated an expectation of cultural safety in the Competencies for Registration as an Occupational Therapist. Entitled Culturally Safe Practice, the goal is to: "Provide a service that takes the socio cultural values of the client/tangata whaiora, family/whanau and significant others" into account (New Zealand Occupational Therapy Board, 2000).

Technical rational approach

'Professions' have developed within the origins of technical rationality, and a view widely accepted is that professional knowledge is the "application of scientific theory and technique to the instrumental problems of practice" (Schon, 1983, p. 30). The medical profession, and to a certain extent allied health professions have developed scientifically, with knowledge that is valued because it is based in scientific experiment and research. Professional development and the generation of knowledge have been strongly shaped by the model of Technical Rationality, whereby "professional activity consists in instrumental problem solving made rigorous by the application of scientific theory and technique" (Schon, 1983, p. 21). This definition of professionalism currently excludes Maori Mental Health workers, due primarily to the current limited research and scientific evidence supporting Maori styles of intervention.

Health professions have developed and expanded their knowledge and consequently their skills over the years, resulting in specialisation. Much of this knowledge is generated via scientific means. As more knowledge is generated, scientific processes facilitate further dissection and close examination of intricacies; things are looked at in more and more detail. This is often at variance with Maori views of knowledge generation, where a holistic approach and broad perspective is utilised. The way knowledge is developed in the Maori world is not only through analysing, dissecting or looking inwards, but more importantly through going outwards, looking to the relationships people have with wider systems. This includes relationship with families, with land and with sky (Durie, 1985).

As knowledge increases, professionals have to make more choices about their field of practice and subsequent specialisation (Schon, 1983). This specialisation has resulted in strict boundaries around services based on entry criteria that are invariably linked to medical psychiatric diagnosis. People who present with health issues must have their issues/problems clearly defined within the medical model before they can access a service. If they have a number of health related problems they may need to access a number of services. For example, mental health services and intellectual disability services in the case of a person with depression and a learning disability. This practice is in conflict with both Maori views of health and illness and the culture of occupational therapy which both favour a holistic approach.

Systems and boundaries also exist around the way services are provided. Standard assessment techniques in mental health have evolved to become the accepted norm; standardisation is developing in most areas of assessment and treatment planning. For instance, structured initial assessment forms, standard planning of psycho-education sessions, group work to a pre-planned format. In a review of literature McFarland (2001) concluded that some standardised interventions in mental health are generally superior to usual care, Assertive Community Treatment or primary care of depression. However, what was considered usual care is not defined. Disease-specific medical treatment protocols have heightened the need for accurate diagnostic procedures leading to further standardisation of interview

techniques such as the use of DSM IV Structured Clinical Interview (Zimmerman, 1994). Furthermore, increasing encouragement to incorporate evidence of effectiveness into our practice supports standardisation of our services to the highest quality (Lloyd-Smith, 1996). Although accepted assessment and diagnostic tools are culturally bound in the western paradigm and may have little meaning for Maori, they continue to be utilised in the assessment and treatment of the Maori population. Definitions of abnormality are linked to social and cultural norms. Definitions which guide treatment processes "reside within a reality which Maori people have not created or, indeed, been a party to" (Lawson Te-Aho, 1993, p. 26). It would appear definitions of quality treatment are also culturally bound.

Professionals are encouraged to formulate their treatment decisions based on the best available research evidence, a concept now known as Evidence Based Practice (EBP). Bury and Mead (1998) have outlined steps for the effective use of research and evidence, based on formulating practice questions and conducting appropriate literature searches to identify relevant research results. Emphasis is placed on the practitioners' ability to critically appraise the evidence, evaluate its specific usefulness, implement relevant findings in practice and then evaluate the impact of the changes (Bury & Mead). As stated by Geddes, Reynolds, Streiner, & Szatmari (1997) one essential ingredient in making mental health services clinically effective is to ensure that clinicians know how to use evidence. Guidelines for conducting systematic reviews of literature have been developed for clinicians to ease the path through the overwhelming amount of literature now available (Bannigan & Clegg, 1997; Lloyd-Smith, 1997). Clinicians also need easy access to high quality evidence (Geddes et al., 1997). Computer technology and relevant electronic databases make this information increasingly accessible.

Knowledge is often formulated in an academic environment removed from practice areas. This results in a problem of how formal knowledge is translated into practical knowledge and impacts on the effectiveness of research and evidence on clinical practice (Coles, 1996). The types of research conducted have been evaluated and hierarchies of scientific evidence exist based on validity and usefulness. In medicine, randomised controlled trials are considered to be of highest value. Assertions such as the following have been made:

> evidence was classified according to a hierarchy, with meta-analysis of randomised controlled trials and randomised controlled trials at the higher levels and with case studies and expert opinion at the lower levels. Ideally intervention should be based on the higher levels of evidence where these are available. (Sweetland & Craik, 2001, p. 256)

Occupational therapists, along with other health professionals, are encouraged to become increasingly involved in research, as consumers of research, participants in research and proactive researchers (Eakin et al., 1997). The College of Occupational Therapists in the United Kingdom (UK) have adopted a slogan that illustrates the extent of the move in this direction within the UK: "Research will be done by some, facilitated by others and implemented by all" (Dickenson, 2000, p. 243). A study of views and perceptions of occupational therapists of evidence-based practice was conducted by Curtin and Jaramazovic (2001). Results indicated that therapists are generally positive about EBP particularly regarding the benefits of improved clinical practice and raising the profile of occupational therapy as a method for obtaining funding. However, there was some concern that EBP did not suit the way occupational therapists work as it would narrow practice and make interventions less creative (Curtin & Jaramazovic).

A report on primary mental health strategies in New Zealand recommended that service delivery be based on best practice and interventions of known efficacy, and that mental health professionals provide the services (Ministry of Health, 2002). This illustrates the drive toward mainstream professionalism and a technical rational approach to knowledge in New Zealand mental health services, as per the trend in the western world.

A search of literature indicates that very little research specific to Maori and mental illness has ever been conducted. Best practice guidelines for kaupapa Maori services revolve around cultural processes and Maori views of health and ill-health, and are not based on research or scientific evidence (Milne, 2001). The gold standard for research does not appear to be culturally appropriate for Maori in the arena of mental health.

Maori ways of knowing

The concept of what it means to be Maori is itself shifting, as explored by Mason Durie (1997). He has identified many difficulties in clearly defining what being Maori means in the current political and social climate, and emphasised the fact that a more coherent picture of Maori realities needs to be painted before true health gains can be realised.

The limited amount of literature specific to Maori mental health indicates that this picture is far from being painted, particularly for the non-Maori mental health practitioner encouraged to use research-based evidence to guide practice. Almost ten years ago it was reported that little clinical research had been undertaken with the Maori population (Ministry of Maori Development, 1996). This situation has not markedly changed.

Durie (1997a) identified a lack of cultural identity as a cause for social and mental health problems. Historical alienation of Maori people from their land and their culture, legislation leading to the erosion of identity, and a lack of social and institutional opportunity for the maintenance of identity were all identified as contributing to this loss of identity. "If the mistakes of the past are to be avoided psychiatric treatment should not carry with it any risks to cultural identity" (Durie, p. 56).

According to the Ministry of Maori Development (1996) Maori are over-represented in almost all areas of Mental Health Services, and have higher rates of admission than non-Maori (Ministry of Maori Development 1996). Much of this has been identified as a "commentary on ineffective primary health care as [much as] the actual rates of illness" (Durie, 1999, p. 6).

Maori have a higher risk of psychiatric hospitalisation than non-Maori; admission rates for schizophrenia, substance abuse and personality disorder are particularly high for Maori compared with non-Maori. Admission under the Mental Health Act, and via the Criminal Justice Act is higher for Maori than non-Maori. These rates have increased considerably in the last 20 years (Sachdev, 1989). This perhaps indicates a decline in Maori mental health and continuing ineffectiveness of mental health services in treating Maori.

Maori view health as a "unity of soul/spirit, mind, body and family" (Durie, 1984, p. 1). The concept of separating mental health from other aspects of health and not having a holistic overview of the person and their relationship with whanau and community has little traditional meaning for the Maori. Maori society includes people who have passed away as an integral part of current society. Family is crucial to health, as is interdependence on each other. The western view of good mental health being equated with independence, self-motivation, self-sufficiency and severance of generational ties is the antithesis of Maori concepts of mental health.

> Interdependence (rather than independence) is considered desirable in Maori society, personal ambition is less healthy than ambition for their children, and blunt speaking is not necessarily regarded as the epitome of communication skills. To be totally independent and a separate person is, in Maori terms, unhealthy. (Durie, 1984, p. 8)

So what then is mental illness for Maori? The concepts of tapu and noa are critical in understanding Maori views on behaviour, including sickness behaviour. A state of tapu requires a person, article or area to be considered 'special', requiring respect, often avoidance, and overall a cautious approach (Durie, 1995). A breach of tapu was traditionally believed to be a major cause of illness. A state of noa was in contrast to tapu, free of restriction. Removal of tapu often depended on a tohunga, in many respects the tohunga was a combination of physician, judge and priest (Durie, 1997b).

Tapu was a major factor in illness for which there was no obvious external cause, known as mate Maori. Another concept in Maori culture that explains mate Maori is makutu:

> a person or family who has committed an offence could be rendered distraught in either physical or mental terms, by the incantations of a tohunga, often from a distance. Matuku, without intervention from another tohunga, could lead to death. (Durie, 1995, p. 342)

Although there was a spiritual basis to mate atua, it was closely linked with accepted social values and often suggested a departure from community norms either by the patient or the family. Clinical presentation of mate Maori is not dissimilar to severe depression with psychosis (Durie, 1995).

Therefore assessment, diagnosis and treatment of mental illness with the Maori population should focus on the Maori view of wellness. The restoration of cultural identity and care for the mauri (the essence of the person) are considered vital (Milne, 2001). Best practice guidelines for kaupapa Maori mental health services were established at a national hui in 2001 (Milne). These guidelines state assessment and treatment protocols need to follow established Maori protocols such as the full powhiri process, karakia, involvement of whanau and kaumatua, and the ability to have service users taken out of a state of tapu with the use of a tohunga. Adherence to this protocol in mainstream facilities, within mainstream systems is difficult procedurally, and at times difficult for mainstream clinicians to accept.

The Ministry of Health (2001) consultation document 'Building on Strengths' proposed the adoption of Mason Durie's framework for Maori health promotion – Te Pae Mahutonga (the Southern Cross). The six stars of the cross represent access to Te ao Maori (Mauriora), environmental protection (Waiora), healthy lifestyles (Toiora), participation in society (Te Oranga), leadership (Nga Manukura), and autonomy (Te Mana Whakahaere). The document also advocated for a holistic approach that recognised mental wellbeing is not just a health issue. Durie (1995) points out the current trend where in many respects the concepts of tapu, noa, matuku and the role of the tohunga provide a reality for Maori is not always found in western medicine.

Discussion

From a technical rational perspective, there is limited evidence specific to Maori mental health on which to base assessment and treatment. Mainstream assessment and treatment is the preference of clinically qualified professionals, the appropriateness and effectiveness of this for Maori is questionable. It can be argued that quantitative research is not a good fit with occupational therapy or with Maori views of knowledge. "The reality of occupational therapy practice is that it is impossible to find evidence from a Randomised Control Trial (RCT) for most of the treatment modalities used by occupational therapists in everyday practice" (Tse et al., 2000, p. 183). A search of current literature indicates the same could be said for many standard mental health treatment procedures, specifically with the Maori population. The first evidence based practice workshop for occupational therapists and creative arts therapists was held in England in 1996. Here concerns were voiced by a number of speakers about the appropriateness of quantitative research for therapy in mental health. "It was felt that qualitative research methods would provide a better basis for the understanding of therapy, especially with regard to mental health services where therapy goals are harder to define" (Pringle, 1996, p. 669).

The recent emergence of a journal of EBP for Mental Health (Evidence Based Practice for Mental Health, in collaboration with the Royal College of Psychiatrists, the British Psychological Society and the Royal College of Nursing) does in part meet the need for easy access to evidence in psychiatry, however occupational therapy specific input in that journal is limited and Maori seems non-existent. The fact that there is no journal of Maori health or for Maori health practitioners

further illustrates the difficulty in using evidence in culturally specific treatment.

Most health professionals in New Zealand are non-Maori. In 1996 only 6.9% of individuals engaged in the health workforce identified as Maori (Ministry of Health, 2001). Training by Maori for Maori in culturally specific assessment and treatment has resulted in an increase in these statistics in recent years however those courses are not generally accepted as 'professions' by mainstream services. Therefore Maori mental health workers are not generally case managers. The majority of Maori people with a moderate to severe mental illness are treated and supported primarily by clinicians of another culture, utilising practices that are not necessarily supported by evidence that they are effective for Maori. Maori knowledge is not necessarily generated in such a technical way and therefore often does not command the respect of mainstream professions. Maori views of mental illness, and causes for particular 'signs and symptoms' are not included in DSM IV resulting in at times, inappropriate diagnoses being made. Consequently Maori are often distrustful of and reluctant to access mental health services until absolutely essential. It would be interesting to have empirical data on how many people of Maori culture are effectively treated by whanau and reach a place of recovery without western model intervention.

Services are provided based on the diagnosis and medical or allied health professional intervention required and not generally based on culture or intervention preferences. Consequently the concept of holism which sits so comfortably with the occupational therapy profession and which is an integral part of Maori culture is not always possible in service provision.

There is very little evidence that would be acceptable in a technical rational perspective available to guide mental health practitioners when working with Maori, or to guide Maori practitioners who are working in a Kaupapa Maori way. Best practice recommendations following evidence generated in mental health are often unsuitable for Maori. For example, the use of Cognitive Behavioural Therapy in anxiety disorders (National Health Committee, 1998) relies on a separation of thoughts, feelings and actions. This would be a paradigm shift for many Maori. It would appear there is limited generation of Maori specific knowledge in health acceptable to the technical rationality model, and limited evidence based guidance available to Maori when changing or validating health care practices. Recent literature on Maori mental health seems to focus on explaining why mainstream approaches are not appropriate, but does not generate acceptable alternatives using a technical rational approach.

The development of Kaupapa Maori services, although in the early stages, does indicate a shift towards mainstream services being more accepting of Maori views of knowledge, and is facilitating the development of parallel services ultimately more appropriate for Maori. Aligned with this is the willingness of the Health Research Council of New Zealand to fund Maori research units, and encouragement for researchers to develop methodological frameworks that are relevant for Maori (Durie, 1999).

However there are limitations to the sole use of Kaupapa Maori in the treatment of mental illness. Although the illness itself may be viewed and defined in different terms by Maori, and although the cause may be linked to identity or culturally based issues, the behaviours and symptoms remain distressing for the individual and for the community. Maori are entitled to the benefit of western medications and treatments as much as non-Maori, and at this point in history, these ways are often of considerable benefit. Some western treatments that focus on symptom reduction are very effective at restoring a sense of wellbeing in the short term.

There is a trend towards government departments making a commitment towards ensuring culturally safe practice. The literature this has generated over the last fifteen years also indicates potential for a shift in attitudes and practices of non-Maori professionals.

Many Maori do not identify as Maori and choose to remain isolated from their cultural traditions. Although it can be argued from a Maori perspective that perhaps they do not have this choice, current New Zealand law and society support the concept of choice. In many community mental health teams consumers have choice regarding what treatments they receive and regarding whether or not they access Maori mental health services.

Many of the behaviours Maori exhibit, perhaps as a result of colonisation, are unacceptable to both Maori and non-Maori communities. The community as a whole has an expectation that mental health services or justice services will act on behalf of the individual. Much of the Maori approach to assisting people towards health is dependent on the availability of supportive and safe environments for Maori. In many communities these are limited. Respite houses, hospital wards and prisons are equipped to provide places of safety and although far from ideal they are at least available.

There are large gaps in western knowledge of Maori culture and the concepts of health and illness from a Maori perspective. These gaps appear more evident in mental health and Maori equivalents to mental illness than physical illness. Research is required in the areas of Kaupapa Maori mental health services, in the success of treatment provided by tohunga. Research is also needed to identify the effectiveness of Maori environments for the provision of care compared with mainstream supported accommodation or hospital. There is a gap in research regarding psychiatric diagnosis and aetiology of the conditions diagnosed. Quantitative research may not be appropriate within Maori culture or within occupational therapy culture. A study completed by Hammell (2001) in relation to qualitative research indicates that while not accepted as the norm for evidence, it is appropriate for the way occupational therapists work. "Like occupational therapy, qualitative research views individuals as inseparable from their social, cultural, physical, economic, political, historical and legal environments" (Hammell, p. 231). Perhaps qualitative research would also be a more appropriate method for gathering evidence for Maori?

Literature indicates mate Maori can be diagnosed in the western diagnostic framework as depression, anxiety, schizo-

phrenia or personality disorder. It would be interesting to know how these presentations would have responded to input from kaumatua and tohunga rather than medication. Many Maori can be supported through difficult times by whanau and by their marae. It would be interesting to identify how many of those admitted to psychiatric hospitals end up in the western system purely because they are estranged from their whanau and cultural identity. The difference between the cultures are becoming more evident to the western dominant culture, however the health implications for Maori seem to indicate that more research is required on treatment alternatives.

Conclusion

There are significant limitations to the technical rational model of knowledge generation. These limitations become particularly evident when practicing in the area of mental health as an occupational therapist or with Maori clients. Primary and secondary health systems in New Zealand depend on the technical rational approach in service planning and delivery. Aspects of this approach, such as the principles of evidence based practice, standardised assessment tools or the standard guidelines for treatment do not allow for the differences in experience of ill-health between cultures. They do not acknowledge the differences in knowledge generation between the cultures or enable Maori to effectively develop and deliver appropriate services for their own people. This impacts on the Maori individual's ability and willingness to both access services as consumers, and to train as professionals within the services.

Many parallels can be drawn between occupational therapy and aspects of Maori culture. Many of the threats to aspects of Maori culture are present for occupational therapists working in standard mental health services. This includes threats to concepts fundamental to both occupational therapy and Maori cultures such as holism, value of environment and extended community.

The professional culture of occupational therapy has the potential to practice effectively and safely with consumers from a Maori background, perhaps more so than any of the other traditional western medical professions. However, occupational therapists working in such systems need an understanding of the difficulties created by these clashes of culture, guidance and supervision from Maori colleagues and sensitivity to the impact of colonisation on Maori. As Jungerson (2002) stated "A culturally safe occupational therapist works with clients' realities and experiences from a critically aware perspective" (p. 9). This critical awareness must be fostered and developed within the profession in order for occupational therapists in New Zealand to be able to practice in a culturally safe manner with people of other cultures, including Maori.

> Just as it is a perfectly natural assumption to make that cultural realities offer a brand of truth for those who subscribe to them, it is a logical progression to identify that 'truth' is relative, and that no one body of knowledge can be considered to offer the 'truth' since 'truth' must be located within the cultural context of those who generate it and live by it and therefore accept it as real. (Anderson, cited by Lawson Te-Aho 1993, p. 25)

Key points

- Mainstream mental health services in New Zealand are provided primarily within the medical model, which has evolved from knowledge gained through a scientific or technical-rational paradigm.
- Traditional Maori views of health and of healing are at variance with many aspects of current mental health service provision.
- Parallels can be drawn between aspects of traditional Maori cultures and the culture of occupational therapy.
- Occupational therapy as a profession is well placed to take up the challenge of further developing culturally safe and effective practice, and working in partnership with Maori to enhance and positively influence mental health service provision for Maori.

Acknowledgement

Whilst researching for this article I have reflected on my own practice with Maori consumers and have a greater understanding of cultural safety. I am acutely aware my knowledge and understanding of Maori ways of knowing is limited by my own non-Maori culture. I have developed greater empathy for my Maori colleagues and understanding of the struggles they face in working effectively with their people in our system. I have come to the point where I have more questions and more doubts than before about current service provision for Maori, and huge respect for what Maori mental health teams are achieving. I am grateful for the patience and respect shown me by Maori colleagues and friends as we strive to work together.

Endorsement

Both ourselves, our Kaumatua and staff of Te Korowai Hou Ora have critiqued this journal article recently written and submitted by Helen Jeffery. We found her views and arguments of the Technical / Rational approach versus the Maori Way of Knowing to be sound, and in her case based on practical experience working with Maori in that setting. We generally agree with this composition of her work and fully endorse it as an accurate view of the current climate of issues facing Maori who enter mental health services today all over New Zealand.

Heoi Ano, Walter Fowler

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