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TE WHARE WĀNANGA O TE KURAHUNA
MAHI A ATUA
TĒNEI TE PŌ NAU MAI TE AO- TRANSFORMATION IN ACTION
Mahi a Atua:
Committed to developing indigenous systems for positive community outcomes.

Institutional Racism in Mental Health

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Be brave, be bold, be curious, and embrace the potential of Mahi a Atua and Te Kurahuna!

The pūrākau of Mataora, tells the story of an ariki (high chief) who had believed he was not accountable to anybody. However, guided by the love he had for his wife, Niwareka, Mataora became a kaitiaki for changing attitudes, beliefs and behaviour; firstly his own and then actively influencing changes in those around him. Guided by the knowledge embedded in the pūrākau of Mataora, Te Whare Wānanga o Te Kurahuna understands genuinely addressing equity for Māori requires an uniquely transformative Indigenous approach. Te Kurahuna is the kaitiaki of Mahi a Atua: a 'way of being' which privileges Indigenous knowledge and practice as the basis for addressing institutional racism, strengthening best practice, and realising equitable outcomes for Māori.[1]

Directly responding to evidence presented across multiple reports, inquiries and reviews that institutional racism must be addressed in order to realise equitable outcomes for Māori[2], alongside overtly operationalising the necessary paradigm shift to whānau ora and whānau-centred practice, Te Kurahuna and Mahi a Atua are centrally positioned to realise the systemic innovation and transformation across sectors which has long been called for. This paper, part of the *Tēnei te Po Nau Mai Te Ao - Transformation in Action Series*[3], examines institutional racism in mental health.

Introduction

Expert evidence presented to WAI2575 defined institutional racism as 'inaction in the face of need'.[4] All parties to the WAI 2575 Claim, including the Crown agreed that the severity and persistence of health inequity Māori continued to experience was an indicator that the health system was institutionally racist. Reflecting that inequity stems not only from differential access to services, but that services do not provide the same benefits to Māori, and in some cases actually serve to maintain disadvantage and increase inequity for Māori, the concept of 'inappropriate' action can be added to the definition of institutional racism.[5] 'Inappropriate' action includes those that occur when systems and services continue to

be founded upon and embedded within monocultural perspectives and worldviews, despite evidence which indicates the ineffectiveness of doing so.[6]

A Medically Dominated Mental Health System

Both the 2018 Government Inquiry into Mental Health & Addiction, and the Initial Mental Health & Wellbeing Commission identify a central element of the institutional racism perpetuating inequity for Māori across the mental health system is domination by a monocultural, bio-medical, deficit-oriented, risk-averse paradigm, with existing systems only serving to strengthen that domination.[7] The privileging of this bio-medical model as the foundation for 'usual care' in
mental health has persisted, with widely known significant inequity for Māori failing to evoke any demonstrable change to this dominant paradigm.[8]

Paradigms upon which understandings of mental health, distress and wellbeing are based guide and inform priorities for training, research, interventions, and understandings of what is considered effective and what is not.[9] Psychiatry and psychology, as behavioural sciences premised upon causal, universal, diagnostic-based models of mental disorder, are grounded within what some refer to as the 'technological paradigm'.[10] Based on a pathologised deficit model, mental health problems are viewed as resulting from universally described and individually located, biological, cognitive or emotional processing defects which exist independent of any broader context.[11] The technological mind-set also explicitly prioritises the status of the 'expert' professional, with innovation perceived as deriving from 'technical' experts only, as opposed to local communities themselves.[12]

Because these 'technological' ways of understanding mental illness are perceived of as being the only 'scientific' way to understand distress, universal, diagnostic-based models of mental illness are considered superior to any other forms of understanding, including Indigenous psychologies.[13] The past decade has seen the emergence of the Movement for Global Mental Health which seeks to train more workers around the world in assessment, diagnostic, and intervention technologies premised upon the biomedical technical paradigm of mental health.[14] There is however a growing counter-discourse concerned at the global exportation of this Western technological paradigm.

Challenging the dominant way of framing and understanding states of distress, critical psychiatry has centred its arguments on the way in which the technological approach disconnects discussions about distress from the 'non-technical' aspects of mental health, such as values and relationships. Echoing this view, the 2018 Government Inquiry into Mental Health & Addiction emphasised the way in which the dominant mental health paradigm served to reflect a "colonising world view largely hostile to Māori understandings of wellbeing",[15] in the process essentially eliminating the opportunity to consider relationships, meaning, values, beliefs and cultural practices important to Māori.[16] Related to colonial authority and the replacement of realities which result from the colonial project, the concept of 'mental health' is itself directly linked with economies of extraction, and Indigenous dispossession, relocation and containment.[17]

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Validity of Diagnostic Frameworks

Lying at the heart of the technical paradigm are diagnostic classification systems of disorder, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD). It is these diagnostic systems which regulate access to the medically dominated and controlled mental health system, with the majority of resources consumed by individualised psychiatric treatments, clinics and units.[19] Medically focused approaches which define distress as illness and as such require people to present as 'sick' in order to qualify for assistance, are not only restrictive, they are counter-productive.[20]

A lack of empirical evidence supporting the clinical utility of diagnostic frameworks is identified[21], emphasising that the intellectual and practical deficiencies of both mental health diagnostic typology and the therapeutic responses which occur as a result, have long been evidenced.[22] In addition, not only are mental health services as they are currently configured of limited effectiveness in treating mental health conditions, they may be more likely to prolong the difficulties faced.[23] Reflecting the colonial underpinnings of the dominant paradigm, and emphasising the fundamental importance of addressing this, it has been concluded that "diagnostic-based services are inherently institutionally racist, and no service that takes seriously trying to provide a culturally-appropriate service can claim to have made such forward strides in doing so without first abandoning the use of diagnostic-based thinking".[24]

The 2018 Government Inquiry into Mental Health & Addiction highlighted past mental illness prevalence survey methodology based on DSM diagnostic criteria was unable to capture the full range of challenges and distress encountered by communities. Likewise the commonly used terms 'mild', 'moderate' and 'severe' have been rejected as not capturing the full range of experiences and needs of those in distress. Whilst distress can be disabling, it can also be understood and addressed with a non-medicalised response, and as such should not be classified as illness.[25] In resisting the relevance and importance of contextual information, dominant paradigms of mental health contribute to the rigid medicalisation of problems that are more accurately categorised as "problems of living".[26] The British Psychological Society have been explicit in proposing a conceptual change to psychiatric classifications relating to emotional distress, and troubled or troubling behaviour, seeking to frame them not as illness but as reasonable responses to adverse social and cultural states of being.[27] As emphasised by the 2018 Government Inquiry into Mental Health & Addiction, the concept of 'distress' is able to encompass those who are severely distressed, through to those reacting 'normally' in response to stressful situations.[28]

> *... dominant disease-focused psychiatric classification systems continue to minimise psychosocial causal factors, in the process concealing links between people's experiences, distress and behaviour, and their social, cultural, familial and personal historical context.*[29]

Complex challenges, in particular addictions, homelessness, and poverty, are seen as significant drivers of compounding stressors for individuals, whānau and communities.[30] Furthermore, the evidence clearly shows wider social and economic determinants of health create a level of disadvantage for Māori even before there is engagement with the health system.[31] Given this, it is impossible to separate out the emergence and experience of mental distress from wider society and culture, including people's experiences of power and powerlessness. Supporting the importance of an enhanced emphasis on the integration of an equity lens within therapeutic contexts, utilising non-diagnostic understandings of emotional and psychological distress and troubling behaviour has been shown to reveal

complexities a diagnostic model serves to obscure.[32]

Aligned with Kaupapa Māori, whānau ora and cultural safety theory, Te Kurahuna draws on the work of the British Psychological Society (BPS) who through their 'Power Threat Meaning Framework' provide 'an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, as an alternative to psychiatric classification and diagnoses system';[33] and the position statement from the BPS Division of Clinical Psychology which calls for a paradigm shift in relation to the classification of behaviour and experience in relation to functional psychiatric diagnoses.[34] Central to the training provided by Te Kurahuna is that dominant disease-focused psychiatric classification systems continue to minimise psychosocial causal factors, in the process concealing links between people's experiences, distress and behaviour, and their social, cultural, familial and personal historical context.[35]

Whilst not denying biological understandings of distress and experiences, Te Kurahuna emphasises the evidence which shows current classification systems which have originated from and are embedded within western worldviews, such as the DSM, and ICD, are not reliable, valid or generalisable, nor do they expand understandings of how human beings relate to their wider environment.[36] Conversely, the evidence indicates how such systems are in reality discriminatory to a diverse range of groups, overlooking key elements such as ethnicity, sexuality, gender, class, spirituality and culture.[37]

Not only are there limitations in the utility of a diagnostically driven model for purposes such as determining interventions, developing treatment guidelines, and commissioning services, and research, the evidence also demonstrates the diagnostic model is over-reliant on psychiatric medications, whilst at the same time minimising the serious physical and psychological effects of those medications.[38]

Findings such as these reflect the importance of developing ways in which states of distress, madness, and dislocation in Indigenous societies can be discussed without automatically invoking the idiom, language, and assumptions of Western psychiatry.[39]

These views are consistent with whānau experiences in Aotearoa who criticise mental health services, both for their reliance on pharmaceutical approaches, as well as their failure to acknowledge the extent to which mental wellbeing is related to meaningful work, healthy relationships with family, whānau and community, good physical health, and strong connection to land, culture and history.[40] For many, the essential elements of effective assistance to deal with distress are the development of supportive and trusting therapeutic relationships based on narrative dialogue, relationship, and evolving meaning.[41] That the most effective support may be found in community led, culture-specific initiatives encompassing these elements is also highlighted.[42]

The 'Evidence'

> *That significant resources have been invested in the development of strategies and research that have failed to address inequity, alongside a constantly identified lack of investment in the development of mātauranga Māori approaches[43], evidences all the characteristics of institutional racism: a lack of action; inappropriate actions; and lack of consequence for poor outcomes.*

Despite it being recognised that unless the deeply engrained bias towards Western knowledge in mental health and wellbeing is addressed, inequity for Māori will persist,[44] the bio-medical model dominating mental health seeks the scaling-up of 'evidence-based' interventions.[45]

Consistent with transformative Kaupapa Māori theory, the priority given by Te Kurahuna and Mahi A Atua to Indigenising spaces recognises that these spaces, both physical and mental, have been dominated by a colonised world view which has, and continues to, deliberately exclude and delegitimise Indigenous world views and knowledge.[46]

However, because emotional and behavioural distress will always reflect prevailing social and cultural discourse and norms, meaning a global psychiatry or psychology simply cannot exist,[47] what is truly required is a scaling down of Western psychiatry and psychology.[48] Confronting the evidence regarding the history of harm manifest by psychiatry and psychology on Indigenous peoples is essential if the mental health system itself is to be fit for purpose.[49]

A lack of investment into growing the research and evaluation base for mātauranga Māori approaches to wellbeing, and the impacts of this, particularly in terms of ongoing perpetuation of the view that mātauranga approaches lack a robust evidence base, significantly contributes to
persistent systemic institutional racism in health systems.[50] Māori voice to 2018 Government Inquiry into Mental Health & Addiction expressed astonishment that ineffective, individualised, deficit-focused foreign models were still being imported and invested in. This astonishment resulted not only from the demonstrated lack of benefit for Māori from such models, but also the growing evidence base displaying the presence of successful Indigenous models.[51]

Also relevant to the issue of the evidence base is mātauranga Māori approaches being measured and assessed according to dominant paradigm frameworks, which have in themselves contributed to the very existence of health inequity for Māori.[52] With an identified need for culturally relevant evaluations and assessment mechanisms, quality for Māori must be defined by Māori,[53] with Māori data and analytical approaches serving to strengthen and broaden evidence bases for health care.[54] Reflecting an understanding of how inequities are created and maintained, commonly used measures of access, such as increased service utilisation, cannot automatically be considered a proxy for decreased inequity.[55]

Contradictions are clearly evident when the importance of not relying solely on international research to meet the specific needs of Aotearoa is emphasised, whilst at the same time stressing new initiatives should not be implemented in the absence of robust research and evaluation.[56] Building an evidence base around what works continues to be emphasised as important, however the same attention and consequence is not evident when the ineffectiveness of imported, mainstream models for Māori is apparent.

That significant resources have been invested in the development of strategies and research that have failed to address inequity, alongside a constantly identified lack of investment in the development of mātauranga Māori approaches[57], evidences all the characteristics of institutional racism: a lack of action; inappropriate actions; and lack of consequence for poor outcomes.

Te Kurahuna: Transforming a Paradigm

The overwhelming message provided to the 2018 Government Inquiry into Mental Health & Addiction was the need for a new approach. Māori voices to the Inquiry were clear that a radical transformation away from the existing dominant biomedical model to a wellbeing paradigm founded within Te Ao Māori was critical.[58] Central to the paradigm shift required if inequities for Māori are to be eliminated is a critique of the power relations responsible for the deliberate and systemic marginalisation of mātauranga Māori and the

resulting inequitable outcomes for Māori communities.[59] Critical questions can be raised regarding the limitations of attempting to address issues created by colonial authority with solutions which are themselves created within that same system.[60]

Te Kurahuna training recognises that systemic change entails the workforce understand ways in which historical factors have contributed to structuring opportunity that in turn unfairly disadvantage Māori.[61] An understanding of those factors then needs to be woven into therapeutic relationships with whānau, with a critical component of the paradigm shift sought by Te Kurahuna being whānau awareness of the wider context in which their distress is positioned is deliberately enhanced.

Consistent with transformative Kaupapa Māori theory, the priority given by Te Kurahuna and Mahi A Atua to Indigenising spaces recognises that these spaces, both physical and mental, have been dominated by a colonised world view which has, and continues to, deliberately exclude and delegitimise Indigenous world views and knowledge.[62] The prioritising of mātauranga Māori does not abandon Western approaches. By facilitating movement away from solely using Western ideology to categorise distress, and moving instead towards the elevation of other principles such as relationships, a quicker, more connected response is enabled, as opposed to one which serves to essentially disempower whānau and communities.[63]

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